youth

Article

What Young People Want from Clinicians: Youth-Informed Clinical Practice in Mental Health Care

Jessica Stubbing [1,2,*] and Kerry Gibson [2]

[1] Koi Tū: The Centre for Informed Futures, The University of Auckland, Auckland 1010, New Zealand
[2] School of Psychology, The University of Auckland, Auckland 1010, New Zealand
* Correspondence: jessica.stubbing@auckland.ac.nz

Abstract: Evidence from around the world consistently indicates young people experience high rates of mental ill-health, but frequently have limited engagement with treatment. One powerful influence on young people's engagement with mental health care is their relationships with treatment providers. A strong relationship with clinicians may be key to sustaining engagement, reducing dropout rates, and improving outcomes from treatment. However, research into young people's perspectives on qualities they value in their clinicians has often been limited by traditional methodologies which explore young people's attitudes to clinicians they have already worked with. This limits young people's responses and, therefore, our understanding of who an effective 'youth mental health clinician' could be. In this study, 94 young people from New Zealand participated in innovative research workshops in which they described their ideal mental health clinician. Thematic analysis identified five themes which summarized these young peoples' priorities for an ideal mental health clinician: Someone Like Me, Someone I Connect With, Someone Who Protects My Space, Someone Who Treats Me as an Equal, and Someone Who Works in the Right Way for Me. The presence and demonstration of these qualities may support both initial and sustained engagement with treatment, with the potential to improve outcomes for young people. Importantly, the connections between these themes highlight that young people are less likely to value 'relatability' as an isolated quality in their clinicians and most desire to work with clinicians who balance a warm and comfortable personal style with professional expertise and boundaries. These findings provide guidance for clinicians from a range of orientations who wish to work effectively with young people as to how they can adapt their approaches and seek feedback to improve their work with young people.

Keywords: youth; mental health; clinicians

check for updates

Citation: Stubbing, J.; Gibson, K. What Young People Want from Clinicians: Youth-Informed Clinical Practice in Mental Health Care. *Youth* **2022**, *2*, 538–555. https://doi.org/10.3390/youth2040039

Academic Editor: Todd Michael Franke

Received: 7 September 2022
Accepted: 21 October 2022
Published: 27 October 2022

Publisher's Note: MDPI stays neutral with regard to jurisdictional claims in published maps and institutional affiliations.

Copyright: © 2022 by the authors. Licensee MDPI, Basel, Switzerland. This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution (CC BY) license (https://creativecommons.org/licenses/by/4.0/).

1. Introduction

Young people globally need acceptable and accessible mental health treatment to address high incidence and prevalence of mental health problems [1], however youth (defined as young people aged 12–25) have the poorest engagement with treatment of any population group [2]. While this is a complex issue, it should be particularly concerning to mental health clinicians that even after accessing mental health treatment young people have very high drop-out rates [3]. There are several reasons young people may disengage from treatment, however many drop out of therapy because of dissatisfaction including dissatisfaction with their clinician [4].

Poor engagement of young people in mental health treatment is associated with a number of factors, including a shortage of services, perception of services, stigma, and understanding of mental health. There is clear evidence that the clinician, their style of working, and the therapeutic alliance are powerful factors in determining whether young people will engage with treatment. Young people's engagement in treatment is closely influenced by their clinician [5–8], and young people often report clinician qualities such as a collaborative attitude are among the most helpful aspects of their treatment [9–11]. By

contrast, young people who drop-out of services are more likely to report a poor therapeutic alliance [12–14], with those who do not like their therapist's approach or who have issues in their relationship being most likely to drop out without expressing their dissatisfaction directly to their clinician [4]. As such, if we intend to improve young people's engagement with mental health treatment, there is scope to focus on factors within the control of individual clinicians. Clinicians can be empowered to improve their relationships with young people, in order to reduce drop outs and improve engagement.

1.1. Clinician Factors and Adult Outcomes

Most research into the impact of clinician characteristics and the counselling relationship has focused on adults [15]. Beutler and colleagues (2004) have conceptualized clinician characteristics that impact outcomes as falling within four domains—observable traits, such as age, sex, and ethnicity; observable states, such as training and experience; inferred traits, such as personality style and therapeutic approach; and inferred states, such as the therapeutic relationship with a client. In adult research, there is varied evidence as to the impact of gender, ethnicity, and age of clinician on outcomes with some reporting no difference in outcomes based on these variables and others finding some evidence suggesting that demographics may impact outcome and early termination [16,17]. Similarly, results vary as to what type of training and experience improve outcomes [16]. Friendliness is consistently associated with good outcomes [16], but results vary as to the impact of other personality traits [17]. While many of these other domains may produce varied results, evidence suggests that 'inferred states', particularly the therapeutic alliance, may be most strongly associated with outcomes [18–20]. A recent meta-analysis of studies which reported correlations between therapeutic alliance and treatment outcomes found significant evidence that the therapeutic alliance is positively related to outcomes of treatment, above and beyond client or clinician characteristics [21]. As such, the therapeutic alliance has often been suggested to be the most important factor in sustaining engagement of adults [16]. Positive regard, genuineness, collaboration, warmth, sensitivity, and good communication are all key factors in building therapeutic alliance for adults [22].

1.2. Clinician Factors and Young People

By contrast, significantly less research investigating the impact of clinician factors on engagement and outcomes has been conducted with young people. In order to improve young people's engagement with clinicians we need greater understanding of this [23], particularly as young people's needs are likely to be different to adults given their different developmental priorities [24]. However, this body of literature is growing. For example, observable traits may be more impactful for young people than adults and appear to directly relate to inferred states including the therapeutic alliance, with research suggesting that gender and ethnicity matching can improve the therapeutic alliance, decrease drop-outs, and increase likeliness of completing treatment for young people [25].

1.3. Young People's Perspectives on Engagement with Clinicians

Traditionally, research into client/clinician relationships has not attended to the client's experiences of and perspectives on their own treatment but relies on independent ratings of quality of relationship or clinician perspectives [26]. For young people, this research often relies on parent and clinician reported outcomes [27]. Historically, mental health clients have often been perceived as unable to accurately comment on their own relationship with clinicians due to factors like their mental state [28], insight [29] and 'distorted' views [30]. However, research has identified that client perceptions of therapy correlate better with treatment outcomes than the views of professionals [31,32]. Additionally, it has been found that accommodating a client's preferences into the therapeutic relationship is correlated with decreased drop outs and improve outcomes [33]. Therefore, considering client's perspectives on what clinician factors they value in treatment is likely to be an effective way of improving engagement.

Even less research has been devoted to understanding young people's perspectives on working with clinicians [34]. This is likely to be related to traditional conceptualizations of young people as a 'difficult' group who lack the motivation and insight to comment on their experiences [35–37]. These historic attitudes that young people are incapable of making decisions about their treatment have lingered [38–40], and relate to beliefs that young people are immature and irrational [41]. However, young peoples' reported relationship with their clinician correlates closely with their treatment outcomes [42] suggesting young people's perspectives too are valuable and should be considered. It has been repeatedly noted that clients bring their own values, beliefs, experiences, and culture to therapy [43] and this includes young clients. Additionally, the United Nations have set precedent that young people should have the right to express their views about services provided to them [44]. As such, it is important that we prioritize hearing and understanding young people's perspectives on the clinicians they work with.

Young people have consistently indicated that the relationship with their clinician is important to them when seeking mental health treatment [26,45]. From the research that has been conducted, the most common factors which young people report improve their engagement with clinicians include being listened to [26,46,47]; experiencing a genuine connection [34,48]; feeling accepted without judgment or stigma [49–52]; having their autonomy respected [34,49]; a less hierarchical relationship [26,34,49,50,53,54]; a more informal and friendly relationship [34,49,50]; a sense of control and choice in their own care [34], which may be particularly significant for young men [55]; trust [56] particularly regarding confidentiality [46,57]; and empathy and care [49,50,52–54,58]. More supportive clinicians with strong communication, clear acceptance, empathy, and non-judgmental attitudes are valued highly [59]. Young people also indicate a preference for youth-friendly clinicians who understand their worldview [54,60] and who are not perceived as patronizing [46]. Young people also have a preference for multi-disciplinary teams, and the opportunity to work with a range of different professionals with different expertise [61].

