Adolescents' Attitudes towards Psychological Therapy

Submitted April 2011

By

Anna Kershaw

To the University of Leicester, School of Psychology, Clinical Section

In partial fulfilment of the degree of,

Doctorate in Clinical Psychology

Declaration

I confirm that this thesis is my own original work, except where otherwise stated with reference to the original author(s). It has been submitted in partial fulfilment of the degree of Doctorate in Clinical Psychology and no part of it has been submitted for any other degree or academic qualification.

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Section A: Thesis Abstract

The literature review explored adolescents' experiences of psychological therapies. Sixteen studies were reviewed and a narrative synthesis found that therapist characteristics, the wider context of mental health and personal feelings were important aspects of the therapeutic encounter for the adolescent population. Synthesis of the evidence was limited by methodological weaknesses. Further research regarding what hinders engagement in therapy and macro-level influences on the therapeutic encounter was suggested.

The research study utilised a qualitative, semi-structured interview design to explore adolescents' experiences of psychological therapy. The accounts of eight adolescents were analysed using Grounded Theory methodology (Glaser & Strauss, 1967). The findings suggested that adolescents' attitudes towards psychological therapy were affected in a complex and dynamic manner by their experiences of the therapeutic process, their experiences of the therapist and their views about what others' think. The research also suggested that adolescents represent a high risk group for disengagement from psychological therapy. The findings were discussed in the context of existing research and it was suggested that professionals providing psychological therapy should consider taking an active political role in shaping future service developments to enable

services to engage better with this client group. Further research exploring whether these findings are more widely generalisable was suggested.

A personal account of the researchers' reflections on the research process is provided in the critical appraisal.

Acknowledgements

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Section B

Exploring adolescents' views of psychological therapy: A systematic literature review

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1. Literature review abstract

The current systematic review set out to explore how adolescents experience psychological or talking therapy from their perspective and, therefore, focused on qualitative research. Sixteen papers were reviewed and a narrative synthesis of the evidence produced. Methodological weaknesses were common across studies. Despite these limitations, the review tentatively concludes that characteristics of therapists, others' views of services and personal feelings about psychological therapy were key to adolescents' understandings of and response to the therapeutic encounter. Further qualitative research is required to lend weight to the current field, to understand what hinders the process of engagement in therapy and how the views of the system interplay and affect adolescents' attitudes towards therapy. Enhancing understanding of adolescents' experience of talking therapy will inform current debates about how to improve therapeutic experience and outcomes for adolescents.

Key words: Adolescence, teenager, psychological therapy, experience, view, understanding

Target Journal: Child and Adolescent Mental Health

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See appendix A for "Author Guidelines for Child and Adolescent Mental Health"

2. Introduction

2.1. Background

"Youth are heated by nature as drunken men by wine" (Aristotle, cited in Dahl, 2006, p.5)

Adolescence is a developmental stage in the human life cycle that is characterised by biological and social transitions. Biologically, pubertal changes are known to occur within the body and the brain. Socially, within western society the adolescent is expected to make the transition from dependent child to independent adult. Biological and social transitions are interrelated. Recent social neuropsychological research suggests that the brain's socio-emotional system changes during the transitional change into puberty; reward-seeking/risk-taking increases as a result of a drastic remodelling of the brain's dopaminergic system (Steinberg, 2008). Furthermore, during the transition from adolescence to adulthood, structural and functional changes occur in the prefrontal cortex and its connections to other brain regions, improving an individual's capacity for self regulation. These differences in cognitive processing are commensurate with the notion that emotion plays a key role during the developmental stage of adolescence. Managing these significant transitions is likely to have an impact on adolescents' psychological wellbeing.

Prevalence rates for mental health difficulties within the adolescent population are high, with one in five adolescents thought to experience mental ill-health (Audit Commission, 1999). This statistic perhaps reflects the impact of the transitional changes

outlined above. Furthermore, the major sources of death and disability in adolescence (suicide and alcohol and drug misuse) are related to difficulties controlling emotion and behaviour (Dahl, 2006). These research findings suggest a need for psychological support for the adolescent population.

Despite adolescents' apparent need for psychological support, research has consistently found that they find it difficult to access and engage with psychological therapies (Beck, 2006; Boyd *et al*., 2007; Bury, Raval & Lyon, 2007; Drauker, 2005; Garland & Besinger, 1996; Le Surf & Lynch, 1999; Naylor, Lincoln & Goddard, 2008; Street & Herts, 2005). Reasons suggested for this are varied; ranging from difficulties experienced at person-to-person level through to difficulties experienced at a wider systemic level. For example, Paul (2004) found that adolescents did not want to engage in therapy when family members instigated referrals to therapy and Street & Herts (2005) found that social stigma surrounding mental ill-health prevented adolescents from accessing services.

Research suggests that difficulties accessing psychological therapies are even greater for vulnerable groups of adolescents such as those who in the care system, homeless young people and those seeking asylum (Edwards, 2008; Golding et al., 2006). The prevalence of attachment difficulties and post traumatic stress is high within these groups and influences the development of social and emotional skills (Golding et al., 2006). A delay in these skills is likely to exacerbate difficulties engaging with traditional therapeutic approaches.

Considering how difficult adolescents find engaging with psychological therapy, understanding and acting upon their views to shape and inform the therapeutic encounter

would appear to be vital to those delivering psychological services. Recent legal and

policy frameworks have recognised the paramount importance of adolescents' views

(Children Act, 1989; 2004; United Nations Convention on the Rights of the Child, 1989;

Department for Education and Skills [DfES], 2004; Department of Health [DH], 2003).

For example, the core principle of the "Framework for Developing a 'Comprehensive'

CAMHS" policy (DH, 2002) holds that the commissioning and delivery of services

should be informed by adolescents' views. Despite the principle of hearing and acting on

young peoples' views, consultation with adolescents has shown that they feel

inadequately informed about their options and not listened to by professionals (Fegert et

al., 2003; Law, 1998). Government rhetoric places understanding and acting on

adolescent's views about psychological therapies high on the Child and Adolescent

Mental Health Service (CAMHS) agenda. It is unclear, however, in which way, if at all,

these views are subsequently used to influence CAMHS decision making.

2.2. Hearing the voice of the adolescent within CAMHS

The increased legal and policy focus on hearing the voice of the adolescent does

not appear to have shaped the research agenda; there is a paucity of literature exploring

adolescents' views about psychological therapies. Much of the literature on adolescents'

views focuses on areas other than CAMHS, notably social care provision for children

(Mann & Tolfree, 2003; Thomas, 2005) and adult generic health services (Coffey, 2006).

The available literature has not provided a sufficient understanding of the issues of

concern to those who work in CAMHS. Indeed, research indicates that within the CAMH

field, there is a history of the adolescents' views being largely overlooked (Street &

Herts, 2005).

To date, no systematic reviews of the literature regarding adolescents' views of psychological therapies have been published. There are, however, two published systematic reviews relevant to the broader subject area. Davies and Wright (2008) reviewed literature pertinent to looked-after young people's views of mental health services and Freake et al. (2007) reviewed literature regarding adolescents' views of the helping professions. Both reviews identify key themes regarding adolescents' views of mental health services more generally. The themes emerging from Davies and Wright's (2008) review focused on three areas: firstly perceptions, evaluations and recollections of interventions; secondly personal skills, attitudes and qualities of staff; and thirdly the therapeutic process and outcomes. Freake et al.'s (2007) review reported a number of key themes that were grounded in the adolescents' accounts including: "They listen to me", "They are non-judgemental", "They explain things and give me information and advice" and "They are kind, caring, sympathetic, understanding".

2.3. Aims of the current review

The current review aims to explore adolescents' views of psychological therapies. The review focuses solely on qualitative research and excludes quantitative literature, as quantitative research by necessity limits the responses that participants can make and the shortage of research in this area suggests that there is little evidence upon which to base quantitative surveys. Qualitative research forms the basis of this review because it allows participants to voice the aspects of their experience of psychological therapies which they feel are most relevant. The findings may inform further quantitative research that could assess the robustness and ability to generalise these findings.

The aims of the current review are therefore to provide: 1) An overview of the recent qualitative research in this area and 2) An understanding of adolescents' experience of psychological therapies based on a synthesis of themes across the qualitative evidence base.

3. Method

Narrative synthesis refers to the use of words and text to summarise and explain the findings of the synthesis. The term "narrative review" is defined in this paper as, a review that searches and appraises the literature systematically and offers a textual, rather than quantitative summary, of the evidence (Miller, Bonas & Dixon-Woods, 2007). Guidance for narrative synthesis in systematic reviews has recently been developed by the Economic and Social Research Council (ESRC) (Popay et al., 2007). The wider aim of the current review is different from the foci of the ESRC guidance and therefore utilises some, but not all, of the techniques outlined in the guidance (see section 3.5. for a full description of methods used).

3.1. The review question

The review question focused on adolescents' experiences of talking therapy as reported in qualitative studies. The review question answered was "How do adolescents' understand their experiences of psychological therapy?"

3.2. Search strategy

Structured strategies were used to search for papers for the current review in the following databases; Applied Social Sciences Index and Abstracts (ASSIA), Medline, PsychInfo and Web of Science (WoS). Three different strategies were applied to the

search: the use of thesaurus terms and the use of free text terms both suggested by Shaw et al. (2004) and the scanning of reference sections and citations (see Appendix A).

3.2.1. Using thesaurus terms

Search databases contain controlled systems of keywords (thesaurus terms or subject headings) that are used to categorise each record stored. The thesaurus terms used varied for each database according to its indexing system. For example, the "exploding" function on Medline was used to broaden out thesaurus terms. Exploding the term "therapy" generates subcategories of the term, all of those that pertained to talking therapies e.g. "cognitive therapy", "psychoanalytic therapy", "gestalt therapy" were selected.

3.2.2. Using free text terms

Free text terms were used to find articles that were pertinent to the research question. The author searched the databases utilising every combination of the following commonly used terms: "view" or "experience" or "attitude" and "adolescent" or "teenage" or "young person" and "therapy" or "mental health". Truncations were used to ensure maximum search efficacy.

Titles and abstracts were scanned for relevancy and inclusion and exclusion criteria were applied to select the articles for further analysis.

3.3. Inclusion and exclusion criteria

Articles that contained some investigation of adolescents' experiences of psychological therapy were selected for review. Due to the shortage of research in this

area, any study that demonstrated that themes found emerged directly from participants accounts (rather than being based on researchers' preconceptions) was included. To ensure relevance to the review topic, only articles where the mean age of participants was between thirteen and nineteen years were included to focus the search on the adolescent population. It is recognised that there may be cultural differences and differences in policies and practice in delivering psychological/ talking therapies in different countries, however, due to the low number of relevant papers, geographical boundaries were not imposed in order to amass a reasonable body of literature to consider. Again, due to scarcity of relevant literature, the search criteria were extended to include journal articles from 1990 to the current date. Books, dissertations, theoretical and opinion papers and articles that did not discuss participants' views in their own words were excluded from the analysis.

3.4. Assessment of quality

A quality appraisal checklist for qualitative data was not used. This is because research suggests that using a checklist to vet papers for inclusion can sometimes result in undue importance being attached to a single aspect of a paper that may not be particularly relevant to either that paper or the participants' accounts contained within it (Dixon-Woods et al., 2007). Therefore, using an inclusive approach was considered vital in order not to miss findings that are unique to a particular study. As a result of the author adopting an inclusive position, studies were included even when they had some short-comings, but their findings seemed plausible overall. Whilst the author made a judgement to assess whether any of the papers were 'fatally flawed' i.e. overall findings did not seem plausible (Dixon-Woods et al., 2007), none were found to fall into this category. All

papers that were judged to offer a useful contribution were included so that no relevant themes were lost from this small body of literature. In order to acknowledge any quality concerns with individual papers, comments are included in Table 1. The methodological weaknesses of the papers included did not impact on the results sections of those papers and therefore justified their inclusion in this work.

The evidence obtained, lended itself to being reviewed in the form of a qualitative meta-analysis rather than in the traditional literature review structure.

3.5. Synthesis of the evidence

The author made notes on each paper and the themes were assembled in tabular form (See Table 1). Methods described in the Economic and Social Research Council (ESRC) Guidance (Popay et al., 2006) were used to synthesise the data. These included textual descriptions, groupings and clusterings, translation of primary themes or concepts across the studies to explore similarities and/ or differences between different studies (Pawson, 2002; Popay et al., 2006) and thematic analysis (Popay et al., 206). Thematic analysis was used to identify recurrent and dominant themes within the literature. These themes were compared, contrasted and then used to generate superordinate themes which make up the structure of the current review.

3.6. Author's position

Before reporting the findings of the analysis, it is important to acknowledge the background of the author and consider the impact of this on the nature of the current review. The author is a trainee clinical psychologist who has worked with adolescents who were reluctant to use CAMHS and social care services. She has no previous

experience of researching in this area. The author recognises that she has a bias towards the perspective of those who do not want to use or who hold negative views about services. During the analysis and write up of the current review she used research supervision to reflect on these biases and ensure that the results were genuinely supported by the literature.

4. Results

Initial searches identified 3230 articles that were potentially relevant. Screening of these articles on the basis of method (including participants' views in their own words) and topic (adolescents' views of therapy) yielded 303 abstracts that were possibilities for inclusion in the current review. Following a subsequent appraisal of relevance of articles to the topic of adolescents' views of psychological therapy and quality, and removal of duplicates, 16 articles were deemed suitable for inclusion (for full literature search details see Appendix B)

4.1. Article quality

The majority of the papers included were categorised as weak in terms of quality. Using the criteria defined above, none were considered to be 'fatally flawed'. Quality issues were wide ranging and are summarised below. A lack of researcher reflexivity regarding ethical issues and their personal position in relation to the topic area was evident; only three papers reviewed addressed this in detail: Bury, Raval & Lyon, 2007; Newton et al., 2007 and Offord, Turner and Cooper, 2006. Those articles that used surveys with open questions had low response rates to some of the questions, yet the

authors claimed generalisability for example, in Beck (2006) some questions were only answered by three respondents. A lack of clarity about method of analysis was also evident and there were attempts to generalise findings without achieving theoretical saturation. None of the papers discussed the inclusion of people who struggle to articulate their views, who have a learning disabilities or communication difficulties, for example. Some papers offered suggestions for practice that were not based explicitly on research findings, for instance Le Surf and Lynch (1999), who made generalisations that themes identified could be beliefs held in the wider and possibly adult population. This claim was unsubstantiated by the research findings. Finally, papers did not ground all of their findings with direct quotes from participants. This has limited the author's ability to ground the current analysis by using direct quotes; where quotes were available they have been used.

4.2. Narrative synthesis of the evidence

The thematic analysis of the seventeen papers generated three superordinate themes: the wider systemic context of mental health services, the connection with the therapist and the influence of the young person's thoughts and feelings on the process. Subthemes were subsumed within the three superordinate themes in a hierarchical structure. In turn, the superordinate themes were intrinsically linked with each other and subsumed within the overarching theme "Adolescents' views about psychological therapies". In many of the papers, the relationship with the therapist was of central concern, particularly the therapist's characteristics. To some extent the synthesis reflects this, yet wider systemic and more personal influences on the experience of therapy also featured recurrently. The current synthesis attempts to bring together these key aspects.
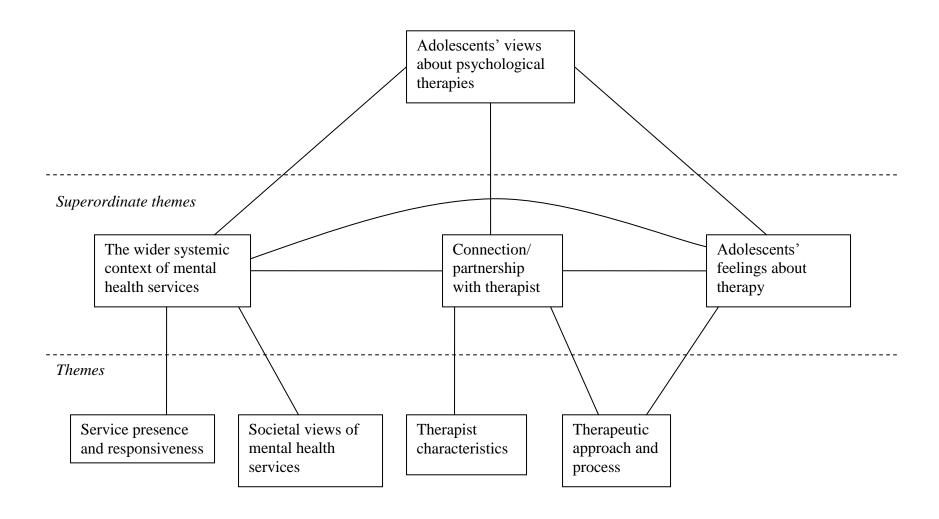
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Figure 1: Pictorial representation of themes emerging from studies reviewed

First author and year	Methods used	Themes identified/ headings explicitly labelled relevant to review question	Quality comments; reflexivity,	Contribution to evidence base and directions for future research
Beck, 2006	Thematic analysis	Barriers to accessing services- Physical obstacles Stigma Desired service- Similar or dissimilar to what they have experienced before	Lack of reflexivity Piloted on young people and revisions made Thematic analysis not well described quality checks made e.g. triangulation Subjectivity of analysis recognised Variable response rates to questions Survey design generated few ideas Not representative sample- ethnic minorities underrepresented.	Implications for services and recruitment of CAMHS professionals stated. Idea generation about what services they would like was difficult- future research ongoing dialogue.
Boyd, 2007	IPA	Barriers to accessing services-lack of anonymity, culture of self reliance, stigma, access was school based Preferred supportive over structured counselling Valued therapist characteristics- caring, non judgmental, genuine, young, able to maintain confidentiality	Team approach to reflexivity- not explicit about what this was	Implications made re how therapy happens in rural communities. Attempts to generalize through making suggestions for policy change; further research required first.

