A Portfolio of Study, Practice and Research Submitted for the Doctorate of Psychology (PsychD) in Clinical Psychology (Conversion Programme); University of Surrey.

ADOLESCENTS' EXPERIENCE OF RECEIVING HELP FROM A MENTAL HEALTH SERVICE: A GROUNDED THEORY APPROACH


1998
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2. Copy of the candidate’s clinical psychology degree qualification

3. Dissertation submitted by the candidate (in 1985) in part fulfilment of the requirements for the British Psychological Society Diploma in Clinical Psychology, entitled: Self-management of disruptive classroom behaviour in 10-12 year old boys
Acknowledgements

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Lastly, thank you to my best friends and supporters for their patience, encouragement and belief, my partner Maire, and my daughters Stefane and Maeve to whom I dedicate my work on this portfolio.

Pat Corbett
October, 1998.
Summary of the content of the portfolio

This portfolio comprises five sections. Section One consists of the candidate's personal study plan. In this section, the overall aims of the portfolio are outlined as are the aims, objectives, rationale and plan for each of the three dossiers, academic, professional and research.

Section Two comprises the academic dossier and contains three academic reviews of approximately three thousand words each. These reviews address respectively 'Problems in settling to sleep and night-waking in early childhood', 'The prevalence and correlates of suicidal ideation and behaviour in childhood and early adolescence' and 'Adolescent motherhood and child maltreatment.'

Section Three comprises the professional dossier and has two sub-sections. The first sub-section is a report of a service development project entitled 'Intervening in a special school in relation to management of behavioural difficulties.' The second sub-section consists of an outline of the candidate's post-qualification curriculum vitae.

Section Four comprises the research dossier. This is a report of a study entitled 'Adolescents' experience of receiving help from a mental health service: a grounded theory approach.'

Section Five contains the additional materials required to be included in the portfolio. These are a course summary of the British Psychological Society Diploma in Clinical Psychology (completed by the candidate in 1985), a copy of the candidate's clinical psychology degree qualification, and a reformatted copy of the dissertation submitted by the candidate in part fulfilment of the requirements for the British Psychological Society Diploma in Clinical Psychology.
Section One: Personal Study Plan

Name: Patrick Corbett

Date of Registration: April 1995

Registration Number: 3418316
1. **Overall aims**

1.1 To attain greater professional competence in order to enhance the contribution of clinical psychology to health care.

1.2 To enhance and promote the standing of the psychology department with the Southern Health Board’s services.

1.3 To promote the principle of continuing professional development within the psychology department.

1.4 To fulfil a personal ambition.

2. **Academic**

2.1 **Aims**

2.1.1 To enhance my academic competence in three specialist areas of clinical psychology so as to develop the services offered by the department and the profession.

2.1.2 To update the provision of literature regarding these three areas within the department.

2.1.3 To promote the integration of theory and practice in the clinical work of the department.

2.1.4 To develop the knowledge of other members of the department through the presentation of seminars.

2.2 **Objectives**

2.2.1 To complete three critical academic reviews, one for each of the three specialist areas.
2.2.2 To acquire specialist and updated knowledge in each of these three areas.

2.2.3 To enhance my competence in critical evaluation of the research literature in clinical psychology.

2.3 Rationale
The author's department is currently concerned that demands exist for services in the three areas reviewed and that the academic knowledge of the department in these areas is not completely adequate.

2.4 Plan
To complete critical academic reviews in the following three areas:

1. Problems in settling to sleep and night-waking in early childhood.

2. The prevalence and correlates of suicidal ideation and behaviour in childhood and early adolescence: a review of recent research.

3. Adolescent motherhood and child maltreatment: a review of recent research.

3. Professional

3.1 Aims

3.1.1 To increase personal professional competence.

3.1.2 To develop the range of services offered by the department.
3.2 Objectives
3.2.1 To describe a service development undertaken and to place it in its psychological framework.
3.2.2 To obtain experience of working with an organisational perspective.
3.2.3 To increase competence in the use of a consultation model.

3.3 Rationale
The project described afforded the opportunity of developing a model of service delivery which could be used to respond to a number of demands currently being made on the author’s department.

3.4 Plan
To complete and to provide an account of a service development project entitled: Intervening in a special school in relation to management of behavioural difficulties.

4. Research
4.1 Aims
4.1.1 To increase the author’s research competence.
4.1.2 To increase the research knowledge and skills available to the author’s department with particular reference to qualitative research.
4.1.3 To improve the standing of the author’s department as a research resource within the Southern Health Board.
4.1.4 To begin to enable the child and adolescent client’s ‘voice’ to be heard by clinicians, service planners, and providers by obtaining the young people’s own accounts of their experience as clients.

4.2 **Objectives**

4.2.1 To carry out and report on a research project which will make evident increased research competence.

4.2.2 To produce a piece of research which will be a contribution to knowledge.

4.3 **Rationale**

Little research has been carried out on young clients’ experience of receiving help from a child and adolescent mental health service. The present study afforded the opportunity to explore this experience in a rigorous way while foregrounding the young clients’ own accounts.

4.4 **Plan**

To complete and provide an account of a research project entitled: Adolescents’ experience of receiving help from a mental health service: a grounded theory approach.
Section Two: Academic Dossier
Problems in settling to sleep and night-waking in early childhood
Introduction

Sleep problems in young children are both common and distressing. According to Bartlett et al. (1992) “most sleep disorders in early childhood resolve without help from professionals in the community or hospital” (p.67). It could be argued, therefore, that treating these difficulties constitutes a poor use of professional resources. The other side of the story however, is that families of children with sleeping difficulties can often suffer two or three years of misery before things improve. “Depression, fatigue, parental accident-proneness, marital disharmony, child abuse and day-time behaviour problems are commonly associated with sleep problems” (Bartlett et al., 1992, p.267). The majority of studies of sleep-related difficulties have focused on night-waking as the primary problem; the second most common problem investigated is that of difficulty in settling to sleep (Stevenson, 1993). These are also the most frequent sleep-related problems referred for clinical assessment and management. In a review of five years experience of a clinic for children’s sleep problems, Bartlett et al. (1992) do not define or describe the problems they dealt with, other than referring to them as “sleep problems” or “sleep disorders”; however, a reading of their article makes it clear that over 90% of the problems presenting were difficulties in initiating and maintaining sleep. In this review the concern is only with difficulties in night-waking and settling to sleep; however, to avoid awkwardness in style the terms, sleep disturbance or sleep difficulties are used as shorthand for these two problems.

The primary concern of this review is to clarify the implications of the research evidence for clinical management of children’s sleep difficulties; the emphasis therefore will be on problems as reported by parents rather than problems as defined by researchers; of course management of the former is informed by data from the latter, and while not being reviewed in detail, reference will be made to researcher-defined measures as appropriate.
Prevalence of sleep-onset and night-waking problems in young children.

Problems in initiating and maintaining sleep are common among preschool children. A commonly accepted definition of sleep problems in early childhood is that of Richman (1981); she defined problem sleep in 1-year-olds as either sleep onset periods associated with fussing that last longer than 30 minutes on a regular basis, or night-waking episodes that occur at least four nights a week and require parental intervention. The following studies used parents’ reports in community-based samples. Frequent night waking (4 or more nights per week) occurs in approximately 20% of 1 to 2 year-olds, 14% of 3 year olds and 8% of 4 year olds; difficulties in getting to bed/settling to sleep occur in 12.5% of three year olds and 5% of four year olds (Jenkins, et al., 1980; Richman, 1981; Richman, et al., 1975). These two problems are often found together; 55% of 1 to 2 year olds and 29% of 3 year olds who wake in the night also have trouble settling to sleep (Richman, 1981; Richman et al., 1975).

Persistence of sleep-onset and night-waking problems in childhood.

There is considerable continuity in sleep disturbance in early childhood. Jenkins et al (1984) found that 44% of children with frequent night-waking at 6 months continued to show it at 1 year; of the night-waking babies at 1 year, 41% continued to show it at 18 months; from 18 months to 2 years, 54% continued with the problem.

In a follow-up study, Kateria et al. (1987) found that 84% of children with sleep disturbance at 15 to 18 months continued to have problems three years later. Richman et al. (1982) found that almost half of 3 year old ‘wakers’ in their study had had their problems from birth, and that 40% of the children who had sleep problems at 8 years had had problems at least from the time they were 3 years old. These reports suggest that sleep problems in infancy are often persistent and may lead to chronic sleep difficulties.
Research on associated factors

Perinatal Experience
Specific problems (mild asphyxia, longer labour, longer time to cry after birth) during pregnancy, labour, and delivery have often been shown to have some predictive relationships to later sleep difficulties (Blurton-Jones et al., 1978; Richman, 1981); longitudinal studies by Moore & Ucko (1957) and Bernal (1973) found that poorer Apgar ratings at birth were associated with greater sleep problems as reported by parents in later infancy. Richman (1985) reported that an experimenter-defined sleep-problem group were twice as likely to have had adverse perinatal events as compared to a control sample which did not have sleeping difficulties.

Adverse perinatal difficulties may have as consequences hypertonicity and raised responsiveness to stimulation; these characteristics may lead to increased crying, continued night-waking and feeding difficulties. It seems inevitable that these behaviours would influence parental perceptions, emotions and behaviour, which in turn would have effects on the child's behavioural pattern.

Birth weight and prematurity
Many studies have failed to find an association between sleep difficulties in infancy and low birth-weight (Grunwaldt et al., 1960; Moore & Ucko, 1957) or prematurity (Zuckerman et al., 1987; Anders et al., 1985). In a recent prospective epidemiological study (Wolke et al., 1995) of preterm infants, no differences in sleeping behaviour compared with healthy term children were found at twenty and fifty six months of age.

Sex
A number of studies have failed to find a significant association between sex and sleep difficulties (Moore & Ucko, 1957; Bernal, 1973; Jacklin et al., 1980; Zuckerman et al., 1987); all of these studies used parents' reports. Studies using automated recording devices have also not found a relationship between sleep difficulties and sex in young children (Thoman & Whitney, 1989; Anders et al., 1985).
**Infant temperament**

Findings in this area are extremely difficult to interpret. There are indications of a relationship between sleep problems and parents’ ratings on temperament questionnaires (Carey, 1974; Weissbluth, 1981), parents’ retrospective recall of baby activity (Blurton-Jones et al., 1978) and parents’ retrospective recall of irritability. However, in aetiological terms no conclusions can be drawn from studies using parents’ ratings of temperament as such ratings are to some extent subjectively determined (Bates, 1983; Bates & Bayles, 1984; Zeanah et al., 1986). Present data do not allow us to come to any conclusions regarding an aetiological role in sleep difficulties for child temperament.

**Infant self-soothing**

Polysomnographic and time-lapse video studies of infants have shown that they do not sleep continuously through the night (Anders & Keener, 1985). Many of them wake for brief periods and return to sleep without their parents’ knowledge. Settling back into sleep by infants without parental attention has been termed self-soothing. Approximately 44% of 2-month olds, 78% of 9-month olds and 60% to 70% of 1-year olds appear to be able to self-soothe (Anders et al., 1992). The development of this capacity and its use by infants seem likely to be influential regarding whether or not sleep difficulties present. However, it is unclear how either its development or its use by infants are influenced by or interact with the other factors reviewed above (Anders et al., 1992).

**Socio-economic status**

Different types of investigation have consistently failed to find an association between night-waking and socio-economic status (Moore & Ucko, 1957; Butler & Golding, 1986; Bernal 1973; Scott & Richards, 1989; Zuckerman et al., 1987).

**Maternal depression**

A number of investigations have reported that maternal depression is associated with children’s sleeping difficulties. Richman (1981) found a higher rate of maternal depression in an experimenter-defined sleep-problem group of toddlers, as compared to
a control group. Zuckerman et al. (1987) found that maternal depression at eight months was associated with persistent sleep problems at eight months and at three years. Guedeney & Kreisler (1987) and Scott & Richards (1990) also reported relationships between sleep problems in the first 18 months of life and maternal depression. However, as all of these studies were correlational and cross-sectional in design, it is not possible to ascribe causality.

**Parental night-time behaviour**

One of the more consistent research findings in relation to sleep problems in early childhood is the association of sleep problems with parental night-time behaviour. Blurton-Jones et al. (1978) reported that mothers of an experimenter-defined sleep problem group at 15 months were more likely than the rest of the sample to pick the baby up at night and then let the child settle. Adair et al. (1991) reported that infants whose parents remained with them at bed-time until they went to sleep were significantly more likely to wake at night than infants whose parents did not. Wolke et al. (1995) in a study of sleep difficulties of infants admitted to Special Care Baby Units reported that parental interventions such as staying with the child until asleep and taking the infant into bed at night were related to night-waking problems.

Unfortunately, the designs of these studies do not allow for any ascription of causality.

However strong support for ascribing a causal role to parental night-time behaviour comes from three well-controlled studies with a preventive approach. Adair et al. (1992) investigated the provision of advice to parents at child age: 4 months “to begin establishing a bed-time routine that included putting their infant into the crib partially awake so the child could learn to go to sleep without an adult being present” (p.586). They used a prospective cohort design with historical controls; there were 164 infants in the intervention group and 172 in the control group. They found that at child age: 9 months, the intervention infants were reported to experience significantly less night-waking (p=.02) and to be significantly easier to settle to sleep (p=.009) than control infants.
Wolfson et al. (1992) taught first-time parent couples that “infants do not require parental assistance to fall asleep” (p.43). These authors randomly assigned first-time parent couples to a four-session training group (n=29) or a control group (n=31); their results showed that at age 6 to 9 weeks, infants in the training group displayed significantly better sleeping patterns than did control infants.

Pinilla & Birch (1993) investigated “the effects of a behavioural training programme focused on facilitating the breast-fed infant’s transition to sleeping through the night” (p.437). They randomly assigned twenty-six first-time parents to treatment and control groups (13 in each group); a short-term longitudinal design was used, from the last trimester of pregnancy to until the eighth week after birth. The parents in the treatment group “were instructed to try not to hold, rock or nurse their infants to sleep, to accentuate differences in environmental cues for day and night-time hours (.....) to feed the infant at a focal feeding time each night (between 10.00pm. and midnight) and to make sure the infant was really complaining before picking him or her up (the difference between crying and whimpering was discussed)” (p.378). They found that at 4 weeks 38% of infants in the treatment group were sleeping through the night (defined as lasting from midnight to 5.00am.); “by 8 weeks, all infants whose parents received training instructions were sleeping through the night, compared with only 23% in the control group” (p.442).

The results of this study are so good that replication seems very important. A useful improvement of the study would be the use of video-recording of the infant’s night-time sleep, rather than dependence on parents’ diaries. Despite this point, however, the results of Pinilla & Birch (1993) do appear to provide fairly strong evidence of the influence of parental night-time behaviour on their infants’ sleep patterns. More specifically the results of all of the studies in this section have a resonance with the data noted earlier in relation to infant self-soothing, possibly suggesting that the development of this capacity may be influenced by parental night-time behaviour.
Feeding
Carey (1975) reported a relationship between breast-feeding and night-waking at 6 and 12 months; this may be explained either by parental contact with the infant or nutrition, or a combination of both. He suggests as an explanation the possibility that breast-fed infants may come to expect more attention on waking. However a review by Messer & Richards (1993) concluded that all the studies which attempt to relate feeding practices to sleep patterns should be treated with great caution. These authors point out that many social and psychological factors are associated with choice of feeding method, and that breast-feeding, giving solids or bottle-feeding are at best broad and very variable categories of behaviour.

Non-sleep behaviour problems
Two studies used a multivariate analysis in this area. Richman et al. (1982) carried out a cluster analysis of behavioural difficulties with a sample of 183 three year olds; she found that sleep problems did not emerge as a distinctive feature of any of the clusters but she did find that settling at night and night-waking were associated with overall behavioural problems. Needlman et al. (1991) in a sample of 508 three-year olds, carried out a multi-dimensional scaling analysis, and found an association between sleep difficulties and frequent temper tantrums. In a community-based prevalence study Richman et al. (1975) using a 1 in 4 random sample of 705 3-year-olds in a London borough, found sleep difficulties as part of an overall pattern of behavioural difficulties in some children and as an isolated difficulty in others. To summarise, we can only conclude that sleep disturbance in young children may present either as an isolated problematic behaviour, or as part of an overall pattern of behavioural difficulties.

Research on treatment approaches
Medication
Ounsted & Hendrick (1977) have reported that by 18 months a quarter of all first-borns in Britain have been given sedatives to help their sleeping; Chavin & Tinson (1980) in another UK study, found that 71% of infants who were judged to have serious sleep problems were given drugs; prescribing practices in this area may have
changed since the late seventies but in 1994 Skuse stated that “drugs continue frequently to be prescribed for this condition” (p.478).

Richman (1985) examined the effect of trimepazine tartrate in reducing sleep problems in a community sample of 22 1 and 2 year old children; using parental monitoring, she reported that “sleep was significantly improved on the drug compared with the original baseline and the placebo” (p.591) but that “this improvement was clinically only moderate with many wakeful nights still occurring” (p.591). She further concluded that taking the drug produced no permanent effect on sleep patterns, a follow-up of 14 of the children 6 months post-treatment showing persisting sleep problems in the majority. Simonoff & Stores (1987) also used trimepazine tartrate to treat night waking in 1 to 3 year old children; eighteen children were randomly assigned to either a treatment or placebo group using parental diaries. They found that the treatment group had statistically fewer awakenings, less time awake at night and more night-time sleeping compared to those on the placebo. However, they found no difference between the baseline level of sleep disturbance and the level when the drug was no longer administered. These two studies suggest that the use of trimepazine tartrate may be a helpful short-term measure, but does not have long-term effects in reducing sleep difficulties in young children.

**Behavioural management approaches**

**Introduction**

In their 1985 paper on behavioural methods in the treatment of children’s sleep disturbance Richman et al. stated “there is very little written about the use of behavioural techniques for night-waking in children” (p.582) However, Herbert (1975) quotes a case description from Thomas et al. (1968) in which behavioural management principles were used; Herbert (1975) also describes a study carried out by Holder (1969) in which an extinction approach was used. Clearly, despite the absence of evidence regarding the efficacy of behavioural management approaches, the use of extinction (or ignoring) was widely practised and recommended; obviously this was based on the assumption that parents’ behaviour could be a significant influence on children’s sleep difficulties.
Exploratory studies

Rapoff et al. (1982) using a single-case design evaluated ‘ignoring’ techniques with six children (with a mean age of 3 years); three of the children showed substantial improvement; the authors attribute the lack of improvement in the other three children to their parents not following the treatment recommendations. France & Hudson (1990) also using a single-case design found ignoring to be successful with all seven children (age eight to twenty months) in their study.

Seymour et al. (1983) used a combination of improved organisation of bed-time routines and extinction (the minimising of rewards for calling out or getting out of bed); 208 children were studied, all under the age of six years; 7% of the families did not implement the programme; for the remainder there was a substantial improvement after four weeks (the mean number of night-wakings per week reduced from approximately 7 to approximately 1). A pre-test/post-test design with no control group was used.

Richman et al. (1985) used a combination of extinction, reinforcement, shaping, cueing and bed-time routines with 35 children aged 1 to 5 years; the parents of five of the children dropped out of treatment; improvement was rated as “marked or complete” (p.585) in 90% of those who completed treatment. The design used here was also pre-test/post-test without a control group.

Seymour (1987) (using the treatment approach described above in relation to this author’s 1983 article) carried out a study using a multiple-baseline design across four cases and concluded that the treatment was reasonably successful.

Mindell & Durand (1993) employed a multiple-baseline, simultaneous-replication design across subjects with 6 children; the treatment approach consisted of implementing an improved bed-time routine and graduated extinction; the authors concluded that the treatment approach used was successful with all six children.
Minde et al. (1993) treated 24 children using “a dynamically oriented behavioural approach to allow parents to effectively manage their children’s night-time behaviour” (p.525). “Clinical reports at 6-month follow-up visits suggested that 83% of the children had significantly improved sleep patterns after treatment” (p.532). Although the authors “feel that there is good clinical evidence for the efficacy of the counselling process” (p.532), the design used was pre-test/post-test with no control group.

In summary, considering the number of studies reviewed above, the range of authors and the variety of approaches, the results strongly suggest that behavioural approaches are useful in managing sleep problems in young children; however, all of the above studies suffer from either very small subject groups or poor design methodology. A robust test of the use of behavioural approaches requires control group designs with randomised assignment. Studies which used such designs are reviewed in the next section.

**Control group designs with randomised assignment**

Rickert & Johnson (1988) compared ‘scheduled awakenings’ and ‘ignoring’ in terms of their effectiveness at reducing night-waking in 33 children (aged 6 to 54 months) randomly assigned to one of three groups, scheduled awaking, ignoring, or control. “Scheduled awakenings consisted of a parent arousing and feeding or consoling the child 15 to 60 minutes before typical spontaneous awakenings” (Rickert & Johnson, 1988, p.203). Statistically and clinically the ‘scheduled awakening’ and ‘ignoring’ groups awoke and cried less frequently than children in the control group during 8 weeks of treatment and at three and six week follow-up checks; ‘ignoring’ reduced the problem more rapidly, but the authors point out that ‘scheduled awakening’ seems a viable alternative particularly for parents who do not find ‘ignoring’ an acceptable procedure.

Seymour et al. (1989) used random assignment and a control group; 45 children (aged 9 to 60 months, with a mean age of 18 months) were randomly assigned to a group following a therapist-based treatment programme with follow-up telephone calls, a
group provided with only a simple written guide with no follow-up telephone calls, and a waiting-list control group. The treatment procedure used was as in Seymour et al. (1983) and Seymour (1987). Both treatment groups were found to significantly improve after a four-week period as compared to the control groups; follow-up showed that the improvements were maintained over a three-month period. Because of the robust design of this study, it provides solid support not only for the effectiveness of the use of a behavioural approach to young children’s sleep difficulties, but also for the use of written information for parents without therapist support.

However, the behavioural paradigm as used in the studies outlined above does not allow for possible emotional stress for the child or parent, or for disturbed family dynamics which may underlie the sleeping difficulties; as noted above young children’s sleeping difficulties are associated with maternal depression and they may present as part of a broader pattern of behavioural difficulties. A behavioural approach may ‘work’ despite this, but with possible unknown detrimental effects. There is also the possibility that the treatment itself, particularly the ‘ignoring’ component could have a detrimental effect on the child’s developing sense of his/her parents as responsive. In none of the above studies has such a possibility been considered or evaluated.

Other treatment approaches
Scott & Richards (1990) investigated the “effects of providing advice and support” (p.551) to mothers of night-waking infants in a randomised controlled study with three groups; “groups received a specially written advice booklet and support visits, the booklet only, or no intervention” (p.551). According to Scott & Richards (1990) “the booklet differed from others on children’s sleeping problems in that it emphasised that modifying parental expectations, perceptions and attitudes towards their infants’ sleep may be at least as effective as employing more direct strategies (eg. behaviour modification)” (p.556) and the “overall aim was to present information in a neutral way and to encourage parents to make their own decisions with a better understanding of the pros and cons” (p.556). No significant differences in terms of outcome measures (using parents’ diaries) were found between the three groups. However, the approach
taken has attractive elements in broadening the intervention beyond a narrowly
behavioural procedure and taking parents’ perceptions and feelings into account.

Daws (1992) describes a psychoanalytic approach to young children’s sleep difficulties;
she notes that “advice is rarely given” (p.24) and “solutions are as much the province
of parents as of myself; my task is to restore their ability to think effectively so they can
provide the answers for their child” (p.24). Unfortunately she provides no report of
evaluations of the approach.

**Discussion**

Amongst the biological factors addressed by research the only ones we can safely
conclude to be related to sleep problems are adverse perinatal difficulties (i.e. mild
asphyxia, longer labour, longer time to cry after birth and lower Apgar ratings). The
development of self-soothing by infants seems likely to be an influential factor but it is
unclear in what ways. Amongst the social factors addressed the only ones we can
safely conclude to be related to sleep problems are maternal depression and parental
night-time behaviour. The direction of causality in the relationship between maternal
depression and children’s sleep difficulties is unclear. We know that the parents of
children with sleep difficulties are more likely to remain with their babies at night until
they settle to sleep, are more likely to pick them up at night if they wake (and the
parents become aware of it), and are more likely to take their babies into their own
beds if they wake (and the parents become aware of it). It is also established that
preventive work with parents in relation to allowing infants to learn to fall asleep
without an adult being present, leads to significant improvement in infants’ sleeping
patterns. It seems reasonable to conclude therefore that parental night-time behaviour
is causally related to young children’s sleeping difficulties for some children and
parents. A key factor appears to be development by the infant of the capacity to fall
asleep without the presence of an adult. It seems that the caretaking adults can
facilitate the development of this capacity.

The relationships between each of the factors noted above and sleep difficulties have
been studied separately. It would be fruitful if research now began to address
relationships between these factors and the ways in which these relationships may influence the development of sleep difficulties. There may be a number of pathways leading to the development of such difficulties, with different combinations of variables leading to similar outcomes. Possible relationships are easily discerned. For example maternal depression may influence parental night-time behaviour which in turn may influence the development of self-soothing. Peri-natal experiences may be related to maternal depression, and to the development of self-soothing. Further research should attempt to disentangle these various potential relationships with a view to identifying particular combinations of variables leading to sleep difficulties. Such research could inform both preventive work and clinical practice by providing a clearer focus for intervention.

There are clear implications in the above conclusions for preventive work. Two ‘at risk’ groups can be identified, children with a history of peri-natal difficulties and children of depressed mothers, and the efficacy of a preventive approach to intervention is established (Adair et al., 1992; Wolfson et al., 1992; Pinilla and Birch, 1991). Children with adverse peri-natal difficulties can be identified from birth and a preventive intervention may be helpful to the parents of these children. A literature search did not identify any studies in this area and the usefulness of such an approach is not established; however, considering the evidence reviewed above it is an approach worth researching.

The identification of young children of depressed mothers is dependent on the families being involved with services. However, community-based intervention projects with parents of young children living in disadvantage would be likely to have contact with many such women. A literature search has not identified any studies relating to preventive work on children’s sleep difficulties with such a group; again, such a study seems well-worth completing. Indeed, depending on the finance required, it may be feasible for an area-based health service to provide such information and support to all parents of young children either at the pre-natal or early post-natal stage. The Seymour et al. (1989) study referred to earlier suggests that written information alone may be effective. More research in this area would be very useful.
In relation to treatment with medication, there is evidence that trimeprazine tartrate may be useful as short term measure, but it does not have persisting effects. As noted earlier, it does seem that behavioural approaches have been and are, widely used in managing young children’s sleeping difficulties. However the research evidence supporting the use of such approaches is quite weak. There are many studies which used single-case designs and a few studies which used poorly controlled group designs, which suggest that behavioural approaches are useful. However, only two published studies used control group designs with randomised assignment in researching this area, Rickert & Johnson (1988) and Seymour et al. (1989). Both of these provide strong support for the efficacy of behavioural approaches. However this does seem a rather narrow research base for an apparently widespread clinical practice. As noted above, the behavioural approach also suffers from difficulties arising from not allowing for possible emotional stress for parent or child, or for possible disturbed family dynamics underlying the sleeping difficulties; and from the further unresearched possibility that the treatment itself might have a detrimental effect on the child’s developing sense of parental responsiveness. Considering the narrow research base of the behavioural approach in this area and the possible weaknesses identified above, clearly further research is required to expand the base and to address the weaknesses.

Although there is as yet no evidence of the efficacy of alternative treatment approaches, it seems worthwhile to pursue some of the available leads, particularly as they appear to address the identified weaknesses of the behavioural paradigm. In particular the Scott & Richards (1990) attempt to take parents’ perceptions and feelings into account, and Daws’ (1992) attempt to help parents “provide the answers for their child” (p.24) provide ideas that seem responsive to a family’s own experience of difficulty. Further research on such approaches would provide a welcome broadening of perspective.
References


The prevalence and correlates of suicidal ideation and behaviour in childhood and early adolescence: a review of recent research
Introduction

"Previously, many mental health professionals questioned whether pre-adolescents were capable of genuine suicidal behaviour; they were thought to lack the capacity to conceptualise death in an adultlike manner" noted Milling & Martin (1992, p.327). Such a view was supported by Shaffer & Hicks (1994) who, in reviewing epidemiological data noted that “Suicide is uncommon in childhood and early adolescence [....... (and) ......] this pattern is remarkably consistent across different countries” (p.341). They present a summary of WHO data from 23 countries for suicide rates per 100,000 between the ages of 5 and 14 years; these range from 0.00 (Iceland) to 1.68 (Hungary), with only Luxembourg above this at 4.65. However, the reviews of Shaffer & Piacentini (1994) and Milling & Martin (1992) suggest that although the number of completed suicides amongst young people under the age of fifteen may be low, many of them engage in a range of suicidal behaviours including completed suicides, suicide attempts, suicidal threats and suicidal ideation. Such behaviours come to the notice of clinicians and naturally arouse great concern. However, it is difficult to assess the clinical significance of such behaviours as information on them, particularly arising from recent research, is not easily accessible. For example, in the two most recent reviews, Shaffer & Piacentini (1994) although providing some information on under-fifteens, primarily address the evidence relating to older adolescents; and Milling & Martin (1992) do not, obviously, refer to any research published after 1991. The present review attempts to ameliorate the difficulty of accessibility; the objectives of the review are to outline, summarise and evaluate recent research pertaining to the prevalence and correlates of suicidal ideation and behaviour in childhood and early adolescence.

In the following, definition of the age-range of childhood and early adolescence is first considered, and then definition of suicidal ideation and behaviour. Research on the prevalence and correlates of suicidal ideation and behaviour is then considered. Samples from three populations have been studied, community, child psychiatry outpatient and child psychiatry inpatient. The research on each of these populations is addressed separately.
**Definition of age-range**

As indicated in the title of this review the age range being addressed is childhood and early adolescence. Alternative terms are used interchangeably in the literature, such as pre-adolescent and pre-pubertal. Despite the apparent meaningfulness of these terms, in carrying out empirical studies researchers invariably use chronological age as the criterion for inclusion in a study. Populations falling into a variety of age-ranges are considered in the research addressed in this review. For present purposes the essential point is to decide on an upper age limit to define the term childhood and early adolescence. Choosing a precise age has to be somewhat arbitrary. However, the criterion chosen is determined to a large extent by the research to be reviewed. On this basis, for purposes of this review the age of 14 years is chosen as the upper limit of the age period of childhood and early adolescence (the 15th birthday therefore being the cut-off point). The age of 15th birthday is also the cut-off point used by several national and international organisations to differentiate between childhood and adolescent suicide (Shaffer & Fisher, 1981).

**Defining suicidal ideation and behaviour**

The “conceptual leadership in the study of preadolescent suicidal behaviour” (Milling & Martin, 1992, p.327) has been provided by Pfeffer (1986); she has defined suicidal behaviour amongst preadolescents as “any self-destructive behaviour that has an intent to seriously damage oneself or cause death” (p.14). This definition is widely used in the research literature and provides a definitional basis for this review. According to Pfeffer’s view of suicidal behaviour a child need not have achieved an adultlike understanding of death “but it is necessary to have a concept of death, regardless of how idiosyncratic it may be” (p.14); her view requires that “death has a specific meaning to the child and that this meaning is associated with a solution to the child’s perception of overwhelming distress” (p.14).

Pfeffer’s (1986) system for classifying non-fatal life-threatening behaviour, the Spectrum of Suicidal Behaviour, is frequently used in the literature reviewed below and is therefore outlined here as follows:
Level Behaviour Pattern
1. Nonsuicidal: No evidence of self-destructive thoughts or actions.
2. Suicidal Ideation: Thoughts or verbalisations of suicidal intention.
3. Suicidal Threat: Verbalisation of impending suicidal action and/or precursor action that if carried out, would lead to harm.
4. Mild Attempt: Actual self-destructive act that realistically would not have endangered life and did not necessitate ICU (Intensive Care Unit).
5. Serious Attempt: Actual self-destructive action that realistically could have led to the child’s death and may have necessitated ICU.

It is assumed by Pfeffer (1986) that this spectrum is a continuum and that children who exhibit the more dangerous forms of suicidal behaviour also engage in the less dangerous forms. Rating on the scale is carried out by a clinician based on data gathered from interviews with a parent and a child. (Pfeffer et al. 1988, p.35) state that “The internal and interrater reliabilities and discriminative validity of the research instrument(s) have been established previously”, by Pfeffer et al. (1979, 1980), Pfeffer et al. (1982) and Pfeffer et al. (1984).

In many of the studies considered below, measures other than Pfeffer’s spectrum have been used to assess suicidal ideation and behaviour. In relation to each study the particular measure used is identified and is described in as much detail as was provided in the original study.

Research on the prevalence and correlates of suicidal ideation and behaviour

Community Samples
Suicidal ideation and its correlates were investigated by Kashani et al. (1989) in a community-based sample of 210 subjects stratified by age and sex in a midwestern town in the USA. The sample comprised three groups of 8, 12, and 17 year olds; only the findings specific to the former two groups are presented here. Data were collected from the children through the use of the Child Assessment Schedule (Hodges, 1987).
Suicidal ideation was determined through questions from the CAS (a semi-structured interview) and "a child was considered suicidal only if she/he indicated recurrent thoughts of hurting self and/or committing suicide" (p.913). Kashani et al. (1989) do not report on the interrater reliability of the measures used to assess suicidal ideation and their conclusions appear to have been based on clinical judgement. They found that 5.7% of both eight year olds and twelve year olds presented with suicidal ideation; they also found for both age groups, that children with such ideation showed a significantly higher degree of depressive symptomatology than those without such ideation. Data collected from parents were not broken down by age group, and therefore it was not possible to identify findings specific to the population addressed in this review.

Child reports of suicidal ideation in a random sample of families in New York state were studied by Velez & Cohen (1988). Although the age range of the sample was from 9 to 18 years, data were provided separately for those subjects under 15 years (n=539). Data were collected through use of the Diagnostic Interview Schedule for Children; this schedule has established reliability and validity (Costello et al., 1985). Velez & Cohen (1988) concluded that the prevalence of suicidal ideation as reported by the child varied greatly depending on how such ideation was defined; if it was defined as endorsing at least one of the items in the scales used, a prevalence as large as 26% is obtained; however if it is defined as endorsing at least three items in the scale, the prevalence is 6.7%.

In a large urban area in the U.S. a further community-based study was carried out by Pfeffer et al. (1984). These authors investigated suicidal behaviour in a stratified random sample of 101 children aged from 6 to 12 years; each child and a parent were interviewed by either a child psychologist or a child psychiatrist; suicidal behaviour was assessed through the use of the Spectrum of Suicidal Behaviour Scale; other instruments used were "a Spectrum of Assaultive Behaviour Scale, a Precipitating Events Scale, Affects and Behaviour Scales (recent and past), Child Concept of Death Questionnaire and Scale, Family Background Scale and Questionnaire, Ego Mechanisms Scale, Ego Defence Scale and Medical-Neurological History
Questionnaire” (p.417); discriminative validity and internal reliability for these measures had been reported by Pfeffer et al. (1979, 1980), Pfeffer et al. (1982), and Pfeffer, et al. (1984); it was found that 8.9% of the sample had suicidal ideation, 2% had made suicidal threats, and 1% had made mild suicidal attempts. Comparison of the children who had exhibited suicidal ideation or behaviour with the rest of the sample indicated that the ‘suicidal’ group showed significantly more preoccupation with death, recent depression, depression in the child’s past history, tendency for the mother to have experienced suicidal thoughts, and recent and past signs of general psychopathology. Pfeffer et al. (1988) carried out a two-year follow-up study with these children. However data could be obtained only on approximately two thirds (67) of them. At follow-up it was found that 17.9% of the children had suicidal ideation and 1.5% of them had made suicidal threats; there had been no suicide attempts. In relation to continuity, “approximately 15% of the children who were not suicidal initially were suicidal at follow-up (........), 50% who had suicidal tendencies at the initial assessment had suicidal tendencies at follow-up” (p.39). Analysis of the follow-up group data indicated that the ‘suicidal’ group showed significantly more preoccupation with death, aggression and signs of general psychopathology than the ‘non-suicidal’ group.

The prevalence of suicidal behaviour in a sample of 1,542 12 to 14 year olds (98% of the eligible subjects) in a suburban school district serving “a diverse socio-economic group” (p.1006) in the U.S. was studied by Garrison et al. (1991). As part of a broader study the adolescents completed a depression scale to which “three suicide items (‘I felt life was not worth living’, ‘I felt like hurting myself’, and ‘I felt like killing myself’) were added” (p.1007); each item response was scored “on a four point scale ranging from zero (indicating symptom presence ‘rarely or none of the time’) to three (indicating symptom presence ‘most or all of the time’)” (p.1006-7). The authors did not provide information on the reliability or validity of this measure. On the basis of responses to these three items Garrison et al. (1991) concluded that “25 percent of our sample of young adolescents reported low levels of suicidal ideation during the preceding week and 5 percent more severe or sustained ideation” (p.1012). (The cut-
off points used were scores of at least one and less than six for ‘low’ and six or more for ‘severe or sustained’).

It is difficult to summarise these data on community samples, as different measures (two of which were of unknown reliability and validity) were used to assess suicidal ideation and behaviour in the studies considered; different measures were also used to assess the correlates of such ideation and behaviour; and different age-ranges were considered in each study. To summarise broadly, prevalence rates ranging from 5% to 26% were found for suicidal ideation depending on how such ideation was assessed. Some increase in the prevalence of suicidal ideation was found over time, but not in suicide attempts. Some subjects persisted with suicidal tendencies throughout a two-year study period, while others did not; some who did not show suicidal tendencies initially did so later; the factors associated with these changes are unclear.

In relation to correlates, there are indications of significant relationships between suicidal ideation and measures of depression, preoccupation with death, a tendency for mother to have experienced suicidal thoughts, signs of general psychopathology and in an older group, aggression.

