PRAGMATICS OF INTER-PROFESSIONAL COLLABORATIVE PARTNERSHIPS

To the memory of Peter
and the future of our children
Paul and Andrew

PRAGMATICS OF INTER-PROFESSIONAL COLLABORATIVE PARTNERSHIPS

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DECLARATION

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ABSTRACT

The focus throughout this thesis is on the pragmatics of interprofessional collaborative partnerships in the area of work with children and families. It comprises three sections, the first of which reviews government mandates and research outcomes, outlines essentials for inter-professional collaborative partnerships and suggests possible ways of effectively implementing these.

The research section combines an example of collaborative working between clinical psychology and health visiting in the form of a jointly planned and delivered Self-esteem Focus Programme, with an evaluation of the effects of the programme on participant's self concept and self-esteem. This programme was delivered over eight weeks, the contents of which are detailed, as is the theoretical underpinning for the programme. Both quantitative and qualitative methods of analysis were used to evaluate the effect of the programme on the participants. A total of 45 mothers took part in the quantitative analysis, carried out by using repeated measures multivariate analysis of variance on scores obtained from the completion of the Rosenberg Self-esteem and the Pearlin and Schooler Psychological Coping Resources Questionnaires at four times during the data collection period. Eleven of this group of mothers took part in depth interviews which were analysed qualitatively to assess changes in self concept. Participants showed significant increase in self-esteem and mastery accompanied by significant decrease in self-denigration, at the 0.01 level of significance, following participation in the programme. These changes were maintained six months after completion of the programme. Qualitative analysis of the depth interviews showed an increase in feelings of self worth, self confidence and feelings of normality. Responses also reflected change in the way participants related to their children, spouses or partners, others and towards themselves.

The final section contains details of a case study requiring multi-professional participation. This outlines how the health visiting - clinical psychology partnership was effectively conducted and the difficulties encountered on occasions when the various professionals did not share similar philosophies of collaborative partnership.

SECTION A

PREFACE

PREFACE

A common thread throughout my professional career has been a fascination with the intergenerational transmission of interpersonal relating styles. My first experience in the clinical field was in a Children's Home in South Africa. The discovery that most of the children in the Home had parents who themselves had been brought up in similar settings, aroused a strong desire to increase my knowledge in the area and explore possible ways of breaking the cycle.

Much of my work in South Africa involved enabling the development of substitute parent-child attachments. These attachments were either within the Children's Home setting between children and house-parents or between children and families in the community, who wished to offer the children the opportunity to experience 'ordinary family life'. Occasionally some work was possible in the rehabilitation of the natural parent-child relationship. The resources for the development of prevention or early intervention programmes at that time in South Africa were, as far as I was aware, non-existent.

My work in the Children's Home introduced me to another complexity in the field, that of inter-agency working. Children were placed in the home, a church based organisation, by Social Services. The delivery of

services to parents as well as the overall responsibility for the welfare of the child, remained with Social Services. Collaborative working between Social Services and the Home was essential if the child was not to be caught between inter-organisational differences and disputes. Each child also attended an educational institution. Collaborative partnerships were equally important between schools and the Home, to ensure that the children's welfare was kept at the centre of organisational activity. In practice, inter-organisational collaboration seldom happened, and when it did, it was by chance rather than by design.

On my arrival in the United Kingdom, the long awaited opportunity to be involved in the development of prevention and early intervention programmes became a reality. The NHS Trust I was to be employed by, was searching for a psychologist to run a pilot project combining clinical psychology and health visiting skills and expertise, with the focus on prevention and early intervention. The opportunity and setting was ideal as it allowed the continued development of all three areas of my professional interest. In the first instance it involved working with 'vulnerable' families where change in the intergenerational pattern of dysfunctional interpersonal relationships, was being sought. Secondly, the focus was on developing preventative and early intervention services, and thirdly, the project involved inter-professional collaboration.

The pilot project ran for 18 months, after which the collaborative clinical psychology - health visiting partnership became integral to both services. The work presented in sections C and D of this thesis, namely, the research and case study respectively, are direct outcomes of this collaborative partnership.

Firstly however, Section B reviews the literature in the field of inter-agency and inter-professional working, within children's services. The aim of this section is twofold: firstly, to provide a background as to the kind and amount of literature available in the field, and secondly, to highlight the contexts within which clinical applications of collaborative work seem to be taking place.

Most of the literature available is specific to child protection and much of that, in the form of government directives. These directives have often emerged as a result of inquiries into what is seen to be avoidable tragedies in child abuse. Still pertaining to child protection, another section of the literature focuses on the complexities and difficulties experienced when various agencies have attempted to work together. In practice, inter-agency and inter-professional collaborative working becomes virtually an impossible task as a result of lack of agreement as to what is required and how it is to be achieved. Little is found in the literature when looking for inter-professional collaborative work in non-child protection areas, and the same applies when searching for examples with a prevention or early intervention focus. Section B further reports on possible explanations as to why inter-professional collaborative partnerships are so difficult to achieve, and proposes a systemic approach as an alternative to facilitate the translation of the ideal into practice.

Section C contains details of the development, implementation and evaluation of a research project entitled '*An investigation into the effects of a self-esteem focus programme on self concept and self-esteem*'. The programme was developed as a response to a gap, identified by health visitors, in their service provision. On occasions they came across parents who had themselves experienced negative

interpersonal relationships in their own development. Some parents were aware of the connection between past experiences and current behaviour and expressed their wish to learn skills to avoid repeating the same interactional pattern with their own children. Health visitors were interested in providing a service that would enable parents to change problematic patterns of interaction. They had made a number of interventions to help parents showing such difficulties, including education, modelling and encouragement. Some parents were able to benefit from what had been offered, however there were others for whom these methods were not effective. The opportunity of working collaboratively with a clinical psychologist offered the possibility of exploring another, hopefully more effective, way of responding to these clients' needs.

The programme was developed and delivered in collaborative partnership between clinical psychology and health visiting. Participants were mothers on health visitor case loads, either self referred or identified by health visitors, presenting with low self confidence and poor self-esteem, interpersonal relationship difficulties and often aware of the connection between their past experiences and current behaviour. The programme consisted of eight weekly, one and a half hour sessions, run jointly by the clinical psychologist and two / three health visitors to a group of between six and nine mothers. The aim of the programme was to enable participants, through a process of guided reflection, to examine their individual self concept with specific reference to their self worth, to question the validity of messages of worthlessness received, to create affirmative messages regarding their self worth and to explore ways of implementing these in everyday living.

Evaluation of the programme was carried out using both qualitative and quantitative measures. The variables chosen to evaluate the programme were self concept and self-esteem. Change in self concept was assessed by means of depth interviews, undertaken with 11 participants, between nine and eleven weeks after completion of the programme. Responses were analysed according to themes, some elicited through the interview questions and others emerging spontaneously from participants' verbal responses. Analysis of these responses showed an increase in feelings of self worth, self confidence and feelings of normality. Responses also reflected changes in the way participants related to their children, spouses or partners, others and towards themselves. Other emergent themes included decreased levels of social isolation and 'better ways of coping', as experienced by the specific participants.

The self-esteem variable was measured using two questionnaires, namely, the Rosenberg Self-esteem Scale and the Pearlin and Schooler Psychological Coping Resources Questionnaire, comprising three factors: self-denigration, mastery and self-esteem. Questionnaires were completed four different times during the research period - two months before commencement of the programme, immediately prior to commencement, on completion of the programme and six months after completion of the programme. Repeated measures multivariate analyses of variance were used to compare changes in means over time, and Bonferroni pairwise comparisons used for post hoc tests. On all four scales participants showed significant increase, at the 0.01 level of significance, in self-esteem and mastery, and decrease in self-denigration, as a result of the programme. The noted change was evident both when

comparing pre and post programme means and when comparing pre and six months after completion means.

Section C also reports on situational factors affecting the inter-professional collaborative partnership. Dissolution and mergers of NHS trusts, resulted in the professions of clinical psychology and health visiting being housed in two different trusts. The programme of collaborative partnership originated within an organisational structure that housed the two professions. However, the implementation including the data collection, was carried out from the time of announcement of the dissolution of the one trust to one year into the existence of the two separate trusts. The impact of the change of organisational and managerial structures on the quantity and quality of health visitor involvement in the programme, throughout the 18 months of data collection is reported. The effects of the organisational change on the collaborative partnership and some of its implications for practical arrangements are also noted.

Section D contains details of a case requiring the involvement of various professionals within both the Health and Social Services organisations. The client in this case study is a mother, diagnosed with Multiple Sclerosis, who endured physical, sexual and emotional abuse from her biological mother, throughout her childhood, until the age of six. Both the physical condition of Multiple Sclerosis and her past experience of abuse impacted on her parenting of her toddler daughter. The case study highlights the need for inter-professional collaborative partnerships, gives detailed accounts of how this was managed in the health visiting - clinical psychology partnership and outlines the difficulties encountered on occasions when professionals did not share a similar philosophy of collaborative partnership.

Consistent throughout the various sections of this thesis is the recognition that when multi-faceted interventions are required in the area of work with children and families, collaborative professional partnerships are essential. This is as important when intervening in child protection cases, as when developing and delivering prevention services, or when packages of combined inter-organisational / inter-professional interventions are required. The absence of such collaborative partnerships may often result in fragmented service delivery, unproductive inter-professional tensions and an inefficient use of taxpayers' money.

SECTION B

INTER-AGENCY WORKING WITHIN CHILDREN'S SERVICES

A LITERATURE REVIEW

INTER-AGENCY WORKING WITHIN CHILDREN'S SERVICES

A LITERATURE REVIEW

The result will be a system
where the energies of health and social services
are not dissipated in fruitless debate on boundaries -
one where peoples' needs are paramount
in developing and delivering services

DoH, Partnership in Action, 1998

Introduction

Since the early 1970s, when both health and local authorities underwent reorganisation, the philosophy of co-ordinated service planning was introduced and encouraged (HMSO, 1972). It was however not until the emergence of the 1989 Children Act that inter-agency collaboration in the provision of children's services became a formal requirement. The call from government for co-ordinated planning and delivery of services has been unreserved, its seriousness and urgency based on the undisputed recognition that children need to be protected from neglect and abuse (DoH, 1992; DoH, 1995a).

As a result of concerns for child protection the majority of government directives and guidelines have focused on inter-agency working arrangements particular to the issues of child protection (Home Office *et al.*, 1991; Hallet, 1995; DoH, 1995b). In recent years, however, the collaborative focus has also been placed on other inter-agency services. Examples comprise services delivered by the three main agencies identified as Health, Social Services and Education, and include intra and inter-agency professional partnerships. The '*Seen But Not Heard*' report examined the delivery of services to 'children in need' by Community Child Health and Social Services. (Audit Commission, 1994) while the '*Together We Stand*' document reviewed Child and Adolescent Mental Health Services (HMSO, 1995). Presently, a consultative document addressing the education of 'looked after children', involving inter-professional working between Education and Social Services is under consideration (DfEE, 1999). Although not specific to Children's Services, the '*Partnership in Action*' document is unequivocal in its commitment to promote and provide opportunities for Health and Social Services to work in partnership (DoH, 1998a). Regardless of the agencies or professions involved, the conclusions and recommendations are uniform: effective multi-agency co-operation is rarely found and the proposal for joint assessment of need, formulation of intervention plan and delivery of service, is repeatedly recommended.

With such clear and consistent calls for co-operation and collaboration arising from reviews, investigations and audits of services, it begs the question as to why progress in the effective implementation of joint working has been so slow. Three decades after the philosophy of co-ordinated services was introduced, the literature retains a high proportion of directive documents, some new

and others in the form of further guidelines and addenda to ones previously published (Home Office *et al.*, 1991; DoH, 1998a; DoH, 1995a). Studies highlighting the difficulties encountered when co-ordinated work has been attempted are found in abundance (Birchall & Hallett, 1995; Birchall & Hallett, 1996; DoH, 1995b; Lupton & Khan, 1998; Hallett & Stevenson, 1980; Taylor & Tilley, 1990). What is absent in the literature is a shared definition of 'inter-agency working' whether in a general sense or specifically for a given situation, as are guidelines as to how to transform the philosophical aspiration into functional reality .

What constitutes 'Inter-agency working' ?

The variety of interchangeable terms found in the literature is indicative of the lack of definition, and as a result, lack of clarity as to what is meant by 'inter-agency working'. 'Working together', 'inter-agency co-operation', 'joint working', 'inter-agency collaboration', 'inter-agency partnership' are all used referring to the same complex concept (Hallett, 1995; Hallett & Birchall, 1995; Lupton & Khan, 1998). It is also evident that different professionals involved in inter-agency working have different notions as to what is expected of themselves and from each other (Taylor & Tilley, 1989; Taylor & Tilley, 1990; Sutton, 1995). This emerges despite clear guidelines of what is legally expected in child protection procedures. Hallett (1995) describes the discrepancies in views of different professional groups at various stages of the procedure. The intensity and spread of inter-agency involvement varies throughout the life of a child protection case. During the initial stages comprising referral, immediate protection of the child, planning of the investigation, investigation and initial assessment, culminating in the child protection conference, much inter-agency communication is found. The communication is,

however, predominantly information exchange. Once the case conference has taken place and a comprehensive assessment and consequent planning and implementation of intervention is required, the inter-agency involvement decreases markedly.

The lack of a shared definition of what constitutes inter-agency working is even greater in non child protection cases where inter-agency involvement is required, as a result of no available guidelines (Kirby, 1994). In the professional experience of the researcher, attempts at engaging in inter-agency working, highlighted not only the discrepancy in the definition of inter-professional inter-agency working, but also the lack of a shared understanding of how to achieve the jointly identified goals (Kirby & John, 1995; Kirby & John, 1996). The increased difficulty in achieving inter-agency collaboration in prevention and early intervention work is supported by the National Children's Bureau's document on Children's Service Plans (Sutton, 1995). Possible reasons suggested include the fact that the effectiveness of preventative services is notoriously difficult to evaluate and that when faced with limited resources, deciding to finance preventative services rather than funding the tertiary ones may be difficult to justify.

Scenarios requiring multi-agency involvement are diverse in their purpose and goals. It would thus seem appropriate to examine what is meant by inter-agency working depending on the needs of the specific situation. Some situations may require joint goal planning and equal relationships among colleagues (Conoley and Conoley, 1982), whereas others may be better served by the 'transplant' model of Cunningham and Davis (1985), where the 'expert' owns the knowledge and skills and the 'aide' uses ('transplants') the information

needed to carry out particular tasks. Probably the most often used model is the multi-disciplinary team where professionals independently address aspects of a problem and create a forum to meet and discuss their aims and objectives, with or without the client. Partnerships are often egalitarian, but joint goals are not established (McGrath and Davis, 1992).

The need for inter-agency working

Health and welfare legislation tends to be prepared by individual government departments. The legislation is then left to different agencies to implement, some of which are accountable to locally elected representatives, some to central government and some to management boards. Without collaboration between the agencies gaps and overlaps are likely to occur, resulting in services that are neither effective nor economical, and that fail to see the child as a whole (Sutton, 1995).

The importance of inter-agency working requires little elaboration when referring to child protection work. Two tragic cases, Maria Colwell and Jasmine Beckford are extreme examples of what can happen in the absence of effective inter-agency working (DHSS, 1974; Brent Borough Council, 1985). The lives of children are at stake. At a less dramatic level, but still extremely important, is the cost implication of the lack of co-ordinated work. Uncoordinated work by independent agencies results in the duplication of services, financial waste, frustrated professionals and fragmented, or possibly contradictory, services to clients (Hornby,1993; HMSO, 1993).

The Literature

Literature in the field of inter-agency working can be broadly divided into four sections. Firstly, there are the government ***directives*** ranging from recommendations to what is legally expected. Guidelines, conclusions from audit reports and messages from research undertaken by government all fall within this section. Secondly, there are ***investigations.*** These consist of audits, assessments on availability of co-ordinated services and reports on specific cases that have gone tragically wrong. The third section consists of ***research*** based literature. And lastly we find the more ***theory*** based writings often emerging from aspects of all three above.

In the present literature review, far more has been found in the sections of directives and investigations than in those of research and theory. This paper will attempt to bring together the central themes of all four sections with particular emphasis on the debate as to why the transition from philosophy to practice seems to be so very difficult, and some ideas on possible ways forward.

Directives and Investigations

Although distinct in nature, government directives and investigations are strongly interrelated, the former often being a direct result of service audits and reviews. For this reason they shall be grouped together in this presentation. A proportion of government publications refer to the planning of Children's Services. These publications focus on services for children that for many and varied reasons, require the care and attention of health and social services throughout their young lives. The documents refer to services for 'children in need' (Home Office, 1991; Audit Commission, 1994; Sutton, 1995) and services affecting 'looked after children' (DoH, 1998b; DoH 1998c),

with specific reference to the co-ordination between the Departments of Health and Social Services. Further directives are found from the Department for Education relating to children looked after by local authorities (DfE, 1994; DfEE, 1999). As from March 1997 it became mandatory that each Health Authority develop a strategy for Children's Services that incorporated joint inter-agency planning. The strategy is expected to reflect the roles and contributions of agencies such as health, social services, education and the police, in the provision of children's services.

A large proportion of government directives relate to child protection procedures. A six stage model to ensure comprehensive assessment and planning in cases where children are at risk of neglect and / or abuse, is clearly outlined in the *'Working Together'* document (Home Office *et al.*, 1991). Guidelines as to the duties and responsibilities of the various agencies are clearly stated in this document. Subsequent to this, a guide to inter-agency working to safeguard and promote the welfare of children is in draft form and presently undergoing consultation (DoH, 1999). In a similar manner to the original document (*'Working Together'*) it sets out the roles and responsibilities of the different agencies and the procedures to be followed in joint working. It still fails to give any guidance as to how such joint working is to be achieved, it does however contain a possible avenue for consideration. The document outlines the need for inter-agency training and development, and gives the Area Child Protection Committees (ACPC) the responsibility for the strategic overview of planning, delivery and evaluation of inter-agency training. However, it does not clarify the relationship between the ACPC and each agency. A situation is created where a mandate is given without consideration as to how it is to be carried out.

Research

As in the sections of directives and investigations, research into inter-agency working is predominantly in the area of child abuse and child protection. Among others, studies include reviewing procedural aspects of the child protection system (DoH, 1995a) and examining inter-professional relationships amongst those engaged in inter-agency co-operation (Birchall & Hallett, 1995; Hallett, 1995; Taylor & Tilley, 1990). Despite clear procedural guidelines, studies showed that the extent of inter-agency collaboration varied markedly at different stages of the child protection process (Hallett, 1995). Co-operation was found to be widely acceptable, at the investigative stage, in the form of information exchange. Once the case conference had taken place, the comprehensive assessment, planning and delivery of service was left virtually totally within the remit of Social Services.

Studies also showed considerable tension and friction among professionals involved in inter-agency collaboration. Although most professionals agreed that multi-agency involvement was required when attending to child protection, in practice each tended to follow their own methods, resulting in an overlap of information gathering and other activity (Birchall & Hallett, 1995). Conflict over diagnosis, management of cases and disputes over allocation of responsibilities between social workers and health visitors was found (Taylor & Tilley, 1990), as was mistrust between social workers and family doctors (Burton & Smith, 1997).

Only one study was found where inter-agency collaboration in the wider remit of children's services was the focus (Bradford, 1993). It involved the development of a Multi-Agency Consultation Team (MACT), whose aim was to provide a forum where the Health, Social

Services and Education could access a multi-agency perspective on cases of complex need. The MACT further made recommendations to Service Directors as to the most appropriate way forward in cases where planning became stuck. Conclusions indicated that inter-agency collaboration and co-operation was possible. This was measured in the form of consensus between all three agencies, in the decision making as to the best way forward in each case. Financial constraints, however, were at times problematic. Managers were not always able to sanction recommendations that were beyond the range of local solutions.

Successful accounts of inter-agency working were found, albeit not within the domain of children's services. The *'London Health Partnership'* (LHP), set up to improve services for elderly people, involved professionals from Health, Social Services, Local Authority and the private sector. Included in the partnership were staff from Royal Mail, the transport department, housing association and leisure centre managers (Plamping, 1997). The partnership adopted a 'whole system approach', underpinned by the recognition that actions taken by one organisation or part thereof, have consequences - often unpredictable - elsewhere in the system. In the experience of the LHP, there was no lack of will to be involved in inter-agency working. There was however a scarcity of methods to support effective inter-agency working. The creation of partnerships necessitated much time and commitment, and issues of legitimacy, accountability and authority had to be resolved.

Further successful inter-professional collaboration was found between psychologists and health visitors in the form of a consultation service (Wilson, 1995), as it was found in the *'WellFamily Project'* in the form of

a family support co-ordination service (Weir, 1997). The management of postnatal depression has been effectively achieved through the collaborative working of health visitors, midwives and psychologists (Holden *et al.*, 1989; McClarey & Stokoe, 1995).

Theory

The frequency of reported difficulties encountered when attempting effective inter-agency co-ordination, has led some researchers to focus on the search for possible explanations. In reviewing the available literature some common themes regarding areas of difficulty emerge.

a) Interpersonal relationships

Interpersonal relationships between the professionals concerned comes high up on the list of essential factors for effective inter-agency working. Seaburn *et al.* (1996), in outlining the key ingredients for effective collaboration, made the 'relationship' factor the most important. They hold the view that "the quality of the collaboration often reflects the quality of the relationship between the collaborators" (p. 47). They stress that collaborative relationships need to go through the familiar stages found in the development of any relationship: self-disclosure, checking each other out and building trust. Mutual respect results, which in turn enables effective communication and reduces sabotage.

Lupton & Khan (1998) also make mention of interpersonal factors as affecting collaboration. They are similar to those that impact on any interpersonal interaction, aspects such as race, disability, sex, class and status, with particular awareness of the often value-laden status some professions have above others. Beattie (1994) refers to the

'undertows' in (professional) interpersonal relationships requiring attention, if effective inter-agency collaboration is to be accomplished.

The literature contains examples of studies, projects and services where the characteristics of mutual respect and trust between professionals have enabled effective inter-professional and inter-agency working (Plamping, 1997; Bradford, 1993; Weir, 1997), and others where the lack thereof has impeded the process (Taylor & Tilley, 1990; Statham, 1994; Yerbury, 1997)

b) Interprofessional factors

Differences in training, knowledge base and skill is most often seen as the reason why different professionals approach a given common situation from different, possibly contradictory, viewpoints (Beattie, 1995; Soothill *et al.*, 1995; Lupton & Khan, 1998). The paradigms used to interpret and understand what is being presented, can be very divergent (Seaburn *et al.*, 1996). Many different paradigms can however be used in collaboration, as long as they are not mutually exclusive.

Beattie (1994) refers to common perspectives, goals and visions needing to be jointly created if effective inter-agency working is to be attained. Hallett & Birchall (1995) in a review of 'inter-agency co-ordination in child protection' literature concluded that friction between professionals was evident as a result of unrealistic or incompatible ideas about what the different professionals were either supposed to do or capable of doing. "And once the cogs of the machine began to grate, it was common for political factors of power

and status and resource dependency to intervene and for there to be territorial disputes" (p 71).

c) Inter-organisational factors, including government policy making

Health, Social Services and Education all have different organisational structures with regard to priorities, boundaries and finances. Separate budgets make joint planning and delivery of services extremely difficult (Bradford, 1993; Hudson, 1994; Sutton, 1995). Funding is often time limited which further complicates effective medium and long term planning.

Inter-organisational structures are closely affected by government policy making. The 1990 NHS reform, creating the purchaser and provider structure, simultaneously created ambiguities in responsibilities and lines of accountability of health professionals working with child protection (Home Office *et al*, 1991; DoH, 1995a). Similarly, the present re-organisation, creating the Primary Care Group structure (DoH, 1997) will again require re-organisation as a result of change in responsibilities and lines of accountability. The effects of frequent change, resulting in fragmentation and re-organisation, without the opportunity for consolidation and learning from experience, is damaging to inter-professional and inter-agency communication (Sadler, 1994).

The work of Lupton and Khan (1998), Seaburn *et al.* (1996) and that of Beattie (1994) all refer to the crucial impact of inter-organisational factors in effective inter-agency working. The need for compatible, if not common, structures, finances and priorities, are considered to be essential. Robust and coherent management arrangements emerge

as one of the four key ingredients for effective collaborative working in the research by Hardy *et al.* (1992).

Recognition of the organisational context is emphasised in the work by Knapp *et al.* (1992) as an essential in effective collaboration. Distinction is made between five different types of organisational contexts. The '*unitary agency*' context refers to the situation where a single agency has responsibility for the development of the service / project, even though funding and initial planning may be shared. The '*semi-independent agency*' context is when the service / project is run through a separate organisation, whereas the '*lead agency*' context refers to one agency taking the lead to manage a development but others contribute to the development. The '*joint agency*' context is one in which bilateral responsibility between two agencies for leading and managing a service / project is undertaken, and a '*multi-agency*' context, one in which several agencies share the responsibility and management of a project.

Davidson (1976) also highlights the different types of organisational arrangements. When agencies share information, ideas and feelings about whatever subject matter, they are merely *communicating*. If communication leads to some arrangement of working together but where tasks and goals are left vague, this would be called '*co-operating*'. When arrangements become more formalised, with tasks and goals clearly defined, a '*confederation*' is formed. When organisations define tasks and goals precisely and create a formal structure to carry these out, conceding autonomy to that joint structure, a '*federation*' exists. In the event of organisations forming a structure, where they are willing to give up their own identities as

organisations, with regard to the particular service / project in development, they then form a new '*formal organisation*'.

Essentials for collaboration

Inter-agency collaboration is inherently a vulnerable process (Hardy *et al.*, 1992), requiring in the first instance the recognition of the sources of vulnerability, and the identification of essential components, if effective collaboration is to be achieved. Combining the various 'key ingredients' proposed by the above-mentioned authors, led the researcher to formulate the following clusters of components seen to be essential in effective inter-professional / inter-agency collaboration.

a) Recognition of the organisational context

This needs to be the first step in thinking collaboratively - the recognition of the framework within which change needs to take place. Identifying the organisational structures involved, their opportunities and their limitations, enables the collection of information required to assess whether collaborative partnerships are possible.

b) Clarity of purpose

Defining what constitutes inter-agency collaboration for the particular project in question, becomes the first focus in this second cluster of essential components. Defining goals, individual roles and responsibilities, how communication between the various professionals is to take place and how the goals are to be assessed, are all aspects of clarity of purpose. In the process of acquiring clarity and definition, possible inter-personal and inter-professional issues may need to be addressed.

c) Commitment and shared ownership

This third cluster of essential factors applies to both personal and organisational levels. Commitment of time, commitment to the shared vision central to the project, commitment to funding, commitment to involvement and commitment to decisions taken under '*clarity of purpose*', are all seen as crucial in the process of collaborative working.

d) Robust and coherent management arrangements

Clear responsibility and lines of accountability within the multi-agency group in question is essential. The same applies to arrangements regarding funding and financial control. How the various organisations, with their individual policies and structures, link with one another to create a coherent overall structure, sustainable for the duration of the inter-agency project, needs to be created and put in place.

The above-mentioned clusters of components can be seen as necessary ingredients in the establishment of effective collaborative partnerships. Aspects of collaborative working are however still possible in the absence of the whole range of essential ingredients. As crucial as it may be to identify the list of ingredients, this alone does not provide all that is required to ensure effective collaborative partnerships. The various components, depending on how they interact with one another, affect the final outcome of the intended collaboration. Understanding how the ingredients affect one another, how the various components interrelate and with what consequences on other components, and on the final product (collaboration), is greatly facilitated by the use of systemic thinking.

A systemic approach

By definition, a system is "a set of objects together with relationships between the objects and between their attributes, in which objects are the components or parts of the system, attributes are the properties of the objects, and the relationships tie the system together" (Watzlawick *et al.*, 1967, p. 120). Although the systemic approach was originally developed within the family therapy context, in recent years its application has widened to include work with individuals, couples, groups and organisations (Campbell, 1999; Campbell & Draper 1985).

Basic to systemic thinking and awareness is the appreciation of the following three factors:

- behaviours and events can be understood in different ways depending on the context in which they occur
- there is a direct link between a person's beliefs and their behaviour
- the observer is part of the system (Campbell *et al.*, 1989a).

In the context of inter-agency working, each professional involved is both a part or component of and an observer of the same system. Each professional is required to move between the 'component' and the 'observer' role and take into account the impact of the relationship between the two roles. The use of systemic thinking and awareness facilitates the appreciation of each professionals' 'links' between beliefs and behaviours, how these behaviours are interpreted depending on each individual's view of context, and how each component of the system impacts on every other component of the same system.

Viewing inter-agency collaboration as a system enables further understanding as to why the process is fraught with difficulties and offers a framework to help address these difficulties. Unless there is an appreciation that different parts of a system affect other parts of the same system, professionals and individual agencies will be tempted to continue to work within the comfort of their own professional boundaries, unaware of the impact they have on the function of the system as a whole. The awareness of how government directives, organisational contexts and the clusters of necessary components interrelate and impact on each other and on the proposed outcome, enhances the transition from the ideal of collaborative working, to its actual practice.

What is seen to constitute inter-agency collaboration, for a given situation, remains central to the importance of systemic thinking usage. If, for example, the purpose of the collaboration is information collection, systemic awareness may not be as crucial as when professionals are required to provide a multi-faceted service to a client. It is the researcher's view that when multi-professional involvement is required in the delivery of a service, it becomes essential that systemic thinking be used if the client is to receive a holistic and co-ordinated service.

When considering the literature and the emerging 'essentials' for collaboration, obstacles to effective collaborative working were encountered in many and varied areas. It seems, however, that the major difficulties are to be found at the organisational level. This refers to organisation at any level - organisation within a particular department, within a directorate, within a trust, within the health authority, within the NHS, within the Department of Health or within

government. Similar levels of organisation exist in the Social Services and Education agencies. The grouping of professionals from different agencies to form an identified system in its own right, with a specific and common purpose, requires the application of the essential ingredients for collaboration. In addition to the elements incorporated in the 'clarity of purpose' cluster, the commitment of the organisation to the financial and management arrangements from the various agencies involved is of paramount importance. This seems to be where collaboration is most likely to fail. At the present time no agency or body has the mandate to ensure that inter-agency collaboration works. Every agency is given the directive by government to work in partnership with other agencies, but no one is given the overall responsibility, or resources, to ensure it happens. If as recommended by the consultative document (DoH, 1999) the Area Child Protection Committee is to be given overall responsibility for the training required for inter-agency collaboration, then it is imperative that they are given the authority to implement that responsibility over various agencies and professionals involved with child protection. A similar body exercising authority needs to apply Children's Services as a whole, where collaboration is necessary.

Possible ways forward

In order to move towards a more effective functioning of inter-agency collaboration, the following is suggested:

- the overall approach needs to be systemic

- a recognition and understanding of government directives, and consequent limits and opportunities, and

how these either facilitate or hinder the process of collaboration

- an appreciation of the essential components required in effective inter-agency collaboration

- the appointment of a body responsible for the implementation of effective collaborative working

- a feedback loop to government as to what aspects of its directives are hindering the process of inter-agency collaboration with opportunities for debate and close working in interpreting that legislation and in its implementation.