Bury, 2007	IPA	*Expectations of therapy-* Being in difficulty Feelings regarding referral and stigma Ambivalence Therapist has the answer- mixed feelings *Beginning therapy* Mixed feelings How therapist responded *Therapeutic process* Learning the ropes- Directive approach positive. Setting unnatural. Facilitative aspects- Manner of therapist. Value of professional nature of relationship. Value of personal aspects- listening, taking concerns seriously, acceptance, validation. Demands of therapy painful. Power- difficulties challenging therapist *Endings* Ambivalence Separation and loss Moving on Findings understood at societal, developmental and individual level	Validity reflexivity both addressed in detail and throughout article. Independent audit of 2 transcripts. Cross checking between authors and with literature Ecological validity Respondent validation and triangulation were not used- deemed inappropriate.	Contribution to evidence base re quality and accessibility of services. No claims of generalisability; suggests meanings attached to therapy should be equally as important as outcome measures. Future research- negative experiences of young people in therapy, incorporating therapists' perspectives. Practice implications- addressing power differentials early on. Services should provide more opportunities for feedback
Craigen, 2009	IPA	*My counsellor* Helpful behaviours- listening,	Thorough methodology Little personal reflection from	Suggests feminist approach to counselling

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			researcher	women who SH
		understanding, a friend. Unhelpful behaviours- lack of understanding, forcing ideas *Counselling process* Techniques, behavioural alternatives, talking was helpful, no harm contracts were ineffective, focus of treatment *Counselling reflections*- feelings in counselling were negative Liked not being judged, disliked expert status –preferred partnership.		
Drauker, 2005	Grounded theory	*Pitfalls*- they'll think I'm crazy, they'll tell my business, they wont have a clue *Venturing through the system*- steering clear, holding back, letting it take hold- worker who relates at their level has a sense of humour, has time, importance of confidentiality *3 working conditions* support of parent/ caregiver; clinician being non-judgemental, trustworthy, receptive to teen's concerns and "hung in there"; teen decided to let their guard down	Sample well described. Reflexivity not explicit. Constant comparison method used.	Practice implications- clinicians to be aware of pitfalls especially for African American children Generalisable? Future research- multiple perspectives on therapy for adolescents including treatment providers, tracking of teens to see what socio-cultural factors influence the course of their illness.
Garland,	Thematic	Reasons for attendance- family	Explicit about respecting	Findings- adolescents

1996	analysis Satisfaction ratings scales- CSQ-8	problems Goal- improving self esteem- mental health services viewed as a growth opportunity Expectations- frightening/ intimidating Perceptions about concerns of others- breaking confidentiality/ discomfort disclosing info. Perceived benefits- quality of relationship and specific problem solving. Differences between males and females re expectations, concerns and what they didn't like. Found no significant differences in satisfaction between subjects of differing gender or race or whether or not they had sought counselling themselves.	confidentiality/ consent/ opportunities to opt out. Small sample size for quantitative aspects of study (25). No mention of bias of researcher's opinion- but triangulated. Recognition of sampling bias No reflexivity Directive questioning- could lead to participants thinking there is a right or wrong answer Standardized element may prevent participants from being thoroughly explorative? 33 interviews occurred but only 25 used- deemed as representative of all views Themes identified and triangulated (independently coded by 2 other researchers)- Csq 8- normed on adult population.	capable of discussing expectations, concerns and satisfaction well formulated opinions. Recommendations for services to consult more Suggestions about generalizing findings to educate providers and the wider public
Lee, 2006	Thematic analysis Attitude towards services measured with	*Benefits of MH services* Receiving help with emotional issues, coping skills, behaviour change, developing insight *Relationship with MH professional* Listening and attending,	Little personal reflexivity Good use of quotes Use of confidence scale on attitudes to services	Generalises themes and makes recommendations for service providers

	Attitude toward seeking professional psychological help scale	engagement, consistency and accessibility, feeling supported, empathy and understanding, authenticity, *Helpfulness* general helpfulness, Problem solving, advice giving, help with daily living *Treatment concerns,* medication issues, ineffective or unhelpful, coerced treatment, physical restraint, it made me worse *Negative relationship* Didn't listen, didn't like, stigma, doesn't care about me, allied with the system or guardian, unprofessional conduct		
Le Surf, 1999	Grounded theory	*Factors that hinder willingness to seek counseling* adolescent's attitudes to their problems Negative attitudes to discussing feelings with others Previous experience of relating to adult figures Confusion about nature of process-social stigma *Factors that encourage YP to attend counseling* qualities of relationship	Only 3 interviews Purposeful sampling Ethics of research with young people made explicit Description detailed. Limited use of quotes. Description of systematic analysis not clear. Unclear number of people in each group Themes developed from the data	Makes generalizations that themes identified could be beliefs held in wider population e.g. adults- unsubstantiated.

		Confidentiality, safe, trustworthy, treated as equals, not belittled or patronized, element of control, non-judgmental, acceptance, dress-casual *Factors desirable in a service.* Discrete location, flexible and informal, continuity in counselor		
Narbors, 1999	Thematic analysis Satisfaction survey Client satisfaction questionnaire CSQ8	*Benefit of MH service* Positive caring relationship Trust Emotional resilience Learning new interpersonal and coping skills *Drawbacks* Sessions too short Counselor not immediately available. Clinician training and ability Less available led to greater satisfaction	No description of how survey was developed or topics covered Good description of participants Little reflexivity Trying to do too much understand experiences and generalize but does neither in depth. No description of saturation of themes. Predominantly black inner city young people	Findings are not generalisable although authors attempt to do so. Future directions were guesses at why satisfaction differed across populations, not emerging from data.
Naylor, 2009	Thematic analysis based on grounded theory	Initial wariness behaviour change due to service being relevant/ connection with therapist Practionner manner-respectful,	Purposefully sampled Aim stated as a conclusion rather than a clear aim Reflections made about the usefulness of qualitative	Research used to guide service development No claims of generalisability Research contributions:

		genuinely wanting to help, accommodating needs and preferences Effects on behaviour- reduced anger and offending Effects on family- improved relationships and communication *Factors in overcoming barriers to engagement* Practitioner manner Flexibility/ outreach capacity Clinical effectiveness Relevance Explanation and clarity	approach with this client group Acknowledged sampling limitations/ social desirability bias/ influence of setting Researcher reflexivity not addressed Extensive use of quotes	how to engage hard to engage young people in research process. New insight- user's views of attributions about workers' personality were based on service level characteristics e.g. flexibility.
Newton, 2007	IPA	Safe place Normalising and destigmatising Learning from helping others *Role of facilitators* Make everyone feel special Positioning participants as experts Exploring psychotherapeutic skills e.g. Socratic questioning, guided discovery Managing the interaction	Good reflection on research method Good use of reflection on self/ reasons for research Detailed descriptions Grounded in data	Role of individual therapy where strong external explanations about voice hearing are held Role of systemic interventions to maintain benefits of therapy.
Offord, 2006	IPA	Removal from normality versus connecting with the outside world Treated as an anorexic versus a unique individual in distress Control and collaboration	Good use of reflexivity, cross checking of analysis, "member checking" (sharing themes with participants), research diary	Recommends further quantitative research in order to generalize the findings.

		The importance of peer relationships	Grounded in the data, extensive quote use.	
Reid, 2008	Thematic analysis	Practical and caring approach Focus on managing eating disorder Adoption of coping strategies Effective communication Listening Feeling cared for	Lack of reflexivity Not directly about therapy but about service in general that uses therapy Extensive use of quotes grounded in data.	Treatment for anorexia nervosa needs to facilitate sufferers' need for control by striking a balance between practica and empathetic approaches. Further research regarding opinions about other services is required
Strickland-Clark, 2000	Qualitative inductive approach based on Grounded Theory. Use of video of therapy sessions to prompt discussion re significant events Significant event analysis based on Comprehensive Process Analysis (CPA) Children interviewed post FT sessions	Being heard Not feeling heard Therapists' expertise Coping with challenges Bringing back memories- reminder of painful times Difficulty saying what you think and feel Worries about reactions from others- Needing support in the session	Very small sample, sampling not purposeful Explicitly mentions results cannot be generalized No reflection of researchers influence Nothing about internal/external validity Mentions relevant literature and theory Interpretation of significance is based on certainty that being heard was a key category. Is this possible to assert? Extensive use of quotes Areas of overlap between themes from 2 methods were	Power imbalance within therapy led to teenagers withdrawing from sessions Future research- include adolescent views in clien satisfaction surveys and clinical audit.

	Helpful Aspects of Therapy Questionnaire (Llewellyn, 1988) used as basis for interview		considered. No cross checks or member checks or triangulation but using 2 methods allowed richness of detail and consideration of events in context. Broad and focused perspectives	
Teggart, 2006	IPA	*Service presence and responsiveness* Positive- information provision Negative- service flexibility, accessibility, waiting times, resource limitations, practicalities, information provision, frustration/ disappointment, incomplete services *Process and experience of attending* Positives- connecting (with therapist and other young people in groups), interpersonal skills, solidarity/ support, affective engagement, professional communication Negatives- connecting, interpersonal skills, solidarity/ support, practicalities, stigma, professional communication, consultation being heard (top down approach), not having control	Little demographic info re participants Very detailed descriptions of themes Not representative of those who have not engaged Recognition of importance of consultation not being tokenistic Method- consecutive groups until no new info would have been ideal Transcription then independent thematic analysis by 2 researchers who came together to compare results	Identification of salient issues- powerful for service development.

		Outcomes Positives- endorsements, advice and guidance Negatives- advice and guidance, preferred service models		
Thompson, 2007	Transcript based content analysis	Therapists' characteristics: Collaborative approach; casual presentation; calm; neutral; unbiased; non-judgmental; authentic; active; humour; task-centred *Therapists tasks* advice-giving, guidance, insights, opportunities Task focus was valued *Negative aspects* Being overwhelmed by emotional topics / forced to talk about things	Addresses generalisability issue Intercoder agreement Evidence of importance of therapists' connections with clients Doesn't address what part of engagement process related to outcome Questions asked were not made explicit Interviews at home parents and adolescents together. Bias in what was being said? Non purposeful sampling	Future research: Importance of understanding more about relative importance- building alliance with therapist or building alliance with family members

Table 1: Studies included in literature review

4.2.1. The wider systemic context of mental health services

The wider systemic context of mental health services emerged as a theme from the literature and falls largely into two subthemes: the influence of societal views of mental health services and the influence of service presence and responsiveness.

4.2.1.1. Societal views of mental health services

The literature suggests that adolescents are aware of stigmatisation of mental health services within wider society (Beck, 2006; Boyd et al., 2007; Draucker, 2005; Garland & Besinger, 1996; Le Surf & Lynch, 1999; Naylor, Lincoln & Goddard, 2009; Newton et al., 2007; Teggart & Linden, 2006). A recurring theme across papers was that mental health services and therapy were for "mad" or "crazy" people.

"Only people who are screwed up in the head go to see counsellors – I think this is the view of a lot of young people" (Le Surf & Lynch, 1999 pp. 238)

Several papers reported that adolescents views about others' perceptions of mental health services and/or therapy, affected their attitudes towards attending services (Beck, 2006; Bury, Raval & Lyon, 2007; Draucker, 2005; Le Surf & Lynch, 1999). Papers identified negative perceptions of mental health services as influencing adolescents' thoughts and feelings about therapy and consequently, their initial willingness to engage in the process of therapy (Le Surf & Lynch, 1999). This influence appeared to be on a continuum with different papers reporting different levels of influence. At the most extreme level, the influence of others' thoughts prevented

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adolescents from accessing therapy. Matthew, (cited in Draucker, 2005) when asked

whether he would have liked to have received therapy for his depression, answered:

"No not at all. It was just, I associated that with being crazy. And I wasn't crazy. I

just hated my situation … I guess that has a negative connotation, when you say,

would you like mental help, you know, and you start to think, well, you know, oh

no, they're going to lock me down, I don't think I would have wanted it"

(Draucker, 2005).

Adolescents' accounts within the papers reviewed also indicated that representations of

mental health services in the media also influenced their attitudes towards attending

psychological therapy:

"You do, you have the lying down on a chair image. It's just what you see in the

movies all of the time, it does definitely colour your experience" (Bury, Raval &

Lyon, 2007 pp.85)

4.2.1.2. Service presence and responsiveness

Adolescents discussed how both, accessibility to mental health services and the

service's ability to respond to their needs, were important aspects of their experiences of

therapy. Services that were viewed as "flexible" were perceived as wholly positive by

adolescents (Draucker, 2005; Le Surf & Lynch, 1999; Naylor, Lincoln & Goddard,

2008). The accounts contained within the papers discussed this flexibility as occurring at an interpersonal level, i.e. within the adolescent and therapist dyad:

> "He was always asking me for when would be a nice time for the next meeting and he wasn't telling me, "I'll be coming back on this day and this day"" (Naylor, Lincoln & Goddard, 2008 pp.282)

Inflexibility however, was viewed by adolescents as an inhibitory factor to engaging in psychological therapy (Teggart & Linden, 2006; Narbors et al., 1999). Across papers, it was apparent that adolescents reported varying views of their experiences of the accessibility of CAMHS; with some finding them readily accessible (Lee et al., 2006) and others encountering difficulties such as waiting times and resource constraints (Teggart & Linden, 2007). Provision of information about services was identified by adolescents as affecting their experiences of CAMHS both positively and negatively; lack of information about services was seen as a barrier to accessing CAMHS (Beck, 2006; Teggart & Linden, 2007). Adolescents talking about psychological therapy services:

> "I don't even know the number or where they are" and even, "what are they?" (Beck, 2006 p.57)

4.2.2. Connection/ partnership with the therapist

Across all studies the theme of the connection or partnership with the therapist was recurrent in adolescents' accounts of therapeutic services and assumed a key role in

their experiences of therapy. For example, Anne reported that the relationship with the therapist was the most important factor in facilitating the therapeutic process:

"the pivot of everything. Yeah it really is" (Bury, Raval & Lyon, 2007 pp.88)

The narrative emerging from the literature tended to focus on two areas; the therapists' characteristics (tending to be the characteristics that the adolescents found helpful, rather than unhelpful) and the therapists' approach to the work.

4.2.2.1. Characteristics of the therapist

The two characteristics mentioned most often in participants' accounts were: being non- judgemental (Boyd et al., 2007; Craigen & Foster, 2009; Draucker, 2005; Le Surf & Lynch, 1999; Thompson et al., 2007)

"I would be able to approach them and them not judge me" (Boyd et al., 2007 pp.198).

and being genuine or authentic (Boyd et al., 2007; Lee et al., 2006; Naylor, Lincoln & Goddard, 2009 and Thompson et al., 2007)

"I felt like he actually wanted to help me cos… he was the one making the journey every time" (Naylor, Lincoln & Goddard, 2006 pp.282).

