An Exploration of Adolescent Mental Health, Clinical Care and the [Inevitable] Relationship with Parents

By

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Acknowledgements

I have been extremely fortunate to work and live on the unceded territory of the Coast Salish People, specifically my writing of this paper was written at my home located on Səlilwətaɬ (Tsleil-Waututh) land. The territory of the Sḵwx̱wú7mesh Úxwumixw (Squamish Nation) overlaps this area and I have had the great pleasure of working with young people from these various First Nation Communities. I am humbled to acknowledge my small, settler status on this land and the beautiful people who were here long, long years before me.

I would not have been able to complete this graduate program without the endless support of my husband, Andy. With four kids, full time jobs, a chronic health diagnosis and a new puppy we have completed this degree together! Thank you for giving me the gift of time. The two laptops have also been very sweet but truly, you haven't stopped giving for three years. I thank you and look forward to the next season together.

This capstone is given to any person who has walked alongside a struggling adolescent. For parents who have lost hope, I encourage you to give your child and yourself one more day, one more chance to see what happens. For the clinicians who work with adolescents and have given countless hours listening, problem solving and worrying, I encourage you to be brave and press on in the face of their complicated stories and heartbreak.

I deeply hope parent and clinician can find each other and share a camaraderie in caring.

Abstract

The aim of this work is to expose clinicians to the nuanced, sometimes complicated but always necessary relationship between adolescents and their parents. The field of counselling adolescents outside of their family context is a relatively new endeavour. While psychology was one of the first fields to identify and study the adolescent phase of development, today's practice of one-to-one counselling with adolescents does not have such history. The lack of robust research of methods and no clear, professional standards is concerning and has come under criticism. Adolescents are considered a unique and vulnerable profession that are in need of recognition and protection when entering into a therapeutic alliance. A review of the literature will demonstrate the need for adolescents to be treated within in the context of their developmental phase and family relationships. The parent-adolescent relationship is examined, three perspectives are shared, and an investigation of expanding therapeutic alliance to include families is explored. Furthermore, there is specific review of the impact of adolescent depression and suicidal thoughts in relational context of parents and clinicians. Implications for minority adolescent groups and absent parents is addressed. This Capstone Project includes a created video that addresses for counselling clinicians or other youth working professionals, the material in this paper. The goal is to provide foundational ideas for discussion and learning in order to bring about innovative movement towards tri-directional alliance between adolescents, their parent(s) and the clinician.

Keywords: adolescents, counselling in context, expanded therapeutic alliance

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Chapter 1: Introduction

This capstone paper will highlight an overlooked area of professional understanding in the field of youth services: parent and guardian influence on adolescent mental health.

Purpose of the Paper and Research Questions

How can a therapist promote, protect, and sustain the family life of an adolescent and why would they want to? This study will deepen an understanding of therapeutic rapport between adolescent clients, their parent(s), and their counsellors with potential strategies to build a working alliance with all stakeholders. We will explore the benefits and limitations of therapy with adolescents with or without parental involvement to support this intent by answering the following questions:

1. What are the pros and cons of parental involvement in an adolescent's therapeutic journey?
2. What is the standard of care when working with adolescents, and what ethical considerations should be addressed?
3. How can professionals honour an adolescent's developmental needs for both autonomy and security?
4. How does therapeutic rapport with family stakeholders affect outcomes for adolescents in therapy?

Reflection and Self-Positioning Statement

I approach this subject with a great deal of personal and professional experience. I am informed and invested in the subject matter as a long-time youth worker in different contexts, a parent of teenagers, and a friend to parents of teenagers.

As a professional working with youth in various contexts and with multiple colleagues, I have experienced an attitude of reluctance and suspicion regarding parental engagement. Over 15 years ago, before I had children, I remember a situation where an older man came into the youth centre where I worked. The man was troubled, looking for his daughter. He told us she

had not been home for several days and he hoped he could find her or leave a note for her with us. Although my colleague listened to the father's story, he quickly deflected the request for information or connection to the daughter. The father was ushered out of the centre with an assertive statement about privacy and the age limits on offered services. I discovered afterward that there was no such policy in place. Rather, my colleague had strong feelings about parents being permitted in the centre and was concerned that the daughter might be hiding from an abusive family. This was an assumption, and though I expressed my frustration and confusion at his attitude, this was not the last time I encountered such dismissal of parental involvement.

The family relational context of youth is rarely considered by workers on the front line of youth services. With experience as a youth worker in a non-profit agency, a specialized support worker for at-risk adolescents in the education system, a novice counsellor in a private clinical setting, and a parent of three teenagers, I have struggled to understand the vague reluctance of professionals to include parents or guardians in discourse over their adolescent's problems. And on the other hand, I have observed reluctance to engage with adolescents regarding their family relationships. I often have the sense that the adolescent is treated in a "bubble", separate from the relational systems, influences, and the current happenings of their household. Placing the youth in this imaginary bubble is often described as protecting an adolescent's "privacy" or "confidentiality," but I suspect there is another underlying motive: to avoid the mistrust and chaos that often accompanies family involvement.

As a parent, I have been in and out of clinicians' offices attempting to find support for my distressed teenage daughter. Over the course of two years, my daughter received repeated services with no effort for continued treatment, a long-term safety plan, or connection to her lived experience in her home. Doctors, social workers, ministry counsellors, youth workers, and public health nurses expected my daughter was "safe enough" at home each time she left their care, only to have her re-emerge days later in a distressed state. I had a number of these professionals admit they had assumed our home life was distressing. Upon meeting my husband

and I, they discovered their assumptions were wrong. One emergency doctor's statement, "I should have spoken with you before I discharged her, I did not realize you were here with her," sums up my experience as a parent to a mentally distressed teenager. Professionals provided help but then clocked out of their shifts, while I was still "on duty" as a parent providing support: waiting up at night, taking phone calls from police officers, paying for counselling sessions, driving her to the emergency room, looking for her in bus depots, and talking to the school guidance counsellor. The problem was that the professionals were satisfied to help my daughter without fully understanding her life and family context. Without continuity and a complete picture of my daughter's situation, these support services made little impact.

My daughter's struggles in young adolescence were not a surprise to me as I was prepared to deal with some challenges during these years, but the necessity for outside support was a blow to my confidence as a parent and highly frustrating. I needed guidance, information, safety, and support from the other adults in her life but I struggled to understand the system I was part of. I felt like a desperate outsider, and rarely felt seen or supported by the professionals working diligently to help her.

Eventually, one of my daughter's counsellors insisted that my husband and I attend the sessions together with our daughter. I discovered later what it meant in the counsellor's bio that she practiced with an "attachment lens". We were now officially in this struggle together with our daughter. We were no longer searching for a common language or solving disparate problems. Instead, this professional practiced a team approach with a daughter and her parents. My struggles with fear, inadequacy, and confusion were addressed in an open dialogue after my daughter's complex problems were voiced. I was no longer adrift as an outsider to her distress, but I, along with my husband, became a tangible support. With effort, we experienced first-hand the life-saving benefits of attachment theory. We learned that where there is an improvement in pa-

rental warmth, communication and connection, there will be a parallel improvement in adolescent perspective, social relationships, and mood (Vieno et al., 2009, Withers, 2016). Although I had not set out to be included in her therapeutic journey, nor could I have imagined how to do so, the attachment-based approach improved our connection. The slow and painful process improved my daughter's sense of security and transformed my understanding of parenting.

Being on the receiving end of supportive services for my daughter was a turning point in my understanding of a parent's experience of their adolescent's therapeutic journey. Now I look at this period as a great gift, both for our family and my internal evolution as a secure adult and future counsellor.

Given some of my background experience described above, I have some obvious bias:

1. I believe all adolescents should be treated with special consideration of their unique family relational context at their developmental stage. A reluctance to acknowledge the position and needs of adolescents can lead to further isolation and prolonged distress for both adolescents and their families.
2. I believe that many helping professionals tend to villainize parents and leave them out of critical junctions in an adolescent's life. Whether this exclusion is made intentionally or not, the resulting (or continued) rupture in the family life of a teenager can cause further insecurity in their support system.

These biases will be addressed in chapter two when I conduct a literature review. In this chapter, I will confront and compare my experience with peer-reviewed research.

I further acknowledge that my agency and a system of privilege contributed to my ability to engage with my daughter's journey. I am a white, able-bodied, cisgender heterosexual woman. I have been partnered for 25 years. I am a mother to two biological children and two daughters adopted and born in Thailand. I am middle-class. I practice spiritual disciplines and belong to a community of faith I find comfort in. I have been employed for all my adult life and was able to take long parental leaves for each child.

Significance of the Capstone: A Vulnerable Population

The status of being a minor in Canada, and specifically in British Columbia until the age of 19, is enacted through laws and guidelines that regulate various activities from using marijuana, watching movies, travelling outside the country, getting a tattoo, participating in sexual activity or being able to vote. Adolescents are a distinct group categorized as minors, and they, like children, are a vulnerable population that need specialized consideration especially when it comes to professional helping services. The relational reality of an adolescent's dependency on family relationships in combination with the need to experience autonomy make for a complex stage of development. If Canadian society has recognized adolescents as a unique age group requiring protection, clinicians have a responsibility to ensure a professional standard when working with them.

It is essential to acknowledge potential areas of vulnerability in the adolescent population.

Epic Biopsychosocial Developmental Phase

The first consideration is the significant physiological development of emotional, cognitive, and social growth in adolescence. The intense cognitive developments of adolescence contribute to an ever shifting and rapidly expanding concept of self. Self-criticism, changes in mood, and interpersonal conflicts can lead to an intense emotional vulnerability (Klingle & VanVliet, 2019; Siegal, 2013). Adolescents are shifting from concrete thinking to abstract thinking, and so beginning the challenging process of self-reflection (Klingle & VanVliet, 2019). Initially, self-reflection is accompanied by criticism and confusion (Klingle & Vanvliet, 2019). An understanding of self-reflection in adolescence as an underdeveloped skill should lead clinicians to use developmentally appropriate inquiry and supportive language. When developing therapeutic rapport with a young person, it is essential that a clinician understand that rapidly changing perspectives and moods can impact decision-making, emotional regulation, and self-evaluation (Klingle & VanVliet, 2019). Counselling an adolescent is not the same as counselling an adult

(Housby et al., 2021). Ongoing physiological developments greatly impact adolescent perceptions of stress and relational difficulties and can complicate their experience of the change process (Housby et al., 2021; Klingle & Van Vliet, 2019).

Unique Engagement with the Therapeutic Process

The second consideration is the typical adolescent engagement with the therapeutic process. Research reveals that adolescents engage in therapy differently than adults (Becker et al., 2018; Radovic, 2015). For example, youth engage in therapeutic relationships for a short duration and must often overcome multiple barriers to get there (DiCroce et al., 2015; Kelleher & Hoagwood, 2017; O'Keefe et al., 2020). In fact, youth and their families do not access mental health services in congruence with the reported need (Becker et al., 2018). This discrepancy is due to many complex factors, some unique only to the adolescent population (Becker et al., 2018). The reality that poor engagement results in poor treatment outcomes is well demonstrated (Andriessen et al., 2021; Becker et al., 2018). O'Keefe's research (2019, 2020) confirms that many adolescents drop out of treatment without formally withdrawing and view mental health support as a temporary, flexible support service. This way of accessing therapeutic support adds to the youth's potential vulnerability (DiCroce et al., 2015). Furthermore, a youth's non-traditional way of accessing counselling underscores the great need for a complete understanding of relational and community supports outside the office (Becker et al., 2018).

It is essential to create meaningful, purposeful engagement strategies that meet the unique needs of the adolescent population (Andriessen et al., 2021; Sibley et al., 2022). Using the family as a potential intervention for engagement can be helpful (Sibley et al., 2016). Partnering alongside the current family relationships will serve the youth and the counsellor in promoting consistency in attending sessions and collaboration in engagement with therapeutic material (Stige et al., 2021). Conversely, understanding possible family dysfunction will aid the counsellor in engaging the youth's consistent attendance and, importantly, continuation of support outside of the office (DiCroce et al., 2015, Sibley et al., 2022). Although greater discussion

around a unique approach for this population's engagement is needed, this paper will specifically address using the family as an aid in engagement and therapeutic intervention. Further research and creative initiatives are needed to support engagement with the adolescent population (Becker et al., 2018).

