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**INCREASING CHILDREN'S PARTICIPATION IN THERAPY: COMBINING AN
UNDERSTANDING OF CHILDREN'S EXPERIENCES OF THERAPY WITH
EVIDENCE-BASED PRACTICE.**

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**Submitted in fulfilment of the requirements for the Professional Doctorate in
Psychology (Counselling Psychology)**

April 2008

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ACKNOWLEDGEMENTS

I would like to acknowledge the many people who participated in or supported me in undertaking this thesis. Firstly, to the children who kindly and bravely agreed to participate in the study and share their experiences - I feel privileged to have met such an interesting and insightful group of people. To my colleagues in the tier three CAMHS service, particularly Dr Grania Clark, Dr Rita Harris and Debbie Lampon, and to the school counsellors who facilitated children's participation in this study. To my supervisor Dr Malcolm Cross for his supervision and advice. To Dr Crispin Day for his generous consultation. To my manager Graham Music for his ongoing support and interest in my research. Finally, but very importantly, sincere thanks to my husband, family and friends for their continued support and practical help over the past four years.

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ABSTRACT

This thesis examined children's experiences of therapy and used grounded theory (Strauss & Corbin, 1998) to develop a theory that may explain this. Eighteen children aged 7-14 years who had attended therapy at a child and adolescent mental health service or school-based therapy service participated in an individual interview. The study found that therapy is a process for children and identified sub-processes and activities that work to affect children's experiences of therapy. The professional practice component is a case study describing the use of cognitive behaviour therapy with a thirteen-year-old girl presenting with symptoms of anxiety. The literature review component is a critical review of the empirical literature on the use of motivational interviewing with children.

Keywords: Child and adolescent mental health, client experience, therapy process.

SECTION A

PREFACE

PREFACE

Mental health problems and mental disorders in children can devastate the lives of those affected and destroy the quality of life of those around them (Primary and Community Healthcare Division, National Assembly for Wales, 2001). However, despite mental health problems in children being common and having increased in frequency since World War Two (Kramer & Garralda, 2000), only a minority of children with diagnosable problems receive professional intervention (Fonagy et al., 2002). This has increased the focus on child and adolescent mental health and highlighted the need for greater research and development in relation to the psychological services available to children and their families. This thesis researches and critically analyses three different areas related to psychological therapy with children, reflecting some of the current issues, themes and challenges for clinicians who work with children. The Doctorate in Psychology (D.Psych) degree at City University, London requires the submission of a portfolio of work incorporating a preface, an original piece of applied research, a clinical case study and a critical review of literature. In this chapter the different components of the thesis are described, followed by a discussion of some of the common themes raised in these pieces of work. The chapter concludes by summarising the contribution of this work, including the clinical challenges it identifies, before proposing future research directions.

The aim in section B (the research component) was to build upon the limited research on children's experiences of attending therapy. Section B describes a qualitative grounded theory study, which used individual interviews with eighteen children aged between seven and fourteen years to systematically examine children's experience of therapy. The study set out to identify the core concepts for children and

the potential relationships between concepts, in order to build a theory that may help to explain children's experiences. This study found that therapy is a process for children and it identified a number of sub-processes and specific activities that contribute to how children experience therapy. These are outlined in a theory, described diagrammatically in a model. The theory emphasises the role and impact of the conditions present for the child at the commencement of therapy, that the child is an active member of the therapeutic encounter, and that the actions of the clinician and child interact and mutually influence each other over the duration of therapy. One of the unique contributions of this research is that it moves beyond a descriptive account of children's experiences of therapy to propose a theory that holds some explanatory power. These findings have theoretical and clinical implications for clinicians conducting therapy with children. Perhaps the most important of these is that a greater appreciation of children's experiences enables clinicians to reflect upon and potentially refine their practice in order to be more attuned to children's needs.

Section C (the professional practice component) is an example of direct clinical work, in a community-based setting, with a child presenting with anxiety. This case illustrates how the assessment and a scientist-practitioner perspective were utilised to select an appropriate intervention, namely cognitive behaviour therapy (CBT). In this case parental involvement in therapy was incorporated in order to try to enhance the effectiveness of the intervention. Section C reviews the evidence supporting parental involvement in child-focused CBT as well as highlighting the issues associated with doing so in practice. The intervention achieved quite rapid symptom relief before focusing on the core beliefs underlying the child's anxiety in an attempt to facilitate generalisable and long term change. Section C outlines the strengths and clinical challenges of this intervention, comments upon the role of the

therapeutic relationship and reflects upon what this case may suggest about the essential components of a child-focused CBT intervention.

The final component of this thesis, Section D, is a critical review and analysis of the empirical literature on the use of motivational interviewing (MI) with children. The use of MI with children is relatively new. After reviewing the published studies to date, a number of recommendations are made for further qualitative and quantitative research to address fundamental issues related to using MI with children and to refine the knowledge base in this area. Finally, the section outlines theoretical and empirical evidence suggesting that MI could make an effective contribution in the area of child and adolescent mental health.

Although the three components of this thesis are distinct and discrete pieces of work, they are linked in that they reflect some of the current theoretical and practical issues in clinical practice with children. These include; an increased focus on the role of psychological therapies, an increased research interest on therapy with children, the use of evidence based practice in counselling psychology, increased child participation in services that affect them and the movement towards community based mental health provision.

The use of psychological therapies or 'talking therapies' for common mental health conditions has been highlighted in recent years due to consistent research findings that they are as effective as medication, with good long term effectiveness and high acceptability for clients. Psychological therapies are now widely recommended in The National Institute for Clinical Excellence (NICE) guidelines and strong economic and clinical arguments have been made for their use (The Centre for Economic Performance, 2006). The UK Department of Health has committed to increasing the availability of psychological therapy through the

Improving Access to Psychological Therapies initiative. The use of psychological therapies has been particularly highlighted for children, with recommendations that they should be the “first line” of action for children with conditions such as depression (The European Medicines Agency, 2006). There is now a focus on how psychological therapies can be most useful and suitable for children. This thesis continues this focus and the three components of the thesis examine the appropriate use of psychological therapies with children from different perspectives.

Research on therapy with children has been limited in comparison to the adult literature and counselling psychology as a discipline has been identified as one that has traditionally neglected research and practice with children (Powell & Vacha-Haase, 1994). Certain areas of research have been particularly lacking, such as effectiveness research and studies that include the role of a child’s family, school and community (Waddell & Godderis, 2005). This thesis examines areas in which research is at an early stage and in doing so it aims to contribute to some of the gaps in the literature. An example of this is that Section D describes how an adult intervention, motivational interviewing, has been utilised with a child population, in the absence of a strong empirical basis. Section D outlines the type of research needed to refine the knowledge base in this area, to enable clinicians to have greater confidence in using MI with children. An example of a more established area of research is the use of CBT with childhood anxiety, as discussed in Section C. However, even in this area, key issues such as the optimal role for the child’s parents in therapy, remain unclear. In contrast, Section B aimed to contribute to research from a different perspective, by consulting children directly about their experiences of therapy.

The three sections of this thesis also reflect the importance of the use of evidence based practice in counselling psychology. The notion of evidence based practice and the scientist practitioner model has been heavily scrutinised and criticised in recent years (Lane & Corrie, 2006). However, it could be argued that much of this criticism relates to a narrow understanding of what constitutes evidence based practice or confusion with the more narrow concept of empirically supported treatments (APA Presidential Taskforce on Evidence Based Practice, 2006).

Counselling psychologists advocate the use of a broader, more open definition of the scientist practitioner model and evidence based practice (Lane & Corrie, 2006). This definition incorporates multiple sources of evidence and a broader range of clinical activities, retains a focus on the client and can incorporate factors such as therapist variables and the therapeutic relationship (Lane & Corrie, 2006). Each component of this thesis reflects the use of evidence based practice within such a framework and the thesis particularly highlights the value of incorporating research on client experience as a valuable component of evidence based practice.

This thesis also signals the movement towards increasing child participation in services that affect them. Participation can be defined as asking children what works, what doesn't and what could work better, and involving them on an ongoing basis, in the design, delivery and evaluation of services (Children & Young People's Unit, 2001). Child participation is thought to facilitate positive change, particularly in relation to achieving better outcomes for children and families. This thesis provides examples of child participation, such as: involving children directly in research (Section B); the use of techniques or tools, such as therapeutic contracts, to enhance children's participation in therapy (Section C); and highlighting the need for research with children regarding how they experience an intervention (Section D). It

is hoped that these examples may illustrate the value in having an ongoing dialogue with children as a routine part of clinical practice.

Finally, this thesis reflects a movement towards community-based mental health provision, whereby intervention is provided in the child's environment such as at home or school. This development is consistent with a broader philosophy of children being cared for in the least restrictive or intrusive environment possible (Furman & Jackson, 2002). This movement is reflected in each of the three components of this thesis; in Section B half of the research participants attended therapy in a school setting, in Section C the child was seen in a school setting and Section D reviews the use of motivational interviewing which can be used in settings where children commonly present (Stern et al., 2007). Some of the advantages and challenges of community based mental health provision are discussed throughout the thesis.

This thesis has a number of theoretical, research and clinical applications. The model proposed in Section B can be used as a tool for clinicians to reflect upon their practice with children and the utility and generalisability of the model can be examined in future research. The findings of this study can also be used to help clinicians focus on the importance of process and therapeutic factors, consistent with the philosophy of counselling psychology. Other applications include an emphasis on the need for greater information and preparation for children prior to therapy and the suggestion that children are willing and competent participants in research. This thesis also discusses some of the challenges inherent in conducting research and therapy with children, such as the impact of utilising an 'opt in' model of research participation and the difficulty in determining the optimal role of parental involvement in therapy. Although research in this area is rapidly expanding, future

research is needed to resolve some of the therapeutic dilemmas with child populations. It is hoped that this thesis may contribute towards the increased research and clinical focus on psychological intervention with children, particularly in relation to strengthening the voice of children in therapy.

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SECTION B

RESEARCH

Chapter One

INTRODUCTION

Epidemiological research indicates that mental health problems in children are common, persistent and handicapping (Kramer & Garralda, 2000). One in five children experience psychological problems at any one time (Fonagy et al., 2002) and ten percent of children meet the diagnosis for a mental health disorder (Roose & John, 2003). Mental health problems in children have increased in the latter part of the twentieth century (Roose & John, 2003) and research suggests that these problems do not remit spontaneously (Fonagy et al., 2002). The World Health Organisation and the United Nations Children's Fund warn that unless more is done to address the issue of child and adolescent mental health there will be serious public health problems in the future (World Health Organisation, 2002).

Psychological therapies have an important role to play in helping people with mental health problems (Department of Health, 2001). They have demonstrated benefits and have been found to be a cost effective treatment for common mental health problems (The Centre for Economic Performance, 2006). There are many different models of psychological therapy, including; cognitive behaviour therapy, psychoanalytic therapies, systemic therapy, eclectic therapy, integrative therapy and humanistic therapy. However, the effectiveness of all forms of therapy depend on the therapist and the client forming a good working relationship (Department of Health, 2001). Psychological therapies are provided by mental health professionals from a range of disciplines, with an emphasis on utilising an evidence based approach to practice. However, research on psychological therapy with adults is still some way ahead of that for children (Fonagy et al, 2002). It is suggested that service provision to children is also lacking, only a minority of children with diagnosable mental

health problems receive professional intervention, children with the most complex needs being the least likely to reach appropriate services (Fonagy et al, 2002).

The increasing number of children with mental health problems has focused attention on the quality of child and adolescent mental health services (Buston, 2002), leading to an increased emphasis on evidence-based practice, service evaluation and user involvement (Foskett, 2001). One aspect of user involvement is the need to consult child service users directly about their experiences. Children's rights to be involved in matters that affect them has been enshrined in legal frameworks, such as the United Nations Convention on the Rights of the Child Article 12 and 13, The Children's Act of 1989 and the National Service Framework for Children, Young People and Maternity Services. Health policy in the UK has set out to create a 'patient-centred' service where children's voices and those of carers are heard and used as a lever for improvement (Day, Carey & Surgenor, 2006). However, despite this, few child and adolescent mental health services in the United Kingdom have initiated work in the area of user involvement (Hart, Saunders & Thomas, 2005).

Definitions of Psychotherapy and Client Experience

This study will focus on children's experiences of one component of mental health services, psychotherapeutic services in outpatient and community settings. Psychotherapy practice is enormously diverse and it is difficult to define psychotherapy in a concise 'non-sectarian' manner (Gordon, 2000). The definition that will be used in this study is that of Holmes and Lindley (1989) "the use of the relationship between therapist and client, as opposed to pharmacological or social methods, to produce changes in cognition, feeling and behaviour" (p.7). Elliot and James (1989) studied the basic domains of client therapeutic experience and their

definition of client experience will be used in this study. Elliot and James suggested that “client experience refers to client’s sensations, perceptions, thoughts and feelings during, and with reference to, therapy sessions” (p. 444). This is a broad definition that focuses on the content of client experience and recognises client agency and the role of the client as an active participant in the therapeutic process (Gordon, 2000). This definition does not assume that process and outcome bear a simple cause and effect relationship to one another (Stiles & Shapiro, 1989).

Research on Client Experience

The professional point of view, together with professional values and assumptions, has dominated journal articles to the exclusion of the client point of view and the client experience (Foskett, 2001). Some of the reasons why client experience has been poorly studied are related to the field of therapy having largely conformed to the medical and academic model of evaluation (Foskett, 2001) and followed the assumptions and practices of natural science (Gordon, 2000). These disciplines have been largely uninterested in client experience and unwilling to alter their methods and assumptions in order to take account of it (Gordon, 2000). Gordon discussed other contributing factors, including a focus on proving the scientific credibility of a model of therapeutic practice and the previously held notion of the client as a passive recipient of clinician intervention. Gordon (2000) also noted that researching client experience can be difficult for ethical and practical reasons. Clinicians themselves may have contributed to the lack of emphasis on client experience, with research suggesting that clinicians generally react with resistance to client feedback systems (Jarrett, 2008). At a service level, client views may radically challenge the philosophy and operation of a service, and a wish to maintain the status

quo may be another reason why client experience has been poorly researched (Laws, 1998).

Children's experiences have been even more poorly researched. Opinions from child and adolescent mental health service users have been almost completely limited to the views of the parent or carer (Roose & John, 2003). This is partially due to children having had a restricted voice in society (Greig & Taylor, 1999) and the cultural reluctance to take children's ideas seriously (Morrow & Richards, 1996). Consequently, in the past, children's views regarding their own treatment were rarely taken into serious consideration (Franklin & Sloper, 2005). Children have also been portrayed as suspect data providers compared to adults (Mayall, 1996). The cognitive limitations of children have been stressed, undermining the value placed on their views and raising doubt about their interpretive validity (Howieson & Semple, 2000). Finally, the increased difficulties in conducting research with children, including adults' gate-keeping access to children (Morrow & Richards, 1996), has limited research in this area.

The lack of research on children's experiences of therapy is not in keeping with the way in which the literature has evolved to an appreciation of the importance of client experience. It is now far more recognised that the client has causal powers, that his/her action is purposeful and he/she is an active agent that constructs and manages his/her social world (Gordon, 2000). There is an emphasis on the importance of client-defined outcomes (Chesson et al., 1997). There is also an increase in the popularity of models of therapy that value client opinions, such as systemic therapy (Conran & Love, 1993), and privilege the client's voice (Duncan, Miller & Sparks, 2004). The latter authors describe how many postmodern therapies, such as narrative and solution focused approaches, "put the client's voice at centre

stage” (pp 127). Duncan, Miller and Sparks (2004) describe how in their approach they “invite and formalise client input and feedback, enlist client resources and value collaboration” (pp 127).

It is more recognised that there are significant advantages to consulting clients about their experiences of therapy. Study of client experience provides researchers, theoreticians and clinicians with a better understanding of the process and action of psychotherapy (Elliott & James, 1989). Studying client experience can also enable clinicians to offer a more sensitive and effective therapeutic experience (Strickland-Clark, Campbell & Dallos, 2000). A study of client experience can lead to the development of more effective services, as clinicians become more sensitive to the intentions, concerns, experienced impacts and other perceptions of clients (Elliot & James, 1989). Finally, understanding client experiences has the potential to facilitate help-seeking and improve the user friendliness of services, potentially boosting attendance rates, and improving engagement with programs and treatments (Buston, 2002).

In studying client experience it is important to consult children directly about their experiences, as research indicates that children, parents and clinicians have different perspectives and concerns (Gould, Shaffer & Kaplan, 1985). Research suggests that children want to and can be effectively consulted regarding their own therapy. Even quite young children can engage well in the research process (Hill, Laybourn & Borland, 1996). Children have been described as: able to provide clear and coherent accounts (Buston, 2002); thoughtful and articulate in their answers and able to reflect on their experience in a meaningful way (Strickland-Clark, Campbell & Dallos, 2000); and fair, balanced, and responding in a responsible and constructive manner (Howieson & Semple, 2000). Children respect the notion of research

(Strickland-Clark, Campbell & Dallos, 2000); they want to be consulted and value the opportunity to have input (Flitton & Buckroyd, 2002).

Review of the Literature on Children's Experiences of Therapy

This study will systematically examine children's experiences of therapy. This chapter is a review of the existing literature, in order to provide a context for this study. The review is limited to studies that examine children's experiences of therapy from the child perspective, rather than that of a trained rater, clinician or parent. This was done in order to gain the most direct source of information about client experience (Elliott & James, 1989). Elliott and James argue that clients have 'privileged access' to certain areas of therapy process, so where information about the meaning and value of therapy is sought, the client may be the only accurate source of information.

Criteria for Inclusion

Studies were included in this literature review if they examined children's experiences of either individual or family therapy. Studies of client experience in group therapy were excluded due to the group variables that make this a qualitatively different experience. The studies included were those that focused broadly on children's experiences, allowing children to define the issues of most importance to them. For this reason studies that focused on one discrete aspect of client experience, selected by the researcher, were excluded. These include studies on the extent to which children come to therapy unknowingly and unwillingly (Paul, Foreman & Kent, 2000), children's ability to identify risks and benefits of therapy (Kaser-Boyd, Adelman & Taylor, 1985) and children's conception of confidentiality within the therapeutic relationship (Messenger & McGuire, 1981). Finally, studies were largely excluded if the participants were not aged within the legal definition of childhood

(under eighteen years old). An exception was made in relation to the age criteria in order to be able to include three important studies. In each of these studies the average age of participants was under eighteen years and only a small number of participants were over eighteen years. It is acknowledged that the age criteria resulted in the exclusion of an important United Kingdom national research study on the experiences of young people from Black and minority ethnic groups in using child and adolescent mental health services (Street, Stapelkam, Taylor, Malek & Kurtz, 2005) however this will be referred to briefly in this chapter and in the discussion.

A literature search, using the above criteria, revealed two studies on children's experiences of individual therapy, five studies on children's experiences of family therapy, two studies where the children received primarily individual therapy with some family involvement and one study in which children received individual therapy or family therapy or both. Of those children who received individual therapy, not all studies specified the therapeutic model guiding intervention but those which did included psychodynamic therapy, behaviour therapy, eclectic therapy and person-centred therapy. Of these ten studies, eight are published and two are unpublished. It was decided to limit inclusion to published studies, however the two unpublished studies were included as they made a unique and valuable contribution to the research in this area. Nine of the ten studies examined children's experiences at a whole treatment level, while one study examined children's experiences at a session level. Four studies involved children who were currently in therapy, six studies involved children who had concluded therapy. All of the studies utilised qualitative methodology. The characteristics of each study are summarised in Appendix A. A thematic analysis was undertaken to distil the key findings in these studies and the

categories identified include: pre-therapy and early therapy experiences; the process of therapy; satisfaction and perceived outcomes; and suggestions for change.

Pre-Therapy and Early Therapy Experiences

How Therapy was Initiated

All of the studies found that therapy is largely adult-initiated, and confusion surrounded the commencement of therapy for many children. Hart, Saunders and Thomas (2005) reported that only one child, in their sample of twenty-seven children, self-referred. In all other cases parents explicitly asked for help or were a key factor in their child's attendance, with an element of tension over the referral in some cases. Vossler (2004) found that there were three pathways of entry to therapy: in nine out of seventeen cases therapy was parent-initiated, in two cases it was child-initiated and in six cases attendance was negotiated between the parent and child, with the decision to "try out" therapy. One outcome of therapy being adult-initiated was that some children initially had a limited understanding of where they were going and for what reason (Clark, 2001).

Reason for Attending Therapy

The studies that did ask children about their reason for attending therapy reported that many children were vague (Clark, 2001) and unclear (Stith et al., 1996). Clark (2001) reported that some children had the notion 'of speaking to someone to help', similarly Stith et al. (1996) found that most children thought that they were coming to therapy due to the existence of problems that needed to be solved. However, Stith et al. indicated that children's understanding of this was poor despite the parents reporting that they made some effort to prepare their child.

Two of the studies reported that children took responsibility for the issue that brought them to therapy. Lobatto (2002) noted that while not all of the children in

her study were clear about the nature of the problem, all of the children took possession of the problem. Lobatto hypothesised that this may have been partially due to the children being interviewed in front of a parent/carer, creating a reluctance by children to refer to adult participation in the problem. Hart, Saunders and Thomas (2005) also found that children were often readily able to accept whatever problem they had, however none of the parents discussed how their behaviour may have had an impact on the child and his/her problems.

Children's understanding of the reasons for attending therapy were sometimes different from the reasons cited by their parents (Lobatto, 2002; Stith et al., 1996; Vossler, 2004). Vossler (2004) found that this occurred in a third of cases, which he hypothesised was partly due to the child not being included in the intra-familial negotiation process that led to therapy.

Expectations and Intentions

Children's expectations about therapy and personal intentions for therapy are not well researched. Expectations refer to a person's understanding of the probability that an event will occur (Tinsley, Bowman & Westcot Barich, 1993). There was an absence of clear expectations from children about their first appointment and the process of therapy (Day, Carey & Surgenor, 2006) and most children did not possess a realistic understanding about what would occur (Vossler, 2004). In the absence of clear expectations for therapy, children focused on what they least wanted or most feared (Montgomery, 2003). They imagined therapy to be formal, intimidating and a place where they would be judged and questioned intensively. There was also a feeling of pessimism that the therapy process would not be helpful. Montgomery concluded that these perceptions were based largely on media portrayal of therapy and the opinions of the child's peer group.

Intentions refer to the hopes, aims, tasks and intentions that the client brings to therapy (Elliott & James, 1989). The studies reviewed did not ask children about their own intentions for therapy. This omission could reflect the influence of the idea that the client is a passive recipient of therapy or may reflect that children do not initially have clear or identifiable intentions for therapy. None of the studies reported whether provision of information in the first session assisted children in developing their own intentions for therapy.

Initial Feelings

Client feelings refer to the client's in-session feeling state or mood (Elliott & James, 1989). Initially many children felt negative in-session feelings, including feeling: shy and suspicious about the therapeutic team and equipment in the room (Montgomery, 2003); anxiety, fear and worry (Clark, 2001); low motivation to engage in therapy (Vossler, 2004); scared (Kuehl, Newfield & Joanning, 1990); and ambivalent (Strickland-Clark, Campbell & Dallos, 2000). Children did not feel at ease (Montgomery, 2003) and felt very uncertain (Clark, 2001) in the early phase of therapy and it has been suggested that this impacted on their behaviour in early sessions; for example Kuehl, Newfield and Joanning (1990) reported that children would try to say as little as possible.

Process of Therapy

Orlinsky and Howard (1987) defined process as everything that can be observed to occur between, and within, the client and clinician during their work together. Although very few studies have examined children's experiences of the process of therapy, the ten studies in this review reported a range of findings related to children's feelings in therapy and their participation in therapy.

Children's Feelings

In most cases children's feelings about therapy became more positive over time (Clark, 2001). Researchers suggest that this was due to: children's increased level of comfort with the interpersonal aspects of therapy (Stith et al., 1996); seeing therapy as an opportunity to find solutions to problems (Strickland-Clark, Campbell & Dallos, 2000); and remaining in therapy for long enough to be able to share successes with the clinician (Kuehl, Newfield & Joanning, 1990). However, not all children felt more positively about therapy over time. A small number of children continued to have negative feelings about therapy (Clark, 2001; Kuehl, Newfield & Joanning, 1990) and some children continued to feel confused about the rules of therapy and behaviour required of them (Lobatto, 2002).

Children experienced strong feelings within therapy sessions (Clark, 2001; Kuehl, Newfield & Joanning, 1990; Strickland-Clark, Campbell & Dallos, 2000) and when they were experiencing strong emotions they found it difficult to express themselves verbally, heightening their feeling of not being heard (Strickland-Clark, Campbell & Dallos, 2000). It was also difficult for children when therapy brought up feelings and memories of painful times and in hearing family members talk about feelings (Strickland-Clark, Campbell & Dallos, 2000). Children worried about upsetting family members in therapy sessions and about getting things wrong (Lobatto, 2002). Children found it difficult to express how they were feeling in therapy sessions, which Strickland-Clark, Campbell & Dallos (2000) hypothesised was related to: a belief in the clinician's expertise; questioning whether the clinician cared what he/she thought; the experience that feelings weren't acknowledged in the session; and when the clinician asked the child to do something that he/she didn't know how to do.

Children actively tried to manage and regulate their feelings in therapy.

Lobatto (2002) found that this was through children choosing to stay quiet, deflecting attention from themselves, playing with younger siblings, becoming noisy in the session or inventing a problem for discussion. She noted that the children had varying degrees of resourcefulness in being able to negotiate a position that they were comfortable with. Day, Carey and Surgenor (2006) found that children tried to regulate both the intensity and the intimacy of the therapeutic interaction to suit the stage of the child-clinician relationship from their perspective.

Participation in Therapy

Children were active participants in therapy and were consciously trying to position the therapy in a way that best suited their needs (Kuehl, Newfield & Joanning, 1990). Lobatto (2002) found that children's participation in therapy is complex. She reported that children were internally very active throughout therapy, constantly monitoring the alliances in the room and working to maintain a position for themselves that felt comfortable. Yet she also found that children were trying very hard to do the right thing in the sessions and on occasions did something that they did not really want to do. Most children were open to the therapeutic process and actively engaged, despite some children being initially defensive (Clark, 2001; Montgomery, 2003; Vossler, 2004).

Clinician Characteristics, Skills and Decisions

Clinician characteristics, articulated by children as his/her personality and behaviour, were found to be an essential, if not the central, ingredient to therapy. It was important to children that the clinician was nice (Stith et al., 1996), friendly and empathetic (Hart, Saunders & Thomas, 2005). Montgomery (2003) reported that children valued the clinician having a non-judgmental attitude, being non-prejudicial,

not having an agenda or telling them what to do, not placing pressure on them to behave in a certain way, and being genuine. Neither race nor sexual orientation was reported an issue for children, however, gender emerged as significant (Hart, Saunders & Thomas, 2005; Montgomery, 2003) in that children, particularly girls, had a preference for a female clinician. Hart, Saunders and Thomas (2005) also found that children preferred a young clinician.

Therapeutic Skills

Children emphasised being listened to (Hart, Saunders & Thomas, 2005) and being heard (Strickland-Clark, Campbell & Dallos, 2000). Day, Carey and Surgenor (2006) found that children liked it when their words and ideas were repeated back to them by the clinician, as this helped them to feel understood. Children also reported finding it helpful when the clinician was empathetic (Hart, Saunders & Thomas, 2005) and transparent regarding the course of action (Vossler, 2004). Correspondingly, it was experienced as unhelpful when children did not feel heard and when children felt that their reality was not acknowledged or understood in sessions (Strickland-Clark, Campbell & Dallos, 2000). Children felt uneasy when the clinician was not transparent in relation to the conduct and objective of therapy and when they did not include the children in the sessions from the beginning (Vossler, 2004). Children also found it unhelpful when the clinician's questions and advice suggested that they did not really understand what family members were thinking or feeling, which decreased children's motivation towards therapy (Kuehl, Newfield & Joanning, 1990). Hart, Saunders and Thomas (2005) described children as being 'Rogerian' in relation to the characteristics and skills that they valued in an ideal clinician; they concluded that person-centred skills were more relevant to children than particular intervention techniques.

Confidentiality

Confidentiality was of great importance to the majority of children. McConnell and Sim (2000) found that two thirds of children expressed appreciation for the fact that therapy was confidential, explaining that it made them feel safe and that they were glad that their parents were not informed about what was discussed. Similarly, Day, Carey and Surgenor (2006) noted that the confidential nature of appointments provided the basis upon which children felt comfortable to talk about their concerns. However, McConnell and Sim (2000) found that not all of the children interviewed had a positive experience of confidentiality. Hart, Saunders and Thomas (2005) reported that the importance of confidentiality to some children led to difficulty in satisfying all parties regarding the level of feedback given.

Therapeutic Techniques

While some children found it difficult to articulate what the clinician was doing in sessions that was helpful (Hart, Saunders & Thomas, 2005), other children were able to identify some of the therapeutic techniques that they found helpful and unhelpful. Children expressed a preference for the inclusion of activities (Clark, 2001) and the use of materials in therapy (Montgomery, 2003). Day, Carey and Surgenor (2006) found that children enjoyed playing games, drawing pictures and engaging in other child-friendly activities. They suggested that, in addition to simply being more enjoyable, these activities maintained interest and helped participants talk and express themselves. However, Lobatto (2002) found that play was more an activity that children could perform to enable space from the therapeutic situation, rather than being an integral part of therapeutic communication, and that opportunities for including children through play as dialogue were not taken. Children valued the clinician being able to generate relevant suggestions to problems

(Kuehl, Newfield & Joanning, 1990) and teach specific strategies to help solve problems (Stith et al., 1996). Children liked being included in the decisions about the structure and themes of therapy sessions (Vossler, 2004) and appreciated the willingness of the clinician to be flexible about the timing, frequency and length of therapy (Hart, Saunders & Thomas, 2005). Children also appreciated it when the clinician functioned as a mediator between them and their parents in the session (Vossler, 2004).

Children also articulated techniques that they found unhelpful. One of the main issues cited related to the use of questions. Day, Carey and Surgenor (2006) found that children felt overwhelmed and unsettled by the volume of questions, which could be experienced as too personal, causing tension and anxiety. They were annoyed by repetitive questions that implied that their answers had not been respected or believed. McConnell and Sim (2000) reported that children felt interrogated by the use of questions. Clark (2001) found that frequent and complex questions made it difficult for children to understand or follow what was happening in the session. Questions were experienced as particularly intrusive and personal at the beginning of therapy because at this time clinicians were perceived as strangers (Clark, 2001; Day, Carey & Surgenor, 2006). Day, Carey and Surgenor found that the child's discomfort was intensified by their inability to prepare for the questions and the implicit expectation that the questions should be answered.

Other unhelpful techniques included a verbally focused style of therapy (Vossler, 2004) and sessions dominated by talking, which were perceived as dry and uninteresting (Day, Carey & Surgenor, 2006). Children found it unhelpful when the clinician was on "too strict a program" and one study found that therapy could stall at this point (Kuehl, Newfield & Joanning, 1990). Children also reported feeling

uncertain and suspicious about the reflecting team and equipment in family therapy; despite being given explanations children did not appear to understand the role of the equipment or the break (Clark, 2001).

Modality and Model of Therapy

The modality of therapy, whether and how individual family members are included, directly or indirectly, in therapy (Hart, Saunders & Thomas, 2005), was very important to children. Hart, Saunders and Thomas (2005) found that which family members to include and how to manage their inclusion in therapy was a contentious issue. Some children reported feeling uncomfortable talking in front of their parents and that having their parents in the session was inhibiting (Day, Carey & Surgenor, 2006). Hart, Saunders and Thomas (2005) found a gender difference in relation to this, with girls generally happy for their parents to be in the session sometimes whereas boys would have liked less parental involvement. They reported that most children wanted the decision about who to include in the sessions to be made jointly between the child, clinician and parents. The presence of siblings was also contentious, with some children finding that the presence of their younger siblings was a distraction (Clark, 2001). Interruptions caused by siblings or other adults were perceived as disruptive and as showing a lack of privacy and respect, causing anger and irritation (Day, Carey & Surgenor, 2006).

Achieving an acceptable balance of attention between the child and the parent in family sessions is a complex and continually shifting process (Lobatto, 2002). Some children felt that in family sessions there was not enough focus on their interests (Vossler, 2004) and often children felt excluded from the therapeutic conversation (Lobatto, 2002). Kuehl, Newfield and Joanning (1990) reported that the children in their study indicated that their style of relating may have been more

honest and that they would have been more willing to work on the issue if there were some individual sessions as well as family sessions.

Only one of the studies reported children's preferences regarding the model of therapy. Hart, Saunders and Thomas (2005) found that all except one of the children in their study wanted a proactive approach from the clinician, either psycho-educative or behavioural, in addition to the basic core Rogerian manner.

Satisfaction with Therapy

The majority of children in the studies reviewed reported that therapy had been helpful to them (Clark, 2001; Montgomery, 2003; Stith et al., 1996, Vossler, 2004). Several of the researchers noted that this was contrary to the negative expectations that many children had at the commencement of therapy. Most children felt positively towards the clinician. Montgomery (2003) found that fifteen of the seventeen children she surveyed described the relationship with the clinician as positive, using the words comfortable, friend and caring, and describing it as a different relationship than that with other adults. Kuehl, Newfield and Joanning (1990) found that children were most satisfied with therapy when the clinician was both caring and understanding and able to generate relevant suggestions. Hart, Saunders and Thomas (2005) reported that many children had faith in the clinician and felt that they knew what they were doing. However, Vossler (2004) found that despite high levels of satisfaction with therapy some children required further treatment.

Not all of the studies reported high participant satisfaction. McConnell and Sim (2000) reported that almost half of the children expressed satisfaction with therapy, while a quarter of children said that it was not helpful and the remaining quarter gave mixed responses. Montgomery (2003) found that two of the seventeen

young people surveyed had felt that their needs were not fully met in therapy, some young people in this study remained suspicious of therapy and the clinician, and three children reported deliberately withholding information from the clinician. Similarly, Kuehl, Newfield and Joanning (1990) reported that some of the children in their study were not open to establishing a strong therapeutic alliance with the clinician, were quite mistrustful and were actively trying to mislead the clinician and stay in control of the therapy process. There was some suggestion that children were more satisfied with individual therapy than with their experiences of family therapy (Vossler, 2004). There were also indications that the child's perception of the outcome of therapy differed from those of their parents and the clinician, particularly in relation to the reasons why they considered therapy to be successful or unsuccessful (McConnell & Sim, 2000).

Therapeutic Impact

Therapeutic impact refers to the client's sense of therapy itself, their sense of being affected by therapy either as a whole, by a particular session, or by an event within a session (Elliot & James, 1989). Most of the therapeutic impacts cited by children were whole treatment impacts. Children reported that therapy helped them to solve particular problems (Stith et al., 1996). Day, Carey and Surgenor (2006) identified that the resolution of the presenting problem was the primary benefit of therapy for children, children wanted to feel better and get on with their lives. In relation to who was responsible for resolving the problem, Day, Carey and Surgenor (2006) found that most children perceived that the clinician had sorted out the problems for them, while Montgomery (2003) reported that children felt more able to solve other problems themselves as a result of therapy.

Children also perceived that therapy led to a change in relationships, such as bringing family members closer (Stith et al., 1996) and provoking an open talk between parents and children (Vossler, 2004). Some children felt that therapy led to changes in other family members (Clark, 2001) and some children were appreciative of clinician involvement with their school (Hart, Saunders & Thomas, 2005).

Positive changes in feelings and behaviour were also identified by children. Therapy was linked to changes in children's feelings about themselves, such as reinforcing self-esteem (Vossler, 2004), and increasing self-confidence, self-respect and motivation (Montgomery, 2003). Children also associated therapy with behavioural changes, such as a reduction in self-harming and re-engaging with school (Montgomery, 2003).

A final impact of therapy was that it provided an emotional release for children (McConnell & Sim, 2000), which was gained from talking directly about their difficulties and through the use of activities (Day, Carey & Surgenor, 2006). Montgomery (2003) suggested that therapy relieved some children of pressure that they were under.

Suggestions for Change

Some children made suggestions for change, however many of the suggestions cited in the studies appeared to be made by the researchers based on the children's feedback. Recommendations related to three key areas: the commencement of therapy; therapy being more child-centred; and the process of therapy.

Most researchers recommended improvements in relation to how therapy commences with a child and/or family. Day, Carey & Surgenor (2006) suggested greater preparation for the first appointment by the clinician, such as a letter or phone

call. Stith et al. (1996) encouraged parents to better prepare their child, being explicit about why the family will be attending therapy and suggesting that this discussion may need to be held more than once for the child to understand. It was proposed that explicit negotiation should also be used in the early phases of therapy (Day, Carey & Surgenor, 2006; Hart, Saunders & Thomas, 2005; Lobatto, 2002; Strickland-Clark, Campbell & Dallos, 2000; Vossler, 2004). This includes: discussion around familial and cultural ideas about including children in conversations (Lobatto, 2002); negotiation regarding each party's respective involvement in therapy and other therapeutic processes, such as multi-disciplinary meetings and letters (Hart, Saunders & Thomas, 2005); explanations regarding the therapeutic logic behind the session (Hart, Saunders & Thomas, 2005) and the format, arrangement and management of sessions (Day, Carey & Surgenor, 2006). Strickland-Clark, Campbell and Dallos (2000) recommended formulating a clear contract at the beginning of therapy, particularly regarding issues such as confidentiality and ending therapy.

Researchers suggested that clinicians be more child-centred in their practice, as children want to be included in therapy but wish to participate in a different way from adults (Stith et al., 1996). Suggestions for increasing child-centred practice included: using a variety of methods, activities, play and games (Clark, 2001; Day, Carey & Surgenor, 2006; Stith et al., 1996); slowing the process of therapy and modifying the use of questions so that they remain appropriate for the stage of the relationship (Day, Carey & Surgenor, 2006); and supporting children in answering questions, such as by providing multiple choice responses for younger children (Clark, 2001; Lobatto, 2002). It was suggested that it is particularly important to build and maintain a positive therapeutic relationship with the child.

