

ENGAGING DEPRESSED ADOLESCENTS IN TALK THERAPY

by

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## Abstract

This manuscript-style thesis discusses depression among adolescents with an emphasis and how to create meaningful and engaging therapeutic experiences for this population. Particular interest is given to the role that gender plays in the identification and treatment of depression among youth. A review of depression among youth, specifically males, an analysis of how to develop a strong therapeutic alliance with adolescent clients, and specific engagement strategies and therapeutic approaches targeted at adolescents are explored in order to provide an in-depth review of practices to improve services offered to the adolescent population.

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TABLE OF CONTENTS

|   |     |
|---|-----|
| Abstract .....  | ii  |
| Acknowledgements .....  | iii |
| CHAPTER I Gender Differences in Adolescent Depression .....                 | 1   |
| CHAPTER 2 The Therapeutic Alliance with Adolescents .....                   | 15  |
| CHAPTER 3 Engagement Strategies for Adolescents .....                       | 26  |
| CHAPTER 4 Treatment Modalities for Dealing with Adolescent Depression ..... | 39  |
| CHAPTER 5 Depression and Masculinity .....                                  | 52  |
| References .....  | 63  |

## **CHAPTER I**

### **Gender Differences in Adolescent Depression**

#### **Introduction**

This manuscript-style thesis provides a discussion of depression among adolescents. Each chapter discusses an aspect of adolescent depression through the lens of counselling: the effects of gender, how to create a therapeutic alliance with adolescents, specific engagement strategies for work with youth, effective therapeutic modalities for work with adolescents, and a discussion of how traditional notions of masculinity affect our understanding of depression as well as the experience of depression. Each of these topics addresses an important component of informed practice for work with depressed adolescents.

#### **Adolescence**

Adolescence marks the intermediary phase between childhood and adulthood. Culturally dependent, adolescence may be better thought of as various developmental and emotional transitions rather than an experience defined by age. Steinberg (1996) describes how during this period, adolescents transition in eight primary ways: biologically (puberty and the onset of sexual reproductive capabilities), emotionally (the detachment from parents and the development of individual identity), cognitively (the ability to think and reason from perspectives other than one's own), interpersonally (a shift from a family focus to a peer focus), socially (the development of life goals and responsibilities), educationally (enrollment in junior/high school), legally (change from juvenile to adult), and culturally (some marked by socially sanctioned rites of passage).

During adolescence, as the transition away from parents becomes more important, teens tend to develop stronger peer relationships. Mid and late adolescence can be defined by the gradual shifting away from, conflicting with, and eventually finding a balance with adult relationships. Importantly, peer relationships allow youth to develop their own self-image. The depth of these relationships differ between males and females: women are known to develop smaller, more intimate peer groups whereas men relate in larger groups marked by less intimate qualities (Marcell & Monasterio, 2003). The difference in these peer groups during the developmental phases of adolescent males may, in part, contribute to differences in emotional language between genders.

### **Gender Differences in Depression**

Depression is an important mental health concern to consider in work with the adolescent population. First, it is important to understand what depression is. Depression, like many terms in the mental health world, has many working definitions, making it difficult to discuss and compare. The American Psychiatric Association (2013) outlines multiple forms of depression such as Disruptive Mood Dysregulation Disorder, Major Depressive Disorder, and Persistent Depressive Disorder (Dysthymia) in the DSM-5. The authors explain that features of a depressive disorder include “the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual’s capacity to function” (p. 155). This thesis refers primarily to Major Depressive Disorder which is the experience of five or more depressive symptoms experienced over a two week period. These symptoms include a persistent depressed mood, loss of interest in regular activities, changes in weight or appetite, dysregulated

sleep, psychomotor agitation, loss of energy, low self-worth, difficulty in concentration and/or recurrent thoughts of death or suicide (American Psychiatric Association, 2013).

Another useful definition is one provided by Beck and Alford (2014), which identifies similar symptoms and captures the pervasive effects of depression. They define depression as:

- 1) A specific alteration in mood: sadness, loneliness, apathy.
- 2) A negative self-concept associated with self-reproaches and self-blame.
- 3) Regressive and self-punitive wishes: desires to escape, hide or die.
- 4) Vegetative changes: anorexia, insomnia, loss of libido.
- 5) Change in activity level: retardation or agitation (p. 8).

Another important term referred to throughout this thesis is gender. Gender can be defined as “a social construction based primarily on sex, consisting of traits, interests and behaviours ascribed to each sex by society” (Denmark, 2004). It is important to see gender as being the result of societal expectations rather than through a simply biological lens. Although gender may have roots in what one considers “sex”, is it better understood as a social construct which includes members of the LGBT communities. Contrasted with gender is sex, which can be defined as “the biological differences in genetic composition and reproductive structures and functions of men and women” (Denmark, 2004). Sex refers to the biological makeup of an individual whereas gender refers to the individual’s own association with a particular group. Gender and sex are particularly important terms to understand within a discussion of depression, as differences are noted in the prevalence of depression between genders. Societal gender expectations are also discussed as playing a role in the development or perpetuation of depression further in this chapter, as well as in Chapter 5.

It has been well reported that a shift occurs during adolescence regarding the prevalence of depressive symptoms. Prior to age 13, males tend to have a higher rate of depression. However, as the preadolescence phase transitions into adolescence along with the physical onset of puberty, a marked increase of depression among females is noted, with a very little increase in male depressive symptoms (Cyranowski, Frank, Young, & Shear, 2000). These differences in gender in the prevalence of depression among adolescents are well reported, however, little is known as to the *causes* of such differences. (Steinberg & Sheffield Morris, 2001). Some theories have been generated and studied, such as the tendency for women to have developed different cognitive patterns of thinking, namely a stronger tendency towards rumination which is thought to maintain or contribute to depressive symptoms (McGuinness, Dyer, & Wade, 2012). Such studies have reported that factors such as women's tendency to seek help more easily, to depend on community and relationships, to report somatic complaints, pubertal timing and the higher presence of externalizing behaviours may be contributing factors to the higher prevalence of depression among females (Silverstein, Edwards, Gamma, Ajdacic-Gross, Rössler, & Angst, 2013; Conley & Rudolph, 2009; Behmani & Upmanyu, 2015).

Calvete and Cardenoso (2005) completed a study of 856 Caucasian adolescents in Spain in order to determine if a relationship existed between gender, cognitive variables and depression. The results of the study suggested that females' tendency to view problems as hopeless or unsolvable, as well as having a higher prevalence of negative self-cognitions compared to males, may contribute to the higher rates of depression. Other such studies have suggested that the release of the neuropeptide



oxytocin (OT) in combination with women's caretaking proclivities and socialization to focus on intimate relationships and community may predispose them to experience depression after stressful life events (Cyranowski et al, 2000).

By the age of 15, it is reported that the prevalence of depression between females and males is 2:1 (American Psychiatric Association, 2013). Culturally the higher prevalence of depression among women appears to remain consistent according the Diagnostic and Statistical Manual of Mental Disorder (2013). However, it appears that there may also be reason to speculate that differences in the depression rates among genders could be, in part, due to a different presentation in depressive symptoms, underreporting from men, or differences in the presentation of depression symptoms compared to women (Marcell et al., 2003; Behmani et al, 2015; Brownhill, Wilhelm, Barclay, & Schmied, 2005).

Some have argued that the transition into adulthood for adolescent boys differs from adolescent girls in regards to a presence (or lack thereof) of biological markers. Marcell et al. (2003) explain that for women, the passage into becoming a woman is clearly marked by the onset of puberty and the menstrual cycle, however, boys are left without a clear, physical rite of passage, leaving them to "[earn] their 'manhood' by performing challenges and overcoming hardships through formal initiation rights" (p. 568). It is proposed that males may seek to define this transition by taking part in more risk-taking behaviours, competing in physical challenges, or the well noted tendency to define oneself in relationship to competition over another (Horne, Englar-Carlson, & Kiselica, 2008) as an attempt to prove one's status.

However, these theories fail to account for the cultural and societal pressures that contribute to the experience of masculinity. A focus on how culture influences gender may serve to illuminate some of the differences noted in the prevalence of depression between genders. This socially driven paradigm is well explained in a classic text by Sandra Bem (1993), who states that it is “not simply that women and men are seen to be different but that this male-female difference is superimposed on so many aspects of the social world that a cultural connection is thereby forged between sex and virtually every other aspect of human experience, including mode of dress and social roles and even ways of expressing emotion and experiencing sexual desire” (p. 2). This text remains relevant for counsellors today, and can help practitioners to frame the way in which gender is addressed, as well as provide practitioners with a better understanding of how traditional notions of gender can perpetuate and contribute to the development of depressive symptoms among youth. This culturally manufactured gender difference may account for some of the differences in reporting of depression in men, due to the societal expectations that demand that men are independent, stoic, and self-assured.

Bem’s shift into considering gender as a social phenomenon rather than a biologically-based reality allows counsellors and psychotherapy research, particularly in reference to gender, to shift into a continual consideration of the influences of gender. Bem explains that US culture is “androcentric “. This male-centeredness has far-reaching effects on how one views gender and how the concepts of gender itself have developed. She argues that the focus on biological differences between genders fails to account for the cultural discourses that perpetuate, orchestrate, and rigidly impose these gender values onto individuals. Females and males are treated differently throughout life and

these cultural expectations reflect a gender-polarized society that privileges the male.

However, there are negative effects on both genders of this culturally sanctioned binary between “female” and “male”. Bem explains that:

Androcentrism exacerbates the male’s insecurity about his status as a real man in at least two different ways. It so thoroughly devalues whatever thoughts, feelings, and behaviours are culturally defined as feminine that crossing the gender boundary has more negative cultural meaning for men than it has for women – which means, in turn, that male gender-boundary-crossers are much more culturally stigmatized than female gender-boundary crossers (p. 150).

She goes on to explain the unrealistic ideal that these gender definitions create. As the stakes become higher for men to break the cultural depiction of “male”, it is perhaps understandable that less males report symptoms such as those found in depression, as these symptoms suggest a potential “boundary-crossing” that undermines one’s “male” identity.

