WHAT WORKS WITH YOUTH?
AN EVALUATION OF THE ADVENTURE DEVELOPMENT COUNSELLING PROGRAMME.

A thesis submitted in partial fulfilment of the requirements for the Degree of Doctor of Philosophy in Education in the University of Canterbury
by
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ABSTRACT

Within New Zealand and internationally the capacity to deliver effective treatment for adolescent mental health problems has been identified as a priority concern. This research sought to evaluate an established New Zealand adolescent counselling programme (Adventure Development Counselling), and to shed light on factors associated with successful treatment outcomes.

A mixed-methods research design was adopted to meet the unique challenges of studying adolescent behaviour in a community-based clinical setting. The design included administration of standardised measures of mental health and other individual and contextual variables immediately prior to, after, and six months following, treatment. In addition, qualitative data (observations and interviews) were collected on a small group of clients as they progressed through an ADC programme.

Results from a series of repeated-measures analyses of variance indicated that ADC clients (n=42) achieved significant improvement on multiple indices of mental health, improvements which were largely maintained six months after completion of the programme. Further analyses identified several client factors (severity of problem behaviour, number of previous interventions) and contextual factors (parent/caregiver involvement, community support) as being significantly associated with treatment outcome (programme completion and level of improvement in mental health).

The qualitative enquiry revealed the importance in the early phases of counselling of a client's readiness to make changes, and a developmentally appropriate and acceptable client-counsellor relationship. However, once youth were committed to making changes in their lives, approaches such as wilderness therapy that were action-orientated, intensive, challenging, enjoyable and group-based were perceived as particularly helpful.

This thesis has contributed to the pressing need for research that clarifies the real-world applicability of counselling interventions for youth. Further, it is among the first such study applicable to the New Zealand context, contributing to improved understanding of factors associated with successful treatment outcomes for this country's youth.
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PART I:
INTRODUCTION, LITERATURE REVIEW
AND METHODOLOGY OVERVIEW
CHAPTER ONE:  
INTRODUCTION

Delivering effective interventions for youth with mental health concerns has increasingly come to be recognised in New Zealand and internationally as an important priority for governments (Mental Health Commission, 1999; Ministry of Health, 2004; World Health Organisation, 2001b). Contributing to the development of effective services has thus become an important focus for researchers (Kazdin, 2004). Despite the high prevalence of mental health disorders amongst New Zealand youth (Horwood & Fergusson, 1998), mental health concerns are often unrecognised and under-treated. Yet without intervention, the personal and social costs are often high, both in the short and long-term (Kazdin, 1993). Effective treatment is essential both to limit suffering, and reduce the risk of problems continuing into adulthood.

The focus of this thesis is an innovative intervention for adolescents known as the Adventure Development Counselling Programme (ADC). The aims of the thesis were to evaluate the effectiveness of this programme in improving the mental health of its adolescent clients, and to explore factors associated with successful treatment outcome.

The ADC programme has been operating more or less in its current form since 1996. It is available in three South Island regions (Canterbury, Otago and Southland), with a combined intake of just under 100 young people per year. Clients in the 12 to 18 years age bracket are referred from multiple sources, typically presenting with alcohol and drug problems and/or other mental health concerns. The programme philosophy is based around developing independence in the young person through mobilising their own strengths, but also increasing support systems in their family and other services in the community. Despite being reasonably well-established, the programme had yet to be subjected to rigorous, independent evaluation.

The model of counselling utilised by the programme is unique within New Zealand and internationally. Clients participate in the programme for an average of six months. Weekly sessions of individual and family counselling are combined with a short period of intense wilderness therapy known as ‘the Journey’, after which there are several months of follow-up. ADC counsellors incorporate into an individualised programme an eclectic mix of therapeutic approaches tailored to the needs and goals of the young person and their family.
Anecdotal reports from ADC participants and their parents had suggested that the model was successful in achieving positive outcomes. The current study sought to investigate more closely whether this innovative counselling approach was indeed successful, and if so, to shed more light on the ways in which the young people were being assisted in their efforts to achieve positive change.

The specific research objectives of this thesis were as follows. The first and primary objective was to evaluate whether the ADC programme was effective. More specifically, this meant examining whether ADC clients exhibited improvements in their mental health and problem behaviours following programme participation and, importantly, whether these improvements were maintained. A second objective was to identify those for whom the programme worked best, by identifying the personal and contextual characteristics associated with successful completion of the programme, and improved outcomes. The final research objective was to explore the impact of ADC approaches and programme content from the perspective of the adolescent clients themselves. This last objective was aimed at better understanding the processes that may have contributed to the achievement of therapeutic change by these youth.

1.1 Organisation of the Thesis

Part I: Introduction, Literature Review and Methodology Overview

Following this introduction and overview, Chapter Two reviews the relevant literature. This review is divided into four sections. The first section (2.1) considers the current situation in New Zealand with regard to adolescent mental health, and provides context to the environment in which the ADC programme operates. The terms of reference relevant to the thesis are discussed, in particular, issues associated with key definitions such as ‘adolescence’ and ‘mental health’. This is followed by a review of problem types most frequently identified as of concern for New Zealand adolescents, together with data on prevalence. This provides background information on the youth concerns which the ADC programme attempts to target. The range of adolescent mental health services available in New Zealand are then outlined, together with difficulties encountered in the provision of, and access to, these services. The gaps in services to assist youth with more serious mental health concerns is noted.

The next section (2.2) reviews what is currently known about effectiveness of services for youth with specific mental health concerns, together with an examination of the magnitude of change that can be expected from such interventions. The
programmes and approaches that research has found to be successful are described, together with their reported outcomes, providing benchmarks from which to compare the approaches and outcomes of the ADC programme.

Section 2.3 examines research on factors associated with successful adolescent counselling outcomes, the application of this knowledge may assist in identifying and explaining factors associated with the ADC programme and its client groups that contributed to successful outcomes.

The last section (2.4) summarises the literature review, highlighting the limitation and gaps in the research that this thesis seeks to address. Finally, the specific research questions of the thesis are outlined.

Chapter Three presents the mixed method design chosen to fulfil the research objectives of this thesis. This includes also a discussion of the rationale and issues raised through combining quantitative and qualitative methodologies in a single study, given their apparently contrasting theoretical natures.

Part II: Quantitative Study: Methodology, Results and Discussion

Chapter Four presents the methodology of the quantitative study: a description of the research design, subjects, procedures and data analysis. Chapter Five is divided into four sections. Section 5.1 is a detailed descriptive analysis of the ADC programme and its clients. Section 5.2 is an evaluation of the ADC programme’s treatment outcomes, in which evidence is presented of significant and stable improvements in clients’ mental health following participation on an ADC programme. Section 5.3 identifies factors (client and contextual) that are associated with successful treatment outcomes (programme completion and greater levels of therapeutic change). Section 5.4 discusses these results in relation to other relevant research.

Part III: Qualitative Study: Methodology and Findings

A description of the qualitative methodology is set out in Chapter Six, including details of the research participants and research processes. The findings of this enquiry into the processes that contribute to therapeutic outcomes from the perspective of the ADC clients themselves is presented in Chapter Seven. This chapter is also divided into four sections. Section 7.1 looks at personal ‘client’ factors, while section 7.2 explores the contribution of counsellor factors. Section 7.3 examines
the impact of programme content, particularly the wilderness therapy component known as the ‘Journey’. Section 7.4 investigates the extent to which ADC’s theoretical approach to counselling is useful in accounting for comments and perspectives offered by the youth.

**Part IV: Summary of Findings, Implications and Conclusions**

Chapter Eight brings together the main findings of both the quantitative and qualitative studies. This is followed by a general discussion of the implications that have arisen from the research, together with several recommendations both to researchers and practitioners.
CHAPTER TWO:
LITERATURE REVIEW

2.1 Adolescent Mental Health in New Zealand

This first section of the literature review provides a broad outline of the current state of adolescent mental health and its treatment in New Zealand. The aim of this section is to provide context and relevant background information on the specific adolescent mental health service and its participants which is the focus of this research (the Adventure Development Counselling Programme). There is a review of the type of mental health problems New Zealand youth face, along with discussion of high rates of prevalence, and the continuity and stability of problems if left untreated. This is contrasted against the low rates of help-seeking behaviour found in youth with mental health concerns. There is then a review of the mental health service options that are currently available to New Zealand adolescents, with attention given to the current shortfall in provision of such services. However, the section begins first with a brief discussion on certain terms of reference relevant to this thesis, in particular the difficulties in achieving consensus with definitions of ‘adolescence’ and ‘mental health’.

2.1.1 Defining Adolescence

Adolescence has been described as “a journey from the world of the child to the world of the adult ... adolescents are no longer children, but not yet adults” (World Health Organisation, 2002, p. 5). However, obtaining a clear and agreed-upon definition of what adolescence is, and in particular when it begins and ends, is an elusive goal. Cobb (1995) argued that three perspectives are necessary for an understanding of adolescence. Firstly, a biological perspective is necessary, to consider the events of puberty that transform the bodies of children into those of sexually and physically mature adults. A psychological perspective distinguishes adolescence in terms of cognitive abilities and developmental tasks accomplished. Thirdly, a social perspective defines adolescence in terms of sources of influence, and adolescents’ status within society.

In deciding on the lower and upper age range that best defines adolescence, difficulties arise in applying these boundaries across different individuals, cultures and time periods. Changes take place at different rates for different individuals, as a result of genetic make-up and environmental influences. Arnett and Taber (1994)
have pointed out how different cultures recognise different events as representing an emergence into adulthood. For example, in non-Western cultures, entrance to adulthood is socially defined, often marked by a social event such as marriage. While in the contemporary West there is a strong emphasis on developmental markers of independence and individualism, with the entrance to adulthood defined and marked individually. Elements of this include the achievement of residential and financial independence, and the attainment of cognitive self-sufficiency, emotional reliance, and behavioural self-control.

A report by the Ministry of Health in 1996, considering adolescence from a Māori perspective, noted that traditional Māori did not have a word equivalent to ‘adolescence’ to describe a separate development stage in life. However, it was suggested that with the movement of Māori from rural to urban society, and the changing nature of modern society, young Māori probably were now negotiating the developmental tasks of adolescence. In particular, the development of a personal identity in relation to their culture might now occur in a different way than would have been so within their traditional culture (Ministry of Health, 1996).

A final difficulty in deciding on an age range that best defines adolescence is noted by Kazdin (1993), who points out that, even across different time periods, there is no stability. He cites the example of girls in present times reaching menarche four years earlier compared to previous centuries. Cobb (1995) gives other examples of changes across time that have an influence on defining adolescence from a social perspective, such as changes in rates of unemployment, together with trends of prolonged educational involvement, particularly attendance at university. All of these factors impact on a young person’s ability to achieve independence.

In summary, a clear and concise definition of adolescence that attend to the biological and psychological development of a young person, whilst taking into account the influences of society and culture, is elusive. Therefore, whilst acknowledging its limitations, for the purposes of this thesis a working definition of adolescence has been adopted based on a simple age range. The definition chosen is that given by the World Health Organisation (2002), which specifies that adolescence refers to “… a person who is between 10 and 19 years of age” (p. 5).

This age range is consistent with the definition used by the New Zealand Ministry of Health in New Zealand. The McGeorge Report (Ministry of Health, 1995) recommended a further delineation of adolescence with early adolescence being
considered 10-14 years, and late adolescence being 15-19 years old. Use of the 10-19 years age range is also appropriate in regards to the focus of this research, the ADC programme, which accepts referrals from youth aged 12-18 years, a clientele which according to the McGeorge Report would be considered to span early to late adolescence. In this thesis the terms ‘youth’ and ‘adolescent’ are used interchangeably.

2.1.2 Defining Mental Health

A number of definitions of mental health have been offered, each influenced by the social values and belief systems of those developing the definition. In his review of adolescent mental health, Kazdin (1993) suggested a definition of mental health which involved two broad domains. The first domain was the absence of dysfunction in psychological, emotional, behavioural and social spheres, while the second domain referred to optimal functioning or well-being in psychological and social domains. While dysfunction refers to impairment in everyday life, wellness is not synonymous with an absence of impairment, but refers to the presence of personal and interpersonal strengths that promote optimal functioning. As noted by Kazdin (1993), while these two dimensions are obviously related, they represent different conceptual approaches to mental health. A focus on positive mental health, involving an emphasis on strengths, resilience and coping skills to enhancing functioning, tends to be associated with prevention strategies. Treatment interventions such as psychotherapy, psychiatric hospitalisation and medication are, however, more likely to focus on dysfunction and impairment, with the implication of diagnoses of disorders or maladaptive behavioural patterns (Kazdin, 1993).

There appears to be a general consensus that mental health involves more than the mere absence of a mental disorder (Ministry of Health, 2002a; World Health Organisation, 2001a). However, the definition offered by Kazdin could be criticised as being overly constrained by the scientific paradigm. In 2002, the New Zealand Ministry of Health published a mental health promotion strategy for New Zealand, titled ‘Building on Strengths’. In this publication the following broader definition of mental health was cited, originating from an international workshop in Toronto:

... the capacity of each and all of us to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of
equity, social justice, interconnections and personal dignity. (Ministry of Health, 2002a, p. 18)

The authors of this publication pointed out that any New Zealand definition of mental health should acknowledge the inter-connectedness between physical, spiritual, environmental and mental health. The above holistic definition of mental health is probably more attuned to views of health and well-being held by Māori and Pacific people. Māori health experts see health (including mental health) of the individual, and ultimately of society, as a complex set of relationships that include social, economic, political, cultural, historical and spiritual factors (Disley, 1997). These elements have been expounded in the Māori health model called Whare Tapa Whā, Te Wheke and are viewed similarly in the Samoan Fonofale model of well-being (Ministry of Health, 2002b).

The ADC programme purports to use a ‘strengths-based approach’ in working with its young clients, as opposed to a ‘problem-solving’ model that seeks to find, diagnose, and treat problems, which is more commonly used within mental health fields. A strength-based approach focuses on clients’ strengths and competencies, and aims to discover, in a collaborative manner, how these personal resources can be applied to building solutions (Clark, 1998). Therefore, while the goals of the ADC programme fit well with more holistic definitions of mental health (enhancing overall well-being and as a result reducing dysfunction), they are unlikely to use ‘mental health’ or related terms (see following discussion) when working with the young clients.

Labelling a client as displaying a mental health problem would not fit well with a strength-based approach. However, the funding for the ADC programme comes from government mental health funding, specifically for youth with alcohol or drug problems or other serious mental health problems. To qualify for funding, the programme must, therefore, be defined as an adolescent mental health service. However, in the day-to-day contact with the ADC clients and their families, this concept is not actually in evidence. The end objectives of funders and programme providers are the same, but choice of terminology related to the strengths-based approach differs.

In this thesis the ADC programme is described as a mental health programme: this reflects the funded objectives of the programme, and is a term widely used in
research related to such programmes. However, it should be noted that this is not the
terminology the clients or the staff of the ADC programme tend to use.

Related Mental Health Terms

Other terms are commonly used in relation to mental health, including mental
illness, mental disorders, and mental health problems. Despite acknowledgment of
broader and more holistic conceptions of mental health, many of the official New
Zealand health publications (with perhaps the exception of health promotion
publications) commonly refer to mental illness and mental disorders. Government
policy and planning tends to make heavy use of academic research. Such research, in
the interest of maintaining international consistency and facilitating communication,
tends use widely shared and more precise scientific definitions. Hence, in this context
terms such as 'mental illness' or 'mental disorder' are more common. Such terms
focus more narrowly on the presence of dysfunction, and conceptualise disorders as
being conditions that although influenced by environment factors, affect first and
foremost the individual. The American Psychological Association (APA) for example
has defined a mental disorder as:

... a clinically significant behavioural or psychological syndrome or pattern
that occurs in a person and that is associated with present distress (e.g., a
painful syndrome) or disability (i.e., impairment in one or more important
areas of functioning) or with a significantly increased risk of suffering death,
pain, disability, or an important loss of freedom. (APA, 1994, p. xxi)

Terms such as 'mental health', 'mental illness' or 'mental disorders' are
avoided by ADC programme staff when counselling clients and their families. These
terms may, however, be used in communications with the funders in relation to
programme outcomes. This thesis necessarily discusses and refers to mental
illness/mental health disorders in order to compare outcomes of the ADC programme,
and the findings of this research, with other published research where the use 'mental
disorder' terminology is the norm.

Two systems of classifying mental illnesses or disorders are widely
recognised. They are the International Classification of Diseases (ICD-10) developed
by the World Health Organisation (1992) and the Diagnostic and Statistical Manual
The mental disorders that affect children and adolescents have been grouped in several ways (Ministry of Health, 1998; Kazdin, 2004). Disorders arising in childhood and adolescence include autistic disorder, Asperger’s Syndrome, attachment disorders, attention deficit/hyperactivity disorder, and disruptive behaviour disorders such as conduct and oppositional-defiant disorder. Some disorders may evolve into adult personality disorder and disturbances, while others raise the risk of psychiatric disorders developing in adulthood. An example of the former is conduct disorder in a child or young person, which may evolve into antisocial personality disorder in the adult.

Other disorders are similar to adult conditions but present differently in children and adolescents. These include substance-related disorders, depression, anxiety disorders, eating disorders, schizophrenia, and bipolar disorder.

The more commonly-found adolescent disorders can be broadly categorised into either ‘externalising disorders’ (e.g., disruptive behaviour disorders, substance use disorders), which are manifested in behaviours which are observable by (and often troubling to) other people; or ‘internalising disorders’ (e.g., anxiety disorder and depressive disorders), where the problem constitutes an inner experience of pain or discomfort (Horwood & Fergusson, 1998; Ministry of Health, 1995). The prevalence of these disorders in New Zealand adolescents are reviewed shortly.

In relation to adolescents specifically, other descriptors or sub-groupings related to mental health are in common use and, therefore, also require mention. These include ‘youth at-risk’, adolescents who engage in ‘problem behaviour’ or ‘multiple problem behaviour’, and ‘juvenile delinquent’. All these labels can accurately be used to describe the youth who participate on ADC programmes.

Considerable overlap tends to occur between youth with ‘mental health concerns’ and those referred to as ‘at-risk’, having ‘multiple problems’ or being ‘delinquent’. This overlap can cause much confusion. The label ‘youth at-risk’ has developed in reference to youth who engage in ‘risky’ or ‘problem’ behaviours such as the use of illicit substances, truancy, stealing, vandalism, and precocious and unprotected sex. The reference to ‘at-risk’ behaviours (or problem behaviours) occurs because the behaviour arguably increases the likelihood of adverse psychological, social and health outcomes (Kazdin, 2004). Donovan (1996) defines problem behaviour as:
...behaviour that departs from the norms – both social and legal – of the larger society; it is behaviour that is socially disapproved by institutions of authority and that tends to elicit some form of social control response, whether mild reproof, social rejection or even incarceration. (p. 380)

Some have argued that the term ‘at-risk’ is misleading, given that these individuals are already engaging in the very behaviours of which they are supposedly ‘at-risk’ of experiencing. According to Tidwell and Garrett (1994), rather than being ‘at-risk’ they have in fact ‘arrived’. Others suggest the term is useful only if it is used as a continuum; those identified as engaging in ‘at-risk behaviours’ may still be ‘at-risk’ of more severe consequences (McWhirter, McWhirter, McWhirter, & McWhirter, 1995). Kazdin (2004) points out that while many youth engaging in risky or problem behaviour might well meet the criteria for a psychiatric disorder (e.g., substance abuse), a larger proportion of the ‘at-risk’ group would not.

Another related term is ‘multiple problem behaviour’. In a New Zealand study, youth with multiple problem behaviour were defined as those displaying more than one of following: conduct disorder, police contact, substance abuse, early onset sexual activity, suicidal ideation, mood disorders and low self-esteem (Fergusson, Horwood, & Lynskey, 1994). The overlap here with mental illness is more pronounced as the presence of several disorders (e.g., conduct disorder, substance abuse, mood disorders) is part of the criteria.

The final label or category is ‘delinquency’. Kazdin (2004) proposes that delinquency is a legal designation, describing behaviours that violate the law such as robbery, drug use, and vandalism. The overlap with mental illness is again evident, however, as Kazdin concedes the distinction between delinquency and mental disorder is not always sharp, with individuals readily meeting the criteria for both, based on the same behaviours (e.g., some symptoms of conduct disorder).

Taking into account the above arguments, for the purpose of this thesis, unless an author has specified a particular mental health phrase, the term ‘mental health concerns’ is used as a broad term encompassing all related terms (mental illness or mental disorders, mental health problems, at-risk or problem behaviour, multiple problem behaviour or delinquency). It is acknowledged that this term is not used by ADC programme staff in their communication with clients, but it does coincide with the language used in the research reviewed for this thesis and hence, assists with
comparison of the results of this research with those of other published outcome studies.

2.1.3 Prevalence of Mental Health Concerns

The availability of New Zealand data on rates of prevalence for adolescents with mental health concerns is limited to just a few studies. The main ones are the two South Island longitudinal studies, the Dunedin Multidisciplinary Health and Development Study (DMHDS), and the more recent Christchurch Health and Development Study (CHDS). These two studies used standardised diagnostic schedules to determine the presence or absence of mental illness in New Zealand adolescents. The CHDS has followed a birth cohort of 1265 children born in the Christchurch urban region during mid 1977, while the DMHDS studied 1,037 children born at Queen Mary Hospital in Dunedin during 1972-1973. Rates of psychiatric disorders in the cohorts were researched at age 15 (Fergusson, Horwood & Lynskey, 1993; McGee et al., 1990) and 18 years old (Feehan, McGee, Nada Raja & Williams, 1994; Horwood & Fergusson, 1998). Given the comparatively low population of Māori and Pacific Islanders in the South Island, the results of these studies may not reflect the prevalence of mental health disorders in those ethnic groups nationally. More recently, the Adolescent Health Research Group (AHRG) of Auckland University conducted a nationally representative youth health survey of secondary school students (N=9569) aged 12-18 years (AHRG, 2003). The survey was conducted in 2001 and collected self-report information on youth health problems, concerns and risk factors. Coming from a nationally representative sample the results are more generalisable than the South Island samples of the Dunedin and Christchurch studies. On the other hand, the AHRG survey was limited to youth who were attending school. A positive aspect of the AHRG survey, however, was that information was also collected on protective and resiliency factors as well at-risk factors and mental health disorders.

Table 1 summarises the prevalence rates of mental health disorders from the DMHDS and the CHDS studies when the birth cohorts were 15 and 18 years old. Although it is difficult to compare results across studies due to differences in the assessment of disorders and the populations sampled, what is consistent is the finding that a significant proportion of New Zealand adolescents are affected by mental health disorders. At age 15 years, these studies found around 22 percent of youth were
diagnosed with one or more mental disorder, which increased to between 37 and 43 percent by age 18 years. Horwood and Fergusson (1998) cautioned that these high prevalence rates included conditions of widely ranging severity, and are best considered as upper limits of rates of psychiatric disorder. Reviews of international epidemiology studies confirm higher rates of psychopathology as age increases (Roberts, Atkinson & Rosenblatt, 1998; Ministry of Health, 2002c; Weisz & Hawley, 2002). In the longitudinal studies higher rates of disorder associated with age were predominantly due to increases in rates of internalising (anxiety and mood) disorders, and substance use disorders.

Table 1.

The prevalence rates (%) of mental health disorders for 15 and 18 year olds, from the DMHS and CHDS studies.

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Dunedin MHDS</th>
<th>Christchurch HDS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15 years (DSM-III)</td>
<td>18 years (DSM-III-R)</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>10.7</td>
<td>27.7$^a$</td>
</tr>
<tr>
<td>Mood Disorders</td>
<td>4.1</td>
<td>20.0</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>7.3</td>
<td>5.5</td>
</tr>
<tr>
<td>Substance Use Disorders</td>
<td>-</td>
<td>15.6</td>
</tr>
<tr>
<td>Any Disorder</td>
<td>22.0</td>
<td>36.6</td>
</tr>
</tbody>
</table>

Data in Table I compiled from data cited in Feehan et al. (1994); Fergusson & Horwood (2001); McGee et al. (1990).

$^a$ included obsessive compulsive disorders

$^b$ included substance abuse as well as dependence

The AHRG survey sampled a wider age range (12-18 years) of adolescents, which makes direct comparison with the longitudinal studies more difficult. Rates of
mental health disorder increase with age, and the inclusion of younger adolescents in the AHRG sample is, therefore, likely to bring overall rates down. In the AHRG survey the biggest concern reported, in terms of emotional health, was depression. Approximately 13.9 percent of students reported levels of depressive symptoms that were considered to be serious and requiring professional assistance. As expected, the rates of other mental health disorder symptoms in this survey were lower, with anxiety 4.8 percent and conduct disorder symptoms 3.5 percent.

The AHRG survey also collected information on self-reported suicide ideation and attempts. The rates were highest for those aged 15 years: at this age, 33.9 percent of females students and 20.2 percent of males students reported that they had thought about killing themselves in the previous 12 months. Of this age group, 13.9 percent of female students and 6.2 percent of males students reported having actually attempted to kill themselves. These findings are slightly higher than the CHDS which found 17.1 percent of the sample reported some suicidal ideation before the age of 18 years old, and 5.4 percent having made a suicide attempt (Horwood & Fergusson, 1998). The CHDS study noted that Māori rates of suicidal behaviour were higher than for non-Māori, a trend supported by other sources (Ministry of Health, 2002c). Among young people overall, the majority of deaths by suicide occur among those aged 19 to 24 years (Ministry of Health, 2002c). New Zealand’s youth suicide rates (for 15-24 year olds) have been ranked the highest amongst OECD countries (New Zealand Health Information Service, 2002), although, the youth suicide rate in New Zealand has been decreasing for the past four consecutive years (Ministry of Health, 2002c).

Prevalence rates of mental health disorders in New Zealand adolescents appear to be similar to those found elsewhere around the world. Horwood and Fergusson (1998) reviewed other epidemiological studies in the USA, Canada, the Netherlands and South America, and found results were generally comparable. However, a national survey of Australian adolescents' mental health found a lower prevalence of mental health disorders (of 14 percent) for 13-17yrs, but this did not include substance use disorders (Sawyer et al., 2000). A review of seven countries by the World Health Organisation (2001b) found an overall prevalence rate of mental and behavioural disorders of between 10 and 20 percent. This included developed and developing countries, with age ranges from infants to 16 years. These lower rates, compared to New Zealand, are most likely to reflect the greater age range of the international samples, and a greater proportion of younger children who, as mentioned previously
have lower overall rates compared to older adolescents (Weisz & Hawley, 2002; Roberts et al., 1998). Inclusion of substance use disorders also serves to increase the New Zealand rates of prevalence. As already noted, Horwood and Fergusson (1998) cautioned that their figure of 43 percent was likely to be an upper limit estimate of the number of people requiring psychiatric treatment, since some of those meeting the criteria for disorder may not have symptoms of sufficient severity to justify clinical treatment.

Comorbidity

In the longitudinal studies, of those who met the criteria for at least one disorder, including substance use disorders, between 41 percent and 46 percent were co-morbid, displaying the symptoms of two or more disorders (Fergusson et al., 1993; Feehan et al., 1994; Horwood & Fergusson, 1998). The AHRG survey did not report on comorbidity as such, but noted that 11.8 percent of students reported engaging in five or more health risk behaviours, including use of substances, sexual behaviour, violence and suicidal thoughts.

Rates of comorbidity in clinically-referred youth have been found to be even higher. A survey of New Zealand youth admitted to a New Zealand inpatient unit for severe psychiatric disorder found 64.5 percent had a disorder comorbid with substance abuse (Swardi & Bobier, 2003). A large survey of youth attending specialist mental health services in England also found 95 percent had more than one problem area that justified referral to a child and adolescent mental health service; the most common number of problems identified was five (Audit Commission, 1999).

Despite these high rates of comorbidity in adolescents, a review by Weisz and Hawley (2002) noted comorbidity has rarely been addressed in adolescent treatment research. They found that of 114 studies reviewed, only 10 percent explicitly referred to youth with comorbid disorders.

Gender

Studies tend to show that at age 15 years substantial gender differences occur: one fifth of boys met the criteria for at least one disorder, while approximately one third of the girls met the criteria. The higher rate of disorder amongst girls was largely accounted for by higher rates of internalising (anxiety and mood) disorders (Fergusson et al., 1993). Gender differences in overall rates of disorder for males and
females at age 18 were less apparent, but the variation in the patterning of the disorder remained, with females having higher rates of internalising disorders and males being more prone to externalising (conduct, substance use) disorders. The AHRG study also found female students reported higher levels of emotional problems, in particular symptoms of depressions that were considered to be serious and in need of professional assistance (18.3% of females to 8.9% of males).

**Ethnicity**

Only the CHDS reported ethnicity data: Māori between 16-18 years of age had higher rates of mental health disorders (55%) compared to non-Māori (42%). Māori males emerged as a group particularly at risk, with higher rates of both conduct and substance use disorders. This is consistent with admission rates to psychiatric hospitals, where Māori males aged 15 to 20 years have higher rates of admission and readmission than non-Māori (Ministry of Health, 2002c). However, Fergusson, Horwood and Lynskey (1997) caution the increased rates they could also reflect differences due to the regional nature of their sample. The ethnic differences found in the South Island may be less pronounced than ethnic differences in the North Island. These authors suggested more research is needed to clarify such findings.

**Continuity and Stability of Mental Health Concerns**

Regarding adolescence as a transient period between childhood and adult has led some to conclude that mental health concerns arising at this time are transient and will be out-grown (Harrington, 2001). However, research suggests that without treatment mental health disorders tend to be relatively stable during adolescence, and often persist into adulthood.

Fergusson and Horwood (2001) reported a clear continuity in mood disorders, in which those showing early onset of disorder are at significantly increased risk of further episodes of anxiety and depression. A prior history of any mental health disorder at age 14 to 16 years often predicted presence of disorder at 18 years of age (Horwood & Fergusson, 1998). An epidemiology study conducted in the United States with youth diagnosed with a disorder such as anxiety, depression, ADHD, conduct, oppositional defiant and substance abuse, found that, when re-examined three years later, more than a third had reconfirmation of an existing diagnosis (Cohen, Cohen & Brook, 1993). In New Zealand, an even higher rate has been found:
two-thirds of those who met criteria for at least one mental health disorder at age 15 years still suffered some form of mental health disorder at age 18 (Feehan, McGee & Williams, 1993).

The DMHDS team also noted increased risk of later mental health disorders for those with disorder in adolescence, but concluded that risk varied across type of disorder: conduct disorder and depression in combination with anxiety were most strongly associated with continuity at age 18 years (Feehan et al., 1993). Symptoms of conduct disorder have also been found to be relatively stable in an 18–month follow-up of British children (Goodman, Ford & Meltzer, 2002), and Garber, Keiley and Martin (2002) noted that approximately one third of adolescents with elevated levels of depressive symptoms also continued to report high levels of depression from six to 24 months later.

Continuity of psychopathology from adolescence to early adulthood appears somewhat greater than from preadolescence to adolescence (Achenbach, Howell, McConnaughy & Stanger, 1995; Feehan et al., 1993; Hofstra, Van Der Ende & Verhurist, 2001). Hofsta and colleagues found that high rates of ‘total problem behaviour’ in adolescence (as measured by the Youth Self Report, Achenbach, 1991c), was a risk factor for psychiatric disorders in adulthood. They also found that a number of syndromes in adulthood were best predicted by their adolescent counterparts (i.e., withdrawal, somatic complaints, anxious/depressed, aggressive and delinquent behaviour) indicating longer-term continuity of these problems (Hofsta et al., 2001). In terms of specific disorders, researchers have found continuity of adolescent symptoms into adulthood for depression (Judd, Cohen, Cohen & Brook, 1999), antisocial behaviour (Harrington, 2001), and substance use (Chassin, Pitts & Prost, 2002).

There is, therefore, ample evidence to suggest a high risk that mental health disorders in adolescence will, without treatment, persist into adulthood. This has important implications for the provision of services to this population, particularly in terms of effective early intervention. It also indicates that evaluators of existing services, should include follow-up measures to determine whether improvements are maintained.
Prevalence Rates of Health Risk Behaviours and Substance Use

Many of the behaviours that result in youth being referred to mental health services place them at-risk of adverse health consequences. The health consequences of behaviours such as the misuse of substances, inappropriate sexual behaviour, suicide ideation and acts of violence are of particular concern to mental health service providers. As such these behaviours have been termed ‘health risk behaviours’ (AHRG, 2003). For example, immediate health consequences of substance abuse include increased risk of death from overdose, injury or death while driving a vehicle, or acquiring a sexually transmitted disease through unprotected sex. Less immediate consequences are: school failure, poor occupational adjustment, crime, mental disorders and chronic dependency on alcohol and drugs.

The exact prevalence of health risk behaviours in youth with mental health concerns is not clear, but there is a clear overlap between these behaviours and many diagnoses. There have been surveys conducted in New Zealand on prevalence rates of such behaviours in samples of high school students (AHRG, 2003; Coggan, Disley, Patterson & Norton, 1997). The most recent (the AHRG survey) found that in the four weeks prior to the survey, more than a quarter of youth reported having been in a car driven by someone who was potentially intoxicated. Many were at risk of injury as a result of violence, with 52 percent of males and 41 percent of females reporting being hit or physically harmed by another person at least once in the previous 12 months. Further, a disturbing number of students were at risk of emotional harm, with nine percent of males and five percent of females reporting being bullied at least once a week. An experience of unwanted sexual behaviour (sexual abuse) was reported by 22 percent of females. In terms of sexual health, around 40 percent of youth reported not always using contraception to prevent pregnancy. In addition 24 percent of males and 31 percent of females reported failing to use a condom as a means to protect themselves against a sexually transmitted infection the last time they had sex.

Perhaps the health risk behaviour most commonly surveyed in New Zealand, and the behaviour of most relevance to this research is use of substances such as tobacco, alcohol and cannabis. The AHRG survey found that 13 percent of males and 20 percent of females reported smoking tobacco at least weekly. Further, 19 percent of males and 15 percent of females reported drinking weekly or more, with 41 percent of males and 39 percent of females reporting an episode of binge drinking (more than five drinks) in the previous four weeks. This is similar to high rates of alcohol use
reported in other surveys (ALAC, 2003; Ministry of Health, 2002c). However, the Youth Drinking Monitor 2003 noted a slightly decreasing trend in the number of 14-17 years olds reporting binge drinking in the previous two weeks (20%) compared to the two previous years (29% in 2002; 32% in 2001). Misuse of alcohol among youth is still a major concern in New Zealand. The Youth Health Status Report, published by the Ministry of Health (2002c) reported that 23 percent of deaths among those aged 15 to 24 years are attributable to alcohol. Another concern is the use of marijuana/cannabis among youth. The Ministry of Health estimated that almost 10 percent of young people are dependent on cannabis by the age of 21 years (Ministry of Health, 2002c). They further noted that the use of cannabis before the age of 16 is associated with later problems in adolescence, such as juvenile offending, mental health problems, school drop-out and use of other drugs. The AHRRG survey found eight percent of males and six percent of females were using marijuana weekly or more frequently.

These high rates of prevalence in youth of these particular health risk behaviours, and the concurrent risk of serious health consequences, further point to the importance of developing and delivering effective interventions.

2.1.4 Help-seeking Behaviour

The high rates of mental health disorders in New Zealand adolescents raises the question as to the frequency with which these youth seek and obtain treatment. Several studies have surveyed help-seeking behaviour; there is a general concern among researchers that, despite the large number of youth identified as requiring treatment, only a relatively small proportion appear to actively seek treatment. Hence, the ability of a programme to attract youth referrals is an important aspect of any programme.

The CHDS examined help-seeking behaviour at ages 15 and 18 years (Fergusson et al., 1993; Horwood & Fergusson, 1998). At both ages, it was found that less than a quarter of those meeting criteria for mental health disorders received any form of treatment or assistance. This was a similar figure to that reported by the DMHDS (McGee et al., 1990) and of the Australian national survey conducted by Sawyer and colleagues (2000).

Research here in New Zealand (Horwood & Fergusson, 1998) and in Australia (Sawyer et al., 2000) has found that the most common sources of treatment for mental
health disorders were general practitioners and counsellors (notably school counsellors). A survey of a sample of New Zealand youth attending one of two New Zealand primary health services (n=87) found 53 percent attended on their own imitative, 33 percent at a parent’s suggestion; and 20 percent were referred by someone else (Inder, 1997). However, although 47 percent had levels of psychopathology that would be considered in the clinical range, of this sample over 90 percent were presenting for physical health problems, not mental health difficulties.

The CHDS found that treatment seeking was more common among those with mood disorders, and least common among those with substance use disorders (Horwood & Fergusson, 1998). Further analysis suggested that those most likely to seek treatment had high levels of impairment as a result of the disorder, and those or a previous history of psychiatric contact. In another New Zealand study on adolescent help-seeking behaviour (Carlton & Deane, 2000), the authors were concerned to find that higher levels of suicidal ideation were associated with lower levels of help-seeking intentions.

The major reason for young people with psychiatric disorders failing to seek assistance appears to centre around the individual’s belief about need for treatment. In the CHDS, nearly all of those who failed to seek treatment gave one of three reasons: (1) that it had not occurred to them to seek help, (2) that they did not need help and could handle any problems on their own, or (3) that they thought the problem would get better by itself without help. Other barriers to treatment seeking identified by other researchers, such as lack of available treatment, costs of treatment or embarrassment or fear about seeking treatment, were found relatively infrequently in the CHDS survey (Horwood & Fergusson, 1998).

The failure of Horwood and Fergusson to find embarrassment or stigma as a major barrier to seeking treatment contradicts findings of other research and reports. In relation to mental health concerns for all ages, the World Health Organisation describes stigma along with discrimination as the most important barriers to overcome. It was suggested that a multilevel approach was required, including a role for the mass media, and the use of community resources to stimulate change (World Health Organisation, 2001b). A research study carried out here in New Zealand on youth with depression confirmed the relevance of negative experiences related to the stigma associated with mental illness (Dunnachie-McNatty, 2000). The Mental Health
Commission has identified ‘work to reduce stigmatisation’ as a priority area in child and adolescent mental health.

It is important to understand ways of increasing help-seeking behaviour in youth with mental health concerns. The implications of youth recognising the need for help, and ways to reduce the stigma, are explored later in this thesis in relation to the ADC programme.

2.1.5 Provision of Adolescent Mental Health Services in New Zealand

The ADC programme is one mental health service within a broad range of services that are currently available to New Zealand youth. Table 2, is based on information produced by the Ministry of Health (1998), and provides a breakdown of the complete range of service options available to New Zealand youth and their families, to cater for the varying levels of severity of mental health problems.

The mental health services available to young people and their families in New Zealand are often referred to as either primary, secondary or tertiary. These service levels refer to the degree of specialisation of the service. The primary mental health services are those to which consumers have direct access, and are often the first point of contact for a young person or their family. These services are aimed at assessing and intervening with mild to moderate mental health problems. The Ministry of Health (1998) refer to the following as examples of primary mental health services: general practitioners, Māori community health workers, school staff such as guidance counsellors, public health nurses, private practitioners, school or community-based youth services, and some community-based agencies such as youth services and iwi-based or community counselling agencies (including Non Government Organisations). As noted earlier, the most common treatment service sought by adolescents for mental health concerns were general practitioners and counsellors (Horwood & Fergusson, 1998; Sawyer et al., 2000), which are both primary mental health services.

The introduction of Youth Health Centres or ‘one-stop shops’ also rates a mention. These are being developed as part of the Youth Health Strategy, to improve the range of accessible and appropriate services for youth. Developed to be youth friendly and provide one location that youth can go to get help on all their health needs, they address areas of priority concerns such as suicidal behaviour, sexually transmitted diseases and unintended pregnancies. They allow for self-referral which
may increase accessibility for users of primary mental health services. A survey of youth opinions on mental health services rated these services highly (Ministry of Health, 2000). The Ministry of Health (1998) also noted that there are services without a specific mental health focus that also contribute to the provision of primary mental health services. These include agencies from sectors such as education (e.g., Group Special Education) and social welfare (e.g., Children, Youth and Family services) and other medical specialist services (e.g., paediatricians).

Table 2.

Service configuration based on severity of mental health problem

<table>
<thead>
<tr>
<th>Severity</th>
<th>Personnel/Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild/transient problems</td>
<td>• Self / parent / whānau / lay diagnosis and treatment</td>
</tr>
<tr>
<td>Moderate problems</td>
<td>• General Practitioner (GP) / Public Health Nurse / private practitioner / Paediatrician / family counselling services</td>
</tr>
<tr>
<td></td>
<td>• Māori community health worker</td>
</tr>
<tr>
<td></td>
<td>• School / School Guidance Counsellor / Group Special Education Services (GSE)</td>
</tr>
<tr>
<td></td>
<td>• Non Government Organisations</td>
</tr>
<tr>
<td></td>
<td>• Children Youth and Family Services (CYFs)</td>
</tr>
<tr>
<td>Severe / chronic problems</td>
<td>• Child Adolescent Mental Health Service (CAMHS)/ Youth Speciality Service (YSS)</td>
</tr>
<tr>
<td></td>
<td>• GSE / CYFs / GP / Paediatrician with consultation /liaison support from CAMHS and YSS</td>
</tr>
<tr>
<td></td>
<td>• Specialist Māori mental health services</td>
</tr>
<tr>
<td></td>
<td>• Other specialist services, e.g., Drug and Alcohol; Early Intervention; Eating Disorders.</td>
</tr>
<tr>
<td>Chronic / life threatening</td>
<td>• CAMHS /YSS /other specialist services and hospital staff.</td>
</tr>
<tr>
<td>problems</td>
<td></td>
</tr>
</tbody>
</table>

Source: Ministry of Health (1998)
The next level up from primary health services are the secondary and tertiary mental health services, often referred to as specialist mental health services (Ministry of Health, 1998). The ADC programme receives funding to provide a secondary/specialist mental health service. In the McGeorge Report, secondary services are described as specialist services in community clinics and residential settings, whereas tertiary mental health services are those provided in hospitals and residential centres (Ministry of Health, 1995). A distinction is often made between tertiary care and secondary mental health services in terms of the former being services provided in one or a few places in the country, offering highly specialised treatment (Mental Health Commission, 2003) for individuals with the most complex and severe levels of mental health problems (Cochrane et al., 2000). However, more often than not the two levels of service are referred to together as ‘specialist mental health services’.

People access specialist services when their needs cannot be met by primary care services. Specialist services may be provided as community-based services, day treatment programmes or inpatient care. In the Blueprint for Mental Health Services in New Zealand (Mental Health Commission, 1998) it is suggested that the following service components are provided for by specialist mental health services: crisis care, acute inpatient, secure inpatient, multidisciplinary community teams (child and family), respite services and community day and residential programmes.

Youth specialist mental health services in New Zealand are primarily provided by two government agencies: the Child and Adolescent Mental Health Services (CAMHS) and Youth Speciality Services (YSS). CAMHS work with children and youth up to the age of 19 years. In some areas YSS have been developed to work with young people aged 15-19 years, and where YSS operate, CAMHS work primarily with those aged 0-14 years (Ministry of Health, 1998). Additional specialist treatment services for drug and alcohol problems or eating disorders may be provided within these agencies or contracted out to other agencies. The majority of drug and alcohol services are delivered in the community, but a limited number of residential programmes are available for the most severely dependent youth.

The ADC programme would be classified as a community-based specialist mental health service with a particular focus on the treatment of drug and alcohol problems. At the time the research was carried out, the programme was run by staff employed by Group Special Education which is under the jurisdiction of the Ministry of Education, although, it was funded from government regional health funding
(District Health Boards). Subsequent to data collection, in 2004 ADC became a private company, but was still on contract to the Shared Services Agency of the Southern District Health Boards.

There have been several recommendations over the years on how youth mental health services in New Zealand should be delivered. An early report by McGeorge in 1995 called for the decentralisation of services (Ministry of Health, 1995). This has been echoed more recently by the Mental Health Commission calling for an increased emphasis on community-based care (Mental Health Commission, 1999). This is in line with the New Zealand Mental Health Strategy (Ministry of Health, 1994, 1997) and international models of best practice. The World Health Organisation suggests that de-institutionalising mental health services, away from hospitals towards community-based services, reflects a shift in social values related to perceptions of mental illness. Further, the World Health Organisation reports that community-based services afford better outcomes and quality of life than hospitalisation, can reduce stigma, and are more cost-effective (World Health Organisation, 2001b).

Other recommendations for New Zealand include an increase in individualised 'wrap around' services, something that requires an increase in inter-service collaboration (Ministry of Health, 2000) and, in particular, the development of multi-disciplinary community teams (Mental Health Commission, 1999). A recent survey of youth mental health services in Australia arrived at a similar recommendation (Sawyer et al., 2000). This report pointed out that adolescents with mental health problems tended to have problems that were not limited to a single aspect of their lives, but were wide-ranging including suicidal ideation, conduct problems, alcohol use and drug abuse. There was consequently a need to develop joint policies and strategies across the different services that provide help to young people with the full range of mental health problems.

Increasing Access of Youth to New Zealand Mental Health Services

The need to expand and strengthen mental health services for youth in New Zealand has long been recognised as a priority area in New Zealand (Ministry of Health, 1994, 1995). National strategies for the provision of mental health services for New Zealand youth over the last decade have been guided by several key planning documents. These include the ‘Looking Forward’ (Ministry of Health, 1994), the
McGeorge Report (Ministry of Health, 1995), the Blueprint for Mental Health Services in New Zealand (Mental Health Commission, 1998) and the ‘New Futures’ (Ministry of Health, 1998). In 1994, the National Mental Health Strategy ‘Looking Forward’ identified the expansion and development of specialist mental health services for children and youth as a priority area within the broader goal of implementing comprehensive community-based mental health services. In response to this the McGeorge Report and the Blueprint published benchmarks as target levels of service provision that were estimated as necessary to meet the mental health needs of the children and adolescents of New Zealand. These figures were based on the prevalence rates of mental health disorder in New Zealand youth found in the DMHDS. The McGeorge Report recommended that a benchmark for the provision of primary health care be set at 10 percent (i.e., to provide services for 10 percent of all youth, and address less serious mental health concerns), while a benchmark of five percent be set for the provision of specialist mental health services (Ministry of Health, 1995). These were reported to be conservative estimates of what was required to meet the needs of those youth with the most severe mental health problems. At the time it was noted that less than one percent of youth with serious disorders were accessing mental health services. The Blueprint revised the latter benchmark to three percent provision by the year 2000/01, moving to five percent in subsequent years.

A recent report by the Ministry of Health in 2000 identified significant gaps in services for specific groups of children and youth and were prioritised for future funding and development by the Ministry of Health. They included: Māori and Pacific children and youth, children and youth with severe problems and multiple needs (i.e., the three percent with most severe mental health problems), and other areas of identified high need (rural areas, alcohol and drug dependency, suicide prevention and work to reduce stigmatisation). The ADC programme targets several of these groups and areas, including those with severe mental health problems, drug and alcohol dependency, suicide, and those living in rural areas. Further, around a quarter of ADC clients identify as Māori or Pacific Island peoples.

The Mental Health Commission is responsible for monitoring progress towards implementing the guidelines and benchmarks laid out by the Blueprint. Increased funding, following the recommendations of the above reports has resulted in an increase the number of services provided. However, access and provision of services continues to fall short of benchmark levels. The most recent progress report
published in April 2004 (Mental Health Commission, 2004), suggested only about 1.1 percent of New Zealand youth under the age of 20 years had been seen by a public mental health service (including adult services). Concern was expressed that there had been no increase in the number of young people and children accessing services from the previous year (Mental Health Commission, 2003). This figure is well below the conservative three to five percent estimated to need treatment in the Blueprint (Mental Health Commission, 1998) and a tiny fraction of the 43 percent identified in the CHDS as meeting the criteria for a DSM-IV mental health disorder (Horwood & Fergusson, 1998).

The Mental Health Commission pointed out that the lack of progress in service provision was compounded by shortages in the available workforce, with many District Health Boards failing to fill available full time positions (Mental Health Commission, 2004). The shortfall in workforce had been identified several years previously, and much attention has been directed at increasing and maintaining the adolescent mental health workforce (Ministry of Health, 2000).

2.1.6 Summary

In summary, deciding on an adequate definition of adolescence and mental health is a complex task, with available definitions reflecting the social values and belief systems of those who developed the definition. More recently there appears to have been a trend towards a broader understanding of mental health as represented in the recent Ministry of Health ‘Building Strengths’ Mental Health Promotion Strategy (Ministry of Health, 2002a) and the Auckland Health Research Group’s Student Survey (AHRG, 2003). Despite this, it was interesting to note that much government policy related to adolescent mental health is influenced by academic research which is predominantly written from within a scientific paradigm, focusing on individual pathology, diagnosis and the presence of dysfunction. For the purpose of this thesis, adolescence was defined as an age range (youth aged 10-19 years), and the phrase ‘mental health concerns’ was adopted to describe the ADC programme objectives and outcomes. However, it was acknowledged the ADC programme although funded as a mental health services, does not use this terminology when working with its clients.

Overall, available studies suggest rates of prevalence of mental health concerns of New Zealand adolescents are high, with the most recent CHDS finding a staggering 43 percent of 16-18 year olds meeting the standardised diagnostic criteria
for at least one psychiatric disorder (Horwood & Fergusson, 1998). For many these mental health concerns are multi-faceted. Internationally, New Zealand’s youth suicide rates (for 15-24 year olds) have been noted as being among the highest of OECD countries (New Zealand Health Information Service, 2000). Also of concern is the risk to these youth of serious health and social consequences as a result of engaging in or being subjected to health risk behaviours such as substance abuse, inappropriate sexual behaviour, acts of violence and other risky behaviour.

Against these clear needs, the levels of mental health service delivery and access continue to fall short of benchmark levels set several years ago by the Government. Despite increased funding, recent reviews by the Mental Health Commission have identified important gaps in services for specific groups of children and youth (Mental Health Commission, 1999) and have noted services are still below benchmark levels (Mental Health Commission, 2003).

There is, therefore, a need to strengthen and expand mental health services for adolescents, something continuing to be recognised as a key priority by the Mental Health Commission (Mental Health Commission, 1999). To make best use of the limited funds available, evaluations of existing adolescent mental health programmes such as the ADC are needed to ensure available resources are directed towards services of demonstrated effectiveness, or which at least display clear promise. If found to be effective, examination of the ADC treatment model may provide useful information to other services seeking to assist youth with mental health concerns.
2.2 The Effectiveness of Adolescent Counselling Programmes

This second section of the literature review examines how effective counselling programmes are in assisting youth with their mental health concerns. Presentation of existing programmes that have been the focus of research efforts, together with their outcomes, provides benchmarks from which to compare the ADC programme. The section starts with a brief discussion of some terms and definitions specific to this field of research. This is followed by a review of meta-analysis research on the overall effectiveness of counselling as an intervention for adolescents with serious mental health concerns. Then there is a presentation of treatments and programmes that have been found to be effective with specific adolescent mental health concerns. The specific mental health concerns reviewed are those that have received the greatest research attention and account for the most clinical referrals for adolescent psychotherapy (the same needs that the ADC clients are likely to present with). They include disruptive behaviour disorders, substance use disorders and emotional disorders. Finally there is description of the broad categories of counselling approaches; this will help in the clarification of the approaches utilised by ADC. There is also a review of Adventure/Wilderness Therapy, a less well-known approach, but one with special relevance to the ADC programme.

2.2.1 Definitions of Counselling

Counselling and Psychotherapy

The focus of this thesis is an adolescent counselling programme. In order to relate the relevant literature to this programme, it is necessary to define ‘counselling’ and discuss how this relates to a similar and commonly used term, ‘psychotherapy’. The New Zealand Association of Counsellors (2004) published the following definition of counselling:

Counselling involves the formation of professional relationships based on ethical values and principles. Counsellors seek to assist clients to increase their understanding of themselves and their relationships with others, to develop more resourceful ways of living, and to bring about change in their lives. (p. 2)

This is a necessarily broad definition in order to be applicable to the wide range of counselling approaches that exist. On first reading, it appears there is an emphasis on a person-centred approach to helping (see section 2.2.5), with the
suggestion of collaborative efforts and client self-actualisation. This definition appears to fit well with the approaches and objectives of the ADC programme.

Psychotherapy is a related term commonly used in North America, and one sometimes used interchangeably with counselling. A definition offered by Weisz, Weiss, Han, Granger and Morton (1995) in their research review of child and adolescent psychotherapy interventions is as follows:

... any intervention intended to alleviate psychological distress, reduce maladaptive behaviour, or enhance adaptive behaviour through counselling, structured or unstructured interaction, a training programme, or a predetermined treatment plan. (p. 452)

This particular definition is wide ranging in terms of the type of approach that may be included as psychotherapy, but appears to refer to approaches adopting what was described earlier as a ‘problem-solving’ model. There is more emphasis placed on identifying and reducing dysfunctions than on client self-actualisation. This model is more commonly associated with the field of scientific research, whereas the counselling definition noted earlier appears more closely associated with the practice of counselling/psychotherapy practitioners.

It appears much confusion still remains over the differentiation between counselling and psychotherapy. Some of this confusion has arisen due to the origins of the term psychotherapy, which was originally used to refer to a less intense form of psychoanalysis (see section 2.2.5) and is still understood by some professionals as being associated with this particular approach to therapy, also referred to as psychoanalytic psychotherapy (Feltham, 2000). These professionals would argue that the term psychotherapy, therefore, relates only to the approaches that address the deep, unconscious, long-standing personality and behavioural problems of clients, often thought to be a result of early relationships in childhood and/or partly from innate drives. Psychoanalytic psychotherapy is usually intensive, and continues for several years. Therapists require three to four years of training together with mandatory personal therapy.

Feltham (2000), however, pointed out that other approaches, in addition to psychodynamic, are now referred to as both counselling and psychotherapy. For example, person-centred approaches are now commonly referred to as both counselling and psychotherapy, usually without distinction. ‘Behavioural
psychotherapy' is another common term, which might be regarded by psychoanalytic professionals as a contradiction in terms, given the theoretical framework of each approach. Also some 'brief psychotherapies' challenge the simplistic claim that psychotherapy must be long-term, and counselling brief. Feltham's own view was that one cannot ultimately distinguish between counselling and psychotherapy. Indeed the British Association of Counsellors and the Association of Counsellors of South Australia chose not to differentiate between the two.

This thesis shares the view of Feltham, and for the purposes of this research, the terms psychotherapy and counselling are used interchangeably. The majority of the research studies from which much of this literature review is based refers specifically to psychotherapy. However, according to definitions such as that offered by Weisz, Weiss et al. (1995) such research would regard counselling programmes such as the ADC programme as a psychotherapy intervention. Therefore, the psychotherapy literature appears relevant to this thesis. It is noted, however, that in New Zealand, and in respect to the ADC programme, the term counselling is more appropriate and is used more widely.

Other Field Specific Relevant Terms

Of particular relevance to a review on the effectiveness of counselling and psychotherapy interventions is a description of some terms that have developed specific meaning within this field of research. These include the difference between studies which determine the 'efficacy' of an intervention compared to those looking at their 'effectiveness'; what is meant by an 'empirically supported treatment'; and the difference between an intervention that demonstrates 'clinically significant’ and one that demonstrates 'statistically significant' improvement.

Differentiation of the terms 'efficacy' and 'effectiveness' has come about due to an increased interest in the empirical substantiation of treatments in applied settings as opposed to the previously more commonly researched, university laboratory settings (Lambert & Ogles, 2004). 'Efficacy' has been referred to as the extent to which a treatment has been shown to produce change in well-controlled studies in which several conditions of treatment delivery depart from clinical practice (Kazdin, 2004). Efficacy studies emphasise internal validity, and use either experimental or quasi-experimental research design (Lambert & Ogles, 2004). Typical research experiments involve carefully selected subjects with stringent selection criteria, the
use of manuals to standardise treatment, training of therapists prior to the study, control of treatment dose by delivering only a specific number of therapy sessions, and the use of random assignment.

‘Effectiveness’ has been referred to as the extent to which change has been shown in the context of clinical settings in which several conditions are much less controlled, and characteristics of the clients, therapists, and treatment usually depart from those in research settings (Kazdin, 2004). Effectiveness studies emphasise the external validity of the experimental design, attempting to demonstrate that the treatment can be beneficial in an applied, clinical setting (Lambert & Ogles, 2004). Typically, clients are clinically referred rather than pre-selected, treatment dose is not controlled, therapists may not receive specific training in the approach/model being studied, and adherence to specific treatment style is not monitored. Effectiveness studies may, however, still use random assignment to control for threats to internal validity. This study is concerned with examining the effectiveness of the ADC programme, rather than its efficacy.

In reviewing the efficacy/effectiveness of counselling and psychotherapy interventions, the term ‘empirically supported treatment’ (EST) has arisen as one standard to compare an intervention or programme against, and as a result is frequently referred to in the literature. In North America in particular, where the majority of published research in this field appears to come from, there has been a growing interest in identifying specific treatments that have demonstrated effectiveness with specific types of clinical problems. This has partly been in response to increased accountability required by those funding such interventions, and efforts by governmental agencies and professional organizations particularly in the United States to establish practice guidelines (Lonigan, Elbert & Johnson, 1998). In the United States in the 1990’s, with the emphasis on managed care in medicine and related health areas, and acceptance within the medical community of fixed payment per diagnosis, it became necessary to standardise treatments and provide evidence of efficacy (Wampold, 2001). As a result several terms such as ‘empirically supported treatments’ have been adopted to identify those interventions for which positive evidence exists that they work with specific problems. Other related terms include ‘empirically validated treatments’, ‘evidence-based treatments’, and ‘evidence-based practice’ (Kazdin, 2004). Criteria for making the delineation can vary slightly
according to which term is being used. The criteria ‘empirically supported treatments’ (EST), which appears to be the most commonly used, is discussed here.

