Service Related Project

Evaluating Parents’ Expectations and Experience of the Assessment and Brief Consultation Clinic in a Child and Adolescent Mental Health Team.

Trainee Number: 05/46

Lancaster University: Doctorate in Clinical Psychology

Word Count: 13,956 (excluding references and appendices)
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Evaluating Parents’ Expectations

Abstract

This paper reports on a study using qualitative methods to examine the views of mothers before and after experiencing an Assessment and Brief Consultation (ABC) clinic, part of a busy Child and Adolescent Mental Health Service. The ABC approach is a brief, parent orientated; strengths based intervention which focuses on the development of a therapeutic relationship and open communication. Semi-structured interviews were carried out with seven mothers before the ABC process and four of the mothers following discharge. All mothers had volunteered to take part in the research and all had sons who were referred to the ABC clinic. Analysis of the participant’s responses, using interpretative phenomenological analysis (IPA), produced a comprehensive set of themes and sub-themes and a narrative of the mother’s journeys through the clinic. Findings revealed that the attributions of children’s behaviour before attending the clinic included biomedical beliefs, which need to be assessed and managed sensitively. Therapeutic relationships with clinicians had been formed and the ABC sessions had been beneficial for most, despite only 1-3 sessions. Specific areas for improvement were noted with some negative feedback from participants. The findings will be fed directly back to the service to inform future service planning and training.
The assessment and brief consultation (ABC) approach is intended as a brief, parent focused, collaborative way of working with families presenting to Child and Adolescent Mental Health Services (CAMHS) which specifically addresses user engagement. The CAMHS clinic at the centre of this study is based in a busy, diverse area of North-West England. The ABC clinic has been introduced as a way to cut waiting lists, as the average wait for families was previously over 6 months, whilst still maintaining a good quality service for less complex cases. The aim of the current research was to evaluate parents’ expectations and experiences of the ABC clinics. The professionals involved in this CAMHS team were keen to find out how the users experienced the ABC clinics and therefore were supportive of research that would provide such information. All were experienced CAMHS clinicians who received training and a manual of the ABC approach, with ongoing supervision.

The introduction will follow two main themes. Firstly the ‘ABC’ philosophy and process will be discussed. ABC follows a clear, three session structure and the rationale and format of this will be outlined below. Certain key features regarding the process and principles will also be discussed; these are the development of a therapeutic alliance, strengths-based family consultation, and the notion ‘blame’ within a family intervention setting.

Secondly the research background and the nature and rationale for this research will be outlined. The research underlying the development of the ABC approach will be critically reviewed and the political, economic and social context in which ABC clinics are being implemented, will be discussed. The research will use a
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qualitative exploration of the views of the users of the ABC clinics, therefore the rationale for such an approach will also be outlined, as will ‘service user’ initiatives.

Assessment and Brief Consultation

Therapeutic alliance

The importance of the therapeutic relationship is widely recognised (Roth & Fonagy, 1996). One of the key goals of the ABC approach, is the development of a therapeutic alliance, which has been described as a neglected area of study in child services (Green, 1996). Therapeutic alliance is an umbrella term that encapsulates a variety of therapist-client interactional and relational factors that occur during therapy (Green, 2006). It has been described as the most important factor in determining whether an intervention is successful (Kazdin, Seigal & Bass, 1990). The ABC approach aspires to develop open communication whereby the therapist can get a clear understanding of the needs and the viewpoint of the family and the intervention can be tailored accordingly (Heywood et al., 2003). This then facilitates the development of rapport, engagement and a patient sense of appropriateness (Green, 1996). Quality of engagement and the level of empathy perceived by service users are strongly associated with treatment outcome (Orlinsky & Howard, 1986, Green, 1996) and therefore something that should be noted within this evaluation.

Consultation

Family services have seen a recent growth in strengths-based consultative approaches as opposed to more ‘pathology’ based services (Allison et al., 2003). Consistent with the ABC approach, the process of consultation allows the family to discuss their issues from their perspective leading to a collaborative, client centred interaction. A consultative approach, such as ABC, focuses on the systems in which the ‘problem’ has been constructed and is a collaborative rather than an instructional
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process (Partidge, Bennett, Webster & Ekdawi, 1995). Consultation encourages the family to choose whether to engage in the process and to move the situation forward, thereby reducing the potential for power imbalance within the relationship and facilitating therapeutic alliance (Green, 2006). Within the realms of social constructivist thinking, the consultation approach encourages the idea that both the family and the therapists have expertise, strengths and resources which can be useful. In the ABC clinics being examined here, team supervision is used to open up ideas and formulations, encouraging the use of multiple perspectives on the situation. The consultation model aims to move a family forward by working through or choosing options, which could lead to positive change. The process aims to be empowering for families, acknowledging their strengths and current coping and facilitating their drive for change (Wheeler, 2000).

   The initial sessions involve discussion of the following:

   □ The process leading to referral
   □ The family’s ideas and descriptions of the problems and difficulties
   □ Ideas and theories about causation
   □ Expectations about the CAMHS involvement and role of the therapist.

The therapist involved would try to assess the stage of change the family is at and would encourage appropriate goals accordingly (Street & Downey 1996). During the initial sessions the clinician may provide the parents (and child) with specific advice information to assist with the problem. Encouragement and reinforcement would be given to any useful strategies already being used, allowing the family to accept what they feel is most appropriate for them (Heywood et al., 2003). The ABC process is thought to be successful if the family experience a sense of hope from the
consultation (Heywood et al., 2003) and this is an aspect which will examined for in the responses given by participants.

Structure

The ABC process consists of up to three sessions offered to all families presenting to a CAMHS team with ‘routine needs’. Two initial sessions would be used primarily for information gathering, to discuss any difficulties, to assess their presenting issues and to offer advice. A follow up appointment can be arranged to review progress, this would usually be up to two months later (Heywood et al., 2003). The three session structure was designed to fulfil the therapeutic requirements of a first, last and follow-up session, any lapse in time between sessions thought to be critical in optimising improvements (Barkham, Shapiro & Rees, 1999). It is thought that the two-month gap before follow-up would promote therapeutic impact and facilitate change (Wolberg, 1980), although the evidence regarding this aspect remains contentious. The limited number of sessions and the structure of ‘ABC’ are made explicit to each family at the outset.

Three sessions

Research has suggested that parents expect their contact with CAMHS to be brief (Wheeler, 2000). In practice, families are often seen less than three times (Stallard & Sayers 1998), this figure was also found in a pre-school child mental health service (Beer, 1992). Talmon’s (1990) research exploring the use of brief intervention in a family service, found that professionals saw a family only once (one representing the modal number of family contacts) and the vast majority of families seen, reported improvements in functioning. The use of a ‘consultation service model’ within a range of services has led to a reduced number of sessions used by services without affecting the quality of the service (Jones, Moss & Holtom, 1997) thereby
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offering families a limited number of sessions with a more focused format than was traditionally practiced, as used with the ABC process.

Research suggests that clinical change occurs early on in the therapeutic intervention (Orlinsky & Howard, 1986) with a diminished effect in subsequent sessions. This is referred to as the ‘dose-effect’ and would support the use of fewer sessions for maximum impact. It would be useful to find out from this research, how parents view the structure and brevity of the ABC process, and if a ‘brief’ intervention can have a positive effect on children’s problems, supporting the idea of clinical change occurring within a few sessions.

_Triage_

The ABC approach functions as a first step into CAMHS (Stallard & Sayers, 1998) and has considerable potential in the management of waiting lists within its capacity as a form of ‘triage’ (Barkham et al., 1999). Most routine problems are dealt with within the three ABC sessions but if, during the ABC process, the clinician thinks that more specialised, multidisciplinary or long-term input is indicated, families can be referred into Tier 3 and/or other more appropriate services (Heywood et al., 2003: Department of Health (DoH), 2004). In this way, the ABC process would facilitate the prioritisation of families with severe difficulties for specialist intervention and appropriate services. During the sessions the clinician can also provide the family with information of additional services that may be more appropriate for them, and could help the family to identify other options open to them.

_Blame and responsibility_

As the research aimed to assess the views of the parents, the beliefs and opinions that the parents held at interview was considered to be an important consideration. Whom families blame for the presenting difficulties is thought to affect
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their response to the difficulties and to affect their engagement with services (Wolpert, 2000). Research has shown that there is a tendency for families presenting to services, to blame the referred child for the referred problem (Munton & Stratton, 1990, Wolpert, 2000). Individuals tend to attribute blame to negative and adverse events, resulting in issues of blame and responsibility about the child’s difficulties being central to families presenting at CAMHS (Stancombe & White, 1997). Parental attributions of blame towards the child have been associated with conduct disorders and increased risk of abuse (Baden & Howe, 1992) and parental self blame or the suggestion of parental blame from others has been associated with reduced engagement in services (Furlong & Young, 1996). A key task in family interventions is to assess and to reframe the blaming attributions of the family, aiming for a non-blaming understanding of the difficulties (Burnham, 1986). Research has demonstrated that family therapists tend to use more environmental and systemic explanations for a child’s problems rather than explicitly blaming an individual family member (Wolpert & March, 1995). This is consistent with the consultation/ABC approach. Despite this, some models of family work have been criticised as explicitly blaming family members (Reimers & Street, 1993) and particularly the mothers (Piercy & Sprenkle, 1990). Research suggests that clinicians need to be more sensitive to aspects of blame and the attributions that parents may make in session as this could affect engagement and drop out (Wolpert, 2000). Researchers working in this field have suggested that future research should examine the parent’s explanations of the difficulties and their subsequent compliance with and evaluation of the service they receive (Stratton, Preston-Shoot & Hanks, 1990, Wolpert & March, 1995) rather than focus on blame and responsibility. A more ‘strengths’ based, consultative approach has been suggested which is in accordance with the principles
Evaluating Parents’ Expectations of ABC, which would help with engagement and to promote parental involvement (Wheeler, 2000). The researcher would seek to identify any issues regarding ‘blame’ that occurs within the ABC sessions and the parental views and opinions that develop accordingly.

**Past and Current Research**

**Past research**

The aim of the current research is to find out how the ABC process is experienced. The ABC approach is based on Barkham and Shapiro’s (1989) 2+1 model and Street and Downey’s (1996) systemic model. The ABC approach was used successfully in adult psychotherapy services and pilot studies have reported on use of the model in adult mental health service (Jones, Moss & Holtom, 1997) and in CAMHS with a manualised package also being developed (Heywood et al., 2003).

Barkham et al, (1999) evaluated the 2+1/ABC model in adult services. 120 participants were assigned randomly to CBT or psychodynamic therapy within the ABC framework. Comparison was also made between those receiving the consultation process within four weeks with those who were delayed before receiving the intervention and three ‘severity’ bands according to scores on a validated questionnaire (1-stressed, 2-sub-clinical depression, 3-low level clinical depression). Outcome measures used indicated that two thirds of the participants in each severity band improved, no significant differences were found for those waiting 4 weeks longer. Those in receipt of cognitive-behavioural orientated clinics maintained improvements at 1 year follow up.