Research into young people's priorities for their clinicians is consistent with what we might expect their priorities to be on the basis of developmental literature. Adolescence is widely accepted to be a key stage for identity development, and is associated with a growing desire for independence and autonomy [62–68]. As a result of this, young people are sensitive to attempts to control them [50] but tend to hold very little power [69]. Indeed, young people are less likely than other clients to have control over their engagement with mental health services, and are most often treated in services designed for and focused on adult priorities [70]. The disconnect between the priorities of young people and their adult clinicians could contribute to challenges engaging young people in treatment including high drop-out rates [71]. It is likely that respecting young people's priorities will aid the formation of a strong therapeutic relationship, in order to allow young people to truly engage in and become active participants in therapy [48]. This means reconsidering the ways in which we give voice to young people's perspectives [72,73] and providing more opportunities to explore the complex issue of agency for young people in a system which often provides them with little power [74].

1.4. The Present Study

This study was conducted in New Zealand, an island nation in the South Pacific. New Zealand has a young demographic, and the primary ethnic groups are Pakeha people (also known as New Zealand European, people who are descended from European immigrants or who recently immigrated from Europe), Māori people (The indigenous people of New Zealand), Pacific Island people (People recently immigrated from or descended from the people of the islands in the Pacific), Asian peoples (People recently immigrated from or descended from people who immgigrated from the Asian continent) and other immigrants, most commonly from Africa, the Middle East, and South America [75]. New Zealand young people have high rates of mental ill health and often have poor service access [76] but have rarely been consulted about their perspectives on treatment and clinicians [34].

This study explores New Zealand young people's views on the clinicians they would most like to work with when engaging in mental health treatment.

2. Materials and Methods

2.1. Participants

Ninety-four participants between the age of 16 and 25 with an interest or background in mental health participated in eight workshops across New Zealand. Participants responded to an advertisement calling for young people with personal experience or passion for mental health. Participants either contacted the researcher over email for further information or spoke directly to a representative at their organization (e.g., an elected teacher) to receive further information. Participants then completed an informed consent form which they could either return to the researchers over email or provide in person on the day of their workshop. Participants were offered a koha (gift) acknowledging their contribution to the research, equivalent to NZD$40.

Workshops were conducted in six different localities across New Zealand, including high density urban areas and townships of both the North and South Island. 4 workshops were held in New Zealand's 3 largest cities, with 35.1% of participants attending in these cities. 23.4% of participants attended workshops in smaller cities/regions of the South Island and 41.4% of participants attending workshops in smaller cities/regions of the North Island. 79% of participants were young women, 19% were young men, and 2% were non-binary. 68% of participants were Pakeha, 15% Māori, 10% Asian, mixed origins, and 6% Pacific Islanders. 9% were immigrants or international students from Asia, the Middle East, South America, and Europe. The ethnic diversity of the group closely resembled the diversity of New Zealand [75] with a slight under representation of most groups. While not all participants identified as service users (57% had been involved with mental health services) this study sought to also include those who may not have accessed services due to barriers including their pre-conceived notions of treatment, as well as those who had supported others with mental health challenges. Participants ranged in age from 16–25, with a mean age of 17.77. 16% identified as members of the LGBTQIA+ community, a category including all young people identifying their sexual orientation as something other than heterosexual/straight (including Lesbian, Gay, Bisexual, Pansexual, Queer/Questioning). All participants were either currently enrolled in secondary or tertiary education, or had graduated from secondary school. As such, no participants had disengaged from formal education.

2.2. Data Gathering

Given the clear value in hearing young people's perspectives on clinicians for improving their engagement and decreasing drop-outs, it is important that research considers their voices [34]. For this reason, a qualitative methodology was chosen to allow young people to share both depth and breadth of experiences. Much of the research that has been conducted thus far in this area has utilized traditional qualitative methodologies. However, challenges with traditional qualitative methodologies may limit young people's responses, including tendencies towards to peer agreement within focus groups, lack of depth to answers on surveys, and limited perspective taking in individual interviews [77].

In this study, we apply a novel methodology intended to elicit more creative solutions and encourage participants to see beyond the conventional social construction of the role of 'clinician' to new possibilities of what this role could look like. As such, we integrate traditional qualitative methodologies with participatory approaches. One such methodology is a collaborative workshop methodology, piloted by Calder-Dawe and Gavey [78] which aims to empower young people to develop solutions to problems that affect them and to improve their skills. In this way, the research process is intended to not only elicit information but also to be mutually beneficial to participants themselves in a process that is empowering to the young people who are involved.

The workshop method incorporated individual surveys at the beginning and ending, to elicit initial thoughts and any responses to the topics discussed that might not be

expressed such as if they would be considered socially undesirable. A group discussion typical of a focus group then occurred, in which young people responded to questions about their experiences of and goals for clinicians. This was followed by an activity in which young people responded to a prompt—a newspaper article about a proposed new mental health service. Lastly, participants engaged in creative group projects in which they worked in teams to design an ideal mental health service, including the ideal clinicians with whom they would like to work, which they then presented to the full group. It was noted that, in addition to addressing some challenges of qualitative research and eliciting nuanced and creative ideas, the mixed methods utilized in the workshops also allowed different participants to 'shine' in different activities, with some very vocal in discussions, others writing more, some annotating their newspaper articles, and others drawing services. Workshops lasted between two and three hours dependent on group size and were facilitated by the lead author, a training psychologist and doctoral candidate. The size of the focus group varied from three to twenty two participants.

2.3. Data Analysis

The data was analyzed using Braun and Clarke's [79] framework for thematic analysis, which involves identifying themes that reflect important trends in the data relevant to the research question.

Data was transcribed and combined with written survey answers. Prior to analysis, all identifying information was removed from the transcripts. The analysis began with immersion in the data and the full transcripts of the focus groups were read several times. All statements that related to young people's attitudes to or ideals for clinicians and mental health professionals were then extracted. These statements were then tentatively grouped into overarching categories that related to similar subjects using NVivo software for support given the large amount of data. These were then refined and shaped into themes. To ensure trustworthiness of the analysis, the themes were discussed, reviewed, and refined by both researchers at each stage of the analysis to ensure consensus and increase fidelity [80]. Examples that illustrated the beliefs of participants within each theme were extracted from the transcripts. Any remaining identifying information included in the examples was removed. Descriptors such as 'many' and 'a few' were used to indicate how frequently themes or specific ideas within a theme were addressed by participants but are not intended to imply the possibility for statistical generalization which is not appropriate in this kind of qualitative research.

Reflexivity is regarded as an important criteria for establishing the quality of qualitative research [81]. The first author is of mixed Māori and European heritage. She is a student on a doctoral clinical psychology program and a young person within the age range of our participants. The second author, a South African migrant to New Zealand, is a researcher and psychologist with experience of working clinically with young people. Given our professional positioning, it was important to resist and challenge tendencies to confine the accounts of participants into dominant explanations or notions of professionals, particularly our own ideals within our practice, and to pay attention to the different and novel ideas young people were proposing.

2.4. Ethical Considerations

Ethics approval was granted by the University of Auckland Ethics Committee. As is accepted in New Zealand as participants were 16 years and older, all participants provided their own informed consent to participate without need for parental permission. Participants were advised that they could share their participant information sheets and discuss their participation with family members and other trusted adults if they wished before deciding whether to participate or not. The researchers recognized the sensitivity of the research and care was taken to establish the safety of participants. Workshop conversations were monitored for content suggesting distress, and procedures were in place to support young people who were considered in need of services or intervention

on the basis of conversation. Participants were also provided with contact information for support services should they need it.

3. Results

Five themes were identified. These themes are presented separately for the purposes of the analysis, however they are not conceptually or theoretically independent. These themes are best considered synergistically; it is the combination of these ideas, and the overlap that exists in the space between them, that best represents the participant's perspectives on the ideal professional with whom they would like to work.

