A qualitative investigation into childrens’ and parents’ views of mental health services

A thesis submitted to the University of Manchester for the degree of Doctor of Clinical Psychology in the Faculty of Medical and Human Sciences

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Simeon Hanson: School of Psychological Sciences
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Word Count: 26,296 (excluding abstracts, references and appendices)
Abstract

This thesis investigated the views, opinions and experiences of children, young people and parents of mental health services and Triple P parent training using qualitative methods. It is divided into four separate papers, the first three written as standalone journal papers. Paper 1 is a systematic review and synthesis of qualitative studies exploring children’s views and opinions of mental health services. The review used specific databases, a search of qualitative journals and a general Internet search to identify relevant studies. The paper utilized inclusion/exclusion criteria and a quality appraisal assessment. Fifteen studies meeting inclusion and quality criteria were identified exploring the experiences of 378 children and young people aged between 5 and 16 years, from a range of countries. The review then involved synthesising the findings of these studies to generate several overarching themes. Themes that emerged were; the stigma of mental health difficulties; alliance making and breaking properties; the physical location of services; consent and confidentiality; preferences for creative therapies and a recognition of therapeutic stages. Paper 2 is an original research study that explored the experiences of parents of Triple P parent training. Eight parents were interviewed using a semi-structured protocol. Data were analysed using Interpretative Phenomenological Analysis. Emergent themes were; a search for a cause; the stigma of parenting difficulties; the destruction and recreation of family life and a shift in perspective. Paper 3 explores the views and opinions of children whose parents have recently undertaken Triple P parent training. This qualitative study used ‘In My Shoes’, a computer assisted interview tool, to explore the experiences of eleven children from England aged between five and sixteen years. Children’s data were analysed using Thematic Analysis. Children’s themes were; a search for a cause; changes in life brought about by Triple P and wider difficult life circumstances. Parents and children’s narratives broadly agreed though children talked about being smacked before Triple P and parents did not comment about chastisement. The final section of the thesis was a critical appraisal of the literature review, research study and research process as a whole, including methodological reflections, implications for future research and clinical practice, and the researcher’s personal reflections in undertaking the research.
Declaration

No portion of the work referred to in this thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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iv. Further information on the conditions under which disclosures and exploitation may take place is available from the Head of School of Psychological Sciences.
Acknowledgements

I would like to thank my supervisors Professor Rachel Calam and Dr. Fiona Ulph for their support, guidance and invaluable help throughout the research process.

I dedicate this work to my mum and dad for all of their support over the years, and, to Zanib, Ayman and Layla who make me realize what is important in life and provided me with the strength to complete this work.

Consummatum est
‘Is anyone listening?’

Metasynthesis of children and young people’s views of Child and Adolescent Mental Health Services

This is paper 1 and has been prepared in the format of a journal article to be submitted to the Qualitative Health Research Journal (Appendix 1). Where the paper differs in style to the guidelines of the Qualitative Health Research Journal this is to conform to University doctorate standards and for ease of reading.

This paper is a literature review using a meta-synthesis approach reviewing the experiences and views of children as service users of mental health services, and, audits of the level of participation that children’s views have received.

Word Count 8000
Abstract

The purpose of this metasynthesis was to draw together the views and opinions of children and young people about child mental health services and to audit the influence that their views had using Alderson and Montgomery’s model of participation. Fifteen studies were included in the metasynthesis. Several themes were identified including; stigma, alliance making and breaking properties, consent and confidentiality, therapeutic skills, therapeutic process. A model of children’s views of mental health services was developed that could provide a template for future research. An audit of the depth of influence of children’s views revealed that they are still largely ignored at policy level. Professionals and academics should both hear the voices of children and adapt services to their needs. Professionals should be aware of attributes that support the therapeutic alliance and be mindful that for at least the first few appointments children may mask their true feelings.

Keywords

Children and young people; service users; views; participation; child and adolescent mental health; meta-synthesis.

Introduction

Obtaining the opinion of patients is now central to both national and international government policy on providing healthcare (Coulter, 2006). Indeed, patients’ rights to determine aspects of their health care are now enshrined in international human rights legislation and professional standards mandates (Royal College of Paediatricians, 2005; National Health Service (NHS), 2002; Royal College of Psychiatrists, 2006). Recent research suggests that there is an increasing call from patients demanding more say in the decisions that are made by or about them (Fulford & Williams, 2003). In a document entitled ‘The
future of Mental Health’ Main (2006) argued that the balance of power will no longer be with the health care system, rather, health care will be more of an equal partnership between services and individual consumers. This ‘coproduction’ (Ahuja & Williams, 2010) or movement of increasing participation has been demonstrated to be imperative for improving outcomes for patients (Coulter, 2006).

The movement towards greater participation for patients in health care has been neglected in child health services and in particular mental health services (Worrall-Davies, 2008). The topic of children as service users has received little academic attention (Davies & Wright, 2008) and has yet to be seen as a legitimate area of research and not just an adjunct to other research (Becker, Bryman & Sempick, 2006). Despite evidence (Wolpert, Maguire & Rowland, 2001) highlighting best practice standards for children and young people to be allowed to express their views on the services they receive, some authors continue to question the validity of involving children in the decision making process (Becker, Bryman & Sempick, 2006). Research consistently reveals that children are not asked for their views by those making decisions about their care or lives (Davies & Wright, 2008). Furthermore, evidence suggests participation of children is having little impact upon the decisions made about them (Carr, 2004).

Despite a paucity of research, many studies have demonstrated the rationale and benefits for including children and young people in
determining their health care (Cavet & Sloper, 2004). This has been coupled with increasing recognition and acknowledgment of the benefits and importance of qualitative perspectives in understanding children’s unique experiences regarding mental health issues (Roose & John, 2003). When consulted, children have a good deal to say about their care (Gersch, Holgate & Sigston, 1993) and can provide valuable insights into aspects of their care experience (Daley, 2005). Children as young as five and those with profound disabilities have given valuable feedback regarding health care services (Garland, Lewczyk-Boxmeyer, Gabayan & Hawley, 2004). Children have been shown to be largely unhappy regarding the ways they have been treated by some health services and feel there is a lack of communication regarding decisions about their care in mental health (Sinclair, 2004).

Giving children a voice can give them a sense of ownership conveying respect (Obigwe, 2004) and can help service providers better understand the patient experience (Carr, McDonnell & Owen, 1994). Research has also indicated that where children are consulted this can improve self-esteem, confidence and personal responsibility in children (Halsey, 2006). Best practice now suggests that consulting with children regarding policy and service should be routine (Maybery, Ling, Szakacs & Reupert, 2005).

Whilst no synthesis of children’s views has been undertaken to date, the views of adults as service users’ has received relatively more attention
though has been focussed on specific aspects of care. These include the use of crisis intervention (Hopkins & Niemic, 2007), patients’ understanding of mental illness (Wang, 2012), the usefulness of mental health nurses (Bee, Playle, Lovell, Branes, Grey & Keeley, 2008) and outcome measures (Crawford, Thana, Patterson & Weaver, 2010). When consulted about services, several themes have emerged in the research. Patients’ have spoken about: the stigma of having mental health difficulties (Wang, 2012; Powell, 2006; Gilburt, Rose & Slade, 2008); the physical environment (Goodwin, Holmes, Newness & Waltho, 1999); aspects of over medication (Rose, 2001); making sense of mental illness (Wang, 2012); the importance of the therapeutic relationship, and, positive and negative intrapersonal qualities of therapists (Bee et al, 2008; Powell, 2006; Gilburt, Rose & Slade, 2008); the need for greater and clearer information about mental health (Goodwin et al., 1999; Hopkins & Niemic, 2007).

Much has been written regarding operationalizing consultation and participation of children as service users from being asked about services to influencing the decision-making processes (Franklin & Sloper, 2005). The present study adopted a widely inclusive term based upon Alderson and Montgomery’s model (1996) of four levels of participation: (1) Being informed; (2) Expressing a view; (3) Influencing service decisions; (4) Being the main service decider.
Aim

Without reviewing qualitative studies the development of knowledge and implications for clinical practice are impeded unless the important and salient factors are highlighted from research and explored. Given the lack of research exploring children’s perspectives as service users and in particular as recipients of mental health services, the purpose of this paper was to review and synthesise qualitative research exploring children’s experiences of mental health services. The specific research question was ‘What are the views of children about mental health services for which they have received care from’? A subsidiary question given the framework above was ‘what levels of participation have children’s views reached’?

Methods

Meta-synthesis

Meta-synthesis is the process of exploring, analysing and synthesising qualitative research undertaken by different researchers in a related field (Walsh & Downe, 2005). While to some critics it is a controversial methodology its use has increased amongst qualitative researchers (O’Connell & Downe, 2009). A metasynthesis was considered the most appropriate review technique to meet the aim of the research question of the present study since it focuses upon children and young people’s views and opinions regarding sensitive issues that may not be
addressed by quantitative measures. The aim of meta-synthesis is to
develop an explanatory theory or model that explains the findings of a
group of similar studies. Whilst a relatively new technique, meta-
synthesis has been applied to diverse areas of research (Clemmens,
2003; O’Connell & Downe, 2009) to afford a greater understanding of a
subject area than that is available from a single study or to provide a
more holistic interpretation of the evidence (Harden, 2008).
There is no template for undertaking a meta-synthesis (Harden, 2008).
This paper followed others (Sandelowski & Barroso, 2007) using Noblit
and Hare’s meta-ethnographic approach (1998). This approach
preserves the interpretative properties of the data and acknowledges
the partial and interpretative aspect of the research. The analysis
involved several phases; (1) Getting started and deciding on the
phenomenon to be studied; (2) Deciding what qualitative studies are
relevant to the study using inclusion and exclusion criteria (below); (3)
Reading the qualitative literature. Data were read and re-read to
identify key themes, concepts and findings and how they are related
to each other or not. Key phrases ideas and arguments were
juxtaposed; (4) Re-reading themes and translating data into each
other based upon phase 3; (5) Synthesising the translation. This step
involved synthesising and re-categorising themes into higher order
categories that provided a synthesis of the published data, (6) Writing
the synthesis.
In line with quality assurance and good practice for undertaking qualitative research all stages were monitored in supervision from an experienced researcher (Stiles, 2003). 'Peer debriefing' from a small cadre of four doctorate students was utilized for quality control (Lincoln & Guba, 1985; Janesick, 2004).

**Procedure**

An initial scoping exercise revealed a small number of published studies from diverse geographical areas. A synthesising of the qualitative research in this area had not been undertaken and it was therefore decided that a metasynthesis could be an important addition to the literature.

**Inclusion and Exclusion criteria**

Table 1 (below) outlines the inclusion and exclusion criteria. Studies were included if they adopted qualitative methods with children aged 16 or younger commenting about mental health. Included were papers written in English (including studies conducted within Europe, North America and English speaking Canada) published from 1990 since this represents a stepped change in the inclusion and participation movement (Graham & Fitzgerald, 2010). Studies that focussed upon primarily parental views were excluded from the synthesis since evidence suggests that parents may not accurately represent the views of children.
Studies that adopted mixed methods of data collection were included if the results from the qualitative aspects of the methodology were separated from the quantitative results as to ensure that data could be easily attributed to the children themselves. Studies were excluded if they adopted a quantitative methodology or where qualitative results were synthesised in such a fashion as to make extraction of qualitative data difficult. Papers were excluded if they were not published or subject to a peer review process or were an expression of an opinion. Papers focusing on physical and not mental health were excluded. Papers where no methodology was outlined were discussed with the peer-debriefing group for consideration of inclusion/exclusion.

Table 1: A table outlining Inclusion and Exclusion criteria

<table>
<thead>
<tr>
<th>Inclusion Criteria</th>
<th>Exclusion criteria</th>
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<tbody>
<tr>
<td>English Language</td>
<td>Non English Language</td>
</tr>
<tr>
<td>Geographical Coverage</td>
<td></td>
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<tr>
<td>English speaking journals.</td>
<td>Non-English speaking journals.</td>
</tr>
<tr>
<td>Timing of Studies</td>
<td></td>
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<tr>
<td>Published from 1990.</td>
<td>Published prior to 1990.</td>
</tr>
<tr>
<td>Study Method</td>
<td></td>
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<tr>
<td>Qualitative methods of data collection or mixed methods where qualitative data was clear and extractable.</td>
<td>Non-Qualitative methods of data collection.</td>
</tr>
<tr>
<td>Population of interest</td>
<td></td>
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<tr>
<td>Studies focussing on children &lt;16 years.</td>
<td>Children &gt;16 years of age.</td>
</tr>
<tr>
<td>Conditions of interest</td>
<td></td>
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<tr>
<td>Studies concerned with children and young people’s views of mental health services.</td>
<td>Studies whose primary focus is not children and young people and their views of mental health services.</td>
</tr>
<tr>
<td>Study type</td>
<td></td>
</tr>
<tr>
<td>Studies that included empirical research – primary data.</td>
<td>Book reviews, opinion pieces, literature reviews.</td>
</tr>
<tr>
<td>Quality appraisal</td>
<td></td>
</tr>
<tr>
<td>Studies that meet pre-determined quality appraisal.</td>
<td>Studies that are not quality appraised or fail to meet the criteria</td>
</tr>
</tbody>
</table>
The following databases were searched: AHMED, Embase, Medline, Ovid MyJournals, PsychINFO, PubMed, SSCI. Key qualitative journals such as Qualitative Health Research, Qualitative Research in Psychology were searched. Grey material from Young Minds, The Royal College of Psychiatrists (Child and Adolescent Faculty), The Division of Child Psychology (British Psychological Society) were either hand or electronically searched. A Google scholar search was also undertaken and further citations examined. Figure 1 below highlights the sifting process.

Search terms were subdivided into four categories in order to identify the widest sample of studies: (1) The study design term (for example, qualitative, interviews, focus groups, IPA, Grounded Theory, Thematic Analysis, Content Analysis); (2) terms related to experience such as views, service user, perspectives, thoughts, opinions; (3) terms based upon perspective such as children, young people, service user; (4) terms relating to mental health (for example, child and adolescent mental health, mental, psychiatric, psychological illness, condition, disorder, CAMHS). This search strategy afforded a broad approach to find all potential studies and is recommended and routinely adopted at the Evidence for Policy and Practice Information Centre (EPPI-Centre, 2008) when undertaking systematic reviews of studies in preference to merely searching for individual terms.
Quality Control

The quality of the studies was assessed using guidance from the Critical Appraisal Skills Programme (CASP, 2006; Appendix 2). The CASP tool assesses three areas of quality; rigour; credibility and relevance using ten prompt questions. Following this appraisal a further scrutiny of the studies was undertaken using a checklist devised by Walsh and Downe (2005), widely accepted as a gold standard approach for qualitative research. Walsh and Downe’s criteria assesses the appropriateness and coherence of the study, the scope and purpose, design, sampling
strategy, analysis, interpretation, researcher reflexivity, ethical
dimensions, relevance and transferability. Studies were scored on a
scale from A-D (Appendix 4). Scoring of the studies were then
scrutinised by the peer-debriefing group to achieve consensus and
validity. Studies scoring D were discussed with the group for
consideration of exclusion though remained included in the study if the
results were considered useful in addressing the research aims.

Results

Characteristics and quality of the included studies

Fifteen studies were included in the synthesis. Table 2 outlines the
studies. The studies were undertaken in a variety of countries such as
the UK, New Zealand, USA and Ireland and were predominantly from
nursing and psychology viewpoints with one study being written from a
Social Worker’s perspective.

A summary of the quality of studies can be found in Appendix 3
measured against CASP and Walsh and Downe’s (2008) standards. The
studies ranged in quality. Four studies were judged to be of the highest
quality. Six studies had very few flaws. Three studies with significant
flaws were discussed with the ‘peer-debriefing’ group and included in
the study due to the importance of the themes highlighted. The flaws
included where the number of participants were not outlined in the
study (although due to the nature of the recruitment site and the
methodology undertaken it was presumed to be small). In addition, significant flaws were highlighted in the analysis of data in some studies because no specific methodology was mentioned. Some studies failed to mention ethical approval although this may reflect the age of the studies.

The studies reported the experiences of at least 379 children and young people from the age of 4 up to 20 with an average (mean) number of participants of 27 children in each of the study. A number of parents were interviewed in some of the studies though the findings of these were discarded since they were irrelevant to the review.

The studies adopted a variety of qualitative approaches. Ten studies adopted a basic Content or Thematic Analysis. One study adopted a Grounded Theory approach whilst two others utilised Interpretive Phenomenological Analysis. Two studies did not outline a specific methodology though by the nature of the reported finding they appeared to use Thematic Analysis.

The studies were largely unclear reporting specific demographics and specifically not ascribing an age to participants who were merely reported as ‘children’. Six studies reported the genders of the participants and only three studies gave an indication of the ethnicity of the participants.
All children's level of participation in the studies did not exceed level 2 according to Alderson and Montgommery's (1996) model of participation. In the studies outlined children were asked for their views on services though there was evidence that their voices were used to inform further service policy or delivery.
<table>
<thead>
<tr>
<th>STUDY NO.</th>
<th>Author / Year</th>
<th>Data Source and publication</th>
<th>Setting</th>
<th>Sample</th>
<th>Design</th>
<th>Analysis</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Farnfield &amp; Kadzup (1998)</td>
<td>Universal child services.</td>
<td>Self selecting cohort of young people who have received mental health services</td>
<td>35 young people aged 7 to 20 years</td>
<td>semi-structured interview</td>
<td>Thematic analysis</td>
<td>General skills; Counselling skills; Ethical stance; Making things happen.</td>
</tr>
<tr>
<td>2</td>
<td>Strickland-Clarke, Campbell &amp; Dallos (2000)</td>
<td>Children and adolescents views of family therapy.</td>
<td>Outpatients at a Family Therapy service.</td>
<td>5 Children aged 11-17.</td>
<td>Semi structured interviews.</td>
<td>Grounded Theory.</td>
<td>Therapy is a challenge; Stigma; Consent; Need to be heard; Enjoyed talking.</td>
</tr>
<tr>
<td>3</td>
<td>Buston (2002)</td>
<td>Adolescent's views of inpatient services.</td>
<td>Inpatient therapy</td>
<td>32 young people aged 14-20 (21 male 11 female)</td>
<td>Semi structured interviews.</td>
<td>Content analysis</td>
<td>Wanted more of a say; Lack of advice on mental health issues; Need for empathy</td>
</tr>
<tr>
<td>STUDY NO.</td>
<td>Author / Year</td>
<td>Data Source and publication</td>
<td>Setting</td>
<td>Sample</td>
<td>Design</td>
<td>Analysis</td>
<td>Themes</td>
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<td>5</td>
<td>Curtis, Liabo, Roberts &amp; Barker (2004)</td>
<td>Young people's views of their local health service.</td>
<td>Various community and clinical settings.</td>
<td>149 children (77 male; 72 female) 60% white; 40% BME</td>
<td>Semi structured interviews, play therapy and web based questionnaire.</td>
<td>Thematic analysis.</td>
<td>Enjoyed talking and being listened to; Physical environment; Stigma; Staff should be friendly and approachable.</td>
</tr>
<tr>
<td>6</td>
<td>Hepper, Weaver &amp; Rose (2005)</td>
<td>Children's understanding of psychiatric inpatient admission. Clinical Child Psychology and Psychiatry.</td>
<td>Inpatients in a London child and adolescent psychiatric hospital.</td>
<td>23 children aged 8-12 years of age. 7 males; 15 females. 14 white; 9 black.</td>
<td>Longitudinal qualitative study of semi structured interviews on discharge.</td>
<td>Interpretive Phenomenological Analysis</td>
<td>desire for a greater say in care; Stigma accessing services; Prefer activity based; Dislike confusing language; Controlling impression.</td>
</tr>
<tr>
<td>STUDY NO.</td>
<td>Author / Year</td>
<td>Data Source and publication</td>
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<td>7</td>
<td>Aubrey and Dahl (2006)</td>
<td>The views of vulnerable children on their service providers and the relevance of services they receive.</td>
<td>Children with a key working Social Worker.</td>
<td>36 children for focus groups.</td>
<td>3 x Focus groups in 3 schools with high and low attainers.</td>
<td>Thematic analysis</td>
<td>Young children enjoyed activity based techniques; Children enjoyed access to I.T. facilities; Children enjoyed being listened to; Few studies examine children’s views.</td>
</tr>
<tr>
<td>STUDY NO.</td>
<td>Author / Year</td>
<td>Data Source and publication</td>
<td>Setting</td>
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<td>8</td>
<td>Day, Carey &amp; Surgenor (2006)</td>
<td>Children's key concerns. Piloting a qualitative approach in understanding their experience of mental health care. Clinical Child Psychology and Psychiatry.</td>
<td>Outpatients in a London child and adolescent mental health service.</td>
<td>11 children (5 male; 6 female)</td>
<td>3 x Semi Structured Focus Groups. 1 x Participant Validation group. 11 Individual interviews.</td>
<td>Thematic analysis.</td>
<td>Children unaware of referral / appointments / purpose; discussions around confidentiality facilitate wider discussions; interruptions to appointments are disruptive; therapists are initially strangers - stranger danger; enjoyed being understood; Personal questions can cause discomfort; pace questions to stage of relationship; Prefer activity based activities; Sometimes prefer important adults in sessions; Talking is helpful.</td>
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<td>STUDY NO.</td>
<td>Author / Year</td>
<td>Data Source and publication</td>
<td>Setting</td>
<td>Sample</td>
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<td>10</td>
<td>Le Francois (2007)</td>
<td>Tier 4 CAMHS in U.K.</td>
<td>Inpatient tier 4 CAMHS</td>
<td>Unstated</td>
<td>Semi structured interviews</td>
<td>not-stated presumed thematic analysis</td>
<td>Consent access to information; Choice and decision making; Participation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Child and Adolescent Mental Health</td>
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<td>11</td>
<td>Gordon and Russo (2009)</td>
<td>Children's views matter too! A pilot project assessing children’s and adolescents experiences of clinical psychology.</td>
<td>Outpatients in a Clinical Psychology service.</td>
<td>15 children (7 males; 8 females.)</td>
<td>Semi structured interviews.</td>
<td>Content analysis</td>
<td>Enjoyed talking; stages of therapy relate to likelihood of disclosure; Didn’t know about referral or attending; Preferred activities / play; Ask for consent to talk; Stages of therapy themes; physical environment; Stigma.</td>
</tr>
<tr>
<td>STUDY NO.</td>
<td>Author / Year</td>
<td>Data Source and publication</td>
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<td>STUDY NO.</td>
<td>Author / Year</td>
<td>Data Source and publication</td>
<td>Setting</td>
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Synthesis of findings

After reviewing and synthesising the main themes, the following model outlined in Figure 1 was developed to conceptualise the main themes emerging from children and young people’s views of mental health services.

Figure 2: A conceptual synthesis of the main themes
Due to the lack of rigour in most of the studies the current study was unable to provide a synthesis of findings according to demographic variables such as gender, ethnicity, age of children or diagnosis. A reciprocal translation of the overall themes emergent from all children was therefore produced. Where subtle nuances did occur in the data according to variables of certain demographics these would be discussed where relevant.

The synthesis highlighted seven major themes that characterised the views and opinions of children and young people of mental health services that they had experienced. These were:

1. Stigma and negative judgment of others about mental illness.
2. Alliance making themes within therapists.
3. Alliance breaking themes within therapists that disrupt therapy.
4. The physical location and environment of services.
5. Consent and confidentiality issues.
6. Preferences for modes of therapy such as creative or play based modalities.
7. Recognition of therapeutic subtleties and the stages of therapy being crucial to the therapeutic work undertaken.
Table 3 lists the studies that reported or discussed the relevant themes. A number of studies reported similar themes and there was significant overlapping of themes. The peer-debriefing group checked emergent themes. The agreement of themes occurred despite there being a wide variation in the standard and rigour of the papers presented for the meta-synthesis. Where a theme was absent in a study, this was due to the theme being not emergent (illustrated by ‘-‘ in Table 3) rather than a contradiction of themes (illustrated by ‘No’ in Table 3).
Table 3: Summary of themes across the 15 studies

<table>
<thead>
<tr>
<th>Themes from the studies</th>
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<td>Preferences for modes of therapy</td>
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Theme One: Stigma and negative judgment of mental illness

A number of studies highlighted that young people were concerned with both a personal stigma of attending mental health appointments and how others would view them (Teggart & Linden, 2006). Kurtz and Street (2006; 49) comment that:

‘Perhaps one of the most prominent themes of the study focus groups and individual interviews was the fear of the stigma surrounding mental health’ (Kurtz & Street 2006; 49)

This theme was similar to adult studies (Wang, 2012; Powell, 2006; Gilburt, Rose & Slade, 2008) and was linked in some research to aspects of the physical environment that could reinforce or challenge the stigma of mental health (Goodwin, Holmes, Newness & Waltho, 1999). The plethora of poorly designed posters regarding mental health reinforced this opinion. Gordon and Russo (2009; 43) highlight one young person who queried ‘am I going mad?’ on attending a mental health appointment.

Concern regarding being thought of or going ‘mental’ was common throughout the studies. Mitchell-Lowe and Eggleston (2009; 288) further highlight the dilemma facing children in whether to tell their friends:
It was a bit like should I tell my friends or should I keep it a secret.

Young people felt far more comfortable with the idea of physical health rather than mental health when disclosing their issues to their friends:

I usually make up excuses... check on my ears and stuff, ‘cos I used to have grommets [sic].

Similar to adult studies, themes of stigma were amplified when children were involved in inpatient care (Gilburt, Rose & Slade, 2008). Hepper, Weaver and Rose (2005; 569) highlight a conversation between interviewer and child:

**FH:** Do your friends know that you’re here?

Child C: A couple do. I only told two friends. And they’re the only people who know – I can trust them. They know I’ve had trouble in the past.

