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ABSTRACT

Marginalized youth are at elevated risk for mental health difficulties, yet they encounter numerous barriers to engagement with mental health services. Past negative experiences with family, social workers, and systems of care contribute to distrust of service providers and ambivalence about engaging in trusting relationships with adults. This longitudinal qualitative study explored how marginalized youth living with mental health conditions make decisions about trust in their relationships with helping professionals. Semi-structured, open-ended in-depth interviews were conducted with 13 young women living with a mood or anxiety disorder, exploring trust, mutuality, and disconnection in relationships between marginalized youth and helping professionals. Eleven of the participants also participated in a second interview, 3 months later, that explored participants' relationships with friends and family. Transcripts were analyzed using thematic analysis and interpreted through the lens of relational-cultural theory. Results indicated that the majority of interview participants described feeling unseen, judged, or invalidated in their relationships with family members. Four themes emerged as factors in the assessment of the trustworthiness of service providers: genuine caring; understanding; non-judgmental acceptance; and adult respect for youth agency. Concerns about confidentiality and mandated reporting informed participants' decisions about disclosure in these relationships. Analysis of findings reveals evidence of the central relational paradox in these descriptions of helping relationships, reflecting the simultaneous appeal and peril of vulnerability in relationships, especially relationships characterized by power differentials. Findings suggest that practitioners working with marginalized youth can expect both openness and guardedness in the treatment relationship.

1. Introduction

1.1. Marginalized youth and relationships with supportive adults

For marginalized youth (older adolescents and young adults ages 17–24) in the United States, the transition to adulthood can be a precarious time (Institute of Medicine (IOM) and National Research Council (NRC), 2014). Many of these youth have experienced economic, social, political and/or cultural marginalization as a result of poverty, discrimination, violence and trauma (IOM and NRC, 2014). These experiences have been linked to both higher rates of mental illness (Cicchetti & Toth, 2005; Reiss, 2013) and difficulties in interpersonal relationships (Ahrens et al., 2011; Herman, 1992). For these youth and young adults, relationships with supportive adults are a crucial protective factor (Munson, Brown, Spencer, Edguer, & Tracy, 2015; Ungar, 2013). Supportive adults can be formal mentors (Spencer, 2006), natural mentors (supportive adults with existing ties to youth; (Greeson & Bowen, 2008; Munson et al., 2015; Munson, Smalling, Spencer, Scott, & Tracy, 2010), and social workers or other service providers (Munford & Sanders, 2015a). These relationships provide emotional support, informational support, and tangible assistance (Ahrens et al., 2011; Greeson & Bowen, 2008; Munford & Sanders, 2015a; Munson et al., 2015; Munson et al., 2010; Visser, 2018). Additionally, relationships with supportive adults often serve as foundations for the development or improvement of relationships with others (Geenen & Powers, 2007; Greeson & Bowen, 2008; Spencer, Tugenberg, Ocean, Schwartz, & Rhodes, 2016).

Researchers have identified several qualities that facilitate meaningful relationships between marginalized youth and supportive adults. Young people appreciate adults who understand the complexity of their lives (Munson et al., 2015; Munson et al., 2010; Spencer, 2006). Adult mentors who share interests, backgrounds, or life experiences may be uniquely suited to relate to marginalized youth (Ahrens et al., 2011; Albright, Hurd, & Hussain, 2017; Deutsch & Spencer, 2009; Manuel et al., 2018; Munson et al., 2015; Munson et al., 2010; Spencer, 2006; Spencer et al., 2016). Authenticity, defined as the ability to represent

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oneself fully in relationship (Miller & Stiver, 1997), reliability (Ahrens et al., 2011; Deutsch & Spencer, 2009; Munson et al., 2010) and genuine caring are also traits valued by marginalized youth (Ahrens et al., 2011; Greeson & Bowen, 2008; Munson et al., 2010; Spencer, 2006).

1.2. Engagement in mental health services

American young adults have both elevated rates of mental illness and lower utilization rates of mental health services than other age groups (Kessler et al., 2012; Pottick, Bilder, Vander Stoep, Warner, & Alvarez, 2008). A substantial body of literature has explored the ways that marginalized youth access, engage, and navigate health services (Robards, Kang, Usherwood, & Sanci, 2018). This literature describes numerous barriers, both structural and developmental, that function to limit the abilities of marginalized youth and young adults to access needed services. Structural barriers include the cost of services (Robards et al., 2018; Stafford & Draucker, 2020) services that are not developmentally geared to young adults (Klodnick et al., 2020; Osgood, Foster, & Courtney, 2010), and concerns about encountering discrimination (Robards et al., 2018). Psychological barriers to accessing mental health services include young people's knowledge, attitudes, and beliefs about mental illness and the efficacy of treatment (Munson & Lox, 2012; Munson, Narendorf, & McMillen, 2011; Robards et al., 2018; Stafford & Draucker, 2020); concerns about confidentiality and how providers will relate to them (Anderson, Howarth, Vainre, Jones, & Humphrey, 2017; Robards et al., 2018); and stigma and shame around help-seeking (Munson & Lox; Robards et al., 2018). Gender also plays a role, with research suggesting that females hold more positive attitudes towards mental health services than males (Chandra & Minkovitz, 2006; Munson et al., 2011). In an American cultural context that privileges autonomy and pathologizes dependency (Fineman, 2004; Fraser & Gordon, 1994), older youth and young adults express a preference for handling problems on their own (Samuels & Pryce, 2008; Sylwestrzak, Overholt, Ristau, & Coker, 2015). These desires for self-sufficiency coexist with ongoing needs for emotional support from others, creating a unique tension and relational ambivalence for marginalized youth in helping relationships (Manuel et al., 2018; Munson & Lox, 2012; Munson, Stanhope, Small, & Atterbury, 2017).