The term ‘empirically supported treatment’ has been adopted by the Task Force of Division 12 (Clinical Psychology) of the American Psychological Association. They have also sub-divided ESTs into either ‘well-established’ or ‘probably efficacious’ depending on the level of evidence available. For an intervention to be deemed a ‘well-established’ EST, the following criteria apply. There must be at least two good between-group design experiments demonstrating efficacy in one of the following ways: (a) superior to pharmacological or psychological placebo or to another treatment, or (b) equivalent to an already established treatment in experiments with adequate statistical power. The experiments must be conducted in accordance with a treatment manual, sample characteristics must be detailed, and at least two different investigators or investigatory teams must demonstrate the intervention’s effects. For an intervention to be classified as a ‘probably efficacious’ EST, either two experiments must demonstrate that the intervention is more effective than a wait-list condition, or one or more experiments must meet all criteria for a well-established treatment, except for the requirement that a treatment effect be shown by two different research teams (Kaslow & Thompson, 1998).

A final point for consideration is whether the effectiveness of a treatment has been shown to be ‘statistically’ and/or ‘clinically’ significant. The scientific evaluation of psychotherapy has focused primarily on testing whether the average person who received treatment had a better outcome than the average person who did not receive treatment (Lambert & Ogles, 2004). This type of analysis, which averages group results, can mask the outcomes of treatments on individual subjects and makes no definitive statements regarding the clinical meaning of the findings. Hence, in the last two decades many researchers have supplemented statistical between-groups comparisons with follow-up analyses that investigate the clinical significance of the findings. A definition of ‘clinically’ significant results, offered by Kendall and colleagues, is that treated clients are empirically indistinguishable from ‘normal’ or (in relation to the treatment of conduct disorder) non-deviant peers, following treatment recovery (Kendall, Gracia, Nath & Sheldrick, 1999).
2.2.2 Meta-Analyses on the Effects of Psychotherapy on Adolescent Mental Health

This first sub-section of the literature reviews the results from broad-based meta-analyses that have investigated the overall effect of counselling and psychotherapy. These studies were designed to answer the question of whether counselling / psychotherapy, including interventions such as the ADC programme, can be beneficial for youth with mental health concerns.

Meta-analysis is a method of integrating the evidence of a large number of studies systematically, using replicable procedures and explicit decision rules for the inclusion of individual studies. This type of analysis relies on effect sizes (ES) produced by the various treatments, which are calculated from post-treatment means for the treatment group minus means for the control group divided by standard deviation of outcome measure. In other words, effect sizes are an indication of the magnitude of change in terms of therapeutic outcome clients achieved as a result of a treatment. Effect sizes of around .50 are commonly classified as ‘medium’, and around .80 as ‘large’ (Cohen, 1988). To answer the question of whether psychotherapy works for children and adolescents, the studies compared the average effect size achieved by groups who received psychotherapy (combining the results of a wide range of counselling approaches) to those who were left untreated.

In relation to adult populations, there have been hundreds of meta-analyses on thousands of studies researching the effectiveness of psychotherapy (Lambert & Ogles, 2004), and the conclusion reached by reviewers of these studies is that psychotherapy is beneficial (Lambert & Ogles, 2004; Wampold, 2001). A recent review of such meta-analyses in fact concluded that psychotherapy is ‘remarkably efficacious’ (Wampold, 2001, p. 71), citing consistent evidence of large effect sizes of between 0.75 and 0.85. In contrast, there have been relatively few meta-analyses on the effectiveness of child and adolescent psychotherapy, with just four such meta-analysis reviews located (Casey & Berman, 1985; Kazdin, Bass, Ayers & Rodgers, 1990; Weisz, Weiss, Aliche & Klotz, 1987; Weisz, Weiss et al., 1995). Collectively, these meta-analyses have summarised the results of over 300 outcome studies across a broad range of treatments, involving children and adolescents between the ages of two and 18 years with a wide range of treatment problems (internalising and externalising disorders). The findings have been relatively consistent in demonstrating significantly superior outcomes for those who receive psychotherapy.
Casey and Berman (1985) reported a mean effect size of 0.71 for a collection of 75 treatment outcome studies with children 15 years of age and younger (studies published from 1952-1983). Weisz et al. (1987) reported a mean effect size of 0.79 for 108 studies with youth aged 4-18 years old (studies published from 1952-1985). Kazdin, Bass et al.’s (1990) meta analysis included studies focusing on the same age range as Weisz et al. (1987) but for studies published more recently (1970-1988). They reported a mean effect size of 0.88 for treatment versus no-treatment comparisons. Finally, the most recent meta-analysis by Weisz, Weiss et al. (1995), focused on the widest age range (1-17 years old) and covered studies published from 1967-1993. They reported a more moderate effect size of 0.54, lower than the previous studies. This effect size can be interpreted as indicating that the average youth who received psychotherapy fared better than 70 percent of the control group (Wampold, 2001). Weisz, Weiss et al. (1995) attributed their lower average effect size to the way they analysed the data. They chose to use the weighted least squares general linear model which takes into account the sample size of the studies involved, with an increased weighting given to larger sample sizes. They noted that effect sizes tend to be inversely related to sample size. One explanation they gave for this was the result of publication bias in favour of statistically significant treatment effects. That is, when sample sizes are small, only large effects will be statistically significant and thus likely to be published. Interestingly, when they ran the analysis using similar methods to the previous meta-analyses they found a similar average effect size to the previous studies of 0.71. Re-applying a weighted least squares analysis on results of a meta-analysis on adult psychotherapy provided a similar reduction in effect size (Shaddish et al., 1997).

Taking the results of these broad-based meta-analyses together, it appears that psychotherapy for children and adolescents is certainly more effective than no treatment. Although, the study which utilised the most sophisticated methodology found ‘moderate’ effect sizes rather than the ‘large’ ones which were reported in earlier studies. Hence, effect sizes for children and adolescents appear to be slightly smaller than those found in the adult studies.

Some limitations to the results of these meta-analyses need to be considered. Studies group together children and adolescents, even though the type of treatments and response to treatment is likely to differ with age (Kazdin, 2004). There is a mixing together of a wide range of therapies, therapy settings and therapist level of
training, and as noted by Kazdin, Siegel and Bass (1990) little attention has been given to therapy effects in applied settings.

2.2.3 Psychotherapy for Specific Problem Areas

In reviewing the efficacy or effectiveness of counselling and psychotherapy for adolescents, it was noted that research tended to focus on identifying effective approaches for specific problem areas. Indeed, many research studies tested treatments for individual disorders, and therefore, purposely selected homogeneous samples and excluded clients with comorbid conditions. This next section is based on this literature and, hence, is a review of the treatments for the specific externalising and internalising disorders. The problem areas that are the focus of these treatments coincide with the referral criteria for the ADC programme, that is, either substance use disorder or serious mental health problems. Hence, the treatments reviewed in this section are those found to be effective for the various problems ADC clients present with. It should, however, be noted that the ADC clients are more likely to present with comorbid or multiple mental health problems rather than with a single mental health disorder.

The treatments for the following mental health concerns will be reviewed: externalising disorders including disruptive behavioural disorders and substance use disorders; together with a brief summary of treatments for the internalising disorders of anxiety and depression.

Externalising Disorders

The DSM-IV manual (American Psychological Association, 1994) groups together conduct disorder (CD), oppositional defiant disorder (ODD) and attention deficit hyperactivity disorder (ADHD) under the heading of ‘attention-deficit and disruptive behaviour disorders’. Despite all three having separate formal diagnostic criteria, it is recognised that there is considerable comorbidity amongst these disorders (Brestan & Eyberg, 1998; Brinkmeyer & Eyberg, 2003; Dadds, 1997). Indeed the degree of overlap led Dadds (1997) to question their independence. In this review CD and ODD will be considered together, followed by a brief section on ADHD. Interpreting the literature in this area is made difficult by many studies using broad samples that group together children and adolescents, who were referred for
disruptive behaviour (Dadds, 1997), of which varying proportions may or may not have met the specific diagnostic criteria for CD, ODD or ADHD.

**Conduct disorder (CD) and oppositional defiant disorder (ODD)**

The term 'conduct disorder' refers to a pervasive and persistent pattern of antisocial behaviour which extends beyond the family to the school and community. It involves serious violations of rules and is characterised by defiance of authority, aggression, destructiveness, deceitfulness and cruelty (Brosnan & Carr, 2000). A predictable developmental progression of the disorder has been identified, starting with oppositional behaviour in the home, moving towards aggression, peer rejection, and academic failure in schools, and ending with antisocial behaviour in the community (Dadds, 1997). The prevalence of CD in New Zealand youth has been found to be between 4.8-7.3 percent (see Table 1, in section 2.1), lower than that of emotional disorders. However, the disruptive and violent behaviour associated with the disorder, cause a great deal of familial, school and societal concern. As a result, CD and other disruptive behaviours are reported to be among the most common causes of referral to mental health services (Weisz & Weiss, 1991).

Considering the high referral rates, it is unfortunate that reports of the successful treatment of CD are uncommon. It has been found to be relatively unresponsive to treatment (Brosnan & Carr, 2000); it is also difficult to engage CD youths and their families in treatment; and high drop-out rates from treatment are common (Dadds, 1997). The prognosis for youth identified as having CD is poor, with 80 percent likely to meet the criteria for a psychiatric disorder in the future (Kazdin, 2003).

ODD is differentiated from CD as being a less pervasive disturbance, and does not include violations of the law (Behan & Carr, 2000). Researchers have reported that ODD is probably a milder form of, and often a precursor to CD (Behan & Carr, 2000, Dadds, 1997). It is more commonly associated with children rather than adolescents and therefore, less relevant to ADC clients. However, epidemiology studies have found ODD cases present at a rate of around 12 percent in late adolescence (Cohen, Cohen, Kasen et al, 1993). The similarity and high levels of comorbidity have led researchers to often group CD and ODD together in terms of their diagnosis and treatment (Dadds, 1997). However, treatments developed and researched specifically for ODD appear to have been designed for children of pre-
school age to under 12 years of age rather than for adolescents (Weisz & Hawley, 2002).

Behan and Carr’s (2000) review of 24 studies on the treatment of ODD concluded that behavioural parent training combined with child-focused problem-solving skills training was a particularly effective intervention for preadolescent children. Kazdin (2003) concurred with this conclusion, citing evidence of the effectiveness of a similar programme for children aged 2-13 years diagnosed with CD. Behavioural parent training targets the context in which the disruptive behaviour occurs. It teaches parents to use specific behavioural skills based on learning theory to manage their child’s behaviour, in particular to change the reinforcement contingencies that maintain the adolescent’s deviant behaviour. The problem-solving skills aim to help children acquire skills for self-regulation and for the development of pro-social peer relationships. Several forms of behavioural parent training have been identified as empirically supported treatments for pre-school age children (Bestan & Eyberg, 1998). With older children, problem-solving skills programmes, cognitive-based anger coping therapy, and assertiveness training are interventions identified as ‘probably efficacious’ ESTs. Dadds (1997) noted that there is strong research support for the effectiveness of early interventions, but as children move into the teenage years the evidence for effectiveness becomes weaker.

In terms of interventions for disruptive behaviour disorders for adolescents, far fewer interventions appear to have been specifically developed and researched. Weiss and Hawley (2002) reviewed ESTs for adolescents with conduct problems, and found only seven treatments were tested at least in part with adolescents. Weiss and Hawley (2002) reported that of these seven, two were developed primarily for children but were sometimes extended upward to the early adolescent age group. These were the two interventions described above, parent training and problem-solving skills training. Parent training programmes have been delivered to adolescent age children (Brosnan & Carr, 2000), but it has been argued that behavioural parent training programmes should not be used with adolescents because they frequently do not respond well, and their reactions may in fact exacerbate family conflict (Weisz & Kazdin, 2003). The other four of the seven that Weiss & Hawley (2002) listed were downward adaptations of treatments designed for adults (anger coping therapy, anger control training with stress inoculation, rational emotive therapy and assertiveness training). These interventions target the disturbed cognitive processes and behavioural deficits
thought to produce aggressive and disruptive behaviour (Weersing & Weisz, 2002). Of the seven ESTs identified, only one was developed primarily for adolescents; this was multisystemic therapy (MST). One other adolescent-specific intervention known as multidimensional treatment foster care is also receiving growing support (Brosnan & Carr, 2000; Chamberlain & Smith, 2003). These two interventions are reviewed here.

Multisystemic therapy (MST) is an intensive family and community-based treatment for adolescent youth who engage in severe and ‘wilful’ misconduct. The term wilful was chosen by the authors as it is sufficiently broad to encompass the wide range of serious clinical problems addressed by MST (Henggeler & Lee, 2003). These include chronic and violent juvenile offending, substance-abusing juvenile offenders, adolescent sexual offenders, youth in psychiatric crisis and maltreating families. Across these groups the overarching goals are to decrease the rates of antisocial behaviour, improve functioning and reduce the use of out-of-home placements (e.g., residential treatment and incarceration).

The roots of MST are in social ecological theory (Bronfenbrenner, 1979) and family systems. The youth, family, school, work, peers and community are viewed as interconnected systems with dynamic and reciprocal influences on family members (Borduin, 1999). The aim of MST is to work within these systems to change the context in which the disruptive behaviour occurs. To optimise ecological validity the programme is delivered in the natural environment (home, school, neighbourhood), and assesses and addresses potential risk factors in a comprehensive yet individualised way. MST uses well validated treatment strategies derived from strategic family therapy, behavioural parent training, and cognitive-behaviour therapy. In addition, where biological contributors are identified, psycho-pharmacological treatment is integrated into the approach. It is noted in the review by Henggeler and Lee (2003) that, due to the complexity of wilful misconduct and related problems, considerable flexibility in the design and delivery of interventions is required. The individualised and flexible aspect of MST is operationalised through adherence to nine core treatment principles that guide treatment planning (see Henggeler & Lee, 2003, p. 304). The programme is usually delivered by a master’s level therapist who has a caseload of four to eight families and is available 24 hours a day, seven days a week, but with therapeutic intensity typically decreasing over the course of treatment.
Contact may be daily at the start, then reduce down to weekly during the course of the three to five months of treatment.

Evidence on the effectiveness of the programme comes from eight published outcome studies of youth presenting with serious clinical problems, seven of which incorporate randomised control design and one a quasi-experimental design. Henggeler and Lee (2003) summarised the results of three trials with violent and chronic juvenile offenders. They reported that MST produced 25 percent to 70 percent decreases in long-term rates of re-arrest, and 47 percent to 64 percent decreases in long-term rates of days in out-of-home placements. One of these trials involved the comparison of MST to individual therapy (Borduin, Mann, Cone & Henggeler, 1995). Findings showed MST was more effective than individual therapy in improving key family correlates of antisocial behaviour and in ameliorating adjustment problems in individual family members. Other reported outcomes of MST included improvements in youth and parent psychopathology, in family relations and functioning, and decreased drug use (Kazdin, 2004). In a review of MST, Kazdin (2004) reported that the evidence on behalf of MST has several strengths, including a focus on seriously disturbed adolescents, replication of treatment outcomes in several randomised controlled trials, evaluation of clinically and socially important outcomes, and assessment of long-term follow-up. MST is also one of the few interventions whose ‘effectiveness’ as well as ‘efficacy’ has been tested. Henggeler and colleagues demonstrated the efficacy of MST on clinically referred youth when delivered in community-based, service-oriented settings (Henggeler, Schoenwalk & Pickrel 1995). These studies and their findings have allowed MST to be identified as an empirically supported treatment by Brestan and Eyberg (1998), and recommended by other reviewers as an effective treatment (Carr, 2000; Kazdin, 2004). A pilot trial of MST is currently underway in Christchurch, New Zealand, its existence a reflection of the encouraging empirical support for this approach.

Multidimensional treatment foster care (MTFC) aims to modify conduct problem-maintaining factors in the youth, family, school, peer group and other systems by placing the youth (12-17 years) temporarily within a foster family. The foster parents have been extensively trained to use behavioural strategies to modify the youngster’s antisocial behaviour. The youth also receives a broad package of services including individual therapy focusing on pro-social skill building, behavioural family therapy with their family of origin, and a behavioural management
programme at school. Chamberlain and Smith (2003) have conducted a recent review of MTFC. They reported it as being based on social learning theory, with the individual’s behaviour, attitudes, and emotions thought to be highly responsive to influences provided by the contexts in which they live. The method of the programme was described as introducing the youth into a new and powerfully pro-social system. The programme was developed as an alternative to institutional, residential, and group care placements, which are costly, have minimal family involvement and tend to create associations with other delinquent peers, which have all been found to be disadvantageous (Chamberlain & Smith, 2003). The goal of MTFC is to prevent long-term separation of the adolescent from their biological family: as progress is made the adolescent spends increasing amounts of time with the natural/biological family. Placements are typically from six to nine months long. The programme is reported to entail an intensive, well-coordinated set of interventions including family and individual therapy, skill training, academic support, case management, and psychiatric consultation for medication management.

Brosnan and Carr (2000) reviewed three studies on MTFC, involving youth referred from community agencies including juvenile justice and a mental health hospital, and found the average effect size based on recidivism rates was 0.9 after treatment, maintained at follow-up of one to two years. Therefore, the average treated case fared better in terms of recidivism than 82 percent of controls. An even larger effect size of 1.4 was found for parent reported improvement in conduct problems at follow-up (average treated case faring better than 92 percent of controls). Further supporting evidence from more recent studies has been reviewed by Chamberlain and Smith (2003), including significantly improved rates of completion and subsequent criminal behaviour compared to ‘treatment as usual’ community-based group care. Chamberlain and Smith (2003) also noted the cost of MTFC is approximately one-third less than placement and treatment in group care. Brosnan and Carr (2000) concluded that treatment foster care was effective in reducing conduct problems and recidivism rates in the short- and long-term with repeat offenders and other adolescents diagnosed with severe conduct problems.

Dadds (1997) concluded that treatment for CD should be approached from a developmental perspective, with CD being conceptualised as a developmental sequence involving multiple causative factors that interact at critical points or transition phases of a youth’s life. Therefore, rather than identifying one treatment of
choice, it is better to think in terms of ‘windows of opportunity’ from childhood to adolescence and young adulthood, corresponding to the developmental progress of the disorder and the setting in which it occurs, and match a treatment accordingly. Similarly, Brosnan and Carr (2000) argued that a ‘continuum of care’ should be offered to adolescents with CD, based on the severity of the problem. Less severe cases might be offered parent training or functional family therapy. Moderately severe cases and those who do not respond to family interventions may be offered MST. Extremely severe cases and those unresponsive to intensive MST may be offered MTFC.

**Attention deficit and hyperactivity disorder (ADHD)**

Attention deficit and hyperactivity disorder (ADHD) is a chronic and pervasive condition characterised by developmentally inappropriate levels of inattention, impulsivity, and/or hyperactivity (American Psychological Association, 1994). Other labels that have been used to describe this syndrome include hyperkinetic disorder (ICD-10, World Health Organisation, 1992), attention deficit disorder, hyperkinesis and minimal brain dysfunction. It has been reported as being one of the most common disorders of childhood (Pelham, Wheeler & Chronis, 1998). Contrary to popular opinion, most children do not outgrow their ADHD symptoms on reaching adolescence (Anastopoulos, 1997). The following features have been used to subtype ADHD: the pervasiveness of the problem, the presence or absence of both inattention and hyperactivity, and comorbidity with conduct disorder (Nolan & Carr, 2000). In the adolescent age group, it is perhaps the latter sub-group that is most likely to come to the attention of mental health service providers such as the ADC programme. This group is also at increased risk of comorbid depression, anxiety disorders and substance abuse (Anastopoulos & Farley, 2003). Where a comorbid conduct disorder is present, children show greater academic problems and suffer more extreme relationship difficulties with peers, teachers and family members. While showing some response to psycho-stimulant treatment, they rarely respond to psychosocial individual and family interventions alone (Anastopoulos & Farley, 2003; Nolan & Carr, 2000).

A review by Nolan and Carr (2000) involved 20 well-controlled studies of either psychological interventions, or combined psychological and pharmacological interventions. They concluded that there was a range of psychological interventions
that have achieved positive short-term effects with ADHD symptoms and related problems. These include youth-focused interventions (social skills training, self-instructional training, therapy-based contingency management); family-based interventions (behavioural parent training, problem-solving and communications training, family therapy), school-based interventions (school-based contingency management), and multidimensional interventions where child, family and school-focused interventions are combined into a multi-component package. It should be noted, however, that the majority of these psychosocial interventions are more appropriate for children than adolescents; for example, parent-training was developed for parents of children 4-12 years of age. Problem-solving communication training is, however, likely to be more appropriate with adolescents (Anastopoulos & Farley, 2003).

Nolan and Carr (2000) reported that the effects of psychosocial interventions were enhanced when combined with stimulant therapy (i.e., medication); indeed, it was reported that many were no more effective than stimulant therapy alone. Others have also conceded that stimulant therapy is not only the most common treatment but has the greatest degree of evidence in favour of its effectiveness (Anastopoulos, 1997; Pelham et al, 1998). However, Nolan and Carr (2000) cautioned that there are side-effects from stimulant/medication therapy, and limited information on possible long-term negative effects.

Psychodynamic or person-centred interventions were not included in Nolan and Carr’s review, as they could not find any studies that included a control group and therefore met the inclusion criteria of being ‘well-controlled’. Yet they noted that, historically, individually orientated play therapy based on psychodynamic or client centred theories have been widely used in the treatment of ADHD. Fonagy and Target (1994) found, after a year of psychodynamic treatments, 69 percent of 93 cases who had disruptive behaviour disorders showed clinically significant improvement. Included in Fonagy and Target’s sample were several disruptive behavioural disorders. Those with ODD were most likely to improve, while those with CD least likely, and those with ADHD showed improvement rates that fell between these two groups.

The conclusion reached by Nolan and Carr (2000) was that for effective short-term treatment of ADHD, a multisystemic intervention involving multi-component treatment packages combined with low dose stimulant therapy was the treatment of
choice. Such multi-component treatment packages should include behavioural parent-training, self-instructional training, and school-based contingency management elements, and should span 17-29 sessions over 8-12 weeks (they also specified that low dose methylphenidate stimulants should be based on 0.3 mg/kg body weight). The individual components of behavioural parent-training and behavioural school-based interventions have been identified by Pelham et al. (1998) as meeting the criteria as well established empirically supported treatments in their own right. However, Anastopoulos and Farley (2003) made the point that, rather than curative, most short-term interventions for ADHD aim to reduce symptom levels and related behavioural or emotional difficulties; when treatments cease, symptoms often return to pre-treatment levels. For effective long-term treatment, Nolan and Carr (2000) argue that a long-term care model of service delivery is probably required, offering the option of infrequent but sustained contact with a psychological and paediatric service over the course of childhood and adolescence.

Substance abuse and dependency

Substance use disorders are characterised by a maladaptive pattern of substance use leading to clinically significant impairment or distress. The same diagnostic criteria is applied to adolescents and adults by the DSM-IV (American Psychological Association, 1994). ‘Substance abuse’ involves recurrent use despite one or more adverse consequences as a result of the substance use: harmful effects (or the risk thereof) to physical health, problems with social relationships, failure to fulfil major role-obligations, and legal problems. ‘Substance dependence’ is associated with three or more symptoms of dependency in a 12 month period; these symptoms include increased tolerance to the substance, symptoms of withdrawal, use of larger amounts or longer use than intended, persistent desire or unsuccessful efforts to cut down or control use, much time spent obtaining, using, or recovering from effects of substance, important social, occupational or recreational activities given up or reduced because of substance use, and continued use of substances despite the knowledge of having persistent or recurrent physical or psychological problems caused or exacerbated by use. Substance use disorders are the primary reason for referral to the ADC programme.

Some researchers have noted the similarity between the manifestations of substance use disorders in adults and adolescents (Westermeyer, 1997). Others
however, question the applicability of the same criteria for both youth and adults, given developmental differences (Martin, Langenbacher, Zkaczynski & Chung, 1996; Shand, Gates, Fawcett & Mattick, 2003). For example, compared to adults, adolescents have been found to have a lower prevalence of symptoms such as withdrawal and substance-related medical problems, which generally emerge only after several years of heavy drinking (Martin, Kaczynski, Maistro, Bukstein & Moss, 1995; Nelson & Wittchen, 1998). Other symptoms such as tolerance have a low specificity for adolescence with the rapid physical development that occurs during this period influencing tolerance levels. Legal problems, if applied strictly, could also result in a diagnosis of alcohol abuse of any youth consuming alcohol unsupervised. However, despite these limitations no other better system of diagnosis has yet been developed (Spooner, Mattick & Howard, 1996).

When these criteria were applied to a New Zealand birth cohort, substance use disorders were found to be the most common mental health disorder in 18 year olds, with a prevalence rate of 24 percent (Horwood & Fergusson, 1998). Horwood and Fergusson (1998) also found a high level of comorbidity with mood disorders and in particular, conduct disorder: nearly 90 percent of adolescents (16-18 years) who met the criteria for conduct disorder also had a substance use disorder. Cormack and Carr (2000) commented that the complexity of the relationship between substance use disorders and other psychological problems can complicate treatment, as substance use may precipitate or maintain other mental health disorders. Spooner et al. (1996) also noted the importance of taking a wider perspective stating:

Failure to see drug abuse as part of a larger pattern of behaviour can be a barrier to effective interventions, particularly as each risk behaviour could be contributing to another risk behaviour ...the good news is that given their shared aetiologies, the interventions that can change an adolescent’s risk status for one problem behaviour are likely to be effective in changing the other risk behaviours. (p. 464)

There are a range of treatments delivered to adolescents with substance use disorders. Treatments can be placed on a continuum, based on the severity of the problem, from brief educational interventions to community-based counselling/therapy, intensive day programmes, residential treatment and finally, for the most severe conditions, hospitalisation. These treatments can involve a variety of approaches including behavioural and CBT approaches, 12-step orientated models
(Alcoholic Anonymous/Narcotic Anonymous), family and multidimensional models of therapy, and therapeutic community/milieu therapy approaches (Cormack & Carr, 2000; Jainchill, 2000; Spooner et al., 1996). The treatment goal for some approaches is abstinence, whilst for others it is harm minimisation. Considerable debate continues over which treatment goal is the more appropriate.

There are a variety of dedicated alcohol and drug initiatives in New Zealand. A review by Nelson (2000) found services ranging from community-based short-term interventions to residential treatment programmes. More recently there has also been the development of youth drug and alcohol day programmes. A survey of a small sample of youth alcohol and drug providers found CBT approaches to be the most common (Nelson, 2000).

Well-controlled research into the outcomes of different treatments for substance use disorders has been lacking (Shand et al., 2003; Spooner et al., 1996), and conclusions on effectiveness remain tentative. In an early review by Catalano, Hawkins and Wells (1990) of 34 adolescent treatment studies, testing a variety of approaches using experimental, quasi-experimental and one-group pre-post designs, it was concluded that some treatment is better than no treatment, but that few comparisons of treatment method have consistently demonstrated superiority of one method over another.

There is evidence from randomised controlled trials that treatments of various forms can be effective (Catalano et al., 1990; Cormack & Carr, 2000; Spooner et al., 1996). Spooner et al. (1996) noted both family therapy and behavioural methods achieved evidence of efficacy. Others have found family therapy and multidimensional forms of therapy (MST and multidimensional family therapy) to be superior to individual-based treatments. Multidimensional approaches were also found to be superior to group-based treatment (Cormack & Carr, 2000; Stanton & Shaddish, 1997). When there are difficulties engaging families, an individually-based variant of family therapy, ‘one-person family therapy’, has been found to be an effective alternative (Cormack & Carr, 2000). In cases where youth were resistant to treatment, parental training that included more than just education (e.g., communication and conflict resolution skills) may be effective (Cormack & Carr, 2000). Shand et al. (2003) suggested that brief and motivational interventions appear to be effective for adolescent heavy drinkers. There appears to be a consensus among reviewers that treatments must be developmentally sensitive, and address the range of
concerns of special relevance to adolescents (Cormack & Carr, 2000; Jainchill, 2000; Shand et al., 2003).

In summary, evidence is emerging that, similar to other externalising problems, treatments that involve wider systems of influence, particularly inclusion of the family are superior. This could, however, simply be a reflection of an increased focus on family intervention research, as noted by Weinberg, Radhart, Colliver and Glantz (1998). It must also be remembered that not all adolescents have sufficient support from their families to facilitate positive treatment outcome (Spooner et al., 1996).

As several authors have noted, more well-controlled research needs to be carried out to determine the best treatment options for adolescents with substance use disorders (Catalano et al., 1990; Shand et al., 2003; Spooner et al., 1996). Compared to research on treatments for disruptive behaviour, this area of research has lagged behind in the use of randomised controlled trials to test treatments. However, it has focused on older adolescents and young adults and is, therefore, more relevant to the population of interest in this thesis. Further, many of the family-based and multi-dimensional interventions tested the ‘effectiveness’ of interventions in community out-patient settings (Cormack & Carr, 2000).

**Internalising Disorders**

Problems most commonly referred for treatment are externalising and disruptive behaviours. These behaviours are more visible and disturbing to parents or teachers, who typically initiate the referral to treatment on behalf of the youth. Internalising disorders or emotional problems, despite usually having higher rates of prevalence, are often overlooked (Kazdin & Weisz, 2003) and as a result have received less research attention (Kaslow & Thompson, 1998). Research on the treatment of anxiety and depression in adolescence is reviewed next.

**Anxiety**

Broadly speaking, anxiety is a response to a stimulus perceived as threatening (Hagopian & Ollendick, 1997). It is generally accepted as being a multidimensional construct, with responses often occurring across different modalities. These may include behavioural avoidance, cognitions of impending harm and danger, increased physiological arousal, and feelings of dysphoria or even terror. An anxiety disorder is
said to exist if the anxiety is extreme and of greater severity and duration than would be expected to occur as part of normal development, and if it occurs to the extent that the child or adolescent's functioning is impaired (Hagopian & Ollendick, 1997). Within the DSM-IV (American Psychological Association, 1994), distinctions are made between a variety of different anxiety disorders based on the type of feared stimulus of situations (e.g., phobias) or the nature of the anxious response (e.g., panic disorder).

The following types of anxiety disorders are identified by DSM-IV diagnoses: separation anxiety, phobias, generalised anxiety disorders, panic disorder, post-traumatic stress disorder and obsessive compulsive disorder. Separation anxiety is the only anxiety disorder exclusively diagnosed by DSM-IV as 'usually first diagnosed in infancy, childhood or adolescents'; the other anxiety disorders are classified according to the same framework used with adults. However, the emergence of anxiety disorders is believed to follow a developmental course, with specific disorders more common at different transitory periods, paralleling that of normal fears. Generalised anxiety, panic disorder and social phobia and obsessive compulsive disorders are more common with the onset of adolescence (Moore & Carr, 2000a). At this phase, adolescent fears tend to be related predominantly to social and interpersonal situations (Hagopian & Ollendick, 1997). Anxiety disorders are believed to be among the more common types of psychiatric disorder experienced by children and adolescents (Weersing & Weisz, 2002). Prevalence rates at ages 15 years and 18 years old in New Zealand have been found to vary from 10 to 27 percent (see Table 1, section 2.1). Presence of comorbidity is high between different anxiety disorders, and between anxiety and other psychiatric disorders. Comorbidity in children and adolescents tends to involve conduct problems or, to an even greater extent, major depression (Hagopian & Ollendick, 1997; Horwood & Ferguson, 1998).

In terms of treatments for anxiety, most are based on behavioural principles of classical, operant, and vicarious conditioning. Behavioural learning theories of anxiety view pathological fears and phobic behaviours as acquired responses. In learning-based interventions, anxious youth engage in activities designed to promote the unlearning of old fear responses and the learning of new associations and coping behaviours. The more commonly used learning-based strategies with children and adolescents include systematic desensitisation, graduated exposure, flooding, contingency management, and modelling (Hagopian & Ollendick, 1997). In addition
to learning-based interventions there are also CBT interventions. These interventions have as a primary focus modifying the inaccurate cognitions characteristic of anxious and phobic youth. Anxious youth tend to erroneously interpret ambiguous situations as threatening, over-estimate the likelihood of dangerous events, view the worlds as unsafe and full of risk, and perceive themselves as unable to successfully cope with these threats (Weersing & Weisz, 2002).

Ollendick and King (1998) reviewed treatments for children and adolescents with phobic and anxiety disorders to determine which treatments met the criteria to be identified as empirically supported. They found for phobias that imaginal desensitisation, in vivo desensitisation, filmed modelling, live modelling, and cognitive behavioural interventions that use self-instruction were ‘probably efficacious’ and that participant modelling and reinforced practice were ‘well established’. For anxiety disorders, only cognitive-behavioural procedures (either with or without the inclusion of family involvement) were found to be ‘probably efficacious’.

Weisz and Hawley (2002) noted that, as with treatments for disruptive behaviours, those identified as EST were not specifically designed for adolescents. They were either designed and delivered primarily for children but sometimes extended ‘upwards’ to younger adolescents, or were ‘downward’ adaptations of treatments designed for adults. Some programmes have adolescent-specific versions, such as Kendall and colleagues’ child-focused cognitive-behavioural programme called Coping Cat (Kendall, Aschenbrand & Hudson, 2003), and the FRIENDS programme of Barrett and colleagues, a group-based CBT programme with parental involvement (Barrett & Shortt, 2003). However, in the main the research demonstrating the effectiveness of such programmes has focused on the child versions of the programmes, and is thus less relevant to the adolescent population that is the focus of this thesis.

Moore and Carr (2000a) noted that programmes and research on interventions for the treatment of panic disorder and post-traumatic stress disorder which can afflict adolescents were generally lacking. In their review they concluded that brief outpatient rather than extended inpatient treatment is preferable. For severe anxiety problems including generalised anxiety disorder, separation anxiety and social phobia, a combined 24 session programme of individual and family-based CBT was recommended. The individual-based CBT taught youth to monitor and challenge
anxiety-provoking cognitions, develop coping self-instructions and relaxation skills to reduce anxiety, and self-reinforcement for consolidating successful coping responses. The family-based component focused on contingency management, personal anxiety and management for parents, and problem-solving and communications skills training for all family members.

**Depression**

Depression has been described by Clarke, DeBar and Lewinsohn (2003) as a chronic and recurrent illness that is associated with significant impairment in family, social and academic functioning. In terms of meeting the DSM-IV diagnosis for major depressive disorder (American Psychological Association, 1994), adolescents require one or more episodes in which at least five depressive symptoms have been present for at least two weeks. One of these five symptoms must be either an increase in depressed or irritable mood or greatly diminished interest or pleasure. The other symptoms may include significant changes in weight (gain or loss), sleep (insomnia or hypersomnia), or psychomotor activity; increased fatigue, increased feelings of worthlessness or guilt; diminished concentration or decisiveness; or recurrent thoughts of death or suicidal thoughts or actions. A related condition is dysthymic disorder, which is differentiated from major depressive disorder as having a longer duration but a constellation of milder depressive symptoms (Mufson & Moreau, 1997).

There is no separate diagnostic criteria for depression in children and adolescents, just minimal modification of the adult DSM-IV criteria applied to children and adolescents. One modification is the inclusion of the presence of 'irritable mood' in addition/or instead of 'depressive mood' as a main depressive symptom. However, several authors have noted differences in the symptomatic profile of adolescents compared to adults, such as more interpersonal problems and higher rates of suicide attempts. There are also differences in responses to treatment, in particular to pharmacological interventions (Mufson & Moreau, 1997; Weisz, Southam-Gerow, Gordis & Connor-Smith, 2003).

In terms of prevalence, the New Zealand longitudinal studies found mood disorders range from four to six percent in 15 year olds, rising to 17-28 percent by the age of 18 years (see Table 1, section). Up until puberty there is little or no difference in relation to gender, but thereafter a marked gender difference emerges, with females
experiencing higher rates of depression than males (AHRG, 2003; Horwood & Fergusson, 1998). Weisz et al. (2003) reported that comorbidity among clinical samples is very high. They found, in their community-based clinical sample, over 80 percent of the youth who had depression also met the criteria for one or more disruptive behaviour disorders. Unfortunately the prognosis for youth with depression is relatively poor, with those who have suffered from a major depressive disorder at significantly higher risk for future episodes of depression both in late adolescence and early adulthood (Moore & Carr, 2000b; Mufson & Moreau, 1997).

Research on the treatment of adolescent depression has lagged behind that of other child and adolescent disorders, and that of adult depression (Kaslow & Thomspson, 1998). This has been attributed to long-standing debates over the reality of depressive disorders in youth, inconsistencies in the assessment and diagnosis of mood disorders in children and adolescents, and the fact that depression has received less attention because it is less disruptive than externalising problems to the people in the youth’s environment (Kaslow & Thompson, 1998). However, research is available on programmes that primarily targeted adolescents. However, these programmes are also downward adaptations of programmes developed for adults (Kaslow & Thompson, 1998; Weisz & Hawley, 2002).

There appears to be a wide range of psychosocial treatment programmes available for children and adolescents with depression. These include psychodynamic psychotherapy and psychoanalysis, cognitive-behavioural therapy, interpersonal psychotherapy, family therapy and group therapy. However, as with other problem areas, in contrast to the number of treatments available only a small number have been tested empirically (Mufson & Moreau, 1997). A concern noted by Weisz and Hawley (2002) was that, of those researched, treatment outcome studies on depression did not seem to address suicidality; in fact they noted several studies that explicitly excluded subjects who were suicidal, making their findings less applicable to real-world clinical practice.

In a survey of the literature on well-controlled treatment outcome studies for adolescent depression, Kaslow and Thompson (1998) identified only seven well-controlled treatment outcome studies, and of these only one programme (Coping with Depression Course) met the criteria of being an empirically supported treatment; this was only at the lesser ‘probably efficacious’ sub-category. Subsequently, Mufson and Dorta (2003) used evidence from recent research studies to claim that their
Interpersonal Psychotherapy intervention for depressed youth met criteria for being a ‘probably efficacious’ EST.

Coping With Depression for Adolescents (CWDA) is described as a cognitive-behavioural programme that combines the behavioural social learning theory of depression with the cognitive model of depression (Clarke et al., 2003). A group-based intervention of 16 sessions, it includes the option of a parallel course for parents or guardians. The intervention has two main components, the first being behavioural therapy aimed at increasing the youths’ rates of involvement in pleasant activities. The second component is cognitive therapy aimed at reducing ‘cognitive distortions’, by changing underlying beliefs. There are also several subsidiary components including relaxation training, problem-solving, communication and social skills (Clarke et al., 2003). Evidence for the effectiveness of the programme comes from four randomised controlled trials. All studies are reported to have yielded significant, positive treatment results with treatment effects maintained up to two years following treatment. In terms of clinical significance, youth who had been diagnosed with major depression and/or dysthymia had post-treatment recovery rates ranging from 46-67 percent following CWDA, compared to just 5-48 percent for the control condition. The authors reported that they were surprised to find that the inclusion of parental involvement created few significant advantages. They did add that in their experience the parents who participated were the ones least likely to need it, and those parents whose families displayed significant family conflict were typically unavailable to participate.

Interpersonal Psychotherapy for Depressed Adolescents (IPT-A) has been developed from the original adult version of the programme. The focus of IPT treatment is on the patients’ depressive symptoms and their current interpersonal context, regardless of the aetiology of the disorder. Diagnosis and intervention focuses not only on the symptoms and behaviours that comprise the disorder but also the individual’s interpersonal interactions and the communications involved in these interactions (Mufson & Dorta, 2003). The programme is an individual treatment but does have a parent/guardian component. IPT-A consists of four phases; (1) identify the problem area, (2) relate the depressive symptoms to problem area, (3) focus on current relationships, and (4) help the patient master the interpersonal context of his or her depression (Mufson & Dorta, 2003). Evidence for the effectiveness of the programme is based on a randomised controlled trial (Mufson, Weissman, Moreau &
Garfinkel, 1999), and the comparison of IPT-A to a waitlist condition from a second research team (Rosselló and Bernal, 1999). Mufson and colleagues found that IPT-treated youth diagnosed with major depression had significantly fewer self-reported symptoms, higher rates of recovery and improvements in social functioning compared to a control clinical monitoring condition. Rosselló and Bernal (1999) found that IPT resulted in a greater reduction in depressive symptoms, and significant increases in self-esteem and social adaptation compared to a wait-list control condition.

Reviewers have concluded that effective psychosocial intervention programmes are available for adolescents with depression, most of which are based on a cognitive-behavioural model (Kaslow & Thompson, 1998). Not many have been empirically supported, although it is encouraging that existing studies have used clinically referred samples (Mufson & Dorta, 2003; Weisz et al., 2003) and more recently priority has been given to testing the ‘effectiveness’ of programmes in real-world, community-based clinical settings (Weersing & Brent, 2003; Weisz et al., 2003).

In summary a range of treatments with differing characteristics have been developed for the different mental health disorders. Across the externalising disorders, interventions with the strongest research evidence for adolescents were those that sought to influence wider systems of influence, and included cognitive behavioural approaches. Treatments for internalising disorders were more individually-focused, used behavioural and cognitive-behavioural approaches with less support for family involvement. The ADC programme aims to work with youth who present with both externalising and internalising disorders and often with more than one disorder. Of the treatments reviewed above, it appears only MST had been tested with more than one type of mental health problems. Of interest then for this research is examining the approaches and programme content utilised by the ADC programme in order to be effective across such a wide range of youth mental health concerns.

2.2.4 Limitations of Child and Adolescent Mental Health

Treatment Outcome Research

Several limitations need to be recognised in the treatment outcome research that has been reviewed. Despite researchers typically finding a differential effect of treatment outcomes for children and adolescents (Brestan & Eyberg, 1998; Durlak,
Fuhrman & Lampman, 1991; Kazdin, 2004), many studies fail to distinguish between children and adolescents, making interpretation of findings difficult. Lonigan et al. (1998) conducted a survey of treatments for specific child and adolescent treatments for autism, conduct, emotional and attention deficit disorders, that met specific rigorous criteria as to warrant the status of ‘empirically supported’. Twenty five treatments were identified as ESTs, yet just fourteen targeted adolescents, with the remainder directed at children (Weisz & Hawley, 2002). Further, many of these 14 were either upward adaptations of child programmes or downward adaptations of adult programmes rather than being specifically developed for the adolescent age group. Clearly an increased focus on developmental issues specific to adolescence, is needed in research and treatment (Holmbeck & Kendall, 2002; Steinberg, 2002; Weisz & Hawley, 2002).

Concern has also been expressed on how well these research findings relate to those involved in actual clinical practice (Goldfried & Wolfe, 1996; Kazdin, 1997a; Weisz & Hawley, 1998; Weisz, Donenberg, Han & Weiss, 1995).

A survey of practising child and adolescent clinicians conducted by Kazdin, Siegel et al. (1990) found the majority of clinicians viewed psychodynamic (59% of respondents), family (57%) or eclectic (73%) interventions as useful “most” or “all of the time”. Yet research attention is not directed so much at these approaches but more at behavioural or CBT approaches. For example, Weisz and Hawley (1998) point out that in one of the broad-based meta-analysis 70 percent of all studies that qualified to be included in the analysis involved behavioural or CBT, and fewer than 10 percent involved psychodynamic, client centred, family or eclectic models.

One explanation for the overemphasis on behavioural and CBT approaches is the increased focus on identification of empirically supported treatments (EST). While many agree that identification of ESTs is an important step forward towards the provision of effective treatments for children and adolescents with mental health concerns (Kazdin, 2004, Lonigan et al., 1998), there have also been some criticisms noted. Some of the criteria used to identify an empirically supported treatment, such as standardisation or the production of replicable therapy manual, has resulted in treatments that are amenable to such criteria likely to be over represented (i.e., cognitive behavioural interventions). Treatments such as psychodynamic approaches that do not lend themselves to standardisation have thus not received the same degree of research attention. Kazdin (2004) has commented that some treatments may not
only be effective but are in fact optimal, but simply haven’t been researched sufficiently. Another concern expressed by Kazdin was that the emphasis with EST is on technique, when effectiveness may depend on other variables, such as therapist characteristics. This concern is supported by Wampold (2001) who has estimated that in adult psychotherapy, technique accounts for a relatively small proportion of variance in outcomes (8%), where as common factors and unexplained variance which are not the focus of ESTs account for a much greater percentage (92%). Further, ESTs have generally been developed and tested to improve the outcome of one specific disorder, with subjects with more than one disorder (comorbidity) typically screened out (Graham, 2001; Weersing & Weisz, 2002). As Graham has pointed out, the vast majority (95%) of clinical referrals have comorbid conditions, hence, as Weersing and Weisz (2002) have suggested, EST treatments may be being developed for clients who are relatively rare, those with mental health concerns limited to a single area.

The arguments above relate to another criticism of the treatment outcome literature, which perhaps raises the greatest concern. This is the neglect of research testing treatment ‘effectiveness’ in real-world settings. There are a range of important differences between the characteristics and conditions of therapy in clinical practice settings as compared to research trials. Rigidly controlled environments of research (random assignment, control groups, fixed length duration, clearly specified inclusion/exclusion criteria, single disorders, non-referred populations) are designed to produce unambiguously interpretable results. In contrast, clinical practice involves clients referred from a wide range of sources, many of whom have comorbid diagnoses, and who remain in the interventions for varying lengths of time depending on the severity of the problem and their individual responses to treatment. The treatment itself is usually conducted by clinicians of varying skill levels and professional backgrounds (Weisz & Hawley, 1998). Therefore, effects of treatment models tested under carefully constructed, optimal conditions may not generalise well to the services offered to youth and families in need of mental health services seen at most mental health settings.

A review of treatment outcome studies between 1972 to 1991 found only nine controlled studies that investigated treatments delivered as routine clinical practice (Weisz, Donenberg et al., 1995). Of particular concern is that the effect sizes for these nine studies were low, suggesting a negligible impact of treatment. Effect sizes ranged
from -0.40 to 0.29, with an overall mean effect size of just 0.01 (Weisz, Donenberg et al., 1995). This mean effect sizes is well-below the 0.54-0.71 found in the four main child and adolescent psychotherapy meta-analyses, which were predominantly based on results of tightly controlled research trials in laboratory settings. A later meta analysis by Shadish et al. (1997) found more comparable effect sizes between research-trials and studies that were considered more clinically representative. However, they noted no studies were found that met the most stringent level of clinical representativeness (i.e., no truly 'real-world' treatment programmes).

A final shortfall in the research reviewed above is the absence of New Zealand studies. None of the research trials published used New Zealand adolescents; hence, questions arise over the applicability of the findings to this country.

The limitations to current research identified above have implications for the choice of research design for this study. This research is based on a New Zealand 'real-world' intervention, designed specifically for adolescents. As such the study has aimed to produce findings applicable to clinical practice within the New Zealand context.

2.2.5 Theoretical Approaches to Counselling

When researching treatment programmes such as ADC, it is important to describe the counselling approaches utilised. This allows for a better understanding of the processes which may account for the programmes outcomes. Therefore, this final section reviews some of the main categories of counselling approaches and their theoretical underpinning that are commonly used by adolescent treatment programmes and counselling in general, some of which have already featured in the treatment programmes described earlier.

In a recent count, over 550 different types of child and adolescent counselling psychotherapy have been identified (Kazdin, 2004). However, these different types can be grouped into three broad categories, based on the underlying theory of the counselling approach: psychodynamic, cognitive-behavioural and existential-humanistic or person-centred (Feltham, 2000; Hollanders & McLeod, 1999; Ivey, Ivey & Simek-Morgan, 1996). Others divide approaches more broadly into behavioural or non-behavioural, with cognitive-behavioural techniques being included within the behavioural category, and psychodynamic and person-centred (humanistic) included in the non-behavioural category (Casey & Berman, 1985; Weisz et al., 1987;
Weisz, Weiss et al., 1995). In addition to these broad categories, further approaches are introduced that have particular relevance to the ADC programme, these include postmodern approaches to counselling, Māori approaches, eclectic models, and the use of adventure and/or wilderness therapy.

**Broad Categories of Counselling Approaches**

Psychodynamic approaches to counselling are primarily associated with the founder of psychoanalytic theory Sigmund Freud. However, Ivey and colleagues (1996) suggest that current psychodynamic practice has been largely influenced by later derivatives of Freud’s theory, such as the work on attachment theory of John Bowlby and the researcher Mary Ainsworth. The related terms psychoanalytic, analytic, and dynamic share assumptions about the existence and power of an unconscious dimension of the mind, with its complex conflicts, symbolisms and defence mechanisms (Feltham, 2000). As mentioned in the introduction to this section, these approaches tend to be termed by some, but not all, as ‘psychotherapy’. Some of the key aspects of psychodynamic theory cited by Ivey et al. (1996) are as follows. The developmental history of a client, including events in their childhood, is considered important to the understanding of how an individual acts or behaves in the present. These developmental histories are influenced by key people (object-relations) with whom important relationships have been formed. Individuals are assumed to be unaware (unconscious) of how such histories (and, at times, other biological drives) are impelling and motivating them towards action. The aim of the psychodynamic counsellor is to help their clients to make sense of how their present actions relate to their past experiences. This can often entail a relatively long and intense process. Feltham (2000) listed four widely recognised psychodynamic approaches: Freudian, Jungian, Alderian and Kleinian. In a recent survey of 150 randomly selected child and adolescent therapists, it was found that 28 percent of therapists listed ‘psychodynamic’ first in their description of their practice with 62 percent endorsing at least some use of dynamic techniques (Weersing, Weisz & Donenberg, 2002). This is similar percentage to the 59 percent found in an earlier survey by Kazdin, Siegel et al. (1990).

The second category, cognitive-behavioural approaches to counselling, is the commonly used term to describe a combination of cognitive and behavioural approaches to therapy, often referred to as cognitive-behavioural therapy (CBT). Ivey
and colleagues (1996) report that these approaches originated from the early work of B.F. Skinner, who considered himself a pure behaviourist, believing cognition or the mind to be relatively unimportant. Skinner's behavioural theory was then extended by theorists such as Donald Miechenbaum, Albert Ellis, Aaron Beck and William Glasser who went on to demonstrate the importance of cognition as well as behaviour (Ivey et al., 1996). Some treatments could be described as purely cognitive or purely behavioural therapy, but this is now less common, with general recognition of certain mediating thought processes between behaviour and distress. In contrast to psychodynamic approaches, cognitive-behavioural techniques (and pure behavioural approaches) emphasise the elimination or reduction of distressing behaviour in the short-term, with less concern for their alleged underlying causes, or with global personality changes (Feltham, 2000). Broadly speaking, CBT counsellors assist clients to examine how they think about themselves and their world, and if necessary, to help them change these cognitions with the aim of affecting behaviour. The goal is to produce observable behaviour change in the short-term that can then be maintained. Feltham (2000) has listed the following as commonly used counselling approaches that would be included in this category: Rational Emotive Behaviour Therapy (REBT), Reality Therapy, Personal Construct Therapy and Multimodal Therapy. In the survey by Weersing et al. (2002) 10 percent of the sample of therapists identified their primary approach to counselling as cognitive and 14 percent as primarily behavioural. Nearly half of therapists indicated they used cognitive (43%) and behavioural (47%) techniques. Again, these are similar proportions to the earlier survey by Kazdin, Siegel et al. (1990) who found 49 percent of therapists surveyed endorsed cognitive approaches and 55 percent behavioural.

The third category Ivey et al. (1996) referred to is existential-humanistic approaches to counselling. The roots of the existential-humanistic tradition lie in European philosophy, but according to Ivey and colleagues, it was the work of Carl Rogers and his person-centred, non-directive counselling, which has been the most influential in popularising the existential-humanistic approach to counselling. A key aspect of the existential-humanistic tradition is the nature and meaning of the client and counselor relationship, with a focus on "people-in-relationship one to another" (Ivey et al., 1996). Central to existential-humanist approaches to counselling is a firm belief in 'self-actualisation'. Clients are seen as co-equal humans, responsible for determining their own destiny when sufficiently empowered. Counsellors listen
carefully to clients, aiming to enter their worldview, understand how they make sense of the world, and then to facilitate clients finding their own new directions and frames of thinking. The emphasis, therefore, is similar to CBT approaches, more on the present and the future rather than the past. Feltham (2000) included the following forms of therapy under the heading of humanistic approaches; Person-Centred Counselling, Gestalt Therapy and Transactional Analysis. In the survey conducted by Kazdin, Siegel et al. (1990) they found existential-humanistic approaches were rated by 14 percent of practitioners as being "useful most or all of the time", while person-centred approaches specifically were rated as such by nearly 20 percent.

Postmodern Counselling Approaches

The three categories of counselling presented above are described by Hansen (2002) as all being conceived within a modernistic epistemic framework (i.e., that phenomena have certain objective truths). For example, psychodynamic approaches believe in the objective existence of unconscious conflict in clients, cognitive approaches assume the existence of real cognitions, humanists of actual mental contents with which to emphasise and behaviourists with objective environmental contingencies (Hansen, 2002). However, many of the counselling approaches that are popular today, and indeed some of those mentioned above have since been influenced by postmodern epistemology.

Postmodernist epistemology rejects the modernist worldview and contends that reality is constructed by the observer (i.e., constructivism) or social group (i.e., social constructionism), (Hansen, 2002; Hoffman 1990). Approaches to counselling that subscribe to this constructivist or social constructionist theory of reality and knowledge are described in this thesis as postmodern, although are referred to by others as constructionist therapies (O’Connell, 2000; Clark, 1998) or constructivist psychotherapies (McAuliffe & Eriksen, 1999; Neimeyer, 1993). These counselling approaches are characterised by “the counsellor enculturating the client in a particular explanatory system that organises and gives new meaning to the presenting problems” (Hansen, 2002, p. 316). Counselling becomes a dialogue, where two parties (client and counsellor) construct the problem and the meaning (O’Connell, 2000). Approaches involve explanatory narratives about reality (or stories) rather than essential truths (McAuliffe & Eriksen, 1999), and therefore, the emphasis is on
persuasion rather than the identification of actual psychological phenomena (Hansen, 2002).

Postmodern counselling approaches are introduced here because the ADC programme incorporates several styles of counselling that would be best described as belonging to such a category. These include Narrative Therapy (Freedman & Combs, 1996; White & Epston, 1990) and Solution-Focused Brief Therapy (de Shazer, 1985).

Māori Approaches to Mental Health Counselling

The New Zealand context in which this research was conducted means that Māori perspectives on mental health and counselling are important considerations. Around a quarter of ADC participants are Māori, and Māori mental health has been identified by the Mental Health Commission as a priority area for New Zealand (MHC, 1998).

Also relevant is that the New Zealand Government is obligated under the Treaty of Waitangi to consult with Māori, and involve them, in the planning and provision of culturally appropriate services for Māori. Generally, the outcome of such consultation has been that Māori have voiced preference for access to, and choice of, both culturally appropriate services located within the mainstream mental health services, or separate kaupapa Māori services, delivered by iwi and/or other Maori providers (MHC, 1998).

The Māori approach to mental health is very much a holistic one: mental or psychological health is considered to be one part of four inter-related aspects of health and wellbeing. Known as “Te Whare Tapa Wha” model (Durie, 2001), the four elements are Te Taha Hinengaro (psychological health), Te Taha Wairua (spiritual health), Te Taha Tinana (physical health) and Te Taha Whānau (Family health). It is generally agreed that, for services to be effective for Māori, they should respect and address, in an integrated manner, all of these four dimensions (Durie, 2001).

Within this Māori model of health, poor mental health is often seen to be associated with an insecure identity as well as unsatisfactory relationships with others, be they individuals or institutions. Hence, a key aspect of mental health services is in understanding how healthy relationships can be achieved or restored. Further, there is concern to examine how Māori cultural identity, and the values, beliefs and behaviours which are part of that identity, may be supported and enhanced.
Identity is not viewed primarily as an inner experience or personal conviction, rather it is a construct derived from the nature of relationships with the external world (Durie, 2001). As such there are overlaps with the postmodern approach to counselling described above, which feature in the ADC programme.

Other characteristics of the ADC programme share some commonalities with aspects of the Māori Te Whare Tapa Wha model. These include working with families and other systems of influence, and the development of healthy relationships among group participants on the Journey. It would be interesting to consider the extent to which the ADC programme provides a culturally appropriate service to its Māori clients, although this question was beyond the scope of the current investigation.

Eclectic Counselling Models

The above categories encompass the main theoretical underpinnings behind the different counselling approaches, although perhaps the most common of all, is an eclectic mix of approaches. Lambert, Bergin and Garfield (2004) cited evidence of a continued growing trend towards eclectism, with one-half to two-thirds of practitioners indicating they use a variety of approaches arising from different theoretical backgrounds. In relation to child and adolescent mental health providers, Kazdin, Siegel et al. (1990) found that an eclectic approach to counselling was rated by (73%) of practitioners as useful most or all of the time, the highest rating of all listed approaches.

Hollanders and McLeod (1999) have commented on the difficulty in arriving at a precise operational definition of the concepts of eclecticism and integrationism. Lambert et al. (2004) suggested ‘eclecticism’ represents the use of procedures or techniques from different theoretical systems, whilst ‘integrationism’ represents the theoretical joining of two or more positions into a single, hybrid approach. This later definition has generated considerable debate over whether it is possible and appropriate to combine more than one theoretical approach to counselling and maintain a coherent and effective intervention.