Directives alone do not produce the desired results. Unless a comprehensive effort is made to address this problem, in such a way that incorporates the elements outlined above, the governments intentions and plans for '*Partnership in Action*' will not happen. The present approach to multi-agency is hierarchical and fragmented. The government directs and each agency implements directives in accordance with their own perspective. The suggested resolution requires a systemic approach, government needs to provide the directives, whilst the agencies need to work towards creating a formal organisational structure. Equally, government needs to take into account the feedback from the agencies and provide the necessary resources or change to structure for such implementation to take place. Unless all the agencies share a common view of what is required and how to go about achieving it, then the task becomes impossible.

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SECTION C

RESEARCH

AN INVESTIGATION INTO THE EFFECTS OF A SELF-ESTEEM FOCUS PROGRAMME ON SELF CONCEPT AND SELF-ESTEEM*

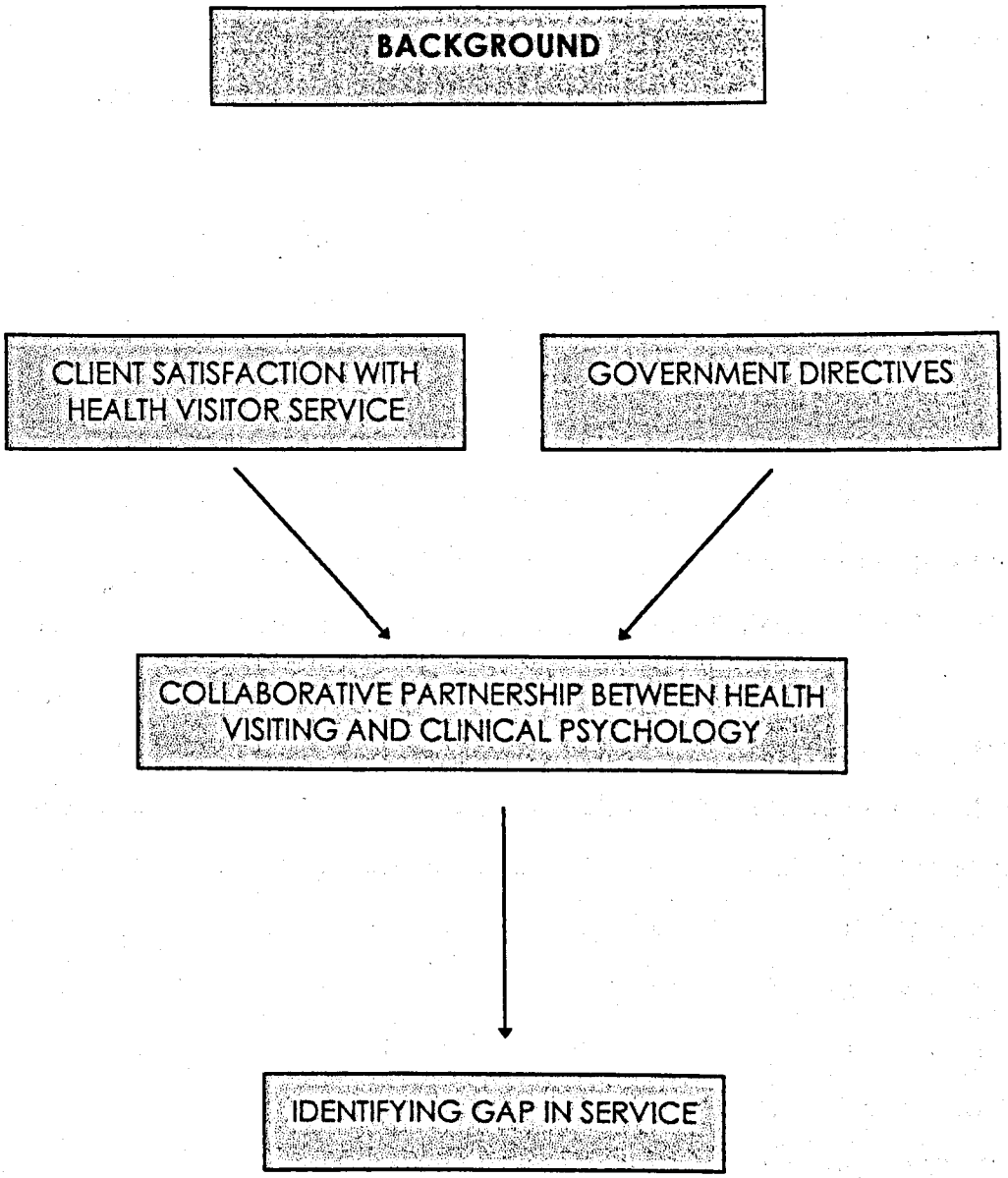
* The research conducted investigated a third variable, reflective function, accounting for the title difference in various forms found in the appendix. The results of this variable will not be included in this thesis due to the amount of data already presented. A separate paper will report on the reflective function findings.

ABSTRACT

This study investigates the effects of a self-esteem focus programme on participant's self concept and self-esteem. The programme, jointly planned and delivered by clinical psychology and health visiting, is an example of collaborative working between the two professions. The programme was delivered over eight weeks, the contents of which are detailed, as are the theoretical underpinnings for the programme. Both quantitative and qualitative methods of analysis were used to evaluate the effect of the programme on the participants. A total of 45 mothers took part in the quantitative analysis, carried out by using repeated measures multivariate analysis of variance on scores obtained from the completion of the Rosenberg Self-esteem and the Pearlin and Schooler Psychological Coping Resources Questionnaires at four times during the data collection period. Eleven of this group of mothers took part in depth interviews which were analysed qualitatively to assess changes in self concept. Participants showed significant increase in self-esteem and mastery accompanied by significant decrease in self-denigration, at the 0.01 level of significance, following participation in the programme. These changes were maintained six months after completion of the programme. Qualitative analysis of the depth interviews showed an increase in feelings of self worth, self confidence and feelings of normality. Responses also reflected change in the way participants related to their children, spouses or partners, others and towards themselves. In addition the study notes the impact of organisational structures and management in the development and implementation of collaborative partnerships.

CHAPTER ONE

Schematic Representation



CHAPTER ONE

BACKGROUND

1.1 Introduction

The decision to investigate the research topic was a direct result of a Clinical Psychology - Health Visiting collaborative project. The Primary Care Directorate in the trust where it took place had created a clinical psychology post specifically to explore ways of working collaboratively with health visitors. The post was a response to recommendations made in a study, undertaken by the trust, into client satisfaction with the health visiting service (Quine & Povey, 1993).

At the same time that the opportunity to work inter-professionally was created and encouraged at a local level, the government directives suggested, and at times demanded, inter-professional / inter-agency collaboration (Home Office, 1991; Audit Commission, 1994; HMSO, 1995). The task at local level focused on exploring and evaluating innovative ways of inter-professional working, within the remit of prevention and early intervention. The task at national level was far more imperative in nature - it demanded that professionals and agencies work collaboratively in the effective management of child protection. Although very different in focus, local and national agendas were seen as opposite ends of the same continuum. In their work with families, health visitors were equally involved in child protection cases, as they were in providing a service that strived to offer as much prevention and early intervention as possible.

1.2 Client satisfaction study

Health visiting services have, in the recent past, been directed at families with children under the age of five years. The aim of the health visiting service is to offer advice, support and information on a range of health related subjects and to work with families towards the prevention of physical, social, and psychological / emotional ill-health (Quine & Povey, 1993). It is a service geared towards empowering families, through partnership, to make full use of their health potential, within their cultural context (Twinn & Cowley, 1992).

Two years prior to the commissioning of the client satisfaction study, the Trust implemented a 'matching need to resources' system whereby health visitors identified 'high dependency' or 'vulnerable' families using a standardised format (Appendix A) (Scott, 1991). This system allowed health visitors to allocate extra time to such families with the view to provide more support and prevent the increase of family distress. It also enabled health visitors to more adequately assess the severity of the situation and refer families to other services if necessary.

The client satisfaction study was commissioned for two reasons. The first was to investigate the acceptability and availability of health visiting services to clients and the second was to investigate the effectiveness of targeting services towards vulnerable families. Conclusions suggested that a valuable service was offered, but more could be done (Quine & Povey, 1993). The introduction of a clinical psychologist to work jointly with health visitors was seen as a further step in the effective matching of resources to the need.

1.3 Government directives

Inter-professional collaborative working has been a directive from government receiving increasing attention over the last decade (Home Office, 1991; Audit Commission, 1994; DoH, 1995, HMSO, 1995: DoH, 1998). Research in collaborative working, commissioned mainly in the area of child protection has concentrated on the difficulties, conflicts and dilemmas of inter-professional working (Taylor & Tilley, 1989; Taylor & Tilley, 1990; Sadler, 1994; Hallett & Birchall, 1995; Birchall & Hallett, 1996; Lupton & Khan, 1998). When reviewing the relevant literature, few articles were found on the benefits of collaborative work, and particularly so, in areas other than child protection. Those found however, all stressed the positive gain for the client, in terms of client satisfaction and effectiveness of intervention, while some also made reference to the financial gain involved (Bradford, 1993; McClarey & Stokoe, 1995; Wilson, 1995; Sone & Plamping, 1997; Weir, 1997).

1.4 Creating the collaborative partnership

Health visitors are specialised nurses, attached to GP practices, who offer a service to every family during the first five years of a child's life. In addition to the services of immunisation and advice to parents on infant/child related problems in areas such as breastfeeding, weaning, teething and sleeping, to mention just a few, health visitors also offer parents an opportunity for the discussion of emotional difficulties. They are often trusted by family members, particularly the mother, and are often used as confidants. Health visitors are also known to the family over many years, particularly in families with more than one child. They develop a unique position - although a professional, the health visitor is seen to have a natural and normal involvement with the family. This places the health visitor potentially in

a position of great influence, with far greater 'entry power' into the family system than any other 'outside' professional (Luker & Orr, 1992; Twinn & Cowley, 1992; HMSO, 1998)

1.5 Identifying gaps in the service

One of the first tasks of the clinical psychologist (hereafter referred to as the researcher) was to identify what were the gaps in service provision from the health visitor's point of view, and their views on collaboration with clinical psychology. While gathering information, one of the needs identified by health visitors was in the area of mother-child bonding. They reported to the researcher, that during their first visit to families following the birth of a child, they often detected potential problems in the attachment process. In some cases, mothers expressed unease, or even avoidance, in holding and touching their babies; in other cases health visitors were alerted to possible difficulties in the light of complex and problematic inter-generational relationship histories. This often emerged in the routine history taking when health visitors inquired about clients' relationships with their parents. Alternatively, when health visitors discussed social and emotional support systems, a necessary element in helping new families cope with the pressures brought about by the birth of a child, information regarding troublesome relationships with their own parents would frequently surface.

Health visitors also noticed that the above-mentioned families were often the same families that frequently contacted the health visitor throughout the following years of involvement, with a variety of problems, ranging from finance and accommodation issues to interpersonal ones involving child protection. Common presentation of problems included mothers expressing feelings of worthlessness,

lack of confidence and that they easily became uptight with their children. Their handling of their children resulted in them having feelings of guilt, particularly when aware that they were repeating behaviour that had been displayed to them as children. Relationship difficulties between adults were also common, whether between partners or with other significant people such as their parents.

Health visitors had made use of a number of interventions to help parents showing such difficulties. These included education, in the form of information leaflets or relevant articles, modelling through practical demonstration and encouragement whenever possible and appropriate. Although some parents were able to benefit from what was offered, there were others for whom these methods were not effective. A closer look at the characteristics of the latter group of parents revealed some common elements. These included:

- they had had poor / conflicting / absent relationships with their own parents
- they presented with anxious, insecure or disorganised attachment histories
- they had often spent periods of time in children's homes or in alternate care
- they presented with current relationship difficulties
- they expressed poor concept of self
- they expressed a lack in confidence.

The abovementioned characteristics were akin to those mentioned in the work of Fraiberg (1980) and Bowlby (1988) - parents who themselves had had anxious, insecure or disorganised attachment experiences. What health visitors were presenting seemed to match the idea of inter-generational cycles of attachment, emotional

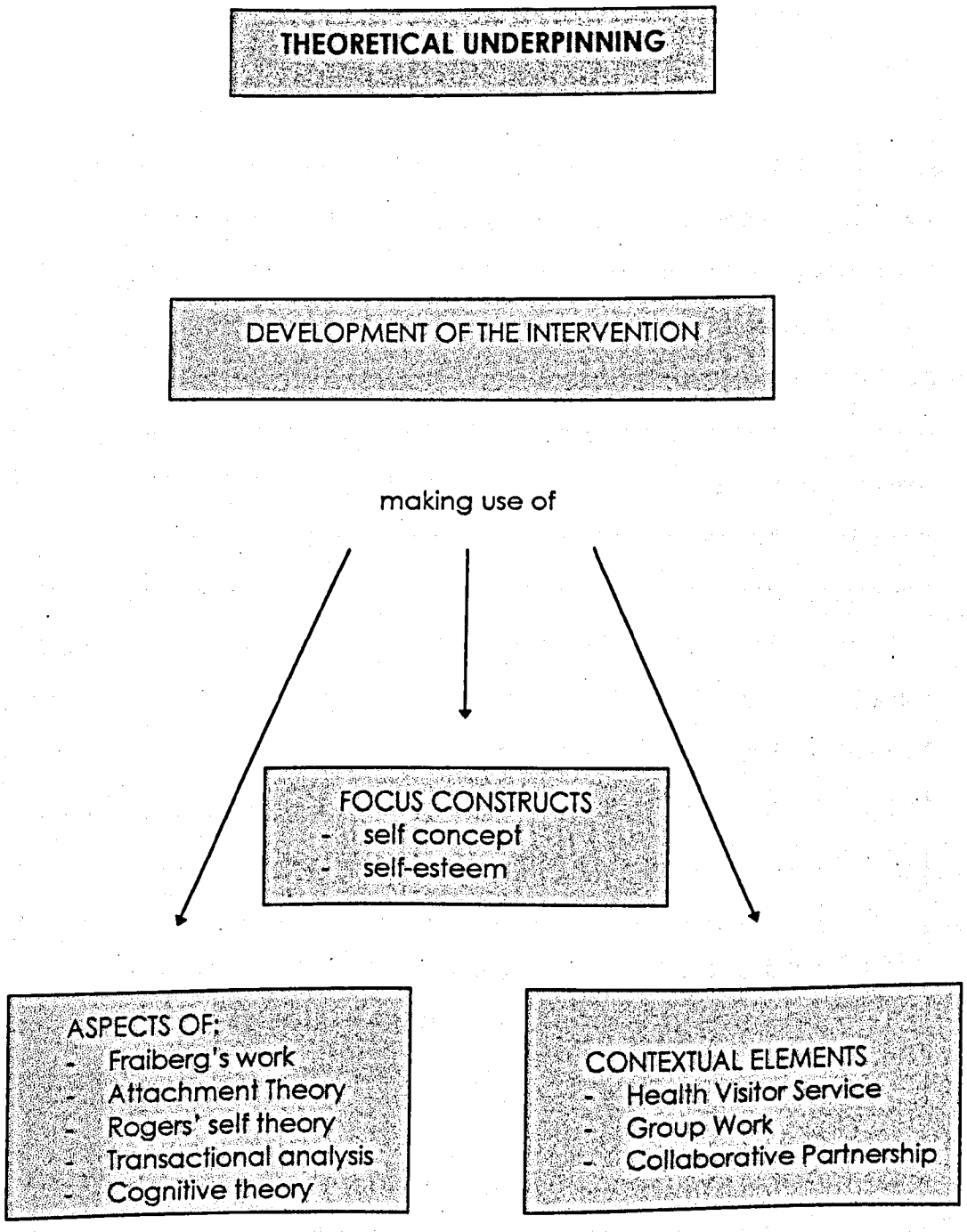
deprivation, and possibly, abuse and neglect (Egeland & Sroufe, 1981; Critchley, 1982; Fonagy *et al.*, 1991; Ainsworth, 1991). It therefore seemed necessary to develop an intervention that facilitated parents understanding of how their own experiences of being parented affected how they were parenting their children. The intervention was also required to facilitate the practical implementation of whatever insight and knowledge they acquired.

Although health visitors were available to both parents, and both mothers and fathers manifested the abovementioned characteristics, in reality it was mainly mothers who made use of the health visiting services. For the sake of clarity and since the present research involved only mothers, the term 'mothers' rather than 'parents' shall be used from here onwards.

The following chapter focuses on the various theoretical underpinnings used in the development and formulation of the programme.

CHAPTER TWO

Schematic Representation



CHAPTER TWO

THEORETICAL UNDERPINNING

2.1 Introduction

Health visitors were aware of mothers presenting needs in a number of areas. Mothers needed skills in managing the behaviour of their children, yet when this was given in the form of information, they found it difficult to put it into practice. Within adult relationship difficulties, one of the main problems seemed to be the way in which mothers saw themselves and the roles they adopted within relationships. They often saw themselves as deserving of the punitive treatment they received. Encouraging them to explore different ways of relating or offering suggestions gave temporary relief on occasions, but old patterns would re-emerge. Health visitor accounts seemed to indicate that the mothers' self concept was a crucial factor underpinning the problems being presented, whether in the area of behaviour management of children or in the area of adult relationships. Mothers interacted with those in their interpersonal world from the base of a poor self concept and resultant low self-esteem. It thus seemed wise to focus on what was seen to be the basis for the presenting problems rather than to direct the intervention at the presenting problems themselves.

The intervention used the constructs of self concept and self-esteem as foci. These were also the constructs used to measure any change taking place in mothers, as a result of the intervention. If the intervention was to provide mothers with the opportunity for insight and understanding of the impact of past relationships and

experiences on their present interpersonal interaction, and it was to facilitate the practical implementation of the acquired understanding, then the intervention would need to incorporate aspects of attachment and self concept theory as well as theoretical models that assisted the understanding of behaviour. Three cornerstones were thus considered essential in establishing a solid base:

- focus constructs
- theoretical underpinnings
- contextual elements

2.2 Focus constructs

2.2.1 *Self concept*

For centuries humanity has been in search of an understanding of itself, yet it has only been in the last century that the term 'self concept' has emerged as a psychological construct open to scientific investigation (Burns, 1979). Previously, the quest for self understanding occupied mainly thinkers in the domain of philosophy and religion. Descartes' "I think therefore I am" is an example of the philosophical thinking of the early 17th century, emphasising the centrality of the self in consciousness.

William James (1890) was the first psychologist to make the self as subject versus self as object distinction - 'I' being the subject and 'me' the object. The self as object, as known to the subject, or also known as the empirical self, comprised four components - spiritual self, material self, social self and bodily self. For each person the four components combined in a unique way to form an integrated picture, that the person held of him / herself. Although he identified components he was also of the view that these were so intricately linked that they were not clearly separable from each other. The 'I -

Me' distinction, while both simultaneously existing to form the Self, was a crucial differentiation that was to become the base on which other theorists developed their thinking. The 'Me' referred to the self concept.

At the turn of the century the thinking regarding the concept of self started to turn towards the aspect of interaction between the self and society, or the 'individual - society' relationship. Cooley (1912) introduced the term 'looking-glass self'; expressive of how he viewed the self. His view was that the self concept was very influenced by what the individual believed others thought of him. Mead (1934) took this thinking further. For him, the self concept as an object, was the result of social interaction; it was the result of the individual's concern about how others reacted to him. The combination of the different 'elementary selves' arising from different social situations fused to create a 'complete self'. This could be seen as the different roles the person had - each one being a part and all together making up the complete whole.

The constructs of 'ego' in Freudian and neo-Freudian thinking shared aspects of previous theorists 'self', but the conceptual framework was quite different. For Jung, for example, the self was seen as the integration of the conscious and unconscious - it was an archetype representing the person's striving for unity and wholeness (Jacobi, 1942). Theorists such as Adler, Sullivan and Horney all shared the idea of a sociocultural base in the development of the self concept, but they were more concerned with its implication for therapy than for self theory as such (Hall & Lindzey, 1957). Of the neo-Freudians, only Erikson paid specific attention to the self as object. The self was the

base from which identity emerged in contrast to the ego (as subject) that remained his central organising force (Erikson, 1968).

Following on from the organismic theorists, such as Maslow, Angyal and Goldstein, who viewed the person as an organised system, indivisible into separate elements to be studied, and where self-actualisation is the only motivating drive, recent self concept theory has developed mainly within the phenomenological school of thought. Phenomenologists maintain that "behaviour is not only influenced by past and current experiences but by the personal meanings each individual attaches to his perception of those experiences" (Burns, 1979, p. 30). They view the self concept developing from the perceptions of reality rather than from reality itself. Perceptions are influenced by factors such as motives, goals, attitudes and defence mechanisms and as such are selective. The self concept is at the centre of phenomenological thinking, whether viewed as the core area within the life space region, in Lewin's field theory, or as the heart of the self which lies at the centre of the phenomenal field, in the theory proposed by Snygg and Combs (Burns, 1979).

Carl Rogers has been seen by many as the most influential thinker within the phenomenological viewpoint. The self concept was not only at the centre of his self theory, but also underpinned the development of his client-centred approach to psychotherapy. The self concept was defined as "the organised, consistent conceptual Gestalt composed of characteristics of the 'I' or 'me' and the perceptions of the relationships of the 'I' or 'me' to others and to various aspects of life, together with the value attached to these perceptions" (Rogers, 1959, p. 200). The self concept was seen as the

most important determinant of behaviour, governing the perception of meanings attributed to the environment from which it stems. The self concept was not an accumulation of experiences, but rather a part of the organism that was driven to self-actualise through constant activity. It influenced the direction of activity rather than initiating it and directing it entirely.

2.2.2 *Self-esteem*

Whereas the self concept concerns itself with the knowledge about the self, self-esteem generally refers to the evaluation of that knowledge. Not all self concept theorists have made the distinction between self concept and self-esteem even though most are concerned with the aspect of evaluation. The model proposed by Burns (1979), viewing the self concept as a set of self-attitudes, clearly places self-esteem as an integral component of the self concept. 'Attitude' is defined as consisting of four components: a belief (knowledge or cognitive component), an affective (emotional) component, an evaluation and a predisposition to respond (p. 52). Self-esteem is the evaluative component of the self-attitudes.

A particular belief or cognition will evoke an emotional response, dependent on the social and cultural context in which it takes place. The emotional response in turn carries an evaluative component equally dependent on the social and cultural context. Self evaluation is not fixed; if the context changes so does the evaluation of emotion evoked by the belief in question.

For most theorists differentiating between self concept and self-esteem, it is the evaluation element that defines self-esteem. For James (1890) self-esteem was totally linked to the person's view of

himself regarding his success or failure in relation to others' skills and abilities. For the organismic theorists (e.g. Maslow, Angyal and Goldstein), where all behaviour was motivated by one drive, that of self-actualisation, esteem needs were one of the five sets of needs comprising the self-actualisation drive. For Rogers, positive regard from others, defined as warmth, liking, sympathy and acceptance, was a need inherent in every person. According to his model, if this positive regard was experienced and internalised, it would result in positive self regard that for Rogers was synonymous with self-esteem.

The work of Stanley Coopersmith into the antecedents of self-esteem provides valuable pointers in the understanding of the development of self-esteem (Coopersmith, 1967). His research involved approximately 1,700 10-12 year olds, and aimed to discover links between levels of self-esteem (high, moderate and low) and factors affecting it's development, either in the form of personal characteristics or other environmental influences. He found no significant relationship between self-esteem and physical attractiveness, social class, income level, size of family or height. He did however find that self-esteem was strongly associated with parental attitudes and child rearing practices. Parental warmth and acceptance, the demonstration to the child that it was regarded as a significant person and the use of rewards rather than punishment in conjunction with consistent limit setting in the management of behaviour, were all strongly associated with high levels of self-esteem. Parents who were characteristically cold, withdrawn, inconsistent and rejecting, had children who showed low levels of self-esteem.

Extensive research involving over 5,000 adolescents was conducted by Morris Rosenberg, in the investigation of factors associated with

high and low self-esteem (Rosenberg, 1965). He concluded that it was the amount of parental attention and concern that influenced levels of self-esteem. Similarly to Coopersmith, his research suggested that social class and ethnic group membership were not impacting factors on levels of self-esteem.

2.3 Theoretical underpinnings

No one particular theory was used in its entirety, but rather aspects of various theories that the researcher judged to fit cohesively, were combined to form the base of the Self-esteem Focus Programme.

2.3.1 The work of Selma Fraiberg

Based on psychoanalytic theory, the work of Selma Fraiberg presented a clear account of the practical implementation of theory (Fraiberg, 1980). It was particularly relevant to this research as there were strong similarities between the presentations depicted in her work and some of those reported by the health visitors involved in this investigation. In a field as complex as impaired mother-child relationships, it provided a valuable model to keep in focus due to its pragmatic nature and optimistic outlook.

Her work was naturally collaborative, involving both families and professionals. Families mentioned in her writings were seen in a developmental clinic setting, and referred for a variety of reasons, examples including 'child looks neglected', 'mother not coping', 'depressed mother' and 'failure to thrive'. Fraiberg used different levels of approach in her intervention depending on what was deemed to be required. The levels comprised crisis intervention, developmental guidance, environmental support and infant-parent psychotherapy (Fraiberg,1987).

The type of treatment most relevant to this study was the infant-parent psychotherapy intervention. It involved identifying the aspects of parental psychological conflict that impeded the development of stable bonds between parent and baby. Accounts from parents that showed the repetition of the past (maladaptive and destructive interactive patterns) in the present, became the key to the understanding of what seemed inexplicable and illogical. Parents repeatedly verbalised how determined they were to give their child a better experience of life and 'growing up' than the one to which they had been subjected. However they could see themselves repeating interactive patterns that had been so personally painful in their past.

Parents could often recall events of what had occurred in their past. They were able to give detailed accounts of their experiences, whether these were physical beatings or sexual abuse or what they had to do when a parent was drunk, for example. Frequently what was not easily recalled was the associated affective experience. They remembered the events but not the associated feelings. It seemed that the feelings of unbearable intensity and pain had undergone repression. The therapeutic work involved unravelling the past. In the process of unravelling the past and becoming in touch with the feelings that were evoked by the past behaviour, parents became aware of the connection between the affective aspect of the past and the present behaviour towards their own child. This in turn enabled the parent to consider different, more effective ways of relating towards their children (Fraiberg, Shapiro & Cherniss, 1980).

Fraiberg's hypothesis was that in remembering the affective component of their memories, parents were freed from the blind

repetition of their past. "Our hypothesis is that access to childhood pain becomes a powerful deterrent against repetition in parenting, while repression and isolation of painful affect provide the psychological requirements for identification with the betrayers and the aggressors" (Fraiberg, Adelson & Shapiro, 1980, p. 195).

The aspect of unravelling parents' painful past as a way of avoiding the repetition of the interactive pattern with their own children in the present and future was seen to be a valuable component to incorporate into the Self-esteem Focus Programme. A second aspect of Fraiberg's thinking that was integral in the development of the Programme was that of adapting psychotherapeutic techniques to the opportunities presented. In her writings Fraiberg refers to 'psychotherapy in the kitchen', advocating that therapeutic work should be adapted to reach the client in the most effective manner. With her client group, this was often not in the conventional format where the client visited the therapist in the consulting room; rather therapy took place wherever it was most convenient for the client. Following this concept in the present study, working with parents through the existing alliance between parents and health visitors was seen to be the most effective way of working with the presenting difficulties.

2.3.2 *Attachment Theory*

Whereas theoretical aspects and practical techniques of Fraiberg's work were incorporated into the formulation and implementation of the Self-esteem Focus Programme, the role of attachment theory was one of background understanding. Recent research on infant attachment has provided evidence for the intergenerational transmission of both patterns of attachment and interaction (Egeland

& Sroufe, 1981; Critchley, 1982; Egeland & Farber, 1984; Fonagy *et al.*, 1991).

John Bowlby and Mary Ainsworth, both psychoanalytic in background, are most commonly associated with the development of attachment theory. From the beginning of his career, Bowlby was particularly interested in the influence of early family environment on later behaviour, whether that behaviour be the development of neurosis or the intergenerational transmission of attachment patterns (Marrone, 1998; Bretherton, 1991). Ainsworth, on the other hand, initially a student of 'security theory' formulator William Blatz, was interested in the link between the child's secure dependence on parents and its ability to cope with the demands of learning skills and developing knowledge. Her view was that unless the child had a 'secure base', (referring to the secure dependence of child on parent) it would not be able to venture with confidence and maximise the learning opportunities available to them. Ainsworth is particularly known for developing the 'strange situation procedure', a standardised method of assessing the parent-child attachment relationship and formulating the classification system denoting secure, insecure-avoidant, insecure-ambivalent attachment patterns (Marrone, 1998).

An awareness and understanding of the essential underpinnings of attachment theory were seen to be relevant. Participants' experiences of their own attachments would emerge throughout the programme. It was important that programme facilitators were aware of the possible impact of participants' attachment style on their current relationships. The understanding of attachment theory was seen as a tool to be used when necessary, to facilitate the unravelling of past and present behaviours and emotions.

The original research plan for this thesis included a third variable to be investigated, reflective function. Attachment theory was crucial in the understanding of reflective function and was seen as an essential theoretical underpinning. Since the reflective function variable has not been reported on in the thesis, the detail of attachment theory has been omitted.

2.3.3 Rogers Self Theory and Client Centred Therapy

Central to Rogers Self Theory is the view that the self concept is the most important determinant of how people respond to their environment. Fundamental to his model of client centred therapy is the view that each person has worth and dignity in their own right (Rogers, 1951). These two views were central in the researcher's formulation of the self-esteem programme. Each person carries multiple self concepts, each one relating to a different aspect of himself. For example, the same person may see himself as a brilliant mathematician yet as a poor artist. The resulting self-esteem (regarding these two self views) depends on how the person evaluates each particular self-view. Within the context of the programme, the aspect of self-esteem that was focused upon was the sense of the concept as detailed by Rogers. It referred to the value or worth of being a person, regardless of levels of ability, social standing, educational attainments or any other attribute often responsible for engendering self worth.

Self-esteem resulting from abilities and from social status or standing within the family was referred to. Examples of situations where these would be paramount were given. For example, when going for a job interview, the ability to perform the required duties would be the

focus. In that situation both self concept and self-esteem would be related to ability. However in the context of the programme, the focus would be solely on the value or worth of being a person.

The focus of the programme was on self-esteem rather than self concept. It questioned how individual participants valued themselves and where their evaluations stemmed from. The rationale was that if participants were able to value themselves more, not because of any specific ability, but because they were of worth as a person, they would start to see themselves in a different light. This change in self concept would in turn enable a change in their response to their environment (Rogers, 1967).

2.3.4 Transactional Analysis

Transactional Analysis is a model for understanding human personality, relationships and communication developed by Eric Berne. Central in its theory is the concept of ego states, defined as a set of related behaviours, thoughts and feelings (Stewart & Joines, 1987). The model portrays three distinct ego states, Parent, Adult and Child. A second central concept is that of 'life-script'. These were the two aspects of Transactional Analysis that were used in the formulation of the programme.

