An Exploration of Adolescents' Experiences and Perceptions of Psychotherapy

By

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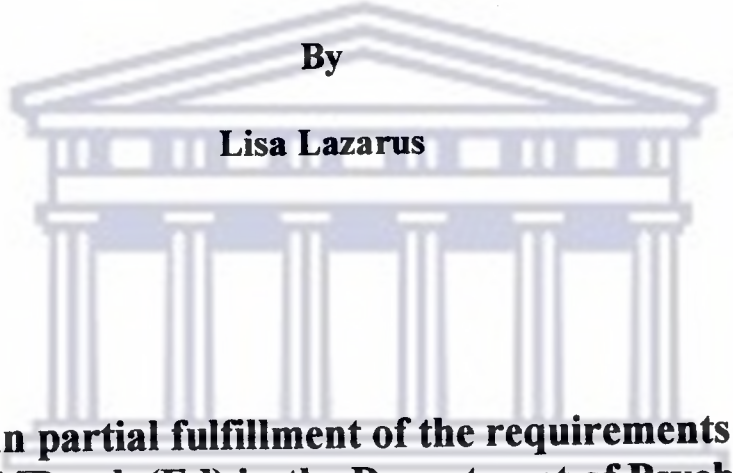

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Abstract

Adolescent psychotherapy research is frequently empirically based. Little attempt is made to elicit this age group's subjective perceptions of their therapy experience despite the fact that adolescents experience multiple emotional problems and that psychotherapy is often the intervention of choice. This study sought to explore the therapy experiences of eight adolescents. Participants were asked about any changes that occurred as a result of therapy, the reasons of these changes of lack of changes, their perceptions of the psychotherapy relationship as well as their perceptions of other's attitudes towards their therapy. Reasons for initiation and terminating therapy were also discussed as the high adolescent psychotherapy drop-out rate is often noted in the literature. The overall research design was qualitative. Phenomenology and developmental theory informed the design and the interpretation of this study. The participants were asked about their experiences through the use of semi-structured interviews. The interviews were then transcribed and a thematic analysis was carried out. It emerged that some adolescents felt that behavioural and insight orientated changes had occurred. Although some participants preferred to see changes as self-motivated rather than as a consequence of the therapy experience. This could be as a result of the adolescent's desire to separate or individuate from the therapist in the same manner that the adolescent wishes to separate from the parents. This adolescent challenge was again reflected in some adolescents' reasons for termination – certain participants wished to handle problems on their own. The therapeutic relationship was often compared with that of friendship although it was noted that therapy offered additional benefits such as the increased power of the therapist and the ability to share certain information with the therapist that couldn't be shared with friends. Adolescent peers were generally felt to be accepting of therapy, however therapy was often

viewed as shameful and secret during the childhood years. The findings suggest that additional research is needed, particularly with adolescents receiving therapy from state services such as hospitals and school clinics.

Declaration

The author hereby declares that this whole thesis, unless specifically indicated to the contrary in the text, is her own work.

Lisa Lazarus

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I wish to express my sincere gratitude and appreciation to my supervisor, Professor Broekmann of the University of the Western Cape, for his comments and motivation. He was correct. I could finish my thesis this year.

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Chapter One

Introduction

1.1 Overview

Psychotherapy with adolescents is a common method of dealing with a variety of emotional problems that this age group experiences. The question is, however whether this time consuming and costly practice is actually effective. The answer to such a question is useful to a variety of people besides practising psychotherapists. For example, parents and clients themselves could well find such information relevant and important before embarking upon psychotherapy.

Much of the research that attempts to answer questions about child and adolescent psychotherapy is empirical in nature (cf. Fonagy & Moran, 1990; Kazdin, Bass, Ayers & Rodgers, 1990; Weisz & Weiss, 1993; Weisz, Weiss & Donenberg, 1992) with the emphasis being on objective methods of some kind which relate either to the process or outcome of therapy. Toukmanian & Rennie (1992) indicate that if a researcher wishes to find out more about the nature of therapy it makes sense to point to the participants as authorities. Yet clients are not often asked about their subjective experiences of therapy (McLeod, 1990).

The broad aim of this study is to explore adolescents' perceptions of their experience of long-term private therapy. The factors which will be explored in some depth include the types of change or lack of change that adolescents feel resulted from therapy and the reasons for this change or lack of change. Perceptions of the psychotherapeutic

relationship as well as beneficial and non-beneficial aspects of therapy will be examined. The initiation and termination of therapy will be looked at as well as adolescents' perceptions of how others viewed their therapy. It is important that the above issues are considered in the context of the adolescent developmental period. The research aims to open a door to an area that is under-researched in order to raise some relevant issues and also then to highlight possible areas for future research.

This research is phenomenological in orientation. Hence, it looks at the structure and essence of an experience of a particular phenomenon for certain people (Patton, 1990). Semi-structured interviews will used in order to elicit participants' experiences.

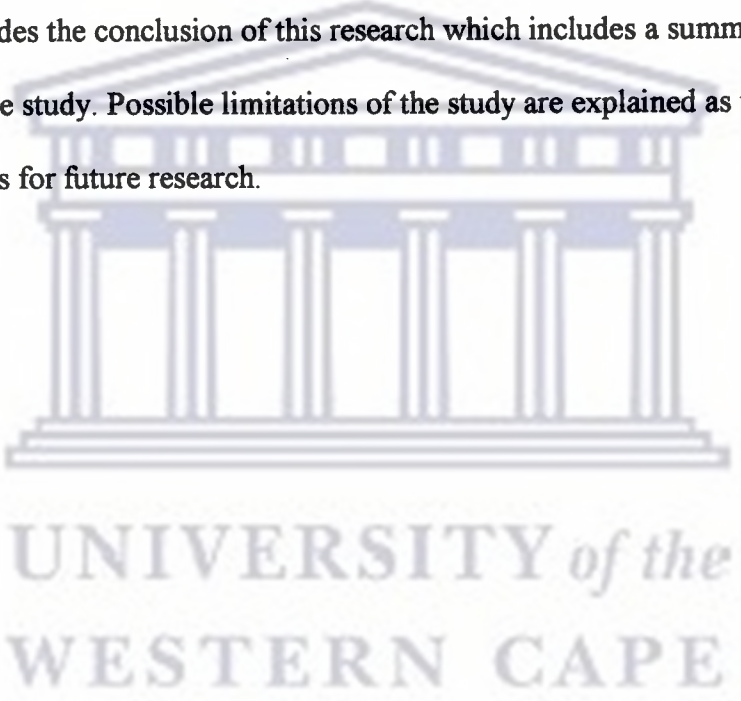
1.2 Synopsis of the current study

Chapter Two reviews the literature in the following areas: firstly, the child and adolescent psychotherapy research which is largely empirical and outcomes-based; secondly, the adolescent developmental period in order to raise some important developmental challenges of this period; thirdly, the fairly limited literature that explores clients' subjective experiences of their therapy.

Chapter Three outlines the methodological approach used in this study. The reasons for using qualitative research are mentioned. In addition, the sampling and participant characteristics are described as well as the type of interviewing used and the process of analysing the data.

Chapter Four incorporates an analysis and interpretation of the data. Common themes are mentioned as well as contradictions that exist between participants and within a participant's experience. Qualitative thematic analysis is used in order to interpret the data. Relevant links with the literature are noted in order to assess the degree to which this study substantiates previous research. An attempt is also made to examine the role of the researcher in gathering and influencing the data.

Chapter Five provides the conclusion of this research which includes a summary of the main findings of the study. Possible limitations of the study are explained as well as recommended areas for future research.



Chapter Two

Literature Review

"The theory is that the patient weaves a story and, in so doing, lays bare his or her most profound experience" (Paul V. Trad, 1993, 329)

2.1 Introduction

Michael Seriven, a member of the American Psychological Association's Board of Social and Ethical Responsibility, after examining outcome studies, questioned the moral justification for dispensing psychotherapy (Bergin, 1975). Although such a comment was made more that 20 years ago it appears that there is a continued necessity to provide sound psychotherapy research in order to assert with confidence that the application of psychotherapy is both moral and efficacious. VandenBos (1986) points out that the function of psychotherapy research is to understand the way in which patient change occurs in order to develop more effective methods of treatment. However, this presupposes that patient change actually occurs through therapy, although by about 1980 a consensus was more or less reached that psychotherapy as a treatment was more effective than no treatment (American Psychiatric Association, 1982 in VandenBos, 1986).

Many adolescents receive psychotherapy, whether privately, at clinics or at in-patient units. Much of the assessment of such therapy is empirical in nature (cf. Fonagy & Moran, 1990; Kazdin, Bass, Ayers & Rodgers, 1990; Weisz & Weiss, 1993; Weisz, Weiss & Donenberg, 1992). After reviewing the literature it can be seen that frequent attempts have been made to assess outcomes between different types of therapy or between using a therapy and a no therapy condition. On the other hand psychotherapy process-research seems to occur in one of two ways: (a) the process of therapeutic change (b) the participant's experiences of therapy (Toukmanian & Rennie, 1992). These authors further point out that if a researcher wants to know about the nature of therapy it makes sense to point to the participants as authorities because it is their experiences which are being researched.

The empirical psychotherapy research frequently fails to let people tell their own stories about their therapy. According to Kazdin, Bass, Ayers and Rodgers (1990) observers and independent raters were used most often in order to assess therapy. Although children and adolescents were used as sources of information, symptom (or problem) reduction was by far the most frequently used assessment focus. Thus, the varied richness of individual accounts of therapy experiences is under-represented in the literature.

Children and adolescents have different developmental challenges and resulting problems, yet much of the literature on psychotherapy fails to note these distinctions. For example,

Weisz and Weiss (1993) begin their book on the 'Effects of Psychotherapy With Children and Adolescents' by stating that children and adolescents will be referred to as children as though no developmental differences exist between them. However, separate research on adolescents and children and their experiences in psychotherapy is vital, given their differing developmental status.

Psychotherapy research is useful to a variety of people beyond psychotherapy researchers (VandenBos, 1986). Practising psychotherapists, educators and supervisors as well as increasingly educated and informed consumers, media reporters and policymakers all make use of such research findings (DeLeon, VandenBos & Cummings, 1983 in VandenBos, 1986). However, this American article might not reflect the situation in South Africa where the consumer could well be uninformed about the nature of psychotherapy, especially the adolescent consumer. Research into the experiences of such consumers is extremely relevant in order to assess in part areas of potential education about the nature and concept of therapy so that expectations are not disappointed.

2.2 History of Psychotherapy Research

The study of the psychotherapeutic process (as opposed to more outcomes-based research) from an empirical vantage point is a fairly young discipline taking place in the last 30 years (or slightly more as the article that claimed this was written eight years ago) (Marmar, 1990). According to Strupp (1986) psychotherapy research is and has been characterised by heated debate, confusion and frustration often as a result of definitional

problems. The perspective that one is taking (eg. practitioner, researcher or policy maker) also serves to compound the confusion and frustration. Central issues in the research are about what psychotherapy actually is, what it achieves or does not achieve, who should be allowed to practice and what actual value psychotherapy has to both society and the individual (Strupp, 1986).

Different aspects of these issues have enjoyed prominence at different times in psychotherapy's short history. According to Breuer and Freud (in Strupp, 1986) psychotherapy was a medical treatment, although with the advent of psychoanalysis there was a gradual but not complete abandonment of the medical analogy. As researchers became involved, psychotherapy was often defined as a 'treatment' with certain outcomes that could be specified. This in turn led to statistical comparisons of experimental with control groups and attempts to separate 'active' ingredients (so called 'specific' factors) from 'common' ('non-specific' ones) (Strupp, 1986, p. 122). In line with this Orlinsky and Howard (1986 in Shapiro, Startup, Bird, Harper, Reynolds & Suokas, 1994) tried to link psychotherapy process research with outcome research. In so doing they hoped to go beyond the assertion that all psychotherapies are equal by attempting to define occurrences that occur both within and between the client and the therapist that bring about positive change in the client's life and personality. They reviewed a number of studies in which "real" patients saw therapists in "real" treatment situations (Orlinsky & Howard, 1986 in Shapiro et al., 1994, p.4). They found that the following list of treatment

processes could be linked with positive outcomes:

- the bond between the patient and therapist needs to be characterised by "empathetic resonance (and)...mutual affirmation"
- the client and the therapist need to "focus their interventions on the patient's feelings"
- the client needs to be properly prepared for participating in therapy and both client and therapist need to take responsibility for problem solving
- within certain time frames "having more rather than less therapy" (Orlinsky & Howard, 1986 in Shapiro et al., p. 4).

However, when Shapro et al., (1994) repeated the above meta-analysis and looked again at Olinsky's and Howard's thirty three publications their findings re-iterated the conventional view that non-equivalent treatment methods were responsible for equivalent outcomes.

There has also been a history of dividing process psychotherapy research from outcome psychotherapy research with outcome research predominating (VandenBos, 1986). However, outcome or "efficacy" research has lessened in importance and instead the process of change during psychotherapy has assumed maximum relevance (Kiesler, 1985 in VandenBos, 1986). Some researchers argue that the distinction between process and outcome variables is relatively arbitrary and that the emphasis should be on the relationship between process and outcome (Marmar, 1990).

2.3 Empirical literature

According to Weisz and Weiss (1993) there is a large amount of literature about child psychotherapy. Much of this literature consists of case reports wherein therapists describe their work with particular children as well as the respective outcomes. After reviewing the psychotherapy literature it appears that there is also a fair amount of literature which attempts to assess child psychotherapy empirically. Psychotherapy is only one amongst a variety of other treatment options for adolescents, however psychotherapy is of special interest for a number of reasons (Kazdin, 1993). Firstly, outpatient psychotherapy can result in the more costly, restrictive and disruptive intervention of hospitilisation and residential care becoming unnecessary. Secondly, the conceptual approaches of psychotherapy (eg. psychoanalytic, family and cognitive) and the actual treatment techniques themselves are used in many settings, including juvenile centres, hospital programmes and schools. Hence, psychotherapy is often the tool used in order to precipitate change.

2.3.1 Review Studies of Psychotherapy Research

Hendren (1993) attempts to review the adolescent psychotherapy research and comes to the conclusion that there are many methodological flaws in psychotherapy outcome research with children and adolescents and therefore there is not indisputable evidence concluding that individual psychotherapy is efficacious. However, most of the review studies (including the meta-analyses) claim that individual psychotherapy is useful with this group of people. He also notes that very few studies pinpoint adolescents as their field of

inquiry. Instead adults and children are often studied together. Takanishi states that adolescence is less will understood than other periods of the life span such as infancy, early childhood, the adult years and old age, although it is better understood than the period of middle childhood (Collins, 1984 in Takanishi, 1993).