3.1. A Shared Background: Someone like Me

Across the workshops, young people consistently expressed a desire to work with mental health clinicians with whom they have shared experiences and identities. Participants expressed how this can provide a sense of being implicitly understood. As one participant stated: "We want diversity in them, with a range of background knowledge and experience similar to what we have".

Within this theme, participants spoke about several types of experience and identity which they would like to share with their professionals. The most common of these was a shared cultural background with their professional. Young people reported that this gives them a sense the professional will understand their cultural upbringing and their family dynamics better. This young person described it like this:

> *Your background and your religion has a lot to do with who you are and where your problems are based from so if you have a counsellor that's tailored to you then that will help you way more to open up cause they'll understand about cultural things.*

This need was particularly expressed by participants from minority ethnicities in New Zealand, particularly Pacific Islander and Māori participants, with agreement from their peers of other cultural backgrounds. One young Māori woman particularly drew attention to the ways in which cultural competence alone is not an acceptable alternative to culturally matched professionals, stating:

> *You can be a Pakeha [Non-Indigenous] person and go to different courses and things like that and you know, learn your mihi [formal greeting] and things like that, but at the same time it's not the same experience. And so I think it's really important to have Māori counsellors, specific counsellors, counsellors from different ethnicities all over so that we can understand the culture . . . My ideal counsellor would be like a Māori, young Māori woman . . . because it would make me feel comfortable to talk to them because I could feel like they can relate to me.*

Young people also reported a desire to work with professionals with whom they shared lived experience with mental ill health. They particularly emphasized how this can help them to feel understood, and increase feelings of safety. As this young person stated: "Counsellors with personal experience can be great as well because they can kind of understand what you're going through. Like, they've gone through similar things to you".

Participants spoke about a need for more potential for sexuality and gender matching among the professionals they work with. Young LGBTQ+ participants emphasized how training alone is not enough to educate a professional without the shared identity about what that experience is truly like, similar to discussions about cultural matching. They also spoke about the desire to see professionals of different gender identities, including both gender matching to men and women and the option to work with transgender or non-binary professionals.

Young people who participated in workshops emphasized the need for clinicians they see as sharing a background with them.

3.2. Friendliness: Someone I Connect with

Participants spoke about the need to connect with their professionals in order to work with them. Most participants spoke of a desire to have a more relaxed, friendly relationship with their professionals. For many, this meant knowing more about their professionals and having a stronger sense of their personality, interests, and background—rather than seeing them as just a "name and a title". One participant put it this way: "I feel like the more casual it is the more you take from them . . . Like, I take more advice from my friends than a counsellor so if the counsellor's your friend then I can take more on". Many of these young people pointed out that these relationships would take time to build, but described how more relaxed relationships would help them to feel more comfortable, and could reduce power dynamics and feelings of intimidation. As this participant shared: "It's less of like a power thing. It's more like, I guess we could be friends if we wanted to even though they're your counsellor. It's like, I could see you as a friend".

Participants spoke about how age could be a factor that helps them connect with professionals, particularly younger professionals whom they might perceive as more relatable due to being closer in age to them. This young person put it as: "I feel like . . . other people might not understand the things that teenagers are going through whereas like younger people might because they're around a similar age to us".

Some participants expressed discomfort about working with professionals who were much older than them due to feeling they do not understand them and might have old-fashioned judgments of them. As this participant said: "It's just a bit awkward and uncomfortable, especially if you're like 20 years younger than the person who's talking to you. Like, I just feel like old people have that belief that like, you know, self-harming's attention seeking".

However, to contrast this perspective, many participants also spoke about how they might connect more with older professionals. One young person stated their ideal age for a professional was over 40 because: "You know that they have a lot more experience in their life and can be, you know, wiser".

Finally, participants spoke about the importance of humble professionals who would be able to admit when they were not the right fit for them, and could be honest about what they know and do not know. One described it as: "They can be honest about this . . . rather than we are the all-knowing gods of mental health and everything you are experiencing is distilled into this word and will be handled like this".

Across the workshops, young people emphasized the importance of working with professionals whom they connect with, which could be related to their style of relating, friendliness, age, and humility.

3.3. Professionalism: Someone Who Protects My Space

Young people expressed their need to work with professionals who they believed were capable of keeping them safe and effectively treating them. For some participants it was important to have the safety providing by professional boundaries. While a sense of connection was valuable, some participants explained that they wanted to feel they could focus on their own needs rather than the person they were speaking to. That is, the distinction between working with a 'friendly professional' and a 'friend'. As this participant put it:

> *Professionalism is extremely important . . . if your counsellor's telling you about their day and their work, it's like 'I don't really care, this is meant to be about me'. But like it sounds selfish but like that is what you're paying for and that's what you're going for.*

Some of these participants described how they appreciated the stance of a professional who can give more objective advice: "I think that if you make a counsellor basically become your friend, your friends are more likely to not tell you the complete truth of what they think of a situation".

Many participants extended this balance between friendliness and safety from a professional to the issue of confidentiality. This participant spoke about the importance of both a relaxed connection and professionalism in creating a safe space: "If people want to see a therapist it needs to be a chill environment where you can feel safe, where they're not going to give away your secrets".

Many participants shared their frustration with policies around confidentiality and parents being notified about risk, noting how restrictions around confidentiality had prevented them from being honest with clinicians. For several participants, there was frustration with not understanding what information will be kept confidential or not. One expressed "I don't know, where is that line? Like, it's not really clear". For many, it was felt that there was need for greater transparency about bounds of confidentiality. In general, young people who understood the legal bounds on confidentiality were the most accepting of the occasional need to break confidentiality.

However, the greatest frustration for young people around confidentiality was feeling as though it was breached unnecessarily and unprofessionally, outside of situations where there were safety concerns. Situations like these were the majority of breached confidentiality experiences described. Many described having teachers told the content of their visits to school counsellors. One described an experience: "They tell you it's confidential and then they go around telling everyone and it's like 'I thought this service was confidential!'".

Young people expressed how, for them, professionalism would include transparency, and the clinician sharing their interpretation of events and their justification for treatment. As one participant put it: "They can inform and explain rather than tell you. You can see the reasoning behind what they're saying and that comes with a respect that you deserve to know".

Many participants spoke about their desire to work with professional and competent clinicians, who they trusted to adhere to professional practices like boundaries, confidentiality, and transparency.

3.4. Respect: Someone Who Treats Me as an Equal

Young people across the workshops expressed a need for clinicians who are respectful of them and their experiences. Underlying this desire was a substantial number of negative experiences around disrespectful and patronizing clinicians.

Young people expressed how respectful clinicians would take them and their experiences seriously. Many participants described interactions with professionals who did not believe their problems, blamed them for situations they had been through, or told them to "just get over it." Many adolescent participants particularly pointed out how they felt their problems were dismissed because they were teenagers. Older participants who had experienced mental health services both as a teenager and as a young adult also noted this and reflected on how their experience in mental health services had changed, with one stating:

> *I've noticed a difference from being most recently in the past year compared to being in it when I was 15 . . . They really treat you differently in the sense that you don't deserve to know what's going on with you and you don't really deserve to know what [they're] thinking about. . . . and I felt like I was being belittled or patronized or disrespected and there's no worse feeling . . . I've realized they're kind of reinforcing that vulnerability rather than empowering you.*

Other young people spoke about how being respected as a young person includes not being 'babied' or patronized by clinicians. These young people described times when they had sought mental health treatment and were offered models that felt like they were designed for much younger children. As this participant states:

> *A lot of counsellor's kind of use similar treatments to how they would like a child. Like a ten year old. Like, one lady like got a bunch of little lego characters and shit and told me*

> *to like put them in places around me . . . I saw like a lot of the same things being used as when I was like six.*

Participants described a respectful clinician as listening, believing them, and "really soaking up what the person is saying and just taking it in and thinking about it".

Young people also described the importance of being compassionate, stating that they "should be validated" by their clinicians. This stood in contrast to many young people's experiences of questioning the compassion of their clinicians. As one said: "It's almost like they see the patients as more of like a pay check maybe".