The study findings should be interpreted cautiously as participants all had ‘mild’ mental health problems and those with more severe problems were not included. Further limitations arose from the characteristics of the research therapists
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(who were primarily researchers dedicated to the research without other clinical commitments) and no control group was included in the design affecting generalisability.

Heywood et al (2003) carried out a pilot study of this model in CAMHS, Stockport. A within subject design was used with 50 families referred to the service. Outcome scores were compared before and after service involvement and the researchers found significant improvements for both outcome measures used (P<.005). The authors concluded that the majority of families seen with routine problems had benefited from the model, with changes in parental thought patterns and attitude towards the child and the problem. 95% of parents rated that they were satisfied with the service and 78% of respondents stated that they felt more able to cope with the problems. Benefits were also noted for the professionals using the brief consultation model who stated that were more reflective but focused within the structure of the model. Again, methodological limitations have been noted e.g., that this was a non-controlled study, and need to be considered when reviewing the results of this study.

*Parental experiences of CAMHS*

No research has been published that examines the expectations or experience of ABC from the family or the parent’s perspective. Due to benefits for waiting lists, ABC approaches are being used within services in the NHS (Lockhart, 2007). Research focusing upon the user or parental perspective would provide us with information about how such ABC clinics are being perceived and whether beneficial changes can be made to improve the experience for the users.

Demand for CAMHS is great (DoH, 2004) leading to long waiting lists. It is estimated that 10% of 5-15 year olds have a mental health problem. Such problems
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are associated with educational failure, family disruption, disability, offending and antisocial problems (Office for National Statistics (ONS), 2004). Longitudinal evidence demonstrates that childhood mental health problems persist into adulthood affecting social and occupational functioning. The cost of childhood mental health problems is high for the individual, the family and society.

A CAMHS referral can often be a last resort for families, it can occur at the end of a long period of worry and contact with a variety of services such as the GP, school nurses, health visitors and paediatricians. To then wait an excessive time for an appointment can result in the problems getting worse, unhelpful patterns of coping becoming entrenched, increased levels of distress and families becoming disillusioned and angry with services before they are even seen (McGarry, McNicolas, Buckley, Atkin & Ross, 2007). Long waiting lists have been strongly associated with higher rates of non-attendance proving to be a resource drain for the NHS (DoH, 2004).

The ABC clinics are an efficient way of seeing families. They have been shown to lead to significant reductions in generic waiting lists (Street & Downy, 1996, Heywood et al., 2003; McGarry et al., 2007) without affecting service quality (Partridge et al., 1995; Jones et al., 1997). CAMHS users see such waiting times reductions as essential (DoH, 2004).

User evaluation

The current research intends to seek the views of the users of the ABC service. Recent health and social care legislation (DoH, 2003, 2004) has called for the need to improve user participation in the NHS, stating that services need to be evaluated from the service user perspective to ensure appropriate service development, to inform users and stakeholders and to encourage innovation. Over the past two decades, government has been advocating that service users should be involved in service
Evaluating Parents’ Expectations planning, delivery and evaluation (DHSS, 1983; DoH, 1989, 1998). The Commission for Health Improvement (2004) states that service users’ views are essential to information about the quality of care being delivered. Other benefits noted by Street and Herts (2005) include; providing an opportunity to share frustration and appreciation, for users to recognise that their views and opinions can make a difference, can enhance knowledge regarding the strengths and weakness of a service and to aid the development and responsiveness of services. Satisfaction is related to better use of services, compliance with treatment and better social and clinical outcomes (Mahin et al., 2004) and addressing why users are dissatisfied can help us reduce drop out from services. Recent documents have noted the lack of studies examining users’ views, particularly within CAMHS teams (Lockhart, 2007, Rosen-Webb & Morrissey, 2005) with little agreement on how this should be done.

The methods predominantly chosen for service evaluation have been criticised (Stallard, 2001) as they are typically poorly designed questionnaire studies with little or no follow-up (Sitzia, 1999). Satisfaction studies, usually completed with questionnaires are often cheap and easy to carry out but may produce biased results, as the respondents may be those who hold favourable views of the service (Stallard, 1995). As ‘satisfaction’ with the service is often found, this is seen as evidence of a good service and justification for things to stay the same, rather than to conclude that the service was adequate for those who responded (Williams, Coyle & Healy, 1998). Uniformly high levels of satisfaction may also reflect social desirability factors, common with such data collection methods (Sitzia, 1999). In addition, the data produced has been criticised as being too general, without adequate providing enough adequate information for services to act upon (Brannan et al., 1996).
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More sophisticated methods have been recommended to assess the complex nature of the service user’s experience (Williams et al., 1998). Qualitative research has been suggested to compliment and enhance any quantitative findings (Caan et al., 1996). Such research would also be more likely to detect and assess dissatisfaction with services, to find ways services can be improved and to find out where services are doing things right. The current research aims to seek parental expectations and experiences before and after service involvement, which appears to be an unusual and novel within the CAMHS literature reviewed. Some studies have sought the views of children rather than infer opinion or ask the views of parental figures (Copeland, Koeske & Greeno, 2004) although as ABC is a parent focused intervention, the parental views were felt to be salient in this instance.

Study Aims

The aims of the current research were to evaluate parents’ expectations and experiences of being in the ABC clinic. Their views were to be assessed before parents reached the ABC clinics (whilst they were on the waiting list) and followed up after their discharge from the ABC clinics. The research did not set out to discuss universal experiences of ABC clinics or CAMHS, but to undertake an exploration of the following questions:

1) How did the parent’s view their children’s problems and how did this affect the ABC process? Inherent in the analysis of data, the researcher would seek and uncover any comments made pertaining to blame and responsibility in respect of the referred child, by parents before the ABC process.

2) What were parents’ expectations of what would happen in the ABC clinics?

3) How did these expectations change following the ABC process?
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Did parents comment on the structure of the clinic or on the process on relationship development and consultation? Whether parents rated the approach to be beneficial will also be reviewed. The use of a qualitative approach in gathering data to address the above aims and for service evaluation will also be examined.

Method

Procedure

The research received ethical approval by the relevant local ethics committee and research governance approval was also granted by the healthcare trust in which the CAMHS service resided and from where the participants were recruited (see ethics section).

All families on the waiting list for the CAMHS ‘ABC’ waiting list were contacted by post with information outlining the research, also stating that involvement in the research was optional (appendix A). Interested parents contacted the researcher by post or phone, volunteering to participate. Seven families volunteered for participation.

Parents were contacted to arrange a convenient time to meet to carry out the first interview (the pre-ABC interview). Parents were required to complete a consent form regarding participation in the study and to allow the interviews to be transcribed (See appendix B). Informed consent was obtained satisfactorily from all the participants. Pre-ABC interviews lasted between 20-45 minutes. All pre-ABC interviews were audio-taped and then transcribed. Parents were identified with a pseudonym, which was then used throughout data analysis and write up of the research. During transcription, any identifying information was removed or replaced (e.g., names, name of child’s school, profession of parent) and the tapes of the
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Interview were destroyed. Parents were informed that they would be contacted following their ABC clinic involvement but were not obliged to take part in any further aspect of the research. Their involvement in the research would not be disclosed to the ABC clinician, unless they chose to do so.

As each family completed their ABC input, they were contacted to request their involvement in a post-ABC interview (the researcher was informed of their ABC completion by an administrator not involved directly in the clinics). Interviews were completed and audio-taped and the tapes were transcribed under the conditions outlined above. Interviews lasted between 15-35 minutes.

The range and clinical needs of the participating families was discussed anonymously with a CAMHS Consultant Psychologist, to ensure that they represented a typical range of referrals.

Participants and Sampling

All families on the waiting list for the ABC clinic of CAMHS were considered for inclusion in the research. Out of 36 families referred onto the waiting list in a two-month period, seven families participated in the pre-ABC interview. In the pre-ABC group, participants were all mothers of the children referred into the service and the term participants hereafter will refer to the mothers involved in the research rather than ‘families’ (the term used earlier in this paper). To protect their anonymity, the mothers have been given a pseudonym and these are; Ann, Bernie, Clare, Diana, Esther, Fiona and Greta.

Of the self-selected sample, Ann, Bernie and Greta were single mothers, Greta’s son’s father remained involved, but the other fathers had no contact at all. Clare, Diana, Esther and Fiona were married/living with the fathers of the referred child, but the mothers stated that the fathers had chosen not to be involved in the
Evaluating Parents’ Expectations research. All of the children concerned were boys that were aged between 5 and 14 years old. Five of the mothers were white.

Diana, Ester, Fiona and Greta agreed to have post-ABC interviews and during their time in the ABC clinics, these mothers had been seen by three of the ABC clinicians. Clinician A saw Diana, clinician B saw Esther and Fiona throughout their ABC experience and clinician C saw Greta. Of the mothers that did not participate in the post-ABC interviews, Ann had not attended any of the ABC appointments offered and Bernie and Clare had been triaged onto more complex CAMH services such as the youth offending team and ‘Child in Need’ team.

The reduction in numbers was disappointing but, to some degree, an expected outcome. Despite the reduction, all four mothers who were asked to participate in the post-ABC interview agreed to do so. As all mothers had finished with the service by this stage and were not obliged to be re-interviewed this may have been an indication that the researcher had engaged the participants well in the pre-ABC interview.

Instrument

Semi-structured interviews were carried out with the mothers who volunteered for the study (see appendix C). The interview schedules were developed by the researcher, the supervisors and relevant research (e.g., Heywood et al., 2003). The pre-ABC interview questions were constructed with the aim of letting each mother tell their story about their referral to the ABC clinic and their expectations of what would happen. The post ABC interview would discuss their experiences of the clinic and their perception of how things had changed.

The interview was used in an iterative way, adapting and altering the questions according to the respondent (DiCicco-Bloom & Crabtree, 2006). The first question used was broad and open-ended, reflecting the nature of the research and was aimed
Evaluating Parents’ Expectations to be non-threatening with prompts that repeated words used by the interviewee, requesting elaboration and clarification, rather than leading the interviewee, in line with interpretative phenomenological analysis (IPA) format (Smith et al., 1995). Such a non-didactic approach to interviewing may facilitate the development of rapport between researcher and participant (Sheldon, 1998). Later in the interview, when more rapport and trust had developed, ‘exploration’ could take place where making sense of what had been said could be probed and explored (DiCicco-Bloom & Crabtree, 2006).