**Child psychiatry outpatient samples**

The prevalence of suicidal behaviour in a sample of 40 consecutive outpatient children aged between 3 and 12 in Ohio, USA. was investigated by Milling, Gyure et al. (1991). Each child was assessed by a team consisting of one psychiatrist, one social worker, and “a variety of trainees from the fields of psychiatry, psychology and social work” (p.284). Each diagnostic report was evaluated using a structured chart review instrument based on Pfeffer’s (1986) Spectrum of Suicidal Behaviour Scale. Milling, Gyure et al. (1991) found that 15% of the sample was rated as having displayed some form of suicidal behaviour and almost 3% “was rated as having engaged in an actual self-destructive action that realistically could have led to death” (p.287). They did not provide a breakdown for different diagnostic categories. In considering their findings the authors suggest that the chart review methodology used “may have been somewhat insensitive to the occurrence of suicidal behaviour, particularly suicidal ideation”
(p.287) as the clinicians may not have routinely asked every child whether they had thought about or attempted suicide, or alternatively may have failed to consistently document suicidal behaviour in their diagnostic report; if this view is correct the results may be underestimates of the level of suicidal behaviour in their sample.

The relationship between suicidal behaviour and childhood onset depressive disorders was studied by Kovacs et al. (1992) in Pittsburg, USA. The subject children and their families were recruited “primarily from among sequentially-referred cases to the child psychiatry outpatient service (…..) a few cases were accessed through other avenues” (p.9); the children were aged between 8 and 13 years. Three groups were compared; the first was a combined group consisting of children with a major depressive disorder (MDD), major depression superimposed on dysthymic disorder (MDD/DD) or dysthymic disorder (DD) (n=113); the second group consisted of children with adjustment disorder with depressed mood (ADDM) (n=18); and the third was a comparison group (n=48) consisting of children with psychiatric diagnoses other than a diagnosis of a form of depression.

Family psychiatric history was obtained primarily from mothers using the Schedule for Affective Disorders and Schizophrenia - Lifetime version (SADS-L) and diagnosed via the Research Diagnostic Criteria (RDC) (Endicott and Spitzer, 1978). Psychiatric evaluations were completed with the parent and child with the Interview Schedule for Children (ISC), which has established reliability (Kovacs, 1985). Suicidal behaviours also “were assessed with the ISC via specific items regarding suicidal ideation, frequency of suicide attempts, the contemplated or actual method(s) of attempt, and related constructs” (p.11). It was found that children in the affective disorders group reported rates of suicidal ideation of 67.3% and of suicide attempts of 13%; the ADDM group rates were 58% and 5%, and the comparison group rates were 39% and 0%. The overall rates were 55% for ideation and 6% for attempts. For both suicidal ideation and attempts, the differences in rates between the affective disorders group and the other two groups were statistically significant. Age was the only demographic variable that distinguished the children who had and who had not attempted suicide, those with a history of suicide attempt being older at study entry.
To summarise the data on child psychiatry outpatient samples, prevalence rates ranging from 15% to 55% were found regarding suicidal ideation, and ranging from 3% to 6% for suicide attempts; there is a suggestion that differences in methodology may have contributed to the difference in these rates. In relation to correlates of suicidal behaviour, it was found that children with diagnosed affective disorders had significantly higher rates both of suicidal ideation and attempts than children with adjustment disorders with depressed mood, or children with psychiatric diagnoses other than a form of depression. There was also an indication that children who had attempted suicide were older than those who had not.

**Child psychiatry inpatient samples**

Asarnow and her colleagues have published four studies of suicidal behaviour in inpatient samples of children in California. The relationships between suicidal behaviour and coping strategies, hopelessness, and perceived family environment were addressed by Asarnow et al. (1987). The subjects were 30 children (18 boys and 12 girls) aged 8 to 13 years drawn from consecutive admissions to a pre-adolescent inpatient unit; to be included in the study children had to have a WISC-R IQ of 70 or above, and show no evidence of an acute confusional state. A DSM-III diagnosis was arrived at through direct interviews using the Schedule for Affective Disorders and Schizophrenia for School Age Children (K-SADS-E) (Puig-Antich et al., 1983). A rating of each child’s level of suicidal behaviour was based on reviews of Depression Self-Rating Scale responses (Asarnow & Carlson, 1985) by one of the authors, on results of the K-SADS-E interviews and on documentation of suicidal behaviour in the child’s clinical record; the authors indicate a very high rate of inter-rater reliability for these ratings which indicated that 33% of the children showed suicidal ideation, while 26.6% showed attempts.

Children’s ratings of their depressive symptoms and hopelessness were obtained from the scores on the DSRS; perceived family environment was measured by the use of the Family Environment Scale (Moos & Moos, 1981); the authors devised a measure of coping strategies for which they established reliability. The results indicated that
"children who attempted suicide saw their families as less cohesive, higher in conflict, and less controlled than did non-suicidal children. Suicide ideators differed from non-suicidal children only in their perception of less control in their families" (p.364).

Using the same population, inclusion criteria and measures, as in Asarnow et al. (1987), Asarnow & Carlson (1988) investigated the relative power of measures of perceived family environment, hopelessness, and depression for the classification of suicide attempters and non-attempters in a separate sample of 25 children aged between 8 and 13 years (15 boys and 10 girls). Data on suicidal ideation were not addressed. There were 6 (24%) attempters and 19 (76%) non-attempters. It was found that the perceived family environment measure "alone yielded an 88% correct classification rate, with 100% of the suicide attempters being correctly classified ..... no increments in classification accuracy were achieved when the other variables were sequentially added" (p.133). The authors concluded "the present results provide strong support for a link between suicide attempts in children and children's perceptions of low family support" (p.135).

Again using the same population, inclusion criteria, and measures for suicidal behaviour and depression, Asarnow & Guthrie (1989) investigated the relationships between suicidal behaviour, depression, and hopelessness in another sample of 55 children (37 boys and 18 girls) aged from 6 to 13 years. In this study children's reported feelings of hopelessness were assessed using the Hopelessness Scale for Children (Kazdin et al., 1983). The authors reported that 18% of the sample showed suicidal ideation only and a further 40% had made actual suicide attempts; they found that suicidal ideation was significantly associated with hopelessness and that suicide attempts were significantly associated with both hopelessness and a diagnosis of depression.

In a further study using the same population, inclusion criteria and measures, the relationships between suicidal ideation and attempts, and perceived family stress and depression were investigated by Asarnow (1992). She studied a separate sample of 55 children (41 boys and 14 girls) aged from 6 to 13 years. She found that 31% of her
subjects showed suicidal ideation while a further 35% had made suicide attempts; she replicated the previous finding of Asarnow et al. (1987) that compared to non-suicidal children, suicide attempters see their families as less cohesive and higher in conflict; she also found that compared to non-suicidal children, the combined group of suicidal ideators and attempters reported significantly higher levels of depressive symptoms, not counting suicidal thoughts or behaviours.

The relationships between self-esteem, depression, hopelessness, and suicidal intent among 123 consecutively admitted psychiatric inpatient children in New Haven (79 boys and 44 girls) were investigated by Marciano & Kazdin (1994). The age range was from 6 to 13 years; and all had a WISC-R IQ at or above 85. The subjects were divided into three groups on the basis of scores on the Suicide Assessment Battery (Kazdin, 1985) which was derived from K-SADS (Chambers et al., 1978); these groups consisted of 39 ideators (32%), 42 attempters (34%) and a comparison group of 42 (34%) who reported neither suicide attempts nor ideation. The following self-report measures were also administered to the children, the Child Depression Inventory (Kovacs, 1981), the Hopelessness Scale for Children (Kazdin et al., 1986), and the Self-Esteem Inventory (Coopersmith, 1967); all of these measures have established reliability and validity. As the ideators and attempters did not differ significantly on any of the clinical or demographic variables they were combined into one “suicide group” (p.154) and compared to the control group; it was found that the suicidal children were significantly higher in depression and hopelessness, and lower in self-esteem, than the children in the control group; it was also found that depression, as measured by the CDI, was the single best predictor of suicidal ideation and attempt.

Two further studies of inpatient samples were carried out in Ohio, U.S.A.; Milling, Campbell et al. (1991) investigated the prevalence of suicidal behaviour among 45 consecutive admissions aged 5 to 13 years, to a child inpatient unit. A chart review method was used, based on the Spectrum of Suicidal Behaviour Scale. The authors found that 4.4% of their sample’s charts indicated threat, 6.7% indicated a mild attempt, and 8.9% indicated a serious attempt. However, as in Milling, Gyure et al. (1991) regarding outpatient children, they concluded that their chart review
methodology may have led to underestimates of prevalence. This conclusion appears to be supported by the findings of a later study carried out at the same site. Milling et al. (1994) investigated the prevalence of suicidal behaviour among 61 consecutive admissions aged 5 to 13 years, to a child inpatient unit. Suicidal behaviour was assessed by use of the Spectrum of Suicidal Behaviour (Pfeffer, 1986) based on separate interviews of parents and children. Milling et al. (1994) reported good interrater reliability for their assessments. The indications of the parent interview were that 43% of the children were non-suicidal, 28% showed suicidal ideation, a further 23% had made threats, 3% had made a mild attempt, and almost 2% had made a serious attempt; the indications of the child interviews were that 54% were non-suicidal, 26% had shown ideation, 16% had made threats and 3% had made a mild attempt. Unfortunately, the authors did not estimate the level of agreement between individual parent and child reports.

A series of investigations was carried out by Pfeffer and her colleagues in the course of a six to eight year longitudinal study of a group of 106 consecutively hospitalised child and early adolescent psychiatric inpatients and a comparison group of 101 young people selected randomly from a community population aged from 4.6 to 14.7 years. The research instruments used were the Spectrum of Suicidal Behaviour (Pfeffer, 1986) and the K-SADS-E (Puig-Antich et al., 1983) which were used to classify current and past DSM-III-R psychiatric disorders. At initial assessment 79% of the inpatients reported suicidal ideation and/or attempts while approximately 12% of the non-patients reported suicidal ideation, threats, or attempts (Pfeffer et al., 1991); [this non-patient sample is the one studied by Pfeffer et al. (1984) referred to above].

In the follow-up study, data were available only for 69 of the 106 former inpatients and 64 of the 101 former non-patients. The authors found that “the most significant risk factor present at the initial assessment, for suicide attempt during follow-up was the severity of suicidal behaviour. A diagnosis of a mood disorder, either subsequent to the initial assessment or over the subject’s lifetime, was the strongest diagnostic risk factor” (Pfeffer et al., 1991, p.613). However, Pfeffer et al. (1993) reported that “Mood and substance abuse disorder, impaired social adjustment, and stressful life
events were factors associated with risk for recurrence of suicide attempts (........) the effects of each of these risk factors were similar for each of the subject groups defined at the initial assessment” (p.110). They added that “these risk factors, especially when present at a time near to the suicide attempt in the follow-up period were stronger risk factors than whether a child had a history of suicidal ideation or a suicide attempt” (p.110).

Pfeffer et al. (1994) estimated the rates of suicidal behaviour and psychiatric disorders among relatives of 123 of the subjects in the study of Pfeffer et al. (1991); data on the other ten sets of relatives were not available. Information was collected from parents through the use of the Schedule for Affective Disorders and Schizophrenia - Lifetime version (Endicott & Spitzer, 1978) and the Family History - Research Diagnostic Criteria method (Andreasen et al., 1977). There were no significant differences in distributions of gender, age, race, social status, or religion among the subgroups of subjects. It was found that “Although no first degree relatives committed suicide, significantly more first degree relatives of child suicide attempters reported suicide attempts than first degree relatives of either non-suicidal child psychiatric patients or normal children” (p.1091), and the first degree relatives of suicide attempters and suicide ideators showed significantly higher rates of “assaultive behaviour, substance abuse disorders, anti-social personality disorders, family discord, and psychiatric hospitalisation” (p.1091).

Only one non-American study was identified; it is therefore included here, despite being somewhat dated. Kosky (1983) reviewed all admissions subsequent to suicide attempts over a four year period to an inpatient psychiatric unit for children in Western Australia. The study group consisted of 15 boys and 5 girls under the age of 14 (the mean age of the sample was 11 years). A control group of 50 “psychiatrically ill non-suicidal children (....) was selected from among the inpatients of the hospital during the same period” (p.458) on a random basis. A chart review method was used in this study. “Data were available on all subjects and their families from psychiatric examinations, nursing reports, reports from social workers and psychologists attached to the hospital, and from teachers, paediatricians and psychiatrists who had been in
contact with the children” (p.458). It was found that “suicidal behaviour was associated with mostly the male sex, personal experiences of significant losses, academic underachievement, marital disintegration among the parents and past intrafamilial violence, including physical abuse of the index child” (p.466).

To summarise the prevalence data on child psychiatry inpatient samples, rates ranging from 31% to 79% have been found for suicidal ideation; rates ranging from 3% to 40% have been found for attempts, with most studies finding between 24% and 40%.

Significant relationships have been found between suicidal ideation and perception of less control within the family, hopelessness, depression, low self-esteem and higher rates of psychological difficulties in first degree relatives; significant relationships have been found between attempts and being male, experience of loss, educational and family difficulties, perception of family as less cohesive, less controlled and higher in conflict, hopelessness, depression and a high rate of suicide attempts amongst first degree relatives. There is also an indication that current psychosocial risk factors may have a stronger relationship with a recurrent suicide attempt than historical risk factors.

**Implications of the choice of cut-off age**

As noted above the choice of a precise age cut-off although essential, is somewhat arbitrary. In the present review an obvious consequence of the choice of the 15th birthday as the cut-off age is that studies of older age adolescent samples which included some individuals meeting the age criteria of this review were not addressed. Although the prevalence and correlates of suicidal ideation and behaviour differ as between the two broad groups of adolescents above and below the 15th birthday, there will obviously be overlap and it is reasonable to presume that the prevalence and correlates of suicidal ideation and behaviour in the older group will apply for many members of the younger group also, although they have not been adverted to in the above. Such factors include (a) a higher prevalence of completed suicides, including an increase in prevalence in males in the last three decades (Schaffer & Piacentini, 1994); (b) a higher prevalence of attempts, particularly in females (Schaffer & Piacentini, 1994); (c) a higher prevalence of suicidal ideation (Pfeffer et al., 1988), particularly in
females (Choquet & Mencke, 1989); (d) a higher prevalence of suicidal ideation and behavior amongst lesbian and gay adolescents than amongst heterosexual adolescents (D’Augelli & Hershberger, 1993; Rotherham-Borus et al., 1994); and (e) relationships with aggression, anger and other anti-social behaviour (Schaffer & Piacentini, 1994).

**Discussion**

It is clear from the above that the data presently available pertaining to the prevalence and correlates of suicidal ideation and behaviour in childhood and early adolescence while shedding some light on these phenomena, do not shed it very widely or brightly. Two methodological issues pose problems for interpretation of results. A serious difficulty in coming to conclusions is presented by the use of different instruments, some of them of unknown reliability and validity, to assess suicidal ideation and behaviour; it is therefore unclear how comparable are the results of the studies reviewed. For reliable estimates of prevalence there is a need for valid, reliable measures of suicidal ideation and behaviour to be developed and used consistently in further studies with both community-based and clinical samples. The Pfeffer ‘Spectrum’ provides the basis of such a measure; however, a standardised approach to data-elicitation for rating on the Spectrum needs to be developed. A second difficulty for interpretation arises from the narrowness of the sample base which is almost totally American. Studies in other countries are required, particularly in the U.K. and Ireland for our purposes.

Indications for further research arise from each of the three sets of studies reviewed. Despite the low prevalence of completed suicide in childhood and early adolescence, suicidal ideation and behaviour are significant features amongst community-based, child psychiatry outpatient and child psychiatry inpatient samples with trends of increasing prevalence and seriousness across these samples. The results of the community-based studies reviewed indicate that suicidal ideation is surprisingly common in childhood and early adolescence. However, the implications of such ideation are unclear. It is not known how many young people with such ideation receive a clinical service, show continuity of presentation, deteriorate to presenting with attempts or indeed complete suicide. Nor is there any data on the natural history
of such ideation, or on factors which may lead to amelioration or deterioration. Prospective longitudinal studies would be most useful in elucidating these questions. The suggestions of increasing prevalence of suicide attempts with age and of relationships between suicidal ideation and depressive presentation, preoccupation with death, and indications of personal and maternal emotional difficulties should inform the development of such studies.

As the decision-making processes leading to hospitalisation are unknown, it is unclear in what ways the child psychiatry outpatient and inpatient samples differ. They are again treated separately here while no assumption is made that they are representative of different populations, other than defined by the question of hospitalisation.

In relation to child psychiatry outpatient samples there are indications that a substantial proportion of the samples studied present with suicidal ideation and attempts. However, as with the community-based samples, the longer-term implications of such presentation are unknown and follow-up studies are required to clarify these. Significant relationships were indicated between suicidal ideation and attempts, and a psychiatric diagnosis of affective disorder. However, in relation to children and early adolescents with such a diagnosis, the question of which factors may differentiate between those who do and those who do not present with suicidal ideation and/or behaviour has not been investigated. This is an important question for further research. The tautological possibilities of the use of psychiatric diagnosis in these studies need to be borne in mind, as the presence of a 'suicidal' component may contribute to a diagnosis of affective disorder.

The studies on child psychiatry inpatient samples provide a broader range of data and suggest some heuristic possibilities. The indications are that quite large proportions of the samples studied present with suicidal ideation and attempts. The relationships indicated between suicidal ideation and attempts and a range of personal and family variables provide suggestions for the direction of further research with both clinical and community-based samples. In particular, it seems worthwhile to explore the
significance of perceptions of the family process variables of cohesion, control and conflict.

As noted above in relation to implications of the choice of cut-off age, correlates of suicidal ideation and behaviour found in older age adolescent samples seem very likely to apply to many individuals meeting the age-criteria of the present review. Further research is required to investigate the significance of these factors for the under-fifteen age-group, particularly at the older end of this group where overlap is most likely.

Three implications for clinical practice arise from this review. Firstly, the rates of suicidal ideation and attempts are such, particularly in clinical samples, that all clinical assessments of children and early adolescents should include investigation of this area. Particular attention is indicated for children and early adolescents presenting with depressive feelings because of the strong relationships identified above.

Secondly, in the course of clinical practice the identification of those most at risk of suicidal ideation and behaviour may be facilitated by obtaining data on the correlates identified in this review; these include current factors (depressive feelings, hopelessness, low self-esteem, preoccupation with death, and perceptions of family cohesiveness, control and conflict), historical factors (experience of loss, educational difficulties and family difficulties), and familial factors (mother's experience of suicidal thoughts, psychological difficulties in first degree relatives, and suicide attempts among first degree relatives).

Thirdly, in the context of the management and treatment of children and early adolescents whose clinical presentation includes suicidal ideation and behaviour, it may be productive, as part of the treatment plan, to pay particular attention to difficulties in areas identified in this review as correlates of such ideation and behaviour. Although the evidence is correlational only, it seems likely that such attention would provide many useful hypotheses to inform therapeutic support.
The indications of this review show that any doubt that "pre-adolescents were capable of genuine suicidal behaviour" (Milling & Martin, 1992, p.327) should be set aside. Although the incidence of completed suicide in this age group is very low, a range of suicidal ideation and behaviour is a factor in the lives of a significant number of children and young adolescents. It is hoped that this review of recent research provides useful information to clinicians supporting these children and their families, and indicates fruitful directions for further research.
References


Adolescent motherhood and child maltreatment: a review of recent research.
Introduction

Adolescent girls who become pregnant tend to be vulnerable. They are more likely to come from lower socio-economic groups (Kiernan, 1980; Babb, 1993), come from disrupted homes, and to have lower educational attainments and vocational aspirations even before becoming pregnant (Simms & Smith, 1986); it is more likely that their own mother was an adolescent parent (Simms & Smith, 1986; Kovacs et al., 1994). There is an association between socially deviant behaviour and early pregnancy and parenthood; Kovacs et al. (1994) found that early onset conduct disorder constituted a risk factor for teenage pregnancy; Abrahamse et al. (1988) found that measures of problem behaviour were associated with becoming a single, adolescent mother. Elster et al. (1990) found an association between problem behaviour and the birth of a first child prior to age 19 years.

Becoming a mother in adolescence raises the probability of disruption of schooling (Upchurch & McCarthy, 1989). The teenage mother is more likely to suffer adverse circumstances such as poverty, poor housing, low academic attainment, unemployment and disrupted relationships (Brooks-Gunn & Furstenburg, 1986).

An adolescent mother is likely to be a deprived, vulnerable young person, at risk of experiencing a range of problems. It is not surprising therefore that there has been concern that the children of adolescent mothers are at risk of maltreatment. This question has been the focus of a great deal of research; Stier et al. (1993) listed twenty-three studies published in the 1970's and 1980's which addressed the relationship between young maternal age and child maltreatment. According to Moore & Rosenthal (1993) “the prevailing wisdom is that these children face a bleak future with increased risk of parental neglect, child abuse, abandonment, and other forms of parental maltreatment” (p.160). This article will review the recent research literature relevant to such ‘prevailing wisdom’.

In the following, firstly the definition of child maltreatment is considered. Research is then reviewed addressing (a) parenting-related issues with pregnant adolescents and adolescent mothers, (b) the comparative frequency of maltreatment of the children of
adolescent and adult mothers and (c) characteristics of those adolescent mothers whose children may be at risk of maltreatment.

**Defining child maltreatment**

The definition of child maltreatment is extremely problematic. Ammerman (1993) refers to "the almost insurmountable difficulties in arriving at a universal consensus for an operational definition of abuse and neglect" (p.439), because "Child maltreatment is inextricably embedded in cultural and community values and perspectives" (p.439).

Giovannoni (1989) reviewed the definitional issues involved historically and in terms of medical, legal and social service definitions; she noted that 'Child development researchers and theoreticians have (........) been asked to study and explain phenomena that have not emerged or been identified out of their own body of knowledge" (p.27)

However, in order to address the phenomenon of child maltreatment a definition must be attempted. Two elements are essential to this definition, intentionality of the abuser and effect on the child (Ammerman, 1993; Giovannoni, 1989). Numerous definitions have been used (Giovannoni, 1989); typical examples are those recommended as criteria for registration as child abuse throughout England and Wales by the Departments of Health, Education and Science, the Home Office and the Welsh Office (1991). These are described by Browne (1995) as follows:

- **Neglect**: The persistent or severe neglect of a child or the failure to protect a child from exposure to any kind of danger, including cold and starvation or extreme failure to carry out important aspects of care resulting in the significant impairment of the child’s health or development including non-organic failure to thrive.
- **Physical injury**: Actual or likely physical injury to a child or failure to prevent physical injury (or suffering) to a child, including deliberate poisoning, suffocation and Munchausen’s syndrome by proxy.
- **Sexual abuse**: Actual or likely sexual exploitation of a child or adolescent. The child may be dependent and/or developmentally immature.
- **Emotional abuse**: Actual or likely severe adverse effects on the emotional and behavioural development of a child caused by persistent or severe emotional ill-treatment or rejection (p.44-45).

These definitions have been arrived at for use by social service and legal systems. They fall very far short of operational definitions, but are reasonable approximations.
considering the complex historical, social and cultural contexts from which they
developed. For purposes of a critical psychological review of research literature, there
is no choice but to use such definitions while remaining aware of their shortcomings.

**Research on parenting-related issues with pregnant adolescents and
adolescent mothers**

Sommer et al. (1993) investigated ‘cognitive readiness’ for parenting in 171 pregnant
adolescents, 48 non-pregnant adolescents and 38 pregnant adults. (Cognitive readiness
for parenting was measured by three self-report instruments addressing knowledge
about child development, parenting style and parenting attitudes, for which the authors
report good reliability). The subjects were recruited through local services on a
voluntary basis. The representativeness of the samples is therefore unknown. Their
analysis of the data, before controlling for demographic factors indicated that their
adolescent (both pregnant and non-pregnant) subjects were less ‘cognitively prepared’
than their adult subjects. When four demographic factors (IQ, SES, race and
educational level) were controlled for by using them as covariates, the differences
between the groups were attenuated; in this analysis “there were no overall differences
between the pregnant adolescent and adult groups on the (.....) cognitive readiness
measures” (p.393).

Passino et al. (1993) used three groups, (a) 191 pregnant adolescents (b) 60 non-
pregnant adolescents and (c) 53 pregnant adults, in a study of personal adjustment and
parenting behaviour. The subjects were recruited on a voluntary basis through local
agencies, so the representativeness of the sample is unknown. A number of self-report
measures was obtained, and observational measures of the mother’s behaviour with
their infants were also obtained; a series of multivariate and univariate analyses of
covariance procedures adjusted for age, race and sex and SES differences was used.
They found that pregnant adolescents were less socially competent and less proficient
in social problem-solving than their non-pregnant peers; [social competence was
measured by the Social Competence Scale of the Youth Self-Report (Achenbach and
Edelbrock, 1987); social problem-solving was measured by a ‘Social Situation
Problem-Solving Assessment’ adapted by the authors from the Means-End Problem-
Solving Procedure (Spivack and Levine, 1963); Passino et al. (1993) quote inter-rater
agreement of 97% for their adaptation]. On a Maternal Interaction Scale developed
for use in the study (and for which they reported an inter-rater agreement of .85),
Passino et al. (1993) found that adolescents as mothers showed less “appropriate and
responsive parenting behaviour” (p.109) than the adult mothers.

Baranowski et al. (1990) compared the ‘parenting attitudes’ of nineteen adolescent
mothers (ages: 15 to 19 years) and twenty-five older mothers (ages: 21 to 34 years) as
measured by the Adult-Adolescent Parenting Inventory (Bavolek, 1984). The subjects
were “volunteers” (p.783) from a local medical centre, so the representativeness of the
sample is therefore unknown. In this study the educational level, monthly income and
numbers married were lower for the adolescent than the adult group. However,
“despite the apparent disadvantaged status of the adolescent mothers in this sample
(........) group similarities, rather than differences predominated in fundamental
parenting attitude constructs” (p.778).

Haskett et al. (1994) used psychometric measures obtained during the perinatal period
with “a sample of convenience consisting of 66 adolescents who were pregnant or who
had recently delivered their first child” (p.464) to investigate “individual differences in
risk of child abuse by adolescent mothers” (p.461); the subjects were “enrolled in an
alternative school with a programme for adolescent mothers” (p.464) and were aged
from 13 to 18 with a mean age of 15.85. The Adult-Adolescent Parenting Inventory
(Bavolek, 1984) was used to measure parenting attitudes and beliefs, and the Child
Abuse Potential Inventory (Milner, 1986) was used to measure “abuse risk” (p.461).
Both of these measures have good psychometric properties as described by Haskett et
al. (1994). They found that the proportion of the sample “who scored in the high-risk
range on the CAP Inventory is certainly greater than would be expected in the general
adult population” (p.470) and that the AAPI “scores were indicative of more
inappropriate parenting attitudes and beliefs when compared to adult norms” (p.466-
467). However, they noted that “in the absence of a comparison sample of adult
parents matched on relevant socio-demographic variables, we are not able to conclude that age alone is the factor that places some of our sample at risk for abuse” (p.470). They did find however, that in a comparison of the CAP scores of those subjects younger than 16 years (N=27) with those 16 and older (N=39), the younger group expressed a significantly higher level of unhappiness, and a significantly stronger belief “in the value of physical punishment” (p.471).

To summarise these somewhat disparate findings, Sommer et al. (1993) found no overall differences between groups of pregnant adolescents and adults on measures of cognitive readiness for parenting when demographic factors were controlled. Passino et al. (1993) found that pregnant adolescents were less socially competent and less proficient in problem-solving than their non-pregnant peers and that adolescents as mothers, showed less appropriate and responsive parenting behaviour than adult mothers. In comparing ‘parenting attitudes’ of adolescent and older mothers Baranowski et al. (1990) found similarities rather than differences between the groups, even though the adolescent group was more disadvantaged than the adult group. Because of the lack of controls in Haskett et al. (1994) no conclusion can be reached about an adolescent/adult comparison: however, in an intra-group comparison they found that younger (<16 years) adolescent mothers were more unhappy and believed more strongly in the value of physical punishment than older adolescent mothers.

**The comparative frequency of maltreatment of the children of adolescent and adult mothers**

Two comprehensive reviews published in 1993 addressing the comparative frequency of maltreatment of the children of adolescent and older mothers came to similar conclusions. Buchholz & Korn-Bursztyn (1993) stated “There is no consensus (.........) as to whether children are generally at risk for maltreatment as a result of parental immaturity” (p.361). Referring to attempts to synthesise the results of the many publications in this area Klerman (1993) stated “none have succeeded largely because of the field’s methodological problems” (p.309). She suggested that methodological improvements were required in the following areas:
1. controlling for reporting bias,
2. clarity regarding definitions of maltreatment,
3. clarity regarding identity of perpetrators (i.e. adolescent mother or other),
4. controlling for socio-economic influences, and
5. clarity regarding definition of adolescent mother by age.

A literature search identified only one recent publication, that of Stier et al. (1993) which, using a longitudinal cohort design, satisfied all of the methodological requirements recommended by Klerman (1993). The subject cohort in Stier et al. (1993) was made up of all singleton children born at Yale-New Haven Hospital between October 1st 1979 and December 31st 1981, who had at least two visits to the hospital primary care centre before six months of age, and at least one visit to any hospital inpatient or outpatient department after ten months of age. For each subject data was collected from medical records of the four “major” (p.643) health care facilities in New Haven; (the authors do not say whether or not this was a comprehensive coverage of all of the health care facilities which the subjects could possibly have attended). Data were collected from birth to the child’s fifth birthday.

For the “index group” (p.643) they identified 219 infants born to mothers who were 18 years of age or younger. A comparison group of 219 children, born to mothers aged 19 to 34 years, were matched with the above “according to date of birth (within 9 months), ethnicity, gender, birth order and method of payment for hospitalisation (....) as a marker for socio-economic status” (p.643). Age of the mother and socio-economic variables were thereby controlled. The adverse outcomes which were assessed for each child were:

1. maltreatment, including physical abuse, neglect or sexual abuse; [“To minimise detection bias which may occur if the assessment is made with knowledge of the mother’s age” (p.643) a “blinded” review procedure was used];
2. poor growth (defined by specific growth criteria, or hospitalisation for non-organic failure-to-thrive); and
3. changes in the child’s primary caretaker; [“Changes were classified as those in which the child was placed by the state’s child protective service agency in foster care or those in which less formalised changes in the guardian occurred” (p.643)]. The definition of maltreatment in this study was thereby operationalised and reporting bias was controlled for. Data were also collected on the identity of the perpetrator of any physical abuse where this was noted in the medical records. The statistical analysis consisted of the calculation of unmatched risk ratios and logistic regression in order “to compare the frequency of the outcomes in the children born to young mothers with those in the comparison group” (p.643).

In addressing their results Stier et al. (1993) state that “maltreatment, in particular neglect, occurred twice as frequently to children of younger mothers compared with children of older mothers” (p.647). Although this statement is true it is incomplete, in that it reports incidence without reference to probability. In fact the results of the statistical analysis were that “though each type of maltreatment occurred more commonly in children of young mothers, only neglect, by itself was statistically significantly different” (p.646). No significant difference was found in relation to ‘poor growth’. They did find that changes in the child’s caretaker occurred statistically significantly more often in the “index group”. “Of the 28 index children who had a change in caretaker, 14 were placed by the child protective system and 14 were left in a less formalised arrangement in the care of a primary guardian other than their mother” (p.645). It is difficult to know what can be deduced from this finding; the authors suggest that “many of the separations (........) were a consequence of the disorganised social environments that seemed to occur more commonly in the families of the young mothers” (p.646).

In summary the results of this well-controlled study suggest that children of adolescent mothers are more likely to experience neglect and a change in caretaker before the age of 5 years, than children born to adult mothers.
Characteristics of those adolescent mothers whose children may be at risk of maltreatment

All three studies addressed in this section were carried out in the U.S. Zuravin & di Blasio (1992) carried out a retrospective survey study “to identify characteristics that discriminate between neglectful and non-maltreating teen mothers” (p.472). The study reported on a sample of 102 low income single mothers, who were recipients of Aid to Families of Dependent Children (AFDC) for at least one natural child age 12 or under, resident in Baltimore (U.S.A.) during the sampling month of January 1984, and who had given birth to their first child before the age of 18. The representativeness of the sample is not described. Of the 102 subjects studied by Zuravin & di Blasio (1992) 22 of them had been identified as neglectful by the Child Protection Service of the City Department of Social Services. The other 80 mothers, who made up the comparison group, had never received any of the child welfare services. At the time of the survey interview the average age of the 22 neglectful mothers was 23.1, and that of the comparison group was 26.3. Neglect was operationally defined by the CPS in terms of a minimum score on a rating scale which measured parental omissions in care. However, the rating scale scores assigned depended on the judgement of child protection workers, so their reliability is unknown. The authors state that “none of the neglectful mothers was known to have a child who had been physically abused” (p.473).

Zuravin & di Blasio (1992) state that “Lacking a well-developed body of knowledge about child maltreatment by teen mothers, selection of the independent variables ...... was guided by theory and findings from the maltreatment and other relevant literatures” (p.473). On this basis they investigated the relationship of 11 variables with neglect using a logistic regression analysis. The data were collected through in-home interviews with the mothers. The interviewers were unaware of the child maltreatment status of their respondents. Zuravin & di Blasio (1992) found that five of the eleven variables were associated with neglect, independent of race; these were:
1. mother's experience of sexual abuse,
2. age of mother at first birth,
3. total number of children of mother,
4. prematurity/low birth-weight of the first child, and
5. educational level of mother.

As long as the shortcoming regarding representativeness and unknown reliability of the measure of neglect are borne in mind these results can be taken as suggestive of factors which differentiate neglecting from non-neglecting low-income single mothers who had given birth before the age of eighteen.

Boyer & Fine (1992) investigated “the adolescent parent’s own victimisation as a risk factor for maltreatment of her children” (p.5). The subjects were 476 women who were recruited on a voluntary basis through organised programs for pregnant and parenting adolescents so the representativeness of the sample is unknown. “The criteria for project involvement were that they be no older than 21 when completing the survey and 19 or younger at the time of their first pregnancy” (p.5). Information is not provided on the participants’ SES. The data for this study were collected through a self-report questionnaire, including the data on maltreatment of the adolescent mothers’ own children; it seems likely as the authors noted, that this would result in an underestimate of maltreatment in the sample. For the purpose of collecting data about the adolescent mothers’ own sexual victimisation prior to the first pregnancy, Boyer & Fine (1992) used clear operational definitions of molestation, attempted rape and rape; (62% had experienced sexual victimisation while 38% had not). However, they do not describe the definition or the measures used to collect data on maltreatment of the children of the adolescent mothers. They concluded that “significant differences in child maltreatment were found between mothers who had been abused and those who had not” (p.10), with the children of the former experiencing more maltreatment. However, the authors do not specify how ‘significance’ was calculated.

There is a difficulty in interpreting the meaning of these results because of unknown representativeness of the sample, the lack of definition of maltreatment of the children of adolescent mothers and the absence of a description of the measures used to gather the data. The conclusions of this study therefore may only be seen as suggestive; the suggestion which can be made is that the children of those adolescent mothers who
have a history of sexual abuse are more likely to experience maltreatment than the children of adolescent mothers who do not have such a history.

The relationship between childhood victimisation and adolescent pregnancy outcome was investigated by Stevens-Simon & McAnarney (1994). Their subjects were 127 consecutive low-income black maternity patients who were less than 19 years at conception. “Data collection consisted of determining the prevalence of abuse during childhood and quantifying associated factors which could influence pregnancy outcome” (p.570). Data were collected through standardised patient interviews incorporating measures with established reliability, and physical and laboratory examination. A total of 42 (33%) of the subjects reported that they had been physically or sexually abused prior to conception. The data collected from this group were compared to those collected on the 85 non-abused subjects. The findings were that “previously abused adolescents scored significantly higher on stress and depression scales, rated their families as significantly less supportive, were significantly less likely to identify their mothers as support people, and were significantly more likely to report that they had used illicit drugs and alcohol during pregnancy” (p.572), and that “abused adolescents gave birth to significantly smaller, gestationally less mature infants” (p.572). Stevens-Simon & McAnarney (1994) suggest that their findings should give rise to particular concern “because published data indicate that the preterm and low birth weight infants of young, stressed, depressed, poorly supported, substance using mothers are at higher than average risk for abuse and neglect” (p.573).

To summarise, the findings of these three studies suggest (a) that neglect of children of low income single adolescent mothers may be related to the mother’s experience of sexual abuse, age of the mother at her first birth, the total number of her children, prematurity/low-birth weight of her first child, and her educational level, (b) that the children of adolescent mothers who have experienced sexual abuse are more likely to experience maltreatment than the children of adolescent mothers who have not, and (c) that there may be a relationship between childhood victimisation and a number of negative outcomes indicating risk for abuse and neglect, for low income, black, adolescent mothers. These findings suggest that the adolescent mothers whose
children are most at risk of experiencing maltreatment are those who themselves have experienced deprivation and victimisation.

There is a suggestion in the above of a possible intergenerational transmission of child maltreatment. This hypothesis has been comprehensively and critically reviewed by Rutter (1989) and Kaufman and Zigler (1989). Both of these reviews conclude that experience of maltreatment as a child puts one at risk of being abusive as a parent but that most abused children do not become abusive parents. In this regard Rutter (1989) in particular emphasises the importance of social support in adulthood, particularly from a spouse, and other social and educational experiences. These reviews do not specifically address adolescent mothers, but it seems likely that similar dynamics may operate in terms of support and positive experiences.

**Discussion**

Taken together, the findings of the broad range of research considered above provide a framework clarifying our present knowledge of the relationship between adolescent motherhood and child maltreatment, allow identification of areas requiring further investigation, and suggest implications for practice.