Participants expressed a desire to feel respected by their clinicians, through validation and compassion as opposed to being patronized.

3.5. Responds to the Individual: Someone Who Works in the Right Way for Me

Young people across the workshops outlined how their ideal clinician would be someone who works in a way that aligns with their personal beliefs. Young people spoke passionately about their desire for having options and some kind of agency in who [they're] dealing with. For many, this meant being able to engage with their preferred type of clinician. Participants expressed desire to be able to choose whether they worked with a range of clinicians including counsellors, psychologists, psychiatrists, occupational therapists, speech language therapists, nurses, and peer support workers. For some young people, there was a perception that they were not being offered treatments to properly address their needs. This participant describes her experience like this:

> *When I did counselling it was like, just every week instead of what was meant to be happening, like dealing with the feelings I was having . . . it was like, 'you know what will make you happy? Let's make cupcakes this week!' and it was like 'Can we talk about my trauma?' And it was like 'No! We're gonna make cupcakes!'*

These participants often expressed a need for more therapeutic approaches that they perceived as helping them more directly. Several participants expressed frustration that they had not been offered evidence based treatment options including cognitive behavioral therapy and dialectical behavior therapy, such as this young person who said:

> *There was this type of therapy . . . CBT or something. Cognitive behavioral therapy. Yeah, I think that would be helpful. Because my psychologist talked about it but we never got to it or she never really even explained it to me so I had to like research it myself.*

Other participants by contrast described seeking alternative ways to interact with their therapists, such as by expressing themselves through crafts and music, when they found talking too uncomfortable. As one said: "I reckon there needs to be alternative ways of mental health as well if that makes sense. Like there can't just be sitting down and talking to someone because some people just don't express like that".

Overall, these participants spoke about a desire to work more collaboratively with their clinicians, being offered choices, and having a say in treatment planning. One put this as: "You are not obliged or forced to do anything. You are in control of this whole process".

For many other participants, having agency over therapeutic decisions meant having the option to choose whether or not they would take medications, having their options properly explained to them and presented in collaboration with other therapy models. As one participant described:

> *They might say an option is to take medication as well . . . but you don't have to. Everything comes with the support that this can happen but you don't have to because you're still a human being and you should still feel as though you have agency, no matter what age you are.*

For many participants, it was important that the professionals working with them consider their treatment individually. As this participant put it:

> *Young people sort of get put into like a homogenous group. We're all young people, since we're all the same age we all think exactly the same, but like that's just not true at all.*

> *There's people with different political beliefs, different upbringings, everything like that. And so there's sort of not really one method that can cure every one of their, you know, mental health problems.*

For other participants, part of the value of being professional meant that clinicians had specialist knowledge in particular areas of mental health. For these participants, there was often a feeling that a more specialized clinician would be more educated and focused on the problems of particular concern to them. As this participant described:

> *I reckon . . . it should be different counsellors that study different like departments. So it's more personalized to go to not just one counsellor that you know, knows a bit of everything. If you've got one specific problem you've got a specific person that can help you.*

Participants were eager for individualized therapy approaches that take into account their unique needs. One young person described how they felt professionals could meet this need:

> *In my opinion, a good counsellor . . . should be able to forsee this, should be able to see the sort of things that would benefit an individual case because everyone's unique and certainly some strategies will be more effective on them than others. Others may really just benefit from talking and others might benefit from more getting out and doing things. And that just fits into a whole there's no one size fits all kind of rule.*

Young people who participated in workshops emphasized the importance of working with clinicians who respect their unique needs and values in the treatment planning process.

4. Discussion

This analysis identified five themes that describe the ideal mental health professionals young people would like to be able to work with: a clinician with a shared background, who they connect with, and is professional, respectful, and responsive to their individual needs. The significance of these results is bolstered by the consistency between our findings and other research that has been conducted with young people. This study offers a framework which combines disparate research across fields relating to different kinds of mental health professional.

The need for gender and ethnicity matching between mental health professionals and clients has been raised in a number of studies, and it has been found that for young people gender and ethnicity matching can improve the therapeutic alliance and increase likeliness of completing treatment [25]. While gender matching has often been seen as a stronger preference among young women than men, it may also be valued by younger men [82]. Some research has suggested that young people value clinicians who are similar to them in age, gender, and experience as this improves relatability [83]. Research investigating the impact of ethnicity matching on therapeutic outcome is varied, with one meta-analysis identifying small impacts of ethnicity matching on outcomes for most people and an overall decline in preference for ethnicity matching among adults in recent decades [84]. The importance of ethnicity matching to young people specifically could be related to the importance of identity formation during this stage of development for young people. Interdisciplinary research has identified that ethnic identity formation is a complex and important process for young people, particularly of minority ethnicities, and that the experience of an 'othered' ethnic identity can impact a young person's sense of agency [85,86]. As such, reducing the feeling of 'othering' and creating opportunities for identity formation within the therapeutic alliance by ethnicity matching may increase a young person's sense of empowerment and of being understood rather than othered within their treatment.

Despite the importance of ethnicity matching to young people and its potential benefits to their therapeutic outcomes, many regions face the challenge of having few clinicians from minority ethnicities who are also often over-represented in mental health system. In order to meet the desire for gender, ethnicity, and sexuality matching among young people

it is important to consider how training programs can contribute to increasing the number of professionals of minority ethnicity and sexuality moving into the workforce. At present, ethnicity, gender, and sexuality matching will often not be possible. As such, it may also important for clinicians to consider turning attention to the ways in which they may not be the ideal therapist for their young client, to acknowledge this, and seek supervision and consultation with others who hold these identities.

Very little research has evaluated if there is any impact on therapeutic outcomes from working with professionals who have lived experience with mental health. This may be due to traditional professional boundaries, which discourage clinicians from sharing this kind of experience with their clients. There may be room to evaluate whether, even without disclosing experience to clients, there is a difference in outcome for professionals with and without their own lived experience.

It has been well established that young people prefer to work with professionals who they perceive as approachable, compassionate, warm, friendly, and authentic (see [87] for a review of such studies). These traits are typically depicted as important for how they facilitate the process of building rapport, or a relationship, between client and clinician. While clearly a priority for young people, this should also be a priority for professionals given well established evidence that rapport is a key component in effective youth mental health care [12,13,88,89]. This study provides additional evidence that this is highly valued among young people, and that friendliness and a relaxed environment may be key to engaging some young people in treatment.

However, focusing on building a connection with a client can often be misperceived as unprofessionalism due to misconceptions of a false dichotomy between connection and professionalism. Young people in this study demonstrated that they do not value connection or professionalism in isolation from each other, but rather would prefer to work with a professional who is equally capable of connecting with them and conducting themselves professionally. This includes someone who is experienced and capable of holding their needs, who maintains confidentiality, informs them of their plans, and can clearly articulate what they are doing and why. This is consistent with the results of meta-analysis suggesting a key desire for young people is information about what their professionals are doing and why [87] and other studies demonstrating that young people value experienced and competent clinicians [90] and clinicians with boundaries and integrity [49]. When considered together, young people's desires for clinicians who are both friendly and professional show that it is not sufficient for young people to feel a rapport with their clinician. They also need to have faith that their professionals have the competence to adequately treat them, and trust that they will adhere to professional practices. Rather than perceiving professionalism and connection as two ends of a dialectic, it is important to consider how clinicians can embody both of these practices.

One way professionals may integrate this into their work can be to allow young people to establish the kind of relationship they would like to have and meet them in their need. For example, if a young client sets a tone of more relaxed communication, a professional might consider how they can meet this in a way that still allows them to respect professional boundaries such as by sharing some of their interests, professional background, or sense of humor, or otherwise engaging in a more relaxed style. If a client prefers more professional boundaries, rather than assuming they would prefer to be more relaxed given their age, it may be more appropriate to prioritize professionalism and consider why they might be in need of reassurance of this.

