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Methodological Considerations for Conducting Qualitative Interviews with Youth Receiving Mental Health Services

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Abstract: Use of qualitative interviews with individuals currently receiving mental health services has increased over the last decade in the United States due to calls for system change that emphasizes individuals' perceptions of their own progress. However, interviews with youth receiving mental health services are rarely encountered. In this article, an overview of methodological considerations when conducting an interview inquiry with youth currently receiving mental health services will be discussed, incorporating suggestions from the published literature and our experiences with previous interview studies. Our theoretical definition of youth receiving mental health services along with six major areas of concern: appropriate interview questions, youth development of cognitive ability, ethical issues, power relationships, cultural competency, and methods of interview inquiry are discussed. Finally, other researchers are encouraged to investigate techniques for gathering rich data through interview research with youth receiving mental health services.

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1. Introduction

I, Kathryn, felt my anxiety increasing as the time ticked away before the start of my first qualitative research interview with a youth seeking mental health treatment. My vita includes the titles of "researcher," "evaluator," and "youth counselor," and I have interviewed multiple youth for non-research purposes, yet conducting a research interview made me feel awkward and uneasy. Although there are similarities between a research interview and a clinical interview, there are also differences, which I had yet to fully appreciate. For example, in this research study I had not received access to any background information regarding the participants. Without access to background information I had no knowledge of how long the youth had been in treatment, previous therapeutic and medical treatments, and I had approximately 20 minutes, the time limit that we assumed a youth could sit through either before or after an hour long meeting with their therapist, in which to gather data. While waiting for the interview to begin, I wished for a document with guidelines or techniques for interviewing youth currently receiving mental health services (i.e., distinctive respondent). However, based on a previous literature review I knew that such a document did not exist. It was at this moment that I began to fully comprehend the complexity of the methodology in which I was about to engage. After discussing this tension with Maria I decided to proceed with the study, journaling my adventure in the hope of gathering pertinent information regarding interview methodology for researching youth currently receiving mental health services. These efforts were the basis for this article, which provides recommendations that will assist other researchers engaging in interview investigations with similar youth. [1]

2. An Overview of Interview Inquiry in the Field of Mental Health

In the United States the mental health field is transforming to focus on the needs of the consumer (i.e., client, patient) and to incorporate a more comprehensive form of mental health care (U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES [USDHHS], 1999, 2003). A highlight of this movement is to understand the experiences and strengths of individuals receiving mental health services, and to set up support systems of care for youth and their families (PUMARIEGA, WINTERS, & HUFFINE, 2003). Conversely, the major focus of the previously embraced mental health system included evaluating symptoms while not striving to empower the individuals seeking treatment (ANTHONY, 1993; JACOBSON, 2001). An important part of this transformation includes using language that is respectful of youth and families as people first (e.g., a person has a mental health condition, a youth who has a disability). “Person first language puts the person before the disability, and describes what a person *has*, not what a person *is*” (Snow, 2008, p. 3). As authors we attempt to use people first language throughout the article, while acknowledging that at both the national and international level language conveys highly different meanings. [2]

As part of this movement there is a concerted effort to understand the perspectives of mental health consumers. The application of interview techniques in the field of adult mental health has been increasing throughout the last decade as a way of capturing the experiences of individuals currently receiving mental health services. For example, BRUNI (2005) investigated young adults' retrospective views of previous psychotherapy received during adolescence. DEEGAN (2003), RIDGEWAY (2001) and YOUNG and ENSING (1999) conducted interviews with adults who were currently receiving mental health treatment to gain a more thorough understanding of the process of mental health recovery. On the other hand, few interview studies have been conducted with youth receiving mental health services (e.g., DEATRICK & LEDLIE, 2000). [3]

While interviews with youth currently receiving mental health services are rare, scholars have investigated youth participants' (who have not experienced mental health issues) understanding of mental health as a concept (ARMSTRONG, HILL, & SECKER, 2000; ROOSE & JOHN, 2003; SECKER, ARMSTRONG, & HILL, 1999). The majority of studies investigating the mental health issues of youth involve interviews with parents/caregivers or clinicians. For example, HARDEN (2005), PEJLERT (2001) and MILLIKEN (2001) interviewed parents of children struggling with mental health problems to gain a deeper understanding of parents' views as a caregiver. In addition, NELSON, BRENDEL, MIZE, LAD, HANCOCK, and PINJALA (2001) examined the therapists' perceptions of ethnicity issues in family therapy. [4]