There is no evidence that adolescent mothers as a broad group are deficient in their ‘cognitive readiness’ for parenting or in their ‘parenting attitudes’ as compared to adult mothers. There are indications that pregnant adolescents are less socially competent and less proficient in social problem-solving than their non-pregnant peers, that adolescent mothers show less appropriate parenting than adult mothers in interaction with their infants, and that the children of adolescent mothers are more likely to experience neglect and a change in caretaker, before the age of 5 years, than children born to adult mothers. At a level of greater specificity there is an indication that mothers younger than 16 years are more unhappy and believe more strongly in the value of physical punishment than older adolescent mothers; and there are suggestions that an adolescent mother’s experience of deprivation and victimisation, particularly sexual victimisation, is associated with experience of maltreatment by her children.
A number of areas would benefit from further investigation. While interesting and suggestive in themselves it is difficult to relate findings regarding 'cognitive readiness' for parenting and 'parenting attitudes' and 'beliefs' to the actual care which adolescent mothers may provide for their children. It would be useful to investigate how such variables relate to parenting behaviour so that the value of further research on them could be clarified. The findings of the studies reviewed were somewhat conflicting but this may be accounted for simply by the poor controls for representativeness of the samples. What would probably be of greatest value in this area would be further studies of the parenting and care behaviour of adolescent mothers. Further investigation of the comparative frequency of maltreatment of the children of adolescent and adult mothers does not seem likely to open up heuristic avenues of research. It seems likely that the assumption of homogeneity underlying this research may be unhelpful. Such an assumption hides great variability, demographic, social and psychological. For further investigation, it would seem more fruitful to try to identify sources of support and stress amongst adolescent mothers rather than to search for general differences between them and adult mothers.

Indeed in the course of drafting the discussion of this review the author came to accept that the question addressed (i.e. do the children of adolescent mothers face a future of increased neglect and maltreatment?) was for him a much less important, and perhaps more stigmatising (because of the focus on negative outcomes) question than others which should be considered. The research literature relating to the question addressed is narrowly focused and gives little attention to current relevant factors in the lives of adolescent mothers or to broader social structural variables. In retrospect the author would prefer to have addressed a diversity of experiences, relationships and broader social contexts amongst this age-group of mothers, with a view to clarifying connections between influential factors and both positive and negative child outcomes. Such an approach seems likely to lead to a more informed and respectful understanding of the lives of adolescent mothers and their children and more likely to provide a clearer focus for both preventive and interventive work relating to negative child outcomes.
The suggestion that the adolescent mothers whose children are most at risk of experiencing maltreatment are those who themselves have experienced deprivation and victimisation may repay further investigation. It may be that the increased risk of neglect for the group as a whole may be due largely to the increased risk for a deprived, victimised sub-group. Alternatively, it may be that the children of deprived, victimised adult mothers may be at the same level of risk, and that the mother’s age may not be a crucial factor. Although there is a suggestion of possible intergenerational transmission, presently the evidence from research is such that we do not know if adolescent mothers differ from adult mothers with respect to the intergenerational transmission hypothesis; nor do we know what social supports or educational experiences of adolescent mothers may reduce the risk of maltreatment of their children. These seem likely to be fruitful areas for further investigation.

The above summarising framework provides clear implications for practice. As the children of adolescent mothers appear to be at some risk of neglect, it seem worthwhile to target these mothers and children for prevention of such neglect. The most promising programmes for the prevention of maltreatment are multi-dimensional, and are capable of simultaneously addressing many factors which create contexts for maltreatment (Olds & Henderson, 1989). Such programmes include components such as home visiting, prenatal support and information, parent education regarding infant development, enhancing informal support of family and friends, and enhancing linkages with formal services. Additional components of a prevention strategy are indicated in the framework above; it seems worthwhile to provide support to pregnant adolescents in the areas of social competence and social problem solving, because of the importance of such skills in developing a network of social support, and in dealing with personal and social difficulties. Following the birth it would seem useful to provide support to adolescent mothers in interacting sensitively and effectively with their infants. Such work could be based on clinical applications of attachment theory (Richer, 1994). It seems worthwhile to provide extra support to younger adolescent mothers, particularly in relation to their possible unhappiness and views relating to physical punishment. Support for the group most likely to be at risk, these adolescent
mothers who have experienced deprivation and victimisation, particularly sexual victimisation, should include all of the components noted above, and in addition a therapeutic component focusing on possible post-traumatic issues. It would be very useful to evaluate the effects of such support strategies, as it is presently unclear as to what are the effective components of a strategy to prevent child maltreatment (Wolfe, 1993).

On a final point regarding research, there is a striking absence in the literature of the voice and experience of adolescent mothers themselves. The literature in this area would be enhanced by research on the experience of becoming and being a mother in adolescence, on what these mothers find supportive and distressing in relation to their own development and to their care and parenting of their children.
References


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1. Intervening in a special school in relation to management of behavioural difficulties
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1. INTRODUCTION

1.1 Context of the project

This project originated in a request to the author’s department from the principal of a special school (St. P’s) for a ‘psychological service’ to the school. Consideration of the request at this department concluded in a decision that the author would respond and that the time to be allotted would be no more than two hours per fortnight, for no longer than six months at which point or earlier, the position would be reviewed. The author’s interest in pursuing this project and writing it up for this portfolio arose from the two objectives for the professional dossier as stated in Section One above; these are firstly, to obtain experience of working with an organisational perspective and secondly, to increase competence in the use of a consultation model.

The following information was provided by the principal. St. P’s is designated a ‘special’ school by the Department of Education. It serves pupils between the ages of ten and fifteen, deemed to be at risk of neglect, abuse and disadvantage in their homes, and at risk of leaving school without a good basic education. It provides places for 24 pupils. The school is located in a detached three-storey house on the periphery of Cork city centre; it is located in an area with administration and commercial developments, with little residential development and little sense of community. The school’s catchment area includes urban and rural areas; the pupils live within ten to twelve miles of the school; most of them live in suburbs around the city, within two miles or so of the school. There is an accessible and reliable public transport system. The teaching and other staff complement of St. P’s is as follows:

1 Principal (who is also effectively the manager of all of the services provided by the school),
2 Class Teachers,
2 Youth Counsellors (one with a background in Social Work, the other in Youth and Community Work), and
3 Classroom Assistants.

(The school also has a secretary and a caretaker. They had no involvement in the present project and the use of the term ‘school staff’ in the following does not include them).
As noted above the principal is the manager of the school. Each classroom assistant is accountable to a specific teacher (including the principal), and the two teachers are accountable to the principal. The two counsellors are also accountable to the principal in a managerial sense but not in a professional sense. The role of the counsellors is not explicitly described in the school policy. In practice they provide individual and group counselling for the pupils; they work supportively with the families of the pupils, focusing on the young people’s needs; and they liaise with other agencies with whom the pupils are involved. One or other counsellor works with every pupil on an ongoing basis. Both counsellors seem to know all of the pupils well, whereas the teachers and class-room assistants seem very familiar only with their own pupils. The counsellors, by virtue of their role, are also familiar with the families of the pupils, whereas the teachers and classroom assistants have little involvement with them.

The school was established in order to provide educational placements for young people between the ages of ten and fifteen deemed to be ‘at risk’ as noted above. The young people who attend St. P’s have experienced serious difficulties in maintaining their placements in their mainstream schools, either because of poor attendance or disruptive behaviour or both.

The primary aims of the school are to provide each pupil with the following: a basic formal education to ensure adequate literacy, numeracy and general knowledge; an informal education to allow the development of creativity and recreational interests; an opportunity to deal with his/her problems in a non-threatening environment, with proper support and confidentiality; support to pupils’ families in learning to accept the presence of problems, the need to find solutions and, to help them understand and deal with their children’s needs.

It can be concluded that St. P’s is a well-resourced agency in terms of staffing, with a clear management structure, and with broadly stated aims which have not been defined in terms of specific objectives.
1.2 Consideration of response options

The initial problem to be addressed by the author was how best to respond to a request for a service to as many as 24 ‘at risk’ young people, many of whom were likely to be presenting with emotional, behavioural, social and/or educational difficulties, when only two hours psychologist time per fortnight was available. A traditional individual referral approach would obviously be inadequate and inappropriate. The following is a summary of a review of relevant literature, with a view to deciding on the approach to be taken.

The problem posed for psychologists by an individual-referral approach to managing emotional and behavioural difficulties in school is succinctly described by Galvin & Costa (1994): “too many children with too many problems, and too few visits”(p.145). The traditional individual-based approach to responding to children’s problems has been greatly undermined by epidemiological studies which have shown that many more children have problems than receive services (Rutter et al., 1970; Rutter, 1989).

Criticisms of the models which had early domination of child therapy services have been made since the 1970’s. These criticisms came from a number of sources and with different targets. Tizard (1973) pointed to the ineffectiveness of the Child Guidance clinics. Others (Lane, 1973; Lawrence, 1973; Hart, 1979; Miller, 1990) pointed to the impact of context and argued for a more systems-orientated approach, in which not the individual but rather the context might be the focus for a programme of change.

Barker’s (1968, 1978) argument that there was a ‘fit’ between milieu and behaviours and Bronfenbrenner’s (1979) theory of the ecology of human development and behaviour offered an alternative approach to construing behavioural development, and therefore an alternative way of construing therapeutic support. This alternative approach emphasised the value of addressing social contexts and social systems. Such approaches have provided the theoretical base and values for what has come to be called ‘community psychology’ (Orford 1992). In turn, work from a community psychology perspective has informed practice in clinical and educational psychology to the point where Heller (1989) has argued that those theories which highlight the importance of social and environmental factors in behaviour and the necessity of
conceptualising intervention from a proactive and preventive stance, have become mainstream. This approach also has roots in work in institutional settings concerning the view that organisations have an effect on the groups and individuals who are a part of them (Handy, 1976). This effect has been given many names, ‘culture’, ‘ethos’ and ‘climate’, being the most common. There is an accumulating body of research evidence about the nature of this effect on the lives of children in schools (Anderson 1982; Mortimore et al., 1988).

In Britain, Rutter et al. (1979) carried out an influential early study in investigating what might be influential in-school factors. Their results suggested that effective schools had common policies on behaviour; they made regular use of rewards; they took trouble to set up a pleasant working environment; and thought carefully about what constituted effective classroom management strategies.

The Elton Report (Department of Education and Science, 1989) made 138 suggestions as to how schools could promote good behaviour, the vast majority of which were underpinned by the central theme that schools can make a difference to behaviour. Galvin and Costa (1994) summarised the implications of the above body of work as follows: schools do make a difference; behaviour can be managed as well or as badly as any other area of school life, and a positive approach does work. They concluded: “To manage behaviour, schools need a philosophy, a policy and a set of practices. In essence, schools are required to develop a clear ethos, a recognised set of values about behaviour, and to have in place some basic strategies for managing behaviour” (p. 148-149). For purposes of the present project, it was concluded that, in addressing the initial problem posed, an approach based on the school as an organisation would be the most efficacious one to take and that the conclusions reached by Galvin & Costa (1994) above, provide the rationale for the implementation of such a model.

This conclusion precluded work with parents within the context of this project. Indeed such work was precluded by the amount of time available. The various ways of working with the parents of children presenting with behavioural difficulties at school are variants of three approaches:
1. an individual case-management approach, which involves clinic-attendance by a child and his/her parents, with the psychologist working therapeutically with them and advising and supporting the teacher separately,

2. a joint approach involving the psychologist and teacher working together with the parents and child, usually meeting and working within the school (Dowling, 1994; Dowling & Pound, 1994), or

3. the psychologist consulting with the school staff in relation to the staff's work with parents and pupils (Lindsey, 1994; Gray & Noakes, 1994).

If work with parents were to be included in the present project it would necessarily be on the basis of the third model and, indeed, such a development could well arise from this project. However, considering the psychology time and resources available, it was decided that the response would be restricted to working with within school factors only. To summarise, it was concluded that an individual-referral approach was neither feasible nor appropriate, that the value of taking an organisational approach is established, and that the amount of psychology time available precluded the involvement of parents in such an approach in the first instance.

Taking such an organisational approach implies the use of a consultation model. Consultation is the process whereby an individual (the consultee) who has a responsibility for providing a service to others (the clients) voluntarily consults another person (the consultant) who is believed to possess some special expertise which will help the consultee provide a better service to his or her clients (Orford, 1992). Almost all writings on consultation in mental health settings trace their lineage back to Caplan's (1970) classic account. According to Caplan (1970) mental health consultation represented a shift from the previous clinical model in three significant ways as follows:

1. The focus of attention was no longer exclusively the individual client, but was enlarged to include the setting in which the difficulty occurred.

2. The consultant worked with the consultee and not the clients.

3. The aim of the consultation was limited to enable the consultee contain and resolve
the difficulties encountered with the clients, not to reform, cure or treat the client, nor, for that matter, the consultee.

Taken together these shifts firmly differentiate consultation from clinical treatment, on the one hand and the giving of technical advice on the other, and establish it as an interventive approach aiming to promote the mental health of individuals in the operation of larger systems.

In an effort to define consultation more precisely most writers on the subject have been at pains to distinguish between a consultation relationship and other types of relationships with which it might be confused. Caplan’s (1970) view was that consultation did not include supervision or education or any similar process in which two people had a superordinate-subordinate relationship in which the subordinate party was not totally free to seek out the other party, to continue or discontinue the relationship, or to set the agenda. The notion of the consultant-consultee relationship being a ‘co-ordinate’ one with no built-in hierarchical authority tension, and with no compulsion on either side is fundamental to Caplan’s idea of consultation.

However not all writers on the subject have construed consultation in this way. Taylor (1994) defines consultation succinctly as “attempts on the part of specialists to help organisations attain greater efficiency in achieving their objectives” (p. 137). Orford (1992) states that from the point of view of community psychology “the touchstone is the sharing of specialist knowledge and expertise more widely with groups of people who are more in touch with the community from which clients come, and/or in touch with larger numbers of clients than can be the case for the consultant or the professional group which he or she represents” (p. 140). Dare (1982), writing in relation to child mental health described the major feature of consultation as “the way in which clinical skills are made available across institutional, departmental and disciplinary boundaries, so as to enhance the efficacy of colleagues without usurping their responsibility for their own practice activities” (p. 5). In this way, according to Dare, the consultee receives some training, some counselling in regard to the personal elements, and may also feel supported and partially supervised by the consultant.
However the consultant does not become responsible in a managerial sense, for either the training, or clinical or other professional work of the consultee.

Considering the objectives of the present project, its social context and the apparent levels of knowledge and skill of the school staff involved in its implementation, it seemed that a combination of Orford’s (1992), Dare’s (1982) and Caplan’s (1970) views provided appropriate principles to underpin the use of consultation in the present project. A summary of these is as follows, with the source of each principle identified in parentheses:

1. The sharing of specialist knowledge and expertise with staff who are more in touch with clients and with larger numbers of clients than can be the case for the consultant (Orford, 1992).
2. Some teaching/trainee of the consultees (Dare, 1982).
3. Some counselling of consultees in relation to personal issues arising from implementation of a project (Dare, 1982).
4. Ongoing support and supervision regarding the practical implementation of a project (Dare, 1982).
5. The consultant not becoming responsible in a managerial sense for either the training or work of the consultees (Caplan, 1970; Dare, 1982; Orford, 1992).

2. METHOD

2.1 Outline of this section
The action taken by the author in the course of this project consisted of six meetings with members of the staff of St. P’s as follows: the first meeting was with the principal only, and the second with all of the staff; there followed three meetings with the principal and the two counsellors, and a final meeting with the two counsellors only. Each meeting is described below in terms of its purpose, content and outcome. At the fourth meeting it was agreed that the author would design a model of intervention and evaluation to be used at the school. For clarity in following the sequence of events the development of the model is described at that point. The final two meetings are then described. The period between each meeting was one to two weeks.
2.2 First meeting: with the principal

This meeting was arranged for purposes of initial information gathering and exchange of views. As outlined at the meeting the principal's view in summary was:

1. Many of the pupils (possibly up to half of them) presented with problems in behaviour within the school. (Examples of such problems were: talking loudly off-task, leaving seat without permission, interfering with other pupil's work, verbal and, sometimes, physical aggression and non-compliance. Some of the difficulties occurred in class, while others occurred in other parts of the school).

2. The psychologist would work with the two counsellors and the parents in helping the pupils to gain control of their behaviour.

3. Individual teachers would be involved in this work in relation to their respective pupils.

4. The model of intervention would be individual case management. There was no element of systems thinking in his view.

As indicated above, the author's view, in summary, was:

1. The amount of psychology time available precluded an individual case management approach and suggested the use of a form of consultation as a model.

2. The approach taken should have an organisational perspective and should attempt to harness as many of the resources of the school as possible.

Though not committing himself to the author's recommended approach, the principal agreed to the author's request for a meeting with all of the teaching and care staff of the school; the author and the principal agreed that the general purposes of this meeting would be:

1. to enable the author to outline his views on how best to attempt to manage difficult behaviour within a school, and

2. to facilitate engagement of the staff in developing the school's policy and practice regarding management of behavioural difficulties.
2.3 Second meeting: with all of the staff

This meeting took place at the school as part of a staff training day. It comprised the morning session of approximately three hours (with a half hour break). The author’s objectives were:

1. to outline an approach based on the assumptions that behaviour can be managed effectively within a school, and that a positive approach does work,
2. to attempt to make explicit the staff’s present responses to difficult behaviour, and
3. to attempt to have the staff consider their satisfaction/dissatisfaction with these responses.

During the first half of the session the author addressed the problems of responding to difficult behaviour within a school (as described below); the second half of the session was taken up with discussion of this presentation in the context of the staff’s view of St. P’s needs. The following is a summary of the content of the meeting.

Following an introduction and an outline of the plan for the morning, the author posed the question:

“What are the behaviours that you are concerned about”?  

The responses were noted on a board. (They included non-compliance, leaving seats, talking loudly, not attending to work, verbal aggression to other pupils and to teachers, and physical aggression to other pupils). There seemed to be little variation between the responses of the teachers, classroom assistants, and counsellors. The following request was then made.

“Will you describe the ways that you respond to these”.

The responses were again noted on the board. The responses of the teachers and classroom assistants included reprimands, requests for compliance, lines, detention, removal from the classroom and sending to the principal; every response described was punitive. However, the responses of the counsellors were quite different reflecting both alternative ways of construing difficult behaviour and also the contexts within which the counsellors worked with the pupils. The responses of the counsellors were, understandably, couched in terms of counselling, and identification and expression of feelings; they did not seem to be oriented to addressing changes in behaviour directly,
and did not appear to attempt to integrate their approach with that of the teachers and classroom assistants.

The following questions were then raised in a discussion context.

"Do you discuss these responses with your colleagues or principal?"
"Do you discuss these responses with a psychologist or social worker?"
"Do you plan these responses?"
"Does the school have a policy regarding how to respond to behavioural difficulties?"
"Is your approach agreed with colleagues and supported by them?"
"Is your approach discussed with parents and supported by them?"
"Is your approach discussed with the pupils and supported by them?"
"Is your approach punitive or supportive?"
"Are your rules explicit, clear and agreed with staff, parents and pupils?"
"Are your rewards explicit, clear and agreed with staff, parents and pupils?"
"Are your sanctions explicit, clear and agreed with staff, parents and pupils?"
"What other agencies are available to give you support?"
"In what practical ways do they support you?"

A summary of the responses was that the individual staff member responded in an unplanned, unsupported, non-explicit, punitive manner, and that nobody on the staff was satisfied with the current approach. Problems arising from this approach which were identified by the staff were "feeling isolated", "self doubt", "feeling demoralised", and a general sense of "feeling unsupported and stressed".

The author described an alternative approach based on the material outlined above in 'Consideration of response options'. The practical requirements of developing a clear ethos, a recognised set of values about behaviour, and basic strategies for managing behaviour were outlined. The general response of the staff appeared to be enthusiasm and interest. The session concluded with the arrangement of a follow-up meeting involving the principal, the two counsellors and the author.
The author’s conclusion from these discussions was that two separate approaches to construing and managing behavioural difficulties existed within the school; the approach of the teachers and classroom assistants seemed punitive, with no focus on positive development of appropriate behaviour; the approach of the counsellors seemed supportive and reflective but also without a focus on positive development of appropriate behaviour.

2.4 Third meeting: with the principal and the two counsellors

The principal opened this meeting by stating that the school staff were interested in developing a policy and strategies along the lines which I had recommended. He gave his view that involving the whole staff in plenary meetings to work on such development was not feasible. He gave two reasons for this; firstly, with so many people involved he felt that progress would be slow and difficult; and secondly, he would have great difficulty with the logistical problem of enabling all of the staff to be free from other duties at the same time in order to meet regarding this project. He suggested that the two counsellors and he, as a teacher’s representative, would form a ‘project team’ within the school and that the author would work supportively with them.

Both of the counsellors and the author held the view that including all of the staff in development and implementation of the project would engender a greater sense of ownership and motivation. However, the logistical problem of releasing all of the staff of their duties at the same time could not be overcome. Although the model proposed by the principal was congruent with the planned consultancy role of the author, it was in danger of simply replicating the previous management system and culture of the organisation. It did not seem likely that such an approach could successfully tackle inertia in the school system as it did not directly involve the teachers and classroom assistants. The success of such an approach also depended very much on the commitment to change of all three members of the ‘project team’, their capacity to work together with a clear focus, and their skills in engaging the other teachers and the classroom assistants in the planned changes. Although the author would continue to have a strong influence on the ‘content’ of the intervention, the management of the
process of the intervention would be out of his control and would be in the hands of the project team.

Nevertheless the suggestion of a project team seemed feasible, on condition that the other two teachers and the three classroom assistants were consulted and informed on an ongoing basis by the team members. The author stated this explicitly and also outlined his impression of the complex set of relationships and varied roles within the school. As the suggestion of a project team within the school supported by the author, was the only option available, the author agreed to accept this way of working. A further meeting was arranged, and it was agreed that the objective of the next meeting would be to specify issues identified by the staff as needing to be addressed.

2.5 Fourth meeting: with the principal and the two counsellors

In order to frame the discussion as broadly as possible, the author opened the business part of this meeting by noting the agreement come to and by suggesting that the agenda be set by the question “What issues need to be addressed?” There followed an enthusiastic discussion. The following is a summary of the main responses of each of the three school staff members, abstracted from the author’s notes of the meeting.

The principal’s suggestion of issues to be addressed
1. Behavioural difficulties in class.
2. Pupils finding it hard to deal with their aggression.
3. Pupils finding it hard to relate to the adults.
4. Tying people in to the same agenda.
5. Being clear about what we do as a team.
6. Being clear about the value of what we do.
7. Accountability regarding work with individual children.

Counsellor A’s suggestion of issues to be addressed
1. Behaviour of pupils in school
2. A clearly understood focus
3. Clear objectives
4. More support amongst the staff
5. An understanding between the staff and the youngsters about what we are doing.
6. To be able to track the progress of each individual child.
7. To be able to show the young people what they have gained.
8. The whole team to figure out what we are at.

Counsellor B’s suggestion of issues to be addressed
2. Evaluating what we do.
3. Being clear about what skills the young people already have.
4. A means for measuring and monitoring goals.
5. Everybody (staff) being involved.
6. Clarity about a therapeutic approach.

Examination of these points and of the relationships between them indicated three broad issues needing to be addressed as follows (the suggestions stated above are identified in parentheses; P indicates Principal, CA indicates Counsellor A, CB indicates Counsellor B; their suggestions are identified by number).

1. The need for agreement amongst the staff on clear behavioural standards
   (P4, P5, CA2, CA3, CA5, CA8, CB3, CB5, CB6)
2. The management of difficult behaviour presenting in school, (P1, P2, P3, CA1, CB1)
3. The need for a means to measure progress for each pupil, (P7, CA6, CA7, CB2, CB3, CB4).

The broad strategy adopted by the author had been to facilitate the consultees in defining the problems to be addressed. This had been a collaborative process. However, it was agreed at this meeting that the author would take the initiative next, to develop (a) a model of intervention to respond to these problems and (b) an evaluation
of the intervention. This development was to be informed by the author’s view as described earlier (the use of a consultation model and an organisational perspective) and was to address the three broad issues identified by the principal and the counsellors. The model of intervention is described next and the evaluation is described in the section following.

2.6 The proposed model of intervention

2.6.1 Introduction

The model of intervention consisted of three components as follows:
(a) a consultation process between the author and the project team,
(b) the development of a consensus amongst the staff on values about behaviour and the expression of these values in clear rules,
(c) strategies to be used by the school staff to manage pupils’ difficult behaviour, which include the means of measuring progress for any pupil towards agreed behavioural objectives.

Objectives of the proposed intervention can be identified at three levels as follows:
1. in the short term, to change the ways in which St. P’s staff construe and respond to difficult pupil behaviour,
2. in the medium term, to reduce the frequency of difficult pupil behaviour within the school, and
3. in the long term, to change the culture of the school in such a way that as an organisation it would become supportive of the self-management of every pupil.

The three components of the model are described below.

2.6.2 The consultation process

The principles underlying the use of consultation in the present project are outlined above. The implications of these for the project are that the author would:
1. share specialist knowledge and expertise with the school staff,
2. provide some training for them,
3. provide some counselling in relation to personal issues arising,
4. provide ongoing support and supervision,
5. while not becoming responsible in a ‘managerial’ sense for their work.

It was proposed that consultation between the author and the project team would take place at fortnightly two-hour meetings at the school.

2.6.3 The development of a consensus amongst staff on values and rules
Following from the conclusions reached by Galvin & Costa (1994), in order to begin to address the pupil’s behavioural difficulties, the staff of St. P’s would have to come to a consensus on a recognised set of values about behaviour. Such values would then need to be expressed in clear rules about behaviour in school. A ‘school-wide consensus’ could be achieved only by involving all of the school staff in discussion of these. The essential point was that the agreement and support of all of the staff was required on these values and rules and that this would come about only if all of the staff were involved in their development. Therefore each member of staff would need to be facilitated to address, in discussion with colleagues, (1) the values underpinning the school’s policies regarding behaviour and (2) the expression of these values in clear rules about behaviour in school. How this could be done would depend on logistics within the school. However, the author would be available to support the project team in managing this in the context of the consultation process.

The agreed values and rules would provide the context and logic within which objectives would be set jointly with individual pupils when the ‘strategies to manage behaviour’ are being implemented. The statement of the values underlying the school’s policies and the expression of these in clear rules about behaviour in school would be displayed in each classroom. The question of values would be discussed with the pupils and the rules about behaviour explained in classroom discussion.

2.6.4 Strategies to be used by the staff to manage pupils’ behavioural difficulties

The approach chosen by the author was to use the consultation meetings to support the counsellors in learning to use a ‘self-directing’ model of behaviour change with the pupils, and then to support them as they in turn passed on these skills to the other school staff.
In a review of the effectiveness of psychotherapeutic treatment of children and adolescents Kazdin (1993) concluded that “it produces effects that exceed changes associated with no treatment” (p.646) but that “the paucity of studies for a given treatment technique and the heterogeneity of treatments within a broad class, preclude firm statements about the relative impact of alternative interventions” (p.646).

However, considering the context of the present project, there is evidence that behavioural and cognitive-behavioural approaches have been effective in similar contexts with similar populations. For example Kolvin et al. (1981) researching the effects of direct intervention in a school setting, found that a behavioural approach was the most effective with older children; cognitive-behavioural treatments have been shown to reduce aggressive and anti-social behaviour amongst children and adolescents (Kazdin et al., 1990; Kendall et al., 1991); Wheldhall and Merrett (1985) and Chisholm et al. (1986) have also shown the usefulness of a behavioural approach within schools.

The framework provided by a cognitive-behavioural approach would clearly be useful in the context of the present project. However, it was important that the approach used would facilitate generalisation of whatever skills are developed in order to help the pupils to be better able to deal with emotional, behavioural or social difficulties outside of their school lives. Further, the approach to be used needed to be easily accessible to school staff, not require a great deal of training and study, and provide a means to measure progress towards agreed targets.

An approach which appears to fulfil each of these criteria to some extent is the ‘self-directing’ model as described by Traxson (1994). This model is essentially a variant of behavioural self-management. However, Traxson’s approach is also informed by humanistic (Egan, 1990) and Adlerian (Gordon, 1991) perspectives; there is “a maximum involvement of the young person selecting every aspect of the programme” (p.232), with a view to achieving “lasting change by helping the young person choose a new way of behaving that brings about more acceptable outcomes for all parties” (p.284). A detailed description of this model is given in an appendix.
Because of its potential capacity to facilitate generalisation of new skills, and its apparent accessibility to the school staff, it was decided to adopt this approach. It was planned that the author would present and explain the approach to the project team and would support the counsellors in learning to use it as part of their ongoing work in the first instance; over time, it was envisaged that the counsellors in turn would support the other staff members in learning to apply the self-directing approach in their work with the pupils. It was not intended that a completely new programme of therapeutic work would begin; rather it was intended that all of the staff would, over time, adopt the strategies of the self-directing model and use them in addressing difficult pupil behaviour. The fact that this approach is based on a skills-learning model seemed likely to make it more acceptable and accessible to the staff of a school. Instruction, training, supervision and support would be provided by the author insofar as the time available allowed.

The minimum that could be achieved by the use of this model was that the work of the counsellor would be more structured, more focused, more positive, and more involving of the pupils than previously; however, it was hoped that all of the staff would adopt the perspective of the approach and integrate it into their work.

2.7 The proposed evaluation of the intervention

2.7.1 Introduction

As noted above objectives of the intervention could be identified at three levels. It would have been useful to complete evaluations of the intervention in relation to the first and third of these, in terms both of outcome and of the processes of change involved. However, such evaluations would have required time and resources well beyond what was available. The only evaluation which was feasible was an outcome evaluation of the second objective identified above, i.e. the impact of the intervention model (consisting of the consultation process, development of a consensus amongst staff on values and rules, and the implementation of the 'self-directing' strategies to be used by the staff to manage pupils' difficult behaviour) on the frequency of difficult pupil behaviour within the school.
The question to be addressed was whether or not implementation of the intervention would lead to a reduction of the overall frequency of difficult behaviour observed within the school. (Specific targets set by and for individual pupils while using the ‘self-directing’ strategies were not relevant here).

2.7.2 Summary description
The following is a brief description of each element of the proposed evaluation. The development of the evaluation plan is then described.

Research design: This is an interrupted time-series design with four data-points in the pre-intervention phase and fourteen data-points in the intervention phase. A data-point consists of one school day of each week of an eighteen-week period.

Experimental group: This consists of all of the pupils of the school.

Independent variable: This is the implementation of the model of intervention as described above.

Dependent variable: This consists of each instance of observed rule-breaking behaviour within the school.

Data-elicitation: This consists of systematic observation by the school staff in which every defined instance observed would be recorded.

2.7.3 The independent variable
For purposes of deciding on a research design it was essential to define the independent variable; in one sense an intervention was taking place from the first contact between the author and the school staff, and continued through the later meetings. It is possible that these discussions had an influence on staff perceptions and behaviour, which in turn may have influenced the behaviour of the pupils. However, there was no possibility of measuring such effects in this project.

What was possible was to obtain a measure of the impact of the implementation of the model of intervention on pupils’ difficult behaviour. For purposes of the research design therefore, the independent variable was defined as the implementation of the model of intervention described above.
2.7.4 The research design

A 'true' experimental design was not feasible in this project. Random allocation to different treatments was not possible within St. P's (as the intervention was focused on the 'whole' school) and no control group was available in a comparable school (no other such school exists in this area).

A quasi-experimental approach was required therefore and an 'interrupted time-series' design was identified as appropriate. "As the simplest form of this design, there is just one experimental group, and a series of observations or tests before and after an experimental treatment (...........) interpretation is based on a knowledge of the design itself in interaction with the particular pattern of results obtained and contextual factors" (Robson, 1993, p.105). The logic underlying the approach is the same as that underlying single-subject experimental designs, an approach described by Barlow et al. (1984) as a time-series methodology. In this project the 'experimental group' consists of all of the pupils of the school. Fife-Schaw (1995) states that "the main virtue of such a design is that it is relatively less likely that short-term historical events (that is, history effects) will either co-occur with the treatment and/or that they will have a lasting effect over time" (p.92), and that "any maturation effects should be reflected in gradual trends in time-series data, and not radical changes coincident with the treatment intervention" (p.93). However, Fife-Schaw (1995) points out that 'testing effects' and 'instrumentation effects' pose threats to the internal validity of such a design.

When using an interrupted time-series design the larger the number of data points available the greater the confidence that can be placed in the conclusions drawn, that is "with more data points, (...........) the experimenter is in a much stronger position to assess the nature of the trend" (Robson, 1993, p.105). Deciding on the number of data-points and the time period between them to be used in a project such as this depends to an extent on the nature of the intervention and the likely processes involved in influencing any change. In the present project the work involved for the staff and the targeted change in pupil behaviour seemed likely to require a lengthy time period.
Therefore, a period of 18 school weeks was decided on for the period of the evaluation.

The data points would be a full school day of every Thursday of school during that period. Four data-points would be used in the pre-intervention period and fourteen during the intervention period. The intervention period (the period of implementation of the agreed model) would begin with the first consultation meeting; work on the development of staff consensus on values and rules, and the implementation of the ‘self-directing’ management strategies (by the counsellors in the first instance) would begin within a week of this first consultation meeting. The pre-intervention period would consist of the four weeks prior to that first consultation meeting. A diagrammatic illustration of the design is as follows:

<table>
<thead>
<tr>
<th>Data points:</th>
<th>Pre intervention period</th>
<th>First consultation meeting</th>
<th>Intervention period</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4</td>
<td></td>
<td>5 6 7 8 9 10 11 12 13 14 15 16 17 18</td>
<td></td>
</tr>
</tbody>
</table>

2.7.5 The dependent variable

The dependent variable in the present design consists of all observed instances of rule-breaking pupil behaviour. Operational definition of the dependent variable is problematic in this evaluation because development by the staff of a consensus on values and rules about behaviour does not take place until the intervention period begins; the likely outcome would be a more precise definition of ‘rule-breaking behaviour’ than existed during the pre-intervention period. Therefore the pre-intervention and intervention period measures of rule-breaking behaviour would not be equivalent. However, despite the lack of equivalence, there is no alternative to using the available measures. The score for each data point is the total number of such instances observed on that day. As noted above, when using a time-series design, the larger the number of data points available the greater the confidence that can be placed
in any conclusions drawn. The use of such a design, therefore, requires a type of data and a form of data-elicitation which lend themselves to such repeated measures.

2.7.6 Data elicitation
In the present design the data used were pupil behaviours and the form of data-elicitation was to be systematic observation and recording by all of the teaching and care staff. Such an approach would make feasible the collection of data at a large number of data points.

As complete a measure as possible of the frequency of the identified behaviours was required, so every defined instance observed would be recorded, giving frequency data for a predetermined period.

The method of recording would be as simple as possible. For each data-point (a full-school day) each member of the school staff would have a dated record sheet. On every occasion on which an instance of 'rule-breaking behaviour' was observed it would be noted by marking the sheet. At the end of each data-point school day these records would be collected by one of the counsellors and a frequency total for the day computed.

Three possible disadvantages of using an observational method of data-elicitation are indicated by Wilkinson (1995). Reactivity (i.e. the effect of being observed) can present a threat to validity of data by affecting the way a person would normally behave in a given situation. Reactivity may also have an effect on the observer, through observer bias, by influencing a "perception of events" (Wilkinson, 1995, p.227). "A rather more straightforward threat to the reliability of observational data comes from the understandable limitations of the observers themselves" (Wilkinson, 1995, p.228). They may not be efficient observers, they may be uninterested, tired, or may not be clear about the procedure. The staff of St. P's were to be made aware of these possible sources of bias.
2.8 Fifth meeting: with the principal and the two counsellors

The purposes of this meeting were for the author to outline the model and evaluation as described above, and for the project team and the author to discuss how it could be advanced. The author described his proposal under the following headings:

(a) the consultation process
(b) the development of a consensus amongst the staff;
(c) the strategies to be used by the staff to manage pupils' behavioural difficulties, and
(d) the evaluation.

Following the author’s presentation the counsellors were supportive of the plan; however, it quickly became clear that a wide gap existed between the principal and the author as to what was desirable and feasible. The principal made it clear that he saw the proposed model, particularly the evaluation component, as requiring an amount of work and time that was well beyond what was possible, and also to aim for changes in practice which were unnecessary. Also, as the meeting progressed it became evident that the principal and the counsellors had very divergent views as to what sort of organisation St. P’s should be. It seemed that the principal viewed St. P’s primarily in terms of traditional school organisation and management. On the other hand the counsellors seemed to view St. P’s as a ‘helping’ agency requiring flexibility of organisation and management as determined by the pupils’ needs for support in addressing their emotional and behavioural difficulties.

This disappointing meeting ended with the principal stating that he could not support implementation of the project as outlined; however, he would agree to the counsellors implementing elements of it in consultation with the author, as part of their ongoing work. He suggested that he would withdraw from the project team, that the counsellors and the author would meet again to consider how they might proceed with the project on a much smaller scale, and that the counsellors would then discuss any new proposal with him. The counsellors expressed a wish for such a meeting.

Although it was now clear to the author that the conflicting views within the staff would preclude implementation of the recommended model, he agreed to the meeting for purposes of supporting the counsellors and considering an alternative approach.
2.9 Sixth meeting: with the two counsellors

The counsellors informed the author at this meeting that there had been no further discussion within the school of the proposed project. However, they reported that there was more open informal discussion within the school of how best to respond to the pupils' behavioural difficulties; they also felt that there was a greater appreciation by the teaching staff of the counsellors' potential contribution within the school. According to the counsellors it was now accepted within the school that any developments in relation to the management of behavioural difficulties would be mediated through the counsellor's present roles; they might develop these roles and pass on new ideas and approaches to the other staff, but no radical changes in current practice were to be implemented in the immediate future. The role of the author would be simply to be available to the counsellors for consultation in relation to their work, the context of which would remain unchanged.

The author's view was that this was a request for a service very different from that which he had recommended and that he could not proceed with it. He advised that the current involvement was ended as there had not been agreement on an approach but that a request for a different service could be made of this department.

3. DISCUSSION

This report describes the response of the author to a request for a service for up to 24 young people presenting with behavioural difficulties in a special school. It was decided to take an organisational approach and to use a consultation model. Relevant information was gathered from the school staff and a 'school project team' was established. It was agreed that the author would develop a model of intervention and an evaluation and that he would present these to the project team. When this model and evaluation were presented to the team it was not accepted as either feasible or desirable by the principal and therefore it was not implemented.

With the benefit of hindsight it seems evident that the failure of the proposed model to be carried though originated in inappropriate construing of the task in hand. Having
considered the response options, the author appropriately concluded that an approach based on the school as an organisation would be the most efficacious one to take. However, from that point the author construed his task as delivering a model to an agency which, with support, would implement that model in a relatively non-problematic way; in retrospect, it seems clear that the task would have been more appropriately construed in terms of organisational change.