Engagement is best understood as a continuum of behaviors, ranging from initial contact with services, intake appointments, and continued retention in and investment in services (Kim, Munson, & McKay, 2012). A key component of engagement is the working relationship, or therapeutic alliance, between clinician and client (Becker, Boustani, Gellatly, & Chorpita, 2018; Robards et al., 2018; Ungar & Ikeda, 2017; Yatchmenoff, 2005). The therapeutic alliance refers to the emotional bond between the client and the therapist and their ability to work collaboratively towards mutually-agreed-upon goals (Bickman et al., 2004; Teyber & McClure, 2011). A strong therapeutic relationship is essential to a positive treatment outcome (Duncan, Miller, Wampold, & Hubble, 2010; Teyber & McClure, 2011; Tosone, 2013).

Marginalized youth, particularly those with past experiences in systems of care, bring unique relational histories to engagement with mental health services (Munson et al., 2015; Scott Jr, McCoy, Munson, Snowden, & McMillen, 2011). Young people who have been involved in the child welfare system may come to therapy with a relational legacy of disappointing and disrupted relationships with family members as well as social workers and other helping professionals (Geenen & Powers, 2007; Lee, Cole, & Munson, 2016; Munford & Sanders, 2015a; Samuels, 2008). Past experiences of trauma, insecure attachment, and negative experiences with service providers can contribute to reluctant participation in mental health treatment (Munson et al., 2015; Munson & Lox, 2012) and distrust of service providers (Klodnick et al., 2020; Munson & Lox, 2012; Samuels & Pryce, 2008; Stafford & Draucker, 2020).

1.3. Trust and the therapeutic alliance

"Therapy is a profession based on trust" (Teyber & McClure, 2011, p. 46); yet the vulnerability and power asymmetries inherent in helping relationships often result in gradual and iterative decisions around trust (Mechanic & Meyer, 2000). Qualitative research with adults living with mental health difficulties shows that the development of trust in relationships with both providers and peer support workers is a process. Clients must decide how much of themselves to share in new relationships with providers and how to know if providers are able to see them as people (Eriksen, Arman, Davidson, Sundfør, & Karlsson, 2014; Eriksen, Sundfør, Karlsson, Råholm, & Arman, 2012; Longhofer, Kubek, & Floersch, 2010). Despite their desire for connectedness, clients struggle with self-disclosure and carefully evaluate professionals on their trustworthiness, given the risks of rejection in self-disclosure and feelings of loneliness that resulted from feeling not understood by others (Eriksen et al., 2012). Similarly, in peer support relationships, the development of trust depends on peers' ability to share power and control, listen to the client, and also share part of their experience (Coatsworth-Puspoky, Forchuk, & Ward-Griffin, 2006).

Despite the importance of trust to a successful therapeutic alliance, many marginalized youth with mental health difficulties are likely to have histories of interpersonal trauma (Lucenko, Sharkova, Huber, Jemelka, & Mancuso, 2015; Ringeisen, Casanueva, Urato, & Stambaugh, 2009). One relational consequence of trauma is difficulties with trust in interpersonal relationships (Burton, Cherlin, Winn, Estacion, & Holder-Taylor, 2009; Kulkarni, 2009; Sparks, 2004; Wolfe, 2006). Experiencing repeated empathic failures from caregivers can lead marginalized youth to expect disappointment from others (Duval & Vincent, 2009). When adults have proven to be unreliable, the decision by young people to withdraw from adults who offer help can be understood as a strategy to maintain their well-being (Ungar, 2013).

In a therapeutic relationship, the development of trust requires a therapist who can communicate compassion, nonjudgmental acceptance, and empathic understanding (Robards et al., 2018; Stafford & Draucker, 2020; Teyber & McClure, 2011). Nonjudgmental acceptance refers to providers who can both feel connected to clients and endorse their autonomy simultaneously (Berlin, 2005; Manuel et al., 2018; Munson et al., 2015). The research on youth relationships with case workers, social workers, foster parents and clinicians indicates that marginalized youth appreciate efforts by helping professionals to forge genuine relationships in spite of the bureaucratic requirements of the role (Munford & Sanders, 2015b; Sapiro & Ward, 2019). Marginalized youth appreciate providers who understand, respect, and welcome their unique ethnic and cultural heritage (Munford & Sanders, 2015a) and their sexual/gender identity without judgment or discrimination (Robards et al., 2018). Other factors that promote engagement include a client-centered focus on the goals of the young person (Klodnick et al., 2020; Ungar & Ikeda, 2017), an avoidance of stigmatizing language (Klodnick et al., 2020; Munson et al., 2016), and a preference for shared decision-making whenever possible (Skehan & Davis, 2017). The literature urges providers to understand the impact of trauma on marginalized youth, while maintaining an ability to see the young person's strengths and potential and not just their problems (Jivanjee, Kruzich, & Gordon, 2009; Manuel et al., 2018; Munford & Sanders, 2015a; Ungar & Ikeda, 2017). More research is needed in this area, since most research on engagement interventions do not focus on older youth and young adults (Skehan & Davis, 2017). Given their need for mental health services and the impact of interpersonal trauma on trust, this longitudinal qualitative study explores how marginalized youth living with mental health conditions make decisions about trust in their relationships with helping professionals.