There were also recommendations made in relation to the process of therapy. Hart, Saunders and Thomas (2005) suggested the need to be flexible and inclusive, Strickland-Clark, Campbell and Dallos (2000) highlighted the importance of individual preferences in relation to how therapy is conducted and Lobatto (2002) recommended that clinicians monitor the shifting position of the child throughout therapy.

Research Participation

Despite the controversy and concern regarding children's participation in research, only three of the studies discussed children's ability to participate in the research and only four studies examined the impact of their participation. There was a consensus in these studies that children were able to participate effectively in the research process. They were found to articulate complex and intricate ideas (Day, Carey & Surgenor, 2006) and reflect on their experience in a meaningful way (Strickland-Clark, Campbell & Dallos, 2000). Strickland-Clark, Campbell and Dallos (2000) and Lobatto (2002) reported that children were willing to be involved in the research and were pleased to be asked for their opinion. Strickland-Clark, Campbell and Dallos suggested that being asked to give their view appeared to be empowering for children, it helped them to step out of their role as 'problem' and into a role where they had something to offer. Strickland-Clark, Campbell and Dallos also reported that children seemed to respect the notion of research and the idea that they were helping clinicians in their work. Hart, Saunders and Thomas (2005) found that the opportunity to meet with people in similar circumstances was very important to the participants in their study and that participants were positive about the research summary that was sent at the conclusion of the research. The exception to the positive findings was that Montgomery (2003) reported that three of her participants

felt anxious about participating in the research and she suggested that it was likely that some of the children were not fully aware of what they were committing to in agreeing to be interviewed.

Difficulties Conducting Research with Children

Four of the ten studies discussed difficulties in the research process, which largely centred on sampling and recruitment difficulties. One of the key difficulties identified was that carers or clinicians acted as 'gatekeepers' to children, limiting their ability to participate in the research (Clark, 2001; Day Carey & Surgenor, 2006; Hart, Saunders & Thomas, 2005; Strickland-Clark, Campbell & Dallos, 2000). Day, Carey and Surgenor also identified problems recruiting children from ethnic minority backgrounds.

Limitations of the Research

Most of the studies cited difficulties in obtaining a sample of adequate size and diversity. Convenience sampling of mainstream children was the main sampling method used and there were particular difficulties in attracting an ethnically diverse sample and participants under ten years of age. While there was some diversity in relation to the model of therapy utilised in the studies, some of the most commonly used models of therapy with children, such as cognitive behaviour therapy, were not represented. Possibly as a result of the sampling techniques used, clinician selection and self-selection, the samples were positively biased regarding their experience of therapy. While qualitative studies do not adhere to the quantitative concept of statistical generalisability, achieving theoretical generalisability or generalisability of concepts is increased by the diversity of the sample. Therefore, the lack of diversity in the sample is a significant limitation in most of the studies reviewed.

There were also limitations associated with analysis and reporting. Important contextual information was often lacking, such as age, ethnicity, how long the child had attended therapy, whether children and parents were interviewed together or how soon after therapy concluded the children were interviewed. It was often difficult to establish how representative a view was within the sample or who in the family held a particular perspective. In a small number of the studies there also appeared to be a blurring between the reporting of child and researcher perspectives. Finally, in some studies very few quotes from children were used and children's responses were reported in categories or percentages, which reduced the richness of the data.

Most of the studies were small, exploratory studies. Many studies were designed to provide information to assist with an evaluation of the service, which may have limited the scope of the research. In addition, each of the studies was an isolated piece of research, rather than building directly upon previous research. In each of the studies the authors conducted some form of thematic analysis which did not extend to looking for relationships between the concepts identified. For these and the other reasons outlined above many of the researchers stated that they could not make claims about the generalisability of their findings.

Summary

The negative pre-therapy expectations of children in these studies are consistent with the widely held views amongst both clinic samples and children who have never accessed therapeutic services (Smith, 2004) which have found that therapy can hold negative, pathological connotations for children. This is in contrast to studies demonstrating that children have a good understanding of mental health issues (Roose & John, 2003), although there is some suggestion that this may not be the case for Black and ethnic minority children (Street et al., 2005). Negative pre therapy

expectations are significant given recent research highlighting the importance of client expectations to the psychotherapy process (Greenberg, Constantino & Bruce, 2006).

Children's lack of involvement in the process of commencing therapy resulted in a lack of understanding regarding what therapy would involve, significant confusion and anxiety. This appeared to impact upon children's ability to form their own intentions for therapy. It may also have implications for: child participation (Vossler, 2004); engagement (Paul, Foreman & Kent, 2000); the therapeutic relationship and the relationship within the family (Paul, Foreman & Kent, 2000); motivation for therapy and premature termination (Kaser-Boyd, Adelman & Taylor, 1985); and therapy outcome (Paul, Foreman & Kent, 2000). The studies provide support for the idea that the difficulties surrounding children's commencement of therapy are less a function of age or developmental level and more due to a lack of appropriate information and discussion from adults (Reiter-Theil, Eich & Reiter, 1991). The confusion that appears to exist at the commencement of therapy is concerning, as under these circumstances it is questionable whether it is possible to gain truly informed consent from children for therapy.

Clinician characteristics emerged as being very important to children and the studies indicate that children are actively assessing clinicians in relation to their helpfulness and have clear ideas about the qualities they wanted from professionals. The qualities cited were largely consistent with those outlined in other studies examining the helping qualities of adults sought by non clinical samples of adolescents (Martin et al, 2006). The desired clinician qualities cited by children were also in line with a Rogerian perspective on the characteristics that precipitate positive change during therapy, specifically empathy, unconditional positive regard

and genuineness (Trull, 2005). Building and maintaining a positive therapeutic relationship appears to be crucial in working with children (Hart, Saunders & Thomas, 2005), echoing long standing findings in the adult literature that clinical practice needs to be relationally grounded (Goodheart & Carter, 2008). Therapeutic factors were of central importance to children, however they were also able to identify therapeutic techniques that they experienced as helpful or unhelpful. The emphasis on interpersonal factors may suggest that these are the issues of primary importance to children. Alternatively, it may reflect children's difficulty in identifying how something was helpful (Hart, Saunders & Thomas, 2005) or the type of therapy received. In relation to the latter it is important to note that none of the children in the studies reviewed had experienced a more skills focused therapy such as cognitive behavioural therapy.

Children's negative feelings and expectations prior to therapy were largely not born out and most children were satisfied with their therapy experience. There were differences in the preferences and experiences of children, highlighting both the importance of not treating children like a homogenous group (Morrow & Richards, 1996) and the need for a comprehensive pre-therapy assessment. This is consistent with findings in the adult literature, across health and mental health settings, on the need to individualise intervention and that individualised interventions are more effective (Suhonen, Valimaki & Leine-Kipi, 2008). Finally, children and researchers made some specific recommendations for the improvement of therapeutic services to children, which if implemented may lead to lower dissatisfaction with therapy (Stallard, 2001).

The literature to date has identified some of the key areas relating to children's experiences of therapy. It can be argued that the field is at a point of

having a promising set of concepts that could enable clinicians to examine the sensitivity of their practice (Day, Carey & Surgenor, 2006). However, additional research is required to verify the existing themes identified and to test for additional themes, in order to be able to extend the explanatory power of the research. The literature in this area currently lacks an organising framework, which is also lacking in the broader research on process in therapy with children (Weersing & Brent, 2004). Some of the ways in which this study aims to contribute to this field are by involving a more diverse participant group than those of existing studies, who have experienced different types of therapy in different settings, and to explore in more detail some of the identified themes, particularly the issues around the process of commencing therapy. This study will also extend the research by moving beyond thematic analysis to develop a theory about children's experiences of therapy. Strauss and Corbin (1998) suggest that developing theories about phenomena is important to the development of a field of knowledge.

This study aims to build upon the existing body of research on children's experiences of therapy. The first research objective is to systematically examine children's experience of therapy, to identify the core concepts of significance for children. The second research objective is to identify possible relationships between concepts, to build a theory that will help explain children's experiences of therapy. These research objectives will be achieved through the adoption of a qualitative research methodology, using individual interviews with children. The research will use grounded theory methodology (Strauss & Corbin, 1998) to develop clinically relevant and applicable theory about children's experiences of therapy.

Chapter Two

METHODOLOGY

Chapter two discusses the research methodology adopted in this study. As outlined in chapter one, the research objectives in this study are exploratory in nature and sought to uncover in-depth information directly from children about their experiences of therapy. It will be argued that being informed by a constructivist paradigm, having a grounded theory design and utilising individual interview methodology is an appropriate way in which to meet the research objectives of this study. In addition, this chapter will outline the measures taken to maintain ethical and child-centred research practice.

The Importance of the Research Paradigm

A paradigm is the worldview or belief system that guides the researcher (Guba & Lincoln, 1998). The paradigm provides guidance regarding both the philosophical assumptions about the research and the selection of tools, instruments, participants and methods used in the study (Ponterotto, 2005). The literature on the differences between paradigms initially evolved from a position of there being 'paradigm wars', to a view that the basic beliefs of the different research paradigms are contradictory (Guba & Lincoln, 1998). The current position is that it is less useful to discuss paradigms as being in contention and more useful to analyse where and how paradigms exhibit confluence and where and how they exhibit differences, controversies and contradictions (Guba & Lincoln, 2005). In their more recent work, Guba and Lincoln (2005) cautiously suggest that it is possible to blend elements of one paradigm into another, so that a researcher is engaging in research that represents the best of both worldviews. However, it is still considered important that counselling researchers understand and outline their operating paradigm in the

reporting of studies, as locating the study within a paradigm enables the reader to both understand and evaluate the quality of the research (Ponterotto, 2005).

Selection of Research Paradigm

Creswell (1994) presents five criteria for selecting an appropriate research paradigm: the researcher's worldview; the training and experience of the researcher; the researcher's psychological attributes; the nature of the research problem; and the audience of the study. Greig and Taylor (1999) suggest that another consideration should be the nature of the research participants. Based on these factors it is suggested that the most appropriate paradigm for this research is the constructivist paradigm. In the next section the constructivist paradigm will be briefly outlined, followed by the rationale for its selection.

The Constructivist Paradigm

The constructivist paradigm is an alternative to the positivist paradigm (Schwandt, 1994). The aim of inquiry in constructivism is to achieve a consensus construction of the 'lived experience' (Guba & Lincoln, 1998), from the point of view of those who live it day-to-day (Ponterotto, 2005). The basic beliefs of the constructivist paradigm will be summarised in relation to ontology, epistemology, axiology, methodology, action and control.

It is the ontological position that most differentiates constructivism from other paradigms (Guba & Lincoln, 1998). Ontology concerns the nature of reality and being (Ponterotto, 2005). In contrast to the positivist position that there is a single, objective, external reality, constructivism holds a relativist position that assumes multiple and equally valid constructed realities (Schwandt, 1994).

Constructivists propose that reality is subjective and influenced by the context of the

situation (Ponterotto, 2005). In this way reality is socially and experientially based, local and specific in nature (Guba & Lincoln 1998).

Epistemology is concerned with the relationship between the research participant and the researcher (Ponterotto, 2005). Guba and Lincoln (1998) describe the constructivist position as transactional and subjectivist. As reality is viewed as socially constructed, the dynamic interaction between the researcher and the participant is central in capturing the experience of the participant (Ponterotto, 2005) and creating findings (Guba & Lincoln, 2005).

Axiology concerns the role of researcher values in the scientific process (Ponterotto, 2005). While some positivist and post-positivist paradigms advocate that there is no role for values in the research process, constructivists maintain that the researcher's values and lived experience cannot be divorced from the research experience (Ponterotto, 2005).

Research methodology, the process and procedures of the research, flows from the researcher's position on ontology, epistemology and axiology (Guba & Lincoln, 1998). While positivist and post-positivist paradigms advocate the adoption of strict scientific methods and procedures, constructivists utilise more naturalistic (qualitative) methodologies (Ponterotto, 2005). The constructivist position on methodology proposes that meaning is hidden and dialectical, elicited and refined through the interaction between the participant and researcher (Guba & Lincoln, 1998).

Guba and Lincoln (2005), in revisiting the issue of research paradigms, focused on several new issues that differentiate paradigms, including the issues of action and control. The issue of action on research results has become a major point of controversy; positivist/post positivist researchers predominantly still consider

action the domain of communities other than researchers and research participants, while constructivists view the research inquiry as incomplete without action. The issue of who controls the study is also contentious, constructivists view control as being shared between the researcher and participants and they support participants in taking an increasingly active role in the research process and in sharing research findings (Guba & Lincoln, 2005).

The nature of the research problem and the aims of the research in this study were consistent with a constructivist inquiry, in that there was no existing theoretical base for the study, it was an exploratory study, an inductive approach was required, the full range of variables were unknown and the context is important (Creswell, 1994). It was assessed that the audience for this research would be likely to view a constructivist paradigm as a viable, legitimate approach for the study. The constructivist paradigm was also selected based on researcher variables, as my personal world view favours the constructivist position, my training and previous research experience lies more within qualitative methodologies and my own psychological attributes fit more within a constructivist than positivist paradigm. Constructivism is also an appropriate paradigm for the study of children (Greig & Taylor, 1999). Constructivist researchers perceive the child as a subjective, contextual, self-determining and dynamic being (Greig & Taylor, 1999). They suggest that the nature of the child is not objectively knowable or measurable (Greig & Taylor, 1999). The child has his or her own perspective but is also socially determined and theories are inextricable from context and culture (Greig & Taylor, 1999).

Forms and Criticisms of Constructivism

There are several different forms of constructivist philosophy, including radical constructivism, social constructionism, the constructivist paradigm and educational connoisseurship (Schwandt, 1994). The form of constructivist philosophy that has influenced this work is the constructivist paradigm of Egon Guba and Yvonna Lincoln, which has been described as a wide ranging eclectic framework (Schwandt, 1994). In deciding to utilise a constructivist paradigm to guide this study it was recognised that there are criticisms of constructivism, including debates between quantitative and qualitative methodologies and debates from within qualitative and constructivist circles. In relation to the latter, criticisms include the issue of criteria and objectivity, the lack of a critical purchase, the problem of inquirer authority and privilege, and the confusion of psychological and epistemological claims (Schwandt, 1994).

Selection of Method

Questions of method are secondary to questions of paradigm (Guba & Lincoln, 1998). Guba and Lincoln suggest that both qualitative and quantitative methods can be used appropriately within any research paradigm. However, the constructivist-interpretivist paradigm provides the primary foundation and anchor for qualitative research methods and the positivist paradigm underlies quantitative methods (Ponterotto, 2005). Qualitative methods refer to a broad class of empirical procedures designed to describe and interpret the experiences of research participants in context-specific settings (Denzin & Lincoln, 2000). The use of a qualitative methodology for this study is consistent with the constructivist idea of naturalistic designs (Ponterotto, 2005) and is based on the scientific activity of induction, i.e. the procedure for generating new theories in which theory emerges from the data (Greig

& Taylor, 1999). The characteristics of qualitative methodology, including a focus on process rather than outcome, an interest in meaning and the researcher as the primary instrument for data collection and analysis (Creswell, 1994) were also in keeping with the objectives for this study. Creswell suggests that qualitative research is appropriate when the notion of the concept being investigated is 'immature' due to lack of previous research or theory, when there is a need to explore the phenomena to develop theory or when the researcher is examining participant's perceptions and experiences and the way that they make sense of their lives.

Common qualitative research designs include ethnographies, grounded theory designs, case studies and phenomenological studies (Creswell, 1994). The research design that will be utilised in this study is grounded theory (Strauss & Corbin, 1998). This design will be supplemented by the use of a single-item likert scale and a three-item quantitative scale (the Youth Satisfaction Questionnaire). It is suggested that, through using two quantitative methods, overlapping and different facets of children's experiences of therapy may emerge (Greene, Caracelli & Graham, 1989). Creswell (1994) notes that there are three main models of combined designs: two phase designs, a dominant-less dominant design and a mixed methodology design. This study could be characterised as a dominant-less dominant design, as the study is presented within a single dominant paradigm with one small component of the overall study drawn from an alternative paradigm. The use of quantitative methods within a qualitative study is an example of data triangulation, where a combination of methodologies are used to study the same phenomenon (Creswell, 1994). In this study it is suggested that the quantitative data may corroborate the findings from qualitative data while the qualitative data can provide an understanding of the quantitative findings (Pandit, 1996).

A Review of Grounded Theory Analysis

Grounded theory is one of the most established and respected qualitative methods and has been called the market leader in qualitative research (Ponterotto, 2005). The origins of grounded theory methodology will be briefly reviewed, the key features of the approach outlined and the strengths and weaknesses of the methodology discussed. The position on grounded theory taken in this research will be stated and key elements of this approach will be identified as they pertain to this study.

Origins and Evolution of Grounded Theory

Grounded theory derives its theoretical underpinnings from pragmatism and symbolic interactionism (Corbin & Strauss, 1990). Corbin and Strauss suggest that grounded theory has not changed in form since it was first introduced in 1967; however, the specificity of its procedures has been elaborated as the method has evolved in practice and it has been adapted and used to study diverse phenomena (Strauss & Corbin, 1998). This research study has closely followed the grounded theory approach of Strauss and Corbin (1998) and has also been influenced by Charmaz (2000).

Key Characteristics of Grounded Theory

Grounded theory is a methodology for developing theory that is grounded in data systematically gathered and analysed through the research process (Strauss & Corbin, 1998). The major difference between grounded theory and other approaches to qualitative research is its emphasis upon the development of theory, defined as “a set of well-developed concepts related through statements of relationship, which together constitute an integrated framework that can be used to explain or predict phenomena” (Strauss & Corbin, 1998, p.15). The procedures and canons of grounded

theory are as follows: data collection and analysis are interrelated processes; concepts are the basic units of analysis; categories must be developed and related; sampling proceeds on theoretical grounds; analysis makes use of constant comparisons; patterns and variations must be accounted for; and process must be built into the theory (Corbin & Strauss, 1990). The criteria of saturation, the point in category development when no new properties, dimensions or relationships emerge during analysis, is used to decide when it is appropriate to end the research process (Strauss & Corbin, 1998).

Strauss and Corbin differentiate between substantive and formal theories, with formal theories being less specific than substantive theories to a group and place, therefore applying to a wider range of disciplinary concerns and problems (Strauss & Corbin, 1998). Researchers using grounded theory can aim at various levels of theory but most studies have been directed at developing substantive theory (Strauss & Corbin, 1998). A grounded theory is reproducible in a limited sense in that it is verifiable and generalisable insofar as it specifies conditions that are linked through action/interaction with definite consequences (Strauss & Corbin, 1998). If theoretical sampling is more widespread then greater generalisability, precision and predictive capacity can be achieved (Corbin & Strauss, 1990).

Evaluating Grounded Theory

Corbin and Strauss (1990) and Strauss and Corbin (1998) advocate that for any grounded theory study, the specific procedures and cannons they describe should provide the major basis of evaluation. They suggest that in evaluating a study that claims to generate a theory, four types of judgements should be made. Judgements should be made about the validity, reliability and credibility of the data. Secondly, judgements should be made about the plausibility and value of the theory.

Judgements should also be made about the adequacy of the research process and Strauss and Corbin (1998) identify seven criterion that need to be assessed in evaluating this. Finally, judgements should be made about the empirical grounding of the research findings and Strauss and Corbin (1998) provide eight criterion for evaluating the empirical grounding of a study.

In outlining the above it is important to note that terms such as validity and reliability require redefinition to fit the realities of qualitative research (Strauss & Corbin, 1998). In relation to validity, grounded theory researchers suggest that: construct validity is enhanced by clearly specifying operational procedures (Pandit, 1996); internal validity is enhanced by establishing casual relationships where certain conditions are shown to lead to other conditions (Pandit, 1996); and external validity is achieved by clearly specifying the domain to which the findings of the study can be generalised (Strauss & Corbin, 1998). In relation to reliability, Strauss and Corbin (1998) suggest that if subsequent researchers hold the same theoretical perspective of the original researcher, follow the same general rules for data gathering and analysis and assume a similar set of conditions, then they should arrive at the same or a similar theoretical explanation about the phenomenon under study.

Strengths and Criticisms of Grounded Theory

Grounded theory is a widely used and well-regarded methodology. Its strengths include the strategies that guide the researcher step-by-step through the analytic process, the self-correcting nature of the data collection process, the focus on theory rather than contextual description and emphasis on comparative methods (Charmaz, 2000). However, the methods and methodology of grounded theory have also been subject to debate and criticism. While some researchers argue that it is necessary to clearly demonstrate systematic methods for data analysis that are both

reliable and replicable, others say that if not used well these methods can result in a collection of empty categories that have limited value (Priest, Roberts & Woods, 2002). Charmaz (2000) outlined other criticisms that included: questioning whether data needs to be 'forced' through the methods advocated by Strauss and Corbin; whether grounded theory glosses over the meaning in people's stories; and if fracturing the data may actually limit understanding the subject's experiences in its fullness.

There have been a number of misconceptions and controversy regarding the application of grounded theory, due to: the diffusion of its application across a number of disciplines leading to adaptations of the method (Goulding, 1999); the continual rewriting of the method (Andrews, 2006); and the divergence in thought regarding conceptualisation of the method by its two original authors (Goulding, 1999). This has caused conflicting perceptions regarding its methods and implementation, which some authors have referred to as the 'methodological slurring' of grounded theory (Wells, 1995). One example of this is the role of literature in grounded theory. While it is generally acknowledged that one can not commence research 'with a totally blank sheet' (Goulding, 1999), some researchers consider that it is essential to avoid the literature in the immediate area that is being studied so as not to prejudice or influence the perceptions of the researcher (Goulding, 1999). However, other researchers argue that a preliminary reading of the literature is entirely consistent with the principles of grounded theory (Andrews, 2006). McCallin (2006) proposed that in reality the timing of the literature review does not matter so long as the analyst is critically analytical of the literature at all times, and does not allow existing knowledge to pre-empt identification of the

research problem or formation of the emergent theory. This thesis was guided by the latter view.

There is also some debate regarding the anchoring paradigm of grounded theory research. Ponterotto (2005) suggests that one can locate components of grounded theory within multiple research traditions. Charmaz (2000) discusses that there are both positivist (objective underpinnings, explicit coding and data reduction/analytic procedures) and post-positivist (verification focus) components of grounded theory. Hall and Callery (2001) suggest that most discussions of method have placed grounded theory in the post-positivist tradition but they acknowledge the view that Strauss and Corbin's (1998) work moved grounded theory toward a constructivist paradigm. Ponterotto (2005) reviewed grounded theory studies published in the *Journal of Counselling Psychology*, concluding that while the original writings of the authors were more positivist or post-positivist, the actual practice of grounded theory is more located within the constructivist paradigm. Charmaz (2000) suggests that it is possible to adopt a constructivist grounded theory approach and use grounded theory methods without adhering to positivist leanings, thereby avoiding some of the criticisms of grounded theory. She describes a constructivist grounded theory as lying between post-modernist and post-positivist approaches to qualitative research. The key features of a constructivist grounded theory include: attention to multiple realities and the multiple viewpoints within them; recognition that the researcher is a part of creating the data and analysis; an aim on meaning rather than truth; a stronger emphasis on studying people in their natural environment; and the use of grounded theory methods as flexible strategies rather than formulaic procedures (Charmaz, 2000).

This study used grounded theory, in accordance with both Strauss and Corbin (1998) and Charmaz (2000). As advocated by Corbin and Strauss (1990), the key components of the research process will be clearly laid out in Chapter Three so that the theory can be more adequately assessed. This study also incorporated the notion of reflexivity in order to try to increase the validity of the findings (Hall & Callery, 2001). Strauss and Corbin (1998) did acknowledge reflexivity, defined as critically examining one's effect as a researcher on the research process (Hall & Callery, 2001) but Hall and Callery suggest that this was not emphasised. Some of the steps taken to incorporate reflexivity will be outlined later in this chapter.

Selection of Interview Methodology

The data for a grounded theory can come from various sources (Corbin & Strauss, 1990). This study utilised individual interviews with children. In this section the advantages and disadvantages of the use of individual interviews will be discussed, before focusing specifically on their use with children and contrasting this with the other principle qualitative method of engaging children, the use of focus groups.

Individual interviews enable respondents to describe their points of view and enable researchers to understand the subjective perspective of respondents (Faux, Walsh & Deatrck, 1988). Creswell (1994) states the advantages of individual interviews are that informants can provide historical information and they allow researcher control over lines of questioning. However, Creswell also identified disadvantages to their use in that: they provide indirect information filtered through the views of interviewees; they provide information in a designated place rather than the natural field setting; the researcher's presence may bias responses; and not all people are equally articulate and perceptive. There can also be difficulties with the

way in which interviews are conducted, such as failure to establish rapport with participants, the researcher dominating sessions or asking leading questions and becoming constrained by pre-formulated questions rather than adopting a more open-ended conversational style (Pidgeon & Henwood, 1997). Other potential issues are that younger children can become bored with purely verbal means, some children find it difficult to express themselves verbally and children normally express themselves using a variety of means (Hill Laybourn & Borland, 1996).

Individual interviews are frequently used as a data collection method in research with children. Faux, Walsh and Deatrck (1988) suggest that the strengths of interviews with children include that they: allow for great flexibility in asking questions; provide the opportunity to observe nonverbal behaviour; enhance the depth and richness of the data; and permit children and adolescents to define and describe the problem being studied in their own words and with their own frame of reference. Research suggests that interviews are a valid and reliable method for children at the Piagetian stage of concrete operations (seven to twelve years), with children of this age described as being accurate and reliable historians of their condition (Gorman, 1980). However, despite their frequent use, there is a lack of guidance on how to best use interview methods with children (Bricher, 1999; Greig & Taylor, 1999; Hill, Laybourn & Borland, 1996), particularly children aged five to twelve years (Greig & Taylor, 1999).

The strengths and weaknesses of individual interviews can be contrasted with the other main data collection method with children, the use of focus groups. Focus groups are a research technique that collects data through group interaction on a topic determined by the researcher (Morgan, 1997). Focus groups are more controlled than participant observation and less controlled than individual interviews (Morgan,

1997). The advantages of focus groups are that they allow free-flowing discussion about the issue, so that issues of most importance to children emerge; they enable direct comparison of children's similarities and differences regarding the issues as opposed to reaching such analysis post-hoc; and they are considered to be a child-friendly method (Morgan, 1997). However, there are also disadvantages of focus groups, primarily concerning the impact of the group on the data produced. These include: the possibility of group effects, with some voices being heard more than others (Greig & Taylor, 1999); a tendency towards conformity, in which some participants withhold things that they might say in private (Morgan, 1997); and a tendency towards polarisation, in which some participants express more extreme views in a group than in private (Morgan, 1997). Finally, practical difficulties have been reported by researchers which can reduce participation rates, such as some participants finding it difficult to travel to a focus group and difficulties in finding an agreeable common time (Clark, 2001; Day, Carey & Surgenor, 2006).

While studies directly comparing the use of individual interviews and focus groups with the same children suggest that each can obtain slightly different information and that children can behave differently in each context (Hill, Laybourn & Borland, 1996), there is no evidence to suggest that one method produces more or better ideas (Morgan, 1997). There is also no evidence that the researcher's impact is greater in one or the other (Morgan, 1997). However, some of the advantages of individual interviews over the use of focus groups are that an individual interview is a more private and confidential situation (Greig & Taylor, 1999), they allow a more in-depth understanding of individual children's experiences and opinions (Morgan, 1997) and allow for a more naturalistic setting which is more in keeping with the constructivist paradigm (Morgan, 1997).

Based on the above factors it was decided that individual interviews were the preferred data collection method for this study. An additional reason for this decision was that two of the most recent studies in this area, those of Hart, Saunders and Thomas (2005) and Day, Carey and Surgenor (2006) utilised focus groups. If the two different methods can demonstrate different aspects of children's experiences and opinions (Morgan, 1997), the use of individual interviews may be beneficial in adding to the body of knowledge on children's experiences of therapy. The remainder of this chapter discusses some of the measures taken to address the additional considerations that exist when interviewing children (Hill, Laybourn & Borland, 1996). These are primarily related to ethical issues and the use of research methods that can enhance children's participation.

Ethical Considerations

Ethics in research relates to the application of a system of moral principles to prevent harm or wrong doing to others, to be respectful and to be fair (Sieber 1993). The importance of ethical considerations are commonly addressed by qualitative researchers (Creswell, 1994) and it is essential to be aware of the ethical issues when conducting research with children (Ireland & Holloway, 1996). Ethical issues need careful thought and exploration throughout the research process, not just at the study's inception and design (Ireland & Holloway, 1996). There will be a brief discussion of some of the ethical issues associated with qualitative research and research with children. Some of the measures taken to address these issues will be discussed in this chapter, with more specific details outlined in Chapter Three.

In relation to the ethical obligations of qualitative researchers, Strauss and Corbin (1998) believe that researchers have an obligation to contribute to the knowledge of their respective disciplines, to give research participants a voice, and to

give feedback to participants, particularly in relation to how we have interpreted their experiences. Strauss and Corbin also state that researchers have a responsibility to develop theory that will have at least some practical applications and use to wider audiences.

There are two different perspectives on the nature of ethical issues associated with research involving children. The first is that there are probably no unique ethical issues in research with children but that certain issues tend to arise with greater force or in unusual ways (Allmark, 2002). Within this perspective the general rights of research participants also apply to children, specifically the right to not be harmed, to be able to give informed consent and voluntary participation in research (Ireland & Holloway, 1996). Other general principles include the right to privacy, anonymity and confidentiality (Ireland & Holloway, 1996). In contrast, the second perspective is that there are specific ethical issues associated with conducting research with children due to their vulnerability and relative powerlessness in a research situation (Ireland & Holloway, 1996). Some of these issues include: the unequal power relationship between adults and children (Ireland & Holloway, 1996); difficulties associated with obtaining informed consent (Ireland & Holloway, 1996); and that complete confidentiality cannot be guaranteed to child research participants (Mahon, Glendinning, Clarke, & Craig, 1996).

This research project took the more conservative view that there are special ethical issues when conducting research with children. However, it was also the experience of this researcher that there is a lack of clear ethical guidance in this area. Not all research guidelines make specific reference to children and existing guidelines on ethical research conduct with children focus primarily on issues to do with quantitative research (Allmark, 2002). The ethical guidelines of psychological

and medical bodies have been criticised on the basis that they focus on the age of the children involved but pay little attention to factors such as ethnicity, gender or the power relationships between researcher and child (Morrow & Richards, 1996). For these reasons existing ethical guidelines appear unlikely to provide specific, clear applications to some of the dilemmas in research with children (Morrow & Richards, 1996). Personal ethical choices by the researcher are important (Morrow & Richards, 1996) and there is a need for a reflexive approach. Punch (2002) suggests that researchers need to be reflexive throughout the research process and critically aware of the range of reasons why research with children may be different from research with adults (one of the ways in which the researcher was reflexive in this study was through the use of a research process log).

The welfare of research participants is one of the key factors considered when reviewing the ethical soundness of research (Allmark, 2002). Although qualitative research with children is considered to be low risk (Allmark, 2002) and is described in medical guidelines as falling within the category of minimal harm (Ireland & Holloway, 1996), it is not without risk. Exploring people's feelings and experiences has the potential to be psychologically damaging (Allmark, 2002). Some issues, such as the problem of adult authority in relation to a child, may be more acute when the child and the adult are together on a one-on-one basis. In recognition of these issues, this research project followed the existing ethical guidelines, took the advice of the Trust peer review process and Local Research Ethics Committee, utilised university supervision sessions and sought the advice of two experienced colleagues who had conducted successful research projects in this area. Reading was undertaken in the area of ethical research with children and the advice set out in publications such as

McCrum and Hughes (1998) was followed. The specific ethical procedures used will be outlined in Chapter Three.

An example of a specific ethical issue that arose during this research process was the issue of paying or compensating children for their participation. Offering payment or inducements to research participants is a common, longstanding, yet uneven and contentious practice (Grady, 2005). The researcher wanted to be fair to children who volunteered their time for the study and to demonstrate respect for their contribution. However, it was also recognised that there is the potential for payment to influence the decision to participate and obscure risks, impair judgement or encourage misrepresentation (Grady, 2005). Some consider this to be particularly the case for economically disadvantaged children and families or for children who are members of ethnic minority groups (DeSantis, 2007). Limited data exists to support or refute these concerns (Grady, 2008).

The contrasting position is that paying participants is an acceptable and potentially necessary part of recruitment. There are also philosophical arguments for paying participants, such as it can help to minimise the power differential by making participation seem less like a 'favour' that the participant is being asked to do for the researcher (Dickert & Grady, 1999). In relation to children, it has been argued that children deserve the same consideration as adults participating in research and should be compensated for their time, effort and risk (Lobo, 2007). The researcher agreed with Grady (2008) that a modest amount of money, calculated on the basis of time or contribution, is an indication of respect for the contributions that research participants make. It was also recognised that payment can be made in various ways, some of which are more ethically acceptable than others (Dickert & Grady, 1999). For these reasons the decision was made to offer a music, sports or book gift voucher

for participation, to the value of ten pounds for a secondary school child and five pounds for a primary school child.

Payments to children can be ethical elements of research with children if they are established, reviewed and implemented in a thoughtful and consistent manner and adhere to the principles of ethical research (Field & Behrman, 2004). The following steps were taken in order to ensure that use of gift vouchers was ethical and age appropriate: ensuring the value of the voucher is developmentally appropriate and not excessive; referring to the voucher in the information sheet but not unduly emphasising it; giving the voucher to the child not the parent to prevent parents coercing a child to participate; giving a voucher that could not be redeemed for money; and taking additional care to ensure that the child understood the nature of the research and was freely giving consent. The use of a gift voucher was assessed and overseen by the Local Research Ethics Committee. Research with children on the impact of financial incentives for research participation and written policies on payments for research participants, (including child participants), could be helpful to future researchers in managing this issue.

A final ethical consideration is how a researcher can enhance children's ability to participate in research. The methods used, the research populations and subjects studied and the interpretation of the data are all influenced by the researcher's view of children (Morrow & Richards, 1996). James (1995), as cited in Christensen and James (2000), discussed a four-fold typology of ways in which to 'see' children: the developing child; the tribal child; the adult child; and the social child. The latter, the social child, offers an approach to ethical research with children. This perspective describes children as research subjects comparable with adults but with different rather than inferior competencies. It is suggested by James that if we

can engage with children by making use of their different abilities then they can engage more productively in research. This research project approached children in line with the idea of the social child and designed data collection methods that would help to utilise children's competencies, enhance their ability to participate and overcome some of the ethical problems identified. This chapter will conclude with a brief overview of some of these methods.

Use of Appropriate Research Methods

Familiar Settings

Giving children a choice of interview location (in this case their home, school or the researcher's office) allows children the opportunity to be in a familiar setting or the setting in which they will feel most comfortable. Most authors recommend interviewing children alone (Ireland & Holloway, 1996; Mahon et al., 1996), some researchers who have interviewed children in front of their parents have questioned the impact of this on children's accounts (Hart, Saunders & Thomas, 2005). Therefore in this study the decision was made to interview children alone unless they requested their parent's attendance. In the case of younger children it was recognised that time spent prior to the start of the interview with both the parent and child may be helpful in establishing comfort and trust (Bricher, 1999).

Flexible use of Appropriate Methods and Techniques

One of the most important factors in research with children is utilising familiar and developmentally appropriate materials, flexibly adapted to suit the cognitive and linguistic competence of each age group (Greig & Taylor, 1999). In order to ensure that the interview guide was developmentally appropriate a semi-structured interview guide was used. This both enabled an in-depth exploration of some of the topics identified in the literature and allowed children the freedom to

identify and discuss issues of importance them. The interview schedule was constructed using what Morgan (1997) referred to as the 'funnel technique', which tries to obtain a compromise between more and less structured interview techniques by beginning with a less structured approach, emphasising free discussion and then moving on to a more structured approach with specific questions. This approach makes it possible to hear the participant's own perspectives in the early part of each discussion as well as their responses to the researcher's specific interests in the latter part of the discussion (Morgan, 1997).

Developmental considerations were taken into account in devising the interview schedule. Flexible adaptation is particularly important in relation to use of language, ensuring that this is suitable for the cognitive and linguistic development of the child (Hill, Laybourn & Borland, 1996). Bricher (1999) suggests this involves finding an appropriate balance between professional or adult terminology and talking down to children, exploring the meanings that children have for specific words and clarifying with the child the adult's understanding of their response. In this study this was also achieved by taking a reflexive approach to practice and carefully reviewing interview tapes with the use of language in mind. Consideration was also given to the optimal time frame for the interview. Faux, Walsh and Deatrick (1988) suggest children under ten years of age can be interviewed optimally for approximately 30-45 minutes and that children older than ten may be interviewed for an hour or more.

In this study a combination of traditional research methods that are used with adults and techniques considered to be more suitable for use with children were used to enhance children's participation in the interview. Punch (2002) suggests that using a range of different methods and techniques enables the researcher to capture children's different experiences and competencies. In this study, methods that have

been successfully utilised in other studies with children were included, such as visual prompts, use of a scenario, the use of puppets with younger children and sentence completion cards. The 'about myself' sheet described by Hill, Laybourn & Borland (1996) was also incorporated at the start of the interview to build rapport and to reinforce that the interview was about children's perceptions rather than right and wrong answers.

Addressing Issues of Power

Unequal power relationships between children and adults exist in many aspects of children's lives and attention to these issues of power is essential when interviewing children (Bricher, 1999). This research project attempted to move towards a model of shared power during the research process. This involved a commitment to obtaining truly informed consent, fully explaining the rationale for the research, answering children's questions, explaining what would be done with the research findings and having a planned finish to the interview to enable children to feel more in control of the end of the interview (Bricher, 1999). It was also recognised that due to the unequal power relationship between adults and children it is necessary to actively seek out issues such as dissatisfaction (Stallard, 2001).