Approach to the data

Qualitative research methods were chosen as a way to pursue the aims of the study. Qualitative approaches have been described as being highly relevant in ‘family’ research as they can provide rich description of family phenomena and can add to our understanding of the meaning that individuals attribute to events and changes in the lives of themselves and those around them (Gilgun, 2005). IPA is the qualitative framework used within this research with the intended aim to provide and develop descriptions of the human experience in relation to the phenomena being studied. IPA originated in health psychology and was based upon two key theoretical paradigms (Smith et al., 1995, 1999). Firstly ‘critical realism’ acknowledges that reality exists beyond individual conceptualisation, therefore different individuals experience different realities and form their own reality accordingly (Fiske & Taylor, 1991). The second paradigm; social cognition, is based on the premise that an individual’s speech and behaviour can reflect the reality that they perceive and accept. This premise leads to the use of interviews as an acceptable form of gathering data, to allow detection and analysis of such differences (Fade, 2004).
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IPA seeks to gain an ‘insider’ knowledge of the phenomena (Smith et al., 1999) but the beliefs and experiences of the researcher are seen as necessary for making sense of what is being studied, reflexivity can be utilised formally to acknowledge this interpretative aspect. An idiographic case study method is the IPA approach used within this research (Smith et al., 1999) to explore and develop themes found between the small number of participants.

Analytic Procedure

The first interview was transcribed into text and included non-verbal information and field notes gathered and recorded during the interview process (Fade, 2003). The transcript was read several times, with notes made that described the pertinent issues. By a process of abstraction, themes were then made and inserted into the text. The themes were made up of either ‘higher level’ abstraction e.g. by asking ‘What is going on here?’ or thinking how this issue relates to other incidents within the data. Alternatively, literal themes, borne out of the text were also used. Memos outlining any analytical decisions were kept to provide a rationale and assist with further analysis (Fade, 2003). Themes were then abstracted and listed, connections between themes sought to allow for meaningful clusters to emerge and for ‘master’ themes to develop. Further interviews were then carried out with the master themes in mind. A reflexive dialogue was used throughout the interviews to seek immediate feedback from participants; field notes were also kept to enhance the dependability of the data (Smith, 1996). Following completion of all the interviews, a list of the relevant and salient master themes was developed. Each master theme then formed the basis of a narrative account by re-visiting the data and memos kept during analysis, and linking into existing literature on this topic. A meta-matrix was developed to give a condensed overview of the data (Miles & Huberman, 1994).
Author Biases

The author did have previous knowledge of observing and carrying out some ABC clinics, as a trainee clinician, as well as previously being involved in the CAMH service being studied. This provided an important insight into the phenomena that the participants were discussing. The researcher was interested in the psychological experience of being referred into and experiencing the ABC clinics and this interpretative aspect was therefore reflected in the questions asked, which led the analysis in a particular direction (Willig, 2001). It is therefore acknowledged that the result would reflect a ‘co-construction’ of the participant and researcher (Osborn & Smith, 1998). The researcher adopted a reflexive approach to the study, monitoring their own reflections and assumptions to allow additional consideration of how they impacted upon the analysis and interpretations made (Sheldon, 1998), in an attempt to enhance rigor and minimise researcher bias (Reay, 1996).

Findings

The findings will be described by first outlining the pre-ABC data themes and then themes found in the post-ABC interviews. The author will then give a case by case overview to summarise the journey that each mother went through during the clinics including the themes already discussed, any other pertinent but case specific findings.

Pre-ABC Data

Overview of data findings

Five main themes emerged from the pre-interview data analysis, some had subheadings which were tabulated (Table 1). The five main themes were;

1. Descriptions of behaviour

1 All Tables are found in appendix D. Figures found in appendix E.
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This refers to the words and statements used during the interviews by mothers regarding their child and the underlying beliefs of intentionality and desirability of the behaviours that this represented.

2. Beliefs about causation

This theme captured any theories or beliefs that were put forward during the interview to indicate what influenced the development or occurrence of the problems. In addition, this theme included speculation that mothers made about whether the clinic professionals would attribute any causative blame towards the mother or other individuals.

3. Expected Focus of CAMHS intervention

This aspect refers to the beliefs that the mothers expressed about the expected focus of the CAMHS intervention. This theme appears to map closely with the theme ‘belief about causation’ therefore they will be described together.

4. Strategies used

‘Strategies used’ describes methods used by the family to address or ameliorate the problem themselves before or leading up to the referral to CAMHS, this theme reflected the ‘origin’ or beliefs about the cause of the problem and this will be discussed.

5. Beliefs and Feelings about CAMHS

This cluster of sub-themes indicated what mothers thought the purpose and role of CAMHS was and how they felt about the referral and the imminent appointment.

Table 2 gives an overview of the individual mother’s findings and the overall themes (Miles & Huberman, 1994). In this format the data has been reduced into discrete categories to provide a coherent overview of the findings as a whole and to give a flavour of how each ‘case’ or how each family has presented and how each
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main theme has been expressed (Miles & Huberman, 1994). Each main theme was
then analysed in more depth and is discussed below and interactions between the
themes on a case by case basis have been analysed and discussed.

Descriptions of behaviour

All of the mothers gave many examples of their child’s behaviour during the
interviews and these descriptions were predominantly of undesirable behaviours. In
all cases such behaviours were the reason for the CAMHS referral. Some desirable
behaviours were also described but the expression of these types of behaviour was
much less frequent.

The most common undesirable behaviours being described were those that
involved violence and aggression, with six of the seven mothers describing aggression
to others, the exception was Clare who described thoughts about self harm from her
son. Typical examples are from Ann; “He goes out battering people…he boots my
walls and doors” or Esther; “He growls, slams, stamps, he kicks off.”

Ann, Bernie and Esther have described their child’s behaviour almost
exclusively as intentional and undesirable. This indicated that they feel such
behaviours are deliberate and under the control of the child e.g., Ann stated; “He
knows it’s dangerous”, “He thinks everything should be done his way;”

In contrast Clare and Fiona have described all or most of the child’s behaviour
as undesirable but unintentional e.g., Clare; “His illness causes him to have bad
thoughts, self harm thoughts.” Diana and Greta have an equal balance of intentional
and unintentional undesirable behaviours and these two mothers also gave the highest
level of desirable, positive behaviours when describing their children.

The description of intentional and unintentional behaviours was by far the
most frequent classification of behaviour that came from the interviews. All of the
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mothers described their son’s behaviour within these categories but in very differing degrees. The beliefs they appear to hold, as to whether their son is choosing to do the aggressive behaviour or not appears to be a salient issue which interacts with many of the themes to be discussed. In general, describing behaviour as intentional suggests that there may be an element of blaming the child for the problems that have led them to CAMHS. As many of the mothers in this sample have used some description of ‘intentional’ behaviour, the findings here support existing research that found that families come to services with a tendency to blame the referred child (Wolpert, 2000).

The spread of intentional and unintentional behaviours throughout the families are demonstrated in Figure A (Appendix E). This figure, and those used throughout this document, acknowledges, describes and aligns the mother’s views during the interview and it is recognised that this is one off ‘snap-shot’ of time and may not fully represent their views. The author has placed the mothers on the continuum in the order that the mothers expressed and thereby represented that particular viewpoint. In Figure A, the author placed the mothers along side each other, dependant on the number of comments made and the balance of the comments. Ann and Esther made a similar amount of comments about their son’s intentional behaviour, Bernie, who is a little further up the continuum line, made a similar amount of comments regarding intentional behaviour, but she also spoke of a few unintentional behaviours (as discussed above). Greta and Diana spoke of a similar number of intentional and unintentional behaviours, and they appeared less clear as to whether their sons were to blame or not for their behaviour.

Insert Figure A here.
Beliefs about causation and focus of the CAMHS intervention

During the interview, all mothers hypothesised as to the cause of the problem with their sons. Six of the mothers (with Diana being the exception) suggested a diagnostic label as a possible cause of their son’s problematic behaviours. Ann, Clare and Fiona appeared to hold a firm belief that there was a biomedical problem with their child which they hoped would be identified by CAMHS. Fiona states early on in the interview that “I think he’s mildly autistic, mild aspergers, he was different from an early age, and he stood out.” Ann suggested ‘ADHD’ as a cause of her son’s problematic behaviour. Clare also stated that she firmly believed that her son’s problems were diagnosis related and that this needed addressing by a professional.

Bernie, Diana, Fiona and Greta all suggested a mixture of biomedical and social/psychological explanations for the problems they were experiencing. These mothers appeared to be more open to the possibility that social/psychological factors had contributed to the reason for referral, suggesting parental management problems (Bernie, Diana, Esther, Greta), bullying at school (Bernie) or early life events (Bernie and Esther). Greta opened the interview with a summary of the reason for the referral to CAMHS:

“He has always displayed a streak of behaviour that I have found challenging…I’ve tried to be reasonably knowledgeable as a parent, follow all the guidance….I love the fact he is focused and interested but it just makes ordinary life and getting things done awkward….this is all of us, not just him”

Greta immediately involved herself, and possible shortcomings in her management of her son’s behaviour, in this description which is typical of similar statements made during the interview. Despite this, in another part of the interview she hypothesises that there may be biomedical explanations also;
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“There may be something a bit autistic in him?”

Esther also acknowledged that her son may have inherited a particular temperament that led to his problematic behaviour but she also acknowledged problems with her and her husband’s current parenting differences and her early behaviour to a demanding baby:

“From the moment he was born I was agitated, over protective, gave him everything he wanted….I feel I failed him. The other part is my husband, he does not back up anything I say, so my son has learnt to play us off against each other”

This mixture of views could reflect an open-minded approach to the causality of problems on the part of the mothers. Alternatively, it may be viewed as ambiguous and a little confused. Confusion may happen when families have been coping with problematic behaviours and symptoms for some time, speculating about what is causing problems, seeking solutions and then waiting for a CAMHS referral. Six of the seven mothers mentioned a specific diagnostic label when speculating about their son’s problems. Ann, Bernie and Esther all mentioned ADHD as a possible cause, Clare, Fiona and Greta all mentioned autism/aspergers as a possible biomedical explanation. This may reflect that the mothers have been ‘seeking’ reasons for the problems they are experiencing, but it also reflects the way such ‘diagnostic labels’ are becoming well known within society.

Fiona and Greta both verbalised concerns that the CAMHS clinician may ‘suspect’ them of causing the child’s problem. Greta stated;

“In the back of my mind is...will I be discovered as a bad mother....”

Fiona had had previous experiences where she had felt ‘blamed’ by healthcare professionals and she feared that this might be the case in CAMHS;
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“I had post-natal depression and… I think that’s something they could use against me…. a history of depression means I’m a neglectful parent…. it’s something they pick up on.”

Closely linked to beliefs about causation were the mother’s beliefs about the expected focus of the CAMHS intervention. The more bio medically focused mothers (Ann, Clare and Fiona), expected the intervention to target and help the child, whereas the mothers who felt that social/psychological factors were also important in the causation of the problem, expected the CAMHS intervention to address family issues and interactions (see Figure B: Appendix E).

Insert figure B here.

