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Autobiographical memory, problem solving and coping strategies of parents referred for parent training

Rollinson, Lynne

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**Title: Autobiographical memory, problem solving and coping strategies of parents
referred for parent training.**

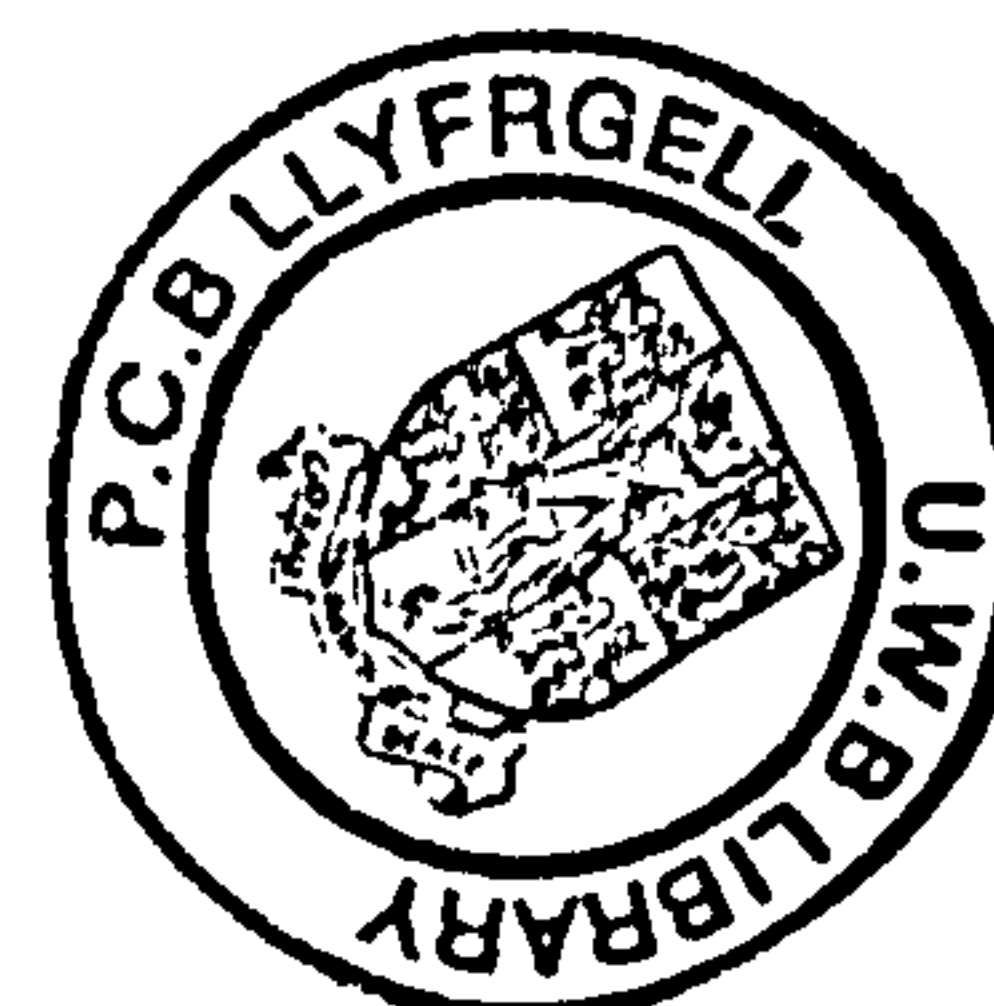
Lynn D. Rollinson - BSc (Hons).

**Thesis submitted in part fulfilment of the requirements of the degree of Doctor of
Clinical Psychology.**

University of Wales – Bangor

June 2004

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LIBRARY ONLY**



Acknowledgements.

A big thank you to all of the parents who gave their time to take part in this research- it would not have been possible without them. I would also like to thank colleagues at the Maelor Hospital and to the consultants and nurses within the dermatology clinic for their help. Thank you also to Patrick and Moira at Lawnside Child services for their time and support.

A big thank you to my mum who always had faith in me, and to Katie Elliott and Jean Abson for their friendship and laughs throughout these years.

Thank you to Dr. Richard Hastings for his encouragement and help, and to Dr. Judy Hutchings for her advice on the PCAMT.

I would like to express my sincere appreciation to my supervisor Dr. Elizabeth Burnside for her insight, feedback and support. Thanks also for finding the time to provide encouragement and supervision amongst so many other demands.

Lynn Rollinson

June 2004

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AUTOBIOGRAPHICAL MEMORY, PROBLEM SOLVING AND COPING STYLES OF PARENTS REFERRED FOR PARENT TRAINING

ABSTRACT

Parents of children with behavioural problems have been found to experience greater difficulties in problem solving (Pakaslahti, Asplund-Peltola, & Keltikangas-Järvinen, 1996, 1998), and to be less specific in their autobiographical memory (Hutchings, Nash, Williams & Nightingale, 1998). However, links between problem solving and the autobiographical memory recall of parents of children with behavioural problems has not yet been researched. Nor has research considered how these factors may relate to their coping strategies. This paper considers such links, particularly in relation to the tasks of behavioural training programmes.

Associations between the Parent-Child Autobiographical Memory Test (PCAMT, Hutchings, 1996), and the Autobiographical Memory Test (AMT, Williams and Broadbent, 1986) were explored. In addition, differences between parents referred for parent training (n=19), and a control group (n=15) were explored on autobiographical memory recall, problem solving (Problem Solving Inventory, Heppner & Peterson, 1982), coping strategies (Brief COPE, Carver, 1997), and depression (Beck Depression Inventory II, Beck, Steer & Brown, 1996). Relationships between these variables were also explored.

There were significant associations between AMT and PCAMT scores on both overgeneral recall ($r(34) = .59, p=.00$) and specific memory recall ($r(34) = .59, p=.00$). Overgeneral memories on both measures were significantly associated with emotion focused coping strategies (AMT, $r(34) = .49, p=.00$, and PCAMT, $r(34)=$

.36, $p=.04$). Group comparisons showed that parents referred for parent training reported significantly more maladaptive coping strategies than the control group, and more problem focussed coping, problem solving confidence and depression. However, no significant differences remained once depression was controlled for. Findings are discussed in relation to the tasks of parent training programmes, directions for future research and implications for clinical practice.

SECTION 1

Ethics proposal and amendments to protocol

~~Awdurdod Iechyd Gogledd Cymru~~
North Wales Health Authority
Research Ethics Committee
(West, Central & East sub-committees)

Important guidance notes accompany this form. Applicants MUST refer to the corresponding note before answering each question. Incomplete forms cannot be accepted.

1. Title of project : Autobiographical memory and coping strategies
in parent training programmes

2. Principal investigator :

name : Lynn Rollinson

address : School of Psychology, University of Wales – Bangor,
43 College Road, Bangor, Gwynedd, LL57 2DG

job title: Trainee Clinical Psychologist

telephone number: Through Bangor – 01248 382205
Personal Mobile number

3. Other investigators :

Dr. Elizabeth Burnside

4. Who is initiating this project?

Lynn Rollinson

5. Where will the research take place?

In participants' home or when participants attend a clinic, depending on participant's preference. Participants will already have been assessed for clinical groups, and therefore known to service, participants from local nursery will be known to nursery leader and where possible, participation will take place at the nursery.

6. Objectives of the project :

The project aims to

- i) explore the correlation between autobiographical memory for events in a carer's own life and that for events in their child's life.
- ii) To investigate cognitive factors and coping strategies and for parents referred to a parent training group, in comparison to another clinical group and a control group. These factors may, to some extent effect the success or lack of success of the parent training intervention. In the longer term, added to the existing body of knowledge, it is hoped that the research findings will assist in the development of more specialized interventions to meet the differing needs of parents.

7. Scientific background to the project :

Conduct problems are enormously costly to society and, given the size of the problem it is important that future research aims to identify underlying mechanisms which characterise such families in order to understand their difficulties more fully and design appropriate interventions. One potential mechanism which may account for some of these difficulties is autobiographical memory style.

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Autobiographical memory refers to memory for events from a person's own life history. Williams and Broadbent (1986) reported in a study of people who had recently attempted suicide that, in comparison to controls, the suicide attempters had difficulty in retrieving *specific* memories from their lives in response to cue words. The suicide attempters tended to respond with memories of categories of events such as 'Whenever I go to parties' rather than a single event that happened on a particular day. This same tendency to respond with 'overgeneral' memories has been reported in a range of clinical populations, including depressed patients (e.g. Williams & Scott, 1988) when compared with controls. Further evidence suggests that the origins of overgeneral autobiographical memory may be in traumatic childhood experiences, and particularly childhood sexual abuse (Kuyken and Brewin 1995, Henderson et al 2000) It has been suggested that an overgeneral style may serve to reduce negative affect associated with such events (Burnside, Byatt, Rollinson, Startup & Hill, 2002). The majority of the research in this area has been conducted using the Autobiographical Memory test (AMT, Williams and Broadbent, 1986)

Overgeneral autobiographical memory has been associated with parenting difficulties. Wahler and Afton, (1980) conducted a study of women who were experiencing problems in their relationships with their children. They reported that such women had difficulties in recalling specific details about their children's behaviours. Hutchings (1996) devised a parent - child version of the autobiographical memory test (PCAMT), in which participants are asked to remember events from their *child's* lives in response to cue words. Parents who had been referred for behavioural management advice regarding their children reported more overgeneral memories than parents in the control group. Although both AMT and PCAMT have been found to be associated with parenting difficulties, a direct comparison between the two measures is lacking..

One possible reason for the associations reported between memory style and parents referred for behavioural management is the relationship between autobiographical memory and problem solving skills. Evans, Williams, O'Loughlin and Howells (1992) studied problem solving in a group of parasuicidal patients. Problem solving was assessed using the Means End Problem Solving (MEPS, Platt & Spivack, 1975) test, in which participants are presented with vignettes representing problem situations, followed by the resolution of these problems. Participants are required to fill in the gap by describing how the problem may have been solved. Evans et al reported that the parasuicidal patients were more overgeneral than a group of controls, as well as generating poorer problem solving solutions. Moreover a positive correlation was reported between specificity of autobiographical memory and the effectiveness of solutions generated. Goddard, Dritschel and Burton (1997) investigated the same phenomena in a non-clinical group of college students, categorising them as depressed or not depressed based on scores obtained from the Beck Depression Inventory. Significant correlations between problem solving scores and autobiographical memory specificity were reported within the 'depressed' group. A further explanation of the link between depression and autobiographical memory may be the stressful social circumstances that exist for some families and how people cope with these. Hutchings et al (1998) found higher levels of social deprivation to be associated with more overgeneral autobiographical memory. It is argued that attentional deficits that occur in stressful conditions may account for the link between depression and autobiographical memory. However, problem solving may only be one aspect of the coping strategies that people employ in stressful circumstances.

Lazarus et al (1984) defined coping as "cognitive and behavioural efforts to manage demands that are appraised as taxing or exceeding the resources of the person" (Lazarus and Folkman, 1984. P141). In this definition coping involves efforts to alter the stressful situation (i.e. problem-focused coping).

the emotional distress associated with the situation (i.e. emotion-focussed coping). Problem-focussed coping includes seeking information, planning and taking action; whereas emotion-focussed coping includes focussing on positive aspects of the situation, mental or behavioural disengagement, and seeking emotional support from others. Lazarus argues that both forms of coping are used in the most stressful circumstances. It may be necessary therefore to explore more specifically the type of coping that parents access in order to deal with behavioural difficulties and to explore the relationship between coping styles, and problem solving, and how these link with autobiographical memory.

In the proposed study, the question raised is whether the same association between poor problem solving style and overgeneral autobiographical memory exists within parents of children with behaviour problems, and whether this association also exists for parents of children with other clinical presentations. In addition, the author will explore whether coping style is associated with difficult autobiographical memory style. The implication of such a finding is that in addition to behavioural management programmes services may be advised to include interventions which address parents' overgeneral autobiographical memory style, although further work would still be required to determine whether overgeneral autobiographical memory is *causally* associated with behavioural management difficulties. Previous research has indicated that individual work with adults can effect change in autobiographical memory style (Dritschel, Burnside, Williams and Shapiro, 1991; Williams, Segal, Teasdale and Soulsby, 2000).

In addition, the study will explore the relationship between AMT and PCAMT.

8. Study design (incorporating randomisation and placebo details) :

The study will utilize an independent subjects design where group membership represents the independent variable, as assessed by a frequently used measure of behavioural difficulties. There will be three groups involved: i) parents referred to parent training group; ii) parents who have to manage and cope with a child who has a chronic health condition (other clinical group); iii) and a control group of parents whose child has neither behavioural problems or a chronic health condition. Those in the outpatients and control group with scores reaching the clinical threshold for behavioural difficulties (as measured by Strengths and Difficulties Questionnaire) will be excluded.

Parents attending outpatients with a child with a chronic skin condition such as eczema, have to manage the child's physical well being and any restraints imposed by that condition (e.g. certain activities may inflame the condition) They may also have to manage the child's emotions surrounding any limitations of activities. Parents in this group may therefore have extra demands to cope with compared to a control group, but in a different way to the parent training group, and are therefore considered to be a suitable clinical comparison group.

Dependent variables will be measures of both autobiographical memory styles relating to events in parent's life and child's life, depression, problem solving skills and coping style.

The autobiographical memory test will be audiotaped and rated by the principal researcher. A subsample of 10 participants will be rated by a second person to establish inter-rater reliability.

9. ~~Have you had statistical advice in preparing your protocol? If so, from whom?~~

Yes. A power calculation has been completed and it is suggested that 63 participants should be sufficient for the analyses to detect a large effect size at a power level of 80%.

I have also received some advice from Dr Richard Hastings – Research Director and Reader in Psychology (University of Wales – Bangor)

10. What are the possible benefits and hazards of this research?

Parents will be offered a place in the parent training groups or within the other clinical group (skin clinic) regardless of whether they agree to participate in the research project. Participants recruited for the control group will be recruited from a local nursery. There are no particular personal benefits to taking part in the research. It is not envisaged that taking part in the research will be likely to distress participants. However, as there is a small possibility that recall in autobiographical information may cause distress, participants will be given a telephone number to contact the principal investigator if at any time they wish to discuss issues raised by the research. The researcher will help the participant access further support should they then wish to do so.

11. Participants :

11.1 type of participant

All participants will be parents who have children three years old or older.

Parent training group - Participants will be parents of children referred for behaviour problems to Maelor Children's Centre. Each participant will have already been offered a place on a Webster-Stratton 'incredible years' training programme.

Other clinical group – participants will be parents whose children have a chronic condition that is not life threatening (e.g. eczema) These will be recruited within a clinic run within Maelor hospital. The children will be of similar age range to the parent training group children.

Control group – participants will be parents of children in a local nursery within Wrexham.

11.2 method of recruitment

Parent training group - Following the initial offer of a group place, parents will be contacted by a researcher by telephone who will explain that she would like them to consider taking part in research and permission sought to send them written information about the project.

Clinical group – The researcher will visit the clinic within Wrexham Maelor hospital and explain to parents who are attending the clinic that she would like them to consider taking part in research and permission sought to send them written information about the project.

Control group - The researcher will attend a local nursery within Wrexham and explain to parents that she would like them to consider taking part in research and permission sought to send them written information about the project.

For all participants - For those who agree, an information sheet will be sent, followed by a phone call a week later. During the second call, parents will be asked if they would like to take part. If they agree, the researcher will arrange to meet them in order to carry out the research. When the meeting takes place, participants will be asked to sign a consent form before data collection commences. They will, however, be informed (both verbally and via the information sheet) that they are free to withdraw from the project at any time and that this will in no way affect the service offered to them in regard to their child.

11.3 numbers of participants involved

At least 21 participants in each group

11.4 age groups involved

Participants will be over 18 and parents of children aged over 3. There will be no upper age limit.

11.5 do you intend to recruit 'vulnerable' participants?
(if yes, please explain)

Parents could be vulnerable in that they may have contact with services. However, the researcher is independent of any therapeutic relationship and the information sheet clearly states that participation, or non-participation in the study will not effect their treatment.

11.6 will consent be written or oral, or both?

Both (see consent form)

11.7 are participants competent to give informed consent?

Yes

11.8 how much time will be allowed between explaining the research and requesting consent?

Participants will be given as much time as they require to come to a decision, the only deadline being the commencement of the group before data has been collected. It is envisaged that in real terms this will mean a minimum of two days for those recruited late to groups, but for participants recruited in time, a week will be allowed.

11.9 who will witness the consent?

The researcher

11.10 will individuals already participating in other research be excluded?

Yes

11.11 will participants be inconvenienced in any way as a result of taking part in the study?

Participants are likely to be inconvenienced only by the time given to data collection, which is likely to amount to no more than one and a half hours.

11.12 will participants receive payment or reward for taking part? If so, please give details.

No

12. Disclosure of payment or reward to investigators :

12.1 will any payment be made to the investigators or department / unit in respect of this trial?

No

12.2 if yes, will the payment be a block grant, or will it be based on the number of participants recruited ?

N/A

12.3 if a block grant, please state amount awarded and explain how monies received will be spent.

N/A

12.4 if payment is based on number of participants recruited, please state total sum payable per capita, and number of participants agreed.

12.5 will participants be informed if the investigator / department is receiving payment, and if so, will they be told the name of the sponsor?

N/A

12.6 do any of the investigators have a personal involvement in the sponsoring company? If so, please give details.

N/A

13. Consent of others clinically involved :

13.1 will the participant's GP be informed of their involvement in the project?

GP's of the parents for the parent training group and the clinical group will be informed.

13.2 will the consent of others clinically involved be obtained?

Consent of appropriate clinicians within Maelor Children's Centre and Maelor outpatients will be obtained. The study has been discussed with clinicians in both departments and permission in principle obtained.

14. Resource / service implications :

14.1 will your research have resource / service implications for the NHS?

Yes.

14.2 if yes, please indicate the applicable areas

Staff time in helping the researcher access participants. This will be mainly in terms of staff briefly asking permission for the researcher to contact parents, and then providing the researcher with names and contact details. The research will be explained to parents in full by the researcher.

Dr. Burnside will be supervising the research and it is envisaged that this will take approximately one hour a fortnight from her staff time.

14.3 have you discussed any additional workload and / or financial consequences of your project with the departments and budget holders concerned?

Yes

15. Extra substances to be given to the participants:

15.1 additional drugs

None

15.2 dosage form and presentation of these drugs

N/A

15.3 route of administration of these drugs

N/A

15.4 amount

15.5 frequency

N/A

15.6 desired effect

N/A

15.7 possible side effects

N/A

15.8 precautions

N/A

15.9 does the study medicine to be used have a marketing authorisation (product licence)?

N/A

15.10 if yes, will the medicine be used in accordance with, and for the indications specified in, the licence?

N/A

15.11 if the medicine does not have a product licence, or it will not be used in accordance with a product licence, does it have a clinical trial certificate (CTC) or an exemption under either the CTX or DDX schemes?

N/A

15.12 is the clinical trial randomisation code to be held by pharmacy?

N/A

15.13 what procedures will be followed if the codes are to be broken in an emergency?

N/A

15.14 please give full details of any other extra (non-drug) substances to be given to participants

N/A

16. Extra interventions :

16.1 will the project involve any extra venous samples? If so, please give details.