The ideas underlying Bem’s model understanding gender are echoed by Marcell and Monasterio (2003). These authors explain the difficult transition for males as they navigate the world of adolescence while attempting to maintain their culturally encouraged bravado and independence by explaining that boys learn and absorb the culturally acceptable gender norms, primarily from male role models in their lives, and incorporate these into their own values systems. These cultural values “[emphasize] traditional notions of masculinity, valuing competence, power, strength, and achievement over sensitivity and expressions of caring and affection, boys typically assimilate the

former traditional values, attitudes, and beliefs” (Marcell et al., 2003, p. 566). Given these cultural values that focus on masculinity as being defined by a lack of emotion, stoicism, and bravery, one can postulate that at an early age, males are culturally programmed to resist depressive feelings and to maintain the illusion of independence. This resistance or denial may be seen to have an impact on the identification of depression in males, the efficacy of therapeutic approaches, and the higher prevalence of female depression.

Some researchers have sought to question society’s acceptance of the disparity in depressive presentation across genders. Some question whether it is truly a difference in susceptibility of depression, or if society might better view these statistics through a cultural lens and with consideration of the social environment in which males are brought into. Brownhill, Wilhelm, Barclay, and Schmied (2005) propose that gender differences appear “not in the experience of depression per se, but in the expression of depression” (p. 928). Emotional distress, constrained by traditional notions of masculinity, may explain why depression in men can often be hidden, overlooked, not discussed, or ‘acted out’. There are implications for the types of questions asked of men to detect depressive symptoms. Through interviews conducted with seventy-seven men, the authors performed a grounded-theory study aimed to inform the existing gap between male and female depression rates by questioning the differences between the *manifestation* of depression and the *measurement* of depression. The results of the study suggest that perhaps men express depression differently than how society typically recognizes depression based on understood and accepted diagnostic criteria. Perhaps men express their experience of depression through antisocial and risk-taking behaviours, rather than

the more commonly viewed symptoms of hopelessness and loneliness. The authors explain that “detecting depression in men is likely to be made more difficult to identify because some maladaptive behaviours in response to depressive symptoms may be socially sanctioned and therefore masked” (Brownhill et al, 2000, p. 926). Here the authors explain that men have developed various coping strategies that society has accepted such as substance-use, anger, or violence. For these reasons, depression may be undetected as these “coping” strategies mask the more culturally understood markers of depression such as sadness and loneliness. The authors addressed several themes in how men interact with depression: avoiding ‘it’, numbing ‘it’, escaping ‘it’, hurting me, hurting you, and stepping over the line. All of these themes were developed by men who were interviewed, based on feedback reported regarding their experience with depression.

Consistent with the idea that depression is manifested differently according to gender, one study addresses the effect of the apparent gender disparity on how depression is detected by professionals. This study demonstrated variations in the ways in which diagnosis of depression is made, suggesting the over diagnosis of depression among females and an under diagnosis of depression among males (Potts, Burnam, & Wells, 1991). Although this study is dated, limited studies since this time have aimed to differentiate the prevalence of gender differences in depression with the bias that may be included in the detection of such findings. Many studies report the differences in the expression of, thought patterns, or the social influences that may contribute to depression, however, these studies neglect to consider the validity and possible biases of the instruments used to gather information or to diagnose depression, particularly those being used by primary care-givers.

Potts et al. (1991) studied 523 clinician participants representing mental health specialists and medical practitioners. The data was taken from the National Study of Medical Care Outcomes conducted in the US, a longitudinal study aimed to examine the process and outcome of care with adult patients. As previously stated, the study noted a tendency in mental health specialists to over detect depression in women and medical practitioners to under detect depression in men. The study underlined that one should not assume that these professionals were “wrong” in their diagnosis and that the instrument used by the researchers was “right”, however to focus on the importance of the statistically relevant differences in the diagnosis of depression based on both gender of the participant, and role of the care professional. An important conclusion drawn in this study, among others, is the idea that men appear to be at greater risk of under detection of depression, specifically when seeing medical professionals.

A different study conducted by Calvete et al. (2005) aimed to discuss depression among females. The study was conducted in Bizkaia, a province in Northern Spain, and focused on Caucasian adolescents. In the conclusion, the study offers several factors leading to the possible differences in the perception of depression across genders. They identified a link between depression and females’ cognitions and automatic thoughts, yet also identified men’s “justification of violence and impulsivity/carelessness style, which were associated with delinquent behaviour” (Calvete et al, 2005, p. 190). Although not the aim of the study, these conclusions suggest and reinforce the idea that perhaps depression in men is externalized through different behaviours that are not recognized culturally as being associated with “depression” such as anger, aggression or violence.

A study of the effects of romantic relationships in adolescence and the presence of depression also addressed the difference in presenting behaviours of males and females, noting that males are more prone to delinquent behavior or to abuse substances (Joyner & Udry, 2000). There remains a call for further studies that might illuminate the experience of depression, and may call to question how society defines depression and how that may influence men's understanding of their own emotional experience.

Other studies have suggested similar findings in that there may be a lack of information in regard to subtle differences that may exist between the *presentation* of depression versus the *presence* of depression. Often it seems that without the visible signs of depression, one might assume the absence of depression. Some researchers have aimed to explore this relationship further. One such study was conducted by Silverstein, Edwards, Gamma, Ajdacic-Gross, Rossler, and Angst (2013) and based on their findings, it is proposed that the prevalence of depression among women may be best explained by an analysis of the definitions used. The authors explained that the current, broad definition of major depression might be better divided into two categories: somatic depression, and pure depression. The study suggests that the disparity between genders and depression may be due to the focus of diagnostic criteria on somatic symptoms that are more often reported by women. The authors explain that “we might conclude that a distinct disorder, somatic depression, has been subsumed within the criteria of a widely used diagnosis, major depressive disorder, received by large numbers of women” (Silverstein et al., 2013, p. 262). With these results in mind, one might begin to see how, perhaps our current understanding of depression privileges the female experience, creating an under-representation of the symptoms of “male” depression and creating an

unnecessary gender binary. Although this study utilized the DMS IV (American Psychiatric Association, 2000) diagnostic criteria, there may be a need to further these studies findings through the lens of the DSM V (American Psychiatric Association, 2013) in order to determine if the correlation continues to exist despite developing criteria for various forms of depression.

Consistent with the findings of this study by Silverstein et al. (2013), the DSM V also addresses the fact that, cross culturally, depression is most often documented through somatic symptoms despite the fact that non-somatic symptoms are included in the diagnostic criterion. This finding holds true regardless of culture. The DSM states that the findings on the prevalence of depression

Do not permit simple linkages between particular cultures and the likelihood of specific symptoms. Rather, clinicians should be aware that in most countries the majority of the cases of depression go unrecognized in primary care settings and that in many cultures, somatic symptoms are very likely to constitute the presenting complaint (American Psychiatric Association, 2013, p. 166).

### **Cultural Understandings of Depression and Masculinity**

Regardless of the findings on the basis of the prevalence for depression among women, depression among men is nonetheless existent. Despite the lower prevalence of depression among men, one might suggest that the severity of the depression experienced by men might be considered more significant, if not equally significant to that of women. Although men tend to present with fewer depressive symptoms, they have a higher rate than women regarding suicidal ideation and suicide completion, regardless of their race



(Khan, Upmanyu, Vinayak, & Kumar, 2014; Marcell et al, 2003). Marcell et al. (2003) address the impetus for practitioners to be aware of difficulty in recognizing depression and the underestimation of the male experience when stating that:

One of the difficulties in preventing suicide in adolescent males is that they do not always show the typical signs of depression or fit the DSM IV criteria for depression, making the identification of the adolescent male with depression challenging for the primary care provider (p. 577).

The authors explain that medical and mental health professionals must be well versed in proactive screening measures by continually remaining attentive to signs of isolation, withdrawal, severe loneliness, changes in eating and sleeping habits, suicidal thoughts, recent behavioural changes, feelings of hopelessness and helplessness, low self-esteem, rejection, social isolation, and feelings of expendability. The authors also note that professionals “should also recognize that depression in the male may be characterized by anger and rage, sarcasm, rebelliousness, or even boredom” (Marcell et al., 2003., p. 577). Here the authors attend to the idea that depression may be manifested or presented in non-traditional ways that may warrant further investigation in order to provide adequate care to the client.

## **Conclusion**

Overall, it is critical that mental health practitioners become aware of the possible factors leading to the lower incidence of depression among men. It is important to consider how cultural and social factors may contribute to these statistics and to maintain a critical mindset in regard to the implications of these findings. Mental health

professionals must understand that despite the lower prevalence of depression among men, the effects of depression are nonetheless deserving of appropriate services and therapeutic approaches. With the higher risk of completed suicide among men who attempt, care providers must ensure that adequate screening include the detection of non-traditional symptoms of depression and that this occurs on a regular basis. Being mindful of society's expectations regarding masculinity and gender roles and how this may be contributing to the disparity of depression across genders may help to prevent under-reporting of male symptoms in order to better serve our clients and our communities.

## CHAPTER 2

### **The Therapeutic Alliance with Adolescents**

#### **Defining “Therapeutic Alliance”**

When working with adolescents, it is understood by practitioners that the bond between the counsellor and the client is important to the overall outcome or success of therapy. The Penguin Dictionary of Psychology defines therapy as the “use of absolutely any technique or procedure that has palliative or curative effects upon any mental, emotional, or behavioural disorder” (“Psychotherapy,” 2009). The term “psychotherapy” is similar, however typically implies the practice of a recognized trained professional. Therapy aims to alleviate emotional and mental distress, and a key component of its effectiveness is the relationship between the client and the therapist. The relationship that is built and fostered in therapy is often referred to as the “therapeutic alliance”, “therapeutic rapport”, “working alliance” or “therapeutic working alliance”(Hill, 2005; Ackerman & Hilsenroth, 2001; Karver, Handelsman, Fields, & Bickman, 2005; Bordin, 1979). Given the importance placed on relationship in therapy, understanding the precise definition of this term is critical in order to accurately study its significance in psychotherapy. A unified definition, however, is not clear in the existing research on therapeutic alliance. A common definition is likely difficult to achieve provided the complex factors involved in the relationship occurring through therapy, however, there are some unifying themes among the definitions being used to date.