It seems that the author's underestimation of St. P's organisational complexity led to the development of an overly prescriptive approach. Having gathered the essential initial data, the author developed the intervention model and evaluation without ongoing consultation with the school project team. A consequence of this was that the model developed was too demanding in terms of work and time for the principal to accept. Involvement of the school project team in the development of this model would have precluded this outcome as differing views would have become evident much earlier.

Rather than take such a prescriptive approach it would probably have been more appropriate and useful to begin to address the different and possibly conflicting perspectives of the staff on the values, objectives and policies of the school as an organisation, and to consider more basic questions such as 'who sees what as a problem within the school?' or what difficulties there were for the staff in working in their particular multidisciplinary team. It may have been more productive for the author to utilise an organisational change approach. Useful models for this would be Caplan's (1970) 'administrative consultation' or the 'action-research' approach described by Taylor (1994). The use of such a model of intervention and a formative evaluation of it, may have led to a more appropriate understanding on the part of the author and the staff, of the dynamics involved in attempting to change the practice of managing pupils' behavioural difficulties at St. P's.

More consideration should have been given to the organisational elements of St. P's. As noted in the introduction above, the role of the counsellors had never been made explicit. Therefore there may have been different understandings and expectations of
this role on the part of the various staff members. It would have been useful to explore this early in the life of the project.

The fact that the teachers and counsellors have very different backgrounds in training, experience and role is likely to have influenced their values and the objectives of their work. For example, the counsellors were involved with the families of the pupils in a way that the teachers were not, probably giving the counsellors a fuller view of the reality of the pupils’ lives. The possibility of conflicting perspectives on values and objectives amongst the two groups should also have been addressed at an early stage. In fact, the differing (and conflicting) perspectives of the principal and the counsellors did not become explicit until the author’s third and final meeting with them.

In retrospect it is possible to identify indications of likely difficulties for the project in the conflicting views expressed at the meetings. At the meeting with the full school staff, in describing the ways that they responded to unacceptable behaviour by pupils, the approach of the teachers and classroom assistants seemed punitive, while that of the counsellors seemed supportive and reflective. It had seemed at that meeting that there had been no attempt to integrate the behaviour management approaches of the different school staff. At the first meeting between the principal, the counsellors and the author, there was disagreement between the principal on the one hand, and the counsellors and the author on the other, regarding the involvement of all of the staff in the school in a whole-school approach. The significance of these indications of an absence of consensus amongst the staff should have been noted by the author and should have led to a change of direction in the project towards addressing this lack of consensus.

Considering the principal’s response to the evaluation component of the proposed model, it seems that the author was overly ambitious in relation to what might be acceptable and achievable in carrying out the evaluation within the school. The author’s objective of gaining a high degree of control regarding the research design and measuring the dependent variable created tension with the principal’s view of how much time and effort his staff could appropriately allocate to the evaluation.
In conclusion it is appropriate to return to the author's objectives in taking on this project and to consider what has been learned from the experience. In working with an organisational perspective, what has been learned is that the nature of any work involving organisational change needs to be determined by the elements and dynamics of the organisation itself; that it is essential to be sensitive and responsive to these and not to presume to be prescriptive. In working with a consultation model what has been learned is that the consulting must happen at every step in a process and that to take one step without consultation may be to undermine an entire sequence.
References


Appendix


The following is a slightly edited version of Traxson's (1994, pp. 232-238) detailed description of the self-directing approach. This description is designed for use by school counsellors and teachers.

1. Self-directing is one strategy which can be used easily in the classroom, which helps make students less dependent on external adult control and moves them towards self-regulated social behaviour.

2. It enhances the young person's view of what they are doing, how this affects other people, and what they are able to change.

3. It releases important time, which the teacher spends on controlling behaviour, for other functions such as facilitating the learning of the children in the class.

4. It helps to achieve a primary goal of education, which is to turn out self-motivated, self-aware and self-controlled young people.

5. It encourages young people to set realistic and achievable goals for their behaviour and to be clear about what would constitute progress.

6. It brings about a generally more effective way of achieving the maintenance and generalisation of a skill to new situations.

7. It provides clear, useful feedback to young people regarding the success that they have achieved in changing their behaviour, thus enhancing their self-esteem.

8. It enhances the motivation of young people who have recognised that there is a problem that needs addressing.

9. It establishes a process for reviewing progress, which is totally child-centred and should make use of the language they use to describe the changes in their behaviour.

10. As the approach develops, aspects of it can be selectively faded out, in a negotiated order so as to put increasing responsibility on the young person via his/her own internal dialogue.

11. It should encourage a developmental progression to a constructive state of self-discipline.

12. It should become a positive cycle of growth rather than a vicious circle of
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self-perpetuating and increasingly complex problems.

13. It reduces the need for a power relationship over children, thus increasing their personal efficacy.

An individual programme is designed by the young person and a counsellor (or other "key" person) working together in a planning conversation. Traxson (1994) describes the purposes of a planning conversation as including the following:

1. To indicate that we are optimistic about the future for the young person.
2. To demonstrate that we believe that the problem is not an integral part of their make-up.
3. To explore and map the extent, nature and characteristics of the problem, using, wherever possible, the young person's own labels, descriptions and explanations. This will help to personalise the approach, and the child's ownership of it.
4. To understand the difficulties from the young person's perspective, because their ownership of the problem is vital to their seeing that it needs solving.
5. To discuss how they would like the situation to change and the actions that they can see themselves taking in order to get there.

He also provides a set of useful questions for a 'planning conversation' as follows:

1. Describe how you see the difficulties and successes that you are having at the moment? What would I see if I watched it on a video recording?
2. Which people are affected most by these behaviours (positive/negative) and in what order would you put them in terms of the effects?
3. What do other people think about you? If I was to ring all the important people in your life on my 'Magic Telephone', what would they say about you?
4. What good news has there been recently in any area of your life?
5. How would you like things to change in the next six months? What things can you see yourself doing differently?
6. What will be the easiest things for you to change? What will be the hardest? (Put them in order).
7. Which people will be most affected by these changes? Who will notice and be
pleased the most? Who the next most? (and so on).

8. Who or what will you be doing this for? (Put in order of importance.) Who will be pleasantly surprised if things improve?

9. How will you feel when you get to this stage?

10. How are you going to make a start? Which behaviours are you prepared to record and how will you record them?

11. How will you reward yourself when progress is achieved?

12. How would you like to record these changes?

13. Whom do you want to talk this over with on a regular basis, where and how long for?

14. What other people would you like to be told about any improvement as the problem goes away from you?

15. How should these people be told/involved?

16. What would ‘better’ feel and look like?

17. How will you know when you have got there?

18. How will you keep the progress going?

The planning conversation leads to the joint drawing up of a detailed programme for behaviour change. This programme includes specific details of the behaviours to be worked on (perhaps including task sheets), a means of self-rating/recording behaviours, and a means by which a teacher (or other staff) can report back to any other key person.

Traxson (1994) also provides a “menu of components of a self-directing programme” (p.234), a menu of “approaches for rating/recording behaviours” (238), and a menu of “formats” (p.236), that can be used.

He outlines a list of ways of increasing the success of a self-directing behavioural programme as follows:

1. Only positive information should be recorded, in order to avoid demotivating the child and, more importantly, to put the responsibility for describing any problems
onto the child’s shoulders. The key person should facilitate this by encouraging
the child to describe what happened honestly.

2. The *locus of control* is within the child, and adults have to believe this and convey
this message clearly in all conversations, e.g. ‘It’s you that has achieved this, well
done!’ or ‘Who made the decision to have a “wobbler”? ’ Encouraging ‘I ...’
statements also helps to achieve this.

3. We need to acknowledge the ‘*fight-or-flight reaction* ’ as a normal part of human
behaviour. Some people, for a variety of reasons, have a lower threshold to this
biological reflex. When the adrenalin rush has occurred and a child is
involved with a member of staff, the best professional approach is to allow the
child to ‘cool off’ in a safe place without further confrontation, which would only
end with an increased risk of aggression. Once the kidneys have flushed out the
adrenalin in 10-20 minutes, this is the right time to talk it through. This action
creates a ‘both win’ situation out of a potentially major confrontation.

4. *Self-directing needs to be distinguished from other, punishment programmes*,
such as report cards. By all staff accepting this distinction the chances of the
students shifting their ground are enhanced.

5. The primary aim is *honest and open communication* between the young person and
their confidant. An honest appreciation of the effects of their behaviour and what
could be done to change it will be far more motivating in the end than any hammer
hanging over a child’s head.

6. *Being average is OK*, we must not expect an absolute improvement or we will be
disappointed. A child behaving within the normal range of acceptable behaviour
must be seen as a success.

7. *Flexibility of the programme* and adapting it to meet changing needs is essential,
so the regular meetings between the child and key person should be a way of
negotiating changes and revisions of targets. This freshening up of the
programme is a way of avoiding the ‘two-week wonder’ phenomenon that one
gets with a lot of behavioural interventions.

8. *The role of the key person/counsellor* is fundamental to the success of the
approach. The young person should select a person they trust and who they feel
will give them the attention they need.

9. *Maximising the involvement of the child* or ownership of the approach are not buzz phrases in this approach. They are the approach. Consent and agreement are vital, at all stages.

10. *Awareness or recognition of a problem* needs to be accepted as the essential prerequisite of change in behaviour.

11. Talking about feelings is a fundamental part of open communication. The four basic emotions can be summarised as:
   
   Glad - Joy/Satisfaction  
   Sad - Down/Depressed/Tears  
   Mad - Angry/Frustrated/Aggression  
   Bad - Frightened/Self-doubt/Poor self-esteem

Emotions are the legitimate domain of any helping relationship. Also, a balanced dialogue on head or heart statements is necessary, as it is often the heart that pumps the warning sense of motivation through our bodies. We want it to be more than an intellectual exercise.

12. Let’s take a risk and do it the child’s way, because individuals are the best judges of what is possible for them to tackle as well as what is the most appropriate way to do things at a particular point.
2. Post Qualification Curriculum Vitae
2.1 Employment

September '85 - May '87
Clinical Psychologist at the Children's Unit, St. Stephen's Hospital, Southern Health Board. (This unit provided outpatient and residential child and adolescent psychiatric services to the Cork city, West Cork and North Cork Community Care areas).

June '87 - May '91
Psychologist in the Community Care Programme, Southern Health Board. Within this programme a Child and Adolescent Psychology service was provided to the following departments: Social Work, Speech and Language Therapy, School Medical and Public Health Nursing within the Community Care areas noted immediately above.

June '91 - December '95
Senior Psychologist in the Community Care Programme, Southern Health as described immediately above.

January '96 - January '98
Senior Psychologist in the (newly developed) Department of Child, Adolescent and Family Psychology, Southern Health Board (Cork City and South Cork Community Care Areas). This department provided services to children and adolescents who were at risk of, or had experienced abuse, neglect or family breakdown, and to their parents or other carers.

February '98 to the present
Senior Clinical Psychologist at the Department of Child and Adolescent Psychiatry, St. Finbarr's Hospital, Southern Health Board (Cork city and North Cork Community Care Areas.) This department provides mental health services to young people up to the age of sixteen years.
2.2 Committee Memberships (Professional Bodies)

Southern Psychologists' Group (Psychological Society of Ireland),
Committee member: '85 - '90.
Secretary: '86 - '87.
Chairperson: '87 - '90.

Clinical Division (Psychological Society of Ireland),
Committee Member: '87 - '91.
Honorary Treasurer: '88 - '91.

Association for Child Psychology and Psychiatry (Irish Branch),
Committee Member: '91 - '96.
Chairperson: '93 - '94.

Board of Examiners for the Diploma in Postgraduate Professional Psychology (Clinical) of the Psychological Society of Ireland.
'93 - '95.

Accreditation team of the M.Psych.Sc. (Clinical Specialisation) at University College Dublin, on behalf of the Psychological Society of Ireland.
'93.

2.3 Memberships Of Boards Of Management (Representing The Southern Health Board).

Knocknaheeney Family Centre, (Knocknaheeney, Cork).
'89 - '95.

Newbury House Family Centre, (Mayfield, Cork).
'90 - '95.

Scoil Chaoimhin (Youth Encounter Project).
'92 - '95.
2.4 **Membership Of Southern Health Board Working Parties And Committees.**

Working Party on an Assessment Service in Child Sexual Abuse.
'88

Child Care Advisory Committee (A Statutory Committee under the Child Care Act, 1991).
'93 to the present.

Child Health Services Review Group.
'96.

Working Group on Therapeutic Support Services to Families (Chairperson).
'97.

'97 - '98.

2.5 **Courses and teaching events attended for purposes of continuing professional development between completion of the BPS Diploma in Clinical Psychology and the date of registration for the PsychD.**

1. Experiential training course in Gestalt approaches to group work (two and a half hours weekly, May-June '88, September '88-May '89, plus two residential weekends).

2. Introductory training course in family therapy (four and a half hours per week, for six weeks, April 6th '90-May 11th '90.

3. Two or three training events of one or two days duration were attended each year; these included the following:
   - updates on the psychometric assessment of children and adolescents
   - social skills training for children and adolescents
   - integrative psychotherapy
   - bullying at school
   - the psychologist and legal responsibility
   - assessment and treatment of sexually abused children
   - assessment and management of head injury in children
   - treatment and education of autistic children
   - social deprivation and children’s learning
• use of the SPSS
• sexualised children.

2.6. **Courses attended for purposes of continuing professional development during the period of registration for the PsychD**

1. ‘Management Development’ training course (six training days in April/May/June ‘95).
2. Training course entitled ‘Introduction to Management’ (six training days during October/November ‘95).
3. ‘Chairing Case Conferences’ (four training days in May/June ‘96).
4. Management Development and Organisational Change training course (four training days during ‘97).
Section Four: Research Dossier
ADOLESCENTS’ EXPERIENCE OF RECEIVING HELP FROM A MENTAL HEALTH SERVICE: A GROUNDED THEORY APPROACH.
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ABSTRACT

A semi-structured interview was carried out with five adolescents who were recent clients of a mental health service. The interview comprised open-ended questions devised to explore the adolescents’ experience of receiving help from such a service. The interviews were audio-taped and a typed transcript of each was produced. The transcripts were analysed using a grounded theory approach. Two major categories were constructed from the data-analysis. The first was entitled ‘Feeling reluctant to attend’ and was made up of three sub-categories, ‘Apprehension’, ‘Shame’, and ‘Irrelevance’. The second major category was entitled ‘Experiencing a therapeutic relationship’ and was made up of six sub-categories, ‘Talking’, ‘Confidentiality’, and four ‘Clinician Qualities’ (‘Pleasant and Supportive’, ‘Understanding’, ‘Calm’ and ‘Listens’). The results are discussed and related to the relevant literature.
CHAPTER ONE: INTRODUCTION
1.1 GENERAL BACKGROUND

Child and adolescent clinical psychological and psychiatric departments are long established as integral parts of the health services in the United Kingdom and Ireland. The administrative organisation of these services varies between different Health Trusts (in the UK) and Health Boards (in Ireland) with a single unified department of child and adolescent mental health in some areas, and separate departments of clinical psychology and child and adolescent psychiatry with a range of joint working relationships, in others. The core professions working in these departments, common across different organisational systems, are clinical psychology, child and adolescent psychiatry, and social work, and to a lesser extent, such professions as occupational therapy, speech therapy, child psychotherapy and child care work. The young people receiving these services are those presenting with difficulties of behaviour, emotion or social relationships, which are sufficiently marked or prolonged to cause distress to the young person, or distress or disturbance in his/her family. In psychiatric terminology, they are young people who present with disorders as described in the International Classification of Diseases, version 10 (ICD 10) of the World Health Organisation (WHO, 1992). The major proportion of difficulties presenting to these services, in terms of ICD 10 classification can be described as either conduct or emotional problems, or a combination of these. For example Hoare et al. (1996) in an audit of 7,000 successive child and adolescent psychiatry referrals in Scotland using the ICD 10, found that conduct disorders, mixed disorders of conduct and emotion, adjustment, emotional and mood disorders, accounted for 64% of all cases. The remainder were accounted for as follows, encopresis (3%), hyperkinetic (2%), anorexia/bulimia (2%), enuresis (1.5%), pervasive developmental disorder (0.8%), tics (0.5%), schizophrenia (0.4%), miscellaneous (10%), and no disorder (14.5%). A range of therapeutic approaches is used by these services, the main ones being parental counselling, family therapy, cognitive-behavioural therapy, individual psychotherapy and pharmacotherapy. Most of the services have access to residential or inpatient treatment facilities when required, for the most severe presentations.

A major aspect of recent developments in these, along with all other health services, is the promotion of evaluation. The importance of evaluative research for child and
adolescent mental health services has been emphasised by both the National Health Service Research and Development Committee (Department of Health, 1995) and the Audit Commission (1994). The present study addresses one aspect of evaluation, the experience of young clients themselves of receiving help from a mental health service. It is useful to distinguish between summative and formative evaluation. The former is concerned with outcome, the latter with process. The study of process variables in therapeutic work with young people is not well-developed. In reviewing research on therapeutic work with children and adolescents Kazdin (1993) concluded that it “produces effects that exceed changes associated with no treatment (...........) and that the magnitude of these effects (...........) closely parallels those obtained from outcome research with adults” (p.646). However, he goes on to lament the rarity of studies “of factors that moderate treatment outcome for children and adolescents” (p.648), emphasising the poor development of formative evaluation or process research in this area. This is reiterated in the most recent review to hand, that of Kazdin & Weisz (1998) who note that “outcome studies frequently illustrate that a treatment programme has beneficial effects but rarely identify the effective ingredients associated with the effects identified. For both practical and theoretical reasons, much more needs to be known about the mediators of change” (p.30).

Although there is poor development of process research in therapeutic work with children and adolescents there is an established and vibrant research tradition regarding therapeutic work with adults. Process research in therapeutic work with adults can be traced back to the studies of Carl Rogers and his colleagues in the 1940s. According to Goldfried & Wolfe (1996) much of this early psychotherapy process research “involved discrete and isolated transactions between therapist and patient (...........) rather than functional units that might conceivably reflect the process of change” (p.1008), whereas more recently “a new generation of process research has evolved in which the primary focus is to look at those aspects of psychotherapy that are likely to contribute to change” (p.1009).

A useful five-dimensional model of ‘therapy process’ is provided by Elliot (1995). The five dimensions in this conceptual model are:-
1. Perspective of Observation (who observes the process: client, therapist, or researcher).
2. Person/Focus (who is observed: client, therapist or dyad).
3. Aspect of process (what communication feature is observed: content, action, style or quality).
4. Unit level (the hierarchical order or scale at which observation occurs, e.g. sentence/idea, speaking turn, episode, session, or treatment).
5. Sequential phase (the temporal orientation or purpose of observation: to understand either context, process or impact)” (p.53-54).

Elliot (1995) suggests that “specifying one’s interests on each of these five dimensions seems to be essential for measuring and describing the therapy process” (p.54). The present study addresses adolescent clients’ experience of receiving help from a mental health service. In terms of Elliot’s (1995) model, the perspective of observation is that of the adolescent client: the focus is the adolescent’s experience; the aspect of process involved is ‘qualities’ of the experience; the unit level is the entire course of therapeutic help; and the sequential phase involved is that which happened during the unit, that is, process.

1.2 Research on the Child/Adolescent Client’s Perspective

1.2.1 Context

In discussing the child’s voice within mental health practice Glaser (1996) states that “Children rarely initiate their own attendance at child psychiatric, child guidance or child mental health settings (.....) Not infrequently, children and young persons attending these services for the first time are unsure why they have come, let alone what to expect. It is in this context that the notion of a child’s voice needs to be considered” (p.78). The acceptance of the value of hearing the ‘child’s voice’ in the area of child and adolescent mental health reflects and is part of a significant change in recent years in the way in which children in our society are perceived. Enhanced rights have been granted to children to participate in decisions affecting their lives, for example through the 1989 Children Act and the United Nations Convention on the rights of the child. Sinclair (1996) has claimed that there is “a changed understanding
of the status of children recognising that they are people in their own right” (p. 87); she further claims that there is “a growing acceptance of the principle that children should be consulted and have their voices heard in matters relating to them; a developing theoretical literature which recognises the very active part that children play in creating their social worlds, the necessity of understanding those worlds as experienced by children and recording them through children’s own accounts” (p. 87). These changes have both impacted upon and been influenced by those involved in social research with children. In the past most information about children has been gathered through ‘objective’ measures designed and constructed by researchers, or from proxy accounts by adults who were thought to know the child. It appears that in the past few years researchers have recognised the importance of directly recording children’s own perspectives. Sinclair (1996) suggests that “This not only demonstrates a proper respect for children and their opinions, it acknowledges that children are the most important source of evidence on how their lives are lived and experienced” (p. 87); she adds that the Economic and Social Research Council research initiative ‘Children 5-16: Growing into the 21st Century’ encouraged proposals that would draw on children’s experiences and views and that the Joseph Rowntree foundation expects disabled children and young people to be active participants in all aspects of any project which it will fund. These changes in the way children in our society are perceived have not been well reflected in psychological research and practice. However, their significance was signalled by Davie (1993) who admonished “Listen to the child” adding the suffix “a time for change” (p. 252).

Acknowledging that “children are the most important source of evidence on how their lives are lived and experienced” (Sinclair, 1996, p. 87), it is the aim of the present study to ‘give voice’ to young clients of a mental health service by exploring their own experience of receiving help from such a service. The research literature addressing young people’s own accounts is not extensive and is addressed below. However, there is a substantial literature on adult clients’ experience of receiving therapeutic help. In an early publication addressing outcome measures in psychotherapy Strupp & Hadley (1977) advocated a tripartite model to take account of three major vantage points from which a person’s mental health may be judged. Strupp (1996) defines these as “(a)
society (including significant persons in the patient's life), (b) the individual patient, and (c) the mental health professional" (p.1018); he goes on to note that "the individual client evaluating his or her own mental health uses a criterion distinctly different from that used by society" (p.1019) and that "their perspective has a validity of its own" (p.1022). Lambert & Hill (1998) suggest that a "major way to categorise process measures is by the perspective from which therapy is described: therapist, client or non-participant judge" (p.90); they go on to note that "most empirical research has found minimal correlations among the three perspectives on various measures" (p.90), indicating that research on therapy processes must include client perspectives if it is to aspire to comprehensiveness.

Different methodological approaches have been used to study adult clients' experience of therapeutic help. McLeod (1992) has reviewed interview-based studies of adult clients' experience of counselling and psychotherapy; the review of Orlinsky et al. (1994) of questionnaire-based studies of psychotherapy process and outcome included numerous studies addressing client perspectives; and a programme of research on adult clients' experience of therapy sessions has been carried out by Rennie (1992, 1994) using grounded analysis of Interpersonal Process Recall interviews.

A literature search attempting to locate relevant theoretical and empirical publications regarding young people's own accounts of their experience of receiving therapeutic help identified only studies in the areas of audit and consumer satisfaction. In fact, as yet audit research has included little investigation of the child/adolescent client's perspective, although there are indications of a growing awareness of its value. The next section describes relevant studies in the area of audit and the following section describes relevant studies in the area of consumer satisfaction.

1.2.2 Recent research on audit in child and adolescent mental health services
Consequent to increasing accountability and a focus on quality improvement within the health services, greater attention is being given to service audit. In recent years a number of audits of child and adolescent mental health services have been carried out, which predominantly address outcome. Furthermore, the measures used have been
very narrowly defined and there is little appreciation of the value of obtaining the child/adolescent client’s report.

As part of an audit covering one year’s work in a child psychiatry clinic, Thomas & Hardwick (1989) obtained the responses of 30 families to a questionnaire “to determine the effectiveness of treatment” (p.10) and “to assess the service offered by asking the consumers themselves” (p.13). They do not state which members of the families completed the questionnaire, but it is clear from their report that a parent or parents did so; no attempt was made to obtain a response from the child/adolescent client; the parents were seen as the consumers of the service.

Fitzpatrick et al. (1990) compared the views of “families with whom family therapy had been used, with those of families with whom more traditional symptom-directed therapy models had been used” (p.9). In order to obtain their data they used a semi-structured ‘family interview’; “where there were differences of opinion within the family as to how a question should be answered the family was asked to come to an agreement about how they wished to answer the question. If this was not possible the opinion of the majority was recorded” (p.9); the child/adolescent clients therefore had the opportunity to contribute their views in this study but only in the context of a family interview.

Subotsky & Berelowitz (1990) carried out a study of consumer views at a community child guidance clinic. This involved a survey of the parents of 60 children and 26 referrers. No data was gathered from the child/adolescent clients as consumers.

An audit of practice at a child and family centre, including a postal survey of 45 families and an interview survey of GP referrers was carried out by Carr et al. (1994). No contribution to the audit was requested of the child and adolescent clients. It was found that “only 15% of children liked attending the clinic a lot” (p.150); however this finding was based on parent’s responses to a questionnaire item.

An audit of 7,000 successive child and adolescent psychiatry referrals in Scotland was carried out by Hoare et al. (1996). The only outcome measure used was the clinician’s
assessment of improvement. However in their conclusions, the authors note “Ideally, the measures of outcome should involve the parent’s and child’s or adolescent’s views as well as independent evidence” (p.240), hopefully indicating a growing awareness of the value of obtaining a contribution to outcome measures from the child/adolescent client.

A major development in this area was the ‘Proposed Core Data Set for Child and Adolescent Psychology and Psychiatry Services’ of the Association for Child Psychology and Psychiatry (Berger et al., 1993) in which a framework for measuring outcomes is suggested. These authors identify three types of outcome as follows: (1) Clinical outcome (which includes “reduction in severity or frequency of behaviour problems; achievement of mutually agreed goals for change; the acquisition of new skills or strategies; improved ability to participate and function in everyday life; reduced re-admission rates and duration of stay in instances of chronic illness; and improved self-esteem and parent management of chronic illness and disability” (p.100), adapted from BPS (1993a); (2) Outcomes of service quality, which “are concerned with such aspects as the setting, delivery and efficiency of the service” (p.100); (3) Service impact which “refers to epidemiological change” (p.100). Berger et al. (1993) add that outcome data should have ecological validity “that is, indices of outcome and their interpretation should not be isolated from the contexts in which they arise” (p.99). They acknowledge that there is already a tradition of research into treatment outcomes within child and adolescent psychiatry and psychology, but suggest that such “research studies have limited relevance to the evaluation of in-vivo intervention. Clinical services do not usually treat homogenous groups carefully selected to meet the sorts of criteria necessary in research studies; nor can they rely on a single, coherent and standardised treatment process, as is hoped for in systematic research” (p.101). This point is reinforced by Wilkinson et al. (1994) who suggest that “The clinician (.....) has to deal with a wide range of situations and normally becomes eclectic because this diversity forces clinicians to rely upon different theories and methods at different times, according to the needs of their patients” (p.71). Wilkinson et al. (1994) go on to suggest that a problem with traditional treatment models evaluation is that the models rely upon a common outcome measure, whereas for the clinician the needs of each
individual are assumed to be different “so that not only is the treatment different but also the method of evaluation of outcome” (p.71). This would appear to suggest that outcome studies of clinical services are impossible; however it may be more appropriate to see it as suggesting that different types of outcome data/knowledge are required in order to give a fuller picture.

Berger et al. (1993) attempted to devise an approach to outcome measurement which would “deal with the heterogeneity of clients and their clinical problems by introducing a set of global ratings that can be used across most if not all cases” (p.104). Their framework included a set of indices of model rating factors to be used in conjunction with global rating scales; “These indices cover characteristics of the problem (complexity, severity) and aspects of manageability of the case (compliance, controllability of external factors)” (p.104-105). The global ratings in this framework were a judgement of clinical change by the clinician, the clinician’s judgement of the extent to which the intervention met the intentions of the referrer, and “global ratings by the patient, carers and referrer” (p.104). The rating to be made by the client/patient is a judgement of the extent, if any, of benefit of the contact with a service. [The ratings are as follows: “1. very helpful, 2. helpful, 3. some help, 4. made no difference, 5. worse, 6. not applicable (e.g. young child)” (p.107)].

Use of the outcome measures recommended would provide very valuable information for a service evaluation, and the recommendation that the child/adolescent client/patient be given the opportunity to provide a measure of outcome is very positive. However, the amount of information which would be provided by this particular measure is minimal and does little to inform understanding of the young person’s experience. Furthermore, the preconceived categories are formulated by adults and therefore constrain and limit the range of responses which could be made by the young clients.

A study which did obtain the views of child/adolescent clients of a mental health service was that of Chesson et al. (1997). These authors obtained young people’s own accounts in investigating “how both child and parent from the same family viewed
psychiatric input, it’s functioning and effects, and whether they shared similar perceptions” (p.25), with children admitted to a residential child psychiatric unit. For the purposes of the present study, only material relating to the children needs to be addressed. An “interview survey” (p.254) of all 20 inpatients admitted to the unit between June 1993 and December 1994 was carried out. Three interviews were completed with each child according to the following schedule:

1. prior to admission;
2. six weeks after admission;
3. two to four weeks following discharge.

The authors describe their interview as semi-structured. However, the interview schedule itself consisted of a structured set of questions, the main topics addressed being reasons for admission, knowledge of treatment and unit staff, and perceived effects of hospitalisation. It was planned that the interviews with the children would not last longer than 30 minutes. The children were 16 boys and 4 girls with an age-range of 5.6 to 13.5 years (the mean age was 9.3 years). Kappa statistics were used to establish test inter-rater reliability.

The children’s answers to the questions about reasons for admission and knowledge of treatment and unit staff were considered in terms of their accuracy; the children’s own ‘understandings’ appear not to have been explored. In general, at the preadmission interview the “children did not have a clear idea of the reason(s) for their admission” (p.258), while at the six-week interview they had a clearer view of the reason for their admission, but “Few children were able to identify interventions, and the majority were unable to say if they were having any special programmes or medicines” (p.259). At the final-stage interview, nineteen of the children were asked “whether their problems were the same or better or worse since going into” (p.261) the unit; nine of the children reported their stay as being helpful, four reported that it had helped a little or were not sure, and six reported that nothing helped much.

Chesson et al. (1997) concluded that their study “suggests that it is not only feasible but valuable to know children’s thoughts and opinions” (p.267) and that “Our
experience would reinforce the view that direct interviewing is both a simple and effective way of auditing and evaluating child mental health services” (p.267). This claim seems rather too strong, but such data would make a very valuable contribution to audit and evaluation. The approach used also is an advance on the various methods referred to above in obtaining a fuller account of young clients’ views, and thereby better informing understanding of their experience.

To conclude, the views of child/adolescent clients of mental health services have received little attention in audit studies of these services. However, there are indications of a greater awareness of the importance of including such data (Hoare et al., 1996; Berger et al., 1993) and one study has demonstrated the feasibility of using an interview methodology, even with primary school age children.

1.2.3 Recent research on consumer satisfaction in child and adolescent mental health services

Consumer satisfaction with mental health services has received a great deal of attention in recent years. Although in the main this work has been carried out in the context of adult services, a number of studies with child and adolescent clients have been published. Stuntzner-Gibson et al. (1995) describe the development of a ‘Youth Satisfaction Questionnaire’. In this study, following an interview with a parent, a questionnaire was left with him/her for the child to complete, along with a self-addressed, stamped envelope for return by post. Completed questionnaires were returned by 66% (165) of the sample. Of those who responded 68% were males and 32% females, with an age-range of 9-18 years, and a mean age of 13.2 years. The initial questionnaire consisted of five general items with yes/no answers (e.g. Did you like the help you were getting?). It was found that “three items provided the most internally consistent composite score. These items measured the extent to which youth liked the help they were getting, got the help they wanted, and felt that services helped in their lives” (p.620); the alpha co-efficient of these three items was .80. A general satisfaction score was calculated by summing responses to these three items; it was found that “although the distribution of scores was biased towards higher levels of satisfaction (........) the extent of variation in scores suggested that children collectively
had a wide range of opinions about services” (p.620). The authors suggest that “general satisfaction ratings provide an incomplete picture of children’s opinions about events in their lives” (p.622).

As part of a program towards developing a self-report scale of satisfaction for adolescent clients of mental health services, Garland & Besinger (1996) collected qualitative and quantitative data from 33 adolescent clients “regarding their perceptions of the purpose, goals, expectations, frustrations and benefits of services” (p.356). The sample comprised 17 males and 16 females, who had an age-range of 13 to 18 years and a mean age of 15.6 years. The qualitative data was collected through the use of a semi-structured interview, consisting of “16 open-ended questions regarding mental health services” (p.358); however, these questions were predetermined by the researchers to reflect the themes of the study as indicated above. Data from only the first 25 interviews were reported on as the authors considered these to be representative of the entire sample. Content analysis was carried out on the interview data and inter-rater reliability established.

Two types of quantitative data were collected. Firstly, the adolescents rated their satisfaction in each of seven “domains” (p.358) on Likert scales. (These domains were convenience/accessibility, meeting needs, staff competence, personal relationships with staff, effectiveness of treatment, comfort/appropriateness of centre, and costs and paperwork. They also ranked the domains in order of importance in determining satisfaction). Secondly, the adolescents completed an 8-item scale “designed to assess global satisfaction among consumers of mental health services” (p.359) which had been standardised on an adult population. The authors describe their findings in great detail; the findings relevant to the present research are as follows. “When asked what concerns other people might have about counselling services, the adolescents’ most frequent responses were breaking confidentiality and discomfort disclosing personal information” (p.371). The most common problems identified by the adolescents were “feeling overly directed by counsellors (……..) and wasting valuable time” (p.371).

Two types of benefits of counselling were strongly indicated; the first related to “the quality of the interpersonal relationship with the provider and personal growth”
the second related to “specific problem-solving” (p.371). Overall, the adolescents ranked ‘meeting needs’ as the most important domain of satisfaction, and rated their overall satisfaction with services as generally high.

A ‘Youth Client Satisfaction Questionnaire’ was developed and pilot-tested through use of a telephone interview with 150 clients of a child and adolescent mental health service by Shapiro et al. (1997). The sample was 52% female and 48% male; the age-range was 11 to 17 years, with a mean age of 13.2. “Responses were recorded in the format of a 4-point Likert-type scale” (p.90). The questionnaire initially consisted of seventeen items, fourteen of which “met criteria for test-retest reliability, part-whole correlation, and correlation with a validation item” (p.87). A factor analysis of the responses to these fourteen items identified two major factors, ‘Relationship with Therapist’ (explaining 34% of the variance) and ‘Benefits of Therapy’ (explaining 33% of the variance); an inter-factor correlation of .61 suggested that these factors were strongly related.

It is difficult to summarise the findings in this area, as different measures and different types of data-elicitation were used in the studies considered. Although the samples consisted mainly of adolescents there is variation amongst the age-ranges. There are indications that measures of consumer satisfaction can be developed, for which reliability and validity can be established. There are also indications of the sort of variables which may underlie this concept. However, the data-elicitation methods in all of these studies used preconceived categories formulated by the researchers, thereby precluding the possibility of developing a sense of the meanings attributed by the young clients themselves to their experiences.

A further problem in this area relates to the definition of satisfaction. In a review of research Young et al. (1995) note that “Most child and adolescent mental health service researchers have assumed that the definition of satisfaction is commonly understood and have not provided formal definitions in their writings” (p.221). These authors suggest that satisfaction is a multidimensional concept. In addressing evaluations of adult mental health services Williams & Wilkinson (1995) suggest that
“problematic and contradictory research findings may stem from unstable assumptions about the concept of satisfaction” (p.559). They note that when qualitative methodology is employed, there is little evidence to support the assumption of a continuum of satisfaction. It would seem that further research clarifying the ‘multidimensional’ nature of the concept of ‘satisfaction’, leading to some precision regarding definition, is required.

1.3 RATIONALE AND RESEARCH QUESTION OF THE PRESENT STUDY
The present study addresses one aspect of formative evaluation of child and adolescent mental health services, the experience of young clients themselves of receiving help from such a service. It is the aim of the present study to ‘give voice’ to such young clients by exploring their own experience of receiving such help. The above review of the relevant literature indicates a growing awareness of the value of obtaining young clients’ views of mental health services which they attend. It also provides indications of the sort of variable which may underlie the concept of consumer satisfaction with such clients. However, it provides little information on the experience of such young clients of attending services; and what information is available arises from the use of preconceived categories formulated by researchers.

Research in this area does not appear to be at a deductive stage as yet. It seems that an inductive phase of research is required which may provide data at a taxonomic level from which further theory may develop. With a view to providing such data the research question in the present study is as follows. What qualities or patterns of qualities of the experience of receiving help from a mental health service are identified as salient by young clients?
CHAPTER TWO: METHODOLOGY
2.1 ETHICS AND METHODOLOGY IN SOCIAL RESEARCH WITH CHILDREN AND ADOLESCENTS

Recent developments in ethical thinking regarding social research with children have been marked by the publication of a special issue of the journal Children and Society in 1996 and a commissioned work by Barnardos (Alderson, 1995). These publications reflect developments in ways of construing young people which have significant implications for the methodologies used in carrying out research with them. Davie (1993) noted that a central principle underlying the 1989 Children Act is “that a child’s perspective must be taken seriously and given due weight” (p.252). This principle is a central and mandatory feature of policies and procedures in social services and child law, and Davie (1993) argues that listening to the child has a basis both in efficacy and equity. Asserting that children within our culture and indeed many others throughout the world are accorded little real autonomy or respect, he suggests that this particular tide may be turning and identifies as a starting point for this trend the publication of Who Cares? (Page & Clarke, 1977). This was a report on a small scale study which elicited the views of young people in care about the treatment they had received in the care system. Davie (1993) suggests that professional and political opinion had moved quite far on the issue of involving young people in care in decision-making by the time of the Child Care Law Review in 1985, which led eventually to the Children Act. However the Cleveland crisis involving child sexual abuse brought the issue of listening to children to centre stage. In the report of the investigation of this crisis, Butler-Sloss (1988) made three recommendations of particular relevance to the theme of listening to children. These recommendations were as follows: “Professionals should always listen carefully to what the child has to say and take seriously what is said (......) Throughout the proceedings the views and wishes of the child particularly as to what should happen to him/her, should be taken into account by the professionals involved with their problems (......) The views and wishes of the child should be placed before whichever court deals with the case” (p.245). Davie (1993) suggests that there is an “overwhelming consensus, extending well beyond child sex abuse” (p.253) in legal and social service fields in relation to the above recommendations.
In the area of education, Davie (1996) refers to the Code of Practice on the identification and assessment of special educational needs (Department for Education, 1994) in relation to the question of involving the child; the code (para 2;35) identified the benefits of such involvement as: "practical --- children have important and relevant information. Their support is crucial to the effective implementation of any individual educational programme, principle --- children have a right to be heard. They should be encouraged to participate in decision-making about provision to meet their special educational needs" (p.2). Gersch (1996) suggests that the Code of Practice, the Children Act and the United Nations convention "all encourage educational professionals to seek the views of children" (p.28). He has carried out projects in which a consultation process was used to involve children in a whole school systems change (Gersch & Noble, 1991) in which children had the opportunity to express their views about their strengths, weaknesses, plans, needs and aspirations in a student report as part of the assessment process (Gersch et al., 1993), and in which semi-structured interviewing was used to investigate the views of young adolescents excluded from school (Gersch & Nolan, 1994). The value of such a perspective is emphasised by Cooper’s (1993) view that "as clients of special educational services pupils are a vital source of information about the nature, quality and effects of the services they receive" (p.129), and Davie’s (1996) view that “The child is of course the ultimate consumer in the education system” (p.10).

