“An Investigation of families’ and their systemic therapists’ use of attributions of blame and exoneration in relation to the presenting problem”.

Portfolio submitted for
the Doctorate (PsychD) in Clinical Psychology
from
The University of Surrey
April 1998
by
Miranda Wolpert.

Incorporating
Volume 1: Clinical and Academic Dossiers
Volume 2: Research Dossier.
Volume I.

Clinical and Academic Dossiers.
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Personal Study Plan

Name: Miranda Wolpert
Date: 20 May 1996
Date of Registration: 2 April 1996
Registration Number: 3519244

OVERALL OBJECTIVE

To produce a portfolio which explores ways of understanding and responding to the difficulties that bring children and their families to child mental health services and is concerned with issues of maximizing service uptake.

CLINICAL DOSSIER

Aims:
♦ to demonstrate professional competence
♦ to reflect on clinical practice

Proposed content:

A summary of my professional practice since qualification will be provided.

One clinical innovation will be reported in detail: the introduction and running of a cognitive-behavioural group for primary school children, referred with issues of aggression and poor peer relationships. Despite the fact that the research literature suggests that cognitive behavioural groups promote pro-social behaviour in children (Target & Fonagy, 1996), few such groups have been established in the context of child mental health services. In reporting the process of establishing such a group in a tier three outpatient child mental health service, the following issues will be discussed: how to adapt existing cognitive-behavioural group techniques to meet the specific needs of children referred to a tier three service, how to address the difficulties facing attempts to set up groups of this sort in child mental
health services, how to evaluate the group and how to interpret the outcome of the group.

**Academic dossier**

**Aims:**

♦ To enhance my knowledge of areas of clinical psychology which are relevant to my current clinical concerns.

♦ To improve my skills in the critical evaluation of the relationship between theory and practice.

♦ To develop ideas for future clinical practice and service delivery.

**Proposed content:**

Two 4,500 word reviews will be produced on the following topics:

**Literature review of research into the organic bases and treatment options for Attention Deficit and Hyperactivity Disorder in children**

Increasing numbers of children are being diagnosed as having Attention Deficit and Hyperactivity Disorder (ADHD) in Britain (Taylor, 1994). This has led to debate amongst mental health professionals as to what this diagnosis implies, what is the most appropriate way to treat children with this diagnosis and why the diagnosis is currently so popular. The dominant viewpoint is that ADHD is an organic disorder that is best treated with medication and that the increasing popularity of the diagnosis is a reflection of advances in understanding and treating the disorder (cf Furman, 1996). In order to assess the bases for this view, a review of research published since 1990 into the possible organic origins of ADHD, and into the relative effectiveness of current treatment approaches, will be undertaken. Alternative explanations for the popularity of the diagnosis will be discussed. Clinical issues raised by the literature will be explored.
Literature review of factors affecting drop out from treatment in child mental health services

Up to 60% of all referrals to child mental health services drop out of treatment - that is, they fail to attend treatment sessions that are offered to them and do not return to treatment (Kazdin, 1996). This is thought to have a detrimental effect on the efficient allocation of resources and possibly on therapeutic outcome (Kazdin, Mazurick & Segal, 1994). The methodological and conceptual challenges facing attempts to investigate this topic will be explored. The main findings of research carried out since 1980 will be outlined. Studies that look at possible clinical initiatives to reduce drop out rates will be reviewed. The implications in terms of future research and clinical practice will be raised.

Research Dossier

Aim:

♦ To increase research competence

Research project 1: Factors influencing the referral of 3 year old and 10 year old children to child mental health services.

Originally submitted to the British Psychological Society Diploma in Clinical Psychology. Included here as per the regulations for the degree of PsychD.

Research project 2: An investigation of families' and their systemic therapists' use of attributions of blame and exoneration in relation to the presenting problem

Research supervisor- Clare Twigger Ross.
Background and relevance

Family therapy textbooks frequently refer to the necessity for therapists to be sensitive to issues of blame in their work with children and their families (Burnham, 1986; Treacher & Carpenter, 1993). It is thought that parents characteristically come to therapy blaming the referred child for the difficulties, and that high levels of blame of the child by their parents may contribute to poor therapeutic outcome (Frude, 1991). It is this blaming attributional stance that the therapist is urged to challenge, by offering alternative explanations of the difficulties that do not blame anyone (Stratton Preston-Shoot & Hanks, 1990). However, family therapists have been criticized for shifting the blame for the difficulties from the child onto the parents, in particular the mother (Goldner, 1985; Treacher & Carpenter, 1993). It is suggested that any blame by the therapist of the parents for the difficulties, may contribute to an increased risk of that family dropping out of therapy (Frude, 1991).

Despite the perceived centrality of blame in family therapy, few studies have sought to investigate how blame arises in a therapeutic context, and none set out to explore its impact on drop out rates. Those studies that do exist have not used operational definitions of blame that take into account the attributional dimensions identified in the social psychology literature as relevant to judgements of blame, namely: “internality”, “intentionality”, “controllability” and “universality”.

This research project will develop operational definitions of blame, and of exoneration, based on these four attributional dimensions, that can be used to code causal attributions about the presenting problem as they arise in naturally occurring conversations in child mental health services. These will be used to investigate the patterns of blaming and exonerating attributions about the presenting problem made by family members and the therapists they see, and to explore the relationship between these patterns of blame and exoneration and drop out from therapy.
Methodology:

Two studies will be undertaken.

In study one, a multiple case design will be employed. The operational definitions developed will be used to code causal attributions about the presenting problem made by a sample of ten families and their therapists. The patterns of attributions of blame and exoneration about the presenting problem, made by family members and the therapists they see, will be investigated and the possible relationship between these attributions and drop out from therapy explored.

In study two, a single case design will be used. The operational definitions of blame and exoneration will be used to code attributions of blame and exoneration in one therapeutic encounter. The results of this coding will be compared with the results of a conversation analysis of that therapeutic encounter, in order to determine how far the coded attributions can be taken as representative of participants' constructions of blame and exoneration within that encounter.

Data collection:

Ethical permission will be applied for.

Study one: The pre-session meeting, the first twenty minutes of the session and the intervention at the end of the session will be videotaped for ten cases. All causal attributions about the presenting problem will be identified and transcribed.

Consent will be sought from each of the participating families and therapists.
Study two: The pre-session meeting between therapists and the first meeting between the therapists and that family will be video-taped. These conversations will be transcribed in full.

Consent will be sought from the participating family and therapists.

Data analysis:

In study one, family members' and therapists' patterns of attributions will be analysed in terms of the percentage of attributions about the presenting problem they make that are coded as "blaming" or "exonerating". The possible relationship between levels of blame and drop out will be explored using Multi-dimensional Scalogram Analysis (MSA).

In study two, the results of the conversation analysis, in which participant's implicit construction of blame and exoneration will be identified in terms of the verbal devices of "repetition", "discounting" and "verbal phrasing" (Buttny & Jensen, 1995), will be compared with the results of coding causal attributions about the presenting problem using the operational definitions of blame and exoneration developed. By this means, it will be determined how far the coded attributions made by a speaker could be taken as reflecting that individual's construction of blame and exoneration by other means in that conversation.

Type of help required:

♦ regular supervision.

♦ Advice on appropriate use of MSA.
References


CLINICAL DOSSIER
Professional practice since qualification

Employment details

1991 - present: Clinical Psychologist (currently two sessions a week),

1996 - present: Independent Psychologist (one session per week),

Clinical work

*My clinical work at Wolverton Gardens has comprised the following elements:*

- family work using both systemic ideas and cognitive-behavioural techniques
- individual work with both children and parents
- group work with children
- consultations around specific cases to professionals such as teachers, G.P.s and health visitors
- clinical supervision of trainee clinical psychologists, qualified psychologists and other trainees in the department
- undertaking service developments, such as establishing an outreach service to provide temporary support to primary health care professionals, to cover a shortfall in clinical psychology provision in the community (1997-1998)

*My work at St. Paul’s Girls’ School involves*

- seeing pupils on a confidential, drop in basis
- providing consultations to staff around specific issues
Audit

I have taken a lead role in co-ordinating a number of audit projects, including:

- developing outcome criteria (1991-1992) which are now routinely used across Riverside Mental Health Trust
- telephone follow up of clients seen by our service (1995-1996)
- audit of children with ADHD in the caseloads of clinical psychologists in the North Thames Health Region (1996-1997)

Teaching

Recent teaching I have undertaken includes the following:

- Child behaviour problems (to medical students at Westminster and Imperial Medical School, 1995, 1997)
- Family therapy (to psychology undergraduates at University of Hertfordshire, 1995; medical students at Westminster and Imperial Medical School, 1998)
- Enuresis, encopresis and sleep problems (to clinical psychology trainees at University of East London, 1996, 1997)
- Lifespan development (to clinical psychology trainees at University College London, 1997)
- Cognitive-behavioural group work with primary school children (to child mental health workers in Riverside Mental Health Trust, 1997)

I convened the following day conferences organised by the North Thames Special Interest Group - children and young people:

- Working with difference (1995)
- Therapeutic narratives (1996)
- Children and divorce (1997)
Membership of professional bodies

- Association for Child Psychology and Psychiatry
- British Psychological Society
- Special Interest Group for Clinical Psychologists working with Children and Young People
- Young Minds

Committee membership.

I sit on the following committees:

- North Thames Special Interest Group for clinical psychologists working with children and young people (chair, 1995-1997).
- Research sub-committee for the Royal Holloway Doctorate in Clinical Psychology.

Post-qualification training

I have taken part in post qualification training courses offered by Riverside Mental Health Trust, including:

- introduction to group psychotherapy (1991)
- introduction to family therapy (1992)
- child protection training (1995)
- training in going to court (1996)

Recent one day external training events I have attended include:

- Working with refugees (N. Thames S.I.G.- children and young people 1995)
- Promoting parenting (National S.I.G - children and young people 1996)
- Prejudice in family therapy (Marlborough Family Centre 1996)
- Using qualitative research methods (Surrey University 1996)
- Working with ADHD (National S.I.G - children and young people 1996)
Publications


Accepted for publication


Cognitive-behavioural group work with primary school aged children within child mental health services is an under-developed area. Reports of cognitive-behavioural group work with children have tended to focus on work with non-clinic populations, where they have been found to be effective in increasing pro-social behaviour (Target & Fonagy, 1996). What research there is on clinical samples suggest that children presenting to child mental health services with problems of aggression and poor social skills may benefit from cognitive behavioural group work (Kazdin, Bass, Siegel, & Thomas, 1989; Kendall, 1993). There is a suggestion that primary school aged children with these sorts of problems may particularly benefit from a group approach along these lines (Dwivedi, 1993). Yet the clinical experience is of the extreme difficulty of establishing any such groups in the health service (McClure, 1997).

I will use this opportunity to reflect on the experience of establishing and running an anger management group for primary school aged children in a tertiary level child mental health service.

The setting

The group was run in a tier three multidisciplinary child mental health team which sees children with long-standing and complex difficulties on an outpatient basis. The team is made up of psychiatrists, psychologists, family therapists and child psychotherapists. The

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1 HAS report (Williams & Richardson, 1995) divided child mental health services into primary, secondary and tertiary level outpatient services. Tertiary services are multidisciplinary teams that provide a service to children with more complex and long-standing problems.
orientation of the team is mainly systemic family therapy and psychodynamic, but there is a willingness to use other techniques and models as appropriate. No group work had been undertaken in the team for seven years. During this time, spasmodic attempts had been made to set up groups for children and or parents, but none had actually taken place.

The presenting problem

In a team discussion about difficult cases that team members were currently working with, a number of clinicians reported that they were currently seeing cases of primary school aged children presenting with problems of aggression towards their peers, whom they felt “stuck” with. They felt that it was difficult to progress further with the family approach that they were currently adopting with these cases.

Establishing the group

It was agreed that cognitive behavioural group work might be advantageous with this group of children. I joined with a colleague (a recently qualified psychologist) in taking responsibility to establish such a group. We determined that a number of issues needed to be addressed if such a group was to be set up successfully within our service. In particular we needed to:

• develop a group that would meet the needs of the high levels of emotional and behavioural disturbance shown by the children who attended our centre.

• identify the reasons that previous groups had failed to materialise despite clinical interest, and to address each reason in turn.
Devising a group that met the needs of children with a high degree of emotional and behavioural disturbance

Given that most of the evidence for the efficacy of group cognitive behavioural work with children came from community based studies, it was felt that we would need to adapt existing programmes to make them suitable for the type of children seen in our service. To do this the following strategies were employed:

- Reducing the cognitive training component of the work

There are three key elements in cognitive behavioural work with children: teaching problem solving skills, modelling desired behaviour and using contingency reinforcement. One of the limitations of the cognitive approach is that children with problems in this area may not be functioning at a cognitive developmental level that would enable them to profit from direct teaching of problem solving skills (Wasserman, 1983). For instance, Camp (1977) concluded that aggressive boys may not be able to make use of covert self-commands. Modelling and contingency reinforcement, on the other hand, do not require verbalisation and thus can be used with children operating at a less sophisticated cognitive level (Wasserman, 1983).

We based our group on an American manual which detailed how to run a conflict resolution group for children in mainstream school - Conflict Resolution for Kids (Lane, 1995). This was devised as a preventative programme for children in school who had not been referred for psychological intervention. In order to modify this programme to make it more relevant to our population of children, it was decided to: eliminate those exercises that relied on covert self-commands and complicated problem solving, to include a greater
degree of modelling and contingency reinforcement and to break down the problem solving teaching into a number of simpler steps - focusing particularly on enhancing emotional awareness.

* Making the group as containing as possible

It was recognised that the children coming to our clinic had generally experienced many losses and traumas in their lives. They constituted an emotionally disturbed and vulnerable group of children, who were likely to find the group process quite daunting and potentially threatening. It was decided to style the group as a “detective group”, in which the children would be encouraged to become detectives in their own lives to search out clues to understand their own behaviour and that of others and to develop ways of solving difficulties. This approach was adopted to make the groups as unthreatening and as fun as possible.

In addition, it was deemed important to make the group as containing as possible by:

* making sure that each group started and ended on time
* ensuring that any absences were noted and an opportunity was given for any of the children to comment upon them
* setting out clear rules at the outset and sticking by them
* making clear at the outset to the children and their families how many groups there would be
* acknowledging whom knew who in the group prior to the group starting
* requiring that the parents should wait for the children whilst the group was in progress. In this way any excessive levels of disruption by an individual child could be handled by sending them out to sit with their parents for five minutes
It is known that these non-specific factors can have a powerful effect on the process of therapy (Dwivedi, 1993; Reid & Kolvin, 1993).

Offering appropriate input to the parents

We would have liked to run a parents' group alongside the children's group, but resources did not allow for this. We therefore decided to provide written handouts to the parents each week outlining the content of the group, and to give them individual verbal feedback after each session about how their child was doing and what ways we had found helped to reinforce their child's pro-social behaviour.

It was felt vital to stress from the outset the very limited goals of such an intervention with this population of children, who showed such long-standing difficulties. It was felt important not unrealistically to inflate parents' hopes and so promote disillusionment as a result.

Tackling issues that had led to the failure of previous groups in the centre

We concluded that the following factors had contributed to the failure to establish group work in the past in this setting:
- Practical difficulties of getting more than one colleague to co-ordinate and make a weekly commitment to group work had led to more than one group being abandoned.
- Lack of belief by clinicians in the team that group work was as effective as individual or family work with children with the sorts of difficulties that team members routinely saw, and concern that groups are introduced largely as cost saving exercises. The myth that groups are primarily used because they are less costly than other forms of
intervention is thought to have contributed to the scepticism about group work felt by many clinicians (McClure, 1997).

We endeavoured to address each of these issues directly by:

♦ Setting aside sufficient time and resources at the outset.

I and my colleague made a commitment to offer a group in three months' time - leaving ourselves enough time to set up the group. We agreed to offer a brief, time limited (six week) group. We set up regular supervision slots with a consultant psychologist who had extensive experience in running groups with adolescents in an in-patient setting.

♦ Allaying team members' fears about what the group would mean.

We provided a series of workshops about group work to team members, and summarised the relevant literature. We encouraged full discussion of the pros and cons of our approach and the limitations of our aims. We stressed that the aim of the group was not to be a cost saving exercise. Instead, we emphasised the way group work might provide unique benefits to this population.

Criteria for group membership

It was decided to include children in the group who suffered from a range of difficulties in relation to conflict resolution. In particular, it was decided to include those who were primarily the recipient of aggressive behaviour as well as those who primarily initiated aggressive behaviour. This was because the literature suggests such mixed groups are advantageous (Dwivedi, 1993; Reid & Kolvin, 1993).
It was felt important that the children who joined the group should come from within a fairly narrow age range, so that exercises could be pitched at the right level. It was agreed that we would accept referrals of children aged 7-11.

It was decided that we would only accept referrals of children who had already been seen by a clinician at the centre. This was because it was felt important that families should have access to ongoing support to take up any emotional issues that were raised for the children and their families by the group work. It was left to the referring clinician to decide what level of interventions to offer alongside the group work.

Referral procedure

Because of lack of time it was decided not to offer individual assessments to potential group members. Team members were asked to let us know of any children in their caseload who might benefit from the group. If, in discussion with us, it was felt that the child was an appropriate referral, a place in the group was offered. If the family said they wanted to take up this offer they were contacted directly by us to explain the practical details.

Aim of the group

For the children to improve their ability to find non-violent ways of resolving situations of potential conflict.

Evaluating the group

The group was evaluated using the following measures:
• The Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1996), was given to parents and teachers before and after the group. The SDQ provides two scores of relevance to this group: a peer problems score and a pro-social behaviour score. This measure has recently been validated with parents and teachers (Goodman, 1997). A copy can be found in Appendix 1.

• Children's questionnaire. The children were given a short open ended questionnaire, asking what they expected from the group and what they hoped to do in the group at the outset. At the end of the groups they were given another questionnaire, to assess what they felt they had achieved. A copy can be found in Appendix 1.

• Verbal feedback from parents and referring clinicians. It was agreed that verbal feedback from parents, and from the referring clinicians, would be gathered at the end of the groups.

It was arranged that all group members and their families would meet one week before the groups started, and one week after they ended, in order to complete pre- and post- treatment measures.

Running the Group

Participants

Five children attended the group (an additional girl, who had been the victim of aggression in the past, attended the pre-group evaluation but her mother decided not to let her join the group). The names have been changed in order to preserve anonymity.
Dean (10) was referred to the group by a psychiatrist who had been seeing him for six months. Dean showed extreme aggressive behaviour both at home and school. He had been excluded from two primary schools for aggressive behaviour and was on a temporary exclusion from his current school. He had had extensive treatment in the past, including in-patient treatment. He was the eldest child in a family consisting of three other half-siblings and his mother.

Luke (8) was referred to the group by the psychologist (co-leader of the group). She had been seeing him and his family for four months. He had been excluded on two occasions by his current school, and was said to be alternately aggressive and withdrawn at school and home. He was the oldest of two children in the family. His parents were separated.

Jodie (10) was referred by a psychologist who had been meeting her and her family over a course of 10 months. She showed aggressive behaviour to other children at school. She had recently moved school. Her brother had died a year previously, and the psychologist had been working on bereavement issues with the family. Jodie had another brother and both parents at home.

Charles (7) was referred by a family therapist who had been working with the family for 16 months. Charles was a quiet boy, who had experienced bullying in the past; he was said to be very provocative in school and to get into fights. He had been excluded on five occasions. He was the only child of a single mother.

Peter (9) was referred to the group by the psychologist co-leader. She had been working with him for three months. He had experienced bullying in a previous school and recently moved to a new school where he had begun to be bullied once again. Teachers reported that
he was socially isolated and appeared to lack the social skills to make friends and react in situations of potential threat. He was the older of two brothers and his parents were both at home.

Pre-group evaluation

The scores for each of the participants, as rated by their mothers, are shown in table 1.

Table 1: Pre-group SDO parent scores

<table>
<thead>
<tr>
<th></th>
<th>peer problems</th>
<th>Pro-social behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>normal = 0-2</td>
<td>normal = 6-10</td>
</tr>
<tr>
<td></td>
<td>borderline = 3</td>
<td>borderline = 5</td>
</tr>
<tr>
<td></td>
<td>abnormal = 4-10</td>
<td>abnormal = 0-4</td>
</tr>
<tr>
<td>Dean</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Luke</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Charles</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Jodie</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Peter</td>
<td>6</td>
<td>9</td>
</tr>
</tbody>
</table>

All the children, except Charles, were rated by their parents as having some degree of problems relating to their peers. All the children were viewed by their parents as having pro-social behaviour within the normal range.

The scores for each of the participants, as rated by their teachers, are shown in table 2.

Table 2: Pre-group SDO teacher scores

<table>
<thead>
<tr>
<th></th>
<th>peer problems</th>
<th>Pro-social behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>normal = 0-3</td>
<td>normal = 6-10</td>
</tr>
<tr>
<td></td>
<td>borderline = 4</td>
<td>borderline = 5</td>
</tr>
<tr>
<td></td>
<td>abnormal = 5-10</td>
<td>abnormal = 0-4</td>
</tr>
<tr>
<td>Dean</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Luke</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Charles</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Jodie</td>
<td>not available</td>
<td>not available</td>
</tr>
<tr>
<td>Peter</td>
<td>9</td>
<td>6</td>
</tr>
</tbody>
</table>
Teacher ratings on the SDQ rated Peter, Charles and Dean as having some degree of difficulty with peer relationships and Luke as within the normal range. Only Charles was seen as having impaired levels of pro-social behaviour, all the others were rated as within the normal range.

The childrens' own hopes and expectations of the group are summarised in table 3.

Table 3: Children’s hopes and expectations of the group

<table>
<thead>
<tr>
<th>Name</th>
<th>“What do you think this group is for?”</th>
<th>“What are you hoping to do in this group?”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dean</td>
<td>to help us learn</td>
<td>very good things</td>
</tr>
<tr>
<td>Luke</td>
<td>to help me get along with others</td>
<td>to play board games</td>
</tr>
<tr>
<td>Charles</td>
<td>to help me get on better with others, like teachers and children</td>
<td>play games</td>
</tr>
<tr>
<td>Jodie</td>
<td>to co-operate with other children</td>
<td>to get on with other children</td>
</tr>
<tr>
<td>Peter</td>
<td>to help me cope with being bullied</td>
<td>to help me get on with others</td>
</tr>
</tbody>
</table>
The treatment

Six groups were run, of one and a half hours each. Each group started with a snack, followed by warm up “games”, followed by group exercises. Every group ended with a discussion of how each member had dealt with a situation of potential conflict that week. The parents were given a handout each week outlining the main themes for the group that week. Copies of these handouts can be found in Appendix 2.

The group was explained to the children as a sort of “detective training”, in which they would learn to be detectives in their own lives and notice what they were thinking and feeling in stressful situations, so that they could choose the best course of action.

In the first group, the children were given a folder and two coloured pens as well as a “detective log” (an empty exercise book) in which they were asked to record a conflict each week. The folder and pens were kept in the centre but given to the children at the end of the groups.

The games at the start of each group focused on encouraging positive social interaction and group cohesion. For example, the “gesture name game” involved each person in turn saying their name with an accompanying action, and then the rest of the group copied. Another example of a game was the “magic microphone”. In this, the “microphone” (a bean bag) was passed round. Only the person holding the microphone could speak. Participants were given a particular topic to speak on, such as one thing they liked. Each member had a turn.

The exercises that followed generally focused on naming and talking about emotions. For example one exercise involved an emotions spinning wheel in which group members took it in turns to spin a
pointer on a wheel on which a number of emotions were written (e.g. anger, pride, envy, happiness). They then had to act out the emotion indicated, or, in another variant, tell of a time they experienced that emotion. In group four, the “social skills game” (Searle & Streng, 1996) was introduced. This is a board game designed to work as a therapeutic tool, to aid reflection and to help practise some of the children’s newly acquired skills. In the last two meetings, role play was employed to practise using the skills the children had been learning.

Following the completion of the exercises, the children were given their folder and pens and asked to draw something that related to that week’s work. Thus one week the children had to draw how they felt in a particular situation, another week they had to draw an example of a conflict. The children were encouraged to share their pens so that they could have access to a range of colours for their art work.

The “good ideas wheel” was introduced in group three. This listed different ways of reacting in conflictual situations, such as “saying sorry”, “getting help”, “trying to share”. The children were helped to make their own wheel of possible responses to situations of potential conflict, such as “walking away”, or “making a joke”. The use of this was reviewed in relation to real situations.

The last part of each group was taken up with discussing an example of a conflict the children had brought in and looking at how group members had dealt with such conflicts. Each week, a different aspect of conflict resolution was focused on.

At the end of each group, parents were given individual feedback on their child. In particular, we fed-back to the parents any positive behaviour we had witnessed on the part of their child, and encouraged them to look at the minutiae of interaction to notice improvements. In
the last group, the parents were invited to watch their children play the "social skills game" from behind a one-way screen, so that positive aspects of their children's behaviour could be demonstrated and reinforcement of appropriate behaviour modelled by the therapists in interaction with the group. At the end of the groups, verbal and written individual feedback was given to each parent and child (see Appendix 3 for copies of feedback given to parents). With the parents’ agreement a copy of the written feedback was sent to each child’s teacher.

**Observations on the children's progress in the group**

The attendance rate for the group was high - 80% attendance was achieved. In the first meeting, the children bonded in terms of what levels of antisocial behaviour they had achieved - each vying with each other to recount instances of aggression. Thus, Luke said he had broken another child’s finger in a fight; Jodie retorted by saying she had hospitalised another child by ramming them into a tree. The therapists responded to this by encouraging the children to focus on how they felt during these fights, and to identify what thoughts went through their mind.

From the beginning, care was taken by the therapists to ignore unhelpful behaviour that occurred in the room and to praise pro-social behaviour. Thus, in the first session, when Dean bumped into Jodie’s chair deliberately as he passed, Jodie was congratulated for not responding. When the coloured pens were handed out it was explained that each child had only two colours but if they shared with each other they would have access to a wider range. The children were able to share and were repeatedly praised for doing so by the therapists. At one point, Jodie commented, “This feels weird; getting on with people".
Initially, the children found it hard to concentrate on the tasks at hand and were easily distracted by disruptive behaviour by other members of the group. However, by week four most group members were increasingly able to focus on a particular exercise or activity. Dean, however, became increasingly provocative. He constantly attempted, sometimes successfully, to co-opt Luke and Charles into fights. Luke and Charles were praised for the times they resisted this.

The children initially found focusing on emotions hard. As the weeks progressed, however, they became more able to notice, and talk about, how they felt in difficult situations. For example in group four, when asked to act out a time when she had felt envy, Jodie demonstrated her, “I don’t care at all face”. Initially when asked to describe how she felt inside, she said, “It doesn’t matter to me”; but with prompting she was able to describe in detail how her pain at the other person having something she wanted led her to act in this way.

In the first four groups, the main emphasis was on helping the children develop new strategies for dealing with stressful situations. They made their own “good ideas wheels” and were encouraged to incorporate their own ideas and suggestions. Luke, for example, suggested that one might “go home and hit some plasticine” when feeling frustrated by a situation.

In the last two weeks, the children used role play to practice using some of the ideas in difficult situations. For example, role play was used to help them practise stopping and thinking in stressful situations. In one instance, Dean was required to role play a situation with Jodie, in which he had to tell her he did not like what she was wearing in a non-offensive way. He managed to do this, and was given
much positive feedback both from the group leaders and the other group members.

At the last group, members were each encouraged to share what they had learned from the group with each other and their parents - who were invited into the group for the last 20 minutes. Each member was given a certificate, in front of their parents, and the group leaders described what they felt each member had achieved.

Outcome

SDQ measures
The "peer problems" and "pro-social behaviour" scores for each child, as rated by their parents after the group, are shown in table 4. No teacher returned the post-group SDQ, so pre-and post group ratings made by teachers could not be compared.

<table>
<thead>
<tr>
<th></th>
<th>peer problems</th>
<th>Pro-social behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>normal = 0-2</td>
<td>normal = 6-10</td>
</tr>
<tr>
<td></td>
<td>borderline = 3</td>
<td>borderline = 5</td>
</tr>
<tr>
<td></td>
<td>abnormal = 4-10</td>
<td>abnormal = 0-4</td>
</tr>
<tr>
<td>Dean</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Luke</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Charles</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Jodie</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Peter</td>
<td>5</td>
<td>9</td>
</tr>
</tbody>
</table>

Jodie was rated by her mother after the group as within the normal range of behaviour in relation to peer problems and pro-social behaviour. Charles was rated as borderline for both. Dean, Luke and Peter all were rated as having abnormal levels of peer problems, but as having pro-social behaviour within the normal range.
Comparison of parents’ pre and post-group scores shows mixed results (see figure 1). In relation to peer problems, only Jodie and Peter were rated as having lower levels of peer problems after the group than before. Dean, Luke and Charles were all rated as having higher levels of peer problems after the group than before.

In terms of pro-social behaviour: Dean, Jodie and Luke were all rated by their parents as having higher levels of pro-social behaviour, Luke was rated the same and Charles was rated as having lower levels of pro-social behaviour than before the group (see figure 2).
Figure 2: group members' "Pro social" scores on the SDQ as rated by their parents before and after the groups.

Table 5: Children's post-group questionnaire

<table>
<thead>
<tr>
<th></th>
<th>&quot;how far have your hopes for changes been achieved&quot;</th>
<th>&quot;what were the most helpful aspects of the group?&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dean</td>
<td>not a thing</td>
<td>not a thing</td>
</tr>
<tr>
<td>Luke</td>
<td>I was hoping to make a friend - and I did with the whole group</td>
<td>playing games</td>
</tr>
<tr>
<td>Charles</td>
<td>It was hard but I was starting to like it</td>
<td>I liked the way we were all treated the same</td>
</tr>
<tr>
<td>Jodie</td>
<td>To ignore stuff</td>
<td>to say sorry</td>
</tr>
<tr>
<td>Peter</td>
<td>I was hoping to cope with being bullied and to gain self confidence and it helped a little with both things.</td>
<td>to meet other children with problems</td>
</tr>
</tbody>
</table>
Verbal feedback from parents

Each parent of a child involved in the group reported some instance of improvement by their child, which they attributed to the group. **Dean's** mother related an instance that had occurred in school, in which for the first time Dean had accepted responsibility for starting a fight. The teachers had been amazed, and pleased, that he had been prepared to “own up”. **Charles's** mother reported that he had said “sorry” for the first time at school and this had prevented him being excluded. **Luke's** mother reported that he had managed to avoid getting in a fight by “walking away”, although she said she knew he still found this hard. She commented that he had “really enjoyed coming to the group” and that he tried to apply what he learnt at home and at school. **Jodie's** mother reported that there had been no incidences of any fights since Jodie had attended the group. **Peter's** mother said he had successfully applied the strategies on one occasion, but that overall there had been little change and that he still had very low self esteem.

Verbal feedback from referring clinicians

The psychologist working with **Jodie** and her family felt Jodie had progressed sufficiently within the group for her to be discharged from the service once the group was ended. The other children all continued in treatment with the referring clinician. **Charles** continued in family therapy for some months after the end of the group, but was then discharged as it was felt significant improvement had been made. The psychiatrist who has been working with **Dean** used the recommendation made by the group leaders that longer term, more structured work might be advantageous to lobby successfully for an out of borough boarding school placement for him. **Luke** and **Peter** continued to be seen for further family work. All the referring
clinicians reported that they had found feedback from the group helpful in working with these families.

Service developments

Feedback about the group was given at a meeting of all team members shortly after the group was completed. Much interest was expressed and suggestions for further group work put forward by other members of the team. A professional development day on group work was organised by management for all clinicians within the child mental health trust. A formal presentation on the setting up, running and outcome of the group was made. The difficulties of establishing groups within the trust were discussed, and as a result a commitment was made by management to support supervision across services within the trust.

Another conflict resolution group for primary school aged children referred to this team is planned for later this year. The co-leaders will be the psychologist who co-led the above group with me and a trainee clinical psychologist currently on placement with us. I will supervise their work.

Discussion

The fact that the group actually got started and that it led to other groups being run, shows that it is possible to set up cognitive-behavioural groups within a tier three outpatient child mental health service. It was felt that addressing the anxieties of colleagues at the outset, having clear and limited goals, setting up adequate supervision and providing feedback both to referring clinicians and to the team as a whole, all aided the successful establishment of the group within this service.
The outcome of the group based on the SDQ results was mixed. Two members of the group (Jodie and Peter) were rated by their parents as having lower levels of peer problems after the group, and higher levels of pro-social behaviour, than before the group. One member of the group (Dean) was rated as having higher levels of pro-social behaviour after the group, but also higher levels of peer problems, than before the group. Two members of the group (Luke and Charles) had higher levels of peer problems after the group and their pro-social behaviour was unchanged and lower respectively.

Yet the verbal feedback from all the parents was good, although Peter’s mother did express reservations. All the children, except Dean, reported that they felt that they had benefited in some way from participation in the group. This feedback suggested that the group was perceived by the parents as facilitating some positive changes and was actively enjoyed by many of the children.

It may be that the disappointing results on the SDQ reflect the fact that the SDQ does not measure behaviour in enough detail to be able to track the limited changes likely to occur in children with such long term difficulties in the short space of time the groups ran for. It is striking that the initial scores for pro-social behaviour given to the children by their parents and teachers were quite high given the range of disturbance the case histories of these children suggest. It may be that the difficulties these children had in dealing with social situations did not manifest themselves in the behaviours that the SDQ measures, or it may be that some parents came with unrealistic views of their children’s behaviour and that the group enabled them to see their children’s difficulties in this regard more clearly.
It was felt that future groups could benefit from outcome measures that tracked more minute changes in the children’s behaviour within the group. For example, one option might be to videotape the children playing the social skills game at the first group meeting and again at the end, and rate behaviours such as eye contact, compliance with requests etc.

The fact that the majority of parents and children perceived there to be benefits from the group, and the high attendance rates, suggest that they found the group as a whole to be a positive experience. Our clinical impression was that by providing psycho-educational input in a non-threatening way, via games and exercises, and by harnessing peer reinforcement, the children gained in ways that would not have been possible by more traditional means. It may be that a group that ran for a longer period would produce greater gains.

Had there been more time available it would have been useful to have carried out individual pre-group assessments with each of the children who were to take part in the group and their families. This would have helped us to discuss with them their expectations of the group and how they meshed with what we felt we could offer. This might have been particularly helpful in relation to Peter and his family, to explore what they wanted from the group.

One of the issues this group raised for us was the difficulties of including both aggressors and bullied children in the same group. It was unfortunate that one of the children whose problems had primarily been of being bullied, dropped out at the evaluation stage, and that Peter was the only child in the group whose main problem was being bullied. It was felt, with hind sight, that more could have been done to work with him and his parents on how his specific issues could be tackled.
It was felt that, with greater resources, it would have been very helpful to have run a parents’ group alongside the children’s group, to have given the parents an opportunity to discuss how they could reinforce their children’s pro-social behaviour.

**Conclusion**

By addressing some of the issues that were thought to have prevented the running of groups in this tier three child mental health service in the past, a cognitive behavioural group for primary school aged children was successfully established and completed, and further groups were undertaken. Although the results of the evaluation of the group based on scores on the SDQ (Goodman, 1996) were mixed, verbal feedback from parents, children and referring clinicians suggested that the group did provide some benefits to the children, and their families, who took part.

**References**


## Appendix 1

<table>
<thead>
<tr>
<th>Section</th>
<th>Column 1</th>
<th>Column 2</th>
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<tbody>
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*Please note that the table content is not legible due to the image quality.*
Appendix A: Strengths and Difficulties Questionnaire

or each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child’s behaviour over the last six months or this school year.

Child’s Name ..................................................................................................................

Date of Birth ..................................................................................................................

<table>
<thead>
<tr>
<th></th>
<th>Not True</th>
<th>Somewhat True</th>
<th>Certainly True</th>
</tr>
</thead>
<tbody>
<tr>
<td>Considerate of other people’s feelings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restless, overactive, cannot stay still for long</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often complains of headaches, stomach-aches or sickness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shares readily with other children (treats, toys, pencils etc.)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Often has temper tantrums or hot tempers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rather solitary, tends to play alone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generally obedient, usually does what adults request</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Many worries, often seems worried</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helpful if someone is hurt, upset or feeling ill</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Constantly fidgeting or squirming</td>
<td></td>
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<tr>
<td>Has at least one good friend</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often fights with other children or bullies them</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often unhappy, down-hearted or tearful</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generally liked by other children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easily distracted, concentration wanders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nervous or clingy in new situations, easily loses confidence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kind to younger children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often lies or cheats</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Picked on or bullied by other children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often volunteers to help others (parents, teachers, other children)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinks things out before acting</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Steals from home, school or elsewhere</td>
<td></td>
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<tr>
<td>Gets on better with adults than with other children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Many fears, easily scared</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sees tasks through to the end, good attention span</td>
<td></td>
<td></td>
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</tbody>
</table>

Signature ..............................................................................................................

Date ..........................................................................................................................

Parent/Teacher/Other (please specify):

Thank you very much for your help
Appendix B. Provisional banding of SDQ scores

These bands, which are not adjusted for age or gender, have been chosen so that roughly 80% of children in the community are normal, 10% are borderline and 10% are abnormal.

<table>
<thead>
<tr>
<th></th>
<th>Parent Completed</th>
<th>Teacher Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Normal</td>
<td>Borderline</td>
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<tr>
<td><strong>Total Difficulties Score</strong></td>
<td>0 - 13</td>
<td>14 - 16</td>
</tr>
<tr>
<td><strong>Emotional Symptoms Score</strong></td>
<td>0 - 3</td>
<td>4</td>
</tr>
<tr>
<td><strong>Conduct Problems Score</strong></td>
<td>0 - 2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Hyperactivity Score</strong></td>
<td>0 - 5</td>
<td>6</td>
</tr>
<tr>
<td><strong>Peer Problems Score</strong></td>
<td>0 - 2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Prosocial Behaviour Score</strong></td>
<td>6 - 10</td>
<td>5</td>
</tr>
</tbody>
</table>
Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months or this school year.