Hollanders and McLeod (1999) introduced the notions of ‘broad-band’ and ‘narrow-band’ orientations to help clarify the use of the term eclectic. They used the term broad-band orientation to represent the underlying theory or metatheory behind a particular approach (e.g., psychodynamic, behavioural or humanistic). Hence a broad-
band eclectic approach would describe a practitioner who, despite having a preferred theoretical base, is prepared to reach across broad-band orientation boundaries in order to make use of concepts and methods of other metatheories. They suggested this is close to ‘integration’ which has been used to refer to the weaving together of a coherent ‘new’ theory out of strands of theory from a number of broad-band orientations. A narrow-band approach was described as a specific application of a broad-band metatheory, (e.g., Rogerian, Gestalt Therapy or Transactional Analysis falling within humanistic-existentialism). Hence, a narrow-band eclectic approach would be used to describe a therapist who remains within a single broad-band orientation but makes use of a variety of concepts and methods from within their preferred broad-band. Others have referred to this as ‘technical eclecticism’ or the integration of counselling techniques (McMahon, 2000). In the survey of over 300 British counsellors, Hollanders and McLeod (1999) found 42 percent explicitly identified themselves as broad-band eclectic, with a further 35 percent implying such practice.

**Adventure Therapy and Wilderness Therapy**

One final approach to counselling that requires mention, is ‘adventure and/or wilderness therapy’ (A/WT). This is a focal element of the ADC programme, and the inclusion of which has uniquely defined the programme. This approach to therapy has received little research attention from mainstream adolescent counselling/psychotherapy researchers. However, one early meta-analysis of adolescent drug prevention programmes found that ‘alternative’ programmes that included ‘physical adventure’ were effective for drug abusing adolescents (Tobler, 1986).

Despite this relative lack of research attention, adventure/wilderness therapy is becoming an increasingly popular form of treatment, especially for ‘youth at-risk’, including those with mental health concerns. This is particularly true in North America where a survey conducted in 1994 found over 250 therapeutic wilderness programmes were operating in the United States, of which 54 were classified as mental health programmes (Davis-Berman, Berman & Capone 1994). In 1998, another US survey identified up to 700 wilderness experience programmes (Friese, Hendee & Kinziger, 1998). There have been papers published showing the application of adventure/wilderness therapy to a variety of populations including; young offenders (Castellano & Soderstrom, 1992; Kelly & Baer, 1971) adolescents with
psychiatric difficulties/ behavioural disorders (Berman & Anton, 1988; Sachs & Miller, 1992) and substance use disorders (Kennedy & Minami, 1993; Gillis & Simpson, 1991) and families seeking counselling (Bandoroff & Scherer, 1994; Gillis & Gass, 1993).

Adventure and/or wilderness therapy has not been as well understood as other more traditional approaches to counselling/psychotherapy, and has suffered from unclear definitions. Many terms are used interchangeably within adventure or wilderness therapy such as ‘adventure-based counselling’, ‘therapeutic adventure’, and ‘action-orientated therapy’. In understanding adventure and wilderness therapy it is important to recognise the difference between the different modalities used in ‘adventure’ compared to ‘wilderness’ therapy, but perhaps even more important is to understand how these ‘therapy’ programmes are different to other ‘recreational’, ‘educational’, or ‘enrichment/development’ type adventure/wilderness programmes.

Friese et al. (1998) have offered the general term of ‘wilderness experience programmes’ to include a range of activities with varying objectives, but which all use the ‘wilderness’ modality:

... programs [conducted] in wilderness or comparable lands for purposes of personal growth, therapy, rehabilitation, education, or leadership/organisational development (p. 1).

Although Friese et al. (1998) referred specifically to wilderness settings, the same broad definition could be extended to ‘adventure’ type programmes also. This definition shows the range of objectives that various wilderness or adventure experience programmes may have (i.e., personal growth, therapy, rehabilitation, education, or leadership/organisation development), however, only those programmes with the primary purpose of ‘therapy’ should be considered ‘wilderness therapy’ or ‘adventure therapy’.

A more precise definition of adventure and wilderness therapy has recently been developed by the Australian/New Zealand Working Group for the Development of a Professional Association for Adventure and Wilderness Therapy Practitioners:

Adventure and wilderness therapy is the ethical application of explicit theories of human change using adventure and wilderness modalities by appropriately trained professionals in the service of clients with identified problems who seek specific therapeutic outcomes to alleviate distress and restore functioning. (Crisp, 2003b, p. 2).
This definition is an attempt to differentiate adventure and wilderness ‘therapy’ programmes from other forms of adventure/wilderness experience programmes such as those referred to above by Friese et al. (1998) or described by others as ‘enrichment’ or ‘recreation’ programmes (Crisp, 1996; Gass, 1993). Confusion has arisen as, unfortunately, many use the term ‘adventure therapy’ inappropriately as an umbrella term to describe the entire field of wilderness, outdoor and adventure experience programmes (Crisp, 1996). This has resulted in widespread misunderstanding outside (and within) the field. Grouping of adventure/wilderness ‘recreation’ and ‘enrichment’ programmes with ‘therapy’ programmes has resulted in the idea that adventure and/or wilderness ‘therapy’ consisted simply of the participation in adventure activities in outdoor or wilderness settings and that the recreational experience somehow ‘miraculously’ provides a therapeutic outcome. While the same outdoor activities may be used for all these programmes, the facilitation of these activities must be different in order to achieve the required objectives. As highlighted in the definition offered by Crisp (2003b), the specific and intentional objective of adventure/wilderness ‘therapy’ programmes are therapeutic outcomes, not simply recreation, personal growth, or enrichment outcomes.

The differentiation of ‘adventure therapy’ and ‘wilderness therapy’ is perhaps a simpler task. Crisp (1996) has provided a summary of characteristics which help to distinguish the two. Adventure therapy involves the use of contrived activities of an experiential, risk taking and challenging nature, in the treatment of a group or individual, but need not take place in a wilderness environment. The emphasis of adventure therapy is described as the selection and design of the activity to match targeted therapeutic issues. Crisp (1996) differentiated wilderness therapy by an emphasis on the impact of an isolated natural environment and the use of a living community or ‘therapeutic wilderness milieu’. Wilderness therapy is typically of longer duration and may include establishing a wilderness base camp, or involve an expedition moving from place to place in a self-sufficient manner (Crisp, 1996).

For the purpose of this thesis, an ‘adventure/wilderness experience programme’ (AWEP) is used as an umbrella term to describe all forms of adventure/wilderness programmes, recreation, enrichment and therapy programmes. The terms adventure therapy (AT) or wilderness therapy (WT) will be applied only to therapy programmes that fit with the Crisp (2003b) definition cited above.
Evidence supporting the potential effectiveness of adventure and wilderness therapy is beginning to emerge. It has been hampered until recently by misunderstandings in definitions, as discussed above, but also through a lack of well-controlled outcome research (Newes, 2001b; Gillis & Thomsen, 1996). Indeed an application of the American Psychological Association Task Force 12 criteria for empirically supported treatments to adventure therapy by Newes (2001a) found that AT/WT was severely lacking in empirical evidence needed for it to be identified as an EST. There have, however, been at least four meta-analyses on AWEPs in general (Cason & Gillis, 1994; Hans, 2000; Hattie, Marsh, Neill & Richards, 1997; Wilson & Lipsey, 2000).

In the first meta-analysis Cason and Gillis (1994) found an average effect size of 0.31 for 43 studies of outdoor adventure programming with adolescents. This represents a small to moderate effect size (Cohen, 1988), indicating 62 percent of adolescents who participated in adventure programming were better off than those who did not participate. Although not clearly defined in the study, it appears that outdoor adventure programming is equivalent to what this thesis has termed AWEP, of which only some would be classed as AT or WT. The wide variety of AWEPs included may explain the large range of effect sizes (-1.48 to 4.26). However, a comparison of different population groups, adjudicated youth, inpatients, emotionally or physically challenged, at-risk and ‘normal’ adolescents found no significant differences in effect sizes. Unfortunately the quality of the research design of the studies included was questionable. The authors acknowledged that 70 percent of studies included did not use random assignment or control groups. They also noted that many studies were hindered by small sample sizes. Further analysis found that effect sizes were related to the quality of the research design, with higher rigor associated with lower effect sizes.

These methodological limitations were also evident to a varying degree in a further two meta-analyses. A second meta-analysis by Hattie and colleagues (1997) looked at ‘adventure programmes’ for school age children. As with the previous meta-analysis such programmes are likely to have included a broad range of AWEPs, and interestingly revealed a wide range of effect sizes, with a similar average effect size (0.34) to that of Cason and Gillis (1994).

Hans (2000) limited her meta-analysis to the effect of adventure programming (AWEP) on the construct of ‘locus of control’. Analysis of 30 effect sizes revealed an
average of 0.38, with participants generally found to have achieved a modest shift towards internal locus of control. Interesting in this study was that programmes whose reported goal was primarily ‘therapeutic’ (as opposed to recreational, educational, developmental, or adjunct therapy) were found to achieve larger average effect sizes (0.64).

The final meta-analyses by Wilson and Lipsey (2000) was limited to the impact of wilderness challenge programmes on delinquent youth. This analysis only included studies that incorporated a control group, although they did not have to be randomly assigned. Analysis of 28 eligible research studies found the lowest effect size of the four meta-analyses of just 0.18. However, programmes that included explicit therapy components were found to have larger effect sizes, with short-term therapeutic programmes (up to six weeks) having an average effect size of 0.54, while longer-term programmes had a lower average effect size of 0.2. These data support the findings of Hans (2000).

Well-controlled research studies using random assignment specifically on AT or WT programmes for adolescent clinical populations are limited to just two examples (Sachs & Miller, 1992; Witman, 1987). Sachs and Miller (1992) found significant improvement in cooperative behaviour with behaviourally disturbed adolescents who participated in a wilderness camping experience programme. Witman (1987) also similarly found significant increases in cooperation and trust, following an adventure programme, in adolescents involved in psychiatric treatment. Although lacking the rigour of randomised control trial, significant improvements as a result of AT or WT programmes have been found in other adolescent clinical populations, including outpatient groups (Davis-Berman & Berman, 1989; Kingston, Poot & Thomas, 1997) and for the treatment of adolescent substance use disorders (Kennedy & Minami, 1993; Gillis & Simpson, 1991).

The lack of well controlled studies and confusion over definitions of AT and WT makes it hard to form conclusions on their effectiveness. Results from meta-analyses suggest small to modest effect-sizes are possible with AWEP. A meta-analysis on purely adventure/wilderness therapy programmes has not been conducted, although there is evidence to suggest those programmes with more of an intentional therapeutic component may have larger effect sizes. Clearly more research is required on AT and WT interventions incorporating more rigorous designs before any definitive conclusions can be made.
2.2.6 Summary

In summary, the research findings from the broad-based meta-analyses conclusively demonstrate that counselling and psychotherapy can produce substantial benefits for adolescents with mental health concerns. Using the most conservative research finding, the average youth receiving psychotherapy is still likely to fare better than 70 percent of a comparison group who did not receive psychotherapy. Therefore, a realistic expectation would be for the majority of ADC clients to benefit significantly in terms of improved mental health, as a result of participation on the ADC programme.

The search for empirically supported treatments has progressed towards identifying which treatments work best for which problem areas. Regardless of type of problem or diagnosis, all empirically supported treatments identified could be categorised as using either behavioural or cognitive-behavioural treatment (CBT) approaches. Despite similarities in theoretical approaches found to be effective, it was also evident that different problem areas respond differently to different types of treatment. In general, treatments for externalising disorders appeared to benefit more from working with wider systems of influence than did internalising disorders. For example, the use of family therapy was found to be helpful in the treatment of substance use disorders but not in the treatment of depression. Parent training also had mixed results dependent on problem areas. The treatment of anxiety was effective with pure behavioural strategies, whilst ADHD appeared still to require inclusion of psychostimulant medication.

Several limitations were identified in the child and adolescent treatment outcome research. More research is needed that has a developmental focus, that tests the ‘effectiveness’ of treatments, and tests treatments that are favoured among child and adolescent mental health practitioners. Clearly research conducted in clinical practise settings on clinically referred samples is a priority. There is also a conspicuous lack of research on programmes involving New Zealand adolescents.

The final sub-section reviewed the major approaches to counselling including a relatively new approach known as adventure or wilderness therapy. This review is relevant to subsequent sections which identify and discuss the elements and processes of the ADC programme designed to effect change.
2.3 Factors Affecting Treatment Outcome

In the field of adolescent counselling and psychotherapy research, several authors have suggested that much more attention is needed towards understanding how treatments achieve therapeutic change (Kazdin, 2004; Shirk & Russell, 1998; Weersing & Weisz, 2002). These authors have pointed out that there has been a conspicuous neglect of theory development and testing in the adolescent treatment literature. As a result we really do not understand very much about adolescent therapy, why and how it achieves change, and for whom it is and is not effective. Not knowing the critical factors of therapy means we probably do not optimize those components that will effect change (Kazdin, 2004). Therefore, one objective of this research is to gain a better understanding of the therapeutic change processes involved in participation on an ADC programme. This objective is pursued through two different approaches, a quantitative investigation of factors that predict successful treatment outcomes of the ADC programme, and a qualitative enquiry exploring the perspectives of the ADC clients themselves, as to what they viewed as important in assisting them to make changes in their lives.

This section of the literature review presents the findings of studies which investigated factors associated with successful treatment outcomes of other adolescent counselling programmes. Theories put forward by researchers to explain how therapeutic change occurs are also discussed. Factors identified in these studies will be considered when conditions that affect the outcomes of the ADC programme are explored. This section of the literature review also provides information and theories to aid in the interpretation of the youths’ perspectives on how therapeutic changes were achieved.

Before presenting this research, a couple of methodological issues require clarification. The majority of studies to be reviewed use research designs that assess the degree of ‘association’ between treatment outcome and the variables being investigated. These studies are termed ‘descriptive’, and have the goal of identifying the ‘moderators’ of treatment, i.e., the conditions on which the effects of treatment depend (Kazdin, 2004). They do not set out to reach conclusions on the ‘mechanisms’ of change. For example, a descriptive study may reveal that gender is a moderator of treatment outcome, but this finding does not explain what it is about gender that influences response to treatment. Research that seeks to understand how or why the moderator works is described as ‘explanatory’ (Kazdin, 2001). In ‘explanatory’
research at least three steps are required: (1) specification of the processes or factors presumed responsible for change, (2) developing measures of these processes, and (3) demonstrating that these processes change in advance of therapeutic outcomes (Kazdin, 2001). Unfortunately, an extensive review of youth treatment outcome literature (Weersing & Weisz, 2002) found only six studies out of 67 that explicitly tested mechanisms of action underlying therapy effects, all of which displayed significant methodological limitations. Therefore, this section of the review is based predominantly on descriptive research which attempts to identify the conditions upon which effective application of treatment depends. Authors may offer hypotheses on ‘why’ or ‘how’ the moderators affect treatment outcome but in most cases these remain untested theories.

The review is organised according to three types of moderators of treatment: factors related to the clients themselves (individual and contextual), those related to the counsellors, and factors related to the characteristics of the different programmes. As will become evident, there is considerable overlap in categories relating to the individual moderating factors. For example, the moderating factor of the client-counsellor relationship may be influenced by clients’ receptiveness and motivation for counselling, the counsellor’s style of engagement or experience, or by the programme treatment model (e.g., client-centred vs. CBT). However, this framework provides a useful starting point for discussion of the processes and condition that affect outcomes.

2.3.1 Client Factors

A commonly asked question of researchers and programme providers is “With whom does this programme work best?”. Several studies have attempted to identify the client characteristics that best predict successful treatment outcomes. Characteristics studied include demographic features such as age, gender and ethnicity; contextual factors related to client’s social networks and family characteristics; nature of client’s mental health concern (type and severity); and individual motivation to participate in the counselling process.
Demographics

Age

The ADC programme receives referrals of youth whose ages range from 12-18 years. This is a wide age range covering mid- to late-adolescence. Considering this breadth of age range, an interesting question arises as to whether the programme is equally effective for all ages. Some studies have revealed mixed results in regards to the effect of age on treatment outcome. For example, results from the meta-analyses of child and adolescent counselling and psychotherapy by Casey and Berman (1985) found no significant relationship between age and therapeutic outcome. However, Weisz et al. (1987) found a significant negative relationship, suggesting older youth (13-18 years old) showed less positive changes in therapy than younger (4-12 years) participants. This in turn has been challenged by the most recent meta-analysis: Weisz, Weiss et al. (1995) found treatment outcomes were better for adolescents than for children (although this effect became non-significant when therapist training was controlled for). Weisz, Weiss et al. (1995) also noted a significant interaction between age and year of publication, with more recent studies showing larger effect sizes for adolescents. The authors suggested that changes in age effect from earlier to later meta-analyses may reflect on-going improvements in the efficacy of treatments for adolescents.

The mixed results may also be explained by other hypotheses. Weisz, Weiss et al. (1995) suggested that developmental differences in cognitive and social capacities and in developmental differences in conformity to social norms and responses to adult authority mean that, as children grow older, they are less inclined to cooperate with adult therapists, and less likely to adjust their behaviour to societal norms. This may relate to Brestan and Eyberg’s (1998) observation that interventions that involved behavioural parental training were more likely to be effective with younger children rather than adolescents. However, Weisz, Weiss et al. (1995) noted that cognitive changes such as the development of abstract thinking that accompany maturation might also mean that, in contrast to children, adolescents better understand the purpose of therapy and are better suited to the verbal give and take that accompanies many forms of therapy.

This latter explanation is supported in part by a meta-analysis conducted by Durlak and colleagues (1991). CBT interventions focus on cognitive processes and behaviour and, therefore, might be expected to be influenced by age and cognitive
development. Durlak et al. (1991) reviewed only studies that used a CBT approach to

counselling and found that treatment outcome was moderated by age. Young
adolescents (11-13 years) had an average effect size of 0.92, while children aged 5-10
year had a lower average effect size of just 0.55. The authors concluded CBT was
more effective for children in the ‘formal operations’ stage of cognitive development
than for children in the ‘pre-operational’ and ‘concrete operation’ stages. However,
when they tested the association between change in cognitive processes and behaviour
improvement, no significant relationship was found. Hence, the underlying
mechanism of change in CBT remained unclear.

The importance of taking a developmental perspective in the treatment of
adolescent mental health concerns is emphasised by several authors (Holmbeck &
Kendall, 2002; Steinberg, 2002). They note that those developing treatments for
adolescents have been slow to incorporate developmental principles into treatment
approaches, with most treatments for adolescents having originally been developed
for either children or adults and then adapted for adolescents. Steinberg (2002)
suggested that part of the reason for the lack of developmentally sensitive treatments
for adolescence is the absence of a developmentally appropriate taxonomy of
disorder. The current systems for categorisation and definitions of disorders that
treatment developers consult have typically also been developed from clinical
observations of adults and children, and then applied to adolescents.

A final note with regards to the effect of age as a moderator is offered by
Phillips et al. (2000). They reviewed 34 studies that looked at factors that predicted
outcomes, and noted an age-by-diagnosis interaction. Four studies predicted poorer
outcomes for older adolescents with depression, while three studies found better
outcomes with older adolescents with substance abuse disorders. Hence, problem type
and treatment model may influence the effect of a treatment on different age groups.

Gender

Another demographic characteristic normally considered along with age is
gender. Casey and Berman (1985) found a significant gender relationship (p<0.05)
whereby programmes involving predominantly female participants had better
outcomes than those involving mostly boys. A similar trend was found by Weisz et al.
(1987), but the difference was not significant. Weisz, Weiss et al. (1995) found
therapy had more beneficial effects in samples with female majorities (mean
ES = 0.71) compared to male majorities (mean ES = 0.43). However, this gender effect was highly significant amongst adolescents, but not significant among children. These authors cited arguments that adolescent girls are particularly sophisticated in the use of interpersonal relationships for self-discovery and change, and that these skills may facilitate use of the therapeutic relationship to achieve treatment gains. They also noted that therapists were more likely to be female.

The qualitative review by Phillips et al. (2000) similarly found mixed results. While the majority of the 34 studies reviewed found no reliable differences, there were two studies that found female clients were less likely to be incarcerated or have school problems at follow-up assessments. On the other hand a further three studies suggested that, for depressed adolescents, being female predicted a poorer clinical outcome.

**Ethnicity**

Many reviewers of adolescent treatment outcome studies have raised the importance of considering cultural factors (Carr, 2000; Kazdin, 2004). Despite this fact, ethnicity as a demographic variable has received the least amount of research attention. It is of course highly relevant to the ADC programme, which has participants from a number of ethnic groups, including those identifying themselves as New Zealand European, Māori, and from various Pacific Island states. Further, in New Zealand provision of effective mental health services for Māori and Pacific youth are a government priority area (Ministry of Health, 2000). Unfortunately, no research could be found that examined the impact of culture or ethnicity on outcomes achieved by youth mental health service providers in New Zealand. Internationally, a North American study by Tharp (1991) reviewed aspects of cultural diversity and the treatment of children. Tharp noted a similar contradiction to that noted above, that despite associations such as the American Psychological Association providing guidelines that psychologists should recognise ethnicity and culture as significant parameters in understanding psychological processes, research addressing such issues with children and adolescents was scant. In his review Tharp cited evidence of cultural differences in response to treatment such as different drop-out rates, and varying responses to particular treatment models. For example, it was found that Hong Kong Chinese parents were reluctant to engage in parent behaviour training because course content was regarded as inconsistent with their customary child-
rearing values and practices. Tharp concluded that consideration of cultural differences in the treatment of children is highly desirable. However, he qualified this enthusiasm with the comment that although there are differences among cultures, there are also important differences between members of a single culture. Hence, while it is important to accommodate issues that arise due to cultural difference, variability within cultures must not also be overlooked.

Nature of the Mental Health Concern

A further client factor of relevance is the nature and severity of mental health concern with which young clients present. This factor is also relevant to the ADC programme, where clients may present with a range of mental health concerns, and often with more than one area of concern. Therefore, it would be of interest to understand whether the ADC programme is more effective with certain types of problems, or specific combinations of problems, and different levels of problem severity.

In terms of the type of mental health concern (or what is typically referred to in the literature as 'problem behaviour'), researchers tend to divide these up into the broad categories of 'internalising' or 'externalising' problems or, as some have termed, 'over-controlled' and 'under-controlled' to describe the same categories (Weisz et al., 1987; Weisz, Weiss et al., 1995). These broad categories were used in two meta-analyses to investigate if type of problem was a moderator of treatment outcome. As it turned out, no reliable differences were found (Weisz et al., 1987; Weisz, Weiss et al., 1995). This finding was supported by a recent review by Kazdin (2004), who concluded treatment is equally effective for externalising and internalising problems. However, the earlier meta-analyses (Casey & Berman, 1985) using narrower categories found a lower mean effect size for social adjustment problems than for phobias, somatic problems, or self-control problems. A review by Phillips et al. (2000) also found outcome could be predicted by diagnosis. He reported that diagnoses of conduct disorder or substance abuse (externalising problems) predicted poorer outcomes than affective (internalising), though the former responded better to treatment than did attention deficit, or oppositional defiant disorder (both externalising problems). Phillips et al. (2000) found that those with psychotic symptoms had very poor outcomes. These latter findings, suggesting grouping
diagnosis into broad categories such as externalising or internalising problems, may be masking differential effects.

Fonagy and Target (1994) noted a three-way interactional effect between diagnoses, age and treatment outcome. Younger children with externalising disorders had better treatment outcomes than did older children and adolescents (over 9 years of age). However, no such age related difference was found in youth with internalising disorders.

When comorbidity of different mental health concerns is considered the patterns becomes even more complex. Phillips et al. (2000) reported mixed results, with around half the studies reviewed showing that comorbidity didn’t relate to treatment outcome. The remaining studies suggested comorbidity resulted in poorer outcomes, especially for depressed youth with comorbid anxiety, substance abuse, conduct disorder or obsessive compulsive disorder. However, others have noted an apparent ‘buffer’ effect of comorbid anxiety in disruptive youth (Fonagy & Target, 1994) and substance abusing youth (Randall, Henggeler, Pickrel & Brondino, 1999), with the presence of comorbid anxiety predicting better outcomes. Pelkonen and colleagues found that having a mood disorder was also associated with treatment completion for adolescents attending an outpatient psychiatric intervention (Pelkonen, Marttunen, Laippala & Lonnqvist, 2000).

The severity of the problem behaviour or level of global impairment at intake is another aspect of mental health concern that has also been the subject of research. Phillips et al.’s (2000) review found that severe symptoms and functional impairment at baseline were commonly associated with poorer treatment outcomes in studies of adolescents being treated for depression, substance abuse, and behaviour disorders. Early termination from treatment has also been found to be associated with higher levels of problem severity (Kazdin & Mazurick, 1994; Kazdin, Holland & Crowley, 1997). However, this review did find one early study (Friedman & Glickman, 1987) which reported “unexpected” findings, namely that adolescent substance abusers with more reported psychiatric symptoms improved to a greater extent than those who reported fewer. It was pointed out, however, that this sample of court-referred youth reported relatively lower levels of psychiatric symptoms compared to a sample of drug-abusing high school students. The authors explained these findings by suggesting that clients who were more self-evaluative and more open and self-revealing about their disturbing inner thoughts and feelings (reporting greater
severity) might have been more trusting, more ready and better motivated for counselling.

**Previous Counselling**

Another aspect of problem behaviour investigated in relation to treatment outcomes is whether clients had received previous treatment. Phillips et al. (2000) identified three studies that looked at previous treatment and subsequent outcomes for adolescents. All three studies found that clients who had received previous treatment were predicted to have comparatively poorer outcomes in the current treatment programme. Heijmens-Visser, Van Der Ende, Koot and Verhulst, (2003) suggested that previous treatment was an artefact of problem severity, with those youth receiving treatment on multiple previous occasions more likely to have the most severe and chronic problems, which explained the poorer outcomes.

**Motivation**

Motivation to change, sometimes referred to as ‘therapeutic readiness’, is frequently commented on as an important variable influencing treatment outcome (Carr, 2000; Kazdin, 2004; Miller & Rollick, 1991). Children and adolescents are often initially referred by others, which indicates that this variable may have special significance in relation to progress made through counselling interventions (DiGiuseppe, Linscott & Jilton, 1996; Shirk & Russell, 1998). It is certainly accepted by practitioners as an important variable. A survey of over 1000 child and adolescent mental health service providers found that, along with relationship factors, parental cooperation and problem behaviour characteristics, motivation for change was rated by the clinicians as one of the most influential factors on treatment outcome (Kazdin, Siegel et al., 1990).

Research specifically on motivation to change in youth appears largely limited to the field of substance abuse. Motivation to change is the central tenet of Prochaska and DiClemente’s (1982) ‘Transtheoretical Model of Change’. This model was originally developed to explain how people change addictive behaviours such as smoking. It was later adapted as a treatment approach for substance abuse, which is referred to as ‘motivational interviewing’ (Miller & Rollnick, 1991). The model has emerged as a promising approach to treating substance abuse in adults and youth (Borsari & Carey, 2000; Miller & Rollnick, 1991). Cady, Winters, Jordan, Solberg
and Stinchfield (1996) used the transtheoretical model to develop a measure of motivation to change in adolescent substance abusers. They found that higher levels of reported motivation or readiness predicted post-treatment variables including drug use and abstinence. Freidman, Granick, and Kreisher (1994) also found a moderate association between stated degree of importance of getting help and counselling for drug and alcohol problems, and reduction of such problems at follow-up.

Based on clinical experience, the view of many practitioners is that these findings transfer well to other mental health concerns (Kazdin, Siegel et al., 1990). Indeed, a review by Prochaska, DiClemente and Norcross (1992) noted that measures of readiness, and the processes of change used by clients, out-performed variables such as client demographics and problem characteristics (history and severity) in predicting outcome and treatment completion for a range of health behaviours.

This is obviously an area where more research is required; perhaps an area worthy of specific attention is how motivation for change in a young person can be enhanced.

**Contextual Factors**

Contextual factors are those indirectly related to the client, including characteristics of the family such as socio-economic status, involvement with other support services, and nature of peer associations. Such factors have been suggested as influencing treatment outcomes in adolescent counselling programmes (Carr, 2000; Kazdin, 2004). In New Zealand, onset of mental health disorders has been found to be related to a number of adverse social and family factors that include impaired parenting, family dysfunction, exposure to child abuse, social disadvantage, school difficulties, negative peer influences and prior history of psychiatric disorder (Horwood & Fergusson, 1998). The strongest predictors found have been factors in the individuals’ immediate social environment (family, school and peers) rather than broad social and economic factors (Horwood Fergusson, 1998). Therefore, it follows that such factors that predict onset may also contribute to maintenance of the problem behaviour, and may also be obstacles to the successful delivery of treatment (Kazdin, 2004).

The review by Phillips et al. (2000) examined whether family characteristics predicted outcomes. Of the studies that considered these characteristics, poorer outcomes were commonly predicted by family characteristics, whether it was family
dysfunction or problems with parental psychological and social functioning. The exception to these findings was family structure (number of parents and/or relationship to youth) and poverty, where no significant associations were found on outcomes. A couple of individual studies compared the contribution of family factors relative to other factors, and family characteristics were found to be the most powerful predictors of outcome. For example, parental cooperation was found to be the most powerful predictor in a multi-modal day treatment for children with severe behaviour problems when compared to other client characteristics such as the nature of the problem behaviour (Grizenko, 1997). Similarly, out of 39 predictor variables assessed, client or parent reports of family functioning were found to be the best predictors of outcome in an adolescent outpatient treatment programme (Friedman, Terras & Kreisher, 1995). Poor family functioning, history of parental psychopathology and socioeconomic disadvantage have also been found to be significantly associated with early dropout from treatment (Kazdin & Mazurick, 1994; Kazdin et al., 1997; Pelkonen et al., 2000).

As was mentioned earlier, few ‘explanatory’ studies have tested variables to see if they are actual mediators of treatment, i.e., explained how therapeutic change occurred. However, three studies that did attempt to test mediators examined family and contextual characteristics. Improving family functions and reduction of negative peer associations are two of the goals of MST. Hence, Huey and colleagues examined whether family functioning and associations with delinquent peers mediated effects of MST (Huey, Henggeler, Brondino & Pickrel, 2000). They showed that therapists who adhered to the MST protocol achieved improvements in family relations (family cohesion, family functioning and parental monitoring) and decreased delinquent peer affiliations. Further analysis suggested these improvements appeared to mediate reductions in delinquent behaviour, and are important factors to consider in the treatment of adolescent externalising behaviour. Similarly, Eddy and Chamberlain (2000) found family management skills and deviant peer associations were mediators of the effect of multidimensional treatment fostercare, accounting for 32 percent of the variance in subsequent antisocial behaviour. On the other hand, a study by Kolko and colleagues which examined whether family function mediated the effects of cognitive and family therapies on adolescent depression, concluded that, for these forms of therapy, family dysfunction was not a moderator or mediator of outcomes for the depressed youth (Kolko, Brent, Baugher, Bridge & Birmaher, 2000).
ADC counsellors engage youth in individual and group counselling, but family therapy and general involvement is also a significant component of the ADC programme. Therefore, family factors and other contextual factors may well moderate outcomes.

2.3.2 Counsellor Factors

A comprehensive review on the effect of counsellor/therapist\(^1\) variables on outcomes of adult counselling and psychotherapy has been conducted by Beutler et al. (2004). These authors examined many observable qualities such as therapist demographics, interpersonal psychotherapy style, techniques used, and professional discipline and experience. They also looked at therapist values, attitudes and beliefs, together with inferred traits such as personality, emotional well-being and inferred states such as the therapeutic relationship. They found varying degrees of association between these therapist variables and outcomes, from no relationship to moderately strong effects. Among the more significant predictors were therapist well-being and cultural attitudes and the quality of the therapist-client relationship. They concluded that more attention needs to be given to the interactive effects of other moderators such as therapy approach and client characteristics relative to therapist factors.

The overall impact of counsellor/therapist factors on outcomes with adult clients has also been examined by Crits-Christoph and Mintz (1991). Using meta-analysis procedures, they reviewed 10 studies that researched the effect of therapist characteristics on treatment outcomes. They found an overall average ‘therapist effect’ which accounted for between 0-13.5 percent of outcome variation, and when individual measures of outcome were considered, this rose to 39 percent in one study. Such results suggest that therapist factors in some cases may be contributing significantly to outcomes achieved.

In terms of the adolescent age group and the effect of therapist variables, much less research has been conducted, and the transference of findings from adult studies

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\(^1\) Early in the literature review (section 2.2.1) there was a discussion about the terms ‘counselling’ and ‘psychotherapy’. It was noted that term ‘counselling’ was more appropriate for this research but because most research used the term ‘psychotherapy’, it was decided that the two terms could be used interchangeably. The same discussion is relevant here in relation to the terms ‘counsellor’ and ‘therapist’. Although it is recognised that the term counsellor is more appropriate in relation to New Zealand and the ADC programme, for the purpose of this research, the two terms are assumed to have the same meaning and will also be used interchangeably.
cannot be assumed. This section will be limited to those therapist variables that have been considered in the child and adolescent counselling and psychotherapy research.

**Level of Counsellor Training**

Some attention has been directed at whether level of therapist training or experience affects outcomes. In adolescent treatment outcome research, results have been mixed. The first meta-analysis by Casey and Berman (1985) found no significant relationship between therapist experience, education, or sex of therapist, and treatment outcome. Weisz et al. (1987) also found no reliable relationship between level of training and outcome. However, when Weisz, Weiss et al. (1995) investigated whether fully trained clinicians produced the most beneficial therapy effects, they found that paraprofessionals (typically parents or teachers trained in a specific intervention) generated larger treatment effects than either student therapists or fully trained professionals. They also noted no reliable differences were found between student and fully qualified professionals. Their conclusion, however, was not to question the value of professional training; rather they pointed to a study limitation, that the beneficial effects produced by paraprofessionals and students in these studies followed training and supervision provided by professionals who had in most cases designed the treatment procedures.

As further support that training and experience were important, they noted a training-by-problem type interaction consistent with a finding by Weisz et al. (1987). Both studies found that less experienced therapists had poorer outcomes with internalising problems, whilst more experienced therapists were equally effective with internalising and externalising problems. They hypothesised that the interventions needed for the more subtle and less overt problems tend to fall within the internalising category, and do indeed require substantial professional training. Weisz et al. (1987) also noted that trained professionals were equally effective with all ages, but graduate students and paraprofessionals were less effective with older clients. This suggests that, possibly because of developmental issues, adolescents are more difficult than children to treat successfully, but formal training may provide professionals with sufficient therapeutic skills to deal with such age-related differences.
**Therapeutic Relationship**

One process factor that has received comparatively more attention in child and adolescent counselling research is the effect of the therapeutic relationship. Beutler et al. (2004) noted the reciprocal influences between client and therapist characteristics in the development of a therapeutic relationship; this thesis, however, has opted (like others) to review this issue under therapist factors. Shirk and Karver (2003) conducted a meta-analysis on the prediction of treatment outcome from client-therapist relationship variables in child and adolescent therapy. They pointed out that, from a developmental perspective, the therapeutic relationship may be more critical in child and adolescent therapy than in adult therapy. They point out that children and adolescents often fail to recognise the need for therapy, are less likely to refer themselves for treatment, and that as a result formation of a therapeutic alliance can be a formidable challenge. They also noted that during adolescence there is a trend towards increasing autonomy from adults, and thus potential for increased resistance to forming alliances with adult therapists.

The meta-analysis of 23 studies researching a variety of child and adolescent approaches to counselling found a moderate but consistent relationship between therapeutic relationship and outcome. The average effect size found ranged from $r=0.20$ to $r=0.26$ depending on different analyses; these effect sizes are very similar to that found in adult meta-analyses of $r=0.22$ (Beutler et al., 2004; Martin, Garske & Davis, 2000). Individual studies have also found that client-therapist relationship problems are significantly predictive of early dropout from psychotherapy (Garcia & Weisz, 2002) and have been found to be perceived as a barrier to treatment completion (Kazdin & Wassel, 1999; Kazdin et al., 1997). Hence, it appears that client-counsellor relationship may be an important moderator of outcome.

Shirk and Karver (2003) investigated factors that impacted on the association between therapeutic relationship and treatment outcome. They noted that client age, model of therapy, use of treatment manual and context of therapy (research versus clinical setting) were not found to reliably moderate the association. However, they did find that youth with externalising problems had a stronger association between relationship and outcome than those with internalising problems ($p<0.05$). DiGiuseppe et al. (1995) have hypothesised that youth with internalising problems may form a therapeutic relationship more readily due to motivation to reduce internal discomfort. Problem characteristics have also been found to be associated with
alliance formation (Eltz, Shirk & Sarlin, 1995). Eltz and colleagues found that severity of interpersonal problems in maltreated adolescents was the best predictor of alliance development, but that those adolescence who failed to form positive alliances with their therapist had the poorest outcomes. They suggested that reluctance to trust others, coupled with hostility, may explain the maltreated adolescents’ initial difficulties in forming alliances. However, they also noted that adolescents who showed more positive change in alliance quality, regardless of maltreatment status, evidenced greater treatment gains across sources of outcome ratings. This suggests that changes in pattern of alliance may be a better predictor of outcome than ‘one-shot’ assessments of relationship quality.

Although the effect size of the association between client-therapist relationship and outcomes is a moderately strong one, the causal role of relationship is still unproven. Shirk and Karver (2003) found that measures of the relationship obtained late in therapy were more strongly associated with outcomes than measures taken early in therapy. Their suggestion that relationship formation may evolve more slowly with children than adults, however, also raises the question of the predictive association of relationship and outcomes, and whether treatment progress might be the mediating factor explaining the association, i.e., good treatment progress results in a more positive alliance.

It is hard to assess how relationship factors compare to other process variables due to the lack of research that directly compare relationship variables to others in predictive power. However, in one of the few studies that considered the perspective of the young clients themselves, the therapeutic relationship during a CBT intervention for anxiety was viewed to be one of the more salient treatment components (Kendall & South-Gerow, 1996).

Other Therapist Factors

Therapist experience and therapeutic relationship are factors that have received the most attention. However, there are a few individual studies that have evaluated other therapist factors. Fonagy and Target (1994) included the continuity of counsellor (i.e., no change in therapist) amongst a set of predictors called ‘treatment characteristics’, and found ‘no change in therapist’ performed best in predicting improvement in emotional disturbed adolescents, accounting for 20 percent of the variance. However, for youth with disruptive disorders, this set of predictors was less
important (accounting for 14% of the variance in outcome). This points again to an interaction between problem type and other process variables such as having stability in the therapist working with the youth.

An earlier study by Friedman and Glickman (1986) included certain therapist factors in their investigation of factors that predicted successful treatment of adolescent drug abuse. This was a large study investigating characteristics of 74 adolescent drug programmes using a variety of approaches to counselling. Therapist use of techniques and interpersonal style was one factor considered. Friedman and Glickman (1986) noted an ‘unexpected’ trend toward a positive significant association between the uses of confrontation in group counselling/therapy and treatment outcome. This was supported in an early study by Truax and Wittmer (1973). That study also looked at therapist use of confrontation in the treatment of adolescent delinquents, and found across several measures of outcome that confrontation of what the authors termed ‘defence mechanisms’ was significantly associated with treatment progress (cited in Shirk & Russell, 1998).

Another factor found by Friedman and Glickman (1986) that trended towards a significant positive relationship with treatment outcome was when the client perceived that the therapist encouraged ‘spontaneous actions and free expression’, which the authors suggested created a positive emotional response in clients, and enhanced motivation to reduce drug use. This therapist technique is related to the counselling approach, being more typical of ‘insight’ and non-directive styles of therapy which encourage spontaneous verbal interaction (Russell, Greenwalk, & Shirk, 1991). These authors found favourable results in children who received therapy that encouraged spontaneous verbal interaction, compared to therapies the authors described as constrained by goal-orientated formats or those emphasising behavioural exchanges (characteristics of behavioural and CBT approaches).

Finally, Feehan et al. (1993) and Fergusson et al. (1994) highlighted the importance of therapists taking a macrosociological perspective. They have made the point that the childhoods of many multiple-problem teenagers are marked by a long-standing history of disadvantage, family dysfunction and impaired socialisation which act cumulatively to influence problems of adjustment in adolescence. Given this history and duration, they have suggested it is perhaps not surprising to find the short term attempts at behavioural intervention are of limited success in modifying behavioural patterns that have developed over a lengthy period during the course of
an unsatisfactory and inadequate childhood. Hence, they recommended that mental health professionals consider the wider socio-political factors and expand their role to influencing social policy, as well as being concerned with effectiveness in the here-and-now.

Research on therapist factors that influence outcomes in adolescent counselling is clearly lagging behind the research field on adults. There are many other therapist factors that still need to be researched. For example, Carr (2000) has suggested that, along with therapist skills (alliance and technical skills), other factors should be considered including frequency and quality of supervision, quality of interagency collaboration, and cooperation with the referral system and other team members.

2.3.3 Treatment/Programme Factors

Understanding the mechanisms of therapeutic change, whether they are specific to a treatment approach or common to many approaches, may also prove helpful in explaining how the ADC programme affects change in its clients. Therefore, this last section reviews research on treatment characteristics and their relationship to treatment outcome.

Research that has attempted to identify how counselling programmes work has tended to investigate two competing hypotheses. One hypothesis is that processes 'specific' to different treatment models account for change, while the other hypothesis attends to processes 'common' across treatments. The majority of researchers interested in the first hypothesis compare the efficacy of different theoretical approaches to counselling; that is they have investigated whether a specific treatment model (behavioural or non-behavioural) is the 'moderator' of treatment outcome. More recently designs have become more sophisticated, with the aim of identifying and testing treatment processes or mechanisms that are specific to a particular treatment (Weersing & Weisz, 2002). The opposing hypothesis is that treatment specificity is unimportant and that positive outcomes are achieved through a common set of factors or mechanisms of therapeutic change that operate across the range of different available treatments (Wampold, 2001).
Factors Related to Therapy Approach

Within the adult therapy outcome literature, much attention has been given to comparing different schools of therapy, usually with psychodynamic or humanistic ('verbal' or 'insight') therapies being compared to behavioural or cognitive ('action') therapies (Lambert & Ogles, 2004). The conclusion reached by Smith, Glass and Miller (1980) in their landmark meta-analysis was that "all psychotherapies are equally effective, or nearly so" (cited in Weisz, Weiss et al., 1995, p. 450). This conclusion, was dubbed "the Dodo verdict" (originating from the Dodo bird's conclusion at the end of the race in Alice in Wonderland: "everybody has won, and all must have prizes," Wampold, 2001, p. 22). In their summary of the evidence in relation to adult psychotherapy, Lambert and Ogles (2004) reported the conclusion that most, but not all, supported Smith et al. (1980): that there are little or no differences. Where differences emerged, they tended to show small but consistent advantages for cognitive and behavioural methods over traditional verbal and relationship-oriented therapies. Lambert and Ogles (2004) pointed out, however, that such differences could often be explained in terms of methodological differences. One of the more recent meta-analysis comparing treatments (Wampold et al. 1997) included only studies that directly compared two or more treatments, attempting to eliminate some of the earlier methodological problems. No differential effects were found that would suggest the superiority of any of the bona fide psychotherapies. If this is the case, these findings not only argue against the idea of treatment specificity, but also against the current trend of identifying empirically supported therapies that purport to be uniquely effective. However, these results have been based on predominantly adult samples; child and adolescent research is not quite so conclusive.

Within the child and adolescent psychotherapy field the evidence has been inconsistent, but tending to favour behavioural approaches. Casey and Berman (1985) initially found that behavioural approaches yielded significantly larger effect sizes than non-behavioural approaches (0.91 vs 0.40). However, when they excluded cases in which outcome measures were very similar to the treatment procedures, the superiority of behavioural approaches was reduced to a statistically marginal level. Weisz et al. (1987) found behavioural therapies produced significantly more positive outcomes than non-behavioural, even after eliminating studies whose outcome assessments were measures that were “unnecessarily” similar to treatment activities, a previously identified confound. Weisz, Weiss, et al. (1995) also found behavioural
approaches were associated with larger therapy effects (ES=0.54) than non-behavioural (ES=0.30), and that this pattern held up when they controlled for outcome measures that were similar to treatment procedures.

There is, therefore, some evidence against the 'Dodo verdict' for child and adolescent psychotherapies. However, it should be noted that only 10 percent of treatment groups in Weisz, Weiss et al.'s (1995) analyses used non-behavioural interventions, and therapist allegiance was not controlled for. Further, Ammerman and Hersen (1997) made the point that the superiority of behavioural treatments may be related to the fact that behavioural and non-behavioural treatment outcome studies tend to target different problems, and that behavioural studies measure more specific (rather than global) indices of functioning, and that these may be more reactive to treatment.

As research designs have become more sophisticated, so the research questions have become refined. The previous meta-analyses were limited to investigating whether treatment approach is a moderator of treatment outcome. More emphasis is now being placed on 'explanatory' research, or understanding the actual mediators of therapeutic outcome: that is, what it is about a particular programme that effects therapeutic change. Weersing and Weisz (2002) reviewed research testing mechanisms of action (mediators) associated with specific treatments aimed at youth. The found mixed evidence in studies of varying degrees of methodological rigour. One study reviewed directly tested the mechanisms of action of a CBT intervention for youth depression (Kolko et al., 2000). Although the intervention was able to show significant improvements in the symptoms of depression, the theoretical mediator, cognitive distortions, was found not to mediate the effects of the treatment, presenting a substantial theoretical challenge to the CBT model. Weersing and Weiss (2002) reviewed other studies that did provide some evidence of treatment specific mediators. Self-talk was found to mediate treatment effects of CBT for youth anxiety (Treadwell and Kendall, 1996). While parent involvement/behaviour mediated both the long-term effects of a parent training programme for seriously disruptive youth (Patterson & Forgatch, 1995) and the effects of MST for young offenders (Huey et al., 2000). A combination of parent skills and youths' association with deviant peers mediated the effect of multi-dimensional fostercare on antisocial behaviour (Eddy & Chamberlaine, 2000). These family and peer factors, while reviewed as contextual
factors earlier, were specific goals of these therapies, and hence are mentioned here also.

Weersing and Weisz (2002) commented that all the mediator studies had some methodological limitations, such as treating their mediator as another outcome variable, and measuring the mediator at treatment termination (measurement of mediator before termination is required to demonstrate a mediation effect, Kazdin, 2001). They concluded that, although methodological advances have been made, remarkably little is yet known about how youth psychotherapies work, and at this stage, it would be difficult to conclude that treatments were working through the mechanisms specified by their respective theoretical bases.

Non-Specific Programme Factors

With little evidence unearthed on the mechanisms explaining therapeutic change of particular treatment models, the next consideration is programme factors that may moderate outcome that are not specific to any particular model of treatment. Factors applying to all (or most) therapies, and that may be responsible for therapeutic benefits are referred to as ‘common factors’ (Lambert & Ogles, 2004; Wampold, 2001). There are different views on what may appropriately be referred to as a common factor. Grencavage and Norcross (1990) reviewed 50 publications that discussed commonalities and found the most frequently endorsed commonalities were the development of therapeutic alliance, opportunity for catharsis, acquisition and practice of new behaviours, and clients’ positive expectancies. Research on therapeutic alliance in relation to adolescent clients has been reviewed in the previous section. In regards to clients’ positive expectancies, it was surprising, when reviewing client factors, expectancies in relation to treatment outcome did not appear to have received much research attention.

The common factors of catharsis and acquisition and practice of new behaviours could both have relevance to the ADC programme. These processes could be important aspects of the ‘Journey’ component of the ADC model. During this residential/wilderness phase the clients are encouraged to try out (acquire and practice) new pro-social behaviours during their community living arrangement. Many of the outdoor activities they engage in also offer opportunities for expression of intense emotional responses.
Research into these processes on adolescent groups appears scant, although emotional expression has been covered in a review on child and adolescent psychotherapy process research (Shirk & Russell, 1998). These researchers reviewed over 50 years of process research studies, with one third of their review being devoted to emotion processes in child and adolescent psychotherapy; however, much of the review did not relate these processes to outcomes. One observation made was that emotional expression in therapy, for children and adolescents, appeared to be affected by the therapists’ reflective and empathic engagement, pointing to the role of the therapist in facilitating cathartic experiences for clients. They concluded that emotion expression was a key ingredient in many forms of child therapy, but also noted that emotion factors did not emerge as the single or first factor in studies. The authors suggested this may imply that child therapy may be organised around other interactional phenomena than affect expression. However, they cautioned that such a suggestion may be premature, with more detailed and developmentally-informed research required. Once again, it should be pointed out that much of the research was based on children as opposed to adolescents.

Other programme factors that have received a little more research attention in relation to the adolescent age group include the effect of therapy format (group versus individual) and the length of the treatment. There are several implications of group therapy for the adolescent age group. In their chapter on individual and group interventions, Larroque and Hendren (1997) commented that, developmentally, adolescents are engaged in the process of separating from their parents and families and discovering their own identity. Therefore, peers provide a powerfully important influence, which may mean that a group intervention involving input from peers may have a potentially stronger impact on adolescents. Larroque and Hendren (1997) caution, however, that all members of the group must be stable (rather than in crisis), or group therapy can have harmful effects.

Results from the youth psychotherapy meta-analyses, which group together results from interventions with all types of mental health concerns, revealed trends that favour individual over group therapy. All three meta-analyses (Casey & Berman, 1985; Weisz et al., 1987; Weisz, Weiss et al., 1995) found effect sizes favouring individual therapy, but these differences only reached significance in the Weisz, Weiss et al. (1995) study, and only for the weighted least squared analysis, not the more rigorous un-weighted least squares analysis.
However, another consideration is the type of mental health concerns of the group. Group therapy with antisocial youth has been regarded as having potentially adverse affects on individual members. A review by Mulvey, Arthur and Reppuci (1993) found that peer group-based outpatient or residential programmes for delinquent youth were at best ineffective. Chamberlain and Smith (2003) commented that association with delinquent peers results in increased risk for the maintenance and enhancement of delinquent behaviour, resulting in further bonding, socialisation and delinquent skill training.

The Journey component of the ADC programme is a group format, consisting of a heterogeneous group of youth of whom most, but not all would be considered ‘delinquent’ or ‘antisocial’. Hence, it is interesting to consider the effect of this format, and how it compared to the periods of individual therapy.

The effect of length of treatment on treatment outcome (dose response effect) has been investigated in relation to adults. A review by Lambert and Cattani-Thompson (1996) concluded that, while benefits from counselling can be seen in relatively brief time periods, the percentage of clients who show substantial improvement increases as the number of counselling sessions increases (e.g., 50% of clients showing improvement after 8-10 sessions; 75% after 26 sessions or six months, etc).

In relation to an adolescent client group, Kazdin (2004) noted that most therapy research is conducted on brief time-limited treatment, where the number of sessions is fixed (usually eight to ten sessions) as a requirement by the research project. Hence, the effects of more intensive treatment are unknown. Yet, Kazdin has suggested that, for many problems such as conduct disorder, major depression and ADHD, brief and time-limited interventions are likely to produce weak outcomes, and longer treatments might be more promising. The potential effectiveness of an intensive, high-strength programme is illustrated by the MST programme which targets youth with serious disturbance. This programme is on average three to five months long, and very intensive, with therapists initially on call 24 hours a day and working daily with their clients. This programme has considerable research evidence in its favour.

There have been a few individual studies that have examined whether a dose response effect occurred on adolescent clients. Latimer, Newcomb, Winters and Stinchfield (2000) researched the role of treatment factors in the treatment of
adolescent substance abuse. They found that receiving sufficiently long treatment predicted long-term outcome. It wasn't clear from the study what the authors considered 'sufficiently long', but the research had been based on a programme that averaged one month's duration, and so is still likely to be referring to relatively brief interventions. However, for adolescents receiving residential treatment for substance use disorders, no relationship was found between dose response and treatment outcome (Spooner, 1999).

A study by Angold, Costello, Burns, Erkanki and Farmer (2000) found a significant dose response relationship between the number of speciality mental health treatment sessions and improvement in psychiatric symptoms in clinically referred children and adolescents. These authors noted that real improvement was not apparent until an individual had received more than 8 sessions; further, the number of symptoms continued to reduce as the number of sessions increased to over 21 sessions.

The ADC programme averages 20 sessions, in addition to the 9-day component of residential wilderness therapy. This is a relatively long and intense programme compared to most treatments researched under laboratory settings. However, compared to regular 'real-world' community-based programmes, which according to Kazdin, Siegel et al. (1990) average 27 weeks, ADC is shorter. It could be that longer, more intensive treatments may be justified if clinically referred clients have more severe mental health concerns.

2.3.4 Summary

It is reasonable to conclude from this review that although some potential moderators of treatment have been identified (e.g., family involvement, reduced delinquent peer associations and client-therapist relationship factors), little is still known about the actual mechanisms of action that explain therapeutic outcomes. The magnitude of the task at hand is evident when one considers that even a moderately strong moderator, such as client-therapist relationship, still only accounts for a small amount of the total variance in outcomes (little over 5%; Shirk & Karver, 2003). The complexity of this task is apparent when the number of potential therapeutic moderators are considered. Also, the effects of psychotherapy to be explained are broad, including many emotional, cognitive, behavioural, familial and more broadly social processes; outcomes can also vary according to the perspective of the informant.
(i.e., the youth, parent, therapist or observer; Casey & Berman, 1985). Then to complicate matters further, as has been noted above, many factors interact with each other in relation to outcomes, such as client age or problem type interacting with therapist factors such as experience or alliance formation.

In response to this complex task, the emergence of more sophisticated ‘explanatory’ designs that aim to test mediators of change, suggests the tools are now available to gain a better understanding of how treatments work. Others have suggested that phenomenological approaches that consider the perspective of the clients may also be important (Friedlander, Wildman, Heatherington and Skowron, 1994). Weersing and Weisz’s (2002) concluded, following their review on mechanisms of action in youth psychotherapy, that research conducted on real-world samples “may end up being the better science” (p. 24). They point out that process research that is conducted under the strict conditions of research trials (screening out cases that are too severe, complicated by comorbidity or because of chaotic life circumstances, or serious parental psychopathology) may be missing out on theoretically important constructs, resulting in misspecification of models.

Regardless of differing recommendations in relation to research design, there is consensus among researchers that more research is needed (Carr, 2000; Russell & Shirk, 1998; Phillips et al., 2000; Weersing & Weisz, 2002). While the complexity and magnitude of such a research objective is daunting, a quote offered by Kazdin (2004), perhaps provides some perspective in relation to the research objectives laid out at the start of this section:

The task is to end up with conceptual views of how, why, and for whom therapy is effective, along with supportive evidence, but we can begin with just good ideas [emphasis added]. (p.568).

Consequently, this thesis employs a combination of approaches to better understand how the ADC programme works, and while specific mechanisms on how therapeutic change occurs are not ‘tested’, the research aims to provide some valuable initial groundwork, and ‘good ideas’ for later development and exploration.
2.4 Summary, Rationale and Aims

This section briefly summarises the findings of the literature review giving special attention to gaps and research limitations identified, and areas of priority concern within New Zealand. The aims of the thesis are then presented, demonstrating how this research contributes towards addressing these concerns and some of the other shortfalls in research on adolescent counselling treatments.

Section 2.1 highlighted the scope of the problem facing New Zealand in relation to adolescent mental health. The high prevalence of mental health disorders in youth was described, and the high risk of continuity, and further suffering, without intervention noted (Feehan et al., 1993; Fergusson & Horwood, 2001). Also discussed were the difficulties in the provision of mental health services, with low help-seeking behaviour being displayed by youth, coupled with a serious shortage in services and professional staff to operate them (Mental Health Commission, 2003). Together, this situation explains why adolescent mental health has long been recognised and remains today a priority area for the New Zealand Government (Ministry of Health, 1994, 2004).

Section 2.2 reviewed research on the efficacy/effectiveness of counselling interventions for youth with mental health concerns. Consistent evidence from meta-analyses suggested that counselling interventions can produce significant benefits for youth experiencing mental health difficulties. It was also evident that there has been considerable progress in demonstrating the efficacy of several treatments that target a range of mental health disorders. However, there were several limitations noted in this area of research. In general little attention has been given to developmental considerations, with treatment studies frequently failing to recognise the differing needs of children and adolescents. All of the research studies reviewed were conducted overseas which points to a lack of research on adolescent counselling programmes in New Zealand, and raises questions about the applicability of such findings to New Zealand. Also lacking in research are well-controlled studies looking at the effectiveness of interventions utilising adventure or wilderness therapy approaches. However, perhaps the biggest concern expressed by many was the degree to which current research evidence relates to real clinical practice (World Health Organisation, 2001b; Kazdin, 2004). The tightly controlled characteristics of experimental research trials (random assignment, control groups, fixed length duration, clearly specified inclusion/exclusion criteria, single disorders, researcher
selected/volunteer subjects) are designed to produce unambiguous results. In contrast, clinical practice involves clients who have been referred from a wide range of sources, have comorbid diagnoses, and remain in the interventions for varying lengths of time depending on the severity of the problem and individual’s commitment to treatment. To date the majority of treatment programmes remain untested under the conditions of actual clinical practice. It has also been noted that the treatment models that tend to be the focus of research are behavioural or CBT, while surveys indicated that practising child and adolescent clinicians frequently favour eclectic, family or psychodynamic approaches to counselling.