Active listening was also frequently mentioned as a helpful characteristic. (Bury, Raval & Lyon, 1007; Craigen & Foster, 2009; Lee et al., 2006; Reid et al., 2008):

"… it's actually having someone who's listening to what I say and suggesting different ways. I think that's the best form of support" (Rachel, cited in Reid et al., 2008 pp.958).

Other helpful therapist characteristics emerging from participants' accounts could be brought together under the term "traditional counselling skills". These were acceptance (Le Surf & Lynch, 1999), validation (Bury, Raval & Lyon, 2007), understanding (Craigen & Foster, 2009; Lee et al., 2006), empathy (Lee et al., 2006) and maintaining confidentiality (Boyd et al., 2007; Le Surf & Lynch, 1999):

"I suppose I felt a bit more comfortable with the psychologist because I felt like she had this anvil looming over her head that sort of said you can't tell anyone" (Boyd et al., 2007 pp. 198).

Adolescents also spoke about the personal qualities of the therapist that they found helpful. For example: being caring (Boyd et al., 2007; Narbors et al., 1999; Reid et al., 2008):

"A feeling that they actually want to see you get better and they will stick with you (Helen, cited in Reid et al., 2008 pp.959).

having a good sense of humour (Draucker, 2005; Thompson et al., 207); relating to the adolescent at their level (Draucker, 2005; Le Surf & Lynch, 1999); consistency (Lee et al., 2006, Commitment to the adolescent (Draucker, 2005) and a casual presentation (Le Surf & Lynch, 1999; Thompson et al., 2007). Unhelpful therapist characteristics emerging from adolescents' accounts included a lack of understanding (Beck, 2006; Craigen & Foster, 2009) and forcing ideas on the adolescent (Craigen & Foster, 2009).

4.2.2.2. The Therapist's Approach

Adolescents' accounts highlighted how they felt about the therapeutic process, techniques used and positioning within the therapeutic dyad. A recurrent theme regarding the process was the importance of having the process explained to them (Bury, Raval & Lyon, 2007; Naylor, Lincoln & Goddard, 2009). Some adolescents spoke about the negative experience of feeling forced into talking about things before they were ready (Thompson et al., 2007).

The techniques used by the therapist also emerged from adolescents' accounts, with them being experienced both positively and negatively by adolescents. Receiving advice and guidance was experienced as both a positive (Lee et al., 2006; Thompson et al., 2007; Teggart & Linden, 2006) and a negative (Teggart & Linden 2006) experience. Specific techniques that were repeatedly noted by adolescents as being helpful included; problem solving (Lee et al., 2006), guided discovery (Newton et al., 2007) and being taught positive coping strategies (Offord, Turner & Cooper, 2006; Reid et al., 2008):

"Like in the films and like the therapist might come out with these ideas and answers and a small part of you just hopes that will happen" (Peter, cited in Bury, Raval & Lyon, 2007 pp.85).

The way that adolescents felt positioned by the therapist within the therapeutic dyad was a further recurrent theme. The majority of adolescents favoured a supportive or partnership approach over a structured or expert approach (Boyd et al., 2007; Craigen & Foster, 2009; Newton et al., 2007) and a minority favoured the therapist managing the interaction (Newton et al., 207). Being treated as an individual was also highlighted as key to a positive experience (Offord, Turner & Cooper, 2006).

4.2.3. Young person's feelings

Adolescents spoke about their own feelings in their accounts of therapy. Adolescents' accounts focused more on their feelings about the initial and mid-stages of therapy, rather than the end. With regard to the initial stages of therapy, some adolescents reported worrying about discussing feelings with others (Le Surf & Lynch, 1999), with some feeling a sense of desperation and despair about engaging in the process (Bury, Raval & Lyon, 2007). The theme of finding it hard to talk to others continued over the course of therapy as seen in Sue's account:

"What was the session like for you?"

Sue: "Umm I find it hard talking, I always find sessions hard, talking, especially when there's more than one person to speak to, it is easier than most sessions, I think, but I just, it just upsets me, to hear things. I'd rather not listen to it really,

try and switch myself off…" (Strickland-Clark, Campbell & Dallos, 2000 pp. 334).

Other feelings evoked as therapy progressed were also discussed, for example letting one's guard down (Draucker, 2005), not feeling heard (Strickland-Clark, Campbell & Dallos, 2000) and feeling powerless (Le Surf & Lynch, 1999).

Feelings evoked by the end of therapy were highlighted in Bury, Raval & Lyon paper (2007). Yvonne spoke about experiencing ambivalent feelings towards the end:

"I started getting all panicky coz I come here every week for months now and its gonna be really weird and really different not coming her again and like how am I going to cope with that? And it's sort of exciting in a way. I'm starting a new life in a way. In some ways I was worried and in other ways I was really excited as well" (Bury, Raval & Lyon, 2007 pp.91).

5. Discussion

Creating a narrative synthesis of the qualitative research into adolescents' experiences of psychological therapy allowed their opinions to be heard as recommended in current legal and policy directives (Children Act, 1989; 2004; United Nations Convention on the Rights of the Child, 1989; DfES, 2004; DH, 2003; DH, 2002). The current synthesis attempted to highlight the interplay and complexity (rather than the individual weighting) of influences on adolescents' experiences of therapy. As such, the

themes grounded in adolescents' accounts reflect the aspects of services that are important to them.

5.1. Summary of findings.

Consistent with previous reviews (Davies & Wright, 2008; Freake et al., 2007), the current review identified that therapist characteristics are important to adolescents' experiences of therapy. The synthesis of findings found that the context of mental health services, including others' views about services and the way that services respond to adolescents, was also important to them. Within the literature, adolescents also discussed their personal feelings about the therapeutic experience. This was not alluded to as a separate theme within previous reviews.

The quality of the articles reviewed was relatively weak overall. One may argue that by confining the literature search to qualitative papers, the analysis was limited. Had quantitative papers been included, claims of generalisability may potentially have been made. However, to answer the review question "how do adolescents' understand their experiences of psychological therapy?" focusing on papers that highlighted adolescents' own accounts of psychological therapy rather than including those that used standardised questionnaires as a method of data collection seemed a more relevant approach.

The author took an "intuitive expert stance" (Miller, Bonas & Dixon-Woods, 2007) when selecting papers for review. This technique is not as readily able to make claims of transparency as other more structured approaches. Nonetheless, the author considers that because of the paucity of the evidence available and the importance for the review question of hearing the narrative of the young person, a more structured quality appraisal tool may have omitted papers that contained useful and interesting accounts.

This inclusive approach meant that findings must be tentative. It would therefore be beneficial for the model proposed to be subject to interrogation by further research.

5.2. Directions for future research and implications for clinical psychology

While it has been possible to create a narrative synthesis of the available evidence within this research field, a number of gaps were identified. The literature tended to rely on interviews, rather than more diverse ethnographic approaches, as a means of collecting data. Furthermore, the majority of articles used IPA as the methodology of choice and as such are not readily able to make claims of generalisability. The research field would benefit from the use of qualitative approaches which are better positioned to make claims that findings are both robust and representative due to the use of theoretical sampling and seeking of saturation of themes.

The literature reviewed tended to focus on the positive attributes of the therapeutic encounter rather than obtaining a more balanced perspective. It is unclear whether this is a result of selection biases for example, the adolescents who had a more positive experience of services were more willing to take part in the research, or whether research was commissioned based on "what works" for adolescents within the therapeutic encounter. To develop knowledge, it would be of benefit for future studies to research the views of adolescents who have disengaged from therapy. Such research will face significant challenges; in particular, how to engage adolescents who did not engage in therapy in the research process. An increased awareness about what hinders engagement in psychological therapy may help to improve services for difficult to engage groups.

The findings of the current synthesis highlighted the effect that others' views about mental health services had on participants' experiences of therapy. Despite this,

the research has not explored how the views of adolescents, therapists and parents interact and the impact this has on adolescents' experiences of therapy. The papers also tended to focus on micro rather than macro level influences on perceptions of therapy. Focusing on the impact of societal influences on experiences of therapy may be useful for those developing services for the adolescent population.

Expanding the knowledge base regarding adolescents' experiences of psychological therapy will be invaluable to clinical psychologists and other professionals working with adolescents. At a time when CAMHS are moving towards using short-term therapy models such as the Choice and Partnership Approach (Mental Health Foundation, 2009), it is vital that services understand the factors that are important to adolescents when engaging in psychological therapy in order to ensure that resources are targeted effectively.

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Section C

Adolescents' Attitudes towards Psychological Therapy

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by

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1. Research Report Abstract

The current study set out to explore and create a model of adolescents' experiences of psychological therapy. Eight individuals took part in one-to-one semi-structured interviews, which were then transcribed verbatim and analysed using Grounded Theory methodology (Glaser & Strauss, 1967). The final model emerged from participants' accounts and describes adolescents' attitudes towards therapy.

The findings suggested that adolescents' attitudes towards psychological therapy were affected to varying degrees by their experience of the therapeutic process, their experience of the therapist and their views about what others' think. These three categories are also interrelated in a complex and dynamic manner with each other. Additionally, the research suggested that adolescents may represent a high risk group for disengagement from psychological therapy.

It was concluded that clinical psychologists and other healthcare professionals should consider further research that explores whether these findings are generalisable to the wider adolescent population. Furthermore, health care professionals should consider taking a politically active role in the shaping the direction of therapeutic services.

2. Introduction

2.1. Background

2.1.1. Legislative context

In recent years, legal and policy frameworks have highlighted the importance of hearing the voice of young people who are accessing Child and Adolescent Mental Health Services (CAMHS). The key legislative and policy documents regarding children that have been either passed as law or published since 2003 have upheld the principle of children's views of being of paramount importance (Children Act 1989; 2004; United Nations Convention of the rights of the child, 1989; Department for Education and Skills [DfES], 2004; Department of Health [DH], 2003). Despite the increase in attention to their views, research suggests that young people do not feel listened to and consider that they are inadequately informed by statutory services about their options (Fegert et al., 2003; Law 1998).

2.1.2. Adolescence and mental health

The neuropsychological research evidence base for the developmental period of adolescence suggests that the brain's socio-emotional system changes during puberty (Steinberg, 2008). This significant biological transition is echoed socially; western society dictates that during adolescence, the adolescent is required to renegotiate their role in society from dependent child to independent adult. Managing this period of biological and social transition impacts on adolescents' mental health and prevalence

rates for mental illness in this client group are high (Audit Commission, 1999; Dahl, 2006).

2.1.3. *Adolescents' experiences of therapy*

The evidence base suggests that despite the apparent need for psychological support amongst the adolescent population, adolescents find it difficult to access psychological therapies (Beck, 2006; Boyd et al., 2007; Bury et al., 2007; Drauker, 2005; Garland & Besinger, 1996; Le Surf & Lynch, 1999; Naylor, Lincoln & Goddard, 2008; Street & Harts, 2005). It is widely acknowledged in the literature, and within CAMHS more generally, that engaging adolescents in psychological therapy tends to be a difficult process. Adolescents have reported feeling coerced into attending therapy sessions by others and whilst not feeling able to refuse to attend, are reluctant to do so (Edwards, 2009). This impacts on the therapeutic process as a reluctant child is a difficult child to engage (Barish, 2004). The high drop out rate of adolescents from therapy is further evidence of the difficulty of engaging them in the process (Miller et al., 2006). Despite these acknowledged difficulties, there is a paucity of literature investigating adolescents' experiences of the process of engagement in therapy across the therapeutic encounter.

There is a scarcity of published literature exploring adolescents' views and experiences of attending psychological therapy appointments (Kershaw, 2011). Much of the literature focuses on either adolescents' experiences of the mental health or, more general, social care systems, or on parents', carers' or therapists' perceptions of how adolescents' experience therapy. With regard to its adherence to the standard measures of qualitative research the quality of literature available to review was relatively weak. There was also a tendency within the literature to focus on the positive attributes of the

therapeutic encounter rather than obtaining a more balanced perspective. IPA was the primary qualitative methodology of choice in the available literature. This limits the articles ability to make claims of generalisability and does not provide an overarching model to support understanding of the social processes involved in attending therapy.

2.2. The current study in context

As outlined above, the body of research pertaining to adolescents' experiences of attending psychological therapy is currently very limited, with little known about how adolescents either experience or make sense of the therapeutic encounter. The legal and policy frameworks recommend that agencies and therapists listen to adolescents' views when designing and implementing services. At the current time, National Health Service (NHS) resources are becoming increasingly constrained and many UK-based CAMH services are moving towards shorter term working practices e.g. Choice and Partnership Approach (Mental Health Foundation, 2009). Any further knowledge about what helps and hinders the process of engagement in psychological therapy will enable resources to be targeted more effectively. Furthermore, the literature suggests that researching adolescents' experiences of engagement in the therapeutic process has the potential to radically improve outcomes for this population. It is considered vital to develop a better understanding of how therapy is experienced by those who are experiencing mental health difficulties.

2.3. Aims of the current research study

The aim of the proposed research is to generate a model of how adolescents experience and make sense of the therapeutic encounter from their personal accounts and reflections of therapy. The current study interviewed adolescents about their experiences of meeting with a therapist. The interviews asked participants about their experiences of engaging (or failing to engage) effectively in therapy, and allowed themes to emerge from these accounts that informed a theory of how adolescents engage in therapy. For the purposes of this research, engagement in therapy is defined as a reciprocal process of forming and holding a relationship so that the work of the therapy can occur.

3. Method

3.1. Participants

Eight adolescents (four male, four female) participated in the study. All of the participants had accessed therapy through CAMHS provided by the NHS UK in two separate counties with a mix of urban and rural populations. The participants had accessed services as a result of experiencing a variety of mental health difficulties. These included generalised anxiety disorder, agoraphobia, obsessive compulsive disorder, anorexia nervosa, depression and substance misuse with emotion regulation difficulties.

All young people interviewed accessed psychological therapy delivered by a qualified practitioner (e.g. clinical psychologist, community psychiatric nurse or psychotherapist etc), no less frequently than fortnightly and for more than three sessions to ensure that they could reflect on the therapeutic experience beyond the process of initial engagement. All participants had finished therapy within one year of the research

interview. The length of time that the eight participants accessed therapy for ranged from four months to eight years (mean length of therapy 23.5 months, median length of therapy 9.5 months) and age of participants from 13 to eighteen years (mean age 15 years 7 months).

Adolescents who were looked after in a residential care home setting were actively excluded from the study because there are significant differences between their experiences and those of adolescents who are cared for in family settings, such as disruption due to staff turnover and level of general psychological distress (Nicholas et al., 2003).   Children under the age of thirteen and adults over the age of eighteen were actively excluded from the research. The decision to research on this population alone was made in order to:

1. increase the chance that the young person has capacity to consent to the research

2. achieve a greater depth of analysis (Smith and Osborn, 2003)

3. develop an understanding about therapy for a population that is characterised by transition.

The participants who were aware of the theoretical orientation of their therapist reported working variously within cognitive behavioural therapy, systemic family therapy, behavioural therapy and graded exposure therapy frameworks.

3.2. The researcher

When conducting qualitative research an awareness of how the researcher's personal beliefs and experience may influence the framing of the research and how it is conducted, analysed and interpreted. Therefore the researcher took steps to engage in

reflexivity, in order to examine her influence on the process with a view to avoiding bias. During both data collection and analysis, the researcher was in the final year of clinical psychology training. She was aware that her previous experience of working with adolescents who struggled to engage with traditional mental health services influenced her clinical practice and, therefore, her a-priori assumptions about adolescents' views regarding therapy. She used reflexive techniques both alone and within supervision, to manage the impact of her values and beliefs on the current study. These included taking field notes after interviews and reflecting on them and discussing coding in supervision. The researcher holds a contextual constructionist epistemological position which contends that results differ depending to the context in which the data was collected and analysed (Madill, Jordan, & Shirley, 2000) (See Appendix C for discussion of epistemological position).