One particular area of practice where professionalism and connection can appear to contrast is around confidentiality. Young people have continually raised their concerns about confidentiality [57], and these challenges will be very familiar to all clinicians who work with young people. What may surprise clinicians is that young people in our study were understanding of the need to breach confidentiality when this had been explained to them fully and they were aware of the 'line', even if they did not like this need. What young people struggle with most often is feeling their clinicians are unprofessionally or

unnecessarily breaching confidentiality. This is consistent with research finding that young people with poor experiences of therapy often report that processes involved in treatment were not properly explained to them [54,91]. There is room to navigate confidentiality professionally while still building connection. By practicing transparently, professionals can empower young clients and position themselves as allies to them on their journey to better mental health. One direction professionals could pursue is ensuring they are informing their clients of their policies around confidentiality.

A respectful professional is someone who is perceived as validating and who takes their client seriously. This is distinct from someone you connect with, as a young person may build rapport with a professional who then does not take them seriously. Additionally, clinicians who focus on professionalism may not prioritize respecting their young client's perspective. Desires for respectful clinicians who take their young clients seriously and listen to their perspectives align with findings that young people are often deterred from help-seeking due to fears they will be judged by their mental health clinicians [51]. Other research has identified that young people have had the most positive experiences of counsellors who are seen as listening and understanding rather than dismissing or patronizing [10,90,92]. Respectfulness is a piece that can tie together both professionalism and connection, and can aid clinicians who find each way of relating more natural to them to practice in a youth-friendly manner.

There are clear links between a young person's desire to be respected by their clinicians and both the developmental stage of youth and sociological views on what it is to be a young person in society. The desire for increased autonomy is a well-established aspect of development for young people, as they begin to deepen their identity formation both as individuals and group members [93]. By contrast, in many contexts around the world, young people are often positioned as relatively powerless with limited control over their lives such as decisions about their health [69]. In psychological research, young people are often characterized as difficult, unmotivated, and incapable of making decisions about their own care [35–40]. When young people are disrespected, they are further disempowered at a developmental stage when they are most sensitive to their desire for agency. As such, it would follow that young people would prefer to work with clinicians who respect and build up their growing autonomy rather than undermining them or treating them as children. Additionally, research has indicated that autonomy among young people can predict greater psychological wellbeing [94]. As such, clinicians that prioritize autonomy may promote wellbeing in and of themselves without considering the added benefit of reducing drop-out rates and promoting service engagement. By positioning themselves as non-judgmental, compassionate, and open by taking their clients seriously, not minimizing their experiences, and considering for themselves why they may struggle to take some clients seriously professionals could improve outcomes for their young clients and reduce disengagement.

Research has also established that young people are eager for opportunities to participate in their own care (see [90]). For many young people, this can enable them feel as though they are taking control and helping themselves [95]. While professionals might be concerned about young people's capacity to guide their care, studies have demonstrated that young people can be effective participants in care planning particularly when professionals focus on identifying communication methods that work for their clients [96]. It may be time to rethink the role of professionals who work with young people as dictating care decisions for their client based on professional opinion. Allowing young people a voice in decision making may not only aid their engagement, but also improve their outcomes. Clinicians may achieve this by considering how to involve their clients in an age and ability appropriate manner. For example, if considering multiple therapeutic models they may consider presenting these and the rationale for each approach to a client for their perspective. If inappropriate to consult a client in this way, professionals could consider clearly explaining their decision including why there is no other option available to the young person. It may also be helpful for clinicians to consider how young people in our

study highlighted the benefit of 'small' choices, such as where to sit and how to start a session, which may help to build empowerment in therapy.

Across the workshops, it was clear that young people who have experienced mental health services have rarely worked with professionals in this way. As such, many young people have had poor experiences with clinicians and may therefore take more time to build trust and be more sensitive to issues with new clinicians with whom they engage. It is important for clinicians to consider how they can help address these concerns and past experiences for clients.

Nevertheless, as mental health professionals there is room to consider how our behavior can shift to be more in line with the needs of young clients, and where any resistance to this change may come from. Many professionals may already be incorporating several of these principles, or may see easy behavior changes they can make. Others may feel resistance to these principles or see great disconnect between the perspectives of young people and how they have been trained to practice. While some may feel that as experts our practice is fundamentally correct, and should not be adjusted to suit our clients, it is critical that we reconsider this attitude. A more efficient and engaging service requires professionals who are willing to be flexible and adaptable to the unique needs of the population they serve, and who can hold this flexibility alongside their training. Mental health professionals can and should be able to uphold high standards of professional behavior while also adapting their behavior and attitudes to better address young people's needs.

While it may not be possible to meet young people's needs in every therapeutic encounter, it is important to provide early opportunities for young people to connect with a clinician in order to promote their engagement with professional support and prevent drop out. A solid working alliance between a clinician and their young client not only provides a feeling of safety and comfort for young people, but can sustain some of the more challenging aspects of therapy. Importantly: There is no single clinician who can be the ideal mental health clinician for every young person. When we as clinicians cannot operate as 'ideal' youth mental health practitioners, we can invite conversation and promote open, respectful, and transparent conversation with the young people we serve in our clinical practice.

Many countries around the world are reconsidering their mental health systems broadly, or youth mental health systems more specifically. Even when widespread change is not underway, many individual services are increasingly recognizing the need to better serve the needs of young people. While widespread systemic, cultural, and structural change is needed it can often feel insurmountable, unachievable, and expensive. This can leave services trapped in traditional, unhelpful patterns of care while they juggle the challenge of addressing these needs. This study demonstrated that when given the freedom to identify any features that could improve their engagement, young people often focused on characteristics of clinicians. This should empower clinicians to be confident their practice can substantially impact a young client. This study also details changes individual professionals can make which may improve the engagement and outcomes of young people. Many of these practices can be implemented quickly and individually, while others may require managerial decision making, but few should require substantial or expensive changes to services. These changes should not be considered an alternative to broader system change, but a supplement and an option that services can integrate quickly even before undergoing larger scale change.

Limitations

While this sample was diverse and reflected many groups from around New Zealand, these results may not be truly reflective of the perspectives of all young people. In particular, Māori and Pacific Islander young people who were underrepresented in this sample and are over-represented in mental health statistics may have different needs for their professionals [97]. Their opinions may need to be investigated in an additional study building on this research. This sample was also gender imbalanced, as is unfortunately

common in mental health research and mental health treatment broadly. Our results therefore primarily reflect the perspectives of young women in New Zealand, and may not be reflective of young men's views. However, young men in New Zealand have high rates of mental health challenges that continue throughout their lives and their perspectives will be important for developing clinical approaches that are both effective and engaging for young men. As such, it may be necessary to consider developing unique methodologies for gathering the perspectives of young men that are better able to engage them in research. Importantly, our understanding of limited engagement of men in research and treatment often relates difficulties men experience in talking about mental health to traditional models of masculinity [98]. However, much of this research has been conducted with adult men of majority identities [98] and greater research is needed to understand the impacts on young men's engagement. It is particularly important to step away from contributing men's limited engagement to factors within them (e.g., stubbornness) [99] and towards developing our understanding of what we as researchers and clinicians can do to improve their engagement. Additionally, given the nature of data collection, we were unable to compare the perspectives of young people across demographic groups—an important area for exploration in future research.

5. Conclusions

Awareness is rapidly growing of the poor mental health experienced by many young people around the world. Despite greater awareness, and increased understanding that the current mental health system is not sufficiently meeting the needs of young people, less attention has been paid to factors that clinicians can control which may contribute to limited service engagement, high drop-out rates, and poor outcomes among young people. Less research still has focused on the perspectives of young people themselves as to how they believe professionals can work better with them. This study seeks to fill some of that gap, by providing a set of principles for professional practice based on the perspectives of young people. Based on this study, young people seek to work with professionals with whom they share a background, who they connect with, who are professional, who respect them, and who work in a way that is adapted to them. By incorporating some of the practices we recommend, mental health professionals can align their practice more closely with the needs of young people.

Author Contributions: Conceptualization, J.S. and K.G.; Formal analysis, J.S. and K.G.; Methodology, J.S. and K.G.; Project administration, J.S.; Supervision, K.G.; Writing—original draft, J.S.; Writing—review and editing, K.G. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki, and approved by The University of Auckland Human Participants Ethics Committee (Reference number 021731, approved 3 August 2018).