No

16.2 will the project involve any extra arterial samples? If so, please give details.

NO

16.3 will the research involve extra x-rays, radiation, ultrasonics, scanning, ecg or other tests? If so, please give details.

NO

16.4 will the research involve extra biopsies? If so, please give details.

No

16.5 will the research involve extra local or general anaesthesia? If so, please give details.

No

16.6 will the research involve any other extra invasive procedures such as cannulae, probes, catheters, internal examinations, endoscopies or lumbar punctures? If so, please give details.

16.7 No

16.7 will the research involve extra psychological tests? If so, please give details.

Autobiographical Memory Test (AMT, Williams and Broadbent, 1986). The Autobiographical Memory Test requires participants to recall specific events from their own lives in response to 10 cue words (5 negative, 5 positive) presented to them one at a time on cue cards. A time limit of 30 seconds is allowed for responses to be made. Responses are coded as general or specific and total scores obtained by summing the number of each type of response, both for the test as a whole and within cue types.

Parent- Child Autobiographical Memory Test (PCAMT, Hutchings, 1986). Is the same as the Autobiographical Memory test except that parents are asked to recall specific events from their child's life rather than their own life. Again 10 cue words are presented (5 positive, 5 negative) and 30 seconds allowed for a response.

In each group - for half of the participants AMT will be administered first, and for half PCAMT will be administered first - to avoid response bias.

16.8 will the research involve extra questionnaires? If so, please give details.

Depression Inventory Second edition (Beck AT Steer RA & Brown GK Beck, 1996). This is a 21 item self-report questionnaire. Total scores represent levels of current depressive symptoms.

Problem Solving Inventory (PSI, Heppner and Peterson, 1982). This is a 32 item self report questionnaire. Total scores represent reported level of problem-solving skills.

Strengths and Difficulties Questionnaire (SDQ, Goodman 1987). The SDQ is a behavioural screening questionnaire. There are two questionnaires, one applicable to children aged 3 and another for those aged 4-16. It is designed to be completed by parents of teachers and consists of 25 items which represent 5 subscales. These are i) emotional symptoms, ii) conduct problems, iii) hyperactivity/inattention, iv) peer relationships problems and v) prosocial behaviour.

~~Brief COPE - (Carver, 1997) This is a 28 item self report questionnaire exploring 14 aspects of coping. There are 2 items for each scale, and each response is coded 1-4. The two items in the scale are summed to give a total for that aspect of coping. The scales are: i) self distraction, ii) active coping,; iii) denial, iv) substance use, v) use of emotional support, vi) use of instrumental support, vii) behavioural disengagement, viii) venting, ix) positive reframing, x) planning, xi) humour, xii) acceptance, xiii) religion, and xiv) self-blame.~~

See Appendix D for copies of these questionnaires.

16.9 will the research involve any other extra procedures not mentioned above, such as those using heat or electricity etc.? If so, please give details.

No

16.10 will the research necessitate any treatments or procedures being withheld which would otherwise be administered? If so, please give details.

No

17. Ionising radiation :

17.1 will subjects be exposed to ionising radiation as part of this study?

No

17.2 if so, specify the procedures which will be performed, and state the total effective dose in msv which will be received.

N/A

18. What problems may hinder successful completion of this study?

The study will be hindered if too few participants take part, or if access to a local nursery is declined.

19. What steps will be taken to safeguard confidentiality of the research records?

Data (questionnaires and audiotapes will be identified by coded numbers and stored securely in a locked cabinet. A separate and secure database will match names with numbers and this will be kept on a floppy disk and stored in a different room in a locked cabinet at the researcher's workplace.

20. Please explain any arrangements made for indemnity cover for participants.

none

21. Does the project comply with the requirements of the data protection act?

Yes

22. Please state the anticipated start and end dates for your study.

Anticipate start date September 2003

Anticipated end date July 2004

23. Investigator's declaration :

The information provided above is to the best of my knowledge and belief accurate. I fully understand my obligations and the rights of the participant, particularly with regard to freely given informed consent.

Signed: *L. Rolinson* Print name: LYNN ROLINSON Date: 11/7/03

24. Head of Department's endorsement :

see attached fax

I hereby endorse this research proposal with my approval.

Signed: Print name: Date:

24. Head of Department's endorsement :

I hereby endorse this research proposal with my approval.

Signed: *R. P. Hastings* Print name: DR R.P HASTINGS Date: 10/7/03

Signed in context of attached comments only.




RESEARCH PROJECT RESOURCE AND RISK ASSESSMENT FORM

This form must be submitted and completed with your application for ethic committee approval and will be scrutinised by the:

"Risk Management Sub-Committee of the R& D Committee (NE Wales Trust)."

Explanatory background: In order to comply with 'All Wales Risk Pool' (AWRP) requirements for insurance cover for clinical research, in addition to research proposals complying with ethical criteria, the Trust is required to consider the: financial provisions, service implications, line accountability and risk management.

Name of project in full: Autobiographical memory and coping strategies in parent training programmes	
Date of submission to LREC: 11/7/03	
Is the proposal an MREC approved study? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Name/s of Principal Investigator/s Lynn Rollinson	
Signature/s 	Date: 11/7/03

SECTION A

1. Can you affirm that there is no new or increased risk of injury to anyone which might arise as the result of your research project? YES NO

IF NO, please provide details.

There is a small possibility that memories recalled in the Autobiographical Memory Test may be distressing for participants. Participants will be debriefed following data collection and during this time the researcher will ask whether they were at all distressed by taking part. All participants will have a telephone number to contact the researcher should they become distressed some time after the actual data collection. The researcher will help participants access appropriate services.

It is anticipated that the researcher will often be conducting home visits. There is a 'lone worker' policy within the trust which will be adhered to, and the researcher will let colleagues know her whereabouts and expected times of arrival and departure for each visit. She will carry a mobile phone and inform colleagues when she has left the home of a participant. If she does not ring, a colleague will phone to check and if no reply, will alert a more senior colleague.

2. Is there insurance in place to indemnify everyone against the risk of injury and/or adverse effects to anyone involved in the project:
- (a) in case of any negligence? YES NO
- (b) in a case where there has been no negligence? YES NO

IF YES, please provide details.

3. Will a suitably qualified person be in attendance at all times when there is any risk of any injury and/or adverse effects? YES NO
4. Will everyone involved in the project be properly trained and working within the limits of their competence and will all equipment or devices be used within their specification limits? YES NO
5. Will all relevant legislation and regulations be complied with (e.g. Radiation Protection, Data Protection, Health and Safety)? YES NO
6. Is all project activity, and are all project patients/clients for which the Trust has responsibility fully under the clinical/managerial direction of Trust staff? YES NO

IF NO, please explain.

SECTION B

1. Will transparent records of all payments be made available to the Trust on request? YES NO

IF YES, who maintains the records and how may they be accessed?

2. Is it clear (from sources as appropriate e.g. granting body) to whom and for what purpose funds are allocated? YES NO
3. Would it be correct to say that there are no intellectual property rights to be claimed in respect of the research or its conclusions? YES NO
WAL

IF NO, please explain.

4. Has at least one of the principal investigators been involved in a formally ethically approved research project in the past? YES NO
5. Are all investigators without previous or pending professional disciplinary or legal action in the context of research? YES NO

SECTION C

This section is concerned with costs. Excess costs in general are those which would not arise in the absence of the project Excess 'direct costs' include consumables -drugs/devices etc: Excess 'indirect costs' include additional use of NHS facilities and services/use of NHS staff:: Loss of Benefit, non-project patients or clients disadvantaged by the project e.g longer waiting times/extra work for other departments etc: Benefit, equipment /facilities/services/staff time/training)

1. Has funding been allocated to cover any excess direct or indirect cost to the Trust through employment of NHS facilities or services or staff or equipment? YES NO

IF NO, please provide details.

No funding has been made available to cover staff time although this is minimal apart from Dr. Burnside's supervision time. Dr Burnside's supervision time has been agreed by her line manager.

2. Has everyone who will be affected by extra use of Trust assets approved the project? YES NO
3. Are you satisfied that other patients or clients or employees of the Trust will not be disadvantaged or experience loss of benefit in any way by this research? YES NO

IF NO, please provide details.

4. Are there any actual or possible benefits which may accrue in addition to meeting the objectives of the research? YES NO

IF YES, please provide details.

5. Has the project appropriate line management approval? YES NO

Any questions or queries regarding completion of this form, please contact Mrs Julie A Jones, Quality Coordinator (Research & Development) 01978 291100 ext 7453

Protocol

Participants

Participants will fall into 3 groups – those referred for parent training, those from another clinical population and a control group.

Parent training group - Participants will be parents of children referred for behaviour problems to Maelor Children's Centre. Each participant will have already been offered a place on a Webster-Stratton 'incredible years' training programme.

Other clinical group – participants will be parents whose children have a chronic condition that is not life threatening (e.g. eczema) These will be recruited within a clinic run within Maelor hospital. The children will be of similar age range to the parent training group children.

Control group – participants will be parents of children in a local nursery within Wrexham.

Recruitment

Parent training group - Following the initial offer of a group place, parents will be contacted by a researcher by telephone who will explain that she would like them to consider taking part in research and permission sought to send them written information about the project.

Clinical group – The researcher will attend the clinic within Wrexham Maelor hospital and explain to parents that she would like them to consider taking part in research and permission sought to send them written information about the project.

Control group - The researcher will attend a local nursery within Wrexham and explain to parents that she would like them to consider taking part in research and permission sought to send them written information about the project.

For all participants - For those who agree, an information sheet will be sent, followed by a phone call a week later (no less than two days later for late recruits to parent training groups). During the second call, parents will be asked if they would like to take part. If they agree, the researcher will arrange to meet them in order to carry out the research. When the meeting takes place, participants will be asked to sign a consent form before data collection commences. They will, however, be informed (both verbally and via the information sheet) that they are free to withdraw from the project at any time and that this will in no way affect the service offered to them in regard to their child

Procedure

Data will be collected from parent training participants before the start of the parent training group. Data from the other clinical group and the control group will be collected between October 2003 and March 2004.

Participants will be asked to take part in two memory procedures lasting no more than 10 minutes each, and to complete four self report questionnaires.

Questionnaires and audiotapes will be labelled with code numbers and stored securely at the researchers place of work. A disk linking names to code numbers will be kept separately in a locked cabinet in a separate room at the researchers place of work. Questionnaires and audiotapes will be destroyed at the end of the study.

Results.

Data from all measures will be stored as numbers and analysed quantitatively using SPSS statistical software. The results will be written up as a thesis for the DClin Psy. Programme at Bangor University. Results will be submitted for publication in a peer reviewed journal.

Amendments to the agreed ethics protocol

As recruitment to the eczema group of parents was proceeding more slowly than anticipated, a new procedure was proposed in agreement with the consultant of the dermatology clinic. Amendments to the following paragraph of the original ethics proposal were:

11.2 method of recruitment

Clinical group – The researcher will visit the clinic within Wrexham Maelor hospital. Potential participants will be identified by the consultant dermatologists and invited to take part in the research. Those who are interested will be introduced to the researcher and the research explained in full. An information sheet will be issued to participants at this stage. For participants who agree, the researcher will obtain written consent and proceed to conduct the autobiographical memory test. Questionnaires will be issued with a prepaid reply envelope addressed to the researcher. Potential participants who do not wish to take part will not be introduced to the researcher, and those who do not wish to take part after the explanation of the research will be thanked and will leave. Neither the consultants nor the researcher will attempt to persuade participants who are unsure or decline. In addition, the researcher will delete and destroy data collected for participants who subsequently wish their information to be excluded from the research project,

Information sheet changes

It was also necessary to amend the information sheet for this group. The following amendment was made to this section of the information sheet.

Do I have to take part?

Participation is entirely voluntary. Although you may not benefit directly, your information can help plan services for the future, and will be very much appreciated.

If you do not wish to take part you can tell Lynn straight away, or at any time during the research. You do not have to give any reason if you decide not to take part. The research will be quite informal and, at any point you will be able to stop and ask questions, or to say that you don't want to carry on. If you decide not to take part in the study, this will not affect the service that you are offered in any way. If you do take part, and then change your mind about having taken part, please contact Lynn and any information collected from you will be deleted from the computer, and any forms will be destroyed.

Results of change in recruitment procedure.

The new recruitment procedure resulted in 17 people taking part. However, only 10 of these returned questionnaires despite reminder phone calls. Of these 10, only 4 participants met the research criteria that the SDQ scores for conduct problems for the children were below borderline or clinical range. The level of input, and restraints on time, made it unlikely that the number of participants needed could be recruited in the time left. This group was therefore reluctantly excluded from the research.

SECTION 2

Parents' problem solving styles and links with autobiographical memory

PARENTS' PROBLEM SOLVING STYLES AND LINKS WITH
AUTOBIOGRAPHICAL MEMORY

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Abstract.

Purpose.

Research evidence for theoretical links between problem solving and autobiographical memory styles in clinical populations will be discussed, and how this may relate to problem solving styles of parents whose children have behavioural problems. Further research that may contribute to understanding the role of autobiographical memory, and possible links with the problem solving of parents of children with behavioural problems, is explored.

Method.

Literature searches were conducted using electronic databases (PsychInfo, Medline, and Social Sciences Index). In addition, psychological literature from conference proceedings, relevant articles and theses used by known researchers in the field were included.

Results.

Parents of children with behavioural problems have been shown to be less effective at helping their children solve their problems (Pakaslahti, Asplund-Peltola, & Keltikangas-Järvinen, 1996, 1998), and less specific in their autobiographical memory style than control group parents (Hutchings, Nash, Williams, & Nightingale, 1998). Overgeneral autobiographical memory has been consistently associated with less effective problem solving in clinical groups (Pollock & Williams, 2001), and more recently with avoidance of problems (Goddard, Dritschel, & Burton, 1996), but these links have not been explored with parents of children with behavioural problems.

Conclusion.

Parental autobiographical memory style may be a factor influencing parental problem solving style in parents of children with behavioural problems. This may have implications for both the maintenance of children's behavioural problems and parental engagement with services.

Conduct Disorder (CD) is the most common psychiatric diagnosis in childhood with a prevalence rate of 7% in boys and 3% in girls (Meltzer, Gatward, Goodman, & Ford, 2000), and is the most common reason for referrals to child and adolescent clinical services (Audit Commission, 1999). Conduct problems can be persistent and pervasive, and it is estimated that up to 40% of children diagnosed with CD by age 8 are repeatedly convicted of crimes such as theft or vandalism in adolescence (Farrington, 1995). Furthermore, early onset of CD behaviour is associated with subsequent marital disruption, interpersonal difficulties, physical health problems and various mental health problems in adult life (Kazdin, 1995). Thus there is a high personal cost over time to individuals and their families. The prognosis of children with CD is poor, and a recent study estimated average costs to public services to be about £70,000 (Scott, Knapp, Henderson, & Maughan, 2001), 10 times higher than costs for those with no conduct problems. It is therefore important to understand some of the possible factors that may both contribute to, and maintain, behavioural problems in children.

Research evidence suggests that there are multiple interactive factors that contribute to the development of behavioural problems in children, including genetic factors, child individual factors (such as temperament), and environmental factors (for review see Hill, 2002). Child cognitive factors have also been shown to be significant; children with conduct disorder have been found to perceive ambiguous social situations as hostile and consequently retaliate to a perceived threat in an aggressive manner (Crick & Dodge, 1994). Such perceptions may suggest some distortion in problem solving, as generating alternative explanations and possible strategies for dealing with ambiguous situations may be limited by the child's tendency to globally perceive situations as hostile (Coy, Speltz, DeKlyen, & Jones, 2001). There is

evidence to suggest that children's problem solving strategies may be influenced directly by the parent's own problem solving processes (Huesman & Eron, 1989). Thus, how parents solve their problems may impact on the development or maintenance of a child's behavioural difficulties. As there is a plethora of factors that have been found to contribute to conduct problems, any research focus may only partially account for the contribution and maintenance of deviant behaviour in children. The focus of this paper will be to consider potential links between parents' problem solving and parenting, and the role that parental autobiographical memory may play in this process. This will be considered particularly in relation to a clinical intervention for behavioural problems in children – parent training programmes.

Parent training programmes.

Parent training programmes are based on the work of Patterson (1982) who found that parents often lack fundamental parenting skills, and furthermore, that aversive interaction patterns between the parent and the child have their roots in a child's early years. Using a social interactional model, Patterson argues that parents of children with behavioural difficulties ineffectively deal with everyday disciplinary confrontations, which in turn leads to an escalation of the child's behaviour. In an attempt to avert such escalation, parents relent, thus reinforcing the child's behaviour and, at the same time, making it less likely that parents will place similar demands on the child in the future. Thus, an aversive pattern of parent-child interactions is established.

Parent training programmes have been shown to an effective intervention for children with behavioural problems (see meta-analysis by Serketich & Dumas, 1996). Scott (2002) identifies six main characteristics of effective parent training programmes. These are: i) there is a structured sequence of topics introduced in a set

order over 8-12 weeks; ii) topics include play, praise, incentives, setting limits and discipline; iii) there is an emphasis on promoting sociable, self-reliant child behaviour and calm parenting; iv) there is constant reference to the parent's own experience and predicament; v) practice is informed by extensive empirical research and that this is made explicit to parents; and iv) parents are provided with a detailed manual to enable replicability outside sessions. Furthermore, Scott states that clinicians facilitating groups should encourage a collaborative approach acknowledging parents' feelings and beliefs. This will involve exploring parents' beliefs about parenting and their approach to dealing with their child's problematic behaviour. Parents' understanding about their own problem solving skills will be a part of this system of beliefs. Before considering research on parents' problem solving, it is important to understand what problem solving is.

Problem solving

Problem solving models suggest that people who are effective problem solvers are able and willing to recognize the existence of a problem (general orientation), define specifically what the problem is (problem definition), generate a number of possible solutions (generation of alternatives), decide on a strategy to solve the problem (decision making), and finally, evaluate whether the solution worked (evaluation) (Heppner, 1978; Heppner & Peterson, 1982). Research evidence suggests that effective problem solvers report less anxiety, less depression, a more internal locus of control, less frequent problems, and less distress associated with problems (Nezu, 1985, 1986a, 1986b). Those whose scores classified them as ineffective problem solvers therefore report more emotional distress. As 50% of mothers of children with disruptive behaviours are depressed (Alpern & Lyons-Ruth, 1993) one might expect that parents of children with behavioural problems may also

be ineffective problem solvers, and that this may contribute to parenting difficulties in one of two ways. Firstly, emotional distress may impact on their ability to effectively problem solve in relation to the management of the child's behaviour. Secondly, difficulties in parents' problem solving skills may affect parents' abilities to address the difficult behaviour, in turn causing emotional distress for parents. Parents' problem solving effectiveness may therefore be an important factor to consider in relation to a child's behavioural problems, and this is considered next.

Parenting and problem solving

Researchers considering problem solving and parenting skills have shown that parents of children with behavioural problems experience particular difficulty in specifically identifying problem behaviour of their children (Wahler & Afton, 1980; Wahler & Dumas; 1989, Wahler & Sansbury, 1990), and have less effective problem solving strategies (Pakaslahti, Asplund-Peltola, & Keltikangas-Järvinen, 1996, 1998).