**FH:** What did you tell them?

Child C: Um I just said, ‘you know me, that I’ve got little worries. And this place is going to help me and make the worries easier’.

**FH:** What did they say about it?
Child C: Well I thought that they were both very understanding. They are very supportive and that. They said ‘well I hope it all works out and it gets easier’.

The study also revealed children physically located in inpatient units perceived themselves to be seen as deviant using pejorative descriptions: ‘weird’, ‘mental’ ‘a spastic’, ‘having something wrong with you’ and ‘needing help’ as a descriptions of their difficulties. This reinforced negative feelings of stigma.

In addition to stigma a number of the studies highlighted the anxiety that children faced when attending appointments that affected the initial therapeutic encounter (Hepper, Weaver & Rose, 2005; Day, Carey & Surgenor, 2006). A child commented that:

I just sat there very stiff, because I was a bit nervous.

(Hepper, Weaver & Rose, 2005; 263)

Familiarity, growing confidence, the use of the same room, knowing other friends were attending CAMHS, and staff talking about themselves alleviated many of the children’s fears on attending the appointments.
Theme 2 Alliance making

The therapeutic relationship was seen as important to children as being critical to participation and sharing. Younger children could not discriminate different therapeutic approaches from the individuals providing care. This further made the therapeutic relationship crucial. For younger children the therapeutic relationship was encompassed with adults being ‘nice’ or ‘friendly’ with them. A child explains:

> When we got there, they were really nice and stuff... I expected them to be friendly, so it wasn’t a big surprise for me that they were like that.
> 
> Mitchell-Lowe & Eggleston (2009; 288)

The studies highlighted that children largely welcomed the opportunity to talk about problems with staff and enjoyed the experience (Aubrey & Dahl, 2006). Day, Carey and Surgenor (2006) demonstrated that children found talking through their problems helpful and enjoyed the experience of an adult to talk to them. This was reminiscent of adult studies (Hopkins & Niemiec, 2007). One child commented in their study (2006; 150) that:

> It helps to get everything out and not keep it on the inside.
Theme 3 Alliance breaking

Several studies referenced issues of language and comprehension for children. Clarity of language and communication is also highlighted as important in adult studies (Hopkins & Niemiec, 2007). Those children in the inpatient studies (Bierling & Jensen, 2011; Le Francois, 2007) commented that they often felt talked down to by the clinicians and struggled to understand what was being told to them. This alongside adult studies (Wang, 2012) reinforced notions of stigmatisation. One child cited in Curtis et al.’s study (2004; 154) commented that:

They come out with such long words man…they talk to my parents and even they don’t understand.

Gordon and Russo (2009; 43) highlighted one child that commented:

It was good to speak to a person who saw me as a whole person rather than just a medical condition.

Interestingly, some children found therapeutic terminology used by clinicians confusing with misunderstanding regarding terms such as ‘goals’ and ‘solution focussed’. Hepper et al. (2005; 567) discuss children’s confusion about terms such as working towards goals. They comment:
There was general bewilderment about how ‘work on goals’ related to their problems.

Children and young people struggled to access the language of mental health and therefore partook in sessions for perceived rewards rather than developing skills to manage their problems.

A key aspect for young people to engage in services was that they needed to feel believed and perceived that their issues were being examined. Colm (Buston, 2002; 234) explained that:

They (psychiatrists and nurses) don’t dig deep into the problems, what’s really the matter with you. They don’t do that at all. They never ever talked to me properly…I don’t think they’ve ever asked me anything like this before, like you’re listening to me today, the doctors or anything. That’s terrible isn’t it? I just felt that they didn’t really try and understand it.

The word understanding was crucial to making or breaking the therapeutic alliance. Sian, an adolescent who received psychological treatment echoed others in studies that felt that empathy and understanding were very important to her:
Well I went to the doctors first and she just says ‘I think it’s just attention seeking’, cause of the wee noises, right. And she says ‘so we’ll nip it in the bud’, to my mum. Mum says ‘right’ …I was thinking ‘that’s strange’ (Buston, 2002; 235)

Many young people experiencing severe and enduring mental health difficulties were upset at the lack of opportunities to talk through their problems. Instead, young people commented that all too readily drugs were considered to be the first choice of treatment:

They just give you medicine all the time when you’re not feeling good… They try to talk to you but if you cannæ [sic] talk there is nothing else they can do, they just give you medicine…. It would be better to let it all instead of getting thingey [sic] on medicine, but they don’t try and make you talk enough. (Buston, 2002; 236)

As mirrored in adult studies (Gilburt, Rose & Slade, 2008), several young people commented that when placed on medication this was not explained to them adequately. Clare (Buston, 2002; 236) a young adolescent with a history of self-harm commented that:

When you start the drug they only give you a small dose so it’s like the capsules in the blister pack they only give you one
section thing so you don’t have the leaflet in it. The leaflets in the boxes are brilliant if you get one with it...there have been several times I haven’t had a clue like things like if they’ve got side effects...Like some of them you have not to take a lot of exercise or you’ve got to limit things like alcohol and things like that. Not that I’m a drinker but just things like that, you’d like to know. I mean like is a glass of wine with my dinner going to kill me or something.

Other young people were concerned regarding a lack of diagnosis for their health problems. Carol explains:

The thing that really annoys me is that no one seems to be able to put a label on my illness. No one has ever said to me ‘you have this’ or ‘you have that’ and it’s really annoying...if someone says ‘what’s wrong with you?’ I’d be happier to turn round and say ‘I have such and such’. I feel as if I can’t get on with my life not knowing from one year to the next how I’m going to be. (Buston, 2002; 237)

Diagnosis was linked to a lack of practical advice about dealing with their mental health difficulties. Carol further explained the need for professionals to give practical advice:
Nobody ever told me how to deal with it. I just deal with it anyway because I’ve had it for such a long time and my family are used to it that we deal with it. Nobody says ‘if this occurs again do such and such’. (Buston, 2002; 237)

**Theme 4 Physical location of service**

Children in a number of studies commented on how important physical context was to aiding work and therapy (Buston, 2002; Tyler, Turner & Mills, 2006; Flatman, 2002). Children in Curtis et al.’s (2004) study disliked waiting and requested a separate children’s area from adult patients. Mitchell-Lowe and Eggleston (2009) mentioned that children liked age appropriate magazines. One child in their study (2009; 289) commented:

I wish they had, like toys that kids could play with as well.

They should have proper magazines like TV hits and stuff…maybe a couple of magazines, ‘cos there were magazines there, but they were for older people.

Understandably, the physical environment was crucial to how children as inpatients saw care and supported the therapeutic relationship. Hepper et al., (2005; 569) highlight one child:

**FH: What are the things here that make it fun?**
Child Q: Pool, Play Station, the playground, the activity room.
Staff are nice as well.

FH: On a scale of 0 to 10, how important is it to have those things here?

Child Q: Ten.

FH: Crucial?

Child Q: Yeah 'cos if they didn't have them, they might get all depressed and leave with problems they didn't come with and stuff.

Linked perhaps to themes of stigma and shame, a number of young people stated that school was not an appropriate choice of venue for mental health services and confiding in teachers was not considered to be an appropriate source of support. One female participant stated that:

You've got to spend the rest of the year with them and you might think that they might think about you, that you’re like nothing [sic] (Roose & John, 2003; 547).

Interestingly though young people did not like the idea of speaking to someone using confidential phone lines. A participant explains:
It’s even worse over the phone because you haven’t got a clue what the person looks like (Roose & John, 2003; 547).

Furthermore:

I also think it should be out of school because if there are problems out of the school, you might think the thing is just for in school not out of school and you don’t know where to go. Also you would not want everyone in school to know where they are going and the others might believe it was to be done with them and be upset. (Roose & John, 2003; 547)

**Theme 5 Consent and Confidentiality**

Consent was a theme common to many studies (Cairns & Brennan, 2005; Strickland-Clark, Campbell & Dallos, 2000; Buston, 2002). This was perhaps linked to therapeutic subtleties and narratives of children being unwilling or uncomfortable in early sessions to disclose personal information. Day, Carer and Surgenor (2006; 146) highlight that children were concerned that that they did not know about appointments to mental health services. A participant in this study explained:
If they sent...a letter or something or phoned...(I) would have been more aware and like, think, could think of the questions they would ask...and then think of the answers.

Moreover this reflected a further concern raised by children that they were not asked if they would like to attend appointments and did not refer themselves for help. This was particularly the case with young children. A child in Gordon and Russo’s (2009; 43) study explained that:

The psychologist asked me if I wanted to attend but my family did not ask me.

Children valued being asked whether they wanted to attend appointments. There were examples in the research of children finding out about CAMHS appointments on the way to clinics or at the clinics themselves. This reflected a wider concern regarding children’s desire for greater participation in the process of receiving health that will be explained later.

Confidentiality

Confidentiality was a major area of concern for children. Day, Carer and Surgenor (2006) explain how discussions around the limits of confidentiality can have the effect of facilitating discussions regarding the child’s difficulties. Whilst children preferred to talk about their
problems (Tyler, Turner & Mills, 2006) confidentiality was clearly important (Buston, 2002) and children welcomed the opportunity to talk separately from parents. This presented as a dilemma with studies utilizing a family therapy approach (Strickland-Clark, Campbell & Dallos, 2000) where children were encouraged to discuss problems in from of their family. In this light, therapy was seen as a challenge and children worried about the reaction of their parents though the process of therapy gave them an increased confidence in saying what they felt and being heard.

Issues of consent and confidentiality still pervade children’s negative experiences of mental health services. This concurs with Ross (2003) who found that most children attending appointments at a mental health service had little understanding of why they were there, what might happen when they were there and how it may help. Recent studies (Tyler, Turner & Mills, 2006) have continued to show this trend.

**Theme 6 Modes of therapy**

A number of studies (Ross, 2003; Windows, Richards & Vostanis, 2004; Flatman, 2002; Tyler, Turner & Mills, 2006) comment that for many children activities other than talking were preferable. Children highlighted the importance of play, toys, drawing, pool and play-station (Strickland-Clark, Campbell & Dallos, 2000). Younger children
valued creative mediums to express themselves Gordon and Russo (2009; 44) highlighted one participant as saying

I like the stuff I do, I get to play, and I get to write.

In addition, therapeutic sessions dominated by talking were perceived as ‘dry and uninteresting’ (Ross, 2003).

Creative sessions were perceived by children as being more conducive to express their feelings, a young child explains:

When it’s fun you could tell them anything ‘cos they’re letting you play with toys and do what you want while they speak to you. (Ross, 2003; 11)

Other children enjoyed the experience of working with puppets or responded very positively to the use of computers during the sessions (Windows, Richards & Vostanis, 2004). Children did caution on the over-use of creative materials that would hinder talking once a therapeutic relationship had been established. The use of activities was highlighted by children in inpatient care as crucial to stave off boredom (Worrall-Davies & Marino-Francis, 2008). This theme differeded significantly from adult service users views who readily welcomed opportunities to talk thorough their difficulites (Wang, 2012).
Theme 7 Therapeutic subtlety / process

Some of the research highlights that children were aware of different stages in the therapeutic process. Children described a first appointment as being anxiety provoking with personal questions causing discomfort (Ross, 2003). Therapy was seen initially as a challenge (Strickland-Clark et al., 2000). Gordon and Russo (2009) found that children often lied about issues affecting them until the later stages in therapy when they felt much more likely to disclose emotionally difficult issues. This is perhaps linked with themes of stigma and shame highlighting an initial tendency for children not to disclose fully in the initial sessions. Children commented that they found breaks with key workers as disruptive to helping talk (Window et al., 2004) and different personalities affected the ability to talk (Ahuja & Williams, 2010) as were interruption to the sessions by for example, siblings (Day et al., 2006) or even a change in room (Mitchell-Lowe & Eggleston, 2009). Instead, children recognised that questions should be differentiated to the stage of the relationship. A child commented that:

After the first couple of sessions, it was OK. I lied about my problem, but after that I felt like blurring it out. (Mitchell-Lowe & Eggleston, 2009; 289)
Discussion

The study revealed that despite a decade of both national and international legislation promoting the voice of the child and health professional guidance there is still a dearth of qualitative studies interviewing young children to ascertain their views of the services they receive.

Despite evidence that children as young as three can participate in research and can give valuable information (Aubrey & Dahl, 2006), and, children themselves requesting more of a say in their health services (Hepper, et al., 2005) the voices of children are largely absent. Younger children and those from vulnerable groups in particular are excluded from research. This study revealed only four papers that included children under the age of 11 and only grey literature that addressed the specific views of black and minority ethnic children under the age of 11.

Such is the scarcity of research in this area that Worrall-Davies & Marino-Francis (2008; 14) comment that ‘it is difficult to make clear recommendations for best practice from the limited evidence available.’
Links to adult studies

The metasynthesis revealed that many of the themes that emerged from children’s studies were to be found in the adult literature. Stigma and shame were particularly present in both areas. This perhaps highlights the contemporary relevance of Goffman’s (1963) theories of how stigma and shame and the negative perception of others can begin to detrimentally affect an understanding of self. Issues of consent were also prevalent though in adult studies though this was reflected in notions of coercion. Narratives of self-reflection / making sense of mental health were largely absent in child studies but prevalent in adult studies. This could be as a result of children’s emergent developmental abilities to self-reflect as opposed to those skills being more developed in adults.

Age considerations

Curtis et al. (2004; 15) comment that if flexible age appropriate techniques are employed then “young people, even those ages 4 or 5 years old are able to comment on their experiences of service provision.” Coyne (2006) suggests that this should not mean that all children receiving services should be pressurised into comment upon the services that they receive. Rather, it is an acknowledgement that children want to be listened to and can play a significant role in their health. Furthermore it is an acknowledgment of children’s rights to be listened to and to be informed (Coyne, 2006). Far from giving children
sole responsibility in the decision making process (Flatman, 2002) this is rather a participatory and inclusive approach to providing health care services. Coyne (2006: 12) further states “Children want to be heard and consulted and evidence indicates that the promotion of children’s autonomy leads to the enhancement of wellness and resilience in children positively influences healthcare outcomes.

Levels of Participation

No study moved significantly above level 2 of Alderson and Montgomery’s participation ladder. In this regard, the research concurred with Curtis et al. (2004) in highlighting that very few studies outlined how eliciting the voices of children has led to changes in service delivery or development, and in this light service responses to children’s views lags behind and the pace of change is slow. Worrall Davies and Marino-Francis (2008) have queried whether this is a phenomenon unique to mental health service since other sectors of services to children such as health and social services have clear evidence of service improvements given the increased views of children and young people (Tyler, Turner & Mills, 2006; Cairns & Brennan, 2005). Carr (2004; 10) states that ‘evidence from the few evaluation that exist suggest that the participation of children and young people is having little impact on decisions made in relation to agency policy and practice.’
Methodological Limitations

The studies used in this review demonstrated a number of methodological flaws. Several studies did not specifically highlight a methodological approach to data analysis. Most data were analysed using thematic analysis, which, is the least rigorous of the qualitative methods and arguably the most open to criticism. (Robson, 2010)

Some published studies on the perspective of children included only two participants (Ahuja & Williams, 2010) whilst others chose to concentrate the majority of research on families and children despite evidence that in this context children’s views can be lost. Therefore it is possible that the data in some studies did not reach saturation point enough to adequately address all potential issues that may have arisen. Most studies addressed the views of children around adolescence and not before (Day, Carey & Surgenor, 2006). These limitations make issues of generalizability of findings problematic.

Sampling of the research participants was in general poor and lacked scientific rigour. Most employed a convenience sample acquired on the basis of ease of access. Studies also included ‘in house’ reviews rather than external researchers being employed leading to potentially biased research.
Little regard was paid to ensuring participants were from diverse backgrounds and there is little evidence of whether samples were representative of their own mental health care service in all but one study. There was no evidence in any of the studies for data reaching a ‘representativeness of concepts’ (Robson, 2010) that is, the extent to which the concepts raised adequately represent all those available in the field of study.

**Future research and clinical implications**

This study highlights the need for more research with children and young people to build up a bank of resources and knowledge in this area.

Young children have been found to be able to participate in research yet are virtually excluded from all studies. Future research could specifically address the needs of children below the age of adolescence. Studies could address a larger number of participants in this area.

The research suggested that clinicians should be aware that for the immediate sessions children may mask or even lie about issues that affect them and that it may take several sessions for them to build confidence in them. This may present as a systemic problem for services that insist on short assessment protocols.
Clinicians should be keenly aware of the language they use and ensure that children and young people understand their terminology.

The current paper also makes clear aspects of inter and intrapersonal characteristics that endear children and young people to clinicians and aspects that disrupt or prevent a positive therapeutic alliance.

Research with children could utilise methods that children themselves have commented that they would enjoy. In particular, there is a gap in material using new and novel technologies such as computer-based interviews like ‘In My Shoes’ (Calam, Cox, Glasgow, Jimmieson, Groth Larsen, 2000) as a way to elicit the voice of the child in trying to gain their views.

Further studies could triangulate themes arising from parents and children and should address the methodological constraints of the studies such as sampling and recruitment. Future research would be enriched by purposive or more rigorous approaches to the sampling of younger aged children since this group is underrepresented in the available literature.
Conclusion

This study was undertaken after a decade that has witnessed a growing trend and appreciation of consulting with children and young people about their views as recipients of care and services. The right to consultation and participation is now enshrined with national and international legislation, recommended as best practice and is mandated by health care professional bodies. Whilst the review highlighted some evidence that children are being consulted there is certainly more work to be undertaken in this area particularly in mental health. Furthermore, an increasing emphasis needs to be placed on the outcomes stemming from this research and how children’s views can change health care practice or services. Service users’ perspectives must begin to move beyond merely asking patients for their thoughts and must include a more meaningful understanding of participation to incorporate the development of services, policies and protocols. Unless this is given sufficient attention there is a danger that the process of consultation becomes a ‘lip service’ and the children and young people themselves become disillusioned from the participatory activity.

One of the surprising aspects of the research is that for the past twenty years when asked about services children have been saying similar things in relation to the physical environment and the attributes that make a good therapist and those that do not. In this regard the themes
emerging from this research are unsurprising. It must be time to now ask the question in an age of user participation and unprecedented funding of child and adolescent services of who is listening and truly taking notice of children for themes to be re-emergent. In light of the paucity of research the author considers whether there exists a cultural hegemony that prevents services truly being reflexive to the views of children and young people.
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A parenting journey: Parent's experiences of the ‘Triple P’ Positive Parenting program

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Abstract

Being a parent can at times be stressful as some parents struggle with the daily demands of parenting. Parenting programmes are at the heart of strategies to intervene and support families through challenging times. This study sought to understand and explore how parents made sense of themselves as parents and their experiences of parenting after undertaking Triple P parent training. Purposive sampling was employed to recruit a homogenous sample of parents. Semi-structured interviews were conducted with 8 parents who had recently completed Triple P. Interpretative Phenomenological Analysis was employed to analyse the data. Five main themes emerged: a search for a causal explanation of the difficulties; the stigma of struggling with parenting; the destruction of family life; the recreation of family life and a shift in perspective to a child centred viewpoint. Parents’ narratives were influenced by perceived cultural norms in parenting that lead to feelings of shame for not living up to them. The study reaffirmed the detrimental effects that shame and stigma has upon individuals and highlighted the effects of family coercion cycles.

Key Words

Parents; mental health; parenting programme; service user's perspectives; qualitative methods; Triple P.
Becoming a parent is one of the most rewarding yet challenging activities in life (Rhee, 2008). Parenting is pivotal in promoting social, emotion and psychological adjustment in children (Cochrane, 2012). The quality of parenting has been demonstrated to be crucial for long-term developmental and psychological outcomes in children and adults (Wilson & Prior, 2011). The effects of poor parenting practices (such as low warmth, harsh punishment and low monitoring for children) have been associated with negative outcomes and an array of psychological disturbances and disorders (Lynch, Turkheimer, D’Onofrio, Mendle, Emery, Slutske, 2006; Prior, Sanson, Smart, & Oberklaid, 2000). Poor parenting has been blamed for a wide variety of social problems including the 2011 riots (New National Priority, 2011). Such is the importance of parenting on children’s lives that it has been described as ‘playing for high stakes’ (Bowlby, 1988; 15) and can place a great deal of stress and pressure upon parents who may struggle with daily demands of parenting (Rizzo, Schiffin & Liss, 2012). In recent years there has been a greater awareness of the many struggles parents face when raising their children, particularly coping with externalizing child behaviors (National Institute for Health and Clinical Research, NICE, 2006; Achenbach & Rescorla, 2000). Considered from an ecological systemic theory (Bronfenbrenner, 1979) the Transactional Stress and Coping model (Thompson, Gustafson, Hamlett, & Spock, 1992) suggests that the pressures of parenting can affect all aspects of family life and in turn wider stressors, such as the stability of the
environment or socio-economic demographics can affect the quality of parenting and outcomes for children as families try and adjust to stressors (Adam, 2004).

Parenting programmes are at the heart of strategies to intervene with and support families and parents struggling with the demands of parenting their child. Parent training has been demonstrated to be the most effective intervention for reducing childhood conduct problems and reducing parental stress both in clinical and in community settings (Hutchings & Lane, 2005; Ogden & Hagen, 2008). Such has been the effectiveness of parent training that they are now considered to be the first line treatment of choice by the UK National Health Service (NICE, 2006) and internationally (World Health Organisation, 2009). Parent training has even shown improved outcomes for parental depression, self esteem and school management (Foster, Olchowski & Webster Stratton, 2007).

The Triple P - Positive Parenting Program is a multi level, preventively orientated parent and family support programme (Sanders, 2008). With a wealth of evidence demonstrating its efficacy and effectiveness Triple P is widely regarded as an exemplar amongst evidence based parenting programmes (Thomas & Zimmer-Gembeck, 2007). Level 4 Triple P is a 10-session programme incorporating examining the causes of children’s behaviour problems, strategies for encouraging children’s
development and strategies for managing misbehaviour. This is achieved through teaching, reflecting and discussing active skills such as: promoting clarity and consistency in boundaries and ground rules; goal setting and reward charts; use of praise; establishing planned special time; problem solving and strategies to remain calm.

Despite intense research and policy interest in parenting programmes, Kane, Wood & Barlow (2007; 785) highlight that there is 'still a sense that we do not know what it is that makes parenting programmes meaningful and helpful to parents.' Additionally, studies of parent training have failed to articulate the process of change within the family (Moran, 2004) and even the current Cochrane review (2012) states that the process and effects on families of parenting programmes is still unclear. Whilst parenting programmes have been demonstrated to be effective there remains important parental views and factors that remain barriers to treatment (Thornton & Calam, 2011). By understanding the views of parents regarding parenting interventions, outcomes could be further improved (Reyno & McGrath, 2006). Ronzoni and Dogra (2012) highlighted strong evidence demonstrating that including parent’s views on services can dramatically improve attendance rates.

Taking account of the views of parents as recipients of services should be appreciated from the perspective of service user accountability.
that has become a guiding principle for the UK National Health Service (Day, 2008). The most recent government mandate for health is ‘No decision about me, without me’ (Department of Health (DoH), 2010). Patients now have the right to be involved directly in the planning of health care services, proposals for changes in the way those services are provided, and in clinical decision making (DoH, 2010). Whilst patients’ participation has been contextualised as a human rights issue (Coulter, 2006), evidence also demonstrates improved service delivery and clinical outcomes when patients’ views are taken into account (Coad et al., 2008).

Despite a wealth of quantitative studies and several meta-analysis demonstrating the efficacy and effectiveness of Triple P (de Graaf, Speetjens, Smit, de Wolf & Tavecchio, 2008a, 2008b; Nowak and Heinrichs, 2008; Thomas & Zimmer-Gembeck, 2007) relatively little qualitative research regarding parenting programmes has been undertaken (Kane, Wood & Barlow, 2007) and no studies have explored issues in Triple P parent training. This is despite an emerging recognition in the past decade that evidence based practice should not be restricted to quantitative studies (Dixon-Wood & Fitzpatrick, 2001).

A metasynthesis of qualitative research undertaken in 2007 (Kane, Wood & Barlow, 2007) revealed that only four papers had examined
the views of parents of parent training. All of the papers concerned the ‘Incredible Years’ parent training programme (Webster-Stratton, 2000) and highlighted that the main issues for parents were around control, guilt, wider social problems and knowledge and skills training brought by the intervention.

Furlong and McGilloway’s study (2011) examined the process of change and contextual factors with parents in Ireland who had undertaken the Incredible Years parenting programme. Three main themes emerged from their data. Parents recognized the positive changes that the parenting programme brought and this was attributed to the acquisition of useful parenting practices such as focusing on the positive aspects of their child, developing empathy and staying calm. Parents also commented on the personal and social challenges of being a parent and mentioned issues such as struggling with wider social and personal relationships, conflict with partners and dislike of praising children. Parents identified aspects of the programme that they disliked such as a feeling of personal intrusion and dislike of group work. Whilst the study highlighted the important cultural, personal and environmental challenges of parenting, it primarily focused upon skills based outcome processes rather than a deeper psychological understanding of the narratives occurring during parent training. The study only touched very briefly upon crucial topics such as
parental reflection of their own childhood reported to be pivotal in parenting change (Levac, McCay, Merka & Reddon-D’Arcy, 2008).

Stewart-Brown, Patterson, Mockford, Barlow, Klimes and Pyper (2004) adopted a mixed method approach to measuring 12 months outcomes of a Webster-Stratton group. Using a thematic analysis of 38 interviews the authors report that parents recalled experiencing profound difficulties such as depression, isolation, frustration and stress before parent training. Parents felt that before parent training their lives were out of control. After parent training, parents felt more able to cope, were more confident, supported and skilled at dealing with their child’s behavior. Although the paper raises some important issues it is more concerned with the reporting of normative statistical data highlighting the efficacy of parent training. The result is a lost opportunity to explore significant narratives in how parents understand themselves through this process of change.