2. Theoretical framework

This study is informed by relational-cultural theory, a theory of

psychological development that emphasizes the centrality of connection with others for growth and development (Jordan, Hartling, & Walker, 2004). Relationships characterized by authenticity and mutual empathy facilitate growth (Jordan, 2009), while those characterized by power imbalances and lack of mutual empathy can lead to feelings of chronic isolation (Miller & Stiver, 1997). In order for relationships to facilitate growth, individuals must feel able to represent themselves authentically, meaning that they feel comfortable representing their thoughts, feelings and experiences "with increasing truth and fullness" to the other (Miller & Stiver, 1997, p. 54).

Healthy relationships are characterized by mutuality, in which both parties respond to each other in empathic ways that lead to growth (Miller, 2008). Mutuality refers to an openness by both parties in a relationship to being affected by the other person; it does not imply egalitarianism or negation of power differences (Miller & Stiver, 1997). The development of trust in a relationship depends on mutuality (Baumeister & Leary, 1995). However, many people have experiences in family relationships that are nonmutual and characterized by a lack of mutual empathy and chronic disconnection (Miller, 2008). In these relationships, particularly those family relationships characterized by power imbalances, experiences of chronic disconnection lead to feelings of distress and shame in the person with less power (Miller, 2008). Relational violations, including abuse, are the most extreme example of this pattern. Over time, these early relational experiences fuel the development of relational images, which refer to both conscious and unconscious expectations of relationships (Jordan, 2009). These relational images also inform a person's expectations and fears for future relationships (Miller & Stiver, 1997).

Despite the universal need for human connection, past experiences of betrayal or abuse can lead to a wish to avoid further experiences of rejection (Sparks, 2004). Experiencing frequent disconnection, rejection, and shame in relationships creates a paradox in which people simultaneously yearn for connection to help process strong emotions, while at the same time the fear of experiencing further shame or rejection leads them to keep their thoughts and feelings out of the relationship (Miller, 2008). These behaviors are best understood as a survival strategy, sometimes described as strategies of disconnection (Miller & Stiver, 1997). This paradox of seeking connection while at the same time keeping important parts of oneself out of connection is referred to as the central relational paradox. Miller and Stiver (1991) describe it this way:

The central issue is the power of the often unseen desperate reaching for connection, hoping others will perceive and respond to this yearning while simultaneously continuing the techniques for staying out of connection. This is the paradox which patient and therapist face as they undertake therapy. (p. 3).

While the central relational paradox is understood to be universal (Miller & Stiver, 1997), it is particularly pronounced among survivors of interpersonal violence. Feminist scholars have documented the central relational paradox in studies with foster care alumni (Goodkind, Schelbe, & Shook, 2011; Kools, 1999; Samuels & Pryce, 2008), young women in a juvenile detention facility (Sparks, 2004) and low-income mothers with histories of abuse (Burton et al., 2009). However, this pattern has not to date been investigated specifically with marginalized youth living with mental illness, despite their ongoing needs for relationships with health professionals as well as peers, and their reported difficulties in relationships with others (Gilmer et al., 2012; Jivanjee, Kruzich, & Gordon, 2008; Leavey, 2005).

Relational-cultural theory suggests that people who have experienced multiple relational violations in the past may be especially guarded against trusting unknown others in new relationships (Burton et al., 2009; Miller & Stiver, 1997; Sparks, 2004). This study draws on relational-cultural theory to investigate the development of trust in relationships between marginalized youth and helping professionals. Research utilizing relational-cultural theory has elucidated important attributes of successful mentoring relationships (Liang, Spencer, Brogan, & Corral, 2008; Munson et al., 2010; Spencer, 2006); the difficulties of adolescent relational development in the context of interpersonal violence (Kulkarni, 2009); and the challenges of conducting a girls' group in a juvenile detention facility (Sparks, 2004). This longitudinal study seeks to expand the application of relational-cultural theory to understand the relational experiences of marginalized youth receiving services at an urban outpatient mental health clinic.

3. Methods

3.1. Procedure

The data for this study were collected under the auspices of a federally funded developmental feasibility intervention study (R34-MH102525-01A1; PI: Michelle R. Munson, PhD) that took place at an urban outpatient mental health clinic in the northeast United States. The Cornerstone intervention was designed to provide a supportive transition from child to adult mental health services for low-income older youth and young adults, many of whom have histories of maltreatment and involvement in public systems of care. The intervention includes case management, psychotherapy, and mentoring and was provided to youth through a combination of social workers and peer support workers who met with youth both in the clinic and in the community. Youth were eligible for the study if they were between ages 16–20, English-speaking, and living with a primary diagnosis of a mood disorder, anxiety disorder, or a psychotic disorder. Fifty-six youth were recruited for the larger study and randomly assigned to either the intervention condition or best available treatment. In addition to living with a psychiatric diagnosis, all participants came from low socioeconomic backgrounds, and over 80% reported a history of child maltreatment.