Finally, section 2.3 examined studies that have attempted to understand the conditions that affect outcomes achieved by adolescent counselling programmes. Although lagging behind research on adults, several client, counsellor and programme factors have been identified that appear to be moderators of treatment outcome. Overall, however, it was concluded that very little is known about how counselling actually works to help adolescent clients achieve change. Not knowing the critical factors of therapy means components that effect change may not be being optimised. Hence, research that further explores the factors associated with successful outcomes is considered a priority (Kazdin, 2004; Russell & Shirk, 1998; Weersing & Weisz, 2002).

In turning then to the current research project, the study of a New Zealand adolescent counselling programme, an opportunity occurs to address several areas of concern and limitations noted in current research.

With a high prevalence of mental health disorders in New Zealand youth, together with shortfalls in services, and a climate of funding scarcity, resources for adolescent mental health services must be directed towards programmes with proven effectiveness. This thesis sought to evaluate an established community-based intervention, the ADC programme, whose effectiveness was not yet known. While the findings of this study are among the first that are applicable to a New Zealand adolescent population, they also contribute to the urgent need internationally for research that examines the real-world applicability of counselling interventions for youth.

In addition to an outcome evaluation, another objective of the thesis is to gain a better understanding of the factors that are associated with successful treatment outcomes. It has been stated that “in the long term, the greatest impact of treatment
will derive from understanding how treatments work.” (Kazdin, 2004, p. 564). Therefore, to optimise the effectiveness of the ADC counselling intervention, it is critical to gain a clearer picture of how the ADC programme works. Specifically, data were sought on processes or characteristics of the ADC clients and their families, and of the programme and its counsellors, that were important in achieving therapeutic change. Findings from this study may assist other adolescent counselling interventions to maximise their therapeutic impact.

The rationale for focusing on the ADC programme arises from several considerations. It has been operating in its current form since 1996, and referrals to the programme continue to increase. This suggests it is a sustainable treatment model that succeeds in the everyday conditions of clinical practise, and is able to attract the youth it seeks to help. Further, the ADC counselling model is a potentially rich case study, providing opportunity for increasing our knowledge about adolescent treatment. The innovative model developed is unique within New Zealand and internationally. It combines empirically supported counselling approaches, such as multisystemic therapy and family therapy, with other less researched approaches such as narrative and wilderness therapy. Though the wilderness therapy component is just one of several in the overall approach to treatment, its inclusion perhaps makes the ADC programme stand out as unique, and attracts particular interest to the programme. Finally, despite anecdotal support from clients, parents and referral agents on the success of the programme, it had not yet been subjected to a rigorous evaluation.

In summary, this thesis has three main aims. The primary aim is to investigate the effectiveness of a unique New Zealand adolescent counselling programme in improving the mental health of its clients. Improvement in mental health has been defined as reductions in the frequency and severity of mental health disorders and problem behaviours (including drug and alcohol use), as well as in improved functioning in other psychological and social domains. To this end, 42 adolescents from three geographical regions were assessed on specific measures of mental health immediately prior to and after treatment, and then again six months later.

A second aim of the research is to explore within a New Zealand context the factors associated with completion of treatment and high levels of therapeutic change. This aim sought to increase knowledge of the ways in which characteristics of clients, contextual factors or treatment variables influence outcomes. Discriminant function
and multiple regression analyses were used to assess the contribution of diverse factors, including client characteristics such as demographic differences, type and severity of problem behaviour, together with other contextual and treatment variables.

The third aim is to increase understanding of the treatment methods and other process variables that have been perceived as the most helpful in assisting youth to make changes in their lives. While similar to the second aim, this objective takes special consideration of the perspective of the adolescent clients themselves. To achieve this, a broad qualitative inquiry using participant observation and semi-structured interviews was conducted.

2.4.1 Research Questions

To address these aims, the following research questions were investigated:

1. Do ADC adolescent clients demonstrate significant improvement in their mental health? More specifically, are there significant reductions in internalising, externalising (including alcohol and drug use) and total problem behaviour, and significant improvements in pro-social functioning and individual treatment goals, as perceived by clients, their parents, and counsellors, immediately after programme completion and six months later?

2. Is it possible to identify characteristics of clients, contextual factors or treatment variables that are significantly associated with completion of treatment and greater levels of therapeutic change?

3. What treatment methods or other factors do participants perceive to be most helpful in assisting them to make changes in their lives?
CHAPTER THREE:
METHODOLOGY OVERVIEW

This chapter presents the rationale for adopting a mixed-methods research design to address the research aims described in the previous section. The epistemological (nature of knowledge and relationship between enquirer and knower) and ontological (assumptions about the nature of reality) assumptions typically associated with quantitative and qualitative methodology are described, and the implications and rationale of combining these two approaches are discussed.

3.1.1 The Debate Over Mixed-Method Research Designs

The overall research design chosen for this research is known as a mixed-methods (Creswell, 2003; Marvasti, 2004) or multi-method (Brannen, 1992) design, where quantitative and qualitative methodologies are combined together to best meet the aims of the research. Some researchers view the combination of these two methodologies as advantageous (Marvasti, 2004; Hammersley, 1992), arguing that the different strengths of each approach result in an increase in the knowledge and understanding that can be gained. This view is expressed aptly in the quote below:

The qualitative and quantitative traditions can provide binocular vision with which to deepen our understanding. (Reichardt & Rallis, 1994b, p.11)

Some argue however, that it is inappropriate to combine the two methods on the grounds that the epistemological and ontological assumptions associated with each method are incompatible (Denzin & Lincoln, 2003). To further explore these competing arguments, it is necessary to briefly review the theoretical paradigms, and the ontological and epistemological assumptions commonly associated with these two methods.

Research Methods and Theoretical Paradigms

Within effective research there is assumed to be a correspondence between ontology, epistemology and methodology (research strategies). Denzin and Lincoln (2003) have suggested that a researcher approaches the world with a set of specific ideas or framework (ontology) that specifies a set of questions (epistemology), leading the researcher to examine matters in a specific way (methodology). The two
theoretical paradigms most commonly associated with quantitative and qualitative methodologies are postpositivism and constructivism\(^2\) (Lincoln, 1992; Mertens, 1998) and are reviewed below.

**Quantitative methods**

The dominant paradigm that has guided educational and psychological research, and is associated with quantitative methodologies, has been positivism and its successor, postpositivism (Marvasti, 2004; Mertens, 1998; Reichardt & Rallis, 1994a). The ontology subscribed to by positivists is that reality is ‘out there’, available to be captured, studied and understood. The researcher’s job is to use scientific methods to discover that reality (naïve realism). This view was revised by postpositivists who contended that reality does exist but that due to the researcher’s human limitations, it can not be known perfectly (critical realism), and that it must be accepted that researchers can only discover reality within a certain realm of probability (Mertens, 1998).

The epistemology of early positivist thinking was that researcher and the subject of the study were assumed to be independent (objectivism). The stance of current postpositivists differs, in acknowledging that the theories, hypotheses, and background knowledge held by the researcher can strongly influence what is observed (Mertens, 1998; Reichardt & Rallis, 1994a). Hence, the postpositive researcher strives to remain neutral to prevent values or biases influencing the research findings. Only when the researcher manipulates and observes phenomena in a dispassionate, objective manner, can ‘truth’ and ‘meaning’ be uncovered.

**Qualitative methods**

Denzin and Lincoln (2003) have suggested that qualitative methods have been used within a range of interpretative paradigms, including positivism, postpositivism, critical theories (Marxist, feminist, emancipatory) and constructivism. However, it is the constructivist paradigm that is described here, as it is used widely to describe the theoretical perspectives commonly associated with qualitative research (Denzin &

\(^2\) Constructionism, symbolic interactionism, interpretivism and postmodernism are also philosophical perspectives associated with qualitative research, sharing a commonality in their reaction to postpositivism (for further discussion see, Bogdan & Biklen, 1992; Denzin & Lincoln, 2003; Marvasti, 1998).
Lincoln, 2003; Lincoln, 1992; Mertens, 1998; Tashakkori & Teddlie, 2003) and was of greatest relevance to this research.

Constructivism adopts a relativist ontology (realitivism), that holds that multiple realities exist. Reality is socially constructed, and it is possible, therefore, for different people to construct meaning in different ways, in relation to the same phenomenon (Mertens, 1998). These constructions are not ‘more’ or ‘less true’ in any absolute sense, but simply more or less informed (Guba & Lincoln, 1994). The researcher’s goal is to understand the multiple social constructions of meaning and knowledge related to the phenomenon of interest.

The constructivist paradigm assumes a subjectivist epistemology, where the researcher and respondent interact to co-create understanding (Denzin & Lincoln, 2003). The assumption is made that data, interpretations and outcomes are rooted in contexts and persons apart from the researcher, and it is the researcher’s job to understand the point of view of those they research (Mertens, 1998). It is also acknowledged that the values and perspectives of the researcher influence the production of knowledge and, therefore, these should be made explicit, and become part of the interpretation of data.

Compatibility of quantitative and qualitative methods

As is now apparent, the ontological and epistemological assumptions of the postpositivist and constructivist paradigms typically associated with quantitative and qualitative methodologies are very different. Denzin and Lincoln (2003) suggest that that mixed methodologies within each paradigm can make good sense, but argue that combining methodologies of different paradigms is not possible. Others, however, dispute this position (Brannen, 1992; Marvasti, 2004; Newman & Benz, 1998; Reichardt & Rallis, 1994a). They argue that, while there are differences, the two paradigms share more compatibility than incompatibility making their partnership justifiable. Further, they suggest that the choice of methodology should be based on the goals and circumstances of the research rather than being derived from philosophical or methodological commitments (Hammersley, 1992; Marvasti, 2004). Their view is that different theoretical and methodological approaches can address different research objectives and, therefore, combining the two provides the opportunity for greater understanding in relation to the research interest. These lines of reasons are explored further below.
Reichardt and Rallis (1994a) set out in a comprehensive essay the compatibility between postpositivist and constructivist paradigms. They examined presumed differences, and suggested that arguments for incompatibility (e.g., principles of theory-ladeness of facts, the fallibility of knowledge, under-determination of theory by fact, value-ladenness of inquiry) are inaccurate, and that these principles are applicable to both paradigms, but are simply approached in a different manner. For example, in relation to the ‘theory-ladenness of facts ’ (i.e., that theory, hypothesis, framework, or background knowledge held by an investigator can strongly influence what is observed), they state that this principle is acknowledged in both paradigms, with postpositive researchers putting measures in place to achieve objectivity, whilst interpretivist/constructivists chose to make their existing values and knowledge explicit (Reichardt & Rallis, 1994a).

Reichardt and Rallis (1994a) further suggest that there are shared fundamental values between these paradigms that are often overlooked; this is supported by others, especially in relation to evaluation (Mavasti, 2004; Yin, 1994). Researchers from either paradigm are seen to share a commitment to understanding and improving the human condition, and the expectation of providing usable knowledge about social problems to develop strategies to address them. While each believe in different approaches to increase understanding, they share in the expectation that deeper understanding is needed to solve social problems. Both are also likely to recognise that knowledge produced should be shared and used to make a difference to those it concerns. Finally, researchers from both paradigms agree that the world is complex and stratified, often difficult to understand, and there is thus a need for rigor, conscientiousness and critique as they employ their respective methods to create knowledge (Reichardt & Rallis, 1994a). Reichardt and Rallis (1994a) concluded that a meaningful and enduring partnership between qualitative and quantitative researchers based on the shared fundamental values is both possible and desirable (p. 85).

While the above discussion points to the compatibility at the theoretical level of the two research approaches, the second line of reasoning in support of mixed-methods research is based on a utilitarian perspective directed at the level of method. It is argued that while the two approaches to research (qualitative and quantitative) are commonly associated with differing epistemological positions, a distinction can and should be made at the level of method (Hammersley, 1992). Each can be viewed as a tool for doing research (independent from an epistemological framework), and that
the aim should be to select the tools that are most suitable for the task at hand. It is, therefore, the purpose of the research or evaluation, and the research questions, that should determine the methods used (Hammersley, 1992; Marvasti, 2004; Newman & Benz, 1998).

As different ‘tools’, quantitative and qualitative methods each have their own strengths, weaknesses and distinct characteristics, thus each has the potential to achieve different research objectives. It is the differences between these two methods that becomes then the rationale for combining them (Bryman, 1992; Hammersley, 1992). Tashakkori & Teddlie (2003) describe this rational for using mixed methods as the ‘complementary strengths thesis’. Some of these key differences and strengths are highlighted below.

The research process typically associated with quantitative methods is deductive: research is designed to test theory using scientific methods, to prove or disprove pre-defined hypotheses (Bryman, 1992; Newman & Benz, 1998). The focus of such research is narrow, with specific measures selected to test the hypotheses put up. The aim of the research tends to be to generalise and make inferences about a phenomenon, from a sample to a stated population. In contrast, the qualitative research process is more likely to be inductive: concepts, insights and understanding are developed from patterns in the data, rather than collecting data to assess pre-conceived models, hypotheses or theories (Brannen, 1992; Newman & Benz, 1998). The purpose is often to understand a phenomenon from the point of view of the individuals being studied. This entails a quest to gain deeper understanding that is directed towards reconstructions of previously held constructions; as such the process is expansionist rather than reductionist (Lincoln, 1992). Therefore, combining the two approaches within a single piece of research allows for different research objectives to be addressed and increased understanding to be achieved.

While arguing a commitment to a theoretical perspective should not dictate which research methodology ought be employed, neither does it mean that theoretical perspective can be ignored. Consistency must be maintained in relation to the initial theoretical assumptions under which the data were collected, as data can only be understood in relation to the purposes for which they are created. In turn, the results or findings must be expressed in ways appropriate to the methodology by which they were collected (Bryman, 1992; Brannen, 1992). For example, while it may be appropriate to generalise results generated by true experimental (quantitative)
methods to a stated population or to suggest casual relationships, it would not be appropriate to quantify qualitative data from a small unrepresentative sample of interviewees, and attempt to generalise the findings or infer causal relationships. This is echoed by Morse (2003) who expressed that researcher must retain the assumptions of a paradigm, as the adhoc mixing of such assumptions is likely to be a serious threat to validity. To avoid such errors, Brannen (1992) has suggested it is important for the researcher to specify as precisely as possible the particular aims of each method, the nature of the data that is expected to result, and how the data relate to theory. This useful suggestion has been incorporated into this thesis. Therefore, what follows is such a specification in relation to the mixed methodology used.

Rationale for a Mixed-Methods Research Design for the ADC Research Study

The research study was conceived within a postpositivist framework, and the primary research objective was to evaluate outcomes following participation on the ADC programme. Quantitative methods were selected in order for inferences to be made about the effectiveness of the ADC programme. Data were collected using established and standardised measures so that findings could be compared to those of other adolescent mental health programmes. The outcome data were intended to be useful to the funders of the programme, as well as others interested in effective treatment of adolescents with mental health concerns.

The second objective was to increase understanding of how the ADC programme worked, in particular to increase knowledge of the ways in which characteristics of clients, contextual factors or treatment variables influenced treatment outcomes. Quantitative methods were selected to test specific theories and explanations identified through previous research, with the aim of furthering the scientific understanding of how best to assist youth with mental health difficulties.

The third research objective was similar to the second: to better understand how the ADC programme worked. However, this third objective differed in that it was concerned with the point of view of the recipients of the programme, the adolescent clients themselves. The aim was to understand the clients’ personal constructions of effective counselling, and the therapeutic change process, based on their experience of the programme. Hence, a broad qualitative enquiry from a constructivist perspective was selected as best suited to address this objective. This required the researcher to ‘step outside’ the original postpositive paradigm while
conducting this enquiry, and see what additional knowledge in relation to this research could be generated by adopting an alternative theoretical perspective. The broad focus of the qualitative enquiry allowed the construction of new ways of understanding how counselling worked, privileging the knowledge offered by the youth. The objective of the qualitative enquiry was to build and develop ideas, rather than test theories.

3.1.2 Summary

The choice of a mixed-method research design for this study was based on the complimentary strengths argument presented by Tashakkori and Teddlie (2003). The use of both quantitative and qualitative methods would allow for the different research questions of this study to be answered. The intention was not to integrate the two resulting data sets, but to increase the knowledge generated through the use of two approaches thus providing the “binocular vision” described by Reichardt and Rallis (1994b). Details of the actual quantitative and qualitative methodologies employed are described in separate sections, along with the findings derived from each approach. The quantitative method and results appear in Part II, while the qualitative methods and findings appear in Part III.

Within these two fields of inquiry, specific styles and format have been adopted to present the respective methodologies and findings, therefore, the reader will note that the style and format of Parts II and III have been tailored so as to be appropriate for each approach. For example, Part II continues to be written in the third person, while Part III switches to first person. A section describing the research limitations of the quantitative study appears following the discussion of results in section 5.4, whilst reflections on the rigour of the qualitative research are ongoing, and appear in the methods section and throughout the presentation of the findings.
PART II:
QUANTITATIVE STUDY
CHAPTER FOUR:
QUANTITATIVE METHODOLOGY

The two main objectives of the quantitative study were to evaluate the effectiveness of the ADC programme and identify factors that predicted programme completion and successful treatment outcomes. This chapter presents the methodology chosen to answer these objectives and address the corresponding research questions.

4.1.1 Research Design

The research design utilised in the quantitative study was a single-group (uncontrolled) investigation of 89 subjects. The intervention was an established community-based adolescent counselling programme. The subjects were clients referred using the standard ADC referral process (i.e., clinical referrals), and the intervention was delivered by the regular ADC counsellors (i.e., this was a ‘real-world’ intervention).

Subjects were assessed using a series of psychometric tests immediately prior to and after treatment, and then again six months later. Data were collected from several sources including the clients, their parents, referral agencies and counsellors. This design and data collection regime enabled several analyses to be conducted. Descriptive statistics of pre-programme data provided detailed information of the characteristics of the ADC programme and its clients. A series of repeated measures analysis of variance (RM-ANOVA) on data collected across the three time points evaluated the subjects’ short-term, and importantly, longer-term treatment outcome. Discriminant function analysis (DFA) and multiple regression (MR) of pre-programme data was used to examine which client and contextual factors were able to predict short and long-term treatment outcome and programme retention.

In quantitative research it is generally accepted that the ‘gold’ standard in terms of research design is the randomised control trial; second to this is quasi-experimental or wait-list control designs. The use of control groups in such designs aims to maximise the internal validity of the study (controlling, for example, effects such as maturation or natural recovery, or effects of the testing procedure) and therefore, increasing the ability to isolate causal effects between treatment and outcome. Consideration was given to instituting a more sophisticated design incorporating a control group, but this was rejected for a number of practical and ethical reasons which are discussed below.
Conducting research the results of which are applicable to 'real-world' practising clinicians, has been identified in the literature review as an important priority for adolescent counselling research. Hence, the choice was made to research an adolescent counselling intervention (ADC) that was already operating in a community setting, thus increasing the external validity of findings. However, practical restraints associated with researching ‘real-world’ interventions became evident in the planning stage of this research.

In some of the rural areas of Central and South Otago where it operates, ADC is the only programme of its type being offered to adolescents. It would, therefore, not be possible to randomly assign a client to an alternative mental health programme, for comparison purposes. The referral process of the programme also posed a potential problem. Referrals for the programme came from many sources, and it was considered unrealistic to seek the cooperation of all such referral agencies in randomly assigning their young people to a control group or even a wait-list control. This concern was borne out in a recent Australian evaluation of an adolescent substance abuse programme (Spooner, Mattaick & Noffs, 1999), when their randomised controlled trial was abandoned due to problems with agencies refusing to refer clients if it meant they could be assigned to a wait-list control comparison group.

Even had it been logistically practical to randomly assign to a comparison group or even a wait-list control, the ethical issue of withholding treatment from these particular young people was considered unacceptable. Some young people were referred to the programme because of suicidal ideation, or because of dangerous abuse of substances, in which case treatment could have been life-saving. Clients such as this are usually screened out of university setting clinical research trials (Kazdin, 2004), but these are the very clients that mental health services most need to be able to assist, and why concern has been expressed about the applicability of findings from experimental research trials to ‘real-world’ settings.

The reality of the ethical concern of withholding treatment was illustrated during data collection when a young person was referred to the programme due to abuse of inhalants. As a first step ADC counsellors worked with the parents to help move the young person into the family home for closer supervision. The following week, the sleep-out the young person had been sleeping in burnt down when a candle set fire to curtains. Local police suggested that, if the young person had been in the premises, and incapacitated as a result of abusing inhalants, he/she may well have died in the fire.
In addition to these practical and ethical limitations, randomised controlled trials may not be an appropriate research design in real clinic settings because of the heterogeneous nature of ‘real-world’ client groups, (i.e., large within-group variability). This factor makes it very difficult to detect small treatment effects between groups. Randomised controlled trials have very strict inclusion and exclusion criteria in order to create homogeneous samples, and increase the ability to detect small treatment effects. However, creating homogenous groups of clinically referred clients limits the applicability of the results to ‘real-world’ samples, and thus defeats the very reason for conducting research.

Admittedly, an implication of not including a control group is that definitive conclusions on causal effects of the ADC programme on treatment outcomes could not be made. However, the threat to internal validity by not having a control group is balanced by an increase in external validity through researching a ‘real-world’ programme and, as a result, increasing the applicability of the findings for practising clinicians and youth with mental health concerns seeking their assistance. It was also felt that with the repeated collection of data from several sources, including the use of widely published reliable and validated instruments (that would allow a degree of comparison to instrument population norms and results from other studies) together with collection of detailed qualitative data (see Chapter 6.0), there would be sufficient information collected to be able to make reasonably informed comment on the effectiveness of the programme.

4.1.2 Subjects

Selection

Subjects in this research project were all clients who participated in an Adventure Development Counselling (ADC) programme during the period July 1999 to December 2000. This included clients from three programme intakes (programmes formally started in July 1999, February 2000 and July 2000) across three regions (Southland, Otago and Canterbury). Within each region subjects were referred onto the programme using the normal ADC referral process. This may have been self-referral, or referral by family, school counsellor, general practitioner, CYF social worker, other therapeutic agencies or the judicial system. As a result the subjects all met the ADC's selection criteria of being between 12-18 years old, having, or being at risk of, a significant drug/alcohol problem or any other significant mental health disorder, and behaviour that was affecting their expected social and/or academic development. Clients with physical disabilities are not
excluded from the ADC programme, however, if their physical disability was considered to be a risk management issue in relation to the Journey component, they would be limited to individual counselling only.

**Sample Size and Power Calculations**

In the planning stages of the research methodology power calculations were carried out to determine the sample size needed for the planned analyses. From ADC records of previous years intakes, it was estimated that around 8-12 clients selected for participation in any one ADC programme from each of the three regions, would complete the programme. Southland, Otago and Canterbury were known to run at least two programmes a year.

It was, therefore, originally expected that with two programme intakes, data could be collected on approximately 60 subjects. This sample size was calculated to have an 80 percent chance of finding a statistically significant difference (p<0.05) of a small to medium (0.37) effect size (Dupont & Plummer, 1992). Achieving this effect size was felt to be a reasonable expectation, given that meta-analysis of outcome studies on adolescent behaviour following treatment have found effect sizes ranging from 0.54 – 0.88 (Casey & Berman, 1985; Kazdin, Bass et al, 1990; Weisz et al, 1987; Wiesz, Weiss et al., 1995). With regards to finding associations between subject characteristics and treatment success with 60 subjects, for any single variable it was calculated there would be an 80 percent chance (α<0.05) of finding a correlation coefficient of r=0.37 (Dupont & Plummer, 1992).

Referral and completion rates were, however, found to be lower than anticipated during the first two programme intakes, so data collection was extended for a third intake. This resulted in 99 potential subjects referred and accepted onto an ADC programme during June 1999 to December 2000. Thirteen ADC counsellors working over this time period collected data for the research. Two of these discontinued during the first six-month time period and so did not collect post-test data. Their clients (n=10) could not be used in the study. This left a total of 89 possible research subjects, all of which agreed to to participate in the research.
Response Rates

Table 3 provides a breakdown of the data collected across the three regions over the period July 1999 to December 2001.

Table 3.  
Summary of data collected.

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>Data Collected</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accepted onto programme</td>
<td>89</td>
<td>81</td>
<td>92%</td>
</tr>
<tr>
<td>Completed programme</td>
<td>53</td>
<td>47</td>
<td>89% (53%)\textsuperscript{*}</td>
</tr>
<tr>
<td>Six month follow-up</td>
<td>53</td>
<td>42</td>
<td>79% (47%)\textsuperscript{*}</td>
</tr>
</tbody>
</table>

\textsuperscript{*}Bracketed percentage refers to response rate compared to original sample of n=89; data were only attempted to be collected from those that completed the programme: n=53.

Pre-test data

Response rates refer to the primary treatment outcome measure, the Youth Self Report (YSR). Of the 89 clients who participated on the ADC programme, pre-test data were collected for 92 percent (n=81). The missing YSR data related to one counsellor who omitted to collect the research data (n=5), while four other pieces of missing data were due to counsellors’ error (oversights during the implementation stage of the research).

As mentioned above, the 92 percent response rate relates specifically to the Youth Self-Report data; other demographic and programme information are available for all 89 clients. Response rates for the other treatment outcome variables varied across measures. There was a 71 percent response rate for the CBCL (n=63); the BFAM had an 83 percent (n=74) response rate; the CGAS 70 percent (n=62), and the alcohol and drug consumption data achieved a 72 percent (n=74) response rate. The assessment of DSM-IV substance use disorder had the lowest response rate at 64 percent (n=57). Some of the data that was not collected related to individual counsellors’ efficiency in data collection, while some missing inventories (CBCL/BFAM) were a result of parents’ failure to fill out these questionnaires.

Post-test data

Post-test research data were collected by the counsellors when their clients had finished the programme. Of the 89 clients who commenced the ADC programme, 39
percent (n=35) terminated their counselling before the end of the programme, and 61 percent (n=54) completed the programme (this includes one client who was carried over for participation in another programme when data collection finished, i.e., not yet completed). Data were not collected on those who terminated prematurely. While this might have been desirable, it involved time demands on the counsellors that could not be justified (it was expected that those terminating early would be difficult, if not impossible, to contact or, if contacted, reluctant to participate further in research activities). Fifty-three clients finished the programme and post-test data were collected on 89 percent (n=47). Missing data was due to counsellor error (n=5), plus one client who moved and could not be contacted.

Six-month follow-up data.

All those who had completed the post-test data (n=47) were followed up by this researcher for six-months post-programme completion data. Of these, 89 percent (n=42) were contacted and completed the six-month follow-up assessment. This represented 79 percent of those that completed the programme (n=53) and 47 percent of the original group who started the programme (n=89). Data that could not be collected included one client who declined to participate, two clients who failed to return the forms by post, and two clients who had moved and could not be contacted.

Subject Characteristics

Demographic information, including age, gender and ethnicity, appears in Table 6, of Chapter Five. The first part of Chapter Five (section 5.1) provides a more comprehensive description of clients that participate in ADC programmes than has previously been available.

4.1.3 The ADC Programme / Intervention

The intervention studied was the ADC programme. The programme has been developing for over 15 years and has been running in its current form since 1996. At the time of the research the programme was delivered by the Specialist Education Services (Ministry of Education) in Southland, Otago and Canterbury, and funded by the Shared
Services Agency on behalf of the District Health Boards. An outline of the programme’s format and content appears in Table 4.

The programme runs for approximately six months, with clients typically receiving an hour a week of individual and/or family counselling, with an average of 20 contact hours in total per client. ADC counsellors are either registered psychologists or masters level counsellors. Approximately two thirds of the way through the programme, clients participate as a group on a nine-day wilderness therapy 'Journey' (providing they meet specific risk management criteria), in a residential setting in Mt Aspiring National Park. The nine days of wilderness therapy is in addition to the 20 community-based contact hours. There is also a follow-up period of another 12 weeks involving phone contact and further meetings as required. Where other agencies are involved with the participant and their family a 'Co-ordinated Intervention Plan' may be negotiated. This includes written agreements for tasks and responsibilities for the different agencies at the outset of the programme.

The ADC programme uses a systemic-based model to address clients' problems, incorporating systems of influence such as the family, school and peers. Within this model the counsellors combine an eclectic mix of therapeutic approaches into an individualised programme tailored to the needs and goals of the young person. Major influences include Narrative Therapy (Freedman & Combs, 1996; White & Epston, 1990), Solution-Focused Brief Therapy (de Shazer, 1985), Multisystemic therapy (Henggeler, Schoenwalk, Borduin, Rowland & Cunningham, 1998) and Motivational Interviewing (Miller & Rollnick, 1991). Attention is also given to developmental considerations. During the 'Journey' wilderness therapy is emphasised. This is an action-orientated approach that utilises the impact of an isolated natural environment and living in a community or “therapeutic wilderness milieu” (Crisp, 1996).

NB: More detailed descriptions of the ADC programme and its participants appear in the qualitative study (See sections 6.1.2 and 7.3)

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3 Subsequent to data collection, in 2004 ADC became a private company, but is still on contract to the Shared Services Agency of the Southern District Health Boards.
Table 4.
Outline of ADC Programme

<table>
<thead>
<tr>
<th>Week (approx.)</th>
<th>Phase</th>
<th>Setting</th>
<th>Tasks / content</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3</td>
<td>Referral, Assessment and Selection</td>
<td>Community-based:</td>
<td>• Initial meeting with client – introduction to programme</td>
</tr>
<tr>
<td></td>
<td></td>
<td>School / office / home</td>
<td>• Client / parent signed consent collected</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Inter-agency liaison as appropriate</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Comprehensive assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Agreement on individual treatment goals</td>
</tr>
<tr>
<td>3-10</td>
<td>Individual and/or family therapy</td>
<td>Community-based:</td>
<td>• Weekly counselling sessions towards achieving individual treatment goals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>School / office / home</td>
<td>• Crisis management as necessary</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Preparation for Journey, agreement of goals for the Journey, collection of bond</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Risk management assessment for participation on Journey</td>
</tr>
<tr>
<td>10 -12</td>
<td>9 day Journey – Group and/or individual therapy</td>
<td>Residential setting:</td>
<td>• Wilderness therapy - Therapy is conducted during participation in various</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tititea Homestead, Mt. Aspiring National Park</td>
<td>activities such as completing daily chores (e.g., cooking, cleaning, chopping</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>firewood, and maintaining fires), rock climbing, wilderness tramps, individual</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>reflection time, high and low elements of a ropes course, co-operative group</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>problem-s solving tasks.</td>
</tr>
<tr>
<td>12-20</td>
<td>Individual and /or family therapy</td>
<td>Community-based:</td>
<td>• Ongoing therapy – Consolidate changes made on Journey into everyday life.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>School / office / home</td>
<td>• Work on new issues (set new goals as necessary) that arose during the Journey</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Client’s story is written</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Negotiated ending – suggested referral if appropriate</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Presentation of certificate of completion.</td>
</tr>
<tr>
<td>20-32</td>
<td>Follow-up</td>
<td>Community-based:</td>
<td>• Phone contacts and other contact as needed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>School / office / home</td>
<td></td>
</tr>
</tbody>
</table>
4.1.4 Treatment Outcome Variables

The research aims of this thesis involved evaluating, predicting and, therefore, measuring ‘treatment outcome’. For the purposes of this research, successful treatment outcome was assessed using a variety of variables that measured aspects of adolescent mental health. A balance was sought between variables indicating absence of dysfunction as well as those indicating presence of optimal functioning (Table 5). Rather than relying on single measures, where possible information from several sources was utilised.

Table 5.

Summary of treatment outcome measures

<table>
<thead>
<tr>
<th>Treatment Outcome Variables</th>
<th>Methods of Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dysfunction</td>
<td>• Total Problem Score, Aggression, Delinquency (YSR/CBCL); Individual treatment goals as specified by client; Counsellor reports (CGAS).</td>
</tr>
<tr>
<td>• Antisocial Behaviour (Aggression and Delinquency).</td>
<td></td>
</tr>
<tr>
<td>• Alcohol and Drug Use (quantity and frequency of consumption, presence of DSM-IV Substance Use Disorder).</td>
<td></td>
</tr>
<tr>
<td>• Emotional Disturbance (Anxiety, depression).</td>
<td>• A&amp;D section of diagnostic interview (K-SADS); Self-report of quantity and frequency from clients; Individual treatment goals as specified by client.</td>
</tr>
<tr>
<td>Optimal Functioning</td>
<td>• Anxiety, depression (YSR/CBCL); Individual treatment goals as specified by client; Counsellor reports (CGAS).</td>
</tr>
<tr>
<td>• Pro-social functioning.</td>
<td>• Client and parent rating of family functioning (Brief FAM); Individual treatment goals as specified by client. Counsellor reports (CGAS)</td>
</tr>
<tr>
<td>• School Performance.</td>
<td>• Academic Performance (YSR); Individual treatment goals as specified by client. Counsellor reports (CGAS)</td>
</tr>
</tbody>
</table>

Key: YSR - Youth Self Report (Achenbach, 1991c)
CBCL - Child Behaviour Checklist (Achenbach, 1991a)
CGAS - Children's Global Assessment Scale (Shaffer et al., 1983)
Brief FAM - Brief Family Assessment Measure (Skinner, Steinhauser & Santa-Barbara, 1995).
K-SADS – Kiddie-Schedule for Affective Disorders and Schizophrenia, Kauffman et al., 1997)
4.1.5 Instrumentation

The first few sessions of the ADC programme involve the counsellors collecting assessment information from their clients. It was recognised that a large proportion of this information was also useful for research purposes and it was felt important to spare the clients the duplication of the collection of this information. Therefore, the selection of research instruments was carried out after consultation with the ADC director and counsellors. The aim was to continue collecting the same information but to replace assessment tools where possible with an instrument with established validity and reliability, and ensure standardisation of the assessment procedures. This generated considerable discussion, particularly about how to collect data that was both valid and reliable, but in a way that the counsellors felt would not hinder the development of a therapeutic relationship between the client and their counsellor, and did not increase the length of the assessment period before counselling began.

The following describes the instrumentation that was agreed upon. Due to the anticipated low reading age of many of the clients who participate in the ADC programme, instruments were administered in an interview format. A summary of the testing schedule can be found in Appendix A. Counsellors collected data at the start and end of the programme, while six-month follow-up data was collected by the researcher. Copies of testing instruments developed for the research appear in Appendix B, sources for published instruments appear below.

Client Characteristics Form.

Counsellors collected the following client information during initial assessments: age; gender; ethnicity; referral information; involvement in other interventions (previously or concurrently); family / living situation; caregiver occupation; history of caregiver’s antisocial behaviour; history of childhood abuse; school situation; onset of problem behaviour; criminal history; gang involvement; relationships with peers; health information (see Appendix B).

Youth (YSR) and Parent (CBCL) Behaviour Checklists

The Child Behaviour Checklist Inventories are a set of forms that allows the collection of parallel self-rating data from youth (Youth Self Report [YSR], Achenbach, 1991c), their parents (Child Behaviour Checklist [CBCL], Achenbach,
1991a) and their school (Teacher Report Form [TRF], Achenbach, 1991b). Forms contain competence items and problem items (113 in total) that provide a basis for comparing the adolescents' views of their own functioning with data from their parents and, where appropriate, their teachers. Each form can be self-administered or completed via interview and takes an average 20 minutes to complete. Results are collated together to provide scores for: total competence (activities and social); total problem behaviour; internalising behaviour; and externalising behaviour. Scores are also available on eight sub-scales: withdrawn; somatic complaints; anxious/depressed; social problems; attention problems; thought problems; delinquency; aggression. It is a widely-used instrument that assesses a broad range of childhood/adolescent dysfunction, with established validity and reliability (Achenbach, 1991a, 1991b, 1991c).

Stability correlations (test-retest reliabilities) ranging from .69 to .89 have been reported for periods as long as two years (Achenbach, 1991a, 1991c). Regarding validity, Achenbach (1991a, 1991c) cites studies that have supported the construct validity of the measure through high correlations between CBCL and other behaviour checklists (range=.52 to .86). Content validity is supported by discriminant function analyses that indicated a youth being referred for behaviour problems correlated highly with high T-scores on the behaviour problem scales; further, CBCL and YSR scores significantly discriminated between diagnosably disordered youth and non-disordered youth (Achenbach, 1991a, 1991c).

The scales were developed and normed using samples of North American adolescents. However, researchers have found that the scales are robust across diverse cultures (Crijnen, Achenbach & Verhulst, 1997; Achenbach, 1991a, 1991c) including Australia (Bond, Nolan, Adler & Robertson, 1994).

It was intended to collect information on all three forms; however, it became evident early in the research that there were problems in the administration of the TRF. Counsellors were finding it difficult to identify a teacher who was willing and felt they knew the particular client sufficiently to complete the form in a valid way. School guidance counsellors at the client's high schools reported that students worked with several teachers over the course of a weekday and that behaviour would vary with different teachers; hence they felt it was difficult for any one teacher to accurately report on the general behaviour of the young person in question.
Difficulties were also experienced in collecting the information for the competence sub-scales (social, activity, academic and total competence) on the YSR and CBCL. Twenty percent of the youth were not at school when they started the ADC programme, with a further proportion not attending school at the end of the programme. This meant that academic competence and, therefore, total competence scores (which was a sum of social, activity and academic competence) could not be calculated for these youth. In addition, counsellors reported this section of the questionnaire did not fit well with youth who were their clients, and in some instances they opted not to complete this section. For example, many of the ADC clients were enrolled in subjects such as art, design and physical education, and academic achievement in these subjects was not recognised on the forms. It was also noted in forms that were completed by counsellors, scores for ‘activities’ appeared to varied according to the creativity of the counsellors in thinking of activities to include (e.g., hunting, fishing, skateboarding, listening to music). For these reasons competence items were not included in the final analysis.

With the established validity, reliability and wide use of this instrument, total problem behaviour and internalising and externalising behaviour were considered the primary measures of treatment outcome.

Target behaviour.

In addition to total problem behaviour, internalising and externalising behaviour and the eight sub-scales of syndromes of behaviour, target behaviour was also assessed. For the purposes of this research target behaviour was considered to be the particular sub-scale for each individual with the highest elevation (degree of severity). This variable is individualised for each youth, does not include problems or domains clinically irrelevant for a particular youth, and allows comparison of youth on the sub-scale for which treatment would most likely have been targeted. For example, progress for a youth with high levels of depression could be compared against a youth with high levels of aggression. This is a variant of Weiss, Carton, Harris and Phung’s (1999) Target Problem Scale, and has also been used with success as a primary outcome measure by others (Crisp, O’Donnell, Kingston, Poot & Thomas, 2000).
Kiddie-Schedule for Affective Disorders and Schizophrenia (K-SADS).

Kiddie-Schedule for Affective Disorders and Schizophrenia (K-SADS, Kauffman et al., 1997) is a semi-structured diagnostic interview developed to assess current and past episodes of psychopathology in children and adolescents according to DSM-IV criteria. Reviews have found the instrument to have concurrent validity and excellent test/re-test reliability (Kauffman et al., 1997; Hodges, 1993). Supplement #5 of the K-SADS is used to assess substance abuse or dependency according to DSM-IV criteria. This supplement was used in isolation from the full interview schedule. Screening questions determined if it was appropriate to conduct this section of the interview schedule. Following consultation with the author of the K-SADS, the format of the interview was modified to collect information on alcohol and drugs concurrently (where more than one substance screened positive) rather than repeating the schedule for each substance the young person used.

Drug and Alcohol Consumption.

Information was collected on the quantity and frequency of subjects’ drug and alcohol consumption (See Appendix B). Dawson (1998) has expressed concern about the validity and reliability of self-reported drug and alcohol consumption information. Others have shown self-reports to be generally reliable if there is no motivation to falsify answers (Spooner et al., 1999). Using other methods such as urine or blood analysis was considered, but these also have validity problems, and researchers have questioned the value of the extra expense involved (Spooner & Flaherty, 1992, cited in Spooner et al., 1999). Such invasive methods were also unacceptable to ADC programme facilitators who felt they were not conducive to building an honest relationship with their young clients. In an attempt to maximise the validity and reliability of the self-report consumption data a graduated frequency and substance specific questioning style was incorporated, as recommended by Lemmens (1994) following a research review on the topic. In addition, retrospective information on clients’ substance consumption levels was collected from participants at follow-up as recommended by Aiken (1986).

The unit of measurement in research on alcohol consumption is typically the ‘standard drink’. However, there is some discrepancy in New Zealand and internationally as to what a ‘standard drink’ is (Turner, 1990). For the purposes of this research a standard drink was deemed to contain 10grams (12.7ml) of alcohol: the
amount of alcohol that various agencies in New Zealand (including the Alcohol Advisory Council of New Zealand or ALAC) quote (ALAC, 2002). Another commonly used classification of drinking behaviour in youth is ‘binge drinking’. This was defined in this study as five or more standard drinks on one drinking occasion. This is consistent with definitions used internationally in alcohol related research (ICAP, 1997). This is also the same quantity ALAC uses to define ‘risky’ drinking or ‘heavier drinkers’ (ALAC, 2001).

**Brief Family Assessment Measures (BFAM).**

The Brief Family Assessment Measures (BFAM, Skinner et al., 1995) provides an overview of family functioning. The scale consists of 14 items and can be administered and scored in 5-10 minutes. It has been designed as a screening tool, but can also be used to monitor family functioning over time or during the course of treatment. The authors have reported adequate reliability and validity (Skinner et al., 1995).

**Individual Treatment Goals (ITG).**

The ADC programme has an individualised approach to treating clients, focusing on each client's needs. Hence, the specific treatment objectives vary from client to client. To account for this individualised approach to treatment, individual treatment goal rating scales (ITG), were developed for the research to monitor progress towards such goals (See Appendix B). Clients decided on their treatment goals with help from their counsellor as per the usual ADC procedure and then recorded them on the 0-10 point scale in the ITG form. To increase the reliability of the goal ratings, each scale had a space to record the scale-specific behavioural descriptors of progress towards each goal (e.g., if a goal was to reduce alcohol consumption, the number of drinks per week that would reflect an improvement or deterioration in alcohol consumption was noted). The clients then rated their perceived progress towards each goal during the programme as per normal counselling practice, and at the end of the programme, and at the six-month follow-up. At six-months follow-up, in addition to the rating of their current progress the clients also made a retrospective rating with the researcher of where they felt they were at the start of treatment.
Children’s Global Assessment Scale (CGAS).

The Children’s Global Assessment Scale (CGAS, Shaffer et al., 1983) was selected to collect data on treatment outcome in terms of global functioning from the perspective of the counsellor. The CGAS has been designed to assess the lowest level of functioning for a child or adolescent during a specified period of time. The scale has been found to be reliable between raters and across time and has demonstrated discriminant and concurrent validity (Shaffer et al., 1983). The CGAS is a child version of the DSM-IV Global Assessment of Functioning (GAF). As with the GAF, scores range from 1 (representing the most functionally impaired young person) to 100 (the healthiest). Scores above 70 on the CGAS are designated as indicating 'normal' function. The instrument contains behavioural descriptors at each of 10 anchor points that depict behaviours and life situations applicable to children aged 4-16 years old. This scale allows the counsellor to assimilate and synthesise their knowledge about many different aspects of the client’s social and psychiatric functioning and condense it into a single clinically meaningful index of severity of disturbance. The brevity of the scale (less than 5 minutes to complete) means it can be repeated at regular intervals to monitor progress throughout treatment.

4.1.6 Ethical Approval

Ethical approval was granted from the University of Canterbury Human Ethics Committee and the Canterbury Human Ethics Committee of the (then) Health Funding Authority. Copies of consent approvals appear in Appendix C.

4.1.7 Procedures

Prior to commencing data collection, a pilot study was conducted in May 1999 to help finalise methods. The pilot included several meetings with ADC staff to discuss the proposed research methodology, observing several ADC counselling sessions and participating in one of the nine-day wilderness therapy Journeys. Once the research methodology had been finalised, each ADC counsellor participated in a training session in the implementation of the research measures to ensure standardisation of administration. Each counsellor was provided with a training manual detailing administration instructions for all instruments for further reference as needed.
Potential clients were referred to the ADC programme and assigned an ADC counsellor in their region as per the normal ADC referral procedure. Details of the research were explained to each client by their counsellor and a printed information sheet was provided. The ADC counsellor then obtained informed consent from their client to participate in the programme evaluation and for their assessment/evaluation information to be used for research purposes. (Copies of the information sheet and consent form appear in Appendix D.) Within each of the regional Group Special Education Offices, the Māori liaison individual (Kaitakawaenga) was approached and their agreement sought that they would be available to help explain the research and process of informed consent to Māori clients, as required.

Standard ADC practice meant that the first 3-4 sessions were devoted to selection issues and assessment. During this period the counsellors arranged for the collection of demographic information, ADC assessment information and for the completion of all other research measures (see section 4.1.4). Clients then continued on with the ADC programme as per normal practice. Initially it was agreed that counsellors would rate their clients' progress monthly through the completion of individual treatment goals (ITG) and the global functioning of their clients (CGAS). However, ratings on the ITG were often less frequent than this, as counsellors reported they found it difficult to keep to a regular schedule of rating. Often they would turn up to a session intending to assist their clients to rate their progress on goals only to find there had been a crisis that needed to be dealt with and which took priority over the research data collection. However, in every case, ratings were taken at the start and end of treatment.

Approximately two to three months after starting the ADC programme, clients would be offered the opportunity to participate on the standard ADC 'Journey'. Clients then completed the final three to four months of the ADC programme. At the end of the programme the counsellor arranged for a re-test of the research measures collected at the start of the programme. Six months later, the researcher then re-contacted those clients that had completed the programme to arrange for a final re-test, once again using the same evaluation measures.

The follow-up period of six months was decided on as it was felt long enough to encompass relapse (Spear, Ciesla & Skala, 1999) but not so long that it would have made locating subjects more difficult, thereby lowering the response rate. An 18 month follow-up of clients who participated on a similar type of youth programme
(the Te Whakapakari Youth Programme near Auckland) experienced great difficulties in locating clients for re-assessment (Eggelston, 2000). It was also felt that a six-month follow-up was close enough to the intervention period to avoid contamination from subsequent interventions (Spooner et al., 1999).

4.1.8 Data Analysis

The primary aim of the data analysis was to investigate whether subjects who participated on an ADC programme displayed improvements in their overall mental health. A second aim was to see if it was possible to identify characteristics of subjects that are associated with completion of treatment and successful outcomes.

The first stage of data analysis was to enter all data from the quantitative assessments into the Statistical Package for the Social Sciences (SPSS, version 10.1 for Windows, 2001) for data processing and statistical analyses. Data were then screened for errors in data input, individual values were checked to ensure they were all within the expected range, and that means and standard deviations were plausible. Missing data were examined and where appropriate replaced by the relevant group means. In cases where missing values were replaced, sensitivity analyses were carried out whereby analyses were repeated without and then with the replaced missing values to assess the effect of replacing the missing values. The distribution of scores for each scale were examined to determine if they were normal, skewed or bimodal, and checked for outliers and any conflict to the underlying assumptions of the statistical procedures applied.

Before any further analysis could be carried out it was important to assess if there were any differences in the data that had been collected (n=42) compared to that which was lost (n=12). Demographic details, amount of counselling received and treatment outcome variables of the clients with incomplete data at the six-month follow-up stage were compared to those clients with complete data. Differences were examined using independent t-tests or Chi-square analysis as appropriate (results are presented in Tables A1 and A2 in Appendix E). There were no significant differences found on the demographic information, counselling statistics or treatment outcome variables. The exception was ethnicity, where it was found that a higher number of non New Zealand European (NZE) subjects in the group had incomplete data. Non NZE with missing data included five Maori, one Samoan and one Fijian Chinese. To check for potential bias as a result of this disproportionality in the missing data
proceeding analyses were always re-run with weights applied to the non NZE and NZE subjects (calculated by the inverse of the probability of getting complete data from each ethnic category (89% for NZE subjects and 56% for non NZE subjects). Non NZE subjects were given a weighting factor of 1.79 whilst NZE subjects were given a weighting factor of just 1.12. With the weights applied, no significant differences were found in any of the analyses, suggesting this potential bias of results towards non NZE subjects had been accounted for.

Once the data had been checked, descriptive statistics were presented to describe the characteristics of the study sample and the intervention being researched. This included statistics on the demographics and the mental health status of the sample together with information on the intervention such as rate of completion, number and type of sessions and the sources and reasons for referral.

The data set was then subjected to the two main analyses: first, to investigate the effect of treatment (ADC) on the subjects’ mental health, and second, to explore the characteristics of subjects that were associated with completion of treatment and successful treatment.

**Treatment outcome analyses**

To investigate the effect of treatment (ADC) on subjects' mental health a series of repeated measures analyses of variance (RM-ANOVA) were carried out. Changes in treatment outcome were analysed across three time points: before, immediately after and six months following treatment. For the treatment outcome variable of total problem behaviour (TOTPB) between subject factors of gender, ethnicity and region were also assessed using two way repeated measures ANOVAs. All individual results were subjected to Mauchly’s test of Sphericity (SPSS, 1997) and in cases where the assumption of sphericity had not been violated the univariate averaged F-test of the repeated measures ANOVA was used. This test was chosen rather than the multivariate F-test in order to maximise the power of the analysis. If the assumption of sphericity was violated then the degrees of freedom were adjusted accordingly and the more conservative Greenhouse Geisser test results were used (Field, 2000).

Where significant main effects were found pair-wise comparisons were carried out using the SPSS GLM repeated measures options. Comparisons were made between pre- and post-test, and follow-up results using the Bonferroni correction method, as recommended by Field (2000).
Consideration was given to running a multivariate analysis of variance (MANOVA) to assess the effect of treatment on all treatment outcome variables in conjunction. However, this was decided against because of the varying levels of missing data across the different dependent variables. Significant main effects may have been hidden because of reduced power as a result of lower response rates for some variables. Rothman (1986) also recommended avoiding the use of MANOVA when variables are not necessarily expected to change to the same extent (e.g., internalising and externalising sub-scales of YSR checklist), and/or when variables are related (e.g., subscales of total problem behaviour with internalising and externalising behaviour sub-scales of YSR checklist).

Test for ‘practical’ and ‘clinical’ significance were also applied to the YSR and CBCL results. Practical significance is a measure of the magnitude of change, and is usually assessed through the calculation of an ‘effect size’. Clinical significance is a measure of clinical change. In this study a ‘test of equivalency’ (see Kendall et al., 1999) was applied to the ADC data, to determine if, after treatment, the ADC groups’ level of functioning could be considered to fall within a normative range.

With the counsellors’ rating of global functioning (CGAS) only two measures were taken: pre- and post-treatment. Therefore, a paired sample t-test was used with this variable. The alcohol and drug consumption data were found to be positively skewed and containing several extreme scores. This is not unusual with this type of data (Greenfield, Midanik & Rogers, 2000; Spooner et al., 1999). The data were subjected to several transformations with log 10 producing improved results, but still not satisfactory, with some distributions remaining significantly different to normal (Kolmogorov-Smirnov > 0.05). Further, when the variable distributions for ‘average alcohol quantity’ and ‘cannabis frequency of use’, were examined across time it became evident that their shape was changing from nearly normal to positively skewed to a ‘U’ shape, with extreme values still present. Interpretation of results using mean scores (log 10, inverted log or even raw data) seemed to misrepresent the changes that were occurring in the data set. Therefore, it was decided that distribution-free non-parametric statistics would be more appropriate for this data, with a Friedman ANOVA carried out followed by Wilcoxon Matched Pairs Signed Rank Test where significant differences were found. Data were also coded into frequencies of different levels of consumption for presentation purposes.
Analyses for predicting treatment outcome

The second set of analyses explored the characteristics of subjects that might be associated with completion of treatment and successful treatment outcome.

Discriminant functional analysis (DFA) was used to investigate if it was possible to identify variables that significantly predicted completion of the ADC programme. Subjects were divided into one of two groups depending on whether they completed the programme (C) or terminated early (TE). Predictor variables (independent variables) considered included individual client characteristics such as age, gender, number and severity of problem behaviours, age of onset, physical health, criminal behaviour, and contextual variables such as family functioning, living situation, status of school attendance, gang involvement, parental history of antisocial behaviour and/or mental health issues, family social economic status, and number of previous interventions. These variables had been previously identified as being related to treatment completion and positive outcome in adolescent treatment programmes (Catalano, 1990; Crisp, 1996; Fongay & Target, 1994; Kazdin, Bass et al., 1990; Kazdin, 1997b; Swardi, 1992). A comparative analysis was then performed to compare the two groups on the above independent variables. Differences between the two groups for variables that were categorical were determined using Pearson’s Chi-square and differences in continuous variables were analysed using two tailed t-tests for independent means.

The final selection of predictor variables to be entered into the DFA analysis were those found by the comparative analysis as being most likely to have possible predictive power, together with consideration of low correlations with other predictor variables and reliability of the sources of measurement. Data and variables were examined for any conflicts with the assumptions of DFA, multivariate normality, outliers, homogeneity of variance-covariance, linearity, multicollinearity and singularity.

A direct DFA was conducted which enters all the predictor variables into the analysis simultaneously. A linear combination of the independent variables is formed and serves as the basis for assigning cases to groups. For classification, group sizes were used to estimate prior probabilities of group membership.

The final set of analyses performed were standard multiple regression analyses to explore factors that might predict greater gains in treatment outcome. There were several possible measures of treatment outcome but for the purposes of this analysis
youth reports (YSR) of total problem behaviour was selected, as it provided a measure of change in a young persons’ overall perceived dysfunction (which was the aim of the counselling programme); it also had a high response rate as well as good reliability and validity.

Two treatment outcome scores were created: ‘treatment outcome one’ (TO1) was the change in total problem behaviour at the end of the programme compared to the start; ‘treatment outcome two’ (TO2) was the change in total problem behaviour six-months following the programme compared to the start. Both measures were divided by the pre-programme standard deviation of total problem behaviour to create standardised z-scores.

Factors to be considered as independent variables were similar to those used with the DFA analysis with the addition of some treatment/counsellor variables which had been found in the literature to influence treatment outcome (Crisp, 1996; Kazdin, Bass et al., 1990; Kazdin, 1997b; Kazdin & Wassell, 2000; Latimer et al., 2000). Tabachnick and Fidell (1989) suggest the minimum number of cases per variables should be five, which meant with sample size of 42 for this analysis, a set of no more than eight variables could be included in the analysis. The variables to be entered into the analysis were selected based on the correlation coefficients of each of the variables with the dependent variables of TO1 and TO2, together with consideration of the quality of the data available (validity, reliability and missing data).

Data and variables to be included in the multiple regression analysis were examined for any conflicts with the assumptions. This included screening for univariate and multivariate outliers, multicollinearity and singularity. Following the analysis a normal plot of the standardised residuals was checked to assess normality; scatter plots of the standardised residuals against standardised predicted residuals assessed threats to linearity and homoscedasticity; and a scatter plot of standardised residuals against the individual cases checked for independence of residuals.
CHAPTER FIVE:
QUANTITATIVE RESULTS AND DISCUSSION

In this chapter, three sets of results are presented based on analyses of data collected in the quantitative phase (Part II) of this thesis. The first section (5.1) is a descriptive analysis of the ADC programme and its clients, providing information on the research sample and intervention. The second section (5.2) presents the results of the evaluation into the effectiveness of the ADC programme. The last section (5.3) displays the results of the investigation according to factors that predict level of treatment outcome and programme retention. The discussion of these results is left until the final section of this chapter (5.4).

5.1 Descriptive Analysis of the ADC Programme and its Clients

In this section the characteristics of ADC clients and the ADC programme are described. Such information has two purposes. First it provides important descriptive data in terms of the research methodology, i.e., describing the research sample and the research intervention. Second, in terms of further ADC programme development, it provides more detailed information than has previously been available on who the clients are, what happens to them, and specific details of the treatment received.

5.1.1 Demographic Information

The research sample consisted of all clients referred onto the ADC programme between July 1999 and December 2000, across all three south island regions (Southland, Otago and Canterbury). Data collection covered three programme intakes in each region, together with a six month follow-up period. Over this period a total of 89 clients were referred onto the programme and were included in the study. Table 6 presents demographic information on clients who participated in the research study. The age range was 12-18 years, with a mean age of 14 and a half years. The majority were New Zealand European males who were enrolled at school (although at the time of referral many clients were subject to disciplinary action and at risk of expulsion). The proportion of Māori (15-19yrs) residing in the South Island is estimated at 10.3 percent (Statistics New Zealand, 2001). Therefore, as with other health services, Māori are over-represented in the ADC programme at 22.5 percent. Nearly 50 percent of the ADC clients lived with a single parent, around six percent lived with caregivers
that were not family members and a further five percent were flatting or living with a sibling. Living situations generally were very unstable, with 30 percent of the clients living in a different situation by the end of the programme.

Clients that had been living with the same adult caregiver(s) for at least six months, were, together with their caregivers, asked to report on their perception of family functioning (BFAM, Skinner et al., 1995). The BFAM provides a score of family functioning from 0-42 which is then converted into a T-Score. T-Scores of 50 reflect ‘average’ family functioning with higher scores representing increasingly problematic family functioning. The average T-score for the ADC youth was 56.8 (SD=10.8) and for their parents 58.5 (SD=12.1). The BFAM manual (Skinner et al., 1995) interpreted these scores in the range of “more than average number of family difficulties”, with 75 percent of a normative group of respondents scoring below this (fewer family difficulties).

Table 6.
Demographic information on ADC clients accepted on to the ADC programme.