The methods outlined above were designed to enable the children to utilise their competencies, to participate in the study effectively and to address some of the ethical concerns that have been identified. It was also hoped that through the use of these methods children's interest and attention would be maintained during the interview, that children would feel a greater degree of comfort in taking part in the study and that participation would be enjoyable.

Chapter Three

METHODS

Chapter Three outlines the methods utilised in this study. It begins with a brief overview of the design of the study, the participants that were involved, the instruments that were used and the procedures followed. It concludes with an overview of how grounded theory methodology was used to analyse the data. In this chapter the main data collection and analysis phase and the validation phase of the study are described as distinct processes. This has been done in order to provide greater clarity for the reader as opposed to their being completely separate processes.

Design

This qualitative study utilised a grounded theory design. A semi-structured interview was the main research instrument, supplemented by the use of a single-item likert scale and a three-item quantitative scale which were administered in the interview. In the validation phase of the study a clinician's focus group was used to help refine and validate the developing theory. A second interview was conducted with three of the participants in order to validate the theoretical scheme against raw data.

Participants

The inclusion criteria for participation in this study were that children had attended therapy within the past twelve months, were aged seven to fourteen years at the time of attending therapy and that they were neither currently in therapy or exhibiting signs of psychological distress. The use of theoretical sampling resulted in a decision to include two participants who were fourteen years old when they commenced therapy but sixteen and seventeen years old at the time of participating, the rationale for this is described later in this chapter. Participants were recruited from two sources, children who were former clients of the Child and Family Department

at a tier three child and adolescent mental health service (CAMHS) in London and children who were former clients of a school based therapy service.

CAMHS Sample

Children who attend therapy at the CAMHS are routinely mailed a client feedback questionnaire after finishing therapy, on two occasions information about this study was attached to the bottom of the questionnaire and there was space on the questionnaire for children to opt to be contacted by the researcher to receive more information. The first mail-out was to all children aged seven to fourteen years who had concluded therapy in the past twelve months. The second mail-out, which took place three months later, was to all children aged seven to fourteen years who had concluded therapy in the past two months.

School Therapy Sample

The participants who had attended therapy at a school-based service were recruited via the clinician as a mailing list of these clients did not exist. Fifteen clinicians working in schools in a London borough were approached in relation to the study. Five of these had one or more clients that fit the research criteria and agreed to give these children a letter explaining the study and a form consenting to be contacted by the researcher.

Participant Information

Eighteen children aged seven to seventeen years participated in this study, the participant characteristics are outlined in Appendix B. The mean age was 11.6 years and the standard deviation was 2.9 years. Eleven participants were male and seven were female. The participant's ethnic backgrounds were; White British (n=11), White European (n=1), Mixed Race Black African (n=3), Asian British (n=1), Asian (n=1), Latin American (n=1). Ten of the participants lived in a single parent

household, six participants lived with both parents, one lived with his grandparents and one participant lived in a foster placement.

Eleven participants had attended therapy at the CAMHS and seven participants had attended a school-based therapy service. The participants who had attended the CAMHS were younger on average (10.6 years) than those who had attended a school based service (13.1 years). The number of therapy sessions attended were; 1 (n=1), 2-10 (n=6), 11-20 (n=3), 20-50 (n=3) and over 50 (n=5). The participants attended therapy either with their family (n=7) or individually (n=11). In the latter case a small number of the children had a beginning or final session with a parent present. In seventeen of the eighteen cases the clinician was female and in one case the clinician was male.

The children who had attended therapy at the CAMHS had experienced a psychoanalytic or systemic model of therapy (obtained from clinic records), whereas children who had attended a school-based therapy service experienced a psychoanalytic, psychodynamic, humanistic or client-centred model of therapy (obtained directly from clinicians).

Obtaining Informed Consent

In both methods of recruitment the child and carer had to give written consent to be contacted by the researcher and provide a telephone number. If consent was given then the researcher made telephone contact, explained the study to the carer and if the carer gave permission then spoke to the child to explain the study. Eighteen children who were former clients of the CAMHS indicated an interest in receiving more information about the study and eleven of these children consented to take part. Seven children who were former clients of a school therapy service indicated an interest in the study and all seven of these children consented to take

part. For ethical reasons, in order to ensure children did not feel under any pressure to participate, if children declined to participate in the study the reasons for this were not requested. If child and carer consent was given then a tentative interview time was established at a location of the child's choosing. In order to ensure that the child was providing free and informed consent, information forms were then mailed to the child and carer. These forms outlined the nature of the study, risks and benefits of participating, that the child could withdraw at any time and that the child would receive a book/music/sports voucher incentive of £5 for primary school children and £10 for secondary school children. A minimum of three days was provided to enable the child to read the information form and consider participation. The researcher then contacted the child and carer again to ask if there were any questions. If the child and carer affirmed their consent to participate then the interview time was confirmed.

Ethical Review

Children were treated in an ethical manner throughout this study in keeping with the guidelines set by City University (London) and the British Psychological Society. This study went through several ethical review processes. As a component of the Doctor of Psychology degree the study was submitted to the Senate Ethics Committee at City University. It was also peer reviewed by a Senior Clinical Psychologist at the Trust involved in the research and approved by the Local Education Authority. However, the most rigorous ethical review was by the NHS Local Research Ethics Committee. The purpose of a Local Research Ethics Committee is to consider the ethics of proposed research projects that will involve human subjects and which will take place broadly within the NHS (Department of Health, 1991).

The researcher was required to present the study to the entire committee of the Local Research Ethics Committee (LREC), where members asked the researcher questions and voiced any concerns. A number of issues were identified by the committee and the researcher was required to respond to these in writing, including: a perception that the initial age group of the study was too broad; questions regarding an appropriate way for young children to make contact with the researcher; concerns about the amount of payment for participants; and questions about how to guarantee child confidentiality if parents were present in the home or at the interview. The resolution of these concerns involved written proposals going back and forth between the researcher and the committee over several months. Not all issues were able to be resolved. The LREC would not approve any method whereby ex services users would meet in a group format (such as a focus group) or any method of recruitment other than a written opt-in method. Furthermore the researcher had to submit a proposal for approval for any changes to the original research protocol, such as the introduction of the validation interviews. Additional ethical processes were put in place as a result of recommendations by the Local Research Ethics Committee. These included the development of separate age-appropriate information and consent forms (based on the age bands of seven to eleven years and eleven to fourteen years) and having a default position of younger children being interviewed individually with a trusted adult in the vicinity.

Theoretical Sampling

Theoretical sampling was used in order to maximise opportunities to discover variations in concepts and to provide additional information regarding categories (Strauss & Corbin, 1998). This was most evident on two occasions. Firstly, in conducting the interviews with the children who responded to the first mail out to

former CAMHS clients, it was observed that some of the younger children had difficulty remembering very specific information, therefore the second mail out specifically targeted children who had concluded therapy in the past two months. Secondly, after the first eight interviews the average participant age was 10.6 years, so in order to ascertain if there was any difference in the way in which older children reflect on their experiences, two children were included in the study who were fourteen years old when they started therapy but at the time of participating in the interviews were sixteen and seventeen years old.

Instruments

Main Data Collection and Analysis Phase

The four measures used in the main data collection and analysis phase of the study were: a semi-structured individual interview; an Ethnic Background Record Form; three items from the Youth Satisfaction Questionnaire; and a single-item likert scale measure.

Semi-Structured Individual Interview

The semi-structured individual interview was the main data collection tool. In keeping with the principles of grounded theory the initial interview protocol was broad and open, allowing children to discuss the issues of importance to them. The initial interview protocol was developed through the researcher's sensitising assumptions from clinical experience (Lobatto, 2002) and through a review of the literature, the latter established themes of significance and highlighted areas in which little information was known. The questions were viewed as a stimulus to children being able to talk about their experiences and as such they were largely open-ended questions.

The interview protocol was revised slightly after each interview, with major revisions made after interviews 4, 8 and 15. Revisions were made to aid children's comprehension and ability to answer the questions, based on children's feedback regarding the questions and the researcher's observations regarding the extent to which questions were developmentally appropriate. The interview protocol was also revised in keeping with Strauss and Corbin's (1998) recommendation that, once data collection begins, the initial interview protocol is altered to allow for concepts that emerge from the data. Initial analysis highlighted concepts and categories, revisions were then made to the interview protocol to enable an examination of the nature of these categories and the relationship between these categories. These revisions resulted in the interview protocol becoming progressively more focused. The interview protocol was continually revised until the analysis revealed that a saturation in concepts, categories and relationships had been achieved. A copy of the original interview protocol is attached in Appendix C.

Ethnic Background Record Form.

Ethnic background information was collected from children at the start of the interview using the Ethnic Background Record Form (UK Department for Education and Skills). In accordance with the recommendations made regarding the collection of this information by the Information Commissioner, children aged over eleven years had the opportunity to decide their own ethnic identity. A parent or person with parental responsibility was asked to assist children under eleven years in providing this information. A copy of the Ethnic Background Record Form is attached in Appendix D.

The Youth Satisfaction Questionnaire.

The Youth Satisfaction Questionnaire (Stuntzer-Gibson, Koren & DeChillo, 1995) measures children's views regarding the services that they receive. It was designed for use by children aged nine years and older and the five items were adapted from items in adult satisfaction scales with simplified response alternatives and simplified language. The scale was tested on a sample of 165 children and it was found that three of the five items provided the most internally consistent composite score. These items measured the extent to which children liked the help that they received, received the help that they wanted and felt that services helped with their lives. The Alpha Coefficient associated with these three items was 0.80. Alpha Coefficients were calculated separately for boys and girls and for children aged nine to eleven years, twelve to fourteen years and fifteen to eighteen years of age and all of these met the criteria for acceptable internal consistency. A general satisfaction score is formed by summing responses to the three items. The theoretical midpoint is six. Scores that are lower than six represent a higher level of satisfaction, scores that are higher than six represent a lower level of satisfaction. Stuntzer-Gibson, Koren and DeChillo (1995) reported that the scale can effectively measure variation in children's opinions. A copy of the three items from the Youth Satisfaction Questionnaire is attached in Appendix E.

Likert Scale.

A single-item likert type scale was used as a measure of global satisfaction. Children were asked to rate their experience of therapy on a scale of one to ten, with the worst it could have been (one) and the best it could have been (ten) as anchors. Younger children were shown a picture of a likert scale with these anchors to assist them and they circled the relevant number.

Validation Phase

Focus Group

A focus group was conducted after interview fourteen with five clinicians who worked in either a school-based counselling service or the CAMHS. The primary aims of the focus group were to assist in refining the developing theory and to validate the emerging theory. Feedback from the focus group led to some modifications and additions to the theory and was also used to guide the final revision of the interview protocol.

Validation Interviews

Three of the original eighteen participants were interviewed on a second occasion using a semi-structured individual interview. The aims of the validation interviews were to validate the theoretical scheme against raw data by asking participants to comment on how well the developing theory appeared to fit their case (Strauss & Corbin, 1998).

Procedure

Main Data Collection and Analysis Phase

Semi-Structured Interviews

Children were interviewed at their home, school or the researcher's office. For primary school children a parent was present for the explanation of the study, obtaining of consent and collection of demographic information. The researcher read through and explained the information sheet, providing information about confidentiality and the child's right to withdraw his/her participation. The researcher asked the child if he/she had any questions. The researcher then read through the consent form with the child and this was signed by the child. If the parent was present the parent consent form was also signed at this time or it was collected at this

time in the case of secondary school children. Children were asked for the following demographic and personal background information; their age; gender; approximate number of therapy sessions attended; with whom they attended therapy; the gender of the clinician; and who the child lives with. A measure of socio-economic status was not used due to the ethical issues associated with asking children for this information (Morrow & Richards, 1996). The child's ethnic background was collected using the Ethnic Background Record Form. All identifying information was later stored separately from the data.

After the collection of demographic information if a parent/carer was present then he/she was invited to wait outside while the interview took place. However, in two cases, in both of which the child was quite young, the child requested that their parent stay with them in the room and in the interests of child comfort this was agreed. In both cases the parent did not speak during the interview. The researcher requested the child's permission to audio-tape the interview and all of the children agreed.

The interviews took an average of fifty minutes each. Time was spent at the beginning of the interview getting to know the child and building rapport. For younger children this was done using the 'About Me' worksheet and for secondary school children this occurred verbally. Children were asked to rate, out of ten, how they felt at the beginning of the interview. A debrief was provided at the end of the interview where children were asked to talk about what it was like participating in the interview and to rate again how they were feeling. All participants rated themselves the same or more highly at the end of the interview than at the beginning. None of the children reported any distress nor were any signs of distress observed. All except one child reported that they had enjoyed talking about their experiences

and that they liked the idea that they may have been helpful. All of the children were given a sheet of follow-up support options in case they were in any way distressed by participating in the interview, however no follow-up support was requested. The interview with Participant Five was a shorter interview as, once the researcher attended the house and the interview commenced, it became clear that the child had actually attended a therapeutic group rather than individual therapy.

The interviews with children took place over a five-month period. The length of time between the first and last interview was due to: simultaneous data collection and analysis; the use of theoretical sampling which necessitated recruiting participants in stages throughout the study; needing to go back to the ethics committee on one occasion; and due to the six-week summer break in which many potential participants were not available.

The interviews were transcribed verbatim from the interview tape and then the tape was destroyed. The interview transcripts were coded in a non identifying manner and no personal information about the child was recorded on the interview transcript. The interview transcripts were saved on a personal computer which only the researcher had access to and which was password protected. Other material which did contain identifying information, such as consent forms, was stored separately in a locked filing cabinet that only the researcher had access to.

Validation Phase

Clinician Focus Group

The researcher invited clinicians from the child and family department of the CAMHS and from school based therapy services to participate in a focus group. A clinician information sheet was given to those who were interested in participating and a mutually agreeable time and location was established for the focus group. The

focus group was attended by three clinical psychologists, a social worker and a systemic therapist.

At the beginning of the focus group information sheets were redistributed and written consent sought from participants. The researcher provided clinicians with an overview of the study to date and clinicians were provided with short anonymous and non-identifying excerpts from children's transcripts regarding aspects of therapy. Clinicians were given five minutes to read over the excerpts and a guided focus group discussion was held where the clinicians discussed their thoughts about the issues raised by the children. The focus group was audio-taped.

Validation Interviews

Three validation interviews were conducted after the main eighteen interviews. The inclusion criteria for participation in a validation interview was that children were of secondary school age, due to the conceptual difficulty involved in the material and the need for more developed literacy levels, and that children had attended at least ten sessions of therapy. Within this group of children three participants were selected based on their having attended therapy in different settings and experienced different models of therapy. The three children were approached by letter, the validation process was explained and they were invited to participate. As stated in the letter the researcher later contacted the family and further information was provided. All three children agreed to participate and verbal parental consent was obtained. The child chose an interview time and location, and then the child and parent information and consent forms were mailed out.

At the interview the researcher reviewed the aims of the validation phase and read through the information sheet with the child. Written consent was obtained from the child and the parent consent form was collected. Consent was obtained to audio

tape the interview. The interview was semi-structured whereby the researcher provided an overview of the research findings and asked the child a series of questions about these. The validation interviews took an average of forty minutes each and the child received a gift voucher for participating. All three of the participants in the validation phase indicated that they understood the components of the model and that the theory developed did explain their experiences of therapy.

Dissemination of Research Findings

At the end of the research process all of the participants were mailed a developmentally appropriate summary of the research findings and information about how these findings would be used. The clinicians who invited their former clients to participate in the study and the clinicians who attended the focus group were also given a summary of the findings. The findings of the study were also disseminated through a clinical meeting at the CAMHS and through presentations to a school counsellor's network meeting and to interested staff at the CAMHS.

Data Analysis

Main Data Collection and Analysis Phase

The individual interviews were transcribed and analysed using grounded theory methodology as outlined by Strauss and Corbin (1998). The first step in this analysis included microanalysis of the initial interviews, which incorporated both open and axial coding. This revealed a large number of concepts and further analysis explored the range of potential meanings contained within each concept. The concepts were then grouped into tentative categories. Where ever possible concepts and categories were labelled using the words that participants used. Subsequent interviews and analysis explored and examined possible sub-categories, the properties and dimensions of categories and the relationships between categories. A

particularly important step in this process was the use of the paradigm, an analytical tool devised to help integrate structure and process (Strauss & Corbin, 1998). The central category, therapy being a process for children, emerged through the selective coding process. While other central ideas were present in the data, such as the theme of the power differential in therapy, the idea of therapy being a process was selected for several reasons. Firstly, this category emerged repeatedly in the initial analysis. Secondly, the researcher coded for process throughout the analysis, finding this to be very useful in understanding the data. Finally, the choice was reinforced by the use of a storyline memo and by recognising that only this category met the criteria set out by Strauss and Corbin (1998) for choosing a central category. Theoretical saturation, where no new properties, dimensions or relationships emerge during analysis (Strauss & Corbin, 1998), appeared to have been achieved at interview 15. This was confirmed by the remaining three interviews.

Validation Phase

The theoretical scheme was refined and validated through the clinician's focus group. Refining the theory involved presenting the theory to the clinicians. The subsequent discussion was intended to identify both any redundant information and categories that were poorly developed. The clinicians highlighted some concepts that they felt would benefit from being further developed, such as: the emphasis that children gave to verbal methods in therapy; how children of different ages perceived the role of talking in therapy and the role of the therapist; the idea that explanations may need to be given at multiple points in therapy; and a perceived distinction between worries about confidentiality and having a lack of trust in the therapist. The identification of these ideas led to a refinement of the final interview protocol to ensure that saturation was achieved in these areas. The focus group was also used to

validate the emerging theory. In presenting the theory to a group of clinicians who work with children, the aim was that the theory should be recognisable to the clinicians and it should be perceived as a reasonable explanation of children's experiences of therapy. Clinician feedback was positive in this respect.

Participant validation interviews were also used to validate the theoretical scheme; this was a part of the selective coding process. Strauss and Corbin (1998) suggested that participants should be able to recognise themselves in the story that is being told and perceive it as a reasonable explanation of what is going on. The three participants involved were unanimous in this regard, they indicated that they understood the theory and felt that it did explain their experiences of therapy. They also volunteered additional examples that were relevant to key themes in the theory, such as children making the distinction between therapy being a nice experience and a helpful experience.

Finally, the researcher undertook validation in accordance with the recommendations of Strauss and Corbin (1998), who discussed the need to validate the theoretical scheme developed against the raw data. This was done by doing a high level comparative analysis. Strauss and Corbin suggested that the theoretical scheme should be able to explain most of the cases, which it did. Particular attention was given to an outlying case, a child who described a negative experience of therapy and this case was reviewed to examine the extent to which the theory accounted for his experience. It was concluded that his experiences fell at the extreme dimensional range of many of the categories identified in the theory and that the theory did still explain his experiences of therapy.

Chapter Four

RESULTS

Chapter Four outlines the results of this study. The results from the two quantitative measures will be presented first, followed by the qualitative analysis. This chapter will briefly discuss the research findings in the context of previous research in this area, identifying the similarities and differences between this study and previous knowledge.

Quantitative Satisfaction Questions

Children were asked to rate their experience of therapy on a global measure of satisfaction (single-item likert scale). The range in likert scale ratings was 3-10 (1 being low, ten being high). The mean rating was 7.53, with a standard deviation of 2.07. Children's responses to the second quantitative measure, the three items from the Youth Satisfaction Questionnaire, are outlined in Table 1.

Table 1. Responses on the Youth Satisfaction Questionnaire.

	Yes (n)	Sort Of (n)	No (n)
Did you like the help you were getting?	10	7	1
Did you get the help you wanted?	10	6	2
Did it help with your life?	12	4	2

The mean score for the Youth Satisfaction Questionnaire items was 4.83, with a standard deviation of 1.46. Ninety-four percent of children had scores at or below the theoretical midpoint of 6.0, indicating a high level of satisfaction with therapy. There was within-participant variation on the three items of the Youth Satisfaction Questionnaire, suggesting that children were able to discriminate between the items and about the therapy that they received.

The alpha coefficient associated with these three items was 0.54. This is lower than the generally agreed cut-off of 0.7 (Nunnally, 1978) but there may be a number of valid reasons for this. The most important of these is that interpretation of Cronbachs Alpha depends on the number of items in the scale. Having a cut-off of 0.7 is considered appropriate based on a scale of 10 items or more, however Todd and Bradley (1994) argue that for a three-item scale an alpha coefficient of 0.5 might be regarded as sufficient. Other reasons for a lower alpha include the small sample size and the fact that three participants were under the age of nine years, which the authors of the Youth Satisfaction Questionnaire suggest is the minimum age for the scale. In relation to the latter, Cronbachs alpha was recalculated after taking out these three participants. The alpha increased to 0.71, which may support the author's stance that the scale is appropriate for children nine years and over.

While statistically it would appear that the Youth Satisfaction Questionnaire provides an internally consistent composite score of children's satisfaction in this sample, evidence from the qualitative interviews suggest that the three items may be measuring slightly different aspects of client satisfaction. After children had completed these three items they were asked to talk about their responses. Their feedback demonstrated that their ratings were considered and that, for many children, liking the help that they got, getting the help that they wanted and feeling that therapy helped with their life were slightly different aspects of client experience. Four examples will be given to support this. Participant 1 (male, 8 years) reported that he enjoyed coming to therapy, he did like the help that he was getting and he felt that his life had changed through coming to therapy. However, he reported that he did not receive the type of help that he actually wanted. He described wanting help with his maths and his behaviour, his maths being the most important issue for him.

Participant 11 (female, 14 years) liked coming to therapy, she received some of the help that she wanted but she felt that therapy did not help with her life, as she felt that therapy could not help her with the issues that she was facing. Finally, Participant 17 (male, 9 years) described that he did like the help that he was getting in therapy, this was the help that he wanted but it only somewhat helped with his life because other family members did not make the changes that were agreed. Finally, Participant 9 (male, 16 years) described how a child may still like therapy even if they did not get the help that they wanted.

Even if you don't get exactly what you want you are sort of letting out your troubles anyway.

(Participant 9, male, 16 years. Validation interview 3, transcript page 3)

The two quantitative measures of satisfaction were used to gain an understanding of the level of satisfaction in the sample, rather than being a focus of the study. For this reason, and the small sample size, level of satisfaction was not differentiated by gender, age or ethnicity. None of the other studies in this area reported using a quantitative satisfaction measure, therefore, it is difficult to compare the level of satisfaction in this and similar studies. The results from the quantitative measures suggest that children's relationship with therapy is complex. While children rated their experience highly, the quantitative ratings cannot explain why this was, nor can they account for the between-item variability or the variability between different children. The main qualitative component of this study enables a fuller understanding of children's experiences of therapy and these findings are presented below.

Qualitative Interview

In the analysis of children's interviews the notion that therapy is a process for children emerged repeatedly and this became what Strauss and Corbin (1998) refer to as the central category, around which all other data is organised. In this study process was viewed as a series of evolving sequences and shifts in actions and interactions rather than in terms of stages of therapy (Strauss & Corbin, 1998). While some children's accounts did resemble a stage theory of therapy this was not present for all children. Analysis revealed that a number of sub-processes were working to affect children's experience of the process of therapy and within each sub-process specific activities contributed to children's experiences. The relationship between sub-processes and the activities within these is explained by Strauss and Corbin (1998), who describe sub-processes as the ways in which the journey occurred and activities as the ways in which the players tried to influence the journey.

The sub-processes are described diagrammatically in Figure 1. The model summarises the main premises of the study as follows:

- Children commence therapy within a complex set of macro and micro conditions that create a context for the child's experience.
- These conditions impact on children's feelings in the first session, which directly impacts on their behaviour in the session.
- Clinician actions provide the structure and tools for therapeutic work, these can either improve or maintain children's feelings about therapy.
- Children respond to the clinician's actions in a purposeful way to try to increase their feelings of comfort or control in the situation or to increase the relevance/usefulness of the session.

- Clinician and child actions interact and mutually influence each other over the duration of therapy.
- The impact of the conditions surrounding therapy and the clinician and child actions shape the child's experience of the process and outcome of therapy.
- Based on their own experiences of therapy and their belief about the helpfulness of therapy, children are more or less willing to consider re-engaging in therapy if they have a need in the future or recommending therapy to a friend.

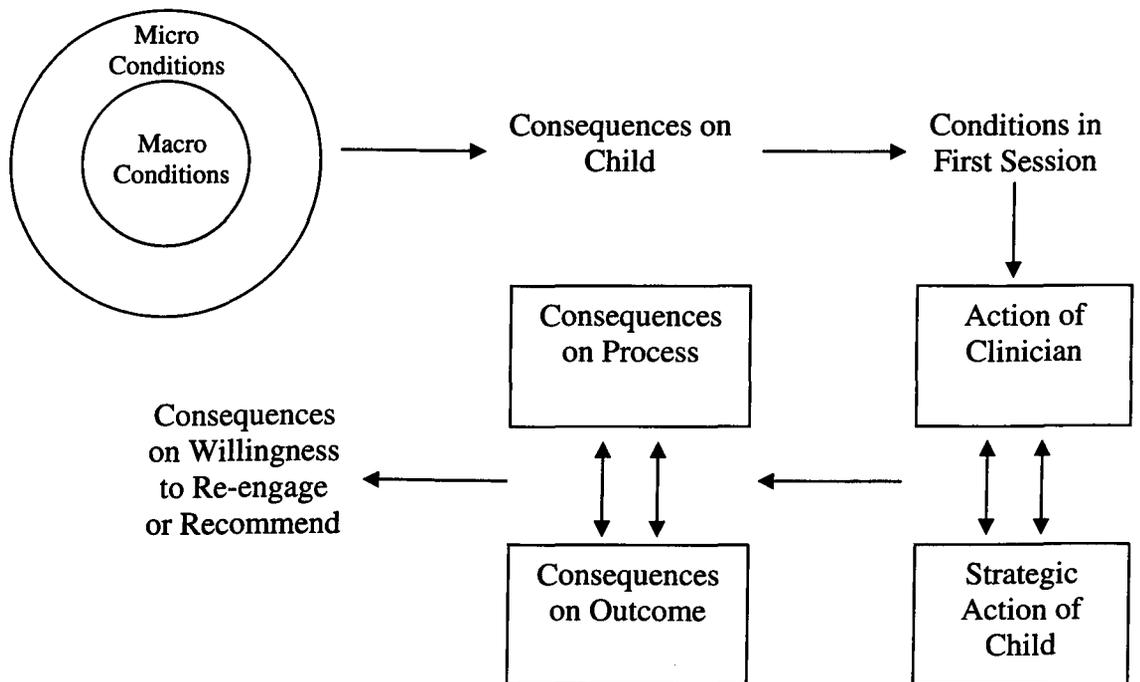


Figure 1. A Model of Children's Journey Through Therapy.

Each of the components of the model will be outlined below. This study suggests that the sub-processes and activities within these are experienced by all children but that children's experiences of these vary dimensionally.

Conditions

Conditions are “the sets of events or happenings that create the situations, issues and problems pertaining to a phenomenon and, to a certain extent, explain why and how persons or groups respond in particular ways” (Strauss & Corbin, 1998 p. 130). A number of conditions that related to children’s commencement of therapy were identified in this study. Children’s experiences of each of these conditions varied dimensionally and particular conditions were most salient for different children, creating a very individual context for therapy. The conditions that emerged in the analysis have been grouped into macro conditions, those that are broad in scope and possible impact, and micro conditions, those that are narrow in scope and possible impact (Strauss & Corbin, 1998). Both macro and micro conditions worked to create a context for a child’s experience of therapy. While each of the conditions will be discussed individually below, they relate in a non linear way, they affect one another as they are circular, simultaneous and overlapping.

Macro Conditions

Three macro conditions were identified.

Therapy is an unfamiliar experience. Therapy is a largely unknown and unfamiliar experience for children. Only one child in the study had any prior experience with therapy and neither younger nor older children had an accurate understanding of what therapy was or involved. Some of the older children held stereotypical ideas about therapy which they reported originated in the media, particularly films.

You see people on TV and films and that, so you kind of know what it is about.

(Participant 14, female, 13 years. Transcript page 2)

The finding that therapy is an unfamiliar experience for children has been supported by other studies which concluded that children held vague, inaccurate or stereotypical ideas about therapy prior to a first appointment.

Therapy is adult-initiated. Therapy was adult-initiated in seventeen out of eighteen cases. In this sample nine children perceived that therapy was initiated by a parent, usually their mother.

I went with mummy when I went there, it was her idea to go there.

(Participant 3, female, 7 years. Transcript page 3)

Seven children reported that therapy was initiated by a teacher, Head Teacher or Head of Year at their school.

They just sent me there.

(Participant 15, female, 13 years. Transcript page 3)

One child did not know who initiated therapy and one child reported that it was her idea to commence therapy (however this child was eight years old). The adult initiation of therapy appeared to strongly contribute to children's perception that the adults were in control in therapy.

Because she was the one that arranged it all and usually the one that arranges it is in charge.

(Participant 16, male, 9 years. Transcript page 5)

However, while the adult initiation of therapy appeared to contribute to children feeling a lack of power, there was also an indication that adult involvement might be necessary as children may not know that help is available or may be reluctant to ask for help themselves.

It was an idea but I had never really thought about doing it until someone offered it to me...I wouldn't ask for it because I don't really talk about me.

(Participant 14, female, 13 years. Transcript page 2)

The finding that therapy is adult-initiated echoed previous research findings that therapy is overwhelmingly initiated by adults rather than children (Clark, 2001; Hart, Saunders & Thomas, 2005; McConnell & Sim, 2000; Vossler, 2004). However, this study did not find there to be an element of tension regarding this.

The child is the identified client. When describing why they attended therapy sixteen of the eighteen children identified themselves as the client in therapy.

Because I had been a bit naughty and got into trouble.

(Participant 1, male, 8 years. Transcript page 3)

Two of the children who attended family therapy identified family issues.

Because we kept on having arguments.

(Participant 6, male, 10 years. Transcript page 1)

This supports previous research in finding that children took responsibility for the issues that brought them to therapy (Hart, Saunders & Thomas, 2005; Lobatto, 2002) even though not all of them were clear about the nature of the problem. However, this study does not support Lobatto's hypothesis that this may be a consequence of interviewing children in front of their parents, as children in this study were interviewed individually. However, it is possible that the very act of only interviewing the child in this study may have unknowingly reinforced his/her role as the client.

Micro Conditions

Seven micro conditions were identified as working to create the context for a child's experience of therapy.

Understanding the reason for the referral to therapy. Consistent with previous research (Stith et al., 1996) most children felt that they were attending therapy to get help to solve a problem and most identified themselves as having the problem. Younger children expressed the problem in concrete behavioural terms and this was often externalising in nature.

Because I had a bad temper.

(Participant 12, male, 9 years. Transcript page 2)

Older children were usually able to provide a clear description of why they were referred to therapy and they were more inclined to include an internalising description.

For me to get stronger within myself, so I could feel better about myself.

(Participant 14, female, 13 years. Transcript page 2)

However, as has been found in previous research, not all children appeared to understand the reason why they were referred to therapy.

Because I was having problems with myself or something like that.

(Participant 13, male, 10 years. Transcript page 2)

In addition, two children had inaccurate understandings of why they were referred to therapy.

I think I was going because I couldn't speak English properly.

(Participant 5, male, 12 years. Transcript page 3)

Expectations of therapy. Children had a range of expectations about both the process and outcome of therapy. However, consistent with previous findings not all of these expectations were accurate (Kuehl, Newfield & Joanning, 1990). Children's expectations about the process of therapy included the common expectation that therapy was a verbal activity to do with answering questions, and this seemed acceptable to many children.

I saw my best friend and he said it is all about chatting.

(Participant 1, male, 8 years. Transcript page 3)

However, some children's expectations were that this would involve a lot of questions that would feel negative and intrusive.

I thought that she was going to be really horrible and try and butt into my personal life and ask really personal questions that I wouldn't want to answer.

(Participant 15, female, 13 years. Transcript page 1)

Children were evenly split regarding whether their expectations about the process of therapy were positive or negative. Those that held positive perspectives tended to expect therapy to be a supportive process.

Like someone tell me it was alright and stuff like that, comforting.

(Participant 2, male, 12 years. Transcript page 2)

Negative expectations about the process of therapy centred upon therapy being scary and a place where the child would get into trouble.

I thought that I was going to get into trouble and umm, it was a scary place.

(Participant 3, female, 7 years. Transcript page 3)

In these situations, consistent with Montgomery (2003), in the absence of clear expectations participants focused on what they least wanted or most feared. Many of

children's negative expectations were very similar to those reported in other studies, particularly that of Vossler (2004). However, unlike Vossler's study, participants in this study did not associate therapy with stigmas such as mental illness.

Expectations about the possible outcomes of therapy varied greatly. Most children expected that therapy would be helpful. For some children, particularly older children, this positive expectation centred on addressing a specific problem.

That we would stop arguing and get everything sorted.

(Participant 6, male, 10 years. Transcript page 2)

I hoped that we would talk about what happened until I was sick and tired of it.

(Participant 9, male, 16 years. Transcript page 4)

Other children, particularly younger children, expected that therapy would lead to a complete transformation in their life, fixing everything about a child's life or situation.

It would change my life...bad to good.

(Participant 1, male, 8 years. Transcript page 3)

This study did not find that there was a feeling of pessimism regarding the therapy process (Montgomery, 2003), however a very small number of children believed that therapy could only be minimally helpful in resolving the presenting problem.

In a way she can't do nothing about it and in a way it is all still in my head. It is me that's going through it and she does understand in a way but not exactly because she's not the one.

(Participant 11, female, 14 years. Transcript page 1)

A number of children indicated that they were unable to have expectations about the possible outcomes of therapy as they didn't know what therapy was.

I had no idea, absolutely no idea.

(Participant 18, female, 14 years. Transcript page 4)

I didn't really think that anything would be different because I didn't know what was going on.

(Participant 15, female, 13 years. Transcript page 1)

Worries about attending. Many children described feeling worried about the prospect of attending therapy. As illustrated in the following quotes children were able to articulate that most of their worries were related to the unfamiliar elements of the situation and the prospect of meeting an unknown adult.

Going somewhere that I hadn't been before not quite sure what it would be like.

(Participant 6, male, 10 years. Transcript page 2)

I think talking to someone you don't really know about your troubles and your personal stuff.

(Participant 2, male, 12 years. Transcript page 2)

Other worries that children described included a fear of being judged by the clinician, worrying about how to talk about the issues, concerns regarding the impact of talking honestly in front of family members, a fear of disclosing and then feeling that the clinician did not care, and concerns about confidentiality.

Pre-therapy preparation. The extent of pre-therapy preparation reported by children varied greatly. Over half of the children did not recall getting an explanation about therapy prior to their first appointment and reported feeling very confused about what was happening.

I didn't get told, I wasn't sure where I was going when I went to therapy, I thought I was going shopping with my mum or something.

(Participant 5, male, 12 years. Transcript page 9)

I didn't really know that much what was happening.

(Participant 6, male, 10 years. Transcript page 1)

Other children recalled that a parent or teacher had provided some information prior but for many of these children this did not feel sufficient.

She gave us some hints.

(Participant 7, female, 14 years. Transcript page 1)

However, a small number of older children recalled being given what felt like adequate information and preparation prior and this appeared to decrease the level of worry that these children felt.

Consistent with previous research by Day, Carey and Surgenor (2006), the most common request from children was for a greater level of information prior to their first appointment. In some cases children wanted quite detailed information about therapy and the clinician. The primary function of the desired information appeared to be to provide reassurance about the process of therapy and to enable the child to form a mental picture of the clinician. In addition to this, some children suggested that it would have been useful to have met the clinician prior to the first appointment.

Because then you feel more comfortable talking to them if you knew them a bit.

(Participant 14, female, 13 years. Transcript page 4)

Support of therapy by others. For some children, the referral to therapy was encouraged or supported by an adult other than the referring adult. These people included the child's doctor, peers, teacher, school nurse, an older friend or their Head of Year. The relationship that the child had with this person affected the value that the child placed on his/her support of therapy. In many cases this was developmentally significant, older children found it easier to hear support for therapy from a friend or a trusted independent adult such as a Head of Year.

It is very difficult to hear things from your parents. Maybe not so much for a 7 or 8 year old or up to an 11 year old but certainly 13 plus.

(Participant 10, male, 17 years. Transcript page 9)

Those participants who had support for therapy, by a person other than the initiating adult, reported higher levels of willingness to attend a first appointment.

Children's perception of potential helpfulness. Children overwhelmingly felt that therapy could be helpful to them, which is significantly more positive than Vossler's (2004) finding that children are "not placing much hope in this kind of help" (p. 57). In this study fifteen children said that they thought that therapy could be helpful, two children felt that therapy may be able to be helpful and one child felt that therapy would not be helpful. The feeling that therapy could be helpful appeared to override the affect of some of the other conditions surrounding the commencement of therapy, making children more willing to attend.

I didn't really want to go at first but then when it was offered to me I thought well I might as well try if it is going to help me.

(Participant 14, female, 13 years. Transcript page 2)

Extent to which child identifies a need. There appeared to be a qualitative difference between children who did identify that they had a need for help and children who identified the existence of a problem but who were attending primarily for another's benefit. Older children were more likely to be attending for their own benefit.

I think I made myself go because I thought I have to go, I have to start somewhere, I have to talk about this because this is dangerous.

(Participant 9, male, 16 years. Transcript page 2)

Children who identified that they had a need for help were far more likely to be willing to attend therapy. However, for some children the identified need had to become quite serious, or the situation reach crisis point, for them to consider therapy.

It couldn't have got much worse.

(Participant 18, female, 14 years. Transcript page 4)

I thought it was more like you need to do it than it can be helpful to do it. Like it was one of the last things you could do.

(Participant 14, female, 13 years. Transcript page 3)

These two children discussed that the need had to be very significant to consider attending therapy, such that the consequences of not going to therapy felt greater than the feared consequences of attending. This is consistent with Vossler's (2004) finding that client families only seek professional help when all other attempts to overcome the problem have failed.