Levitt (1957; 1963; 1971 in Hendren, 1993) did one of the most prominent early reviews of child psychotherapy research when he compared neurotic children to a control group (obtained from treatment dropouts). According to him 78% of the treated children improved at follow-up compared to 72,5 % of the untreated children who had also improved. Levitt's methodology could be criticised (eg. his choice of drop-outs for his control group) but despite this doubts have remained about the efficacy of psychotherapy for children and adolescents. Prior to Levitt, Eysenck's research in 1953 (in Kazdin, 1993) is well regarded as a significant departure point for psychotherapy research. In his study he found that traditional forms of psychotherapy were no better than spontaneous remission - his review included child therapy research. As can be imagined this study sparked off great debate.

Hendren (1993) claims that the following have received support as potential outcome predictors for children. Firstly, patient and family variables which include the family's participation, socioeconomic status, whether the child has been prepared for therapy (Bush, Glenwick & Stephens,1986 in Hendren, 1993), when different treatment conditions

are used then children with neurotic disorders tend to respond better than children with conduct disorders and girls respond better than boys (Kolvin., Gerside., Nicol; et al., 1981 in Hendren, 1993), child personality characteristics and parental involvement. It seems too that the child's attitude towards the therapy and the interpretation of the experience are of vital importance. Secondly, there are only a few studies to support the notion that the therapist's experience and style have an effect on outcome with children and adolescents, although Kolvin et al. (in Hendren, 1993) found that with young people the best therapeutic outcome was brought about as a result of therapists who were extraverted, assertive and open. Thirdly, therapy variables are frequently isolated as important predictors of outcome. For example, Barrnett, Docherty and Frommett (in Hendren, 1993) concluded that some studies found cognitive, behavioral, group or family therapy superior to individual therapy whereas other studies noted no differences between these therapy types. Fourthly, most of the psychotherapy outcome studies with children and adolescents took place in an outpatient setting with a school population of youngsters who were not specifically looking for treatment for a disorder. Therefore, it is unclear how readily these studies can be generalised to clinical practice. Kazdin (1993) notes further that there are not many studies that look at factors moderating treatment outcome in children and adolescents. Some factors that have been examined are: chronological age, sex, influence of peers, frequency of treatment delivery and parent involvement.

There are many adult psychotherapy research articles that look at such factors as patient

and therapist characteristics and their relationship to outcome (eg. Lambart & Asay, 1984). Some of these findings will be mentioned here as they could well have some bearing on adolescent psychotherapy research.

Research has shown that what the patient brings into therapy is the single most important factor relating to outcome (Strupp 1980a in Lambert & Asay, 1984). Motivation has frequently been pinpointed as an important variable in therapy success. According to Lambert and Asay (1984), motivation implies a desire to change. Yet this desire needs to be congruent with the goals of the therapist. Such a definition of motivation is very therapist focused and would emerge in contexts where the therapist's views are being elicited. When clients' perceptions are obtained then the term motivation might well refer to the meeting of the client's goals. It could be hypothesised that with adolescents the concept of motivation is an important one as this age group could frequently be attending therapy as a result of the wishes of others, therefore motivation levels might be low.

Another important variable relates to the client's expectations. It has been found that when clients' expectancies are similar to the therapist's expectancies then clients are less likely to drop out of therapy (Lambart & Utic, 1979 in Lambart & Asay, 1984). A further important predictor is the patient's participation in the therapeutic relationship. However, a contentious view emerges here, namely that if the therapist provides the "average expectable" atmosphere of being basically empathic and benign then the outcome of the

therapeutic encounter is related to the characteristics of the patient such as his / her personality makeup, including ego, organisation, maturity, motivation and the ability to become productively involved in therapy (Strupp, 1980a, b, c, d in Lambart & Asay, 1984). Such an argument locates a large degree of the responsibility for successful therapy at the patient's door, thereby freeing the therapist from many important professional decisions beyond providing empathy and being benign. In reality, with adolescents the competent therapist would also need to assess the most important therapeutic intervention, obtain relevant collateral and ensure that the adolescent is in fact willing to receive help.

The following has been noted in the literature. According to Barrett and Wright (1984, p. 362) the qualities that were originally thought to be "necessary and sufficient" (eg. warmth, genuineness and accurate empathy) appear now to be related to other variables in complex ways and do not just stand by themselves. Dent (1978 in Barrett & Wright, 1984) came to the conclusion that there isn't a specific personality pattern that defines the effective therapist. Instead different disorders require different treatments. Further, it could be hypothesised that different age groups (eg. adolescents) might benefit from different personality patterns. In support of this assertion, a number of researchers (Eg. Staples, Sloane, Whipple, Cristol & Yorkston, 1976 in Barrett & White, 1984) have found that even when there are definite differences between therapies and therapists, outcome has been similar and positive.

Hendren (1993) notes external validity problems with much of the psychotherapy outcome research with children and adolescents, as many of the subjects are not typical of clinical practice. Instead subjects are often recruited from schools and are treated with behavioural and cognitive methods for circumscribed and relatively minor problems. On the other hand, clinical practice usually involves individual, interpersonal, psychodynamic family-based interventions with a population that is seriously disturbed. However, an assumption of serious disturbance in a clinically referred adolescent needs to be questioned.

Hoagwood, Hibbs, Brent and Jensen (1995) draw an important distinction between studies of efficacy and those of effectiveness. In the former control has often been exercised regarding sample selection, the way in which the intervention was delivered and also the conditions under which the treatment was administered. An example of such a study would be a randomised clinical trial which takes place in a university laboratory setting. On the other hand effectiveness studies take place when interventions which are seen as efficaceous are studied with a more heterogeneous samples in more naturalistic settings (eg. a home or a school) and actual practitioners rather than research therapists are used.

Many subsequent child and adolescent psychotherapy research reviews have tended to focus on methodological limitations (eg. poor control groups or the lack of matching in assigning patients to control groups) and the way in which variables that may influence

outcome are neglected, thereby concluding that treatment is ineffective or unproven (Weiss and Weisz, 1990). In response to this Weiss and Weisz (1990) undertook a study to determine whether methodological limitations (both internal and external validity) invalidated the conclusions that psychotherapy is effective and found that methodological factors were responsible for a substantial although a smaller amount of variance than other more substantive factors such as age and the therapy type.

However, there are more positive psychotherapy meta analyses where the methodological flaws were less serious. Tramontana (1980) reviewed adolescent psychotherapy research and came to the conclusion that the median rate of positive outcome with psychotherapy was 75 % compared with 35 % without psychotherapy. This researcher found further that a disproportionate amount of emphasis of adolescent psychotherapy outcome research seems to be given to group therapy with delinquents. Furthermore, there are not many open-ended type questions asked in this area of adolescent research. For example, what therapist qualities are necessary for intervention to be helpful ? What are the reasons given for changes or lack of change ? Casey and Bermen (1985) reviewed 75 studies and found that those children who were treated with psychotherapy showed greater improvement than untreated children - treated children achieved outcomes approximately two thirds of a standard deviation above untreated children. All forms of treatment elicited positive effects. However, the focus of this study was children under the age of 13 and not adolescents.

Kazdin, Bass, Ayers and Rodgers (1990) attempted to identify the main characteristics of child and adolescent psychotherapy by analysing studies between 1970 and 1988 (N = 223). They found that there is an underdeveloped child psychotherapy literature when compared with adults (Casey & Burman, 1985; Goldfried, Greenberg & Marmar, 1990 in Kazdin et al., 1990). Furthermore, they claim that at least 230 different forms of therapy are in use for children and adolescents although only a few of these have been evaluated empirically (Kazdin, 1988 in Kazdin et al., 1990). It is particularly those treatments which are used in private practice (eg. individual psychotherapy, psychodynamic therapy, family therapy) in which there are only a limited number of studies (Kazdin, Siegal & Bass, 1990; Koocher & Pedulla, 1977 in Kazdin et al., 1990). One of the recommendations that these authors make is that there is a need to move beyond technique variables and to focus on patient (child / adolescent), parent and family variables and how they affect outcome.

Studies were excluded from the above meta-analysis if they took place in a hospital, institutional, residential or day-treatment programme. This rules out many of the settings where essential psychotherapy takes place. Therefore, the generalisability of the findings is then seriously limited.

Weisz, Weiss and Donenberg (1992) reviewed four recent meta-analyses all of which

comprise more than 200 outcome studies. One of these was the Kazdin, Bass, Ayers and Rodgers meta-analysis mentioned above. The other was the Casey and Berman meta-analysis also mentioned above (1985 in Weisz, Donenberg, Han & Weiss, 1995). The other two were: (1) Weisz, Weiss, Alicke and Klotz (1987 in Weisz et al., 1995) reviewed outcome studies between 1952 and 1983, however they looked at children between the ages of 4 and 18. Their findings showed that on average those who were treated did better than 79 % of control group subjects; (2) Weisz, Weiss, Han, Granger and Morton (1995 in Weisz et al; 1995) conducted a recent meta-analysis looking at studies published between 1967 and 1993 with children between the ages of 2 and 18. They found that after treatment the average treated child was functioning better than 76 % of the control group subjects. These controlled outcome studies point to the efficacy of child and adolescent therapy. As mentioned above many of the studies included in the meta-analyses could be referred to as research therapy which has certain characteristics that separate it from clinic therapy.

With clinic therapy the clients are generally seriously disturbed, the problems are heterogeneous, therapy is directed at many problems, therapists are not likely to have had intensive, recent training, therapy can not be limited to a few techniques and neither treatment manuals nor systematic external monitoring is common. In such clinic based studies effects have been much more moderate, in fact there has often been no significant effect (Weisz et al., 1992). Weisz et al., (1995) undertook a recent meta-analysis of the

only nine studies of clinic therapies produced by a search for outcome studies between 1972 and 1991. The findings were much poorer with a mean ES (Effect Size) being 0.01 which was well below the mean ES of the four meta-analyses discussed above (ie. 0.77).

This is of obvious interest as much of the therapy happening in the 'real world' takes place in a clinic setting and not a research one. Weisz et al., (1995) set forward a number of hypotheses for this differential in ES including the following which were found to have support as a result of various statistical tests:

- Clinic cases are more difficult to treat successfully than children recruited for research therapy as clinic cases are more seriously disturbed.
- Laboratory settings are more likely to bring about therapeutic gain than clinic settings as laboratory settings and conditions are made very appealing in order to entice parents and children to attend regularly.
- Lastly, laboratory studies use behavioural therapy techniques and are therefore more likely than clinic studies to have better outcomes.

This last point is of obvious interest to therapists. Are behavioural techniques more successful with this age group or are their results more tangible and hence, easier to measure ? This is especially interesting when one examines clinicians' perceptions. Kazdin, Siegel and Bass (1990), after reviewing 1162 child clinicians (psychologists and psychiatrists) found that many viewed psychodynamic (59 % of respondents) interventions as useful most or all of the time. This was compared with 57 % for family interventions

and 73 % for eclectic interventions. Yet the majority of treatment outcome research involves behavioural modification and cognitive behavioural therapy (Kazdin, Bass et al., 1990). Therefore, eclectic or psychodynamic intereventions with children attending a non-laboratory based intervention (eg. a clinic or private practice) are frequently viewed by clinicians to be useful interventions, but according to the literature are very under-researched. This study hopes to fill part of this gap.

According to Kazdin (1991) the meta-analytic reviews seem to show that child and adolescent psychotherapy in general is more effective than no treatment (and it closely resembles outcome research with adults). This is substantiated by Hoagwood et al. (1995, p. 683 - 684) who claim that, "Meta-analytic reviews unanimously found that children who receive some form of psychosocial treatment function better than children in control conditions." But there are not many studies that look at the effectiveness of therapies in naturalistic settings such as community clinics (Weisz, Weiss & Donenberg, 1992 in Hoagwood et al., 1995) where conditions are less controlled. Kazdin claims further that these extensive reviews do not help answer questions about which techniques are useful, for which problems under what conditions. Empirical analyses keep attempting to partition off smaller and smaller areas of research. For example, Kazdin (1991) notes that there are very few studies which research only a particular technique and how it varies across different problems and populations. Such studies would increase the sensitivity in isolating differences in treatment. It is as if the smaller the area, the greater the accuracy and

reliability of the findings (eg. systematic desensitisation, not broad behaviourism on a particular population with a particular problem). Instead the area becomes isolated from what actually happens in the therapy room. An example of this in operation is the following: Kazdin (1993) in a later paper notes that a methodological advance in the research has been the operationalisation of treatment in the form of manuals - although these manuals might be useful for therapists it is unlikely that such manuals are stringently followed in any other place besides the research laboratory.

Persons (1991) criticises traditional psychotherapy outcome studies as they are removed from the way in which psychotherapy is actually practised. In reality, the therapist working individually will carry out an assessment and on the basis of this determine a treatment which is unique to that patient, while controlled outcome studies frequently standardise and separate assessment and outcome. This can result in a "scientist-practioner gap" where often the clinician is blamed for not reading the relevant literature. Instead it could be that the researcher carries a great deal of this blame for not producing studies that resemble ways of conceptualising cases and treatments described by theories of psychotherapy (which are individual in their nature). Persons (1991) recommends the case formulation approach to outcome based research where assessment and treatment are not separated but are theory-driven, ideographic and based upon the patient's specific problems and the model of psychotherapy used by the therapist. This article emphasises the importance of assessing psychotherapy as it occurs in practice in the clinician's room.

This is supported by Kazdin (1993) who claims that many cases in a clinical practice are referred as a result of a parental, school or court referral. Obviously motivation for treatment as well as the types of problems could well differ as a result of recruitment through a parental, school or court referral. Kazdin (1993) also recommends using the single case research design in order to narrow the gap between research and practice. The present study aims to examine each adolescent's experience of therapy (ie. case by case). Of course each adolescent's therapy will differ as it does in practice in a therapist's room.

There is also empirical research which attempts to dissect the process of psychotherapy research and to assess the relative merit of different modes of psychotherepeutic treatment (Stiles, Shapiro & Elliot, 1986). According to Marmar (1990) there is international effort to note processes that bring about change (ie. on a more macro level, the identification of change episodes and change events through segmenting the process into meaningful patterns) that then impact upon outcome. This emphasises the relevance of the "therapist / patient relationship, patient experiencing, and related variables in predicting the course of psychotherapeutic outcome" (Marmar, 1990, 265). It seems therefore that in this empirical psychotherapy process research the experiences of the patient are necessarily of importance.