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>61</td>
<td>68.5</td>
</tr>
<tr>
<td>Female</td>
<td>28</td>
<td>31.5</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NZ European</td>
<td>64</td>
<td>71.9</td>
</tr>
<tr>
<td>Māori</td>
<td>20</td>
<td>22.5</td>
</tr>
<tr>
<td>Pacific Island</td>
<td>3</td>
<td>3.4</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>2.2</td>
</tr>
<tr>
<td><strong>Living Situation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two caregivers (family)</td>
<td>36</td>
<td>40.5</td>
</tr>
<tr>
<td>Single caregiver (family)</td>
<td>44</td>
<td>49.4</td>
</tr>
<tr>
<td>Caregivers (non family)</td>
<td>5</td>
<td>5.6</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>4.5</td>
</tr>
<tr>
<td><strong>Attending School</strong></td>
<td>73</td>
<td>82.0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>89</td>
<td>100.00</td>
</tr>
</tbody>
</table>

*Ethnicity was based on clients' and their families' own classification
5.1.2 Referral Information

Table 7 below gives a breakdown of the sources of referrals for ADC clients who participated in this study. The majority of referrals to the programme came from schools, either through senior staff or the guidance counsellor (57%). The remaining referrals came from a range of sources including self, and family, other government agencies, and non-government community agencies.

Table 7.
Sources of referrals for ADC programme.

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>School</td>
<td>51</td>
<td>57.3</td>
</tr>
<tr>
<td>Parent</td>
<td>8</td>
<td>9.0</td>
</tr>
<tr>
<td>CAMHS &amp; YSS (Specialist MH)</td>
<td>8</td>
<td>9.0</td>
</tr>
<tr>
<td>Community agencies &amp; other</td>
<td>8</td>
<td>9.0</td>
</tr>
<tr>
<td>private mental health providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CYFs (Social Services)</td>
<td>4</td>
<td>4.5</td>
</tr>
<tr>
<td>Self-referral by young person</td>
<td>3</td>
<td>3.4</td>
</tr>
<tr>
<td>GSE (internal referral)</td>
<td>3</td>
<td>3.4</td>
</tr>
<tr>
<td>Truancy Officer</td>
<td>2</td>
<td>2.2</td>
</tr>
<tr>
<td>Youth Aid Officer</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Workplace Chaplain</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>89</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Referral agents were asked to provide the reason for initiating the referral. The most frequent reason reported was concern over alcohol and drug misuse (27.5%) followed by problems at school (25.7%) and simply “behaviour” (unspecifed) (21.1%). Other reasons included problems at home (13.7%), violence (5.5%), mental health concerns (4.6%) and criminal offending (1.8%). Nearly a quarter of clients were referred for more than one reason. Unfortunately the available information has limited value as it tended to lack detail (‘behaviour’ could of course overlap with any of the other categories).

An alternative indicator of reason for referral or presenting problem is from the standardised YSR (Achenbach, 1991c). As described in section 4.1.5, the YSR produces a profile of eight sub-scales of syndromes of behaviour; the sub-scale with the highest elevation (greatest degree of severity) for each individual is referred to in
this research as the ‘target behaviour’. ‘Target behaviours’ were likely to be the behaviours of greatest concern to ADC counsellors, and hence the behaviour clients were likely to be focusing their efforts on. It therefore, indicates a likely reason for referral.

Table 8 below shows the sub-scales with the highest clinical elevation for the clients accepted onto the ADC programme. It reveals that delinquency (which includes drug and alcohol use), and aggressive behaviour, both externalising-type behaviours, were the most frequently occurring ‘target behaviours’. As a group the mean scores for ‘target behaviour’ were, according to the youths’ reports, 73.5 (SD=7.9). According to their parents’ reports, the mean score was 76.5 (SD=8.8). These scores indicate that as a group, ADC clients display more extreme symptoms than would be found in 98 percent of adolescents (T-score of over 70, based on North American normative sample Achenbach, 1991a, 1991c).

Table 8.

Presenting target behaviour (YSR) of all the clients accepted on the ADC programme.

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>External</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aggression</td>
<td>17</td>
<td>20.5</td>
</tr>
<tr>
<td>Delinquency (Incl. A&amp;D)</td>
<td>41</td>
<td>49.4</td>
</tr>
<tr>
<td>Internal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety/Depression</td>
<td>3</td>
<td>3.6</td>
</tr>
<tr>
<td>Somatic Complaints</td>
<td>3</td>
<td>3.6</td>
</tr>
<tr>
<td>Withdrawn</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Problems</td>
<td>4</td>
<td>4.8</td>
</tr>
<tr>
<td>Attention Problems</td>
<td>9</td>
<td>10.8</td>
</tr>
<tr>
<td>Thought Problems</td>
<td>4</td>
<td>4.8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>83</td>
<td>100</td>
</tr>
</tbody>
</table>

*Data were unavailable for nine clients, and three clients had two identified target behaviours (two sub-scales with equally high scores)

Most research provides information on DSM-IV diagnoses to describe the reason for referral of clients. While the YSR is not a diagnostic interview, the authors have reported the approximate relationships of the sub-scales to DSM-IV diagnosis
(Achenbach, 1991c). Delinquency and aggressive behaviour have been found to have an approximate relationship to conduct disorder and oppositional defiant disorder. Other approximate relationships published include: anxiety/depression as overanxious disorder, major depression and dysthyemia; somatic complaints as somatisation disorder; thought problems as schizotypal personality, psychotic disorders; withdrawn as avoidant disorder; and attention problems as attention deficit hyperactivity disorder.

5.1.3 Client Profile – Mental Health

Information was collected on several measures of mental health including parents’ (CBCL) and youths’ (YSR) self-reports of total problem behaviour, internalising and externalising behaviour, counsellor ratings of global functioning (CGAS) and measures of alcohol and drug consumption and patterns of use (K-SADS).

Total Problem, Internalising and Externalising Behaviour

Figures 1 and 2 present ADC clients’ total problem behaviour, internalising and externalising behaviour as reported by the ADC youth (YSR T-Scores) and their parents (CBCL T-Scores). The graphs also indicate the borderline clinical and clinical cut-off points based on a North American clinically referred sample (Achenbach, 1991a, 1991c). The authors of the YSR/CBCL derived the cut-off points from analysis of North American normative and clinically referred samples: t-scores falling between 60 and 63 are considered borderline-clinical, and those above 63 are considered clinical. Scores within this range represent the 82nd to the 90th percentile of the normative sample (Achenbach, 1991a, 1991c), i.e., scores above the clinical cut-off indicate more extreme symptoms than are found in 90 percent of adolescents in the general population.
Figure 1. Total problem behaviour, internalising and externalising behaviour reported by the ADC clients (n=81).

Figure 2. Total problem behaviour, internalising and externalising behaviour as reported by the parents (n=63) of the referred ADC clients.
From the graphs, which are based on youth and parent reports, ADC clients as a group would be considered either borderline or clinical on all measures, except for male youth reports of internalised behaviour which fell just below the borderline clinical cut-off point. Female ADC clients’ reported higher levels of problems compared to their male counterparts, scoring well above the 90th percentile in total problem behaviour and externalising behaviour. Both youth and parents reported higher levels of externalising behaviour than internalising behaviour. However, parents reports contradicted youth reports in terms of gender. Parents found male ADC clients to have higher levels of overall problem behaviour (Total, External and Internal) rather than the females, as reported by the youth. Parents scored their children above the 90th percentile on all measures, with total problem behaviour and externalising behaviour scoring well above the clinical cut-off.

Figure 3 presents the range of problems that ADC clients presented with, which the ADC programme must, therefore, address. The graph shows the percentage of clients that would be considered in the clinical range across the eight YSR sub-scales. Scores above the borderline clinical cut-off indicate more extreme symptoms than are found in 95 percent of adolescents (based on North American normative sample Achenbach, 1991c).

The most common presenting problems were externalising behaviours, with over 70 percent of the group being considered in the clinical range for delinquency and around 50 percent for aggressive behaviour and attention problems. Emotional disturbance as suggested by the anxiety/depression sub-scale was also, high with nearly 30 percent of the group being in the clinical range. The high proportion of clients across the eight sub-scales indicates the ADC programme needs to be capable of addressing a wide range of mental health problems.

An important mental health issue amongst New Zealand youth is depression and suicide. The YSR is not designed specifically to assess risk of suicide but there are two individual items on the YSR that ask the youth ‘how often do you think about killing yourself’ (item 91) and ‘how often do you deliberately try to hurt or kill yourself’ (item18). Fifty one ADC clients (41%) reported that ‘it is sometimes true’ that they think about killing themselves; while five clients (4%) reported they thought about it ‘all the time’. Thirty seven clients (30%) reported that sometimes they had deliberately tried to hurt of kill themselves, with one client reporting that this had happened ‘often’.
Figure 3. Percentage of ADC clients in the clinical range across the YSR sub-scales of problem behaviour.

NB: Clinical status based on T-scores published by YSR author (Achenbach, 1991c).
Counsellor Ratings of Global Functioning

These high levels of dysfunction reported by the youth and their parents are supported by the counsellors' average CGAS ratings of overall severity and disturbance. The average score given by the counsellors for the ADC clients, as a group, was 54.9 (SD=8.4) suggesting below-normal functioning (scores of 70 and above represent 'normal' functioning). This supports the clinical status of these clients, as indicated by the YSR and CBCL results. According to the scales' classification system, scores in this category represent 'variable functioning with sporadic difficulties or symptoms in several but not all social areas'.

Substance Use

During the assessment phase counsellors completed section five of the K-SADS semi-structured interview assessing whether clients accepted onto the programme met DSM-IV criteria for a substance use disorder. Table 9 shows that 56 percent of the ADC clients were judged by the counsellors as having met criteria for a substance use disorder (abuse or dependency). Of those, 15 (42%) met criteria for more than one substance.

Table 9.

Presence of DSM-IV substance use disorders for clients accepted on to the ADC programme.

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSM-IV Substance Use Disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependency</td>
<td>19</td>
<td>29.7</td>
</tr>
<tr>
<td>Abuse</td>
<td>17</td>
<td>26.6</td>
</tr>
<tr>
<td>Sub-Threshold</td>
<td>28</td>
<td>43.5</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>64</td>
<td>100</td>
</tr>
</tbody>
</table>

*Information was unavailable for 25 clients initially accepted onto the programme.

Information on drug and alcohol consumption was also collected by the counsellors from their clients at the start of the programme. Results appear in Table 10. Data were missing or incomplete for 20 clients (22.5%), either through
counsellors omitting to record specific quantities, type and frequency of substance use, or in some cases clients withdrawing before the information was collected.

Table 10.
Frequency of high levels of alcohol and cannabis consumption reported by clients to their counsellors.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Consumption</td>
<td></td>
<td></td>
</tr>
<tr>
<td>More than 5 std. drinks(^a) on a typical drinking occasion.</td>
<td>56</td>
<td>82.4(^b)</td>
</tr>
<tr>
<td>Frequency of drinking = at least once a week.</td>
<td>32</td>
<td>47.8(^b)</td>
</tr>
<tr>
<td>Cannabis Consumption</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency of using cannabis = weekly or more.</td>
<td>29</td>
<td>41.9(^b)</td>
</tr>
</tbody>
</table>

\(^a\) A 'standard drink' is a drink that contains 10 grams (12.7 ml) of alcohol
\(^b\) Information was unavailable for 21 clients initially accepted onto the programme.

The average quantity of alcohol consumed per drinking occasion was nine standard drinks, one to two times per week, although, some clients were drinking considerably more. Two reported that they would drink the equivalent of two 1125 ml bottles of low strength (23% alcohol) spirits over the course of a single afternoon/evening. On average the equivalent of one cannabis joint was smoked over three times a week. However, again, some clients (n=2) who were using cannabis up to six times per day.

Clients were also asked what other substance they had used or were currently using. Of those who disclosed information of this type (n=72), 43 percent reported having used other substances, and of those two thirds had experimented with more than one substance. Twenty nine percent of ADC clients had used solvents/inhalants (petrol, butane, paint, lighter fuel, glue, LPG or asthma inhaler) with one client meeting the criteria for dependency on solvents. Nineteen percent had used a type of stimulant (e.g., ritalin, speed, and/or cocaine). Eighteen percent reported using hallucinogens (e.g., LSD, ecstasy, fantasy, magic mushroom, and/or datura). One client reported using opium.

It is likely that the above results are an underestimation of actual levels of consumption, as indicated by retrospective data on consumption levels that was
collected at the end of the programme and at six-months follow-up. Of the nine clients who reported to their counsellors at the start of the programme that they were not currently drinking alcohol, retrospective data indicated that half (n=4) of these had actually been drinking regularly at the start of the programme. Similarly, 23 clients reported to their counsellor that they had not been using cannabis, but of those that completed the programme again over half reported retrospectively that they had been using cannabis. Possible reasons for these discrepancies will be discussed in section 5.4.

5.1.4 ADC Programme Characteristics.

ADC Counsellors

During the period of study data were collected by 11 counsellors across the three regions; but only six were still working with ADC at the end of the study period. This apparently high turnover was partly due to the impact of restructuring of the programme in one region. Eight were males and three were female, and all would identify as New Zealand European, with the exception of one, a recent arrival from North America. The age range was 34-47 years old (M=42, SD=4.3), and the number of years counselling experience ranged from 1-18 (M=8; SD=4.9).

Rate of Programme Completion

Of the 89 clients who were accepted on to the ADC programme during the period of research data collection, 54 completed the programme (61%) while 35 (39%) were considered not to have completed the full programme (see Table 11). For the purposes of the research, non-completion was considered to include clients voluntarily withdrawing, referral to another programme, moving out of the region, or the counsellor terminating the counselling.

Nearly 16 percent of clients withdrew voluntarily; some informed their counsellor they were withdrawing, while others simply stopped attending appointments. Three clients were judged as insufficiently motivated and their participation terminated by the counsellor (although these clients had the option of continuing counselling at a later date if they could demonstrate improved motivation). Seven of the clients finished counselling when they moved out of the area, while nine did not complete the programme because they had been referred to another service. These clients were usually referred to more specialised treatment such as a residential
drug and alcohol programme or treatment by Youth Speciality Services. Two clients started attending a new work experience course and opted not to continue with the programme. Many of the 35 clients classified as ‘not completing’ the programme had engaged in the counselling process to a certain degree, with an average of 12 sessions completed before terminating counselling or moving on.

Table 11.
Completion rate of clients accepted onto the ADC programme across all three regions, and reasons for early termination (July 1999 to September 2001).

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed ADC</td>
<td>54</td>
<td>60.1</td>
</tr>
<tr>
<td>Did not complete ADC&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client voluntary withdrawal</td>
<td>14</td>
<td>15.7</td>
</tr>
<tr>
<td>Referred on to another service</td>
<td>9</td>
<td>10.1</td>
</tr>
<tr>
<td>Moved out of region</td>
<td>7</td>
<td>7.9</td>
</tr>
<tr>
<td>Counsellor assigned withdrawal</td>
<td>3</td>
<td>3.4</td>
</tr>
<tr>
<td>Attending a new work experience course</td>
<td>2</td>
<td>2.2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>89</td>
<td>100.0</td>
</tr>
</tbody>
</table>

<sup>a</sup> Reasons given by ADC counsellors

Programme Content

The average length of time on an ADC programme for those who completed it to the satisfaction of their counsellors is six months (M=6.0; SD=1.88). The mean number of counselling sessions was 18.8. The nine-days wilderness residential component, the ‘Journey’, was in addition to this. Table 12 gives a breakdown of the number and type of counselling sessions received by the 54 clients who completed an ADC programme during the period of the study.

Over half the counselling sessions were recorded as ‘individual’, involving just the young person and the counsellor. A third were ‘family’ sessions, and the remainder were ‘Agency’ which referred to sessions which included meetings with referral agents or other relevant agencies.
Table 12.
Average number and type of ADC counselling sessions (n=54).

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean No. of Sessions</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of Sessions</td>
<td>18.8</td>
<td>5.6</td>
</tr>
<tr>
<td>Type of Sessions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>10.6</td>
<td>4.7</td>
</tr>
<tr>
<td>Family</td>
<td>5.8</td>
<td>3.6</td>
</tr>
<tr>
<td>Agency</td>
<td>2.4</td>
<td>2.0</td>
</tr>
<tr>
<td>Number of sessions prior to Journey</td>
<td>10.8</td>
<td>4.6</td>
</tr>
<tr>
<td>Number of sessions post Journey</td>
<td>8.0</td>
<td>4.0</td>
</tr>
</tbody>
</table>

In terms of the content of the ADC counselling sessions, information is available from two sources: individual treatment goals, and counsellor records of issues covered during the course of counselling.

Individual treatment goals

At the beginning of the programme ADC clients discussed with their counsellors the individual goals that they felt were important and were motivated to work on. Priority was given to what the client wanted to work on, and the goals set were not necessarily synonymous with the reason they were referred. On average four goals were set (M=4.3, SD=1.78), but in some cases as many as eight, or as few as one, were listed. Often new goals were added and redundant goals removed as treatment progressed. Table 13 gives an idea of the type of goals set by ADC clients. Data were collected from 44 clients who completed the ADC programme (83% response rate). Two counsellors (n=2) did not record goals in a sufficiently structured way to enable analysis.

Nearly 70 percent of the ADC clients had at least one goal related to reducing their use of substances. Most goals, especially those related to alcohol, were harm reduction goals rather than of abstinence, although some clients did set goals to give up cannabis completely. School-related goals were set by over 50 percent of the clients, with goals aiming to improve school behaviour, school academic work and relationships with teachers / authority. Another common goal for over half the ADC
clients was to gain control over anger. Just under half the clients had goals to improve their family situation. Most of these goals were about getting on better with their mother, or father or step parent, and a few related to siblings. Goals around relationships (29.5%) were about getting on with peers or in some cases getting on better with adults. Other goals listed below are self explanatory. Most of the goals set were short term goals related to the behaviours they needed to change ‘right now’ and towards which progress could be monitored. There were very few long term goals listed, such as career aspirations (n=3).

Table 13.
Content of individual treatment goals written by the ADC clients and their counsellors.

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>Percentage of ADC clients (n=44)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Reduce substance use</td>
<td>38</td>
<td>68.2 a</td>
</tr>
<tr>
<td>- Improve situation at school</td>
<td>31</td>
<td>52.3 a</td>
</tr>
<tr>
<td>- Gain control over anger</td>
<td>23</td>
<td>52.3</td>
</tr>
<tr>
<td>- Improve family situation</td>
<td>25</td>
<td>47.7 a</td>
</tr>
<tr>
<td>- Improve interpersonal skills / relationships</td>
<td>13</td>
<td>29.5</td>
</tr>
<tr>
<td>- Increase confidence / self-esteem</td>
<td>9</td>
<td>20.5</td>
</tr>
<tr>
<td>- Stop crime</td>
<td>8</td>
<td>18.2</td>
</tr>
<tr>
<td>- Become straight / honest</td>
<td>8</td>
<td>18.2</td>
</tr>
<tr>
<td>- Improve attitude (more positive)</td>
<td>6</td>
<td>13.6</td>
</tr>
<tr>
<td>- Become assertive (saying no, standing up for self)</td>
<td>5</td>
<td>11.4</td>
</tr>
<tr>
<td>- Stop violence / bullying</td>
<td>5</td>
<td>11.4</td>
</tr>
<tr>
<td>- Other (grief/mood mgmt (3), changing associates (3), career/work (3), insomnia (2), new interests (2), health (2), creativeness (1), stay on programme (1))</td>
<td>17</td>
<td>-</td>
</tr>
</tbody>
</table>

* Some clients set more than one goal under a specific category. For example, eight clients had more than one substance use goal (e.g., alcohol, cannabis and/or tobacco), eight clients had more than one goal related to school (e.g., behaviour, academic work, and/or relationships with teachers) and four clients had more than one goal related to family relationships (e.g., mother, step parent and/or sibling).
Counsellor record of issues covered

The ADC counsellors keep a record of the issues covered during the course of the programme. Table 14 displays the data recorded by the counsellors, and indicates the typical frequency with which the different issues were covered (Mossman, 2003). The most common issues covered over the course of the programme were substance use, poor relationships with parents, problems with self-control and anger, and problems at school such as truancy and poor relationships with teachers. This is consistent with the individual goals set by the youth, and the wide range of presenting problems displayed in Figure 3. On average, a counsellor worked with the young person on 12 of these issues displayed in Table 14, (M=12.1, SD=4.7), supporting the earlier observation that the ADC clients arrive with and require assistance with multiple problems.
### Table 14.

**Issues covered in counselling as recorded by ADC counsellors**

<table>
<thead>
<tr>
<th>Focal Issues</th>
<th>Number of Participants</th>
<th>Percentage of Group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In relation to self</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anger</td>
<td>23</td>
<td>64</td>
</tr>
<tr>
<td>Grief/Loss</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Self Concept/Self Esteem</td>
<td>15</td>
<td>42</td>
</tr>
<tr>
<td>Suicide - Attempt or Ideation</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Self control/Responsibility for Self</td>
<td>23</td>
<td>64</td>
</tr>
<tr>
<td>Weight/Shape</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Smoking addiction</td>
<td>12</td>
<td>33</td>
</tr>
<tr>
<td>Marijuana use</td>
<td>29</td>
<td>81</td>
</tr>
<tr>
<td>Alcohol</td>
<td>26</td>
<td>72</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td><strong>In relation to family</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parental mistrust</td>
<td>25</td>
<td>69</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>12</td>
<td>33</td>
</tr>
<tr>
<td>Parental separation</td>
<td>14</td>
<td>39</td>
</tr>
<tr>
<td>Separation from family</td>
<td>10</td>
<td>28</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Difficulties with siblings</td>
<td>9</td>
<td>25</td>
</tr>
<tr>
<td>Running Away</td>
<td>7</td>
<td>19</td>
</tr>
<tr>
<td><strong>In relation to peers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conflict, violence</td>
<td>12</td>
<td>33</td>
</tr>
<tr>
<td>Loneliness, few/no friends</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Social skills</td>
<td>9</td>
<td>25</td>
</tr>
<tr>
<td>Perpetrator of bullying, putdowns</td>
<td>10</td>
<td>28</td>
</tr>
<tr>
<td>Victim of bullying</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Unsafe sexual behaviour</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td><strong>In relation to society</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs dealing</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Stealing</td>
<td>11</td>
<td>31</td>
</tr>
<tr>
<td>Vandalism</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Gang involvement</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td><strong>In relation to school</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Truancy</td>
<td>20</td>
<td>56</td>
</tr>
<tr>
<td>Academic</td>
<td>19</td>
<td>53</td>
</tr>
<tr>
<td>Relationship problems with teachers</td>
<td>24</td>
<td>67</td>
</tr>
<tr>
<td>Suspensions</td>
<td>10</td>
<td>28</td>
</tr>
<tr>
<td>TOTAL</td>
<td>36</td>
<td>100</td>
</tr>
</tbody>
</table>

---

4 This data is taken from a recent ADC Evaluation Report (Mossman, 2003).
5.2 Evaluation of Treatment Outcome.

One of the primary aims of the research was to investigate whether clients who participated on the ADC programme exhibited an improvement in their mental health. To this end changes in the clients’ mental health was assessed via several treatment outcome variables prior to and after treatment, and then again six months later. Treatment outcome variables included the youths’ perception of their functioning (YSR) and, where available, parents’ perception (CBCL), counsellors reports on global functioning (CGAS), data on family functioning (BFAM), drug and alcohol consumption, and progress on individual treatment goals. This section presents the results of a series of repeated measures ANOVAs and subsequent post-hoc analyses to determine what changes occurred following participation on the ADC programme. A summary of the findings in relation to all these treatment outcome variables appears in Table 19 at the end of this section.

5.2.1 Youth (YSR) and Parents’ (CBCL) Reports of Behaviour Change

Repeated measures ANOVAs were carried out on the YSR and CBCL variables of total problem behaviour, and internalising and externalising behaviour to test for differences across the three occasions of testing. Complete sets of data (pre-, post- and follow-up) were available for 42 clients, and from 23 of their parents. The smaller amount of completed parent data is indicative of the instability of the clients’ living situations. To complete the CBCL in a valid and reliable way parents needed to have been living with the young person in a stable situation for several months. However, in 30 percent of cases (n=16) the young person was in a different living situation (living with a different parent, caregiver or in some cases independently) at the time of follow-up. In these situations, valid parent (CBCL) data could not be collected. In a further three cases parents failed to return forms.

Two clients had partial data missing (one had an incomplete YSR pre test and one an incomplete follow-up YSR). It was decided with the small sample available for analysis that it would be preferable to replace the two missing values rather than discard the remaining data that had been collected; a conservative method of replacing values with relevant group means was used, as described by Tabachnick and Fidell (1989). Subsequent analyses were subjected to sensitivity analysis with tests repeated with and without the replaced values. No differences were found in main effects reported.
The data were checked for violations of assumptions for repeated measures ANOVA using the guidelines described by Tabachnick and Fidell (1989) and Stevens (1999). This included checking for within cell outliers, equal sample sizes, normality, homogeneity of variance and sphericity, with no violations found.

Figures 4 and 5 display the changes in total problem behaviour, and internalising and externalising behaviour following participation on the ADC programme as reported by the youth and their parents. All three treatment outcome variables show a decline from pre- to post-test with a further decline from post-test to follow-up. These declines in scores represent improvements in mental health. The groups’ T-scores for total problem behaviour and externalising behaviour move from what was considered clinical, to non-clinical. Internalising behaviour T-scores moved from borderline clinical to non-clinical. According to the scales’ norms, this suggests clinically significant improvements (Achenbach, 1991a, 1991c). The results of the repeated measures ANOVA appear in Table 15 and Table 16. Results indicate that these improvements following participation on the ADC programme were also highly statistically significant.

**Youth report (YSR)**

According to the youths’ self-reports, their total problem behaviour improved following participation on the ADC programme $F(2,82)=56.8$, $p<0.001$. Total problem behaviour was reduced from a mean of 65.7 (SD=10.2) at pre- treatment to a mean of 56.4 (SD=10.5) following treatment. Post hoc pair-wise comparisons (with Bonferonni adjustment) found this to be a significant improvement ($p<0.001$). There was a further significant improvement from post-test to follow-up ($M=52.9$, $SD=9.2$, $p<0.01$).
Figure 4. Youth self-report problem behaviour (YSR) following participation on the ADC programme (n=42).

Figure 5. Parent self-report problem behaviour (CBCL) following participation on the ADC programme (n=23).

NB: High scores represent greater dysfunction
Table 15.
Repeated measures ANOVA on YSR Total Problem, Internalising and Externalising
Behaviour over time.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean (Std. Dev)</th>
<th>df</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Problem Behaviour</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>65.7 (10.2)</td>
<td></td>
<td>56.8</td>
<td>.000</td>
</tr>
<tr>
<td>Post</td>
<td>56.4 (10.5)</td>
<td>(2,82)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up</td>
<td>52.9 (9.2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internalising Behaviour</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>61.8 (9.9)</td>
<td></td>
<td>41.7</td>
<td>.000</td>
</tr>
<tr>
<td>Post</td>
<td>52.3 (10.8)</td>
<td>(2,82)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up</td>
<td>48.4 (8.8)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Externalising Behaviour</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>68.2 (9.8)</td>
<td></td>
<td>49.8</td>
<td>.000</td>
</tr>
<tr>
<td>Post</td>
<td>59.9 (9.8)</td>
<td>(2,82)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up</td>
<td>57.4 (8.4)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 16.
Repeated measures ANOVA on CBCL Total Problem, Internalising and Externalising
Behaviour over time.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean (Std. Dev)</th>
<th>df</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Problem Behaviour</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>66.2 (9.1)</td>
<td></td>
<td>23.6</td>
<td>.000</td>
</tr>
<tr>
<td>Post</td>
<td>59.6 (10.0)</td>
<td>(2,44)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up</td>
<td>54.3 (12.8)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internalising Behaviour</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>62.7 (12.3)</td>
<td></td>
<td>16.5</td>
<td>.000</td>
</tr>
<tr>
<td>Post</td>
<td>56.5 (11.1)</td>
<td>(2,44)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up</td>
<td>51.5 (12.0)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Externalising Behaviour</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>67.4 (7.6)</td>
<td></td>
<td>17.5</td>
<td>.000</td>
</tr>
<tr>
<td>Post</td>
<td>60.7 (10.2)</td>
<td>(2,44)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up</td>
<td>57.3 (11.5)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The youth also reported significant improvements in internalising behaviour $F(2,82)=41.7$, $p<0.001$, and externalising behaviour $F(2,82)=49.8$, $p<0.001$ following participation on the ADC programme. Internalising behaviour was reduced from a mean of 61.8 (SD=9.9) at pre-treatment to a mean of 52.3 (SD=10.8) following treatment, post hoc pair-wise comparisons (with Bonferroni adjustment) found this also to be a significant improvement ($p<0.001$). There was a further significant improvement from post-test to follow-up ($M=48.4$, SD=8.8, $p<0.01$). Externalising behaviour was reduced from a mean of 68.2 (SD=9.8) at pre treatment to a mean of 59.9 (SD=9.8) following treatment, with post hoc pair-wise comparisons (with Bonferroni adjustment) similarly indicating this to be a significant improvement ($p<0.001$). There was a further improvement from post-test to follow-up ($M=57.4$, SD=8.4) but this was not significant ($p=0.150$).

**Effects on youth report by gender and ethnicity**

The between-subject characteristics of gender and ethnicity were also examined. A two-way repeated measures ANOVA (time X gender) was performed on the youths' reports of total problem behaviour. There was no significant difference for the main effect of gender $F(40,1)=.55$, $p>0.05$, or for the interaction of gender with time $F(80,2)=1.02$, $p>0.05$. A two-way repeated measures ANOVA (time X ethnicity) was performed on the youths' reports of total problem behaviour. The ethnicity classification was whether the youth identified themselves as New Zealand European or non New Zealand European, (10 identified themselves as Māori and one was from Thailand). There were no significant difference for the main effect of ethnicity $F(40,1)=.46$, $p>0.05$, or for the interaction of ethnicity with time $F(80,2)=.13$, $p>0.05$.

**Parent report (CBCL)**

Parents' reports also showed total problem behaviour improved significantly following participation on the ADC programme $F(2,44)=23.6$, $p<0.001$. Total problem behaviour was reduced from a mean of 66.2 (SD=9.1) at pre-treatment to a mean of 59.6 (SD=10.0) following treatment; post hoc pair-wise comparisons (with Bonferroni adjustment) found this to be a significant improvement ($p<0.001$). There was a further improvement from post-test to follow-up ($M=54.4$, SD=12.8) but this was just outside the significant level ($p=0.051$).
Parents reported significant improvements in internalising behaviour $F(2,44)=16.5$, $p<0.001$, and externalising behaviour $F(2,44)=17.5$, $p<0.001$, following participation on the ADC programme. Internalising behaviour was reduced from a mean of 62.7 (SD=12.3) at pre-treatment to a mean of 56.5 (SD=11.1) following treatment; post hoc pair-wise comparisons (with Bonferonni adjustment) found this to be a significant improvement ($p<0.01$). There was a further improvement from post-test to follow-up (M=51.5, SD=12.0) but this was again just outside the level of significance ($p=0.079$). Externalising behaviour was reduced from a mean of 67.4 (SD=7.6) at pre-treatment to a mean of 60.7 (SD=10.2) following treatment; post hoc pair-wise comparisons (with Bonferonni adjustment) found this to be a significant improvement ($p<0.001$). There was a further improvement from post-test to follow-up (M=57.3, SD=11.5) but this was not significant ($p=0.306$).

**Practical and Clinical Significance**

The results above focus mainly on ‘statistically’ significant results. In the field of counselling and therapy it is also, and perhaps more important, to consider the ‘practical’, and ‘clinical’, significance of the results (Thompson, 2002).

The practical significance, otherwise known as the ‘effect size’, is a standardised measure of the difference in treatment outcome as a result of the intervention. When there is a comparison group the effect size is calculated by subtracting the mean of the experimental group from mean of the control group. However, for a repeated measures design without a control group (such as this one), the effect size is calculated by subtracting the post-treatment score from the pre-treatment score and dividing by the population standard deviation$^5$ (based on published population standard deviation for clinically-referred sample, Achenbach, 1991a, 1991c).

Effect sizes were calculated for total problem behaviour. According to youth reports the effect size was 0.8 for post-programme outcomes, increasing to 1.1 at follow-up. For the parents the effect size post-programme was 0.7, which increased to 1.2 at follow-up. According to Cohen’s (1988) ratings (see section 2.2.2), these would be considered large effect sizes.

---

$^5$ It should be noted that same group repeated measures calculations of effect size are based on intraparticipant variance, which is not comparable to conventional variance statistics, and thus do not appear to warrant equal weighting with studies that include independent treatment and control groups (Weisz, Weiss et al., 1995).
In terms of clinical significance, Thompson (2002) suggested the ultimate standard is whether the treated individuals as a group are indistinguishable from a normal population. According to youth reports of total problem behaviour (YSR) the percentage of the group who would be considered in or above the clinical range went from 76 percent pre-programme, to 44 percent post-programme, with just 24 percent being considered in the clinical range at follow-up (Achenbach, 1991c). Kendall and colleagues have recently promoted a test of equivalency to determine statistically if, after treatment, a group's level of functioning falls within a normal range (Kendall et al., 1999). Using this test on the measures of total problem behaviour reported by the youth, the ADC clients were clinically equivalent to a normal sample (Achenbach, 1991c) on total problem behaviour post-programme and follow-up (p<0.025 and p<0.0005, respectively). Parents' reports also suggested clinical equivalency to a normative sample (Achenbach, 1991a) but just at follow-up (p<0.005). Kendall and colleagues further recommended calculating a traditional t-test to determine if there was a statistically significant difference between the normative samples and the treatment group (ADC Clients). In this case ADC clients were considered statistically significantly different (p<0.05) to the normative samples. When this discrepancy occurs (clinically equivalent, but t-test showing statistically significant difference) it is suggested as likely to reflect a sample size being large enough to produce statistically significant results, but the size of this difference likely to be clinically meaningless.

**Academic Performance**

Only 50 percent (n=26) of ADC clients were attending school over the entire duration of the research data collection period. Clients may have been temporarily or permanently suspended, may have opted for alternative education schemes or have left school at the end of Year 11 to find work. YSR data on academic performance were collected for eighteen clients (70% of those attending school). The youth were asked to list the subjects they were taking and to rate whether they were failing (0), below average (1), average (2), or above average (3). Self-report data from these clients indicated that their academic performance improved from the start of the programme (M=1.6, SD=0.6) to the end of the programme (M=1.8, SD=0.6) with a further improvement at follow-up (M=2.1, SD=0.5). Repeated measures ANOVA found these improvements to be statistically significant F(34,2)=6.59, p<0.01. Post
hoc pairwise comparisons (with bonferonni adjustment) found there to be a significant improvement from the start of the programme to the re-assessment at six-month follow-up (p<0.001). Improvements from pre to post-programme did not reach statistical significance (p=.526, p>0.05). It should be noted these results although indicating positive outcomes in terms of academic performance as perceived by the youth, relate only to a small proportion of the ADC clients and should be interpreted with caution.

5.2.2 Counsellors’ Ratings of Global Functioning (CGAS)

Counsellors rated client global assessment of functioning (CGAS) at the start of treatment and at the end. Data were collected on 39 clients who completed the ADC programme (73.6% response rate). Figure 6 shows the mean CGAS ratings pre- and post-treatment. Counsellors rated their clients on the CGAS scale as having improved from a pre treatment mean of 54.0 (SD=7.9) to a post-treatment score of 67.4 (SD=9.1), an average improvement of over 10 points (lower scores represent greater dysfunction). A paired-sample t-test found this difference to be a statistically significant (t=8.74, df=38, p<0.001).

![Figure 6. Counsellors’ ratings of impairment (CGAS) following participation on the ADC programme (n=39).](image)

According to the scales’ classification system, this shift indicates an improvement in functioning from ‘variable functioning with sporadic difficulties or symptoms in several but not all social areas’ to ‘some difficulty in a single area, but
generally functioning pretty well'. This is still, however, below the score of 70 which was originally described by the authors as 'normal' functioning (Shaffer, et al., 1983). Other researchers have suggested a cut-off of 61 might better discriminate clinical from non-clinical status (Bird et al., 1990). This would then indicate an improvement in functioning from clinical to non-clinical, as seen with the YSR and CBCL scores.

5.2.3 Family Functioning (BFAM)

A measure of family functioning (BFAM) was primarily collected as an independent variable that might help explain variance in treatment outcome. However, it was also of interest as a treatment outcome variable, as ADC clients on average received six sessions of family therapy during the course of their treatment. Where possible the BFAM was collected from the youth (n=33) and their parents (n=19) before, after, and six months following, treatment. As with the CBCL there were problems in collecting complete sets of data. Only two thirds of the clients were living in the same family environment over the period of data collection and therefore able to complete three sets of BFAM forms. Hence the results relate to change in family functioning only for clients who were in stable family situations. They exclude young persons who moved from one parent to then live with the other, those that moved from their family to live with a caregiver, or those that returned to live with their family. Figure 7 shows the changes in family functioning as reported by the youth and their parents (low scores represent good functioning).

The graph indicates that both the youth and their parents reported improvements in mean T-Scores of family functioning, from the beginning to the end of treatment. The youths’ reports remained fairly stable at follow-up but the parents’ scores returned almost to baseline levels. Repeated measures AVOVAs showed the youths’ perception of family functioning improved significantly over time F(64,2)=12.7, p<0.001. At the start of treatment youth rated their family functioning with a mean score of 57.8 (SD=10.8) which improved to a mean of 52.3 (SD=9.6). Pair wise post-hoc comparisons (Bonferroni adjusted) found this to be a statistically significant difference (p<0.01). At follow-up the youth rated their family functioning as 51.9 (SD=9.6); this small improvement was not significant (p=1.00). The parents’ perceptions also changed significantly over time F(36,2)=4.46, p<0.05. The improvement from pre-treatment (M=57.4, SD=12.9) to post-treatment to (M=51.9, SD=12.0) was significant (p<0.050), but the difference between pre-test and follow-
up (M=56.1, SD=15.2) after regression back to near pre-test levels was not a statistically significant difference (p=0.118). It should be noted that T-scores of 50 represent average family functioning according to the scales’ norms and hence scores from the ADC parents and youth were clinically not very different from what represents typical family functioning.

![Graph showing family functioning over time](image)

Figure 7. Self-reported family functioning (BFAM) following participation on the ADC programme.

### 5.2.4 Drug and Alcohol Data

**Drug and Alcohol Consumption Data**

Drug and alcohol consumption was a key treatment outcome variable. The selection criteria for the ADC programme require the youth to have or be at risk of developing a significant drug/alcohol use problem or any other significant mental health disorder and be exhibiting behaviour that is affecting expected social and/or academic development. Drug/alcohol use problems were the most frequent reason for referral, and of the clients accepted onto the ADC programme during the period of study over half (56.3%) were classified as meeting DSM-IV criteria for a substance use disorder (Kaufman et al., 1997). For the purpose of assessing treatment outcome two measures of substance use were selected. For alcohol, ‘average quantity consumed on a typical drinking occasion’ was chosen, and for cannabis use ‘average frequency of use’ was selected. This latter measure was chosen because collecting accurate measures of quantity of cannabis used was complicated by people sharing
joints, non-standardised measures of joints, and variations in mode of use (e.g., from smoking joints to using cones in pipes or inhaling via spotting, etc.).

This data was collected by counsellors at the start of the programme and on completion and by the researcher at follow-up, and is referred to as 'current use reporting'. At follow-up clients were also asked to report retrospectively on their pre- and post-programme consumption levels; this is referred to as 'retrospective reporting'. Collection of current use reports, resulted in 37 complete sets of data (pre-, post- and follow-up), whilst collection of retrospective reports resulted in only 26 complete sets. The lower number of complete sets of retrospective data was due to clients not always being able to remember, at follow-up, their levels of consumption (pre- or post-programme). Further, those who returned their data via post were not asked retrospective information as this issue was thought to be too complicated to explain via written format.

As discussed in section 4.1.8, the distribution of the substance use data failed to meet the assumptions of normal distribution required for parametric statistical analysis. Therefore, distribution-free, non parametric statistical analyses were conducted. A Friedman ANOVA was carried out, followed by the Wilcoxon Matched Pairs Signed Rank Test where significant differences were found. Results were complicated by discrepancies between current use measures and retrospective reports of pre- and post-programme consumption, raising questions on the validity of the different self-report measures. Results using both current use reports and retrospective reports are presented in Table 17, and the discrepancies discussed in more detail in section 5.4.

The Friedman ANOVA assigns ranks for each individual based on the relative quantities of alcohol reported and frequency of use of cannabis across the three testing occasions with the lowest quantities/frequencies scoring one and the highest scoring three. Results, therefore, indicate relative changes in use (reported increases or decreases) following participation on the ADC programme, but do not provide information on the magnitude of changes. The mean ranks for substance use appear in Table 17, while the results for the Friedman ANOVA and Wilcoxon Matched Pairs appear in Table A3 in the Appendix F.
Table 17.
Mean ranks of substance use consumption following participation on the ADC programme.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean Rank Current Use Reporting</th>
<th>Mean Rank Retrospective Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n=37)</td>
<td>(n=26)</td>
</tr>
<tr>
<td>Average Quantity of Alcohol Consumed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>2.0</td>
<td>2.5</td>
</tr>
<tr>
<td>Post</td>
<td>1.7</td>
<td>1.4</td>
</tr>
<tr>
<td>Follow-up</td>
<td>2.3&lt;sup&gt;a&lt;/sup&gt;</td>
<td>2.1&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Average Frequency of Cannabis Use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>2.2</td>
<td>2.7</td>
</tr>
<tr>
<td>Post</td>
<td>1.7</td>
<td>1.5</td>
</tr>
<tr>
<td>Follow-up</td>
<td>2.1&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1.8&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>a</sup>Differences in follow-up rankings are due to differences in total n available for each calculation. There were fewer complete sets of retrospective data available, n=26 compared to n=37 for current use reporting.

Results in Table 17 show a similar trend for both alcohol and cannabis consumption: a decline in consumption from pre-programme to post-programme followed by an increase in consumption at follow-up. These changes across the three time points were all statistically significant (p<0.05) according to the Friedman ANOVA results.

When the current use reports of average quantities of alcohol consumed or average frequency of cannabis use were analysed, the Wilcoxon Matched Pairs tests found no significant difference between the pre-programme and follow-up reported levels of consumption (p>0.05), suggesting programme effects had not been maintained. However, with retrospective reporting, while there was an increase from post-programme to follow-up, the follow-up levels of consumption for alcohol and cannabis remained significantly lower than the pre-programme levels (p<0.01 and p<0.0001 respectively). Therefore, if reports of current use are used, the ADC programme effects on substance use are not maintained six months following the programme. But if retrospective reports are used, it suggests the ADC programme appears effective in lowering levels of substance use and maintaining levels of consumption lower than pre-programme levels at six months following the programme.
To gain an idea on actual levels of consumption of alcohol and cannabis, Table 18 presents the change in proportion of ADC clients that was using these substances at high and low levels (again using both *current use* and *retrospective reports* of consumption).

| Percentage of ADC clients using alcohol and cannabis at high and low levels. |
|-----------------------------------------------|-----------------------------------------------|
| Percentage of ADC Clients – Concurrent Use Reporting (n=37) | Percentage of ADC Clients - Retrospective Reporting of Pre-Programme Consumption (n=26-27) |
| Pre | Post | F-Up | Pre | Post | F-Up |
| Alcohol |
| Non-drinkers | 16.2% | 24.3% | 27.1% | 11.5% | 30.8% | 30.8% |
| Drinking > 5 std. drinks | 67.5% | 43.5% | 59.4% | 84.6% | 31.0% | 53.7% |
| Cannabis |
| Non Users | 40.5% | 64.9% | 51.4% | 20.7% | 65.5% | 58.6% |
| Using > than once a week | 27.0% | 5.4% | 21.6% | 72.4% | 3.5% | 20.7% |

This frequency data shows a similar pattern of results to the rank order data: all patterns of consumption improved from pre- to post-programme, but with some relapse occurring at six-months follow-up. This data also indicate that the ADC programme had greatest success with reducing use of cannabis. At six-months follow-up, only 21 percent of clients reported using cannabis more than once a week, compared to retrospective pre-programme reports of over 70 percent. However, with alcohol at follow-up nearly half the clients still reported drinking more than 10 standard drinks on average during a typical drinking occasion, although this was down from nearly 85 percent at pre-programme (again based on retrospective reports). As with the signed ranks results, the *retrospective reports* indicated much higher pre-programme levels, and hence more positive outcomes post-programme and at follow-up.

**DSM-IV Substance Use Disorders**

Pre-, post- and follow-up DSM-IV substance use disorder information was collected using the K-SADS semi structured interview. Response rates across the three testing occasions varied from 74-91 percent. However, complete sets of data (pre-, post-and follow-up) were collected from only a disappointing 60 percent
(n=32). Figure 8 presents the proportion of ADC clients diagnosed with either substance dependency (either alcohol or cannabis or both), substance abuse (either alcohol or cannabis or both) or sub-threshold (no substance use disorder present). Numbers of clients sub-threshold increased after the ADC programme with 84 percent of clients being classified as sub-threshold. This slipped to 75 percent at the six-month follow-up. Numbers of clients classified with abuse or dependency decreased after the programme to nine percent and six percent respectively; for dependency relapse was slightly higher at follow-up, at 16 percent. The above results support the retrospective reports of substance consumption noted above, with patterns of use at follow-up remaining below pre-programme levels.

![Bar Chart]

Figure 8. Frequency of DSM-IV substance use disorders after participating in the ADC programme (n=32).

The low response rate, and discrepancies revealed with the retrospective reporting, suggest the alcohol and drug data is fraught with validity and reliability issues. An in-depth discussion of these discrepancies appears in section 5.4. It is recommended that the above results must be interpreted with caution.
5.2.5 Individual Treatment Goals

Complete data were collected for only 31 of the ADC clients (59 percent response rate). Three counsellors chose not to use the rating system to monitor progress towards goals. Figure 9 shows that average ratings (ratings averaged across all the different goals that clients set for themselves) changed over the course of the programme (higher scores represent greater progress towards goals). It appears that the group noticed a large improvement from the beginning (M=3.7, SD=1.6) to the end of the programme (M=8.0, SD=1.6), with just a slight slip in progress at the six-months follow-up (M=7.5, SD=1.8). Repeated measures ANOVA found these differences to be significant (F(60,2)=87.95, p<0.001). Post-hoc pair-wise comparisons (with bonferonni adjustment) found the improvement from pre- to post-programme to be statistically significant (p<0.001) but there was no significant difference from post-programme to follow-up (p=0.258, p>0.05). The follow-up ratings remaining were still significantly improved compared to pre-programme ratings (p<0.001).

Interestingly the retrospective reports of progress towards goals collected at follow-up, showed a pattern similar to the substance use retrospective ratings, with the clients viewing their behaviour as more in need of treatment in hindsight. Retrospective pre-programme mean was 2.2 (SD=1.3) compared to the pre-programme mean of 3.7 (DS=1.6).

![Figure 9. Youths' ratings of their progress toward their individual treatment goals (ITG) following participation on the ADC programme.](image-url)
A summary of the significant improvements in mental health following participation on the ADC programme presented in this section appear below in Table 19.

Table 19.
Summary of statistically significant improvements found in measures of mental health following participation on the ADC programme.

<table>
<thead>
<tr>
<th>Measure of Mental Health</th>
<th>Pre to Post</th>
<th>Post to Follow-up</th>
<th>Pre to Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>YSR – Total Problem Beh</td>
<td>p&lt;0.001</td>
<td>p&lt;0.001</td>
<td>p&lt;0.001</td>
</tr>
<tr>
<td>YSR – Externalising</td>
<td>p&lt;0.001</td>
<td>n.s.</td>
<td>p&lt;0.001</td>
</tr>
<tr>
<td>YSR – Internalising</td>
<td>p&lt;0.001</td>
<td>p&lt;0.01</td>
<td>p&lt;0.001</td>
</tr>
<tr>
<td>CBCL – Total Problem Beh</td>
<td>p&lt;0.001</td>
<td>n.s.</td>
<td>p&lt;0.001</td>
</tr>
<tr>
<td>CBCL - Externalising</td>
<td>p&lt;0.001</td>
<td>n.s.</td>
<td>p&lt;0.001</td>
</tr>
<tr>
<td>CBCL - Internalising</td>
<td>p&lt;0.01</td>
<td>p&lt;0.01</td>
<td>p&lt;0.001</td>
</tr>
<tr>
<td>Academic Performance</td>
<td>n.s.</td>
<td>n.s.</td>
<td>p&lt;0.001</td>
</tr>
<tr>
<td>CGAS</td>
<td>p&lt;0.001</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>BFAM - Youth</td>
<td>p&lt;0.01</td>
<td>n.s.</td>
<td>0.001</td>
</tr>
<tr>
<td>BFAM - Parent</td>
<td>p&lt;.05</td>
<td>n.s.</td>
<td>n.s.</td>
</tr>
<tr>
<td>Alcohol Use – Current Reports</td>
<td>n.s</td>
<td>p&lt;0.01&lt;sup&gt;a&lt;/sup&gt;</td>
<td>n.s.</td>
</tr>
<tr>
<td>Alcohol Use – Retrospective Reports</td>
<td>p&lt;0.001</td>
<td>p&lt;0.01&lt;sup&gt;a&lt;/sup&gt;</td>
<td>p&lt;0.05</td>
</tr>
<tr>
<td>Cannabis Use - Current Reports</td>
<td>p&lt;0.01</td>
<td>p&lt;0.05&lt;sup&gt;a&lt;/sup&gt;</td>
<td>n.s.</td>
</tr>
<tr>
<td>Cannabis Use - Retrospective Reports</td>
<td>p&lt;0.0001</td>
<td>p&lt;0.001&lt;sup&gt;a&lt;/sup&gt;</td>
<td>p&lt;0.05</td>
</tr>
<tr>
<td>Individual Treatment Goals</td>
<td>p&lt;0.001</td>
<td>n.s.</td>
<td>p&lt;0.001</td>
</tr>
</tbody>
</table>

<sup>a</sup> Relapse - statistically significant reduction
5.3 Predicting Treatment Completion and Treatment Outcome

A second aim of this research was to identify characteristics of clients or other ADC programme factors that were associated with successful treatment outcomes. To investigate this aim two aspects of treatment outcome were examined. First, a discriminant functional analysis was conducted to examine the ability of specific variables to predict completion or early termination of the ADC programme. Second, multiple regression was used to explore factors that might predict the greatest increases in therapeutic change.

5.3.1 Predicting Treatment Completion

Discriminant Functional Analysis (DFA) assesses the ability of variables to predict group membership. Of interest in this research was predicting whether a client belonged to the group that completed the ADC programme (C) or to the group that terminated early (TE). Of the 89 ADC clients who were accepted onto the programme, 54 went on to complete the programme, while 35 terminated early (see section 5.1.4 for description of early termination). The predictor variables considered for the DFA included client characteristics such as age, gender, number and severity of problem behaviours, age of problem onset, physical health and criminal behaviour, and contextual variables such as family functioning, living situation, status of school attendance, gang involvement, parental history of antisocial behaviour and/or mental health issues, family social economic status, and number of previous interventions. These variables were included because they had each been previously identified by research as related to completion and/or positive outcomes in adolescent mental health treatment programmes (see section 4.1.8). Consideration was also given to pragmatic issues such as quality of available data (validity, reliability and missing data).

Comparative Analysis

The first stage of the DFA was to conduct a comparative analysis of the two groups (completers and early terminators) on the predictor variables of interest. Some predictor variables were categorical (e.g., gender) while others were continuous (e.g., age). Differences between the two groups for variables that were categorical were determined using Pearson’s Chi-square and differences in continuous variables were analysed using two tailed t-tests for independent means. Results for the comparative
analysis appear in Table 20 (categorical variables) and with Table 21 (continuous variables).

Table 20 shows that programme completers and early terminators were not significantly different on any of the categorical variables, or individual or contextual factors. However, in Table 21 four individual factors emerge on which the two groups were found to be significantly different (significant differences appear in bold). Parents’ reports (CBCL) of target behaviour (severity of problem behaviour), total problem behaviour (number of problem behaviours) and externalising behaviour were significantly higher in the group of clients who terminated early. The group who terminated early also had had more previous interventions (treatment/therapy) compared to those that completed the programme.

Table 20.

Chi square results for categorical predictor variables for the completers and early termination groups.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Completers</th>
<th>Terminated Early</th>
<th>χ²</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Individual Factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender (Male)</td>
<td>37</td>
<td>68.5</td>
<td>24</td>
<td>68.6</td>
</tr>
<tr>
<td>NZ European</td>
<td>36</td>
<td>66.7</td>
<td>28</td>
<td>80.0</td>
</tr>
<tr>
<td>Attending School</td>
<td>45</td>
<td>83.3</td>
<td>26</td>
<td>74.3</td>
</tr>
<tr>
<td>Diagnosed Health Problems</td>
<td>13</td>
<td>24.1</td>
<td>14</td>
<td>40.0</td>
</tr>
<tr>
<td>Criminal Behaviour</td>
<td>30</td>
<td>57.7</td>
<td>21</td>
<td>65.6</td>
</tr>
<tr>
<td>DSM-IV Substance Use</td>
<td>23</td>
<td>29.2</td>
<td>8</td>
<td>29.4</td>
</tr>
<tr>
<td>Sub-threshold</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contextual Factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living Sit. (two parents)</td>
<td>23</td>
<td>50.0</td>
<td>22</td>
<td>66.7</td>
</tr>
<tr>
<td>Parental History of Probs</td>
<td>26</td>
<td>81.3</td>
<td>17</td>
<td>85.0</td>
</tr>
</tbody>
</table>
Table 21.

Independent t-test results for categorical predictor variables for the completers and terminated early groups

<table>
<thead>
<tr>
<th>Variables</th>
<th>Completers</th>
<th></th>
<th>Early Terminators</th>
<th></th>
<th></th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X (SD)</td>
<td>n</td>
<td>X (SD)</td>
<td>n</td>
<td>t</td>
<td></td>
</tr>
<tr>
<td><strong>Individual Factors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>14.5 (1.2)</td>
<td>54</td>
<td>14.6 (1.0)</td>
<td>35</td>
<td>0.62</td>
<td>.540</td>
</tr>
<tr>
<td><strong>No. Prev. Interventions</strong></td>
<td>1.0 (1.0)</td>
<td>45</td>
<td>1.7 (1.3)</td>
<td>18</td>
<td>2.33</td>
<td>.023</td>
</tr>
<tr>
<td>Prob Beh Age of Onset</td>
<td>11.3 (2.9)</td>
<td>44</td>
<td>9.5 (4.8)</td>
<td>24</td>
<td>1.69</td>
<td>.100</td>
</tr>
<tr>
<td>YSR – Tot. Prob Beh</td>
<td>64.6 (9.8)</td>
<td>54</td>
<td>63.2 (8.8)</td>
<td>27</td>
<td>0.63</td>
<td>.530</td>
</tr>
<tr>
<td>YSR – Internal Beh</td>
<td>60.2 (10.0)</td>
<td>54</td>
<td>58.8 (12.2)</td>
<td>27</td>
<td>0.54</td>
<td>.593</td>
</tr>
<tr>
<td>YSR – External Beh</td>
<td>67.4 (9.5)</td>
<td>54</td>
<td>66.7 (9.3)</td>
<td>27</td>
<td>0.28</td>
<td>.778</td>
</tr>
<tr>
<td>YSR – Target Beh</td>
<td>74.2 (7.6)</td>
<td>54</td>
<td>72.3 (8.7)</td>
<td>27</td>
<td>1.01</td>
<td>.313</td>
</tr>
<tr>
<td><strong>CBCL – Tot. Prob Beh</strong></td>
<td>66.2 (10.1)</td>
<td>45</td>
<td>73.0 (9.9)</td>
<td>18</td>
<td>2.43</td>
<td>.018</td>
</tr>
<tr>
<td>CBCL – Internal Beh</td>
<td>63.2 (10.7)</td>
<td>45</td>
<td>67.7 (14.4)</td>
<td>18</td>
<td>1.38</td>
<td>.174</td>
</tr>
<tr>
<td>CBCL – External Beh</td>
<td>68.4 (8.9)</td>
<td>45</td>
<td>73.4 (8.5)</td>
<td>18</td>
<td>2.91</td>
<td>.041</td>
</tr>
<tr>
<td>CBCL – Target Beh</td>
<td>74.4 (8.0)</td>
<td>45</td>
<td>81.7 (8.7)</td>
<td>18</td>
<td>3.61</td>
<td>.002</td>
</tr>
<tr>
<td><strong>Contextual Factors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SES</td>
<td>4.8 (1.6)</td>
<td>51</td>
<td>4.7 (1.2)</td>
<td>31</td>
<td>0.13</td>
<td>.901</td>
</tr>
<tr>
<td>Family Support (BFAM)</td>
<td>56.8 (10.8)</td>
<td>50</td>
<td>56.8 (11.1)</td>
<td>24</td>
<td>0.02</td>
<td>.985</td>
</tr>
</tbody>
</table>

Discriminant Function Analysis

Following comparative analyses a direct discriminant function analysis was conducted to assess the ability of specific variables to predict completion or early termination of the ADC programme. Variables selected for entry into the analysis were those revealed by the comparative analysis to be most likely to have possible predictive power (i.e., target behaviour, total problem behaviour and externalising behaviour as reported by the parents and the number of previous interventions).