<table>
<thead>
<tr>
<th>Child's Name</th>
<th>Male/Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth</td>
<td>Not True</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item</th>
<th>Not True</th>
<th>Somewhat True</th>
<th>Certainly True</th>
</tr>
</thead>
<tbody>
<tr>
<td>Considerate of other people's feelings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restless, overactive, cannot stay still for long</td>
<td></td>
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<td>Constantly fidgeting or squirming</td>
<td></td>
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<tr>
<td>Has at least one good friend</td>
<td></td>
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<td>Often volunteers to help others (parents, teachers, other children)</td>
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<td>Thinks things out before acting</td>
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<tr>
<td>Sees tasks through to the end, good attention span</td>
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</tbody>
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Please turn over - there are a few more questions on the other side
Overall, do you think that this child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes - minor difficulties</th>
<th>Yes - definite difficulties</th>
<th>Yes - severe difficulties</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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</tbody>
</table>

If you have answered "Yes", please answer the following questions about these difficulties:

* Do the difficulties upset or distress the child?

Not at all □ Only a little □ Quite a lot □ A great deal □

* Do the difficulties interfere with the child's everyday life in the following areas?

PEER RELATIONSHIPS □ □ □ □
CLASSROOM LEARNING □ □ □ □

* Do the difficulties put a burden on you or the class as a whole?

Not at all □ Only a little □ Quite a lot □ A great deal □

Signature .................................................................................................................. Date .............................................................

Class Teacher/Head of Year/Other (please specify:)

Thank you very much for your help
New Year Group

Pre-group questionnaires for children

Date:

Name: ________________________________

What do you think this group is for?

What are you hoping to do in the group?

Do you have any worries about what the group will involve? If so what are they?

Is there anything you want us to know about you that will help us in running this group?
New Year Group

Post-group questionnaires for Children

Date:

Name: _______________________

What were you hoping for from the group and how far has it been achieved?

What do you think was the most helpful aspect of the group?

What do you think was the least helpful aspect of the group?

Please write any comments you would like to make about the group overleaf.


Appendix 2

The group will mainly be an opportunity for the children to get to know each other and to agree the rules. Group members will be asked to agree to respect one another and abide by the basic rules of good behaviour. If we ask whoever is the responsible adult who can come and collect the group and wait with the children until they are able to rejoin the group.

In the first meeting we will introduce the idea of how we do things and what goes on in an argument. We will also introduce times to some relaxation skills as a way of calming down and practising these skills that we plan for next week. All group members will be...
New Year Group: 1

handout for parents

As we discussed last week the aim of these groups is to help the children develop ways of dealing with conflict without getting out of control. We will also be helping them learn how to collaborate, get on with others and work together as a group.

We will encourage group members to become like detectives in their own lives. We hope they will become more able to notice the clues given by themselves and others as to how they feel, and to develop their skills at problem solving both at home and at school.

The groups should be both educational and fun. There will be tasks, or "detection work", that we will ask the children to do each week between groups. We will let you know what the task is each week, but please feel free to ask us if you want further information.

This first group will mainly be an opportunity for the children to start to get to know each other and to agree the rules of the group.

All group members will be asked to agree to respect one another and to abide by the basic rules of good behaviour. If they do not do this we will ask whoever is the responsible adult who is waiting for them to come and collect them and wait with them in the waiting room until they are able to rejoin the group.

In this first meeting we will introduce the idea of how to think about what goes on in an argument.

We will also introduce them to some relaxation skills that can be used as a way of calming down and creating time to think.

Detective Task for next week: All group members will be asked to draw and/or write about an arguments or conflict in their "detective log". They will be asked to indicate; where it happened, who was there, what happened and how they felt about it. These must be brought back to the group next week.
New Year Group: 2
handout for parents

This week we will explore different ways group members can help themselves get on with others better when faced with situations of potential conflict. We will be introducing the "good ideas" wheel today which will help give clues to the detective trainees as to how to act in difficult situations.

Some of the techniques your child might practice using are; cooperation, listening, taking turns, sharing, postponing, getting help, avoiding, and using humour!

We will also be practising relaxation techniques. These are useful to help children notice the difference between feeling relaxed and feeling tense, they can also be used by children to help themselves calm down and they help to give them a chance to think through what to do when confronted with a difficult situation.

Detective task

Group members will again be asked to write about and/or draw an argument, preferably one they have been involved in. It does not have to have happened this week. They will be asked to indicate, or be able to talk about, where it happened, who was there, what happened, how they felt, which strategies they used, and which other strategies they might have used.

Please help them remember to bring back their detective book to the group next week.
This week we will start with a review of the rules of the group with both group members and parents present. If group members are finding it too hard to abide by the rules they will be asked to wait with their parents for 5 minutes to allow the rest of the group to get on with their detective training.

The group will start with some exercises to encourage listening skills. We will then review the detective tasks from last week and look at what other ways the children could have handled the difficult situations.

We will use the good ideas wheel to suggest different options for the children to try out. Options include; taking turns (e.g. agreeing not to play with something right away but to have a go after another child has finished), avoiding conflict (e.g. just walking away from a potential fight), getting help (e.g. asking a teacher or a parent to intervene), apologising (saying sorry does not mean that you were wrong in the first place, only that you are sorry with the way things turned out) and listening (being prepared to hear the other persons point of view). Group members will make their own wheels choosing ways of resolving conflict that they want to try to practice.

**Detective Task for next week:** All group members will take home their own good ideas wheels and will try using it in difficult situations. They will be asked to note in their “detective log” which good ideas they tried out and what happened as a result.

**As always please help your child to remember to bring back his or her detective log next week.**
New Year Group: 4
handout for parents

This week we will continue to work on using the good ideas wheel to think about different ways to deal with potentially difficult situations.

The group will start with some exercises looking at feelings and encouraging group members to notice how they are feeling. Becoming aware of how they feel in different situations helps children to monitor and control their responses.

We will review with them how they have found using their good ideas wheels and whether they have come up with any new suggestions for how to behave difficult situations.

Detective Task for next week:

All group members will take home their good ideas wheels and will again try using them in difficult situations. They will be asked to note in their “detective log” which good ideas they tried out and what happened as a result and in particular to indicate how they felt before during and after the argument or difficult situation.

As always please help your child to remember to bring back his or her detective log next week.
New Year Group: 5  
handout for parents

This week we will consolidate some of the ideas about how the children can react differently in potentially difficult situations.

In these groups we are not aiming to alter the children’s daily experience. We cannot control how others behave towards them nor make every interaction fair and kind. What we are hoping to do is extend the children’s own range of behaviours so that they can have more choice about how they respond to others rather than thinking the only way to respond to conflict is to hit out or to withdraw entirely.

We will again be looking at feelings and encouraging group members to notice how they feel in different circumstances and how they can show these feelings in a helpful way. Becoming aware of how they feel in different situations helps children to monitor and control their responses.

We will review with them the situations in which they have tried out different strategies in the last week.

Detective Task for next week:

All group members will be asked to interview friends, family and teachers to find out what strategies they use to help in difficult situations, and to bring back the results of their detection next week.

As always please help your child to remember to bring back his or her detective log next week.
New Year Group:6
handout for parents

This is the last week of the group will meet as such. Next week both parents and children will be asked to be present so that we can hear how you have found the groups, and give you individual feedback on your child. We will also discuss how the ideas introduced in the group can be built on.

In the group this week we will be playing the “Social skills game” with the children. This is a board game specially designed to help children practice some of the skills we have been working on over the last 6 weeks.

We will also be reviewing what has been learned over the course of the groups with the children.

At the end of the group, when you come up to collect your child, there will be a short presentation in which a certificate will be awarded to each child who took part in the group.
Appendix 3

responded very well and showed some improvement in his attempts at constructive behaviour. This improvement was noticeable in play and in the group activities, and he showed an increased ability to take part in activities. He also showed an increased ability to join in with group activities and to participate in group discussions.

He had a powerful presence in the group, and when alive and engaged, he was extremely helpful. He would use his excellent memory to help other group members with their ideas, and would share his plans willingly when he had developed them. He was able to respond to provocations and to discuss and reflect on the improvements in his behaviour, and was able to leave the meeting in the last two weeks.

It can still be very difficult for him, as indicated by his lack of constructive and cooperative behaviour. However, he did make progress in this area, which he would benefit from supporting and input from the group. His work was considered very positive, and he received feedback and positive suggestions in the group setting. He was encouraged to develop his skills further and to push deeper into self-understanding his behaviour.

It is believed that he can benefit from firm boundaries and high-level enforcement for any future attempts, however tentative, to employ constructive strategies, which, at this stage, are still so new to
FEEDBACK FROM NEW YEAR GROUP

Dean attended the New Year Group, 9th January to 27th February. The group aimed to help children to get on with one another and develop new skills in social situations. He attended five of the six groups, missing one due to ill-health.

Dean's ability to join in and play a central role in the group was initially hindered by his strong reliance on physical aggression as the only possible response to difficult situations. He found it extremely hard to stick to the rules, initially seeking to assert his leadership in the group by encouraging others to test the limits of the group as well.

Dean responded well to firm boundaries and consistent reward for, and acknowledgement of, his attempts at constructive behaviour. Through listening to other group members feedback Dean seemed to develop more ideas of how to cope with conflict, such as seeking help from an adult or walking away. These do not come easily to him however. His dominant reaction is still to use physical or verbal aggression, other types of solution only come to his mind as a second thought and he is more uncertain about them. However, he is able to think of constructive solutions when encouraged and guided by an adult.

Dean was a powerful presence in the group, and when able to harness his contributions constructively he could be extremely helpful. For example he was able to use his excellent memory to help other group members in the "memory game", and would share his pens willingly when drawing. He was also increasingly able not to respond to provocation from others as the weeks went on. The improvement in his behaviour was reflected in the fact that he did not have to leave the meeting in the last two weeks.

Dean can still seem very troubled at times as indicated by his angry thoughts, language and behaviour. Whilst he did make progress in the group it is likely that he would benefit from more intensive input than this group set out to provide. We would recommend that Dean receive further help in this area, preferably in a well-structured and long-term setting, where he would be able to develop his skills further and look in depth at some of the emotions underlying his behaviour.

In general Dean will benefit from firm boundaries and high levels of positive reinforcement for any attempts, however tentative, to employ new more constructive strategies, which at this stage are still so new to him and he remains so uncertain about.
FEEDBACK FROM NEW YEAR GROUP

Luke attended the New Year Group, 9th January to 27th February
The group aimed to help children to get on with one another and develop new skills in social situations. Luke attended all six of the groups.

Luke initially found it hard to abide by the rules seeking to impress his peers by testing the rules. As the group progressed he seemed to be able to find ways that he could gain acceptance from others in the group whilst also being helpful and making useful contributions in relation to the group leaders. He also became more able to identify and talk about his own sorrow at not being able to get along with others as well as he would like to at times.

Luke was very creative in his thinking, working out new strategies to cope with his feelings when confronted with difficult situations such as hitting plasticine to calm himself down when he returned home.

He remembered the strategies we had discussed each week and was helpful in his suggestions to other group members. He contributed particularly well when not distracted. As his motivation to take part increased so he was able to give positive feedback to other members and to help them abide by the rules. His contributions were always interesting and he made good attempts at trying out new strategies for coping with conflict in role play situations.

Luke would benefit from continued acknowledgement of his wish to get on with others in more helpful ways, as well as space to talk about how he feels in difficult situations. He would also benefit from further practice of the different approaches we have begun to explore, such as walking away and getting help, and saying sorry. His new skills can be encouraged by very positive response to any attempt to use new strategies, however tentative.
FEEDBACK FROM NEW YEAR GROUP

Charles attended the New Year Group, 9th January to 27th February. The group aimed to help children to get on with one another and develop new skills in social situations.

Charles attended all but one of the six meetings.

When Charles first attended the group he seemed unsure of how best to engage with the other children and the group leaders. When in doubt it appeared as if he would resort to joking about or withdraw into silence.

As the weeks went on Charles joined in more willingly. Although it remained somewhat unpredictable when Charles would contribute spontaneously, what he did he volunteer was generally extremely useful and well-thought out. He had clearly been absorbing a lot of ideas discussed in previous weeks.

Charles also showed evidence of trying out new ways of dealing with difficult situations and in the groups was increasingly able to ignore attempts to draw him into horseplay. Over the weeks he became more able to make good links with the other group members without this element of horseplay and join in constructively with them in the group exercises and tasks.

With prompting and encouragement Charles was able to talk about his feelings in different situations and to reflect on how these influenced his behaviour. Continued sensitivity to his, as yet, tentative attempts to name and explore these feelings should help him develop greater self-awareness and thus gain greater control over his possible responses in difficult situations.

Charles might also benefit from more practice in how to initiate contact with other children without needing to resort to “fooling around” and in how to encourage other children when they attempt to build links with him.
FEEDBACK FROM NEW YEAR GROUP

Jodie attended the New Year Group, 9th January to 27th February.

The group aimed to help children to get on with one another and develop new skills in social situations.

Jodie attended all six of the group meetings.

When Jodie started to attend these groups she was already aware of some of the different ways she could help herself cope in difficult situations, but she sometimes found it hard to carry out these strategies consistently. Thus if someone was teasing her she could ignore them for a short time but found this difficult to carry on at length. As the weeks went on she increasingly used strategies to ignore or defuse difficulties, and thus not get involved in fights. She was able to remain friendly and enthusiastic despite sometimes having to cope with attempts to provoke her anger.

Jodie is an extremely deep thinking and bright girl who was an asset to the rest of the group in all the meetings. She was able to think carefully about how she felt in different situations and able to articulate this to others. She was also sensitive to how others in the group were feeling and behaving. She was good at making friendly approaches to others in the group, was always willing to join in activities and was particularly good at role plays, where her evident acting abilities were to the fore.

She would benefit from continued feedback on her skills in different situations, for example she responded well to encouragement to notice her use of body language e.g. looking people in the eye when she talked to them. She would also benefit from time being made available to think about how she feels in different situations, such as when people are making unkind personal comments, and from continued encouragement to persevere in trying out different strategies in difficult situations.
FEEDBACK FROM NEW YEAR GROUP

Peter attended the New Year Group, 9th January to 27th February. The group aimed to help children to get on with one another and develop new skills in social situations. Peter attended four of the six groups, missing two because of ill-health.

Peter came to the group with a sense that he had already tried a lot of different solutions and ideas, but felt quite hopeless at the possibility of any of them working. He felt it was not worth trying any more. He also appeared initially to feel that any assertiveness on his part was tantamount to aggression. This placed him in a dilemma as he wanted to avoid aggression at all costs whilst also wanting to stand up for himself more effectively.

The way Peter persevered in coming and trying out different techniques despite his sense of uncertainty about the benefits of the group was very impressive. In the groups was a helpful and committed member, who was well able to observe the rules and concentrate on the task in hand.

As the group progressed Peter started to tentatively practised new ways of carrying out old strategies. For example he role-played saying “no” in a number of different ways, such as “proudly” as opposed to “unhappily”. He found it challenging to try new ways of interacting with others but showed signs of progress, and was pleased with achievements he made. The fact that he missed two groups somewhat limited his opportunities to practice these skills in the group.

Peter was very open with the other members of the group and prepared to show his vulnerability. Whilst his honesty is commendable it may be that Peter would benefit from help thinking about where and when it was best to show his vulnerability. He should be encouraged to develop his awareness that he is in control of what he reveals to others.

It was to Peter credit that he persisted in making attempts to form connections with others in the group. He was good at making positive comments to others and at sharing, for example his pens, with them. He made good links with the other group members and became a valued member of the group.

Peter would benefit from continued encouragement to try new ways of presenting himself and to experiment with new strategies for coping with difficult situations. Continued support and praise for any attempts he initiates, together with promotion of his independent action in order to help him be assertive, will help boost his self esteem which is so vital to help counter the sense of despondency that sometimes feels so overwhelming for Peter.
ACADEMIC DOSSIER

In recent decades, there has been a significant increase in the number of children diagnosed with ADHD. In the USA, the number of children diagnosed with ADHD increased from 1.5 million in 1994 to 5.5 million in 2007, a 50% increase (Taylor, 1996). However, it is thought that this increase is due to better diagnostic tools and increased awareness among professionals (Taylor, 1996). This increase has led some to argue that ADHD is a cultural construct rather than a medical diagnosis (Fonseca, 1997).

In recent years, the dominant view of ADHD is that it is a disorder characterized by inattention, hyperactivity, and impulsivity. However, the basis for this conclusion has been questioned, and alternative theories have been proposed, such as the concept of a developmental disorder rather than a medical diagnosis (Fonseca, 1997).
Attention deficit and hyperactivity disorder (ADHD) has been called “the Diagnosis du Jour” (Bogas, 1997). It is a term that is used to describe children who do not attend, do not sit still and do not do what they are told. Between 3-6% of all school-aged children worldwide are estimated to be diagnosable as having ADHD using DSM IV criteria (Barkley, 1997). In the USA, it is estimated that 4.4% of all school-aged children are currently diagnosed with ADHD and being treated with stimulant drugs (Furm an, 1996). Historically, in Europe far fewer children have been diagnosed with ADHD and prescribed medication. In eight European countries (England, Italy, France, Germany, Norway, Sweden, Denmark and Finland), the sum of whose populations is similar to that of the USA (273,800 million to 245,100 million), fewer than a total of 6,000 children were receiving psycho-stimulants in 1994 (Furm an, 1996). However, it is thought that in Britain ever increasing numbers of children are being diagnosed as having ADHD and prescribed medication in response (Taylor, 1996). This had led some to argue that an “American epidemic called Attention Deficit Hyperactivity Disorder” is on its way over here (Furm an, 1996; Reid & Maag, 1997).

In the USA, the dominant view of ADHD is that it is a discrete diagnostic entity which is inherent to the individual and biological in origin (Tannock, 1998). Yet the basis for this conclusion has been challenged. Thus Reid & Maag (1997) comment, “Through literally thousands of articles, presentations, and exposure in the popular media, ADHD has been reified into a concrete physical disorder; although there is no conclusive (or in our opinion compelling) evidence substantiating this conclusion” (p. 11). It has been suggested that the growing use of this diagnosis, and the concomitant increase in the use of medication to treat it, is not based on growing knowledge about the organic bases of the
disorder, nor on the proven superiority of drug treatment over other approaches, but on a range of benefits that the diagnosis and prescription of medication provides for parents and professionals alike (Cooper & Ideus, 1995; Furman, 1996; Maag & Reid, 1997; Hinton & Wolpert, forthcoming). This review will look at the evidence for this argument.

The literature on the topic of ADHD grows daily. The Psychlit database lists over 1000 peer-reviewed articles published since 1990. A comprehensive review of all attempts to investigate ADHD is therefore not feasible. The large literature that examines the cognitive dimension of the disorder will not be reviewed for reasons of space (for a recent review see Tannock, 1998). This paper will focus on reviewing the recent research (carried out since 1990) into the possible biological bases of ADHD, and into the efficacy of current treatment options. It will also consider what alternative explanations have been offered for the current popularity of this diagnosis and for medication as the primary treatment of choice.

The following topics will be reviewed in turn:
1) issues in the classification of ADHD
2) methodological issues
3) evidence for an organic basis for ADHD
4) research into the efficacy of existing treatments for ADHD
5) the effects of a diagnosis of ADHD, and prescription of medication, on parents and professionals.

Classification of ADHD

At present, there are two main diagnostic systems that categorise children who do not attend, do not sit still and do not comply: DSM IV and ICD 10 (American Psychiatric Association, 1994; World Health
Organisation, 1993). DSM IV categorises a child as having ADHD, when that child displays the following behaviours: inattention, over-activity and/or impulsivity. For the diagnosis of ADHD, DSM IV presents a list of nine symptoms for deficits in attention and nine for hyperactivity. Any six in either category make possible a diagnosis of ADHD. These symptoms must have been present from early childhood, cannot be accounted for on basis of psychoses or pervasive developmental disorders and must be displayed at both home and school (Hinshaw, 1994). It has been pointed out that all 18 symptoms are of a totally subjective nature and that each could be aspects of a normal child’s behaviour (Furman, 1996). For example, included are: “makes careless mistakes” and “talks excessively”. No objective criteria are given for judging what constitutes “excess” in the latter case, or “carelessness” in the former.

The ICD 10 criteria for Hyperkinetic Disorder are less inclusive. The DSM IV definition has an either/or clause with regard to hyperactivity-impulsiveness or inattention, whilst ICD-10 require both to be observed. This means that while fewer children are identified using ICD-10, they tend to show more severe symptoms and to have a worse prognosis (Sergeant & Steinhausen, 1992). As with DSM IV, no objective criteria are given for judging the extent of a child’s “over-activity” or “impulsiveness”.

The DSM IV criteria are widely used in the USA and Canada, whilst ICD-10 definitions were more commonly used in Europe and the UK. However, the term ADHD is now in widespread use, and the DSM IV criteria are increasingly applied in the UK. It is a constantly evolving concept, as shown by the fact that in the last year the standard notation has changed from ADHD to AD/HD. Moreover, there has been an increasing interest in delineating different subtypes of ADHD. Based on factor analysis and empirical studies, symptoms of
impulsiveness and hyperactivity may be seen as being part of a single cluster and associated with greater risk of poor prognosis than symptoms of inattentiveness (Lahey et al., 1994).

Issues of categorisation are further complicated by the high degree of co-morbidity. Between 50%-80% of children diagnosed with ADHD also meet diagnostic criteria for other disorders (Jensen, Martin & Cantwell, 1997). The most frequently observed co-morbidity is with conduct disorders, although co-morbidity with emotional disorders and learning difficulties is also high.

ADHD, as defined by DSM IV, purports to be an a-theoretical symptom diagnosis. However, ever since Still (1902) first identified a group of children with "abnormal incapacity for sustained attention ...[and] restlessness, fidgetiness", and argued these behaviours were not due to child rearing, but to inherited or constitutional factors, issues of diagnosis have been interwoven with issues of aetiology. Thus, when Bradley (1937) found, by chance, that a psycho-stimulant, amphetamine, could reduce levels of hyperactivity and behavioural problems, this strengthened the belief in the existence of a distinct problem and in its biological basis.

In the 1950s and 1960s, the diagnostic category of "Brain Injured Child Syndrome" was introduced, and was quickly modified to the slightly more tentative form "Minimal Brain Dysfunction". This came to be applied to children with a wide range of behavioural and learning difficulties, who, in most cases, showed no sign of neurological damage. Dissatisfaction with this catch-all category led to a redefinition of these children based on their behaviour and not on supposed aetiology (Reid, 1995). An increasing belief amongst a number of researchers that inattention and not hyperactivity was the key feature (Douglas, 1992), led to the establishment of the Attention
Deficit Disorder category in DSM III (American Psychiatric Association, 1980).

Subsequent re-formulations have all been based on behavioural manifestations (currently focusing on inattention, impulsiveness and over-activity). Thus, whilst the diagnosis itself does not imply cause (it simply describes a group of children who do not attend, do not sit still and do not comply), it has always been interwoven with arguments about cause and treatment. The ascendant assumptions of the last decade has been that a diagnosis of ADHD implies a biological basis for the disorder (Milberger, Biederman, Faraone, Chen & Jones, 1996; Tannock, 1998), and that medication is the most crucial component of any treatment. It is the evidence for these assumptions that will be reviewed below.

Methodological issues

There are two main areas of difficulty that render problematic any conclusions based on existing studies into the possible aetiology of ADHD:

1) Problems of categorisation
   - differences in definitions
   The definition of ADHD has changed over the past decades and different countries have used different systems of categorisation (as discussed above): This makes it difficult to compare findings from different studies.

   - the problem of co-morbidity
   Often studies do not report on co-morbid diagnoses of children with ADHD, making it difficult to compare a given sample of children with ADHD with other sample groups in the literature.
2) Problems of research design

- lack of control groups

Few studies have included psychiatric comparison groups. Without such control groups, it is impossible to say whether the factors that differentiate children diagnosed with ADHD from non-diagnosed children are specific to ADHD or not. Where studies have included psychiatric controls they have often failed to corroborate the specificity of the suspected causal agents.

-the problems of interpreting correlations

Much research is cross-sectional, whereby a group of children already diagnosed with ADHD is compared with a group of children not diagnosed with ADHD in relation to a specific variable (e.g. brain abnormalities). Any variable that differentiates the two groups may be a consequence rather than a cause of the disorder.

Before going on to summarise the main findings of the research literature, one study will be reviewed in depth to illustrate how some of the methodological problems outlined above impact on its interpretation.

Milberger and colleagues (1996) set out to investigate the role of maternal smoking in the aetiology of ADHD. They studied a sample of 140 boys diagnosed with ADHD together with 120 “normal” boys (6-17 yrs). Based on maternal report they found that 22% of the children diagnosed with ADHD had a maternal history of smoking during pregnancy, compared with 8% of the non-ADHD sample. From this they conclude that maternal smoking may contribute to an increased risk of ADHD in the unborn child. Yet the methodological shortcomings in this study mean that it is hard to draw such clear conclusions.
The researchers do not address the issue of co-morbidity. All the children diagnosed with ADHD were recruited from child psychiatry clinics whilst the children without ADHD were recruited from paediatric clinics. Whilst children were excluded from the study if they had major sensorimotor handicaps (paralysis, deafness, blindness), an IQ of less than 80, autism or psychosis, no assessment was made of co-morbidity of other psychological disorder. Thus it may be that the children diagnosed with ADHD had a range of other psychological difficulties that differentiated them from the “normal” controls.

No psychiatric control group was included. Thus it is impossible to say whether the differences between the two groups reflect differences between children with a range of emotional and behavioural problems and those without, rather than being specific to ADHD.

The findings are essentially correlations between one variable (maternal smoking during pregnancy) and another (diagnosis of ADHD in the child). Some possible mediating factors were controlled for in the study - socioeconomic status, maternal ADHD, paternal IQ and paternal ADHD. However it may be that factors other than the effects of nicotine on foetus may explain the correlation found. It could be argued that the association is due to some intervening factor such as maternal mental state or levels of stress at the time of pregnancy and early childhood, which might influence both smoking behaviour and child-rearing practice. Alternatively it may be that maternal reporting of smoking during pregnancy is related in some way to having a child being seen at a child psychiatric unit. For example a mother distressed by her child's difficult behaviour and searching for an explanation may be more likely to admit to smoking during pregnancy than a mother without a child diagnosed as having ADHD.
In reviewing the research below the methodological issues raised above will be born in mind.

Evidence for an organic basis for ADHD

Efficacy of medication

Because medication (particularly the use of psycho-stimulants such as methylphenidate) has been found effective in helping children diagnosed with ADHD to attend better, it has come to be assumed that the underlying causes must therefore also be organic (e.g. Milberger et al., 1996). Yet this is a non sequitur: it is known that such medication will enhance most people’s ability to attend, concentrate or sit still, regardless of whether they “have ADHD” or not (Taylor, 1996).

Correlation with physical trauma

Taylor, Sandberg, Thorely and Giles (1991) found that perinatal problems (delay in starting breathing, jitteriness, seizures and the need for special care nursing) and developmental delay were more common in children with hyperkinetic disorder than in normal children or those with lesser degrees of attention deficit. This led them to argue that there may be a biological basis for the disorder. However, they did not compare degrees of trauma in children with other psychiatric diagnoses, nor did they allow for other factors that might mediate increased risk of trauma, such as parents with psychological problems or low socio-economic status.

Brain abnormalities in children with ADHD
In the last five years there have been an increasing number of studies that explored whether brain abnormalities exist in children diagnosed with ADHD. The most common measures used have been MRI scans and EEG recordings (Castellanos et al., 1994; Filipek et al., 1997). For example, Filipek et al. (1997) compared a group of 15 boys (mean age = 12.4 years) with 15 non-psychiatric controls (mean age = 14.4 years). They found that the right pre-frontal cortex was smaller in the boys diagnosed with ADHD. These findings are taken to support the theoretical model that abnormal frontal-striatal function may occur in children with ADHD (Barkley, 1997). However, they used non-clinical controls, and the difference may be accounted for by the age difference between the control group and the children with ADHD.

Electroencephalography (EEG) studies have tended to investigate a particular segment of participants' EEG pattern, known as their P300 wave. This is generated when an individual is attending to and discriminating a particular event, although its relation to cognition and behaviour is unclear. Children diagnosed with ADHD had longer P300 latencies than non-clinical controls, suggesting that completion of stimulus evaluation takes longer for individuals with ADHD (Klorman, 1991). However the results are variable. For example, Taylor et al. (1993) compared 32 children diagnosed with ADHD (mean age = 8.8 years) with 32 non-clinical children (mean age = 11.8 years). They found that the children with ADHD had more variable response times, but were not generally slower than the control group. Moreover, P300 abnormalities have been found in other disorders, such as schizophrenia and autism (Strandburg et al., 1994).

Thus, whilst these studies suggest there are some differences between children with ADHD and children without a psychiatric diagnosis, the specificity of this finding in relation to ADHD has yet to be established. Even if further studies, using children from a clinical population as a
control group, were to establish this specificity, the aetiological implications would remain unclear. Abnormalities in brain structure and function can occur as the result of genetic, hormonal or environmental factors - or, indeed, an interaction between them.

**Family aggregation studies**

There is evidence of a higher incidence of ADHD amongst first degree relatives of children with ADHD (Faraone & Biederman, 1994). This is true even when psychiatric control groups are used (Biederman, Faraone, Keenan, Steingard, & Tsuang, 1991). This has been taken as indicating a genetic, biological basis to ADHD. However, such familial clusterings could be understood in terms of shared environmental factors (such as shared culture or family relationships), rather than in terms of genes. Twin and adoption studies are then referred to, to help differentiate between the effects of these different factors.

**Adoption and twin studies**

One study compared 111 pairs of biologically related siblings with 221 pairs of unrelated siblings, as well as with a group of 94 adoptees with no siblings (Van der Oord, Boomsma, & Verhulst, 1994). Evidence of a strong genetic component was obtained: 47% of the variance in relation to parental ratings of attention problems on the Child Behaviour Checklist (Achenbach, 1991) was obtained, with no significant sibling interaction or shared environmental effects.

Twin studies of ADHD, using comparison of monozygotic (MZ) and dizygotic (DZ) concordance rates, have shown higher concordance rates for MZ than DZ twins,. From this it has been concluded that there is a large genetic component to ADHD. However this type of research assumes that the shared environment of MZ twins is not
greater than that of DZ twins. This assumption is likely to be an oversimplification, and may lead to erroneous conclusions about the relative importance of genetic and environmental influences (Plomin, Owen & McGuffin, 1994).

Sherman, McGue and lancan (1997) examined a community sample of 194 monozygotic twins and 94 dizygotic male twins (age 11-12) and found that concordance rates for ADHD were greater for MZ than DZ twins according to both mother and teacher report. However there were differences between the teachers and mothers in how they rated the children. Teachers’ ratings yielded moderate MZ (53%) and DZ (37%) concordance rates, whereas mothers’ ratings indicated a high MZ (67%) and zero DZ concordance for ADHD. This suggests that whilst genetic factors may have a role in the aetiology of ADHD rater bias effects may also be operative. They concluded that a model that included additive genetic and nonshared environment factors provide the best fit for their data.

Thus, there does seem to be some evidence of genetic influence - but what exactly is inherited remains obscure. It could, for example, be a tendency to inattention, or it could be a propensity to respond to familial stress with inattention. The suggestion, on the basis of these results, that there may be a single gene responsible for ADHD has not been validated in the literature. (Tannock, 1998). The fact that only 51% of MZ co-twins of ADHD probands will themselves have ADHD attests to the role of environment (Goodman & Stevenson, 1989).

**Summary**

Despite a large, and ever growing literature, the review above suggests that there is little conclusive evidence of a uniform underlying biological causal agent for ADHD. Yet the diagnosis is commonly seen
to presuppose a biological origin, and has led to the widespread assumption that medication alone is necessary to treat this condition (Reid & Maag, 1997). In reviewing the research into the possible treatment approaches, below, the extent to which this assumption is justified by the literature will be discussed.

**Efficacy of treatment for ADHD in children**

Psycho-stimulants have been the most studied form of intervention in the literature (Barklay, 1997). The use of methyl-phenidate has been found to result in immediate short term improvements in concentration and impulse control (Maag & Reid, 1994). However, the research literature suggests that medication should not be seen as a cure and should not be used in isolation without employing educational and behavioural strategies (Kewley 1995). It does not improve academic performance in the long-term, and there are known to be side-effects to medication for some children - including suppression of appetite, insomnia and lethargy (British Psychological Society, 1996).

Research suggests that medication plus psychological therapy is more beneficial than medication alone (Target & Fonagy, 1995). Satterfield, Satterfield and Cantwell (1981) looked at multi-modal treatment, compared with brief treatment and with stimulant medication alone, in a group of 6-12 year old hyperactive boys. The actual components of treatment were individually tailored and modified as necessary (reflecting clinical practice), and might include individual psycho-dynamic treatment, family therapy, parent training, social case work, group therapy or educational intervention. Families were treated for up to three years. It was found that longer treatment (at least two years), was associated with greater improvement on a variety of relevant measures of adjustment and behaviour. A later report (Satterfield, Satterfield, & Schell, 1987) carried out a nine-year follow up, comparing multi-modal
treatment with stimulant medication alone. They found that the group who had received multi-modal intervention were doing better on a wide range of outcome measures. For example, of the young adults who had been prescribed medication alone, 30% had at least two arrests for felonies. Only 7% of those who had received multi-modal intervention had the same level of arrests.

However, there is precious little conclusive research on which psychological intervention strategies are most effective with children diagnosed with ADHD. Cognitive therapy, in particular self-instructional training (Meichenbaum & Goodman, 1971) has generated the largest research literature, but the results remain disappointing, particularly for children under 11 years old (Dush, Hirt & Schroeder, 1983). Moreover, there appears to be a lack of generalisation of the skills learnt (Kendall, 1993). To date, the most promising interventions that have been researched have used behaviour therapy techniques focusing on the consequences of a child’s behaviour, using positive reinforcement, response costs and behavioural reduction strategies.

A review of 115 intervention studies (Fiore, Becker, & Nero, 1993) suggests that many different psychological approaches are being examined, including: behavioural modification (such as the use of positive reinforcement, behaviour reduction strategies and response cost and parent or family training), cognitive behavioural techniques (such as self-instructional training, problem solving, cognitive restructuring and social skills training) and environmental manipulation. However the effectiveness of these strategies appears to remain open to interpretation.

Summary

Research to date suggests that the use of medication may improve the symptoms of children with ADHD, but is not a “cure”. The reasons
why it helps remain debatable. Therapy alongside medication appears to be more effective than medication alone, but little is yet known of which psychological therapies to use. It would seem that increased diagnosis of ADHD and prescription of medication is not based on major advances in terms of treatment. Other possible explanations for the increasing popularity of the diagnosis will now be discussed.

The effects of diagnosis and prescription of medication

The conflation of the ADHD diagnosis with organic accounts of the cause of the difficulties, alluded to above, may be a significant factor in accounting for the current popularity of the diagnosis. In particular, the diagnosis seems to free parents and teachers alike from responsibility and blame for the child's behaviour - it has been called the "diagnosis of forgiveness" (Reid & Maag, 1997) - and it may unlock the door to powerful benefits for parents and professionals alike (Hinton & Wolpert, forthcoming).

For those diagnosed as having ADHD there may be important advantages. Cooper (1997) points out that notions of the stigmatizing nature of disability labels, and their use as instruments of social control and suppression, are increasingly anachronistic. ADHD sufferers are increasingly self-defined as a group. A diagnosis of ADHD is seen as a definition of a problem which frees the individual from being seen as morally responsible for their behaviour, and may also free the parents of children with such behaviours from blame for their child's behaviour (Furlong & Long, 1986). The development of parent and adult sufferer movements, such as CHADD (Children and Adults with Attention Deficit Disorder) in the USA and groups like LADDER in the UK, are a reflection of the way in which a diagnosis of ADHD can be seen as a basis for providing individuals with access to resources.
In particular, both of these groups have campaigned for increased access to pharmacological intervention for sufferers.

It may be that, once the ADHD label is attached, and medication prescribed, the parents feel relieved of responsibility for their child’s behaviour, and can also feel free to forgive the child for his or her “bad” behaviour. Evidence for this is provided by a recent study by Wright (1997), in which she interviewed 16 parents whose children had been prescribed Ritalin following a diagnosis of ADHD. She found that the response by the parents to a diagnosis of ADHD and the use of Ritalin was overwhelmingly positive. Several parents commented spontaneously that the diagnosis helped them to see their child as not "naughty" or "bad", and that they felt they themselves had been freed of blame by the diagnosis. The majority of parents stated that they wished a diagnosis had been made earlier. “We felt we were on trial until proven innocent” one parent reported (p. 54).

No evidence exists as to how children perceive the diagnosis of ADHD or the use of Ritalin.

For the diagnosing health professional, the diagnosis of a specific disorder may seem to provide a tidy encapsulation of an array of difficult behaviours that are hard to work with. By diagnosing ADHD, the professional may feel gratified at being able to present him or herself as an “expert” in possession of the correct technical knowledge, and by being able to provide the “forgiveness” which the parents so often crave. There may be implications for medical professionals in particular in respect of power gains to be made (Cooper & Ideus, 1995). Also, reaching the diagnosis of ADHD operates for the professional as the gateway for prescription of drugs which may help children enormously - a fact which itself may be assumed by all concerned to confirm the “accuracy” of the diagnosis.
For teachers, again there may be a number of reasons why ADHD has become such a popular label. In a manner similar to parents, teachers may feel less blamed when this diagnosis is provided, for then it may seem that it is not their teaching or classroom management that is central to the difficulties presented by the child, but the child's own condition that is causing the problem. The label can be seen as a way of explaining to others both inside school and in the outside world that the child's difficulties are separate from, not caused by, any aspect of the school environment.

There may be other powerful groups that benefit from increasing use of the diagnosis of ADHD. It has been remarked upon that the manufacturers of Ritalin provide cash grants and in-kind services to support groups such as CHADD (Furman, 1996). The manufacture of such drugs is, of course, a multi-million dollar industry. A significant proportion of the income of the American Psychiatric Association is derived from its publications, prominently including the sales of the DSMs as well as its professional journals, extensively supported by advertising by the pharmaceutical industry, as reported in the Associations Psychiatric News (1995).