Ann showed some differences from the other families within these two dimensions. In addition to being more aligned with a biomedical explanation for her son’s problems and expecting the intervention to focus solely upon him, during the interview the mother also described a number of incidents that had occurred in the past. In contrast to the other interviews (such as Bernie), Ann did not appear to relate traumatic past events to her son’s current problems; rather she described them as a way of describing how difficult things had been for her.

“He was on the child protection as his father…dropped him on his head when he was 2 months old and fractured his skull, he also hit him over the head with a brush….there’s been a lot of violence and disputes in this house. When I was
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poorly last year, social services took them all off my hands. I’ve had all this...”

Rather than assuming that the referred problem of violent and aggressive behaviour was caused by such adverse life events, Ann still stated that she thought her son had ADHD, or that he was seeking attention, hence the more biomedical beliefs about causation and the expectation that the CAMHS needed to focus their intervention and their “tests” on her son. This may reflect a cohort view that problems experienced with your child need external help rather than examining what may be going on within the family unit.

Strategies used

Five of the seven mothers described the strategies that they had tried in an attempt to manage the referred behaviour. Ann and Clare were the exceptions as they did not comment on any strategies employed. Some of the mothers appeared to have tried a wide range of strategies before seeking the referral and most of the strategies were described as being implemented by the mothers only. Typical strategies discussed were: parenting techniques, from programmes or books, (Fiona, Greta, and Esther) nagging (Bernie), being extra patient (Bernie, Greta), long discussions about the problems (Diana, Greta) and use of parent phone lines (Greta).

In terms of the involvement of others in implementing ‘strategies’, Esther had attended a parenting course which she felt had been beneficial, but she felt that it was threatened by her husband who did not use the same strategies, reducing the strength of what she was doing. Only Diana spoke positively about father involvement, describing a ‘whole family strategy.’ Schools and educational professionals had

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2 This quote was used as it would not be expected to lead to identification of Ann as she did not attend the ABC clinic.
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expressed concerns about all the boys concerned. For Ann, Diana and Greta, members of the school staff had become involved in addressing undesirable behaviour. In all the other cases (Bernie, Clare, Esther and Fiona), educational psychologists were involved with the boys. This indicates the degree of the problems that these children were experiencing and the disruption that these problems were causing to their schooling.

The results show that many of the mothers had invested time and effort in trying to help with the ‘problem’ before seeking a referral. The mothers that had made the greatest amount of effort to help with the problem tended those who also considered social/psychological reasons for the problems they were experiencing, and those who expected the intervention to target the ‘family’ rather than just focus upon the child. This interaction is demonstrated in Figure C (Appendix E).

Insert figure C here.

Beliefs about CAMHS

This theme overlapped with ‘Expected focus of CAMHS’ but it was included as a separate theme as it was felt that this information would be useful to CAMHS service. All mothers spoke about what they thought a ‘CAMHS’ service would do, although most of the mothers stated that they had no concrete idea about what would happen at the appointment but all wanted more information. In addition, many mothers stated that they had not thought too much about what would happen. Ann thought that the appointments would involve ‘tests’ to clarify what wrong with her son. Bernie, Clare and Greta thought that the intervention would be ‘talking about feelings’ in a way that they were unable to do with their sons. The provision of
specific advice and helpful techniques were expected from Diana, Esther, Fiona and Greta again. These were the mothers who had more social/psychological beliefs. The impression given by these mothers was that the advice and strategies given at the appointments may then go on to be used by the mother to help the child and the family unit as a whole. Some of the mothers spoke of apprehension about the impending appointment (Bernie, Fiona and Greta); others stated that they were “indifferent” (Ann and Clare). Four mothers stated they were hopeful that they were going to be seen by a specialist service that may help their current situation (Diana, Esther, Fiona and Greta).

*Post-ABC Findings*

Ann did not attend any of the three ABC clinic appointments offered to her by letter, this was unexpected as she had been a participant in the research. Bernie’s son had had to be redirected to the offending team due to an incident that occurred whilst on the waiting list; Clare was referred into ‘Tier 3’ as it was felt that the needs of her son were greater than previously thought. As none of these 3 mothers actually participated in the ABC process they were not contacted to participate in the rest of the research.

Diana, Esther, Fiona and Greta were contacted following discharge from the ABC clinic and they all agreed to take part in a post-ABC interview, which was seen as very positive in terms of their commitment to the research. Diana had been seen once, Esther had been seen twice; Fiona and Greta were seen for the full three session structure. Three main themes, each with sub themes, were found during data analysis (shown in Table 3: appendix D). The main themes found were:

1. Session characteristics.
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This theme encompassed comments and reflections that the mothers made about particular processes and techniques occurring during the sessions, and any individual aspects of the therapist, that they felt were pertinent.

2. Family involvement.

This theme followed comments made about other family members and their involvement during or following the ABC sessions.

3. Description of Changes.

This theme developed from the range of ways that the mothers described and rated the changes that had occurred due to taking part in the ABC process and the way that they had evaluated and reflected upon their experiences since the clinic. The terms they used to define ‘changes’ were unique and diverse, as will be demonstrated.

Session characteristics

In terms of the process and structure of the clinics, positive comments were made about being able to see the same clinician throughout and therefore being able to develop rapport and a relationship (Fiona and Esther). The openness of the process was also commented on (Diana and Esther) e.g. speaking with the child about the problem and the issues involved, not just the parent. Both Fiona and Diana stated that the time they had had in the clinics was adequate, Diana commented;

“ It was just enough, it wasn’t too intimidating, or too formal, just nipping it in the bud, I would not have liked a too long or too intensive thing”

Greta though, thought that she and her son had not had enough time in the clinics and had been moved on through the process too quickly. She commented on the “superficiality of the process due to time constraints.”

Diana, Esther and Fiona all spoke positively about the amount of time that the session(s) spent focused on the child’s opinion and thoughts; “They spent more time
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with my son than I thought, rather than just me….it showed that they were focusing on his issues not mine” (Fiona). “it was mainly him and her, I was just sitting there” (Diana). Conversely, Greta felt that the time spent in the clinics was unfairly focused upon her as the parent and that not enough time was spent with her son:

“I would have liked more time with him, seeing him in different settings...I expected at least two of the sessions to be an analysis of him, it wasn’t, it was more like an assessment of me, a review of progress we’ve made ourselves. She couldn’t have seen enough of him.”

Within this section of her narrative, Greta seemed to imply that she felt analysed and blamed for her son’s problems, by the therapist. This was not an aspect that came out in any of the other interviews, with Fiona even stating overtly that she didn’t feel blamed by the ABC therapist, as she had been expecting.

It should be noted at this point that Greta saw a different clinician than Diana, Esther or Fiona. Greta’s experiences may therefore reflect a number of things, such as the individual clinician’s style or techniques or a problematic relationship.

All mothers stated that they felt that any previous strategies used to help, had been acknowledged in the sessions. Fiona stated that “They recognised what we were doing, what we were coping with” and she concluded the interview with “I came away feeling I was managing a difficult situation well.” Greta also felt that she had been acknowledged for managing certain difficult situations well, but that it had been done in a patronising way. Greta concluded that;

“If we weren’t managing so well, maybe she would have talked to him more, we’ve been penalised for managing too well.”

Moving onto specific techniques that were used during sessions, Diana commented on aspects she found particularly useful,
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“The therapist didn’t directly tell us things, it came out in conversation
between him and her, it wasn’t being told, it was looking at it from a different
perspective.”

Esther also voiced similar ideas about the way that questions were used in sessions,
not in a directive way, but to draw out information from the child,

“By the questions that the therapist asked…it made him (my son) think about
how he had behaved in certain situations and how he feels when he’s done
wrong, it was good for us all to hear and for him to say it.”

This technique also appeared to have been used effectively with parents too, as Esther
describes,

“He (his dad) wasn’t told directly, he wouldn’t have liked that, it just came
out indirectly from the session, he thought about it later on.”

In addition, some specific techniques such as being given clear advice and
information were commented on positively by Diana, Esther and Fiona, e.g., “the
advice helped as well” (Diana), “the therapist gave us some information” (Esther),
“the therapist ruled out what it was and what it probably wasn’t” (Esther). Greta had a
very different view of her experience, describing a lack of concrete information and
no specific advice, leaving her with many unanswered questions about her son, his
behaviour and his future.

*Family involvement*

Fiona and Esther stated that they “insisted” on their partners attending at least
one of the sessions, and reflected that this had been extremely beneficial for the
partner, and for the outcome of the sessions. An example to demonstrate this was
stated by Esther,
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“I’m glad my husband was there because the therapist got a family view, not just me. Maybe it took the referral for him (my husband) to realise, he couldn’t be in denial anymore, and it was good for our son to see him there.”

Fiona makes a strikingly similar comment about the importance of father involvement,

“It’s good for them (CAMHS) to hear from both of us. It was important for my son to see his dad interested and joining in.”

Diana commented on the benefits of family involvement once getting home and implementing the strategies and issues discussed. Greta made no comments throughout the interview about family involvement.

Description of outcome

All of the mothers made statements about how they had evaluated the ABC process since their discharge. Overall, Diana, Esther and Fiona evaluated the outcome positively and spoke particularly of a good relationship with the CAMHS clinician; Greta felt the outcome had been negative.

Diana commented on positive aspects that occurred with her son during the session, which included him entering the session closed and non-communicative but leaving the session having opened up and having talked openly throughout due to the skills of the clinician. Diana was also the only mother, who gave feedback about how her son directly felt about the ABC clinics,

“He came out and said ‘that was great,’ he’s said it since too.”

Diana’s expressions of a positive outcome related directly to a reduction in the problematic behaviours that she initially sought help about e.g., “he sleeps better, he’s less angry, he’s happier.” Fiona appeared to evaluate the outcome differently but still positively by statements such as “now we can get on with things, we can now be
taken seriously,” as if attending CAMHS had validated her concerns, and had validated the problem behaviours demonstrated by her son. Esther, also commented that the outcome had been positive stating the following,

“We now know what we’re dealing with; we can follow things through now.”

All of these mothers have appeared to have got what they desired from the ABC clinics and rated the therapist positively; therefore they saw the outcome as positive. Greta appeared to be left with a lot of unanswered questions; “Is it going to cause problems in the future? What can I do to help? Is there something that makes him different?” Her evaluation of the process and subsequent outcome was poor and she blamed this on the therapist not listening or taking her concerns seriously and not assessing her son adequately.

*The Mothers’ Experience*

Each mother’s story will be outlined below to give an overview of their views.

Ann described her son’s behaviour in very negative terms, and most of these behaviours she described as deliberate and intentional. Ann described her son’s childhood as being characterised by violence and separation from her. Ann suggested that her son’s violent and antisocial behaviours may be the result of ADHD, she did not describe any strategies that she had tried that had worked with her son and she hoped CAMHS would carry out some tests to sort the problems out. She expressed that she was indifferent to the referral. Ann did not attend any of the ABC sessions offered to her, despite repeated invitations for an appointment.