In spite of the growth of interviews in mental health research and the current guidelines that exist for interviews with children and youth in the general population (e.g., EDER & FINGERSON, 2002; FINE & SANDSTROM, 1988; GRAUE & WALSH, 1998; LAHMAN, 2008), suggestions for gathering rich data specifically with youth currently receiving mental health services have not been established. It is likely that one of the reasons for such a dearth of information in the research methodology literature is youth receiving mental health services being perceived as "doubly vulnerable persons" (MOORE & MILLER, 1999, p.1034), having "multi-faceted vulnerability" (RADLEY in LIAMPUTTONG, 2007, p.4), and "overlapping marginality" (LIAMPUTTONG, 2007, p.4). Not only does this status make the youth more difficult to access as research participants, but it also presents some unique challenges. We argue however, that this special status puts even more importance on the need to honor these youths' voices. [5]

In this article, we will discuss the methodological themes that were identified in a study in which Kathryn conducted interviews with youth currently receiving services for mental health treatment. First, we will briefly describe the qualitative investigation using interviews with these youth. Secondly, we will explain the investigator's theoretical definition of youth receiving mental health services. Thirdly, we will discuss six major areas of consideration: appropriate interview questions, developmental ability, ethical issues, power relationships, cultural competence, and types of relevant interview methods. Finally, we will conclude with a discussion of future directions for methodological and applied research. [6]

3. The Research Study

3.1 The researchers

Kathryn is a research methodologist specializing in the area of psychology and mental health. For the past three years, Kathryn has worked at the Mental Health Center of Denver (MHCD) as an evaluation specialist, where she has conducted multiple studies using qualitative and quantitative research techniques (i.e. interviews, focus groups, surveys) to determine the characteristics of mental health recovery for youth and adults. Prior to working in psychological research, Kathryn worked as a youth counselor for substance abuse prevention programs where she conducted informal interviews with children involved with state human services. Kathryn was a doctoral student in Maria's qualitative research methods course when she began the qualitative study including youth participants receiving mental health services. It was clear only a month into the project that the topic of interviewing these youth was going to be a difficult process due to the stigmas related to mental health and associated legal issues of youth. As the research progressed, Kathryn began to meet regularly with Maria to discuss both the progress and barriers that were continuing to arise. Engaging in the reflexive process allowed Kathryn to use her prior experience in conjunction with Maria's experience, described below, to constantly adapt the research. We believe that discussing the issues will encourage other researchers to investigate the views of these youth in order to incorporate their views into the clinicians', directors', state and federal policy makers', and additional stakeholders' decision making regarding youth mental health services. [7]

Maria is a qualitative methodologist whose specialty is early childhood education where she has conducted multiple interviews with children ages three through eight. However, since she works primarily in the elementary classroom it is rare for her to work with children with formal mental health diagnoses. Maria's role in this study was primarily to reflexively engage with Kathryn (FINLAY & GOUGH, 2003; HERTZ, 1997), as we sought to interpret, reframe, and represent what we know about researching children and youth from populations who do not receive mental health services, to youth who receive mental health services. This was an intriguing and challenging process that has powerful implications. Maria functioned as a peer check (MERRIAM, 1998), thus enhancing the trustworthiness of our comments. Children in general are often marginalized in research (EDER & FINGERSON, 2002; LAHMAN, 2008; ROBINSON & KELLET, 2004) and it seems that decisions made regarding youth mental health services may not directly include the voices of the youth themselves. The heart of this article is a testimony that these youth do have a story to share. [8]

3.2 The research design

This qualitative study, which we refer to as the "youth mental health study" throughout the article, utilized interviews with youth currently receiving mental health treatment services to investigate the process of mental health recovery, resiliency, and systems of care at a large community-based mental health center.