Spitzer, Webster-Stratton & Hollingsworth’s (1991) ambitious study was a Grounded Theory analysis of 77 mothers and 60 fathers regarding living with the stresses of children with conduct problems throughout parent training. Parent’s spoke of feelings of despair, anger and of losing control and feeling helpless in light of their child’s behavior. Parent training empowered parents with a sense of control and competency that enabled them to be more respectful of their child. As the study
utilised large study numbers for a qualitative study, it failed to elucidate the subtleties that can emerge from much smaller but much more in depth analysis.

Kilgour and Fleming’s (2000) thematic analysis of 11 mothers using a Critical Social Science Analysis revealed parents’ powerlessness, and, attempts to understand the cause of their child’s problems including self-blame and locating the problem within children for behavioural difficulties. The study also highlighted parents’ use of aggression and violence to micromanage their child’s life, but, lacked depth in analysis in fully exploring interpretations and meanings parents gave to understanding themselves through parent training.

Barlow and Stewart-Brown’s (2001) grounded theory analysis of 11 parents describe a pilot study to evaluate the effectiveness of a school-based parenting programme. The three areas in which parents appeared to benefit from included: support from other parents; regaining of a sense of control in their lives through through an increase in their capacity to think about matters calmly; and an increased ability to empathize and identify with their children. The authors suggested that empathy in particular is central to effective parenting.

Whilst the aforementioned studies provide a valuable insight into the lives of parents after parent training and contribute to the body of
research, no study addresses specific issues from the perspective of parents who have undergone a Triple P programme. Since Triple P is a significant public health intervention this represents a significant gap in research. Additionally some studies (Nowak & Heinrichs, 2008; Thomas & Zimmer-Gembeck, 2007) address outcome processes of parent training and are limited in their appreciation of psychological aspects of change throughout the process. Although studies have highlighted the importance of parental self-reflection as critical to the success of parenting they have neglected the richness of data that can be extracted from fewer participants using a more detailed analysis. This presents as a gap in the research that this study aims to address.

The aim of this research was to explore parent’s perspectives of themselves and the changes that Triple P brought to family life in order that new insights and understanding of the effect of parent training on the family might be developed.

**Method**

*Theoretical framework*

The study sought to understand and explore how parents made sense of themselves as parents and their experiences of parenting after Triple P. Interpretative Phenomenological Analysis (IPA Smith, 2008) was employed since the central objective of the study was to understand the meanings participants give to their experience (Smith, 2011) and
how they made sense of the world (Smith & Osborn, 2009). IPA facilitates the extraction of rich subjective data from participants using an idiographic approach (Smith, 2011) but also recognizes a reflexive 'double hermeneutic' (Willig, 2005) wherein the researcher tries to make sense of the data and through reflection and interpretation co-constructs meaning with the participant who themselves are also reflecting and interpreting their experience (Smith, 2011).

Parents’ data were analyzed using procedures outlined by Smith (2009). During the process a reflective diary was employed to aid transparency, trustworthiness and reflection (Forrester, 2010). The reflective diary aided the process of reflexive bracketing (Ahern, 1999) whereby the researcher reflected on their beliefs, thoughts, values and presence to consider the effect of these on any data to become fully open to the phenomenon being studied (Finlay, 2008).

**Participants and recruitment**

Following ethical approval from the University of Manchester (ref. 11044, Appendix 11) trained Triple P Family Support Workers approached families whom they had recently worked with on a level 4 Triple P group programme to invite them to participate in the research. Families were informed that the study focused on their views of Triple P and the effects that it had on themselves, their families and children. An information sheet was given (Appendix 5 & 6). Consent was sought
from parents for the researcher to contact them regarding the study (Appendix 7 & 8) to further explain the study and set up the interviews. Participants were all mothers aged between 25 and 45 years old from working class northern cities in multicultural areas. All but one of the mothers was a single parent. Four parents were from an ethnically Mirpuri Pakistani background whilst the other 4 were of White British ethnicity. Of the 8 mothers, 1 was in full time employment. All mothers except one were single parents. Data were obtained using a semi-structured interview protocol (Appendix 9) devised by the researcher under supervision based on previous qualitative research (Knight, Wykes & Hayward, 2002) that focused on: individuals’ personal experience of parenting; the social understanding of parenting problems and the effects on their life, and a reflection of the impact Triple P had on themselves and family. Interviews were conducted in a relaxed conversational style of open curiosity with minimal direction where the researcher clarified, reflected and summarized in order to further elicit quality data (Connor, Dexter & Walsh, 1984). Interviews lasted approximately 70 minutes and were conducted in the participant’s homes.

Data Analysis

Data analysis was informed by Smith, Jarman & Osborn (1999) and adopted an idiographic approach. The first transcript was read a number of times, the left-hand margin being used to note interesting or
salient issues. From this, emergent themes were listed on a sheet of paper, and connections between them were made. The next stage involved a theoretical ordering to make sense of the connections between emerging themes. Some themes were clustered together, and some emerged as superordinate concepts. As the clustering of themes emerged and transcripts were checked to make sure the connections worked in the actual words of the participant. This was an iterative process and involved a close interaction between reader and text. The researcher drew on his interpretative resources to make sense of what the interviewee was saying whilst concurrently checking his sense making against what was actually said. After this a table of the themes was produced. The clusters were named to represent the superordinate themes. A table of themes was then devised with examples given from the text to substantiate the theme. During this process themes that did not fit well into the emerging structure were dropped. The first analysis then informed the analysis of other transcripts, to help orient the subsequent analysis. New emerging themes were noted. Once each transcript was analysed by the interpretative process, a final table of superordinate themes was constructed. As IPA is an iterative process, as the analysis continued, other transcripts were reviewed in the light of the new superordinate themes, and instances from those earlier transcripts were included in the ongoing analysis until the final theming was achieved.
All data analysis was developed with supervision from an experienced qualitative researcher throughout the process and ‘peer-debriefing’ (Lincoln & Guba, 1985; Janesick, 2004) was utilized for quality control.

**Results**

Five superordinate themes emerged from the parents’ data: parents searched for a cause and explanation of their child’s problems (partly to remove a feeling of responsibility and guilt); parents struggled with the stigma and shame of having parental management difficulties, often feeling powerless and passive; family life was destroyed by the difficulties within the home before a recreation of family life through Triple P; during the process of change parents shifted perspective to being more child centred. Table 4 contains an overview of the superordinate and sub-ordinate themes.
In this results section, participant narratives are interwoven with existing research and theory in order to create a symbiotic dialogue between theory and data (Geertz, 1973). Participants’ quotations are presented as they were including repetitions in order to assist in conveying the life experience of participants (Blauner, 1987).

**Themes**

1. **A Search for a cause and meaning to the problems**

A major theme that emerged from the participants concerned a search for an explanation as to why they were experiencing difficulties
with either their parenting or their child’s behaviour. Subordinate themes concerned issues of who was to blame and locating difficulties within parents themselves or their children. Some parents considered that there was something different or ‘not right’ with their child:

I was at the time going to everyone I could think of seeing, saying “I don’t think that this is normal”.

Parent 1

The above parent’s terminology of normality suggested a feeling that her child was abnormal. Reflecting on this, a feeling of abnormality tended to imply a belief in some that there was something medically wrong with their child. She continued to explain that there is “a problem with the way his brain functions”. Some identified difficulties immediately from birth:

From the moment I had him he was really, I mean really hard work, hard to settle. He would cry all the time. I have always struggled with him since day one.

Parent 5

The question as to whether there was something wrong with their child presented as a profoundly challenging question for parents trying to come to terms with a potential organic difficulty:
I don't know if there is anything else going on or if she is just strong willed.

Parent 4

For some, the suggestion of a medical explanation was cathartic and may be interpreted as an implied shift in responsibility away from being perceived to be to blame. One mother spoke of her relief when medical professionals recognise the difficulty:

I felt glad cos [sic] I thought (god this sounds awful) but if someone else could see what he was like they might be able to help him and realise that there was something not right and in a way it wasn’t all my fault.

Parent 5

Some parents further distanced themselves from blame by highlighting development difficulties as causal:

He didn’t sleep. He was very late walking...he didn’t learn to sit up until he was about 11 months.

Parent 1
When he was younger we described him as a child who had gone into the terrible 2’s at 15 months old and never ever came out of the other side of it.

Parent 6

Again, a reference to normative development hinted at a perception of abnormality. A reference and comparison of ‘normal’ or ‘abnormal’ was implied throughout the narrative with comparison to other more ‘normal’ siblings or in fact how development should be:

And there was nothing I could do at times to comfort him he would just cry and cry and cry. He even fed differently to the other and just would not go to sleep.

Parent 5

When babies are tiny you can comfort them, you can pick them up when they’re hungry or hurt or when they need changing. Our son was completely different. The only way you could comfort him was to lie him down and leave him. He went stiff when you picked him up and he would pull his neck away, even when he was a tiny baby and had no neck control he’d pull his neck away from you. He didn’t make eye contact with you.

Parent 1
Parent 1’s narrative constantly stresses the ‘he’ suggestive of a strong belief of a problem within her child.

A narrative in some interviews linked past problems with current difficulties even though for parent 5 she suggests this may be a spurious connection:

With X though I think it was always hard with him from the very beginning like I said, we just didn’t get on, how stupid does that sound but we are still very different and we tend to clash all of the time and still do.

Parent 5

Searching for a cause of the difficulties is an interesting finding from this study and highlights the richness of data that can emerge from an IPA study that focuses less on outcomes and more of psychological processes. Previous studies have tended to focus on parents blaming themselves (Stewart Brown et al., 2004; Kilgour & Fleming, 2000) as an attribution of difficulties as opposed to deeper ontological questions that arose in the present study.
(2) **Stigma and Shame**

A repeated theme in the data from the parents when commenting on the most difficult aspects of life before Triple P was the stigma of having a child with behavioural difficulties and the perceived negative judgments from others regarding their parenting skills. This is reflected throughout many of the qualitative studies of parenting (Spitzer et al., 1991; Kilgour & Fleming, 2000; Barlow & Stewart-Brown, 2001). In the present study the presence of stigma may suggest why parents distanced themselves from blame in adopting causal explanations strongly focussed within the child. Additionally, the presence of stigma may highlight a wider social and cultural hegemony suggested by previous research (Kilgour & Fleming, 2000) that parents feel they do not live up to and can therefore feel judged by others.

For some parents, picking up children from school became extremely difficult:

> Oh it were [sic] horrible and I hated it. They saw me as crap, sorry, rubbish saw me as really bad. I did have a few parents actually come up and say to me “how could you bring your child in knowing that he is only going to hurt other kids?”

**Parent 7**
Whilst reflecting on the feelings of the perception of being judged as a danger to her child a parent tearfully commented:

We were viewed as child abusers we were accused that we had done this to our son that that we weren't fit parents that we were a dysfunctional family that needed taking apart

Parent 1.

All of the parents highlighted that as a result of having difficulties raising their children this had a detrimental effect on their view of themselves:

Erm we knew we were struggling, felt like a failure to both of my children... I could not look at myself in a mirror, could not look at myself in a mirror.

Parent 1

A particularly salient repetition in the narrative of not being able to look at her self magnifies the imagery of psychological distress felt by feeling a failure. Feelings of failure and fault were common in parents’ voices:

I was getting a bit deflated thinking that everything was my fault and I was doing something wrong.

Parent 2
Some parents spoke of the distress and loneliness that parenting problems brought, feeling a sense of isolation from everyone. Many parents lost the support structures of friends and family. Using metaphors of doing something wrong (above) could perhaps be interpreted as an attempt to construe sympathy by adopting a role of passive victim (which will be discussed later) to expiate blame or again may highlight the parent’s perception of herself as failing to meet cultural norms. Parent 1 conveyed strong feelings of distress, tragedy and loss in losing friends and family repetitively stressing how few friends she now had:

We have no contact with our families now because it was too difficult for them to deal with X. We have very very few friends very few.

Parent 1

Shame and stigma was also demonstrably present in the parents' interviews in that which remained unsaid. An allied study to this paper explored children’s perception of life through Triple P. Children across ages and genders made reference to being smacked prior to Triple P. Parents made no reference to this. Parental aggression and violence has been previously highlighted as common before parent training (Fulong & McGilloway, 2011). The absence of parents narratives of smacking may indicate layers of continually constructed narrative
centred on parents distancing themselves from blame (as earlier narratives suggest), as a coping mechanism and defending against feelings of being perceived to be a poor parent by the researcher. It may also be interpreted as highlighting the socially constructed aspect of the narrative used to shift blame from parents to children with some parents adopting roles of innocent victims.

(3) The battle and loss of family life

Many parents spoke of the effects that their children’s behaviour had and the struggle to parent on the family over a longer period of time. Life at home was described as ‘chaotic’, ‘crazy’ and ‘terrible’ using metaphors of battles and fights. Parent 2 emphasised just how much like a war family life had become and how defeated she felt in being ‘overpowered’ by her child, conveying a strong sense of defeat on being asked to describe life before Triple P:

Anger, erm violence, aggression, controlling, dominant, just overpowering [sic].

Parent 2

Emerging from the vivid descriptions, a narrative emerged around a scramble for dominance and control. Narratives from this superordinate theme were reminiscent of Patterson’s coercion theory (Patterson, 1992) that highlights how parents are increasingly dis-
empowered as a result of a process of escalation. This eventually leads to parents' 'giving in' to child demands that further increase the likelihood of needing more coercive strategies on the next occasion. The process in which problems escalate and parents feel increasingly disempowered may explain in part why parents experience stress and depression directly related to the parenting role. Themes of dominance and a loss of control are also to be found in other literature about life before parenting programmes (Spitzer et al., 1991; Kilgour & Fleming, 2000).

Parent 5 described how life had become symbolised as a battle for survival and in doing so emphasised her passivity and loss of control, which on reflection, could be interpreted as an attempt to adopt a passive victim role:

> It was like a living hell where you just wanted to survive and get through every day.

Parent 5

Some parents’ spoke of a game plan or an attempt to micromanage life at home to regain control, but many felt beaten and overcome. Parent 3 conveys this idea by referencing her perceived role as parent and an attempt to wrestle back authority:
I think they forgot at times that I was the parent and it was just like at times trying to bring that back in again.

Parent 3

With parent’s complaining of non-stop difficulties at home and the toll this took on their families, life was described as ‘horrific’ for several mothers. Some commented they would have welcomed social services or anybody to come and take their children away. This further reinforced the interpretation of passivity by highlighting a desire for a rescuer:

Really well like I say it got to the point when I really didn’t want him. I was just I basically felt I wanted someone to take him away from me. I got to the point where I just could not cope. I wanted anybody to take him away, it sounds awful but I just wanted anybody to take him away. If somebody had have come along and taken him I would have been so grateful.

Parent 6

Many parents described how the day-to-day stresses of life at home made them ill. Difficulties with eating, lethargy, depression, sleep problems, low self esteem and phobias were common. These themes extend previous research (Spitzer et al., 1991; Stewart-Brown et al.,
2004) that mention parental frustration, despair and stress as a theme of family life before parent training. This study further reaffirms themes predominant in research on shame and stigma and how isolation, depression and poor coping can develop from this (Crossley, 2000; Gilbert, 2000).

Parent 1 conveyed this message through reference to trauma interestingly objectifying the difficulties as ‘it’ perhaps emphasising her powerlessness:

It took our lives and threw them away as if they were nothing.
I’m not the person I was. I’ve got health issues relating to the trauma of what happened and what we went through in our parenting life.

Parent 1

Some parents talked of a ‘tipping point’ in their physical and mental health and one parent described a breakdown as a result of life at home:

I felt so stressed not just once or twice but it was like non-stop, all the time stress. Cos [sic] It affected everything, I couldn’t sleep it felt like I couldn’t think you know it made me feel sick like I’d get this knot feeling in my stomach. I got ill though with
all the stress of it and I was stressing out at the kids and they were stressing out at me all of the time. I couldn’t get a break and eventually something just snapped and I became ill. I still haven’t recovered.

Parent 5

All of the problems wrought by these pressures lead to the dissolution of family life with everyone leading separate lives:

We didn’t spend much time together as a family. Everyone was doing their own thing.

Parent 3

Parent 5 uses a simile of penal life to highlight just how much family life had dissolved:

I felt like it was becoming like a prison in my house.

Parent 5

(4) The recreation of family life

The battle and destruction of family life was strongly contrasted with life after Triple P. Themes of change highlighting a narrative of ‘before and after’ parent training are common in all of the previous qualitative
studies (Furlong & McGilloway, 2011; Stewart-Brown et al., 2004; Kilogour & Fleming, 2000; Spitzer et al., 1991). Parents spoke of new routines, increased communication, participation in joint activities and feeling more confident and empowered as a result of Triple P.

Parent 1 spoke strongly about the gratitude she felt for the programme.

I always say that even though you label it as a parent training course it is so much more so much more...it’s a life course and erm [sic] anything that I can ever do I would shout it from the roof tops if I could but I think it should be available. It should be available to everybody.

Parent 1

Family life was salvaged from earlier metaphors of ‘chaos’ and ‘battles’ both at an individual level for parents and children and also a resurrection of family systems and structures such as spending time together, discipline and praise and being positive.

Some parents highlighted improved positive quality time:

There’s a lot more one on one time now ...just the two of us go shopping and stuff like that or visiting places or whatever.

Parent 3
The language parents used to describe their lives after Triple P suggested a greater degree of confidence about themselves. Parent 7 explained how Triple P improved her health:

**Int.**  What were the main messages you took from TP?

**Parent 7**  Be more positive. It’s like being more positive in myself what I say and how I come across to people... positive attitude in myself and towards other people that’s one of the main things that I learned.

**Int.**  Do you think that Triple P changed you?

**Parent 7**  Yeh [sic] it did changed me cos [sic] I was depressed’.

Parents considered aspects of Triple P that had most had an effect on their lives. For parent 1 it was simple but profound “We can communicate now”, whilst others highlighted how this communication had become removed from the language of battles:

The praising, the praising and acknowledge when they are doing something well and letting them know.

Parent 2

Parent 7 concluded with real joy at the reconstruction of family life, “we are a family once more”.

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This study together with previous research (Stewart-Brown et al., 2004; Barlow & Stewart-Brown, 2001) highlights the symbiosis of new parenting strategies with increased confidence, self-esteem and improvements with life at home.

(5) **Perspective change: through a child’s eye**

Parents’ experience of Triple P caused a shift in perspective and viewpoint to a more child focussed perspective. This narrative had been briefly mentioned in one previous study (Barlow & Stewart Brown, 2001) as a sub-theme, but was not fully developed.

Prior to undertaking Triple P parents commented that some of their frustrations centred around their child’s failure to appreciate how difficult life was for them as individuals and a feeling that children should appreciate the effort and work that parenting takes. Implicit was that some parents believed that intuitively their children should be able to appreciate things from a maternal perspective:

> I was nagging them all the time over really basic things that I thought I shouldn’t have to tell them

Parent 5

A parent explained that the aim of Triple P before the parenting intervention was:
Trying to make them understand and get through to them really.

Parent 3

Parents clearly struggled with attempting to get their children to appreciate life from their perspective. This belief contrasted with parents’ narratives after Triple P:

I think I was just expecting them to change and I realised that it was me that had to change, that I had to change too you know for us all to change for us to work... It helped me to see things from my kid's perspective and their point of view.

Parent 3

Parent 3’s narrative hinted at a deeper perception of the nature and cause of the problems being parental because she highlighted a required personal change. This theme is subtle and differs from the prevailing interpretation of parents distancing themselves from blame.

Shifts in perspective from parent to child enabled parents to appreciate life from their child’s view and accept their child for who and what they are “and I accept now that X is just X” (Parent 4) in contrast to narratives of blame.
Discussion

Overall, five superordinate themes containing 24 sub-ordinate themes were developed that provided a detailed and vivid description of the lived experiences of eight parents through Triple P parent training. All parents commented on the difficulties of life before Triple P and how real physical and psychological changes had occurred as a result of Triple P.

Parenting programmes are of considerable interest to researchers and practitioners (Furlong & McGolloway, 2011) since they represent one of the most effective ways of intervening in the lives of families to promote positive change and outcomes. This is the first study of its kind adopting IPA to investigate the psychological processes that underlie Triple P parent training. As such the study sheds important light on what occurs for parents during the processes of change in parent training that have been suggested are crucial to the successes of parent training (Kane et al., 2007).

The study adds further evidence in support of Triple P as a positive intervention in the lives of families and parents as a clear narrative emerged from the data contrasting a negative picture of life before Triple P with a positive one after the intervention. Similar to other studies (e.g. Patterson et al., 2005) this study highlights the correlation of new parenting techniques with increased confidence, self esteem and the
removal of shame and guilt, factors likely to improve and sustain outcomes (Hutchins, Lane & Kelly, 2004). As such the study highlights key psychological changes in parents, children and family life brought about by the Triple P intervention.

The study builds upon previous studies on parenting highlighting themes of changes in life before and after parent training but a key strength of the study derives from the richness of data derived from IPA and novel themes such as a search for a cause or meaning to children’s behavioural difficulties have emerged. Additionally, the study built upon emergent narratives such as the psychological effects of life at home before parent training that have previously been raised in research (Spitzer et al., 1991) though little attention has been paid to them. This may additionally add to literature on the challenges of parenting during parent training in disadvantaged communities which research has clearly demonstrated is more complex due to social and economic disadvantage (e.g. Gardiner, Hutchings, Bywater & Whitaker, 2010; Reyno & McGrath, 2006).

The study highlights the effects of cultural norms on parenting practice as seen through issues of shame and stigma raised in recent research with parents feeling pressures from society to conform to norms of being a better parent (Furlong & McGilloway, 2011). This research is novel in that a further study undertaken with some of the children of
the parents of this study (Paper 3) highlighted a discrepancy between parents and children’s narratives on the subject of being smacked. Parents did not talk about smacking their child despite their children commenting on this subject. This suggests that the shame and stigma from culturally accepted practices might in turn affect the information given to the researcher.

The research further reaffirms themes predominant in research on shame and stigma and how isolation, depression and poor coping can develop from feelings of shame (Crossley, 2000; Gilbert, 2000) particularly when wider support systems become weakened as a result of behavioural management difficulties.

The contemporary relevance of Patterson’s (1992) ‘Coercion Theory’ provides a useful theoretical framework to understand how parents became increasingly disempowered through the escalation of conflict. Parents described losing battles at home and 'giving in to' child demands that are increasingly likely to need more coercive strategies on the next occasion. This, in turn lead to feelings of disempowerment for parents and increased stress and negative feelings. Additionally the wider symbiotic relationship of parental mood, parenting and stress can be seen as additional evidence of Thompson’s (et al., 1992) ecological models of family life whereby one aspect of family life can affect all others either positively or negatively. Critically, Triple P
reversed coercive cycles by giving parents behavioural techniques that improved confidence and relationships with their children that punctuated negative cycles of interactions.

Limitations

There were a number of limitations affecting the reliability and validity of the study. Fathers were not represented amongst the participants. This is a common theme in parenting research (Fletcher, Freeman and Maltheys, 2011). Fathers were approached to participate in the study but chose not to, further research could explicitly focus on both the views of fathers and perhaps their views of partaking in parenting research.

An epistemological limitation concerned the role of language in facilitating data generation. Willig (2005) highlights how language used during interviews can be used to construct meanings. The language used by the researcher may have lead to constructed meanings that may have deviated from the understandings of the participants (Watson & Parke, 2009). The researcher believed that by utilising a reflective diary and supervision from an experienced researcher that these concerns were appropriately addressed.
**Implications for Clinical Practice**

The study demonstrates the efficacy of Triple P parent training as an approach of intervening with families in distress and should be seen as part of a wide body of research to further support access to such programmes by parents. Parent’s perceived Triple P to have real demonstrable positive effects on the quality and standard of their lives.

A key subordinate theme in the narrative was the extent to which parents before parent training struggle with physical and psychological illness as a result of the effects of family life. Parents spoke about feeling hopeless, depressed and stressed to the extent that some wanted to leave their families. This narrative suggests that clinicians should be keenly aware of the extent of the distress in families and may need to undertake standard risk assessments on their initial contact with families. This could lead to further family support in order to increase the propensity of successful outcomes. Clinicians could also signpost parents to additional support services on referral. Research has indicated that one area that hard to reach families can obtain help is through web based support sites and the Internet (e.g. Fletcher, Vimpani, Russell & Keatinge, 2008; Hudson, Campbell-Grossman, Fleck, Elek & Shipman, 2003).

By comparing child (in paper 3) and parents’ narratives a clear difference emerged regarding smacking of children. This adds further
support to recommended best practice from child protection and statutory guidelines (e.g. Department for Children, Schools and Families, 2009) on talking and working with children separately of their parents in order to understand issues within the home environment.
References


Patterson, J., Mockford, C., Stewart-Brown, S (2005) Parents' perceptions of the value of the Webster-Stratton Parenting Programme:


Children's views of the ‘Triple P’ Positive Parenting Program

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Bios

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Abstract

Behavioural difficulties in children are increasingly prevalent. Parent training programmes such as Triple P have emerged as a first-line treatment of choice to support families and children with behavioural difficulties. Research indicates that parents’ and children’s views are largely ignored when assessing the impact of interventions. Parents and children can have different views of the same experience. This study explored the views of children about Triple P parent training. Purposive sampling was employed to recruit a homogenous sample of participants. Semi-structured interviews were conducted with 11 children. ‘In My Shoes’, a computer based assessment tool assisted interviews with children. Data were analysed using Thematic Analysis. Children’s themes were: a search for a causal explanation; difficult life contexts, changes in life through Triple P. When consulted, children could provide a valuable insight into the experience of a mental health intervention. Children young as five years old (with appropriate methods) can provide valuable insights into changes in family life. Young children tended to internalise blame in families, whilst older children externalise difficulties. ‘In My Shoes’ was a useful tool for eliciting good quality information from children.