The definition most commonly referred to in current literature on alliance is the definition proposed by Bordin (1979) which defines the “therapeutic working alliance” as

a rapport constructed of three tiers: an agreement on goals, an assignment of a task or series of tasks, and the development of bonds (Shirk, 2010; Ackerman & Hilsenroth, 2003; Hill, 2005; Baldwin, Wampold, & Imel, 2007; Chu, Suveg, Creed, & Kendall, 2010). The division of the various elements involved in the therapeutic working alliance was helpful for many studies in order to refine the view of the processes being observed.

Although this definition serves many current studies, there may be a need to reevaluate Bordin's original definition. In a literature review conducted by DiGiuseppe, Linscott and Jilton (1996), it was noted that the three tiered definition of therapeutic working alliance may be off-balance when applied to the younger population of children and youth when they are pre-school to high-school age. The authors explain that the pillars of Bordin's definition begin to shift when this definition, originally created in consideration of the adult population, is applied to youth. When working with children, it is likely that the negotiation and development of tasks and goals is outside of the scope of child, and that the working alliance becomes defined primarily by the bond itself. The authors suggest that "this age group may have little concern about the implied social contract involved in therapy. Less of the variance in outcome may be related to agreement on the goals or tasks" (DiGiuseppe et al., 1996, p. 89). Here the author's suggest that when working with children, one tier of Bordin's definition plays a more prominent role in predicting outcome compared with others due the child's level of development. The authors also make specific reference to the need to distinguish between therapeutic relationship and therapeutic alliance, as relationship is often considered to only be the "bond" that is felt, whereas "alliance" implies a therapeutic agenda. It is

suggested that the therapeutic alliance viewed among children and youth is more of a unitary construct as opposed to being founded on three separate therapeutic goals.

Duff and Bedi (2009), in their study of counsellor behaviours that predict therapeutic alliance, define therapeutic alliance as “the client and counsellor’s subjective experience of working together towards psychotherapeutic goals in the counseling context, including the experience of an interpersonal bond that develops while engaged in this endeavor” (p. 91). It appears that this definition, although sharing many of the core themes of Bordin’s (1979) explanation, moves into two primary components of alliance: the shared work towards therapeutic goals as well as the emotional bond. The main difference between this definition and Bordin’s explanation is the idea of therapeutic “tasks”. Provided that the alternative definition proposed by Duff and Bedi (2009) appeared 30 years after Bordin’s initial definition, perhaps the new definition better reflects the variety of therapeutic modalities of the current era, many of which may be more resistant to the terminology of therapeutic “tasks”.

Yet another definition is used by authors Karver, Handelsman, Fields and Bickman (2005) in their development of a model of common process factors in Youth and Family Therapy. The authors posit that alliance is made up of the relational, emotional, and cognitive connection that is fostered between the client and the counsellor. This definition, although similar to the others provided, differs from Bordin’s (1979) in reference to the importance of tasks, and differs from the definition provided by Duff & Bedi (2010) in reference to whether the experience of alliance is viewed from within the individuals of the alliance, or whether it is an observable trait. Duff & Bedi (2010) make specific reference to the fact that alliance should be measured from within

the individuals involved in the relationship, whereas other definitions do not exclude the option of an outsider being able to observe and evaluate the client-therapist relationship.

These differentiated understandings of the therapeutic alliance have had an effect in researchers' ability to measure and observe the same factors and variables in therapy. Perhaps the greatest effect could arguably be demonstrated through the various instruments used to measure "therapeutic alliance". Shirk et al. (2010) note that research on therapeutic alliance "has yet to converge on the use of a measure or set of measures" (p. 77) and explain that many of the instruments developed to analyze alliance have short-lived usage in research, often developed for a specific study. This poses a problem in consistency of the variables being measured in such studies. In their review of the current state of research on the therapeutic alliance in adolescent treatment, Shirk et al. (2010) explore the various assessment tools used to study alliance such as the Working Alliance Inventory (WAI), the Penn Helping Alliance Scales (PHAS), the Therapeutic Alliance Scale for Adolescents (TASA) and the Working Relationship Scale (WRS) among many others. The authors also question the current methods for assessing alliance, explaining that the majority of studies that exist use a "snapshot" approach that limits the opportunity to observe the therapeutic alliance as it develops and varies throughout treatment. The authors conclude by explaining that:

Although the clinical literature casts the alliance in a starring role in adolescent therapy, current research has yet to determine whether the alliance will play a leading, supporting, or peripheral role in the outcome literature (Shirk et al., 2010, p. 86)

Similar ideas and concerns are raised by Karver et al. (2005) who explain that although the relationship between therapeutic alliance and outcome has been demonstrated, little is known about the “how”. The authors explain that “there is a need for a theoretical model that proposes a testable theory of how these constructs contribute to treatment outcomes” (p. 46) however one such model has not been proposed in either the adult or youth treatment literature. In their discussion, Karver et al. propose that despite the interest in separating therapeutic alliance from therapeutic relationship, these terms “appear to be the same construct called by different names” (p. 47). They argue that there is no advantage in attempting to separate these two from one another. It should be noted that opposite suggestions were proposed by DiGiuseppe et al. (1996) who noted the importance of distinguishing between relationship and alliance as the authors explained that in child psychotherapy research, too heavy a focus on rapport (therapist being warm and accepting towards the alliance) diminished the importance of the goals and tasks of therapy.

The research performed on therapeutic alliance suggests a need for a more unified working definition of the construct in order to enhance and further current research. This potential unified definition will allow research to begin to move beyond proving the existence of the alliance, and may lead it into discovering the how and why of the therapeutic alliance, thereby creating an opportunity for specific alliance-building education and training for practitioners.

### **Working with the Adolescent Population**

Working with the adolescent population has many unique qualities that make the work quite different from work with their adult counterparts. Youth are known for having a high dropout rate ranging from 28-85% (Karver et al., 2005). In 2013, over one million youth in Canada were affected by depression (Statistics Canada, 2013). These statistics, coupled with the wide-ranging effects of depression, suggest the importance of developing strategies unique to the youth population that improve the quality of mental health services.

An important domain known to impact change, although as discussed requiring further investigation, is the therapeutic alliance to which discussion thus far reveals its vitality and significance in the therapeutic task. Further discussion will sustain and augment this fact. A study performed by Hawley and Weisz (2005) suggests a strong relationship between youth-therapist alliance and a decrease in negative mental health symptoms. A second study developed by Hawley & Garland (2008) interviewed 78 adolescents from the ages of 11 to 18 at two outpatient therapy clinics in San Diego, California. Participants were interviewed at the beginning of therapy and 6 months after their first interview. Interviews with participants assessed the client's alliance with their therapist using the Working Alliance Inventory (WAI). The results of the study suggest that youth alliance is strongly related to therapy outcomes including "decreased symptoms, improved family relationships, increased self-esteem, and higher levels of perceived social support and satisfaction with therapy" (p. 70).

A study conducted by Shirk, Gudmundsen, Kaplinski & McMakin (2008) examined the potential strength of the therapeutic alliance to predict treatment outcomes. The study involved 54 adolescents from the Rocky Mountain West area, and provided a



12-session manualized CBT treatment implemented by trained psychologists. The results of the study suggest that early reports of therapeutic alliance from the perspective of the client had a strong relationship with a reduction in depressive symptoms. It is interesting to note that therapist reports of alliance were not as statistically significant, suggesting that the outcomes of treatment demonstrate a stronger relationship with client perceptions and reports of the alliance as compared to the therapist's.

A different study conducted by Langer, McLeod, & Weisz (2011) garnered similar results. This study involved 76 youth aged 8-15 who received treatment in various community clinics for depression and/or anxiety. The youth received either a manualized treatment or a nonmanualized usual care treatment. Youth were interviewed throughout treatment using the Therapy Process Observational Coding System and at the end of treatment using the youth report Therapeutic Alliance Scale for Children. Although the study aimed to determine if there is a difference in therapeutic alliance and results between manualized and non-manualized treatments, a secondary result of the study demonstrated consistent evidence suggesting a relationship between early alliance reports and treatment outcome.

Although further investigation is required on the precise mechanisms at work within the therapeutic alliance, the value in pursuing ways to ensure, maintain, and improve its existence in therapy are noted.

### **Youth Specific Challenges**

Many studies suggest that there is an inherent difficulty when working with youth given that the majority of youth appear to therapy upon the referral of an authority figure

such as a care-giver or teacher (Hawley & Garland, 2008; DiGiuseppe et al., 1996). This mandated therapeutic agenda is sure to have an effect on the potential development of rapport or the negotiation and agreement of therapeutic goals. DiGiuseppe et al. (1996) explain that this referral from others, compounded with an adolescent's desire for autonomy and independence, make certain elements of the therapeutic alliance more difficult yet even more critical. One way to alleviate the effect of mandated attendance is to address the youth's concern and to focus specifically on collaboration with the client rather than pursuing more directive approaches (Constantino, Castonguay, Zack, & DeGeroe, 2010).

Constantino et al. (2010) explain that although the instruments used to assess therapeutic alliance from a scientific standpoint are varied, they serve as a tool for practitioners to assess the quality of the therapeutic relationship with their youth clientele. The authors explain that:

Given that clinicians now have at their disposal a number of instruments to measure relationship quality, it would be regrettable for the assessment of the working alliance to be restricted to research projects (p. 26).

The authors explain that using such assessment measures can allow therapists to see any discrepancies in the perceived alliance, and can use this information to further deepen the connection and process of therapy. This idea becomes particularly relevant when considering the results of the study by Shirk et al. (2008), where client perceptions were significant predictors of treatment outcome.

### **Rupture and Repair**

Related to client-driven feedback are the concepts of rupture and repair. It is well documented that throughout treatment, the strength of therapeutic alliance may vary (Constantino et al., 2010; Ackerman & Hilsenroth, 2003). Some of these variances in alliance can be considered “ruptures”, where situations negatively affect the therapeutic alliance. In a review of how to resolve alliance ruptures in therapy, Chu, Suveg, Creed and Kendall (2010) address the further complicated difficulties when these ruptures occur in therapeutic alliances when working with the adolescent population. The authors explain that “it may be even more difficult for some adolescents to initiate a conversation about alliance rupture given the added potential for perceived power differences between therapist and client” (p. 106). It is therefore beneficial for the therapist to be reflective and to address any sensed shifts in therapeutic alliance rather than expecting clients to be forthcoming with their discomfort or disappointment.