Power and Privilege of Adult Counsellor

The third consideration is acknowledging the power differential between an adult clinician and an adolescent. When any client enters a therapeutic alliance, there is an immediate power imbalance in that the client will expose their distress and problems, and the counsellor will not (Hart, 2022). This power imbalance can be compounded by other factors such as race or socioeconomic status (Hart, 2022). Deeper intersections of power happen between an adult clinician and a youth. Youth are used to being led, corrected, directed, and taught by adults. In a one-on-one conversation, youth may defer or hide certain aspects of their behaviour or opinion to please or placate an adult (Stige et al., 2021). Studies tell us that youth feel anxiety in a therapeutic session that includes feelings of responsibility for the conversation, not knowing the correct answers, or misunderstanding the therapist's words (O'Keeffe et al., 2019). Therefore, an adult clinician's responsibility is to share power with the youth while not expecting them to lead the therapeutic process. This is an essential balance to strive for as it can lead to a better chance for authentic therapeutic engagement from the teenager (Gibson et al., 2016; Housby et al., 2021). Reducing the use of overly technical language, creating an invitational environment, giving a choice over treatment plans, and ensuring a safe space for feedback discussion can promote a more balanced alliance (Hart, 2022).

Counsellors must create boundaries that are both recognized and retained. Boundary violations harm adolescent clients and have the potential to create confusing situations to repair (Hart, 2022). Striving to be professional and non-judgmental are ways to acknowledge and share power with adolescents within the therapeutic alliance (Gibson et al., 2016, Hart, 2022).

The British Columbia Association of Clinical Counsellors (BCACC, 2014) has a guiding principle of *Responsible Caring* which asserts that clinicians should limit their practice to areas of competence in which they have gained proficiency. This paper will provide a relational, contextual view of the adolescence. The principle of Responsible Caring suggests that counsellors consider their competency before beginning treatment with adolescents and ensure they are informed about this biopsychosocial developmental stage.

Outline and Remainder of the Paper

This research project will explore:

1. The impact of family involvement at any level in adolescent therapy. An examination of the barriers to a therapeutic alliance with the parents of adolescents will include a brief study of common impairments in parent-youth relationships.
2. The perspectives of the three stakeholders in an adolescent's mental well-being: adolescent, therapist, and parent(s).
3. Fundamental ideas for engaging parents as partners in the therapeutic alliance. This will include assessment ideas and the importance of collecting feedback.
4. Important considerations for adolescents whose parents are unable to be engaged or give support to the therapeutic process. Special consideration of youth minority groups will be discussed.

Chapter three will be formatted into a video that is accessible using YouTube. A summary script and handout will be provided to accompany the listener. The video will provide suggestions for best practices when working with adolescents and their parents. The conversation is centred around the unique relationship each adolescent has with their parent and how this translates into a flexible, individual, and creative approach for each client (Lambkin, 2022).

Definition of Terms

Adolescence - this bridge of time between childhood and adulthood is generally seen as starting with the beginning of puberty to the assumption of an adult role in society, usually between the ages of 10–24 (Diamond et al., 2014).

Biopsychosocial - refers to the interconnection between biology, psychology, and the socio-environmental influences at play in an adolescent's developmental stage (Cicchetti, 2018).

Clinician - the term used in this paper for a health practitioner responsible for and working directly with clients or patients.

Countertransference (CT) - refers broadly to the reactions clinicians have to their clients.

Expanded therapeutic alliance - a term used to indicate the bond between therapist, client and others who participate in the therapy to create a positive collaborative connection (Benetiz et al., 2020).

Growing autonomy - this term refers to an evolution that occurs over a lifespan in an individual's ability to think, feel, make decisions and act independently (Baltes & Silverberg,1994).

Healthy autonomy - refers to a state in which an individual has capacity for both independence and exploration with emotional support (Baltes & Silverberg,1994).

Primary Care Providers (PCPs) - health care practitioners who *first* see individuals needing health care; this includes nurses, physicians or counsellors.

Tri-directional relationship - describes the relationship between three parties. In this paper, tri-directional refers to an adolescent, their parent(s), and their counsellor (Karver et al.,2019).

Chapter 2: Literature Review

Adolescents visit mental health clinicians for a wide range of issues and presenting problems. Research on the effectiveness of therapeutic care for adults is plentiful, as is research for therapy with children. However, adolescent-specific research is not as common.

The following review will discuss the research around parental involvement in adolescent therapeutic care. With this theme in view, I have avoided focusing on one specific modality or intervention, preferring to gather literature from various specialties.

Parents as Barriers

Theories about the stage of adolescence first began in the field of psychology, starting with the work of G. Stanley Hall (1824-1924) (Britannica, 2022; Hanley et al., 2012;). Hall studied the evolution of developmental stages in childhood, adolescence, and the elderly (Britannica, 2022; Parry, 2006). He was a primary founder of psychology as a profession and, in 1878, was awarded the first psychology Ph.D. in the United States (Parry, 2006). Hall also founded the American Journal of Psychology in 1887, which remains a significant, respected journal of psychological research worldwide (Britannica, 2022). Hall's notion of the *Storm and Stress* of adolescence has persisted into common vernacular and remains a foundational principle in the fields of sporting and education (Hanley et al., 2012). Developmental psychology and the process of its evolution in the stage of adolescence has its origins in G. Stanley Hall and continues to impact today the study and application of youth-specialized psychology today (Britannica, 2022).

Although some of Hall's ideas have been assessed as outdated and discredited in adolescent behaviour, there remains an invaluable amount of wisdom in his over 400 published works (Hanley, 2012; State University, 2022).

Over the past 50 years, since Hall's ground-breaking work, over 500 psychosocial treatments for youth have been developed (Okamura et al., 2020). Despite this explosion of interest

and study, there are few unifying protocols for therapy with adolescents across therapeutic modalities (Okamura et al., 2020). There is also uncertainty around the effectiveness of therapy for adolescents (Weisz et al., 2017). Nevertheless, counselling remains the number one most recommended service for young people with distressing behaviours or emotions (Okamura et al., 2020, Weisz et al., 2017).

The relationship between adolescent-specific therapy and parents is complicated. Since the early 1920s, parents have been observed, judged, and therapized concerning their children's presenting problems (Hoque, 2021; Novick & Novick, 2011, 2021). Hall's *Storm and Stress* theory, published in 1904, posits that biological changes create an adolescent's need for independence from parents and authority figures, which in turn causes conflicts (Hoque, 2021). The need for independence is viewed as an inevitable disturbance in adolescents' relationships with their parents (Hoque, 2021). Consequently, negative behaviours, conflicts in the home, and mental health problems have long been blamed on parents and their interaction with the biological changes of their young person (Cohen-Filipic, 2013). Mothers have taken the brunt of the unhelpful and pathologizing labels of psychoanalysis (Brafman, 2018; Cohen-Filipic, 2013). Until the late 1970s, researchers have implicated mothers or outright blamed them for various disorders including hyperactivity, extreme mood swings, sociopathy and even autism (Cohen-Filipic, 2013).

Early psychotherapists disagreed and debated as to whether work with children required work with parents (Brafman, 2018). Some believed it was unavoidable and essential, while others felt autonomy and individuation were to be prized and used as a sole method of treatment (Novick & Novick, 2005; Cohen-Filipic, 2013). Fortunately, the tide of professional opinion and a demand for more robust research has shifted psychology's view on the parent. Today, the difficulties inherent in the parenting role are more readily acknowledged (Cohen-Filipic, 2013). Further, psychotherapists now generally agree that parents have a powerful influence on the psychological state of their children and adolescents and can be respectful, helpful partners in the

therapeutic process (Schlim et al., 2021; Sheridan et al., 2010). However, how to approach the parent-child relationship was, and remains, under scrutiny (Brafman, 2018; Brown, 2018, Sheridan et al., 2010). Clinicians express a sense of hesitancy and uncertainty to include parents in the treatment plans of mental health support for their young people (Cohen-Filipic, 2013; Reardon et al.,2017).

Parents are recognized as both essential and a nuisance to the therapeutic process and clinical interventions (Radovic, 2015; Reardon et al., 2017). Parents who report poor alliance with their adolescent's therapist are suspicious and uncertain of the structure of the care (Fredman, 2019; Sheridan et al.,2010). Conversely, parents who experience a good rapport with their adolescent's therapist will support and maintain that therapeutic relationship (Gergov et al., 2021; Golden, 2009). When a parent or caregiver is reluctant about therapy for their adolescent, it is unlikely that the adolescent will be able to access continuous clinical care (Fredman, 2019, Blake, 2011). Parents are certainly able to sabotage or support the therapeutic process (Golden, 2009). This dynamic has caused parents to be labelled as the "key gatekeepers" to accessing mental health support for their children and young adolescents (Reardon et al., 2017, Schnyder et al.,2020).

Both parties, adolescent, and parent, are stakeholders in an adolescent's mental health and well-being, but usually, only the adolescent is identified as the primary client (Brown et al., 2018; Schnyder et al., 2020). Young people are almost always referred to counselling by an adult, and often that adult is a family member or parent (Karver et al., 2019; Mathias et al., 2021; Sheridan et al., 2010). Families may present their young people as "the problem" to the therapist which can present problematic relationships and expectations between the therapist and the parents. Presenting young people as the problem to be fixed may indicate that parents have removed themselves from involvement in the therapeutic process (Novick & Novick, 2011, Stige et al., 2021). However, some young people agree to and initiate therapy on their own initiative (Mathias et al., 2021). In light of these various scenarios, the discovery of who or whom

the primary client is will require assessment and clarity in the initial meetings (Cohen-Filipic, 2013). The initial motivation to access mental health support will differ across the family group, but the therapeutic relationship begins here. This alliance has been described as “tri-directional” with a parent(s), a youth, and a therapist (Karver et al., 2019).

Impairments in Youth-Parent Relationship

The relationship between adolescents and their parents carries significant weight. There is evidence to support that family and parent dynamics directly contribute to young people’s stability and vulnerability to mental health problems (Brown et al., 2018, Schynder et al.,2020). Furthermore, adolescent distress is tied to the quality of relationship they have with their parent or caregiver (CINI, Wolicki et al., 2021). A parent’s contribution to the state of adolescent mental health cannot be understated.

Most adolescents seeking support from clinicians report a poor-quality relationship with a parent (Sheridan et al., 2010; Withers et al., 2016). This dynamic presents a unique challenge for clinicians who seek to treat the adolescent in a relational and developmental context (Sheridan et al., 2010).

The spectrum of a parent’s ability to manage parental duties and relational capabilities varies widely. The strain of new relational territory in the adolescent stage can leave parents feeling confused, out of control and angry (Sheridan et al., 2010). Furthermore, poor mental health amongst parents is associated with poor mental health in young people (Wolicki et al., 2021).

The following section will review barriers to good quality relationships between adolescents and their parents. I have included suggestions for recognizing and addressing each one. This is not an exhaustive list of potential barriers but providers the reader with an overview of common, perhaps obvious, problem areas. Parenting behaviours can contribute to adolescent

distress through multiple avenues (Golden, 2009). Assessing the quality of the parent-youth relationship will support the basis for a case conceptualization and treatment recommendations (Karver et al., 2018).

Chronic Arguments and Conflict

Poor communication results in less parental support, coaching and warm interactions (Barone et al., 2021; Withers et al., 2016). Adolescents who report poor communication with their parents have more externalizing behaviours such as aggression, social withdrawal, and criminal activities (Withers et al., 2016). Teenagers with depression and anxiety usually report families with high levels of verbal conflict (Withers et al., 2016).

Interestingly, there is evidence that adolescents and their parents experience conflictual communication on different timescales, meaning that processing language and meaning happens at different times throughout a day (LoBraico et al., 2020). Providing this information may help adolescents and their parents to improve perceptions of arguments and ongoing confusion surrounding conflict.

Misunderstanding of Inevitable Developmental Changes

Parents may experience their adolescent's need for autonomy as a rejection of the relationship, family values or the parent themselves (Barone et al., 2021). Parents often feel confused about their new role as caregivers to a rapidly changing teenager who needs both support and freedom. As a result, parents may become aggressive and controlling or, in contrast, emotionally distant and uninvolved (Barone et al., 2021). Both outcomes produce adverse effects for adolescents. Parenting during this period requires a nuanced and negotiated balance (Baltes & Silverberg, 1994). A posture of extreme control or emotional distance can disrupt the healthy development of autonomy. Conversely, youth who have remained in connected and supportive relationships with their parent(s) show improved competence in managing the myriad of complex developmental tasks of this stage (Baltes & Silverberg, 1994; Diamond et al., 2014).

It could very well be that a lack of understanding of the adolescent's developmental stage is the root of many conflicts between teenagers and their parents (Diamond et al., 2014).