Five youth within the age range of 8 to 18 years, who were currently receiving services for mental health treatment, participated in a single semi-structured interview (CHARMAZ, 2006). Interviews were conducted in a quiet room at a mental health center, ranging from 10 to 30 minutes in length. Participants varied in their cultural/ethnic backgrounds, diagnosis, length of time in treatment, as well as the type of treatment(s) they were receiving (i.e. drug therapy, individual therapy, group therapy). The community-based mental health center from which participants were sampled is a non-profit organization serving high need individuals with lower than average social economic status. The following are examples of interview questions: What kind of changes have you noticed about yourself since coming here [the mental health center]? What does a good day look like for you? What does a bad day look like for you? How is school going? The responses to the general questions were followed up with a request for more description in a particular area. [9]

4. Theoretical Definition of a Youth Experiencing Mental Health Problems

Who is a youth currently receiving mental health treatment services? How do we, the authors, as researchers view and define youth currently receiving mental health services? Both of these questions need to be answered prior to our discussion of interview techniques. Researchers describing how to conduct interviews with youth have reviewed the issue of how to define a youth/child (CHRISTENSON, 2004; DAVIS, 1998; LEWIS, 1992; MAUTHNER, 1997; MILLER, 2000), but youth receiving mental health services will increase the complexity of this issue. For example, most of the current interview research describes youth as "social beings," implying a youth is a product of his or her social environment, in agreement with how he or she is described from the perspective of educational psychology (JAMES, JERK, & PROUT, 1998; JAMES & PROUT, 1990). The social being perspective suggests that youth can communicate their opinions and views, however, they may prefer and/or may be better able to communicate through other media (MILLER, 2000). When conducting interviews with youth currently receiving mental health services the methods for identifying the youth's most comfortable means of communication may be more challenging due to interfering symptoms associated with their condition and/or medication(s). For example, the youth mental health study previously described in Section 3.2, is currently being expanded to include focus groups and Photovoice techniques, where participants take pictures and then discuss the pictures in an interview (WANG & BURRIS, 1994). This form of communication may be beneficial to provide youth another means of communication. [10]

Researchers who include youth receiving mental health services as participants should be aware of multiple stigmas, discussed earlier, that may be present in interviews with this specific population. First, a youth is not an object, but a person similar to adults. Therefore, we suggest assuming that youth can communicate in interviews as well as adults, but they may require other forms of communication. Second, youth and families of youth may recognize mental health as a negative stigma, and may not care to identify with the term. For example, a quote from Kathryn's journal after interviewing a youth and his parents stated,

> "I have seen this now in two parent interviews that the parents do not make direct eye contact when discussing their child's mental health issues or problems, but they seem to make eye contact when discussing positive progress. I am not sure if this is due to embarrassment, varying cultural influences, or something else." [11]

ARMSTRONG et al. (2000) investigated youth participants' opinions regarding their understanding of the concept of mental health. The findings suggested that "The term mental health was salient and understandings of it were often uncertain" (p.69). The negative stigma is commonly associated with misinterpretation of mental health provided in our society (HAYWARD & BRIGHT, 1997). [12]

5. Methodological Themes in Interview Research of Youth Receiving Mental Health Services

Throughout the investigation rigorous research notes were taken regarding methodological issues that might have affected the richness of the data collected. Themes emerged in the areas of appropriate interview questions, development of cognitive ability, ethical issues, power relationships, cultural competency, and methods of interview inquiry. Although the following six themes are discussed independently we acknowledge there is significant overlap among them. [13]

5.1 Appropriate interview questions

Appropriate interview questions are vital when researching youth currently receiving mental health services. CHRISTENSEN (2004) emphasized, that the interview questions are not developed by youth participants, but rather they are developed by the researchers. MILLER (2000) suggested applying interview questions focused around a youth's "normal day," suggesting that they may be easier for youth to answer and may provide key insight into potential subsequent questions and discussion. While MAUTHNER (1997) suggested, "to draw out children's suggestive experiences is to encourage them to describe events from their daily lives through storytelling and anecdotes" (p.20), DEATRICK and LEDLIE (2000) recommend having prompts, or verbal reminders, to be added to the interview dialog with youth to get more specific information. Creating developmentally appropriate interview questions is not a novel concept in qualitative research (CHARMAZ, 2006; CROTTY, 1998), but we feel it is critical to emphasize it, as it has a crucial role in establishing rapport and gathering rich descriptive data from youth receiving mental health services. [14]