Bernie described many undesirable behaviours from her son that led to the CAMHS referral, she felt that the behaviours were mostly intentional but that his ‘temperament’ meant that he was more likely to behave in these ways. Bernie acknowledged that early experiences and behaviours from herself and her son’s dad
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may have contributed to the current difficulties. She felt the ABC clinics would focus on her son and allow him to open up. Before attending the ABC clinic her son’s problems worsened and he was referred onto a youth offending team.

Clare stated that her son had a diagnosable problem, all his problematic behaviours were due to this problem and the CAMHS clinic would address her son’s problems. She was unsure how this would be done but was sure she was not capable of helping her son without professional help and diagnosis. Clare was redirected to more complex CAMH services.

According to Diana, her son’s undesirable behaviours were due in part to his temperament, but that he also had some control over what he did. She and the family had tried to manage his behaviour and worked hard to think up strategies to help him. She was hopeful the ABC clinic would help the family to help the situation. On attending one session of the ABC clinic, Diana stated that she and her son learnt some new strategies to try out at home and Diana observed her son open up to the clinician, and during this she came to further conclusions about ways to help her son. She spoke highly of the clinician and how she and her son felt listened to and acknowledged. Following the session, Diana felt hopeful and motivated she commented on the skill and quality of the therapist. Diana disclosed that she and the family implemented all that was suggested and concluded and they continued to talk openly and honestly about the problems, as had been modelled in the ABC session. Her son’s behaviour had already improved and she was glad that she had attended the ABC clinics.

Esther again appeared to believed that her son’s temperament was responsible in part for the problems they were experiencing, but that parental management problems played a large role, particularly inconsistency between herself and her husband. She stated that she hoped for a mixture of things from CAMHS including
anger management for her son and help and advice for the family. Esther had already tried a number of strategies to help the situation over the years and was keen and hopeful about the appointment. Following the clinics, Esther felt that her concerns were taken seriously by the CAMHS clinician, that her son was fully assessed and that the information and advice they were given was clear, effective and appropriate. She particularly felt that having a ‘professional’ make suggestions about her parenting strategies and by her husband attending the appointment, changes had already been made and she stated that their parental inconsistencies had improved.

Fiona stated that she felt her son had a stable, biological problem that needed recognising. She put a lot of effort and time into strategies to help manage her child, which were effective but she wanted his problems to be recognised so that she may receive help in the future. Fiona was sceptical about what help and acknowledgement she would receive from CAMHS. Despite this, Fiona felt that she had been listened to by the CAMHS clinician, and that she and her concerns had been taken seriously. She stated that she was pleased she had attended and felt more hopeful about the future.

Greta described her son’s problematic behaviours as a mixture of deliberate and non-deliberate acts. She described behaviours that she was unable to cope with, but others that she had managed to control using a range of parenting strategies. Greta speculated that there was an issue with his behaviour and her coping, but she also suggested that there may be something ‘autistic’ in the nature of his problems. Greta was relieved that the appointment for the ABC clinic would be so soon after making the referral. However, her experience at CAMHS was disappointing; she did not feel that her views and concerns were heard, or that her son was fully assessed. She stated that she came away with many unanswered questions and a feeling that she wished she had not attended the appointment.
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Discussion

The research used an IPA methodology to explore the expectations and experiences of CAMHS users. The themes developed within the analysis will be discussed in relation to the overarching aims laid out in the introduction, any additional findings will be discussed accordingly and the discussion will relate to psychological theory and past research findings. Implications for the CAMHS service in which the research was based will be outlined, as will recommendations for future research and limitations of the methods used.

Key Findings

How did parents view their children (and how did this affect the process)?

Past research has found that, while parents tend to see problems as residing within the child whilst therapists tend to use more environmental explanations (Wolpert & March, 1995, Wolpert, 2000), consistent with a psychological, systemic ABC approach. The theme ‘descriptions of behaviour’ demonstrated that many of the mothers used statements that implied that they thought some (or all) of the problematic behaviours were intentional and under the control of their child, supporting previous research. Parental understandings of a child’s behaviour have been shown to influence help-seeking decisions and parenting methods (Johnston & Ohan, 2005). Greater levels of blame towards the child and a reduced acknowledgement in environmental influences have also been associated with non-attendance in family services (Wolpert, 2000). Studies have also shown that when parents view problem behaviours as intentional, the response is more negative and punitive (Johnston & Ohan, 2005). Identifying such beliefs would therefore be seen as crucial for the ABC clinician. Ann was the participant in this study, who appeared to attribute much of the problem to her son, and she also seemed to state that his
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behaviour was intentional; she then failed to attend any appointments offered to her.

With rates of non-attendance at CAMHS appointments at around 40-60% (Kazdin & Wassell, 2000) factors which might account for this, such as holding a more biomedical view to problems, need to be acknowledged and addressed if these families are to have access to CAMHS e.g., by more proactive ways of accessing such families. If such views are different to those held by clinicians, and if those clinicians do not deal with this ‘difference’ sensitively, it is understandable why certain groups of users do not continue to attend or do not attend at all.

Under the theme ‘beliefs about causation’ six of the mothers use a diagnostic label as a possible cause of their son’s problems (three mothers used the term ADHD, three used the term autism or aspergers). This again supports the finding that mothers are looking for explanations for the occurring problems within their children, rather than wondering ‘Is this something to do with how we function as a family? If I try this strategy…will the behaviour improve?’ The specific use of diagnostic terminology demonstrates a greater societal awareness of such ‘diagnostic labels’ and a greater tendency for them to be used by lay people (Kutscher, 2005). Alternatively it may reflect a ‘fundamental attribution error’ (Kelly, 1967) where there is a tendency for us to explain other’s behaviour as due to internal factors, as oppose to external or situational factors. This may be in contrast to the views held by professionals. Once a behaviour has been conceptualised (by a parent) in such a way, other explanation tend to be discounted, even with strong evidence (Kelly, 1967), this is something that would need to be acknowledged and dealt with sensitively by the ABC clinician. This would take advanced assessment and therapeutic skills, particularly in a ‘brief’ intervention.
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The analysis indicated an association between particular views and beliefs. The mention of more intentional (deliberate) behaviour was also associated with a belief that the ABC clinic would focus more solely on the child than the family and that fewer strategies had been attempted to help manage the behaviour. Such findings reflect previous research within the attribution literature (Joiner & Wagner, 1996, Munton & Stratton 1990). Namely that causal attributions about presenting problems are made by some parents that tend to cluster towards being intentional, internal, controllable (by the child and not the parent). Such attributional style has been associated with poorer prognosis and drop out from services (Wolport, 2000). Diana, Esther and Fiona appeared to acknowledged some environmental explanations for their son’s problems and they all recognised, even before the clinics, that strategies utilised by themselves would help the situation. For these mothers, the ABC process was successful.

For clinicians, being aware that families presenting to the ABC clinics may hold such attributions would be essential in understanding where the family are coming from and what they want from the service, a role that ABC aspires to achieve (Heywood et al, 2003). Once acknowledged, the clinician can then sensitively suggest other possible causes for the problems the family are experiencing and can assess how the attributional style brought by the family is impacting on the problem at hand. Gaining an insight into how the family view the presenting problem is seen as an integral part of the ABC model and this is something that this research would indicate is important. This appeared to be an aspect that worked with Fiona. She went to the first session with the view that her son had a diagnosable problem. Despite not receiving a diagnosis, in the post-ABC interview she stated she was satisfied with the result of the ABC clinic as her views had been listened to and acknowledged.
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Alternatively, Greta appeared to hold a mixture of biomedical and psychological/social views before attending the ABC clinic. Despite this, she appeared to feel that her views had been disregarded and the biological aspect had been minimised by the clinician. What do these differing outcomes/experiences tell us about therapeutic alliance? It may be that there is the need for an informal, non-judgemental reflective context; empathic listening; and making parents feel understood on their own terms, before attempting to move them to different ways of understanding the problem and intervention. It may be that Greta was not led through this process at a pace that she liked, or that she was allowed to express her viewpoint, or that the clinician was unwilling to allow the parent to contribute to the process. This is not how ABC should be carried out.

What role might such attributions hold for mothers? Attributing blame and responsibility for the problem onto the child may have a protective function. This may be reflected in the comments made by some mothers in the pre-ABC interview e.g. “will I be found out as a bad mother.” This may reflect societal views that having problems with your child indicates you are a bad mother. If something is ‘wrong’ with the child it absolves the mother of responsibility. Studies have shown a decrease in self-blame following a diagnosis of ADHD (Singh, 2004). The data here also indicated that by thinking that there is something biologically wrong with your child, may mean that you then give up trying strategies to help, as may have been the case with Ann and Clare. Such findings may have to be addressed at a larger scale within primary care settings and mental health promotion and prevention strategies.

*What were the expectations of the ABC process?*

Feedback here was limited as mothers stated that they had not thought particularly clearly on this topic. Beliefs that were stated about CAMHS were varied
Evaluating Parents’ Expectations and feelings about attending were mixed with some mothers having feelings of uncertainty and apprehension about the process. All mothers stated that more information was needed before going to the ABC clinics. More specific information may prevent any client dissatisfaction as seen within this sample and reduce false speculation about what might ‘happen’ to them once attending the clinics. The items identified within the theme ‘beliefs about CAMHS’ would be fed directly back to the service to inform the clinicians regarding the information that needs to go out to families before attending the clinics (see the relevant section below).

How did the expectations meet with the experiences of the ABC clinic?

It appears that those mothers who got what they expected from the ABC clinics had a better experience. In addition, all the mothers who had a good outcome commented on the skills and relationship that had developed with the ABC clinician despite only having three or less appointments. For example, Diana only had one ABC session but in the post-ABC interview commented on how much she trusted and regarded the clinician. This fits with the rationale behind ABC in terms of working with families to develop a therapeutic alliance (Green, 2006) and to help their situation according to their beliefs, expectations and hopes. Once an alliance has been formed, the therapist can facilitate the adaptation of a family’s beliefs about their child, and help to rectify the situation (Green, 2006) and it could be speculated that this occurred with Diana, Fiona and Esther. This did not appear to happen with Greta and that perhaps the conditions of strong therapeutic alliance and good consultation were not achieved. This could be related to the characteristics of the clinician or Greta.
being unable to, or being ambiguous when stating her hopes, beliefs and expectations for the ABC sessions.3

The therapeutic relationship has been described as the most important determinant of treatment success (Kazdin, Siegal & Bass, 1990) and therapeutic alliance has shown to be more predictive of a better clinical outcome than the type of treatment used (Harrington et al., 2000). The key aspects rated as essential within the dimension of therapeutic alliance for the therapist include; acknowledging and validating the views of the users and feeling that they shared a common viewpoint on the problems (Krupnick et al., 1996), all features aimed for in ABC. This did appear to occur and be successful for Diana, Esther and Fiona who all commented on the skills and techniques of the ABC clinicians, how they had achieved what they wanted from the sessions and how this had contributed to their perceived positive outcome.