2.4 Period of adolescence

Mental disorders have been noted as the major cause of disability amongst adolescents between the ages of ten and eighteen (National Centre for Education in Maternal and

Child Health, 1990 in Takanishi, 1993). However, these are American statistics and might not be readily applicable to South Africa. According to German, (1987), Jegede (1982) and Odejide, (1989 in Robertson, 1991, p. 23) Southern Africa "has not featured in the sparse literature on child and adolescent psychiatric disorders in Africa", especially black children and adolescents. Psychiatrists from the three largest cities in South Africa (Cape Town, Johannesburg and Durban) combined their epidemiological data from particular service centres in areas populated mostly by black people. Bearing in mind that adolescents and children have been mixed here, the data did not represent all the race groups in South Africa and the rates reflect the situation at three units and not the population at large, it was found that the prevalence range of Conduct Disorders was from 2 to 15 %, Major depression and dysthemia was 2 - 22%, Mental Retardation was 10 - 50 % (these were the largest categories).

The period of adolescent development is a complex one. Offer and Schonert-Reichl (1992) state that myths abound about the typical adolescent being constantly conflictual, incapable of rational thought and uncontrollable. Erikson (1968 in Kroger, 1989) claims that Identity Formation generally occurs during adolescence as a result of the childhood process of introjection and identification. Identity formation occurs only when the adolescent is in a position to select some and discard other of the childhood identifications in a manner consistent with his/her interests, talents and values. Blos (1967), an object relations theorist, names the adolescent period 'the second individuation process'. There is

an increased vulnerability to the personality organisation, the necessity for an alteration in psychic structure as a result of maturational developments and in the event of a failure to individuate, specific deviant development is likely to occur. There is a need for therapy if development is interrupted.

Barton and Borduin (1991) have critically reviewed psychotherapy outcome studies with adolescents between 1978 and 1988. They have concentrated solely on outcome studies, thereby excluding many other relevant and important studies about adolescent psychotherapy. Barton and Borduin (1991) evaluated individual psychotherapy as well as systemic (especially family therapy) studies. Their findings indicated that there are positive short-term outcomes for individual therapy, however, long-term outcomes still need to be investigated. On the other hand, systemic therapies often had positive outcomes that were maintained over follow-up periods. Their review excluded studies which made use of psychotropic medication, academic tutoring and / or bibliotherapy. No justification was given for this exclusion.

Lewis (1993) links adolescent social development with psychotherapy and in so doing points out two distinct stages of social development: Detached Relatedness (early adolescence) and Disappointment in Relatedness (middle adolescence). In order to conduct effective psychotherapy with adolescents it is necessary to be aware of their specific developmental stage. Initially the adolescent exhibits the following characteristics:

a tendency to remain removed from attachment so that group membership is paramount, the value of the other is minimised, extreme self consciousness predominates, idealisation of a hero might take place and introspection does not readily occur resulting in the therapist perhaps reducing his / her goals aimed at attaining closeness and empathy.

Lewis (1993) explains `Disappointment in Relatedness' as the adolescent becoming aware of the limitations of involvement with the hero and acquiring a sense of the limitations of relatedness itself, depression is fairly common as the adolescent becomes aware of his / her capacity to cause harm and guilt takes on a different meaning. As a result the experience of disappointment might emerge in the therapeutic relationship with its concomitant feelings of loneliness and guilt.

Hendren (1993) points out that this in turn makes it difficult to evaluate outcome research with adolescents and children. For example, it is sometimes hard to distinguish between behaviour which is phase specific and developmental and those symptoms that are longer lasting and need intervention. Similarly when assessing adolescents' perceptions of therapy it is important to note their developmental stage as some of their evaluations could stem largely from their developmental stage (eg. the desire not to attend therapy might be a function of their need to assert their independence from adult authority figures).

2.5 Criticism of the Empirical Literature

All the above meta-analyses excluded studies that did not use statistical techniques to evaluate results. So reviews, discussions and case studies were excluded. This positivist approach to the understanding of adolescent psychotherapy advocates an understanding that this research can isolate separate variables (eg. family therapy and problem behaviour at school) and quantify, describe and explain the relationship between these variables through using controls and the application of particular statistical tests (Dawes & Donald, 1994). One of the outcomes of positivist research is that the child is seen as separate from the social context. The child and the social context are perceived as two distinct realities about which one can find universal truths (Dawes & Donald, 1994).

The empirical research indicates further that an effective assessment of therapy rests upon carving the research into small, isolated units of investigation which fall under three main areas: the effects of treatment, conditions that influence outcome and the process through which change is achieved (Kazdin et al., 1990). Often one of these areas is split off for special attention and measured independently of the other areas. For example, Reynold and Coats (1986 in Mann & Borduin, 1991) assessed adolescents on a variety of outcome measures (eg. depression, self-esteem) after either receiving cognitive behaviour therapy, relaxation training or no therapy.

The distinction between effects, pertinent conditions that influence therapy and process

seems a false one, designed predominantly to assist with empirical observation. The influence of each of these factors upon the total experience of therapy seems crucial. In addition Kiesler (1966 in Hill, 1994) points out that an assumption of a uniformity myth often operates, namely that certain processes affect everyone in the same way. Hill (1989 in Hill, 1994) conducted a study with eight anxious/depressed clients and found that some therapist techniques (eg. interpretation, approval) were helpful in all the cases, whereas other techniques were helpful in some cases but not in others (eg. direct guidance, confrontation).

Various mechanisms are used in order to transform psychotherapy into a science. It could be argued that this occurs through both a reliance upon a positivist paradigm and the construction of psychotherapy within a medical discourse. An alternative philosophical framework (which perceives the individual as an active agent constructing his / her own environment) is perhaps more useful (Howard, 1984). It is argued that such a framework need not and should not replace the current reliance upon positivism and experimental methods of investigation. Instead there needs to be an acknowledgement of the utility of both these frameworks of understanding.

"Positivism... described science as a system of universally binding propositions verified at each step by objective observations" (Brown, 1977 in Sadler & Hulgus, 1991, p. 22). Logical empiricism which grew out of positivism depicted science as the formation of

rational propositions which were open to observable testing (Sadler & Hulgus, 1991). Dawes (1994) contends that adhering to a positivist paradigm (and accompanying methodology of experimentation) allows the production of predictive statements as well as the specification of the conditions under which specific outcomes are likely to occur. Hence, it is apparent that the application of such a paradigm to psychotherapy research led to a belief in the desirability of empirical testing in order to elicit predicitive statements regarding the relative efficacy of treatments.

However, Dawes (1994) contends that a positivist paradigm fails to deal with agentic aspects of human behaviour as well as postulating a perception of human-social relations as dichotomised. In psychotherapy research subjects have frequently been viewed as "somewhat passive respondents to external influences" (Howard, 1984, p. 440). The reactions of humans to a wide array of interventions (as opposed to their active construal of such interventions) has been researched. Research such as this is only partially relevant, it is necessary to consider individuals as active agents whose behaviour is meaningful in terms of being goal directed (Howard, 1984).

According to Strupp, (1986, p.120) there are numerous references in the literature which locate psychotherapy within a medical discourse. Thus, psychotherapy is described as having "deep roots in medicine". Psychotherapy was defined as a form of medical treatment in the 1950's and such a viewpoint is again gaining ascendancy. He argues

further that the changing definitions of psychotherapy (which have a profound effect on appropriate psychotherapy research) were largely determined by political and economic factors as opposed to new insights regarding the nature of psychotherapy. Therefore, in the 1970's an analogy was drawn between psychotherapy and a drug. This was in direct response to political considerations (ie. policymakers entered the debate regarding the efficacy of psychotherapy in the 1970's). Moreover, this medical discourse constructs psychotherapy as a 'treatment' which is employed after a 'diagnosis' and is administered by a therapist to a 'passive patient' (Strupp, 1986).

However, psychotherapy is not a medical treatment. Instead the emphasis should rest upon a unique human relationship that the therapist creates, maintains and manages. Obviously empirical methodologies which aim for scientific accuracy have a role to play in drug research but their effectiveness is more problematic when applied to the researching of all the subtleties inherent in a human relationship. Forsyth and Strong (1986) pose the question whether studies that take place in a laboratory setting should be applied to psychotherapy.

It is apparent that there is a necessity for a model or research which acknowledges the active agency of humans in constructing and interpreting their environments. Harre (1974 in Howard, 1984, p.431) claims that the adoption of such a model "requires a very radical departure from the simple-minded positivist methodology of dependent and independent

variables, of statistics and correlation coefficients". Morrow-Bradley and Elliott (1986 in Elliott & Anderson , 1994) add further that descriptive accounts of therapy from writers, supervisors and clients tell us much more about how to do therapy than quantitative results of psychotherapy research. However, therapy researchers typically follow a number of simplifying assumptions which are part of our positivist research traditions (Lincoln & Guba, 1985; Polkinghorne, 1993 in Elliott & Anderson, 1994).

One such simplifying assumption mentioned by Polkinghorne (1993 in Elliott & Anderson) which crops up in literature and which is particularly pertinent to this study is the following: the single perspective of measurement. This assumption claims that a single point of view (eg. client, therapist or outside observer) is adequate for assessing the process of therapy so that the data provided by clients is enough to describe the therapy process. There are a variety of views about the relative merit of the client's perspective on therapy. For example, Truax and Carkhuff (1967 in Elliott & Anderson, 1994) adopting what could be termed a radical view, claim that client information is so biased as a result of response sets and defensive style as to render it invalid as an evaluation of the therapy process. In addition clients cannot recognise therapist empathy without training. Although the view put forward by Truax and Carkhuff is extreme and is obviously refutable in its assumptions that all clients are essentially insensitive to noting therapist empathy, the simplifying assumption mentioned above does need to be taken more seriously. The available literature on clients' experiences of therapy is fairly limited hence any addition to

this literature (especially from an adolescent perspective, which is under-researched) is useful as a starting point in this area of therapy research.

Toukmanian and Rennie (1992) note the difference between the 'paradigmatic' approach (ie. logico-scientific reasoning giving rise to hypotheses and verification or rejection of hypotheses) and the 'narrative' approach (ie. qualitative, hermenuetical and inductive) - both are present in psychotherapy research. In psychotherapy process research the paradigmatic approach has dominated, the narrative approach being relatively new. They claim further that there are two main areas of psychotherapy process research: the process of change and the study of participants' experiences. The first area ties in with the paradigmatic approach and the second, the narrative. The advantage of the later approach is the chance to uncover aspects of therapy that might not be seen by researchers working within the change-process perspective.

Many of the studies do not discriminate between younger children and adolescents. For example, in a meta-analysis by Weisz, Weiss, Alicke and Klots (1987 in Weisz et al., 1992) the 105 outcome studies which were examined focused on children between 4 and 18 years. Yet adolescents differ markedly from younger children as well as from adults. And so "(t)herepeutic work with adolescents is often seen as more challenging, difficult, and less fulfilling than work with adults or younger children" (Biever, McKenzie, Wales-North, Gonzalez, 1995, p. 491). Furthermore, Kazdin et al., (1990) claim that there is a

lot of research which focuses on the 6- to 11- year age group. There is also slightly more research on boys than girls.

2.6 Research on clients' experiences of being in therapy

As mentioned above, there are not many studies which report on the client's subjective experience of being in therapy. McLeod (1990) reports that clients are seldom asked about their views on their psychotherapy and counselling. He outlines a number of reasons for this, including the strong institutional pressures for people to do research that obeys the assumptions and practices of natural science - in other words researchers need to make reliable, objective measurements of variables in conjunction with experimental control in order to test hypotheses. This results in the subjective feelings, beliefs or values of clients being deemed non-legitimate and unresearchable. Clients' experiences are also neglected as a result of the influence of psychoanalytic theory which often interprets the client's claims as defensiveness, fantasy or transference making it difficult for the client's accounts to be taken at face value. This scepticism about the validity of clients' responses is even apparent in research that investigates clients' perceptions. For example, Murphy, Cramer and Lillie (1984, p. 187) studied patients' perceptions of curative factors yet showed their own lack of faith in their patients' perceptions by writing the following, "This study is an exploratory one and attempts to observe whether patients are *capable* (italics mine) of developing a list of consistently suggested curative factors".

Rogers conducted the earliest studies on clients' experiences in the late 1940's (Axline,

1950; Lipkin, 1948, 1954; Rogers, 1951 in McLeod, 1990). This was followed by research by Strupp, Fox and Lesster (1969) when they published a book titled 'Patients view their psychotherapy'. Strupp et al. wanted to investigate the reasons people give for seeking help with therapists, the steps they followed in order to become patients, what they experienced when they underwent therapy and finally their reactions to the whole process. They wanted "the patients to speak for themselves and to assess the over all value of their experience" (Strupp et al., 1989, p. xv).

This study importantly used private patients seen in individual therapy over a lengthy period as well as clinic patients. So the problems inherent in laboratory-based psychotherapy research were overcome. Unfortunately most of the therapists were psychiatrists, who may well have had different emphases and orientations to psychologists, thus the results can not be easily generalised to therapy with psychologists.

Furthermore, the study made use of a questionnaire in order to elicit information about patients' experiences. Approximately six out of eighty nine questions were open-ended. Also, patients had to respond to a number of statements in order to indicate the extent to which the statements described the therapy experience. Patients were told to "disregard that at one point or another in therapy you may have felt differently" (Strupp et al., 1989, Appendix B). Such an instruction coupled with many closed-ended questions would fail to elicit contradictions, ambivalence and gaps in people's experiences of therapy.

Mayer and Timms (1970) used an interview technique in order to find out more about clients' experiences of counselling. Most of their clients were working class women. One of their main aims was to contrast the experiences of those people who were satisfied with therapy with the experiences of those who were not. This study was important and stimulated much interest as a result of: the disjunction between client and counsellor expectations and assumptions and because it also demonstrated the feasability of doing research on clients by 'outsiders' (McLeod, 1990, p. 3).