The concept of ‘the child’ underlying these views is reflected in recent developments in the sociology of childhood, “a sociology which attempts to take children seriously as they experience their lives in the here and now as children” (Morrow & Richards, 1996, p.92). In criticizing what they described as “developmentalism’s supremacy” (p.118), Hood et al. (1996) identify it’s disadvantages as “the idea that developmental perspectives constitute the only truth about children; the individualising of children and childhood, which distracts attention from their social positioning as a minority group; and the designation of children as incompetent and the complementary exclusion of children from participation in constructing their own lives” (p.118). These authors assert that “childhood is a permanent social category and children’s understandings of their childhoods contribute to knowledge of the social order” (p.118). James & Prout
(1997a) state “it is now much more common to find acknowledgement that childhood should be regarded as a part of society and culture rather than a precursor to it; and that children should be seen as already social actors, not beings in the process of becoming such” (p.ix). They argue that “a new paradigm for the study of childhood is emerging” (James & Prout, 1997b, p.2) and that one of the central tenets of this paradigm “is that childhood and children’s social relationships and cultures are worthy of study in their own right and not just in respect to their social construction by adults. This means that children must be seen as actively involved in the construction of their own social lives, the lives of those around them and the societies in which they live” (p.4). They add that this implies that research should focus on “the meanings they themselves attach to their lives” (p.5). Prout & James (1997) suggest that the growth of interpretative perspectives in the social sciences gave an impetus to the development of this new paradigm and “fostered an interest in children as social actors and childhood as a particular kind of social reality” (p.15).

In an overview of the ethics of social research with children, Morrow & Richards (1996) identify the dilemma that “we (as adults, parents, or researchers) tend not to be respectful of children’s views and opinions” (p.91) and suggest that “the challenge is to develop research strategies that are fair and respectful to the subjects of our research” (p.91). They argue that “the challenge for social research is to find ways of eliciting children’s opinions and experiences, and to develop appropriate methods and corresponding strategies to deal with ethical dilemmas that may arise” (p.97). They suggest that “ultimately, the biggest ethical challenge for researchers working with children (....) is the disparities of power and status between adults and children” (p.98). In supporting the development of participatory, empowering research with children Alderson (1995) states that “When there are discrepancies of power, such as between children and adults, it is not possible to be neutral; research either reinforces the unequal status quo or questions it” (p.42).

Boyden & Ennew (1997) in advocating the development of participatory research with children state that “The aim is to develop methods that are not only scientifically satisfactory but that can also be used (........) in ways that are appropriate to their levels
of understanding as well as respecting their needs and vulnerabilities” (p.9). In acknowledging that adults have power over children in all known societies, they argue for an empowering element in research with children. Following the language of feminism they suggest that “To be child-focused is to find ways of bringing children into the foreground, so that their lives can be as clearly seen as those of adults” (p.11). Hood et al. (1996) argue that the recognition that children are a minority group has implications for the methods and purposes of research carried out by adults; “In our view it is basic to this conceptualisation that research should be not on children but with them and for them. And the ‘with’ and the ‘for’ are linked in terms of goals and methods. Understanding children and childhood, if one starts from the social position of adulthood, requires listening attentively to their agendas, and participating with them in the research process. Researchers should also be for children; in the end the justification for the research - for ‘collecting the data’ is to help make children heard” (p.118-9).

The view of the child outlined above as a person in his or her own right, whose voice should be heard as the ultimate consumer of a service, informs the design of the present study at a fundamental level. Following from this point and the suggestions above that ethical research with children should be respectful of their views and should empower them by bringing them to the foreground and allow data to be co-produced in the relationship between the adult researcher and the participating child, helping to make children heard, it was decided to follow the suggestion of Morrow & Richards (1996) that “a more social-anthropological approach that allows data to be co-produced in the relationship between researcher and researched, rather than being driven by problem-oriented adult questions, may be useful in child research” (p.101). “In other words, having a general idea about the topic under investigation, rather than a set of scientific, positivistic questions that needs an adult-framed answer, may be useful at the pilot stage (and beyond) of any research with children” (p.101). Such an approach required the use of a qualitative research methodology.

A researcher can investigate people’s experience through experiments, questionnaires, surveys, examining personal and institutional documents or observation. However,
Seidman (1991) suggests that if a researcher’s goal “is to understand the meaning people involved (…) make of their experience, then interviewing provides a necessary if not always completely sufficient avenue of enquiry” (p.4). Considering the research question of the present study it was concluded that an interview format would be the most appropriate data-elicitation method; and that as co-production of data would not be possible through the use of individual structured interviews, or group focus-interviews, a semi-structured interview would be the most appropriate method.

The decision to use a semi-structured interview has implications for the age-range of the participants. There is little research evidence pertaining to the effect of children’s development on the quality of data collected from them in qualitative studies (Deatrick & Faux, 1991). The literature contains many warnings that a child’s cognitive and emotional development must be taken into account (Hood et al., 1996; Mahon et al., 1996; Ireland & Holloway, 1996) but no precise indications as to how to do so. In addressing the question of ‘What children can tell us’ Garbarino & Stott (1992) conclude that “school-age children’s thinking still shares some of the vulnerabilities of younger children’s” (p.65). McGurk & Glachan (1988) in attempting to identify “how children perceive what adults say to them” (p.20) concluded “that with increasing age children’s representations of the world of adults are transformed from being predominantly undifferentiated and anecdotal at four years, to being successively organised in terms of physical and socially determined characteristics as the children progress through the early and middle school years, until by young adolescence representations are structured in terms of characteristics which are primarily personal and self-determining” (p.29).

Because of the methodological uncertainty indicated in the use of semi-structured interviewing with school-aged children and younger, it was decided that the participants in the present study should be at the older end of the client group of a child and adolescent mental health service. While acknowledging that any age cut-off would be somewhat arbitrary, it was decided to include as participants young people aged from 12 to 16.
2.2 QUALITATIVE METHODOLOGY IN PSYCHOLOGICAL RESEARCH

In addressing recent developments in the discipline Smith et al. (1995) suggest that there is a "move to a more naturalistic psychology" (p.2). They see psychology as becoming "more open to research on a range of previously neglected areas which are central to the psychology of everyday life (.....) to different types of data-collection, for example field-experiments, diary studies, self-reports (.....) (and including) more appropriate participant groups" (p.2). They suggest that psychology "needs to find new methods, methods which are more appropriate to the questions it now wants to ask and to the settings in which it wants to ask them" (p.2); they quote Allport as having succinctly stated a vital point thirty-five years ago, "We should adapt our methods so far as we can to the object and not define the object in terms of our faulty methods" (1963, p.28). The ‘new methods’ for psychology advocated by Smith et al. (1995) are derived from the qualitative tradition in the social sciences.

Qualitative data gathering has always been a part of the methodological repertoire of psychology but usually as an adjunct or a pilot phase to what has been seen to be the main task, that of quantitative data gathering and analysis. However, psychology has recently begun to become more accommodating to qualitative approaches and methods, particularly "in contexts which explicitly link psychological theory with social issues and professional practice (e.g. social, health and community psychology)" (Henwood & Nicholson, 1995, p.109). This accommodation is reflected in the recent publication of a number of texts on the use of qualitative methods in psychology (e.g. Bannister et al., 1994; Richardson et al., 1996; Smith et al., 1995). Qualitative research approaches have a long history in the disciplines of anthropology and sociology. These approaches emphasise developing an understanding of the context of a phenomenon and of its meaning to the persons being studied. The term qualitative research is used to refer to a variety of approaches, the unifying commonalities of which are their roots in the phenomenological paradigm. Its primary attributes are a concern with an understanding of human behaviour or experience which stems from the individual's own frame of reference, a basis in data and resultant face validity and
credibility, and a holistic, process-oriented and inductive approach to developing understanding.

Academic psychology has a historical attachment to implementing a model of research that is believed to underpin progress in the natural sciences. This model combines a particular epistemological approach, that of empiricism, with a privileging of the collection and statistical analysis of numerical data, thus leading to the convention of describing this model of scientific practice as the quantitative paradigm. In contrast to this, a ‘qualitative’ paradigm rests on the adoption of a different epistemological position, that of constructivism, and research within this paradigm tends to involve more open-ended and detailed analysis of verbal, written, or visual material, which has not been converted into numerical scales. There are a variety of expressions of epistemological constructivism; however, in summarising the broad thrust of this epistemological approach, Henwood & Nicolson (1995) state that “broadly, the suggestion is that meanings - including lay and scientific knowledge of the world - do not merely reflect the world as it exists, but are produced or constructed by persons and within cultural, social and historical relationships” (p.109).

Henwood (1996) asserts that the quantity versus quality debate has been an important feature in discussions of social science methodology in the mid to late twentieth century, challenging and relativising the assumptions of positivist science. She notes that “qualitative research lays down its claim to acceptance by arguing for the importance of understanding the meaning of experience, actions and events as these are interpreted through the eyes of particular participants, researchers and (sub)cultures, and for a sensitivity to the complexities of behaviour and meaning in the contexts where they typically or ‘naturally’ occur .... Accordingly, interchangeable labels for the qualitative paradigm are ‘interpretative’, ‘contextual’ and ‘naturalistic’ inquiry” (p.27). She goes on to suggest that qualitative methods are privileged within the qualitative paradigm “because they are thought to meet a number of reservations concerning the uncritical use of quantification; in particular they address the problem of inappropriately fixing meanings where these are variable and renegotiable in relation to their contexts of use” (p.27).
Bannister et al. (1994) state that they want to encourage researchers “to go beyond positivism, and to do psychology in a way that is useful and relevant” (p.v). These authors define qualitative research as ‘the interpretative study of a specified issue or problem in which the researcher is central to the sense that is made” (p.2). They argue that qualitative research is “(a) an attempt to capture the sense that lies within, and that structures what we say about what we do; (b) an exploration, elaboration and systematisation of the significance of an identified phenomenon; (c) the illuminative representation of the meaning of a delimited issue or problem” (p.3); this suggests that qualitative research in psychology takes as its starting point an awareness of the gap between an object of study and the way we represent it, and the way interpretation necessarily comes to fill that gap. They assert that interpretation is a process that continues as our relation to the world keeps changing, and that in following this process we must acknowledge that there will always be a gap between the things we want to understand and our accounts of what they are like, if we are to do qualitative research properly.

In considering philosophical foundations for qualitative research, these authors identified two contrasting foundations, realism and social constructionism. The realist position is that any science must operate with adequate models of the objects of study, and the methods used to investigate and explain the way those objects operate must be appropriate to the object; “It is in the nature of human beings, and a ‘power’ they have, to reflect upon their actions and to give account of those actions, and this means that a properly scientific approach to the study of action and experience should employ methods which engage with rather than try to screen out these powers” (Bannister et al., 1994, p.9). The social constructionist position is that “all forms of knowledge, including scientific knowledge, produce images of the world that then operate as if they were true” (p.9). A social constructionist view therefore would see science as a form of knowledge which creates as well as describes the world, implying that the personal and political interests of researchers, which structure their research questions, need to be explored and made explicit rather than hidden away. Bannister et al. (1994) argue that the ways in which we theorise a problem will affect the way that we examine it,
and the ways we explore a problem will affect the explanation we give. They suggest that qualitative research does not make claims to be ‘objective’ but that it does offer a different and more sceptical way of working through the relationship between objectivity and subjectivity; “A reflexive analysis which respects the different meanings brought to the research by researcher and volunteer is an ethical enterprise, and characteristics, whether of the situation or the person, are treated as valued resources rather than factors that must be screened out” (p.14).

Henwood (1996) however, argues that while the distinction between the quantitative and qualitative paradigms is accepted, it should not be presumed to imply that the methods and perspectives of the two paradigms are mutually exclusive, or “that there is a one-to-one relationship between ‘quantity’ and epistemological realism, on the one hand, and ‘quality’ and constructionism, on the other” (p.30). Following Harding (1987) Henwood (1996) suggests that one should distinguish one’s epistemological position from one’s research methodology and in turn from any particular method which is adopted; “This framework can be used to demonstrate how different theoretical choices link particular epistemologies, methodologies and methods, and thus go beyond the simple technical and epistemological versions of the quantity-quality debate” (Henwood, 1996, p.31).

In addressing the use of qualitative research in health care Pope & Mays (1996) suggest that the increasing complexity of modern health services has generated a range of questions which have encouraged a search for new ways of conducting research. They argue that qualitative methods should be an essential component of health services research “not just because they enable us to access areas not amenable to quantitative research, such as lay and professional health beliefs, but also because qualitative description is a pre-requisite of good quantitative research, particularly in areas that have received little previous investigation” (p.2). They describe the goal of qualitative research as “the development of concepts which help us to understand social phenomena in natural (rather than experimental) settings, giving due emphasis to the meanings, experiences and views of all the participants” (p.4). In arguing that in health services research the differences between qualitative and quantitative methods
are overstated, Pope & Mays (1996) suggest that they have different objectives and strengths. They suggest that in health services research, because of its applied nature, "much research is driven not by the theoretical stance of the researcher, but by a specific practical problem which has turned into a research question" (p.6); following Brannen (1992) they suggest that there is no necessary correspondence between epistemology and methods, and that "the choice of method and how it is used can perfectly well be matched to what is being studied rather than to the disciplinary or methodological leanings of the researcher" (p.6). Pope & Mays (1996) argue that it would be invidious to suggest that one source of knowledge is somehow more valid than another; "suffice it to say that different research settings and different methods allow access to different levels of knowledge (...) combining methods can help to build a wider picture" (p.7). They suggest that "different methods enable the researcher to gain access to different types of knowledge. These types of knowledge are not necessarily hierarchically arranged nor can they be added together to provide a bigger or better picture of what is 'really' happening" (Mays & Pope, 1996, p.viii). They suggest that qualitative and quantitative methods can be viewed as complementary and be used to generate a richness of understanding and interpretation. They describe three ways in which qualitative and quantitative methods can be characterised as complementary rather than exclusive; firstly qualitative work can be conducted as an essential preliminary to quantitative research; secondly, qualitative methods can be used to supplement quantitative work as part of a multi-method approach; and thirdly qualitative research can complement quantitative work "by exploring complex phenomena or areas not amenable to quantitative research" (p.7); "Qualitative work can reach aspects of complex behaviours, attitudes, and interactions which quantitative methods cannot" (p.8).

Pope & Mays (1996) suggest that we need a range of methods at our fingertips in order to understand the complexities of modern health care. They quote from Hammersley (1992) as follows "What is involved is not a crossroads where we have to go left or right. A better analogy is a complex maze where we are repeatedly faced with decisions, and where paths wind back on one another. The prevalence of the distinction between qualitative and quantitative method tends to obscure the
complexity of the problems that face us and threatens to render our decisions less effective than they might otherwise be” (p.9).

Hammersley (1996) addressing the relationship between qualitative and quantitative research notes that “Some see these approaches as in conflict, with one as the true way, the other as the way of error or even of sin!” (p.160). He discusses two views, (firstly that quantitative and qualitative research represent competing paradigms; and secondly, that they are of equal value and should be used as and when appropriate) and concludes that neither is acceptable. In relation to precision of description he states that “our decisions about what levels of precision, structure, and context are appropriate in relation to any particular study should depend upon the nature of what we are trying to describe, upon the likely accuracy of our descriptions, upon our purposes, and upon the resources available to us, not on ideological commitment to one methodological paradigm or another” (p.162). With regard to the relationship of the two approaches to theory he states “One can distinguish between studies that are primarily exploratory, concerned with description and with generating theoretical ideas, and those which are more concerned with testing hypotheses. But these types of research are not alternatives: we need both” (p.166). Hammersley (1996) suggests that “in many respects the quantitative-qualitative distinction is unhelpful. It does not accurately map the differences in practical method or in philosophical position that are actually to be found among researchers” (p.172-3); and he concludes that what is required “is a methodologically aware eclecticism in which the full range of options is kept in mind, in terms of both methods and philosophical assumptions” (p.174). This is not a ‘tidy’ conclusion but it is a reasonable account of the current state of philosophical and methodological debate regarding the relationship between qualitative and quantitative research and it informs the present author’s broad position.

2.3 SEMI-STRUCTURED INTERVIEWING

“I interview because I am interested in other people’s stories. Most simply put, stories are a way of knowing”; thus, Seidman (1991, p.1) begins his book ‘Interviewing as Qualitative Research’. He goes on to suggest that “Telling stories is essentially a meaning-making experience” (p.1). Interviewing is a basic mode of social inquiry and
has a long history in psychology. The generally accepted typology of interviews is structured, semi-structured and unstructured (Breakwell, 1995). In the present study data is elicited through the use of semi-structured interviews. Smith (1995) suggests that “researchers use semi-structured interviews in order to gain a detailed picture of a respondent’s beliefs about, or perceptions or accounts of, a particular topic” (p.9). Seidman (1991) using the term ‘in-depth interviewing’ to describe his approach, suggests that underlying it “is an interest in understanding the experience of other people and the meaning they make of that experience” (p.3).

Bannister et al. (1994) suggest four main reasons for the use of semi-structured interviews in research, “a concern with subjective meanings” (p.50), permitting the “exploration of issues that may be too complex to investigate through quantitative measures” (p.50), provision of “a salutary lesson in research involvement and practice (........) as an interviewer, one is forced to confront one’s own participation within the research” (p.51) and finally, making explicit “the question of power relations in research” (p.51).

Smith (1995) suggests that a range of theoretical positions may be adopted while conducting a semi-structured interview-based study. Bannister et al. (1994) suggest that broadly speaking, four approaches inform semi-structured interview practice, ethnographic, new paradigm, feminist and post-modernist, noting that ‘reflexivity’ is accorded a key role in all of them. Seidman (1991) describes his approach as “phenomenologically based “ (p.9). A similar position is adopted by Smith (1995) who describes it as an “interpretative phenomenological approach” (p.10). This position is based firstly on phenomenology insofar as “It is assumed that what a respondent says in the interview has some ongoing significance for him or her and that there is some, though not a transparent, relationship between what the person says and beliefs or psychological constructs that he or she can be said to hold” (Smith, 1995, p.10); and secondly, on a symbolic interactionist position insofar as “it is recognised that meanings are negotiated within a social context” (Smith, 1995, p.10). The theoretical position adopted in the present research regarding the use of semi-structured interviewing is the ‘interpretative phenomenological’ approach as described by Smith (1995).
2.4 CHOICE OF METHOD OF DATA ANALYSIS

A number of approaches to qualitative analysis of interview data have been described; Huberman and Miles (1994) suggest that qualitative data analysis is a "growth industry" (p.428) considering the number of new journals, handbooks and conferences in the area. In producing a typology of qualitative data analysis Tesch (1990) identified a total of twenty-six different approaches, reducing these to four basic groupings where the interest is in:

a) the characteristics of language,
b) the identification of regularities,
c) the comprehension of the meaning of text or action, and
d) reflection.

Smith et al. (1995) outline methods grouped under three headings, 'the search for meaning', 'discourse as topic', and 'research as dynamic interaction',

To answer the research question of the present study (What qualities or patterns of qualities of the experience of receiving help from a mental health service are identified as salient by young clients?) requires an analytic method aiming for the identification of regularities and searching for meaning. The essential requirements of any analytic approach are that it be systematic in application and transparent in description. As a researcher new to qualitative data analysis the present author felt the need for a method which would provide the support of detailed description of how to carry out the analysis.

Three methods of data analysis seem to fit these criteria, 'transcendental realism' (Huberman and Miles, 1994), 'interpretative phenomenological analysis' (Smith, 1995), and 'grounded theory' (Glaser & Strauss, 1967; Charmaz, 1995). These three methods are broadly similar and indeed in practice overlap to some extent. The three linked sub-processes described by Huberman & Miles (1994) as comprising their approach, data reduction, data display and conclusion drawing/verification, could also be used to broadly describe the operation of the other two methods. Indeed, Smith (1995) identifies Charmaz (1995) as "writing from a broadly similar perspective"
The differences between the three approaches are mainly in the mechanics of the data-reduction process.

Huberman and Miles (1994) describe a set of thirteen tactics for “generating meaning” (p.432) such as ‘noting patterns and themes’, ‘clustering by conceptual grouping’, ‘making metaphors’ and ‘making contrasts and comparisons’. Smith (1995) describes “a set of procedures” (p.19) consisting of a cyclical process of reading and rereading a transcript, noting anything of significance or interest in one margin, and during the process of rereading, documenting emerging themes; these themes are in turn examined for connections between them, and ‘clustered’ with a view to describing superordinate concepts or ‘master’ themes. Charmaz (1995) also describes a cyclical approach beginning with the naming of each line of data in a transcript (‘line-by-line coding’); then shifting to ‘focused coding’, “taking earlier codes that continually reappear ....(....).... and using these codes to sift through large amounts of data” (p.40) thereby attempting to create categories of meaning.

The broad similarities amongst these approaches are obvious and there is no basis on which to privilege any one over the others as being the ‘best’ or most appropriate one to use. Rather as Smith (1995) notes each researcher “will need to find a method for working with the data that suits” (p.18) her or him.

For the present author as a neophyte qualitative researcher, the specificity of the strategies to be followed in the grounded theory approach appeared to provide the most explicit supportive context for the process of interpretation; his sense was that this approach was the most likely to keep him grounded in the data of the interview transcripts. For this reason and perhaps also “because it provides a specific set of steps that are closely aligned with positivist science” (Highlen & Finley, 1996, p.178) thereby providing a sense of security in unknown territory for the author, the method of analysis chosen for use in the present study is the grounded theory method.
2.5 GROUNDED THEORY METHODOLOGY

Grounded theory was developed by Glaser & Strauss (1967), two sociologists writing at a time when “sociological practice was almost exclusively reliant on quantitative methods” (Pidgeon, 1996, p.76) and when “beliefs in scientific logic, objectivity and truth supported and legitimised reducing qualities of human experience to quantifiable variables” (Charmaz, 1995, p.29). Glaser & Strauss (1967) argued that the quantitative testing of propositions derived from abstract ‘grand theories’ “led to a theory that was impoverished, in the sense of having a restricted empirical relevance to any particular ‘substantive’ content domain” (Pidgeon, 1996, p.76). They argued that this research seldom led to new theory-construction and challenged what they considered to be an arbitrary divide between theory and research. They made explicit, analytic procedures and research strategies that had previously been implicitly used by qualitative researchers and described a set of written guidelines for conducting qualitative research. Grounded theory methods consist of a set of inductive strategies for analysing data. Beginning with accounts of individual cases, incidents or experiences the approach aims to “develop progressively more abstract conceptual categories to synthesize, to explain and to understand (.....) data, and to identify patterned relationships within it” (Charmaz, 1995, p.28).

Pidgeon (1996) states that two fundamental analytical commitments shape this methodological stance, and differentiate grounded theory from traditional content analysis or other forms of thematic analysis, the method of constant comparison and the use of theoretical sampling. “The method of constant comparison defines the principal analytical task as one of continually sifting and comparing elements (such as basic data instances, cases, emergent categories and theoretical propositions) throughout the lifetime of a research project” (Pidgeon, 1996, p.78). “Theoretical sampling (.....) involves the active sampling of new cases as the analysis proceeds. Since the goal of grounded theory is the elaboration of a conceptually rich, dense and contextually grounded account, there is no compunction to sample multiple cases where this would not extend or modify the emerging theory. Accordingly, sampling is often explicitly driven by theoretical concerns with new cases being selected for their
potential for generating new theory by extending or deepening the researcher's emergent understanding" (Pidgeon, 1996, p.78).

In its original development by Glaser & Strauss (1967) grounded theory methodology was “founded upon a critique of the technical appropriateness of quantification in research in the human sciences (........) but did not challenge the received view of scientific inquiry in and of itself” (Pidgeon 1996, p.81), and some aspects of the methodology reflect a positivist, empiricist epistemology. A fundamental problem arises from the assumption made by Glaser & Strauss (1967) that theory emerges from data, implying “that a set of social or psychological relationships exist objectively in the world, are reflected in qualitative data, and hence are there to be ‘captured’” (Pidgeon, 1996, p.81). This difficulty has given rise to a constructionist revision of the approach, first outlined by Charmaz (1990, 1995); this revision provides the epistemological basis of the methodology as used in the present study. Noting that the original description of grounded theory implied that “categories inhere in the data and may even leap out at the researcher” (p.32), Charmaz (1995) disagrees and suggests “Rather, the categories reflect the interaction between the observer and observed. Certainly any observer’s worldview, disciplinary assumptions, theoretical proclivities and research interests will influence his or her observations and emerging categories” (p.32). Pidgeon (1996) suggests that “what appears to be the ‘discovery’ or ‘emergence’ of concepts and theory is in reality the result of a constant interplay between data and the researcher’s developing conceptualizations” (p.82). Henwood & Pidgeon (1995) suggest that with this approach “the value of the methodological strategies of the grounded theory approach (........) is that they help to keep researchers on an analytic path while committing them to be extremely wary of simply reproducing their pre-existing perceptions, ideas and concepts unchanged (........) (while) acknowledging the multiple dimensions of subjectivity which ground knowledge claims in science” (p.117).

As originally developed the aim of grounded theory was to build comprehensive theoretical systems from purposively sampled sets of relevant cases. However, Henwood & Pidgeon (1995) suggest that this is a very ambitious goal and may not be achievable for many projects. Charmaz (1995) states that “most grounded theory
works" (p.48) are not actually theory. “At present, most grounded theory researchers have aimed to develop rich conceptual analysis of lived experience and social worlds instead of intending to create substantive or formal theory. They wish to pursue more basic questions within the empirical world and try to understand the mysteries and puzzles it presents” (Charmaz 1995, p.48). Henwood & Pidgeon (1995) advise the defining of achievable goals and suggest three types of research activity with this in mind, as follows:

1. basic taxonomic development, to identify relevant features of a corpus of data,
2. focused conceptual development of the properties of a limited set of categories, of particular relevance to the problem under investigation, and
3. cycles of interpretation (of data collection, coding and category building) where it is suspected that theorizing may be limited by the initially available data.

The objective of the present study, to provide data at a taxonomic level from which further theory may develop, encompasses the first and second of these types of research activity.

2.6 RELIABILITY AND VALIDITY IN QUALITATIVE RESEARCH

The most common criticisms of qualitative research are summarised by Mays & Pope (1996) as follows: “firstly, that qualitative research is merely an assembly of anecdote and personal impressions, strongly subject to researcher bias; secondly, it is argued that qualitative research lacks reproducibility - the research is so personal to the researcher that there is no guarantee that a different researcher would not come to radically different conclusions; and finally, qualitative research is criticised for lacking generalisability” (p.10). Robson (1993) suggests that “researchers collecting and analysing qualitative data have to take serious note of the potential for bias in these processes” (p.402), and quotes Miles & Huberman (1984) as follows, “Each [qualitative researcher] is a one-person research machine: defining the problem, doing the sampling, designing the instruments, collecting the information, reducing the information, analysing it, interpreting it, writing it up” (p.230). Such an approach challenges the assumptions of universality and replicability that represent central tenets of mainstream quantitative research in psychology. The essential point of the criticisms is that qualitative research cannot satisfy the requirements for validity and reliability
demanded by the positivist quantitative research approach within psychology and it is the case that most qualitative research cannot satisfy these requirements. However, they may not be appropriate criteria to apply in relation to qualitative research and the types of 'knowledge' it produces. This seems particularly true for research which is at an inductive stage of theory development as the present research is. For example, writing on research design Breakwell (1995) suggests that “A broader range of data types, elicitation techniques with lower control (......) and qualitative treatment of data may be most appropriate in the early inductive phase” (p.132); and Good & Watts (1989) in referring to the need for clarity by a researcher as to whether he or she is doing “exploratory reconnaissance or hypothesis testing” (p.214) note, “There is a place for both but their methodological requirements are very different” (p.214).

Smith (1996) in addressing the question of validity, argues that qualitative research should be judged against criteria appropriate to that approach; “In other words qualitative research should not be evaluated in terms of the canons of validity that have evolved for the assessment of quantitative research, since these have different epistemological priorities and commitments” (191-192). Robson (1993) supports the argument of Lincoln & Guba (1985) that the conventional understandings of reliability and validity are inappropriate when dealing with qualitative research. However, methodological rigour is inherent in psychological investigation and criteria have been developed to attempt to ensure such rigour in qualitative research. Lincoln & Guba (1985) propose four alternative criteria “which appear to reflect more faithfully the assumptions behind this strategy - credibility, transferability, dependability and confirmability” (Robson, 1993, p.403).

In establishing 'credibility' Robson (1993) states that the objective is “to demonstrate that the enquiry was carried out in a way which ensures that the subject of the enquiry was accurately identified and described” (p.403). He suggests that techniques which may enhance credibility include triangulation, peer debriefing and member checks. Yin (1989) suggests that the validity of a study can be checked by having all of the data filed in such a way that somebody else could follow the chain of evidence and line of argument of the research report, in essence carrying out an enquiry audit.
Transferability is the construct corresponding to external validity or generalisability in conventional quantitative research; “When a sampling methodology is not used it is clearly inappropriate to make the same kind of statistical generalisation to a population which is a fundamental part of statistical inference” (Robson, 1993, p.404-5).

Regarding the qualitative researcher, Lincoln & Guba (1985) suggest that “it is (........) not the task to provide an index of transferability; it is his or her responsibility to provide the data base that makes transferability judgements possible on the part of potential appliers” (p.316).

Dependability in qualitative research is analogous to reliability in quantitative research. Dependability can also be supported through the use of or possibility of, an enquiry audit. An enquiry auditor would carry out the tasks of examining the processes and products of a research project; “If the processes followed are clear, systematic, well-documented, providing safeguards against bias (........) this constitutes a dependability test” (Robson, 1993, p.406).

Confirmability corresponds to the concept of objectivity in quantitative research. “The change signals a move away from some attribute of the enquirer (is he or she objective?) to the case study itself. Have we been told enough about the study not only to judge the adequacy of the process, but also to assess whether the findings flow from the data?” (Robson, 1993, p.406). Again an enquiry audit provides a technique for checking confirmability of a study, in which an ‘audit trail’ is followed during which various categories of information are, or can be, examined.

In addressing the requirements for establishing rigour in qualitative research Huberman & Miles (1994) suggest that “the most basic solution (...)(is) careful retention in easily retrievable form, of all study materials, from raw data, through data displays and final report text” (p.439). However, they suggest that this solution rests on another, “a reflexive stance to the conduct of the study that assumes regular ongoing, self-conscious documentation” (p.439) of the data-analytic processes.
Robson (1993) suggests that the following categories would be included in an audit trail.

“(a) raw data - field notes, documents, tapes etc.;
(b) processed data and analysis products - write-ups, summaries, etc;
(c) data reconstruction and synthesis products - codes, patterns, matrices, etc. and final report;
(d) process notes - procedures, designs, strategies, etc.;
(e) materials relating to intentions and dispositions - original proposal, personal notes, intentions, expectations, etc.;
(f) instrument development information - pilot forms, schedules, observation formats etc.” (Robson, 1993, p.406).

Completion of such a process would be an enormous task both for the ‘auditor’ and the ‘auditee’ and Robson (1993) suggests that “it is over-optimistic and probably over-formalistic, to expect all small-scale researchers to follow this route at this time” (p.406-407); nevertheless, he suggests that “it provides a useful example even if only used on an ‘as-if basis” (p.407). Indeed, it seems that such a process would be a useful model for all qualitative researchers to follow, so that on completion of a project, a researcher would be able to state that his/her materials are organised and available in such a way as to facilitate such an audit being carried out.

Because of limitations of time and resources in the present study such techniques as triangulation, peer debriefing and member checks have not been possible. However, all of the materials required for an audit trail have been maintained in such a way that an enquiry audit would be feasible; the analytic procedures employed are described explicitly and in detail; and the reflexive stance maintained by the author is evidenced in the discussion and the reflexive view sections below.

2.7 ETHICAL ISSUES IN QUALITATIVE RESEARCH

The ethical issues requiring to be considered specifically in research with children and the implications of these for the choice of methodology in this study, are dealt with in
2.1 above. Ethical planning in the present research is also informed by the ethical guidelines for conducting research of the British Psychological Society (1993b). The present research is also ethically informed by the work of Miles & Huberman (1994) who very usefully identify a series of twelve ethical issues “that typically need attention before, during and after qualitative studies” (p.290). These twelve issues are identified here, with each issue briefly explicated by a relevant question (or questions) or examples.

1. **Worthiness of the project**: Is the study worth doing?
2. **Competence boundaries**: Does the researcher have the expertise to carry out a study of good quality? Is appropriate support and supervision available?
3. **Informed consent**: Have the participants been given full information about what the study will involve? Is their consent to participate freely given?
4. **Benefits, costs and reciprocity**: Is it clear what each party to the study will gain, if anything? Is the balance equitable?
5. **Harm and risk**: What might this study do to hurt the people involved? How likely is it that such harm will occur?
6. **Honesty and truth**: Is the researcher telling the truth to the participants? Is the relationship involved based on trust?
7. **Privacy, confidentiality and anonymity**: In what ways will the study intrude or come closer to people than they may wish? How will confidentiality of information be guarded? How identifiable are the individual participants of the study?
8. **Intervention and advocacy**: What does the researcher do if she/he observes wrongful behaviour on the part of others during a study? Should the researcher speak for anyone’s interests besides her/his own? If so, whose interests?
9. **Research integrity and quality**: Is the study being conducted carefully, thoughtfully, and correctly in terms of reasonable standards?
10. **Ownership of data and conclusions**: Who owns the researcher’s field notes and analyses? Who controls dissemination of any reports on the research?
11. **Use and misuse of results**: Does the researcher have an obligation to help the findings to be used appropriately? What is the obligation on the researcher if the results are used harmfully or wrongly?
12. Conflicts, dilemmas and trade-offs: Examples are: validity versus avoiding harm; anonymity versus visibility; scientific understanding versus individual rights; detached enquiry versus help; help-giving versus confidentiality; freedom of inquiry versus political advantage.

Following submission of a detailed protocol application, approval to conduct the present research was granted by the Clinical Research Ethics Committee of the Cork Teaching Hospitals. This Ethics Committee “is charged with the responsibility for review and surveillance of research involving human subjects carried out in the Cork Teaching Hospitals” (Clinical Research Ethics Committee, 1996, p.4). This protocol, which was developed according to the requirements of the committee, along with a consent form also developed according to these requirements and other documents submitted to the committee, are provided in appendices A to E.

[It is a requirement of the Clinical Research Ethics Committee that all protocols, “must be sponsored by individuals holding consultant appointments at the Cork Teaching Hospitals” (p.5) or staff of University College Cork of Lecturer status or higher. The present research was sponsored by the Consultant Child and Adolescent Psychiatrist at the author’s department, who was thereby named as the ‘Principal Investigator’ in the research protocol]

The title of this study has been amended slightly from the title used in the research protocol submitted to the ethics committee to make it more concise while retaining its meaning.
CHAPTER THREE: METHOD
3.1 LOCATION OF THE STUDY
The study was carried out at the Department of Child and Adolescent Psychiatry of the Southern Health Board, St. Finbarr’s Hospital, Cork. The author is a Senior Clinical Psychologist at this department. The department had been established less than four years at the time of the study. It is in the process of expansion but is presently relatively small. The staff complement is as follows:
1 Consultant Child and Adolescent Psychiatrist
1½ Registrars in Child and Adolescent Psychiatry
1 Senior Social Worker
1 Social Worker (Basic Grade)
1 Senior Clinical Psychologist
½ Occupational Therapist
½ Speech Therapist
2 Secretarial staff
The age-range of children and adolescents accepted for referral is from birth to their sixteenth birthday. The service is based in a Child Guidance Clinic on the grounds of a general hospital. Presently the service provides only a clinic-based (i.e. outpatient service); those children and adolescents requiring inpatient care are referred to appropriate services in other Health Board areas.

3.2 PARTICIPANTS
3.2.1 Criteria for participation
Potential participants in the study were young people aged 12 to 16 years who had been clients of this department within the six months prior to the beginning of the study, and whose cases were closed because of improvement in the original presenting problems. Exclusion criteria were indications of psychosis and intellectual disability. It was planned to have between five and ten participants in the study.

3.2.2 Identification of potential participants
The proposed research was discussed with all of the clinicians in the department, and all were supportive of it. (At this time the author and the Occupational Therapist were recent appointments to the department and neither had worked with cases fulfilling the
above criteria). All of the clinicians in the department agreed to identify potential participants from their case-loads fulfilling the above criteria and to supply their names to the author. This process led to the identification of thirteen potential participants. Ten of these cases had already been closed and the other three were expected to be closed within six weeks or so following their identification.