The ABC approach aspires to move away from being an individualistic problem-focused approach to be more ‘strengths’ orientated. This is consistent with the trend seen within family services and research that supports the use of such methods (Allison et al., 2003). Recognising and commenting on strengths and strategies already tried was also commented on positively by three of the four mothers. Again, this is a key element within the ABC approach and the findings demonstrate that strengths based work can be beneficial. It could be speculated that acknowledging strengths of the child and the situation was empowering for those mothers and may have contributed to their perception that the relationship had been positive. As was found in Greta’s case though, recognition of skills and then building upon them, needs to be done sensitively and with open communication and mutual agreement.

3 The clinicians were unaware of who had taken part in the research
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One criticism that comes from the study findings may be that the more resourceful people, who can express their beliefs and concerns to the clinician effectively, resulting in better communication and understanding. Such individuals may also be those who can identify with the views and opinions clinicians, and will ultimately get the best from the services offered. For example, parents who hold predominantly environmental influences for their child’s problems and have the resources and the ability to engage in and seek more strategies to help their child may fare better in such CAMH services. Diane was typical of this. She was an educated woman who was able to express her needs and her opinions within the interviews, who had read about what might be the problem with her son and had help and resources to implement strategies to help once suggested by the clinician. If this is the case, a whole group of individuals may be alienated from or ‘put off’ accessing or complying with services offered, such individuals may also have greater needs (DoH, 2004).

Consistent with the wider literature, this study has found that when using a ‘strengths’ based approach, individuals do receive benefits and do express satisfaction with the services, but that the outcomes are unique for each person. This was demonstrated in the post-ABC theme ‘description of change’ which showed the multifaceted way that different individuals described the outcome of the intervention. This detail could only have been gathered using qualitative methods which are therefore deemed appropriate for this area of research (Stacey et al., 2002).

The importance of family involvement was an additional finding that came from the data. Diana, Esther and Fiona were the 3 mothers, who all described positive outcomes, were the only three mothers who commented on family involvement. This is consistent with the wider research that discusses the need for family involvement
Evaluating Parents’ Expectations and social support (White & Verduyn, 2006; Ahmann, 2006). This is something which the ABC service needs to encourage.

**Strengths and Limitations of IPA**

The data received was a deemed a ‘thick’ description (Gilgun, 2005) that produced themes relating to the initial aims. Importantly, the data provided some clear areas of feedback for the service, positive features and areas to for improvement. Questionnaire based satisfaction methods have been criticised for producing overly simplified and biased ‘satisfactory’ results (Sitzia, 1999). As a result of the qualitative methods used, the researcher can feedback a more detailed but balanced view of the service (see below). The negative aspects would be sensitively fed back to the service in a constructive way, with the aim of addressing what could have gone wrong with Greta’s case and may indicate a training need. Despite this, negative feedback is essential in moving services forward and improving them (Williams et al., 1998).

The use of pre and post interviews appears to be a novel use of IPA, but remains consistent with the phenomenological tradition of trying to examine and reveal a ‘phenomenon’ (Giorgi, 1995). What was revealed via this method, was a number of common themes within this sample but great diversity and at times, polarisation within the themes. The analysis has attempted to account for both shared and distinct features while at the same time maintaining and describing each family’s story and an analysis of their views over time. A balance had to be struck between demonstrating what was said with interpretations being made reflecting theory and other research (Smith & Osborn, 2003).

The IPA methods used here have relied upon text from interviews, under the presumption that the language used represented the experiences of the participants (Willig, 2001). It has been argued that language can never give a true and consistent
Evaluating Parents’ Expectations

expression to experience and relies more on context (Smith, 1996). It has also been suggested that IPA is limited as it is not suitable for those who are unable to articulate their views in the sophisticated manner required for qualitative analysis (Willig, 2001), limiting the applicability of this method.

Qualitative research has been described as merely an assembly of anecdotal and personal impressions, strongly subjective and researcher biased (Mays & Pope, 1995). To address such critiques, strategies were used within this research to ensure rigour. The research endeavoured to describe an account of the methods used to collect and analyse the data, which is transparent and driven by the IPA literature. The researcher also aimed to develop a plausible and coherent explanation of the phenomena that was under scrutiny (Mays & Pope, 1995).

Lack of time and resources reduced other strategies that could increase rigour e.g. transcripts were only coded by the one researcher and there was no feeding back to participants as to whether they found the ‘findings’ a reasonable account of their experiences (Rolfe, 2004), or participant validation. Interviews such as those used in IPA have been viewed as being invasive and oppressive (Ribben & Edwards, 1998). The use of reflexivity was utilised here, with the aim of reducing this, the researcher gave thought to their role and any power differentiates, e.g., valuing the contribution of the participants by acknowledging they had specific knowledge that the researcher needed and without them the research would not be possible.

The researcher struggled with the presentation of the research findings. By reducing the data into themes (Miles & Huberman, 1994), the researcher felt that the individual story became lost, reducing the diversity that was apparent during the interviews. This was particularly noticable as the majority of the participants took part in a pre and post interview, increasing their individuality and building a picture of
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their experiences. In light of this, the researcher reflected on this research process and considered that a narrative approach may have been particularly suited to the exploration of the research aims, which would have maintained the ‘story’ of the individuals involved (Murray, 2003).

Strengths and Limitations of the Study

It was judged that the methods employed within this research were adequate with respect to recruiting service users to discuss their expectations and then their experiences of a service. Finding out ‘users’ views before and after experiencing a service was novel and provided unique data into their journey throughout the ABC clinics, rather than assessing one snapshot of their views, or asking for retrospective information. A very positive aspect was the continued commitment to the research by four of the participants, even when they had finished their involvement with CAMHS and were not obliged to continue with the post-ABC interviews. This could be attributable to the relationship developed with the researcher at the pre-assessment interview, and this may then have resulted in more open and honest responses at the post-ABC interviews.

Data was only gathered from one parent per family, and not from the children involved in the ABC clinics. Focusing on the parental view was done intentionally as ABC is recognised as a parent orientated approach. Despite this, evaluative research has been carried out with children (Copeland, Koeske & Greeno, 2004), and has criticised family orientated research which does not take account of the child’s view (Garland & Besinger, 1996) stating that parental service evaluation would be incomplete and inaccurate.

All of the children concerned within this study were boys. Although there are more boys than girls presenting to CAMHS (ONS, 2004), to have a sample made up
Evaluating Parents’ Expectations

entirely of boys does limit generalisability of the results as some of the features discussed by the mothers may have been specific to boys. In addition, the prevalence of health problems are represented differently in boys and girls (ONS, 2004).

As the research participants were all mothers and no fathers took part in the researcher, this again skews the findings. The need to involve fathers in their child’s mental and general healthcare has been recognised for some time (Ahmann, 2006) and the benefits to the child of father involvement have been demonstrated (Moore & Kotelchuck, 2004). The lack of participation of the fathers did reflect that for three of the participant families, the fathers were not living with the family, for two of these families the mothers disclosed that the father did not have any contact with the child. Such a high proportion of lone mothers in this sample is not representative of the general population but is more representative of families presenting at CAMHS (ONS, 2004). Interestingly, two of the mothers made a point of telling the researcher that they had ‘made sure’ the fathers had attended some or all of the ABC appointments and spoke of the benefits for all because of this. Two of the participants were from a non-white origin which does enhance the representativeness of the sample for the local population (DoH, 2005).

Limitations of time and resources meant that recruitment was limited to 6-10 families. Although this research has produced adequate results to explore the initial research aims, the use of more participants would have been beneficial and may have contributed more views and opinions, increasing the applicability of the research. Drop out between pre and post ABC interviews should have been anticipated therefore more numbers should have been recruited initially. In addition, smaller numbers of participants may threaten anonymity as cases are more obvious when there are fewer people (Pyett, 2003). Despite this, the researcher at times felt that
there was an adequate number of participants and any more would have resulted in
the individual ‘story’ being lost any more than it was here.

*Personal Reflections and Researcher Role*

Qualitative research involves the immersion of the researcher in the field
under examination, referred to as the ‘thick description’ (Gilgun, 2001). To develop
this, the researcher is required to make personal connections with those who they
research. Qualitative family research often involves highly personal and emotional
topics, which can impact on the researcher and participants (Gilgun, 2005).
Researcher self awareness is important in such a context and the researcher must have
integrity to represent the views of the participant honestly and truthfully (Elliot,
Fischer & Rennie, 1999). The researcher must also manage their own reflexivity so
that the representation of the data is balanced. This subjectivity provides opportunities
for development of rich and deep data, but subjective reactions can risk the loss of an
analytic stance (Gilgun, 2005).

The researcher was aware of the limits of their ‘research’ role and where they
were aware of the ‘pull’ towards a being a clinician. This was particularly apparent
when interviewing Greta who was unhappy with her ABC involvement and had many
unanswered questions. The researcher was aware of Greta’s feelings of being ‘let
down’ by the service, and not receiving what she had hoped for. The researcher also
felt the desire to ‘help’ Greta, which was obviously outside the remit as a researcher.
The urge to help and advise mothers also occurred in the pre-ABC interviews when
the researcher was aware that some of the interview time was spent with the mothers
ventilating their concerns and asking for reassurance. This was at times difficult for
the researcher to manage, but the researcher was mindful of their role and would re-
direct the questions and queries from the mothers to their imminent ABC sessions.
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Carrying out a qualitative project was a useful exercise which provided the research with a valuable experience and insight into what constitutes qualitative enquiry. The relationship and time spent with the participants was important and essential considering the aspects explored within this project, which would not have been achievable using quantitative methods. The analysis was more challenging than had been expected, as was discussing the implications of findings from qualitative methods. The need to incorporate previous research findings despite such a unique and complex data set was difficult and should be anticipated for future qualitative research.

Introducing a research interview before and after CAMHS involvement provided the mothers with an opportunity to reflect on their thoughts about the referral and experiences, and to ventilate concerns. Some mothers commented that they would not have normally thought about particular issues e.g., their beliefs about the clinics, but they appreciated the opportunity to do so. For some mothers it may have been a negative experience e.g., Ann, who did not attend any ABC appointments.

A major part of conducting any research is anticipating and maintaining ethical awareness (Barker, Pistrang & Elliot, 2002). The nature of the research was personal therefore the researcher had to be sensitive to the needs of the participants, and to be aware of any challenging issues that the researcher may need to seek help with. The professional and personal responsibility to maintain confidentiality was an important consideration that the researcher was mindful of throughout the research process and beyond; when considering dissemination of the findings.