**Conclusion**

It would appear that the current beliefs that a diagnosis of ADHD implies the existence of an underlying organic problem, and that medication is a "cure", are not based on the research literature. It does appear that in our current culture the diagnosis of ADHD, and the subsequent prescription of medication, confers a range of advantages upon parents and professionals alike, although the advantages to the child remain less clear. It is these advantages for parents and
professionals that may account for the growing use of this diagnostic category, and of medication to treat children once diagnosed.

The increasing numbers of children being given the label of having ADHD, and being prescribed medication, in relation to behaviour which is as yet little understood, may mean that a number of children are being treated inappropriately. In the light of our current state of knowledge, one way forward that has been suggested is to replace a diagnosis of ADHD with a functional analysis (Maag & Reid, 1996). Such an approach involves detailing individual-specific deficiencies within the child and within the environment, that interfere with the production of socially appropriate behaviour. Such an approach renders diagnosis irrelevant. It makes explicit the implicit tautology inherent in the current diagnosis, namely that it simply describes a range of difficult behaviours. This would not rule out the possibility of medication, but the reasons for it would have to be clarified with the family (e.g., that it limited motoric activity rather than it was seen to rectify a known organic imbalance).

However, such an approach would not provide the benefits identified above as currently accruing to parents and professionals following a diagnosis of ADHD. If clinical work is to advance in this area, it may be that these benefits have to be recognised and families, for example, have to be freed from blame in some way, without the necessity for an intervening diagnosis. If the argument advanced above is correct, it indicates that clinicians may need to be more attuned to the issues of blame and exoneration in therapy generally. In seeing children where the possibility of ADHD has been raised, causal explanations must be disentangled from the application of the category “ADHD”, and issues of possible aetiology should be separately explored with the family. Until this is carried out, parents with children with these sorts of difficulties may well feel that one of the only ways they can escape
being blamed is by a diagnosis of ADHD for their child. Only when a non-diagnosis of ADHD is no longer seen by parents as implying a diagnosis of blame in relation to them, is there likely to be an opportunity to explore more fruitful ways to assess and help children who do not attend, do not sit still and do not comply.

References


Literature review of factors affecting drop out from treatment in child mental health services

The degree of the problem

Research, primarily carried out in the United States, indicates that between 40-60% of all children who enter treatment leave “prematurely” - that is, without prior agreement with the treatment providers - and do not return within that clinical episode (Kazdin, 1996). Studies conducted in Britain suggest a similar pattern of drop out. Cottrell, Hill, Walk, Dearnaley and Lerotheou (1988) studied 100 consecutive cases referred to a child mental health team and found that 63% dropped out of treatment. Thomas and Hardwick (1989) in their audit of 112 cases referred to a child guidance clinic found that 11% never attended, 21% attended once and 23% attended twice.

Drop out from therapy can be seen as one of a number of ways that children are “filtered” out from receiving mental health care (Wolpert & Fredman, 1994; 1996.). Epidemiological studies in Britain suggest that between 7-14% of children in the general population have psychological problems severe enough to warrant referral for psychological help (Richman, Stevenson, & Graham, 1982; Rutter, Tizard, Yule, Graham, & Whitmore, 1976). Yet only a tiny percentage of these are ever seen by mental health professionals (9-10%) (Richman et al., 1982; Rutter et al., 1976). Of these, 40-60% drop out of treatment (Kazdin, Holland, Crowley, & Bretton, 1997). Thus the vast majority of children identified in epidemiological surveys as in

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1 I have been unable to find any figures relating to how many of these clients return to therapy at some later date, either within the same service or to a different service.
need of psychological help, either are never offered treatment by mental health professionals, or do not complete treatment once begun.

The nature of the problem

Dropping out of treatment has sometimes be taken as synonymous with treatment failure (see Kazdin, 1996 for a discussion of this issue). Yet, to assume that all patients that drop out of treatment are failures is to be guilty of “Clinic-centrism” (Ambruster & Kazdin, 1994). Clients who drop out need not necessarily be seen as treatment failures, but may indicate that the client’s goals, as opposed to the therapist’s, have been met (Viale-Val, Rosenthal, Cirtiss, & Marohn, 1984). Nor can it be assumed that clients who drop out necessarily view the service negatively. Farley, Peterson and Spanos (1975) found that that 88% of families who had dropped out of treatment, when contacted, said they would recommend the service to others.

However, even in the light of the above, drop out from services can be seen to be a serious problem for the following reasons:

• those who drop out are less likely to improve than those who remain in treatment (Kazdin, Mazurick, & Siegel, 1994; Prinz & Miller, 1994; Santisteban et al., 1996; Szapoczhik et al., 1998)

• there may be a high cost in terms of remediable morbidity (Emison, 1986). Children who drop out of outpatient treatment may be more likely to end up receiving in-patient care. Outpatient services that maintain children in their own homes may be preferable to the more costly alternative of hospitalisation (Schaefer & Swanson, 1988). Reducing attrition rates in outpatient services may have a preventative function in addressing clinical issues before a crisis is precipitated, leading to hospitalisation.
• dropping out of treatment increases the costs of providing the clinical service and reduces the efficiency of the service (as appointments are missed that could have been occupied by someone else) (Larsen, Nguyen, Green, & Atkisson, 1983).

• clients who drop out of treatment are frequently experienced by staff as evidence of personal failure and may contribute to low staff morale (Novick, Benson, & Rembar, 1981).

• High drop out rates can jeopardise research findings. Since the purpose of research is to draw experimentally valid inferences about the intervention, the loss of cases can affect that interpretation of results in terms of group differences (Armbuster & Kazdin, 1994).

The extent of research

Drop out from adult services has received considerably more attention than drop out from child services. It has been estimated that only 1-2% of all studies of drop out focus on children and adolescents (Pekarik & Stephenson, 1988).

The factors most studied, as potentially affecting drop out rates in child services, have been those related to characteristics of the referred family, although some characteristics of the child and of the service have also been looked at (Armbuster & Kazdin, 1994). Only in the last decade has there been the beginnings of interest in looking systematically at process factors in relation to service uptake in child services. In particular, Kazdin et al., (1997) have recently proposed a model of treatment uptake that conceives families as facing multiple barriers that may impede participation in treatment. These barriers include factors arising from: the characteristics of the family, the
service and the therapeutic process. Kazdin argues that it is important to start to consider the way these factors might interact with each other, cumulatively or otherwise, if a more sophisticated model of drop out from child mental health services is to be achieved.

Reviewing the literature on this topic will involve:
1) an analysis of the difficulties of carrying out research in this area
2) an overview of what the literature, since 1980, suggests are the factors that influence drop out after being seen on at least one occasion
3) a review of studies of clinical initiatives designed to reduce drop out rates.

Difficulties of research into drop out

Defining drop out

Differences in definitions of what constitutes “dropping out” of treatment make it hard to compare between studies. A “drop out” can be defined as anyone who leaves therapy at any point between an initial referral, assessment and treatment. Different researchers have adopted different criteria for determining when a child is said to have dropped out of treatment. Garfield (1989) defines drop out as withdrawal from treatment after one or more therapy sessions. He terms those who complete an “evaluation” but do not proceed with therapy as “refusers”. However a clear demarcation line between assessment (or “evaluation”) and treatment is often not made in clinical practice, particularly when a psychodynamic or family systemic approach is being taken. Cottrell et al. (1988) differentiate

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2 1980 is taken as a cut off point because it was felt that studies before that point often related to service structures and populations far removed from those currently operating.
between "non-attenders" (those who were offered an appointment but did not appear), "immediate drop outs" (those who attended once), "late drop outs" (those who attended more than once) and "agreed discharges" (those who continue or complete therapy).

Different researchers have also taken different stances on how the reasons given for termination of therapy influence whether a child is deemed to have "dropped out". Access to services for children is almost invariably mediated by adults - principally their primary carer. Thus a child "dropping out" of treatment cannot be taken to reflect the wishes of the child themselves. A child not continuing with therapy is generally the result of behaviour on the part of an adult. On the whole, parents do not inform the therapist that they are "dropping out" of treatment - the decision is inferred by the therapist based on the family repeatedly not attending treatment appointments. However, when families do inform therapists of their reasons for stopping, researchers vary in how they treat this information. For example, Richmond (1992) excludes families from drop-out status if their premature termination is for such "logistic reasons" as moving out of town or conflicts with work schedules. However, this begs the question of what qualifies as a logistic reason and assumes the lack of such reasons where there has been no communication with the service.

Comparing between samples

The usefulness of studies that look at drop out is limited because of difficulties comparing results garnered from different clinical populations. In assessing the relationship between socio-demographic factors and drop out, for example, it is difficult to compare a study of a relatively homogenous inner-city clinic (Gould, Schaffer, & Kaplan, 1985) with a study of multiple urban and rural clinics (Weisz, Weisz, & Langmeyer, 1987).
Differences between studies in terms of the age groups of the children looked at, or the types of presenting problem explored, are rarely addressed when the results of different studies are explored.

Differences in services may also make it hard to compare between studies. Services vary as to how to differentiate between “assessment” and “treatment” and how many sessions need not to be attended before the family is not offered further appointments and is deemed to have dropped out. Services also vary in terms of the explicitness with which it is decided whether families should or should not come back. For example, it is relatively common practice in family therapy to offer the family a further appointment, but to say they can cancel it if they wish. If they do not attend but do not cancel, should this be counted as drop out or termination by consent? Often, differences in referral and intake procedures are not reported in the studies (Armbuster & Kazdin, 1994).

The problems of correlation

Much of the research in this field looks for correlation between the independent variable (drop out) and a dependent variable (e.g. socio-economic status). All too often, if a correlation is found, it is assumed that the dependent variable causes variation in the independent variable. Yet variables that might show differences are not to be confused with underlying processes. For example even if socio-economic status were found to differentiate consistently between those who drop out of treatment and those who do not, such a finding would not explain why this should be the case. Processes associated with class (such as child-rearing practices, difficulties in transportation, clash of belief of a given class with those who provide treatment) all
need to be identified, and their role in contributing to the finding explored.

One paper will be looked at in depth to highlight some of the methodological issues that make research into this area so difficult. Weisz, Weisz and Langmeyer (1987) sought to explore whether children who dropped out from child psychotherapy differed from those who stayed in treatment. They examined 304 children and young people (6-17 years) each referred to one of nine mental health clinics. One hundred and sixty six children dropped out of therapy and 138 completed therapy. The groups were compared on demographics, on Child Behaviour Checklist scores, on Depression Inventory scores, on therapist age and sex and on parent perception of the clinic and of the child. No reliable group differences were found from which the researchers conclude that there may be no difference between “dropouts” and “completers”.

In this study “dropouts” were defined as cases where the children and their families had completed an intake procedure but had not appeared for any sessions after that. Other researchers have termed this group “refusers”, limiting the term “dropouts” to those who undertake at least one session of therapy and then do not come back (Garfield 1989). This makes it hard to compare the results of this study with those of other studies which did find significant differences between drop outs and completers but which used different definitions of what constituted drop out (e.g. Kazdin et. al 1997).

The children in the study ranged in age from 6-17 years and were assigned to a total of 61 different therapists in nine mental health clinics, four located in urban districts and five in rural locations. The researchers suggest that this diversity helped insure that the finding did not reflect idiosyncratic characteristics of any single therapist,
However it also means that factors pertaining to drop out in a particular clinic or in relation to a particular therapist will have been lost. The large age range means that any differences in reason for one age group dropping out of treatment as opposed to another may be obscured.

This study highlights the difficulty of drawing any conclusions that are likely to apply to all children and families regardless of age, locality or problem type and indicates the need for more specific studies that explore how the complex interaction between child, family and clinic factors contribute to affecting uptake of service.

In reviewing the research findings below, attention will be paid to the methodological limitations that make these studies so hard to interpret and compare.

Factors associated with drop out from child mental health services

Family characteristics

Attempts to understand who drops out of treatment, and why, have traditionally focused on characteristics of the family. The following family factors have been investigated:

i) Socio-economic status of the referred family

Some studies have suggested that families with lower socio-economic status may be more likely to drop out of treatment than those with higher socio-economic status (Kazdin, 1990; Kazdin, Mazurick & Bass, 1993). However, several studies have found no relation between socio-economic status and dropping out (Gould et al., 1985; Weisz et al., 1987). Some studies have found that higher socio-economic status predicts drop out (Singh, Janes, & Schectman, 1982). The pattern of
results across these different studies suggests that the impact of socio-economic status may vary with the point of drop out. For example, one study noted that more of the higher socio-economic families of adolescents referred for psychodynamic psychotherapy kept initial appointments, compared to lower socio-economic families, but that fewer higher socio-economic status families remained in treatment once begun (Viale-Val et al., 1984).

Even if it were to become possible to tease out the differential way in which class affects service uptake at different points, the mechanisms which lead these factors to predict drop out would remain unclear. Socio-economic disadvantage is associated with a range of factors that may themselves be the causative agent - difficulties accessing transport to the clinic, more severe child and adult physical and mental health problems, and parent expectations likely to be discrepant with those of the clinic staff (Kazdin et al., 1997). These characteristics, alone or in combination, might be the basis for dropping out that underlies low socio-economic status as a factor.

**ii) Ethnicity**

Minority groups have been found to have significantly higher rates of drop out from therapy than non-minorities, in some studies (Novick, Benson, & Rembar, 1981; Viale-Val et al., 1984). However other studies found no association between ethnicity and drop out (Pekarick & Stephenson, 1988; Singh et al., 1982; Weisz et al., 1987). Ethnicity may affect drop out differently at different phases of treatment. Viale-Val et al. (1984) found that black families dropped out of treatment more frequently than white families, but that white families were more likely not to attend their first appointment than black families, when socio-economic status was controlled for.
Where differences have been found between ethnic groups in relation to drop out, these may not be due to minority status per se, but rather may reflect a mismatch of services or reflect an incompatibility of cultural/ethnic views between those who receive and those who provide services (Cheung & Snowden, 1990). Flaskerud (1986) found that ethnic/racial differences between clinician and client, and location of the agency outside the ethnic/racial community, all predict drop out. In addition to issues of differences in language and general culture, there may be specific issues in relation to beliefs about therapy. Ethnic communities may feel it is particularly shameful to seek psychological help, or may feel it is more appropriate to seek the help of traditional or ethnic medicine (Yeh, Takeuchi, & Stanley, 1994).

iii) Family composition
In the majority of studies that looked at this issue, single parent families have been found to be more likely to drop out (Cottrell et al., 1988; Kazdin et al., 1993 and Novick et al., 1981). Where the referred child is under five, families with larger numbers of children may also be more likely to drop out than families with smaller numbers of children (Pekarik & Stephenson, 1988). Whether these results reflect the fact that these families face greater physical barriers to accessing treatment than other family types, or some other mechanism, has not been determined.

iv) Parental attitudes to treatment
The majority of studies have concluded that a crucial factor in treatment uptake is the parents' positive attitude toward, and motivation to participate in, therapy (Cottrell et al., 1988; Pekarik & Stephenson, 1988; Singh et al., 1982 and Viale-Val et al.,1984). However, very different means have been used to measure this factor.
Kazdin et al. (1997) - using a questionnaire that assessed parents’ perceptions of factors that prevented them attending therapy: “Barriers to treatment participation scale (BTPS)” - found that the perceived relevance of treatment was the domain that distinguished most clearly between completers and drop outs. However, when Mason, Watts and Hewison (1995) looked at parents’ views and expectations of therapy - by sending out questionnaires to all first time outpatient referrals to a psychiatrist, asking, among other things, whether they agreed with the referral to see a psychiatrist - attendance was not predicted by whether the parent thought the child should be seen by a psychiatrist or not.

The differences between these two studies may be accounted for by the fact that Mason et al. asked parents prior to therapy for their views, whilst Kazdin et al.. asked them at the end of therapy. Thus, the BTPS could be seen to be measuring not so much the parents’ attitudes to therapy generally, but their response to the particular therapy they had received.

v) Parental stress and mental health difficulties
Parental stress has been found to be associated with higher rates of drop out (Kazdin, 1990a). When ten life events were recorded in one study, divorce one year prior to referral predicted drop out (Novick et al., 1981). Severity of parental mental health problems has been positively associated with drop out rates in some studies (Gould et al., 1985), but not in others (Kazdin, 1990a; Singh et al., 1982).

Child characteristics

i) Age of child.
Despite the fact that clinicians frequently report that adolescents are more likely to drop out of treatment than either children or adults, this is not borne out by the research findings (Gould et al., 1984; Viale-Val et al., 1984). Age has not been found to be a predictor of drop out (Weisz et al., 1987).

**ii) History of previous psychiatric treatment**

The majority of studies that looked at this issue found that previous psychiatric treatment of the child was associated with low rates of drop out (Viale-Val et al., 1984). However, when phase of treatment was taken into account, adolescents with no previous psychiatric treatment were more likely to drop out during the assessment phase, while those with previous treatment were more likely to fail their first appointment or drop out during the treatment phase (Viale-Val et al., 1984). One study found no association between previous treatment and drop out rates (Pekarik & Stephenson, 1988)

**iii) Severity of child’s symptomatology**

Some studies have found that children with more severe conduct disorder and delinquent behaviour have been found to be more likely to drop out of treatment prematurely than those with less severe difficulties. (Kazdin, 1990b). Other studies have not found a relationship between drop out and severity of problems (Gould et al., 1985).

**iv) Child’s attitude to treatment**

Few studies have examined the referred child’s attitude to treatment. One study that did attempt to explore this issue in relation to adolescents referred for individual psychotherapy, rated the adolescents’, and/or their parents’, attitude in a pre-meeting telephone contact (Viale-Val et al., 1984). A negative attitude was
judged to exist when the adolescent and/or parent “denied the problems” and did not “acquiesce” in the recommendation for treatment (p. 586). A negative attitude to treatment was found to relate to increased risk of drop out. The researchers do not report how the reactions were rated, nor whether inter-rater reliability was established. Nor do they report in how many cases it was the adolescent themselves that was spoken to, and in how many cases it was their parent. Given these limitations in methodology, no firm conclusions can be drawn on the basis of this study.

Service characteristics

i) Referral source

Findings from studies relating to referral source have been contradictory. Some studies have noted a positive correlation between referral by a school and drop out from treatment (Gould et al., 1985). Others have found that parental self-referral has been found to predict dropping out of treatment (Singh et al., 1982). Yet others have found no relationship between referral source and dropping out (Cottrell et al., 1988; Garber & Tornsciolo, 1990; Pekarik & Stephenson, 1988).

The contradictory findings in relation to the impact of referral source on drop out rates have been explained in a number of ways. One suggestion is that this variable interacts with other factors (as yet unidentified). Consistent with this view is the finding that a history of parental mental health problems in combination with a school referral predicted increased drop out rates (Gould et al., 1985).

ii) Type of treatment offered

The pattern of findings in relation to the effect of treatment factors on drop out is unclear. Patients seen more frequently than once a week have been found to be less likely to drop out of treatment (Viale-Val et
al., 1984). However, other studies found modality unrelated to attrition (Pekarick & Stephenson, 1988).

**iii) Locality of clinic**
Living further away from the clinic was found to be associated with dropping out of treatment by Novick et al. (1981). However, other studies have found no relationship between distance and attrition (Weisz et al., 1987).

**iv) Professional background of therapist**
This issue has been little studied. What research there is found that psychologists and social workers in one clinic had much lower drop out rates than psychiatrists in the clinic (Pekarick & Stephenson, 1988). However, this may have reflected differences in caseload as much as differences in approach.

**Process factors**

**i) Congruence between family and therapist views**
Families are most likely to continue to attend clinics if there is good matching of the families' expectations with clinic expectation (Burck, 1978; Cottrell et al., 1988). Mason et al. (1995) looked at parents' views of the nature of the problem compared with therapists' views in relation to treatment uptake. They coded view of the main problem into eight descriptive categories. Therapist and parent were treated as having congruent views if their view of the problem fell into the same category. It was found that there was higher attendance where views were congruent, but that this was not statistically significant (77% vs 59%).

**ii) Positive therapeutic alliance**
Poor therapeutic alliance has been implicated in premature
termination among adults (c.f. Mohl, Martinez, Ticknor, Huang, &
Cordell, 1991), but little studied in relation to children (Green, 1996).
A number of suggestions have been made by clinicians about how
therapeutic alliance, or "engagement", may influence service uptake.
In particular, it has been argued that the degree to which parents feel
blamed or criticized by therapists may influence the likelihood of their
remaining in therapy - the more blamed they feel, the more likely they
may be to drop out (Reimers & Street, 1993). However this has not
been empirically tested.

A recent attempt to study the relationship between therapeutic
alliance and therapeutic outcome in outpatient child psychiatry found
that there was a positive association between the two (as measured by
questionnaire responses). However, no attempt was made to look at
drop out in relation to therapeutic alliance (Green, 1996).

The contribution of the different factors to drop out rates

Kazdin et al. (1997) carried out a study of 260 children referred for
outpatient cognitive-behavioural treatment for conduct disorder.
Multiple characteristics, known from prior research to predict poor
participation in treatment were assessed at intake. Participation in
treatment (7-10 months as pre-agreed with families at the outset of
treatment) was evaluated continuously over time, until families
dropped out or completed treatment. At the end of treatment, parents
and therapists were assessed by independent raters using the
"Barriers to treatment participation scale" (BTPS). This questionnaire
asks about four principal types of barrier: stressors and obstacles that
compete with treatment; treatment demands; perceived relevance of
treatment; and relationship with therapist.
The results indicated that, where the parents perceived treatment as irrelevant to their needs, saw themselves as having a poor therapeutic alliance with their therapist and perceived themselves as experiencing multiple stressors during therapy (as rated by either the parents themselves or their therapist), that family was more likely to drop out of treatment than families with low scores on these dimensions. Scores on the BTPS were not so highly correlated with measures of family and child factors, or critical life events, as to indicate that the relationship between scores on the BTPS and drop out can be explained in terms of these other factors alone.

There were several limitations to this study. Only families of children with conduct disorder were included. These families are characterised by high rates of clinical dysfunction, socio-economic disadvantage and multiple sources of stress (Kazdin, 1995). Thus, the findings cannot necessarily be assumed to apply to other populations of families. Moreover, as discussed above, the BTPS was administered at the end of therapy, and thus may have reflected the justifications of those who had decided to terminate prematurely. However, even with these limitations in mind, it would appear that parental perceptions of therapy and the therapeutic alliance may affect drop out rates, in addition to characteristics of the family or service.

Relatively few studies have as yet investigated whether intervening on any of these dimensions promotes staying in therapy. Those studies that have been undertaken will be reviewed below.

Clinical initiatives to try to reduce drop out rates

Providing ethnic-specific services
Yeh et al. (1994) compared drop out rates after the first session for Asian-Americans (n = 489) seen for out patient treatment in mental health centres especially designed to meet the needs of the Asian community with drop out rates of Asian Americans (n = 423) seen in mainstream mental health outpatient services. The ethnic specific services consisted of four services that had been set up to meet the needs of ethnic minorities. The study found that clients seen at ethnic specific services were five times less likely to drop out after a first session than those seen in mainstream services. This was true even when demographic differences in the two groups (such as age of child and level of functioning at admission) were controlled for.

Yeh et al. note that these results need to be treated with some caution. The centre type variable is a complex one, and it is not possible on the basis of this study to determine what factors were responsible for the results. Yeh et al. focus on ethnic matching between therapists and parents as a likely factor. However, it may be other factors are involved. For example, the staff at the specific centres may be more enthusiastic, more committed or better trained than the staff at mainstream centres - these factors were not studied. Also the children were not randomly assigned to the centres. Although some variables were controlled for (age and diagnosis), it is not possible to assume that the populations did not differ in some other significant way (such as attitude to therapy).

Changing family expectations of treatment

Prinz and Miller (1994) looked at 147 families of boys (aged 4-9) with conduct problems. They randomly assigned families to standard family therapy focusing exclusively on parental management, or to an "enhanced" family treatment that also promoted frequent discussion of
adult issues (e.g. job stress, personal worries, family issues). The combined treatment led to significantly less attrition than parent training alone (29% vs 47% respectively).

The aim of this study was to test the assertion that parents’ tacit expectations of the treatment process critically affect drop out from social learning family treatments. The enhanced family treatment was supposed to provide “greater attention to parents’ tacit expectations about the treatment process” (p. 645). However the results are confounded by the fact that the enhanced treatment could alternatively be characterised as providing therapy for parents alongside family therapy.

Improving the therapeutic alliance

Whilst there have been a number of successful efforts to develop interventions to reduce attrition rates in adult psychotherapy by improving the therapeutic alliance (Kournay, Garber, & Tornusciolo, 1990), few controlled studies have been undertaken which examine whether clinical interventions designed to improve therapeutic alliance are related to reduced attrition rates in therapy with children and families.

Szapocznik and colleagues have developed intervention techniques within the conceptual framework of brief strategic therapy (Minuchin 1974) for use with Hispanic families of adolescent drug-users, in an attempt to increase the numbers of those who completed treatment (Szapocznik et al., 1988; Santisteban et al., 1996). Special engagement techniques include early contact by phone in which each member of the family was spoken to, potential obstacles to attendance are discussed and tasks for different members were set. The special engagement condition was compared to the usual clinic procedure in
two randomised trials. The results of the first trial indicated that many more cases that received the special engagement procedure completed treatment (75% vs 25%) (Szapocznik et al., 1988). However, the results of the second, larger, trial indicated that, whilst families in the special engagement condition were more likely to attend the first appointment, they were no more likely to complete the treatment than those in the control group (Santisteban et al., 1996).

Conclusions

Researchers have concentrated largely on characteristics of families that may affect drop out, such as socio-economic status, ethnicity and parental attitudes to therapeutic intervention. The findings of these studies are often inconsistent, and are hard to interpret because of the methodological and conceptual limitations of the research. Rather than look at global characteristics, such as “socio-economic status” or “ethnicity” of families, it appears more advantageous to unpack the range of factors that may account for the correlation sometimes found between these characteristics and drop out rates. Whilst the limitations of Kazdin’s model of the “Barriers to treatment participation” have been noted above, such an approach does provide a useful way forward to examine how a range of factors interact to prevent children receiving the full range of help on offer from child mental health services.

What is needed now is more detailed investigation of what processes in therapy may relate to drop out. In particular, the role which the therapeutic relationship may play in determining drop out rates would appear to warrant further investigation. Research that analyses attempts to reduce drop out rates, suggests that interventions that
enhance the therapeutic relationship may sometimes be efficacious in reducing premature termination from treatment. Further controlled studies need to be undertaken.

The clinical implications of the literature are that it may be important to develop services that take into account the potential barriers to participating in therapy that face families referred for help. Possible ways to enhance the family-therapist relationship, in order to reduce drop out, include: the establishment of services that are designed to relate to the specific needs of a given community; greater explicit interest in what families want and fear from therapy at the outset of treatment and increased contact with families prior to the start of treatment; possibly by phone. It is likely that only by developing innovative ways to improve the relationship between clinicians and the families they seek to help can the maximum number of children come to benefit from the range of services on offer from child mental health provision.

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This study investigates whether specified child characteristics (sex, type of problem and age of child), parent characteristics (social class and ethnic group), and referrer characteristics (length of experience and type of practice of GP), influence the referral decisions of parents and professionals. 211 parents, 36 GPs and 38 clinical psychologists completed questionnaires containing descriptions of different children exhibiting a variety of psychological symptoms. Subjects were asked questions about their likely response to the child described in the vignette. These questions were designed to elicit information about attitudes and behaviours related to the referral process.

Results suggested that age of child and type of problem presented significantly affected subjects' responses, whilst sex of child did not. Ethnic group of parent significantly influenced their responses, whilst their social class did not. Years of experience of GP and type of practice significantly influenced GP responses. The main findings were: psychologically disturbed 10 year olds may be more likely to reach child mental health services than psychologically disturbed 3 year olds; children presenting with conduct disorder cause more concern to their parents than those with emotional disorder; Asian parents are less worried about psychologically disturbed children than European parents and GPs with less than 10 years experience are more likely to refer a child immediately to a mental health professional than those with more than 10 years experience. The implications of the results for an understanding of the referral process are discussed, and suggestions for clinical practice and further research are put forward.
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INTRODUCTION

1.1. Purpose of study

This study investigates factors influencing the referral of pre-pubertal children to psychological services. Children reach mental health services after many stages in a referral process. First, their parents or carers have to decide that they are concerned enough about a child's behaviour to consult a professional. This professional must then decide whether or not to refer on to a mental health specialist. Selective bias could occur at any stage of this referral process. This study is intended to shed light upon the factors which might influence the ultimate referral of children to mental health professionals. A finding of systematic biases influencing referral would have important implications for service planning and provision.

1.2. Modelling the referral process

1.2.1. Goldberg and Huxley's model of the referral process.

Goldberg and Huxley (1980) have developed a model to depict the different stages that must be passed through before an adult attends psychiatric services. Their model consists of five levels, starting with the population of psychiatrically disturbed individuals in the community and going through to the population of patients in inpatient psychiatric care. (See Figure 1, p.2).
Goldberg and Huxley point out that in order to pass from one level to another it is necessary to pass through a "filter". A filter can be thought of as the route that connects one level of care with another. For example, the route between level 3 and level 4, (see Fig.1), is via referral by a GP to psychiatric services. They argue that each route or filter is selectively permeable, so that some individuals are more likely to pass through than others, and suggest that the key people in deciding who shall pass through are the patient and the family doctor.

1.2.2. Adapting Goldberg and Huxley's model to the referral of children

Goldberg and Huxley developed their model in relation to adult psychiatric services only. The present research applies and adapts this model to help conceptualise the stages involved in children's "pathways to psychological care" (See Fig.2, p.3).
Each stage in this adapted model will be described below to highlight the salient points.

Level 1: Children with psychological problems in the community

It is clear that there is a large discrepancy between estimated prevalence rates of childhood psychological problems based on community surveys, and the numbers of children actually seen by psychologists and other mental health professionals. In population studies, such as that carried out by Richman et al. (1982), 14.3% of 3 year old non-immigrant children in a London Borough were judged to have behaviour problems severe enough to warrant referral to child mental health services. Yet at follow-up, aged 8 years, only 9% of the original children identified
as the "problem group" had been taken by their families to child guidance services because of concern about their behaviour, and in most of these cases contact had been brief and for assessment purposes only.

Similarly in Rutter's Isle of White Study (1976), of the 7% of 10 to 12 year olds judged to have psychological problems severe enough to cause them social handicap, only 1 in 10 were actually under psychiatric care, and the majority were receiving no help whatsoever.

Given these high levels of discrepancy surprisingly little research has been carried out to look at what factors determine which children receive psychological help and which do not.

Level 1a: Children with psychological problems who have aroused parental concern
The child's parents can be seen as playing a key role in deciding which children pass from the population of disturbed children in the community to those who are eventually seen by a mental health professional. Thus it was thought necessary to add level 1a, parental concern, to Goldberg and Huxley's original model.

Research suggests that a prime discriminating factor between referred children and non-referred controls is parental anxiety and desire for help rather than any simple correlation with the severity of symptom (Bailey and Garralda 1989). Levels of parental concern and the wish for professional help may themselves be determined by the severity of the child's behavioural disturbance, but they may also be affected by other factors, such as the parents view of the efficacy of psychological services, their cultural and socio-economic background and their previous experiences. Thus it is important to be aware of parent variables in looking for factors influencing referral of children with psychological problems.
Level 1b: Children with psychological problems who have elicited the involvement of a professional

Primary health care and non-medical professionals play a central role in the referral of children. The G.P. is not invariably the first professional contacted, as is implied to be the case in Goldberg and Huxley's model for adult pathways to psychological care. Thus level 1b, involvement of professional, is included in the revised model. For example, the significant influence that teachers exert on parental decisions to seek child mental health consultations has been well demonstrated by Lurie (1974). In their recent study of parental consultations to GPs about child behaviour problems, Bailey and Garralda (1989) found that half the parent sample had already consulted other sources of help before contacting their GP. The majority of these were educational services, including headteachers, and educational welfare officers.

Level 2: Children with psychological problems who are seen in primary care

There is some evidence that children identified in community studies as having significant behaviour problems present at their GP with somatic symptoms more frequently than children without behaviour problems. Garralda and Bailey (1986) found that 23% of children attending a GP practice showed psychological disturbance, although in only 8% of cases was the behaviour disturbance given as the main reason for visiting the G.P. Thus GPs may play a crucial role in diagnosing a child as psychologically disturbed when the parents themselves have not identified the child's behaviour as such as a cause for concern.

Level 3: Children with psychological problems who have been diagnosed as psychologically disturbed by their GP

In his survey of child psychological problems in primary health care practices in America, Earls (1980) found a prevalence rate of 24% of children consulting their GP for somatic problems were judged by a psychologist to have significant behavioural problems. Of these only 29% were referred on to child mental
health services. In their British study, Garralda and Bailey (1986) also highlighted the high rates of psychological disturbance amongst children aged between 7 and 12 years old attending a primary health care practice: (23%). They contrasted this with the small percentage of children referred on to psychiatric services, (8%), and commented on how little is known about the factors determining whether a child is identified as in need of psychological help (level 3, Fig.2), or the determinants of the decision to refer on to specialist services, (level 4, Fig.2).

Level 4: Children with psychological problems who are being seen for outpatient psychological treatment
The policy of the service providers themselves can influence the permeability of the service to different children. Service providers are often not just the passive recipient of referrals but play an important role in telling potential referrers what constitutes an appropriate referral and what does not. Thus agencies shape the referral practice of referrers by the type of referral they accept.

The potential pathways to psychological care available to a child and his or her parents may vary between different geographical areas. For example, different mental health service appear to have different primary sources of referral. A recent study of referral to a child guidance clinic found that the majority of referrals, 34%, came from educational sources, with 24% coming from medical sources, whilst 28% arose from self-referral by parents, and the remaining 14% came from social services (Richards 1990). In contrast, Thomas and Hardwick (1989), in their study of referral to a child mental health service in Dorset, found that 64% of referrals were from GPs and only 5.4% from parents. They suggested that clinics develop idiosyncratic referral patterns. These may depend on the type of service being offered and the policy of the service providers.
Thus it can be seen that for children the key people in deciding who shall pass through each filter are generally the parents of the designated "problem child", the primary professionals involved (eg the GP, the child's teacher or a social worker), and, finally, the specialist mental health professionals themselves.

1.2.3. Clinical implications of the model

Each filter between the various levels in the model may be selectively permeable to different groups of children. For example, children of different ages, classes and sexes may be more or less likely to pass through a given filter. This research aims to look at some of the factors that may be affecting the permeability of the filters to different groups of children. It would be important to determine if systematic biases were operating on the basis of certain child, parent, or GP variables.

1.3 Overview of research into factors affecting referral of children to child mental health services

In surveying the literature concerning factors affecting the referral of children to psychological services, each potentially relevant variable will be looked at in turn. In each case relevant epidemiological data (ie relating to the population of children identified at level 1: the community, Fig.2) will be given first and then any data on referral rates (ie relating to the population of children identified at level 4; Outpatient psychological care, in Fig.2) will be stated. The reasons for any discrepancies between these two populations will then be explored. Since the referral of pre-pubertal children is the focus for this study, issues concerning the referral of adolescents and adults will only be covered where relevant to this topic.
1.3.1 Child Variables

a) Severity of symptom
Garralda and Bailey (1988) found that severity of symptom did significantly correlate with GPs tendency to refer. This is consistent with Langner et al.'s (1974) New York study which showed that more severely psychiatrically impaired children were more likely to be referred. This is in accord with the recommended criteria for referral to mental health professionals, (Kessel 1963).

There have, however, been contrary findings. Shepherd et al. (1966) found that severity of symptom did not differentiate between referred and non-referred children and Garralda and Bailey (1988,1989) point out that severity of symptom is not the only factor influencing referral, and may not even be the main factor.

If severity of symptom is not the only factor that influences whether children move from level 1 (the community) to subsequent levels (eg level 1a: making parents concerned enough to consult a professional), then it would seem worth investigating what other factors might be influencing this process.

b) Type of problem
There is general confusion regarding classification in child psychiatry. However Boyle and Jones (1985) have reviewed the field and identify two consistent broad-based categories: emotional disorder and conduct disorder (Rutter 1976), also described as internalizing and externalizing syndromes (Achenbach and Edelbrock 1978). Emotional disorders are defined by Rutter (1975) as those in which the main problem involves an abnormality of the emotions such as anxiety, fear or depression. Conversely conduct disorders are those in which the chief characteristic is abnormal behaviour which gives rise to social disapproval. The category includes some types of legally defined delinquency, but also includes non-delinquent disorders of conduct as shown by
lying, fighting, bullying and destructive behaviour. In preschoolers it is often accompanied by frequent temper tantrums, (Graham 1986). The distinction between conduct and emotional disorders is no longer thought to be entirely clear cut, and there is often evidence of mixed symptomatology. However conduct disorders have been consistently separated from emotional disorders, especially in research which uses factor analysis, (Boyle and Jones 1985).

Epidemiological studies suggest that emotional disorders are more common than conduct disorders, in school age children at least. In their survey of children aged 7 - 12 attending a general practice, Garralda and Bailey (1986) found that of the children identified as exhibiting "psychiatric disorder", 52% were diagnosed as presenting with emotional disorder and only 13% as presenting with conduct disorder. A further 25% were said to have mixed conduct/emotional disorder.

It has not proved possible to find systematic data on the respective numbers of referrals of conduct as opposed to emotional disturbance, but there is general agreement that conduct disorders are more likely to lead to referral than emotional disorders in children (Garralda and Bailey 1988). Support for this is found in a recent survey of 62 parents attending a community child guidance clinic. 26.7% gave the child's behaviour as their reason for attendance, as opposed to only 13.3% who gave the child's emotions as their reason. In the same study, the majority of professionals (50%) who had referred the child to the clinic cited the child's behaviour as the prime reason for referral, and only 11.5% gave the child's emotions as the reason (Subotsky and Berelowitz 1990).

In part, the discrepancies that exist between the prevalence rates found in community surveys and those found in studies of clinic populations reflect the different prognoses for the two forms of psychological disturbance since generally there is a better prognosis for children suffering from emotional disorders.
than for those suffering from conduct disorders (Zeitlin 1986). This may suggest that parents and professionals are right to be more concerned about a child exhibiting conduct disorder as opposed to emotional disorder.