Key Words

Children and young people; Triple P; parenting programmes; service users perspective; views; mental health; qualitative methods.
**Behaviour problems and parenting programmes**

Disorders in conduct are ‘the most common psychiatric disorder.’ (Lavigne, 2007; 449) and the most common referral to child mental health services (Rutter & Taylor, 2008). The Department for Education and Skills (2003) estimates that up to 15% of all 5 year old children may be described as having oppositional and defiant behaviours. Research also indicates that behavioural difficulties in young people are increasing (Campbell, Spiekel, Burchinal & Poe, 2006) and that an increasing number of children are experiencing difficulties with regulating behaviour from an earlier age (Cochrane, 2012; Webster-Stratton, 1991). Whilst behavioural difficulties in childhood may for some be transient and limited to a developmental period (Ogden & Hagen, 2008), for some children early signs of aggression and behavioural difficulties are indicative of maladaptation and significant health issues. Studies have highlighted that amongst children classified as ‘anti-social’ in pre school years, 50-60% are still classified as such in adolescence (Kazdin, Siegel & Bass, 1992; Trembley, Masse, Pagani & Vitaro, 1996).

For children diagnosed with behaviour and conduct disorders, the prognosis is poor (Burke, Loeber, Lahey & Rathouz, 2005). Indeed, ‘If early starters do not receive behavioural interventions, they face bleaker developmental trajectories.’ (Foster, Olchowski & Webster...
Stratton, 2007; 1416). Hinshaw and Lee (2003) outline increased school dropout rates, out of home placements, substance misuse, criminal involvement and psychiatric disturbance as emblematic of the developmental trajectory of untreated behavioural conduct disorders. Young people with conduct disorders are three times more likely to develop anxiety disorders including panic disorder, generalised anxiety and social phobia (Nock, Kazdin, Hiripi, & Kessler, 2006), and, later occupational, marital and social integration has been shown to be difficult for this cohort (Fergusson, Horwood and Ridder, 2005). The costs for individuals and society are then high (Mihalopolous, Sanders, Turner, Murphy-Brennan & Carter, 2007).

Parent training has been demonstrated to be the most effective intervention for reducing childhood behavioural problems (National Institute for Health and Clinical Excellence, NICE, 2010). Such has been the effectiveness of parent training programmes that they are now considered to be the first line treatment of choice by the National Health Service (NICE, 2006) and internationally (World Health Organisation, 2009).

The Triple P - Positive Parenting Program is a multi level, preventively orientated parent and family support programme (Sanders, 2008). With a wealth of evidence demonstrating its efficacy and effectiveness Triple P is widely regarded as an exemplary evidenced based
parenting programme (Thomas & Zimmer-Gembeck, 2007). Level 4 Triple P is a 10-session programme incorporating examining the causes of children’s behaviour problems, strategies for encouraging children’s development and strategies for managing misbehaviour. This is achieved through teaching, reflecting and discussing active skills such as: promoting clarity and consistency in boundaries and ground rules; goal setting and reward charts; use of praise; establishing planned special time; problem solving and strategies to remain calm.

*Children – Increasing participation*

Research suggests that families using mental health services want an increasing say about interventions that affect them (Fulford & Williams, 2003). Involving mental health patients in their care has been neglected for children and families (Worrall-Davies, 2008) despite recommended practice (DoH, 2010; DoH, 2003b). Some researchers have even questioned the use and validity of involving children in the decision making process (Becker, Bryman, & Sempik, 2006). Despite Wolpert, Maguire & Rowlands’ (2001; 15) assertion that ‘the minimum standard for good practice is that children, as service users, be given the opportunity to express their views on the services they receive,’ the views and opinions of children in ‘co-production’ aspects of health care have remained neglected (Davies & Wright, 2008). Children’s voices are largely absent from service evaluations (Cavet & Sloper, 2004) and limited to parents only (Roose & John, 2003) despite
evidence suggesting that parents and children’s views differ widely (Daley, 2005; Garland, Lewczyk-Boxmeyer, Gabayan & Hawley, 2004).

Children as co-participants in research have historically been marginalized. Perceived as lacking capability and competence until recently, their views and opinion were not taken into account (Hill, Laybourn, & Borland, 1996; Carter, 2009). The past decade however has witnessed an increasing appreciation and recognition of the need to include children in research in part due to the growing acknowledgement of children as having human rights worthy of recognition and respect (Graham & Fitzgerald, 2010). Gaining children’s views is now central in aspects of policies and services that address their needs (Graham & Fitzgerald, 2010). When consulted, children have a good deal to say about services (Gersch, Holgate & Sigston, 1993) and can provide valuable insights into aspects of their care experience (Daley, 2005). Children as young as five and those with profound disabilities have given valuable feedback regarding health care services (Garland, Lewczyk-Boxmeyer, Gabayan & Hawley, 2004). Children have been shown to be largely unhappy regarding the ways they have been treated by health services and feel there is a lack of communication regarding decisions about their care in mental health (Sinclair, 2004). Further, including children in research and decision-making avoids misrecognition of their needs and the negative
effect this has on their children’s sense of identity and self esteem (Graham & Fitzgerald, 2010).

Giving children a voice can give them a sense of ownership conveying respect (Obigwe, 2004) and can help service providers better understand the patient experience (Carr, McDonnell & Owen, 1994). Research has also indicated that where children are consulted this can improve self-esteem, confidence and personal responsibility in children (Halsey, 2006). Graham and Fitzgerald conclude that including children leads them ‘to discover and negotiate the essence of who they are and their place in the world’ (Graham & Fitzgerald, 2010; 137). Including the views of children has also lead to increased attendance rates (Ronzoni & Dogra 2011).

Madge & Willmott’s (2007) review of parent training evaluations highlighted the absence of children’s and young people’s views in all studies. They found very little evidence that children had been involved at any level in the development, administration and evaluation of parent training programmes. They conclude that involving children in research should be an important research priority. Instead, qualitative evaluations have centered upon parents’ perspectives. A metasynthesis of qualitative research was undertaken in 2007 (Kane, Wood & Barlow, 2007) and revealed only four papers had examined the views of parents of parent training. All of the papers concerned The
Incredible Years (Webster-Stratton, 1991) parent training and revealed that the main issues for parents were around control, guilt, wider social problems and knowledge and skills training brought by the intervention.

The current study was the first to explore Triple P from a child’s perspective using qualitative methods to gain a rich picture of how children understand the changes taking place at home through Triple P. Previous parenting research has primarily been quantitative (i.e. Thomas & Zimmer-Gembeck, 2007), using standardized measures to make causal links between variables. These studies have demonstrated that Triple P has reduced childhood behavioural difficulties, stress and adjustment problems. To date, no study has provided a detailed picture of the experiences and meanings that children have of parent training in addition to normative measures.

**Aims of the research**

The aim of this research was to explore children’s perspectives of themselves and the changes that Triple P brought to family life in order that new insights and understanding of the effect of parent training on the family might be developed.
Methods

Design

The study adopted a qualitative design to examine the lived experience of children (Smith, 2007). The paper sought to explore complex social processes and sensitive themes in depth to provide valuable insights that may have been overlooked by quantitative methods (Willig, 2005). Additionally, qualitative research is useful in exploring under researched and neglected areas in order to discover novel themes and narratives (Denzin & Lincoln, 2005).

Participants and recruitment

Following ethical approval from the University of Manchester (ref. 11044 Appendix 11) trained Triple P Family Support Workers approached families whom they had recently trained to invite them to participate in the research. Families were informed that the study focused on their views of Triple P and the effects that it had on themselves, their families and children. An information sheet was given to parents and children (Appendix 5 & 6). Consent was sought from parents for their children to be interviewed and further assent was sought from children. Parents were asked to explain the study to the children and seek their assent prior to the interview. Children were a given a choice as to where they wanted to participate by both parents and the researcher.

At the beginning of the interview each child was asked if they
understood the research and this was further explained. Children were
given the opportunity to ask any questions and verbal and assent was
checked before commencing the interview. Children were informed
that they could withdraw from the interview at any stage and if they
felt uncomfortable they could choose not to answer some questions.
Parents were not present during the interviews and reassurance was
given about confidentiality. Confidentiality was explained to the
children in an age and developmentally appropriate manner in order
that they understood that what they said remained confidential unless
they disclosed issues of immediate concern and harm. Permission was
gained to use the audiotape recorder. Children were informed that
only the researcher and the supervisor would hear the tapes and that
during the write up of the interviews they, their families or
neighbourhoods would not be identified. Ice breaking activities such as
introductions and name stickers were used to address power
imbalances. Reflection, care and consideration were given during the
introduction not to give information that might bias or influence the
view of children (Hill, Laybourn, & Borland, 1996).

Participants were aged between 5 and 16 years old from working class
northern cities in multicultural areas. Eleven children agreed to
participate in the study. Nine children were from single parent families.
Three children were female and 8 were male. Five children were of
Mirpuri Pakistani ethnicity, 2 children were dual heritage White British
and Mirpuri Pakistani and 4 children were of White British ethnic heritage. Table 5 (below) outlines some brief demographic information regarding the participants.

Table 5: Brief demographic information about the participants.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Sex</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child 1</td>
<td>15</td>
<td>Female</td>
<td>White British</td>
</tr>
<tr>
<td>Child 2</td>
<td>16</td>
<td>Male</td>
<td>White British</td>
</tr>
<tr>
<td>Child 3</td>
<td>5</td>
<td>Female</td>
<td>White British</td>
</tr>
<tr>
<td>Child 4</td>
<td>8</td>
<td>Male</td>
<td>White British</td>
</tr>
<tr>
<td>Child 5</td>
<td>5</td>
<td>Female</td>
<td>Mirpuri Pakistani</td>
</tr>
<tr>
<td>Child 6</td>
<td>7</td>
<td>Male</td>
<td>Mirpuri Pakistani</td>
</tr>
<tr>
<td>Child 7</td>
<td>8</td>
<td>Male</td>
<td>Mirpuri Pakistani</td>
</tr>
<tr>
<td>Child 8</td>
<td>9</td>
<td>Male</td>
<td>Mirpuri Pakistani</td>
</tr>
<tr>
<td>Child 9</td>
<td>9</td>
<td>Male</td>
<td>Dual heritage White British and Mirpuri Pakistani</td>
</tr>
<tr>
<td>Child 10</td>
<td>10</td>
<td>Male</td>
<td>Dual heritage White British and Mirpuri Pakistani</td>
</tr>
<tr>
<td>Child 11</td>
<td>9</td>
<td>Male</td>
<td>Dual heritage White British and Mirpuri Pakistani</td>
</tr>
</tbody>
</table>

The number of participants was influenced by previous published research using thematic analysis with children (Fielden, Silence & Little, 2011; Lawlor, Mihaylov, Welsh, Jarvis, and Colver, 2006).

Measures

Data were obtained using a semi-structured interview protocol (Appendix 10) devised by the researcher based on previous qualitative research (Knight, Wykes & Hayward, 2002) that focused on children’s views of life at home, their views of parents and the activities they enjoy. In addition, the interview was conducted using ‘In My Shoes’ (Calam, Cox, Glasgow, Jimmieson, and Groth Larsen, 2000) a
computer-assisted interview that helps professionals communicate with children about their life, views and experiences. The interviewer sits alongside the child and assists, guides and interacts with them through a structured interview process. ‘In My Shoes’ was chosen as a research tool since it is an evidence based tool shown to be effective in eliciting children’s views of issues and has a sound research base (Wardman, 2008; Glasgow & Crossley, 2004).

Interviews lasted approximately 45 minutes. The length of the interviews was kept relatively short in order to account for children’s limited attention span (Miller, 2000), and, by using ‘In My Shoes’ with a semi-structured interview, the study took account of research suggesting that more than one single technique is more conducive to producing good quality research data form children (Darbyshire, MacDougal, & Schiller, 2005). The researcher also adopted a style of ‘interested idiot’ (Darbyshire, MacDougal, & Schiller, 2005), a style shown to be useful in engaging with children when an adult feigns ignorance in order for children to guide them in understanding the life of the child. Skills of attentiveness as to what children were saying, clarifying and summarizing in line with good practice (Smythe, 2009). Three interviews (participants 1-3) were undertaken in the childrens’ houses whilst all other interviews were conducted in a family room at school.
Data Analysis

Thematic analysis was used to interpret data in order to report the experiences, meanings and the reality of participants (Braun & Clarke, 2006). Through highlighting significant themes in narratives thematic analysis allowed the researcher to glimpse aspects of life for children by exploring experiences and meanings. Thematic analysis is a widely used form of data analysis with children (Willig, 2005) since it can be utilized on variable data set quality and size that children can often produce and is very flexible (Bernard, 2010; Ryan & Bernard, 2000; Braun & Clarke, 2006). It can also be used with a smaller number of child participants (Fielden et al., 2011; Lawlor et al., 2005).

The author adopted the methodological position of acknowledging the need to incorporate the individual experiences of the children, the meanings they gave to them and a consideration of the wider social context. Braun and Clarke (2006) describe this as 'contextualist' lying between realist and constructionist paradigms. Willig (2005; 15) highlights that this allows us to acknowledge that ‘while experience is always the product of interpretation and, therefore, constructed ... it is nevertheless ‘real’ to the person who is having the experience’.

Data were analysed using Braun & Clarke’s (2006) template for thematic analysis. Taking an inductive approach, the author familiarized himself with the data by transcribing, reading and re
reading data noting down ideas. Initial codes were then generated in a systematic fashion across the data set and data was collated relevant to each code. Codes were then collated into potential themes and all data relevant to each theme were gathered. Themes were checked in relation to codes and extracts from the texts were used to highlight codes. A thematic map was then generated. Further analysis was undertaken and a name for each theme was developed. The final analysis was then undertaken with vignettes of vivid, compelling examples of text to be used in the write up. All data analysis was developed with supervision from an experienced qualitative researcher throughout the process and ‘peer-debriefing’ (Lincoln & Guba, 1985; Janesick, 2004) was utilized for quality control. Throughout the research the author utilised a reflective journal (Boden, Kenway, & Epstein, 2005) to note down thoughts, ideas and concepts that arose during the researching process.

**Results**

Three themes emerged from the children’s data: children searched for a cause and meaning to difficulties at home; narratives explicitly described differences before and after Triple P with changes highlighted in many aspects of life such as parents mental illness, activities, and perspectives; finally children talked about wider contextual difficulties placing stress on their family.
In this results section, participant narratives are interwoven with existing research and theory in order to create a symbiotic dialogue between theory and data (Geertz, 1973). Participants’ quotations are presented as they were including repetitions in order to assist in the life experience of participants (Blauner, 1987).

(1) Causal factors for home difficulties

Children themselves had much to comment on understanding the causes of difficulties in their families. There was a clear divide by age with children in the study who were 10 or less tending to internalise difficulties in the family and blame themselves. This may reflect wider developmental issues or could reflect research on the changes that occur in adolescence between teenagers and their parents. A young child explained:

   My mum sometimes tells me off. She tells me off cos [sic] I do things that are wrong

   Child 3 (age 5)

Another commented:

   I used to have a big anger in me [sic] and I was going astray

   Child 10 (age 10)
Older children in the study reflected that parents themselves could be to blame for difficulties at home. Child 1 normalised difficult behaviours as being part of being a teenager:

She used to complain all day that I was being a pain all the time over not cleaning my room, schoolwork, being cheeky, well every kid is aren’t they?

Child 1 (age 15)

Many of the children and parents commented that difficulties in the families resulted from sibling rivalries. Many of the children had siblings and they identified these often-turbulent relationships as the cause of many problems:

There were lots of arguments between us two. We used to have fights about silly little things all the time.

Child 6 (age 7)

(2) Change

Children described life before Triple P as stressful, miserable and sad. Children felt that they got into trouble and were told off regularly at home. In this light children perceived poor parenting practices such as low warmth, harsh punishment and low monitoring and these have been associated in literature with child and adolescent behaviour
problems (Lynch et al, 2006; Prior, Sanson, Smart, & Oberklaid, 2000).

Child 4 (age 8) explained:

She used to stress at me all the time...she went mad at me and my brother and used to shout at us all of the time.

Child 2 described a typical approach of adolescent response to the stress of the house by walking out which further exacerbating problems of control:

I used to like always get out of the house ‘cos I didn’t like it cos it was so stressful [sic].

Child 2 (age 16)

Some younger children dreamed of being with another adult carer highlighting in the narrative similar themes of wanting a break:

Sometimes it was really bad at our house and I wanted to go and live at my grans ‘cos [sic] my mum was doing my head in all of the time and she would just stress me out.

Child 4 (age 8)

This was in stark contrast to life after Triple P:
Well if you could see me more you would know that I am
laughing more now these days

Child 9 (age 9)

Child 7 described his relief and suggests a previous period of injustice
by a description of life before Triple P as involving ‘the wrong stuff’. This
objectifies difficulties in an attempt to perhaps remove blame from
parents:

It makes me feel happy now because I am happy that all of
that wrong stuff has gone away so things are good now

Child 7 (age 8)

2.2 Parental Illness and change

Children recognised their parent(s) were struggling. Some children
specifically mentioned that their mother was depressed, but several
spoke of their parent being stressed or unhappy. A seven year old
commented:

Int. “And how do you think your mum felt”?  
Child 6 “Sad ....She used to be angry a lot of the time”
Int. “How did you know she was angry”?  
Child 6 “Because she used to fold her arms and look angry
all of the time.”
Whilst children recognised that their mothers were unhappy, they also recognised changes after Triple P. A girl aged five expressed the symbiosis of parent-child mood:

She was sad and I was sad too and I couldn’t watch any of my programmes and I was like “mummy can I watch my TV please” ’cos she always used to sit there and watch her programmes like Loose Women and stuff and sometimes I would be like “mummy I want to watch my stuff” and then it used to be sad but now it has got a lot happier now

Child 3 (age 5)

Wahl’s (2002) review of children’s views of mental illness found that younger children do not show a clear concept of mental illness, but their understanding becomes more sophisticated with age. Yet, children in the present study had some limited knowledge about mental illness and an understanding of how it impacted on them. Considered from an ecological systems theory (Bronfenbrenner, 1979) the effects of maternal depression on all aspects of the family can be seen.

2.3 Change in activities

Most children stated that before Triple P time with their parent and family was very limited and centred on negative discipline. Children
identified spending more time together as a family as a major factor in life post Triple P:

Well we go on trips, day trips and we go out to like x and play golf...we go and play golf together all of the time. We do play on the computer more play and play... We all get to play some board game and we watch TV together. We go to the parks and stuff on Mondays and on Thursdays and Fridays.

Child 8 (age 9)

In addition to spending more time together as a family, some children spoke very fondly regarding special time together with their parent:

“On Wednesdays I get to stay up late with her and it is our special time together when we watch a film.

Child 4 (age 8)

We can have a laugh together and spending much more time together where we can do each other's hair or watch a programme on TV.

Child 1 (age 15)
These narratives strongly indicated a coming together of the family through positive changes brought through Triple P.

2.4 A change in perspective

Children recognised a difference in perspective by their parent and commented that their parents often listened to their perspectives much more:

Now she has done [Triple P] it she can understand more about what is going on like for example, if two sides are getting picked she will go to find out what has happened and go for the most sound reasonable side and argument.

Child 2 (age 16)

2.5 Changes in discipline

Children spoke with consternation regarding systems of discipline before the parenting programme. Interestingly children’s views were much more explicit about smacking before Triple P in contrast to their parent’s narratives (paper 2). Children talked about being smacked by their parents linking themes of stress, pressure and smacking to recognising that their parent was struggling:
She just used to get stressed and didn’t know how to deal with things. She used to get stressed at me and X all the time and used to shout...she used to hit us a lot, but hasn’t done it since parent training, she screamed, shouted, swore she was really struggling.

Child 1 (age 15)

Even a child as young as five recalled discipline before Triple P:

Int. “Can you tell me about a time when you were crying at home?”

Child 5 “When my mummy smack me. She smacked me long time ago when I’ve been naughty and we had lots of arguments.”

Int. “Did she smack you a lot?”

Child 5 “Yes all the time”

Int. “Does she smack you any more?”

Child 5 “No. No she doesn’t smack me any more.”

Many children could not identify reasons for being hit and perceived chastisement resulting from their mothers being stressed and shouting as opposed to any understanding of rules and systems of behavioural management:

It was really bad and sometimes she used to swear at me and my brother...sometimes we didn’t do anything wrong
and she would just go mental swearing and shouting all of the time and proper stressing out non-stop for hours on end.

Child 4 (age 8)

Emerging from the vivid descriptions of chastisement, a narrative emerged around a scramble for dominance and control. Narrative from this theme was reminiscent of Patterson’s Coercion Theory (Patterson, 1992) which highlights how escalations increasingly disempower parents through inconsistent boundaries and 'giving in' to child demands. This further increases the likelihood of needing more coercive strategies on the next occasion that can escalate into smacking. Themes of dominance and a loss of control are also to be found in other literature about life before parenting (Spitzer et al., 1991; Kilgour & Fleming, 2000).

Children recognised that their parents were approaching parenting differently instead of reacting with shouting and screaming. Children recognised that they were being listened to and their perspectives were taken into account. Child 2 felt that his mum “understands me more” and when asked to explain this further a child explained:

Cos [sic] she spends a lot more time with me and she will listen to me like she never used to and like for example, when me and X have a fight she will take us aside and ask us what happened and listen to both sides of the story before doing
something. It means that she listens to me a lot more and that’s why I am happier.

Child 4. (age 8)

Children spoke of a change in parenting approaches highlighting Triple P techniques such as the use of praise, ignoring bad behaviours; reward charts, rota\s, sanctions and some mentioned the Triple P manual. Whilst they could not describe the whole programmes they gave several examples of a new discipline structure in place:

She had the tick boxes and she was giving me ticks. If I got all the ticks then that means I get all my reward.

Child 7 (age 8)

(3) Context

All of the children in the study identified several contextual factors in addition to discipline that detrimentally affected life at home. Child 6 (age 7) spoke tearfully when asked about his father:

Int. Can you describe your dad to me?
Child 6 I don’t know ‘cos I haven\’t seen him in a long time.
Int. How long is it since you have seen him?
Child 6 Well I think it\’s about 4 months or so
Issues children identified were: loss of a father figure since nine children had little or no contact with their father, parental illness, transient step partners and siblings with special needs or disabilities. All these factors placed added stress at home and evidence could be seen of an ecological systemic model (Bronfenbrenner, 1979) such as the Transactional Stress and Coping model (Thompson, Gustafson, Hamlett, & Spock, 1992) in that a number of inter and extraneous factors were placing stresses on families and affecting the whole of family life. Many children were acutely aware of how life at home became increasingly stressful because of the difficult contexts in which they lived. One child tearfully described the pain of these circumstances:

It’s like when my mum and dad argued and they got into a big argument and broke up … and mummy said go away to daddy and it scared me when they just shouted and mummy was just like all crying and I saw her and I came in and I said just said why are you always doing this to daddy and she just said to go away … go away.

Child 3 (age 5)
Discussion

The research corroborates previous work in demonstrating that even very young children can appreciate changes in their family life brought about by a parenting intervention. Children as young as 5 were able to appreciate both ambient changes in family life and some basic behavioural technologies employed in Triple P such as the use of special time, constructive joint activities, star charts and rewards and time outs. Children also clearly described the end of poor parenting practices such as inconsistent boundary setting and smacking. This clearly has major implications for clinical practice in further involving children in research and using qualitative methods to appreciate their views.

Children’s narratives were clearly affected by their chronological and developmental ages consistent with prior research (Wellman, Gelman, Khun & Siegler, 1998). Younger children commented on physical life changes within the home such as spending more time together and the end of being smacked, whilst older children were able to reflect upon perspectives and their role in life and difficulties at home similar to other studies (Wahl, 2002). Younger children tended to internalise difficulties and blame themselves, whereas older children identified parental relationships as the cause of family difficulties. Children demonstrated an emergent understanding of parental mental illness.
It is generally assumed that parental influence becomes less important as children enter adolescence, due to the increasing influence of peers, and due to young people spending less time in the home and therefore being less amenable to change through typical parenting strategies (Kazdin, 2000). However, this study reaffirmed research confirming the strong and enduring influence of parenting practices during late childhood and early adolescence (DeVore & Ginsburg, 2005).

The research built further on existing work demonstrating the effectiveness of using ‘In My Shoes’ (Calam et al., 2000) as a means to quickly develop a positive rapport with children that is conducive to eliciting personal information from them in a safe manner.

The contemporary use of Patterson’s coercion theory (Patterson, 1992) was seen in the data which highlighted how escalations were increasingly dis-empower parents. Themes of dominance and a loss of control were also evident in the themes that have also been found in other research (Spitzer et al., 1991; Kilgour & Fleming 2000).

Limitations of the study

A limitation of the study was sample size. Such small participant numbers may affect the extent to which findings would be
transferable. However, sample size was appropriate for thematic analysis and in line with other studies, and, the study reached data reached saturation. Small sample sizes can give a rich insight (Watson & Parke, 2011) and can highlight further research (Chapman & Smith, 2002). A further study perhaps utilising mixed methods could validate the themes outlined in this study.

The findings from the study could have potentially been open to bias since due to rigorous checks for consent only participants who were very keen to participate in the research chose to do so. The author was aware that several children from marginalised groups with potentially rich data did not participate in the study as they were absent from their homes and could not be contacted for recruitment.