3.3. Procedure

3.3.1. Recruitment of participants

Due to the exploratory nature of the study, value was placed on the participants having had a range of experiences of engaging in talking therapy. CAMHS clinicians identified adolescents who met the inclusion/exclusion criteria. The process of recruitment of participants utilised three different methods. Firstly, those participants who were no longer involved in therapy through CAMHS were sent research information packs (Appendix D) by post and asked to opt into the study. Secondly, where an adolescent's therapy was coming to an end, their therapist discussed the research with them face-to-face and they were given the same research information packs and asked to

opt in. This initial recruitment strategy sought to recruit participants within the criteria discussed that would provide maximum variation in terms of gender, type of therapy undertaken, geographical location and socio-economic background in order to generate as many categories as possible (Charmaz, 2006). Once it seemed that new categories were no longer emerging from new interviews theoretical sampling was utilised, that is the process of using knowledge gained during the collection and analysis of data to direct further data collection (Glaser & Strauss, 1967). Accounts from participants who might challenge the categories e.g. with negative cases (Charmaz, 2006) were then explored with the aim of ultimately achieving saturation of categories. The researcher identified and recruited three participants seen as 'deviant cases' to the developing theoretical account. The first, Tommy had a less favourable experience of psychological therapy. Having a less favourable account of therapy helped to elaborate themes across all categories. The second and third, Jess and Jason, felt that their therapy had ended before they felt ready. Focusing on participants who had experienced less favourable endings deemed important because within the first few accounts positive experiences of endings had emerged from the data. Having accounts of therapy which were less favourable, allowed the initial data analysis to be challenged.

3.3.2. Interview guide

A semi-structured interview schedule (Appendix E) focused the interview on the areas of interest identified, yet allowed participants to tell their story of the process of engagement in therapy over the entire process from start to finish in their own words. The researcher endeavoured to facilitate a "directed conversation" (Lofland & Lofland, 1984). The initial part of the interview used demographic questions which aimed to set

the participants at ease (for example, "When did you start therapy?"). Participants were

subsequently asked to describe their initial contact with their therapist; their thoughts and

feelings both prior to and during their first contact. They were also asked to talk about

what enabled them to engage in the process of therapy and what the barriers were to

engagement. Another area concerned the concept of engagement over time; participants

were asked about maintaining the relationship over the course of therapy and if there

were disruptions, how these were managed. There were also requests for examples of

what had happened in their own experience of therapy. Finally, how the participants

experienced the ending of the therapeutic relationship was explored. At the end of each

interview, questions were designed to debrief the participants and opportunities were

provided for the participants to ask the researcher any questions they may have had about

the research process.

The interview guide was not static but rather developed throughout the research

process in congruence with the ideas of theoretical sampling (Charmaz, 2006). The later

interviews became increasingly focused on themes that emerged from the previous

analysis.

The researcher ensured that participants had her contact details should they wish

to contact her with questions or concerns about the current research. All participants

advised that they would like to receive written feedback regarding the outcomes of the

study.

3.3.3. Data collection

Participants were interviewed at both a time and NHS location convenient for

them. At the outset of each interview, the consent/assent forms (Appendix F) were given

to participants and their parents (if under 16 years old). These forms contained

information about confidentiality, right to withdraw and other ethical issues. They were

explained verbally by the researcher and written assent from participants and consent

from parents (for those under 16 years old) to take part in the research was obtained.

Interviews were recorded using a digital voice recorder.

3.3.4. Transcription and analysis of interview data

The researcher used the digital recordings of each interview to produce

transcripts, which included all words spoken by the participant and the researcher, pauses

and laughter. The approach taken to transcription and analysis was informed by

Grounded Theory methodology (Charmaz, 2006). Grounded Theory was chosen because

of all the qualitative methodologies, it seeks to identify themes that can be developed into

theory to inform future practice (Starks & Trinidad, 2007). The three central tenets of

Grounded Theory methodology; coding of data, memo-writing and theoretical sampling

were utilised with each data set. These techniques supported both the generation and

validation of codes and categories (Charmaz, 2006; Strauss & Corbin, 1990). The final

categories emerged and were grounded in the participants' accounts.

3.3.4.1. Coding

Coding the data set line-by-line required the researcher to label or code the

phenomenon contained within each line. For example; "Knowing that the first time you

go this that this is it and that he's going to help you and if this works and then you'll be

able to be like normal sort of thing, makes you feel happy as well when you're there"

(Millie 2, 93-96). The codes generated from this example were: anticipation ("this is it");

expecting the therapist to be helpful ("he's going to help you"); hoping to be normal ("you'll be able to be like normal sort of thing"); and feeling happy ('makes you feel happy as well"). Initial coding reflected emerging ideas rather than a description of topics (Charmaz, 2006). Codes were then compared, defined analytically and grouped together to generate conceptual categories at a more abstract level (see Appendix G for an example of line-by-line and focused coding).

3.3.4.2. Memo-writing and theoretical sampling

Memos were used to define what is implicit and what is explicit within the data (Charmaz, 1995). Creating and reflecting on memos enabled the researcher to have a greater understanding of the categories and relationships between them; this allowed fuller category definition. Memo-writing also helped to identify areas where discrepancies and gaps in the developing theory occurred which were then addressed through further data collection (see Appendix H for an example of memo-writing).

3.3.5. Methods to enhance quality

Quality enhancing measures were used throughout the research process, from generating the initial research idea through data collection and analysis to writing the current paper. Reflexive techniques such as using supervision to try to understand and articulate the dynamic interplay between the researcher, research participants, data and the emerging theory and keeping a reflexive journal (Lincoln & Guba, 1985) were an integral part of the research process. Within the reflexive journal, bracketing or recognising and setting aside a priori assumptions and knowledge with the goal of

attending to the participants' accounts with an open mind (Starks & Trinidad, 2007), was

utilised. Techniques aimed at enhancing the trustworthiness of the study included, peer

discussion of the research process and findings, which itself included an independent

audit of two transcripts (recommended by Turpin et al., 1997) and intensive engagement

with the data set (Merrick, 1999; Stiles, 1993). The researcher also made her

epistemological position explicit within the current account.

4. Results

4.1. Making sense of the findings

The current study aimed to generate a model to explain adolescents' experiences

of psychological therapy. As noted by Silverman (1993) over the course of the analysis,

the focus of qualitative research may adopt a different direction as the researcher became

aware of issues which are conceptually relevant. This process occurred to an extent

within the current study. The researcher used reflexive processes such as reflecting upon

detailed field notes and discussing reflections in supervision to consider the codes and

categories reached throughout the analysis. As a result of this process, the original

categories identified were considered to be shaped too much by the research agenda

rather than being 'grounded' in the participants' accounts of the therapeutic encounter

(see Appendix I for a model of the original categories). The aforementioned reflexive

techniques were again used to complete a major reorganisation of categories (see figure

2).

"Attitude towards therapy" was developed as the core category tying the rest of the model together. The term "attitude" was chosen because it indicates both the

Figure 2: Pictorial model of adolescents' attitudes towards therapy

participant's position and feelings in relation to the therapy. Three main categories: "Experience of the Therapist", "The Therapeutic Process" and "What Others Think" emerged from the data. These main categories represent the three central phenomena spoken about by participants and are intrinsically linked with the core category and with each other. The relationships between the core and main categories within the current

findings are not hierarchical but rather interwoven. The model of the main categories provides a structure that organises the following account of the findings. For each of the main categories a descriptive account termed a 'story' is provided (Strauss and Corbin, 1990).

Each category is described and illustrated with example quotations from the interview transcripts that were anonymised by using pseudonyms and removing any detail that may reveal identity. Table 1 provides a summary of the use of grammar in quotations

Symbol	Meaning
,	Indicates a short pause in speech
…	Indicates a longer pause in speech
[text]	Words have been added by the researcher to clarify the meaning of quotation for the reader
Text	Indicates the participant placing verbal emphasis on these words e.g. by volume spoken

Table 1: Use of grammar in quotations

4.2. Experience of the therapist

The way in which adolescents experienced the therapist within the therapeutic encounter emerged as a main category from the data. Subsumed within this category three sub-categories relating to the experience of the therapist were apparent within the

participants' accounts: "a sense of difference", "the therapist as a motivator" and "the therapists' approach" directive/ non-directive negotiator/ fluidity. Participants' attitudes towards their therapist were interwoven within their accounts and are integral to describing the category.

4.2.1. The "fit" between adolescent and therapist

A key theme spoken about by participants was how the therapist fitted or did not fit with their experiences of people; i.e. how similar or different they were to others they knew. This affected their attitude towards therapy. There was variation in whether this difference was seen as helpful or unhelpful by the participants. The sense of difference appeared to exist on a continuum with the therapist being different at one end of the pole and being normal at the contrasting end. The therapists' position on the continuum was not static but rather changed over time: some participants described experiencing a sense of difference and a sense of normality with the same therapist.

The therapist being experienced as different, because she was perceived as a special person was a key theme that emerged from Kayleigh's account. Kayleigh spoke about her therapist acting in ways that were integral to changing her life and making her happier and thus she positioned the therapist as special to her:

> "…the help that she's given to all these different people its kind of extraordinary because she's just… she was amazing, I did really look up to her… because she was so caring and sweet and she was always there for me… I'm so grateful to her because seeing how my life was then and how it is now is just universes apart. I am so happy now I'm so grateful for what she did." (Kayleigh: 229-242).

For some this sense of difference was that the therapist held a position of knowing or understanding because they were trained and had experience of working with people who had difficulties similar to the adolescent's own difficulties. This set the therapist apart from "normal people":

> "Normal people, not therapists don't understand how you actually feel like some people might think that its stupid but he actually understands because he's worked in it and he's seen it and he's experienced it himself as well so its like different… you know that what you are saying to this person is not, you don't feel silly or anything because you knew that they know what you're on about." (Millie: 215-220).

Although Millie experienced her therapist as different, she also talked about him being a normal person and this sense of normality helped her feel better:

> "He was a really nice person (laughs) he was just really friendly he had like children of his own and he was just a normal person really he had his own fears in life and stuff which he told me about which helped me feel better in myself like knowing that people do get scared of things and stuff and its ok to feel like that" (Millie: 326-329).

This experience was not unique to Millie. For other participants, the therapist was experienced like other people familiar to them. For Kayleigh it seemed to instil confidence in her therapist:

> Interviewer- "how did that make you feel when she was talking about herself?"
> Kayleigh- "she sort of reminded me of like probably of like my Mum or my teachers you have good relationships with those people so you kind of she kind of made that kind of relationship with me." (Kayleigh: 91-92).

For others, experiencing the therapist as different to familiar people was helpful. Within the context of experiencing the therapist as a normal person, an important theme that emerged from accounts was that the adolescents felt that the therapist spoke to them as an equal / a peer:

> "They do a lot of sort of "you need to cut it down you plonker" "you're a twat" they'll we'll use quite bad language because we're like good mates doyaknowhatimean you don't have to be formal and proper" (Tommy: 391-393).

> "She spoke to me at my level, she wasn't patronising or anything" (Kayleigh: 36).

Not being too different from themselves emerged as a code from the data. This was important to the participants as it enabled them to relate better to their therapist:

"I liked having a younger person because you can sort of relate to them more in a way" (Jess: 223-224).

"I think he's like twennyfive and he's just a proper lads' lad and I get on really well with him" (Tommy: 377-378).

A negative case which challenged this category was identified which suggested that experiencing the therapist as different was not helpful to all participants. Tommy had the experience of finding his other therapist too different and not understanding what she meant.

Tommy- "It was a bit like ah what's this shit you mean, it doesn't mean anything to me … "

Interviewer- "How did you kinda deal with that in the session? What did you do?"

Tommy- "just pretty much turned my ears off, just didn't listen to them"

(Tommy: 284-293).

4.2.2. Therapist as a motivator

The experience of being motivated by the therapist was apparent in a number of the accounts. The ways in which therapists motivated the adolescents and the adolescents' reaction to the techniques used varied, but was generally viewed as a positive experience. Some adolescents were motivated by being pushed by their therapist into trying things that they were scared of:

"They're not like normal therapists like you talk about your problems and stuff, they actually push you and want you to like get out there and just face your fears and stuff … in the best way for yourself, so I didn't really find it challenging, more like motivating sort of thing" (Millie: 237-244)

"He like took me you know into town and stuff he didn't like tek me dar but he just took me just, just in to it so really just like entering into all the crowds and then each time we went a bit further and we like pushed it … but I can walk there now and I'm fine" (Jason: 399-404).

Some adolescents were motivated by hearing about the therapists' experiences:

"…and like he told me about all the things he's done in his life and stuff and it jus inspires you to know that you can be like… you can do things with your life…" (Millie: 333-335).

"He'd tell me about, like it weren't much but he'd tell me about when he's gone to visit someone in the prison and what its like and stuff like that and I don't want my life to be like that [ ] so… in the end that was it my life changed around" (Jason: 251-253).

4.2.3. How directive the therapist was

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A further subcategory that emerged from the data was the how the adolescents experienced the therapist's approach during their therapeutic encounter. There is some overlap between the subcategories "how directive the therapist was" and the "techniques used" in therapy, linking the two main categories experience of the process and experience of the therapist. The two categories were considered to be conceptually different enough to warrant separate but interlinked subcategories, because "techniques used" focuses on participants' accounts of the techniques that the therapists used, whereas "therapists' approach" focuses on the therapist's position in relation to the participant (whether they are directive or non-directive).

Analysis of the accounts suggests that the therapists' approaches appear to be situated on a continuum. At one pole of the continuum, the therapists were solely directive in their approach and at the contrasting pole the adolescents had full control. Some adolescents' spoke about the therapists' approach in both directive and non-directive terms during their therapeutic experience. The therapists approach therefore was not experienced as static (either directive or non-directive) by all participants, for some it shifted along the continuum in a flexible manner. A number of participants' accounts spoke about the therapist's approach being at the directive end of the continuum and considered this to be a wholly positive experience. For some this was experienced as overtly directive:

"They make you do things that you don't want to do right it's just facing your fears so you just have to they're not like oh like oh they're not all soft on you and they're like go and do it and stuff" (Millie: 97-99).

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"Yeah, erm she would instead of sort of asking me what I wanted she would make the right decisions for me … and er make the right choices and right ideas and stuff like that" (Delroy: 328-333).

And for others the directive nature of the therapists' approach in the interaction was more subtle. For instance, being in control of the structure of the appointments:

"… if there was something, like when they were arguing, when Mum and Sebastian used to argue we used to have sessions on our own then because otherwise Penny would think we wouldn't be able to say some of the stuff we wanted to cos the other person was there" (Isaac: 230-232).

… and giving advice:

"…she will give me advice and it just gets sorted out and then I know in my brain what I've got to do to sort it out" (Niamh: 128-129).

The therapist being overtly directive was also viewed by adolescents as working well within family interactions within therapy:

"Jill would tell us what I was doing wrong and what my mum was doing wrong and like, for like an example, my Mum got annoyed with one thing that I did, I

think I might have bought alcohol into school again or something like that and I knew it was bad and then my Mum just wanted to cut everything off she just wouldn't talk to me and then I was, I didn't say how I didn't like that, I didn't, cos I don't really share my emotions … and then Jill was telling my Mum like how she'd done the wrong thing and she was telling me how I needed to tell my Mum what I wanted … and then that helped get everything back and it just put stuff behind us. Um... that worked". (Niamh: 365- 376).

In contrast, Tommy did not experience a directive approach by his therapist as positive. Rather, he experienced it as being reprimanded and it would appear from his account that he would have preferred more control over the session:

"It was just the same old shit every time I came it was like how are you doing, oh I heard you went and got pissed the other night and it was just like who gives a shit if I went out and got pissed the other night it's my life … I didn't get nicked locked up or anything, but um, yeah like they're like "you've gone and got drunk again or smoking weed" and its like "shuttup and let me get on with my life" dyaknowhatimean that's how I felt a bit… you've no need to have a go at me dyaknowhatimean?" (Tommy: 254-261).

"I just didn't want to do it. I wanted to get on with my life instead of have people telling me how to run my life" (Tommy: 405-406).

These passages also suggest that where the therapist's approach was not flexible during therapy, the approach was not experienced as helpful to the adolescent.

Therapists taking a non-directive approach also emerged as a theme from the data. Participants spoke about a non-directive experience as wholly positive. The non-directive approach of not being forced into doing or saying anything was a key code that emerged from a number of the accounts:

> "Anything that I didn't want to talk about she didn't make me go into it … and she was always very friendly and we wouldn't always just talk about umm the eating and stuff we'd talk about general things like what I had been doing at school and how I was feeling about school and stuff so it was better than… it put you at ease slightly" (Kayleigh: 37-43).

> "She never like forced you into doing anything, like she'd let you do, like say what you wanted to say and she wouldn't make you say anything more than you wanted to say" (Isaac: 109-110).