Burns and Auerbach (1996) explain that there can be a proactive approach taken by the therapist when rifts in the therapeutic alliance are felt (as cited by Constantino et al., 2010). Addressing the issues and acknowledging one’s responsibility (the therapist), helps to disarm the client, can model appropriate responses to conflict, and can demonstrate empathy and understanding to the adolescent. Constantino et al. (2010) explain that:

Adolescence, perhaps more than any period in one’s life, is a time when poor ways of interacting with others are either further ingrained in the individual or altered as a result of adaptive encounters with others (p. 43).

Here the authors suggest that as adolescence is a time involving many changes, therapists can use this flexibility as a teaching tool that can both improve the client's communication skills as well as deepen the therapeutic alliance by demonstrating respect and empathy.

### **The Parent and Care-Giver Role**

Parents and care-givers play an important role in adolescent treatment outcome given that many adolescent clients are not self-referred. As Hawley & Garland (2008) note, "even in individual youth therapy, there is not just one therapist-client relationship. At the very least, both youth and parent connections to the therapist may be important for continued attendance and active engagement in therapy" (p. 60). When working with adolescents there are often more individuals involved than the specific "client", even if family therapy is not the chosen modality. Balancing these relationships (client and care-givers) becomes an important task for the therapist.

A study performed with 65 adolescent clients, their parents, and their therapists at an outpatient mental health center in Los Angeles suggests that there is a strong relationship between parent-therapist alliance and retention rates for youth clients (Hawley & Weisz, 2005). Similarly, the study previously mentioned performed by Hawley & Garland (2008) saw strong relationships between parent-therapist alliance and externalizing symptoms for youth. Both of these studies suggest the positive relationship between therapy outcome and parent-therapist alliance.

Taken together, there is significant value in ensuring that parent-therapist relationships are fostered within the therapy setting, and that time is taken to address any issues facing parents or clients.

## **Conclusions**

Therapeutic alliance, although seemingly difficult to define in current research, is undoubtedly a critical component to positive client outcomes in therapy. Therapeutic alliance, specifically at the beginning of therapy, shows positive correlations with symptom reduction and client satisfaction. Further research, specifically in the field of adolescent therapy, is needed in order to better understand ways to develop, maintain, and improve the therapeutic alliance. It appears that when adolescent clients feel comfortable, respected, valued, and heard, and when goals are co-created rather than directed, better alliance outcomes are reported (DiGiuseppe et al, 1996; Constantino et al., 2010). Parent-therapist alliance also appears to be related to therapeutic gains, specifically in regards to retention and externalizing symptoms (Hawley & Garland, 2008; Hawley & Weisz, 2005). Ensuring that therapists work towards facilitating a positive initial experience through the use of specific practices such as being flexible, honest, respectful, trustworthy, confident, warm, interested and open may help to promote positive therapeutic alliances (Ackerman & Hilsenroth, 2001).

Overall, an important component of positive therapeutic outcomes is the therapeutic alliance. Therapists should take time to explore clients' feelings regarding alliance, should work towards repairing alliance ruptures, and should work at creating a positive alliance with parents of their adolescent clients in order to positively impact client outcomes.

### CHAPTER 3

#### Engagement Strategies for Adolescents

With the understanding that therapeutic alliance accounts for much of the relationship within therapy, engagement focuses on the task involvement within sessions. Kim, Munson, and McKay (2012) define client engagement as “a continuum that includes initial contact, intake appointments, continued retention in treatment, along with investment in treatment by both the client and provider of services” (p. 242). Other terms such as “participation” (Herman, Borden, Hsu, Schultz, Carney, Brooks, & Reinke, 2011) seem also to be used in lieu of “engagement” but with similar connotations. In their study of critical shifts in engagement with adolescents, authors Higham, Friedlander, Escudero and Diamond (2012) define engagement as “the client’s experience of therapy as meaningful, a sense of involvement, and an active negotiation of the goals and tasks of therapy with the therapist” (p. 26). Along with these two existing similar definitions are many other differing definitions, many of which rely solely on the retention or attendance in therapy to define engagement. Again, a failure to consistently define a key element in psychotherapy has resulted in inconclusive data regarding its influence on outcome and a difficulty in accurately understanding it as practitioners. Kim et al. (2012) highlight this frustration and the potential effect on research by explaining that “often social service professionals, and particularly researchers, account for engagement in care by measuring attendance, while professionals know that attendance alone does not equate to being engaged in treatment” (p. 243). These authors contest the notion that engagement is defined by attendance and number of appointments, but rather that it involves both these more “behavioural” components as well as an “attitudinal” component that includes one’s

emotional investment in the process. This chapter aims to study how therapists can work to foster the “attitudinal” dimension of engagement, and refers to vocabulary such as “participation”, “involvement” and “investment” to describe the meaningful experience that a youth may have when they are engaged in the therapeutic process and participate actively in therapeutic tasks. How practitioners can facilitate this form of engagement is the primary focus of this chapter.

Engagement is also seen as a process rather than a specific event in therapy (Bolton Oetzel & Scherer, 2003; Higham et al., 2012; Liddle, 1995). As opposed to therapeutic alliance, which remains more relatively stable, engagement refers to a process that is made up of multiple events within a therapy session. Engagement may shift within the therapeutic process, or within a session from task to task (Friedlander, Heatherington, Johnson, & Skowron, 1994).

### **The Role of Resistance or Reluctance in Understanding Engagement**

In order to fully understand engagement, a look at its opposites may help illuminate its significance in the therapy realm. Words such as “resistance”, “reluctance” and “disengagement” provide a contrast to engagement that may deepen one’s understanding of the term.

In an exploratory study of change processes in adolescence, “rolling with resistance” was identified as one of five therapist strategies that resulted in successful adolescent engagement (Higham et al., 2012). When therapists were able to respond in an accepting manner to adolescent resistance, and adapt their approach by gently questioning and eliciting responses from youth as well as responding non-judgmentally to the negative behaviours, more positive outcomes were reported.

Similarly, Sommers-Flanagan, Richardson and Sommers-Flanagan (2011) promote a more positive outlook on resistance by positioning resistance within both the therapist and the client, rather than solely on the client. The authors suggest that when resistance is encountered, that it should be used to help inform one's practice and act as a sign to change one's approach or become more flexible. They explain that counsellors should "stop looking for and labeling resistance" (p. 74) and suggest seeing this behavioural marker as feedback on how to better proceed in order to better engage the adolescent.

Liddle (1995) also offers a unique perspective on low-motivation within a family therapy context for work with adolescents. He explains that:

At the outset of this process or at periods throughout treatment, adolescents and parents may express reluctance about entering the conversations we call therapy.

This reluctance is understood in terms of the natural difficulty of facing and experiencing the kinds of personal and relationship challenges arising in this kind of work. (p. 40).

Liddle goes on to explain his wariness towards terms such as "resistance" as they carry with them a pathologizing or "negative attributional" quality that are best avoided when forming positive therapeutic alliances.

### **The Need for Adolescent-Specific Engagement Strategies**

Throughout the adolescent period, teens are changing physically, cognitively and socially. Bolton Oetzel and Scherer (2003) explain that although many techniques for engagement are borrowed from child and adult practices, they may not be effective with the adolescent population due to this population's developing cognitive ability, emotional



awareness, perceived value of consequences, as well as their more general differences in behaviour and coping strategies. They further explain that “therapists treating adolescents need to begin their work by assessing a variety of developmental considerations and determining how these developmental factors may help or hinder therapeutic engagement” (p. 220). Due to the vast changes that occur during adolescence as well as the range regarding the onset of puberty, involving an assessment of the adolescent’s development may help the practitioner to involve more relevant and therefore more effective engagement strategies that draw upon the abilities of the adolescent.

Further in their review of engagement strategies with adolescents the authors discuss the abstract thought often required in many therapeutic approaches as well as the assumption that a high level of emotional intelligence is accessible. They explain that often therapeutic approaches require clients to “have the ability to self-reflect, manipulate complex concepts mentally, bear in mind the future consequences of behaviour, and consider the perspectives of others, while experiencing intense emotion” (p. 220). These emotional and cognitive demands are often too onerous for the average adolescent and may result in confusion, resistance, disengagement and attrition. As adolescents begin to develop these skills, they may become more difficult to access when their emotions are heightened. There is a risk to both under evaluating an adolescents’ cognitive ability as well as overestimating it. As well, the authors explain that a limited understanding of the purpose of treatment or doubts regarding its efficacy often pose difficulties for engagement and can result in resistance and disengagement.

The call for adolescent-specific interventions is echoed by Sommers-Flanagan & Bequette (2013). The authors explain that specific interventions, including the way the initial interview is approached, need to be adapted for work with teens. They explain that common openings such as “How can I be of help” are “ill-fitted for psychotherapy with adolescents because they assume the presence of insight, motivation, and a desire for help—which may or may not be correct” (p. 17). Here the authors allude to the unique scenario facing much of the adolescent work, which is that many adolescent clients do not seek therapy on their own accord but are ‘referred’ by either parents, teachers, or other government-related professionals. This “mandated” attendance has a large effect on motivation and overall engagement, therefore avoiding assumptions that clients *want* to be there at the initial introduction may benefit the therapeutic alliance and the future success of engagement strategies.

### **Autonomy to Promote Engagement**

Developmentally, as youth begin to differentiate themselves from their parents during adolescence, developing their own autonomy becomes important. Bolton Oetzel and Scherer (2003) explain the unique challenge facing teens as it can be difficult for adolescents to both ask for help while attempting to maintain or develop their own autonomy. This can create conflict and confusion and can result in seemingly resistant behaviours during session. This autonomy may also result in a reluctance to seek help as adolescents may begin to feel that they should be able to solve problems on their own (Rickwood, Deane, & Wilson, 2007).