For example, in the youth mental health study the research question was "What is the process of recovery, resiliency, and systems of care in youth current receiving mental health services?" This question was acceptable for researchers and clinicians; however it would not be appropriate for youth participants. Many youth currently receiving mental health services have not personally recognized that they are experiencing any form of mental health issues even when they are in treatment; therefore, researchers should not assume that this notion is established when entering an interview. As previously discussed, the term "mental health" should not be used in a research question with youth, unless the meaning of the term can be assumed to be understood by all participants (ARMSTRONG et al., 2000). The questions in the interviews were adapted to avoid making assumptions and to be in line with the verbal language of the participants. The two initial questions that Kathryn asked the participants were: What does a good day look like for you? and What does a bad day look like for you? Only after establishing that the participant acknowledged in some form they are receiving treatment service to achieve a goal that is related to increasing positive mental health, did Kathryn ask, How do you know that you are getting better? A male adolescent participant did not imply that he felt he was working on mental health issues, as a result the conversation was directed toward asking about family, school, and activity (e.g. How do you like school?), in an attempt to identify changes in these domains without directly discussing mental health. A positive note found in many of Kathryn's journal entries included the notion of "participant experiences no excessive emotionality or concern with interview questions asked." The repeated documentation suggests that varying questions were more appropriate then having a standard set of research questions, although this process is more difficult when explaining the study to stakeholders (i.e. IRB, mental health centers, participants, guardians). [15]

5.2 Development of cognitive ability

A major concern in mental health research is the developmental ability level of the participants. We want to be explicit that we are *not* referring to the intelligence level of the participants, but to the developmental level of their cognitive ability. Intelligence, or crystallized intelligence, is a static trait commonly measured and defined by an IQ test, which is expected to remain relatively constant throughout life. In contrast, cognitive ability, also referred to as fluid intelligence, is related to a person's developing ability to learn, retain information, and carry out tasks, in which these skills can be learned and are expected to change across a lifetime. As a researcher it is difficult to quickly assess cognitive ability due to the common occurrence of dual diagnoses and negative environmental influences (i.e., risk factors) in youth with a mental health diagnosis (MARSHALL & DEANE, 2004). Several interview researchers have discussed the importance of different developmental levels associated with the age of the participant; however, they do not focus on developmental levels that may vary among individuals of the same age or age groupings. For example, DEATRICK and LEDLIE (2000) suggested that youth participants 10 years of age and older were better able to focus on the research questions and flow of the interview than youth younger than 10. In contrast, participants receiving mental health services may experience different developmental skills that may not be directly related to their chronological age due to their own illness. For example, a 12 year old who experienced years of severe abuse throughout childhood and is beginning to display symptoms of a personality disorder in adolescence may have a lower developmental level than a 12 year old experiencing minor depression. Therefore, to gain a better understanding of this relationship, we suggest grouping based on developmental characteristics in addition to the participant's chronological age. Similarly, KENNEDY, KOOLS, and KRUEGER (2001) reviewed the importance of participant's developmental level while discussing the concepts of being mutually understanding and empathic when determining the most appropriate data collection techniques. CHRISTENSEN (2004) suggested that young interview participants seemed to be puzzled about the researcher's interest in their illness, while older participants were more direct in answering questions regarding their illness. It is generally accepted in the field of mental health that participants receiving treatment services will vary in their acknowledgment and application of their own developmental ability. [16]

An apprehension when conducting the previous interviews was our lack of knowledge regarding participants' cognitive ability level prior to the interviews. Although other research designs may allow for access to information regarding treatment and cognitive assessment, as a precaution the interviewer should be ready to adapt to a variety of developmental levels regardless of the chronological age of the participant. It is the researcher's obligation to deal with the emotions of the youth when conducting research. We believe that training in mental health and child development can assist the researcher when assessing the developmental level of the participant. Through Kathryn's experience with conducting the interviews we would suggest that when researching youth currently receiving mental health services the researcher(s) should: (1) acknowledge and be able to identify different developmental levels and, if possible, (2) have an interviewer trained in mental health, or who has at least received guidance from a mental health professional prior to conducting interviews. [17]