There were five cases of missing data for number of previous interventions. These were replaced with the overall group mean which is a conservative method of
dealing with missing data (as recommended by Huberty, 1994). There was also a significant proportion (n=26) of missing CBCL data (i.e., scores for total problem behaviour, externalising and target behaviour). This was due to parent CBCL data being unavailable for all ADC clients (as discussed above in section 5.2.1). This meant that the DFA analysis had to be limited to clients whose parents had completed a CBCL (n=63). In such cases it is recommended that potential bias as a result of missing data is examined (Huberty, 1994). A Chi-square analysis revealed there was a significant difference ($\chi^2 = 7.8$, p<0.01) in distribution of missing CBCL data and group membership (‘completers’ tended to have more parents available and willing to complete a CBCL than did ‘early terminators’). It is possible in such circumstances to replace the missing data with an overall group mean for relevant variables. However, exploratory analysis inserting overall group means for ‘TotPb’, ‘Ext’ and ‘Target’ resulted in the elimination of all group differences that had been found in Table 21, and would have resulted in a non-significant DFA model. An alternative option was to insert the mean for the relevant variables of the different groups (C and TE). It was felt this option would have resulted in “stacking” the data, and exaggerating the differences (Huberty, 1994). Therefore, it was decided to continue with the current data set but with the clear acknowledgment that the results of the analysis would be applicable only to those ADC clients who had parents available and willing to fill out the CBCL.

Evaluations of assumptions of DFA identified one case as a multivariate outlier (p<0.001), which was removed. A within-groups correlation matrix was used to check for multicollinearity, the results of which revealed the CBCL sub-scale scores (Total Prob Beh., External Beh. and Target Beh.) were highly correlated ($r=.8$ to $.9$). Following an exploratory step-wise DFA, it was decided to drop the correlated sub-scales of total problem behaviour and externalising behaviour from the analysis, leaving two predictor variables, ‘target behaviour’ and ‘number of previous interventions’ to be entered into the analysis. Evaluation of assumptions of linearity, normality, and homogeneity of variance-covariance matrices revealed no other conflicts to the assumptions of DFA. Results of the direct discriminant function analysis on these remaining variables appear in Table 22.
Table 22.

Results of a direct discriminant function analysis to predict group membership
(completion or early termination of ADC programme).

<table>
<thead>
<tr>
<th>Predictor Variables</th>
<th>Corr. of predictor variables with discriminant function</th>
<th>Univariate F(1,60)</th>
<th>Standardised canonical discriminant function coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Func. 1</td>
<td></td>
<td>Func. 1</td>
</tr>
<tr>
<td>Target Behaviour</td>
<td>.77</td>
<td>7.84</td>
<td>.89</td>
</tr>
<tr>
<td>No. Prev. Interventions</td>
<td>.49</td>
<td>3.18</td>
<td>.65</td>
</tr>
<tr>
<td>Canonical Correlation</td>
<td>.43&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eigenvalue</td>
<td>.22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wilks’ Lambda</td>
<td>.82</td>
<td>Sig.</td>
<td></td>
</tr>
<tr>
<td>Chi-square</td>
<td>11.87</td>
<td>.003</td>
<td></td>
</tr>
</tbody>
</table>

*18% of the variance explained

Table 22 shows the results of the direct discriminant function analysis were significant. (Wilks’ Lambda = .82, $\chi^2(2) = 11.87$, p<0.01). However, the canonical correlation discriminant function results suggest that combining these two predictor variables accounted for a relatively small (18%) of the variance in predicting group membership. The correlation of predictor variables with discriminant function shows that target behaviour is the best predictor for distinguishing between programme completers and early terminators. Parents of the group of early terminators reported higher scores (greater severity) on target behaviour (M=80.9) compared to programme completers (M=74.4). Number of previous interventions was moderately correlated with the discriminant function, with early terminators having had on average one and a half interventions whilst programme completers on average had just one. The standardised canonical discriminant functions coefficients show that both variables had loadings in excess of .50 but with target behaviour again making the greatest contribution to the overall differentiation between completers and early terminators.
The analysis produced correct classifications of group membership in 82 percent of cases (50 out of 62). Results appear in Table 23 below.

Table 23.
Classification matrix for group membership (completion or early termination of ADC programme).

<table>
<thead>
<tr>
<th>Actual Group</th>
<th>No. of cases</th>
<th>Predicted Group Membership</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Completers</td>
<td>Early Terminators</td>
</tr>
<tr>
<td>Completers</td>
<td>45</td>
<td>42</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(93.3%)</td>
<td>(6.7%)</td>
</tr>
<tr>
<td>Early Terminators</td>
<td>17</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(47.1%)</td>
<td>(52.9%)</td>
</tr>
</tbody>
</table>

Prior probabilities: Completers = .73; Early Terminators = .27
- 82.3% of original grouped cases correctly classified
- 77.4% of cross-validated grouped cases correctly classified.

The classification accuracy is higher than the 60 percent chance (37 out of 62) of classifying correctly based on probability alone (using unequal prior probabilities to reflect unequal group sizes). The discriminant function was more effective at correctly predicting programme completers (93.3% correct), than it was early terminators, with just 52.9 percent correctly classified. The stability of the classification was checked by a cross-validation run, with 76.3 percent of cases correctly classified, which suggests a fairly high degree of consistency in the classification system.

It is important to note again, that these findings apply only to those ADC clients who had a parent willing and available to complete a CBCL score.

5.3.2 Predicting Treatment Outcome

Multiple Regression analyses were carried out to explore factors that might predict the greatest gains in treatment outcome. Section 4.1.8 describes the choice of treatment outcome measure selected (i.e., the youth report (YSR) of total problem behaviour), and the calculation of two treatment outcome scores (‘TO1’, was the
change in total problem behaviour at the end of the programme compared to the start, and ‘TO2’ was the change in total problem behaviour six months following the programme compared to the start, i.e., changes that had been maintained). Large scores for both measures indicated large gains in treatment outcome. Fifty-three clients completed the ADC programme, and data were available for 46 clients at the end of the programme (87% response rate) and 42 clients at the six-month follow-up (79%).

Factors considered as independent variables were similar to those used with the DFA analysis, with the addition of some treatment/counsellor variables which had been found in the literature to influence treatment outcome (see section 4.1.8) Variables initially explored included ‘individual client characteristics’ of number and severity of problem behaviours, age of problem onset, presence of internalising disorders, level of substance use (none, low, medium or heavy) and number of previous interventions; ‘contextual variables’ such as family functioning, parental/caregiver support, living situation, status of school attendance, parental history of antisocial behaviour and/or mental health issues, family social economic status and number of concurrent agencies and services involved with the young person; also ‘treatment variables’ such as total number of counselling sessions, length of treatment, and counsellor age and experience.

With sample sizes of just 46 at the end of the programme (TO1) and 42 at follow-up (TO2) it was not possible to include all these variables in the analysis; the minimum number of cases per variable for standard multiple regression is five (Tabachnick & Fidell, 1989), which meant there should be no more than nine variables entered into the analysis. The selection of variables was made by examining the correlation coefficients of each of the variables with the dependent variables of TO1 and TO2, together with consideration of the quality of the data available (validity, reliability and missing data). The final nine to be included in the analysis were:

---

6 Parental/caregiver support was included following the DFA analysis revealing significant association between parent/caregiver availability and willingness to complete a CBCL form and treatment completion.
Individual Characteristics

- Youth self-report of number and severity of problem behaviour, YSR Total Problem Behaviour (Tot Pb),
- Level of substance use (A&D)
- Age

Contextual characteristics

- Family functioning (BFAM)
- Status of school attendance (Sch Att),
- Community Support: the number of concurrent agencies/services working with the young person (Comm Supp)
- Parental Support, whether a parent/caregiver was willing and available to fill out a CBCL (Parent Supp)

Treatment Characteristics

- Total number of sessions (No. Sess)
- Years of counsellor experience (Cslr Exp).

Results of Multiple Regression Analysis

Evaluation of the assumptions of multiple regression revealed one univariate outlier in family functioning. This was adjusted to the next highest within range score (Tabachnick & Fidell, 1989). Observation of the data revealed no multivariate outliers or problems with multicollinearity or singularity. Standard multiple regression analyses were performed on each treatment outcome variable (TO1 & TO2) and the eight individual, contextual and treatment variables listed above. Assessment of residual plots following the analysis found no problems with normality, linearity, homoscedasticity or independence of residuals.

Predicting treatment outcome immediately after completing the ADC programme (TO1).

In the search for the best regression model it is important to consider the number of variables included in the final model. With small samples sizes and larger numbers of variables there is the risk of ‘overfitting’ (i.e., finding a model that fits this particular sample of data but does not generalise well). Such a model will perform
poorly when applied to a new sample drawn from the same population (SPSS, 1997). Therefore, the model building process involved looking for and eliminating variables that were performing less well (low tolerance scores, low Beta weights and small t-scores). Models were then re-run with the goal of finding the best model but with the minimum number of variables (limiting the risk of overfitting). Following this process the variables relating to age, school attendance, level of substance use, community support and counsellor experience were removed. The results of the final standard multiple regression appear in 24.

Table 24.

Standard multiple regression of treatment outcome (TO1) on individual, contextual and treatment variables.

<table>
<thead>
<tr>
<th>Variables</th>
<th>TO1</th>
<th>P Supp</th>
<th>No.Sess</th>
<th>TotPb</th>
<th>BFAM</th>
<th>B</th>
<th>Beta</th>
<th>Sig t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent Supp</td>
<td>.27</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.53</td>
<td>.29</td>
<td>.047</td>
</tr>
<tr>
<td>No. Sessions</td>
<td>-.05</td>
<td>.37</td>
<td></td>
<td></td>
<td></td>
<td>-.04</td>
<td>-.27</td>
<td>.073</td>
</tr>
<tr>
<td>Tot Prob Beh</td>
<td>.39</td>
<td>.16</td>
<td>.19</td>
<td></td>
<td></td>
<td>.04</td>
<td>.44</td>
<td>.003</td>
</tr>
<tr>
<td>BFAM</td>
<td>-.12</td>
<td>-.05</td>
<td>-.11</td>
<td>.18</td>
<td></td>
<td>-.02</td>
<td>-.22</td>
<td>.118</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Mean</td>
<td>.95</td>
<td>.71</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SD</td>
<td>.84</td>
<td>.46</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R=.54</td>
<td>R²=.29</td>
<td>Adj R²=.22</td>
<td>F=4.20</td>
<td>p=.006</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
correlation between TotPb and TO1 (r=0.39, p<.01) suggests a moderate positive relationship with high scores on pre-programme TotPb (YSR total problem behaviour, i.e., number and severity of problem behaviour) having high treatment outcomes (TO1) at the end of the programme. TotPB on its own accounted for 17 percent (Sr²=.17) unique variance of R². The correlation of TO1 and Parent Supp was a small positive correlation (r=.27, p<.05) suggesting those who had a parent available and willing to fill out a CBCL form at the start of the programme were more likely to have better treatment outcome at end of the programme. This variable accounted for nine percent (Sr²=.09) of the unique variance in R². The four independent variables in combination contributed to another 14 percent (Sr²=.14) shared variance. Altogether 29 percent (22% adjusted) of the variance in TO1 was predicted from these variables. Overall this would be described as a weak model with a relatively small amount of variance in TO1 accounted for by initial total problem behaviour (YSR), parents’ availability and willingness to fill out a CBCL, family functioning (BFAM) and total number of counselling sessions.

**Predicting treatment outcome six months following the end of the ADC programme (TO2).**

The same process of model building that was used for predicting TO1 was used for predicting TO2. As a result the variables relating to age, number of counselling sessions, level of substance use, school attendance and family functioning were removed. This left Csllr Exp, TotPb, Parent Supp and Comm Support to be entered into the standard multiple regression analysis to predict TO2. The results appear in Table 25.
Table 25.

Standard multiple regression of treatment outcome (TO2) on individual, contextual
and treatment variables.

<table>
<thead>
<tr>
<th>Variables</th>
<th>TO2</th>
<th>P. Supp</th>
<th>Cslr Exp</th>
<th>TotPb</th>
<th>Comm Supp</th>
<th>B</th>
<th>Beta</th>
<th>Sig t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent Supp</td>
<td>.34</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.40</td>
<td>.23</td>
<td>.061</td>
</tr>
<tr>
<td>Cslr Experience</td>
<td>-.14</td>
<td>-.08</td>
<td></td>
<td></td>
<td></td>
<td>-0.05</td>
<td>-.18</td>
<td>.135</td>
</tr>
<tr>
<td>Tot Prob Beh</td>
<td>.53</td>
<td>.16</td>
<td>.01</td>
<td></td>
<td></td>
<td>.04</td>
<td>.49</td>
<td>.000</td>
</tr>
<tr>
<td>Comm Support</td>
<td>-.37</td>
<td>-.12</td>
<td>-.05</td>
<td>-.00</td>
<td></td>
<td>-.17</td>
<td>-.35</td>
<td>.006</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Constant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>1.2</td>
<td>0.7</td>
<td>4.2</td>
<td>64.2</td>
<td>1.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SD</td>
<td>0.8</td>
<td>0.5</td>
<td>2.8</td>
<td>9.5</td>
<td>1.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R=.70</td>
<td></td>
<td>R²=.49</td>
<td>Adj R²=.44</td>
<td>F=8.95</td>
<td>p=.0000</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The R for the regression equation using all four independent variables was significantly different from zero (R=.70, F(37,4)=8.95, p<.0001). Two of the independent variables contributed significantly to the prediction of TO2, TotPb youths’ reports of pre-programme total problem behaviour (p<0.001) and Comm Supp (p<0.01). The correlation between TotPb and TO1 (r=.53, p<.001), again suggests a moderate positive relationship with high scores on pre-programme YSR total problem behaviour having high treatment outcomes (TO2) six months following the end of the programme. TotPb accounted for 24 percent (Sr² =.24) of the unique variance of R². Interestingly the correlation between the number of concurrent agencies and services involved with the young person (Comm Supp) and treatment outcome (TO2) was a moderate negative correlation (r= -.37, p<.01). This suggests that, for these ADC clients, the larger the number of agencies involved with the young person the poorer the treatment outcome at six months post-programme. It might have been expected that more support available for the young person would mean greater likelihood that treatment outcomes achieved would be maintained; this will be discussed further in section 5.4. Community support on its own accounted for 12
percent ($\text{Sr}^2=.12$) unique variance of $R^2$. The four independent variables in combination accounted for another 14 percent ($\text{Sr}^2=.14$) in shared variability. Altogether the variables accounted for 49 percent (44% adjusted) of the variability in TO2. This model is superior to the previous model and identifies two significant predictors of high levels of treatment outcome six months following the end of the ADC programme: high levels of pre-programme severity of total problem behaviour, and fewer numbers of community agencies involved. However, a further 51 percent of the variance was still unaccounted for by these variables.
5.4 Discussion of Quantitative Results and Study Limitations

This section discusses the quantitative results presented in the previous three sections. The characteristics of the ADC programme and its clients are discussed with particular reference to New Zealand Government priority areas for funding. The significance of the treatment outcomes are examined and compared to outcomes achieved by other well established and empirically supported mental health treatment programmes. Then the main findings of the discriminant function analysis and multiple regression are discussed in relation to other research that has investigated factors that are associated with successful outcomes in the treatment of youth with mental health concerns. The section concludes with a review of the limitations of this quantitative study.

5.4.1 Characteristics of the ADC Programme and its Clients

ADC Programme Characteristics

Content of programme and counselling sessions

Data collected provided a breakdown of the treatment that a typical ADC client receives. On average clients receive 19 community-based counselling sessions, of which over half were individual sessions with the counsellor, and a third sessions with family members or caregivers. The remainder were recorded as ‘agency’ sessions, allowing for ‘system-based’ work with referral agents or other groups relevant to the treatment of the young person. In addition, clients received nine days of group-based wilderness therapy (the ‘Journey’). The complete treatment experience, including the Journey, was spread over an average period of six months.

This treatment model serves to enlist multiple systems of influence, both at the individual level, as well as from the family, other agencies and, during the Journey component of the programme, peers. This systems-based approach is characteristic of several of the more successful and empirically supported adolescent treatment programmes, especially those working with serious disruptive or antisocial behaviour, such as Multisystemic Therapy and Multidimensional Treatment Foster Care (See section 2.2.3). Targeting wider systems of influence is also recommended, where possible, for the treatment of substance use disorders (Cormack & Carr, 2000; Spooner et al., 1996), which were also common amongst ADC clients.

In terms of the content of the counselling sessions, the four most common individual treatment goals that the youth agreed to work towards were decreasing
misuse of substances, reducing difficulties experienced at school, improving control over anger, and improving relationships with family members. These client goals were consistent with the records kept by counsellors on the issues covered during counselling. This consistency between content of counselling sessions and clients’ recorded goals may be a reflection of ADC counsellors respecting their clients’ goals and motivation.

Client motivation has been recognised as a key factor in achieving successful outcomes (Carr, 2000; Kazdin, Siegel et al., 1990; Miller & Rollnick, 1991) and, in the case of adolescents, may require special attention, as these clients are often referred to treatment by others (Kazdin, 2004; Shirk & Russell, 1998). For this reason, DiGiuseppe and colleagues (1998) have proposed that first achieving agreement on treatment goals with clients is a critical factor in successful counselling of adolescents. ADC counsellors worked alongside the youth in deciding on the treatment goals: while it is unclear how much the counsellor might have influenced the young person in their choice of goals, data collected as part of the qualitative enquiry (Part III) provide further support for ADC counsellors respecting their clients motivation. The qualitative data provided support for the importance of motivation generally in the therapeutic change process. To maximise the effect of motivation, it was noted that ADC counsellors had developed a flexible approach that allowed them to work on issues that their clients were motivated to work on, and adapt to changes in this motivation as their clients became increasingly engaged in the counselling process, thereby becoming motivated to make more significant changes.

The range of issues (Table 14) covered by the ADC programme is indicative of the complexity of the problems facing these referred youth. On average counsellors recorded working on 12 different issues per client. This was consistent with the mental health profile data that indicated ADC clients presented with multiple problems. Clearly the ADC programme format had to be sufficiently broad in scope to address the wide-ranging issues presented by its clients.

**Length of treatment**

In terms of treatment length, ADC is longer than many adolescent counselling programmes that have been researched under tightly controlled university-type trial settings, but is similar to other community-based programmes. The optimal length of treatment for adolescents has not been well-researched, but, some researchers have
noted that the complexity of problems that adolescents typically present with may warrant longer, more intensive treatment (Kazdin, 2004). The length of the ADC programme was to an extent individualised for each client, ranging from just one month up to eleven months for one particular client, with the assessed needs of each client the determining factor.

Interestingly, multiple regression analysis did not find a significant relationship between length of ADC treatment and treatment outcome (i.e., better outcomes were not achieved with a more or less sessions of counselling). This could be interpreted as supporting the ADC’s individualised approach, where treatment continues until clients are judged by their counsellors to have reached a satisfactory level of outcome (i.e., required level of improvement is held relatively constant, but length of participation in order to reach this point can vary).

This variable length of treatment differs to typical fixed dose required by university researched programmes. A fixed dose may of course be appropriate under controlled research conditions, where efforts are taken to create a homogenous group of clients, with single disorders, and where more serious cases (requiring more intensive treatment) are typically screened out. However, these luxuries do not apply in ‘real-world’ programmes such as the ADC, hence the amount of treatment individuals may need is likely to vary, with more serious cases requiring longer.

**Rate of completion**

Another important programme characteristic is the rate of completion. Just under 40 percent of ADC clients were recorded as having terminated prematurely. Retention of adolescent clients and their families in treatment programmes has been recognised as a challenge (Pelkonen et al., 2000; Robbins, Turner, Alexander & Perez, 2003). A meta-analyses of 125 studies that assessed psychotherapy dropout (adults, adolescents and children) revealed a mean dropout rate of 47 percent (Wierzbicki & Pekarik, 1993), and similarly for child and adolescent group specifically rates have been reported to range between 40-60 percent (Kazdin, 1996). The ADC dropout rate, therefore, appears to be within the normal range for this population.

The definition of dropout or early termination used in this study would be considered as fairly liberal (Wierzbicki & Pekarik, 1993). Those categorised as ‘not completed’, included those who withdrew for reasons unrelated to the programme.
such as family and/or client moving out of the area, and being referred onto another service. Clients were considered ‘early terminators’ regardless of the number of sessions completed. Other studies have used more conservative definitions of dropout, such as a client failing to attend a scheduled session (termination-by-failure), or not completing a fixed number of sessions (Wierzbicki & Pekarik, 1993). Using these stricter definitions, the dropout rate for the ADC programme would be lower. Those clients who completed the ADC programme or terminated early were investigated using discriminant function analysis (section 5.3) and results are discussed later in this section (5.4.3).

ADC Client Characteristics

Demographics

The demographic breakdown of the referred ADC clients revealed that the majority were males (69%), self-identified as New Zealand European (72%), and were attending school (82%). The majority of clients were New Zealand European, although, Māori clients, at 23 percent, were represented at a higher rate than their proportion of the regional population. The CHDS study also found adolescent Māori were at greater risk of mental health disorders (Horwood & Fergusson, 1998). The same research found higher rates of mental health disorders in females (45.6%) compared to males (40.8%), though this was not reflected in the pattern of referrals to ADC, with a higher proportion of males referred. This latter fact could be an indication of generally lower rates of help-seeking behaviour of females or, perhaps more likely, the high rate of externalising problems (70%) which is more prevalent in males (Horwood & Fergusson, 1998), which is associated with higher levels of referral (Weisz & Weiss, 1991) to services such as ADC.

Analysis of demographic information revealed an apparent instability in the ADC clients’ living situations. In attempting to collect parental self-report data it was found that 30% of the clients were in different living situations six months after completion of the programme. For the youth with parents that were separated, a common occurrence appeared to be a switch from living with one parent to the other, often the result of relationship difficulties being experienced in one household. A less frequent occurrence was youth taking up an independent youth benefit and opting to live independently, or in some cases flating with siblings.
This instability in living situation may have adverse effects on a youths’ mental health and their progress in treatment. The Dunedin longitudinal study (DMHDS) found that adolescents who experienced more frequent change of residence were at greater risk of mental health problems (McGee, Stanton & Feehan, 1991). In this study it was found that youth whose parents were available to be involved with assessment had better outcomes. Inevitably, difficulties arise in maintaining family involvement when youth switch to living with a different family member. Considering the potential importance of family involvement, the delivery of programmes such as ADC needs to be sufficiently flexible to cater for these frequent changes in family environment and living situation.

Reasons for referral

The highest proportion of referrals came from schools (57%) and the rest from a broad spectrum of sources. In terms of reasons for referral, 70 percent of all youth referred to the ADC programme presented with externalising behaviour (delinquency or aggression) as the target behaviour. This is consistent with findings of other research, that despite the comparatively lower rates of prevalence of externalising disorders (McGee et al., 1990; Feehan et al., 1994; Fergusson & Horwood, 2001), youth with externalising disorders are more commonly referred for help than those with internalising disorders (Weisz & Weiss, 1991). Although externalising behaviour was the most common target behaviour, proportions of this research sample were considered to be in the clinical range for each of the eight YSR sub-scales, again indicative of the breadth of problems the ADC programme is required to address.

One of the main selection criteria for entry to the ADC programme was ‘having or being at risk of a significant drug and alcohol problem’. It was surprising, therefore, that less than a third of referral agents listed this as the main reason for referring clients to the programme: over 40% of ADC clients were judged to not meet criteria for a DSM-IV substance use disorder.

There are several possible explanations for this high number of youth apparently without significant substance use problems. The ADC programme inclusion criteria includes those ‘at-risk of’ a significant drug and alcohol problem. This includes youth who may be using substances at a low level but who were considered at greater risk of developing a significant problem because of their current circumstances (e.g., they had parents with a substance use disorder or who engaged in
drug dealing). Hence, some of these youth were effectively being referred for early intervention. It is also likely that the data collected underestimated the number of with a substance use problem, as it was found subsequently that some youth were apprehensive of disclosing such behaviour early on in the treatment (when the pre-programme data was collected). Finally, it may reflect delayed awareness of a shift in programme emphasis, which prior to 1996, ADC had been funded for behavioural problems rather than substance use and mental health problems. Recent evaluation reports (Mossman, 2003, 2004) suggest later ADC programmes have a far greater focus on substance use problems.

**Mental health profile**

Youth and parent reports (YSR and CBCL) indicated that externalising behaviour was the most common problem for both male and female clients, with parents reporting slightly higher levels of severity than the youth. There were discrepancies in parent and youth reports in relation to which gender had the highest level of severity. Female clients reported having more problems than males across all three measures, whilst parent reports indicated that, from their perspective, male clients had the higher levels of problem behaviour. Discrepancies found in parent and youth reporting of mental health symptoms are common (Andrews, Garrison, Jackson, Addy & Mckeown, 1993; Kramer et al., 2004; Seiffge-Krenke & Kollmar, 1998), and is one of the reasons why it is recommended that such information be collected from more than one source.

Research by Kramer et al. (2004) supports the finding of this research, that parents tend to report higher levels of problem behaviour compared to the youth themselves. Although other studies have found adolescents report more problems (Andrews et al., 1993; Sawyer, Baghurst & Clark, 1992; Seiffge-Krenke & Kollmar, 1998). Reasons offered for the discrepancies between parents’ and youths’ reports include differences in interpretation of questions, lack of parental awareness of certain behaviour (e.g., delinquency) and differences in thresholds of what is considered problematic (Kramer et al., 2004. Andrews et al. (1993) suggested that adolescents may under-report certain symptoms due to ‘denial’ of behaviour, or because of the social unacceptability of target behaviours. This was supported by this study where youth appeared retrospectively, to recognise higher levels of pre-programme problems, than they had first admitted.
Authors have also suggested differences may relate to the type of problem. Parents tend to report fewer symptoms when these symptoms are not a problem for them, or are internalised by the adolescent (Andrews et al., 1993; Rey, Schrader & Morris-Yates, 1992) but are more likely to report behaviour that is visible and annoying to them (Rey et al., 1992; Sawyer, Baghurst & Mathias, 1992). In the ADC sample externalising behaviour was most common, and being more visible may, therefore, account for the high parental reports. Alternatively, it is possible that parents over-reported or exaggerated in an attempt to ensure that intervention occurred. Level of agreement between parents and adolescents has also been found to vary according to marital discord (Seifge-Krenke & Kollmar, 1998) and family cohesion (Andrews et al., 1993), indicating that parental reporting of adolescent symptoms can be influenced by parents’ own problems.

Only a couple of studies were found that reported on differences in reporting according to gender. Sawyer, Baghurst and Mathias (1992) found the same pattern of results as above, with adolescent females reporting comparatively higher levels of problems than their male counterparts. Seifge-Krenke and Killmar (1998) found parental agreement was better with daughters than sons, and suggested that males may be less inclined to disclose personal worries and problems to their parents, or reveal symptoms of emotional stress (i.e., it may be more socially acceptable for females to report certain problems, resulting in higher reports in problem behaviour).

The differences in child/parent reporting reviewed above has relevance later on in this section in discussing further discrepancies found the discriminant function and multiple regression analysis results.

In terms of severity of mental health problems the analysis of the mental health profile data suggested that as a group, the ADC sample had scores on total problem behaviour and externalising behaviour (YSR and CBCL) that indicated more extreme symptoms than would be found in 90 percent of adolescents (based on North American norms). Scores on target behaviours (sub-scale with highest clinical elevation) indicated symptoms that were more extreme than would be found in 98 percent of adolescents (again based on North American norms). Furthermore, compared to a North American ‘clinically referred’ representative sample, the YSR and CBCL scores of this ADC sample indicate they had more severe symptoms than those adolescents typically referred to mental health services in North America (Achenbach, 1991a, 1991c).
It is unfortunate that there are no New Zealand norms available from which to make direct comparisons, as it is possible that the results reported above could reflect a difference due to cultural factors. However, studies conducted on German and Australian adolescents have found similar norms to the North American YSR and CBCL scores (Achenbach, 1991a, 1991c; Bond et al., 1994).

Australia is one of our closer neighbours culturally, and results of a recent national survey there offer support for the CBCL scale to detect clinically significant behaviour (Sawyer et al., 2000). Sawyer and colleagues conducted a nationally representative survey and found that 14 percent of children and adolescents scored in the clinical range on the total problems scale of the CBCL, while a similar 14.1 percent of the same sample received a DSM-IV mental health disorder diagnosis using diagnostic interview procedures. Interestingly, comparisons of the YSR total problem behaviour scores for ADC sample with Australian clinically referred out-patient samples also indicated more severe symptoms for the ADC sample (Kingston et al., 1997; Sawyer, Sarris, Baghurst, Cornish & Kalucy, 1990). Other measures of mental health also point to the severe clinical status of the ADC youth: counsellors’ ratings of global functioning, DSM-IV diagnosis of substance use disorders, and the high rate of suicidal behaviour and ideation reported by the youth.

In summary, the descriptive information on this sample of ADC clients and their mental health profile raises several points of note. First, the youth referred to this programme have a high degree of severity, multiple mental health problems, and come from complex and unstable living situations. It is of concern that the characteristics of these ‘real-world’ ADC clients appear different to those that have been the main focus of research studies. The research focus to date has been on the development and testing of programmes (i.e. empirically supported treatments) to treat a single disorder, as such research trials have tended to eliminate the more serious, comorbid and complex cases and in many cases those that cannot guarantee consistent parental support. These characteristics raise the question over the applicability of many of the ‘empirically supported treatments’ to the ‘real-world’ situation. This research suggests that a treatment programme needs to be effective with severe, multiple and complex problems. Hence, research needs to re-focus on the development of programmes that are applicable to clients with these characteristics.
Second, from the client characteristics presented, the ADC programme appears to be working with youth who meet several of the priority areas identified by the New Zealand government in terms of youth mental health. The New Zealand Government's National Mental Health Strategy requires mental health services (including alcohol and drug services) to be delivered to the most severely affected three percent of 0-19 year olds with mental illness (Mental Health Commission, 1998). From the information presented it would appear that the majority of ADC clients would fit into this category. The ADC clients had more extreme symptoms in one syndrome of problem behaviour (target behaviour) than 98 percent of adolescents, and scores on total number of problem behaviours were more extreme than those of 90 percent of adolescents (based on North American norms). The ADC programme also appears to be addressing other important gaps in youth mental health services in New Zealand (Ministry of Health, 2000), such as services for Māori youth, and other high need areas such as youth in rural areas, alcohol and drug dependency, and suicide prevention. Nearly a quarter of these ADC clients considered themselves Māori, while 40 percent indicated they may be at risk of self-harm and nearly 60 percent met the criteria of having a substance use disorder. Finally, ADC counsellors based in the main centres regularly travelled several hours to meet with clients in rural areas.

This comprehensive description of clients that participated in an ADC programme is a valuable resource for programme providers in terms of their understanding of the characteristics and needs of the clients they are working with. Such information is also useful in the planning and development of future ADC programmes, and the refinement of the referral and selection processes. This descriptive information also provides important details on the characteristics of the research sample, and therefore, provides information on the type of adolescent client the findings from this research may be of most relevance to.

5.4.2 Treatment Outcome

Section 5.2 evaluated treatment outcomes following participation in an ADC programme. Overall, findings indicated significant improvements in mental health according to the youth, their parents and the counsellors, at the end of treatment, and again up to six months after completion of the programme. Results for all treatment outcome measures are summarised in Table 17, section 5.2.
Primary Measures of Treatment Outcome

The primary measures of treatment outcome were the youth (YSR) and parent (CBCL) behaviour checklists. Using these measures, both youth and parent reports revealed statistically and clinically significant improvements in total problem behaviour, and in internalising and externalising behaviour. At six-months follow-up, improvements were not only maintained but also, for half the measures, continued to improve to a statistically significant degree (YSR total problem and externalising behaviour; CBCL internalising behaviour). The inclusion of longer-term measures of treatment outcome is one of the strengths of this research. Recent reviews have pointed to a general failure of adolescent psychotherapy research to measure the long-term effects of treatment (Kazdin, 2004; Weisz & Kazdin, 2003). Obviously, if treatment effects cannot be maintained in the longer term, questions are raised over the value of a treatment. The positive effects of the ADC programme appear to be consistent for both males and females, and across different ethnic groups.

As described in section 5.2.1, the mean effect sizes according to youth and parents, post programme and at follow-up were considered ‘large’ according to Cohen’s classifications (Cohen, 1988). The ADC effect sizes compare favourably with those reported by other adolescent counselling programmes. A comparison of the findings from the most recent child and adolescent psychotherapy meta-analysis by Weisz, Weiss et al. (1995), indicates that those produced by the ADC programme (0.7 to 1.2) are superior to those typically expected in adolescent psychotherapy programmes (0.54), and considerably better than those accessing routine clinical practice ‘real-world’ interventions (0.01).

However, caution is required in making direct comparisons in this way, as different methods have been used for calculating effect sizes that would potentially favour the ADC sample (i.e., repeated measures). More appropriate is direct comparison between effect sizes of adolescent counselling programmes where the same method of calculation has been used. Such comparisons are possible when studies have published pre- and post-programme evaluation data over similar periods of treatment, and reported sufficient data to calculate effect sizes in the same way they were calculated for the ADC programme.

Such comparisons indicated that the ADC programme resulted in larger effect sizes as reported by parents than several large scale evaluations of community-based adolescent mental health services in North America (CBCL, TotPb, ES=0.55; Dalton
et al., 2003; TotPb, ES=0.59; Bickman, Noser & Summerfeldt, 1999) and larger youth reported effect sizes than an intensive ten-week, day programme in Australia (YSR, TotPb=0.07; Crisp, 2003a). ADC effect sizes were also found to be similar to or better than CBCL effect sizes of several 'empirically supported treatments' including MST (Ext, ES=0.657; Henggeler et al., 1999), Problem Solving Skills Training (TotPb, ES=0.76; Kazdin & Wassell, 2000) and IPT-A for depression (TotPb, ES=0.44; Rossello & Bernal, 1999).

Without a control group it is not possible to differentiate effects produced by the programme from those of other factors such as simple maturation or natural recovery, regression to the mean following a point of crisis, or testing effects. A control or comparison group was not employed here, but other studies testing adolescent mental health interventions have done so. Interestingly, effect sizes for adolescent wait-list controls over similar periods as the ADC programme (10 weeks to 1 year) ranged from 0.03-0.29 (Barrett, Dadds & Rapee, 1996; Dalton et al., 2003; Dishion & Andrews, 1995; Kendall, 1994; Rossello & Bernal, 1999; Weiss et al., 1999). Thus, the effect sizes for the ADC programme were considerably larger than all of these control-group effect sizes. This provides some assurance that improvements in ADC clients were over and above those that may have been expected as a result of non-programme factors, pointing to some specific impact (at least in part) by the ADC programme itself. Nevertheless, caution is needed when making comparisons with studies which use control groups, as inevitably there are sampling differences (e.g., client characteristics, duration of intervention).

A final consideration of the specific impact of the ADC programme is from research that indicates mental health problems in adolescence are not transitory (Cohen et al., 1993; Hofstra et al., 2001), in fact are often considered chronic (Heijmens Visser et al., 2003). Literature reviewed earlier in this thesis suggested considerable continuity and stability of adolescent mental health disorders into young adulthood (Achenbach et al., 1995; Hofstra et al, 2001). The relevance of such findings to the current study is high, given that many of these studies used the same measures (YSR/CBCL) to assess stability. Research within New Zealand has also found that those with specific mental health disorders are at higher risk of developing chronic mental health problems (Feehan et al., 1993; Fergusson & Horwood, 2001).

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7 Effect size for externalising behaviour (CBCL) for ADC clients was calculated to be 0.61.
Externalising disorders, which were the most common presenting problem for the ADC sample, have been found to have particular stability over time (Stanger, et al., 1996; Achenbach, Howell, McConaughy & Stanger, 1998). These research findings reduce the likelihood that natural ‘recovery’ is a plausible explanation for observed changes in the ADC clients following programme participation.

Other Measures of Treatment Outcome

Discussion so far has focused on outcomes measured by one set of instruments, the YSR/CBCL behaviour checklists. It is important to note that additional measures of treatment outcome reported by the youth, parents and counsellors also produced statistically significant improvements post-programme. These included youth reports of perceived academic performance, reduced consumption of substances, family functioning, progress towards individual treatment goals, parents’ reports of family functioning, and counsellors’ assessment of presence of DSM-IV substance use disorders and ratings of global functioning. A degree of relapse was, however, seen at six-months follow-up on parent-rated family functioning, youth reports of substance use and ratings for individual treatment goals.

The reasons why parents, but not youth, reported a slight relapse in family functioning at six-months follow-up are difficult to identify. It could be that youth have developed different coping skills following the intervention, which resulted in them having more positive perspectives on difficult family environments, while their parents might be struggling to cope without the support of counsellors. Also of relevance was the failure to collect information on the state of relationships with other family members, e.g., brothers, sisters, spouses, was not collected, which may have impacted on reports of overall family functioning. Interestingly qualitative data collected from parents four to six months post-programme suggested that parents believed the behaviour of their son/daughters following the programme was much improved (see section 7.3). It is also important to note that data were only collected from youth remaining in the same family environment over the course of the research. In 30% of the cases, youth were living in different living situations, some returning home from foster homes, and others moving out of home, perhaps to a different parent. These unrecorded cases may have reported different perceptions of changes in family functioning.
Relapse in adolescent substance use following treatment is common (Jainchill, 2000; Spear et al., 1999). Spear and colleagues (1999) found 79.6 percent of adolescents treated for chemical dependency had relapsed to pre-treatment levels within 12 months of completing treatment. The degree of relapse in this study varied according to treatment outcome variables and with A&D outcomes whether ‘retrospective’ or ‘current use’ reporting was used (this discrepancy in reporting is discussed below). Individual treatment goals which showed a small degree of relapse related to specific problem areas, and may indicate that the individual problem areas identified by the youth were more prone to relapse, while more general measures of mental health such as the YSR/CBCL showed continued improvement. These results point to the importance of relapse prevention strategies to ensure the maintenance of all treatment outcomes achieved.

Retrospective Self-Reports

As noted above, the treatment outcome results revealed discrepancies between retrospective and current use reporting of substance use. Self-report is an important data source for the evaluation of treatment programmes, but collection of accurate data on substance use is particularly prone to distortions such as poor recall of what has been consumed, social desirability influencing the disclosure of sometimes illegal behaviour, and the difficulty in quantifying amounts consumed when joints or bottles of often mixed liquor were shared amongst a group. The use in this study of retrospective reports of pre-test levels of drug and alcohol consumption provided a different dimension to the evaluation, and revealed a negative retrospective shift (more serious or severe retrospective assessments of original behaviour).

This retrospective shift has been found elsewhere in evaluation of counselling training (Manthei, 1997b) and in the evaluation of drug treatment programmes (Aiken, 1986). Possible explanations for the shift include ‘impression management’, where clients present themselves more favourably at the start of treatment. Similar shifts have also been noted following an enhanced understanding of themselves and their earlier deficiencies, following training or other intervention. An alternative ‘impression management’ interpretation cannot be ruled out, simply that the youth sought to please the interviewer by presenting the picture of a more positive outcome from the programme at follow-up. Evidence cited by Aiken (1986), however, supports a negative retrospective shift; it was noted that reported amounts of substance use
increased with length of stay in treatment, when confidentiality is assured and clients have nothing to gain from hiding aspects of their lives. It appears that more valid reports are obtained under these conditions. This explanation was supported by ADC counsellors, who in the planning stage of the research had commented that they often found clients more ready to disclose illicit behaviour such as substance use as counselling progressed and the client-counsellor relationship developed. This was also confirmed by several reports by clients at follow-up. As briefly mentioned in section 5.1, over half the clients who reported at the start of the programme that they did not drink alcohol or use cannabis, reported to this researcher at follow-up that they had in fact been regular users. It is interesting to note that counsellors’ assessment of DSM-IV diagnosis of substance use disorders, based on client report of behavioural symptoms rather than absolute levels of consumption, mirrored more closely the retrospective reports than the current use ones. Assessing patterns of substance use behaviour (e.g., negative consequences) may prove more reliable than enquiring about absolute levels of consumption.

Further research is required to establish whether retrospective or current use reporting provides the most accurate indication of substance use. However, it may be that the inclusion of retrospective reporting is a useful strategy in evaluating substance use treatment programmes. Without this pre-treatment self-reports may in fact obscure genuine gains in treatment.

In summary, considering the clinically and statistically significant improvements in multiple measures of treatment outcome according to multiple informants, it seems likely that the ADC programme contributed to significant improvement in adolescent mental health, which was largely maintained six months following completion of the programme.

5.4.3 Prediction of Successful Treatment Outcomes

A secondary objective of this thesis was to explore factors associated with successful treatment outcomes, in particular characteristics of clients more likely to complete an ADC programme, and factors that are associated with greater improvements in therapeutic outcome.

Results indicated that the best predictor of ‘programme completion’ was parents’ reports of lower target behaviour (i.e., clients most likely to complete an
ADC programme had relatively lower/less serious levels of target behaviour, as reported by parents). Number of previous interventions was also a significant predictor, with completers having participated in fewer previous interventions.

The best predictor of large gains in treatment outcome (improvements in YSR total problem behaviour) immediately following completion of the ADC programme, in contrast to the findings for treatment completion, was higher scores of pre-programme total problem behaviour, but this time based on youth report. This indicates youth who reported a higher number of problem behaviours demonstrated the greatest gains in treatment outcome. Having a parent willing and available to complete a CBCL also significantly predicted greater levels of therapeutic change. Treatment outcome at six months following completion was again significantly associated with higher levels of pre-programme total problem behaviour (YSR), and also having fewer concurrent community agencies and services involved with the client during the programme.

The review of literature (section 2.3) identified the main factors that have been found to be predictive of treatment completion (e.g., SES, parental psychopathology, client-therapist relationship, problem type) or greater treatment outcomes (e.g., age, gender, problem type, SES, family/parent functioning, delinquent peer associations, therapist factors or length of treatment). Very few of these client, treatment or therapist factors were found to be predictive in this research. The exception was problem severity, which has consistently been found by other research to be associated with both completion of treatment (Kazdin & Mazurick, 1994; Kazdin et al., 1997) and gains in therapeutic outcomes (Phillips et al., 2000) and proved also to be predictive here. However, as noted above, discrepancies were found in relation to how this variable predicted treatment outcome, being dependent on parent or youth report and treatment completion versus gains in treatment outcome. Parents’ reports of low problem severity predicted treatment completion, and youths’ reports of high problem severity predicted the greatest gains in treatment. A discussion of some explanations and implications of these discrepancies, and the other factors found to be associated with successful treatment outcomes follows.

Factors Affecting Treatment Completion

In discussing the results of the DFA on treatment completion, it is important to remember that, due to measures selected for the DFA model, the results apply only to
youth with parents who were available and willing to complete a CBCL (see section 5.3.1). Results from the analysis were consistent with a handful of studies which focused on factors related to client attrition (Kazdin & Mazurick, 1994; Kazdin et al., 1997). This study found that clients with higher levels of problem severity (CBCL, Target Behaviour), and those with a higher number of previous interventions were more likely to terminate counselling early.

Previous research that has found a similar positive relationship between problem severity and treatment completion has tended to use parent reports (Kazdin & Mazurick, 1994; Kazdin et al., 1997). An interesting observation from this study was that youth reports of problem severity (YSR) did not predict treatment completion. In fact a closer examination of group comparisons in Table 19, suggests that, although not statistically significant, youth who completed the programme had on average higher reports of problem severity than those who terminated early. A study by Blood and Cornwall (1992) who looked at pre-treatment variables that predict completion of an adolescent substance abuse treatment programme, found similar results. They noted that higher reports by males (but not females) of internalising behaviour (YSR) were significantly associated with treatment completion. These authors suggested that high reports by youth could indicate recognition of a problem and need for help, and therefore, motivation for treatment; alternatively, they could indicate increased levels of distress, which when relieved through treatment, sustained involvement and treatment completion. However, whether the ADC clients’ problem behaviour was actually more severe, or whether higher reports indicated increased problem awareness remains unclear. An alternative explanation could be that parents’ reports may reflect the more observable behaviour, typically disruptive behaviour problems, which some research has found to be more resistant to treatment, making clients harder to engage with, and leading to corresponding higher rates of drop-out (Bronson & Carr, 2000; Dadds, 1997; Phillips et al., 2000).

Number of previous interventions has been interpreted as also signifying problem severity, with those youth receiving treatment on multiple previous occasions likely to have more severe and chronic problems (Heijmens Visser et al., 2003). Another possible explanation is that youth who have received more treatment are less responsive to treatment, or have built up a resistance to treatment over time, and, therefore, are harder to engage and maintain in treatment.
Perhaps a different understanding of client drop-out may be achieved by focusing on the ‘decision process’ of those who have dropped out of therapy, rather than client characteristics and demographic variables (Garcia & Weisz, 2002; Kazdin & Wassell, 1999). More recent research has identified barriers to treatment completion such as practical difficulties in attending, perception that treatment is ‘irrelevant’ or too demanding, and failure to engage adequately with a therapist. Assessing subjective experiences such as recognition of need for treatment and level of distress may also help to understand factors contributing to client drop-out. Such factors may be more amenable to change, and may prove to be more useful in reducing client attrition.

In terms of programme providers identifying and intervening with those clients at greater risk of dropping out of counselling, this study has identified two variables (problem severity and number of previous interventions) that warrant attention. The results of this research suggest that clients with the more entrenched, severe and chronic problems (according to their parents), and therefore, most in need of treatment, are the hardest to retain in treatment. Yet according to youths’ reports, as reviewed below, if retained they are likely to make the greatest gains.

**Factors Predicting Greatest Gains in Treatment Outcome**

A second aspect of successful treatment outcome investigated was the factors associated with greater gains in therapeutic outcomes. The results of this study contradict most previous research which has found higher problem severity predicted poorer treatment outcome (Phillips et al., 2000). In contrast, this study found the best predictor of gains in treatment outcome immediately following completion and at six-months follow-up was youths’ reports of higher levels of pre-programme problem severity. A few previous studies have produced similar results, in particular two that studied treatment outcomes of adolescent substance abuse (Friedman & Glickman, 1987; Heights, Norbert & McMenamy, 1996). Other significant predictors of gains in treatment outcome in this study, immediately following completion, were parent availability/willingness to complete a CBCL and, for outcomes at six-months follow-up, the involvement of fewer community agencies.

There are several plausible explanations for these results and their inconsistency with previous research. The results noted above were derived from youth reports of problem severity, not parent reports (which have more commonly
been used in other studies). Yet, as discussed earlier, different results can be found depending on parent or youth report, and as evidenced in this study, in relation to predicting treatment completion. One large study of youth referred to mental health services (n=1652) used both youth and parent reports of problem severity and found both predicted poorer outcomes six years later (Heijmens Visser et al., 2003).

An explanation for this present study’s findings may be similar to the explanations provided by Blood and Cornwall (1992) described above in relation to client attrition. They suggested that higher scores could indicate youth who are experiencing greater levels of distress. They and others also suggested that reports of low problem behaviour by youth may indicate problem ‘denial’ (Andrews et al., 1993), whereas reports of more serious problems may indicate more accurate problem recognition (Friedman & Glickman, 1987). Both awareness or problem recognition and high levels of distress are likely to result in youth perceiving they have more to gain from treatment, and may lead to increased motivation for treatment (Crisp, 2003a) and, thereby, better outcomes. Indeed the explanation of internal discomfort has been used previously to explain improved outcomes with internalising problems compared to externalising problems (Shirk & Russell, 1998). Also possible is that a ‘ceiling effect’ occurs whereby youth with lower scores have less room for improvement, while those with the highest scores had the greatest room for improvement, or for regression back to the mean.

Having a parent willing and available to complete a CBCL also significantly predicted treatment outcome. This could be indicative of parental support and/or family involvement in treatment, which have been found to be strong predictors of superior treatment outcome (Phillips et al., 2000; Huey et al., 2000). Grizenko (1997) found parental cooperation (attendance) to be the most significant predictor of treatment outcome in children who received treatment for severe behavioural problems five years after completion of a treatment programme. Systems-based theories such as social-ecological, family systems, and social learning models also point to the importance of family, suggesting an individual’s behaviour, attitudes, and emotions are responsive to influences provided by the contexts in which they live. Indeed, Huey et al. (2000) suggested that the positive relationship between family involvement and treatment outcome supported core assumptions among family systems theorists and researchers, specifically that improved family functioning contributes to decreased problem behaviour. However, further analysis of measures of
family functioning (BFAM) indicated that there was no difference in the functioning of the families of ADC clients who had parents that completed a CBCL compared to those who did not. This suggests that pre-programme levels of perceived family functioning, don’t account for parents’ willingness/availability to be involved.

Another possible explanation is that parents who did not complete a CBCL, tended to be those whose children had changed residence during the course of the study. Heijmens Visser et al. (2003) found a small but significant correlation between youth who had had a change in family composition, and poorer mental health outcomes five years later. As mentioned previously, New Zealand research has also found that frequent changes of residence were associated with higher levels of mental health disorders (McGee et al., 1991).

At six-months following completion of the ADC programme, community support (the number of concurrent agencies/services involved with the young person, e.g., CYFs, truancy officers or youth aid officers) was found to be a significant predictor of treatment outcome. However, the correlation was negative with clients involved with fewer agencies having comparatively better treatment outcomes. This was an unexpected finding, especially given the current government focus on increasing inter-service collaboration (Mental Health Commission, 1999; Ministry of Health, 2000). While it might have been expected that with more support available for the young person, treatment outcomes were more likely to be achieved and maintained, as already noted, an alternative plausible explanation could be that youth involved with a greater number of services had more chronic and serious problems. Alternatively, they had learned to ‘resist’ the effect of interventions. Certainly, involvement in different services suggests increased problem complexity, with CYF involvement often associated with childhood physical or sexual abuse, and Youth Aid associated with criminal offending. However, further analysis of those who had involvement with a greater number of services did not reveal significant differences in severity according to YSR or CBCL scores. This adds weight to the alternative explanation that increased exposure to services provokes a negative response from the young person, especially when at a developmental stage centred on striving for autonomy. It will be seen in Part III of the thesis that this was true for one female client, who expressed anger at the number of adults ‘telling her what to do’ (see section 7.1.2). It was also interesting that during data collection one of the ADC counsellors commented that they tended not to get involved if the young person
already had several other agencies involved, as in their view it was counterproductive when 'too many adults were vying to influence a young person'.

The results of discriminant function analysis and multiple regression, while statistically significant, have less practical significance, as predictor variables such as problem severity, are not amenable to change. Further, all models left a fairly large proportion of variance in treatment completion (82%) and outcome (51-71%) unaccounted for. The greatest variance by any one predictor (pre-programme problem severity -YSR) did not reach more than (24%). Therefore, the potential explanatory features of ADC clients with better outcomes remains largely unidentified. For more clarity a larger sample size and inclusion of different variables would be needed to uncover the complex interaction the full range of variables. Alternatively, qualitative methodology such as that carried out in Part III of this research may prove useful in uncovering individual differences and factors of more practical significance than was possible using a quantitative methodology. However, these findings have raised some interesting points worthy of further consideration, such as the impact of involvement of parents and other agencies, and the importance of attending to whether problem severity is based on parent or youth report.

5.4.4 Limitations of the Quantitative Study and Recommendations for Future Research

Before outlining some of the limitations of this study, it seems appropriate to stress that an important objective and indeed strength of this research was the collection of data from a ‘real-world’ adolescent counselling programme, addressing a gap in research that has hitherto been largely limited to interventions developed and tested under the conditions of university research trials. Due to problems commonly associated with collecting data in field settings, the goals of this research were never to be a conclusive testing of theory, or providing scientific evidence of the efficacy of the ADC programme. Rather, the research was more exploratory in nature, with findings emphasising external validity and relevance to practising counsellors of adolescents. Several of the limitations discussed below represent the trade-off between internal and external validity associated with the collection of data in an applied setting.

In relation to the quantitative research design, the first limitation was the absence of random assignment to treatment and control or comparison groups. As
already discussed at length in section 4.1.1, ethical and practical constraints precluded the use of a control group. Consequently, there is limited scope for conclusive assessment of the contribution of the ADC programme to the changes observed in the clients who participated in the programme. The degree of contribution by other factors such as natural recovery, maturation, testing, regression to the mean, etc. could not be reliably assessed. However, given the availability of published norms, studies using the same measures, and research on the stability and continuity of mental health problems, it seems reasonable to presume that the observed therapeutic changes of the ADC clients were at least in part due to participation on the ADC programme.

It seems unlikely, when issues of life-threatening behaviours are involved, that researchers will ever be permitted to randomly assign referred youths to treatment and no-treatment control groups (Bickman et al., 1999). Hence, more common is to compare the treatment of interest to ‘usual’ or ‘standard’ care, rather than a no-treatment control. Despite the typical great expense to implement such research trials, if no significant differences are found between the usual care and the treatment of interest, as has been the case in several large scale studies (Bickman, 1996; Spooner et al, 1999), little can be concluded in regards to the effectiveness of either treatment (Bickman et al., 1999).

Hence, although randomised control trials may provide the strongest evidence of efficacy, researchers of adolescent counselling/psychotherapy treatments may need to consider alternative designs and levels of evidence (Graham, 2000). Researchers may adopt mixed-methods designs similar to this, that combine in-depth qualitative data with normative comparisons for the evaluation of clinical significance (Kendall et al., 1999). Other options to consider include the use of single-subject research designs (Donenberg, 1999) or designs that use multiple baseline measures (Bickman et al., 1999) that increase the ability to draw conclusions about the effectiveness of adolescent counselling interventions, without using a no-treatment control group. Graham (2000) has suggested that qualitative research methods may prove especially valuable in developing effective practice for those working with adolescent with mental health concerns.

One of the more significant limitations of the quantitative study was the difficulty in collecting complete sets of data. In particular, when parental reporting was sought, difficulties often arose when youth had moved from one family member to live with another during the course of the research, making post-test comparison
invalid. Further, some youths’ parents were unwilling or unavailable to be involved in the research or the ADC programme.

This posed a significant problem for the DFA, where parent measures were found to be one of the more significant predictors. Because CBCL data were only able to be collected for 63 out of the 89 youth, the results could not be generalised to the 26 youth who did not have a parent willing and available to be involved, which represents a significant proportion of youth referred for treatment. Other data with low response rates included family functioning (BFAM) and the data on substance use collected by the ADC counsellors. Although analyses were conducted to assess the effect of missing data, there were limitations in regards to data available for multiple variable analyses and for more general conclusions to be drawn from the data.

Quantitative data collection spanned a two year period (three ADC programmes across three regions, together with a six-month follow-up). Despite this lengthy period, the current sample size was sufficient to establish only the larger and more straightforward relationships between variables. This is not inappropriate given the exploratory nature of this investigation; however, future researchers might well be advised to use larger sample sizes in order to shed light on the apparently complex relationships between treatment completion, treatment outcome and predictor variables, or consider other research designs such as qualitative methods.

In relation to the prediction of treatment completion, findings were further hampered by a broad definition of early termination, which included all who failed to complete an ADC programme. Counsellor records suggested that early terminators were influenced by moving out of the region, counsellor termination, voluntary withdrawal, or referral to another service. Different factors are likely to be associated with these individual reasons for early termination, and grouping them together may not be valid or helpful. If a larger sample was available, the different sub-groups of early terminators might have been investigated separately, which may have pointed to different interpretations of results. It was suggested that qualitative research designs, may again prove useful here, in revealing the decision processes and subjective experiences of clients which may help to explain early termination.

Weaknesses in the validity of self-report data became evident during this study, and should be highlighted. Discrepancies were evident between youth and parent reporting on the YSR and CBCL instruments in all sections of the quantitative enquiry. In the prediction of treatment completion or gains in treatment outcome,
substantially different results occurred depending on whether youth or parent reports were used. For example, parents’ reports of low problem severity predicted treatment completion, whereas youth reports did not. On the other hand, a seemingly contradictory result was found in the prediction of gains in treatment outcome, which was significantly associated with youth reports of high levels of problem severity, but not parent reports. While both the YSR and CBCL scales have been tested for content, criterion and, in the case of the CBCL, construct validity (Achenbach, 1991a, 1991c), the results from this research indicate that the scales appear to be assessing problem behaviour differently. It was suggested that youth reports of high levels of problem behaviour may also be an indication of ‘problem recognition’ by the youth which, if associated with increased motivation, would account for the significant positive relationship with improvements in mental health. On the other hand high levels of problem behaviour reported by parents may be associated with the more observable disruptive behaviours, which can be more resistant to treatment.

These discrepancies between parent and youth reports have been noted previously. It is surprising then that research in the field of adolescent counselling/psychotherapy has commonly used just parent reporting alone (CBCL) as a measure of outcome, and to predict treatment completion or outcome. The implication of these discrepancies in the interpretation of these and other research results requires further attention. Ideally, researchers should include multiple self-report informants (e.g., youth, parent, counsellor), accompanied also by behavioural observations such as school/training attendance, criminal record, drug testing results, counsellor ratings and subsequent referrals to mental health services, as means of verifying self-reports and assisting in the interpretation of research findings.

Discrepancies based on the timing of clients’ self-report were also observed. Clients reported higher levels of substance use retrospectively compared to self-reported current use. It was suspected that pre-programme current use self-reports minimised actual use. As a result, the effectiveness of this and other similar programmes may be at risk of underestimation. Researchers may be advised to consider the use of retrospective reporting as an alternative or additional method of data collection, although this method of assessment requires further research to establish its validity. Alternatively, the appropriateness of more intrusive methods of assessing levels of substance use, such as urine or blood analysis could be considered. It is also possible that the context in which substance use is self-reported (e.g.,
consideration of social desirability and privacy factors) could be attended to, to increase the accuracy of data collected.