For this study, a sub-sample of 13 young women ages 17–20 participated in pairs of in-depth interviews. The first interview explored their relationship with a significant formal helper in their lives. Eleven of the 13 young women participated in a second follow-up in-depth interview three months later, focusing on relationships with peers and family; the remaining 2 participants could not be reached for follow-up interviews. The first author developed and conducted all in-depth interviews based on the literature on the relational experiences of marginalized youth with mental health challenges. First interviews lasted an average of 23 minutes, and second interviews lasted an average of 38 minutes. Immediately following each interview, the author completed a follow-up assessment survey for the larger Cornerstone study, which took an additional 45 minutes. These assessments included a range of measures of social support, maltreatment history, depression symptoms, and measures of recovery. Each young person who completed both the interview and the assessment received $40, as well as transit fare to cover their travel costs. Interviews took place in an empty office at the clinic and were audio recorded with the consent of the participants. This study was approved by the IRBs of both the author's institution and the host institution of the Cornerstone study. All names are pseudonyms, most chosen by the participants themselves.

3.2. Participants

This study focused on young adult women living with mood and anxiety disorders, as they were the most common diagnoses of Cornerstone participants. This is also not surprising, as mood and anxiety disorders are more prevalent among young women than among young men (Merikangas et al., 2010). From the larger group of eligible participants, a purposeful sample of young women that was racially and ethnically diverse were invited to participate (Miles, Huberman, & Saldaña, 2013; Patton, 2002), with the goal of reflecting the diversity of the larger Cornerstone sample.

Interviewees were female-identified participants from the larger study, with a primary diagnosis of a mood or an anxiety disorder

according to DSM-5. All were between the ages of 17–20 and were either current or past service recipients of the mental health clinic. The mean age of interview participants was 18.23 years (SD = 1.01), slightly older than the age of the average Cornerstone participant. Nearly half of the participants were White (46%) with the remaining participants identifying as African American (15%), Latina (15%), and biracial or multiracial (23%). Four out of 13 interview participants (31%) identified as lesbian, gay, bisexual or transgender (LGBT). The majority of participants were low-income (85% Medicaid-eligible), with those not reporting Medicaid eligibility also coming from families who are poor or near poor. Data from the Child Trauma Questionnaire (Bernstein, Ahluvalia, Pogge, & Handelsman, 1997) included in the Cornerstone assessment revealed that 85% of the young women (n = 11) reported a history of at least one form of child maltreatment (physical abuse, emotional abuse, sexual abuse, or neglect).

3.3. Data collection

Semi-structured, open-ended in-depth interviews explored relationships between youth and helping professionals, as well as relationships with friends and family members. In the first interview, participants were first invited to think about a "formal helper," any adult who had been helpful to them in a formal capacity. Eleven participants discussed a current or former therapist or social worker, and 2 discussed educators (teachers and guidance counselors). Four of the helping relationships described were in the past, and the remaining 9 were current relationships. The lengths of these helping relationships ranged from 1 month to over 3 years. In the second interview, participants were invited to discuss relationships with both friends and family. Interview questions explored the nature of support that participants received from both friends and family, acknowledging that relationships often have both supportive and challenging aspects.

Interview protocols were developed using the guiding framework of relational-cultural theory (Miller & Stiver, 1997), focusing on sensitizing concepts of trust, mutuality, and disconnection. A sample question about trust was: "Do you feel like you can trust ___? If yes: How did you decide that ____ was someone you could trust? If not: Why not? What would have to change for you to feel like you could trust him/her?" In the second interview, a sample question about family relationships was: "How is the support you get from your friends similar to the support you get from the people you define as your family? How is it different?" All interviews were recorded and professionally transcribed.

3.4. Data analysis

Two analysts (the author and a doctoral-level research associate with training in qualitative research methods) coded the interview transcripts, using Atlas.TI qualitative data analysis software. Using thematic analysis (Braun & Clarke, 2006), we sought to identify recurring themes in the data and test the applicability of relational-cultural theory to themes identified across interviews.

The author listened to the audio for each interview and corrected the transcripts. Both coders read each interview, making notes on recurring themes, and then compared summaries of the interviews to identify salient themes in participants' descriptions of their relationships. This initial review served as the basis for generating the initial code list for the thematic analysis. Both inductive and deductive codes were developed, using theory and prior research as sensitizing concepts as well as deriving in-vivo codes from the text itself (Boyatzis, 1998; Padgett, 2008). Using the code list, as well as in-vivo codes, the author coded all 24 interviews, using Atlas.TI qualitative analysis software. The second analyst coded one quarter (n = 6) of the interviews. Both coders met to discuss areas of discrepancy and resolve disagreements around theoretical concepts. The author grouped the codes into overarching themes and sub-themes, using conceptually-clustered matrices (Miles et al., 2013) to provide evidence for emerging themes in cross-case analysis.

Several strategies were employed to ensure the rigor of this study, including keeping an audit trail, triangulation of data sources and analysts, peer debriefing, and member checking. Eleven of the original 13 participants participated in a second interview, during which the author shared with them a written summary of the first interview as a way to check the accuracy of the interpretation.