Relationship Between Conditions

As previously outlined, the macro and micro conditions interact and mutually influence each other. The combination, interaction and intensity of the macro and micro conditions experienced impacted on how a child felt about attending the first

session. If a child had worries about attending, was not well prepared by adults and had negative expectations, then this appeared to increase his/her feelings of nervousness and fear. However, if a child understood the reason for the referral, and was well prepared for attending therapy, and if therapy was supported by a trusted person, then they were far less fearful and more willing to attend. Some participants articulated the role of individual differences in how these conditions would impact on other children, discussing that different children may feel more or less nervous because of their personality or age.

Of all of the conditions identified two conditions appeared to dominate: children's perception of the potential helpfulness of therapy and the extent to which the child perceives a need for therapy. These two conditions were potentially able to override the impact of other conditions. When a child identified a need and believed that therapy could potentially be helpful, they were willing to attend a therapy appointment even though they had worries or held some negative expectations. As will be discussed further, the macro and micro conditions identified also remained part of the situational context and interaction in therapy over time, thereby continuing to impact upon the child's experience of therapy.

Consequences of the Macro and Micro Conditions on Children

This component of the model describes the consequences of the macro and micro conditions on children and how they create a context for the child's commencement of therapy. The biggest consequence was found to be on children's willingness to attend therapy. In this study eight children were willing to attend therapy, eight had mixed feelings about attending and two children did not want to attend therapy. Those that were willing to attend were often willing as they viewed therapy as a means of resolving a problem.

Yeah because I wanted to try and sort it out.

(Participant 6, male, 10 years. Transcript page 1)

A small number of younger children were also willing to attend therapy because it gave them time out of school and it was a different or novel experience.

Because I was out of class and I was talking to a different person.

(Participant 13, male, 10 years. Transcript page 2)

The children who had mixed feelings about attending therapy did recognise that there was a problem that they wanted to resolve but they had worries or concerns about therapy.

I did to help me but then I didn't because it was a bit awkward.

(Participant 7, female, 14 years. Transcript page 1)

In most of those cases children still had some degree of willingness to try therapy, despite their fears.

I thought I might understand more about it than if I just said no and not trying what it is.

(Participant 15, female, 13 years. Transcript page 2)

In a small number of cases children with mixed feelings about therapy may have attended due to the influence of adults.

At first I didn't but then I gave in.

(Participant 3, female, 7 years. Transcript page 3)

Cause I didn't want to argue back with the teacher.

(Participant 15, female 13 years. Transcript page 2)

The level of concern about therapy reported by children in this study appeared to be higher than that found by Vossler (2004) but more positive than findings by Stith et al. (1996) who found that most children did not want to come to therapy at first. The

nature of the macro and micro conditions identified appears to provide support for the assertion by Stith et al. (1996) that children's initial protests said more about their unfamiliarity with therapy than a lack of interest in the process or the problem.

Conditions in the First Session

This component of the model describes how the child's experience of the macro and micro conditions impacts upon their feelings and behaviour in the first session. Most children described attending the first session with varying degrees of hesitation and reservation.

A bit sickening and should I go or shouldn't I go in my head.

(Participant 15, female, 13 years. Transcript page 2)

Children described feeling vulnerable and reported that commencing therapy is "not a comfortable experience" (Participant 11, female, 14 years. Transcript page 1). The most common word used by children to describe how they felt in the first session was nervous, with other words including scared, shy, not confident and sick. Similar feelings were cited in other studies, (Clark, 2001; Kuehl, Newfield & Joanning, 1990; Montgomery, 2003), however, it appears that a larger percentage of children in this study reported these types of feelings. Despite this, children did not report low motivation or a negative attitude towards therapy as described by Vossler (2004) nor the ambivalence reported by Strickland-Clark, Campbell and Dallos (2000). This may be partially due to their largely being willing clients and because they did not perceive the clinician to be an ally of their parents as was found by Vossler (2004).

The central reason why children appeared to find the first session so difficult was that therapy and the clinician were unknown.

Because I had never met her before and I didn't know what her name was, I didn't know what she was doing with me.

(Participant 13, male, 10 years. Transcript page 1)

Another child described how the situation being so unknown led her to worry about what would occur in the session and how best to respond to this.

Nervous and thinking would I lie or should I tell the truth?

(Participant 11, female, 14 years. Transcript page 2)

In contrast the one child who did have some prior experience of therapy described himself as “not fussed” in the first session (Participant 10, male, 17 years. Transcript page 1). For a small number of younger children the unknown elements of the situation also led to feelings of excitement or intrigue alongside feelings of nervousness.

Children also reported finding the first session difficult because they did not know the ‘rules’ of therapy.

What is she going to do, is she going to tell anyone about it?

(Participant 11, female, 14 years. Transcript page 1)

It is easier if you know what the rules are.

(Participant 14, female, 13 years. Transcript page 4)

Just under half of the children did not recall being given any information about therapy in their first session, which may have maintained this problem.

The sensitive nature of the issues that were being discussed was another reason why the first session felt so difficult for children.

It brought back memories...it was sad.

(Participant 2, male, 12 years. Transcript page 4)

It was really hard because I didn't want to talk about it.

(Participant 9, male, 16 years. Transcript page 1)

I find it hard to talk about personal stuff anyway.

(Participant 9, male, 16 years. Transcript page 3)

Finally a small number of children described feeling bored in the first session.

Cause there was nothing really to do there.

(Participant 16, male, 9 years. Transcript page 1)

Children reported that their feelings did impact upon their behaviour in the first therapy session. They described being more quiet, shy and reluctant to ask questions.

I was too shy to play with the toys in front of a different adult.

(Participant 13, male, 10 years. Transcript page 1)

I remember the first time I was just fiddling with my jewellery, I felt a bit awkward and lost concentration.

(Participant 18, female, 14 years. Transcript page 3)

A bit scared and I felt a bit shy and I didn't really have eye contact with them like I do with Mummy.

(Participant 3, female, 7 years. Transcript page 3)

Some of children's feelings and concerns appeared to recede after the first session of therapy. The large majority of children said that they felt they understood more about therapy after the first session and ten of the eighteen children reported feeling differently about therapy. In most cases this involved a reduction in feelings of nervousness.

I didn't feel quite so nervous and I knew more about what was going on and what would happen.

(Participant 6, male, 10 years. Transcript page 2)

One child suggested that children needed to be able to manage their feelings and relax for therapy to be helpful.

It's a fear and getting over that.

(Participant 9, male, 16 years. Transcript page 3)

As will be discussed further, participants reported that it took between one and four sessions to feel relaxed in therapy.

Action of the Clinician

Children appeared to be actively evaluating the clinician and his/her actions throughout therapy. Children's experiences of clinician actions varied dimensionally and this accounted for much of the variation in children's experiences of therapy. Children were able to identify clinician actions that they experienced as helpful or unhelpful. Clinician actions appeared to mediate the impact of the contextual conditions surrounding therapy. In most cases the clinician actions helped the child to relax however in a small number of cases clinician actions contributed to the maintenance of the negative feelings that the child had in the first session. This component of the model describes the clinician characteristics, actions or decisions identified by children as significant in their experience of therapy.

Clinician Characteristics

The personal characteristics of the clinician emerged as being very important to children. Most children described their clinician as 'nice'. Other words used by children were: understanding, kind and gentle.

I think it was the way she was saying things, really understanding and she was kind.

(Participant 15, female, 13 years. Transcript page 2)

These descriptions were contrary to children's expectations prior to therapy and appeared to be accompanied by feelings of relief and surprise.

She was not bossy or anything like that, very calm.

(Participant 16, male, 9 years. Transcript page 4)

Sue was very good not to judge you on what you said and what you did.

(Participant 9, male, 16 years. Validation Interview 2, transcript page 4)

One impact of the clinician's characteristics on children was that they enabled children to feel more relaxed in therapy.

You just feel like you can relax around her. You don't feel like you have to be sitting up really straight and things.

(Participant 15, female, 13 years. Transcript page 3)

Feeling cared about by the clinician emerged as very significant to children. Older children in particular spoke of needing to feel that the clinician was not just mechanically doing her job.

I was scared that if I told her stuff about how I was feeling then she might turn around to me and not be very caring and be like can we go now.

(Participant 9, male, 16 years. Transcript page 3)

This child discussed how feeling cared about by the clinician was particularly important to him because, due to the circumstances that brought him to therapy, he was already feeling very vulnerable. Children were able to identify specific clinician actions and behaviours that demonstrated care including; listening, taking time with them, paying attention and appearing to have planned the session. Listening was

particularly highlighted by children. Children, such as Participant 11, were able to provide detailed descriptions of how they knew that the clinician was listening to them.

She looks at me, she looks in your face and talks to you. She doesn't look around or do something else while I am talking to her.

(Participant 11, female, 14 years. Transcript page 6)

Non-verbal cues and body language were also cited by many children as very important and indicators of care. Participant 9 suggested that children readily 'pick up on things' such as tone of voice, body language and other non-verbal characteristics.

I definitely think that kids notice things more, whether it is a comfortable silence or not a comfortable silence, awkwardness or not awkward.

(Participant 9, male, 16 years. Validation Interview 2, transcript page 5)

This study provides support for the Hart, Saunders and Thomas (2005) finding that children are Rogerian when it comes to describing the core skills and values of an ideal clinician. However, in this study most children did not express a strong preference regarding the demographics of the clinician, although several of the girls expressed a preference for a female clinician.

Ability to Form a Therapeutic Relationship

Children, almost unanimously, wanted to form a relationship with the clinician. However, children also reported that it is difficult for them to form a relationship with an unknown adult and therefore clinician actions became significant.

Because sometimes I find it quite hard to, you know, really open up, there were so many things that were upsetting me but I just didn't feel like I could tell anyone, especially not an adult. I find it harder to talk to adults.

(Participant 18, female, 14 years. Transcript page 5)

There was a theme in older children's interviews that the therapeutic relationship needed to be experienced as different from relationships that children may have with other adults who were authority figures to them. Participant 9 discussed how this relationship needs to have a 'human' quality to it.

I think that they need to be human to children because people forget that teachers and people aren't humans.

(Participant 9, male, 16 years. Validation Interview 2, transcript page 2)

This participant discussed how he felt that having this human quality in the therapeutic relationship, where the child realised that the clinician was a normal person, would result in trust and respect from the child and enable the child to talk freely.

While the clinician being a stranger was seen as a difficulty initially, it was also seen as an advantage in that the children perceived the clinician as an independent person who was not involved in their situation.

It is a bit weird talking to someone that I didn't really know but it is better to have someone a bit further out so they don't really know. Like if I spoke to my mum I don't really say some things, it is better to speak to somebody out of the picture so then I feel more comfortable speaking to them.

(Participant 14, female, 13 years. Transcript page 3)

The clinician's ability to move from the position of being a stranger to being a trusted adult was therefore significant. Many of the children appeared to quickly trust the clinician.

I suppose I just innately trusted her. I don't tend to distrust people until they give me good reason to.

(Participant 10, male, 17 years. Transcript page 5)

In several cases a parent facilitated the establishment of trust by conveying their trust in the clinician to the child. Children also described things that the clinician did that appeared to help build a relationship. Central factors, consistent with the literature, were the clinician listening to the child and the clinician being interested in the child.

She was into stuff about me.

(Participant 12, male, 9 years. Transcript page 6)

An older child described something similar.

I feel to make the person feel relaxed is if the therapist seems like they are intrigued a lot of the time in what the person is saying.

(Participant 9, male, 16 years. Validation Interview 2, transcript page 6)

For many children, particularly older children, feeling that they knew the clinician was very important and led them to feel more comfortable in the session and more able to disclose information. In getting to know the clinician children appeared to be seeking a more reciprocal quality to the relationship, where they knew a little about the clinician as well as the clinician getting to know them. Some children discussed actively making attempts to get to know the clinician, appreciating it when the clinician chose to answer their questions and finding it difficult when the clinician chose not to do this.

I asked her some questions, she asked me some questions, we talked about life in general, we got to know each other which I thought was really good. Then after that I began to tell her more deep things.

(Participant 9, male, 16 years. Transcript page 1)

Another child spoke of her confusion when she asked the clinician questions about herself and these were not answered. When she was later asked in the interview what would have increased her satisfaction with therapy the girl replied,

Possibly by telling me a bit about herself.

(Participant 18, female, 14 years. Transcript page 5)

The role of clinician self-disclosure was also highlighted by Kuehl, Newfield and Joanning (1990) and Day, Carey and Surgenor (2006).

The nature of the relationship formed with the clinician varied greatly. Some children did not remember who they had seen nor details about the person, whereas other children had clear recollections of the person, referring to them by name and with affection.

She made me feel like, not friends as such but like I could trust her and it was easier for me to talk to her.

(Participant 9, male, 16 years. Transcript page 1)

Modality of Therapy

Children in this study stated that the modality of therapy was something that was decided by the clinician (contrary to the findings of Hart, Saunders and Thomas, 2005). Children were able to discuss the actual and potential impact of different modalities, based both on their own experience and in a more hypothetical sense. Children who attended therapy with their family identified two major advantages of this model of therapy. The first is that it enabled other people in the family to receive

help and secondly they felt more comfortable in the session with their parent/s or family present.

I feel quite comfortable when mummy is around.

(Participant 3, female, 7 years. Transcript page 4)

Participant 6 said that, while it was useful to have his whole family there, one negative impact of this was that he felt that his father corrected and negated his views on some subjects. He also reported that he felt that the adults did more of the talking and he would have liked to talk more in the session. However, the children in this study who attended family therapy did not report some of the other concerns that are reported in the literature, such as feeling that therapy had been adult-dominated (Vossler, 2004), feeling excluded from the sessions (Day, Carey & Surgenor 2006) or that it was difficult to negotiate their position within a family therapy context (Lobatto, 2002).

The children who attended individual therapy discussed several advantages of this modality. Some children articulated that therapy was their time and for their benefit, therefore they preferred to attend alone.

I thought this was for me and I didn't really want anyone else to come with me.

(Participant 9, male, 16 years. Transcript page 5)

A small number of children felt that their relationship with their parents was too conflictual to attend therapy together, whereas for some older children not wanting parental involvement appeared to be more a reflection of the developmental stage of adolescence.

They're my parents, I don't really want to talk to them about anything.

(Participant 18, female, 14 years. Validation Interview 1, transcript page 1)

Finally, many of the older children felt that they could not be totally honest if their parents were present.

With family there you can't be honest and you can't talk really.

(Participant 9, male, 16 years. Transcript page 5)

A similarity between this and previous studies is children's concern about talking in front of family members. In this study children were scared of making family members angry, as opposed to children in the Lobatto (2002) and Strickland-Clark, Campbell and Dallos (2000) study, who were scared of upsetting family members.

Children who attended individual therapy recognised that a disadvantage of their family not attending sessions was that they could not get help and make changes. However, these children seemed prepared to accept this as a trade off, it appeared more important to them to be able to talk privately. Some children described how the clinician offered to discuss particular issues with the child's parents. In one case this was experienced as very positive and led to the resolution of the presenting issue. In another situation the child did not feel that this was needed but experienced it as supportive that the clinician had offered to do so.

A small number of children experienced a slightly hybrid model of individual therapy, where their parents attended the first and last therapy session or the first session and review meetings. This was perceived by these children as being a good balance. While Participant 14 was adamant that she wanted individual therapy, she described it as very helpful to her that her parents came to the first session with her and that they were "working together on something" (Participant 14, female, 13 years. Transcript page 6). For this girl, the clinician was able to communicate issues to her parents that she was not able to talk about and this was experienced as very useful.

It woke him up that I wasn't the perfect girl that did everything right, it was helpful.

(Participant 14, female, 13 years. Transcript page 9)

However, this participant acknowledged that, although she later found her parents' involvement very helpful, she did not initially want her parents involved.

I thought it was a good thing that my parents had to come, even though it wasn't at the time, I didn't like it at the time, it was a good thing.

(Participant 14, female, 13 years. Validation Interview 3, page 4)

Most children expressed a preference for the mode of therapy that they received and they felt this was appropriate for them. Consistent with Vossler (2004), there was a trend towards older children wanting individual therapy, some of whom valued there being limited contact with their parents. However, younger children had mixed views. Some children liked having individual time with the clinician and other children wanted to attend with their family or at least a parent. Unlike the findings of Hart, Saunders and Thomas (2005) there was no clear gender distinction in this study regarding the preferred level of parental involvement.

Activity in Session

Children described therapy sessions as centring on talking and activities or play. Most children in this study experienced a verbally focused style of therapy and this appeared to feel appropriate to them. Many of the younger children reported appreciating toys and activities as a part of or adjunct to therapy.

The best thing was that you were allowed to play while talking.

(Participant 17, male, 9 years. Transcript page 1)

However, there was a sense from these children that play was secondary to the primary aim of talking.

I don't think it would be good for one whole session just to play.

(Participant 2, male, 12 years. Transcript page 3)

Therapy isn't all about toys. It's about, well you know what it is about, well it's about telling them things.

(Participant 3, female, 7 years. Transcript page 5)

This view on play is contrary to Day, Carey and Surgenor's (2006) finding that activities are preferred by children to talking but it is consistent with the idea that play helps children to feel included (Stith et al., 1996) and that play can give children space from the therapeutic situation rather than being an integral part of therapeutic communication (Lobatto, 2002). For a small number of children who received psychoanalytic therapy, play formed a larger component of the session. These children described that their sessions were comprised of "playing and talking" (Participant 12, male, 9 years. Transcript page 5) and most of these children described liking this combination of activities. In describing what he liked most about therapy, Participant 12 said "Playing football and talking about if I was worried." (Participant 12, male, 9 years. Transcript page 6).

The children identified two main functions of the talking in therapy. The first was that it gave them someone to talk to about problems and difficulties.

It was my weekly unload session.

(Participant 10, male, 17 years. Transcript page 2)

Children described that being able to talk about their problems in therapy gave them a sense of relief.

I'd left something there. Like I'd told her what happened and left it behind.

(Participant 11, female, 14 years. Transcript page 7)

You just need someone to talk to, it just lets out your stress.

(Participant 9, male, 16 years. Validation Interview 3, transcript page 3)

The second function of talking in therapy identified by children was that it facilitated solving the presenting problem. This was also found by Stith et al. (1996) and Day, Carey and Surgenor (2006). Older children discussed that one of the ways in which the problem got resolved was that they gained an increased understanding of the situation.

When it's been out loud, you can talk to someone and they say things back, it is easier to understand what is going on. Cause if you are on your own and you're thinking about things you don't get other people's point of view.

(Participant 9, male, 16 years. Validation Interview 3, transcript page 1)

A second way in which talking helped to solve the presenting problem was that it provided an opportunity to learn strategies to manage the problem and prevent future problems.

I realised through Sue that it was important that I have some preventative measures as well, otherwise I would be eternally in counselling.

(Participant 10, male, 17 years. Transcript page 8)

Another child discussed how she had expected that she would learn skills and strategies in therapy.

That is what I expected, people to give me some ideas because at the time I was being really badly bullied and I didn't know what to do, so I suppose some help with what to do would feel better.

(Participant 18, female, 14 years. Validation Interview 1, transcript page 2)

Most children discussed that it was optimal if therapy provided both a chance to talk about the problem and release associated emotions, and a chance to increase their

knowledge and learn strategies and skills in relation to the issue. This was expressed by Participant 14.

It's easy for you to talk and get it all out but you also need some help when you are not with the counsellor so it is better to have some strategies.

(Participant 14, female, 13 years. Validation Interview 3, transcript page 1)

Unlike Day, Carey and Surgenor (2006), there was little suggestion from children that a verbally focused style of therapy was taxing, overwhelming or uninteresting. However, some children, particularly younger children, suggested that children may need help and encouragement to talk in therapy. Participant 16 suggested that the clinician provide ongoing encouragement and opportunities for children to participate.

You really want to ask them if they, if they like, do you want to say anything now. If they say no, wait for a minute and see if you want to say anything now.

(Participant 16, male, 9 years. Transcript page 1)

Other children highlighted that it would be useful if the clinician gave them permission to talk about certain issues, followed up on 'hints' that the child is trying to give and asked about signs of nervousness.

Role of the Clinician

Children had quite clear views as to what they saw as the role of the clinician. They saw the clinician as the person responsible for structuring the sessions and as the agent of change. In relation to the former, both younger and older children felt that the clinician's role was to ask the questions and provide the structure for therapy.

She was normally the one who asked the questions.

(Participant 9, male, 16 years. Transcript page 6)

This seemed to be particularly acceptable at the beginning of therapy.

What really helps is when the therapist asks a lot of questions a lot of the time because sometimes you really don't know what to say.

(Participant 14, female, 13 years. Validation Interview 2, transcript page 6)

Older children identified that within this structure they were still able to have a lot of control over the content of the sessions and talk about issues of importance.

She allows you to feel in control and to take the sessions where you need but still through that can still provide you with all the things you need to help with whatever the problem may be.

(Participant 10, male, 17 years. Transcript page 4)

There was some indication that children expected and needed the clinician to provide some structure for therapy. This is illustrated by Participant 9 who discussed that, while he wanted to talk about his feelings, due to the patterns of adult child interaction in society he was waiting for a cue from the clinician to do this. He also highlighted how his perception of the clinician as an expert contributed to this.

I think that it is also because we think of them as doctors and teachers, they have this job and you believe that they have gone through all this training and university and stuff and they know all the tricks, what to do and where to go, kind of like surgery.

(Participant 9, male, 16 years. Validation Interview 2, transcript page 5)

The clinician was also perceived by children to be the agent of change and responsible for the outcomes of therapy, although children's belief in this idea varied developmentally. Younger children's language revealed their belief that the clinician was the sole agent of change. There was not a strong sense from primary school children that they were co-collaborators in therapy. However, some children

expressed limits and boundaries in relation to the clinician's role as the agent of change. One child felt that it would be negative if the clinician gave her opinion too much or became too involved in her life.

Try to interrupt a bit too much with your friendships and your personal life.

(Participant 15, female, 13 years. Transcript page 8)

Participant 8 did not want the clinician to take direct action regarding the issues but instead to leave this to her parents. In comparison, some of the older children felt that they were the main agent for change, with help from the clinician. One child explained how the clinician did this in saying:

She goes in your view, she thinks in our view and she just suggests, tries to help you all the time.

(Participant 11, male, 17 years. Transcript page 6)

There was some suggestion that children may develop their understanding regarding agency for change through experience in therapy. Participant 18 discussed that at the time she believed that it was "probably the therapist" (p. 2) who was responsible for change however in retrospect she reflected that:

The therapist is supposed to be there for support and to help out and to generally support and it is my job to change what is going on.

(Participant 18, female, 14 years. Validation Interview 1, transcript page 2)

She elaborated that she did not think that she recognised this when she was attending therapy as,

I didn't know what was going on.

(Participant 18, female, 14 years. Validation Interview 1, transcript page 2)

Helpful and Unhelpful Actions

Children identified a large number of clinician actions that they found helpful and a smaller number that they experienced as unhelpful. The helpful clinician actions can be grouped under two broad headings: actions that empower children and clinician flexibility.

Children valued any efforts that the clinician made to empower them in therapy. This appeared to help children to feel more confident in therapy. The theme of empowerment was also found to be important by Hart, Saunders and Thomas (2005). One of the most helpful things identified in this study was when the clinician provided explanations and information about therapy and specific processes or actions taken. This appeared to be relevant particularly at the beginning and the end of therapy. The level of information provided about therapy varied. Some children recalled being given good explanations by the clinician, some children felt that the information given was not sufficient and some did not recall being given any information about therapy. When children were given adequate information about therapy this served to alleviate their fears and worries.

At first I didn't know what was going on at all but once she explained it was ok.

(Participant 15, female, 13 years. Transcript page 6)

I didn't feel so nervous and I knew more about what was going on and what would happen.

(Participant 6, male, 10 years. Transcript page 2)

There appeared to be a relationship between the child's degree of unfamiliarity in the therapy setting and the level of information that they wanted. Participants in the validation interviews highlighted the need to give information and explanations to

children on multiple occasions. Several children suggested that the clinician provide information in the second session of therapy as well as the first session due to children's feelings of nervousness in the first session. There was some evidence to suggest that if children weren't given adequate information about therapy initially then they remained confused throughout.

I didn't know it was therapy until like a year in.

(Participant 18, female, 14 years. Transcript page 5)

A second clinician action that appeared to empower children was when they were given choices. The children appreciated being involved in decisions about therapy, this was also found by Vossler (2004) and Hart, Saunders and Thomas (2005). Several children discussed being given the choice not to disclose information straight away, the choice to not attend therapy one week, choices about the frequency of sessions and the clinician consulting with them before communicating with other members of the system. Consistent with the findings of Day, Carey and Surgenor (2006), choices about appointment times appeared to be valued by children, with participants discussing that there were good times and bad times to attend therapy. The impact of attending therapy at a bad time was discussed by Participant 14.

Because I feel that if they have to go into the room at a bad time then they are going to get there in a bad mood.

(Participant 14, female, 13 years. Validation Interview 2, transcript page 4)

Participants wanted to be involved in decisions about clinician contact with their school. Most children had serious reservations about this and wanted to be consulted or involved in this process.

Being given choices appeared to help children feel more comfortable and confident in therapy and helped to create a positive therapeutic relationship.

It makes you more confident when you are speaking to them. I think it is better when you get choices about what you want to speak to them about and what time and that.

(Participant 14, female, 13 years. Validation Interview 3, transcript page 2)

We both signed a contract that it would be ok if at any time in the session it was uncomfortable then I could leave. Those kinds of things make the other person feel comfortable and there is a bond.

(Participant 9, male, 16 years. Validation Interview 2, transcript page 2)

The theme of empowerment through information and choices was particularly strong for older children but also present for some of the younger children, contrary to the finding that younger children do not expect to participate in therapy on a more symmetrical basis (Cederborg, 1997).

Children cited far fewer unhelpful clinician actions, however, the issues raised included: the pace of therapy feeling too fast; not being given enough time to think about and respond to questions; talking about things that felt unnecessary; finding periods of silence very uncomfortable; having to repeat themselves; and the impact of having to change clinician.

Sometimes I had to say something twice, three times, four times, five times.

(Participant 16, male, 9 years. Transcript page 6)

Children also found it unhelpful and annoying when the clinician did something that they did not understand the relevance or meaning of. Examples cited included interpreting the child's drawings or having periods of silence in the session.

She said that I was drawing stuff for a meaning when I was just trying to draw something.

(Participant 4, male, 14 years. Transcript page 3)

Some children, possibly due to their own satisfaction with therapy, found it hard to think of any unhelpful things about therapy.

If I didn't like it I would have loads of things to say.

(Participant 14, female, 13 years. Validation Interview 2, transcript page 4)

Children overwhelmingly stated that they would not have volunteered information about unhelpful clinician actions to their clinician. When asked what the clinician could do to enable them to provide this feedback, children reported that the clinician would need to ask for detailed and specific feedback rather than general feedback and to create an environment where the child felt safe to provide this. However, children were still unsure if they would feel able to provide negative feedback to the clinician. Two children discussed that this was partly because they did not want to hurt the clinician's feelings or provide negative feedback to someone who was trying to help them.

It appeared that helpful clinician actions could mitigate and reduce the impact of the macro and micro conditions surrounding the commencement of therapy. However, unhelpful actions were difficult to raise and resolve due to the same macro and micro conditions, in particular the power imbalance between clinician and child.

Strategic Action of the Child

When children discussed their own actions and behaviour in therapy sessions it revealed that they were active participants throughout therapy. Children's actions included both observable actions and their own internal management of the situation. Children's actions were often strategic in nature, in that they were considered and active responses to situations. As such, they meet Strauss and Corbin's (1998) definition of strategic actions, "purposeful or deliberate acts that are taken to resolve a problem and in doing so shape the phenomena in some way" (p. 133). There was

clear evidence of children monitoring their behaviour and regulating their feelings and actions in therapy. Children also adjusted their behaviour in line with the clinician's actions. The findings of this study were consistent with previous findings that children are internally active (Lobatto, 2002), manage their participation in therapy (Lobatto, 2002) and even when silent try to position therapy in a way that best suits their needs (Kuehl, Newfield & Joanning, 1990). The intention behind many of these actions appeared to be to increase the child's feelings of comfort and control in therapy, to enhance therapy's helpfulness or relevance and to minimise the chances of something unwanted occurring. Children's actions varied throughout the process of therapy in response to the actions of, and interactions with, other players and in order to meet the child's changing needs. Four categories of child actions were found to be important; choice and timing of disclosures, volunteering or withholding information about therapy, behaviour in session, and ending therapy.

Choice and Timing of Disclosures

Perhaps the most common strategic action reported by children was to choose what and when they would disclose in therapy. Consistent with the findings of McConnell and Sim (2000), Day, Carey and Surgenor (2006) and Hart, Saunders and Thomas (2005), confidentiality was found to be very important to children. A small number of children trusted the clinician quickly, while others felt reassured by explanations of confidentiality given by the clinician and they felt able to disclose when they felt comfortable (this was reported to take between one and four sessions for most children). However, a small number of children had concerns about the limits of confidentiality throughout therapy, specifically what the phrase 'at risk of harm' meant. These children did not disclose some information because they were unclear under what circumstances the clinician would need to inform their parents.

I suppose the reason why I didn't tell my therapist was because there was just something that made me a bit scared that she would tell my mum.

(Participant 18, female, 14 years. Transcript page 11)

Participant 14 emphasised that clinicians need to clearly explain the limits of confidentiality to children, saying “they really have to spell it out” (transcript page 5). This is in order to readdress poorly defined boundaries regarding confidentiality (McConnell & Sim, 2000). Similar to the findings of Lobatto (2002) there were indications from several children that, if the issue of confidentiality was not resolved, it remained an issue throughout therapy. Some children managed concerns about confidentiality by choosing not to disclose important information throughout their time in therapy. Concerns about confidentiality did not seem to exist alongside a basic mistrust of the clinician but were more a recognition from children that clinicians were required to communicate certain types of information.

She wouldn't say anything to anyone else. She would keep it to herself I think.

But if she was worried about me she would tell.

(Participant 12, male, 9 years. Transcript page 7)

Children who did not feel comfortable disclosing information asked gave several reasons for this, including; not knowing the clinician, not feeling relaxed in therapy and not feeling comfortable in the physical setting. This provided support for the findings of other research that children delayed important disclosures in keeping with the stage of the child-clinician relationship from the child's perspective (Day, Carey & Surgenor, 2006; Lobatto 2002; Stith et al., 1996). Similar to the findings of Lobatto (2002), children in this study reported using a number of strategic actions to manage situations when they didn't wish to disclose. One child discussed how she chose to discuss peripheral issues, “things that didn't really bother me” (Participant

18, female, 14 years. Transcript page 7), rather than disclosing issues that were more important to her. Another child chose to withhold information in front of her parents but was more open in subsequent individual sessions.

In the first session I was with my parents so I didn't want to say anything right then.

(Participant 14, female, 13 years. Transcript page 5)

Several children discussed that they had contemplated lying if they felt forced to disclose things that they weren't comfortable talking about. For some children, their choice to withhold a piece of information proved to be a significant action in helping them to feel more comfortable and in control.

Volunteering or Withholding Information About Therapy

Most children did not volunteer information to the clinician about how they were experiencing therapy. Particularly difficult issues included: telling the clinician that the strategies suggested didn't seem relevant; that they wanted therapy to have a different focus; that they had forgotten the question that they were asked; or that they wanted therapy to end. Children had views on the frequency, timing and modality of therapy sessions but did not feel able to volunteer their opinions about this unless they were asked directly.

I knew that I wanted to do it on my own but I found it a bit hard to say.

(Participant 18, female, 14 years. Transcript page 2)

Many children withheld information because of the power differential between the clinician and child. The issue of the power differential has also been described as a belief in the clinician's expertise (Strickland-Clark, Campbell & Dallos, 2000) and as a perception of adult authority (Vossler, 2004). One child

illustrated this by suggesting that children see clinicians as similar to teachers and that in the latter relationship there is an inherent power imbalance.

Teachers are always higher than you, so you don't start speaking to a teacher really unless they speak to you, unless you ask for help with your work or whatever.

(Participant 9, male, 16 years. Validation Interview 3, page 5)

This perspective is consistent with Lobatto's (2002) finding that children in therapy followed the conventional norms for children's participation in adult conversation. However, as illustrated by two children, some children deliberately withheld information to spare the clinician's feelings.

It's kind of like if someone is trying to help me, I don't like upsetting people.

(Participant 18, female, 14 years. Transcript page 6)

I cut after I started and I felt really uncomfortable about telling her. I thought that she would think that she hadn't done a good enough job or something.

(Participant 14, female, 13 years. Transcript page 12)

Participant 14 elaborated on this issue in the validation interview, discussing that the power differential, not wanting to offend and an awareness of the ongoing nature of the therapeutic relationship made make volunteering information about therapy difficult.

I don't like offending people at all, like if I said I don't think that will work I would feel uncomfortable because they are trying what they do and they are the professionals at it and if I'm telling them no that's not what I think then I would feel a bit uncomfortable whenever I see them again.

(Participant 14, female, 13 years. Validation Interview 3, transcript page 2)

Participant 18 described that she dealt with her difficulty in volunteering information by trying “to hint” (p. 6) that she wanted to stop therapy and hoping that the clinician would guess what she was trying to communicate. Similarly, some children reported only feeling able to give feedback if the clinician asked them very directly about the issue in question. Individual characteristics, particularly age, played a role in a child’s decision not to ask questions or volunteer information.

I don’t really ask questions, I prefer people to tell me and that’s probably like a lot of young people, they don’t like to ask for things.

(Participant 14, female, 13 years. Transcript page 4)

The finding that children are reluctant to volunteer information about therapy supports Vossler’s (2004) suggestion that children need to rely on clinicians and parents to perceive their needs and consider them.

Behaviour in Session

Children described regulating their behaviour in therapy sessions in a range of ways, such as; being conscious of not talking too much, changing the conversation topic to more relevant issues, engaging in non-problem talk when the intensity of the subject matter was too great, drawing in session while talking about difficult issues, fiddling with things when they were uncomfortable with silence, and playing in the session. These behaviours appeared to be used as strategies by participants to help regulate their emotions and manage difficult periods in the session, thereby increasing their comfort in therapy. This is consistent with previous findings that children actively try to regulate their feelings and manage their discomfort in therapy (Day, Carey & Surgenor, 2006; Lobatto, 2002). Children also described using behaviours to try to position therapy to best suit their needs, rather than to mislead the clinician and sabotage therapy (Kuehl, Newfield & Joanning, 1990) or because of

an overt power struggle between the child and the clinician (Strickland-Clark, Campbell & Dallos, 2000). It is suggested that the children in this study accepted the existence of a power differential between the clinician and child and chose to regulate their own behaviour rather than challenge the clinician directly.

Ending Therapy

The way in which therapy ended was significant to children. Although many children reported that ending therapy was an adult decision, some children reported an active role in this process. There was some evidence to suggest that children recognised when a problem was resolved or improving and that they may be able to assess when they are ready to finish therapy.

I sort of knew that I needed it still. I still needed the offload and I was starting to get the techniques and things but I wasn't there yet so I knew that I still needed to be going.

(Participant 10, male, 17 years. Transcript page 6)

In a small number of cases involving older children, children reported initiating ending therapy because they felt that they had improved and did not need to keep attending.

I was the one to stop the session because it was just like I didn't need to come any more. She knew that already, probably a couple of weeks before, but she was just nice enough to let me figure it out for myself I think.

(Participant 9, male, 16 years. Transcript page 4)

In another example, when the clinician suggested ending therapy, Participant 10 was able to discuss that he did not feel ready for this. The therapy then continued for a short while until he did feel ready to end. In a third situation, Participant 14 discussed that the clinician raised the idea of ending and this was mutually agreed. However,

she pointed out that, even though she did feel ready to end therapy, she would not have voiced this unless the clinician had explicitly raised the subject.

I wouldn't have said anything if I'd wanted to stop, I would have just kept on going.

(Participant 14, female, 13 years. Validation interview 3, transcript page 3)

Not all children felt able to openly express their wishes in relation to ending therapy. In two cases the children described desperately wanting to end therapy as they were not finding it helpful, however even though both children were older this had to be negotiated by their parents with the clinician. In both cases this resulted in an adult decision for the child to continue in therapy for longer than they wished to. While in these two cases the child's lack of power in the situation was a key factor, Participant 14 discussed another reason for children's difficulty in expressing a desire to end therapy.

I suppose it is like ending a relationship, you've been talking to that person for so long and then I'm not going to talk to you anymore.

(Participant 14, female, 13 years. Validation Interview 2, transcript page 1)

A child's ability versus inability to voice their wishes regarding ending therapy appeared to partially reflect the extent to which the clinician was able to decrease the power imbalance in the situation. Some children felt that they had a voice in the process of therapy whereas others felt unable to openly express their wishes and they required adult intervention. This is similar to some of the previous examples cited which suggest that, due to the power differential in therapy, many children are likely to respond to and shape situations rather than initiate new action and change. The power differential appeared to result in some children being more

strategic and covert to create a situation where they felt comfortable and with some control.

Experience of the Process of Therapy

Most children experienced the process of therapy as a journey from something that was unfamiliar and scary, to something that became a positive and helpful experience. This component of the model reflects children's experience of the process of therapy.

Most children described therapy as having been a largely positive experience, in which their fears and negative expectations were not met. Most children were able to feel relaxed in therapy after between one and four sessions and many children reported enjoying spending time with the clinician. While there was evidence that children were not sufficiently integrated into the therapy process at the commencement of therapy (Vossler, 2004), children did not report this as an ongoing issue. Instead this study provided support for the Strickland-Clark, Campbell and Dallos (2000) finding that children were able to be included in therapy in a meaningful way. Consistent with Clark (2001), children described how their feelings had become more positive over the duration of therapy.

Nervous, to a little bit better, to much better.

(Participant 6, male, 10 years)

Some children discussed that at the end of therapy they felt a sense of achievement, that they had done something that was positive.

I felt like I had talked about stuff and that was healthy...I felt like I had helped myself, I was pleased with myself.

(Participant 9, male, 16 years. Transcript page 8)

When you've come to the end you know you've achieved something...everything is sorted out.