There were also a number of other interview studies. Oldfield (1983) conducted a study and subsequently wrote a book about the experiences of clients of the Isis Centre in Oxford (ages 17 to 63) using questionnaires and interviews. Part of the findings examine the helpful and unhelpful factors in the counselling relationship. Regarding the helpful factors it was found that an attitude of genuine warmth and concern was very important. In addition to this warm, understanding approach a stance of being uninvolved and detached from the situation was also seen as beneficial. At times it was found that an 'aggressive', 'strong' counsellor who could on occasion be 'blunt' was useful (Oldfield, 1983, p. 71). Beyond creating this facilitative environment, the counsellor's cognitive approach was also important - that is the approach to problems and dilemmas. For example, some clients found that the way the counsellor drew attention to underlying themes was very useful. In addition, several participants stressed the helpfulness of seeing

their problems in a new light (Oldfield, 1983). There was also emphasis placed on the beneficial role of positive, encouraging comments from the counsellor.

Murphy, Cramer and Lillie (1984) looked at patients' perceptions of curative factors. They found that patients perceived talking to someone who understands and receiving advice as being of therapeutic help. These factors are positively, although only moderately, related to outcome. Unfortunately the participants mostly received cognitive behavioural therapy, which limits the generalisability of these findings. Oldfield's (1983) study substantiates this as she found one of the perceived unhelpful factors was the absence of advice - this could lead to disappointment and frustration Several people felt that their counsellors could have played a more active role in the sessions. This could have led to some passive aggressiveness on the part of the clients as some participants spoke of bringing material that was not really relevant to their concerns but was designed rather to elicit specific responses as they felt that their counsellors were so inactive during the sessions. It was not only the nature of the relationship that some clients felt was unhelpful, it was also the content of the work, namely, focusing on childhood experiences that was felt not to be useful. Some clients felt that there wasn't much point in stirring up past, negative experiences. It can be seen from the above that much useful information can be obtained from talking to clients directly.

However, it could be hypothesised that taking all clients from one centre, namely the Isis

Centre in the Oldfield study (although useful and interesting in its own right) brings a certain bias into play: the institutional character of the setting is likely to impact upon counsellors working there resulting in the counselling that takes place there being slightly different from counselling or therapy that takes place from a variety of different therapists working in private practice. Oldfield (1983, p. 10) states this in the first chapter of her book, "(The book's) aim is to describe the style of therapeutic work that has evolved in this setting".

Llewelyn (1988) used questionnaires in order to elicit clients' and therapists' perceptions of helpful and unhelpful events during therapy - after each session and after termination. There were some adolescents in this study as the participants' ages ranged from 15 - 60 (20 % fell in the 15 to 25 age group), however no distinction was made between the responses of different age groups although one could well expect that different age groups might find different factors helpful or unhelpful. She notes that during therapy clients placed the greatest emphasis on the reassurance and relief provided by the therapy, whereas in retrospect they valued the problem solving aspects of therapy. Therapists placed their emphasis, both after termination and during therapy, on the cognitive and affective insight which they hoped their clients would develop through therapy. One of Llewelyn's explanations for this discrepancy centres around a difference in the importance of gaining insight for clients and therapists. Generally clients might be less interested in self-knowledge than solving problems and feeling better on a short term basis, whereas

therapists generally are more concerned about helping clients understand the root of the problem so as to prevent their recurrence. In an earlier study Llewelyn and Hume (1979, p. 32) noted that, according to the patients, non-specific activities were more useful than either psychotherapeutic or behavioural type activities (the highest ratings were given to items 'getting reassurance and encouragement' and 'the therapist and I talking about my problems' whereas the lowest rating was given to the item, 'talking about my childhood and seeing how it relates to present needs').

McLeod (1990) divides the findings of the main studies in this field into three areas: becoming a client, the middle phase of counselling and the final phase: ending. Initially clients might find it difficult to seek help, perhaps as a result of norms prevalent in Western society which encourage self reliance rather than dependence. It is not known whether this well hold true for most South Africans.

During the middle phase of counselling, three central aspects have emerged in the literature. Firstly, the experience of self during which the client may be able to work through previously unexpressed thoughts and feelings or perhaps new areas will emerge. There is immersion in the self which is followed by reflection on the self. Secondly, the experience of the relationship was one of the strongest themes to emerge from the studies and this related to the view that overall relationships with therapists were often ambivalent, with therapists being seen as expert and helpful but also as often missing the

point. Thirdly, the experience of significant or helpful events was noted during therapy.

Murphy, Philip, Cramer and Lillie (1984 in McLeod, 1990) found that more than half of the participants in their study (which had involved interviewing twenty four out-patients who had received cognitive behavioural therapy) noted the following factors as having been helpful: advice from therapists, talking to someone who was interested in their problems and who understood, encouragement and reassurance, instilling hope as well as self-understanding. Other studies have also arrived at similar conclusions (eg. Hunt, 1985; Mayer & Timms, 1970; Strupp et al., 1964) and have added the importance of catharsis or emotional release and problem solving.

Liataer and Nierinck (in McLeod, 1990) looked at factors that hindered therapy in client centred therapy and reached the following findings. Firstly, therapy was hindered when clients did not co-operate with the therapist, either by being silent, talking superficially or not being willing to talk about certain things. Secondly, sometimes problems emerged in the relationship between the therapist and the client (eg. the therapist not valuing the client enough or confronting too little or too much). Thirdly, difficulties occurred when therapists made interventions which took clients off their 'track' or when therapists made comments that did not feel right. Bearing in mind that this study focused on client centred therapy it could be possible that the researchers were slightly biased in defining hindrances as factors which were in conflict with this type of therapy (eg. when therapists made

interventions which took clients off their 'track').

During the termination phase of counselling the main themes that emerged were emotional investment and dependence on the therapist, ambivalence about the termination as well as the loss of support. According to McLeod (1990) this is an area that requires further research.

Toukmanian and Rennie (1992) point out that allowing clients to relate their subjective experiences assumes that clients know what they are experiencing, can verbalise it and will be truthful when doing so. It does seem that there is a relative paucity in the literature about client's experiences of their therapy, "A few years ago, Smith et al. (1980) were able to review 475 studies of the effectiveness of therapy. When the number of studies of the experiences of counselling or therapy approaches that figure, it will be possible to be much less tentative about what it can be like for clients to take part in this process." (McLeod, 1990, p. 5) and there appear to be no studies which use adolescents as the client group.

2.7 The importance of this study

It is often claimed that adolescents have a tendency to drop out of psychotherapy (Tramontana, 1980) and clinical experiences seem to substantiate this view (Suzuki, 1989). While few studies have examined this area systematically, Suzuki found that that

dropout rate was high at the assessment stage and that adolescents had a propensity to terminate unilaterally. However, if one considers the patients who remained in psychotherapy beyond assessment and even if one includes those who dropped out during assessment it appears there was no higher rate of premature termination than reported for adults.

Suzuki attributes the perception of the high drop out rates in adolescent populations to the countertranference feelings that are evoked in the therapist during unilateral termination (ie. the therapist feels strongly that the adolescent patient is leaving unprepared for separation and independence which is very similar to the parents' feelings towards the child).

The data was collected from therapists who had to fill in questionnaires about their patients' reason for termination. Such a method is one-sided and may serve to highlight countertransference responses instead of adolescents' own constructions of their (perhaps valid) reasons for premature termination.

Weisz (1987) also examined drop-out rates with children between the ages of 6 and 17 years. They found very little difference between children and adolescents who dropped out of therapy and those who remained in terms of child demographic variables (eg. Socio Economic Status (SES), birth order), therapist variables (eg. gender, age), child

psychological problems and parent-perception variables (eg. parents' perceptions of the clinic and the child's experience there). This finding has important relevance in the utilisation of drop-out subjects as part of a naturally occurring control group for outcome research. It is not clear why the children themselves weren't questioned about their premature termination and instead only the parents were supplied with the opportunity of providing qualitative feedback. Such questioning of the children might have opened up some useful avenues for further research.

2.8 Conclusion

In conclusion, psychotherapy is frequently researched. This makes sense if one considers the vast sums of money, time and hope that are poured into this activity. Understandably the literature in this field is enormous as well as being at times contradictory. Two problem areas have been identified in the above discussion. Firstly, adolescent psychotherapy is less well researched than adult psychotherapy. Secondly, much of the literature adopts an empirical analysis of enquiry with the result that therapy is seen as a scientific endeavour which can be objectively researched. This leads in turn to the loss of a great deal of very rich data which could prove very useful. This literature review has needed to focus on three broad areas: adolescent psychotherapy research, adolescent developmental literature and the limited literature that explores clients' perceptions of therapy.

Regarding the results of adolescent psychotherapy research, most of the review studies

(including the meta-analyses) claim that psychotherapy is more useful than no therapy with this group of people. It must be kept in mind that many studies are research and not clinic studies and as a result there are a number of accompanying problems (eg. participants are not as seriously disturbed or as heterogeneous as those encountered in clinics or private practice). Adolescence has been termed the 'second individuation period' and as such it brings with it its own specific hurdles. This complicates psychotherapy research as certain findings could be the result of developmental changes rather than specific to the therapy. It is important to be aware of the developmental challenges and their likely impact on the therapy process when researching adolescent psychotherapy. When clients' own perceptions of therapy are elicited there often emerges a disjunction between the perceptions of the client and those of the therapist - with the former placing emphasis upon reassurance and relief and problem solving whereas the later tended to emphasis cognitive and affective gains. It is frequently found that clients value the 'non-specific' aspects of the therapy situation rather than specific therapist techniques. Clients' experiences of psychotherapy is clearly under researched. Adolescents do not seem to have been questioned about their experiences at all, leaving a large gap in the available psychotherapy research.

Chapter Three

Methodology

3.1 Introduction

The primary aims of this research were the following:

- To gather adolescent's subjective experiences of being in therapy.
- To interpret common themes as well as contradictions, gaps and ambiguities in their stories.
- To explore any perceived changes in behaviour that occurred as a result of therapy and also to examine the reasons for this change or lack of change.
- To look at those aspects of therapy which were seen to be harmful and those which were seen to be beneficial for these adolescents.
- To find out about how this group of adolescents perceives the psychotherapeutic relationship.
- To explore some of the issues around initiation and termination of therapy and also these adolescents' perceptions of how others viewed their therapy.

Thus, the voices of the clients themselves were of particular importance. The study therefore used a qualitative research design.

Merriman (1988 in Creswell, 1994) notes three important assumptions inherent in qualitative research. Firstly, meaning is of primary importance (ie. how people make sense of their experiences and how they structure their world). Secondly, the researcher is the most important instrument for data collection and analysis, such research is primarily

descriptive (Eisner, 1991 in Creswell, 1994 explains this concept further by stating that data are reported in words, primarily those of the participants rather than numbers). Thirdly, the process is generally inductive in that hypotheses and theories are built up from details. Qualitative research differs from quantitative research in that specificity rather than replicability is important - hence, the adolescents' particular meanings about their therapy needed to be thoroughly explored (Bannister, Burman, Parker, Taylor & Tindall, 1994). It is the sense which underlies a particular case (or the single case study) which is seen as having great relevance. So an in-depth analysis of the meanings at work is called for rather than an attempt to skim over as wide a surface as possible. As a result collecting outcome data from many adolescents' therapy would not have provided an in-depth analysis of the multiple meanings at work within each participant's account as well as between the adolescents' accounts.

Frequently with qualitative research problems the concept is "immature" as there is a lack of previous research, the available theory is felt to be inappropriate or biased, there is also a need to explore and describe the phenomenon and in so doing to develop theory (Creswell, 1994). In the present study it can be seen that there is a lack of previous research that directly assesses adolescents' perceptions of their therapy, much of the theory is empirically based, which is inappropriate for asking the kinds of questions that this study asks, and there is a need to explore such perceptions in order to draw up hypotheses and resultant theory. This study aims to draw up some hypotheses about adolescent psychotherapy which would then need to be researched further.

The role that the researcher plays is of fundamental importance in qualitative research (Banister et al., 1994). The perceptions of the researchers assist in defining the problem - so the subjectivity of the researcher needs to be seen as a resource and not as an impediment.

3.2 Theoretical Basis for the Research

The questions that are asked in a qualitative study affect the qualitative methods used which in turn have broader theoretical underpinnings. This thesis draws upon phenomenology - the understanding of this term is varied and multiple and unfortunately space does not permit an in-depth analysis of this term. Patton (1990) states that phenomenology is a theory that perceives meaning in the structure and essence of an experience of a particular phenomenon for certain people. Phenomenology would look at how people describe and experience phenomena through their senses (Husserl, 1913, 1962 in Patton, 1990). Furthermore, their subsequent interpretation of this experience has relevance. Phenomenologists look at how people put together the phenomena they experience in such a way as to make sense of the world. Importantly phenomenology notes an essence(s) to shared experience and core trends which are mutually understood through a common experience (Patton, 1990). There is a search for these commonalties (Eichelberger, 1989).

In addition Eichelberger notes that each person has a unique set of experiences. Contradictions and inconsistencies between different accounts can then be anticipated. Therefore, this study moves away from straight empirical analyses of psychotherapy

research as a result of the critiques noted above. However, phenomenology still allows commonality and some generalisability to emerge while placing the adolescent's own subjective experiences at the forefront of importance. The term empirical phenomenology would accurately describe the theoretical basis of this research - that is, the research is open to all perceivable dimensions of the phenomenon that is being researched. Therefore, the experiences of both participants and researcher are of importance (Tesch, 1990).

According to Smith (1995) it is thought that a respondent's contributions in an interview has some significance for him or her. In addition there is some relationship (although not a transparent one) between what a person says and the beliefs or psychological constructs that that person holds. Giorgi (1995 in Smith, 1995) states that this approach could also be described as phenomenological. However, meanings also occur within a social context and are negotiated in such a context.

3.3 Sampling

Marshall and Rossman (1989) note that an appropriate site for research has the following qualities. Entry needs to be possible, there must be a high possibility that many of the people, processes and interactions under investigation actually occur and the methods of sampling need to be adequate in order to ensure that the data has quality and credibility. As a result pupils at Boston House College were chosen as participants - eight were interviewed altogether. Entry and acceptance of the researcher's presence was possible as the researcher had taught at this school two years ago. Furthermore, there are many adolescents at this College who receive private therapy, hence making it possible to

investigate 'real life' therapy that has none of the pitfalls of research based therapy as outlined in the literature.

This study needed to rely upon volunteers who felt comfortable talking about their therapy experiences. It is possible that volunteers may share certain characteristics which influence their construction of their therapy. Rosenthal and Rosnow (1969 in Mouton & Marais, 1991) note that volunteers are frequently more intelligent and display lower levels of authoritarianism.

A number of selection criteria regulated participation in the research (1) the adolescents had to have been in therapy for at least five months as this gave them sufficient time to gain an impression of the experience of therapy; (2) the therapy must have been predominantly private although one client had been hospitalised for a short period of time and (3) it was preferable that clients had completed their therapy - unfortunately this was not always possible and there was one participant who was still in therapy. Although retrospective memories have certain limitations, it was hoped that participants who had completed therapy would have had time to assess the longer term effects of their therapy.