On the other hand it does appear that emotional disorders may respond better to psychological intervention than conduct disorders. In her review of follow-up studies from clinic populations, Robins (1979) found that outcomes were much worse for conduct-disordered children than for those with predominately emotional disorders.

One of the reasons that conduct disorders may be more likely to cause high levels of concern and lead to referral to psychological services may be because they are more likely to be disruptive for adults than emotional disorders. In terms of the model, it may be that many children with psychological disturbance at level 1: the community, who show their distress in terms of emotional problems, are being overlooked. In particular there is a growing literature on the underdiagnosis of depression in children (Rutter and Hersov 1985)

c) Age of Child
Prevalence rates for 3 year olds of psychiatric disturbance were 14.3% in a London Borough (Richman et al. 1982), whilst those for 10-12 year olds in another similar area in London were found to be 25.4% (Rutter et al. 1975).

Referral rates to child mental health services differ between different age groups. This may, however, be heavily influenced by the policy of the service: for example, if it specialises in adolescents, it is likely to get more referrals of children in their teens. In their survey of referrals to a child guidance clinic in a London Borough, Gath et al. (1977) found that 48% of the referrals came from the 5 to 10 year age group, 38% of the referrals came from the 11 to 15 year age group, 15% from the
under-fives and 2% from the over 15s.

This does appear to be in accordance with the epidemiological data concerning the relative prevalence of psychological disturbance in preschool and school age groups. However the low rate of referral of under-fives may also reflect the belief that problems in this age group tend to be more transient than problems at a later stage. This has recently been disputed by Richman et al. (1982), whose longitudinal study of children between the ages of 3 and 8 showed a marked continuance of problems over this time span, with 62% of those identified as the "problem" children at 3 years old still being assessed as displaying deviant behaviour at 8 years old.

Thus it may be that children aged 5 or under who display signs of disturbed behaviour in the community (level 1) are less likely than older children to elicit high levels of parental and/or professional concern (levels 1a and 1b) because it is mistakenly believed that their problems will be shorter lived and are therefore seen as less worrying.

d) Sex of Child
Epidemiological studies show some disparity in presentation of problems between the sexes. There is evidence of a sex difference in terms of certain types of problem: for example, the ratio of boys to girls diagnosed as exhibiting conduct disorder is 12:1 (Quay and Werry 1986). This difference has been found quite consistently in studies looking at primary and secondary school age children in Britain and America. However, this effect does seem to interact with race. Earls and Richman (1980) remark on the fact that an unexpectedly high proportion of girls from West Indian families are diagnosed as exhibiting conduct disorder.

Sex differences in the rates of conduct disorders amongst preschoolers are less clear cut. Few sex differences in terms of symptomatology and prevalence amongst children under 5 years old were found in a London Borough (Richman et al. 1982). Earls
(1980) found that there were no sex differences in the prevalence of behavioural problems in a population of 3 year olds in a rural American community. Campbell (1987), in a British study looking at the course of behaviour problems in pre-schoolers, found no significant differences between boys and girls in maternal ratings of symptomatology at age 3 years and 6 years, although her small sample size precluded her drawing many conclusions from this data.

Emotional disorders are found in equal rates in both sexes until puberty; from puberty onwards more adolescent girls than boys are referred for emotional problems, and this pattern remains throughout adult life (Rutter and Hersov 1985).

In terms of referral patterns there is consistent evidence that for the majority of psychiatric problems more boys are referred to child psychiatric services than girls. For example, in their study of referral patterns to a child guidance centre in Croydon, Gath et al. (1977) found that in the years 1962-66 three boys to every one girl were referred to the clinic. The difference was greatest for the 5 to 10 year old age group. There is some speculation that these sex differences in referral rates may be changing. LaClave and Campbell (1986) in an American study, found that in a comparison of one clinic's referrals of boys and girls in 1973 with those in 1983, the discrepancy between male and female referrals, whilst remaining in favour of males, revealed a significant increase in female referrals over the 10 year period. More recent studies have, however, replicated earlier findings. For example, Richards (1990) analyzed all referrals made in the years 1987 and 1988 to the a child guidance service: 63% were boys and 37% were girls. She points out, however, that from the age of 13 upwards more girls than boys were referred.

One explanation for why there is an excess of boys to girls referred to child mental health services is because of the different ways boys and girls manifest their psychological disturbance. It is argued that boys tend to present their
psychological distress more in terms of antisocial behaviour and conduct disorders, whereas girls may be more likely to become emotionally disturbed. Emery’s (1982) study of a non-clinic population of boys and girls, showed that where there was marital conflict this was more likely to lead to aggression in boys than in girls. Rutter also found that family discord led to more antisocial behaviour in boys than in girls (Rutter 1970).

Achenbach and Edelbrock (1981) in their study of 1300 referred children and 1300 matched controls, found there to be no overall gender difference in levels of behaviour problems as measured on the Child Behaviour Checklist (CBCL). However, they did find that there were significant differences between boys and girls on individual items. In particular, boys tended to score higher on items measuring "externalizing" syndromes (eg overactivity, aggression to others), whilst girls scored higher on items associated with "internalizing" syndromes, such as headaches or sadness.

Since conduct disorders are more likely to lead to referral than emotional disorders (see the discussion above), this could account for the increased numbers of boys referred relative to girls.

To an extent, the increased rates of behavioural problems in boys can be related to the increased rates of developmental delay in male children. Boys are twice as likely to be mentally handicapped than girls and 4 times as likely to suffer from the specific mental handicap of autism (Quay and Werry 1986). They are also substantially more likely than girls to have language and learning difficulties (Rice et al. 1981). These sorts of problems are correlated with raised levels of behavioral disturbance, particularly conduct disorder. However, since the ratio of boys to girls is 12:1 for diagnosis and treatment of conduct disorder, it is unlikely that the whole difference can be accounted for by differential rates in learning difficulties.
An alternative suggestion in the literature is that in some instances the differences in referral rates of boys and girls may be due to biases on the part of parents and professionals in their perception of male and female behaviour (Eme 1979). There is some evidence that there may be more reporting of male deviance. In a study focusing on mothers' perceptions of child problems, Shepherd et al. (1966) found that they expected boys' difficulties to be longer lasting than girls and were less tolerant of such difficulties in boys. Mothers and teachers have been found to be less tolerant of male hyperactivity; lack of persistence; distractibility and disruptiveness than of female deviance in these areas (Serbin and O'Leary 1975). Lyons and Serbin (1986) suggested that adults may be more likely to label behaviour as aggressive when the child in question is thought to be male than when it is perceived to be female.

Thus it may be that referral biases on the part of parents and/or teachers contribute to the fact that more boys are referred to child mental health services than girls. It could be argued that psychologically disturbed boys in the community (level 1) are more likely to elicit concern in parents and professionals, (levels 1a and 1b), and thus more likely than girls to be referred on for outpatient psychiatric treatment (level 4). This may be by virtue of the fact that they tend to present their problems in terms of antisocial behaviour or because adults are more likely to notice and respond to deviant behaviour in boys.

1.3.2 Parent variables

a) Social Background of Parents
In epidemiological studies there is evidence of psychosocial disadvantage being associated with increased rates of childhood psychiatric disturbance (Rutter et al. 1974). However, in their study of children between the ages of 3 and 8 years old, Richman et al. (1982) found that whilst bad housing was associated with
increased rates of behaviour problems in children, there was no significant association between social class per se outcome of problems at 8 years old. Earls (1980) found no evidence that class affected prevalence of behavioural problems in children in his American study.

Little direct research has been done looking at whether parents’ socio-economic status and social situation affect the likelihood of referral to child mental health services. In their study of children referred to psychiatric services, Garralda and Bailey (1988) found higher rates of unemployment and social stress in the group of children referred for help. They argue that it is likely that high levels of current family stress contribute to referral. There is evidence that mothers who are under stress are more likely to take their children to see their G.P.s more frequently (Roghmann and Haggerty 1972). Unemployment is associated with increased GP consultation in adults (Smith 1985).

Given the research quoted above, it can be posited that high levels of social stress may increase the permeability between level 1 (children with psychological problems in the community), and level 1a (parental concern): it is likely that social stressors make it harder to deal with children with deviant behaviour and thus make parents more desirous of outside help, and hence more likely to consult a professional (level 1b or level 2).

b) Ethnic group of parents
Epidemiological research has shown no difference in rates of behaviour problems in 3 year old children of West Indian families as compared with an indigenous population, despite the fact that the former were subject to more social and economic stress factors than the latter (Earls and Richman 1980). However, in a study by Rutter et al. (1974), teachers rated West Indian children as having problems more frequently than a matched indigenous group, whilst there was no difference in parental ratings.
It may be that this discrepancy between the teachers' ratings and those of the parents reflects racial bias on the part of the teachers (see discussion on referrer variables below), or an under-diagnosis of psychological problems on the part of the parents.

Little systematic research has been carried out which looks at whether the number of children of West Indian origin seen at mental health services accurately reflects numbers in the population, or whether such groups are over represented or under represented. The literature on referral of adult West Indian patients suggests that they may be overrepresented in inpatient contexts (particularly in terms of diagnosis of schizophrenia), but under-represented in out-patient facilities (Fernando 1988). There is a general impression among those who work in areas with large Afro-Caribbean populations that "black " children are also under-represented in out-patient child psychiatry.

There is some suggestion in the literature that children from Asian backgrounds are under-represented in child psychiatry clinics. In their study of referrals to a child psychiatric department in a London hospital in an area with a large Bangladeshi population, Stern et al. (1990) found that Asian children were under-represented when compared with the local population. One suggestion to account for this is that Asian adults are better adjusted than their native counterparts (Cochrane and Stopes-Rose 1977). Alternatively, Stern et al. (1990) suggest that the attitude of Asian parents to psychological problems is an important factor. They report that the Bangladeshi community's attitude to deviant behaviour in children is to see such behaviour as due to badness, and thus to be dealt with by punishment, or as a manifestation of physical illness, or as the result of the activity of the spirits. This is in line with Kallarackal and Herbert (1976) who suggest that apparently lower rates of disturbance in Asian children might be due to parents not recognising certain types of behaviour as
psychological problems. In addition, Deyo and Inui (1980) have argued that cultural norms may prevent help being sought outside the extended family, and they point out that communication problems due to lack of fluency in the host culture's language have been implicated in non-attendance at out-patient clinics.

It would seem that if a child comes from an Asian or West-Indian family background this may reduce the permeability of the filters in the pathway to psychological care. In particular, the literature suggests that parents of Asian origin may be less likely to become concerned about a child's deviant behaviour such that they seek outside help, (level 1a).

1.3.3. Referrer Variables

Teacher variables
The importance of teachers as influential in the referral of children to child mental health services has already been noted, yet no research has been carried out to look in more detail at their role in the process. Drabman et al. (1987) lament the lack of research into possible sources of teacher referral bias. As already noted above, it may be that teachers may be biased by the race or the gender of the child (Rutter et al. 1974; Serbin and O'Leary 1975).

GP variables
Surveys of GP practice in relation to referral of adult patients, have found several GP variables to affect significantly the likelihood of an individual being referred for specialist psychological help. Urban doctors are more likely to refer than rural doctors; older and more experienced doctors more likely to refer than younger doctors (Shortell and Daniel 1974). A Scottish study reports that single handed city practices had higher referral rates than group practices (Robertson 1979).
1.3.4. Service Provider Variables

The policy of each department may affect who is encouraged to refer and what sorts of children are prioritized. This is an area that is overlooked by Goldberg and Huxley's original, rather simplified, model.

1.4 The Problem to be investigated

The present study seeks to fill in some of the gaps highlighted in the literature review. In particular, it has been argued that there has been little systematic investigation of whether the population of children who are referred to outpatient psychiatric services (level 4) are a biased sample of the population of children with psychological problems existing in the community (level 1).

This study focuses on three child variables that may effect the referral process: the sex of the child; the type of problem presented and the age of the child. It also considers two parent variables as potentially affecting the referral process: the class of the parent and the ethnic group of the parent. In relation to referrer variables, the type of practice the GP has (whether single or group), and the GP's length of experience will also be explored, as these are also suggested in the literature as potentially influencing referral decisions. In this way it is hoped to further extend knowledge about the possible determinants of the permeability of the various filters in the pathway to psychological care.
1.5 Hypotheses (stated in null form)

1.5.1. Hypothesis 1: Referral attitudes and behaviours of parents, GPs and psychologists are not significantly influenced by:

a) the gender of the child.
b) the type of problem presented by the child (conduct vs emotional).
c) the age of the child (3 years vs 10 years).

1.5.2. Hypotheses 2: Parents' attitudes and behaviours are not significantly influenced by:

a) the ethnic group of the parent.
b) the social class of the parent.

1.5.3 Hypothesis 3: GPs' attitudes and behaviours are not significantly influenced by:

a) the years of experience of the GP (under 10 years vs over 10 years).
b) the type of practice of the GP (single vs group).
METHOD

2.1 Design

This study investigates the relationship between referral attitudes and behaviour, and child and referrer characteristics.

INDEPENDENT VARIABLES:

1) Child characteristics
Subjects were asked to respond to written vignettes describing children in which the sex, age and type of problem of the child were varied (see materials).

2) Referrer characteristics
Relevant demographic information was collected about respondents. Data on the social class and ethnic group of the responding parents was gathered. Data on the length of experience, and type of practice of the responding GPs was also gathered.

DEPENDENT VARIABLES:

1) Referral attitudes
Subjects were asked to respond to questions designed to elicit attitudes and beliefs that might influence referral practice.

3) Referral behaviour
Subjects were asked to respond to questions asking what they would do in response to a child presenting with psychological disturbance.
2.4 Subjects

Three groups of subjects were contacted:
1) parents of 3 year old and/or 10 year old children attending selected state schools in a district health authority in West London (West Riverside);
2) all GPs practising in the same district health authority;
3) all clinical psychologists specialising in child work in the regional health authority incorporating that district, and in the regional health authority bordering this.

Questionnaires were distributed to 601 parents. Parents were selected from 13 junior and mixed infant schools which were randomly selected from all primary schools in the health district in order to control for socioeconomic and racial variation.

211 parents returned the questionnaire, a return rate of 35% which is in line with levels of response to other postal questionnaires (Berdie et al. 1986).

The majority, (83.4%), of the returned questionnaires were completed by mothers. The mean number of children in a family was 2.3 (range 1-6). Only 12% of respondents had been to see their GP at any time in the last 6 months because they were worried about their child's behaviour.

Each family's social class was scored on the basis of the parents' stated occupations (Bebbington et al. 1988). Table 1 shows the class composition of responding parents. Although the categories used were not identical, the percentage of each social class found in the 1981 census in the relevant borough for men 16 - 64 is also given for comparison purposes (OPCS census 1981, County Report Greater London Part 2)
Table 1: Percentage of responding parents in each social class

<table>
<thead>
<tr>
<th>social class</th>
<th>percentage respondents</th>
<th>percentage 1981 census</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 professional</td>
<td>12.4</td>
<td>5.9</td>
</tr>
<tr>
<td>2 managerial, executive</td>
<td>25.9</td>
<td>20.1</td>
</tr>
<tr>
<td>3 intermediate, routine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>non-manual; skilled manual</td>
<td>22.8</td>
<td>37.6</td>
</tr>
<tr>
<td>4 partly skilled manual</td>
<td>9.8</td>
<td>13.3</td>
</tr>
<tr>
<td>5 unskilled</td>
<td>14</td>
<td>6.9</td>
</tr>
<tr>
<td>unemployed/missing</td>
<td>15</td>
<td>16.2</td>
</tr>
</tbody>
</table>

It would appear that there may be some overrepresentation of social classes 1 and 2 in the sample of responding parents. Alternatively, these differences may be due to demographic changes in the borough since 1981.

The ethnic composition of responding parents is shown in table 2. No comparable data exists for the relevant geographical area, and thus no conclusions can be drawn about the representativeness or otherwise of the sample in terms of ethnic composition.

Table 2: Percentage of responding parents in each ethnic group

<table>
<thead>
<tr>
<th>ethnic group</th>
<th>percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>European</td>
<td>62.9</td>
</tr>
<tr>
<td>Asian</td>
<td>5.6</td>
</tr>
<tr>
<td>African</td>
<td>6.1</td>
</tr>
<tr>
<td>Caribbean</td>
<td>10.8</td>
</tr>
<tr>
<td>Middle Eastern</td>
<td>.9</td>
</tr>
<tr>
<td>Far Eastern</td>
<td>2.8</td>
</tr>
<tr>
<td>Other</td>
<td>4.7</td>
</tr>
<tr>
<td>Missing data</td>
<td>6.1</td>
</tr>
</tbody>
</table>

Questionnaires were distributed to all 84 GPs in the district health authority. 36 GP questionnaires were returned representing
a return rate of 42.9%, which is again in line with postal questionnaire returns (Berdie et al. 1986).

Where possible demographic information collected from responding GPs was compared with demographic data on all GPs in the district health authority. This data was supplied by the local Family Practitioner Committee.

On the basis of the demographic variables measured, the GP sample was generally representative of GPs in the district health authority, for example in terms of gender distribution of respondents (table 3). However there does appear to be some bias towards more experienced GPs and those in larger practices replying (table 4). In addition the majority of responding GPs, (91.7%), had referred to child mental health services at some point in the past and this may represent an additional source of bias in the sample.

Table 3: Percentage of GPs of each sex as compared with sex distribution of GPs in district health authority.

<table>
<thead>
<tr>
<th>sex of GP</th>
<th>percentage of responding GPs</th>
<th>percentage of all GPs in area</th>
</tr>
</thead>
<tbody>
<tr>
<td>male</td>
<td>72.2</td>
<td>73.8</td>
</tr>
<tr>
<td>female</td>
<td>27.8</td>
<td>26.2</td>
</tr>
</tbody>
</table>

Table 4: Length of practice of responding GPs as compared with length of practice of GPs in district health authority.

<table>
<thead>
<tr>
<th>length of practice</th>
<th>percentage of responding GPs</th>
<th>percentage of all GPs in area</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 5 years</td>
<td>22.2</td>
<td>26.2</td>
</tr>
<tr>
<td>5 - 10 years</td>
<td>13.9</td>
<td>22.6</td>
</tr>
<tr>
<td>&gt; 10 years</td>
<td>63.9</td>
<td>51.2</td>
</tr>
</tbody>
</table>
The mean list size for responding GPs was 2340 patients, (range 200 - 4000). In W. Riverside as a whole the mean list size was 2165.

The mean number of partners in a practice was 3.5 (range 1-7), whereas in W. Riverside as a whole the mean number of partners was 2.1.

Questionnaires were distributed to all 48 clinical psychologists specialising in work with children in the relevant regional health authorities.

38 clinical psychologist questionnaires were returned, representing a return rate of 79%.

The majority of responding psychologists (78.9%) were women. 47% of psychologists had worked for over 10 years post-qualification and 57.9% had worked for over 5 years in child services. The majority (50%) worked in child and family services, with the remainder working in district clinical psychology services; paediatric services; child development centres; child guidance clinics; social services and mental handicap services. Thus the responding psychologists comprised a group of experienced clinicians whose work covered the main services to children.

2.3 Materials

Each of the three subject groups was given a different version of the same questionnaire. Although the format of the questionnaire was basically the same for all three groups, the phrasing of individual questions was varied appropriately for each group. Copies of all three versions of the questionnaire can be found in Appendix 1.
2.3.4 Vignette component of questionnaire

Each subject received a questionnaire containing four different vignettes. Each vignette described a child exhibiting a variety of "symptoms." Each subject received: two vignettes concerning 3 year old children, in one of which the child displayed emotional problems and in the other the child displayed conduct disorder; and two vignettes concerning 10 year old children, in one of which the child displayed emotional problems and in the other the child displayed conduct disorder. For GPs and psychologists it was specified that the child in question showed no physical or intellectual disabilities.

The sex of the child with the problem was randomly varied across subjects.

Thus each subject received one of the following combinations of vignettes:

**Combination A**
- 3 year old conduct disordered boy
- 3 year old emotionally disordered girl
- 10 year old emotionally disordered boy
- 10 year old conduct disordered girl

**Combination B**
- 3 year old conduct disordered girl
- 3 year old emotionally disordered boy
- 10 year old emotionally disordered girl
- 10 year old conduct disordered boy

The order in which the vignettes were presented was varied randomly.

**Construction of vignettes**

The vignettes about 3 year olds were created using the Behavioural Screening Questionnaire (BSQ), a 12 item behaviour
scale which was developed as a means of identifying psychiatrically disturbed preschool-age children (Richman and Graham 1971). Symptoms are assigned scores of 0, 1 or 2 according to type and severity. Each vignette-child was assigned a combination of symptoms to yield a total score of 10, the cut-off identified by Richman and Graham as indicating need for referral to child mental health services.

The BSQ has been found to discriminate significantly between clinically referred and non-referred groups, and to correlate significantly with clinician's ratings of psychiatric status (Rutter et al. 1984). It is widely used in the literature as a measure of prevalence in community populations of the under-fives (Richman et al. 1982).

Although the BSQ itself does not differentiate between emotional and conduct disorders, the Preschool Behaviour Checklist (PBCL), a later scale developed by Richman, does. This is very similar to the BSQ, but designed specifically for use by teachers. On the basis of this later scale, and on the general principles for differentiating between conduct and emotional disorders, the vignettes about 3 year olds were constructed to describe one child who was primarily exhibiting emotional disorder and one who was primarily exhibiting conduct disorder. Thus behaviours such as fear, difficulties in separating, and sadness were taken as relating to emotional problems and behaviours such as fighting and tantrums were taken as relating to conduct disorder.

The vignettes about 10 year olds were created using the Rutter Children's Behaviour Questionnaire, scale A (for completion by parents). This is a 31 item behaviour scale which was designed as a means of identifying psychiatrically disturbed school-age children (Rutter et al. 70). Symptoms are assigned scores of 0, 1 or 2 according to type and severity. Each vignette-child was assigned a combination of symptoms to yield a total score of 13, the cut-off identified by Rutter as indicating need for referral to child mental health services.
Rutter's scale has been found to discriminate significantly between clinically referred and non-referred groups, and to correlate significantly with clinician's ratings of psychiatric status and is widely used in the literature as a measure of prevalence in community populations (Rutter et al. 1970). The scale specifically differentiates between emotional and conduct disorders, and it was on this basis that the 10 year old vignettes were constructed to describe one child who was primarily exhibiting emotional disorder and one who was primarily exhibiting conduct disorder. Thus behaviours such as excessive crying, fear of new situations and raised anxiety were taken as evidence of emotional disorder, and behaviours such as stealing, fighting and lying were taken as evidence of conduct disorder as specified in the scale itself.

Four independent judges rated the vignettes using the BSQ and Rutter scales as appropriate. The percentage of them in agreement with the ratings attributed to the vignettes in the present study ranged from 75% and 100%. (See Appendix 2 for table of results).

The design of the vignettes allowed for investigating the influence of sex, type of problem and age of child on parent responses:

1) Comparison of ratings of boys and girls was made possible by matching the child vignettes in every way and only varying sex of child.

2) The type of problem (conduct or emotional) was matched within each age group in terms of number of problem behaviours displayed, length of duration of symptoms and severity as rated on the scales used.

3) For both age groups each vignette was designed to score the specified cut-off point on the relevant scale. Since in both cases this cut off point was meant to differentiate children needing psychological help from those not needing it, the levels of disturbance should be roughly equivalent. There remains,
however, some difficulty in comparing responses to vignettes based on two different scales in this way, and this needs to be taken into account when analyzing the results.

2.3.2 Question component of questionnaire.
The questions asked about the vignettes varied depending on the group being addressed. In each case the questions were chosen because they were thought to reflect attitudes or behaviours likely to influence the referral process. The main questions asked of parents, GPs and psychologists are summarised in tables 5, 6 and 7 respectively. In addition demographic information was gathered from each respondent. (Copies of all 3 questionnaires are in Appendix 1).

Table 5: Questions asked of parents

<table>
<thead>
<tr>
<th>Question concerns</th>
<th>Type of measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Perceived frequency of problem</td>
<td>4 point scale: v.rare - v.common</td>
</tr>
<tr>
<td>2) Degree of worry about problem</td>
<td>4 point scale: not at all worried- extremely worried.</td>
</tr>
<tr>
<td>3) Wait before seeing GP</td>
<td>5 point scale: go immediately</td>
</tr>
<tr>
<td></td>
<td>wait up to 3 months</td>
</tr>
<tr>
<td></td>
<td>wait 4 - 7 months</td>
</tr>
<tr>
<td></td>
<td>wait 8 - 11 months</td>
</tr>
<tr>
<td></td>
<td>wait 12 months or more (incl. option - unlikely to ever go)</td>
</tr>
<tr>
<td>4) Professional most likely to consult in first instance</td>
<td>6 options: teacher, GP, health visitor, social worker, &quot;other&quot;, none.</td>
</tr>
</tbody>
</table>
In addition, the following demographic data was requested from each parent: their sex; the number of children in the family; the occupation of both them and their partner and their ethnic group (respondents were asked to select from 7 categories: European, Asian, African, Caribbean, Middle Eastern, Other).

Table 6: Questions asked of GPs

<table>
<thead>
<tr>
<th>Question concerns</th>
<th>Type of measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Frequency with which problem seen by GP</td>
<td>4 point scale: v.rarely - v.often</td>
</tr>
<tr>
<td>2) Degree of worry about problem</td>
<td>4 point scale: not at all worried - extremely worried.</td>
</tr>
<tr>
<td>3) Most likely response to referral</td>
<td>5 options: reassure parents, arrange to see again, refer to specialist, refer to specialist and see again.</td>
</tr>
<tr>
<td>4) Professional GP most likely to refer to</td>
<td>6 options: social worker, health visitor, paediatrician, psychiatrist/psychologist, &quot;other&quot;, would not refer.</td>
</tr>
<tr>
<td>5) judgement of whether child needs psychological help</td>
<td>yes, no</td>
</tr>
<tr>
<td>6) Wait before referring to mental health professional</td>
<td>5 point scale: refer at once up to 3 months 4 - 7 months 8 - 11 months 12 months or more incl. option - unlikely to refer</td>
</tr>
</tbody>
</table>
In addition, the following demographic data was collected from GPs: their sex; years of experience; practice type and size; whether they had children or not; whether they had ever referred to child mental health services and, if so, how frequently on average they did so.

Table 7: Questions asked of psychologists

<table>
<thead>
<tr>
<th>Question concerns</th>
<th>Type of measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Perceived frequency of problem</td>
<td>4 point scale: v.rare - v.common</td>
</tr>
<tr>
<td>2) Degree of worry about problem</td>
<td>4 point scale: not at all worried - extremely worried.</td>
</tr>
<tr>
<td>3) appropriateness of referral</td>
<td>yes, no</td>
</tr>
<tr>
<td>4) Most likely response</td>
<td>5 options: refer elsewhere, see child alone, see parents alone, see whole family, &quot;other&quot;.</td>
</tr>
</tbody>
</table>

In addition, psychologists were asked to state their sex; their length of experience; whether they had children or not; what service they were part of and the most frequent source of referrals to that service (they were asked to rank 8 options: GPs, teachers, social workers, health visitors, paediatrician, school doctors, parents or "other").

In order to assess the test-retest reliability of the questionnaires, 20 parents, 15 GPs and 12 psychologists outside the sample groups were contacted and asked to complete the questionnaire. Two weeks later they were sent the same version of the questionnaire and asked to complete it. 14 of the 20 parents approached complied, but only 1 GP and 2 psychologists sent back the questionnaire the second time.
Test-retest correlations yielded high reliabilities of between .75 and .88 for scaled questions, and 71% - 100% agreement on the categorical questions on the parents questionnaire. (See Appendix 2 for table of results). Since the majority of GPs and psychologists failed to return their re-test questionnaire, no reliabilities could be estimated on them.

2.4 Procedure

Questionnaires were distributed direct to parents via their childrens' schools in 9 of the 13 schools concerned. A covering letter explaining the nature of the study and requesting their participation was attached, and a self addressed stamped envelope was supplied to each family for the return of the questionnaire. At the request of the schools concerned, in 2 of the schools an exploratory letter was sent to the parents first to ask if they would be prepared to participate and if they sent their name and address to the researcher, a questionnaire was then sent directly to them. Again at the request of the schools concerned, in 2 of the schools the questionnaires were handed directly by the researcher to parents.

All GPs were sent the questionnaire by post complete with a covering letter explaining the nature of the study and requesting their participation. A self addressed stamped envelope was supplied for return of the questionnaire. After 5 weeks all GPs who had not sent back the questionnaire were contacted by telephone and asked if they would complete the questionnaire if they still had it, or if they would be prepared to complete a new one if they were sent it.

Questionnaires were sent by post to psychologists in the designated region. Once again, an accompanying explanatory letter was attached and a self addressed stamped envelope was supplied.

Copies of the covering letters sent to all groups can be found in Appendix 3.
3.1 The referral pathway

The vast majority of parents (91 - 100%) would consult a professional for advice about the child presented in each vignette. The professional whom the greatest number of parents said they would contact for 3 year old vignette—children was a health visitor (33 - 46%), whilst for 10 year old vignette—children it was a teacher (51 - 67%). The majority of parents said that they would take the child presented in each vignette to a GP if the problem did not improve (69 - 93%).

The majority of GPs (75 - 100%) said that they would refer the child to a mental health professional if the problem described did not improve.

The majority of psychologists (85 - 95%) said that the child described in each vignette was an appropriate referral to their service, and 95 - 100% indicated that their first response to such a referral would be to see the whole family.

When psychologists were asked about which professional group were the most frequent source of referrals to their service, most (49%) reported GPs to be the most frequent referrers, with only 9% putting teachers first, and 6% putting health visitors first.
3.2 Testing the Hypotheses

The results were analysed using independent and paired t-tests, chi-square, McNemar and binomial tests and ANOVAs as appropriate.

Testing Hypothesis 1:
Does the sex, type of problem, and/or age of the child influence the referral attitudes and behaviours of parents, GPs and psychologists?

Sex of child
Analysis using independent t-tests revealed that sex of the child did not significantly affect the responses of any of the 3 subject groups. Parents', GPs' and psychologists' ratings of the perceived frequency of the problem, their level of worry about it, and how they would be most likely respond, did not significantly differ depending on whether they were responding to vignettes describing girl or boy children matched for age and type of problem (all t < .46 p > .54). (See Appendix 4 for tables of results).

Type of problem
Whether the vignette-child presented with conduct disorder or emotional disorder had a significant effect on some parental and GP responses, but not on any psychologist responses:

Parents’ ratings of worry, how common they thought the problem was and how long they would wait before seeing a GP in response to the different types of problem were compared in each age group using paired t-tests. Parents reported higher levels of worry about conduct disorders than emotional disorders in both 3 year olds (t=4.68, df= 204, p< .001) and 10 year olds (t=6.99, df=198, p<.001). Parents rated that they would wait significantly longer before consulting a GP about a conduct disordered 10 year old than an emotionally disordered 10 year old (t=8.80, df=196, p<.001). However, there was no significant difference between the length of time they would wait before seeing a GP about a
conduct disordered, as opposed to an emotionally disturbed, 3 year old. Parents' perception of the frequency of occurrence of the behaviour did not differ significantly between the two problem types in either age group (Table 8).

Table 8  Influence of type of problem on parent referral attitudes

<table>
<thead>
<tr>
<th>scale</th>
<th>mean score conduct disorder</th>
<th>mean score emotional disorder</th>
<th>df</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 year olds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>perceived frequency of behaviour</td>
<td>2.3700</td>
<td>2.4100</td>
<td>199</td>
<td>-.62 n.s.</td>
</tr>
<tr>
<td>level of worry</td>
<td>3.0341</td>
<td>2.7463</td>
<td>204</td>
<td>4.68***</td>
</tr>
<tr>
<td>wait before going to GP</td>
<td>3.5911</td>
<td>3.9015</td>
<td>202</td>
<td>-1.54 n.s.</td>
</tr>
<tr>
<td>10 year olds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>perceived frequency of behaviour</td>
<td>2.0526</td>
<td>2.0158</td>
<td>189</td>
<td>.60 n.s.</td>
</tr>
<tr>
<td>level of worry</td>
<td>3.5477</td>
<td>3.2261</td>
<td>198</td>
<td>6.99***</td>
</tr>
<tr>
<td>wait before going to GP</td>
<td>3.6396</td>
<td>1.2893</td>
<td>198</td>
<td>8.80***</td>
</tr>
</tbody>
</table>

*** p<.001

89% of parents stated they would see a GP at some point about an emotionally disordered 10 year old, while only 72% would ever see a GP about a conduct disordered 10 year old. (Mcnemar $\chi^2=25.9286$, p<.001). However, there was no significant difference in the likelihood of parents seeing a GP about conduct disordered, as opposed to emotionally disturbed, 3 year olds.

66% of parents indicated they would see a teacher first when a 10 year old was described as showing conduct disorder, as opposed to 56% when the child in question was presenting with emotional disorder. (Mcnemar $\chi^2=5.8226$, p<.05)
9% of parents stated they would see a social worker first when a 10 year old was described as showing conduct disorder, as opposed to 3% when the child displayed emotional disturbance (binomial, t-tailed p<.002).

GPs' ratings of frequency of contact, worry, and length of wait before referring to a specialist in response to the different types of problem within each age group were compared using paired t-tests. The results showed that they saw emotionally disturbed 10 year olds significantly more frequently than conduct disordered 10 year olds (t=-5.32, df=35, p<.001), but this was not the case for 3 year olds. There was no significant difference in their level of worry, or length of wait before referring to a mental health professional in response to emotionally disturbed, as opposed to conduct disordered children, in either age group. There was also no significant difference between GP responses to the two types of problem in terms of whether they would refer to a mental health professional or not. (Table 9).

Table 9 Influence of type of problem on GP referral attitudes

<table>
<thead>
<tr>
<th>scale</th>
<th>mean score conduct disorder</th>
<th>mean score emotional disorder</th>
<th>df</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 year olds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>frequency of GP contact</td>
<td>1.9444</td>
<td>1.7500</td>
<td>35</td>
<td>1.42 n.s.</td>
</tr>
<tr>
<td>level of worry</td>
<td>2.4167</td>
<td>2.3333</td>
<td>35</td>
<td>.59 n.s.</td>
</tr>
<tr>
<td>wait before referring on</td>
<td>2.5000</td>
<td>2.5000</td>
<td>33</td>
<td>.00 n.s.</td>
</tr>
<tr>
<td>10 year olds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>frequency of GP contact</td>
<td>1.6667</td>
<td>2.3889</td>
<td>35</td>
<td>-5.32***</td>
</tr>
<tr>
<td>level of worry</td>
<td>2.6389</td>
<td>2.4167</td>
<td>35</td>
<td>1.75 n.s.</td>
</tr>
<tr>
<td>wait before referring on</td>
<td>1.8667</td>
<td>2.0667</td>
<td>29</td>
<td>-.90 n.s.</td>
</tr>
</tbody>
</table>

*** p<.001
86% of GPs judged that a conduct disordered 10 year old needed specialist psychological help, whereas only 57% stated this when the 10 year old was described as showing emotional disorder. (binomial, 2-tailed, p<.05). There was no significant difference in terms of GP assessment of need for psychological help in response to the two problem types in 3 year olds.

Psychologists' rating of the perceived frequency of the behaviour, and their level of worry about the child did not differ in response to conduct disorder and emotionally disturbed children, when compared using paired t-tests. (all t<1.35, p>.14).

Age of Child
Paired t-tests were used to compare parent responses to 3 year olds as opposed to 10 year olds matched for type of problem. Parents' rated both conduct and emotional disorder as occurring more frequently in 3 year olds than 10 year olds (t=4.57, df=193, p<.001, and t=5.69, df=194, p<.001). They reported higher levels of worry about 10 year olds than 3 year olds in relation to both conduct disorders (t=-8.01, df=200, p<.001) and emotional disturbance (t=-6.80, df=202, p<.001). Parents would wait longer before seeing a GP about a 3 year old as opposed to a 10 year old with emotional problems (t=10.64, df=200, p<.001), but there was no difference in how long they would wait for the different age groups in relation to conduct disorders. (Table 10).
Table 10: Influence of age of child on parent referral attitudes

<table>
<thead>
<tr>
<th>scale</th>
<th>mean score 3 year olds</th>
<th>mean score 10 year olds</th>
<th>df</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>conduct disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>perceived frequency of behaviour</td>
<td>2.3866</td>
<td>2.0515</td>
<td>193</td>
<td>4.57***</td>
</tr>
<tr>
<td>level of worry</td>
<td>3.0348</td>
<td>3.5373</td>
<td>200</td>
<td>-8.01***</td>
</tr>
<tr>
<td>wait before going to GP</td>
<td>3.5930</td>
<td>3.6683</td>
<td>198</td>
<td>-.36 n.s.</td>
</tr>
<tr>
<td>emotional disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>perceived frequency of behaviour</td>
<td>2.4103</td>
<td>2.0103</td>
<td>194</td>
<td>5.69***</td>
</tr>
<tr>
<td>level of worry</td>
<td>2.7488</td>
<td>3.2365</td>
<td>202</td>
<td>-6.80***</td>
</tr>
<tr>
<td>wait before going to GP</td>
<td>3.9154</td>
<td>1.2886</td>
<td>200</td>
<td>10.64***</td>
</tr>
</tbody>
</table>

*** p < .001

89% of parents indicated that they would go to see their GP at some point when a 10 year old child was described as showing signs of emotional disorder, as opposed to only 73% when a 3 year old child was described. (Mcnemar $\chi^2 = 22.7556$, p < .001). For conduct disordered children, there was no significant difference between parental responses to 3 and 10 year olds regarding whether they would ever consult a GP or not.

Analysis of GP responses using paired t-tests revealed that GPs reported that they saw 3 year olds with conduct disorder more frequently than 10 year olds (t = 2.14, df = 34, p < .05), but that they saw 10 year olds with emotional disorder more frequently than 3 year olds (t = 4.53, df = 36, p < .01). Their responses indicated that they would wait significantly longer before referring a 3 year old with conduct disorder to a mental health professional.
as opposed to a 10 year old (t=3.19, df=33, p<.05), although there was no different in their responses to 3 and 10 year old emotionally disordered children. (Table 11).