Niamh whose account endorsed a directive approach also spoke positively about non-directive approaches such as the therapist giving her control and offering her choices:

> "she was just, she wouldn't judge … she was just so laid back and she wouldn't ask questions it would be like what we wanted" (Niamh: 305-306).

"I'd just say everything and then like usually I'd say it like not in chronological order so she has to figure it out … what I'm actually talking about… and then she will go well how do you want to react to this then" (Niamh: 133-138).

A blend of both directive and non-directive approaches was also helpful to Kayleigh:

"She was guiding me and listening to what I had to say rather than someone just saying what I needed to do" (Kayleigh: 68-69)

4.3. What others think and do

"What others think and do" emerged from the data as a further main category. Participants placed emphasis on how the views of others affected their therapeutic experience. The more abstract term, "Others" is used as it refers to people occupying positions in relation to the participants within a layered social system from a micro, (family and immediate social contacts) to macro (cultural or societal e.g. political/ media influences) level (Bronfenbrenner, 1979; Duncan, 2007; Orford, 2008). Participants' accounts spoke of how others' views affected their experience of therapy throughout the therapeutic process, from initial engagement, during and through to the end of therapy. What also emerged from the accounts was a strong sense of how stigma about mental health difficulties in general, and accessing assistance in particular, affected the adolescents' experiences of therapy.

4.3.1. Encouragement from others

A number of participants recounted how others within their micro system, namely parents, peers, and professionals known to them, encouraged them to attend therapy and in the first instance. Participants' experiences of being encouraged to attend therapy varied. Some adolescents considered that the other person had control over their attendance with the adolescent themselves having no choice.

Interviewer- "So what actually got you going to therapy at the beginning if you wanted to avoid it?"

Kayleigh- "I don't think I actually had a choice. It was kind of my Mum just picking up and taking me there" (Kayleigh: 290-292).

"Erm well I didn't really get much of a choice erm my Mum just erm always went every so often and I wouldn't really know about it and I erm my Mum would just take me here" (Delroy: 112-113).

"Yeah cos I started seeing Sukdev from Youth Offending … I did then he started bringing me here because I think he got a bit worried and stuff … so he started bringing me here and bought in some woman to see some woman and that" (Jason: 21-29).

Whereas, other participants experienced the other person's views as advisory, to some extent. The participants spoke about using the other person's views to inform their decision making about attending:

"I didn't want to come but someone persuaded me to come … so without them saying I wouldn't have come… well it was my girlfriend at the time, I was with her we were together about a year and a half, proper serious and she was like, "Tommy why not give it a go, what harm can it do?" and I was like, "No I'm not gonna see a head therapist", and she was like, "Just give it a go like do it for me" and I was like, "Oh alright"" (Tommy:52-54).

"And then I went to the doctor and he said to come here and I was like well, I best come here cos I didn't want ta, I didn't want to like … sort of be on your own sort of about it, like I deeded ta I needed ta I thought getting help would be better" (Jess: 44-46).

The adolescents' accounts also highlighted how their peer group influenced their experience of attending therapy. The actions of friends who were getting on with 'normal life' provided a powerful pull away from engaging in therapy for Tommy and Jason:

"I think that mostly that was when I was out with ma mates [ ] cos I'd be like we'd start to do stuff and then it be like nah I don't wanna leave my mates now I wanna stay out with them" (Jason: 268-273).

"In our school uniform we'd go and get like twatted [drunk] and then um just went off the rails really so I was didn't care what I thought about it I just thought I'm gonna get drunk in a minute with my mate" (Tommy: 107-108).

The adolescent's accounts also highlighted how other people's views and actions remained influential over the course of therapy and during the ending of the therapeutic encounter. Some participants spoke about disruption during therapy and parents views and subsequent actions being helpful in negotiating these disruptions with the therapist:

"I mean when that like, appointment that I didn't like happened, I just like didn't want to come back cos I thought it would be awkward and that's when Mum decided to have the four of us then because I wanted to" (Niamh: 255-257).

"in the end I think my parents knew I was at the end of my tether really and I was just like, "I'm not doing it anymore" and um … yeah so I think they pretty much said to Dr Raju "Y'know we don't think he needs this anymore" and they sort of discharged me" (Tommy:399-401).

The views of others motivated one participant to end her therapy. Emerging from Niamh's account was the desire to prove wrong the negative views that others held of her, based on stigma about counselling:

"People at school, I dunno they called me a sociopath or whatever that is and said that I need more counselling and I wanted to prove them wrong that I didn't" (Niamh: 527-529).

Niamh's narrative links the two subcategories "encouragement from others" and "stigma".

4.3.2. Stigma

The stigmatisation of mental distress and of attending therapy emerged as a further subcategory from the data:

"I think there's always a bit of stigma isn't there like people always, like if you have a mental, not that it's a mental illness what's it called like… just… what's it called like, is it a mental illness is that what it's called?" (Jess: 351-353).

Stigma affected the adolescents' attitude towards therapy. Some thought that others would negatively stereotype them for attending a CAMHS setting:

"Well let's be honest if someone said this place is for mental health you'd think looney wouldn't you? Well most people would" (Tommy: 486-487).

Participants also discussed stigma at a macro level. They recognised that media representations of mental distress were not the same as their lived realities. This led them to worry about how media representations affected others' views of mental distress:

"once I saw a [TV soap] episode right and the person had OCD and they were

writing stuff over and over on the walls and like I don't do that … and I think

some people must have thought … the people who I told at first I think they might

have been like "ok you have that" but no I have to like explain exactly what it is"

(Jess: 346-349).

And Niamh was concerned that she may be bullied because others' had been influenced

by negative media representations:

"I just thought oh my god, I honestly thought counselling was just like for weirdos

to be honest because what you watch on telly when someone is going to

counselling its just… I thought it would be a prime thing for someone to like bully

me about" (Niamh: 42-44).

4.4. Process

Attitude towards process issues emerged as a main category from all of the

participants' accounts. Subsumed within this main category were subcategories that mark

attitudes to different aspects of the process; from beginning the work of therapy, through

attitudes towards the CAMHS environment awareness, on to techniques used during

therapy and finally to the process of the ending.

4.4.1. Beginning the work of therapy

4.4.1.1. Importance of feeling ready

Feeling ready to begin the work of therapy was a strong theme borne out of a number of participants' accounts. Participants were ready for therapy because they were unhappy with their lives and looking to change their situations. For these participants their attitude towards the process of therapy was positive from the start:

> "well, I was just really happy to actually start getting help cos I'd been suffering with like anxiety and panic attacks for about four years… I started seeing Gethin [therapist] and we basically I was just really happy and I was up for doing whatever he wanted me to do to sort myself out" (Millie: 39-45).

> "I think I was really desperate to have… to help myself in some way" (Jess: 146).

> "I didn't want to come but then I wanted to change. I'd got to the stage where I was like fed up with how I was" (Niamh: 104-105).

For Isaac it was different, he came because his other people wanted him to attend and there was a sense of him not having agency over the decision:

> "Then something happened between Mum and Sebastian [brother] and then Mum had to go to hospital for a bit… and then so we started to come again" (Isaac: 13-14).

4.4.1.2. Motivation for attending versus not attending therapy

A number of participants described feeling unmotivated for therapy; they wanted to maintain problematic behaviours. This affected participants' attitudes towards, and ability to begin, the work of therapy. Some participants spoke about not wanting therapy in the context of wishing to maintain some of the specific "difficulties" that they were going to therapy to address, for example, anorexic eating behaviours and alcohol misuse:

"I wanted to be the best at everything so I obviously wanted to be the best anorexic, I wanted to lose as much weight as I could so I'd do anything to lose as much weight as I could so at the beginning I could have avoided going to therapy because I wanted to lose as much weight as I could so if I had a chance to arrange my own appointments I wouldn't have" (Kayleigh: 285-288).

"In our school uniform we'd go and get like twatted [drunk] and then um just went off the rails really so I was didn't care what I thought about it [therapy] I just thought I'm gonna get drunk in a minute with my mate" (Tommy: 107-108).

Prioritising peer relationships over attending therapy was also evident in Jason's account:

"I think that mostly that was when I was out with ma mates … cos I'd be like we'd start to do stuff and then it be like nah I don't wanna leave my mates now I wanna stay out with them" (Jason: 268-273).

Jason's account highlighted how motivation to begin the work of therapy changed over time. Both he and other participants spoke about their attitudes towards the process of therapy changing due to circumstances occurring within their wider social systems:

"I got to a point where if I got in trouble anymore I'd be going straight to prison so just thinking about getting locked up every night weren't my thing, its not so I just thought about it and changed" (Jason 246-247).

"And now I've got to the stage where I don't wanna be bad. I just want a good education and I want to be where I want to go" (Niamh: 501-502).

"I knew that I needed to talk to my mum and I knew that these appointments would be the chance that she would listen" (Niamh: 389-390).

Others felt ready to begin the work of therapy. A sense of self motivation emerges from the accounts:

"I started to because I needed to get it off my chest and I needed to like get all my issues cos keeping them all tied in was just like not like good" (Niamh 618-619)

"So I thought this was the only sort of way, sort of like the need to help like, that its only going to get better if I do talk about it sort of thing" (Jess: 150-151)

"Don't wanna be a prick anymore to be honest, I wanna change… so I will do hopefully" (Tommy: 468)

4.4.2. Reaction to the therapeutic setting

The data revealed that participants' attitude towards the therapeutic process was affected by their reaction to the therapeutic setting. Feelings that emerged from the data in relation to the clinical environment were all negative in nature and ranged from feeling weird to feeling intimidated. Participants spoke about how their feelings about the environment adversely affected their engagement in the process. For some, more specific aspects of the environment were salient to their attitude towards the process for example, being filmed within therapy and having to wait in a waiting room for the appointment:

"I felt a bit intimidated because there was this camera camering me and I didn't want a camera kind of like, I mean they did say, they did say are you ok with it and I sort of was but I don't know I didn't really like being filmed and people being behind the screens you couldn't see them and I was just like okay I dunno I wasn't really comfortable with that but I suppose the second time we were in a smaller room and there weren't any cameras with people watching so that made it a bit easier yeah" (Jess: 93-105).

"I didn't want to sit in the waiting room cos I just thought it would be really weird … I don't know I just thought there would be really really weird people here and just stare at me or something like that" (Niamh: 51-54).

For others their reaction to the environment in general adversely affected their attitude towards the process:

> "I think I found it hard when we come here, cos I'm more of an outdoor person not an indoor person and that so…" (Jason: 354-355).

> "It does feel like jus like a prison doesn't it, some of the rooms are worse than this that I had to go with my psychiatrist. Some have none, no pictures on the walls and they're just a blank room and its just awful (laughs), it just feels weird" (Millie: 414-417).

4.4.3. Techniques used by the therapist

The techniques used by the therapist within the sessions emerged from participants' accounts as a subcategory of the main category "process". As discussed in detail above, there is overlap between this subcategory and the subcategory "How directive the therapist was". Participants spoke about how talking and alternative ways of externalising affected their experience of the process and their attitude towards therapy as a whole.

4.4.3.1. The merits and pitfalls of talking

Talking emerged as a key code from Jason's interview. Jason's account was ambivalent about the merits of talking. On the one hand he spoke about how he found talking as a technique on its own boring…

"I used to get bored of coming here just sitting around all day … just talking" (Jason: 141-145)

… yet he also spoke about instances when talking was useful to him, for example, calming him down when he became angry. The talking that Jason found useful was outside of formal therapy session time.

"So we used to talk on the phone to try and get me to calm down… when he said it were for my own safety [therapist not visiting him] that's what calmed me down" (Jason: 299-300).

Jason also spoke explicitly about how he found talking together with his therapist about coping strategies helpful:

"I used to get in a lot of trouble and that Sukdev I could, one of the things I could sit down and talk to him about it … and how it would help me not to go where I were getting in trouble and different stuff to do and stuff" (Jason: 194-196).

4.4.3.2. Having things explained in different ways

Participants also spoke about techniques other than talking. The data suggests that some participants found these alternative techniques helpful in changing their understanding of their situation and improving confidence in their ability to progress…

"…sometimes she'd have a sack and every problem would like go in it…so you have to get rid of all those problems some way and she'd explain in that way it would be a lot easier to understand to be more confident in a way" (Delroy: 251-254).

"Just helps you realise that the thoughts you are having aren't real… when you see them down, like we used a whiteboard and stuff" (Millie: 252-254).

"if it was in your head you'd forget it, whereas if you've got it on paper that also helps you realise like what progress you're making and stuff" (Millie: 209-210).

and some did not:

Tommy- "Freya used to draw circles and be like "what makes you bored and what can you do instead of going for a drink" and that's about it really" Interviewer- "Did it work?"
Tommy- "No" (Tommy: 327-332).

"She'd write it down in her little notes and I hated that. The whole like taking notes" (Niamh: 328-329).

Rather than taking these as deviant cases that challenge the sub category, the link to the core category of "attitude towards therapy" holds these accounts together. Within the subcategory, "Having things explained in different ways" some participants experienced hearing or seeing the therapists point in a different way positively, and some experienced it negatively.

4.4.4. The process of ending therapy

Participants' accounts highlighted the importance of the process of ending the therapy. How the ending was decided and handled emerged as a significant factor in understanding participants' attitude towards this aspect of the process of therapy.

4.4.4.1. How the ending was decided

Participants' accounts of the endings were varied. It appeared that where the participant had experienced a negotiation of the ending, their attitudes towards the ending were more positive:

"…it was just based on weight gain and um how I kind of taken on what she was telling me and how I'd been using that to try and get myself between and just general progress and um how I was happy to have more freedom away from that so that was kind of how it was decided" (Kayleigh: 256-258).

"…and erm then but Gethin just kept giving me more and more and kept explaining to me look I'm not going to let you go until I know that you're ok" (Millie: 107-109) which helped a lot as well cos you feel like you're actually getting somewhere and you don't need to like pretend you're getting somewhere" (Millie: 113-114).

Where the ending was not negotiated with the participant, their feelings about the ending came across as more negative:

"They just kind of thought I was doing ok so it maybe it was time for me to stop… erm they just said that I could still talk to Penny whenever I wanted to but we couldn't have like regular sessions like we normally did… I was a bit sad cos I liked coming here and I didn't know if I'd be able to like say to Mum I wanna go" (Isaac: 254-262).

Jason- "He said before it ended he said he was going to get in touch with me and have a couple more sessions and then when I got them letters come through I thought well it must have finished then yeah but once them letters come through that were it I didn't hear from no one… but"
Interviewer- "and how did it feel when you thought well that's it then?"
Jason- "I didn't feel ready to finish yet" (Jason: 424-434).

4.4.4.2. Fearing the end

Fear about ending therapy was identified as a significant code from a number of participants' accounts. The fear affected how able the participants felt about going through with the process of ending:

"I thought without them we would just go back to how we were" (Niamh: 421).

"I think I was just worrying that I needed more and I couldn't have anymore but because I didn't want to come with someone else" (Jess: 279-280).

"I felt a bit nervous obviously cos I was meant to end like loads of times but then he kept giving me more and erm when I actually knew it was going to end I was like oh god I've got to go and do this on my own now" (Millie: 423-425).

4.4.4.3. Preparing for the end

The process of preparing for the end is intertwined with the fear of the end. Participants' considered that being prepared for the end helped them to feel better:

"It felt better because I knew that I'd have done everything poss… that I could possibly do to ensure that I was going to be alright" (Millie: 452-453).

Techniques such as increasing time between appointments and seeing other professionals more often gave participants an opportunity to get used to not attending:

"They said I had another appointment after but that was like a quite spaced

appointment between them so I was like right ok I can get used to not having an

appointment cos it was like 4 weeks before I had the next one so… I could get

used to this and if it wasn't working well I would tell them" (Niamh: 408-411).

"Erm I didn't see Jocelyn an awful lot. I saw her every so often but not constantly.

I saw my social worker a bit more" (Delroy: 635-636).

4.4.4.5. Feelings about the end of therapy

The participants' accounts spoke about mixed feelings during the process of

ending therapy, sadness akin to a grief reaction yet also relief and happiness.

"I'd be a bit upset that I wouldn't be seeing Jocelyn … and erm sort of erm

relieved cos it shows that I am ok now and nothing is going wrong" (Delroy: 434-

443).

I remember I was really upset when it came to the end because it had been a big

part of my life for so long … So when it actually did come to the end it was kind

of upsetting. And obviously happy at the same time because it's like trying to

move on a forgetting all of that" (Kayleigh: 249-251).