In their study of engagement shifts, Higham et al. (2012), through the observation of videotapes of 29 families with at-risk youth, determined five key elements that resulted

in a shift from negative to positive engagement: structuring therapeutic conversations, fostering autonomy, building systemic awareness, rolling with resistance, and understanding the adolescent's subjective experience. Fostering autonomy was seen as interventions where the therapists attempted to support the adolescent in making decisions independently. This was done by demonstrating a consideration of both parent and adolescent opinions but encouraging the adolescent to feel open to developing their thoughts that may be different from those of their parents. These interventions included "statements validating the adolescent's experience and inquiries about the thoughts or feelings that were presumably difficult for the adolescent to express" (p. 38). In the vignettes provided, the therapists collaborated with the client in order to help them explore their own unique feelings regarding a situation that may have been in contrast to their parents. It appears as though this encouragement and understanding of the important differences between the youth and the parent, and validating the youth's experiences contributed to more positive engagement within the therapeutic process.

Church (1994) explains that:

Autonomy becomes re-defined as adolescents' conviction that they have freedom and capability to articulate and to act on their own goals while remaining in relation with their parent. Adolescent's capacity for autonomy emerges as they start to see themselves as agents of their change. Their sense of autonomy develops through identifying aspirations and through working out their own sense of self. In this process, the adolescents internalize some of their parents' values, while they reject or modify others. (p. 102).

In this way, adolescent autonomy is marked by a transition and negotiation within family roles, and may be challenging as they attempt to navigate difficult emotional problems on their own. It is therefore critical for counsellors to present themselves as allies and collaborators rather than authority figures, in an attempt to create a space where teens are able to air their difficulties without threatening their developing sense of autonomy.

### **Collaboration in Adolescent Psychotherapy**

An exploratory, process-research study examined 10 adolescents receiving family therapy for substance-abuse in an inner-city, university-based clinic (Diamond, Liddle, Hogue & Dakof, 1999). The study aimed to identify therapist behaviours that were attributed to positive changes in adolescent alliances. After generating a list of alliance-building interventions, and analyzing videotaped family therapy sessions, the researchers then aimed to determine whether naïve raters would be able to identify and measure these interventions with reliability. Five of these interventions were reliably coded. These interventions were: orienting the adolescent to the collaborative nature of therapy; formulating personally meaningful goals, attending to the adolescent's experience; presenting the self as an ally; and addressing trust, honesty and confidentiality. Of these five behaviours, the collaborative aspect of therapy, or "presenting oneself as an ally", was reported to have the greatest effect on improved alliances. The authors explained that becoming an ally with the adolescent resulted in adolescents who "participated more fully in the therapeutic process" (p. 365). Provided the definition of engagement suggested by Kim et al. (2012) that refers to engagement being related to level of participation, it appears as though presenting oneself as an ally with youth may result in greater engagement as seen through participation in therapeutic tasks. Similarly, Liddle

(1995) explains the importance of the co-construction of therapeutic goals in order to engage the adolescent and to resist any authoritative stance within therapy.

### **Choice and Negotiation**

As adolescents differentiate themselves from their parents, feeling as though they have greater independence as well as the power to engage in negotiation and have choice in their treatment, these factors may result in greater overall engagement. Much research frames the role that choice and negotiation may have on facilitating adolescent engagement in psychotherapy (Bolton Oetzel & Scherer, 2003; Digieuseppe, Linscott, & Jilton, 1996; Sommers-Flanagan et al., 2010; Liddle, 1995; Castro-Blanco, 2010).

Bolton Oetzel and Scherer (2003) suggest that based on their review of process literature, adolescent development and socioecological studies, there is a unique challenge facing youth psychotherapy. They explain that the intrinsic motivation of youth to attend therapy is often undermined by the fact that they are mandated to therapy, often by external forces such as parents or teachers. They propose that one way to combat decreased motivation is to offer adolescent choice wherever possible. The authors explain that:

Allowing adolescents to choose their therapist, or giving them treatment intervention options from which to choose, or offering them the choice of what to discuss in therapy may enhance the relevance of and motivation for psychotherapy for the adolescent client, leading to a higher level of engagement. (p. 222).

Based on the research available, it appears that maximizing the possibility for choice may help teenagers to find ways to re-assert their independence by exercising their own free-will and disarming their potential resistance or reluctant postures.

### **TEEN: A Negotiation-Based Intervention Program**

Castro-Blanco (2010) offers a specific approach targeted at increasing the engagement of adolescents. The approach aims to teach families negotiation skills with the hope of encouraging family members to be more willing to participate in therapy and work collaboratively to approach and address problems. TEEN (Techniques for Enhancing Engagement through Negotiation) provides families with 10 specific guidelines to promote more effective negotiation. The author believes that by demonstrating a willingness to negotiate and involve the adolescent, parents demonstrate their reason and flexibility and may encourage the teen to participate rather than resist goal-setting and family collaboration. Castro-Blanco (2010) explains that:

By incorporating the teen and family members as parties to a negotiation rather than as adversaries, the focus of treatment can remain on the goals and issues in contention rather than on recrimination and blame avoidance. The adolescent is enlisted as a collaborative partner in the treatment team, participating in the formulation of treatment goals, identification of desired outcomes, and steps towards compromise. (p. 128)

The program aims to teach adolescents how to communicate, identify problems, generate options, and accept compromise. The ultimate goal is to train the family to become independent and to learn to incorporate the strategies in daily life. The TEEN approach makes use of a number of specific techniques such as social tokens to promote

positive behaviour, feeling thermometers to aid in discussing and identifying feelings, assumption cards that help families to explore assumptions that underlie recurring disagreements, rules and roles cards that help the family to gain perspective on behaviours and roles that may influence family dynamics, role-play activities, and the creation of an emergency safety plan. The primary goal of TEEN is to promote family collaboration to solve disputes or problems. Castro-Blanco (2010) concludes by explaining that “just as problems are seen to be systemic, rather than idiopathic, so too are their resolutions” (p. 135).

### **Confidentiality**

Important to facilitating active engagement with teens is the concept of confidentiality. Just as the need for greater autonomy during adolescence was discussed, the importance of confidentiality appears to be connected to their quest for more independence. It is suggested that the assurance of confidentiality is necessary for many teens to feel comfortable to actively and freely engage in therapy. For many youth, the fear of authority figures or of consequences has significant negative impact on their participation (Kalogerakis, 2004). However, difficulties with confidentiality arise for practitioners due to the common scenario that the client is not self-referred and therefore someone other than the adolescent is invested in the goals and outcomes of therapy (Church, 1994). This may complicate the rules and laws that exist around confidentiality and therefore assuring that the practitioner is knowledgeable, well-versed, and obtains proper consents from both parents and the adolescent are critical. Ensuring that the adolescent understands the limitations of confidentiality as well as having open and ongoing conversations with the youth regarding the practitioner’s individual practices

regarding privacy are critical components to developing safety, rapport and engagement (Bolton Oetzel & Scherer, 2003).

Sommers-Flanagan and Bequette (2013) provide in their research a vignette that highlights some of the possible difficulties when navigating confidentiality in a family context. The story demonstrates that there may be times when an adolescent's behaviour does not meet the criteria for breaking confidentiality, but may still be considered dangerous. Parents may have the expectation that they would be told of such situations whereas adolescents may assume that their privacy be kept. In these scenarios, openly and frankly discussing these possibilities at the onset of therapy with both parents and youth are very important. It may also be important to explain to the youth that there may be unsafe situations that pose a threat to their personal safety and therefore may warrant parent involvement. Such involvement can facilitate better trust and openness between the client (the adolescent) and the counsellor.

Ultimately, confidentiality is very important for youth as they develop independence from their parents and may be involved in rebellious or difficult behaviours and activities. Having clear boundaries and policies around these situations and openly discussing confidentiality boundaries with both the adolescent and the parent is imperative to safe and ethical practice.

### **Barriers to Adolescent Engagement**

There do exist certain barriers to therapeutic engagement when working with the adolescent population. When working with culturally diverse children and adolescents, having an awareness of different cultural practices, as well enquiring as to an adolescent's preferences during treatment, may reduce cultural barriers and promote



engagement (Stewart, Simmons, & Habibpour, 2012). Being aware of one's own cultural biases and assumptions is also important when combined with an ongoing desire to challenge and learn about diversity and the individual's personal experiences. Donaldson, Spirito and Boergers (2010) explain that "cultural and familial factors such as traditions, social norms, acculturation level, mistrust of the health care system, and values (such as interrelatedness vs. autonomy) all have the potential to affect treatment engagement" (p. 211).

Gender may also pose a barrier to engagement in psychotherapy. Men in general, and adolescent males seek help less than females yet have a greater probability of completing suicide (Rickwood et al., 2007).

Finally there are many service barriers such as availability, waitlist times, financial burdens, transportation, and familial support that may negatively impact the potential engagement of adolescent clients (Donaldson et al., 2010). Although these barriers may partly be embedded within the systemic processes of the agencies, an open discussion regarding barriers with youth upon intake may help to illuminate potential concerns as well as solutions that may exist.

## **Conclusion**

Overall there are many factors that affect engagement with the adolescent population. Being aware of their unique traits and working alongside youth may be the foundation to facilitating active engagement thereby increasing the potential treatment outcome. It is important for practitioners to be aware of how engagement impacts outcome and to be knowledgeable of factors that may lessen engagement. Incorporating

adolescent-specific strategies may help to promote both the therapeutic alliance with the youth as well as their involvement and perception of value of psychotherapy.

## CHAPTER 4

### **Treatment Modalities for Dealing with Adolescent Depression**

Given the prevalence of depression among teens, coupled with the vulnerability of adolescents to suicide and self-harming behaviours, it is important that developing youth-specific approaches is at the forefront of the mental health field. Despite the urgency of tailoring therapeutic approaches to younger populations, it appears as though few youth are seeking treatment relative to the prevalence of depressive symptoms, suggesting that perhaps therapeutic approaches do not match the needs and preferences of the adolescent population. A study conducted in Britain aimed to research the help-seeking behaviours of young adults. The study interviewed a random sample of 3004 young adults from both urban and suburban locations. The results of the study demonstrated that of the young adults affected by depression, 20.2 % of females and 10.8% of males sought help for their mental health concerns, including seeking help from family and friends (Biddle, Gunnell, Sharp, & Donovan, 2004). These statistics suggest that there is a large population of unreached youth and young adults who suffer from symptoms of depression such as poor social functioning, low school performance, substance use and dependence, and suicide yet who do not receive mental health services (Jaycox, Rosenbaum Asarnow, Sherbourne, Rea, LaBorde, & Wells, 2006).