Table 11: Influence of age of child on GP referral attitudes

<table>
<thead>
<tr>
<th>scale</th>
<th>mean score 3 year olds</th>
<th>mean score 10 year olds</th>
<th>df</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>conduct disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>frequency of GP contact</td>
<td>1.9714</td>
<td>1.6857</td>
<td>34</td>
<td>2.14*</td>
</tr>
<tr>
<td>level of worry</td>
<td>2.4286</td>
<td>2.6571</td>
<td>34</td>
<td>-1.85 n.s.</td>
</tr>
<tr>
<td>wait before referring on</td>
<td>2.3824</td>
<td>1.7941</td>
<td>33</td>
<td>3.19**</td>
</tr>
<tr>
<td>emotional disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>frequency of GP contact</td>
<td>1.7568</td>
<td>2.3514</td>
<td>36</td>
<td>-4.53**</td>
</tr>
<tr>
<td>level of worry</td>
<td>2.3243</td>
<td>2.4054</td>
<td>36</td>
<td>-.65 n.s.</td>
</tr>
<tr>
<td>wait before referring on</td>
<td>2.5667</td>
<td>2.1667</td>
<td>29</td>
<td>1.42 n.s.</td>
</tr>
</tbody>
</table>

* p<.05
** p<.01

88% of GPs stated that a conduct disordered 10 year old child needed psychological help, whereas only 58% of GPs felt that a conduct disordered 3 year old needed psychological help (binomial, 2-tail, p<.01). There was no significant difference between GPs' assessments of need for psychological help amongst emotionally disordered children of either age group.

Psychologists' ratings of judged frequency of occurrence and levels of worry about the different age groups (matched for type of problem) were compared using paired t-tests. Psychologists indicated that they thought both conduct disorders and emotional disorders were more common in 3 year olds (t=2.32, df=36, p<.05
and $t=4.07$, $df=37$, $p<.01$). Their level of worry was significantly higher for 10 year olds in relation to both types of problem ($t=-3.10$, $df=35$, $p<.01$ and $t=-5.24$, $df=36$, $p<.36$). (Table 12).

Table 12: Influence of age of child on psychologist referral attitudes

<table>
<thead>
<tr>
<th>scale</th>
<th>mean score 3 year olds</th>
<th>mean score 10 year olds</th>
<th>df</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>conduct disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>judged frequency of behaviour</td>
<td>2.3514</td>
<td>2.0270</td>
<td>36</td>
<td>2.32*</td>
</tr>
<tr>
<td>level of worry</td>
<td>2.3889</td>
<td>2.8056</td>
<td>35</td>
<td>-3.10**</td>
</tr>
<tr>
<td>emotional disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>judged frequency of behaviour</td>
<td>2.3947</td>
<td>1.8684</td>
<td>37</td>
<td>4.07***</td>
</tr>
<tr>
<td>level of worry</td>
<td>2.2162</td>
<td>2.8649</td>
<td>36</td>
<td>-5.24***</td>
</tr>
</tbody>
</table>

* $p<.05$
** $p<.01$
*** $p<.001$

3.2.2. Testing Hypothesis 2:
Does the social class or ethnic group of parents influence their referral attitudes and behaviour?

Social Class
One way analysis of variance was conducted. No significant differences were found in relation to parents perceived frequency of occurrence of behaviour ($F=1.6571$, $df=4,636$, $p=.16$); level of worry ($F=1.0822$, $df=4,640$, $p=.36$); or time they would wait before consulting a GP ($F=.9714$, $df=4,495$, $p=.4227$).
Ethnic Group
Independent t-tests showed significant differences between certain ethnic groups: Asian parents indicated significantly lower levels of worry than European parents ($t=2.16$, $df=570$, $p<.05$), all other comparisons were non-significant (all $t<1.28$, $p>.20$).

3.2.3 Testing Hypothesis 3:
Does the length of experience of the GP and/or the type of practice he or she works in, affect his or her referral decisions

When the responses of GPs with over 10 years experience were compared with those of under 10 years experience using independent t-tests, no significant differences were found. That is, length of practice did not influence GPs reported frequency of contact with children similar to those described in the vignettes, GPs levels of worry, nor how long they would wait before referring on (all $t<.96$, $p>.315$).

However, 65% of GPs who had been in practice for under 10 years indicated that they would refer to a mental health professional in the first instance, as opposed to only 43% of GPs who had been in practice for over 10 years ($\chi^2=5.62268$, $df=1$, $p<.05$)

Type of Practice
When the responses of GPs working in group practices were compared with those working in single practices using independent t-tests, type of practice was found to have a significant affect on GPs' assessment of the frequency of seeing children with these sorts of behaviours: GPs in group practices reported that they saw similar children to those described in the vignettes more frequently than GPs in single practices ($t=-2.72$, $df=140$, $p<.01$). Type of practice had no significant effect on any other GP responses (all $t<-.95$, $p>.35$).
4.1 Summary of Results

Of the child characteristics investigated (hypothesis 1), both type of problem and age of child affected the referral responses of parents and professionals, whilst sex of child had no significant effect on responses. In relation to type of problem, parents were more worried about conduct disorders than emotional disorders. However, they were more likely to take an emotionally disordered 10 year old to a GP than a conduct disordered 10 year old. GPs did not rate themselves as more worried about conduct disorders than emotional disorders, nor did they indicate that they would respond differently to these types of disturbance, however, they were significantly more likely to rate a 10 year old with conduct disorder as requiring specialist psychological help than a 10 year old with emotional disturbance. Psychologists' responses did not differ on the basis of type of problem presented.

In relation to age of child, parents reported higher levels of worry about 10 year olds than 3 year olds, and would wait longer before taking an emotionally disturbed 3 year old to their GP than an emotionally disturbed 10 year old. There was no significant difference between GPs' levels of worry in response to 3 year olds as opposed to 10 year olds, but they would wait significantly longer before referring a conduct disordered 3 year old as opposed to a 10 year old, to child mental health services. Psychologists reported significantly higher levels of worry in response to 10 year olds than 3 year olds.

In terms of parent variables (hypothesis 2), social class of parent had no significant effect on parents' responses, but ethnic group did; Asian parents reported significantly lower
levels of worry than European parents.

In terms of referrer characteristics (hypothesis 3), the type of practice the GP worked in did not affect referral attitudes or behaviour, although it did appear that GPs in group practices saw children similar to those described in the vignettes more frequently than GPs working alone. Length of experience affected referral behaviour; GPs with less than 10 years experience were more likely to refer to a mental health professional in the first instance than those with over 10 years experience.

Thus the pathway to psychological care would appear to be more permeable, at certain stages at least, to 10 year olds than 3 year olds, to children presenting with conduct disorder than to those presenting with emotional disorder, and to children of European parents rather than children with Asian parents. Moreover if a child sees a GP with less than 10 years experience they are more likely to be referred to a mental health professional in the first instance, than if they see a GP with more than 10 years experience.

In addition the present results indicate that GPs were generally not the first professionals that parents chose to consult about a child's disturbed behaviour. For 3 year old children parents were most likely to consult a health visitor first, and for 10 year old children a teacher. Yet according to responding psychologists the main source of referral of children to psychological services was GPs.
4.2 Further modification of the model of the pathway to psychological care

In the light of these results, the model of the pathways to psychological care for children (Fig.2), based on that of Goldberg and Huxley for adults (Fig.1), can be further refined. In particular, it emerges that it is vital not to confuse process with structure. In Goldberg and Huxley's original model, diagnosis of psychological disturbance is put as a separate level (Fig.1), whereas it is evident from these results that diagnosis of psychological disturbance may or may not influence the likelihood of referral to a specialist, depending on other factors. For example, although GPs were more likely to judge a conduct disordered 10 year old as in need of psychological help, this did not make them more likely to refer that child to a mental health professional.

Moreover, it was thought that it might help to clarify the referral process if the model made explicit the fact that at each stage there would be a number of psychologically disturbed children who were siphoned off and who did not pass to the next stage. This did not necessarily mean that they were not receiving help of any kind, but only that they were less likely to be seen by a mental health professional.

The revised model is presented in Figure 3. It is this model which will be alluded to when discussing the interpretation of the findings of the present study.

This model still presents a considerably simplified view of the possible stages involved in the referral of children to mental health services. For example, it excludes consideration of those children who, although not psychologically disturbed, arouse parental concern and who are referred for professional help. This might be an interesting area for future research.
Figure 3. Revised model of the pathway to psychological care

LEVEL 1
psychologically disturbed CHILD

LEVEL 2
arouses concern of PARENT

LEVEL 3
consultation of a PROFESSIONAL
does not arouse concern of PARENT

LEVEL 4
referral to GP

LEVEL 5
referral to MENTAL HEALTH PROFESSIONAL
no referral to MENTAL HEALTH PROFESSIONAL

TEACHER
SOCIAL WORKER
HEALTH VISITOR
OTHER
4.3 Interpretation of Results

The fact that generally parents choose to consult a professional other than a GP in the first instance when they are concerned about a child's behaviour is in line with earlier research findings (Bailey and Garralda 1989). The fact that the majority of referrals to child mental health services are from GPs rather than from other professionals is also in line with some earlier studies (Thomas and Hardwick 1989). This would suggest that for 3 and 10 year old children, health visitors and teachers respectively may play a role in helping parents to decide whether or not to consult their GP, rather than initiating referrals themselves and thus may play an important part as gatekeepers between parents (level 2) and GPs (level 4), (see Figure 3).

It would appear from the results that whilst 69% or more of parents would consult their GP at some point about a child presenting with significant psychological disturbance if the problem did not improve, this leaves up to 31% in some cases who would not. This suggests that there may be underdiagnosis of all psychological problems by parents and this may contribute to the discrepancy between the large number of children diagnosed as psychologically disturbed in epidemiological studies and the small proportion seen by mental health professionals (Bailey and Garralda 1989). It does appear that when confronted with children described as displaying symptoms of psychological distress, the majority of GPs (75 - 100%) would refer on to a mental health professional, and the majority of psychologists (85 - 95%) would see this as an appropriate referral.

In terms of the factors influencing referral decisions, the most striking finding was the impact that the age of the child had on questionnaire responses. The results suggest that parents are more likely to be worried about 10 year olds than 3 year olds. This is in line with the literature which suggests that preschool children displaying signs of psychological disturbance may be less likely than older children to elicit concern in adults.
(Richman et al. 1982). Thus the filter between children with psychological problems in the community (level 1) and children who have aroused the concern of parents (level 2), (Fig 3), may be more permeable to 10 year olds than 3 year olds.

One possible reason for this may be that because parents in this study estimated behavioural problems as more common in 3 year olds, this led them to view disturbance in this age group as more of a norm, and thus they may have considered it less worrying.

Parents reported that they would wait longer before seeing a GP about an emotionally disturbed 3 year old as opposed to an emotionally disturbed 10 year old, whilst there was no such age difference for conduct disordered children. This may suggest that with emotional disorders the filter between concerned parents (level 2) and GPs (level 4) is more permeable to 10 year olds rather than 3 year olds. The fact that there is less of a difference for the two groups in terms of conduct disorder may be because parents are more likely to seek other professional help for conduct disordered 10 year olds, such as from a teacher or social worker, rather than medical help, as will be discussed in more detail below.

The type of problem presented also appears to influence referral attitudes. Parents were more worried about conduct disorders in both age groups. This is in line with the literature that suggests that parents are more concerned about antisocial behaviour than emotional disturbance (Garralda and Bailey 1988). However, in relation to 10 year old children, parents were more likely to see their GP about an emotionally disordered child than a child displaying conduct disorder.

This result may be less paradoxical than it at first appears when it is added that parents were more likely to see a teacher or social worker about a 10 year old child with conduct disorder than one with emotional disorder. Thus high levels of worry do
not automatically indicate increased likelihood of GP consultation; it may be some other professional who is consulted. In this case it would seem that the filter between parents (level 2) and professionals (level 3) may be more permeable to children displaying conduct disorder than those with emotional disorder, but this does not necessarily mean that these children are more likely to become primary care patients (level 4).

The responses of GPs supported this finding; GPs indicated that they saw emotionally disordered 10 year olds more frequently than conduct disordered 10 year olds. Although they were more likely to judge a conduct disordered 10 year old as more in need of specialist psychological help than an emotionally disordered child of the same age, they did not indicate that they were more likely to refer conduct disordered children to a mental health specialist. What cannot be determined from the present research is whether they would treat these conduct disordered children in a different way from those with emotional disorders. For example, their appraisal of conduct disordered children as more in need of psychological help may mean they are more likely to offer treatment themselves to that child than for emotionally disordered children.

In terms of age of child, GPs did not indicate that they were significantly more worried by 10 year olds than 3 year olds. However, they were more likely to assess a 10 year old with conduct disorder as in need of psychological help and they waited longer before referring 3 year olds with conduct disorder to a specialist, even though they reported that they actually saw more 3 year olds than 10 year olds with conduct disorders. Thus it would appear that the filter between GPs (level 4) and mental health professionals (level 5) is more permeable to 10 year olds than 3 year olds, at least for those children who display their disturbance in terms of antisocial behaviour.

Psychologists rated themselves as more worried about 10 year old children than 3 year olds, and thought problems were more common
in 3 year olds than 10 year olds. This may further increase the permeability of the filter between GPs (level 4) and mental health professionals (level 5) for 10 year olds relative to 3 year olds, for if psychologists are more concerned about 10 year olds relative to 3 year olds they may accept referrals of 10 year olds more readily from GPs, and may encourage further referrals from this age group.

Thus the pattern of results across all 3 subject groups can perhaps help to explain the fact that fewer preschool children are referred to mental health specialists than school-age children (Gath 1977). This is of interest in light of the fact that research shows that psychological difficulties in preschool children are more persistent than once thought, and psychological problems at age 3 are likely to persist to age 8 at least (Richman et al. 1982).

The sex of the child did not influence the referral responses of any of the subject groups. This is in contrast with the literature that suggests that sex of child influences the perceptions and attitudes of parents (Serbin and O'Leary 1989). This may be because the present research failed to stress sufficiently the sex of the child, and thus perhaps subjects did not attend to it, or it may be that whilst sex of child influences certain parental and professional judgements, it does not influence those attitudes and behaviours tapped by the current research.

Alternatively, it may be that whilst sex of child does not directly influence referral attitudes and behaviours, there may be some indirect effect. The literature suggests that boys are more likely to express their psychological distress in terms of conduct rather than emotional disorders (Rutter 1970). If this is true, it may mean that parents are more worried about boys with psychological problems than girls, and GPs are more likely to diagnose boys as in need of psychological help. This supports the argument that boys are more frequently referred to
psychological services because of the way they present their psychological disturbance, rather than because of a sex bias per se. (Achenbach and Edelbrock 1981).

Turning to parent variables, it would appear that parents' social class did not influence their referral attitudes and behaviours. This is in contrast to the findings in the literature which show that increased rates of GP consultation are associated with lower socio-economic status (Roghmann and Haggerty 1972). This may be explained by the fact that the literature highlights social stress as leading to increased likelihood of consulting a professional about a child's behaviour, but this cannot be equated simply with social class of the individual. Since in this study social class was measured simply on the current occupational status of the parents, the present study cannot be said to have measured social stress. Further research would need to be done examining current life stressors to explore this area more fully.

The major effect observed in terms of ethnic background of parents was that Asian parents were less worried than European parents. This is in line with the literature which suggests that Asian parents may be less likely to be concerned about, and seek help for, their children's psychological problems (Kallarackal and Herbert 1976). Thus the permeability of the filter between children with psychological problems in the community (level 1) and children whose parents are concerned about them (level 2) may be reduced for children of Asian origin. However, since there was no significant difference between Asian and European parents in terms of the length of time they would wait before seeing a GP or indeed the likelihood of them seeing a GP at all, care needs to be taken in interpreting this result. It may be that their lower levels of worry would have an impact on determining whether help was sought for a less seriously disturbed child, but this would need further research to establish.

In terms of referrer variables, the number of years a GP had been
that responses were consistent over at least a number of weeks.

The fact that this study was largely based on questionnaire returns may have introduced important sources of sampling bias. Although the return rates were in line with other such studies (Berdie et al. 1986), and for the psychologist subject group were exceptionally high, it would have been helpful to have gathered demographic data on non-responders. In particular, the GP sample may have been biased towards those who had already used child mental health services, with those who did not regularly use these services not returning questionnaires.

For the parent sample, it does appear that there was an overrepresentation of mothers, and of the higher social groups amongst respondents. It is not known whether the sample was biased towards those parents who had had previous contact with child mental health services. It would have been helpful to have found out more about how much contact the parent had had in the past with child mental health services.

The design of the questionnaires may not have emphasised sex of child sufficiently for respondents to differentiate between vignettes describing boy children and those describing girl children. It would have been instructive to interview subjects who had completed the questionnaire to try to elicit which factors they had been attending to when making their responses.

The findings relating to the influence of the age of child are complicated by the fact that the vignettes about 10 and 3 year olds were created from different scales. The results may therefore mean that the cut-off point on the Rutter scale actually relates to more severe symptomatology than that on the Richman scale, rather than there being a bias on the part of respondents to be more concerned about the behaviour of 10 year olds as such. However, if this were the case, this would have important implications for our understanding of comparative epidemiological studies of the incidence of psychological
to influence referral decisions? The numbers in the present study were too small to allow this sort of analysis.

The present research concentrated on factors affecting referral to mental health services. There is an increasing body of literature on factors affecting service uptake (Cottrell et al. 1988). In the light of the current findings, it would be of interest to investigate whether the same factors that appear to influence referral attitudes and behaviours also influence whether parents actually attend appointments once offered them by mental health professionals. For example are Asian parents lower levels of worry likely to mean that they are less likely to attend appointments if offered them? A potential area for further research might be to explore the attitudes and assumptions of Asian parents about child behaviour problems and their view of psychological services.

4.6 Conclusions and implications for clinical work

In the light of the finding that parents are most likely to approach a health visitor or teacher when concerned about 3 and 10 year old children respectively, this research emphasises the need for psychologists to be involved in helping to train these professionals in how best to respond to such requests for help. This is in line with the findings of the recent MAS study which stressed the need for psychologists to become more active in training and supporting other professionals.

It would appear from the current findings that both parents and professionals need to be made more aware of the fact that problems in 3 year olds have long-term implications, and are unlikely to disappear if left untreated. In addition, it might be advisable to put service resources into educating parents and GPs to notice and respond to signs of significant emotional disturbance.
The results also suggest that it may be worth targeting Asian communities to make sure that children with psychological disturbance are not being overlooked, and to provide some input to GPs who have been practising for over 10 years about the scope and relevance of psychological services.

Above all, this research highlights the need for mental health professionals to be aware of the fact that the children they see are not necessarily representative of the population of children with psychological problems existing in the community. Many factors have combined to determine which children are eventually referred to mental health professionals and which not. It is important for psychologists and other such professionals to be aware of this so that they can help encourage appropriate use of services and not support existing biases where these run contrary to the best interests of the child.
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APPENDIX 1

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</thead>
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<td>Questionnaire sent to parents</td>
<td>64</td>
</tr>
<tr>
<td>Questionnaire sent to GPs</td>
<td>70</td>
</tr>
<tr>
<td>Questionnaire sent to clinical psychologists</td>
<td>76</td>
</tr>
</tbody>
</table>
A 3 year old boy has been difficult to manage in the last six months, for example his parents find it hard to stop him from destroying things. He appears to be irritable for more than an hour at a time on most days. He has temper tantrums daily, during which he kicks out and screams. These generally last for about 15 minutes. He fights with his peers every day and repeatedly interrupts their games. He does not concentrate on a task for more than five minutes at a time.

1) How common do you think it is for a boy of this age to behave in this way? (please tick one box only)
   [ ] Very rare, less than 1 boy in 100 behaves like this
   [ ] Quite rare, 1-10 boys in 100 behave like this
   [ ] Quite common, 11-20 boys in 100 behave like this
   [ ] Very common, more than 20 boys in 100 behave like this

2) If this were your son how worried would you be about him? (please tick one box only)
   [ ] Not at all worried
   [ ] Mildly worried
   [ ] Worried
   [ ] Extremely worried

3) If the child’s behaviour did not change how long would you wait before going to see your G.P., if you went at all? (please tick one box only)
   [ ] Unlikely to ever go to G.P. about this behaviour
   [ ] Would go immediately
   [ ] Would wait up to 3 months
   [ ] Would wait 4-7 months
   [ ] Would wait 8-11 months
   [ ] Would wait 12 months or more

4) Who would you be most likely to ask for advice about this child’s behaviour, apart from family and friends, if anyone? (please tick one box only)
   [ ] Would not talk to anyone, apart from family and friends.
   [ ] School Teacher
   [ ] G.P.
   [ ] Health Visitor
   [ ] Social Worker
   [ ] Other (please specify)______________________________
A 10 year old boy has been complaining of stomach aches at least once a week for the last six months. About once a week he cries on arrival at school, and on one or two occasions has appeared to be quite distressed. He is afraid of new situations, such as meeting new people. He spends most of his time alone. He worries about many things, for example if he feels he has done something wrong. He often wakes early in the morning and finds it difficult to settle back to sleep.

1) How common do you think it is for a boy of this age to behave in this way? (please tick one box only)
   [ ] Very rare, less than 1 boy in 100 behaves like this
   [ ] Quite rare, 1-10 boys in 100 behave like this
   [ ] Quite common, 11-20 boys in 100 behave like this
   [ ] Very common, more than 20 boys in 100 behave like this

2) If this were your son how worried would you be about him?
   (please tick one box only)
   [ ] Not at all worried
   [ ] Mildly worried
   [ ] Worried
   [ ] Extremely worried

3) If the child’s behaviour did not change how long would you wait before going to see your G.P., if you went at all?
   (please tick one box only)
   [ ] Unlikely to ever go to G.P. about this behaviour
   [ ] Would go immediately
   [ ] Would wait up to 3 months
   [ ] Would wait 4-7 months
   [ ] Would wait 8-11 months
   [ ] Would wait 12 months or more

4) Who would you be most likely to ask for advice about this child’s behaviour, apart from family and friends, if anyone?
   (please tick one box only)
   [ ] Would not talk to anyone, apart from family and friends.
   [ ] School Teacher
   [ ] G.P.
   [ ] Health Visitor
   [ ] Social Worker
   [ ] Other (please specify)

If you have any comments you would like to add please write overleaf
A 10 year old girl has been caught taking pens and other possessions from her classmates on six occasions in the last six months. On one occasion she has also been found to tear up their work. She is unpopular with the other children and often fights with them, in particular she is liable to bully younger children. She is disobedient to her parents and teachers and lies to them.

1) How common do you think it is for a girl of this age to behave in this way? (please tick one box only)
   [ ] Very rare, less than 1 girl in 100 behaves like this
   [ ] Quite rare, 1-10 girls in 100 behave like this
   [ ] Quite common, 11-20 girls in 100 behave like this
   [ ] Very common, more than 20 girls in 100 behave like this

2) If this were your daughter how worried would you be about her? (please tick one box only)
   [ ] Not at all worried
   [ ] Mildly worried
   [ ] Worried
   [ ] Extremely worried

3) If the child's behaviour did not change how long would you wait before going to see your G.P., if you went at all? (please tick one box only)
   [ ] Unlikely to ever go to G.P. about this behaviour
   [ ] Would go immediately
   [ ] Would wait up to 3 months
   [ ] Would wait 4-7 months
   [ ] Would wait 8-11 months
   [ ] Would wait 12 months or more

4) Who would you be most likely to ask for advice about this child's behaviour, apart from family and friends, if anyone? (please tick one box only)
   [ ] Would not talk to anyone, apart from family and friends.
   [ ] School Teacher
   [ ] G.P.
   [ ] Health Visitor
   [ ] Social Worker
   [ ] Other (please specify)____________________________

If you have any comments you would like to add please write overleaf
To be returned to:
Miranda Wolpert
Trainee Clinical Psychologist
Willesden Centre for Psychological Treatment
Willesden Hospital, Harlesden Road
London NW10 3RY
A 3 year old girl has been difficult to manage in the last six months, for example her parents find it hard to stop her from destroying things. She appears to be irritable for more than an hour at a time on most days. She has temper tantrums daily, during which she kicks out and screams. These generally last for about 15 minutes. She fights with her peers every day and repeatedly interrupts their games. She does not concentrate on a task for more than five minutes at a time. Physical examination reveals no abnormalities and all investigations are normal. There is no indication of developmental delay.

1) How frequently do you see a girl like this?
   (please tick one only).
   [ ] Very rarely; less than once a year
   [ ] Quite rarely; 1 or 2 a year
   [ ] Quite often; 3 or 4 a year
   [ ] Very often; 5 or more a year

2) How worried would you be about this child’s behaviour?
   (please tick one only)
   [ ] Not at all worried
   [ ] Mildly worried
   [ ] Worried
   [ ] Extremely worried

3) Indicate what you would be most likely to do in this case.
   (please tick one only)
   [ ] Reassure the parents and take no further action
   [ ] Counsel child/parents yourself and arrange to see again
   [ ] Refer to specialist and do not arrange to see again
   [ ] Refer to specialist and arrange to see again
   [ ] Other (please specify)_________________________________

4) Indicate to whom, if anyone, you would be most likely to refer this child in the first instance. (please tick one only)
   [ ] Would not refer
   [ ] Social Worker
   [ ] Health Visitor
   [ ] Paediatrician
   [ ] Child Psychiatrist/Psychologist
   [ ] Other (please specify)_________________________________
5) Do you feel that this girl needs specialist psychological help? (please tick one only)

[ ] Yes  [ ] No

6) If you did not refer to a Child Psychiatrist or Psychologist in the first instance, and the child's behaviour did not improve, how long would you wait before referring to a child mental health specialist, if at all?

(please tick one only)

[ ] Unlikely to refer at all
[ ] Would have referred at once
[ ] Up to 3 months
[ ] 4-7 months
[ ] 8-11 months
[ ] 12 months or more

7) Which child mental health service, if any, would you be most likely to refer to at that point?

(please tick one only)

[ ] Would not refer to a child mental health service
[ ] Child and Family Psychiatry
[ ] Child Guidance
[ ] Child Development Centre
[ ] Child Psychology
[ ] Educational Psychology

If you have any comments you would like to add please write below
A 3 year old boy has appeared quite miserable for more than an hour at a time on most days for the last six months. He worries repeatedly over minor events, such as changes in his routine. He follows his mother around, even into the toilet. He is afraid of dogs, cats and other animals. He runs away from them and only calms down after being comforted. He wakes at night two or three times a week and on these occasions ends up spending the night in his parents' bed. Physical examination reveals no abnormalities and all investigations are normal. There is no indication of developmental delay.

1) How frequently do you see a boy like this?
(please tick one only).
[ ] Very rarely; less than once a year
[ ] Quite rarely; 1 or 2 a year
[ ] Quite often; 3 or 4 a year
[ ] Very often; 5 or more a year

2) How worried would you be about this child's behaviour?
(please tick one only)
[ ] Not at all worried
[ ] Mildly worried
[ ] Worried
[ ] Extremely worried

3) Indicate what you would be most likely to do in this case.
(please tick one only)
[ ] Reassure the parents and take no further action
[ ] Counsel child/parents yourself and arrange to see again
[ ] Refer to specialist and do not arrange to see again
[ ] Refer to specialist and arrange to see again
[ ] Other (please specify)_______________________________

4) Indicate to whom, if anyone, you would be most likely to refer this child in the first instance. (please tick one only)
[ ] Would not refer
[ ] Social Worker
[ ] Health Visitor
[ ] Paediatrician
[ ] Child Psychiatrist/Psychologist
[ ] Other (please specify)_______________________________

PLEASE TURN OVER
A 10 year old girl has been complaining of stomach aches at least once a week for the last six months. About once a week she cries on arrival at school, and on one or two occasions has appeared to be quite distressed. She is afraid of new situations, such as meeting new people. She spends most of her time alone. She worries about many things for example if she feels she has done something wrong. She often wakes early in the morning and finds it difficult to settle back to sleep. Physical examination reveals no abnormalities and all investigations are normal. There is no indication of developmental delay.

1) How frequently do you see a girl like this? (please tick one only).
   [] Very rarely; less than once a year
   [] Quite rarely; 1 or 2 a year
   [] Quite often; 3 or 4 a year
   [] Very often; 5 or more a year

2) How worried would you be about this child's behaviour? (please tick one only)
   [] Not at all worried
   [] Mildly worried
   [] Worried
   [] Extremely worried

3) Indicate what you would be most likely to do in this case. (please tick one only)
   [] Reassure the parents and take no further action
   [] Counsel child/parents yourself and arrange to see again
   [] Refer to specialist and do not arrange to see again
   [] Refer to specialist and arrange to see again
   [] Other (please specify)

4) Indicate to whom, if anyone, you would be most likely to refer this child in the first instance. (please tick one only)
   [] Would not refer
   [] Social Worker
   [] Health Visitor
   [] Paediatrician
   [] Child Psychiatrist/Psychologist
   [] Other (please specify)
5) Do you feel that this girl needs specialist psychological help? (please tick one only)

[ ] Yes [ ] No

6) If you did not refer to a Child Psychiatrist or Psychologist in the first instance, and the child's behaviour did not improve, how long would you wait before referring to a child mental health specialist, if at all?

(please tick one only)

[ ] Unlikely to refer at all
[ ] Would have referred at once
[ ] Up to 3 months
[ ] 4-7 months
[ ] 8-11 months
[ ] 12 months or more

7) Which child mental health service, if any, would you be most likely to refer to at that point?

(please tick one only)

[ ] Would not refer to a child mental health service
[ ] Child and Family Psychiatry
[ ] Child Guidance
[ ] Child Development Centre
[ ] Child Psychology
[ ] Educational Psychology

If you have any comments you would like to add please write below
A 10 year old boy has been caught taking pens and other possessions from his classmates on six occasions in the last six months. On one occasion he has also been found to tear up their work. He is unpopular with the other children and often fights with them, in particular he is liable to bully younger children. He is disobedient to his parents and teachers and lies to them. Physical examination reveals no abnormalities and all investigations are normal. There is no indication of developmental delay.

1) How frequently do you see a boy like this? (please tick one only).
   [ ] Very rarely; less than once a year
   [ ] Quite rarely; 1 or 2 a year
   [ ] Quite often; 3 or 4 a year
   [ ] Very often; 5 or more a year

2) How worried would you be about this child's behaviour? (please tick one only)
   [ ] Not at all worried
   [ ] Mildly worried
   [ ] Worried
   [ ] Extremely worried

3) Indicate what you would be most likely to do in this case. (please tick one only)
   [ ] Reassure the parents and take no further action
   [ ] Counsel child/parents yourself and arrange to see again
   [ ] Refer to specialist and do not arrange to see again
   [ ] Refer to specialist and arrange to see again
   [ ] Other (please specify)________________

4) Indicate to whom, if anyone, you would be most likely to refer this child in the first instance. (please tick one only)
   [ ] Would not refer
   [ ] Social Worker
   [ ] Health Visitor
   [ ] Paediatrician
   [ ] Child Psychiatrist/Psychologist
   [ ] Other (please specify)________________________________________

Please turn over
5) Do you feel that this boy needs specialist psychological help? (please tick one only)
[ ] Yes  [ ] No

6) If you did not refer to a Child Psychiatrist or Psychologist in the first instance, and the child’s behaviour did not improve, how long would you wait before referring to a child mental health specialist, if at all? (please tick one only)
[ ] Unlikely to refer at all
[ ] Would have referred at once
[ ] Up to 3 months
[ ] 4-7 months
[ ] 8-11 months
[ ] 12 months or more

7) Which child mental health service, if any, would you be most likely to refer to at that point? (please tick one only)
[ ] Would not refer to a child mental health service
[ ] Child and Family Psychiatry
[ ] Child Guidance
[ ] Child Development Centre
[ ] Child Psychology
[ ] Educational Psychology

If you have any comments you would like to add please write below
BACKGROUND INFORMATION

1) Your sex:
   [ ] Male   [ ] Female

2) Years working as a G.P.:
   [ ] Less than 5 years
   [ ] 5-10 years
   [ ] more than 10 years

3) Please state:
   Individual list size ____________
   Practice list size ____________
   Number of partners ____________

4) Have you any children yourself?
   [ ] Yes   [ ] No

5) Have you ever made a referral to child mental health services?
   [ ] Yes   [ ] No

6) If your answer to the question above was "Yes", which of the following services have you referred to?
   (please tick as many as appropriate)
   [ ] Child and Family Psychiatry
   [ ] Child Development Centre
   [ ] Child Guidance
   [ ] Child Psychology
   [ ] Educational Psychology
   [ ] Other (please specify)______________________________

7) On average how often do you make a referral to child mental health services in a year? (please tick one only)
   [ ] Less than once a year
   [ ] 1-6 times a year
   [ ] 7-12 times a year
   [ ] More than once a month

THANK YOU FOR YOUR HELP
CHILD REFERRALS QUESTIONNAIRE

To be returned to:
Miranda Wolpert
Trainee Clinical Psychologist
Willesden Centre for Psychological Treatment
Willesden Hospital, Harlesden Road
London NW10 3RY
A 3 year old boy has appeared quite miserable for more than an hour at a time on most days for the last six months. He worries repeatedly over minor events, such as changes in his routine. He follows his mother around, even into the toilet. He is afraid of dogs, cats and other animals. He runs away from them and only calms down after being comforted. He wakes at night two or three times a week and on these occasions ends up spending the night in his parents bed. His G.P. reports that physical examination reveals no abnormalities, and there is no indication of developmental delay.

1) How common do you estimate it is for a boy of this age, who is not mentally or physically disabled, to behave in this way? (please tick one only).
   [ ] Very rare, less than one boy in a 100 behaves like this
   [ ] Quite rare, 1-10 boys in 100 behave like this
   [ ] Quite common, 11-20 boys in 100 behave like this
   [ ] Very common, more than 20 boys in 100 behave like this

2) How worried would you be about this boy's behaviour if he were referred to you? (please tick one only)
   [ ] Not at all worried
   [ ] Mildly worried
   [ ] Worried
   [ ] Extremely worried

3) Do you feel that this would be an appropriate referral to your service? (Please specify which service you are part of).
   Service ________________________________
   Is this an appropriate referral? [ ] Yes [ ] No

4) If you feel it is inappropriate please give reasons for your answer. (Please continue overleaf if necessary).

5) What would you be most likely to do first in this case if this boy were referred to you? (please tick one only).
   [ ] Refer on elsewhere
   [ ] See the child alone
   [ ] See the parents alone
   [ ] See the whole family
   [ ] Other (please specify) ________________________________
A 3 year old girl has been difficult to manage in the last six months, for example her parents find it hard to stop her from destroying things. She appears to be irritable for more than an hour at a time on most days. She has temper tantrums daily, during which she kicks out and screams. These generally last for about 15 minutes. She fights with her peers every day and repeatedly interrupts their games. She does not concentrate on a task for more than five minutes at a time. Her G.P. reports that physical examination reveals no abnormalities, and there is no indication of developmental delay.

1) How common do you estimate it is for a girl of this age, who is not mentally or physically disabled, to behave in this way? (please tick one only).
[ ] Very rare, less than one girl in a 100 behaves like this
[ ] Quite rare, 1-10 girls in 100 behave like this
[ ] Quite common, 11-20 girls in 100 behave like this
[ ] Very common, more than 20 girls in 100 behave like this

2) How worried would you be about this girl's behaviour if she were referred to you? (please tick one only)
[ ] Not at all worried
[ ] Mildly worried
[ ] Worried
[ ] Extremely worried

3) Do you feel that this would be an appropriate referral to your service? (Please specify which service you are part of).
Service _____________________________
Is this an appropriate referral? [ ] Yes [ ] No

4) If you feel it is inappropriate please give reasons for your answer. (Please continue overleaf if necessary).
____________________________________________________________________

5) What would you be most likely to do first in this case if this girl were referred to you? (please tick one only).
[ ] Refer on elsewhere
[ ] See the child alone
[ ] See the parents alone
[ ] See the whole family
[ ] Other (please specify) _____________________________
A 10 year old girl has been complaining of stomach aches at least once a week for the last six months. About once a week she cries on arrival at school, and on one or two occasions has appeared to be quite distressed. She is afraid of new situations, such as meeting new people. She spends most of her time alone. She worries about many things for example if she feels she has done something wrong. She often wakes early in the morning and finds it difficult to settle back to sleep. Her G.P. reports that physical examination reveals no abnormalities, and there is no indication of developmental delay.

1) How common do you estimate it is for a girl of this age, who is not mentally or physically disabled, to behave in this way? (please tick one only).

[ ] Very rare, less than one girl in a 100 behaves like this
[ ] Quite rare, 1-10 girls in 100 behave like this
[ ] Quite common, 11-20 girls in 100 behave like this
[ ] Very common, more than 20 girls in 100 behave like this

2) How worried would you be about this girl's behaviour if she were referred to you? (please tick one only)

[ ] Not at all worried
[ ] Mildly worried
[ ] Worried
[ ] Extremely worried

3) Do you feel that this would be an appropriate referral to your service? (Please specify which service you are part of).

________________________________________________________________________

Is this an appropriate referral?  [ ] Yes  [ ] No

4) If you feel it is inappropriate please give reasons for your answer. (Please continue overleaf if necessary).

________________________________________________________________________

5) What would you be most likely to do first in this case if this girl were referred to you? (please tick one only).

[ ] Refer on elsewhere
[ ] See the child alone
[ ] See the parents alone
[ ] See the whole family
[ ] Other (please specify) ____________________________________________
A 10 year old boy has been caught taking pens and other possessions from his classmates on six occasions in the last six months. On one occasion he has also been found to tear up their work. He is unpopular with the other children and often fights with them, in particular he is liable to bully younger children. He is disobedient to his parents and teachers and lies to them. His G.P. reports that physical examination reveals no abnormalities, and there is no indication of developmental delay.