4. Results

The majority of interview participants described feeling unseen, judged, or invalidated in their relationships with family members. Empathy and nonjudgmental acceptance were also relevant dimensions by which participants assessed the trustworthiness of helping professionals. The decisions participants made about trust and disclosure in these relationships revealed a "both/and" tension in most participants – a desire to be open with professionals, alongside continuing wariness and guardedness in these relationships. This section first discusses the lack of understanding and acceptance in participants' family relationships. It then discusses four themes that emerged in analysis of interview transcripts related to the process of assessing trustworthiness in a helping professional. It concludes with a discussion of decision-making around disclosure in helping relationships and an illustration of the central relational paradox in participants' descriptions of their relationships with helping professionals.

4.1. Lack of understanding and acceptance in families

Perhaps unsurprisingly for a group of older youth and young adults, nearly every interview participant in this study who talked about family relationships mentioned some aspect of her life experiences that her family did not understand. The empathic failures, or acute disconnections, they described fell into three distinct but sometimes overlapping categories. Some participants described their parents' difficulties to understand and accept their sexual identities. For example, Lola discussed her father's difficulties accepting her coming out:

he was very off about it, like he didn't believe me. And it kind of sucks when you're a person and you have these qualities and you have these traits about you that they're just not real to people…that kind of sucked.

Similarly, Thefa described her father's inability to accept her sexual and gender identity:

if I talk to him about wanting to date another girl, he'll lose his mind…Or if I tell him, you know, that I want to cut my hair short, like I did, he'll lose his mind because that's not feminine.

Other participants mentioned parents who struggled to grasp their mental health challenges. In one example, Angela expressed frustration with her mother's inability to empathize with her struggles with her mood:

And my mom, she tried to say I'm a crazy person and all this extra stuff and how I need the pills when I get upset and I just be like it's just a bunch of stuff overwhelming me and I literally have nobody to talk to about it.

Some participants believed that their families' cultural backgrounds and beliefs made it more difficult for them to understand their need for mental health treatment. Z explained:

My mom and my grandma, they're from Eastern European backgrounds, so they're like very conservative minded. It's kind of hard to talk to them about stuff that I experience. And also they really don't understand mental illness. They think it's something that you could just smile and everything will be okay, and that's like a big problem.

Several participants identified themselves as either children of immigrants or members of families with strong ethnic, cultural, or religious identification. These participants talked about their families' failure to understand their desire for independence from communal

expectations. Leigh described how generational differences and cultural beliefs affect her relationship with her mother:

Like her life is about honor, my mom. Without your honor, you are nothing, you know, and for her if you have sex, that ruins your honor, like before marriage. If you do drugs, she's very like super old fashioned. She says I can't date anybody until I'm ready to get married. And I can't explain to her that I need to date before I start looking for a potential husband, because I need to know what qualities I like and I don't like…. But she doesn't even understand that, but like we butt heads so much because she's so old fashioned and I'm more modern. But I am, it's how she was raised, so I just respect it.

For many reasons, most participants felt misunderstood by members of their families. Consequently, most sought evidence of understanding and acceptance in evaluating the trustworthiness of helping professionals.

4.2. Factors in assessing trustworthiness.

Interviewees agreed that the establishment of trust in a helping relationship is a process that develops gradually over time. Many participants acknowledged that they began relationships with professionals with fairly low expectations. For some, this was grounded in a relational image they held from a previous relationship; those participants who had negative experiences in a previous helping relationship were less inclined to trust professionals going forward. Others had more generalized expectations of professionals as unhelpful at best or harmful at worst. Four factors emerged related to the development of trust in relationships with helping professionals.

4.2.1. Genuine caring

The presence of genuine caring in helping professionals was very important to participants. Young people described how they evaluated whether adults truly cared about them as people or were just "doing their job." Yasmine explained how she looked to see whether her therapist would respond to her with genuine emotion:

when you see a therapist, like you wanna see first like if, what they're reacting when you're saying things about stress and how they're reacting to things that are good… And when I was talking about stressful things, she was just like concerned and trying to be helpful and when it was happy things, she has this really happy look on her face and I'm like yep, she cares. That's what's important.

Leigh described how she began her most recent therapeutic relationship by lying to her therapist. Her previous experiences in therapy had left her feeling disillusioned: "I've seen a handful of therapists before that and I never felt like anybody was genuinely interested in helping me, like it was just, I was just going there and it was just their job to listen to me." Leigh described herself as someone who was habitually dishonest in therapy, and who had a poor impression of the therapists to whom she had been lying: "I was just like I thought that you guys just shook your heads to everything that I said and then I just went on my day." She found one therapist's directness and insistence on her honesty to be an expression of genuine caring and desire to help:

'Cause she called me out, like she said it, she told me I could just sit there and not say anything, or I could say the truth, but to not lie to her. And that, when she said that I was like yeah, she doesn't wanna hear bullshit. She wants to help or there's no point of me lying.

For Leigh and other participants, the communication of genuine caring and interest on the part of helping professionals furthered the development of trust.