Insecurity or Fear in Parenting

Parents who are unable to regulate their own difficult emotions have trouble cultivating quality connectedness in the family (Benetez et al., 2020). Parents who report high levels of sadness or anger often have adolescents who experience similar emotions as well as increased risk of an early diagnosis of major depressive disorder (Benitez et al., 2020; Schwartz et al., 2018, MDD). When parents are plagued with low confidence, fear, or insecurity in their parenting role, they can become paralyzed in their reactions to and interactions with their teenagers (Schwartz et al., 2018). Skill training in self-regulation practices in family groups has been proven to be a protective factor for adolescents (LoBraico et al., 2020).

Unknowing Transfer of Emotional Distress

Studies reveal that shame and anger can be inherited and shared in a family system (LoBraico et al., 2020). Adolescents pick up parents' anxiety, depression, and anger (Butterfield et al., 2021, LoBraico et al., 2020). Not only does the teenager absorb parental emotions, but parents also take in their young person’s feelings. In families, the transmission of emotions occurs organically from parent to child, but the direction of transmission has the potential to change in adolescence (Butterfield et al., 2021). Due to a shifting hierarchy or adjustment in parenting boundaries, bidirectional transference of emotions happens more frequently (LoBraico et al., 2020). A pattern of back-and-forth passing of emotions can cause frustration, making families feel stuck in an endless web of confusion (Benitiez et al., 2020). Adolescent difficulties and dysregulated emotions can compromise parenting abilities and overwhelm even the most well-resourced parent (Fredman, 2019).

The receptivity of both parties to emotional exchanges can be recognized and used as an opportunity for connection rather than contributing to an ongoing conflict with no conclusions (LoBraico et al., 2020). Indeed, the permeable nature of this reciprocal sharing relationship can

either deepen stress or lead to increased hope and resilience (Benetiz et al.,2020, LoBraico et al.,2020).

Mental Pathology of a Parent

A parent's mental health must be considered when assessing an adolescent client's mental health (Cicchetti, 2018). Adolescents with poor mental health are eight times as likely to have a caregiver with poor mental health (Wolicki et al., 2021). Young people whose parents experience personality and mood disorders are at an increased risk for experiencing emotional and social difficulties (Wolicki et al., 2021). The externalized behaviours of parents can create young people who are overwhelmed and victims of their parents 'bullying behaviours (Cicchetti, 2018, Novick & Novick, 2011). If left untreated, parents may become isolated, resulting in further isolation of their children from social support (Wolicki et al., 2021).

Early intervention in an adolescent's life can "reduce or eliminate" the emergence of psychopathology (Cicchetti, 2018, p.38). Developmental science understands mental disorders as resulting from both biological and psychosocial influences. Developmental scientists urge us to consider the emergence of mental disorders as a multifaceted experience in the developing brain (Cicchetti, 2018). Psychosocial and neurobiological factors converge throughout a person's life, making the development of a mental illness transactional and biological (Cicchetti, 2018). Therefore, deliberate psychosocial interventions can alter physiological structures and mediate evolving dysfunctions (Cicchetti, 2018). Therapeutic work becomes preventative and life-saving in this situation.

The adolescent-parent relationship is filled with complex and unique challenges. Assessing the quality of the relationship and analyzing a parent's influence is an essential assessment task to work effectively with adolescents.

Therapists have a distinct role to play as they navigate the adolescent-parent relationship. A new alliance will be forming. The relationship of three has unique perspectives and feedback on the therapeutic process.

Perspectives on Therapeutic Process and Alliance

Adolescent Perspective

After the age of 12, young people are often offered more choices and opportunities for independence. This independence can be reflected in the degree of influence or involvement a parent is given in their young person's commitment to and engagement in therapy (Fredman, 2019). For example, parents may be offered very little involvement when mental health support is provided in public community centres or agencies as a drop-in service (Matthias et al., 2021). In contrast, in an emergency room or private practice, a parent is most likely involved at the outset (Government of Canada, 2017; Welmers-van de Poll et al., 2017). Although there is growing evidence that adolescents and parents tend to agree on the need for counselling, adolescent clients generally attend therapy because an adult believes they have a problem (Karver et al., 2019; Schnyder et al., 2019). Adolescents who do not get to choose or initiate mental health support are more likely to be resistant and less motivated to engage in the therapeutic process (Karver et al., 2019).

Whatever setting an adolescent finds themselves in, receiving therapeutic support may be their first experience of moving into a reciprocal relationship with an adult other than a parent. There is growing research around specific adolescent feedback to therapeutic experiences. A unifying theme for young people is the value of the unique relationship with their counsellor and how it is separate from the rest of their lives (Cook & Monk, 2020). This reflects the psychosocial development of an adolescent who is growing in autonomy (Cook & Monk, 2020; Lava et al., 2019). A sense of independence in visiting a counsellor can create novel feelings of self-determination and empowerment.

Adolescents have numerous fears and barriers to engaging with mental health support, including being evaluated as an "attention seeker," receiving negative feedback, being associated with negative stigma, or worrying about confidentiality breaches (Curtis et al., 2018; Gibson et al., 2016). These fears can become significant barriers to engaging in therapeutic support

(Curtis et al., 2018). As well, a large majority of adolescents report a disinterest and low desire to engage in therapeutic support (Sibley et al., 2022).

Conversely, through interviews with adolescents, researchers have identified many practical values that can support adolescent therapeutic engagement (Fredman, 2019; Gibson et al., 2016). This section will highlight some findings on adolescent perspectives of the therapeutic alliance and ideas regarding the implications on their lived relationships with family.

Speaking Freely Without Repercussions. More critical than getting tips for problem-solving or accomplishing other therapeutic tasks, adolescents value the ability to speak freely (Gibson & Cartwright, 2013; Gibson et al., 2016). Being able to talk openly makes the therapeutic space safe to explore without judgement or repercussions (Housby et al., 2021). In a way that is distinct from conversations with a parent, an adolescent in therapy appreciates the sense that an adult hears their feelings, opinions and emotions without interruption, advice-giving, or corrective measures (Gergov et al., 2021; Gibson et al., 2016). Adolescents report that being taken seriously while sharing vulnerable emotions increases their likelihood of returning to the counsellor's office (Bury et al., 2007; Gibson et al., 2016). From the adolescent's perspective, shared responsibility, and decision-making for the treatment plan is a significant marker of a good quality therapeutic alliance (Gergov et al., 2021; O'Keefe et al., 2020)

Sharing Power. An adolescent's desire for collaboration highlights the unique need for shared power with the therapist (Gibson et al., 2016). The developmental task of gaining independence creates a sensitivity to hierarchy and power imbalances and therefore, shared concern and mutuality in conversation are of utmost importance (Gibson et al., 2016; Stige et al., 2021). A positive therapeutic relationship is considered more like an adolescent-adult friendship in that the therapist is willing to let the adolescent get to know them as a person (Housby et al., 2021; Stige et al., 2021). Reciprocal and genuine sharing balances the relationship and assures the young person a degree of influence over the therapeutic process (Cook & Monk, 2020; Stige et al., 2021). Interestingly, self-disclosure of the therapist is helpful for the therapeutic alliance,

though it should be balanced (Cook & Monk, 2020). Counsellors should practice caution, as youth do report feelings of anxiety or strained expectation when counsellors share more than what was expected (Cook & Monk, 2020; Stige et al., 2021). Sharing power by sharing oneself appears to be a sensitive yet powerful contribution to the therapeutic relationship.

Collaboration and Sharing Feedback. To create a non-judgmental space for adolescent clients to reflect on their experiences, it is recommended that therapists ask for feedback directly regarding the alliance (Gergoc et al., 2021; Stige et al.,2021). Giving feedback supports the adolescent as the "central informant for their treatment" (Gergov et al., 2021, p. 3). Although giving feedback can be difficult for an adolescent, modelling receptive communication is invaluable, as it offers an excellent skill for young people to have when advocating in conversation with parents or other adults (Cook & Monk, 2020, Stige et al., 2021). Inviting an adolescent's participation in the therapeutic relationship should be done early on. For example, a counsellor may model how to set the agenda for time together, abide by it and eventually allow the youth to set the agenda with their own hopes and feelings (Cook & Monk, 2020; Housby et al., 2021). Including specific time for the adolescent to offer feedback engagement on the agenda can further deepen ownership and collaboration (Cook & Monk, 2020).

Adolescents highly value collaborative and open communication, which is experienced as autonomy and trust (Fredman, 2019; Housby et al., 2021). The sense of exploring and discovering issues together with their therapist can create a meaningful experience that young people ultimately identify as helpful and successful to their therapeutic process (Housby et al., 2021). Conversely, when therapists assume an "expert" position, adolescent clients report feeling insecure, awkward, uncertain, and frustrated (Housby et al., 2021).

Contained, Purposeful Dialogue. Time-constrained conversations with counsellors are productive and relieving for adolescent participants (Cook & Monk, 2020). This can be opposed to conversations between parents and youth which are often ongoing and undirected, and cause more profound frustration. Many problems of a circular or unsolvable nature might feel

never-ending when families live together (Cook & Monk, 2020; LoBraico et al., 2019). The sense that the presence of the therapist enables a predictable give-and-take conversation has been described by an adolescent as a “contained” experience that encourages safe exploration (Housby et al., 2021, p. 13).

Addressing Privacy and Ruptures. Adolescents are concerned about what information will be shared with their parents and will restrict themselves in conversations if they feel uncertain about confidentiality with a counsellor (Gibson et al., 2016, Hawkes, 2015). If a young person believes that their parents and the therapist have been joining forces without their knowledge, they immediately erect a barrier (Fredman, 2019). Adolescents want to be confident that what they discussed with their clinician is private (Gibson et al., 2016). When young people are sure about what will be discussed with parents and what will be kept confidential, they report a sense of hope for their future well-being and safety (Karver et al., 2018; Schlim et al., 2021).

Open communication between an adolescent and their therapist regarding out-of-session discussions with parents is necessary (Cook & Monk, 2020; Goldstein, 2020). Clinicians must be aware of the possibility of triangulation and broken trust when conversations occur outside of sessions (Curtis et al., 2018, Housby et al., 2021). Ruptures of a minor nature or a more obvious rift can be a significant cause of dropout and disengagement amongst adolescents (Goldstein, 2020). However, ruptures caused by insecurity regarding confidentiality can be avoided (O’Keefe, 2020; Schnyder et al., 2019). During initial meetings with adolescent clients and parents, the tri-directional dynamic of the relationship should be acknowledged (Karver et al., 2018; O’Keefe, 2020). Ensuring adolescent clients understand confidentiality and discussing its limits can promote open communication rather than uncertainty or a hesitancy to share (Hawkes, 2015; Stige et al., 2021). It demonstrates to the adolescent that they are safe in the partnership and capable of understanding expectations and regulations around confidentiality and accountability in the professional clinical arena (Gibson et al., 2016; Housby, 2021).

Between Peers and Parents. It is evident to adolescents that parents and peers function differently for various benefits (Lavik et al., 2019). Dependence on parents becomes more selective as adolescents practice more autonomous thought processes, decision-making and social interactions (Baltes & Silverberg,1994). Peer relationships give adolescents social warmth that is a protective factor against loneliness and isolation (Lavik et al., 2019). Reaching out to peers in times of emotional distress can be difficult for an adolescent initially. However, once a safe friendship is established, there is a tremendous benefit for improvement in mental health (Lavik et al., 2019). Whereas parental relationships provide a sense of safety during tumultuous challenges, establishing close peer relationships is important for belonging and connectedness (Blake, 2011; Lavik et al., 2019). In situations of school absenteeism, depression or suicidality, conversations with parents and clinicians give adolescents a sense of security and groundedness (Blake, 2011; Lavik et al.,2019). While adolescents rely on their peers for social or short-term concerns such as clothing or music choices, distressing or long-term concern decisions are still brought to parent(s) for consultation (Baltes & Silverberg,1994).

Social connection to peers and family are of equal importance and central to an adolescent's maturity (Baltes & Silverberg, 1994). Although a youth may feel that their choice to get support is an "either or" situation, counsellors can highlight the different yet important roles of all relationships. Peer social networks and a sense of belonging to the family can co-exist without confusion or frustration (Lavik et al., 2019). Interviews affirm that youth recognize this in their own experience but need support to identify the fluctuating roles of various connections (Baltes & Silverberg, 1994; Lavik et al., 2019)

Therapists Can Handle It. Adolescents want to trust their counsellor with the weight of their problems without being concerned for the counsellor's mental well-being (Dunne & Parker, 2020). Confidence in the clinician's ability to protect and support the adolescent's therapeutic process, goals, and information is highly important to young people (Dunne & Parker, 2020;

Housby et al., 2021). This may stand in opposition to what a youth feels about their parental relationship. At home, a young person might strive to please their parent or withhold information to meet the parent's expectations of them (Cook & Monk, 2020). A therapeutic relationship must be relationally connected but also professional and boundaried (Cook & Monk, 2020, Housby et al.,2021). Therapists must demonstrate that they "can handle" frightening or big emotions, whereas a parent may be perceived as unable or ill-equipped to do so (Cook & Monk, 2020; Gibson et al., 2016).