During childhood every person writes a story for himself. The story represents the strategy developed by the child to survive the world in which he finds himself. The story is written early in childhood and is unaware to the person in adulthood, unless the effort is made to discover it. A child encountering threat to satisfying his needs during childhood, will have written his story according to the best way available to him (as a child) to survive such conditions. As adults,

people continue to react in similar ways when in the Child ego-state and sensing threat to the satisfaction of needs or even to survival. Scripts can be classified as being *winning, losing or non-winning* in type. Most people write a combination of the three types.

Any script can be changed. Becoming aware of the script, and the areas in which *losing* decisions were made, enables the person to change them to *winning* decisions. This possibility for change of script was a crucial factor in the formulation of the self-esteem programme. Specific exercises focused on participants exploring their life-script and changing *losing* decisions to *winning* ones. Unless this change takes place, the *losing* story continues to be played out throughout adult lives, with unwanted consequences.

The term 'life-script' was not used in the implementation of the programme. The use of theoretical jargon was kept to a minimum. The term 'message' was used, referring to the same concept. During the course of the programme participants addressed only one message of their life-script.

2.3.5 Cognitive Theory

The behaviour principles of classical and operant conditioning, proposed at the turn of the 20th century, underpin cognitive-behaviour theory. Classical conditioning refers to the process whereby the association of a naturally occurring physiological response to a natural stimulus (such as fear when confronted with danger) with a neutral stimulus results in the neutral stimulus eliciting the physiological response. Operant conditioning refers to the principle that if a particular behaviour is followed by a reward, that behaviour is more likely to occur again.

Cognitive-behaviour thinking focuses more on a model of therapy than on theory per se. During the mid-century decades the principles of classical and operant conditioning were extensively applied in practice and by the end of the 1970s behaviour therapy had became the treatment of choice for many disorders, among them phobias, obsessions and sexual dysfunction (Hawton *et al.*, 1989). The last three decades have witnessed an enormous shift in cognitive-behavioural thinking. No longer is it only involved in the observation, measurement and attempted change of descrete units of behaviour, it also incorporates metatheoretical paradigms that serve to present cognitive psychotherapies within a coherent framework (Carmin and Dowd, 1988).

Freeman *et al* (1990) states that cognitive therapy is "based on a straightforward, commonsense model of the relationship among cognition, emotion and behaviour in human functioning in general and in psychopathology in particular" (p.4). Each of these three aspects of human functioning affect the others, thus thoughts can affect feelings which in turn can affect behaviour. Similarly, feelings can affect thoughts and behaviours. Furthermore, the aspect of cognition incorporates automatic thoughts, underlying assumptions and cognitive distortions. The goal in cognitive therapy is to modify any or a combination of the possible components in the cycle that perpetuates the client's problems. This could be to enable change in the client's automatic thoughts or improve the client' mood or modify the behaviour aspect.

In this study cognitive-behaviour thinking was extensively used particularly in the latter sessions of the intervention when the focus was

on enabling participants to translate their insights into practical applications. A problem solving approach was used that incorporated:

- assisting participants to identify the problem,
- helping them to recognise the resources they possessed to approach the difficulty,
- teaching them systematic ways of overcoming the difficulty,
- enabling their sense of control over their difficulties, and
- equipping them with methods for tackling future problems. (Hawton and Kirk, 1989).

2.4 Contextual elements

2.4.1 Health Visiting Service

The health visiting service was seen as an ideal vehicle with which to deliver the self-esteem programme for a variety of reasons. In the first instance, the unique relationship between health visitor and participant, as outlined in section 1.4, placed the health visitor in a position of great influence. This position was seen to facilitate the participant's recognition of the difficulties experienced and the decision to engage in the intervention offered. Secondly, the fact that health visitors were involved in the delivery of the programme, normalised the difficulties experienced. Health visitors are available to all families. Their work is seen as being directed to the 'normal', in sharp contrast to the view of the work done by clinical psychologists. As a result of health visitor involvement, participants' openness to the intervention was greatly increased. A third consideration was the fact that participants would continue to have contact with the health visitor after completion of the programme. Reinforcement of the new ways of addressing the difficulties, learnt during the programme, could

be done within the natural context of the health visitor - client relationship.

The involvement of health visitors in the self-esteem focus programme was also in line with the Health Visitor Association guidelines. To motivate people to live healthier lives, to facilitate self-empowerment, to consider the relevance of self-esteem in health matters and to enable people to achieve their full health potential, are all seen as falling within the remit of the health visiting profession (Twinn & Cowley, 1992).

2.4.2 *Group work medium*

The medium of group work provided an environment within which participants with similar experiences and needs, could, under the direction of group leaders, share their experiences, consider alternate ways of addressing difficulties and feel the support of 'not being alone' in their experience.

In formulating the self-esteem programme the natural stages of group evolution were kept in mind. The programme was semi-structured, each session containing clear goals and objectives. The content of each session was structured, but within that structure participants had the opportunity to explore their individual experiences and consider ways forward, in an unstructured and spontaneous manner. The particular phase of development of the group was kept in mind when considering the content. Whitaker (1985) refers to the *formative, established* and *final* phase in the life of a group. Other theorists such as Tuckman and Levine suggest four phases comprising the life of the group (Wright, 1989). Tuckman named these the *forming, storming,*

norming and *performing* stages, while Levine referred to the *parallel, inclusion, mutuality* and *termination* phases. Regardless of the terminology, the characteristics of the first phase of a group include the establishing of a sense of safety, where participants can feel comfortable enough to take the risk of emotional exposure. It also needs to provide the opportunity to establish group norms that will support the life of the group, providing structure, and minimising the opportunities for destructive conflict.

The middle phase in the life of a group, be it called the established phase, or the inclusion and mutuality phase, is characterised by a sense of working on the purpose for the group. Activities or structured exercises are geared towards facilitating this work. In the self-esteem focus programme, sessions three, four and five (out of a total of eight) formed the established phase.

The termination phase is characterised by experiences of separation, loss and mourning and the opportunity for stocktaking and planning for the future. Chapter 4 contains details of how these experiences and opportunities were managed during sessions seven and eight of the programme.

In summary, the formulation of the self-esteem focus programme combined elements of psychoanalytic thinking, attachment theory, client centred therapy and transactional analysis. Carl Rogers view of the worth of the individual was the core of the underpinning structure. The understanding of how that sense of worth is obtained was sought in the theory of attachment, while the notion of life-script provided a clear yet comprehensive way to enable the participants understanding of their own experiences. The work of Selma Fraiberg

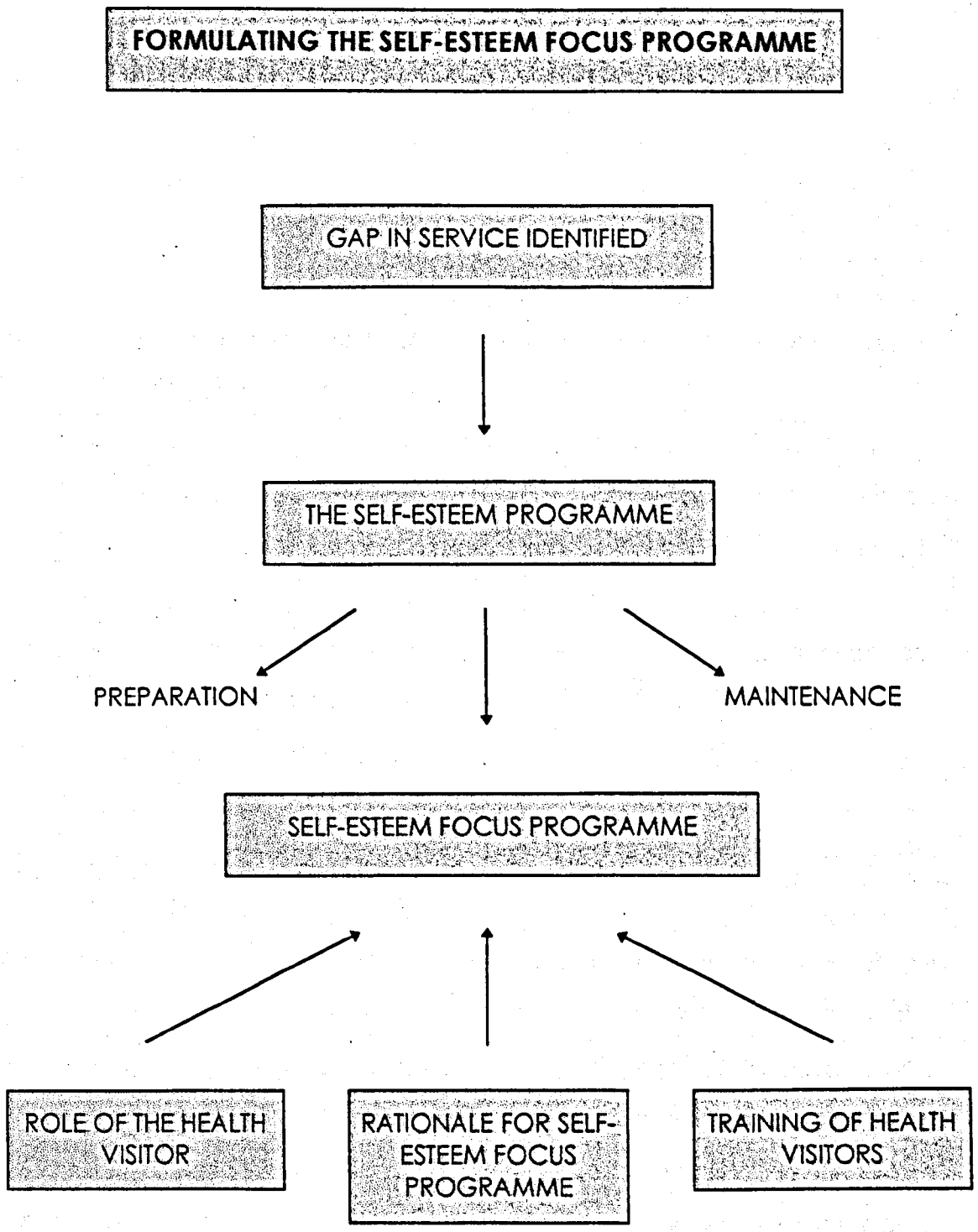
gave both a theoretical understanding of the intergenerational transmission of feelings and behaviours and also provided an invaluable model for the problem to be addressed.

The contextual elements in the form of the health visiting service and the group work medium were used to facilitate and maximise the effectiveness of the intervention. The constructs of self concept and self-esteem were focused upon as indicators of any change produced by the participation in the programme.

The following chapter contains details of the rationale behind the formulation of the self-esteem programme and the role of the health visitor in its implementation.

CHAPTER THREE

Schematic Representation



CHAPTER THREE

FORMULATING THE SELF-ESTEEM FOCUS PROGRAMME

3.1 Introduction

Health visitors identified the service need, and in conjunction with the researcher, it was decided that the intervention needed to include:

- focus on self-esteem,
- facilitation of the understanding of how previous, some of them early, experiences of significant relationships affected present interpersonal interaction with children and adults alike,
- enabling mothers to implement, in a realistic and practical manner, whatever changes they decided upon as a result of the insight and knowledge acquired.

Health visitors and the researcher (clinical psychologist) were jointly involved in the formulation of the intervention. Much discussion took place between the two professions, making the maximum use of the complementary sets of skill and expertise. Health visitors held a wealth of experience regarding the needs, potential, practical difficulties and situational contexts of the client group. They were in an ideal position to advise the researcher as to whether emerging ideas were practically viable or not. The researcher's role, on the other hand, was to match as adequately as possible, the identified need with the most effective tools to achieve a desired outcome.

3.2 The self-esteem Programme

The intervention was called the *Self-esteem Programme*, a title agreed upon by both professions. It was a title that incorporated one of the central topics dealt with in the intervention, but did not denote pathology. It was a title that mothers could feel comfortable with using when talking to family or friends. The programme consisted of three parts. The first was the preparation phase, where participants received information about the programme and had the opportunity to discuss and decide whether it contained that required to address their individual needs. This happened over varying lengths of time depending on what the mother needed to discuss in order to make a decision. This phase was often dealt with by the participant's 'own' health visitor, and once a decision had been made to attend the programme, one of the health visitors involved with the delivery of the programme would visit the mother and take over the contact and arrangements related to the self-esteem programme.

The second phase was an eight week programme, delivered on a group basis, where intensive reflective work was facilitated, as was the practical application of insights gained. The reflective work comprised a five stage process whereby each participant:

- chose a recurrent situation that provoked anxiety or that led to feelings of worthlessness
- explored the first recollections of that same feeling (connecting past to present)
- identified the essence of the message received (as part of the life-script)
- questioned the truth of the received message - this often involved facilitating the verbalisation of the experience/s that

were seen to create the message, and acknowledging the context within which the experience took place

- changed the received message to one that, although not experienced as true, was intellectually known to be true.

An example of the above process would be:

- every time the participant and partner had an argument, she was left feeling that it was all her fault and that she was no good
- she recalled various situations where her father would put her down, stating she was no good, and she would never get anywhere in life
- the message received was "I am no good"
- while exploring the context within which the message took place, the participant recalled hearing that her father wanted a son (rather than a daughter), that he often put her mother down, that there were many arguments between the parents and that whatever she did to try to stop these, she was never successful. Guided questioning and reflection led to the participant accepting that as a child she was not in a position to stop the parents arguing. Her lack of success was not due to the fact that she was "no good"
- the changed message formulated by the participant was "I am OK - I have worth".

How each participant chose to apply the insights gained to everyday life was then considered. If the choice was made to change a particular behaviour, the implications were discussed as to what effect that may have on the rest of the family or significant others. The

following chapter contains details of the exercises done to carry out this process.

The third, or ongoing (maintenance) phase, was far less structured in nature than the previous two. It was delivered in a variety of ways, sometimes during individual contact between participant and health visitor, or at others via monthly meetings held for all those having attended a self-esteem group. This provided the opportunity for participants to meet up with others having participated in the programme. The content of the monthly meetings was chosen by the participants, and so the opportunity for further exploration, or to ask advice regarding the implementation of insights was within their control. The health visitors provided a framework to ensure the opportunity for ongoing work on self-esteem was available.

3.3 The vital role of the health visitor in the delivery of the programme

The combination of health visitor and clinical psychologist was an ideal one for the delivery of the self-esteem programme. In the main, health visitors enjoyed a position of trust with mothers, particularly those showing vulnerability. The study of client satisfaction with the health visitor service, indicated that 70 - 80 % of all women (in the study) perceived the health visitor as someone whom they could trust, who exhibited positive regard and who showed a willingness to listen to the clients' concerns. Vulnerable families experienced health visitors as more helpful than non vulnerable families (Quine & Povey, 1993). The infra-structure was in place - the relationships, the trust, the established routes for communication and intervention between mothers and health visitors. The knowledge and skill of the researcher was an extra ingredient, an 'add-on', delivered as part of the

established health visiting service, creating a service accessible to a wide group of mothers in the form of an early intervention programme.

The recognition of the vital position of the health visitor and her potential influence within the family, was used to the maximum in developing the self-esteem programme. Health visitors would be pivotal throughout the delivery of the programme. Firstly, they had direct access to mothers and were aware of those who would potentially benefit from the programme. Secondly, they were to present and discuss the content of the programme and facilitate the decision making process with potential participants. Because the programme was one requiring active involvement from participants, it was essential that they knew beforehand what to expect, so as to avoid disappointment, disillusion and possible dropout.

Health visitors also had a central role in the delivery of the eight week self-esteem focus sessions, taking the lead in whatever group activities they chose and taking the main facilitating role with individual participants. Whereas the researcher took overall responsibility for the delivery of all sessions, health visitors were encouraged and assisted to undertake as much as they could of the delivery of sessions.

Health visitors continued their involvement in the programme after the termination of the eight week group. They ran monthly sessions, open to any mother who had attended a self-esteem group, where continued reinforcement of areas covered in the group, took place. They were also available for mothers to contact them individually should they need or wish.

3.4 Rationale for the Self-esteem Focus Programme

The *Self-esteem Focus Programme* refers to the eight weekly intensive group sessions which forms the second part of the overall Self-esteem Programme. Since the research was limited to this part only, no further reference will be made to the preparation or maintenance aspects of the overall programme.

Lack in confidence, low self worth and a history of poor relationships with their own parents culminating in (current) relationship difficulties were the common characteristics of mothers referred to the Self-esteem Focus Programme. Although there was no formal checklist or distinct criteria used to either include or exclude mothers from the programme, every referral was made after discussion between the mother and the health visitor as to whether the referral was appropriate. In order to address the presenting difficulties, the intervention needed to incorporate a number of essential components. The first was to facilitate the understanding of the origins of self concept and self-esteem (Burns, 1979). As referred to in section 2.1, negative self concept was seen to be at the root of many of the presenting difficulties. The second was to assist with reflection on past experiences and then link the connection between the effects of internalised messages from those experiences and current interpersonal behaviour (Stewart & Joines, 1987). This was followed by enabling participants, when reflecting on past experiences, to assign motives, thoughts, feelings and behaviours to the various people involved in those past experiences (Fonagy *et al.*, 1991). The fourth component focused on the details of how the past messages manifested themselves currently, and the fifth was to give participants very clear practical skills as to how to modify their current behaviour. All the above needed to take place within a safe environment

(Rogers, 1980) and one that was structured to encourage participants to arrive at their own solutions and conclusions.

Providing an accepting and safe environment whilst encouraging reflection on the past potentially created a situation where participants could feel very exposed having revealed painful and distressing experiences. It was important that whenever such situations arose, that they were dealt with with the greatest of respect, and all the skill that they deserved. One of the essential functions of the researcher was to remain active and present throughout the eight weeks, so as to facilitate or take on further individual work with the participant if necessary.

3.5 Training of health visitors

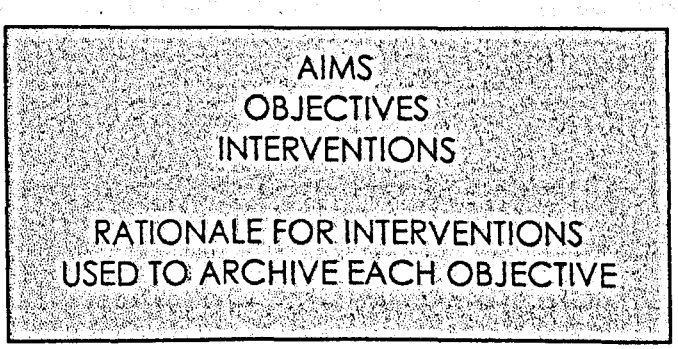
Health visitors in the research project were trained by the researcher over six group sessions. This included background regarding how the programme came into existence, the rationale behind the main aims of the programme, the theoretical underpinnings and finally, an experiential exposure to the reflective process that participants would undertake. Health visitors had to identify some aspect of their own behaviour they wished to explore and change. Care was taken to limit what was chosen so as not to affect the professional relationship with their colleagues. The aim of the reflective experiential aspect of the training was to enable the health visitors to obtain an insight and understanding regarding the reflective process they were to facilitate as leaders. It was also felt that experiencing the process would raise their levels of empathy for the participants. Chapter five contains details of how health visitors experienced the training, their views as to its suitability and any changes they recommended.

Details regarding the implementation of the programme is the subject matter of the following chapter. The aims, objectives and content of each of the eight sessions is elaborated upon and the rationale for the intervention to achieve each objective is given.

CHAPTER FOUR

Schematic Representation

containing



for each specific session

CHAPTER FOUR

IMPLEMENTING THE SELF-ESTEEM FOCUS PROGRAMME

4.1 Introduction

The programme consisted of eight weekly, one and a half hour sessions, run jointly by the researcher and two / three health visitors to a group of between six to nine mothers. Child care facilities were provided for the participants' children.

Each of the eight session had clearly identified aims, objectives and a semi-structured plan of intervention. Selected parts of the sessions were conducted with all participants in a group as a whole, while other sections were conducted in smaller groups of one health visitor and a maximum of three mothers. Before each session and immediately after, the researcher and health visitors would meet to discuss any relevant information. This included deciding who was going to take the lead for particular exercises or updating each other on individual contact that may have taken place between health visitor and participants throughout the week. It was also an opportunity to discuss any difficulties that may have emerged in the small groups and to formulate co-ordinated ways of response. The aims and objectives remained the same for all groups held, whereas the details surrounding the presentation of specific interventions were subject to change, when necessary, to accommodate individual differences in any particular group of mothers.

4.2 The eight sessions

Each of the eight sessions contained clear and specific aims including a semi-structured format of intervention to enable health visitors to facilitate the reflective process. What follows are plans of the individual sessions and the rationale for specific interventions used to achieve the outlined objectives.

4.2.1 Session One

Aim: To establish and create a sense of group.

Objectives:

1. To facilitate participants feeling comfortable with one another and with the professionals.
2. To give details of the eight week programme.
3. To encourage participants to establish the group rules.

Interventions:

Welcome

A formal welcome was given to the group as a whole, usually by the researcher. Informal introductions would ideally have taken place before the group assembled. At this stage no formal introductions were made.

Ice-breaker

The group was given the following instruction: *Think about what you would do if you had a day when you could do just as you pleased, money being no object, and share your fantasies with the rest of us. Also, when introducing yourselves, those of us with*

short memory spans, like myself, would really appreciate you writing your name on the sticky label provided, and place it on yourself.

Overall Plan

The content of each sessions was outlined making use of a flip chart, and the opportunity given for comments as to whether what was presented matched what they were expecting.

Break

A 15-20 minute break provided the opportunity for the taking of refreshments and facilitating socialisation.

Group rules

For this discussion, the group sub-divided forming smaller groupings of 2-3 mothers with each health visitor. They were asked to individually consider: *How do I want to be treated in this group? What rules and norms would I like to see in place?*

Feedback

All smaller groupings came together and each gave feedback on what they had considered important. A list was complied, specific to that group, which was then placed in a prominent position during every session throughout the eight weeks.

Child care arrangements

Mothers were given information regarding child care arrangements in the event of sickness, a distressed child or any other specific situation that concerned them.

Chinese whisper

This was a group activity receiving and relaying a whispered message. It started with one of the professionals who would decide on an appropriate saying, unknown to others, often appreciative and welcoming in nature, relayed to the person next to her, who would in turn whisper what she had heard to the person next to her. The last person to hear the message would say it out aloud and comparisons were made between the original saying and whatever emerged at the end. This was usually seen by participants as a fun way to end the session, yet containing a reminder regarding confidentiality. The version at the end was always different from the one at the start. A similar process was likely to happen if they were to speak about happenings within the group.

Ending

Social greetings ended the session and mothers proceeded to collect their children.

Rationale for interventions used to achieve objectives:

Objective 1 - *To facilitate participants feeling comfortable with one another and with the professionals.*

Professionals made themselves available as the mothers arrived, to facilitate them feeling comfortable with what they often experienced as a very difficult task: arriving in a strange place and not knowing anyone. Mothers were taken to the child care facilities and introduced to the staff and to fellow participants. Each mother would have had some contact with at least one health visitor, even if only through the discussion of information regarding the research, and the filling in of the pre-group questionnaire. The researcher however, would not have met any of the participants before the first session.

Because the central aim of the programme was to enable the participants to experience a sense of worth, not linked to their abilities or social status, but rather because they were people, it was essential that the professionals expressed their sense of worth for the participants, through their behaviour in a congruent manner. Being aware of the possible difficulties experienced at first contact and creating a welcoming environment was one way of expressing that value in a tangible way.

The combination and order of activities, for this first session, was established taking into account participants possible feelings of anxiety. On arrival each experienced individual (welcoming) contact, followed by group membership with no demand (the 'welcome'). A demand was then placed in the form of the 'ice-breaker' but one where any response was acceptable. They did not have to reveal anything about themselves other than their name. Professionals were participants in the ice-breaker activity, often being the ones to start

the fantasy sharing. The 'overall plan' required no input from participants and this was followed by a 'social break', where professionals could gauge individual feelings and respond accordingly. The 'group rules' required input, which was made more comfortable as a result of being done in smaller groups led by the health visitor with whom they had had previous contact. During this intervention the health visitor encouraged the group to select a spokesperson that would give feedback to the whole group. If no one automatically took the invitation, then the health visitor would act as spokesperson for the group. Throughout 'group rules' and 'feedback', mothers were free to partake as much or as little as they wished. 'Child care arrangements' required no response, while that required in 'chinese whisper' was anonymous in nature - if the saying changed between start and finish there was no way of knowing where this had occurred. The alternating between interventions that required response and those that allowed observation only, was designed to enable participants to get acquainted and feel at ease within their comfort zone.

Objective 2 - *To give details of the eight week programme.*

All participants would have been informed about the content of the eight week programme before deciding to attend. This would however have been done by different health visitors under different circumstances, resulting possibly in participants receiving slightly different information. Presenting the overall plan for the eight sessions gave all participants the opportunity to clarify any misunderstanding, and also to start the group with the same information.

Objective 3 - *To encourage participants to establish the group rules.*

It was seen as important to have participants take some ownership of what was to take place over the following eight weeks. The clear message was that their views and wishes were valued and as a result became part of what would be upheld throughout the running of the group. Consistent elements emerging from this exercise included the following needs: confidentiality, respect for their wish to participate or not, not to be judged by regardless of whatever they exposed, not to be spoken down to, their need to be listened to and to have whatever they said treated as important. Throughout the 'feedback' section, special attention was given to ensure that whatever comments participants made were integrated into the final summary of the group rules.

The above-mentioned activities were the formative stage of the group development. The opportunity was given for participants to sense the level of safety through exercises that encouraged but did not demand involvement, and to contribute to the creation of group norms. The exercises were also structured to enable the participant to experience that whatever response she chose to give, was respected. No response was judged as correct or otherwise. Whatever level of involvement was comfortable and felt safe for them was accepted.

4.2.2 Session Two

Aim: To enable participants to get an understanding of the link between self concept and related messages received throughout their lives.

Objectives:

1. To explore how people generally get to develop self confidence and self-esteem.

2. To enable participants to explore who and what affects the development of the concept of self.
3. To differentiate between people's abilities and value as people.

Interventions:

Welcome

The group was welcomed and asked to comment on anything from the previous session or from the week they feel they would like to mention. They were also asked to rewrite name tags to help with remembering fellow participants' names. Any queries about the child care cards given out the previous week were invited.

Outline for the day

The second session was to be a brainstorming session. Concepts such as

- confidence
- self-esteem
- self confidence
- self worth

would be examined, as would factors that possibly contribute to people feeling the way they do about themselves.

Exercise One

In order to help us achieve this, the group leaders role-played three different scenarios, each of them involving a parent and child.

It was strongly emphasized that in observing the role-play it needed to be kept in mind that the scenarios were fictional. The purpose of the role-play was to stimulate thinking and each scenario was purposefully acted out in an intense manner to bring the message across in the least amount of time possible. Participants were asked to observe carefully what happened in each role play and asked to question two points as they observed: -

What is this child feeling?

What image is she creating of herself?

Participants were given a pen and paper to make any notes or comments if they wished to.

The three scenarios were each of a mother and child and started in the same way. The child played with blocks, or with any other toy, while the mother sat reading a book. The child asked the mother to play with her.

Scenario One

The mother responded to her child, engaging in play, praising her when she was doing things well and helping her when she was finding something difficult. The mother also differentiated between what the child was doing and how she saw herself as a result of it. So if the child said that she was stupid because she could not do something, mother would clarify that not being able to do an

activity did not mean that she was stupid. Also if the child did something or approached a dangerous situation, the mother would protect her.

Scenario Two

The mother in the second scenario responded to the child by indicating that she (mother) was busy and that she did not have time to play. When the child mentioned that she could not do something, the mother responded in a putting down manner, saying that she was stupid, that she should go away, that she should not bother the mother. When the child went to touch something dangerous, the mother responded in anger and sent the child to her room.

Scenario Three

In this scenario the Mother responded in a way where everything was acceptable. Any construction of building blocks was absolutely fine regardless of what the child was saying. The messages were that the child could do anything and everything was correct, even though in reality it wasn't. If the child went to do something dangerous, the mother responded saying 'It's OK, you will learn through that'.

Having observed the scenarios, participants went into the small groups and discussed the two questions '*What is this child feeling? What image is*

she creating of herself? with regard to each scenario. Following that all groups came together and shared their views and thoughts.

Common views included that in scenario one the child felt loved, secure and happy. She would create an image of herself that included being valued, being of importance to mother, having a positive concept of herself.

In contrast in scenario two the child would feel angry, bad and 'no good'. Her concept of self would include that she was 'a pain', not wanted around, too much of a bother and not able to please mother. She would develop a negative concept of herself, in that situation.

The child in the third scenario although feeling good about herself in the relationship with mother, participants' views were that as soon as the child had contact with other children, she would be confused and feel insecure. Her concept of herself would be a confused one, not being able to combine the feedback from mother with that of the outside world.

Break

The usual break for refreshments took place at this stage.

Exercise Two

This was done in the group as a whole. Participants were asked to think about situations that people encountered that would affect how they thought and felt about themselves. The exercise asked that they brainstorm as to possible contributing factors in people's concepts of themselves. Some examples on the list were: -

- parents
- the media
- society
- friends
- the church
- husbands/partners
- the work place
- professionals
- special people
- grandparents
- and others

Exercise Three

The purpose of this exercise was to introduce the distinction between 'abilities' and 'value as a person'.

It was explained that very often there was confusion between what people could do and who people were; most often in society the value that people received from others depended largely on what they could do. Some examples

were given in the form of "If you were asked who is more important – the doctor or the teller at Tesco, what would you say?" Inevitably 'the doctor' was the answer. In many life situations, the value of what people were able to do was seen as synonymous with their value as people.

What was explained was that for the purpose of this group, we would not be focusing on abilities. We would be focusing on value as people regardless of any particular abilities, social standing, or cultural and familial status. Participants were asked to come up with examples of what people could do in contrast to aspects of people that were valued from the point of being people, rather than linked to what they could do. For instance in the example above of the doctor or the teller at Tesco what they did was very different, but they could be equally caring people. This distinction between abilities and value as a person was to be used throughout the implementation of the programme.

Ending

The session was bought to a close, wishing participants a good week.

Rationale for interventions used to achieve the objectives:

Objective 1 – *To explore how people generally get to feel the way they do regarding self confidence and self-esteem.*

The role-play was used to get participants thinking about the link between how the child was reacted to by others and the concept she started to create about herself. If a child is repeatedly in situations where a particular concept of self is reinforced, it is likely that that particular concept comes a strong element of the overall self concept. It was stressed repeatedly that the scenarios were not real situations, that they were role plays with the intention of stimulating thinking about how the feeling of self and self concept develops. It was also emphasised that in reality no one behaves in the role-play fashion all the time: everybody does some of these things, some of the time. The rationale behind that was to avoid participants identifying with any of the role-plays and rather to see their purpose as stimulating thinking and to explore the connection between people's reactions and the development of the self concept.