4.2.2. Understanding

Most participants described the importance of feeling understood and having their experiences validated when speaking with a therapist or educator. Rosie appreciated that her guidance counselor was conscientious about checking that his understanding of a student's needs continues to be accurate:

He listens and asks questions and sits there and like makes sure he gets like the whole situation correctly and then he like checks with you before he does any actions, which is a really nice thing that he does. He like is like, "Is this okay for you?" He like double checks it all to make sure like in case you have any last things you need to say, and like it's like he's like doing his job in a way that actually helps the student and not just what the job requires…

Leigh described working with a social worker who understood that she was often overwhelmed by the content of their sessions and would sometimes walk out of session:

'Cause she understood like I was just too overwhelmed in that moment. And then the next session we had, she'd be like, "I hope you don't walk out this time!" You know, and I'm like, "I hope I don't either, so don't push me too much!"

The demonstration of thoughtful, nuanced understanding by adults of young people's needs and life circumstances was another important factor in the development of trust in these relationships.

4.2.3. Non-judgmental acceptance

Judgment was a recurring theme related to the development of trust, in regard to whether or not helping professionals were able to project an accepting and nonjudgmental stance. Participants appreciated feeling accepted in their relationships with therapists; many referenced this trait explicitly as something that helped them trust their therapists. Flower described her therapist's support in terms of her nonjudgmental acceptance: "She never judged, you know, because I've been through a lot." Similarly, Yasmine appreciated that her therapist was nonjudgmental, explaining, "I'll just complain about anything and she will not judge me… Which is part of her job, but it feels good."

At the same time, a number of participants referenced a concern about encountering judgment in the treatment relationship. For some, it was expressed as a worry that the professional would see them through the restrictive lens of a stereotype based on their age, their sexuality, or their status as a client in need of mental health services. Thefa talked at length about how much she appreciated her therapist and how much she had grown as a result of their work together. However, she was careful to point out that she was initially concerned to work with an older therapist whom she worried might stereotype her as a young person:

But that didn't necessarily mean I trusted her at first, so like I was a little wary about certain things, wary about how she would react 'cause… she was an older therapist so I wasn't sure you know, how open to things she would be and you know, when, when you're like LGBT, millennial, and you know, you know a lot of people think oh, you're just a kid, you're stupid, you don't know anything and you have all these bizarre ideas that no one else believes in, it's like you know, worrying when you meet someone who's older.

Other factors, including social class, were also mentioned by participants as potential sources of judgment by helping professionals.

4.2.4. Respect for youth agency

The final trait that came up in interviews as a facilitator of trust in helping relationships was the perception that professionals were respectful and aware of the power differential in the helping relationship. This meant that they made an effort to affirm the right of young people to make their own decisions wherever possible. This theme manifested in a few forms. For some participants, they appreciated having therapists who allowed them to direct the flow of the session and did not impose their own agenda. For example, Angela appreciated her therapist's emphasis on making the session about her. She explained, "She's so nice! She makes the session about me, she doesn't cut off any of my sentences. She lets me finish my sentences and then waits a full 3 seconds before she says, 'So what I'm hearing is…'"

Other participants emphasized the importance of their therapists working collaboratively with them – seeking out their input, respecting their ability to make decisions, and avoiding patronizing language.

Thefa explained how much she appreciates her therapist helping her with decision-making, while feeling that she ultimately retains control over her own decisions. She described how whenever she and her therapist disagree on something, their conversation consists of

debating on you know, options and stuff. She gives me a bunch of options and it's like let's lay out the pros and cons and then you pick one….'Cause she never feels the need to force me into doing one thing or the other. I feel very much that I have a lot of control with her, which is really important to me.

Many young people described previous relationships with therapists in which they did not feel that their agency was respected. Lola had a previous therapist whom she experienced as overly directive:

But I had a therapist previously – I've had a lot of therapists – and she pretty much, every time I said how I didn't wanna have a relation with my mom, she would shove it down my throat that I should and that I'm just being stupid and I need to change my mind.

Rosie also valued her counselor for his ability to focus on "what the student actually wants and what would be beneficial for the student." She explained how he took her concerns seriously when she went to him with a complaint about a teacher: "Like he wasn't just like, you know, 'I'm sure she's just trying to do this' and like he took my complaint seriously." For these youth, the experience of having their autonomy and right to make decisions respected in a helping relationship was a major factor in building trust.

4.3. Decisions about disclosure: Confidentiality and mandated reporting.

Another topic that was a key factor in the development of trust and participants' decisions around disclosure was the confidentiality of the helping relationship. A few participants specifically referenced the confidentiality of the treatment relationship as an important facilitator of trust. Z explained: "I kind of automatically trust social workers, because I know there are certain like rules that they cannot like break like confidentiality…" Yasmine was also appreciative of the confidentiality in her relationship with her therapist: "Oh man, I talk to her about anything… There's a whole confidentiality thing that wraps around this place."

At the same time, several participants mentioned mandated reporting of child abuse and neglect as a factor in their decisions about disclosure. Francesca referenced a belief that disclosure to therapists can be risky, as a result of their mandated reporting obligations:

But I was taught also by my mom and then other, like I don't know, just in general I feel like there's a lot of fear of therapists and psychiatrists, and like you say this and this will hurt your life forever.