3.4 Participants

The gender, age, grade, presenting problem and with whom the adolescent lives are presented in Table 1 below.

Table 1
Participant Characteristics

Participant	Gender	Age	Grade	Presenting Problem	Lives with:
One	Female	17	12	Depression, extreme shyness at school	Mother and father who are married
Two	Female	18	12	Parents going through a divorce	Mother, mother's boyfriend and brother
Three	Male	20	12	Self destructive behavior - cutting himself.	Don't know - currently lives with girlfriend.
Four	Female	17	12	Teasing at school, eating disorder, wanted to commit suicide.	Parents, brother and grandmother
Five	Female	18	12	Depression and later peer pressure and drugs	Mother and sister - parents divorced
Six	Male	16	10	Aggression, disruption -	Mother - parents divorced
Seven	Female	15	10	Addicted to slimming tablets, depression, mood swings	Mother
Eight	Male	17	10	Attention problems, aggression, unable to control temper	Parents

The characteristics of each participant's therapy are presented in Table 2 on the next page. The length of the therapy, the number of different therapists seen, whether the participant is still attending therapy, the number of sessions per week and the type of therapy are all included in this table.

Table 2
Characteristics of therapy

Participant	Length of therapy	Number of different therapist seen	Still attending therapy	Number of sessions per week	Type of therapy
One	Off and on for seven and a half years.	Seven or eight therapists.	No.	Generally once a week but at times two or three times a week.	Doesn't know.
Two	Off and on for two years	Three	No	Once a week except when hospitalised	Doesn't know
Three	Off and on for two years	One	No	Once or twice a week	Doesn't know
Four	Off and on for eight years	Three	No	Once a week or once every two weeks	Doesn't know
Five	Off and on for ten years	Two	Yes	Between one and three times a week	Doesn't know
Six	Two Years	Two	No	Once a week	Doesn't know
Seven	Two and a half years	One	Ending on day of interview	Once or twice a week	Doesn't know
Eight	Year and a half	Three	No	Once a week and then once a month	Doesn't know

3.5 Interviewing

One of the main points of the interview is to attempt to perceive the world through the individual being interviewed (Ely, Anzul, Friedman, Garner & Steinmetz, 1991). Bannister et al. (1994) and Ely et al. (1991) note that this aims to move closer to hearing people's subjective meanings of their world and trying then to interpret these meanings. There is an assumption underlying qualitative interviewing, namely that the viewpoint of others is "meaningful, knowable and able to be made explicit" (Patton, 1990, p. 278). Part of the rationale for using interviews in this study stems from the complexity of the subject of investigation. It is anticipated that there will be nuances and subtleties. Banister (1994, p. 50) states that it may not always be possible to simplify issues which involve "contradictions and complexities" into a questionnaire.

Interviews, particularly more unstructured ones, allow the interviewer to alter the interview in order to fit individual comments or questions (Banister et al., 1994). In the present study the researcher used semi-structured interviews. Semi-structured interviews and qualitative analysis is especially useful if the researcher is interested in complexity or when an issue is controversial and personal (which therapy is) (Smith, 1995). Patton (1990) refers to three approaches to interviewing: the informal conversational interview, general interview guide approach and the standardised open-ended interview. The interview guide best approximates the type of interview that will be used. A set of issues was outlined before interviewing began (see Appendix One). These issues were not presented in any particular order and the actual wording of the questions varied between

respondents. This allowed for an open and flexible approach so that each individual had an opportunity for his or her unique stamp.

Massarik (1981) drew up a typology of interviews. According to such a typology the interviews conducted in this study could be termed 'rapport interviews'. That is an attempt is made to establish a genuinely human relationship between the interviewer and the interviewee, a measure of mutual trust exists and although the interview objectives are fairly focussed there is some space for small talk, casual by-play and interpersonal activity.

Interviewing which incorporates reflexivity will make more visible power relations between myself and the adolescents (Banister et al., 1994). For example, I interviewed adolescents so an age differential exists. However, allowing these adolescents to tailor each interview to their specific needs, helped reverse the obvious power inequality between researcher and researched.

However, interviews have various shortcomings. Marshall and Rossman (1989) note that co-operation may not always exist during interviews. The participants in this study were not coerced in any way in order to participate, although it is possible that some of them may have transferred their negative feelings towards the therapy process onto the interviewer, hence reducing co-operation. It did appear that those participants who viewed therapy in a negative light required greater effort on the researcher's part and were less fluid and verbal in their responses. It is possible though that it is these precise subject

characteristics (eg. limited verbal ability) which resulted in long term therapy not being the most beneficial for such clients. Moreover Marshall and Rossman (1989) claim further that interviewees may not always be truthful and the interviewer may ask inappropriate questions. It does appear that the participants in this study were able to express very negative viewpoints about therapy perhaps indicating a degree of truthfulness. It seems though that all these limitations would exist with other research strategies such as questionnaires.

Patton (1990) critiques the interview guide approach by claiming that altering the sequence and wording of questions can elicit substantially different responses from different perspectives, thus hampering comparability of responses. However, it is precisely these different perspectives and alternative constructions of the subjective meaning of therapy that is of interest in this thesis.

3.6 Analysis of the data

It needs first to be noted that the research design, data collection and analysis are not separate stages in qualitative research. Instead there is a constant interplay between these processes (Bryman & Burgess, 1994). There is usually some analysis (eg. personal reflections) on entering the field.

The tape recorded sessions from the interviews were transcribed verbatim by the researcher in order to conduct a content thematic analysis. The content can refer to any message that has been communicated be it words, symbols, ideas or themes (Neuman,

1997). This method of analysis involves the drawing up of categories that comes from and helps to explain the data (Ely et al., 1991). Content analysis can be qualitative or quantitative - the researcher used an interpretive or qualitative version of content analysis (Neuman, 1997).

After the transcription had taken place coding could start. Prior to coding though, the researcher used a method outlined by Smith (1995). Hence, one transcript was studied in detail (in this case it was the first one as it was the most lengthy and the interview schedule had been followed more rigidly then with the other interviews) before moving to the others. This idiographic approach to analysis starts with particulars and then works up to generalisations. On one side of the margin the researcher noted anything that struck her as interesting or significant - these could be summaries or associations or connections. On the other side, emerging theme titles were written down. A separate sheet of paper was used to document the connections between the various themes and also to group main and subordinate themes. Coffey and Atkinson (1997) state that coding could consist of a number of approaches that assist with the organisation, retrieval and interpretation of the data. The coding in this piece of research was carried out for two purposes which may appear contradictory but frequently co-occur (Coffey & Atkinson, 1997):

(1) Data simplification or reduction which was done in order to reduce the data to manageable proportions. This results in certain data segments being categorised under the same codes. According to Seidel and Kelle (1995 in Coffey & Atkinson, 1997) this helps in noting commonalties, contradictions and patterns.

(2) Expansion, transformation and the reconceptualisation of the data in order to open it up to a wide range of analytic possibilities. This is carried out in order to come up with new questions and levels of interpretation (Coffey & Atkinson, 1997).

The researcher began the coding procedure with a simple framework in mind which was based upon the research literature as well as the researcher's interests. However, the process of reading through the data brought other themes to light. Coffey and Atkinson (1997) point out that ideas for coding can come from a number of sources which are not mutually exclusive. General categories as well as sub-categories were identified and direct quotations were used to illustrate such categories. Both similarities in adolescents' perceptions as well as their contradictions were sought. According to Coffey and Atkinson (1997, p. 47), it is very important to look for the "exceptions, misfits and 'negative findings'".

Part of the analysis of the data in the present research stemmed from a log which was kept throughout my data gathering. Ely et al. (1991) state that the log should incorporate all data that was gathered through the interviewing process. The log has a number of functions: records of what was learnt and insights around that, the basis for the analysis and facing the self as a tool through personal dialogue about feelings, problems, hypotheses and doubts.

3.7 The Researcher: Self-Reflexive Issues

The importance of reflexivity has previously been mentioned in qualitative research, hence, this section focuses on my own experiences and perceptions during the research process. This will draw on notes that I kept at the end of each interview session.

Although strong attempts were made to establish rapport with participants by means of empathy this was not always successful. At times certain participants became very mono-syllabic or else responded in an irritated, slightly aggressive manner. Therefore, it was difficult to draw out their views fully. This could have been a feature of their limited verbal skills. Alternatively, it could be that some participants were aware of the age gap that existed between myself and them, perhaps resulting in a subtle power differential which led them to believe that I might not understand or accept their true views. It could also be that some of them may have had this perception of me as an "authority figure" of some sort, especially as I played the role of the "asker of questions" and they merely responded to the question. I did attempt though to alter the interview in response to the particular issues that each participant raised. However, such a division or roles might have evoked other such social interactions that adolescents are familiar with (Eg. parent - child, teacher - pupil) and as a result certain adolescents might respond with rebelliousness or passive aggressiveness - hence, minimal responses and an occasional irritable tone.

At times I was aware that the manner in which questions were phrased was indicative of my own biases and difficulties that I experience as a therapist. For example, silence during

the therapy was frequently mentioned by this group of adolescents. At times I would ask if this silence made them feel uncomfortable - instead of asking the question in a more open ended manner. This was more a projection of my own therapeutic difficulties rather than an open ended exploration of the participants' perceptions. In addition, there were times when a participant's discussion of therapy gave clues about the type of therapy that had taken place (eg. cognitive based therapy or psychodynamic therapy). It was difficult not to let my own biases emerge through the manner in which I phrased the questions. Therefore, a different interviewer might have phrased questions in an alternative manner which might have elicited different responses from the participants.

An additional factor that might have impacted upon the participants' responses was the fact that I taught English at that school two years ago. One of the participants was a former student of mine. I found that it was very easy to establish rapport with this participant and her interview was the longest. She divulged a lot of information to me that I might not have been able to gather had I not established a relationship with her in the past.

3.8 Ethics Appraisal

All interviewees participated with informed consent. Prior to giving their consent students were told about the aims of the research as well as how it would be written up. The interviews, recordings, transcriptions and analyses were kept confidential. However, they were available to the participants (if they requested an opportunity to view their transcripts). The interviews, recordings, transcriptions and analyses were also available to

the supervisor. In the writing up of the thesis anonymity was guaranteed. Feedback was offered to the participants if so desired.

Chapter Four

Results and Discussion

4.1 Introduction

This section will outline the various themes that emerged from the literature as well as the in-depth interviews. It needs to be kept in mind that this list of themes is not exhaustive. Instead the most important themes are mentioned. Such themes were seen as being important if they raised issues that were particularly pertinent to the adolescent developmental stage or if a fairly large number of participants raised similar issues. In addition, the categories that emerged are not always discrete. The themes outline both similarities and contradictions between participants as well as some contradictions which occurred within individual participants' responses. Some of the themes overlap and the categories themselves are not always distinctly separate from one another as certain perceptions could probably appear in more than one category.

The main categories that will be discussed in this section include the following:

- Types of change - both insight-orientated and behavioural changes
- Understandings of why therapy does or doesn't bring about such changes
- Perceptions of the psychotherapeutic relationship
- Factors that were judged to be helpful and non-beneficial in therapy
- Initiation and termination of therapy
- Perceptions of how others (family and peers) viewed the adolescent's therapy

The numbers that appear in brackets after each excerpt from a participant indicate which participant has spoken. These numbers correlate with Table 3.1 in the Methodology

section. In addition, with some excerpts the interviewer's and the participant's comments are quoted. Where the letter `I' appears this refers to the interviewer, where the letter P appears this refers to the participant and the number after the letter P again indicates which participant is quoted.

4.2 Types of Change

Participants were asked about any changes that had occurred since the commencement of therapy. There are multiple changes that could occur as a result of therapy. Corey (1991) mentions some of the following: restructuring the personality, building up trust in oneself, reducing anxiety, curtailing maladaptive behaviours and learning more adaptive behaviours and making the unconscious conscious.

4.2.1 Insight Orientated Changes

Oldfield (1983) comments on the types of changes that could be expected. She notes that the client needs to acknowledge weaknesses as well as destructive impulses without excessive shame and guilt. These more insight orientated changes (ie. knowledge and understanding of feelings and behaviours) were also noted by some participants.

1. ... **and so one of the things is that I am able to pinpoint in myself without getting upset or defensive my bad points and I am able to accept, ok, this is something I do. (5)**

2. **I stopped being so sensitive. I started to accept myself more and it helped me to get over a lot of family members died in my childhood and it helped me to get over that (1)**

Oldfield (1983) points out that in striving for changes clients could well experience a growth in self-esteem and greater self-confidence. The second quotation illustrates this growth in self-esteem as the participant comments that she started to accept herself more. However, therapy also seems to bring about knowledge and understanding that deals with the specific set of demands of the adolescent developmental period.

3. In the last two and half years a helluva lot has happened. I have changed a lot. I have gone through so many different groups of friends and different phases of my life. And I think it would have been really, really confusing. It was really, really confusing, it is really, really confusing but it would have been more confusing if I hadn't had someone to go and speak to about it. And like it helps you like see what's actually happening when you sit down and you actually speak about it. (7)

Two aspects of adolescent development are apparent here. Firstly, it can be seen that group affiliation dominates (Lewis, 1993) - the group prescribes attitude, dress and behaviour. There is particular "closeness" in being separate from attachments (Lewis, 1993, 346), however, Lewis maintains that the therapist may have to reduce his / her readiness for closeness and empathy. Yet with the above participant it appears that it is closeness with the therapist that is the one stable, anchoring force in her life during a developmental period which is sometimes characterised as tumultuous. Secondly, the talk

about confusion highlights what Anna Freud referred to as a "normal period of abnormality" (Freud, 1958 in Steinberg, 1987) - a time of life during which turmoil and muddle could be viewed as normal.

Not all participants were as effusive about insight orientated changes that occurred as a result of therapy. For example, this 16 year old male had the following to say:

I just think it's a load of rubbish because it didn't help. Maybe like a tiny bit I mean but over two years like it made me think a little bit. It's a waste of money. (6)

"Thinking a little bit" is hardly comparable to a deep confrontation and exploration and working through of thoughts and feelings that have previously been avoided - one of the functions of therapy (McLeod, 1990).

