The impact of diagnosis and medication on the family relationships of children with Attention Deficit Hyperactivity Disorder (ADHD): An Interpretative Phenomenological Analysis.

Submitted by

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as part of course requirements of the University of Surrey Psych D Clinical Psychology

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Year 1

What is Psychiatric Rehabilitation? Discuss with reference to at least three models of intervention.
1. INTRODUCTION

Psychiatric rehabilitation is generally understood to refer to a process undertaken by psychiatric services in conjunction with its clients or users, to manage the effects of a psychiatric breakdown. This essay will describe the historical and legal context of psychiatric rehabilitation and the various models of intervention that are used in psychiatric rehabilitation today. For each model it will discuss what picture of illness and consequent needs it assumes and what structure it provides for putting into practice the meeting of needs and evaluating if those needs have been met. It will also describe to what extent the models achieve a balance between the views of professionals and users, to what extent they are responsive to the needs of the individual and how far they can adapt to the fluctuating needs of the psychiatrically ill. Conclusions will be drawn on these bases as to how effective psychiatric rehabilitation can be, bearing in mind the limitations of the general models in catering for individual needs within this complex process.

2. MODELS OF REHABILITATION

2.1 Historical development

Psychiatric rehabilitation originated during the Victorian era of enlightenment when institutions were established to provide humane treatment of the insane and the concept of asylum was developed. During this era of ‘Moral Therapy’ mental illness was seen as a deviation from socially acceptable behaviour which could be cured by treating people with respect, providing a normal domestic environment, social re-education, work and leisure activities. It soon became apparent however, that institutions failed to ‘cure’ people by these methods and during the ‘custodial’ era of the latter part of the 19th century the aims changed in being simply to ensure quiet behaviour and prevent escape (Watts & Bennett, 1983). Such institutional environments have been decried by various authors, such as Goffman (1961), for their features of block treatment and depersonalisation through which people’s difficulties worsened. With the aid of pharmacotherapy a major drive was initiated to decrease hospital populations, in what
was known as the 'deinstitutionalisation' movement. Moving people out of hospitals into smaller units however did not eliminate their problems and institutional practices appeared on a smaller scale (Kings, Raynes & Tizard 1971, Ryan, 1979). From this the 'revolving door syndrome' developed due to inadequate follow-up for clients and there was an increasing burden upon family and community for their care (Watts & Bennett, 1983). Historically therefore, a process of trial and error in practices for caring for the mentally ill has led to the current concept of what rehabilitation should be. The most recent modification to the process of caring for people outside of hospitals has been the introduction of the Community Care legislation.

2.2 General definitions

Ekdawi & Conning (1994) argue that rehabilitation is not the same as Community Care as the latter is a legal principle stated in the National Health and Community Care Act (Department of Health, 1990) where the emphasis is on providing care outside of hospital with responsibility being shifted from health to social services. They argue that Community Care is a guiding principle in psychiatric rehabilitation, particularly as it is linked to research showing the positive effects of alternatives to hospital (as long as care addresses all needs, is ongoing, assertive, flexible to the individual and provided seven days a week, twenty four hours a day as described by Hoult, 1986). Community Care is also informed by descriptions of specific principles for planning care that have developed out of practice e.g. Bachrach (1989) who delineates thirteen principles that can be applied across a variety of different settings:

a) prioritising care for the chronic patient,

b) inter agency communication and linkage,

c) total care,

d) individualised planning,

e) responsiveness to the distinctiveness of local culture,

f) specialised personnel,
g) in-patient care if necessary,

h) self monitoring of programmes,

i) affirmation of strengths,

j) assertive outreach,

k) aggressive leadership,

l) eclecticism in reception to various kinds of assistance, and

m) the ability to plan ahead in an unbiased way.

Wolfensberger’s (1970) notion of normalisation i.e., ‘the use of culturally valued means in order to enable people to live culturally valued lives,’ is seen by Ekdawi & Conning as another guiding principle behind rehabilitation, using Goffman’s (1961) ideas to describe how hospital care increases the stigma and ideas of difference attached to the mentally ill. Both these guiding philosophies need to be distinguished from psychiatric rehabilitation which is more of a practical venture. It is clear however that guiding philosophies develop themselves from the different historical practices of rehabilitation.

An important defining feature of psychiatric rehabilitation is the population it seeks to serve (Morgan & Cheadle, 1981). It is generally accepted that those involved are the chronically mentally ill. The National Institute of Mental Health (1977) define chronicity as marked by, “a single period of hospitalisation in the last five years of at least six months duration, or two or more hospitalisations in a twelve month period” (Ekdawi & Conning, 1994). Shepherd (1984) further clarifies this population into the old long stay, the new long stay, and the new long term who have repeated and extended contact with the services. Watts & Bennett (1983) describe how rehabilitation is not just for those with schizophrenia but also can be applied to those with neurotic, affective and conduct disorders, substance misuse and mentally disordered offenders. As such it is a defining feature of rehabilitation that it deals with a highly heterogeneous population.
Some general definitions of rehabilitation have been attempted by various authors. Watts & Bennett (1983) discuss how it is a concept borrowed from physical medicine and implies a two stage process of treatment of symptoms and permanent adaptation to the environment. They describe how it has developed through several stages in psychiatry from ideas of disability and compensation, through economic employment, cure and coping, before finally arriving at the definition of it being, “the process of enabling a psychiatrically disabled person to make the best use of his or her residual abilities in order to function at an optimal level in as normal a social context as possible.” As Ekawi and Conning (1994) argue such, there is within rehabilitation, the notion of an interaction of person and setting, an emphasis on maintaining functioning and preventing deterioration, the idea of it being a process rather than an endpoint i.e., different from resettlement, and a focus on capacities and strengths. This latter point is also emphasised by Lamb (1994) in his discussion of Wing and Brown’s (1970) notion of promoting the mastery of the psychiatrically disabled person. It is difficult however to tease out general definitions of rehabilitation, that do not overlap and merge into guiding philosophies and therefore they often remain vague. This suggests that psychiatric rehabilitation can be more clearly defined by considering models of intervention and what happens in practice.

2.3 Cure model

Historically an important model of intervention in psychiatry has been the cure model based on the idea that a particular set of symptoms leads to a particular diagnosis, intervention plan and cure (Ekawi & Conning, 1994). The cure can be effected by pharmacological or psychological means, but either way the aim is to eliminate dysfunctional thoughts, behaviour or feelings. This model of psychiatric rehabilitation upholds the psychiatrist as the expert on the patient’s needs and holding the key to his recovery through correct diagnosis. Although attractive in its simplicity and useful perhaps for the psychiatrically disturbed and their families to explain problems, it has become apparent, since the introduction of anti psychotic drugs in the 1950s, that the ‘disease/cure’ notion of psychiatric illness is not entirely useful. This is due in part to the varied response of clients to psychotropic medicine and doubt about the validity of psychiatric diagnosis. About 25% of people with schizophrenia show little amelioration...
of symptoms in response to psychotropic medicine, (Christison, Darrel & Wyatt 1991) and even if ‘positive symptoms’ are removed there remain problems of ‘negative symptoms’ and side effects (Wing & Brown, 1970). The model reinforces the sick role and implies that patients should passively accept treatment. As such, the contribution of medication is acknowledged as being only a part of rehabilitation with an emphasis on management rather than elimination of symptoms. Medication and psychologically based treatments, such as Cognitive Behaviour Therapy for hallucinations and delusions (Birchwood & Tarrier, 1992) probably need to be combined. These new approaches to the management of positive psychotic symptoms and delusions are based on a notion of adaptation to illness rather than cure. Fowler, Garety and Kuipers (1995) outline the evidence for the effectiveness of such treatments and suggest that initial results are promising but larger scale and longer evaluations are required to determine the need for follow up and to distinguish the characteristics of clients who may benefit.

2.4 Disability model

Another model of intervention is the Disability model which recognises the limits of an exclusively medical or exclusively social picture of mental illness (Ekdawi & Conning, 1994). They state how Wing (1981) defines the concept of disablement as a result of three factors:

a) primary or intrinsic impairments that are a direct result of the illness e.g., hallucinations or delusions;

b) secondary impairments that are responses to illness e.g., loss of confidence, low motivation, poor coping; and

c) tertiary or extrinsic handicaps due to poor housing or social networks.

This model provides a comprehensive descriptive picture of the difficulties entailed in mental illness using a more individualised approach and suggests intervention on all three levels. However, it still focuses on deficits in a medical sense and does not specify how to actually assess, intervene or to evaluate the outcome of an intervention. It is
limited as a model in that it describes difficulties but does not provide practical guidelines.

2.5 Functional (Skills) model

Another important model of rehabilitation is the 'Functional' or 'Skills' model developed by Anthony (1977). This model is based on the assumption that the psychiatrically ill have lost the skills necessary for survival outside of psychiatric institutions. There is a three stage process for re-developing these skills: the identification of the deficit, assessment of the present and required functioning for each skill and intervention to eliminate discrepancies between these.

Outcome can be assessed by observable measures of achievement such as changes in community behaviour and skills. Later developments in the skills model have taken into account the fact that skills training only brings partial improvement and there are continuing deficits and symptoms such that environmental provision in the form of sheltered accommodation and work is necessary. This approach takes a positive individualistic approach to rehabilitation and defines psychiatric illness in functional pragmatic terms, demanding the active involvement of the user in the implementation if not the planning of services and provides a clear structure for assessing, intervening and evaluating outcome. The approach could however, be criticised for its linear emphasis which is reminiscent of the cure model and does not allow for the possible fluctuating effects on skills of motivation and relapse. It also suggests a rather mechanistic view of rehabilitation that does not have a framework for the social and emotional difficulties that psychiatric illness entails. The approach is however, self admittedly partial and the actual implementation of the model has illustrated that remediation of skills deficits is only one aspect of the needs of the psychiatrically ill. The idea of skills teaching has always been important in the rehabilitation of the psychiatrically ill as seen in the use of token economy programmes in psychiatric hospitals (Allyon & Azrin, 1968). Rather than being the sole focus of a model, skills development needs to be linked to more comprehensive view of the person's total ongoing needs.
2.6 Needs approach

A development from the skills approach to rehabilitation, is the Needs approach (Ekdawi & Conning, 1994) which has been described by Bachrach (1989) as the British approach to rehabilitation. It is based on the Patient's Charter's concept of clinical need (Department of Health 1991). This is seen as a more flexible approach to rehabilitation since it implies alternative methods of meeting needs than just through skills teaching. It is based on the desire to provide individualised goal oriented treatment based on a thorough assessment of the patient (Conning & Rowland, 1992) for example, the use of the Needs for Care Assessment (Brewin, Wing & Mangen 1987). This assessment identifies a 'primary need for care' when the level of functioning falls below some specified level i.e. there is disablement and this disablement is due to some potentially remediable or preventable cause. It is acknowledged that these needs are expert defined and are value judgements. A distinction is made between a need for a specific item of care (i.e., advice, treatment, shelter) and the need for a service to provide this item of care. Areas of need cover clinical state and social functioning and in each a minimum level of functioning and a set of appropriate interventions is identified. The 'needs for care' in each area are then determined by comparing the provided items of care with what an ideal model predicts those items of care should be. The assessment makes a distinction between competence and performance and also links client need to the needs of the system i.e., it helps to identify service deficits. In this way it is a thorough method of operationalising the process of rehabilitation and seems to fill the gap left by the disability model of how to put concepts of intervention into a useable form. This leads to clear ways of assessing outcome by considering whether or not the described needs have been met.

However a lack of clarity in defining need has led to tensions between client and staff views of needs and the term has been over inclusive, leading to failure to provide clear strategies for actually meeting patient needs as illustrated by Khwaja (1985) cited in Ekdawi and Conning (1994). Structured assessments may remove the problem of accurately defining need. The concept of need helps to normalise the problems the mentally ill encounter, focuses on quality of life and implies consideration of clients views as the person best placed to identify needs. In practice though, incorporating
clients views becomes an ideal rather than a reality given the day to day constraints of using structured assessment. Shepherd, Murray & Muijen (1995) showed that client perceptions of need were for more practical considerations such as shelter and housing in contrast to professionals who saw the needs to be for more of their own particular services.

2.7 Roles approach

Another approach to rehabilitation is a Roles approach which is perhaps the least clearly developed in practice (Ekdawi & Conning, 1994). It is broadly based on the idea that social adjustment occurs when a person has their status in society defined by what they do. The long tradition in psychiatric rehabilitation of the importance of work in giving people structure, social contact and explicit rules in a social situation (Watts & Bennett, 1983; Shepherd, 1984) is central to this approach. Work has also been cited as a perceived measure of social adjustment by disabled people (Collis & Ekdawi, 1984). Ekdawi and Conning (1994) suggest that work rehabilitation requires a central facility for assessment, planning and implementing interventions and work provision from open employment to very structured work environments, with a support system for workers, employers, staff and families.

Watts and Bennett (1983) expand the concept of roles beyond work to roles such as parenting and roles in marriage, since interpersonal relations require skills of motivation, behavioural and social skills, all of which may be damaged by mental illness. They describe the process of rehabilitation as one of socialisation analogous to childhood, requiring nurturing and discipline. The actual process of rebuilding interpersonal skills and roles is not explicitly mapped out with aims and methods in the same way as work rehabilitation but none the less, it seems to point to an important area. The whole concept of roles is less of a deficit model and focuses mainly on the interaction between person and environment suggesting that cognitive impairments and symptoms are not problematic given that the person can maintain a valued social role. This is a point emphasised by Breier & Strauss (1984) in their analysis of the role of social relationships in recovery from psychosis and by the extensive work done to identify characteristics of families that are relapsogenic i.e. families with high levels of Expressed Emotion (Tarrier, Barrowclough, Porceddu & Fitzpatrick, 1994). The
Essay 1: Psychiatric rehabilitation.

approach is less expert driven and suggests that the whole concept of professional treatment maintains the sick role and therefore does not help rehabilitation. The broad principle of having a valued social role is central to rehabilitation but this model of intervention requires a more explicit and coherent structure of how to achieve this.

Other more recent approaches to rehabilitation that could also be classified as ‘roles’ approaches, have emphasised the emotional impact of a psychotic episode and suggest that working through the impact on identity is crucial and basic to good rehabilitation. Strauss (1989) suggests that many of the negative symptoms e.g., social withdrawal and avoidance of demands, are not pathological in themselves but are actually an attempt to cope with the stigma of mental illness, the threat of return of symptoms, and guilt for past dysfunction when acutely ill. Appello (1993) develops this theme and put psychiatric rehabilitation within a grief model as the psychiatrically ill exhibit many of the features of grief such as, loss of interest, difficulty concentrating, anxiety and depression. He argues that through grief therapy this ‘emotion oriented coping’ needs to be replaced with problem solving coping skills. Thus this author suggest a model of intervention that is about grieving for lost identity and finding ways to rebuild a new identity. This point is also emphasised by McGlashlan (1976) by his describing recovery from mental illness as requiring adjustments in self perception and finding meaning, similar to tasks in recovering from post traumatic stress disorder. He advocates an ‘integrative’ rather than a ‘sealing over’ style of adjustment to the experience. These more therapeutically based approaches to rehabilitation are perhaps one way of operationalising the roles approach. Although normalising psychiatric symptoms to some extent they still demand a certain amount of professional involvement and although highlighting what seems to be a crucial common denominator to rehabilitation (the development of a new identity that is adjusted to the real and ongoing nature of psychiatric illness) these approaches require more practice and evaluation. The effectiveness of rehabilitation in enhancing self esteem and a rejection of the patient role has been shown empirically by Collis and Ekdawi (1984). It is also quite clear that emotional adjustment does not occur in a vacuum and is probably highly dependent on additional necessities of accommodation, medication, work and social support.
2.8 **Fountain House model**

It can be seen from dividing rehabilitation into different models of intervention based on cure disability, skills, needs or roles that a clear pattern emerges. When models have been put into practice and their results evaluated, a common result has been the widening of the approach to incorporate more and more elements of the person’s life such as, work, accommodation, social and emotional adjustment. It becomes clear that a single focus (e.g. on skills) is not adequate and as such the usefulness of the ‘needs’ and ‘roles’ approaches is their breadth and their capacity to be umbrella concepts within which to include these different elements. A useful illustration of this point is the Fountain House model of rehabilitation (Beard, 1982) that primarily adopts the Roles approach to rehabilitation stressing the importance of social and vocational rehabilitation and includes a belief in the productivity of even the most disabled clients. The essential element to this approach is the concept of membership whereby a person is needed and expected in the running of the house. The Fountain House system is designed to be fluid and user led, with awareness of needs evolving out of members experiences. As such, a comprehensive system of work, social and accommodation services has evolved along with an awareness of the importance of medication and other professional services and the need to evaluate the service with a recognition that members themselves need to be involved in the design of outcome measures. The striking element to the Fountain House model and its U.K. ‘Clubhouse’ equivalent is the comprehensiveness of service and its natural evolution as guided by what users see as their needs. Although tensions remain between this approach and the more conventional Care Programme Approach to rehabilitation, particularly in the emphasis on the need for professional advice and how to give direction in a more subtle form, it is a good example of how a model of intervention in rehabilitation when put into practice and guided by users tends towards the kind of ‘total care’ suggested by Bachrach (1989).

**3. CONCLUSION**

The exploration of the different models of rehabilitation leads to the conclusion that psychiatric rehabilitation is a practical venture that is informed by and itself informs the current guiding philosophies and law in mental health. In being practical it is always
partly defined by the idiosyncrasies of local context and individual users not least because of the heterogeneity of the population that it is involved with. Practice has also show the need for a service to be comprehensive and flexible involving an awareness of all the different elements outlined in the separate models described above. Psychiatric rehabilitation therefore consists of a guiding philosophy and a clear model for implementation at the local level that is fluid and able to be modified through careful specification of aims and evaluation at a local level. Although the effectiveness of psychiatric rehabilitation has been accepted (Dion & Anthony 1987) outcome studies are hampered by problems of defining homogenous client groups and outcome measures which may differ according to guiding philosophy. This combined with the diversity of practice outlined above and the usual holistic ‘total care’ packages in practice militates against clear knowledge of the most significant factors in outcome which would help to define more clearly what psychiatric rehabilitation should be.

4. REFERENCES


Concern has been raised regarding a relationship between two clients of the same sex and different levels of ability living in a staffed home. What are the areas that need to be considered when reflecting on this relationship with specific reference to consent and policy issues?
1. ABSTRACT

A relationship between two learning disabled clients of the same sex living in a staffed home raises complex issues involving consideration of the law as well as policy and education for both staff and clients. This essay will begin by describing the current legal position on this relationship focusing particularly on how to establish the existence of consent. The limits to the legal guidance will be discussed along with the consequent policy and educational issues for both staff and clients and their own limitations and difficulties. This analysis will reflect the need for practitioners involved in such scenarios to make a careful well documented group decisions involving assessment of the risk and benefits of the action taken.

2. CONTEXT

Issues around sexuality for learning disabled people in residential care have become more complex in the context of a general liberalisation of attitudes concerning their sexual rights. This is due to the closure of the old institutions which were often regarded as a means of preventing reproduction in this population (Brantlinger, 1988) and normalisation philosophy which now tends to guide services has the goal of removing obstacles to normal living for people with a learning disability (Wolfensberger, 1972). Furthermore, the United Nations Declaration on the Rights of Mentally Retarded Persons (1983) states that they have “a right to such education, training, rehabilitation and guidance as will enable them to develop their ability and maximal potential.”

3. LEGAL AND CONSENT ISSUES

3.1 The law relating to homosexuality

A consideration of the legitimacy of a relationship between two clients immediately poses the question of legality because of the known vulnerability of this population to sexual abuse and exploitation (Brown & Turk, 1992). The legal consequences of
promoting or preventing this relationship depend on the age, sex and level of ability of the participants as well as the place in which it occurs and the nature of the activity.

In order for concern to be raised regarding this relationship there must be descriptions of activities between the two clients which can be the basis for consulting the law. There are numerous legal limitations imposed upon sexual relationships created by the Sexual Offences Acts of 1956 and 1967 as outlined by Gunn (1996). Some apply to all people and others, specifically to people with a learning disability. At age eighteen homosexual activity between two consenting men becomes legal, providing the activity takes place in private. The 1994 Criminal Justice and Public Order Act extended the law of rape to include anal intercourse with a man while the Sexual Offences Act (1956) defines the offence of rape as occurring if a partner does not consent and the other partner is aware of the lack of consent or is reckless as to whether consent is given or not. If the relationship does not involve actual anal intercourse the contact could still be classed as indecent assault if there is no consent. Indecent assault is defined as "actual or apprehended physical contact in circumstances of indecency" where the accused has an indecent motive (Section 14 Sexual Offences Act, 1956). Indecency has been described by the House of Lords in R v Court (1988) as "conduct that right thinking people will consider an affront to the sexual modesty of a woman," or "that right minded people would consider indecent or offensive to contemporary standards of decency and privacy." For two women the same law on indecent assault would apply and it is stated that boys or girls under sixteen cannot give consent to prevent an act being an assault so that this creates an age of consent for lesbian activity. Other legal issues arise in that a relationship between two members of the same sex may lead to indecent exposure as an offence under section 7 of the Vagrancy Act (1824) if the clients understanding of privacy is limited.

Specific laws for learning disabled people apply if the level of disability is severe enough to render the person 'defective.' A 'defective' be they male or female is not

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1 This includes buggery, (the legal term for anal intercourse) and gross indecency (Section 12 Sexual Offences Act 1967 as amended by Section 145 Criminal Justice and Public Order Act 1994).
legally able to give consent in law to make indecent assault or rape legal (Sexual Offences Act 1956, Criminal Justice and Public order Act 1994) although the accused would not be guilty if he did not know that the partner was defective. The Sexual Offences Act 1967 makes the same ruling for buggery using the term ‘severe mental handicap’ which means the same as defective. Gunn points out however that the 1994 amendment to the earlier Acts does not mention men with ‘severe mental handicap’ so it is not clear if the ruling on inability to consent to buggery still applies. This appears to mean that the law relating to buggery places fewer restrictions upon people with severe learning disabilities engaging in male homosexual acts (as long as consent was established) than in heterosexual activity, lesbian acts or two men engaging in gross indecency.

Overall the law seems to mean that two men with a severe mental handicap may legally have a homosexual relationship if neither could be expected to and do not recognise the degree of impairment of his partner. A man may also be able to have a relationship with another man with a severe mental handicap if he is not aware of the disability which may be the case with a man with a mild learning disability. Gunn argues that this special defence means that it is possible to permit non-exploitative relationships between two men. Although the acts are technically offences, the legal process means that actual prosecution is unlikely. The old code for Crown Prosecutors suggests that in such matters prosecution will not be followed through unless there is evidence of abuse or exploitation (Gunn 1996).

3.2 Practitioners level of responsibility

Thus the law offers some guidelines for practitioners but there are many practical issues in real scenarios which are not answered by it. Additionally there has been little case law to help interpret the statutes (Gunn 1996). Under general law from the age of eighteen, parents, doctors and other professional people have no legal right to make decisions on the behalf of clients unless granted specific power to do so. These specific powers would come into play only if the client was under guardianship under the Mental Health Act (1983) however, the conditions to meet this requirement are quite stringent. Even if this were the case, their consent is still required for anything other than medical treatment (Gunn 1996). As such, staff who are aware of a relationship between two
clients have a responsibility to allow the clients their sexual freedom and a certain level of risk taking as would be the remit of any non-disabled person.

However since sexual activity raises the possibility of legal offences being committed, staff need to know their own responsibilities to prevent offences occurring on their establishments. Criminal Law states that a person can be guilty of a crime by causing or encouraging another to commit it or facilitating it or providing real assistance at the time the crime was committed. This could mean that by ignoring an offence staff could be liable. Section 127 of the Mental Health Act (1983) states, “It shall be an offence for any individual to ill treat or wilfully neglect a mentally disordered patient who is for the time being subject to his guardianship under this Act or otherwise in his custody or care (whether by virtue of any legal or moral obligation or otherwise)”(Gunn 1996). The term mental disorder covers all forms of learning disability and staff providing a service of accommodation in a staffed home have an obligation to their clients as stated in this clause and therefore could be seen as negligent if harm or damage is suffered by them. Preventing abuse as far as is reasonably possible is therefore an important duty for care staff. If a relationship is to be allowed it could also be argued that services could be found negligent by not providing clients with sufficient education and understanding of the activities to protect themselves from harm i.e., the importance of safe sex. Even though it may be unlikely that failure to educate would constitute criminal neglect on the part of staff, it seems important that services provide sex education particularly as education is stated as one of the rights of learning disabled people in the U.N. Declaration.

The translation of such legal responsibilities of staff and services into local policy documents facilitates clearer decision making. For example, the Sexuality Guidelines of Cornwall and Isles of Scilly Learning Disability Trust (1996) require staff to ask the question of whether the relationship causes, “significant harm, loss of dignity or alienation for the client or others.” Although these questions may not be straightforward to answer, they at least provide a procedure for groups of staff to follow so that the clients sexual rights are not unnecessarily curtailed.
3.3 Assessment of the level of learning disability

An assessment of the level of disability of the clients involved is required to determine the legality of the relationship. Both terms ‘defective’ and ‘severe mental handicap’ used in the law are the same as the definition of severe mental impairment in the Mental Health Act (1983) (less the requirement for abnormally aggressive or seriously irresponsible conduct on the part of the person concerned) and mean ‘a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning.’ Nonetheless there is no clear method for classifying people as ‘defective’ (Gunn 1996). In some key cases the Court of Appeal has decided that the meaning of defective is in, “the words of the ordinary English Language” and is measured by, “the standards of normal people” and defectiveness could be assessed by a jury (R v Hall, 1987) without expert evidence (R v Robbins, 1986). However, in everyday matters Gunn suggests that comprehensive professional assessments covering social and intellectual functioning are the best guide since very few cases have actually reached court and in those that did there was little discrepancy between jury and professional perceptions. Brown & Turk (1992) state that juries are often conservative and lean towards protection and as such professional decisions must be carefully documented.

3.4 Assessment of consent

Staff must next decide whether the relationship is consensual since it is upon this matter that most sexual offences hinge. However, the definition of consent is not made clear in the law despite the fact that staff need clear guidelines so that they do not become overly cautious and unnecessarily limit clients sexual rights. Gunn (1996) points out that there could be a ‘low’ or a ‘high’ standard of consent, the former for example, involving an understanding that the act was sexual and involved penile penetration, the latter demanding an awareness of the significance of sexual relationships and their implications. The former bestows more sexual freedom on people with learning disabilities but the latter is more protective. Finding the correct balance is perhaps the central problem for service providers. Staff have good reasons to be concerned regarding the likelihood of abuse. People with learning disabilities are vulnerable
because of their lack of sexual knowledge, their reduced opportunities to explore sexually, their susceptibility to coercion and their living context where privacy and control over intimate care are limited (Brown & Craft, 1989 Turk & Brown 1993). Allington (1992) showed that although 68% of staff in a sample felt that their clients were at greater risk of abuse than other people, only a third ever discussed the subject in their work place. Allington attributes this to embarrassment and a lack of confidence and clear direction how to respond to messages they receive from clients.

Brown & Turk (1992) present useful guidelines to assist in deciding whether sexual activity between clients might be deemed to be consensual or abusive. They point out how clear objective decisions are difficult. The observer is usually acting on partial information and has to take account of legal definitions as well as trying to assess the impact of the behaviour on the victim and the intentions of the perpetrator. All this operates in the context of social norms and taboos that may shift. They define sexual abuse by; the nature of the acts and whether consent was given. Potentially abusive sexual acts are classified as either contact or non contact abuse. Although the latter category moves beyond situations where legal sanctions exist Brown & Turk argue that standards should be set for these behaviours in operational guidelines nonetheless, particularly given the dependency that characterises the lifestyles of most adults with a learning disability.

Brown & Turk (1992) describe how the issues of consent are twofold; whether a person could or did give it. A person is deemed by them to be unable to consent if the nature and severity of their learning disability undermines their understanding of the basic elements of sexual behaviour in terms of recognition of the behaviour as a sexual act, its appropriateness, value and consequences. This judgement is independent of whether the other person was deliberately exploiting their ignorance or inadvertently abusing it. Even if such judgements are possible other barriers to consent exist that preclude against real choice being made e.g. the presence of a parental, familial, custodial or caretaking relationship between the persons, the use of force or the presence of a power imbalance. A thorough analysis of these factors develops a clearer picture of whether an abusive and exploitative relationship was taking place. However such criteria for establishing consent are demanding of people with a learning disability and it may be that in
individual policy guidelines practitioners may choose to make the balance between abuse and sexual freedom slightly less stringent.

### 3.5 Dealing with abuse

If the acts were deemed to be abusive then clearly new complex issues would be raised for staff such as how to prevent further abuse of the same or other clients, and whether or not to pursue legal action on the clients behalf. Gunn (1996) suggests that the emphasis should perhaps be more upon managing the effects of abuse due to the obstacles to successful prosecution for people with a learning disability in law. Sysmanski and Rosefsky (1980) suggest that the therapeutic needs of this group may not be very different from those of people without learning disabilities and the approach taken by staff needs to be sensitive. Clements, Clare & Ezelle (1995) point out how a 'gender blindness' within learning disability services in general often means that the needs of those who have been sexually abused are ignored. This highlights the need for clear policies on action to be taken on suspecting and discovering abuse.

For the instigator of the abuse in this scenario, it is likely that they were unaware of the victim’s inability to consent and so technically could not be prosecuted. In most cases minor or initial offending is overlooked if the alleged perpetrator has a learning disability (Gunn, 1984) and the needs of the abuser are also important to consider. Charman & Clare (1992) describe an exploratory group designed to educate a group of mildly disabled men on the ages of consent to sexual activity, the importance of privacy and how to recognise cues that indicate non-consent. They argue that these men often have not had the opportunity to learn the commonly accepted norms or to develop appropriate inhibitions. Although only evaluated in terms of increase in knowledge rather than decrease in actual offending behaviour, Chapman & Clare argue that these groups are a useful and humane intervention for offenders.

### 3.6 Management of a non abusive relationship.

If after consideration of consent issues it is agreed that the relationship in the considered scenario is not abusive then for clients who are not classed as defective it would need to be supported by staff. A further legal implication may apply here in that the legal
requirement for privacy for homosexual acts may be particularly difficult to enforce in a staffed home particularly given the usual limits on rooms and the possible institutional history of clients where privacy was not a normal experience. Gunn (1996) points out that it would be in a client's defence if he or she had no understanding of the offence he was committing and the obstacles to prosecution already considered would also apply. It would be important however for staff to educate clients as far as possible towards the norms of sexual behaviour in conjunction with allowing it.

Perhaps the most complex scenario for staff is when either or both clients are judged by law to be incapable of consenting to the sexual activity and yet the relationship does not appear to be abusive (Brown & Turk, 1992). Staff are faced with having to either infringe what appear to be the client's integral sexual rights or to condone technically illegal activity. Again however, the discretion to prosecute is unlikely to be exercised unless there is evidence of exploitation or abuse. Furthermore the consequences of preventing the activities may be more damaging for those involved (e.g. possibly leading to other illegal sexual activity) (Gunn, 1984).

Parallels can be drawn between this dilemma for staff and the situation described by Shelton (1992) when he documents the procedures involved in teaching a profoundly handicapped man how to masturbate. Although this procedure could have been be classed as indecent assault since the client was not able to consent, it was successfully carried out by a core team by holding risk taking meetings and building in various safeguards to ensure confidentiality and to avoid misinterpretation of the programme. Carson (1990, 1992) comments on this procedure and points out that in not aiding the sexual expression of the profoundly disabled, services are allowing them to suffer significant loss which they could technically sue for. He points to the need for professionals to follow a strict procedure that clarifies facts and motivation and involves a risk analysis. This method, of assigning numerical values to the possible harm or benefits likely to result from the relationship, completed in a group format with all relevant professionals presents appears to be an appropriate decision making process. It does however, have the disadvantage of making the process quite bureaucratic and making public the clients' sex lives (Booth & Booth, 1992).
4. POLICIES AND EDUCATION

4.1 Policies

The above discussion emphasise how policies are necessary at a local level to clarify issues left unclear in the law (Booth & Booth, 1992). Leyin (1992) examines general trends in the development and style of guidelines and describes the first policy document produced by Hounslow Social Services which covered the following areas;

a) clarification of legal issues;

b) specific guidance on contraception, sexual intercourse, marriage, masturbation and homosexuality;

c) recognition of conflicts between personal values of staff and their expected behaviours at work; and guidelines of what to do in such conflicts,

d) and the importance of staff development and training.

Policies are also required in order to make up for the lack of regard in current legislation for the importance of choice and the dignity of risk within the current normalisation principles. The Avebury Working Party on good practice in residential care emphasised that responsible risk taking should be regarded as normal (C.P.A., 1984). Booth & Booth describe how policies support staff decision making in often highly emotive situations, bring the issue of sex into the open and serve as a public statement of the sexual rights and needs of people with a learning disability which provides consistency and accountability in practice. Furthermore, policies emphasise sexuality not as a problem to staff but as an aspect of individual identity and a source of emotional well-being. In reviewing recently developed policies Booth & Booth describe their style as often being vague and ambiguous, possibly because of trying to negotiate a host of conflicting influences i.e., the morals of staff, the law and the views of relatives, politicians and the wider public. Kohealtee and Dustin (1991) in a survey of policies in the South West Thames Region conclude that policies are useful but that there is a large amount of apathy concerning their creation within services which is characteristic of the general neglect and devaluing of people with a learning disability.
Despite these difficulties Kempton and Caparulo (1983) provide clear guidelines on how to set up policies using a task force model. Booth & Booth (1992) describe how policies could be improved by involving people with disabilities themselves in the setting up of guidelines and by making policies consistent across agencies and public and private sectors. They state that facilitating sexuality is a question of resources as well as attitudes i.e. how people with disabilities can have sufficient privacy in staffed homes. They emphasise how policies should focus on creating opportunities for sexuality, not just reacting to crises, perhaps by using ordinary facilities such as dating agencies and homosexual networks.

Leyin (1992) questions how staff can be encouraged to actively use policies since research has shown that guidelines are not actively used but are read only in a crisis (Dicks 1987) and informal culture and decision making tend to take over. He finds a solution in business management where there has been an actual reduction in policies in view of the fact that they cannot cover any eventuality and if too formalised they restrict staff initiative. He describes a ‘tight loose’ approach where the organisation is tightly controlled by its value system but still insists on autonomy and initiative. He envisages policies as having a strong philosophy with which all actions are consistent, rather than having guidelines stating specific responses to particular situations. In giving primacy to philosophy and values he argues for a entire supportive system where policies guidelines and training are inextricably linked and staff development is essential (Leyin 1992).

4.2 Education for staff

It is clear that the issue is not simply about consulting the law or a policy document. Education and philosophical guidance for staff is at the heart of the successful implementation of any sexuality policy (Harvey, 1983). Kempton and Caparulo (1983) describe sequential stages of attitudes in carers towards clients sexuality; the desire to eliminate it, tolerating it, accepting it and finally cultivating it. They argue that this last stage should be the goal but is hardly ever the case. As Shelton points out, sexuality is generally ignored rather than explored in the normal population and with the added stigma of a learning disability, the taboos may be heightened (Shelton, 1992). Johnson & Davies (1989) reported that the majority of British and Canadian staff they surveyed held attitudes such that they would assist people in their expression of sexuality.
However the authors felt that this may not be translated into action because of feelings of inadequacy or ambivalence not least because of a small number of staff who were extremely cautious in their approach had a disproportionate influence. Kempton (1983) describes a comprehensive package for training staff including presenting factual information and correcting misinterpretation and myths. This may be particularly important when considering homosexuality as Clements et al (1995) point out that staff often operate on a principle of ‘heterosexism’ where they view homosexual activity as a function of the person’s inability to discriminate sufficiently to choose a heterosexual partner. The second essential element of training is to allow an exploration of staff’s personal attitudes to sexuality in order to equip them to recognise when conflicts occur. Rose and Holmes (1991) have demonstrated the effectiveness of such workshops in changing staff attitudes towards clients sexuality.

4.3 Education for clients

Thorough education for clients is also vital to their sexual freedom particularly as Brown & Turk (1992) see knowledge of the risks and consequences of sexual activity as a defining feature of consent. The legal position for staff educating clients on homosexuality is complicated by the Local Government Act of 1988 which prohibits expenditure for the promotion of homosexuality except for the purpose of preventing or treating disease. However, it can be argued that if the person has already shown their sexuality in the form of behaviour or needs to be educated to learn how to deal with homosexual overtures, then homosexuality is not necessarily being promoted (Gunn, 1996). McCabe & Schreck (1992) argue that in order to educate people with learning disabilities at the right level much more needs to be known about their actual sexual knowledge, experiences, feelings and needs. This emphasis increases the chances of their sexuality becoming a positive aspect of life rather than a problem. Lindsay, Michie, Staines, Bellshaw & Culross (1994) illustrated changes in attitudes in clients as a result of a sex education programme. They found that client attitudes were generally very conservative prior to the programme and that even after it they exhibited naiveté and still placed a high importance on secrecy around sex. Their attitudes towards homosexuality were also conservative and shifts in attitude produced by the group were not very durable on follow up. (showing the possible pervasiveness of homophobic
beliefs among peers and society in general). This analysis suggests the practical difficulties with the ideal of sex education for people with disabilities and highlights the need to continue to devise and evaluate teaching programmes that may help to sustain and increase accurate knowledge and pride particularly regarding homosexuality. There is also very little literature on attempts to raise the awareness of sexuality in those with more severe communication difficulties who are precisely the ones most vulnerable to abuse and neglect of their sexual rights.

5. CONCLUSIONS

It has been shown by the above analysis that the issues raised for staff and services by this scenario are very broad, requiring consideration of law, policy and education. It has also been shown that there are shortcomings in all these areas for clarifying how staff deal with client sexuality. There is a fundamental tension between the responsibility to protect the client and the need to promote sexual expression in this group. This situation is exacerbated by the rather outdated law which leans in the favour of protection of clients from abuse rather than protection of their sexual rights. More support from the law would make policy decisions less idiosyncratic and would encourage the development of more sophisticated educational procedures for clients and staff. Currently, practitioners are forced to operate on a principle that their decisions would not reach prosecution even if technically illegal. This cannot inspire them with confidence to be fully committed to developing the clients sexual expressions and the best existing procedure seems to be for a multi-disciplinary team to make careful group decisions around each individual case with a clear process for assessing risks and benefits of the particular action to be taken. It remains the case that such a procedure still limits the true normalisation of clients sexual activities and much thought needs to be given as to how the reduce the intrusiveness of these procedures.

6. REFERENCES

Essay 2: People with learning disabilities.


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Discuss the changes in the psychoanalytic view of child sexual abuse and its repercussions in adults who have been abused. If possible illustrate with examples from your own clinical work with particular reference to the issues abused patient’s bring to the process of therapy.
1. INTRODUCTION

This essay describes the development of psychoanalytic thought on child sexual abuse focusing mainly on the work of Freud and Ferenczi. It also discusses the effect on abuse survivors of conceptualising their difficulties according to the perspectives of these two authors, using examples from clinical experience of the issues brought to the process of therapy by these people.

2. FREUD'S SEDUCTION THEORY

2.1 Description of the Seduction Theory

Freud was one of the first psychoanalysts to publicise his views on the importance of child sexual abuse in the aetiology of hysteria or neurosis (Freud, 1896). He described a sample of eighteen patients whom he concluded had all been the victims of unwanted sexual assaults by caretakers. Freud claimed that the often incomprehensible symptoms of these patients were due to recollections of these emotionally painful seductions that had been repressed into the unconscious realm because of the over-excitation of the child's psychical system that they had caused. The symptoms exhibited by the adult were caused by the memory of the trauma, often triggered by an apparently trivial sexual incident. Although the memory or current psychical representation of the trauma was the key etiologic factor and the focus for therapy, this was acknowledged as being the result of real prior experience (Garcia 1987).

Freud's proposal showed awareness of a range of psychological disturbances as a result of abuse in what has become known as his 'Affect Trauma' model (Bateman & Holmes, 1995). He described how the early sexual experience could have been passive and aversive to the child leading to neurotic symptoms or alternatively, actively sought by the child and possibly enjoyable, later leading to guilt and obsessional symptoms. Freud's therapeutic method of 'abreaction' or catharsis, developed with Breuer from hypnosis (Breuer & Freud, 1895), worked on the principle that once memories of this early trauma were brought into conscious awareness and verbally expressed the
psychical balance would be restored and the nervous excitation would no longer be repressed and manifest in problematic symptoms.

Karl Abraham contributed to the development of the Seduction Theory when he proposed that children are predisposed to provoke sexual trauma and in many cases unconsciously desire it. The sexual trauma then becomes sought out and repeated over time in a process of "traumatophilic diathesis", an idea which went on to be developed into Freud's repetition compulsion (Abraham, 1907a, b). However as Good (1994) describes whether this repetition developed because of the child's constitutional precocious sexual development or because of earlier sexual abuse or other traumatic experiences was left unclear by Abraham.

2.2 Implications for survivors of the Seduction Theory

One of the major strengths of the Seduction Theory was its recognition of child sexual abuse as a reality and its emphasis on the environment as contributing to psychological difficulties which was unique among the geneticist explanation of human behaviour of Freud's era (Joyce 1995). Rego (1989) points out the common link between child sexual abuse and adult somatisation disorders such as chronic pelvic pain and argues that this bears out Freud's early views on hysterical symptoms as a product of repressed affect. Freud's early ideas are also supported by a general acceptance among qualified clinicians of the phenomenon of recovered memories (Andrews, Morton, Bekerian, Brewin, Davies & Mollon, 1995). Kupfersmid (1992) and Christo (1997) liken Freud's theoretical position to modern theories of Post Traumatic Stress Disorder (PTSD) that are useful in explaining reactions to abuse. Christo however, points out that PTSD formulations of the effects of sexual abuse are often not sufficient to explain the pervasive and sustained stress for victims even between sexual contacts or the range of effects e.g. sexualised behaviour.

Freud also raised awareness that sexual abuse could lead to physical pleasure for the child. In doing so, he warned clinicians of a still highly relevant clinical reality that often causes blocks to therapy; i.e., if therapists assume that the abuse experiences must have been entirely unbearable. This attitude can alienate clients who may have
experienced some pleasurable feelings during abuse and is likely to increase their sense of guilt (McCarthy, 1988).

Abraham's conceptualisation of traumatophilic diathesis in abuse is also applicable in current clinical work as Wyatt, Guthrie & Notgrass (1992) provide empirical evidence of the tendency for abusive experiences to be repeated. Abraham's ideas have caused controversy because of the 'adultomorphic' view of children as desiring sexual contact (Good, 1994), but as a description of effects of abuse they remain extremely salient.

Despite these early insights Freud's seduction theory appears limited by its historical context and the scientific ethos which directed him to seek a single etiologic feature for neurosis. This led to the inflexible concept that all neurosis was due to abuse and that treatment by abreaction should absolve the difficulties. This meant a focus on uncovering abuse without further consideration of the effects of disclosure or a more extensive exploration of the on-going effects of abuse. His theory also gave a rather narrow portrayal of how abusive memories may exist i.e., in a completely repressed or completely acknowledged form. This perspective did not consider the possibilities that a survivor could be fully aware of the experiences with an inability to verbalise them or that survivors may speak openly about the abuse whilst being removed from the affect expected to accompany the memory of the experiences.

2.3 Clinical example: Known as Ms R

This twenty four year old client with a mild learning disability was referred for psychological help with aggression and agoraphobia. Ms R described a history of sexual abuse in having been 'touched up' by her father at the age of four when he was drunk and having been the victim of an attempted rape by three teenage boys in a residential establishment when aged twelve. In the past she had suffered from anorexia nervosa, laxative abuse and self harm. Therapy over twelve sessions was focused around challenging and testing out core cognitions about:

a) herself, i.e. “I'm useless, I can't be trusted, I'm dangerous,” that were central to her low self esteem and anger outbursts, and
b) others, i.e. "People will hurt me," which occurred in situations of physical proximity to others.

The manifestation of Ms R’s symptoms appeared to support Freud’s theory of how early abuse causes a tendency towards ‘hysterical symptoms’ in later parallel situations, since physical proximity to men or the undertaking of medical procedures involving physical contact caused her great distress. However, the complexity of her difficulties and history illustrate the naiveté of attempting to classify symptoms and find a discrete aetiology. In terms of the therapeutic process she also illustrated that disclosure of the abuse can hold complex meanings and is often the starting point of therapy rather than the goal. Ms R greeted the therapist outside the day centre for her first therapy session and stated immediately, in a matter of fact way how she, “had been raped by three boys.” This presentation of her experience of sexual abuse seemed to show a dissociation of affect as well as a desire to minimise the experience and her fears of discussing it. This disclosure may have had some ‘abreactive’ element but was more important in providing information about the client and setting the scene for ongoing therapy.

3. FROM THE SEDUCTION THEORY TO THE THEORY OF INFANTILE SEXUALITY

3.1 Freud’s Theory of Infantile Sexuality

Freud gradually altered the Seduction Theory, replacing it with the Theory of Infantile Sexuality (Freud 1905). Why he rejected his early ideas on seduction and how much he retained parts of the theory throughout his life remain a source of conjecture. As such, there exist differing accounts of the changes in the psychoanalytic views of child sexual abuse; firstly from those who feel that the seduction theory was rejected out of hand with damaging consequences for survivors who disclose, and secondly from those who claim it remained a part of psychoanalytic thinking alongside the new theory and thus continued to be helpful for conceptualising these people’s difficulties.

Freud (1905) asserted that the very young child wished for sexual attention from the beloved parent or caretaker to provide a release of inner sexual tensions. Hence it was
the uncovering of these fantasies that were witnessed during therapy. The wishes led to unconscious conflict between the desire to possess the parent and the fear of retribution from the other parent and this was the etiologic factor in neurosis rather than seduction. This theory therefore replaced the notion of a universal external aetiology for neurosis with a universal internal one and was a part of Freud comprehensive theory of human behaviour (Joyce, 1995).

Freud claimed that the pleasure seeking activities of infants such as suckling at the breast were sexual in nature and that these activities were normal and beneficial to the child’s development. The concept of psychosexual stages focused upon the developmental course of the different sources or objects of sexual pleasure for the child from oral to anal to genital areas. The culmination in this progression of the child’s sensual life was the oedipal phase whereby the child’s unconscious sexual wishes focused on the opposite sex parent.

Freud (1913/1950) argued that in normal cases there would exist a healthy tension between the incest desire and the incest taboo and the prohibition against the impulses maintained by the parents would lead to the child accepting the unrealisability of his or her oedipal desires allowing them to develop a normal sexual identity. The normal child would then have a healthy balance between the structures of the id (the source of the sexual and destructive impulses), the ego (the conscious arena of thought managing the unconscious desires in the real world) and the superego (that controls the ego’s pursuit of the id’s desires) (Freud, 1923).

The internalisation of the parent’s prohibition would be the foundation of the superego or conscience and if handled harshly would result in the ‘castration complex’ in men and similar symptoms of guilt, repression of sexual impulses and inhibited sexual identity in women. Therapy was therefore to be about promoting insight; i.e. bringing these desires into conscious awareness to enable accommodation of the urges and a more healthy relationship between the three structures of the mind. The unconscious desires would be uncovered by dream analysis and free association and by being aware of their manifestation in the relationship with the therapist (the notion of transference) (Freud, 1900, 1912).
3.2 Reactions to these changes

Masson (1985) claims that Freud abandoned the seduction theory because it was a professional liability. He argues that Freud could not face the implication to the middle class male professionals that abuse was rife within their ranks and so reinterpreted his patients complaints as fantasy. Jortner (1985) argues that Freud silenced the sufferers of sexual abuse and colluded with the abuse in an extremely anti therapeutic manner by reacting to disclosures of abuse with disbelief and implicitly blaming the victim by suggesting their experiences were all a result of fantasy. Other critics of Freud claim that he did not deliberately suppress his knowledge about abuse but was a victim himself of the transference processes engendered by abuse survivors in taking the role of collusive mother and blaming father.

A more sympathetic stance is taken by Eissler (1992) who states that the seduction theory had to be rejected in its early form because of Freud’s notion of causality and that it was his search for a universal theory of the human mind that changed the emphasis in his thinking. The seduction theory implied that the exclusive cause of neurosis in adults was sexual abuse in childhood. As such, discovery of even one neurotic who had not been abused would falsify the theory and Freud had only been able to establish the reality of abuse through external validation in a few cases. Shengold (1989) argues that Freud also became aware of the fact that neurotic symptoms were present in virtually all men and women and for seduction theory to be true it would then mean that all caregivers were sexually abusive, a notion that seemed implausible. Additionally the abreaction method was unsuccessful and patients fled from treatment proving to Freud that the theoretical stance needed refining. He argues that Freud nonetheless continued to acknowledge the importance of child sexual abuse in his clinical work and to consider the relative impact of external and internal events.

3.3 Implications of changes for survivors

Masson (1985) sees the changes in theory as clear cut and extremely damaging to adults who have been abused in that they have suffered from several decades of a therapeutic tradition which stated that their experiences were fantasy. In putting the onus of proof onto the survivors they were being set up to fail in that the nature of their abusive
experiences often left them unable to differentiate reality and unreality because of the damage to ego functions of severe trauma (Jortner, 1985). In fact very little was written on the treatment of survivors until the last decade (Wolf & Alpert, 1991) when there was an increase in awareness of the prevalence of child sexual abuse and a cultural shift in the power differential between children and adults as enshrined in the Children Act (1989)(Good, 1994). This supports Masson’s claim that psychoanalytic theory turned a blind eye to the reality of abuse. However, this controversy seems to be more at the level of theory and to be part of a dichotomy in arguments for internal and external influences in the history of explanations of psychological problems.

In contrast to this theoretical dichotomy, studies of actual clinical practice with adults (including those of Freud) reflect that therapists seldom have difficulty in deciding whether to believe or disbelieve a client. Fortgang (1992) surveyed the practices of psychoanalytically trained psychotherapists dealing with abuse survivors and found that in eight cases of treatment none of the clients presented incest as an initial complaint but that once disclosed all clinicians accepted it as a real event. This suggests that clinicians do not seem to be so influenced by the Theory of Infantile Sexuality as to reject their patients suggestions as Masson feared. Shengold (1989) asserts that actual sexual traumas in childhood are easily recognisable in clients, having more profound damaging effects than do the fantasies of such experiences.

The ongoing False Memory debate is closely tied to this debate in the psychoanalytic literature since the proposers of a False Memory Syndrome disavow the reality of derepressed memories in therapy particularly those obtained under hypnosis and fall into an ‘internal’ rather than an ‘external’ aetiology camp (Loftus & Ketcham, 1994). Nonetheless most trained clinicians accept the phenomena of recovered memory (Andrews et al 1995) and while there may be difficulty establishing the actuality of abuse, Searle & Streng (1996) suggest that even if an allegation of child sexual abuse is objectively false it identifies emotional distress and a perception of abuse that should not be dismissed. Clinical work can proceed on the basis of ameliorating the client’s disturbing perception of abusive relationships. Garcia (1987) argues that working with the client’s current psychological reality is more crucial than establishing historical facts.
3.4 Example from clinical experience

With Ms R there was external validation of the attempted rapes although the early abuse by the father was less easy to ‘prove’. However, in line with the clinical thinking cited above, the issue of belief/disbelief was not central to the therapy which focused on the client’s current self perceptions. The seduction by the father could have been a metaphor for the sense of deprivation, rejection and lack of privacy suffered by Ms R throughout her life as a result of her learning difficulties and institutionalisation but this lack of certainty did not affect the clinical aims. The client expressed no desire to act on these allegations and no longer had contact with her father.

4. LATER PSYCHODYNAMIC IDEAS ON CHILD SEXUAL ABUSE

A greater awareness of abuse and the insights of later psychoanalytical work into the powerful emotional processes that operate in therapy may have made clinicians less victim to pressure to dismiss their clients claims. Later psychoanalytic exploration of the processes occurring within the therapeutic relationship give some useful accounts of the effects of abuse that combine ideas from both of Freud’s theories. Clark (1993) claims that Freud’s disavowal of his original trauma theory was a necessary precondition for the development of theories that are comprehensive enough to treat trauma victims.

4.1 Ferenczi’s ideas.

As described by Rachman (1989) in 1932 Ferenczi presented the seminal work for a new method for psychoanalysis, the reintroduction of the seduction hypothesis and a professional focus on the emotional demands on the analyst in treating difficult cases. The work was initially suppressed and criticised by Freud and not published in English until 1949.

Ferenczi emphasised the reality of violence and rape in families and challenged the tradition of believing this to be a fantasy of the child and hysterical lying in adults. He described how seduction creates confusion for the child as they receive ‘passion’ from
the abuser rather than the 'tenderness' they require. The child becomes 'tongue tied' and cannot refuse the sexual advances because of the need for love. Various pathological defence mechanisms operate because of this intensely conflictual situation such as identification with the aggressor, dissociation, depression, schizoid withdrawal and blunted affect.

Ferenczi therefore introduced the idea of empathic failure as a primary source of childhood disturbance taken to the extreme when adults impose their sexual needs on children. Ferenczi owes much to Freud regarding the concepts of defences and the child's desire for closeness to the parent (reframed as of an affective rather than sexual nature in line with the ego psychologists wider definition of 'sensuality' in terms of relational rather than sexual needs) (Rachman 1989). Analytically, Ferenczi was renowned for his success with more difficult cases using an active and empathic technique. He questioned Freud's technique of having the therapist blank and non-responsive, seeing this recreating the original trauma where the victim would read negative judgements about themself from the therapist's silence. He outlined the employment of four related techniques to maintain a democratic, empathic stance in therapy, particularly in the face of client anger:

a) Freud's idea of countertransference would be developed to include a more through analysis of the analyst's emotional reactions as an indicator of the clients reaction towards them (Katz 1988). Criticisms of the therapist from the client would be openly discussed rather than assuming these to be evidence of resistance.

b) Self disclosure by the analyst would allow a confidence to develop in the patient towards the analyst so that the relationship could provide a corrective emotional experience from the past.

c) Mutual analysis, an experimental procedure, would occur whereby the patient was invited to comment on the analysts behaviour and method of interaction, therefore challenging the idea of the therapist as expert.

d) A fuller analysis of the analyst and periodic return to analysis was seen as crucial. This was because trauma cases were an immense challenge to the therapists ability
to maintain empathy because of the transference process whereby the client would experience much aggression towards the therapist (Ferenczi, 1933).

4.2 Implications for survivors.

Ferenczi’s work was revolutionary for incest survivors in conceptualising abuse as a failure of empathy within the primary care giving relationship. It shed light on the difficulties both patient and analyst face in therapy in re-enacting these relationships and also highlighted the powerful potential of the therapeutic relationship in facilitating change. Ferenczi clearly pointed out the stresses placed on therapists in being involved in these dynamics and the need for therapists self awareness. Anticipating object relations theory, he gave a good account of the child’s defences for dealing with the abuse (dissociation and identification with the aggressor) and the consequent importance of anger and confusion in the therapists reaction to the client, and the self perpetuation of abuse. His notion of the child’s need to retain the affective tie to the adult was a more acceptable explanation of children’s compliance in abuse than their precocious sexuality.

Ferenczi’s ideas have been emphasised consistently in the psychoanalytic literature since for example Masterson (1976) and Alexander (1992) expand on the purpose of object relations defences, as being to preserve the object, the self and the attachment between them. Blizard & Bluhrn (1994) further explain and illustrate these defences using both PTSD and attachment theory. They argue that dissociation occurs because the child is only able to preserve his necessary tie to the abusing caregiver by separating intolerable experiences of abuse from more benign experiences of the caregiver. The concept of dissociation highlights the confusing and conflicting roles the therapist can be placed in by the client either being seen as idealised or as an abuser. ‘Identification with the aggressor’ as a defence occurs to preserve the self by taking on the power of the abuser at a time when the victim is totally powerless. The victim then acts out the internalised image of the abuser in self harm or by choosing abusive relationships. This affects the therapeutic relationship as the client may induce abuse in the countertransference reaction of anger. Ferenczi’s work identifies the potential for the therapist to act out this role and become angry or violate the clients boundaries.
4.3 Example from clinical experience.

The work with Ms R illustrated how easily boundary violations can occur with abused patients. It was difficult to contain issues to the privacy of the therapy room and there was often a temptation to run over-time in sessions because of the intensity of affect the client displayed particularly towards the end of sessions. Countertransference reactions were also apparent as seeing this client engendered a sense of hopelessness and reluctance in the therapist, as well as thoughts that the client was too damaged to help, and the constant concern that therapy may be doing harm. The therapist was also preoccupied with the client’s issues and crises outside of sessions. Chu (1991) describes how this over involvement and over concern with abused clients is due to the therapists underlying feelings of anger towards them.

5. FURTHER PSYCHOANALYTIC THOUGHT ON CHILD SEXUAL ABUSE

Most papers since Freud and Ferenczi present case examples rather than large scale multi subject empirical studies or theoretical reformulations (Wolf & Alpert, 1991). These case studies generally focus on father daughter incest and illustrate that effects are serious and long-standing with severe ego, and superego impairments. Treatment strategies vary according to therapists orientation and patient symptoms. Stone’s (1989) case studies illustrate the breadth and variability of symptoms of abuse survivors ranging from depression and anxiety to multiple personality disorder and dissociative states. This contention is supported by Knutson (1995) in his review of abuse outcome studies showing few specific effects beyond poor sexual adjustment. Stone takes up Ferenczi’s idea that despite the variability, the typical personality will have predominant traits concerning mistrust and dependency and as such the therapy model of a non-exploitative, reliable and empathic relationship is crucial. He states how severity of psychopathology depends upon the length of time the abuse took and the balance between exploitation and care in the relationship. As such therapy can range from straightforward re-education about relationship patterns, to more in-depth therapy to develop integrated views of self in more severe cases. Dewald (1989) illustrates the
concept of protective factors put forward by Stone, in a case study where a patient's pre-oedipal relationship with her mother meant a good capacity for basic trust that mitigated the effects of later abuse. Although this idea of protective factors is implicit in Ferenczi's concept of the importance of empathic relationship it is only fully brought out by these later thinkers in line with more modern 'salutogenic' approaches to survivors that emphasise their strengths (Sanford 1991).

McCarthy (1982) reports how both seduction theory and later Freudian ideas of developmental stages can be combined in explaining how the nature and severity of symptoms depends on the age and developmental level of the child when the abuse occurred. For example if abuse occurred at the oedipal stage, issues in therapy will be about triumph and guilt and acknowledging the clients feelings that the abuse may have been positive in securing the fathers affections.

McCarthy (1988) also provides a more thorough analysis of Ferenczi’s concept of anger being engendered in the therapist by these clients. He discusses the issue of 'hate' that is present in all incest victims and that can be acknowledged or repressed and projected (using a Kleinian concept). He emphasises the importance of a solid, dependable therapeutic relationship which can survive the client’s ‘acting out’ to provoke seduction, loss of control or hate from the therapist. He also gives a cautionary note as to how the therapists unconscious hate can be manifest in avoiding referrals to treat them.

Sinason (1988) also explores the strains placed on the therapist in working with survivors. She describes how the victim has to become stupefied and numbed to accommodate the abuse and the therapist will become both sickened and stupefied through counter transference, describing her feelings of nausea in sessions when abuse is revealed. Although discussing work with children, she highlights the need for the therapist to be able to resist the stupefying process and accept the reality of the abuse. Kraemer (1988) extends this analysis to the systemic level in describing how teams of professionals often become 'split and stupefied' in making decisions about abuse cases.

Other papers have brought together Freud’s theoretical positions in discussing the interaction of actual abuse with childhood fantasy. Gardner (1993) describes how the normal tension between the child's oedipal fantasies and the adults prohibition is lost
when abuse occurs as oedipal fantasies are crudely brought into reality. The child's normal fantasy life is curtailed by this experience and the guilt and inner confusion prevents formation of a clear representation of the event as having actually occurred. The capacity to distinguish imagination and reality termed the 'metaphoric function' in later life is impaired. As such there needs to be a phase in therapy where the patient and therapist accept the actuality of the abuse in 'non metaphorical statements' so that ego functions can be re-established. This acknowledgement phase leads the way into work in the transference and makes this more manageable by having already separated past from present more clearly.

6. CONCLUSIONS.

The changes in the psychoanalytic theories of child sexual abuse have had numerous implications for survivors. Freud's early seduction theory introduced the reality of abuse and its traumatic effects into psychology and has been influential ever since. His later theory of infantile sexuality, although criticised for denying the reality of abuse, has also been usefully integrated within the early 'affect trauma' model to provide a more sophisticated understanding of the effects of abuse occurring at different ages. The historical controversy about the reality of abuse has prompted further consideration of the relationship between fantasy and reality which is crucial to the issues that survivors bring to therapy.