4.5. Attitudes towards therapy

The core category "Attitudes towards therapy" is both implicitly and explicitly linked throughout the preceding categories. Adolescents' attitudes towards therapy were influenced by their experiences of the process, the therapist and by what others thought and did. These influences both helped and hindered engagement in the process and resulted in both positive and negative attitudes towards the therapy at different stages of the therapeutic encounter and within different subcategories. Participants' accounts regarding some subcategories encouraged a wholly positive attitude towards therapy, for example; a non-directive approach by the therapist and endings of the encounter being negotiated between therapist and adolescent. Conversely, adolescents' attitudes towards therapy were affected negatively by their experience of the CAMHS environment and by perceived stigma regarding mental health and attending therapy. The participants held mixed views in relation to the other subcategories and subsequently their attitudes towards therapy were affected both positively and negatively.

5. Discussion

5.1. The findings in context

Participants' accounts of their therapeutic encounters highlighted that their attitudes towards therapy were affected to varying degrees by their experience of the process, their experience of the therapist and their views about what others thought.

The current study found that the opinions and actions of others, including experiencing stigma and encouragement from others, influenced adolescents' attitudes

towards therapy. Individual differences were observed in how others' opinions and actions were experienced and whether they were a help or hindrance to engagement in therapy. The negative impact of stigma on participants' attitudes towards therapy is consistent with previous literature (Beck 2006; Boyd et al., 2007; Draucker, 2005; Le Surf & Lynch, 1999; Teggart & Linden, 2006 and Strickland-Clark, Campbell & Dallos, 2000). The current study however, found that some adolescents did not experience stigma. This contrasting opinion did not emerge from previous literature. This may reflect a societal shift where increased awareness about mental health issues is thought to be challenging the stigmatisation of the condition (Myers et al., 2009). Findings also suggest that adolescents experienced encouragement from others on a continuum ranging from feeling forced by others to attend therapy to accepting advice from others about attending therapy. This encouragement was generally reflected on as a positive experience and lends weight to the existing evidence base (Draucker, 2005; Offord, Turner & Cooper, 2006 and Teggart & Linden, 2006). A new insight into this area emerged from the current research: the actions of peers did not always support engagement in the therapeutic process. Adolescents spoke about wanting to stay out with their peer group over and above attending psychological therapy.

The current study found that the experience and technical approach of the therapist, the fit between adolescent and therapist and the therapists' approach to motivation also had a profound effect on the participants' attitude towards therapy. Findings suggest that the how directive the therapist was had an affect on their attitudes towards therapy, with some finding that a directive approach positively affected their attitude towards therapy and others experiencing a directive approach negatively. Other

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adolescents preferred a collaborative approach. The mixed experiences of the therapist being directive versus non-directive were consistent with findings from previous research (Craigen & Foster, 2009; Offord, Turner & Cooper, 2006). An implication of this could be the need for therapists to tune in with clients' preferences and to be flexible to this. However, sometimes it may also be helpful for the client to be challenged, so it may not simply be a case of doing what they want. It is unclear from participants' accounts what factors predict what approach they prefer and so further investigation into this may be beneficial. Likewise, the current study found that how similar or different the therapist was from the adolescent or those they know had varied effects on their attitudes towards therapy. This finding is also consistent with the literature (Beck, 2006). The therapist taking a motivating role has not emerged as a finding from the existing field of literature and this finding expands the existing knowledge base. Some adolescents found a motivating approach helpful: either being pushed by the therapist or being motivated by the therapist's experiences.

Finally, the accounts highlighted the effect that the adolescents' experience of the therapeutic process had on their attitudes towards therapy, including both how they began and ended the work of therapy, and the techniques used. Consistent with the available literature (Bury, Raval & Lyon, 2007), the current study found that adolescents had mixed feelings at the beginning of therapy. Existing research tends to focus on helpful and unhelpful therapist characteristics (Boyd et al., 2007; Craigen & Foster, 2009; Lee et al., 2006; Narbors et al., 1999 & Thompson et al., 2007) with adolescents experiences of the techniques used by therapists briefly mentioned in only a couple of studies (Craigen & Foster, 2009; Newton et al., 2007). The current study offers new insights in this area,

discussing adolescents' mixed experiences of talking and techniques alternative to talking.

The current findings describe how the three main categories and their subcategories do not stand in isolation from one another but rather are interrelated in a complex and dynamic manner within the core category adolescents' attitudes towards therapy (see figure 2 for an expanded pictorial representation of the model ''Adolescents' attitudes towards therapy''). Adolescents' attitudes towards therapy has been explored through a mixed methods study using a survey (Bradley et al., 2010) but in-depth qualitative analysis of adolescents' opinions in their own words and generation of a usable model has not occurred. The current research provides this and in doing so meets
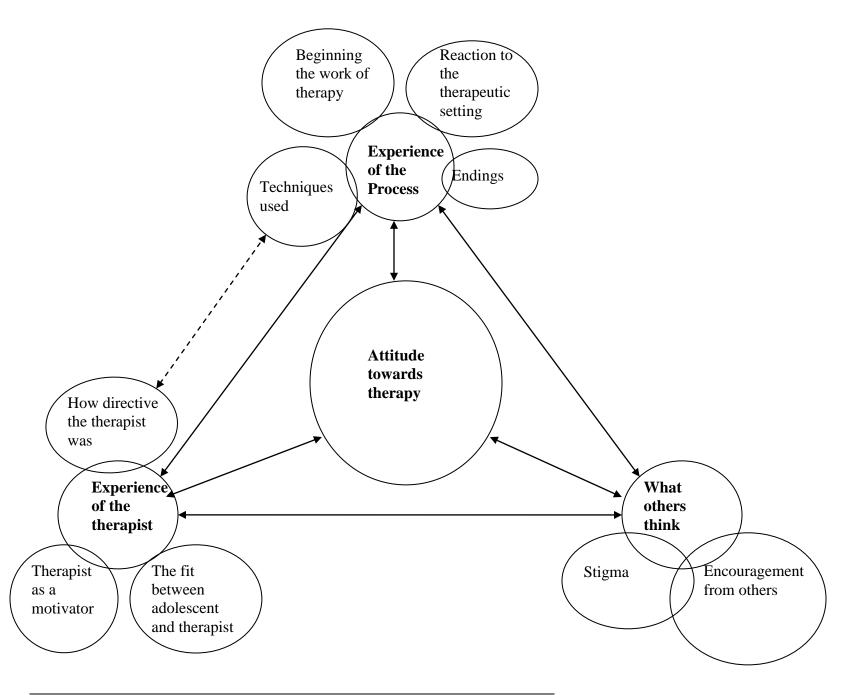
Figure 3: Expanded pictorial representation of the model: Adolescents' attitudes towards therapy.

the wider government agenda of seeing CAMHS services "through the eyes of children" (DH, 2004).

5.2. Methodological considerations

5.2.1. Value of the findings

The limited ability to generalise findings to a wider population is a criticism often directed at qualitative research (See Willig, 2008 for discussion). It has not been possible to fully represent the views of adolescents who have accessed psychological therapy within the accounts of eight individuals. The small sample size also meant that it was not possible to explore the ways in which factors such as age, socio-economic status, attachment difficulties and level of parental/ carer support interacted with adolescents' attitudes towards therapy. This study however, did not intend to be wholly representative, but rather it sought to produce a model of adolescents' experiences of engagement in therapy.

It is difficult to know whether saturation of the proposed model was achieved within the current study. The time limitations imposed on this study meant that data collection was necessarily halted after completing the eight interviews proposed in the research plan. It is possible or even likely that further research could extend this model however, it provides a useful starting point for further development. The current study therefore provides both valuable insights into how adolescents experience therapy and what some of the factors might be that influence their attitude to engaging in the therapeutic process. In doing so it contributes to the development of knowledge in this field. Through the process of further investigation, it is hoped that a more comprehensive

understanding of factors affecting adolescents' attitudes towards and subsequent engagement in therapy can be created.

5.2.2. Study limitations and directions of future research

A number of factors suggest that the participants who took part in the current study were not representative of the wider adolescent population. Clinicians in the CAMHS field approached participants to take part in the current study. Recruitment was, therefore, not impartial and selection bias towards inviting those who had experienced therapy positively, may have occurred. Furthermore, the researcher took a non-interventionist approach to recruitment. The sample was therefore made up of participants who actively responded and consequently wanted to be involved in the project. This suggests a reasonable level of ability to engage with adults. The above considerations may suggest that the adolescents participating in the current research have greater ease engaging with services in comparison with the wider adolescent population. Despite this, negative attitudes towards aspects of services and difficulties engaging with services still emerged from their accounts. One may conclude then, that the wider population of adolescents may represent a high-risk group for disengagement from CAMHS.

Not all participants had information about the therapeutic modality their therapist was working within. It is possible that adolescents' attitudes towards therapy may also have been affected by the psychological theory and models employed by their therapist and future research could examine this issue further.

Reliable statistics regarding adolescents' disengagement from services (for instance statistics that describe reasons for not continuing with therapy) are currently unavailable. Further research into the reasons for, and prevalence of, disengagement and its relationship with attitudes towards therapy would therefore be of value to improving engagement in therapy for this client group. These considerations are interesting when contemplating how findings from the current study relate to the wider adolescent population in the UK which includes marginalised groups, such as looked after and adopted children, those in forensic settings, asylum seekers and refugees and those with a learning disability. Further research with marginalised groups would be of value in developing the evidence base in this field.

The adult literature has examined clients' experiences of psychological therapy and the therapeutic alliance (for examples of reviews in this area see Ackerman & Hilsenroth, 2003; Ivan, 2009 and Martin et al., 2000) and might usefully be drawn upon for comparison purposes in future research.

5.3. Clinical implications

The findings of the current study suggested that adolescents' attitudes towards therapy and their subsequent level of engagement with therapy are affected by the views of others, their experience of the therapist and their experience of the process of therapy. If these findings are found to be robust, then clinical implications occur at all levels of service provision.

At an individual level, the research indicates that attention to understanding the adolescents' experience of the therapist and the process within the therapeutic dyad is important. Within current UK health service culture, in terms of importance, therapeutic

techniques overshadow relational aspects of therapy within government policies and initiatives, (Marzillier & Hall, 2009). This focus on technique and short term working is being compounded by the upcoming financial restrictions following the current NHS reform paper "Liberating the NHS: Legislative frameworks and next steps" (DH, 2010). Therapists operating in this context may find it useful to consider systemic approaches for example engaging in relational reflexivity (Burnham, 1993) which is described as, 'The intention, desire, processes and practices through which therapists and clients explicitly engage one another in coordinating their resources so as to create a relationship with therapeutic potential' (Burnham, 2005, p.3).

At a wider systemic level, within the adolescents immediate social group e.g. family and peers and wider system, there would appear to be a role for clinicians in understanding and addressing the negative stigma that continues to impact on adolescents attitudes towards therapy. Furthermore, the current climate of NHS service cuts has led to a shift towards very short term psychotherapeutic interventions: 4-6 weeks (Mental Health Foundation, 2009). In order for psychologists to continue within this climate and facilitate the most effective therapeutic outcomes for adolescents, there is a clear need for them to engage with politics that shape CAMHS services at both a local and national level.

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Section D

Critical Appraisal

Submitted April 2011

by

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To the University of Leicester, School of Psychology, Clinical Section

In partial fulfilment of the degree of,

Doctorate in Clinical Psychology

1. Introduction

This paper is an account of my personal reflections on the process of writing the current research. It is based on notes kept in my reflective journal and aims to summarise what I learned from the experience, paying attention to both personal and professional development.

2. Deciding on the research topic

The promotion of a fair society, where equality of access to statutory services for all exists as a standard, is a subject I feel strongly about. My previous career as a social worker strengthened my beliefs and developed my knowledge base and activism skills in this area. Whilst working as a social worker, I was exposed to the impact which an unjust society has on both children and their families. The stories which I heard, and cases that I worked with, evoked strong emotional responses of sadness, anxiety and anger in me. I have used the energy generated by these strong emotional responses to drive my clinical work in general, and this thesis in particular.

2.1. Working with adolescents

Throughout my social work career, I worked therapeutically with adolescents who were being 'looked after' within the care system or who had been adopted. These adolescents had all experienced abuse perpetrated by adults and, therefore, often had difficulties trusting other people. They would not engage with traditional Child and Adolescent Mental Health Services (CAMHS) and so working in an outreach capacity and utilising creative techniques became my modus operandi. I felt increasingly

frustrated and angry that professionals working within traditional settings could or would not work in more flexible ways to meet the needs of this population. Moving from social work into clinical psychology training did not dissipate the anger that I felt, rather increased a sense of constraint by being part of a tightly boundaried system which I did not consider worked for looked after and adopted adolescents. Being supported to work with adolescents during my training in a more creative way has released my feelings of constraint, yet their stories of the impact that the wider systems have on them continues to inspire me to take action.

During my work with adolescents I was struck by the enormity of abuse and significant life disruptions that they have suffered, often at a very young age. I marvelled at how many adolescents coped with the emotional impact of these circumstances whilst negotiating the difficult developmental stage of adolescence and without a stable attachment base. I have found adolescents' capacity to cope and maintain hope in the most adverse of circumstances inspirational.

The selection of my research topic was therefore driven by my feelings of anger towards government systems and services that fail to provide effective support for vulnerable and damaged young people and their families and the desire to achieve a better understanding of what helped and hindered adolescents' engagement in the process of therapy. I wanted to use this understanding to create a model that could be used to influence service design.

2.2. Understanding the personal significance of my choice

The importance of reflecting on the reasons for choosing topics has been highlighted by Stiles (1993) who noted the importance of reflecting on the personal

reasons for choosing research topics as this can affect the research process and findings. I have found the process of clinical training and experiences in personal therapy helpful in this regard. On reflection, it became apparent to me that I experienced the most powerful emotional reactions when hearing stories of injustices. As a result of my life experiences, I seem to have a tendency to be acutely aware of others' perceptions of injustice and the subsequent affect this has on their relationships. Being aware of this and paying attention to my feelings throughout the research process enabled me to notice where a sense of justice emerged in the data. When this happened, I took care to ensure that any emerging codes or categories were firmly grounded in the participants' accounts.

2.3. Choosing a methodology

Qualitative research design appealed to me from the outset of the research process. The stories of the adolescents I worked with, both prior to training and clinical experience whilst on placement, highlighted my interest in the richness and complexity of human experiences. Furthermore, ideas from social action research and community psychology, for example, combining adolescents own stories with my power as a clinical trainee to enable action to be taken at a wider level (publication and dissemination of findings to influence service provision) became increasingly important. The reflexive and grounded nature of grounded theory, staying true to participants' accounts appealed to my sense of justice as it gives a voice to their experience and views.

3. The research planning phase

Having identified my research topic and consulting with an academic supervisor who was interested in the therapeutic alliance and qualitative techniques, I spoke with people involved with looked after adolescents. This included; a psychiatrist, clinical psychologist and a previous trainee who had conducted research in this area. These conversations highlighted the following points:

- The need to conduct the interviews following discharge from services and the potential difficulties recruiting participants post discharge with the limited numbers of looked after adolescents undertaking therapy.

- The importance of ensuring that local clinicians working in this area were on board with my research agenda and process.

- The importance of considering methodological and ethical issues when working with this population.

As a result, I then took the following action:

- Changed the focus of my research to include a wider demographic of adolescents' not just those within the care system

- Contacted a number of local CAMHS clinicians and spoke with them about their opinions of my research project. The benefits of these meetings were two-fold: they enabled me to gain expertise from clinicians working in this field with regard to recruitment of participants and ethical issues, and also to help consolidate the focus of the research so it would be of value to clinicians and CAMHS services. As a result of these meetings a number of clinicians agreed to lend their support to the recruitment process and to provide premises where the interviews could take place.

- With the support of academics within the school of psychology clinical section and field clinicians, I prepared my NHS research ethics committee application. This involved producing research packs suitable and appealing for an adolescent audience. I trialled the research packs on the adolescent children of friends and made changes based on their recommendations.