Pakaslahti et al (1996, 1998) studied parents' problem solving strategies in families with aggressive boys (1996) and aggressive girls (1998) in comparison to those of parents of non aggressive children. In an investigator rated semi-structured interview using six hypothetical social conflict scenarios that their child may face, parents were asked about their problem solving strategies to help the child deal with each scenario. Parents' answers fell into four main categories: providing a direct solution (i.e. telling the child what to do); discussion with the child without providing a direct solution; diverting the responsibility of providing a solution to someone outside the home (e.g. telling the teacher); and, indifference (e.g. would do nothing). The child's aggression was measured using peer ratings (elicited by common scenarios), and teachers' ratings (using Likert rating scales).

Results showed that aggressive children were frequently left without help from their parents, who did not offer direct advice unless asked for. In addition, mothers of aggressive children often diverted responsibility to outside the home or reprimanded their daughters for the problems, whilst fathers were largely indifferent to their child's problem. In contrast, parents of non-aggressive children did not direct responsibility elsewhere and often offered direct solutions. It would seem, therefore, that the problem solving style of parents may be related to aggression in children and that parents of children with aggressive behaviour, may avoid problems or experience difficulties in generating solutions. If, as Pakaslahti et al (1996, 1998) suggest, aggressive children are often left without help, it may be that their parents are not motivated to address the child's difficulties and therefore avoid them. This lack of help may also reflect the effects of aversive interactions as described by Patterson (1982). That is parents of children with behaviour problems may experience a sense of learned helplessness with regard to problem solving because they have tried many approaches to deal with problems and have failed. Over 50% of parents of children with behavioural problems have been found to be depressed (Alpern & Lyons-Ruth, 1993) and this may be indicative of this learned helplessness. Parents' confidence in their ability to solve problems therefore may be severely eroded and may prevent them offering solutions.

The externalization of responsibility found by Pakaslahti et al (1996, 1998) may also be related to avoidance in a slightly different way, in that parents do not regard the problems of the child as their responsibility, and therefore do not perceive their input as necessary. This argument is supported by evidence that parents of children with behavioural problems who attributed more blame to their child at baseline, experienced less benefit from parent training, and moreover, did not change their

attributions during or after the training programme (Wahler & Afton, 1980).

However, both externalization of the problems and the lack of help that parents of children with behavioural problems offer their children may also relate to parents' confidence in, or ability to, specifically identify problems and to generate alternative solutions. The research evidence for this argument is discussed next.

Specificity and parenting

Effective problem solving involves orienting oneself to and specifically defining the problem. Researchers have found that parents of children with behavioural problems experience some difficulty in being specific about their child's behaviour. In a study by Wahler & Afton (1980) 15 mother-child dyads were compared at baseline, at the end of a parenting group, and at four month follow up. Mothers who made greatest gains during parent training, and at follow up, provided more detailed descriptions of their child's behaviour at baseline. It seemed that higher specificity in defining the problem was associated with greater gains from parenting groups, and the maintenance of such gains. Furthermore, parents who were global in their attributions at baseline did not become more specific during the parenting group, despite practicing such strategies during the programme. The role of autobiographical memory (discussed later) may be pertinent to this process.

Research evidence has also shown that parents of children with behavioural problems not only failed to see episodes of their child's positive behaviour but, surprisingly, also identified less negative behaviour. Wahler & Sansbury (1990) conducted an observational study of 33 mothers whose children had been referred for behavioural problems and compared mothers' monitoring of their child's behaviour to trained observers' coding of the same behaviour. Contrary to their expectations, they found mothers' and observers' ratings of prosocial behaviour were similar, but in

comparison to observers' ratings, mothers significantly undercoded their child's deviant behaviour. The authors suggest that mothers failed to identify all of the deviant behaviour rated by observers, and that they had different criteria for what was identified as deviant behaviour in children. Furthermore, mothers often gave general descriptions of such behaviour (e.g. he was being mean), suggesting that even when deviant behaviour was observed, it was not specifically defined. Thus, the ability to specifically define behavioural problems is related to gains in parent training programmes. This further reinforces the link between parenting and problem solving specificity. Parent training programmes explicitly focus on behavioural and social learning principles whilst only implicitly encouraging effective problem solving strategies, but whether these programmes can be effective without also explicitly addressing parental problem solving, is questionable. This is considered next.

Problem solving training versus behavioural skills training

A comparison between problem solving interventions and behavioural interventions gives insight into the importance of problem solving in interventions for children with behavioural problems. Magen & Rose (1994) compared a group of parents using problem solving strategies, with a group of parents using behavioural skills training and a control group. Parents reported on their child's behaviour and on their own problem solving before and after the intervention. The researchers found that both the problem solving and behavioural intervention groups reported significantly greater improvements in behaviour than the control group. This suggests that both problem solving and behavioural interventions are effective.

An interesting finding in this study related to parents' perceptions of their child's problems. Many of the children's initial behaviour assessment scores did not fall within the clinical range for problem behaviour, although parents had actively

sought parent training which suggest that they perceived their child's behaviour to be problematic. This discrepancy between parental perceptions of their child's behaviour to objective measures of this behaviour may be linked to parents' perceptions of their own strengths and limitations in relation to dealing with the child's behaviour. The control group received no intervention during the study, yet they reported improvements in their child's behaviour over time. Maybe the child's behaviour did indeed improve whilst on the waiting list, but it may be that this reported improvement is actually related to parents' perceptions about their ability to deal with the problematic behaviour, which may have improved with the knowledge that help is forthcoming. The authors note that although "we cannot demonstrate that the changes in parental perceptions translated into behavioural changes on the part of either the parent or the child, the value of perceptual change should not be discounted" (p187). It seems that parental understanding of their ability to deal with the problem behaviour of their child may be an important factor to consider. Changes in perceptions and attributions for events may rely on the ability to correctly specify differences to such global scripts. For parents who have more global styles of thinking, such perceptual change may be difficult to achieve and the role of autobiographical memory provides some insight into this process.

Autobiographical Memory

Autobiographical memory is a person's memory for their personal history. During a study on mood and memory recall using the Autobiographical Memory Test, Williams and Broadbent (1986) noticed that suicidal patients tended to have difficulty in recalling specific memories, even when prompted to do so by their counsellor. The Autobiographical Memory Test (Williams & Broadbent, 1986) consists of 5 positive, 5 negative, and 5 neutral cue words, and respondents are asked to recall a specific

memory lasting less than a day, associated with that cue word. For example, to the cue word 'good' an example of a specific memory would be "I had a good time at my friend's party last Saturday". Overgeneral memories consist of those referring to categories (e.g. "I always enjoy a good party"), those referring to extended periods of time (e.g. "I had a good time on my holiday abroad"), and those where a semantically associated response is given (e.g. "I enjoy life"). Williams and Broadbent found that the patients recovering from attempted suicide recalled significantly more overgeneral memories than the control group. These findings have been replicated among other clinical groups with major depression (Kuyken & Dalgleish, 1995; Williams & Scott, 1988), obsessive-compulsive disorder (Wilhelm, McNally, Baer, & Florin, 1997), post-natal depression (Croll & Bryant, 2000), post traumatic stress disorder (e.g. McNally, Lasko, Macklin & Pitman, 1994), and borderline personality disorder (Jones et al. 1999). The process of how overgeneral autobiographical memory relates to emotional distress is a matter of current debate within autobiographical memory research. Williams (1986) suggests that during normal childhood development, memory retrieval becomes progressively more specific. He suggests that childhood trauma can interrupt this development, and thus adults surviving childhood trauma, are left to rely on the overgeneral retrieval style that characterizes early developmental stages. This premise is supported by research findings that adult survivors of childhood sexual abuse report more overgeneral autobiographical memories than non abused adults (Henderson, Hargreaves, Gregory, & Williams, 2002, Kuyken & Brewin, 1995). However, recent research findings have contested this explanation suggesting that depression may be the factor which is most strongly related to overgeneral recall (Burnside, 2001; Wessel, Meeren, Peeters, Arntz, & Merckelbach, 2001).

The literature also outlines relationships between overgeneral autobiographical memory and problem solving. As parents of children with behavioural problems experience difficulties in being specific (discussed earlier), and have less effective problem solving styles, it is pertinent to consider this literature next.

Autobiographical memory and problem solving

Effective problem solving involves being able to prospectively hypothesize the outcome of the various possible solutions before actually deciding on the strategy that will generate the most desirable outcome. This ability to prospectively hypothesize is thought to draw on memory mechanisms for past events in one's own life that are important in solving open-ended problems. (Williams, 1996). Within this framework, specific memories provide a rich and detailed database that offers a wide range of cues, from which to construct a wide variety of solutions. In comparison, general memories offer a more restricted database from which the solutions are more fixed for example, making a bed does not require a variety of possible solutions, and thus the problem can be solved using a general memory. Inability to draw on specific examples in our past (overgeneral memory) is thought to undermine the ability to use memory in imagining the future and in solving current interpersonal problems (Williams, 1996).

A relationship has been demonstrated between overgeneral autobiographical memory and problem solving with persons who have attempted suicide (parasuicidal patients) (Evans, Williams, O'Loughlin, & Howells, 1992; Pollock & Williams, 2001; Sidley, Whitaker, Calam, & Wells 1997). In the study by Evans et al (1992), 12 parasuicidal and 12 control patients were compared on both their autobiographical memory recall (using the Autobiographical Memory test, AMT) and problem solving ability (using the Means Ends Problem Solving Task, MEPS, Platt & Spivack, 1975).

The MEPS involves presenting the beginning and the end of a scenario to respondents who are then required to complete the middle section of how the solution was achieved. Results showed that parasuicidal patients provided less effective strategies of solving the problem, recalled significantly more overgeneral memories, and took longer to retrieve memories on the AMT, than the control group. This provides further evidence for the suggestion that overgeneral memory may impact on the cognitive database of memories that can be drawn upon to solve problems. Participants who could see no means of solving the problem were also overgeneral in their autobiographical memory recall. This may be indicative of a different association, one of avoidance of problems and overgeneral memory.

The sample in Evans et al's study was small, and to test whether results were robust, Sidley et al (1997) replicated the study with a higher number of parasuicidal patients. They found the same association between overgeneral memory recall and ineffective problem solving, although not as strongly correlated, and Sidley et al proposed that this may be due to heterogeneity of the suicide sample used.

Pollock and Williams (2001) compared first time suicide attempt patients, patients with other psychiatric presentations, and a community control group. The selection of a homogenous parasuicidal group hoped to address any confounding influence of the severity of parasuicide, and the inclusion of a psychiatric group enabled comparisons to be made with other clinical presentations. Pollock and Williams' findings supported those of Evans et al, in that suicide attempters produced significantly less specific, and more overgeneral memories on the AMT than controls. Furthermore, suicide attempters performed more poorly on all tasks than psychiatric patients with other clinical disorders. On the MEPS, the three groups differed significantly from each other with the parasuicidal group providing the least effective

means of problem solving and less effective solutions, and the control group producing the most effective- the psychiatric group fell between the other two. The authors concluded that a robust relationship existed between overgeneral memory and ineffective problem solving, and that effective problem solving depended on specific autobiographical memory recall.

The influence of overgeneral memory may be important to consider in relation to parents of children with behavioural problems, who, as discussed earlier, have been shown to have difficulties in being specific about their child's problems and to have less effective problem solving solutions. However, as autobiographical memory has been strongly associated with depression, and there is a high prevalence of depression for parents of children with behavioural problems (Alpern & Lyons-Ruth, 1993), it is important to consider associations between depression, autobiographical memory and problem solving efficacy in greater detail.

Similar findings of ineffective problem solving and overgeneral autobiographical memory have been reported with depressed individuals (Goddard, Dritschel, & Burton, 1996, 1997), and in those with bipolar disorder (Scott et al, 2000). In a comparative study of 16 depressed outpatients and 16 physiotherapy outpatients, Goddard et al (1996) sought to more accurately identify which elements of autobiographical memory were involved with both poor and effective social problem solving strategies. In line with previous research, AMT was used to assess memory recall and MEPS was used to assess problem-solving. In addition, the participants were asked to talk aloud about the memories brought to mind during the MEPS and these were also coded in terms of specific or categoric memories – a subdivision of overgeneral memories that refer particularly to memories recalled from categories e.g. “when I go for a walk”. Goddard et al found that that specific retrieval

on the Autobiographical Memory Test was related to more effective problem solving which is consistent with previous research in the area. Furthermore, she discovered that some participants with categorical memory recall failed to orient themselves to the problem presented and thus provided no solution at all. This would seem to indicate that avoidance of problems may be particularly associated with categorical recall and possibly broader overgeneral autobiographical memory recall.

Qualitative analysis of the responses during the MEPS (Goddard et al, 1996) revealed an interesting phenomenon. The number of specific memories on AMT has been found to be related to effective problem solving, but Goddard et al explored the type of specific memories recalled whilst performing the MEPS and found that it is the *relevance* of specific memories that may be the key to effective problem solving. They found that specific autobiographical memories of depressed patients recalled during the MEPS task, were often less relevant to the tasks of problem solving. For example, when presented with a scenario of making up with a partner, one participant recalled "I'm in that situation at the moment ... it went through my mind that he phoned this morning and he still says he loves me" (p615). Although a specific memory was recalled, its usefulness in the generation of alternative strategies was limited. The authors argue that specificity in memory may be useful in generating alternative strategies only if an analogous situation is recalled from memory, as with this control participant e.g. "Me and my wife split up for a month and that's what we did – we sat down and talked about it and got it sorted out" (p615).

Goddard et al were particularly interested in the influence of categoric memories recalled during the MEPS and how this affected problem solving. Categoric recall during the MEPS was associated in both control and depressed groups, with fewer means of problem solving (i.e. fewer possible solution were

generated). However, categoric autobiographical memory recall was associated with less effective solutions in the depressed group only. Goddard et al postulate that for the depressed group, the association with less effective solutions may be partially accounted for by rumination encouraged by a categorical retrieval, which creates an impasse in problem solving. However, this could not explain the association between categoric memories and fewer alternative solutions being generated, in the control group. Goddard et al's findings also revealed that recalling a categoric memory may be more detrimental than recalling no memory at all, as people who recalled no autobiographical memory during the MEPS task did not generate significantly fewer solutions. They propose that recalling categoric memories somehow frustrates the ability to use knowledge from other sources, whereas recalling no memory may motivate participants to consider other resources and knowledge to solve the scenario. However, if categorical memories are also related to problem solving avoidance, this would provide an alternative explanation of why participants recalling categoric memories provided fewer alternative strategies during the MEPS, and why depressed individuals, who may report a higher level of avoidance than controls, also produced less effective problem solving solutions.

There is strong research evidence for links between autobiographical memory recall and problem solving effectiveness in clinical groups. However, research considering how autobiographical memory relates to parents of children with behavioural problems is in its infancy. To date the researcher knows of one study considering autobiographical memory recall of parents of children with behaviour problems and no studies considering autobiographical memory and problem solving in this population.

Parenting and autobiographical memory

Hutchings, Nash, Williams & Nightingale (1998) compared autobiographical memory styles of 26 mothers referred to a parent training group for help with their child's behaviour were with those of a group of 22 mothers recruited from local playgroups. The Autobiographical Memory Test was modified for mothers to recall events in their child's life, as this appeared to have more face validity to mothers attending for help with their child. This new version called the Parent Child Autobiographical Memory Test (PCAMT) was reported by Scholey (1998) to have high correlations with the Autobiographical Memory test (Williams and Broadbent, 1986). As predicted, PCAMT autobiographical memory scores differentiated between mothers referred for parent training, and those in a non-referred community group.

However, closer examination of the difference between the clinical and control group scores revealed that the difference was largely due to the very low recall of specific memories by parents referred for parent training who then failed to attend parent training. Furthermore, this difference was not related to differences in depression (as measured by the Beck Depression Inventory, Beck, Steer, & Brown, 1996). Hutchings et al were offered no clear explanation for this finding. One possible explanation is that low specificity scores and attendance at parent training may in some way be mediated by parents' problem solving approach to, or avoidance of, the tasks of parent training.

One of the main tasks for parents during parent training is to identify triggers and maintaining factors within the aversive interactions between themselves and their child. Parents are encouraged to identify and praise the child's positive behaviour, and advised on strategies to manage the negative behaviour of the child more effectively. These tasks require that parents become more adept at specifically

identifying and discriminating their child's behaviour, and generating possible solutions to deal with that behaviour. Whilst this may be encouraged and practiced for the duration of the parenting group, maintenance of any gains learned within parenting groups will require implementation of effective problem solving strategies in the variety of new situations that parenting a child will demand. This would require that parents continue to be able to specifically identify problem behaviour, be able to think of potential alternative strategies, and evaluate solutions to novel problematic behaviour.

As discussed earlier, research shows that parents of children with behavioural problems have difficulty in identifying their child's problem behaviour. This may explain why some parents fail to benefit from parenting programmes. However, difficulties with being specific are relevant to the second and subsequent stages of problem solving (i.e. defining the problem and generating solutions). But for parents referred for help with their child's behaviour, the initial stage of problem solving - orienting oneself to the problem (i.e. attending parent training group) may be difficult. Hutchings et al findings may lend some support to this proposition as a large proportion of the differences in autobiographical memory recall between referred and non-referred mothers was accounted for by parents who did not attend the parenting group (see discussion earlier). These mothers had been offered a potential chance to address their difficulties but failed to accept this offer. As these mothers also reported less specific autobiographical memories, this provides an indication that autobiographical memory and avoidance of problems may be linked. Or, it may be that parents lack confidence in their problem solving abilities, or externalize the source of the problem and thus avoid actively taking responsibility to sort them out. If this is the case then interventions such as parent training, aimed at parents accepting

responsibility for their part in the process of maintaining the child's deviant behaviour, and at changing their own skills may therefore appear unappealing or irrelevant to parents.

Conclusion

No research to date has considered how parents of children with behavioural problems view their own problem solving abilities, particularly in relation to avoidance or engagement with problems. And, although autobiographical memory research has consistently shown overgeneral memories to be associated with ineffective problem solving solutions, and generation of alternative strategies, little attention has been paid to whether autobiographical memory has a role to play in the first stage of problem solving – orienting oneself to the problem. Such a study would provide insight into factors that affect parent's engagement in parent training, and into whether additional services would need to be developed to overcome the cognitive styles that may impede such engagement.

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SECTION 3

Autobiographical memory, problem solving and coping styles of parents referred for parent training

ABSTRACT

Objectives.

To explore the association between autobiographical memory recall on the Parent-Child Autobiographical Memory Test (PCAMT, Hutchings, 1996), and on the Autobiographical Memory Test (AMT, Williams and Broadbent, 1986). In addition, to explore differences between parents referred for parent training and a control group on autobiographical memory recall, problem solving (Problem Solving Inventory, Heppner & Peterson, 1982), coping strategies (Brief COPE, Carver, 1997) and depression (Beck Depression Inventory II, Beck, Steer & Brown, 1996).

Relationships between these variables will also be explored.

Design.

Measures for parents of children with behavioural problems referred to parent training were compared to parents from a community control group.

Methods.