Psychoanalytic thought on child sexual abuse is however limited by focusing mainly on the experience of women, particularly incest victims. The experiences of men who are abused are neglected in psychoanalytic work as is the link between being a victim and becoming a perpetrator of abuse. These ideas are nascent within some of the psychoanalytic concepts such as identification with the aggressor but have not been elaborated. Only recently has there been recognition of the protective effects of other experiences for abuse survivors and the huge variation in severity and nature of psychological difficulties caused by abuse. This is possibly because the nature of the psychoanalytic endeavour is to seek overarching theories of internal processes which have historically been separate from contextual influences.
Essay 3. Psychodynamic models

Perhaps the most valuable contribution of psychoanalytic thought in this area is its thorough conceptualisation of the powerful processes that operate in the therapeutic relationship with abuse survivors and the acknowledgement of the potential and pitfalls of psychotherapy with these people. To some extent these powerful processes seem to have been acted out within the history of psychoanalytic thought on child sexual abuse itself. Although consistently outlined in case studies these important contributions of psychoanalytic thought merit more empirical investigation. The operationalisation of these concepts remains a challenge as does the research on effectiveness given the documented methodological difficulties in outcome studies of treatment of abuse survivors (Beutler & Hill 1992).

7. REFERENCES


Essay 3. Psychodynamic models


Essay 3. Psychodynamic models


ESSAY 4: OLDER ADULTS

Year 2

What factors are involved in suicidal behaviour in older people?
1. ABSTRACT

Suicide has been defined as a conscious act of self induced annihilation occurring in a life situation where death is felt to be the best possible solution (Schneidman, 1989). Suicide amongst older people (defined as those as over sixty five years of age) is a significant cause of death although, the recognition of and response to psychological distress in this age group is often difficult and complex. This essay will outline the epidemiological features of suicide, attempted suicide and indirect self destructive acts in older people. It will also describe what is known about associated risk factors and aetiology drawing on research and theoretical perspectives from all ages. The issues of recognition and prevention of suicidal behaviour in this group will also be considered.

2. EPIDEMIOLOGY OF SUICIDAL BEHAVIOUR IN OLDER PEOPLE

Epidemiological data emphasises the need for the issue of suicide to be taken very seriously in this age group.

2.1 Suicide

Pearson, Conwell, Lindesay, Takahashi & Caine (1997) in a review of international literature describe how males aged over seventy five years of age have the highest suicide rates in nearly all industrialised countries and that among many of these nations suicide rates rise with age. Pritchard (1992) found that in twenty countries, the relative suicide rate in old age had increased steadily between 1974 and 1988. In the UK, Lindesay (1991) found that the relationship between age and suicide is complicated by cohort effects and significant age related increases were apparent in all cohorts. Gender also appears to be a complicating variable as for men the relationship between old age and suicide remains linear into extreme old age but for women there is a peak in the years surrounding menopause with a subsequent decline (Woodbury, Manton & Blazer,
Katona (1994) argues that despite the complexity of interactions between age, period, cohort and gender effects there is a high absolute rate of suicide in old age.

### 2.2 Attempted suicide/para-suicide

Pearson et al (1997) describe the low ratio of attempted to completed suicides among older people in the U.S. and the U.K. Stenback (1980) has estimated that the ratio of attempts to completions is around 4:1 in older people and between anything from 8:1 to 200:1 in younger age groups according to McIntosh, Santos, Hubbard, & Overholser (1994). McIntosh (1992) attributes this to greater motivation to die, the use of more lethal methods, the greater likelihood of succumbing to physical damage and the greater social isolation of older people. Identified risk factors for attempted suicide in older people namely depression and ill health (McIntosh 1992) are similar to those for suicide itself which suggests that there is less difference between attempted and actual suicide in this group than perhaps in younger age groups.

### 2.3 Indirect suicidal behaviour

It has also been argued that older people, because of their life circumstances, are more prone to use less overt methods of suicide such as through omitting behaviours that would sustain life i.e., neglecting medical treatment, refusing to eat or placing themselves in hazardous situations (Kastenbaum & Mishara, 1971). There is little research on this indirect self destructive behaviour (McIntosh, 1992) but Nelson & Farberow (1980) suggest that it occurs in high rates in residential care.

### 3. Risk factors for suicidal behaviour in older people

#### 3.1 Psychiatric illness in suicide

For suicides that have been studied using a 'psychological autopsy' method, consisting of detailed interviews with relatives and examination of case notes, it appears that
psychiatric illness (in particular depression) is present prior to death in a high percentage of cases. For example, in the U.S. affective disorder of late onset without comorbid substance use was found to be the most common profile (Conwell, Duberstein, Cox, Hermann, Forbes & Caine 1996) and Dennis & Lindesay (1995) found similar patterns in the U.K. Tobias, Pary & Lippmann (1992) state that elderly depressed patients have a risk of suicide about four times as great as their younger counterparts.

3.2 Psychosocial factors

Vogel & Wolfensdorf (1989) argued that psychiatric illness is not a sufficient explanation of suicide in itself. They examined the clinical files of 24 suicide victims aged over 65 and found that they were more likely than younger counterparts to have had previous family conflict, recent bereavement, loneliness and the presence of a curable or incurable disease. Sainsbury (1973) found moving house to be a risk factor in older people because adjustment to a new environment was difficult in later life. Other psychosocial factors such as isolation, urban living, and retirement have also been shown to be relevant. Sex remains a significant risk factor for suicide in all age groups, in that males are more likely to commit suicide than women. Marital status also influences risk with the divorced, widowed or single elderly three times more likely to commit suicide than the married (DeLeo & Ormskerk, 1991).

3.3 Risk factors for depression

The literature on risk for depression in older adults further supports this emphasis on psychosocial factors. Jorm (1995) used epidemiological data to review predictive factors for depression in older people and found that physical illness (Kennedy, Kelman & Thomas, 1992) and disability (Wallace & O'Hara 1992) rather than dementia or cognitive impairment were important. Furthermore residential care did not predict depression independently of physical illness (Henderson Korten, Jorm, Christensen, Mackinnon & Scott 1994). Personal vulnerability factors emerged as the next strongest predictor i.e. severity of baseline symptoms were strongly predictive of onset and recovery from depression as was a history of depression (Kivela & Pakhala, 1989) and
neuroticism (Finch & Zatura, 1992). Social support predicted depression independently of physical ill health, although its predictive power was small after illness and personal vulnerability. Adequacy of support was more predictive of depression than social networks per se (Oxman, Berkman, Kasl, Freeman & Barratt, 1992) and negative social ties involving anger, social exploitation and disappointment were more predictive than the absence of positive social ties. (Finch & Zatura 1992). As for other life events, bereavement of spouse predicted short term but not long term depressive symptoms (Harlow, Goldberg & Comstock, 1991) and the highest risk was for those with bereavement complicated by higher initial depressive symptoms and whose spouse had committed suicide.

3.4 Implications of consideration of risk factors.

Despite the rather wide ranging focus of this literature and methodological difficulties (such as the use of retrospective investigations and the possible different presentation of depression in older people) it seems that suicidal motivations for older people are more often social in nature compared to those of the young and likely to involve several factors interacting rather than a single one as Johnstone (1996) argued. Richardson, Lowenstein & Weissberg (1989) point out the wide variety of loss events occurring in older age (physical, occupational, economic, social, and cognitive) and suggest that it is their combined effect that makes older people more vulnerable to suicide and more likely to respond to depression with suicide. Of course those factors predictive of suicide for all ages (e.g., previous attempts or psychiatric illness, suicidal ideation, plans and availability of methods (McIntosh, 1992) are also relevant to older people.

It appears that knowledge of the multiple and often more psychosocial risk factors for suicide in older people is important in alerting professionals to high risk cases. Nonetheless, there are limits to the therapeutic effects derived from knowledge of risk factors. Goldstein, Black, Nasrallah & Winokur (1991) developed a statistical model designed to predict suicide in in-patients with affective disorders based on knowledge of risk factors and found that it failed to identify any of the patients who went on to commit suicide. They concluded that the knowledge of health care professionals about
individual patients is the best tool for prevention of suicide given its unpredictable nature. This individual unpredictability is perhaps better addressed by theoretical models that emphasise that it is the manner in which stresses are perceived and managed by the individual that predicts suicide. However, these individual vulnerability and coping styles may be more difficult to conceptualise and research than demographic factors and have been explored less in the literature.

4. THEORIES OF SUICIDAL BEHAVIOUR

4.1 Description of theories

Various theoretical models of suicide exist that are compatible with research on risk factors and provide more guidance in conceptualising the factors involved in suicide for individuals. Baumeister (1990) proposes an ‘escape’ theory of suicide that is closely linked to empirical literature. He proposes six main steps in the theory. The first step is that suicide becomes likely when a person’s current circumstances fall far below their expectations because of either very high expectations or severe problems or both. Internal attributions are then made so that the disappointing outcomes are blamed on the self and create negative implications about the self. This leads to an aversive state of high self awareness resulting from comparison of the self with standards accompanied by depression and anxiety. Escape from the negative affect is achieved by entering a state of ‘cognitive deconstruction’ which is characterised by concreteness, absence of distal goals and the rejection of higher levels of meaning. The escape however, is not fully successful and an individual requires more powerful means of terminating painful thoughts and feelings. One consequence of the ‘deconstructed state’ is reduced inhibitions and this increases the likelihood of suicide. Baumeister argues that the empirical evidence for these steps is extensive although the elements of high self awareness and the cognitively deconstructed state require further investigation. He stresses that his theory is fully compatible with other theoretical accounts of suicide such as those describing the central role of hopelessness cognitions in suicide (Bedrosian & Beck, 1979), lack of social integration as a significant stressor (Durkheim, 1897/1967)
and suicide as a means of problem solving (Baechler, 1980) This model also has much commonality with Kerkhof, Visser, Diekstra & Hirschhorn's (1991) description of suicide as a response to an unbearable situation. Other authors have described problem solving deficits in suicidal in-patients. Schotte & Clum (1987) for example, have developed from these studies a diathesis-stressor model of suicide combining life stress, cognitive rigidity, interpersonal problem solving deficits and hopelessness.

A slightly different approach although still compatible with escape theory is that of Petrie & Brook (1992) who base their theory on factors promoting psychological adjustment rather than pathology and introduce a 'sense of coherence' as a theoretical construct designed to predict suicide. Coherence is made up from three elements; a sense of having meaning in life, having personal resources to cope with difficulties and the extent to which the world is understandable and makes sense. They found that lack of a sense of coherence predicted current and future suicide attempts more successfully than hopelessness or well known risk factors in themselves. The emphasis on the importance of meaning and productivity perhaps relates to the evidence for multiple losses in the lives of older people and their relationship to suicide.

Other studies have considered the life histories of those who engage in self destructive behaviour and have found a relationship between childhood trauma, disrupted attachment and self destruction. (Van der Kolk, Perry, & Herman, 1991 ) This evidence fleshes out the 'escape' model to explain the different tolerance of individuals to stressors, as a result of prior experiences.

Overall the different theoretical explanations of suicide appears to be very consistent stressing the importance of how stressors interact with a person’s self esteem and cognitive style to produce a suicidal outcome.

5. THEORIES OF AGEING

5.1 Description of theories
There are no major theoretical accounts of suicide pertaining particularly to older people but much has been written about the central tasks and characteristics of people of this life stage and their relation to psychological well-being. For example Erikson (1963) describes the central psychological task of older people to be a successful resolution of the tension between ‘ego integration and despair’. In order to attain the preferred state of ‘ego integrity’ the person must have ‘taken care of things and people, and adapted to the triumphs and disappointment adherent to being’ before death. The importance of accepting one’s life is raised by the prospect of death. A person’s ability to achieve ego integrity depends however, on their successful resolution of earlier life stages. In the context of escape theory this suggests that older people may be more likely to react to stress and depression with excessive psychological pain and resultant suicide because the salience and importance of congruent expectations and actuality is high at this time of life. Erikson’s notions of successful old age being dependent on resolution of previous life tasks also supports the concept of personal vulnerability and individual life history in depression and suicide. The psychosocial nature of risk factors for suicide in this age group also supports this model by suggesting that psychological health may well be focused on issues of role and identity in later life.

Viney (1993) in her personal construct approach to the ageing process suggests that older people are confronted with major changes in their bodies, selves and interpersonal and social roles. She argues that psychological well-being as for people of all ages depends upon how well they manage to integrate these changes into their self concept. Poor resolution of these changes reflects inflexible personal constructs and a mismatch between the ideal and actual self, a preoccupation with self defeating stories and poor adaptation to the pace of technological change. Successful resolution of these changes leads to more coherent and self empowering accounts in older people of control, competence, humour, self actualisation, religious beliefs and good relationships with family and friends. This theory, with its emphasis on the self, also appears to be very compatible with escape/diathesis-stressor and coherence models of suicide and suggests how older people may both have increased stresses to deal with and a greater salience of issues about the self in older age. This account does not however, lose sight of the rich coping strategies many older people possess. Viney describes the therapeutic
applications of this theory in life review processes (Butler, 1963) designed to elicit more self empowering life stories by ‘tightening and loosening’ constructs of the self and others. There is however, little empirical operationalisation of these models of psychological well being in older age and the salience of these issues for older people remains at a speculative level.

Other theoretical accounts of ageing suggest that older people have no socially sanctioned role (Burgess, 1960) and are disadvantaged in terms of power distribution between selves and society and in familial relationships (Blau, 1982). Such a view would be compatible with the notion of increased life stresses upon older people and the potential for a mismatch between expectations and actuality.

However, such view have been condemned as ageist and to contributing to a ‘loss - deficit’ model of older age that is inappropriate (Knight, 1993). Knight proposes a different model of ageing called his ‘contextual, cohort based, maturity/specific challenge’ model which emphasises older people’s potential strengths as a consequence of their age as well as their more frequent confrontation with life’s most difficult challenges of illness, disability and grief. He describes how studies of the actual cognitive and emotional characteristics of older people presents a more positive picture of ageing for example, although older people may be slower cognitively, they also enter a stage of ‘post formal cognitive development’ requiring more expert cognitive systems where they are more able to see that thinking depends on context and that two opposing viewpoints may have elements of the truth (Rybash, Hoyer & Roodin, 1986). In terms of learning and memory Knight argues that research shows few differences between older and younger people if material is relevant to them, but that they may need prompting to use newly learned strategies. In terms of emotional reactions, evidence suggests that older people may be less impulsive, have less extreme emotional reactions and be more appreciative of the situational determinants of emotion. Such features of thinking and emotion in older people would seem to be protective in a model of suicide that stresses narrowed cognitive processing and impulsivity. How these characteristics
would affect the stages in models of suicidal behaviour however needs further theoretical exploration and research.

5.2 Implications of suicide theories and theories of ageing

Theoretical explanations of the increased likelihood of suicide in older age are sparse and indirect. More research is required on the vulnerabilities and coping styles of older people in response to multiple stresses and extreme negative affect since there may be generational issues about the legitimacy of expressing feelings or ‘psychological mindedness’ (Coltart, 1988). Such generational effects would also explain older people’s reluctance to use mental health services and their different manifestations of psychological distress. It is likely that there is much commonality between vulnerability and coping at all ages and theoretical understanding of how older people cope with extreme psychological pain could draw on a wide range of literature outlining different coping strategies in response to specific life events such as physical illness (Felton, Revenson & Hinrichsen, 1984), bereavement (Stroebe & Schut, 1995) and the effects of gender on coping styles (Stroebe, Schut, & Stroebe, 1995).

As with any age group it seems that the individual’s vulnerability to stress is one of the most important predictors of suicide and theories describing the importance of traumatic life events and abuse are just as crucial in understanding suicide in older people. There is little known about how such experiences affect the ageing process particularly in a group of people who have lacked familiarity with the kind of psychological help available today.

6. ASSESSMENT AND TREATMENT OF SUICIDAL BEHAVIOUR.

Research shows that recognition and treatment of suicidal behaviour in older people is complex. Vassilas & Morgan (1994) showed that older people are less likely to use mental health services and McIntosh, Hubbard & Santos (1980) found that older people represented only 1-2% of the case-load of suicide prevention centres in the U.S. possibly because of a greater sense of stigma in this cohort about using institutions and
agencies. The need to help older people access services has been recognised in various outreach programmes designed to find at risk older people in their homes (DeLeo, Carollo & Buono, 1995; Dyck, Florio, Rockwood & Hendrix, 1994).

However, it also appears that suicidal older adults present to primary care services quite often prior to committing suicide (Miller, 1978) with physical rather than mental health symptoms (DeLeo & Ormskerk, 1991). This suggests the need for more training in recognising depression and suicide for professionals as research also shows that physicians are not sufficiently alert to the significance of certain signs (Rapp & Davis, 1989). Gallo, Anthony & Muthen (1994) have shown that older people, particularly men (Allen-Burge, Storandt, Kinscherf & Rubin, 1994), are less likely to acknowledge dysphoria or anhedonia even on the same level of depression as younger people but are more likely to endorse thoughts of death and sleep disturbance. The co-occurrence of physical illness with depression in older people also obscures the possibility of relying on the somatic symptoms as a good indicator of depression in younger people (Allen & Baldwin, 1994). Furthermore depression may be more likely to manifest in older people as hypochondriasis, somatic complaints, behavioural disorders, loneliness, anxiety and paranoid ideas (Pitt 1986).

Some attempts have been made to overcome these problems of detection. Dennis & Lindesay (1995) have described specific policies for detecting and treating geriatric depression in the UK. These policies include screening of patients over 75 as proposed in the Working for Patients White Paper (DoH, 1987) and education on these issues for those with frequent contact with the elderly i.e. district nurses, wardens, voluntary agencies etc. (DoH, 1990). Training of G.P.s known as ‘academic detailing’ i.e., the presentation of a concise educational message regarding questions useful for diagnosis and information on prevalence has shown to improve their recognition of depression, (Pond, Mant, Kehoe, Hewitt & Brodaty, 1994; Rutz, Van Knorring & Wallinder, 1989). McIntosh (1992) also warns that attitudes among health professionals can also affect the success of therapeutic interventions and that therapists need to confront issues of ageism and countertransference e.g., a professional treating talk of death as a natural part of old age - ignoring it as a sign of suicide (Morgan, 1989). Cohen (1990) in a similar vein,
stated that changes in memory and cognitive capacity, sleep patterns, and sexual capacity should not be dismissed as concomitants of the ageing process itself.

The notion of therapist's and service's attitudes towards older people also becomes extremely salient in considering indirect suicidal acts. Conwell, Rotenberg & Caine (1990) argue that the presence of suicidal behaviour in the absence of a treatable affective illness is uncommon in older people and that the argument that an older person may have a rational and legitimate wish to die must not lead to 'therapeutic nihilism'. On the other hand there are often difficulties around determining the competence of an older person's right to refuse artificial resuscitation, for example following a heart attack or in the advanced stages of a progressive dementia. The philosophy of paternalism within medicine means that there is a danger that older peoples right to self determination and informed consent may be overlooked. Research shows that when physicians judge older people's quality of life as they have to do when making decisions on their behalf in their 'best interests' they tend to rate it lower than the older people do themselves (Uhlmann & Pearlmann, 1991). A recent Law Commission report has aimed to address some of these issues with suggestion of a 'Mental Incapacity Bill' with clearer definitions of the criteria of 'bests interests' and recommendation of the wider use of advanced directives (Law Commission, 1995).

As for treatment, the Royal College of General Practitioners and Psychiatrists have reported that older people respond well to treatment once connected to services (Old Age Special Interest Group 1993) This is confirmed by recent empirical studies showing a good response of older people to anti-depressants (Flint & Rifat, 1997) and to psychosocial treatment, studied through a meta analysis of a variety of cognitive behavioural, reminiscence and psychodynamic therapies (Scogin & McElreath 1994) Orrell, Baldwin, Collins & Katona (1995) however identified a clear need for further training of geriatricians and old age psychiatrists in how to treat depression. Many of the studies of late life depression have focused on treatment of those without concurrent physical or psychiatric illnesses and this may well complicate both recognition and treatment (U.S. Department of Health and Human services 1993) Callahan, Hendrie, Dittus, Brater, Hui & Tierney (1994) showed a lack of effectiveness of a psychosocial
intervention for primary care patients with conjoint physical illness and depression and argue that the development of effective treatments for depression in the physically ill remains an important challenge.

7. CONCLUSIONS

Overall it seems that the difficulties of recognising and treating suicidal behaviour in older people are recognised and steps are being taken within services to address these difficulties based on sound knowledge of risk factors. Theories of suicide across age groups are well developed and offer more detailed conceptualisation of the specific factors that may prompt suicide. They stress the importance of considering the individual's life history and vulnerabilities however, theoretical understanding of older people's responses to stress and psychological pain and their attitudes towards services and psychological help remains limited. Further research on the differences and commonalities between the coping styles of older and younger people in response to various life events is needed in order to refine approaches to psychological difficulties in the older age group.

8. REFERENCES


Essay 4: Older adults


ESSAY 5: NEUROPSYCHOLOGY

Year 3

Is neuropsychological rehabilitation effective?
1. ABSTRACT

This essay will describe the typical areas of psychological functioning addressed in neuropsychological rehabilitation as well as definitions and conceptual models of neuropsychology and rehabilitation. It will also comment on the studies of efficacy that have been undertaken within these different models to illustrate the methodological difficulties inherent in this kind of research and the theoretical diversity in models of brain function and rehabilitation that has exacerbated them. It then reviews more recent studies that have begun to address these issues.

2. DEFINITIONS

2.1 Neuropsychology

Neuropsychological rehabilitation is based on the science of neuropsychology which is defined as, "the branch of psychology that studies and treats brain damaged patients and that attempts to infer from their symptoms the brain mechanisms underlying both normal and impaired behaviour" (Sutherland, 1991). The history of neuropsychology has seen the evolution of several models of how to conceptualise the relationship between brain and behaviour. Traditional neuropsychology attempted to link specific cognitive function to specific parts of the brain, developing concepts such as lateralisation of function and studies of phenomena such as visual neglect and aphasia (Walsh, 1985). The main methodology of this classical approach was group studies of dysfunction and intervention. More recently an approach more closely linked to cognitive science has been developed (Seron & Deloche, 1989). This is cognitive neuropsychology which emphasises that lesions to the same area and with the same symptomatology may be due to damage to different systems within an information processing unit and as such require different strategies for remediation. This approach also means that group studies of such deficits are impractical because of the heterogeneity of difficulties that may be found within one area of functioning.
2.2 Neuropsychological rehabilitation

Neuropsychological rehabilitation definitions are often multi-faceted and when studying their effectiveness present a significant problem by defining their outcomes in many different ways. Ward and McIntosh (1993) define neurological rehabilitation as a holistic, goal-directed and collaborative enterprise leading to the 'restoration of personal and social identity'. They describe how identifying what actually needs rehabilitation can be controversial given that people operate within a political system that defines concepts of normality and disability. They see a useful framework as the World Health Organisation distinction between impairment, disability and handicap. They describe how the process of rehabilitation requires strategic short and long-term goals with monitoring of progress and follow up. At the service level this involves the collaboration of client, family and professionals with negotiated contracts and defined operational policies upon which the decision to accept and discharge clients should be based. These policies need to take into account the likelihood that the rehabilitation will make a major difference, hence the need for efficacy studies.

Neuropsychological rehabilitation is one aspect of neurological rehabilitation and appears to be a pragmatic and evolving enterprise using ideas in varying degrees from the new and old sciences of neuropsychology. Ben Yishay and Diller (1993) describe use the term 'cognitive remediation' and describe it as having elements of a traditional, biological model of recovery aimed at 'restoring' impairments, through stimulation and practice combined with a second 'compensatory' model which focuses on both learning and the influence of environmental inputs in the recovery of function. Within this second model psychological factors facilitate and mediate events in the biological system and functional adaptation occurs by providing the patient with techniques or prostheses to bypass the original deficit or impairment. Gianutsos (1991) points out that the concept of 'restoration' of function after brain injury is still being debated and that the mechanism of how damaged tissue may recover is yet to be established. Congruent with this, cognitive remediation takes the approach that whether recovery of function occurs in the actual damaged tissue and/or by bypassing the damaged elements and in
practical terms is not relevant. Riddock and Humphries (1994) discuss how cognitive neuropsychology has traditionally had little impact on rehabilitation because of sociological factors i.e., a separation between academic studies of cognitive processing and rehabilitation therapy studies. They point out however, that application of cognitive neuropsychology could offer much to rehabilitation presumably in being able to better identify the areas needing ‘restoration’ and help to articulate more individualised cognitive ‘compensatory’ strategies.

2.3 Areas of function

Most studies of efficacy of neuropsychological rehabilitation have focused on the effects of acquired brain injury with an aetiology of trauma and stroke despite the fact that neuropsychological problems and rehabilitation affect a wider range of people such as those with degenerative diseases, psychosis and learning disabilities. The review of efficacy studies will focus on two areas: those assessing holistic rehabilitation programmes following brain injury with cognitive deficits being one element in the rehabilitation: and those considering the rehabilitation of specific psychological disorders following a brain lesion.

3. EFFECTIVENESS STUDIES

3.1 Studies of the effectiveness of holistic rehabilitation

Most studies of holistic rehabilitation programmes involving some form of neuropsychological rehabilitation take place during post-acute care. Prigatano, Fordyce and Zeiner (1984) assessed their program addressing cognitive impairment, personality changes and social and work related problems after head injury using a combined cognitive and interdisciplinary approach. They found that compared to clients in a standard rehabilitation programme their group fared better on cognitive tests and on return to work. Similar results were reported by Ben Yishay, Silver, Piasetsky and Rattok (1987) and Cope, Cole, Hall and Barkans (1991) also showed good results when they investigated post acute rehabilitation assessing outcome in terms of residential and
work status and hours of attendant care pre and post treatment. Wehmann, Kreuzer and West (1990) provide information on 53 cases given a work focused model of rehabilitation with elements of supported employment and job coaching and show an improvement in the employment ratio of clients from 36% to 75%.

Despite these positive results MacMillan and Greenwood (1993) highlight methodological problems in these studies as they either lacked adequate control groups, did not randomly allocate clients to treatment groups or failed to control adequately for spontaneous recovery. Furthermore, the holistic approach makes it difficult to evaluate the effectiveness of the separate components of the treatment. Holistic approaches and their effectiveness studies are not consistently guided by a coherent theoretical model of rehabilitation. There is a tension between therapeutic goals (the provision of comprehensive treatment) and research and purchaser goals of establishing crucial elements in such programmes.

3.2 Studies of the effectiveness of rehabilitation of specific cognitive impairments.

3.3 Memory

The rehabilitation of memory difficulties has received much attention and both restorative and compensatory strategies have been examined. Wilson (1991) argues, that despite the existence of detailed models of memory processes such as Baddeley’s (1990), restoring memory to its premorbid level is unrealistic and that rehabilitation is better focused on compensatory strategies. This approach is supported by Collerton (1993). He describes how for declarative memory, practice (a restorative technique) has not been shown to have any effect on mnemonic ability though it may be used to teach specific items of information such as an address (Glisky, Schacter & Tulving, 1986). Other techniques have been used such as varying the conditions of learning in ways that have been shown to be beneficial in normal memory (for example using imagery, the organisation of information, acronyms, and systematic cueing) or using spared procedural memory to try to teach specific skills to people with amnesia (Glisky &
Schacter, 1988). Collerton concludes that some of these have had limited effects in laboratory settings but in general fail to generalise to everyday life. Richardson’s (1995) study supports this view and emphasises the importance explicit prompting and of motivation in the successful use of imagery strategies for memory deficits.

The use of external aids such as diaries and cues appears to be the most effective form of intervention for memory problems as demonstrated in approaches such as reality orientation in dementia (Holden & Woods, 1988) although, such interventions are by nature situation specific and not generalisable. Harris (1978) sets out principles of effectiveness of environmental manipulation insofar as cues need to be active not passive, specific for a particular action, occur only at the appropriate time and easily accessible. Some behavioural techniques have also been successful such as the modelling and talking through of skills to substitute functions normally undertaken by memory (McGlynn 1990).

In the remediation of memory problems interventions seem to be most successful at the level of handicap, rather than impairment in a field where there is a high level of agreement on models of memory function.

3.4 Language disorders

Byng and Jones (1993) discuss how studies of rehabilitation of aphasia have a history of inconsistent results regarding effectiveness. They attribute this to both the poor conceptualisation of the nature of language disorders and of therapy which is usually determined by the traditional classifications of aphasia. These classification rely on clustering patients into syndrome groups based on the presenting symptoms, assuming homogeneity of the underlying cause. The fact that the same deficit may result from different underlying impairments explains why the same therapy is often successful in some cases but not others. Caramazza and Hillis (1993) illustrate this point in their study of two patients both with impairments of oral reading i.e., making semantic errors. Through further testing they revealed differences in the cognitive processes impaired in each case i.e., damage to the semantic component of the lexical system in one case and to the phonological output lexicon in the other.
As such, there has been much effort to apply information processing models of normal language abilities (e.g., Patterson & Shewell, 1987) more consistently in understanding and rehabilitating language disorders. It is generally assumed that this approach necessitates single case studies to show how an individual's pattern of impaired and retained language components can be explained for example, De Partz (1995), who illustrated the positive effects of a written lexical segmentation strategy in treatment of the alteration of the graphemic buffer. Robertson (1990) argues that there are some hints in the literature that highly specific language skills can be taught by computers in some cases but few studies have focused on the therapeutic potential of this because of the adherence to notions of wide ranging and non specific language rehabilitation.

The area of language rehabilitation illustrates the most extensive application of cognitive neuropsychological models, which appear to hold more promise for rehabilitation than older general language therapy programmes. However there is still debate around how such specific skills would generalise beyond improvements on test scores.

### 3.5 Visuo spatial disorders

The phenomenon of unilateral visual neglect has shown some promise for the effectiveness of rehabilitation strategies. Weinberg, Diller, Gordon, Gerstman, Lieberman, Lakin, Hodges and Ezrachi (1987) have shown improvement in function after twenty hours of rehabilitation while Worthington (1996) showed the effectiveness of cueing strategies in neglect dyslexia in a single case study. Hanlon, Dobkin, Hadler, Ramirez and Cheska (1992) describe the treatment of a patient who had marked hemi-visuo spatial inattention, visuo perceptual and perceptuomotor dysfunction and impaired visual memory, following right thalamic infarct. A multiple baseline across behaviour design was used and the patient showed significant improvement in attention to left hemispace in response to directed intervention and improvements in activities of daily living. They describe how these results indicate process specific effects of strategic cognitive interventions. Robertson, Grey and MacKenzie (1988) found positive effects of computerised training on visual neglect using reorientation to the left by voice synthesis and visual cues as well as giving structured exercises in dividing and scanning
a screen. However, such positive results were not replicated in randomised controlled trial of computerised training. Robertson (1990) attributes this to a possible practice effect for the repeated neglect tests in the single cases and urges that caution is needed in interpreting single cases and that replication studies are needed.

### 3.6 Frontal dysfunction

#### 3.6.1 Problem solving

In the area of frontal functioning an absence of established theory has led to the design of heuristic models to orient rehabilitation. Sohlberg and Mateer (1989) describe 'structure' as a heuristic guiding principle in rehabilitation of problem solving with two aspects; process specific exercises such as self instruction (Cicerone & Wood, 1987) and restructuring of the environment to compensate for persistent difficulties e.g., using external cues and reminders. Lawson and Rice (1989) reported the partial usefulness of these kinds of overarching executive strategies for verbal memory problems in their single case study of a subject who could recall details of strategies but not use them spontaneously. In a single case study, Von Cramon, Matthes-von Cramon and Mai (1991) showed the efficacy (on both tests scores and behavioural measures) of a training programme for problem solving techniques involving cueing and fading for training in self instruction. These authors concluded that the sphere of influence of executive training is not as wide as expected but that it may be more effective than stimulus specific rehearsal. Ben Yishay and Diller (1993) argue that rehabilitation of problem solving is an area that holds promise because of its attention to the process of cognitive function i.e. the rules that govern how information is organised and response styles indicating which strategies are used for information retrieval and utilisation. They argue that knowledge and operationalisation of such strategies may be useful in rehabilitating many types of cognitive difficulties.

Newcombe (1993) describes how studies in this area exemplify the problems of designing accurate effectiveness studies in rehabilitation such as, lack of consistent definitions of difficulties and theoretical models and problems of measuring subtle difficulties in a precise and valid way using standard neuropsychological tests. This is
because routine cognitive tests have been designed to tap familiar, over learned material rather than problem solving strategies for unfamiliar problems and the tests themselves usually provide structure. She describes that despite the innovation in models of problem solving and their partial success in application to problems, larger studies are needed with randomised controls and multiple baseline measures to clarify the mechanisms of improvement and recovery and that these also need to be linked to emerging cognitive theory of executive processes such as that of Shallice (1988).

3.7 Attention

Studies have shown improvements in attention after rehabilitation (Robertson, 1990). In one such study, Sohlberg and Mateer (1987) carried out four single case studies using training of simple reaction time, choice reaction time and 'alternating attention' tasks. They used a multiple baseline by function design and where the measure of attention was a paced auditory addition test. In one case this had dramatic short term positive effects although whether this generalised to real life functioning or performance on other types of psychological tests was not established. As Robertson describes, similarly, Sturm, Dahmen, Hartje, and Wilmes (1983) matched two groups each of 15 mixed head injured and stroke patients testing them in a comprehensive neuropsychological battery. They were then trained on attentional and perceptual speed tasks of which the difficulty was systematically increased. They used a cross over design and two control groups and found that significant gains were found in the training group which persisted for a month after completion of training. The improvements also generalised to outcome measures similar to training tasks. A group study (Robertson, Gray, Pentland, & Waite, 1990) also showed improvement after 6 months delay which was explained by the learning of a strategy for regulating attention and arousal which was practised in every day life. Robertson et al argued that these findings need replication on a more sensitive range of real life measures to rule out that they are not test specific.

As such some success has been seen in the area of rehabilitation of attention with a greater attention to carefully controlled methods. However more replication and evidence of generalisation of findings is needed and more comprehensive theoretical
modelling of the actual restorative or compensatory processes that occur to effect these apparent changes.

3.8 Studies of sensory stimulation for the vegetative state.

Wilson, Powell, Brock and Thwaites (1996) describe a meta analysis of data from twenty four single case experimental studies evaluating the immediate effects of sensory stimulation treatment on patients in vegetative state following traumatic brain injury. They showed that multimodal stimulation produced greater changes in those behaviours suggestive of arousal than unimodal stimulation and that the use of personally salient stimuli produced the greatest changes of all. They concluded that although there no statistically significant differences in behaviour changes in response to treatment between the groups who did and did not later emerge from coma, there were qualitative differences in their behaviour patterns, (i.e., those who emerged did show elevations in arousal as a result of treatment that were not sustained whereas those who did not emerge showed invariant behaviour pre to post treatment).

This work illustrates the value of using single case studies in order to orient possible future group studies. It also illustrates the methodological complexity of teasing out treatment effects from spontaneous recovery and sets an example of the care and innovation required in measurement of change. The most striking conclusion drawn from this work is that what are assumed to be homogenous diagnostic categories of problems constantly evolve in response to careful attempts at measurement.

4. SUMMARY OF ISSUES ARISING FROM THESE STUDIES

4.1 Overview

Effectiveness studies in different areas of psychological functioning illustrate the diversity of theoretical and methodological approaches in neuropsychological rehabilitation. Probably because of this heterogeneity of outcome measures and the methodological difficulties inherent in any treatment studies, what is also striking is the
lack of strongly replicated positive findings in any domain of functioning. Furthermore there is a lack of theoretical explanation of why rehabilitation in certain areas appears to have had more success than others.

4.2 Methodological problems

This review demonstrates that there are major methodological pitfalls in both single case and group designs that have undermined the validity of findings. Robertson (1994) summarises the common problems such as the failure to report negative findings, the lack of blind assessment, practice effects of repeated testing and failure to control for non-specific therapeutic effects. There is also the problem of spontaneous remission although many studies control for this by arguing that patients are on the 'plateau phase' of disorder. Robertson argues that this is difficult to justify since little is known about recovery rates over time and there may be large individual variability. Group studies in particular face difficulties of heterogeneity of problems and with controlling for non-specific mechanisms that could affect change. Robertson argues for the need for statistical analysis in single case experimental designs and the need to use multiple baseline by subject designs. He makes the point that even one study showing positive results needs multiple replications in both group and single case studies and that a separation between the single case and group methodology which has grown out of different theoretical approaches is not helpful. Even within cognitive neuropsychology he argues that group studies should be used to measure the effectiveness of an individualised approach to assessment and treatment in large randomised group trials. Robertson however points out that cognitive neuropsychology, is far from a level of sophistication that would enable it to articulate such individual approaches in all cases and this raises an issue of cost effectiveness and whether such potentially long and arduous research endeavours at the level of impairment would lead to meaningful differences in patients quality of life.
4.3 Defining outcome.

Even within more holistic programmes which address levels of disability and handicap there appears room for better and more homogenous definitions of what constitutes a good outcome. In a single program, Depoy (1992) demonstrated the lack of congruence between formal and informal measures when measuring the outcome of head injured patients. Possl and Von Cramon (1995) assessed various aspects of treatment evaluation and found that despite satisfaction with the programme of cognitive, language and physical therapy a majority desired amelioration in the future, judged their life quality as reduced in comparison to time preceding the brain injury, reported difficulties in accepting deficits and were frightened of becoming dependent on others. This study suggest a need to rethink measures of effectiveness to include what is most salient to the clients themselves. In turn this suggests the need to direct more therapeutic attention to emotional well-being and life satisfaction in order for rehabilitation to be comprehensive.

There is however very little research on the best means of addressing the emotional and psychosocial effects of head injury despite several authors highlighting its importance. Ruff and Nieman (1990), Silver, Yudofsky and Hales (1991) and Ben Yishay et al (1987) suggest that principle sources of success in rehabilitation outcome are improvements in self awareness and regulation of emotional responses that would increase the effectiveness of residual information processing capacities.

A useful model to orient this kind of work is that of Moore and Stambrook (1995) which describes the relationship between quality of life outcomes, coping patterns, and beliefs regarding self efficacy following traumatic brain injury. They hypothesise that brain injury creates learned helplessness with deficits in coping, altered locus of control beliefs and over generalising of the effects that injury has in everyday life. They urge evaluation of the clinical utility and empirical validity of this model and exploration of how organic factors and these cognitive moderators interact for example in concretised thinking. Ben Yishay and Diller (1993) point out that rehabilitation studies rarely consider factors such as motivation, nature and content of stimulus materials, didactic
4.4 Theoretical issues in rehabilitation

Caramazza and Hills (1993) describe how despite the fact that cognitive neuropsychology has produced some complex and explicit models of cognitive deficits, what is still lacking is a theory of remediation of these deficits. They argue that even if it is possible to identify damage to a single component of cognitive processing it is an erroneous assumption that those with the same site of damage are the same with respect to the variables that are relevant to the rehabilitation outcomes. They illustrate this with an example of how therapy was able to improve the difficulties in one patient but not in another with the same phonological output lexicon deficit. They point out that these differences may be due to a variety of factors such as the severity, neurological or functional form of the damage (because the orthography to phonology conversion may be a multi-faceted process in itself) or the stage of neuropsychological recovery in each patient. Other confounding factors may be differences in residual capacity to relearn skills and premorbid characteristics of the patients (age, motivation, family support, opportunity for practice). A theory of intervention thus requires; articulation of the relationship between pre and post therapy states, determination of how the changes occurred (i.e., compensation or restoration) and determination of the characteristics of the patient and the patients brain damage that are relevant to treatment outcomes.

This argument concurs with those studies demanding more attention to the interaction of emotional and cognitive effects of head injury. This paper also emphasises that the main limitations of cognitive remediation are that not enough is known about how restoration or compensation occurs for different problems and whether in fact there is any validity or practical use in this distinction. Ben Yishay and Diller (1993) argue that some understanding of this issue is found in the work of Luria and recent studies of neural plasticity and synaptic regeneration, but that even if were possible to define the relationship between neuropsychological events in the brain and recovery of function, a theory of remediation requires more than identification of biological markers. This is
because recovery involves factors beyond the individual's cognitive functioning. This conclusion illustrates how ideas from rehabilitation studies at the level of impairment and those at the level of handicap need to be more integrated for a clearer theory of rehabilitation. McGlynn (1990) also argues that a theory of remediation should use the principles of learning theory more extensively since the application of these techniques have been successful.

Another theoretical critique of cognitive neuropsychology as a basis to rehabilitation comes from more recent connectionist models of neural functioning that conceptualise complex interactions between many computationally simple processing units. Riddoch and Humphries (1994) argue that these may be more useful to model non-modular factors such as, motivation and rate of learning or level of arousal, as opposed to specific attentional operations that would be relevant to rehabilitation.

4.5 Recent studies and innovations in rehabilitation.

Many of these issues considered herein have begun to be addressed. Recent trends are to draw together the issues along clearly delineated terms such as proposed by Gordon and Hibbard (1992) who outline key principles of remediation. Emphasis has been placed on; the need to assess different treatment mixes within theoretically grounded holistic rehabilitation programmes with outcome defined by everyday living skills and the related need to develop more valid and consistent outcome measures.

The first point is illustrated by the work of Rattok, Ben Yishay, Ezrachi, Lakin, Piasetsky, Ross, Silver, Vakil, Zide, and Diller (1992) where different programmes of cognitive training and group interpersonal skills training were assessed. Joint treatment was shown to be superior to individual treatment alone because of the groups increased ability to regulate affect in interpersonal situations. Ho and Bennett (1997) also addressed some of the methodological problems of previous studies such as subject variability, lack of formal protocols in remediation, inconsistent definitions of cognitive rehabilitation and lack of applicability of cognitive rehabilitation activities to daily living. They assessed a group of mildly brain injured patients receiving individualised programmes with both remedial and compensatory strategies with the aim of improving
subjects independence. Although improvements in tests scores were found this did not
generalise to measures of everyday functioning. They conclude that this may be due to
motivational factors but also reflects the lack of sensitivity of standard measures to the
kinds of changes that may occur in day to day living after this intervention, particularly
in not picking up how subjects may use compensatory strategies. This last point is also
illustrated by Teasdale, Skovdale, Hansen, Gade and Christensen (1997) who found that
improvement on neuropsychological tests scores was not related to employment status
after holistic intensive post acute rehabilitation programme. Clearly these kinds of more
sophisticated studies are in their infancy but Ben Yishay and Diller (1993) argue that
through replication they may eventually be able to help discriminate which kinds of
treatment work for which kinds of injuries and a taxonomy of subtypes of brain injured
patients and of remedial techniques could be developed. This could lead to more
appropriate cognitive remediation techniques and prioritisation and co-ordination of
them with other rehabilitation techniques. MacMillan and Greenwood (1993) argues
that more case management based on similar principles to psychiatric care are needed to
implement these ideas at the service level.

The second point is addressed by Wilson and Pender (1997) who conclude that different
outcome measures are needed for early and late stages of rehabilitation in order to reflect
the multi dimensional nature of rehabilitation. They also stressed the need to define the
purposes for which outcome measures would be used, in that some may be more
appropriate for convincing health purchasers of effectiveness. They describe how the
seminar concluded with agreement on the need for joint research on the best of the
available measures to further establish reliability and validity. It is clear that such
consistency in outcome measures would give more coherence and impetus to research in
effectiveness of neuropsychological rehabilitation.

5. CONCLUSION

This essay shows how the study of the effectiveness of neuropsychological rehabilitation
has been hindered by the diversity of models of both brain function and rehabilitation
leading to a vast array of different outcome measures. This has exacerbated the
methodological difficulties inherent in any kind of research on treatment effectiveness. This field requires more integrated studies of the different levels of rehabilitation (impairment, disability, and handicap) applying the knowledge gained from both holistic and more focused studies of cognitive impairments. Associated with these studies is the need to develop more valid measures of cognitive changes affecting everyday life and more theoretical models of the key elements in remediation of neuropsychological problems possibly drawing more on learning theory. These will lead to a better assessment of effectiveness which would then enable more strategic service policies.

6. REFERENCES


CLINICAL CHAPTER
PLACEMENT 1

Adult Mental Health


Location: Community Mental Health Team, The Rookery, Queen Mary’s University Hospital, Roehampton, London.

Supervisors: Mrs Kathy Taylor

Mrs Ewa Rula

Summary of Experience Gained

The placement involved work in community mental health team and primary care settings, with input to a rehabilitation hostel for people with long term mental health problems. Individual therapy was undertaken with nine clients. Presenting problems included specific phobias, (eating in public, needles), generalised anxiety, social phobia, depression, low self esteem and poor social skills following childhood abuse, obsessive compulsive disorder, hypomania and self harm as a result of delusional beliefs. A mainly cognitive behavioural approach was used with some formulations and interventions made in accordance with psychodynamic and systemic models. Neuropsychological assessment of memory difficulties was undertaken one client after repeated epileptic seizures and with another to investigate the possibility of a psychogenic amnesia. Other activities included the planning and facilitation of a didactic behavioural group to address assertiveness, with four clients with long term mental health problems; and a training session for staff in the rehabilitation hostel on the functional analysis of challenging behaviour.
RICHMOND, TWICKENHAM & ROEHAMPTON HEALTHCARE NHS TRUST

CLINICAL PSYCHOLOGY SERVICE

Contract for Training: Adult Placement
6.10.95 - 22.3.96

Clinical Psychologist in Training: Suzy Mackechnie
Clinical Psychologist Supervisors: Ewa Rula
Kathy Taylor
Psychology Department, QMUH

Aims of Placement

1. To provide experience of working with a large range of clients referred to adult services.
2. To develop some basic competency in provision of psychological therapy in adult mental health.
3. To provide exposure to the variety of adult mental health practice in the Trust.
4. To develop understanding of the roles of clinical psychologists in the Trust.
5. To develop some competency in formal psychological assessment.
6. To develop skills in effective interaction with other members of the Trust.

Objectives of Placement

a) Client Contact

1. To work with at least ten clients from a broad range including one client each from young adult, middle and older age up to age 65.
2. To work with clients with anxiety problems, depression, obsessive-compulsive disorder, sexual and marital problems, adjustment/adaptation difficulties, eating disorders.
3. To have some experience of work with clients acute and long-term psychiatric problems.

b) Assessment Skills

1. To learn and use appropriate interviewing skills.
2. To use standardised assessments and rating scales e.g. Beck Depression Inventory, Fear Inventory, psychometric/cognitive tests including WAIS-R, NART, WMS-R.

c) Therapeutic Skills

1. To learn and use cognitive-behavioural therapy.
2. To learn and use relaxation techniques.
3. To gain some knowledge of other forms of psychological interventions e.g. brief psychodynamic psychotherapy approaches, integrative work and counselling.
4. To gain some experience of group work e.g. anxiety management or relaxation group.

d) Settings/Contacts With Other Professionals
1. To work in both health centre and hospital settings.
2. To attend Day Hospital Clinical Review.
3. To visit inpatient unit and attend psychiatric ward round.
4. To observe psychiatric unit patient clinic.
5. To attend community team meetings and clinical reviews.
6. To visit community drop-in and day centre.
7. To observe a psychologist working in primary care.
8. To attend case reviews at Westmoor House (Rehab Hostel) and participate in drawing up rehab programme.

e) Teaching
1. To do a case presentation at the Clinical Seminar in psychology department.
2. To give a training session to staff at Westmoor House.

f) Organisational/Management Activities
To attend:
1. District Psychology Meetings - once a month
2. Adult Psychology Meetings - business - monthly
   - clinical seminar - monthly
3. CMHT/Day Hospital meetings.
4. Supra-regional Primary Care Special Interest Group.

Supervision
1 hour a week with Ewa Rula
1 hour a week with Kathy Taylor

Study
Half a day per week

Signed: Suzie Mackechnie
Ewa Rula
Kathy Taylor
PLACEMENT 1 ABSTRACT

Adult Mental Health

All identifying information has been removed.

**A cognitive behavioural intervention for low self esteem and social skills in a survivor of childhood abuse.**

A twenty five year old male of Indian origin with a history of physical and emotional abuse by his father and other family members was referred for therapy to address poor social skills. Assessment was undertaken by clinical interview, using standard measures of depression and anxiety and a self report diary.

The clients difficulties were conceptualised according to a model of cognitive schemas focusing on issues of mistrust, social isolation, alienation and defectiveness/shame. These had given rise to depressive symptoms following precipitating events of a mugging and a visit from the clients father. The difficulties were maintained by negative thoughts, physiological arousal and avoidance in social encounters. A cognitive behavioural approach was taken to these difficulties with a particular emphasis on a historical review of the clients strengths, behavioural tests of key cognitions and the use of activity to counteract depressive symptoms. Clients strengths and skills that were revealed during therapy were capitalised upon. The therapeutic relationship was used to specifically address issues around mistrust and avoidance of social encounters.

The client reported significant improvements in mood and behavioural changes in social situations. Formal outcome measures were not employed as the client did not attend a follow up appointment.
PLACEMENT 2

People with Learning Disabilities

Dates: April 1996-September 1996

Location: Psychology Department, The Martyn Long Centre, Horsham, West Sussex.

Supervisors: Mr Nigel Mills

Summary of Experience Gained

This placement was based at a residential treatment centre for people with learning disabilities and severe challenging behaviour. Some client work was undertaken in the community and at a local social services day centre. Nine clients with severe, moderate and mild learning disabilities were seen individually for assessment and/or therapy and a further nine clients were seen as part of a group intervention. Two clients were seen at home in sheltered accommodation for individual therapy to address difficulties with anger, low self esteem and depression and an assessment of intellectual functioning and parenting skills was carried out with a couple, both with a mild learning disability. Within the residential centre in depth assessments were made of clients with difficulties with self harm, obsessional behaviours, incontinence and aggression and recommendations for behavioural strategies were made and implemented where possible. Skills assessments and intellectual assessments using standard measures were also completed in the residential unit. Teaching on functional analysis of challenging behaviour was undertaken with staff groups and two social skills groups were facilitated at the social services day centre.
CRAWLEY HORSHAM NHS TRUST
CLINICAL PSYCHOLOGY

Contract for Training in Learning Disability.

Clinical Psychologist in Training: Suzy Mackechnie

Supervisors: Nigel Mills
Helen Brownrigg (Informal)

Aims

1) To develop some competency in formal psychological assessment.
2) To develop some competency in therapeutic approaches
3) To gain experience of professional issues and philosophies of care.
4) To develop awareness of organisational issues.
5) To understand the relevance of work with learning disability to other specialisms.

Objectives:

At the end of the placement the trainee will be able to:

1.1) Apply and interpret the WAIS-R, Bereeweke, and Scale for assessing coping skills.
1.2) Describe the purpose and interpretation of language assessments especially BPVS.
1.3) Undertake a functional analysis.
1.4) Undertake a family assessment, cognitive behavioural, and interpersonal assessment.

2.1) Select an appropriate therapeutic model, for a given client a) Mild, b) Moderate, c) Severe disability.
2.2) Design and evaluate behavioural programmes, a) to increase skills, b) decrease challenging behaviour.
2.3. Apply the following approaches:

Supervisor

a) Interpersonal skills Verna Bailey
b) Cognitive-behavioural/Gestalt Nigel Mills
c) Psychodynamic (attend Psychodynamic Supervision with R. Squier and present case) Helen Brownrigg
d) Systemic

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2.4 To work therapeutically with a family, a group and individuals with different levels of disability (mild to profound).

2.5. Communicate (verbally and written form) effectively with carers and staff about the course and outcome of psychological intervention. Including presentation to a Multidisciplinary meeting.

3.1 Describe the role of SIG for PLD.

3.2 Describe relevant philosophies of care and their effect on psychological intervention.

3.3. Manage Time and Case load efficently.

4.1 Discuss the institutional response to human need and implications of for Martyn Long Centre.

4.2 Work within Service networks - at Martyn Long and in Community Teams and in Day Centres.

4.3 To take a lead role in a Multidisciplinary meeting.

4.4. To describe the network of resources for PLD in Crawley Horsham and how these work together.

4.5. Prepare, deliver and evaluate a teaching session for staff.

4.6 Describe the role of other professions in PLD.

5. To describe the relevance of work within L.D. to other specialisms.

SUPERVISION

2 Hours per week with Nigel Mills
plus informal arrangement with Helen Brownrigg

Study ½ day per week.

Signed: Suzy Mackechnie

................................ SUZY MACKECHNIE

................................ NIGEL MILLS

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PLACEMENT 2 ABSTRACT

People with learning disabilities

All identifying information has been removed.

A cognitive behavioural intervention for depression in a woman with a moderate learning disability.

A female client aged twenty five living in sheltered accommodation was referred for assessment of intellectual ability and possible depression by her social worker because of her recent lack of attendance at the local day centre. Assessment involved client interviews, diary keeping, the completion of a standardised depression measure and the WAIS R, as well as interviews with day centre and hostel staff.

The clients symptoms of depression were thought to result from a mismatch between her presentation and ability as her level of functioning was in the mild learning disability range. This led to difficulty in satisfying the expectations of family and carers. She was also thought to have some unresolved separation issues. Low self esteem was addressed using simplified cognitive behavioural techniques and an ‘ecological’ approach was taken to her difficulties by reframing and normalising her symptoms to carers and day centre workers and recommending a more suitable living environment.

The questionnaire measure reflected a significant reduction in symptoms of depression after nine individual session but it was unclear whether or not this reflected the client’s continuing desire to present as functioning well, which was central to the formulation of her difficulties.
PLACEMENT 3

Children, adolescents and families

Dates: October 1996-April 1997

Location: Child and Family Services for Mental Health, John Grenville House, Chichester, West Sussex.

Supervisors: Mrs Ann Kimber

Ms Mary John

Summary of Experience Gained

Based within a multidisciplinary team, sixteen referrals from all age ranges were seen individually, and four cases were seen with the family therapy team. Individual work with children involved cognitive assessment and play therapy to address post traumatic stress disorder following head injury; an extended assessment to explore the effects of divorce using projective techniques; supportive/educational sessions for a sibling of an obsessive compulsive disorder sufferer and cognitive behaviour therapy for panic attacks with an adolescent girl. Work with parents included assessment of toileting problems in a child with severe learning difficulties; and advice on parenting skills and behavioural techniques in two cases involving Attention Deficit Hyperactivity Disorder (ADHD) and one involving Gilles de la Tourette’s syndrome. The mother of a child with learning difficulties was seen to address attachment issues and parenting skills and to monitor risk. Family interventions included assessment of a child with communication difficulties, and a behavioural intervention to address non compliance and aggression in a child with ADHD. Cognitive assessments of children aged two, nine and eleven were carried out. Family therapy interventions addressed difficulties involving abuse, fire setting and enuresis. A research project was conducted exploring the effects of medication on family relationships in ADHD.
Child and Adolescent Placement Contract

Contract between Ann Kimber and Suzy Mackechnie 25.09.96 - 21.03.97.

The trainee will be allocated office space and secretarial support at John Grenville House, Chichester. The placement will be in an out-patient setting, with clients from 0-18 years. The client group encountered is to include behavioural problems in normally developing children; children with developmental delays; children with educational, emotional and conduct problems of varying degrees; children with a psychiatric illness and children who have been victims of abuse. (For fuller details see University of Surrey Child and Adolescent Placement guidelines).

Aims of the Placement

1. This placement aims to provide the trainee the experience of working with children, adolescents and their families in a mental health setting.

2. It also aims to provide the trainee with clinical psychology skills to work with children of varying ages and with varying psychological difficulties.

3. To provide experience of assessment, formulating and intervention skills with children and adolescents, and to vary these skills appropriately to the client's age and stage of life.

4. To provide trainees with an insight into the wider support network of the child, and how such inter-agency work is conducted.

Objectives of the Placement

The competencies listed in the University of Surrey Child and Adolescent Placement Handbook will be used as a framework to achieve the aims of the placement.

Specifically trainees will be provided with the opportunity of observing children in the following settings

- nursery schools
- EBD schools
- MLD schools
- SLD schools
- hospital based child assessment unit
Trainees will also have the opportunity to observe the following professionals -

- Consultant Psychiatrist
- Clinical Nurse Specialists
- Psychiatric Social Workers
- Family Therapists
- Clinical Psychologists
- Paediatricians
- Speech and Language Therapists
- Ophthalmologist
- Physiotherapist
- Educational Psychologists
- Education Welfare Officers
- Social Workers

Trainees will be expected to plan and deliver teaching sessions to specified groups, i.e. health visitors, junior doctors.

Trainees will be supported to attend the Child and Adolescent SIG meetings that occur during placement.

Small Scale Research

Trainees will be allowed to dedicate one session a week to concentrate on the planning, running of and writing up of a small scale research project.

Reports of Clinical Activity

Trainees are expected to keep up to date clinical records/notes for each client and to send a letter to the client’s GP within 2 weeks of completing an assessment. This letter is to include a psychological formulation and treatment plans.

Trainees are to be allocated a proportion of clinical time to write an extended report (5000 words) on a piece of clinical work that is grounded in theory and reflects an unidentified case.

Supervision

Supervision is to be provided by Ann Kimber for one and a half hours weekly. In Ann Kimber’s absence, trainees may obtain advice from other members of the multidisciplinary team.
Additional supervision is to be provided by Mary John for one hour a week. This session is a joint supervision if more than one trainee is on placement.

An additional hour and a half teaching slot is to be provided on a weekly basis.

Signed.................................. Date..........................

Signed.................................. Date..........................
PLACEMENT 3 ABSTRACT

Children, adolescents and families

All identifying information has been removed.

Assessment for Post Traumatic Stress Disorder (PTSD) and intervention using play therapy techniques with a six year old child.

A six year old child was referred to address behaviour problems and apparent flashbacks to an accident involving a fall from a third story window approximately three months previously. A second referral was made for cognitive assessment of the child.

Assessment for the behaviour problems and possible PTSD involved an in depth interview with the child’s mother which reflected the existence of a range of PTSD symptoms. A single consultation or ‘debriefing’ session was held with the child using the medium of play to facilitate processing of the traumatic event. This session suggested the need for further exploration in play of issues including the effects of the accident on the child’s self esteem and complex family circumstances particularly as the child made good use of the medium of play. The child’s lack of co-operation with psychometric testing was thought to reflect the effect of the accident on his sense of efficacy.

Two further play therapy sessions were undertaken and counselling for the child’s mother with another member of the multi-disciplinary team was recommended to address her own symptoms of PTSD as a result of the accident. Progress in play therapy was to be monitored using a rating scale but this was hampered by inconsistent attendance of the family at the clinic. It was hypothesised that this lack of attendance may have been an avoidance behaviour associated with the mother’s PTSD.
PLACEMENT 4

Older adults

Dates: April 1997-October 1997

Location: Department of Psychology, Surbiton Hospital, Surbiton, Surrey.

Supervisors: Ms Catherine Dooley

Dr Anna Iwnicki (neuropsychological testing)

Summary of Experience Gained

This placement involved assessment and therapy with twelve clients ranging from sixty four to seventy six years of age. Five of these clients were seen within a group format at a social services day care and residential facility and seven were seen at home or in hospital outpatients. Assessment and treatment was undertaken individually with four clients with difficulties of post traumatic stress disorder and a phobia of car travel; adjustment to physical illness and depression; depression and conflict with carers; and social anxiety in the context of organic memory impairment. An in depth assessment of psychological factors pertaining to placement issues was made of a client with ‘personality problems.’ Three neuropsychological assessments were undertaken to assess for cognitive decline. One of these was in the context of possible late onset Gilles de la Tourettes syndrome; another was made of a client with a history of alcohol abuse pending an appeal against section under the Mental Health Act. A group intervention over nine weeks was designed and facilitated for five clients in a social services centre to address coping with loss of mobility. Two training sessions on assessment and treatment of depression in younger and older adults for health visitors and district nurses were designed and carried out. The protocol developed was to be used for future training.
KINGSTON & DISTRICT COMMUNITY NHS TRUST
DEPARTMENT OF CLINICAL PSYCHOLOGY
CORE PLACEMENT - SERVICES TO OLDER ADULTS

CONTRACT FOR:

AIMS

• To gain an overview of the services available for Older Adults in Kingston and District and an understanding of how these fit together to form an organisation.

• To gain an understanding of the role of the Clinical Psychologist providing services for older adults and how this differs from other professions.

• To have experience of working in a variety of work settings, with a range of client groups and problems and to develop skills and approaches when carrying out interventions e.g. networking, liaising with other professionals, family therapy, martial work, behaviour modification, personal construct theory, bereavement counselling etc.

• To undertake some area of service development/project work/training.

OBJECTIVES

1. To carry out assessment and intervention with approximately ten clients with functional and organic conditions including:

1a. DIRECT WORK with clients and families in outpatient/community settings including problems of anxiety, depression, bereavement, adjustment to disability, health issues and carers issues.

1b. INDIRECT WORK with clients and staff including dementia care in inpatient or residential settings, networking - e.g. setting up a care package for a client at the Oak Day Hospital.

2. To become familiar with different settings - e.g.:

• Oak Day Hospital
• Wards for Older Adults with mental health problems at Tolworth Acacia Unit.
• Wards for Older Adults with physical health problems at Tolworth Hospital.
• Social Services Residential Homes, e.g. Newent House, Murray House.
• Private and Voluntary Residential Homes.
• South Place.
3. To spend time with a Consultant Psychiatrist, Social Worker and CN both in client meetings and if possible in individual client work.