*Service Implications and Dissemination*
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It was important that the findings of the research were reported back to the service, to acknowledge the time and effort given by the participants and to inform the service and the clinicians of how the clinics were working, with a view to the future of the ABC clinics. The information needed to be reported sensitively, so as not to reveal who the participants were, or who the clinician was whose practice was criticised. A table of the key findings was developed and is planned to be fed-back to the service imminently by the researcher who will elaborate and describe the findings (Table 4: Appendix D). The table particularly summarises the post-ABC findings in terms of the processes and techniques commented on by the participants. The additional information required by service users before attending the clinics would also be communicated back, as will the need to acknowledge the attributional style of those parents attending and the proposed value of the therapeutic alliance in facilitating engagement.

Direction for Future Research

Future research in this field could gain great insight from those individuals who do not attend for treatment or do not finish their treatment. ‘Pre’ interviews could be utilised as has been carried out successfully here, to explore some of the reasons for non-attendance. This study focused upon mothers and sons which will have biased the results found. Greater numbers of participants, actively recruiting fathers and referrals for girls would provide more balanced and representative data. Exploration of the father’s experience may also contribute to the development of new services or services that men find more accessible (Ahmann, 2006). Also accessing the views of the children experiencing the ABC clinics would also be paramount in moving ABC forward as a viable and acceptable process (Copeland, Koeske & Greeno, 2004).
Evaluating Parents’ Expectations

The issue of therapeutic alliance deserves additional research, and in the context of the ABC model, further qualitative research may benefit from the additional use of a therapeutic alliance rating scale (e.g., Working Alliance Inventory: Horvath & Greenberg, 1989) to test this issue directly. Additional demographic and treatment issues may benefit further similar research so that additional conclusions could be drawn e.g. children’s diagnosis or severity of problems.

Conclusion

In summary, the research provided evidence from service users about the expectations of the clinics, and of the benefits and any shortcomings of the ABC approach. Many mothers held beliefs that their son’s behaviour was in part, or in full, intentional and that there was (in part or fully) a biomedical cause for the problems. This aspect has many implications for parental management and compliance with service which needs to be sensitively assessed and managed by the clinician. ABC was shown to encourage the development of a therapeutic alliance, to acknowledge and focus upon individual needs and prior beliefs, it was strengths based and was, in the majority of cases, deemed beneficial. This was all despite being a ‘brief intervention’ of between 1 and 3 sessions. The results give support for the service but also indicate areas for improvement. The methods used produced ‘thick’ and descriptive data, reflecting the diversity and complexity of the type of presentations and views of those typically seen within a CAMHS service. The findings reflected not just a blanket rating of ‘satisfaction’ from specific individuals who chose to feed back their satisfaction via a questionnaire. Instead the findings demonstrated the complexity of what people expect, want and need for their children from a mental health service, what constitutes a positive outcome, but also where the service could improve.
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References


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London: Tavistock.


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Appendices

Appendix A

Information Sheet

University Headed Paper

Evaluating the ABC Clinics (Form A)*

I am a Trainee Clinical Psychologist studying at Lancaster University. I am carrying out some research looking at the parent’s/guardian’s experience of the ABC clinics that you will be involved in, within Trafford Child and Adolescent Mental Health Services (CAMHS). I am looking for parents/guardians to volunteer to take part in this research.

What will be involved?

☐ One 30-40 minute interview with myself, some time before your first ABC appointment, where I will ask you about your expectations of the ABC clinic.

☐ A second 30-40 minute interview with myself following your last ABC appointment. You will be asked to tell us about your experience of the ABC clinic. Interviews will be tape recorded.

Do I have to take part?

☐ No, it’s up to you to decide. If you do want to take part you will need to sign the enclosed consent form. You are still free to withdraw at any time and without giving a reason. Taking part, or not, will not affect your care.

Where and when will these take place?

☐ These interviews would be arranged between ourselves to ensure that the time and place are convenient e.g. this could be at home in the evening or at a clinic during the working day.

☐ If we are unable to arrange a convenient time to meet before your first 2+1 appointment we will not carry out that 1st interview and you will not be able to take part in the research.

Who can take part?

☐ Only parents/guardians of the child referred to services are expected to be interviewed.

☐ One or more people can be interviewed; who takes part is entirely your decision.

Will this affect my care in the ABC clinic or CAMHS?

☐ The clinicians doing the ABC clinics will not know who is involved in the research unless you choose to tell them.

☐ Being part of the research will not alter the normal care you receive from the ABC clinics.

☐ You are free to withdraw from the research at any time and can do so by contacting myself.

* Draft 2/16th May 2006
Evaluating Parents’ Expectations

What will happen to the Information discussed at the interviews?

☐ The research information collected during the interviews will be anonymous. Any identifying information will be removed. Your names will not be used in the finished version of the research.

☒ The finished version of the research may be submitted to a Psychological journal. This will be to inform other Child and Adolescent services about the findings. Again, no information identifying the research participants will be used. Tapes of the interviews will be destroyed after 6 months.

Any Questions?
If you have any questions or queries then please contact me, Jane Toner. My contact details are below.

Jane Toner
Trainee Clinical Psychologist
Doctorate in Clinical Psychology
Whewell Building
Lancaster University
Lancaster
LA1 4YT
01524 592970
j.toner@lancaster.ac.uk

If I am away from the office, please feel free to leave me a message and I will get back to you as soon as possible.

If you are interested in being part of the research then please complete Form B and return it to me in the envelope supplied. You can keep this information sheet for further reading.

As a Trainee Clinical psychologist at Lancaster University, I am not an employee of Trafford Child and Adolescent Mental Health Services. The service is supporting the research, the information within this form, and will be providing me with supervision and guidance. I also receive supervision about the research process from Lancaster University. (This study has been given ethical approval for conduct in the NHS)

Further Help
If you are feeling that you would like to talk to someone about any mental health concerns that you or your family have, and would like to do this in confidence, the organisations listed below will be able to help.

NHS Direct
Tel: 08457 46 47
www.nhsdirect.nhs.uk

MIND
08457 660 163
www.mind.org.uk

Samaritans
Tel: 08457 90 90 90
www.samaritans.org

Family Contact Line
0845 120 3788 (Trafford service)
www.fcl.34sp.com

Your General Practitioner (GP) can also discuss any concerns with you and refer you onto appropriate services.

Thank you
Appendix B
Consent Form

Evaluating Parents’ Expectations

University Headed Paper

Evaluating the ABC Clinics:
CONSENT FORM (Form A)⁵

I am interested in taking part in the research and I have been given opportunity to ask questions about the study

Yes/No

I understand that my participation is voluntary and I am free to withdraw at any time, without giving reason and without my medical care being affected.

I agree to have the interviews tape recorded

I agree to take part in the above study

Name of Parents/Guardians:..........................................................................................................................
to be included in the research:....................................................................................................................

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

Address:..........................................................................................................................................................
....................................................................................................................................................................
....................................................................................................................................................................

Telephone Number/E-mail address:..........................................................................................................
(please specify when it is most appropriate for us to contact you):..................................................................

SIGNED:______________________________________ DATE:_______

SIGNED:______________________________________ DATE:_______

SIGNED:______________________________________ DATE:_______

Please note, a signature is required from parents/guardians who agree to be involved in the research. One or more individuals can be involved in the research. This signature is only to indicate your consent to take part in this study. This form will be kept separate from the interview information to ensure your views remain anonymous.

Thank you

⁵ Draft 2/16th June 2006
Interview 1

Thankyou for taking part.
Confidentiality limits.
Purpose of the research.
Request for permission to tape the interview.
(Prompts only to be used if required)

☐ Would you tell me a little bit about how you ended up coming into the Child and Adolescent Mental Health Services?
   o Prompts (if required)
     o Were they in agreement with the referral
     o Length of time before being referred
     o Involvement in other services e.g. Peadiatrics, GP.

☐ What are your expectations about the process of the ABC clinics?
   o Prompts
     o Who will you be seen by
     o Will they get chance to speak/put their view across.
     o Will there be enough time (esp if problem is severe)
     o Have you any thoughts how your child will react/behave?
     o Will my child be able to speak/contribute?

☐ How do you feel about being referred into the ABC clinic?
   o Prompts (If required, a sheet will be provided outlining a range of emotions with an equal number of positive and negative emotions, to act as prompts. Examples are: Relief, apprehension, annoyance, pleasure).

☐ What are your hopes about the ABC clinics?
   Prompts
     o The practitioner will be pleasant
     o I won’t feel uncomfortable
     o I won’t be blamed for the problem
     o My Child will be OK, not distressed.
     o It will help

☐ Do you have any doubts or concerns about the ABC clinic?
   Prompts
     o I will be blamed, held responsible
     o It will be uncomfortable

---

5 Draft 1/18th May 2006
Evaluating Parents’ Expectations

- We/I won’t get our point across.
- It’ll be a waste of time
- I won’t understand what the clinician is saying.

Interview 2

Thank you again for taking part
Repeat confidentiality issues and limits
Request permission to tape interview.

☐ How did you find the process ABC clinic?
  - Convenient-timing, geography.
  - Did the format allow you to speak if you wanted to.
  - Did the format allow your child to speak if desired.
  - Did you have enough time?
  - Did you get enough information throughout the process.
  - Did you feel listened to
  - Did you feel your opinion was valued.
  - Did you feel as though your family was valued and respected by the process.

☐ Did the ABC clinic live up to your concerns?
  - Can give overview of fears discussed at interview 1

☐ Did the ABC clinic lives up to your hopes?
  - Can give overview of items discussed at interview 1.

☐ Can you think of ways that the ABC clinics could be improved?
☐ Do you feel the ABC process helped your family/your child/your current situation?
### Table 1

*Pre-ABC themes and subthemes*

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-theme</th>
<th>Example from interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Descriptions of Behaviour</td>
<td>Intentional</td>
<td>He’ll go for things that he knows he’ll not damage (Esther)</td>
</tr>
<tr>
<td></td>
<td>Unintentional</td>
<td>He can’t tell me what’s going on in his mind (due to the meds) (Clare)</td>
</tr>
<tr>
<td></td>
<td>Desirable</td>
<td>He’s a lovely little boy (Fiona)</td>
</tr>
<tr>
<td>2) Beliefs about Causation</td>
<td>Biological</td>
<td>It’s hereditary, I think it’s his wiring (Fiona)</td>
</tr>
<tr>
<td></td>
<td>Environmental (home)</td>
<td>He has learnt how to play one of us off against each other. (Esther) Perhaps if I’d been a bit better, there for him more (Bernie)</td>
</tr>
<tr>
<td></td>
<td>Environmental (other)</td>
<td>I don’t think the school do a lot, they should be working with him, loads of kids are like it. (Esther)</td>
</tr>
<tr>
<td>3) Expected focus of CAMHS</td>
<td>Child (biological)</td>
<td>Tests? To find out what wrong with him? (Ann)</td>
</tr>
<tr>
<td></td>
<td>Child (Emotional)</td>
<td>He might open up to someone there (Bernie)</td>
</tr>
<tr>
<td></td>
<td>Family</td>
<td>We want something we can do as a family (Diana)</td>
</tr>
<tr>
<td>4) Strategies used</td>
<td>Strategies</td>
<td>I’ve followed guidance, been consistent, set boundaries, reward charts. (Greta)</td>
</tr>
<tr>
<td>5) Beliefs and Feelings about CAMHS</td>
<td>Negative Feelings</td>
<td>I don’t feel hopeful at all (Esther)</td>
</tr>
</tbody>
</table>
Evaluating Parents’ Expectations

<table>
<thead>
<tr>
<th>Positive feelings</th>
<th>I’m quite looking forward to it, I’m relieved. (Bernie)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fears</td>
<td>Not prozac or pills I hope (Greta)</td>
</tr>
<tr>
<td>Uncertainty</td>
<td>I’ll just wait and see (Ann)</td>
</tr>
<tr>
<td>Practice of CAMHS</td>
<td>They know how to talk to kids, how to approach them. (Bernie) Anger management (Esther)</td>
</tr>
</tbody>
</table>

Table 2
Overview of Findings.