1) How common do you estimate it is for a boy of this age, who is not mentally or physically disabled, to behave in this way? (please tick one only).
   [ ] Very rare, less than one boy in a 100 behaves like this
   [ ] Quite rare, 1-10 boys in 100 behave like this
   [ ] Quite common, 11-20 boys in 100 behave like this
   [ ] Very common, more than 20 boys in 100 behave like this

2) How worried would you be about this boy's behaviour if he were referred to you? (please tick one only)
   [ ] Not at all worried
   [ ] Mildly worried
   [ ] Worried
   [ ] Extremely worried

3) Do you feel that this would be an appropriate referral to your service? (Please specify which service you are part of).
   Service ____________________________
   Is this an appropriate referral?  [ ] Yes  [ ] No

4) If you feel it is inappropriate please give reasons for your answer. (Please continue overleaf if necessary).

5) What would you be most likely to do first in this case if this boy were referred to you? (please tick one only).
   [ ] Refer on elsewhwere
   [ ] See the child alone
   [ ] See the parents alone
   [ ] See the whole family
   [ ] Other (please specify) ____________________________
1) Your sex:
   [ ] Male [ ] Female

2) Years working as a qualified clinical psychologist:
   [ ] Less than 5 years
   [ ] 5-10 years
   [ ] more than 10 years

3) Years working as a qualified clinical psychologist specialising in work with children:
   [ ] Less than 5 years
   [ ] 5-10 years
   [ ] more than 10 years

4) Please state your main area of work with children, eg as part of a Child Development Centre or in Child and Family Psychiatry or as part of Paediatric Services, and so on.

5) Please rank the following in order of who you estimate makes the greatest number of referrals to your service, as specified above, each year:
   (Please rank the source whom you estimate to make the greatest number of referrals as 1, and so on down to the least frequent source of referrals, who should be ranked at 7.)
   [ ] G.P.
   [ ] Social Worker
   [ ] Health Visitor
   [ ] Paediatrician
   [ ] School Doctor
   [ ] School Teacher
   [ ] Parent
   [ ] Other (please specify)

6) Have you any children yourself?
   [ ] Yes [ ] No

THANK YOU FOR YOUR HELP
2nd February 1990

Dear Parent or Guardian,

I am writing to ask if you would be prepared to take part in a research project looking at what makes parents worry about a child's behaviour. It will take less than 10 minutes of your time. It is hoped that the results will be used to further develop services in Hammersmith and Fulham to help children with behavioural and emotional problems.

If you agree to take part I will send you a questionnaire to fill in containing descriptions of 4 different young children. In the questionnaire you will asked to indicate how worried you would be about these children if they were your children.

You will not be asked to give your name and address on the questionnaire, and thus all replies will be anonymous.

If you are prepared to do this please send me the completed slip below in the self-addressed-stamped envelope provided. If you have any questions please contact me.

Yours sincerely,

Miranda Wolpert
Trainee Clinical Psychologist

I am prepared to be sent a questionnaire to fill in.
Please send it to:

Name _______________________________________

Address ______________________________________
Dear Dr,

I am conducting research into factors that influence referral to child mental health services in West Riverside. It is hoped that the results will aid service development in your area. I am a trainee clinical psychologist employed by N.W.Thames Regional Health Authority, currently based at Willesden Hospital. This research forms part of my qualification in clinical psychology. I would be very grateful for your help.

The enclosed questionnaire consists of 4 short descriptions of children who might be brought to your surgery. In each case please read the description and answer the questions below which relate to how you would be likely to respond to such a case. The whole thing should not take more than 10 minutes to complete.

At the end you are asked for some basic information about you and your practice to help me control for demographic variables. All information will be treated as confidential.

I will send you a copy of my results when the project is completed. If you have any queries please contact me.

Please return the completed questionnaire to me in the envelope provided as soon as possible. Thank-you for your cooperation.

Yours sincerely

Miranda Wolpert
Trainee Clinical Psychologist

N.W.Thames In-Service Training Course in Clinical Psychology
Dear ^F1^,

I am a trainee clinical psychologist on the N.W. Thames In-Service Training Course, currently on placement at Willesden Hospital. For my dissertation for the diploma in Clinical Psychology I am investigating factors that influence referral of children to child mental health services. It is hoped that the results will aid the development of psychological services for children. I would be very grateful for your help.

The enclosed questionnaire consists of 4 short descriptions of children who might be referred to your service. In each case please read the description and answer the questions below it. Please feel free to add any comments you would like to make. The whole thing should not take more than 10 minutes to complete.

At the end you are asked for some basic information about you and your service to help me control for demographic variables. All information will be treated as confidential.

Please return the completed questionnaire to me in the envelope provided as soon as possible. If you have any queries please contact me. I will send you a copy of my results when the project is complete.

Thank-you for your cooperation,
Yours sincerely,

Miranda Wolpert
Trainee Clinical Psychologist
APPENDIX 4
Influence of sex of child on subject questionnaire responses

Table A: influence of sex of child on parent responses

<table>
<thead>
<tr>
<th>scale</th>
<th>mean score boy</th>
<th>mean score girl</th>
<th>t</th>
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</thead>
<tbody>
<tr>
<td>perceived frequency of behaviour</td>
<td>2.2283</td>
<td>2.2015</td>
<td>.45</td>
</tr>
<tr>
<td>level of worry</td>
<td>3.1470</td>
<td>3.1204</td>
<td>.46</td>
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<tr>
<td>wait before going to GP</td>
<td>3.2403</td>
<td>3.4642</td>
<td>-1.02</td>
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Table B: Influence of sex of child on GP responses

<table>
<thead>
<tr>
<th>scale</th>
<th>mean score boy</th>
<th>mean score girl</th>
<th>t</th>
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</thead>
<tbody>
<tr>
<td>frequency of GP contact</td>
<td>1.8684</td>
<td>2.000</td>
<td>-.85</td>
</tr>
<tr>
<td>level of worry</td>
<td>2.4474</td>
<td>2.4429</td>
<td>.04</td>
</tr>
<tr>
<td>wait before referring on</td>
<td>2.2394</td>
<td>2.5692</td>
<td>-1.42</td>
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Table C: Influence of sex of child on psychologist responses

<table>
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<th>scale</th>
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<th>mean score girl</th>
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<tbody>
<tr>
<td>judged frequency of behaviour</td>
<td>2.1974</td>
<td>2.1447</td>
<td>.49</td>
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<tr>
<td>level of worry</td>
<td>2.5135</td>
<td>2.6081</td>
<td>.83</td>
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</table>
AN INVESTIGATION OF FAMILIES' AND THEIR SYSTEMIC THERAPISTS' USE OF ATTRIBUTIONS OF BLAME AND EXONERATION IN RELATION TO THE PRESENTING PROBLEM

Dissertation submitted to Surrey University as part of the requirements for the degree of PsychD.

[19,993 words]
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### 3. STUDY TWO:
CODING PARTICIPANTS' ATTRIBUTIONS OF BLAME AND EXONERATION IN ONE THERAPEUTIC ENCOUNTER, ALONGSIDE A CONVERSATION ANALYSIS OF THAT ENCOUNTER.

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I am very grateful to all the family members and therapists who took part in this research. I would like to thank: Clare Twigger Ross for supervising this research; Paul March and Ruth Kossoff for their contribution to data collection; Nigel Woodger for his help in creating the MSA graph; Lorraine Nanke, Glynnis Lawes and Lewis Wolpert for their comments on earlier drafts and Philip Sales for proof reading and ongoing support. I would also like to thank Natasha and Benjamin Sales for their tolerance and support.
ABSTRACT

This study set out to develop operational definitions of blame and exoneration, that could be used to code causal attributions about the presenting problem as they arise in naturally occurring conversations in child mental health services. Two studies were undertaken. Study One used the Leeds Attributional Coding System to code causal attributions about the presenting problem made by a sample of ten families and their therapists, and to categorise these attributions as either blaming or exonerating. The different patterns of blame and exoneration made by family members and therapists was investigated and the possible relationship between levels of blame and drop out from therapy was tentatively explored using Multi-dimensional Scalogram Analysis (MSA). The ten mothers and three children in the study tended to make attributions that blamed the referred child, whilst the two fathers mainly made attributions about the difficulties that exonerated the child. The five therapists tended to make attributions that exonerated the child. MSA indicated that blame of parents by therapists in their interventions, might be a factor worth exploring in relation to premature termination of treatment. Study two set out to explore the validity of the coding system developed, by comparing the results of using the coding system with the results of a Conversation Analysis of a therapeutic encounter. It was found that the coded causal attributions could be taken as representative of the participants' construction of blame and exoneration for the difficulties in that encounter.
INTRODUCTION

1.1 Purpose of study

This study sets out to develop operational definitions of blame and exoneration that can be used to code naturally occurring causal attributions that arise in clinical settings. These definitions will be used to investigate the patterns of blaming and exonerating attributions made by family members and the therapists they see about the presenting problem, and to explore the relationship between these patterns of blame and exoneration and drop out from therapy.

1.2 Blame and systemic family therapy

People tend to seek to attribute blame for negative events that befall them (Finerman & Bennett, 1995; Hewstone & Fincham, 1996). Issues of blame are thus likely to arise in any initial encounter between a therapist and a family who have come to seek that therapist’s help because of difficulties they are having in relation to their child. “...in seeking therapy individuals signal some change, or breach of the everyday for which they must account to the therapist....This means that issues of blame and responsibility are central”. (Standcombe & White, 1997 p. 23).

Whom family members blame for their problems, and to what extent they blame them, is thought crucially to affect their response to their difficulties (Frude, 1991). It has been argued that where parents blame their children for negative events that happen it may contribute to the development of conduct disorders in those children (Baden & Howe, 1992), to the increased risk of abuse of those children by their parents (Silvester, Bentovim, Stratton, & Hanks, 1995) and to be associated with poor outcome of family therapy (Frude, 1991). Where parents
blame themselves, or experience themselves as being blamed by others, it may reduce their ability to engage in useful therapeutic work (Furlong & Young, 1996; Furman & Ahola, 1989).

Systemically orientated therapists are particularly interested in the role of blame in therapy. It is widely argued that families characteristically come to therapy with an entrenched "blame frame"; whereby family members seek to blame one person, generally the referred child, for causing the difficulties that have led the family to seek clinical help (Byng-Hall, 1980; Hoffmann, 1981; Stratton, Preston-Shoot, & Hanks, 1990; Walzlawick, Weakland, & Fish, 1974). Meyerstein (1994) writes: "Blame is one of the most pernicious, toxic and widespread styles of heightened emotional responsivity in families... blame constitutes family members' attempts ...to solve a problem by assigning culpability" (p. 26).

It is thought that one of the key tasks for the therapist is to challenge this blaming attitude and help the family come to a different understanding of the difficulties that does not involve assigning blame (Burnham, 1986; Stratton et al., 1990). It is suggested that this can be done in part by a "reframing" of the difficulties, whereby the problem is re-described by the therapist in a different way, such that the family is able to take on a new non-blaming understanding of the difficulties (Burnham, 1986; Pocock, 1995).

1 Systemic therapy is an approach to working with children and their families which focuses upon interactional rather than individual phenomena. The three schools of therapy which are based upon systems theory are: the "Milan Systemic", "Structural" and "Strategic". The Milan Systemic approach, which is the focus of this study, particularly concentrates on the way in which family members' interpretation of the causes and nature of the problem contributes to the difficulties (Penn & Sheinberg, 1991). For a comparison of the three approaches see Burnham (1986). "Milan Systemic" and "systemic" will be taken as synonymous from this point on.

2 "To reframe, then, means to change the conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and to place it in another frame which fits the "facts" of the same concrete situation equally well or even better, and thereby changes its entire meaning" Watzlawick et al. (1974), p. 95.
Much of what Milan systemic therapists actually do in therapy can be seen as intended to help challenge the blaming attributions brought by families and to enable family members to develop alternative non-blaming explanations. Therapists work in teams so that they can then tap different perspectives on the same problem (Tomm, 1984; Sgrenkle & Bischof, 1994). The therapeutic team meet for some time before the family arrives to “hypothesise” about possible ways of understanding the family’s difficulties on the basis of any information they have at that time. The therapists attempt to develop hypotheses that relate to the interaction between individuals in the relevant system that are not blaming of any individual or indeed of the family as a whole (Burnham, 1986; Penn & Sheinberg, 1991).

In the session itself one therapist interviews the family while his or her co-worker(s) sits behind a one-way screen. The therapist(s) behind the screen can phone through to the therapist in the room to make suggestions and comments or ask for specific questions to be put to family members. Questions are not just used to gather information, but are also designed to de-stabilise existing beliefs and to introduce new links and ideas (Tomm, 1984a; Tomm, 1984b; Burnham, 1986). Therapists challenge blaming explanations both by adopting a non-blaming stance in general, and by seeking to elicit alternative non-blaming explanations from family members (Melidonis & Bry, 1995; Meyerstein, 1994).

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3 The summary of therapeutic practice given in the text above will principally reflect Milan therapy as practised in the team where the research was carried out. This practice is likely to be representative of mainstream Milan therapy given the fact that senior team members were involved in teaching Milan therapy both within and outside the team. Only those elements of Milan therapy relevant to the present research will be highlighted. For a full account of this mode of therapy see Burnham (1986), or Stratton et al. (1990).

4 Interestingly the term “exoneration” is not used in the family therapy literature. It will be used here, and taken to be interchangeable with “non-blaming”.

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Towards the end of the meeting the primary therapist leaves the family and meet with his or her co-worker(s) to discuss the issues raised. He or she then returns to the family and offers an “intervention” which generally includes some suggestions as to how the families’ difficulties might be viewed. It is the intervention that is the vehicle by which new attributions and perspectives are formally introduced which may challenge the families pre-existing beliefs (Burnham, 1986). This can be done in a number of ways, for example: a normative perspective can be offered, the effect of external events can be stressed or the positive intent behind the behaviour can be emphasised (Coppersmith, 1981; Stratton, 1992).

One of the criticisms of systemic therapy is that in attempting to exonerate the child the therapist implicitly blames the family unit as a whole. Treacher and Carpenter (1993) comment: “many of the conceptual frameworks and techniques that have been adopted by family therapists... implicitly or explicitly blame family members for the predicament of the family symptom bearer” (p. 14). In particular some systemic therapists have been criticised by feminists for focusing on the role of the mother rather than other family members, particularly the father (Bograd, 1984; Goldner, 1985; Piercy & Sprenkle, 1990).

In response to these criticisms there have been calls for therapists to increase their vigilance against the danger of replacing family members’ blaming of one individual with alternative “blamings”, such as of the family as a whole (Treacher & Carpenter, 1993). For example Reimers and Street (1993) comment on the need for therapists to increase their sensitivity to the way their interventions may be heard by family members as blaming the family for the difficulties. “there is a difference between encouraging people to take responsibility for bringing about change on the one hand, and blaming them for being the cause of the problem in the first place. The feeling of being blamed is
very common and a poor basis for seeking change, because of the defensiveness it understandably stirs up in parents" (p. 52)

It has been suggested that if parents feel they are being blamed by the therapist for the difficulties, they will not engage in a positive therapeutic alliance with that therapist, and may be more likely to drop out of treatment (Howe, 1989; Kuehl, Newfield, & Joanning, 1990; Mason, Watts, & Hewison, 1995; Reimers & Street, 1993). Given that 40-60% of all families terminate psychological treatment prematurely (Armbuster & Kazdin, 1984; Cottrell, Hill, Walk, Dearnaley, & Ierotheou, 1988; Novick, Benson, & Rembar, 1981) it is argued that therapists must be particularly sensitive to these issues (Furlong & Young, 1996). 5

In the light of this it has been argued that the therapist must strive to minimise the possibility of parents feeling blamed at the outset of therapy, in order to increase the chances of positive “engagement” occurring, and in order to reduce levels of premature termination of treatment by families (Howe, 1989; Treacher & Carpenter, 1993).

Despite this concern with the issue of blame, there is a surprising lack of debate in the clinical literature about exactly which verbal or other acts can be taken to constitute blame. It would seem to be a prevalent assumption that it is clear to all what blame is and when it is being used, the only issue remains as to how to best combat it.

This lack of debate amongst clinicians is intriguing since in fact blame is an extremely difficult concept to define, particularly when trying to

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5 It is important to note that drop out cannot necessarily be taken as a measure of treatment failure - just because a family drops out does not mean treatment was not successful (Kazdin, 1996). However, drop out remains a problem in itself in that it wastes clinical time waiting for families who do not appear and may make it
determine its existence or otherwise in naturally occurring conversation.

1.3 The nature of blame

Blame is defined in the Oxford English Dictionary as: a verb “to find fault with” or “fix the responsibility on” and as a noun “censure” or “responsibility for a bad result”. Exoneration is defined as “to free from blame”.

It is crucial to distinguish between responsibility and blame. Blame always implies responsibility but responsibility does not invariably imply blame. For blame to occur there must be an attribution of responsibility and also moral censure. (Brewin and Antaki 1987).

Blame is an extremely slippery concept to define operationally, particularly in a naturally occurring context such as a clinical encounter. For example if a mother describes the presenting problems to the therapist thus: “the problems have arisen because my child is a very active child” should this be taken as a blaming or non-blaming statement? At first sight the mother may be assumed to be holding her child to blame for the difficulties in that his activity levels are responsible for the “bad result”. Yet whether she “censures” him for his behaviour may depend on a number of other factors. For example it may depend on whether she thinks his levels of activity are intentional in creating the negative outcome and on whether she feels his activity levels are outside his control or not.

Attempts to explore how to define blame in interpersonal communication have largely arisen within the attribution literature.

harder for families to feel able to return to the service in the future if they feel the need (Emison, 1986).
An attribution was defined by Heider (1958) as any statement about an event that assigns a cause to that event. Clearly any event can have a huge number of possible causes, but Heider proposed that cause could be usefully categorised into two basic types, which came to be termed “internal” and “external” (Weiner, 1986). Internal attributions suggest an outcome arises due to factors within an individual, external attributions suggest an outcome arises due to factors in the environment that are external to an individual. The more factors internal to an individual are deemed to have caused an outcome, the less factors in the environment are deemed to have caused that outcome, and vice versa.

Since Heider's original formulation a vast literature has been spawned in which ever increasing numbers of dichotomous attributional dimensions have been identified and studied, and some of these have been applied to the study of clinical interactions in relation to child and family work (Joiner & Wagner, 1996). It has been argued that blame can be seen to arise from the interplay of a number of attributional dimensions (Hewstone & Fincham, 1996; Shaver, 1985). In particular the following four dichotomous dimensions have been identified as influencing judgements of blame in clinical settings:

- Intentional-unintentional

The more an individual is seen to have intended a negative outcome to have occurred the more he or she is likely to be held to blame for that event (Hewstone & Fincham, 1996; Shaver, 1985). However, this is not invariably the case. An individual may not be held to blame for an intentional act if they are seen as in some way not being in control of their actions. Thus if an individual kills someone, and intends to do so, but does so because voices in their head told them they had to, that individual may not be taken as to blame for their actions.

Alternatively, individuals are sometimes blamed for effects which they
did not intend. For example, when a person acts in a way which is reckless, he or she may be blamed for any negative consequences that ensue.

- Internal-external
It has been argued that the more an observer regards the negative outcome as resulting from factors internal to the individual, the more he will consider that individual to blame (Hewstone & Fincham, 1996; Fincham, Beach, & Baucom, 1987; Shaver, 1985). By extension, it can thus be argued that the more an observer regards the negative outcomes as resulting from factors external to the individual the more he will consider the individual exonerated from blame. However, this is not invariably the case, as a cause may be internal to an individual but seen as outside their control. For example, a two year old may wet the bed, but this may be perceived as due to their small bladder or their developmental immaturity, and so they may not be morally censured for this negative outcome (Butler, Brewin, & Forsythe, 1986).

- Controllable-uncontrollable:
The more the factors that lead to the negative outcome are seen as controllable by an individual the more that individual may be seen to be to blame for that outcome (Brewin & Antaki, 1982; Shaver 1985; Smail, 1993).

- Personal-universal:
The more the internal factors that lead to the negative outcome are seen as personal (or idiosyncratic) to the individual, as opposed to universal (or generally applicable), the more that individual will be held to blame for the negative outcome of their actions (Brewin & Antaki, 1982; Janoff-Bulman, 1979).
It would appear that blame is likely to increase with increases in the following attributions: intentionality, internality, controllability, and particularity. It is most likely to decrease with increases in the following attributions: unintentionality, externality, uncontrollability and universality. However, as yet no attempt has been made to integrate these dimensions to explore blame as it arises in clinical situations.

Whilst researchers have looked at one or more of the attributional dimensions identified above as they arise naturally in clinical settings (e.g. Larrance & Twentyman, 1983; Silvester et al., 1995; Stratton et al., 1986), no attempt has been made to use these dimensions to explore systematically blame itself. On the other hand, what research does exist that sets out specifically to explore issues of blame in clinical settings (e.g. Sporakowski, McKeel, & Madden-Dedrich, 1993), has not involved any attempt operationally to define blame along the lines suggested above.

Before reviewing this research literature it is first necessary to provide a brief overview of the type of measures that have been used to explore blame in clinical situations.

1.4 Measures used to explore blame in therapeutic settings

1.4.1 Questionnaires

Only two questionnaires have been identified that have been used specifically to investigate blame in relation to family difficulties (Joiner & Wagner, 1996): The Parent Attribution Questionnaire (PAQ) (Walker & Masters, 1989), as used in a modified form by Baden and Howe (1992), and the Mother-Adolescent Attribution Questionnaire (MAAQ) (Grace, Kelly, & McCain, 1993).
The PAQ as modified by Baden and Howe (1992) relies on hypothetical examples of child behaviour which the subject then has to rate on a number of attributional dimensions, including “child’s intent”, on a five point Likert-type scale. Baden and Howe take “child’s intent” to be synonymous with blame in their research (p. 481). The MAAQ uses hypothetical scenarios, in which each participant is asked to rate their “partner’s” behaviour on a number of attributional dimensions, including “blame”, on a six point Likert-type scale. The definition of blame given is “the other person in the dyad is held accountable for the behaviour” (p. 203).

The operational definitions of blame used in these questionnaires do not take into account the range of relevant dimensions identified above. Moreover, neither questionnaire deals with attributions of blame as they arise naturally in real clinical situations, and this approach has been criticised for lacking ecological validity (Stratton, Munton, Hanks, Heard, & Davidson, 1988).

1.4.2 Coding of naturally occurring conversation

Dissatisfaction with reliance on questionnaire responses has led some researchers to develop methods of coding attributions occurring naturally in therapeutic encounters (Stratton et al., 1986). Melidonis and Bry (1995) operationally define blame as occurring in any speech act that consists of a) “a put down”, b) “a complaint” and c) “a specification of the problem”. However, it remains unclear what constitutes a “put down” and a “complaint”. Also the researchers do not deal with the issue, raised above, of how to distinguish the occasions when the individual’s complained about behaviour is seen as causally responsible for the problem from those when it is seen as reflecting other factors.
A coding system developed by Stratton and colleagues, “the Leeds Attributional Coding System” (LACS) (1988), whilst not looking at blame directly, does offer a way of coding the attributions identified above as likely components of blame. In this system any statement that answers the question “why?” is coded on the following five dichotomous attributional dimensions:

- **internal - external**: assesses whether a cause is perceived as located within a person or located in the environment.
- **personal-universal**: assesses the degree of uniqueness or idiosyncracy.
- **controllable-uncontrollable**: assesses the degree to which a person is held to be able to control a cause or outcome.
- **stable-unstable**: assesses the degree to which a cause is perceived as being persistent over time.
- **global-specific**: assesses the degree to which causes are perceived as being generalisable over events.

Curiously, despite Stratton et al. (1990) emphasising the role of blame in therapy, no means is offered of coding statements directly on a blame-exoneration dimension. However, the five dimensions listed are not meant to be exhaustive nor is it suggested that each dimension will necessarily need to be measured for every study. Similarly, whilst The LACS has generally been used by researchers to code all causal statements, regardless of their subject matter, it can be used to code only certain categories of attributions that are of interest to a researcher.

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6 The LACS is currently in the process of being revised and updated and some attempt is likely to be made to introduce a dimension of blame - Hewison personal communication.
What the LACS provides is a way of identifying and coding attributions occurring in natural settings with the suggestion that the dimensions employed can be modified depending on the aims of a particular research project.

1.4.3 Micro-analysis of conversations in therapy.

Another approach to researching blame as it arises in therapeutic encounters is the use of micro-analysis of conversations in therapy. This approach relies on a detailed analysis of language as used in a particular context, which may involve looking at the way an individual uses language to blame and exonerate others (Labov & Fanshel, 1977; Stancombe & White, 1997). It is based on a recognition of the fact that any therapeutic encounter involves both explicit and implicit propositions as to what has caused the difficulties.

Furman and Ahola (1989) comment that any therapeutic encounter can be characterised as:

"an exchange between two or more individuals of causal attributions related to problematic behaviour. Clients expose their own causal attribution to the clinician by telling what they believe is the cause of the trouble or by speaking about the problem in a way that implies causal explanations. Clinicians support those attributions or offer alternative ones for the clients to consider. These alternative attributions may be suggested either explicitly by telling the patient what the clinician believes is the cause of the behaviour or implicitly by asking certain types of questions or making certain types of suggestions" (p. 186). It is these implicit attributions that micro-analysis of conversation can be used to identify.
A distinction needs to be made at this point between different types of micro-analysis. One form of micro-analysis, based on a social-constructivist epistemology, involves analysis of language without implying an assumption by the researcher that underlying structures of thought or beliefs exist in the minds of the interlocutors (Stancombe & White, 1997). This will be termed discourse analysis from this point on.

In their discourse analysis of a session of family therapy, Stancombe and White (1997) comment on the fact that blame is a central issue in therapy that has been insufficiently studied, and argue that discourse analysis can be used to explore the text of a therapy session to determine: "how do parents do blamings" (p. 26). But, whilst a fine grained analysis is applied to the text in terms of the rhetorical devices used by the participants, no definition of blame is offered. Blame is taken to be a self-evident event that occurs whenever an "unhappy incident" is recounted that is linked in any way to behaviour on the part of the "blamed" spouse (pp. 28-29).

The second type of micro-analysis derives from an empiricist perspective and involves measures of expansion of the text combined with linguistic analysis to determine how meaning is created (Labov & Fanshel, 1977). This form of analysis will be termed conversation analysis for clarity from this point forward. Conversation analysis describes how language is used by speakers to achieve particular results (Gale, 1993). It provides a means of expanding the text of a conversational encounter to make explicit implicit propositions (Labov & Fahshel, 1977). In particular, it provides practical methods for inferring the way a speaker assigns relative importance to the propositions he or she puts forward in relation to a particular topic.
Buttny and Jensen (1995) used conversation analysis to look at the way participants in an initial session of family therapy offer different constructions of the problem. Participants are taken to signal the importance of certain key propositions in their construction of the causes of the problem, by means of a number verbal and non-verbal devices (Buttny & Jensen, 1995). The following three verbal devices are identified as being involved in emphasising one construction at the expense of others:

- repetition: when a participant repeats a proposition in the discourse, or says the same thing in a number of different ways
- discounting: when a participant responds to a particular element in their interlocutor’s speech, or fails to respond to a key aspect of their interlocutor’s speech.
- verbal phrasing: when a participant use verbal phrases that emphasise a point such as asserting “so my point is...” or “what I am trying to say is...”.

Although no explicit definition of blame is offered, conversation analysis can be used to explore the way in which the participants in a therapeutic encounter prioritise certain explanations about the presenting problem implicitly (by the questions they ask and suggestions they make) as well as explicitly (by the statements about cause that they offer), and thus to investigate how far these involve blame or exoneration. It is, however, a very time consuming process and unsuited to looking at multiple cases (Potter & Weatherell, 1987).

In reviewing the research literature below it will be noted what measures were used to explore issues relating to blame, and each study will be assessed to see how far the results indicate a blaming stance on the basis of the dimensions outlined above.
1.5 Research literature on blame and families in therapy

1.5.1 Blame by parents in therapy

Researchers have found some evidence of a particular attributional style amongst families in therapy that is different from that of a group of control families. Munton and Stratton (1990) used the LACS (Stratton et al., 1988) to code a sample of ten therapy sessions and ten control interviews with families. They demonstrated that families in therapy tend to attribute the causes of negative events to internal and personal causes, to a greater degree than control families. They found that 17% of all attributions about events with a negative outcome, made by family members in the clinical group, were internal and personal, whereas only 9% of attributions about events with a negative outcome, made by family members in the control group, were internal and personal.

Parents in distressed child-parent relationships appear to be apt to use attributions about their child that may be seen as components of a blaming stance. Baden and Howe (1992), using the PAQ (Walker & Masters, 1989), found a sample of 40 clinic mothers significantly more likely to describe their child's negative behaviour as intentional on the part of the child than 40 control mothers (using an analysis of variance). Compas, Friedland-Bandes, Bastien and Adelman (1981) assessed 116 children and mothers from a psycho-educational clinic using a questionnaire specifically designed for the study. They found that parents tended to attribute the cause of behavioural difficulties to factors within the child more frequently than to factors external to the child.

7 Only the verbal devices are explored here.
Butler et al., (1986) investigated attribution of cause made by 68 mothers of enuretic children using a questionnaire made up of 16 statements of cause of enuresis commonly reported in clinical practice (such as “he/she is a worrier”, “he/she has something physically wrong” etc.). Whilst most mothers saw the cause as internal to the child but uncontrollable by him or her (in particular, the majority of mothers endorsed the statement - he/she is a heavy sleeper) a minority of mothers perceived the cause as being more controllable by the child (endorsing the statements “he/she will not do as she is told”, “it is a way of getting back at me”). It was these mothers who showed least tolerance of the enuresis and this was associated with poorer treatment outcome.

Parents who have abused their children appear to be particularly likely to use attributions about their children that may be seen to be components of a blaming stance. Larrance and Twentyman (1983) investigated three groups of mothers attending a child guidance clinic; with a prior history of child abuse, a history of child neglect and no history of child mistreatment. Each group was made up of 30 mothers. The mothers in each group were shown photographs depicting their own children and other children in situations where a negative event had occurred (e.g. where toys were broken) or where something good had been achieved (e.g. a completed task). They found that abusive mothers made significantly more internal attribution for negative child behaviour than did comparison mothers. Silvester et al. (1995) using the LACS to examine spoken attributions produced by 18 families during assessment sessions in therapy, found that abusive mothers produced spontaneous attribution of causality for negative events that were characterised by high control for child and low control for self.

In the light of the above research it would seem that parents attending child mental health services may come with attributions of
cause that are internal to the child and controllable by the child. This is especially the case where there is a history of abuse or the child or the parent-child relationship is particularly stressed. These attributions can be seen as likely to invoke blame in that they hold the child responsible for unwanted outcomes and see the behaviour as either intentional on the part of the child or within the child’s control.

Research not based directly on attribution theory lends further support to this finding. In Australia, Watson (1986) looked at a sample of 70 families attending a family therapy clinic, using pre-first session interviews in which parents were asked open ended questions about what they thought made their child the way they were. She then derived six categories of explanation from the data; “within child”, “immediate family”, “school”, “previous spouse” “incidents” and “don’t know”. Although the categories were not seen as mutually exclusive the primary category used by each parent was noted.

Watson found that both mothers and fathers most commonly attributed emotional disturbance to something within the child (such as character traits, or physical factors). The second major category was the immediate family, with the majority focused on the mother and a smaller number attributing cause to the father. The third major category was the school (generally a particular teacher was seen as the cause of the difficulties). Only a small proportion (7% of both mothers and fathers) cited incidents as involved in the difficulties at all.

It is hard to determine from this study how far the parents blamed the child, since it is not possible to determine the parents attributions of intentionality, controllability or universality in relation to the child’s role in causing the difficulties.
Mason et al. (1995) sent questionnaires to all parents who had been referred for the first time to a child psychiatrist in an outpatient unit. 62 questionnaires were returned (only 37 of these were completed). Over 71% of respondents saw the problems as arising within the child, 37% arising in school, 37% at home. Where the child was diagnosed as having conduct disorder (17 cases) 100% of parents thought the problem was in the child. Once again it is possible that these parents may have been holding the children to blame in these cases but it is not possible to say so conclusively since essential information is lacking.

Stancombe and White (1997) used discourse analysis to re-analyse an initial family therapy, previously analysed by Frosh, Burck, Strickland-Clark and Morgan (1996). The session involved a recently separated husband and wife and a family therapist. Stancombe and White describe the context as a situation in which “each parent is anxious to project blame for the breakdown of the relationship on the other” (p. 28). However, they offer only one instance of “implicit blame”. This occurs when, in answer to a therapist’s question about his role in deciding to seek help, the husband says he was told about the appointment for therapy by his wife three weeks before the appointment, without a prior discussion as to whether they should ask for an appointment. Stancombe and White take this as evidence of a “successful blaming” by the husband of the wife for “her failure to discuss or consult”. Why this should be seen as blaming, or as “successful” remains unsupported by any other evidence.

Buttny and Jensen (1995) carried out a conversation analysis of a first session of family therapy with a couple. They point to the fact that in this first meeting issues of assignment of blame are central. They analyse a “blame-defence” linguistic sequence between a wife and husband who each seek to blame the other for their marital
breakdown. However, Buttny and Jensen do not seek to offer any elaboration of the term blame or how they come to decide what counts as blame and what does not, nor do they choose to look at blame specifically in relation to the cause of difficulties that brought the couple to therapy in the first place.

1.5.2 Blame by children in therapy

There has been remarkably little research or even speculation in this area, although one study exists. Compas et al. (1981), using the questionnaire specifically designed for the study, found that children were relatively more likely than their parents to attribute cause of negative outcome to external factors (analysis by t-test) than to factors internal to themselves. However, they note that half of the 116 children explained the difficulties in terms of factors internal to themselves, and suggest that these children may be worthy of further investigation. However, no subsequent study along these lines is evident in the literature.

1.5.4 Blame by therapists working with families

Little attempt has been made to look at therapist attributions about the nature of families’ difficulties as they arise in a child mental health setting, although some studies do exist that relate to this area. Sporakowski et al. (1993) looked at a sample of 157 family therapists and 121 advocate-counsellors working in women’s shelters. They asked participants to indicate who they thought was “responsible for abuse” in relation to a number of vignettes that detailed instances of domestic violence. They found the two groups surprisingly similar in their attributions despite differences in theoretical background and training. In particular, they noted that despite the family therapists
“systemic” perspective they attributed the cause of the violence to the man rather than to relationship factors.

Once again, whilst this study does not cover all the attributional dimensions identified above as relevant to a judgement of blame, it does suggest the possibility of blame. The finding may mean that despite their training, therapists may revert to internal (and thus potentially blaming) attributions when confronted with extremes of behaviour or those that they morally disapprove of.

March and Harris (1995) compared a sample of 42 family therapists to 40 (non-clinic) parents in terms of how they understood childhood difficulties. They sent out a questionnaire specially designed for the study, which used vignettes of children with behavioural difficulties. Respondents were asked to rate how far they felt the children’s behaviour was caused by a number of factors including: “past events”, “present circumstances”, “physical factors” and “personality”. Although parents did tend to endorse more child centred attributions (such as child’s personality) whilst therapists used more parent-centred attributions (such as parent’s personality), the results were not statistically significant. March and Harris argue that the lack of difference between the two groups is likely to be due to the fact this was a non-clinical sample of parents, who may be less strongly child-centred than clinic parents in terms of their explanations of difficult behaviour.

In their discourse analysis of an initial family therapy session Stancombe and White (1997) point out that previous discourse analyses have failed to give as much weight to the therapist as to the family members. They seek to redress this by pointing to the way the therapist in the session they review uses language to encourage family members to relinquish their existing attributions of blame.
1.5.5 Blame and drop out from therapy

No research was found that looked at this issue directly. However, there are indications in the existing literature that levels of blame might be implicated in drop out rates.

Watson’s (1986) study looked at the effect of parental attributions on therapy outcome. She found that if the mothers saw the problems as due to something within the child outcome was worse (as measured by pre-and post-behaviour rating scores) than if they saw the problem as a function of outside influences such as the family or the school. Watson did not look at drop out as such, indeed she excluded all families who dropped out from her analysis of outcome. She does point out that it was her impression that: “the least successful families appear to "drop out" at the beginning of therapy. When the attributions ...of these two groups, (i.e. the continuers and the drop outs) are compared it would seem likely that differences would be accentuated even further” (p. 280).

Mason et al. (1995) found that parents frequently come expecting and dreading blame. They asked their sample of parents how far they expected blame to be apportioned in therapy. They found that half their sample of families referred to a child mental health outpatient service expected blame to be apportioned by therapists, and the majority of these thought they would be the main recipient of such blame and appeared nervous of the prospect; for example, one parent added “I do hope not”. However, they did not explore the effect of these expectations on service uptake, nor the extent to which these expectations were born out in practice.
In his recent review of the literature on drop out, Kazdin (1996) suggests that drop out appears to be multi-determined by a range of factors in the family (including: low socio-economic status, single-parent families, young mothers and belonging to an ethnic minority). Kazdin comments on the scarcity of information about the effect of family beliefs and family-therapist interaction on service uptake and calls for further study in this area, suggesting these are likely to be of central importance. Kazdin, Holland, Crowley and Breton (1997) have gone on to develop a “barriers to treatment participation” scale which seeks to measure some of the factors that may relate to drop out. Although this scale seeks to measure a range of beliefs held by the family and the therapist (such as perceived relevance of treatment), issues of assignment of blame are not represented on this scale.

Yet blame would appear to be a major contender for influencing drop out rates. It would appear that where parents blame their children for the difficulties, there may be an increase in the likelihood of poor outcome, which may include the family dropping out of therapy prematurely (Watson, 1986). Moreover, where parents feel blamed by the therapist, it could be hypothesised that it is likely that this too may contribute to an increased likelihood of drop out. These issues would appear to be worthy of further exploration.

1.5.6 Summary.

Blame is highlighted as a central issue in systemic therapy with families. The assumption is that parents characteristically come to therapy blaming a particular child and fearing blame of themselves.

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8 It is important to recognise that in child mental health services it is almost invariably the parents rather than the children themselves who determine drop out rates. It is the parents who are generally in control of deciding whether the child returns or not.
Therapists attempt to shift blame away from any individual family member, or indeed from the family as a whole. It has been suggested that patterns of blame may affect drop out rates; that high levels of blame of the referred child by the parents may increase the likelihood of poor outcome and that if parents' feel blamed by this may contribute to families terminating treatment prematurely.