3.2.3 Requesting participants' involvement in the study

In relation to the ten young people whose cases were closed, a letter was sent to the parents of each requesting their agreement and the agreement of their son/daughter “to consider his/her participation in this research” project. (A copy of this letter is supplied in an appendix). The research project was briefly outlined in this letter and the practicalities of participation described. The letter stated that if the parents and young person agreed to consider participation in the study, a meeting would be arranged between the parents, the young person and the author to “explain and describe the research and answer any question you or he/she may have”, and “to make sure that you and he/she are fully informed about the research before deciding whether or not to consent to participate in it”. Enclosed with this letter was a form (reproduced in an appendix) indicating agreement to “discuss the possibility of participation” in the research project with spaces for the signatures of the parents and the young person; a stamped addressed envelope was also enclosed. If the parents and young person agreed to consider participation the letter requested that they indicate their agreement either by returning the enclosed form, or by phoning the author at the Child Guidance Clinic.

In relation to the three young people whose cases were expected to close, a copy of the letter to the parents, referred to above, was given to the relevant clinician. These clinicians agreed that if and when one of the cases was closed, at the closing appointment they would outline the contents of the letter and request consideration by the parents and young person of agreement to participate in the study. If the parents and young person agreed to such consideration the clinician would inform the author, who in turn would contact the parents to arrange to meet for purposes as described above.
Of the ten young people whose cases were closed and to whose parents letters were sent, forms were returned in relation to two of them and parents telephoned in relation to two others. One of the telephone contacts was from a parent whose child wished to participate but who did not wish to attend any meeting herself; it was explained why participation could not occur on this basis, and no further contact was received from this parent. Of the three young people and their parents to whom the research was outlined and a request made to consider agreement to participate by the relevant clinician at the closing appointment, assent to such consideration was given in all three cases. The total number of young people, who along with their parents, agreed to consider participation in the research therefore was six.

3.2.4 Discussion of the research project and of informed consent with the potential participants and their parents

As described above, the author’s intention was to arrange a meeting with each potential participant and his/her parents to outline the research project and to answer any questions. It was intended also, at this meeting, to discuss the principle of informed consent, to discuss the consent form and to have this form signed. In fact a meeting to deal with the above, separate from the meeting to conduct the interview was not required in any case. The author contacted the parents of each of the six potential participants by telephone for initial introduction of the project, and with a view to arranging appointments for the intended meeting and the interview itself. The first two parents contacted indicated that they considered that they and their son/daughter had enough information (from the letter and the telephone conversation) to decide to participate, without the need for a further separate meeting, and that the issue of consent and the signing of the consent form could be dealt with at the appointment for the interview. As this arrangement would make fewer demands on the participants, their parents and the author, during the telephone discussion with the parents of the other four potential participants, a choice was offered between this arrangement and a separate meeting; none requested a separate meeting, and all indicated their own and their son’s/daughter’s agreement to participate in the research.
During each of these telephone conversations, the parents were informed that the study was being carried out under the auspices of the Clinical Research Ethics Committee of the Cork Teaching Hospitals, and that it was a requirement of this committee that a participant’s family doctor be informed of the proposed research and agree to his/her patient’s participation in it. Each parent was asked for permission for the author to contact the family doctor and they each gave it. During the week following each telephone contact, the particular family doctor was contacted by the author by telephone; he/she was informed of the agreement of the parents of his/her patient and the patient himself/herself, to consider participation in the research. The research was briefly described and the doctor was asked for his/her agreement to his/her patient’s participation in it. They all gave their agreement.

In all six cases therefore an appointment was arranged to conduct an interview with the young person, with the proviso that before the interview took place, the study would be discussed with the parents and young person; the principle of informed consent would be discussed; the consent form would be read through and discussed; and at that point the parent(s) would decide on consent, and the young person on assent, to participate or not in the research; if they decided in the positive the consent form would be signed. In the event, this was the arrangement for all six cases, and in each case the parents consented and the young people assented to participate.

3.2.5 The study participants

The following provides a summary description of each of the six study participants.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age at date of interview yrs.</th>
<th>Number of months case was open mths.</th>
<th>Number of months since case was closed yrs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Male 13</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>B</td>
<td>Male 14</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>C</td>
<td>Female 15</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>
3.3 THE SEMI-STRUCTURED INTERVIEWS

3.3.1 Development of the interview protocol

Development of the interview protocol was informed by the recommendations of Smith (1995) and Bannister et al. (1994). The research question of the present study is: What qualities or patterns of qualities of the experience of receiving help from a mental health service are identified as salient by young clients? In attempting to provide data from which to develop answers to this question the objective of the interview was to get as detailed a picture as possible of each participant’s account of his/her experience of receiving help from the service as a client, i.e. his/her beliefs, views, perceptions and feelings. In order to encourage, facilitate, and support the participants to respond as broadly and deeply as possible, it was necessary to identify a set of question areas which would provide reasonably comprehensive coverage of the range of possible experiences which might have salience for participants, while keeping the length of the interview within manageable limits.

Three broad question areas were decided on. These were:

1. a participant’s description of his/her involvement with the service;
2. a participant’s account of what it meant to him/her, and what it felt like to attend the service as a client;
3. a participant’s report of what (if anything) they considered to be helpful to them in their attendance at the service.

The purposes of using the first question area were firstly to stimulate memories of attending the service for a participant in the hope that later discussion would be richer in clarity, detail and feeling, secondly, to provide the author/interviewer with some sense of the context of each participant’s attendance at the service and thirdly to provide as many opportunities as possible to ask the participants to elaborate on issues relevant to the second two question areas. In this regard, the ‘probe’ questions, ‘Can
you tell me more about that?’, ‘How did you feel about that?’, and ‘What was that like for you?’, were to be used frequently throughout the interview.

It was decided to begin the interview therefore with this question area. It seemed that the ‘helpfulness’ question area, because it would involve some consideration of the substantive reason for attending the service, would be the most sensitive area; so, it was decided that this would be the last area to be addressed. Thus the sequence of areas to be addressed in the interview was clear, while it was accepted that the nature of a semi-structured interview involves flexibility, responsiveness and an element of unpredictability.

A set of questions was drawn up to address each of the three general question areas, and this provided the first draft of the interview protocol. At the end of the interview two further questions were added. The first provided the opportunity for the participant to address anything of significance to him/her which had not been included in the protocol. The second addressed the issue of what it was like for the participants to complete the interview, and was included to inform the author’s reflexive view. To check for suitability and comprehension of the questions, their neutrality, use of jargon, and being closed rather than open, this draft was discussed with professional colleagues and two adolescents (the author’s daughters); only minor changes in phraseology arose from these discussions. The resulting interview protocol was as follows.

**Description of involvement**

1. Can you tell me about your involvement with this service and how you came to attend?
   **Prompt questions:** 1. When did you first come?
                              2. How long did you attend for?
                              3. Whose idea was it for you to come?

2. Can you tell me what happened during your attendance?
   **Prompt questions:** 1. Do you remember your first appointment? Can you tell me about it?
                              2. Who worked with you?
3. Who attended with you?
4. What used to happen at your appointments?

3. Can you tell me about anything that was difficult or unpleasant for you in attending at this service?

What it meant to attend
1. As an adolescent what was it like for you to attend this service?
2. How did you feel about coming to appointments?

What was helpful
1. Can you tell me about some things that you found helpful about attending at this service?
2. Can you tell me in what ways x was helpful to you (x referring to any issue, experience or quality identified by a participant)?
3. Can you tell me about some things that you found unhelpful about attending?
4. Was there anything that would have been helpful but wasn’t done?

Other
1. Is there anything else which you would like to tell me about your attendance at this service?
   Prompts: 1. that you think might be useful for me to hear?
   2. that you feel strongly about?
2. Can you tell me what it was like for you to do this interview?

3.3.2 Audio-taping of the semi-structured interviews
All of the interviews took place with only the participant and the author/interviewer present. The audio-tape recorder used was small and compact (Sony Cassette-Corder TCM-939), about 9x5.5x2 inches in size. It was battery operated; in case of difficulty the author brought a back-up set of batteries and the mains plug of the machine to each interview. However no difficulties arose. Before beginning each interview the working of the audio-tape recorder was demonstrated to the participant; sound-testing
was carried out both by the author/interviewer and the participant to familiarise him/her with the taping procedure. None of the participants expressed any discomfort with the tape-recording.

3.3.3 The pilot interview

It was essential to complete a pilot of the interview in realistic circumstances to inform the author regarding the practicalities of carrying out this particular interview in relation to language and structure, any difficulties in tape-recording, the time required, and his own feelings and behaviour during the interview. So that the pilot interview would be realistic, it was decided that the first interview undertaken would be treated as the pilot, and that the data arising from this interview would not be included in the analysis. The participant in the pilot interview was A. The interview took place at A’s home on the afternoon on June 16th. A attends secondary school and was on school holidays at that time. A’s mother was present. Discussion of the research project and of the consent form took place with A’s mother and A, and the form was signed. A seemed quite comfortable during this discussion and seemed happy to co-operate. The interview lasted approximately thirty-five minutes. The author made some notes during the interview, and further notes during transcription and review of the transcript. The following, based on these notes, were the learning points arising from the pilot interview.

Three sources of difficulty were apparent. Firstly, the author was not familiar enough with the audio-tape recorder used; this caused some anxiety at times that it was not operating properly, and a need by the author to check it on two occasions; secondly the author appeared not to be familiar enough with the interview to converse without too much dependence on it; and thirdly the copy of the protocol used by the author did not lend itself to user-friendly recording of when a question or question area had been dealt with. These difficulties seemed to lead to a lack of ease and flexibility on the author’s part in the course of the interview.

The solutions to these difficulties were fairly obvious and were followed. Firstly, the author became very familiar with the use of the audio-tape recorder; secondly, he
learned the interview protocol more or less off by heart; and thirdly, he devised a simple marking system on an index card to provide a user-friendly system of noting the questions and question areas addressed during the course of the interview.

3.3.4 The study interviews

The interview with B took place at the Child Guidance Clinic on the morning of July 1st. B attends secondary school and was on school holidays at that time. She was accompanied to the clinic by her mother; the research project and the consent form were discussed with both of them and the form was signed. B seemed comfortable during the interview and eager to give her views. She impressed as reflective and articulate. The interview lasted approximately forty-five minutes.

The interview with C took place at her home on the morning of July 8th. C is employed full-time and this was her day off. Her mother was present; the research project and the consent form were discussed with both of them and the form was signed. C seemed pleased to co-operate and seemed comfortable and relaxed. However, at times she seemed tired; her verbal expression seemed less fluent than might be expected considering her age, and she used the expressions “d’you know” and “you know, like”, a great deal as substitutes for elaboration of a point. The interview lasted approximately thirty-five minutes.

The interview with D took place at his home on the evening of July 22nd. D is a secondary school student with a job during his school holidays. Both of D’s parents were present; the research project and consent form were discussed with all three of them and the form was signed. D seemed pleased to help, and impressed as an intelligent, articulate boy. During the interview he impressed as relating in a somewhat adult, almost business-like fashion. His answers were clear and succinct but seemed guarded in relation to areas bordering on the personal. The interview lasted approximately forty-five minutes.

The interview with E took place at her home on the afternoon of July 27th. E is a secondary school student with a job during her school holidays; she took time off work
to be at home for the interview. E's mother was present; the research project and the consent form were discussed with both of them and the form was signed. E seemed interested to be of help. Throughout the interview, more so at the beginning, she seemed a little tense. However, she impressed as intelligent, reflective and articulate, though perhaps tending to lack a little in self-confidence.

The interview with F took place at her home on the morning of September 3rd. (It was originally planned for mid-August but could not take place as the author was absent from work through illness for three weeks). F is a secondary school student who was still on school holidays on that date. F's father was present; the research project and the consent form were discussed and the form was signed. F seemed interested in the project and eager to be involved. She seemed quite comfortable throughout the interview though a little reserved in relation to personal matters. She presented as a reflective, articulate young person.

3.4 DATA ANALYSIS
3.4.1 Transcription of the interviews
Following each interview a letter identifying the participant was written on the cassette tape. All of the transcription was carried out by the author. The first interview (with A) was transcribed directly onto the author's PC; however, this was very awkward to manage physically, so with the other five tapes the author transcribed the interviews by hand, and then typed from the handwritten transcription onto the PC. Each of the transcripts was printed in single spacing on A4 sheets. The number of pages in the transcript of each participant was as follows:

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<tbody>
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<td>B</td>
<td>18</td>
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<td>C</td>
<td>13½</td>
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<tr>
<td>D</td>
<td>10</td>
</tr>
<tr>
<td>E</td>
<td>15½</td>
</tr>
<tr>
<td>F</td>
<td>14½</td>
</tr>
</tbody>
</table>

Each page was numbered, and every fifth line on each page was numbered. The A4 sheets were then copied onto A3 sheets to allow space for coding.
3.4.2 Coding the data

The procedures used in the present study for coding the data are primarily those described by Charmaz (1995). "Coding is the process of examining what the data are all about" (Charmaz, 1995, p.37). The first step is to examine each line of data and define the actions or events that occur in it or are represented in it. Charmaz (1995) suggests the following "basic questions" (p.38) for a researcher to have in mind while carrying out line-by-line coding.

1. What is going on?
2. What are people doing?
3. What is the person saying?
4. What do these actions and statements take for granted?
5. How do structure and context serve to support, maintain, impede or change these actions and statements?" (p.38)

She further advises that codes should be framed in terms which are specific and active. Each line of each transcript was coded following these procedures. This coding was done following the typing of each transcript and was ongoing over the period during which the interviews were taking place. This process provided a large number of initial codes for each transcript which were written in red ink in the right-hand margin of each A3 sheet. For example, in E’s transcript the total of initial line-by-line codes was ninety-nine.

The following example of line-by-line coding is taken from B’s transcript.

```
I was told like, I had no choice about it, but if my mam said I don’t have to go, I don’t, but I had no say in it. That kind of annoyed me, but I knew it was true anyway, like. Course I hated being told, you hate being told you’ve no choice, but if your parents say you don’t have to come, then you don’t. But it’s you that comes here to speak, so you should have the choice even though you don’t like. Knowing she had no choice about attending. Feeling annoyed because of lack of choice. Resenting lack of choice. Seeing parent as having the power to decide. Claiming the right to choose.
```
From a grounded theory perspective according to Charmaz (1995), these initial line-by-line codes help “to break the data into categories” (p.39) and help the researcher to begin to see processes. “Line-by-line coding frees you from ‘going native’, or from becoming so immersed in your respondents’ categories or worldview that you fail to look at your data critically and analytically” (Charmaz, 1995, p.39).

The next step involves ‘focused coding’. This “refers to taking earlier codes that continually reappear in your initial coding and using these codes to sift through large amounts of data” (Charmaz, 1995, p.40). Through this process, categories for capturing the data can be created and tried out. “By categorising, you select certain codes as having over-riding significance in explicating events or processes in your data” (Charmaz, 1995, p.40). Focused coding was carried out with each transcript soon after the initial line-by-line coding of that transcript was completed, over the period during which the interviews were taking place. It was, therefore, first completed with B’s transcript, then with C’s, and so on. The focused coding of each of the last four transcripts, therefore, was influenced by the work which had been done with transcripts earlier in the sequence. The potential categories created during the process of focused coding were noted in the left-hand margin of each A3 transcript sheet when first decided on, and numbered chronologically in blue ink. The number of each potential category, again in blue ink, was used to identify each line-by-line code relevant to a particular category. The number of focused codes (potential categories) created for each participant’s transcript was as follows:-

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<tr>
<td>B</td>
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<td>D</td>
<td>14</td>
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<td>E</td>
<td>18</td>
</tr>
<tr>
<td>F</td>
<td>19</td>
</tr>
</tbody>
</table>

The following example of focused coding is taken from F’s transcript.
He sort of understood, you know... really like he didn’t understand what I was going through, cause he obviously wasn’t going through it himself at the time or whatever, but he made me feel like that ... you’ve got this problem and .... I’m going to help you and you know, a lot of people never did that, like, they didn’t take the time to sit down and listen to you.

This example of focused coding is taken from E’s transcript.

I didn’t expect her to be that way ... she was laid-back, like, and I kinda thought, you know, she’d be all smart and, d’you know, she wouldn’t have such a laid-back conversation with you, that it would be all kind of technical with her, and stuff like that, I thought she’d just ask questions. I didn’t think she’d help as much as what she did, like ... t’would be just a case of, you know, I’ll ask you my questions, and you answer them and I’ll .... d’you know .... I’ll tell you my opinion of you then and what I feel, .... that’s the way I thought it would be anyway.

The next step in the process is memo-writing. This is a means by which “processes, assumptions and actions that are subsumed under your code” (Charmaz, 1995, p.42-43) are elaborated. While memo-writing the codes are no longer treated solely as ways to sort data into topics, but are explored as processes. It consists of taking categories apart by breaking them into their components, and defining their properties using the method of constant comparison. The objective of memo-writing is to help a researcher “to go beyond individual cases and to define patterns” (Charmaz, 1995, p.43). It helps to clarify which categories are major, which are minor and to identify patterns among them. Memos are preliminary and always adjustable.

In the present study memos were written on A4 sheets, with the related data from the transcripts identified by participant, page number and line number for each category involved; on each memo was noted the date and time of its writing, so as to have a clear chronology. A file was created for each potential category in use, in which the relevant memos were stored; when a category was discarded or collapsed into another
category, relevant memos were transferred to the file for the appropriate category and redundant memos were transferred to a separate file. An example of memo-writing from the present study is as follows:

The experience of talking and of being listened to seems to be wished for but missing in the context of family and peer relationships. Obstacles to this happening seem to be worries, firstly of being judged or put down, and secondly of what is said not being treated as confidential. Being able to talk openly to a clinician is made possible by the clinician being supportive, respectful and confidential. Talking to a clinician and being listened to is helpful because the clinician’s listening is active and is responsive to the young person.

The final stages of the analytic process involve “attempts to integrate the emerging categories by creating links between them” (Pidgeon & Henwood, 1996, p.98). These links are explored through constant comparison in the course of coding and memo-writing. Pidgeon & Henwood (1996) suggest that in the later stages of analysis, it is useful to sort and group sets of related concepts.

The method used in the present study was to construct a conditional matrix, described by Strauss & Corbin (1990) as “an analytic aid, a diagram, useful for considering a wide range of conditions and consequences related to the phenomenon under study. The matrix enables the analyst to both distinguish and link levels of conditions and consequences” (p.159).

Before the conditional matrix was constructed, focused codes which seemed connected were clustered together as suggested by Smith (1995). The conditional matrix constructed was a row and column chart. Across the columns were the letters identifying each participant; down the rows were the shorthand labels of the potential categories; these labels were organised according to the clustering mentioned above, for ease of comparison. In the matrix cells were sample quotes from participants relevant to each category.

A matrix such as this is a tool which enables a researcher to clarify, refine and integrate categories through the use of constant comparison. In the present study work on the first version led to the construction of two separate conditional matrices, addressing
two major categories. Each of these two matrices underwent two further revisions and reconstructions before the results described in the next chapter were arrived at. It is not relevant, nor would it be informative to reproduce the conditional matrices here because, except for the final versions, they were large pieces of paper used as working documents, with numerous possible connections indicated and many discarded. The final matrices arrived at are those provided in the results section.

To make the analytic process more transparent the following example uses an extract from D's interview to illustrate the relationship between line-by-line coding, focused coding, memo-writing and the construction of a sub-category ('understanding' as an experienced clinician quality). Here the interview extract is on the left and the line-by-line coding on the right.

You couldn't be telling your friends like, 'cause they'll think you're weird... they'd just say that's stupid or forget it.....so nobody knows what it's like. But you could talk there like, if you wanted to....'cause you know she wanted me to....and she kinda knew what I was talking about 'cause she had loads of people like me....and I'd be talking and she'd just let me like.....and she wouldn't say much. She'd just ask me a question and I'd start telling her....and I don't know....but they were good questions cause I'd start telling her and I never told anyone else cause they wouldn't understand ....and it was alright like cause she didn't think it was weird.... she knew what it was like for me....and she didn't think I was a psycho like and that made it easy

Feeling he couldn't tell his friends. Being free to talk at clinic.
Clinician understanding what he's talking about
Feeling comfortable talking at clinic
Clinician asking insightful questions
Being comfortable telling clinician about difficulties
Feeling accepted/respected by clinician
Feeling understood by clinician
Feeling accepted/respected by clinician

Through the process of focused coding the line-by-line codes in the above example contributed to the construction of 'focused codes' as illustrated in the following example: -
Focused codes

1. Experiencing a clinician as insightful and understanding

Line-by-line codes

Clinician understanding what he's talking about
Clinician asking insightful questions
Feeling understood by clinician

2. Feeling accepted and respected by clinician

Being comfortable telling clinician about difficulties
Feeling accepted/respected by clinician (1)
Feeling accepted/respected by clinician (2)

3. Being comfortable talking at clinic

Being free to talk at clinic
Feeling comfortable talking at clinic
Being comfortable telling clinician about difficulties

The first of these 'focused codes' contributed to the construction of the following memo.

There is an experience of the clinician as insightful and understanding and this is seen as contributing to helpfulness. However, there is little elaboration of this quality in the data of any of the participants. There is a sense that the capacity of the clinician to 'understand' is perceived by the young clients as an intuitive skill which the participants could not describe in words.

This memo is a distilling of various line-by-line codes describing elements of the data of each of the participants which contributed to the construction of the sub-category 'understanding' of the major category 'Experiencing a therapeutic relationship'.
CHAPTER FOUR: RESULTS AND DISCUSSION
4.1 INTRODUCTION

The aim of the present study is to ‘give voice’ to young clients of a mental health service by exploring their own experience of receiving help from such a service. Having reviewed the relevant literature it was concluded that an inductive phase of research was required in this area which may provide data at a taxonomic level from which further theory may develop. With a view to providing such data the research question in the present study was as follows: What qualities or patterns of qualities of the experience of receiving help from a mental health service are identified as salient by young clients?

Before presenting results and discussing them, three issues relevant to representativeness must be noted. Firstly, the participants in this study were five young people aged between fourteen years, nine months and sixteen years, six months who had been clients of the author’s service within the six months prior to the beginning of the study, and whose cases were closed because of improvement in the original presenting problems. Insofar as they are representative at all, it is only of a very narrow range of clients. There are no participants who did not attend, who dropped out or who attended and did not improve. Therefore, the discussion below reflects only the experience of adolescents who attended a service and whose original presenting difficulties improved during the period of their attendance. Secondly, these participants were all clients of the same service. Four different clinicians were involved with the participants, bringing their individual personal qualities, professional training and theoretical leanings to their work. However, it seems likely that any particular service develops its own culture and organisational style. In the present study because only one service is in question, it is possible that this service culture is reflected in the young people’s accounts in ways that cannot be identified. Thirdly, the present study is deductive, “primarily exploratory, concerned with description and with generating theoretical ideas” in the words of Hammersley (1996, p.166), with no attempt made to establish a random or representative sample drawn from a population. In relation to the results of this study therefore, no claims can be made other than in terms of describing potentially useful theoretical constructs and suggesting potentially fruitful directions for further investigation.
“Qualitative reports (.....) have considerable flexibility in the relationship between results and discussion” according to Smith (1995, p.24), and Bannister et al. (1994) suggest that “the exact format to be followed (.....) will very much depend on the precise methodology used” (p.169). In the following, the results are presented firstly in static terms in summary matrices. They are then discussed interpretatively insofar as it seems appropriate to do so, and related to existing literature insofar as it is possible to do so.

4.2 SUMMARY MATRICES

A grounded theory analysis of the semi-structured interview transcripts produced results which can be summarised as follows. Two major categories were constructed from the data. The first of these is termed ‘Feeling reluctant to attend’. This category which was present in the data of all five participants was made up of three sub-categories; the matrix below names the sub-categories and identifies with quotations from transcripts, the participants in whose data each of the sub-categories is found.

<table>
<thead>
<tr>
<th>Sub-category</th>
<th>Participant</th>
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<tbody>
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<td></td>
<td>B</td>
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<tr>
<td>Apprehension</td>
<td>(Expected) very uncomfortable atmosphere</td>
</tr>
<tr>
<td>Shame</td>
<td>People would think there’s something wrong</td>
</tr>
<tr>
<td>Irrelevance</td>
<td>Don’t know anything about me ... so how is she going to help?</td>
</tr>
</tbody>
</table>

The second major category is made up of qualities of attendance which were experienced as helpful and is termed ‘Experiencing a therapeutic relationship’. This
category was also present in the data of all five participants and is made up of six sub-categories; the matrix below names the sub-categories and identifies with quotations the participants in whose data each of the sub-categories is found.

<table>
<thead>
<tr>
<th>SUB-CATEGORY</th>
<th>PARTICIPANT</th>
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<td>Talking</td>
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<td>Clinician</td>
<td>pleasant</td>
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<td>Qualities</td>
<td>and kind</td>
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<td>Supportive</td>
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<td>Understanding</td>
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<td>Calm</td>
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<td>Listens</td>
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<td>listen to you</td>
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With a view to making the analytic process more transparent the example at the end of section 3.4.2 (Coding the data) above, demonstrating the relationship between line-by-line coding and the sub-category ‘Understanding’ in the above matrix, is further
illustrated here by quotations (extracted from the interview transcripts of each of the participants) which contributed to construction of the sub-category.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Quotation</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>She would always kinda make you feel better, no matter what it was....she’d say yeah, I know like.....it was like someone understood you but I don’t know.</td>
</tr>
<tr>
<td>C</td>
<td>She’d be asking us all important stuff like, then you know ...when I’d get nervous d’you know, she’d see it and she’d change to my job or my friends, and then when she thought I was alright she’d go back again like...she was very good like that.</td>
</tr>
<tr>
<td>D</td>
<td>It was like sitting down talking to my friends, like somebody who knew about things that happened to me.</td>
</tr>
<tr>
<td>E</td>
<td>I didn’t have to explain everything to her but she really made me notice what I didn’t like about myself when she’d say things.</td>
</tr>
<tr>
<td>F</td>
<td>She was just generally, I think a nice person....the way she talked to me and listened to me. I could talk to her about whatever I wanted to and she’d know how I felt.....so it was easy to talk to her and that was helpful.</td>
</tr>
</tbody>
</table>

This summarised static presentation of the data provides useful taxonomic information and is of value even at this level; it informs our understanding of how adolescents experience receiving help from a mental health service, and identifies potentially heuristic suggestions for further study. However, it is one of the strengths of the grounded theory approach that “data should guide but certainly not limit theorising”
4.3 DISCUSSION

4.3.1. Category 1: Feeling reluctant to attend

As noted above two major categories were constructed from the analysis of the interview data. The first of these is termed ‘Feeling reluctant to attend’. It was striking that all five participants in the study stated explicitly that when they learned of the referral to the service they had not wanted to attend. The language used was quite clear, ranging from “I wasn’t too pleased about that” (D) to “I hated going at first” (E). The analysis indicated that underlying this reluctance to attend lay one issue common to all five participants, ‘apprehension’ about attending; a second common across four of them, a sense of ‘shame’, and a third present for two of them, a feeling that attendance at the service was irrelevant to their difficulties.

The sense of apprehension seems to stem partly from facing into the unfamiliar and partly from the expectations that the young person had about the service. Generally, they seem to have expected “a very uncomfortable atmosphere” (B). There are strong indications that a sense of apprehension arose from an expectation of a clinician who would not listen and who might be critical. B thought “you’d come along and somebody would go uh huh, uh huh and then they’d say, I don’t think you should”. D expected somebody “direct” who might say “what’s your problem, and eh ... here’s what we think you can do, instead of asking us”. Very similarly, E thought “t’would be just a case of, I’ll ask you my questions and you answer them and I’ll tell you my opinion of you then”. Beyond the sense of the unfamiliar it seems that the participants had broadly similar views about what to expect and that this involved not being listened to and not being respected. B may have indicated the likely source: “that’s what you see on TV.”.

A sense of shame arising from attending at a mental health service seems to be strongly felt by some of the participants. Indeed D described such attendance as “demeaning and degrading”. This sense of shame appears to have two elements. The first element
seems to relate to a young person’s self image. There is a sense of confirming that “there’s something wrong … we definitely did have a problem” (D), and the type of problem has serious implications. E thought it meant “that I was a bit mental”; C thought that she was going to a service for “mad people”. The second element may magnify the first; this is the possibility that it may become known that the young person is attending such a service. The possibility of being seen as someone who attends a mental health service seems very worrying. D was concerned that “if someone found out …(it)… would be spread around” and damage his reputation. E thought that everyone who knew about her attendance “had an opinion of me like that”. (i.e. that she was “a bit mental”). In this regard, using a mental health service waiting-room seems to hold particular dangers; “there’s people around me like … oh my God, they know why I’m here” (B).

There are indications from two of the participants of a sense that attendance at the service could not be relevant to their problems, and that there was no point in attending. B had thought “she doesn’t even know me, so how is she going to help me”. F had felt that “there’s nothing wrong with me …. I could sort it out for myself” and expected attendance to be “a waste of time”. These two participants seemed to be the most resistant to attending and also seemed to be experiencing the most severe emotional difficulties before attendance. In seeing attendance at a mental health service as irrelevant they may be representative of those adolescents who simply refuse to attend or engage with services. It seems worthwhile to investigate the question of perceived “relevance” of such services with a view to developing strategies to increase such attendance or engagement.

It is difficult to relate the components of this category to existing research on young clients. A literature search did not identify any previous work relating to the issue. The reason for this may be the same reason that such a factor does not arise in the review of consumer satisfaction studies in the introduction of this study; the relevant questions simply were not asked; and the young clients were not facilitated in providing their perceptions and views, outside of the context of the pre-set questions of these studies. There may be some resonance with the finding of Stuntzner-Gibson et
al. (1995) that their participants showed a very wide variation in satisfaction scores; however, this finding may also simply be due to the probable multi-dimensional nature of the concept of satisfaction. A relevant finding from the literature on adult clients is that of Timms and Blampied (1985) who interviewed fifty clients of a marriage guidance service and found that two-thirds of them reported feelings of shame associated with entering counselling; and Hunt (1985) who interviewed fifty-one clients of a marriage guidance service and found that a common description of emotional state at first session was of anxiety.

If a feeling of reluctance to attend child and adolescent mental health services is widely felt amongst potential young clients this may be contributory to poor attendance and drop-out rates. Cottrell et al. (1988) found that of cases referred to a child and adolescent psychiatry service, 16% failed to attend at all and 40% dropped out. Kazdin (1996) referring to U.S. research, suggests a drop-out rate of 40 - 60% and notes that, “At this point, from the research it is difficult to identify a profile of factors of cases who drop out of child and adolescent therapy” (1996, p.136). Further investigation of these phenomena may benefit from addressing the young clients’ possible feelings of reluctance to attend.

The possibility of the existence of such feelings also has implications for the question of ‘engaging’ with those adolescents who do attend. The development of the ‘therapeutic alliance’ in child and adolescent work is little researched as noted by Green (1996), but it seems reasonable to suggest that this development is influenced by the feelings and expectations brought by an adolescent to a therapeutic relationship. Investigations of the development and maintenance of the therapeutic alliance may also benefit from addressing the possible contribution of factors such as those indicated in the present study.

Considering the indications of the present study regarding adolescent clients’ possible expectations of, and feelings about mental health services, it also seems worthwhile to investigate the images which the broad population of children, adolescents and indeed adults may have about these services. The importance of taking an ‘ecological’
approach (McGuire et al., 1997) to such an investigation would indicate that local contexts for such investigation would be most appropriate.

4.3.2 Category 2: Experiencing a therapeutic relationship

Being a young client of a mental health service consists in the main of various forms of ‘talking’. This may happen with one or more clinicians, and is likely to include parents on some occasions and to occur on a one-to-one basis on others. The participants in this study each had contact with two clinicians, but for each participant their predominant contact was with one. The parents (one or both) of each participant were involved throughout the process of attendance, although much of the contact was on a one-to-one basis between the young person and the clinician. It is not surprising therefore that the participants identify ‘talking’ as a helpful quality of their attendance. Indeed it provides the framework within which all of the other qualities of experienced helpfulness cohere within the second category constructed from the analysis of the interview data, termed ‘Experiencing a therapeutic relationship’. What is perhaps a little surprising is how much these qualities taken together describe a relationship between a young client and a clinician. Parents do not loom large in the participants’ accounts of their experience. They are certainly present but somewhat peripheral to the main action. They are instigators of referrals, the source of difficulties, accompany the young person to clinics, hope for change, observe and report on improvement or disimprovement, but for only one participant are they reported as contributors to the process of change and then only in a minor role. According to the accounts of the participants in the present study helpfulness derived primarily from the experience of a therapeutic relationship between each participant and his or her clinician. This suggestion is congruent with a finding of Garland & Besinger’s (1996) study of consumer satisfaction described earlier; only two types of benefits of counselling were strongly indicated in that study and one of them related to the quality of the interpersonal relationship with the clinician. It is also congruent with a finding of Shapiro et al. (1997) in their study of client satisfaction, of two strongly related factors accounting for most of the variance, which they labelled ‘Relationship with Therapist’ and ‘Benefits of Therapy’.
The indication in the present study may reflect the culture of this particular service in the way clinicians relate to adolescent clients; alternatively it may indicate that adolescents experience therapeutic help as relatively autonomous persons, more similar to how a young adult might experience it than a younger adolescent or child. This possibility seems worth further investigation. As indicated by Barker (1990) in relation to clinical interviewing and by Steinberg (1983) in relation to treatment issues, working therapeutically with adolescents is made particularly problematic by the developmental process in train. Greater understanding of how adolescents identify as clients of a mental health service would be useful in relation to development and delivery of such services.

The importance of the therapeutic relationship as a contributory factor in work with adults is well-recognised. The classic therapist variables accepted as contributing to therapeutic effectiveness are those described by Rogers (1942, 1955, 1965), empathy, warmth, and genuineness, although a recent review of components of the therapeutic alliance in work with adults (Hougaard, 1994) suggests that the only therapist contributions shown to relate to successful outcome were empathy and warmth. Unfortunately as noted by Kroll & Green (1997) "there is a surprising lack of similar work within the child and adolescent field" (p.432). The importance of this relationship from the adult client's perspective seems established. In their comprehensive review of questionnaire-based studies Orlinsky et al. (1994) found that from the "patient's perspective" (p.360) thirteen of the twenty-four process variables which related to outcome "reflect the importance of the therapeutic bond" (p.360). In Rennie’s (1992) grounded theory study of clients' experience of the therapy hour, one of the four main categories constructed was the "clients' perception of the relationship with the therapist" (p.219).

In the present study five qualities of this talking/relationship are identified as contributing to helpfulness by the participants. All five qualities are present in the data of three participants, three qualities in the data of one participant, and two in the data of the apparently least verbally able of the five.
The confidential nature of the discussions, and the corollary of trusting the clinician to maintain confidentiality, seem to have been very important if not prerequisite to the development of the relationship. Indeed two of the participants indicated that previous relationships with clinicians had not developed because of their inability to be trusting of the clinician in question. Confidentiality provides the opportunity to “say anything you want” (B), to get “things laid on the table” (F); confidentiality facilitated the young person in being open without feeling judged, or without feeling that they were upsetting their parents. It facilitated the young person in talking with the clinician about problems and feelings that they could not talk about to anyone else. The importance of providing a sense of safety and trust through ensuring confidentiality in working therapeutically with young people is emphasised in a range of therapeutic approaches (Geldard & Geldard, 1997; Barker, 1990). However, it has not been possible to identify any research on children’s or adolescents’ views of such confidentiality. There is perhaps some resonance in the suggestion of the present study with a finding of Garland & Besinger (1996) noted earlier. The adolescents in their study reported the view that the main concerns other people might have about counselling services related to breaking confidentiality and discomfort disclosing personal information. The acknowledged importance of the issue of confidentiality in working with young people suggests a great lack in the fact that young clients’ views of it appear to have been little investigated. It seems likely to be an important component of a young client’s therapeutic engagement with a clinician and service, and support and maintenance of such engagement would benefit from a better informed knowledge base.

As all of the participants in the present study had experienced improvement during the course of attendance at the service it is not surprising that they all describe their clinicians in generally positive terms, as pleasant, kind and caring. Such positive descriptions are scattered throughout the accounts of the five participants and certainly cohere as a reported salient quality of their experience of receiving help. It is tempting but perhaps a little too simplistic to relate this to Rogers’s concept of warmth.
However, the data in relation to it do not seem rich enough to develop this sub-category conceptually and the temptation is resisted.

In the data of all five participants, the clinician’s capacity to understand him/her is identified as contributing to helpfulness. There is little elaboration on this in the data of any of the participants. B said she had thought “how did she get that” and that “it was as if she was there before or something” but could not describe her experience of this in any greater detail; there is a sense that the capacity of the clinician to understand them is perceived as an intuitive skill which the present participants could not describe in words. In this case, it seems reasonable to suggest a resonance with the concept of empathy as described in work with adults. Again in relation to this possibility, as noted above there appears to be a dearth of research with regard to work with young people.

In a study of the ‘therapeutic alliance’ Green (1996) attempted to include young clients’ responses to a questionnaire which included a measure of ‘empathy’. However, a minimal number of young clients responded, and as in many of the studies referred to in the introduction of the present study, only parents’ responses were investigated. In concluding, Green (1996) refers to the importance of gaining the young clients’ views. It may be that one reason for such a dearth of research in this area is difficulty in designing an appropriate methodology. It may be that the methodology developed for use in the present study would be a useful model to follow.

A quality of calmness is identified in the data of three of the participants as contributing to helpfulness. The import of this is not easy to clarify. Again, the research literature is not helpful. Some tentative connections with clinical literature can be made. For example, Geldard & Geldard’s (1997) description of the need for a counsellor of children and adolescents to be in touch with his/her own childhood, and emotionally detached are widely accepted. Insofar as these qualities are operative in therapeutic contexts, they may be interpreted by the young person as contributing to ‘calmness’. Interestingly, there seems to be an element of surprise in the participants’ views; “I didn’t expect her to be that way, she was very laid-back like” (E); and this surprise seems to apply particularly in circumstances in which the participant himself/herself is emotionally aroused; F said “I always thought she was very calm .... even if I started
feeling angry .... she still looked calm to me .... and that’s ..... that’s what I like about it”; and B explained “no matter what it was .... you’d think, god, she’s very calm”. It seems that the participants expect their emotional arousal to lead to the emotional arousal of the clinician. It is possible that this may be their experience within their families and other close relationships. If so, the clinician’s calmness may be helpful in ‘containing’ the emotion for them and facilitating them in improving their own management of emotional arousal. It may also contribute to the young person’s learning about emotional boundaries.