(Participant 14, female, 13 years. Transcript page 10)

Children offered a number of reasons for the increase in positive feelings over the duration of therapy. There was some indication that exposure to therapy helped children to feel more comfortable, while other children discussed that disclosing issues and achieving a level of relief helped them to feel more relaxed. Some children indicated that they felt more positively in therapy over time because they were feeling better within themselves.

It was a lot easier to talk then because I had gotten out of the rough stage.

(Participant 14, female, 13 years. Transcript page 10)

Many other children cited clinician actions that helped them to feel more relaxed in therapy and more able to participate effectively in the process. Children also made suggestions about things that could help other children to feel more relaxed in therapy. Most of these centred on the provision of information prior to the first session.

Probably if I had read a leaflet first I would have felt comfortable at first, not so nervous.

(Participant 15, female, 13 years. Transcript page 8)

This supports the finding of Stith et al. (1996) that the more that children understand about what is happening in therapy, the more comfortable they feel.

However, not all children were able to relax in therapy and a small number felt shy or awkward throughout, echoing the findings of Clark (2001). Some children were unhappy about specific issues, such as the use of the reflecting team and one-way mirror, while two children found therapy to be unsatisfactory overall. For the

latter children therapy was experienced as difficult through out, this became less tolerable over time and these children were actively trying to end therapy. One of these children described how therapy did not feel relevant and therefore over time she felt less willing to attend.

When something doesn't really grab you, when you could be doing something else more sort of...that's going to help you more.

(Participant 18, female, 14 years. Validation Interview 1, transcript page 4)

Children's feedback suggested that if difficulties were not resolved early in therapy they remained problematic throughout, in keeping with the idea that successes in later phases of therapy often depend on successes of earlier phases (Kuehl, Newfield & Joanning, 1990).

Children understood the reasons for ending therapy to different extents, just as children were consulted about and in agreement with this to varying degrees. Most children believed that therapy had ended at the clinician's suggestion because the presenting problem had been fully or partially resolved.

Because she thought that I was improving and she thought that it would still get better.

(Participant 2, male, 12 years. Transcript page 5)

For most children it felt appropriate for the clinician to make the decision about when to conclude therapy. However, for other children the decision to end therapy felt confusing and unclear, they felt that it had not been adequately explained to them why this was occurring. Many children described feeling more comfortable in ending therapy if they knew that they could access help again if needed. While most children described feeling happy to end therapy, some children revealed that there was also some sadness attached to this.

I won't have a therapist to talk to me about stuff.

(Participant 13, male, 10 years)

Experience of the Outcome of Therapy

This component of the model outlines what children perceived as the outcomes of therapy for themselves and others. All except one participant reported that they had received some benefit from attending therapy. Children reported that therapy had led to different levels of change in their lives. One child reported no change, other children reported minor changes, some children reported that the presenting problem was resolved and the two oldest children reported positive changes beyond the resolution of the presenting problem. An example of the latter is that Participant 9 described how therapy had led him to realise that he must be a good person if the clinician cared about him. Children also reported that changes had occurred in different areas of their life to different extents.

It didn't help with my school work but it helped at home.

(Participant 6, male, 10 years. Transcript page 4)

She helped me be a bit more happier and relaxed at school.

(Participant 11, female, 14 years. Transcript page 9)

Some children found it difficult to identify if therapy had led to any changes in their life. Participant 18 discussed that it may be hard for children to notice changes.

I was told by my Dad's girlfriend that apparently it changed me a lot, that I was a lot different after it. But of course, like you said I have grown a lot, I don't really notice it myself because I stay at the same level.

(Participant 18, female, 14 years. Validation Interview 1, page 4)

While children felt that the value of therapy had largely been for them, there was some acknowledgement that other family members may also have benefited.

Children were most able to identify changes within other members of their family when they had attended family therapy or when their parents had attended at least one session with them.

It helped my mummy because it helped her to realise that she's raised a very good child.

(Participant 3, female, 7 years. Transcript page 6)

It has definitely changed my dad a lot. I think it has changed my mum as well. He thought I was just a girl that got on with everything but I think that he's realised that it is not always that way.

(Participant 14, female, 13 years. Transcript page 11)

The level of satisfaction with the outcomes of therapy appears to be higher than that reported by other studies, although it is difficult to make comparisons with other research due to the different ways in which satisfaction was assessed and reported. In this study there were no significant differences regarding satisfaction with the outcome of therapy between those children who had individual versus family therapy.

However, not all children reported that they received the help that they wanted, nor the help that they felt that they needed. One child reported that while some things had changed, he felt that his presenting issue had not changed.

Sometimes you want something to be sorted out, the thing that you go there for, but it sorts out other things but the thing that you went there for didn't get sorted out.

(Participant 17, male, 9 years. Transcript page 7)

Other children described how they felt they needed specific help that they did not receive.

It's ok now because I have sorted everything out but at the beginning I think that I should have had anger things to calm down a lot more.

(Participant 14, female, 13 years. Transcript page 7)

I really wanted maths help and I thought that they were going to do maths help but they didn't.

(Participant 1, male, 8 years. Transcript page 7)

I wanted them to try and make me not remember it.

(Participant 2, male, 12 years. Transcript page 6)

When children did not get the kind of help that they wanted or felt that they needed they often still described therapy as having been a positive experience but not a completely satisfactory one. In further exploring this issue with each of the three participants cited above, each child said that they did not disclose what type of help they wanted to the clinician and this may only have been revealed if the clinician had assessed this quite carefully.

Although most children reported that therapy had been helpful, many were not able to articulate how it was helpful. This is in keeping with Hart, Saunders and Thomas's (2005) finding that none of the children were able to offer any explanation regarding the techniques employed by the clinician or the specific manner in which they were helped. Some of the factors that appeared to relate to this included developmental factors, the extent to which the clinician provided explanations during therapy and the extent of the child's experience in therapy. One child suggested that it might be hard for children to identify what has been helpful as "it is not something that you notice when it happens." (Participant 10, male, 17 years. Transcript page 3).

It may also be that the model of therapy impacted upon a child's ability to identify what had been helpful. The children who attended family therapy or therapy

with a psycho-educational component were more able to do this than those who had psychoanalytic psychotherapy. However, in saying this, most children aged thirteen years or older were able to articulate some ideas about what the clinician had done and the changes they had made themselves that led to a positive outcome.

She said things that would make me do things that would help.

(Participant 14, female, 13 years. Transcript page 7)

Children identified it as helpful when they had been 'taught' something important.

She taught me to think about myself a lot more and I got more respect for myself.

(Participant 14, female, 13 years. Transcript page 7)

Children differentiated between therapy being a nice experience and a helpful experience. While the clinician and therapy being nice appeared to be an essential pre-requisite for change to occur, it was not in itself sufficient to ensure a helpful therapeutic experience. This is illustrated by Participant 11, who talked about how children wanted concrete strategies and suggestions to help them to sort out their problems and prevent them from happening again. She said that she would only rate therapy as a five out of ten if:

She never gave you suggestions or spoke to you about it, she just listened to you.

(Participant 11, female, 14 years. Transcript page 10)

This distinction between therapy being a nice versus a helpful experience was further supported by all three participants in the validation interviews.

I definitely believe that there is a difference between those two. Like it might be nice but it didn't really help that much or it helped a lot and it was nice.

(Participant 9, male, 16 years. Validation Interview 2, transcript page 2)

For many children, therapy needed to be both a nice experience and helpful in order to receive a high satisfaction rating. This finding is similar to the Kuehl, Newfield and Joanning (1990) distinction between a clinician being caring and able, with both characteristics needed for family members to give therapy a high satisfaction rating.

Willingness to Access Again or Recommend to Others

Perhaps another way to gauge children's experiences of therapy is to ask about their willingness to re-engage with therapy if there were a need to do so in the future or their willingness to recommend therapy to a friend. Children were more or less willing to consider doing this based on two factors, their own experience of therapy and their belief about the potential helpfulness of therapy. Children who described their experience of therapy as very positive said that they would re-engage or recommend therapy to a friend. Some children had already done the latter.

If I thought that they needed it I would have no qualms about recommending it.

(Participant 10, male, 17 years. Transcript page 8).

Children with mixed experiences of therapy indicated that they would still consider re-engaging with therapy and recommending therapy to a friend. However, this was qualified as depending on the situation and some children said that they would advise their friend to seek a lot of information prior. There were several reasons why children who had mixed experiences were still willing to re-engage with or recommend therapy. It seemed that many had a 'good enough' therapy experience and were satisfied overall. Some children held the belief that even if therapy leads to a small change for someone then that is worthwhile. Finally, many children retained their beliefs about the helpfulness of therapy despite their own mixed experience.

Like going on a painkiller, sometimes it doesn't cure my headache but I know it is supposed to, so if someone's got a headache I give them painkillers.

(Participant 9, male, 16 years. Validation interview 2, transcript page 5)

Even the small number of children who had some negative experiences of therapy were able to recognise that therapy may be helpful to other children or to people in a different situation.

Chapter Five

DISCUSSION

Chapter Five will discuss the results of this study and is designed to accomplish several tasks. The first is to briefly summarise the key findings of this study. This will enable the reader to evaluate the unique contributions of the study. Secondly, this chapter will outline the strengths, limitations, evaluation criteria and ethical issues associated with the study, to assist the reader to interpret the results accordingly. Finally, the clinical, organisational and research implications of the study will be addressed.

Summary of Research Objectives

The first research objective was to systemically explore children's experiences of therapy by building on the existing research. This was achieved through the use of individual interviews with children aged seven to seventeen years who had accessed a specialist child and adolescent mental health service or a school-based therapy service, experiencing a range of models of therapy including psychoanalytic, systemic and humanistic. The second research objective was to build a theory, examining the ways in which the identified themes may be related, in an effort to try to explain children's experiences of therapy. Grounded theory was used as the method of analysis and theoretical sampling was used to explore and clarify emerging themes. Through the simultaneous data collection and analysis process a model was developed. It was then refined and validated through the use of a clinician focus group and in validation interviews with participants. The model was based upon the central category in this study, that therapy is a process for children. The model suggests that therapy is a journey for children, from feeling scared and nervous about the prospect of attending therapy to concluding that therapy has been a helpful experience. This study identified key components of this journey, within

these components there are specific sub processes and activities upon which children's experiences varied dimensionally.

Summary of the Key Research Findings

This study found that most children were satisfied with their experience of therapy. Children largely gave thoughtful and considered responses to both the single-item likert scale and the Youth Satisfaction Questionnaire. There are two reasons why it is unlikely that the relatively high levels of satisfaction reported in this study are an example of satisfaction scales being biased towards socially desirable responses. Firstly, although high levels of satisfaction were found, there was within-participant variation in scores, suggesting that children had a range of opinions about the therapy that they received. The three items in the Youth Satisfaction Questionnaire did appear to have good discriminate validity and did not produce uniformly high satisfaction ratings, supporting the assertion that children can make meaningful distinctions using satisfaction questionnaires (Hennessy, 1999). Secondly, children were able to explain the rationale for their ratings and this qualitative information provides some insight into what constitutes a satisfactory experience for children. However, there may be other factors contributing to the high levels of satisfaction reported. Satisfaction can be seen as the degree of discrepancy between expectation and experience (Stallard, 1996). It may be that relatively high ratings of satisfaction were partially due to children's experience of therapy being equal to or more positive than their negative pre-therapy expectations. However, critics of this perspective might argue that children were not able to form realistic expectations of therapy due to their lack of knowledge and limited contact with therapy (Stallard, 1996). Due to this lack of knowledge and a lack of awareness of other ways that therapy could be, children may have no standard against which to

assess service quality and are, therefore, more likely to give high satisfaction ratings (Stallard, 1996).

This study explored the pre-therapy period in more detail than previous studies. The impact of the pre-therapy period is emphasised more in this study than in the adult literature (such as in the Orlinsky and Howard model), suggesting that this reflects the key pragmatic differences between therapy with children and adults (Weersing & Brent, 2004). Three macro conditions and seven micro conditions were identified that impact on children's experiences of attending therapy and it is suggested that children's experience of these conditions varies dimensionally. A unique contribution of this study was the suggestion that there are relationships between conditions, with children's perception of the potential helpfulness of therapy and the extent to which a child identifies a need for therapy being more significant and able to override the effect of other conditions. It is suggested that there have been improvements in the way that children are prepared for therapy since Ackerman (1970) identified that children are brought to therapy, sometimes without their prior knowledge and sometimes this involved manipulation, coercion and lies. However, there is still evidence that children are insufficiently integrated in the processes that lead to the commencement of therapy (Vossler, 2004). It could be questioned whether the notion of the child being integrated into the therapeutic process is in fact an appropriate goal or whether instead the way in which therapy begins with a child needs to evolve to become a far more child-focused process whereby, rather than simply informing children, we create an open dialogue in which their feedback and wishes are valued.

This study highlighted the extent to which the conditions surrounding the commencement of therapy impact on children's willingness to attend and can result

in children feeling nervous, fearful and apprehensive about the first therapy session. These feelings can impact on the child's behaviour and reduce their ability to participate in the first session.

There was evidence in this study that children were actively evaluating the clinician throughout therapy and they were able to identify six clinician actions that felt important to their experience of therapy. Of these, the personal characteristics of the clinician were highlighted as central for children, supporting findings that clinician characteristics can counter the initial fears and reservations of children (Vossler, 2004) and assist in involving children in therapy (Stith et al., 1996). The children in this study emphasised the role of clinician characteristics such as being nice, kind and caring, consistent with the theme of clinician warmth that has been found to be important in reviews of the child therapy research (Weersing & Brent, 2004). Hart, Saunders and Thomas (2005) found that the clinician's characteristics were an essential ingredient to therapy and more relevant than any particular intervention technique. A similar finding has been found in the adult literature, Jarrett (2008) reported that therapeutic outcomes have more to do with the clinician than the treatment approach they use. However, this study suggests that while clinician characteristics are an essential prerequisite to successful therapy, as well as being an intervention in their own right, they are not the only important factor in therapy being a satisfactory experience for children.

Specific clinician actions appeared to help children to relax and feel comfortable in therapy sessions, such as the clinician being able to form a positive therapeutic relationship with the child, the appropriateness of the modality of therapy selected by the clinician, the provision of structure for the therapy session and any clinician actions that empowered children such as giving children information and

choices. The central importance of the therapeutic relationship has been consistently found in research across many models of therapy for children and with many types of presenting problems (Weersing & Brent, 2004). There was also some evidence from this study supporting the notion that problems in the therapeutic relationship can result in the child prematurely ending therapy (Weersing & Brent, 2004).

Children's views on the activity that took place within the therapy session centred on the idea that therapy is primarily a verbal activity, with some children appreciating play and activities as a part of therapy and as a support to the verbal activity of therapy. The lack of emphasis on play/activities in this study compared with some other research may be a result of ten children in this sample being in secondary school. Consistent with the notion that the importance of play may vary by age (Stith et al., 1996), play may not have felt as relevant to them as it may have to a sample of younger children.

Children identified various actions that they took throughout therapy in order to increase their feelings of comfort and control and to help therapy feel more relevant. Particularly key actions included: if and when to disclose personal information; the choice to volunteer or withhold information about how they were experiencing therapy; consciously regulating their behaviour in therapy; and having some involvement in the end of therapy. Children's accounts of their own actions in therapy support the notion that children are active and strategic participants in the therapy process who try to position therapy to best meet their needs.

Children were able to reflect upon the process and outcome of therapy, with most describing therapy as a positive experience from which they benefited. Participant's responses indicated that therapeutic factors and the acquisition of knowledge and skills relevant to their issue were equally important in their

experience of therapy. Consistent with the existing literature, children viewed the main benefit of therapy as the resolution of the presenting problem (Day, Carey & Surgenor, 2006). Children were largely satisfied with their experience of therapy, which this study proposes can be understood as a consequence of children having largely positive experiences of the categories identified in the model. Children appeared to view the model and modality of the therapy they received as being appropriate for their presenting problem, which has also been found to be important in previous research (McConnell & Sim, 2000). Children's overall satisfaction with therapy appeared to be a product of their experience of both the process and outcome of therapy. Therapy had to be experienced as both nice and helpful for children to be completely satisfied. Children were willing to consider re-engaging with or recommending therapy, however in many cases this was qualified by the child. Rather than viewing this negatively, it appeared that a child's experience of therapy may increase their knowledge and understanding of therapy, moving them from the belief that therapy can 'fix' or 'cure' to a more realistic position of therapy having the potential to be helpful.

Perhaps the key contribution of this study is that it proposes a model that suggests a series of relationships between the concepts identified. This had been attempted in prior research, Lobatto (2002) aimed to connect categories into a larger framework which she hoped would speak about the process of therapeutic change. However, Lobatto reported that the data did not divide easily into a causal account due to the contradictions in children's accounts. The key distinction between this study and Lobatto's research is that this study did not set out to create a causal account nor does this theory propose causality. Instead, by taking a process approach to children's experiences of therapy, it was possible to identify some core concepts

that were present for children. When these core concepts are considered to be dimensional and as influencing subsequent processes, it becomes possible to explain the range of children's experiences, including any apparent contradictions. A process approach also enabled the recognition that these concepts are dynamic and evolving for children throughout therapy. In this way it is proposed that the model may be able to capture the range and variability in children's experiences.

In summary, it is suggested that the field has advanced from the position of wanting to develop some insights into children's worlds (Stith et al., 1996). This study has contributed to the small body of studies that together are building a picture of children's experiences in therapy, with this study suggesting how the concepts of importance to children may be related. This study set out to generate a substantive theory, using a diverse sample to try to build greater variation into the theory and increase the explanatory power of the theory. This study utilised a sample of children of different ages, who had accessed different models of therapy and therapy modalities in different settings. In doing so it is suggested that a greater level of explanatory power may have been achieved and the theory generated from this study may have some explanatory power beyond the sample of this study. There is not currently a generic model that synthesises the findings of the child therapy process research, a body of research that has been described as being sparse and scattered (Weersing & Brent, 2004). Weersing and Brent discussed that it is problematic for an adult-derived model to be used, therefore it is important to arrive at a child-derived framework. As such, the development of the model is a unique contribution of the study and something that can be explored in future research.

The findings of this study are very much consistent with the philosophy underpinning counselling psychology as a psychological discipline. The findings

highlight the need for clinical practice to be relationally grounded and client centred (Goodheart & Carter, 2008). Also consistent with the philosophy of counselling psychology, this study emphasises the importance and value of the personal, subjective experience of the client over and above notions of diagnosis, assessment and treatment (Lane & Corrie, 2006). Some suggest that counselling psychology is experiencing a tension between the opposing tendencies of 'being in relation' and 'technical expertise' (Woolfe, Dryden & Strawbridge, 2003). However, this study would question whether these should be viewed as opposing issues. Children's feedback, consistent with a long history in the research (Goodheart & Carter, 2008), supports the importance of both a sound therapeutic relationship and a relevant intervention approach in creating a positive experience of therapy.

Strengths and Limitations of this Study

Strengths

Strauss and Corbin (1998) suggest that the purpose of theory building studies is to develop valid and grounded theory that speaks to the issues and concerns of those we study. It is proposed that this has been achieved in this study and that the design of the study provided a number of strengths that enabled the research objectives to be met. The sampling and recruitment techniques used in this study were largely successful in attracting a diverse sample of children who were interested in participating. It was successful in attracting both male and female participants, children of different ages and ethnic backgrounds and children who had attended different forms of therapy in different settings. This is in contrast to much of the previous research in this area which reported difficulties in obtaining an adequate sample size or obtaining ethnic diversity within a sample (Day, Carey & Surgenor,

2006). The diversity achieved in this sample provides support for the idea that a representativeness of concepts may have been achieved (Strauss & Corbin, 1998).

Individual interviews were successfully used as a measure to gain relevant and in-depth information from children. Children responded well to the interview, were articulate in their responses and provided a wealth of detailed information about how they experienced therapy. One of the factors that facilitated this was that, through efforts to build rapport, a favourable power differential was achieved. While in research settings the power differential between an adult researcher and child participant can never be completely eradicated, it is suggested that it was lessened in this study. This limited right answer effects and encouraged children to give their honest point of view. Evidence for this assertion is that children asked questions of the researcher throughout the interview, raised less positive issues about therapy, indicated when they had not understood a question and provided low ratings on scales when appropriate.

It is suggested that another reason why individual interviews were successful is that age-appropriate techniques were used, such as the use of flash cards and scales, which appeared to help even quite young children discuss their experiences. In the interviews children responded particularly well to a combination of open-ended and specific (closed) questions and it is suggested that both have an important role in qualitative research with children. The use of individual interviews also had practical advantages in that children were able to attend an interview at a time and location that suited them, which may have contributed to a good sample size. Using individual interviews within a theoretical sampling framework provided the ability to follow up emerging areas of interest and obtain a greater depth of knowledge of these areas. The use of theoretical sampling also created a time delay between interviews.

This allowed for additional time to reflect, analyse the data and refine the interview protocol for the next interview, thereby resulting in the creation of more dense concepts and achieving a true interplay between data and analysis as advocated by Strauss and Corbin (1998).

A final strength of this study was that it had a broad focus. It was able to explore in more depth issues that had been highlighted in previous research and to ask children about issues that had been less well researched, such as their own intentions for therapy. This broad focus was possible as, unlike most of the existing literature, this study did not have a service evaluation orientation and was not, therefore, focused on or confined to only these issues.

Limitations

There were two main limitations in this study, the first relates to the nature of the sample and the second relates to the nature of the model developed. While other researchers in this area have identified recruitment and sampling as methodological constraints in their study which resulted in a small sample size, this was not an issue in this study. However, there were limitations in relation to the type of children who were eligible to participate. The children in this study had largely positive views of therapy, with only two of the eighteen participants having had a negative experience of therapy. This is suggested to be the result of being required to use an 'opt-in' model of recruitment which results in issues of self-selection (Stallard, 1996). Perhaps the central weakness of this method is that by focusing solely on people who respond to calls to participate in research you achieve a more satisfied sample which can positively skew results (Stallard, 1996). An opt-in model may have also resulted in gaining a sample of children with quite stable personal circumstances, all participants lived in family-based accommodation and were engaged in education. In

this study this meant that the model developed is based on a group of children who engaged with, and participated in, the therapeutic process. These participants also had positive experiences of therapy services at a systemic level. For example they did not experience issues such as poor continuity of care, which have been identified in other research with children (Street et al., 2005).

Having a satisfied sample is a common problem in research in this area, as Laws (1998) noted consultation normally happens with those that are in the system and for whom the system works. It was initially hoped that this study could also target those children who did not engage, such as those who did not attend their first session or who prematurely terminated therapy, however this was not permitted by the Local Research Ethics Committee. Therefore a limitation of this model is that it reflects the process of therapy from a satisfied perspective. It is unclear if children who were less satisfied would have introduced new concepts into the model or given additional definition to negative experiences. If ethical issues could be resolved to enable future research to target and include those participants who did not engage or who were less satisfied, then the model could be evaluated in relation to its ability to account for their experiences. If a representativeness of concepts was truly achieved, however, then it may be that the experiences of these children can still be understood within the same set of dimensionalised concepts.

The second main limitation relates to the nature of the model that was developed. Due to the research design, only children's concrete and conscious perceptions could be measured and consequently an explicit, concrete, conscious model was developed. The proponents of some models of therapy might argue that processes outside conscious awareness are central to therapeutic change. However, these can't be captured in this model unless some of the unconscious processes have

become conscious through therapy. Similarly, the model can only capture those factors that children are able to put into words. While the model may reflect what is important to children, it is also limited to what children are able to articulate.

Evaluation Criteria

This study will also be evaluated against the criteria established by Strauss and Corbin (1998) and some of the criticisms identified in the methodology chapter. In relation to the latter, criticisms of constructivism were cited, such as the issue of objectivity, the lack of a critical purchase and the problem of inquirer authority and privilege (Schwandt, 1994). These criticisms are related to the two most commonly cited weaknesses of the constructivist paradigm: issues of power that privilege certain constructions over others; and the elevation of the meaning of the researcher over any other (Schofield Clark, n.d.). These criticisms have been acknowledged and the steps taken to address them have been specified earlier in the thesis, including the use of reflexivity to continually monitor the impact of the researcher on the study and the use of validation procedures. It is suggested that these measures were successful in reducing the impact of these issues. This enabled a diversity of views and opinions from participants that led to a richness in the properties and dimensions of the concepts identified. However, it could also be argued that criticisms such as objectivity are a product of methods being seen differently by constructivists and logical empirical scientists (Schofield Clark, n.d.). From a constructivist perspective, it is suggested that the theory developed in this study is a worthwhile interpretation of how children experience therapy that is open to further elaboration and testing by other researchers and children.

This study can also be evaluated against the criteria established by Strauss and Corbin (1998), including: the validity, reliability and credibility of the data; the

plausibility and value of the theory; the adequacy of the research process; and the empirical grounding of the research. The rigour of the study, (reliability, validity and credibility), has been established by clearly specifying the procedures followed, incorporating a validation phase, triangulation of qualitative and quantitative data and negative case analysis. The theory that was developed was a formal theory, which it is proposed is both a plausible account of children's experiences of therapy and clinically relevant. It is suggested that sufficient detail was presented in the method section to demonstrate that the research process was appropriate for a grounded theory study. This included how the sample was selected, the basis upon which theoretical sampling proceeded and how the core category was selected. Finally, it has been demonstrated that this study was empirically grounded. Concepts were generated that were systematically related, categories were formed that were well developed and conceptually dense, variation was built into the theory, the macro and micro conditions were specified, and process was central in the theory. The remaining two criteria for empirical grounding, the significance of the findings and whether the theory stands the test of time, will be assessed by future researchers.

Ethical Considerations

Given the concern regarding potential ethical issues associated with children's participation in research, it is important to revisit these issues as they pertained to this study. A key ethical issue in research with children is the extent to which children are given the opportunity to decide to participate in research if they wish to. Previous research has found that parents and/or clinicians can act as gatekeepers, blocking children's ability to participate (Clark, 2001; Day, Carey & Surgenor, 2006; Hart, Saunders & Thomas, 2005). While there were examples of gatekeeping in this study, it was more common that parents and clinicians were

willing to allow children to make their own decision in relation to participation and there was a high response rate when the researcher spoke to the child. However, an unexpected ethical issue did arise through this process, which was that on three separate occasions a parent had other motivations for their child to participate in the study, including hoping that participation might encourage the child to re-engage in therapy and wanting to know how the child now viewed issues within the family. On one occasion this was identified in the initial phone contact with the parent and the researcher took the stance that it was unethical for the child to take part unless she freely expressed a desire to do so. On two other occasions the issues arose at the child's home. This had to be managed in an ethical manner and the researcher had to be clear regarding the boundaries of her role and the confidentiality of the child's material.

There are also concerns in the literature about potential negative impacts of research participation on children and this was closely monitored in this study. The children were overwhelmingly positive about their participation in the study and no adverse affects were reported or observed. Consistent with the findings of Strickland-Clark, Campbell and Dallos (2000), children were not distressed by the interview. Children seemed pleased to be asked their opinion and felt it was appropriate that they be consulted. There was support for the idea that giving their views on their experiences of therapy is empowering for children, helping them to step out of their role as the problem carrier and into a role where they had something to offer (Strickland-Clark, Campbell & Dallos, 2000). Children tried very hard to be helpful throughout their interview and gave very thoughtful and considered responses. When asked what motivated them to take part most participants talked about wanting to help other children. Some of the older children also talked about how therapy was

such a positive experience for them that they wanted to give something back.

Children did not report that reflecting upon their experience of therapy was upsetting and several described participating in the research as having been useful to them.

However, some children felt that it might be difficult for children under seven years of age to take part.

While not questioning the need to safeguard child research participants, the researcher might tend to agree that the pendulum has swung too far towards safeguarding children (Ross, 2004), and this may in fact be at odds with children's willingness to participate in services that affect them. However, that is not to say that there were not ethical issues in this study. The inherent power difference between adult researcher and child participant was still evident through the process, particularly with primary school aged children, suggesting that researchers cannot afford to be complacent about this purely because safeguards are built into the research design. An example of this is that reviewing the interview tapes reinforced the need to reflect on how the questions asked could potentially shape children's responses or result in the omission of important information. A second example is that on several occasions children's behaviour in the research setting mirrored their behaviour in the therapy setting, for instance specific information was not revealed until very specific questions were used. Therefore, it is suggested that there need to be robust safeguards in place for child participants of research, while still viewing children as potentially competent and willing participants.

Use of Reflexive Practice

As previously outlined, a constructivist view suggests that the researcher and the participant are interdependent in the social process of research (Pidgeon & Henwood, 1997). Therefore, the role of the researcher should be made explicit and

be documented in the study (Pidgeon & Henwood, 1997). In this study a reflexive journal was kept which reflected upon the role of the researcher and noted researcher observations through out the course of the study. This facilitated researcher learning. The most significant area of learning related to my interviewing style. I was conscious from the outset of the possibility of shaping children's responses and so I tried to reduce this by doing things such as equally reinforcing positive and negative answers. However, in reviewing the interview tapes I became aware of other more subtle ways in which my interviewing style could shape responses, including not giving children enough time to respond, asking questions that were too long and not asking for examples if I was unclear. I also became more aware of the impact of the child's developmental level, for example children had to be at a particular developmental level in order to be able to recall quite detailed information or to articulate 'how' something was helpful to them. Finally, I became more conscious of the need to strictly maintain the boundaries of the role of researcher despite children asking for my opinion on things or confiding information.

Use of reflexive practice involves incorporating learning to improve subsequent interviews and the overall research process. As indicated above I did make improvements to things such as my interviewing style as the study progressed, however I would also do some things differently if I were to do the study again. In this study theoretical sampling worked well and I would use this even more in a future study. An example of this is that if I was seeking quite detailed or specific information I would sample more secondary school children or would only target younger children who had concluded therapy very recently. In future research I would assess the child's developmental level more carefully both in my initial phone contact with the child and in the initial stages of the interview. I would also work

harder to make the interview developmentally appropriate to children who appeared to be operating at a lower developmental level than their chronological age would suggest. I would also modify my interview style, asking even more open ended and broad questions at the start of the interview, giving children more time to respond to questions, asking shorter questions and I would be conscious of talking less after the initial rapport building period.

Clinical, Service and Research Implications of the Study

The findings of this study could have implications for how we conduct therapy with children, how therapy services for children are organised and evaluated, and for further research with children. One purpose of elevating children's experience is to influence and change service delivery (Day, Carey & Surgenor, 2006). However, it is recognised that, as this is an emerging field, there is currently a lack of published information and experience in operationalising findings and implementing changes in real world settings (Hart, Saunders & Thomas, 2005).

Clinical Implications

One of the most important contributions of client experience is that it can inform and influence clinical practice (Day, Carey & Surgenor, 2006). The clinical implications of this study will be discussed in five broad categories. However, one of the key findings of this study, the central importance of building and maintaining a positive therapeutic relationship, is not discussed below. This is because it is already well recognised as a central theme in both the adult and child literature (Weersing & Brent, 2004) and as such the therapeutic relationship can be considered to be meta to the issues identified in this study. In addition, changes in relation to the following areas of clinical practice should also work to strengthen the therapeutic relationship.

Socialise Children to Therapy

This study provided overwhelming support for the need for greater pre-therapy preparation (Day, Carey & Surgenor, 2006) and socialisation of children to therapy (Vossler, 2004). The need to socialise children to therapy is already advocated for some specific therapies such as cognitive behaviour therapy (Wilkes & Belsher, 1994), however the findings of this study suggest that this also needs to occur more broadly, with children indicating that this needs to be done at a universal as well as an individual level. In relation to the former children suggested that guest speakers and posters at school and readily accessible written information should be provided to all children to help them to develop a better understanding of, and more realistic expectations about, therapy. The movement towards having some child and adolescent mental health services in the UK in community settings may also assist in increasing children's familiarity with therapy services. In this study children discussed film and television as mediums through which they obtain impressions of therapy. However, television and films have been criticised as providing a misguided view of mental health issues (Triggle, 2005). There are some recent examples of how this is improving (Triggle, 2005) and it is suggested that with collaboration from psychologists and other professionals this medium could be further utilised in a helpful manner.

At an individual level this study identified the importance of the referring adult and other adults supporting a referral to therapy. The broader literature suggests that this may be particularly important for Black and ethnic minority groups (Street et al., 2005). Initially it is these adults who begin to socialise children into therapy, so it may be useful for professionals to play a greater role in assisting them to do this.

This could involve teaching carers and other adults how to have a helpful discussion with a child about therapy or providing written information to carers about how they could do this. Stith et al. (1996) indicated that this discussion should be quite frank in nature and may need to be repeated to ensure that the child does understand the adult motivation for seeking therapy. The findings of this study would suggest that it is important to explain to referring adults that a child being nervous or reluctant about therapy may be more a sign of therapy being unknown and unfamiliar than the child not wanting help. This study also suggests that a carer or teacher reassuring the child that they can trust the clinician is beneficial. Children also asked for specific written information about therapy prior to a first appointment, echoing the emphasis on information that has been found in other studies (Street et al., 2005). This information should be based on what children themselves say that they wish to know, such as basic information about the clinician as a person rather than their qualifications. Written information could also target common misperceptions about therapy, such as the idea that the child will get into trouble. It would be particularly important for written material to clearly communicate the confidentiality policy of the service (Street et al., 2005). Children have also suggested that a phone call from a clinician in the service prior to the first appointment might be useful in alleviating anxiety (Street et al., 2005).

This study suggests that it may be helpful if socialising the child to therapy becomes a large part of the first session. The macro and micro conditions identified in this study could be used as a tool, and exploring the child's experience of each of these conditions could enable a more comprehensive understanding of the context surrounding the child's commencement of therapy. The clinician may then be in a position to target information appropriately and on an individual basis. The literature

reflects that the provision of information should include: information about the process of therapy (Strickland-Clark, Campbell & Dallos, 2000); the idea that exposure to painful feelings is part of the therapeutic process and this may be uncomfortable (Strickland-Clark, Campbell & Dallos, 2000); the 'rules' of therapy (Lobatto, 2002); and the goals and methods of therapy (Vossler, 2004). Children in this study particularly highlighted the need to provide clear and comprehensive information about the nature of and limits to confidentiality. Studies suggest that children gradually evolve a conception of confidentiality (Burgess-Messenger & McGuire, 1981), therefore information needs to be given at a developmentally appropriate level. Finally, there is evidence to suggest that other family members may also feel somewhat confused about therapy (Kuehl, Newfield & Joanning, 1990) so the process of socialising the child to therapy may also be beneficial for other family members.

Socialising children to therapy could become the prelude to the more formal process of obtaining informed consent from all participants in therapy. Informed consent is the client's agreement to therapy after having understood the procedures, their benefits and risks, and being informed of relevant alternatives (Reiter-Theil, Eich & Reiter, 1991). The notion of obtaining informed consent has evolved and informed consent is now viewed as an important mechanism for ensuring that individual autonomy is respected (Henkelman & Everall, 2001) or promoted (Reiter-Theil, Eich & Reiter, 1991). Reiter-Theil, Eich & Reiter suggest that taking clients seriously, disclosing information, listening to and answering questions, and conversing about uncertainties treats clients as partners who are competent to choose to actively participate in and evaluate therapy. In obtaining informed consent there is a shift away from the notion of the clinician making the decisions for the client, to a

collaborative orientation in which the client is provided with all necessary information to make an informed decision (Henkelman & Everall, 2001).

Increasingly, in the practice of informed consent the focus has changed from the professional's obligation to disclose information to the quality of the client's understanding and consent (Reiter-Theil, Eich & Reiter, 1991). There is also greater appreciation that informed consent needs to be considered an integral part of therapy, rather than a step to hurry through prior to beginning the 'real' therapy (Henkelman & Everall, 2001).

In relation to obtaining informed consent from children, the research indicates that adolescents are developmentally mature enough to make well informed decisions about involvement in therapy and that children in general can effectively participate in treatment decisions (Shalan & Griggs, 1998). Henkelman & Everall (2001) discuss the various developmentally appropriate ways in which consent can be obtained, and Reiter-Theil, Eich and Reiter (1991) discuss that gaining consent from children can be a catalyst to working through issues associated with therapy, stimulating the child's curiosity and interest in therapy. It could also work to provide the structure or explicit permission that children in this study discussed needing in order to raise issues of concern.

Holding a Process Perspective

The findings of this study reinforce the existing literature on the importance of the clinician having an ongoing awareness of process issues throughout therapy. Therapeutic process emerged as highly significant to children in this study. There were strong indications that children are conscious of, are able to reflect on and have opinions regarding process issues. Lobatto (2002) recommended that clinicians hold an awareness of the shifting position of the child as the session progresses. While

Lobatto was largely referring to children's shifting position in relation to the clinician and family members, it is suggested that this can be extended to clinicians having an awareness of children's shifting position in relation to therapy itself. This could be explored directly and specifically with children, through the clinician giving the child permission to speak about these issues, in addition to the clinician monitoring non-verbal indicators such as children's body language.

Holding a process perspective could influence the way in which the clinician approaches therapy, for example, recognising that a child may feel so nervous about the prospect of meeting a strange adult that this may reduce their ability to participate effectively in the first session, which may result in the clinician deciding to slow the pace of therapy and allow more time to build a relationship with the child. Attending to process issues may also facilitate a more positive therapeutic experience for children, leading to potentially better therapeutic outcomes. An example of this is that exploring children's hopes for therapy or assisting them to form intentions for therapy may both increase the relevance of therapy and help to target the intervention, thereby increasing the opportunity that the child will experience therapy as helpful. However, children in this study reported that they would not initiate volunteering process information and this is something that the clinician would need to initiate. Roberts (1998) also discussed the value in asking clients directly how they are experiencing various aspects of the therapeutic process. This study would suggest that key questions might include the child's views on: the therapeutic relationship; confidentiality; the appropriateness of the modality and model of therapy; the inclusion of activities or play; and the structure of sessions. Client feedback is more commonly used with adults in order to improve outcomes in therapy. Lambert (2007) has developed an approach whereby the clinician asks the client some brief questions

prior to each session about how they feel that therapy is progressing, the client's answers are compared to the average progress made by similar clients with similar presenting issues at that stage in therapy, which enables an assessment as to whether therapy is 'on track' or 'off track'. If it is assessed as being off track then this is explored further, a follow-up questionnaire is used and a list of recommendations is given to the clinician about how to best intervene.