Three participants mentioned this as playing a role in their decisions what to share with professionals. Thefa stated that she can tell her therapist "just about anything," but admitted to feeling nervous talking about past experiences of abuse, even though she was no longer a minor:

I'm a little afraid to tell her in regards to like you know, some of the abuse I've gone through and stuff… I do worry at times that you know, if I tell her something, it may prompt her to like you know, tell somebody because I've always had that kind of hanging over my head through the school system and stuff, like you know… You can tell us anything, but if you tell us a certain thing, we have to tell somebody about it and you know, it's hard to get used to that not being as much of a thing.

In a similar vein, Ocean described her choice to focus on her own individual concerns in her therapy sessions, and reflected that she is "very careful" to avoid speaking about her family because she had a previous bad experience with a therapist violating her confidentiality: "Because my bad experience had to do with my family…And I'm scared of that being repeated…So I don't really bring up my family as much." Confidentiality and its limits were a clear factor in the ways these youth made decisions about what personal information to share with helping professionals.

4.4. The central relational paradox in helping relationships.

Nearly all interviewees expressed both a desire to disclose and thus benefit from their relationships with professionals, alongside wariness about the potential risks of disclosure. This tension is referred to in relational-cultural theory as the central relational paradox, and it reflects the simultaneous appeal and peril of vulnerability in relationships, especially relationships characterized by power differentials. For most participants, this tension was not easily resolved – it continued to manifest in the ways they talked about relating to professionals, opening up and holding back.

A number of participants discussed both how much they valued the ability to be open with their therapists, while also feeling wary about disclosure. For example, Lola said of herself, "it's hard for me to open up to people." She admits that she still struggles between talking about her feelings openly and being "closed off" to others:

Like I wanted help and it took me a while to realize I wanted help, but I didn't know how to get that help because I felt like I was being so closed off…And I still do that now where I'll go through periods of being very like closed off from people.

At the same time, she described herself as very willing to talk about topics that are important to her, even if they are sensitive or potentially stigmatizing: "I feel like if I wanna talk about something, I'll talk about it, and if it does me good, then I'll talk about it till I get blue in the face."

Thefa quite eloquently captured the central relational paradox when she described her attitude towards disclosure: "Yeah, I mean like in regards to you know, telling people things. I'm very, very open…. And I'm also very afraid, and that doesn't mesh well." With regards to her therapist, whom she initially worried would judge her based on her age or sexual identity, she said, "I'm pretty open, I can tell her just about anything and not really be too worried about it."

Participants identified a number of reasons for their guardedness in therapy. Some described themselves as temperamentally shy or disinclined to open up to others, like Flower: "Honestly, I'm not the type of person who will open up to anybody that quick." For a few participants, their reluctance to open up to a new provider was connected to past feelings of loss. Jessica described working with a series of therapists, each of whom left the clinic, severing the relationship. With one therapist, she did not feel strongly connected, and then noted, "Although we started to have one slowly, but then sadly when we have some kind of a connection, they have to leave."

Other participants attributed their reluctance to be vulnerable in session to feelings of fear, shame, or embarrassment. Leigh was guarded about her drug use with her therapist and struggled with worries about how her therapist would perceive her if and when she relapsed:

Well in the beginning, yeah, of course, like I felt like I couldn't discuss anything with her but as we became more open, I just felt like I couldn't discuss if I used the drug, I was like, I didn't wanna tell her because I felt like she would look down at me and be disappointed in me.

Reflecting on her work with this therapist, Leigh said, "she showed me how good, like how helpful being honest with her and to myself could be."

Francesca cherished her candid relationship with her therapist and admitted that she feels that she is comfortable enough that "I don't need to watch what I say." At the same time, she also admitted that as open as she is with her therapist, "there are things that I probably haven't said to her yet or maybe never will that I just like don't bring up because maybe I don't want to talk about them."

5. Discussion and limitations

This study is subject to a number of limitations. The interviews were not developed with the direct input of marginalized youth with lived experience of mental health challenges. The situating of the data collection within the larger Cornerstone study and in the physical environs

of a mental health clinic may have led some participants to feel less comfortable criticizing their current therapists. As a consequence of the interviews being paired with follow-up assessments, interviews by necessity were time limited in order to minimize participant burden.

In addition to the inherent challenge of describing dynamic interpersonal processes, interviews were limited by the extent to which participants were willing to share personal information with the author, a relative stranger. While all research participants make choices about what to share with an interviewer, and for young people, this is an important source of power and control (Raby, 2007), several participants seemed intentionally vague in their interviews with the author. In some cases, respondents spoke freely about certain areas of their life experiences (such as their mental health histories) and were circumspect about other areas (most often family history). This combination of openness and withholding responses is of course a source of data in itself, another form of the central relational paradox manifesting in the research setting. The study attempted to address the expected reticence of participants by conducting two interviews with each participant. In general, participants were more engaged and more forthcoming during the second interview.

Notwithstanding these limitations, this study's findings contribute to the literature in several ways. The findings reinforce the existing knowledge base on engagement in mental health services. Echoing the findings of Anderson et al. (2017) and Robards et al. (2018), these participants expressed concerns about the confidentiality of the working relationship, as well as concerns about how they would be treated by service providers. Findings show that older youth and young adults value confidentiality, and at the same time are acutely aware of the limits to confidentiality in helping relationships. Marginalized youth, even though they may have reached the age of majority, may have vivid memories of experiences in which disclosures to therapists resulted in a report of possible child maltreatment. These findings suggest practitioners working with marginalized youth need to explicitly solicit and address the concerns their clients may hold about disclosure in the therapeutic relationship.