Maturation and Evolution of Self. Adolescents appreciate that counsellors are getting to know them as the updated version of themselves they are experiencing. The adult world can be experienced as disempowering by young people as they tend to be infantilized well into their young adult years (Lavik et al., 2019). When it comes to the parent-child relationship, parents relate to their young people with history and may not acknowledge the changes that are rapidly occurring (Cook & Monk, 2020). Being able to leave behind a childish image and express an evolving mindset is an exciting prospect in an adolescent's relationship with a counsellor (Cook & Monk, 2020).

An adolescent's evolving view of self can lead to greater confidence in problem-solving with other appropriate sources outside the parental relationship (Fredman, 2019). A desire to share thoughts and problems with an adult outside of the family's primary relationships indicates good attachment skills and evolving maturation in autonomy (Diamond et al., 2014; Stige et al.,2021).

Counsellor's Perspective

Adolescents report feeling both secure and uncertain about the alliance between counsellors, themselves, and their parents, and interestingly, clinicians feel the same uncertainty (Hawkes, 2015). The function of a therapeutic alliance with an adult in contrast to a therapeutic alliance with a youth shares some features but there are also important differences to be con-

sidered (Karever et al., 2018). The most obvious difference is developmental. Building a therapeutic alliance with an adolescent involves the presence of parental influence, attachment, and connection (Karver et al., 2018). Even in the context of individual therapy with an adolescent, these realities have serious implications for treatment (Karver et al., 2018). The common resolution to this problem of uncertainty appears to be communication between all parties initiated and led by the therapist. There is strong evidence that when a non-collaborative approach is taken, the therapeutic process will suffer (Housby et al.,2021; Novick & Novick, 2011). Therefore, before treatment begins an effort to forge a relationship with parents can outline to all stakeholders how collaboration benefits the youth and family structure (Mathias et al., 2021; Sheridan et al., 2010).

Regardless of intervention or modality, the quality of the therapeutic alliance is understood to give the best outcomes of therapy (Fredman, 2019; Karver et al., 2018; Welmers-van de Poll et al., 2017). Clinicians acknowledge this and recognize the essential benefits of the alliance for effective change (Cook & Monk, 2020; Schlimm et al.,2021). Adolescent-specific research agrees and confirms this to be true for young people as well: a positive therapeutic alliance consistently gives positive outcomes over and above any one modality (Dunne & Parker, 2021; Schlimm et al., 2021).

However, when considering how to build therapeutic rapport with a young person as a therapist, it is essential to acknowledge the parental presence that influences treatment planning and outcomes (Christogiorgos & Giannakopoulos, 2014; Spiro, 2021). In addition, research demonstrates that the quality of the parent-therapist relationship directly impacts outcomes for young adolescents (Cook & Monk, 2020). Both parents and therapists recognize the need for a robust therapeutic alliance, but a tri-directional alliance requires leadership and initiative, skills that may not have been deliberately developed in the clinician's skill set (Schlimm et al., 2021; Spiro, 2021). Unfortunately, there is little research on the "how-to" of fostering a positive working alliance with parents (Cohen-Filipic, 2013).

For a large thesis completed in 2019, Emily Fredman performed extensive research regarding therapists' perspectives on parental involvement when working with adolescents and children in therapy. Fredman (2019) titled a chapter “Contamination vs. Collaboration” to reflect the scope of terms used to describe the potential relationship and influence parents have on the therapeutic alliance. These terms are an apt description of a clinician’s perspective on the relationship with an adolescent client’s parents.

Although it is generally viewed as central to good practice, the scope of the partnership with parents of adolescents remains undefined and fluid (Dunne & Parker, 2021). Depending on a clinician’s perspective, working with the parents of an adolescent client can be viewed as an obligation or a partnership (Kelleher & Hoagwood, 2017; McQueen & Hobbes, 2014).

Reluctance. The historical influence of therapists who have blamed parents for a young person’s behavioural problems combined with the potential chaos of including multiple people in therapeutic work creates a significant challenge for therapists working with adolescents.

They are not alone in this experience. Radovic et al. (2015) showed that doctors, nurses and nursing assistants, primary care providers (PCPs), share this historical reluctance to engage parents in helping work. In this study, PCPs working in an extensive pediatric network in the United States shared their experiences of routine screening for depression in adolescents aged 15–17. Although PCPs felt parental engagement was necessary in an adolescent’s journey to access mental health care, connection and attention to parents was not likely to occur. Due to poor connection between professionals and parents, follow-up care was an impossible and frustrating challenge. PCPs could identify mental health difficulties in both adolescents and their parents but found continual barriers in communication and had no integrated process to address and support both parties. Parents were labelled as a contributing barrier to the full mental health resources the PCPs could offer young people. This dynamic resulted in poor adoles-

cent outcomes and a cyclical problem for the PCPs. It is important to note that local support services in Vancouver, BC, where this paper is being written, report similar barriers to care (Leon et al., 2013; Malla et al., 2018).

Countertransference. Therapeutic work with children and adolescents specifically can contribute to intense experiences of countertransference (CT) (Christogiorgos & Giannakopoulos, 2014). The reality is that it may be unavoidable for counsellors not to react to the conflicts their adolescent clients bring forward concerning their family relationships (Tishby & Wiseman, 2020). Client disclosure tends to trigger unresolved conflicts within the counsellor's history and relationships, and there is significant evidence of resulting CT (Tishby & Wiseman, 2014).

Researchers have theorized that the reluctance of therapists to engage with parents comes from "deep and intense countertransference" that stirs up feelings of defensiveness, childhood fears, and avoidance (Christogiorgos & Giannakopoulos, 2014; Novick & Novick, p.20, 2011). If a therapist unconsciously identifies themselves or their parents in the stories of their adolescent client, there can be a great danger in accommodating distressing behaviours (Tishby & Wiseman, 2020). If negative CT is left unaddressed, it is associated with more ruptures and less resolution in the therapeutic relationship (Tishby & Wiseman, 2020). A negative perception of a client's parents correlates to the therapist's ability to attune in a neutral, positive way (Tishby & Wiseman, 2020).

Additionally, therapists have identified an unintentional tendency to take on parental function and feelings that reflect a client's dysfunction or complaints in regards to their parents (Tishby & Wiseman, 2020). Research reveals that therapists react with complex "parental and protective" feelings toward their adolescent clients (Novick & Novik, 2021; Tishby & Wiseman, 2014). Preserving neutrality, recognizing triggers to countertransference, and resisting negative responses to parents may take a great deal of forethought and supervision (Christogiorgos & Giannakopoulos, 2014). CT should be expected, identified, and used to produce engagement

that is helpful for the client. It can be managed to minimize negative effects in sessions and potentially used for good within the therapeutic relationship (Tishby & Wiseman, 2014).

In the Middle. The potential for triangulation can cause clinicians to avoid connection with parents (Halder & Mahato, 2019). Counsellors report feeling as if they are "in the middle" between the adolescent and their parents (Hawkes, 2015). Establishing a trusting therapeutic alliance is difficult when it feels like the parent is attempting to influence the counsellor to value one voice over the other (Blake, 2011; Hawkes, 2015). In addition, parents will sometimes initiate conversations outside of their adolescent's sessions through phone calls or emails. These connections can feel like a breach of privacy and promote a sense of distrust in the alliance between therapist and youth.

Additionally, counsellors agree that parental expectations can be intimidating or misleading (Halder & Mahato, 2019; Hawkes, 2015). Some caregivers expect the counsellor to "fix their teenager" or to influence their adolescent to simply "get along at home" (Hawkes, 2015, p. 54). These unrealistic and rigid expectations create a sense of pressure and ultimately disappointment for all stakeholders (Hakes, 2015). Without the deliberate engagement of parental expectations, veiled comments made in passing can cloud the therapeutic work and an adolescent's goals.

Blaming, Bias and Power. Therapists report feelings of blaming parents for the young person's struggles (Cohen-Filipic, 2013; Radovic et al.,2015). Knowing that parents also have histories of attachment problems, trauma, conflicts, anxieties, and emotional distresses, which in turn affect the quality of their relationship with their young people, can be intimidating for a counsellor to tackle (Diamond et al., 2014; Novick & Novick, 2011). The therapist may feel a loyalty to their adolescent client that produces feelings of defensiveness or anger when interacting with parents (Radovic et al., 2015).

Clinicians feel the weight of the power imbalance in a relationship with the parents of their adolescent clients. Becoming conscious of this dynamic and making deliberate efforts for collaboration can be an extra strain (Hawkes, 2015; McQueen & Hobbs, 2014).

Parent Perspective

When a parent steps into the therapeutic process with their young person, rather than out of the therapeutic process altogether, mental health outcomes dramatically improve for the whole family (Benitiz, 2020; Brown, 2019). However, the barriers to enacting a collaborative therapeutic relationship are widespread (Karver et al., 2018). Primarily, the position of the parent(s) as caring for their adolescent with mental health difficulties is challenging and overwhelming (Bratt et al., 2019; Fredman, 2019). Parents struggle with feelings of inadequacy, guilt and frustration over not being able to support or help their young person (Bratt et al., 2019; Schlimm et al., 2021). Parenting through adolescence is tumultuous at any time; however, additional mental health problems are distressing to a greater degree (McQueen & Hobbs, 2014). Parents experience greater frustration, depression, and uncertainty than other parents with youth who are not struggling with distressing behaviours (Bratt et al., 2019). The intensity and seriousness of the situation in which parents find themselves as they deal with mentally distressed youth cannot be overstated. Parents can experience their young person's mental distress in various circumstances, from bullying to attempted suicides to newly diagnosed learning disabilities. Upsetting adolescent life events can create heartfelt anguish and uncertainty in the family system (Sheridan et al., 2010). One parent said this: "Because of the difficulty with our adolescent, our lives turned upside down, more than anything I had ever been through, and it spilled over into every area of our lives" (Sheridan et al., 2010, p. 149).

In the task of parenting teenagers, there is both familiarity and unfamiliarity for every parent. With previous experience as adolescent themselves, there is no blank slate as parents enter this stage with their children (Sheridan et al., 2010). A personal history of one's own adolescence is usually unresolved (Sheridan et al., 2010). There is tension as parents recall and relive

these years of watching their children experience similar situations and emotions. (Sheridan et al., 2010; Novick & Novick, 2011).

Transitioning from parenting a child to parenting an adolescent happens within a rapidly oscillating time frame for which parents may be unprepared (Seigal, 2013). For most parents, there is a lack of education regarding this stage of development, the notable changes occurring within, and the rapidly evolving social culture of adolescence (Bratt et al., 2019). Parents have a wealth of information about raising babies, toddlers, and elementary-aged children. However, the journey through the adolescent stage has traditionally been a stage of life where parents are re-engaged with the workplace and have less time to commit to studying or educating themselves about parenting (Novick & Novick, 2011; Seigal, 2013).

When parents can collaborate with professionals in a trusting and genuine manner, there can be profound positive outcomes (Brown, 2018; Karver et al., 2018). Therapeutic practices can encourage and promote collaboration (Karver et al., 2018). But first, it is essential to understand the parental experience of having an adolescent child attend therapy.

Undermining of Parental Capacity. Some parents may experience having their adolescent in therapy as preventing them from being supportive and performing typical parental duties (Fredman, 2019). Parents report feeling confused and uncertain about how to approach their adolescents after therapy sessions (Schlimm et al., 2021). When a teenager shares what counsellors may have suggested in session with their parents, parents report feeling upset, a sense of misunderstanding, and blame. Conflicting messages from the parent's experiences at home with the adolescent compared with what the therapist communicates can increase the parent's sense of frustration and hopelessness (Brown, 2019). Many parents report an increased negative self-perception of their capacity to parent, leading them to withdraw from the relationship with their young person or even attempt to sabotage the therapeutic alliance (Fredman, 2019).