A final advantage of holding a process perspective is that it enables the clinician to individualise therapy for each child, assessing their unique needs and preferences regarding the process of therapy. This is consistent with previous literature which recommends that it is important to incorporate the perspective of individual children in the arrangement and management of sessions (Day, Carey & Surgenor, 2006).

Techniques to Facilitate Participation

Both this study and the wider literature reflect the need to increase children's ability to participate in therapy. While the findings of this study suggest that there has been some progress in this area, the children in this study indicated that they still need help to talk and participate in therapy. It is also recognised that children need the opportunity to participate in therapy in ways that are different from the ways in which adults participate (Stith et al., 1996). It is suggested that clinicians need to create structures and opportunities to enable children to more fully participate in therapy.

The children in this study identified a number of therapeutic techniques that felt useful for them and enabled them to participate in therapy. These included: clinician self-disclosure; the use of a therapeutic contract; giving the child permission not to disclose immediately; and asking specific questions to help children to voice

their preferences. The literature also identifies techniques that may be useful in facilitating children's increased participation, including the use of explicit negotiation and discussion (Hart, Saunders & Thomas, 2005; Lobatto, 2002). There is a range of literature on conducting research with children which suggests the use of specific techniques, such as allowing children to help set the agenda for what is being discussed, using specific concrete prompts and using varied activities to help children to structure their answers (Hill, Laybourn & Borland, 1996). It is proposed that these suggestions also have the potential to be helpful in a therapeutic context.

Therapeutic tools may also be useful in helping children to participate in therapy. There is considerable literature on the use of tools such as games and storytelling to help children to participate in therapy (Bow, 1988). Children in this study responded well to the two quantitative measures used and this elicited specific information that was not volunteered previously. This supports the idea that evaluation instruments can become participation instruments (Vossler, 2004) and it is suggested that these could be used regularly throughout therapy rather than simply at the end of therapy. This may provide a structure within which children feel comfortable in providing information. Finally, tools that facilitate client participation are emerging directly from research in this area. An example of this is that Hart, Saunders and Thomas (2005) developed the Therapeutic Continuum of User Involvement that can be used as an information and decision making tool regarding the modality of therapy and communication with other stakeholders.

Addressing Issues of Power

The issue of the power difference between the adult clinician and the child client was raised by most of the children in this study. While it is recognised that there will always be an inherent power imbalance between a clinician and a child,

there is a growing awareness of the potential value in reducing this imbalance. The idea of a collaborative approach to therapy, sharing responsibility for problem-solving (Orlinsky & Howard, 1987) and the transformation of traditional clinician/client roles to a more egalitarian relationship (Conran & Love, 1993), have existed for some time in the adult literature. Clinical work is being increasingly described as a collaborative process (Roberts, 1998) with clients viewed as participants in this process (Conran & Love, 1993). More recently these themes have also been highlighted in therapeutic work with children. Children have consistently expressed a desire to be more fully consulted about their own care (Laws, 1998).

Roberts (1998) suggests that the way that we view the role of the clinician and the nature of therapy can move us towards or further away from being able to address power issues within therapy. Roberts identified social constructionist ideas as being helpful in this regard, where the clinician joins with the client as a collaborator rather than as the expert. The literature also contains specific recommendations regarding how children can be assisted to be more equal participants in therapy, including ensuring that children are fully informed, consulted, involved in decision-making processes, made aware of their rights in the situation, made aware of how to make a complaint and have the right to consent or not consent to therapy (Powell, 2001). Research on children's experiences of therapy has made similar recommendations, such as the need for explicit negotiation about elements of therapy and the therapeutic logic employed (Hart, Saunders & Thomas, 2005) and the use of contracting to clarify issues (McConnell & Sim, 2000). The children in this study discussed how it was helpful to have choices, to be given information throughout therapy and to be involved in decisions regarding contact with their carer or school. This emphasis on choice was also highlighted by Street et al. (2005). The current

study also pointed to the value in thinking about children's behaviour in light of issues of power. If children try to redirect the content of therapy sessions, this could be viewed by some as resistance, whereas children in this study discussed this as a means of repositioning therapy to suit their needs.

Contribution to Reflexive Practice

Children's feedback offers a unique contribution to the reflexive practice of clinicians. There are various kinds of knowledge that clinicians can draw upon to refine their practice (Andersen, 1997) including socially or relationally constructed knowledge, an example of which is what we learn from clients about therapy and the role of the clinician (Roberts, 1998). Client feedback can contribute to reflexive practice by leading to changes to the clinician's repertoire of practice, moving the clinician into new therapeutic positions and sensitising the clinician to what the client wants to talk about (Andersen, 1997). The process of listening to client feedback can enable an appreciation of some of the pre-judgements and pre-understandings that clients have about therapy (Conran & Love, 1993) and it can ultimately shape and re-define ourselves as clinicians (Roberts, 1998). The researchers in this field have recognised the potential of their findings for reflexive practice, for example, Hart, Saunders and Thomas (2005) described how practice development can be aided by understanding what children find useful and effective. The findings of this study might cause us to re-examine some of our assumptions about therapy with children, including a greater appreciation of the level of anxiety that children feel prior to the first session, recognising that even quite young children want to be involved in decisions regarding therapy and that children are very reluctant to volunteer information about the process of therapy even when an issue is significant for them.

Organisational or Service Implications

Stallard (2001) discussed that if clients views are sought and taken seriously then their views need to be acted upon, service changes specified and implemented, and consumer opinions reassessed. This study points to a number of actions that could be taken at an organisational level to enhance children's experiences of therapy. As has been indicated in previous work in this area, one of the implications is in relation to the type of clinicians employed by services offering therapy to children. Hart, Saunders and Thomas (2005) proposed that services need to ensure that they have clinicians with the confidence and ability to work in a flexible way with clients and who are prepared to negotiate engagement. Day, Carey and Surgenor (2006) pointed to the importance of interpersonal qualities to children's care and how, in addition to the NHS requirements of CAMHS clinicians, it is essential that clinicians are able to build and maintain helping relationships with children. In addition to these factors this study highlighted that clinicians need to be qualified and experienced in working across modalities, tailoring therapy to the specific needs of the child and family, addressing process and power issues throughout therapy and with a willingness to incorporate other methods such as skills-based activities.

The ability of the clinician to be flexible was experienced positively by children, however, in order for an individual clinician to be flexible this has to be supported at an organisational level. This was discussed by Hart, Saunders and Thomas (2005) who noted that more flexible styles of working, where the clinician responds flexibly to the needs of the child or family rather than the family having to fit into a model of therapy or service delivery, would have implications for clinician caseloads. The children in this study identified issues such as flexible appointment times, being able to choose the gender of the clinician and the modality of therapy,

which would impact on the ways in which referrals are received and allocated by services. In order to be able to incorporate client preferences from the outset of therapy, client involvement would need to occur both at the point of referral and when negotiating a first appointment.

This study reinforces the value of children's feedback in service development and evaluation. This study strongly supports the finding of Stuntzner-Gibson, Koren and DeChillo (1995) that children can be meaningfully and usefully involved in evaluating services, including identifying problem areas (Laws, 1998) and ideally this should occur on an ongoing basis (McConnell & Sim, 2000). In the past client feedback was often only gained by clinicians conducting follow-up interviews with clients (Conran & Love, 1993), however, methodologies have since been developed that can track client experience on a session by session basis (Jarrett, 2008). At an organisational level service evaluation could involve ongoing structured ways in which children's views are fed back into the organisational system, such as regularly monitoring and seeking client feedback regarding various aspects of service delivery or instituting a child users group. It has also been suggested that children's feedback could be used with organisations to help them to reflect upon the institutional conditions and approaches that make it difficult for children to participate in therapy (Vossler, 2004).

Implications for Future Research

The process and outcomes of this study offer some reflections on conducting research with children. These ideas are related to the use of individual interviews, the potential contribution of quantitative measures and procedural issues.

Use of Individual Interviews

As previously discussed individual interviews were utilised very successfully in this study and enabled the research objectives to be met. One issue that emerged during the process of conducting the interviews was that significant differences in language and comprehension skills were noted in children of similar ages. It was an ethical requirement of this study that all written materials and interview questions were age-banded. This was found to be useful and is recommended for future research. However, it was the experience of this researcher that age-banding is not in itself sufficient and should not lull the researcher into a false sense of security that this ensures that the interview is developmentally appropriate. Examples to support this include the case of an eight-year-old girl in this study who was able to communicate at a far more sophisticated level than a number of children who were three years older than her and correspondingly a child of eleven years who needed more support to participate in the interview than many of the younger children. This study highlighted the importance of assessing each child's capacity to participate in the research rather than making assumptions based upon age.

The Potential Contribution of Quantitative Measures.

The studies on children's experiences of therapy to date have been qualitative studies as most were exploratory in nature. However it is suggested that the field has now evolved to the point of having some consensus on the core concepts of importance to children. Therefore quantitative measures may now be able to make a useful contribution. Quantitative methods may have a role in measuring and confirming thoughts, beliefs and relationships, thereby increasing our understanding of certain issues and areas (Creswell, 1994). The two quantitative measures utilised in this study enabled children to make fine distinctions between issues that could be

explored further in the remainder of the interview. In many cases they enabled children to voice ideas that had not yet emerged in the interview. While the Youth Satisfaction Questionnaire was very useful in this study, one criticism of the scale is that it is based on components of satisfaction derived from the adult literature.

Another way in which to advance the body of literature in this area is in the development of quantitative measures that accurately and reliably measure children's views based on the qualitative research regarding the issues of most importance in their experience of therapy. One such questionnaire emerged from the research of Day, Carey and Surgenor (2006), the development of the Child and Adolescent Service Experience measure which measures children's experiences of mental health care. Questionnaires based upon children's qualitative feedback have the potential to be used as a process instrument in clinical work with children, as a routine outcome measure and in monitoring whether changes made by services do in fact result in improvements to children's experience.

Procedure

A number of procedural issues were identified in this study that may have implications for future research. This study highlighted the importance of a personal approach to recruitment when conducting research with children. The participation rate was very good once the researcher was able to speak to the child, however, the recruitment methods permitted by the NHS Local Research Ethics Committee, i.e. post contact and written methods, are those that produce the lowest response rate (Stallard, 1996). As previously discussed this has the potential to introduce a sampling bias, producing a sample of motivated children, who were more likely to have had positive experience of therapy and be confident enough to volunteer. The use of these recruitment methods is likely to reduce the sample size and future

researchers may wish to consider utilising a personal recruitment approach whenever possible, particularly if the response rate or sample size is an important consideration. Researchers may benefit from experimenting with a range of measures of recruiting child research participants that are both ethically acceptable and involve a more personal approach, including the use of phone calls and email/internet approaches.

The optimal time to collect information from children about therapy emerged as an issue in this study. It is recognised that the greater the length of time between ending therapy and being interviewed, the greater the probability of recall bias and children forgetting issues which were important in their contact with the clinician (Carr-Hill, 1992). However, the literature does not currently offer definitive guidance regarding the most appropriate length of time post-therapy for a child to be interviewed about their experiences. In the literature the time-frames used vary widely, from six to twenty-four months (Andersen, 1997) to three to four years post-therapy (Vossler, 2004). Based on the experiences in conducting this study it is suggested that interviews should be conducted within six months of concluding therapy for primary school aged children, while a longer timeframe can be used for older children. Ultimately the optimal interview time reflects a child's developmental capacity to store and retrieve information and the influence of age/stage and memory deterioration due to time effects. There may also be ethical considerations in determining the optimal time for participation in research. Laws (1998) discussed the need for children to be able to move on from their experiences as a mental health consumer. Future research may also explore when the optimal time is to collect information about particular issues, for example, it could be interesting to compare

children's expectations about therapy both pre and post-therapy in order to assess the potential influence of experience in therapy upon children's responses.

A final procedural issue related to future research concerns the use of validation interviews. There are critics of a one-off interview approach to data collection (Charmaz, 2000; Punch, 2002) but for practical and ethical reasons one-off interviews have been widely used in this field and in this study a single interview was sufficient to enable the collection of a rich body of information. However, in this study the validation interviews played a very useful role in refining and validating the model and it is suggested that they may offer a useful contribution to future studies that seek to build theory.

Future Research

As previously outlined, in recent years research has developed our understanding of children's experiences of therapy and some consensus is emerging regarding the issues of significance to children. Some of the implications of this study for future research have already been outlined above. Therefore, this final section will focus on the role of future research in exploring the value and relevance of the proposed model. Future research could evaluate the extent to which the model is able to explain different children's experiences of therapy, particularly those children who were not well represented in this study, such as children presenting with externalising problems and children who were completely unwilling to attend or engage in therapy. As previously identified this may require more creative recruitment methods to access those children who may wish to take part but will not formally opt-in, particularly if future studies also wish to target a less mainstream client population such as children with special needs. If future research also includes children who experienced other commonly used models of therapy with children,

such as cognitive behaviour therapy, this may enable an assessment of whether the model developed in this study can be considered to be a generic model of children's experiences of therapy.

Future research would also be helpful in examining the components of the model and the links between components. It is not known whether each and every component in the model contributes independently to process and outcome variance, this would need to be tested in further qualitative studies. Future research could also examine and refine our understanding of the links between the components. Of particular interest would be a closer examination of the interaction between child and clinician actions. A research design which enabled the assessment of children's views and behaviour at multiple points throughout therapy may be able to achieve some insights into this.

There is also a role for future quantitative research. The development of quantitative instruments based on children's qualitative reports could be used to examine whether there is a statistically significant difference in children's experiences of therapy based upon factors such as the model and type of therapy and client variables such as the child's presenting issue. Quantitative research could also be utilised to examine potential process and outcome relationships, such as how children's experience of the concepts identified might relate to their attendance and to changes in their symptoms and functioning. Finally, quantitative research may be able to contribute to a greater understanding of how the concepts associated with children's satisfaction with therapy may be related to the therapeutic outcomes for the child.

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Appendix A

The Characteristics of Studies Examining Children's Experiences of Therapy.

Study	N and Age	Design	Analysis
Clark (2001)	Ten children aged 8-11 years who attended family therapy.	Focus groups stratified by age.	Interpretative phenomenological analysis
Day, Carey & Surgenor (2006)	Eleven children aged 9-14 years who attended primarily individual therapy.	3 semi-structured focus groups stratified by age.	Thematic content analysis.
Hart, Saunders & Thomas (2005)	Twenty-seven children aged 11-18 years and their parents who had attended primarily individual therapy with some family sessions.	Individual interviews and three focus groups stratified by age and gender.	Thematic analysis.
Kuehl, Newfield & Joanning (1990)	Thirty-seven family members who attended family therapy, 17 of which were aged 14-20 years.	Ethnographic interviews, ranging from 1-6 interviews per family.	Developmental research sequence.
Lobatto (2002)	Six children aged 8-12 years who attended family therapy.	Individual interviews with a carer present.	Grounded theory.
McConnell & Sim (2000)	Twenty-four children aged 8-15 years and their mothers who attended individual therapy.	Semi-structured individual interviews with mother present, pre and post-therapy.	Not stated.
Montgomery (2003)	Sixteen 12-26 year olds who attended individual therapy.	Semi-structured individual interviews.	Not clearly stated.
Stith, Rosen, McCollum, Coleman, Herman & Tech (1996)	Sixteen children aged 5-13 years and a parent who had attended family therapy.	Semi-structured individual interviews, child interviewed twice.	Modified version of constant comparative data analysis.

Strickland-Clark, Campbell & Dallos (2000)	Five children aged 11-17 years who had attended family therapy.	Semi-structured interview, children interviewed twice. Session level.	Grounded theory methodology and comprehensive process analysis.
Vossler (2004)	Seventeen 13-22 year olds, 2 attended family therapy, 7 had individual and family sessions, 8 attended individual therapy.	Semi-structured individual interviews.	Structured content analysis.

Appendix B

The Characteristics of Individual Interview Participants.

Participant	Age	Gender	Ethnicity	Sample	Sessions Attended (n)	Modality of Therapy
1	8	Male	Mixed Race (Black African)	Clinic	5	Family
2	12	Male	Latin American	Clinic	6	Family
3	7	Female	Mixed Race (Black African)	Clinic	4	Family
4	14	Male	White British	Clinic	Over 50	Individual
5	12	Male	Asian British	Clinic	Over 50	Group
6	10	Male	White British	Clinic	3	Family
7	14	Female	White British	Clinic	1	Family
8	8	Female	White European	Clinic	20 to 50	Individual
9 ***	16	Male	White British	School	16	Individual
10	17	Male	White British	School	Over 50	Individual
11	14	Female	Asian	School	15	Individual
12	9	Male	Mixed Race (Black African)	School	Over 50	Individual
13	10	Male	White British	School	20 to 50	Individual
14 **	13	Female	White British	School	14	Individual
15	13	Female	White British	School	20 to 50	Individual
16	9	Male	White British	Clinic	6	Family
17	9	Male	White British	Clinic	6	Family
18 *	14	Female	White British	Clinic	Over 50	Individual

* Participant in Validation Interview One ** Participant in Validation Interview Two

*** Participant in Validation Interview Three

Appendix C

The Original Semi-Structured Interview Protocol

Review Information Sheets, obtain consent from participant and parent.

Complete Ethnic Background Record Form and check demographic details.

Complete 'About Me' questionnaire.

Ask the participant to rate how he/she is feeling right now (out of ten).

Questions:

1. What did you think when you first got the questionnaire from (name of service)?
 - How did the questionnaire get filled out?
 - What do you think about services asking children for their opinion?

2. Think back to the first time that you came to therapy, what do you remember about it?

Give flash cards to participant, ask him/her to read each card and respond:

- Whose idea was it to go to therapy?
- Did you want to go?
- Why did you think that you were going?
- What did you think was going to happen?
- Who explained therapy to you?
- Did you have any worries about going?
- What did you hope might be different if you went to therapy?
- Did you think that going could be helpful?

- What was it like the first time that you went? How did you feel?
 - After your first session did you understand more about therapy?
 - If you were worried or didn't understand something did you tell the therapist?
 - Did anyone ask you in your first session what you wanted to happen in therapy?
 - Did you feel any differently about therapy after you had been once?
3. Who attended therapy sessions with you? How was this decided? How did you feel about this?
 4. What kinds of things did you do in therapy sessions?
 5. Can you tell me what your therapist was like?
 6. What was the most helpful bit about coming to therapy?
 - What was the most unhelpful bit?
 - What did you like about coming to therapy?
 - What did you not like about coming to therapy?
 7. At first you said that you felt (insert) about attending therapy, how did you feel halfway through? How did you feel in your last session?
 8. What do you understand about why you stopped coming to therapy?

9. Ask the participant to complete the 3 questions from the Youth Satisfaction Questionnaire on paper: (using the fixed choice options; Yes, Somewhat, No)

- Did you like the help you were getting?
- Did you get the help you wanted?
- Have the services helped with your life?

Ask the child to expand on their responses to the questions. Did therapy help anyone else in the family? Have there been any other changes for anyone since attending therapy?

10. How many marks out of ten would you give the therapy? How come such a low/high score? What would it have taken to get one point more?

11. What is the most important thing that we should keep doing in therapy?
What is one thing that we should change?

12. Imagine that this frog is a really good therapist and that children find her very helpful:

- What is she like?
- What does she do in the session that is helpful?
- What does she do outside the session that is helpful?

Now imagine that this monkey is a really unhelpful therapist:

- What is she like?
- What does she do in the session that is unhelpful?
- What does she do outside the session that is unhelpful?

13. Would you recommend therapy if you had a friend in a similar situation?

What do you think that they should know before they come?

14. If there is one thing that we haven't talked about today that we should have, what is it?

15. What has it been like being part of this research project?

Would you suggest that I change anything in my interviews with other children?

Ask the participant to rate how he/she is feeling right now (out of ten).

Give out support sheet.

Ask if the participant has any questions.

Explain the remainder of the research process and that all participants will get written feedback.

Give gift voucher.

Appendix D

The Ethnic Background Record Form

Ethnic Background Record Form

Pupil's name

Class/Form

Our ethnic background describes how we think of ourselves. This may be based on many things, including, for example, our skin colour, language, culture, ancestry or family history. **Ethnic background is not the same as nationality or country of birth.**

The Information Commissioner (formerly the Data Protection Registrar) recommends that young people aged over 11 years old have the opportunity to decide their own ethnic identity. Parents or those with parental responsibility are asked to support or advise those children aged over 11 in making this decision, wherever necessary. Pupils aged 16 or over can make this decision for themselves. Please study the list below and tick one box only to indicate the ethnic background of the pupil or child named above. Please also tick whether the form was filled in by a parent or the pupil.

White

- | | |
|------------------------------|--------------------------|
| British | <input type="checkbox"/> |
| Irish | <input type="checkbox"/> |
| Traveller of Irish Heritage | <input type="checkbox"/> |
| Gypsy/Roma | <input type="checkbox"/> |
| Any other White background | |
| Greek | <input type="checkbox"/> |
| Greek Cypriot | <input type="checkbox"/> |
| Turkish | <input type="checkbox"/> |
| Turkish Cypriot | <input type="checkbox"/> |
| Albanian – Excluding Kosovan | <input type="checkbox"/> |
| Kosovan | <input type="checkbox"/> |
| White European | <input type="checkbox"/> |
| White Other | <input type="checkbox"/> |

Mixed

- | | |
|----------------------------|--------------------------|
| White and Black Caribbean | <input type="checkbox"/> |
| White and Black African | <input type="checkbox"/> |
| White and Asian | <input type="checkbox"/> |
| Any other mixed background | <input type="checkbox"/> |

Asian or Asian British

- | | |
|----------------------------|--------------------------|
| Indian | <input type="checkbox"/> |
| Pakistani | <input type="checkbox"/> |
| Bangladeshi | <input type="checkbox"/> |
| Any other Asian background | <input type="checkbox"/> |

Black or Black British

- | | |
|-----------|--------------------------|
| Caribbean | <input type="checkbox"/> |
|-----------|--------------------------|

African

- | | |
|--------|--------------------------|
| Somali | <input type="checkbox"/> |
|--------|--------------------------|

- Nigerian
- Congolese
- Any other Black African
- Any other Black background

Chinese

Any other ethnic background:

- Latin American
- Kurdish
- Any other ethnic background

I do not wish an ethnic background category to be recorded

This information was provided by:	
Parent	<input type="checkbox"/>
Pupil	<input type="checkbox"/>

Please return the form to the school within four weeks in the enclosed envelope, or by bringing it into the school office (or by email if it's been sent to you that way).

(Any information you provide will be used solely to compile statistics on the school careers and experiences of pupils from different ethnic backgrounds, to help ensure that all pupils have the opportunity to fulfil their potential. These statistics will not allow individual pupils to be identified. From time to time the information will be passed on to the Local Education Authority and the Department for Education and Skills (DfES) to contribute to local and national statistics. The information will also be passed on to future schools, to save it having to be asked for again.)

Appendix E

The three items from the Youth Satisfaction Questionnaire

- | | | | |
|---|-----|----------|----|
| 1. Did you like the help that you were getting? | Yes | Somewhat | No |
| 2. Did you get the help you wanted? | Yes | Somewhat | No |
| 3. Did it help with your life? | Yes | Somewhat | No |

Appendix F

The Letter of Invitation to Primary School Children Who Accessed a School Based Counselling Service.

Dear (Insert Name),

I am writing to invite you to participate in a study about children's experiences of having counselling at school. I was given your name and contact details by the counsellor that you saw at your school.

I am a Psychologist who works with children and this study is a part of my Doctor of Psychology course. The study aims to find out what primary and secondary students who have been to counselling at their school in the last twelve months think about the counselling that they had. Finding out what children think about counselling is very important because it could help counsellors to improve how they work with children.

Participating in the study involves attending an interview with me that lasts up to an hour, whatever you say in this interview will be private. You will receive a £5 gift voucher to a sports, music or book store for participating in the study. I have attached an information sheet about the study, if you read this it should answer any of your questions. However, if you have any other questions that you would like to ask me you are very welcome to contact me on 0207 349 0252.

If you are interested in the study or would just like to hear more about it then please fill out the reply slip below and return it to me in the self addressed envelope. Please ask your parent/carer to sign the slip too. I will then call you to discuss the study.

Thank you for your help,

Justine Stefanoff
Counselling Psychologist

.....

Reply Slip – Involving Children in Therapy Services

I would like to receive more information about the study on children's experiences of school based counselling services.

My name:

My age:

My contact number/s:

Signed:

Parent/Carer Signature:

Date:

Appendix G

The Letter of Invitation to Secondary School Children Who Accessed a School Based Counselling Service.

Dear (Insert Name),

I am writing to invite you to participate in a study on children's experiences of attending counselling at school. I was given your name and contact details by the counsellor that you saw at your school.

I am a Psychologist who works with children and adolescents and I am conducting this study as a part of my Doctor of Psychology course. The study aims to find out what primary and secondary students who have been to counselling at their school in the last twelve months think about the counselling that they had. Finding out what young people think about counselling is very important because it could help counsellors to improve how they work with children and young people.

Participating in the study involves attending a confidential interview with me that lasts up to an hour. You will receive a £10 gift voucher to a sports, music or book store for participating in the study. I have attached an information sheet about the study, if you read this it should answer any of your questions. However, if you have any other questions that you would like to ask me you are very welcome to contact me on 0771 942 5305.

If you are interested in the study or would just like to receive some more information then please fill out the reply slip below and return it to me in the self addressed envelope. I will then call you to discuss the study.

Thank you for your help,

Justine Stefanoff
Counselling Psychologist

.....

Reply Slip – Involving Children in Therapy Services

I would like to receive more information about the study on children's experiences of school based counselling services.

My name:

My age:

My contact number/s:

Signed:

Date:

Appendix H

The Participant Information Sheet for Primary School Children Who Have Accessed a School Based Counselling Service.

Involving Children and Young People in Therapy Services Participant Information Sheet – For Primary School Children

What Is This Study About?

This study is about what children thought about the counselling that they had at school. The researcher is a Psychologist who works with children, her name is Justine Stefanoff, and her supervisor is Dr Malcolm Cross from City University.

Can I Take Part In The Study?

You can take part in this study if you are 7-14 years old and you have had counselling at your school in the last year.

How Can I Take Part?

You can take part in the study by having an individual discussion (interview) with the researcher. She will ask you about what you thought about the counselling that you had. Examples of things that she will ask about are; whose idea was it to go to counselling, what was the best bit and worst bit about counselling and whether you think that anything should be changed about counselling. Anything that you talk about is private and your counsellor will not find out that you took part. You will not have to discuss anything personal about yourself or anyone else. You won't be asked to talk about the things that you talked about in counselling. The interview will be taped (sound only), it will only be listened to by the researcher, then it will be erased. The interview will last for up to an hour and you can have breaks if you need to. The interview can be at your home, school or the researcher's office, what ever is easier for you to get to.

Do I Have To Take Part?

No, it is your choice if you take part, you don't have to. If you decide to take part you can change your mind at any time and stop at any time. You don't have to answer any questions that you don't want to.

What Are The Good And Bad Things About Taking Part In The Study?

There shouldn't be any bad things. The researcher will not tell anyone that you took part or what you said (unless you say something that sounds like you are not safe, in this case she might need to talk to your parent/carer or school). The good things are that you will be given a £5 book, sports or music shop voucher to thank you for taking part and if it cost you any money to go to an interview then this will be paid. The other good thing is that what you say will help adults working with children to better understand what they think about counselling, which should help other children. A small group of counsellors will meet to talk about all of the ideas from the children in the study however they will not know the names or anything personal about the children who took part. When the study is finished you will be mailed a summary of the results.

How Can I Get More Information?

You can call Justine Stefanoff, on 02073490252. If someone else answers the phone or you get an answering machine please say 'I am ringing about Justine's therapy study', say your name and your phone number and she will ring you back.

Appendix I

The Participant Information Sheet for Secondary School Children Who Have Accessed a School Based Counselling Service.

Involving Children and Young People in Therapy Services Participant Information Sheet – For Secondary School Children

What Is This Study About?

This study is about what children thought about the counselling that they had at school. This study is being conducted by a Psychologist who works with children, Justine Stefanoff, from City University London, as part of her doctoral dissertation. Her supervisor is Dr Malcolm Cross from City University London.

Can I Take Part In The Study?

You can take part in this study if you are 7-14 years old and you have had counselling at your school in the last year.

How Can I Take Part?

You can take part in the study by having an individual interview with the researcher. She will ask you about what you thought about the counselling that you had. Examples of things that she will ask about are; what it was like to start counselling, what was helpful and unhelpful about counselling, and whether you would recommend counselling to a friend. Anything that you talk about is private and your counsellor will not find out that you took part. You will not have to discuss anything personal about yourself or anyone else. You won't be asked to talk about the things that you talked about in counselling. The interview will be taped (sound only), it will only be listened to by the researcher, then it will be erased. The interview will last for up to an hour and you can have breaks if you need to. The interview can be at your home, school or the researcher's office, what ever is easier for you to get to.

Do I Have To Take Part?

No, it is your choice if you take part, you don't have to. If you decide to take part you can change your mind at any time and stop at any time. You don't have to answer any questions that you don't want to.

What Are The Good And Bad Things About Taking Part In The Study?

There shouldn't be any bad things. The researcher will not tell anyone that you took part or what you said (unless you say something that sounds like you are at risk of harm, in this case she might need to talk to your parent/carer or school). The good things are that you will be given a £10 book, sports or music shop voucher to thank you for taking part and if it cost you any money to go to an interview then this will be paid. The other good thing is that what you say will help adults working with children to better understand what they think about counselling, which should help other children. A small group of counsellors will meet to talk about all of the ideas gained from the children in the study however this will be done anonymously e.g. without knowing the names or any other information about the children who took part. When the study is finished you will be mailed a summary of the results.

How Can I Get More Information?

You can call Justine Stefanoff, on 0771 942 5305 or 02073490252. If someone else answers the phone or you get an answering machine please say 'I am ringing about Justine's therapy study', say your name and your phone number and she will ring you back.

Appendix J

The Participant Information Sheet for Primary School Children Who Accessed the Child and Adolescent Mental Health Service.

Involving Children and Young People in Therapy Services Participant Information Sheet – For Primary School Children

What Is This Study About?

This study is about what children thought about the therapy that they had at (name of CAMHS). The researcher is a Psychologist who works with children, her name is Justine Stefanoff, and her supervisor is Dr Malcolm Cross from City University.

Can I Take Part In The Study?

You can take part in this study if you are 7-14 years old and you have been to therapy at (name of CAMHS) in the last year.

How Can I Take Part?

You can take part in the study by having an individual discussion (interview) with the researcher. She will ask you about what you thought about the therapy that you had. Examples of things that she will ask about are; whose idea was it to go to therapy, what was the best bit and worst bit about therapy and whether you think that anything should be changed about therapy. Anything that you talk about is private and your therapist will not find out that you took part. You will not have to discuss anything personal about yourself or anyone else. You won't be asked to talk about the things that you talked about in therapy. The interview will be taped (sound only), it will only be listened to by the researcher, then it will be erased. The interview will last for up to an hour and you can have breaks if you need to. The interview can be at your home, school or the researcher's office, what ever is easier for you to get to.

Do I Have To Take Part?

No, it is your choice if you take part, you don't have to. If you decide to take part you can change your mind at any time and stop at any time. You don't have to answer any questions that you don't want to.

What Are The Good And Bad Things About Taking Part In The Study?

There shouldn't be any bad things. The researcher will not tell anyone that you took part or what you said (unless you say something that sounds like you are not safe, in this case she might need to talk to your parent/carer or school). The good things are that you will be given a £5 book, sports or music shop voucher to thank you for taking part and if it cost you any money to go to an interview then this will be paid. The other good thing is that what you say will help adults working with children to better understand what they think about therapy, which should help other children. A small group of therapists will meet to talk about all of the ideas from the children in the study however they will not know the names or anything personal about the children who took part. When the study is finished you will be mailed a summary of the results.

How Can I Get More Information?

You can call Justine Stefanoff, on 02073490252. If someone else answers the phone or you get an answering machine please say 'I am ringing about Justine's therapy study', say your name and your phone number and she will ring you back.

Appendix K

The Participant Information Sheet for Secondary School Children Who Accessed the Child and Adolescent Mental Health Service

Involving Children and Young People in Therapy Services Participant Information Sheet – For Secondary School Children

What Is This Study About?

This study is about what children thought about the therapy that they had at (name of CAMHS). This study is being conducted by a Psychologist who works with children, Justine Stefanoff from City University London, as part of her doctoral dissertation. Her supervisor is Dr Malcolm Cross from City University London.

Can I Take Part In The Study?

You can take part in this study if you are 7 -14 years old and you have been to therapy at (name of CAMHS) in the last year.

How Can I Take Part?

You can take part in the study by having an individual interview with the researcher. She will ask you about what you thought about the therapy that you had. Examples of things that she will ask about are; what it was like to start therapy, what was helpful and unhelpful about therapy, and whether you would recommend therapy to a friend. Anything that you talk about is private and your therapist will not find out that you took part. You will not have to discuss anything personal about yourself or anyone else. You won't be asked to talk about the things that you talked about in therapy. The interview will be taped (sound only), it will only be listened to by the researcher, then it will be erased. The interview will last for an hour and you can have breaks if you need to. The interview can be at your home, school or the researcher's office, what ever is easier for you to get to.

Do I Have To Take Part?

No, it is your choice if you take part, you don't have to. If you decide to take part you can change your mind at any time and stop at any time. You don't have to answer any questions that you don't want to.

What Are The Good And Bad Things About Taking Part In The Study?

There shouldn't be any bad things. The researcher will not tell anyone that you took part or what you said (unless you say something that sounds like you are at risk of harm, in this case she might need to talk to your parent/carer or school). The good things are that you will be given a £10 book, sports or music shop voucher to thank you for taking part and if it cost you any money to go to an interview then this will be paid. The other good thing is that what you say will help adults working with children to better understand what they think about therapy, which should help other children. A small group of therapists will meet to talk about all of the ideas gained from the children in the study however this will be done anonymously e.g. without knowing the names or any other information about the children who took part. When the study is finished you will be mailed a summary of the results.

How Can I Get More Information?

You can call Justine Stefanoff, on 0771 942 5305 or 02073490252. If someone else answers the phone or you get an answering machine please say 'I am ringing about Justine's therapy study', say your name and your phone number and she will ring you.

Appendix L

The Parent/Carer Information Sheet

Involving Children and Young People In Therapy Services Information Sheet For Parents/Carers

This study is about children's experiences of counselling and therapy. The study is being conducted by Justine Stefanoff, City University London, as part of her doctoral dissertation. Her supervisor is Dr Malcolm Cross who can be contacted at the Department of Psychology, City University, Northampton Square, London EC1V 0HB. Dr Cross can also be contacted on 0207 040 5060.

Children are eligible to take part in this study if they are aged 7-14 years, have attended therapy at (name of CAMHS) or a school based counselling service in the last twelve months and are not currently experiencing psychological distress.

This study involves children and young people attending an individual interview with the researcher about their experiences of attending counselling or therapy. The interview will last approximately an hour and the researcher can come to the child's home or school for the interview. Children will be told that they do not need to reveal personal information about themselves or anyone else and they do not need to talk about the things that they spoke about in counselling or therapy. The interview will be audio taped and the tape will be erased once the interview has been transcribed. The transcript will not contain the child's name, initials or any identifying information. Children will receive a voucher to thank them for taking part and any travel expenses will be paid.

Participation in this study is totally voluntary. Children who agree to participate are entitled to change their mind and withdraw their participation at any time without penalty. Children are entitled to avoid answering questions that they feel are too personal. Children's confidentiality and anonymity will be maintained at all times unless they reveal something that suggests that they are at risk of harm.

There are no risks to children involved in this study. However, in the unlikely event that a child does feel upset after talking about his/her experiences then the researcher will give the child the opportunity to talk about his or her feelings. If a child does feel upset then the parent/carers will also be provided with a list of resources that can be accessed to provide the child with further support.

The children's involvement will be very useful in achieving a greater understanding of how children experience counselling and therapy, which may assist other children in the future.

If there is any aspect of the research that concerns you, you can make a complaint. City University has established a complaints procedure via the Secretary to the Research Ethics Committee. To complain about the study, you need to phone 020 7040 8010. You can then ask to speak to the Secretary of the Ethics Committee and inform them that the name of the project is 'Involving Children in Therapy Services'.

Appendix M

Summary of Findings For Primary School Participants

Dear

I am writing to give you a summary of the research study that you participated in last year about children's experiences of counselling or therapy. Firstly, I wanted to thank you again for giving up your time to meet with me, it was very helpful.

Summary Of The Study

I interviewed eighteen children. I wrote notes from the interview tapes, picked out the main points that children talked about, I thought about what these might mean and then formed a model (picture) to explain children's experiences of therapy.

What Were The Main Things That Children Talked About?

The main things that children talked about were:

- Many things affect how children feel about starting counselling or therapy, including: whose idea it was to go, whether children understood why they are going, what children expect will happen in counselling and whether they have any worries about attending.
- Most children described attending the first session feeling a bit nervous or shy.
- It was helpful if the counsellor or therapist was nice and kind, listened to the child, gave choices and explained things. It wasn't helpful if the session moved too quickly or children didn't understand why things were happening.
- Children played an active role in counselling, for example they decided if and when they felt comfortable saying things.
- Most children were fairly happy with the counselling or therapy that they had and found it helpful. Children reported that they liked being able to talk about things that were important to them and learning new ways to solve problems.
- Most children would be willing to think about going to counselling or therapy again if they needed to and most would recommend it to a friend.

What Happens Now?

Your ideas will be used to help improve counselling and therapy for other children.