4.2.2 Behavioural Changes

Malan (1979 in Oldfield, 1983) points out that many clients experienced changes in the way they related to other. This could involve movement from either a position of excessive passivity or extreme aggression. This would involve taking responsibility for an appropriate degree of assertiveness. Some participants were able to pinpoint such behavioural changes that followed from their therapy experiences.

1. **I as a person have become more assertive. I mean people will say something you know if they say something horrible to me, right I know I mustn't talk back but I can turn around and I can say something horrible back to them without feeling bad**. (4)

2. I: Do you think it (therapy) has changed you at all ?

P8: Ja, well I am not so aggressive anymore like I used to be...

I: Ok, do you think therapy has changed that or do you think it's other stuff ?

P8: I think it's therapy. Because I mean if I didn't go to therapy I would still be like pretty mad...

I: But do you still get aggressive ?

P8: Ja, I still get aggressive. But like I can control it now you know whereas I never could control it. I mean I used to hit my teacher as well. (8)

It is evident that therapy has played a role both in increasing assertiveness (and decreasing passivity) (Participant Four) and in decreasing aggressiveness (Participant Eight). Therapy also appears successful in modifying some typically adolescent behaviours such as smoking and taking drugs - it is well documented that more adolescents then ever before are experimenting with drugs at a younger age (Takanishi, 1993).

1. **And generally being able to depend on the escapes less and less and less. At first it was drugs and then it became eating disorders and then it was this and then it was that. And just letting go of those types of escapes.(5)**

2. **Well, last year I smoked alright...And I quit smoking a few weeks ago... And last year he was like telling me, no, smoking does this to you and that and I wasn't really listening and then this year I remembered what he had said and I thought you know what he is saying is right and I shouldn't really be smoking. (4)**

However, there was not always consensus about the behavioural changes induced by therapy.

1. **I mean I still have these problems that's why I say it (ie. therapy) doesn't really, I don't think it helped me that much… Ja, I don't cut myself anymore. But that wasn't because of the therapy. I mean that was just because I got myself sorted out and my girlfriend doesn't really like it at all. (3)**

2. **Ja, it's (ie. therapy) helped me to recognise it but it hasn't helped me to stop it (ie. extreme mood swings of mania and depression) (1)**

4.3 Adolescents' understanding of why therapy can or cannot bring about behavioral and insight orientated changes

Some of the reasons for therapy's success in bringing about positive changes could be attributed to the characteristics of the client as well as an understanding of the process of therapy. With regard to client characteristics, the following quotations illustrate an openness about receiving help, a certain attitude of trust towards the therapist as well as the client assuming some responsibility for change within therapy:

1. **I am always open to help and that's how I see it. And I also I never had a problem with opening up or trusting the therapist. (5)**

2. **Ja, I would say I have a good attitude towards therapy. I believe that it can be a good thing or a bad thing depends how you want to make it, it's all up to you. It's a two way thing which is what I learnt through therapy as well. (5)**

These attitudes substantiate some of the findings apparent in the adult psychotherapy literature about subject characteristics that impact positively upon therapy. For example, an important predictor in the therapeutic relationship is the client's participation in the therapy relationship (Lambart & Asay, 1984). It is obvious that the level of participation is high in the above participant's comments and according to her assessment, her therapy has been largely successful. Client openness in the relationship has also been shown to be related to positive outcome (Kolb, Beutler, Davis, Crago & Shanfield, 1985 in Whiston & Sexton, 1993). Furthermore, it has been found that when clients' expectations are similar to those of the therapist then clients are less likely to drop out of therapy (Lambart & Asay, 1984). Unfortunately the expectations of the therapist are unknown in this study but it could be hypothesised that the expectations expressed above of taking responsibility for the success of therapy and therapy being a two way thing are likely to be expectations of most therapists.

With regard to the process of therapy it seems that there needs to be an understanding that therapy passes through different stages.

When I think that if you actually pursue it (ie. therapy) you find out that there are a lot of stages. I know that I have gone through so many stages. I have gone through stages of confusion and then anger and then hurt and then this and then that and eventually you become more self reliant and you start to realise things and you are able to put things into perspective. (5)

This can be contrasted quite strongly with reasons put forward for the lack of success of therapy in bringing about behavioural changes. One participant who desired a certain change from therapy - ie. to stop engaging in the self-destructive act of cutting himself claimed that he was reluctant to explore his childhood, perhaps indicating that he was reluctant to explore some of the roots of his problem despite realising the importance of such exploration.

She was always trying to go back into my childhood as I was saying which I don't like talking about. And it rather upset me a bit. But I guess that was the root what she said was the roots of my problems... I mean stuff started coming out and then when it started coming out I was like really get upset sort of thing. I mean you don't want to think about things like that... maybe I started remembering things that I don't want to remember and things like that but why would I want to, I put it behind me... I don't find it helpful to me that much (5)

Despite his realisation of the importance of talking about such "stuff", this client is understandably resistant and so seeks to transform this resistance into an explanation that remembering and dealing with such information is not helpful to him and won't help him solve the current self-destructive behaviour. Of course the work of therapy can at times be very painful and disconcerting -and there are two therapeutic assumptions that are being challenged by this participant, namely that the past is relevant to the present and that dealing with disturbing feelings helps one to deal better with them (Oldfield, 1983). Certain clients in the study by Oldfield (1983) also reported feeling troubled by focusing on childhood memories and unpleasant memories. According to Anna Freud (1936, 1958,

1966 in Steinberg, 1987) the developing ego may deal with powerful feelings by means of psychologically defensive manoeuvres such as the denial of strong feelings (either to oneself or to others). Steinberg (1987) maintains that the use of denial occurs frequently in psychotherapeutic work with adolescents.

The viewpoint that therapy had little effect in altering behaviour was a fairly common thread amongst those adolescents who had more negative assessments of therapy.

1. I: Ja, and therapy's helped you to recognise those states ?

P1: Ja, it's helped me to recognise it but it hasn't helped me to stop it.

I: Ok

P1: I would have to think that myself. (1)

2. I: Ok and you say that not much has changed except perhaps that you are a bit better at controlling your temper ?

P6: No, a lot has changed but not because of therapy.

I: What has made these changes for you ?

P6: Me, I have decided to change. I mean it's my choice no-one is going to make me change unless I want to. (6)

These comments alert one to an interesting finding. It seems important for some adolescents to maintain a sense of their own autonomy when it comes to dealing with their problems. There is a reluctance to acknowledge the role of an adult in bringing about such changes. This again emerges as a fairly prominent theme when the

participants describe their reasons for termination (which will be discussed later). Blos (1967) writes about the second individuation process of adolescence during which there is a getting rid of family dependencies and a simultaneous loosening of infantile object ties. There is often an attempt to disengage from the parental ego support, hence making it more appealing for adolescents to view changes as self determined rather than object determined. Blos comments further that as the loosening of infantile object ties occurs so too the ego becomes increasingly antagonistic towards the re-establishment of those somewhat abandoned ego states and drive gratifications that were apparent during childhood. This effort to separate from infantile dependencies (both internal and external) might make it preferable for some adolescents to view change as self-directed.

Steinberg (1987) points out that adolescent patients may well experience a degree of resulting ambivalence - eg. the hostile rejection of a therapist upon whom one is dependent. Of course such ambivalence could be present in any therapeutic situation. It is likely to be somewhat amplified during adolescence due to the very strong urge to separate and individuate. There was some indication of this ambivalence in certain participants' responses. For example, Participant Six noted the uselessness of therapy yet later acknowledged his desire to continue at some future date.

I mean ja, you go to therapy. I was there for like two years and like maybe like that two years just made me realise like a few little things you know - it just didn't help much. You sit there and waste your time.

And then later in the interview:

I: So even though it didn't really help you, you could still see yourself going back to therapy ?

P6: Ja, it's not like I don't want to go, no. But if I have a problem, I will go. Like something to do with drugs or something like that.

I: So let's say you had a drug problem what would you do ?

P6: I would go to therapy, maybe it would help (6)

There could be an alternative explanation for understanding the reasons for the change in adolescents' problems. It could be that developmental changes have resulted in an increased ability to deal with the demands that have resulted in the adolescent attending therapy in the first place. This problem is reflected in the literature - Kazdin (1993) claims that problematic behaviour could well be the result of the age and stage of the development of the child or adolescent. As a result of the rapid changes adolescents undergo, problems may appear and disappear. One of the participants explains this dilemma in her own words.

I: But do you think that (ie. her increased assertiveness) came about because of the therapy or in part because of the therapy ?

P4: Well, partly because of the therapy and also I have grown up as a person. (4)

4.4 Perceptions of the psychotherapeutic relationship

It is difficult to define the psychotherapeutic relationship (Gelso & Carter, 1985 in Whiston & Sexton, 1993) yet it is this interpersonal interaction between client and therapist which is often the basis of therapy - therapeutic techniques can only take place

within this relationship (Whiston & Sexton, 1993). McLeod (1990) substantiates this view by stating that it is necessary for the client and the counsellor to establish an emotional bond in order to work together constructively. Yet how do adolescents view this relationship ?

It seems that two scenarios are likely. In the first place the therapist is perceived as a friend and the relationship is seen as one of friendship.

1. I saw her as a friend. I mean she was always trying to help me and sort out my life (3)

2. I: So for you seeing a therapist and seeing a friend isn't much difference in talking to the person ?

P6: Ja. (6)

3. Before I did actually see her as a friend and more than a psychiatrist but now I am aware of the reality (5)

Participant number Five quoted above throws some light upon a possible reason for viewing the relationship as one of friendship. In her own words:

... when she first told me about the Medical Aid and that I have to be cutting down my sessions I realised that I did see her as more than a psychiatrist even though I knew that she was, obviously because I don't pay for my sessions. So I don't really

feel the fact that you pay for a service you know. So for the first time I realised she is a service that we do pay for her. (5)

It is unlikely that adolescents will pay for their own therapy, thereby making it easier for them to view the therapist as a friend rather than as a professional who engages in a contractual relationship. This does not occur across the board though. The following participant has a more cynical assessment of the nature of psychotherapy.

I never treated my therapists as like a friend you know. It was always just my mom's paying. Let me talk to this person kind of thing. (2)

The literature indicates that this is not an uncommon perception. Maluccio (1979 in McLeod, 1990) found that clients frequently referred to their counsellors as good friends. In addition, Timms and Blampied (!985 in McLeod, 1990, 8) used the term, `formal friend' to convey the perception that many informants had towards their counsellors. The above is an important issue as it has a deep effect on the nature of the working alliance. Whiston and Sexton (1993) claim that the working alliance incorporates the emotional bond between client and therapist, the quality of the involvement in the therapy as well as the extent of the agreement between them about the goals of therapy. The strength of the working alliance has an effect on the therapy (Strupp, 1983 in Whiston & Sexton, 1993). However, the effects of viewing the therapist as a friend are fairly varied and not always positive. One participant noted that it was difficult to open up to those therapists who were perceived as friends as a result of a fear of being rejected.

Some of them (ie. therapists) were cold and some of them were very, very warm. They were like friends. And the problem was when it was ones who were like friends, especially my childhood I would be scared to tell them certain things because maybe they wouldn't like me anymore if I told them that. (1)

This is interesting as Offer and Schonert-Reichl (1992) claim that adolescents prefer to share personal information with their peers rather than their parents. Yet the pressure for peer conformity and peer "appropriateness" seems to make the sharing of information with peers at times difficult. Another participant found the similarity of therapy to friendship most comforting.

I saw her as a friend. I mean she was always trying to help me and sort out my life. And you know try to get me back on track. And ja, I found that very comforting and very friend sort of thing. (3)

The perceived similarity between friendship and the therapy relationship led to a participant feeling that therapy offered nothing different or useful.

You just there and blabber on like, I can say the same things to other people anyway so, I don't know I just don't see the point. (6)

However, even those adolescents who viewed their therapists as their friends contradicted themselves at times thereby indicating that the psychotherapeutic relationship was qualitatively different from friendship.

1. **I mean I knew I could talk to her and nothing would be said or things you wouldn't normally tell your other friends you could actually tell her. (3)**

2. **I: Would you say a therapist responds the same way that a friend would ?**

P6: I don't know. No, not really.

I: How would you see them as being different ?

P6: ... I was in lots of trouble at school. They wanted to kick me out and then like my therapist like phoned the school and like got me out of a lot of trouble... I mean my friends wouldn't be able to anything like that. (6)

Theories of dynamic psychotherapy state that the stimulus of the therapist will evoke differing transferences of object relations (Corey, 1991). In the case of adolescents the importance of the peer group is so strong that it is fairly easy for adolescents to draw upon a `friendship template' in their understandings of the therapy relationship and of the therapist. This fact that adolescents do not pay the therapists themselves could make it more likely that these perceptions will rise to the fore. However, such understandings are not without their contradictions as these participants who view their therapist as friends also noted that the therapist may possess adult powers which peers do not have. Moreover, the therapy relationship is one where certain issues could be spoken about which were not acceptable in a friendship.

It was mentioned above that there are two likely scenarios for the way in which adolescents might view their therapist and their psychotherapy. The second of these is a

perception of the therapist as an authority figure, perhaps even a parent. Mishne (1983, p. 156) points out that the therapist, by means of the positive transference, becomes an important adult "whose lead is followed, who is trusted, and believed as a helping adult". She later notes that there might even be a desire for the parenting role to be taken over literally by the therapist.

I: As you say he made you feel quite anxious.

P4: Ja, because I think I would rather have looked at him as a parent kind of person. Cause the way he holds himself and the way he spoke was very serious... He wouldn't laugh like all the time like my other ones did. They were very nice but he was effective. (4)

At other times it can be surmised that the therapist is being perceived as an authority figure.

I just said whatever he told me. I just told him. (8)

Offer and Schonert-Reichl (1992) dispel many myths about adolescents including the assertion that the typical adolescent is in constant conflict with parental and authority figures. Participant Four's experience substantiates this. She does not appear to be in conflict with her `authority figure' therapist but rather such authority held sway for her.

This year I remembered what he had said and I thought you know what he is saying is right and I shouldn't really be smoking. (4)

It seems that an authoritative therapist could well be comforting and reassuring for certain adolescent clients. It is interesting that this participant describes herself as "insecure" and "very shy".

4.5 Helpful factors in the therapeutic relationship

The following factors were identified as helpful: advice (although contradictions were evident), a trustworthy therapist, the provision of a safe space that concentrates on the client, the therapist's knowledge of the client often as a result of the long-term relationship between therapist and client, the therapist not showing his / her own emotions, the provision of an outside perspective and the youth of the therapist. Unfortunately space does not permit a discussion of all these factors. The following factors will be discussed as they raise interesting issues in the literature or they were factors that many participants commented upon: advice, a trustworthy therapist and the provision of a safe space that concentrates on the client.