In terms of assessing substance use disorders, assessing patterns of behaviour (i.e., DSM-IV diagnosis) associated with substance use appeared to be more reliable, but applicability of DSM-IV criteria for diagnosis of adolescents may require attention. Some of the criteria have different implications for adolescents (e.g., increased tolerance, legal consequences), and could be associated with over diagnosis.

Although the research sought to measure competence as well as problem behaviour, difficulties in administering the YSR and CBCL to this population resulted in an over emphasis on problem behaviour. Academic performance could be assessed only for a small group of clients, as not all clients were at school. Other measures of competence should be sought, particular those flexible enough to capture successful placement on work schemes or career-related training courses, as well improved attendance or performance at school. More effort is needed to devise ways of assessing mental health more compatibly with the holistic definitions of mental health appropriate to the New Zealand population (see section 2.1.2).

Despite this study’s limitations, it has been able to provide valuable data on a real-world adolescent counselling intervention, and is among the first conducted on a New Zealand sample. Further, the use of a mixed-method research design has meant that some of the limitations mentioned above were able to be addressed in Part III of the this study, the qualitative enquiry.
PART III:
QUALITATIVE ENQUIRY
CHAPTER SIX:
QUALITATIVE METHODS

Part III of this thesis describes the methodology and findings of the qualitative enquiry. The aim of this enquiry was to understand which counselling methods and processes were most effective, with particular reference to the perspective of adolescent clients themselves. This chapter describes the development of the research methodology, the research participants, and the processes involved in collecting, analysing and interpreting qualitative data. The chapter ends with a reflection on the research process with a discussion on ‘positioning’, and a researcher’s responsibility towards research participants. The main findings of the qualitative enquiry appear, in four sections, in Chapter Seven.

As discussed earlier (Section 3.0), the writing style and content of this part of the thesis (Part III) differs from the preceding one (Part II), as it has been adapted so as to be appropriate for qualitative research methodology.

6.1.1 The Journey into Qualitative Research

Within the field of qualitative research, particular attention is given to the relationship between epistemology, theory and method (Denzin & Lincoln, 2003; Taylor & Bogdan, 1998). As discussed in the Chapter Three, the assumptions, interests, and purpose of the researcher influence the methodology chosen, and how it is carried out. This is particularly the case with qualitative research, where the researcher is the primary ‘instrument’ of research, and an integral part both of the research process and the knowledge generated. It is important, therefore, for the researcher to be aware of, and to disclose their assumptions, values and possible biases (Merchant & Dupuy, 1996). My choice to incorporate qualitative methodology started out at the method level, which then in turn influenced the theoretical perspective adopted.

The use of qualitative methods in this thesis was based on my judgement that qualitative methods would be best suited to address a key aim of the research: to understand, from an adolescent perspective, which treatment methods and related process variables were most helpful in assisting them to make changes in their lives. The decision that qualitative methods were most appropriate to address this research aim was based on two lines of reasoning.
First, a primary goal of qualitative research is to understand people within their own frames of reference, attempting to experience and record "reality" as they experience it (Taylor & Bogdan, 1998). From the literature review it became evident that existing research efforts within the field had been predominantly quantitative, and involved the testing of theories generated by academics and programme providers. The adolescent clients' own perspective on 'what works' had been virtually ignored (Le Surf & Lynch, 1999; Butson, 2002), hence my desire to understand this overlooked perspective, for which qualitative research methods appeared the most appropriate.

Second, qualitative research methods are recognised as being 'discovery orientated', and well suited to situations where there is little existing knowledge (LeSurf & Lynch, 1999) and where the aim is to be expansive rather than reductive in relation to the phenomenon of interest (Lincoln, 1992). This appears especially relevant to the field of adolescent psychotherapy/counselling, where it has been concluded that very little is known about how counselling actually works to help youth achieve change (Kazdin, 2004; Russell & Shirk, 1998; Weersing & Weisz, 2003). Hence, qualitative methods again seemed well suited towards increasing knowledge and understanding of appropriate treatment methods and processes for adolescent clients.

This pragmatic decision (to incorporate qualitative methods) was made from what I now recognise as a postpositivist world view. My background as an academic and researcher had been dominated by postpositive research projects across a variety of subject areas (e.g., sport psychology, health science, offender rehabilitation and, more recently, adventure therapy). I have always been keen to explore different methods of research, evidenced by the variety of methodologies I have used in previous research projects, including experimental research, survey research, single-subject research methodology and even qualitative research. However, I now understand that even my attempts at qualitative research, which involved counting the number of responses given by a 'sample' of research participants, were in fact conducted from an implicit postpositivist perspective. I nevertheless had a sense there was more to qualitative research, and approached this thesis-related research as an opportunity to understand and develop the skills as a qualitative researcher.

In developing a thesis proposal in which I would use qualitative methods, I read several qualitative research texts. I began to understand that whilst qualitative
research can be conducted from within a variety of theoretical paradigms, including a postpositivist one (Denzin & Lincoln, 2003), as a methodology it has greater potential for understanding participants’ views and experiences if conducted within a constructivist framework which incorporates multiple socially-constructed realities (Lincoln, 1992; Marvasti, 2004; Mertens, 1998). Hence, I decided to conduct the qualitative enquiry from such a perspective. As a researcher I was excited at the opportunity to explore the adolescents’ views using this constructivist approach, although I recognised that my postpositive background meant that this might prove to be a challenging exploration.

To successfully achieve this research goal, I needed to ‘let go’ of my postpositive expectations of anticipating, then looking for and finding evidence of definitive answers on ‘what works’ in counselling adolescents. Instead I had to learn to listen to the perspectives offered by the youth, and look for and be open to new ways of thinking based on the adolescents’ constructions of helpful counselling experiences. This was indeed a challenge for me, especially with topics that I felt I had more knowledge on, such as wilderness therapy. On reflection I can see, especially early on, that I was often waiting for the youth to give me the ‘right’ answers (i.e., the ones I was expecting), and would find myself feeling frustrated when I didn’t get them, assuming I hadn’t asked the ‘right’ questions. I found it a little easier when I enquired about their experiences of the community-based counselling, as I had fewer pre-conceived ideas in relation to this area and was keen to learn, based on what was offered by the youth.

Several things helped me to develop as a constructivist researcher, to learn to listen, contemplate and appreciate alternative ways of thinking offered by the youth. The tape recording of interviews gave me the opportunity to re-listen to the youths’ comments over time as my constructivist thinking developed. I found it was often the little comments or phrases made by the youth that in the end became important findings. Initially I had overlooked such comments and was only able to recognise the significance of such comments later on in the data analysis process as I developed a more constructivist way of conducting research. I was assisted in this process by the youth themselves who, fortunately for me, were often quite adamant in their replies. This meant I had to look for new ways of understanding their perspectives, to make sense of their comments. However, perhaps most influential were the meetings with my supervisors and colleagues, where my persistent tendency to revert to a
postpositive perspective could be highlighted and challenged. As this process continued I recognised the value of using this approach to help gain some understanding of adolescents’ constructions of effective counselling, and consider how others may assist them in the process of therapeutic change.

**General inductive approach to qualitative research**

The methodology chosen for the qualitative enquiry is perhaps best described as a constructivist version of a broad interpretative (Smythe, 2000) or general inductive approach (Thomas, 2000). Thomas (2000) has suggested that while many researchers use these labels to describe their methodological approach, it is also possible to identify the use of a general inductive approach in many qualitative research projects that have not explicitly labelled their research methodology. The overall purpose of the general inductive approach has been described as:

> To allow research findings to emerge from the common, dominant or significant themes inherent in raw data, without the restraints imposed by structured methodologies. (Thomas, 2000, p. 13)

Therefore, in employing a general inductive approach in this research, I aimed to discover the youths’ common, dominant and significant constructions of effective counselling that emerged from the interview and observation data.

According to Thomas (2000) the key principles of a general inductive approach and those emphasised in this enquiry (to be consistent with a constructivist theoretical perspective) include the following.

- It is accepted that the relationship between the researcher and participants is interactive, and that common understandings will result from co-creation of meaning. The researcher must, therefore, acknowledge the multiple discourses affecting interactions with participants in the research setting and the interpretation of participants’ comments, while keeping an open mind towards research objectives.
- Data analysis is influenced by both the research objectives (deductive) and by multiple readings and interpretations of the raw data (inductive), however, the researcher allows the voices of the individuals directly involved with the issues under investigation to guide the process.
• In terms of rigour, reliability is seen as the trustworthiness of the observations or data, while validity is viewed as the trustworthiness of interpretations or conclusions.

These principles and assumptions are reflected in the methods and approaches presented in the rest of this chapter.

6.1.2 The Research Process

Research Participants

Recruitment

As part of this qualitative enquiry I sought to follow a group of adolescent clients as they progressed through an ADC programme. As noted previously, the ADC programmes operate in three regions: Southland, Otago and Canterbury, and the plan was to recruit participants from one regional programme intake. Hence, the first decision I had to make was which region to select for study. Given the location of my residency the obvious choice was Canterbury, as this would allow easy access to programme activities and participants. However, I noted that the Canterbury ADC programme was, of the three, the most recently established, with recruitment and other matters relating to employment of counsellors still being finalised. Otago was the initial programme developed, and was the model which the others were replicating. Therefore, despite the prospect of regular five-hour drives, I decided on the Otago option. The programme studied was known as ‘ADO10’, and referrals to this particular intake were from the Otago region, in early 2000.

All of the clients formally accepted on to ADO10 were subsequently asked by the ADC counsellor to participate in this research. They were told the purpose of the study, and what their involvement was likely to entail (especially in relation to interviews and observations). The counsellor then issued an information sheet, together with an informed consent form, to the client and the parents/caregivers of the client, to be completed if they agreed to be research participants (See Appendix G).

A description of the research participants recruited, and their involvement in the research, was a story that involved several ‘comings’ and ‘goings’. There were 34 youth initially referred to ADO10, of whom twelve were accepted and formally started on the programme. All 12 agreed to be research participants. An additional two clients from South Canterbury were to be on the same ‘Journey’ component of the programme as the ADO10 clients (which I was planning to observe); fortunately
these two clients also agreed to participate in the research. Without their permission and agreement, it probably would not have been appropriate for me to attend the Journey element and observe the ADO10 clients. This brought the final total of research participants to 14.

Of this group, five failed to complete the programme: one moved out of the region before the programme ended, one required transfer to a residential drug and alcohol programme, and three opted to withdraw. This left nine clients who completed all elements of the programme, including the Journey.

I observed the initial 14 participants to varying degrees as they proceeded through their ADC experience. I was able to locate and gain agreement from twelve of these participants for a formal interview after the end of the programme (i.e., semi-structured, tape recorded interview). Of the two I did not interview: one declined, and the other (the one who had moved out of the area) I was unable to contact despite extensive efforts. Therefore, twelve participated in the formal interviews, and their comments are presented in subsequent sections. These twelve have been assigned the following pseudonyms: Gerry, Jane, Andrew, Martin, Sue, David, Terry, Keith, Peter, Melissa, Ricky and Sam.

In addition to this core group of participants, I had some degree of contact with almost a hundred additional ADC clients during the course of my data collection (including that covered in Part II of the thesis). These clients were also assigned pseudonyms: comments presented against names other than those twelve listed above are from this larger group of clients. All of these clients were also briefed about the research by their counsellors once accepted on to the programme, had received information sheets, and had signed informed consent forms. I hoped that my casual conversations and observations of this larger group would aid my interpretation of those aspects of the ADC experience which adolescent clients regarded as significant to the therapeutic change process.

Other participants in the research included the counsellors, parents/caregivers of clients, and referral agents of the youth. The counsellors included two males, one in his mid 30’s and one in his late 40’s, and one female counsellor in her early 40’s, all of whom identified as NZ European. I met or spoke with the parents/caregivers of the eleven of the 14 core research participants. I was also able to interview five referral agents, including four school guidance counsellors and one social worker. These
participants were all introduced to the research by me personally, and were provided
with information sheets and informed consent forms to sign.

**Description of research participants**

It is common in qualitative research to introduce research participants by
reference to background information on each, which provides context to their
comments and perspectives. It is also common, in situations where individuals may be
identifiable, to summarise characteristics. I have chosen the latter procedure.

The main group of research participants consisted of five females and nine
males ranging in age from 13 years to 16 years. Ten identified themselves as New
Zealand European (NZE), three as Maori and one as Tongan. Referrals had come via
schools (6), parents (2), CYF (2), Youth Aid (1) and other mental health services or
community agencies (3). Five were not attending school at the time of referral, and all
but one had previously received some form of psychological/psychiatric treatment or
counselling.

The reasons for referral to the ADC programme for these individuals varied in
complexity and severity. Those summarised in Table 26 are based on counsellor
assessment and relate to the programme’s funding criteria (having, or being at risk of,
a significant drug/alcohol problem or any other significant mental health disorder, and
whose behaviour was affecting their expected social and/or academic development).

This tabulated information fails to fully describe the complexity and severity
of problems characteristic of many of these young peoples’ lives, and so is
supplemented with further descriptive information. Clients were typically living apart
from one or more parent. This estrangement typically came about when their parents
had separated, with one parent then moving away, or where CYF had removed the
young person from their family because of concerns for their safety (sexual or
physical abuse), or because of high levels of (youth) offending. Many of the families
had experienced difficulties including problems with accommodation, finance, legal,
medical and/or relationships. Around a third of the research participants’ parents had
histories themselves of substance use problems, criminal behaviour or psychiatric
difficulties. Some of these parents were affiliated with gangs, with the clients having
been exposed to drug dealing and/or subjected to severe violence.
Almost half of the research participants had been victims of violence from an adult family member at some stage of their lives, and many had been subjected to emotional abuse. An example of the latter was a client who, as a child, had observed her pet dog being killed, buried, and then told that “you could be next”. Two clients had either attacked or been attacked by siblings, including one stabbing incident. One client had been expelled from school as a result of assaulting a fellow student, breaking their collar-bone. Several clients had engaged in criminal activities, which included shoplifting, stealing cars, stealing from their families, or burglaries. As illustration of the severity of the disturbance experienced by these clients, one who withdrew from the programme after just a few sessions was later convicted of armed robbery and sentenced to prison.

Research participants were also experiencing emotional difficulties. One client suffered from social phobia, one was obsessively fearful of being abducted, with another client experiencing symptoms of pathological grief over the death of a sibling. Several clients used solvents and abused alcohol: it was not uncommon to hear reports of regular drinking binges where individuals would drink a litre of spirits (23% proof)
over the course of a single occasion. Many were regular users of cannabis. One client described himself as being “stoned 24-7”. Unsafe sexual behaviour, coupled with excess drinking, had resulted in one client recently terminating a pregnancy. Educational difficulties appeared related to disruptive behaviour at school, truancy, learning difficulties, and removal from the school system. The difficulties in the lives of three clients had led to suicide attempts.

The majority of clients were dealing with at least three major issues of the types described above.

Methods of Data Collection

Two principal methods of data collection were carried out: participant observations (which I have termed researcher observation), and interviews.

Researcher observation

Participant observation is described by Bogdan and Biklen (1992) as a process of data collection whereby the researcher enters the natural setting of the participants and systematically observes behaviours and interactions, which are recorded as field notes. The aim is to get close to people, making them feel comfortable enough with your presence so you can observe and record information about their lives. Data collection occurs in naturalistic settings that are typically more familiar to the participants than the researcher. This is also referred to as ‘field work’ (Bogdan & Biklen, 1992; Taylor & Bogdan, 1998)

Ely (1990) has suggested that the meaning of ‘participant-observer’ ranges from full participant to mute observer. The style of observation which I adopted was less than a full participant, as I was of course not an active participant receiving counselling. The observations were limited to participants’ interactions with their counsellor and within the ADC programme generally. In this respect my style of observing was similar to what Ely (1990) described as a ‘limited’ observer, where one observes, asks questions, and builds trust over time, but does not have a public role other than researcher. I have chosen to describe my style of observations as ‘researcher observation’ as opposed to ‘participant observation’ as I believe this reflects more accurately the limitation of my participation.

The majority of these ‘researcher observations’ occurred between February and December, 2000. This covered the period of ADC involvement for most the
research participants (although one client was carried over to the next programme, ADO11). My general involvement with the programme was, however, for a greater period (June 1999 through to November 2003), and this extended period of time allowed for many opportunities for informal observation and conversations with a wide range of individuals.

Researcher observations typically involved shadowing an ADC counsellor during a typical day. I was privileged to sit in on over 30 counselling sessions with research participants and their families. These counselling sessions took place at ADC offices, at schools and, for those not at school, either in their homes or places of alternative education/training course. Some days tended to be mostly office-based, with clients coming in to meet with their counsellors, or the counsellor briefly popping out to a nearby school for appointments. Other days involved driving with a counsellor for up to three hours to rural locations. Sometimes several clients would be seen in an area, which might mean staying overnight so the counsellor had sufficient time to meet with all clients. I also observed/participated in three Journeys during my involvement with the programme: one in which the ADO10 clients participated, one prior to that, and one subsequent. I had been told by counsellors that each Journey could vary substantially, dependent on the make up of the staff members present and the client group. I therefore wanted to avoid limiting my observations to a single Journey.

In addition to observing clients' participation in counselling experiences, I observed the typical daily activities of the ADC counsellor, including arranging appointments, chasing up missed appointments, talking on the phone with parents, referral agents or other related third parties, various administrative duties, staff meetings, ADC staff training, and even coffee and lunch breaks. This allowed me to put into context the ratio of contact to non-contact time, and the different forms of contact counsellors had with clients. I also made notes from over 20 telephone conversations with counsellors. Finally, I received a wide range of ADC documents including assessment material, counsellor records, Journey log books, training manuals and ADC promotional material.

My periods of direct observation were limited to intermittent (though concentrated) periods of time, varying from two to nine days. This schedule was the result of having to travel several hours to research sites. They were concentrated because, once I was there, I was anxious to observe as much as possible before
leaving on the long trip home. I tried to time ‘visits’ to observe all phases of the programme: recruitment, assessment, pre-journey counselling, the Journey itself, and post-Journey counselling.

A positive aspect of these concentrated observations was gaining a fairly complete ‘snap shot’ of ADC, the busy bits as well as the more mundane parts of the day. Had I employed easier access to the field, I may well have observed less, through choosing only what seemed at the time to be the ‘interesting’ parts of the day. By spending just a morning here, and an afternoon there, I may have developed a less complete picture. However, a drawback to these concentrated periods of observation was fewer opportunities to reflect and make notes on what I was observing before re-entering the field for further observations.

I avoided making notes in the presence of the youth or counsellors to avoid interrupting the typical flow of counsellor-client interaction. I would, however, make brief notes throughout the day at opportune moments. Typically I had to wait until evening to make more detailed notes, and then several days before returning home and completing full sets. This effort to minimise my influence on programme processes appeared to have been moderately successful, at least in relation to the counsellors, with one commenting that he was barely aware that I was present. On another occasion a counsellor joked, however, that there was probably “better language” (less swearing) in the counselling sessions I sat in on, which indicated that, at times my presence may have influenced what I was observing. For the clients, in response to my questioning, one (a male) felt he had ‘said less’ in counselling sessions when I was present. On the other hand one counsellor suggested some of his clients appeared more at ease when I was present, and spoke more freely. Either way it seems likely, at least in the initial stages, that I was influencing what I was observing to a certain extent.

The most sustained periods of observations were whilst participating/observing the nine-day Journey. These days were very busy, and making detailed notes was often difficult. However, as all Journey participants had log books themselves in which they were required to record notes, I was able to discreetly make brief notes during the days without it being noticeable. When I felt I was getting behind in my note-taking, I would excuse myself from parts of the programme in order to catch up.
Overall, my experience of the Journey was probably closer to that of the ADC counsellors than the youth. I slept in the same area as the counsellors, was involved in ‘adult’ only staff meetings; the counsellors also tended to include me in their conversations, sharing thoughts and perspectives. There were times when I even found myself acting like a Journey leader, such as giving assistance to youth in goal-setting. However, there were also times when I experienced the Journey more like a participant, especially when sharing with the chores, and participating in games and activities. I certainly experienced similar feelings of exertion and effort whilst tramping, and enduring the sometimes extreme weather conditions.

I concluded that the youth perceived me as ‘different’ to the counsellors. I came to this conclusion because several participants ended conversations with “but don’t tell [my ADC counsellor]”. I have no doubt, however, that I was also perceived as very different to the youth themselves. As such, my choice of term ‘researcher observation’ fitted well as a description of the data collection method.

All hand-written notes from my researcher observations were typed up using a word processor. At that stage I also added more detailed reflections on what I had been observing. Approximately 640 pages of typed text were produced. These typed notes were then imported into NVivo (QSR, 1999), a software package that has been developed specifically to assist in the management and analysis of qualitative data.

**Interviews**

In addition to my periods of researcher observation I also conducted ‘formal’ interviews with research participants. These formal interviews were tape recorded, semi-structured interviews, ranging from 30 minutes to over an hour and half. The interviews were semi-structured in that there were specific issues I wanted to explore, but also unstructured to the extent that all questions were open-ended and I was happy to explore any perspectives offered by the clients on their counselling experience.

Each interview started with an explanation of the nature of the interview, that it was confidential, and that participation was voluntary, together with a description of the purpose of the interview. This I explained as ‘for you to help me understand what you had found helpful about your ADC experience’. I also checked if they were comfortable with me using the tape recorder. I would then typically begin the

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8 I operated under the same agreement of confidentiality as the counsellors. I kept things confidential unless I was concerned for the safety of the client or others.
interview with a description of what I meant by the ADC programme (i.e.,
community-based counselling and the Journey). I followed this with questions I hoped
would be simple to answer and might help to put them at ease. These included
questions like; ‘How did you find out about the programme?’; and ‘How keen were
you to be involved?’ I then proceeded with some very broad questions such as; ‘What,
if anything, did you feel you had achieved?’, ‘What had you found most helpful about
the programme?’; and ‘How had you found the ADC counsellor?’ These broad
questions were to encourage comments less solicited by direct questioning, as I later
followed up with more specific questions on how they had found the different
components of the ADC programme (e.g., family counselling, writing their story, the
Journey).

I started out using a prepared list of questions, but found that interviews
tended to jump around, and didn’t always follow the order of my written questions. I
replaced the interview guide with a type of tree diagram I had developed, which
included all issues I wanted to cover, but on a single page that allowed me to move
freely from topic to topic as the clients wished, whilst keeping track of what we had
and had not yet talked about (See Appendix H).

Tape recordings of interviews were transcribed verbatim by me and were
imported into NVivo (QSR, 1999) along with the observation notes. This produced
approximately 450 pages of typed text. The many informal interviews, conversations
and phone calls I had with research participants were integrated into the observation
notes; I indicated in the notes if I had recorded participants actual words or quotes.

**Interviewing adolescents**

During my initial data collection I often felt that the interviews were awkward
both for myself and the participants. I had the sense that participants were either
unwilling or struggling to respond to my questions. As a result I found myself
modifying the way I collected data. Relevant here were characteristics which I
perceived to be unique challenges posed by adolescent participants. I had read other
researchers who had found that adolescent participants had difficulty articulating their
experiences (e.g., Dunnachie-McNatty, 2000; who explored young peoples’
experiences of depression). ADC clients appeared to have similar difficulty in
explaining what had been helpful to them in making positive changes and overcoming
their problems. This may have been because they were simply un-aware of what had
been helpful, or lacked the verbal ability to articulate it. During interviews two clients described how they had often found it hard to say what they meant to their counsellor, and how they had found it helpful when the counsellor ‘put into words’ for them ‘exactly’ what they were trying to say. I often found myself resorting to a similar strategy in an attempt to elicit from them what they might have been thinking. However, this ‘leading question’ approach seemed to limit the quality (and probably validity) of some of the data collected.

Taylor and Bogdan (1998) suggested, that “a good qualitative researcher sometimes gets people to talk about things they would otherwise keep hidden, or never think to mention” (p. 157). In relation to this the work of DeVault (1990) is relevant, who suggested people are often unable to articulate some of their experiences and feelings, and the researcher must help them come up with the words (cited in Taylor & Bogdan, 1998). While the information gathered was sometimes in my words (and as such could not be presented as ‘data’), I did feel it assisted in understanding what the youth were trying to convey. In turn, this may have resulted in my asking more helpful questions to the next participant, or being able to attend more readily to the significance of another client articulating a similar experience, and therefore, productive to the overall research purpose.

There is also the possibility, however, that the adolescent clients simply did not feel sufficiently comfortable discussing things with me (see section 6.1.3). Because the presentation of the qualitative data collected reflected the emphases made by the youth, I may have missed other aspects, perhaps in relation to personal issues, that had been helpful but which youth were less willing to talk to me about (e.g., sexual abuse, family issues, relationship difficulties with significant others). It is of course difficult to ascertain whether such key concerns existed but were not disclosed by the youth.

Analysis and Interpretation

Data analysis was a combination of analysis during data collection (in-the-field) and analysis following data collection.
Data analysis during data collection

During the data collection phase, following observations, conversations and interviews, I recorded memo notes to myself. These memos consisted of personal reactions to the data being collected, things that surprised me, things I didn’t understand, and also things that seemed important, either because of their apparent significance or because they appeared to represent a common (or differing) perspective among participants. On returning from the field, I typed up observation notes and interviews which I printed out and re-read, jotting down more notes in the margins. Documents were then imported into NVivo so that I could start coding. Following this writing, re-reading and coding, I made further memo notes on developing ideas and recorded them in NVivo.

This analysis in-the-field allowed me to reflect on the data I was collecting, ideas for interpretation, and areas for further enquiry. I could then respond to these thoughts through the focus of my subsequent observations and interviews. Planning of future data collection sessions allowed me to follow up leads or retrieve data that was missing. The process would then be repeated: more memos, writing-up, reading, coding, then more memos and reflecting, before re-entering the field for further data collection. While my concentrated periods of data collection allowed little opportunity for reflection during these two-to nine-day periods, there were often weeks in between to write up notes, code the data and make notes on my reactions to the data.

The coding of the data, as mentioned above, started concurrently with the data collection. The coding process has been described as bringing together and analysing all data bearing on major themes, ideas, concepts, interpretations, and propositions (Taylor & Bogdan, 1998). The process of coding I undertook was greatly assisted by NVivo software. I retrieved the documents of observation notes and transcribed interviews, and as I read through them, created a code (or what NVivo refer to as a ‘node’). This was a label that I felt best represented the content of either a point of observation or interview statement. The software then automatically collected together under one node all similar observations or comments. I could then look through a node and compare and contrast all related data, thus refining my ideas on this issue. The management of nodes in NVivo is simple. Coding one phrase or observation into several nodes was easy, and re-defining nodes, or cutting and pasting content from one node to another is also straightforward.
Bogdan and Biklen (1992) liken the data analysis process to an open-ended funnel: things are open at the beginning (or start) and more directed and specific at the bottom. The focus of the research should emerge only after time has been spent in the field with the research participants. My data collection and subsequent coding reflected a similar process. Early on in the coding process I had over 50 nodes to represent the data. As I collected more data and did more coding over time, it became evident that some nodes contained more data than others (i.e., some issues appeared to be emerging as more significant than others). As I started to focus my attention on these larger nodes, I was effectively ‘listening’ to the priorities of the youth, and letting their concepts of importance emerge inductively from the data. As the research became ever more focused, I then set about re-organising the nodes. Nodes were added, others collapsed, integrated, expanded or redefined. I subsequently developed broader categories into which I could organise the individual nodes. NVivo represented these categories in a tree format, with one major category having several sub-categories, which in turn has further sub-categories.

Data analysis following data collection

On completion of the data collection, I had already coded all the data, and several broad categories had emerged (e.g., ‘view of what works’, ‘what it was like’ and ‘relationships’), each of which had several levels of sub-categories beneath them. However, as I re-read, thought about, and re-read again what was becoming very familiar data, key themes of common experience began to take shape that I thought represented the participants’ perspective. These themes were more abstract than the initial codes. Morse (1995) describes themes as often ‘indicated’ by the data rather than concrete entities directly described by the participants. Identification of themes was assisted by asking myself the question “What might it mean that they are saying this?” This was a shift from my previous postpositivist style of qualitative research, where the question would have been “Is what they are saying valid or accurate?”. In deciding on themes I would think back to my time in the field and consider whether the theme fitted well with my observations.

Once I had settled on a theme, I would proceed to write it up, recording together my interpretations alongside the data that supported them. Sometimes I found a theme ‘worked’ and was supported by the data, while other times I came to the
conclusion that I was trying to 'force the data' to fit my formulation. If so, I would go back to the data and re-evaluate the theme.

Presentation of data

The aim of the general inductive approach is to understand the common, dominant or significant themes inherent in raw data. The findings presented in the next chapter reflect the major themes identified by the youth as contributing to their process of therapeutic change. Verbatim quotes are all represented in italics and presented as indented single lined paragraphs. Quotes prefixed by 'EM’ represent my own comments, which are included to allow the reader access to the interaction that prompted the response. While these quotes are verbatim, and priority was given to content emphasised by the youth, it must be recognised that they are inevitably ordered according to the thematic patterns I have formulated, and are clustered around the interpretations I have made.

Issues of Rigour

In qualitative research the primary research 'tool' is the researcher him/herself; when the researcher collects data they do so by looking through their own personal, political and theoretical 'lenses'. It is through these lenses that the researcher attempts to interpret the perspectives of the research participants, before preparing the 'findings' of the research. Therefore, in qualitative research, postpositive terms of validity and reliability are replaced by the notion of 'trustworthiness'. Reliability relates to the trustworthiness of the observations or data, while validity relates to the trustworthiness of interpretations or conclusions (Stiles, 1993).

There are several measures that can be taken by qualitative researcher to help enhance the 'trustworthiness' of the research. It is important to describe the researchers' internal processes while collecting the data and developing interpretations, which I have attempted to do above in this section, and throughout the presentation of the findings. Further, a disclosure of the researcher's own assumptions, beliefs and experiences, and acknowledgment of how these may have influenced the interpretations, are important, and some of that which is relevant to the present researcher appear below. Other measures include 'member checking',
supervision and triangulation, which I incorporated in this research and also describe below.

Personal disclosure

What follows is a declaration of my position as the researcher, starting with some background information locating my origins, and a discussion on how these factors may have impacted on the research undertaken.

In terms of demographics, I am female and was born, brought up and educated in England in a middle-class family up until my early 20’s, when I travelled, studied and worked abroad before finally settling in New Zealand in my late 20’s. I was in my mid 30’s at the start of this research.

My academic and personal interests have been dominated by activity-based pursuits. My early academic focus was on competitive sports and, in particular, how sport psychology could be used to enhance performance. However, over time this focus shifted to an interest in non-competitive outdoor recreation-type activities, more recently arriving at an interest in therapeutic effects of outdoor adventure activities. This lead directly to an interest in researching the Adventure Development Counselling programme.

When I embarked on this research I had already studied several applications of therapeutic adventure, including personal development for high school students, rehabilitation of incarcerated adult offenders, and recovery of adults suffering mental illness. These research projects each had used adventure/wilderness activities for what I observed to be educational and personal development goals. I had concluded that positive effects could indeed be gained from participating in adventurous outdoor activities.

I regarded the current research project as an opportunity to extend my knowledge on the therapeutic application of adventure/wilderness activities. In particular, I was interested in investigating whether such activities could be used to achieve intentional therapeutic change in a clinical population, and whether it was possible for these therapeutic outcomes to be subsequently maintained in participants’ lives. I approached this project with the expectation that these achievements and their transfer were indeed possible, perhaps even likely.

I had felt quite comfortable researching the previous therapeutic adventure programmes, as they were facilitated by individuals with an outdoor education bent
which didn’t feel was too far removed from my own sporting background. However, I felt a little out of my ‘comfort zone’ understanding the ADC programme, which was facilitated by counsellors or psychologists with Masters’ level qualifications. I recognised that my lack of knowledge on theories of counselling for adolescents with mental health concerns (or indeed for any clinical population) might limit my understanding of therapeutic changes, the core objectives of the programme. To alleviate this concern, in the early stages of the research, I sat in on some Masters’ level counselling courses, and read extensively on the counselling approaches used by ADC programme personnel. This included texts on motivational interviewing, narrative therapy, brief and solution-focused therapy, and multisystemic approaches.

As I became more familiar with qualitative research methods I also became aware that my lack of knowledge could, paradoxically, be viewed as a strength. As a ‘naïve’ observer, I may have been able to collect data in a less biased manner, free from pre-conceived ideas on which theories of counselling were more or less valid. Indeed it is an accepted tenet of research that researcher allegiance, in this case to a particular theory of counselling, can be a confounding variable (Stiles, 1993; Wampold, 2001). However, I acknowledge that limited knowledge on counselling theory may also have diminished the quality of observations I was able to make, and reduced my ability to understand subtle but significant events observed, resulting in failure to capture or explore these issues with the youth.

An area of research that I also recognised as challenging was in understanding the perspectives of adolescents with mental health concerns, the focus of the qualitative enquiry. Given my demographics and background, I was acutely aware, of how different I was from the research participants. My memories of my own adolescence in England, though fading fast, are characterised by a relatively privileged up-bringing, from which exposure to counselling services was absent. Similarly, having been brought up in a relatively mono-cultural social environment in England, (which changed little even when moving to New Zealand), my ability to understand the experiences of Māori and Pacific Island adolescents was even more limited. I had received offers of help from Māori researchers to assess the cultural appropriateness of any interpretations; however, it was not an area that I felt qualified or comfortable to explore fully. The interpretive limitations of this factor need to be recognised.
More recently I have had opportunity to live with and observe my partner’s three children (all NZ Europeans) as they progressed through adolescent development phases, a seemingly precarious phase of life for both parent and adolescent. While at times there were challenges, on the whole what I observed seemed to be successful ‘transitions’. I recognised that I was going to have listen very carefully to be able to hear and accurately represent the perspectives being offered by the research participants. Such comments are offered as considerations in assessing the credibility of my interpretations.

**Member checks**

‘Member checking’ is a strategy employed by researchers to help establish the credibility of interpretations (Ely 1990; Taylor & Bogdan, 1998). A member check ascertains whether the researchers’ interpretations accurately represent the perspectives of those being researched. I used a version of member checking with ADC clients by ‘feeding back’ my interpretation of the participant’s words (or in some cases observed behaviour) to that person, usually by paraphrasing comments made, to determine whether I had understood what the person meant. Sometimes the youth would correct me, while other times they nodded enthusiastically at my interpretation. There may, of course, have been occasions where it was easier to agree with me than for the client to persevere in explaining what they had perhaps really meant. Member checking typically occurred during interviews, but with repeated contact with some participants I was able to check my interpretations, especially in relation to observed behaviour, retrospectively.

**Supervision**

I was fortunate to receive two forms of supervision which further enabled me to check the trustworthiness of my interpretations. These included meetings with my university supervisors, and with peers. Regular meetings with the former provided the opportunity to present the data I had collected (observation notes and interview transcripts), together with examples of my coding and memo-taking. I then received feedback on my interpretations and methods of data collection. Early on in the data collection, I found these meetings particularly valuable in improving my note-taking and interviewing skills, and in better focusing my in-the-field data analysis. As I began to write up my findings, the confirmation or challenges I received from my
supervisors in relation to the interpretations I was making became increasingly important.

A second form of supervision is with peers not directly involved with the research project. Stiles (1993) uses the term ‘peer debriefing’ or ‘consensus among researchers’ to describe this strategy. I met regularly met with a fellow PhD student who was also conducting qualitative research with adolescent participants. We were able to share findings, and our interpretations, and thereby to check out with each other whether our interpretations were reasonable. My fellow PhD student had in fact herself shifted from a postpositive to a constructionist research orientation, and I greatly benefited by the reflections she shared. I found these meetings very informative, and they greatly assisted my efforts to conduct the research from a constructivist perspective.

**Triangulation**

A final strategy to increase the trustworthiness of the data collected and its interpretations was the use of triangulation (Marvasti, 2004; Stiles, 1993). This is where data are collected from multiple sources and/or methods and assessed for convergence (Stiles, 1993). I collected data and perspectives from several sources in addition to the youth, including the counsellors, parents and referral agents, and also used several different methods (interview, observation and quantitative data).

Marvasti (2004) cautions that aggregation of data from different sources will not necessarily produce a more complete picture, but suggests differences in perspectives can add depth and complexity to the data and analysis. It should be noted that my intention was to understand the perspective of the adolescent clients and not simply to assess ‘accuracy’. However, I found triangulation between my interview data and observation notes particularly helpful; at times the quantitative data assisted in making sense of the qualitative data. As suggested by Marvasti (2004), it was often discrepancies between data sets that provoked the most valuable reflecting and formulating.

**6.1.3 Reflecting on the Research Process**

Before moving on to the presentation of the qualitative findings some final reflections on the research process are offered. Consistent with a constructivist epistemology it is appropriate to reflect on the power and positioning between the
researcher and participant, considering the effect this dynamic may have had in the production of knowledge. Fundamental to qualitative research is a responsibility of care towards the research participant; therefore, consideration is also given to reciprocity occurring between researcher and participants, including measures taken to ensure their participation was ethically obtained.

**Power and Positioning**

A constructivist understanding of the nature of knowledge acknowledges an interactive link between researcher and participants in the co-creation of understanding. The power and positioning between these two parties impacts on the knowledge that can be produced.

I felt a degree of vulnerability in my position. I recognised I was very much dependent on the willingness of the adolescent research participants to disclose often very personal information to me, and I questioned my ability to develop sufficient rapport for the youth to feel comfortable in making such disclosures. I perceived myself as an outsider to these adolescents in just about every respect (age, culture, peer group, family life, life in and out of school, etc.) all of which seemed likely to inhibit the extent to which they chose to share information with me. The Journey might have provided greater opportunity to create some shared experiences, but I still expected to be considered far more of an outsider than an insider.

In one respect being an outsider may have been an advantage. It became evident through the collection of data, and reading the literature, that confidentiality was extremely important to these young people. Through being an outsider, the youth may have perceived me as less of a threat, perhaps deciding that it was safe to disclose personal information to me. However, being an adult who travelled, associated with, and no doubt appeared to get on well with the adult ADC counselling staff, I was inevitably perceived by the youth, to a certain extent, as an ‘insider’ of that group. This perception may have restricted what the youth were prepared to tell me, perhaps especially in relation to any negative experiences with ADC counsellors.

To address this concern I always stressed the commitment to confidentiality. For example I always explained that, if they shared negative feelings about their counsellor, I wouldn’t go ‘running back’ and tell the counsellor. I also undertook measures to maintain a separateness from the counsellors. Early in interviews I would remind the client that I was not a counsellor (this was also to avoid my comments
being interpreted as having any therapeutic intent). I turned down invitations from counsellors to play an active part in counselling sessions, or to run activities on the Journey, and on the Journey I occasionally would sit out from activities and distance myself from the counsellors (this also acted as an opportunity to catch up on notes).

From my perspective, I felt the “balance of power” was in favour of the adolescents, although, I recognised that the youth probably didn’t perceive it that way. Being an adult ‘researcher’ from the University of Canterbury made it likely I was perceived as an ‘expert’. Further, I routinely heard client accounts of negative experiences with adults in positions of power over them, including family members, teachers and even helping professionals. To address this perceived power imbalance I sought to explain that I needed their help in trying to understand “what young people like yourself think about counselling”. Sometimes I would start a question saying “Now you’re an expert on [counsellors], tell me what you think?”. Another strategy was to self-disclose selected personal details myself, to try and equalise the power differential and make it easier for them. Subsequent reports from the participants supported the validity of this assumption (see section 7.2.3).

Despite my concerns over the limitations posed by my perceived ‘positioning’, I was pleasantly surprised at a degree of connection I frequently felt with the research participants. This was often conveyed through nods and smiles and mischievous looks rather than elaborate self-disclosures. In the end I felt very honoured by their efforts to help me understand their perspectives and experiences.

Responsibility to the research participants

Ethical considerations

In terms of ethical considerations, this research project was subjected to review, and approved by, the University of Canterbury Human Ethics Committee and the Canterbury Health Research Council (See Appendix C). These committees function to ensure that standard ethical procedures are in place. Many of the key ethical procedures are covered in the informed consent process. Participants received information sheets and verbal explanations which outlined the purpose of the research, what their involvement would be, that any participation was voluntary, and that they were free to withdraw without adversely affecting their current or future treatment. Most importantly they were assured of complete confidentiality. Participants signed an informed consent form to confirm their agreement to
participate. This process was to an extent repeated verbally throughout the research. Prior to the researcher sitting in on a counselling sessions, the ADC counsellor would gain verbal consent from their client, and I always checked whether participants were happy to proceed prior to conducting a formal interview.

Reciprocity

Marvasti (2004) has suggested that an obvious inequality of power and status exists between researchers and underage respondents. He suggests one way to avoid exploiting this position is to ensure that young respondents' participation in the research is of value to them, and their communities. This relates to the concept of reciprocity, a degree of 'giving and taking' between researcher and participant.

From my perspective, it appeared the adolescent clients were primarily the 'givers' of information, for which I was indebted. On completion of my final interview with a participant, I therefore gave them a 'thank-you' gift of confectionary as a small token of my appreciation. However, I was surprised at the embarrassment this provoked in several of the participants. It appeared they had not been expecting anything in return for their involvement. I reflected that they were perhaps grateful for the opportunity to participate in the ADC programme, and viewed their participation as an act of reciprocity towards the programme and its staff. This formulation was validated by clients frequently asking me to pass on their appreciation to their counsellors and other members of ADC staff.

From another perspective, ADC counsellors suggested my meeting with participants following their completion of the programme represented an opportunity for debrief for the clients, which the counsellors believed would be beneficial to the clients. The counsellors viewed my meetings with the clients as a chance for the youth to reflect on their participation, what they had achieved and whether they were still heading in the direction they had planned. In this respect the interview may have been a stimulus to revisit goals, or to enjoy the sense of having made and maintained changes. It was also an opportunity for clients to get queries or problems followed up, as I was happy to be used as a contact to get in touch with their counsellor on their behalf if they so wished. Many participants thanked me on completion of the data collection this I hoped, signified that they perceived themselves as having benefited from the research process itself.
A final means of reciprocity, noted by Marvasti (2004), is through providing assistance to the participants’ community. In introducing the research I explained that the purpose was to understand the best way to assist young people like themselves who were experiencing difficulties. In this respect the participants were aware that a major aim of the research, and hence their involvement, was for the benefit of other young people like themselves who may seek assistance from programmes like ADC in the future.
CHAPTER SEVEN:
QUALITATIVE RESULTS AND DISCUSSION

The main objective of the qualitative enquiry was to gain a better understanding of the therapeutic process, specifically what it was about the ADC programme experience, according to the youth, that 'worked'.

In section 2.3 of the literature review it was noted that a major concern expressed by researchers was a lack of knowledge about how adolescent counselling/psychotherapy works (Kazdin, 2004; Russell & Shirk, 1998; Weersing & Weisz, 2002). This is surprising when it is considered that therapy or counselling for adolescents has been widely recognised as posing specific challenges (Kazdin, 2004) and, as a group, adolescents have been identified as among the most difficult to engage in counselling (Diamond, Hogue, Liddle & Dafok, 1999; Hanna, Hanna & Keys, 1999). While there have been articles (DiGiuseppe et al., 1996; Hanna et al., 1999; Sommers-Flanagan & Sommers-Flanagan, 1995) and books (Bertolino, 1999; Geldard & Geldard, 1999) written that report on effective strategies for counselling adolescents, they are invariably based on the perspectives of researchers or programme providers. There has been a conspicuous lack of attention to the perspective of adolescent clients themselves on what works (Le Surf & Lynch, 1999; Butson, 2002). Yet in trying to understand the best ways to deliver counselling to adolescents, a logical and important avenue of enquiry would seem to be the perspectives of the clients themselves on their experiences of counselling and what in their view 'works'. Hence, in this enquiry I have focused predominantly on the comments made by the adolescent clients in relation to their experience of the ADC counselling programme. While I also sought the perspective of the counsellors, parents and referral agents, the aim of this enquiry was for the youths’ perspectives to 'lead' the data analysis.

As I began collecting and later analysing the data I was particularly interested in the specific aspects of the ADC programme that the youth had found helpful. Might it have been the Journey itself, the family therapy, or the content of specific counselling sessions? During the review of literature I had found the intent of most research had been either to demonstrate the effectiveness of specific programmes or techniques, or to show whether certain theoretical approaches to counselling were superior to others. As a result, during my interviews with the ADC clients, I was
anticipating that they would describe the content of various sessions, specific components of the ADC programme, or particular conversations with their counsellors that had been especially significant. I thought I would then compare their responses to see if they supported or contradicted the literature. I realise now this was a postpositive, rather than a constructivist approach to conducting qualitative research. At the time I was surprised and a little frustrated to find (with the exception of the Journey component of the programme) that clients in fact had comparatively little to say about the specific content of their sessions with their ADC counsellor. What they did talk about was how they experienced their counsellors generally, things they liked and did not like about the way their counsellor interacted with them, and the impact the Journey had had on them. When I listened carefully, there was also recognition of their own contribution to the change process. These topics, therefore, form the three main categories of findings that emerged from the youth in describing what had helped: “It was me”, “It was my counsellor” and “It was the Journey”.

In the first section (7.1 Client Factors - “It was me”) I have examined the perspectives offered by the participants concerning their own contribution in the therapeutic change process. Their words are interpreted to reveal how an important part of change centred around them making a ‘decision’ that changing their behaviour was what ‘was best for them’ and, as a result, being ready to take action. In the second section (7.2 Counsellor Factors - “It was my counsellor”) I have explored the role of the counsellor, according to the youth, in which they describe aspects of their counsellor, and the relationship, that appeared to be important in helping to achieve change. In these first two sections the youth focused on what I categorised to be necessary conditions, or pre-requisites for change (motivation and a therapeutic relationship). Having established these conditions, the third section (7.3 Programme Factors - “It was the Journey”) is what the youth described as helpful in actually making changes happen. This focuses on the content and approaches used in the programme. The Journey component of the programme emerged as especially important. In the final section (7.4 Theoretical Explanations – “making sense”) I attempt to bring together these main points and discuss the apparent role of the counselling approaches and theoretical underpinnings of the ADC programme in explaining the therapeutic change factors identified by the youth.

Throughout sections 7.1 to 7.4, whilst listening to the perspectives offered by the youth, implications for counselling practice and research regularly arise. These are
highlighted briefly in context, but are subsequently revisited in section 8.0. This section presents the overall implications of both the quantitative and qualitative research findings.

7.1 Client Factors - "It was me"

In this section the significant role the youth felt they played in the therapeutic change process is examined. I look at the clients’ acknowledgement of their own contribution. Then, in order to understand better how this contribution unfolds, some context is provided as to how these young people embarked on their counselling journey. An examination of the referral process and in particular how it differs to self-referral processes of adult clients, points to a critical phase in adolescent counselling related to readiness to make changes. The youths’ decision to change, based on their understanding of a need to make change, is examined, together with how a counsellor might assist a young person in making such a decision. A final note is made in regards to the importance of the clients’ ownership of their achievements in relation to one of the goals of the ADC programme: empowerment of clients.

7.1.1 “I think it was also me”

During the interviews with the ADC clients, I asked what they felt they had achieved from their ADC experience. I typically followed this with a question on what it was about ‘the programme’ they felt had helped them. As mentioned above, my focus on ‘the programme’ was a consequence of my literature review, which lead me to assume achievements would be largely a function of programme variables, such as counselling strategies or techniques. However, when I grouped together comments from the participants on what they felt had (or had not) been useful to them in their efforts to make changes, a set of data emerged that I had not really anticipated. I labelled this set of data as the ‘me factor’, and included under it any comments or observations which signified clients’ own contribution to change.

It is perhaps surprising that despite my initial focus on programme factors, with the exception of one participant, all of the ADC clients who were formally interviewed pointed out some degree of ownership in the changes they had made. Whilst acknowledging the contribution of the ADC programme itself and/or their particular counsellor, the following comments illustrate in simple terms ADC clients’ acknowledgement of their own role:
EM: ... going back to the ... stopping smoking dope, what helped you do that? Was there anything in particular about the programme that helped you?

Jane: Um, it was the programme, but I think it was also me as well...

EM: ... and that sort of stuff [relationships with friends] has changed because of the programme, or you just decided to change it, or...

Sue: Me, and the programme, yeah.

Similarly, during an interview with Amy, she had spoken of a dramatic reduction in her use of substances, and described how she felt she was responsible for this achievement but added that she ‘couldn’t have done it’ without her counsellor.

The participants’ clear and often adamant comments of their contribution encouraged me to broaden my focus away from only programme factors. Once I had acknowledged this contribution, it felt important to understand more about the ways the clients felt they were responsible for their changes. What was it they did? Hence, in the remainder of this section I explore some of the ways clients’ indicate their role in the therapeutic change process. These include the youth gaining insights into the need to make changes, which was then followed by a decision to do so. It appears that their readiness to make changes, was an important element of the therapeutic change process.

Previous research that has investigated the effect of client factors on counselling outcomes has focused on demographic variables such as age and gender, and also the type and severity of the adolescent client problem. These variables are more easily analysed quantitatively, which is the dominant research method in this area. However, when the youth explained their contribution to achieving change, the phrases that seem to reoccur were ones such as ‘when I was ready’, ‘when I decided’ or because ‘I realised I needed to’, which pointed more to the client factor of motivation. This client factor is now more widely accepted by practitioners as an important contributor to treatment outcomes. A survey of over 1000 mental health service providers found client motivation to be among the most influential factors on treatment outcome (Kazdin, Siegel et al., 1990). Yet there is little research that examines this assumption.

It has been suggested that the neglect by researchers and programme developers of client motivation, is particularly remiss in the field of adolescent counselling, where referral is more often made by others such as parents or school
guidance counsellors (Kazdin, 2004; Shirk & Russell, 1998). Self-referral requires that the client seeking help has already reached some insights into the need to change, and therefore, is ready to take action. While self-referral is common with adults, this is not the case for adolescents. As a result, this state of readiness is not necessarily present (DiGiuseppe et al., 1996). Before exploring the youths’ perception of their own part in the progress, it seems important then to consider the context of referral of these clients.

7.1.2 Understanding the Context of Referral

During my periods of observation and collection of the quantitative data I built up a picture of how referrals to the ADC programme typically arose. As noted above, most adult counselling clients seek treatment with at least a vague sense of needing help or some distress they hope can be relieved. These factors thereby motivate them to participate actively in counselling (Everall & Paulson, 2002; Sherwood, 1990).

However, this was different to the common scenarios I observed with adolescent ADC clients. The quantitative data collected for all referrals during July 1999 to September 2001 (see Table 7) indicated that, of the 89 young people referred to the ADC programme, only three cases of self-referrals were recorded. The rest were referred either by the school (n=51), other helping professionals (n=27) or parents (n=8). Of the 14 research participants in the qualitative study, not one was self-referred.

I was able to gain a fuller understanding of the motivations of the adolescents and/or those who made the referrals through interviewing and observation. There seemed to be a continuum, ranging from youth who were very keen, to those who had been pressured (or required) to attend the programme and, as a result, were not highly motivated to make changes. I found self-referrals often resulted from a recommendation by a friend who had previously been on the programme and had a positive experience; and could perhaps be described as friend or peer referral. These self or peer-referred clients appeared more committed to participating in the programme.

Observations and interviews suggested that parent referrals were made out of desperation that their son or daughter receive help. The problem behaviour was usually primarily of concern to the parent:
Parent of Terry:

_The biggest issue was around school. There was no one to help us. Terry was struggling at school with his ADHD. [But] the teachers didn't seem to understand his needs. ...The school was telling me he's the problem, but wouldn't offer any help._

_I approached the RTLb and I was told there was nothing wrong with Terry. ...but I felt that a child that 'seemed' [parent emphasised the word seemed] to be in so much trouble, all the time, that there was something wrong with him. Then I received a booklet... through the ADHD support group... and because it was put out by Special Education Services I thought oh good I'll contact them._

A couple of clients interviewed confirmed that the reason they initially signed up for the programme was because it was what their parents had wanted. For example, when Andy was asked if he had initially signed up because he wanted to get help, he replied:

Andy: _Na, It was [because of] me mum._

Referrals from elsewhere tended to result from a young person having come to the attention of CYF social workers, community mental health agencies, or Truancy or Youth Aid Officers. These agencies sought services that they felt would be helpful to the young person they were working with. Although I didn’t collect detailed data on the level of motivation of these youth to participate in the ADC programme, there were a couple of occasions where the young person expressed being ‘fed up’ with the number of adults apparently making decisions in their lives:

Gerry: _I was filled with anger, there was all these people like my social worker, and Mum, and they were telling me what I should do._

One client described how his referral agent (his G.P.) hadn't even asked if he wanted to participate on the ADC programme but had just told him!

Martin: _Yeah, she just said, like she didn't say, "Would you like to go?" She said, "You're going," yeah..._

The majority of referrals (over half) came via schools, either the school guidance counsellors or a senior teacher. Whilst shadowing ADC counsellors going into schools to meet with prospective clients or to work with existing clients, I witnessed a few students approaching their school guidance counsellor and asking to
get on the ADC programme. This was often, as noted with self-referrals, after a friend who had been on the programme had recommended it. However, I gained the impression that more commonly the referred young people had come to the attention of staff at the school, either because they had been in trouble at school or a teacher was concerned for their well-being, rather than the youths’ own assessment that they needed help. The school staff then arranged for the students to talk to an ADC counsellor about the programme. In other words, as highlighted by Sue, signing up for the programme was typically based on others’ assessments of what would be best:

Sue:  [The school guidance counsellor] thought I needed some time off school. And he just thought instead of telling me to have some time off this [ADC] would be better. ’Cause it would benefit me in other ways as well, like. And he talked to Dad about it and Dad thought it would good for me so...

At the far end of the continuum of personal motivation, there were some referrals to the programme whom ADC counsellors referred to as “conscripts”. They were youth to whom the ADC programme was offered as an alternative to more severe consequences. Some may have arrived through school referral, or as a consequence of a family group conferences or even by a Youth Court referral. Several instances were described to me of young people who faced expulsion from school, but were given the option of signing up for the counselling programme as an alternative.

In sum, it would appear the conditions of referral for the majority of the ADC clients meant that only a minority of clients arrived for counselling having made their own decision to do so. For the majority, their involvement with the programme was initiated by others.

7.1.3 Client Motivation as a Changeable State

Participants talked of initially agreeing to sign-up for counselling because others thought it was best for them. However, as the counselling proceeded, many participants described that this changed as they realised themselves that counselling, and the opportunity to make changes, could be good for them also.

In understanding such changes in motivation it is useful to consider one of the more popular models of motivation and how people change, the Transtheoretical Model, more commonly termed the ‘Stages of Change Model’ (Prochaska & DiClemente, 1982; Prochaska, DiClemente & Norcross, 1992). This model has been
applied successfully in the understanding of how people change across 12 problem behaviours (Prochaska et al., 1994) including youth at-risk (Lerner, 1990). Within the model motivation is understood as an individual’s stage of readiness for change. The authors have proposed that people pass though a series of stages in the course of changing a problem. For many this may involve recycling through the stages several times before finally achieving long-term behaviour change.

Stage one is ‘pre-contemplation’; at this stage a person has not contemplated having a problem or the need to make change. Pre-contemplators are unlikely to present themselves for counselling. The second stage, ‘contemplation’, involves some awareness of the problem, and the person may enter a period characterised by ambivalence about it (Miller & Rollnick, 1991). They are undecided, and may vacillate between considering and rejecting change. There is not yet any commitment to take action. It is only at stage three, known as ‘preparation’ or ‘determination’, that the balance tips in favour of change. From here the person moves to stage four, ‘action’, where they engage in a selected process intended to bring about change. The final stage is ‘maintenance’ where people attempt to sustain the changes that have been made and prevent relapse (Miller & Rollnick, 1991; Prochaska et al., 1992).

The progression through the different stages of readiness to make changes described by this model, as will be seen, appears to relate well to the changes in motivation observed in ADC participants.

**Signing-up - ‘For them - what they thought was best for me’**

As noted, all of the adolescents who participated in the qualitative enquiry had been referred by someone else. I was interested in understanding how the youth themselves, had felt about participating in counselling when they first started on the programme. There were a mixture of responses, including a couple who suggested that, despite being referred by someone else, they were keen to be involved and were ready to consider making changes:

**EM:** *So take me back right to the beginning, how did you find out about the programme, how did you get on it?*

**Jane:** *Umm Mr ...[School Guidance Counsellor] suggested ... that it might be useful....*

**EM:** *And at that point what did you think about it, were you keen or were you.*
Jane: Yes I was keen, 'cause I was sick of it [dependency on cannabis and the associated negative consequences].

EM: What made you decide to come on the programme?
Jim: I had to, my life was shit, really shit, I had to change.

The comments from these two clients provide some support for explanations suggested of the quantitative results, that clients with higher levels of distress or discomfort may be more motivated to make changes, which may explain superior outcomes.

However, for most clients their initial motivation would at best be described as ambivalent:

EM: How did you end up signing up for the ADC programme?
Gerry: My school guidance counsellor suggested it to me. I was in foster care and wanted to get back home. ...I was and I wasn't keen.

EM: When your mum first contacted [ADC counsellor], how did you feel about going on the programme?.
Terry: I didn't really care. 'Cause I mean it was help, and I would give it a try more or less.