Objective 2 – *To enable participants to explore who and what affects the development of self concept.*

This was initiated through the role-plays but then further developed with the exploration of who and what contributed to the way people develop their self concept. It was seen as an awareness creating exercise, highlighting the various influences that play a part in people's concepts of themselves. It was stressed that different people will have different contributing influences and that for some these may be very strong in comparison to others. The impact of a particular influence, for example the church, may vary at different times in one's life, whereas the impact may be high at a certain time in life, it may be minimal at others.

Objective 3 – To *differentiate between 'people's abilities' and 'value as people'.*

Because the overall goal of the group was to enable participants to increase their self-esteem, from the point of view of them valuing themselves as a person with whatever characteristics they had, it was important to distinguish between their ability and their value as a person. The group was not geared to increase their self-esteem as a result of increased ability in a particular area. This was an important distinction for some of the work happening in the following sessions.

4.2.3 Session Three

Aim: To identify an individual message previously received to do with self concept that is still having a negative impact at the present.

Objectives:

1. To explore individual messages relating to poor self concept and low self-esteem.
2. To identify and verbalise one negative message still impacting at present.
3. To question whether that message was true.

Interventions:

Welcome

The usual welcome, providing the opportunity for comments from the previous session or the previous week was given.

Outline for the day

A link between Session Two and the current session was made. During the previous session the group had considered how people generally came to have the different self concepts they did. Whether people felt worthy and confident or not depended on many factors and on many messages received throughout their lives. As discussed in the previous week, there were a number of different factors and messages received throughout their lives and it was not possible to consider them all.

Exercise One

An invitation was made for participants to think of one message of low self worth, to explore a situation where they felt particularly lacking in confidence, or a situation where they repeatedly found themselves feeling worthless. Help was given by means of examples of possible situations where necessary. Participants were asked to think about a recurring situation where they felt bad about themselves. The whole group then divided into their smaller working groups, where the health visitors, with the help of the researcher, facilitated the process whereby participants identified their particular message. A help sheet designed to aid health visitors through this process can be found in Appendix B. At the end of this exercise, participants completed the following sentence on a card 'The message I received is...' This became the message

they worked on for the remainder of the programme.

In facilitating the identification of a message, the focus was on a 'being' message as opposed to a 'doing' message. If participants came up with messages about abilities, such as 'I am good at spelling', she would be guided off the ability subject and encourage finding a message that related to her value as a person. Examples of messages experienced by participants were 'I am not important', 'I am no good', and 'I am good for nothing'.

Some messages needed clarification to ensure that an appropriate message was being addressed. For example the message 'I am no good' would be further questioned as to 'no good at what', or further questioned as to what was being meant. It may well be true that the participant was not good at a particular activity. In that sense the message was true, but not really relevant to the point of the exercise. The purpose of the exercise was to enable participants to consider whether all people had worth, and more specifically, whether they had worth regardless of their abilities.

Break

The usual refreshment break would take place at this stage.

Exercise Two

This exercise, performed in the small groups facilitated the questioning of the validity of the message received. Was the message actually true? Some participants were able to appreciate the lack of truth in the message. Others had to be guided through the unraveling of thoughts and feelings that were often a product of adult needs and behaviour patterns. Through this exercise participants often started appreciating how much of the message was due to someone else's difficulties rather than a reflection of their own value as a person.

A clear example can be found in the message 'I am dirt' chosen by a participant who had been sexually abused. To be able to appreciate the circumstances surrounding the development of that message regarding her concept of herself, and to not take full blame for its existence, was the purpose of the exercise.

Throughout this session it was stressed that to blame what they experienced on others in their past was not what was intended. The purpose of the unravelling was to assist with understanding. Once understanding had taken place, it was then possible for each to take a more active and

conscious role in controlling the impact of past experiences in present behaviour and feelings.

Rationale for interventions used to achieve the objectives.

The three objectives for session three all form part of the unravelling of past and present thoughts and feelings as elaborated by Selma Fraiberg. The rationale for use of interventions can therefore be presented as one.

The first objective '*to explore the individual messages relating to poor self concept and low self-esteem*' was the beginning of the exploration into feelings of the present. Asking participants to consider times when they felt feelings of low self worth on a recurrent basis was the first step. They often thought and mentioned various situations but identifying one particular message that focused the process, further helped the participant to select and work on that one. The choice was left to the participant, the rationale being that whatever came spontaneously to the participant would be a message that had a significant impact.

Throughout the unravelling process, the focus was on 'being' messages rather than 'doing'. The purpose of the programme was not to increase self-esteem as a result of increased ability, but rather to focus on their value as a person. Thus the message chosen needed to be one that related to their value for themselves as people, a 'being' message.

The third objective, that of '*questioning whether the message was true*' was an essential step in starting to differentiate between what thoughts, feelings, motives and behaviours belonged to the

participant and which of those thoughts, motives, feelings and behaviours belonged to the other people involved in the particular message. Until the participant was able to put the responsibility where it belonged, it was impossible to move onto the next stage, i.e. changing of the message. Throughout the session it was stressed that blaming others was not the objective. To understand where the responsibility lay, or to understand the conditions under which the message developed was important in terms of insight, and as a result of that insight to be able to assign the feelings, thoughts, behaviours and motives to different people. The object was one of understanding, not of blaming.

The use of the 'message' ties in with transactional analysis thinking. If a message was verbally or non-verbally given and reinforced often, it would become part of the self concept. Also in line with the life script theory, it is only when a person becomes aware of the story that they have created for themselves, that they are empowered to change it. So the process of unravelling the feelings and experiences of the past and present, brings together the thinking of Selma Fraiberg and of transactional analysis. In the unravelling process the underlying focus remains on the value of the person as a result of being a person.

4.2.4 Session Four

Aim: To reverse the identified non-truthful message.

Objectives:

1. To check whether the ideas discussed during Session Three had been maintained for each individual participant.

2. To ensure that participants were at the point of intellectually knowing that the message they had chosen was not true.
3. To enable each participant to create a substitute and true message.
4. To enable affirmations in individual situations.

Interventions:

Welcome

The usual welcome procedure was followed.

Exercise One

In the small groups the health visitors checked whether the identification of the message was still clear; whether the message was in the 'I am' format; and whether participants could intellectually recognise that the message chosen was not true. This enabled the leaders to check whether the work done the previous week was still in focus. Sometimes participants needed some further help or clarification particularly in the respect of intellectually recognising the lack of truth in the chosen message.

Participants then formed one big group, and the 'affirmation sheet' was handed out, its contents read and discussed. A copy may be found in Appendix C. The affirmation sheet contained some explanatory notes and the repetitive nature of

messages, and gave suggestions as to the formulation of their new message.

Exercise Two

Participants regrouped with their leader where the formulation of an affirmative message, regarding their worth as a person was facilitated. Each participant in turn considered the message they had received and with the guidance of the affirmation sheet, formulated a new message.

For example the participant whose negative message had been 'I am good for nothing', having considered how that message came into being, recognising that she was not to blame for the circumstances at the time, could then consider reversing the message 'I am someone of worth' became the 'new' substitute message. The new message was written on a card for her future use.

Break

The usual break for refreshments was taken.

Exercise Three

In the small groups with health visitors facilitated by the researcher, participants were helped to explore how they could affirm themselves with their new message in the week that was to follow. They were asked to think about situations they were likely to get themselves into over the following week, where

they were likely to experience the old message; and how they felt they could respond to it. The purpose of this exercise was to enable each participant to leave the session with a clear idea regarding how to start changing the message. Participants were also encouraged to have the new message visible somewhere and to repeat it to themselves as often as possible. Each participant was required to come up with at least one way they were to use it to serve as a reminder. Examples included sticking the wording of the message, or a symbol thereof on the fridge door, or inside the tea caddy, or inside their cigarette box. The important aspect was that they repeat the message as often as possible and allow themselves to see how they felt.

Rationale for interventions used to achieve objectives.

Objectives 1 and 2, *to check whether the plan proposed during Session Three had been maintained for each individual participant* and *to ensure that participants were at the point of intellectually knowing that the message they had chosen was not true,* was the content of Exercise One. Their purpose was to ensure that the work that had been done the previous week was still in focus. At times because this work was so foreign to participants, concepts that were clear when working on them during a session, often faded during the week that followed. Exercise One was a way of bringing people back to the point where they were the previous week. Also if some participants had not achieved all of the objectives the previous week,

the opportunity for going over and consolidating concepts was made available.

Objective 3 was to enable each participant to create a substitute and true message. The rationale behind this objective emerges from the life script theory; i.e. life script stories can be changed. This objective was the start of the changing of message process. With the help of the notes on affirmation (Appendix C) the participant was able to formulate a different message. At first she would not be able to believe it. All that was necessary was that she intellectually agree that the new message was true.

Objective 4 – *to enable affirmations in individual situations* – was moving the process into the practical implementation of the insights gained. It was recognised that the messages of the life script are very strong and difficult to shift unless specific behaviours are put in place in order to help that process. During Exercise 3 of this session the leader in each group helped each participant to look at individual situations throughout the week that could be used to reinforce the new message. The clearer it was for the participant as to what to do and how to put the message into practice, the greater the possibility that change would start. As participants said the new positive message to themselves, they would start to feel it at some point. This would lead to participants behaving differently to others with whom they came into contact. What was required of participants was that they experiment during the week with repeating the new positive message and experience what happened. The following week these experiences would be reported back and the way of implementing ideas changed if necessary.

4.2.5 Session Five

Aim: To consolidate the positive self message.

Objectives:

1. To obtain feedback from each participant as to how the practical implementations of the goals set the previous week worked.
2. To enable any necessary change in the implementation process.
3. To explore ways of valuing the self.

Interventions:

Welcome

The usual welcome was given with the opportunity of participants commenting either on the session of the previous week or on anything that they would want to share with the group as a whole before working in their own individual groups.

Outline for the Day

A general outline linking what was presented during the previous session, and the suggested work to be done during the week with the plan for today was given by one of the leaders. Presentation of the outline for the day was sensitive to the fact that some participants could be excited about what they had tried and how it had worked, and some participants may have tried and be feeling quite despondent because whatever they were expecting had not worked. It was important to be

aware that in all probability a mixture of the two experiences was likely, and that there needed to be no judgment or expectation portrayed in what was said.

Exercise One

This took place in the small groups where each group leader received feedback from participants as to how the affirmation implementation plan had worked. Difficulties experienced were discussed as was how people responded to the changes in participants. Some participants put their affirmations into practice by showing others their changed thinking, while others used the opportunity to repeat the new and positive message within their mind. The awareness of how change in the participant was affecting the system within which she lived was very important. Very often the participant was not aware of the implications of her becoming more assertive, and some of the consequences could be negative for her. It was still her responsibility to choose whether she was going to put them into action or not, but it was the leader's responsibility to facilitate insight as much as possible before the participant got herself into situations that she did not expect and did not want. If the participant had done some of the implementation in the form of change of behaviour towards others, it was important to enquire about what that change was doing to the participant. For

example, if the participant was behaving in a more assertive manner towards the spouse, how was this being responded to? Was that creating more arguments? Was it creating a dangerous situation? At all points in time it was stressed that the responsibility for the choice of response remained with the participant. Leaders were not there to say how things should be done or to give a list of prescribed behaviours. The purpose of the programme was to create insight, and through that insight to enable participants to feel in a more powerful position to choose how to relate and respond to others around them. It was important to keep a systemic awareness throughout this exercise.

Break

The usual break took place at this point.

Exercise Two

Objective 3 – *to explore ways of valuing the self* – was the purpose of Exercise Two. In the small groups the leaders led sessions questioning the following:

- how do you value yourself?
- what characteristics do you value about yourself?
- how do you show yourself that you value yourself?

- how much time do you give to yourself?
- do you expect respect and value from others, or are you a doormat?

These questions were asked to facilitate thinking regarding self care. In most cases participants didn't ever think of themselves as people that they could show their own value to, or that they did something for. The idea was foreign to many of them. The rationale for this exercise comes from Rogers' work, the purpose being to have participants able to give themselves positive regard, and acknowledge the value that they have. The positive regard from others received as a child, that became self-esteem has either gone through a depleting phase or was never well established. Either way, participants are needing to increase the positive regard. As adults the opportunity to receive positive regard from others in high quantities is rare; by adulthood, the positive regard, turned to self-esteem should have been internalised. If the participant can gain insight of skills of how to give herself positive regard, this will allow for the increase of her self-esteem.

It was intended that by the end of the exercise each participant would have chosen one particular way in which to start the process of valuing themselves. Suggestions included a five minute slot

every day where the participant would sit down with a cup of tea, be able to say to themselves that they are important to themselves, that they are valuable, that they deserve to spend some time with themselves. It was also recommended that this was done at the same time of day to make it into a regular feature of every day. If the participant was able to look at more than one way in which to value herself, that was encouraged. Once the work had been finished in the small groups, all gathered in the big group, and general feedback was given by the leaders. At this point leaders also expressed anything they felt would be of value to the group, this was a way of bringing back focus to the groups as a whole.

4.2.6 Session Six

Aim: To create a balance between the 'heavy' emotional and 'fun' aspects of self awareness and self management.

Objective: That each participant have the opportunity to obtain information and advice on their colour coding, make-up, clothing styles and body shape.

This session was a very different session to the others. It was called the 'colour session' and what happened was that a colour consultant took the content, and ran the group for the day. She did a colour coding of each participant suggesting what colours would suit, what

colours could be used to emphasise or to portray a particular mood. She also gave advice on shape of clothes that would suit the participant's particular body shape. It was a very light session in contrast to the heaviness of working with past emotional issues. It was a fun session and the rationale for bringing colour coding in as part of the self-esteem focus programme was in part to balance the heavy emotional aspect with some very practical fun sides, but also to demonstrate that taking more control of what happened in their lives could be done in complementary ways. Participants became aware of what colours suited, of what shapes of clothes would enhance their own natural beauty, and this was all in line with the overall objective of the programme, namely that through insight the participants were better able to manage their lives. Through insight whether that was insight and understanding of how particular behaviours in the past were affecting what currently happened, or whether that was insight in the form of recognising that certain colours made them more noticeable if that's what they wanted to do, all that insight enabled the participant to have more say, to take more responsibility, to have more control in deciding what to do with their life. By helping the participants look and feel better it was felt their self-esteem and self belief could be enhanced, a central theme to the programme.

4.2.7 Session Seven

Aim: To consolidate the positive self-image and value of self.

Objectives:

1. To look at progress regarding implementation of the new message and the new ways of valuing the self.

2. To consider further options in the implementation process.

Interventions:

Welcome

The usual welcome and enquiring about comments took place.

Exercise One

There was the review of what had taken place two weeks previous, since the previous week had been the colour session, and therefore no work on the implementation or finding out about how messages were being dealt with had taken place. In Exercise One of the session, the participants in their small groups with the health visitor fed back on how they managed to value themselves over the previous two weeks. Feedback was given as to what had been decided, the actual way in which they were going to do it, whether they had been able to take their five minutes for a tea break (or whatever else they had decided) and whether they actually managed to do that or not. In cases where they were not able to do it, the leader helped look at what had stopped them and whether there was another way of giving themselves time. The difficulties experienced were discussed and again, ways in which those difficulties could be overcome were debated.

Exercise Two

This was another recapping exercise asking how the repetition of the new message was being put into practice. Was this message still being repeated, or did the focus of taking care of themselves replace repetition of the new message and therefore them not maintaining a positive self-image? Because there had been effectively a two week break due to the colour session, it was far more difficult to keep aware of the need to repeat the new message than it had been during the week following session five. This difficulty was used to highlight the fact that unless clear reminders are in place to keep focused, it was very easy to revert to the old way of thinking.

Break

The break then took place in the usual way.

Clarification

After the break clarification of possible ambiguities took place. The first one concerned itself with the temptation to blame others for what had gone wrong in the past. It was explained how dangerous this could be and not the purpose of the exploration. The purpose throughout the programme had been one of understanding, not one of blame. A discussion took place as to what was achieved or not through blaming and the importance of understanding rather than blame.

The second point was to emphasise the belief that every person has value. It was mentioned that it may be that some of the participants would feel that unless they had many of the 'being' characteristics that were spoken about at times during the programme, that they were not valuable. It was reinforced that the emphasis was not on comparison between people, but rather on the belief that every person regardless of ability, has a value.

The third point requiring clarification was through their insight into how many people in their past had an impact on their lives, it sometimes became very scary to realise how much impact they as parents had on their own children. The emphasis here became on the awareness as being the biggest strength. If they as participants were aware of what they were doing they were then in a position to change it and that was what made the difference. All people do things that they regret at times and if aware they then have the possibility of changing that behaviour.

The fourth point that was discussed was that sometimes all the messages from the past could feel incredibly overwhelming. In the programme we had taken one and tried to unravel it. When in the future they felt this overwhelming feeling of the

many different aspects of messages coming in together, the important thing was to try and pick up one part and follow the procedure that we had done in the group.

Exercise Three

This exercise was attempting to go beyond the end of the programme. It attempted to enable participants to look somewhat ahead and be aware of situations that were likely to be particularly difficult, where some preparation would assist in handling those situations. Often participants would come up with occasions such as Christmas or family functions where it would be particularly difficult to give themselves the new message, or to value themselves. This exercise provided the opportunity to discuss possible difficult situations and attempt putting something into place to either avoid them or to handle them in a better way.

Rationale for interventions used to achieve the objectives:

Both objectives in session seven were to do with consolidation. Often participants found it easy to understand why certain behaviours were taking place, but to go back into the real world and change those behaviours was a far more difficult process. That was the reason why a number of weeks of the programme were dedicated to consolidation. Through this participants were able to go back into their families and try things out, get a feel of what it was like for them and what reactions they received from others around. They were

then able to come back and to get feed back on that; if ideas were going wrong the opportunity to reformulate was provided.

4.2.8 Session Eight

Aim: To bring the group to a close.

Objectives:

1. To assess how the process of change had been put into practice.
2. To explore maintaining the effects of the change.

Interventions:

Exercise One

In the small groups the health visitors and participants gave feedback on a number of items that they had been doing throughout the previous weeks.

The first aspect that was considered was 'care of self'; how had they managed it throughout the week? How were they planning to continue to take care of themselves after the end of the programme? Times when it was going to be difficult for them to take care of self was also considered and discussed.

Secondly, had they been able to repeat the new message and were they being able to put it into practice? What about the future? Were they

going to be able to continue to remind themselves?

Item three concerned itself with checking if there were things about any of the sessions that didn't quite tie together or that didn't make sense. This was an opportunity to enquire and to try to make sense of the programme as a whole.

The fourth was to identify situations that would be particularly difficult to put the new messages into practice, and what strategies had they thought about in order to help them with that. This exercise was yet again consolidating but with emphasis on 'how are you going to carry on doing this after the end of the programme?'

What followed was the discussion of the content of the reminder sheets. (Appendix D). The reminder sheets set out the different stages of the process that had been undertaken in the programme so that if they wanted to try to unravel some other message in the future they had something to remind themselves of the stages to go through. The second sheet was a reminder about taking care of themselves and how important it was to give themselves positive and affirmative messages, also how important it was for them to use the insights in as best a way as possible.

Where to from now?

As the programme progressed, some participants became aware of other problems that they wanted to address. This slot of 'where to from now?' gave information to all participants as to what was available depending on what they felt they needed next. For most the eight week programme had been valuable and provided what they had expected. Information about the ongoing monthly meetings was given. It was explained how reminder letters would be sent out to them once a month informing them of the topic for the following meeting. They had the opportunity of putting their names on the mailing list if they so wished. Others felt they required further help – and for these information regarding available services was given.

Break

The usual break for refreshments then took place.

Filling in of questionnaires

After the break the two questionnaires used in the research, the Rosenberg and the Pearlin and Schooler were given out for participants to complete. They were also asked to complete a views and opinions form. (Appendix E) Questions there included asking for what had they found most helpful, what had they found least helpful, various aspects about the programme, did they find it easy

or difficult to follow: in general, feedback as to how the programme was received by participants. Once questionnaires were all filled in, the last exercise, the balloon exercise, was done. Each participant received a sheet of paper with a diagram of balloons where messages could be written inside the balloons. A copy can be found in Appendix F. Participants were asked to write their name in the box at the bottom of the paper and to leave their sheet of paper on their chair. Everybody was then asked to go around to each individual sheet and write something for the person whose name appeared at the bottom. They were asked to write something that they had appreciated or that they had valued in that person. That could be anything – it could be their smile, it could be any particular characteristic that they appreciated and so everybody wrote something for everybody else in the group. At the end each participant could then get a feel of what others in the group had appreciated or had valued about them and this was something that they could take home. It was a memento from the group indicating various aspects that people did like about them or that they had valued. As the group came to a close, after the balloon exercise, people bade each other farewell.

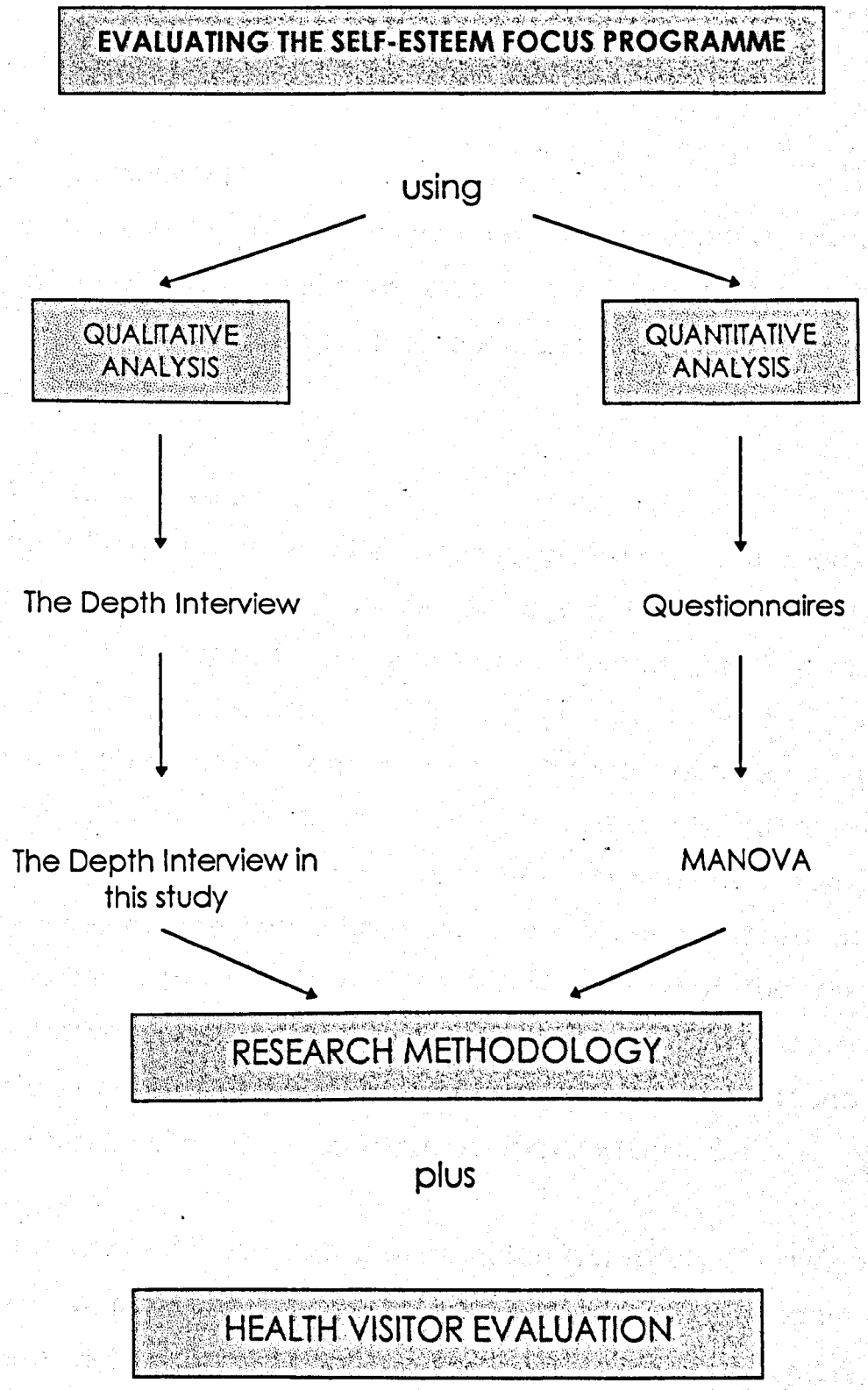
Rationale for interventions used to achieve the objectives:

The rationale for this session's interventions was in keeping with that of session seven: the consolidation of the positive image; the

consolidation of the valuing of self; the addressing of situations that could make the new insights difficult to implement; and giving participants the opportunity to make changes for the future. This session was in line with the closure stage of the group: looking at the future, of looking at how to close a process that had been going on for eight weeks. The reminder sheet, the where to go slot, the completion of questionnaires, the balloon exercise, these were all activities, leading to and helping with the closure of the group and the closure of the programme.

CHAPTER FIVE

Schematic Representation



CHAPTER FIVE

EVALUATING THE SELF-ESTEEM FOCUS PROGRAMME

5.1 Introduction

The Self-esteem Focus Programme was evaluated using both qualitative and quantitative measures. What follows is a brief overview of the research methodologies and the specific aspects used in this study.

5.2 Qualitative analysis

Qualitative research has often been regarded as a 'soft approach' in scientific investigation (Chapple & Rogers, 1998), attracting much criticism from supporters of quantitative methods (Sellitz et al., 1964; Miles, 1979). Silverman (1993) distinguishes between positivism (quantitative methods) and interpretive 'schools' of research in social science. Interpretive social science embodies qualitative research which generates hypotheses using meanings derived from social observations. The two schools have often been defined as polar opposites with quantitative researchers dismissing the merits of qualitative data, and qualitative researchers criticising quantitative data as neglecting the enriching evidence that can be found in the observation of social behaviour, meanings and attitudes.

Authors have defined qualitative research in a variety of ways, ranging from "a particular tradition in social science that fundamentally depends on watching people in their own territory" (Kirk & Miller, 1986, 9), to it being described as closely related to common sense (Robson,

1993). Huberman & Miles (1998) define qualitative data as words and text based on methods of study such as observations and interviews, executed in the field. They can be unstructured, such as open ended interviews, or structured and guided by the researcher, such as questionnaires. Nicolson (1995) describes qualitative research as useful for exploring human social behaviour and the development of psychological issues, as well as being able to complement quantitative research when used in conjunction with each other.

Criticism levelled against qualitative research include the fact that there are no standard rules applied to the use and analysis of qualitative methods, as there is no agreement regarding how to ascertain validity and reliability of a piece of qualitative research (Huberman & Miles,1998). This results in qualitative methods often being viewed as ambiguous and even unreliable (Silverman, 1993).

The advantages of qualitative methods, as recorded by Hammersley & Atkinson (1983), are that research conducted in the field can give a more detailed and dimensional view of the research in question, as opposed to simply finding relationships between variables. The lack of constraint placed upon field research allows for the expansion of the theory to be "pursued in a highly effective and economical manner" (p. 24). Silverman (1993) states that "unlike other research which usually shares a common model, field research depends on a *variety* of theoretical positions with very different implications" (p. 28) thus suggesting that qualitative research is not as superfluous as purveyors of quantitative research would want to emphasise.

Qualitative data analysis is essentially about detecting links and providing coherence and structure to complex presentations of data.

Whatever method is used it should be chosen as a result of the facilitative properties it holds to achieve the desired goal. Qualitative data analysis can be used to define concepts, mapping the nature and dynamics of a phenomenon, creating categories, finding associations, seeking explanation and developing new ideas. (Ritchie & Spencer, 1994)

There are some authors who view the dichotomy between positivism and interpretivism as simplistic and unhelpful (Silverman, 1993), preferring to combine the two forms of research, when appropriate, to produce more balanced and multifaceted results. Central to determining which method/s should be used in a particular piece of research, should be what is being sought from the research. Despite the difficulties, qualitative research can be a valuable tool, either as the main form of interpretation or in tandem with other forms of research, adding colour and depth to the final analysis.

5.2.1 The depth interview

The depth interview is one of the methods used to collect qualitative data. It is a conversation whereby an interviewer encourages an interviewee to relate, in his / her own terms, experiences, attitudes or feelings related to a particular subject of research (Walker, 1985). Jones (1985) describes the interview process as a "complicated, shifting, social process occurring between two individual human beings which can never be exactly replicated" (p.48). Although qualitative research characteristically lacks clear rules and structures, various authors have suggested guidelines regarding the formulation of interview questions, conducting the interview, and finally analysing and presenting the results.

5.2.1.1 Formulating the interview

What ultimately constitutes the format of the depth interview depends on the nature of the research topic and on the particular information sought about it. Jones (1985) refers to essential aspects that need to be kept in focus when formulating the depth interview. These include the degree of structure versus the degree of ambiguity incorporated in the questions; interviewer bias as an aspect not to be avoided, but rather to be used creatively and consciously, and the social situation in which the research is taking place including the relevance that the research has for the participants. All of these require detailed consideration as to the possible impact each will have on the collection and use of data. Furthermore practical constraints such as time, energy, money and organisational demands should be taken into account as to how these affect the formulation and implementation of the research.

Robson (1993) refers to a 'conventional sequence' structure of the interview process consisting of five stages. The introduction stage includes not only the interviewer introducing him / herself but also allows for the opportunity to give any explanations that may be necessary, asking permission to tape the interview and answering any questions that the interviewee may have. The second or 'warm-up' stage consists of non-threatening questions aimed at getting both interviewer and interviewee into the pattern of what is to follow, which is the third stage or main body of the interview. This third stage covers the main purpose in the interview, where questions pertaining to the central themes of the research are asked. The fourth, named the 'cool-off' stage consists of a few ending questions, usually related but not central to the main enquiry. The fifth and final stage is the 'closure' incorporating thank you and goodbye.

Regarding specifics of depth interviews Robson (1993) refers to a number of details that should be kept in mind. Long questions, questions with many parts, leading questions and the use technical language should all be avoided. Open ended questions are generally used in depth interviews giving participants greater opportunity to answer questions as freely and as openly as they wish (Jones, 1985). The interview format has the benefit of the 'question-answer adjacency pairs' whereby the interviewee feels obligated to answer when asked a question (Silverman 1993).

5.2.1.2 Conducting the interview

The interviewer should appear neutral throughout the interview process. Fontana & Frey (1998) point out that long explanations regarding the research study should be avoided, and that the interviewer should not stray from the given introduction, question sequence, or wording. The interview should not be interrupted, and only the interviewee should answer questions. They further say that the interviewer should not help with answering questions neither should s/he voice agreement or disagreement regarding answers. The interviewer should not attempt to interpret the meaning of a question, but instead simply repeat the question, and if necessary provide any instructions that were given in training.

5.2.1.3 Analysing the data

Adequate recording of interview data is essential, audio taping being the method most favoured and to subsequently transcribe the interviews. Transcripts are viewed as extremely reliable accounts, indispensable in research involving depth interviews (Atkinson & Heritage, 1984; Kirk & Miller, 1986).

Depth interviews can be analysed in a number of ways. The most common method used is the identification of themes, categories, codes and comparisons (Mishler, 1990; Robson, 1993; Miles and Huberman, 1984). Central to qualitative analysis is the detection of links between aspects or components of the data available. Miles and Huberman (1994) advocate the search for patterns and themes, making sense of the information available by grouping the data, counting the inferences made in order to assess the frequency of a category, making comparisons, and examining the relationships between different categories.