Therapy as a "Fix It" Endeavour. Parents who expect a professional to diagnose and fix their youth usually leave mental health support services frustrated and hopeless (Brown,

2019). Unfortunately, many distressed parents hope an outside solution or relationship will ease their youth's problems (Brown, 2019). Finding time, resources, and motivation to engage with therapeutic work is challenging for many families and therefore, focusing on experts to fix the problem appears easier for some (Brown, 2019; Withers et al.,2016). Unfortunately, this focus on the help of "others" or experts" to fix the adolescent is detrimental to the therapeutic process. Parents who are invested in "others" as the only solution will have a difficult time engaging with the challenging experience their youth will encounter in therapy (Brown, 2019). With little understanding or empathy for the process, parents can easily find fault with professionals who do not "fix" their young person. Eventually, when the parent's expectations are not addressed or met, the treatment will likely reach a disappointing conclusion (Brown, 2019).

Along with this, parents may also view their youth as the primary problem and believe that the adolescent alone should be able to fix it (Brown, 2019). If this is the parent's posture, it will be challenging for them to see the relevance of being involved in the therapeutic process themselves (Brown, 2019; Karver et al., 2918). This "hands-off" approach can leave an adolescent without an anchor during the distressing circumstances that led them to therapy. Out of session, the adolescent has no extended therapeutic support (Karver et al., 2018).

Increased Isolation and Stigma. Parents report feeling humiliated after clinical practitioners dismiss or belittle their concerns (Bratt et al., 2019; Cohen-Filipic, 2013). They can experience a sense of being judged by their child's therapist and blamed for their distressing emotions. This results in isolation from their adolescent, insecurity in their parenting role and reluctance to engage in the therapeutic alliance (Fredman, 2019).

Furthermore, parents are usually left out of the treatment plan for mental health problems or diagnoses, further deepening feelings of separateness and insecurity (Bratt et al., 2019). Parents report significant degrees of self-stigma, which paralyzes them and increases feelings of helplessness (Bratt et al., 2019). With the feeling of being blamed and ostracized by professional help, parents may feel suspicious of connections initiated by clinicians (Hawkes,

2015). Parents who have experienced blame from mental health practitioners may remove themselves from the opportunity for a therapeutic relationship (Cohen-Filipic, 2013).

Responsible But Helpless and Inept. Parents feel the tension of being fully responsible and yet not having the influence or resources to support their adolescent. Unfortunately, this sense of helplessness can deepen when the youth undergoes therapy. In one parent's words, "I'm there with him every single day, and you [the counsellor] see him once a month, and you know that much, and I know nothing…" (Schlimm et al., 2021, p. 1026). Parents remain with their adolescents long after therapy and the therapeutic alliance is over. Conversely, research suggests this sense of helplessness can be transformed when the parent is acknowledged and reassured by clinicians (Fredman, 2019; Schlimm et al., 2021).

Acknowledgements and reassurance from clinicians and an increasing personal sense of agency can significantly impact the parent-adolescent relationship (Karver et al., 2018). When parents discover ways to connect with their young person, their confidence rises, and they start noticing the personal contributions that support or impair the therapeutic journey (Brown, 2019; Welmers-van de Poll et al., 2017).

Therapy as Protected Space. The environment of the therapy setting has been described as a "safety blanket" by parents who have adolescents in therapy (Schlimm et al., 2019). At times, this safety extends to the parent's inclusion or the parent's exclusion. Moreover, this vacillation appears to be understood by most parents (Fredman, 2019; Schlimm et al.,2019). Parents report being aware and understanding of sessions alone between their young person with the therapist. At times this is bothersome, and other times, desirable. When the "structure of therapy" is discussed with parents, uncomfortable thoughts seem to dissipate, and excitement for the therapeutic process begins (Sheridan et al., 2010). To ensure that the therapeutic space is private, some parents attempt not to ask or "badger" their youth about sessions (Schlimm et al., 2021). Similarly, a posture of not wanting to intrude on the young person's process is typical for many parents (Sheridan et al., 2010)

Therapy as a Shared Burden. Many parents report feeling “less alone” when their adolescent enters a therapeutic relationship (Fredman, 2019). There is an increased sense of security in that a professional is now “on their team” and willing to help (Schlim et al., 2019; Sheridan et al., 2010). Parents can experience a sense of newfound hope based on being interconnected with a professional (Brown, 2018; Sheridan et al., 2010). For some parents, there is a sense of desperation and extreme relief when they connect with a therapist for their adolescent. This is expressed in a mixture of thankfulness, hope and anxiety (Sheridan et al., 2019).

Therapy as Reassurance or Reinstated Agency. Several parents have acknowledged that a therapist’s reassurance about their efforts to care for the youth allowed them to feel more confident in their capacities (Fredman, 2019). Conversely, parents also report a loss of their intuition and confidence when the therapist’s care is overemphasized (Brown, 2018). These conflicting experiences can be recognized as part of the evolving process of adolescent therapy. The need for parental engagement in the therapeutic alliance will vary according to many factors. Research reveals that reliance on experts rather than one’s own agency weakens a parent’s ability to care for their young person (Brown, 2018). Therefore, clinicians must work towards promoting a parent’s abilities for better long-term care of adolescent clients. As well, parents would do well to recognize that an intermediary step in the evolving process may in fact be increased reliance on a therapist’s care (Bratt et al., 2019; Brown, 2018). While parents re-adjust their expectations and benefit from self-care strategies, youth can be using the therapeutic relationship (Karver et al., 2018).

In addition, this focus on the “expert” can cause some parents to avoid investigating their contributions to their young person’s difficulties (Karver et al., 2018). When parents make the shift from reliance on a clinician to more personal engagement, they report an increase in hope and empowerment to do the difficult work of parenting (Benitiz, 2020; Cohen-Filipic, 2013) When a parent steps into rather than out of the therapeutic process, mental health outcomes dramatically improve (Benitiz, 2020; Brown, 2019).

Therapy as Skill-Building. Including parents in selected therapy sessions is helpful depending on individual needs, motivation to participate and abilities. When parents participate in the therapeutic process, they report feeling optimistic about the outcomes for connectedness and pleased with a new understanding of the developmental context of their young person (Bratt et al., 2019; Brown 2018; Fredman, 2019; Schlimm et al.,2021). In addition, most parents preferred having some adult-only sessions but reported feeling happy and connected when in sessions with their adolescent (Brown, 2018; Sheridan et al., 2010).

A shift in perspective of their adolescent's problems happens when a parent gains personal awareness and sees concrete results in their youth's behaviours (Bratt et al., 2019, Sheridan et al., 2010). In addition, growing personal awareness through therapeutic sessions with parents (with or without the youth) produces greater parental self-confidence, agency, calm, hope and appropriate interpersonal boundaries (Bratt et al., 2019; Schlimm et al., 2021).

Depression and Suicide: Treatment of Adolescents with Parental Relationships in View

The following section of the literature review will focus on one presenting problem for adolescent clients and their parents: depression. Although there are many problems and disorders that can affect adolescents, depression is well-researched and has a significant amount of empirically supported evidence for treatment.

This section will not address a single modality or therapeutic approach for depression in adolescents but instead focus on the unifying evidence of the value of working in partnership with parents or caregivers.

This paper is limited to investigating depression in the context of parental involvement and influence. However, studies for other adolescent-specific problems and the efficacy of various treatments and modalities appear to be increasing. The reader should be aware that issues such as compulsive sexual behaviours including pornography use (Efrati & Gola, 2019), disordered eating (Balottin et al., 2017; Dalle Grave et al., 2019), bullying (Murphy et al., 2017), Internet gaming disorders including gambling (Bonnaire et al., 2019), and self-harm (Curtis et al.,

2018) have been gaining much needed age-specific study. Clinicians are responsible for understanding what treatments have the best results according to current research.

In Canada, a study among young people aged 15 to 24 reported that 11% had experienced depression in their lifetime (Government of Canada, 2017). Depression disrupts social lives, school attendance, physical activity levels and can evolve into suicidal ideation or attempts (Diamond et al., 2014). Suicide is the second-largest cause of death among 15 to 24-year-olds in Canada and yet has been described as a preventable public health concern (Government of Canada, 2017; World Health Organization [WHO], 2021). Along with anxiety, depression is considered the most prevalent mental health concern for young people (WHO, 2021). This age group has the highest reported rates of anxiety and depressive mood disorders, which are the two most common mental health disorders among youth in Canada (Government of Canada, 2017; Malla et al., 2018). 12 - 27% of young people and their families seek professional help through informal and formal methods (Canadian Institute for Health Information [CIHI], 2022; Government of Canada, 2017; Larner, 2009). This means that depression will undoubtedly appear in the counsellor's office, though not as frequently as needed (CIHI, 2022).

Depression and suicidal ideation usually appear together (Herres et al., 2021). Yet, studies among parents reveal that adolescents are less likely to access mental health support when parents do not recognize symptoms of depression (Radovic et al., 2015). When adolescents make it to a clinician's office, clinicians should be aware that the adolescent may be acknowledging distressing symptoms that have not been previously identified (Larner, 2009). Although the need to treat suicide ideation may be evident to parents, clinicians may have to communicate the essential need to treat depression and, in some cases, anxiety (Herres et al., 2021; Radovic et al., 2015). Clinical competency will require not only an assessment for suicide risk but knowledge of what the best treatment of depression is in this population.

Depression will rob adolescents of their "inner compass" and often their ability to ask for help or express their despair (Diamond et al., 2014). To protect themselves from experiencing

rejection or further sadness, depressed adolescents may withdraw from parents, become angry, withdraw from social activities, and get lost in apathy (Diamond et al., 2014; Johnco & Rapee, 2018). Yet, most parents will not recognize these behaviours as concerning (Johnco & Rapee, 2018; Larner, 2009). Research tells us that when parents cannot identify symptoms of depression or anxiety, their teenagers access support at lower rates (Radovic et al.,2015; Schwartz et al.,2018).

Family relationships dramatically contribute to the development and experience of adolescent depression in both negative and positive ways (Diamond et al., 2014; Housby et al.,2021; Reyes-Portillo et al., 2017). Previous studies indicate that the lack of a supportive parent relationship for adolescents indicates a higher potential for depressive symptoms (Butterfield et al., 2021; Zisk, 2019). In a corresponding way, improved interpersonal family communication and relationships are proven to be a significant factor in reducing depressive and suicidal thoughts (Housby et al., 2021; Reyes-Portillo et al., 2017). Further research supports family as vital in protecting youth from depression and suicidal ideation (Arango, 2019; Euguene, 2021).

Unfortunately, many parents report having a negative, critical reaction to their young person’s depression (Johnco & Rapee, 2018). Parents may try to control or manage teenagers' emotions, which only pushes them further into withdrawal and depression (Diamond et al., 2014; Larner, 2009). These adverse reactions create a neural response in the adolescent brain similar to being threatened (Butterfield et al., 2021). Therefore, when parents respond with overprotection, harsh critique, control or frustration, the severity of the adolescent’s depression increases (Butterfield et al., 2021; Johnco & Rapee, 2018)

Assisting the adolescent out of despair and helping them to express their experiences within the family system can counteract parents' adverse and confused reactions (Schwartz et al., 2018; Diamond et al., 2014). When this relationship can move into a place of receptive caring, it can result in lower levels of depressive effects (Butterfield et al., 2021; Tsvieli et al., 2019). Restoring parents ’ability to create a protective and secure relational environment can

dramatically amend the mental health of the whole family (Diamond et al., 2014; Johnco & Rapee, 2018; Tsvieli et al., 2019).

Given the significance of the parental relationship's effect on adolescent depression, the need for thoughtful parental involvement in therapy and deliberate family therapeutic intervention is essential (Larner, 2009; Schwartz et al., 2018). Parents who can provide emotional coaching give their adolescents the "scaffolding" for adaptive emotional expression (Schwartz et al., 2018). Using family-based therapies is effective for reducing depressive symptoms and serves to decrease suicide risk (Butterfield et al., 2021; Diamond et al., 2014; Lear & Pepper, 2018; Reyes-Portillo et al., 2017). Research suggests that when there is some degree of positive connection between a parent and their teenager, there is a corresponding effect of an improved positive mental health for all family members (Butterfield et al., 2021; Tsvieli et al., 2019).

Acute Depression and Hospital Admission

At times, depression and suicidal thoughts can become so severe that young people are admitted to the hospital. When parents bring their adolescent to the emergency for psychiatric care and assessment, they hope for safe and supportive measures in the face of an unknown mental health state. However, the effectiveness of emergency hospital visits is unclear (Larkin et al.,2015; Lear & Pepper, 2018; Leon et al., 2013). Research suggests that hospital visits increase the risk for suicide and prolonged continuation of depressive symptoms (Malle et al., 2018). An intimidating list of resulting complex feelings for hospitalized youth includes such things as increased isolation, social stigma, an internalized sense of pathology and extreme disruption to family and school routine (Larkin et al., 2015; Lear & Pepper, 2018).