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: The data presented in this study are not available for ethical reasons, due to the sensitive nature of qualitative research and the importance of maintaining participant anonymity.

Acknowledgments: The authors would like to acknowledge all young people who participated in this research and shared their lived expertise with us, and all organizations and schools who supported recruitment.

Conflicts of Interest: The authors declare no conflict of interest.

References

1. McGorry, P.D.; Purcell, R.; Hickie, I.B.; Jorm, A.F. Investing in youth mental health is a best buy. *Med. J. Aust.* **2007**, *187*, S5–S7. [CrossRef]
2. McGorry, P.; Bates, T.; Birchwood, M. Designing youth mental health services for the 21st century: Examples from Australia, Ireland and the UK. *Br. J. Psychiatry* **2013**, *202*, s30–s35. [CrossRef] [PubMed]

3. de Haan, A.M.; Boon, A.E.; de Jong, J.T.; Hoeve, M.; Vermeiren, R.R. A meta-analytic review on treatment dropout in child and adolescent outpatient mental health care. *Clin. Psychol. Rev.* **2013**, *33*, 698–711. [CrossRef] [PubMed]
4. O'Keeffe, S.; Martin, P.; Target, M.; Midgley, N. 'I Just Stopped Going': A Mixed Methods Investigation Into Types of Therapy Dropout in Adolescents With Depression. *Front. Psychol.* **2019**, *10*, 75. [CrossRef] [PubMed]
5. Atzil-Slonim, D.; Tishby, O.; Shefler, G. Internal Representations of the Therapeutic Relationship Among Adolescents in Psychodynamic Psychotherapy. *Clin. Psychol. Psychother.* **2014**, *22*, 502–512. [CrossRef]
6. Berry, C.; Greenwood, K. Hope-inspiring therapeutic relationships, professional expectations and social inclusion for young people with psychosis. *Schizophr. Res.* **2015**, *168*, 153–160. [CrossRef]
7. Watsford, C.; Rickwood, D. Disconfirmed expectations of therapy and young people's clinical outcomes, help-seeking intentions, and mental health service use. *Adv. Ment. Health* **2014**, *12*, 75–86. [CrossRef]
8. Fernandez, O.M.; Krause, M.; Pérez, J.C. Therapeutic alliance in the initial phase of psychotherapy with adolescents: Different perspectives and their association with therapeutic outcomes. *Res. Psychother. Psychopathol. Process. Outcome* **2016**, *19*, 1–9. [CrossRef]
9. Griffiths, G. *Scoping Report. Helpful and Unhelpful Factors in School-Based Counselling: Client's Perspectives*; British Association for Counseling & Psychotherapy: Lutterworth, UK, 2013.
10. Lynass, R.; Pykhtina, O.; Cooper, M. A thematic analysis of young people's experience of counselling in five secondary schools in the UK. *Couns. Psychother. Res.* **2012**, *12*, 53–62. [CrossRef]
11. Ness, O.; Kvello, Ø.; Borg, M.; Semb, R.; Davidson, L. "Sorting things out together": Young adults' experiences of collaborative practices in mental health and substance use care. *Am. J. Psychiatr. Rehabil.* **2017**, *20*, 126–142. [CrossRef]
12. Garcia, J.A.; Weisz, J.R. When youth mental health care stops: Therapeutic relationship problems and other reasons for ending youth outpatient treatment. *J. Consult. Clin. Psychol.* **2002**, *70*, 439–443. [CrossRef] [PubMed]
13. Hawley, K.M.; Weisz, J.R. Youth Versus Parent Working Alliance in Usual Clinical Care: Distinctive Associations With Retention, Satisfaction, and Treatment Outcome. *J. Clin. Child Adolesc. Psychol.* **2005**, *34*, 117–128. [CrossRef] [PubMed]
14. O'Keeffe, S.; Martin, P.; Midgley, N. When adolescents stop psychological therapy: Rupture–repair in the therapeutic alliance and association with therapy ending. *Psychotherapy* **2020**, *57*, 471–490. [CrossRef]
15. Lambert, M.J.; Barley, D.E. Research summary on the therapeutic relationship and psychotherapy outcome. *Psychother. Theory Res. Pract. Train.* **2001**, *38*, 357. [CrossRef]
16. Beutler, L.E.; Malik, M.L.; Alimohamed, S.; Harwood, T.M.; Talebi, H.; Noble, S.; Wong, E. Therapist variables. In *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change*; Lambert, M.J., Ed.; Wiley: New York, NY, USA, 2004; pp. 227–306.
17. Blow, A.J.; Sprenkle, D.H.; Davis, S.D. Is Who Delivers the Treatment More Important than the Treatment Itself? The Role of The Therapist in Common Factors. *J. Marital Fam. Ther.* **2007**, *33*, 298–317. [CrossRef] [PubMed]
18. Horvath, A.O.; Bedi, R.P. The alliance. In *Psychotherapy Relationships That Work: Therapist Contributions and Responsiveness to Patients*; Norcross, J., Ed.; Oxford University Press: London, UK, 2002.
19. Orlinsky, D.E.; Rønnestad, M.H.; Willutzki, U. Fifty years of psychotherapy processoutcome research: Continuity and change. In *Bergin and Garfield's Handbook of Psychotherapy and Behaviour Change*, 5th ed.; Lambert, M., Ed.; Wiley: New York, NY, USA, 2004; pp. 307–389.
20. Wampold, B.E. *The Great Counselling Debate: Models, Methods, and Findings*; Erlbaum: Mahwah, NJ, USA, 2001.
21. Fuckiger, C.; Del Re, A.C.; Wlodasch, D.; Solomonov, N.; Horvath, A.O.; Wampold, B.E. Assessing the alliance-outcome association adjusted for patient characteristic and treatment processes: A metaanalytic summary of direct comparisons. *J. Couns. Psychol.* **2020**, *67*, 706–711.
22. Cooper, M. Towards a relationally-orientated approach to therapy: Empirical support and analysis. *Br. J. Guid. Couns.* **2004**, *32*, 451–460. [CrossRef]
23. Donald, I.N.; Rickwood, D.J.; Carey, T.A. Understanding therapeutic change in young people—A pressing research agenda. *J. Psychother. Integr.* **2014**, *24*, 313–322. [CrossRef]
24. Sauter, F.M.; Heyne, D.; Westenberg, P.M. Cognitive Behavior Therapy for Anxious Adolescents: Developmental Influences on Treatment Design and Delivery. *Clin. Child Fam. Psychol. Rev.* **2009**, *12*, 310–335. [CrossRef]
25. Wintersteen, M.B.; Mensinger, J.L.; Diamond, G.S. Do Gender and Racial Differences Between Patient and Therapist Affect Therapeutic Alliance and Treatment Retention in Adolescents? *Prof. Psychol. Res. Pr.* **2005**, *36*, 400–408. [CrossRef]
26. Bury, C.; Raval, H.; Lyon, L. Young people's experiences of individual psychoanalytic psychotherapy. *Psychol. Psychother. Theory Res. Pr.* **2007**, *80*, 79–96. [CrossRef] [PubMed]
27. Prasad, P.V.V.; Boote, K.J.; Allen, L.H., Jr.; Thomas, J.M.G. Super-optimal temperatures are detrimental to peanut (*Arachis hypogaea* L.) reproductive processes and yield at both ambient and elevated carbon dioxide. *Glob. Chang. Biol.* **2003**, *9*, 1775–1787. [CrossRef]
28. Bohart, A.C.; Elliot, R.; Greenberg, L.S.; Watson, J.C. Empathy. In *Psychotherapy Relationships That Work*; Norcross, J.C., Ed.; Oxford University Press: New York, NY, USA, 2002; pp. 89–108.
29. Elliot, R.; James, E. Varieties of client experience in psychotherapy: An analysis of the literature. *Clin. Psychol. Rev.* **1989**, *9*, 443–467. [CrossRef]
30. Macran, H.R.S. The importance of considering clients' perspectives in psychotherapy research. *J. Ment. Health* **1999**, *8*, 325–337. [CrossRef]