Measures for the parents referred for parent training were administered before they commenced the parent training group. Both groups completed the measures once only.

Results.

There was a significant association between AMT and PCAMT scores. Overgeneral memory on the AMT was significantly associated with emotion focused coping strategies. Parents referred for parent training, reported more problem solving confidence, more problem focused coping strategies and higher levels of depression than their control counterparts. However, no differences remained significant after depression had been controlled for.

Conclusion

Previous research using performance measures of problem solving has suggested that parents of children with behaviour problems employ ineffective problem solving strategies. This study used a self report measure and results showed that parents referred for parent training reported high levels of confidence in their problem solving abilities. The clinical implications of this disparity are discussed.

INTRODUCTION

Conduct problems are enormously costly to society (Scott, Knapp, Henderson & Maughan, 2001) and were reported by the Audit Commission (1999) to be the most common reason for referrals to child and adolescent clinical services. It is therefore important for clinicians to identify factors that influence the effectiveness of interventions for meeting the needs of families of children with conduct problems. Parent management training has been shown to be an effective intervention for parents whose children have behavioural problems (see meta-analysis by Serketich and Dumas, 1996). However, some parents fail to benefit from this intervention and the literature identifies many factors associated with this, including overgeneral autobiographical memory style (Hutchings, Nash, Williams, & Nightingale, 1998). Parents of children with conduct problems have been found to be poorer at problem solving (Pakaslahti, Spoof, Asplund-Peltola, & Keltikangas-Järvinen, 1996, 1998), and research considering other clinical groups has linked poor problem solving with overgeneral autobiographical memory (Evans, Williams, O'Loughlin, & Howells, 1992; Goddard, Dritschel, & Burton, 1996; Pollock & Williams, 2001; Sidley, Whitaker, Calam, & Wells, 1997;). This paper will explore the relationship between autobiographical memory and problem solving in parents of children with and without behavioural problems, and furthermore how these factors may relate to coping styles.

Problem solving models postulate the existence of five broad stages within the problem solving process. People who are effective problem solvers are able to recognize the existence of a problem (general orientation), define specifically what the problem is (problem definition), generate a number of possible solutions (generation of alternatives), decide on a strategy to solve the problem (decision making), and, evaluate whether the solution worked (evaluation) (Heppner, 1978,

Heppner & Peterson, 1982). Problem solving processes may be a factor in maintaining children's problem behaviour, as research evidence suggests that parents of children with behavioural problems have difficulties attending to their child's problem behaviour (i.e. orienting themselves to the problem). Wahler and Afton (1980) found that parents of children with behavioural problems not only identified fewer episodes of their child's positive behaviour but, surprisingly, also identified less negative behaviour in comparison to researcher ratings. Furthermore, parents of children with behavioural problems were found to be less specific in their descriptions of behaviour at baseline and attributed more blame to their child than control parents. (Wahler & Sansbury (1990). Parents who were identified as less specific in their descriptions at baseline did not appear to alter in their style, and furthermore made fewer gains by the end of the parenting programme, and at four month follow up. As parent training programmes involve being able to address specific behaviour, parents who have more general descriptions may experience some difficulty in defining the problem behaviour accurately and thus may be impeded in engaging with the tasks of parent training fully. This in turn may hinder improvements in the child's behaviour.

Parents of children with behavioural problems have also been found to offer fewer problem solving solutions than parents of non-aggressive children, and to divert responsibility to outside the home or be more reprimanding in dealing with their child's problems (Pakaslahti et al, 1996, 1998). In contrast, parents of non-aggressive children were less likely to divert responsibility elsewhere, and more likely to offer direct solutions. These findings have clinical implications in two ways. Firstly, that parents of children with behavioural problems may be less likely to generate alternative solutions and accept responsibility for solving problems. They may therefore be less inclined or able to engage in identifying solutions within parent

training programmes. Secondly, children's problem solving strategies may be influenced directly by the parent's own problem solving processes (Huesman & Eron, 1989), and thus how parents solve their problems, and their resultant behaviour may impact on the development or maintenance of a child's behavioural difficulties.

Autobiographical memory processes have been found to differentiate between parents referred for parent management training and to a control group (Hutchings et al, 1998), and have also been found to be associated with poor problem solving in clinical populations (Evans et al, 1992; Goddard et al, 1996; Pollock and Williams 2001; Sidley et al, 1997). Autobiographical memory is one's memory for events in one's life and differences have been found between clinical and non-clinical groups between the number of specific and overgeneral memories recalled. Specific memories would be a memory of an event lasting less than a day (e.g. "I enjoyed my friend's party on Saturday"). Overgeneral memories consist of those referring to categories (e.g. "I always enjoy a good party", those referring to extended periods of time (e.g. "I had a good time on my holiday abroad"), and those where a semantic association response is given (e.g. "I enjoy life"). Using the Autobiographical Memory test (AMT) (Williams and Broadbent, 1996), several clinical groups have been reported to have responded with significantly more overgeneral memories than controls, including studies considering depression (Brittlebank, Scott, Williams, & Ferrier, 1988, Kuyken & Dalgleish, 1995), obsessive-compulsive disorder (Wilhelm, McNally, Baer, & Florin, 1997), post-natal depression (Croll & Bryant, 2000) post traumatic stress disorder (McNally, Lasko, Macklin, & Pitman, 1994) and borderline personality disorder (Jones et al., 1999). The evidence suggests that overgeneral autobiographical memories may contribute to, and/or maintain emotional distress in clinical populations.

Williams (1986) suggested that overgeneral autobiographical memory inhibits successful problem solving. Access to specific memories is purported to provide access to a rich database of past experiences that may assist with the generation of alternative problem solving strategies (Goddard et al, 1996), and overgeneral autobiographical memories serve to limit this access. Using the Means End Problem Solving (MEPS) task (Platt & Spivack, 1995), parasuicidal patients were found to produce more overgeneral memories and less effective problem solving solutions than control patients (Evans et al, 1992, Pollock & Williams, 2001, Sidley et al, 1997). There is some evidence that it is particularly categorical memories that were associated with poor problem solving on the MEPS (Goddard et al 1996).

The evidence suggests that overgeneral autobiographical memory recall is strongly associated with poorer problem solving abilities in clinical groups. In a study of a non-clinical population of students, the recall of specific memories was identified as being salient to successful problem solving, but this was mediated by the severity of self reported depression (Goddard, Dritschel, & Burton, 1997). Parents of children with behavioural problems may not themselves be 'a clinical group' as it is their child who is referred for help from services. However, as over 50% of mothers of children with disruptive behaviours have been found to be depressed (Alpern & Lyons-Ruth, 1993), one might expect that any findings may be similar to other clinical groups in terms of autobiographical memory and problem solving.

Researchers have used objective measures to assess parents' problem solving abilities, but less is known about parents' own perception of their problem solving ability. In a study comparing problem solving of depressed and non-depressed individuals, Goddard et al (1996) asked participants to 'think aloud' during the MEPS task, to gain insight into what sort of possible memories and solutions were generated

during the task. Many of the clinically depressed respondents made no effort to solve the problem presented but instead focused on their own past failures. It is therefore pertinent to consider parents' confidence in addressing problems, and whether this is related to approaching or avoiding problems. Parents' perceptions of their problem solving abilities may be relevant to parents rejecting or engaging in a parent training programme aimed at them changing their style of dealing with problems, particularly if parents perceive themselves as proficient problem solvers.

Hutchings (1996) developed a modified version of the Autobiographical Memory Test, the Parent-Child Autobiographical Memory Test (PCAMT), in which parents were asked to recall specific events in their child's life rather than their own life (as in AMT). Using the PCAMT, Hutchings et al (1998) found that parents referred to parent training programmes were significantly less specific in their autobiographical memory recall than control parents, but that this difference was attributable to a large proportion of parents referred for parent training who did not attend. This does not seem to fit with Williams (1986) proposal that overgeneral autobiographical memory is associated with poor problem solving because it restricts the ability to generate solutions as in Hutchings et al's study, parents had been offered a solution (parent training), that may help with the behavioural problems, but failed to take up the offer. Hutchings findings may indicate that overgeneral memory may be involved in an earlier stage of problem solving, that of initially orienting oneself to the problem, and the wider literature on coping with problems may help clarify this.

Lazarus and Folkman (1984) defined coping as "cognitive and behavioural efforts to manage demands that are appraised as taxing or exceeding the resources of the person" (ibid, p141). In this definition coping involves efforts to alter the stressful

situation (i.e. problem-focused coping) as well as efforts to regulate the emotional distress associated with the situation (i.e. emotion focused coping). Problem-focused coping includes seeking information, planning and taking action and is most like effective problem solving whereas emotion-focused coping includes focusing on positive aspects of the situation and seeking emotional support from others, as well as using more maladaptive strategies to deal with emotions such as mental or behavioural disengagement, denial or venting of emotions. Lazarus and Folkman argue that both forms of coping are used in the most stressful circumstances. It may be necessary therefore to explore the coping strategies accessed by parents of children with behavioural difficulties. If, as in Hutchings et al's study, parents are not engaging with the problem focused aspect of coping, then it may be useful to know whether they are engaged in more emotion focused coping strategies in their lives.

One study has considered the coping styles of parents referred for parent training (McKee et al, 2004). Results showed that parents who generally reported more general maladaptive coping strategies were observed to display more coercive parenting, and that their children displayed more problem behaviour. They suggest that emotionally focused coping, and particularly maladaptive coping strategies, may have a part to play in the aversive interactions described by Patterson (1982).

Although the parents in this study had children with Attention Deficit Hyperactivity Disorder comorbid with their oppositional behaviour, which may effect the coping strategies of parents, results indicate that parental coping styles may impact on the maintenance of children's problem behaviour. How coping styles relate to problem solving and how autobiographical memory relates to this process, has not as yet been studied.

This study aims to explore the strength of association between autobiographical memory scores (AMT) and parent-child autobiographical memory scores (PCAMT). In a small study of 12 mothers of children referred for behavioural problems (Scholey, 1998) PCAMT scores were found to be highly correlated with AMT scores ($r(12) = .75, p = .00$). The present study will attempt to replicate these findings with a larger sample. Any differences between control parents and parent training group parents in the number of overgeneral memories and specific memories recalled on both autobiographical memory tests will also be explored. The study will consider whether overgeneral or specific autobiographical memories are associated with parents' reports of problem solving, and if overgeneral memories are associated with maladaptive coping strategies. Potential differences between the two groups in terms of their problem solving and coping strategies will also be explored.

METHOD

Participants

Parents referred for parent training were recruited from two NHS child psychology services in North Wales, one hospital based service for children aged 5 and under, and a community based mental health team for children up to 16 years old. Parents in the control group were recruited from local nurseries and schools to match the ages of the children referred in the clinical sample.

A total of 41 participants were recruited for the study. However, two participants in the parent training group reported borderline behaviour problems on the SDQ, and five participants in the control group reported SDQ scores meeting borderline or clinical threshold. These seven participants were excluded from the study to create a 'pure' control group reporting no behavioural problems on the SDQ,

and a parent training group with scores reaching the clinical threshold for behavioural problems.

The parent training group participants had also been assessed by a qualified clinician and deemed as being suitable for a parent training group to address their child's difficulties. A total of 19 participants met inclusion criteria for the research. The mean age of participants in this group was 33.42 years (SD 5.42, range 23-44), the mean age for children of parents in this group was 5.47 (SD 2.01, range 3-8). The children included two girls and 17 boys.

A total of 15 control group participants met the inclusion criteria for the research. The mean age of parents was 34.13 (SD 5.67, range 24-43) and children was 5.2 (SD 2.4, range 3-11). The children included five girls and 10 boys.

Measures

Strengths and Difficulties Questionnaire (SDQ)

The SDQ (Goodman, 1997) is a well-used and standardized self-report questionnaire that parents complete. It is used to screen for child psychiatric disorder and consists of 25 items enquiring about child behaviour in relation to subscales of conduct disorder, hyperactivity, emotional problems, peer problems and pro social behaviours. On the conduct disorder scale, parents are asked about their child's behaviour e.g. "Often has temper tantrums or hot tempers", and are asked to respond whether this is not true (score = 0), sometimes true (score = 1) or certainly true (score = 2). The scores on each scale are summed and a score of three on the conduct disorder scale indicates 'borderline difficulties' and a score of four and above indicates 'clinical range' of difficulties.

Beck Depression Inventory Second Edition (BDI, II)

The BDI II (Beck et al, 1996) is a well used and standardized self report questionnaire for participants to complete about their mood in the last two weeks. It has 21 items asking about depressive symptoms such as sadness, hopelessness, loss of energy and loss of appetite and is reported to have a high level of internal consistency ($\alpha = .92$). There are four possible responses in each item ranging 0-3. A score of '0' indicates no symptom, and '3' indicates a severe symptom. Scores are summed to give an overall indication of the level of depression.

Brief COPE

Coping strategies of parents were assessed using the Brief COPE (Carver, 1997). A general coping measure, rather than a parenting style measure was used in order for comparisons to be made with both the general style of the AMT and the general problem solving questions responded to on PSI.

The Brief COPE consists of 28 items each answered on a four point Likert scale, 1= "I haven't been doing this at all" to 4= "I've been doing this a lot". Carver et al (1989) suggested that the original 14 subscales could be meaningfully summed into three broad approaches to coping: problem-focused coping (consisting of active coping, planning, and instrumental support subscales); emotion focused coping (consisting of emotional support, positive reframing, religion, and humour subscales); and maladaptive coping strategies (venting emotions, behavioural disengagement, self distraction, denial, substance abuse, and self blame subscales). The internal consistency for all three summary scales in this study was good (problem focused coping $\alpha = .82$, emotion focused coping $\alpha = .74$, and dysfunctional coping $\alpha = .83$) and thus the summary scales were used for analysis.

Problem Solving Inventory (PSI)

The PSI (Heppner and Peterson, 1982) is a 32 item scale with each item being answered true or false. The items sum into three factors of problem solving: problem solving confidence (e.g. "I make decisions and am happy with them later"), personal control (e.g. "I make snap judgements and regret them later), and approach/avoidance style (e.g. When I am confronted with a complex problem, I do not bother to develop a strategy to collect information so I can define exactly what the problem is"). Items are scored '1' for a 'true' response, and '0' for a false response. For items that are reverse scored, true is scored '0' and false responses are scored '1'. Items are summed within each factor, and the factors are then summed to give a total problem solving score. A high problem solving total score indicates good problem solving but it should be borne in mind when interpreting results that because of reverse scoring a high problem solving avoidance score therefore indicates low avoidance. Comparisons of internal consistency with the original sample of students were good. For problem solving confidence $\alpha = .75$ (original $\alpha = .85$), personal control $\alpha = .77$ (original $\alpha = .72$), and approach/avoidance $\alpha = .87$ (original $\alpha = .84$).

Autobiographical memory test (AMT)

The AMT (Williams and Broadbent, 1986) consists of 15 cue words (five positive, five neutral and five negative) matched for emotionality ratings (see Brittlebank et al, 1993). Researchers have found both positive and negative words elicit differences between populations but neutral words have revealed little differences. Following personal communication with the author of AMT, it was considered acceptable to exclude neutral words. Positive words used were: 'sunny', 'proud', 'eager', 'happy', and 'relieved'. Negative words were: 'guilty', 'hopeless', 'worse', 'failure', and 'ugly'. Standardized instructions are read to participants who

are asked to recall a memory of a specific event lasting less than a day in relation to each cue word, within 30 seconds. The cue words are both read and shown on a prompt card. Responses were taped. Memories are coded in line with Williams (1986) criteria, as to whether they are specific, overgeneral (includes semantic, categoric and extended memories), or whether no memory is recalled. The total number of memories recalled in each category gives the overall scores used for analysis.

Parent-Child Autobiographical Memory Test (PCAMT)

The PCAMT (Hutchings, 1996) is a version of the AMT where parents are asked to think of a memory in the child's life, that the cue word reminds them of. An example of a specific response in this test would be "Joey enjoyed his birthday". Administration and scoring are the same as AMT. Positive words used were: 'excited', 'calm', 'pleased', 'proud', and 'peaceful'. Negative words were: 'helpless', 'upset', 'hurt', 'bad', and 'guilty'. Total scores for specific and overgeneral memories were used for analysis.

Inter-rater reliability was conducted for 10 participants, five from each group. Items rated by each rater were compared for both AMT and PCAMT. Kappa coefficient for AMT was .85 and for PCAMT was .84, inter-rater reliability was considered very good for both measures.

Procedure.

All potential participants for the parent training group were sent information sheets with a covering letter from the service, asking parents to contact the service if they did not want the researcher to contact them subsequently. No parents refused to take part at this stage. After a week, the researcher telephoned the participant and if s/he agreed, a convenient time and place was arranged to conduct the research. 22

participants were approached to take part and there was only one refusal. Response rate was 95%.

Schools or nursery staff issued control group parents with an envelope containing a participant information sheet, an 'opt-in' reply slip and stamped addressed envelope.. Response rate was poor (approximately 11%) and of 74 reply slips received, 41 respondents (55%) agreed to take part. Attempts were made to contact 30 respondents within the time scale of the research. However, six parents were excluded for the following reasons: one parent had moved house, three parents had children with learning difficulties, and two had already attended parent training programmes, leaving 24 parents who completed the study. Although the researcher did not specify which parent was to take part, in all cases it was the mother who took part.

The SDQ was used as a screen for behavioural problems in children. Nine of the 'control' parents reported their child as having 'borderline' or 'abnormal' range of behavioural difficulties on the conduct scale of the SDQ, and two of the parenting group reported only 'borderline' difficulties. These were excluded in line with the ethical approval creating two 'pure groups' (19 parent training and 15 controls). However, some statistical power was lost.

Half of the overall sample were administered AMT first, and the other half PCAMT first. Questionnaires were completed independently by mothers except in one case where the mother had literacy problems and the researcher was engaged in reading the questionnaire items and noting her responses.

Statistical analysis

Analysis was conducted using the Statistical Package for Social Sciences (SPSS) version 6.1.1 for Apple Mac. Distributions were explored using the

Kolmogorov-Smirnov test, for variables within both the parent training group (n=19) and the control group (n=15) The variables were total BDI score, Problem solving scores – all three subscales and total score, coping scores – three subscales, AMT and PCAMT scores, on overgeneral memories and specific memories. The distributions were reasonably normal except for the parent training group personal control scores, and overgeneral memories recalled on the AMT. Within the control group non-normal distributions were found for personal control, problem solving confidence, and overgeneral memories recalled on the PCAMT. Correlations were performed using Pearson's product-moment correlation and then checked using Spearman's Rho for non-normal distributed variables. T-Tests were used to explore all differences between the groups. Analysis was repeated using the Mann Whitney U test for those variables having non-normal distributions. Any differences in results were reported.

RESULTS.

There were no significant differences between the two groups in terms of participants' or children's ages. Differences between parents referred for parent training and the control group parents on all variables was explored using t-tests (see Table 1).

Insert table 1

There were no significant differences between the groups on either the AMT or PCAMT scores. As, PCAMT specific memories neared significance, the effect size was calculated using the difference between the means of the two groups, divided by the pooled standard deviation for the two groups. The effect size was moderate ($d = .61$). Because of the non-normal distribution of all overgeneral memories on

PCAMT, analysis was repeated using the Mann Whitney U test and results neared significance ($u= 87.50, p=.05$).