4. To meet Managers within EMI Service and Elderly Community Service.

5. To run a therapeutic group for Older Adults.

6. To observe and carry out neuropsychological assessment using WAIS R, Coughlan, MEAMS or Mini Mental State.

7. To attend meetings and seminars in Psychology Department and other meetings within Services for Older Adults.

8. To have 1.5 hours of supervision on a weekly basis.

9. To have one session of study time per week.

10. To possibly carry out some teaching.

11. To possibly undertake an area of project work to familiarise self with organisational issues.

PERSONAL GOALS

1. To develop therapeutic skills and gain confidence in own therapeutic style.

2. To develop an understanding of organisational processes and the application of psychological theory to these.

3. To develop skill and confidence in assessing and intervening in cases where there is an organic impairment.

4. To become familiar with the Psychologist role in a health psychology setting.

5. To make theory and practical links more explicit in supervision and to practice formulating cases from different models in a more formal way.

6. To develop confidence in networking with other professionals and presenting psychological ideas in a multi-disciplinary setting.

Catherine Dooley
Consultant Clinical Psychologist

Trainee Clinical Psychologist

1/5/97
PLACEMENT 4 ABSTRACT

Older adults

All identifying information has been removed.

A neuropsychological assessment of dementia in an older adult with a diagnosis of late onset Gilles de la Tourettes syndrome.

A sixty seven year old man exhibiting symptoms of Gilles de la Tourettes syndrome (involuntary swearing) being treated pharmacologically for depression, was referred for assessment of possible dementia. Given a history of hypertension and cardiovascular disease, a vascular condition was thought to be the most likely profile. A broad cognitive screening for features of cognitive decline was undertaken. Neuropsychological screening involved an interview and administration of the National Adult Reading Test, the Wechsler Adult Intelligence Scale (Revised), the Adult Memory and Information Processing Battery and the Reitan Trail Making Test. Depression and anxiety were assessed using a standard measure interview.

Test results did not suggest significant evidence of cognitive decline despite a slight deficit in verbal learning. The client’s test profile and behaviour during testing were thought to reflect functional impairments associated with depression. The client’s difficulties, including the involuntary swearing, were formulated from a psychological perspective bearing in mind recent losses and relationship difficulties. Recommendations were made for repeat testing to monitor verbal learning and for a therapeutic intervention for the couple, which they declined to take up.
Placement 5: Systemic therapy

Placement 5

Systemic Therapy

Dates: October 1997-April 1998

Location: Department of Child and Adolescent Psychology, Elm house, Surbiton Surrey. Psychology Department, Hampton Community Mental Health Team, Hampton, London

Supervisors: Dr Karen Partridge (adult)

Dr Georgina Bell (child)

Summary of Experience Gained

This placement involved a grounding in the theory and practice of systemic constructionist work within an adult mental health services and a child service. The emphasis was placed upon Milan and Narrative models. Within the child service the author was the lead therapist with seven families addressing difficulties following divorce, sleep problems, behaviour difficulties, school refusal and anxiety with children and adolescents aged 5-17. Work was undertaken with a co-therapist on three of the cases and with a family therapy team for one. Participation as a family therapy team member occurred for three further families. Within the adult part of the placement three clients were seen individually to address difficulties with anger, obsessive compulsive disorder and a history of sexual abuse. The author was the lead therapist of the team for a further two cases addressing problems of adjustment to psychiatric illness, and depression. She was also a team member for cases addressing on depression, anxiety, loss, and alcohol problems. This part of the placement involved exposure to adult clients with chronic mental health problems.
CONTRACT FOR SPECIALIST PLACEMENT
SYSTEMIC WORK WITH ADULTS, CHILDREN AND FAMILIES

Trainee Suzy MacKechnie

Supervisor Dr Karen Partridge (Adult)
Dr Georgina Bell (Child)

Base 1. Elm House, 84 Ewell Road, Surbiton
       Wednesday, Thursday (a.m. only)

2. Maddison Centre, Hampton CMHT
   Thursday (p.m. only and Friday)

Aims and Methods

1. To provide Suzy with a grounding in the theory and practice of systemic
collectionist work within the context of an adult mental health service and a child
service (in the community).

   • Dr Partridge and Dr Bell to provide reading materials

   • Time to be put aside to discuss theory - practice links in supervision

2. To enable Suzy to begin working with families and more complex adult cases at an
    "advanced" level, with particular emphasis on systemic perspectives and techniques
    and integration of models in the child part of the placement.

Adult

• Working with the systemic team on at least three cases who have complex
difficulties and/or are at the in-patient continuum, on one of these cases Suzy
MacKechnie is to be the therapist

• Working as a solo therapist with at least one individual case using the narrative
model

Child

• Working with the systemic team on at least three cases. Suzy MacKechnie is to be
the therapist with one of these.

• Individual work with at least three families - using video.

• Some joint work with Dr Bell where appropriate
Adult and Child

- Suzy MacKechnie to experience different positions (e.g. therapist, reflecting team member, meta-team member)

- Suzy MacKechnie to expand repertoire of questions and positions via these experiences

3. To develop personal style and identity and confidence as a therapist, with reflection on this the systemic model relates to others.

- Supervision

4. To identify and discuss personal reactions that arise from casework and the work context, and to discuss the therapeutic use of identifying these reactions.

- Supervision (Child)

- Reading

5. Participation in Psychology Department meeting, Psychology Speciality meetings, clinical seminars and other meetings.

Reading to Cover

- Narrative therapy
- Cronen and Pearce model
- Systemic theory and techniques (Milan method)

Supervision Format

1. 1 hour per week - Dr Bell
2. 1½ hours per fortnight, Dr Partridge and Rupert Nieboer

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PLACEMENT 5 ABSTRACT

Systemic Therapy

All identifying information has been removed.

A family intervention following divorce using Narrative Therapy

A ten year old boy was referred for assessment of anger outbursts, depression and friendship difficulties in the context of his parent's recent divorce. Assessment included interviews with the child, his brother and mother using questioning derived from several systemic models. The child's father and school teachers were interviewed by telephone. The child's difficulties were formulated as being due to his parents very acrimonious relationship and his mother's belief that the divorce had had little effect on the children, making it difficult for her to acknowledge and ameliorate her son's distress. These hypotheses formed the basis for a systemic approach.

Narrative Therapy was used to address the difficulties in sessions with the child, his brother and mother. The problem was 'externalised' and named 'the Dark side' and the families joint tactics for defeating it were explored and utilised. Separate sessions were held with the child's parent's to address the effects of their animosity on him using systemic techniques from the Milan School.

As a result of this intervention parent report reflected a significant improvement in the child's mood and the child's diary reflected a marked reduction in days won to the 'Dark side.'
PLACEMENT 6

Forensic clinical psychology

Dates: April 1998-September 1998

Location: Broadmoor Special Hospital, Crowthorne, Berkshire.

Supervisors: Ms Fiona Clark
Dr Nashater Deu (group work)

Summary of Experience Gained

This placement involved a range of assessment and interventions with mentally disordered offenders in a maximum security setting. A total of thirteen clients were seen. Assessments involving a minimum of six sessions, were undertaken including; a joint admissions assessment with the placement supervisor of an eighteen year old client diagnosed with personality disorder; an assessment of psychological factors involved in a violent offence in a client diagnosed with schizophrenia; and a psychosexual assessment of a client diagnosed with mental illness and convicted of a sexual offence. Individual therapy was undertaken with two female clients using cognitive behavioural techniques to address low self esteem and psychotic symptoms and difficulties with anger. The author co-facilitated a ‘relapse prevention’ group for five sex offenders and was involved in several teaching sessions for a group of ten clients on the relapse prevention model. Knowledge of the organisational issues was gained by attending meetings case conferences and visits to a regional secure unit, a prison and court.
PLACEMENT CONTRACT

TRAINEE: Suzanne MacKechnie
SUPERVISOR: Fiona Clark
PLACEMENT DATES: 30.4.98 - 24.9.98
LOCATION Broadmoor Hospital

CONTENT OF PLACEMENT

1. Induction
Hospital Induction Course
Introduction to the Department

2. Assessment
Observation of Admission Assessment Fiona Clark
Psychosexual Assessment Fiona Clark
Assessment of Psychological Factors Contributing to Violent Offence Fiona Clark
Observation of Psychodynamic Assessment Dr Gwen Adshead
Neuro-psychological Assessment Dr M Hill

3. Intervention
Cognitive Behavioural Therapy for Psychotic Symptoms/Low Self-Esteem Fiona Clark
Systemic Approach to Bereavment Therapy Pat Short
Relapse Prevention Group for Sex-Offenders (Co-facilitator) Dr Nashater Deu
Anger Management Fiona Clark

4. Knowledge of Organisation and Forensic Services
Attendance at Department/Directorate Meetings
Ward Clinical Team Meeting
Case Conferences
Admission Panel
Forensic Special Interest Group

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Visit to
Regional Secure Unit
Old Bailey (or other court)
Prison
Social Work Department
Occupations Area(s)

PLACEMENT ORGANISATION

1. Days of Week on Placement
Wednesday, Thursday and Alternate Fridays

2. Accommodation
Desk in shared office, access to phone, filing cabinet and computing/word processing facilities.

3. Supervision
Supervision with main supervisor Wednesdays 2.00 - 4.00 pm
Supervisor available in department at other times.
Supervision from additional supervisors to be arranged as appropriate.

4. Study Time
Alternate Fridays

5. Secretarial Support
Sarah Roberts.

.......................... Fiona Clark
Supervisor

.......................... Suzanne MacKechnie
Clinical Psychologist In Training
RESEARCH CHAPTER
A discussion of the potential application of Attachment Theory to the aetiology and treatment of sexual offending.
1. INTRODUCTION

Attachment Theory (Bowlby 1969) has been proposed as a framework for conceptualising the interpersonal deficits that could inform the formulation and treatment of sexual offending (Marshall, 1989). This review considers the potential application of Attachment Theory for delineating the developmental antecedents and psychological characteristics of sex offenders and for consideration of the consequent treatment and risk. Since there are no empirical studies of sex offending conducted explicitly within an Attachment framework, it will describe Attachment Theory and relevant research, focusing on those elements relevant to sex offending. It then describes and evaluates proposals made to integrate attachment research into sex offending and evaluates a range of research and theoretical perspectives that have relevance to sex offender's attachments. The study concludes with an evaluation of the future potential and limitations of Attachment Theory research for the aetiology and treatment of sex offenders and suggests how this may be a key group to study in an Attachment framework in order to refine theoretical understanding of the relationship between attachment sexuality and aggression across the life span.

2. BASIC TENETS OF ATTACHMENT THEORY

Bowlby (1969, 1973, 1980) developed Attachment Theory in order to give the object relations school in psychoanalysis a more scientific basis in ethology and control theory (Holmes, 1993b). His main aim was to explain the emotional distress arising in infants as a result of separation from the primary caregiver. He proposed an Attachment Behavioural System for regulating infant safety and survival of equal importance to the systems guiding feeding and reproduction where the infant continually monitors the proximity of a protective ‘attachment figure’. Initially infants achieve this through crying, smiling and clinging and later through a goal oriented system focused on a specific caregiver (Bowlby, 1969). This provision of a ‘secure base’ enables the child to engage in exploratory behaviours and to internalise self reliance (Bowlby, 1973).
The attachment behaviour system is regulated by representational 'working models' of self and the attachment figure which are organised during the early sensitive period (7 months to 3 years) and become increasingly fixed in ensuing years so that future relationships are perceived according to them. Negative affective states such as anger and anxiety are functional reactions to elicit a response from the care giver and to renew the attachment bond as documented by the observational studies of Robertson (Robertson & Bowlby, 1952) who documented sequences of protest, despair and detachment following loss. Infant's means of regulating the affect aroused by different parenting patterns has been expanded and experimentally validated by Ainsworth, Blehar, Waters and Wall (1978), who identified three organised behavioural patterns of 'secure', 'anxious-avoidant' and 'anxious-ambivalent,' attachment linked to 'sensitively attuned', 'aversive' or 'unpredictable' parenting styles respectively. These findings have been replicated and distributions of attachment patterns world wide have been calculated (Van Ijzendoorn & Kroonenberg, 1988). Recently a fourth 'disorganised' attachment pattern has been described. This is characterised as a 'collapse of behavioural strategy' linked to frightening or frightened behaviour of the attachment figure (Main & Soloman, 1990).

Bowlby (1980) extends his theory to consider effects of the permanent loss of an attachment figure and outlines his 'Information Processing Approach to Defence'. This explains how early deprivation of attachment needs leads to the development of maladaptive representational models of self (functional for maintaining the attachment system in unfavourable circumstances such as idealisation or role reversal) which contribute in later life to 'disordered mourning'. In the case of 'chronic mourning' with intense, prolonged anger and self reproach, the person is unable to recover from the loss because of an idealisation of the lost figure and a sense that they are themselves a worthless person. This habitual model of self and other coexists with a latent model comprised of a longing for love and a resentment against those failing to meet the attachment needs with unconscious murderous desires for revenge and possible displaced anger. The second form of response to loss, the 'prolonged absence of grieving', is due to cognitive biases resulting from disparaging parental responses to requests for comfort, leading to the cultivation of self sufficiency and the disavowal of
the need for support. Here the alternative 'needy' self-other model may exert its influence on compulsive caregiving. In contrast to both these patterns Bowlby saw the healthy reaction to loss as marked by an absence of contradictory working models, a sense of self as worthy of support and an expectation of others as likely to provide it.

3. SEXUAL OFFENDING

3.1 Clinical and legal definitions

Research on the psychological characteristics of sex offenders is plagued by definitional problems. Blackburn (1993) distinguishes between 'sexual deviance' defined by fluctuating societal standards, and 'sexual offending' based on legal classifications (e.g., the use of force, disparities in age, violations of close relationships and violations of public order) which have an indirect relationship to each other. The Diagnostic and Statistical Manual IV (DSM IV) (A.P.A., 1994) uses the term 'paraphilia' emphasising the unusual nature of the specific object of sexual attraction such as non-human objects or children. Blackburn argues that the usefulness of DSM IV for classifying the psychological features of sex offenders is questionable because of the existence of deviant sexual fantasises in a wide proportion of the population (Hariton & Singer, 1974) and the fact that not all paraphilias are illegal. Surveys suggest that multiple rather than specific paraphilias or offences may be the rule in incarcerated sex offenders reflecting a more generalised deficit of control over deviant sexual behaviours. There is also controversy over whether some sexual offences such as rape can even be classed as paraphilias if motivated by power or control rather than sexual arousal (Abel & Rouleau, 1990). Attempts to explore the psychological features of sex offenders is confounded by preliminary considerations of who to consider a homogenous group. There is also the problem of representativeness of those incarcerated sex offenders who are accessible and consent to be involved in research.
3.2 Typologies

Such definitional problems have been addressed by the development of typologies of sex offenders based on motivational variables (Prentky, Cohen & Seghorn, 1985; Knight & Prentky, 1990). Knight and Prentky (1990) have investigated the reliability and validity of Cohen, Seghorn and Calmas's (1969) typology of four types of rape using complementary inductive and deductive methods. They identify four superordinate types of rapists; opportunistic, pervasively angry, sexual and vindictive with subdivisions of sadism and social competence. The child molester typology involves a hierarchical decision tree along two axes; the first dividing offenders by degree of fixation and social competence, the second by amount of contact with children, the meaning of the contact (interpersonal or narcissistic) and the level of physical injury and sadism. These five variables lead to a possible twenty four types of offender. They argue that this categorisation system has yielded meaningful differences in terms of life span adaptation but needs further refinement and suggest that types of offending should have distinct developmental roots which are relevant to treatment decisions. Their work draws attention to the conceptual complexity of such typologies and it is unsurprising that there is little research linking types to developmental history. There are clear benefits of a structured method of researching and categorising childhood experiences, such as that provided by Attachment Theory, to further investigate this model and developmental antecedents.

3.3 Theories of sex offending

Marshall and Barbaree (1990) document a diversity of factors contributing to sexual offending, such as biological dispositions, conditioning, social learning, cognitions and socio-cultural context. They draw on the most suggestive research findings in proposing an integrated theory of sexual assault. The theory states that given a close link between neural centres for sexual activity and aggression, adolescent boys must learn to inhibit a natural capacity for sexual aggression. Due to adverse childhood experiences such as unskilled parenting and receipt of violence, some fail to acquire the required empathic and social skills to do so or to develop satisfying peer and sexual relationships. Such
boys become vulnerable to cultural influences such as rape myths as expressed, for example, in pornography, and are more readily sexually disinhibited by transitory influences of alcohol, intoxication or anger. Once forced sexual experience has occurred, positive reinforcement leads to further likelihood of more assaults particularly if punishment is not contingent. This theory has been criticised particularly for its assumption of the biologically determined nature of sexual aggression (which ignores the distinction between angry and instrumental aggression) (Blackburn, 1993) but nonetheless remains influential (Fisher & Howells, 1993).

Finkelhor (1986) has also proposed a theoretical model based on four likely preconditions for child molestation:

a) 'emotional congruence' of sexual relations with children, possibly due to their non-dominance for offenders with a low sense of adequacy and control over the environment (as a result of their own previous negative or abusive experiences),

b) sexual arousal to children by conditioning through masturbatory fantasises,

c) 'blockage' of adult relationships because of heterosexual anxiety, and

d) 'disinhibition' to sexual relations with children made possible by lack of empathy, alcohol or cognitive distortions.

These theories suggest the importance of childhood experiences on the sex offender and also illustrate the complexity of modelling the developmental antecedents of a sexual offence because of the multiple influencing factors. The very broad nature of these theories means that they do not describe the relative influence of different types of childhood experiences and do not explain different types of sexual offending. There is a need for a clearer understanding of how relationships with primary caregivers interact with other significant influences in these models. Theories of sex offending tend to be multi-factorial and Blackburn (1993) suggest the need for single factor theories to address each element of which a focus on early relationships could be one.
4. ATTACHMENT THEORY AND SEX OFFENDING

As such, Attachment Theory (particularly the work on loss) describes how early maltreatment provokes the development of psychological defences in the form of cognitive systems or working models that preserve a particular view of self and other. This can lead to later disordered interpersonal functioning for example; displaced anger, role reversal or emotional detachment. These patterns are described by Bowlby in response to loss of the attachment figure but it seems reasonable to suggest that these processes could occur in response to diverse forms of trauma and be a more general feature of adult functioning. Thus, Bowlby’s basic theory seems relevant to the interpersonal patterns that enable offenders to commit sexual acts that involve lack of empathy and aggression, often with high levels of denial (Laflen & Sturm, 1994) and possible role reversal in family patterns (Caffaro, 1991). However, how each of these interpersonal patterns and concomitant psychological defences may facilitate sexual offences requires much more systematic study. Apparent similarities e.g., between children’s capacity for denial about poor parenting and adults capacity for denial about abusive sexual acts may be qualitatively different. The methodological difficulties inherent in a study of unconscious psychological defences remain a challenge. There is also a need for more formal validation of how these proposed attachment based interpersonal patterns may occur across the lifespan and in response to adult difficulties other than loss.

4.1 Attachment in adulthood; theory

Weiss (1982) developed Bowlby’ (1984) ideas in interview studies to argue that intimate sexual relationships, as opposed to friendships, in adulthood guard against ‘emotional loneliness’ and can be understood in terms of Attachment Theory since there is a desire to be comforted under stressful conditions and protest if the partner threatens to become unavailable. Ainsworth (1991) and Heard and Lake (1987) in theoretical theses support this argument and also class adult friendships as attachments. Bartholomew (1990) proposes four attachment styles in adulthood linked to internal working models of the self and others. The secure and anxious ambivalent models correspond to childhood
patterns leading to high intimacy or unsatisfactory fluctuating levels of intimacy respectively. The anxious pattern is divided into two types, both with a negative view of others; those who avoid social contact through fear of rejection (negative view of self) leading to superficial intimacy and those who are dismissive towards relationships (positive view of self) with very low levels of intimacy and propensity to hostility. Bartholomew and Horowitz (1991) report some preliminary empirical test of this model.

Despite giving theoretically justified accounts of how 'intimacy' may be patterned in adulthood, these models have not been subject to extensive empirical test. The concept of 'intimacy' as a manifestation of attachment in adulthood requires more rigorous definition with clearer behavioural indicators along the lines proposed by Bartholomew. This would also help to define the relationship between sexual behaviour and the concept of 'intimacy'. A host of questions remain unanswered about 'intimacy' patterns such as their stability over time and within different relationships and how they may manifest in sexual relationships as opposed to friendships.

4.2 Attachment and sexuality: theory.

How sexual behaviour and emotional relationships might be linked clearly has implications for understanding the disordered sexual behaviour of sex offenders and some theoretical postulates have been proposed. Bowlby highlights the close links between attachment behaviour, parental caregiving behaviour and adult sexual behaviour. However, in contrast to traditional psychodynamic 'libido' theory, he does not see them as expressions of a single drive, since the activation of the systems may vary independently and their 'class of objects' and 'sensitive periods' of development may be different (Bowlby, 1969). Furthermore, each of these types of behaviour serves its own distinctive biological function (Bowlby, 1984). For Bowlby the 'obvious links' between these systems are best understood by keeping them conceptually distinct and he calls for more research to unravel how they overlap (Bowlby, 1969).

Belsky, Steinberg and Draper (1991) propose an evolutionary theory of socialisation in which two divergent patterns of reproductive strategy appear as a result of different child rearing practices. Insecure attachment bonds in childhood lead to a mistrustful internal
Literature review

working model and an opportunistic, interpersonal orientation which involves aggressive non-compliance in males and anxiety and depression in females. This pattern also leads to early pubertal development and precocious sexuality, unstable pair bonding in adulthood and limited investment in child rearing. In contrast, secure attachment leads to a trusting internal working model and a reciprocally rewarding interpersonal orientation, later pubertal maturation, later sexual activity and long term enduring pair bonds with greater parental investment.

Shaver and Hazan (1988) use a similar model to Bartholemew (1990) but make clearer statements regarding sexual behaviour. They argue that the attachment system underpins the care giving and sexual mating systems since it is the first to appear in the infant’s course of development. They conceptualise adult attachments as including reciprocal caregiving and sexuality. Secure attachments are suggested to give rise to mutual intimacy and pleasure in sexual relationships while avoidant attachments lead to the inability to give or receive care, emotional distance during sex or promiscuity. Ambivalent attachments then lead to compulsive caregiving and care seeking with the use of sexual behaviour to satisfy the need for love and security. Feeney and Noller (1990) investigated attachment style (using a single item measure) as a predictor of adult romantic relationships and ‘love styles’ as delineated by Shaver and Hazan (1988) and found some support for this theoretical framework. Their thesis however remained at the level of ‘romantic’ styles and did not address sexual behaviour. Feeney and Raphael (1992) highlight this paucity of research on the relationship of attachment style to sexual behaviours and attitudes. In the context of the Aids epidemic they hypothesise that attachment style may predict involvement in high risk sexual activities, attitudes towards safe sex and competence in negotiating sexual encounters and urge more empirical investigation of these issues.

Theory and limited empirical research suggests that actual sexual behaviours are likely to be linked to attachment style. Understanding of these links within the ‘normal’ population is limited both by sparse articulation in theory and inconsistency in defining and operationalising adult relationships in the few studies that exist (for example, studies have considered ‘stability of pair bonding’ and ‘love styles’). As such it is
difficult to hypothesise how more deviant sexual behaviour may be an expression of disordered attachment. An investigation of attachments of those who exhibit more extremely disordered sexual behaviours may help to elucidate these links.

5. EMPIRICAL BASES

5.1 Measures of attachment in adulthood

Various measures of adult attachment exist. As Feeney and Raphael (1992) outline, these measures vary in the degree of detail obtained (for example Hazan and Shaver (1987) use a single item forced choice measure of current relationships), the conceptualisation of attachment, and the focus on either current or parental relationships.

The Adult Attachment Interview (A.A.I.) (George, Kaplan & Main, 1985) is perhaps the most sophisticated measure of adult’s ‘attachment state of mind’ and its links to early experiences with care givers. The measure was developed on the widely accepted premise that measures of mental representations of attachment would be more useful than unreliable reports of actual experiences (Bretherton, 1985). The manner in which those experiences are conveyed, rather than the nature of the experiences, yields an overall classification of the adult’s current state of mind with respect to attachment. The classifications of ‘autonomous’, ‘dismissing’, ‘preoccupied’ and ‘unresolved’ are thought to bear a systematic association to infant patterns of attachment of secure, avoidant, ambivalent and disorganised attachment respectively. The accessibility of

1 ‘Autonomous’ accounts reflect objectivity, balance and coherence in discussing favourable or unfavourable childhood experiences. ‘Dismissing’ accounts are characterised by derogation, idealisation, insistence on the inability to recall and formulations divorced from affect. ‘Preoccupied’ accounts reflect over involvement with childhood experiences and subjects appear over-welmed and confused by the topic of attachment reflected by incoherence anger or passivity. ‘Unresolved disorganised’ accounts are characterised by lapses in the monitoring of reasoning or discourse occurring in the discussion of traumatic events. Interview transcripts are rated on a series of scales concerning the adult’s probable experience of having been parented in either a loving, role reversing or rejecting manner and other features such as idealisation, preoccupying anger, derogation, insistence on the in ability to recall and overall coherence. All of these contribute to the final categorisation.
this measure is however limited, given that it is unpublished and requires extensive training to administer and score (Main & Goldwyn, 1985-1994).

Main (1996) reviews the status of the A.A.I. and argues that empirical results so far (see next section) have illustrated 'the predictability of discourse usage in life history narratives evolving out of early interactions patterns, rather than the stability of behavioural reaction patterns', since discourse has no direct resemblance to infant behaviours. She sees the interview as a reasonable measure of attachment beyond infancy but highlights a need to avoid 'early determinism' and to consider the influence of heritable factors in attachment and the effect of family life events in patterns of coherence or incoherence (as shown by Waters, Merrick, Albersheim, & Treboux, 1995). Although the measure appears promising in using discourse to operationalise the defence mechanisms that Bowlby described, questions remain about the exact links between adult's representations of attachment and their actual childhood experiences since the main empirical link has been between their style on interview and *their children's* characteristics (which is initially how the tool was developed). If the A.A.I. is to be accepted as a measure of stable representational models of self and other built up in childhood from real experiences, rather than a measure of personality or temperament, further empirical support in longitudinal studies is clearly required (Jones, 1996). Benoit and Parker (1994) examined the relationship between infant 'Strange Situation' classification and adolescent and young adulthood classification on the A.A.I. showing a 75% match between dismissing, preoccupied and secure categories, but clearly this requires replication.

5.2 Empirical studies of attachment across the lifespan

5.2.1 Purpose of studies

A body of research has been built up mainly using the A.A.I. to illustrate the importance of parent-child relationships in the aetiology of psychological disorder (Jones, 1996).
5.2.2 Correspondence between infant and mother classification

The correspondence between mother’s classification on the A.A.I. and infant’s attachment status has been examined prospectively and retrospectively and a meta analysis of the relationship in 18 samples shows a high correlation between aspects of coherence and incoherence in the mother’s interview and a secure versus insecure infant response, even when the A.A.I. is conducted before the birth of the first child (Fonagy, Steele & Steele, 1991; Van Ijzendoorn, 1995).

5.2.3 Intergenerational transmission of aggressive behaviours

Bowlby (1988a) explained violence towards children as a ‘redirection’ of the anger generated from the abusing parent’s own experience, to a less dominant target. De Lozier (1982) tested similar theoretical hypotheses using a semi structured interview and the Hamsburg Separation Anxiety test to illustrate how mothers who physically abused their children had a high degree of anxious attachment manifested in ongoing anxiety and anger; a yearning for care with an expectation of rejection and finding new and unknown situations (such as child birth) extremely stressful. They described their own childhood as involving threats of abandonment, a lack of a protective figure and some degree of role reversal. These findings were supported by Main and Goldwyn (1984) who showed that three primary behavioural characteristics of child battering parents i.e., difficulty with the control of aggression; aversive unsympathetic pattern of response to distress in others and self isolating tendencies, were seen in their children aged 1-3 years. They reported a behaviour pattern termed ‘harassment’ in these children which seemed to be purely to distress the victim and occurred without provocation. Parent’s own experiences of rejection and distortion of representations of their own abusing parents (e.g., idealisation) were also apparent on A.A.I. transcripts. Lyons-Ruth (1996) documents how longitudinal research on attachment has furthered understanding of childhood aggressive behaviour disorders and risk of mental disorder in adolescence; particularly the importance of the ‘disorganised’ classification in children.
Another major area of attachment research is the link between attachment classification and clinical diagnosis. Rosenstein and Horowitz (1996) found that in psychiatrically hospitalised adolescents, those with ‘dismissing’ attachment status on the A.A.I. were more likely to show a psychiatric disorder where distress is minimised such as conduct or substance abuse disorders and narcissistic or anti-social personality disorder. In contrast, those with a ‘preoccupied’ attachment classification were more likely to have disorders reflecting high subjective distress such as affective, histrionic or borderline personality disorders. Fonagy, Leigh, Steele, Steele, Kennedy, Mattoon, Target and Gerber (1996) have also shown a strong link between borderline personality disorder and preoccupied attachment status.

Allen, Hauser and Borman-Spurrell (1996), showed that hospitalisation at age fourteen of severely disturbed adolescents was predictive of insecure attachment classification eleven years later when assessed by the A.A.I. They found a high incidence of the ‘unresolved with regard to loss or trauma’ category in this group, particularly with trauma defined as abusive or frightening behaviour by an attachment figure. Their study reflected a link between criminal behaviour in early adulthood and dismissing and unresolved attachment classifications. They also found several categories of attachment which were unclassifiable within this severely disturbed group.

On the other hand, a meta analysis of thirty studies found no systematic association between clinical diagnosis and attachment classification (Van Ijzendoorn & Bakermans-Kranenburg, 1996) and Jones (1996) argues that insecure attachment may simply turn out to be a common denominator in the vast majority of the psychiatrically disturbed (and by reasonable extension those in forensic settings). He calls for new models of psychiatric disorder that capture more behavioural and psychological dimensions and suggests that this may better differentiate the relationship between clinical status and attachment.
6. SEX OFFENDING AND ATTACHMENT THEORY

6.1 Potential relevance of recent developments in Attachment Theory to sex offending

The A.A.I. appears promising method of providing a means of consistently operationalising more subtle distinctions of the child caregiver relationships as they impact upon current functioning for different psychological disorders. The measure accepts the inevitability of retrospective report in studying attachment in adulthood and attempts to deal with the existence of psychological defence mechanisms. Although further longitudinal studies are required to address the validity of the measure for childhood experience, the importance of intergenerational transmission of attachment style and particularly aggressive patterns has been illustrated in a robust manner at least as far as childhood. Links between adult attachment classification, personality disorder, anti-social traits and criminal behaviour have been shown, which validates Bowlby’s early theoretical postulation on delinquent behaviours (Bowlby, 1944) but again more longitudinal studies are required. Upon this basis the extension of attachment research into the forensic field seems justified and may help to refine the use of the measure to include other categories of childhood experiences that may apply to more extremely disturbed populations. For example, the interaction between childhood sexual abuse and attachment has not been investigated and may be particularly relevant to understanding the development of sex-offending (see next section). There is clearly a need to examine whether attachment classifications can differentiate offending behaviour (as they appear to differentiate different psychopathologies) or are simply a poorly discriminating common denominator.

6.2 Intimacy and sex offending

The relevance of Attachment Theory to sex offending has been made explicit by Marshall (1989) and Marshall, Hudson and Hodkinson (1990) who argue that a neglect of the emotional life of sex offenders is due to a historical focus on the behavioural aspects of development and treatment of their problems. Drawing on Weiss’ (1982)
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concepts they argue that failure to achieve intimacy in relationships with adults produces emotional loneliness which leads to an aggressive disposition and a tendency to pursue sex with diverse or less threatening partners in the hope of finding this intimacy through sex. They claim that males, who form the overwhelming bulk of sex offenders, have been shown to have greater difficulty in forming intimate relationships than women (Perlman & Fehr, 1987) and cite studies showing a relationship between self reported loneliness and an acceptance of violence towards women (Check, Perlman & Malamuth, 1985).

They state that the early histories of sex offenders almost invariably reflect violence and/or erratic and rejecting parenting (Marshall & Barbaree, 1984) leading to insecure attachment with lack of empathy and self confidence or exploratory skill manifest in problems relating to adult females (Hammer & Glueck, 1957; Panton, 1978) and peers (Tingle, Barnard, Robbins, Newman & Hutchinson, 1986). They suggest that the need for intimacy is shown by clinical examples of how offenders often display 'courting' behaviours inappropriate to the age of their victims and have fantasies of victims falling in love with them. Some, because of sexual abuse in childhood have had an inappropriate model of how to achieve intimacy since any parental intimacy they received was combined with sex. Their study of the sexual preferences of exhibitionists and matched non-offenders also denies the primacy of sexual motivation in these offences seeing it based on poor self esteem and highlights the high degree of parental rejection in life history (Marshall, Payne, Barbaree & Eccles, 1991). Furthermore high rates of adolescent sex offending supports the centrality of attachment for sex offenders since transitions to adulthood exacerbate poor attachments (Marshall, Laws & Barbaree, 1990). The authors cite evidence that parental rearing practices are the best predictors of juvenile anti-social behaviour and they hypothesise that the essential difference between adolescents who offend in a sexual or non-sexual manner is the degree of severity of intimacy deficits. These authors call for the validation of the hypothesis of intimacy deficits in sex offenders using current measures of attachment.
6.3 Comment on intimacy and sex offending

Marshall et al.'s (1990) argument assumes that intimacy deficits in sex offenders influence the nature of adult sexual relations. This is an intuitively appealing but somewhat 'blanket' hypothesis. In a similar fashion to studies of attachment and sexuality in a normal population, the links between intimacy needs and the many possible sexual behaviours ranging from unusual sexual practices to actual offences are left unclear, as is the process of how attachment and socio-cultural influence may interact. The proposal includes many different forms of intimacy deficit (poor social skills, self esteem, lack of empathy and inappropriate pairing of parental care and sex) all of which require clearer definition of terms with links to Attachment Theory made more explicit. It also discusses how severity of intimacy deficits may discriminate between sexual and violent offending behaviour but does not explain how the degree of intimacy deficit should be measured. It seems that the authors do not use Attachment Theory to its full potential as they simply focus on insecure attachments (i.e., intimacy deficit) rather than the different forms of insecure attachment.

6.4 Studies of the developmental antecedents of sex offending

6.4.1 Sexual vs violent offences

Awad, Saunders and Levine (1984) found sex offenders and violent delinquents to be very similar in terms of violence and sexual deviance in parents, disruptions in parent-child relationships and inadequate parenting but were more likely to be middle class, of low intellectual functioning and to have shown less externalising problems; a finding supported by Kempton and Forehand (1992). These findings were however drawn from clinical interview rather than established measures and they conclude by recognising the tentative nature of the results due to small sample size. Fagan and Wexler (1988) through self report and consultation of official records showed that juvenile sex offenders were more likely to have a history of spousal violence and child physical and sexual abuse than juvenile violent offenders. They were also more sexually and socially isolated, with less sexual interests and activity. The authors describe these boys as a
‘hidden population’ more closely resembling normative populations on a variety of social factors and attitudinal variables and argue that a combination of social isolation and dependence upon abusing care givers breed sexual aggression. Although they call for more specification in theory of how sexual aggression is specifically learned (i.e., the processes of victim selection and associated developmental deficits of impulse control, social isolation and sexual immaturity) their finding suggest that sex offenders have more severely impaired intimacy deficits than violent offenders. These studies highlight the complexity of developmental antecedents to offending and the diversity of measures and methodologies used to assess family variables which militate against conclusive results.

6.4.2 Types of sexual offences

Other studies have compared different types of sexual offenders. Tingle, Barnard, Robbins, Newman, and Hutchinson (1986) completed structured retrospective interviews with rapists and non-violent child molesters in a treatment unit and found ‘conflicts involving aggression’ for rapists and ‘early dependency conflicts’ for the child molesters. They state however, that their results could be confounded by the inclusion of homosexual paedophiles in the child molester group. Saunders, Awad and White (1986) divided adolescent sexual offenders into three groups who had either ‘courtship disorder’ (exhibitionism, toucherism, and obscene phone calls) sexual assault or paedophilic offences. Data gathered from clinical assessments showed that the adolescents in the first group were from less disorganised families than the other two. The second group had had more long term parent-child separations but had better peer relationships than boys in the other two groups and were not so socially isolated. The third group had witnessed more physical violence between parents and had disliked physical affection. They point out that the size of sample, the lack of longitudinal and follow up data and the reliance on correlation do not allow for causal hypotheses around these family characteristics. Freund and Kuban (1994) state preliminary findings that a relationship between self report of child sexual abuse and offending exists for paedophilia but not sex offences in general. Despite the methodological difficulties these studies suggest that family variables may well be important in differentiating
different types of sex offenders but clearly more investigation of the crucial discriminating variables are required.

6.4.3 Prediction of sexual aggression

Kobayishi., Sales, Becker, Figueredo and Kaplan (1995) tested a theoretical model of the aetiology of degree of sexual aggression by adolescents including family factors shown to be important previously i.e., perceived parental deviance, child physical and sexual abuse, and bonding. They found that physical abuse by the father and sexual abuse by males increased sexual aggression by adolescents whereas bonding to the mother decreased it. They argue that these findings fit well with Social Learning Theory and Attachment Theory as maternal support deters the adverse effects of sexual victimisation. Their study however is limited by a simplistic measure of bonding (i.e., a numerical scale of asking the adolescent how important the person is to them) which relies upon a rational answer and does not take account of the psychological defences described by Bowlby.

Prentky, Knight, Sims, Knight, Strauss, Rokous and Cerce (1989) examined the developmental antecedents of sexual and non-sexual aggression in a group of 82 male volunteers in a secure treatment centre for sexual offenders. They sought to predict the severity rather than the frequency of the violence affording this greater importance in terms of discretionary decision making by the courts. They used clinical interviews and archival data to obtain information on four areas previously identified as important in the literature those being; care giver and institutional histories during childhood and early adolescence, physical abuse and child sexual abuse. Institutionalisation and physical abuse were predictive of the severity of non sexual violence whereas care giver inconstancy and sexual deviation of parents and sexual abuse predicted greater sexual aggression. They argue that the effect of sexual deviation and abuse is important in term of modelling behaviour and also must involve a poor relationship with the primary caregiver that engenders low self esteem and hostility, enhancing the potential for anger and aggression in intimate relationships. Although these findings are highly suggestive of the importance of the primary care giving relationship in sexual aggression, the study
is limited to only some types of offending i.e., aggressive sexual attacks and does not differentiate between the types of offenders in the sample. It also focuses on the offence and does not compare sex offenders with those who commit only violent offences. The authors also point out the problems with retrospective self report and the need to examine those subjects with similar histories who did not become sex offenders.

6.5 Comment on the studies of the developmental antecedents of sex offending.

The empirical literature on the developmental experiences of sex offenders is suggestive of impaired attachment bonds combined with the occurrence of sexual abuse in childhood, possibly to a greater degree than for solely violent offenders. However, methodologically the studies are heterogeneous in terms of conceptualisation and operationalisation of developmental variables, choice of subjects, comparison groups and settings in which research was conducted, such that they cannot be seen as mutually supportive. Furthermore, most rely on retrospective self report and hold problems of validity although, the use of archival information modifies this to some extent. As such, it is impossible to draw any firm conclusions as to the psychological variables that may discriminate between non-offenders, violent offenders, and sexual offenders of different types. A more consistent methodology and definition of important developmental variables is required. The discriminatory power of Attachment Theory for sex offending and non-sexual offending and different types of sex offending needs to be tested out by comparing otherwise equally matched subjects on the attachment measures.

7. OTHER THEORETICAL PERSPECTIVES

7.1 Psychodynamic perspectives on sex offending.

Rosen (1979) documents how Freud originally proposed that failure of caretakers to respond appropriately to basic psychosexual needs exacerbates conflicts between the id, ego and super ego leading to ‘fixations’ or discharge of sexual drives towards inappropriate objects. In his early work the ‘perverse’ drive component results from the
real childhood ‘sexual’ trauma of either seduction whereby a ‘hyper libidinization’ occurs and ‘perversions’ are compulsive repetitions of the early trauma and a means of gaining ego mastery over the events. In later work Freud however, reverted to an explanation of the excessive drive being due to an internal excess of instinct not connected to the outer world.

Anechario (1990) documents changes in psychodynamic theorising of the ‘perversions’ with the development of object relations theory, examining particularly the work of Kohut (1977), to focus on the importance of self esteem as the deepest level of concern in human development. Object relations theorists describe how major developmental tasks involve internalisation of self/other representations. In normal development the needs of the self (‘affectionate mirroring, support for healthy assertiveness and the availability of calming idealised others’) are met by an empathic parent. However, if the caregiver fails to respond adequately to these needs, the disorder of ‘narcissism’ develops whereby the self regresses to an earlier grandiose stage of primary narcissism where self and other were undifferentiated and there was an experiences of omnipotence. In this state the gratification of sexual and aggressive drives replaces unavailable self enhancing relationships. Anechario links this theory to the empirical findings of Prentky et al (1989) that severity of sexual aggression is predicted by the degree of traumatising caregiver inconstancy.

Barnard, Hankins and Robbins (1992) in an empirical investigation of these hypotheses document a high incidence of child sexual abuse, current P.T.S.D. symptoms, narcissistic character traits, (shown in a high predominance of Diagnostic and Statistical Manual III cluster B disorders) and multiple forms of sexual deviance in a sample of sex offenders. They argue that narcissistic character traits (of grandiosity, poor self esteem, chronic hostility, poor impulse control, lack of empathy and exploitation of others and aggression) are exacerbated by PTSD symptoms. They argue that narcissism is a possible male response to childhood trauma possibly facilitating sexual offending.

Analysis of cognitive factors operating during sex offending draws parallels with psychodynamic accounts. Ward, Hudson and Marshall (1995) describe how a process of
'cognitive deconstruction' occurs for sex offenders to reduce the negative implications of self awareness. This is a tendency set up in childhood or adolescence to cope with stressful circumstances whereby there is a focus on concrete sensations and the ‘here and now’ as an escape from aversive states. The likelihood of using sexual activity in this state is enhanced as it is a behaviour producing powerful physical reinforcement.

These theories and recent empirical operationalisation of their concepts supports the discussion of attachment as central in the development of sex offending. They also make the links between poor attachment and deviant sexuality, clearer through the idea of narcissism, whereby sexual activity becomes a powerful means of regulating self esteem. Nonetheless, the primary motivations for attachments within theories are somewhat different i.e., self preservation for Bowlby and self esteem per se for object relations theorists. The account of narcissism is similar to Bowlby's account of ‘segregated systems’ of self representations resulting from loss or maltreatment, particularly the pattern described in ‘prolonged absence of grieving ’ whereby emotional detachment and self focus prevails.

Barnard et al (1992) argue that sexual abuse, as an extreme form of childhood trauma, as opposed to deprivation is more likely to lead to narcissism. There is a need to consider whether an attachment framework can integrate sexual abuse as a parental behaviour. This has been considered by Main and Soloman’s (1990) work on ‘frightening’ parental behaviour and ‘disorganised’ attachment in infants, but the specific role of sexual behaviour of parent to child and its possible effects needs to be made more explicit.

8. APPLICATION OF ATTACHMENT THEORY TO THE TREATMENT OF SEX OFFENDERS

Treatment approaches for sex offenders have traditionally focused on behavioural and cognitive aspects of offending by modifying deviant arousal and fantasies, providing social skills training, addressing denial and minimisation of the offence and developing victim empathy; mainly using cognitive behavioural techniques in a group format. Hudson, Marshall, Johnston, Ward and Jones (1995) suggest the effectiveness of these
treatments although effects on long term recidivism rates are notoriously difficult to assess. The recent introduction of relapse prevention techniques (Pithers, 1990) to identify chains of events leading up to offending (including intimacy problems) and prevention strategies have been shown to be effective although evaluation studies are limited (Marshall, Hudson & Ward, 1992). Most authors stress the importance of holistic and multi-modal interventions for sex offenders.

If Attachment Theory is used to conceptualise the interpersonal problems of sex offenders then it could be argued that psychotherapy focusing on relationship issues using an Attachment model as outlined by Fonagy et al (1996) would be a valuable addition to these programmes. The role of a 'reparative' relationship with an empathic and reliable therapist (a secure attachment) has long been emphasised as a key factor in psychotherapy outcome across different models (Holmes, 1993a) to address the effects of maladaptive interpersonal patterns. To address such patterns in a sustained and in-depth way may be particularly pertinent with sex offenders addressing the fundamental psychological basis of social skills deficits, victim empathy deficits and denial; the latter outlined as a key target in sex offender treatment by Laflen and Sturm (1994). The A.A.I. also provides a means of measuring current state of mind with regard to attachment and is sensitive to change in therapy (Fonagy et al, 1996).

The possible difficulties of Attachment therapy with sex offenders needs to be emphasised such as the difficulty of establishing therapist trust in a setting of incarceration. Marshall, Hudson, and Ward (1992) have also emphasised the danger of reducing the responsibility taken by offenders for their offences as a result of exploring their difficult childhood experiences. Much greater research is necessary to establish at what stage of treatment and in what way the attachment needs of sex offenders should be addressed and to highlight any contraindications for any particular kinds of offenders.

9. CONCLUSIONS

This review has emphasised that the empirical study of sex offenders has been plagued by problems of defining homogenous groups and recently developed motivational
typologies have not yet been used in a systematic way. General aetiological theories of sex offending suggest the importance of childhood factors but also point to the complexity of their interactions with other influences and the need for a systematic methodology for investigating them.

Attachment Theory may help to discriminate the psychological features of sex offenders in providing operationalisable constructs of attachment in both infancy and adulthood and a strong ethological rational for the development of disordered interpersonal functioning. There is ample evidence from empirical studies that poor relationships with childhood caregivers are linked to sex offender status. Although methodological difficulties disallowed a cohesive body of research on the key childhood factors for different kinds of offence, empirical investigations have nonetheless been remarkably congruent with theorising from psychodynamic and cognitive perspectives.

The research on adult attachments is however, in its early stages and it is not yet clear whether the Adult Attachment Interview can discriminate stable enduring attachment styles in adulthood. There is also little theoretical understanding of links between sexuality and attachment behaviour and few studies in the normal population of the links between actual sexual behaviours and adult attachment status.

Given that more longitudinal investigations using the A.A.I. are required, a systematic investigation of the current attachment styles of sex offenders could be useful in the following ways;

a) to show whether perceptions of early childhood experiences can discriminate between sexual and non sexual offenders and between different types of sex offenders. Attachment style could be related to the existing motivationally based typologies of sex offenders or to taxonomies based for example, on features of the crime. This could clarify whether certain types of offences have stronger links to attachment status and could investigate the influence of both parents. This could either advance etiologic accounts by operationalising more subtle distinctions in family backgrounds or simply show that poor quality parenting per se is a common factor in the background of the majority of offenders. This would clarify whether
the sexual aspect of offending is a function of some other, perhaps situationally
dependent, transitory factor or more stable sexual tendencies that are not related to
the attachment style of the offender.

b) to investigate whether the current attachment classifications are applicable to an
extremely disordered population and whether further adult classifications need
development and validation.

c) to shed more theoretical light on the links between sexuality, attachment and
aggression.

d) to explore treatment issues. The usefulness of a general etiologic accounts of sex
offending may be limited because of the conceptual and methodological
difficulties in mapping the exact determinants of the offenders state of mind,
before, during and after the offence as well in a therapeutic setting. Attachment
research would however provides a detailed account of the offender’s style of
relating that has therapeutic implications. The status of attachment classification
on the A.A.I. has been shown to be sensitive to therapeutic change (Fonagy, 1996)
and developing a more coherent account of past relationships and how they impact
on current functioning may be a good indication of therapeutic progress in sex
offenders. It would involve confrontation of the offence and an examination of
past relationships, possibly a resolution of the defence mechanisms of denial and
issues of poor interpersonal skills and empathy that render these offenders
continually dangerous.

10. REFERENCES


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Literature review


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Perceptions of behaviour and family relationships in parents and their children with Attention Deficit Hyperactivity Disorder who are treated with medication
1. ABSTRACT

This study examines the correlation between changes occurring in parent’s and clinician’s perceptions of behavioural symptoms of children suffering from ADHD and changes in the child’s perceptions of family relationships due to treatment with stimulant medication. The study also considers the correlation between changes in behaviour and family relationships and the child’s age, initial symptomatology and maternal psychopathology. The study used a pre and post one sample design. Due to the small scale exploratory nature of the study and practical and ethical considerations a control group was not included. Parents and clinicians completed a series of ratings of behaviour and family relationships while children completed the Bene Anthony Family Relations Test prior to and post treatment with the medication. Results showed significant changes in parent’s and clinician’s ratings of the behavioural symptoms of the ADHD children and improvement in home life but there were no significant changes in parents ratings of emotional closeness to their children or in the children’s ratings of family relationships before and after treatment. There was a non-significant trend for children to perceive improvements in relationships with siblings. Significant correlations between measures of improvements in behaviour as rated by parents and measures of improvements in relationships with siblings as rated by children were found. It was concluded that children’s relationships with siblings appeared more amenable to change in accordance with treatment with stimulant medication than relationships with parents.
2. INTRODUCTION

2.1 Definition of Attention Deficit Hyperactivity Disorder (ADHD)

Attention Deficit Hyperactivity Disorder (ADHD) is the term used to describe a common childhood psychiatric disorder with three main groups of symptomatology; overactivity, inattentiveness and impulsiveness as outlined in the Diagnostic and Statistical Manual (DSM) IV (A.P.A., 1994) (see Appendix 1). The International Classification of Diseases (ICD 10) (W.H.O. 1992) describes a similar disorder with slightly more stringent criteria (see Appendix 2).

2.2 Overview

The use of stimulant medication for children diagnosed with ADHD is widespread and has been extensively researched (Schachar & Tannock, 1993, Swanson, McBurnett, Wigal & Pfiffner, 1993). Literature reveals the immediate short term benefits (as perceived by parents, teachers etc.) from such medication. Barkley (1977) showed methylphenidate to be effective in reducing activity and increasing attention to tasks while Schachar, Tannock, Cunningham & Corkam (1997) indicate that core symptoms are improved by medication. This study investigates changes in children’s behaviour and parent’s and children’s perceptions of family relationships that occur when a child is diagnosed with ADHD and is treated with stimulant medication.

2.2.1 Studies of parent-child interactions

Cunningham & Barkley (1979) and Mash & Johnston (1982) found mothers of ADHD children to be more directive, controlling and intrusive, and less responsive to the child’s social interactions, solitary play and compliant behaviour than controls. These kinds of difficulties are reported to be worse for younger children (Mash & Johnston, 1982) but are also apparent in adolescents (Barkley, Fischer, Edelbroch & Smallish, 1990). Johnston (1996) found that parents with hyperactive children described using more negative reactive strategies and fewer positive parenting strategies than a control group even when controlling for commonly associated aggressive and defiant behaviour.
disorder. It has been suggested that the negative interactional style between parents and ADHD children contributes to both the development and severity of the disorder (Jacobitz & Sroufe, 1987; Anderson, Hinshaw & Simmel, 1994). Barkley (1989) suggests that this is a response to the child’s disturbed behaviours since medication improves interactions and parents do not always exhibit similar parenting behaviours with to non-problem children. Marshall, Longwell, Goldstein & Swanson (1990) illustrated that parent’s emotional attitudes towards their children predicted their behaviour in interactions but the child’s degree of aggression did not and they concluded that aggression and conflictual parent child interactions are independent risk factors for long term psychopathology in ADHD.

These studies leave several questions unanswered about the nature of parent-child interactions in ADHD. For example whether disturbed interactions are present when oppositional defiant or aggressive behaviour is controlled for (since the majority of studies included a heterogeneous group of children). Furthermore, ‘interactions’ have been conceptualised and measured differently in different studies. They focus mainly on the mother-child relationship and are limited to parental report or laboratory observation.

2.2.2 Studies of family functioning in ADHD

Early studies of family functioning showed that the ‘emotional climate’ was poorer in families of ADHD children than controls (Hectman, 1981) and Mash & Johnston (1981) reported more sibling conflicts in these families than in controls although, Cunningham, Benness & Siegal (1988) found that control and ADHD families did not differ on measures of communication, problem solving, role allocation, affective responsiveness, affective involvement or general functioning. Lewis (1992) also found no difference in family adaptability, cohesion and family type between control and ADHD groups but within groups found poorer functioning when there were high levels of oppositional defiant behaviour. Schachar & Wachsmuth (1991) found that ADHD children without concurrent conduct problems did not differ from controls on measures of family dysfunction. However, they add a cautionary note that there may be ‘pathology’ in these families which the measure used was not sensitive enough to detect and that as the ADHD children were not medicated they may have had less severe problems than many.
The reported variability in findings could be due to the varying definitions of family functioning used and the mixed groups of children studied. It seems that parent-child interactions are more likely to differ from the norm than more global family measures, possibly suggesting that disturbances are specific to certain family members.

2.2.3 Studies of family relationships in ADHD from the child’s perspective

The child’s perspective on family relationships in ADHD has been considered in only two studies. Cullaty (1993) explored the interpersonal aspect of the environment in boys aged seven to twelve with and without a diagnosis of ADHD using psychological ‘distance maps’. It was found that the ADHD boys overall felt less close to others than controls and there was a significant negative correlation between affective distancing and relational need i.e., the greater the need for closeness the less psychologically close they represented themselves to others. This study however, did not investigate how behaviour change may have affected these feelings. Marshall et al (1990) looked at the emotional attitudes towards each other of ADHD children and their parents using a five minute speech sample rated for Expressed Emotion characteristics to see if this or the level of aggressiveness was associated with negative parent-child interactions. They found that children’s emotional attitudes were not correlated with their interactional behaviour with parents. Parent’s and children’s emotional attitudes were however, highly correlated and they concluded that the lack of correspondence between children’s attitudes and their interactional behaviour was puzzling and may have been due to behaviour difficulties masking more subtle affective cues in measurement. These studies indicate that interpersonal relationships from the children’s point of view may be disturbed and that children’s attitudes are related to their parent’s attitudes. This supports the importance of investigating whether or not children perceive changes in interpersonal relationships as a result of medication use.

2.2.4 Studies of factors affecting family functioning.

Poorer family functioning has been related to the increasing age of the child and to higher levels of parent perceived impulsivity and hyperactivity, regardless of medication status or the child’s aggression (Lewis-Abney, 1993). Parental stress, which may be seen to be an indicator of how well a family copes with ADHD, has been found to be
predicted by parental psychopathology, severity of ADHD and levels of oppositional
defiant behaviour and child and maternal health status (Anastopoulos, Guevremony,
Shelton & Du Paul, 1992). It seems therefore that certain child and parental
characteristics worsen the family situation in ADHD.

2.2.5 Studies of parental and demographic characteristics

Literature illustrates that certain parental characteristics are more common in families
affected by ADHD such as, maternal depression (Befera & Barkley, 1985; Cunningham,
Benness & Siegal, 1988; Johnston, 1996) although not in comparison with other clinic
referred children (Frick, 1994), low self esteem, feelings of guilt, social isolation (Mash
& Johnston, 1983), more separations from their children (Schachar & Wachsmuth,
1991), lower socio economic status (Hartsough & Lambert, 1982) and more residence in
overcrowded homes (Sandberg, Rutter & Taylor, 1978). The occurrence of these
features in ADHD families supports the likelihood of disturbed interactions although the
direction of effects of the variables remains unclear.

2.2.6 Studies of the use of stimulant medication

In the limited studies where long term outcomes are mentioned both researchers and
practitioners are unanimous about the importance of combining medication with other
forms of intervention (Hinshaw, 1994; Swanson et al 1993). Long term behavioural
prognosis in ADHD has been shown to be more strongly related to initial defiance,
aggressiveness and family dysfunction than to initial overactivity and inattentiveness
(Loney, Kramer & Milich, 1981) which may explain why the use of medication to treat
overactivity and inattentiveness appears to have no marked long term impact when used
alone. Weiss, Kruger, Danielson & Elman (1975) found that academic performance,
positive adjustment and the absence of anti-social behaviour in ADHD was related to
family functioning in a group of children receiving stimulant medication. While in a
longitudinal follow-up study, ‘family fights’ were most frequently cited as contributing
to children’s difficulties (Hectman & Weiss, 1983). Schachar, Taylor, Weiselberg,
Thorley & Rutter (1987) argue that the evident importance of family functioning in the
prognosis for ADHD is an important reason for further investigating the effects of
stimulant medication use upon it.
2.2.7 Studies of the effects of medication on family functioning

Humphries, Kinsbourne & Swanson (1977) and Barkley & Cunningham (1979) illustrated the beneficial effects of medication in experimental situations on mother-child interactions. These included more frequent compliance, reduced off-task behaviour in children, a decrease in frequency of commands and more positive response to child initiated behaviours in parents.

Schachar et al (1987) refined these investigations into a more natural setting. They found, when children responded to medication (as defined by a 50% decrease on parent and teacher hyperactivity ratings) there was a significant increase in expressed maternal warmth, less expressed maternal criticism, greater frequency of contacts between mother and child and a non significant trend towards fewer negative encounters between children and siblings in the family. These were measured by ratings of parental interviews. The use of a placebo condition in their investigations indicated that these changes were not simply due to parental expectations or to changed perceptions as a result of having a medical diagnosis for their child. However, this study used a quasi-experimental design, administering medication in a structured way at home over a three week period that differed from medication use in common clinical practice which usually limits medication use to school hours. When Schachar, Tannock, Cunningham & Corkum (1997) assessed the behavioural effects of four months of methylphenidate treatment using the standard clinical practice they found that medication improved symptoms of ADHD and oppositional behaviour at school but not at home and that parents reported more side effects than teachers. It therefore remains unclear exactly how much effect medication may have on family relationships in normal clinical practice although these previous studies indicate the likelihood of improvement.

2.3 Present Study

2.3.1 Overview

The present study examines whether behavioural changes brought about by medication are related to changes in family relationships as measured from the child’s perspective. The study focuses specifically on emotional attitudes within the family. Additionally,
the paper will investigate whether some parental and child characteristics affect these perceptions of change in behaviour and emotional attitudes after medication, given that certain characteristics have been shown to be associated with poorer family functioning in ADHD.

2.3.2 The importance of considering the child’s perceptions of family relationships

The British Psychological Society now places some confidence in the revised diagnostic category of ADHD according to DSM IV (British Psychological Society, 1996). They highlight the need for ‘multi level interventions’ in ADHD, implicating the family as a crucial arena for managing the difficulties. The extensive use of stimulant medication raises important questions about which kinds of families are amenable to change as a result of the behavioural changes brought about by medication and which require more complex interventions. Maternal depression for example, has been shown to be a powerful intervening variable in how children are perceived (Brody & Forehand, 1986; Freidlander, Weiss & Taylor, 1986) and may limit the improvements that are possible in families as a result of behaviour changes in children.

Almost all previous research on family functioning in ADHD has taken a ‘top down’ perspective focusing on either parental reports of behaviour or researchers observations of interactions. This study adds a ‘bottom up’ view i.e., exploring the child’s perspective. Obtaining the child’s perspective on family relationships was felt to be useful in order to assess the agreement between parental and child opinions of family functioning as this may have therapeutic implications. Social Learning Theory (Bandura, 1977) predicts that parental and child perceptions of relationships would be related, probably more so in the younger age group.

2.3.3 Theoretical Support of Proposed Hypotheses

The research hypotheses of this study, propose that behaviour change would be associated with changes in relationships as perceived by children and parents and is supported by General Systems Theory (Von Bertallanfy, 1968) which predicts that a change in the family (i.e., a significant change in the child’s behaviour and the addition of information about the child’s difficulties as a result of diagnosis and stimulant usage)
would be reflected by a change in the family's patterns of relating which should be
discernible by both the child and the parents. Attachment Theory (Bowlby, 1969) also
predicts that a change in the behavioural and affective interchanges (such as those likely
to be brought about by a change in the child's behaviour with stimulant medication)
between parent and child would lead to a change in the child's internal representations
of relationships with significant others in the family. Attachment may also be more
malleable in the younger age group but Bowlby is optimistic about change in
attachments occurring across the life cycle.

Subsidiary hypotheses, supported by Piagetian Theory, suggest that changes in
behaviour and emotional attitudes would be more likely in younger children. Piagetian
Theory predicts that the relative egocentrism and less sophisticated reflexive abilities of
younger children results in them having less stable internal representations of self and
family members or that schema and changes in these internal representation or schemes
would be more closely tied to the behavioural changes (Piaget, 1932).

2.3.4 Research Hypotheses.

There were four main hypotheses on the effects medication would have on a family with
an ADHD child:

a) **HYPOTHESIS 1:** There would be a decrease in the child's behaviour
symptoms measured by the Conners' Parents Rating Scale (CPRS) (Goyette,
Conners & Ulrich, 1978), the Home Situations Questionnaire (HSQ) (Barkley &
Edelbrock, 1987) (see Appendix 3) and the Children's Global Assessment Scale
(see Appendix 4)

b) **HYPOTHESIS 2:** There would be an improvement in parental perceptions of
family relationships measured on Likert scales;

c) **HYPOTHESIS 3:** There would be an improvement in the child's perceptions
of family relationships particularly in terms of enhanced mother-child relationship
and child-sibling relationships measured by the Bene Anthony Family Relations
(BAFR) Test (Bene & Anthony, 1985); (see Appendix 5).
d) **HYPOTHESIS 4**: Child behaviour changes as perceived by clinicians and parents would be related to improvements in family relationships as perceived by children and parents i.e., there would be a positive correlation between change ratings.