An epistemological limitation concerned the role of language in facilitating data generation. Willig (2005) highlights how language used during interviews can be used to construct meanings. The language used by the researcher may have lead to constructed meanings that may have deviated from the understandings of the participants (Watson & Parke, 2009). This is a particularly pertinent as children may be more impressionable and eager to please the researcher as opposed to provide accurate information.
All of the participants had parents who had in the previous six months undertaken parent training. Questions remain as to the longitudinal effects of parent training and this could be addressed in future research.

Conclusion

Children and families views have been largely ignored when evaluating mental health interventions. Practitioners should seek the views of children and young people regarding interventions as it is their right to be consulted and their views can assist understanding the impact and effect of interventions. In addition, children and parents’ accounts can differ around culturally sensitive issues such as physical punishments.
References


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Paper 4 – Critical Appraisal

Children's, young peoples and parents' views of mental health services and the Triple P Parenting Program

This paper appraises the research process as a whole. It is not intended for publication. The paper reviews the work undertaken in paper 1, 2 and 3, and, provides a consideration of methodologies and a personal reflection of the experience of research. This report was written on the completion of the research and reflects the journey of a novice researcher in learning how to approach and undertake research.

Word count 6453
Qualitative methods – An overview

This current work was concerned with lived experience and the meanings that children, young people and parents have whilst receiving support and guidance from either mental health services or Triple P parent training. A myriad of research exists demonstrating the effectiveness of interventions using quantitative methods. In comparison there is relatively little attention paid to the potential for rich qualitative data that lies behind the plethora of quantitative data to explore the meanings that individuals give trying to understand themselves and their families as recipients of services. For this reason papers one, two and three adopted qualitative approaches and whilst notions of generalizability and significance were abandoned, the researcher hoped that a more detailed insight and understanding was gained into how others make sense of their contact with mental health services.

Paper 1

Summary and interpretations of the findings

The researcher undertook a meta-synthesis to review and synthesise existing qualitative research into the views and opinions of children as recipients of mental health services. The paper also sought to assess
the extent to which children’s views are taken into account measured against a common model of participation. From this synthesis several key themes emerged in the data: the stigma and shame of having mental health difficulties; alliance making and breaking indicators; issues in consent and confidentiality; approaches to therapeutic skills and processes in therapy. The research also revealed that in the studies outlined children’s participation did not move beyond being asked for their views and hence participation did not progress to influencing policy and services.

The researcher was struck that after twenty years of a wide range of advocates promoting consideration of the views of children’s and young people’s and recent government legislation stating ‘No decision about me without me’ children’s views are still largely ignored (Department of Health; DoH, 2010). Additionally, the narratives and themes of children’s views that emerge from the literature have been known for many years, yet they still remain to be addressed effectively. Worrall-Davies (2008) believes that seeking childrens’ views and not acting upon them is unethical, yet the research still suggests that children are being ignored. At a meeting of the National Advisory Council’s Young People’s Reference Group (2011), young people spoke about the pain of not being understood and the question posed by this research should surely be; ‘when people are going to listen and
do something in response to children’s views?’ Only then can services really respond to the needs of children.

**Metasynthesis**

Since paper 1 concerned childrens’ and young people’s views, thoughts and opinions a qualitative approach was adopted since they excel in eliciting and exploring people’s views, opinions and thoughts (Robson, 2005). Meta-synthesis is the process of exploring, analysing and synthesising qualitative research undertaken by different researchers in a related field (Walsh & Downe, 2005). Whilst it remains controversial it has become an increasingly popular methodology adopted by recent research (O’Connell & Downe, 2009). A metasynthesis was considered the most appropriate review technique to meet the aims of the research question since it focuses upon amalgamating qualitative studies regarding childrens’ and young people’s opinions. The aim of meta-synthesis is to develop an explanatory theory or model that explains the findings of a group of similar studies. Whilst it is a relatively new technique, meta-synthesis has been applied to diverse areas of research (Pielstick, 1998; Paterson, Thorne, Canam & Jillings, 2001; Clemmens, 2003) to afford a greater understanding of a subject area than that is available from a single study or to provide a more holistic interpretation of the evidence (Harden, 2008).
It was felt by the researcher that a quantitative approach adopting a systematic review would not provide a rich picture of children’s views and opinions and could have limited the paper to reporting aspects of normative statistics highlighting correlations between data sets. Additionally, other qualitative methods such as narrative review would not have been as effective or have amalgamated research to provide a new understanding of the issues.

**Synthesis methodology**

There is no methodological template for undertaking a meta-synthesis (Walsh & Downe, 2005). This has resulted in published meta-syntheses being approached very differently leading to criticisms in the perceived rigour and clarity of academic papers.

The research adopted guidance on the meta-synthesis from Noblit and Hare’s (1998) meta-ethnographic approach. Noblit and Hare’s approach was utilised in this paper since it is the most developed and frequently utilised method of synthesising qualitative research in recently published studies. The researcher further utilised guidance from the Critical Appraisal Skills Programme (CASP, 2006) and from Walsh and Downe’s (2006) checklist to help discern and quality appraise appropriate studies. Whilst not universally adopted in qualitative research, CASP has been described as a ‘good’ appraisal tool by both national guidelines (Ring, Ritchie, Mandava & Jepson,
2010), Cochrane collaborations (Cochrane collaboration, 2010) and is widely utilised in published research.

**Critique of the Metasynthesis**

A significant limitation of metasynthesis is that themes emerge from the analysis of others’ opinions and not original data. This could mean that incorrect presumptions or themes from original papers are continued into the current metasynthesis. The researcher wondered whether his assumptions would have differed from the original research and considered to what extent original bias in the studies were amalgamated into the present paper. In order to counteract this, the researcher used peer debriefing (Lincoln & Guba, 1985; Janesick, 2004) for quality control that comprised of a small group of doctoral students using qualitative approaches within the University that met and discussed aspects of their research. The researcher felt many of these concerns were addressed by the peer-debriefing group.

The papers included in the study varied widely in quality and whilst the quality of the articles was validated by the peer debriefing group this coupled with studies adopting eclectic methodologies (and at times varied research questions) lead the researcher questioning the validity of amalgamating the papers.
The researcher also considered the possibility that his interpretation of categories from the data and models may be only one of a number of different interpretations available. Whist this was discussed by the research group validating the researcher’s categories, several other categories could have been developed from the data.

**Literature search**

Initially the paper was designed to assess the views and opinions of children below the age of 11 of mental health services since this would be unique. After initial trawls of literature it became clear that only a few papers specifically addressed children of this age group and this would have be insufficient to undertake a metasynthesis. A decision was therefore taken to include studies that also incorporated children up to the age of 16. A detailed set of inclusion and exclusion criteria highlighted fifteen studies to be included in the synthesis. These were the only qualitative studies available that matched the inclusion criteria. Methods of eliciting qualitative studies from electronic databases are still underdeveloped when compared to quantitative studies (Dixon–Woods & Fitzpatrick, 2001). A number of non-peer reviewed papers and position studies from support and pressure groups were available. These studies did ask children for their views and were available but were not included in the review because they were unpublished, not peer reviewed and lacked academic rigour. The researcher reflected as to the reasons why several position papers had
remained unpublished and considered whether journals were disinterested in hearing the views and opinions of children. The researcher thought that clinicians and academics should become more proactive in publishing their work with children.

Journal publication

The paper was originally written to follow the British Medical Journal since it has a strong reputation for publication and an unspecified word limit allowed for greater freedom developing narratives in the qualitative field. In discussion with the research supervisor it was decided that since publication of meta-synthesis are rarely to be found in the British Medical Journal a more qualitative research paper would be more appropriate. After researching several journals The Qualitative Health Review was chosen as the preferred publication. The Qualitative Health Review was considered more likely to publish the paper since the journal places an emphasis on meta-synthesis and child based health topics. Additionally, the Qualitative Health Research journal was the first to publish metasynthesis, and it currently publishes more metasynthesis studies than any other journal (Bondas and Hall, 2002). Whilst length of submissions for Qualitative Health review is unlimited, it was evident that it was necessary to constrain length. The first draft of paper 1 required substantial revision and reduction. The result of this culling was to significantly reduce the review and possible restrain the developing narrative. This is a common tension of
qualitative studies that require length to develop arguments in contrast to the demands of journals that require succinctness and brevity.

*Implications for future research, theory and practice*

This is the first study to present a meta-synthesis of children and young people’s views of mental health services that they encounter. As such, the study presents an important contribution to the research since it provides a collective overview of the views of children and young people that can be used to inform clinical practice and service delivery.

The paper highlighted that there is still a scarcity of studies, services and protocols that actively involve children and young people in gaining their perspectives of services despite government and best practice mandates. When children and young people are consulted their views and opinions appear to be largely ignored or not taken into account. Service users’ perspectives must begin to move beyond merely asking patients for their thoughts and must include a more meaningful understanding of participation to incorporate the development of services, policies and protocols.

One of the surprising aspects of the research is that for the past twenty years when asked about services children have been saying similar things in relation to the physical environment and the attributes that
make a good therapist and those that do not. In this regard the themes emerging from this research are unsurprising. It must be time to now beg the question (in an age of user participation and unprecedented funding of child and adolescent services) of who is listening and truly taking notice of children for themes to be re-emergent and whether there exists a barrier that prevents services truly being reflexive to the views of children and young people regarding mental health services.

The research suggested that clinicians should be aware that for the immediate sessions children may mask or even lie about issues that affect them and that it may take several sessions for them to build confidence in them. This may present as a systemic problem for services that insist on short assessment protocols.

The paper also makes clear aspects of inter and intrapersonal characteristics that endear children and young people to clinicians and aspects that disrupt or prevent a positive therapeutic alliance.
Paper 2

Summary and reflection on findings

Paper 2 explored parent’s views and experiences of the Triple P parent training program and the impact it had on themselves and their families.

The researcher undertook eight interviews with parents who had recently undertaken Triple P parent training. Interpretative Phenomenological Analysis was used to analyse the data.

Five main themes emerged from the data: a search for a cause or an explanation for the difficulties, with parents often locating problems as largely located organically within their child; the stigma and shame of struggling with parenting; the destruction of family life wrought by difficulties at home with metaphors of battles and fights where a struggle for power and control ensues; the recreation of family life by the introduction of Triple P and finally the perspective shift from adult to child perspective through Triple P.

Participants and recruitment

Parent trainers supported the process of recruitment by making first approaches to parents since they already had an established relationship with them. This provided a useful relationship in which to
recruit parents. It was clear though that in the recruitment areas of the study Triple P was offered to the most vulnerable and needy families and the researcher believes that this affected recruitment since many families were hard to reach and contact.

Methodological reflections

The study was undertaken due to the passion and experience of work with children, young people and their families. The researcher was surprised to find so little qualitative research that addressed parents’ views of the process of going through a family intervention such as Triple P parent training despite a plethora of quantitative research demonstrating their efficacy. Parenting programmes are now the recommended treatment of choice for a range of presentations with Triple P being one of the major public health interventions worldwide.

On reflection, the researcher wondered whether the study should have amalgamated children’s and parent’s narratives into one paper rather than produce two separate papers. However, evidence demonstrates that children’s and parent’s view differ considerably. Additionally, there were methodological difficulties of ensuring parity of interview questions and methodologies and therefore it was decided that two papers would be more appropriate. However, it was the belief of the researcher and the supervisor that there was some strength of
producing a paper which cross-referenced parents and children’s views, which, would have been a first in parenting research.

Another idea was to adopt a case study approach and limit the number of participants to individual families to attempt a 360-degree perspective of what was going on in families through parent training. Concerns were discussed though with the research group that this would limit the voices of children to one or two individual families.

**Interpretative Phenomenological Analysis**

A number of qualitative approaches were available to the researcher who was new to qualitative methods. The researcher understood why these approaches have been described as ‘an attractive nuisance’ (Miles, 1979) since the attractiveness of the approaches enabled a real insight into children and parents’ worlds. However, the researcher found that several of the methodologies overlapped and found the lack of an accepted template or set of conventions for analysis confusing and opaque. In the absence of experience, the researcher required much thinking time, supervision with an experienced qualitative supervisor and active discussion with colleagues.

Interpretative Phenomenological Analysis was chosen as the approach to analysing the adult data since IPA seeks to understand what experiences mean to those people who experience them. Thus IPA
analyses how participants describe events such as parent training and the emotions they feel to provide an experiential account in order (as Smith, 2011 describes) what it is like to walk in another’s shoes. IPA has been used to understand perspectives in a variety of different contexts and with different presentations. Critically, IPA recognises a double hermeneutic because the research reflects on their own views and opinions whilst trying to make sense of how others describe and interpret events.

**Critique of IPA**

Whilst IPA has become increasingly recognised as a bona fide qualitative methodology both within the UK and internationally having an increasing number of papers published using the method there are a number of limitations to IPA as a methodology. Smith himself (1996) highlights that truly being able to access another’s lived experience is fraught with difficulties and questions remain as to whether research can truly elicit an objective and impartial first person account. The researcher constantly struggled with this question.

An epistemological limitation concerned role of language in facilitating data generation. Willig (2005) highlights how language used during interviews can be used to construct meanings. The language used by the researcher may have to construct meanings that may have deviated from the understandings of the participants (Watson &
Parke, 2011). The researcher used supervision and the peer debriefing group review to address these issues though it remains a constant potential weakness of qualitative research.

Whilst IPA recognises (perhaps more than any other qualitative methodology) a ‘double hermeneutic’, the effect of the researcher and the relationship between the researcher and the ‘researched’. The results merely provide a snapshot of interpretation at a given moment and care must then be taken in transferring meanings to others and indeed to individuals themselves.

IPA has been described as a methodology that ‘is easy to do badly and difficult to do well’ (Larkin, Watts & Clifton, 2006; 103) since many researchers fail to move beyond merely describing hierarchical themes to a conceptual analysis. This was the researcher’s first experience of IPA. The researcher thoroughly enjoyed the challenge of learning a new methodology. In order to support the IPA learning experience initial IPA analysis were checked for quality control by an experienced qualitative researcher and all transcripts were made available for review.

Sample size

Since IPA places much more emphasis on meaning as opposed to statistical generalizability, sample sizes are much smaller than other
research methodologies due to a more detailed and rigorous approach to analysing the data. Whilst it is becoming increasingly common to see IPA studies conducted on single participants the most common number of participants is between 5 and 8 (Smith, Flowers & Larkin, 2009). This study adopted 8 parents for the IPA research and was therefore commensurate with similar studies.

**Paper 3**

Paper three explored children and young people’s views of parent training and the impact it had upon them and their lives. Eleven children were recruited to the study ranging in age from 5 to 16 years of age.

Adopting a Thematic Analysis, three main themes emerged from the children’s data: children searched for a cause and meaning to difficulties at home; narratives explicitly described differences before and after Triple P with changes highlighted in many aspects of life such as parents mental illness, activities, and perspectives; finally children talked about wider contextual difficulties placing stress on their family.

*In My Shoes*

‘In My Shoes’ is a computer package that helps professionals communicate with children about their life, views and experiences
including sensitive and distressing topics. The interviewer sits alongside the child and assists, guides and interacts with them through a structured interview process. ‘In My Shoes’ was chosen as a research tool since it is one of the few evidence based tools to be effective in eliciting children’s views of issues. ‘In My Shoes’ has a sound research base (Wardman, 2008; Glasgow & Crossley, 2004) and is divided up into eight modules: Introduction; Emotions; Emotions and Scenes; Places; People; Somatic Experiences and Subjects. The research study initially intended to use all modules except Somatic Experiences as this was not directly relevant to the research, but after pilot interviews and testing, emotions and scenes were deleted from the interview. The researcher thought that a combination of ‘In My Shoes’ coupled with a semi-structured questionnaire alongside was too long for young children and produced data of not direct relevance to the study.

Reflecting on the use of In My Shoes, children engaged well in the interviews. In this research, children as young as five were able to access the study through ‘In My Shoes.’ It was felt by the researcher that by using ‘In My Shoes’ a positive rapport was established very quickly and children became very enthusiastic to take control of the programme and were then much more likely to answer questions about their family than using a standard semi structured interview protocol. The researcher reflected on the use of the computer programme that appeared to act as a mediator between the researcher and the child who when faced with some potentially
difficult questions that could have appeared to be intrusive or perhaps intimidating to children they were able to engage using the programme.

Another benefit of ‘In My Shoes’ according to the researchers’ perspective was the flexibility that the programme offered in that modules could be expanded through discussion or shortened or even dropped should it have proven conducive to do so. During the research it was clear that some of the adolescents in the study (aged 15 and 16) were of such an age that they preferred a face-to-face semi structured interview to ‘In My Shoes’ since they were very comfortable and understood the nature of the study more.

Interviews lasted approximately 45 minutes. The length of the interviews were kept relatively short in order to account for children’s limited attention span (Miller, 2000) and took account of research that suggests that more than one single technique is more conducive to producing good quality research data form children (Darbyshire, MacDougal, & Schiller, 2005). The researcher also adopted a style of ‘interested idiot’ (Darbyshire, MacDougal, & Schiller, 2005), a style shown to be useful in engaging with children when an adult feigns ignorance in order for children to guide them in understanding the life of the child. Skills of attentiveness as to what children were saying, clarifying and summarizing in line with good practice (Smythe, 2009).
The aim of the research was to capture the experience of children who had recently completed Triple P training. After initial discussion it was decided that children and parents who had completed parent training in the past 6 months would be recruited as the issues and changes brought about by Triple P would still be fresh. Specifically the researcher wanted to explore how children understood the changes that may or may not have occurred through Triple P and whether children would be able to recognise a change in their families.

The researcher, as a father of two children found some of the themes that emerged from the data (such as children being slapped) emotionally difficult. Whilst recognising the inevitable struggle of family life and the demands that children can place upon their parents, the researcher recognised at times negative feelings of judgment towards some parents particularly when children were described as the cause of problems in family life. This contrasted with the researchers' personal view of the causes of difficulties in families being concerned with family systems and structures placing stressors on families that relate to further difficulties such as behavioural and management issues in children. This was explored through talking to the research group and the researcher utilised the research diary to explore these themes.
Other qualitative methods were available but it was felt that they were not as appropriate to the study. Content Analysis was rejected since it seeks to identify categories and theory before the data emerges (Willig, 2005) and this may have imposed a structure irrelevant to the study that was essentially exploratory in nature. A Grounded Theory approach may have approached the research differently by for example, attempting to understand the theoretical issues explaining why children and parents experienced parenting in a certain way to develop further theories. Narrative methods may have focussed the study away from meanings to a more social and political context of parenting. Whilst these may have been interesting approaches they were nevertheless of secondary importance to the aim of this study being primarily concerned with gaining insight into the lived experience of others.

*Thematic Analysis*

Whilst it may have added to the coherence of the study to adopt a single qualitative methodological approach for both parents and children, it was decided that IPA would not have been the most appropriate method of analysing the children’s data. IPA depends upon the participant being able to fully reflect upon their experiences and provide a coherent account of meaning (Willig, 2005). IPA requires rich reflective data to analyse that may be difficult to acquire from young children in particular. This makes IPA very challenging. A recent
audit of IPA research revealed only two studies using children (Hefferon & Gil-Rodriguez, 2011). These studies involved older adolescents. IPA then was not considered to be the most conducive methodology appropriate given that the developmental issues may hinder a reflective account from being given. Other more ‘child friendly’ qualitative approaches were available and published research in this area suggests that thematic analysis was the most efficacious and evidence based method with children since it does not require a complex interpretative hermeneutic, rather, a consistent and clear approach to determining themes of importance to children that are easily accessible through methods such as using ‘In My Shoes’.

**A joint narrative**

Children’s themes largely concurred with parents; a search for an explanation of the behavioural difficulties with younger children tending to internalise their problems; changes in life through Triple ‘P’ such as being praised more, spending time together as a family, not being smacked and parents being more understanding of them.

Interestingly, children’s and parent’s narratives differed significantly in the description of physical punishments at home. Several children commented that they had been hit, sworn and shouted at and could not understand the justification for this. Parents did not mention this in their accounts. The researcher reflected on the possibility of a complex
psychological defence within the parents’ narratives of locating blame within children to shift responsibility and ‘saving face’ in order not to appear abusive or to blame by failing to talk of negative aspects of parenting such as physical punishment. Parents may have also felt social shame by resorting to such measures and wanted to protect themselves from being perceived negatively therefore negating mention of this aspect of family life.

**Journal Choice**

After researching several journals The Qualitative Health Review was chosen as the preferred publication for papers 2 and 3. The Qualitative Health Review was considered more likely to publish the paper since the journal places an emphasis on qualitative approaches and child based health topics.

The journal affords an unlimited word count and this presented as a challenge to the researcher to limit the paper. The researcher felt that having to present the research in such a concise format would lead to a much-increased likelihood of publication.

**The interview schedule**

Much consideration went into developing the interview schedule particularly for children. Challenges arose from the study having such a wide age range of children (aged 4-16) with very different abilities and
in different developmental stages. Questions that were appropriate for 16 years were not appropriate to 5 year olds and Vice versa. Additionally the researcher had to consider that many of the children may not have heard of Parent Training or Triple P so direct questions relating to parenting programmes may not have been conducive to obtaining quality data. Consideration was then required as to how best to structure questions for children and adolescents and whether to have a separate questionnaire for older children. After initial pilot interviews that asked very direct questions about parenting it was agreed in supervision that questions should concentrate of descriptions of life at home, descriptions of parents and discipline and things children did and did not enjoy. This would then provide a rich snapshot of life at home before probing whether things have changed in life at home for them. These questions could be accessed by children young and old and would easily fit in to the ‘In My Shoes’ protocol. It was interesting to reflect on the importance of the questions in the protocols particularly with young children since subtle changes and differences in emphasis could yield significantly different results. Sometimes the researcher felt that asking children direct questions about issues yielded very little whilst asking questions around those issues provided a much richer data set. This does have implications for further research undertaken with children with researchers who may presume that merely differentiating questions to a developmentally appropriate level would yield rich data whereas paper 2 suggests that
asking around issues on their periphery provides a road towards much greater data. This was a particular strength of ‘In My Shoes’ since it allows issues to be discussed by accessing first children’s views of life at home and relationships and then progressing to more sensitive areas.

Participants and recruitment

Following ethical approval from the University of Manchester (ref. 11044 Appendix 11) trained Triple P Family Support Workers approached families whom they had recently trained to invite them to participate in the research. Families were informed that the study focused on their views of Triple P and the effects that it had on themselves, their families and children. An information sheet was given (Appendix 5 & 6). Consent was sought from parents for their children to be interviewed and further assent was sought from children. Parents were asked to explain the study to the children and seek their assent prior to the interview. Children were a given a choice as to where they would like to undertake the interview. On beginning the interview each child was asked if they understood the research and this was further explained. Children were given the opportunity to ask any questions and verbal and written assent was checked before commencing the interview. Children were informed that they could withdraw from the interview at any stage and if they felt uncomfortable they could choose not to answer some questions. Parents were not present during the interviews and reassurance was
given about confidentiality. Confidentiality was explained to the
children in an age and developmentally appropriate manner in order
that they understood that what they said remained confidential unless
they disclosed issues of immediate concern and harm. Permission was
gained to use an audiotape recorder. Children were informed that
only the researcher and the supervisor would hear the tapes and that
during the write up of the interviews they, their families or
neighbourhoods would not be identified. Ice breaking activities such as
introductions and name stickers were used to address power
imbalances. Reflection, care and consideration were given during the
introduction not to give information that might bias or influence the
view of children (Hill, Laybourn, & Borland, 1996).

The researcher struggled throughout with recruitment of children. It
was hoped that the study would achieve a sample of 20 children
although clear themes did emerge in the data from the current sample
and the researcher felt that data saturation was reached. The
researcher found that adolescent children appeared largely
uninterested and at times suspicious of the study. Families of the cohort
included children who had significant and profound special
educational needs and eliciting data from some children was very
difficult even with an accessible tool such as ‘In My Shoes’. On
reflection and with more time the researcher could have recruited
from other areas where Triple P is offered as an early intervention tool
rather than a remedial intervention as this may have improved participant numbers.

**Risk Issues**

The researcher was coached in issues concerned with risk and challenges associated with home visits by the research supervisor through lectures and supervisory support. In addition due to the potential difficult issues arising from the research a protocol was developed when conversations became too distressing. The researcher was mindful also of issues in child protection and vulnerable adult guidelines whilst researching with families at home. Whilst the home environment was the most accessible for children and families after initial visits it was clear that home visits brought several different challenges. Some of the older adolescents did not wish to participate in the study and were suspicious of the researcher’s presence in their home. During the home visits there were other children present leading to ethical issues of privacy and the appropriateness of having other children present during the interview? In some homes it was not possible to find a private area to undertake the interviews and whilst issues of physical punishment and perceived injustice of parental rules were discussed within earshot of the parent this made researching very difficult. Home visit protocols were developed with the senior researcher and field supervisor during home visits. Eventually the researcher decided that logistically interviews were more appropriately
conducted in the schools of the children where families had received Triple P training. In this regard the researcher was particularly grateful for the schools’ willingness to participate in the research and in particular the parent liaison officers of the school.

**Reflective Journal**

Throughout the research from initial ideas of a subject area until write-up the researcher utilised a reflective journal. Use of a reflective journal is recommended as good practice by qualitative researchers (Boden, Kenway & Epstein, 2005). The research diary served to keep a historical record of the research process and the development of research skills. The diary also provided a useful template to reflect on issues and problems in the research as they arose and formed the basis of discussion with the research supervisor and peer review group. The researcher recognised the common journey of many new researchers in that the process of qualitative research is presented in texts as a seamless, linear process in comparison to reality of difficulties that arise during the process.