5.3 Ethical issues in researching youth receiving mental health services

Most national human subjects research ethics boards (LIAMPUTTONG, 2007; ISRAEL & HAY, 2006), such as the United States (US) Health and Human Services Institutional Review Board (IRB) guidelines (2005), state that youth with a mental health diagnosis are considered to be members of two vulnerable groups, minors and the cognitively impaired. Therefore, protection of youth currently receiving mental health services is typically of great concern to human subjects research boards; however, in the US there are no direct guidelines for investigating the experiences of this distinct group. We have found a considerable amount of ambiguity in this arena which may delay IRB research approval for lengthy time periods. Regardless of human subjects research requirements, all investigators should consider how best to deal with the following three issues related to researching youth receiving mental health services: working with gatekeepers, the process of consent, and reporting harm. [18]

5.3.1 Working with gatekeepers

Strategies for working with gatekeepers, or individuals who provide access to participants and/or research sites, is a common topic in the methodological literature (MAUTHNER, 1997; MILLER, 2000; THOMAS & O'KANE, 1998).

Researching youth receiving mental health services extends the traditional definition of gatekeepers to include the caregivers, therapists, and the IRB, among others. In the previous interviews, we quickly determined that the success or failure of this study was largely reliant on the therapist gatekeepers, due to their previously established relationship with the participants and caregivers. Kathryn thought that the therapist gatekeepers displayed more protective characteristics than the caregiver gatekeepers because if the participant's clinicians supported the youth participating in the research, the youth and caregiver both supported the research. A quote from Kathryn's journal illustrates this,

> "The child did have trouble reading the consent form, but signed the form with no questions after it was read to him. All of the participants interviewed seemed to just sign the consent form without much attention, as long as their therapist supports it [the research project]." [19]

Therefore, it was critical to establish relationships between the researcher and the clinicians. [20]

MILLER (2000) conducted interviews with children who were diagnosed with health problems and reported that parents seem to trust the researcher even without having previous contact. A study conducted with adult participants receiving mental health services defined this phenomenon as "therapeutic misconception," suggesting that participants believe that the researcher is obligated to focus on the best interest of the participant, implying that there is no difference in the researchers' goals and the goals of their practitioners (APPELBAUM, ROTH, & LIDZ, 1982). Although not directly investigated in the youth mental health study, it seemed that youth participants did not differentiate the researcher from their clinical practitioners and seem to apply the therapeutic misconception. Due to the misinterpretation of a researcher in a mental health setting, it is even more critical that the researcher hold the wellbeing of the youth participants as a primary focus. [21]

In addition, research ethics board gatekeepers may influence the researchers' decision regarding techniques for obtaining consent. For example, MILLER (2000) was required by an ethics board to have parents present when the youth participants signed the consent form, in an attempt to empower the participant in the presence of the researcher. Research involving youth participants receiving mental health services will involve a great variety of gatekeepers who should be identified; strategies to work with these gatekeepers should be developed early in the research process. [22]

5.3.2 In-depth consent

Another inherent issue in researching youth receiving mental health services is the procedure used to gain informed consent (MAUTHNER, 1997; MILLER, 2000; THOMAS & O'KANE, 1998). In the US all researchers are required to gain consent from caregiver(s)/guardian(s) and assent from youth participants; these two criteria may be considered the bare minimum in ethical consent when interviewing youth currently receiving mental health treatment services. First, mental health issues have been reported to have a genetic component, therefore the participants may also have a parent struggling with their own mental illness, especially among severe and persistent forms of mental illness (PLOMIN, DEFRIES, McCLEAN, & McGUFFIN, 2000). THOMAS and O'KANE (1998) acknowledged the complication of dealing with problems arising from gaining consent when youth participants are guarded by the state, which may occur more frequently when parents are struggling with their own mental illness. At the mental health center in the youth mental health study, regardless of the parent's mental health it was a common notion that a parent(s)/caregiver(s) may or may not be involved in the youth's lives at varying levels. Therefore, the process of gaining parental consent may be complicated due to the lower rate of actively involved parent/guardian to read and approve the consent form. [23]