31. Bohart, A.C.; Tallman, K. Clients: The neglected common factor in psychotherapy. In *The Heart and Soul of Change: Delivering What Works in Therapy*, 2nd ed.; Duncan, B.L., Miller, S.D., Wampold, B.E., Hubble, A.A., Eds.; American Psychological Association: Washington, DC, USA, 2010; pp. 83–111.
32. Busseri, M.A.; Tyler, J.D. Client–therapist agreement on target problems, working alliance, and counseling outcome. *Psychother. Res.* **2004**, *14*, 77–88. [CrossRef] [PubMed]
33. Swift, J.K.; Callahan, J.L.; Cooper, M.; Parkin, S.R. The impact of accommodating client preferences in psychotherapy: A meta-analysis. *J. Clin. Psychol.* **2018**, *74*, 1924–1937. [CrossRef]
34. Gibson, K. What young people want from mental health services: A youth informed approach. Routledge: London, UK; New York, NY, USA, 2021.
35. Biever, J.L.; McKenzie, K.; Wales-North, M.; Gonzalez, R.C. Stories and solutions in psychotherapy with adolescents. *Adolescence* **1995**, *30*, 491–499. [PubMed]
36. Sommers-Flanagan, J.; Sommers-Flanagan, R. Psychotherapeutic techniques with treatment-resistant adolescents. *Psychotherapy* **1995**, *32*, 131–140. [CrossRef]
37. Trepper, T. Senior editor's comments. In *Adolescents and Their Families: An Introduction to Assessment and Intervention*; Worden, M., Ed.; Haworth Press: New York, NY, USA, 1991; pp. 7–13.
38. Prout, H.T. Counseling and psychotherapy with children and adolescents: Historical, developmental, integrative and effectiveness perspectives. In *Counselling and Psychotherapy with Children and Adolescents: Theory and Practice for School and Clinical Settings*, 4th ed.; Prout, H.T., Brown, D.T., Eds.; Wiley: New York, NY, USA, 2007; pp. 1–31.
39. Lack, C.W.; Green, A.L. Mood Disorders in Children and Adolescents. *J. Pediatr. Nurs.* **2009**, *24*, 13–25. [CrossRef]
40. Zirkelback, E.A.; Reese, R.J. A review of counselling outcome research: Considerations for school-based mental health providers. *Psychol. Sch.* **2010**, *47*, 1084–1100. [CrossRef]
41. Alderson, P. *Childhoods Real and Imagined*; Routledge: New York, NY, USA, 2013.
42. Shirk, S.R.; Karver, M. Prediction of treatment outcome from relationship variables in child and adolescent therapy: A meta-analytic review. *J. Consult. Clin. Psychol.* **2003**, *71*, 452–464. [CrossRef] [PubMed]
43. Gelson, C.J.; Carter, J.A. Components of the psychotherapy relationship: Their interaction and unfolding during treatment. *J. Couns. Psychol.* **1994**, *41*, 296–306. [CrossRef]
44. The United Nations. Convention on the Rights of the Child. *Treat Ser.* **1989**, *1577*, 3.
45. Gibson, K.; Cartwright, C.; Kerrisk, K.; Campbell, J.; Seymour, F. What young people want: A qualitative study of adolescent's priorities for engagement across psychological services. *J. Child Fam. Stud.* **2015**, *25*, 1057–1065. [CrossRef]
46. Freake, H.; Barley, V.; Kent, G. Adolescents' views of helping professionals: A review of the literature. *J. Adolesc.* **2007**, *30*, 639–653. [CrossRef]
47. Knight, K.; Gibson, K.; Cartwright, C. "It's like a refuge": Young people's relationships with school counsellors. *Couns. Psychother. Res.* **2018**, *18*, 377–386. [CrossRef]
48. Oetzel, K.B.; Scherer, D.G. Therapeutic Engagement With Adolescents in Psychotherapy. *Psychotherapy* **2003**, *40*, 215–225. [CrossRef]
49. Binder, P.-E.; Moltu, C.; Hummelsund, D.; Sagen, S.H.; Holgersen, H. Meeting an adult ally on the way out into the world: Adolescent patients' experiences of useful psychotherapeutic ways of working at an age when independence really matters. *Psychother. Res.* **2011**, *21*, 554–566. [CrossRef]
50. Everall, R.D.; Paulson, B.L. The therapeutic alliance: Adolescent perspectives. *Couns. Psychother. Res.* **2002**, *2*, 78–87. [CrossRef]
51. Heflinger, C.A.; Hinshaw, S.P. Stigma in Child and Adolescent Mental Health Services Research: Understanding Professional and Institutional Stigmatization of Youth with Mental Health Problems and their Families. *Adm. Ment. Health* **2010**, *37*, 61–70. [CrossRef]
52. Hollidge, C. Adolescents' Perceptions of the Factors that Enhance the Therapeutic Relationship: A Qualitative Study in School-based Health Settings. *Adolesc. Psychiatry* **2013**, *3*, 277–287. [CrossRef]
53. Bacha, K.; Hanley, T.; Winter, L.A. 'Like a human being, I was an equal, I wasn't just a patient': Service users' perspectives on their experiences of relationships with staff in mental health services. *Psychol. Psychother. Theory Res. Pr.* **2019**, *93*, 367–386. [CrossRef] [PubMed]
54. Lavik, K.O.; Veseth, M.; Frøysa, H.; Binder, P.-E.; Moltu, C. 'Nobody else can lead your life': What adolescents need from psychotherapists in change processes. *Couns. Psychother. Res.* **2018**, *18*, 262–273. [CrossRef]
55. Doherty, M.; Conway, J.; Clark, J.; Merritt, F. Should I stay or should I go? The impact of a sense of control on young men's therapeutic engagement. *Couns. Psychother. Res.* **2017**, *17*, 209–217. [CrossRef]
56. Løvgren, A.; Røssberg, J.I.; Nilsen, L.; Engebretsen, E.; Ulberg, R. How do adolescents with depression experience improvement in psychodynamic psychotherapy? A qualitative study. *BMC Psychiatry* **2019**, *19*, 95. [CrossRef]
57. Booth, M.L.; Bernard, D.; Quine, S.; Kang, M.S.; Usherwood, T.; Alperstein, G.; Bennett, D.L. Access to health care among Australian adolescents young people's perspectives and their sociodemographic distribution. *J. Adolesc. Health* **2004**, *34*, 97–103. [CrossRef]
58. Henriksen, A.K. Adolescents' reflections on successful outpatient treatment and how they may inform therapeutic decision making—A holistic approach. *J. Psychother. Integr.* **2014**, *24*, 284–297. [CrossRef]