In Canada, adolescent visits to the emergency department continue to rise (CIHI, 2022; Leon et al., 2013), and during the COVID-19 pandemic, visits drastically increased again (CIHI, 2022). The emergency room has become a catch-all service for mental distress of all varieties and among all age groups. Unless youth have access to a specialized hospital, the assessment

and admission processes are not designed to consider this unique population (Malle et al.,2018). Unfortunately, young people with early disordered thinking or severe depressive symptoms carry a particular risk of disengagement from mental health supports (Larkin et al., 2015). Emergency rooms must offer safe environments that support complete contextual and developmental assessment (Malle et al., 2018). However, unless a clinician is specifically trained to work with children and youth, young people will be treated outside of their developmental and relational context (Malle et al., 2018; Kenneback & Bonin, 2022).

When parents accompany their young person to the hospital, they report feeling hopeless, helpless, overwhelmed, excluded, and blamed by professionals (Larkin et al., 2015; Lear & Pepper, 2018). To alleviate this dangerous and isolating dynamic, it is recommended that adolescents and their parents are interviewed both together and separately by an emergency doctor for assessment (Kenneback & Bonin, 2022). Moreover, upon release, the confusion and frustration often continue. An effort to actively engage whatever family member is present in the care outside the hospital setting will support long-term positive outcomes for everyone involved (Larkin et al., 2015; Van den Steen et al.,2019).

Research among families who have had adolescents in psychiatric care in hospitals reveals that collaborative work between professionals and family members gives the best outcomes for the long-term functioning of the young person (Kenneback & Bonin, 2022; Lear & Pepper, 2018; Van der Steene et al., 2019). Family-based outpatient programs provide ongoing support. These programs aim to reduce feelings of depression and suicidal thoughts by using family and the home environment as a protection against stigma and social isolation (Lear & Pepper, 2018). In addition, parents or guardians are given the training to understand and initiate caring responses to their young person (Lear & Pepper, 2018; Van der Steene et al., 2019).

Negative experiences of hospitalization are a missed opportunity to engage with young people and their families, for whom the hospital may represent their first contact with clinical psychological services (Mathias et al., 2021; Larkin et al., 2015; Leon et al., 2013).

The Emergency Room Relevance to Counsellors

The gaps in mental health support for adolescents are consistent and chronic within the system (Kenneback & Bonin, 2022). Clinicians who are aware of the crisis of care in the emergency department and the lack of follow-up services will be better equipped to surround their clients with possibilities for supportive relationships and tools.

The increase in non-urgent presentations to the emergency room (dangerous behaviours, anxiety) points to the lack of community resources to support mental health needs in young people (CIHI, 2022; Leon et al.,2013). When an adolescent makes it into the chair of a counsellor's office, they and their parent have come up against multiple barriers and inconsistencies in accessing help. Plus, navigating a fragmented system has likely resulted in deep frustration, suspicion, and fatigue for both the young person and their parent. So, counsellors have the unique opportunity to advocate for specialized care for their adolescent clients.

Assisting young people and educating their caregivers to access the specialized help they need begins a collaborative process. Large hospitals have both general and specialized practitioners (Kenneback & Bonin, 2022). Psychiatric assessment of adolescents should be performed by those with specialized training and experience with psychiatric problems (Kenneback & Bonin, 2022). When specialized help is unavailable, counsellors can recognize the limitations and advocate for developmentally appropriate treatment.

Local Context of British Columbia

Until recently, there were no national guidelines or structures for emergency adolescent-specific mental health care in Canada. Services had been labelled "largely insensitive to young people" (Malla et al., 2016, p. 5). Cities and small communities across the country may have attempted to mobilize teams of specialists, but updating, training, advertising and inter-agency connectedness were underdeveloped and drastically underfunded (BMCA, 2021; Leon et al., 2013; Malla et al., 2016).

In 2015 in British Columbia (B.C.), a slow transformation began when a network of specialized youth health centres was established for people aged 12–24. Foundry centres include primary care supports for sexual health and substance abuse, walk-in counselling and family or peer support groups (Mattias et al., 2021). Foundry is committed to offering specialized services as to community needs, therefore they offer unique services at centre locations (Mattias et al., 2021; Foundry, 2019).

In 2021, in response to the difficulties recognized among young people and their families in accessing services, the British Columbia Ministry of Mental Health and Addictions (BCMA) introduced a new framework. Followed some ground-breaking work done in New Brunswick called the Service Delivery Framework, the idea of using *Integrated Child and Youth Teams* was birthed in British Columbia (Government of B.C., 2019). Integrated Child and Youth Teams (ICY) are comprised of multidisciplinary professionals who support children and youth to connect to care in their schools and community (Government of BC.,2019). The mandate for the ICY teams includes support for families and parents.

The lack of connection with secondary schools is an observable challenge and is a continued barrier to service integration. Accessing Foundry services can be difficult for any youth in an urban centre or not. Despite an impressive online database for supporting youth anywhere, anytime, the Foundry model is dependent upon a youth “walking through the door” (Amato, p.1, 2022). While transportation is recognized as a barrier for young people, mental health services continue to be offered in buildings away from secondary schools and neighbourhoods (Amato, 2022). Adolescents who want to obtain health care from Foundry services need to find transportation and ensure they arrive at the correct time for their preferred service to be delivered. Adolescents want and do access health support in private and have the right to do under Canada’s Infant Act. The location and transportation barrier can be eliminated when health services are located on campus or inside secondary schools, as is done in the New Brunswick model of

care. There are still service gaps and fragmented pieces in B.C.'s effort to deliver specialized health care to its young people.

Parents as Partners

The influence of parents on the therapeutic alliance, process and outcomes is well-established. However, although this paper has included many recent recommendations and studies, including parents in the therapeutic process is not straightforward in clinical application (Welmers-van de Poll et al., 2017). Potential partnerships between therapist, adolescent and parent can be imagined with a wide spectrum of nuanced connections.

Pursuing Family Connection

The essential benefit of a strong therapeutic alliance with both an adolescent and their parent(s) is the ability to work together towards a stronger experience of family connectedness. Family *connectedness* or *parental warmth* are used to describe feelings of warmth, caring and belonging between family members, specifically between a parent and young person (Arango, 2019; Euguene, 2021). Pursuing family connectedness or parental warmth is a research-based recommendations for work with youth experiencing almost any problem; bullying (perpetration or victimization), depression, anxiety, and non-suicidal self-injury (Foster et al., 2017, Rothenberg et al.,2020).

The term parental warmth has been used in multiple studies to describe varying attributes within a family dynamic that reflects the quality of the connection between parents and young people (Diamond et al., 2016, Nir et al.,2020). Parenting behaviours that contribute to this term are availability to relationships, response to sadness or rejection, acknowledgement of fear and assisting in problem-solving (Butterfield et al.,2021, Rothenberg et al.,2020). Across many cultures, parental warmth appears to function similarly as a protective factor for distressing adolescent feelings and behaviours (Rothenberg et al.,2020, Zisk et al., 2019). The sense of nearness and presence of a parent without domination or negative engagement works to soften the adolescent and improve connections and communication (Tsvieli et al., 2019, Zisk et al., 2019).

Attachment-based family therapy (ABFT) and Multidimensional family therapy (MDFT) have extensive studies on the effects of a secure attachment relationship and the promotion of parental warmth as an intervention (Butterfield et al., 2021, Diamond et al.,2016, Herres et al., 2021, Nir et al.,2020). Adolescents who experience a responsive, available caregiver appear to use this relationship as a "secure base" in which they can navigate difficult situations or distressing emotions from a place of confidence and support (Diamond et al., 2014, Herres et al., 2021). The benefits in pursing family connectedness for young people are numerous:

- Increased school involvement and interest (Foster et al.,2017).
- Lower levels of emotional distress and behavioural problems (Foster et al.,2017, Sieving et al.,2017).
- Improved coping skills and ability to express complex thoughts (Herres et al., 2021, Nir et al., 2020).
- A buffer from depressive symptoms and social anxiety (Foster et al, 2017, Rothenberg et al.,2020).
- A protective measure proving to give higher self-esteem, and adaptive problem-solving skills (Foster et al.,2017, Sieving et al.,2017).
- Decrease in social withdrawal and depressive symptoms (Eugene, 2021,Rothenberg et al.,2020).
- Protective against poor health-related outcomes (Brown et al., 2020, Sieving et al.,2017).
- Improved sexual awareness and health (Foster et al., 2017, Sieving et al.,2017).

Assessment

Of foremost importance is the recognition that young people come to counsellors to gain help and find relief for their problems (Braufman, 2019). Therefore, the primary goal of assessment is to understand the young person and begin the process of reaching for their "imagined meaningful life" (Blake, 2011; Lavik et al., 2019).

A thoughtful, initial assessment for adolescent clients is recommended to be:

Multi-Informant

Research as to whom to use in the youth's life for assessment has revealed that parents and the youth themselves are the best informants (Nichols & Tanner-Smith, 2022; Weisz et al., 2017). Using teachers or other involved adults as informants was helpful for comparison with parents and surfaced differences in behaviour in various settings, but the effects of parental and youth scores were shown to be more influential and informative to the process (De Los Reyes et al., 2015, Weisz et al., 2017).

Additionally, including parents in the assessment session can promote collaboration by engaging both parties to agree or disagree, modify, or expand on shared information (Halder & Mahato, 2019).

Contextual Importance of Relationships and Attachments

Adolescents straddle a dynamic period of dependence and independence. It is important to note that dependency does not denote weakness but can be framed as positive and necessary part of being human; furthermore, dependency for connection and solidarity is a need of all humans (Baltes & Silverberg, 1994). Adolescents, who are moving between these two dimensions, can experience the benefits of both. It is essential that adolescents stay connected to their parental relationships as much as needed. Recognizing the complexity of the nature and necessity of interdependence will create a foundational, safe space for adolescent clients in a therapeutic relationship (Baltes & Silverberg, 1994).

Sensitive to Developmental, Biopsychosocial Capabilities.

Recognizing the complex developmental agenda of the adolescent stage will serve the therapist well in conceptualizing ideas, conversations or interventions that are effective and appropriate (Baltes & Silverberg, 1994). Adolescents have critical limitations and challenges: increased emotional and social turmoil, higher risk-taking behaviours, immature decision-making skills, heightened emotional vulnerability and extreme mood changes. (Klingle & VanVliet, 2017). Conversely, therapists cannot forget the burst of newfound self-discoveries of this age. Adolescents experience increased independence, gain more physical strength or stature, and discover the power of love and deepening friendships (Diamond et al., 2014). Within the phase of adolescence there will be variations. For example, older adolescents may fully engage with autonomy in thinking and behaviours, whereas younger adolescents still need to bridge the need for parental security and autonomy (Dalle Grave et al., 2019). Older adolescents may cognitively be more able to engage and accept an adult form of therapy, while younger adolescents may require some active play and shorter session time (Dalle Grave et al., 2019). The wide variety of developmental differences in autonomy throughout the adolescent stage can be assessed and used to provide services that will support the young person in the therapeutic process (Braufman, 2019; Withers et al.,2016).

Conceptualizing the adolescent as evolving from immature to mature will cultivate a sense of continual growth that happens over a long period, one day at a time (Klingle & VanVliet, 2017).

Capacity of Parent and Youth

Along with this assessment stage, evaluation of parental capacities helps inform treatment planning (Brafman, 2018; Brown, 2018). For example, are parents able to support their young person and to what degree? Indeed, when parents are unable to give protective care or supportive engagement during the therapeutic process, it is necessary to adjust the approach (Brafman, 2018). Studies show that an upfront conversation is valued and welcomed if needed

or necessary between clinician and parent(s) (Halder & Mahato, 2019). Parents who hold unhelpful beliefs about their young person's problems can lead to a delay in the therapeutic process (Leigh & Clark, 2016). With the young person's permission, a counsellor may find it helpful to invite parents in after some progress has been made and share how the young person is feeling about presenting original problems with the parent(s) (Leigh & Clark, 2016). In so doing, counsellors must practice sensitivity and lead these meetings with decisive openness, ensuring positive regard for the young person who is sharing (Leigh & Clark, 2016).

Many therapeutic interventions include specific parental components (Withers et al., 2016). Interventions should be adapted as needed, especially when symptoms seem to involve an adolescent's relationship with their parents.