In addition to parental consent, there is incongruence in the US between the regulations for providing treatment services and those for performing research with youth who are receiving mental health services. The United States Health Insurance Portability and Accountability Act (HIPPA), along with state laws allow mental health services to be provided to adolescents 16 years of age and older without caregiver consent (USDHHS, 1996), while US IRBs commonly request caregiver consent for adolescents 17 years of age and younger (USDHHS, 2005). Therefore, in many studies, including the youth mental health study, participants who are in treatment without parental/guardian consent are excluded from the study; consequently preventing representation of this group of participants in many research studies. The previously discussed issues, along with the participant's different developmental abilities, may be barriers when conducting informed consent procedures that researchers should be aware of. Researchers should be cognizant of the previously discussed issues, along with the participant's developmental abilities, as they could be potential barriers when conducting informed consent procedures. [24]

Methodologists have suggested a variety of techniques to improve the consent/assent process (THOMAS & O'KANE, 1998; MILLER, 2000), although these procedures may not overcome all barriers regarding ethical consent. The interviews Kathryn carried out included several procedures suggested for conducting research with youth, including a detailed discussion of consent with parents and caregivers, providing the participant with the control of the audio recorder to stop the interview at any time, and reading the consent form to individuals upon request. While precautions were established in our study, we feel that consent was not achieved in its ideal form. For example, caregivers of youth receiving mental health services seemed to be overly familiar with the process of signing consent forms. Every caregiver in the study signed the form without appearing to read the full document. This phenomenon could be related to parent(s)/guardian(s) of youth receiving mental health services being more accustomed to signing consent forms and legal paper work regarding their children, in addition to the therapeutic misconception associated with the researcher. In this study, most of youth and their families reported being in and out of mental health clinics/hospitals, and/or dealing with legal issues throughout their lives. In addition, the youth participants seemed honored by the fact that we were asking for their signature, which decreased their focus on the provided description of what the consent meant and entailed. [25]

Future researchers may want to attempt more rigorous procedures in order to gain ethical assent/consent. Researchers may care to fully read the assent forms to all youth participants, although this process may still be confounded by the attention span of the individuals. THOMAS and O'KANE (1998) used varying levels of consent, applying active consent for youth participants and passive consent for their caretaker. The active consent included sending the youth participants a leaflet or audiotape describing the research, an activity sheet, and an information sheet for caretakers to learn how to discuss consent jointly with the participant. In addition, we would suggest having extremely simple assent/consent forms for youth participants receiving mental health services, above and beyond what is required through IRB regulations. In the research Kathryn conducted the assent forms were written at a lower reading level although the forms were not created in accordance to the lower developmental levels and limited attention span of a few participants. In an excerpt from Kathryn's journal she stated,

> "I am glad that I got the buy in from clinicians, but I wonder about how this is influencing the participants' engagement in the consent process. Maybe they trust their clinician (which is great rapport in therapy), but so much that they don't pay attention to their own consent [or assent]. When discussing this in class, another student responded, 'What is wrong with that, you have the buy in?' which I think is my whole point. What if my gatekeepers buy in is negatively affecting my ability to gain proper consent, although I have met all the usual good requirements?" [26]

We encourage future researchers to explore techniques for implementing ethical consent and assent, and researchers should know that these issues may be encountered. [27]

5.3.3 Reporting harm

Researchers investigating youth receiving mental health services should include a discussion of reporting harm to one's self or others versus the participant's confidentiality (THOMAS & O'KANE, 1998). By attempting to empower youth participants selected researchers have suggested that if participants report harm this is an indication that the participant was ready to communicate this information, and the researcher is responsible in assisting the participant in communicating this information with someone who can help them, but only with the participant's consent (THOMAS & O'KANE, 1998). This interpretation of harm does not seem to fully comply with US ethics IRB guidelines. Due to the above average experience of abuse and displayed aggression in youth receiving mental health services and their families (JOHNSON, 2002), we took a more traditional approach to reporting harm of participants receiving mental health services. We suggest stating prior to the interview that "if harm to you (the participant) or harm to others is reported, I will have to tell someone," and also included this information in the consent and assent forms. In the youth mental health study, this information was stated prior to the interview. Mental health professionals must follow the traditional procedures of reporting harm, in addition to mental instability; therefore, youth participants receiving mental health services may recognize this process. We believe that the buy-in from the therapist, caregivers, and ethics board gatekeepers was increased because we took a traditional position on reporting harm. [28]