4.5.1 Advice

The giving of advice in therapy is a contentious issue reflected in both the participants' comments and the literature. With respect to the participants' comments the following was said.

1. **We talked through a situation like what happened at school or at home or something and he would say, "how would you have handled this" and I would have said, "dededdeh" (a sound expressing the participant talking). And then he would have said, well I think you should have handled it this way and so in**

future you handle it this way... He was good. I would go back to him if I had problems. (4)

2. **And I think a good therapist doesn't give advice straight away. (5)**

3. **He'd like, he wouldn't tell me anything you know, he'd like ask me questions and say like you know. He'd let me find my own solution to it. (8)**

According to Murphy, Cramer and Lillie (1984) adult psychotherapy patients claim that the receiving of advice is helpful. This factor is also positively, although moderately, related to outcome. This is substantiated by Murphy et al. (1984 in McLeod, 1990) and by Oldfield (1983) in her study - some of her adult clients were disappointed by the absence of advice. They had hoped to receive specific guidance about their problems and some were disappointed by its absence although others responded positively to working in a different manner. Those clients who desired advice wished to be "guided, led and advised" (Oldfield, 1983, p. 67). She relates this to clients' dependency needs. It is interesting that it is Participant Four who so strongly found the giving of advice useful in therapy. This participant is the one who was earlier described as "insecure" and "very shy" and it was she who saw her therapist as an "authority, parent figure". It could be hypothesised that shy, insecure adolescents desire a connection with a strong, adult authority figure who will give them advice. This could also tie in with a reluctance to separate through a desire to remain dependent upon the figure of the therapist.

4.5.2. Therapist as trustworthy

It seemed important for these adolescent clients to feel that they could trust their therapists. For them this often meant that information would be kept confidential and not passed onto others (eg. parents or friends).

1. **I mean I knew I could talk to her and nothing would be said (3)**

2. **Ja, I felt like a mutual trust and stuff like that, like I could trust him and he wouldn't like do anything that I wouldn't want him to do you know. Speak to my parents about what I was saying to him about stuff that I did. (8)**

The breaking of trust through the breaking of confidentiality was noted as a very unpleasant event.

Quite a while back I think what actually broke the trust or broke the whole like I can't speak to her about that part is, I like broke down quite hectically last year and I went through a helluva lot of crisis and times... she said to my mom, you need to give C. more boundaries... she need more limits... So my whole social life went down the drain and I blamed this a lot on my psychologist. (7)

The above reflects a dilemma for the therapist treating the adolescent, namely, the difficulty with working with an age group that equates confidentiality with trustworthiness, yet the necessity of feedback sessions with parents or guardians.

Steinberg (1987) notes that adolescents have mixed feelings about the degree to which they want to be left alone and the extent to which they want to be looked after (which mirrors the separation individuation struggle) - the feedback sessions could at times be seen as an attempt to look after or interfere in the adolescent's life (as it did for the participant quoted above) and thus cause a degree of conflict within the adolescent.

4.5.3 The provision of a safe space that concentrates upon the client

It seems that the creation of a certain atmosphere is construed as beneficial for some adolescents. Similarly certain clients in Oldfield's (1983) study found that the formation of a supportive, accepting atmosphere led to clients being able to be open and spontaneous. One of the characteristics of this atmosphere is that it can be seen as protective. Adolescence must be a particularly challenging and difficult time as vast physical, emotional and cognitive changes take place. Therefore it is easy to imagine the relief provided by the therapy relationship from the harsh glare of the peer group, the ambivalent connections with the family as well as the possibly painful but burgeoning sense of identity. The quotation below hints at the sense of regression that this space allows (ie. `hide in the room').

To me therapy is like my room... you can just hide in the room and close the door and you know it's your safe place. (5)

Participants also spoke about the way in which therapy focused on themselves and how this was perceived as very useful, especially as this experience differed from what they encountered in the outside world.

1. **Ja, it's (ie. therapy) very different in that I have always been a person whom everyone comes to and speaks to... And for therapy it's like, she's there for me. I am not there for her. (7)**

2. **When I leave my therapist's room I just feel like I have all these obligations to other people and I can't put myself first... and that's why it's really important to me because it's a place where I come first you know. (5)**

4.6 Non-Beneficial Factors in the Therapeutic Relationship

The following factors were mentioned by the participants as being non-beneficial (this term is preferred to that of `harmful' as it can not be stated that the factors mentioned below actually caused harm but rather that they did not seem to bring with them any benefits for the client): the nature of the communication between the therapist and the client, repetition of issues, difficulty defining the problem, the breaking of trust through the breaking of confidentiality (which has been mentioned above), the difficulty and lack of relevance of dealing with painful issues that arose from therapy (this has also been dealt with above) and the feeling that certain behaviours were unacceptable to the therapist.

4.6.1. The nature of the communication between the therapist and the client

This category seemed to encompass a number of issues such as the following:

a) Being pushed to talk when the client felt that there wasn't anything to say or having to say what the client though the therapist required.

1. **It was like she was pushing you to say something when there wasn't really anything that I actually had to say. (2)**

2. **She would almost get upset with me you know get cross because I wasn't saying what I am supposed to say. (2)**

Llewelyn (1988) in her study of clients' views of their psychotherapy found that the second most frequently mentioned unhelpful event was unhelpful confrontation by the therapist. Although this client earlier contradicted herself by stating that at times she was not forced to talk about issues that she did not want to.

She wouldn't push me to speak about issues that I didn't want to you know. (2)

It is interesting that Malucio (1979) found that clients perceived too little or too much confrontation as hindering the therapy process. Of course it must be difficult to judge the right degree of confrontation, especially with adolescents who might view such confrontations as a direct or indirect attack on their newly forming sense of identity.

b) The constant asking of questions which could lead to feeling `bothered'.

He was like constantly asking me question the whole time which I didn't have any answers to... he would always be like bothering me. (2)

c) The therapist not saying enough, which is the other extreme to the asking of multiple questions.

She just sits there and listens. I mean she hardly said a word. We went through one session where we sat dead quiet for twenty minutes until she decided to say something... It was rather awkward. (3)

Note the words `she decided' - it seems that this adolescent placed the responsibility for the session on the therapist rather than assuming responsibility for the course of the session. Oldfield (1983) arrived at some similar findings. She noted that clients sometimes suffered when they were unable to take responsibility for the sessions. It is important for the therapist to be able to empathise accurately with the resulting emotions that might be evoked in such a situation as well as internal fantasies that this situation might precipitate.

d) Having nothing to talk about and the ensuing uncomfortable silences.

I mean you would talk about things and then you would run out of things to say. (3) I often go there like, ok, now what am I going to speak about this week... And I remember a stage when I used to go into therapy and there'd be like very, very uncomfortable silences. (7)

Lietar and Neirinck (1987) looked at clients' perceptions of those factors that hindered the progress of client-centred therapy (the therapy experiences of the adolescents were much more eclectic). They found that clients felt that things had not gone well when they were silent and when they had not co-operated with the therapist. Hence, it would be interesting to find out whether the adolescents above felt that that those sessions when

they were silent were unsuccessful. It is thought that therapists, on the other hand, would have a different view of assessing productive sessions which would not necessarily rest upon the relative silence or talkativeness of the client.

4.6.2. Unsatisfying Problem Solving

According to Piaget (1955, 1977 in Steinberg, 1987) there is vast cognitive development during adolescence. At about 14 - 15 years adolescents become more able to think in an abstract manner as they move from a concrete operations stage to a formal operations stage. It is possible that certain adolescents whose cognitive development might be slightly slower still struggle to think abstractly, build up hypotheses and distinguish ideas, fantasies, beliefs, probabilities and possibilities from each other. This could be one possible explanation for some adolescents' unhappiness about the problem solving that took place during the therapy. This category encompasses two aspects: (1) repetition of the issues in therapy and (2) difficulty defining the problem.

With respect to the repetition of issues, one adolescent had the following to say.

It was almost as if you know with all of them (ie. therapists) was that you're never actually getting to the point. You just go around in circles just talking and talking about nothing. (2)

It is interesting that Mayer and Timms (1970, p. 130) in their study on working class clients' perceptions of casework found that some of their dissatisfied clients spoke about therapists who "kept returning to the same topics and raised the same questions over and over again".

A difficulty with defining the problem was mentioned a number of times. It seems that the lack of tangibility or the diffuse, abstract nature of the problem resulted in some adolescents feeling that therapy wasn't beneficial.

In my childhood we could say these are my problems let's talk about them. In the last years that I went it was always now what is your problem... And there would never ever be a solid problem. (1)

We never actually got to the reason that I actually came there (2)

Another adolescent mentioned that therapy only seemed to solve current problems but not previous problems (although it is interesting that this adolescent was particularly reluctant to look at painful childhood memories).

But I mean I didn't see how that (ie. therapy) was helping my previous problems that was just problems at the time. I mean that came up. (3)

The above perceptions about therapy's lack of ability to engage in relevant problem solving is most important. Llewelyn (1988) found that when a good outcome and a poor outcome adult therapy groups were compared, the successful outcome was more likely to have taken place when, from the client's perspective, more problem-solving events were seen to have occurred. In addition, successful outcome seemed to be associated with more problem clarification events from the client's perspective (although this was a non-significant trend). Hence, it seems important for the therapist working with adolescents to ensure that problem clarification occurs fairly early in the sessions (bearing in mind that

some adolescents might need quite a concrete understanding of the problem as they haven't yet moved to the more abstract cognitive style). Also, attempts need to be made to address some of these problems. Of course the fluidity of therapy as well as the type of therapy practiced does not always make this easy.

4.6.3. Perception that therapist perceives certain behaviours as unacceptable

One adolescent felt that she could not divulge her drug taking behavior to her therapist as a result of her therapist not understanding such behaviour. In addition, the adolescent's belief that the therapist had not engaged in such behaviours confirmed for her that her therapist would not be able to understand this aspect of her lifestyle.

There's a lot I don't speak to her about. I can speak to her about like relationships with people... But I can't speak to her about drugs and stuff... because in her eyes it was completely wrong. Even if I could speak to her about it, she wouldn't understand it because she has never been on drugs. (7)

It is commonly understood that it is important for a client to feel understood and accepted by a therapist. Perhaps with adolescents this is a more difficult task. It is difficult to know whether the above excerpt represents a realistic appraisal of this therapist's difficulties with accepting her client's behaviours or whether this adolescent chooses to perceive her therapist thus. Although the same could hold true for many of the other factors mentioned above. Steinberg (1987) points out that denial and ambivalence on the part of the adolescent can make therapy particularly tricky with adolescents. So too their rapid changes of mood. It is also likely that adolescents may perceive their therapists as

`adults' (see above) and therefore a large gap exists between the adolescent and the therapist with regard to their understandings of different types of experiences.

4.7 Beginnings and Endings

It is often the case that the adolescent client does not have a say in the initiation of therapy. Rather it is the decision of the parent or some other authority. This could lead to the possibility that the adolescent in not engaged in the process (Gallatin, 1982). The table below indicates whose decision it was to initiate therapy.

Table 5.1

Decision to initiate therapy

Participant	Decision to initiate therapy
One	Parent's decision
Two	Mother's decision
Three	Mother's decision
Four	Mother's decision
Five	Participant's decision
Six	School's decision
Seven	Mother's decision
Eight	School's decision

Even the one participant who decided to enter therapy herself did so only after having been persuaded to enter therapy by her mother when she was about ten years old.

Obviously this impacts upon adolescents' motivation towards therapy. This participant had initial resistance towards therapy which was later overcome.

Because I mean like that first four or five things (ie. sessions) you know, I just sat there and like stared at him. I didn't say anything to him. I thought, ja, what's this idiot you know - just another idiot and who's he, he can't tell me you know. I mean that's what my mentality was like at the time. (8)

This participant has some insight into the fact that his attitude and motivation towards therapy was fairly poor. However, his responses throw little insight onto how such resistance can be lessened.

P8: He also, he just tried to talk his way into stuff and I just shut up you know. I just sat there and said, "oh, is it, oh" you know. I didn't listen to him. But then after a while I got...

I: So what changed for you ?

P8: I don't know, it's just like, I just started talking one day - I just felt like talking. I don't know and then got further and further.

Interestingly, the decision to terminate is in stark contrast to that of the decision to initiate therapy.

Table 5.2

Decision to terminate therapy

Participant	Decision to terminate
One	Participant's decision

Two	Participant's decision
Three	Participant's decision
Four	Participant's decision
Five	Hasn't terminated
Six	Participant's decision
Seven	Participant's decision
Eight	Doctor's decision

The literature indicates that adolescents have a tendency to drop out of therapy (Tramontana, 1980). Other researchers though have indicated that the drop out rate only appears high, due in part, to the particular counter transference feelings that it evokes in the therapist (Suzuki, 1989). Regarding this study it appears that the adolescent him or herself frequently made the decision to terminate, however, it is not always known whether this was in collaboration with the therapist or unilaterally. Although a few adolescents did mention that their therapist was not in agreement.

P3: I just told her that I didn't want to go back... And she agreed with me in the end and said, "ok, well fine".

I: In the end you say ? She didn't agree with you initially ?

P3: Ja, she thought I had a lot of problems which still had to be worked out and everything and I just disagreed with her. (3)

4.7.1 Reasons for termination

The adolescents in this study did not seem to initiate their own therapy but they did seem to terminate it themselves. There were three main reasons for termination.

(a) A desire to handle one's problems independently was mentioned.

1. **But at the moment it's difficult enough to deal with problems by myself and I don't want to forget how to do that. (1)**

3. **I felt as a person I was mature enough now to handle my own problems (4)**

4. **I could actually deal with things better on my own than actually having someone else there as well. (2)**

It is possible that the adolescent experiences a similar pull to separate from the therapist and individuate as that experienced relative to the parents. Similar battles are being fought with the end result being the creation of personal identity in terms of Erikson's psychosocial model (Steinerg, 1987). Hence, the adolescents' emphases on handling one's **own** problems - attachment to the therapist and joint handling of problems might be too enmeshed for some adolescents who are in the crux of a second individuation process.

(b) A feeling that nothing was being gained from therapy.

1. **I just felt that you know there wasn't really any point in me going back because I wasn't gaining anything from it. (2)**

2. I didn't really see that it was helping me that much (3)

The reasons why therapy was perceived as not being very beneficial have been mentioned above.

(C) The notion that the person no longer needed therapy.