As Biddel et al. (2004) note, less males seek treatment than females. This statistic is made more interesting when considered in light of a study by Bradley, McGrath, Brannen and Bagnell (2010) that hypothesized that males would prefer antidepressants as a treatment approach to psychotherapy. The results of the study disproved their hypothesis and suggested that both males and females preferred talk therapy over

antidepressants alone with minimal significance in the differences between the two sexes (92% of males to 94.9% of females). Despite the similarities in preferences for treatment modality between sexes, there continues to be a discrepancy in the use of mental health services, with men accessing mental health services 10% less than women with similar mental health concerns as seen in the study by Biddel et al. (2004). It appears that although psychotherapy is widely accepted and valued treatment choice, barriers exist that prevent men from accessing this type of treatment. This chapter aims to explore treatment options and modalities that exist that may help to reduce barriers and stigma associated with depression and psychotherapy.

It is also important to consider that research suggests that the role of gender in the prevalence of depression rates is inflated (Vasiliadis, Lesage, Adair, & Boyer, 2005). In a study by Levinson and Ifrah (2010) that interviewed 4864 Jewish Israelis, Arab Israelis and Immigrants living in Israel, researchers attempted to examine the differences in rates of service usage between genders. The study aimed to determine whether this difference is better accounted for in terms of psychosocial differences between genders or differences in the prevalence of common psychiatric disorders and levels of distress. The results of the study suggest that after adjustment for age, population group, education, family status, employment status, chronic physical conditions, reported violence, or sexual violence and levels of distress, that there were no significant differences in the prevalence of mood or anxiety disorders between genders. The study also confirmed that despite the limited differences between genders in the susceptibility to depression, that there continued to be a difference in the use of mental health services when the same psychosocial stressors were accounted for, with males using fewer services. These

findings suggest that the social expectations of masculinity may create a barrier for seeking help for mental health concerns among males.

Jaycox et al. (2006) address this gender disparity by stating that “the gender difference may indicate a missed opportunity to engage teenage boys in effective treatments” (p. 205). The authors go on to explain the importance of the issue considering that males are more likely than females to complete suicide (e.g. by using more lethal methods and by not engaging in the same rate of help-seeking behaviour.

It appears that with the growing knowledge of effective treatments for depression, addressing male-specific needs and preferences is an important area for future research.

### **Therapeutic Approaches for the Treatment of Depression**

Four common therapeutic approaches that are empirically supported for work with depressed adolescents are Cognitive Behavior Therapy, Interpersonal Psychotherapy, Attachment-Based Family Therapy, and Dialectical Behaviour Therapy. These approaches and their effectiveness with the adolescent population will be discussed.

#### **Cognitive Behaviour Therapy**

Cognitive Behaviour Therapy (CBT) is a therapeutic approach that has been well studied, with many successful reports on its efficacy for treating adolescent depression (Curry, 2014). CBT works from the theory that thoughts, feelings, and actions are interrelated. One of the principle goals of CBT when addressing depression is to identify faulty or distorted cognitions that may lead to or maintain depressed moods. CBT often uses various strategies such as psychoeducation, self-monitoring, emotional awareness,

challenging negative thoughts and activity scheduling to help clients develop strategies to combat depression (Gledhill & Hodes, 2011).

CBT is considered to be one of the most effective treatments for depression and has been well researched (Rohde, 2011). One very well-known study, The Treatment for Adolescents with Depression Study (TADS), aimed to determine which therapeutic approaches are most effective at targeting depressive symptom using a randomized, controlled trial. The study found that combined treatment of psychotherapy and medication was the most effective treatment for depression in adolescents (TADS Team, 2004). A further study done by the TADS team aimed to determine the effectiveness of treatment upon 1 year follow-up and concluded that the combined treatment of antidepressants and CBT resulted in quicker recovery from depressive symptoms, and that longer term treatment resulted in superior outcomes to short-term treatment as well as decreasing the chances of relapse of depression (TADS Team, 2009)

### **Interpersonal Psychotherapy for Depressed Adolescents**

Interpersonal Psychotherapy (IPT) is also considered an evidence-based practice for the treatment of depression. Originally developed in the 1960's, IPT has since been adapted to suit the specific needs and development level of the adolescent population (IPT-A). IPT-A works from the theory that depressive symptoms (regardless of the cause) are intertwined within the individual's relationships. The goals of IPT are to decrease depressive symptoms and to enhance interpersonal functioning by improving communication skills in important relationships (Mufson, Pollack Dorta, Moreau, & Weissman, 2004). The framework of IPT conceptualizes four potential areas where problems occur that lead to depressive symptoms: interpersonal disputes, role transitions,

grief and interpersonal deficits. The therapist, after completing a full assessment, will choose to focus on one of these key areas to provide the foundation for the treatment.

Authors Brustein-Klomek, Zalsman and Mufson (2007) provide a summary of seven clinical studies that evaluated the effectiveness of IPT-A, noting that it is considered to be an empirically-supported treatment option for depression. When comparing CBT to IPT, studies have garnered mixed results and IPT has not yet been tested against medication, pill placebo, or combination treatment (Curry, 2014).

CBT and IPT-A are similar in that both approaches have been adapted and proven successful for work with the adolescent population, both involve collaboration with the adolescent client, and both emphasize specific therapeutic techniques (Sburlati, Lyneham, Mufson, & Schniering, 2012). The two approaches differ in their conceptualization of the “problem” where CBT positions depression within the thought processes of the adolescent combined with environmental factors yet IPT draws from interpersonal, social, and attachment-based theories (Sburlati et al., 2012).

### **Attachment-Based Family Therapy**

Attachment-Based Family Therapy (ABFT) is a therapeutic approach that focuses on improving the quality of adolescent-parent attachment relationships among depressed and suicidal youth (Diamond, 2014). The approach can be conceptualized as having two phases, with the first focusing on the adolescent identifying and communicating the rupture to their parents, ending in an apology as well as forgiveness. The second phase of treatment focuses on promoting and encouraging adolescent autonomy (Diamond, Siqueland, & Diamond, 2003). There are seven targets and proposed mechanisms of change: 1) parent criticism, 2) adolescent motivation, 3) parental stress, 4) ineffective

parenting, 5) family disengagement and conflict, 6) affect constriction, and 7) negative self-concept. In order to address these targets, the therapist will engage the adolescent and the family in a series of treatment tasks (relational reframing, alliance building with the adolescent, alliance building with the parent, reattachment, promoting competency). The ultimate goal of ABFT is that “parents become a safe and secure base to which the adolescent can turn for comfort, support and guidance” (Diamond et al., 2003, p. 117).

Curry (2014) notes that ABFT has been proven to be effective in two studies, however remains relatively new in terms of empirical support. ABFT also has not been studied in comparison with medication, pill placebo, combination treatment, or other therapeutic approaches.

### **Dialectical Behaviour Therapy**

Dialectical Behaviour Therapy is a variation of CBT that was initially created for treatment of Borderline Personality Disorder. It has since been studied and adapted, proving to be effective for the treatment for variety of disorders. DBT has also been adapted for work with adolescents (Koerner, 2012, Singh & Singh, 2013). DBT blends many elements of CBT with mindfulness and meditation practices. Although DBT remains to be studied for its effectiveness with depression, there is empirical support for its effectiveness in youth with Borderline Personality Disorder as well as other self-harming and injurious behaviours (Macpherson, Cheavens, & Fristad, 2013).

Group DBT for adolescents consists of 16 weekly individual and family skills training group sessions, and focuses on balancing change and acceptance. DBT situates the problem in five possible areas: confusion about self, impulsivity, emotional instability, interpersonal problems, and adolescent-family dilemmas (Miller, Nathan, &



Wagner, 2010). The therapist works collaboratively with the adolescent to ensure engagement. DBT views negative behaviours as understandable attempts by clients to solve problems, and this sense of validation is important to the approach. The therapist then works towards developing better mechanisms for dealing with and coping with negative feelings and situations.

When introducing the youth and the family to the DBT approach, the therapist initiates the “treatment agreement” which is a contract developed at the beginning of the therapy, after the approach and expectations have been made clear. There is an expectation of commitment throughout the therapeutic process where the therapist actively seeks out ways to engage the client to commit to the treatment plan.

Therapists make use of two strategies to help maintain client engagement- reciprocal communication and irreverence. Reciprocal communication is used to make the therapist approachable, personable and genuine by facilitating a warm, sharing environment. The goal of irreverent communication is “to get the patient’s attention, shift the patient’s affective response, and help the patient see a different point of view” (Miller et al., 2010, p. 193).

The term “dialectical” comes from the idea that dialectics, or the discussion of ideas and their opposites, is an overarching theme throughout the treatment approach. Miller et al. explain that dialectics exist on multiple levels:

First, within the therapeutic interaction, the therapist consciously monitors the balance of change and acceptance, flexibility and stability, challenging and nurturing, and other dialectics to engage adolescents and maintain a collaborative working relationship in the moment-to moment interactions. Second, the therapist

teaches and models dialectical thinking and behaviour in the session by opposing any term or proposition with its opposite or an alternative (p. 198).

DBT also focuses on learning specific skills that the adolescent can implement: mindfulness skills, distress tolerance skills, emotion regulation skills, interpersonal effectiveness skills, and “walking the middle path” skills (Koerner, 2012, p. 21).

DBT continues to be a well-researched modality. Since its original development for the treatment of Borderline Personality Disorder, studies are now aimed at researching its suitability and its effectiveness for work within the youth population.