Relatively few studies have focused specifically on investigating blame in the therapeutic context. Those that have, have not developed an operational definition of blame that takes into account the attributional dimensions identified in the social psychology literature as relevant to a judgement of blame namely: internality, intentionality, controllability and universality.

Findings from studies that do explore some of these dimensions in clinical settings indicate that parents characteristically come to child mental health services with the following attributions about the causes of the difficulties: internal (to the child), personal (to the child), controllable (by the child) (Munton & Stratton, 1990; Baden & Howe, 1992). Children have been less studied, but what findings there are suggest that whilst they are relatively more likely to attribute the difficulties to external factors than their parents, a substantial number do make internal attributions to themselves for their difficulties (Compas et al., 1981). The small body of research that looks at therapist attributions about the cause of problems indicates that therapists may make fewer attributions that are internal to the child than parents (March & Harris, 1995).

Micro-analysis of individual sessions suggests blame is a central topic for much of the therapeutic conversation, particularly in the initial sessions (Buttny & Jensen, 1995; Stancombe & White, 1997). However such analyses have not focused specifically on attributions of blame in
relation to the difficulties that brought the family to seek help, nor explored how therapists themselves may make construct blaming propositions.

1.6 Aims of current research

- To use operational definitions of blame and exoneration to code causal attributions about the presenting problem that occur naturally in conversations in a clinical context.  

- To investigate patterns of attributions of blame and exoneration amongst family members and therapists in relation to the presenting problem, and to explore their possible relationship with drop out from therapy.

- To situate these coded attributions within a micro-analysis of a specific clinical conversation, in order to determine how far they can be taken as representative of an individual's construction of blame in conversation within one case.

Two studies were undertaken to achieve these aims.

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9 It is important to stress that this research is only seeking to create operational definitions of blame and exoneration that can be used in a specific context, i.e. where the presenting problem is being explained in therapy. This research does not set out to create universally applicable definitions of blame and exoneration that can be applied to all contexts.
STUDY ONE:
INVESTIGATION OF ATTRIBUTIONS OF BLAME AND EXONERATION FOR THE PRESENTING PROBLEM MADE BY FAMILIES AND THEIR THERAPISTS.

2.1 Aims

To use operational definitions of blame and exoneration to code causal attributions about the presenting problem, that arise in initial clinical encounters in a child mental health setting.

To explore the following questions:
1) Do the majority of attributions made by family members at the start of an initial session blame the child for causing the current difficulties?
2) Do the majority of attributions made by the therapist, in the pre-session meeting and the intervention, exonerate the child from causing the current difficulties?
3) Might high levels of blame of child by family members at the start of the initial session (over 50% of all attributions) and any blame of parents by the therapist in their intervention in the initial session, possibly be associated with increased rates of drop out?

2.2 Method

2.2.1 Design

A multi-case design was used. Ten families and their therapists took part.
It was decided to look at initial clinical encounters, as these were most likely to involve explicit discussions of the causes of the presenting problems (Buttny & Jensen, 1995; Firth-Cozens & Brewin, 1988).

To tap family members' attributions, the first twenty minutes of the session were used. Only the first twenty minutes were used because this is likely to be the site of most clear discussion of the presenting problem; in subsequent sessions (and towards the end of the first session) it would be expected that attributional change would have occurred (Stratton et al., 1990; Munton & Antaki, 1988).

To explore the main therapists' initial attributions, his or her causal attributions made during the pre-session hypothesising meeting was analysed, as this was seen as reflecting framework of ideas with which they entered the therapeutic dialogue. The end of session intervention was looked at as a key site at which therapists' formally offered their thoughts, in relation to the presenting problem, to the family.

2.2.2 Participants

The families were drawn from referrals to a London child and family psychiatric service. All families referred to the department within a 15 month period were considered for inclusion subject to the following criteria: that the researcher was not involved in the case, that this was an initial meeting at the department, that there was no current or likely future court involvement, that the referral was not for an assessment of abuse, that the therapist was prepared to take part in the study and that the session was videotaped.

The total number of families seen for a first appointment during this period was 354. Of these, 26 families met this criteria for inclusion. Of
these, 15 never attended and one family declined to be involved. Thus ten families were involved in the study. The children ranged in age from 16 months to 15 years, with a mean age of five years old. There were eight boys and two girls. Seven were referred by GPs, one by a health visitor, one by a school physician and one was a self-referral. Four of the children were black British, three were white British, one French and one Algerian-British. Half the sample were first born (see table 1).

Table 1: Demographic information

<table>
<thead>
<tr>
<th>family name</th>
<th>age</th>
<th>sex</th>
<th>referrer</th>
<th>problem</th>
<th>ethnic origin</th>
<th>who came</th>
<th>who made attributions</th>
<th>main therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith</td>
<td>11</td>
<td>f</td>
<td>self</td>
<td>suicidal</td>
<td>Black British</td>
<td>mother and child</td>
<td>mother</td>
<td>Dr Thomas</td>
</tr>
<tr>
<td>Jones</td>
<td>4</td>
<td>m</td>
<td>H.V.</td>
<td>behaviour problems</td>
<td>Algerian/British</td>
<td>mother father, child and brother</td>
<td>mother</td>
<td>Dr Briggs</td>
</tr>
<tr>
<td>Watts</td>
<td>2</td>
<td>m</td>
<td>G.P.</td>
<td>behaviour problems</td>
<td>French</td>
<td>mother and father child and sister</td>
<td>mother</td>
<td>Dr Brown</td>
</tr>
<tr>
<td>Harris</td>
<td>5</td>
<td>m</td>
<td>School Dr.</td>
<td>behaviour problems</td>
<td>White British</td>
<td>mother, stepfather and child</td>
<td>mother</td>
<td>Dr Green</td>
</tr>
<tr>
<td>Trent</td>
<td>11</td>
<td>m</td>
<td>G.P.</td>
<td>tics</td>
<td>White British</td>
<td>mother and child</td>
<td>mother</td>
<td>Dr Green</td>
</tr>
<tr>
<td>Clark</td>
<td>11</td>
<td>m</td>
<td>G.P.</td>
<td>behaviour problems</td>
<td>Black British</td>
<td>mother, child and brother</td>
<td>mother</td>
<td>Dr Thomas</td>
</tr>
<tr>
<td>Reid</td>
<td>13</td>
<td>f</td>
<td>G.P.</td>
<td>behaviour problems</td>
<td>Black British</td>
<td>mother and child</td>
<td>mother</td>
<td>Dr Green</td>
</tr>
<tr>
<td>Saunders</td>
<td>15</td>
<td>m</td>
<td>G.P.</td>
<td>behaviour problems</td>
<td>Black British</td>
<td>mother and child</td>
<td>mother</td>
<td>Dr Thomas</td>
</tr>
<tr>
<td>Mace</td>
<td>6</td>
<td>m</td>
<td>G.P.</td>
<td>behaviour problems</td>
<td>Black British</td>
<td>mother, father and child</td>
<td>mother</td>
<td>Dr Green</td>
</tr>
<tr>
<td>Clements</td>
<td>1.5</td>
<td>m</td>
<td>G.P.</td>
<td>behaviour problems</td>
<td>White British</td>
<td>mother and child</td>
<td>mother</td>
<td>Dr Mullins</td>
</tr>
</tbody>
</table>

Five therapists acted as the main therapist for the ten families involved in the study. Two of these were clinical psychologists, two

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10 All names have been changed to preserve confidentiality. All therapists have been given the title "Dr" for ease of reference.
were psychiatrists and one was a family therapist. Three were female, two were male. They were all, bar one (Dr Brown), trained in systemic family therapy. While the style of the individual therapists obviously varied, the department as a whole had a Milan-systemic orientation and all the clinicians attended weekly workshops on this approach to therapy as well as routinely working together on cases.

2.2.3 Materials

video recordings were made of:
• The therapists' pre-session meeting (which generally lasted around twenty minutes),
• The first twenty minutes of the session
• The intervention

2.2.4 Procedure

The video-taped material was viewed and all verbal attributions about cause of difficulties were identified and transcribed.

All statements that could be taken to answer the question "why are there difficulties?", or could coherently be pre-fixed with the phrases "there is a problem because." or "the explanation for the difficulties is." were extracted. Two independent raters identified statements as making causal attributions - 75% agreement was achieved initially, the disputed cases were resolved by joint discussion.

In the pre-session meeting only the attributions made by the prime worker were coded. In the sessions all attributions made by any family member were coded. In the intervention only the attributions made by the main therapist were coded. Each separate speech act was seen as one statement.
The presence of the following family attributes, identified by Kazdin, Mazurick and Siegel (1994) as related to increased drop out rates, as recorded in the referred child's case file, were noted.

- **single parenthood:**
  This was taken to be present where one parent was living alone with the children. (Where a new partner was known to be resident in the family home, the family was categorised as a two parent family).

- **low socio-economic status (SES):**
  This was determined by housing. Those in council accommodation were deemed to have low SES

- **belonging to an ethnic minority:**
  Any families who were not white Anglo-Saxon were categorised as from an ethnic minority.\(^{11}\)

### 2.2.5 Analysis of data

The LACS was used to code all causal attributions about the presenting problem on the following four dimensions:

- **Internal:** cause is attributed to the features of the subject of the attribution. **External:** cause is attributed to an event/condition in the outside world.
- **Personal:** cause is attributed to something idiosyncratic about the subject of the attribution. **Universal:** cause is attributed to something most people (more than 50%) would be likely to do.
- **Controllable:** cause is attributed to something that can be controlled by the subject of the attribution. **Uncontrollable:** cause is attributed to something that cannot be controlled by the subject of the attribution.
- **Intentional result:** result is attributed as intended by the subject of the attribution. **Unintentional result:** result is attributed as not intended by subject of attribution.\(^{12}\)

Each attribution was then coded as either "clearly blaming", "exonerating" or "potentially blaming" according to the operational definitions given below:

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\(^{11}\) This is clearly not an exhaustive list of factors likely to influence drop out. Only those factors capable of ready measurement from routinely collected referral information were selected.

\(^{12}\) Although intentionality is not a dimension standardised on the LACS it was the LACS as an instrument is designed to allow for this sort of flexibility.
• “Clearly blaming” - where the attribution was rated as internal, personal, intentional and/or controllable.
  e.g. “The difficulties have arisen because he wants to hurt me.”
• “Exonering” - where the attribution was rated as either external
  e.g. “The difficulties have arisen because of the divorce.”
  or internal, universal and uncontrollable and/or unintentional.
  e.g. “The difficulties have arisen because that is how two year olds
  behave.”
• “Potentially blaming” - where the attribution was rated as internal
  but could not be in rated as universal, intentional or controllable.
  e.g. “The difficulties have arisen because he is very sensitive.”

It was decided to include a definition of “potentially blaming”
attributions since it was thought likely that it would often be hard to
judge in a natural setting whether a statement fulfilled all the criteria
deemed necessary to be “clearly blaming”. Moreover, it was felt
important in a clinical context to be over-rather than under-inclusive,
given the presumed heightened sensitivity of both family members and
therapists to the issue of blame. It was judged that these “potentially
blaming” statements could be heard as blaming, whatever the original
intent. Whenever a statement is said to have been coded as indicating
an attribution of “blame” below, this can be taken to include both
“potentially blaming” and “clearly blaming” statements.

Codings were made using two independent raters - 85% agreement
was achieved initially, disputed cases were then agreed after
discussion between the two raters. Inter-rater reliability was further
investigated using ten independent rates, who each rated ten causal
attributions about the presenting problem, taken from the clinical
material. The raters agreed with the original researcher on 94% of all
codings (see Appendix ).
Levels of blame were calculated as follows:

- Where over 50% of attributions made by family members were either clearly blaming or potentially blaming of the referred child, the family were said to have a “high level” of blame of the child.
- Where the therapist used one or more attribution that clearly blamed or potentially blamed the parents, then the therapist was said to be “blaming the parents”

2.3 Results

2.3.1 Numbers of attributions made

Participants made 148 attributions about the presenting problem in the clinical conversations studied. Therapists made 77 attributions about the problem in the pre-session meetings and 18 in the interventions. Family members made 53 attributions about the problem in the first twenty minutes of the session: mothers made 39 attributions, fathers made 8 attributions and children made six attributions (see table 2).

Table 2: Number of attributions made by participants

<table>
<thead>
<tr>
<th>case</th>
<th>therapist (pre-session)</th>
<th>mother (session)</th>
<th>father (session)</th>
<th>child (session)</th>
<th>therapist (intervention)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith</td>
<td>7</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Jones</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Watts</td>
<td>12</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harris</td>
<td>10</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trent</td>
<td>8</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Clark</td>
<td>5</td>
<td>7</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Reid</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sanders</td>
<td>3</td>
<td>3</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Mace</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Clements</td>
<td>9</td>
<td>3</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>total</td>
<td>77</td>
<td>39</td>
<td>8</td>
<td>6</td>
<td>18</td>
</tr>
<tr>
<td>mean</td>
<td>7.7</td>
<td>3.9</td>
<td>.8</td>
<td>.6</td>
<td>1.8</td>
</tr>
<tr>
<td>range</td>
<td>3-12</td>
<td>2-7</td>
<td>1-3</td>
<td>0-4</td>
<td></td>
</tr>
<tr>
<td>mode</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
It is worth noting at this point the relative lack of attributions made by fathers and children compared to mothers. Of the five fathers who attended the first session only two made causal attributions about the presenting problem in the first twenty minutes. Of the thirteen children who attended the session only three made attributions about the presenting problem in the first twenty minutes. This may reflect the fact that questions in the first twenty minutes were mainly directed at the mothers, or that mothers were more inclined to offer explanations for the difficulties. Whatever the reason (which it was not the aim of this study to explore) the difference in talk time between mothers and other family members may introduce an important source of variability in their attributions.

2.3.2 Types of attributions made by family members

Family members made 20 clearly blaming attributions, 15 potentially blaming attributions and 18 exonerating attributions (see table 3).

Table 3: Types of attributions made by family members

<table>
<thead>
<tr>
<th>case</th>
<th>attributions made by mother</th>
<th>attributions made by father</th>
<th>attributions made by child</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>clear blame</td>
<td>potential blame</td>
<td>exonerate</td>
</tr>
<tr>
<td>Smith</td>
<td>2 child</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Jones</td>
<td>0</td>
<td>1 child</td>
<td>4 child</td>
</tr>
<tr>
<td>Watts</td>
<td>0</td>
<td>3 child</td>
<td>1 child</td>
</tr>
<tr>
<td>Harris</td>
<td>2 teacher</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Trent</td>
<td>2 child</td>
<td>1 teacher</td>
<td>0</td>
</tr>
<tr>
<td>Clark</td>
<td>0</td>
<td>2 child</td>
<td>1 father</td>
</tr>
<tr>
<td>Reid</td>
<td>3 child</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sanders</td>
<td>1 child</td>
<td>1 mother</td>
<td>1 child</td>
</tr>
<tr>
<td>Mace</td>
<td>4 child</td>
<td>1 child</td>
<td>0</td>
</tr>
<tr>
<td>Clements</td>
<td>2 child</td>
<td>0</td>
<td>1 child</td>
</tr>
<tr>
<td>total</td>
<td>18</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>mean</td>
<td>1.8</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>range</td>
<td>0-3</td>
<td>0-4</td>
<td>0-4</td>
</tr>
</tbody>
</table>
2.3.4 Types of attributions made by therapists

Therapists made no clearly blaming attributions, 31 potentially blaming attributions and 57 exonerating attributions (see table 4).

Table 4: Types of attributions made by therapists

<table>
<thead>
<tr>
<th>Therapist</th>
<th>case</th>
<th>pre-session meeting</th>
<th>intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>clear blame</td>
<td>potential blame</td>
<td>exonerate</td>
</tr>
<tr>
<td></td>
<td>clear blame</td>
<td>potential blame</td>
<td>exonerate</td>
</tr>
<tr>
<td>Dr Thomas</td>
<td>Smith</td>
<td>0</td>
<td>2 mother</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 child</td>
</tr>
<tr>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>3 child</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>1 mother</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3 child</td>
</tr>
<tr>
<td>Dr Briggs</td>
<td>Jones</td>
<td>0</td>
<td>1 child</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 mother</td>
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<td></td>
<td></td>
<td>2 child</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>1 father</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4 child</td>
</tr>
<tr>
<td>Dr Brown</td>
<td>Watts</td>
<td>0</td>
<td>3 mother</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 child</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>4 child</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 mother</td>
<td></td>
</tr>
<tr>
<td></td>
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<td>1 family</td>
<td></td>
</tr>
<tr>
<td>Dr Green</td>
<td>Harris</td>
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<td>1 father</td>
</tr>
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<td></td>
<td></td>
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<td>9 child</td>
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<td></td>
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<td>0</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>2 child</td>
</tr>
<tr>
<td>Dr Green</td>
<td>Trent</td>
<td>0</td>
<td>4 child</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>2 family</td>
</tr>
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<td></td>
<td>0</td>
<td>1 child</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 mother</td>
</tr>
<tr>
<td>Dr Thomas</td>
<td>Clark</td>
<td>0</td>
<td>1 mother</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4 child</td>
</tr>
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<td>0</td>
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<td></td>
<td></td>
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<td>2 child</td>
</tr>
<tr>
<td>Dr Green</td>
<td>Reid</td>
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<td>1 child</td>
</tr>
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<td>1 family</td>
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<td></td>
<td></td>
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<td>0</td>
</tr>
<tr>
<td>Dr Thomas</td>
<td>Sanders</td>
<td>0</td>
<td>2 child</td>
</tr>
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<td></td>
<td>1 child</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 child</td>
</tr>
<tr>
<td>Dr Green</td>
<td>Mace</td>
<td>0</td>
<td>1 father</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4 child</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 child</td>
</tr>
<tr>
<td>Dr Mullins</td>
<td>Clements</td>
<td>0</td>
<td>3 mother</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5 child</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 mother</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>total</td>
<td>0</td>
<td>26</td>
<td>42</td>
</tr>
<tr>
<td>mean</td>
<td>0</td>
<td>2.6</td>
<td>4.2</td>
</tr>
<tr>
<td>range</td>
<td>0</td>
<td>1-6</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0-4</td>
</tr>
</tbody>
</table>

2.3.5 Did the majority of attributions made by family members blame the child?

Twenty of the 53 attributions made by family members blamed the child as opposed to 16 which exonerated the child. Seven attributions blamed someone else and three attributions exonerated someone else (see table 5).
Differences between families were examined. Seven families (Smith, Watts, Trent, Reid, Sanders, Mace, Clements) mainly used attributions that blamed the child to explain the difficulties (i.e. more than 50% of all their attributions blamed the child). One family (Harris) mainly used attributions that blamed others to explain the difficulties and two families (Jones and Clark) mainly used attributions that exonerated the child.

The data was broken down to look at the attributions of different family members.

**Attributions made by the mothers.**

Twenty two attributions made by the mothers blamed the child, ten exonerated the child, three blamed a teacher, two the father and two blamed themselves (see table 6).

<table>
<thead>
<tr>
<th>subject of attribution</th>
<th>clearly blaming</th>
<th>potentially blaming</th>
<th>exonerating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15 child</td>
<td>13 child</td>
<td>16 child</td>
</tr>
<tr>
<td></td>
<td>3 teacher</td>
<td>2 father</td>
<td>2 family</td>
</tr>
<tr>
<td></td>
<td>2 mother</td>
<td></td>
<td>1 father</td>
</tr>
<tr>
<td>total</td>
<td>20</td>
<td>15</td>
<td>19</td>
</tr>
</tbody>
</table>

Table 5: Attributions made by family members

<table>
<thead>
<tr>
<th>subject of attribution</th>
<th>clearly blaming</th>
<th>potentially blaming</th>
<th>exonerating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>14 child</td>
<td>8 child</td>
<td>9 child</td>
</tr>
<tr>
<td></td>
<td>2 mother</td>
<td>2 father</td>
<td>1 family</td>
</tr>
<tr>
<td></td>
<td>3 teacher</td>
<td></td>
<td></td>
</tr>
<tr>
<td>total</td>
<td>19</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

Table 6: Attributions made by the mothers
Two of the mothers (Ms Reid and Ms Mace) offered exclusively blaming attributions about their child to explain the nature of the difficulties. A further four mothers (Ms Watts, Ms Trent, Ms Sanders and Ms Clements) used blaming attributions about their child as their primary means of explaining the difficulties. One mother used an equal number of blaming attributions about her child as other attributions (Ms Smith). One mother used exclusively blaming attributions about a teacher (Ms Harris). Two mothers (Ms Jones and Ms Clark) made predominantly exonerating attributions about their child to explain the difficulties. No mother used exclusively exonerating attributions to explain the difficulties (see table 3).

The majority (14) of the attributions made by mothers blamed the child. For example, Ms Smith said of her daughter who had been referred following a suicide attempt “[she] exaggerated things and now we are all here”. Ms Trent described her son’s behaviour as the cause of the difficulties: “I think he does it to annoy me”. Ms Clements described her son as having a “vicious temper” and having to “have his own way”.

Three attributions made by the mothers blamed the child’s teacher, with one mother, Ms Harris, offering this as her only explanation for the difficulties: “His headmistress has it in for the boy” and “the headmistress sees a problem with the child, the other teachers do not”.

The two attributions made that blamed the father did so in terms of his absence from the child’s life. Thus Ms Watts commented on her son’s behaviour in the light of his father’s long working hours: “he wants a reaction from his father - there is no reaction” and another mother said in relation to her ex-husband’s remarriage “they have been let down by their father”.

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The ten attributions that exonerated the child focused largely on events experienced by the child and physical factors. Ms Jones said her son’s difficult behaviour might be affected by the medication he received “when he has steroids he moves non-stop”. Ms Clark related her son’s difficulties to his father having recently left: “he’s a reflection of what is going on in the family”, adding later: “the whole family is upset by [the father] promising to come back for a long time [and not appearing].”

Attributions made by the fathers.

Only one potentially blaming attribution was made by a father. Mr Watts said of this two year old’s problematic behaviour: “he is very demanding and bright”. However he went on to explain his son’s difficult behaviour primarily in terms of medication and the family’s current circumstances: “his tantrums are down to all the medicines he is having...another factor is ..we all four of us live in a one bedroom place - it is very small and cramped”.

The other father who took part in this study, Mr Mace, explained his child’s behaviour mainly in terms of developmental norms; “I don’t think there is anything abnormal about him, he is just at a particular place on the spectrum of six and a half year olds”.

Table 7: Attributions made by the fathers

<table>
<thead>
<tr>
<th>subject of attribution</th>
<th>clearly blaming</th>
<th>potentially blaming</th>
<th>exonerating</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1 child</td>
<td>5 child</td>
<td></td>
</tr>
<tr>
<td>1 father</td>
<td></td>
<td>1 family</td>
<td></td>
</tr>
<tr>
<td>total</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>
Attributions made by the children.

All the attributions made by the children blamed the referred child. No exonerating attributions were offered: “it is all my fault dad left”, “I am the oldest I should be responsible” and “I always do something wrong” averred the daughter of Ms Smith, who had been referred following a suicide attempt. The son of Ms Trent said of his difficult behaviour “I enjoy it sometimes”, and the son of Ms Clark explained his brother’s behaviour in terms of his brother’s character traits: “he gets worked up about things”.

Table 8 : Attributions made by children

<table>
<thead>
<tr>
<th>subject of attribution</th>
<th>clearly blaming</th>
<th>potentially blaming</th>
<th>exonerating</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 child</td>
<td>2</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>total</td>
<td>2</td>
<td>4</td>
<td>0</td>
</tr>
</tbody>
</table>

2.3.6 Did the majority of attributions made by therapists in the pre-session meeting exonerate the child?

Thirty five of the 42 attributions made by therapists exonerated the child, seven exonerated others, ten blamed the child, ten blamed the mother, and seven blamed someone else (see table 9).

Table 9: Attributions made by the therapists in the pre-session meeting

<table>
<thead>
<tr>
<th>subject of attribution</th>
<th>clearly blaming</th>
<th>potentially blaming</th>
<th>exonerating</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>10 child</td>
<td>35 child</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10 mother</td>
<td>1 father</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 family</td>
<td>5 mother</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 father</td>
<td>1 family</td>
<td></td>
</tr>
<tr>
<td>total</td>
<td>26</td>
<td>42</td>
<td></td>
</tr>
</tbody>
</table>

When the data was explored in terms of differences between cases it was found that in four cases therapists predominantly used
attributions that exonerated the child to explain the difficulties (Harris, Clark, Mace and Clements). In two cases, the therapist predominantly used attributions that exonerated the range of people (Watts and Jones). In one case, the therapist predominantly blamed the child (Sanders). In three cases, the therapist predominantly used attributions that blamed a mix of family, the mother and the child (Smith, Reid and Trent).

Possible differences between therapists were looked at in relation to the two therapists who acted as the main worker for more than one family in the study (Dr Thomas saw three families, Dr Green saw four families). No consistent patterns were found. Thus Dr Thomas used predominantly exonerating attributions (in relation to the child) when discussing the Clark family, but predominantly blaming attributions (in relation to the child) when discussing the Sanders family, and an equal number of blaming and exonerating attributions when discussing the Smith family (see table 3).

Looking at the attributions made by therapists in the pre-session meeting as a whole, the majority (35) exonerated the child. The majority of these (26) involved speculation about possible external events and their likely impact, including: the possibility of abuse, the effect of divorce, the effect of starting a new school, the effect of the mother’s new partner coming to live with the family and simply to “an event” not currently known by the therapist. Nine of the attributions that exonerated the child related to internal factors in the child which were seen as being part of a normative stage or likely to be universally applicable, in particular the child’s age and sex. For example Dr Mullins said that one toddler’s problematic behaviour might be

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13Similarly there was no clear pattern in terms of therapist difference in the intervention. For example, in her intervention to the Harris family Dr Green only made attributions that exonerated the child, whilst in her intervention to the Trent family she only made blaming attributions (one to the child one to the mother).
explained in terms of "the developmental context of a 2 year old frustrated at her inability to express herself".

Ten attributions were made in the pre-session meeting that potentially blamed the child for the difficulties. For example, Dr Green referred to the child’s tic as being possibly a way of establishing control “symptoms... obsessional...trying to control something by blinking...trying not to see something...becomes out of his control...but at some level still in his control”. Dr Thomas described the drinking of an adolescent boy as a form of “acting out”, “it is an attempt at independence ... a message to mum ‘I am tied to you but I don’t like it, you cannot control me’.

In the pre-session meetings as many statements blamed the mother as blamed the child. For example, Dr Briggs said of a mother who had requested referral because of her son’s tantrums, which she was reported to have linked to her husband’s aggressive behaviour, “I wonder if mother is pathologising father’s behaviour and wants to come here to sort it out”. Dr Brown said of a two year old boy with behaviour problems and unwilling to attend nursery, “it may be that his mother does not want him to go to school”. In discussing the reason for two adolescent boy’s difficulties in the context of their parents’ long term separation, Dr Thomas said, “mother’s belief system may be that the parents will get back together”.

However, these attributions of potential blame of the mother were often balanced by exonerating statements in relation to the mother. Thus Dr Brown, who had referred to the possible unwillingness of the child’s mother for his attendance at school as contributing to the difficulties, spoke of her “being overwhelmed by her circumstances” and of possibly being incapable of dealing with two active children “due to her own childhood”. Dr Mullins referred in one case to:
“mother’s perceptions being faulty - it may be that the mother has problems relating to this child”, and also speaks of that mother as “worried and unsupported, [she] fits into Brown and Harris’s finding about unsupported depressed mothers”.

Fathers were referred to in potentially blaming terms in the pre-session meeting less frequently than mothers. Only in two instances was an attribution of blame made about a father. When discussing a five year old with behaviour problems, whose father had died two years earlier, Dr Green said: “If father died by a self destructive act or recklessness it makes me wonder what was his attitude to being a parent and how did this impact on his son and help to explain the current behaviour”. Dr Mullins, talking of a six year old referred with conduct disorder, said: “If the parents are separated maybe dad was violent”.

The family as a whole was blamed in four attributions in the pre-session discussions. Dr Thomas, hypothesising about a 13 year old’s suicide attempt, said: “The family has been brought up on a secret, in the face of this secret larger and larger fantasies are produced”. Dr Green speculating about the cause of a child’s persistent facial tic, said: “In some families you have to have a thing, an imperfection - your burden in life”. In another case, Dr Green, discussing the possible ways of understanding a 13 year old girl’s repeated late night sorties from home, pondered: “Is it a family who are well used to dangerous situations and who only really react to crisis?”.
2.3.7 Did the majority of attributions made by therapists in the intervention exonerate the child?

Thirteen of the 18 attributions made by therapists in the intervention exonerated the child, three blamed the mother and two blamed the child (see table 10).

Table 10: Attributions made by the therapists in their interventions

<table>
<thead>
<tr>
<th>subject of attribution</th>
<th>clearly blaming</th>
<th>potentially blaming</th>
<th>exonerating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>3 mother</td>
<td>13 child</td>
</tr>
<tr>
<td></td>
<td>2 child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>total</td>
<td>5</td>
<td>13</td>
<td></td>
</tr>
</tbody>
</table>

With respect to the interventions: in four cases the therapist only made attributions that exonerated the child (Harris, Clark, Watts and Jones), in two cases the therapist mainly made attributions that exonerated the child (Smith and Trent), in one case the therapist made equal attributions blaming and exonerating the child (Mace) and in two cases the therapist made only blaming attributions (Clements and Trent) (see table 4).

Half the therapists made exclusively exonerating statements in their interventions. The subject of these exonerating statements in all cases was the child. In two cases blame was attributed exclusively and in two cases some element of blame was suggested (see table 10).

Where blame was attributed, it was the mother who was most frequently blamed. When feeding back to the family his understanding of the child’s facial tics, Dr Green said to the mother: “I wonder what effect your sense of lack of control has had on [child’s name]”. Dr Mullins, when commenting on the behaviour of a two year old child, whose mother had denied any effect of life events on him, said: “I
wonder about the effect of your own abusive relationships from the past

2.3.8 Could high levels of blame of the child by family members, and/or any blame of parents by therapist, be associated with increased likelihood of drop out after an initial meeting?

Four of the ten families dropped out after the first session, one family dropped out after two sessions, two families agreed not to come for further meetings after the first session, and three families ended by mutual agreement with the therapist after between two and five sessions (see table 11). Table 12 summarizes the presence or absence of possible risk factors for dropping out of therapy for each family.

Table 11: Attendance and drop out from therapy

<table>
<thead>
<tr>
<th>case</th>
<th>no. of sessions attended</th>
<th>no. of sessions offered not attended</th>
<th>dropped out of treatment =1 ended by mutual agreement =2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Jones</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Watts</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Harris</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Trent</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Clark</td>
<td>5</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Reid</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Saunders</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Mace</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Clements</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
The relationship between drop out after the first meeting and the factors summarized in table 12 was explored using Multidimensional Scalogram Analysis (MSA). MSA is a non-metric multidimensional scaling technique whereby the multivariate attributes of a given item, once represented as numerical data, can be converted into coordinates in multidimensional space (Zvulun, 1978). MSA analyses the categorical data and plots the items as a point in geometric space in such a way that the best possible fit between the attribute categories and their representation as regions in space is achieved. In effect this means that those items which share similar categorical codings will be plotted closer together, and those which share fewer categorical codings will be further apart.

MSA thus allowed for each of the ten families to be represented visually in terms of their multivariate qualities. Each row of data in table 12 above, can be seen to represent the profile of that family. MSA combines this profile as co-ordinates in multidimensional space. Each family is then represented by a point in geometric space (Wilson & Canter, 1993). The closer a family is to another family spatially the more similar the two families are on the dimensions studied, the further apart two families are the less similar they are on the
dimensions studied. The main plot, which is shown in figure 1 below, displays the connection between each family's drop out status and the other characteristics identified as potentially relevant.¹⁴

The results of the main plot of Multi-dimensional Scalogram Analysis (see figure 1) indicate that those families who dropped out shared some characteristics, as they are all generally aligned to the right hand of the plot (the shaded area in figure 1). The graph shows that three of the four cases who dropped out of treatment had a combination of high degree of blame by family members of the child alongside the therapist having invoked blame of the parents in the intervention (Smith, Trent and Clements). In the fourth case (Harris) there was neither a high degree of blame of the child by his parents, nor was there explicit blame of the parents by the therapist, but there was exclusive blame of the teacher by the parents.

Three of the four families who dropped out after one meeting were not from an ethnic minority (Clements, Trent and Harris). The fourth non-ethnic minority family in the study did not drop out after one session (Watts).

There did not appear to be an association between drop out and number of parents in the family (see figure 1), and there were too few families of high socio-economic status to look at differences between them. In terms of ethnicity, three of the four non-ethnic minority families dropped out, and only one of the six families from an ethnic minority dropped out.

¹⁴ Socio-economic status is not displayed in the plot because all but one of the families fell into the same grouping - that of having low SES.
fig 1. M.S.A. Plot illustrating the relationship between the identified factors and drop out

<table>
<thead>
<tr>
<th>Reid (bc)</th>
<th>□</th>
<th>Smith (bc) (bp)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saunders (bc)</td>
<td>■</td>
<td>Clements (bc) (bp)</td>
</tr>
<tr>
<td>Clark Mace (bc)</td>
<td>□</td>
<td>Trent (bc) (bp)</td>
</tr>
<tr>
<td>Jones</td>
<td>■</td>
<td></td>
</tr>
<tr>
<td>Harris</td>
<td>●</td>
<td></td>
</tr>
</tbody>
</table>

Dropped Out
After one Session

Did not Drop Out
After one Session

● Watts

Key-
■ or □ = from an ethnic minority
● or ○ = not from an ethnic minority
■ or ● = two parent family
□ or ○ = one parent family
(bc) = high levels of blame of child by parents
(bp) = blame of parents by therapist
Thus the results of Multi-dimensional Scalogram Analysis suggest drop out may be associated with therapist blame of parents and with families not from an ethnic minority. There did not appear to be an association between single parenthood and drop out, whilst the lack of variation in the families in terms of socio-economic status meant it was not possible to explore this factor.

2.3.9 Summary of results

Causal attributions about the presenting problem were made by family members and therapists, in the sections of conversation under scrutiny in this study. There was high inter-rater agreement in their identification and high inter-rater agreement in their coding, using the operational definitions developed above.

The following patterns of attributions were found in this sample:

- Family members when taken as a whole tended to explain the presenting difficulties by blaming the child. There were, however, differences between family members. The ten mothers and the three children predominantly used blaming attributions, whilst the two fathers predominately used exonerating attributions.

- The therapists predominately used exonerating statements in their pre-session hypothesising, and never used clearly blaming statements. However, therapists did use some blaming attributions, and where they did attribute blame this tended to be in relation to the mother.

- In their intervention to the family the therapists used predominately exonerating attributions in relation to the child - referring to
external factors such as ill health, medication or family events. Whilst they never used any clearly blaming attributions, they did occasionally make attributions that potentially blamed the parents and child.

- Four of the ten families dropped out of treatment prematurely. In three of these cases there had been a high degree of blame of the child by family members and the therapist had blamed the parents in the intervention. The results of the MSA suggested that blame may be a factor worth exploring further in relation to service uptake.

2.4 Discussion of results

The operational definitions developed made it possible to investigate how blame and exoneration for the presenting problem were attributed by participants in naturally occurring clinical conversations. Enough statements were identified as offering causal attributions about the presenting problem in the selected segments of conversation to allow for coding, and high inter-rater agreement was achieved.

However, some limitations of the procedure were noted. It was a relatively time consuming process, since in each case over one hour's worth of tape had to be listened to, and the relevant attributional statements extracted. Given the careful listening that had to be done to make out exactly what was said, and to check that no attributional statements were missed, this could take several hours for each hour's worth of video-tape. Moreover, it became clear that not all statements that related to how the speaker understood the presenting difficulties could be coded in this way. In particular, statements where a speaker explicitly discounted alternative attributions could not be coded. For example, one mother said she thought her child's behaviour had
nothing to do with her recent separation from her violent partner, whilst another said she had decided the child's behaviour was definitely not due to his asthma - these could not be coded using the criteria developed above.

Whilst recognising these limitations the method employed in this study did appear to provide a potentially useful tool to explore how attributions of blame and exoneration arise in conversations in therapeutic settings.

The patterns of attributions of blame and exoneration made by family members and therapists must be interpreted in the light of the small numbers involved in the study and with an awareness of possible sources of bias in the sample. The sample consisted of ten families who had been filtered down from a much larger pool. For example the fact that any families where abuse was an issue were excluded, may mean that the families included were less likely to be extremely blaming of their children than if families where abuse was an issue were included. The fact that five different therapists took part in the study may have also introduced sources of bias. For example drop out might have been related to differences in the therapists' ways of working, such as in the sort of questions they asked or in the degree of reassurance they gave, rather than to levels of blame per se.

With these limitations in mind the findings do follow the clinical impression that families come to therapy with a tendency to blame the referred child (Hoffmann, 1981). This is in line with existing research findings (Munton & Stratton, 1990; Compas et al., 1981). However it is interesting to note that families did not generally offer only attributions that blamed the child. Almost a third of the attributions made by family members exonerated the child or other family member.
There was some indication of differences between the family members in this sample. The fathers in the study seemed to be less inclined to blame the child, and exhibited a greater tendency to offer attributions that exonerated the child, than either mothers or children. Whilst the small numbers involved in this study mean no general conclusions can be drawn, it does suggest the possibility of future avenues for research.

The findings suggest that the therapists in this study did strive to find non-blaming explanations for the difficult behaviour as is recommended in the clinical literature (Burnham, 1986). The therapists did not, however, offer only exonerating attributions, and did make a number of blaming attributions, particularly in the pre-session hypothesising meetings. This is in line with Spoarkowski et al.’s (1993) finding, that despite a systemic perspective, therapists will sometimes use attributions that focus on the characteristics of one individual. Where therapists did make blaming attributions, these predominately related to the mother or the referred child, and much less frequently to the father. This suggests that Goldner’s (1985) critique of family therapy as tending to blame mothers, rather than fathers, for the difficulties, may be worthy of further exploration.