<table>
<thead>
<tr>
<th>Description of Behaviour</th>
<th>Strategies Tried</th>
<th>Beliefs about Causation</th>
<th>Beliefs about CAMHS</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1 Intentional/Undesirable Violence Dangerous Attention seeking Unintentional He’s cold.</td>
<td>/</td>
<td>Attention seeking ADHD? (Many adverse life events discussed but not linked to problems)</td>
<td>Tests Find out what wrong To help Feelings: Indifference. Intervention Focus: Child</td>
<td>DNA x3</td>
</tr>
<tr>
<td>F2 Intentional/Undesirable Problem behaviours Getting self into trouble Keeps things to self</td>
<td>Nag, Be patient</td>
<td>Deep rooted Past family problems Current family functioning, parenting.</td>
<td>For child to open up Clinical techniques and experience Feelings: relieved but anxious. Intervention Focus: Child, family(?)</td>
<td>Tier 3 (Offending team)</td>
</tr>
<tr>
<td>F3 Unintentional Won’t talk Diagnosis related behaviour.</td>
<td>/</td>
<td>Due to previous diagnosis (hereditary and genetic cause and injury)</td>
<td>To talk, deal with feelings Feelings: indifference. Intervention Focus: Child</td>
<td>Tier 3 (Child in Need)</td>
</tr>
</tbody>
</table>


### Evaluating Parents’ Expectations

| F5 | Intentional Violence.  
<table>
<thead>
<tr>
<th></th>
<th>Naughtiness.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Many tried</td>
</tr>
<tr>
<td></td>
<td>Parental management (in the past and current)</td>
</tr>
<tr>
<td></td>
<td>Temperament</td>
</tr>
<tr>
<td></td>
<td>Counselling</td>
</tr>
<tr>
<td></td>
<td>Anger management</td>
</tr>
<tr>
<td></td>
<td>To help the family</td>
</tr>
<tr>
<td></td>
<td>Feelings: hopeful</td>
</tr>
<tr>
<td></td>
<td>Intervention focus:</td>
</tr>
<tr>
<td></td>
<td>Child, family?</td>
</tr>
<tr>
<td></td>
<td>Good outcome. Clear information given. Good effect on parenting between mum and dad.</td>
</tr>
</tbody>
</table>

| F6 | Unintentional Violence  
<table>
<thead>
<tr>
<th></th>
<th>Challenging He’s different</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Many successfully used.</td>
</tr>
<tr>
<td></td>
<td>More help needed.</td>
</tr>
</tbody>
</table>
|    | Biological/genetic problem.  
|    | ? aspergers           |
|    | Advice, support.       |
|    | Insight into son.      |
|    | Feelings: apprehensive, not hopeful. |
|    | Intervention focus:    |
|    | Child, Family?         |
|    | Positive as felt was taken seriously. Feels hopeful about the future. |

<table>
<thead>
<tr>
<th>F7</th>
<th>Mixture of unintentional and intentional Different Destructive (I’m not coping)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Many successful ones are ongoing</td>
</tr>
<tr>
<td></td>
<td>Emotional, deep down. Parental coping ? autistic?</td>
</tr>
<tr>
<td></td>
<td>To uncover deeper problems</td>
</tr>
<tr>
<td></td>
<td>Assist mum in strategies.</td>
</tr>
<tr>
<td></td>
<td>? diagnosis.</td>
</tr>
<tr>
<td></td>
<td>Feelings: relief, apprehension.</td>
</tr>
<tr>
<td></td>
<td>Intervention focus:</td>
</tr>
<tr>
<td></td>
<td>Family &amp; child.</td>
</tr>
<tr>
<td></td>
<td>Unhappy with process/therapist? Superficial and unhelpful. Many unanswered questions.</td>
</tr>
</tbody>
</table>

### Table 3

*Post-ABC themes and sub-themes.*

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-theme</th>
<th>Example from Interviews</th>
</tr>
</thead>
</table>
| 1) Session characteristics   | Techniques         | The therapist made him think about how he has behaved and why, it was good then for us all to hear. (Esther)  
|                              |                    | It wasn’t being told, it was looking at it from a different perspective (Diana)          |
|                              | Technique (strengths) | There was recognition about what we’d been doing, what we were coping with (Fiona)       |
|                              | Process            | Seeing the same person throughout, continuity (Fiona)                                   |
Evaluating Parents’ Expectations

<table>
<thead>
<tr>
<th>2) Family Involvement</th>
<th>Effect on CAMHS</th>
<th>It was important for them (CAMHS) to hear from us both (Fiona)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Effect on family</td>
<td>We laid it all out to his dad and brothers, then we were all working together (Diana)</td>
</tr>
<tr>
<td>3) Description of Outcome</td>
<td>Within session</td>
<td>He started to open up (Diana)</td>
</tr>
<tr>
<td></td>
<td>After sessions (family management)</td>
<td>We’re are following it through now, it took the appointment for us to do it (Esther)</td>
</tr>
<tr>
<td></td>
<td>After session (symptoms)</td>
<td>His sleep, it’s great, he’s less angry (Diana)</td>
</tr>
<tr>
<td></td>
<td>After session (others)</td>
<td>We’re going to be taken seriously now (Fiona)</td>
</tr>
<tr>
<td></td>
<td>After session (self)</td>
<td>I came away thinking I was silly, it wasn’t relevant (Greta)</td>
</tr>
<tr>
<td></td>
<td>Unanswered questions</td>
<td>Is there something that makes him different? (Greta)</td>
</tr>
</tbody>
</table>

Table 4
Feedback to CAMHS

Feedback regarding ABC: Process and Techniques
Aspects that promoted engagement and compliance

<table>
<thead>
<tr>
<th>Positive Aspects</th>
<th>Negative Aspects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being able to see the same clinician throughout</td>
<td></td>
</tr>
<tr>
<td>Routine problems were given adequate time</td>
<td>Can appear Superficial</td>
</tr>
<tr>
<td>Evaluating Parents’ Expectations</td>
<td></td>
</tr>
<tr>
<td>---------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Not too formal</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Not too intimidating</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Time spent talking to child was appreciated (and surprised some)</strong></td>
<td><strong>Too much time spent with the mother. Not enough focus on child and their views. Child without parent.</strong></td>
</tr>
<tr>
<td><strong>Acknowledgement and recognition of strategies already tried at home.</strong></td>
<td><strong>Not to judge this as the only progress that can be made. Look why the problem occurred in the first place</strong></td>
</tr>
<tr>
<td><strong>Not being told things directly</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Being able to look at the problem from a different perspective (e.g., during discussions between child and clinician)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Being given relevant information to take home (concrete information)</strong></td>
<td><strong>Lack of concrete information e.g., regarding diagnosis (if that is a concern)</strong></td>
</tr>
<tr>
<td><strong>Acknowledging concerns and worries (e.g., is it something to be worried about)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Giving time and attention to the relationship</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Being listened to</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Being ‘in sync’ with the clinician</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Beliefs about CAMHS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tests</strong></td>
</tr>
<tr>
<td><strong>Anger management</strong></td>
</tr>
<tr>
<td><strong>Talking to/analysing the child?</strong></td>
</tr>
<tr>
<td><strong>Assessments, finding out what is wrong with them</strong></td>
</tr>
<tr>
<td><strong>To see what is wrong with them.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Things Parents would like to know before attending</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Should I bring my child with me?</strong></td>
</tr>
<tr>
<td><strong>Will I have time to talk on my own?</strong></td>
</tr>
</tbody>
</table>
Evaluating Parents’ Expectations

| Will somebody be there to watch my child? |
| Will there be things for my child to play with? Is that allowed? |
| Can I bring other people? |
| Can I make notes? |
| Will they be analysing me? |

Appendix E: Figures

**Figure A:** Continuum representing family’s descriptions of undesirable behaviour.

<table>
<thead>
<tr>
<th>Intentional Behaviour</th>
<th>Mixture of Unintentional &amp; intentional</th>
<th>Unintentional Behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Esther</td>
<td>Bernie</td>
<td>Ann</td>
</tr>
<tr>
<td>Diana</td>
<td>Greta</td>
<td>Fiona</td>
</tr>
<tr>
<td>Clare</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Figure B:** Continua representing beliefs about causation of referred problem and expected focus of CAMHS intervention.

<table>
<thead>
<tr>
<th>Causation: Biological</th>
<th>Causation: Environmental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clare</td>
<td>Fiona</td>
</tr>
<tr>
<td>Esther</td>
<td>Bernie</td>
</tr>
<tr>
<td>Greta</td>
<td>Diana</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intervention focused on Child</th>
<th>Intervention focused on family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ann</td>
<td>Fiona</td>
</tr>
<tr>
<td>Clare</td>
<td></td>
</tr>
<tr>
<td>Bernie</td>
<td>Greta</td>
</tr>
<tr>
<td>Esther</td>
<td>Diana</td>
</tr>
</tbody>
</table>
### Figure C: Continua demonstrating: beliefs about causation; expected focus of CAMHS intervention and strategies used.

<table>
<thead>
<tr>
<th>Causation: Biological</th>
<th>Causation: Environmental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clare Ann  Fiona</td>
<td>Esther Greta  Bernie  Diana</td>
</tr>
<tr>
<td>Intervention focused on Child</td>
<td>Intervention focused on family</td>
</tr>
<tr>
<td>Ann Clare  Fiona</td>
<td>Bernie Greta Esther  Diana</td>
</tr>
<tr>
<td>No Strategies Tried</td>
<td>Many Strategies Tried</td>
</tr>
<tr>
<td>Ann Clare  Bernie  Fiona  Esther  Diana  Greta</td>
<td></td>
</tr>
</tbody>
</table>
Evaluating Parents’ Expectations