### **Alternative Approaches**

There exists many other therapeutic approaches that demonstrate effectiveness for work with depressed youth. It is important to note that there is no panacea for depression, particularly when working with the adolescent population, and therefore having an awareness of a breadth of therapeutic approaches will deepen one's understanding of this vulnerable population as well as provide diverse options that allow for better client-specific treatment choices. In a discussion of the problematic terminology of “evidence-based practices” and the rise in population of ESTs (Empirically-Supported Treatments), Bohart (2005) addresses the importance of treating clients as individuals, and knowing how to cater an approach to their individual needs in conjunction with a working knowledge of effective psychotherapeutic strategies. Bohart explains that “The practitioner tries things out, looks for feedback, and then revises and sharpens based on that feedback. Practice is always evidence-informed but not evidence-driven.” (p. 41). It is important to rely not only on the standard approaches that are most commonly used to treat depression, but to be open to other approaches that show promise

in work with adolescents, and that better suit and help certain clients in need. The following approaches may be helpful in work with the adolescent population.

### **Wilderness Therapy**

Wilderness Therapy is a difficult approach to study, mainly due to varying definitions and standards used to describe this theoretical model (Russell, 2001). Many confuse outdoor boot camp-style programs or other Wilderness Experience Programs with Wilderness Therapy. This is particularly concerning considering the liability and negative results of these types of programs.

According to Kimball and Bacon (1993), Wilderness Therapy is “1) a group process, 2) a series of challenges in a wilderness setting, 3) structured clinical interventions and therapeutic techniques such as reflection and journal writing, individual counseling, and self-disclosure, and 4) varied length” (as cited by Norton, 2010, p. 229). Wilderness therapy shares views with psychodynamic and object-relations theories, and aims to provide adolescents with opportunities to progress through developmental stages (or return to missed stages) through the outdoors, through challenges, and through adventure. It is an experiential approach and makes use of various activities such as backpacking, paddling and rock-climbing. Norton (2010) explains that:

In essence, the challenges they overcome provide them with new evidence about themselves. The creation of a new narrative may increase the depressed adolescent’s ability to envision themselves in a new place emotionally, creating a deeper sense of future (p. 230).

Although there is much to learn and study about wilderness therapy, its unique approach may appeal to various adolescents. It provides a holistic and natural experience

where youth can safely challenge themselves, explore new ways of being, and develop strategies and self-awareness through experiences and exploration.

### **Arts-Based Therapies**

For some youth, traditional talk-therapy can be difficult or uncomfortable. This may be the result of limited emotional awareness, lower verbal skills, or developmental stage. Art-based therapies can provide a medium other than talking, in order to access an individual's feelings. McGlasson (2012) explains that "adolescents may be drawn to this as a less verbal alternative to exploring their personal issues" (p. 19).

Art therapy utilizes various tools and media to encourage an adolescent to explore their feelings, experiences and thoughts. There is a wide variety of approaches and specific interventions or techniques in art therapy, and prompts can be directive or non-directive, appealing to the growing sense of autonomy in adolescents. Lombardi (2013) explains that "through this in-depth discussion about the child's imagery, the therapist gains an understanding of the child's symbolic language" (p. 53) but also cautions practitioners not to assign meaning to drawings but rather to use drawings and creations as a medium to talk. Practitioners must ensure that it is through the client's perspective that explorations and conclusions are made.

Another form of artistic therapy is music therapy. Music may appeal to many adolescents as adolescents may often turn to music as a comfort, support or release. Music is also well known to adolescents and may be less intimidating than other forms of therapy (McGlasson, 2012).

Hadley and Steele (2013) explain that there are four main approaches used by music therapists: listening to music, performing music, composing music, and

improvising music. One program exists that makes use of many of these approaches: “Doing Anger Differently” (DAD), a percussion-based group therapy for boys with anger problems (Currie, 2004). Although this study does not focus primarily on depression, provided the research on the externalizing symptoms of depression of many males provided in Chapter 1 of this thesis, a focus on anger may be helpful in dealing with depressive symptoms. The DAD program utilizes three levels of intervention: 1) the theory of individual change, 2) the division of the experience of anger into several focus areas, and 3) the group context. Currie explains that the approach “takes account of the difficulties in engaging and treating [adolescent boys], through the use of percussion and a theory of change at the level of identity and cognition of the self” (p. 291).

### **Other Approaches**

Many other treatment options exist that may serve the unique adolescent population, and that may specifically cater to the needs and development stages of males. Existential Therapy, Strengths Perspective (Yip, 2005), and Positive Psychology (Kiselica & Englar-Calson, 2010) are among other approaches that have been used for work with the adolescent population and with males specifically. Although an in-depth look at each therapeutic approach is beyond the scope of this chapter, the understanding that many approaches exist that may suit the needs of individual clients can provide a solid foundation that may compliment effective practice in work with adolescents.

### **Choosing the Right Approach**

Although this chapter provided a summary of various empirically supported approaches, it should not come at the cost of listening to clients and being flexible in treatment approaches. Although CBT and IPT-A are considered empirically supported

approaches, many studies are limited in scope and have demonstrated weaker overall results and some studies have shown that efficacy results may be inflated in controlled environments when considered in more realistic settings (Stewart & Chambless, 2009). A study done by David-Ferdon and Kaslow (2008) suggests that although CBT and IPT-A are well supported, there is evidence to suggest that other approaches may also be effective, and should be considered when assessing the specific needs, skills and deficits of our clients.

In order to best serve our clients and to contribute to their overall well-being, ensuring that our approach “fits” with them is important. McGlasson (2012) eloquently explains that:

The suggestion is not that clinicians change their current approach or theory but rather, when we learn to truly ‘listen’ to the messages of adolescents today and become more sensitive to their unique needs and the environmental pressures they face, we will be more likely to utilize the interventions that are most helpful to them and their families (p. 20).

Considering that research that male adolescents have lower response rates of accessing mental health resources or remaining in psychotherapy, it is important to have an awareness of a variety of approaches that may help to engage adolescent males in therapy. In general, we need to ensure that we are listening to clients and that practitioners implement meaningful interventions that take into consideration the diverse needs, interests and personalities of our clients. There continues to be a need for male-driven treatment approaches that demonstrate sensitivity to the challenges created by the concept of “masculinity”, as well as an effort to reduce the stigma that many men face

when struggling with mental health concerns. Future research should consider this population, in hopes of creating better engagement and service usage for male-identifying adolescents, as well as decreasing and preventing suicide attempts among this vulnerable population.

## **Chapter 5**

### **Depression and Masculinity**

#### **Introduction**

This manuscript-style thesis has explored adolescent depression with a specific focus on the adolescent experience, specifically when seen through the lenses of gender and the social expectations of gender norms. How depression can differ between genders is an important consideration for practitioners, as the risk of under detection of depression can lead to serious consequences such as suicide (Khan, Upmanyu, Vinayak, & Kumar, 2014; Marcell & Monasterio, 2003). It is noted that not only do adolescent males have a higher rate of completed suicide, but also have significantly lower help-seeking tendencies as well as a higher threshold for when to seek help (Biddle, Gunnell, Sharp, & Donovan, 2004). Taking this information into consideration, it seems important for the mental health field to move forward in developing assessment tools, intervention strategies, and therapeutic modalities that reflect a consideration of how masculinity may affect the experience of, the expression of, or the help-seeking tendencies of those struggling with depression. By working towards removing potential barriers, reducing stigma around mental health concerns, and providing beneficial care, it is possible that in the future these discrepancies across genders may be diminished, and that all those needing services, regardless of gender, will be able to do so and will benefit equally.

Understanding not only how to assess and diagnose depression among boys, but also how to develop rapport, how to engage with male youth, and various therapeutic approaches are significant in order to best mitigate the effects of depressed mood.



Fleming and Englar-Carlson (2008) clearly capture the importance of identifying depression when stating that:

A significant concern is that boys mask feelings of sadness, hopelessness, and depression to the point where it becomes severely debilitating, and potentially fatal in the case of contributing to suicidal thoughts, feelings, and behaviour (p. 132).

Counsellors must have training on gender development as well as an awareness of how pressures from society can negatively affect individuals and their mental health. The stoicism and independence expected of men in North American society can act as a barrier for them to seek the resources needed when concerns for mental health arise. These societal pressures can act not only as a barrier, but can also be the cause of such mental health concerns. The stress of feeling that one needs to attain certain status or hide aspects of themselves in order to be socially acceptable and to avoid rejection can put a significant strain on the individual's mental health. For this reason, counsellors must have an awareness of how the relationship between race, ethnicity, culture and gender can cause problems for individuals as they struggle with finding their own identity amidst the societal expectations of these facets of identity (Howard-Hamilton M.F. & Frazier, 2005). Fleming and Englar-Carlson (2008) aptly frame the emotional dilemma facing many adolescent males:

If he is not tough enough, smart enough, or not successful enough, or if any way he shows himself to be a 'sissy', a boy may be racked with shame for not living up to his perceptions of what others expect him to be and of what he expects of himself. And those feelings of shame can be the source of his desire to punish

himself. Whereas girls and women often learn to express their pain, take care of themselves, and reach out to others for social support, men are traditionally socialized at a young age to act on problems, be independent, and disdain emotional pain. In this regard, males are often alone with their pain, and feel they cannot express it or ask for help (p. 138)

Entering into conversations with male clients about what pressures they face, and how they interact with those cultural values may open an important dialogue that can allow the individual to see their experience from a different perspective, and may allow themselves to understand the difficult emotions they are facing.

### **Suicide and Adolescent Males**

As noted, males have a higher rate of completed suicide than their female counterparts. Females tend to have a higher rate of suicide attempts, with a lower rate of suicide completion. Males tend to use more lethal means such as firearms, and therefore despite the lower incidence of depression as well as fewer suicide attempts, there are higher rates of completed suicide for adolescent males (Sommers-Flanagan & Sommers-Flanagan, 2007; Fleming & Englar-Carlson, 2008; Biddle et al., 2004).