2.3.5 Subsidiary hypotheses

a) **HYPOTHESIS 5**: Child characteristics would affect change on these measures in-particular, there would be more change in younger children and more change in those children with initial lower impulsivity and conduct problems.

b) **HYPOTHESIS 6**: Parental characteristics would affect change on the measures behaviour i.e., changes in maternal psychopathology as measured by the General Health Questionnaire (GHQ) (Goldberg & Williams, 1988) (see Appendix 3) would be related to changes on these measures.

3. METHOD

3.1 Subjects

The children in the study were referred to Chichester Child and Family Mental Health Services having been diagnosed as having ADHD and consequently prescribed a course of stimulant medication. Fourteen children were assessed before and after a ten week course of stimulant medication. Ten weeks was the routine time between initial prescription of a gradually increasing dose of medication and follow-up. For all children in this study this treatment was the first to use stimulant medication although they may have had other treatment from the service or contact with educational psychology services. Children with learning difficulties or a diagnosis of language disorder were excluded. Informed consent was obtained from parents (see Appendix 6) The child was assured confidentiality concerning his test statements unless there were concerns that he or she was at risk (H.M.S.O. 1989). Ethical approval was gained from the local research ethical committee (see Appendix 7).
3.2 Measures

3.2.1 Diagnostic assessment

Only those children with a score of greater than fifteen in the Abbreviated Symptoms Questionnaire (ASQ) of the CPRS were seen at the ADHD clinics (Goyette et al, 1978). This criteria has been suggested as a useful indicator of clinical hyperactivity in local clinical guidelines. If the children were then diagnosed as having ADHD by the Consultant Psychiatrist, Paediatric Registrar or Consultant Clinical Psychologist according to ICD 10 clinical criteria (WHO 1992), medication was discussed with parents. The fact that children satisfied these criteria meant that they met the criteria for the DSM IV subtype of ADHD with combined features of inattention and hyperactivity.

3.2.2 Demographic information.

At follow-up the primary caregiver was given a questionnaire asking them to describe family structure, parental employment status, child and parent major medical problems and any positive or negative stresses occurring in either the six months prior to or during the two months of medication (see Appendix 3). Any previous contact with services (clinic, social services or educational psychology services) was noted. At initial assessment and follow-up the primary caregiver completed the 28 item version of the GHQ to screen for significant psychopathology. GHQ scoring giving a cut off of 4/5 for psychopathology was used, as recommended by Goldberg & Hillier (1979) and Goldberg & Williams (1988). The GHQ was selected to provide both an overall measure of psychiatric difficulties as well as a more specific depression subscale.

3.2.3 Measures of child’s behaviour

3.2.3.1 Interviewing clinician

The clinician gave each child a rating on the CGAS (Schaffer et al, 1983) at initial and follow-up appointments as a measure of the child’s overall severity of disturbance and adequacy of social functioning. Evaluation studies have shown that the CGAS is reliable across raters ($r=0.84$) and over time ($r=0.85$) and demonstrates good discriminant validity i.e., between inpatient and outpatients ($p=0.01$). It was thought
that the measure would minimise the variance in this study due to having three different clinicians rating the group of children. The clinicians ratings were blind to the child's scores on the Family Relations test and the second rating was given blind to the first.

3.2.3.2 Primary caregiver

The primary caregiver completed the CPRS (Goyette et al, 1978). This scale is a more simple version of the previous 93 item scale that was developed to aid in the identification of hyperactive children and to evaluate treatment effectiveness (Conners, 1969, 1970, 1973) It has good test-retest reliability (r=0.70-0.90, based on teachers questionnaire) and discriminates between normal and hyperactive children (Conners 1970). It has a structure of five factors (conduct problems, learning problems, psychosomatic problems, impulsivity/hyperactivity, and anxiety) with adequate inter-rater reliability between parents and teachers. Of particular interest were the conduct and impulsivity/hyperactivity subscales as the dimensions most relevant to ADHD. Scores on the ten items of the Hyperkinesis Index or ASQ (Conners, 1973) were also included in the analysis as this scale has been shown repeatedly to be sensitive to treatment effects (Sprague & Sleator, 1973) with correlations of 0.94 to the hyperactivity factor and 0.92 to other factors (Werry, Sprague & Cohen, 1975).

The primary caregiver completed the HSQ (Barkley & Edelbrock, 1987) which asks parents to rate compliance in a range of home settings and provides a mean severity score and a score of number of problematic settings. The measure has test retest reliabilities of 0.62 for mean severity score and 0.66 for number of settings and good discriminant and concurrent validity.

3.2.4 Measures of family functioning

3.2.4.1 Primary caregiver

The primary caregiver was asked to rate on a ten point scale the level of emotional closeness felt towards the child before and after medication. This pragmatic measure was used because more reliable measures of attachment were too lengthy to include in this study. Parents were also asked to rate on a five point scale how much they felt home life had improved since the child had been on medication (see Appendix 3).
3.2.4.2 Child

Children completed the BAFR Test (Bene & Anthony 1985) with the researcher immediately after the initial clinic interview and follow up interview. This test has shown acceptable test-re-test reliability (for example r=0.87 for positive items, r=0.59 for negative items) (Kaufman, Weaver & Weaver, 1972) and validation studies have shown it to discriminate between clinical and non clinical groups of children (Philip & Orr, 1978). Children’s responses to the test have also been shown to reflect independent assessment of both parents feelings towards them (Bene & Anthony, 1985). The test requires the child to classify descriptions of various behavioural and emotional interactions according to whom they occur most commonly with in the family. This results in overall ratings of outgoing and incoming, positive and negative feelings towards each family member. Total positive and negative feelings within the family as a whole were calculated and incoming positive and negative feelings towards the child were obtained as a total as it was felt that these summary scores would provide an indication of the child’s emotional well-being.

3.3 Description of sample

3.3.1 Characteristics of children

The ages of the children ranged from 6 to 12 (mean 9), two being female. The number of siblings ranged from 0-5 (mean 2.7). Three (of fourteen) parents reported major medical problems in their children in the past, while one reported major medical problems in a sibling. Ten of the children had previous contact with either the clinic, social services or educational psychology services. None had been previously seen in an ADHD clinic, received a diagnosis or prescribed stimulant medication. Mean pre-treatment scores on the impulsive/hyperactive and conduct subscales of the CPRS questionnaires were as follows; hyperactivity 2.45 (s.d. 0.64, range 0.5-3.0); conduct problems 1.73 (s.d. 0.67, range 0.63-2.88). Both were greater than two standard deviations above the mean in a non-clinical sample aged 6-8 and 9-11 (Goyette et al, 1978).
3.3.2 Characteristics of parents

In all cases the primary caretaker and informant on behaviour was the mother. Five out of fourteen fathers attended the clinic with the mother and child. Three of the families had a stepfather and three were single parent families. Seven out of fourteen of the mothers worked either part or full time and all of the fathers were employed. Eight out of the fourteen primary caretakers said that they were responsible for disciplining the child on their own and six said that this was a joint responsibility. Eight out of fourteen mothers reached the threshold for psychiatric caseness on the GHQ at initial appointment and three of these dropped below the threshold at the follow-up appointment. Eleven out of fourteen identified positive or negative stresses in the six months leading up to the initial appointment and at follow-up nine out of fourteen identified stresses during the past two months. No parents reported any major medical problems.

All the children except one who was seen at home, were interviewed at the clinic. Eight out of fourteen were seen at the clinic for follow-up and six were seen at school. All the parents completed the questionnaires whilst at the clinic following their appointments.

3.3.3 Excluded families

Three families were excluded due to the child having significant learning difficulties. A total of seventeen families opted to try medication in the time of the study and all agreed to participate in the study. Three of these families were not assessed at follow up as one stopped medication of their own accord and did not reattend, another was forced to change their follow up assessment beyond the deadline for the study and one family declined to fill in the questionnaires at follow up.

3.4 Statistical Analysis

3.5 Tests used

All data analysis was performed using the Statistical Package for the Social Sciences (SPSS). Change on each variable before and after medication was assessed using Wilcoxon Matched Pairs Signed Ranks (WMPSR) Tests as the most appropriate non
parametric test for a repeated measures design. Non-parametric tests were used in order to be conservative given that from this small sample it was difficult to judge population parameters i.e., whether they would conform to a normal distribution.

An improvement score for each variable measured before and after medication was calculated. On the Family Relations Test improvement was classed as a either a decrease in negative feelings towards family members or an increase in positive feelings toward family members. The association between improvement scores was assessed using Spearman's non-parametric correlation coefficients (r). The relationship between change on measures of perceptions of behaviour and family life and the child's age, initial conduct problems, initial hyperactivity and changes in maternal psychopathology were also examined in this way. Two tailed significance values were calculated to minimise the increased chance of a type two error given the large number of correlations calculated and to allow for the possibility of a result in an unexpected direction. Correlations are discussed as clinically meaningful if of a magnitude greater than 0.45 even if the small numbers in the study prevented them from reaching statistical significance (Bellack & Hersen, 1984).

3.6 Power calculation

Required sample size for this repeated measures design was estimated based on key measures used in the study i.e., the CPRS and the BAFRT. Calculations based on mean values from a previous studies of drug effects using the Conners ASQ scale, suggested an effect size of 0.54, requiring 18 subjects to give a conventionally acceptable statistical power of 70%. For the Family Relations Test effect size of 0.70 was estimated based on means from a normative and clinical group, thus requiring 10 subjects for similar statistical power (Chmura Kraemer & Thiemann 1987).

The actual sample size (14) meant that there was a 70% chance of detecting correlations between measures only of a magnitude of 0.6 or greater.
4. RESULTS

4.1 Research Hypotheses

Notes for all tables

1. * denotes significant at or = the 0.05 level
2. ** denotes significant at or = the 0.01 level

4.1.1 Hypothesis 1

HYPOTHESIS: There would be a decrease in parent’s and clinician’s perceptions of behaviour symptoms pre and post medication.

4.1.1.1 Changes in parent’s perceptions of child’s behaviour

Table 1.  
WMPSR test for parents ratings of behaviour

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre medication</th>
<th>Post medication</th>
<th>z score</th>
<th>p value - two tailed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>s.d.</td>
<td>Mean</td>
<td>s.d.</td>
</tr>
<tr>
<td>Conners' ASQ</td>
<td>22.23</td>
<td>5.75</td>
<td>13.43</td>
<td>8.72</td>
</tr>
<tr>
<td>Conners' conduct subscale</td>
<td>13.85</td>
<td>5.35</td>
<td>8.25</td>
<td>5.45</td>
</tr>
<tr>
<td>Conners' impulsivity/hyperactivity subscale</td>
<td>9.79</td>
<td>2.58</td>
<td>6.21</td>
<td>3.85</td>
</tr>
<tr>
<td>HSQ Mean Severity Score</td>
<td>5.64</td>
<td>1.87</td>
<td>4.05</td>
<td>1.93</td>
</tr>
<tr>
<td>HSQ Number of settings</td>
<td>12.57</td>
<td>3.65</td>
<td>10.50</td>
<td>4.54</td>
</tr>
</tbody>
</table>

Table 1 shows that there were significant improvements between initial and review appointments on all of the parent’s ratings of their child’s behaviour except for the number of settings on the HSQ.
4.1.1.2 Changes in clinicians perceptions of behaviour

Table 2. *WMPSR test for clinician’s ratings of behaviour*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre medication</th>
<th>Post medication</th>
<th>z score</th>
<th>p value - two tailed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>s.d.</td>
<td>Mean</td>
<td>s.d.</td>
</tr>
<tr>
<td>CGAS</td>
<td>48.36</td>
<td>7.46</td>
<td>57</td>
<td>9.03</td>
</tr>
</tbody>
</table>

Table 2 shows that there was a significant improvement in the children’s scores on this measure between initial and review appointments as rated by clinicians based on parental reports from the interviews.

4.1.2 Hypothesis 2

HYPOTHESIS: There would be a change in parents perceptions of family relationships measured pre and post medication.

Table 3. *WMPSR Test for parents ratings of family relationships*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre medication</th>
<th>Post medication</th>
<th>z score</th>
<th>p value - two tailed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent’s rating of emotional closeness</td>
<td>5.92</td>
<td>2.66</td>
<td>6.07</td>
<td>3.20</td>
</tr>
</tbody>
</table>

There was no significant change in parents ratings of how close they felt towards their child between initial and follow-up appointments as shown in Table 3. After their follow-up appointments two (14%) of the parents said that there had been no improvement in home life since their child had been on medication, eight (57%) said there had been some improvement in home life while only four (28%) said that there had been a good deal of improvement.
4.1.3 Hypothesis 3

HYPOTHESIS: There would be a change in children’s perceptions of family relationships pre and post medication particularly in terms of improved mother-child relationships and child-sibling relationships.

Table 4.  
WMPSR test for children’s ratings of family relationships

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre medication</th>
<th>Post medication</th>
<th>z score</th>
<th>p value - two tailed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>s.d.</td>
<td>Mean</td>
<td>s.d.</td>
</tr>
<tr>
<td>Positives re. father</td>
<td>8.73</td>
<td>6.17</td>
<td>9.91</td>
<td>9.08</td>
</tr>
<tr>
<td>Negatives re. father</td>
<td>8.09</td>
<td>7.87</td>
<td>9.00</td>
<td>6.97</td>
</tr>
<tr>
<td>Positives re. mother</td>
<td>14.14</td>
<td>7.68</td>
<td>15.07</td>
<td>8.86</td>
</tr>
<tr>
<td>Negatives re. mother</td>
<td>6.21</td>
<td>6.84</td>
<td>5.57</td>
<td>4.62</td>
</tr>
<tr>
<td>Positives re. siblings</td>
<td>16.67</td>
<td>16.56</td>
<td>20.58</td>
<td>16.81</td>
</tr>
<tr>
<td>Negatives re. siblings</td>
<td>16.67</td>
<td>9.29</td>
<td>11.83</td>
<td>9.18</td>
</tr>
<tr>
<td>Incoming positives</td>
<td>18.14</td>
<td>13.89</td>
<td>18.86</td>
<td>13.64</td>
</tr>
<tr>
<td>Incoming negatives</td>
<td>12.07</td>
<td>4.20</td>
<td>10.29</td>
<td>4.79</td>
</tr>
<tr>
<td>Total positives</td>
<td>35.29</td>
<td>19.23</td>
<td>40.50</td>
<td>27.17</td>
</tr>
<tr>
<td>Total negatives</td>
<td>26.86</td>
<td>8.42</td>
<td>22.79</td>
<td>11.23</td>
</tr>
</tbody>
</table>

There were no significant changes in the children’s perceptions of family relationships between initial and follow-up appointments in terms of negative and positive feelings towards parents or siblings or overall negative and positive feelings. There were no changes in the child’s perception of incoming positive and negative feelings. There was however, a non-significant trend towards a decrease in negative feelings towards siblings (see Table 4).

4.1.4 Hypothesis 4

HYPOTHESIS: Behavioural improvement as perceived by clinicians and parents would be related to changes in family relationships as perceived by parents and children.
4.1.4.1 Relationship between clinician’s ratings of improvements in behaviour and parent’s ratings of improvement in behaviour and home life/family relationships.

Table 5. Correlations between improvements on CGAS and parents ratings of improvements in behaviour and family life

<table>
<thead>
<tr>
<th>Measure</th>
<th>Spearman’s correlation coefficient with CGAS</th>
<th>p value - two tailed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conners’ ASQ score</td>
<td>0.43</td>
<td>0.16</td>
</tr>
<tr>
<td>Conners’ conduct problems subscale</td>
<td>0.48</td>
<td>0.10</td>
</tr>
<tr>
<td>Conners’ impulsivity/hyperactivity subscale</td>
<td>0.58</td>
<td>0.03*</td>
</tr>
<tr>
<td>HSQ Mean severity score</td>
<td>0.76</td>
<td>0.00**</td>
</tr>
<tr>
<td>HSQ Number of Settings</td>
<td>0.58</td>
<td>0.03*</td>
</tr>
<tr>
<td>Parents rating of emotional closeness</td>
<td>-0.02</td>
<td>0.94</td>
</tr>
<tr>
<td>Parents rating of improvement in home life</td>
<td>0.69</td>
<td>0.01**</td>
</tr>
</tbody>
</table>

There were significant correlations between improvement on the clinician’s rating on the CGAS and the parent’s ratings of improvement on some behaviour measures namely the Conners’ impulsivity/hyperactivity subscale and the compliance measure (HSQ). The improvement in the clinician’s rating was also significantly related to the parent’s rating of improvement in home life. There were moderately high non-significant correlations between improvements on the clinician’s rating and the parent’s Conners’ conduct subscale ($r=0.48, p=0.10$). Contrary to the prediction there was no correlation between improvement on the clinician’s rating and the parent’s ratings of emotional closeness.
4.1.4.2 Relationship between parents ratings of improvements in behaviour and parents ratings of improvements in home life/family relationships.

Table 6. Correlations between parents ratings of improvements in behaviour and parents ratings of improvements in home life

<table>
<thead>
<tr>
<th></th>
<th>Conners'</th>
<th></th>
<th>HSQ</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ASQ score</td>
<td>Conduct problems subscale</td>
<td>Impulsivity /hyperactivity subscale</td>
</tr>
<tr>
<td>Improvement</td>
<td>r 0.57</td>
<td>0.72</td>
<td>0.64</td>
</tr>
<tr>
<td></td>
<td>p 0.05*</td>
<td>0.01**</td>
<td>0.01*</td>
</tr>
<tr>
<td>Emotional closeness</td>
<td>r 0.08</td>
<td>0.55</td>
<td>0.24</td>
</tr>
<tr>
<td></td>
<td>p 0.79</td>
<td>0.06</td>
<td>0.43</td>
</tr>
</tbody>
</table>

There were significant correlations between parents ratings of improvements in behaviour on all of the Conners' scales and the compliance scale (HSQ mean severity score) and their ratings of improvement in home life. There was a moderately high non-significant correlation between improvement in the number of settings where compliance was a problem and parent's ratings of improvement in home life ($r=0.49, p=0.08$).

Contrary to the prediction there were no significant relationships between improvement on any of the parent's behaviour measures and parent's ratings of improvements in emotional closeness however there was however a moderately high non-significant correlation between improvement in ratings of conduct problems and improvements in ratings of emotional closeness ($r=0.55, p=0.06$).
4.1.4.3 Relationship between clinician’s and parent’s ratings of improvements in behaviour and home life/family relationships and children’s ratings of improvements in family relationships.

Table 7. Correlations between parent’s ratings of improvements in behaviour and home life and children’s ratings of improvements in family relationships

<table>
<thead>
<tr>
<th></th>
<th>Conners'</th>
<th></th>
<th>HSQ</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ASQ score</td>
<td>Conduct subscale</td>
<td>Impulse/hyperactivity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>subscale</td>
</tr>
<tr>
<td>Positives re. father</td>
<td>r -0.21</td>
<td>0.43</td>
<td>-0.22</td>
</tr>
<tr>
<td></td>
<td>p 0.60</td>
<td>0.24</td>
<td>0.54</td>
</tr>
<tr>
<td>Negatives re. father</td>
<td>r 0.00</td>
<td>-0.15</td>
<td>-0.10</td>
</tr>
<tr>
<td></td>
<td>p 1.00</td>
<td>0.71</td>
<td>0.78</td>
</tr>
<tr>
<td>Positives re. mother</td>
<td>r 0.32</td>
<td>0.26</td>
<td>0.22</td>
</tr>
<tr>
<td></td>
<td>p 0.30</td>
<td>0.42</td>
<td>0.48</td>
</tr>
<tr>
<td>Negatives re. mother</td>
<td>r -0.12</td>
<td>-0.34</td>
<td>-0.33</td>
</tr>
<tr>
<td></td>
<td>p 0.72</td>
<td>0.28</td>
<td>0.28</td>
</tr>
<tr>
<td>Positives re. siblings</td>
<td>r -0.10</td>
<td>0.03</td>
<td>-0.05</td>
</tr>
<tr>
<td></td>
<td>p 0.79</td>
<td>0.93</td>
<td>0.88</td>
</tr>
<tr>
<td>Negatives re. siblings</td>
<td>r 0.75</td>
<td>0.55</td>
<td>0.57</td>
</tr>
<tr>
<td></td>
<td>p 0.01</td>
<td>0.10</td>
<td>0.07</td>
</tr>
<tr>
<td>Incoming positives</td>
<td>r 0.39</td>
<td>0.43</td>
<td>0.45</td>
</tr>
<tr>
<td></td>
<td>p 0.21</td>
<td>0.17</td>
<td>0.12</td>
</tr>
<tr>
<td>Incoming negatives</td>
<td>r 0.44</td>
<td>0.13</td>
<td>0.15</td>
</tr>
<tr>
<td></td>
<td>p 0.15</td>
<td>0.69</td>
<td>0.64</td>
</tr>
<tr>
<td>Total positives</td>
<td>r 0.06</td>
<td>0.17</td>
<td>0.03</td>
</tr>
<tr>
<td></td>
<td>p 0.85</td>
<td>0.60</td>
<td>0.93</td>
</tr>
<tr>
<td>Total negatives</td>
<td>r 0.46</td>
<td>0.20</td>
<td>0.26</td>
</tr>
<tr>
<td></td>
<td>p 0.13</td>
<td>0.52</td>
<td>0.39</td>
</tr>
</tbody>
</table>

a) Parents: Improvements in children’s ratings of relationships specifically with parents were not significantly related to clinician’s or parent’s ratings of improvements on any of the behaviour measures. The primary caregiver’s ratings of improvements in emotional closeness were related to an increase in negative
feelings expressed towards the mother by the child ($r = -0.53, p=0.06$) and to an increase in negative feelings expressed towards the father by the child ($r = -0.51, p=0.13$). These relationships were approaching significance but were in the opposite direction to prediction.

b) **Siblings:** Improvements in negative feelings towards siblings were significantly related to parent's ratings of improvements in hyperactivity on the Conners' items from the ASQ. There were also moderately high non-significant correlations between improvements in negative feelings towards siblings and parents' ratings of improvements on the Conners' conduct problems subscale ($r = 0.55, p=0.09$) and hyperactivity/impulsivity subscales ($r = 0.56, p=0.07$) respectively.

c) **Summary measures:** Improvement in the child's rating of overall incoming positive feelings was significantly related to parents' ratings of improvement in compliance measured on the HSQ. There was a moderately high non-significant correlation between improvement in the level of total negative feelings expressed by the child and parents' ratings of improvements in hyperactivity on the Conners' items of the ASQ ($r = 0.46, p=0.133$).

### 4.2 Subsidiary hypotheses

#### 4.2.1 Hypothesis 5

**HYPOTHESIS:** There would be more change in behaviour and relationships in younger children and more change in those children with initially less severe hyperactivity/impulsivity and conduct problems.
4.2.1.1 Relationship between parents perceptions of improvements in behaviour and family relationships and child's age, initial severity of conduct and impulsivity/hyperactivity problems.

Table 8. Correlations between child's age, initial severity of conduct, initial impulsivity/hyperactivity problems, change in maternal psychopathology and change in maternal depression and parent's perceptions of improvements in behaviour and home life

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>Initial conduct problems</th>
<th>Initial impulsivity/hyperactivity problems</th>
<th>Change in maternal psychopathology</th>
<th>Change in maternal depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conners' ASQ score</td>
<td>r</td>
<td>-0.44</td>
<td>-0.25</td>
<td>-0.12</td>
<td>-0.15</td>
</tr>
<tr>
<td></td>
<td>p</td>
<td>0.15</td>
<td>0.42</td>
<td>0.73</td>
<td>0.64</td>
</tr>
<tr>
<td>Conners' conduct problems subscale</td>
<td>r</td>
<td>-0.31</td>
<td>0.12</td>
<td>-0.14</td>
<td>0.21</td>
</tr>
<tr>
<td></td>
<td>p</td>
<td>0.23</td>
<td>0.69</td>
<td>0.64</td>
<td>0.53</td>
</tr>
<tr>
<td>Conners' impulsivity/hyperactivity subscale</td>
<td>r</td>
<td>-0.41</td>
<td>0.00</td>
<td>0.06</td>
<td>0.02</td>
</tr>
<tr>
<td></td>
<td>p</td>
<td>0.14</td>
<td>0.10</td>
<td>0.83</td>
<td>0.93</td>
</tr>
<tr>
<td>HSQ Mean Severity</td>
<td>r</td>
<td>-0.51</td>
<td>0.14</td>
<td>0.08</td>
<td>0.28</td>
</tr>
<tr>
<td></td>
<td>p</td>
<td>0.06</td>
<td>0.64</td>
<td>0.76</td>
<td>0.37</td>
</tr>
<tr>
<td>HSQ Number of Settings</td>
<td>r</td>
<td>0.02</td>
<td>0.26</td>
<td>-0.10</td>
<td>0.27</td>
</tr>
<tr>
<td></td>
<td>p</td>
<td>0.96</td>
<td>0.39</td>
<td>0.73</td>
<td>0.38</td>
</tr>
<tr>
<td>Improvement</td>
<td>r</td>
<td>-0.34</td>
<td>0.02</td>
<td>0.08</td>
<td>-0.12</td>
</tr>
<tr>
<td></td>
<td>p</td>
<td>0.23</td>
<td>0.95</td>
<td>0.76</td>
<td>0.71</td>
</tr>
<tr>
<td>Emotional closeness</td>
<td>r</td>
<td>-0.17</td>
<td>0.13</td>
<td>-0.33</td>
<td>-0.18</td>
</tr>
<tr>
<td></td>
<td>p</td>
<td>0.59</td>
<td>0.67</td>
<td>0.27</td>
<td>0.56</td>
</tr>
</tbody>
</table>

There was a negative correlation between the child’s age and improvement in compliance on the HSQ that was approaching significance ($r=-0.51, p=0.06$). There was no relationship found between improvement on any of the other behaviour measures and the child’s age.

There were no relationships between initial severity of problems and improvement on any of the parent’s ratings of improvement in behaviour or home life.
4.2.1.2 Relationship between the child’s perceptions of improvements in family relationships and the child’s age, and initial severity of conduct and hyperactivity/impulsivity problems.

Table 9. Correlations between child’s age, initial severity of conduct, initial impulsivity/hyperactivity problems, change in maternal psychopathology and change in maternal depression with the child’s perception of improvement in family relationships

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>Initial conduct problems</th>
<th>Initial impulsivity/hyperactivity problems</th>
<th>Changes in maternal psychopathology</th>
<th>Changes in maternal depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positives re. father</td>
<td>r 0.13</td>
<td>0.66</td>
<td>-0.07</td>
<td>0.79</td>
<td>0.51</td>
</tr>
<tr>
<td></td>
<td>p 0.73</td>
<td>0.05*</td>
<td>0.85</td>
<td>0.01**</td>
<td>0.16</td>
</tr>
<tr>
<td>Negatives re. father</td>
<td>r 0.37</td>
<td>-0.18</td>
<td>0.12</td>
<td>-0.31</td>
<td>-0.32</td>
</tr>
<tr>
<td></td>
<td>p 0.28</td>
<td>0.65</td>
<td>0.73</td>
<td>0.41</td>
<td>0.41</td>
</tr>
<tr>
<td>Positives re. mother</td>
<td>r -0.04</td>
<td>-0.08</td>
<td>-0.37</td>
<td>0.35</td>
<td>0.41</td>
</tr>
<tr>
<td></td>
<td>p 0.90</td>
<td>0.80</td>
<td>0.22</td>
<td>0.26</td>
<td>0.18</td>
</tr>
<tr>
<td>Negatives re. mother</td>
<td>r 0.30</td>
<td>0.16</td>
<td>0.29</td>
<td>-0.18</td>
<td>-0.04</td>
</tr>
<tr>
<td></td>
<td>p 0.32</td>
<td>0.61</td>
<td>0.33</td>
<td>0.57</td>
<td>0.90</td>
</tr>
<tr>
<td>Positives re. siblings</td>
<td>r 0.15</td>
<td>0.47</td>
<td>-0.01</td>
<td>0.49</td>
<td>0.28</td>
</tr>
<tr>
<td></td>
<td>p 0.65</td>
<td>0.17</td>
<td>0.98</td>
<td>0.15</td>
<td>0.42</td>
</tr>
<tr>
<td>Negatives re. siblings</td>
<td>r -0.22</td>
<td>0.04</td>
<td>-0.10</td>
<td>0.42</td>
<td>0.57</td>
</tr>
<tr>
<td></td>
<td>p 0.52</td>
<td>0.91</td>
<td>0.77</td>
<td>0.23</td>
<td>0.08</td>
</tr>
<tr>
<td>Incoming positives</td>
<td>r -0.13</td>
<td>0.51</td>
<td>0.24</td>
<td>0.46</td>
<td>0.37</td>
</tr>
<tr>
<td></td>
<td>p 0.66</td>
<td>0.08</td>
<td>0.43</td>
<td>0.13</td>
<td>0.22</td>
</tr>
<tr>
<td>Incoming negatives</td>
<td>r 0.19</td>
<td>-0.30</td>
<td>-0.21</td>
<td>-0.03</td>
<td>0.14</td>
</tr>
<tr>
<td></td>
<td>p 0.54</td>
<td>0.34</td>
<td>0.50</td>
<td>0.93</td>
<td>0.67</td>
</tr>
<tr>
<td>Total positives</td>
<td>r 0.03</td>
<td>0.42</td>
<td>-0.06</td>
<td>0.49</td>
<td>0.40</td>
</tr>
<tr>
<td></td>
<td>p 0.92</td>
<td>0.18</td>
<td>0.84</td>
<td>0.09</td>
<td>0.20</td>
</tr>
<tr>
<td>Total negatives</td>
<td>r 0.13</td>
<td>-0.05</td>
<td>0.14</td>
<td>0.10</td>
<td>0.18</td>
</tr>
<tr>
<td></td>
<td>p 0.66</td>
<td>0.88</td>
<td>0.64</td>
<td>0.74</td>
<td>0.57</td>
</tr>
</tbody>
</table>

Table 9 shows no relationships between age and changes in the children’s perceptions of family relationships. Contrary to prediction, the initial level of conduct problems was significantly positively related to an improvement in positive feelings towards fathers.
There was also a correlation between initial conduct problems and change in overall incoming positives feelings that was approaching significance ($r=0.51, p=0.08$).

There were no relationships between initial hyperactivity /impulsivity and changes in perceptions of behaviour or family relationships.

### 4.2.2 Hypothesis 6

**HYPOTHESIS:** Changes in maternal psychopathology would be related to the amount of change in perceptions of behaviour and relationships in parents and children.

#### 4.2.2.1 Changes in maternal psychopathology

**Table 10.** *WMPSR Test for ratings of maternal psychopathology*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre medication</th>
<th>Post medication</th>
<th>z score</th>
<th>p value - two tailed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>s.d.</td>
<td>Mean</td>
<td>s.d.</td>
</tr>
<tr>
<td>Maternal GHQ overall score</td>
<td>9.77</td>
<td>9.13</td>
<td>4.62</td>
<td>5.56</td>
</tr>
<tr>
<td>Maternal depression GHQ</td>
<td>1.69</td>
<td>2.39</td>
<td>.67</td>
<td>1.44</td>
</tr>
</tbody>
</table>

There was no significant change in overall maternal psychopathology although there was a trend for this to improve between initial and follow-up appointments. There was a significant decrease in maternal depression (see Table 10).

#### 4.2.2.2 Relationship between changes in maternal psychopathology and parents ratings of improvement in behaviour and home life (See Table 8)

Table 8 illustrates that improvements in overall maternal psychopathology or depression were not related to improvements in any of the parents ratings of improvement in behaviour or home life.

#### 4.2.2.3 Relationship between changes in maternal psychopathology and children’s ratings of improvements in family relationships (see table 9).

Improvements in overall maternal psychopathology were significantly related to children’s ratings of improvements in positive feelings towards their fathers. There
were moderately high non-significant correlations between improvements in maternal psychopathology and improvements in positives feelings towards siblings ($r=0.49$, $p=0.15$), improvements in incoming positive feelings ($r=0.46$, $p=0.13$) and improvement in total positive feelings ($r=0.49$, $p=0.09$). Change in maternal depression was not significantly related to improvement in any of the children's ratings of family relationships although there was a correlation of 0.57 between this and a decrease in negative feelings towards siblings.

5. DISCUSSION

5.1 Characteristics of the sample.

The sample was thought to be an acceptably pure group of children with ADHD assessed according to ICD 10 criteria. However, a teachers rating of symptoms was not obtained in every case which meant that the pervasiveness of difficulties was not established by an opinion external to the parents. Although the diagnosis was based on the clinicians assessment according to ICD 10 and the Conners' checklists, a more accurate diagnosis could have been made by use of more stringent checklists such as the Rutter A and B scales (Rutter, 1967) or the Parental Account of Child Symptoms Interview (Taylor, Schachar, Thorley & Weiselberg, 1986). These would have allowed for more systematic screening for co-morbid problems such as emotional disorders, important since clinic referred hyperactive children have been reported to exhibit a high level of co-morbid problems in comparison to community samples (Woodward, Dowdney & Taylor, 1997).

The demographic characteristics of the fourteen children in the study revealed wide variability in family structure and child and parental characteristics. The relationship of these characteristics to change in behaviour and relationships was not explored because of the small sample numbers. As the fathers were all employed the group was thought to be more reflective of children who were not severely socially disadvantaged although socio-economic status was not included in the analysis.
Report of stresses upon families prior to medication and during the two months of the study were almost ubiquitous and it was thought that future studies could analyse in more detail the kinds of stresses that parents reported and their relationship to perceptions of the child and family life. All of the primary caregivers said that they were involved in disciplining the child.

The investigation found a high level of psychiatric problems (as measured on the GHQ), in primary caretakers, supporting previous findings of high incidence in parents of clinic referred children (Taylor, Sandberg, Thorley & Giles, 1991).

None of the children were considered to reach a level of conduct disturbance requiring dual diagnosis of ADHD with conduct disorder according to ICD 10. However on the hyperactivity and conduct subscales of the CPRS the group was greater than two standard deviations above the normal mean at initial assessment so the level of conduct difficulties in the group as a whole was substantial. It is likely that if the children had been assessed formally for Oppositional Defiant Disorder they would have met the criteria. Therefore, the results presented herein are applicable to children and families having both conduct and hyperactivity problems although not of a magnitude to merit diagnosis of a conduct disorder.

5.2 Research Hypotheses

5.2.1 Hypothesis 1

There was a significant change in parent’s perceptions of behaviour with children generally improving on the reported measures although, the number of settings where compliance problems occurred remained unchanged. This suggests that behaviour change in these children is related to a reduction in intensity of problems across settings rather than an elimination of problems in these settings. The medication is thought to have had an effect on the primary attentional symptoms of ADHD and also appeared to affect compliance and conduct problems which, as secondary features of ADHD, have in the past been viewed as less easy to ameliorate without more complex interventions (Barkley, 1977). This highly significant result may be a consequence of the measures used. Given the short term effects of stimulant medication and the expected variability
of these behavioural improvements throughout the day, parents were asked to report their child’s behaviour when on medication and as such the behavioural changes reported in this study probably reflected the child at their optimum functioning. This would account for the large behaviour change in conduct problems and hyperactivity compared to the small change in family relationships. A measure of the child’s overall functioning such as the one used by clinicians would have been more useful for parents to assess the overall magnitude of changes.

Given the absence of a placebo and control condition conclusions about the process of change cannot be drawn. It is not possible to conclude whether the perceived changes in behaviour are a result of medication, parental expectations of change or other factors such as developmental change or reduction in stressors. It was not felt to be ethically viable to withhold treatment from children in the study in order to provide these conditions. Whatever the process of change, this study shows that parents perceive behaviour change and this finding in itself, may have implications for family relationships. It would be useful in further studies to obtain parent’s views of the process of changes, possibly using a more in-depth interview method to gather more information than through questionnaires.

There was a significant improvement in the clinician’s ratings of overall functioning. Since the clinicians ratings are derived as a summary of parental reports in interviews it was expected that they would reflect parental ratings. There may have also been a bias for clinicians to rate their own prescriptions of medication as successful. However, making the initial and follow-up ratings blind to each other was intended to minimise this problem. Future studies would ideally employ a separate rater to the person who prescribed medication to guard against bias.

5.2.2 Hypothesis 2

In agreement with the hypothesis, a high percentage of parents reported an improvement in family relationships since their child had been on medication regardless of how often during the day medication was taken. However, there were some difficulties with this measure. The question used to assess this aspect was designed to limit demand characteristics but the rating scale response was without established reliability or
validity. It would also have been more accurate to rate home life before and after treatment rather than in one retrospective measure. The measure was also a very global rating of improvement and did not differentiate which particular aspects of home life had improved. Given the lack of agreement between this and the children’s reports on family relationships, it was felt that a more in-depth measure of the parent’s perspective was required for future studies to elucidate what aspects of home life are thought to change.

Noteworthy, was the lack of significant change in emotional closeness parents felt towards their child after medication. This is an unexpected result especially considering the significant behaviour changes reported and is contradictory to Schachar & Wachsmuth’s (1987) finding of increased maternal warmth and reduced maternal criticism towards the child after medication although, this could be an artefact of the different measures used in these two studies. The previous study measured maternal warmth by rating the mother’s spontaneous comments about her child during an interview and it may be that those mothers would have shown less awareness of these changes in warmth or criticism if asked directly about them. The mother’s directly expressed feelings of closeness to their child as obtained in this study may reflect more long-term representations of the relationship that are a more stable aspect of the mother-child relationship. Alternatively ‘closeness’ may be a specific concept that does not necessarily relate to dimensions of warmth or criticism.

Conclusions drawn from the measures of parent’s perceptions of home life and emotional closeness must be cautious given the lack of established reliability and validity. The measures were included in the study to assess improvement in home life and of the parent’s relationship with the child to compare to the measurement of children’s emotional attitudes on the Family Relations Test. Future studies need to conceptualise and operationalise the parent’s relationship with the child in more sophisticated ways, possibly using more in-depth measures, observations of interactions and reports of other family members. Beneficial would be the development of a measure which provides the equivalent detail about parents perceptions of family relationships as the Family Relations test does for children. This is not currently available as the adult version of this test addresses the adult’s relationship with his own
parents. There also appears to be a need to be more specific and consistent across studies about the dimensions of 'relationships' that are to be studied.

5.2.3 Hypothesis 3

There were no significant changes in children’s perceptions of family relationships before and after medication although, there was a non-significant trend towards a decrease in negative feelings towards siblings in the group. The lack of change in feelings towards parents was unexpected given the previous findings of an increase in maternal warmth and a decrease in maternal criticism after response to medication and the theoretical support for a prediction of change. It is however, congruent with the lack of significant change in mother’s reports of emotional closeness towards their children. However, both these non-significant results need to be interpreted cautiously given the small numbers in the study. It may be that any changes that did occur were not of a sufficient magnitude to be significant in the group as a whole. Since this measure has not been used in the past to measure change it is difficult to know what constitutes a clinically significant change. The effect size was calculated according to differences between norms and a clinical sample however, these figures may now be outdated. There may also be practice effects on this measure that have not been evaluated that may affect its validity. Furthermore, the measure assumes that less expression of negative feelings and more expression of positive feelings indicates improvement whereas it may be that an increased ability to express negative feelings is actually more psychologically healthy for the child. Aside from these difficulties, the lack of change of both children’s perceptions of relationships with parents and parents ratings of emotional closeness may truly be due to no actual improvements in interactions after medication. This could be clarified by future research which should consider the congruence between measures of children’s and parent’s emotional attitudes and other measures of relationships such as observations of actual interactions. It seems unlikely though, that no changes in interactions occurred given the significant change on measures of behaviour which. Some of the questions measuring behaviour even ask directly about interactions such as those on compliance and several items on the Conners Ratings scales. Inconsistent medication use at home may have reduced the salience of changes occurring when the child was on medication.
Another possibility is that changes in interactions between parent’s and children did occur but the expected change in emotional attitudes was delayed. Parents and children may need the new interactional patterns to continue consistently over an extended period in order for alterations in relationships to be stable. Alternatively change in relationships may occur immediately because of the contrast and novelty of the behavioural improvement. Indeed Schachar & Wachsmuth’s (1987) study measured relationships after only three weeks of stimulant usage and this may account for the improvements. At two months (this study) families may actually have fallen back into more stable interactional patterns despite behaviour changes. Either of these possibilities could be examined by comparing family relationships immediately after first use of stimulants and then at longer intervals in the same group of children. This was the original aim of this study which unfortunately, had to be discarded because of time constraints.

The lack of change may also be explained by the existence of a complex relationship involving variation in attributions for behaviour and interactional change. Interpretations made by parents and children of behaviour and interactional changes may be related to certain child, parental and prior family characteristics (see section 5.3.1) that were not addressed in this study. The heterogeneity of this small group in terms of initial family functioning, response to medication, parent and child characteristics and level of medication taken at home would mean that possible significant changes in perceptions of some children would have been obscured by a lack of change in others. It seems likely that detecting any changes in family functioning requires a much larger study where it is possible to theoretically specify which family characteristics are most likely to be related to relationship change on medication and to be able to control for the individual variation in these characteristics.

It could be argued that a different theoretical perspective may be required to understand the relationship between behaviour and emotional attitudes. Theoretical perspectives such as that proposed by Rachman (1981) are useful by describing possible factors that link behavioural and emotional change. He describes a ‘loose coupling of subjective, behavioural and physiological’ experiences and a consequent discordance between behavioural and affective experience. Similar to Rachman, Leventhal (1979) describes
emotional experience as dependent on information from perceptual-motor, schematic and conceptual levels. This kind of model may be applicable to the processes operating here as change in emotional attitudes appears to be more than just a function of change in the child’s behaviour.

There was a trend towards improvement in children’s perceptions of their relationship with siblings which was in line with previous research. Why children’s perceptions of sibling relationships appear to be more amenable to change than those with parents is perplexing. It may be a result of different types of attachments existing between children and their siblings or parents. Attachment theory suggests that children need to form and maintain a strong and stable relationship with the primary caregiver. Where there is a parental primary caregiver attachments to siblings are probably less crucial for the child’s sense of security and have been shown to be characterised by large individual differences (Boer, 1990). The child’s greater emotional investment in attachment to the primary caregiver as opposed to siblings may account for its stability in the face of behavioural change as a result of medication. Attachment theory states that children are motivated to maintain a stable internal representation of the caregiver even to the extent that this leads to accommodation of an abusive situation by developing a sense of self blame (Bowlby, 1969, 1973, 1980). Attachment theory also proposes that there is an innate drive from poor to healthy attachments and it may be that change or stability in relationships is a function of the prior quality of the attachment to parents and siblings. Additional studies measuring the contribution of sibling/parent status and quality of prior relationship to the variance in improvement in relationships after medication would be useful to investigate these differences. The current project appears to have underestimated the complexity of changes in attachments with parents and siblings by predicting that they would follow on a behavioural shift.

Other explanations for this finding could be:

a) That siblings, because of their age and consequent differences in self control, have had less tolerance to the child’s hyperactive/ impulsive behaviour than parents before medication and consequently their response to the changes in their siblings behaviour is more marked. This possibility could have been explored by
introducing measures of actual interactions into the study as well as respondents reports.

b) That this finding is an artefact of the measure used. In using the Family Relations Test the ratings of incoming and outgoing measures of feelings towards different family members had to be collapsed into a single positive or negative rating of the relationship. It may be that when children rated feelings towards parents there could have been a bigger discrepancy between incoming and outgoing feelings that means the sum of these feelings was a less meaningful measure than for siblings.

5.2.4 Hypothesis 4

5.2.4.1 Relationship between clinician’s ratings of improvements in global functioning and parent’s ratings of improvements in behaviour and home life.

The clinician’s rating of improvement of the child’s global functioning were significantly correlated with changes on the parents ratings of their child’s level of hyperactivity on the Conners’ subscale and on both compliance measures. Although not significantly correlated with the Conners’ ASQ score for hyperactivity or the conduct subscale, the correlations were moderate. This was unsurprising given that clinicians based their rating on information from the parental interview.

The clinician’s global change rating was highly significantly related to overall global rating of improvement from parents but not to improvements in emotional closeness. As discussed earlier this suggests that emotional attitudes between parent and their children are not linked in a straightforward way to the behaviour changes seen when stimulant medication is being used.

5.2.4.2 Relationship between parents perceptions of improvement in behaviour and improvement in family relationships.

The amount of overall improvement in home life was correlated with changes in conduct problems, impulsivity/hyperactivity on the Conners’ subscale, hyperkinesis index and severity of compliance problems but not to the number of settings where compliance was a problem. This suggests that parents do see change in behaviour connected to
changes in home life when considered in this global way. This was expected but the specific nature of these changes requires examination.

Improvement in parents perceptions of emotional closeness were not related to improvements in hyperactivity and impulsivity or compliance but were related to improvements in conduct problem measured on the Conners' subscale although the correlation (0.55) was not significant. A simple bivariate correlation such as this must be interpreted with caution but does suggest that it may be the changes in the specific anti-social qualities of children that affect parents emotional attitudes rather than straightforward changes in their impulsivity, hyperactivity or attentiveness.

5.2.4.3 Relationship between parent's perceptions of improvements in behaviour and home life and children's perceptions of improvements in family relationships.

There was a significant correlation between improvement in impulsivity/hyperactivity and a decrease in negative feelings towards siblings. There was also a non-significant trend for decrease in conduct problems to be related to decrease in negative feelings towards siblings. These findings supports the original hypothesis that, at least in terms of sibling relationships, a reduction in the behavioural symptoms associated with hyperactivity leads to improvement in family relationships. There appears however to be no relationship between parents perceptions of behaviour change and the perceived change of relationships with individual parents for these children. Despite the significant shift in behaviour and parents perceptions of an improvement in home life in general has not seemed to affect emotional attitudes of the child specifically towards parents.

An unexpected finding was that improvement in emotional closeness was moderately correlated with an increase in negative feelings towards parents, although the correlation was not statistically significant and again needs to be interpreted cautiously because of the small numbers in the study. This suggests that the relationship between behaviour change and feelings towards parents is not straightforward. It seems that children do not necessarily react positively to increased feelings of closeness in parents possibly because emotional attitudes are a long-term stable feature of a relationship and the change that occurs in the relationship is unsettling and not in congruence with the
child’s self image. Children with more initial conduct problems or lower self esteem may adapt less easily to change. More information is needed on how ‘emotional closeness’ is manifest in the interactions with the child to understand how it may be aversive. The measure of negative feelings expressed by the child is an amalgamation of incoming and outgoing feelings and considering whether these perceived negative feelings are towards or from the child may help to clarify this issue. Although it is possible to speculate reasons post hoc for this unexpected finding, more confidence in its validity through a larger study is required before such considerations become worthwhile.

There were no significant relationships between behavioural changes and relationships with specific family members as perceived by the child, some relationships were found between behavioural improvement and improvement on some of the summary measures on the Family Relations Test. Improvement in compliance as measured on the HSQ was significantly related to changes in perceived total incoming positive feelings felt by the child. This suggests that children do perceive some general changes in attitudes towards them in the family when they become more obedient. The incoming positives variable is a sum of the increase in positive feelings from all family members combined which is possibly why it is related to change when measures for parents members were not. This gives some support for the initial hypothesis of the study that changes in behaviour would be related to changes in family relationships as perceived by the child although, the large amount of variance unexplained by the measure emphasises the importance of considering prior and intervening variables.

5.3 Subsidiary hypotheses

5.3.1 Hypothesis 5

The child’s age was not related to the amount of change on any of the measures except for compliance. Younger children were found to be more amenable to changes in compliance probably because of the less entrenched nature of their problems. The fact that none of the other changes in child’s behaviour were related to age suggests that age interacts with the type of behaviour change under consideration. It is logical that the
impact of medication on the primary symptoms of ADHD is less affected by age than its impact on associated difficulties.

The child's age was not related to changes in perceptions of family relationships, contrary to the hypothesis that younger children would have less stable internal representations of relationships. This may be a result of the small numbers in the study or it may suggest that change in emotional attitudes is affected by a much more complex range of factors than the child's age. For example, prior family expectations or constructs of acceptable or unacceptable behaviour may be one aspect to measure as these affect their tolerance of the child's difficulties (Thomas & Chess, 1977). This finding supports Bowlby's optimism about the possibility of relationship change across the lifespan.

Initial severity of the children's difficulties was not related to changes on any of the parent's or clinician's ratings of behaviour. This finding suggests that even children with severe difficulties may be able to benefit from intervention with medication although larger numbers would have enabled more confidence in these findings.

Initial level of conduct problems was related to improvements in the child's expression of positive feelings in their relationships with fathers and overall incoming positives feelings regardless of behaviour change. This could indicate that attendance at the clinic affects the attributions father's have about their children's conduct problems although without a measure of the father's attitudes it is difficult to make conclusions about the processes operating here. This result supports the hypothesis that the initial features of the child's behaviour affect changes in perceptions of the child after visiting the clinic. Having a medical diagnosis may have a more powerful effect on the fathers of children with the more severe conduct problems and lead to more changes in relationships than for those fathers whose children have symptoms of hyperactivity and inattention only.

5.3.2 Hypothesis 6

There were only very small correlations between changes in overall maternal psychopathology and depression and perceptions of improvement on any of the behavioural variables. This finding is surprising given previous research showing
perception of children’s behaviour to be related to mothers mood and requires further investigation in a larger study because of the lack of statistical power in the study.

There was a non-significant trend towards less psychopathology in mothers at follow-up and a significant decrease in depression. This suggests that improvements in maternal psychopathology may occur in conjunction with attendance at the clinic regardless of behaviour change possibly due to the increased support mothers feel or their changed attributions for their children’s problems. There was also a significant correlation between improvements in maternal psychopathology and increase in children’s positive feelings towards fathers and total positive feelings. There was also quite a high correlation between improvement in maternal depression and decrease in children’s negative feelings towards siblings. Why decreased maternal psychopathology should be associated with changes in the relationship with the fathers and siblings but not the mother requires further investigation but may again be due to the relative stability of relationship with the primary caregiver because of attachment needs. A larger study with a more powerful statistical design would enable these different variables to be controlled for and the direction of effects would be clearer.

6. SUMMARY OF FINDINGS AND CRITIQUE

Clinicians and parents perceived significant improvements in the primary and associated behavioural symptoms of ADHD and in family relationships despite the heterogeneity of the group in terms of child and parental characteristics. This supports previous research showing the usefulness of stimulant medication as an intervention for this disorder. However, using summary behaviour measures may have biased the results as in practice, there may be large variability in children’s behaviour when on and off medication at home. Furthermore, double blind placebo and control conditions would have been able to elucidate more about the process of change. It is highly likely that there were demand characteristics operating in the study biasing both clinicians and parents to see their choice of intervention as successful.

There were no significant improvements in the primary caregivers rating of closeness towards the child although, parents reported home life to have improved. This suggests
a need to use more reliable and valid measures to examine what aspects of relationships do change from the parent's point of view. It was thought that the likely complexity of the process of relationship change may also merit a more specific qualitative analysis.

There were no significant changes as a result of medication in the child’s perceptions of family relationships although, there was a trend for relationships with siblings to improve. This was explained as possibly being due to a post treatment time effect or the differing nature of attachments between children and their parents and siblings. Furthermore since the use of the Family Relations Test to measure change was an innovative procedure in these circumstances, it was difficult to judge what may have been a clinically significant change on the measure. It was also identified that clinically significant change on this measure within the clinical group may not have been detected given the small numbers in the study.

The association between behaviour change and relationship change showed that improvements in sibling relationships were related to improvements on certain behaviour measures and parents feelings of emotional closeness were related to improvements in children’s compliance. The relationship between behaviour and relationships was found to be mediated by the attributions children, siblings and parents make about the behaviour changes that are a function of initial parent, child and family characteristics and may depend upon the type of behaviour under consideration.

Age was related to behaviour change in compliance but not the primary symptoms of impulsivity and hyperactivity or any of the measures of family relationships. Initial severity did not limit change but seemed to be associated with more change in relationships with father’s regardless of behaviour change. Change in maternal psychopathology also was not related to behaviour change but was related to change in relationships.

Problematic in this study was the small number of subjects and their heterogeneity in terms of initial characteristics. A larger group would have enabled more systematic screening for emotional disorders and oppositional and conduct disorders as called for by recent studies in ADHD.
Small Scale Research Project

Due to the large number of bivariate analyses two tailed p values were calculated to reduce the probability of type II errors. Despite these precautions findings need to be treated with caution. The finding about changes in siblings relationships seem to be the most reliable given that they support previous research and are consistent within the group of children as a whole and across different measures.

7. REFERENCES


8. APPENDICES

Appendix 1. DSM IV criteria for ADHD.

Appendix 2. ICD 10 criteria for ADHD.

Appendix 3. Questionnaires for parents; demographic questionnaire, emotional closeness, GHQ, HSQ, CPRS, follow up ratings of stresses, improvement and emotional closeness.


Appendix 5. Family Relations Test: list of items.

Appendix 1: DSM IV criteria for ADHD
TABLE 1: DSM-IV ADHD CRITERIA

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

A. Either [1] or [2]

[1] Six (or more) of the following symptoms of inattention have persisted for at least six months to a degree that is maladaptive and inconsistent with developmental level.

INATTENTION

[a] Often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities

[b] Often has difficulty sustaining attention in tasks or play activities

[c] Often does not seem to listen when spoken to directly

[d] Often does not seem to follow through on instructions and fails to finish schoolwork, chores or duties in the workplace (not due to oppositional behaviour or failure to understand instructions)

[e] Often has difficulty organising tasks and activities

[f] Often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort [such as schoolwork or homework]

[g] Often loses things necessary to tasks or activities [e.g. toys, school assignments, pencils, books or tools]

[h] Is often distracted by extraneous stimuli

[i] Is often forgetful in daily activities

[2] Six, or more, of the following symptoms of hyperactivity-impulsivity have persistent for at least six months to a degree that is maladaptive and inconsistent with developmental level.

HYPERACTIVITY

[a] Often fidgets with hands or feet, or squirms in seat

[b] Often leaves seat in classroom or other situation where it is inappropriate [in adolescents or adults, this may be limited to subjective feelings of restlessness]

[c] Often has difficulty playing or engaging in leisure activities quietly

[d] Is often "on the go" or often acts as if "driven by a motor"

[e] Often talks excessively

IMPULSIVITY

[f] Often blurts out answers before questions have been completed

[g] Often has difficulty awaiting turn

[h] Often interrupts or intrudes on others [e.g. butts into conversations or games]

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before the age of 7 years.

C. Some impairment from the symptoms is present in two or more settings [e.g. at school [or work] and at home]

D. There must be clear evidence or clinically significant impairment in social, academic or occupational functioning

E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia or other Psychotic Disorder, and are not better accounted for by another mental disorder [e.g. Mood Disorder, Anxiety Disorder. Dissociative Disorder or a Personality Disorder]
Appendix 2: ICD 10 criteria for ADHD
F90 – F98
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence

Hyperkinetic disorders

Note: The research diagnosis of hyperkinetic disorder requires the definite presence of abnormal levels of inattention, hyperactivity, and restlessness that are pervasive across situations and persistent over time and that are not caused by other disorders such as autism or affective disorders.

G1. Inattention. At least six of the following symptoms of inattention have persisted for at least 6 months, to a degree that is maladaptive and inconsistent with the developmental level of the child:

(1) often fails to give close attention to details, or makes careless errors in schoolwork, work, or other activities;

(2) often fails to sustain attention in tasks or play activities;

(3) often appears not to listen to what is being said to him or her;

(4) often fails to follow through on instructions or to finish schoolwork, chores, or duties in the workplace (not because of oppositional behaviour or failure to understand instructions);

(5) is often impaired in organizing tasks and activities;

(6) often avoids or strongly dislikes tasks, such as homework, that require sustained mental effort;

(7) often loses things necessary for certain tasks or activities, such as school assignments, pencils, books, toys, or tools;

(8) is often easily distracted by external stimuli;

(9) is often forgetful in the course of daily activities.

G2. Hyperactivity. At least three of the following symptoms of hyperactivity have persisted for at least 6 months, to a degree that is maladaptive and inconsistent with the developmental level of the child:

(1) often fidgets with hands or feet or squirms on seat;
MENTAL AND BEHAVIOURAL DISORDERS: DIAGNOSTIC CRITERIA

(2) leaves seat in classroom or in other situations in which remaining seated is expected;

(3) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, only feelings of restlessness may be present);

(4) is often unduly noisy in playing or has difficulty in engaging quietly in leisure activities;

(5) exhibits a persistent pattern of excessive motor activity that is not substantially modified by social context or demands.

G3. Impulsivity. At least one of the following symptoms of impulsivity has persisted for at least 6 months, to a degree that is maladaptive and inconsistent with the developmental level of the child:

(1) often blurts out answers before questions have been completed;

(2) often fails to wait in lines or await turns in games or group situations;

(3) often interrupts or intrudes on others (e.g. butts into others' conversations or games);

(4) often talks excessively without appropriate response to social constraints.

G4. Onset of the disorder is no later than the age of 7 years.

G5. Pervasiveness. The criteria should be met for more than a single situation, e.g. the combination of inattention and hyperactivity should be present both at home and at school, or at both school and another setting where children are observed, such as a clinic. (Evidence for cross-situationality will ordinarily require information from more than one source; parental reports about classroom behaviour, for instance, are unlikely to be sufficient.)

G6. The symptoms in G1–G3 cause clinically significant distress or impairment in social, academic, or occupational functioning.

G7. The disorder does not meet the criteria for pervasive developmental disorders (F84.–), manic episode (F30.–), depressive episode (F32.–), or anxiety disorders (F41.–).
Appendix 3: Questionnaires for parents;

Demographic questionnaire (Page 193),

Emotional closeness scale and GHQ (Page 194-195),

HSQ (Page 196),

Conners' questionnaire (Page 197-198),

Follow up ratings of stresses, improvement scale and emotional closeness scale (Page 199).
QUESTIONNAIRE FOR PARENTS

1. Please write down the names of all the people who live in your home at the moment, including yourself, their age and relationship to ............................................

   NAME       AGE       RELATIONSHIP TO ................................

2. Who in your home is mainly responsible for disciplining ..........................................

3. Has ................................ ever had any major medical problems?
   YES  NO (please circle)
   If yes, please describe.

4. Has any other family member had major medical problems?
   YES  NO (please circle)
   If yes, please give names(s) below and briefly describe.

5. Please describe any positive or negative stresses that the family have experienced over the last six months.

6. Please state your occupation and the occupation of other adults living in your household.

Thank you for your co-operation.
QUESTIONNAIRE FOR PARENTS

Please state (on a scale of 0 - 10) how close or distant you feel towards your child at the moment.

0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10
(not very close at all) (very close indeed)

We should like to know if you have had any medical complaints and how your health has been in general, over the past few weeks. Please answer ALL the questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.

Thank you very much for your co-operation.

Have you recently

A1 - been feeling perfectly well and in good health?

Better than usual Same as usual Worse than usual Much worse than usual

A2 - been feeling in need of a good tonic?

Not at all No more than usual Rather more than usual Much more than usual

A3 - been feeling run down and out of sorts?

Not at all No more than usual Rather more than usual Much more than usual

A4 - felt that you are ill?

Not at all No more than usual Rather more than usual Much more than usual

A5 - been getting any pains in your head?

Not at all No more than usual Rather more than usual Much more than usual

A6 - been getting a feeling of tightness or pressure in your head?

Not at all No more than usual Rather more than usual Much more than usual

A7 - been having hot or cold spells?

Not at all No more than usual Rather more than usual Much more than usual

B1 - lost much sleep over worry?

Not at all No more than usual Rather more than usual Much more than usual

B2 - had difficulty in staying asleep once you are off?

Not at all No more than usual Rather more than usual Much more than usual

B3 - felt constantly under strain?

Not at all No more than usual Rather more than usual Much more than usual

B4 - been getting edgy and bad-tempered?

Not at all No more than usual Rather more than usual Much more than usual

B5 - been getting scared or panicky for no good reason?

Not at all No more than usual Rather more than usual Much more than usual

B6 - found everything getting on top of you?

Not at all No more than usual Rather more than usual Much more than usual

B7 - been feeling nervous and strung-up all the time?