5.4 Power relationships

Issues of power in the researcher/participant relationship have been discussed by many child/youth methodologists, providing suggestions to minimize the power differential (CHRISTENSEN, 2004; DAVIS, 1998; LAHMAN, 2008). During the interviews we employed strategies to reduce the uneven power relationship including: (1) maximizing participant control of the interview, (2) allowing the participant to control the tape recorder, and (3) using appropriate verbal and non-verbal language during the interview for the youth's developmental level. After conducting the study we agree with CHRISTENSEN (2004) who suggests, "viewing power as embedded in the process, that is in this case the doing of research" (p.167). We agree that we should attempt to have procedures in place to empower the participants, while understanding the stigmas, previously discussed, for youth receiving mental health services will also influence the power relationship. In the current mental health system it is questionable whether it is legally and developmentally possible to achieve equal power relationships in a research setting when youth participants do not even have their own legal rights. Many of the participants Kathryn interviewed have been in psychiatric hospitals and in court ordered treatment services; therefore, they may associate the mental health system with a reduction in power. The power relationship when conducting interviews of youth receiving mental health treatment services is intrinsically providing power to the researcher. An interesting finding in the study was that being involved in the interview process itself may be empowering for participants, who commonly find themselves learning techniques in therapy for coping with the inherent limitation of their rights in the legal systems, family dynamic, and education system. A display of this empowerment was noted by Kathryn in her research journal, "The participant seems proud of her opportunity to share her successes," and

> "[t]he participant seemed willing to openly discuss her life and thanked me for interviewing her at the end of the interview. This seemed a little strange to me, I just asked you a bunch of question about your personal life and you thanked me. May be associated with thanking professionals or something else?" [29]

Researchers should attempt to put as many techniques in place to empower their participants while being aware of additional influences which may be inherent in the process. [30]

5.5 Cultural competency

A necessary overarching theme among research and human services is cultural competency. In terms of mental health research and service cultural competency is broadly defined as "Involving the recognition and understanding of the diverse values, norms, and needs of a community and integrating the knowledge about service [and research] that are accessible and relevant to that community" (PRADO & DeROCHE, 2008, p.20). The definition addresses more than simply being cultural sensitive in a research design by suggesting that ethical considerations of cultural competency should be continuously examined throughout the research process to allow for proper interpretation of the participants' views in light of the diverse values, norms and communities being represented (LAHMAN, GEIST, RODRIGUEZ, GRAGLIA, & DeROCHE, 2008). FISHER et al.'s (2002) paper on research ethics for minority children outlined how the six characteristics of interviewing youth, discussed in the current paper, are influenced by cultural issues, while identifying that careful attention needs to be taken when discussing and defining race, ethnicity, and culture. Cultural competency plays a role in design, implementation, interpretation, and social policy implication of a research study, and should be thoughtfully planned and evaluated throughout a study. As researchers, we may not be familiar with the cultural group that is being investigated, but should make all attempts to increase our understanding. For example, researchers may be from a different culture and will likely be from a varying generational group than the youth participants whom they are investigating. Therefore, a researcher cannot assume that their viewpoints, language, and forms of communication will be the same as their youth participants (LIAMPUTTONG, 2007). When conducting qualitative data analysis, researchers needs to be open to various interpretations of the meaning of statements in the interview. When the researcher belongs to a different generational group than the participants, which will always occur when an adult interviews a youth, the researcher must access resources for assistance with proper interpretation. [31]