Some groups of adolescents are at an even greater risk for depression, self-harming behaviours and suicide. Youth who identify with minority sexuality or who identify as transgendered or transsexual have significantly higher risk for depression and suicidality. A study conducted by Almeida, Johnson, Corliss, Molnar and Azrael (2009) researched data collected from a two-stage stratified random sample of high schools in Boston, Massachusetts Public Schools. The aim of the study was to investigate the presence of emotional distress among LGBT youth and the perceptions of maltreatment

and bullying as being related to their LGBT status. The results of the study are consistent with past research, suggesting a positive relationship between depressive symptomology and LGBT identification. Among those surveyed, the results demonstrated that LGBT youth displayed more emotional distress when compared to heterosexual, non-transgendered youth and that LGBT males were particularly susceptible to symptoms of self-harm, with 41% of males identifying as LGBT reporting self-harming behaviour. The researchers also noted an interesting finding relating to gender and the presence of depressive symptoms. They explain that for youth who reported being discriminated against, males had an increase in their depressive symptoms whereas no similar increase was noted among females. These results suggest that LGBT identification among male-identifying individuals may result in a higher risk factor than among females, perhaps due to the social stigma and social expectations of masculinity and the perceived risks associated with straying from social norms. It was noted that this discovery warrants further research as there may be explanations such as a “ceiling effect” on females, as there is typically a higher prevalence of depression in this population, therefore limiting the apparent differences in the comparison groups. The authors note that these results suggest that perceived discrimination on the basis of sexual orientation may more strongly account for increased depressive symptoms reported by LGBT boys, compared to the role that it plays in depressive symptoms among LGBT girls (p. 1011).

The pressure that exists within society for men to adhere to strict gender specific behaviours may be connected to the lower incidence of depression yet a higher rate of suicide among adolescent males. When male-identifying youth are faced with problems,

some teens may feel unable to seek help when needed, and may have a limited view and understanding of other ways of managing these difficult feelings, which may result in lower statistics for male depression. However, these statistics may not account for the males who suffer silently and without support. Of these individuals, there are many who may lack emotional language or strategies to help them cope with a depressed mood. Fleming and Englar-Carlson (2008) explain that “whereas emotionally healthy adolescent males deal with pitfalls and other negative feelings and circumstances in life-enhancing ways, boys who are suicidal see this as the only way of handling traumatic events” (p. 134). The authors go on to explain that often, these young men do not wish to die but rather have difficulty envisioning a positive future. It is here that counselors can intervene, by helping young men to develop a positive and forward focus. The concerns noted by Fleming and Englar-Carlson may also suggest the usefulness of Dialectical Behaviour Therapy, specifically with male-identifying clients. This approach, as it validates the individuals attempts to solve problems (suicide) while working with the individual to develop more helpful strategies, may position itself well within the thinking pattern and development stage of many suicidal adolescent males. Further research would be needed in order to determine if this approach has particular benefit to the suicidal-male population.

Another approach that may be well suited to helping young men acknowledge, address and work through the gendered expectations of society is Integral School Counseling. Forbes (2003) explains a model of counseling within schools that may help adolescent males to become more able to challenge or move beyond gender restrictions. The model makes use of a “Wheel of Integral School Counseling” that is built on three

levels: monological (in which the egocentric self is explored), dialogical (the social self), and contemplative (the expanded self). By exploring these three layers of identity, male adolescents can better understand the influences at play in their own lives, the pressures or expectations put on them by society, and can “help male youths avoid attachment to restrictive, conventional notions of masculinity and may allow them to be more open to a full range of their own and others’ experience” (p. 148). This approach may be extremely beneficial in beginning a larger cultural shift in the understanding of the effects of societal expectations of masculinity on the youth population. Skilled counsellors may use this approach to help young men to process the role that culture plays in their own lives, as well as their personal mental health. This awareness may act as a safeguard in the future against the effects of societal norms on their mental health as they enter the later stages of their life.

The need for approaches that take into account the challenges created by masculinity and the pressures of gendered social norms is apparent. Although chapter four discussed various adolescent-driven therapeutic approaches, there remains to be more research focused on gender-specific intervention strategies that may target some of the individual vulnerabilities that are affected by societal expectations and pressures facing some young men. This call for research is echoed by Wisdom, Rees, Riley and Weis (2007) who explain that:

The need to develop more efficacious treatment strategies for long-term depression, the gender differences in rates of depression, and the emerging significance of gender role socialization as related to depression are all important

considerations that suggest that gender-specific psychosocial therapy may provide a useful intervention to supplement currently effective methods (p. 147).

These authors conducted a modified grounded theory study on twenty-two adolescents to gather insight into adolescents' perspectives on the effects of gender stereotypes on depression. The results of the research identified three main themes suggesting that adolescents do have an awareness of understanding of the pressures from society. The themes identified were: depression in adolescents was partially attributed to challenges related to societal expectations and cultural messages; b) pubertal changes were perceived as contributing to depression for girls but not boys; and c) loneliness and rejection were perceived by both boys and girls as being associated with depression (p. 151). In the discussion, some teens were able to identify ideas such as male stereotypes leading to the "denial that boys are experiencing depression at all" (p. 153). These results are significant, and are consistent with the idea that the lower prevalence of depression among males may not be due to a *lack* of depression, but rather to the lack of reporting or help-seeking among male-identifying adolescents. It is therefore necessary that effort be placed in developing ways to make talk-therapy more approachable and adaptable for this population.

Practitioners also need to be well versed in the emotional language of young men. As mental health services are sought more often by females, research may need to look at how interventions or expectations of counsellors may be developing in a way that indirectly caters to females, as this represents a larger sample of their clientele. Fleming and Englar-Carlson (2008) note that counsellors must not be discouraged by anger from boys that may arise within session. Often, expressing anger is a more socially acceptable

display of emotions than it is to discuss feelings of sadness and vulnerability for boys. During session, counsellors may feel threatened or frustrated by boys who may yell, act out, or become more aggressive, however counsellors must see these signs as manifestations of depression. Addressing this, and helping the individual to make the connection between their “acting” out behavior and their sadness, may contribute to a stronger therapeutic relationship. The authors go on to explain that:

By being aware that presenting problems may actually be masking deeper more critical problems, a counselor will be less likely to miss what is really happening in the boy’s life. We have noticed how many boys express relief when someone is able to help them understand at a deeper level what is really happening for them (p. 141).

Similar to needing an understanding of the manifestation of anger among boys, is the need for the need for counsellors to match what their client is experiencing, rather than jumping prematurely into problem-solving language. Sommers-Flanagan & Sommers-Flanagan (2007) recommends “siding with the affect” in order to display similar characteristics that a peer-group might provide an adolescent. In portraying a similar range of emotions to the client, the counsellor is able to reflect understanding, and a sense of connection with the individual. As young men may be coming into session feeling frustrated and confused, allowing for some time to “side with the affect” of the client may allow for a deeper therapeutic experience to develop.

### **Parent Role**

As some boys may be reluctant to seek help, unaware of emotional language to accompany their experience, or confused by the complexity of their feelings, it may be

unrealistic to assume that counsellors and mental health professionals can easily overcome these barriers. It is therefore important that the field not only focus on removing barriers for the individual, but also on increasing awareness among those involved in adolescent males lives such as teachers, coaches and parents. It is likely that these individuals may be the first to notice the initial signs of adolescent male depression.

Fleming and Englar-Carlson (2008) explain that:

If parents are aware that a melancholy mood, irritability, early morning fatigue and substance could be signs of depression, an adolescent boy who exhibits these symptoms might be perceived as defiant, lazy, and unmotivated for school rather than suffering from a potentially serious mental health problem (p. 141).

It is important that not only mental health professionals, but that society as a whole becomes more attuned to recognizing the signs and symptoms of depression.

Recognizing that although statistically there may be a lower incidence of depression among male-identifying adolescents, this statistic may be due to the under detection of depression among young men. Encouraging this awareness may help promote a shift in thinking of depression as a problem facing females, to the understanding that depression can affect anyone and that it is not a gender-specific phenomena.

## **Conclusion**

Depression in young men is more likely to go undiagnosed (Breland & Park, 2008), and provided the high rates of suicide completion, it is imperative that professionals in the field of mental health are knowledgeable about the course of treatment, beginning with identifying potential signals of depression (anger, isolation,



increased sleep, lack of interest etc.), ways of developing rapport with male-identifying clients, ways of engaging boys in treatment as well as therapeutic approaches that may suit the individual's specific needs in order to create a meaningful therapeutic experience. Further research is needed on how therapeutic interventions and approaches may need to better consider the effects of masculinity on the adolescent population. Making use of parents, teachers, coaches as well as proper training for mental health professionals may be a positive first step in creating a more approachable and responsive environment for adolescents struggling with depression.

### **Depression, Adolescence and the role of Counsellors**

Adolescence is an important period of life for practitioners to understand. Counsellors should understand how statistics regarding the prevalence of depression may affect one's judgement. Seeing depression as a global experience, rather than being a gender-specific phenomenon ensures that practitioners do not hold a bias, and that practitioners do not contribute to the potential under diagnosis of depression among boys.

Chapters 1 and 2 of this thesis discussed how depression affects the adolescent population, and how to engage with this group of clients in order to foster a positive therapeutic alliance. Ensuring that practitioners assess alliance and gain client-driven feedback on alliance can help to promote a strong therapeutic alliance. Including parents when possible can also allow for a strong therapeutic bond to be created.

Once a strong therapeutic alliance has been established, choosing strategies and therapeutic modalities that are effective with the adolescent population can help to enhance the overall outcome of therapy. Chapters 4 and 5 discussed how adolescent clients need age-specific strategies, as they are often not self-referred and are learning to

develop autonomy and to differentiate themselves from their parents. Understanding this critical developmental period, and using approaches that are adolescent specific such as Interpersonal Psychotherapy (Adolescent), Attachment-Based Family Therapy, Dialectical Behaviour Therapy or alternative approaches such as Art-Based Therapy and Wilderness Therapy can be useful modalities to consider when working with this population. Ensuring that confidentiality is kept is also a critical component of effective work with teens.

Chapter 5 aimed to ensure that counsellors do not perpetuate the pressures and expectations of society for individuals to dress or behave in gender-specific ways, and discussed how these expectations affect adolescents. Counsellors must provide clients with support, which means being knowledgeable of factors that may be contributing to the negative experiences of clients. Adolescent males are at a particular risk for suicidality, and working with these clients in a culturally respectful manner can help to promote a positive experience. Understanding that boys tend to have a higher rate of completed suicide, and knowing that these statistics increase with LGBT identifying and aboriginal males, can help counsellors to choose appropriate intervention strategies.

Together, these chapters provide a foundation for work with depression among adolescents, by providing an understanding of depression manifests, by providing a series of interventions, strategies, and approaches, as well as an understanding of factors such as gender, that may be important factors to consider for work within adolescent mental health.

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