Some of the ways in which this will be done include:

- Making a new brochure for children coming to counselling and therapy, hopefully this will answer their questions and help them to feel less nervous.
- Talking to staff at (name of CAMHS) and school counselling services about children's feedback.
- Letting other professionals who work with children know about your ideas, this might be at meetings or conferences or by writing an article in a journal.

Remember that everything that you talked about is still totally private, no one will ever know that you took part in the study or what you said.

If you have any questions about this information sheet or the research study please contact me on 0771 942 5305.

Kind regards,
Justine Stefanoff

Appendix N

Summary of Findings For Secondary School Participants

Dear

I am writing to give you a summary of the research study that you participated in last year about children and young people's experiences of counselling or therapy. Firstly, I wanted to thank you again for giving up your time to meet with me, it was very helpful.

Summary of the Study

I interviewed eighteen children and young people. I wrote notes from the interview tapes, picked out themes, looked at how these themes might be related to each other and then formed a model to explain young people's experiences of therapy.

What Did The Study Find?

The main findings from this study were:

- Many things affect how young people feel about starting counselling or therapy, including: whose idea it was to attend, whether the person understood why they are going, what young people expect will happen in counselling and whether they have any worries about attending.
- Most young people described attending the first session feeling nervous or shy.
- It was helpful if the counsellor or therapist was nice and kind, listened to the young person, gave choices and explained things. It wasn't helpful if the session moved too quickly or if the young person didn't understand why things were happening.
- Young people played an active role in counselling, for example they decided if and when they felt comfortable saying things.
- Most young people were fairly happy with the counselling or therapy that they had and found it helpful. They reported that they liked being able to talk about things that were important to them and learning new ways to solve problems.
- Most young people would be willing to think about going to counselling or therapy again if they needed to and most would recommend it to a friend.

What Happens Now?

Your ideas will be used to help improve counselling and therapy for other children and young people. Some of the ways in which this will be done include:

- Making a new brochure for children coming to counselling and therapy, hopefully this will answer their questions and help them to feel less nervous.
- Talking to staff at (name of CAMHS) and school counselling services about children's feedback.
- Letting other professionals who work with children know about your ideas, this might be at meetings or conferences or by writing an article in a journal.

Remember that even when information from this study is shared, your involvement and what you said is still totally anonymous.

If you have any questions or comments about this information sheet or the research study you would be very welcome to contact me on 0771 942 5305.

Kind regards,
Justine Stefanoff

SECTION C
PROFESSIONAL PRACTICE

A CLINICAL CASE STUDY ON THE USE OF COGNITIVE BEHAVIOURAL THERAPY FOR CHILDHOOD ANXIETY

This component of the thesis examines clinical work with children from a different perspective, through the presentation of the process and outcome of intervention with a specific case. This case study describes how cognitive behavioural therapy (CBT) was used as the model guiding intervention with a thirteen-year-old girl presenting with symptoms of generalised anxiety. In this chapter different aspects of clinical work with children, such as the use of evidence-based therapy, are highlighted. However, issues identified in the research component of this thesis, particularly; therapy being an unfamiliar experience for children, decision making around the modality of therapy, the importance of the therapeutic relationship and children valuing therapy being 'nice and helpful' will also be discussed in presenting this case.

Section 1 will outline the theoretical basis for this intervention. Section 2 will describe the assessment and case conceptualisation. Section 3 provides an overview of the therapy offered and section 4 describes the outcomes of therapy. Finally, section 5 provides a summary of the strengths and challenges in therapy with this client and reflects on some of the core components of CBT intervention with children. This case was selected as it illustrates how CBT can be used in a developmentally appropriate manner and how parental involvement can increase the effectiveness of the intervention. All identifying information has been changed to ensure confidentiality.

Theoretical Basis for the use of CBT for Children with Anxiety

Anxiety disorders are the most common type of psychiatric disorder in children (Fonagy et al., 2002). Nine percent of children and thirteen to seventeen

percent of adolescents meet the criteria for an anxiety disorder (Cobham, Dadds & Spence, 1998). Left untreated anxiety disorders, particularly generalised anxiety disorder, have a chronic unremitting course (Linares Scott & Feeny, 2006), interfering with adjustment and academic functioning and being associated with anxiety problems in adulthood (Kendall et al., 1997). Approximately one third of children with one anxiety disorder also meet the criteria for at least one other anxiety disorder and a third suffer from depression (Fonagy et al., 2002). One evidence-based intervention used to treat childhood anxiety is CBT. CBT is widely used with both adults and children and, after behaviour modification, is the most well researched child therapy technique (Grave & Blissett, 2004).

Cognitive Behavioural Conceptualisation of Childhood Anxiety

In CBT a diathesis stress model is used to explain the way in which anxiety develops. This model suggests that a person may have a risk factor that predisposes them to develop anxiety and, when this interacts with stressful life events, anxiety can result (Zinbarg, Craske & Barlow, 2006). Beck (2005) describes the cognitive model of anxiety as being characterised by the themes of threat and vulnerability. He proposed that danger-oriented beliefs (embedded in cognitive schemas) predispose individuals to narrow their attention to threat, engage in dysfunctional safety behaviours and make catastrophic interpretations of ambiguous stimuli.

Although developmentally appropriate cognitive models for explaining anxiety in children are less developed (Stallard, 2002), there is emerging evidence for cognitive biases in anxious children's information processing that supports the cognitive theory of anxiety disorders (Bogels & Zigterman, 2000). Children with anxiety disorders have been found to misperceive ambiguous events as threatening, are overly self-focused and hypercritical, and report increased levels of self-talk and

negative expectations (Stallard, 2002). Similarly, Friedberg and McClure (2002) describe the internal dialogue of anxious children as punctuated by catastrophic predictions and expectations of unsuccessful coping. In the cognitive model, five spheres of functioning change when a child becomes anxious; physiological, mood, behavioural, cognitive and interpersonal (Friedberg & McClure, 2002).

The aim of a CBT intervention is to increase self-awareness, facilitate better self-understanding, and improve self-control by developing more appropriate cognitive behavioural skills (Stallard, 2002). When using CBT with anxious children, clinicians need a systematic plan (Friedberg & McClure, 2002) as CBT interventions are typically multi-component and incorporate a number of cognitive and behavioural strategies (Linares Scott & Feeny, 2006). Friedberg and McClure suggest using CBT techniques in a gradual sequential manner, consistent with the stage of therapy. They propose beginning with self-monitoring techniques and then using relatively simple cognitive and behavioural interventions before proceeding to more complex interventions.

Empirical Evidence for the use of CBT for Children with Anxiety

CBT has been found to be effective in reducing anxiety symptoms for each of the anxiety disorders (Beck, 2005). Clinical guidelines recommend CBT for generalised anxiety disorder as a first option because of its long-term effectiveness (McIntosh et al., 2004). A Cochrane Review (2006) of thirteen studies concluded that CBT appeared to be an effective treatment for child and adolescent anxiety disorders and that the response rate for remission of an anxiety diagnosis was 56% (Soler & Weatherall, 2006).

One of the most extensively studied forms of CBT for childhood anxiety is based on Kendall's Coping Cat model. Kendall (1994) conducted a randomised

clinical trial of the sixteen-session program with 27 children. Kendall found that CBT, when compared to a waitlist control, was associated with positive changes in child and parent reported coping and distress, observations of child behaviour and diagnostic status. At post-treatment 66% of children did not meet the criteria for their primary anxiety diagnosis. This study was replicated and extended by Kendall et al. (1997) using a sample of 94 children. Kendall et al. found that over 50% of treated children were free of their primary anxiety disorder at post-treatment, a significant reduction in severity scores was achieved for those whose primary diagnosis remained, and gains were maintained at the twelve-month follow up. Australian adaptations of the program by Barrett, Dadds and Rapee (1996) found similar outcomes, with 57% of children no longer meeting diagnostic status post-treatment, maintained at the six-month and twelve-month follow-up. A six-year follow-up by Barrett, Duffy, Dadds and Rapee (2001) also found that treatment gains were maintained. Finally, a Dutch adaptation of the program by Nauta, Scholing, Emmelkamp and Minderaa (2003) examined its utility with 79 children, finding that 54% of children in the treatment condition did not meet criteria for an anxiety disorder post-treatment, increasing to 68% at the three-month follow-up.

While the empirical evidence suggests that CBT can be recommended for the treatment of childhood anxiety disorders, there is limited empirical data regarding the active components of CBT, the mechanisms for change in therapy or predictors of treatment outcome (King, Heyne & Ollendick, 2005). Furthermore, a significant number of children do not appear to benefit from CBT (Linares Scott & Feeny, 2006). Therefore, there is a need for further empirical and clinical development in order to increase effectiveness (Soler & Weatherall, 2006).

Theoretical Support for Parental Involvement in CBT for Children with Anxiety

One way in which clinicians have attempted to maximise treatment gains is by directly involving parents in therapy. While the literature reflects the need to treat all children within the context of the systems in which they function (Friedberg & McClure, 2002), this is particularly important when children are anxious as many of the features of anxiety, such as avoidance and a cognitive bias to threat, have been hypothesised to be transmitted, by reinforcement and modelling, within the family context (Cobham, Dadds & Spence, 1998). Research has also found that the parents of anxious children are more likely than the parents of non-anxious children to meet the criteria for an anxiety disorder (Cobham, Dadds & Spence, 1998). Therefore clinicians have moved to involve parents in therapy to try to alter the parent variables that may be contributing to the child's anxiety. Within the literature the specific role of parents in child-focused CBT programs has varied and has included those of facilitator, co-clinician, co-client and client (Stallard, 2005).

Empirical Evidence for Parental Involvement in CBT for Children with Anxiety

The empirical evidence for parental involvement in child-focused CBT is mixed. While the Cochrane Review (2006) found no overall difference in the effectiveness of intervention, some studies have found positive effects, particularly those involving children with a generalised anxiety disorder (Stallard, 2005). Barrett, Dadds & Rapee (1996) found that the addition of family anxiety management training to child-focused CBT led to an increase in the number of children no longer meeting diagnostic status post-intervention, which increased further at the twelve-month follow-up. Barrett, Dadds & Rapee found the most benefits for younger children (seven to eleven years) and female participants.

Cobham, Dadds and Spence (1998) also found that the inclusion of parental anxiety management increased the efficacy of child-focused CBT but only for those children who had at least one anxious parent. However, these effects were less evident at the six-month and twelve-month follow up. A follow-up study by Barrett et al. (2001) found that, while gains were maintained over a five-seven-year follow-up period, in the longer term the CBT and CBT plus parent condition were equally effective.

As Stallard (2005) notes, the empirical evidence at this time does not provide strong support for the widely accepted clinical view that parental involvement enhances child-focused CBT and aids the transfer of skills to everyday situations. A number of reasons have been proposed for this, including: sample sizes not being sufficient to detect small but significant differences (Stallard, 2005); too few parent sessions to establish results (Cobham, Dadds & Spence, 1998; Nauta et al., 2003); too much content to allow parents to change their thoughts and behaviour (Nauta et al., 2003); an insufficient follow-up period (Nauta, et al., 2003); and the anxious parent not attending the sessions (Cobham, Dadds & Spence, 1998). Researchers also note that parental involvement may have other benefits, such as preventing drop-out from therapy (Nauta et al., 2003). Further research in this area is needed.

The Role of the Therapeutic Relationship in CBT

Research suggests that cognitive behaviour therapists employ relationship skills as much as clinicians from other orientations. The therapeutic relationship in CBT is characterised by an active directive stance on the part of the clinician, high levels of support, and high levels of empathy and unconditional positive regard (Keijsers, Schaap & Hoogduin, 2000). CBT clinicians have described the therapeutic relationship as critically important (Padesky & Greenberger, 1995) and an essential

component of CBT (Wright & Davis, 1994) but insufficient to produce therapeutic change (Waddington, 2002).

While the research on the association between the therapeutic relationship and therapy outcome is mixed, an association has been found more often than not (Waddington, 2002). A meta-analysis of 49 child treatment studies by Karver et al. (2006) found that therapeutic relationship variables are moderately strong predictors of treatment outcome for children and adolescents, with the therapeutic relationship having a moderate to large relationship with treatment outcomes. However, the mechanisms through which the therapeutic relationship affects outcome are unclear. Researchers suggest that a precise understanding of the therapeutic relationship (Bannan & Malone, 2002) and the domains that make up measures of therapeutic relationship (Karver et al, 2006) are needed. Clinically, there are few guidelines on the use of the therapeutic relationship in CBT (Wright & Davis, 1994). Research is needed to help clinicians know how to maximise the therapeutic potential of the therapy relationship (Waddington, 2002).

Assessment

Referral

This client was seen through a child and adolescent mental health service, in a tier two team that operated in secondary schools in London. Katie (not her real name), was referred by the School Nurse as she was very distressed and anxious at school, unable to attend her lessons and wanting to go home. The school nurse reported that Katie had regularly presented in this way for the past two months, she was accessing the student office up to a dozen times a day seeking reassurance and had only completed one full day at school in the past week. The assessment took

place across two sessions. The first session was with Katie and the second session was with Katie and her mother.

Appearance and Behaviour

Katie was a white British thirteen-year-old. She looked very young for her age and was initially quite shy. She was tearful at various points throughout the first assessment session but was articulate in explaining how she felt. Katie appeared to be operating at a slightly lower developmental level than might be expected of her chronological age, particularly in the areas of social, emotional and peer development.

Presenting Problem

Katie discussed feeling very worried about her schoolwork, homework, upcoming exams, issues related to peers, her personal safety and safety of family members. Katie described her symptoms as including: crying at school every day, feeling unable to manage in the classroom, frequent stomach pains, difficulty falling asleep at night, difficulty concentrating, feeling sad and angry, forgetting things and shouting at people. Katie was using a number of coping strategies to help her to manage her symptoms. Her primary coping strategy was avoidance. Katie would leave class or school itself when she felt too anxious. Katie also used distraction, sought constant support and reassurance from a range of peers and adults and ceased most of her previous hobbies so that she could focus on her schoolwork. Katie was asked to rate how she felt on a scale of one to ten (one being the lowest, ten being highest). Katie rated herself one and a half.

Katie reported that her symptoms had commenced thirteen weeks prior, at the start of the new academic year. A number of changes had occurred at this time for Katie. She returned to school several days after other students due to a family

holiday, she was no longer with her class group for every lesson, she received more homework than in previous years and there was the prospect of Standard Assessment Tasks (SAT) exams in the coming months.

Katie's mother Pamela (not her real name), agreed with Katie's description of the problem, reporting that Katie gets frightened easily and had always been timid and shy. Pamela said that Katie had never been in trouble at school and always does what she was told. While she agreed that the current problem commenced recently, Pamela explained that in primary school there had been two similar episodes, when Katie sat her SAT exams in year six and later that year when her mother had to go to hospital. Katie had no previous experience of therapy.

Background and Family History

Katie lived with her mother, father and nine-year-old sister on a local housing estate. She described being very close to her parents, especially her mother. Both Katie and her mother reported that there was a lot of stress in the family leading up to Christmas. Katie's anxiety appeared to be causing great distress within the family. In the mornings when Katie was tearful and did not want to go to school other family members also became quite tearful. Pamela reported that she and her husband were not sure whether it was best to allow Katie to come home when she was distressed or whether they should encourage her to remain at school and their response in this situation had varied. Education was highly valued by both parents and Katie appeared to feel under pressure to do well at school.

Pamela reported that four years prior she had significant problems with anxiety and panic attacks after the death of her father. This lasted for a year and she was treated with CBT which she found helpful. It was suggested that Katie's maternal grandmother and her father have some difficulties with anxiety.

Medical and Developmental Issues

Pamela reported that Katie reached developmental milestones at the appropriate ages, however she had a history of medical intervention. Katie had convulsions and had needed to be hospitalised on a number of occasions between the ages of two and four years. She also had a history of urinary infections which necessitated numerous medical investigations and intervention.

In order to rule out anxiety due to a general medical condition, and in keeping with the normal practice of the service, I contacted Katie's General Practitioner (with Katie and Pamela's consent). The GP was concerned about Katie, citing a history of mental health issues in the extended family. He had recently seen Katie and raised the possibility of a psychiatric assessment. Her GP felt that her current anxiety was not related to any medical issues or medication. There was no indication from the GP, Katie or Pamela that there was any substance use that may be contributing to her anxiety.

Feedback From School

With Katie and her mother's permission school staff were consulted for their perspective. Katie's Head of Year described her as 'a plodder' who worked hard in class, tried hard at school and was very conscientious. Her tutor described her as a well-behaved and quiet class member who appeared to worry a lot about her school work, resulting in her frequently checking things and requesting reassurance from her teachers.

Self-Report Measures

Three self-report measures were administered in the assessment sessions, consistent with the practice of integrating interview data and information from assessment instruments (Friedberg & McClure, 2002). The first self-report measure

was the Strengths and Difficulties Questionnaire (SDQ), a brief behavioural screening questionnaire for three to sixteen-year-olds developed by Robert Goodman (1997). This is a 25-item scale which produces five subscales; emotional symptoms, conduct problems, hyperactivity/ inattention, peer relationship problems and pro-social behaviour. The SDQ was used as the standard pre and post-measure within the service and was routinely administered to the child and a second rater (parent or teacher) in the first session.

In addition two scales from the Beck Youth Inventories of Social and Emotional Impairment were administered. The first was the Beck Anxiety Inventory for Youth, which measures children's fears, worrying and physiological symptoms associated with anxiety (Beck, Beck & Jolly, 2001). The second was the Beck Depression Inventory for Youth, which is designed to identify symptoms of depression in children. Each inventory contains 20 statements about thoughts, feelings or behaviours associated with emotional and social impairment in youth (Beck, Beck & Jolly, 2001). Although there were no indicators of depression in Katie's presentation, the depression inventory was administered due to anxiety symptoms being highly co-morbid with depression (Beck, Beck & Jolly, 2001).

The profiles obtained for these measures are attached in Appendix A. Both Katie and Pamela's SDQ rating indicated that Katie was experiencing elevated anxiety. However, there was some discrepancy in relation to their scores on the 'total difficulties' scale. Katie's total difficulties score was within the very high range while Pamela rated her as close to average. Katie's score on the Beck Anxiety Inventory for Youth was in the moderately elevated range compared to a standardised sample of her peers. Katie's score on the Beck Depression Inventory for Youth fell within the average range.

An examination of Katie's scores on specific items on the Beck Anxiety Inventory for Youth revealed that Katie displayed what Beck, Beck and Jolly (2001) refer to as a common core of negative and anxious affect that is characteristic of anxiety disorders, particularly generalised anxiety disorder. When examining the items on which Katie scored most highly, these were largely the items related to worrying.

Provisional Case Formulation

The provisional case formulation was that Katie was experiencing an anxiety disorder. This appeared to be most consistent with the criteria for generalised anxiety disorder, (although not formally meeting the criteria as the symptoms had only been evident for thirteen weeks), defined by the Diagnostic and Statistical Manual of Mental Disorders (IV-TR) as "excessive anxiety and worry, occurring more days than not for a period of at least six months, about a number of events or activities". Katie's level of symptomology could be described as moderate and as impacting on many areas of her life. The low correlation between Katie and her mother's assessment of her symptoms is not unusual (Beck, Beck & Jolly, 2001) and is consistent with the low rate of agreement commonly found between parent, teacher and child ratings of problems in child therapy research (Grave & Blissett, 2004). There were no signs of depression in Katie's presentation or any indication of suicidal or self-harming behaviour or any other risk issues. Although Katie's self-report also suggested problems with attention and concentration, this was not supported by other informants or by clinician observations. Therefore, these symptoms were considered to be a product of Katie's anxiety.

Katie's anxiety can be summarised using the cognitive model's five symptoms cluster. The behavioural aspects to her anxiety included avoiding

situations, crying and constantly seeking reassurance. The emotional components included high levels of worry, some irritability and sadness. The interpersonal elements included being dependent upon close friendships and relationships with adults, only feeling safe and able to manage with other people around her and having less time to spend with her peers due to reducing her out of school activities. When Katie experienced anxiety-provoking situations she reported experiencing physiological reactions such as stomach-aches, headaches and difficulty concentrating. Finally, Katie's cognitions suggested high anticipatory anxiety, including automatic thoughts such as "is my homework right", "what if something goes wrong in my next lesson", "what if Dad has a car accident at work" and "what if I get into trouble for being late". Katie's difficulty in controlling her worry was one of the core features in her presentation.

The development and maintenance of Katie's anxiety can be understood through the diathesis stress model. The diathesis in this case can be hypothesised to include a genetic predisposition to anxiety and reinforcement and modelling of anxiety within her family. In addition, her medical experiences as a young child occurred at a developmental stage when she was unlikely to have understood or had the ability cope with these, resulting in feelings of fear which may have led to the formation of a more general belief that the world is a scary place. The immediate stressors in this case included Katie no longer being in her familiar class group where she felt safe, increased school work and homework and not having appropriate problem solving and affect regulation skills. Katie's anxiety was being maintained by actively avoiding anxiety-provoking situations whenever possible, and her thinking style reflected cognitive distortions such as a tendency to catastrophise and predict failure or problems in situations without any evidence to support this. In addition

people such as parents, teachers and friends were contributing to the maintenance of Katie's anxiety by enabling her avoidance, being over-protective and reinforcing Katie's safety behaviours.

Therapeutic Contract and Plan for Therapy

The case formulation was shared with Katie and Pamela in order to aid collaboration (Friedberg & McClure, 2002), gain their reaction (Friedberg & McClure, 2002), and provide a shared vocabulary to understand Katie's difficulties (Reinecke, Dattilio & Freeman, 2003). Katie and her mother felt that the formulation did explain the problems that Katie was experiencing and was a reasonable basis upon which to proceed with therapy. I assessed that Katie would be able to effectively participate in CBT based upon: her ability to access and communicate her thoughts; her ability to generate alternative attributions of events; her awareness of her current emotions; and an ability to connect thoughts and feelings in different situations (Stallard, 2002). However, I recognised that, due to Katie's age and difficulties with concentration, therapy would need to be both interesting and developmentally appropriate. Developing creative and developmentally appropriate ways to engage adolescents in CBT is a common challenge for clinicians (Newman Kingery et al., 2006).

I explained what CBT would involve and Katie and Pamela were both positive about this intervention. Consistent with the notion that in CBT the child has a key role in target setting and decision making (Stallard, 2002) and in order to develop a collaborative relationship and build rapport and trust (Newman Kingery et al., 2006), I sought Katie's goals for therapy. These included: to feel more relaxed about doing homework; to feel more relaxed in lessons; and to feel comfortable and happier at school. In order to try and address some of the broader issues in Katie's

presentation, with her agreement I added the goal 'learning some ways to manage worries and anxiety about other things'.

These goals were incorporated into a written therapeutic contract. This was used due to the common experience, reported in the research component of this thesis, that therapy is an unfamiliar experience for children and that children are insufficiently integrated into the process of commencing therapy. The contract was used as a way of facilitating discussion about, and clarifying aspects of, therapy. This contract also outlined issues such as confidentiality, it estimated the length of intervention as twelve sessions and it outlined Pamela's role in therapy. In relation to the latter, there is not a framework guiding clinicians in planning for parental involvement in therapy, or empirical data on the optimal role of parents in intervention (Kendall & Choudry, 2003). In this case a balance was required. While Pamela's involvement in therapy would be crucial in addressing some of the family factors in Katie's presentation and in reinforcing the skills learnt (Kendall & Choudry, 2003), time for Katie alone was also important for establishing rapport and promoting self-efficacy (Newman Kingery et al., 2006). Conscious of the finding in the research component of the this thesis that children perceive that the modality of therapy is decided by the therapist, this issue was explicitly discussed and negotiated between Katie, Pamela and myself. It was then agreed that Pamela would attend every second therapy session with Katie, in the role of a co-clinician.

Overview of Therapy

Therapy with Katie consisted of nine sessions and a review session. The first seven sessions took place weekly, the following two fortnightly and the review session three weeks later.

Sessions One to Three

In the first therapy session there was an initial focus on Katie's readiness and motivation for change, utilising motivational interviewing techniques (Miller & Rollnick, 2002). This was in order to build both a therapeutic relationship and motivation and to help determine the focus of therapy (Stallard, 2005). This identified that while Katie felt motivated to try some new things, she was not very confident that she would be able to learn to manage her anxiety. Katie's motivation was consistent with the preparation stage of the Prochaska, DiClemente, Velicer and Rossi (1992) stages of change model.

Initial intervention included psycho-education, helping Katie and Pamela to understand Katie's anxiety from a cognitive behavioural model. This included information about the link between thoughts, feelings and behaviours, introducing the idea of self-monitoring and explaining that behaviours such as seeking reassurance and checking behaviours were safety behaviours that worked to maintain anxiety. Research is not yet able to inform the clinician as to whether to focus intervention on the emotional, cognitive or behavioural domain (Stallard, 2005). However, consistent with the common sequencing of standardised treatment manuals (Stallard, 2005), it appeared that a focus on the emotional and then the cognitive domain was most appropriate in this case. Intervention in the emotional domain included self-monitoring and teaching some basic strategies to help reduce somatic symptoms and to help Katie regulate her emotions when she was distressed. These included deep breathing, progressive muscle relaxation and the use of coping statements.

In the second and third sessions, intervention moved into the cognitive domain. The use of self-monitoring was extended to incorporate thought records,

cognitive distortions (thinking errors) were discussed and Katie was taught to identify when she was using thinking errors. By the end of session three Katie had a good understanding of thinking errors and could identify those that she commonly used. Pamela was very actively involved in helping Katie to think of examples of situations that had occurred during the week, which was helpful in countering Katie's dichotomous thinking. The issue of safety behaviours was also revisited and at the end of session two Katie set herself the goal of reducing the number of times that she went to the student office during the school day. In session three Katie reported that she had accessed the student office much less during the week, she was proud of this and it was used as an example of Katie's ability to regulate her own emotional state and use other coping skills. At this time pleasant event scheduling was also discussed.

Sessions Four to Six

Sessions four to six retained a largely cognitive focus, with clinician support provided for relevant behavioural changes. In session four, the idea of balanced thinking was introduced and Katie was taught how to incorporate this into the thought records and self-monitoring. By session five both Katie and Pamela were reporting significant improvements, including Katie being happier to be at school, hardly accessing the student office and coping well with the mock SAT exams. This is in keeping with findings that the first few intervention sessions constitute a period of rapid positive change (Kendall & Choudry, 2003). We agreed that symptom relief had largely been achieved and psycho-education was provided about the importance of addressing some of the more underlying issues in order to ensure sustainable change. Intervention then moved to identifying the cognitive assumptions underlying Katie's thoughts and behaviour using worksheets from Stallard (2002).

One of Katie's key assumptions was that if she did things perfectly then people would like her and want to be around her.

In session six Katie reported some minor difficulties that had occurred during the week, these were analysed using the thought record and Katie demonstrated an ability to challenge negative automatic thoughts and use more balanced thinking. In session six there was a focus on exploring Katie's core beliefs. This was somewhat challenging as, besides some insights from her early life, there had not been strong indicators of Katie's core beliefs. Therefore, this was explored using the Downward Arrow technique and a self-rating activity about common beliefs from Stallard (2002). Through these activities a tentative core belief was identified, 'the world is scary, things can be difficult and I can't manage on my own'. This links with Katie's assumption about needing to do things in such a way that people would want to be around her. When Katie was asked to rate the strength of this core belief she stated that her belief was ten out of ten at the start of therapy but this had now decreased to two out of ten.

Sessions Seven to Nine

In the final three sessions, intervention continued at the core belief level and in the development of new cognitive skills. Katie's core belief continued to be challenged by examining evidence not supporting this core belief. Katie was also encouraged to think of a new core belief that felt more true to her at the current time and how she wanted to be in the future. Katie and her mother developed the core belief 'I am confident and happy and I can solve any problems that arise'. Katie was given a positive data log to use to identify examples during the week that supported this new core belief.

In session eight the positive data log was reviewed. Katie had identified a number of examples of actions and situations that supported her new core belief. The upcoming SAT exams were discussed and Pamela's presence enabled testing of Katie's beliefs about her parents expecting her to do well at school. Katie and Pamela then identified some balanced ways to think about the exams, which Katie was encouraged to write down on flashcards for use at home. Problem-solving techniques were then discussed and Katie was taught a structured problem-solving technique which encouraged her to generate multiple solutions to different problems that she identified. The prospect of finishing therapy was also discussed, which Katie indicated that she felt ready for.

Session nine became the final therapy session. We again reviewed the positive data log which Katie had been using enthusiastically. She had been able to identify a number of situations in which she was happy, confident and able to solve problems, rating her strength of belief in the newly identified core belief as nine out of ten. The problem-solving technique was revisited and a real-life example worked through. Katie and Pamela confirmed that it felt like the right time to conclude therapy so the notion of relapse prevention, the importance of maintaining therapeutic gains and managing future recurrences of anxiety (Linares Scott & Feeny, 2006), was introduced. Relapse prevention in session nine focused on identifying potentially challenging situations in the future and discussing which CBT techniques would be most helpful in each situation.

Review Session

The review session took place three weeks after session nine, after Katie had finished her SAT exams. Katie and Pamela reported that Katie had taken her exams without feeling too anxious and that positive new behaviours were continuing to

occur, for example, Katie was no longer being walked to school by her grandmother. The remainder of the session was spent focusing on relapse prevention, specifically revising the skills taught through reviewing the handouts and worksheets used during therapy. Katie's gains and how these were achieved were also highlighted to try and increase her sense of accomplishment and confidence.

Outcomes of Therapy

The three self-report measures were administered again in the review session, the results of which are presented in Appendix B. Katie's self-ratings on the Strengths and Difficulties Questionnaire, formerly in the very high range for total difficulties and emotional symptoms, were within the 'close to average' range. The parent self-report also placed her within the close to average range. Katie's scores on the Beck Anxiety Inventory for Youth had decreased from the moderately elevated range to within the average range, and her score on the Beck Depression Inventory for Youth had remained in the average range.

At the end of therapy, school-based informants reported that Katie had excellent school attendance, was staying in all of her classes, was not appearing to be distressed at school, was significantly less reliant on teaching staff and had re-engaged with some after-school activities. Pamela reported that Katie was willingly attending school each day, was no longer distressed when completing her homework and seemed much happier and more relaxed. Katie also reported being much happier, less anxious and able to manage previously challenging situations. From a clinician perspective Katie showed a significant decrease in negative thinking and avoidance behaviour and she was able to demonstrate the use of new skills, such as affect regulation, problem-solving and balanced thinking.

Use of Supervision and Colleague Support

Clinical supervision was used to regularly review progress and issues in this case. In addition, this case was presented at a team meeting, enabling discussion and feedback from multi-disciplinary colleagues. As a part of the assessment I had a consultation with the Psychiatrist attached to the team about the GP's desire for psychiatric input. The Psychiatrist felt that there was nothing in Katie's presentation to suggest that this was needed and we jointly agreed that she would be likely to respond well to psychological input alone. This decision was discussed with the GP who was then in agreement.

Summary and Reflections

This case is an example of parental involvement in child-focused CBT. Clinically significant change was achieved in nine sessions of CBT. Katie's level of anxiety decreased from a moderate level to within the normal range. This change was achieved in less than the average twelve to sixteen sessions advocated by manualised CBT programs for children, however, it is in keeping with findings that significant change can be achieved within fewer sessions (Stallard, 2005). It may also be a reflection of the lack of co-morbidity in the case, the level of symptom severity being moderate rather than severe, no current parental psychopathology and Katie's core beliefs not being fully developed due to her age.

There were a number of strengths in this intervention including the achievement of a strong therapeutic relationship with both Katie and Pamela. The therapeutic stance adopted, namely to act as a resource rather than an authority figure or expert, appeared to have been experienced positively by both Katie and Pamela. In addition, flexibility in focusing on Katie's key concerns, drawing on Katie's interests in therapy and the use of appropriate clinician self-disclosure when discussing issues

such as problem-solving may have contributed to a positive therapeutic relationship. The therapeutic relationship is very important in CBT as it has been found to predict outcome for children at post-intervention (Hughes & Kendall, 2007). As discussed in the research component of this thesis, the therapeutic relationship is also cited by children as being very significant in their experience of therapy.

Other strengths in this case were that some connection was made with Katie's father and there was consultation and support offered to school staff, which contributed towards the adults in Katie's life decreasing anxiety-supporting behaviours. Being based in the school, the primary setting in which the problems were manifested (Newman Kingery et al., 2006), was advantageous in that it allowed for informal observation and the ability to work closely with multiple school staff. A final strength in this case was that therapy appeared to have been both interesting and developmentally appropriate for Katie. Care was taken to provide developmentally appropriate information and resources such as handouts and worksheets. This was also done to further support therapy being experienced as both 'nice and helpful' by Katie (which was found to be important in the research component of this thesis). However, despite the successful process and outcomes there were some clinical challenges. This case also offers some insights in relation to the literature on the effective components of a child-focused CBT intervention.

Clinical Challenges

While it was very useful to be based in the school setting, this was also a challenge. Being based in the school meant that there was a danger of being drawn into the school system, thereby perpetuating the existing issues and reducing the opportunity for effective intervention. One example of this is that after first meeting Katie I felt under some pressure from school staff to authorise a decision to place her

on a part-time timetable until she was more able to manage a full school day. This went against my own clinical judgement as I felt that this colluded with Katie's use of avoidance strategies and did not convey confidence in Katie's ability to cope in the situation. My decision not to support Katie being on a part-time timetable was openly questioned by some staff.

This case also highlighted how the environment in which you work can play a role in the therapeutic relationship (Bannan & Malone, 2002). In this case being easily assessable for two days a week contributed to Katie initially seeing me as another adult in her life who could protect her and someone that she could turn to for reassurance. This was something that I discussed in supervision and was more conscious of as therapy progressed. However, in retrospect I could have used the therapeutic relationship to work with these issues more explicitly. The therapeutic relationship can be used to increase a client's awareness of their own assumptions in relationships (Waddington, 2002) and can provide an opportunity to assess and modify a client's beliefs and assumptions (Bannan & Malone, 2002). If I had worked with these issues more explicitly it may have helped Katie to generalise this experience to other relationships in her life.

The second clinical challenge also related to working within the system surrounding the child, however in this case it related to attempts to involve Katie's father in therapy. I invited Katie's father to attend the first and subsequent sessions, however he was unable to do so because of work commitments. I also tried to involve Katie's father through homework assignments, however this was not successful. His lack of involvement in Katie's therapy was unfortunate given that there were indications that he may have been anxious himself and the effect of this

anxiety on Katie could not be explored, nor could I work with both parents in relation to helpful parental responses to Katie's anxiety.

The third clinical challenge was the temptation and subtle invitation to conclude therapy at the point when symptom relief was achieved (session 5). Katie's tendency towards dichotomous thinking meant that her self-reports on ratings scales were often either very high or very low. Her self-ratings by session five showed an apparently rapid recovery, however consistent with Stallard (2002) I interpreted this as more of a reflection of her dichotomous thinking rather than a sign of lasting improvement. It is also possible that it may have been due to Katie, like other anxious children, being eager to please adults and 'fake good' (Kendall & Chansky, 1991).

Effective Components of Child-Focused CBT Interventions

As previously stated neither the mix of cognitive versus behavioural or family intervention strategies, nor the relative contributions of specific intervention components, nor their optimal timing and sequencing are known (Stallard, 2005). Research is also unable to specify the optimum combination of various CBT techniques for different presenting problems or populations (Grave & Blissett, 2004). However, this case does raise some interesting issues in relation to three of the components thought to be central in child focused CBT, namely behavioural exposure, homework tasks and the role of the parent in therapy.

The role of behavioural exposure has been highlighted in child-focused CBT. Some studies suggest that it is the most important ingredient in CBT (Newman Kingery et al., 2006) while others suggest that the cognitive component of CBT is not effective in bringing about change without behavioural exposure (Stallard, 2005). However, in this case while behavioural changes were discussed and encouraged,

formal behavioural exposure, the use of behaviour contracts or a formal rewards system were not used. Initially this was due to Katie's lack of confidence in her ability to make changes, then later it was assessed that Katie had sufficient interest, motivation and parental support to make appropriate changes as she felt able. It may be that clinician support for reducing safety behaviours and increasing age-appropriate behaviours had a similar effect to formal behavioural exposure, in that it gave Katie the chance to test out her predictions through practice and habituate to fear (Friedberg & McClure, 2002). Alternatively, this study may provide support for Fonagy et al. (2002) who cited two well-designed studies on intervention with school phobia which found that therapeutic support without exposure was equally effective.

Homework tasks are considered a core component of CBT as they allow children to experiment with skills in real-life contexts (Friedberg & McClure, 2002). However, in this case, despite Katie following up on ideas between sessions, formal homework tasks were regularly not completed. There may have been a number of reasons for this such as: Katie's difficulties with organisation; Katie not perceiving the tasks as relevant or important; her initial lack of confidence in her ability to make changes; and her possible ambivalence once symptom relief was achieved. Therapy was successful despite the lack of homework completion which is in keeping with Stallard's (2005) view that, while important, the completion of homework assignments is not essential in child-focused CBT. Similarly, Hughes and Kendall (2007) found that homework compliance did not predict CBT outcome for children.

Finally, this case offered some reflections on the role of the parent in therapy. Pamela's role was most consistent with the position of the parent being a co-clinician (Stallard, 2005). Pamela's involvement and perspective were valuable in that it allowed discussion of parental behaviours and Pamela was able to support Katie's

use of balanced thinking and problem-solving. It is hypothesised that she would also be helpful to Katie in relapse prevention. This case provides support for the idea that parental involvement in child-focused CBT may be more beneficial if parents participate in the intervention session with the child (Stallard, 2005).

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Appendix A

Results of Standardised Assessment Tools Administered Pre-Therapy.