Not at all No more than usual Rather more than usual Much more than usual
<table>
<thead>
<tr>
<th>Question</th>
<th>More so than usual</th>
<th>Same as usual</th>
<th>Rather less than usual</th>
<th>Much less than usual</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1 - been managing to keep yourself busy and occupied?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>C2 - been taking longer over the things you do?</td>
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<tr>
<td>C3 - felt on the whole you were doing things well?</td>
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<tr>
<td>C4 - been satisfied with the way you've carried out your task?</td>
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<tr>
<td>C5 - felt that you are playing a useful part in things?</td>
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<td></td>
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<tr>
<td>C6 - felt capable of making decisions about things?</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>C7 - been able to enjoy your normal day-to-day activities?</td>
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</tbody>
</table>

| Question                                                                 | Not at all | No more than usual | Rather more than usual | Much more than usual |
|------------------------------------------------------------------------|           |                   |                        |                     |
| D1 - been thinking of yourself as a worthless person?                  |           |                   |                        |                     |
| D2 - felt that life is entirely hopeless?                              |           |                   |                        |                     |
| D3 - felt that life isn't worth living?                                |           |                   |                        |                     |
| D4 - thought of the possibility that you might make away with yourself?|           |                   |                        |                     |
| D5 - found at times you couldn't do anything because your nerves were too bad? |           |                   |                        |                     |
| D6 - found yourself wishing you were dead and away from it all?        |           |                   |                        |                     |
| D7 - found that the idea of taking your own life kept coming into your mind? |           |                   |                        |                     |

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>TOTAL</th>
</tr>
</thead>
</table>

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HOME SITUATIONS QUESTIONNAIRE

Child's name __________________________________________ Date ____________________________
Name of person completing this form _____________________________________________________

Instructions: Does your child present any problems with compliance to instructions, commands, or rules for you in any of these situations? If so, please circle the word yes and then circle a number beside that situation that describes how severe the problem is for you. If your child is not a problem in a situation, circle No and go on to the next situation on the form.

<table>
<thead>
<tr>
<th>Situations</th>
<th>Yes/No</th>
<th>If yes, how severe?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Circle one)</td>
<td>Mild (Circle one)</td>
</tr>
<tr>
<td>Playing alone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Playing with other children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mealtimes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting dressed/undressed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washing and bathing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When you are on the telephone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Watching television</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When visitors are in your home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When you are visiting someone's home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In public places (restaurants, stores, church, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When father is home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When asked to do chores</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When asked to do homework</td>
<td></td>
<td></td>
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<tr>
<td>At bedtime</td>
<td></td>
<td></td>
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<tr>
<td>While in the car</td>
<td></td>
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<tr>
<td>When with a babysitter</td>
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</tbody>
</table>

Total number of problem settings ______________ Mean severity score ______________

For Office Use Only
**Connors Parents Questionnaire** (Designed by C. Keith Connors PhD)

**Child's Number: ___________________________ Date filled In: __________/________/________
Your Name: ________________________________ Relationship to child: ______________________

**INSTRUCTIONS:** Listed below are items concerning children's behaviour or the problems they sometimes have. Read each item carefully and decide how much you think your child has been bothered by this problem during the past month NOT AT ALL, JUST A LITTLE, QUITE A LOT, VERY MUCH. Indicate your choice by placing a check mark ( ) in the appropriate column to the right of each item.

<table>
<thead>
<tr>
<th>Score</th>
<th>OBSERVATION</th>
<th>DEGREE OF ACTIVITY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Not at all</td>
</tr>
<tr>
<td>1.</td>
<td>Picks at things (nails, fingers, hair, clothing)</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Cheeky to grown-ups</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Problems with making and keeping friends</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Excitable, impulsive</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Wants to run things</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Sucks or chews (thumb, clothing, blankets)</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Cries easily or often</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Carries a chip on his shoulder</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Daydreams</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Difficulty in learning</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Restless in the 'squirm' sense</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Fearful (of new situations, new people or places, going to school)</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Restless, always up on the go</td>
<td></td>
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<tr>
<td>14.</td>
<td>Destructive</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>Tells lies or stories that aren't true</td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>Shy</td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>Gets into more trouble than others the same age</td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>Speaks differently from others same age (baby talk, stuttering, hard to understand)</td>
<td></td>
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<tr>
<td>19.</td>
<td>Denies mistakes or blames others</td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>Quarrelsome</td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>Pouts and sulks</td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>Steals</td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>Disobedient</td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>Worries more than others (about being alone, illness, or death)</td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>Fails to finish things</td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>Feelings easily hurt</td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>Bullies others</td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>Unable to stop a repetitive activity</td>
<td></td>
</tr>
<tr>
<td>29.</td>
<td>Cruel</td>
<td></td>
</tr>
<tr>
<td>30.</td>
<td>Childish or immature (Wants help he shouldn't need, clings, needs constant reassurance)</td>
<td></td>
</tr>
<tr>
<td>31.</td>
<td>Distractibility or attention span a problem</td>
<td></td>
</tr>
</tbody>
</table>

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197
<table>
<thead>
<tr>
<th>Score</th>
<th>OBSERVATION</th>
<th>DEGREE OF ACTIVITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>32</td>
<td>Headaches</td>
<td>Not at all</td>
</tr>
<tr>
<td>33</td>
<td>Mood changes quickly and drastically</td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>Doesn't like or doesn't follow rules or restrictions</td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>Fights constantly</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>Doesn't get along well with sisters or brothers</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>Easily frustrated in efforts</td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>Disturbs other children</td>
<td></td>
</tr>
<tr>
<td>39</td>
<td>Basically an unhappy child</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>Problems with eating (poor appetite, up between bites)</td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>Stomach aches</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>Problems with sleep</td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>Other aches and pains</td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>Vomiting or nausea</td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>Feels cheated in family circle</td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>Boasts and brags</td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>Lets self be pushed around</td>
<td></td>
</tr>
<tr>
<td>48</td>
<td>Bowel problems (frequently loose, irregular habits, constipation)</td>
<td></td>
</tr>
</tbody>
</table>
QUESTIONNAIRE FOR PARENTS

1. Please describe any positive or negative stresses that the family have experienced over the last two months.

2. Please state (on a scale of 0 - 5) whether home life has improved or not since your child has been on medication.

   0 --------------- 1 --------------- 2 --------------- 3 --------------- 4 --------------- 5
   (no improvement at all) (a great deal of improvement)

3. Please state (on a scale of 0 - 10) how close or distant you feel towards your child at the moment.

   0 ------ 1 ------ 2 ------ 3 ------ 4 ------ 5 ------ 6 ------ 7 ------ 8 ------ 9 ------ 10
   (not very close at all) (very close indeed)

Thank you for your co-operation.
Appendix 4: Children’s Global Assessment scale
CHILDREN'S GLOBAL ASSESSMENT SCALE
For children 4-16 years of age

David Shaffer, M.D., Madelyn S. Gould, Ph.D.
Hector Bird, M.D., Prudence Fisher, B.A.

Adaptation of the Adult Global Assessment Scale
(Robert L. Spitzer, M.D., Miriam Gibbon, M.S.W., Jean Endicott, Ph.D.)

Rate the subject's most impaired level of general functioning for the specified time period by selecting the lowest level which describes his/her functioning on a hypothetical continuum of health-illness. Use intermediary levels (e.g., 35, 58, 62).

Rate actual functioning regardless of treatment or prognosis. The examples of behavior provided are only illustrative and are not required for a particular rating.

Specified time period: 1 month

-91 Superior functioning in all areas (at home, at school and with peers), involved in a range of activities and has many interests (e.g., has hobbies or participates in extracurricular activities or belongs to an organized group such as Scouts, etc.). Likeable, confident, "everyday" worries never get out of hand. Doing well in school. No symptoms.

90-81 Good functioning in all areas. Secure in family, school, and with peers. There may be transient difficulties and "everyday" worries that occasionally get out of hand (e.g., mild anxiety associated with an important exam, occasionally "blow-ups" with siblings, parents or peers).

80-71 No more than slight impairment in functioning at home, at school, or with peers. Some disturbance of behavior or emotional distress may be present in response to life stresses (e.g., parental separations, deaths, birth of a sib) but these are brief and interference with functioning is transient. Such children are only minimally disturbing to others and are not considered deviant by those who know them.

70-61 Some difficulty in a single area, but generally functioning pretty well, (e.g., sporadic or isolated antisocial acts, such as occasionally playing hooky or petty theft; consistent minor difficulties with school work, mood changes of brief duration; fears and anxieties which do not lead to gross avoidance behavior; self-doubts). Has some meaningful interpersonal relationships. Most people who do not know the child would not consider him/her deviant but those who do know him/her well might express concern.

60-51 Variable functioning with sporadic difficulties or symptoms in several but not all social areas. Disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the child in other settings.

50-41 Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area, such as might result from, for example, suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, frequent episodes of aggressive or other anti-social behavior with some preservation of meaningful social relationships.

40-31 Major impairment in functioning in several areas and unable to function in one of these areas, i.e., disturbed at home, at school, with peers, or in the society at large, e.g., persistent aggression without clear instigation; markedly withdrawn and isolated behavior due to either mood or thought disturbance, suicidal attempts with clear lethal intent. Such children are likely to require special schooling and/or hospitalization or withdrawal from school (but this is not a sufficient criterion for inclusion in this category).

30-21 Unable to function in almost all areas, e.g., stays at home, in ward or in bed all day without taking part in social activities OR severe impairment in reality testing OR serious impairment in communication (e.g., sometimes incoherent or inappropriate).

20-11 Needs considerable supervision to prevent hurting others or self, e.g., frequently violent, repeated suicide attempts OR to maintain personal hygiene OR gross impairment in all forms of communication, e.g., severe abnormalities in verbal and gestural communication, marked social aloofness, stupor, etc.

10-1 Needs constant supervision (24-hour care) due to severely aggressive or self-destructive behavior or gross impairment in reality testing, communication, cognition, affect, or personal hygiene.
Appendix 5: Family Relations Test: list of items
2. Form for Older Children.

Mild positive (affectionate) Feelings coming from Child

00 This person in the family is very nice.
01 This person in the family is very jolly.
02 This person in the family always helps the others.
03 This person in the family has the nicest ways.
04 This person in the family never lets you down.
05 This person in the family is lots of fun.
06 This person in the family deserves a nice present.
07 This person in the family is a good sport.
08 This person in the family is very nice to play with.
09 This person in the family is very kind-hearted.

Strong positive (sexualised) Feelings coming from Child

10 I like to cuddle this person in the family.
11 I like to be kissed by this person in the family.
12 I sometimes wish I could sleep in the same bed with this person in the family.
13 I wish I could keep this person near me always.
14 I wish this person in the family would care for me more than for anybody else.
15 When I get married I want to marry somebody who is just like this person in the family.
16 I like this person in the family to tickle me.
17 I like to hug this person in the family.

Mild negative Feelings coming from the Child

20 This person in the family is sometimes a bit too fussy.
21 This person in the family nags sometimes.
22 This person in the family sometimes spoils other people's fun.
23 This person in the family is sometimes quick-tempered.
24 This person in the family in sometimes bad-tempered.
25 This person in the family sometimes complains too much.
26 This person in the family is sometimes annoyed without good reason
27 This person in the family sometimes grumbles too much.
28 This person in the family is sometimes not very patient.
29 This person in the family sometimes gets too angry.

Strong negative (hostile) Feelings coming from the Child

30 Sometimes I would like to kill this person in the family.
31 Sometimes I wish this person in the family would go away.
32 Sometimes I hate this person in the family.
33 Sometimes I feel like hitting this person in the family.
34 Sometimes I think I would be happier if this person was not in our family.
35 Sometimes I am fed-up with this person in the family.
36 Sometimes I want to do things just to annoy this person in the family.
37 This person in the family can make me feel very angry.

Mild positive (affectionate) Feelings going towards Child

40 This person in the family is kind to me.
41 This person in the family is very nice to me.
42 This person in the family likes me very much.
43 This person in the family pays attention to me.
44 This person in the family likes to help me.
45 This person in the family likes to play with me.
46 This person in the family really understands me.
47 This person in the family listens to what I have to say.

Strong positive (sexualised) Feelings going towards the Child

50 This person in the family likes to kiss me.
51 This person in the family likes to hug me.
52 This person in the family likes to cuddle me.
53 This person in the family likes to help me with my bath.
54 This person in the family likes to tickle me.
55 This person in the family likes to be in bed with me.
56 This person in the family always wants to be with me.
57 This person in the family cares more for me than for anybody else.
Mild negative Feelings towards the Child

60 This person in the family sometimes frowns at me.
61 This person in the family likes to tease me.
62 This person in the family sometimes tells me off.
63 This person in the family won't play with me when I like it.
64 This person in the family won't always help me when I am in trouble.
65 This person in the family sometimes nag at me.
66 This person in the family sometimes gets angry with me.
67 This person in the family is too busy to have time for me.

Strong negative (hostile) Feelings going towards the Child

70 This person in the family hits me a lot.
71 This person in the family punishes me too often.
72 This person in the family makes me feel silly.
73 This person in the family makes me feel afraid.
74 This person in the family is mean to me.
75 This person in the family makes me feel unhappy.
76 This person in the family is always complaining about me.
77 This person in the family does not love me enough.

Maternal over-protection

80 Mother worries that this person in the family might catch cold.
81 Mother worries that this person in the family might get ill.
82 Mother worries that this person in the family might get run over.
83 Mother worries that this person in the family might get hurt.
84 Mother worries that something might happen to this person in the family.
85 Mother is afraid to let this person in the family run about too much.
86 Mother is afraid to let this person in the family play with rough children.
87 Mother worries that this person in the family doesn't eat enough.

Paternal over-indulgence

90 This is the person in the family father makes too big a fuss about.
91 This is the person in the family father pays too much attention to.
92 This is the person in the family father spoils too much.
93 This is the person in the family father spends too much time with.
94 This is the person in the family father likes best.

Maternal over-indulgence

95 This is the person in the family mother makes too big a fuss about.
96 This is the person in the family mother pays too much attention to.
97 This is the person in the family mother spoils too much.
98 This is the person in the family mother spends too much time with.
99 This is the person in the family mother likes best.

The items that express positive and negative feelings coming from the child are most likely to be used not only in reference to other people but also in reference to the self. For this reason these two areas contain more items than do the others.
Appendix 6: Letter of ethical approval
Our Ref: MGR/MJC

1 April 1997

Suzy Mackechnie
Clinical Psychologist in Training with Ann Kimber
John Grenville House
72 Stockbridge Road
Chichester
West Sussex
PO19 2QJ

Dear Ms Mackechnie

RE: Project For Exploring The Effects Of Medication On The Family Relationships Of Children With Attention Deficit Disorder

I just write to inform you that I did take the protocol you kindly submitted to the Chichester Research Ethics Committee meeting on 10 March 1997. The Committee understood the rationale behind your proposals and foresaw no ethical issues.

I trust the study proves valuable.

Yours sincerely

[Signature]

Dr M G Ridley MB BS MRCP
Chairman, Chichester Research Ethics Committee
Appendix 7: Letter of approach to parents, information sheet for parents and consent form
Dear

We are conducting a research project on the effects of medication on children with Attention Deficit Hyperactivity Disorder. I am aware that you are due to attend the Clinic on for an appointment with

We would like to request your permission to undertake a short interview with and to give you some questionnaires to fill in. We would like to do this after your scheduled appointment with , which will last approximately 45 minutes, so this would require you to be at the Clinic for a further 45 minutes after this.

I enclose an information sheet about the study.

If you are willing to participate in the study, but would prefer a more convenient time, then we can discuss this when you visit the Clinic next week.

If you decide not to take part in the study, you will be willingly given treatment in the usual way and will be fully respected for your choice.

Yours sincerely

Suzy Mackechnie
Clinical Psychologist in Training
INTRODUCTION

This project is investigating the effects that medication has on the child’s perception of family relationships of children diagnosed with Attention Deficit Hyperactivity Disorder.

We want to explore the child’s view of his family situation before and after a trial of medication.

This will help us better understand the child’s point of view and help us to develop more ways of helping these children and their families.

WHO WILL BE IN THE STUDY?

We will include as many children as possible referred to the Child and Family Service in Chichester, who have been diagnosed as having Attention Deficit Hyperactivity Disorder. We are looking in particular at those children who have been prescribed medication to help with their difficulties.

ASSESSMENTS

1. The child and family will have already received an appointment at the Clinic for an assessment with one of the Clinic Team. They will be interviewed to establish the presence of the disorder and whether or not the child would benefit from medication. The information obtained during this interview will be used as part of the study. The information provided by the school will also be included in the study.

2. After this assessment the child will be given the Family Relations Test. This is a 30 minute test in the format of a game, asking the child about his feelings towards family members and his views of their feelings towards him. The child will be seen on his/her own whilst the parents complete questionnaires (see below).

3. Questionnaires for parents covering:
   1. General information on the family.
   2. The child’s strengths and difficulties.
   3. Parental support.
4. FOLLOWUP

When the child attends for his regular Clinic followup in approximately 10 weeks time, we will repeat the Family Relations Test and the questionnaire covering the child's behaviour.

We also aim to repeat these again in two months after the followup at the Clinic, for which we will send you a further appointment.

We will also be conducting the tests with a different group for children who have been on medication for several months already.

All the information from the assessments will be kept securely and treated in confidence. If you decide not to take part in the study, you will willingly be given treatment in the usual way and will be fully respected for your choice.

Suzy Mackechnie
Clinical Psychologist in Training
with Ann Kimber

Mary John
Consultant Clinical Psychologist

Dr Quentin Spender
MB DCH MRCP MRCPsych
Senior Lecturer and Consultant in
Child and Adolescent Psychiatry
CONSENT FORM FOR RESEARCH PROJECT

EXPLORING THE EFFECTS OF MEDICATION ON THE FAMILY RELATIONSHIPS OF CHILDREN WITH ATTENTION DEFICIT DISORDER

I, ...................................................... (name in capitals),

and, .................................................... (name in capitals),

the parent(s)/guardian(s) of:

........................................................ (child’s name in capitals),

agree to take part in the research project as explained to me by,

........................................................ (name in capitals).

I have read the attached information sheet and understand it.

I am aware that I can stop participating at any time should I wish to.

Signed ....................................................... (Mother)

Signed ........................................................ (Father)

Signed ...................................................... (Researcher)

Date ........................................
RESEARCH REPORT 2

LARGE SCALE RESEARCH PROJECT

Year 3

The impact of diagnosis and medication on the family relationships of children with Attention Deficit Hyperactivity Disorder (ADHD): An Interpretative Phenomenological Analysis.

All identifying information has been removed.
1. ABSTRACT

This study investigated the impact of a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and treatment with stimulant medication on family relationships perceived retrospectively by mothers, fathers, and children. An qualitative approach using semi-structured interviews, diaries, and Interpretative Phenomenological Analysis (Smith, 1996) was selected as appropriate to the field of inquiry. Family members were asked to give open accounts of these experiences and changes in attributions for the child’s problem behaviors, discipline styles, and affect in response were explored. Themes arising from parents' accounts showed that the majority of parents and children perceived a reduction in demands and expectations of trouble with diagnosis and medication but that changes in affect, attributions, and responses to behavior varied considerably according to their previous relationship with the child and parents' sense of efficacy. Methodological issues and the emergent themes are considered in relation to existing literature.
2. INTRODUCTION

2.1 Definition of Attention Deficit Hyperactivity Disorder (ADHD)

Attention Deficit Hyperactivity Disorder is the term used to describe a common childhood psychiatric disorder with three main groups of symptomatology (overactivity, inattentiveness and impulsiveness), that cause significant impairment in social, academic or occupational functioning as outlined by the Diagnostic and Statistical Manual (DSM) IV (A.P.A., 1994) (see Appendix 1 of research report 1).

2.2 Research and theoretical background

2.2.1 Family relationships in ADHD

2.2.1.1 The impact of ADHD on parent child interactions.

Parent-child interactions appear to be affected by the primary features of ADHD and the commonly associated problems of aggression and non compliance (British Psychological Society, 1996). Woodward, Taylor and Dowdney (1998) review a range of studies showing that hyperactive children, particularly under structured task conditions, are less compliant, less easy to focus on task and more demanding of their parents than controls. Mothers have been shown to use more commands, to be more negative and to provide children with greater structure and supervision than controls even in adolescence (Cunningham & Barkley, 1979; Mash & Johnston, 1982; Danforth, Barkley & Stokes, 1991; Barkley, Fischer, Edelbrock & Smallish, 1991). Fathers report lower parenting self esteem than controls (Mash & Johnston, 1983) and father's depression ratings have been linked to general family dysfunction but not specifically to the child level of behavioural disturbance (Cunningham, Benness & Siegal, 1988). Tallmadge and Barkley (1983) showed that fathers, although being more directive than controls, had less conflict with hyperactive children than mothers in that children were more compliant. These differences may be due to mothers being 'the dominant
socialising agent in families' (Baruch & Barnett 1986) with the most day to day contact with the child.

2.2.1.2 The role of conduct problems as an influence on family functioning in ADHD

The issue has been raised as to whether these interactional problems are attributable to oppositional and aggressive behaviour rather than the primary symptoms of ADHD since most early studies did not control for these problems. Cunningham et al (1988) and Lewis (1992) addressing this issue, concluded that the degree of general family dysfunction was related to the child’s level of aggressive behaviour. Schachar & Wachsmuth (1991) found that ADHD children without concurrent conduct problems did not differ from controls on measures of family dysfunction but that those with conduct disorder did. They concluded that inconsistent parenting styles may mediate the development of conduct disorder when a child has ADHD but that ADHD alone does not imply pathological family interactions.

More recent studies have altered the focus of what is meant by family functioning. Johnston & Behrenz (1993) studied ‘child rearing discussions’ and found that couples with ADHD children with both high and low levels of conduct problems were more negative in their discussion of the child’s behaviour than controls. Johnston (1996) studied parenting style and found that parents of ADHD children with both high and low levels of conduct problems reported using more ‘negative reactive’ and less ‘positive’ parenting strategies than controls. Woodward et al (1998) investigated the parenting and family functioning of a community sample of hyperactive children and found that they differed from controls on measures of parent coping and the use of aggressive discipline methods even when controlling statistically for conduct disorder and parental mental health.

What emerges from these studies is that when controlling for conduct problems in ADHD, difficulties are apparent on measures of child caregiver interactions and the use
of discipline, rather than on more general measures of family functioning such as communication, role allocation, problem solving or affective involvement.

### 2.2.1.3 Impact of ADHD on parents

Parents of ADHD children report lower parenting self esteem, more guilt and more social isolation than controls (Mash & Johnston, 1983), fewer and less helpful contacts with extended family and higher depression (Befera & Barkley, 1985; Cunningham et al, 1988; Johnston, 1996). The level of parental stress in ADHD has been found to be high (Anastopoulos, Guevremony, Shelton & Du Paul, 1992; Mash & Johnston, 1983). These studies emphasise that parenting an ADHD child is demanding and stressful and are congruent with evidence for disturbed parent child interactions.

### 2.2.1.4 The importance of further study of family functioning

The group studies reviewed above present mixed evidence about how far family dysfunction is a correlate of having a child with ADHD. This highlighted the need for further investigation of the process by which the syndrome impacts on families. Woodward et al (1998) argue for the central importance of studying the psychosocial processes operating in ADHD as an addition to the traditional focus on behavioural and neurological characteristics and emphasise the importance of family and relationship variables in determining the likelihood of clinical referral, the child's response to treatment and prognosis.

### 2.2.2 Treatment by stimulant medication.

#### 2.2.2.1 Studies of effects on ADHD symptoms

Stimulant medication has been shown to have a beneficial effect on behaviours that define ADHD (Swanson, McBurnett, Wigal & Pfiffner, 1993) i.e., reduced activity and increased attention to tasks (Barkley, 1977) and improves general academic functioning (Douglas, Barr, Amin, O'Neill & Britton, 1988). Schachar, Tannock, Cunningham and Corkum (1997) found significant improvement in the symptoms of ADHD and
oppositional behaviour at school immediately and at four month follow-up after treatment with methylphenidate. In contrast to earlier studies such improvements in behaviour were not reported by parents at home.

2.2.2.2 Studies of effects on social functioning and family relationships

Whalen and Henker (1989) review the effects of stimulant medication on the social functioning of hyperactive children across peers and adults. They argue that the best documented effect is on the decreased rate of disruptive and aversive exchanges, particularly in task, rather than free play, settings. In experimental studies stimulant medication has been shown to improve parent child interaction in enhanced compliance from the child, decrease in commands and a more positive response to child initiated behaviour in mothers although levels of interactive problems are still greater than for controls (Humphries, Kinsbourne & Swanson, 1978; Barkley & Cunningham, 1979). In a more naturalistic study, medication led to increased maternal warmth, less maternal criticism, greater frequency of contacts between mother and child and fewer negative encounters between children and siblings compared to a placebo and control group where the treatment was focused over three weeks (Schachar, Taylor, Wiesberg, Thorley, & Rutter, 1987). A small study (MacKechnie, 1997 - see previous section of portfolio) looked at the effects of medication on children and parent's perceptions of family relationships in routine clinical practice. It concluded that the impact of medication appears to be a complex process probably influenced by prior parent-child relationships, the degree and nature of behaviour change and possibly changes in parents attributions for behaviour when the child is off medication.

2.2.2.3 The importance of further study of the impact of medication on family functioning

Research findings are mixed on what extent and in what way treatment with stimulant medication impacts upon family relationships. Prior to further quantitative group studies being able to pinpoint and test hypotheses regarding the significant factors in this complex process, an in-depth examination of individual cases was thought to be useful.
2.2.3.1 Theory

Other literature gives some insight into the psychological processes that may operate when medication is used to treat ADHD. There has been some discussion of the 'emanative effects' or 'socio-cognitive sequelae' of medication for ADHD i.e., its meaning to parents and children beyond its immediate effects on behaviour. Suggestions have been made that the failure to illustrate long-term beneficial outcome of medication treatment may be linked to a failure to study this context of medication use (Whalen & Henker, 1976). Drawing on the early work of Weiner (later published as Weiner 1986) and Rotter (1966) these authors propose that medication is likely to reduce children's and parent's guilt and anxiety about the disorder by explaining problem behaviours as being caused by a physical condition. Attribution Theory predicts that if the cause of behaviour is regarded as beyond a person's control (i.e., physical condition such as ADHD) this will lead to less distress, more compassion, tolerance and inductive discipline (i.e., explanation and reasoning) than if the behaviour is seen as controlled, wilful and deliberate which in turn would be more likely to lead to criticism, disapproval and power assertive discipline (Weiner, 1986, Kelley & Michela, 1980; Dix & Grusec, 1985). Nonetheless, Whalen and Henker (1976) also suggest that the concept of a diagnosable physical condition may lead to beliefs about the stability rather than variability of cause which will lead to demoralisation about problem solutions (i.e. medication as the only solution) and a reduction in parents and children's mutually influencing sense of efficacy. This distinction between cause and solution attributions is also found in Brickman, Rabinowitz, Karuza, Coates, Cohn & Kidder (1982) and expanded upon in Leventhal's (Leventhal, Prochaska & Hirschman 1985) self regulatory model of illness behaviour.

Social Learning Theory (Bandura, 1977; Herbert, 1991) also supports the link between attributions and the relationship with the child in explaining how attributional processes may determine the schedules of reinforcement parents provide for their hyperactive children. If behaviours are seen as uncontrollable and attributed to the illness, parents
are less likely to respond in a critical and disapproving way to their children, and more likely to respond calmly with tolerance and empathy. The child's tendency to model parental behaviour creates a feedback loop to the parents thereby resulting in overall increased warmth and empathy in their relationship. Parents beliefs about their own and the child's self efficacy may also be internalised and acted upon by the child.

2.2.3.2 Empirical investigations: attributions and parental affect

Bugental and Shennum (1984) proposed a transactional model of adult child interactions. They found that adults had an affective pattern that matched their construal of caregiving situations i.e., caregivers experienced helplessness in interactions with unresponsive (i.e., controlling) children which maintained the child's unresponsiveness. Similarly, Bugental and Cortez (1988) and Bugental, Blue and Lewis (1990) found that adults with low perceived control over a discipline encounter responded with greater negative affect and helplessness to difficult children than did adults with high perceived control. Medvene and Krauss (1989) found that a stronger endorsement of an organic attribution for their children's psychiatric disabilities (i.e., low control) as a result of parent education was associated with a decrease in expressed emotion.

2.2.3.3 Empirical investigations: Attributions and parents discipline style

The relationship between attributions and discipline has shown a consistent pattern in the literature. Dix, Ruble, and Zambarano (1989) assessed whether attributions about children's competence and responsibility for misconduct mediated the effects that the mother's child rearing ideologies, children's ages and children's behaviour had on mother discipline preferences (i.e., induction or power assertion). They found that perceived competence and responsibility in the child led to more power assertive discipline strategies across children's ages, behaviour and mother's ideologies.

Dix, Ruble, Grusec & Nixon, (1986) similarly showed that when parent's perceived misbehaviour as more intentional, they expressed more negative affect and attached greater importance to responding to the child's misbehaviour. Dix and Lochman (1990) and Geller and Johnstone (1995) reported a similar pattern and stressed that it was the
controllability rather than the globality or stability of these behaviours that predicted parents response. Smith and O’Leary (1995) found that the extent to which mothers blamed children for displaying negative affect accounted for a significant portion of the variance in mother’s emotional arousal and over-reactive parenting. Butler, Brewin and Forsyth (1986) showed that perceptions of the causes of enuresis as uncontrollable led to more tolerance on the part of mothers.

2.2.3.4 Studies of parents attributions in ADHD

Johnston and Patenaude (1994) compared attributions for both inattentive/over active behaviours and oppositional defiant behaviours in terms of locus, controllability and stability in diagnosed hyperactive children. They found that the two types of behaviour did not differ in terms of causal locus or stability as they were seen as internal to the child and stable, but that oppositional defiant behaviours were seen as more controllable than inattentive/overactive behaviours and elicited more negative reactions. Johnston and Freeman (1997) compared child centred attributions in parents with diagnosed ADHD children (of whom 60% used stimulant medication regularly but were not medicated during the study) to controls. Their results showed that although parents rated the behaviour characteristics of ADHD children as more internally caused, more uncontrollable, more stable and themselves as less responsible for the difficulties (including contrary to prediction the oppositional defiant behaviours) these child serving attributions did not ameliorate ratings of emotional upset, frustration and annoyance which were higher than controls. As such, the predictions from Attribution Theory of less controllability leading to tolerance and positive discipline are not supported in this study.

2.2.3.5 Empirical investigations: parents efficacy following diagnosis and medication use

Henker and Whalen (1980) report preliminary findings from interviews with children and parents exploring cause and solution attributions after medication use. In their study parents experienced ambivalence about the helpfulness of medication as they
faced serious criticism from the school if they refused to medicate the child, but faced the risk of side effects and of criticism from others if they did. The parental interviews are not however, reported on at length and the full methodological account has not been published. The controversial aspects of medication use for parents is also illustrated by literature showing that parents commonly refuse stimulant therapy and often discontinue treatment (Borden, Brown, Clingerman & Jenkins, 1984; Firestone, 1982). These studies suggest that medication use for ADHD is a difficult and controversial decision for parents. The nature of this controversy and how it influences the relationship with the child is not known. Social Learning theory suggests that parents low self efficacy and beliefs about the child’s low efficacy possibly encouraged by medication use will be internalised by the child and become mutually reinforcing.

2.2.3.6 Empirical investigation: children’s efficacy after medication use

Henker and Whalen’s (1980) interview study of children opinions of medication describes them as ‘active construers’ who saw problems as physiologically based and not remediable by personal or social factors. However, these explanations were not entirely consistent and although children saw behavioural difficulties as a physical phenomenon for which they needed medication, they described some ability to control the behaviours themselves.

Other studies have further investigated the concerns about how the attributional correlates of medication impact upon the child’s sense of efficacy. Bugental, Whalen and Henker (1977) found that those not on medication responded better to ‘self control’ treatments suggesting that medication did reduce their sense of efficacy. Reid and Borkowski (1987) illustrated that including an attributional retraining component in a behavioural intervention programme for hyperactive children significantly increased its success. In contrast, Borden and Brown (1989) found that self control treatment for hyperactivity along with medication led to a stronger parental belief in their child’s efficacy for solving problems than in those families who just received medication, but they did not find a significant differences in children’s efficacy. Furthermore, Milich, Licht, Murphy and Pelham (1989) found that children on medication tended to use effort
or ability, rather than medication as an explanation for performance on tasks. Whalen, Henker, Hinshaw, Heller, and Huber Dressler (1991) argue that these contrasting results may be due to methodological difficulties of measuring children’s causal reasoning as medication serves as an attributional anchor during an open ended commentary whereas effort or ability is likely to dominate when structured formats remind the child of more conventional options.

2.2.3.7 The importance of study of attributional processes in ADHD treatment

The changes in family relationships after medication use may be explainable using Attribution Theory as diagnosis and medication is likely to lead to attributions of uncontrollability for ADHD behaviours associated with more ‘child serving’ parental discipline and affect. This will be the first study to examine the attributional correlates of medication treatment. Given that studies of attributions in ADHD have shown some patterns that are contradictory to the theory, an open qualitative exploration of parent’s perspectives would allow for the possibility of exploring attributional processes idiosyncratic to ADHD. Studies suggest that there is reason to be concerned about the attributional impact of diagnosis and medication treatment on parents and children’s self efficacy but research findings are mixed. The open nature of this research design allows for the salient aspects of participants experiences to emerge.

2.3 Conclusions from literature review. The need for a phenomenological study.

2.3.1 Studies of family functioning in ADHD

The impact of ADHD on family functioning has been studied at length but the results of group studies remain mixed and do not greatly clarify how having a child with ADHD impacts upon family relationships. As such, in-depth and detailed analyses of individual families perspectives was thought to be useful.
2.3.2 Studies of the impact of medication and diagnosis on family relationships in ADHD

The research findings concerning the impact of medication use and diagnosis on family relationships are not extensive and are to some extent contradictory. Several studies point to the beneficial effects of medication on family interactions. Attribution Theory and Social Learning Theory provide some hypotheses about how diagnosis and medication may have a positive effect on parental attributions, discipline strategies, affect and the relationship with the child. Nonetheless, some studies have also shown that improvements in relationships and behaviour at home may not be perceived consistently from the child or parents point of view when medication treatment for ADHD in routine clinical practice is studied. These contradictions in the literature from group studies suggested the usefulness of a detailed analysis of the processes operating in individual cases. A qualitative methodology was chosen to provide in-depth accounts of the participant’s perspectives to allow for the documentation of similarities and differences in parents accounts.

2.3.3 Studies of attributional processes in ADHD and the socio cognitive context of medication use.

Studies suggest that attributional processes may not operate in a straightforward fashion in ADHD as negative parental affect remains unexpectedly high despite attributions of low controllability for problems as a result of diagnosis. Parents and children have been shown to be ambivalent about medication use and studies suggest it may have a detrimental effect on both parent’s and children’s mutually influencing sense of self efficacy or attributions for problem solutions. Given these contradictory results it was felt that theoretical hypotheses of relationship change after diagnosis and medication use (as outlined in Diagram 1) could best be studied through a detailed analysis of individual cases.
2.3.4 Additional reasons for a phenomenological approach

Since ADHD is a behavioural disorder cutting across home and school settings there would be a need to consider how parents reconcile different views and opinions about their children's difficulties and their often controversial treatment choice. How these more holistic factors impact upon changes in family relationships after medication use was thought to require investigation in a more flexible manner than would be possible through the use of more circumscribed quantitative measures (Whalen & Henker, 1976).
3. THE AIMS OF THE STUDY

a) The study will explore parent’s and children’s accounts of the impact of medication and diagnosis on family relationships to identify the important themes and patterns which emerge when parents and children are asked to describe their experiences.

b) The study will examine the similarity and differences between accounts of parent’s and children both within and between families. Very few studies in ADHD have considered the perspectives of fathers and children. It was thought that diagnosis and medication may have less impact on the relationship between father and child as the literature suggests that fathers are less affected by the ADHD symptoms. How children’s and parent’s perspectives would differ was difficult to predict given the lack of studies on children’s perspectives in ADHD, although Social Learning Theory suggests that children, having been socialised by parents, would have similar accounts to them.

c) This study assesses how the experiences of these families could be understood in relation to existing psychological theory specifically Attribution Theory and Social Learning Theory. These theories make predictions about how diagnosis and medication may be related to the attributions about the causes and solutions of the child’s behaviour difficulties and also about the effects of these attributions on parental discipline styles and affect. The study seeks to assess the adequacy of this theoretical framework for understanding these processes particularly given the existence of findings that do not fit this model (see Diagram 1 for initial hypothesised theoretical model). As medication was mainly used during school hours it was anticipated that some problem behaviour would still be displayed at home and that a major impact of the diagnosis and the initiation of medication use would be on parent’s attributions for the behaviour.

Although the diagram is in a linear format the reader is advised that this is for presentation purposes only and elements are thought to be interconnected and mutually influencing at all levels.
4. METHOD

4.1 Description of Interpretative Phenomenological Analysis.

The study employed Interpretative Phenomenological Analysis (IPA) which has a dual commitment to investigating personal accounts of objects or events, (a perspective derived from symbolic interactionism and phenomenology (Blumer 1969) whilst remaining sensitive to the impact of the “researcher’s own conceptions that are required in order to make sense of that other personal world through a process of interpretative activity” (Smith, 1996; pp. 264). IPA has been mainly developed within health psychology where accounts of the personal meaning of physical conditions such as chronic pain have been of interest (Osborn & Smith 1998). It is an essentially ‘idiographic’ or case study approach for documenting complex psychological processes and the content rather than the frequency of phenomena. Patterns across individual cases are sought in order to develop a ‘Grounded Theory’ of the phenomena under consideration. Smith urges that this may be used to ‘interrogate’ or add detail to existing theory and should facilitate the development of more precise and relevant research questions. To facilitate the participants explication of the personal meaning of the phenomena under consideration a semi structured interview is the measure of choice.

4.2 Epistemological stance of IPA

A constructivist methodology such as discourse analysis, is sceptical of the possibility of research subject’s verbal reports being able to reflect their underlying cognitions because of the subject’s and researcher’s role in shaping what is said. By contrast, ‘realist’ methodologies such as traditional social cognition approaches, uphold the possibility of researching and accessing cognitive phenomena such as attributions and schema. IPA takes an epistemological stance between these two positions, stating that although participants cognitions are not readily transparent through interviews and are always subject to the retrospective biases of the subject and the interpretation of the
researcher, there is the possibility of saying something about participant's thinking (Smith, 1996). Henwood (1997) has described this middle position as 'contextualism' where the aim is to elaborate the personal, situationally based meaning of phenomena. In order to obtain rich contextualised accounts of phenomena the research sacrifices the traditional research goal of objectivity.

According to Smith (1996) IPA uses many of the rigorous strategies of Grounded Theory (Glaser & Strauss, 1967) for deriving a set of theoretical outcomes from unstructured qualitative data (Charmaz, 1990, 1995; Pidgeon, Turner & Blockley, 1991). One recent criticism of Grounded Theory has been the impression it has given of being able to provide 'true' and 'unsullied' accounts of participant's experiences not influenced by the researcher's prior conceptions (Charmaz, 1990). IPA takes account of Charmaz's argument for the need for a new 'constructivist version' of Grounded Theory whereby researchers inevitably have a perspective and a set of 'sensitising concepts' from which to build their analyses of data without merely applying them to new data and that the process is one of active theory generation rather than discovery. In this study, 'sensitising concepts' from Attribution Theory and Social Learning Theory provided the initial perspective. In accordance with guidelines of Turpin, Barley, Beail, Scaife, Slade, Smith & Walsh (1997), the Grounded Theory produced whilst being closely tied to participants accounts, would be related back to these existing theoretical concepts in the discussion.

Henwood and Pidgeon (1995) describe how the building of a 'total' theory as described by Glaser and Strauss, is an ambitious goal and suggest three alternatives; firstly, building a 'taxonomy of relevant features' of a data set, secondly, 'focused conceptual development' i.e., exploring the properties of a limited set of categories of particular relevance to the problem under investigation and thirdly cycles of interpretation i.e., further data collection as refined by prior concepts. This project aims to achieve the first two goals.
4.3 **Rationale for the use of a qualitative methodology**

The value of qualitative methods in psychology has recently been recognised (Henwood & Pidgeon, 1992, 1994) particularly within clinical psychology (Orford, 1995) where it has been argued that studies of aggregate group data need to be complemented by an understanding of psychological processes in individual cases (Brown, 1998). Turpin et al (1997) and Hammersley (1997) suggest that their use should be a pragmatic rather than philosophical decision made to suit a specific research question.

As well as exploring the meanings attributed to human transactions and behaviour by participants, qualitative methods are appropriate when there is interest in complexity or process or where an issue is controversial or sensitive such that quantitative measures may be able to elicit only superficial responses and particularly where existing research findings are contradictory (Walker, 1985; Smith, 1995; Turpin et al, 1997). All of these aspects were thought to be applicable to the current study. Bryman (1988) also argues for their use to enable a holistic understanding of events in their context and in order to explore specific phenomena where the explanations of existing theory may be too general to account for variations in cases i.e., where, "...no a priori theory could possibly encompass the multiple realities that are likely to be encountered .....a priori theory is likely to be based on a priori generalisations which while they may make nomothetic sense may nevertheless provide a poor idiographic fit to the situation encountered (Lincoln & Guba, 1985; pp. 41 cited in Wright 1997)". The likely heterogeneity of parent and child characteristics in clinical groups receiving a diagnosis of ADHD and prior mixed research findings on this issue suggested that such an idiographic exploration would be appropriate and of clinical value.

4.4 **Anticipating criticism**

Qualitative methodologies are likely to encounter criticism within a dominant 'positivist' paradigm in psychology (Wright 1997). Issues regarding the problem of subjectivity, interviewer bias, the relationship between data and theory, generalisation, validity and reliability were taken into account in the design of the project. In
accordance with the standards laid down by Turpin et al (1997) for doctoral level qualitative projects, and Smith (1997) the following procedures were used to address the issue of validity. (Note: a more detailed account of these issues and terminology is given in Appendix 1).

a) Internal coherence (the final report was to be coherent and to deal with contradictions and ambiguities within the data).

b) Presentation of evidence (the results section would provide sufficient raw data to allow the reader to interrogate the interpretation being made).

c) Respondent validation (participants were asked to comment on a list of initial themes arising from their accounts).

d) Independent audit (an assistant Psychologist read 60% of the transcripts and theme lists with a brief to check whether themes were warrantable and based on the data).

e) Triangulation (different methods and sources of data were used in so far as both parents and the child were interviewed and behaviour ratings and diary sheets were used in addition to interviews).

4.5 Research Design

4.5.1 Type of sample

The sample was derived by ‘purposeful homogeneous sampling,’ (Patton, 1990) to select families with some similarity of child characteristics, treatment process and response to medication. The criteria were designed to allow comparability across cases but families were not selected to be particularly representative of a population because the aim of IPA is to produce detailed examination of individual cases (Smith, 1994). Osborn & Smith (1998) argue that participants in this kind of study should not be regarded as exemplars of the topic under consideration (in this case the ‘ADHD family’).
but should provide "specific instantiations of the psychological experience" of the impact of diagnosis and medication on relationships (Osborn & Smith, 1998; pp 68).

4.5.2 Inclusion criteria

Recruitment was of families referred to specialist ADHD clinics as part of Child Mental Health Services in six different community and hospital sites. Ethical approval was obtained (see Appendix 2). All children had received a diagnosis of ADHD (by either a Consultant Psychiatrist on four sites, a Staff Grade psychiatrist on one site or a Consultant Paediatrician) in a two stage process i.e., using screening questionnaires and an assessment interview including observation (British Psychological Society, 1996). The diagnosis was made according to DSM IV criteria (A.P.A., 1994) from the assessment interview with parents. Children were required to meet the diagnosis of a combined type of ADHD (attention and hyperactivity) and to score at or above the 93rd percentile (i.e., 1.5 standard deviations above the mean) on an age and sex appropriate rating scale measure of ADHD as suggested by Anastopoulos et al (1992). In this case the impulsivity/hyperactivity subscale of the revised Conners’ Parent Rating Scale (CPRS) was used (Goyette, Conners & Ulrich, 1978) (see Appendix 3). This scale has established reliability and validity and was chosen because of its routine use in clinical practice. Where possible, the parent first and third completions of the questionnaire (at referral and post medication interviews) were used for diagnosis and follow-up given that a practice effect between first and second ratings can lower the second score. (Goyette, Conners & Ulrich, 1978). In order to ensure that problems were apparent across two settings children were required to be above the nearest age appropriate cut off on the IOWA Teacher’s Conners’ Scale (Pelham Milich, Murphy & Murphy, 1989) (see Appendix 4) which is based on the original Conners’ scale (Conners, 1969). This scale provided a more accurate differential measure of aggression and overactive problems than the original factor scales with two five item subscales.

Children with substantial intellectual disabilities were excluded by recruiting only in mainstream schools and by excluding children above level 2 in the educational statementing process unless there was evidence of ability in the average range on a
general measure of intelligence. Children with a Statement of Educational Needs for difficulties clearly unrelated to ADHD (e.g., visual/hearing problems), with major expressive language disorders or with a known diagnosis of conduct disorder were also excluded. Children were aged 8-12 years in order to maximise the possibility of coherent responding to interviews and to avoid issues related to adolescence.

Families had not been in previous contact with ADHD services and medication was the only formal intervention for the difficulties at home. At the time of interview all children had been on an optimum dose of stimulant medication for at least eight weeks. All families had some medication use at home. Parent’s reports of improvement in their child as a result of medication confirmed inclusion in the study (see Appendix 5). Behaviour change was assessed using Conners’ Parents and Teachers ratings scales pre and post medication as described above (but no formal change was needed for inclusion).

4.5.3 Additional sample

Due to difficulties recruiting, a further sample was sought of families meeting the above criteria who had been diagnosed with ADHD and first prescribed medication between 6 months to one year previous (with evidence in case notes of a diagnosis made according to DSM IV or International Classification of Diseases (ICD) 10, W.H.O, 1992).

4.5.4 Method of recruitment

Where possible, children and their parents were informed about the study at their initial appointment at the clinic by way of an information sheet and recruited at follow-up (4-8 weeks). Written consent was obtained (see Appendix 6). Interviews were arranged after the follow-up visit to the clinic. Families who had had medication for longer were approached by way of letter followed by a telephone call during which interviews were arranged.

A total of 153 families were screened (76 new referrals for assessment for ADHD and 77 old cases previously assessed in ADHD clinics) of whom 24 met the criteria and
were approached. 12 declined to participate because of the lengthy nature of the interviews. (see Appendix 7 Table 1 for reasons for exclusion).

4.5.5 Description of sample

Sixteen parents were interviewed including four fathers. All mothers were the biological mothers of the index child and four families had stepfathers, two of whom were interviewed. There were four single mothers (for three of whom the index child was the only child). All social class groups were represented apart from class V, as measured by the Registrar General’s Classification system (Office of Population Censuses and Surveys 1980) and two parent were unemployed and receiving benefits. The modal category was class I (5/12 families).

Six children had one sibling, and three children had two siblings. Of those children with siblings, five were the eldest, three were the youngest and one was the middle child. All children were white males and with English as the first language. The mean age of the children was 9 years and 9 months. A third (4) of the children had medication in the evenings and at weekends, half (6) used it during the daytime and at weekends and a sixth (2) used it at home irregularly at their discretion. For eleven children the diagnosis had been their first contact with child mental health services. One child had previous behavioural and family therapy at a different service. One child had a statement of educational needs to address literacy problems and two children were at stage three of special educational provision. The remainder were at levels one or two of special educational provision. None of the children had a known diagnosis of conduct disorder however, only the new cases (7/12) had been actively screened by clinicians. Furthermore, of those who had been screened, all seven scored above the 93rd percentile on the Conners’ parent’s conduct subscales (as did a further three of the old cases) and two thirds (9) scored above the cut-off on the Teacher’s scale.
4.6 Measures

4.6.1 The Research Interview

4.6.1.1 Construction of the interview schedules

The main measure for parents and children was a semi-structured interview designed according to the guidelines of Smith (1995), Charmaz (1995), Brenner (1985) and Patton (1990). This involved identifying broad themes based on existing literature, putting questions in logical order (with more sensitive questions later), using neutral open questions and avoiding jargon. The aim of these procedures was to gain access to the participants' thoughts on the topic without them being led by the interviewer. The interview schedule was not intended to be prescriptive but acted as a guide for the interview and did not necessarily dictate its exact course (see Appendix 8 for interview schedule).

Children's ability to narrate autobiographical events is thought to be limited by impoverished memory structures or scripts. To address such deficiencies Sayitz & Snyder (1996) use a cueing procedure to teach children to organise recall of an event into categories. These categories are thought to be psychologically salient in script theories of children's event knowledge (i.e., participants, actions, setting, conversation, affective states and consequences). Although the visual prompts of these categories were not used in this study, the categories were used to guide questioning with children. Methods for engaging children were derived from an interview study of children's opinions of medication (Henker & Whalen, 1980). The content of the children's interview schedule was based on the adult topics (see below) with wording simplified where necessary.
4.6.2 Content of the interviews.

4.6.2.1 Part 1: Perceptions of family relationships prior to medication

The content of the questions were derived from the theoretical model as outlined in the introduction. Parents were asked to describe relationships with other family members with prompts if necessary for salient memories, incidents, thoughts and feelings towards the person. These prompts were based on conceptualisation of relationships in the Adult Attachment Interview (George, Kaplan & Main, 1985). For parents, the description of relationships was contextualised with a brief developmental history of the child and a description of the parent's relationship with their own parents and their own parenting style.

4.6.2.2 Part 2: Perception of and attributions for problems and their impact on relationships.

Parent's descriptions of the child's difficulties prior to medication and diagnosis were obtained. Attributions for the cause and maintenance of the difficulties were explored as was their impact on family relationships. Parents were asked to describe responses to the difficulties focusing on particular incidents of behaviour with prompts about discipline and affect and their views on the controllability of the behaviour. Attributions for any prior solutions to the difficulties and the effect of these on relationships was explored.

4.6.2.3 Part 3: Contact with services

Parents were asked to describe previous contact with services, the experience of diagnosis and receiving medication and their understanding of ADHD. The impact of this on their relationship with the child was explored.
4.6.2.4 Part 4: Differences and similarities in child’s difficulties and impact on relationships

Changes and residual difficulties since being on medication and their impact on relationships was explored. Parent’s current response to problematic behaviours were explored if necessary with prompts regarding discipline, affect and attributions of controllability.

4.6.3 Interview procedure

Families were interviewed in their own homes. Interviews with each parent lasted up to ninety minutes and with children up to forty five minutes.

4.6.4 Piloting

Preliminary piloting was conducted with a volunteer family from the supervising clinician’s caseload to assess the length of the interviews and the comprehensibility of questions. Questions were refined for intelligibility and relevance during the initial interviews of the main study.

4.6.5 Diaries

Parents were asked to record 1-2 incidents of problem behaviour symptomatic of ADHD over a two week period preceding the interviews. This method of obtaining material pertaining to the research questions has been used by Smith (1994). In these diaries they gave a description of the behaviour, their thoughts about the causes of the behaviour and the child’s level of control and their responses (discipline and affect) to the behaviour. They were also asked to state their view about similarities and differences in their responses to the behaviour prior to diagnosis and medication. Diary entries were coded and analysed in the same manner as the interview transcripts (See Appendix 9 for diary sheets and completed example).
5. DATA ANALYSIS

Individual and shared themes arising from interview transcripts and diaries were analysed according to Pidgeon et al (1991), Smith (1994, 1995), Smith, Osborne and Jarman (1998) and Charmaz (1995). Interviews were fully transcribed and initial coding involved a process of examining semantic content, language use and key words and phrases were highlighted and labelled with a word or phrase which captured the essence of the content. Each label was required to fit the phenomena in the data exactly and the question in the mind of the researcher when interpreting the data was, “what categories, concepts or labels are needed in order to account for the phenomena of importance in this paragraph?” (Pidgeon et al, 1991 cited in Wright 1997). Once each transcript was been analysed, the codes or labels were clustered together on the grounds of conceptual similarity to create higher order thematic categories. Decisions concerning which instances to include under a particular theme were made with the aim of collecting a set of categories illustrating the multiple facets of each theme (Pidgeon et al, 1991). For each theme a file of transcript extracts was collected.

The next stage of the analysis was to identify commonalities and differences between individual’s accounts through a comparison process with the aim of integrating themes into a theoretical account. As Pidgeon et al (1991) state, coded concepts or themes must be refined, extended and checked against further data and related to each other in order to do this. Themes identified from individual accounts were therefore examined to see if any higher order or cross family themes could be created to bring lower level categories together in a meaningful way. Connections or links between categories formed the basis of the models (see results) and the links were made if either the participant made the link explicitly or if categories appeared to be logically related within a single transcript or across several transcripts according to the researcher. Where several categories clustered together pertaining to a theme this is described as a subtheme in the results section. The themes presented in the analysis are those which emerged most consistently and clearly from the data. Although the diagrams suggest a categorisation of parent’s accounts the differences between parents were sometimes
seen to be more continuous than categorical. This is indicated where appropriate in the results section.

In the following presentation of the themes extracts were chosen for being the most articulate or powerful examples of a common theme (Flowers, Smith Sheeran & Beail 1997). The participant's names and other identifying information have all been changed.
6. RESULTS

6.1 Rating scales

Table 1.  *Time on medication and raw scores on inattentive/overactive (IO) and oppositional defiant (OD) factors of IOWA Conners Teachers Rating Scale.*

<table>
<thead>
<tr>
<th>Time on Medication (months)</th>
<th>Pre medication</th>
<th>Post medication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IO</td>
<td>OD</td>
</tr>
<tr>
<td>Jim</td>
<td>2</td>
<td>11*</td>
</tr>
<tr>
<td>Matthew**</td>
<td>2</td>
<td>9*</td>
</tr>
<tr>
<td>Keith</td>
<td>8</td>
<td>9*</td>
</tr>
<tr>
<td>Darren</td>
<td>2</td>
<td>15*</td>
</tr>
<tr>
<td>Ian</td>
<td>10</td>
<td>14*</td>
</tr>
<tr>
<td>Bill</td>
<td>11</td>
<td>9*</td>
</tr>
<tr>
<td>Terry**</td>
<td>3</td>
<td>10*</td>
</tr>
<tr>
<td>Gavin</td>
<td>6</td>
<td>13*</td>
</tr>
<tr>
<td>Larry**</td>
<td>3</td>
<td>13*</td>
</tr>
<tr>
<td>Jonathan</td>
<td>3</td>
<td>15*</td>
</tr>
<tr>
<td>Lenny</td>
<td>3</td>
<td>15*</td>
</tr>
<tr>
<td>Mark**</td>
<td>12</td>
<td>10*</td>
</tr>
</tbody>
</table>

* denotes above cut off on age and sex equivalent norms for inattentive/overactive and oppositional defiant behaviours

** based on cut off for age group closest to child.

Table 1 illustrates ratings on the IOWA Teacher’s Conners’ scales ratings for each child and indicates whether or not they are above or below the normative cut off for inattentive/overactive behaviour and oppositional defiant behaviour pre and post medication. Post medication data was not available for child 11 as the Teacher’s questionnaire was not returned within the time of the study.
Table 2. *Children’s length of time on medication and raw scores pre and post medication on hyperactive and conduct factors of Conners Parents Rating Scale.*

<table>
<thead>
<tr>
<th>Time on Medication (Months)</th>
<th>Pre medication</th>
<th>Post medication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hyper</td>
<td>Conduct</td>
</tr>
<tr>
<td>Jim: Mum</td>
<td>2</td>
<td>11*</td>
</tr>
<tr>
<td>Matthew: Mum</td>
<td>2</td>
<td>10*</td>
</tr>
<tr>
<td>Matthew: Dad</td>
<td>2</td>
<td>8*</td>
</tr>
<tr>
<td>Keith: Mum</td>
<td>8</td>
<td>9*</td>
</tr>
<tr>
<td>Darren: Mum</td>
<td>2</td>
<td>10*</td>
</tr>
<tr>
<td>Darren: Dad</td>
<td>2</td>
<td>9*</td>
</tr>
<tr>
<td>Ian: Mum</td>
<td>10</td>
<td>8*</td>
</tr>
<tr>
<td>Bill: Mum</td>
<td>11</td>
<td>8*</td>
</tr>
<tr>
<td>Bill: Dad</td>
<td>11</td>
<td>-</td>
</tr>
<tr>
<td>Terry: Mum</td>
<td>3</td>
<td>9*</td>
</tr>
<tr>
<td>Terry: Dad</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Gavin: Mum</td>
<td>6</td>
<td>9*</td>
</tr>
<tr>
<td>Larry: Mum</td>
<td>3</td>
<td>11*</td>
</tr>
<tr>
<td>Jonathan: Mum</td>
<td>3</td>
<td>11*</td>
</tr>
<tr>
<td>Lenny: Mum</td>
<td>3</td>
<td>8*</td>
</tr>
<tr>
<td>Mark: Mum</td>
<td>12</td>
<td>9*</td>
</tr>
</tbody>
</table>

* denotes score at or above cut off (1.5 s.d. greater than normative age and sex equivalent mean score)

Table 2 illustrates ratings on the Conners’ parent’s subscales of children’s behaviour and indicates whether they are above or below the normative cut off for inattentive or conduct problems pre and post medication.
Table 3. Group means, scores, standards deviations and significance of change pre and post medication of Teacher’s IOWA Conners’ rating scale and Parent’s Conners’ rating scale using Wilcoxon Matched pairs signed ranks test

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre medication</th>
<th>Post medication</th>
<th>z score</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>mean</td>
<td>s.d.</td>
<td>mean</td>
<td>s.d.</td>
</tr>
<tr>
<td>Teacher IO</td>
<td>11.92</td>
<td>2.5</td>
<td>6.27</td>
<td>2.94</td>
</tr>
<tr>
<td>Teacher OD</td>
<td>8.50</td>
<td>4.25</td>
<td>4.55</td>
<td>2.84</td>
</tr>
<tr>
<td>Parent hyperactivity</td>
<td>9.29</td>
<td>1.14</td>
<td>6.73</td>
<td>3.26</td>
</tr>
<tr>
<td>Parent conduct</td>
<td>13.43</td>
<td>4.78</td>
<td>9.07</td>
<td>4.35</td>
</tr>
</tbody>
</table>

Table 3 illustrates that for this group of children there were significant changes in hyperactivity and conduct problems as measured by rating scales both at home and school although, for individual children scores remained above the normal range in many cases (see Tables 1 and 2).

6.2 Description of themes

The analysis focuses upon those themes which emerged from interviews with parents and children pertinent to the understanding the impact of diagnosis and medication upon relationships within the family. There were four interrelated themes:

a) Theme1: Reduction in demands and expectations of trouble,

b) Theme2: Impact on the perception of the child’s character and intentions,

c) Theme3: Impact on parents of having an explanation and solution, and

d) Theme4: Making allowances.

Themes 1, 2, and 4 are described and illustrated in full using verbatim extracts from transcripts and diaries and are presented in diagrammatic form. For the sake of brevity the third theme is described in brief with the full account in Appendix 11. This decision was made on the grounds that it covers material of secondary relevance to the main research questions. It is nonetheless referred to in the discussion section in terms of its

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links to the other themes. As children’s themes were conceptualised within some of the main thematic categories they are incorporated with parent’s accounts and the similarity and difference between parent’s and children’s accounts is outlined. A diagram representing children’s themes is given at the end of the results section (Diagram 6). Given the small number of fathers recruited for the study, their accounts are amalgamated with those of the mother’s and the implications of this are addressed in the discussion. The relationship of the emergent thematic models to the original hypothesised model (see Diagram 1) will be addressed fully in the discussion section. A full interview transcript is given in Appendix 12. Transcript notation used is outlined in Appendix 13.

6.3 Theme 1: A reduction in demands and expectations of trouble

Diagram 2. THEME 1: A REDUCTION IN DEMANDS AND EXPECTATIONS OF TROUBLE

6.3.1 Overview of Theme 1

A reduction in demands and expectations of trouble was a common experience for families with diagnosis and medication use. This was also perceived by children who described a decrease in the frequency and severity of problem behaviours and negative interactions with parents. The manner in which the reduction in demands was interpreted differed between families and had a range of consequences in their impact upon the relationship with the child which forms the subject of the later themes. The theme comprises several categories as illustrated in Diagram 2.
6.3.2 ‘Hard work’ children

Parents described children who had been difficult to manage and testing of their skills, particularly in comparison to siblings and children in other families. Although parents differed in their accounts of the affective relationship with the child (see later themes) the notion of ‘difficulty’ in managing the child was ubiquitous; beginning in infancy with the child refusing to sleep or eat or being highly active;

*the first month, six weeks, were really quite hard work. He never slept well right from the start......it was months and months before he slept through the night..........it wasn’t an unhappy time, it was just hard work and I could see that at eighteen months he was just so much harder work than anyone else’s baby (Ian: Mum).*

The demanding task of parenting continued in later childhood where children were portrayed as attention seeking and difficult to occupy;

*he wouldn’t play with anything, but he was quite happy for me to sit there and play with the toys while he watched (Darren: Mum).*

‘Hard work’ also referred to the child’s non compliant behaviours. One parent described the lengthy process of everyday tasks such as putting on a jumper;

*off he’ll go and he’ll come back and say ’What do you think? Shall I wear this one?’ You say ”Well, that’s fine”. And this is how it goes on; it can take, you know, quarter of an hour to get one jumper on (Darren: Mum),*

and also described by the child;

*I kept asking Mum to do my things that she asked me to do (Darren).*
6.3.3 Constant expectation of trouble

Parents described how life had become dominated by the child’s behaviour as they were living with a continual expectation of problems. This ranged from a concern for the child’s safety;

*If he was walking in front of you he’d walk into a lamp post... all his childhood... you had to be constantly aware of what was coming next to get there first (Ian: Mum),*

to the occurrence of overactive and defiant behaviour at home;

*you’re well aware he’s going to get up in the morning and the spring’s going to be wound up and off we go again. It just doesn’t stop (Bill: Dad),*

and at school;

*He’d go to school, get in trouble at school, come home, get in trouble at home.....The only time when he was good was when he was asleep (Larry: Mum).*

Parents and children described how volatile interactions occurred regularly;

*before he could even say anything.....[I] would sort of jump .....I mean I reacted.....I can think of loads of times when I shouldn’t have gone as far, because it wasn’t necessary, but because you are so wound up and stressed, it just happens (Terry: Mum).*

*If I gave her cheek .....she [Mum] used to shout and scream and go over the top and ban me and send me to bed, but she just went on and on and on, shouting and that (Terry).*

6.3.4 A decrease in behavioural symptoms and negative interactions.

Without exception, parents articulated some degree of reduction in these ‘demands’ and expectations of trouble as a result of medication use. This had two aspects; firstly
children became calmer, more compliant, less argumentative and less confrontational thus reducing negative interactions at home and secondly a marked reduction in negative feedback from school.