4. Data collection

4.1. Recruiting participants

The ethics committee process went smoothly and so I was able to begin recruitment of participants within my research timescale. This part of the process was a steep learning curve. My initial intention was to return to the CAMHS teams where I had spoken to individual clinicians about my research, introduce the research via the team meeting and for the wider clinician group to recruit using research packs I provided. I attended the team meetings of five CAMHS team and through this process recruited no participants. On returning to the teams for second team meetings, service difficulties became apparent. In one county they were reorganising the service which increased staff workload, and in the other county all teams had experienced chronic staffing shortages. Consequently clinicians had not been able to prioritise recruitment for my study. I realised that I needed to rethink my strategy and commenced the second phase of recruitment. I met with clinicians on an individual basis, listened to the service difficulties they were experiencing, used our time together to create the thinking space needed to identify potential participants and asked them to commit to sending out two

packs each. Through this process, I was successful in recruiting a sufficient number of participants to the study.

4.2. Interviewing

The interview was piloted on a trainee clinical psychologist who had undertaken personal therapy and volunteered to help my preparation for participant interviews. The trainee kindly provided feedback on my style and the process. I became aware of the importance of knowing my schedule thoroughly in order to improve eye contact and the flow of the interview. As a result of feedback from the trainee regarding process, adaptations were also made to the way the interview was introduced. The interview schedule was also shared with an adolescent child of a friend who had not undertaken therapy for ease of understanding. Their parents were supportive of their involvement in the project and no changes were suggested.

Although the first interview was treated as a pilot, reflections and analysis upon it generated many interesting codes. The interview schedule itself was not considered to need any adaptations and so the data from the pilot interview was included in the final analysis.

Adolescents who had experienced therapy were the participants in my research. My role as a researcher within this context came into tension with the other side of my job, working therapeutically with young people. This dilemma is common to researchers who have an alternative professional role as well as the role of the researcher (Flick, 2006). I became aware of this when reflecting on the process of interviewing a participant whose mother was very protective of her and made this known before the interview

commenced. This awareness evoked feelings within me of needing to protect the

participant during the interview. Furthermore, during the interview the participant

became upset: I had not protected her. It appeared that these two occurrences affected

my style during the interview (I backed away from the subject that caused the emotional

reaction) and I used supervision to reflect on how to manage this should any similar

issues occur in later interviews.

4.3. Factors affecting the power balance in the participant researcher interaction

A power imbalance between the participant and the researcher that may be

supported by education, class, professional status etc, is a normal occurrence in research

studies (Smail, 1994). However, in this study differences in age socio-economic

background, ethnicity and gender and the fact that the participants had been treated for a

condition that is widely stigmatised also impacted significantly on the interaction.

Consideration is therefore given to these areas and how they may have impacted on data

collection.

4.3.1. Age differences

Day (2008) emphasises the need for researchers to pay attention to the power

differential when conducting research with children and adolescents. During the

interviews I felt aware of the power that I held as an adult in a professional position

asking questions. All participants had experienced therapy and consequently had been in

CAMHS settings meeting with people like me. They had varied experiences both positive

and negative of their previous therapeutic relationships. Whilst I clearly outlined the

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interviewee/ interviewer relationship with them initially, I wondered whether adolescents may experience similarities between their therapeutic encounter and the research interview. This was compounded by interviewing the adolescents in NHS buildings, often the CAMHS buildings where they undertaken therapy. Prior to conducting the interviews I wondered how this would impact on the relationship between the adolescents' and myself: Would they be re-traumatised by returning to the base they had therapy in?; How would they find talking about their therapist with another health professional?; Would they experience a conflict of loyalties?; These questions evoked feelings of anxiety in me. I managed this anxiety by trying to ensure that the adolescent felt comfortable and engaged in the process. At times this led to discussions about issues that were wider than the remit of my interview schedule.

4.3.2. Socio- economic differences

The socio-economic advantage that I had as a trainee over a number of young people interviewed was clearly evident to me. Three of the young people interviewed had been in the care system, one had been in an adolescent inpatient setting, five participants in total had experienced significant disruption to their education. I was aware that I was asking them to take part in a research process that would lead to me becoming a clinical psychologist whereas due to socio-economic background, some of the adolescents interviewed were not in a position to pursue their goals. I tried to manage this by expressing empathy with their position and being encouraging if they spoke about progress made during therapy or life goals. During this encounter I experienced a tension between the pull to be a 'neutral' researcher, and a person and a professional who

passionately cares about young people. This tension may have had some influence on how the participants responded to questions. I took care to try and be neutral and open in response to the interview questions in order to manage this.

4.3.3. Differences in Ethnicity

Being part of an ethnic minority brings with it social disadvantages in British society (Mason, 2000). Those who are young, black and living with mental health difficulties could be described as experiencing a triple disadvantage. Two of the participants in the current study described themselves as black. I was acutely aware of the discrimination that black people face in UK society at large and thought about how this discrimination may have already impacted upon the adolescents in my study. Whilst I was not aware of this having an immediate affect on the relationship between the participants and myself during the interview process, I attended to it and worked hard within the interview to reduce the possibility of any felt power differentials.

4.3.4 Gender differences

Four of the participants interviewed were male. According to constructivist theorists, masculinity is a fluid construct situated in specific historical conditions (Spector-Mersel, 2006). Whilst interviewing male participants I was aware of gender differences between myself and them. I became aware that the interview process may challenge western ideas of masculinity. Western psychological research has suggested that men tend to 'bottle up' their feelings: "restrictive emotionality" (Levant et al., 1992). Therefore, asking young men to reflect on their experiences of sharing their emotions with another may not fit within traditional western masculine norms. During the process

of interviewing, I reflected that perhaps this was preventing me from pursuing the emotional reflections with some of the male participants. I attempted to address this within the interviews by staying with the language that they used and allowing time for them to discuss their interests outside of the immediate research topic, such as playing competitive sport.

5. Data analysis

5.1. Familiarisation with Grounded Theory.

At the outset of my research I was unfamiliar with Grounded Theory and set about familiarising myself with it by reading books and articles, attending lectures regarding grounded theory, discussing ideas in supervision, and being part of a grounded theory peer group of fellow trainees. These actions developed my confidence in my ability to complete the analytic process.

5.2. Conducting the analysis

Charmaz (2006) suggests that data analysis should involve the process of fully immersing oneself in the data. The transcription of all of the interviews and subsequent process of coding each transcript line by line, generating focused codes, the use of constant comparison methods and reflexive techniques enhanced my familiarity with the data and helped to further develop my confidence in the model emerging from the data.

Classic grounded theorists (Glaser and Strauss, 1967; Glaser 1978) recommend that the literature review should be the last piece of work done in a grounded theory analysis. Given the time scales and difficulty recruiting, this was not possible in my analysis and thus I began the analytic process with previous literature in mind. This had an affect on the initial quality of my analysis. From the first interview, I generated a set of codes that I thought summed up the account, but on reflection with my supervisor I realised that they were not grounded enough in her language and experience. Re-analysing with the concept of grounding in her language in mind helped develop new categories.

I had concerns that data from the subsequent participants were irrelevant to my research question, for example, how did information about being sectioned relate to engagement in outpatient therapy? Through further consideration I came to realise that the accounts in their entirety were essential in providing a contextual understanding which was fundamental to staying with the grounded theory method; situating codes and categories within social processes.

Extracts from my research journal indicated the sense of total uncertainty and bewilderment that I was experiencing as the analysis progressed. It was difficult to generate a model that brought together eight different participants' stories and yet remain grounded and true to their accounts. I felt that my categories were too closely aligned with my interview schedule and did not speak to the rich experiences that the adolescents described. Research supervision was particularly valuable at this point and talking through my data in plain simple terms with my supervisor enabled me to rethink my categories.

6. Personal and professional development

6.1. Personal development

During the course of conducting my doctoral thesis I have learned that there are more important things than a doctoral thesis. Life continued outside of the thesis and was extremely difficult. Although I did not relish this at the time, it enabled me to put the thesis in its place and realise how I needed to look after myself over and above any work/ thesis commitments. Learning this valuable lesson was hard and required commitment on my part to break from work and practice being kind to myself.

As a consequence of trying to be kind to myself I began looking after myself better. Running became a big part of my life and I have developed new friendships, have more energy and a better work life balance as a result of this. Staying true to myself also came under the umbrella of being kind. I feel proud that despite pressure from others I researched something that I believe is valuable at many levels; to young people, clinical psychologists and the health service as a whole. I hope to publish my research so it can be of use to affect positive change at a service level and therefore stay true to my goals of taking social action to challenge injustice in society. The process of writing a thesis amidst difficulties in my personal life has also enabled me to understand just how much I am able to tolerate. This has increased my confidence in my ability to manage the stress and distress that a career in clinical psychology is likely to bring.

6.2 Development of research skills and implications for clinical practice

This thesis has enabled me to develop skills in the following areas:

- Balancing undertaking a research project alongside clinical work.

- Undertaking research with young people

- Involving parents and carers in the process

- Designing and conducting interviews

- Transcribing, analysing and interpreting interview data using a grounded theory methodology

The process by which this learning has occurred has been tough but despite this, I continue to believe that qualitative methodologies are hugely beneficial in developing our understandings of the complex and dynamic nature of human experiences. I look forward to producing research that is of value to the service user, the health service and as a result wider society throughout my career.

With regard to implications for my clinical work, this research consolidated my desire to work clinically with adolescents who traditional services find it difficult to engage. Alongside this, it also developed my confidence in conducting research with any other groups of people who do not work with traditional mental health services. Although adolescents are the focus of the current research, many of the processes involved in producing the research could also be utilised with other difficult to reach groups of people. Therefore the skills that I have developed may be of benefit in a variety of settings. The process of conducting this research has also helped me feel less constrained by the clinical psychology system; as research legitimates the wider roles of the clinical psychologist as a political and social activist.

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Section E

Appendices

Submitted April 2011

by

Anna Kershaw

To the University of Leicester, School of Psychology, Clinical Section

In partial fulfilment of the degree of

Doctorate in Clinical Psychology

Appendix A:

Guidelines to authors for target journal for literature review

Appendix B:

Literature Review Search Strategies

Literature review search strategies

Step 1: Consultation with mental health professionals and researchers in the field to identify relevant authors, web resources, books and journals

Step 2: Database searches
Searches were conducted in Applied Social Sciences Index and Abstracts (ASSIA), Medline, PsychInfo and Web of Science (WoS) databases using combinations of the following terms

	Search terms (1, 2 & 3 combined with 'AND' syntax)
1	"view" or "experience" or "attitude"
2	adolescent" or "teenage" or "young person"
3	"therapy" or "mental health".

Truncations were used to ensure maximum search efficacy.

Database	Criteria/ limiters	Articles returned
ASSIA	English Language	220
WoS	English Language	13
PsychINFO	English Language, peer reviewed, exclude dissertations	2522
Medline	English Language, peer reviewed, exclude dissertations	475

Total articles	3230
Total articles after including those from hand searches of reference sections and book chapters (n= 14)	3244
Total articles relevant for inclusion after titles/ abstracts scanned for relevancy	33
Total articles after duplicates removed	16

Appendix C:

Trainee's statement of epistemological position

<u>Trainee's statement of epistemological position</u>

The trainee's position in relation to the current research may best be described as 'contextual constructionalist'. Contextualism postulates that all knowledge is situation dependent and provisional (Jaeger & Rosnow, 1988). Hence in relation to data collection in the current study, the trainee did not believe that she would be party to an objective measurable reality regarding adolescents' experiences, but rather adolescents would offer individual constructions of their experiences (Lund, 2005). The way in which adolescents present their constructions is likely to be based on the context of their therapeutic experiences and also the context of the research interview. Taking the position that all accounts are imbued with subjectivity, the trainee recognised that her account in relation to analysis of the data, is also context dependent. This has been described as the 'double hermeneutic' (Smith and Osborne, 2003): as each participant engages in their own process of constructing their experiences, the trainee also engages in her own process of interpreting each participants' account. The trainee used reflexive to understand how her position impacts on how she makes sense of participants' accounts (Starks & Trinidad, 2007). When making sense of the data, within a contextualist framework, there is a desire to ground the results in participants' accounts (Madill, Jordan & Shirley, 2000). To support her contextual constructionalist position, the trainee utilised a critical realist stance which 'grounds discursive accounts […] in social practices whose underlying logical and structure can, in principle, be discovered' (Parker, 1996, p.4, cited in Madill, Jordan & Shirley, 2000).

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Grounded theory and IPA are the qualitative approaches whose theoretical underpinnings are most closely aligned with a contextual constructionalist and critical realist stance. (Charmaz, 2006; Willig, 2008). The trainee chose grounded theory over IPA as of the two qualitative methodologies, grounded theory generates an explanatory theory of basic social processes (Glaser & Strauss, 1967) upon which service interventions can be designed (Starks & Trinidad, 2007). This is in contrast with IPA which focuses on accessing the sense that individuals make of the phenomena they encounter and their resulting constructions of these experiences (Smith, Flowers & Larkin, 2009). Given that the intended aim of the study was to produce a model of how adolescents' experienced psychological therapy, with a view to shaping services available to this group, grounded theory seemed the most useful theoretical approach to take.

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Appendix D:

Research pack

Containing:

1) information sheet for adolescents;

2) expression of interest form;

3) information sheet for parents/ carers.

Can You Help With My Research?

What was it like for you to have therapy?

Lots of people have different experiences of therapy. I am interested to know how you worked with your therapist and whether this was helpful for you. I would like to find out about how you made a working relationship together and what helped or didn't help this to happen. I would like you to talk me through what it was like to have therapy from the start through to the ending. This is your chance to tell your story! If you are aged 13 years old and over AND had at least three sessions of therapy with a CAMHS worker AND are not having therapy anymore, I would really like to hear your stories.

What is research and who is doing it?

Research is a way of finding out answers to questions. My name is Anna Kershaw and I am from the University of Leicester. If you decide to take part in the research I will be the person who interviews you. I am doing the research as part of my professional training to become a clinical psychologist.

I want to hear your story

I think it is really important to hear your story because I want to understand what your relationship with your therapist was like for YOU. By sharing your story with me, I hope it will help me to understand all of the different types of experiences you may have had. It does not matter if you had difficulties with your therapist or if you felt like you needed to stop going to see them, I would still like to hear about your experience. I will also be interviewing other young people as part of this research.

What will happen if you take part?

I would like you to take part in one interview, which will last up to 60 minutes (depending on how much you have to say!). Before an interview you will have time to ask me questions and find out more. You can choose where you want to be interviewed. It will be in an NHS building, like the CAMHS base you went to for therapy or another NHS Partnership Trust base. At the end of the interview I will give you a £20 gift voucher to thank you for your time.

Do your parents/carers need to know if you want to take part?

If you are under 16 years old, you will have to tell your carers that you would like to take part in this research. After talking about this with them, if they think it would be a good

idea that's great! If you are over 16 you do not need to get your carer's consent, but you may decide you want to tell them about it anyway.

What is Consent?

Consent means agreeing to take part in this research project. If you decide you would like to, then you, your carers (if you are under 16) and me (Anna Kershaw) will sign a "consent form" **BUT** you can still change your mind at any point up until one month after we have done the interview together. This means that if you decide at anytime you no longer want to take part that is fine. Whether you decide to take part or not, this will not affect your care at any point now or in the future. If you would like to meet with me or talk on the telephone about taking part this can be arranged. You can either decide at that meeting if you want to take part, and we would then arrange a day for the interview, or if you needed more time to think about it you can ring me within a month to let me know if you would like to take part.

What will happen to what you say?

If you agree to take part, what you say in the interview will be digitally audio recorded. It will then be typed out word for word and saved on a computer using a code instead of your name. If you agree I will show you what I have typed out and see if you think it is right or if there is anything you want to change. This can be done face to face with me, or by post. The original recording of the interview will be stored securely in a locked room at the University of Leicester for five years. After five years it will be destroyed.

How will I make it safe for you to tell your story?

When the interview is typed out, your name will be changed to make sure that everything you have said is "confidential". This means that nobody will find out your personal details or trace what you said back to you. The only time that confidentiality would be broken is if I was worried that you or someone else was at risk of being hurt. If confidentiality was going to be broken I would talk to you about this and explain it in detail before doing so. I will include direct quotes from interviews in what I write about the research but these will be completely anonymous. This means I will write word for word what has been said but no-one will know who said it. What you have said will not be available for your parents or carers to read.

What happens when the research is finished?

When the research is finished, if you want, I will write to you to let you know what I have found. If you are under 16 then your parents or carers will also have the choice to have a copy of my findings. This will involve sending a written summary of what people have said. Remember though, that because all names will be changed, nobody reading the report will know who has said what. Based on what you and the others who choose to take part have said, hopefully the research will help therapists to think about how young people think about working with them and this will hopefully help them to improve the way that they work.