Critically the diary allowed the researcher to reflect on his thoughts, views and opinions of the research as it emerged in order to think about how his views may have influenced the research process (Mruck & Breuer, 2003). This would also help any transparency in the process since qualitative analysis acknowledges the role of the researcher in
producing data. The researcher found the experience of keeping the journal invaluable and much of paper 3 derived from thoughts contained in the diary. The journal also afforded space for a personal reflection throughout the researching process. The researcher felt heavily influenced by his role as a father of two children who understands the day-to-day struggle of parenting and the demands placed upon parents by children yet also recognizing the role that parenting style, mood and approach has on influencing children. As an inexperienced researcher it was felt that on several occasions in the first interviews they were conducted similar to clinical assessments with a fast pace and several follow up questions. In the initial interviews at least listening back to them there were several occasions when the researcher reflected back to the participants what they had just said. This common clinical technique was unhelpful in obtaining the richest data as possible since it broke the narrative from the person being interviewed and could have influenced the results of the interview. This led to the interviews becoming staccato at times. To counteract this, the researcher began to explain at the beginning of the interview that whilst follow up questions may follow on from an answer, in general the researcher would say very little during the process. Although this initially felt very strange and was a completely new way of obtaining data the researcher grew in confidence in conducting the interviews in this manner. Through supervision the researcher became much more confident in taking a listening position during the interview and
allowing the parents and children to talk and pause instead of feeling that pauses should be filled with questions.

**Hidden Affect**

During the interviews on several occasions and with several different participants it was noted that when talking about difficult themes participants would be changed or distracted. After this occurred several times the researcher speculated about the psychological effect and distress parents experienced talking about their difficult feelings they had towards their children. This was most clearly seen in the disparities that existed between parents and children’s explanations of physical punishment. Children spoke very clearly about their feelings of injustice about being smacked regularly for little reason. Parents never mentioned this in their accounts. This could of course reflect parents not wishing to disclose issues that are culturally sensitive, or feeling guilt or shame. The questions may have raised issues of a child protection nature but all of the children described only historical cases of chastisement and were clear that all smacking had stopped because of Triple P.

**Limitations of papers 2 and 3**

There were several limitations apparent in the papers. The sampling could be considered biased since children and parents actively chose
to participate in the research and therefore may well have been more favourable in their views of Triple P. This has been a common theme raised in IPA studies (Smith, 2004).

Several families did not wish to take part in the research and their participation could have shed further light on Triple P in the most vulnerable of families.

In comparison with other studies (Fletcher, Freeman and Maltheys, 2011) this paper was weakened in having no fathers participating in the parent research. There are several reasons for this in the current study. All but one of the families participating had absent fathers who did not play a part in the children’s or families life. Two fathers were keen to participate in this study though did not attend a first or second interview appointment. It remains a frustration as to why so few fathers participate in parenting research but further studies should specifically address this issue, because the voices of fathers remain largely absent from accounts. Further research would be beneficial specifically addressing he role of fathers and their views of Triple P.

**Implications for future research, theory and practice**

To the researcher’s knowledge this is the first paper that has explored childrens and parents’ views of Triple P and the changes that occur because of a parenting intervention using qualitative methods. The
results of the papers therefore potentially offer an important
contribution to research in parenting research and wider public health
interventions.

Children as service users in their own right can have some important
things to say regarding services and interventions that affect their
families. Children as young as five can understand and appreciate the
impact of an intervention such as Triple P and can appreciate the
positive changes brought about in life at home and in their
relationships with parents.

Further research should be undertaken with younger children, those
with disabilities and special educational needs to ascertain the extent
to which these children understand and appreciate Triple P parent
training.

In My Shoes was a useful and efficacious research tool to gain both a
positive and quick relationship with children and to facilitate
conversations with children regarding issues that can be of a sensitive
nature. ‘In My Shoes’ made the experience of interviews for children
fun and this in turn aided the richness of the data that was forthcoming
through the interviews.
Summary

This is the first time the researcher has attempted to undertake qualitative research and specific techniques such as metasynthesis, Interpretative Phenomenological Analysis and Thematic Analysis. The researcher thoroughly enjoyed the learning experience. At times the research process was challenging with a lack of a clear template for approaching qualitative research leading to frustration. However, the researcher enjoyed becoming so immersed in the rich data set though the looming sense of completion dates weighed heavily on the mind. Yet, by being immersed in the subject areas of participation and viewpoints, the researcher was constantly fascinated by the narratives of children and their parents. The richness of the data that emerged from the participant’s narratives never ceased to impress and the researcher struggled to understand why user participation and views have taken so long to incorporate in research and policy to effect changes to service delivery.
References


APPENDICES
Appendix 1 – The Qualitative Health Research Journal Criteria
QHR MANUSCRIPT GUIDELINES

SEPTEMBER, 2011

NOTE TO AUTHORS:
If answers to your questions are not found within the Guidelines, please address your inquiries to QHR-Journal@nurs.utah.edu (please do not send inquiries to other/additional QHR email addresses). You may also telephone our office at 801-585-5378. Thank you for your cooperation.

When APA rules and QHR guidelines conflict, follow QHR.

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Qualitative Health Research

An International, Interdisciplinary Journal

**ABOUT QUALITATIVE HEALTH RESEARCH (QHR)** Editor: JANICE M. MORSE, RN, PhD (ANTHRO), PhD (NURS), FAAN

University of Utah College of Nursing, Salt Lake City, Utah, USA

*Qualitative Health Research,* widely referred to as *QHR,* is an international, interdisciplinary, refereed journal for the enhancement of health care. Published monthly, it is designed to further the development and understanding of qualitative research methods in health care settings. The journal is an invaluable resource for researchers, practitioners, academics, administrators, and others in the health and social service professions, and graduate students who seek examples of qualitative methods.

**COMPREHENSIVE, TIMELY COVERAGE FROM A VARIETY OF PERSPECTIVES**

Issues of *QHR* provide readers with a wealth of information, including articles covering research, theory, and methods in the following areas:

- Description and analysis of the illness experience
- Health and health-seeking behaviors
- The experiences of caregivers
- The sociocultural organization of health care
- Health care policy
- Related topics

Articles in *QHR* examine an array of timely topics such as chronic illness; risky behaviors; patient–health professional interactions; pregnancy and parenting; substance abuse; food, feeding, and nutrition; living with disabilities; milestones and maturation; monitoring health;
children’s perspectives on health and illness, and much more. In addition, the journal addresses a variety of perspectives, including cross-cultural health, family medicine, health psychology, health social work, medical anthropology, sociology, nursing, pediatric health, physical education, public health, and rehabilitation. We also consider critical reviews; articles addressing qualitative methods; and commentaries on conceptual, theoretical, methodological, and ethical issues pertaining to qualitative inquiry.

**Publisher**

QHR is published by Sage Publications, Inc., 2455 Teller Road, Thousand Oaks, CA 91320, USA; www.sagepub.com; telephone 800-818-7243.

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**Contact Us**

Qualitative Health Research  An International, Interdisciplinary Journal

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**Visit Us on the Web:**
http://qhr.sagepub.com/

**Please Do**
- send all QHR-related email messages to only one of the email addresses listed above.
- direct all manuscript-related faxes to the attention of Dori Fortune.
- direct all manuscript-related documents to the attention of Dori Fortune.

QHR-Editor@nurs.utah.edu  QHR-TE@nurs.utah.edu  QHR-Journal@nurs.utah.edu

**Please Do Not**
- submit manuscripts via email.
- send email messages to two or more addresses simultaneously; doing so will cause a significant delay in the QHR response.
- send email messages to “janice.morse@ . . . ” or “dori.fortune@ . . . ”; doing so will cause a significant delay in the QHR response.
- send query letters/email messages asking if we would be interested in your manuscript.

After ensuring that your manuscript complies fully with these Guidelines, the only way to determine if the manuscript is suitable for QHR is to submit it (online) for consideration.

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**Reviewers Needed**

Qualitative Health Research  An International, Interdisciplinary Journal

Reviewers must have a strong background in qualitative health research and/or qualitative methods. They must have a willingness to share their expertise by evaluating manuscripts and providing feedback for authors to assist them in strengthening their articles.

**What's in it for you?**
You have the prerogative of reading prepublication articles in your methodological or substantive areas, and assisting in molding the literature in your field. Also, we give you copies of the other reviews received, so you can review the general consensus about the decision, and in doing so improve your own research, reviewing, and writing skills.

**Do you have to have a doctorate?**
No—but if you are a doctoral student we recommend that you do the first few reviews jointly with your supervisor or some other experienced reviewer, so you can learn the “ins and outs.”

*Qualitative Health Research (QHR)* is an international journal published monthly by Sage Publications. Research articles, developments in qualitative methods, and *Pearls, Pith, and Provocation*—discussion articles on qualitative ethics and other issues—are reviewed. Keynote addresses, editorials, and book reviews are also published.

If you would like to join the review board for *QHR*, please email your curriculum vitae (CV) and complete contact information to QHR-Journal@nurs.utah.edu.

Thank you! We look forward to hearing from you!

Janice M. Morse Editor

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**PERMISSIONS**

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Once you have obtained written reprint permission, submit it along with the original manuscript submission or, if you have obtained it after submitting the manuscript, submit it to *QHR*, being sure to refer to your manuscript ID number:

By email: Send it to QHR-TE@nurs.utah.edu By facsimile: Fax it to 801-587-9838, Attention Dori Fortune

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The ScholarOne Manuscripts / SageTrack system will be triggered to automatically send you ELP information (via email), including instructions to access and complete the form, immediately after an “accept” decision is sent to you. The subject line of the email will read: “ACTION NEEDED: Contributor Form.” If you do not receive this notification, or if you accidentally delete it, you may request a blank (.pdf) ELP form by contacting *QHR* at QHR-Journal@nurs.utah.edu. Under these circumstances, please take the steps listed below to submit your form:

Print the form, complete it (be sure to answer all questions), and sign it. Write your manuscript ID number in the upper right corner of the first page of the form (e.g., QHR-2011-0XXX). Submit the first 2 pages only to *QHR* by one of the following methods:

- By email (preferred): Scan the completed form, save it to your computer, and send it as an attachment to: QHR-Journal@nurs.utah.edu.
- By facsimile: If you use this method, please send an email alerting us to the pending arrival of the fax (QHR-Journal@nurs.utah.edu). Fax the completed document to: 801-587-9838 Attention: Dori Fortune
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By mail/post: Mail the completed document to: Dori Fortune
University of Utah College of Nursing 10 S. 2000 E. Salt Lake City UT 84112-5880 USA
• Note that the corresponding author completes and signs the form on behalf of all coauthors of a particular manuscript; it is not necessary to obtain the signature of each author. Remember that all author names must appear on the first page of the form. Please print legibly!
• Submit only the first 2 pages of the completed form.
• Do not submit a completed Exclusive License to Publish form unless and until you receive word that your manuscript has been accepted for publication.

GENERAL INFORMATION
This section of the Guidelines covers matters of QHR journal style, which are not subject to author preference; adherence is required.

Note: If you still have questions after carefully reading these instructions, please refer to the sample manuscripts (there are several types) beginning on page 35 before contacting the QHR office.

IMPORTANT CONSIDERATIONS
• Qualitative Health Research is a peer-reviewed journal. Only complete, finished manuscripts should be submitted for consideration.
• We do not publish stand-alone abstracts, quantitative studies, manuscript outlines, pilot studies, manuscripts-in-progress, letters of inquiry, or literature reviews. Research articles must be pertinent to health.
• Write both the abstract and the text of your manuscript in first-person, active voice.
• For best results, review this entire document prior to preparing and submitting your manuscript.
• Proper manuscript preparation will speed the peer-review process for your manuscript, and will facilitate a smoother production process if it should be selected for publication.
• Improper manuscript preparation could result in burdensome revisions, lengthy delays in the review and production processes, and the possible rejection of your manuscript.

GENERAL STYLE
We ask authors considering submission to QHR to review these guidelines, survey several issues of the journal, and make their own decision regarding the "fit" of their article for QHR's mission. Please refrain from writing or calling to ask if we are interested in your particular manuscript or idea.


Many universities and private organizations have Web sites devoted to APA style. However, when guidelines found on those sites, or in the APA Publication Manual, conflict with QHR Guidelines, you must follow the QHR Guidelines.

JOURNAL STYLE

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CONFIDENTIALITY AND PROTECTION OF IDENTITY
QHR is committed to protecting the identity and confidentiality of research study participants. With the exception of participatory action research (PAR), no information that could potentially allow identification of a participant—or even a specific study site—should be included in a submitted manuscript or, subsequently, included in a published article.

If the use of participant names is absolutely necessary for reader understanding, each study participant referred to in the manuscript should be assigned a pseudonym. Study sites, such as hospitals, clinics, or other organizations, should not be named, but instead should be described; for example, “Study participants were recruited from the coronary care unit of a large metropolitan hospital on the eastern seaboard of the United States.” Authors who include participant names and/or photos/images in which individuals are identifiable must submit written permission from the participants to do so—no exceptions. Permission to use photographs should contain the following verbiage: “Permission is granted to use, reproduce,
and distribute the likeness/photograph(s) in all media (print and electronic) throughout the world in all languages.”

To protect author anonymity during the review process, author citations in the text should include only the word “Author” and the year: (Author, 2008). Author references in the reference list should also include only the word “Author” and the year: Author. (2008). (See the section on references for more details.)

**WORD CHOICES**

It is always best to use the most precise language possible to convey important data, concepts, and findings. Because *QHR* is an international journal published in U.S. English, there is the added need to avoid commonly used English terms (colloquialisms, slang) that might be misinterpreted by or confusing to readers whose first language is something other than English.

**Word or Phrase**

as amongst as regards can’t, don’t, and so forth Caucasian due to etc. feel female(s) firstly, secondly, thirdly further Importantly in order to Interestingly lastly male(s) may

**Consideration**

Do not use this word when your meaning is *because*.

Use *among* instead.

Use *with regard to*, or *regarding* instead.

Use *cannot*, *do not*, and so forth. Do not use contractions unless they are part of a quotation.

Use *White* instead, capitalized.

Use *because of* instead.

Use *and so forth* instead.

It is appropriate to use this word when referring to a physical sense or state of mind; do not use it when your intent is *think* or *believe*.

Please use *woman* or *women* instead, whenever possible and appropriate. Use *first*, *second*, and *third* instead.

This word is appropriately used when referring to distance, or perhaps with respect to “furthering” something. At the beginning of a new sentence, when writing of something in addition to something already stated, it is more appropriate to use *furthermore, moreover, in addition, or additionally*.

Do not use this word unless it is part of a quotation. Use *to* instead. Do not use this word unless it is part of a quotation. Use *last* or *finally* instead.

Please use *man* or *men* instead, whenever possible and appropriate.

Do not use this word in place of *might*. Use *may* for permission, *might* for possibility, and *can* for ability.

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on the one hand / on the other hand over paper since towards upon U.S./United States while/whilst

**COMMON PROBLEMS**

Acronyms

Anthropomorphism

Back-to-back parentheses Bad beginnings Capitalization Ellipses Hyphenation Horizontal lines Inconsistent writing style Irrelevant data Jargon

Do not use these terms in your writing.

Do not use this word when the intended meaning is *more than*. Use *article* instead.

*Since* is the appropriate word to use when referring to the passage of time; do not use it when your intended meaning is *because*.

Use *toward* instead. Use *on* instead

Use *U.S. only as an adjective*; in all other instances, spell out *United States*. The same rule
applies to UK/United Kingdom.
Use while when referring to concurrent events; do not use it when your intent is whereas, although, or even though. Do not use whilst.
The full spelling of the related words must precede the first usage of an acronym (even if you think everyone knows what the acronym stands for), followed by the acronym in parentheses; e.g., World Health Organization (WHO). Thereafter you may use the acronym alone: WHO.
Avoid the overuse of multiple acronyms.
Anthropomorphism occurs when human characteristics are attributed to things not human.
For example,: This study used a grounded theory approach . . . . Obviously, a study cannot “use” anything. It would be more appropriate to write, In this study we used a grounded theory approach . . . . Eliminate anthropomorphism from your manuscript.
Incorrect: (xxx) (yyy) / Correct: (xxx; yyy)
Do not begin sentences—and especially paragraphs—with and, yet, or but. Use caution when beginning a sentence, and do not begin a paragraph, with however.
Capitalize proper names. Do not capitalize words unnecessarily, such as titles and ranks (e.g., director, professor, doctor, chairperson), or themes, categories, concepts, and so forth. (See also Title Case, below)
Ellipses ( . . . ) are to be used only to represent words missing from quotations. Do not use them to represent pauses in speech.
Refer to the APA Publication Manual, 6th edition, for an excellent explanation of the proper use of hyphens and dashes; do not depend on Word’s “Spell Checker” feature for decisions on hyphenation. With few exceptions (see APA), words beginning with co, non, pre, post, re, semi, socio, and sub do not require hyphenation.
Do not place horizontal lines in your manuscript. If footnote separator lines appear, remove them.
When reviewing your manuscript prior to submission, watch for inconsistent writing style. This is especially important for manuscripts having two or more authors.
Page space in the journal is precious. Refrain from including interesting but irrelevant data or commentary.
QHR readers come from a wide variety of disciplines and backgrounds, and therefore might not be familiar with the terminology related to your particular field or discipline. If you must include jargon, be sure to explain it clearly the first time a discipline-specific word is used.
Avoid the overuse of jargon.
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Non-English words
Paragraph length
Participant characteristics
Repetition
Run-on sentences Spacing
Special formatting Spelling
Title Case
Verb tense
Voice
Word confusion and substitution
The first time a non-English word is used, italicize it. Thereafter, use only Roman font. All non-English words must be explained or defined in the text. Include English translations of all non-English titles in the reference list (refer to APA for instruction on how to do this).
To facilitate ease of reading, paragraphs should be no longer than one half of a double-spaced, 8.5 x 11-inch page. Avoid paragraphs of only two or three sentences in length; combine them as necessary to make paragraphs of more appropriate length.
Under no circumstances should you include individual participant characteristics in your manuscript. Group participant characteristics. In most cases it is best to write group characteristics into the text rather than placing them in a table (use whichever format takes the least amount of page space).
Avoid it! Make your writing as “tight,” precise, and concise as possible. Avoid including the same facts, conclusions, or information in multiple places in the text (this does not mean you cannot summarize, of course). Avoid overuse of the same phrases, and avoid repeating certain characteristics of your sample; for example,: Twelve-year old boys are perceived as . . . This is often a problem for 12-year-old boys. Also, 12-year-old boys are . . .
Avoid long, wordy, complex sentences.
Use *no spaces* before, and only a *single space* after periods (.), commas (,), colons (:), semicolons (;), question marks (?), and closing quotation marks ("). All line spacing (except for text within figures) should be set at *exactly* double, with 0" before and 0" after. *Never use any* coding or formatting in your manuscript that is not called for in these Guidelines.

*QHR* is published in U.S. English. For best results, set the language of your document to U.S. English when you are establishing all other document setup requirements. Note the correct spelling of a few commonly misspelled words: *health care* (two words); *keywords* (one word); *semistructured* (one word, no hyphen). Also, refer to the section on hyphenation, above. *QHR* uses *Merriam-Webster’s Collegiate Dictionary* (2005) as our spelling reference.

Title case is properly created by capitalizing:

- the first letter of the first word
- the first letter of the first word after a colon (:), period (.), or *em* dash (—)
- all important words, and
- *all words containing four or more letters*

Things that happened, were said, or were written in the past should be written about in the past tense. When writing about what is included in your article, use the present tense rather than the future tense (e.g., *In this article we present*, rather than *In this article we will present*).

Write in the first-person, active voice (use of third-person passive voice is not acceptable). When there are two or more authors, avoid the use of “I” statements.

Research studies and articles about research studies are two separate things. Do not confuse the meaning of these words in your writing.

**11 BASIC DOCUMENT PREPARATION**

*See also* a variety of sample manuscripts beginning on page 35. *Note*: Do not use any coding or formatting that is not described within these Guidelines!

**DOCUMENT SETUP AND FORMATTING**

Document file type

- Submit only documents created in *Microsoft Word*, and only with the regular file extension of .doc or .docx (do not submit documents with .docm, .rtf, .pdf or other extensions).
- Letter, 8.5 x 11 inches, with portrait orientation
- None
- Exactly “double,” with 0" before and 0" after

**ORDER OF MANUSCRIPT ELEMENTS**

Compile the elements of your manuscript in the following order:

Document 1: Title page (required)

Document 2: Abstract and keywords (required)

Main manuscript text (required) Notes (if any)

References (required) Appendices (if any) Tables (if any)

Document 3: Figure 1 (if any)

Document 4: Figure 2 (if any; and so forth, with each subsequent figure in a separate document)

**FORMATTING OF MANUSCRIPT ELEMENTS**

Dialogue

Ellipses / *ellipsis points*

*Note*: For ease in locating needed information, the various elements are listed below in alphabetical order, and not in the order of anticipated use.

Presentation of participant dialogue (i.e., two or more “speakers”) should be set as block quotes/excerpts, indented by 1/2 inch (approximately 1.3 cm.) from the left margin. Do not use bullets or hanging paragraphs. Begin the narrative of each speaker on a new line. The first time a speaker name is used, type it in full, followed by an appropriate abbreviation in parentheses prior to the colon; thereafter, use only the abbreviation for the speaker name. Refer to the sample manuscripts for an example of dialogue presentation.

Almost every manuscript contains ellipses. They are used to indicate words missing from quotations, and are to be created in a very specific manner. The proper way to create ellipsis points is as follows:

Three (3) dots, preceded, divided, and followed by spaces (i.e., SPACE.SPACE.SPACE.SPACE), like . . . this.

If it is necessary to indicate missing words between sentences (instead of in mid-sentence):

Place a period (full stop) at the end of the first sentence, then format the ellipsis points as noted, and begin the next sentence (with a capital letter) immediately after the last space (i.e., .SPACE.SPACE.SPACE.SPACE). . . Like this.
Font size: text
Font size: tables and figures
Font style: headings, title page, abstract, keywords, tables, and figures
Font style: main manuscript

Headings
H Level H1 H2 H3 H4

Justification of margins

Length of manuscript

Line spacing
Use 12-point font for everything except text in tables, figures, and (if applicable) conversation analysis.
Use only 8-point font in tables and figures.
Use Gill Sans font style for all of these. This includes figure/table numbers, titles, text within the figures/tables, and citations or explanatory notes below the figures' tables (if any). Note: If you do not have Gill Sans font on your computer, please use Arial instead.
Use Times New Roman font for the main body text. Also, use Times New Roman font for the text (not the headings) of author's notes, acknowledgments, declarations of conflicting interests, funding statements, footnotes, and bios.

Italics should be used only as appropriate in the reference list (see APA); as appropriate in level-2, -3, and -4 headings; and to introduce non-English words, or unusual new concepts (2 to 3 words), and then only when the new word or concept is first introduced in the manuscript; subsequent use of the same word(s) should be in regular Roman font.
All headings, without exception, are to be set in Gill Sans, 12-point font. (Use Arial if you do not have Gill Sans on your computer.) QHR uses 4 distinct levels of headings (H = Heading), including:
Formatting (Note: All headings should be double-spaced, just like the regular text)

Flush Left, Bold Text, in Title Case

Flush left, italicized text, in sentence case, ending with a period. At this level, the paragraph text begins immediately after the heading, instead of on the next line. The heading is part of the paragraph. Use this heading only if you have a total of four (4) heading levels. Note: Try to avoid the use of H3 if possible, and use only H1, H2, and H4 (see below).

Indented (5” or 1.3 cm.), italicized text, in sentence case, and ending with a period. At this level, the paragraph text begins immediately after the heading, instead of on the next line. The heading is part of the paragraph.

Use at least two heading levels:
For manuscripts with 2 heading levels, use H1 and H2 For manuscripts with 3 heading levels, use H1, H2, and H4 [not H3] For manuscripts with 4 heading levels, use H1, H2, H3, and H4

Be aware of limitations on the use of heading levels H2, H3, and H4: You are not required to use an H2 heading below any given H1 heading, but if you do, you must use two or more H2 headings; you cannot use just one. The same is true for H3 headings below any given H2 heading, and for H4 headings below any H2 or H3 heading.
All text should be left justified.

There is no predetermined word or page limit. Provided they are “tight” and concise, without unnecessary repetition and/or irrelevant data, manuscripts should be as long as they need to be.
The editor might require a reduction in length if the manuscript contains material that does not add anything useful to the topic being discussed. Limits might be imposed on the number/size/length of tables, figures, reference lists, and appendices.

Everything, in all elements of the manuscript, from the title page through the references and tables (if any), must be exactly double spaced. The only exception: Text within a figure should be single spaced.