Being listened to by a clinician is identified as contributing to helpfulness by three of the participants. It seems that this may be a particularly important experience for these young clients, as there are indications in their data relating to the sub-categories of ‘talking’ and ‘confidentiality’, that there is often no-one to whom they talk about their problems. The possible importance of this is illustrated by F’s remark about what she felt she wanted when she was beginning her attendance, “I think I wanted someone to listen to me more than anything”. It may seem somewhat tautological to include ‘listening’ as a sub-category of a major category describing a relationship primarily based on talking. However, ‘listening’ in the present context is not described by the participants as a mechanical process. Indeed, as described by the participants the listening which is seen as helpful, has an active quality to it; “she’d just listen to you and she’d have something she’d say” (B); a clinician does not just listen; she responds in context to the young person; “that she’d listen and you know she wouldn’t just stay quiet, she’d talk back and she’d tell you what she felt about it” (E). This type of experience of listening seems resonant of the experience of empathy, and perhaps Axline’s use of Rogers’s technique of reflective listening (Axline, 1947; McMahon, 1992). However, as with many of the other indications in the results of this study, these are perhaps tantalising guesses requiring a great deal more investigation.
4.3.3 Conclusion

In an exhaustive grounded analysis and theory-building concerning a particular issue, once a set of categories has been found to be relevant and useful to explain a corpus of data, theoretical sampling is carried out. This is the collection of further data “to clarify (...) ideas and to plan how to fit them together” (Charmaz, 1995, p.45). This sampling of new cases would be “driven by theoretical concerns with new cases being selected for the potential for generating new theory by extending or deepening the researcher’s emergent understanding” (Pidgeon, 1996, p.78). However, in the present study, it was not possible to continue an exhaustive process such as this because clinical practice did not allow such time and resources as would be required. A number of potential heuristic directions for further research have been indicated above. It is the nature of an inductive phase of research to work towards development of a taxonomy of a corpus of data hopefully identifying potentially useful theoretical constructs. The categories identified in the present study may constitute such constructs and may repay further study. However, considering the limitations of the present study, it seems appropriate that the next stage of research would also be of an inductive nature, using qualitative approaches to explore the understandings of a broader range of adolescent clients attending a number of different services. The young client’s account of his/her experience, his/her judgement of feeling helped or not, and his/her view of what was helpful are essential to a comprehensive investigation in this area. The questions addressed in the present study have the potential to make very useful contributions to aspects of a programme of research investigating the mediators of therapeutic change with this client group.

The two areas of research reviewed in the introduction to the present study, audit and consumer satisfaction seem to be at a somewhat static stage. It may be that these areas of investigation would benefit from using a methodology which would allow the possibility of developing a sense of the meanings attributed by young clients themselves to their experience. The aim of the present study was to ‘give voice’ to young clients of a mental health service, and to do so in a way that would be respectful of their views and empower them, while maintaining methodological rigour. Within the limitations outlined earlier, that aim has been reasonably achieved and the responses of the
participants suggest quite sophisticated understanding of their experience. It is suggested above that the indications of the present study have relevance for a number of areas of research. To conclude, it is further suggested that the methodology of the present study may provide a respectful, empowering approach, which could usefully contribute to investigation of the broader study of adolescent development and experience.

4.4 A REFLEXIVE VIEW

As noted above, the theoretical position adopted in the present research regarding the use of semi-structured interviewing is the 'interpretative phenomenological' approach described by Smith (1995). From this perspective, although a researcher may work towards foregrounding the participants' accounts, his/her access to those accounts depends on his/her "own conceptual framework as well as the interpretative work (he/she) bring to the project" (Smith, 1995, p.25). He therefore suggests that "it can be useful to look explicitly at the factors which may have influenced the project" (p.25). Bannister et al. (1994) put it more strongly stating that "Reflexivity ... is about acknowledging the central position of the researcher in the construction of knowledge" (p.151). They also emphasise the value of "constructive criticality " (p.171) of a piece of qualitative research. The following is a critical reflection on elements of this study on which the author's decisions and interpretations were the primary influences.

As former clients of a mental health service, the participants in this study were clearly vulnerable young people; further, it seems likely that they would have experienced a very great difference in power between themselves, and the service and clinicians; and finally, the nature of the interview was such that very sensitive and difficult personal issues might be touched on. It seems likely that the development of rapport and trust would be less problematic if an interview were carried out by the clinician who had worked with the participant in question. It was feasible to do this as the author could have requested participation of previous clients of his (who had attended at the service where he had previously worked). However, it seemed that the advantages noted above would be outweighed by the disadvantage that the interview would be influenced by the previously existing relationship. The decision therefore, that the interviewer
would not have had an existing relationship with participants may have led to them being less comfortable and open than might otherwise have been the case.

An interview will be influenced to some extent by the expectations which a participant brings to it, and these expectations will be influenced by the manner in which participants are contacted and by the information which is provided to them in the course of this contact. There is of course no way of knowing how any particular system of contacting or type of information will be perceived by any particular participant. The possibilities in the present study are even more problematic as this contact and provision of information is mediated by a third party, parents. A fundamental ethical aspiration of the present study was to empower, rather than disempower the participants, and the initial contact was developed with this aspiration in mind. However, it is acknowledged that the manner of initial contact could have been designed in different ways, that different types of information could have been provided, and that the particular way in which these issues were dealt with in the present study may have influenced the participants in unknown ways.

Although the author is an experienced clinician, before beginning this project he was an inexperienced research interviewer. A great deal was learned from carrying out the pilot interview, but it must be acknowledged that training and further experience would make for more skilled research interview skills. The demands of clinical practice and limited resources did not allow for this in the present study and it is accepted that an experienced research interviewer may have produced data allowing for greater conceptual development than was possible in this study. One difficulty noticed by the author in the course of the interviews was a tension between therapeutic and research modes of interviewing. As a clinician, the former is the author's natural stance, and he was conscious throughout of attempting to stay in the latter. It seems likely that a therapeutic mode may have operated at times and that this may have influenced participants in unknown ways.

Many characteristics of the author may have affected the responses of the participants in unknown ways during the interviews. Three of these characteristics are easily
identifiable, being male, middle-aged and a clinical psychologist. Any one of these characteristics alone may have been perceived by one or more of the participants as connoting status and power, both socially and in terms of psychological understanding; the presence of all three together may have constrained some participants' responses. In particular the construing of the interview of the four female participants may have been affected in unknown ways by the gender difference.

The author's age also seems likely to have impacted on the participants' experience of and behaviour during the interviews. He is older than all but one of the participants' parents, older than all but one of the clinicians who had worked with the participants, and probably older than most of the participants' teachers. It seems likely that the participants would have little experience of conversing with adults (particularly non-family members) of the author's age, and it is possible that their responses may have been constrained by this.

The fact that the author is a clinical psychologist may have caused participants, depending on their expectations of this role, to be guarded in their responses for fear of having their answers 'analysed' or interpreted for 'hidden' meanings. If so, the accounts of some participants may be less open, less comprehensive and/or less detailed than would have been hoped for.

As noted above, towards the end of each interview, each participant was asked what it was like for them “to do this interview”. All of the participants had appeared quite comfortable during the interviews and this was reflected in their answers to this question. Both D and F described it as “straightforward”; for C it was “fine”, though some questions had been difficult to understand. B reported difficulty in answering some questions but noted, “once you started through it, then you kinda knew what you were saying”. E had been unsure how to approach it, “kind of thinking ... should I talk the way I’d talk to my friends like (...) or should I talk to you the way I’d talk to an adult”; of all the participants she seemed the most self-conscious during the interview, but said that she did not find any difficulty with it. There may of course be a 'social desirability' pressure operating regarding this question, and/or the power imbalance
between author and interviewee may have affected their responses. However, it was the author's impression throughout each interview that the assurances given that the participant was obliging the author, and had the right not to answer questions and/or to terminate the interview at any time, had engendered a sense of comfort in the participants and tilted the power imbalance somewhat more in their favour.

Grounded theory "provides a set of strategies for conducting rigorous qualitative research" (Charmaz 1995, p.27) and the steps involved in data analysis can be explicitly described. However, no matter how diligently these steps are followed during data analysis, the researcher still has to interpret the words of the participants typed in interview transcripts. In the present study the author was conscious of a difficulty in presuming meanings. A word does not necessarily have the same precise meaning when used in different contexts, even by the same participant; the meaning of a word can appear to be elaborated on by a vocal inflection or the addition of a remark such as "you know" or "so". There are potential sources of bias in interpretation in the characteristics of the author noted earlier as likely to have influenced participants' accounts, being an older, male clinical psychologist. The age difference, for example, may be reflected in slightly different understandings of social concepts and verbal expressions; there may have been a lack of awareness on the author's part of gendered meanings in the data of the female participants; and the author's clinical perspective may have biased him towards a focus on data relevant to distress as against other types of data. The problem of interpreting meanings is a fact of qualitative research no matter how explicit and rigorous are the data-analytic procedures otherwise and conclusions are always particular to the researcher who interprets.

Given these criticisms, the question must be addressed as to what sort of 'knowledge' has been produced in the present study. The use of a qualitative approach has made it possible to carry out a respectful, empowering study with young participants through which these participants' own reports of their experiences are foregrounded. As noted earlier, qualitative research cannot satisfy the requirements of universality and replicability, central tenets of mainstream quantitative psychological research; and the development and completion of this study has been influenced by the personal
conceptual framework and interpretation of the author. Hammersley (1996) has noted that there is a need both for "studies that are primarily exploratory, concerned with description and with generating theoretical ideas, and those which are more concerned with testing hypotheses" (p.166); the present study is of the former type. The objective of this study was to carry out an inductive phase of research on adolescents' experience of receiving help from a mental health service with a view to providing data at a taxonomic level from which further theory may develop. The 'knowledge' produced in the present study consists of this data and the author's interpretation of it through the use of grounded theory and no greater provenance is claimed for it.

A final point concerns the writing of the discussion. A problematic issue in writing up qualitative research is what McLeod (1996) describes as "obviousness" (p.315). By this he means that "a qualitative study must depict a world we already know, a reality we can recognise, while at the same time leading us toward a new understanding of that reality or phenomenon" (p.315). Throughout the writing of the discussion the author was conscious of a tension between the apparent 'obviousness' of some of the findings and a wish to move beyond this through interpretation of the findings and relating them to existing relevant literature so as to deepen understanding of the issues addressed. The source of this tension was anxiety on the author's part about interpretation possibly going beyond the data, a way of thinking probably arising from training, study and practice with a positivist view of psychological knowledge. The author is very conscious, that either a more conservative approach or a more adventurous, illuminative approach could have been taken in discussing the results of this study and that the present discussion is an attempt to steer a middle course.
References


APPENDICES A to E

Documents submitted to the Clinical Research Ethics Committee of the Cork Teaching Hospitals.

Appendix A: Letter to the Chairman.
Appendix B: Detailed Research Protocol.
Appendix C: Protocol submission form.
Appendix D: Consent and assent form.
Appendix E: Letter to parents requesting their agreement and the agreement of their son/daughter to consider his/her participation in the research, and enclosed form.
APPENDIX A
16th April, 1998.

Professor Denis J. O’Sullivan,  
Chairman,  
Clinical Research Ethics Committee of the Cork Teaching Hospitals,  
Secretariat,  
Clinical Sciences Building,  
Cork University Hospital,  
Wilton,  
Cork.

Re: Protocol submission

**Title of protocol:** Young people’s experience of receiving help from a child and adolescent mental health service: A grounded theory approach.

**Principal Investigator:** Dr. Finbarr O’Leary, Consultant Child and Adolescent Psychiatrist, Department of Child and Adolescent Psychiatry, St. Finbarr’s Hospital Douglas Road, Cork.

**Co-Investigator:** Patrick Corbett, Senior Clinical Psychologist, Department of Child and Adolescent Psychiatry, St. Finbarr’s Hospital, Douglas Road, Cork.

Phone: 021 923288

Dear Professor O’Sullivan,

I wish to submit the above-named research protocol for consideration by the Clinical Research Ethics Committee of the Cork Teaching Hospitals. Enclosed please find:

1. The original Protocol Submission Form.
2. One copy of the Protocol Submission Form.
3. Seven copies of the detailed research protocol.
4. One copy of the letter to be sent to parents describing the research and requesting their consent to the participation of their child.
5. One copy of the parents’ consent (and young person’s assent) form.

/contd......

Department of Child & Adolescent Psychiatry,  
St. Finbarr’s Hospital,  
Douglas, Cork.  
Tel. (021) 92 32 88  
Fax. (021) 92 33 57
An exempt research protocol may be appropriate under category (2) (regarding interview procedures) as described in section IV of the Policies and Procedures Manual of the Clinical Research Ethics Committee. I would appreciate your opinion on this.

I trust that the enclosed is sufficient for consideration by the committee. I look forward to hearing from you.

Yours sincerely,

Patrick Corbett,
C.Psychol.
SENIOR CLINICAL PSYCHOLOGIST.
APPENDIX B
Title of protocol: Young people's experience of receiving help from a child and adolescent mental health service: A grounded theory approach.

Principal Investigator: Dr. Finbarr O'Leary, Consultant Child and Adolescent Psychiatrist, Department of Child and Adolescent Psychiatry, St. Finbarr’s Hospital Douglas Road, Cork.

Co-Investigator: Patrick Corbett, Senior Clinical Psychologist, Department of Child and Adolescent Psychiatry, St. Finbarr’s Hospital, Douglas Road, Cork.

Phone: 021 923288

In the following, the categories used are those provided as a general guideline in the Policies and Procedures Manual (pp.6/7) of the Clinical Research Ethics Committee.

(a) Background
Consequent to increasing accountability and a focus on quality improvement within the health services, greater attention is being given to health care outcome data. In recent years a number of audits of child and adolescent mental health services have been carried out, which included measures of outcome. However, the outcome measures used have been narrowly defined and have not included obtaining accounts from the young clients themselves of what ways, if any, in which such attendance was helpful.

(b) Purpose
The objective of the present research is to try to identify the ways in which ex-clients of this service found attendance here helpful or unhelpful.

(c) Protocol Methodology
The proposed research will consist of individual semi-structured interviews (lasting not more than an hour) with between five and ten young people, aged: 12-16. The interviews will be carried out by myself (co-investigator, Patrick Corbett) and will be audio-taped.

Transcripts of the interviews will be analysed using a grounded theory methodology. Grounded theory methods consist of a set of inductive strategies for analysing qualitative data, such as interview transcripts. Analysis begins with individual "meaning units" in the material and develops "progressively more abstract conceptual categories, to synthesise, to explain, and to understand data, and to identify patterned relationships within it" (Charmaz, 1995, p.28).

/contd......
(d) **Probable duration of the protocol**
If approval is granted by the ethics committee, letters to parents requesting consideration of participation in the research will be forwarded in the week following the granting of such approval. The semi-structured interviews will take place within the following six weeks. The analysis and writing up of the results will begin during this period and will be completed within a further six-week period.

(e) **Location where research is to be conducted**
The semi-structured interviews will take place at this department or at the participants’ homes, depending on their choice and that of their parents.

(f) **Special precautions (eg. re dose modifications)**
Not applicable.

(g) **Type and number of subjects (to be termed ‘participants’ in this study)**
There will be a minimum of 5 and a maximum of 10 participants in the study. The participants will be ex-clients of this department, aged 12-16 years, whose cases were open within the past 6 months and were closed because of improvement in the original presenting problems. Exclusion criteria are indications of psychosis and intellectual disability.

The proposed research has been discussed with the Consultant Child and Adolescent Psychiatrist and the other (psychiatric and social work) clinicians in the service, all of whom are supportive of it. These clinicians will identify clients of the service who fulfill the criteria outlined above.

(h) **Potential risks and benefits to human subjects**
There are no physical risks involved. There may be a risk of embarrassment or anxiety for participants arising from the actual experience of being interviewed. A precaution to be taken against this is to explicitly give the young person the power to respond or not to any questions, and the power to terminate an interview at any time. It will be emphasised to each young person that he/she is obliging the researcher.

There are no obvious benefits to the participants, other than the opportunity to give their views and to be listened to. The potential benefit to society will be provision of new data to inform questions of efficacy, acceptability, audit and quality control of this and similar services.

(i) **Payment to subjects**
Not applicable.

(j) **Procedures to obtain and record informed consent**
A letter introducing and describing the research will be sent to the parents of each identified participant, requesting consideration of participation in the study. If the parents agree to consider participation by their son/daughter in the research, this letter

/contd........
requests that they give it to their son/daughter to read. If the young person agrees to consider participation in the research, the letter requests that the parents contact Mr. P. Corbett with a view to arranging a meeting between the parents, the young person and Mr. Corbett, for the purposes of further informing them about the research, considering the consent/assent form, and, if the parents and young person consent/assent to participation, the signing of this form. A copy of this signed consent form will be provided to the parents, and the original form will be filed in the young person’s medical record at this department. (Copies of the introductory letter and the consent form are enclosed).

(k) **Statistical considerations**
Not applicable.

(l) **Copies of IND**
Not applicable.

(m) **Procedures used to maintain confidentiality of records**
The audio-tapes will be stored securely at this department pending transcription. The transcription will be done by the co-investigator (Mr. P Corbett). Following its transcription each audio-tape will be destroyed or given to the appropriate participant if he/she chooses. The transcripts will be stored securely at this department. Names of participants will not be appended to the audio-tapes or transcripts. Each audio-tape and transcript will have a number appended. A list of participants’ names and identifying numbers will be stored securely, and separately from the audio-tapes and transcripts, at this department.

(n) **Bibliographic references**

(o) **Copy of interview to be used**
The semi-structured interview to be used will consist of the following questions.
1. What was it like for you to attend at the Child Guidance Clinic?
2. Can you tell me about some things that you found helpful in attending at the clinic?
3. In what ways were these helpful to you?
4. Can you tell me about some things which you found unhelpful about attending at the clinic?
5. In what ways were these unhelpful?
6. Can you tell me about some things which you found difficult about attending at the clinic?
7. In what ways were these difficult for you?

/contd.......
8. Can you tell me about some things which would have been helpful but didn’t happen?
9. Is there anything else that you would like to say which you think might be useful for us to hear about?
Supplementary questions to facilitate elaboration will depend on and follow from the young person’s responses.

(p) Assurance that the subject’s family doctor has been notified of and agrees to the proposed research
The family doctor of each participant in the research project will be notified of their patient’s consent and assent to participation, informed about the research project and requested to agree to the proposed participation.

(q) Phase 1 Statement
Not applicable.

(r) Source of investigator finding
No funding is required beyond the normal resources of this department.
APPENDIX C
PROTOCOL SUBMISSION FORM
For New Protocols and Amendments to Existing Protocols Involving the Use of Human Subjects in Research

All items must be completed as indicated; incomplete applications will be returned. A protocol application must include:

1. Protocol Submission Form (pages 1-4) - Original and one copy. Original must be signed on page four.
2. Consent Form (the standard Ethics Committee format) - Seven copies.
3. Detailed Protocol including instruments involved, Investigators Brochure, IND, if applicable - Seven copies.
4. Details of insurance policies in place to cover the study.

To obtain expedited review or waiver of consent, please see page four of this application. For exempt research, refer to the Ethics Committee Policies and Procedures Manual (see below). For amendments to already existing protocols complete page one, signatures on page four and those sections of this form in which a change has occurred; all items left blank will indicate that there is no change in status. Explain exactly what you are changing from your original submission and the rationale for the change. If applicable, submit a revised protocol or consent form highlighting the changes from the original.

The complete application package must be received in the Ethics Committee office by the appropriate deadline in order to ensure review the next month. The Ethics Committee office is located at the Clinical Sciences Building, Cork University Hospital, Wilton, Cork. The telephone number is (021) 901251/345599 and fax number is (021) 343211.

Investigator: Dr. Fingal O'Leary
Appointment: CONSULTANT
Investigator must be a member of the faculty or a consultant.
Office Address: ST. FINGAR'S HOSPITAL
Department: DEPARTMENT OF CHILD AND ADOLESCENT PSYCHIATRY
Phone: (021) 423288

Title of Protocol: Young People's Experience of Receiving Help From a Child and Adolescent Mental Health Service: A Grounded Theory Approach

Co-Investigators: Patrick Corbett (Senior Clinical Psychologist)
Only the co-investigators listed may perform the procedures indicated on this protocol. They may NOT amend the protocol.

Site of Performance of study: DEPT. OF CHILD AND ADOLESCENT PSYCHIATRY

Status of Protocol: New Amendment If amendment, Original Protocol #:

This protocol is part of an active or pending externally funded project: Yes No

If yes, complete the rest of the page:

Agency: ____________________________________________

PI for grant or contract (if not same as investigator responsible for this protocol): ____________________________________________

Grant Proposal Title: ____________________________________________

*To assist you in the submission process, the following items are available from the Ethics Committee office:
Submission Deadline Schedule • Sample Ethics Committee Consent Form and Consent Form Checklist • Ethics Committee Policies and Procedures Manual • Additional copies of this application.
• The Manual includes such items as details of protocol construction, elements of informed consent, consent and assent from children, and protocols exempt from review.
SPECIAL CONSIDERATIONS  All items on this page must be completed.

1. This study is part of a multi-centre project:  
   - Yes  
   - No

   If yes, identify: _______________________________________________________

2. This study involves the use of an Investigational New Drug (IND):  
   - Yes  
   - No

   If Yes, complete 2(a):

   (a) Drug Name, IND#, Company: _______________________________________

   _ Phase I  _ Phase II  _ Phase III

3. This study involves laboratory/clinical procedures NOT part of ordinary management:  
   - Yes  
   - No

4. This study involves the clinical experimental use of radiation or radioisotopes:  
   - Yes  
   - No

5. This study involves the use of biohazardous or infectious materials:  
   - Yes  
   - No

   If yes, please explain: __________________________________________________

6. Human subjects from the following special population(s) may be involved in this study:  
   - Infants (<1 year)  
   - Children (1-17 years)  
   - Elderly (>59 years)

   - Pregnant Women  
   - Prisoners  
   - Mentally Disabled  
   - Mentally Retarded  
   - None of these

   No investigator shall recruit from a student group where he/she, or any of the co-investigators, have material influence over the assessment of academic performance of that student group.

PRECODED STUDY DESCRIPTION  For each of the categories below, please select the item(s) which best describe(s) your study. You may check up to two items for each category.

1. Type of Study:  
   - Behavioral-Social  
   - Compassionate  
   - Descriptive  
   - Diagnostic  
   - Educational

   F) Epidemiologic  G) Preventive  H) Therapeutic  Z) Other: ______________________

2. Organ System(s):  
   - Not Applicable  
   - Breast  
   - Cardiovascular  
   - Dermatologic

   E) Endocrine/Metabolic  F) Gastrointestinal/Hepatic  G) Haematologic  H) Musculo-skeletal


   O) Urinary tract  P) Multisystem (>2 systems)  Q) Cells, blood, other body fluids or tissues only  Z) Other: ______________________

3. Type of Disorder:  
   - Not Applicable  
   - Congenital  
   - Degenerative  
   - Infectious

   E) Immunologic/Inflammatory  F) Malignant  G) Metabolic/Endocrine  H) Normal Physiologic

   J) Psychiatric  K) Traumatic  Z) Other: ______________________

4. Type of Drug/Device:  
   - Not Applicable  
   - Analgesics  
   - Anaesthetics  
   - Anti-asthma/allergy

   E) Anticoagulant  F) Antiinfectives  G) Antiinflammatory/Anticonvulsants  H) Biologicals/Vaccines

   I) Blood Components  J) Cardiovascular/Antihypertensive  K) Chemotherapeutic Agents  L) Contraceptives

   M) Contrast Media  N) Dermatologics  O) Diagnostics  P) Hormones  Q) Immunosuppressives

   R) Sedatives/Antidepressants/Tranquilizers  S) Vitamins  Z) Other:  ______________________
PROTOCOL ABSTRACT - (This page must be completed; Use additional pages as needed).

1. Purpose of Investigation: To identify the ways in which adolescent ex-clients of this service found attendance here helpful or unhelpful.

2. Procedures to which humans will be subjected: One semi-structured interview of not more than one hour's duration.

3. Potential benefits to subjects and/or society: No potential benefit to subjects other than opportunity to give their views. Potential benefit to society will be provision of new data to inform questions of efficacy, acceptability, audit and quality control of this and similar services.

4. Potential risks to subjects and precautions taken to minimise risk: There are no physical risks, there are risks of embarrassment or anxiety for the subjects. The precaution against this is to explicitly give the young person the power to respond or not and to terminate at any time. It will be emphasised to each young person that he/she is obliging the researcher.

5. Alternative procedures, if any, available to subjects: Not applicable.

6. Subjects:
   a. What is the total number of subjects to be studied? Between 5 and 10.
   b. How will subjects be chosen? (Inclusion and exclusion criteria). Subjects will be ex-clients of this department whose cases were open within the past 6 months and were closed because of improvement in original presenting problems. Exclusion criteria are indicators of psychosis and intellectual disability.
   c. Will there be payment to subjects? Yes __ No __
   d. If so, how much? £

7. Methods used to ensure confidentiality of data: Data will be stored securely at this department. Data will not have names of subjects appended.
All research involving human subjects must be submitted to the Ethics Committee. If you think you may qualify and are seeking expedited review and/or waiver of consent, please complete the sections below.

EXPEDITED REVIEW Complete the entire application, (Protocol Submission Form and Detailed Protocol) even if you are requesting expedited review. The Chair of the Ethics Committee will determine whether the research is appropriate for expedited review.

I request that the Ethics Committee review this research project through an expedited review procedure. This research activity poses no greater than minimal risk to the subjects and the only involvement of human subjects will be in one or more of the following categories:

1) Collection of hair and nail clippings, in a nondisfiguring manner, deciduous teeth, and permanent teeth if care indicates a need for extraction.
2) Collection of excreta and external secretions including sweat, uncannulated saliva, placenta removed at delivery, and amniotic fluid at the time of rupture of the membrane prior to or during labour.
3) Recording of data from subjects 18 years of age or older using noninvasive procedures routinely employed in clinical practice. This includes the use of physical sensors that are applied either to the surface of the body or at a distance and do not involve input of matter or significant amounts of energy into the subject or an invasion of the subject’s privacy. It also includes such procedures as weighing, testing sensory acuity, electrocardiography, electroencephalography, thermography, detection of naturally occurring radioactivity, diagnostic echography, and electrocatheography. It does not include the exposure to electromagnetic radiation outside the visible range (for example, x-rays, microwaves).
4) Collection of blood samples by venipuncture, in amounts not exceeding 450 millilitres in an eight-week period and no more often than two times per week, from subjects 18 years of age or older and who are in good health and not pregnant.
5) Collection of both supra- and subgingival dental plaque and calculus, provided the procedure is not more invasive than routine prophylactic scaling of the teeth and the process is accomplished in accordance with accepted prophylactic techniques.
6) Voice recordings made for research purposes such as investigation of speech defects.
7) Moderate exercise by healthy volunteers.
8) The study of existing data, documents, records, pathological specimens, or diagnostic specimens.
9) Research on individual group behaviour or characteristics of individuals, such as studies of perception, cognition, game theory, or test development, where the investigator does not manipulate subjects’ behaviour and the research will not involve stress to subjects.
10) Research on drugs or devices for which an investigational new drug exemption or an investigational device exemption is not required.

WAIVER OF CONSENT Complete the application except for the consent form, and check below indicating the reason for request of waiver.

The Ethics Committee may waive the requirement for the investigator to obtain a signed consent form for some or all subjects if either:
1) The only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. Each subject will be asked whether the subject wants documentation linking the subject with the research, and the subject’s wishes will govern.
2) The research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context.

- In cases where the documentation requirement is waived, the Ethics Committee may nevertheless require the investigator to provide subjects with a written statement regarding the research.
- The Ethics Committee may also approve oral consent for certain studies with minimal or no risk.

Signatures:

I certify that the protocol and method of obtaining informed consent as approved by the Ethics Committee will be followed during the period of this research project. Any changes of protocol, PI or consent will be submitted for Ethics Committee review and approval prior to implementation. Any adverse reactions will be promptly reported to the Ethics Committee office. This research will be carried out only by the approved principal investigator and co-investigators. All records of this research will be maintained as required by the IMB.

Investigator: [Signature] Date: 3/3/38
CONSENT BY PARENT AND ASSENT BY YOUNG PERSON TO PARTICIPATE IN RESEARCH PROTOCOL

Protocol Number:__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __.__
Psychologist). The interview will take place at this clinic or at your home, depending on what you and __________(son/daughter) would prefer. The interview will be recorded on an audio-tape recorder. Mr. Corbett will type out the interview afterwards. A copy of the typed transcript will be given to __________(son/daughter) if he/she wishes. The audio-tape of the interview will also be given to __________(son/daughter) if he/she wishes, or else will be destroyed.

The audio-tapes and typed copies of the interviews will be treated as confidential. While in Mr. P. Corbett’s possession they will be stored securely at this department. Your son/daughter’s name will not be attached to an audio-tape or typed copy. A numbered coding system will be used. The identifying coding will be stored securely, and separately from the audio-tapes and typed copies, at this department.

The interview will consist of the following questions and some discussion of __________’s (son/daughter) answers where clarification may be needed.

1. What was it like for you to attend at the Child Guidance Clinic?
2. Can you tell about some things that you found helpful in attending at the clinic?
3. In what ways were these helpful to you?
4. Can you tell about some things which you found unhelpful in attending at the clinic?
5. In what ways were these unhelpful?
6. Can you tell me about some things which you found difficult about attending the clinic?
7. In what ways were these difficult for you?
8. Can you tell me about some things which would have been helpful but did not happen?
9. Is there anything else which you would like to say which you think would be useful for us to hear about?

In doing this interview, __________ (son/daughter) is obliging us and is free to refuse to answer any particular question or to end the interview at any time.
Potential risks and benefits
There are no physical risks to your son/daughter in participating in this research. Possible psychological risks may be embarrassment or anxiety.

There are no benefits to your son/daughter in participating in this research except perhaps the opportunity to give his/her views and the knowledge that these may be useful in improving our ways of trying to help young people at this clinic.

The general benefit of obtaining your son/daughter's views, along with those of other young people who have attended at this clinic, will be that this service and others like it will be better informed about what young people attending here find helpful and unhelpful. This may lead to improvements in the ways that services are provided to young people and their families by clinics such as this one.

Possible alternatives
You may choose that your son/daughter does not participate in this study, and he/she may choose not to participate.
AGREEMENT TO CONSENT

The research and the treatment procedures associated with it have been fully explained to me. All experimental procedures have been identified and no guarantee has been given about the possible results. I have had the opportunity to ask questions concerning any and all aspects of the project and any procedures involved. I am aware that participation is voluntary and that I may withdraw my consent at any time. I am aware that my decision not to participate or to withdraw will not restrict my access to health care services normally available to me. Confidentiality of records concerning my involvement in this project will be maintained in an appropriate manner. When required by law, the records of this research may be reviewed by government agencies and sponsors of the research.

I understand that the sponsors and investigators have appropriate insurance so that compensation will be available in the event of injury resulting from this research.

I, the undersigned, hereby consent to participate as a subject in the above described project conducted at the Cork Teaching Hospitals. I have received a copy of this consent form for my records. I understand that if I have any questions concerning this research, I can contact the doctor listed above. If I have any further queries concerning my rights in connection with this research, I can contact the Clinical Research Ethics Committee of the Cork Teaching Hospitals, Clinical Sciences Building, Cork University Hospital, Wilton, Cork.

After reading the entire consent form, if you have no further questions about giving consent, please sign where indicated.

Investigator:_________________  Signature of parent:_________________

Witness:________________}_  Signature of young person for assent:_________________

Date:________  Time:________
APPENDIX E
Dear Mr and Mrs

We (Dr Finbarr O’Leary, Consultant Child and Adolescent Psychiatrist and Mr Pat Corbett, Senior Clinical Psychologist) are planning to carry out a research project to investigate what it is like for young people to receive help from our service, at the Child Guidance Clinic, St Finbarr’s Hospital. In particular, we are interested to hear from the young people themselves about what they found helpful and unhelpful in attending this service.

Very little research has been done on what it is like for a young person to attend a service like this. We feel that it is of the greatest importance to try to understand more about what it is like for them. Such understanding will help us in our efforts to develop a service which is as helpful, supportive and respectful as possible, which young people would be comfortable attending.

We are asking for your agreement and the agreement of your son/daughter ______ to consider his/her participation in this research project. This participation will consist of one interview only, lasting not more than one hour. If you decide not to participate, this will not in any way affect any further contact you may have with this service or any other Southern Health Board service in the future.

If you agree to consider _______'s participation in the research please ask him/her to read this letter; if both you and he/she agree to consider participation, a meeting will be arranged (lasting between a half hour and one hour) between yourselves, _______ and Mr Pat Corbett so that he can explain and describe the research and answer any questions you and _________ may have. The purpose of this meeting is to make sure that you and _________ are fully informed about the research before deciding whether or not to consent to participate in it. This meeting will take place either at this clinic or at your home, whichever you choose.

A written consent form has been developed and will be discussed with you at this meeting. Following this meeting, if you consent to _________’s participation in the research and if _________ assents to participation, a further meeting will be arranged for Mr Pat Corbett to carry out the interview with _________. Depending on your choice, this meeting will take place either at this clinic or at your home, and will not last longer than one hour. The interview will be recorded on an audio-tape recorder. _________ may end the interview at any time and can refuse to answer any particular question if he/she wishes.

Department of Child & Adolescent Psychiatry,
St. Finbarr’s Hospital,
Douglas, Cork.
Tel. (021) 92 32 88
Fax. (021) 92 33 57
The interview will consist of the following questions and some discussion of _______'s answers where clarification may be needed.

1. What was it like for you to attend at the Child Guidance Clinic?

2. Can you tell about some things that you found helpful in attending at the clinic?

3. In what ways were these helpful to you?

4. Can you tell about some things which you found unhelpful in attending at the clinic?

5. In what ways were these unhelpful?

6. Can you tell me about some things which you found difficult about attending the clinic?

7. In what ways were these difficult for you?

8. Can you tell me about some things which would have been helpful but did not happen?

9. Is there anything else which you would like to say which you think would be useful for us to hear about?

Ten young people including ________ are being requested to participate in the research. The young people requested to participate are aged 12 to 16 years, were attending this service during the past six months, and their attendance ended because of improvements in their original difficulties.

If you do not wish to consider participation in the research project you need not respond to this letter.

If you and ________ agree to consider participation in the research project I would appreciate it if you would contact me to let me know as soon as is convenient. You can do this either by phoning this department (021 923288) or by returning the enclosed form to me in the enclosed stamped addressed envelope.

Thank you.

Yours Sincerely,

Patrick Corbett
Senior Clinical Psychologist
RESEARCH PROJECT AT THE CHILD GUIDANCE CLINIC

TOPIC: What young people found helpful and unhelpful in attending this service

We agree to meet with Mr. Pat Corbett (Senior Clinical Psychologist) to discuss the possibility of participation in this research project. We understand that he will contact us in the near future to arrange to meet.

SIGNATURES : PARENT(S) ...........................................
...........................................

SON/DAUGHTER  ...........................................

TELEPHONE NUMBER (if available): ...........................................

Please return this form in the enclosed stamped, addressed envelope.

Thank you.
Section Five: Additional material required to be included in the portfolio
1. A course summary of the British Psychological Society Diploma in Clinical Psychology (completed by the candidate in 1985)

Introduction
At the time that the author completed this diploma the requirements for it were as follows:
1. Supervised clinical experience of a minimum of 260 days
2. Taking four written papers of three hours each
3. Submission of ten case reports
4. Submission of a research dissertation
Details of these are given below. All quotations are from BPS (1985).

1. Supervised clinical experience
   The absolute minimum total period of supervised clinical experience required was 260 days. The clinical experience would normally extend over a three year period. Required placements were:
   
   “(a) with adult psychiatric patients;
   (b) with children other than the mentally handicapped;
   (c) in mental handicap;
   (d) a specialist placement” (p.7).

2. Written papers
   Paper 1: Birth to Old Age
   Content:
   “The impact of genetic, biographical, sexual, cultural, educational and socio-economic factors on clinical problems. Clinical applications of normal development from conception to death (e.g. developemental milestones, socialisation, education, personal and sexual relationships, marriage and the family, pregnancy and childbirth, work and leisure, unemployment and retirement, ageing, death and dying). Clinical problems characteristic of particular social contexts and stages of the life-span, and
clinical measurement of age differences and age changes. Implications of the social and developmental context of clinical problems for assessment, treatment and prevention" (p.9).

Paper 2: Abnormal Psychology: Research and Theory

Content:
“Abnormalities of behaviour and experience encountered in clinical practice. Knowledge of research of efficacy of treatment procedures. Detailed and up-to-date knowledge of the contribution of experimental psychology in this field. The effects on specific psychological functions - for example, attention, perception, memory, thinking, learning and feeling - of cerebral dysfunction, other physical illness and physiological abnormalities as well as family and social influences” (p.9).

Paper 3: Clinical Applications

Content:
“Methods used to identify and alleviate problems with respect to individuals, couples and families. The formulation of therapeutic aims on the basis of findings. The rationale and use of interview methods, tests and other clinical instruments” (p.9).

Paper 4: Clinical Services

Contents:
“(a) Clinical procedures: Issues relating to procedures for clinical investigation or intervention. Clinical services in institutional or community settings. (b) Applications of research methods: Principles of psychological assessment and measurement. The use of epidemiological and survey methods in identifying service needs. Methods for evaluating clinical interventions and services. The clinical use of single-case research methods. (c) Professional issues: Relationships with non-psychologist professionals, including teaching. General issues relating to relevant government policies, social issues and the health service. The development and organisation of clinical services. Professional and ethical considerations” (p.10).
3. **Case reports**

"Ten case reports must be presented, which should be selected to demonstrate the candidate’s clinical competence. They should cover a wide range of ages, types of problem and clinical procedures, including both assessments and ways of modifying the behaviour of individuals, groups or institutions. Some cases presenting with severe or chronic problems should be included, and cases where difficulties have been encountered may be submitted. At least two representative case reports must be submitted from each of the three fields of work in which compulsory placements are required (adult psychiatry, children other than the mentally handicapped, and mental handicap). Normally, a case report from the specialist placement should be included" (p. 10).