Another method used in the analysis of depth interviews is cognitive mapping. This involves modelling a persons' beliefs in diagrammatic form. It is primarily used when "seeking to represent persons' explanatory and predictive theories about those aspects of their world being described to us" (Jones, 1985, p.60). Two elements are essential in a map: the persons' concepts of whatever is being researched, and their beliefs or theories about the relationship between them.

Content analysis, another method in qualitative research, is most often used when analysing documents, primarily written documents, but also applicable to non-written documents such as films and television programmes. Robson (1993) describes the technique as 'codified common sense', and suggests that it is comparable to structured observation, whilst Krippendorf (1980) states that "content analysis is a research technique for making replicable and valid inferences from data to their context" (p.21). Jones (1985), however, refers to content analysis in the context of depth interviews - a process requiring categorising data in sentence, phrase or word form. Whatever unit of

analysis is chosen, frequency of use is calculated and comparison between categories made, leading to the development of further definition of the research topic.

In conclusion, whatever aspect of qualitative methodology or analysis is considered, one theme is consistent: an intransigent belief as to the best method is inappropriate. The method ultimately chosen should be determined by its facilitative qualities and its ability to provide answers to the questions asked.

5.2.2 The depth interview in this study

A total of eleven depth interviews were conducted and analysed for this section of the present study. All interviews were conducted between nine and eleven weeks after completion of the Self-esteem Focus Programme. It was taken that any changes that took place as a result of the programme and still experienced ten weeks later, could be considered as more than a fleeting effect.

Although attending the programme at different times, all participants had done so within the same locality, and as a result had all been exposed to the same health visitors and researcher. This was planned to minimise the effect of any possible differences in presentation style between the different groups of professionals leading the programme in each of the three localities involved in the study.

5.2.2.1 Formulating the interview

The main purpose of the depth interview was to ascertain whether participants experienced a change in their concept of self, with specific focus on the worth of self as described by Rogers (detailed in section 2.3.3), as a result of their participation in the Self-esteem Focus

Programme. Consequently, the questions forming the main body of the interview focused on the comparison between how they saw themselves before and after the Programme. The comparison extended to behavioural changes regarding relationships, but including changes in any aspect of their life, after attending the Programme. Furthermore, there was an interest to discover which themes emerged from participants themselves as to how they experienced the Self-esteem Focus Programme and what impact it had on their lives.

The questions were purposefully structured to be specific in some ways as clinically there were questions that needed to be answered, yet open-ended in others. If the Self-esteem Focus Programme was to be delivered as part of a collaborative health visiting - psychology service beyond the research phase, it was essential to identify the benefits for participants and their families, in behavioural terms. It was also essential to identify the impact of such benefits on health visitor case loads. If, for example, participating in the Self-esteem Focus Programme enabled mothers to react towards their children or themselves in such a way as to require less need for health visitor time, then that in itself would justify health visitor involvement in the Programme.

The questions were open-ended allowing participants the freedom to answer in whatever way was relevant to them. This enabled further themes to emerge from participants' responses in addition to the ones identified by the researcher. The questions however, were also specific in the sense that particular information was required on the two main themes central to the study, namely, change in self concept, specifically related to feelings of self worth, and change in

behaviour, specifically in the area of relationships with spouses / partners, children and any other significant others. For each of the three main questions, a number of related questions could be used to explore the themes further, if necessary, as indicated in the depth interview format (Appendix G)

The overall structure of the interview followed Robson's (1993) proposal of 'conventional sequence', as outlined in section 5.2.1.1; all other recommendations regarding questions were also adhered to. The essential aspects referred to by Jones (1985) were incorporated into the formulation of the interview. Mention has already been made regarding what determined the combination of structure and open endedness of questions formulated for this study. The situational context was one where from the professionals point of view, there was a need to show management that the programme worked. The researcher assisted with the formulation of the questions but did not conduct the interview; this was done by a psychologist not involved in the programme. The bias was there in that questions were asked and if not answered, probing questions could then follow. Since the results of the research were very linked to the continuation of the running of the programme, it was one of the essential aspects to take into account as part of the research. The research was done for clinical reasons and the practical constraints were very much kept in mind. Regarding relevance for the participants, there may have been an over positive effect in that they wanted this to carry on.

Three questions formed the nucleus of the interview, they were:

1. *How did you see yourself before you attended the group? I am referring to you as a person, rather than what you are good at doing.*

2. *If you look at yourself now compared to the person you were before attending the group, what do you see?*
3. *Can you give me some practical examples of how in your life you are different since the group?*

5.2.2.2 Conducting the interview

All interviews were conducted by the same interviewer, who had not been involved in the formulation or delivery of the self-esteem focus programme. Since the main questions of the depth interview concentrated on participants personal judgements and feelings regarding the programme, it was seen as essential that the interviewer be someone neutral, thus avoiding participants potentially feeling compromised in their responses. All interviews were audio taped, numbered as outlined in section 5.4 for confidentiality purposes and subsequently transcribed for analysis.

Half the interviews were conducted on NHS premises and the others were conducted at the subjects' homes. Although NHS premises were the first option, for some participants practical reasons made it difficult for them to attend. In those cases, the interviewer conducted the interview in the subject's home. The recommendations made by Fontana & Frey (1998), with regard to interviewing techniques and noted in section 5.2.1.2, were adhered to throughout the interviews.

5.2.2.3 Analysing the data

Only responses to the questions forming the main part of the interview were analysed. Questions regarding how participants had come to know about the Programme and their recommendations for any change were not used in the analysis. Two main categories were created as a result of the interview formulation - self concept and

behavioural change. Sub-categories of behavioural change comprised change in ways of relating to children, spouse / partner, others and self. Since the analysis was one of comparison, each of the categories were further divided into 'before' and 'after' sub-categories. Participants comparisons of how they saw themselves before and after the intervention were annotated (table 6.2), as were changes in ways of relating to the various sub-categories mentioned above (tables 6.3 - 6.6). The more ambiguous third question gave rise to a number of new categories - participants mentioned ways of coping, links between past and present, and degrees of isolation. In addition, a comparison of the expressive language used when referring to experiences and feelings before and after attending the Programme was made.

5.3 Quantitative analysis

Quantitative data refers to "the results of any sort of measurement" (Howell, 1997, p.3), be it people's heights, grades on a test or scores on a self-esteem questionnaire. The school of social science which is associated with quantitative research is positivism, which is generally seen to be more concerned with society than the individual (Silverman, 1993).

Quantitative research monopolised research methods in the early and middle history of the social sciences. The theoretical principles of quantitative research, outlined by Sarantakos (1998), include:

1. There is only one reality - it is objective, simple and positive.
2. Any research method whose data cannot be replicated, verified and retested, is seen to offer unreliable data and to have no empirical relevance.

3. The construction of knowledge is seen to emerge from explicit, exact and formal procedures in defining concepts, and their measurement amenable to reassessment by other researchers. Only then can conclusions be accepted, rejected or modified.

Criticism levelled against quantitative analysis include that its measures fail to capture the essence of social behaviour. Qualitative researchers argue that the methods used for quantitative investigation distances the research object from its social context, and that research should rather follow real life situations as they happen. Quantitative analysis is also seen to be more interested in the method of research rather than in the subject being researched. Objectivity, which is considered to be the most important aspect of quantitative research, is not feasible according to qualitative researchers. They assert that objectivity is not possible, that standardisation transforms the natural, social world into an artificial one, and that often the researcher is required to step into the shoes of the participant and view life as it is viewed by the participants themselves (Sarantakos, 1998).

5.3.1 Questionnaires as a form of quantitative analysis

Questionnaires are the most widely used form of data collection in social-psychological research. They are especially useful in gathering information from large numbers of participants, incur minimal expense and are comparatively anonymous, a desirable characteristic particularly when researching a sensitive subject (Manstead & Semin, 1996). Questionnaires usually consist of a number of statements pertaining to a particular attitude; participants are required to indicate where they would place themselves, regarding that attitude, on an

interval scale. Scales constructed in this way are normally known as Likert Scales, the name derived from the developer of the technique, Robert Likert (1932). Each alternative on a Likert scale receives a score, depending on the respondent's degree of disagreement or agreement with the item. The sum of the scores on all the items provides a good indication of where the person stands on the attribute (Eagly & Chaiken, 1993).

5.3.2 The t-test

The *t*-test is a mathematical calculation which compares the means of two sets of scores. It is used to examine whether the difference between two sets of scores is due to chance or whether the difference can be attributed to the effect of an intervention. In order to use the *t*-test, the data must be normally distributed and scores used must be interval or ratio in nature. Comparisons can be made between dependant (paired) samples or independent ones (Fink, 1995).

The *t*-test is calculated by comparing the differences in scores to the total variance in the differences between scores. The statistic *t* represents the magnitude of the differences between participants' scores in both conditions. For this statistic to be significant, the observed *t* value must be equal to or greater than the critical *t* value (Greene & D'Oliveira, 1982). In the present study the *t*-test was used in conjunction with multivariate analysis of variance to compare scores obtained on the self-esteem questionnaires at four different times on the four measurement scales (dependent variables).

5.3.3 MANOVA

Multivariate analysis of variance (MANOVA) is an extension of the two sample t-test, designed to assess whether differences between sample means involving multiple dependent variables are significant (Diekhoff, 1992; Howell, 1997). The repeated measures MANOVA design was used in this study since the scores obtained were repeated measures of the same participants at different points in time.

5.4 Research methodology

Participants

All 45 participants involved in this research were mothers on health visitor case loads. In some instances, mothers were on the case loads of the health visitors involved in the delivery of the eight week programme whereas in others, mothers were referred to the programme by other health visitors in the Trust. The ages of the participants ranged from early twenties, to late thirties. The acceptance criteria was broad. Participants ranged from mothers who had asked for help in the area of self-esteem and confidence building, to mothers with whom health visitors had facilitated the awareness of the connection between past experiences and current behaviour, and recommended attendance on the programme.

The participants came from three geographical areas covered by the Trust. Four groups consisted of participants from one locality, five groups from the second, and one group was formed by participants living in the third area. Each group varied in the number of participants. Each participant was given a client information sheet containing details of the research. Since the programme ran primarily as a service and not as a research project, it was possible to attend the 8 week group but not take part in the research. Copies of the two

client information sheets and consent forms can be found in Appendices H - K.

All 45 participants completed questionnaires for the research. Of these

8 discontinued after time 2, leaving

37 who participated in the programme; of these

4 discontinued after time 3.

Put another way,

8 completed times 1 & 2 only

1 completed times 1, 2 & 3 only

22 completed times 1, 2, 3 & 4

11 completed times 2, 3 & 4 only

3 completed times 2 & 3 only

Participants who dropped out after time 1 have not been included.

Design

The research investigated the effects of the self-esteem focus programme on two variables: self concept and self-esteem. The intervention was the Self-esteem programme itself, and the dependent variables were the measures of self concept and self-esteem. The degree of change in self concept was measured using qualitative analysis on the depth interview, as detailed in section 5.2.2. The degree of change in self-esteem was measured using quantitative analysis on scores obtained through the use of questionnaires. The scores being compared were of the same participants at different points in time. It was considered that change as a result of the Programme could occur in both directions, and therefore the *t*-test computation chosen was the two-tailed for paired samples.

Although 45 participants completed questionnaires, only 22 did so over all four testing times. Of these, two participants left some questions unanswered as a result of which their scores could not be incorporated into the MANOVA calculation. The MANOVA calculation therefore refers to only 20 participants, 54% of the total number of participants that attended the intervention. Post hoc comparisons were done using the Bonferroni method (Kinnear and Gray, 1997). In order to include the scores obtained from the other 17 participants ordinary *t*-tests were performed on relevant time combination pairs, as outlined in the section *procedure* below.

Instruments

The self concept variable was measured using a semi structured, depth interview; details regarding the formulation, execution, and analysis of the interviews can be found in Section 5.2.

The self-esteem variable was measured through the use of two questionnaires, the Rosenberg Self-esteem Scale (Appendix L) and the Pearlin and Schooler Psychological Coping Resources Questionnaire (Appendix M), comprising three factors: self-denigration, mastery and self-esteem. The Rosenberg is a ten-item scale, internally reliable, unidimentional, with face validity and high test-retest reliability (Rosenberg, 1965). The Pearlin and Schooler Questionnaire is a 16-item questionnaire, 4 of which are concerned with self-denigration, 6 with mastery and another 6 with self-esteem. Psychological resources were defined by the authors as "personality characteristics that people draw upon to help them withstand threats posed by events and objects in the environment" (Pearlin & Schooler, 1978, p.5). The resources reside within the self and form effective barriers to the

stressful consequences of social strain. Three such resources were incorporated into their analysis of life-strains, forming the three dimensions (self-esteem, self-denigration and mastery) used in this study. The structured questions used were closely developed from exploratory interviews and subjected to factor analysis, leaving the authors satisfied that the items were conceptually meaningful (Pearlin & Schooler, 1978). Both questionnaires were chosen due to their direct relevance to the subject being analysed and investigated.

Procedure

The procedure followed for the measurement of the self concept variable has been outlined in detail in section 5.2.2. For the measurement of the self-esteem variable, participants were required to complete questionnaires four times during the research process. These were as follows:

time 1 - 2 months before commencement of Programme
time 2 - immediately before commencement of Programme
time 3 - on completion of Programme
time 4 - 6 months after completion of Programme

Inclusion of participants in the waiting time (time 1) measure depended on practical realities, namely that if the referral was made more than 2 months before commencement of the Programme, participants could be included in the 'while waiting' measure. The waiting time, namely 2 months before commencement of the Programme was chosen to match the duration time of the Programme which was 8 weeks. This was done to assess if there was any change in the dependent variables purely as a function of time.

The rationale for completing questionnaires before commencement and on termination of the Programme is self evident: evaluating the effect of the intervention was a crucial measure. The six months after completion of intervention testing time was chosen partially for practical reasons: all questionnaires could be completed within the time allocated for the completion of the research. Furthermore it was also considered that effects still evident 6 months after completion of the Programme, could be seen as significant. The scores obtained by each participant at the various times were collated (Appendix N). Both multivariate analysis of variance and *t*-tests were used in the analysis of scores.

Post hoc comparisons and *t*-tests were performed on the following pairs of scores / time combinations:

- time 1 / time 2 i.e. waiting / pre-intervention time
- time 2 / time 3 i.e. pre / post intervention times
- time 3 / time 4 i.e. post intervention / 6 months after completion of intervention
- time 2 / time 4 i.e. pre-intervention / 6 months after completion of intervention.

In order to measure the self concept variable, a total of 11 depth interviews were conducted. All interviews were carried out between 9 and 11 weeks after completion of the Self-esteem Focus Programme. The interviews were recorded using audio equipment, transcribed, and analysed using qualitative methods. A full discussion of the implementation of the 8 week programme can be found in Chapter Four.

An important concern during the research process was the assurance of anonymity for each participant. In order to ensure this, a set of stickers, each marked with a number followed by various codes was created. The stickers were placed in unmarked envelopes, and before the first questionnaire was filled out, the participants were asked to select an envelope. They then used the appropriate sticker for that particular questionnaire, placed the remaining stickers in a new envelope, sealed it, and wrote their name on the envelope. At the time of completing the next set of questionnaires, the participants would open their envelope, use the appropriate sticker, and repeat the process of putting the stickers in a new envelope, sealing it, and writing their name on the envelope. In this way, all questionnaires and interviews had the same identifying (participant) number followed by the appropriate questionnaire, or interview, test time code. In this way no names were ever used.

5.5 Health Visitor Evaluation

Six health visitors participated in the delivery of the Self-esteem Focus Programme. Their evaluation was sought in the following nine areas relating to the Programme.

- Training for the programme
- Experience of working with clients in the programme
- Experience of working with other health visitors in the programme
- Experience of working with the researcher in the programme
- Their evaluation of the effectiveness of the programme
- Any impact it had on them professionally or personally
- What were the difficulties or negative aspects of the programme

- What would they like to see as the future of the programme
- Any other comments

Only five health visitors responded. Any percentages quoted in the following summary refer to percentages of the evaluations received rather than percentages of health visitors that took part.

Training for the programme

All health visitors described the training as valuable, with 60% commenting on the experiential aspect as being essential. Two (40%) of the five health visitors expressed they would have found it valuable to have observed the running of a programme before delivering one themselves. One health visitor would have appreciated more theoretical preparation, whilst another expressed that the training gave her the opportunity to reflect on her own upbringing and consider her own self-esteem. Three health visitors referred to the training taking place in a safe environment.

Experience of working with clients in the programme

All health visitors experienced working with clients in this method stimulating and rewarding. Individual comments included that it was a valuable learning experience with regard to the origins of low self-esteem and a very positive way of working with clients, especially as it was structured and allowed greater depth of work. One health visitor found that working with clients in this way deepened her own interest in the mental health of her clients, and the ensuing effect this could have upon the children. This health visitor reported that she was now able to use the experience gained through the programme in her work with clients at home on an individual basis.

Experience of working with other health visitors

Four of the five health visitors found working with colleagues in this way, to be a positive experience. Two commented that their confidence decreased at first when required to work in front of their peers, but that that was soon replaced by a feeling of support.

Experience of working with the researcher

Overall the health visitors found working with the researcher to be a rewarding, positive, and skill enhancing experience. One health visitor found the presence of the researcher 'de-skilling' whilst the comments from others included, in one case, that it was reassuring to know she had the researcher's expertise to fall back on if necessary, another found it extremely useful to be able to discuss the dynamics of the session with the researcher. A third health visitor commented that she did not feel undermined by the researcher's interventions during client contact or during debriefing, due to mutual respect between the two professions. Being able to blend the skills and working patterns had meant that the clients had been provided with a wider and more flexible form of intervention.

Evaluation of the effectiveness of the programme

All health visitors found the programme to be effective in producing positive change in their clients. One questioned the effectiveness of a particular exercise used in the programme and commented on how she would value more feedback from referring health visitors in assessing the effectiveness of the programme. Others gave concrete examples of changes they had noticed in their clients ranging from increased levels of self care, a more positive style of parenting and to some returning to employment.

Personal or professional impact

All health visitors experienced some impact at a professional level. As a result of the programme their workload increased, and they experienced a different way of working with clients which gave them both insight and skills into other ways of addressing a problem. All health visitors stated this had been a positive learning experience. At a personal level, two health visitors commented that they had experienced difficulty in arranging annual leave as a result of their involvement in the programme.

Difficulties encountered

All health visitors found the lack of managerial support to be a problem. Their participation in the programme increased their workload, and having to arrange accommodation, organise crèche workers and hand out the questionnaires put extra pressure on their limited time. Two health visitors commented on the high cost in view of the fact that there was a low rate of referral particularly after trust mergers and organisational changes. These difficulties will be discussed in detail in the next chapter.

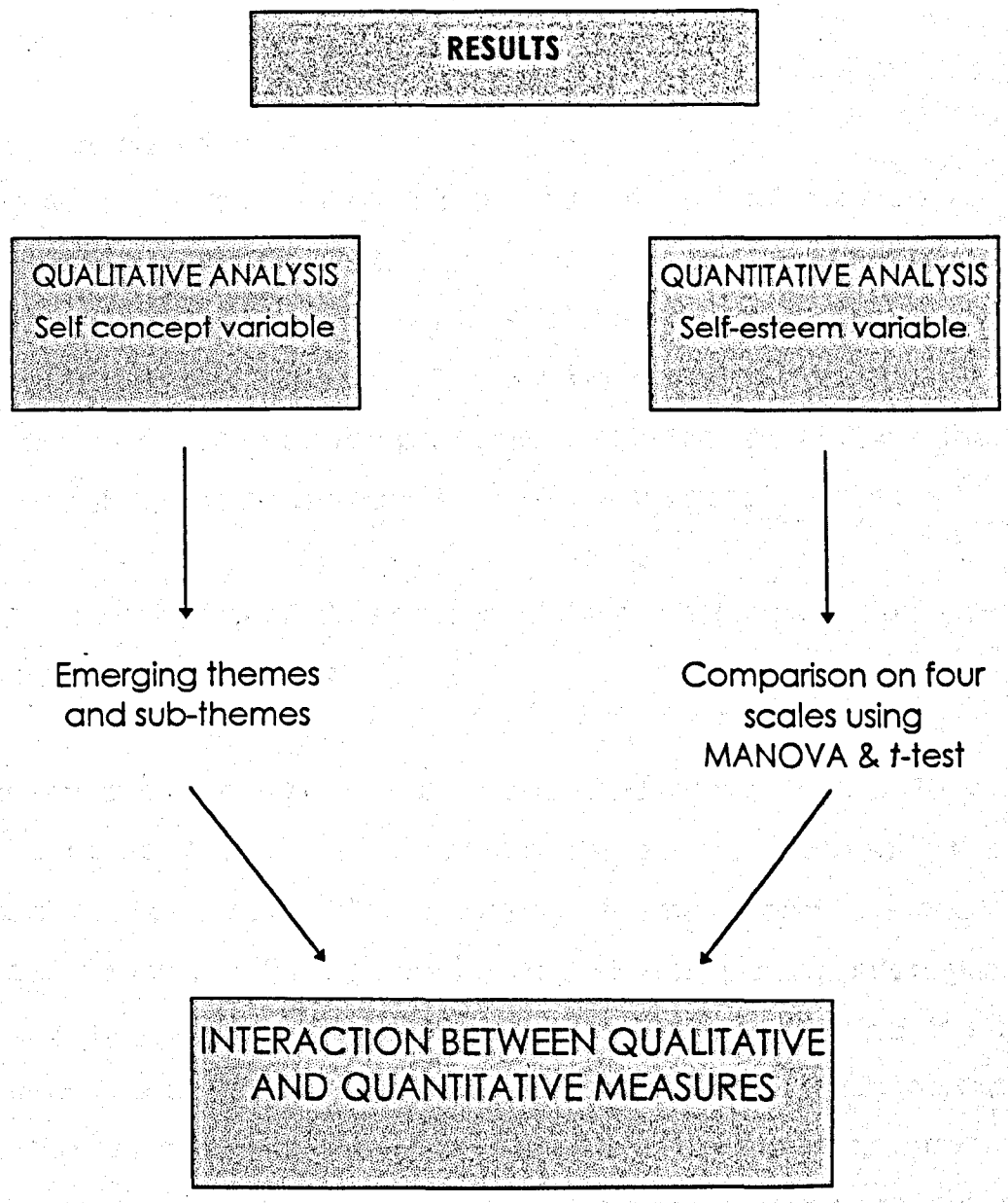
Future of the programme

All health visitors would like to see the programme continue its existence but with changes. Managerial support was a requirement mentioned by all, some seeing this in the form commitment, others in the form of funding and still others in the form of making this an integral part of the health visiting service. Other recommendations included that the programme should be provided for teenagers, for men and as a way of co-working with Social Services.

The following chapter presents the results obtained using both qualitative and quantitative analysis.

CHAPTER SIX

Schematic Representation



CHAPTER SIX

RESULTS

6.1 Introduction

The results will be presented in three sections. Each variable will be presented separately and evaluated using a different method of analysis; the third section will look at the interaction between self concept and self-esteem. This will be done by focusing on the responses from the eleven participants who took part in both the self concept depth interview and the self-esteem questionnaires.

6.2. Results of qualitative analysis of the depth interview on the self concept variable

Eleven depth interviews were conducted approximately 10 weeks after completion of the Programme. These were analysed in the first instance according to emerging themes, and secondly in accordance with the comparisons reported by participants regarding 'how they saw themselves' before and after attending the Self-esteem Focus Programme. As elaborated in section 2.3.3, the aspect of the self concept that was focussed upon in the Programme, was directly linked to Carl Rogers' view that each person has worth and dignity in their own right; that is the worth related to being a person regardless of levels of ability, social standing, educational attainments or any other attribute responsible for engendering feelings of self worth.

The depth interview was purposefully constructed to elicit responses regarding how participants experienced change as a result of the Programme in the following areas:

- how they saw themselves, with specific reference to their self worth and
- the effect that that change had on their way of relating to others.

6.2.1 *Emerging themes*

Analysis of the transcripts of the recorded interviews yielded the themes and sub-themes as shown in Figure 6.1.

The emerging themes were a combination of those elicited by the structured aspect of the depth interview and those spontaneously arising from the open-ended questions. The themes of 'self concept' and 'relationships' were asked for, for reasons mentioned in section 5.2.2.1, but the third theme, that of 'coping' emerged spontaneously. Within the 'asked for' themes of 'self concept' and 'relationships' the opportunity for spontaneous feedback was still available, the response to which can be seen in the emergence of the sub-themes of 'self worth', 'self confidence', 'normality', past-present link and isolation.

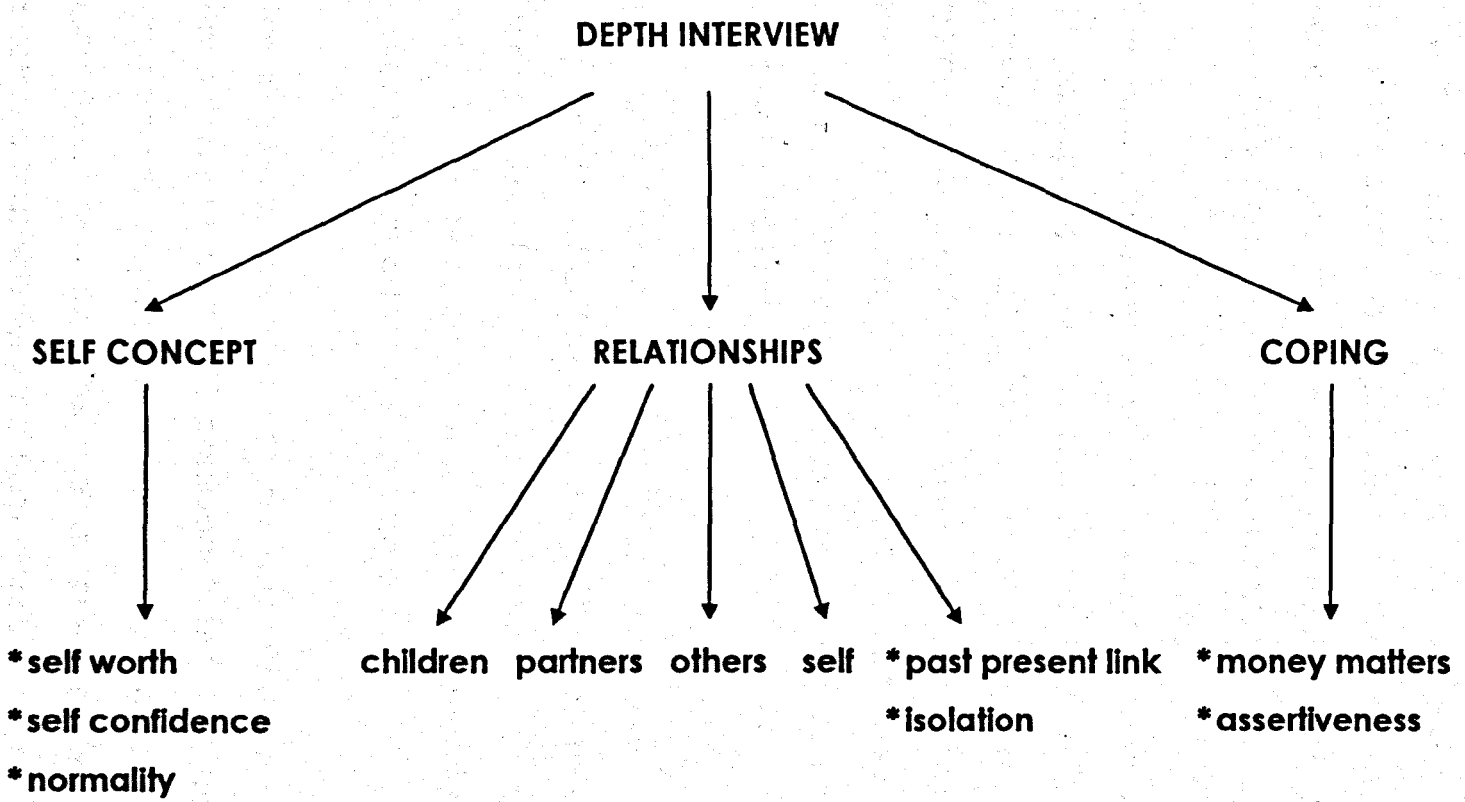


Figure 6.1. Themes and Sub-Themes Emerging from Depth Interview Analysis.

6.2.1.1 Self concept theme

The first theme or category, that of self concept, was one that was directly asked for, but the question was left vague enough to allow each participant to respond in whatever manner was meaningful in her experience. The three sub-themes that emerged can be seen as emerging directly from the participant's experience.

The first sub-theme relates to participants' feelings of self worth. Of the 11 participants, 9 used words such as 'insignificant', 'unimportant', 'worthless', 'hated themselves', to describe how they saw themselves before attending the Programme. The remaining two spoke about being 'overriden by guilt' and being 'full of nerves' respectively. Nine out of the 11 participants reported varying degrees of increased self worth after the Programme.

The second sub-theme, that of self confidence, saw a similar shift. Over half (6 out of the 11) of the participants mentioned their lack in confidence before the Programme, compared to the same number, although not necessarily the same people, mentioning higher levels of self confidence after the Programme.

The trend was repeated with the third sub-theme, namely, feelings of normality. Four of the 11 participants felt that, before attending the Programme, they believed there was something 'wrong' with them. One mentioned that she was a "complete wreck" whilst another disclosed that she suffered from depression and panic attacks, and felt on the verge of a nervous breakdown. One participant was convinced that she was "not quite right". Another participant confessed that she felt weighed down with guilt, which was compounding her other problems. Three of the four above-mentioned

participants reported improvement, specific to feelings of normality, following the Programme. Descriptions included, in one case, the participant stating she no longer saw herself as abnormal, and in the other two cases, mention of attitude change, feelings of calmness, more ablility to forgive self, more selfishness at times, and less compulsive, irrational and aggressive behaviour.

The terminology used when describing themselves before attending the Programme was negative in comparison to that used after attending the Programme. The range of vocabulary was limited and reflected despondency. Participants disclosed less information about their thoughts and feelings experienced prior to the Programme in comparison to the amount of information disclosed to the interviewer after attending the Programme.

Table 6.1 compares terminology used by participants when describing how they saw themselves before and 10 weeks after completion of the Programme. The number of participants that made use of the particular term is represented by the number in brackets.