Table 1 shows that there were no significant differences between parents of children with behavioural problems and control group parents in their scores on problem solving avoidance, personal control, and total problem solving scores. However, there was a significant difference between problem solving confidence with parent training parents reporting higher levels of confidence. This analysis was repeated using Mann Whitney U test and results remained significant ($u=79.50, p=.03$).

As depression was significantly correlated with problem solving confidence (see Table 2), analysis was repeated controlling for depression. Both parametric and non-parametric tests had shown similar results despite the non-normal distributions of some variables, and as the ANCOVA test considered to be reasonably robust to non-normally distributed data, ANCOVA was used with depression entered as a covariate. No significant difference on problem solving scores between the two groups remained once depression had been controlled for.

Significant differences were found between parent training parents and controls for both maladaptive coping and problem focused coping styles, with parent training parents reporting higher on both scales. Maladaptive coping was significantly correlated with depression and thus again, analysis was repeated using an ANCOVA to control for the influence of depression. The differences in maladaptive coping between the two groups of parents were no longer significant once depression was controlled for.

Table 2 shows the results of correlations for variables using Pearson product-moment correlation (n=34). There was no difference in results using Spearman's Rho.

Insert Table 2

The association between AMT and PCAMT scores on both specific and overgeneral recall were explored and Table 2 shows a significant association between AMT and PCAMT overgeneral memory scores, and between specific memory scores on both measures. Associations of overgeneral memory recall in relation to aspects of problem solving, and to coping strategies were explored using Pearson product-moment correlation. Table 2 shows that overgeneral memory recalled on both the PCAMT and AMT was significantly related to both emotion focused and problem focused coping, but there were no other significant associations between autobiographical memory scores and problem solving or coping scores, when the groups were combined. Pearson product-moment correlation was performed separately for the two groups (see tables 3 and 4), to explore the relationship of overgeneral memory recall in relation to problem solving and coping scores. No associations between overgeneral memory recall on either the AMT or PCAMT were found for the parenting group (see table 3), but for the control group, overgeneral recall on the PCAMT was related to higher levels of problem solving avoidance ($r(15) = -.57, p = .03$), and lower problem solving totals ($r(15) = -.52, p = .05$) (see table 4).

Following Goddard et al's suggestion that it may be categoric memories only that are associated with problem solving avoidance, correlations were repeated with

categoric, rather than overgeneral memories, but associations remained the same as those found with overgeneral memories.

DISCUSSION.

As the research sample was small, any results should be interpreted with caution. However some interesting trends were identified by this study. Firstly, scores from the AMT and PCAMT were highly correlated for both overgeneral memories and specific memories. However for both specific and overgeneral correlations, approximately 36% of the variance was explained suggesting that although the two measures overlap, they are measuring slightly different aspects of memory recall. Hutchings et al (1998), using the PCAMT, found that mothers of children with behaviour problems recalled fewer specific memories in comparison to controls. No significant differences were found in this study and this may have been affected by the small sample size. The effect size was moderate suggesting that replication with a larger sample, may produce significant results, thus lending tentative support to Hutchings et al's findings.

Separate group analyses exploring the links between autobiographical memory, problem solving and coping strategies, showed that overgeneral memories as recalled on the PCAMT was significantly associated with problem solving avoidance and less effective problem solving for the control group only. Overgeneral recall in this group may therefore be related to failure to orientate oneself to the problem initially (avoidance of problems) rather than difficulties in generating solutions, as Goddard (1996) and Williams (1986) suggest. No such associations between overgeneral recall and problem solving were found when considering the parent training group only.

Neither specific nor overgeneral recall on either autobiographical memory measures were associated with any of the problem solving scores when examining the

two groups together. These results are surprising and do not concur with previous research in the area. It possible that the different measures used may influence this difference. In previous research, autobiographical memory has been significantly associated with problem solving as measured by the MEPS, an investigator rated measure of problem solving *performance*. In contrast, this study used a self-report measure of problem solving which investigated parents' perceptions of their problem solving abilities.

Overgeneral memory recall on both AMT and PCAMT was significantly correlated with higher scores on emotionally focused coping in the overall analysis. This suggests that those with higher overgeneral recall report themselves as using more emotional support, positive reframing, religion, and humour. However, as emotionally focused coping was also significantly associated with reports less effective problem solving and higher avoidance in problem solving, the 'positive' aspects of emotional focused coping strategies such as using emotional support, humour etc may serve to divert attention, away from problems. If this is true, although no direct link was found between overgeneral memories and problem solving styles, a process of avoidance via emotional coping, may lend some support to Goddard et al's (1996) proposal that overgeneral memory recall in someway deters the process of orientation to the problem presented.

Paradoxically however, overgeneral memories on the AMT were also associated with problem focused coping strategies (active coping, planning, and instrumental support) suggesting that parents with more overgeneral memory recall also perceived themselves as having more problem focused coping strategies In addition results from direct comparisons between groups using t-tests showed that parent training parents perceived themselves to be more confident about their problem solving and reported

feeling more in control of their problems, than parents in the control group. They also reported using significantly more maladaptive coping strategies. This again may relate to the use of measures of perceived problem solving and coping. However, this may be an important factor for clinicians to consider as they will be dealing with parents' reports of their own strengths and weaknesses as well as integrating research evidence into their practice.

Parents in the parent training group, were significantly more depressed, and once depression had been controlled for, no significant differences were found between the groups in maladaptive coping or problem solving confidence. What may be pertinent about these results is that if parents are confident of their problem solving abilities (whether depressed or not), they will bring those qualities to parent training and this is the perception that any clinician will have to work with in the parenting group. If further exploration indicated that the results of these self report capabilities are robust, then clinicians may face the task of addressing any differences between their own clinical assessment or judgement about parental abilities, and the parents' own perception of their problem solving and coping abilities.

Parents perceptions of their own abilities may also provide some explanation for why parents fail to attend parent training, as the aims of parental management training may appear irrelevant to those who perceive themselves as capable. This explanation lends some support to the literature suggesting that parents of children with aggressive behaviours are more likely to divert responsibility for addressing the child's problem to external sources (Pakaslahti, 1996, 1998). An interesting area for further research would be to use both the MEPS to test clinicians' ratings of parents' problem solving ability, and to see how this relates to a self-report measure of problem solving in this population.

Apart from the small sample size there are some further limitations to the study. The use of the Problem Solving Inventory with this population denied direct comparisons with previous literature considering problem solving and autobiographical memory but provided some interesting insight into parents' own perceptions of their abilities. It may be useful to replicate these findings and to further explore associations with coping styles. It would also be interesting to consider wider stressors that may impact on parents coping (such as socio-economic status, family size, life history of depression) but these were beyond the scope of this study. It may also be important to consider whether there is a partner in the home, who may either decrease the impact of stressors by offering support, or increase stressors in terms of marital discord.

CONCLUSION

This study provided further evidence for an association between the PCAMT and the AMT, although associations were not as high as the original research by Scholey (1998). Contrary to previous research, parents referred for parent training groups were not significantly different to a control group in their overgeneral or specific memory recall on either autobiographical memory test. Although the moderate effect size calculated for overgeneral indicates that a larger sample size may show significant differences in line with Hutchings et al's findings. Neither were there significant differences on either coping or problem solving styles between the two groups, once depression had been controlled for. Although not significant, results suggest exploration of parents' own view of their problem solving abilities may provide clinicians with some insight into how parents perceive their strengths and limitations in relation to problem solving, and how this may then affect their

engagement or participation in parent training, an approach which is particularly focused on parental changing their style of addressing behavioural difficulties.

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Table 1. Results of t-test comparisons between parent training group (ptg), n=19) and control participants (n=15)

	Mean value	Standard deviation	T value	P value
BDI - ptg - control	17.05 9.07	11.92 5.60	2.39	0.02*
CopM - ptg - control	23.68 18.27	6.41 5.31	2.63	0.01*
CopE - ptg - control	21.74 21.87	5.06 6.57	-.07	0.95
CopP - ptg - control	18.21 14.80	3.98 4.69	2.29	0.03*
PS avoid - ptg - control	7.47 5.93	4.74 4.70	.94	0.35
PS conf - ptg - control	3.26 1.33	2.66 1.839	2.39	0.02*
PS co - ptg - control	1.68 2.67	1.80 1.54	-1.68	0.10
PS tot - ptg - control	12.21 9.93	5.28 5.20	1.26	0.22
Csgentot - ptg - controls	3.37 2.07	2.23 2.09	-0.73	0.47
Cspectot - ptg - controls	5.80 6.33	2.24 1.83	1.82	0.08
Pgen - ptg - control	4.21 3.07	2.55 2.15	1.39	0.18
Pspec - ptg - control	4.42 5.07	2.29 1.87	-0.88	0.38

Key

- BDI BDI II total score
- Cgen PCAMT total overgeneral memories recalled
- Cspec PCAMT total specific memories recalled
- Pgen AMT total overgeneral memories recalled
- Pspec AMT total specific memories recalled
- CopM Maladaptive coping
- CopP Problem solving focused coping
- CopE Emotion focused coping
- Psconf Problem solving confidence
- PSCo Problem solving control
- PSAvoid Problem solving avoidance
- PSTot Problem solving total score
- * - high score = low avoidance
- ** Problem solving total score significant at $p \leq .05$
- ** Problem solving total score significant at $p \leq .001$

Table 2 Correlations between key variables for the whole sample (n=34)

	BDI	Cgen	Cspec	Pgen	Pspec	CopM	CopP	CopE	PSconf	PSCo	PSavoid	PSTot
BDI	1.0											
Cgen	.09	1										
Cspec	-.11	-.66**	1.0									
Pgen	-.07	.59**	-.42*	1.0								
Pspec	-.03	-.28	.59**	-.69**	1.0							
CopM	.70**	.32	-.21	.17	-.04	1.0						
CopP	.23	.30*	-.17	.36*	-.24	.35*	1.0					
CopE	.000	.36*	-.17	.49*	-.30	.35*	.67**	1.0				
PSconf	.37*	.14	-.19	-.11	.03	.31	-.06	-.14	1.0			
PSCo	-.39*	-.21	.22	.02	.09	-.63**	-.12	.01	-.59**	1.0		
PSavoid	.03	-.10	-.22	-.12	-.06	.09	-.4*	-.34*	.39*	-.36*	1.0	
PSTot	.07	-.12	-.23	-.10	-.02	.02	-.42*	-.35*	.60**	-.26	.93**	1.0

Key

- BDI BDI II total score
- Cgen PCAMT total overgeneral memories recalled
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- Pgen AMT total overgeneral memories recalled
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- PSconf Problem solving confidence
- PSCo Problem solving control
- PSAvoid Problem solving avoidance - High score = low avoidance
- PSTot Problem solving total score
- * significant at $p \leq .05$
- ** significant at $p \leq .001$

Table 3 Autobiographical memory score correlations with coping and problem solving scores, for parent training group (n=19)

	Cgen	Cspec	Pgen	Pspec
Cgen	1			
Cspec	-.92**	1.0		
Pgen	.56**	-.56*	1.0	
Pspec	-.33	.46*	-.81**	1.0
CopM	.40	-.38	.02	.05
CopP	.41	-.23	.25	-.14
CopE	.44	-.34	.42	-.35
PSconf	-.02	-.17	-.27	.17
PSCo	-.18	.26	-.05	.16
PSavoid	.05	-.15	.06	-.07
PSTot	.00	-.15	-.07	.06

Key

- BDI BDI II total score
- Cgen PCAMT total overgeneral memories recalled
- Cspec PCAMT total specific memories recalled
- Pgen AMT total overgeneral memories recalled
- Pspec AMT total specific memories recalled
- CopM Maladaptive coping
- CopP Problem solving focused coping
- CopE Emotion focused coping
- PSconf Problem solving confidence
- PSCo Problem solving control
- PSavoid Problem solving avoidance - High score = low avoidance
- PSTot Problem solving total score
- * significant at p<=.05
- ** significant at p<=.001

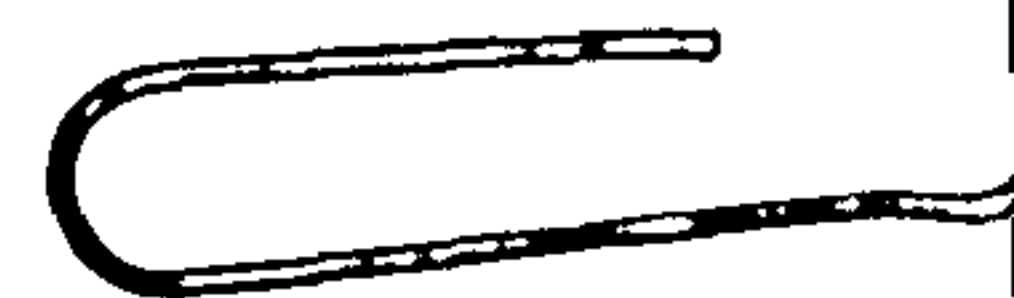
Table 4. Autobiographical memory score correlations with coping and problem solving scores, for control group (n=15)

	Cgen	Cspec	Pgen	Pspec	
Cgen	1				
Cspec	-.23	1.0			
Pgen	.56*	-.16	1.0		
Pspec	-.08	.78**	-.44	1.0	
CopM	-.13	.18	.19	-.02	
CopP	.15	-.01	.36	-.29	
CopE	.34	-.00	.64*	-.26	
PSconf	.06	-.14	-.02	-.07	
PSCo	-.07	.08	.14	-.14	
PSavoid	-.57*	-.28	-.50	.02	
PSTot	-.52*	-.28	-.42	-.05	

<p><u>Key</u></p> <p>BDI</p> <p>Cgen</p> <p>Cspec</p> <p>Pgen</p> <p>Pspec</p> <p>CopM</p> <p>CopP</p> <p>CopE</p> <p>PSconf</p> <p>PSCo</p> <p>PSAvoid</p> <p>PSTot</p> <p>*</p> <p>**</p>	<p>BDI II total score</p> <p>PCAMT total overgeneral memories recalled</p> <p>PCAMT total specific memories recalled</p> <p>AMT total overgeneral memories recalled</p> <p>AMT total specific memories recalled</p> <p>Maladaptive coping</p> <p>Problem solving focused coping</p> <p>Emotion focused coping</p> <p>Problem solving confidence</p> <p>Problem solving control</p> <p>Problem solving avoidance - High score = low avoidance</p> <p>Problem solving total score</p> <p>significant at p<=.05</p> <p>significant at p<=.001</p>
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SECTION 4

Contributions to theory, clinical practice, and learning

Contributions to theory

Literature concerned with autobiographical memory has traditionally used the Autobiographical Memory Test (AMT, Williams & Broadbent, 1986) whereas research considering parents referred to parent training and autobiographical memory has used the Parent-Child Autobiographical Memory Test (PCAMT, Hutchings, 1996). Using both measures in this study permitted comparison with results from both areas of previous research. It also provided an opportunity to test the level of association between the two measures. The association between the two measures was significant and this was consistent with previous findings (Scholey, 1998). The associations in this study were lower than the original correlation and it appears that they may be measuring slightly different aspects of autobiographical memory as the association explained only 36% of the variance.

Although not significant, parents of children with behavioural problems recalled slightly more overgeneral memories as measured on both the AMT and fewer specific memories recalled on the PCAMT. PCAMT specific memory comparisons neared significance and the effect size calculation showed indicated that in a larger sample this result may become significant, offering tentative support for Hutchings, Nash, Williams, and Nightingale's (1996) results that PCAMT distinguished between parents referred for parent training and control parents.

Previous research has identified associations between problem solving and autobiographical memory, and autobiographical memory and parenting. This study allowed exploration of problem solving and autobiographical memory in relation to parents referred for parent training, and to the researchers' knowledge this had not

been explored before. Both observational studies (Wahler & Afton, 1980, Wahler & Sansbury, 1990), and social scenarios (Pakaslahti, Asplund-Peltola, & Keltikangas-Järvinen, 1996, 1998) have been used to explore the problem solving performance of parents of children with behavioural problems. Both of these methods have relied on researchers' ratings of parents' problem solving abilities. In this study the use of a self report measure of problem solving permitted some insight into how *parents* view their problem solving abilities. Parents of children with aggressive behaviour have been found to be more likely than control parents to both externalize the responsibility for solving the problem, and less likely to offer solutions to their children (Palaslahti et al (1996, 1998). One explanation for these factors may be that parents do not feel confident in their ability to solve problems, or tend to avoid problems and the use of the Problem Solving Inventory (Heppner & Peterson, 1982) allowed exploration of both of these concepts, and how they may relate to autobiographical memory.

Previous research evidence suggests that the links between autobiographical memory and ineffective problem solving is the result of restricted access to a rich and detailed memory database from which to generate possible solutions, and thus it is at the stage of generating possible solutions that the problem solving process is affected. Williams (1986) explains this process of restricted access as a 'truncated search' through the hierarchical memory system. He proposes that in usual childhood development memory retrieval becomes progressively more specific and that early traumatic events can interrupt this development, leaving adults with the overgeneral retrieval style characterized by early developmental stages. The early traumatic memories are not fully processed and if specifically recalled are associated with either pain or panic for the individual. Overgeneral memory style serves to 'ward off' the

recall of unwanted memory by truncating the search through the hierarchical memory system before it reaches specific levels of detail. i.e. searches end at categories of memories (e.g. birds) rather than being able to continue the journey to obtain specific events/members within that category (e.g. birds that cannot fly - ostriches). As such, the painful memories are avoided, but so are specifics of other autobiographical events.

It can be seen how memory searches ending at a categorical or generic stage may be unhelpful to the process of problem solving which requires specifically evaluating what worked, and what did not work, as a solution in previous similar situations. However, qualitative inspection of the process of problem solving (Goddard, Dritschel & Burton, 1996) suggested that rather than 'failing at the generation of solutions' stage of problem solving, some participants with overgeneral memories failed to initially orient themselves to the problem. Thus it would seem that an overgeneral memory style might have a more pervasive effect on the problem solving process, in that it may also be associated with problem solving avoidance.

If, as Williams suggests, overgeneral autobiographical memory is the result of traumatic events in childhood, and overgeneral memory is associated with ineffective problem solving, then childhood experiences must have an influence on future problem solving. However, research evidence has also suggested that children's problem solving skills may be directly influenced by their parents' problem solving processes (Huesman & Eron, 1989). It may be unclear whether problem solving difficulties experienced as an adult are therefore a learned response set learned from one's parents, or are more indirectly affected through autobiographical memory processes. It may also be possible that early learned problem solving styles and their subsequent efficiency, may impact on the child's developmental progress from

general memory retrieval styles to more specific retrieval. For example, if a child learns from the parent to avoid problems or use generic solutions (such as aggression), are these then encoded categorically or do the cognitive skills needed for specific encoding or retrieval become dormant through limited practice?