These aspects also formed the most predominant themes within children’s accounts. (See Diagram 6). Children’s descriptions were similar to parent’s in that they described a reduction in their own ‘bad’, ‘naughty’, and ‘silly’ behaviour as well as having become less ‘noisy’, ‘bad tempered’, and ‘annoying to others’ and ‘swearing’ and ‘wandering’ less. They also described parents as less intrusive, angry, likely to shout or make requests and as giving less frequent and/or severe punishments. Children also described a reduction in arguments both about school and behaviour at home.

As one parent explained;

he's calmer, doesn't get so het up, little problems aren't mountains any more - they remain as little problems - but he is quieter...., he's not so fidgety - it's nice not to be nagging him so much (Darren: Mum),

and from the child’s perspective;

I'm not asking them [both parents] all to do things for me, so I can get on with them myself, while they get on with what they're doing. And me shouting at them all the time, to get me a biscuit or something (Darren).

Language used to described parenting became characterised by ‘easiness’ in contrast to the previous accounts of difficult children;

it is a lot easier to deal with, far less tense, and you're not always arguing, telling off......It's easier, easier all round (Terry: Dad),

he's not always on at me, having to tell me off or anything...... he doesn't have to shout at me all the time, so we get on more and we talk a lot more than we used to (Terry).
The expectation of problems had reduced and the reduction in frequency increased tolerance to incidents;

*I haven't got this anger all the time, I haven't got this "I'm ready for you"
(Matthew: Mum),

You don't mind the child's outbursts because it's not all the time - it's only occasional.... (Jim: Mum),

I'm not getting into a lot of trouble like I used to be and like she [Mum] don't have to keep telling me off (Jim).

6.3.5 Improved feedback from school

A striking feature of parent's accounts was the dramatic changes they had experienced in feedback from the child's school. For children, school changes were also the most common theme as medication enabled them to 'concentrate', 'understand the teacher', 'stop and think', 'pay attention' and to resist 'daydreaming'. Many described awards or achievements they had recently received. Others described reduced instances of discipline at school for distracting others or fighting and many described having gained more friends. The powerful nature of this contrast in school was shown by parent's expressions of amazement;

*I think the merits were the first shock I mean within the first two weeks [of using Ritalin]- he's never had a merit since he's been at school - he got four
(Terry: Dad).

Many described less need to be involved with the school and some perceived this as a decrease in unreasonable harassment;

They was on the phone, it was just a non-stop..., it was absolute, pure contact with that school every single day they'd be on the phone, (Jim: Mum).

Such changes also impacted upon home life directly;
I don't yell at him as much because there aren't as many things to yell about [i.e., school problems]...... (Jonathan: Mum).

We're getting on better......really it was school that we got into arguments over. That I should just make more of an effort. .....That I shouldn't get so many pink slips, that I should try and avoid the people who I get into fights with, that sort of thing (Jonathan).
Diagram 3: THEME 2: THE IMPACT OF DIAGNOSIS AND MEDICATION ON THE PERCEPTION OF THE CHILD'S CHARACTER AND INTENTIONS

Although the diagram has a linear presentation all elements within each column are thought to be interconnected and mutually influencing.
6.4 Theme 2: Impact of diagnosis and medication on perceptions of the child’s character and intentions.

6.4.1 Overview of Theme 2

For all parents, diagnosis and medication introduced issues regarding their perception of the child’s character and intentions. Their accounts of these issues were broadly divided into three distinct and contrasting aspects of the theme reflecting the variation between parents. Diagram 3 illustrates this theme with each subtheme comprising one of the three columns. Shared experiences are illustrated by larger central boxes.

6.4.2 Subtheme 1: The good child returns (see central column of Diagram 3)

6.4.2.1 Overview of Subtheme 1

Parent’s description of the impact of diagnosis and medication on relationships was of a movement from a position of bewilderment about the cause of the behaviour, growing resentment towards the child and a sense of inefficacy to an increased appreciation of the child’s qualities and the return of a close and warm relationship.

6.4.2.2 Bewilderment

Parents described how the behaviour had begun to erode their ability to make sense of the child actions. This was characterised by the concept of ‘bewilderment’ which was associated with both frustration and anger towards the child;

*He was unbelievable...... it started off with him just being active, then just telling a few porkies, a few lies, then it was fighting, then the cutting up of clothes and beds - this is sending me absolutely nearly insane. I mean I used to just sit and cry, ask him why, because I couldn't understand it, or take in......... I wanted to hit my head off the wall, because I thought like what's going on?....... it was really, really weird (Jim: Mum).*

Another parent described his reaction to the child’s destruction of a newly plastered wall in a house they had recently moved to;
on the first day to do that, it defied logic I wanted to kill him, hurl abuse at him.... tie him to a stake in the garden..........That sort of action I try to justify within my head in a logical sequence of events and it just causes an overload...........it was completely unpredictable (Bill: Dad).

6.4.2.3 Inefficacy.

Bewilderment was accompanied by a sense of inefficacy, meaning a loss of ability to resolve the situation after a long and generally fruitless search for solutions;

I used to try no sweets, stop tomato sauce, orange squash, which then I found out hasn't got anything to do with it anyway, really, so I was doing that all that time for nothing .......I suppose I kidded myself along the way to think oh maybe it's this or maybe it's that.......I tried everything , I tried punishment, I mean I tried every single punishment that you could think of, everything.......I tried it all (Jim: Mum).

6.4.2.4 Conflicting positive and negative perceptions of child's intentions / increasing resentment and blame.

Parents described their awareness of having started to blame and resent the child. Their descriptions conveyed a tension between the desire to continue to understand and accept the child and the extent to which this had been put to the test by the child's behaviour;

it was pretty bad for a while, his and my relationship........ I would get angry, frustrated. I have to admit I didn't like him very much at times. I mean it is a horrible thing, but you get to the point where you think "I really don't like this little boy, the way he is acting" (Terry: Mum).

Particular aspects (for example argumentativeness, stealing) had come to feel intentional and personally directed towards them;

I was having it thrown at me all the time, ever since he got in from school and everything..... I just couldn't come to terms with the fact that it was something
he couldn't help, because some of the things he was saying to me were horrible, that I just couldn't forget it... (Terry: Mum),

Well, it was a bit bad, and it got to that extent where Dad was actually having a word with me about taking it all out on Mum and everything, and I don't think she liked it. She did try, but sometimes I just wouldn't let her (Terry).

A sense of regret was strongly apparent about how far parents felt they had moved from their previous relationship with the child;

It just made me not trust him... I had to check his schoolbag, check his coat before he went to school; when he come home I was checking..... I didn't like doing that..... I didn't want to be like that with him (Jim: Mum).

The description of a gradual deterioration of the relationship was accompanied by comments about previous efforts to positively connote or normalise gradually worsening behaviours;

he had his problems at infants, but that was just running around, not listening and it was acceptable - could just have been a lively boy who'd buckle down eventually. But it became more and more noticeable as he went through the juniors (Terry: Mum).

This struggle between conflicting views of the child also seemed to have been fueled by a continual message from the school about the child’s unacceptability;

he was brilliant for three years [at school] and then he started getting into trouble .......... I was torn. That's what got me so upset, I was torn between, is the school lying or is he lying .................. I couldn't stand it (Jim: Mum),

you could tell there was an awful lot of people that didn't like him - teachers, and all the rest of it - there was so much bad feeling (Terry: Mum).
6.4.2.5 Good child returns

In this context the diagnosis, behaviour changes and feedback from the school in combination appeared to have enabled parents to regain their original well loved child. Behaviour became explainable in terms of the medical condition and parents were eager to relate the child's pro-social qualities that had become salient;

*It's like somebody took him out and put a different one in... ....... He's just generally a nicer kid to be around. At home he's calmer, he's more thoughtful, he's less selfish, he's less spiteful (Bill: Dad),*

*I enjoy him (Jim: Mum),*

and from the child's perspective;

*It's like I can talk better to her (Jim).*

This description of change in the character and intentions of the child was of a different order to descriptions of behavioural differences brought about by medication as described in Theme 1. Questioning often elicited that the changes were not contingent on specific times of the day when medication would have been active;

*He has two - he has one in the morning and one at school through the day - he doesn't have it in the evening, (Terry: Mum).*

6.4.3 Subtheme 2: Preserving the character and identity of the child (see first column of Diagram 3)

6.4.3.1 Overview of Subtheme 2

For other parents there emerged an active resistance to the idea that medication may have altered their child's personality and for a small minority diagnosis had introduced the notion of an 'abnormal' child leading to an increase in anxiety about the future and doubts about their ability to handle the child. These parents descriptions of relationships prior to medication were qualitatively different from those described
above and they were conceptualised as having been at opposite ends of a continua of bewilderment, inefficacy and resentment/blame towards the child. The level of premedication conduct problems or attentional difficulties measured on the CPRS did not clearly differentiate these children from those described within the other subthemes. Several of these children had a high degree of conduct problems prior to medication for example, Jonathan, Darren and Bill (see Table 2). Furthermore in two families (Terry, Bill) parents gave different accounts about the same child.

6.4.3.2 Normalising and child serving explanations for behaviour.

These parents recounted having used normalising and child-serving explanations for their children's behaviour prior to medication. For one, the notion of 'hyperactivity' had enabled her to explain behaviour as beyond the child's control;

*I said to his teacher, because she was complaining about the fact that he never sits down, I said well he's like that at home, he can't sit still, he has to be on the go all the time and I said, you know, you have to find things that interest him, if he's bored he will play up (Ian: Mum).*

Others displayed a readiness to emphasise their child's ongoing positive attributes and to have accepted and even positively connoted some of the features of ADHD;

*I actually think he's excellent......bloody hard work but very clever and very much a little person in his own right. He was very determined to be, he wouldn't be pushed around even when he was little. He would stand up for himself........I'm still incredibly proud of him because he's so there, he's so you are never going to overlook him, even if you wanted to (Jonathan: Mum).*

*But the good thing about Terry.....he doesn't hate you - well, he thinks you are the worst person in the world - he's never going to talk to you again - half an hour later, he's your best friend. There's nothing - it's forgotten very quickly (Terry: Dad).*
Parents described how they had put difficulties down to temperament, gender or family traits which seemed to have enabled them to avoid the bewilderment experienced by the previous group;

*He was just a different sort of child to Jack. I mean they are all different, but he was just different to Jack - a different sort of child really, and I just put it down to that.* (Darren: Mum).

*We're the kind of family where everybody talks a lot and argues a lot and perhaps shouts a lot. It's that kind of noisy, rather rumbustious family that perhaps again Lenny doesn't stick out very much in.* (Lenny: Mum).

*I can see a lot of Darren in me: At school - I was never very good at school - never did as good as I could at school, and I never knew why - And that struck me the same as Darren.* (Darren: Dad).

Several other parents expressed how the child' difficulties particularly in comparison to siblings had meant a closer relationship with the child;

*I always found I gave him more encouragement and gave him more, you know, well done and what have you because he found it so hard to achieve things.* (Keith: Mum).

6.4.3.3 Efficacy

In all of these cases there were concomitant comments about having had successful strategies to manage the child at home;

*I think because of my job, I've worked in a school [for disturbed children] I saw a whole range of problems and I also had some tricks up my sleeve for dealing with him which meant I never felt like it was out of my control.* (Bill: Mum),

and where a sense of inefficacy was described this was due to the parent’s inability to influence the child in school time. The impetus for referral had been pressure from the
school, particularly threats of suspension. This often strongly conflicted with parent’s own sense of efficacy and appreciation of the child;

School has a problem with Jonathan, I don’t have a problem with Jonathan, I’m exhausted but I thought that was motherhood, but school have a problem, school is not happy and school say that health has got to get involved........ It made me very angry, the school’s behaviour more than Jonathan’s behaviour ....He’s a little boy and he might be a tiring little boy but he’s still a little boy and he was bullied by them and I was bullied by them into doing what they thought was right (Jonathan: Mum),

the containment of difficulties at home was also expressed by the child;

she was trying to keep me in order at home as well. Well, she started to use a bit more discipline, such as if I did something once she’d say: stop it or you’ll go to your room. If I did it again she’d send me to my room because before that she’d just try and ignore it for a fair bit of time but then she’d say: Stop it! (Jonathan).

6.4.3.4 Threat to the child’s identity

In this context of normalising and appreciating the child, parents recounted concerns about the possibility of medication changing their child’s character;

I didn’t really know whether it was a good thing ...... to be taking things that altered how you were as a person. That you were giving him pills and he was going to become somebody else, as if, you know, a different character (Darren: Dad),

I didn’t want to lose Jonathan, (Jonathan: Mum),

and were keen to emphasise how despite the drug the child had remained the same;

He will still argue, he’s still got the cheek......but it’s all part of his character because he has got a nice character - that’s one thing we didn’t want to
change and... He's far calmer, more relaxed, hasn't lost any of his character or his zest - he's still Terry (Terry: Dad).

This was also a concern also raised by children;

No, by the time I get home it's already worn off, so at home I'm just my normal self. I need to have some time as my normal self, some of the time, especially for football, (Jonathan).

One child was keen to state that the tablets had little effect on him;

Because how are they supposed to work? Are they supposed to control your mind or something?... Well they don't work anyway. Because they don't get to my brain (Ian).

Other parent's accounts reflected a desire to preserve the individuality of their child under the threat of the stigmatising label of ADHD.

We never even talk in terms of has he got A.D. what's it stand for?............ Attention Deficit, yes. We never even talk in those terms, between ourselves. (Terry: Dad),

you hear about such extreme cases that at first I thought well surely not. You know, about children who destroy everything they come into contact with and tear wallpaper off walls and that kind of thing. And I thought well that doesn't sound like Lenny (Lenny: Mum).

For some parents and children there was even a reluctance to entirely give up their previous explanations for the difficulties;

I can see that he was disruptive in class but it seemed like a cop out ...............like saying pop this one on drugs and then we won't have to worry about it, then we won't have to do our job properly...... I'm still not one hundred per cent convinced.................It's easier than trying to find out why he's bored with life, why there isn't enough to keep him going on one thing.
What I find difficult to reconcile with the attention deficit thing is that I often think that Jonathan hasn't got an attention problem because there's something wrong with him, but because there's something wrong with us (Jonathan Mum).

For this parent there was a suspicion even about the drug's effect;

School is much happier, I think I could be feeding him Tic-Tacs personally and school would be happier because they think that something's been done. I think the placebo effect, not only works on Jonathan, I also think it works on the bloody teachers. They think that an effort is being made, therefore they see it (Jonathan: Mum),

with a clear increase in the concern and guilt about having had to label the child;

I'd like him to be normal. I don't know whether he is normal and whether I did it wrong (Jonathan: Mum).

In a similar way one child recounted how behaviour at school which was not due to being 'hyper' as everyone thought but was a result of his preference for 'mucking about';

the teachers they don't like mucking about but I muck about in class. My Dad used to be naughty and he told me one thing, this was when I started being naughty and I said to Dad, Dad were you naughty at school? And he goes, yep, every time I got hold of a piece of paper I would make it into a paper aeroplane. So I tried that out but that's when I started being naughty and I couldn't help because it was such fun. I was flying a paper aeroplane and everyone else was grabbing it and joining in. it's really cool and teacher's trying to stop you. Every day I get told off about four hundred times (Ian),

and he shared the previous cynicism about the drug's effect;

I don't think it [Ritalin] works that much... only a tiny weeny bit (Ian).
6.4.3.5 An abnormal child: Increased anxiety and inefficacy (also see Diagram 4 column I and Appendix 11)

A minority of parents described the need to come to terms with the idea of having a child with officially diagnosed problems;

*The disadvantages I think are... trying to accept that one's much loved child has got this problem for life...*(Lenny: Mum),

and a new awareness of salient problem features;

*I remember when he was first diagnosed looking at him and thinking all this years and I've never realised he's not quite right, there something wrong with him, my son. I saw him differently, as a bit odd.......I'd been quite convinced there wasn't anything wrong with him *(Bill: Mum).*

This realisation of abnormality came with an increase in anxiety about the possible future ramifications of the disorder;

*It's not like him just being dyslexic or needing glasses or something, it has so many worrying implications like what's going to happen as he gets older, will he become a delinquent? That sort of thing. I never really thought about any of this until he was diagnosed *(Bill: Mum),*

*What I find is my overriding emotion is worry about him learning to cope with it ......Until now he's had good friends at school but......... he is starting to deviate from the norm in behavior with friends and..... some of them don't quite know how to cope with it and I can see that it's going to be a problem if it can't be contained. ...... we're probably more worried now about the social side of things and about the dangers of low self-confidence and low self-esteem that can lead teenagers into doing silly and dangerous things. ......A more informed worry rather than just being vaguely worried about this peculiar behaviour and what shall we do about it *(Lenny: Mum),*

and about how to deal with the child;
we’re going to a seminar tonight on ADD and bullying and how to prevent the ADD child from becoming a bully. I feel I need some guidance. It will be very interesting to have the benefit of some of these experts (Lenny: Mum).

6.4.4 Subtheme 3 The negatively intentioned child remains (see Diagram 3 column 3)

6.4.4.1 Overview of Subtheme 3

A third group of parents describing similar issues of resentment, blame and inefficacy, were distinguished from the first group outlined previously by the absence of a description of attempts to positively connote the child’s behaviour and by their feelings of demoralisation. They described a very negative view of the child’s intentions and character both before and after diagnosis and medication. For these parents scores on the CPRS reflected little reduction in hyperactive or conduct problems (see Table 2)

6.4.4.2 Resentment, blame and demoralisation

Typical to these parents was an account of a very distant and negative relationship with the child;

*It was his behaviour, I suppose, made me want to turn my back on him....... I got to the point where I absolutely hated him - I didn't love him, I didn't want to know anything about him. I tried to put him in care, basically........... I drove to social services and I sat there and I said "If you don't take these children away, I'm going to kill them"* (Matthew: Mum),

with a concurrent sense of demoralisation;

*he is quite undisciplined, because basically I have just given up.......I think I got to the point where there was just no point talking to him at all, cos there was no eye contact for a start - you were just wasting your breath.* (Matthew: Mum),

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and from the child’s perspective;

_Didn't do anything much.....we don't always get on_ (Matthew).

6.4.4.3 Negative intentions before medication and remaining

There was a sense that medication had not changed the ‘true child’ as characterised by deliberate naughtiness, aggression and manipulativeness;

_Well, we’re still forever at one another.... it’s like war all the time. And when he’s nasty, he is nasty, and it makes you so angry you think: oh you horrible child, because he’s really horrible. And yet when he’s nice, ...say if I’d grounded him for something and he’s going: Oh mummy, he’s a real creep, and he’ll blackmail you, would you like a cup of tea? And he’ll make you a cup of tea and then go: can I go out now? I did make you a cup of tea. He’ll blackmail you, he’ll do it._ (Gavin: Mum).

The intentional nature of the child’s behaviour was often confirmed by their ability to control behaviour for the other parent;

_He does as he’s told and he behaves beautifully when [stepfather] is home, the minute he goes to work and is out that door, he’s back to his old self and I’m battling with him all the time.....(Larry: Mum)._ 

6.4.4.4 Good behaviour dependent on medication

The changes brought about on medication were seen to be contingent on the medication and not generalised;

_you have to watch him when the tablets are wearing off_ (Larry: Mum),

_if I ain’t taken my tablet I have to stay in all day. She’s [Mum] nice, she’s fine with me when I’ve got my tablets_ (Larry).
6.4.4.5 Salience of remaining behaviour problems

These parent’s accounts reflected the salience of behaviour problems which still occurred off medication particularly in contrast to how behaviour had improved at school;

> Just because he’s on Ritalin doesn’t mean to say you’re going to have this wonderful child overnight, because you don’t. The only thing that it does help is his schooling which was the main problem........it can’t be so different at school than at home. At school it’s all praises and he’s doing wonderfully at school whereas at home there’s been no change, if anything he’s been a bit worse since he’s been on the Ritalin (Larry: Mum).

[Mum] she’s okay sometimes but sometimes she gets a bit moody and like she like takes it out on people sometimes. She starts yelling, then goes funny, then sends us to bed early and that, and she’s not like she used to be before she got moody so that’s the sum of it. Also, she sometimes annoys you like she’s busy doing her gardening or something and it’s really annoying when she ignores you sometimes (Larry).

The on/off medication contrast also seemed to enhance the salience of problems at home;

> between eight and ten it’s two hours of sheer backchat, mouthing and sarcastic comments and pulling of faces. It’s really two hours of sheer hell and you think: I don’t need this, he can go to bed early and that’s when he resents me because I send him up to bed because I’ve just had enough. (Larry: Mum).

Paradoxically although one parent actually described a decrease in the frequency of behaviours these changes were rendered insignificant;

> to be honest, there’s been no significant change at home (Larry: Mum),

but when asked whether she would continue with the medication explained;
Yes, because I've tried a day without it... And he was awful, he was terrible, he was hard work, he was offensive. (Larry: Mum).

This salience of remaining problems and the incompleteness of changes was also apparent in the children’s accounts;

It's good because it stops me swearing but the bad thing is not stopping me beating everyone up (Gavin),

I just can't get rid of the answering back, it's just very hard. Like if mum says something, I'll answer her back and it's too late, she's told me off.....I wish there was another thing to stop me answering back, that's the worst thing. Ask someone to invents ones [pills] that stop answering back (Larry).

6.4.4.6 Negative interactions around medication

Parents also described how the taking of tablets became a focus of ‘battles’ with the child;

The minute he comes in the door he's due a tablet and I say Larry have you got your tablet, and if I don't remind him he doesn't take it and then he gets offensive. If I remind him it's: all you ever say is don't forget to take your tablet. So it's quite hard going really. (Larry: Mum),

Only occasionally I lie to my mum and say I ain't taken my tablet when I have (Gavin).

6.4.4.7 The need for more medication

The parents in this group also described a sense that more medication was needed to really make any real difference to their relationship with the child;

I'm still not a hundred per cent certain he's on the right medication to be honest, because of his behaviour at home. I'm wondering whether the strength of the tablet is not enough for him now. It's done fine at school, but
it's trying to get over the behaviour at home that's the problem. (Larry: Mum),

It's okay, it works now but sometimes I'm a little out of time, like an hour (Larry).

6.4.5 Comment on children's accounts relating to Theme 2 (see Diagram 6)

As indicated, children appeared to be conscious of their parents remaining concerns about medication in the sense of sharing their fears about medication affecting their character and about the remaining salience of problem behaviours. In addition to describing a reduction in their negative behaviour (see Theme 1) some children described an increase in their own 'pro-social' qualities, in that they had become more helpful, understanding and friendly to their parents and listened and talked more to them. In response, parents were described as more willing to do activities and to help them, as liking them more and as listening, understanding, trusting and talking to them more. This was congruent with parent's descriptions of an increased appreciation of their child. Even in families where parent's accounts reflected that the child's 'niceness' was contingent on medication, children still described an increase their own and their parent's 'pro-social' qualities. This theme was absent from those families where parents had described a desire to 'preserve' the character of the child despite medication. Children's accounts reflected different issues from parent as follows.

Salience of positive aspects of relationships prior to medication

Despite varied levels of resentment and blame (long-term and recent) being expressed towards children by parents, the majority of children described a range of positive emotional and behavioural features of their relationships such as doing activities with parents, parents being helpful and fair, and having feelings of love and closeness towards them. The implications of this are addressed in the discussion.

Self as the problem
Despite a group of parents describing their attempts to normalise and explain their child's difficulties in a positive light children generally seemed unable to resist negative attributions for their hyperactive and non-compliant behaviour; For example children stated that the medication was needed because 'something had gone wrong with [them],’ for 'hyperactivity and its defects,' because they had 'gone out of control' or had 'been possessed'. Medication was described as acting on a passive child to rid them of unpleasant characteristics, 'its for my behaviour', 'to calm me down', 'to make me good', 'to stop me being nasty and spiteful', 'annoying', 'horrible' or 'stupid'. Although some children described concurrent more self serving reasons for problem behaviour such as copying friends, being 'hyper', the influence of fizzy drinks and chemical imbalance, none seemed to have escaped some negative self depreciating attributions for their behaviour.
Diagram 4  THEME 3: IMPACT OF HAVING AN EXPLANATION AND SOLUTION ON PARENTS

**Behaviour**

- Problem Behaviour
  - Child Serving
  - Bewilderment
  - Child Blaming

**Attribution**

- Child Serving
  - High
  - Low
- Bewilderment
  - Low
- Child Blaming
  - Low

**Efficacy**

- Home
- Home & School
- Home & School

**Domain where help required**

**Attribution of cause**

- Clarity/Certainty
- Confusion
- Guilt

**Attitude to diagnosis**

- Mixed Blessing
- Miracle Cure

**Efficacy**

- Low/High
  - Uncertainty regarding dealing with behaviour
  - Reliance on medication
- High/School
  - Child's well-being improved

**Affect**

- Anxiety/Guilt
  - Relabeling/criticism
  - Stigma/side effects
- Relief
  - Relief
- Disappointment
  - Anger services

**Affect/Relationship**

- Anxious
- Warmth/appreciation
  - Closeness
- Resentment
  - Child as problem

*Although the diagram has a linear presentation all elements within each column are thought to be interconnected and mutually influencing.*
6.5 Theme 3: The impact of having an explanation and solution on parents.

Those aspects of parent’s experiences that were considered to implicitly or explicitly impact on their relationship with the child are covered in this theme. The theme is divided into two subthemes to reflect the different experiences of parents in terms of having an explanation and a solution for the difficulties. Although Diagram 4 presents these subthemes in a categorical manner, parents were seen to be on a continuum in relation to these issues reflected by broken rather than solid lines. For the sake of brevity a summarised version of the theme follows (see Appendix 11 for full account of theme with transcript extracts)

6.5.1 Subtheme 1: A miracle cure

6.5.1.1 A reduction in uncertainty and self blame.

Many parents described a reduction in uncertainty about the cause of their child’s difficulties. The impact of this upon the relationship with the child was linked to parent’s prior and ongoing perceptions of the child’s intentions (as illustrated in the previous theme). For those with a predominantly child serving perspective, reduced uncertainty formed part of the new ability to appreciate or understand the child. However, for those with on-going negative perceptions of the child they were concerned about the child using the diagnosis as an excuse to behave badly (see Theme 4).

Many parents related a reduction in self blame and a renewed efficacy and confidence in parenting as well as greater tolerance to the child (explained fully in Theme 4). For those parents with a very negative perception of the child however, the removal of blame from self seemed to have pinpointed the child as the agent of the problem and as such their resentment towards the child did not decrease.
6.5.1.2 Regaining normal life

For many parent's medication had enabled life to return to normal in enabling family activities and allowing more responsibility to be placed in the child. However, along with descriptions of the transforming effect of medication and diagnosis in parent's lives there was regret that this had not come sooner and high expectations for medication in the future suggesting both reliance on medication and the potential for disappointment with its effects.

6.5.2 Subtheme 2: A Mixed Blessing

6.5.2.1 Confusion/guilt

For other parents the benefits of explanation and solution has simultaneous negative aspects, particularly where pressure for diagnosis had come from the school. Some recognised the lack of clarity in causal accounts of ADHD and ongoing debates about neurochemical or family influences such that they did not feel entirely exempt from blame and described remaining guilt feelings about having 'labelled' the child as explained in Theme 2.

6.5.2.2 Efficacy

Parents described how diagnosis and medication provided a clear course of action to solve the child's problems and so efficacy increased. The significance of this was of being able to suddenly improve the child's well-being by making school life easier and more enjoyable. Nonetheless, for many, medication had been a last resort and there were continued concerns about criticism from others, physical and psychological side effects including detrimental effects on the child's efficacy and stigma. Others regretfully acknowledged a reliance upon the medication and as described in the previous theme had new concerns about dealing with behaviours.

6.5.2.3 Adapting lifestyle to suit the child

Although medication had enabled more family activities, discomfort was expressed by some that such normality had been achieved by the unnatural process of medicating the
child. This led some to use medication at home only occasionally and to resolve the issue of the child not fitting in to 'normal activities' by adjusting their own lifestyle and expectations rather than insisting the child conform.

6.5.3 Children’s accounts (see Diagram 6)

Although children’s accounts did not include specific appreciation of the meaning of the diagnosis they were quick to detect parent’s attitudes about medication whether this was a fear of character change (see Theme 2) or a sense of its importance for their well-being. Children often mentioned that the drug could be dangerous and that only those who really need it should take it possibly, reflecting parental anxieties. In contrast to parent’s concerns and children’s descriptions of the passive action of the drug, its effects appeared to be empowering for children in helping them be independent at home and school.
Diagram 5. THEME 4: MAKING ALLOWANCES

Parent’s attribution for cause/perception of child’s intention
A RANGE

Parent’s action & discipline
A RANGE

Affect & Relationship
A RANGE

PROBLEM BEHAVIOUR

POSITIVE
Child not in control

NEGATIVE
Child willful deliberate

EXPLANATION
PUNITIVE POWER

REASONING
ASSERTIVE

CLOSENESS
RESENTMENT

APPRICATI0N
DISTANCE

WARMTH

AFFECT & RELATIONSHIP

BEHAVIOUR
AMBIGUOUS REGARDING CONTROL
ON/OFF MEDICATION CONTRAST

A DIFFICULT JUDGEMENT

PARENTING STYLE

EXTERNAL STRESS

PERCEPTION OF
CHILD'S INTENTIONS

EXPLANATION
REASONING

SHOUTING
PUNISHMENT

CALM
TOLERANCE
PATIENCE

ANGER
FRUSTRATION
ANXIETY

POSITIVE
Child models parent

NEGATIVE
Child models parent

Although the diagram has a linear presentation all elements within each column are thought to be interconnected and mutually influencing.
6.6 Theme 4: Making allowances (see Diagram 5)

6.6.1 Overview of Theme 4

A major focus of the study was to explore any changes in parent’s attributions for the behaviour in terms of the child’s perceived level of control, their emotional reactions and their discipline strategies. This theme combines parent’s comments from both interview transcripts and diary sheets on this matter. Many parents described a change in their attributions for the child’s behaviours (both overactive and non-compliant) and consequent efforts to make more allowances for the behaviours i.e., to remain calm, patient and tolerant instead of becoming exasperated and angry and using more explanation and reasoning in the place of shouting and punishment;

* alright if he has really got something wrong with him, it’s like if he didn’t do a hundred meter sprint because he’s got a broken leg I wouldn’t punish him for it, I try to stay calm. I didn’t yell at him as much as I would have done and also I didn’t punish him, I just went: Think, stop and think. (Jonathan Mum).*

Children also described less severe punishments after medication as outlined in Theme 1.

Parents descriptions reflected use of a range of styles of discipline to deal with the child’s behaviour prior to medication with some placing more emphasis on explanation and reasoning and others describing the predominance of a more punitive/power assertive style. Most parents described using a mixture of these styles. As such, for some, the attribution of less competence in the child led to an enhancement of their previous ways of dealing with the behaviour rather than a change of discipline style;

* I think I've had more patience with him since we've been going to the clinic, because now I'm thinking there's a bit of reasoning behind it, yes. There's a reason, maybe, why he acts the way he does. But I think maybe.. we've always been that we talk to him first before telling him off about anything - we talk and explain the situation as you know, "You really can't do this", and*
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I think maybe now I'm inclined to talk to him a bit longer and try and reason with him more (Darren: Mum).

6.6.2 The need to make allowances: A difficult task

Parent's descriptions also reflected the effort intensive nature of 'making allowances'. Calm, patience, tolerance and explanation/reasoning were clearly not automatic responses to the child and parent's actual emotional and behavioural response often did not live up to this ideal. Some parent's described how their desired or ideal reactions competed with other responses. Firstly, this was due to the ambiguity of the child's ability to control the behaviour. This difficulty interpreting the child's level of control in-situ was described by several parents on diary sheets. Secondly, the parent's emotional response to behaviours often depended on their current mood determined by other external stresses and/or ongoing exasperation and new anxiety about the behaviour all of which militated against a calm response. These two aspects are illustrated in the following diary extracts;

**DIARY EXTRACT 1:** (description of child, off medication being overactive/hard to control in public place)

What were your feelings in response to this behaviour?

Embarrassment, exasperation

To what extent do you feel your child was able to control this behaviour or not?

I've given up trying to guess (Jonathan: Mum).

**DIARY EXTRACT 2:** (description of child off medication making noise in bedroom at 11.30 pm not sleeping)

What were your feelings in responses to this behaviour?

Angry/tired
To what extent do you think your child was able to control this behaviour or not?

*He can't help this, he just can't sleep till really late. (Ian: Mum).*

**DIARY EXTRACT 3:** (description of child off medication refusing to get washed and dressed after repeated requests.)

What were your feelings in response to this behaviour?

*Exasperation, worry at how to deal with this sort of thing on a long term basis (Lenny: Mum).*

It was clear that the mismatch between the ideal and reality for parents often left them with a sense guilt about falling short:

*when he's settled down I think, oh no, I shouted at him, why have I shouted at him, I shouldn't have shouted at him. So, I have a lot of that, which is hard....... every time I go to see Dr Smith or like I'm speaking to you now, that is always my aim when I walk away, that I will not shout, and I never do it. (Ian: Mum).*

Other parents stated that although having considered the attribution of less competence they had decided not to change their discipline style because of the danger of being overly lenient and neglecting to help the child differentiate good and bad behaviour;

*For a while it made me think about my reaction to how he was...... whether he couldn't help it and so we shouldn't be more hard on him or more soft on him, as long as I knew what the reason was, then he shouldn't be allowed to get away with things: even if there was a reason, he still had to be told what he could and couldn't do and be told what was wrong and I couldn't see a reason to stop doing that (Darren: Dad),*
if it is something that he shouldn't be doing, or wants to go somewhere at eight o'clock at night or something, you still have to say no and he has to accept it (Teny: Dad).

For these parents the decision about how to react to the child’s behaviour had become more complex and demanding task in order to achieve this balance;

There's a difference between understanding and making allowances and letting him just do what he likes. That's a very difficult line for the parent of an ADD child to walk (Lenny: Mum),

But in dealing with it, I will still stop him, because there might be that time when he's just trying it on, just trying to push his luck. (Darren: Mum),

there's certain things I know he can't control, like I know he can't go to sleep, I know that and I accept that. I know he can be quieter, I know he can control the noise he's making. You know, I'm shouting at him for the noise he's making because I know he can control that. The things that he does that I know he can't help I'm calmer with. (Ian: Mum),

and the complexity of the task was also increased by the influence of medication;

I know the difference when he's under the influence of the medication and I know when he's not under the influence of the medication so I know what sort of behaviour I will have out of him so you just adapt to each situation, if and when it arises. (Keith: Mum).

6.6.3 A more competent child?

Other parents, previously described in subtheme 3 of Theme 2, described a process of considering but discounting the child’s lack of competence to control the behaviour. These parents mentioned an increased expectation of the child’s ability to control it;

I'm probably more angry at him now when he's bad. I get frustrated quicker than I did before, if that makes sense..............Because there's a reason for it,
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I suppose, and I think somehow that he should be able to control it now - now that he knows there is a reason. Which is really ludicrous I know (Matthew: Mum),

and an expectation that the child would use the diagnosis and medication in order to manipulate them, leading to the need for an escalation of discipline;

he knows exactly what he's doing on a lot of occasions and he knows just how to work it. You know, he's not stupid, he knows what he's doing. A lot of people will say oh yes, it's to do with the ADHD, you can tell when he's putting it on. ...........but it's got to the stage now that instead of sitting down I have to go and stand over him, and he talks down to you and he's shouting at you. He thought he could walk all over me and I let, instead of arguing with him (Gavin: Mum),

[since you went and you’ve been taking the drugs, what have things been like at home?] They’ve been difficult. Sometimes a bit difficult ....My mum and dad shout at me. It’s mostly my mum (Gavin).

One parent who had recognised the idea of needing to make allowances for the child had found that attempts to discuss behaviour more with the child had failed, raising her demoralisation;

When I do give it, [time for discussion] it backfires on me because he just doesn’t want to talk then, he doesn’t want to know (Larry: Mum).

6.7 Comment on impact of diagnosis and medication on sibling relationships

Few clear patterns emerged from the data regarding changes in relationships with siblings. The effect on sibling relationships seemed to vary a great deal between families. Some parents and children described how arguments with siblings had decreased in line with the general reduction in problem behaviours and the increased pro-social characteristics of the child (Bill, Terry). Others stated that that sibling
relationships had not been adversely affected by the behaviour problems and that children and siblings remained close and had always been involved in activities together (Keith, Matthew). Others described jealousy between siblings (Gavin, Darren, Jim and Larry) but some felt that this was normal for siblings (Jim). Some described the jealousy as improving with medication (Terry) for others it worsened (Larry).

6.8 Comment on differences between mother and fathers accounts.

Three out of the four fathers interviewed were within the group of parents who felt able to cope with the difficulties and perceived little change in their relationships post medication. Two commented that their ability to cope with the behaviour was due to less regular interaction with the child (Terry, Matthew) whereas one worked part-time and undertook most of the routine child care (Darren). The fourth father had only recently become a step-parent to the children and had found the medication effects to be extremely important in improving his relationship with the child.

In other families, discussion with mothers and children highlighted two features. Firstly both children and mothers described how behaviour was better for the father and that since they were less involved in routine child care the impact of both the problems and the intervention was less. Mothers often described how fathers had been more reluctant for the children to use medication. Secondly, when children were asked to describe relationships with their fathers they tended to focus on leisure activities undertaken with fathers such as sport and DIY both pre and post medication.
Although the diagram has a linear presentation all elements within each column are thought to be interconnected and mutually influencing.
7. DISCUSSION

7.1 Outline

Each theme shall be discussed in relation to existing literature and the theoretical model presented in the introduction. There will be introduction of new literature in response to some of the findings as recommended for research based on qualitative study (Charmaz, 1995).

7.2 Theme 1: A reduction in demands and expectations of trouble (see Diagram 2)

'High demands and expectations of trouble' seems to be a manifestation of the concept of 'parental stress' in ADHD (Anastopoulos et al, 1992; Mash & Johnston, 1983). Parent's and children's accounts in this study fitted well with Mash and Johnston's (1990) model of 'parent-child interactive stress' defined as frequent or intense parent-child conflict determined by a combination of child, parent and environmental characteristics. These authors emphasise the role of the child's behaviour in such stress since children with ADHD appear to exhibit 'objectively difficult' behaviour illustrated by the high agreement between parent's and observer's ratings of ADHD behaviours. Parents described the children as 'hard work' regardless of their level of coping or affective relationship with them which suggests a common experience of high levels of difficult behaviour. Both the 'hard work child' and the 'expectation of trouble' are relational concepts encapsulating both a sense of the child's behaviour and its impact on the parent.

The 'constant expectation of trouble' supports Mash and Johnston's (1990) hypothesis that parental automatic cognitive processing plays an important role in ADHD. They suggest that because of a history of behaviour problems parents form a 'cognitive set' for anticipating deviant behaviour that interprets behaviour and guides actions with little or no conscious effort (Brunk & Henggeler, 1984; Chapman, 1981).
The reduction in difficulties with medication use reported in this study supports early laboratory studies of drug effects on parent-child interactions (Barkley & Cunningham, 1979; Humphries, Kinsbourne & Swanson 1977) and later, more naturalistic studies, showing a decrease in maternal criticism (Schachar et al, 1987). These finding contrast with Schachar et al (1997) who found no significant behaviour improvement at home in children. In this study however, parents used medication at home in the evenings and/or at weekends which could account for the difference.

The impact of medication and diagnosis on demands and expectations of trouble arises from the child’s behaviour changes and through simultaneous reduction of external stresses. Parents described a very significant reduction in ‘environmental stress,’ (Mash & Johnston, 1990) i.e., the changed feedback from school (supported by the significant group decrease in the Teacher’s Conners’ scores). The importance of this does not appear to have been highlighted in previous literature and supports Mash and Johnston’s (1990) description of the need for a ‘recursive’ and mutually influencing model of parent, child and environmental factors determining parent-child interactive stress.

If change in this small group of families occurred most consistently at the level of ‘interactive stress,’ this may clarify why group studies of the impact medication on family functioning have had mixed outcomes. Measures which operationalise similar concepts to parental-child stress would be more likely to reflect change than those focusing on closeness or empathy with the child which, as shown in this work, are not necessarily affected by medication.

The length of time on medication did not differentiate parents on this theme. This suggests that these changes remain salient for at least one year post diagnosis and were not due to the novelty of medication. Since a reduction in demands and expectations of trouble is a multi-faceted concept, the relative influence of child and school factors is difficult to assess. Parent’s ratings of reduction in child behaviour symptoms varied a great deal. Some Conners’ scores (particularly for those who had had medication for six months to one year) showed very little decrease in symptoms despite descriptions in interviews of reduced behaviour problems and arguments. This possibly reflects
differences in the level of the children's remaining behaviour problems at home because of the differences in amount of medication use at home and/or that the lower ratings made soon after the changes occurred may was a result of a clearer comparison. These suggestions need to be explored further in longitudinal studies of the same families. Nonetheless, even very minor behaviour changes at home seem important in reducing stress in combination with school feedback. Schachar et al (1997) describe this 'halo effect' of behaviour improvement at home as a result of school changes as a 'bias' but this study suggests that such a bias including a possible placebo effect may still be an important and meaningful aspect of parent's experiences.

This theme supports the initial model (see Diagram 1) by illustrating a reduction in behaviour problems. It also expands upon the meaning of these changes for parents in terms of home life and reflects the fact that they should not be considered in isolation from other influences such as the school.

7.3 Theme 2: Impact of diagnosis and behaviour change on the perception of the child's intentions and character (see diagram 3).

7.3.1 Summary of theme and its relationship to the original model.

Although all parents described a high level of demands and expectations of trouble prior to medication the degree to which they differed in their accounts of child serving or child blaming attributions for the behaviour problems and their more general perception of the child's character was notable. Subthemes reflected three patterns in which parent's accounts of prior positive or negative perceptions of the child's intentions, their sense of efficacy in managing the behaviour and their usual feelings towards the child were interrelated and differentiated the impact of medication and diagnosis on their perception of the child.

The theme as a whole expanded the initial model (see Diagram 1) by illustrating firstly parents very different starting points in at referral to ADHD clinics in terms of the level of control and blame placed on the child. Secondly the concept of efficacy seemed to
play an important role in the attributions parents make about the child’s behaviour which was implicit within the original model but required greater emphasis. Thirdly the negative affect expressed by parents did not necessarily change as a result of the diagnosis and medication. Also the possibility of parents holding conflicting negative and positive perceptions of the child was not addressed by the original model.

7.3.2 Experiences prior to medication: Attributions of intentionality and affect.

Theme 2 is congruent with the extensive literature considering the link between attributions and affect. A parental attribution of negative intent and controllability to the child (child blaming) for behaviours co-occurred with pervasive feelings of distance and resentment towards the child. By contrast, a child serving attribution for the behaviour (gender, temperament or medical condition post medication) was associated with appreciation and closeness to the child. Attribution Theory predicts this link between an attribution of competence and control to the child for a problem behaviour and negative affect in parents (Weiner, 1986; Dix & Grusec, 1985). This result also supports Dix and Lochman (1990) and Geller and Johnston’s (1995) conclusion that the controllability rather than the internality, globality or stability of cause of the behaviour has negative consequences for the relationship with the child (since attributions of gender, family traits or temperament as the cause occurred with a good relationship). Previous studies have conceptualised negative affect in a variety of ways (e.g., anger, over-arousal, helplessness, expressed emotion) which tend to follow specific interpretations of behaviours. Although this research supports the general concepts of available literature, the negative affect expressed by parents in this study was a more global style of relating to the child characterised by resentment and distance or appreciation and closeness. This contrasts to the more transitory anger, frustration and irritation which the majority of parents described in Theme 1. It is not surprising that some parents attribution of negative intent for behaviour dominate the relationship given the constant nature of problem.

The two groups of parents who described very clear positive or negative perceptions of their children are accounted for by the relationship between attributions and affect.
described in the initial theoretical framework (see Diagram 1). However, the group who expressed conflicting positive and negative perceptions of the child prior to medication, do not fit so clearly into categories and were possibly in a transitional state in relation to this model. They expressed difficulties in making any attribution at all about the behaviour and this bewilderment and inability to attribute cause may have reflected fluctuating resistance to blaming the child. The likelihood of bewilderment is supported by the work of Solo, Ashbourne, Earn & Cunningham (1989) who illustrated how caregiving situations in ADHD are perceived as more unpredictable and uncontrollable by the parent than the norm. This study suggests that the attributions parents make about their child’s behaviour are not static or narrowly determined by the behaviour itself but may be influenced by many sources of conflictual information (such as the school feedback and the parental motivation to continue to be an accepting parent).

### 7.3.3 Experiences prior to medication: Efficacy and the negative perception of the child.

What factors enabled a corruption or preservation of the relationship with the child in the face of very demanding and unpredictable behaviour requires explanation and one hypothesis arising from the study was that this may be accounted for by the parents sense of efficacy. The main feature to emerge from the data in conjunction with the perception of a negatively intentioned child was a description of inefficacy in managing the behaviours. The relationship of parenting efficacy to the attribution of negative intentions has been discussed in ‘transactional’ and ‘interactive’ models that have extended Attribution Theory. Dix (1993) described how an attribution of negative intentions to a child is not simply a result of inferential processes within parents in analysing child’s behaviour but is in fact the end product of an less commonly acknowledged interactive process that “reflect[s] parents ability to regulate interactions with children so that outcomes that parents desire occur” (Dix, 1993, pp 635). This argument states that if parents fail to elicit the behaviour they want from the child (inefficacy) (for example due to inexperience or poor problem solving) they are more inclined to think their children have difficult temperaments. Hence the combined effects of children’s behaviour and parent’s attributions in goal oriented interactions.
breed the attribution of negative intent. Supporting this contention others workers have shown that low parenting efficacy is related to a perception of the child as difficult, a readiness to perceive relationship problems, increased autonomic arousal, negative affect and the use of coercive and intense discipline to control the behaviour (Bugental, Blue & Lewis, 1990; Bugental & Cortez, 1988; Bugental & Shennum, 1984; Day, Factor & Szkiba-Day, 1994; Mash & Johnston, 1983). Baden & Howe (1992) stressed the importance of parent’s attributions of blame and expectancies of helplessness in the establishment and maintenance of coercive exchanges as articulated in Patterson’s family coercion model (1982) in the development of conduct disorder.

The concept of efficacy also helps to explain the differences in the degree of negativity and demoralisation in the perception of the child i.e., the differences between subthemes 1 and 3 (represented by second and third column of Diagram 3). Mash and Johnston (1990) describe how low parenting efficacy in ADHD is likely to be related to a gradual impact of the behaviour on parents over time, which would explain well the process parents described in subtheme 1 (the good child returns). They contrast this process of the development of inefficacy with the existence of initial low expectation of efficacy (commonly found in physically abusive parents) as a result of parent’s own experiences of abuse or poor parenting. In this study the experience of those parents described in subtheme 3 (the negatively intentioned child remains) were possibly based on a more pervasive sense of inefficacy. These three parents related either abusive experiences in their own childhood or mental health problems during the early years of their child’s life (post natal depression, agoraphobia) unreported by other parents. Although speculative, this shows how within a group defined by ADHD the distinction made between parents of ADHD children and physically abusive parents is artificial (as Mash and Johnston acknowledge) since ADHD behaviour and more ingrained parental inefficacy are likely to co-occur.

This literature explains why efficacy and negative perception of the child emerged as linked in parent’s accounts. What still requires explanation is why there were such differences in parent’s efficacy. The severity of the child’s difficulties as assessed by the questionnaire measures did not help explain this as many of the ‘coping’ families
rated a similar high degree of conduct and attentional problems as those who described not coping. Within one family (Bill) two parents expressed very different degrees of coping with the same child. Nonetheless, a high level of conduct problems was present in all the families who described inefficacy and negative intent. i.e., it seemed to form a necessary but not sufficient condition for a negative relationship. To explain these differences may require a model similar to Folkman, Schafer & Lazarus’ (1979) transactional model of stress where coping is an interaction of demands and resources used by Quine and Pahl (1991) to analyse coping with caring for a child with severe learning difficulties. No clear pattern emerged of why some parents were so highly resourced although they mentioned relying on friends and family for emotional and practical support, the ability to ‘have space’ from the child through working and only having one child. Parent’s coping may be to do with ‘goodness of fit’ between parents expectancies and actual behaviour (Greene, 1995) determined by their beliefs for example about temperament (Thomas & Chess, 1977).

7.3.4 Experiences post medication.

For those parents with very clearly articulated positive or negative perceptions of their child prior to medication they described how diagnosis and some behaviour change as a result of medication had had very little effect on their relationship. The pervasiveness of these perceptions of the child were thought to be best conceptualised as global and stable beliefs about the child or ‘person schemas’ (Auguostinos & Walker 1995 p 32). Weber and Crocker (1983) emphasise schema maintenance and perseverance and suggest a ‘subtyping’ model of information processing whereby schemas exist in a hierachial structure and information disconfirming the schema is accomodated as an exception or subtype, leaving the overall schema intact. They describe that this process is likely to occur if there are only a few instances of disconfirming evidence and there is a strong motivation to maintain the schema. Schema maintenance may explain how

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vi Defined as “conceptual structures of personality traits or ‘person prototypes’ that enable categorization and inferences to be made from interactions with others” (Cantor & Mischel, 1977).
parents hold a persistent positive perception of the child despite very difficult behaviour, how they resist the suggestion of medication as being personality altering and how they reject the ADHD label. For those with a predominantly negative perception of the child schema maintenance would explain the salience of ongoing behaviour problems to parents despite some changes. Abelson (1986) describes the importance of considering the function of beliefs in their amenability to change. Clearly for those parents with a very positive perception of the child, change to this self reinforcing belief would be resisted. A very negative perception of the child may also serve to preserve parents self esteem by externalising blame. Although clearly a useful heuristic in this study and in clinical practice generally, Schema Theory has been criticised for its poor empirical validation (Augoustinos & Walker, 1995). It may be that this methodology involving an analysis of patterns across a large body of unstructured perceptions may be a more effective means of illustrating the concept of ‘schemas’ than for example more constrained questionnaire measures.

The degree of actual behaviour change at home as a result of medication may have affected the ability of parents to shift perceptions of the child or ‘schemas.’ The three families describing very negative ongoing perceptions of the child rated a high degree of remaining conduct problems post medication on questionnaires measures. However questionnaires also reflect parents perceptions and may be subject to the biases of schemas discussed above. The role of the actual degree of behaviour change could only have been addressed by an observational element in the study which was outside of the realm of the qualitative enquiry.

7.3.5 Children’s accounts in relation to Theme 2 (see diagram 6).

Children’s experiences were partly congruent with parent’s in relation to the impact of diagnosis and medication on perceptions of character and intentions (e.g., expressing concerns about their character changing when on medication and highlighting remaining salient behaviour problems). This congruence could be explained by Dix’s (1993) argument that children may internalise adult’s attributions particularly when old enough to understand the concept of dispositional states but before they become cognitively
sophisticated enough to evaluate the accuracy of parent's perceptions or to integrate information from different sources such as peers and teachers. Social Learning Theory explains this process by reinforcement leading children to act in accordance with the expectations of significant adults.

All children in the study however, viewed their need for medication as emphasising their own faults or defects; even in those families where parents recounted a 'child serving' perspective of the behaviour problems. This finding may reflect these children's likely developmental tendency to make attributions about identity on the basis of behaviour (Damon & Hart, 1988) and the powerful influence of other sources of dispositional information such school and peers on children, particularly as the school had been the initiator of referral in many cases. Whilst not having been 'integrated' with information from parents, these coexisting beliefs could have easily been elicited by interview questions pertaining to different contexts.

Children also emphasised their own 'pro-social' characteristics post medication even in families where parents described dependence on medication for good behaviour. This suggests that children may be affected by the attributional actor/observer bias (Jones & Nisbett 1972) in a positive way. They may also be more susceptible to social desirability pressures within the interview thus giving more weight to positive features.

Children emphasised prior positive relationships with parents despite some parents very negative descriptions. This difference could be a social desirability effect or an artefact of the interview in that children could give very broad descriptions of their relationships and could focus on rare instances of positive interaction such as treats or activities. Bowlby (1980) argued that children are motivated to see their parents in positive terms in order to preserve the concept of a stable attachment figure even if this involves a process of idealisation of the parent and derogation of the self.
7.4 Theme 3: The impact on parents of having an explanation and solution (see Diagram 4)

7.4.1 Summary of Theme 3 and relationship to original model.

Medication and diagnosis were expected to lead to changes in parent's explanations for the causes of and solutions to the child's behaviour problems with consequences for the relationship and sense of efficacy (see initial model, Diagram 1). Parents experiences comprised a separate theme which expands the previous model since their accounts revealed that having a causal explanation and solution had more complex and idiosyncratic meanings than predicted, depending upon the parent's sense of efficacy and perception of the child prior to medication. Efficacy post medication also varied in different domains. This section further illustrates the need to use concepts of efficacy and schemas more fully in a model of families experiences of medication use as explained above.

7.4.2 Miracle cure

Parents who described a prior relationship characterised by resentment, blame and inefficacy related mainly positive aspects of diagnosis and medication use. They acknowledged that it had brought understanding and predictability to their situation as predicted by Attribution Theory (Weiner, 1986). However, the diagnosis and medical solution did not entirely lead to low efficacy (as predicted by the initially proposed model) since relative to their previous experiences self blame decreased and confidence in parenting returned. Medication was welcomed as a means of restoring 'normality' to family activities and giving the child responsibility. Along with efficacy brought about by reduced self blame however there was disappointment because medication was only partially effective.

The impact of parents experiences on the relationship with the child varied since cause and solution attributions were still interpreted in terms of over-riding positive or negative perceptions of the child i.e. a changed attribution about parents own role in the
problem did not necessarily mean blame was lifted from the child. For some, diagnosis did allow a new preferable attribution of the child as 'not in control' of his previous behaviour but for others it was interpreted as further confirmation of the 'problem child.'

7.4.3 A mixed blessing

Parents who reluctantly agreed to medication received the diagnosis with ambivalence. Although acknowledging that it had given them some degree of explanation they also expressed uncertainty and confusion about the cause of the condition and were reluctant to give up their familiar non-stigmatising explanations for the child's behaviour. Given their prior relatively well adjusted position with respect to ADHD, these parent's reactions to the diagnosis appeared to require a different model than that proposed by Attribution Theory. They seemed to be in a process of adaptation to 'the crisis of illness' as conceptualised by Moos and Schaefer (1984) where diagnosis of illness is disruptive to personal and social identity involving issues of stigma and labelling and the crisis is difficult to resolve if there is uncertainty about cause of the illness. How such a process impacted upon the relationship with the child was not clear from this study apart from increased anxiety and some evidence that children were aware of their parent's ambivalence. More follow-up of these parent's may have given an understanding of the outcome of this process.

These same parents were also ambivalent about medication as a solution. Increased efficacy in improving the child's well-being at school was often combined with a decrease in efficacy at home insofar as concerns about handling the child and reliance on medication. This theme expanded the prior model to show that parent's efficacy was not a uni-dimensional concept and varied across different domains.

In line with the initial model parent's had anxieties about children's sense of efficacy as one of the side effects of medication. However children's expressed efficacy was not entirely congruent with parents concerns. Although children seemed very sensitive to parents anxieties about medication and described the passive action of medication upon
them; they also seemed to take credit for their new abilities on medication again reflecting the probable importance of the school environment in providing 'dispositional' information.

7.5 Theme 4: Making allowances (see Diagram 5)

The original model (see Diagram 1) hypothesised that a changed attribution for the behaviour problems as a result of medication and diagnosis (from child as competent to not competent) would alter parent's affective and discipline responses to behaviours. Some support for this model was apparent in the association of parent’s accounts between an attribution of competence to the child and a response of anger and discipline involving shouting and punishment as opposed to explanation and reasoning. Nonetheless, the proposed temporal nature of the shift in attributions, discipline and affect after diagnosis and medication inaccurately described parent’s experiences. Although previous studies have suggested that disciplinary aggression is common in ADHD families, parents in this study described using a range of discipline strategies prior to medication. Clearly a group tendency does not preclude the use of a range of styles in everyday family life.

The original model (see Diagram 1) also seemed accurate in that common to parents after diagnosis was their description of a perceived need for greater tolerance and more explanation and reasoning because of the attribution of less competence. However elaborating upon the initial model, most parents described the difficulty of actually attaining this because of a range of factors including the remaining ambiguity of children’s behaviour in terms of control. This suggests that the likelihood of parents making consistent changes in attributions after diagnosis and acting upon them may be idiosyncratic to specific illnesses (for example, it may be easier to make these attributions for a difficulty such as enuresis as studied by Butler et al (1986) than for the behavioural syndrome of ADHD).

Other parents stated that affective responses (such as anger and frustration) remained because of either external stresses or new anxiety about the disorder. Others described
how parenting decisions became more demanding by having to judge the needs for
tolerance and boundary setting and complexity was increased because the child’s
‘competence’ differed according to medication. Habitual parenting style and perception
of the child’s intentions also seemed to be important in how far they achieved the ideal
of tolerance and explanation. Those who expressed global negative feelings towards
their child had the greatest difficulty in making the attribution of lack of competence.
Larrance & Twentyman (1983) discuss how ambiguity of child behaviour raises the
likelihood of parents making judgements based on pre-existing beliefs.

As such, this theme shows that the predicted model needs some modification to account
for variation in parent’s range of prior discipline styles and the difficulty in making the
attributational, emotional and behavioural changes because of factors specific to the
ADHD syndrome (i.e., ambiguity of behaviour problems). This perhaps explains
Johnston and Freeman (1997) finding that despite making an a general attribution of less
control for behaviour in ADHD consistent with a neurobiological or chronic disease
model, parents find it difficult to apply this to specific discipline situations and remain
upset by the behaviours. There is a need to conceptualise in more detail how parent
manage a conflict between ideal or intended and actual attributions for behaviour.

7.6 Impact of diagnosis and medication on fathers and siblings

Overall the study was in line with previous research in ADHD showing fathers to be less
involved in routine child care and experiencing relatively less ‘interactive stress’ than
mothers, such that they are more reluctant for medication to be used and perceive less
impact of the behaviour changes on their relationship with children. This may also
explain the difficulty recruiting them to the study. Father’s role in children’s lives
appeared to be more focused on leisure activities rather than on everyday routine tasks
which may explain the differences in parental perception since task oriented interactions
are typically problematic in ADHD (Whalen & Henker, 1989). However, given the very
small numbers of fathers these conclusions remain tentative and require replication.
The lack of a clear pattern in sibling relationships may also reflect the fact that siblings are not directly involved in the everyday routine tasks which were the focus of problems and improvement for mothers. The impact of medication and diagnosis on sibling relationships would have been more clearly elucidated by interviewing siblings.
8. DISCUSSION OF METHODOLOGICAL ISSUES

8.1 Strengths of the method

This study achieved the aims outlined by Henwood and Pidgeon's (1995) of building a taxonomy of features of a set of data and exploring a limited set of categories of relevance to the phenomena under investigation. The study also achieved its aims of elucidating the range of experiences of families of medication use and helped to make sense of previous mixed findings regarding both the impact of ADHD on families and the effects of medication on relationships. As anticipated, the design also allowed for an understanding of more holistic factors on this process and the emergence of some novel issues such as some parent's ability to cope with very demanding children. This was thought to be testament to the required openness and flexibility of the interviewing. The idiographic nature of the findings also had much relevance for clinical practice (see below).