BEFORE PROGRAMME		AFTER PROGRAMME	
Nonentity	[1]	Feels better about herself	[2]
Worthless	[6]	Not worthless	[1]
Useless	[2]	Worthy	[1]
Not important	[1]	A bit more confident	[3]
No confidence	[4]	More confident	[2]
Bit of a doormat	[2]	A bit more selfish	[2]
Full of nerves	[1]	Not as angry	[1]
Guilt feelings	[2]	"I am worth something"	[1]
Let people walk all over her	[2]	More calm (about problems)	[3]
Self-conscious	[1]	Feels a lot better (less depressed)	[1]
Shy	[2]	Stronger	[3]
Does not value herself	[1]	Better now than before the group	[4]
"A complete wreck"	[1]	Does not feel so bad about herself	[2]
Not as good as other people	[1]	Worthwhile	[2]
Hated herself	[2]	"I am different"	[2]
"Everything I said or did was insignificant"	[1]	Complete change of feelings and emotions	[1]
Felt that something was wrong with them	[4]	"I want to live my life...I'm going to live it"	[1]
Had the worth, but did not feel it	[1]	More confident with children	[3]
		I can speak my mind	[1]
		Opened up more	[1]
		Significant	[1]
		Living life more confidently than ever	[1]
		More happy	[1]
		Concerned about relapse	[1]
		"I feel like I am a person"	[1]
		"I know I deserve certain things"	[1]
		"I am a good person"	[1]
		Less angry	[1]
		Little bit less compulsive	[1]
		Bit more controlled	[1]
		Has learned to forgive	[1]
		Has days when still hates herself	[1]

Table 6.1
Terminology Used by Participants Reporting on Change in Self Concept Before vs 10 Weeks After Completion of Programme.

Table 6.2 contains participants detailed descriptions of how they saw themselves before, in comparison with 10 weeks after completion of Programme.

PARTICIPANT	SELF CONCEPT	
	BEFORE	AFTER
1	Felt she was a nonentity. Felt useless, no good, worthless.	Has realised that she is not the person that she thought she was. Not so negative about herself. Feels better about herself. Still trying to convince herself that she is basically worthwhile. "I'm a good person".
2	Felt unimportant. No confidence. Bit of a doormat.	Does not feel so bad about herself - more confident.
3	Full of nerves.	Attitude has changed, not as angry, and feels worthy. Feels a bit more confident.
4	Would allow people to walk all over her. Blamed herself for becoming depressed. Self-esteem was rock bottom.	Feels a lot better, much more calm, and realises that she is worth something, not only to herself but also to others. Has realised that she has value as a person.
5	Felt that she was not a person of worth if she was just staying at home with the children. She had no confidence, was a bit of a doormat, and shy.	She feels a lot better than she was. Has "a lot higher self-esteem" and a lot more confidence. She knows she is as good as other people, and describes this as a complete change of what you cannot really see.
6	Felt worthless and shy.	The group helped her to realise that before she had thought very little of herself. She does not really feel different about herself, but does feel more worthwhile.

Table 6.2
Detailed Descriptions of the Self Concept Before Vs 10 Weeks After Completion of Programme.

PARTICIPANT	SELF CONCEPT	
	BEFORE	AFTER
7	Did not feel worth anything to anybody. She hated herself, and had low self-esteem.	Feels a lot better. She has opened up more, has feelings of self worth, and has realised that she is a person. She feels worthwhile, and has a bit more confidence.
8	Her message was "I am insignificant". Nobody took any notice of what she said, and she felt everything she said or did was insignificant to others. She was also walked over.	Doesn't give a damn, is significant, does matter what she says. She is probably living life more confidently than she ever has, although she still worries about being set back. "I want to live my life...I'm going to live it."
9	Weighed down with guilt - and this compounded the other problems. She felt she was a person of worth, but her behaviour probably did not reflect this. She felt just as important as everyone else.	Acknowledges the fact that she is good; she may have faults, but that is all they are. She is more open, and more loving. She is less angry, and irrational. She knows that she deserves things, and is able to accept herself for who she is. The group helped her to stop feeling guilty and she is more focused. She is more forgiving towards herself as well as being less compulsive and a bit more controlled.
10	She had no confidence, and hated herself.	Is better than she was. She feels she has worth and value, and is stronger.
11	She did not see herself as someone of worth. She lacked confidence, and felt that she was the problem. Before the group, was convinced that she was "not quite right", and had incredibly low self-esteem.	Feels calmer. Has a bit more confidence. Feels stronger.

Table 6.2 continued

6.2.1.2 Relationships theme

The second main theme dealt with change in ways of relating to people as a result of attending the Programme. This theme was directly questioned by the interviewer, yet still allowed for participants to respond in a spontaneous manner within the structure of the main question. The interview searched for four sub-themes, namely, change in the ways of relating to children, spouse or partner, others and self. Two other sub-themes emerged, that of linking past and present relationships and of isolation.

Relating to children sub- theme

Of the 11 participants, 9 reported definite changes in how they related to their children. Seven participants reported behavioural change towards their children in the form of spending more time with them, shouting less, finding more effective ways of handling difficult behaviour, and thinking more about what they were about to say their children before doing so. Three participants reported that their relationship with their children was easier or 'more positive', while another mentioned that she felt more understanding of her child. In two cases participants linked the change in behaviour towards their children to the fact that they were feeling better about themselves. One participant reported only slight change and another, although mentioning that she thought more about what she said to her daughter, did not mention any specific examples of change. Table 6.3 contains participants descriptions of change in the way of relating to their children following the Programme.

PARTICIPANT	THEME: RELATIONSHIPS - SUB-THEME: CHANGE IN WAYS OF RELATING TO CHILDREN	
	BEFORE PROGRAMME	AFTER PROGRAMME
1	Constantly shouting at the children. Used to feel negative about herself when the children would wind her up.	Tries not to shout at the children. Will not say things like "you'll go and live with your father".
2	Her daughter was affected by her lack of confidence as they did not go out. She was not very loving towards her daughter, nor did she feel very protective towards her. She was laid back and could not care less.	More loving towards her daughter. "Really" protects her daughter now. She is always there for her daughter, as well as having more time for her.
3	She did not know how to handle her children.	Does not think she relates any differently to the children, but she can deal with the children's tempers and anger a little more.
4	Did not have an easy time with her son, and did not really want him anymore. She felt the only person who really needed her was her son, and she did not want him.	Having more time to herself has meant that she does not begrudge spending all her time with her son. Her relationship with her son still is not perfect, but she is more easy going with her son.

Table 6.3
Reported Change in Ways of Relating to Children Before Vs 10 Weeks After Completion of Programme.

PARTICIPANT	THEME: RELATIONSHIPS - SUB-THEME: CHANGE IN WAYS OF RELATING TO CHILDREN	
	BEFORE PROGRAMME	AFTER PROGRAMME
5	Her and one particular son would argue and keep shouting at each other, and not reach an agreement.	She now copes a lot better with her children, however she has dropped back in to the habit of letting one of the more 'difficult' children get his own way. She does not worry her so much if one of the children gets the better of her, and rather than arguing, has found she can quietly talk to them afterwards.
6	Did not like her daughter going out - felt all she wanted was her mum. Felt unease at her daughter going to school or visiting friends.	Her daughter has become more secure, and she is more positive about her daughter going to school etc.
7	Always gave her children a lot of love because she never had it.	Does not know if she relates differently to her baby. As she feels better about herself, this is reflected on to the baby.
8	Has always told her children she loves them.	Is more understanding, and keeps boosting them.
9	Could not give her daughter attention and do something else at the same time - for example the washing up.	Has realised that it does not matter how long something takes to finish, she can do both at the same time. She is more focused on her daughter.
10	NO INFORMATION GIVEN	Thinks more about what she says to the children.
11	NO INFORMATION GIVEN	Does not relate differently to her daughter, because that depends on her menstrual cycle. However, she does think more about what she says to her. Realises she cannot say things such as "stupid child". Can be irritated by her.

Table 6.3 continued.

Relating to partner sub-theme

Only 8 of the 11 participants were in relationships with a spouse or partner at the time of attending the Programme. Of those eight, one reported that the relationship with the husband had always been a good one and that there had been no change as a result of attending the Programme. All other seven reported changes in the relationship with their spouse or partner. These included interacting in a more assertive manner, thinking before saying 'nasty things', being able to ask for help, being more forgiving and loving and, in one case, getting out of the relationship. Table 6.4 contains participants reports of changes experienced in the relationship with their spouse or partner as a result of the Programme.

PARTICIPANT	THEME: RELATIONSHIPS - SUB-THEME: CHANGE IN WAYS OF RELATING TO SPOUSE/PARTNER	
	BEFORE PROGRAMME	**AFTER PROGRAMME**
1	Her ex-partner used to control her life, even though they lived apart. She felt very intimidated by him and was governed by his threats.	Is no longer so scared to stand up to her ex-partner and is more assertive towards ex-partner
2	WAS NOT INVOLVED IN A RELATIONSHIP WHILST ATTENDING PROGRAMME	
3	She did not know how to handle her husband and yet relied a lot on him.	The rows stopped because her attitude changed - she would think before she said anything nasty. She can accept the fact her husband will never change, and she is now dealing with this because her own anger has decreased.
4	Has always had a good relationship with her husband.	She does not relate differently to her husband.
5	All childcare carried out by the participant alone, felt she did not have the right to ask her husband to help with the children	They are now sharing child care.

Table 6.4
Reported Change in Ways of Relating to Spouse or Partner Before Vs 10 Weeks After Completion of Programme.

PARTICIPANT	THEME: RELATIONSHIPS - SUB-THEME: CHANGE IN WAYS OF RELATING TO SPOUSE/PARTNER	
	BEFORE PROGRAMME	AFTER PROGRAMME
6	NO INFORMATION GIVEN	Her husband has noticed she is happier.
7	Her partner would put her down, and call her names. She felt she could not do enough for him.	She will stand up to her partner and answer back, although the arguments have got worse.
8	WAS NOT INVOLVED IN A RELATIONSHIP WHILST ATTENDING PROGRAMME	
9	NO INFORMATION GIVEN	Relates differently to her partner - is more forgiving and loving, less angry and irrational.
10	Was with her partner for five or six years, but he made her feel horrible.	Has walked away from that relationship.
11	WAS NOT INVOLVED IN A RELATIONSHIP WHILST ATTENDING PROGRAMME	

Table 6.4 continued.

Relating to others sub-theme

All 11 participants reported change in the way they related to others. Four expressed that they were able to socialise better as a result of the Programme; they felt more confident and were able to make social contact with greater ease. A further 3 participants reported various degrees of change in the way other peoples perception of them affected them. Because of the programme they were able to be far less affected by what others thought of them. Two mentioned they were more assertive, whilst another was more able to accept compliments and a third reported seeing her parents in a less punitive light. Table 6.5 contains detailed descriptions of participants reported changes in the way they related to others following the Programme.

PARTICIPANT	THEME: RELATIONSHIPS - SUB-THEME: CHANGE IN WAYS OF RELATING TO OTHERS	
	BEFORE PROGRAMME	AFTER PROGRAMME
1	She hated her father, and blamed mother for all she went through, and for ending up where she is today. She would not tell her mother things, and lied to her.	She no longer holds a grudge against her father, and realises that her mother is her support. The relationship they had when she was younger has re-emerged.
2	NO INFORMATION GIVEN	She finds it easier to accept compliments from others. Her sister compliments her more now than before the group.
3	She felt taken for granted, and unsupported by her family.	She is able to make conversation with people instead of backing away, and can socialise much better than before.
4	Her mother-in-law and her husband's family felt she was drawing attention to herself. She also worried about what other people thought of her.	With reference to her in-laws, she is more "take it or leave it", and she no longer worries what people think of her.
5	NO INFORMATION GIVEN	More confident in going out and meeting people.

Table 6.5
Reported Change in Ways of Relating to Others Before Vs 10 Weeks After Completion of Programme.

PARTICIPANT	THEME: RELATIONSHIPS - SUB-THEME: CHANGE IN WAYS OF RELATING TO OTHERS	
	BEFORE PROGRAMME	AFTER PROGRAMME
6	As she was born partially deaf, her family used to talk to each other rather than her, except from her mother who always used to talk to her. She also thought people were talking about her behind her back.	She finds it easier to talk to her sister and brothers and stands up for herself. She is trying to ignore those who do not think she is worthwhile. Friends say she is joining in a lot, and is different to the old person.
7	Would let people say or do things and would not challenge it.	Will speak her mind.
8	Did not mix with the neighbours. Her family used to tell her she was mad. She never experienced parental affection when she was growing up.	Now greets neighbours as some were members of the group, and no longer tolerates nonsense. Avoids her family as they would only continue to mock her.
9	Felt anger towards her mother.	Feels more loving and forgiving towards people. She no longer feels angry towards her mother, which she did for 13 years. She is also more open with people.
10	NO INFORMATION GIVEN	Recently walked away from someone who was rude to her. Friends have said she is stronger.
11	Her brother was very critical and judgmental of her, and ignored her for years. Her brother and father could be quite nasty to her.	Hopes that if contact with her brother resumes, she will not worry about what he thinks of her. Has come to terms with the fact that he ignores her. She stands up to her father, and has stayed the same towards her friends.

Table 6.5 continued.

Relating to self sub-theme

Of the four sub-themes queried regarding change in ways of relating, this one, referring to ways in which participants reacted differently towards themselves, was the most difficult for participants to respond to. It was also noted, during the implementation of the Programme, that the notion of being kind to oneself or giving oneself time or rewards, was a very foreign concept. On the 11 participants, 4 were not able to mention any changes in the way of relating towards themselves. Four of the remaining seven mentioned being able to spend some time specifically for themselves, following the Programme. Another three were able to be kinder towards themselves, whether by decreasing the pressure put on themselves or being able to recognise positive aspects of themselves. Table 6.6 contains participants responses to how they experienced change in their way of relating towards themselves as a result of the Programme.

PARTICIPANT	THEME: RELATIONSHIP - SUB-THEME: CHANGE IN WAYS OF RELATING TO SELF	
	BEFORE PROGRAMME	AFTER PROGRAMME
1	NO INFORMATION GIVEN	Tells herself not to be a super-woman.
2	NO INFORMATION GIVEN	NO INFORMATION GIVEN
3	NO INFORMATION GIVEN	Makes time for herself, whereas she never used to. Goes to keep fit classes.
4	She did not want to be with herself.	Is more positive about herself. She no longer thinks "I can't do it" but will have a go. She also had a friend who she thought was better than her, but now thinks that they are just different.
5	NO INFORMATION GIVEN	Found out things about herself that she did not really know. Knows she can cope with, and do things. She is also trying to put herself first sometimes.

Table 6.6
Reported Change in Ways of Relating to Self Before Vs 10 Weeks After Completion of Programme.

PARTICIPANT	THEME: RELATIONSHIP - SUB-THEME: CHANGE IN WAYS OF RELATING TO SELF	
	BEFORE PROGRAMME	AFTER PROGRAMME
6	NO INFORMATION GIVEN	NO INFORMATION GIVEN
7	NO INFORMATION GIVEN	Spends some time on herself every day, and feels she has changed herself in a couple of ways.
8	NO INFORMATION GIVEN	Is now able to give herself some time.
9	Had a problem with feeling guilty.	Has more sense of being deserving and so can enjoy things. She gives herself treats, and enjoys them. Acknowledges that "I am who I am", although she has not been able to make more time for herself.
10	NO INFORMATION GIVEN	NO INFORMATION GIVEN
11	NO INFORMATION GIVEN	NO INFORMATION GIVEN

Table 6.6 continued.

Past - present link sub-theme

Four out of the 11 participants mentioned difficulties with specific family relationships that had affected them before attending the group. One participant reported that she hated her father as a result of his alcoholism and was also intimidated by her violent boyfriend. Another participant referred to being intimidated by her father and brother, whilst a third disclosed that she had received no affection from her parents when she was young, and her family tried to convince her that she was 'mad'. The fourth participant felt aggrieved that she invested all her time in her family and did not receive anything in return. She felt taken for granted, isolated and unsupported and that no-one was there to help. All these were mentioned as being causes of continued aggravation at the time of commencement of the Programme. At the time of the depth interview, 10 weeks after completion of the Programme, all four participants mentioned change in the way they reacted to their situation, whether that had been achieved by seeing the 'aggrieving' others' behaviour in a different light, or by changing their response.

Isolation sub-theme

Four participants reported feeling isolated and unsupported before the commencement of the Programme. Specific behaviours included 'not wanting to go out', 'feeling shy', and 'that nobody was there to help'. At the time of the depth interview, seven reported that they felt far more outgoing after the Programme, including one subject enrolling on a college course and another securing a job.

6.2.1.3 Coping theme

Two participants reported that before the Programme they were not coping with life's daily demands. Another admitted to spending money when she found herself in a difficult situation. Following the Programme, 4 of the 11 participants reported that they were finding it easier to cope with their difficulties, and the participant who expressed difficulty in curbing her spending, found that she was better able to cope with her impulsive spending. One participant reported finding it easier to problem solve, whilst another found that she was developing the ability to put matters into perspective.

Participants reported various coping related behaviours following the completion of the Programme. These included an increased ability to stand up more for themselves, improved relationships with their children, increased confidence, more assertiveness, more 'get up and go', less aggression, greater strength and greater calmness. Table 6.7 summarises the coping related themes that emerged in the analysis of the depth interviews. The figures in brackets represent the number of participants that referred to that particular theme.

Stands up for self	[8]
Relationship with children improved	[8]
Feels better about self in general	[7]
Increased confidence	[6]
Better coping ability	[5]
Positive	[5]
Assertive	[4]
Outgoing	[4]
Less angry/aggressive	[3]
More "get up and go"	[3]
More open	[2]
Stronger	[2]
More calm	[2]
Less depressed	[1]
More forgiving towards self	[1]
Less compulsive	[1]
Less irrational	[1]
More focused	[1]
More loving	[1]

Table 6.7
Coping Related Themes Emerging From Interview Analysis

Figures in brackets refer to the number of participants that refer to that particular theme.

6.2.2 *Participants use of expressive language*

It was noted that when participants spoke about how they saw themselves before attending the Programme, the language used was negative. "Worthless" was a word used frequently, as was the phrase "I had no confidence". Participants disclosed less information about their thoughts and feelings as experienced before attending the Programme in comparison with the amount given after completion of the Programme. When referring to experiences prior to the programme words such as *"hate", "horrible",* and *"bitter"* were often used.

Expression of participants feelings experienced following the completion of the Programme made use of more upbeat and colourful vocabulary. Many participants expressed themselves in more positive ways; words such as *"worthy", "worthwhile",* and *"confident"* often appeared in the transcripts. Phrases such as *"I won't be put down" , "I want to live my life...I'm going to live it and this is it"* and *"I don't give a damn, I am significant and it does matter what I say"* demonstrated a stronger and more optimistic outlook. Even when the desired change had not totally taken place, the positive outlook still emerged, as expressed in the following example: *"I can still feel it creeping in sometimes that I'm not as good as other people, but I know that I am...I know in my mind, even if I don't believe it in my heart, that I'm all right, I can do it".*

The second theme, that of change in the ways of relating again attracted vocabulary that was negative when referring to experiences before attending the Programme. The word *"intimidated"* was used by two participants, and words such as *"worrying"* and *"isolated"* gave an indication of the feelings

experienced at the time. Following the end of the group, the language became more positive, especially in reference to the participants' relationships with their children. Participants describe themselves as being better equipped to be able to deal with tempers, arguments and general behaviour.

The language used when referring to the third theme - coping - followed a similar pattern. Mention was made by two participants that they felt they were not coping before attending the Programme. When referring to coping after completion of the programme, the language became more optimistic. The word "cope" was used frequently and expressions such as *"fighting"*, *"assertive"* and *"stand up for myself"*, gave an indication of the positive mood experienced by participants.

6.3 Results of quantitative analysis of questionnaires on the self-esteem variable

Two questionnaires were completed four different times during the research period. The questionnaires used were the Rosenberg Self-esteem Scale and the Pearlin and Schooler Psychological Coping Resources Questionnaire, comprising three factors: self-denigration, mastery and self-esteem. The rationale for the use of the questionnaires and for the timing of their completion have been noted in section 5.4.

Analysis of results were done in two stages. Firstly the scores for the total group of 45 and the scores for the group of 37 participants (i.e. 45 minus the eight participants who discontinued after time 2) were analysed using the *t*-tests and comparisons made. Comparison of the

waiting to pre-intervention *t* values indicated that the group of eight participants who discontinued after testing time 2 differed significantly from those who attended the intervention on two of the four scales, namely the Rosenberg and the Pearlin and Schooler self-denigration scales. As a result they were removed from any further analyses. Table 6.8 contains a summary of the *t*-test analysis for all 45 participants, while table 6.10 shows the *t*-test results once the discontinued 8 had been removed.

Secondly, questionnaire scores were analysed using the repeated measures MANOVA design. As mentioned in section 5.4, only 20 participants had scores for all four scales at all four testing times, as a result of which the MANOVA calculation only included those 20 participants. MANOVA results indicated that on all four scales there had been significant change at the 0.008 level of significance. Table 6.9 summarises the multivariate analysis. In order to keep the error rate for all scales used at the 0.05 level, the Benferroni method was used. Each paired comparison was calculated at the 0.0125 level of significance (calculated by dividing the overall error rate by the number of planned comparisons, in this case 0.05 by 4). Table 6.11 summarises the post hoc comparisons.

In the post hoc comparisons participants showed significant improvement (i.e. raised scores on the Rosenberg, mastery and self-esteem scales and decrease on the self-denigration scale) on all four scales from pre-intervention to post intervention time. No significant change occurred while waiting for the intervention, neither did it occur in the time between completion of intervention and six months thereafter. Comparison between pre-intervention and six months after completion scores showed significant improvement in only one

scale, the Pearlin and Schooler self-denigration scale. However *t*-tests performed on all 37 participants, calculated at a similar level of significance, namely 0.01, show significant improvement between pre and post intervention scores on all four scales as they do on the pre-intervention and six months after intervention comparisons. No significant difference was noted during the waiting time or between post intervention and six months after intervention scores.

Figure 6.2 shows the mean scores for all 37 participants who attended the intervention on the four scales at all four testing times. Figure 6.3 shows the mean scores for the 20 participants included in the MANOVA calculations.

	WAITING - PRE		PRE - POST		POST - 6 MONTH		PRE- 6 MONTH	
	t value	*t* critical	*t* value	*t* critical	*t* value	*t* critical	*t* value	*t* critical
Rosenberg Self-esteem Ques.	-3.02*	2.04	-7.99*	2.72	1.94	2.74	-3.32*	2.74
Pearlin & Schooler: Self-denigration	3.22*	2.75	8.03*	2.72	-2.08	2.74	5.00*	2.74
Pearlin & Schooler: Mastery	-2.68	2.76	-9.15*	2.73	2.63	2.74	-4.23*	2.75
Pearlin & Schooler: Self-esteem	-0.28	2.76	-7.37*	2.73	1.88	2.74	-4.56*	2.75

*p< 0.01, two-tailed.

Table 6.8
Summary of *T*-test Analyses for All 45 Participants on the Four Scales Comparing Testing Times as Indicated.

MULTIVARIATE TEST	VALUE	*F*	*df*	ERROR *df*	LEVEL OF SIGNIFICANCE
Pillai's Trace	0.901	6.059	12	8	0.008
Wilks' Lambda	0.099	6.059	12	8	0.008
Hotelling's Trace	9.089	6.059	12	8	0.008
Roy's Largest Root	9.089	6.059	12	8	0.008

Table 6.9
Multivariate Test for All Variables Within Subjects Over Time

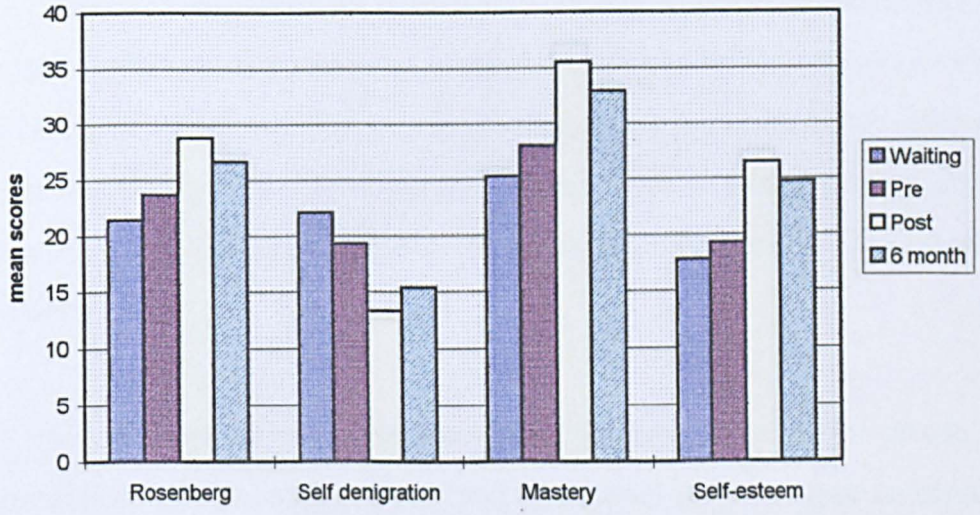


Figure 6.2
Mean Scores for all 37 Participants who Attended the Intervention on the Four Scales at the Four Testing Times.

	WAITING - PRE		PRE - POST		POST - 6 MONTH		PRE- 6 MONTH	
	t value	*t* critical	*t* value	*t* critical	*t* value	*t* critical	*t* value	*t* critical
Rosenberg Self-esteem Ques.	-2.10	2.81	-9.19*	2.03	1.94	2.74	-3.32*	2.74
Pearlin & Schooler: Self denigration	2.79	2.81	8.03*	2.72	-2.08	2.74	5.00*	2.74
Pearlin & Schooler: Mastery	-2.16	2.83	-9.15*	2.73	2.63	2.74	-4.23*	2.75
Pearlin & Schooler: Self-esteem	-1.24	2.83	-7.37*	2.73	1.88	2.74	-4.56*	2.75

*$p < 0.01$, two-tailed.

Table 6.10
Summary of *T*-Test Analyses for the 37 Participants who Attended the Intervention on the Four Scales Comparing Testing Times as Indicated.

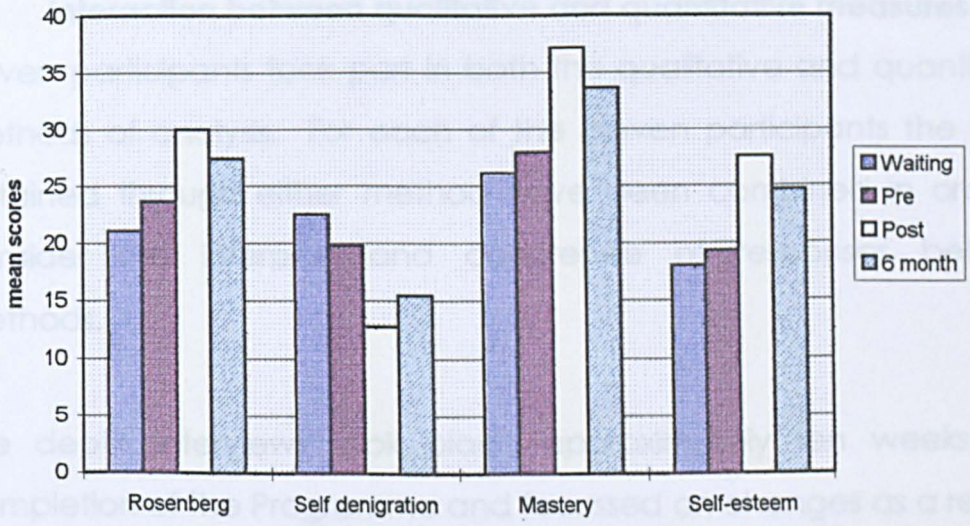


Figure 6.3
Mean Scores for the 20 Participants comprising the MANOVA calculations on the Four Scales at the Four Testing Times.

	WAITING - PRE		PRE - POST		POST - 6 MONTH		PRE- 6 MONTH	
	t value	*t* critical	*t* value	*t* critical	*t* value	*t* critical	*t* value	*t* critical
Rosenberg Self-esteem Ques.	-2.15	2.76	-5.10*	2.76	1.87	2.76	-2.31	2.76
Pearlin & Schooler: Self denigration	2.55	2.76	5.25*	2.76	-2.34	2.76	3.29*	2.76
Pearlin & Schooler: Mastery	-2.23	2.76	-5.95*	2.76	2.74	2.76	-2.73	2.76
Pearlin & Schooler: Self-esteem	-0.96	2.76	-5.07*	2.76	1.97	2.76	-2.69	2.76

*p< 0.0125, two-tailed.

Table 6.11
Summary of Post Hoc Comparisons for the 20 Participants comprising the MANOVA calculations on the Four Scales Comparing Testing Times as Indicated.

6.4 Interaction between qualitative and quantitative measures

Eleven participants took part in both the qualitative and quantitative methods of analysis. For each of the eleven participants the results obtained through either method have been combined in order to consider the interplay and coherence of responses between methods.

The depth interviews took place approximately ten weeks after completion of the Programme and focussed on changes as a result of the Programme. The time frame that the interview concerned itself with was from prior to the programme until time of interview. The same time frame when applied to the quantitative measures on the questionnaires only covered the pre and post intervention scores.

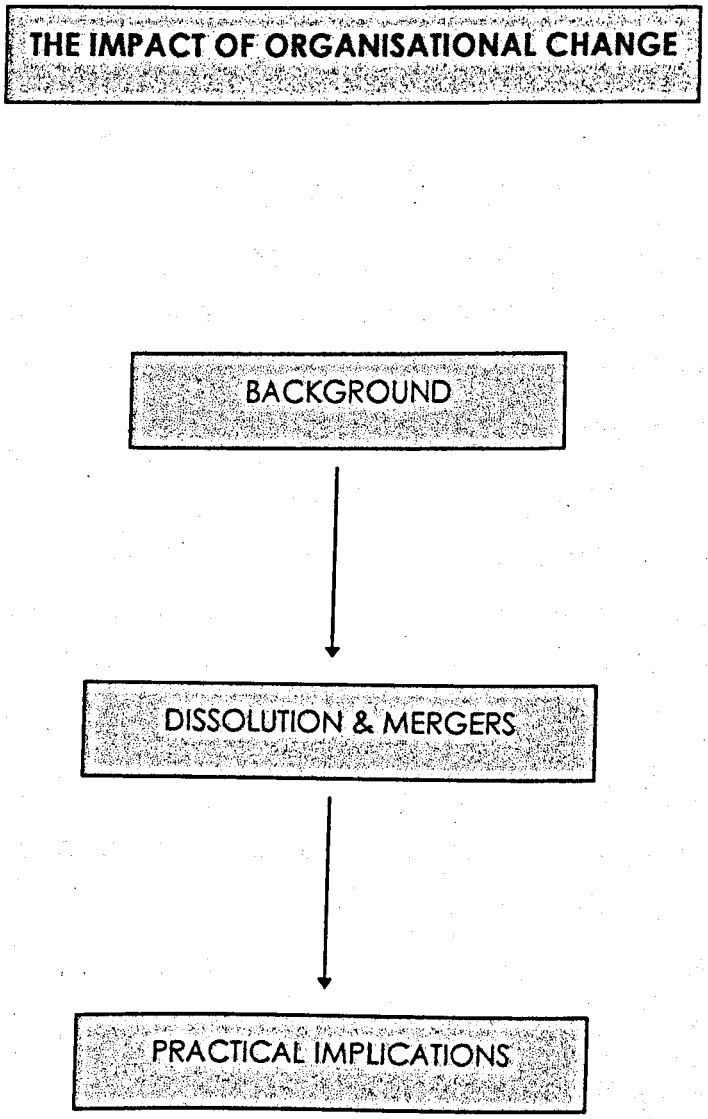
Of the 11 participants, 10 sets of responses concerning qualitative and quantitative measures supported each other. In the depth interviews participants openly expressed improvement regarding their feeling about themselves, their confidence levels, assertiveness, ability to cope with children and other aspects of life, and their sense of worth. The feelings expressed in the interview were borne out by the scores obtained through the self-esteem questionnaires. There was one exception, where the participant showed no change in the pre to post intervention self-esteem scores, however she reported that she felt more worthy, more confident and experienced increased self-esteem. Appendix O contains details of both scores and responses to the depth interview for all eleven participants.