Results from the control group in this study showed that high overgeneral autobiographical memory recall as measured by the PCAMT was associated with self reported high problem solving avoidance, lending some support to Goddard's findings. However, results from the parenting group in this study showed no such pattern. Neither specific nor overgeneral memories were related to any of the coping or problem solving measures within this group and this finding was puzzling. A possible explanation may lie in the comparisons between the two groups. Table 1 shows that parents of children with behavioural problems reported being more confident about their problem solving abilities than control parents, and that they were less avoidant than the control group parents. These results were unexpected, and it may be the use of a self report measure of problem solving may give very different results compared to using a researcher rated measure. Further research employing both a researcher rated measure of problem solving and a self report measure of problem solving should provide more clarification of this issue.

Another possible explanation for this finding may be how parents of children with behavioural problems define the problem differently from researchers. In terms of problem behaviour for example, Wahler and Sansbury (1990) reported that parents of children with behavioural problems often attributed more blame to their child for the problem behaviours. Thus parents may perceive the difficulties in terms of being intrinsic to the child, rather than to do with their own problem solving, and may therefore perceive the solution in terms of obtaining professional help for the child.

Such a scenario could reasonably explain a parent's report a high level of problem solving confidence and a low level of avoidance (e.g. noticed my child has a problem and have done what I can to get my child help). Thus parents' attributions of the cause of the problem may well impact on their reports of their problem solving abilities, and again further research is needed for clarification.

This study aimed to explore the coping styles of parents of children with behavioural difficulties. Results indicated that parents of children with behavioural problems reported using more maladaptive coping strategies than control group parent, and this supports McKee et al's findings. However, no significance remained after controlling for the effects of depression on maladaptive coping strategies. One might expect that either depression or coping with behavioural problems may lead to the use of some maladaptive coping strategies to 'escape' distress (e.g. venting emotions, behavioural disengagement, denial and substance misuse) However, these strategies may also be used for effective 'short-term' relief by many people, and may only become 'maladaptive' if used as long term strategies. Brief COPE is not designed to address this but long term maladaptive coping may be more likely to influence the level of parents' engagement with their child's behavioural difficulties, and possibly be a maintaining factor in such difficulties. Again, further research would clarify this.

It is maybe surprising that parents of children with behavioural problems also used more problem focused strategies but this finding is concordant with the results of the problem solving measure, suggesting that parents perceive themselves to be oriented to their problems.

Implications for clinical practice

In order for clinicians to work effectively with parents of children with behavioural problems, it is important for the clinician to appreciate parents' reports of their strengths and skills. Parental reports of their problem solving confidence scores and problem focussed coping suggest that parents may perceive their problem solving abilities as a strength. If parents perceptions are markedly different from either clinicians or researchers assessment of those skills, then it may be necessary to further explore how academic beliefs surrounding coping and problem solving make sense in relation to parents' real life experiences. This is necessary in order to reach a therapeutic understanding without which progress is unlikely to be made.

If parents do tend to externalize the child's problems (and this fits with some clinical presentations in the researchers own experience) and furthermore, feel confident in their abilities to solve problems, parents may fail to appreciate the relevance of interventions focussed on the their role in the process of maintaining deviant behaviour. This has implications for both parents' engagement with, and progress within, parenting groups which are very much focused on parents' own strategies to deal with problems, and therefore also has implications for maintenance of gains from parent training.

Process and personal issues arising from conducting the research

Recruitment and consideration of the measures were the main process issues in this research.

Recruitment

The most disappointing aspect of the study was recruitment to the study resulting in the small sample size. As there were a number of issues related to recruitment, the difficulties in recruitment for each group will be reported separately.

Parent training group

One of the main issues with recruitment in this group was the number of parents available for recruitment. Initially, it was planned to recruit all participants from one child service within North Wales, and that three parenting groups would run during the data collection period. Based on the previous year's figures, it was anticipated that this would provide a possible 24 participants (eight in each group). Although the first parenting group recruited only five participants, there was still the possibility that there would be enough parents eventually providing that groups leaders managed to recruit 8 parents to each of the subsequent groups, and that all of the parents agreed to take part. However, the trained group leader's maternity leave resulted in the final group being cancelled. It therefore became necessary to seek reciprocal ethical approval to recruit parents from another service in North Wales. This was achieved, but took the researcher's time and attention away from other aspects of the research. Only one group ran in this new area. This resulted in a total of 21 participants, two of which were excluded as their child's problem behaviour did not meet clinical range on the Strengths and Difficulties questionnaire.

Clinical control group

The research project described in the original ethics proposal included recruiting a group of parents whose children had a health problem. This group was included to provide some insight into whether parents who had children with an ongoing problem that was not behaviourally related (such as eczema) were more similar to control

group parents with no apparent problems to deal with, or similar to parents whose children have behavioural problems. i.e. was it the existence of an ongoing 'problem' that was important or were differences specific to parents of children with behavioural problems? The dermatology consultant was reluctant for the researcher to approach parents directly, and so agreement was reached that he would issue potential participants (i.e. parents of children aged between 3 and 10 years old) with envelopes containing the participant information sheet, a reply slip, and a stamped addressed envelope to return their reply directly to the researcher.

After two months, no replies had been received although the consultant had issued 20 envelopes. It was agreed with the consultant that a more effective means of recruitment would be for the researcher to attend the dermatology clinic, which ran for half a day each week, and that the consultant would ask patients if they were prepared to be part of the research. Parents who agreed would then be seen immediately by the researcher to explain the research further, and administer the autobiographical memory tests to willing participants. The questionnaires would be issued with a reply envelope to return responses to the researcher. Parents would be informed that they could 'opt-out' if they changed their mind after taking part and the information sheet would be amended to this effect. As there would be a change to the proposed method of recruitment, it was necessary to gain ethical approval before proceeding. This delayed recruitment for a further month but the changes were approved by the ethics committee.

For two months the researcher attended the dermatology clinic and during this period a total of 17 parents were recruited. However, only 10 of these parents returned their questionnaires despite follow up phone calls. Of these 10 respondents, six reported behavioural problems within the clinical range on the Strengths and

Difficulties Questionnaire (SDQ). These six participants were excluded from the analysis in line with the research protocol agreed by the ethics committee, leaving four participants who satisfied the criteria of the research protocol. This group was therefore excluded from the study.

This highlights two particular issues not anticipated when designing the study. Firstly, although it was expected that some parents would report behavioural difficulties on the SDQ, 60% of the children in this group were reported to have behavioural difficulties on the SDQ. Thus to achieve the required number of parents whose children do not have behavioural difficulties, would have entailed recruitment of double the number actually needed for the research. Secondly, that the time frame for this piece of research did not allow for such large numbers of participants to be recruited for face to face administration of measures.

Control groups

A community sample was recruited from the local population for the two services involved in parent training. Three local nurseries and two local schools agreed to take part on the understanding that parents would not be approached directly by the researcher, and that they did not provide personal details (names and addresses) for the researcher to post information sheets. It was therefore necessary to issue information sheets via nursery staff and school teachers. Both nursery leaders and teachers received enough envelopes for the parents of all children in their group, and these were issued either directly to parents by nursery leaders or teachers, or were given to children to take home for their parents. There was a very poor response rate; no responses at all were received from one nursery. In total over 650 envelopes were issued with only 74 responses being received. This again highlights the level of input

needed by researchers relying on 'opt-in' participants in order to recruit the modest number needed for the research.

There are a number of points that may have influenced response rate – firstly it is difficult to ensure that staff remember to issue the envelopes, and it is unclear how many envelopes were issued by staff directly to parents, and how many were issued via children and may therefore not have reached parents. Clearly this is not an ideal situation for researchers, but the primary considerations for nursery leaders and head teachers in agreeing to take part, were protecting parents confidential details and how much extra work would be involved for their staff. Their good will depended on their workload being kept to a minimum, and this had to be balanced against the likelihood of a poor response rate.

A further issue in recruiting control group participants was the lone worker policy agreement of NHS trusts in North Wales. This was drafted during the course of the research and indicated that employees should not make home visits to clients not previously known to the service unless they are accompanied by a colleague. As this was not possible, recruitment of the control group ceased.

Measures

The Problem Solving Inventory (Heppner & Peterson, 1982) had not been used to assess problem solving skills in relation to measures of autobiographical memory before and therefore direct comparisons with other research considering the relationship between problem solving and autobiographical memory was not possible. Previous research had considered problem solving *performance* using the Means End Problem Solving (MEPS). However, qualitative analysis of responses in the MEPS task highlighted that there may be a need to consider a participant's approach to solving problems (Goddard et al, 1996). For this reason it was considered appropriate

to use a measure considering approach to problems both in terms of approach/avoidance style and in terms of parents' confidence and sense of control in approaching problems. The researcher was also interested in whether a self report measure of problem solving would result in similar findings to a performance measure of problem solving, in its relation to autobiographical memory recall. The findings using a self report measure in this study were quite different.

Interest in parents' view of their own problem solving was also sparked by the fact that parents in performance problem solving tasks are rated by researchers, and the researchers are therefore in a position of judging what the parents' strengths and weaknesses are. Whilst this may contribute to our understanding of cognitive processes, and how autobiographical memory and problem solving may theoretically fit, from a clinical perspective, one is interested in how parents would describe their own problem solving strategies, as this is what parents will bring to sessions, and what the clinician will inevitably be working with. However, replication of the results of this study would be necessary before drawing firm conclusions about how parents may present in clinics. Furthermore, research directly comparing self report and performance measures of problem solving in this population would possibly provide further clarification of any discrepancies between the two.

Consideration was given to the more widely used Social Problem Solving Inventory – Revised (SPSI-R, D'Zurilla, Nezu, & Maydeu-Olivares, 1996) but as neither research about parenting, nor research about autobiographical memory, had used this measure, direct comparisons with previous research would still not have been possible. The SPSI-R also does not consider problem solving confidence but does explicitly permit the "Rational Problem Solving" scale to be broken down into subscales considering problem definition and formulation, generation of alternative

solutions, decision making and solution implementation and verification. Using the SPSI-R may therefore have allowed exploration of which stages of problem solving parents felt they were competent at.

One limitation with self report problem solving measures is that the problems that participants may have had in mind when completing the questionnaire may be different for each participant, and this is unknown to the researcher. The severity of the problem may influence how they respond. The dichotomous response options of true or false on the PSI were reported to be particularly frustrating for people to answer, and a likert scale may be more appropriate to allow participants to respond in a more graded way. Another difficulty with the Problem Solving Inventory is that certain items have a corresponding reverse score item. Participants reported feeling that this was repetitious.

When the ethical proposal was approved, the Brief COPE measure (Carver, 1997) had not been used with a population of parents of children with behavioural problems before. Since the ethics proposal was agreed, results have been published for a study using the COPE to measure coping in parents of children with ADHD and, had this been known to the researcher before, the COPE may have been used in this study to enable direct comparisons. Carver et al (1989) suggest that the individual scales on the COPE can be meaningfully clustered into scales of maladaptive coping, active coping and problem focussed coping, the COPE has been amended to Brief COPE since this original 1989 publication and the internal scales slightly amended. However, as internal consistencies for the coping summary scales were good they were considered appropriate for analysis.

The second issue with the Brief COPE is that, again, researchers do not have an insight into what sort of events the participant has in mind when they are answering

about their coping and thus reports of general coping styles may not accurately reflect coping specific to managing behavioural problems. In addition, Brief COPE asks participants to reply about how they cope with stress but no time indication is given. If the Brief COPE is taken to be reflective of coping style in general, then the assumption is that participants' coping styles are consistent and decontextualized.. Again this may be problematic as coping strategies may differ according to the nature, severity or chronicity of the stress.

The Beck Depression Inventory (Beck, Steer, & Brown, 1996) provides a snapshot of depressive symptoms in the past two weeks which in itself does not equate to a clinician's evaluation of clinical depression. Remitted clinical depression has been linked with overgeneral recall in autobiographical memory (Brittlebank et al, 1993), and for the influence of depression to be measured accurately, a life history of episodes of depression would be necessary, rather than the snapshot of symptoms that the BDI provides. This would either require a clinical group for which a full medical history was available, or would rely on a measure that permits a full history of psychopathology by retrospective reporting (e.g.. SADS-L).

Personal reflection on the research process.

Meeting so many parents of children with behavioural difficulties has been an experience that will be invaluable in my future clinical practice in terms of the emotional strain that some mothers reported in conversation, and in terms of the systemic effects of a child's behavioural problems. Although I preferred to meet with mothers alone to conduct the autobiographical memory tests, this was not always practically possible for mothers. I therefore had the opportunity to witness mothers' aborted attempts to control their child's behaviour, and saw the emotional distress for

both the mother and other children in the family. Such opportunities also left me with a strong sense of the labelling that children with behavioural problems face, and how this may influence the child's sense of identity and future emotional development. In one household, the child was sat quietly listening to his mother talk about how disruptive he was and I felt emotionally drawn to enquire about some of his positive qualities, so that he may hear some positive information.

I noticed that some parents used taking part in the research as an opportunity to 'offload' their concerns and anger about their difficulties with the child. Whilst I did not overtly encourage this, I also appreciated that the women had given me their time, and therefore gave some of my time to listen.

In another household, I was impressed by the mothers' ability to manage four children, one of which had behavioural difficulties. This also made me question whether parenting skills were the main contributor to this child's behavioural difficulties as the other children, who were also being parented by this mother, were reported to be obedient and well behaved. This led me to think about other factors involved in the development or maintenance of this particular child's behavioural problems, and particularly of the sibling relationships in this family.

Conducting the research has been akin to a journey of discovery about both the research process and my own strengths and limitations in relation to this. First there is the exciting stage of deciding where to go and which routes can be taken in the time allowed. This involves reading the literature and deciding what focus of study can be reasonably be achieved. This was a difficult task as there is a plethora of literature on conduct disorder, and researchers have been very productive in researching aspects of both problem solving and coping, and autobiographical memory.

Next, comes the preparation for the journey - reading papers, organising ethical approval, liaising with necessary parties such as services, nurseries and schools, that need to be involved for the journey to go well. This preparation stage requires a lot of clear thinking and good organization skills. Life events occurring during this planning stage can severely detract from the thoroughness of this preparation and be an additional source of stress. I experienced such a life event and found that both my time and concentration were divided at a time when I would have preferred to focus on one event. But, I learnt that I was able to manage these two major demands and effectively use the social support around me to help me achieve this.

The next stage of the journey is to board the train and begin data collection. However, in true rail travel style, the train is delayed and there is uncertainty about reaching the destination in time. Panicky feelings emerge, but these are calmed by orienting myself to the problem and generating alternative solutions. Recruitment was not proceeding as planned, leading to feelings of frustration and worry about what would be the best way to amend this. Possible solutions were to a) stick with the same method; b) gain ethical approval to recruit in another way and other areas; c) give up. After evaluating possible consequences of options a) and c), I decided that option b) was the best way to solve the problem. I decided that change in recruitment was needed for the eczema group and that this required further ethical approval. I also needed to widen the research focus to include participants from another district in North Wales for both parent training group and control groups, which involved seeking reciprocal agreement from a neighbouring NHS Trust. Both of these procedures took time and attention away from preparation for writing the thesis. I found myself feeling frustrated with the internal mechanisms of the ethical process and the length of time that this can take. This experience highlighted to me that

coping with a problem is more than being effective at problem solving, and that coping involves tolerating the emotions that one can experience even when one has solved the problem. It also highlighted to me that some coping strategies can be defined in multiple ways e.g. meeting with family or friends in the pub could be defined as both problem focused coping (using social support) and maladaptive coping (self distraction and substance use).

Once the train started moving again (i.e. ethical approval was granted), I felt that I could relax into the research project and gradually move forward to my destination. However, there was a further delay and I realized that I would have to change my route to reach the final destination in time – parents of children with eczema were excluded from the study. The journey has been more complicated than intended and the number of delays and rerouting seemed to take a lot of my energy. I realized towards the end that there was little time to rest in case I fell asleep and missed the stop, and furthermore that the new route was not as attractive as the original. I decided to enjoy the new view for the little remaining time left on the train and hoped that the destination was near. I finally arrived somewhat relieved and very tired after the long and eventful journey.

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List of appendices

Appendix 1 Copies of letters granting ethical approval

Appendix 2 Participant information sheets and reply slip

Appendix 3 G.P letter

Appendix 4 Consent form

Appendix 5 Measures

Instructions for Autobiographical Memory Test

Instructions for Parent-Child

Autobiographical Memory Test

Beck Depression Inventory

Strengths and Difficulties Questionnaire – age 4-16

Strengths and Difficulties Questionnaire – age 3

Problem Solving Inventory

Brief COPE

Appendix 6 - Word count

Appendix 1

Uned Dderbyn
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✓ c.c. Dr. Elizabeth Burnside,

July 14, 2003

Lynn Rollinson
Trainee Clinical Psychologist
North Wales Clinical Psychology Programme
University of Wales
Bangor
Gwynedd LL57 2DG

Dear Colleague

Autobiographical memory and coping strategies in parent training programmes

Your research proposal (referred to above and on the attached sheet) has been reviewed by the School of Psychology Research Ethics Committee and they are satisfied that the research proposed accords with the relevant ethical guidelines, provided that the amendments outlined in letter from Dr. Robert Jones dated July 10 have been incorporated. If you wish to make any substantial modifications to the research project please inform the committee in writing before proceeding. Please also inform the committee as soon as possible if research participants experience any unanticipated harm as a result of participating in your research.

Once the above-mentioned amendments have been completed, you should forward the proposal to the appropriate Research Ethics Committees of the North Wales Health Authority. They expect one of the investigators to make an oral presentation in support of the proposal at their meeting. You will be contacted by their committee with details as to the date and place of the meeting at which your proposal will be considered. Please also send a copy of the revised proposal to me.

You may not proceed with the research project until you are notified of the approval of the NWhA research ethics committee.

Yours sincerely

A handwritten signature in black ink that reads 'Kath Chitty'.

Kath Chitty
Coordinator - School of Psychology Research Ethics Committee



**Pwllgor Moeseg Ymchwil Ddwyrain Gogledd Cymru
North East Wales Local Research Ethics Committee**

Ysbyty Maelor Wrecsam
Ffordd Croesnewydd
Wrecsam
LL13 7TD

Ffôn a Ffacs: (01978) 725368

Wrexham Maelor Hospital
Croesnewydd Road
Wrexham
LL13 7TD

Tel & Fax: (01978) 725368

Ref: Lynn Rawlinson

22nd September 2003

Ms Lynn Rawlinson

Dear Miss Rawlinson

**Re: Autobiographical memories and coping styles in parent training
programmes
(Amendments suggested by Ethics Committee 23rd July 2003)**

Thank you for the amended documentation regarding this project. This can now proceed.

Best wishes

Yours sincerely

**Dr Peter Rutherford
Chairman, North East Wales NHS Trust LREC**



Pwyllgor Moeseg Ymchwil Canolog Gogledd Cymru
North Wales Central Research Ethics Committee

Gweinyddwraig Etheg /
Ethics Administrator,
Ystafell 1038 / Room 1038,
Ysbyty Glan Clwyd,
Rhyl, Denbighshire
LL18 5UJ

Ffon/Tel: 01745 - 534132 (llinell uniongyrchol/direct line)

Ffacs/Fax: (01745) 583143

Llyth-el/E-mail: Julie.Whitmore@cd-tr.wales.nhs.uk

8 January, 2004

Our ref: 4.12.03/jw

Ms. Lynn Rawlinson,

Dear Miss Rawlinson,

Re: Autobiographical memories and coping styles in parent training programmes - *Reciprocal Approval sought*

Thank you for your letter of 5th January enclosing complete copies of the Participant Information Sheets as requested in our letter of 6th November 2003. I also confirm receipt of written documentation from the Consultant Dermatologists that they are happy for you to approach patients attending the Dermatology Clinic here at Glan Clwyd Hospital for volunteers to participate in the above mentioned study.