Lists Paragraphs
Quotation marks
Quotations
Seriation
Spelling
Vertical lists (i.e., listed down the length of the page) should be either simple dot bullets or bullets numbered 1., 2., 3., and so forth. Leave a blank, double-spaced line after all lists.
Paragraphs are to flow, one after the other, without additional line breaks (with few exceptions; see below), and with no extra space between paragraphs.
Leave a blank (double-spaced) line between the abstract and the keywords.
Leave a blank line after (not before) each block quote, numbered list, or bulleted list.
Leave a blank line between block quotes if you have placed two or more in succession.
Indent the first line of every new paragraph by .5 inches (approximately 1.3 cm.), except:
- the first line of the abstract or the keywords.
- the first (opening) paragraph of the manuscript text.
- paragraphs immediately after level-1 and level-2 headings.
- paragraphs beginning with level-3 headings.
Use Word's Format > Paragraph function to set paragraph first-line indentations, but apply this paragraph by paragraph, and not to the entire document.
Use Word's Format > Paragraph function to set block quote/excerpt and bulleted/numbered list indentations. Note that block quotes/excerpts and lists are to be completely indented (not just the first line) by .5 inches (approximately 1.3 cm.) from the left margin only; do not indent from the right side.
In general, use double quotation marks (e.g., “Xxxx.”) to set off quotations appearing within regular paragraphs, and to set off words being used with “special” meaning (or unusual spelling to convey special meanings within the text; e.g., “busy-ness”). Do not use quotation marks around quotations presented as block quotes/excerpts.
In regular paragraphs, use single quotation marks to set off a quote within a quote (e.g., “Xxx, ‘Yyy,’ xxxx.”).
Note that when closing quotation marks coincide with a comma or period (full stop), the quotation marks go outside (after) the comma or period: “Quotation. . . last word.” Quotations of fewer than 40 words should be surrounded by double quotation marks (“”) and included within the regular sentences of a paragraph. Internal quotations within quotations of fewer than 40 words should be set apart with single quotation marks (’). Quotations of 40 or more words should be set as separate paragraphs, with the entire quotation indented .5 inches (approximately 1.3 cm.) from the left margin (this is also referred to as a “block quote” or “excerpt”). Do not use quotation marks for block quotes unless there is a separate, internal quotation within the larger quotation; in that case, use double quotation marks (”) for the internal quotation only. Make sure all quotations are properly capitalized and punctuated.
Format the indentation for block quotes with Word’s Format > Paragraph feature. See the special section, below, for instructions on formatting conversation analysis.
Seriation refers to “numbered” lists appearing in sentences of regular text (in other words, across the page rather than in a vertical list). The proper seriation style for manuscripts submitted to QHR is (a), (b), (c), and so forth (lowercase letters, enclosed in parentheses).
See “Common Problems,” above. Exceptions to the use of U.S. English include (a) direct quotes from written, published material, and (b) titles in the reference list (which should be spelled exactly as published).

CONVERSATION ANALYSIS

Note: This specific instruction does not pertain to “regular” quotations, excerpts, or block quotes. If you have not conducted conversation analysis in your study, do not use this formatting for your quotations.
For your excerpts of conversation analysis, you will need to create tables with very specific formatting. Use a level-2 heading, but bolded, with the word “Extract” and the extract number. You may also use a colon with a subheading, if you wish. Use the following steps to format your sections of conversation analysis.
Create a table with the left border of the table aligning with the left margin of the page. Set only two columns. Highlight the entire table and set the font for Courier style, 9-point font (this is critical).
In column 1, number the lines, beginning with “1.” When you have numbered as many lines as you think you will need, drag the column separator as far to the left as it will go without
forcing double-digit numbers onto two lines (i.e., make the first column as narrow as possible). Then, drag the far right border of the table to the left, narrowing the table so that the entire width of the table is exactly 3 1/8 inches (approximately 8 cm.) wide.

Begin typing the excerpt on line 1 of column 2. If you need to use speaker names, place them in this same space, followed by a colon and a single space, before the quotation begins. Use abbreviations for speaker identification as much as possible, to conserve space (see the sample, below). Type across the line, ending as close to the right edge as possible, then drop down to the next line and continue typing. Do not allow the typing to “wrap” within the same row. After typing the entire excerpt, you might need to go back and manually change the first letter of some rows (if your computer automatically capitalized it) to lowercase letters (see below).

Manipulate the text within the rows of column 2 to achieve your desired alignment. Place the symbols for your chosen transcription conventions in the type as you go. To delete rows, highlight the selected row(s), and to go Table > Delete rows. To add rows, place your cursor in the last line of the table, and hit the tab key until you have as many rows as you need. “Hide” the lines of the table. Format the entire table for double line spacing (do not use hard returns).

**Sample excerpt of conversation analysis:**

**Excerpt 1: Emilie**

1. Interviewer (I): What happened after 2 that? 3 Emilie (E): Well, after that I 4 walked to the corner without my 5 friend, because he took too long 6 getting ready to go. 7 I: How did you feel walking there 8 by yourself? 9 E: I was a little bit nervous, 10 ‘cause I’m not used to going places 11 by myself.

Note that the sample does not contain transcription symbols. When these symbols are used, cite and reference the transcription style, add a note explaining the symbols if only a few are used, or add a note advising the reader to contact the corresponding author for a key to the symbols.

**WHAT YOU SHOULD NOT DO**

Conversation ■ Do not include a list of the transcription conventions in the manuscript if more than 5 analysis symbols have been used.

15
Ellipses
Emphasis
General formatting
Headings
Line spacing
Margins and indentations
Quotations
Seriation
■ Do not use the “Insert > Symbol” function in Word to enter ellipses. ■ Do not use ellipses to indicate pauses in speech. ■ Do not place ellipses within parentheses ( . . . ) or brackets [ . . . ]; the only exception to this is in conversation analysis, as appropriate for the conventions used.

■ Do not use *italics*, **bolding**, underlining, or ALL CAPITAL LETTERS for emphasis. ■ Do not use *italics* for quotations (long or short). ■ Do not use **bolding** except for level-1 headings, as appropriate (see below).

■ Do not add any special formatting to the document, such as increased line space before and/or after headings.

■ Do not follow APA guidelines for headings; format your headings *only* as described in these QHR Guidelines.

■ Do not use any headings (such as Introduction or Background) at the beginning of the manuscript.

■ Do not create double spacing with hard returns (by striking the “enter” key twice). ■ Do not leave blank lines between paragraphs (with the exceptions of after block quotes/excerpts, bulleted or numbered lists, or sections of conversation analysis; see below).

■ Do not use full justification for any portion of your manuscript. The text at the right-hand margin *should be uneven* (irregular).

■ Do not make indentations using tabs, or by using two, .25” indentations to achieve a .5-inch (approximately 1.3 cm.) indentation.
Do not change margins to create indentations. Do not change the margins for block quotes (margins should remain at 1", or approximately 2.5 cm., on all sides).

Do not use any quotation marks for block quotes unless there is a separate, shorter quote contained within the larger quote; in such a case, use double quotation marks (e.g., Xxxxxx, “Yyyy,” xxxxx.) only for the “inner” quote.

Do not use numbers of any type for in-text seriation; use only (a), (b), (c), and so forth.

“Review” Your Manuscript

One common reason for “revise” decisions is that authors are sometimes so immersed in their data and findings that they lose track of:

• whether the information presented contributes new knowledge
• whether the appropriate method and design have been used
• whether ethical standards have been met
• whether the information is presented in a complete, concise, and logical manner, with attention to writing style, and
• what the reader needs/wants to know (remember that QHR readers have expertise in diverse areas, and therefore many will not be familiar with concepts and terminology common to your research area)

Before submission, we recommend an informal peer review of your article, using the criteria shown on page 55.

Prior to Submission

• Make sure your entire manuscript is prepared in accordance with these Guidelines in every respect.
• Have your manuscript professionally edited by an expert in the English language. This is especially important if English is not your first language. Remember to inform your editor of the need to use U.S.-English spelling, and provide him or her with a copy of these Guidelines.
• Proofread your manuscript aloud; doing so will help you identify awkward phrasing, run-on sentences, incomplete sentences, improper punctuation, missing text, and much more. We recommend that the corresponding author and all coauthors proofread the entire manuscript (including abstract and references) from a paper copy rather than a computer screen.

Your keywords are words related to the article topics that readers or researchers could search on to find your published article. They are also used to assist QHR in selecting appropriate reviewers for your manuscript during the review process. Keywords should follow on the same page as the abstract. Leave a blank, double-spaced line between the abstract and the keywords (see the sample manuscripts beginning on page 35). Include keywords selected only from the QHR Keyword List, below. List them exactly as they are shown in the keyword list, in lowercase letters (except for proper names), horizontally across the page, in the order in which they appear on the keyword list. Try to select at least five keywords. Use the most specific keywords possible from the list provided. Individual keywords should be separated by semicolons; note that some keywords are actually two or more words, and might include commas. Do not capitalize the first keyword unless it is a proper name (i.e., Africa), and do not add a period (full stop) at the end of the keywords.

You may request that new keywords be added to the list, but the words should be general in nature, and not specific to a narrow topic. New keywords will be added at the editor’s discretion.

QHR Keyword List

Note: We recommend reading the entire list to identify the most relevant keywords. Remember that the keywords might not be listed exactly the way you think of them (the specific words and the order of words might be different).

Keywords

asthma
attachment / bonding attention-deficit hyperactivity disorder (ADHD) autism autoethnography
behavior change bereavement / grief biographical analysis bipolar disorder bisexuality blood
body image boundaries brain injury breastfeeding burn injury, burns burnout
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cancer cancer, breast cancer, genetics cancer, psychosocial aspects cancer, screening and
prevention caregivers / caregiving Caribbean people / cultures case studies cerebral palsy
childbirth children children, disability children, growth and development children, illness and
disease China, Chinese culture clinical supervision CNAs coding cognition Colaizzi comfort /
comforting communication communication, medical community and public health community
capacity and development community-based programs comparative analysis complexity
cancer concept analysis concept development concept mapping confidentiality / privacy constant
comparison constructivism consumerism / marketing content analysis contraception
critique conversation analysis coping and adaptation crisis management critical incident technique
critical methods culture / cultural competence cystic fibrosis data collection and management
death and dying decision making delirium Delphi technique dementia depression descriptive
methods developing countries diabetes diaries / journals dignity dimensional analysis
disability / disabled persons disability, developmental disability, learning
discharge planning discipline / subdiscipline disclosure discourse analysis disfigurement
Down syndrome dramaturgical analysis eating disorders education, patient education,
professional embodiment / bodily experiences emergency care emotions / emotion work
empathy end-of-life issues enduring environment epidemiology epilepsy epistemology ethics /
emoral perspectives ethnicity ethnography ethnoscience ethnomethodology ethology Europe, Eastern
Europe / Europeans Europe, Western euthanasia event analysis evidence-based practice exercise /
physical activity exercise / physical activity, older people experiential methods exploratory
methods falls / falling families families, caregiving families, high-risk fathers, fathering
fatigue / exhaustion feminism fertility / infertility fibromyalgia focus groups Gadamer gays
and lesbians gender genetics geriatrics Giorgi grounded theory group
interaction healing health and well-being health behavior health care health care
administration
18
health care disparities health care professionals health care screening health care, access to
health care, alternative and complementary health care, acute / critical
health care, culture of health care, economics of health care, international health care,
terprofessional health care, long-term health care, managed health care primary health
care, remote / rural health care, teamwork health care, transcultural health care, users'
experiences health care, work environment health informatics health information seeking
health insurance health outcomes health policy / policy analysis health promotion health
seeking health, determinants of hearing / deafness heart health Heidegger hepatitis C
hereditary diseases hermeneutics heuristic techniques HIV/AIDS HIV/AIDS prevention holistic
care homelessness hope human resources humanistic perspectives humor Huntington’s
disease Husserl hypertension illness and disease illness and disease, chronic illness and
disease, experiences illness and disease, infectious illness and disease, life-threatening /
terminal illness and disease, prevention illness and disease, progressive illness and disease,
social construction immigrants / migrants immunization induction infants infants, high-risk
instrument development intensive care unit (ICU) Internet
interpretative phenomenological analysis (IPA) interpretive description interpretive methods
intervention programs
interviews interviews, electronic interviews, semistructured interviews, unstructured
knowledge construction knowledge transfer language / linguistics Latino / Hispanic people lay
concepts and practices legal issues leukemia library methods life history literature lived body lived experience longitudinal studies marginalized populations
masculinity medical record medicalization medication medicine medicine, traditional / folk
memory men's health menopause mental health and illness mental health and illness,
children / adolescents mental health nursing mentoring Merleau-Ponty meta-analysis meta-
ethnography metasynthesis Mexican Americans Mexico, Mexicans Middle East, Middle
Eastern people midlife midwifery minorities model building mothers, mothering motivation
multiculturalism multiple sclerosis (MS) musculoskeletal disorders narrative inquiry naturalistic
inquiry nephrology network analysis neurology neuropsychology nursing nursing, community
19
nursing, cross-cultural nursing, maternity nursing, palliative care nursing, pediatric nutrition / malnutrition obesity / overweight observation observation, participant occupational health older people
oral health / dentistry organ donation organizations Pacific / Pacific Islanders pain
pain, chronic palliative care parenting Parkinson's disease participation, social participatory action research (PAR) pediatrics
performance perinatal health pharmacology phenomenography phenomenology philosophy philosophy
photography / photovoice physical therapy
politics postpartum care posttraumatic stress disorder (PTSD) poverty power / empowerment practice guidelines pregnancy pregnancy, unwanted pregnancy, high-risk prisons, prisoners problem solving program evaluation psychiatry psychology psychosocial issues qualitative analysis quality improvement quality of care quality of life race racism recovery reflexivity refugees rehabilitation relationships relationships, health care relationships, parent-child relationships, patient-provider relationships, primary partner relationships, research reliability religion / spirituality reproduction research design research evaluation research participation research, research, research, research, research, research, research, research, research, research, research, research, research, research, research, research, research, research, research, research, research, research, research, research, review
access to participants action clinical collaborative cross-cultural cross-language dissemination and utilization interdisciplinary mixed methods online qualitative quantitative rural Ricoeur risk risk, behaviors risk, perceptions ritual safety, patient SARS schizophrenia self self-care self-efficacy self-harm self-help sensitive topics sex workers sexual harassment sexuality / sexual health situational analysis sleep / sleep disorders smoking cessation social constructionism social development social equality / inequality social identity social issues social services social support social work sociology sorrow spinal cord injury statistics stigma stories / storytelling stress / distress stroke
20 suffering suicide surgery surgical enhancement surveys / questionnaires survivorship symbolic interactionism symptom management systematic reviews teaching / learning strategies technology technology, assistive technology, institutional technology, medical technology, use in research theory development tobacco and health translation transplantation transsexuals trauma triangulation trust tuberculosis (TB) uncertainty urban issues validity van Manen violence violence, against women violence, domestic vision visual method vulnerable populations war, victims of weight management women's health women's health, midlife women's issues workplace wound care young adults

August 23, 2011

MANUSCRIPT PREPARATION

ELEMENTS OF A MANUSCRIPT Note: Some instructions differ for accepted manuscripts; please refer to page 28.
The following elements are required for each manuscript, and should be compiled in the following order:
Title page Abstract Keywords
Main manuscript References
Submit the title page as a separate document.
The abstract is placed on page 1 of the main document. Place the keywords below the abstract, on the same page. Leave a (double-spaced) blank line between the abstract and the keywords.
The main text of the manuscript begins on page 2 of the main document. References begin on a new page, after the end of the manuscript text, or after the notes, if any (do not submit references in a separate document). The following elements are optional, and may be included in your submission:
Notes
Tables
Figures Appendices
Place notes (also known as endnotes) after the main text, before the first page of references.
Place tables, *one per page*, at the end of the main manuscript document, after the references (do not submit tables as separate documents).
Submit each figure in a *separate document*, in order, by number.
Appendices are published *only at the editor’s discretion*. Place any appendices after the reference list, and before any tables (place them before the bios in accepted manuscripts).

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**PREPARATION OF MANUSCRIPT ELEMENTS**

A maximum of four (4) *types* of documents should be submitted: (a) title page; (b) main manuscript; (c) figures (if any); and (d) permissions (if needed). Despite what the online submission system (ScholarOne Manuscripts / SageTrack) might allow, *do not submit such elements as abstracts, references, and tables in separate documents*. Be sure to refer to the sample manuscripts, beginning on page 35.

**TITLE PAGE**

The title “page” may be longer than one page. To maintain author anonymity during peer review, it is submitted as a *separate document*. Title page information *should not be included* in the main manuscript document. *Do not format a running header*. The title page should include the following, *in this order*:
- Article title
- Author names
- Author affiliations
- Corresponding author information
- Author’s / Authors’ Note
- Acknowledgments

A title should convey, as clearly and *succinctly* as possible, the main idea, focus, or content of a manuscript. It should be clear in meaning even when standing alone.

Make your title 10 to 12 words (or fewer) in length; avoid long, “wordy” titles.
Avoid titles with colons or quotations unless they are *necessary* to convey an important concept or idea in the article.
Type your title in *Title Case*; this means you should:
* capitalize the (first letter of) the first word
* capitalize all important words
* capitalize *all words that have four (4) or more letters*
* capitalize the first word after a colon (:), period (.), or em dash (—)

List the name (not just initials) of each author, *without credentials*, in order, horizontally across the page.
If there are two authors, list them as follows: Janice M. Morse and Author Two
If there are three or more authors, list them as follows: Janice M. Morse, Author N. Two, Writer Three, and Fourth Author (and so forth)
After each name (or after the comma following a name, if applicable), use a superscript number to link that particular author with his or her *primary affiliation* (see the section on author affiliations, below).

Using the same superscript numbers as used with the authors’ names (see above), list *only the primary affiliation* of each author, not multiple affiliations (see the sample manuscripts).
Spell out all city, state, and country names (exception: use USA instead of United States).
Spell out any organization or institution names (for example, *University of Utah* instead of *U of UT*, or *World Health Organization* instead of *WHO*).
Use *only* the following format for the corresponding author information, and *do not include* any information that is not listed below. List information only for the individual who should be contacted by readers after (if) the article is published. Note that this should be a *complete mailing/postal address*. Example:
- Janice M. Morse, University of Utah College of Nursing, 10 S. 2000 E., Salt Lake City, UT 84112-5880, USA Email: QHR-Editor@nurs.utah.edu

*This is optional.* This is the place to mention, perhaps, that portions of the article were presented at a professional meeting, or other information of that sort.

*This is optional.* The section is limited to two (2) or three (3) *brief* sentences. Overlong acknowledgments will be reduced at the copyeditor’s discretion. Do not include long descriptions of persons being acknowledged, and do not include roles, titles, or credentials.

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Declaration of conflicting interests
Funding

Bios

Avoid phrases such as We wish to thank, We would like to thank, and We want to thank; just use a simple, We thank, or We acknowledge.

You must use one of the following statements, in the exact words shown below.

If you have no conflicts of interest (or potential conflicts of interest):
The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

If you have conflicts of interest:
The author(s) declared the following potential conflicts of interest with respect to the research, authorship, and/or publication of this article: [Then, in sentence form, list all specific author relationships with organizations and/or products that were declared].

You must use one of the following statements, in the exact words shown below.

If you did not have financial support:
The author(s) received no financial support for the research, authorship, and/or publication of this article.

If you did have financial support:
The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: [Then list, in sentence form, all entities/organizations that funded the research and/or authorship].

Bios are simple and concise, 1-sentence statements about each author. Long bios will be reduced by the copyeditor. In this space you may include department or division names, and secondary affiliations (if any). Use only the format shown below for your bios. Note that primary credentials (the most important only, with a limit of three per person; QHR does not publish long credential strings) and current positions (or affiliations or professional pursuits) are required.

Janice M. Morse, PhD, FAAN, is a professor and presidential endowed chair at the University of Utah College of Nursing in Salt Lake City, Utah, USA.

[Template: Name, bolded, credentials, role or title, affiliation (here you may include department, school, division, and so forth), city, state or province (if any), country.]

ABSTRACT AND KEYWORDS

The abstract should be placed at the top of page 1 of the main manuscript document. It should be a single paragraph, no more than 150 words in length, and briefly describe your article. It should not contain headings or citations, and should not be divided into sections.

Place your keywords below the abstract, on the same page (see "Keywords," above). Double space the entire abstract page (including the keywords). Briefly state the purpose of your research, the main findings, and your primary conclusions. Make sure the abstract is written in the first-person, active voice.

MAIN MANUSCRIPT

Note that the sample manuscripts beginning on page 35 are abbreviated for illustration purposes, and might not contain all optional elements that could be included in an actual manuscript. The sample articles contain all four heading levels.

The main text of the manuscript begins at the top of page 2 of the document, immediately after the abstract page. Write your article in the first-person, active voice.

The main text of the manuscript should be broken into appropriate sections by the use of section headings. Sections should flow in a logical sequence, and include, at a minimum, Methods, Results, and Discussion (these are all level-1 headings); other level-1 headings and subheadings may be used at the author's discretion. The author may choose to use different names for the three main sections, but the basic content should be that which would appropriately fall under the headings of Methods, Results, and Discussion.

There are very specific requirements for the preparation of in-text citations; refer to the APA Publication Manual, 6th edition, for details. Every in-text citation should have a corresponding reference in the reference list—no exceptions.

During the review process, author citations should include only the word Author and the year: (Author, 2008). If and when the manuscript is accepted for publication, the missing information can be restored.

Double space the entire manuscript document, except for text contained in figures. Use only U.S.-English spelling (except in the references, as appropriate, and for direct quotations from published written sources). Use U.S.-English translations of non-English quotations or
excerpts. Use a minimum of two (2) heading levels.
Attend to copyright regulations and permission requirements *(required).* Submit, at the time of manuscript submission, written permission for the use of any names, photographs, or copyrighted tables, figures, and/or text; written permission must come from the person(s) depicted in the photographs, or in the case of copyrighted work, from the copyright holder (which is not necessarily the author or the journal in which it is published; see page 7).

**REFERENCES**

*Note:* Proper formatting of the reference list is the responsibility of the *author*, NOT journal personnel. The reference list (also known as a bibliography) should include complete references for the sources used in the preparation of your manuscript. *Every reference must be cited in the text.*

The reference list should begin on a separate page (not in a separate document) following the last page of manuscript text (or after the notes, if any). Each type of reference (journal article, book, chapter in edited book, newspaper, online reference, and so forth) must be formatted in accordance with the precise guidelines contained in *APA, 6th* edition. *Elements such as listing order, spelling, punctuation, spacing, capitalization, and the use of italics or Roman (regular) font are as important as the content of the reference.* Note that if an author has two or more initials, there should be spaces between the initials; incorrect = X.Y.Z.; correct = X. Y. Z.

References should be listed in hanging paragraph format (with indentations at 1/2 inch or 1.3 cm.), in alphabetical order by the last name of the first author; additional considerations might apply (see *APA*). The hanging paragraphs should be created by using Word’s Format > Paragraph feature.

During the review process, author references in the reference list should include only the word “Author” and the year: *Author.* *(2008).* To prevent author identification during the review process, do not include the article title, journal name, or any other part of the reference. Do not place these references in alphabetical order in the reference list; place them at the very beginning or very end of the list. If and when the manuscript is accepted for publication, the missing information can be restored and properly placed.

*Avoid the use of unnecessary references and lengthy reference lists.* Extensive bibliographies will not be published; articles should include only the “essential” or key references. If the author wishes to offer a secondary reference list (for example, references used in meta-analysis), it should be so stated in a note, and made available to readers by contacting the author directly. Do not include such a list in the manuscript document, but it may be submitted separately for purposes of review.

*Use only the 6th edition of the* Publication Manual of the American Psychological Association *(APA)* *as your source of instruction for references* (this is critically important). Translate non-English titles into English (see *APA* for instruction on how to do this). Reference and cite all other studies mentioned in the article. Test all Internet URLs (Web addresses) immediately before submission to ensure that they are accurate, and that the sites are still accessible; do this prior to submission of all revisions and accepted manuscripts, as well.

**APPENDICES**

Appendices are not encouraged, and are published only at the editor’s discretion. If included, appendices should be placed in the main manuscript document following the reference list, and before any tables (place them before the bios in an accepted manuscript). *Appendices must be referred to in the text.*

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**WHAT YOU SHOULD NOT DO**

Title page
Abstract
Main document
References
- Do not type your title in ALL CAPITAL letters (this is especially important when entering the article title in the ScholarOne Manuscripts / SageTrack system).
- Do not place a period (full stop) at the end of your title.
- Do not include unnecessary words, such as *A Qualitative Study, A Doctoral Student’s Investigation of, An Ethnographic Study,* and so forth.
- Do not list secondary or additional author affiliations (departments, divisions, hospital units, and so forth).
- Do not use abbreviations (except USA).
- Do not include department or division names, or secondary unit names.
- Do not include the manuscript
CITATIONS

AVOID COMMON PROBLEMS:

→ APA has stipulated a particular format for each specific reference type; be sure to use the correct format. Note that not all types of periodicals are referenced in the same manner as journal articles.
→ References and citations should be prepared with exactness and attention to detail. The order of listing, spelling, punctuation, spacing, capitalization, and use of italic or Roman font are all important.

CHECKLIST:

☐ Spell out all journal names, and provide complete page numbers (e.g., 172-185 rather than 172-85).
☐ “Blind” your personal (author) references and citations as noted in the Guidelines.
☐ Double check the spelling of all reference author names, and ensure that both spelling and years of publication are consistent between the reference list and the in-text citations.
☐ Provide English translations for all non-English titles (retain the original titles).

GOAL:
☐ Format your references in hanging-paragraph style and double line spacing. Indent the “hanging” text by 1/2 inch (approximately 1.3 cm.), using Word’s “Format > Paragraph” feature.

TABLES
To organize and present relevant data that would be too cumbersome or complex to write into the text. Our standard is space. If your material can be more efficiently presented as text, do not make a table. A table must not duplicate material already appearing in the text.
Read the instructions for table preparation on page 29 of the QHR Manuscript Guidelines. Place each table on a separate page at the end of your manuscript document.

AVOID COMMON PROBLEMS:

→ The typesetting process removes all bullets from tables (whether numerals, letters, or dingbats); do not use them.
→ The use of underlining, all uppercase (capital) letters, and italics can make a table look busy and cluttered, and can obscure important data. Use these features sparingly or not at all. Use bold font sparingly.

CHECKLIST:

☐ To maintain anonymity, present participant characteristics in aggregate (group) form, and refrain from listing individual participant characteristics.
☐ Make sure your table has a minimum of two (2) columns, a minimum of two (2) rows, and a clear and concise heading for every column. Double space the table.
☐ Create your table in “portrait” orientation on the page, within the regular 1- (approximately 2.5 cm.) margins of the document.
☐ Give your table a clear, descriptive, and concise title. Place individual data items or grouped data in separate rows of the table, rather than placing multiple items in a single row.

FIGURES
To create useful and coherent figures that clarify complex concepts or accurately illustrate models and/or processes.
See the instructions for preparing figures on page 31 of the QHR Manuscript Guidelines. Make your figure simple, clear, and easy to read and understand.