What happens if you get upset?

If you become upset during the interview you can ask me to take a break or to stop the interview altogether. If you feel upset after the interview you can talk to me about it, without it being part of the research. If you are upset and don't want to talk to me then I can help arrange for someone else to talk to you. This might be your parent or carer or a professional person who is already working with you.

Withdrawing from the research

You can withdraw or say "no" to the research at any point, even after you have given written consent. Any information collected from you by that time would then be removed from the study and destroyed.

Who has reviewed the study?
All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, well-being and dignity. This study has been reviewed and given a favourable opinion by Derbyshire Research Ethics Committee.

What if you want to complain?
If you have a concern about any part of this research project, please speak to me and I will do my best to answer your questions (my details are at the end of this information sheet). If you remain unhappy or wish to complain formally, you can contact The Patient Advisory Liaison Service PALS (see the end of the information sheet for details).

If you are interested in taking part then…

1. If you are under 16, show this sheet to your carers and talk about it with them.

2. Fill in the information on the next page and send it back in the envelope provided. I will
   then contact you to arrange a meeting so we can discuss this further and I can answer any questions you may have.

Contact Details

Anna Kershaw
Trainee Clinical Psychologist
School of Psychology,
Clinical Section,
University of Leicester,

Patient Advice and Liaison Service
Leicestershire Partnership Trust,
Groby Road,
Leicester,

104 Regent Road,   Leicestershire,
Leicester,
LE1-7LT.   LE3 9ES.

aek10@le.ac.uk   0116 225 6647
0116 223 1639

<u>Thank you very much for taking the time to read this.</u>

Adolescents' Experiences of Engagement in Psychological Therapy

Date:_____

My Name is: _____ **Age:** _____

My Address is: _____

_____

Tel No _____

Please circle Your Response:

I **HAVE** talked about this with my carers   **YES / NO**

I AM **OVER 16**   **YES / NO**

I would like to take part in an **INTERVIEW**   **YES / NO**

I would like to **MEET WITH THE RESEARCHER** to   **YES / NO**
talk about this more before I decide

Please **CONTACT ME** to arrange this by   **LETTER /**
PHONE

If you have any questions or worries please write them down below.
This will help me to prepare for when I come and meet with you:

_____

_____

_____

Information for Parents and Carers

A research project to look at young people's experience of engaging in therapy

Research is a way of finding out answers to questions. Lots of people have different experiences of having therapy. I am interested to know how young people manage to work with their therapist in therapy. I would like to find out what has helped them to do this and what has not helped. I would like to hear what the experience is like from their perspective.

Who is doing the research?

My name is Anna Kershaw and I am from the University of Leicester. If you decide it is ok for the young person you care for to take part in the research, I will be the person who interviews them. I am doing the research as part of my professional training to become a clinical psychologist.

What will happen if they take part?

I would like young people to take part in one interview, which will last up to 60 minutes (depending on how much they have to say!). Before an interview you will have time to ask me questions and find out more. You can help them choose the NHS base that they want to be interviewed at. For example, this could be at the CAMHS base that they attended or I can book a room at another NHS partnership trust base. At the end of the interview I will give them a £20 gift voucher to thank them for their time.

What if they want to take part?

If the young person you care for is younger than 16 years old, you will need to agree for them to take part in this research project. If you decide you would be happy for them to take part, then you, the young person in your care and me (Anna Kershaw) will sign a "consent form" **BUT** you can both still change your mind at any point. This means that if you decide within two months of the interview you no longer want them to take part that is fine. Whether you decide they can take part or not, this will not affect their care at any point now or in the future. If you would like to meet with me or talk on the telephone about the project this can be arranged. You can either decide then if you are happy for them to take part, and we would then arrange a day for the interview, or if you need more time to think about it you can ring me within a month to let me know if you both agree that the young person would like to take part.

What will happen to what they say?

What they say in the interview will be digitally audio recorded. It will then be typed out word for word and saved on a computer using a code instead of their name. If you both agree I will show the young person what I have typed out and see if they think it is right or if there is anything they want to change. This can be done face to face with me, or by post. The original recording of the interview will be stored securely in a locked room at the University of Leicester for five years. After five years it will be destroyed.

Anonymity and confidentiality

When the interview is typed out, any names will be changed to make sure that everything is "confidential". This means that nobody will find out any personal details or trace what was said back to the young person you care for. The only time that confidentiality would be broken is if I was worried that someone was at risk of being hurt. If confidentiality was going to be broken I would talk to you and the young person about this and explain it in detail before doing so unless doing so would affect the young person's safety. I will include direct quotes from interviews in what I write about the research but these will be completely anonymous. This means I will write word for word what has been said but no-one will know who said it.

What happens when the research is finished?

When the research is finished, if you want, I will write to you both to let you know what I have found. This will involve sending a written summary of what people have said but all names will be changed, and nobody reading the report will know who has said what. Based on what young people who chose to take part say, the research will hopefully help staff to appreciate better how young people understand what it is like to have psychological therapy. The research may be used by CAMHS services when they are thinking about what they offer to young people and how they go about it. The research may also help young people who are having therapy or thinking about having therapy to understand what the experience of having a relationship with a therapist was like for other young people.

What happens if the young person becomes upset?

If they become upset during the interview they can ask me to take a break or to stop the interview altogether. If they feel upset after the interview they can talk to me about it, without it being part of the research. If they are upset and don't want to talk to me then I can help arrange for someone else to talk to them. This might be you, a CAMHS worker or another professional already involved in their care.

Withdrawing from the research

You can withdraw the young person from the research at any point, even after you have given written consent. Any information collected from them at that point would be removed from the study and destroyed immediately.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given a favourable opinion by Derbyshire Research Ethics Committee.

What if I want to complain?

If you have a concern about any part of this research project, please speak to me and I will do my best to answer your questions (my details are at the end of this information sheet). If you remain unhappy or wish to complain formally, you can contact The Patient Advisory Liaison Service PALS (see the end of the information sheet for details).

If the young person you care for is interested in taking part

1. If you are the parent or carer of a young person under 16, they will show you their information sheet and you can talk about it with them.

2. Please help them fill in the final page of their information sheet and send it back in the envelope provided. I will then contact you to arrange a meeting so we can discuss this further and I can answer any questions you may have.

Contact Details

Anna Kershaw
Trainee Clinical Psychologist
School of Psychology,
Clinical Section,
University of Leicester,
104 Regent Road,
Leicester,
LE1-7LT.

aek10@le.ac.uk
0116 223 1639

Patient Advice and Liaison Service
Leicestershire Partnership Trust,
Groby Road,
Leicester,
Leicestershire,

LE3 9ES.

0116 225 6647

Thank you very much for taking the time to read this.

Appendix E:

Interview Schedule

Interview Schedule

Introduce self and go through information sheet

Ask whether the participant and or parent/ carer (where appropriate) have any questions

Obtain written assent/ consent from adolescent and parent/ carer where adolescent under 16 years old

- o Warm up questions

  - o *"How long did you see you therapist for; was that weekly, fortnightly?"*

  - o *"How old were you when you started therapy?"*

  - o *"When did it finish?"*

- Adolescents' views about the initial contact with psychological therapist.
  - o *"Tell me about what happened when you first met your therapist"*

  - o *"What sorts of things did you think the first time you heard from them/ met them?"*

  - o *"Talk me through the time you first met your therapist?"*

  - o *"How did the therapist start your first session?"*

- Adolescents' views about factors that facilitated engagement in the therapeutic process; at a personal, interpersonal and systemic level.
  - o *"What sorts of things helped you to start thinking that therapy would be helpful for you?"*

-     o   *"Did anything have to happen for you before you could start working together?"*

- Adolescents' views of the barriers to engagement; systemic factors, therapist factors, personal factors.

  - o   *"Did anything stop you from finding the therapy useful?"*

  - o   *"Was there anything going on outside of therapy at the time which made it hard to work together with your therapist?"*

  - o   *"Was there anything about what the therapist did or said that made it hard for you to work with them?"*

- Adolescents' views about how engagement was maintained throughout the process of therapy at a personal, interpersonal and systemic level.

  - o   *"What sorts of things helped you to keep going to see your therapist?"*

  - o   *"Did you ever miss sessions?"*

  - o   *"Can you talk me through why that happened?"*

  - o   *"When you went to sessions, how did you feel about going?"*

- Adolescents' views about disruptions to the engagement how were these managed at a personal, interpersonal level.

  - o   *"Was there a time in therapy that things got difficult?" "Could you tell me about it?"*

  - o   *"How did you cope with the difficult times with your therapist"*

- *"How did you get over this?"*

- How was the engagement ended?

  - *"Could you tell me about what happened when you were coming to the end of therapy?"*

  - *"What happened in the last session?"*

  - *"How was the ending for you?"*

- Cool down questions

  - *"How have you found talking to me today?"*

  - *"Do you have any questions that you would like to ask me?"*

The interviewer may at times need to seek elaboration of answers by using prompts such as;

  - *"How come?"*

  - *"What was that about?"*

  - *"Could you tell me a bit more about that?"*

  - *"How was that for you?"*

Remind participant that they have right to withdraw from the study at any time. Ask whether they would like feedback regarding the findings of the study and obtain contact details where this is the case.

Appendix F:

Consent/ Assent forms

Comprising:

1) Assent form aged 16 +

2) Assent and Consent Form aged 13-16

Adolescents' Experiences of Engaging in Psychological Therapy- Assent Form aged 16+

Identification Number:

Researcher: Anna Kershaw, Trainee Clinical Psychologist
Based at: School of Psychology, Clinical Section, University of Leicester, 104 Regent Road, Leicester, Leicestershire, LE1 7LT.

<u>Instructions</u>

Please read this and initial each box if you agree with what is said. Please sign and date at the bottom of the form.

I have read the Information Sheet about this project.

I have met with Anna Kershaw who has explained the project to me. I have had the opportunity to ask questions and understand what I will be required to do.

I understand that the interview will be recorded and will be kept in a safe and secure place and the information I give will be used for this project only.

I understand that the information I give will be treated as confidential unless the researcher becomes concerned someone is at risk.

I agree that what I say in an interview will be anonymised and can be directly quoted in things written about the research and I understand what this means.

I understand that I can change my mind and pull out of the project at any time if I want to. If I do, any information I have given will be withdrawn from the study.

I understand that taking part in the research will not affect my
care at any point now or in the future.

☐

I understand I will be given a £20 gift voucher for taking part in an
interview.

☐

I understand that information collected during this study may be looked at
by individuals from the NHS trust and from regulatory authorities where it is
relevant to my taking part in this research. I give permission for people from
these organisations to have access to my records.

☐

I AGREE TO TAKE PART IN THIS PROJECT

_____ _____
Name of Participant   Signature of Participant   Date

_____ _____
Name of Researcher   Signature of Researcher   Date
**When completed one copy will be given to the young person and one will be kept by
the researcher**

**Adolescents' Experiences of Engaging in Psychological Therapy-
Consent Form aged 13-15**

Identification Number:

**Researcher: Anna Kershaw, Trainee Clinical Psychologist
Based at: School of Psychology, Clinical Section, University of Leicester,
            104 Regent Road, Leicester, Leicestershire, LE1 7LT.**

Instructions

Please read this and initial each box if you agree with what is said. Please sign and date at the bottom of the form.

I have read the Information Sheet about this project.

☐

I have met with Anna Kershaw who has explained the project to me. I have had the opportunity to ask questions and understand what I will be required to do.

☐

I understand that the interview will be recorded and will be kept in a safe and secure place and the information I give will be used for this project only.

☐

I understand that the information I give will be treated as confidential unless the researcher becomes concerned someone is at risk.

☐

I agree that what I say in an interview will be anonymised and can be directly quoted in things written about the research and I understand what this means.

☐

I understand that I can change my mind and pull out of the project at any time if I want to. If I do, any information I have given will be withdrawn from the study.

☐

I understand that taking part in the research will not affect my care at any point now or in the future.

☐

I understand I will be given a £20 gift voucher for taking part in an interview.

☐

I understand that information I give during this study may be looked at by individuals from the NHS trust and from regulatory authorities where it is relevant to my taking part in this research. I give permission for people from these organisations to have access to my records.

☐

I AGREE TO TAKE PART IN THIS PROJECT

_____   _____
Name of Participant   Signature of Participant   Date

_____   _____
Name of Parent/Carer   Signature of Parent/Carer   Date

_____   _____
Name of Researcher   Signature of Researcher   Date

When completed one copy will be given to the young person, one to the parent/ carer and one will be kept by the researcher

Appendix G:

Example of line by line and focused coding
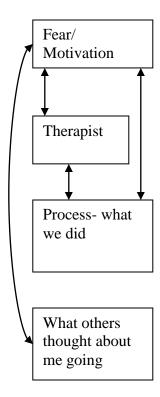
Appendix H:

Example of theoretical memos

<u>Example of Theoretical Memos</u>

January 11th 2011
Thoughts about coding Millie:
 Initial categories e.g. "building the alliance" seem to be based on previous reading rather than grounded in Millie's narrative. Need to use participants' own words e.g. "facing my fears".
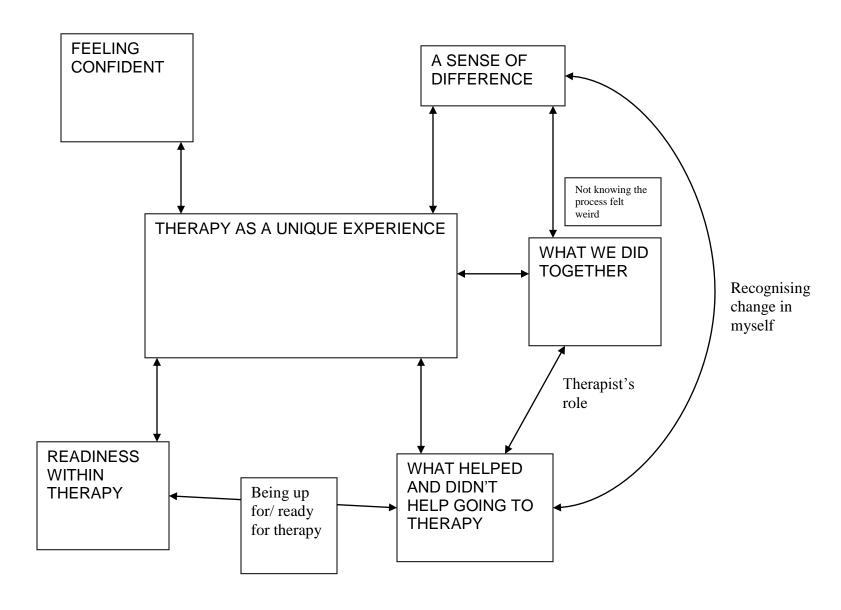
March 3rd 2011
Fear/ motivation as a separate category?

Should fear and be separated from each other and from other categories? They emerge within all other categories. What describes fear and motivation towards therapy? Attitude?

Appendix I:

Original model of categories

FEELING
CONFIDENT

A SENSE OF
DIFFERENCE

THERAPY AS A UNIQUE EXPERIENCE

Not knowing the
process felt
weird

WHAT WE DID
TOGETHER

Recognising
change in
myself

Therapist's
role

READINESS
WITHIN
THERAPY

Being up
for/ ready
for therapy

WHAT HELPED
AND DIDN'T
HELP GOING TO
THERAPY

Original model of codes and categories

Appendix J:

Photograph of making sense of the data

Photograph of making sense of the data

Appendix K:

Chronology of research process

Chronology of research process

January – July 2009	Consult with academic supervisors and field clinicians.
July- November 2009	Discuss recruitment with CAMHS teams Develop draft interview schedule and research information packs Preparation and submission of ethics form
December 2009 - January 2010	Share study materials with adolescents and amend using their feedback. Submission of proposal for final peer review – make amendments Submission of ethics form and draft study materials to IRAS
February- April 2010	Focus on other course deadlines and international placement
April- July 2010	Make amendments to IRAS application Pilot interview schedule
July 2010- February 2011	Recruitment of participants via CAMHS teams Interview participants Transcribe interviews Analyse data
February 2011- April 2011	Complete draft thesis write up Complete final thesis and hand in
June- September 2011	Viva preparation Preparation of journal article and poster presentation Disseminate findings to participants and CAMHS teams

Appendix L:

Letters to and from ethics committee