The results presented in this chapter will be discussed in chapter eight in conjunction with other factors affecting the overall outcome of the

present research. The impact of organisational change, one such factor, is the topic of the following chapter.

CHAPTER SEVEN

Schematic Representation



CHAPTER SEVEN

THE IMPACT OF ORGANISATIONAL CHANGE

7.1 Background

The Self-esteem Focus Programme was jointly created by Clinical Psychology and Health Visiting professionals. The organisational structure of the Community Trust (hereafter referred to as trust A) within which this took place consisted of four directorates, one of which was Primary Care. Both Clinical Psychology and Health Visiting were housed within this same directorate. The Head of the Primary Care directorate, herself a health visitor by training, was an advocate for clinical psychology and was open to exploring ways of the two professions working collaboratively. When the opportunity emerged, in the form of a clinical psychologist interested in the same idea, she arranged the funding for the post and ensured co-operation by directing the change with the health visitors.

Health visitors were encouraged to look at innovative ways of working; they were given flexibility with time management when necessary to accommodate these changes. Managers supported these projects and those health visitors that wished were able to focus on an area of special interest and provide a service in that area to clients outside of her case load. This organisational structure was a coherent one. The Head had the vision, which was shared with the health visitor managers, who in turn encouraged and supported the health visitors some of whom were interested in being exposed to alternate skills. The researcher (clinical psychologist), was in a different department yet in the same directorate, shared the concept of collaborative

working with the Primary Care Head and was able to become an intrinsical part in this coherent structure.

In terms of key ingredients for collaboration the above contained the essentials: there was commitment and shared ownership, there was clarity of purpose including well defined goals and methods of evaluation and there was a management structure that supported the venture.

7.2 Dissolution and Mergers

The programme ran for approximately three years before the research presented in this thesis commenced. Less than a week before the first research group was to begin Trust A announced its dissolution to take effect six months thereafter. At that stage nothing was known regarding where the 'dissolving parts' were to relocate. Although the organisational structure of trust A remained the same until its dissolution, the announcement created an atmosphere of uncertainty, anxiety and even anger. The research groups continued as scheduled over the six months but there was a visible uncertainty regarding planning beyond that date.

As the new organisational arrangements emerged it became known that the health visitors were to merge with an adjacent Trust (hereafter known as Trust B) to form a new Trust, which shall be called Trust C. The child psychologists however, were to join other professionals involved in the delivery of services to children, to form an integrated Child Health directorate as part of an acute trust (Trust D). This meant that the two professions of psychology and health visiting would become part of two independent organisations, one acute, one community, each with separate and different priorities, visions and

management structures. The geographical areas and the remit of work remained the same for each professional group.

7.3 Practical implications

Further to the re-organisation of trusts, the health visiting strategies of trust A and of Trust B were very different. Although health visitors from Trust A were able to continue with the Self-esteem Focus Programme for some time, managers did not support this as an integral part of the health visiting service. The health visitors that participated in the Programme did so in addition to their existing work. As much as health visitors were committed to the programme it became impossible at a practical level to continue to put in the hours that it often required. As a result of this additional pressure some of the health visitors regrettably left the programme.

The lack of managerial support for the programme had a further practical implication to the one discussed in the previous paragraph. Only six health visitors took part in the running of the programme, however it required all the health visitors (there were up to 35 in the area covered by the programme) to be aware of the programme, to inform the client of its existence and if necessary to prepare the client for referral. As the managers did not see this as an integral part of health visiting, the programme was not used as a resource to refer clients to. The direct result of this was that referrals decreased over time; whereas the original plan was for each group to hold 9 -12 participants, some groups ran with as little as two. As a result of the diminishing number of referrals the research period was increased and ran over 18 months, in an attempt to approximate the planned number of participants for research purposes. This research ran to the end of the first year into the existence of the new trusts. During that

time it became increasingly difficult to keep the practical arrangements in place, to the point that the last scheduled group had to be cancelled as a result of rooms being unavailable and no funding for the child care workers.

With regard to the cancelled group some of the participants had been enrolled for over eight months as they had served as controls for the reflective function variable (it has since been decided not to include these results in this thesis). It was explained to these participants about the lack of facilities and funding and the offer made for them to form a group, where the same programme would be delivered, but only by the clinical psychology service. They would be missing out on the health visitor input and on the child care, that was the best that could be offered in the circumstances.

Many of the difficulties encountered as a result of the organisational restructuring were expressed by the health visitors in their evaluation of the programme(section 5.5). The lack of managerial commitment and support was reflected in that they (the health visitors) had to arrange accommodation and sort out child care workers, jobs that in the past (while in Trust A) would have been partially done by clerical staff, this was both frustrating and time consuming. The lack of recognition for the difficult work they were undertaking further lowered their morale in a climate of change and uncertainty

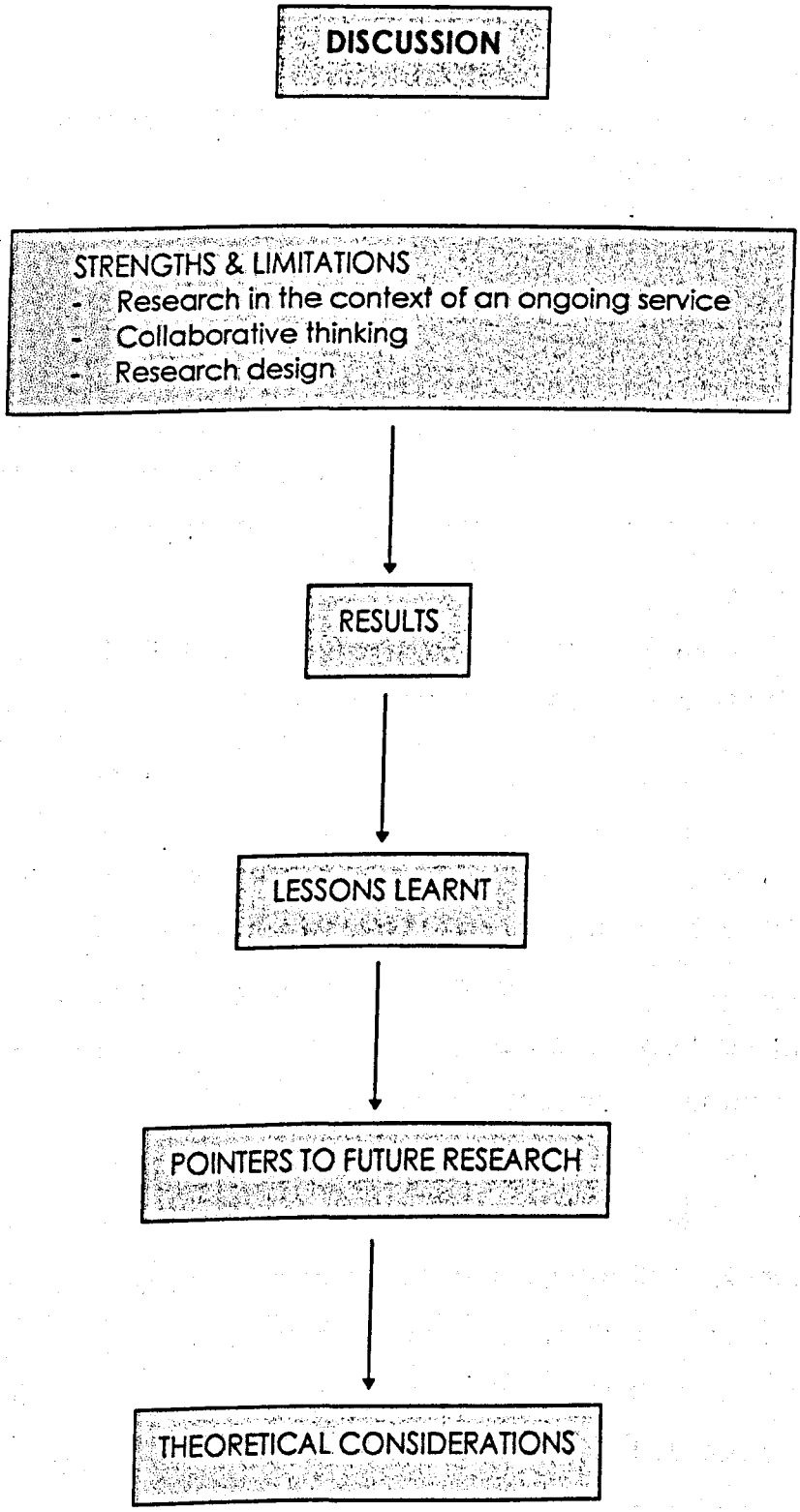
The unplanned organisational changes that took place during the period of research gives a very clear picture of how essential certain key factors were. In this situation many things remained the same, the client group, the health visitors and the researcher, furthermore the purpose of the intervention remained in focus, the commitment from

the professionals remained and clients continued to show that the programme was effective. The only part that had changed was organisational vision and commitment. The health visitors continued to work tirelessly in an effort to overcome this problem, despite their best efforts the lack of organisational commitment cancelled this out.

This is what led the researcher to formulate *'recognition of the organisational context'* as the first cluster of essentials for collaboration, as elaborated in the literature review section (section B) of this thesis. The first step in the thinking of working collaboratively needs to be an assessment as to whether the organisational structures hinder or facilitate the process. Unless there is vision and commitment, together with agreement and clarity of purpose present at an organisational level, all the energy from the practitioners at the ground level will be to no avail.

CHAPTER EIGHT

Schematic Representation



CHAPTER EIGHT

DISCUSSION

This chapter deals with five areas of focus that comprise the discussion of the research. The first of these will examine the strengths and the limitations of

a) conducting research within the context of an ongoing service,

b) collaborative thinking, and

c) the research design.

The second concentrates on the results, the implications of these and how this links with the published literature in the field. Finally, the lessons learnt that may be of use to other clinicians, pointers to future research and theoretical considerations form the other three sub-sections of this chapter.

8.1 Strengths and limitations

8.1.1 Research in the context of an ongoing service

The Self-esteem Focus programme was a service led project where the interaction between the various aspects affecting the final service provision was kept in focus throughout the implementation of the project. The programme can be seen as service led from two viewpoints: firstly, it was developed as a direct result of a need identified by health visitors; secondly, throughout its implementation, the interplay between needs of clients, the circumstances surrounding the health visitors, the change in organisational structures, and the practical possibilities, were kept to the fore. This focus on the interaction between changing components required systemic

thinking, (Watzlawick *et al.*, 1967; Campbell *et al.*, 1989a), which was an element fundamental to this research. The use of systemic thinking beyond the confines of family therapy, on which it was based, has been promoted and described by Campbell (1999), and incorporated into this study.

A strength of conducting research within the context of an ongoing service, particularly where the service takes priority over the research, is that the findings are more representative of what occurs in the day to day existence of both clients and services alike (Hammersley & Atkinson, 1983). Clinicians working within the National Health Service, are rarely in a position to select a particular group of clients who fit a clearly defined set of criteria, matched in all areas seen as having a possible influence on the variable under investigation, on which to conduct robust research. In the majority of cases clinicians need to evaluate services on samples that may present a common behaviour, difficulty or symptom but where it is impossible to match all of the influencing factors. This presents a limitation in obtaining clear, definite and robust findings, particularly in the opinion of supporters of quantitative methods of research (Sarantakos, 1998). The advocates of qualitative methods, however, see conducting research in the field as providing detailed findings linked to reality as opposed to finding relationships between variables in society (Nicolson, 1995). The pull between focus on research versus focus on practice has led to the dichotomy between positivism and the interpretive school in social sciences (Silverman, 1993). Some researchers prefer to combine the two methods so as to produce a more balanced and multifaceted analysis of results (Silverman, 1993); with this in mind a combination of both qualitative and quantitative methods was used in this study.

This study further highlights the limitations of conducting research within the context of an ongoing service, with specific reference to organisational issues. Trust dissolution and mergers took place during the research period resulting in the professions of clinical psychology and health visiting being housed in different and independent trusts. As health visitors integrated into the management structure of the new trust, arrangements made within the structure of the old trust started to break down. Preparation of clients was not as well done as before, and the lack of co-operation between health visitors began to show. There was no more training of health visitors and no more promotion of the programme. Practical difficulties, such as payment arrangements for the colour consultant became a problem. As a result of diminishing awareness regarding the existence of the programme, referrals decreased and it became harder to keep health visitors enthusiastic; low morale, due to all the changes also became a problem. The above-mentioned findings are consistent with the views of Lupton and Khan (1998), Seaburn *et al.*, (1996), Beattie (1994) and Hardy *et al.*, (1992), all of which stress the importance of clear, robust and coherent organisational arrangements if inter-professional collaborative partnerships are to be effective. In this study, the change in organisational structure led to the cessation of the delivery of the service in two out of the three localities where it was offered.

8.1.2 Collaborative thinking

From the time of its conception, the thinking surrounding the Programme was collaborative and systemic (chapters one and three). It was a project that embraced various aspects of theory and different implementation models; it brought together different parts rather than focus on one main aspect (chapter two). The formulation of the

programme itself combined certain aspects of different theories into a coherent whole rather than focus on one particular theory. In this sense it is akin to collaborative working where no one person or profession takes a monopoly; it is a blend of different parts to form something more than the pure summation of those parts; it is an ongoing and changing interplay between them where understanding the effects of that interplay on the individual parts becomes essential. In the process of collaborative and systemic thinking, achieving balance between the various parts to start with and maintaining that balance in a changing system, is of paramount importance.

A possible criticism of this research is that it could be said to lack depth in any one particular area. Conducting research on a topic described as a 'blending of parts to form a new whole' and 'ongoing balancing of various parts at different times', does not provide the ideal situation in which to do research, particularly if wishing to use quantitative measures. As a service led programme, the changing needs of clients and the changing circumstances affecting the delivery of that programme took priority and the research requirements had to become secondary.

The strength however lies in the appreciation of the complexity of collaborative working, and in recognition that objectives of service delivery and those of research are often discordant with each other. However, regardless of complexity, the need to effectively evaluate such services is essential (Roth & Fonagy, 1996); the present study is a step in that direction.

8.1.3 Research design

The research design, a combination of qualitative and quantitative measures is seen to be a strength in this study (Silverman, 1993). This combination allowed for the interplay between the two methods to be examined. The quantitative measures provided an indication as to the amount of change in levels of self-esteem, mastery and self-denigration. It also provided an indication as to whether the positive changes noted on post intervention scores were maintained six months later. The findings that emerged from the qualitative measures added detail regarding the manner in which changes manifested themselves. In this way the results contain both an indication of the amount of change and how that reflected itself in behaviour.

The collection of quantitative data was simple in procedure. The filling in of questionnaires and their scoring was straightforward as was the computation of means and their comparison. The one problem encountered was that in a few cases participants failed to complete all pages of the questionnaire and this was not checked at the time. Since all questionnaires were anonymous it was not possible to get back to the participant for completion. After becoming aware of this problem, a point was made of asking participants to check all pages before returning the questionnaire. There was still a problem with questionnaires completed six months after termination of the programme as these were returned by post and there was no way of ensuring that they were completed in full.

The quantitative analysis combined multivarite analysis of variance and ordinary *t*-test computations to provide comparison of sample means. The combined approach to analysing the data provided

more robust evidence of change since each method had limitations. The multivariate analysis only took into account 54% of participants scores, while the *t*-test analysis was not totally applicable since there were four dependent variables investigated.

The depth interview was more complex; direct questions were asked and this could be seen as going against the purpose of depth interviewing (Jones, 1985). The need to consider practical issues, such as the effectiveness of the programme, as an ongoing service, had to take priority. The fact that the interview allowed for participants to discuss how the programme had impacted on any aspect of their lives in a spontaneous manner, was considered positive. It could be debated that the semi-structured format provided answers to the questions that needed answering; it provided a direct evaluation by participants as to the effectiveness of the programme (to satisfy health visitor management), and also provided indicators as to how the programme had affected participants lives. An essential in qualitative research is that the method used facilitates the answering of the questions asked (Jones, 1985; Robson, 1993; Silverman, 1993). In this case it did so.

The organisational change created a number of problems for the research. Whereas the target number of participants was 60, the final figure was 37. The research period was therefore extended beyond that planned in order to gather larger samples, but in the end the practical difficulties took the leading impact. The statistical results are therefore not as ideally robust as initially planned.

A further criticism of the research could be that the methods used for data analysis were too simplistic for the matter being addressed. Self

concept and self-esteem are complex constructs, affected by many factors. Viewing them as dependent variables of one intervention, the participation in the Programme, could be seen as too simplistic. Many other every day factors affect how people see and feel about themselves. On the other hand, all participants would have had other factors impacting on their lives throughout their involvement in the programme, some positive and others negative. It was assumed that all other impacting factors remained 'constant' and therefore had the same kind of influence on all participants. An attempt was made to consider the effects of medication and other important events on the results. Participants were asked to state whether medication had been introduced, changed or stopped at different stages during the research. They were also asked to state whether there was any other event, other than participating in the programme, that may have affected how they felt about themselves (Appendices P-R). The information received was however not precise enough to draw any clear conclusions, yet provides indicators of aspects to consider in future research.

8.2 Results

The chapter on results (chapter six) describes changes in participants' ways of relating to children, spouses or partners, others and self. Although none of these changes had been given specific mention in the programme, except for ways of taking care of self, it can be seen how change in self concept and self-esteem had an impact on ways participants related to others around them. This is consistent with the theory developed by Carl Rogers (1959) in which he sees self concept as the most important determinant of behaviour. The changes noted are also consistent with the theoretical concepts advocated by Selma Fraiberg (1980) and Eric Berne (1976). In the changes mentioned

regarding their behaviour towards their children, some participants reported how they consciously responded in a way different to how they had been treated as children. This matches the findings described by Fraiberg (1980; 1987). Similarly, having become aware that in certain situations they reacted from the Child ego-state, enabled them to consider changing aspects of their 'life-script', and they did so (Berne, 1976; Stewart & Joines, 1987).

The change in relating to self deserves special mention as this was the most difficult for participants to implement. Although this was an area particularly highlighted during the programme, with specific time allocated to discuss ways of taking care of self, it was still the one that at the time of the depth interview (10 weeks after completion of the programme) many had nothing to say about any change. These results seem to suggest that change to the aspects of self concept that relate to others is easier to change than that that affects only the participant. Reasons as to why this is so and implications of such a finding were not found in the literature reviewed; the question could however become the focus of further interesting and valuable research.

Comparing the expressive language used when reporting on ways of seeing themselves and on behaviours before and after participating in the programme, shows a change in attitude. Both quality and quantity of words used indicate an increased animation after participating in the programme. Participants' moods were more positive as indicated by their use of more positive words (table 6.1; section 6.2.2); they also had far more to say, possibly indicating their feeling greater confidence within themselves after the programme.

Participants showed improvement (raised scores on the Rosenberg, mastery and self-esteem scales and decrease on the self-denigration scale) on all four scales from pre to post intervention times, and from pre-intervention time to six months after completion of the programme (when scores of all 37 participants were analysed by means of the *t*-test). Although there was a decrease in self-esteem and mastery scores, with an accompanying increase in self-denigration scores between the post intervention time and six months later, it was not a significant change. According to these scores, the improvements resulting from participating in the programme were maintained and still evident six months after completion of the programme. When comparing the pre-intervention scores with the six months after completion of programme scores, the positive change recorded was significant at the 0.01 level. These results indicate that the programme had the desired impact on participants and furthermore that the changes created as a result of participating in the programme were evident six months after the completion of the intervention.

An interesting observation was the difference noted in the *t*-test measures depending on the inclusion of the eight participants who discontinued after time 2 measures. When the 'discontinued' participants were included in the waiting to pre-intervention comparison, significant improvement was shown on two of the four scales. When they were excluded from the comparison the sample means showed no significant change. This seems to indicate that the eight participants who discontinued before engaging in the intervention were in some respect different from those who decided to attend the intervention.

Further to the qualitative and quantitative results regarding self concept and self-esteem, the findings relating to the collaborative partnership and organisational aspects of this study require mention. The literature on collaborative working highlights crucial areas that need to be considered when implementing collaborative partnerships, comprising inter-personal, inter-professional and inter-organisational elements (Seaburn *et al.*, 1996; Lupton & Khan, 1998). In their evaluation of the programme, health visitors mentioned the importance of both inter-personal and inter-professional relationships (section 5.5). Their comments included how the inter-professional trust and respect had facilitated working together and how they felt reassured by the presence of the researcher in the event of requiring her expertise. One health visitor experienced the presence of the researcher 'de-skilling'; in this case the un-voiced and consequently unresolved difficulty hindered the collaborative working.

The organisational factors were experienced by all health visitors as strongly affecting the outcome of the programme. The change of management structures during the time the research was being conducted resulted in change in the commitment and shared ownership (by management) of the programme. The subsequent lack of managerial support and recognition of the work achieved by the health visitors, resulted in the decrease of their enthusiasm, morale and involvement and consequently a decrease in referrals. In addition, the practical difficulties encountered in arranging accommodation and child care in the absence of organisational commitment, resulted in the programme having to be stopped in two out of the three localities where it was delivered. These findings are consistent with the research by Hardy *et al.*, (1992), Beattie (1994), Seaburn *et al.*, (1996) and Lupton and Khan, (1998).

8.3 Lessons learnt

The most striking lesson for the researcher was the impact of the organisational change on the running of the programme. As difficult as the dissolution and merger of trusts was to handle whilst trying to continue with the data collection, in hindsight it provided a brilliant opportunity in which to experience the effects of such a change on the practicalities of delivering such a programme. Such an organisational change would never have been purposefully introduced as a variable in any research and its effect on the dependent variables measured. In this study, although not measured, the negative impact is undoubtedly clear.

The experience gained in this study highlights the need to clarify organisational arrangements and obtain organisational commitment before entering the more practical linked arrangements such as content and delivery of the programme. However, as in this study, trust mergers and their consequences cannot always be foreseen.

The results of the study show raised levels in self-esteem and positive changes in participants self concept with associated behavioural changes in ways of relating to others, as a result of participating in the Self-esteem Programme. Although the collaborative partnership was not a variable under investigation, professionals from both clinical psychology and health visiting were aware of the value of the joint venture. Both were of the opinion that neither profession could have achieved the same outcome had the programme been delivered by only one profession. All the professionals felt that the collaborative partnership greatly assisted the results achieved.

The health visitor evaluation highlights the need to address inter-personal and inter-professional issues on an ongoing basis when involved in collaborative working. Although there was usually time set aside after each session for the researcher and health visitors to discuss any difficulties, either specifically related to the session or generally related in any other way, some difficulties were not expressed at the time but rather only emerged when the evaluation was requested at the end of the research period. Highlighting this need at the beginning of a partnership arrangement and seeking opinions as to how to address it in practice may be one way of avoiding the negative impact on ultimate outcomes.

8.4 Pointers to future research

This study is not only concerned with the effect that the programme has on the participants, but also interested in the preventative aspect that change in participants may have on their relationships with others. The fact that participants reported change in ways of relating to children, spouses or partners and other significant others as a result of increased self concept and self-esteem, suggests that further research in this area could be of value. Of particular interest is the change in ways of relating towards children. Further research into the relationship between change in self concept and self-esteem in mothers and how that affects behaviour and self concept development in children would be of particular value. If a direct relationship can be found between positive change in self concept in mothers and the development of positive self concept in their children, then steps will have been taken to break the cycle of low self-esteem (Egeland & Farber, 1984). The value of preventing the consequences of poor self concepts in children and the associated

behavioural problems to the children themselves and society as a whole are well known (Coopersmith, 1967; Rosenberg, 1965).

Of interest to health visitors would be research assessing the relationship between increase in self concept and self-esteem in participants and any possible decrease in their reliance on the health visitor service. In a similar way, the relationship between increased self concept and self-esteem in participants and their reduced use of GP time and resources would be of interest to GPs and the health service as a whole. Decreasing the demand on either service would be welcomed in terms of health gains and financially.

The present study measured the effects of the Self-esteem Programme on its completion and six months thereafter. A longitudinal study investigating the effect of time on the impact of such a programme, would be valuable further research. This would provide more detailed information as to if and when some maintenance input could prevent participants falling back to pre-intervention levels of self concept and self-esteem.

The difficulty shown by participants in effecting change in the way they related towards themselves has not been adequately explained. The question remains as to why this is so and what are the implications of such a finding. Further exploration of the literature and research possibilities would make for interesting enquiries.

8.5 Theoretical considerations

This study brought together various theoretical perspectives relating to self concept, self-esteem and collaborative working. It further made use of Attachment Theory, Psychoanalytic thinking, Rogers Self theory,

Transactional Analysis and Cognitive-behaviour theory in the formulation of the Self-esteem Programme.

Taken individually, each theoretical perspective can be linked to some aspect of the results of this study in a fairly predictable manner. The discussion above has noted how participants responses were consistent with the work pioneered by Selma Fraiberg (!980), the ideas expressed in Rogers work as to the importance of self concept as a determinant of behaviour (Rogers, 1951; 1967), and the expected change in 'life-script' messages as proposed by Berne's Transactional Analysis (Stewart & Joines, 1987). Furthermore, the results were consistent with Rogers view that the experience of worth as a person, in the form of warmth and acceptance from others, which took place within the implementation of the programme, increases the individual's 'positive self regard' (Rogers, 1951). The expected behavioural and mood change as a result of modified automatic thoughts, underlying assumptions and cognitive distortions were evident in the accounts that participants gave during the depth interview (Hawton and Kirk, 1989; Freeman *et al., 1990).* This study's findings regarding collaborative working (section 8.2) are also consistent with those encountered in the literature (Lupton and Khan, 1998; Seaburn *et al.*, 1996; Beattie, 1994 and Hardy *et al.*, 1992).

The various aspects of theory used in the theoretical underpinning can thus be linked with most of the results obtained in this study, yet three further areas deserve theoretical consideration. These are: the value of early intervention, systemic awareness and collaborative working. In the context of this study, these three area are all interlinked making it difficult to isolate any one into a separate entity.

To intervene as early as possible in the hope of avoiding further ill health of whatever nature, is a view not likely to be disputed by anyone. Government directives regarding provision of services encourage and sometimes demand early intervention (DoH, 1998; HMSO, 1995; Home Office *et al*, 1991) and yet it's impact and value is difficult to quantify. Underpinning the decision to undertake this research, was the view that an early intervention programme would not only alleviate the difficulties presented by mothers (section 1.5) but would also help in the prevention of the repetition of inter-generational cycles of problematic behaviour (Fraiberg et al, 1980; Egeland & Sroufe, 1981). Yet no specific literature was found regarding when or how to intervene early. What constitutes early intervention? What are the characteristics that indicate appropriateness of early intervention?

In the context of this study the opportunity to intervene early was only possible if a collaborative partnership was established between clinical psychology and health visiting (section 1.5). Although literature was found in the field of collaborative working, this was predominantly in the area of child protection (Hallett & Birchall, 1995; Birchall & Hallett, 1995; 1996; Lupton & Khan, 1998). Much of the literature addressed procedural issues and professional responsibilities (Home Office, 1991; DoH, 1995; DoH, 1999) whilst other reported on the numerous cases where collaboration was proving extremely difficult (Taylor & Tilley, 1989; 1990; Sadler, 1994). The literature contained theory regarding essentials for collaboration (Seaburn et al., 1996; Lupton & Khan, 1996) as it did regarding organisational structures and arrangements (Hardy et al., 1992; Campbell et al., 1989a; Campbell et al., 1994). However, the literature on organisations limited itself to intra-organisational arrangements and change, whereas this study involved

inter-organisational issues. Systemic awareness (Campbell, 1989a; Section B of this thesis) was the overriding construct through which both collaborative working and early intervention were viewed.

This study integrates various aspects of theory and implementation models. It also incorporates the ideas of early intervention, collaborative working and systemic awareness, all of which are at present not clearly defined as measurable entities. The integrative way of working enables the clinician to work from a variety of perspectives, but in so doing the boundaries between those perspectives often dovetail to create a new perspective. Continued research into the amalgamation of established concepts and new ideas, mindful of the challenge to provide the most effective service to client groups within the limits of resources and organisational stuctures, will lead to the continued creation of theoretical knowledge.

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APPENDICES

VULNERABILITY CRITERIA

ANY THREE OF THE FOLLOWING FACTORS INDICATE CLEAR CRITERIA FOR 'AT RISK' FAMILIES.

1. Admission to a Special Care Baby Unit or a handicapped child.

2. History of emotional disturbance.

3. Midwife or Health Visitor concerns with regard to the handling of the baby.

4. Known to Social Services with reference to child care.

5. Parental ill-health.

6. Relationship or family disharmony or tension.

7. Poor housing.

8. Immature mother.

9. Non-clinic attender or poor developmental screening / immunisation take-up.

10. Poor parenting (physical/emotional/developmental).

SELF-ESTEEM BUILDING PROGRAMME

SESSION THREE HELP SHEET

IDENTIFYING MESSAGE EXERCISE

Participants have been asked to think about a particular situation where they RECURRENTLY feel 'bad' / anxious / lacking confidence.

Stages

1 We explore **PRESENT** situations to get a feel about what the participant is going to work on. Within that exploration we need to be mindful of:

a) is the situation presented to do with **'doing'** messages
b) is it related to a specific situation or does it have a more general feel about it

If the presenting 'story' is to do with **DOING** or with a specific situation, it is not an appropriate 'story line' to follow. We need to bring it into **BEING** focus.

2 We then ask whether this is the first time they are feeling like this or whether this same feeling has been experienced in the **PAST**

So we are linking present day events and feelings with past events and feelings. We need to help them make the connection that what is happening (the story they have just related) is a continuation of the process that was started in the past.

3 We ask what were the feelings experienced in the past.

But we do not dwell on these. This is a short step to get us onto the next step. It's purpose is to connect that the present day feelings are the same as those experienced in the past.

4 We then ask them (taking into account the story they have just told) to try and work out what **MESSAGE** they were receiving from others around them at that time.

They will often have referred to 'being' messages throughout their 'story'. You may find it helpful to pick up on these if they are finding it difficult to get to the formulation of message on their own. If they can do it, it is always better to let them get there on their own.

QUESTIONING VALIDITY EXERCISE

We are now asking them to go back to the events of the past and consider the circumstances under which that particular message developed

This is to enable the participant to question the validity of the message. Some participants may well be able to see that it is not true without going into more detail of the past. In these cases that is enough. But if participants are 'stuck' in that they believe that the message IS true, then we need to go into the past into more detail and question WHY others had the need to do whatever they were doing / pass on the message that they did.