Collecting Feedback

Therapists are not reliable informants on how the therapeutic process is progressing in their clients 'lives (Gergov et al., 2021). Therefore, clinicians are advised to continue periodic check-ins with parents and adolescent clients and maintain awareness of the ebb and flow of dynamic family systems (Karver et al., 2019; Welmers-van de Poll et al., 2017). When it comes to long-term feedback on behavioural or emotional changes over a therapeutic journey, there can be discrepancies of considerable value between the reports of youth and those of their parents (De Los Reyes & Ohannessian, 2016; Nichols & Tanner-Smith, 2022). There appear to be patterns of family systems change that occur throughout therapeutic journey (Gergov et al., 2021). Growth of the alliance and changes within family systems are a better predictor of outcomes than the initial assessment (Karver et al., 2019). Therefore, monitoring and maintenance throughout treatment is recommended for both the youth and the parent(s) (Karver et al., 2019; Welmers-van de Poll et al., 2017). Collecting information from adolescents and parents upon initial consultation remains valuable for comparison with feedback during therapy (Nichols & Tanner-Smith, 2022). Discrepancies between what is shared in therapy versus behaviour at

home or school can inform a more complete view of the adolescent's mental health (De Los Reyes & Ohannessian, 2016; Nichols & Tanner-Smith, 2022).

It is a unique challenge to navigate using the feedback of a parent who reports different experiences and concerns than the young person. Still, it is an opportunity for increased authenticity in the therapeutic relationship when it is brought to the forefront (Karver et al., 2019). Since adolescents are not typically as verbally competent as adults, it is important to elicit feedback with different methods or apart from parents (Gergov et al., 2021). Collecting feedback with short questionnaires for the client to complete every few sessions or even at the conclusion to every session is advised (Nichols & Tanner-Smith, 2022; Selekman, 2017).

Relational Connection as a Protective Measure

If it becomes evident that due to parental characteristics or other barriers, connectedness between the adolescent client and their parent won't be possible, counsellors can begin to look for other supportive adults to come alongside their client (Karver et al., 2019). Connection to caring adults or inspirational others also has similar positive protective outcomes for adolescents (Sieving et al., 2017). Furthermore, it becomes essential for aging adolescents to form positive relationships with adults outside their families (Euguene, 2021). These people can be extended family members, teachers, coaches, pastoral leaders, or youth outreach workers (Selekman, 2017). A growing sense of belonging and connectedness improves the mental and physical health of adolescents (Eugene, 2021, Sieving et al.,2017).

Coaching young people to identify and reach out to supportive adults who are not their parents can bring relief and a sense of empowerment to an adolescent (Novick & Novick, 2021, Sieving et al.,2017). It can be very positive to assist youth in connecting with adults who have made themselves available in the past and have provided care or advice (Selekman, 2017). Creating a collaborative network of *caring others* will support positive long-term outcomes for youth as their autonomy and the need for social system increases.

Additionally, if the young person gives consent and finds value in the process, *caring others* can be invited to participate in some therapeutic sessions (Selekman, 2017). This promotes continuity of concern and connection from the office to the daily reality of the client.

Minority Groups of Special Consideration and Their Familial Context

Counselling services must pay special attention to young populations who are at higher risk of mental disorders, including homeless youth; youth with a family history of substance use, abuse, or mental illness; youth who are or have been in child-youth protection services; Indigenous youth; and new Canadians and refugees (Malle et al., 2018)

Furthermore, it should be acknowledged that when engaging in youth-specific research, most clinical studies have small numbers of underrepresented minority groups (Weisz et al., 2017). When included in clinical trials, this population is more likely to drop out due to transport barriers, employment opportunities or family conflict (Fante-Coleman et al., 2020). Additionally, most surveys are completed in English and therefore, youth whose first language is not English are underrepresented in most studies (CIHI, 2022; Weisz et al., 2017).

Finally, there are gaps in the presentation of distress and use of mental health services between genders. Adolescent females with complex emotional needs or identified disorders, trauma, or substance use are more vulnerable than their male peers (Van den Steen et al., 2019). Although they are more likely to access mental health support, they are also more likely to be prescribed anxiety or mood medication and be hospitalized for distressing behaviours (CIHI, 2022; Curtis et al., 2018; Mattias et al., 2019). Adolescent boys are reluctant to use mental health support and commit suicide at more than double the rate of girls (CIHI, 2022). Both genders suffer uniquely from being an “unseen” minority group therefore specific research, care, and attention are needed.

Trans Youth

It is essential to recognize the impact of parental support on the well-being of trans youth (Caldarera et al., 2021; Pullen Sansfaçon et al., 2019). Social outcomes as well as physical and

emotional health drastically improve when a parent or caregiver accompanies their adolescent to clinical settings (Pullen Sansfaçon et al., 2019). Integrating therapeutic support for adolescent-parent relationships will positively impact mental health outcomes for gender-diverse and trans youth. By acknowledging the emotional upheaval, at times labelled as a grief journey, parents can be equipped as an integral piece of the therapeutic team for their young person (Caldarera et al., 2021; Pullen Sansfaçon et al.,2019). Parents who attend therapeutic group support report less isolation, an increase in hope for their young person's future, reduced fear, and an increase in understanding of gender development (Caldarera et al., 2021). In Canada, the few specialty clinics that serve trans youth recognize that unmet parental needs and concerns regarding their young person's transition or exploration can significantly impede positive mental health outcomes (Pullen Sansfaçon et al., 2019). Collaboration with parents and inclusion in treatment teams is highly recommended (Pullen Sansfaçon et al., 2019), as parents directly influence self-esteem, social integration, and adjustment (Brown et al., 2020; Caldarera et al., 2021). When parents are unable to support their young person, other caring adults should be identified and included to build a sense of protection and belonging for trans youth (Sieving et al.,2017).

Underprivileged and Minority Youth

Studies reveal that visits to the emergency department for youth in mental health distress are more frequent in less affluent families (CIHI, 2022). Underprivileged young people will also be admitted more frequently (CIHI, 2022). Researchers trace this pattern to a lack of community support or clinical care for less affluent populations. In higher-risk communities, low-quality parent-adolescent connections are the primary contributing factor to high-risk behaviours and distressing mental health symptoms (Withers et al., 2016). Using family-based approaches improves results in under-serviced youth populations and minority groups yet presents unique challenges for delivery of services (Reyes-Portillo et al., 2017; Withers et al.,2016).

Adolescents from low socio-economic neighbourhoods report higher levels of depression and anxiety (Eugene, 2021). The experience of chronic of home insecurity, violence, hunger or negligent parenting directly and negatively impacts adolescent mental health (Reyes-Portillo et al., 2017). These challenging living environments highlight potential challenges when professionals attempt mental health support or better connections to adults in the community (Eugene, 2021; Reyes-Portillo et al., 2017).

Indigenous Youth

Forty-six percent of Indigenous peoples in British Columbia are below the age of 24 (Government of Canada, 2016). Therapeutic care of Indigenous youth must take into account their contextual environment and relationships. Youth living on-reserve report higher rates of depression and have more deaths by suicide than youth living off-reserve (Owais & VanLieshout, 2022). In addition, a recent survey conducted in Ontario reports that youth living off-reserve reveal higher levels of depression, phobias, generalized anxiety, and oppositional-defiance symptoms than their non-Indigenous peers (Owais & VanLieshout, 2022). Locally in British Columbia, Indigenous youth accessed the Foundry's support more than non-Indigenous youth (Mathias et al., 2021). Clinicians need to recognize the intergenerational trauma present among Indigenous communities and the ongoing effects on young people (National Collaborating Centres for Public Health [NCCP], 2017). Unique Indigenous concepts of mental well-being are one piece in a balanced, holistic understanding of health (NCCP, 2017). The presuppostion of this paper is that youth have lost connection with their family groups and are now being treated in isolation from those traditional supports. Indigenous communities historically would not have this problem, as the primarily and historic means of developing children and adolescents would come from an extended family. Deliberate sharing of child rearing duties created the family as the frontline of protection and support (Toombs et al.,2021). The trauma of Canadian Indigenous peoples has dramatically effected Indigenous youth in receiving the historical power of community-led, inte-

grated relationships with parents and caring others (NCCP, 2017, Toombs et al., 2021). This author believes that in a time before colonization, Indigenous youth would have had parents and their adult relatives included in all pieces of struggle and development to adulthood.

Mental health supports must be sensitive to traditional ways of healing and the unique protective factors of Indigenous community-led healers and elders (NCCP, 2017). Community and family connection is directly associated with self-confidence and resiliency for Indigenous youth (Toombs et al.,2021). Experiencing cultural continuity through involvement and exposure to cultural activities promotes resiliency and connectedness (NCCP, 2017, Toombs et al.,2021). Consider this short list of opportunities to connect with adults and other members of the community for Indigenous young people: ceremonial events, self-government, learning traditional languages in mainstream schools, activism in reconciliation or land claims, building cultural facilities or creating traditional dance and art (NCCP, 2017; Owais & VanLieshout, 2022). Integrating parental and community influence in therapeutic endeavours is critical for this special population's care (Owais & VanLieshout, 2022). If mental health support does not acknowledge, empathize, and attempt connection with family or community supports for adolescent Indigenous clients, is there potential for perpetuating harm? The concern from this author's perspective is the isolation from communal ceremonies and potential lack of activities that would connect youth to their culture, family, and community. When parents or elders share knowledge and participate in cultural activities, the Indigenous family and community structure benefits and grows (Toombs et al.,2021). In assessing Indigenous youth for therapeutic care, the inclusion of family is essential (NCCP, 2017). Without it, there is a risk of continuing harmful patterns that destroy family connections and deepen isolation from community members.

Counsellors who work with adolescents and their parents are presented with unique challenges. This paper advocates for a blanket inclusion of parents, at the very least during initial rapport building and assessment. Acknowledging familial context and the quality of current relationship connection is essential to understanding the young person (Withers et al., 2016).

The degree of parental involvement will depend on many factors (Leigh & Clark, 2016). It is crucial to acknowledge that therapeutic treatment for adolescents does not need full participation from parent(s). Including parents is not the answer for every adolescent presenting problem. Moreover, in some situations, it is not necessary or advisable. Clinicians will do the essential work of determining how, when, or why a parent would be included or updated when in the therapeutic process with a young person. An integrative approach is undoubtedly a challenge but proves to be of great benefit to adolescents (Mathias et al., 2021).

Chapter 3: Discussion of Findings and Therapeutic Application

The study of parent engagement in the care of adolescent mental health has been an increasing area of study. Amongst various professions that work with adolescents, parents have been acknowledged as significant stakeholders in the well-being of young people. Despite this acknowledgement, clinicians are unsure of the practical and foundational implications to their work.

The tri-directional relationship of therapist, adolescent client and their parent has been minimally studied. The review of the literature demonstrates this relationship has not been centred in any one study. Qualitative studies focused on point of view, have revealed an increase in adolescent-specific reflection and feedback on therapeutic process and relationships. While this is extremely valuable, it fails to recognize the developmental vulnerabilities adolescents have.

While responding to adolescent feedback is important, the acknowledgement of the oscillating dependent and independent dynamic in relationship to parents is essential. This developmental reality (and many others) make the adolescent vulnerable in ways they most likely cannot recognize. Nor is it their job to recognize this reality.

Consider these parallel scenarios of vulnerable groups in our population.

A young child getting their vaccinations does not have the capacity to analyze the data, transport themselves to the nurse or understand the pain they have in their thigh. The feedback the child gives will be limited to their developmental age. In response, we make adjustments on behalf of that child for their health, and comfort.

An Indigenous teenager entering a classroom brings an intergenerational history of traumatic relationship with the education system. In response, we strive to create trauma-responsive classrooms and make accommodations for the comfort of Indigenous students.

A young adult who identifies as gender binary cannot, alone, ensure there is a safe restroom to use while on the job site. In response, we make adjustments to ensure their safety and comfort by providing bathrooms that are labeled as gender-neutral.

These scenarios parallel an adolescent entering into a therapeutic alliance. The young person is in a rapidly evolving developmental phase which results in change at all levels of their humanity; cognitive, social, physical, spiritual. In response we acknowledge the vulnerability of being in a prolonged state of complex development. Recognizing the challenge of decisions making, impulsive behaviours, mood changes and the physiological increased need for sleep we make accommodations to provide safe space and relationship. Furthermore, this paper highlights the vulnerability of adolescents in an oscillating relationship to parental and adult authority. Moving into a healthy interdependency of young adulthood will require making accommodations in recognition of adolescent unique vulnerabilities.

Next Steps

I have created a short informative video (Lambkin, 2022) that addresses, in practical tones, what I have learned from doing this research. It is titled, *Practical Applications for Working with Adolescents and Their Parents in a Therapeutic Setting*.

My hope is that this video can be a tool to assist clinicians in understanding the inevitable relationship with parents. To inform and shape the presented information I used the current research available and my own experience. Additionally, there are multiple sources who have shared their experiences with me; clinicians working in hospitals, clinical counsellors and psychologists, school counsellors, adolescents, and parents.