Strengths and Difficulties Questionnaire-Youth Self-Report Form

Total difficulties score	24	Very high
Emotional symptoms score	8	Very high
Conduct problems score	4	Slightly raised
Hyperactivity score	8	Very high
Peer problems score	4	High
Pro-social behaviour score	6	Slightly low

Strengths and Difficulties Questionnaire – Parent Report Form

Total difficulties score	10	Close to average
Emotional symptoms score	7	Very high
Conduct problems score	1	Close to average
Hyperactivity score	2	Close to average
Peer problems score	0	Close to average
Pro-social behaviour score	10	Close to average

Beck Youth Inventories	T Score	Severity Level
Beck Anxiety Inventory for Youth	61	Moderately Elevated
Beck Depression Inventory for Youth	50	Average

Appendix B

Results of Standardised Assessment Tools Administered Post-Therapy.

Strengths and Difficulties Questionnaire-Youth Self-Report Form

Total difficulties score	7	Close to average
Emotional symptoms score	0	Close to average
Conduct problems score	1	Close to average
Hyperactivity score	4	Close to average
Peer problems score	2	Close to average
Pro-social behaviour score	10	Close to average

Strengths and Difficulties Questionnaire – Parent Report Form

Total difficulties score	8	Close to average
Emotional symptoms score	2	Close to average
Conduct problems score	2	Close to average
Hyperactivity score	4	Close to average
Peer problems score	0	Close to average
Pro-social behaviour score	8	Close to average

Beck Youth Inventories	T Score	Severity Level
Beck Anxiety Inventory for Youth	35	Average
Beck Depression Inventory for Youth	35	Average

SECTION D
CRITICAL REVIEW OF LITERATURE

A REVIEW OF THE CURRENT AND POTENTIAL USES OF MOTIVATIONAL INTERVIEWING WITH CHILDREN

Introduction

This final component of the thesis examines the current and potential contribution of motivational interviewing to clinical work with children.

Motivational interviewing (MI) is a client-centred, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence (Miller & Rollnick, 2002). MI has been described as a 'relative newcomer' to psychotherapy (Arkowitz & Westra, 2004). It was first described in the literature by Miller in 1983 and was originally used as a prelude to intervention, to help people to work through ambivalence in relation to alcohol use and commit to change (Hettema, Steele & Miller, 2005). It was then developed into a coherent theory and a detailed description of clinical procedures (Miller & Rollnick, 1991). Miller and Rollnick (2002) describe MI as an evolution of Carl Rogers' client-centred approach, in that it is a supportive counselling style that focuses on the concerns and perspectives of the individual. However, they note that it differs from the work of Rogers in that it is consciously directive, targeting the resolution of ambivalence towards a particular direction of change. MI also draws upon Bem's self-perception theory and it utilises cognitive behavioural strategies targeted to the client's stage of change (Burke, Arkowitz & Menchola, 2003). As such, MI integrates the use of therapeutic factors and knowledge/skill development, which was highlighted in the research component of this thesis as being important to a child having a satisfactory experience of therapy.

The four general guiding principles of MI are: to express empathy; develop discrepancy between the client's present behaviour and broader goals and values; roll with client resistance; and support self-efficacy (Miller & Rollnick, 2002). In

practice MI has two phases; phase one involves building intrinsic motivation for change while phase two involves strengthening the clients commitment to change and developing a plan to accomplish it (Miller & Rollnick, 2002). The authors outline specific methods that are useful in each phase, for example in phase one they describe the use of open questions, affirming, reflecting, summarising and eliciting change talk. One of the major developments in MI was to link it to the transtheoretical model of change (DiClemente & Prochaska, 1982) which developed in parallel with MI (Britt, Blampied & Hudson, 2003). MI is normally brief and can be used as a freestanding intervention or as a motivational prelude to other intervention (Hettema, Steele & Miller, 2005).

Hettema, Steele and Miller (2005) conducted a meta-analysis of seventy-two studies which tested the efficacy of MI across a range of behaviour domains. They concluded that MI generally shows small to medium effects in improving health outcomes across a range of problem areas, with the strongest support for MI in the area of substance abuse. Large effects were found for MI in promoting treatment engagement, retention and adherence. The effects of motivational interviewing were seen early, with a gradual decrease of effect size across time when used as a freestanding intervention. MI was found to be effective as a stand-alone intervention and to improve outcomes when added to other intervention. However, Hettema, Steele and Miller found a wide variability in effect sizes across studies and within problem areas, even when there have been extensive efforts to standardise training and intervention procedures. They also found few reliable correlates of effect size.

The results of the Hettema, Steele and Miller (2005) analysis were largely consistent with the existing literature. Rubak, Sandboek, Lauritzen and Christensen (2005) found that an effect for MI was demonstrated in 75% of the randomised

controlled trials included in their review, regardless of whether the problems were psychological or physiological. They found a dose effect for both the length of session and number of sessions and that a follow-up period shorter than three months increases the risk of therapy failure. MI has generally proven to be superior to no-treatment control groups and less credible alternative treatments, and equal to viable comparison treatments (Burke, Arkowitz & Dunn, 2002). MI has been found to achieve similar effect sizes to much longer interventions (Britt, Blampied & Hudson, 2003), suggesting that it may be more cost-effective (Burke, Arkowitz & Menchola, 2003). MI has been shown to be particularly useful with clients who are less motivated or ready for change and who are more angry or oppositional (Britt, Blampied & Hudson, 2003).

One of the populations to which MI's use has been extended, and the focus of this review, is with children. The use of MI with children is relatively new, with much of the interest based on promising research outcomes when using MI with adult populations, as well as the ongoing challenge of providing effective services for children (Baer & Peterson, 2002). Researchers have discussed that MI can be effective with children because it: can be used in settings where children typically present (Stern, Meredith, Gholson, Gore & D'Aminico, 2007); can be helpful in outreach and initial engagement (Baer & Peterson, 2002); and can be used to address adherence and retention obstacles (Berg-Smith et al., 1999), particularly the high attrition rate in some adolescent intervention programs (Baer & Peterson, 2002). The brief format of MI is helpful given that many children drop out from extended intervention or are unwilling to commit to more extensive forms of intervention (Breslin, Li, Sdao-Jarvie, Tupker, Ittig-Deland, 2002). Some of the features of MI are thought to be especially appropriate to children, such as emphasis on personal

responsibility, increasing self-efficacy and avoidance of an authoritative stance (Britt, Blampied & Hudson, 2003). In MI, the child is an active participant (Stern et al., 2007), who is viewed as the expert (Walker, Roffman, Stephens, Berghuis & Kim, 2006), in charge of change, selecting their own goals and the process by which they are achieved (Channon, Smith & Gregory, 2003).

MI is proposed to be appropriate to children's developing identity and desire to assert independence (Erickson, Gerstle & Feldstein, 2005), common experience of ambivalence (Baer & Peterson, 2002) and developing autonomy (Baer & Peterson, 2002). The client-centred style and emphasis on choices in MI does not increase resistance and it may circumvent children's usual reactions to adult figures (Berg-Smith et al., 1999). The curious and non-judgemental stance adopted in MI makes it less likely that children will tell clinicians what they want to hear, leading to the use of inappropriate interventions (Bandura Cowley, Farley & Beamis, 2002). MI may be particularly helpful when client resistance is high or children are attending therapy due to outside pressure (Breslin et al., 2002). It is hypothesised that MI may be particularly helpful in the initial therapy sessions by counteracting the impact of some of the micro and macro conditions, identified in the research component of this thesis, that are present for children at the commencement of therapy. For example it may more quickly reduce the level of discomfort experienced by children, encourage them to engage in therapy and help them to formulate their own goals for therapy.

The aim of this review is to explore the current and potential uses of MI with children. The chapter will review empirical literature examining applications of MI with children across all behaviour domains. The effectiveness of the interventions will be discussed, with the limitations of the research and future research needs

highlighted. Then, after reflecting on the use of MI in adult mental health, it will be proposed that MI has a potential role in child and adolescent mental health.

Search Strategy

This review examined articles on the use of MI with children. A search of electronic databases using Proquest5000 was undertaken: this search examined scholarly journals, magazines, trade publications, newspapers and dissertations. In conducting this search the option search 'all databases' was selected, thus commonly used databases in this field, such as PsycINFO and Medline, were included in the search. The search terms were chosen to encapsulate the keywords cited by published articles on motivational interviewing and used various combinations of the terms motivational interviewing, child*, adolescent, mental health. This search was restricted to articles in English. A fortnightly email alert system was utilised to notify the author of any articles that may be added in the future using the identified search terms. In addition to the above, the official MI website www.motivationalinterviewing.org was used. The bibliography on the website and those of previous reviews were searched by hand to ensure that all relevant articles had been identified. The two MI texts by Miller and Rollnick were obtained. Finally, a number of authors were approached regarding research that was in press.

The inclusion criteria for this review followed the general guidelines commonly used in reviews of psychotherapy in that the intervention had to consist primarily of implementing MI, in an individual and face-to-face format (Burke, Arkowitz & Menchola, 2003). However, it was not an inclusion criteria of this review that studies had to be randomised controlled trials, as the use of MI with children is a very new field and many studies are pilot studies rather than randomised controlled trials.

It was difficult to set an upper age limit for inclusion in this review as studies varied greatly in this respect. It was decided to set the age limit for inclusion at eighteen years as this reflects the client group in Child and Adolescent Mental Health Services (CAMHS) in England. The National Child and Adolescent Mental Health Service Mapping Exercise in 2005 indicated that nineteen to twenty-five-year-olds comprise only two percent of the client group for tier two and tier three CAMHS services in England (Barnes, Appleby & Parker, 2006). A secondary reason for this age limit is due to emerging evidence that there may be a difference in how younger and older adolescents respond to MI (Spirito et al., 2004). An exception to the inclusion criteria was made in order to include the Walker et al. (2006) study. This study had an upper age limit of nineteen years, however the participants were all secondary school students, seen in a school setting and the mean age was 15.75 years. It is recognised that, by setting the age limit at eighteen years, a number of relevant studies were excluded from this review.

Ten studies met the inclusion criteria for this review, with all studies published after 1998. Of the ten studies, four studies were randomised control trials and one was a case study.

Current Uses of MI with Children

The first goal of this review was to examine the current uses of MI within child populations. This review included studies across all behaviour domains for which the efficacy of MI with children has been investigated. This differentiates this review from the two previous reviews on the use of MI with children or adolescents, which focused on the application of MI to substance use (Baer & Peterson, 2002) and paediatric health care (Erickson, Gerstle & Feldstein, 2005).

The basic characteristics of each study are outlined in Appendix A. Studies were coded according to their problem area, treatment setting, format and dose of MI. Methodological features such as sample size, study design, dependant measures and follow-up were also coded. The studies examined the use of MI within the following behavioural domains: contraceptive use (1), dietary intake (1), smoking cessation (2), disaffection at school (1), diabetes care (1), marijuana use (2), substance use (1), and alcohol use (1). In two studies the use of MI was combined with another form of therapy, namely narrative therapy (Bandura Cowley, Farley & Beamis, 2002) and cognitive behaviour therapy (Dennis et al., 2004).

Nine of the ten studies took place in outpatient settings, most of which were medical settings including an adolescent health clinic and an accident and emergency department. Three of the studies were set in secondary schools. Samples sizes ranged from one participant to six hundred participants. The age range of the participants was twelve to nineteen years. When a mean age was cited in studies, this ranged from 15.6 years to 16.4 years. Nine of the ten studies examined the use of MI with both males and females and where specified it appeared that the samples were reasonably ethnically diverse. The severity of the populations studied could be largely described as high risk in relation to the specified issue, for example, extreme risk for early childrearing (Bandura Cowley, Farley & Beamis, 2002), high risk of co-occurring psychiatric and substance use disorders (Brown et al., 2003) and serious cannabis-related disorders (Dennis et al., 2004).

Some studies reported a low participant take-up of the intervention, for example 40 participants were eligible for participation and 25 agreed to take part (Channon, Smith & Gregory, 2003). However, in other studies participants volunteered to be involved and a high take-up was reported (Walker et al., 2006).

Seven studies discussed the issue of attrition rates and these varied from 6% (Dennis et al., 2004) to 32% (Knight et al., 2004). Three studies compensated participants or used an incentive (Dennis et al., 2004; Spirito et al., 2004, Walker et al., 2006).

The use of comparison groups differed across studies, with four studies not using a comparison group. Of the six studies that did use a comparison group, two used a no-treatment group, three used a less likely to be effective treatment (brief advice or standard care) and one used other active treatments (Dennis et al., 2004).

The number of outcome measures ranged from one questionnaire and a clinical interview (Bandura Cowley, Farley & Beamis, 2002) to studies that utilised a comprehensive assessment battery. Seven studies utilised both direct and indirect outcome measures, while three studies utilised only indirect measures (questionnaires).

Most studies specified some of the characteristics of the MI intervention used, while a small number of the studies simply stated that they utilised an MI or motivational enhancement therapy (MET) intervention. The number of MI sessions used ranged from one to thirteen sessions, with a duration ranging from five minutes to sixty minutes. When MI was combined with another therapy, it was sometimes difficult to specify how much time was committed specifically to MI.

Descriptions of the measures used to ensure treatment fidelity varied. Eight studies cited the use of measures including clinician training in MI, the use of pilot cases, the use of a manual, follow-up practice, regular supervision and the use of self and supervisor adherence rating forms.

The Efficacy of MI with Children

The second goal of the review was to analyse the efficacy of MI with children. In addressing this goal the efficacy of MI will be examined as both a stand-

alone intervention and a prelude to other intervention. The impact of the intervention will be discussed in relation to both the target symptom and other measures, such as the social impact of the problem. Initial versus sustained efficacy, cost-effectiveness and potential mechanisms for change will also be examined.

Efficacy as a Stand-Alone Intervention

Reviewing MI as a stand-alone intervention allows one to examine to what degree it is efficacious as an intervention in itself (Burke, Arkowitz & Menchola, 2003). Nine of the ten studies in this review examined the use of MI as a stand-alone intervention. Seven of the nine studies reported that the MI intervention did bring about a positive change in the target symptom. Examples include: improvements in school attendance, punctuality and confidence with school work (Atkinson & Woods, 2003); a decision to trial hormonal methods of contraception (Bandura Cowley, Farley & Beamis, 2002); a reduction in the consumption of dietary cholesterol (Berg Smith et al., 1999); and a reduction in smoking (Kelly & Lapworth, 2006). Some of the authors suggest that the effect sizes achieved were modest in size (Kelly & Lapworth, 2006; Walker et al., 2006). Two studies reported that MI had equivalent rather than better outcomes compared to brief advice (Brown et al., 2003) or other active treatments (Dennis et al., 2004).

Most studies reported a mixed or a complex pattern of findings. There was some support for the notion that MI is most successful, and in some cases only successful, with people with more serious or problematic behaviours (Knight et al., 2005; Spirito et al., 2004). This was hypothesised to be related to: greater recognition of the seriousness of the problem (Knight et al., 2005); an improvement being reported in order to avoid further intervention (Knight et al., 2005); and because those with less serious behaviours showed low rates of the behaviour at both baseline

and follow-up (Spirito et al., 2004). In addition, when an effect was found for MI, there was often not an improvement on all variables (Spirito et al., 2004) and in some cases an increase in the problematic behaviour was found for some participants (Knight et al., 2005). There were also mixed findings in relation to the effect of MI on social impact measures, two studies reported a positive impact on these variables (Atkinson & Woods, 2003; Channon Smith & Gregory, 2003), however, one study reported no improvement (Spirito et al., 2004).

Some of the studies discussed the achievement of clinical or meaningful change, as opposed to purely statistically significant change. Walker et al. (2006) reported that meaningful change was achieved by 45% of participants in the MI condition and 33% of the control conditions. Similarly, Kelly and Lapworth (2006) and Bandura Cowley, Farley and Beamis (2002) highlighted the important clinical impact of the intervention on those participants for whom there were positive results, particularly when the sample was on an upward trajectory of problems (Kelly & Lapworth, 2006) or when the decision to change a behaviour had very significant consequences for the child (Bandura Cowley, Farley & Beamis, 2002).

Efficacy as a Component of a Combined Intervention

The use of MI as a prelude and/or adjunct to further services allows one to examine the degree to which MI may be a catalyst that enhances the efficacy of another intervention (Burke, Arkowitz & Menchola, 2003). Dennis et al. (2004) compared five short-term interventions for adolescents with cannabis use disorders. Two of these involved two individual sessions of MET followed by either three or ten group cognitive behaviour therapy (CBT) sessions. The study found that all five conditions demonstrated significant post-intervention affects that were stable in terms of increasing days of abstinence and the percentage of adolescents in recovery.

Effect sizes were generally small, however moderate to large cost-effectiveness differences were found.

Initial and Sustained Efficacy

Most studies were only able to measure the initial efficacy of MI, as they used a pre and post-intervention design. However, three studies did utilise multiple follow-up intervals. These studies found short terms gains in relation to some aspects of the target behaviour, however, mixed support for the sustained efficacy of MI. Spirito et al. (2004) found a sustained reduction in alcohol quantity at the three, six and twelve month follow-up periods. However, sustained efficacy was not demonstrated on other variables, such as alcohol-related problems. Similarly, Kelly and Lapworth (2006) found sustained efficacy on some variables (self-efficacy) but not others (quantity and frequency of smoking). Finally, Dennis et al. (2004) found that while the interventions maintained and increased gains in relation to abstinence and percentage of adolescents in recovery, half of the adolescents went in and out of periods of recovery and relapse and two thirds still reported substance use or related problems at the twelve-month follow-up.

Cost and Time Effectiveness

Dennis et al. (2004) directly analysed the clinical effectiveness, cost, cost-effectiveness and benefit cost of the five different interventions in their study. They found that two sessions of MET and three of CBT were the most cost-effective in trial one and second most cost-effective in trial two, with cost-effectiveness differences being moderate to large. Dennis et al. found limited evidence that simply increasing the dosage of treatment had a differential effect on substance use and associated problems. Other authors reported that the gains achieved in a brief MI intervention compared favourably with a much longer intervention (Kelly &

Lapworth, 2006) and that the potential benefit of MI is quite high in comparison to the low intensity of the intervention (Knight et al., 2005).

Mechanisms of Change

Five of the ten studies directly measured constructs that may reflect potential mechanisms of change in MI. These constructs included measures of: self-efficacy (Brown et al., 2003; Kelly & Lapworth, 2006; Walker et al., 2006); intention to change (Brown et al., 2003); commitment to change (Atkinson & Woods, 2003); and readiness to change (Berg Smith et al., 1999; Channon Smith & Gregory, 2003). These constructs were most often measured using a symptom-specific questionnaire, such as the Smoking Situational Confidence Questionnaire (Brown et al., 2003) and the Diabetes Readiness to Change Questionnaire (Channon, Smith & Gregory, 2003). Four of the five studies reported that the intervention led to a positive change in the measure. However, there were some conflicting findings, including some movement in readiness to change in the direction of a reduced readiness for change (Channon, Smith & Gregory, 2003). Brown et al. (2003) found an interaction with participant's pre-intervention scores, with stronger effects for those who initially had little intention to change, more minimal effects when there was already an intention to change and in one study a slight reduction in intention to change among those with the highest level of intent to change upon admission. The five studies found that increases in these measures were only modestly related to outcome.

Satisfaction with MI

There was qualitative evidence that MI was an acceptable intervention for children. Clinicians reported that adolescents liked being treated as adults and they seemed particularly responsive to the opportunity to express their own choices (Berg-Smith et al., 1999). Kelly and Lapworth (2006) reported that children indicated that

the MI intervention was a more positive, non-judgemental and helpful process than they were expecting. However, a criticism of the literature is that the acceptability of the intervention to children was more often based on indirect measures of client satisfaction such as participation and retention rates. An exception to this was Channon, Smith and Gregory's (2003) finding. This study used a post-intervention satisfaction questionnaire with a seven-point scale and found that 79% (n=15) of respondents rated the helpfulness of the intervention as a 6 or 7. There was also some evidence that clinicians found MI to be an acceptable intervention for children. Clinicians were enthusiastic about having a new repertoire of strategies for working with ambivalent participants (Berg-Smith et al., 1999) and found MI successful in engaging or re-engaging a difficult to reach population (Berg-Smith et al., 1999; Walker et al., 2006).

Limitations of the Research

The lack of a control or comparison group in four of the studies means that the results need to be viewed cautiously. It is unclear whether changes can be attributed to the intervention or factors such as regular contact with the researcher (Channon, Smith & Gregory, 2003), the passage of time (Channon, Smith & Gregory, 2003), or the therapeutic effects of assessment alone (Knight et al., 2005). In studies that combined the use of MI with another active intervention, the reader is unable to ascertain the relative contribution of MI. Finally, the use of a pre and post-test design in most studies meant that they were unable to look at the long-term impact of the intervention.

Predominantly small samples resulted in studies being unable to look at the effects of MI in particular sub-groups, for example, stratified by age, gender or motivation for change. All of the studies used a self-selected sample or a sample that

was already accessing a clinic or service. It could be argued that this is more likely to result in a more potentially motivated sample, as it excludes non-attenders and those who prematurely terminate their involvement. The relatively high refusal rate in some studies (Brown et al., 2003) might also have led to an over-representation of children who were motivated to change. Bias is also possible from attrition. For these reasons the findings may not generalise to other populations of children.

There were also limitations due to the measures utilised. Some of the studies relied solely on self-report measures and not all studies included a broad assessment of the impact of the intervention, leading to a potentially incomplete evaluation of outcomes. Some studies questioned whether their assessment measures were sensitive enough to detect any behavioural changes that took place (Channon, Smith & Gregory, 2003).

An overall criticism of the studies reviewed is the lack of discussion of the developmental issues associated with utilising an adult intervention with a child population. This is in contrast to the view that tailoring MI may be necessary when working with children and the recognition that a child population presents particular clinical challenges (Baer & Peterson, 2002). Only one study mentioned developmental factors: Channon, Smith and Gregory (2003) stated that consideration was given to the need to adapt MI for adolescents but no specific changes were felt to be necessary. Given the lack of information in this area it could have been useful if the researchers had outlined the factors that were considered in making this assessment. None of the studies sampled primary school aged children, suggesting that researchers are making some implicit judgements about the developmental appropriateness of the intervention. The field would benefit from an explicit discussion of developmental considerations, in order to ascertain if there is a lower

age limit in the use of MI. Further attention is also needed to any ethical issues that may arise when using MI with children.

Summary and Future Research

The research on the use of MI with children provides converging evidence that MI is a promising intervention for children. Its use to date has been predominantly in the areas of health behaviours and substance use, where there has been some support for its efficacy as both a stand-alone intervention and a component of a broader intervention. However, there have also been mixed findings in relation to the impact of MI on both the target variable and measures of social impact. While initial efficacy was largely demonstrated, only a small number of studies examined the issue of sustained efficacy and these results were mixed. There was some evidence to suggest that MI is a cost-effective intervention and there was qualitative evidence supporting its use with children. Many of the findings in the child literature are consistent with the findings in the adult literature, however, these findings must be viewed cautiously given the small number of studies and relatively modest effects obtained.

Given the mixed outcomes in both the adult and child literature, future research is needed to clarify the mechanisms for change in MI and to examine the factors that moderate and mediate its effects. Future research should examine how these may differ for children compared to adults. Research needs to address fundamental issues such as optimal intervention length and whether improvements can be maintained long term. Future research also needs to address developmental issues, such as which MI strategies may be more or less effective with clients of different ages (DiGiuseppe, Linscott & Jilton, 1996) and to assess the optimal level of parental involvement in intervention. Research is needed to develop and test MI

intervention manuals specifically for children and adolescents, differentiated by age. Future research also needs to examine new developments proposed to increase the effectiveness of an MI intervention with children, such as using a more flexible tailored approach to delivering feedback (Apodaca, Abrantes, Strong, Ramsey & Brown, 2007). As was highlighted in the research component of this thesis, research with children examining their experiences of MI could make a valuable contribution to increasing our understanding of this approach and increasing the ability of clinicians using MI to offer a more effective therapeutic experience. Future studies should ideally involve larger sample sizes, comparison groups including other active treatments, a longer follow-up period and the use of more detailed and broad outcome measures. There is a need to improve the internal validity of studies, as has also been highlighted in the adult research (Burke, Arkowitz & Menchola, 2003), in order to have greater confidence in findings.

It is suggested that clinical case studies and theoretical papers from practitioners experienced in the use of MI with children are needed to refine the knowledge base in this area. Such papers could examine both macro issues, such as the essential elements of an MI intervention, and micro skills, such as how to structure a session. It would be particularly useful to examine how to adapt MI for different age groups and to explore the role of the therapeutic relationship in MI interventions with children.

The use of MI in Adult Mental Health

With growing support for the use of MI across a diverse range of areas, one of the current challenges is to determine where MI is applicable and where it is not (Miller & Rollnick, 2002). One such area is the field of mental health. MI has developed largely outside the field of mental health and literature in this area is

sparse (Chanut, Brown & Dongier, 2005). However, theory and research suggests that MI might be a useful approach for psychological disorders such as anxiety and mood disorders (Burke Arkowitz & Dunn, 2002). MI holds pragmatic appeal for mental health practitioners (Chanut, Brown & Dongier, 2005) in working with a client population who may be ambivalent about intervention, where drop-out rates can be high, compliance with intervention poor (Humfress, 2002) and remission and relapse common (Baker Towell, Woodford, Redi, Rooney & Towell, 2001).

There is also interest in MI because it is consistent with postmodernist paradigms, emphasising collaboration and client empowerment (Britt, Blampied & Hudson, 2003). It is consistent with evidence-based practice, and with the trend towards time-limited mental health interventions it can be helpful in focusing client and clinician efforts (Chanut, Brown & Dongier, 2005). The philosophy of MI has also been proposed to contribute to a more respectful and collaborative environment within a mental health setting (Chanut, Brown & Dongier, 2005). This section of the review will provide a brief overview of the research and theoretical support for the use of MI in mental health.

Research Supporting the use of MI in Mental Health

MI has been used in a range of ways with clients experiencing mental health issues including: to promote readiness for change prior to intervention (Baker Towell et al., 2001); during the initial interview/assessment phase (Humfress et al., 2002); as an initial phase of a multi-component intervention (Barrowclough et al., 2001); and integrated as a part of another intervention (Barrowclough et al., 2001). Chanut, Brown and Dongier (2005) reviewed 30 studies published after 1996 examining the efficacy of MI with psychiatric patients: most studies examined issues of dual diagnosis, the most common Axis 1 diagnosis being schizophrenia or mood disorder.

Chanut, Brown and Dongier described the findings as preliminary but promising, concluding that MI can: improve engagement in inpatient or outpatient intervention; lead to some positive reductions in alcohol or substance misuse in a dual diagnosis population; and increase medication compliance. However, they noted that, with one exception, the treatment effects found in dual diagnosis populations were more modest than those found in nonpsychiatric populations. Chanut, Brown and Dongier warned that the literature suffers from numerous methodological limitations, including a very heterogeneous sample in relation to intervention setting, type of substance use and psychiatric categories. They discussed the practical difficulties in using MI in mental health, which included the in-depth training and long term commitment required to ensure intervention fidelity, and that MI requires a paradigm shift that contradicts the psychiatrist's role as expert. However, they concluded that MI offers a complement to usual psychiatric intervention and is able to be delivered in a wide range of inpatient and outpatient mental health settings.

Theoretical Support for the use of MI in Mental Health

The theoretical factors that support the use of MI in mental health include: a proposed link between client motivation, intervention adherence and outcome; theoretical support for MI as a prelude to or integrated with other mental health interventions; and theoretical support for the idea that MI can enhance the therapeutic alliance.

The Link Between Motivation, Intervention Adherence and Outcome

Possibly the most common argument for using MI in mental health is to improve adherence with the intervention. Interest in the role of motivation in intervention adherence is related to common features of mental health conditions such as ambivalence about intervention (Britt, Blampied & Hudson, 2003) and poor

insight (Rusch & Corrigan, 2002), which are thought to be central to the outcome of intervention (Rusch & Corrigan, 2002). MI has been said to hold potential for improving outcomes because it links intervention adherence to the person's own goals and encourages people to actively consider their situation (Rusch & Corrigan, 2002). MI can also develop a person's readiness to participate more actively in their therapy (Rusch & Corrigan, 2002), which is relevant as research has found that clients who begin intervention in the action stage show greater improvement than clients in the contemplation stage (Baker Towell et al., 2001). However, while the research suggests that intervention adherence is related to outcome at discharge, research is lacking as to whether adherence is related to long term outcome (Baker Towell et al., 2001).

Support for MI as a Prelude to or Integrated with Other Interventions

MI is thought to work well as a prelude to or in combination with other mental health interventions, the goal of which is to increase the overall effectiveness of intervention. Arkowitz and Westra (2004) suggest that if the significant undertreatment of anxiety and mood disorders is related to ambivalence about the need for intervention then MI may improve the utilisation rates of intervention. Arkowitz & Westra (2004) proposed that clinical indicators suggesting that clients may benefit from MI as a prelude to other intervention include a strong ambivalence about change, resistance to suggested change methods, a history of repeated intervention or change effort failures, low optimism about change and little commitment to change talk.

There is greatest theoretical support for the integration of MI with CBT. MI may be highly complementary to CBT as the MI focus is on preparing people for change whereas CBT provides the active tools and strategies for producing change

(Westra, 2004). MI may contribute to CBT by: increasing intrinsic motivation for change; working with ambivalence about change or resistance; contributing to the nature of the therapeutic relationship; and establishing when and how change methods are introduced (Arkowitz & Westra, 2004). MI can be used with CBT non-responders and integrated throughout CBT (Arkowitz & Westra, 2004). When MI is used with CBT it is proposed that stage-matched therapy is used. Individuals in pre-contemplative and contemplative stages of change may be more suited to MI, while clients in the preparation or action stages might benefit from the introduction of skills-based techniques (Baer, Kivlahan & Donovan, 1999; Westra, 2004).

Support for the Contribution of MI to the Therapeutic Alliance

MI may also be able to contribute to the establishment of a positive therapeutic alliance. MI has been suggested to be helpful in the initial engagement of clients who are unwilling to take a more active approach to their care (Westra, 2004) and as a way of obtaining agreement on the tasks of therapy (DiGiuseppe, Linscott & Jilton, 1996). MI can also be used throughout the therapeutic process to enhance the therapeutic alliance, particularly during periods when client motivation is waning (Arkowitz & Westra, 2004). Arkowitz and Westra (2004) also suggest that a shift to MI in the face of client resistance could help avoid an unproductive struggle between clinician and client.

Adaptations Needed for Mental Health

It is recognised that some clients with mental health conditions may suffer from disordered thinking and/or cognitive impairments including problems with abstract reasoning, concentration and working memory (Handmaker, Packard & Conforti, 2002). Therefore, MI strategies may need to be adapted and the methods made more concrete to limit demands on memory and attention (Rusch & Corrigan,

2002). Clinicians may also focus on the particular consequences of a problem behaviour that have an obvious impact on the person rather than more general motivational issues (Rusch & Corrigan, 2002). It has also been suggested that it is helpful to suspend the expert stance and diagnostic preoccupation that is common in mental health professionals (Chanut, Brown & Dongier, 2005).

Summary and Future Research

The MI literature in the area of mental health suffers from similar shortcomings as the broader MI literature, including small sample sizes (Barrowclough et al., 2001), a lack of long term follow-up (Barrowclough et al., 2001), and a lack of objective data explaining the specific MI mechanisms (Chanut, Brown & Dongier, 2005). Specific criticisms are that mental health issues are rarely the focus of MI intervention in dual diagnosis populations and that much of the research sampled clients with severe and enduring mental illness. For these reasons there have been questions regarding how generalisable the current findings are to other mental health populations (Barrowclough et al., 2001). Future research is needed to examine how MI can most effectively contribute to mental health interventions.

A Case for the use of MI in Child and Adolescent Mental Health

On the basis that MI is a promising intervention with children and in the field of adult mental health, it is suggested that MI may be able to make an effective contribution to child and adolescent mental health. This literature review did not identify any studies that have examined the use of MI in child and adolescent mental health, however a number of studies have examined the role of client motivation in this area (Gowers & Smyth, 2004). An internet search using the key words 'motivational interviewing CAMHS' provides evidence that MI is currently being

utilised in child and adolescent mental health services (CAMHS) in the United Kingdom. This includes the provision of training on MI for CAMHS settings (Royal College of Psychiatry, 2004; CAMHS North Wales Annual Conference, 2006) and MI being cited as an intervention used in a number of CAMHS settings (Eating Disorders Project, Gloucestershire Health Authority; States of Guernsey Psychology Service).

The use of MI may be particularly appropriate in child and adolescent mental health due to the special characteristics of this population, including: children rarely being self-referred to therapy (DiGiuseppe, Linscott & Jilton, 1996); most if not all children commencing therapy in the precontemplative stage of change (DiGiuseppe, Linscott & Jilton, 1996); and adolescents being at greater risk of dropping out of therapy than adults (Barrett, Waldron & Kaminer, 2004). MI may also have a contribution to make in addressing some of the therapeutic dilemmas with this age group, for example, findings that CBT is not equally efficacious for all youth (Barrett Waldron & Kaminer, 2004). It is also suggested that some of the issues identified in the model in the research component of this thesis could be partially addressed through using MI, particularly the issue of children finding the initial session of therapy difficult due to the macro and micro conditions present at the commencement of therapy. MI may also be very practical and relevant when child and adolescent mental health services are provided in community settings, as is increasingly occurring in the UK.

It would appear that practice is leading research in the application of MI in child and adolescent mental health. While the lack of literature in this area makes it difficult to know how MI is being used in practice, it is suggested that it could have a role in prevention, early intervention and therapy. MI has been suggested to work

well as a component of a universal prevention program (Baer & Peterson, 2002). In relation to early intervention, the literature reflects that MI has been successfully utilised in internet and computer-based interventions (O’Leary Tevyaw & Monti, 2004) and could be used in these ways as a component of early intervention or for children who do not reach the threshold for, or who are reluctant to attend, child and adolescent mental health services. MI could also be used in working with parents and teachers in an early intervention, to support behaviour change in younger children.

In relation to therapy, MI could be used by referring professionals as a preparation for further intervention. MI has been suggested to be appropriate as an initial intervention in a stepped care model (Breslin et al., 2002) and could be used in this way in a CAMHS. As in adult mental health, MI could be used as a prelude to or integrated with other child mental health interventions. MI could be used in a discrete manner, for example, to increase the child’s motivation in relation to aspects of therapy such as exposure or homework activities. The MI style could also be used throughout therapy to strengthen the therapeutic alliance between the child and clinician. MI has the potential to be effective in both individual and group formats and it could also make a useful contribution to a consultation model of service delivery. Even if future research finds that there is a lower age limit for the use of MI with children, there is evidence to suggest that it could be used with parents as a means of intervention with younger children (Dishion et al., 2002).

Research is now needed to inform the practice of using MI in child and adolescent mental health. Qualitative research could examine the process of how clinicians are implementing MI in their work in child and adolescent mental health. This echoes the call in the adult literature for sharing innovative approaches to MI’s effective dissemination in mental health (Chanut, Brown & Dongier, 2005).

Qualitative research could focus on the use of assessment and intervention strategies, how clinicians have managed developmental and cultural considerations and any ethical concerns. Research could also outline how clinicians are effectively integrating MI with different systems of therapy. This could be complemented by research with children themselves, by examining how they experience the intervention at both a session and treatment level. Finally, controlled outcome research is needed to examine the effectiveness of MI interventions in child and adolescent mental health, both as a component of other interventions and as a stand-alone intervention.

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Appendix A

Characteristics of Studies Examining Motivational Interviewing With Children.

Study	Setting	N and age	Problem Area	Design Type	Measurement Class	MI Format	Dose of MI (mins) & no of sessions	Longest follow up interval
Atkinson & Woods (2003)	Secondary school.	One child aged 14 years.	Disaffection, poor school attendance.	Single case study.	M1- school attendance. M2 – attitude, self-confidence.	S	Five sessions, of 25-60 minutes.	9 months.
Bandura Cowley, Farley & Beamis (2002)	Adolescent health clinic.	40 children aged 13-18 years, mean age 16.0.	Early child bearing.	Non randomised, uncontrolled case series.	MI –contraceptive use.	S	1-13 sessions, mean of 2. 30 minute duration.	1 to 29 months, mean of 10.3 months.
Berg-Smith et al. (1999)	Health clinic.	127 children aged 13-17 years.	Dietary intake.	Controlled trial, no control group.	M1 – dietary intake.	S	Two sessions, of 5-30 minutes.	Mean of 3.3 months.
Brown et al. (2003)	Private psychiatric hospital (inpatient).	191 children aged 13-17 years.	Tobacco use.	Randomised controlled trial.	M1 – smoking cessation.	S	Two 45 min sessions.	12 months.
Channon, Smith & Gregory (2003)	Medical clinic.	25 children aged 14-18 years, mean age 15.8.	Diabetes.	Controlled trial, no control group.	M1- glycaemic control, self care. M2-wellbeing .	S	1-9 sessions, mean of 4.7. Session length not stated.	6 months.

Dennis et al. (2004)	Four medical sites.	600 children aged 12-18 years, most aged 15-16 years.	Marijuana use.	Controlled trial, no control group.	M1-marijuana use.	C	Two sessions, session length not stated.	12 months.
Kelly & Lapworth (2006)	Secondary school.	56 children aged 14-16 years.	Tobacco use.	Randomised controlled trial.	M1 – smoking reduction or cessation.	S	One session of 60 minutes.	6 months.
Knight et al. (2005)	Medical practice and children's hospital.	49 children aged 14-18 years. Mean age 16.4 years.	Substance use.	Uncontrolled trial.	M1 – substance use, driving while impaired.	S	Two 60 minute sessions	3 months.
Spirito et al. (2004)	Hospital emergency department.	152 children aged 13-17 years. Mean age 15.6 years	Alcohol use.	Randomised control trial.	M1 – alcohol use. M2 – alcohol related problems.	S	One 35-45 minute session	12 months.
Walker et al. (2006)	Secondary school.	97 children aged 14-19 years. Mean age 15.8 years.	Marijuana use.	Randomised control trial.	M1-marijuana use.	S	Two 30-60 minute sessions.	3 months.

S = stand alone treatment

C = component in a combined treatment

M1 = target symptom

M2 = social impact measures tapping into symptom related problems