The fact that patterns of blame by families and therapists mirrored patterns of drop out suggests that where there is any blame of parents by therapists this may increase the chances of the family dropping out of treatment prematurely. The fact that there was no association between drop out and other factors identified in the literature as contributing to drop out rates, such as family composition, and that drop out was associated with ethnicity in the opposite direction from that found in previous research (Kazdin et al., 1994), may suggest that levels of blame may be stronger predictors of drop out than these
factors. Obviously the small numbers involved mean any such suggestions can only be extremely tentative. Moreover, it may be that a third variable, such as therapist personality, or severity of difficulties, influences both levels of blame and service uptake.

To test these competing hypotheses, further larger scale studies would need to be undertaken. What this study does suggest is that including levels of blame by parents and therapists may be a useful additional factor to explore in studies seeking to determine risk of drop out.

A limitation of the study is that data was collected on a small sample of families. However, this is in line with the sample sizes used in much of the earlier studies (e.g. Munton & Stratton, 1990), and reflects the difficulties of collecting large populations when carrying out this sort of research in clinical settings. Whilst the small sample size, particularly in relation to fathers and children, means no attempt should be made to suggest these findings are necessarily generalizable to a wider population, this study does suggest that, for this sample, blame was a significant dimension to explore and points to interesting avenues for further exploration.

This study only looked at causal attributions about the presenting problem and did not explore what other means speakers might use to construct blame and exoneration. The next study extends this research by situating an analysis of participants' causal attributions clinical encounter, to explore the variety of ways that participants construct blame and exoneration in relation to the presenting problem within a detailed micro-analysis of one clinical encounter, to explore the variety of ways that participants construct blame and exoneration in relation to the presenting problem.
STUDY TWO:
CODING PARTICIPANTS' ATTRIBUTIONS OF BLAME AND EXONERATION IN ONE THERAPEUTIC ENCOUNTER, ALONGSIDE A CONVERSATION ANALYSIS OF THAT ENCOUNTER

3.1 Aims

- In what ways do participants verbally construct blame and exoneration in relation to the presenting problem, implicitly and explicitly, in one therapeutic encounter?

- How far can causal attributions about the presenting problem, coded as either “blaming” or “exonerating”, be taken as representative of that individual’s construction of blame in this particular therapeutic encounter?

3.2 Method

3.2.1 Design

This study employed a single case study design.

It was decided to videotape the first case where a family consented to participate in this research, and where the family were coming for an initial session with a team member. The first encounter between a therapist and a family was chosen, since it is in an initial meeting that the assignment of blame for the difficulties is most likely to be raised (Buttny & Jensen, 1995).\(^\text{15}\)

Three conversations were recorded: the dialogue between the main therapist and the co-therapist in the pre-session discussion, the conversation between the therapist and the family in the session and the therapist’s final intervention to the family.

\(^{15}\) The family had been seen before but by a different therapist one year earlier.
3.2.2 Participants.\textsuperscript{16}

The family consisted of a mother (Ms Banner) and her four year old son, John. John had been referred to the local child development centre a year earlier because of delayed language and behaviour problems. He had been assessed by a speech therapist and a psychologist, who had found no neurological or physical difficulties. The family had been referred to the child consultation team three months later, because his mother said she was becoming increasingly worried about, and irritated with, her son. The mother came to an initial consultation with Dr Lyons (a clinical psychologist), without John, and said she was worried that John would turn out like his father, who was a manic depressive.

Dr Lyons was concerned about Ms Banner's high levels of depression, and contacted her G.P., to see if medication or counselling could be offered to her. Ms Banner cancelled a follow up appointment and told her G.P. that she did not want further appointments, as she was "now improved".

The present referral had been initiated by Ms Banner, who had phoned to request a further appointment. She said that John had started to have "a lot of temper tantrums" at school and that the school reported that he appeared "sad". She said that John's father's health had deteriorated.

\hfill
\textsuperscript{16} All names, and some demographic details, have been changed to preserve anonymity.
Dr Lyons was no longer able to see the family so Dr Thomas (a family therapist and psychiatrist) agreed to take on the case. Dr Tanner (a trainee family therapist) joined as a co-worker.

3.2.3 Materials

A video recording was made of the pre-session meeting (therapist and co-worker in conversation), the session (therapist, mother and child in conversation) and the intervention (therapist speaking to mother and child).

3.2.4 Procedure

All verbal statements were transcribed. It was decided to use only the dialogue, and not to attempt to code non-verbal behaviour, for the following reasons;

- basic transcription of dialogue is estimated to take ten times as long as real-time conversation. A transcript including non-verbal information is likely to take twice as long again (Potter & Wetherell, 1987).
- The focus of the research was on expression of beliefs via language - an analysis of dialogue remains the core way of analysing this.
- previous research in this area used an analysis of verbal content alone.
- It has been argued that, if research findings are to be clinically useful, then analyses at the level of meaning are much more easily integrated into practice than micro-analyses which employ the sort of specialised coding system such as would be required to represent non-verbal material (Campbell & de Carteret, 1984).

All causal attributions about the presenting problem were identified, and coded as in the previous study (see pp.126-128 above). Each
coded attribution is presented in **bold** in the transcript with its coding reported in parentheses beside it.

These attributions were then viewed within the context of the “episode” of conversation in which they took place. An episode is a segment of conversation that is focused on a particular topic (Labov & Fanshel, 1977). Each episode was bounded by a shift in the conversation to a different topic.¹⁷

### 3.2.5 Analysis

Conversation analysis was used to make explicit implicit assumptions and inferences in the text (Labov & Fanshel, 1977) and to determine which propositions were being promoted by which speaker. Conversation analysis was felt to be the best method of analysis for this study because it provides methods to infer how speakers ascribe relative importance, or salience, to competing propositions within a conversation (Labov & Fanshel, 1977; Buttny & Jensen, 1995). Moreover, it does not rely on a social constructivist perspective and therefore was compatible with the approach taken in study one.

Speakers were taken to signal the importance of a particular explanation when they employed one or more of the following verbal devices, as outlined by Buttny and Jensen (1995, p. 23):

- “repetition”: when they repeated a proposition in the discourse, or said the same thing in a number of different ways

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¹⁷ Labov and Fanshel (1977) comment that in practice how a conversation is broken down into episodes is often necessarily quite arbitrary. The key point is to have manageable sections of conversation to analyse. They argue that since the results of the analysis itself does not depend on decisions of segmentation it is not vital to concentrate on this issue (p. 38).
• “discounting”: when they responded to a particular element in their interlocutor's speech or failed to respond to a key aspect of their interlocutor's speech.

• “verbal phrasing”: when they used verbal phrasing that emphasised a point such as asserting “so my point is...”. or “what I am trying to say is...”.\(^{18}\)

For each episode the results of this analysis of participants' implicit propositions about the presenting problem were compared with the results of coding their causal attributions about the presenting problem in that episode.

3.3 Results

3.3.1 Pre-session meeting

Two episodes were identified:

1) initial presentation of the problem.

2) discussion of the role of the mother's perceptions

Episode 1

1 Dr Thomas: This is a single mother with a four year old boy called John. As far as I can see
2 mother is divorced from the father of John and he is the one who is said to be manic
3 depressive, the father is said to be manic depressive, and they separated two years
4 ago. And what I've got from the file was John was referred to the Child Development
5 Centre when he was three, because of delayed language and bed wetting and he was
6 offered some speech therapy, and everyone thought he was a fairly healthy well
7 adjusted kid. November referred here by the G.P. saying mother's concerned that
8 she is becoming ratty with him, irritated with him, that was about seven months ago.
9 Seen by Dr Lyons just once and mother's main concern were the existential concern

\(^{18}\) Buttyn and Jensen (1995) also refer to paralinguistic devices that can signal the importance of a concept, but these are not explored in this study -see discussion above.
about John's future. But also, Dr Lyons was worried that she was depressed and she
expressed some suicidal thoughts, and so Dr Lyons contacted the G.P.. Aah, and
what also came out of that is that mother had a fear that John would become manic
depressive like his father, which reminds me, I must look up the percentage figures.
She then cancelled the second appointment, but when the G.P. spoke to her, she
said "Oh I am now improved and I didn't need to go back" - "I just felt like wasting
someone's time waiting for me".

Dr Tanner: And John has never been here, has he; she came on her own?
Dr Thomas: That's right, and said very much that "I really came because I was preoccupied
about myself", that's right. Now re-referred two months ago by mother who'd said
that John is having a lot of temper tantrums at school that the school are also saying
that he is sad. He was seen once by an ed. psych in the school who just observed
him in class and he seemed OK - nothing more was done. But since they were here
last, fathers mental state has deteriorated and - it's quite difficult to know quite in
what way - but mother is now again very concerned that John has inherited the
father's gene and my guess, is that she is spotting everything that he does into
the concept "I think you are now manic depressive" is my guess, and so she's
absolutely preoccupied with that and it has become a pre-occupational bit of
relationship (potentially blaming the mother).

Construction of blame and exoneration

Throughout this episode Dr Thomas's use of repetition, verbal devices
and discounting, can be seen to reflect a construction of the problem
that focuses on Ms Banner as the most significant "cause" of the
difficulties.

Ms Banner's behaviour and beliefs are repeatedly cited as determining
whether help is sought (lines 7-8, 9-10, 10-11, 12-13, 19-21, 24). Her
concerns about John are contrasted with the beliefs of other
professionals: "everyone thought he was a fairly healthy well-adjusted
kid" (lines 6-7), "he was seen once by an ed. psych in the school who
just observed him in class and he seemed OK" (lines 21-22).
Dr Thomas concludes that, in Ms Banner’s meeting with the previous therapist, she was communicating: “I was preoccupied about myself” (line 18-19). He goes on to suggest that currently: “she is absolutely preoccupied” with John being manic depressive (line 27) and: “it has become a pre-occupational bit of the relationship” (lines 27-28). The repetition of the word “pre-occupied” and the re-iterated emphasis on mother’s beliefs suggests this is a central proposition Dr Thomas puts forward to explain the difficulties that have brought the family to therapy.

Dr Thomas discounts alternative explanations both explicitly and implicitly. No hypothesising refers to the father or the child, other than in terms of the impact on the mother’s beliefs and perceptions (lines 12-13, 24-25). The reality of father’s mental health problems, which the mother is reported to see as being crucial, are questioned: he “is said to be a manic depressive” (line 2), “father is said to be manic depressive” (line 3). By this verbal construction Dr Thomas opens up the possibility of doubt about father’s diagnostic status. The repetition of the phrase strengthens its impact.

Dr Thomas signals his perception of the importance of the attribution about the role of Ms Banner’s mental state in the difficulties (lines 25-28) by prefacing it with the verbal construction “it is my guess that” (line 25), which he then repeats at the end of the sentence again (line 26). Such verbal phrases serve to highlight a proposition and suggest it’s relative importance in the speakers’ lexicon of explanations (Buttny & Jensen 1995).

In this episode, it would appear that Dr Thomas’s speech acts implicitly blame the mother and exonerate the child and the father for the current difficulties.
Comparison of results of conversation analysis with results of coding causal attributions about the presenting problem

Dr Thomas makes one causal attribution about the nature of the presenting difficulties in this episode, which potentially blames the mother (lines 25-28). This can be seen as reflecting the way he explains the difficulties throughout this episode. Ms Banner is the focus of the hypothesising, and maternal beliefs are proposed as the key cause of the difficulties.

Episode 2

This episode follows a section of conversation in which Dr Thomas goes to a textbook to look up facts about the inheritance of depression by children in order to "debunk this manic depression nonsense".

1 Dr Tanner: All the anxieties are to do with speech do you think that could be because maybe 
2 he is bilingual?
3 Dr Thomas: This mother is carrying a lot of conscience about herself and about being a 
4 disappointment to her parents. I'm not quite sure in what way, some sort of profound 
5 idea that she was a great disappointment to her parents. And so one possibility is 
6 that she grows up with the idea, well "I'll be at least a perfect mother"; so it comes to 
7 having a child and, well, maybe no, maybe first "I'll become a perfect wife" - that 
8 might be the first thing, and she marries a guy, who for whatever reason goes crazy, 
9 we don't know, and it ends in divorce. Then she has a child and she sees he is 
10 exactly like his father "the very thing I didn't want him to be", and she then finds that 
11 she is not relating to him in the way that she wants, not the ideal way. It becomes 
12 very disconcerting that whatever everyday issues arise in looking after this kid, 
13 it's become multiplied by, she believes that he is crazy like his father, or going 
14 to become crazy like his father, sort of puts him clearly under a microscope all 
15 the time, plus the fact that she had the wish to be a perfect mother and she 
16 feels she's failed at that (potentially blaming the mother).
17 Dr Tanner: Don't forget she told Dr Lyons that she failed twice, she failed her mother and her 
18 father. Her father wanted her to have a career. Her mother wanted her to be a
Dr Thomas: Oh. Right. And so every role that she tries to take, as a daughter, daughter to father, mother to son, wife to husband, has failed. No wonder she's thought it's not worth living.

Dr Tanner: I am quite interested to know why she came to England. She's Asian German. Whether she's got any support over here? It doesn't sound as if she has.

Dr Thomas: It could be if, its a big if, that she doesn't know who she is. She's part this, part that, grew up here, grew up there, she doesn't know who she is. That compounds the fact that who you are is defined by your genes, you know, by your disease. At least John is defined by the fact that mother thinks he is manic depressive (potentially blaming the mother).

Construction of blame and exoneration

In this episode, Dr Thomas talks about mothers life and beliefs as centrally contributing to the present difficulties. It is hypothesised that because Ms Banner thought herself to be a disappointment to her parents, she had a wish to be first a “perfect” wife (line 7) and then a “perfect mother” (lines 6 and 15). Her frustration at her inability to achieve this is postulated to be the root cause of the present difficulties. Repetition of hypothesised key beliefs of the mother- that she was a disappointment to her parents and that she wanted to be perfect in some way- serve to stress this line of reasoning. For example, the repetition of the theory about Ms Banner’s perception of herself as a “disappointment” (lines 4 and 5) serves to emphasise this suggestion. The proposition is given further weight by the use of the adjectives “profound” and “great” (lines 4 and 5).

The mother's ethnic mix is hypothesised as possibly contributing to the difficulties, as it might induce a sense of not knowing who she is. Although the tentativeness of this hypothesis is initially stressed: “It could be if, its a big if” (line 25), the repetition of words lends the proposition weight: “she is part this, part that, grew up here, grew up there” (lines 25-26).
At all times in this episode, Dr Thomas explores issues from the perspective of the mother. The history of the parents getting together and having a child is explored entirely from the viewpoint of her beliefs and expectations. No attempt is made to hypothesise about the father’s beliefs and expectations or those of the child. Their possible behaviour is described, but only mother’s internal reactions to events are hypothesised about. For example, Dr Thomas states: “she marries a guy, who for whatever reason goes crazy, we don’t know and it ends in divorce. Then she has a child and she sees he is exactly like his father “the very thing I don’t want him to be”, and she then finds that she is not relating to him in the way that she wants” (my emphasis) (lines 8-11).

Dr Thomas continues to exonerate the child by discounting any instances of issues specific to the child being raised. Thus he does not take up Dr Tanner’s interest in the impact of John’s bi-lingualism (lines 1-2).

Comparison of results of conversation analysis with results of coding causal attributions about the presenting problem

Dr Thomas makes two causal attributions about the nature of the presenting difficulties in this episode (lines 12-16 and lines 25-29). Both potentially blame the mother for difficulties. These do appear to reflect the position Dr Thomas takes in this episode, as demonstrated by the conversation analysis carried out above.

3.3.2 The session

Three episodes were identified:
1) discussion of John’s role in the difficulties
2) discussion of the school’s role in the difficulties
3) discussion of Ms Banner’s role in the difficulties

Episode 1

This episode follows Dr Thomas explaining to John about what sort of place the clinic is, and a discussion about John’s level of understanding, in which Ms Banner says he is behind in his understanding compared to other children, but that she does not see this as the cause of the difficulties.

Dr Thomas: And is he in school behind?
Ms Banner: Yes, they are the ones that are pressuring me, mainly the teacher, when he goes to school and he is not talking properly like a five year old, the teacher says she has to talk to him twice or three times explain to him something that another child would understand from the beginning what he has to do.
Dr Thomas: Right. Do either the teachers or you have an idea of why that is so?
Ms Banner: No. we don't know why it is so
Dr Thomas: Well, do you think John is behind in his brightness - his intelligence?
Ms Banner: No
Dr Thomas: Do you think there is some emotional problem?
Ms Banner: Well, he is very sensitive. I don't understand why he should have emotional problems because he has a pretty normal home life and if he does have emotional problems he is just extra sensitive (potentially blaming the child).

Construction of blame and exoneration

Statements about cause offered by Ms Banner in this episode can be seen as attempts to exonerate herself from implied blame by Dr Thomas. In lines 2 - 5 she uses repetition and verbal phrases to minimise her own role in the difficulties and emphasise that of others. She repeatedly refers to the teachers being the main people to be affected (lines 2 and 3). She contrasts their concern with her own lack of worry; she presents herself as the passive recipient of their
concerns: "they are the ones who are pressurising me" (line 2). Ms Banner seeks to establish the lack of connection between anything she does and the difficulties: "I don’t understand why he should have emotional problems, he has a pretty normal home life" (lines 11-12). The colloquialism "pretty normal" serves to reinforce the ordinariness of the situation at home.

In response to Ms Banner’s initial comment about the difficulties being noticed by the teacher, Dr Thomas does not take up the issue of the teachers’ concerns directly, but rather pairs mother with the teachers in asking for any ideas about cause (line 6). This construction may be taken as implicitly discounting the idea that the teachers are the only ones involved with these issues.

Comparison of results of conversation analysis with results of coding causal attributions about the presenting problem

Ms Banner makes one causal attribution about the difficulties in this episode, which potentially blames her son. This attribution does appear to reflect her explanation for the difficulties in this episode, as demonstrated by the conversation analysis above.

Episode 2

This episode follows a discussion between Dr Thomas and Ms Banner about the number of times John has behaved inappropriately at school.

1  Ms Banner: At the beginning there was more. Now I told him off and I punished him and it seems to have helped. I think he prefers it when some people are strict with him.
2  Dr Thomas: Right. Do you feel that the school falls down a bit in that or not?
3  Ms Banner: Yes I do
4  Dr Thomas: You do?
Ms Banner: Uhum

Dr Thomas: Have you spoken to them about that?

Ms Banner: Well. Yes. I have spoken to them about that but they have a different way...

Dr Thomas: That's the way they are. Is to be (gestures with hands)?

Ms Banner: Well they have this way they just want...

Dr Thomas: So you're feeling that a lot of the behaviour the teachers describe to you

are to do with the fact that he is not sort of organised there or not controlled

very well there?

Ms B: Yup (potentially blaming the school).

Dr Thomas: Right, do you think that if the school did do that there wouldn't be that problem?

Ms Banner: Yes, it would be better.

Construction of blame and exoneration

In this episode, Dr Thomas's questions shift the emphasis from factors in John (such as his preference for strict discipline - line 2) to the school context in which he finds himself (line 3).

By repeating Ms Banner's assent to criticism of the school (line 5) and reformulating her comments as additional criticism of the school (lines 11-13), he emphasises blame of the school. He then formulates the difficulties as lying primarily with the school (line 15) and asks for her consent to this suggestion (line 15), which she then gives in a modified form: "Yes, it would be better" (line 16).

Comparison of results of conversation analysis with results of coding causal attributions about the presenting problem

Ms Banner's assent to Dr Thomas's description of her view of the role of the school in the difficulties, is taken as a causal attribution about the difficulties, and categorised as potentially blaming the school (lines 11-14). This attribution is in line with the construction of cause of the difficulties at this point in the conversation.
Episode 3

Dr Thomas: Are you worried about anything else? You say he is not autistic or dyslexic.

Ms Banner: There's not many things, but he is almost like, sometimes he is so good he is very very nice, like if I am tidying up he helps me do my room and all of this very nice. And then like sometimes he go to school and he will turn into a different person. It's almost like its a different person, schizophrenic or something, I don't know (potentially blaming the child).

Dr Thomas: That's something else you're worried about?

Ms Banner: I would like to find out about that, yes.

Dr Thomas: What would need to happen to reassure you that John is or isn't dyslexic?

Ms Banner: He is not dyslexic.

Dr Thomas: No. I am asking you what would need to happen for you to be satisfied in your own mind that he is or isn't dyslexic?

Ms Banner: I think more it's his father is dyslexic and his grandfather is dyslexic and I think that he is showing same signs, I think he probably is (potentially blaming the child).

Dr Thomas: So you think he is. Does that worry you?

Ms Banner: Well, yes. Well, it's not a big deal.

Dr Thomas: And, umm, what was the other thing you said that worried you?

Ms Banner: Autistic

Dr Thomas: Yes. Thank you. What would need to happen for you to be assured whether John is or isn't autistic?

Ms Banner: I am sure he is not myself, because...

Dr Thomas: What's happened to assure you of that?

Ms Banner: Its just umm, I have just seen him with other kids, I've seen other kids, I've spoken to other kids and I just feel a bit upset that like, when my friend's daughter she has a tantrum, sometimes I think she acts really strange as well. Her parents think nothing of it. If he does something slightly similar the teachers say that, last year, umm, so , I don't know

Dr Thomas: So you worried about it but then you've seen other children?

Ms Banner: Yes, I've seen other children worse do worse things than him, a lot worse.

Dr Thomas: Right. And what about being schizophrenic, what would need to happen to assure you or reassure you about that?

Ms Banner: I don't know.

Dr Thomas: Do you have any other fears about John other than those three?

Ms Banner: No, its just that I don't know much about those things. Its my first child and we
don't have any children in our family. I don't really, I had nothing to do with children before, him, so...

Dr Thomas: Right. So in a way, you feel as though you are learning as you're going along?

Ms Banner: Yes, as I said, I was never worried about him, about his speech or anything until he started school and the teacher has spoke that he is behind with his speech

Dr Thomas: The three things that you mentioned so far, dyslexic, not so much dyslexic but certainly autistic and schizophrenic are really very serious disorders and what's happened for you to sort of call upon those ideas?

Ms Banner: Well, I just think I'm the type of person when I watch a programme and I see people talking about something or the other I start thinking that I might be having the same problem, or I just hear about something, watch it on TV and I get very worried with myself, even if I have no ...(indistinct)... (potentially blaming the mother).

**Construction of blame and exoneration**

In this episode, Dr Thomas uses repetition and discounting to emphasise the role of mother's beliefs. Taking each of her assertions about possible diagnoses for John in turn, he:

- discounts the central thrust of her concern by not asking for further elaboration of the nature of John's behaviour in response to her expressed concerns about it (lines 7, 9, 16, 29).
- repeatedly asks her about what influences her beliefs (lines 9, 11-12, 20-21, 23, 41-43).
- places them in the context of factors personal to her own life experience (lines 23, 38, 41-43).
- uses verbal devices to emphasise the role of her own perceptions. For example, the use of the phrase “call upon those ideas” (line 43) suggests: there is some sort of value in these ideas for Ms Banner (“call upon” is generally used of positive things as in “call upon friends” or “call upon inner resources”); there exists a repertoire of potential diagnoses that mother has at her disposal and that these ideas are not necessarily reflections of reality.
In this way Dr Thomas's questions help shift the mother's explanations of the difficulties from a focus on factors in her child, to a focus on factors in herself (lines 44-47).

Comparison of results of conversation analysis with results of coding causal attributions about the presenting problem

Ms Banner makes three causal attributions about the difficulties in this episode (lines 4-6, 13-15 and 44-47). The first two potentially blame her son, the last one potentially blames herself. These different attributions reflect the shift in her implicit propositions about the causes of the difficulties that occurs in this episode, from blaming her son to blaming herself.

3.3.3 The intervention

The intervention is taken as one episode.

1 Dr Thomas: What was occurring to us is that in a sense you've described what may not be
2 particularly big problem with regard to John, but also one that might be worth
3 at least taking seriously enough at this stage in his growing up to see if there
4 is any particular help he needs at school, in thinking or drawing, that sort of
5 thing (potentially blaming the child). So what I would like to do is to have a word
6 with the psychologists in the team, just to ask them "Do you think it would it be worth
7 the psychologists seeing John to see if there is any testing or checking to allow us to
8 know does he need any particular school type help or learning type help?". And they
9 might say "No" or they might say, "It is needed at this point just to reassure
10 everybody". There's another sort of area that has struck us in what you've been
11 describing, about the nagging doubts you have been having not just about
12 yourself but also about John and thinking, "I've got something very serious"
13 and maybe part of you thinks that and the other part says, "Couldn't be so". It
14 still nags at you (potentially blaming the mother). You also say that a sense that
15 you are still learning day by day what it is to be thinking about children. Yup? And
16 what we thought the other areas we'd like to think through with you is something
17 more about the background to all this, because it might help us make a bit more
sense of the nagging doubts you have and the uncertainties at times about being a mother (potentially blaming the mother), sort of thing, and so rather than start this now we thought lets stop today. I would talk to the psychologists in the team see if they think it will be helpful for one of them to see John. But also to arrange another appointment with you, next time we will look more about the background. We can see you on Tuesday 2nd, which is about three weeks time, I think at 3.35. Is that OK?

Ms Banner: Yes, so me alone ?

Dr Thomas: Well, I think that what I'd like to do for the moment,let's say you're alone, but if in talking to the psychologists they suggest it will be better to come in a different way then I will write to you.

Construction of blame and exoneration

John’s possible difficulties are acknowledged, but minimised: “may not be particularly big problem with regard to John” (lines 1-2). The suggestion that a psychologist assess John is undermined by the possibility that the psychologist might say “No” (line 9), and that it is only being done to “reassure everyone” (lines 9 -10).

Dr Thomas stresses the role of mother’s perceptions by repetition of the proposition of her “nagging doubts” (lines 11, 14, 18). He also alludes twice to her sense of uncertainty about her parenting (lines 14-15 and 18-19).

Ms. Banner’s response is to ask for confirmation that Dr Thomas is suggesting that she should come alone to the next meeting “Yes, so me alone?” (line 24). This may possibly be taken as an indication of her sense that she is being seen as the focus of the difficulties.

Comparison of results of conversation analysis with results of coding causal attributions about the presenting problem

Dr Thomas makes three causal attributions (lines 1-3, 11-14 and 18).
The first attribution potentially blames the child and the two subsequent attributions potentially blame the mother. This ratio of attributions would appear to reflect the content of the intervention, and the relative weight given to the different elements of it. The main thrust of the intervention is that the mother's role may be central to the difficulties, with the possible role of the child's behaviour being seen as a much less important factor.

3.3.3 Drop out from treatment

Ms. Banner never came back. It is only possible to speculate about the role of blame in this non-attendance. Ms Banner predominately blamed her child for the difficulties and she was blamed by her therapist in the intervention. This is in line with the suggestion raised in the clinical literature, and supported in the previous study, that this combination of patterns of blame might contribute to increasing the possibility of premature termination of therapy. No conclusions can be drawn on the basis of a single case study, however.

3.4 Discussion

The findings suggest that underlying propositions implying blame and exoneration can be deduced based on participants' use of repetition, discounting and verbal phrases. It should be noted, however, that the decision not to code non-verbal data, whilst having advantages in terms of time constraints, did mean that information about the construction of blame and exoneration by non-verbal means, such as tone of voice or expression, may have been lost.

The results of this study are in line with the literature that suggests that in an initial therapeutic encounter participants are likely to be centrally concerned with issues of blame and exoneration (Buttny &
Jensen, 1996), and that the first meeting between this therapist and a parent can sometimes involve a battle for dominance between competing explanations of the presenting problems (Howe, 1989).

The fact that Ms Banner came to therapy with a construction of blame that focused on the child is in line with the literature that suggests parents often come blaming one child (Dr Butler et al., 1986; Watson, 1986). The fact that Dr Thomas's hypothesising focused on mother to the exclusion of other family members is in line with the findings of Sporakowski et al. (1993), that family therapists may make use of more linear models at times.

The results of coding causal attributions about the presenting problem did appear accurately to reflect the construction of blame and exoneration, as identified by conversation analysis, in the episodes under scrutiny here. It would seem that coding causal attributions about the presenting problem in this way may offer a convenient shorthand for the complex attributional work that was achieved by diverse linguistic means in the conversation generally within this therapeutic encounter. Such codings were quicker to undertake than the full conversation analysis.

Whilst it would be necessary to test this out in relation to a number of different cases to see if these findings are more generally valid, these results are encouraging and suggest the operational definitions developed may have uses in further research projects.
DISCUSSION

4.1 Discussion of findings of both studies

The findings of both studies will be discussed in terms of the original aims of the research.

4.1.2 Using operational definitions of blame and exoneration to code attributions in naturally occurring clinical conversations.

Operational definitions of blame and exoneration were created that could be used to code naturally occurring conversation. These were relatively simple to apply and high levels of inter-rater reliability were achieved. Moreover, when compared with the results of a micro-analysis of one particular therapeutic encounter, they appeared to provide a useful shorthand for indicating the attributional stance of the participants within that encounter, being much quicker to use than a detailed micro-analysis of conversation. This would need to be tested further in relation to other cases to determine how far this is universally valid.

Although coding causal attributions was quicker than carrying out a full detailed micro-analysis of a conversation, applying the operational definitions to naturally occurring speech acts was still a time consuming process. It may be that future projects that seek to investigate larger numbers of families may need to look at even smaller segments of conversation - such as the first ten minutes of the pre-session hypothesising meeting and session - or to use semi-structured interviews to elicit causal attributions in a more systematic way.
One limitation of the procedure, already noted, was that only statements that contained a direct attribution about the cause of the difficulties were coded. One possible helpful addition might be to include codings of discounting statements alongside clear statements of attributional cause. Thus a future project might not just look at statements that address the issue, "the cause of the problem is....", but also examine statements that could be fitted into the format "the problem is not caused by...".

4.1.3 Investigating patterns of blame and exoneration made by family members and their therapists in relation to the presenting problem, and exploring their relationship with drop out.

The findings of both studies indicated that the mothers in these studies often came with a "blame frame" in relation to their children. The children who made attributions in the first study tended to accept this attributional stance. It should be noted, however, that a quarter of the mothers' attributions in the first study exonerated the child, suggesting they had also come with alternative attributions that exonerated the child, on which the therapist could potentially build. The fact that the two fathers who took part were more likely to seek to exonerate their child than the mothers, may indicate that fathers generally are less likely to blame their children than mothers, or it may be this was an artefact of the limited talk time the fathers had. Thus it may be that father's only spoke when disagreeing with their partners. However, the numbers involved are too small to draw any conclusions at this stage. More work is needed to explore these possibilities further.

Whilst the therapists in study one predominately used attributions that sought to exonerate the child, they did offer some causal attributions that were potentially blaming. These attributions tended
to blame either the mother or child and rarely focused on the father. This was particularly pronounced in relation to the interventions, where, whilst therapists made few causal attributions, those they did make all blamed the child or mother. This suggests that Treacher and Carpenter (1993) may be right in asserting that systemic therapists may be more blaming than they think they are at times, and that this blame falls disproportionately on the shoulders of mothers (Piercy & Sprenkle, 1990).

In this context it is interesting to note that in the second study the therapist related his attributions about the presenting problem almost entirely to the mother. Whilst it may be that this reflected the particular clinical issues raised in this case, in the light of feminist critique of family therapy, and the findings of study one, it may be that this reflects a wider tendency by clinicians to attribute blame more readily to mothers than to other family members (Goldner, 1985).

The results of study one indicate that any blame by therapists of the parents may possibly be associated with increased risk of drop out. If this finding were replicated in larger studies, it would suggest that it may be crucial to address issues of blame at the outset of therapy, if long-term engagement is to be promoted.

4.1.4 To situate these coded attributions within a micro-analysis of a clinical conversation, and to determine how far they can be taken as representative of an individual's construction of blame in one therapeutic encounter.

Study two indicated that propositions implying blame can be seen to be constructed in verbal interchange by means of a number of linguistic devices, in particular repetition, discounting and verbal phrasing (Buttny & Jensen, 1995). It indicated that issues of blame
and exoneration, in relation to the presenting problem, did appear to take a central place in the initial therapeutic encounter explored.

When situated within this detailed conversation micro-analysis the coded attributions did appear to have some heuristic value. Explicit attributions provided a relatively simple way to explore speakers' explanations for the cause of difficulties in this particular therapeutic encounter. This would need to be tested further in relation to other cases to determine how far this is universally valid.

4.2 Implications

A focus on issues of blame and exoneration offers many possibilities for future research and clinical development.

4.2.1 Implications for future research

The operational definitions developed here may have a role in investigations of the therapeutic process and outcome. They may provide a useful way of measuring levels of blame and exoneration made by individuals in clinical conversations. One extension of the present research might be to use these definitions as a measure in addition to Kazdin et al.'s recently developed "barriers to treatment" scale (1997). The absence or presence of blaming attributions in a therapists' intervention to a family could be noted, and this could be looked at in relation to drop out in a larger study.

Particular groups might be investigated in relation to blame. More could be done to look at differences between family members. Variation in levels of blame in relation to different presenting problems, ethnic groupings or age of the child could all be explored.
A future study might profitably also look at non-verbal aspects of the therapeutic interchange. For example, an exploration of the affective qualities with which participants endow their attributional statements about the presenting problem may help clarify how these attributions impact on the therapeutic process.

This research did not set out to investigate whether a statement coded as “blaming” was actually experienced as “blaming” by the person listening. To have determined this was beyond the scope of the current project, but may well be of interest in future research which looks at the experience of users of family therapy, along the lines carried out by Kuehl et al. (1990).

4.2.2. Clinical Implications

The findings of this research indicate the likely advantages of therapists being aware from the outset of the likely role of blame and exoneration in therapeutic work, and the need to monitor how family members, and the therapists themselves, are constructing blame in their conversations during the course of therapy. It may be helpful for therapists to raise the subject of blame right at the start of therapy, and to address the issues raised with the family at that point (Furlong & Young, 1996).

Increased awareness of the different dimensions potentially involved in attributions of blame and exoneration may lead therapists to seek to clarify with families how far they are holding an individual to blame in a given circumstance. One task for a co-worker might be to note all potentially blaming attributions and to prompt the main therapist to ask for clarification, so that the level of blame can be determined. If it became clear the parent was using attributions that blamed the child,
it might be helpful to adopt questions to de-stabilise this belief whilst clearly exonerating the parents.

The operational definitions developed could also provide a way of identifying statements in the therapist's repertoire that could be potentially taken as blaming family members. One audit project might be to monitor the levels of blaming and exonerating attributions made by therapists in pre-session meetings, or in interventions, and use these to develop guidelines for therapists about how to construct alternative exonerating explanations.

4.3 Conclusion

This research would suggest that therapists and researchers alike may need to hone their sensitivity to issues of blame and exoneration. For researchers, a focus on blame and exoneration may be a way forward to understanding an important factor that may contribute to premature termination of treatment. For clinicians, it may be only by developing a sensitivity to the different ways in which blame may be invoked in conversation, that they can join with families in the construction of alternative explanations of the difficulties that do not seek to attribute blame, and that open up the possibility of therapeutic progress.
REFERENCES


Table showing inter-rater reliability for a selection of ten causal attributions about the presenting problem

<table>
<thead>
<tr>
<th>Attributional statement.</th>
<th>Coding by primary researcher</th>
<th>Coding by rater 1</th>
<th>Coding by rater 2</th>
<th>Coding by rater 3</th>
<th>Coding by rater 4</th>
<th>Coding by rater 5</th>
<th>Coding by rater 6</th>
<th>Coding by rater 7</th>
<th>Coding by rater 8</th>
<th>Coding by rater 9</th>
<th>Coding by rater 10</th>
<th>Percentage agreement with primary researcher</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;The difficulties have arisen because...&quot;</td>
<td>PB</td>
<td>PB</td>
<td>PB</td>
<td>PB</td>
<td>PB</td>
<td>PB</td>
<td>PB</td>
<td>PB</td>
<td>PB</td>
<td>PB</td>
<td>PB</td>
<td>PB</td>
</tr>
<tr>
<td>&quot;he is a very difficult child.&quot;</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
</tr>
<tr>
<td>&quot;of his experience of the divorce&quot;</td>
<td>CB</td>
<td>CB</td>
<td>CB</td>
<td>CB</td>
<td>CB</td>
<td>CB</td>
<td>CB</td>
<td>CB</td>
<td>CB</td>
<td>CB</td>
<td>E</td>
<td>E</td>
</tr>
<tr>
<td>&quot;.. he wants to hurt me.&quot;</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>U/C</td>
<td>CB</td>
<td>CB</td>
</tr>
<tr>
<td>&quot;.. we are living in cramped conditions&quot;</td>
<td>CB</td>
<td>CB</td>
<td>CB</td>
<td>CB</td>
<td>CB</td>
<td>CB</td>
<td>CB</td>
<td>CB</td>
<td>U/C</td>
<td>PB</td>
<td>CB</td>
<td>CB</td>
</tr>
<tr>
<td>&quot;he finds it funny to be naughty&quot;</td>
<td>PB</td>
<td>PB</td>
<td>PB</td>
<td>PB</td>
<td>PB</td>
<td>PB</td>
<td>PB</td>
<td>PB</td>
<td>PB</td>
<td>CB</td>
<td>PB</td>
<td>PB</td>
</tr>
<tr>
<td>&quot;.. she has such a fertile imagination.&quot;</td>
<td>E</td>
<td>E</td>
<td>E</td>
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<tr>
<td>&quot;.. she was abused.&quot;</td>
<td>E</td>
<td>E</td>
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<td>E</td>
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<td>E</td>
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<tr>
<td>&quot;.. that is how all two year olds behave.&quot;</td>
<td>E</td>
<td>E</td>
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<td>E</td>
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<td>E</td>
</tr>
<tr>
<td>&quot;..he has reacted to the medicine.&quot;</td>
<td>E</td>
<td>U/C</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>PB</td>
<td>E</td>
<td>E</td>
</tr>
<tr>
<td>..she gets things out of proportion.&quot;</td>
<td>PB</td>
<td>PB</td>
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<td>100%</td>
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<td>100%</td>
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<td>70%</td>
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</tr>
</tbody>
</table>

Key: CB = attribution coded as clearly blaming, PB = attribution coded as potentially blaming, E = attribution coded as exonerating, U/C = attribution deemed uncodable by rater.