4. **Research Dissertation**

"The dissertation should consist of a research report of an investigation of human subjects and be of clinical relevance. This includes clinical investigations of groups, single case studies of an experimental type, and surveys which are designed to test specific hypotheses or answer pertinent questions (......). The dissertation must not exceed 14,000 words and should be preceded by an abstract not exceeding 250 words. Relevant published papers and other material (such as questionnaires used in the research with which the examiners may be unfamiliar) may be added as appendices. The appendices may be additional to the text of 14,000 words" (p. 12-13).

**Reference:**

2. **Copy of the candidate's clinical psychology degree qualification**
Diploma in Clinical Psychology

We, the President and Council of the British Psychological Society, have awarded this Diploma in Clinical Psychology to

[Signature]

Date: 20th day of September 1995

Chancellor of the Board of Examiners

[Signature]

Self-management of disruptive classroom behaviour

in 10-12 year old boys.
Abstract

Introduction

Context of the present study

Behavioural approaches to dealing with disruptive classroom behaviour

Self-management training with children.

  Introduction
  Self-monitoring
  Self-evaluation
  Self instruction
  Self reinforcement

Self-management in the treatment of disruptive classroom behaviour

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ABSTRACT

This study investigated the hypothesis that the use of self-management of disruptive behaviour in class (derived from clinic-based training in self-monitoring, self-instruction and self-reinforcement) as a component of a treatment package which also includes a behavioural contract and extraneous reinforcement decreases the level of disruptive classroom behaviour beyond that level achieved by the use of a behavioural contract and extraneous reinforcement alone. A single case A-B design with replications across subjects was used. The subjects were seven 10-12 year old boys. The results are described and the implications discussed.
INTRODUCTION

Disruptive classroom behaviour has always been a problem for teachers and schools. In recent years psychology has been drawn on to provide approaches to dealing with it.

Clinically it has been considered by British researchers to be related to conduct problems (eg. Rutter, et al., 1970) and by American researchers to be related to hyperactivity (see Quay, 1979). It is indeed rarely referred to in clinical epidemiological studies.

However, the vast majority of children who show disruptive classroom behaviour probably do not display patterns of behavioural or emotional difficulties which are indicative of clinical psychiatric syndromes; even if some of them do, it is questionable how useful would be this way of construing their difficulties.

It seems more fruitful to consider such a difficulty as one particular “problem in living” for some children, which may be amenable to psychological management, than to locate it as a component of some clinical psychiatric syndrome.

A systems analysis approach has been described by Burden (1978) who suggests that in investigating an individual case, the psychologist’s main responsibility is to widen the teacher’s appreciation of the context within which problem behaviour is occurring. He suggests that in trying to understand the dynamics of problem behaviour in schools the following types of questions need to be asked; “What is the school’s attitude to problems? What constitutes a problem for them? In what terms do they construe their problems? ...... What is the exact nature of the problem referred to? Who says that it is a problem? Does anyone disagree? Whose problem is it: the child’s, the teacher’s or the school’s or all three? Can any problem be seen in isolation? Is information necessary about all aspects of the total situation in which the child is functioning?” (p115-116). Burden’s view is that the school itself should be viewed as a system and that the overall context of the system should be analysed.
A more traditional approach, and one which most schools, teachers and indeed psychologists would feel more comfortable with is that of classroom management (e.g. O’Leary and O’Leary, 1972). Based on operant technology, this approach consists of appropriate contingency management by the teacher.

Both of the above approaches, though differing in fundamental respects from each other, view disruptive behaviour as a problem for teachers and schools and view its management from an organisational perspective.

However, disruptiveness in class is a problem not only for teachers and schools but also for the disruptive child. If the behaviour continues over a period of years the child’s experience of school may consist primarily of a series of reprimanding, displeased, punishing teachers. There is also the probability of an image of a ‘clown’ or ‘troublemaker’ developing amongst peers with accompanying social pressure to behave as such. A child’s social and emotional development will clearly be affected by these experiences in many detrimental ways and it is also likely that his/her educational progress will suffer. In the short run disruptiveness in class often leads to suspension from school; in the long run it may well lead to exclusion and/or a request for special educational placement.

The various contributory factors to disruptiveness in class will not be considered here in any detail. Obviously there are children with such severe educational or behavioural difficulties that a special placement is required; equally obviously there are those whose feelings about school are almost entirely negative and whose disruptiveness in class merely reflects this. These two groups will not be considered further as the present study does not relate to them. Rather, the present study is concerned with children who are intellectually and educationally able and whose feelings towards school are generally positive; in other words they want to continue to attend at school; and they are reasonably well-motivated educationally; other than being disruptive in class they do not have any gross behavioural, social or emotional difficulties.
The present study arises directly out of the need to develop a treatment package for a series of referrals of such children to the clinical psychology service in which the author works.

CONTEXT OF THE PRESENT STUDY

The present study was carried out by the author in the course of clinical work as a clinical psychologist in a child psychiatric service in Cork city. There is no educational psychology service available to first-level schools in the Cork area; there are some educational psychologists working with second-level schools but they work primarily at a social systems level and rarely accept individual referrals.

The point of noting this is to describe the context of the present study. The schools attended by the subjects of this study do not have available to them a psychology service for consultations; the teachers in those schools do not have training or experience in the use of behavioural management approaches in the classroom; and following from these points, there is rarely a perception within the schools that disruptive behaviour is a function of factors other than intra-personal ones.

A number of difficulties are posed therefore for a clinical psychologist accepting referrals in relation to disruptive classroom behaviour against this background. Firstly, he/she cannot depend on a teacher to be able to follow through on recommendations after a relatively brief consultation; secondly, he/she does not have the ongoing involvement with a school which builds up credibility; and thirdly, he/she is faced with the prospect of having to change the perspective of a teacher or a number of teachers regarding the factors which influence disruptive as well as any other kind of behaviour.

Clearly, in the long run this position needs to change; and a great contribution needs to be made by psychologists working at a social-systems level as well as working with individual cases; both clinical and educational psychologists will be involved in making this contribution.
However, for the present author working from a very busy service setting, the question of such involvement does not arise; there is simply not enough time.

The problem for the author in regard to the referrals in question was to devise a treatment package which would help to decrease the frequency of disruptive behaviour in class to a tolerable level, but which would not be dependent on any great involvement on the part of the teacher. The solution decided on was to construe disruptive classroom behaviour as a self-management problem and to devise a treatment package based on self-management principles. The present study provides a description of this package and an evaluation of its use. Various elements of it had been used previously in similar cases but the formal package has been used so far only with the seven subjects used in this study.

**BEHAVIOURAL APPROACHES TO DEALING WITH DISRUPTIVE CLASSROOM BEHAVIOUR**

Behaviour modification as an educational intervention strategy had its origins in the early 1960's; pioneering studies were those of Wolf et al. (1964) who treated an autistic child and Allen et al. (1964) who treated an isolated nursery school child. These studies were clearly set within the operant framework as described by Bijou and Baer (1965). Later extensions of the approach included the treatment of hyperactive, non-social and aggressive behaviour in the preschool setting (Allen et al., 1967; Hart et al., 1968; and Sloan et al., 1967), and the development of token programmes for use in the classroom (O’Leary and Drabman, 1971). The culmination of the pioneering stage can perhaps be seen as the publication of O’Leary and O’Leary’s “Classroom Management” (1972).

Merrett (1981) in his review of studies in behaviour modification in British educational settings notes that experimental work in this area did not begin in Britain until the 1970's. As Yule (1984) noted most of the British studies are descriptive demonstrations of how American techniques can be applied to different British settings; that is to say they remain within the operant framework.
The paradigm for such studies is described by Merrett (1981) as follows: it “typically has four phases:

1. The identification of some behaviour or behaviours in which the experimeter is interested by pinpointing them through an operational definition. The definition is then used to observe, count and record the behaviour(s) to reflect baseline (operant) level of emission, usually in the form of a graph.

2. Analysis of these data in terms of antecedent and consequential events is used to provide information about contingencies and to indicate which may be manipulated profitably.

3. A strategy is devised, based upon the behavioural analysis, in which either antecedent or consequential events (or both) are manipulated in order to bring about changes in the behaviour and to make it more acceptable for the child and for his immediate community.

4. Systematic recording of the behaviour is continued, using the same operational definitions and the same procedures in order to monitor the effects of the intervention strategy”.

The most influential workers in the area of classroom management in Britain and Ireland are probably Wheldhall and Merrett (eg. 1985) whose “Behavioural Approaches to Teaching Project” is being used more and more in the in-service training of teachers and psychologists; it would seem, therefore, that the operant approach to the management of disruptive classroom behaviour is in the ascendant in Britain and Ireland. Yule (1984) claimed that “the broader social learning theory approach of British workers” is becoming clearer; however there is little in the literature to indicate that the theoretically and practically fertile area of self-management is being integrated with presently used approaches.

In the United States research on the use of self-management approaches to disruptive classroom behaviour began with Meichenbaum and Goodman’s (1971) self-instructional training; since then research on the components of self management with children “have shown that youngsters can be taught to observe and record their own
behaviour and administer their own reinforcement contingencies” (Gross and Drabman, 1982).

In Britain and Ireland there have been a few accounts of interventions which have included a self-control or self-management component (eg. Lee, 1979) and publications which have advocated the use of such approaches (eg. McNamara, 1979). However, the application of self-management approaches to disruptive classroom behaviour in Britain and Ireland remains largely uncharted territory.

SELF-MANAGEMENT TRAINING WITH CHILDREN

Introduction

In a recent annotation Kendall (1984) noted “Until a decade ago, traditional psychodynamic and behavioural strategies were dominant in the treatment of psychopathology in the United States. Now recognised as a major theoretical orientation .......... cognitive-behavioural intervention has become an additional force in psychotherapy” (p.173). One of the fastest-developing strands in cognitive-behavioural work with children is that of self-management. Indeed, Copeland (1982) noted that “the enthusiasm which self-management training for children has engendered is striking”.

Gross and Drabman (1982) cite a recent “increasing interest in teaching children methods to alter their own behaviour”. They feel that this shift in forces occurred for a number of reasons. “When parents teachers and other agents control the treatment contingencies they often miss a great deal of behaviour. As such the desired response may not always be consistently reinforced (Kazdin, 1975). Those who administer the contingencies may also become discriminative stimuli. The child may learn to perform the target behaviour only in the presence of the individual who delivers reinforcers (Redd and Birnbrauer, 1969). Moreover when children control their own behaviour, this allows adults to spend more time teaching other important skills (O’ Leary and Dubey, 1979). Finally it is hoped that by teaching children to control their own behaviour stronger maintenance affects will result than those obtained under external
control” (pp. 285-286); Gross and Drabman (1982) see these as the influences leading
to the expansion of applications of self-management training with children.

As Kendall and Williams (1984) noted, “the emergence of self-management as an
acceptable topic for scientific enquiry did not occur without challenges. Those who
expound a radical behavioural position emphasising that patterns of human action are
functionally related to environmental factors were not eager to accept the “self” or
person as components of behaviour. The Skinnerian perspective (Skinner, 1971)
continues to present the argument that an individual’s behavioural repertoire, self-
concept and even life-purpose are modifiable by environmental manipulation”.
However, Kendall and Williams (1982) go on to state that efforts to appraise the
process of self-management from a behavioural perspective have been “enlightening”
but “a less than complete explanatory system has led to the recent efforts to better
understand the ‘self’ component of self-management. As is becoming evident in both
the theoretical and research literature, the ‘self’ component is loaded heavily with
cognitive processing variables. Complete knowledge about self-management requires
that both behavioural and cognitive factors be considered” (pp. 240-241).

In the past decade through a combination of such treatments as modelling, self-
monitoring, self-instruction and self-reinforcement, the problems of impulsivity,
aggression, and anxiety have been particularly well-addressed with component-skills
training (Craighead et al., 1978; Kanfer, 1975; Karoly, 1977) and cognitive self-
instruction (Meichenbaum, 1977).

The self-management components relevant to the present study are self-monitoring,
self-evaluation, self-reinforcement and self-instruction; applications of these with
children are considered briefly in the following sections.

**Self-monitoring**

Self-monitoring, the observing of one’s own behaviour, is a two step procedure.
Individuals first learn to discriminate specific aspects of their behaviour in order to
determine if the target response has occurred. Upon observing the particular behaviour he or she must then make the self-record response.

Self-recording can be used as an assessment tool and as a behaviour-change technique. When self-recording is used as a treatment technique the method is the same as when it is used for assessment.

Self-monitoring is commonly associated with a change in the frequency of the target response. Such reactive effects are usually considered therapeutic because desirable target behaviours often increase while undesirable behaviours often decrease in frequency (Broden et al., 1971; Kazdin, 1974; Nelson, 1977).

The effectiveness of self-recording as a treatment technique with children has been demonstrated in several studies (e.g. Anthony, 1978; Ollendrick, 1981; Gottman and McFall, 1974). There are however reports of behaviour change resulting from self-monitoring being transient (e.g. Kazdin, 1974); there have also been reports of no reactive effects being observed following the implementation of self-monitoring (Mahoney, et al., 1973; Spates and Kanfer, 1977; Stollack, 1967). These inconsistent findings have led to attempts to identify variables influencing the reactivity of the procedure.

Kanfer (1970) hypothesised that self-monitoring is part of a feedback-loop. People discriminate aspects of their behaviour for comparison with their personal behavioural standards. This information then cues self-reinforcement or self-punishment processes to adjust responding accordingly. This suggests that the desireability, or valence, of the behaviour would be an important factor affecting self-monitoring. This hypothesis has been supported by the results of studies by Kazdin (1974), Cavior and Marabotto (1976) and Sieck and McFall (1976).

Gross and Drabman (1982) feel that motivation to alter one's behaviour is an important factor contributing to the therapeutic success of self-recording; they quote a study by Broden et al. (1971) which reported altering the classroom behaviour of two
adolescents using self-recording. The behaviour-change observed with one was short-lived; this adolescent had not requested assistance in changing his behaviour as did the other; rather, in his case the intervention was implemented on the initiative of his teacher. These variables cannot be controlled for in the present study; however, it is important that the results be considered in the light of these findings.

Self-evaluation

Self-evaluation consists of an individual monitoring his or her behaviour and evaluating it against a specific criterion. It is hypothesised that people attempt to behave in a manner consistent with an internal code of behaviour and that self-evaluation serves as a feedback mechanism to guide responding. Cautela (1971) asserts that behaviour-change results from self-evaluation because it elicits covert self-reinforcing or self-punishing statements.

Training children in self-evaluation involves providing them with a specific criterion with which to compare their behaviour. It would be expected that if self-evaluation leads to evaluative statements on the part of the child, it would have the potential to increase or decrease response rates.

When used by itself however, self-evaluation has not been a consistently effective behaviour-change technique. Klein and Gory (1976) had children self-evaluate their maths work; the children were given an answer-sheet with which to compare their work-book assignment answers. The children demonstrated a decrease in mean percent correct, relative to baseline, during self-evaluation. Ballard and Glynn (1975) used self-evaluation in a self-management programme to improve children’s writing skills. The children were asked to compare their writing against a chart describing the target behaviours and to record occurrences of the targeted responses. Self-evaluation had no effect on the target behaviours. When reinforcement was made contingent on the occurrence of the target responses, however, there were large increases in the frequency of these behaviours.
Self-evaluation has also been included as a component in programmes designed to teach self-management skills to children (e.g. Bolstad and Johnson, 1972; Drabman et al., 1979; Robertson et al., 1979). In these programmes however, reinforcement is always paired with self-evaluation. Such, it is not possible to determine the effect of self-evaluation alone on target behaviour.

**Self-instruction**

The impetus for the development of self-instructional training with children was the theoretical work of the Soviet psychologists Luria (1961) and Vygotsky (1962). On the basis of his work with children Luria (1959) proposed three stages by which the initiation and inhibition of voluntary motor behaviours came under verbal control. During the first stage the speech of others, usually adults, controls and directs a child's behaviour. The second stage is characterised by the child's overt speech becoming an effective regulator of his own behaviour. Finally the child's covert or inner speech comes to assume a self-governing role. From this hypothetical developmental sequence Meichenbaum and Goodman (1971) developed a treatment paradigm which was used to train impulsive children to talk to themselves as a means of developing self-control. This training involved several steps. First, the children watched a model perform a task while guiding his behaviour by talking aloud. The child then performed the same task while receiving instruction from the experimenter. This was followed by the child performing the task and verbally guiding his or her own responding. Subsequently, the child performed the task while whispering self-instructions and finally, via covert self-instruction. In the initial stage of training the experimenter modelled task-relevant skills such as problem-definition, planning strategies, guidance, self-evaluation and self-reinforcement. The children were taught to use self-instruction with a variety of motor tasks of various levels of difficulty. On measures of "behavioural” and “cognitive” impulsivity children who received self-instructional training showed significant improvements in performance relative to control subjects. There were no significant differences between groups however, on measures of in-class behaviour.
In laboratory conditions the technique has been shown to have beneficial effects on a variety of behavioural tasks (Bem, 1967; Hartig and Kanfer, 1973; Meichenbaum and Goodman, 1969), but clinical application has produced mixed results (see below under “Self-instruction in the treatment of disruptive classroom behaviour”). Gross and Drabman (1982) state that further research into specific aspects of self-instructional training is required. For example some laboratory experimentation has shown that being reinforced for using self-instructions (Mischel and Patterson, 1976), facility at performing the target behaviour (Higa et al., 1978) and the actual use of self-instruction by the child (Monahan and O’Leary, 1971) “are directly related to the effectiveness of self-instructional training. Yet no attempts have been made to evaluate the impact of these variables on clinical applications of the procedure” (Gross and Drabman, 1982, p.305).

Self-reinforcement
Teaching children to self-reinforce involves two steps. Because it is necessary to discriminate the occurrence of a target response prior to the self-delivery of a reinforcer, self-monitoring is a prerequisite of self-reinforcement. Once the child learns to monitor his or her behaviour he or she is instructed to contingently deliver self-reinforcers. The rules governing the choice of a reinforcer in this instance are the same as those used to guide the selection of any reinforcer; it must be a motivator for the child and it must meet the practical requirements of the intervention situation.

The usefulness of self-reinforcement training with children has been demonstrated in a number of studies. Ballard and Glynn (1975) improved story-writing in elementary school-children by its use; in a multiple-baseline design, the number of sentences, number of action words, and number of describing words used in the children’s daily story-writing were monitored. The children were then instructed to self-record the occurrence of these specific target behaviours. This was followed by the sequential introduction of self-delivered reinforcers across target behaviours. Token points were used as rewards. It was reported that self-recording had little effect on the children’s writing behaviour. The addition of self-reinforcement however, resulted in substantial
increases in the number of sentences written as well as in the usage of action and describing words.

Self-reinforcement has also been shown to be more effective than self-imposed response-cost in altering children's reading behaviour. Humphrey, Karoly and Kirchenbaum (1978) in a counterbalanced ABAC design, had children either self-deliver tokens for correct responses or fine themselves tokens for errors on reading-workbook assignments. Although both self-management procedures produced increases in work accuracy, the children performed best during the self-reinforcement condition.

Although applied studies such as the above indicate that children can alter their behaviour simply by being trained to contingently self-deliver pre-selected rewards, research in developmental psychology suggests a number of variables which may be important in understanding the dynamics of self-reinforcement. Variables such as social comparison (Masters, 1972), modelling of self-reinforcement (Hildebrandt et al., 1973), race and socioeconomic status (Masters and Peskay, 1972), achievement standards (Masters et al., 1977) and previous experience with externally controlled reinforcement (Glynn and Thomas, 1974) have been shown to affect the operation of self-reinforcement. None of these are controlled for in the present study; they are noted in order to indicate that although self-reinforcement can be, and is, used in a relatively simplistic way in applied studies, it is very complex theoretically, requiring extensive research (see also Harter, 1982).

SELF-MANAGEMENT IN THE TREATMENT OF DISRUPTIVE CLASSROOM BEHAVIOUR

Self-monitoring in the treatment of disruptive classroom behaviour

Self-monitoring has been used as a treatment component in a number of studies in which self-management skills were successfully used in dealing with disruptive classroom behaviour (eg. Bolstad and Johnson, 1972; Drabman et al., 1973; Robertson et al., 1979). However, it has been used as a single component in only a few studies. In an early study Broden et al. (1971) used self-recording to increase attending in a
young adolescent girl and to decrease talking out in class in a young adolescent boy; the procedure was successful with the former child, but while initially successful with the latter, the improvement was not maintained.

Gottman and McFall (1972) used self-monitoring to increase classroom participation with a group of potential school drop-out adolescents. Self-recording of instances where the adolescents did not participate, but wanted to, resulted in a decrease in the response. The authors concluded that the reactive effects of self-recording may be therapeutic.

These studies are not particularly strong supports for the use of self-monitoring for dealing with disruptive classroom behaviour; also as noted in the section above on “Self-monitoring” there have been inconsistent findings when self-monitoring is used alone. The clear implication is that self-monitoring should be used as a component of a treatment package; this is the manner in which it is used in the present study.

**Self-evaluation in the treatment of disruptive classroom behaviour**

Few studies have used a self-evaluation component alone in dealing with disruptive classroom behaviour (see Gross and Drabman, 1982).

Santogrossi et al. (1973) investigated the effect of self-evaluation on the classroom behaviour of disruptive adolescents. Following baseline, the adolescents were told to self-evaluate their classroom behaviour and contingently award themselves points. There were no back-up reinforcers associated with the points. Self-evaluation alone had no effect on their disruptive behaviour. Teacher-determined points with back-up reinforcers were then implemented and there was a dramatic decline in disruptiveness.

Similarly Turkowitz et al. (1975) found that self-evaluation had no effect on the level of disruptive behaviour in children manifesting academic and social problems. Teacher-delivered reinforcement however, produced a sharp decline in disruptive behaviour relative to baseline levels. Additionally, it was reported that during self-evaluation, the youngsters’ ratings were very inaccurate.
The results of the studies discussed raise serious questions regarding the effectiveness of self-evaluation as a behaviour-change technique. Evaluating one’s behaviour according to an external criterion cannot be performed without self-monitoring of that behaviour. As such it is very likely that instructing a child to self-record acts as a discriminative stimulus for self-evaluation. According to Gross and Drabman (1982) if this is the case “it would not be predicted that using self-evaluation in a self-management programme would have any further impact on behaviour than what would be expected as a result of the self-recording process” (pp.295-296). Self-evaluation therefore is not included as a component of the treatment package used in the present study, outside of it’s implicit use as part of a self-monitoring process.

**Self-instruction in the treatment of disruptive classroom behaviour**

As noted above the clinical application of self-instructional training has had mixed results (eg. Meichenbaum and Goodman, 1971, described above). Bornstein and Quevillon (1976) taught self-instruction to three overactive four-year old boys. Relative to baseline, an increase of 65% “on task” behaviour was noted following self-instructional training. This improved performance was also observed at follow-up; Robin, Schneider and Dolnick (1976) also reported reducing in-class aggressive behaviour of emotionally disturbed children by using self-instructional training. Friedling and O’Leary (1979) conducted a systematic replication of the Bornstein and Quevillon (1976) study; they failed to observe any systematic changes in “on task” behaviour following self-instructional training. Rosenbaum and Drabman (1979) in their review of self-control training in the classroom suggested that self-instructional training in the treatment of disruptive classroom behaviour needed further research demonstrating its applied significance. The present study constitutes a small part of such research.

**Self-reinforcement in the treatment of disruptive classroom behaviour**

Self-reinforcement was successfully used as a behaviour change strategy for disruptive classroom behaviour in the Bolstad and Johnson (1972) study cited above. They
monitored “on task” behaviour; following baseline the children received training in self-monitoring, self-evaluation and self-reward. At various intervals while the children worked, a tape-recorder sounded a tone. The children were told, upon hearing this tone, to note on specific data sheets whether they were “on task”. They subsequently awarded themselves reinforcers based on the number of intervals that they were “on task”. This procedure resulted in a large decrease in disruptive behaviour. Glynn and Thomas (1974) and Glynn et al., (1976) have reported similar findings.

THE PRESENT STUDY

Variables used in the present study

The independent variable in the present study is the treatment package; the elements of this are used differentially in two separate phases as follows:

Phase I: Baseline period
(i) Behavioural contract
(ii) Extraneous reinforcement

Phase II: Intervention period
(i) Behavioural contract
(ii) Extraneous reinforcement
(iii) Self-management of disruptive classroom behaviour, derived from clinic-based training in self-monitoring, self-instruction, and self-reinforcement.

The dependent variable is the level of the child’s disruptive behaviour in class; the measure of this is provided by the teacher’s record which is kept on a daily basis; the record is kept on a 5-point scale ranging from 1 (not at all disruptive in class) to 5 (extremely disruptive in class).

General hypothesis: The use of self-management of disruptive behaviour in class (derived from clinic-based training in self-monitoring, self-instruction and self-reinforcement), as a component of a treatment package which also includes a behavioural contract and extraneous reinforcement, decreases the level of disruptive
classroom behaviour beyond that level achieved by the use of a behavioural contract and extraneous reinforcement alone.

**Method:**
(1) **Subjects:** The subjects were seven boys aged between 10 and 12 years; all of them were showing inappropriate and disruptive behaviour in class; all of them were considered by their teachers to be of average or low average intellectual and educational attainments. None of them showed any serious difficulty in other areas of their lives although three of them did show mild non-compliance at home. All of them were referred directly by school principals specifically and only because of their disruptive classroom behaviour. No boy who showed evidence of serious educational or intellectual delays or evidence of emotional, social or behavioural difficulties was involved in this treatment programme; (elements of it might of course be used as parts of whatever more comprehensive treatment approach was devised).

(2) **Procedure:** Following initial clinical assessment leading to the decision to use this particular package, the procedure was as follows:
1. A behavioural contract is worked out between the child, his parents, and the therapist; this contract (a) specifies the behaviours which are to change (b) commits the child to attending for clinic appointments and following the treatment plan (c) commits the parents to provide specified reinforcers on foot of the child achieving specified behavioural targets (d) commits the therapist to working with the child and the parents.
2. Having had the treatment package explained to him/her, agreement is reached with the teacher to keep a daily record of the child's behaviour; the measure used is a simple 5-point scale ranging from 1 (not at all disruptive in class) to 5 (extremely disruptive in class). This measure provides the data for the dependent variable (disruptive behaviour in class) in this study. Before the baseline period, a four-week “pre-baseline” is used in order for these two components to have come into effect before the baseline period.
3. During the last week of the baseline period the child is instructed in self-
monitoring, self-instruction and self-reinforcement; it is explained to him that these are techniques which will help him gain greater control over his behaviour in class; a chart is devised and provided for purposes of self-monitoring; the child's self-monitoring does not provide a measure of the dependent variable; in this study self-monitoring is used merely as a treatment component; he is given a written list of the behaviours to be monitored; brief instruction and modelling if necessary is given by the therapist in relation to the self-monitoring; self-monitoring in this study consists of recording any instance of one of the listed behaviours by marking 1 on a daily index card. A sequence of self-instructional statements is then devised by the child and therapist together; this sequence begins with the initial 'thought' or 'feeling', "I will do X" (i.e. a disruptive behaviour); it then moves into a subsequence which relates to a series of negative consequences which might follow from the disruptive behaviour; a statement is then made of the desired consequence (which is usually more or less the opposite of the final negative consequence); this is followed by a statement of a decision not to perform the disruptive behaviour; if the disruptive behaviour is not performed, the next statement is one of self-reinforcement; this is accompanied by a statement regarding significant others being pleased with how well he is doing.

4. When this sequence of self-instructions is ready for use the clinic office is used as a simulated classroom; the therapist models the use of the sequence of self-statements; starting with the initial thought or feeling "I will do X", the child then rehearses their use by reading them aloud from a card; he rehearses them a number of times until he knows the sequence more or less off by heart; he then rehearses saying them silently to himself a few times, still using the card if necessary; during these rehearsals the role of the teacher is played by the therapist; the child describes to the therapist how the teacher would behave and use is made of any idiosyncratic gestures or mannerisms to add to the simulation.

5. He is instructed to begin to use the self-monitoring, self-instruction and self-
reinforcement from the beginning of the next week (i.e. the start of the intervention period).

6. (For purposes of the study) an eight-week intervention period follows the baseline period; (actual clinical treatment lasted longer for some subjects than for others).

7. From the beginning of the “pre-baseline” period the teacher provides details of his/her daily record to the child on a weekly basis; the child shows this to his parents and reinforcement is delivered if the target has been achieved.

8. During the intervention period, fortnightly clinic contact is maintained with the child and his parents; this is primarily for purposes of discussing the use of the treatment procedure with the child, examining his record charts to see that they are being used properly, and ironing out any difficulties which may arise.

Experimental Design
The design used is a single-case A-B design with replications across subjects. This design is one of those described by Campbell and Stanley (1966) as “quasi-experimental”; they note that such a design suffers a number of threats both to its internal and external validities. However, despite these threats, they accept that in some settings the A-B design can be of utility where control-group analysis or repeated introduction and withdrawal of treatment are not feasible; these latter two approaches are rarely feasible in a service setting.

Watts (1984) in advocating more “applicable psychological research” in the NHS noted that the primary goal of such research “is to solve a particular problem rather than to make a general contribution to knowledge”. In responding to Watts, Salkovskis (1984) stated that “Techniques for the acquisition and analysis of data within subjects in the context of normal clinical practice have become refined in ways which allow the clinician to address a much greater range of research questions without losing the basic robustness and internal validity of single-case experimental design”. In particular he cited Barber et al.’s (1984) account of between-subject clinical strategies, “replication-
series". The present experimental design comprises a replication series of single-case A-B designs.

Hersen and Barlow (1976) in their classic text on single-case experimental designs devoted a whole chapter to replication procedures, and noted that the use of such a procedure is one answer to the problem of generalising from one individual to other individuals. They define a procedure which they term “clinical replication” as the “administration of a treatment package containing two or more distinct treatment procedures by the same investigator or group of investigators. These procedures would be administered in a specific setting to a series of clients presenting similar combinations of multiple behavioural and emotional problems which usually cluster together” (p.336). This is the model on which the present experimental design is based.

In the single-case A-B design used in the present study, A refers to the baseline period in which a behavioural contract and extraneous reinforcement will be operative; B refers to the treatment period in which behavioural contract, extraneous reinforcement and self-management will be operative (self-management here refers to a combination of self-monitoring, self-instruction and self-reinforcement). The baseline period is four weeks; the treatment period is eight weeks.

**Results**

As can be seen in the graphed data below, during the intervention period five of the seven subjects showed a consistent decrease in their teachers’ daily ratings (averaged per week) of their disruptive classroom behaviour, as compared to the baseline period; two of the seven (subjects D and G) showed no consistent decrease.

Of the five who showed consistent improvement, only one (Subject B) had a full four-week period during which he was judged to be “not at all disruptive in class”; a further one (subject A) had a full two week period at this level. For four of the five subjects who showed improvement, this improvement did not begin until at the earliest, the third week of intervention.
(The raw data is given in an Appendix).
Conclusion:
For five of the seven subjects there was clear improvement during the intervention period as compared to the baseline period; as this contemporaneous relationship is clean-cut it provides evidence in support of the hypothesis; however, as this relationship is not present for the other two subjects this support must be considered to be somewhat equivocal.

Discussion
Difficulties in interpreting the differential improvement rates
The general hypothesis of this study was that the use of self-management of disruptive behaviour in class (derived from clinic-based training in self-monitoring, self-instruction and self-reinforcement) as a component of a treatment package which also includes a behavioural contract and extraneous reinforcement, decreases the level of disruptive classroom behaviour beyond that level achieved by the use of a behavioural contract and extraneous reinforcement alone. The results of the study allow for some support of the hypothesis, but not unequivocal support.

The data show that compared to the baseline period, five of the seven subjects showed a consistent decrease in their teachers’ average weekly ratings of their disruptive behaviour. The other two subjects showed no decrease and this posed a problem in
interpreting the results. There are a number of possible reasons for the lack of success with these two subjects. Although the self-instructional component of the package was devised specifically for each individual, nevertheless the total package was not individualised; thus it may not have been suitable for these subjects; Copeland (1982) has argued that self-management treatment strategies need to be individualised, and it does seem reasonable to accept that different combinations of techniques and approaches are likely to be successful with different children. Also the self-management components used in this study, are affected by variables which were not, indeed could not be controlled for; Gross and Drabman (1982) feel that motivation to alter one's behaviour is an important factor contributing to therapeutic success of self-recording; laboratory experimentation has shown that being reinforced for using self-instructions (Mischel and Patterson, 1976), facility at performing the target behaviour (Higa et al., 1978), and the actual use of self-instruction by the child (Monahan and O'Leary, 1971) have been shown to be directly related to the effectiveness of self-instructional training; social comparison (Masters, 1972), socio-economic status (Masters and Peskay, 1972) achievement standards (Masters, et al., 1972) and previous experience with internally controlled reinforcement (Glynn and Thomas, 1974) have been shown to affect the operation of self-reinforcement. Any of these factors may have been operating in an uncontrolled way in the present study. The assessment techniques and normative data required for valid decision-making in this area are not yet available (see Kendall and Williams, 1982); clearly a great deal more research is needed in order to provide these.

A further possibility is that the disruptive behaviour of these two may have been more severe than that of the other five. No attempt was made to differentiate between levels of severity of disruptiveness in the present study; this seems an area likely to be fraught with conceptual and measuring difficulties and not a great deal of work has been done on it so far. However, the measure developed by Weinreich (1975), and Kendall and Wilcox's (1979) Self Control Rating Scale are beginnings. Kendall and Wilcox (1979) are beginning to work on the provision of normative data for the SCRS; however it would be necessary to provide British and Irish norms for such a measure to be used with validity in these cultures; indeed considering the differing school systems and
services it would seem that a completely new scale would need to be designed and standardised.

Another set of possibilities relates to the teacher. The teacher-child relationship is ignored in the present study. Indeed the fact that the logistics of the author's work in a service-setting precluded any intensive work in this area was one of the factors influencing the design of the present treatment package (see above under 'Context of the Present Study'). It is clear that if the teacher-child relationship is poor that a self-management approach may not be at all helpful; indeed it is quite likely that such a poor relationship would exacerbate disruptive behaviour; in such a case the actual teacher-child relationship might be the focus of intervention. Another teacher-related difficulty could be a rigid view on the part of the teacher; that is if he/she feels that a child will not change, no matter what intervention is used, he/she is unlikely to be supportive and indeed might not even notice real improvements simply because they were not expected.

A third teacher-related variable could have been difficulty in using the rating scale; no training was given in this and no specific behavioural descriptions were given of the behaviour in question. It may have been the case that some of the teachers might not have rated reliably. Clearly in a study such as this it would be of value to give greater attention to teacher-related factors.

Threats to internal validity
These threat arise from the lack of control of non-specific factors in the treatment. These non-specific factors would be such as attending a clinical psychology clinic and talking about the disruptive behaviour with the psychologist and with parents; a further non-specific factor of expectancy was introduced into the present treatment package, when the subject was told that the self-management techniques used would help him gain greater control over his behaviour in class.

There was no possibility of controlling for these in the present study; one way of attempting to unravel the power of such factors would be to include them as
independent variables. This could be quite cumbersome however and might not be feasible in service-based research. Where service-based research is being done using single-case designs it seems reasonable to control as many non-specific factors as possible within the design and to depend on group-comparison studies to provide data on others (e.g. expectancy, clinic-attendance etc.); the data provided by the group comparison studies can then be used as a context within which to interpret some of the single-case implications.

Threats to external validity
The question addressed by this study was whether the addition of a self-management component to a treatment package of a behavioural contract and extraneous reinforcement would lead to a decrease in the level of disruptive classroom behaviour beyond that level achieved by the contract and reinforcement alone.

The main threat to external validity comes from the shortness of the “pre-baseline” period; this period was used in order to allow the components of the behavioural contract and extraneous reinforcement to come into full effect before the baseline period; this “pre-baseline” period lasted for four weeks; a problem arises from the possibility that this period was not long enough for the behavioural contract and extraneous reinforcement to have come into full effect, and therefore, that some of the decrease in disruptive classroom behaviour seen during the intervention period was due to these two components being more effective at this point than during the baseline period. In retrospect, a longer “pre-baseline” period might have been desireable, though obviously there is a limit to which one could afford such a luxury in service-based research.

A further threat to external validity is the lack of follow-up data; the treatment period is relatively short and there are no data on whether the improvement achieved lasted over any further length of time. As the subjects were all clinical cases, the author of course, is aware of the long-term outcomes; however this is based on verbal reports as the data-gathering used in the study did not continue on the same basis for most of the subjects, beyond the intervention period of the study itself; this is a fault in the design;
in any future study of such a nature the means to obtain reliable follow-up data should be built into the design.

**Unravelling the effects of the self-management components**

Three self-management components were used in the present study, self-monitoring, self-instruction, and self-reinforcement. The design of the study allows only for evaluation of the effects of the three components together as a package; there is no possibility of evaluating their differential effects within this design. As any one or some combination of these components might be the only contributor of treatment effectiveness it would clearly be very valuable if their differential effects could be unravelled; important data relevant to this could be derived from a series of A-B single-case studies with replications such as the present study, where B would be either one of the three components or some combination of these. Indeed such component-analysis is essential for self-management approaches to be integrated into routine clinical practice.

**Conclusion**

As noted earlier the results of this study allow for some support of the hypothesis but not unequivocal support; as there were clear improvements in the teacher ratings of disruptive classroom behaviour in the treatment period as compared to the baseline period, for five of seven subjects, the results suggest that the use of a self-management approach in the treatment of disruptive classroom behaviour is worth consideration. As outlined above a great deal of further research on a number of aspects of the treatment package used is required before this package or one based on it could be recommended for use in routine practice. In carrying out such research the provisos detailed above should be borne in mind.
REFERENCES


Luria, A.R. (1959). The development of speech and formation of mental processes, Psychological Medicine in the USSR (Vol 1), NAUK RSFSR.


## APPENDIX

### RAW DATA

Teachers daily ratings averaged per week (rounded upwards)

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