I feel as though I don't need to go anymore. (7)

This is probably the most positive reason for termination as it implies personal growth and maturity although this is not necessarily the case. It could be that the person is defending against exploring certain issues in therapy. This reason was not mentioned frequently.

4.8 The adolescents' perceptions of how other people viewed their therapy

The peer group is an integral component of the adolescent's socialisation and often serves as a place where the adolescent can develop his or her own identity (Hanekom, 1989). Furthermore, many of the adolescent's emotional and social needs are met through this peer group and if the standards of the group are not met then the adolescent is open to criticism or punishment. Much of the adolescent's evaluation of himself or herself takes place through this peer group. According to Atwater (1983) the peer group fulfils the following functions:

- it helps with a movement away from the family towards peers
- it provides for opportunities for interaction which are similar to those of adults

- it acts as a reference group for the judgement of behaviour
- it helps adolescents to develop their personal identities.

From the above it is apparent that the adolescent's perception of the peer group's attitude towards therapy is likely to have an impact upon the adolescent's own therapy.

When questioned it seemed that the majority of adolescents felt that their peers were accepting towards their therapy.

1. **It was just like I don't know for my age group it's a normal thing to go to therapy. It's nothing major (2)**

2. **They (ie. peers) were fine with it. What could they say you're in therapy (3)**

However, it seems that this accepting attitude is partly a feature of the environment (ie. a private college which encourages individualism and does not have many school rules) as well as the age of adolescence which implies greater maturity (and hence more open, less stigmatising attitudes) to these adolescents than childhood.

1. **I have very, very few friends who haven't been in therapy at one point in their life. And so my friends at College now are very, very open to it...But at my last high school before I came here it was very, very strange. They would like say, "are you insane or something ? Why do you have to go to a therapist ?" (1)**

2. P4: And then as you get older, you can tell them (ie. peers) because as you mature they think, aach, you know therapists you've got to got talk to them if you have a problem or something like that.

I: So it becomes more acceptable ?

P4: Ja, ja as you grow up. If you had to tell somebody in Standard Five they would probably go, "Oh, ja you're so nuts" you had to go and do this. (4)

It seems that these adolescents tend to feel that the most stigmatising attitudes towards their therapy emerge from family members, particularly from parents and grandparents.

1. **... my grandparents are quite conservative and they never had anything like it, so it's kept from my grandparents. They don't know about it. (5)**

2. Well, my dad thought I was like an idiot you know. Like a little psycho or something you know because I had to go and see a therapist. (8)

In addition adolescents seem more likely to feel that their therapy was shameful and thus needed to be kept a secret when they attended therapy as a child. It is difficult to comment about whether this is in fact a feature of general attitudinal change in the population at large towards the concept of seeking help from a psychologist or whether adolescents feel that their peers will be less critical of their therapy when they are no longer young children.

1. I: And in Standard Five only Mom knew about it ?

P4: Well, no the whole family knew about it but we didn't tell anybody else. All I told was my best friend at the time. (4)

2. I didn't tell anybody at my school about it (when she attended therapy as a young child). I was already well I saw myself as an outcast at the school I was at. And so I never ever told not even my closest friends knew just my family and of course the teachers. (1)

It seems that these adolescents' views about other people's perceptions of their therapy seem to alter with age. Moreover, it seems that the adolescents interviewed here felt that their peers would generally be fairly accepting. It is unknown whether this is a feature of the environment of the College where there is a fairly high percentage of children attending therapy. Yet it appears that this is an area worthy of future research as adolescents are so easily influenced by those around them, especially their peers.

4.9 Conclusion

A large variety of themes have emerged from interviewing these adolescents. Many of the issues mentioned above are particularly pertinent to the adolescent developmental period which appears to throw specific challenges to both adolescents and therapists dealing with these adolescents. It also seems that both similarities and contradictions abound in these interviews. It appears that each adolescent's therapy would bring to the fore certain common themes (eg. the separation - individuation challenge, the marked influence of the peer group) yet the manner in which these themes manifest could well

differ from adolescent to adolescent in terms of the way they perceive the therapist, their reasons for termination or any of the other categories mentioned above. A summary of all the themes appears in the Chapter Five.

Chapter 5

Conclusion

5.1 Introduction

This chapter provides a summary of the findings that were outlined in the previous chapter. Some of the limitations of this study are mentioned as well as some suggestions for future research.

5.2 Summary of the main findings

The adolescents in this study expressed a wide variety of perceptions about the relative merit of their therapy. Although some insight and behavioural changes were noted, this was not always the case. It seemed that such changes were more likely to happen when adolescents themselves adopted an attitude of trust, openness and shared responsibility with the therapist. In addition, an understanding of the process of therapy (ie. that there could be a variety of stages that the therapist and client pass through) also seems beneficial with regard to change.

Some adolescents felt that therapy had done little to bring about behavioural change. This finding could be explained in a number of ways. It could be that the adolescent challenge of individuating from external and internal familial ties may lead to a desire to attribute change to self modifications rather than therapist interventions. It seems important for some adolescents to feel a sense of control over adapting their behaviour which needs to

be seen as independent from adults. Alternatively, change could be the result of developmental advances which in turn make the adolescent's problems more manageable. Some adolescents had a tendency to view the psychotherapeutic relationship as one of friendship. This could partly be the result of the fact that adolescents generally do not pay for their own therapy so it is easier not to recognise the professional nature of the relationship. This consequence of such a perception could be either positive or negative. It could make it more difficult for the adolescent to share intimacies as there could be a fear of a loss of affection from the therapist. On the other hand, the perception of the therapist as a friend could prove to be comforting. Yet the perception of the psychotherapeutic relationship as being similar to that of friendship was not without its contradictions as therapists were seen as possessing adult powers which friends do not have. In addition, certain issues could be spoken about in therapy that would not be acceptable in a friendship. It is possible that the therapist is seen as an adult authority figure by some adolescents. Despite popular myths that abound about the conflictual relationship between adolescents and adults, it is not necessarily true that the adolescent is in conflict with such 'authority figure' therapists.

The following factors were perceived as helpful by the adolescent: advice, a trustworthy therapist and the provision of a safe space that concentrates on the client. The findings that emerged from the giving of advice during therapy were particularly contradictory. Certain adolescents felt that the giving of advice was beneficial whereas others preferred to come up with their own solutions to problems. Trustworthiness for adolescents was often equated with confidentiality. The breaking of confidentiality was seen as traumatic

for a number of adolescents. The provision of a safe space that concentrates on the client was seen as beneficial for some adolescents. It is easy to imagine the benefits of such a space if one considers the difficulties associated with the adolescent developmental period (eg. a growing sense of identity, a need to individuate).

There were certain factors that were perceived to be non-beneficial, such as the nature of the communication between the therapist and the client, unsatisfying problem solving and a perception that certain behaviours were perceived by the therapist as unacceptable. It seems that the therapist dealing with adolescents is in a difficult position vis-a-vis communication. On the one hand, adolescents did not like to be pushed to talk when there was not anything to say. Yet on the other hand clients sometimes felt that it was necessary to be pushed to talk about issues that they did not want to. Another contradiction also emerged. It seemed that the constant asking of question felt intrusive yet a therapist that does not say enough also seemed to cause the adolescent some discomfort. At times some adolescents found that the problems that they brought to therapy were not being adequately solved by the therapist as issues were repeated. Also, it seemed that for them there was a difficulty with defining the problem. The other factor that was perceived as non-beneficial (although not that frequently) was the notion that the therapist saw certain behaviours (eg. drug taking) as unacceptable.

There was a definite discrepancy between whose decision it was to initiate therapy and whose decision it was to terminate therapy. Initiation of therapy was generally the prerogative of parents or the school whereas termination was often adolescent

determined. A non-client initiation of therapy is likely to invoke more resistance and lowered motivation on the part of the client. This resistance was at times apparent with some adolescents, although it seemed that it could also be overcome. The method by which such resistance could be overcome was not explored.

Three main reasons for termination were mentioned: the desire to handle one's problems independently - possibly a result of a similar desire to separate and individuate from the therapist as that experienced from the parents, a feeling that nothing was being gained from the therapy and also the perception that the person no longer needed therapy, which could imply personal growth and maturity, although not necessarily.

Lastly the adolescents' perceptions of others' attitudes towards their therapy was examined. This was done as a result of the peer group exerting such a strong influence during these developmental years. Most of the adolescents seemed to feel that their peer groups were fairly accepting of their therapy. This accepting attitude could have been a feature of the College environment (where many children attend therapy and the environment is less rigid). More stigmatising attitudes tended to be perceived as emerging from parents or grandparents. Also, adolescents seemed to find their therapy more shameful and thus kept more secret when they attended as young children.

5.3 Limitations of this study

The main aim of this study was to explore adolescent's subjective experiences of being in therapy as this might have some clinical use for practicing therapists. However, there are limitations with this piece of research.

1. Although the interview technique has a variety of advantages it needs to be noted that there is a likelihood of distortion, error or bias, especially with a nonstandardised, in-depth interview (Maluccio, 1979). For example, the interviewer's responses to participants might differ and be dependent upon the interviewer's personal connection, degree of empathy or understanding that she has for the participant. This was definitely the case with the participants that were interviewed. The connection established with some of the adolescents felt deeper, and as a result the participants seemed to be responding with richer, more in-depth information.
2. Almost all of the participants (except for one) in this study looked at their perceptions of therapy once the therapy was completed. Once again this has its advantages, namely that participants are able to reflect back upon a completed process and also the longer term effect of therapy can be spoken about. However, there might be problems of recall. Several participants spoke about not being able to remember certain aspects of their therapy precisely. Furthermore, if the participants' current situation is positive, that might influence their retrospective portrayal of their therapy experience.
3. As this study only looked at participants' subjective experiences there was no additional information to verify the correctness of some of the adolescents' responses. For example, it is unknown whether behavior change did in fact occur for those adolescents who claimed that it did.
4. The sample interviewed was very small and drawn from a particular environment, namely a private College. It is possible that adolescents attending this College have

particular characteristics that differentiate them from adolescents in the general population. However, generalisability was never a primary aim of this research.

5. There was no control exercised over the types of therapists that clients saw. It is possible that the therapists differed in their theoretical orientation, thus making comparisons between the participants' subjective reports difficult.

5.4 Recommendations for future research

The findings that emerged from this study open up the door for a number of important avenues for future research. Such avenues include attitudes towards termination and initiation of therapy, the responses of peers towards adolescents' therapy and perceptions of the psychotherapeutic relationship. Perceived beneficial and non-beneficial aspects of psychotherapy have been widely explored in the adult literature and a number of the findings in this study seem to replicate such literature.

The large discrepancy between the person who took the decision to initiate therapy and the decision to terminate needs to be explored more fully. It would be worthwhile to look at adolescents' perceptions when they start therapy in order to determine more closely the nature of any possible resistance, especially if the decision to initiate therapy was not their own. Feelings and reasons for termination could also be gathered at termination in order to determine more accurately the possible reasons for a high drop out rate during adolescence.

The peer group was mentioned as a very influential factor in the adolescent's life. This study looked at how adolescents in therapy imagined their peers would feel about their therapy. It is surely important to ask adolescents who are not in therapy what their attitudes and perceptions are towards therapy and towards their peers who attend therapy. This might indicate some future direction for educating adolescents about the nature of mental illness, the role of therapists as well as any common misconceptions.

It would also be interesting to explore in greater depth adolescents' attitudes towards the psychotherapeutic relationship. It seems that as the adolescent age straddles childhood and adulthood there is often a degree of difficulty for the adolescent in defining the psychotherapeutic relationship. Is the therapist an adult against whom one needs to rebel or is the therapist seen as an authoritative, powerful other whom one can safely depend upon ? Alternatively the therapist is frequently seen as a type of peer although one who has greater power. It would be useful to look at which personality types tend to view the psychotherapeutic relationship in a particular light. Such information could be very useful to practicing therapists regarding the likely course of therapy with adolescents.

These adolescents attended private therapy which is unfortunately unavailable to the majority of South African adolescents. A few free services are available to adolescents not in private therapy - eg. school clinics, counseling from Guidance and Counseling teachers and out-patient and in-patient units at child and adolescent units at hospitals. The subjective experiences of attending these other places of service delivery should be investigated in order to see possible areas for improvement.

Lastly it would be useful to look at the perceived reasons for symptom or problem relief in more detail. This study has outlined some of the adolescents' reasons for perceived change or lack of change. Yet this is an important area that requires further study in order to see whether adolescents regard the therapy as the impetus for symptom or problem relief or other factors.

5.4 Conclusion

The present study dealt with adolescents' subjective experiences of attending long-term private therapy. This study emphasised the importance of research that looks at clients' perceptions of the therapy experience. Such research is necessary in order to complement the vast amount of empirical, outcome-based and process-based psychotherapy research. The findings in this study highlight the fact that the adolescent developmental period impacts at multiple levels on the psychotherapy experience. It seems that from the adolescent's perspective, therapy can at times be extremely useful in alleviating some of the suffering that this age group goes through. However, this is not always the case. It is important to take seriously what adolescents say about when and why therapy does not prove to be beneficial. Ultimately as therapists it is only through listening to our clients that we place ourselves in a position to help them at all.

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Appendix A
Interview Schedule

A/ Identifying Data and info. about psychotherapy
Age
Grade
Gender

- For how long
- Was there more than one period or more than one therapist
- Frequency of therapist
- Little about the problem
- Whose idea was the therapy
- What kind of therapy

B/ Attitudes towards the therapy
- How would you describe the whole therapy experience (good or bad)
- Did you find it a very emotional experience (or did you feel very removed from the whole process)
- How much did the therapy help or did it not help
- What do you think brought about the change you described or if there was no change what could have brought about the change
- Useful and least useful aspect of the therapy

C/ Attitude towards the therapist
- How did you feel towards the therapist
- Did you feel trust, did you feel understood
- How would you describe the therapist's manner (stiff, relaxed, natural, accepting, warm, passive, cold, distant, critical)

D/ Termination
- Whose idea was it to end therapy
- How did you feel about ending (would you like to have continued, was it difficult or easy)

E/ Other's responses or attitudes towards therapy
- Was it kept secret
- What were their responses - Family / friends/ specifically other adolescents/ teachers
- Are there common misconceptions

F/ Technical aspects of therapy
- Language used by therapist – technical or abstract
- Time or venues kept the same

Appendix B

The interview transcripts are being kept by the author of the thesis for reasons of confidentiality. If you require any further information about these transcripts, please contact the author directly.