The object in this exercise is that at the end of it, they can INTELLECTUALLY say

"This message is not true"

'Homework' for the week: it will help in the process if they can keep this reality in focus. So we ask them to remind themselves that they have worked out that the message is not true. We know that they cannot feel it as yet. To just say it intellectually is the first step forward.

THIS PROGRAMME WAS DEVELOPED FOR
JOINT PSYCHOLOGY - HEALTH VISITING DELIVERY
IT SHOULD ONLY BE USED IN COLLABORATIVE PARTNERSHIP

AFFIRMATIONS

An affirmation is a positive definition of oneself which presently is not experienced as true. It is a positive statement of what you intellectually know to be true, but emotionally cannot yet experience. It is also a positive statement of who you are, rather than what you can do.

An affirmation is a declaration you make to yourself of something you believe or hope to believe about yourself.

The main points about affirmations are:

1 They are positive statements about self

2 They need to be repeated frequently

3 They are not yet experienced as true

Just think about how often you received the messages that make you feel NOW the way you do about yourself. If you could count the times, the number would easily go into the millions. The reversal of such messages requires great amounts of repetition. You will have to say the new things to yourself many times and you may not experience these as true for a long time. Eventually you will start feeling it.

When formulating an affirmation remember:

1 Make it a positive statement

2 Make it a "being" statement

3 Keep it short

4 Keep it simple

5 Use the present tense

6 Preferably use the word 'I' or 'I am'

7 Repeat the affirmation whenever and wherever you can

8 Start immediately

SELF-ESTEEM BUILDING

REMINDER SHEET

WHEN YOU FIND YOURSELF FEELING BAD ABOUT YOURSELF OR PUTTING YOURSELF DOWN OR FEELING WORTHLESS ASK YOURSELF:

1. What am I saying to myself (maybe unconsciously) that is making me feel this way?

2. Where does this message come from?

3. Is it true?

4. Once you have worked out that it is not true - then use the affirmations list to help you reverse the message.

5. Concentrate on affirming yourself through that new message.

REMEMBER:

1. TAKE CARE OF YOURSELF: DO SOMETHING FOR YOURSELF EACH DAY THAT SHOWS THAT YOU VALUE YOURSELF.

2. UNTIL IT BECOMES "SECOND NATURE" BE CONSCIOUS OF SAYING SOMETHING POSITIVE ABOUT YOURSELF TO YOURSELF EVERY DAY.

3. WHEN YOU FEEL IN THAT STATE OF NEGATIVE FEELINGS / LACK OF CONFIDENCE / NO VALUE FOR YOURSELF, TAKE TIME OUT TO EXPLORE WHERE IT IS COMING FROM. FOLLOW THE STEPS AND IF NECESSARY ASK FOR HELP.

4. UNTIL YOU HAVE WORKED OUT A STRATEGY OF HOW TO DEAL WITH THEM, AVOID PEOPLE THAT PUT YOU DOWN OR PEOPLE THAT DON'T VALUE YOU.

5. MAKE THE MOST OF YOURSELF WITH "YOUR COLOURS".

VIEWS AND OPINIONS

We would appreciate knowing your views and opinions on various points. Please DO NOT put your name or sticker on this page. It is completely anonymous.

1. What did you find most helpful over the last eight weeks?

2. What did you find least helpful?

3. Was the course what you expected? Please tell us about it.

4. Was there anything else you would have liked to have done in this course?

5. Was the course clear or did you find it difficult to follow?

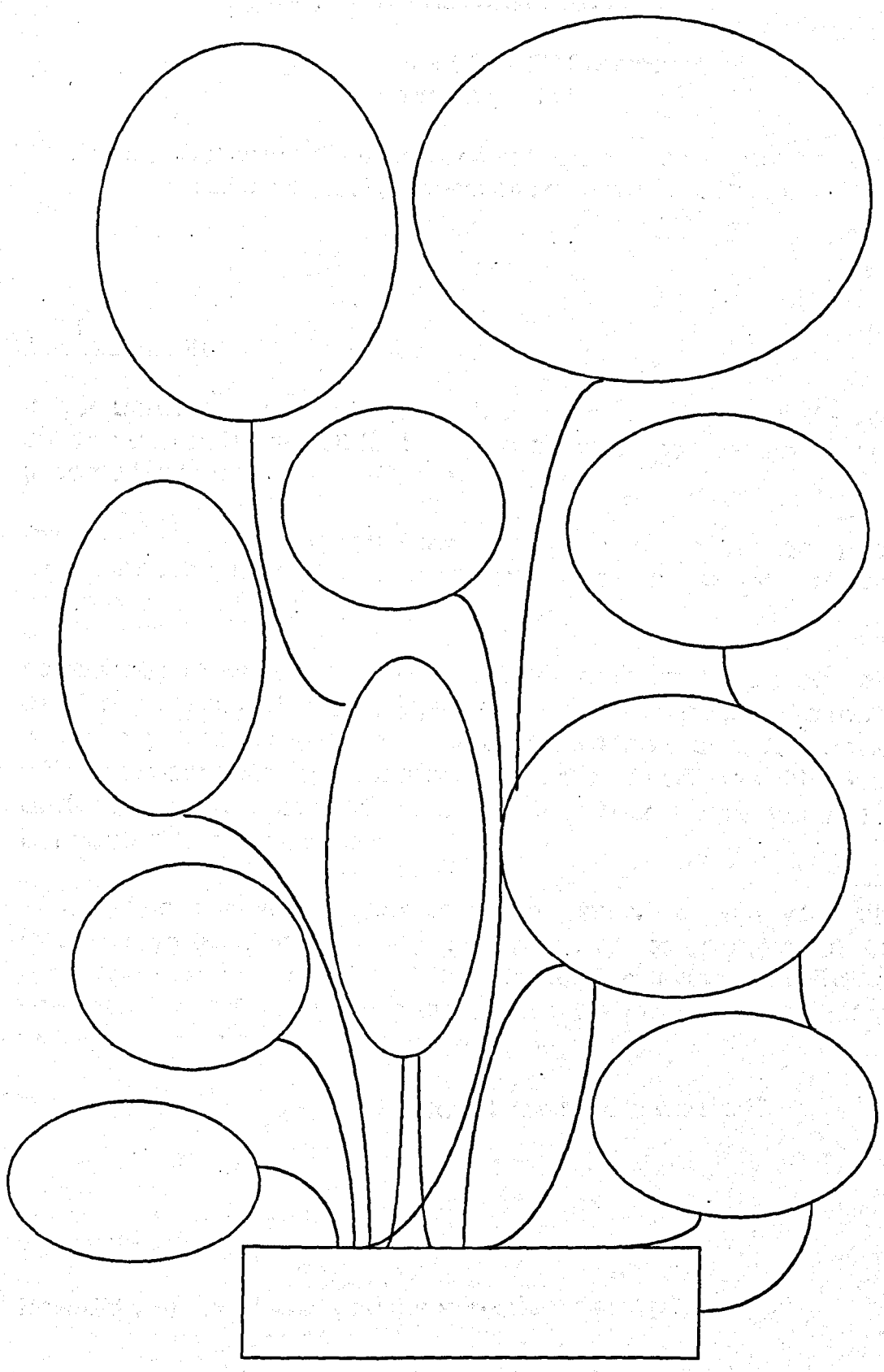
6. What did you think of the Child Care facilities? Would you like anything different?

7. Was the time and place convenient?

8. Anything else you would like to comment on; good, bad, or indifferent?

THANK YOU FOR YOUR INVOLVEMENT AND CO-OPERATION.

THE BALLOON EXERCISE



IN-DEPTH INTERVIEW PROTOCOL

relating to the SELF CONCEPT component of
research entitled

An investigation into the effects of a self-esteem focus programme on self concept, self-esteem and reflective function.

1. Introduction

It has been a few months since you took part in the Self-esteem Building group. Thank you for being prepared to come back and give us some feedback on the effect it had on you.

This interview will focus on how you experienced the group and whether having taken part in the programme made any difference to you in your daily living.

As you may know I was not involved in the running of the programme at all, but am now doing the interview. This is so on purpose to make it easier for you to say whatever you feel about the group. Your answers will remain confidential. Your recorded responses will be written down and then scored according to themes. Your name will not be connected to any response.

In order to link your responses to this interview with your other responses to questionnaires etc., I will need you to open your named envelope and take out the sticker. [*Sticker is put on tape*]. Then will you please put the remaining stickers in a new envelope, seal it and write your name on it.

Is there anything you would like to ask me before we start?

2. Experience of the intervention

How did you come to attend the self-esteem group?

How did you hear about the group?

Why did you decide to attend? Was it an easy or a hard decision to make?

What made it easier/harder for you to attend?

How did people close to you react to your decision to attend this group? By 'people close to you' I mean maybe your partner or family or any other close person.

Would you please tell me what your experience in the group was like?

Is there anything that happened in the group or anything that you learned in the sessions that made a particular impression on you?

What was the best thing about the group for you? What did you enjoy the most?

What was the worst thing about the group for you? What did you enjoy the least?

If one of your friends told you that she was thinking of attending one of these groups, what would you advise her?

3. Self Concept

If I had asked you how you saw yourself BEFORE you attended the group, what would you have said? Here I am referring to you as a person, rather than what you are good at doing

Did you see yourself as someone of worth?
- as someone just as important as anybody else?
- as someone worth being loved?

If you look at yourself now compared to the person you were before attending the group, what do you see?

In what ways are there differences? Can you give me examples?

[If there is no difference:] Skip to the next section.

Can you give me some practical examples of, how in your life, you are different since the group.

Is there any difference in the way you think / act

Are there things you do differently since attending the group?

[It is important to explore the following areas]:
*Is there any difference in the way you relate to your partner?
*What about with your children?
*Has there been a difference in the way you relate to anybody else?

Do other people notice this difference?
[what about yourself?]

4. Wind Down: Expectations Fulfilled etc.

Was attending the group worthwhile for you? Did it give you what you were expecting?

What can we improve on in future groups? How can we make the groups more helpful?

It certainly seems as if you found the group generally helpful [unhelpful]. Could you please tell me if there was anything about the group that we have not talked about yet that you feel would be important for me to know about?
Perhaps there was some aspect of the sessions that did not feel OK to you or perhaps there was something outstanding that you have not yet mentioned?

THANK YOU VERY MUCH FOR TAKING THE TIME TO SPEAK TO ME. YOU HAVE BEEN MOST HELPFUL.

Does the Self-esteem Building Programme really work ?

CLIENT INFORMATION SHEET

The Self-esteem Building Programme was first tried out 3 years ago when Health Visitors wanted to find better ways of helping parents who were experiencing certain relationship difficulties. These difficulties were to do with the handling of children, relationships with other adults (partners, family members, friends) or even their own fears or lack of confidence. Since then about 40 mothers have taken part in the programme. Many tell us how it has changed their outlook and the way they relate to others.

The study I am undertaking aims to show in a more definite way whether the programme does help parents to change and whether the change is lasting. If you agree to participate in this study, you will be required to:

> Fill in two questionnaires on 3 different occasions. The first will be approximately two weeks before the programme, the second immediately after the programme, and the third six months later. Some participants will need to wait for 2-3 months to get on the programme. These people will need to complete questionnaires on 4 occasions; before the 'waiting time', and then the 3 times as above.

Your GP will be informed of your involvement in the programme in case medication is introduced, changed or withdrawn during your participation in the study.

All information collected will be strictly confidential. All questionnaires will be anonymous. If at any stage after signing the consent form you wish to withdraw from the study, you may do so without giving a reason, and this will in no way affect your participating in the Self-esteem Building programme.

Please contact me if you wish to discuss any aspect of the study any further.
ANA KIRBY - Clinical Psychologist - (telephone number)

Does the Self-esteem Building Programme really work ?

CLIENT INFORMATION SHEET ONE

The Self-esteem Building Programme was first tried out 3 years ago when Health Visitors wanted to find better ways of helping parents who were experiencing certain relationship difficulties. These difficulties were to do with the handling of children, relationships with other adults (partners, family members, friends) or even their own fears or lack of confidence. Since then about 40 mothers have taken part in the programme. Many tell us how it has changed their outlook and the way they relate to others.

The study I am undertaking aims to show in a more definite way whether the programme does help parents to change and whether the change is lasting. If you agree to participate in this study, you will be required to:

1. Fill in two questionnaires on 3 different occasions. The first will be approximately two weeks before the programme, the second immediately after the programme, and the third six months later. Some participants will need to wait for 2-3 months to get on the programme. These people will need to complete questionnaires on 4 occasions; before the 'waiting time', and then the 3 times as above.

2. Tell an interviewer, in a 30-45 min taped interview, what effect the programme has had, if any, on the way you see yourself and, as a result, any changes in the way you relate to others. This will take place about a month after completing the programme.

3. Give taped interviews relating to childhood experiences on two occasions; before the programme, and six months after completion of the programme. Interviews will be about an hour long.

Your GP will be informed of your involvement in the programme in case medication is introduced, changed or withdrawn during your participation in the study.

All information collected will be strictly confidential. If at any stage after signing the consent form you wish to withdraw from the study, you may do so, without giving a reason, and this will in no way affect your participation in the Self-esteem Building programme.

Please contact me if you wish to discuss any aspect of the study any further.
ANA KIRBY - Clinical Psychologist - (telephone number)

STANDARD CONSENT FORM WHERE THE PARTICIPANT IS CONSENTING ON HER OWN BEHALF

Name of participant: _____

I, _____, Health Visitor involved in the Self-esteem Building Programme, being researched by Ana Kirby, Clinical Psychologist, have fully explained to this participant the nature and purpose of the research entitled:

AN INVESTIGATION INTO THE EFFECTS OF A SELF-ESTEEM FOCUS PROGRAMME ON SELF CONCEPT, SELF-ESTEEM AND REFLECTIVE FUNCTION

and she has consented to participate. I have given her a copy of the Client Information Sheet, regarding the research project and have answered her questions. She has kept the information sheet for future reference.

Signature of the Health Visitor: _____ Date: _____

Name (in capitals) _____

I (name) _____

hereby consent to take part in the above investigation, the nature and purpose of which have been explained to me. Any questions I wish to ask have been answered to my satisfaction. I understand that I may withdraw from the investigation at any stage and this will in no way affect the care I receive as a client.

Signed

Participant: _____ Date: _____

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Name of participant: _____

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Signature of the Health Visitor: _____ Date: _____

Name (in capitals) _____

I (name) _____

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Signed

Participant: _____ Date: _____

ROSENBERG SELF-ESTEEM QUESTIONNAIRE

Circle the appropriate number to show how you feel about yourself.

		Strongly Agree			Strongly Disagree
1.	I feel that I am a person of worth, at least on an equal plane with others.	1	2	3	4
2.	All in all, I am inclined to feel that I am a failure.	1	2	3	4
3.	I feel that I have a number of good qualities.	1	2	3	4
4.	I am able to do things as well as most people.	1	2	3	4
5.	I feel I do not have much to be proud of.	1	2	3	4
6.	I take a positive attitude towards myself.	1	2	3	4
7.	On the whole, I am satisfied with myself.	1	2	3	4
8.	I wish I could have more respect for myself.	1	2	3	5
9.	I certainly feel useless at times.	1	2	3	4
10.	At times I think I am no good at all.	1	2	3	4

PEARLIN & SCHOOLER QUESTIONNAIRE
HOW DO YOU FEEL ABOUT YOURSELF

Here are some statements about how people feel. Please read each statement and then circle the appropriate number to indicate how you feel at the moment.

1 = Strongly disagree

2 = Disagree

3 = Somewhat

4 = Neutral

5 = Somewhat

6 = Agree

7 = Strongly agree

		Strongly Disagree						Strongly Agree
1.	I certainly feel useless at times	1	2	3	4	5	6	7
2.	At times I think that I am no good at all	1	2	3	4	5	6	7
3.	I wish I could have more respect for myself	1	2	3	4	5	6	7
4.	All in all, I am inclined to feel that I am a failure	1	2	3	4	5	6	7

		Strongly Disagree						Strongly Agree
5.	I have little control over things that happen to me	1	2	3	4	5	6	7
6.	There is really no way I can solve some of the problems I have	1	2	3	4	5	6	7
7.	There is little I can do to change many of the important things in my life	1	2	3	4	5	6	7
8.	I often feel helpless in dealing with the problems of life	1	2	3	4	5	6	7
9.	Sometimes I feel that I am being pushed around in life	1	2	3	4	5	6	7
10.	What happens to me in the future mostly depends on me	1	2	3	4	5	6	7
11.	I can do just about anything I set my mind to	1	2	3	4	5	6	7
12.	I feel good that I have a number of good qualities	1	2	3	4	5	6	7
13.	I feel that I am a person of worth; at least on an equal plane with others	1	2	3	4	5	6	7
14.	I am able to do things as well as most people	1	2	3	4	5	6	7
15.	I take a positive attitude towards myself	1	2	3	4	5	6	7
16.	On the whole I am satisfied with the sort of person I am	1	2	3	4	5	6	7

I.D.	ros-ww	ros-pre	ros-post	ros-6m	ps-sd-ww	ps-sd-pre	ps-sd-post	ps-sd-6m	ps-m-ww	ps-m-pre	ps-m-post	ps-m-6m	ps-se-ww	ps-se-pre	ps-se-post	ps-se-6m
1D - 05	nil	25	30	32	nil	27	12	12	nil	19	35	41	nil	28	26	34
1D - 08	nil	19	26	29	nil	21	16	8	nil	23	28	39	nil	15	27	28
1D - 11	nil	23	29	20	nil	14	12	18	nil	21	37	24	nil	20	25	14
2S - 01	nil	27	37	30	nil	23	6	10	nil	20	38	37	nil	23	30	30
2S - 02	nil	12	12	18	nil	28	27	27	nil	nil	20	19	nil	nil	19	10
2S - 04	nil	24	28	24	nil	24	10	16	nil	28	40	30	nil	11	31	21
2S - 09	nil	15	29	23	nil	26	14	19	nil	25	34	27	nil	10	23	21
2S - 11	nil	23	28	nil	nil	26	19	nil	nil	25	42	nil	nil	23	29	nil
3S - 03	23	15	28	30	25	25	13	14	18	25	30	31	9	13	27	29
3S - 05	24	23	30	35	16	20	7	22	32	30	nil	48	12	19	nil	33
3S - 07	25	27	34	17	21	13	6	6	nil	nil	28	31	27	nil	32	33
3S - 12	15	22	33	16	23	21	13	24	26	35	31	24	11	23	29	11
4D - 01	22	25	28	26	17	16	14	12	18	32	41	37	20	23	30	24
4D - 02	39	40	DISCONTINUED		6	4	DISCONTINUED		33	49	DISCONTINUED		8	35	DISCONTINUED	
4D - 03	23	29	30	33	21	23	17	14	31	31	38	44	19	30	32	33
5S - 13	21	26	30	40	23	12	4	6	35	33	44	40	17	24	29	30
5S - 16	19	24	27	16	22	26	18	24	28	20	32	19	17	10	28	17
5S - 21	18	20	30	26	24	16	12	13	13	20	42	39	11	10	26	21
5S - 22	17	20	32	23	27	24	14	23	29	32	36	21	15	19	32	21
5S - 23	nil	24	23	26	nil	22	17	12	nil	21	26	23	nil	20	20	26
5S - 36	nil	21	25	24	nil	25	20	19	nil	19	35	29	nil	10	24	20
6D - 07	24	23	37	33	20	18	6	14	31	31	45	44	18	18	32	33
6D - 17	22	23	DISCONTINUED		19	16	DISCONTINUED		19	27	DISCONTINUED		nil	27	DISCONTINUED	
6D - 18	25	26	32	38	16	15	13	7	32	32	42	40	23	28	29	31
6D - 19	27	27	DISCONTINUED		21	18	DISCONTINUED		22	20	DISCONTINUED		23	19	DISCONTINUED	
7S - 14	26	27	DISCONTINUED		15	15	DISCONTINUED		29	30	DISCONTINUED		24	17	DISCONTINUED	
7S - 24	19	22	27	24	22	20	16	19	16	35	35	36	27	15	26	12
7S - 26	nil	18	20	21	nil	25	26	24	nil	26	25	21	nil	10	18	21
7S - 34	17	23	DISCONTINUED		27	28	DISCONTINUED		24	13	DISCONTINUED		25	7	DISCONTINUED	
7S - 35	24	24	35	28	23	22	7	17	25	22	37	36	29	29	33	29
7S - 77	nil	24	33	nil	nil	19	10	nil	nil	19	34	nil	nil	14	30	nil
8DL - 02	22	21	29	nil	22	15	12	nil	27	28	37	nil	19	20	23	nil
8DL - 06	27	33	DISCONTINUED		19	22	DISCONTINUED		26	36	DISCONTINUED		27	15	DISCONTINUED	
8DL - 08	24	31	26	22	25	8	16	21	27	27	27	26	21	30	19	24
8DL - 10	30	35	DISCONTINUED		10	7	DISCONTINUED		42	48	DISCONTINUED		26	28	DISCONTINUED	
8DL - 12	32	32	37	35	12	13	5	9	40	40	48	42	28	27	33	32
8DL - 14	24	23	24	19	23	20	23	22	28	29	33	21	21	20	20	13
8DL - 15	21	23	30	27	23	23	9	11	25	34	37	34	23	24	27	24
9D - 20	18	20	29	27	25	23	11	18	22	21	38	29	13	12	26	26
9D - 21	19	24	35	28	24	21	7	11	22	23	43	36	21	13	31	28
9D - 26	20	nil	DISCONTINUED		28	16	DISCONTINUED		25	33	DISCONTINUED		29	20	DISCONTINUED	
10S - 39	nil	20	28	33	nil	23	13	6	nil	21	40	44	nil	10	24	30
10S - 42	nil	13	25		nil	27	11		nil	17	36		nil	7	22	
10S - 45	17	13	24	28	27	24	22	15	16	18	33	38	9	10	21	29
10S - 46	16	31	24	29	27	26	15	14	14	18	31	35	7	7	21	25

Abbreviations:

Ros	Rosenberg
Ps	Pearlin and Schooler
Sd	Self denigration
M	Mastery
Se	Self-esteem
Ww	While waiting
Pre	Pre Programme Testing
Post	Post Programme Testing
6m	Testing 6 Months After
	Completion of the Programme
nil	Questionnaire scores were not available, or the questionnaire was not completed

Questionnaire scores for all scales at four testing times for all participants.

INTERACTION BETWEEN QUALITATIVE AND QUANTITATIVE MEASURES

PARTICIPANT 1

	Pre	Post
Rosenberg	21	25
Self-denigration	25	20
Mastery	19	35
Self-esteem	10	24

In Depth Interview.

This participant described herself as feeling useless and worthless. She also stated that she was a "nonentity". However, following the programme, this participant states that she no longer feels as negative about herself, and feels better about herself in general. This is also reflected in the answers given to the above questionnaires, especially in the instance of self-esteem where the score has made an extraordinary jump from 10 to 24. The self-denigration score however did not fall a great deal, and this is reflected in the fact that this participant says that she is still trying to convince herself that she is basically worthwhile.

PARTICIPANT 2.

	Pre	Post
Rosenberg	22	33
Self-denigration	21	13
Mastery	35	31
Self-esteem	23	29

In Depth Interview.

This participant reported that she felt unimportant, and had no confidence. She also felt that she was not coping, and often felt very down. After the group, this participant reports that she feels more confident, and does not feel so bad about herself. She also feels happier, and is more outgoing. This is reflected in her questionnaire responses. Self-esteem has increased dramatically in both the Rosenberg and the Pearlin and Schooler; self-denigration has decreased, whilst mastery has slightly decreased.

PARTICIPANT 3.

	Pre	Post
Rosenberg	24	23
Self-denigration	22	17
Mastery	21	26
Self-esteem	20	20

In Depth Interview.

This participant stated that before the group began, she was full of nerves. She complained that she felt taken for granted and was unsupported, and simply was not coping. However, after the group, this participant says that she feels more worthy and a bit more confident, and significantly she states that she has "found self-esteem". In both the Rosenberg and the self-esteem component of the Pearlin and Schooler, the scores remained the same between pre and post. Self-denigration fell consistently from the time of pre to post testing, whilst mastery increased at the time of post testing.

PARTICIPANT 4.

	Pre	Post
Rosenberg	15	28
Self-denigration	25	13
Mastery	25	30
Self-esteem	13	27

In Depth Interview.

This participant expressed the fact that before the group, her self-esteem was at rock bottom. She was always worrying about what other people thought of her, and she felt very low and worthless. Following the completion of the group, she realised that she does have value as a person, and that she is worth something. She feels more assertive, and is able to stand up for herself. She states she feels much more positive. These sentiments are certainly represented in the questionnaire results. The Rosenberg score rose between pre and post group testing. The score for the self-esteem component of the Pearlin and Schooler also rose to similar levels. The level of self-denigration fell consistently, and the score for mastery rose continuously throughout the period of testing.

PARTICIPANT 5.

	Pre	Post
Rosenberg	13	24
Self-denigration	24	22
Mastery	18	33
Self-esteem	10	21

In Depth Interview.

This participant commented that she had no confidence, and described herself as a "bit of a doormat". She found that before the group, she did not cope very well, and was very low. After the group, she stated that she has a "lot higher self-esteem", which is certainly reflected in the self-esteem scores of the questionnaires. The Rosenberg rose sharply between pre and post group testing. She also comments that she has a lot more confidence following the group. This participant has found that she can cope, and that she is able to stand up for herself. This can be seen in the self-denigration and mastery scores, which fell and increased respectively throughout the period of testing.

PARTICIPANT 6.

	Pre	Post
Rosenberg	27	34
Self-denigration	13	6
Mastery		28
Self-esteem		32

(missing scores due to incomplete questionnaires)

In Depth Interview.

This participant claims that before the group began, she felt worthless and shy. She also thought people were talking about her behind her back. Following the group, she found that the group had helped her to realise that she is worthwhile, and this apparent increase in self-esteem can be seen in the questionnaire scores. She also states that she is now more outspoken and able to stand up for herself, as well as being more outgoing and positive. This is reflected in the scores for mastery and self-denigration - self-denigration having fallen from 13 at pre group testing to 6 at post group testing. The missing scores are due to incomplete questionnaires.

PARTICIPANT 7.

	Pre	Post
Rosenberg	24	27
Self-denigration	26	18
Mastery	20	32
Self-esteem	10	28

In Depth Interview.
According to this participant, before the group she did not feel worth anything to anybody, she hated herself, and she had low self-esteem. The self-esteem component of the Pearlin and Schooler certainly shows this to be the case, although the Rosenberg shows a higher score.

Following the group, this participant remarks that she has regained her feelings of self worth and feels worthwhile, and has also gained a little more confidence. She feels she can cope better, and is able to stand up for herself. This can be seen in the questionnaire scores, as both self-esteem scores have increased. The self-denigration score fell at the time of pre to post testing, whilst the mastery score rose significantly.

PARTICIPANT 8.

	Pre	Post
Rosenberg	26	30
Self-denigration	12	4
Mastery	33	44
Self-esteem	24	29

In Depth Interview.
This participant described her personal message as being "I am insignificant" , and she also felt that she was walked over. She states that no one took any notice of what she had to say. However prior to the group, both her self-esteem scores are quite high.

Following the completion of the group, this participant is adamant that she is significant, and states that she is probably living her life more confidently than ever before. This is certainly reflected in her questionnaire scores, as the self-esteem and mastery scores have steadily increased, whilst the self-denigration score has fallen to 4 at the time of post testing.

PARTICIPANT 9.

	Pre	Post
Rosenberg	24	35
Self-denigration	22	7
Mastery	22	37
Self-esteem	29	33

In Depth Interview.
With reference to this participant, she states that before the group, she felt she was a person of worth, but her behaviour probably did not reflect this. This can be seen above in the self-esteem questionnaire scores before the group.

Following the completion of the group, this participant intimates that she knows she is good and that she deserves things, and is now able to accept herself for who she is. She also feels that as a result of the group she is able to get on better with people, and yet is harder with people than she used to be. Finally, she states that she feels as though she is on the "right track". The mastery score increased a great deal between the time of pre and post group testing, and the self-denigration score fell from 22 at pre testing to 7 at the time of post testing.

PARTICIPANT 10.

	Pre	Post
Rosenberg	31	26
Self-denigration	26	15
Mastery	18	31
Self-esteem	7	21

In Depth Interview.
In this interview, the participant remarks that before the group, she had no confidence, and she hated herself. She also felt very down, and found it hard to go out. This can be seen in the questionnaire score for the self-esteem component of the Pearlin and Schooler, although is rather contradicted by the results from the Rosenberg questionnaire which show quite a high score for self-esteem. However as expected the score for self-denigration is high when tested before the group.

After the group, the participant reflected that she is better than she was, and feels stronger. She also recognises that she has worth and

value. However she is still fighting the days when she wakes up and feels she hates herself. Both self-esteem scores reflect this in that they are still high at the time of post testing, but the Rosenberg score has dropped slightly - possibly in line with the acknowledgement that sometimes she still hates herself. The mastery score has increased from pre to post testing, whilst the self-denigration score has fallen - again mimicking the comments made in the in depth interview.

PARTICIPANT 11.

	Pre	Post
Rosenberg	20	32
Self-denigration	24	14
Mastery	32	36
Self-esteem	19	32

In Depth Interview.

Before the group began, this participant did not see herself as someone of worth. She lacked confidence, had incredibly low self-esteem, and was convinced that she was "not quite right". This is replicated in her self-esteem scores which are quite low before the group commenced. Her self-denigration score is also quite high, thus reflecting her comments about not seeing herself as someone of worth. However her mastery score is also quite high at the time of pre group testing.

Following the group, this participant states that she has a bit more confidence, and feels stronger, although she still experiences anxious spells. At the time of post testing we can see that her self-esteem scores have continued to rise, as has the mastery score, whilst the self-denigration score has fallen.

MAJOR CHANGES DURING THE LAST EIGHT WEEKS
(Since doing the first set of questionnaires)

During the last eight weeks have any of the following happened:
(please indicate YES or NO)

medication introduced	
medication changed	
medication stopped	

If you answered YES to any of the above, please indicate what medication is involved.

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Has there been any other significant change in your life over the last eight weeks that could have had an impact on the way you are feeling about yourself at the moment ?

If YES, details would be appreciated.

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MAJOR CHANGES DURING THE LAST EIGHT WEEKS
(while you have been attending the group)

During the last eight weeks have any of the following happened:
(please indicate YES or NO)

medication introduced	☐
medication changed	☐
medication stopped	☐

If you answered YES to any of the above, please indicate what medication is involved.

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Has there been any other significant change in your life over the last eight weeks that could have had an impact on the way you are feeling about yourself at the moment ?

☐

If YES, details would be appreciated.

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MAJOR CHANGES DURING THE LAST SIX MONTHS
(since having attended the group)
i.e. the time(date on which group terminated) and now

During the last six months have any of the following happened:
(please indicate YES or NO)

medication introduced	
medication changed	
medication stopped	

If you answered YES to any of the above, please indicate what medication is involved.

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Has there been any other significant change in your life over the last six months that could have had an impact on the way you are feeling about yourself at the moment ?

If YES, details would be appreciated.

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