The ideal audience for this video is any youth-working professional. Specifically, application for clinical counsellors is the most obvious. But school counsellors, youth workers, emergency room staff, youth pastors, or coaches will find it valuable. The foundational ideas and skills are transferrable for any work with adolescents.

The video is divided into two parts. Part one is a review of foundational ideas when entering into a therapeutic relationship with an adolescent.

1. Understand parents as stakeholders.
2. Recognize the context of your therapeutic relationship.

3. Acknowledge the unique developmental stage of the adolescent.

Part two is the practical application of including parents in the therapeutic alliance. When a clinician recognizes the unique developmental phase of their adolescent client, they can be free to build on that knowledge and pursue alliance with parents however seems appropriate. Based on parental characteristics and adolescent need, clinicians are encouraged to make adjustments in the alliance and treatment plan. The scope of the tri-directional partnership is fluid and undefined. The video will give basic ideas as to assessing the needs and capabilities of the parents and adolescent. The overall goal in meeting with parents is to build rapport and gain better understanding of the adolescent.

1. Meet with the parents.
2. Recognize the difficulty journey parents have been on.
3. Outline confidentiality and communication plan going forward.
4. Reflect and assess.
5. Acknowledge that families need your guidance.

In light of the research reviewed in this paper, I would like to invite you to watch and engage with my presentation at this link. Acknowledging, including, or using parents as possible partners begins with a posture of creative and broad application. This video can improve services and therapeutic relationships with adolescents and their families by giving clinicians foundational ideas to create unique therapeutic alliances that work.

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Appendix A: Video Application Script

Practical Applications for Working with Adolescents and Parents in Therapeutic Settings

A Video Script

by

Jolie Lambkin

for the

3rd Chapter of the Capstone Paper titled An Exploration of Adolescent Mental Health, Clinical Care and the Inevitable Relationship with Parents

City University of Canada

July 2022

Video hyperlink:

https://youtu.be/_GOqU7qiE0E

Hi there I am please to present to you some ideas I've been researching as I complete my Master of degree in Counselling.

The ideas today are directed towards people who are working with adolescents. Particularly I will address clinical counsellors but the research and conclusions here can be applied in any setting or relationship a youth worker - type professional has. This can be high school counsellors, youth outreach workers, even hospital emergency staff who have adolescents admitted.

I'll be speaking to you about the inevitable interaction and relationship you will have with your adolescent client's parent. I use the word inevitable that describes a picture I have in my mind from my own experience. Imagine with me a scene from a movie that is almost always included in a anything scary. You have your main character and the lights of their house are flickering….It is most likely a storm outside. Their face fills the screen but in the background is a doorframe. When the screen is dark you focus on your trying to see your main character's face, and then boom, the light flights on and in the framed backdrop there is a shadowy figure. You can't make out who it is. But you know that character is important, intimidating…. the lights go out and back on and the shadowy figure doesn't appear again..

I have over 25 years of experience working with adolescents in various contexts and capacities. My jobs have always been to help with teenagers with problems. It never fails that when I'm speaking with youth about complaint or crisis…. there parent is evident in the story. One way or another, parents become a shadowy figure in the storyline of the distress. They are there, sometimes directly talked about, sometimes not. I'm sure it's the same for you. The question is, what do we do with this third party…. how do we respond?

I'm going to offer up some simple ideas of why and how we would engage with the shadow figures of our adolescent client's life, their parents.

It seems that we work with adolescents happens in two ways, either through individual, private sessions or in family therapy context with varying degrees of family involvement. Both

approaches have pitfalls, and messiness. I would argue that doing family counselling with a reluctant adolescent will be difficult to truly hear the youth's perspective, or feelings. Although family therapists will work with each member of a family, including adolescents, they do not highlight the work with any one individual. They are more interested in the family system. But on the other end of the spectrum, doing adolescent counselling alone often doesn't connect the youth to their lived context, doesn't have as good long-term outcomes and can even deepen barriers between youth & their parents.

I think that both of these extremes can be mitigated by adopting a flexible and individualized approach. That is what I am advocating for you today in your work with adolescents. Rather than rigid rules, I think that having foundational understanding and practical wisdom about family and adolescent development will serve your intuition well if you are working with adolescent clients.

I need to preface this discussion, that I am using the term parents for brevity here but know that I am including guardians, step parents foster parents, anyone who is responsible for and caring for a young person in a home.

I have three ideas to support you as you engage adolescent clients and the inevitable relationship with their parents.

The first idea is to understand parents as "stakeholders" in your adolescent client's mental health. As in the corporate world, engagement with stakeholders is essential but will vary. Understanding stakeholders expectations and, attitudes is an essential piece to making your business run smoothly.

The same applies to the therapeutic alliance. These "parental stakeholders" need to be recognized and heard in order to subvert potential conflicts, and understand your client better. Depending upon parental capabilities, we can considered them as silent partners or active collaborators. Whatever portion the parent takes on while their young person is in (with you) counselling, they are "stakeholders". Parents are invested in the young person…

For obvious reasons and particularly in a crisis situation of an adolescent it is never more important to have had this relationship (your relationship) clarified and connected.

The next idea is to is to recognize the context of your counselling relationship inside the larger picture of the adolescent's life.

Imagine with me a youth in crisis/distress sitting in your office. A recent loss has caused emotional upheaval, dysregulated feelings, thoughts of suicide and unfocused attention. Maybe your next appointment is coming in a few minutes or the school you are in has to shut down at 5….

An adolescent in a counselling room always returns to their family. Unless the adolescent client has non-traditional living arrangements like maybe a group home, or there has been abuse and they need to stay in a shelter, or they need to be admitted to hospital…. they return to their family relationships and shared space. A therapist's presence is usually one hour a week or maybe one hour every other week. A family's presence is most of the other hours! Relationship with parents is a foundational piece to the existing structure of an adolescent's life, their struggles and achievements.

This relational support system is the essential foundation your client needs when outside your care or your office.

A great way to access what parental support looks like in your adolescent client's lived experience is by creating a simple relational map. Creating a relational map is a way to assess the quality and functions of relationships the young person has with adults in their lives. As you discuss supportive adults, be curious about parents. You want to understand the quality of the relationship they have with a parent. Of course, teenagers have many other opportunities to connect with great adults. They usually go to school where they spend six hours a day, so school counsellors, teachers, coaches or youth workers, youth pastors can and do have profound impact and connection to your adolescent client. You want to know what those relation-

ships are. These relationships should be recognized. But recognized as both impactful and limited. Because, these relationships, like (yours) the counsellor-youth relationship are limited by time, and professional boundaries. And this leads us back to acknowledging the context of counsellor-youth relationship.

It is a temporary, boundaried relationship. Helping youth to identify parents or other caring adults as supportive will give them coping skills for the majority of ours that you are not there. Research tells us that most adolescents client coming for mental health support feel isolated, misunderstood and alone. We want to counteract that as much as possible by building up outside, consistent relational supports.

As well, practical tip when discussing these other parent or adult connections is to use collaborative language. Such as “we’ll find a way forward”, “what a good team you have around you”. This will impress upon the young person that there other supports to be tapped into and they are not alone in tackling their current problems that brought them to you. Highlighting caring adults and identifying ways those adults show they care is helpful.

It’s like identifying … the shadowy figure for the adolescent. You’re telling them who is in the background of their life….

The last idea is to recognize the developmental phase of your teenage client. Remind yourself of the enormous changes that are happening. Sure there are physical changes we can see but consider the multitude of invisible developments happening!

The biggest change they are experiencing is that they are oscillating between dependency and autonomy with parental and adult relationships. The adolescent has complex and sometimes competing biological needs in this way. We can recognize the rapidly changing emotional atmosphere and make room for these conflicting behaviours. (That is why most of us work with this age group right? Its always changing)

Youth are making a new kind of autonomy, an interdependent autonomy. A process that happens over years, not hours.

I want to encourage you to not underestimate the weight of the need for security in contrast to the drama and evolution of making autonomy. Detaching from parents yet remaining connected, is a necessary and exciting process, but we know if detachment happens prematurely adolescents can lose essential supports such as emotional support or physical/financial provision and that greats a whole pile of problems and vulnerabilities.

With this physiological process occurring in mind, I have two suggesting in your response of that:

1. Question your assumptions

When you hear adolescents describe their struggles, it is easy to assume parents are villains or deficient somehow. It will be true that there are places parents are deficient and contributing to their young person's struggles. And at the same time, there are areas parents are attempting to connect and increase their abilities to parent well. But most likely if you counsel an adolescent client away from parents you'll not see those attempts. With this in mind, be able to carry a nuanced understanding of the relationship your adolescent client has with their parent. Because undermining a parent's influence of relationship with their adolescent is only going to harm the young person. Although adolescent clients may believe themselves to be invincible, we understand that they are in a vulnerable position of needing care and as they navigate the road to adulthood. And that leads me to my next suggestion;

2. Acknowledge their vulnerability as not-yet adults.

Society has created and upholds many laws concerning protection for adolescents. We mirror society's values in this way, acknowledging potential areas of vulnerabilities. I've given you some ideas here of specific areas of concern for this group but I'm sure you will know of more. For instance the potential for harm & manipulation in the adult-youth power imbalance? Or what about decisions making conversations when cognitive skills are still developing? All the brain science research should inform your dialogue with this group.

As you would for any vulnerable population, be sensitive and aware of those developmental unique needs that actually make them vulnerable.

A quick review of the ideas:

1. Understand parents as stakeholders
2. Know the context of YOUR relationship and
3. Recognize the developmental phase of your client

I want to leave you with clear ideas to acknowledge your adolescent client's parents.

1. Meet with them. Take time, perhaps 30 minutes of a session to introduce yourself and promote the idea of the collaborative journey. Be flexible as to what you feel is needed is needed with this kind of conversation. A 13-year-old client may be different than a 17 year old. And in ways that are surprising to you.
2. When you meet them, recognize the difficult journey the parent has been on, they may have lost hope. They may be afraid and defensive. They might have made some terrible mistakes with their teenager. They may be negligent. Encourage them for showing up and compliment their efforts. Your goal here is to build a little rapport and gain some insight into the family context your client is living in.
3. The next thing you must do at the beginning, is to outline confidentiality, and privacy for all stakeholders. This is obvious beginning intake work. You'll outline the limits of confidentiality; ;egal obligations if therapist is called to disclose record keeping, in the event the client is suspected to harm themselves or another person, if an elder or child is being abused, etc.

That is the defined part of the conversation, the next part of the conversation is a necessity, and it can't be neglected. Be clear what parents and the youth can expect in communication between the three parties - often called a tri-directional relationship now. Explain that what will be shared with parents will be what is approved of by the youth, and only if beneficial to

the therapeutic process. Highlight that your primary client is the youth and their wishes will be respected foremost. Feel free to make suggestion that if they are needing supports themselves it can be determined as the process unfolds. You are not committing to counselling them yourself, this can be a fluid and flexible decision for your own professional capabilities and assessment of the situation going forward. But establish that everybody at some point may or may not need mental health support and acknowledge it.

After that initial meeting is behind you, reflect and access.

4. Assess the needs of your adolescent client. Will their journey require regular updates or inclusion of parents? Or not? For example, if the youth is self-harming parents may already have an appropriate and helpful reaction the the behaviour or it may be the parent is contributing to the behaviours, do they need education to understand the behaviour and have a helpful plan for reaction? Due to the developmental stage and situation of your client, assessing their needs in context to that relationship with their parent is the right thing to do both ethically and for better outcomes over the long term.
5. If you do decide how often you'd like to update or connect with a parent, always discuss the meeting with the youth prior to. With the youth's input you can decide together what will not be shared and what will be. Is there a place they would like you to advocate for them? If parents want to discuss concerns or complaints, decide how that will happen, in what context and purpose. Always let the adolescent know these conversations have occurred or are upcoming. Resist triangulation and be clear about this with parents. If parents continually want input and support from you, it may be time to decide to switch into a more family-oriented approach or if you are able to keep alliance with your youth while including parents in some meetings do that. Be flexible as to what will serve your adolescent client and hear from them what they would prefer.

Lastly and this is for everyone,

6. Families who bring their teenage for mental health support need your guidance. From a personal perspective of a parent of four kids, 2 of which are teenagers and a young adult…. Parents have no set plan to follow when their teenager is in distress. Community supports, hospital emergency rooms and counselling agencies are not easy to navigate for families with teenagers, so any guidance you can offer is actually kind and potentially lifesaving to the young person your work with.

Thanks for taking the time to meet with me I trust that it was helpful but more, I hope it serves those young people you meet with.