8.2 Weaknesses of the method

8.2.1 The problem of retrospective accounts

Parent's and children's accounts of relationship and changes are retrospective in this study. Smith (1994) argues that in recounting the past, people select material which is self enhancing and Greenwald (1980) has suggested autobiographical memory is altered to conform with the current self concept. These features have been illustrated empirically by Conway & Ross (1984) who argue that 'self theories' (either of continuity or change) will determine what factors are emphasised in recall. This bias may be relevant to all themes in the extent to which parents emphasised sameness or change in relationships. In reality there may have been more negative aspects to relationships for those who emphasised a good prior relationship and little change and vice versa. However, such biases were accepted as an inherent part of obtaining contextualised accounts. The aim of the study was to document parents understanding
of changes and their construction of past relationship was regarded as important to current psychological functioning. Acknowledging these biases does not entirely discount the status of parents reports as providing valuable hypotheses for future research and clinical management, particularly as these were coherent and interpretable in relation to existing psychological concepts.

8.2.2 Impact of researcher on the process of research

Smith (1997) suggests that attention must be paid to the perceived impact of the researcher on the generation of findings of qualitative research (although this should not necessarily be classed as a weakness of the research).

One possible effect in this study was the interviewees perception of the researcher as an agent of the medical system. There may have been an expectation from parents that the interview would assume both the diagnostic validity of ADHD and the merits of medication and answers would have been given in accordance with this. The salience of this issue was suggested by the fact that several parents inquired about the researchers opinion of medication use. Several parents were open about their misgivings about medication and diagnosis but it may have been parents level of assertiveness that determined the extent to which they introduced these issues in the interview.

Another bias may have been introduced by diaries which primed parents to reflect on changes in behaviour in response to the child. This may have introduced an expectation that parents should have changes in their responses to the child and this may have biased the final theme 'making allowances' where parents discussed this ideal which was difficult to live up to. When asked to reflect on the experience of the interview, several parents commented that it had made them reflect on their parenting and relationship with the child and one stated that she thought it might 'engender good intentions.'

It was also thought that the researchers own background and training as a clinical psychologist may have sensitised her to parent’s perceptions of children’s intentions and consequent affect since such features have often formed the core material for clinical
interventions with families in her experience. This emphasises Smith’s description of qualitative research as a dynamic interaction between the researcher and subject.

Qualitative interviewing has been used very little with children although the validity of children’s interview reports compared to parent’s has been suggested by (Hedanic, Hedanic, Brown & Wheatt, 1975). It was felt that children may have been particularly prey to social desirability pressures and retrospective biases such as those described above.

8.2.3 Comment on respondent validation

Three families declined to participate in this part of the study due to having already completed lengthy interviews. The majority of parents accepted the face validity of the themes and re-emphasised points they had already made. This may have reflected the importance of consistency of self presentation. Parents also downplayed the negative aspects of the theme, ‘A mixed blessing’. For example, two parents described how the guilt and anxiety about stigma was offset by the usefulness of the label for communication with professionals and the schools. This experience of member validation highlighted the difficulty of knowing how to interpret participant’s disagreements with researcher’s findings. For example this ‘downplaying’ of the negative aspects of this theme could be interpreted as being due to a process of adjustment to the diagnosis over time rather than reflecting initial interpretative inaccuracy of the researcher. It was thought that respondent validation may have been more useful for Henwood and Pidgeon’s third stage in the development of Grounded Theory i.e., the iterative process of further data collection as refined by prior concepts. Time constraints of the study prevented this.

8.3 Comment on sample

Given the use of several different sites and prescribing clinicians the reliability of the diagnosis could be questioned, particularly since a structured diagnostic interview was not used for pragmatic reasons and for two of the older cases the DSM IV checklist was
not available. The practice effect on the Conners' questionnaires also meant that the reduction in behaviour symptoms for some children pre and post medication may have been over emphasised.

Despite the fact that the sample was highly selected they remained varied in terms of family composition, extent of medication use at home, length of time since medication and level of aggressive/conduct problems. Nonetheless, this variety was thought to reflect clinical reality and it was a strength of the qualitative method that differences in parents and children were outlined. The limits of generality must be emphasised. Due to the qualitative design the important concepts derived here are not able to be generalised to the population of ADHD families but are 'transferable' to other similar structural contexts (Osbourne & Smith 1998). Attention is drawn to the high proportion of families in social class group I, and the difficulty recruiting subjects often because of comorbid difficulties, age and other interventions.

8.3.1 Difficulties with recruiting fathers and completion of diaries

It appeared that the time demands of the method exacerbated difficulties with recruitment in general particularly with fathers. It may also have exacerbated the poor completion of diaries (only 5/12 completed).
9. DIRECTIONS FOR FUTURE RESEARCH AND CLINICAL IMPLICATIONS

9.1.1 The relationship between school and home in ADHD

The decrease in interactive stress in families outlined in Theme 1 was a product of changes at home and at school. This highlights the importance of the school's role in identification and management of the disorder and liaison with parents. Maras Redmayne, Hall, Braithwaite & Prior (1997) showed that teachers are becoming more familiar with ADHD and a collaborative model of practice in school for ADHD has been proposed by Evans, Fuller, Heller, Morgado, Salisbury and Salisbury (1997). Future research and clinical consideration needs to be given to schools management of ADHD because of its clear impact on quality of home life.

9.1.2 Investigation of family's resources

A striking finding of this study was the ability of several parents to cope successfully with the pressures of having a child with ADHD. More detailed investigation of the specific resources which made this possible, perhaps using samples derived from the community rather than clinic populations and a model of stress and coping such as Folkman, Schafer & Lazarus's (1979) may be a productive area of further research. This would provide useful clinical information on how to help families maximise natural resources in their own environments.

9.1.3 Development of negative parental perceptions of the child in ADHD

The emergent model described in this study emphasised the existence of a very negative perception of the child in ADHD or 'schemas' combined with perceptions of low efficacy. Prospective studies should investigate the validity and development of such negative parental cognitions and the relationship between them. Mash and Johnston (1990) describe a need for psychometrically sound measures of parental cognitions and a comprehensive theory of them as they are poorly defined and overlap. They argue that
parental cognitions are multi-dimensional and there is a need to understand how different kinds of beliefs relate to one another. This study supports this endeavour by illustrating how 'attributions' and 'schemas' were useful concepts but conceptual differences between them need clarifying.

9.1.4 The need for other forms of intervention

This study revealed that treatment with medication, through decreasing stress on families, may provide an opportunity where other difficulties (such as a very negative relationship) with the child can be addressed (as previously argued by Schachar et al 1987). Medication and diagnosis seemed to improve relationships for a limited number of families i.e., where relationship problems were recent and a product of the ongoing stress of the behaviours. This suggests the need for careful clinical assessment of relationship difficulties since in the context of a very negative relationship medication treatment alone did little to ameliorate these problems. Even those families with very high resources appeared to require ongoing guidance for behaviour management and support for the anxiety engendered by the diagnosis itself. The results of this study are congruent with BPS guidelines (1996) emphasising the need for multimodal approaches to treatment in ADHD.

Further research should investigate how the process of adjustment to 'illness' affects the relationship with the child. Investigations should also consider whether other ways of presenting the disorder to parents such as in the mode of a 'functional analysis' as recommended by Reid and Maag (1997) with specific behaviour targets rather than as a diagnosis, would reduce stigma and anxiety.
10. SUMMARY

This study illustrated that the most consistent impact of diagnosis and stimulant medication upon family relationships was decreased ‘interactive stress’ as a result of changes at home and school.

Changes in parent’s perceptions of the child’s character and intentions appeared to occur in only a few families and it was concluded that parents have both positive and negative powerful schemas regarding their children that are resistant to change.

The impact of diagnosis and medication on parents beliefs about causes and solutions for the difficulties and consequent effects on the relationship with the child varied a great deal according to the parent’s described sense of efficacy and habitual perceptions of the child pre medication. Parents described how their sense of efficacy as a result of having a medical solution varied in different domains.

Parents reported a sense of a need for more tolerance and inductive discipline as a result of attributing less competence to the child but also emphasised difficulties with both making this attribution and acting upon it.

Children’s accounts reflected awareness of a decrease in interactive stress but their self perceptions and sense of efficacy seemed to be affected by factors beyond home life. There appeared to be few consistent changes in relationships with siblings. Relationships with fathers appeared less subject to difficulties but this was based on a very small group of fathers.

Strengths and weaknesses of the qualitative design were highlighted and clinical and research implications of the study discussed.
11. REFERENCES


Johnston, C. (1996). Parental characteristics and parental child interactions in families of non problem children and ADHD children with higher and lower levels of
oppositional defiant behaviour. *Journal of Abnormal Child Psychology, 24, 1*, 85-104.


MacKechnie, S.L. (1997). *Perceptions of behaviour and family relationships in parents and their children diagnosed with Attention Deficit Hyperactivity Disorder who are treated with medication*. Submitted for Doctorate in Clinical Psychology, University of Surrey.


12. APPENDICES

1) Anticipating criticism
2) Letters of ethical approval
3) Parents Conners' questionnaire
4) Teacher's Conners' questionnaire
5) Improvement questionnaire
6) Information sheet, consent form, letter of approach to parents
7) Reasons for exclusion
8) Interview schedule
9) Example of diary sheet (blank and completed)
10) Example of list of themes for respondent validation.
11) Full account of theme 3
12) Sample interview transcript
13) Transcript notation
Appendix 1: Anticipating criticism
INTRODUCTION

The problem of subjectivity

Henwood & Pidgeon (1992) state that the choice of a qualitative method is not purely a 'technical' decision and involves epistemological issues which have implication for the evaluation of a qualitative project. The criteria for evaluating psychological research usually reflect the dominance of positivism in psychology and involve considerations of reliability, validity and generalisability. These uphold the importance of objectivity where the methodological goal is to limit the effects of researcher bias which will distort the discovery of empirical 'facts'. By contrast, qualitative research challenges the possibility of researcher objectivity and the production of unbiased accounts of research phenomena.

Interviewer bias

Critics have argued that lengthy interactive qualitative interviews are likely to have 'reactive' effects i.e., the characteristics of the interviewer will determine responses and influence the data collected (Emerson, 1983) and the researcher's own background and concerns will also affect the interpretation of the unstructured data (Goods & Watts, 1989).

Interpretative phenomenological analysis accepts that a 'personal' or subjective perspective is present at every stage of the project in terms of eliciting, interpreting and documenting participant's perspectives. The end product of this research is acknowledged as being an account or narrative from the researcher's perspective of the phenomena under consideration but this is not thought to detract from its value (amongst a range of methodologies in psychology) in producing rich contextualised accounts of phenomena. Furthermore, the issue of 'subjectivity' also remains unresolved for quantitative research since even these methods rely upon some level of interpretation as clearly documented in studies of the sociology of science (Woolgar, 1997, Henwood & Pidgeon, 1992; Hammersley, 1997). Henwood (1997) argues that
the strength of qualitative research is the explicit recognition and discussion of this issue (how to address the impact of the researcher on the research process) although there is no fail-safe means to do this. Hammersley (1997) describes this as the 'dilemma of the qualitative paradigm' as there is both a commitment to realism and science (by aiming to discover participant's accounts and perspectives) and on the other hand to constructionism through a recognition of the multiple perspectives and subjectivities in the research process. Smith (1997) suggests that the 'problem' of subjectivity cannot be solved but must be made explicit by the researcher giving a full account of the influential factors upon them in interpreting the data.

**The relationship between data and theory.**

Related is the issue of how to conceptualise the relationship between theory and data in qualitative research. Qualitative methods are seen to allow hypotheses to emerge from the data rather than to be testing a priori theory via the hypothetico-deductive method. Since deductive reasoning is the predominant approach in the natural science and the dominant paradigm in psychology, the use of an inductive approach is likely to be viewed as unscientific (Wright 1997, Smith, 1997). Furthermore qualitative researchers are likely to fall into a trap of making claims to having unearthed accounts that are closer to the 'facts' or 'truth' of the topic under investigation because of the more lengthy engagement with participants (Henwood, 1997). Charmaz (1990) has clarified the issue of how qualitative researchers use theory in discussing the problem of how to 'ground' Grounded Theory. She states that the approach neither purely tests a priori theory nor gives a pure inductivist analysis of the data. The resulting Grounded Theory is 'generated' not 'discovered' through a constant interplay between data and the researcher's original and developing theoretical conceptualisations. She describes how Grounded Theory must maintain a 'delicate balance between possessing a grounding in the discipline and pushing it further'. There is an aim for openness to new ideas emerging from data but careful attention needs to be paid to how this may enrich, elaborate and explain contradiction in existing theory by adding context and detail.
The problem of generalisation

Because sampling decisions are not made on statistical grounds the possibility of generalising to populations from qualitative projects has been brought into question i.e., the small numbers may mean findings are atypical (Henwood & Pidgeon, 1992). However, in this case the aim is not to investigate a sample that would be typical of all ADHD families rather to describe a small sample in terms of some overarching concepts that would be ‘transferable’ to contexts similar to the context in which they were first derived. Conrad (1990) argues that it is this ‘applicability or transferability of concepts’ that is the important criteria by which to judge the work and that the context and structural features of the sample and the production of results must be carefully documented.

Validity and reliability

New techniques are being developed to address the issues of the validity and reliability of finding from qualitative research and there is a view that these should be judged by criteria appropriate to the epistemological stance of qualitative research since according to a ‘realist’ paradigm the methods will not be satisfactory. Some proposals have been made of how to address this issue and an argument has been made for judging the quality and richness of the work rather than it’s ‘accuracy’ as a portrayal of reality. Although these issues are still under discussion within the community of qualitative researchers (Smith 1997), the following procedures were implemented in this study in order to meet the standards laid down by Turpin, Barley, Beail, Scaife, Slade, Smith & Walsh (1997) for doctoral level qualitative projects.

Internal coherence and presentation of evidence

The project provides a coherent argument to deal with contradictions and ambiguities in the data in a coherent and ordered way. Enough raw data is presented in the results section to allow the reader to interrogate the interpretations being made.
Independent audit.

Methodological decisions at each stage of the project are documented and a 'paper trail' is included from initial transcripts to results such that the work is open to external audit by colleagues (Lincoln & Guba, 1985; Kirk & Miller, 1986). Smith (1997) distinguishes between independent audit and the traditional notion of inter-rater reliability. The independent auditor is attempting to ensure that the account produced has been systematically achieved and is credible and warrantable based on the data collected but not necessarily the only or definitive account which could be produced.

Respondent validation

The study planned on participants reviewing the researcher's interpretations of their interviews i.e., they would be visited with an initial list of themes (see Appendix 10) and asked to comment on their validity. Disagreements with the researcher's interpretation would be discussed in the final report, but the researcher's theoretical model would not be altered. This stance recognises the fact that 'respondent validation' is not unproblematic in involving power issues and the problem of who's account to privilege if participants disagree. Nonetheless, it is seen as good democratic research practice i.e., giving something back to participants after lengthy interviews (Smith, 1997). Documentation of participant's perspectives on results was thought to be a means of further contributing to the contextualised nature of their accounts.

Triangulation

Triangulation is the process by which different measures and sources are used to investigate the phenomenon under consideration. As Smith (1997) argues, this is not to be misinterpreted as a search for greater 'truth' or accuracy. The relativist thrust of the project would uphold that there would be no absolute or correct picture to be observed and pinpointed but that multiple sources and methods of data collection would simply give a richer and more contextualised account of the phenomena under investigation.
REFERENCES


Appendix 2. Letters of Ethical Approval
2 February 1998

Miss S MacKenzie
Elm House
84 Ewell Road
Kingston KT6 6EX

Dear Miss MacKenzie

Ethical Submission No. 2408: Effects of ADHD on family relationships

The above project was approved by the Harrow Research Ethics Committee at its meeting on 2 February 1998. It would be appreciated if, in any future correspondence relating to this project or in any entry made in case-notes about procedures undertaken in the course of this study, you would refer to it as EC 2230.

I enclose the REC membership list, with those present at the meeting denoted by an asterisk.

The Committee wishes to remind all investigators of the importance of keeping General Practitioners informed of research work affecting their patients particularly when the patient's involvement continues after discharge from hospital.

Yours sincerely

[Signature]

Brian Saperia
Secretary
Miss Suzy MacKechnie  
4 Manor Farm Cottages  
Beechcroft Drive  
Guildford  
Surrey  
GU2 5SB  

Dear Miss MacKechnie,

Re: A Qualitative Study Of The Effects Of Diagnosis And Medication On The Family Relationships Of Children With Attention Deficit Hyperactivity Disorder

Further to my letter of 23 January 1998 I can confirm that the psychiatric representative on the Chichester Research Ethics Committee has looked through your proposal and the subsequent amendment to the study.

He feels that this is a very valuable study and should be approved. I am, therefore, happy to grant you approval to carry out this study in the Chichester area as outlined in your study.

I hope the study proves valuable and would like to take this opportunity to apologise for the delay in writing to you.

Yours sincerely,

Dr J R Quiney BSc MB BS FRCPath  
Chairman - Chichester Research Ethics Committee
WINCHESTER LOCAL RESEARCH ETHICS COMMITTEE  
North and Mid Hampshire Health Authority  
Harness House  
Aldermaston Road, Basingstoke  
Hampshire RG24 9NB  
Tel: 01256 312248  Fax: 01256 312299  
E mail: SANDRA.TAPPING@GW.NM-HA.SWEST.NHS.UK  

Chair: Dr Matthew Dryden  
Co-ordinator: Mrs Sandra Tapping  

Our ref: 024/98WSKT/98124  

29 April 1998  

Ms Suzanne MacKechnie  
4 Manor Farm Cottages  
Beechcroft Drive  
Guildford Surrey GU2 5SB  

Dear Ms MacKechnie  

024/98W - A QUALITATIVE STUDY OF THE EFFECTS OF DIAGNOSIS AND MEDICATION ON THE FAMILY RELATIONSHIPS OF CHILDREN WITH ATTENTION DEFICIT HYPERACTIVITY  

Thank you for your letter in response to my letter dated 1 April. The full committee met on 28 April, and full approval was granted.  

To comply with Good Clinical Practice a list of committee members is enclosed.  

The committee wishes you every success with your study. We would appreciate receiving a brief summary of the results of your study on completion of the work.  

Yours sincerely  

[Signature]  

Dr Matthew Dryden  
Chairman - Winchester Ethics Committee
Ms Suzy MacKechnie
Trainee Psychologist
Elm House
84 Ewell Road
Surbiton
Surrey KT6 6EX

Dear Ms MacKechnie

A QUALITATIVE STUDY OF THE EFFECTS OF MEDICATION AND DIAGNOSIS ON THE FAMILY RELATIONSHIPS OF CHILDREN WITH ATTENTION DEFICIT HYPERACTIVITY DISORDER

Thank you for sending me an amended consent form as requested in my letter of 3 December 1997.

On behalf of the Committee I am now pleased to confirm approval of the above study.

Yours sincerely

[Signature]

Dr G K Knowles
Chairman
Local Research Ethics Committee

Chairman Roy Galley Chief Executive Richard Gibbs
Ms. S. MacKechnie
4 Manor Farm Cottages
Beechcroft Drive
Guildford
Surrey
GU2 5SB

Dear Ms. MacKechnie,

Re: A qualitative study of the effects of diagnosis and medication on the family relationships of children with attention deficit hyperactivity disorder

I am pleased to confirm that Chairman's Action taken to approve the above study was ratified at the meeting of the Ethics Committee on 21st April 1998.

I have attached a signed copy of the application form. Any resource implications and the insurance arrangements for the study should be discussed with Mr. J. Caffrey in the Finance Department of the Royal Surrey County Hospital.

Should the start of the study be delayed by more than one year from the date of approval you should resubmit the protocol to the Committee.

Please inform the Committee of any adverse effects to the subjects which may be related to taking part in the study.

Finally, the Committee requests that you provide a final report of your study or a copy of any published paper.

Yours sincerely,

Dr. J. W. Wright
Chairman, Ethics Committee
Appendix 3: Conners' Parent's Questionnaire
INSTRUCTIONS: Listed below are items concerning children's behaviour or the problems they sometimes have. Read each item carefully and decide how much you think your child has been bothered by this problem during the past month NOT AT ALL, JUST A LITTLE, QUITE A LOT, VERY MUCH. Indicate your choice by placing a check mark (✓) in the appropriate column to the right of each item.

<table>
<thead>
<tr>
<th>Score</th>
<th>OBSERVATION</th>
<th>DEGREE OF ACTIVITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Picks at things (nails, fingers, hair, clothing)</td>
<td>Not at all</td>
</tr>
<tr>
<td>2.</td>
<td>Cheeky to grown-ups</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Problems with making and keeping friends</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Excitable, impulsive</td>
<td></td>
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<tr>
<td>5.</td>
<td>Wants to run things</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Sucks or chews (thumb, clothing, blankets)</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Cries easily or often</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Carries a chip on his shoulder</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Daydreams</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Difficulty in learning</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Restless in the 'squirmy' sense</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Fearful (of new situations, new people or places, going to school)</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Restless, always up on the go</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>Destructive</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>Tells lies or stories that aren't true</td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>Shy</td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>Gets into more trouble than others the same age</td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>Speaks differently from others same age (baby talk, stuttering, hard to understand)</td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>Denies mistakes or blames others</td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>Quarrelsome</td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>Pouts and sulks</td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>Steals</td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>Disobedient</td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>Worries more than others (about being alone, illness or death)</td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>Fails to finish things</td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>Feelings easily hurt</td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>Bullies others</td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>Unable to stop a repetitive activity</td>
<td></td>
</tr>
<tr>
<td>29.</td>
<td>Cruel</td>
<td></td>
</tr>
<tr>
<td>30.</td>
<td>Childish or immature (Wants help he shouldn't need, clings, needs constant reassurance)</td>
<td></td>
</tr>
<tr>
<td>31.</td>
<td>Distractibility or attention span a problem</td>
<td></td>
</tr>
<tr>
<td>Score</td>
<td>OBSERVATION</td>
<td>DEGREE OF ACTIVITY</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
<td>--------------------</td>
</tr>
<tr>
<td></td>
<td>Headaches</td>
<td>Not at all</td>
</tr>
<tr>
<td>32.</td>
<td>Mood changes quickly and drastically</td>
<td></td>
</tr>
<tr>
<td>33.</td>
<td>Doesn't like or doesn't follow rules or restrictions</td>
<td></td>
</tr>
<tr>
<td>34.</td>
<td>Fights constantly</td>
<td></td>
</tr>
<tr>
<td>35.</td>
<td>Doesn't get along well with sisters or brothers</td>
<td></td>
</tr>
<tr>
<td>36.</td>
<td>Easily frustrated in efforts</td>
<td></td>
</tr>
<tr>
<td>37.</td>
<td>Disturbs other children</td>
<td></td>
</tr>
<tr>
<td>38.</td>
<td>Basically an unhappy child</td>
<td></td>
</tr>
<tr>
<td>39.</td>
<td>Problems with eating (poor appetite, up between bites)</td>
<td></td>
</tr>
<tr>
<td>40.</td>
<td>Stomach aches</td>
<td></td>
</tr>
<tr>
<td>41.</td>
<td>Problems with sleep</td>
<td></td>
</tr>
<tr>
<td>42.</td>
<td>Other aches and pains</td>
<td></td>
</tr>
<tr>
<td>43.</td>
<td>Vomiting or nausea</td>
<td></td>
</tr>
<tr>
<td>44.</td>
<td>Feels cheated in family circle</td>
<td></td>
</tr>
<tr>
<td>45.</td>
<td>Boasts and brags</td>
<td></td>
</tr>
<tr>
<td>46.</td>
<td>Lets self be pushed around</td>
<td></td>
</tr>
<tr>
<td>47.</td>
<td>Bowel problems (frequently loose, irregular habits, constipation</td>
<td></td>
</tr>
</tbody>
</table>

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Appendix 4 Conners Teachers questionnaire
Conners Teachers Questionnaire

Name: .............................................  D.O.B.: .......... / .......... / ...........
Date filled in: ............ / ...........

Filled in by: ..............................................  Relationship to child: ..............................................

<table>
<thead>
<tr>
<th>DEGREE OF ACTIVITY</th>
<th>Not at all</th>
<th>Just a little</th>
<th>Pretty much</th>
<th>Very much</th>
</tr>
</thead>
</table>

### OBSERVATION

**CLASSROOM BEHAVIOUR**

1. Constantly fidgeting
2. Hum and makes other odd noises
3. Demands must be met immediately-easily frustrated
4. Co-ordination poor
5. Restless or overactive
6. Excitable, impulsive
7. Inattentive, easily distracted
8. Fails to finish things-short attention span
9. Overly sensitive
10. Overly serious or sad
11. Daydreams
12. Sullen or sulky
13. Cries often or easily
14. Disturbs other children
15. Quarrelsome
16. Mood changes quickly and drastically
17. Acts "smart"
18. Destructive
19. Steals
20. Lies
21. Temper outbursts, explosive and unpredictable behaviour

**GROUP PARTICIPATION**

22. Isolates him/herself from other children
23. Appears to be unaccepted by group
24. Appears to be easily led
25. No sense of fair play
26. Appears to lack leadership
27. Does not get along with opposite sex
28. Does not get along with same sex
29. Teases other children or interferes with their activities

**ATTITUDE TOWARDS AUTHORITY**

30. Submissive
31. Defiant
32. Impudent
33. Shy
34. Fearful
35. Excessive demands for teacher's attention
36. Stubborn
37. Overly anxious to please
38. Uncooperative
39. Attendance problem

---

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Appendix 5. Improvement Questionnaire
Please could you state below how much you think your child has improved or not on medication:

- No improvement
- Some improvement
- Alot of improvement

Thankyou for your help!
Appendix 6: Information sheet, consent form and letter of approach.
INFORMATION SHEET
PROJECT FOR EXPLORING THE EFFECTS OF MEDICATION ON FAMILY
RELATIONSHIPS IN CHILDREN WITH ATTENTION DEFICIT
HYPERACTIVITY DISORDER

PLEASE READ CAREFULLY

What is the study?
This study is being carried out to investigate what happens in families when children are diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and given medication to help with the difficulties. There is very little research into how having medication for this disorder affects family life. If you agree to help with this study you will be making an important contribution to knowledge that will enable us to improve our ways of helping other families in the future.

Being in the study will also give you the opportunity to talk over your experiences of ADHD and medication with a professional who is experienced in working with families with these kinds of difficulties. She will also feedback to you in detail her conclusions about how medication affects family life. Your ideas and opinions will be published in a research thesis at the University of Surrey in which all the information you provide will be made anonymous.

Who will be doing the study?
The study will be carried out by Suzy MacKechnie, Clinical Psychologist in Training as part of her post graduate degree in Clinical Psychology. She has extensive experience in interviewing and working therapeutically with both children and parents.

Who will be in the study?
We would like to invite to take part those families who come to the hospital and when parents and doctor have decided together that medication may be useful.

What will the study involve?

1) Interviews
We would like to interview both parents and the child. If only one parent and the child is able to give an interview this would also be useful. Step parents or live in partners would also be able to give interviews.

The interviews will be conducted separately with each parent and the child. Parents interviews will last for one to one and a half hours. Children' interviews will last about half an hour. The interviews will be recorded on audio cassette. The interviews will take place at the family's convenience, if possible in their own home. The aim of the interviews will be to obtain parents views about coming to the clinic, having a diagnosis and medication for their child and how this has affected family relationships and how they respond to the child’s behaviour. The child will also be asked for his views on these matters in a more simplified way.

Parents and children will not have to answer anything that they do not feel comfortable with. All the information will be completely confidential and not shared with other family members except if the child is thought to be at risk. If anything comes up in the interviews that the parents or child would like to discuss further they will be able to do this with the doctor working with them at the hospital.

A few weeks after the interviews Suzy MacKechnie will visit families again to feed back her ideas about the interviews and ask for comments.
2) Questionnaires
Just before the child goes on medication and several weeks later at his follow up appointment parents will be asked to fill in a questionnaire at the clinic about the child’s behaviour which takes 5-10 minutes. With your permission the child’s teacher will also be sent similar questionnaires.

3) Diary sheets
Both parents will be given some diary sheets to fill in with some short descriptions about the child’s behaviour. These will only need to be filled during one evening and one day just before the time of the interviews.

How will I get involved in the study?
If you decide with the doctor to try medication and are interested in being in the study Suzy MacKechnie will contact you about a month later by telephone when you have had time to think over whether or not you would like to be in the study and to see if your child has responded to the medication. She will then send you the diary sheets to fill in and arrange times for the interviews.

If you decide not to take part you will be given treatment in the usual way and will be fully respected for your choice. If you do participate you will be able to withdraw from the study at any time and this will not affect your treatment.

THANK YOU FOR TAKING THE TIME TO CONSIDER THIS PLEASE ASK IF YOU WOULD LIKE MORE INFORMATION

Contact telephone number 01483 259441.

Mary John. Consultant Clinical Psychologist. Research Supervisor
CONSENT FORM FOR PARTICIPATION IN RESEARCH PROJECTS AND CLINICAL TRIALS

Organisation: University of Surrey/Child and Family Services for Mental Health, Winchester

Title of Project: A qualitative study of the effects of diagnosis and medication on the family relationships of children with Attention Deficit Hyperactivity Disorder

Investigator: Suzy MacKechnie

Supervisor: Mary John
Senior Clinical Tutor University of Surrey

Telephone contact number: 0181 390 8445

Please see information sheet for details of study.

I (name) __________________________ (mother)

and I (name) __________________________ (father)

of (address) __________________________

hereby consent to take part in the above investigation, the nature and purpose of which have been explained to me by __________________________ (name)

Any questions I wished to ask have been answered to my satisfaction. I understand that I may withdraw from the investigation at any stage without giving a reason for doing so and that this will in no way affect the care I receive as a patient.

I also confirm that I have explained the procedures to my child __________________________ (name) and that he/she has agreed to participate.

SIGNED (Volunteers) __________________________ Date __________________________

and __________________________ Date __________________________

(Doctor) __________________________ Date __________________________

(Witness) __________________________ Date __________________________
Dear

I am a Clinical Psychologist in training at the Child and Family Services for Mental Health in Chichester and as part of my post graduate course in Clinical Psychology I am conducting some research into the effects of diagnosis and medication on family relationships for children with Attention Deficit Hyperactivity Disorder (ADHD). My colleagues Dr Alison Downey and Dr Quentin Spender suggested that I write to you to see if you would be interested in helping with this research. I enclose an information sheet about the research and what it would involve.

I will shortly be contacting you by telephone when you have had chance to look over the information sheet and think about whether you would like to be involved. This will also give you the opportunity to ask any further questions you may have about the study. I'd like to thank you for taking the time to consider this matter.

Yours sincerely,

Suzy MacKechnie.
Clinical Psychologist in Training.
Appendix 7: Reasons for exclusion
### Table 1. Reasons for exclusion. Percentages of families in each exclusion category.

<table>
<thead>
<tr>
<th>Reason for exclusion</th>
<th>Percentage of excluded cases</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>New cases</td>
</tr>
<tr>
<td>Not meeting diagnostic criteria</td>
<td>36</td>
</tr>
<tr>
<td>Below threshold on Teachers Conners</td>
<td>1</td>
</tr>
<tr>
<td>Age</td>
<td>13</td>
</tr>
<tr>
<td>Other intervention combined with medication</td>
<td>7</td>
</tr>
<tr>
<td>Medication stopped prior to interview</td>
<td>1</td>
</tr>
<tr>
<td>Global learning disability</td>
<td>1</td>
</tr>
<tr>
<td>Conduct disorder</td>
<td>3</td>
</tr>
<tr>
<td>DNA assessment</td>
<td>21</td>
</tr>
<tr>
<td>Already on medication</td>
<td>3</td>
</tr>
<tr>
<td>No information</td>
<td>14</td>
</tr>
</tbody>
</table>
Appendix 8: Interview schedule for parents and children
1. PARENTS INTERVIEW

1.1 Introduction

Introduce self and the nature and aims of the research project. Stress importance of gaining participants' views and ideas. Explain confidentiality procedures, member validation and availability of copies of research report. Answer questions and obtain consent for recording interview.

1.2 Outline of interview

Explain that the interview will cover the following four areas, not necessarily in the order described:

a) Background information on X (child's name) and relationships in the family.

b) The difficulties X was having that lead to you going to the clinic and how, if at all these affected family relationships.

c) What it was like going to the clinic and receiving medication.

d) What if anything, has changed and what has been the same since X has been on medication and how if at all, this has affected how relationships in the family.

1.3 Part 1

1.3.1 Background information

Could tell me who is in your family and lives here?

(names and ages, any extended family who live there or who have very regular contact)

Could you tell me about your pregnancy and birth with X?

Could you tell me about X as a baby in the first six months?

(prompt on sleeping, feeding, temperament, developmental milestones)

What was X like in the pre-school years?
How did X get on at nursery school?

(prompt on settling in, peer relationships behaviour)

What was school like for X?

(prompt on settling in, peer relationships, behaviour, academic process)

Do you think any of the events we've discussed already affected your relationship with X or not? If so how?

1.3.2 Relationships in the family prior to medication and diagnosis.

Still thinking about X's early life,

How would you describe X?

(prompts; what kind of child was he? what was your view of him?)

How would you describe your relationship with X?

(prompt for particular illustrative memories, typical activities thoughts and feelings towards child)

Has your relationship with X changed over time?

repeat questions for father and siblings (i.e. how would you describe your husband/wives relationship with X etc).

Who if anyone, did X get on best with? What's your explanation for that?

Who if anyone, did X get on worst with? What's your explanation for that?

Who if anyone, was X closest to? What's your explanation for that?

What happened if X was upset?

Were there any differences between your relationship with X and your relationship with your other children?

What's your explanation for that?

1.3.3 Own relationship with parents

How would you describe your relationship with your own parents?
(prompt for particular salient memories activities, thoughts, feelings)

Who were you closest to and why?

What happened if you were upset?

In what way, if any, do you think the relationships you had with your parents affects your relationship with your children?

1.3.4 Views on parenting.

What would you say are your views on how to bring up children?

(prompt for ideas on discipline).

1.4 Part 2

1.4.1 Perception of child's problems

I'd like to move on now to talk about the difficulties that brought you to the clinic.

What were your main concerns about X?

a) at school?

b) at home?

What concerned you most

Why did that concern you most?

When did you first notice the difficulties?

1.4.2 Effect of difficulties on family relationships

Explore for difficulties at school and home

How if at all did these difficulties affect the family?

How, if at all, did these difficulties affect you?

(prompt re thoughts and feelings about self as a parent)

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How, if at all, did these difficulties affect your relationship with X?

(prompt for effect on activities, interactions, view of X, feelings towards X, if no effect explore why)

What did you generally do in response to the behaviour (s)?

How if at all, did that affect your relationship?

(If no effect explore why)

What if anything do you think was the effect of the difficulties on X’s father?

(prompt re thought and feelings re self as a parent).

And on his relationship with X?

(prompt re effect on activities and interactions, view of child, feelings towards child. If no effect explore why)

What would he generally do in response to the behaviour (s)?

How if at all did that affect his relationship with X?

What if anything was the effect of these difficulties on X’s sibling (s)?

(explore for each sibling)

What was the effect on their relationship with X

(prompt for typical activities, interactions, thoughts and feelings towards X. If no effect explore why?)

Who in the family was most affected by the difficulties. Why?

1.5 Description of behaviour incident

Could you describe a typical incident of behaviour that happened at home before you had medication. One of the ones that you would have been most concerned about.

When X did that what if anything, did it make you think about X?

What if anything, did you think had caused the behaviour?

How much control did you think X had over the behaviour?
How did you feel towards X when he did this?

How did you respond to the behaviour?

How if at all do you think this kind of incident affected your relationship with X.?

(If no effect explore why)

1.5.1 Explanations for difficulties (general)

What did you used to think was causing the difficulties?

(prompt to cover explanations for home and school problems).

How much control did you think X had over the difficulties?

In what way, if any had the difficulties changed over time? How did you explain that?

How if at all did thinking.....(substitute cause)......caused the difficulties affect your relationship with X?

How if at all did thinking that affect how you dealt with the behaviour?

How have other people explained X’s difficulties?

(Prompt for teachers, friends, other professionals where appropriate)

What do you make of these different explanations (if appropriate)

1.5.2 Previous contact with services

What previous contact if any had you had with services such as social work, educational psychology?

What if anything was the effect of that contact on you?

And on your relationship with X?

On how you dealt with the behaviours?

What if anything was the effect of that contact on your explanations for X’s difficulties?
1.5.3 Solutions to difficulties

What, if anything, used to help with these difficulties?

(*prompt as to parents and child's actions*)

Is there anything else you'd like to say about the effect of the difficulties on your family prior to attending the clinic/hospital.

1.6 Part 3

1.6.1 Experience of clinic/hospital visit

I'd like to move on now to your experiences of going to the clinic/hospital.

What made you decide to go?

What were your expectations about going?

(*prompt for hopes and fears*).

How did you explain the visit to X?

Were you aware that the visit was to assess for ADHD?

What did you think ADHD was before hand?

In what way did you think it related to X?

Overall what was the experience of the appointment like?

1.6.2 Choosing medication

Were you familiar with the idea of this kind of medication for children?

What did you think about it?

How did you decide to try medication and what was it like making the decision?
1.7 Part 4

1.7.1 Differences and similarities in child’s difficulties.

What if anything has been different about X since he has been on medication? *(prompt for home and school).*

What have been the most significant changes? Why?

1.7.2 Effect of differences in child on relationships

What if anything has been the effect of those differences on you?

*(prompt re feelings and thoughts about self as a parent).*

On your relationship with X?

*(prompt re effect on activities interactions, view of X, feelings towards X If no effect explore why).*

Were you surprised by any of the effects?

Were you disappointed by any of the effects?

What kind of difficulties does X still have?

*(prompt re effect on self and relationship as above).*

1.7.3 Changes in relationships (general)

Have there been any other changes in the family as a result of having gone to the clinic/hospital and had medication?

*(If no effect explore why).*

What is still the same in the family?

Have there been any other effects on you of having gone to the clinic/hospital and had medication?

*(prompt as above).*

On your relationship with X?
(prompt as above)

What is still the same about your relationship?

(Explore view of effects on father and siblings as above).

1.7.4 Responses to problem behaviour

What effect if any has there been on what you do in responses to the difficulties?

(explore for home and school difficulties).

What if anything is the same about what you do in response to the difficulties?

Can you think of a recent example of the kind of typical behaviour we discussed earlier, that has happened since X has been on the medication?

When X did that what if anything, did it make you think about X?

What if anything, did you think had caused the behaviour?

How much control did you think X had over the behaviour?

How did you feel towards X when he did this?

How did you respond to the behaviour?

How if at all do you think this kind of incident affects your relationship with X?

(If no effect explore why)

Were any of these reactions different from what they would have been before you ever came to the clinic/hospital or not?

1.7.5 Changes in explanations for problems

What if anything was the effect of coming to the clinic on what you thought was causing X’s difficulties.

Did it change what you understood by ADHD?

How if at all, did this change in explanation (summarise) affect you?

(prompt as above).
Your relationship with X?

(prompt as above)

1.8 Solutions for difficulties

What was the effect of coming to the clinic on your ideas about what could be done about difficulties?

How if at all did it change what you thought you could do?

How if at all did it change what you thought X could do?

What do you think are the advantages and disadvantages of the medication?

What do you think will happen in the future as regards X taking the medication?

1.9 Reflecting on the interview experience.

Finally I’d like you to think about what it has been like doing this interview.

What has it been like?

What have been the positive things and what have been the negative things?

Do you think taking part will have any effect on you and your relationship with X?

Thank for participation. Ask if any further questions. Arrange follow up visit.
2. CHILD INTERVIEW

2.1 Introduction (adapted from Henker & Whalen, 1980)

I’m doing a study to find out what it’s like for families when a child starts taking the pills you’ve been taking. You are the expert who really knows what it’s like for children to take these pills. Most people ask doctors or parents or other adults but we want to know what you think. We hope to be able to use the information you give us to teach people how to understand and help other children. I’m also asking questions about what life has been like in your family to your Mum and Dad so you all have chance to have your say. There aren’t any right or wrong answers. It’s not a test, it’s for you to say what you think as honestly as possible. Everything you say is just between me and you. I’d only have to tell someone what you said if I was worried that you were in danger. Of course you’re free to tell Mum and Dad all about what you’ve talked about but it’s up to you what you tell them. When the report about the study is written it might have some quotes from what you’ve said in it but your name won’t be on them.

I’m going to ask you what everyone was like in your family and how you got on with them before you started taking the pills.

After that I’ll ask you about going to the clinic/hospital to see Dr .......... and what it was like and what it’s like to take the pills. Then I’ll ask you what life has been like since you’ve been taking them.

Is there anything you’d like to ask? Are you happy for me to tape our conversation or not?

2.2 Part 1

2.2.1 Family relationships before coming to the clinic

Can you tell me who are all the people who live with you at home?

*Draw picture if child is reluctant to engage.*

I’d like you to think back to before you came to the clinic and started taking these pills. OK I’d like you to tell me what everybody was like that you lived with.

Who would you like to tell me about first?

Tell me about X, what kind of person were they?

*(prompt for examples)*
What were your feelings towards them?

How did you get on with them?

*(prompt for examples).*

What if anything did you used to do with them?

What if anything did you used to like about them?

What if anything used to annoy you about them?

If I had come to visit you then what would I have seen the two of you doing?

*Repeat for each family member*

Who if anyone would you say you used to get on best with? Why?

Who if anyone would you say you used to get on worst with? Why?

**2.2.2 Interactions around problem behaviours**

I'd like to ask you now about the times when you used to get into trouble at home.

What kinds of things did you used to get into trouble for?

Who did you get in trouble with?

What did they do and say?

What happened then?

What did you used to think was causing these problems.

**2.3 Parts 2 and 3**

**2.3.1 Explanation of difficulties**

Now lets think about when you first went to the hospital to see Dr ...............

Who told you you'd have to go?

What did they say to you about what it was for?
Did you agree with that?

How did you feel about going beforehand? Why?

Who did you go with?

What happened when you went to the clinic/hospital?

(prompt for who met what talked about feelings)

2.3.2 Effect of difficulties

You said that you thought you went to the hospital/clinic because of ..(substitute child’s explanation)

How if at all did that affect your life?

(prompt for home and school effects)

How if at all did that affect how you got on with Mum?

(repeat for Dad and siblings).

If you hadn’t had that how do you think life would have been different?

2.3.3 Solutions

What if anything had anyone tried to do about (substitute problem) before getting the pills/coming to the clinic?

What if anything had you tried to do about it?

What made it worse?

What made it better?

2.3.4 Attitude to medication

What are the pills called that you were given?

What colour are they?

How often do you take them?
What are they for?

How do you know?

What did you think of them when you were first given them?

What do you think of them now? Why?

What if anything happens when you take the pills?

*(explore effects at home and school)*

What happens if you don’t take them?

If you had a friend who was about to take them what would you say to them about the pills?

What are the good things about the pills?

What are the bad things about the pills?

Since going to the clinic have your ideas changed about what was causing your problems.

2.3.5 Solutions

What if anything has anyone tried to do about *(substitute problem)* since you been to the clinic?

What if anything have you tried to do about it?

What makes it worse?

What makes it better?

2.4 Part 4

2.4.1 Effects on relationships

Since you went to the clinic and started taking the pills what have things been like?

*(explore home and school)*

How do you get on with Mum now?
Is that different from before or did you always do that?

What if anything do you do together?

(prompt for similarity/difference as above)

What if anything do you like about her now?

(prompt as above)

What if anything annoys you about her now?

(prompt as above)

What if anything is different from before about how you get on?

What the same about how you get on?

How do you get on with Dad now?

(prompt as above)

How do you get on with siblings now?

(prompt as above)

Who if anyone do you get on with best now? Why?

Who if anyone do you get on with worst now? Why?

Can you think about the times you get into trouble now?

What do you get into trouble for?

Who with?

What do they do and say?

What happens then?

Is there anything else that you’d like to say about what we’ve been talking about?

2.5 Reflection on the interview experience

What was it like talking about these things?
What if anything was good about it?

What if anything was bad about it?

Is there anything you’d like to ask me?

Thank you very much for helping me with my study.
Appendix 9: Diary sheet (blank and completed example)
INSTRUCTIONS FOR DIARIES  PLEASE READ CAREFULLY

1) WHAT TO FILL IN

Please complete one of these sheets (2 sides) when your child has shown any behaviour with you that you see as problematic, or that you would have seen as problematic in the past.

These behaviours may be things like failing to finish things, being overactive, losing things, arguing or refusing to do what you asked, being cheeky or any other things that concern you.

2) WHEN TO FILL IN THESE SHEETS

You will have these sheets over two weeks. We need each parent to write down 1-2 incidents. The best way to remember to do this may be to choose an evening or a day at the weekend to look out for something to write about.

Parents should ideally each fill in a sheet about a behaviour problem that you both saw. If not its OK to write about separate incidents.

3) ANY PROBLEMS?

If you have any problems filling in these sheets or find the questions or instructions unclear please call Suzy Mackechnie on 0181 3908445 or 01483 537390.
Date
Time
Is child on or off medication?
Time of last medication dose

1) What set the behaviour off and what did the child do?

2) What thoughts about the behaviour went through your head when it happened?

3) What were your feelings in response to the behaviour?

4) What did you do in response to the behaviour?

5) To what extent do you think your child was able to control this behaviour or not?

6) What if anything, would have been different about your response to this kind of behaviour if it had happened before you had a diagnosis and medication?

7) What, if anything, would have been the same about your response to this kind of incident if it had happened before you had a diagnosis and medication?
Date: 19-6-98
Time: 6.30
Is child on or off medication? On.
Time of last medication dose: 1pm.

1) What set the behaviour off and what did the child do?
   We were quietly doing with each other and he got louder and silly and I said 'be calm'
   he got louder and rude - interaction ceased. Performance started - whole shop stared.

2) What thoughts about the behaviour went through your head when it happened?
   Why me, why now, is he really so determined to look stupid when the only other option is to
   be normal.

3) What were your feelings in response to the behaviour?
   Embarrassment, exasperation.

4) What did you do in response to the behaviour?
   Asked him calmly and repeatedly to stop and held him still without hurting. (not that it
   worked). Then he went limp and we released him.

5) To what extent do you think your child was able to control this behaviour or not?
   Given up trying to guess.

6) What if anything, would have been different about your response to this kind of behaviour
   if it had happened before you had a diagnosis and medication?
   I would have left the shop & yelled at him and sent him to bed early (or other punishment)

7) What if anything, would have been the same about your response to this kind of incident
   if it had happened before you had a diagnosis and medication?
   Same as 3. and also assumptions about my poor parenting skills as nobody else
   seemed to jail to control their children as much as me with

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Appendix 10: Example of list of themes used for respondent validation
RESEARCH QUESTION WHAT IS THE IMPACT OF DIAGNOSIS AND MEDICATION ON FAMILY RELATIONSHIPS IN ADHD?

THEME 1: A REDUCTION IN DEMANDS AND EXPECTATIONS OF TROUBLE

Before medication
'Hard work' children Demanding of attention
Non compliant

After medication
School
Less worry

THEME 2 IMPACT ON THE CHARACTER AND IDENTITY OF THE CHILD

Child's 'character' does not change with medication/Medication and diagnosis seen as a possible threat to the child's identity

Before medication
Need for help at school only
Able to explain and understand child's behaviour e.g. due to gender, family traits
Able to cope with problems. Having discipline strategies that work.
Some ADHD features seen as positive, or bring parent closer to child

After medication
Concerns re medication possibly changing personality of child
Emphasis on child being 'the same person' even with medication
The desire to avoid labelling the child as ADHD
Having to accept child has a problem
Increase in concerns about the child's future ability to cope.
Concerns about own ability to cope with behaviours

THEME 3 HAVING AN EXPLANATION

Reduction in uncertainty/anxiety
Being able to do something about child's well being.
Mixed blessing

- initial resistance to medication / medication as a last resort
- side effects (future, current sleep and appetite)
- reliance on medication/ hard to cope without it

THEME 5 MAKING ALLOWANCES

Idea introduced that child is less competent to control behaviour leading to
more tolerance/ less anger and exasperation in response to problem behaviour
more explanation and discussion with child following behaviour incidents

But
Need to judge need for discipline according to situation. Judgements often difficult.
Appendix 11: Full Account of Theme 3
1. THEME 3

1.1 Subtheme 1: A miracle cure

1.1.1 Reduction in uncertainty

The majority of parents described the importance of the diagnosis in reducing uncertainty about the cause of the problems. They described how literature on ADHD clearly fitted their child’s behaviour and enabled them to make sense of it;

*I bought Gordon Fontaine’s book “The Hidden Handicap” and I read it and it rang bells all over the place and I thought, yes, this is what’s wrong with Lenny (Lenny: Mum).*

Those parents with a predominantly ‘child serving’ perspective took this to be part of their new ability to understand and appreciate the child whereas those with remaining negative perceptions of their child were concerned about the child’s possible use of the diagnosis as an excuse to behave badly (see Theme 4).

1.1.2 Reduction in self blame

Many parents described how diagnosis had reduced self blame and enabled a renewed sense of confidence and pride in their parenting and a validation of previous help seeking.

*I don’t feel that I’ve done something wrong now, which I always did, I always felt I wasn’t a very good mother, you know, I brought him up wrong. I don’t feel that now. I feel that I’ve done a bloody good job with him really. (Ian: Mum).*

*Every time Mark had a school medical or they had a problem up at the school, I kept saying something’s wrong with him and they kept saying I was being an over anxious mother. I mean, even Dr..... , the child psychologist bloke said*
Mark was a normal child. Which proves that he was wrong, that I was right........ (Mark: Mum)

For those parents with predominantly child serving accounts this seemed to add to their greater tolerance towards the child post medication (see Theme 4). For others, the removal of blame from self seemed to have highlighted the child as being the agent of the problems;

I suppose it just confirms that there is a problem with him and his behaviour, whether it’s ADD or ADH or whatever. ...It’s just nice knowing there are other children around who are as naughty, are as bad. There are sections in society where you can actually put a label over them and say there is actually a problem with him; (Larry Mum).

1.1.3 Regaining normal life

For many, diagnosis and medication meant that life had returned to ‘normal’. Not only had the child become more acceptable and easier to manage in home and school life but a wider range of family activities suddenly became available to them.

now you go in Safeways and you go and sit in the little cafeteria with him ..........I took him to the pictures and he sat and sort of watched the whole thing...............he never used to get invited anywhere, now if he's going to a friend's: they've noticed the change, that he'll play nicely, (Jim: Mum)

For some parents there was a sense that the problems had been destructive as well as disruptive to family life but that medication had enabled some repair;

It was awful - we never went anywhere, we never did anything, because we knew that if we went.. well basically we weren't a family unit..... because you knew that Matthew would do something and you'd end up coming home and you'd have a really bad time... Now we have a calmer, normal life back..... this was the first holiday that the three of us have ever had when there weren't
really any arguments and it was just all calm and having a good time.
(Matthew: Mum)

Others described more trust and responsibility being placed in the child;

You can actually give him the responsibility of going down the town on his own and know that he's going to get there safely and arrive home safely (Mark: Mum).

However, even with these aspects of the 'miracle cure' there seemed to be a potential for disappointment and regret. Those who had fought for a diagnosis and medication expressed anger and regret at the length of time wasted without medication and the opportunities missed;

I wanted that medicine, I wanted that Ritalin and I didn't care what I had to do to get it. ..........I'm angry at everybody that's ever had contact with him, very angry at the Child and Family Therapy(Matthew: Mum),

as well as some disappointment at the extent of the change in their child (see Theme 2) and some comments which illustrated their future potential for disappointment because of the high expectations of the medication;

Matthew has just got to go through one of the major changes of his life (adolescence) and I hope the medicine will carry him through that (Matthew: Mum).

1.2 Subtheme 2 A mixed blessing

1.2.1 Confusion and guilt

For other parents, despite a recognition of the benefits mentioned above their accounts illustrated that the 'explanation' and the 'solution' had simultaneous negative aspects. This ambivalence featured particularly strongly for those for whom pressure for
diagnosis had come from the school. There was an increase in guilt and uncertainty because of the lack of clarity of the cause of ADHD;

*The majority of what I've read has been completely conflicting.......... probably the bits I like best are the bits that put it down to a chemical problem. The ones I like least are the ones that say its an opt out .. it's attention seeking behaviour taken to its nth degree......saying that I've done a bad job, that I've made such a bad job of it that this kid is so totally messed up and has to be on drugs (Jonathan: Mum),*

such that there was also a reluctance to give up on their prior preferred explanations for the problems.

**1.2.2 Efficacy**

For many parents the diagnosis and medication meant that they had a solution to their child’s problems and their sense of efficacy increased.

*it put a label to it... which went some way to explaining why his behaviour was what it was. That on its own took some stress out of the situation, because if you’re in a stressful situation but you understand the cause of the stress you can do something to manage it, (Bill: Dad).*

For many the significance of this was the sudden ability to improve their child’s well-being;

*The first two years of his life he was just so unhappy at school and he’s happy now, he’s happy going to school and when he’s learnt something he’s so excited, (Ian: Mum)*

At the same time many described how the use of medication had been a last resort;
in the end I thought, no, I want to try it, I want to try it for Ian's sake. But it was purely for the school, because I knew he would end up being expelled if things didn't improve at the school and there was nothing left (Ian: Mum).

So she let me have a choice, new school or go on the medication, it was blackmail really; That's what the school told her to say to me, medication or new school. (Ian),

and there were remaining concerns about criticism from others;

I don't talk to people about it because I just think people get a sort of opinion in their mind without knowing the facts that .... you've drugged him, you've got him on drugs because you couldn't cope (Ian: Mum),

about side effects; physical and psychological;

I still wonder whether we've done the right thing His weight - that he's not eating - that's a major one...... that worries me because he is so small anyway...... he concerned me the other day with something he said. I said to him "You haven't taken your tablet today, have you Terry?" And he said "No, why should I take them anyway. It's not me - it's causing me to be like somebody else." And I thought "Oh no, I don't need this". (Terry: Mum),

The disadvantages are that if there isn't anything wrong with him we're giving him permission to opt out and does he have to stay on a drug to convince him that he can cope for ever...... he has permission to believe he is the odd one out, so now he can always play the cripple, you know....... that's a big opt out clause for someone as clever as him (Jonathan: Mum).

For others there was an explicit or implicit sense of reliance on medication;

it's a sad view on life in the sense that we've relied on him taking the medication for this period of time and if we knew that we could take him off it
tomorrow and he was going to remain the same as he is now, then we would.
But we can't (Bill: Dad).

They said that they wanted to reduce his dose, so we reduced his dose and
then they decided they wanted to give him a break from them to see if he could
get on without them but that was the biggest mistake they made......I ended up
having to phone Dr.......... at the clinic and asking him what would be the
best way to handle Mark (Mark: mum).

1.2.3 Adapting lifestyle to suit child

As mentioned in the discussion on Theme 2 some parents experienced a decrease in
efficacy in handling the child at home. For some although, medication had enabled more
family activities, their discomfort with the fact that such ‘normality’ had been achieved by
medicating the child was expressed. Some parents described a much more occasional
and reluctant use of the Ritalin to manage public activities;

I still sometimes think I wish I could take him to a wedding and have him sit
quietly next to me but I know he's not going to unless I put him on the
medication (Ian: Mum).

This parent went on to describe how she had resolved the issue of her child not fitting
into the usual activities and routines by adjusting her lifestyle and expectations rather
than insisting upon her child conforming;

I think I spent seven years battling, trying to fit Ian into the role of a child, I
was trying to mould him like other children and once he was diagnosed and
once I'd read books and things, I thought it's a losing battle, he's just not
going to be like other children. I have adapted to that and it has definitely
improved. A couple of years ago I'd think well we're going shopping, tough
Ian, if you don't like it, tough, and now I don't, if I haven't told him in the
morning then I don't go. So my life is gauged on his moods and I just accept
that now (Ian Mum),
despite this having its own disadvantages;

but I can't see myself settling down with anyone because.....the whole home
life is adjusted around Ian (Ian Mum).

1.3 Theme 3 - Comment on children's accounts

Although children's accounts did not include specific appreciation of the meaning of the diagnosis it was clear that children were quick to detect parents attitudes about having medication whether this was a fear of 'character change' (see Theme 2) or a sense of its importance for their well-being;

No, all I say is just, if you need them, you take Cos, it's important for me - the medication. I think it's better for me to have [it] (Jim)

Children also often mentioned that medication could be dangerous and that only those who really needed it should take it, possibly reflecting awareness of parents concerns about the powerful nature of the drug. Despite parents anxieties, and children's description of the action of the drug on them as a passive experience the effects of the drug appeared to be empowering for children;

I think more now and I stop myself getting into trouble (Bill),

I'm not asking them all to do things for me, so I can get on with them myself, while they get on with what they're doing (Darren).
Appendix 12: Sample interview transcript
Darren - Mum

S: So, can you just tell me who's in the family?
I: There's myself, my husband, and I've got Darren and then Joe - Joe's six and a half.
S: Right. Can you just start by telling me a bit about your pregnancy and birth with Darren?
I: I had quite a few kidney infections, but other than that everything was fine. It brought on early labour a couple of times with the infections, but they stopped it and everything was fine really.
S: Right. And the birth? Natural birth?
I: Yes.
S: Any problems?
I: No.
S: O.K. And what was he like as a baby in the first six months?
I: Miserable! He was, he wasn't a happy baby at all. He was good at eating and things like that, but we lived with my family then, my parents, and many a night I'd be up pacing and then Mum would have a turn, then Dad, then Bill would have a turn and... basically he was a miserable baby. I mean, since having Darren, having Joe and looking after other babies, I've said now I realise how miserable he was, looking back. But at the time I just thought he was normal - it was normal to be that miserable - they were all like that.
S: In what way do you mean miserable - just difficult?
I: Yes, difficult. You could never please him - put a bottle in and he was still yelling two minutes later, even though he wasn't hungry. And then as he started sort of crawling around and that, he was never really a happy baby. He was always grizzling - he just wasn't a happy baby.
S: Right, what about milestones? Walking and talking, that kind of thing?
I: Talking he was alright, came on quite quickly in that, but walking - he was very late walking. I put it down to the fact that he got around so well crawling because he was very quick on all fours, but he didn't walk, not until he was about nineteen months and he climbed up onto a table and fell and broke his ankle, and with the plaster on, he got up and walked. Whether he didn't ( ) I don't know, but he actually got up and walked with the plaster on.
S: And what about toilet training - was that on time?
I: About two and a half, so that wasn't bad, yes.
S: And you say he was quite miserable as a baby - what about in pre-school toddler?
I: He always wanted occupying - he wouldn't play with anything, but he was quite happy for me to sit there and play with the toys while he watched. But he didn't actually play with them himself. He was quite happy getting toys out, but he didn't do anything with them - he'd turf the whole lot out, but then I had to do the sitting and playing.
S: How did that affect you?
I: It was hard work, but then I think it made it slightly easier having my parents there, because if he didn't get the attention from me, he just sought it somewhere else. And at the time, Bill was coach-driving, working for my Dad, so it meant he used to do school runs, so he was there most of the day as well. So if he didn't get what he wanted from one person, he just went to someone else. So though it was hard work, I think if I refused in the end, it didn't really solve the problem because he'd just go somewhere else.
S: Did that affect how you felt towards him, being that kind of child?

I: No, because Darren and I have always been. I think I am closer to Darren really. I have always felt that Darren has needed me more than Joe has needed me, so I've always been closer to Darren really.

S: Yes? In what way?

I: In that where Darren and I sneak off to the bedroom for little chats, and things like this, out the way, I mean Joe will just come in "Let's have a cuddle Mum" - just like that, it's over, but Darren and I will sneak off to do it when Joe's not around and Darren has always wanted.. I think he's always been jealous of Joe in a way - he's always put over that he needs that bit more attention.

S: So the chats - what were they about?

I: Er, behaviour, about Joe: I mean, still now we disappear off and we talk about school out the way when nobody else is around, you know. A lot about school, football, that sort of thing.

S: Is that because you feel he's upset about things or..?

I: Yes. He takes it to heart more, I think, than Joe. Joe tends to just - it goes in here and back out the other ear. Joe finds things easier to deal with. For instance on the forms that I filled in the other week that Darren had lost a Cub badge that he'd earned, and the difference being Joe would have come in, we'd have had a tear, and that would have been the end of it; but Darren had to carry this on every single day about this badge, which actually turned up in his room about a fortnight later. But he couldn't see that it didn't matter - we'd just get another one from Cubs. That wasn't good enough - he had to keep on and on and on over it. And I had to keep chatting to him about it, you know "We'll get another one, we'll sort it out".

S: O.K. Just going back to school, how did he get on at nursery school? How did he settle?

I: He actually went to two, because the little one here is only open twice a week and I didn't think it was enough for Darren - I thought he needed a bit more - so he actually went to two. The one at ( ) he got on better at, but the one here, he wasn't so good - up here, we used to have tears every time. I put it down in the end to the fact that, at ( ) they just took him from me, tears or no tears, it didn't matter, and took him away and that was that. Up here, they were inclined to make a bit of a fuss "Does Mum want to stay?" and this sort of thing. So really in the end, I felt that it was because of the way they handled the situation - up here they didn't help whatsoever, and we always had tears in the mornings: one of my neighbours, she still says today "You used to kick me" and that was when she used to take him from me.

S: So he wasn't happy about leaving you?

I: No, no. And yet once I'd gone he was fine.