Multiple researchers have discussed the benefit of community-based participatory research (CBPR) techniques for increased cultural competence in mental health programs, evaluation, and research (FISHER et al., 2002; PRADO & DeROCHE, 2008). The use of CBPR will allow a researcher to be informed by community members regarding if the study design and data interpretation are appropriate for the participants in the study. In addition, researchers may care to engage in a participant check, where the transcripts or results of the study are given back to the participant to ensure proper interpretation (MERRIAM, 1998). The youth mental health study is currently recruiting a group of community members to provide continuous feedback regarding the interpretation of the results and decisions made regarding the study. In addition, a new design is being implemented to allow for a participant check the results to ensure that proper interpretation of the data is occurring. [32]

5.6 Methods of interview inquiry

An important consideration is the type of interview the researcher should use. While interview design is often dictated by time and money (LIAMPUTTONG, 2007), when researchers have the ability to influence these decisions they will want to consider whether an individual or group interview will be most effective and how flexible the interview process will be. In the following section we discuss these issues. [33]

5.6.1 Group vs. individual interviews

When designing a study researchers should examine the benefits of different forms of interviews, deciding between group (focus group) or individual interviews. Group interviews have the potential benefit that participants may feel more comfortable around their peers and that may increase how much they are willing to share, whereas, individual interviews are suggested to provide more privacy for discussion of sensitive topics. LEWIS (1992) suggested using group interviews with youth over 8 years of age, due to youth under this age having a variety of characteristics (i.e. distractibility, memory limitations, receptive and expressive language limitations). If group interviews are the desired interview form researchers should be aware of the suggested influences of same gender or mixed gender groups, personality types, age grouping of participants, popularity, friendship patterns, group size, physical arrangements, and moderators (LEWIS, 1992). KENNEDY et al. (2001, p.185) suggested three benefits of conducting focus groups with youth, including:

> "(a) encouraging group involvement through children's higher level of conformity in the social context of peers, (b) facilitating self-disclosure and decreasing self-consciousness with a peer audience instead of an adult, and (c) modeling acceptance of children's own language and statements."

We would also suggest that a group of youth may offset the inherent power differential between a youth and adult researcher. However, the suggested benefits may not function in the same way with youth receiving mental health services who may not be comfortable in the presence of peers due to interfering symptoms, sensitivity of topic, and lack of proper socialization skills. We agree with KENNEDY et al. (2002) that a researcher should pilot various interview and/or data collection techniques to determine which form or forms are most beneficial for their project. We also assume that the youth's feelings associated with individual therapy and/or group therapy settings may also relate to which type of interview gathers the richest data. Researchers may wish to allow youth to choose whether they prefer a group or one-on-one interview. [34]

5.6.2 Flexibility

In addition to the type of interview technique employed, the researchers should also decide on a level of flexibility allowed in the interview (structured, semi structured, un-structured) (MERRIAM, 1998). Researchers may want to incorporate flexible interview methods when collecting information from youth receiving mental health services. During an interview with a 14 year old female Kathryn discovered that the youth was likely functioning at a younger developmental level as evidenced by her discussion of daily activities (i.e., playing with dolls). After the first few minutes of the interview Kathryn changed the interview questions, communication style, and the expected length of the interview, based on observations related to Kathryn's mental health training. The interview yielded a great amount of detailed information from the adolescent, and we attribute this to the flexibility of the interview process. We also suggest trying to interview youth in a naturally occurring manner. This takes more time and would require "hanging out" in their environment. As topics of interest occur, the researcher has a natural conversation with the youth. This is the primary manner in which Maria has interviewed children and she has found it to be an invaluable technique (EDER & FINGERSON, 2002; LAHMAN, 2008). A final suggestion would be to have repeated group or individual interviews with the youth, thereby establishing a deeper sense of rapport over a period of time (LATHER & SMITHIES, 1997; SEIDMAN, 1997). While these two study designs are recommended they are not often employed due to time and money constraints on researchers. [35]

6. Conclusion

This discussion of considerations when interviewing youth participants receiving mental health services contributes to the methodological literature regarding conducting appropriate and effective research. In this article we have emphasized various suggestions for conducting interviews with youth receiving mental health services; however, this is not an exhaustive list of potential issues or suggestions. Our reflection regarding techniques for interviewing youth receiving mental health services has only begun, and we encourage other investigators to add to the knowledge base. Conducting interview research to discover the experiences of youth receiving mental health services, although complex, will undoubtedly provide valuable insights into the field of youth mental health research. [36]

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