After studying the documentation, I am now able to confirm Chairman's approval for this study to proceed locally, with formal ratification being confirmed in writing following discussion at the next available meeting, on condition that:

- The protocol is followed as agreed
- The project commences within 3 years of the date of this letter
- The Committee is notified of all protocol amendments and serious adverse events as soon as possible.
- The Committee receives annual progress reports and / or final report within 3 months of completion of the project.
- That the Conwy & Denbighshire NHS Trust R & D Committee (Ext. 3624) are advised of the study prior to commencement in this area.

The Committee reserves the right to audit local research records relating to the above study. Ethics approval is granted on this basis.

The Committee aims to be fully ICH / GCP compliant. A copy of our working constitution and a list of members, indicating those present at the meeting when this proposal was reviewed will be forwarded to you following formal ratification.

Yours sincerely,

Dr. T. D. Yuille,
Chairman,
NW Central Research Ethics Committee

Pwyllgor Moeseg Ymchwil Dwyrain Gogledd Cymru
North East Wales Local Research Ethics Committee

Cydlynnydd Moeseg
Ethics Co-ordinator
Ysbyty Maelor Wrecsam/Wrexham Maelor Hospital
Croesnewydd Road
Wrecsam/Wrexham
LL13 7TD

Ffon/Tel: (01978) 725368 (linell uniongyrchol/direct line)

Ffacs/Fax: (01978) 725368

Llyth-e/E-mail: Eleanor.Thomas@new-tr.wales.nhs.uk

5th February 2004

Ms L Rollinson

Dear Ms Rollinson

Re: Autobiographical memory and coping strategies in parent training programmes

Thank you for your letter dated 30th January enclosing amendments to the above mentioned study for approval. After reviewing these amendments I am now able to confirm Chairman's approval for this study to proceed locally has been given, on condition that:

- The protocol is followed as agreed
- The project commences within 3 years of the date of this letter
- The Committee is notified of all protocol amendments and serious adverse events as soon as possible.
- The Committee receives annual progress reports and / or final report within 3 months of completion of the project.

Approval from host institutions must be sought separately.

The Committee reserves the right to audit local research records relating to the above study. Ethics approval is granted on this basis.

The Committee aims to be fully ICH / GCP compliant

Yours sincerely,



Miss E Thomas
Research Ethics/Governance Co-ordinator
North East Wales Local Research Ethics Committee

Gweinyddwraig Etheg /
Ethics Administrator,
Ystafell 1038 / Room 1038,
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Llyth-el/E-mail: Julie.Whitmore@cd-tr.wales.nhs.uk

REC Reference Number 04/18(a) /jw - Please quote this number on all correspondence

Lynn Rawlinson,

20 February, 2004

Dear Ms. Rawlinson,

CONFIRMATION OF FULL ETHICS APPROVAL

Re: Autobiographical memories and coping styles in parent training programmes - Approval previously given by East North Wales LREC - Chairs approval given @ 6.1.04

Further to our letter of 6th January 2004 confirming Chairman's approval for the above mentioned study and following a meeting of the North Wales Central Research Ethics Committee on 5th February 2004, I can now provide full ethics approval for this study, on condition that:

- approval from the Trust R & D Committee Internal Review Panel has been obtained
- the protocol is followed as agreed
- the project commences within 3 years of the date of this letter
- the committee is notified of all protocol amendments and serious adverse events as soon as possible
- the committee receives annual progress reports and/or a final report within 3 months of completion of the project.

The Committee reserves the right to audit local research records relating to the above study. Ethics approval is granted on this basis.

The Committee aims to be fully ICH / GCP compliant. Please find attached a copy of our working constitution and a list of members for your information and retention.

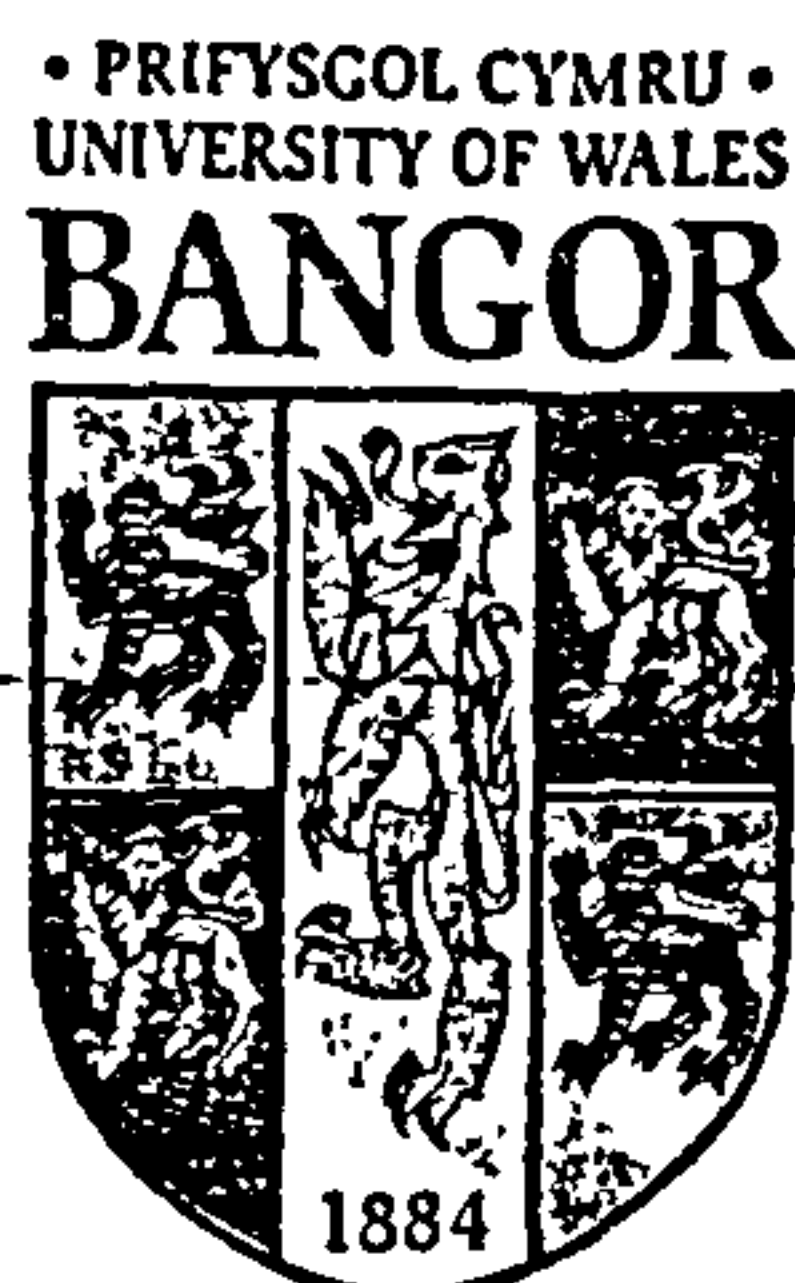
Yours sincerely,

J. A. Whitmore

J. A. Whitmore
Penfold,
Chairman,
NW Central Research Ethics Committee

Cc R & D

Appendix 2



Autobiographical memory and coping strategies of participants parent training programmes

PARTICIPANT INFORMATION SHEET

Researcher: Lynn Rollinson, Trainee Clinical Psychologist

You are being invited to take part in a research project. Before you decide, it is important that you understand why the research is being carried out and what it will involve. Please take time to read the following information and discuss it with your family and friends if you wish. Please feel free to ask if there is anything you are not sure about or if you would like more information.

What is the study about?

Parent groups have been found to be a useful way of helping families where children's behaviour has become a problem. However, parent groups do not work for every family, and some families feel from the start that parent groups are not the answer for them. The purpose of this research is to find out more about parents so we can understand why some families are more likely to benefit from parent groups than others. We hope that this will also help us in the future to design services which are better suited to people's needs. Clues from other research suggest that some of the answers to these questions relate to the different ways that people cope and prefer to tackle problems in their lives and the way people think about and remember events in their life. These are things that this research project will be looking at.

Why me?

You have been invited to take part because you have been offered a place on a parent training group. All parents offered a place on this group will be invited to take part, as well as parents from other groups from this service. In total, over 60 people will be invited to take part in the study.

Do I have to take part?

Participation is entirely voluntary. Although you may not benefit directly, your information can help plan services for the future, and will be very much appreciated.

If you do not wish to take part you can tell Lynn straight away, or at any time during the research. You do not have to give any reason if you decide not to take part. The research will be quite informal and, at any point you will be able to stop and ask questions, or to say that you don't want to carry on. If you decide not to take part in the study, this will not affect the service that you are offered in any way.

What does it involve?

If you agree to take part, first you'll be asked to take part in a memory procedure which looks at your memory style. This is done by showing you some words and asking you to recall events from your own life that each word reminds you of.

~~This takes around twenty minutes. After this, you'll be asked to fill in three questionnaires which will take around 20 minutes. The research can take place either at your own home or at a clinic, whichever you prefer, and at any time that is convenient to you.~~

Occasionally people can feel upset by memories they report. If this happens to you, please tell Lynn who help you to contact people who may be able to help.

Confidentiality

In order to collect information accurately, the memory part of the research will be take recorded. The tapes and questionnaires will be labelled with a number and kept securely and separately from your name. These will be destroyed after the project is complete.

Your GP will be informed by letter that you are taking part in the study and with a brief explanation of what the research is about.

All the information that you give will be confidential to the research unless you tell Lynn something which makes them concerned that there might be a serious risk to you or another person. If this was the case, Lynn would talk to you first.

Further information

If you have any questions about the study or if there is anything which concerns you about it, Lynn will be pleased to discuss this with you. She can be contacted at the following address:

North Wales Clinical Psychology Programme
School of Psychology
University of Wales – Bangor
Bangor
Gwynedd
LL57 2DG

Telephone 01248 382205

If you decide to take part, please keep this information sheet so that you can refer to it in the future. If you have any questions or concerns during or after the research, you can contact Lynn at any point at the address above.

If you have any complaints about the conduct of the study, these should be addressed to:

Ms. Hilary Pepler,
Chief Executive,
North East Wales N.H.S. Trust, Maelor Hospital,
Croesnewydd Road,
Wrexham.

Or Professor F. Lowe
Head of School of Psychology
University of Wales – Bangor
Bangor
Gwynedd
LL57 2DG

Thank you for taking the time to read this information sheet.

Cof hunangofiannol a strategaethau ymdopi cyfranogwyr rhaglenni hyfforddi rhieni

TAFLEN WYBODAETH I GYFRANOGWR

Ymchwilydd: Lynn Rollinson, Seicolegydd Clinigol Dan Hyfforddiant

Fé'ch gwahoddir i gymryd rhan mewn prosiect ymchwil. Cyn i chi benderfynu, mae'n bwysig eich bod yn deall pam bod yr ymchwil hon yn cael ei gwneud a beth fydd yn ei gynnwys. Cymerwch amser i ddarllen yr wybodaeth ganlynol a'i thrafod gyda'ch teulu a'ch ffrindiau os dymunwch. Mae croeso i chi holi os nad ydych yn sicr ynghylch unrhyw beth, neu os hoffech gael gwybodaeth bellach.

Am beth mae'r astudiaeth?

Darganfuwyd bod grwpiau rhieni'n ffordd dda o helpu teuluoedd pan fo ymddygiad plant wedi troi'n broblem. Fodd bynnag, nid yw grwpiau rhieni'n gweithio i bob teulu, ac felly mae rhai teuluoedd yn teimlo nad grwpiau rhieni yw'r ateb iddyn nhw o'r dechrau. Pwrpas yr ymchwil hon yw darganfod mwy am rieni fel y gallwn ddeall pam bod rhai teuluoedd yn fwy tebygol o gael budd o grwpiau rhieni nag eraill. Gobeithiwn bydd hyn hefyd yn ein helpu yn y dyfodol i gynllunio gwasanaethau sy'n gweddu'n well i anghenion pobl. Mae cliwiau o ymchwiliadau eraill yn awgrymu bod rhai atebion i'r cwestiynau hyn yn gysylltiedig â'r gwahanol ffyrdd mae pobl yn ymdopi ac yn dewis mynd i'r afael â phroblemau yn eu bywyd a'r ffordd mae pobl yn meddwl am, ac yn cofio digwyddiadau yn eu bywyd. Mae'r rhain yn bethau bydd y prosiect ymchwil hwn yn edrych arnyd nhw.

Pam fi?

Fe'ch gwahoddir i gymryd rhan oherwydd eich bod wedi cael cynnig lle ar grŵp hyfforddi rhieni. Bydd yr holl rieni sy'n cael cynnig lle ar y grŵp hwn yn cael eu gwahodd i gymryd rhan, ynghyd â rhieni o grwpiau eraill o'r gwasanaeth. Bydd dros 60 unigolyn i gyd yn cael eu gwahodd i gymryd rhan yn yr astudiaeth.

Oes raid i mi gymryd rhan?

Mae cymryd rhan yn hollol wirfoddol. Er na fyddwch chi'n cael budd uniongyrchol, gall eich gwybodaeth chi helpu i gynllunio gwasanaethau ar gyfer y dyfodol, a bydd yn cael ei werthfawrogi'n fawr.

Os nad ydych yn dymuno cymryd rhan, gallwch ddweud wrth Lynn yn syth, neu unrhyw adeg yn ystod yr ymchwil. Nid oes raid i chi roi rheswm dros eich penderfyniad i beidio â chymryd rhan. Bydd yr ymchwil yn eithaf anffurfiol, a byddwch yn gallu stopio ar unrhyw adeg i ofyn cwestiynau, neu ddweud os nad ydych am barhau. Os byddwch yn penderfynu peidio cymryd rhan yn yr astudiaeth hon, ni fydd yn effeithio ar y gwasanaeth a gynigir i chi mewn unrhyw ffordd.

Beth mae'n ei gynnwys?

Os byddwch yn cytuno i gymryd rhan, yn gyntaf, gofynnir i chi gymryd rhan mewn gweithdrefn gof, sy'n edrych ar steil eich cof. Gwneir hyn drwy ddangos geiriau i chi a gofyn i chi am beth mae'r geiriau hyn yn eich atgoffa ynghylch digwyddiadau yn eich bywyd chi.

Bydd hyn yn cymryd oddeutu ugain munud. Yn dilyn hyn, gofynnir i chi gwblhau tri holiadur a fydd yn cymryd oddeutu 20 munud. Gellir gwneud yr ymchwil hon un ai yn eich cartref neu mewn clinig, beth bynnag sydd orau i chi ac ar unrhyw amser sy'n gyfleus i chi.

Weithiau gall pobl gynhyrfu wrth adrodd eu hatgofion. Os yw hyn yn digwydd i chi, dywedwch wrth Lynn all eich helpu chi i gysylltu â phobl all eich helpu.

Cyfrinachedd

Er mwyn gallu casglu gwybodaeth yn gywir, bydd rhan cof yr ymchwil yn cael ei recordio. Bydd y tapiau a'r holiaduron yn cael eu labelu â rhif a'u cadw'n ddiogel ac ar wahân i'ch enw.: Byddent yn cael eu dinistrio ar ôl cwblhau'r prosiect.

Bydd eich Meddyg Teulu yn cael gwybod drwy lythyr eich bod yn cymryd rhan yn yr astudiaeth gydag eglurhad byr o bwrpas yr ymchwil.

Bydd yr holl wybodaeth a roddir i'r ymchwil yn gyfrinachol, oni bai eich bod yn dweud rhywbeth wrth Lynn sy'n eu gwneud yn bryderus bod risg mawr i chi neu unigolyn arall. Pe byddai hyn yn digwydd, byddai Lynn yn siarad â chi'n gyntaf.

Gwybodaeth Bellach

Os oes gennych unrhyw gwestiynau ynghylch yr astudiaeth hon, neu os ydych yn pryderu ynghylch unrhyw agwedd ohoni, bydd Lynn yn falch o'u trafod gyda chi. Gellir cysylltu â hi yn y cyfeiriad isod:

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Ysgol Seicoleg
Prifysgol Cymru - Bangor
Bangor
Gwynedd
LL57 2DG

Ffôn: 01248 382205

Os yr ydych yn penderfynu cymryd rhan, cadwch y daflen wybodaeth hon fel y gallwch gyfeirio ati yn y dyfodol. Os oes gennych unrhyw gwestiynau neu bryderon yn ystod neu ar ôl yr ymchwil, gallwch gysylltu â Lynn ar unrhyw adeg yn y cyfeiriad uchod.

Os bydd gennych unrhyw gwynion ynghylch y ffordd mae'r astudiaeth wedi cael ei gwneud, dylid eu cyfeirio at:

Ms. Hilary Pepler,
Prif Weithredwr,
Ymddiriedolaeth GIG Gogledd Ddwyrain Cymru, Ysbyty Maelor
Ffordd Croesnewydd
Wrecsam.

Yr Athro F. Lowe
Pennaeth Ysgol Seicoleg
Prifysgol Cymru - Bangor
Bangor
Gwynedd
LL57 2DG

iolch i chi i am ddarllen y daflen wybodaeth hon.

Autobiographical memory and coping strategies of participants parent training programmes

PARTICIPANT INFORMATION SHEET .

Researcher: Lynn Rollinson, Trainee Clinical Psychologist

You are being invited to take part in a research project. Before you decide, it is important that you understand why the research is being carried out and what it will involve. Please take time to read the following information and discuss it with your family and friends if you wish. Please feel free to ask if there is anything you are not sure about or if you would like more information.

Why me?

You have been invited to take part because you have not been offered a place in a parent group. Your information is very valuable. It is important that parents whose children do not have behavioural difficulties take part in the research to help us to find out more about the way that parents think in general.

Your information would be used to see if there are any differences between the information from parents whose children do not have behavioural difficulties, and the information from parents invited to attend parent groups. This may help us design future services in relation to parent groups . In total, over 60 people will be invited to take part in the study.

What is the study about?

Parent groups have been found to be a useful way of helping families where children's behaviour has become a problem. However, parent groups do not work for every family, and some families feel from the start that parent groups are not the answer for them. The purpose of this research is to find out more about parents so we can understand why some families are more likely to benefit from parent groups than others. We hope that this will also help us in the future to design services which are better suited to people's needs. Clues from other research suggest that some of the answers to these questions relate to the different ways that people cope and prefer to tackle problems in their lives and the way people think about and remember events in their life. These are things that this research project will be looking at.

Do I have to take part?

Participation is entirely voluntary. Although you may not benefit directly, your information can help plan services for the future, and will be very much appreciated.

If you do not wish to take part you can tell Lynn straight away, or at any time during the research. You do not have to give any reason if you decide not to take part. The research will be quite informal and, at any point you will be able to stop and ask questions, or to say that you don't want to carry on. If you decide not to take part in the study, this will not affect the service that you are offered in any way.

What does it involve?