At the same time, these findings also support existing research on factors that facilitate the development of trust in helping relationships. Genuine caring (Greeson & Bowen, 2008; Munson et al., 2010), nonjudgmental acceptance (Manuel et al., 2018; Munson et al., 2015; Powers et al., 2018), and understanding (Munson et al., 2015; Munson et al., 2010) have all been found to facilitate relationships between marginalized youth and supportive adults. Given the importance of trust for engagement in mental health services, understanding how marginalized youth evaluate the trustworthiness of providers is essential for ensuring that they are able to participate in mental health treatment. Even in the absence of shared lived experience, effective clinicians can communicate acceptance and deep understanding of their clients' lived realities.

In addition, these findings show that participants appreciated when adults respected their agency in the treatment process, by affirming their rights to choose the focus of sessions, direct the flow of conversation, or make decisions on their own as appropriate. Many marginalized youth, particularly those with histories of involvement in systems of care, have had few opportunities for self-determination (Powers et al., 2018). These findings point to the importance of a person-centered approach that includes older youth and young adults as active partners in the treatment process. This approach is found in a number of developmentally appropriate and theoretically informed programs that support the growing abilities of older youth and young adults to make decisions for themselves. Examples of these programs include the Transition to Independence Process model (Dresser, Clark, & Deschênes, 2015), the My Life model (Powers et al., 2018) and the Just Do You model (Munson et al., 2016). These programs are all grounded in principles of positive youth development and emphasize self-determination, shared decision making, and learning in relationship. These principles also fit well with relational-cultural theory, which posits that participating in authentic, respectful, mutually empathic relationships leads to a greater ability to act and a stronger desire to connect with others (Miller & Stiver, 1997; Munson et al., 2016; Powers et al., 2018).

These findings also illustrated a number of concepts from relational-cultural theory. For many participants, experiences of chronic disconnection in their families led to the use of strategies of disconnection (Jordan, 2009) in their relationships with helping professionals. Indeed, many youth with trauma histories protect themselves by keeping a strategic distance from well-meaning adults (Ungar, 2013). Similar to Munson and Lox (2012), participants who had previous negative experiences with service providers entered therapy with low expectations for treatment and a distrust of service providers. These findings build on literature that has demonstrated the presence of the central relational paradox in foster care alumni (Goodkind et al., 2011; Kools, 1999; Samuels & Pryce, 2008), young women in a juvenile detention facility (Sparks, 2004) and low-income mothers with histories of abuse (Burton et al., 2009). In this study, youth expressed both a desire to open up to helping professionals, alongside feelings of wariness about the consequences of being open. For service providers, these findings suggest that trust building is not a straightforward or linear process; rather, it is dynamic and nuanced. Among marginalized youth and young adults, a desire for connection coexists alongside a wariness about disclosure in the working relationship, even among participants who had been working with their therapists for several months or longer.

Findings show that participants experience various kinds of marginalization and disconnection in their families of origin. These findings suggest that even motivated participants come to treatment with numerous concerns, including stereotypes of social workers as harmful or uncaring; past negative experiences with social workers or other adults who failed to demonstrate respect for the young person's needs and wishes; and concerns about the potential for judgment or misunderstanding based on perceived differences. These concerns may be magnified for youth with histories of involvement in systems of care (Geenen & Powers, 2007; Greeson & Bowen, 2008; Munson et al., 2015), and can function as a barrier to connection. Service providers can address these concerns explicitly at the beginning of the working relationship and acknowledge the real and understandable barriers to trust that many young people bring to therapy.

Connectedness with others is a crucial developmental asset for older youth and young adults (Dresser et al., 2015), yet relationships remain a relatively understudied component of the transition to adulthood. In an American cultural context that prioritizes independence as a marker of adulthood (Samuels & Pryce, 2008), there is much more to understand about how youth make decisions about opening up to helping professionals as well as peers. Future research should explore the experiences of young men in relationships with supportive adults. Research is also needed to explore the friendship and dating experiences of marginalized youth living with mental health challenges.

6. Conclusion

Marginalized youth comprise a population with high and frequently unmet needs for mental health services. These findings help illustrate the process by which older youth and young adults assess the trustworthiness of helping professionals and make decisions about personal disclosure in these relationships. Many of the marginalized youth in this study felt misunderstood and judged by family members. For these participants, the presence of genuine caring, understanding, nonjudgmental acceptance, and respect for youth agency all factored into their decisions about whether or not to trust helping professionals. This study shows that even among marginalized youth who can readily identify their motivations for participating in therapy, feelings of wariness coexist alongside their desire to be open with helping professionals. Providers seeking to build genuine and lasting relationships with these young people should recognize both the wishes and the fears that these

youth bring to the treatment relationship. Providers who are able to take time to build respectful, authentic relationships and engage older youth and young adults as partners in the treatment process can support the development of growth-promoting relationships. Patience with the process, along with a willingness to directly address concerns about trust, judgment, and disclosure, can support the development of a genuine, trusting relationship.

Conflict of Interest

Beth Sapiro declares no conflicts of interest.

Author Statement

Beth Sapiro conceptualized this paper, designed the methodology, conducted all interviews, analyzed all interviews, and wrote up the analysis as part of the work for a PhD dissertation.

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