59. Biering, P. Child and adolescent experience of and satisfaction with psychiatric care: A critical review of the research literature. *J. Psychiatr. Ment. Health Nurs.* **2010**, *17*, 65–72. [CrossRef]
60. McCann, T.V.; Lubman, D. Young people with depression and their satisfaction with the quality of care they receive from a primary care youth mental health service: A qualitative study. *J. Clin. Nurs.* **2012**, *21*, 2179–2187. [CrossRef]
61. Scott, E.; Naismith, S.; Whitwell, B.; Hamilton, B.; Chudleigh, C.; Hickie, I. Delivering Youth-Specific Mental Health Services: The Advantages of a Collaborative, Multi-Disciplinary System. *Australas. Psychiatry* **2009**, *17*, 189–194. [CrossRef]
62. Erikson, E.H. *Childhood and Society*, 2nd ed.; Norton: New York, NY, USA, 1963.
63. Erikson, E.H. *Identity: Youth and Crisis*; Norton: New York, NY, USA, 1968.
64. Habermas, T.; Bluck, S. Getting a life: The emergence of the life story in adolescence. *Psychol. Bull.* **2000**, *126*, 748–769. [CrossRef] [PubMed]
65. Klimstra, T.A.; Hale, W.W.H.; Raaijmakers, Q.A.W.; Branje, S.J.T.; Meeus, W.H.J. Identity formation in adolescence: Change of stability? *J. Youth Adolesc.* **2010**, *39*, 150–162. [CrossRef] [PubMed]
66. Kroger, J. Identity development during adolescence. In *Blackwell Handbook of Adolescence*; Adams, G.R., Berzonsky, M.D., Eds.; Blackwell Publishing: London, UK, 2003; pp. 205–246.
67. Marcia, J.E. Development and validation of ego-identity status. *J. Pers. Soc. Psychol.* **1966**, *3*, 551–558. [CrossRef] [PubMed]
68. Schmitt, K.L.; Dayanim, S.; Matthias, S. Personal homepage construction as an expression of social development. *Dev. Psychol.* **2008**, *44*, 496–506. [CrossRef] [PubMed]
69. Hinshaw, S.P. The stigmatization of mental illness in children and parents: Developmental issues, family concerns, and research needs. *J. Child Psychol. Psychiatry* **2005**, *46*, 714–734. [CrossRef]
70. Karver, M.S.; Handelsman, J.B.; Fields, S.; Bickman, L. A Theoretical Model of Common Process Factors in Youth and Family Therapy. *Ment. Health Serv. Res.* **2005**, *7*, 35–51. [CrossRef]
71. Block, A.M.; Greeno, C.G. Examining Outpatient Treatment Dropout in Adolescents: A Literature Review. *Infant Ment. Health J.* **2011**, *28*, 393–420. [CrossRef]
72. Duncan, B.L.; Sparks, J.A.; Miller, S.; Bohanske, R.T.; Claude, D.A. Giving youth a voice: A preliminary study of the reliability and validity of a brief outcome measure 214 for children. *J. Brief Ther.* **2006**, *5*, 71–88.
73. Kelley, S.D.; Bickman, L.; Norwood, E. Evidence based treatments and common factors in youth psychotherapy. In *The Heart and Soul of Change: Delivering What Works in Therapy*, 2nd ed.; Duncan, B.L., Miller, S.D., Wampold, B.E., Hubble, A.A., Eds.; American Psychological Association: Washington, DC, USA, 2010; pp. 325–355.
74. Spencer, G.; Doull, M. Examining concepts of power and agency in research with young people. *J. Youth Stud.* **2015**, *18*, 900–913. [CrossRef]
75. Statistics New Zealand. New Zealand's Population Reflects Growing Diversity. 2019. Available online: https://www.stats.govt.nz/news/new-zealands-population-reflects-growing-diversity (accessed on 1 February 2021).
76. Clark, T.C.; Fleming, T.; Bullen, P.; Denny, S.; Crengle, S.; Dyson, B.; Fortune, S.; Lucassen, M.; Peiris-John, R.; Robinson, E.; et al. *Youth'12 Overview: The Health and Wellbeing of New Zealand Secondary School Students in 2012*; The University of Auckland: Auckland, New Zealand, 2013. Available online: https://www.fmhs.auckland.ac.nz/assets/fmhs/faculty/ahrg/docs/2012-overview.pdf (accessed on 1 February 2021).
77. Morgan, D.L. Focus Groups. *Annu. Rev. Sociol.* **1996**, *22*, 129–152. [CrossRef]
78. Calder-Dawe, O.; Gavey, N. Feminism, Foucault, and Freire: A dynamic approach to sociocultural research. *Qual. Psychol.* **2019**, *6*, 216–231. [CrossRef]
79. Braun, V.; Clarke, V. Thematic Analysis. In *APA Handbook of Research Methods in Psychology*; Cooper, H., Ed.; American Psychological Association: Washington, DC, USA, 2012; Volume 2, pp. 57–71.
80. Hill, C.E. Consensual Qualitative Research (CQR): Methods for Conducting Psychotherapy Research. In *Psychotherapy Research: Foundations, Process and Outcome*; Gelo, O.C.G., Pritz, A., Rieken, B., Eds.; Springer: Vienna, Austria, 2015; pp. 485–499.
81. Morrow, S.L. Quality and trustworthiness in qualitative research in counseling psychology. *J. Couns. Psychol.* **2005**, *52*, 250–260. [CrossRef]
82. Cooper, M. Scottish Secondary School Students' Preferences for Location, Format of Counselling and Sex of Counsellor. *Sch. Psychol. Int.* **2006**, *27*, 627–638. [CrossRef]
83. Clark, M.; Buchanan, R.; Leve, L.D. Young Women's Perspectives of Their Adolescent Treatment Programs: A Qualitative Study. *Int. J. Environ. Res. Public Health* **2018**, *15*, 373. [CrossRef]
84. Cabral, R.R.; Smith, T.B. Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *J. Couns. Psychol.* **2011**, *58*, 537–554. [CrossRef]
85. Jensen, S.Q. Othering, identity formation and agency. *Qual. Stud.* **2011**, *2*, 63–78. [CrossRef]
86. Umaña-Taylor, A.J.; Quintana, S.M.; Lee, R.M.; Cross, W.E.; Rivas-Drake, D.; Schwartz, S.J.; Syed, M.; Yip, T.; Seaton, E. Ethnic and Racial Identity during Adolescence and Into Young Adulthood: An Integrated Conceptualization. *Child Dev.* **2014**, *85*, 21–39. [CrossRef]
87. Plaistow, J.; Masson, K.; Koch, D.; Wilson, J.; Stark, R.M.; Jones, P.; Lennox, B.R. Young people's views of UK mental health services. *Early Interv. Psychiatry* **2013**, *8*, 12–23. [CrossRef]
88. Ross, L. Facilitating Rapport through Real Patient Encounters in Health Care Professional Education. *Australas. J. Paramed.* **2013**, *10*, 1–10. [CrossRef]

89. Mooney, H. Māori social work views and practices of rapport building with rangatahi Māori. *Aotearoa N. Z. Soc. Work* **2012**, *24*, 49–64. [CrossRef]
90. Robinson, S. Children and young people's views of health professionals in England. *J. Child Health Care* **2010**, *14*, 310–326. [CrossRef] [PubMed]
91. Von Below, C. 'We just did not get on'. Young adults' experiences of unsuccessful psychodynamic psychotherapy—A lack of meta-communication and mentalization? *Front. Psychol.* **2020**, *11*, 1243. Available online: https://www.frontiersin.org/articles/10.3389/fpsyg.2020.01243/full (accessed on 1 February 2021). [CrossRef] [PubMed]
92. Crocket, K.; Kotzé, E.; Peter, M. Young people's perspectives on school counselling. *N. Z. J. Couns.* **2015**, *35*, 22–43.
93. Smetana, J. *Adolescents, Parents and Social Development: How Teens Construct Their Worlds*; Wiley-Blackwell: London, UK, 2011.
94. Inguglia, C.; Ingoglia, S.; Liga, F.; Coco, A.L.; Cricchio, M.G.L. Autonomy and Relatedness in Adolescence and Emerging Adulthood: Relationships with Parental Support and Psychological Distress. *J. Adult Dev.* **2014**, *22*, 1–13. [CrossRef]
95. Svanberg, J.; Street, C. Where Next? New Directions in in-Patient Mental Health Services for Young People. Report 2. Young Minds. 2003. Available online: https://www.yumpu.com/en/document/read/29269008/where-next-1-final-version-youngmind (accessed on 1 February 2021).
96. Smith, L.; Callery, P. Children's accounts of their preoperative information needs. *J. Clin. Nurs.* **2005**, *14*, 230–238. [CrossRef]
97. Bennett, S.T.; Liu, J.H. Historical trajectories for reclaiming an indigenous identity in mental health interventions for Aotearoa/New Zealand- Māori values, biculturalism, and multiculturalism. *Int. J. Intercult. Relat.* **2018**, *62*, 93–102. [CrossRef]
98. Seidler, Z.E.; Dawes, A.J.; Rice, S.M.; Oliffe, J.L.; Dhillon, H.M. The role of masculinity in men's help-seeking for depression: A systematic review. *Clin. Psychol. Rev.* **2016**, *49*, 106–118. [CrossRef]
99. Afeck, W.; Carmichael, V.; Whitley, R. Men's mental health: Social determinants and implications for services. *Can. J. Psychiatry* **2018**, *63*, 581–589. [CrossRef]