AVOID COMMON PROBLEMS:

→ Put your efforts into presenting clear, meaningful data rather than “fancy” or artistic creations. Achieving simplicity, accuracy, and clarity should be your goals.
→ Do not use shading, color, or bolded font.
→ Too many lines and arrows, and especially lines and arrows that cross each other or cross text boxes, can lead to confusion and make a “muddle” of a figure, obscuring rather than revealing intended meaning. Do not use “heavy” or “bolded” lines and arrows.

CHECKLIST:
☐ Prepare and submit each figure in a separate document.
Create your figure to be read from left to right and from top to bottom.
- Arrange text boxes in an orderly fashion, making them no larger than necessary to contain your text.
- Make your lines and arrows the proper length, so their beginnings and endings join the cells and clearly indicate direction.
- Use single line spacing for the text, and place the text in a horizontal orientation so it is not necessary to turn the document to read the figure.
- Give your figure a clear and concise title or legend. Include any notes after the title or legend rather than placing them below the figure.
- If using a participant’s artwork, be sure the lines are sufficiently distinct and dark enough to reproduce well if printed in the journal.

**INSTRUCTIONS FOR ACCEPTED MANUSCRIPTS**

If your manuscript has been accepted pending minor revision, the instructions for placement of certain manuscript elements differ from those for manuscripts under review. See the sample manuscript beginning on page 42. When preparing your final manuscript, compile and submit the various manuscript elements in the following order:

1. **TITLE PAGE**
2. **ABSTRACT & KEYWORDS**
3. **MAIN MANUSCRIPT TEXT**
4. **AUTHOR’S/AUTHORS’ NOTE**
5. **ACKNOWLEDGMENTS**
6. **DECLARATION OF CONFLICTING INTERESTS**
7. **FUNDING**
8. **NOTES**

**Required**

Insert your title page at the very beginning of your manuscript, before the abstract page; *do not submit it as a separate document*. Move other elements from the title page to other places, as instructed below, leaving only the following on the title page (in this order):
- Article title
- Author names
- Author affiliations (Note: List *primary* affiliation only; e.g., university)
- Corresponding author information

**Required** except for book reviews, letters to the editor, and guest editorials

Start the abstract at the top of the page after the title page. Leave a blank, double-spaced line between the end of the abstract and the beginning of the keywords.

**Required**

Start the main manuscript text at the top of the page after the abstract and keywords page.

**Optional**

At the end of the manuscript text, simply hit “enter” (or “return”), and begin the author’s/authors’ note (if any), with the heading and text on separate lines.

**Optional**

At the end of the author’s note (or the end of the manuscript text, if there is no author’s note), hit “enter” and begin the acknowledgments (if any), with heading and text on separate lines.

**Required**

At the end of the acknowledgments (or author’s note, if there are no acknowledgments, or the end of the manuscript, if there are neither acknowledgments nor author’s notes), hit “enter” and type the conflicting interests heading and appropriate statement (on separate lines).

*Note:* You are required to use the *specific language* designated in the “Preparation of Manuscript Elements” section, beginning on page 22.

**Required**

At the end of the conflicting interests statement, hit “enter” and place the funding heading and appropriate statement on separate lines. *Note:* You are required to use the *specific language* designated in the “Preparation of Manuscript Elements” section, beginning on page 22.

**Optional**

After the funding statement, hit “enter” and place the numbered notes on separate lines. Do not use superscript numbers in the notes list.

**REFERENCES**

**APPENDICES**

**BIOS**

**TABLES**

**FIGURES**

**Required**
Begin the references on a new page (but not in a separate document).

**Optional** [published at the discretion of the editor] Begin each Appendix on a separate page, with an appropriate Appendix number, followed by the title of the Appendix (required).

**Required**
At the end of the references (or appendices, if any), hit “enter” and place the biographical statements, one per line.

**Optional**
Place each table on a separate page after the bios. Be sure to place your tables in the main manuscript document, and not in separate documents.

**Optional**
Figures are to be submitted in separate documents (one figure per document), and formatted as describe in the “Figures’ section, page 31. Include the figure number in the document (file) name (i.e., Figure 1.doc).

### TABLES

**Note:** QHR personnel neither create nor make significant revisions to tables; this is the responsibility of the author.

Tables organize relevant, essential data that would be too awkward or too lengthy to include in the text, and should be used only to provide data not already included in the text. For example, grouped participant demographics take less space presented in a descriptive paragraph than they do as a table.

Tables are to be accompanied by both their number (Table 1, Table 2, and so forth) and their title (required).

Tables and table placement are mentioned in the text, but the tables themselves are placed at the very end of the main manuscript document. The author should designate placement of each table within the manuscript by entering (flush left, on a separate line between paragraphs), **INSERT TABLE 1 ABOUT HERE.** Table callouts should be placed following the paragraph in which they are first mentioned.

Create the table the way it should appear when published, then double space all text, including column headers and notes.

Use Gill Sans font style for table numbers, titles, content, and any explanatory notes. Use 12-point font for the table number and name, and use 8-point font for table content and explanatory notes.

“Hide” all vertical lines and all horizontal lines except the following: top line of table, bottom line of table, and line below the main column headers. Multiple tables within the same manuscript should be similar in appearance and design. (See the sample table, below.)

**Considerations:**

- Make sure that what you are trying to create actually is a table; all tables must have column headings, at least two (2) columns, and at least two (2) rows. Most simple lists do not qualify as tables.
- You must actually create a table, even though most lines will be hidden. Put each table on a separate page (not in a separate document).
- Use only portrait orientation for your tables. Include only necessary data.
- Ensure that all abbreviations are explained in the notes.
- Ensure that the table is clear and comprehensible even without the surrounding article text (it should be able to “stand alone”).
- Make your table titles concise and descriptive.
- Keep your table as small as possible; use only the space necessary to contain your data. To fit within a single column of the journal, the table should be no wider than 31/8 inches (approximately 8 cm.); to fit across both columns it should be no wider than 6 inches (approximately 15.25 cm.). Narrow the table columns to eliminate unused “white” space.
- Place explanations, clarifications, citations and source notes, symbol and abbreviation identification, and other “nondata” information in notes below the table.

**WHAT YOU SHOULD NOT DO**

- Do not use shading or color, or overuse bolding and/or italics (which can detract from a table, making it look “busy” without enhancing it in any way); do not use “heavy” or bolded lines.
- Do not list participants individually; instead, present group characteristics. Do not set
tables in landscape orientation. ■ Do not use bullets or numbered lists in tables. ■ Do not make simple lists into tables; instead, place the lists in the manuscript text.

Sample table:

<table>
<thead>
<tr>
<th>Table 1. Name of the Table, Bolded, in Title Case</th>
</tr>
</thead>
<tbody>
<tr>
<td>Column Heading</td>
</tr>
<tr>
<td>Data</td>
</tr>
<tr>
<td>Data</td>
</tr>
</tbody>
</table>

Secondary line of data

Data Data Data

Place notes here

Data Data Data Data Data Data Data Data

30

FIGURES

*Note: QHR personnel neither create nor make significant revisions to figures; this is the responsibility of the author.*

Like tables, figures should be used *sparingly,* and only when it is *necessary* to clarify complex relationships or concepts.

Use Gill Sans font for the figure number, title, text, and notes (if any). Single space all text contained *within* a figure (but not the figure number, figure title/caption, and notes, which should be double spaced).

Figure placement should be mentioned in the manuscript text, but each figure *is to be submitted in a separate document,* with the figure number and figure title on the first page, followed by the figure itself on the second page. Figure titles/legends should be *concise* and *descriptive.*

The author should designate placement of each figure within the manuscript by entering (on a separate line between paragraphs) *INSERT FIGURE 1 ABOUT HERE.* Figure callouts should be placed following the paragraph in which they are *first* mentioned.

*Note:* Regular Word.doc documents are *strongly preferred* over .jpg or other document types, and are easier to revise, if necessary.

See APA for requirements regarding the use or adaptation of copyrighted (previously published) material. **CONSIDERATIONS:**

- In the published journal, photographs and other images are referred to as “figures.”
- Use only Gill Sans font for figure numbers, titles, text, and notes (if any).
- Put each figure in a separate document.
- Use only 8-point font for figure text and notes.
- Make sure your figure is created to be read from *left to right, from top to bottom.*
- Use sufficient space between figure elements to ensure clarity, but eliminate unnecessary space.
- Make sure that hand-drawn figures (such as participant artwork) are dark enough to reproduce clearly when published.
- Use bolding and italics *sparingly,* and underlining only if absolutely necessary.
- Place your figure number and title/legend on the first page of the figure document (use Gill Sans 12-point font, double spaced).
- Place the figure itself on the second page of the figure document.
- Make sure your figures have “crisp,” clean lines and text. “Fuzzy” figures are not acceptable, and scanned figures are generally fuzzy.
- Keep figures simple, with as few lines, boxes, and arrows as possible; use plain arrows and solid, nonbolded lines. The style of the various elements of your figure must be consistent. Be careful about spacing and alignment of elements, including beginnings and endings of lines and arrows.
- Be aware that QHR does not publish in color; hand-drawn artwork and all photographs will be published in black and white only.

**WHAT YOU SHOULD NOT DO**

- Do not double space text within figures.
- Do not use shading or color.
- Do not place your figure inside an invisible “box” or “frame”; in other words, do not save the figure as a single item; save it as a collection of discrete elements, each of which can be corrected if necessary.
- Do not include your figures in the main manuscript document.

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*Sample figure, page 1 of figure document:*
Appendix 2 – The CASP Criteria
Critical Appraisal Skills Programme (CASP)

The 10 questions are adapted from Guyatt GH, Sackett DL, and Cook DJ, Users’ guides to the medical literature. II. How to use an article about therapy or prevention. JAMA 1993; 270 (21): 2598-2601 and JAMA 1994; 271(1): 59-63
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Screening Questions

1. Did the study ask a clearly-focused question?
Consider if the question is ‘focused’ in terms of: – the population studied – the intervention given – the outcomes considered.

2. Was this a randomised controlled trial (RCT) and was it appropriately so? Consider: – why this study was carried out as an RCT.
– if this was the right research approach for the question being asked

Is it worth continuing?

Detailed Questions.

3. Were participants appropriately allocated to intervention and control groups? Consider:
– how participants were allocated to intervention and control groups. Was the process truly random?
– whether the method of allocation was described. Was a method used to balance the randomization, e.g. stratification?
– how the randomization schedule was generated and how a participant was allocated to a study group
– if the groups were well balanced. Are any differences between the groups at entry to the trial reported?
– if there were differences reported that might have explained any outcome(s) (confounding)

Yes  Can’t tell  No

Yes  Can’t tell  No
Yes  Can’t tell  No

4. Were participants, staff and study personnel ‘blind’ to participants’ study group? Consider: – the fact that blinding is not always possible

– if every effort was made to achieve blinding – if you think it matters in this study – the fact that we are looking for ‘observer bias’

5. Were all of the participants who entered the trial accounted for at its conclusion?

Consider:

– if any intervention-group participants got a control-group option or vice versa

– if all participants were followed up in each study group (was there loss-to-follow-up?)

– if all the participants’ outcomes were analysed by the groups to which they were originally allocated (intention-to-treat analysis)
what additional information would you liked to have seen to make you feel better about this

6. Were the participants in all groups followed up and data collected in the same way?

Consider:
– if, for example, they were reviewed at the same time intervals and if they received the same amount of attention from researchers and health workers. Any differences may introduce performance bias.

7. Did the study have enough participants to minimise the play of chance?

Consider:
– if there is a power calculation. This will estimate how many participants are needed to be reasonably sure of finding something important (if it really exists and for a given level of uncertainty about the final result).

Yes  Can’t tell  No

Yes  Can’t tell  No
8. How are the results presented and what is the main result?

Consider:
- if, for example, the results are presented as a proportion of people experiencing an outcome, such as risks, or as a measurement, such as mean or median differences, or as survival curves and hazards
- how large this size of result is and how meaningful it is
- how you would sum up the bottom-line result of the trial in one sentence

9. How precise are these results?

Consider:
- if the result is precise enough to make a decision
- if a confidence interval were reported. Would your decision about whether or not to use this intervention be the same at the upper confidence limit as at the lower confidence limit?
– if a p-value is reported where confidence intervals are unavailable

**10. Were all important outcomes considered so the results can be applied?**

Consider whether:

– the people included in the trail could be different from your population in ways that would produce different results

– your local setting differs much from that of the trial

– you can provide the same treatment in your setting

Consider outcomes from the point of view of the:

– individual

– policy maker and professionals – family/carers

– wider community

Consider whether:

– any benefit reported outweighs any harm and/or cost. If this information is not reported can it be filled in from elsewhere?

– policy or practice should change as a result of the evidence contained in this trial

__Yes__ __Can’t tell__ __No__
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Appendix 3 – Quality appraisal of the studies in the review
### Quality rating summary of the studies included in the metasynthesis

**Studies included in the metasynthesis**

<table>
<thead>
<tr>
<th>CASP Criteria</th>
<th>1</th>
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<td>A</td>
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</table>

**Key:**
- ☐ Indicates the study fulfils the criteria
- ☐ Indicates the study does not fulfil the criteria
- ☐ Indicates the presence of minor flaws
Appendix 4 – Walsh and Downe’s (2006) Criteria
Quality Rating Key – Walsh and Downe (2006)

**Key to Quality Rating:**

A – No or few flaws: The study has high credibility, transferability, dependability and confirmability.

B – Some or few flaws: The study has a few flaws which is unlikely to affect the credibility, transferability, dependability and confirmability.

C – Some or few flaws: The study has a few flaws which is likely to affect the credibility, transferability, dependability and confirmability.

D – Significant flaws: The study has significant flaws which are very likely to affect the credibility, transferability, dependability and confirmability.
Appendix 5 – Study information sheet: Parents
Parent Information Sheet

Introduction
We would like to invite your child to participate in research about parent training. This involves your child undertaking an interview on their experience of parenting after you have completed a parent training programme.

Purpose of the Study
The aim or purpose of the interview is to try and capture children’s perspectives of changes in parenting.

What will my child have to do if they take part?
Your child will be invited to an interview with Simeon Hanson who is the researcher for this study and a qualified Educational Psychologist with many years experience of working with children and families.

What will happen if my child takes part?
If your child agrees to take part s/he will be interviewed using a computer program called ‘In My Shoes’, which has been designed to be child friendly. The computer program asks children to choose pictures that represent themselves and their family at home. Simeon will then ask your child a series of questions about parent training and whether they have noticed changes in parenting.

If you or your child wishes you may choose to be present during the interview that is fine, you just need to tell me. The answers your child gives to the questions will be audio-taped and later transcribed to paper so that I can remember what has been said and go back to listen to the tapes time and again as part of analyzing the information I obtain.

Will my child’s data remain confidential?
Yes all data will be anonymised so that no child, family or identifiable data will be present on the recording or transcriptions. The anonymised audiotapes and transcriptions will be kept in secure and locked facilities at the University of Manchester for 10 years.

What are the risks to taking part?
There should be not expected risks to you or your child if you take part in this study. However, if you or your child becomes upset then you may wish to discuss this with Simeon and/or withdraw them from the study.

What are the benefits to taking part?
There are no direct benefits to you or your child from taking part in this study but it may help us to understand more fully the effect of taking part in the parenting program have on children and families in more detail.

What is there is a problem?
If you wish to complain about the conduct of this study then please speak to the researchers in the first instance and if you are still not satisfied please contact Dr. Rachel Calam at Manchester University's School of Clinical Psychology, 2nd Floor, Zochonis Building, Brunswick Street, Manchester M13 9PL (0161 3060401). Contact details can be found at the top of this sheet.

**Why is the research being done?**
Simeon is undertaking the research as part of a doctorate degree at the University of Manchester. His supervisor is:

- **Name:** Dr. Rachel Calam and Dr. Fiona Ulph
- **Address:** School of Psychological Sciences, 2nd Floor Zochonis Building, Brunswick Street, Manchester M13 9PL
- **Tel:** 0161 3060401
- **Email:** rachecalam@manchester.ac.uk; fionaulph@manchester.ac.uk

Simeon has an enhanced Criminal Records Bureau status and the research was approved by the University of Manchester.

**Will I be paid for my child’s participation in this study?**
Need to state if expenses will be paid or if gift vouchers are to be given to the children
You may choose to be present during your child’s interview.

**What will happen to the results of the research?**
At the end of the research Simeon will be required to submit a thesis for examination as part of his doctorate and also publish in academic journals and present his findings at conferences. Please be assured that if any quotes or data is used in these documents or presentations no names will be used and all quotes will be anonymised first.

**Who has reviewed this study?**
This study has been reviewed by an independent group of people known as an ethics committee. The ethics committee that reviewed this study was the University of Manchester Research Ethics Committee One who gave it a favourable opinion.

**Contact information**
Should you have any further questions or concerns about this study please feel free to contact Simeon on:

- **Name:** Simeon Hanson
- **Address:** School of Psychological Sciences, 2nd Floor Zochonis Building, Brunswick Street, Manchester M13 9PL
- **Tel:** 0161 3060401
- **Email:** simeonhanson@postgrad.manchester.ac.uk
Appendix 6 – Information sheet: Children
Young People’s Parent Training - Information Sheet

Please read this sheet carefully.

I would like to invite you to take part in my research study. Lets read the following information carefully and if you have any questions you can ask me or talk about it with a parent or guardian.

What am I doing?

I am here to listen to you!!

I am interested to learn about what people like you think about something called parent training. Some time ago, either your mum or dad attended a parent-training group and you may have noticed that they talk or behave differently with you now. I would like to find out if you have noticed a change in your mum and dad or in life at home generally. If you have not noticed any change that is ok.

Do I have to take part?

It is up to you to whether you want to take part or not. You can talk about it with a parent or guardian who will also have to give permission for you to take part. We will ask a parent or guardian to sign a form on your behalf if you want to take part. If you would like, your parent or guardian can be present during the interview.

What does the study involve?
The study involves a computer program where you choose pictures that relate to you and your family. I will then ask you some questions and the computer will help you to answer questions about an average day in your life and what you like and dislike. As you work with the computer, some of our talk will be audio-taped. This study \textit{WILL NOT} involve going in to hospital or having an injection.

\textbf{What will happen to me if I take part?}
If you want to take part, I will arrange with your parent or guardian when it would be the best time for me to come along and meet you and start the computer program.

\textbf{Why take part?}
I want to know what it is like being a child whose parents have gone through a parent training group and how best we can help children, young people and families in the future.

\textbf{Will personal details be kept confidential?}
All information discussed will be private unless you tell me something that makes me really worried that you might need some help to keep you safe.

\textbf{What if I change my mind?}
If you decide that you do not want to take part or you would like more time to think about it then that is ok.

\textbf{Who can I talk to for further information?}
You can talk to me, Simeon Hanson or a parent or your guardian.

\textbf{IF YOU HAVE ANY QUESTIONS PLEASE ASK.}
This research has been reviewed and approved by Manchester University's Ethics Committee One. Should you have any questions about the study please feel free to contact me at:

School of Psychological Sciences,
2\textsuperscript{nd} Floor, Zochonis Building,
Brunswick Street
Manchester M13 9PL
0161 3060401
simeonhanson@postgrad.manchester.ac.uk

\textit{Thank you for reading this information sheet}
Appendix 7 – Consent form
Consent Form

Project: Parent Training
Researchers: Mr. Simeon Hanson
           Dr. Rachel Calam
           Dr. Fiona Ulph

Please initial box

I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions.

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

I understand that my interview will be audio-taped.

I agree to the information being transcribed

I understand that all information will be anonymised and that any quotes Used in publications will not identify me in any way.

I agree to take part in the study

________________________ __________________________
Name of participant Date Signature

________________________ __________________________
Name of researcher Date Signature
Appendix 8 – Child’s assent form
Children's Assent form

Project: Parent Training
Researchers: Mr. Simeon Hanson
Dr. Rachel Calam
Dr. Fiona Ulph

Please Initial boxes if you agree

I have read and understood the information sheet for the study.

I have been able to ask questions about the study.

I know that my taking part in the study is up to me and my parent (s), and, I can stop taking part at any time if I want.

I know that if I would like to, my parent (s) can be with me during the interview

I agree to my interview will being taped and written down.

I know that my name and/or my parent(s) name will be taken out of any quotes so that no-one will know any information comes from me.

I have agreed to take part in this study

________________________
Name of participant

________________________
Date

________________________
Signature
Appendix 9 – Adult interview protocol
**Draft Semi Structured Interview Schedule - Adults**

<table>
<thead>
<tr>
<th>Rationale for the Question</th>
<th>(1) Can you tell me about how you came to hear about Parent Training.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishes rapport in a non-threatening manner and introduce to study.</td>
<td>PROMPTS</td>
</tr>
<tr>
<td>Addresses the parents’ perspective of parent training.</td>
<td>Who introduced you to the program?</td>
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<td>Explored an initial understanding of how parents perceived parent training.</td>
<td>How was the program explained to you?</td>
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<td>How did you feel about undertaking parent training?</td>
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<td>What was your understanding of parent training?</td>
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<td>What did you think would happen at parent training?</td>
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<tr>
<td>(2) Before undertaking parent training did you feel you needed parent training?</td>
<td>Before parent training how do you think others (children, grandparents, school, community) saw you as a parent?</td>
</tr>
<tr>
<td>Introduces parents to the more sensitive topic of struggling with parents.</td>
<td>Did you see yourself as a successful parent?</td>
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<tr>
<td>Allows parents to reflect on how they were as a parent.</td>
<td>How did you feel you were managing as a parent?</td>
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<tr>
<td>Will allow parents to compare parenting pre to post parent training and therefore address the research question of the effects of parent training.</td>
<td>What was going well for you as a parent?</td>
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<td>What difficulties were you having as a parent?</td>
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<td>How did these difficulties affect you and your children / family?</td>
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<tr>
<td>(3) Can you tell me about some times when you found managing your child's behaviour difficult before the parent training?</td>
<td>How often were you having difficulties managing your child's behaviour?</td>
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<tr>
<td>Allows concrete example of parenting difficulties to compare with later concrete examples of parenting post-parenting programme.</td>
<td>Did these difficulties occur at a particular time of the day?</td>
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<td>How difficult did the challenge of parenting get?</td>
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<td>How long did you struggle as a parent?</td>
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</table>
(4) How would you describe what happens at parent training?

PROMPTS

How many other parents were there?
How long did the sessions last?
How many weeks did the parenting program last?
How many times did you attend?
How were the sessions structured?
What did you think of the sessions?
Were there any sessions that were particularly good or bad – can you tell me more?
What was it like meeting and talking with other parents? Was it reassuring?
What were the lessons / messages that you remember from parent training?
If you could sum parent training up what would you say?
Was there anything you disagreed with about parent training?

(5) In what ways has parent training changed you as a parent?

PROMPTS

How have things changed for you as a parent?
Do you parent / behave differently – can you tell me about this?
How has parent training helped you?
Do you think your children have noticed a change in you? Can you tell me more?
Have others commented on how you have changed?

Explores in detail issues around the principal research question regarding what parents considered the most important aspects of parent training and the lessons learned in parent training.

Addresses the principal research question for parents of in what ways parent training has effected parenting practices and the effects of daily life on the family.
Appendix 10 – Interview schedule for children
Interview schedule for children

(1) Have you heard of ‘Triple P’ or parent training?

PROMPTS

What can you tell me about parent training?
Who told you about parent training?
When did they tell you about parent training?
How was parent training explained to you?
What was said about parent training?
What can you tell me about parent training?

(2) Did you used to get into lots of trouble with your mum/dad?

PROMPTS

What things did you get told off for?
Can you tell me about a time when you got told off?
How often did you have an argument with you parent (s)?
Was there a particular time or issue you used to argue about?
What did your parents use to say to you when you got into an argument?
What did your parents used to do during an argument?

(3) Before parent training / in the past how did your parents spend time with you

What kind of things did you do with your parents? – did they spend lots of time with you?

(4) What can you remember about the time your parent (s) attended parent training?

PROMPTS

Did they say anything to you about parent training?
Did they do anything different with you during parent training?
What differences did you see with your parents?

(5) After parent training have you noticed any differences in your parents?

PROMPTS
Do your parents do anything different with you since parent training? What kinds of things do they do different? Can you give me an example of how they behave differently now to in the past? Are there less arguments with your parents? Do you think other people have noticed a difference in your parent(s)? Has daily life at home changed and in what ways since parent training? Do you think and in what way has your relationship with your parent(s) changed since parent training? In what ways has your parents going through parent training changed you?

(6) What did you think of the computer package we used?

PROMPTS

How did you find the program? What ways did the program help you talk about things? Were some bits of the program better than other? Can you tell me more? How would you make the program better?
Appendix 11 – Ethical approval
Mr Simon Hanson
Trainee Clinical Psychologist
School of Clinical Psychology
Simeon.hanson@postgrad.man.ac.uk

ref: ethics/11044

19 July 2011

Dear Mr Hanson

Committee on the Ethics of Research on Human Beings
Hanson, Calam, Ulph, Mitchel: An Investigation into parents' and children’s perspectives of the triple P ‘Positive Parenting Programme’ (ref 11044)

I write to confirm that the amendments to the information sheet and consent form satisfy the concerns of the Committee and that the above project therefore has ethical approval.

The general conditions remain as stated in my letter of 3rd June 2011.

Finally, I would be grateful if you could complete and return the attached form at the end of the project or by March 2012, whichever is earlier. When completing this form, please reference your project as:

‘Hanson, Calam, Ulph, Mitchel: An Investigation into parents’ and children’s perspectives of the triple P ‘Positive Parenting Programme’ (ref 11044)’

Yours sincerely,

Katy Boyle
Secretary to University Research Ethics Committee 1