If you agree to take part, first you'll be asked to take part in a memory procedure which looks at your memory style. This is done by showing you some words and asking you to recall events from your own life that each word reminds you of.

This takes around twenty minutes. After this, you'll be asked to fill in three questionnaires which will take around 20 minutes. The research can take place either at your own home or at a clinic, whichever you prefer, and at any time that is convenient to you.

Occasionally people can feel upset by memories they report. If this happens to you, please tell Lynn who help you to contact people who may be able to help.

Confidentiality

In order to collect information accurately, the memory part of the research will be take recorded. The tapes and questionnaires will be labelled with a number and kept securely and separately from your name. These will be destroyed after the project is complete.

Your GP will be informed by letter that you are taking part in the study and with a brief explanation of what the research is about.

All the information that you give will be confidential to the research unless you tell Lynn something which makes them concerned that there might be a serious risk to you or another person. If this was the case, Lynn would talk to you first.

Further information

If you have any questions about the study or if there is anything which concerns you about it, Lynn will be pleased to discuss this with you. She can be contacted at the following address:

North Wales Clinical Psychology Programme
School of Psychology
University of Wales – Bangor
Bangor
Gwynedd
LL57 2DG Telephone 01248 382205

If you decide to take part, please keep this information sheet so that you can refer to it in the future. If you have any questions or concerns during or after the research, you can contact Lynn at any point at the address above.

If you have any complaints about the conduct of the study, these should be addressed to:

Ms. Hilary Pepler,
Chief Executive,
North East Wales N.H.S. Trust, Maelor Hospital,
Croesnewydd Road,
Wrexham.

Or
Professor F. Lowe
Head of School of Psychology
University of Wales – Bangor
Bangor
Gwynedd
LL57 2DG

Thank you for taking the time to read this information sheet.

Ysgol Seicoleg
Prifysgol Cymru, Bangor
Bangor, Gwynedd LL57 2DG

Ffacs: (01248) 383718



School of Psychology
University of Wales, Bangor
Bangor, Gwynedd LL57 2DG

Fax: (01248) 383718

Cof hunangofiannol a strategaethau ymdopi cyfranogwyr rhaglenni hyfforddi rhieni

TAFLEN WYBODAETH I GYFRANOGWR

Ymchwilydd: Lynn Rollinson, Seicolegydd Clinigol Dan Hyfforddiant

Fe'ch gwahoddir i gymryd rhan mewn prosiect ymchwil. Cyn i chi benderfynu, mae'n bwysig eich bod yn deall pam bod yr ymchwil hon yn cael ei gwneud a beth fydd yn ei gynnwys. Cymerwch amser i ddarllen yr wybodaeth ganlynol a'i thrafod gyda'ch teulu a'ch ffrindiau os dymunwch. Mae croeso i chi holi os nad ydych yn sicr ynghylch unrhyw beth, neu os hoffech gael gwybodaeth bellach.

Pam fi?

Fe'ch gwahoddir i gymryd rhan oherwydd nad ydych wedi cael cynnig lle ar grŵp rhieni. Mae eich gwybodaeth yn werthfawr iawn. Mae'n bwysig fod rhieni plant sydd ddim ag anawsterau ymddygiadol yn cymryd rhan yn yr ymchwil i'n helpu ni i ddarganfod mwy am y ffordd mae rhieni yn meddwl yn gyffredinol. Bydd eich gwybodaeth yn cael ei defnyddio i weld a oes yna unrhyw wahaniaethau rhwng yr wybodaeth gan rieni plant sydd ddim ag anawsterau ymddygiadol, a'r wybodaeth gan rieni sydd wedi cael eu gwahodd i fynychu grwpiau rhieni. Fe all hyn ein helpu ni i gynllunio gwasanaethau'r dyfodol mewn perthynas â grwpiau rhieni. Bydd dros 60 unigolyn i gyd yn cael eu gwahodd i gymryd rhan yn yr astudiaeth.

Am beth mae'r astudiaeth?

Darganfuwyd bod grwpiau rhieni'n ffordd dda o helpu teuluoedd pan fo ymddygiad plant wedi troi'n broblem. Fodd bynnag, nid yw grwpiau rhieni'n gweithio i bob teulu, ac felly mae rhai teuluoedd yn teimlo nad grwpiau rhieni yw'r ateb iddyn nhw o'r dechrau. Pwrpas yr ymchwil hon yw darganfod mwy am rieni fel y gallwn ddeall pam bod rhai teuluoedd yn fwy tebygol o gael budd o grwpiau rhieni nag eraill. Gobeithiwn bydd hyn hefyd yn ein helpu yn y dyfodol i gynllunio gwasanaethau sy'n gweddu'n well i anghenion pobl. Mae cliwiau o ymchwiliadau eraill yn awgrymu bod rhai atebion i'r cwestiynau hyn yn gysylltiedig â'r gwahanol ffyrdd mae pobl yn ymdopi ac yn dewis mynd i'r afael â phroblemau yn eu bywyd a'r ffordd mae pobl yn meddwl am, ac yn cofio digwyddiadau yn eu bywyd. Mae'r rhain yn bethau bydd y prosiect ymchwil hwn yn edrych arny'n nhw.

Oes raid i mi gymryd rhan?

Mae cymryd rhan yn hollol wirfoddol. Er na fyddwch chi'n cael budd uniongyrchol, gall eich gwybodaeth chi helpu i gynllunio gwasanaethau ar gyfer y dyfodol, a bydd yn cael ei werthfawrogi'n fawr.

Os nad ydych yn dymuno cymryd rhan, gallwch ddweud wrth Lynn yn syth, neu unrhyw adeg yn ystod yr ymchwil. Nid oes raid i chi roi rheswm dros eich penderfyniad i beidio â chymryd rhan. Bydd yr ymchwil yn eithaf anffurfiol, a byddwch yn gallu stopio ar unrhyw adeg i ofyn cwestiynau, neu ddweud os nad ydych am barhau. Os byddwch yn penderfynu peidio cymryd rhan yn yr astudiaeth hon, ni fydd yn effeithio ar y gwasanaeth a gynigir i chi mewn unrhyw ffordd.

Beth mae'n ei gynnwys?

Os byddwch yn cytuno i gymryd rhan, yn gyntaf, gofynnir i chi gymryd rhan mewn gweithdrefn gof, sy'n edrych ar steil eich cof. Gwneir hyn drwy ddangos geiriau i chi a gofyn i chi am beth mae'r geiriau hyn yn eich atgoffa ynghylch digwyddiadau yn eich bywyd chi.

Bydd hyn yn cymryd oddeutu ugain munud. Yn dilyn hyn, gofynnir i chi gwblhau tri holiadur a fydd yn cymryd oddeutu 20 munud. Gellir gwneud yr ymchwil hon un ai yn eich cartref neu mewn clinig, beth bynnag sydd orau i chi ac ar unrhyw amser sy'n gyfleus i chi.

Weithiau gall pobl gynhyrfu wrth adrodd eu hatgofion. Os yw hyn yn digwydd i chi, dywedwch wrth Lynn all eich helpu chi i gysylltu â phobl all eich helpu.

Cyfrinachedd

Er mwyn gallu casglu gwybodaeth yn gywir, bydd rhan cof yr ymchwil yn cael ei recordio. Bydd y tapiau a'r holiaduron yn cael eu labelu â rhif a'u cadw'n ddiogel ac ar wahân i'ch enw. Byddent yn cael eu dinistrio ar ôl cwblhau'r prosiect.

Bydd eich Meddyg Teulu yn cael gwybod drwy lythyr eich bod yn cymryd rhan yn yr astudiaeth gydag eglurhad byr o bwrpas yr ymchwil.

Bydd yr holl wybodaeth a roddir i'r ymchwil yn gyfrinachol, oni bai eich bod yn dweud rhywbeth wrth Lynn sy'n eu gwneud yn bryderus bod risg mawr i chi neu unigolyn arall. Pe byddai hyn yn digwydd, byddai Lynn yn siarad â chi'n gyntaf.

Gwybodaeth Bellach

Os oes gennych unrhyw gwestiynau ynghylch yr astudiaeth hon, neu os ydych yn pryderu ynghylch unrhyw agwedd ohoni, bydd Lynn yn falch o'u trafod gyda chi. Gellir cysylltu â hi yn y cyfeiriad isod:

Rhaglen Seicoleg Glinigol Gogledd Cymru
Ysgol Seicoleg
Prifysgol Cymru - Bangor
Bangor
Gwynedd
LL57 2DG Ffôn: 01248 382205

Os yr ydych yn penderfynu cymryd rhan, cadwch y daflen wybodaeth hon fel y gallwch gyfeirio ati yn y dyfodol. Os oes gennych unrhyw gwestiynau neu bryderon yn ystod neu ar ôl yr ymchwil, gallwch gysylltu â Lynn ar unrhyw adeg yn y cyfeiriad uchod.

Os bydd gennych unrhyw gwynion ynghylch y ffordd mae'r astudiaeth wedi cael ei gwneud, dylid eu cyfeirio at:

Ms. Hilary Pepler,
Prif Weithredwr,
Ymddiriedolaeth GIG Gogledd Ddwyrain Cymru, Ysbyty Maelor
Ffordd Croesnewydd
Wrecsam.

Yr Athro F. Lowe
Pennaeth Ysgol Seicoleg
Prifysgol Cymru - Bangor
Bangor
Gwynedd
LL57 2DG

Diolch i chi am ddarllen y daflen wybodaeth hon.

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Bangor, Gwynedd LL57 2DG

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Autobiographical memory and coping strategies of participants parent training programmes

Dear Parent.

This is a reply slip for you to return to me using the envelope provided. Your response will be confidential to the research project. Please could you tick the box that applies to you. If you agree for me to telephone you, this does not commit you to taking part but will allow you to ask any questions you may have before deciding.

Thank you for your time

Lynn Rollinson (Trainee Clinical Psychologist)

My name is

I would like to hear more about this research project and would like you to contact me

My telephone number is

I do not wish to take part

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Annwyl Riant,

Mae hwn yn slip ateb i chi ei ddychwelyd i mi gan ddefnyddio'r amlen a ddarperir. Bydd eich ymateb yn gyfrinachol i'r prosiect ymchwil. A fydddech cystal â thicio'r bocsy'n berthnasol i chi. Os yr ydych yn cytuno i mi eich ffonio, nid yw hyn yn eich ymrwymo chi i gymryd rhan ond bydd yn caniatáu i chi ofyn unrhyw gwestiynau a allai fod gennych cyn i chi benderfynu.

Diolch i chi am eich amser

Lynn Rollinson (Seicolegydd Clinigol Dan Hyfforddiant)

Fy enw i yw

Hoffwn glywed mwy am y prosiect ymchwil hwn a hoffwn i chi gysylltu â mi

Fy rhif ffôn yw

Nid ydw i'n dymuno cymryd rhan

Appendix 3

Autobiographical memory and coping strategies of participants
parent training programmes

Researcher: Lynn Rollinson, Trainee Clinical Psychologist

Re:

Dear Dr.

I am writing to inform you that your patient named above has agreed to take part in a research project considering coping styles, problem solving style and autobiographical memory. I have enclosed a copy of the participant information sheet for your records.

I hope that the results of the research will help us understand why parent training is successful for some parents and not others. It is therefore important to gain some understanding of coping and problem solving styles of parents more generally, and how these relate to those of parents referred for parent training. It is hoped that, in the long term this understanding will help us develop interventions more suited to different family needs. If you are interested in discussing the findings of the research or if you would like a copy of the final report please do not hesitate to contact me. The study has been approved by the North East Wales Ethics Committee before any data collection commences, but if you have any concerns about the above person's participation in the study, please let me know.

Yours sincerely



Lynn Rollinson
(Trainee Clinical Psychologist)

Cwrs Seicoleg Clinigol
Gogledd Cymru

Ysgol Seicoleg
Prifysgol Cymru, Bangor
Bangor, Gwynedd LL57 2DG

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University of Wales, Bangor
Bangor, Gwynedd LL57 2DG

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Cof hunangofiannol a strategaethau ymdopi cyfranogwyr rhaglenni
hyfforddi rhieni

Ymchwilydd: Lynn Rollinson, Seicolegydd Clinigol Dan Hyfforddiant

Par:

Annwyl Dr.

Ysgrifennaf atoch i'ch hysbysu fod eich claf sydd wedi ei h/enwi uchod wedi cytuno i gymryd rhan mewn prosiect ymchwil sy'n ystyried dulliau ymdopi, datrys problemau a chof hunangofiannol. Amgaeaf gopi o'r daflen wybodaeth i gyfranogwyr ar gyfer eich cofnodion.

Gobeithio y bydd canlyniadau'r ymchwil yn ein helpu ni i ddeall pam bod hyfforddiant i rieni yn llwyddiannus i rai rhieni ac nid eraill. Mae'n bwysig felly cael dealltwriaeth o ddulliau ymdopi a datrys problemau cyffredinol rhieni, a sut mae'r rhain yn gysylltiedig â dulliau rhieni sy'n cael eu hadgyfeirio ar gyfer hyfforddiant i rieni. Gobeithir y bydd y ddealltwriaeth hon yn y tymor hir yn ein helpu ni i ddatblygu ymyriadau sy'n gweddu'n well i anghenion teuluoedd. Os oes gennych ddi-ddordeb mewn trafod darganfyddiadau'r ymchwil neu os hoffech gael copi o'r adroddiad terfynol peidiwch ag oedi cysylltu â mi. Bydd yr astudiaeth yn cael ei chymeradwyo gan Bwyllgor EtheG Gogledd Ddwyrain Cymru cyn y byddwn yn dechrau casglu unrhyw ddata, ond os oes gennych unrhyw bryderon ynghylch cyfranogiad yr unigolyn uchod yn yr astudiaeth, gadewch i mi wybod.

Yn gywir

Lynn Rollinson
(Seicolegydd Clinigol Dan Hyfforddiant)

Appendix 4



Parent Group Research Study – Consent Form

Researcher Lynn Rollinson, Trainee Clinical Psychologist

Please delete
as appropriate

Have you read the information sheet? yes / no

Have you had the opportunity to ask questions and discuss the study? yes / no

Have you received satisfactory answers to all of your questions? yes / no

Do you understand that you are free to withdraw from the study:
at any time? yes / no
without having to give a reason? yes / no

Do you agree to take part in this study? yes / no

Do you agree to be audiotaped as part of this study? yes / no

Signed:

Date:

(Name in Block Letters)

Witnessed by:

Researcher's signature

(Name in block letters)

Date:

GP address:

**Cwrs Seicoleg Clinigol
Gogledd Cymru**

Ysgol Seicoleg
Prifysgol Cymru, Bangor
Bangor, Gwynedd LL57 2DG

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Astudiaeth Ymchwil Grwpiau Rhieni – Ffurflen Cydsynio

Ymchwilydd: Lynn Rollinson, Seicolegydd Clinigol dan Hyfforddiant

Dilêwch fel
sy'n briodol

Ydych chi wedi darllen y daflen wybodaeth?

do / naddo

Ydych chi wedi cael y cyfle i ofyn cwestiynau
a thrafod yr astudiaeth?

do / naddo

Ydych chi wedi cael atebion boddhaol
i'ch holl gwestiynau?

do / naddo

Ydych chi'n deall eich bod â'r hawl i dynnu'n
ôl o'r astudiaeth:

unrhyw bryd?
heb orfod rhoi rheswm?

ydw / nac ydw
ydw / nac ydw

Ydych chi'n cytuno cymryd rhan yn yr astudiaeth hon?

ydw / nac ydw

Ydych chi'n cytuno i ni eich tapio fel rhan o'r astudiaeth?

ydw / nac ydw

Llofnod: Dyddiad:

(Enw mewn llythrennau bras)

Ardystiwyd gan: Llofnod yr Ymchwilydd

(Enw mewn llythrennau bras) Dyddiad:

Appendix 5

MISSING PAGES
REMOVED ON
INSTRUCTION
FROM THE
UNIVERSITY

Third Party Material excluded from digitised copy.
Please refer to original text to see this material.

Instructions for Parent-Child Autobiographical memory test (Hutchings, 1986)

I am interested in your memory for events that happened in (child's name) life. I am going to read you some words. For each word I want you to think of an event that happened to (child), lasting less than a day, which the word reminds you of. The event could have happened recently (yesterday, last week) or when (child) was younger. It might be an important event or a trivial event.

Just one more thing: the event you recall should be of a particular occasion. So if I said the word good it would not be Ok to say "(child) is always good at bedtime" because that does not mention a specific event. But it would be Ok to say "(child) was good when I put him to bed last night" because that is a specific event

Lets try some words for practice: happy, bold, enjoy

Time allowed 30 seconds. , can include 2 prompts.

Further prompts: "Can you think of a particular time?" can be repeated.

Cue words

Helpless

Excited

Upset

Calm

Hurt

Pleased

Bad

Proud

Guilty

Peaceful

Instructions for Autobiographical memory test (Williams and Broadbent, 1986)

I am interested in your memory for events that happened in your life. I am going to read you some words. For each word I want you to think of an event, that happened to you, lasting less than a day, which the word reminds you of. The event could have happened recently (yesterday, last week) or a long time ago. It might be an important event or a trivial event.

Just one more thing: the event you recall should be of a particular occasion. So if I said the word "good" it would not be Ok to say "I always enjoy a good party" because that does not mention a specific event. But it would be Ok to say "I had a good time at Jane's party" because that is a specific event

Lets try some words for practice: enjoy, friendly, bold

Time allowed 30 seconds. , can include 2 prompts.

Further prompts: "Can you think of a particular time?" can be repeated.

Cue words

Guilty
Sunny
Proud
Hopeless
Eager
Worse
Happy
Failure
Relieved
Ugly

**PAGE
NUMBERING
AS ORIGINAL**

Appendix 6

Appendix 6 – word count for thesis

	Number of words	
Abstract for overall thesis	290*	
Ethics proposal	4470*	
Amendments to ethics protocol	478*	
Section 1		
Abstract	225	
Autobiographical memory and problem solving: a review of the Literature	4777*	
References	962	
Notes for contributors to the British Journal of Clinical Psychology	N/A	
Section 2		
Abstract	245*	
A research paper considering Autobiographical memory, problem solving and coping styles in parents referred for parent training.	4937*	
References	791	
Notes for contributors to the British Journal of Clinical Psychology	N/A	
Table 1	Results of t-test comparisons between parent training and control participants	158
Table 2	Correlations between key variables for the whole sample.	311
Table 3	Autobiographical memory score correlations with coping and problem solving scores, for parent training group	

Table 4 - Autobiographical memory score correlations with coping and problem solving scores, for control group

Section 3		
Contributions to theory, clinical practice and learning		4619*
References		349
Appendix 1	Ethics approval letters	approx 5000
Appendix 2	Participant information sheets and reply slip	206
Appendix 3	G.P letter	100
Appendix 3	Consent form	126
Appendix 4	Measures	
	Instructions for Autobiographical Memory Test	186
	Instructions for Parent-Child Autobiographical Memory Test	188
	Beck Depression Inventory	1040
	Strengths and Difficulties Questionnaire – age 4-16	406
	Strengths and Difficulties Questionnaire – age 3	406
	Problem Solving Inventory	706
	Brief COPE	572
Total word count		30, 785
Total word counts for elements of thesis marked*		19257