S: Alright. Right. And how did he get on with other children at the nursery school?

I: Alright, alright. There again they always found that he needed a little bit of attention; he needed someone to sit with him and play with him.

S: Otherwise what would happen?

I: He didn't do anything. But other than that, he always got on alright with the other children.

S: What about behaviour-wise with the teachers? What was that like?

I: At playgroup, I think it was fine. I mean, I was there towards the end because I had already started working just before he left, and I think really, with the teachers, he was fine. When I was there, I tended not to have anything to do with him - if there was a problem, I always left it to somebody else to deal with - because he was mine, I didn't think it was right.

S: And then moving from nursery school to big school: what was that like?

I: It was alright for the first two days, then when he found it was forever, he didn't really like it. There again, he cried at leaving me, but I don't think it helped because ( ); one teacher had left because she was pregnant, and then they got a replacement in for a little while, and then the first one decided she wasn't coming back, so then another one had to do it, and it went on like that for a little while.
S: How did that affect him, do you think?
I: I don't think it helped because he's always liked to be in a bit of a routine, you know, doesn't like his routine mucked up, so I don't think it helped, but in the end there was one very good one that came, and we tried different ways of dealing with it - we tried with me staying for the register, which didn't help, and in the end it was literally that I used to take him up and the minute I went in the door, somebody would take him - and I would just run. We found it was the best way, because the minute I'd gone, he was alright.

S: O.K. So that was settling in, and eventually what happened - did he get used to it?
I: In the end we stopped the tears, but up until very recently we've always had the "I don't want to go", and we occasionally get odd spells of "If I've got tummyache, I don't have to go". "Well, darling, if you're not well, you can come home". "Well, what if it's a sore throat?" Occasionally, we do get that, but it's a lot better now than it was, since he, really since he's been in the top class - that's been just over a year. He dreaded going into that class, but once he got in there, he really liked it.

S: Right. And how does he get on with other kids up there? He's ten now, isn't he?
I: Yes. Fine really - a lot of them are ones he went to playgroup with and has gone up with, so he's known them quite a while and he's always got on alright with them.

S: And academically - it sounds like he's doing well?
I: Not tremendously well - they've had a lot of problems, but his teacher has said that, since starting the medication, he's really changed. I mean, we first saw the educational psychologist when he was about six, because the school felt there was something not quite as it should be - he wasn't going along as he should. We had his hearing tested, which was slightly down, but they said it was nothing to worry about: then he started seeing a speech therapist for a while, and they sorted out a programme for the teachers to work to, which carried on for a while; but then, when he went up into class three, his teacher then decided that she thought.. they talked about it, and talked about it with us, and thought it would be a good idea to see the educational psychologist again, because they felt that he just wasn't coming along as he should be, and he was then dragging further and further behind.

S: In any particular areas?
I: No, the main thing was concentration - it didn't matter what they did, they just couldn't hold him there. And at odd times they used to get one of the assistants to go in and sit with him to try and lift him along a bit. But he was just sort of dragging behind all the others a bit. So then we saw the educational psychologist again, which was June, I think it was, last year, and she worked with Darren for the morning and she was the first one that said that she thought that there could be this Attention Deficit Disorder and she would try and get us an appointment and then we went and saw Dr. Downey in January, I think it was, for the first time, yes.

S: So back then, you said when he was about six, what did you think then was causing it - can you remember?
I: Not really no. We saw the educational psychologist - she said she thought maybe it was just like if his hearing was down: we had his hearing tested, they said it was slightly down and they did monitor it for a while and it did improve, but they said - I think it was the left ear was slightly down - but they said it was nothing really that would affect him. And then nothing more was really done, apart from he saw the speech therapist, who did a programme for the school to work to, and she did see him now and again. Then I had one report through from her and I went and saw the headmistress then, because I wasn't very happy with it. I didn't think it showed a clear picture actually - it was going on about the baby talk and that sort of thing - well, I know we do have that occasionally from Darren, but the minute I say "Oh, talk properly, Darren", he does. Alright - two minutes later he might go back to it, but, just remind him - he will change. And I went and saw the headmistress and she said the same as me; she didn't think the woman had got a clear picture, and she was asking if he could be seen again; which he did get seen again, and then..

S: Another speech therapist?
I: Yes. And nothing was really done then and it wasn't until one day Mrs. Christie, the headmistress was saying to me she felt that he should be assessed again, and she was going to get in somebody she knew, I think it was, to do it, but then the speech therapist decided maybe she should do it again and it ended up that we saw the
educational psychologist in the end, and it was the same one as we'd seen previously. And that was when things really got moving, but it seemed to take a long time to get anything moving really.

S: So back then, you thought it was maybe the hearing problem?

I: Yes, I tended to think at the beginning maybe it was the hearing, but we didn't really know, apart from the fact that we just thought maybe it was that that was doing it. So we weren't really sure what was happening and it did seem to take an awful long time to get anything sorted. And the appointments as well: I mean Mrs. Christie said to me "We are going to put him forward to see an educational psychologist, but it's such a long wait really for anything like that". It seemed to take so long to sort anything out.

S: And also at school - how was his behaviour?

I: Not brilliant - he's never been really spiteful with the other children or anything, but he'd distract the other children and make silly noises and everything, which always made us sitting targets for the next parents' evening - we'd try to stop the silly noises. And it would stop for a while, but then he'd drift back into it. But really, it was more the fact that he couldn't concentrate on his work and all that sort of thing.

S: Was there anything else that happened in his pre-school or early school years - any major life events - accidents, hospital, deaths, or anything major?

I: No.

S: And did he have any significant separations from you or anyone in the family?

I: No. The only thing is, when we moved ( ) here, I think he missed my Mum terribly. Mun's always been very close to Darren. She was actually there when he was born and she said there's a special bond there now with them, through that, and I do think he missed her when we came to ( ).

S: When did you move here?

I: Darren would have been about three, three or four, and I do think he missed not having her around.

S: Right. Do you think any of the things we've discussed so far affected your relationship with him? Nothing formative in your relationship?

I: No, I don't think so.

S: O.K., if we just stay with early life, before you even got to the clinic or anything, how would you have described Darren? What kind of child?

I: Hard work! I always say that if I'd have had Joe first, I'd have wondered what had hit me with Darren. But having Darren first, I took it that all children tended to be like that. I think I just took it for granted and got on with it.

S: As in hard work, you mean, you were saying before about..?

I: Yes, he always needs somebody there, he's argumentative, and if you say, "Don't do it", he will push and push and push and quite often still do it. And he'll just try to see what would happen if he does it and if you said to him "Oh, Darren, we're going out - go and get your jumper", he'll disappear, and a good five minutes later, he'll come back and he'll say "Where was I going?" "To get your jumper, Darren". Off he'll go, and he'll come back and say "What jumper shall I get?" "Well, I don't mind - there's several in your wardrobe, whichever one you want". And off he'll go and he'll come back and say 'What do you think? Shall I wear this one?' You say "Well, that's fine". And this is how it goes on; it can take, you know, quarter of an hour to get one jumper on.

S: And how do you think that affects your relationship compared say, to Joe?

I: I think if anything, it's brought me and Darren closer together because if I say anything to Joe, Joe just gets on with it and that's that. I don't think he really needs me as much as Darren does - I mean I say to Joe "Go and get a jumper", and he's got it on, he's in the car and that's the end of it, you know, whereas Darren, you have to go through it all the time, to try and get him moving.

S: So, just to sum up you relationship with him, how would you describe it?
I: We are very close, yes.

S: Any particular memories to illustrate that?

I: I think, I mean, he will, if I'm not around for some reason, I mean like for instance going to work - I work fulltime and Bill works part-time - and we spend the whole week wondering which my day off is. And I'll say to him "Well, it's probably next Tuesday" or something like that.

S: He does?

I: Yes, wonder the whole week "What day's your day off, Mum; what day's your day off?" And then in the end I say "Oh, well, it's probably going to be Tuesday". But then, when I've got it confirmed and it's say Wednesday - "Oh, I wanted you to be off" and he's at school all day - it doesn't really make a lot of difference. He seems to want me there that bit more than what Joe does - I think it works both ways really.

S: And your feelings towards him?

I: He can be so adorable at times, he really can, but on the other hand he can really push his luck as well. He is hard work and, I mean sometimes when I put him to bed and that, because I do find that is possibly one way of dealing with him - he doesn't like it if I put him to bed and say "That's it, I'm going downstairs" - and I do.. sometimes I'll come down here and it has sometimes reduced me to tears, because you can't seem to win with him. And then two minutes later he wants you there because he wants a cuddle and.. up and down!

S: And have there been any changes in that over time, or have you always felt like that?

I: I think really, as he's got older, it's got more difficult, really. I mean my husband and I say if we have an argument, nine times out of ten, it is caused by Darren. But I think possibly because he pushes his luck and can be difficult, it does sort of tend to put a strain on the family anyway. And then I think you end up a bit touchy and then it causes words that way. But I mean there is no getting over it, he can be very difficult, but on the other hand, he can be a lovely child as well. He can be very thoughtful and very considerate, but it's just that he can be very difficult.

S: Is there anything else you want to say about your relationship?

I: No, I don't think so.

S: And how would you describe his relationship with his Dad?

I: I think he finds it harder with Bill, because Bill is very strict. If Bill says "No, you're not going out to play", he means it, whereas I'm inclined to give in after a while "Oh, well, maybe five minutes". So I do think he finds that hard. But other than that, I mean, as he's got older, I think it's been better because Bill is very into sport and things like that and Darren is very into sport - football, rugby and things. So I think it's become easier that way.

S: What do they do - do they watch things together?

I: They watch stuff together and as Bill works at the school anyway - he teaches football to the boys - and also Darren - we thought it might be a good idea to involve him in clubs and things like that - we joined him up to a football thing in Petersfield, which is Sunday mornings, which he really enjoys. He's not a lot of good at it, but he enjoys it. He loves going, and through Bill taking him there and waiting for him each Sunday, it's got now that Bill actually helps out there as well, so they are actually doing it together, which is nice. But they are very into.. both of them, Manchester United mad. So, as he's got older, I think it's been better.

S: Better in what way?

I: I think they've got closer. Also since - I mean Darren has always been difficult and I've always said I felt maybe it was the hearing that maybe was the problem, whereas Bill always looked at it that nobody had said there was a problem, so there wasn't.

S: What kind of problem did you think?
I: I didn't know. I think maybe I became more aware, as time went on, because of my training with the playgroup and I did a lot of special needs courses and that, and I think I became more aware of it then and I sort of said "Well, maybe there is a problem". And then I was sort of thinking "Maybe there isn't" because nobody had ever said so.

S: This is what your husband was saying?

I: Yes. And I didn't really know what to think, but Bill always felt that if nothing had been identified at school or anything, there wasn't a problem. But since last June when it was first suggested that it could be this Attention Deficit thing, Bill has had more patience with him as well, which has been good.

S: So thinking there was nothing wrong with him, how did that affect how Bill dealt with him?

I: I don't think it made any difference to the way he dealt with him. I think Bill just became more understanding. I mean, still, if he says no, he means no, but he's just a bit more understanding when Darren kicks up about it "Yes, well maybe he can't see it quite as clearly as Joe can see things" and.. so, but I think as Darren has got older and got into sport and that, it's brought them closer together.

S: O.K., and in the past his typical feelings towards Darren - what would you say they were?

I: Oh, I think he's very fond of him really - yes. I think also, because my family have always been a very close family: Bill's family haven't been as close. I mean, if there's ever been a problem, we've always been able to talk about it in the family, whereas Bill's family aren't that open with things, and when I first fell pregnant with Darren, Bill said right from the word go, it's going to be more like I've been with my family, than his family have been; Darren should always be able to come to us, and he wanted there to be that closeness, and even now when we've got a problem, on the phone to Dad, you know "Washing machine's broken". But we could never ring Bill's family like that and say "What shall we do about this?", you know. And Bill has always said that there should always be that closeness - that his family never had.

S: O.K., and just a bit about Darren's relationship with Joe in the past - how would you describe that?

I: He feels it a bit, I think because Joe just gets on with things - he tends to do a bit better at school, and I think Darren does feel that and he does get a bit jealous of Joe. Joe is a very.. he's very tiny, you'll see ( ) - he's got a little round face, a very cheeky little grin, and everybody says "Oh, isn't he wonderful?" Whereas Darren doesn't get that, Darren's just very plain, glasses and hasn't got that character about him that Joe's got. Joe just tends to win people over, but Darren hasn't got that - he'd rather sneak off into the corner; but then I think he does feel it, he gets a bit jealous of Joe sometimes. And he does point out, for instance, with Mother's Day cards and they made my Mum some get well cards the other week - it was very much "Joe's is better" and he could see that Joe's was different to his. "But your's is lovely, Darren - it's really nice writing". "Yes, but look at Joe's card - isn't it pretty?" And Joe had done this - well, beautiful flowers, all over the front and Darren's was - well as Mum put it - she'd got about half a dozen cards all the same from Darren. This one outline of a square vase, three stems, three circles on the top, very plain, no colouring, and he could actually see that Joe's was so elaborate and wonderful - and I think he feels it, because he always points it out.

S: So he feels jealous, yes? And how do you think Joe feels towards Darren - typical feelings?

I: That's a difficult one. They never ever really play together and Joe can wind Darren round his little finger - if I said "Come on, put your toys away", "Oh, well I can only carry this one": and he knows if he plays up enough, Darren will just go and do it all anyway - he will do it for him. And I do have to.. quite often I have to say to Darren "Look, don't give in to him" because the more you give in to him, the more he pushes then. He can, he can wind Darren round his little finger and I think he knows it. And Darren will do it in the end; he'll just do as Joe says.

S: O.K. If you had to say who Darren got on best with out of all of you, who would you say it was?

I: I can't really say. I don't know because he uses us all for different reasons; I mean, Bill is there for the sports, which, I am not into sports whatsoever; Darren'll come in and tell me about this footballer who is so wonderful, and there's me saying "Who?" "You know Mum, he plays for United". So that side of it is Bill: the talking about things is me.

S: If he was upset or hurt, then it would be you?
I: Then it would be me, mm.

S: And that includes closeness - who would you say he was closest to?

I: Me, I think, yes.

S: And who would you say he got on least well with, if you had to say somebody?

I: Joe, I suppose really, because Joe... he is so envious of Joe, yes.

S: O.K., just quickly about how you think your relationship with your parents affects your relationship with the kids. Do you think it does, or in what way?

I: Only the fact that I said with me and Bill talking when I first got pregnant with Darren, we said it had to be... we wanted it to be the same as it had been with Mum and Dad.

S: O.K. Your views on parenting. Really, this might be important for just understanding how families react to medication and things like that. If you had to sum up in a few words, your views about parenting, what would you say? What kind of parent would you like to be?

I: What kind of parent would I like to be!!

S: What you believe about how you should bring up the kids.

I: I don't like... working in playgroup, I've seen a lot of families in various situations and though I think it changes your mind forever, being a parent, on the other hand I think as well there should be bedtimes and things like that, because I think you need your own time together, whereas I've seen round here... people condemn me for saying bedtime is seven o'clock and that's that, no matter what, they will be in bed, and I've always stuck to that sort of thing, because I think you just do need your time together, just me and Bill, but it does change your life forever. There's no getting out of that. I don't know that I'd change anything, looking back really, I'm glad I didn't have them too early in life; I was twenty six when I had Darren, and I am glad I wasn't any younger.

S: Why?

I: I don't think I'd have coped so well. I think being that bit older, I coped better, especially where he was hard work.

S: What about your views on discipline? I think you've said it really.

I: Yes, I don't think they should rule you, I really don't. Although, I mean for instance, when we go on holiday, we do things that they want to do, we also do things that we want to do. For instance, that was last year, we went to Tenby, and we actually took my Mum and Dad with us, and I wanted to go to this cheese factory and Darren didn't and we had looked at some leaflets and he had picked out a chocolate factory. I said "O.K. then - we'll go to the cheese factory and on the way home, we'll go to the chocolate factory". So we did. I think, although when you've got children, you've got to do a certain amount with them, I think also they should blend in with you.

S: It's a sort of compromise?

I: Yes.

S: And when he's naughty, what would be a typical way of dealing with him? Would it be to try and explain or...?

I: We'd try and talk to him first, but with Darren that doesn't always work: but I find really, if things have got really out of hand and he's not doing as he's told, I find the best way is the bedroom and bed, pyjamas on and in bed. And if he is sent to bed, he is not allowed his television on, he's not allowed his megadrive on, he can sit and look at the books up there and that sort of thing, but he is not allowed in the toy cupboards to start playing.

S: So it's explaining up to a point and then...?

I: Yes.
S: And is that similar to Bill?

I: Yes.

S: O.K. let's move on - just a bit more about the problems that brought you to the clinic. Your main concerns at school..?

I: Yes.

S: In particular?

I: I had spoken to Dr. Homer, on a couple of occasions, their G.P., about Darren's behaviour, but not really seriously enough that we were going to do anything about it - it was just that I'd said things weren't easy with him. Then it was mainly through school that we ended up at the clinic, because, school are very good for feeding back things ( ) and that and it was really through that in the end, because ( ) the headmistress felt she wanted to get things sorted out because he goes up to the intermediate school in September, and she really wanted to get things sorted out before he went. Work out some sort of programme or something to try and help him out. And that was really the final thing that she said "Right, we've got to do something". And she said, when we had the first appointment at the clinic and she said "Well, come back and let me know how you get on", but she said "If they turn round and say there's nothing wrong, then we've got to talk to Darren seriously, because there's a reason why he is behaving like he is".

S: And what were you concerned about in particular at school?

I: His work. Also I mean I had concerns about him going to the intermediate because they've helped him out an awful lot up here; we've had lots and lots of long chats about him at various times.

S: The particular problem was not getting on with his work?

I: Yes, it was, and, not necessarily naughty behaviour - I think silly behaviour, one of his teachers said - "He's not really naughty, he's just being silly". He would distract the others; they made a point of not sitting him with certain children because he would distract them and stop them getting on as well.

S: And at home, you said you talked to your doctor a bit about home - what were your main concerns about Darren at home?

I: It first cropped up with the doctor because.. he runs a little surgery in the village hall, which isn't very practical really, because you've got half the world going up there and all the school children running round when he's trying to hold a surgery.. and he did say to me one day about Darren's behaviour up there and I said "Oh, don't worry, it's nothing new", you know.

S: Yes. What was he doing?

I: I had repeatedly told him that he wasn't to run around because the doctor was trying to talk to the patients. And he would sit down and would be quiet for a little while, then it would just get louder and louder and louder, and it resulted in the end to the doctor actually coming out into the room "Will all you mothers keep your children quiet". And he wasn't very happy and I said, you know, that I tried to keep Darren quiet and make him sit still but it just didn't work that well and that was when I first spoke to Dr. Homer about it and I said it just wasn't new for Darren to be like that, it was just the norm.

S: And what did he think was causing it, did he know?

I: To be honest, he just wasn't interested then and it just didn't go any further.

S: Right. So what that what you were concerned about at home as well - that kind of thing?

I: Yes, those kinds of things, yes. I really became more aware about things as Joe got older, because you could send them both to do something and Darren's three years older than Joe, but it was still Joe that would get back, having done it, and Darren would still be wandering around a bit lost and not really knowing where he was going and what he was doing.

S: So it was the not focusing on things that was the real problem for you?

I: Yes, and he will, as well, get worked up about things and worry about things.
S: Which of those were you most concerned about?

I: I think possibly more the fact that he will get wound up and worry about things. Before he's changed classes at school, each time we've had problems at home that "I don't want to go into that class", but the minute he's changed, he's fine, and then he'll settle back down. He will get worked up over things, and wound up, and still now, if we are going out for a day or anything, we never tell Darren - we never tell him we are going to the Zoo or whatever - because he will just get so worked up that you'll have an awful morning with him.

S: Can you give me an example of it, before he was on medication?

I: Before the medication? Yes, just simple things like, Joe will be sat there, Darren will come and sit down and he'll have to start poking him and prodding him. He'll say "Don't do that", so he'll get up [S: Who? Darren will to Joe?] Yes, and he'll turn the television over when Joe's in the middle of watching something. "What did you...?" "Oh, well, I want to watch this" and then he'll just turn it off and disappear. And things like this. But he gets very worked up and excited really, but it tends to go a bit overboard, and you say "Now come on, and get ready", but he won't "Oh, I'm going to play on my Megadrive now" and you'll say, "Well, you've only got five minutes and then you've got to be ready", "Oh, well I'll play on my Megadrive"; "Well, have you finished your game now?"; "Well, no I set it for forty five minutes, and I want to finish it"; "No, we're going".

S: That's a good example, yes. When this used to happen, can you remember what was going through your head about it?

I: Really just that we looked at different ways of trying to solve the problem, and the best one we came up with was that we just didn't tell him we were going out. We just never ever said... and we are still inclined to do that now! We leave it until the very last minute, and I say "Here's your clothes, put them on, we're going".

S: And when that would happen, how did you explain why he was like that compared to Joe? What was your reasoning?

I: He was just a different sort of child to Joe. I mean they are all different, but he was just different to Joe - a different sort of child really, and I just put it down to that.

S: In that he just ( ) more, temperament-wise?

I: Yes.

S: And when he got like that, how would you feel in response?

I: A lot of the time he would just get sent to his bedroom while the rest of us got ready and then I would go and get him ready.

S: So you kind of lost patience with him?

I: Yes, I think I've had more patience with him since we've been going to the clinic, because now I'm thinking there's a bit of reasoning behind it, yes. There's a reason, maybe, why he acts the way he does. But I think maybe... we've always been that we talk to him first before telling him off about anything - we talk and explain the situation as you know, "You really can't do this", and I think maybe now I'm inclined to talk to him a bit longer and try and reason with him more. But I do find that sending him to bed or even telling him that I'm going to ground him, because that he hates. He hates being grounded ( ) really.

S: If that happened now, as opposed to before the medication, what would be different to how you would respond now? You said talk a bit longer...?

I: Talk longer - I think that's about the only thing. I'm still inclined that if he won't calm down and see reason, then it's still bed.

S: Do you think you get to that limit later, or is it still the same?

I: A bit later, I think, later, yes.

S: End of tape - side A.
Third Year Research Project - Appendix 12

I: I think with my background of playgroup and everything, and doing the courses that I've done, I've become very interested in children and since going to the clinic, I came back the first time and I looked up in the library about A.D.D. The second time we went, I spoke to Dr. Downey about another book that I had heard advertised on the radio - it was being talked about on the radio - and she said "Oh, yes, it's very good". So I went and got that and I think with reading those as well I've now got that I'll sit and talk for longer with him and try and make him see reason. Or quite often we'll disappear to the bedroom and talk, because I don't always think it's fair to do it with Joe around because Joe is far more easy going and he'll point out, he'll turn round to Darren and say "Well, I wouldn't do it". I don't really think that's fair - to do it in front of Joe, with Joe pointing out "I'm a good boy". So we tend to disappear and do it, or I'll call him to the kitchen "Come out here a minute, I want to talk".

S: So when it used to happen, had you thought about how much control he had over it?
I: Before we went to the clinic, a lot of the time I just thought that it was him and he was being naughty. Now I tend to think maybe he can't always help it. Maybe it's not all his fault, you know, that he's like he is, that he behaves the way he does.

S: And does that affect the way you deal with him?
I: No I don't think it does really, no. I think maybe I was a bit more defensive when other people said about Darren's behaviour: for an instance, he actually stayed in a hotel - my Mum was rushed into hospital the other week - and the housekeeper at the hotel said "Oh, just leave the boys with me - no problem!" I said "You can't really have them in the hotel" "Oh yes, no problem!" I know that she is not really into children that much, and she said to me afterwards "Cor, that was hard work!" And I said "Well, I did warn you and I had told you that Darren's got problems and we go to clinic and everything". I explained it all to her and I said "I've told you this before; you were convinced you wanted him to stay with you." And she said "Cor, it was hard work". Joe was quite happy to play hide and seek round the hotel, and stick to just the few bedrooms they were allowed in, but Darren wanted and wouldn't stop wanting the fact that he had to go further afield, he wanted the other rooms, he wanted to do this, he wanted to do that. And she said she couldn't seem to get through to him that, if he wanted to play hide and seek - there wasn't really anything else they could do, so they would play hide and seek - but he wouldn't settle to it - he wanted to do more all the time, and I'm a bit more defensive: I said "Well, I did tell you, and if you don't like it", you know.

S: Is that different from how you would have felt before?
I: I don't think I would have been so defensive and for Darren.
S: Right.
I: As in the way I deal with him, I don't think it really makes any difference.
S: So just staying with the past, just to finish off, how did the difficulties affect the family over all?
I: Only that, I think that if we do have arguments, it tends to be over something Darren's done, because he'll do things without thinking what he's doing. So if there is a problem, it's usually caused by something that Darren's been up to or that Darren's done.
S: How does that cause an argument?
I: I think because we both get touchy in the end, because we're wound up over Darren and then we both get touchy and something's said and it just gets out of hand. I always try to treat them both fairly, but I do think that I tend to favour Darren more.
S: Because of the difficulties?
I: Yes, yes. I mean we did actually have a conversation one day - this is going back now when we were in the flat up the road, so it must be going back four or five years - and it was with my sister, actually, that we had the conversation - she was saying about there shouldn't be favourites in children, but she had a favourite in hers, and did we, and I said I wouldn't say it necessarily that he's my favourite, but I feel closer to Darren because I think he needs me more. And I know ( ), more so for Joe because Joe's a lot easier to deal with. Take the easy way out! But other than that, I mean we've always been very close to my parents as well, when we've had a lot of problems with Darren, I mean Mum and Dad have always been very involved, and Dad has
always tried talking to Darren a lot and I mean they do take him out, as well, quite a bit: especially during the
summer, they'll come and take them out, but then they do a little bit more with Darren really. And I mean, it's
very good because Dad knows what we allow and what we don't allow and he sticks by our ways rather than
introducing his own. And when they do have them, it's always Dad who looks after them because Mum's
disabled anyway. And he is very much "Come on, your Mother wouldn't like it, if she knew you were doing
that".

S: What about you and how you saw yourself as a parent - did it have any effect on you, do you think?
I: No, not really, no I don't think so, no. I think possibly, had I been a sit at home all day and be a fulltime
housewife, I think the problems might have got to me more, but where I've worked quite a bit, I come home
fresh to Darren, I ( ) and even when I was only working like part-time in the playgroups and that, it would get
me out and I came home fresh to it each day, which I think made life a bit easier really, because I'd had that
break from here, which I think has been good. And I mean, even now, because I am actually working fulltime
now - most of the time we get weekends off, but occasionally you have to work weekends, then we get time
off during the week, but then those two days I do tend to spend time - rather than...I don't really like having to
catch up on housework and that - I do try to get up really early and get it done really quick, so that I can
spend time with the children, and do their homework with them and things like that. Because that's my time to
be with them.

S: O.K., so the reason it didn't really affect you was that..?
I: I had other things, yes.

S: O.K., what about the effects on Dad, particularly the difficulties - how have they affected him - do you think
they got to him more, or less?
I: Less, I think, really. Yes, I think less.

S: Why do you think less?
I: I say I think, because Bill's not a great talker, so I think if he wasn't told there was a problem, then there was
none. So I think less really.

S: O.K., and what about on Joe - how it affected Joe?
I: Well, Joe's very laid back and doesn't really things just ride past Joe. He's quite happy to just sit and watch
television and let everything pass by.

S: We've talked about what you used to think was causing it and that you weren't really sure - you had some idea
that it might be about special needs, some kind of special needs: and did you think it was the same thing at
home and at school causing the problems?
I: Yes, yes I did, but having said that, I'd done.. the courses and that I'd done - I'd done like mini bits on autism
and things like that and looking back, I would think, well it's not that and it's not that, so is there a problem,
because I couldn't really pinpoint anything, because up until quite recently I hadn't even heard of Attention
Deficit Disorder, so I hadn't.. you know I was given no reason to think anything about it really.

S: Right. And I suppose that kind of not being sure what was wrong with him, did that affect how you got on
with him at all?
I: No, only in that did make us closer together, because I always felt that he needed that bit more.

S: And what do you think his Dad thought was causing it? Did he have any ideas?
I: No, no.

S: And how did that affect him, not knowing what ( )?
I: I think Bill thought, if he wasn't told there was a problem, then there wasn't one - that was it - there just wasn't
a problem.

S: And how would that affect how he dealt with it?
I: I think really he's tried to be like me - I think he's been a bit more patient at times than I, when we've realised that there is ( ) a reason behind it all now, and like me, he's been reading various bits out of the book - each time I've got to a good bit, you know, I've passed it on - "Have you read this?", and he'll sit and read it, and I think we've both tried to understand it all a little bit more now.

S: Staying in the past, what used to make the difficulties better?

I: Oh, dear.

S: Was there anything?

I: No, I don't think there was. I mean, we did go through a spell - was there something he was eating that was upsetting him, and we tried to rule out colourings, was it his diet, and things like that, but in the end I decided that it wasn't that that was doing it.

S: Because it made no difference?

I: No, no. I mean, I took him off sweets and things and I thought for the first couple of days, "Ooh, maybe this is it", and then something else would go wrong, so it wasn't that. And at one point as well, because Joe, as a baby, was diagnosed as being allergic to milk, and I thought "Is it that but it's coming out a different way - instead of making him ill, it's coming out in that behaviour", so I tried to cut down on yogurts and that, but it didn't do any good, so we went back to just eating anything.

S: And was there anything about what you thought you could do in dealing with him that would help?

I: No.

S: Anything he could do?

I: No.

S: O.K. so coming to the clinic - you'd had the previous contact with the educational psychologist and the speech therapist - and then, so coming to the clinic, what made you decide to come?

I: We visited the educational psychologist and she worked with Darren all morning and then we went in about eleven o'clock, something like that, and then she had a long chat with us and right at the end she said, "Right, well I think it could be this - Attention Deficit - have you ever heard of it?" I'd only heard of it once before, which was in a magazine article that my Mum read and sent me over the book and said "Read through this book, and see if there's anything in there that rings a bell", and as soon as I read this article - "That's Darren" - and I said to this educational psychologist that that was the only thing that I'd ever come across about it. And she said what did we think about going to the clinic and we both said "Yes, if it's going to help Darren, it's got to be the best thing". But then, we were originally told we'd be seeing a Mr. Spender and we waited and waited and school kept saying had we heard anything and we still waited and waited and then in the end I went to see Dr. Homer and I said to him about it, that we'd been referred and we hadn't heard anything, and he still wasn't that interested and he said "Oh, I'll try and chase it up"; and he just came back and said "You're on the waiting list - don't worry". We still didn't hear anything and I think it was December, I went back to Dr. Homer and I threatened to change doctors actually - I completely lost my temper with him and "Either you are going to do something, or I will find somebody else that will". And by January we got an appointment, so...

S: Right, and so what made you actually want to go was knowing that you'd read this stuff and it actually fitted?

I: Yes, and with the educational psychologist saying that she'd referred a couple of cases before and she felt very strongly that it could be this.

S: Right, so what were your expectations about going - what were you hoping for?

I: We'd spoken with the educational psychologist; she said there was this ( ) medication they could give him that might help and might not help and she'd seen families where it had helped and other families where it hadn't, and we talked about it. First of all we said that we don't really know whether we want to start the medication, but then we went and we had a long talk with Dr. Downey - we were there for hours - and in the end she said she felt that the medication would be a good idea, but it was up to us ( ) the medication was a diet, which, I ruled that out straight away because he's a very fussy eater and he doesn't eat very much and if
you start cutting things out, is there going to be anything left that he's going to eat? so I ruled that out straight away.

S: Those were the options - medication or.. ?

I: Diet - oh, and I think there was something else that she said - can't remember what the other one was now. Anyway, she did like a questionnaire thing where there was different levels you had to score, sort of thing, and he came out really high in those, so we said "Right, we'll try it, give it a go and see what happens".

S: O.K., and how did you explain the visit to Darren?

I: I told him it would be very similar to seeing the educational psychologist and "do you remember when you saw her?" and explained it like that, which.. that was fine. The only problem that I thought we might have had was when Dr. Downey said that he was going to start the medication and start taking his tablets and he turned round and said "What? ( )" But she dealt with it for me and she explained to him and did it in a lovely way, so it was fine - she did it for me.

S: So beforehand, you were a bit unsure about medication?

I: I thought, if it was going to help Darren, it was a good idea, but then I didn't know whether it was a good idea to stick somebody onto taking pills on a long term thing, especially if it wasn't going to do any good anyway; but, having said that, I think we did the right thing trying it because, with the feedback from the school and everything, I've been really pleased.

S: O.K., so since he's been on it, what have you noticed that's been different, at home first of all?

I: I've said I don't think I really get the full benefit of it, because I'm.. I mean, up until this week, he's only been having it at eight o'clock in the morning, so the minute he's had it he's off to school really, so I haven't seen anything apart from weekends, when I've been with him weekends. The only thing I would say is, we don't seem to have as much.. he's calmer, he's calmer, doesn't get so het up, little problems aren't mountains any more - they remain as little problems - but he is quieter, he's calmer, he's not so fidgety, because he has always picked at his clothes and fidgeted. He's not been one for getting up and running round all over the place, but he fidgets, and he doesn't do that as much.

S: Right. And how has that affected you, if at all?

I: It's making life easier, and it's nice because I always felt that all the time you're telling him off and that, you are forever nagging, whereas I haven't had to keep saying "Don't chew your jumper, don't pick that bit on your trousers" - it's nice not to be nagging him so much. I think it must be nicer for him.

S: Yes, sure. Is there anything else that affected your relationship?

I: It's been nice, because before when we've talked.. because his teacher sees him out of school, sort of thing, and it's always been every bit of it was problems; Darren's, and I did say to him the other day "Isn't that lovely, Darren" because a couple of times just lately and said "He did this wonderful piece of work", and I say "Isn't it lovely, Darren, to get called in like that". Which is nice, it's lovely: as I say, I think it's nice for him, and up at school as well, they have a thing that, if they do something really good, they get sent to the headmistress to show her, apart from being sent there for being naughty, and Darren has come home a couple of times "I got sent to Mrs. Christie" - because he'd done something good and he's not used to that.

S: Right. So those are the differences at school?

I: Yes, so when he's come home, we've chatted about it - I think it's lovely that he can come home and he can say now "I've done this and I got sent to Mrs. Christie", which is nice, yes.

S: That wasn't ( ) before?

I: No, because usually he got sent to Mrs. Christie because he'd made a silly noise.

S: So does it affect your relationship with him, how you get on with him?

I: No, I don't think it affects the way I get on with him, but it's been nice for him and I say "Oh, isn't that lovely, Darren", you know. "It must be nice for you". And he's getting quite excited about little things like that.
S: Has it had any affect on how you feel as a parent?
I: No.
S: No? O.K., and were you surprised by any of the effects of the medication?
I: No, I say no.. we came out to begin with, cos he started on just half a tablet - came out and started this half a tablet and we were a bit - oh, well it's not doing anything: but then when we stepped it up - he's now on one and a half in the mornings, and then a half at lunchtime - and I've been like surprised at how much difference it can make.
S: At school?
I: At school, yes. And the teachers have said the same, that they just can't believe the difference in Darren, ever, in so short a period of time.
S: This is what a lot of parents say - it's amazing actually.
I: Yes. I mean Mrs. ( ) said to me "Oh, you've got to come and see his piece of work" - she just couldn't believe that Darren had done it, because she said he just hasn't produced that sort of work before.
S: Brilliant, jolly good. Are the any problems, difficulties he still has that haven't chancc.,, ed?
I: He will still be argumentative and he will still go on about things - I mean, like yesterday - we were going over to my Mum and Dad and he wanted to watch football and football wasn't on till three and I said "Oh, we'll be back in plenty of time", but he had to keep on about it. "Will we be back?"; "Yes, Darren, we'll be back"; "How long are we staying for?" "Will we be staying long enough for you to have a cup of coffee?" "Will we be staying for tea?" "No, because we're going to be back by three for the football". Ooooh! And then he cleared off and he came back "What time are we going, how long will we be?"
S: Fairly similar to what you were saying earlier on?
I: Yes, he'll keep on like that. That hasn't changed.
S: Right, do you think differently now he's got the medication? Do you think, maybe he ought to ( ) more, or..?
I: No, I don't think so, no.
S: O.K., so your reaction to that kind of thing now, what if anything is different?
I: Well, I just deal with it in the way that, "We're not going to be long" now; I explain it all to him.. a few times and then in the end.. like yesterday, I turned round and I said "We're going. We're coming back when we say we're coming back and not when you say we are, and we will be back in time to watch the football, so stop! We don't need to hear any more!"
S: Is there anything different to how you feel in response to that?
I: No.
S: You were saying before that you were slightly more patient.
I: I think more the fact that I go off and I think maybe there's a reason why he's doing it, but not in the way I treat him, no.
S: How do you explain that though, that that's still the same?
I: Only that, before, I'd go off into the kitchen and think "Ooooh", whereas now I go off into the kitchen and just think there's a reason why he's doing it. It's not just him being awkward.
S: That's afterwards, but you're still dealing with it.?
I: But in dealing with it, I will still stop him, because there might be that time when he's just trying it on, just trying to push his luck. Yes.
S: And the effect over all of having got the medication, on the family?
I: It makes life easier.
S: In what way.

I: Because Darren's calmer, because we're not always having to nag him about things, and I think, as well, having a positive feedback from the school, instead of us worrying all the time about school. I mean, the medication - with him starting a lunchtime dose - it's not a problem at the moment, because Bill works at the school anyway; it might cause a problem come September, when he changes schools, but at the moment I'm just living for now - we'll sort that out when we come to it. Because, I mean, a lot of schools don't like giving medication and that, do they, but.. whereas Bill just does it now, when he's there. But we'll have to sort that out when it comes to it.

S: But things at home are less stressed, you say?

I: Yes.

S: But what hasn't changed in the family is - everything else?

I: Yes! I don't know. I mean, we still treat Darren exactly the same as we always have done and if he does something really naughty, he gets punished and that's that: it's either bed or grounded because those are the two things that I know to upset him. Because I always think that, although he might not be fully in control of what he is doing, there is always that chance that he could be trying it on a bit and trying to rule the roost a bit.

S: O.K. And what do you think has been the effect of the medication and the changes on Darren's Dad?

I: I don't know. I suppose really it's just the same as I've been; I mean, we talked about it, about whether or not he should take them and in the end we decided we'd do it, but it was on a trial thing to see whether we felt it was the right thing. And I mean, we did actually, we took Darren out the other day - we went to the pub for a meal on Mothering Sunday and we took my parents as well - came out afterwards and we all commented on not having to sit there and say "Darren, sit down: Darren, stay there: Darren, shut up!" It was so nice to take him out and not have him.. try to wreck the restaurant really! It was lovely. And, as nice as it is for us not having to keep on at him, it must also be nice for him not to have us nag.

S: Yes, sure. And has there been any effect, do you think, on Joe, from the differences in Darren?

I: Not out the way, because, as I said, they don't really do much together anyway - they don't play together, so no, not really.

S: O.K., and what about Darren and his Dad - do you think their relationship has changed?

I: No, I don't think so.

S: O.K. This is kind of an obvious question, but was the effect of going to the clinic on your explanations of Darren's problems?

I: Only the fact that before it was always well, is there a problem, isn't there a problem, is it just Darren playing up, whereas now I can look at it in the light that he's not the only child like it, the only one that plays up like he does and does the things he does; and that there is probably a reason why he does it. Why he behaves the way he does.

S: You said "probably". Does that mean you're not sure?

I: I don't think everything he does you can put down to Attention Deficit and say, we'll let you get away with that because it could be that, because I think there's always that chance he could play up sometimes, and how do you know which is when he is just playing up and when it's not just him being naughty? Because, I mean, I think all children have their moments, when they are not just being little angels, so, although some of it is because of the Attention Deficit, it might not all be that.

S: And did talking to Alison change what you understood by A.D.D.?

I: Yes, and also, I mean, I came straight home the first time and got a book out and read, and then I spoke to her about another book and she said it was very good, so we went straight off and got it, which I am reading at the moment, because I think the more that we know, the better it's got to be.

S: And what have you learnt from that that you didn't know before - anything in particular?
I: Just that he's not the only one really, and reading it as well, you sort of think, a lot of the time it could be Darren that this book's been written about, you know; this is Darren to a T, you know - the way he is.

S: And what effect does that have on you?
I: It's not such a worry.
S: And does that change how you are with him?
I: No.
S: Why doesn't it?
I: I suppose because we've always been quite close, that'll never change - I don't think that will change at all.

S: Sort of fundamental? And has it changed your thoughts about solutions to the problem? Do you feel now there is more you can do to help him or he can do to help himself, or is it the same?
I: No, I don't think it's changed at all - I think it's still the same. I mean, apart from the fact that Darren's trying this medication, and, touch wood at the moment, it seems to be working. I mean, I actually had to ring them, because when we went up to two tablets... he started off on a Wednesday, I think it was, and by the weekend, his teacher spoke to me because she was very concerned - it was like he was very withdrawn, he'd gone too much into his shell - so I rang her and spoke to her about it and she said that she felt it was just too high a dose for him, so we dropped straight back then, but now we've just introduced.. because there was a vast difference between mornings and afternoons - not so much that we'd noticed it, but there again the school's got him more than we've got him really - but they'd noticed it.. so now we've introduced a half tablet at lunchtime, to get him through the afternoon as well.

S: So do you think there are any disadvantages to the medication?
I: Only remembering to do it! That's the only thing. No, I don't know that there's any real disadvantages. I mean, we were given a sheet about side effects, which.. I mean, he's lost a pound, which.. I mean, he's not very big - which worried me slightly, but she said she didn't think there was anything to worry about because it was only a pound. But she said she would keep an eye on it anyway, but she said she didn't think it was anything to worry about.

S: And what do you think will happen in the future with it - do you think he will carry on?
I: At the moment, carry on with it, and very much play things by ear and see how they go. Just wait and see what happens really.
S: Right. Is there anything that makes you feel you would prefer him not to be on it in the future?
I: Only that I don't know whether it's a good idea taking things on a long term basis really, but then on the other hand, if it is going to help him, then we've got to consider it anyway, because obviously we've got to do what's best for Darren and what's going to be better for him.

S: Great, I think that's about it. One last thing - what do you think are the main advantages?
I: Life's easier, we're not nagging him, the school are pleased, vry pleased.
S: O.K., brilliant. Thank you very much. Just to finish off, what has it been like doing the interview?
I: Alright. Time-consuming! No, alright, really, fine.
S: Any particular bits you found difficult to answer?
I: No, I don't think so.
S: Do you think talking about all these things will affect how you deal with the problems or how you see them?
I: No, I don't think so, no.
S: O.K. thank you very much. That's great.
Darren

S: Who are all the people who live with you at home - who are they - what are their names?
I: Margaret, Bill and Joe.
S: Right. And he's your brother? How old is he?
I: Six.
S: O.K., lovely. So what I'd like you to do is think back before you came to the clinic to see Dr. Downey. Think about that time - before you started having these pills - O.K.? So I'd like you to tell me about all the people you live with, what you used to think about them, how you got on with them, then.
I: Mm.
S: Who do you want to start with? Who shall we talk about first?
I: Mum.
S: Can you tell me about Mum, what kind of person she was?
I: I thought of her - er, and when she like asked me something, I couldn't really concentrate and that - I couldn't.. I kept wandering round wondering what she said and that and I.. asking her to do all my things.
S: O.K. that's great. And what kind of person was Mum - what was she like?
I: Don't know really.
S: You know, what kind of person?
I: Happy.
S: Yes? And how did you used to get on with Mum?
I: Alright, really.
S: Yes? What kind of things did you used to do with her?
I: Went out - go out to places with my Nanny as well, and.. Can't remember.
S: And what things in particular did you like about Mum?
I: When she took me to
S: Yeah, that sounds good. And what kind of things used to annoy you about Mum?
I: When she sends me to bed earlier.
S: Right. And why would she do that - what would that be because of?
I: When I did things wrong. When I kept asking Mum to do my things that she asked me to do. Cos she had to keep wandering around and making me drink every time.
S: Right. So you used to get into trouble with Mum about her asking you to do something and you didn't do it and she had to do it O.K. Who did you get into trouble with for that mostly - was it Mum or Dad?
I: Both of them really, cos.. mostly Dad, cos he had more time than Mum, cos she's got to go to work, so probably Dad.
S: What would you get into trouble for with Dad?
I: Probably not doing my homework.
S: And what would he do, what would he say?
I: He'd make me do it, the next day, make me have two lots of homework to stay in longer.
S: O.K., just going back to Mum - you said what kind of person she was and that you used to go to ( ) and things like that - if I'd come to the house to visit you then, what might I have seen the two of you doing together?
I: Walk.
S: O.K., what about Dad? Tell me a little about Dad. What's he like?
I: Probably about the same as Mum.
S: And how did you used to get on with Dad before the pills?
I: Quite well actually.
S: In what way? And what was alright?
I: Well, he took me on walks with my dog.
S: Oh, have you got a dog?
I: No, he died.
S: Oh.
I: Quite a while ago anyway - before I had the pill.
S: O.K., so that was what you used to like. Anything else you used to like about Dad?
I: When he like took me to fairs and that and he let me play on the bouncy castles.
S: And what kind of things used to annoy you with Dad, back then?
I: Probably the same as Mum - when he would send me to bed early.
S: O.K. And what were your typical kind of feelings towards Mum, back then?
I: Don't know really.
S: And towards Dad? How did he make you feel?
I: Happy.
S: And what about Mum - how did she make you feel?
I: Happy.
S: O.K. Who else have we got?
I: Joe.
S: Yes. Tell me about him. What he like, back then?
I: Annoying.
S: Right. In what way?
I: Well, when I wanted to play games with him, he wouldn't play. Like, he'd go and find another friend to play with and invite them in when I wanted a friend in.
S: What kind of person is Joe? What's he like?
I: Alright.
S: And how did he make you feel?
I: Happy.
S: He made you feel happy too? O.K. And how did you get on with him, do you think?
I: Quite alright.
S: O.K., and what kind of things did you used to like about him?
I: I can't think really - don't know.
S: And what kind of things used to annoy you about him?
I: When he kept asking me to make him a drink all the time.
S: And who do you think, who would you say you got on best with in the past?
I: Probably my Dad.
S: Yes, why was that?
I: Probably cos he was with us more, all the time.
S: Right. And who would you say you got on worst with?
I: No-one really.
S: O.K., any other thoughts or ideas about those people, what they were like?
I: No, not really.
S: So, I just want to ask a little bit more about those times you used to get into trouble at home, before you had the pills. What kind of things did you get into trouble for?
I: Probably falling out, falling out with my brother and that, and not doing things that my Mum said.
S: So, say with the first one - falling out with your brother - who would you most get into trouble with?
I: Probably Mum and Dad really.
S: And what would they do?
I: Sometimes they would make me sit in a chair, just sit in the chair and watch tele and get some toys out to play with in the chair, make us sit near each other really; and me just go to bed really.
S: And what would they say to you - what kind of things?
I: Don't know really.
S: Can't remember?
I: No.
S: O.K., the other thing - with Mum - not doing what she asked you - can we just talk a little bit about that. What would she do when you did that?
I: Don't know really.
S: Can't remember?
I: No.
S: Would she tell you off? What would she say?
I: "Walk up those stairs and go to bed and stay there until dinnertime".
S: And what would happen next?
I: I would just have to sit and lie there, doing nothing.
S: And when those things happened - when you got into trouble like that, what did you think was the cause of it?
I: By probably speaking in a silly voice.
S: And was there anything you used to do to stop yourself getting into trouble? What did you do to stop it?
I: Don't know really.
S: O.K., the next bit's about when you went to the clinic to see the doctor to get the pills. Who told you you would have to go?
I: Probably Mum or Dad - any of them.
S: And what did they say - did you know what it was for?
I: No, until the lady told me.
S: They didn't say what it was for?
I: No.
S: O.K., what did the lady tell you?
I: That I had to take my pills, start off with half, then go to one and then one and a half, then two.
S: Right. Did she say what the pills were for?
I: To make me concentrate on my work at school and stop me wandering around.
S: What did you think - did you agree with that - did you think that was true?
I: Yes.
S: So before she told you that, why did you think you were going there?
I: I thought I was having like a check-up.
S: Like going to the doctor's?
I: Yes.
S: Right, so it was a check-up for your health?
I: Yes.
S: So how did you feel about going before you had to go? Were you O.K. - were you worried?
I: Bit nervous, but then it got better,
S: It was better when you got there?
I: Yes.
S: Why do you think it got better when you got there?
I: Because when I heard this lady talking, I knew what it was about, but I didn't know what I was going there for before we went.
S: So looking back on it now - you know you were saying about the things you got into trouble about - did you think that was why you were going to the clinic, or not?
I: Probably, some of it, yes.
S: Which bits?
I: Probably like talking in a silly voice and acting silly.
S: Is that what you thought at the time?
I: Yes.
S: O.K., so who did you go to the clinic with?
I: Mum and Dad.
S: Right, so you said before you went, you thought it might be for acting silly and talking in a silly voice?
I: Yes.
S: So how was that affecting your life beforehand - at school, for instance?
I: Like wandering around really.
S: It was making you wander around?
I: Yes.
S: What was it doing at school?
I: When my teacher asked me to do a piece of work, I didn't know what she meant at the time.
S: That was how it was affecting things at school. And how about at home? What you went to the clinic for - like acting silly - how did that affect life at home?
I: Probably like the same at school. When my Mum and Dad wanted to go out, wasting my time wandering around. Made us late by not leaving on time.
S: O.K., how did those problems affect things with friends at school - did it affect them?
I: Not really.
S: No? O.K. And how did those problems affect how you got on with your Mum?
I: Alright really.
S: Did having those problems you were saying about - wandering around and talking silly, those kind of things - did that affect how you got on with your Mum?
I: Yes.
S: In what way?
I: By... I can't remember.
S: That's O.K. And what about Dad - did it affect how you got on with your Dad?
I: No, not really.
S: What about Joe - did it affect how you got on with him?
I: No, not at all.
S: O.K., if you hadn't had those problems, what would have been different about your life, do you think?
I: Don't know. Really like it's been now, like it's been taking the pill, but I don't know.
S: And how has it been?
I: Alright now.
S: O.K., what's alright? What's different now? What's gone away?
I: Wandering around and fidgeting and picking the skin off my fingers.
S: O.K., and does that make a difference at school or not?
I: Yes.
S: In what way?
I: Don't know really.
S: That's alright. Before you went to the clinic, had anybody tried anything to help you with these problems?
I: No.
S: No? Nobody tried to do anything?
I: No.
S: O.K. Had you tried to do anything about it?
I: Mm.. no. Can’t remember.
S: Well, it's hard to remember back, isn't it? What kind of things made the problems worse - can you remember?
I: No, can't remember.
S: Was there anything that made you wander about more?
I: They made me wander about more at school, and getting mad at people when they tried to see the blackboard, kept getting in their way.
S: Was there anything else that used to happen at school that you didn't like because of it?
I: No, not really. Not that I can remember.
S: What do you think was the biggest problem with it, before - what was the worst thing about it?
I: Don't know really.
S: Can't remember?
I: No.
S: O.K., so when you went to the clinic, you met Alison, yes - what did you talk about with Alison?
I: I didn't really talk much - it was really my Mum and Dad.
S: What did they talk about?
I: About what the problems were and .. don't know.
S: Can you remember what they said?
I: No, I can’t remember.
S: Did you agree with what they were saying at the time, or not?
I: Yes.
S: Right, so the pills that you were given. What are they called; do you know their name?
I: No.
S: O.K., what colour are they?
I: They are white.
S: And how often do you have to take them?
I: Twice a day.
S: And what are they for - do you know?
I: Well, I think they are to make me concentrate, so that I can understand what my teacher's saying, and stop me wandering around.
S: Is there anything else they do?
I: No.
S: O.K., and have you noticed, or is that what people have told you about them?
I: What people have told me about them.
S: Have you noticed anything - what they do to you?
I: No, no.
S: And when you first had them, what did you think of them?
I: Hard to get them down.
S: Do they taste horrible?
I: Yes.
S: And do you like taking them or not?
I: Not really - don't like taking them with lemon; orange is about the best drink I like taking them with.
S: Is that why you didn't like taking them - the taste? Are there any other reasons why you don't like taking them?
I: No.
S: What do you think about taking them now?
I: Better to get down, since I've had them a long time.
S: So are you O.K. about taking them now, or do you still not like it?
I: I'm O.K. about taking them because I'm used to it now.
S: So when you take them, what happens to you, what's different about you?
I: Don't know really.
S: Think about school, if you've got them at school.
I: I take one at school.
S: You don't?
I: Take half a one at school, at lunchtime.
S: Right, what do they do for you at school?
I: Well, my teacher says that, as it gets alright in the morning, but then it wears off in the afternoons and my Dad... the lady that we went to see... make my Mum and Dad see what it's like at lunchtime, see what it's like in the afternoon.
S: So what happens if you don't take them at school? What happens to you if you are not on them?
I: I just stay like I did before when I didn't have them.
S: Which was what?
I: Can't remember.
S: So what do they help you with?
I: They help me with... not getting in people's way when they want to look at their sheet of paper, what they had to do.
S: Right, anything else they help you with? That's at school.
I: Nothing I can think of really.
S: Do they help with stuff at home?
I: Not.. probably not using a silly voice as much as I used to. That's probably about it really.
S: O.K., right, so if you knew one of your friends and they had the same problems as you had before and they were going to take them, what would you say to them about the pills, if they wanted your advice or to know what you thought?
I: Well, when you first get them, it takes a while to get the first couple of pills down, so they would have to just keep trying until it worked. Can't think of anything else.
S: Would you tell them that they were a good idea, or a bad idea?
I: A good idea, a good idea to take them.
S: Why?
I: Cos if they had the same problem as me, I might be able to say it would stop you from wandering around the classroom and picking your nails and biting your nails.
S: That's good, is it? What does that mean at school: I mean, what difference does it make if you're not doing those things?
I: All sorts, really.
S: What about at home - what would you tell your friend about what would be different at home?
I: When you can like, do things on your own, really. When you know what you are doing, instead of asking your parents - you know what you're doing.
S: I see, that's what they help you with at home?
I: Yes.
S: Right. So, going to the clinic and getting those pills, did that change your ideas about what was causing your problems?
I: Yes.
S: What do you see it as now?
I: Don't know really.
S: Is there a name for it?
I: No.
S: Do you think it's something you were born with or something like a habit you've picked up along the way?
I: No, like a habit I've picked up along the way.
S: Where do you think it came from, that habit?
I: Probably one of my friends, probably the way they talked, they made me like doing naughty things, gets me in trouble.
S: O.K., brilliant. So thinking now, since you were at the clinic and you've been taking the pills, what has life been like at home?
I: Quite alright really.
S: In what way?
I: Probably... don't know really - can't say.
S: But it's been alright?
I: Yes.
S: O.K. and what about school?
I: Probably like, make me understand things more, so I don't have to ask people. Like I don't have to ask the person sitting next to me - I can get on and do it on my own.
S: Right. And what about with your friends - have things been different with your friends at school?
I: Not really. They haven't really noticed I've been taking them. Apart from the person who's sitting next to me at lunchtime, really.
S: Have they noticed?
I: Yes.
S: What have they noticed?
I: That they thought, probably, I think that they thought that I wouldn't, when I first got it... that I wouldn't eat all my dinner up, so I had to stay in longer. Because we have football club on Thursdays and I have to check the lunchboxes, so I thought I would have to stay in for ages and not get a chance to go to football club.
S: No? Because of the pills?
I: Yes.
S: That must have been a bit annoying.
I: Yes.
S: So do they notice you actually taking the pills, or would they have noticed you being different?
I: No, me taking the pills. When my Dad gives them to me.
S: What do you think they think, at school?
I: They don't know really, but they always ask me.
S: Do they? What do you say?
I: They make me concentrate more, so I know what to do and that, and they stop me from wandering around the classroom.
S: What do they think about that though, do they think that's...?
I: Yes, they think it's alright, really.
S: O.K., so just thinking about now, how do you get on with your Mum now?
I: Mm... better than I used to.
S: Do you think so?
I: Yes. I'm not asking them all to do things for me, so I can get on with them myself, while they get on with what they're doing. And me shouting at them all the time, to get me a biscuit or something.
S: So what things do you do together now?
I: Probably the same as I used to, like go for walks and that, and go out, really.
S: And what things do you like about Mum now? The same as before, or different?
I: Same as before.
S: What do you like about her now?
I: Probably the same as before.
S: Yes - what were those things that you like?
I: When she likes taking me on walks and that, in the fields.
S: Right, brilliant. And what annoys you about her now?
I: When she sends me to bed early when I come home from Cubs, if I've done something wrong. Like being silly and saying horrible things to my Mum.
S: Do you think that's different from before, or did that always happen?
I: That's always happened. It still happens now.
S: So is there anything else that's different from before about how you get on?
I: No, I don't think anything else.
S: And what's the same, about how you get on - the walks and that?
I: Don't know really.
S: O.K., nearly finished. You're doing really well - that's brilliant. Just thinking about your Dad - how do you get on with your Dad now?
I: Probably about the same as I did last time.
S: O.K., so that's the same as before. So what kind of things do you do together, with Dad now?
I: Play on my snooker table and that, or play on the Megadrive.
S: And is that the same as before or different?
I: Different probably. Quite.. probably the same as before. Probably the same.
S: And what do you like about Dad now?
I: That he buys me like, football men and things to play with when I get bored, and he buys me stuff I wanted and that - can't think of anything else.
S: That's a good example. Is that the same as before, or different?
I: Probably the same as before.
S: O.K., and what annoys you about Dad now?
I: Probably the same as Mum, really.
S: Which was - you being, told off?
I: Yes. Make you go to bed earlier and staying ( )
S: And is that different from before, or did that always happen?
I: I think that's always happened.
S: And is there anything else that's different about how you get on with Dad?
I: Not really - not that I can think of anyway.
S: O.K. and what about Joe. How do you get on with him now?
I: Probably the same as I used to really.
S: And what do you do together that's different?
I: Probably play on the computer together.
S: Is that different from before or have you always done that?
I: Always done that.
S: And what do you like about Joe now?
I: He plays with me more and goes roller-blading with me.
S: Right, is that different from before?
I: Yes.
S: Do you think so? What's changed it, do you think?
I: Don't know really - probably from having the pills.
S: Why? Why would that affect it?
I: Why I've changed. I can't think of anything else.
S: That's really good. What annoys you about Joe now?
I: When he doesn't.. when he invites a person in, when he knows I'm going to invite one in, and he follows us outside and all that. When he says he won't - he'll just come out with us instead.

S: Is that the same as before, or different?
I: The same as before.
S: O.K., brilliant. So who do you think you get on best with now? Anybody?
I: Mum.
S: Why?
I: Don't know really. Can't.
S: O.K. And who do you think you get on worst with?
I: Probably my brother, really, when he annoys me and that. He still does annoy me.
S: O.K. If we just think about the times you get into trouble now - what do you get into trouble for now?
I: Em, like I've said, when I go to bed early - I still have to do that sometimes. And when I have to do the things that my Mum and Dad wants to do, instead of doing my own things like going on a cage and that. When I want to do that, they just like to go into a different shop.
S: And what do they do, or say to you?
I: Can't tell you really.
S: Do you remember the last time you got into trouble?
I: Mm. Probably on a Tuesday, not last Tuesday, but the Tuesday before. Then I got grounded for a day.
S: Oh, dear. What was that for?
I: Cos I said something, but I can't remember what it was - I said something rude to my Mum, which wasn't a very good idea really.
S: What did she do?
I: She sent me to bed and made me get changed up here and didn't let me have any supper or watch the football that was on.
S: Right, and what happened then - what did you do?
I: I had to lay and not watch the tele and Joe got another ten minutes up, ten minutes.
S: Do you think there was anything different about what Mum did then than she would have done before?
I: No.
S: She would have done the same before?
I: Yes.
S: O.K. When these things happen now, is there anything you can do to stop it happening to you - to stop yourself getting into trouble?
I: Not really. Can't think.
S: No? O.K., brilliant. Is there anything else you want to say about what it's been like having these pills.
I: No, not that I can think of.
S: No? You've said it all, haven't you?
I: Probably, yes.
S: O.K. That's really great. What's it been like for you, talking about it?
I: Embarrassing - talking to my friends about it, cos once I talked to one of them, I had to keep talking to the others. Had to keep telling everyone.

S: But it was embarrassing?

I: Yes.

S: What do you think are the good things about the pills?

I: Probably the same as before. Don't make me wander round.

S: And what are the bad things - you say it's a bit embarrassing talking about it - anything else about it that you don't like?

I: Not really. Not that I can think of.

S: O.K. And what's it been like talking about it to me?

I: Quite alright really.

S: Yes? Anything good about it? Anything you liked?

I: No, not really.

S: Anything you didn't like?

I: No. It was alright.

S: O.K., brilliant. That's really great. Is there anything you want to ask me about it?

I: No.
Appendix 13 Transcript notation used
The notation used when citing respondents comments was as follows:

Material in square brackets is clarificatory information:

A line of dots indicates that some transcript has been deliberately omitted

All participants words are given in italics

Interviewers words given in non italic script.