EM: How did you very first get signed up?
Martin: There was this lady, the doctor lady [G.P.] did it...
EM: And what did you think about that at the time? Were you kind of having your arm twisted a wee bit, or was that something you were keen to do?...
Martin: Uh, I still didn't really know.

This ambivalence was reflected in the clients’ expectations in relation to the programme:

EM: So going back to when the G.P. said about going on the programme, did you have any idea what you were going to get out of it ...
Martin: No, not really.

While several clients appeared to have no particular expectations, I discovered others had motivations that I had not anticipated. Some expressed that, at least initially, their motivation for participating on the programme was to ‘get out of class’, while for others it was a way to reduce the pressure they were under from other adults.
One of the goals of counselling Keith wrote down on his first counselling session was, "to get you guys off my back". I began to understand that when a young person signed up for counselling because parents or school staff felt it was in the best interest of the youth, while for the youth it may have been a strategy to reduce influence over them, i.e., 'get you guys off my back'. Evidence of this was also provided by Keri who was a 'conscript' to the programme. For her, she either had to attend the programme or be expelled from school. She described to me how her behaviour had got worse after having started on the programme. When I asked her why she replied:

Keri: I could get away with more because I was seeing a counsellor.

This motivation and potential effect of counselling was noted by counsellors. One counsellor described how for clients who were not committed to change, counselling was "a chance for a break, an excuse to do nothing". This counsellor explained that people around them tended to give them a 'break' because they were now under the care of a counsellor. Counsellors referred to these clients as using counselling as a "diversionary tactic" and that it was important that this was confronted:

Cslr: I guess my stuff is to say I'm not prepared to continue on indefinitely with someone who isn't prepared to make even small steps. And I have a lot of faith in small steps as opposed to huge ones um, to improve their life. Otherwise I just see us as baby sitters, as support workers, and I think we are at the far-too-expensive end of the spectrum to be carrying out that role.

To avoid being 'baby-sitters' counsellors made a point of assessing or 'sussing out' a client's commitment to change. This was done in several ways: one way was to test a client's motivation by arranging for a counselling session at a time or place that was not convenient to the client. For example, instead of visiting school, it was arranged for them to come to the office after school, or, as described below, during free time rather than class time:

Cslr: Well Martin, this is interesting. What is more important to you, having a lunch break or making some changes? This will tell me something important.

Martin: Making changes [he replies quickly and decisively].
A more common approach was to confront a client if their behaviour was not consistent with the goals they had agreed to work (i.e., if the client was not at least making ‘small steps’ as mentioned in the excerpt above). If clients continued to demonstrate a lack of commitment, counsellors tended to suggest that they should discontinue working with them, but with the offer that:

Cslr: ... *if at some stage in the future, if you feel like you do* [want to make change] *then you have my phone number and you can ring me up at any stage.*

I encountered several youth who explained how this approach had helped them to clarify their motivational state. One female client described how this approach had helped her realise that, she was in fact not ready to make changes at that point in time. She described how her counsellor had confronted her on her commitment because she had re-arranged their appointments so many times. She realised then she wasn’t ready to commit to making changes.

Another client described how confrontation of his behaviour (lying and stealing) had had a positive effect:

Andy: *Yeah, ‘cause, like I did [steal] that bag and I told him that I did no crime. And ... he found out and ...he wasn’t very impressed so he just told me to be honest and that... Yeah, ‘cause if you lie he can’t help you.*

Being honest with this counsellor had apparently helped him to be more honest with himself and about what he was trying to achieve.

Reviewing the client comments above, Jane and Jim may possibly have been in the determination stage, but the majority were more likely to be considered pre-contemplators or contemplators. For example Martin complained of being “told” to go on the programme by his G.P: Andy and others participated only to keep parents and ‘others off their back’, as such more likely fit into the category of pre-contemplation. Gerry and Terry’s comments ‘I was and I wasn’t keen’ and ‘I’d give it a go’ indicated ambivalence and suggested signs of being at the contemplation stage.

It appears there are a range of motivations for attending counselling. The majority of clients referred to the ADC programme did not appear very committed to making changes in their behaviour when they first started with counselling. This
observation was supported by findings from a larger sample of ADC clients (n=30) where only one in five described themselves as ‘keen’ to be involved with the programme when they first signed-up (Mossman, 2003).

Moving to Readiness - ‘It’s for me’

Miller and Rollnick (1991) have developed a counselling approach called ‘Motivation Interviewing’ based on Prochaska and DiClemente’s ‘Stages of Change Model’. This counselling model was developed for working with highly resistant clients such as those addicted to substances. DiGiuseppe et al. (1996) have suggested this approach has particular relevance to adolescents because they are typically referred by others and are initially likely to be ‘resistant’. Miller and Rollnick (1991) suggested that motivation should not be viewed as a personality problem or stable trait, but rather as a ‘state’ of readiness or eagerness to change, which can be influenced.

Listening carefully to the ADC clients who completed the programme, I noticed that several appeared to identify such a change in their ‘state’ of motivation. They described to me a point where their initial ambivalence or lack of personal motivation for change shifted, to wanting to be there, and to get something out of the counselling for themselves. For example, Ann described how initially she looked forward to her counselling because it was a chance to get out of maths, but that later she went along because she wanted to get something out of her counselling sessions. Others noted a similar shift:

Martin: At first it was ... yeah fun, and then it was probably more to get help.

Sue: At the start [it was] “Oh sweet a holiday”... [But then] I went home and thought about it, and realised I could actually get something from it.

Andy who had described how he had signed up for the programme because his mum had wanted him to, also noted a change:

EM: ... was it always sort of for your mum?
Andy: Na it was more for my sake...

These quotes, while providing further evidence of initially low levels of personal motivation, support Miller and Rollnick’s (1991) view of motivation as a
changeable state. Participants' comments indicated that at some point there had been a change in their motivation from ambivalence, or simply being there because others thought it was best for them, to actually wanting to make changes for themselves.

**Readiness to Change – ‘It’s up to me’**

The importance of a client becoming personally motivated to make changes was summed up by one participant as she reflected on the ability of the ADC programme to help people:

*Jessy: It depends on the person, it [the ADC Programme] will help if they want it to.*

This echoes Miller and Rollnick's (1999) suggestion that, the higher the motivation toward change, the higher the probability that change will occur. This has been supported by studies of adolescent substance abuse programmes that have found a significant relationship between motivation to change and outcomes achieved (Cady et al. 1996; Freidman et al., 1994).

I noted that participants described how they were able to make changes when they were ready. When I asked Jane about how she managed to reduce her use of substances; she indicated that it was simply a case of arriving at the point where she had agreed on (and was motivated towards) the goal of lowering her drinking:

*Jane: I’ve limited my alcohol use to seven standard drinks not 12 to 15. [My counsellor] wanted me to get down to seven standard drinks, but [then] I was happy with what I was drinking... EM: So you weren’t quite ready to cut down? Jane: Yep. [pause] But now it’s mine [my goal] ...I only have seven standard drinks.*

Even though she had attained the goal recommended by the counsellor, to her this had occurred not because of what he thought was best for her, but when the time came when she was ready, and the goal became her own.

This last excerpt from Jane combines elements of the preceding section ‘it was for me’ with the current section ‘it’s up to me’. She became ready to make changes (drinking less) when she realised she would be happier (it’s for me) if she changed her current behaviour, and hence became motivated (it’s up to me) to make this happen.
The importance of ‘being ready’, was a strong theme that emerged from youth who failed to complete the programme. One young female who had been referred on from the ADC programme to a residential A&D programme, attributed ‘not being ready’ as the reason she had failed to give-up using inhalants:

Melissa: *I hadn’t really wanted to give up the solvents. I just said to others, like mum and that I did, but I didn’t really want to...I wasn’t ready to give up.*

Melissa’s comments support the idea that motivation is changeable; not being ready implies that there may be a time in the future when she would be ready. Her comments also reveal the complexities of working with adolescents who have been referred by others, and the difficulties in understanding their true motivations.

Another ADC participant who had voluntarily withdrawn from the programme prior to completion and who had subsequently ended up in a secure unit (where he had finally gained more control over his cannabis use), reflected on the importance of his own motivation. He commented how he now realised that:

Ricky: *... it was up to me and my own will to change.*

A client described how she had failed on a previous programme, and explained to me how she now “really wanted” to listen to the ADC staff, and was now hopeful of achieving results. Similarly, she reflected:

Tracey: *...that it was up to you, what you got out of it.*

This apparent increased determination had taken Tracey six months to arrive at, suggesting, as with previous quotes, the timing aspect of becoming ‘ready’. For Tracey this involved extra time and a second chance at treatment. The ‘Stages of Change Model’ predicts that many individuals do not achieve lasting change before cycling through the stages of change several times. This perhaps supports the need for longer treatment for some individuals.

The New Zealand Counselling Association Code of Ethics states that counsellors should establish with the client the aims or purposes of counselling (New Zealand Association of Counsellors, 2004). This suggests there should be an agreement between counsellor and client on the goals of counselling. Manthei (1997a) has elaborated on this by suggesting that an ethical obligation of the counsellor is to
serve the client’s best interest, which means counsellors must respect a client’s wish not to change or to refuse help. This may be fairly straightforward when working with adult self-referred clients, but with adolescent clients who are typically not self-referred, agreement on goals becomes a more complex process. The most common reason for referral for ADC clients was substance abuse (see section 5.1.2), yet as was seen from the comments from Jane it took her some time before she became committed to limit her consumption of alcohol to just seven drinks. Melissa meanwhile appeared not to have reached the point where reducing her use of solvents was her goal, despite verbalising to others that it was. While it may have been the goal of her referral agent and her family, Melissa’s true agreement on such a goal had not been achieved, and therefore, it was not surprising that she failed. It may be that with adolescents who are not self-referred, sufficient time is needed to allow the client and counsellor to reach an agreement or to re-negotiate the goals of counselling. This may account for the relatively longer duration of ‘real-world’ treatment programmes such as ADC that was noted in section 5.4.1.

Adolescent clients, such as Melissa are often labelled as ‘unmotivated’, ‘resistant’ or ‘reluctant’. However, Bertolino (1999) who has written a book ‘Therapy with Troubled Teenagers’ has suggested it is not helpful to think of a client as ‘unmotivated’ as “everyone is motivated for something” (p. 48). He has suggested, that, if a client appears ‘reluctant’, it is not lack of motivation that is likely to be the problem, but rather the goals being put before the young person are the problem. With clients who are not self-referred, it seems important to understand that agreement on goals will be a more complex process than with self-referred clients. Some adolescents may arrive with a clear expectation of what they want to get out of counselling, but for the majority this is unlikely to be the case.

Considering the importance noted by clients of being ‘ready’ and ‘committed’ to making changes, and the potential consequences if this state isn’t reached, it would seem important to understand what needs to happen for this shift in readiness to occur. From the last comment from Jane, it might be inferred that initially she was ‘happy’ consuming alcohol at a high level, but that something changed for her, and that she became happier by drinking less, and therefore, drinking less became her goal. It would be useful to understand how Jane and others arrived at such decisions; an exploration of this issue follows next.
7.1.4 How Change in Readiness Occurs – ‘Deciding what’s best for me’

When clients explained how they changed it was often a simple because “I decided to” or “when I was ready” or “when I realised I needed to”. I gained the impression that in their view such a decision was all that was needed for change to occur. Miller and Rollnick (1991) suggested that making this ‘decision’ is an important part of change, and that it is important not to rush an individual through to ‘action-based’ strategies before the decision to change has been made. Indeed in my ‘rush’ to discover what it was about the programme that was responsible for change, I had nearly overlooked this important phase. According to the Stages of Change Model, giving prescriptive advice on how to change before an individual has decided they want to change, is likely to be ineffective or counterproductive (Prochaska et al., 1992). This is perhaps illustrated by Melissa, when she commented:

Melissa: *When people are pushing you and telling you to stop, then you don’t want to. ’Cause they’re telling you to. You want to when you’re ready*

How a counsellor communicates in order to convey messages in ways adolescent clients are more likely to respond to, is considered in detail in the next section (7.2 Counsellor Factors).

DiGuiseppe et al. (1996) noted that self-referred clients typically arrive for counselling with an insight or awareness that change is desirable. However, these authors reported findings from studies on self-referred adult clients that indicated it may take considerable time (several months or even a year) for these adult clients to have achieved insights about the need to change their behaviour. Similarly, Prochaska and colleagues (1992) found the modal time for adult smokers to remain in the contemplation stage, prior to taking action, was two years. The aspect of the timing needed for becoming ready emerged in several of the ADC participants’ comments. Indeed it could be speculated that clients such as Ricky, Melissa and Tracey, who had failed to achieve change, may simply not have been allowed sufficient time to become ‘ready’.

If it is accepted that clients need time to gain insight into their behaviour before they can decide to change it is worth considering how a client may best be assisted in this process. Reflecting back on my conversations with the research participants I noticed they gave a few clues as to what had influenced them in making their decision to change. These included completing a decision balance, which
entailed weighing up the pros and cons of the behaviour (see below), receiving new information or feedback, and gaining a better understanding of themselves. This is not, of course, an exhaustive list, rather just a few of the main points that arose during interviews with these participants.

**Decision Balance**

Several clients suggested that deciding to change was based on a new understanding of their current behaviour, in particular by re-assessment of the consequences of their old behaviour and arriving at a new decision of 'what's best for me'. When I asked clients like Andy and Sue why or how they had changed their behaviour, they referred to such realisations:

**Andy:**  *Um, [long pause] just when I thought it was better for me, that I knew if I wasn't going to stop that it was going to keep affecting me.*

**Sue:**  *I was getting asked and taught things and I just couldn't remember them. I know it was starting to affect me, so I just thought, 'no, stuff it'.*

Similarly Terry explained that he changed his attitude because:

**Terry:**  *I realised I needed to be less of an arsehole.*

My interpretations of comments such as 'I needed to' and 'it was better for me' was that these clients' motivation was based on an evaluation of 'what's best for me'. However, this assessment by the client of what it is that is 'best for me' can change, as indicated in the three excerpts above. Several clients indicated that the re-assessment of 'what's best for me' occurred as a result of weighing up the consequences of their old behaviour and reaching a decision that the negative consequences out-weighed the benefits, and was no longer 'worth it':

**EM:**  *What made you stop stealing?*
**Alan:**  *It wasn't worth it, there was no point. I realised that you just got into trouble for it.*

**Andy:**  *Crime, I don't steal any more...*
**EM:**  *Why is that?*
**Andy:**  *'Cause I don't think it's worth it.*
**EM:**  *What makes you say that?*
**Andy:**  *'Cause like, you could like go to jail or something doing stealing, let alone like doing bigger crime or something, so I don't think it is really...*
worth it... I worked that out for myself.

Arriving at this decision is not always a simple process, as illustrated when Martin explained some of the competing decisions involved in cutting down his drug use:

EM: So the drugs stuff, ... is that something that you’d wanted to get rid of?
Martin: Yes and no. Sort of like a yes, and a no.

He described some of the reasons why he didn’t want to give up:

Martin: Oh, it’s like my friends started. Like I’ve got a friend... and we found heaps over at the neighbours one time. And we took all that. And after that he had it inside growing and stuff, and he’d give me some and that, and I kept giving it to my friends. Yeah, and then it was sort of after, I just wanted to do it again...I wanted to. I just sort of like growing the plant,...but yeah, um.

Then he went on to describe other considerations such as the effect of his drug use on his relationships with counsellor and family:

EM: So what helped you cut down?
Martin: ...Oh it was ’cause I didn’t want to, and plus otherwise I’d be letting everyone else down, like [my counsellor] and stuff... I’d be telling them a load of lies, that I’d stopped and everything but I hadn’t...
EM: So is it like weighing up if it’s worth it kind of thing?
Martin: Yeah.
EM: And at the moment what do you feel?
Martin: Oh, it wouldn’t be worth it. Oh I’d rather probably not do it than do it.
EM: Why is that?
Martin: If I do it, I’ve got to leave home, and probably my other brother [would have to leave too].

For Martin, there was a complex process of balancing all the different factors which at this point favoured changing his behaviour. It seems evident that clients such as Martin are likely to benefit from being given sufficient time to resolve their ambivalence before attempting to offer advice on how to change.

Miller and Rollnick (1991) have suggested that “working with ambivalence is working with the heart of the problem” (p. 38), but for change to occur it must be resolved. During observations of counselling sessions I observed ADC counsellors helping their clients to assess the pros and cons of their behaviour. However, phrases from clients such as “I thought”, “I realised” and “I worked it out” indicate that clients
felt they were then able to make a decision for themselves based on new information. This has important implications in terms of clients being able to take ownership of the changes made, an issue discussed later in section 7.1.5.

Information and Feedback

An essential part of being able to weigh up the pros and cons is acquiring accurate information and feedback about the current behaviour. Indeed, this is the counselling strategy recommended in Motivational Interviewing for clients in the pre-contemplation stage, with the aim of raising awareness of the problem and also the possibility of change (Miller & Rollnick, 1991). Of interest is to consider the sources of information or feedback that the clients felt has been influential in making the decision to change.

The counsellor is an obvious source of information and feedback. One example of information counsellors provide through the confrontation of clients’ behaviour inconsistent with agreed goals (described earlier). Another example of counsellor information and feedback is provided below:

Sue: *We were sort of hanging around with people who have just got drugs all the time, and I sort of, I was doing, like [ADC counsellor] couldn’t believe it, but to me it wasn’t much. Like I’d have drugs every day but it was only little, but [ADC counsellor] just thought it was heaps, and he asked me how much alcohol I’d drank and I’d say, “Half a bottle to a bottle of ... spirits,” or what ever for the night and he just couldn’t believe it. And I was like, “That’s not much,” but when you think about it, it is.*

EM: *So [your counsellor’s] reaction actually made you think, “Oh maybe it’s more than I thought?”*

Sue: *Yeah, ‘cause I thought that’s not much ‘cause half the people you see would do way more, but I thought that’s not much, I thought I was actually being quite good, but....*

For Sue the surprised reaction of the counsellor was significant in her reassessment of the appropriateness of her current drinking behaviour. Comments from the adolescents suggested it was not just the information but the way information was conveyed by their counsellors that influenced whether they listened to the advice/information. This is discussed in more detail in the next section (7.2 Counsellor Factors).
Some clients referred to gaining feedback on their behaviour via their school. Like Sue, some noticed the effects of drugs on them through struggling to complete school work or in remembering what they had been taught. For Andy it appeared he became more personally motivated to make change following a fairly explicit piece of feedback from his school:

EM:  *Okay, when did that [becoming personally motivated] happen do you reckon?*
Andy:  *When I got expelled, a few sessions after that.*

Feedback from family members was another potential source of influence described by some participants. Amy explained how she became committed to giving up alcohol and drugs following feedback that arrived via her father. She described how he had held her really hard, and put her in front of a mirror and shook her telling her to “look at yourself”, which she said he had never done before. She said she could see she was “really wasted and a real mess”. She also talked of being influenced by thinking about her brother who was in jail and how she didn’t want to turn out like him, and so she decided she needed to give up alcohol and drugs. Others also talked of being influenced by feedback from family members:

EM:  *What helped you to make the changes you have?*
Tom:  *Seeing Mum’s reactions. How she felt about what I was doing to myself.*

The Journey provided the opportunity for feedback for clients from their peers, and for several of them this appeared to be particularly significant. The role of the Journey will be covered more fully in section 7.3, but one example is given below to illustrate the role of the Journey and feedback from peers:

Tina:  *The group feedback at the Journey, what everyone said, the analysing in groups on the Journey, helped me to understand myself better.*

The significance of understanding oneself better is explored below. However, what is interesting from the above excerpts is that the sources of information and feedback reported by the participants cover a variety of systems of influence: the counsellor, the school, the family, and peers.
Understanding Self

The definition of counselling provided by the New Zealand Association of Counsellors (2004) indicates that one of the roles of a counsellor is to assist clients to increase their understanding of themselves. This is potentially an area of particular significance in terms the developmental process of adolescence, where formation of a personal identity has been described as a key developmental task (Geldard & Geldard, 1999). There would seem to be a logical link between understanding oneself, knowing what is wanted out of life, and arriving at a decision about whether one’s current behaviour is, therefore, ‘what is best’.

A few ADC clients appeared to make this link between knowing themselves and being motivated to change. Keith was described by his counsellor as only making minor changes. Comments by Keith suggested that his progress may have been hindered by not having reached a clear understanding of himself. During the interview with me, Keith struggled to say what he had got out of the programme, and at the end of his interview he summed his experience up in the following way:

Keith: Well, I didn’t really fully know what I wanted, and I still don’t know what I really want in life or nothing like that.

The link between identity formation and motivation towards counselling goals was made by Jane in an early phase of the programme:

Jane: I don’t know whether they were really my goals. The problem is I don’t know who I am yet.

In contrast, another client described many positive changes following her participation on the programme, mentioning the importance of understanding herself better in making decisions about what she wanted to get out of the programme:

Sue: ...just like yeah, ‘cause when [my counsellor] first came it was like, “Oh what do you want to work on, what do you, like, what are your problems and everything else?” And I sort of, just excluded everything else until I’d actually thought about what I like about myself, what I didn’t, and things like that. And sort of looked at what was happening with my friends and relationships and things like that... I sort of did put most things out of the road for a while until I knew what I was doing, until I knew what I wanted and that with the programme,....
It is interesting that Sue seemed to emphasise that her counsellor asked her what she wanted to work on, and that she perceived it was her choice. This reflects assertions made in the quantitative data section that ADC counsellors respected clients' personal motivation (5.4.1). As noted by Miller and Rollnick (1991) providing choice is appropriate for clients who have not reached the determination stage of motivation, but is appears particularly relevant for adolescents who, along with forming a personal identity are also striving for individuation and the development of independence (Geldard & Geldard, 1999). An important aspect of independence, of course, is having the ability or freedom to choose. Perhaps this is why Melissa reacted negatively to being ‘told what to do’ by others. Making choices has also been associated with a sense of personal responsibility, which again relates to a clients’ ownership of the change process.

Prochaska et al. (1992) have suggested that assisting an individual to achieve change is about doing the “right things (processes) at the right time (stages)” (p. 1100). They have identified nine processes which they found useful in understanding how people change. They suggested that people use different processes at different stages, because particular processes are more helpful at specific stages. Interestingly ‘receiving information and feedback’ and ‘understanding self’ which were identified above by the ADC clients, relate closely to the processes of ‘consciousness raising’ and ‘self-revaluation’ which Prochaska et al. (1992) have suggested are most useful for those in pre-contemplation and contemplation. As was described earlier, these are the two stages in which ADC clients are likely to be when they are referred to counselling. Hence, there is empirical support for the specific processes which ADC clients identify as significant in helping them to make changes. The ADC programme and its counsellors appear to be doing well in facilitating this process.

7.1.5 Empowerment – ‘I worked it out’

At the beginning of this section it was noted that ADC clients recognised their responsibility, at least in part, for the changes they made. From comments that followed, it appeared that their role and sense of ownership was evident at several points along the way. They spoke of shifting to a realisation that they could get something out of counselling (‘it’s for me’); they then made decisions based on ‘what’s best for me’ before becoming committed to change through realising ‘it’s up to me’. Further, in many of the explanations of how change occurred, phrases such as
“I realised”, “I worked it out” and “I decided” were common, again suggesting the ADC clients were encouraged to believe that they themselves had been responsible for achieving change.

In the earlier excerpt from Andy he suggested that he had decided to stop stealing because he didn’t think it was worth it, and that “I worked that out myself”. During the interview I was surprised at the claim that ‘he’ had worked it out ‘himself’, as I had sat in on a counselling session between him and his counsellor where the counsellor had sought to help him weigh-up the pros and cons of stealing. So I had expected him to say something like ‘I don’t steal anymore’ and ‘that’s because I don’t think it’s worth it’ and ‘that’s something my counsellor helped me to work out’. However, it appeared that his counsellor had somehow enabled him take ownership of the decision he made.

I observed other examples where a client disclosed a problem behaviour to the counsellor, (e.g., drinking a bottle of vodka and a cask of wine over the course of one afternoon and evening) and where, to my surprise, the counsellor didn’t immediately react by advising the client that they should not be doing that. Rather they tended to engage the youth in conversations around alcohol use, and ask them to share their own observations of problems experienced as a result of theirs or, others misuse of alcohol (e.g., discussing a relative that had eventually died from liver cirrhosis through excess use of alcohol; the effects of an alcoholic father on the rest of the family; and problems among friends who had become violent as a result of drinking). Following such a discussion, the counsellor would re-visit the issue presented earlier (e.g. drinking to excess), then ask the client to decide whether their use of alcohol was ‘good for them’. In this way, the counsellor was not responsible for convincing the client, but instead ‘managed’ the conversation and its content, so any decision made came from the client.

Assisting clients to be responsible for their decisions and changes in their behaviour is an intentional goal of the ADC programme. The ADC Training Manual (ADC, 2003) lists four underlying principles, the third of which is:

The client is responsible for choosing and carrying out strategies for personal change. The therapist can assist but will not and cannot do it for them or to them. (p. 2)
One ADC counsellor described how they saw their role as “helping the clients to help themselves”. It was explained that if the client ended up feeling as if their counsellor was responsible for their change, this would not be a satisfactory outcome. If the client then had a problem in the future, they would then feel the need to seek out a counsellor to ‘re-fix them’. The counsellors suggested the desired outcome would be for clients to feel they had solved their own problem and could, therefore, do the same at any time in the future.

Comments from clients suggesting they were, at least in part, responsible for their own changes indicates that one of main underlying principles of the ADC programme ‘the client is responsible for change’, was being met.

7.1.6 Summary

According to these ADC participants, they came to believe that they themselves had a key role to play in the therapeutic change process. This acceptance of responsibility, suggests that the ADC programme is achieving one of its goals, ‘to help clients to help themselves’. The sense of responsibility voiced by clients seemed to centre on making their own decisions based on a re-assessment of ‘what was best for them’, and as a result becoming ‘ready’ to make such changes. Most importantly, they then put in the required effort (it’s up to me) for these changes to occur.

Reaching such insights, decisions and motivational states appears to be a particularly important element in counselling adolescent clients, who are typically referred for help by others. For some this process happens relatively easily, while for others it can be complex and may take more time and effort to achieve; the evidence suggests, however, that it should not be rushed. In the early stages of counselling, providing youth with information and feedback on their behaviour, and helping them understand themselves, may be two key ways to assist them in making decisions and becoming ready to make changes. There are other ways that ADC counsellors or the programme content may influence a young person’s motivation to make changes, and these are covered in the following sections.
7.2 Counsellor Factors – “It was the counsellor”

This section explores the youths’ perspective on the role of the counsellor in the therapeutic change process. The youth indicated clearly that in their opinion, this was an important area. However, before clients were prepared to let a counsellor take up the counselling role, they expressed a need to ‘get to know’ the counsellor. Further, as noted by one client ‘not just anybody’ could be a good counsellor, and in reflecting on what made a good counsellor, the youth voiced strong opinions on what they liked and did not like in a counsellor. In listening to the youths’ constructions of ‘a good counsellor’, key factors that emerged were being trustworthy; treating them in the right way, and having the necessary skills and experience to actually help them.

7.2.1 Importance of the Counsellor - ‘It was him’

While reading the comments made by ADC participants, the importance to them of the counsellor became evident to me in several different ways. There were straightforward statements, such as participants acknowledging the contribution of their counsellor in helping them to make changes. The youth also mentioned their counsellor in relation to significant events or turning points. Also the willingness of participants to talk about their counsellor and the volume of data generated on this topic appeared to signal the prominence of the role of the counsellor in the eyes of the youth.

Statements Acknowledging Contribution of Counsellor

When I asked about aspects of the ADC experience that had been particularly significant in helping participants to make changes, a common response was:

Phil:     *It was the counsellor. He was just sorted. He'd done lots of stuff and I looked up to him.*

This comment illustrates how, for Phil, as for several others, their counsellor was judged to play a crucial role in helping them to make changes. This idea sits comfortably alongside also believing that changes had been brought about by participants’ own efforts and effects of the programme, discussed earlier (section 7.1). For example, Amy, whilst acknowledging her own personal contribution to success in giving up cannabis, also stated that she “couldn’t have done it without her counsellor”. Several parents had similar views to the youth. When I asked one mother
what she thought had made a difference in her son’s control of his drinking, she replied:

Jackie (Parent):

_The counsellor made the programme work. It was him._

Although several similar comments came from youth and parents concerning the positive role of the counsellor, I also got the impression, particularly from the youth, that not all counsellors are necessarily equal in their ability to assist their clients:

EM:  _Do you think because you were ready to make changes, you could have got there with another counsellor other than [your ADC counsellor]?

Jim:  _No I don’t think just anybody._

Indeed the participants had much to say about what they thought made for an effective counsellor (reviewed in detail later on in this section).

**Significant Elements of the ADC Programme, or Turning Points**

When the youth made general statements attributing their changes to either themselves, the programme, their counsellor or a combination of these, I was left wondering what specific events stood out as particularly significant to them. To this end I asked the youth if they could think of any particular aspects of the programme, or event that they viewed as being particularly important, perhaps a turning point for them. Some of the youth couldn’t think of anything in particular, but described their changes as a gradual process over the course of the whole programme.

EM:  _What helped you to stop stealing?_

Alan:  _It wasn’t any one thing. I just kind of gradually worked it out._

EM:  _Can you think was there anything in particular that really helped you?..._

David:  _No, everything._

However, others, while acknowledging that they felt the programme had been supportive and helpful all the way through, were also able to identify specific events. Out of eight clients who completed the ADC programme and were formally interviewed, three clients referred to something their counsellor had done as being a turning point or significant event for them.
Gerry: *Oh when [my counsellor] found out some information on fashion design for me. That was really good. And even though I decided I didn’t want to do it in the end, at the time it meant a lot to me, that he’d gone out of his way to help me out.*

Jane described another counsellor’s response as acting as a turning point for her:

**EM:** *Any bits looking back now... that really stands out, a turning point, ... really useful?*

**Jane:** *Um, when we can both, like opened up. Me and [ADC counsellor] both started talking easier, opened up, that was a lot easier.*

The implications of these particular actions, the counsellor ‘going out of their way’ and ‘opening up’ will be explored later in this section. What is important to note here is that in both instances, something that the counsellor did was perceived by these clients as significant.

**A Topic They Wanted to Talk About**

I was pleasantly surprised at how freely the youth talked about what they liked or did not like about their counsellor, and the role counsellors played in helping them to make changes. It was a topic on which they appeared to have definite views. This was in contrast to the difficulty the youth seemed to have when asked about programme factors which they had found helpful. After just a few interviews I found that questions such as “how did you find your counsellor?” and “what do you think makes a good counsellor?” helped to get the youth to talk more openly before addressing areas that they talked less freely about.

I later reflected on what it meant that the youth appeared so willing to talk about counsellors. I had anticipated that the quality of the relationship they had with their counsellor may have been an important aspect of their ADC experience. My assumption was that a young person would need to ‘get to know’ and be able to ‘get on’ with their counsellor in order for them to open up and engage positively in the relationship and the counselling process. The review of literature supports this assumption, with the results of meta-analysis on 23 studies of adolescent psychotherapy finding an overall positive association between relationship variables and successful treatment outcomes (Shirk & Karver, 2003). The young participants in this study did not use terms such as ‘therapeutic relationship’ or ‘therapeutic alliance’,
but much of what they talked about appeared to relate to factors influencing the development of what researchers or counsellor would call a ‘relationship’ or ‘alliance’ with the counsellor. Therefore, the preoccupation I encountered from the youth in relation to their counsellor provided strong support for the importance of ‘relationship factors’ as predicted by the research.

I had to acknowledge of course, that simply participating in counselling does not make a youth (or an adult for that matter) an expert on theories of counselling. As Berolino (1999) pointed out “clients don’t buy theories; counsellors do” (p. 4). This was endorsed by Russell and Shirk (1998), who found clients did not necessarily respond to the therapist’s espoused brand of therapy, but more often to the varied actions of the therapist. It made sense, therefore, that the youth would be more likely to talk about their counsellor and what he or she was like, than of any of the specific counselling approaches used (such as Motivational Interviewing, Multisystemic Therapy, Narrative Therapy, etc.). However, it is possible, that their experience of their counsellor was at least partly influenced by the counselling approach employed by the counsellor.

A final point I considered was that, on a developmental level, ‘relationships’ feature in many of the developmental tasks of adolescence. During the formation of personal identity, the concept of self, created within the context of relationships, is paramount. Achieving the independence and separateness of individuation involves a renegotiation of relationships with others, especially parents and authority figures. Along with individuation comes the cognitive ability to think critically about other people and interpersonal issues, which enables decisions on how to interact with others. Finally, from a biological perspective and with regard to the development of sexual identity, forming relationships with partners towards whom one is erotically attracted is an important task of adolescence (Geldard & Geldard, 1999). Therefore, considering the likely pre-occupation of adolescents with interpersonal relationships, it is understandable that their experience of counselling should be viewed, to such a large extent, with reference to the relationship with the counsellor.

Support can be found widely in the literature for the importance of the counsellor in the therapeutic change process. The next logical step, therefore, was to explore what it was about the counsellor, and the way they behaved, that the youth considered important.
7.2.2 Getting to Know My Counsellor

In listening to youth talk about their interactions with their counsellors, I noticed that a common theme that emerged was an apparent felt need for the youth to ‘get to know’ their counsellor. They described how getting to know their counsellor was important in order for them to feel comfortable with the person, which in turn appeared to be a prerequisite for them to open up and engage with them.

Sue:  Well I sort of, the first few times, I didn’t know how much I should say to him, until I got to know him a bit better ...

Keith:  I don’t know, I reckon it’s good to get used to the person before you start going into it, ‘cause it’s like yeah ...

If clients felt like they needed to get to know their counsellor before feeling sufficiently comfortable to open up and talk to them, it seemed to me to be important to also understand what the adolescent clients meant when they talked about ‘getting to know’ their counsellor. For several youth it appeared to be a judgment of whether the counsellor was in fact the sort of person they would want to disclose to, and hear from.

EM:  Was there anything that helped you trust him or feel okay to open up to him?...

Sue:  I think it was just sort of, I don’t know. I just sort of thought he seems alright.

In re-reading what the youth told me they liked about their counsellors, or the characteristics they felt made good counsellors, it occurred to me these were perhaps clues to the ways in which they were trying to ‘get to know’ their counsellors before making the judgement of whether they were ‘alright’.

However, before considering what these counsellor factors might be, another apparent effect of ‘getting to know the counsellor’ requires mention. In the previous section on client factors, being ‘ready to make changes’ was discussed as a critical event in order for changes to occur. It appeared for a couple of clients that ‘getting to know’ their counsellor played a role in their becoming more personally motivated. David and Martin initially described themselves as being somewhat ambivalent about (if not hostile to) participating in the ADC programme. During David’s interview he described how his motivation shifted to wanting to do the programme for himself, and suggested that getting to know his counsellor played a role in this shift:
EM: ...were you keen.. or something else, arm twisted a bit?
David: Yeah yeah [nodding and smiling to arm being twisted].
EM: And did that change or did it stay quite a lot of the time?
David: It changed after a while.
EM: And when do you think that happened?
David: When I got to know [ADC counsellor] really well, yeah.

Similarly Martin appeared to link his shift towards being more personally motivated by the contact he had with his counsellor.

EM: At what point did you kind of start thinking oh maybe it would be quite good to get some help? ...
Martin: Probably a wee while after I started seeing [ADC counsellor].

While there are few clues in these comments as to what it was about getting to know their counsellor that resulted in a shift towards readiness, it does appear that in the early stages of counselling ‘getting to know’ the counsellor was an important pre requisite for the therapeutic change processes to commence and develop. What follows next is a detailed discussion of what ADC clients felt made a good (or, in some cases, bad) counsellor. This may help in developing a better understanding of some of the ways that these youth might be trying to ‘get to know’ their counsellor and make a decision about whether they are ‘alright’.

7.2.3 What Makes a Good Counsellor?

During conversations I had with the youth on how they experienced their counsellor, and what they thought made a good counsellor, they talked at length and with conviction about what they thought was important in a counsellor, and what they liked and did not like. I have presented the youths’ constructions of ‘what makes a good counsellor’ under the following three broad themes:

A. A counsellor who is ‘trustworthy’.
B. A counsellor who ‘treats me right’.
C. A counsellor who is ‘experienced in life and counselling’.

A) A Counsellor Who is Trustworthy

Trust was something frequently referred to be the youth, and for Tim trust was apparently something that came about as a result of getting to know his counsellor:
EM:  This may be a hard question but is there anything about the way [the counsellors] reacted or the way they were with you that made it easier to listen to them? Was there anything?

Tim: No, it was more of a trust factor, like I trusted [my counsellor]. ... It was like you know, I know [my counsellor] and he knows me.

Trust also seemed an important aspect of the counselling process for Jim:

EM:  How come you listen to what [your counsellor] has to say?
Jim: ...I don’t know, I trust [my counsellor].

In the previous section on client factors, the importance of clients receiving information and feedback in order for them to make decisions on whether to change to their behaviour was noted. A client not prepared to listen to their counsellor, missed out on an important source of information and feedback. According to the excerpts above, counsellors need to build the trust of the client in order to maximise the effect of offering information and feedback to the client.

What follows is a discussion on ways, according to the youth, that a counsellor may assist in developing a trusting counselling relationship. Through this discussion, it is perhaps possible to understand what ‘trust’ might mean to an adolescent client, that it is about ‘not telling others’, that trust is a reciprocal process ‘if you trust me, it helps me trust you’, and is about being honest. These aspects of trust are discussed under the following counsellor characteristics:

i. A counsellor who keeps disclosures confidential.

ii. A counsellor who is prepared to talk about themselves.

iii. A counsellor who is honest or ‘straight-up’.

(i) A counsellor who respects confidentiality

For many of the clients perhaps one of the most important aspects of the relationship they had with their counsellor was confidentiality. In particular, the youth referred to the importance for them to be able to ‘trust’ their counsellor ‘not to tell’. For ADC clients counselling often involved disclosures of illegal acts (criminal behaviour, substance abuse) or very intimate information (sexual abuse, suicide ideation, family problems, problems with peers). Hence, it is understandable that opening up and disclosing such issues to their counsellor required considerable trust.
Yet being able to disclose such issues featured frequently as one of the things that the ADC clients found most helpful in their ADC experience:

Lisa:  ... just having someone to talk to when I'm in trouble.

Tom:  ... being able to tell someone my problems.

Ben:   ... having support, someone to talk to.

For Max, knowing that these conversations would be confidential was what he found most important.

EM:    What do you think was most helpful to you in making your changes?
Max:   Just being able to talk to someone confidentially.

Others agreed about the importance they placed on a counsellor who kept things confidential:

Martin: ...like confidential is really important, not like going around and yeah...

As suggested earlier, youth appeared to make decisions on whether to disclose things to their counsellor based on an assessment of ‘the type of person’ they judged their counsellor to be. Amy described to me how she found it difficult to trust people, but said she had been able to trust her counsellor because of “the type of person he was”. It appeared that some people were the ‘sort of people’ who would keep things confidential while some were not. Amy suggested that her judgement was based on testing her counsellor. She said how she had told her counsellor some ‘way out stories’, but nothing had ever ’got back to her’, as a result she felt she could tell her counsellor anything and trust him to keep it confidential.

Sue similarly talked about trusting her counsellor to keep things confidential based on his ‘attitude’ and the type of person she judged her counsellor to be:

EM:    Was there anything that helped you trust him or feel okay to open up to him?...
Sue:   I think it was just ... his attitude and that. I sort of knew he wasn’t going to brag, like he didn’t seem like the type of person.
EM:    So confidentiality was important
Sue:   Yeah.
The fear of having confidences broken is perhaps one of the reasons why these youth felt it was important for them to ‘get to know’ their counsellor and assess whether they could trust the counsellor with self-disclosures. The negative consequences of confidentiality broken is illustrated by Martin’s description below of how his mother gave him ‘a hard time’ after she learned of something he had told his counsellor in confidence, and suggested this may have affected what he would be prepared to say to his counsellor in the future.

Martin: *Yeah the confidentiality. Because Mum didn’t know I’d sniffed some petrol, I started sniffing Petrol.*
EM: *What happened?*
Martin: *... it was between me and [my counsellor] and he told Mum, and like when we left Mum goes did you have fun sniffing petrol, yeah.*
EM: *... Does that make you think twice about what you’re going to tell them?*
Martin: *Yeah.*

Another client, Julie, described to me a negative outcome of what she perceived as broken confidentiality. Julie explained that with a previous counsellor, she had found out things she had discussed, which she had understood as being in confidence, had been passed on to a third party without her permission. She said that, as a result, she had refused to see her counsellor again.

Another potential negative consequence for clients who do not have trust in the confidential relationship with their counsellor was illustrated by a counselling session I sat in on. This session between Katie and her ADC counsellor occurred towards the end of Katie’s participation on the ADC programme. Trusting others, especially adults, was not easy for Katie, since one of the issues she brought to counselling was having been the victim of childhood sexual abuse.

Katie: *I don’t drink vodka anymore, not since I got taken to hospital after drinking too much. I drink bourbon and whisky now. [She pauses] Should I be telling you this? Is this confidential?*
Cslr: *You know right from the beginning I will keep things confidential unless...*
Katie: *I know unless I tell you something about hurting myself or others.*
Cslr: *Yes that’s been the agreement from the beginning but you’ve never really trusted me have you? [Katie shakes her head]*
Katie’s counsellor had commented to me than in his view, the progress made with Katie up until this point had been slow, and he felt this was at least in part because of her failure to develop sufficient trust in him.

It was evident that confidentiality was highly regarded by these adolescents, and with good reason considering their experience with broken confidences and the negative consequences. This idea is supported by Geldard and Geldard (1999) who reported that self-disclosure by adolescents usually occurs only when there is strong sense of privacy in the relationship. The importance youth placed on confidentiality is also supported by other research that has considered the perspectives of adolescents on counselling (Dunnachie-McNatty, 2000; Everall & Paulson, 2002; Le Surf & Lynch, 1999). MacDonald, Lambie and Simmonds (1995) have suggested that trust can be nurtured in adolescents by establishing clear rules of confidentiality at the beginning of therapy. In introductory ADC counselling sessions I observed, the counsellors appeared to go to great lengths to explain the confidentiality agreement and its limitations. However, despite Katie clearly remembering the details of the agreement described by her counsellor, she remained very reluctant to trust her counsellor to keep to it.

There are added complexities to the confidentiality agreement between adolescent and counsellor, with parents and referral agents also having an interest in clients’ progress and safety (Dunnachie-McNatty, 2000; LeSurf & Lynch, 1999). While it is an ethical requirement of clinicians that they maintain confidentiality unless there are safety concerns for the client or others (New Zealand Association of Counsellors, 2004), it is not uncommon in counselling adolescents for circumstances to arise that require the counsellor to pass on client information, some of which may have been given in confidence (e.g., disclosures of suicidal intentions, ongoing sexual abuse victimisation, or intentions to cause physical harm to another). Further, there may be occasions when the counsellor feels their clients’ progress may be assisted by enlisting the involvement of third parties (e.g., a parent or teacher recognising and supporting a young person’s efforts to change), something that may require communicating information gained from the client. In situations that require information to be disclosed, it has been suggested that the client must first be fully informed (Dunnachie-McNatty, 2000). Julie indicated that she was particularly upset because she perceived that she hadn’t given her ‘permission’ for her counsellor to inform others. It is possible that the outcome may have been different if there had
been different ways of negotiating the disclosure or clearer communication between herself and her counsellor.

Given the importance, and in some cases reluctance, of adolescents to trust their counsellor, it is useful to consider what else counsellors can do to assist clients in developing trust. The following section looks at how self-disclosure by the counsellor may help in this process.

(ii) A counsellor who is prepared to self-disclose

While trust may develop through counsellors keeping confidential the disclosures of clients, initial disclosure must involve a degree of risk-taking on the youth’s part. Like Amy, they need to disclose something in order to find out if confidentiality is maintained. However, as seen above, some clients (like Katie) are not prepared to take the risk. Another way clients talked about becoming more comfortable in disclosing to their counsellor was if the counsellor was prepared to disclose information about themselves.

Positive effects of counsellor self-disclosure were mentioned by several clients. For example, Jane is recorded in the introduction to this section as saying a significant turning point in her counselling was when “we both, like, opened up”, after which things became “easier”.

Keith also talked positively in relation to his counsellor disclosing personal information to him whilst participating on a Journey.

Keith: *I thought it was quite good to be able to talk to [the ADC counsellors] and that and having a chat, you know, I had quite a few personal chats with [the counsellor].*

EM: *Oh yeah, what were they about?*

Keith: *We were just talking about our backgrounds and stuff. It’s like life, you know. He was telling me about his [family] and you know, and I just told him about my family and my parents. And you know, and what I’d done with my life. I was being totally straight-up with him. I quite liked that, I thought that was good. It makes a good friendship, you know...*

It is interesting to note that Keith talked about being ‘totally straight-up’ with this counsellor when they were talking this way, implying he was being honest in his disclosures. This provides support for the idea that counsellor self-disclosure makes it easier for the client to trust the counsellor sufficiently, and in this case to give honest
responses in reply. It is also interesting to note that Keith talked about this two-way communicating ‘making a good friendship’. Amy who talked of trusting her counsellor to keep things confidential also used the word ‘friend’ to describe her counsellor, someone to whom she could ‘tell anything’.

One client had particularly strong views on counsellor self-disclosure. Ann stated clearly that she preferred a counsellor who self-disclosed. She described how she felt she didn’t get on so well with the counsellor who had replaced her first counsellor and one of the reasons for this was that her second counsellor hadn’t ‘opened up’ as much.

Ann:  Good counsellors tell you about their past experiences, and then you can relate to them better. A counsellor who can’t do this, doesn’t really understand what you are going through.

It appeared that, for Ann, counsellor self-disclosure was a way for the client to understand the counsellor, but also allowed the counsellor to convey understanding of the client. Alan also referred to counsellor self-disclosure as a way for clients to relate to, and feel like they knew their counsellor. He explained how he related to one counsellor in particular:

Keith:  ...because he [the ADC counsellor] had been through the same kind of stuff.

I gained the impression that there was a reciprocal effect, with disclosures from one party resulting in more openness from the other. Ann went on to say that she got on better with her second counsellor after she had learned to open up following the Journey. Keith and Jane also described a similar reciprocal effect. It seems a fairly safe deduction that a counsellor who is prepared to disclose information about themselves can assist clients in their aim of ‘getting to know’ their counsellor, and as a result developing the trust to self-disclose.

Counsellors were also aware of the positive effect of their own disclosures on clients. One counsellor explained how in his view personal disclosures and showing feelings may help their clients to relate to them, by coming across as ‘real people’:

Cslr:  If a client asks me what I did at the weekend, I’ll tell them and then get back to the topic, but now they know I’m a real person.”
Counsellor self-disclosure is, however, considered a grey area in counselling. There is concern that counsellor self-disclosure can result in reversal of client-therapist roles, with clients feeling obliged to support the counsellor. It can also lead to inappropriate intimacy, or in the therapist being less objective in providing feedback to a client. While counsellors can usually ensure their disclosures are used solely for the benefit of the client, maintaining boundaries can be a more complex and subtle issue.

A significant power imbalance exists between an adult counsellor and adolescent clients, and this may cause adolescents to react defensively. Counsellor self-disclosures may effectively reduce this imbalance, creating conditions in which youth feel comfortable to disclose personal material. A counsellor who shares personal stories can assist clients to ‘get to know’ the counsellor, which enables them to build trust to then talk about personal issues. Providing the emotional context which facilitated youth in disclosing problems would seem to be an essential first step in the therapeutic change process.

Others have also argued that self-disclosure from counsellors of adolescents at a personal level can be appropriate as long as ethical boundaries are respected, i.e., counsellor self-disclosure should not be used to satisfy needs of the counsellor (Geldard & Geldard, 1999). These authors have suggested that adolescents are inquisitive, and may seek to connect with the counsellor and know him/her at a personal level rather than as someone hidden behind a ‘professional façade’. Further, adolescents appear more likely to engage with a counsellor if they feel they have interests in common, and/or if they recognise some similarities between the counsellor’s and their own style of relating. Jane, Ann, Alan, and Keith all talked of appreciating a counsellor who shared personal stories that revealed the counsellor had been through similar experiences. Geldard and Geldard (1999) also noted that for adolescent clients it may be a developmentally appropriate way of building relationships. They noted that with adolescents mutual self-disclosure, and disclosure of similar experiences, creates a sense of safety and intimacy that is common when forming important relationships.

(iii) An honest, straight-up, down-to-earth counsellor

In judging whether it is appropriate to trust someone, an appraisal of their honesty would also seem relevant, and this appeared to be true for some of the
participants; a trustworthy person had to be honest. A characteristic that ADC counsellors often referred to was ‘straightness’. It appeared this word was used to represent honesty, in particular not lying, not behaving dishonestly. Working to be more ‘straight’ was often one of the goals clients identified for themselves, and on the Journey were frequently observed working towards it. Apparently, being ‘straight-up’ and honest was something the young people also appreciated in their counsellor:

EM:  And [your counsellor] how much respect would you have for what he had to say, like when he gave you hints on stopping smoking dope and stuff?

Jane:  Heaps.

EM:  You might not be able to answer this but can you work out why you would respect him?

Jane:  Because he was always honest and yeah. He was always honest about the ways [drugs affected a person], and I’d always listen to him.

EM:  ...what kind of person do you think makes a good counsellor?
Sue:  ...someone who tells you straight-up, like what you should or shouldn’t, oh how do I explain this..

A school guidance counsellor who regularly referred students to the ADC programme, put his understanding of being ‘straight-up’ in to these words:

[The ADC counsellor] is straight-up. He is prepared to confront the kids as needed. He doesn’t muck around, and the kids seem to respond well to this.

The ADC counsellors themselves appeared to recognise the importance of being straight to their clients:

Cslr:  ...it was good to be direct and up front talking about sexual abuse and stuff. For difficult clients, it is their only hope, to have someone to the point, cutting out the bullshit.

Cslr:  You can’t sit on the fence and tell them what they want to hear all the time. If you say what needs to be said, sometimes they hate you for it. At the time, they swear, rant and rave, storm out, but they think about it and respect you for it the next week when they come back.

Cslr:  It is important to think about how counsellors respond to clients. Counsellors need to be ‘straight’ in order for them [the clients] to trust us to be ‘straight’ with them again in the future.

Confrontation of client behaviour that was inconsistent with clients’ goals was discussed in the previous section as a way of helping a client to develop motivation
towards change. When a counsellor was prepared to confront or 'challenge' a client, this could also be seen as the counsellor being 'straight' with the youth. For Jim, this was associated with developing trust in his counsellor, as predicted by the counsellors' comments above:

Jim:  I don't know, I trust [my ADC counsellor].
EM:   Why do you trust [him]?
Jim:  I don't know I just do. He challenges me, he's quick.

This 'straight-up' type behaviour of the counsellor could be similar to the Motivational Interviewing strategy of 'confrontation' described by Miller and Rollnick (1991). These authors referred to confrontation as a way to help clients see and accept reality, so that they can change accordingly. This form of 'raising awareness' in clients is particularly relevant to individuals who are in a state of ambivalence in relation to change which, as noted in the previous section (7.1), was a common characteristic of many of the ADC clients when they enter counselling. Although the lay person may understand confrontation as a form of argument, Miller and Rollnick refers to this as 'aggressive confrontation'; this is not the style these authors advocate. Instead they suggest that confrontation should be seen as part of the change process by helping individuals in self-examination.

Appreciation of honesty can also be interpreted as what is sometimes referred to as congruence, genuineness or authenticity (Ivey et al., 1996). Ivey and colleagues (1996) have argued that openness and honesty are central to counselling effectiveness. This may also have particular relevance to adolescents who, according to Braski (1999), have an acute ability to detect 'fakes' or people who merely pretend to show concern. Geldard and Geldard (1999) support this, commenting that adolescents are quick to recognise behaviours which are inconsistent and non-genuine, and that they are likely to be critical in assessing the attributes and behaviours of the adults they meet. Jane spoke of appreciating how her counsellor was honest about the ways drugs and alcohol might affect someone. It would be understandable if a youth who perceived their counsellor as trying to influence their behaviour by exaggerating or misrepresenting facts rejected it as manipulative (Hanna et al., 1999). The following section discusses the youths' appreciation of being treated with respect by their counsellor. In some cases there is an overlap between perceptions of counsellors' honesty or genuineness and reports of mutual respect between client and counsellor.
B) A Counsellor Who Treats Me Right

In talking with ADC clients there was much agreement on the ways that they liked (and did not like) their counsellor to interact or relate to them. How a counsellor interacts with the client is the main basis for clients’ judgement of the type of person their counsellor is, which in turn appears to impact on level of progress made during counselling. The style of interaction that these adolescent clients said they preferred included being:

i. Respectful in a friendly way.

ii. Acting as an ally.

iii. Listening to them and refraining from telling them what they should do.

iv. Being different to other adult figures in their lives, using their language, and being ‘fun’.

(i) A respectful friend

The comments below were from clients who were explaining why they would recommend the ADC programme to other young people:

Mike: *The way I was treated, the ADC people are cool, they treated me how I should be treated, like my mates would treat me, not like the school staff who treat me like I’m a kid.*

Pip: *My counsellor treated me like an adult and didn’t look down on me.*

Sophie: *My counsellor didn’t judge me.*

Parents also made similar observations of how ADC counsellors related to their adolescent clients:

Rachael (Parent):

*Talking to someone who didn't look down on her, and who offered ideas.*

Melanie (Parent):

*They [the counsellors] had a fun way of dealing with the kids, they work with them on their level. I saw him [the counsellor] playing sports, kicking a football around with him [the client], stuff like that. He really respected [the counsellor] and so did I.*
From these comments I gained the sense that what was being described could be termed an ‘egalitarian’ style of counselling. The youth appeared to appreciate being treated as equals, either as an adult, like the counsellor, or a peer, ‘like my mates’. Another aspect of being treated with respect was that clients felt accepted, that they were not being judged or looked down on. One client described how she appreciated this in her ADC counsellor, and contrasted this to her experience with a different counsellor:

Ben: ...this [ADC] counsellor was different. My school guidance counsellor would just roll her eyes at me.

In addition to being respectful, there also appeared to be an appreciation of a counsellor who acted like a friend or, as described by Mike, ‘a mate’:

Sally: My counsellor was more than a case manager, she was a friend to talk to. I could call her up and tell her anything.

The description of counsellors as ‘friends’ occurred quite often. It is interesting to consider what it means for a counsellor to treat a client like a ‘mate’ or a ‘friend’. For Sally it appeared to be someone she felt comfortable to talk to about ‘anything’, which suggests a feeling of acceptance by the counsellor. Previous comments from Keith and Amy suggested they experienced their counsellors as friends because of mutual disclosure and keeping confidences. Another characteristic common to a friend is someone who cares for you. In the introduction to this section Gerry talked about a turning point when her counsellor had ‘gone out of his way to help me out’ and how this ‘had meant a lot to me’. Later in this section it is noted that Terry felt his counsellor ‘wanted’ to listen to him. A friend is also respectful of your values and what is important to you. Although not mentioned directly by clients, this was something I frequently observed in ADC counsellors, who routinely conveyed an interest in the things valued by the youth, such as cars, music, even body piercing.

These characteristics of a friend, someone who listens, accepts you, understands you, and conveys warmth, together with a sense of respect and not being judged, appear similar to the construct of ‘empathy’ described by Ivey et al. (1996). These authors have described empathy as “seeing the world through another’s eyes, hearing as they might hear, and feeling and experiencing their internal world”. They also refer to constructs such as acceptance, positive regard, respect, as well as
congruence or genuineness, discussed earlier. Many of these constructs are associated with the existential-humanistic approach to counselling influenced largely by Carl Rogers. Geldard and Geldard (1999) have suggested that the Rogerian principle of unconditional positive regard, regardless of the clients’ behaviour, may be particularly relevant for adolescents. These authors have pointed out that adolescent behaviour seldom meets the standards of adult behaviour and, not surprisingly, they frequently feel judged and criticised. They are quick to recognise disapproval, and are then unlikely to disclose to counsellors if they believe that negative judgements are being made about them.

In listening to the preferences expressed by the youth for counsellors who act like a ‘friend’, issues emerge around maintaining appropriate boundaries similar to those discussed earlier in relation to counsellor self-disclosure. A counsellor of adolescents must always find a balance between acting in ways that are both effective but also professional.

(ii) A counsellor who is an ally

In addition to empathy and unconditional positive regard, clients also appreciated being made to feel important, and in particular feeling that their needs and desires were respected. This was described by some clients as a counsellor who is ‘there for me’ rather than ‘for others’. Jane appeared to be describing this experience in explaining why she preferred her ADC counsellor to others she had worked with:

EM:  And how did you find [your counsellor]?
Jane:  Good, like I found him the best, like I’ve had about six [counsellors].
EM:  Can you tell me why he was better?..
Jane:  [speaking louder] The other ones were people I had to go to. And they didn’t understand and they were only doing what the school said, told them to do. They didn’t care about anything else, they were just there so I wouldn’t get into trouble.

This sense of ‘being there’ for the client matches what others have described as counsellors presenting themselves as an ally (Everall & Paulson, 2002; Hanna et al., 1999). These authors have suggested youth are more likely to respond to counsellors whom they see as allies rather than another ‘authoritarian adult’. If the counsellor is able to create a feeling of personal importance in their client, they are likely to influence clients’ self-esteem and self-efficacy. Increasing a clients’ self-
efficacy is a motivational strategy, often argued as particularly appropriate for clients who are in a stage of ambivalence towards change. According to Tobler (1991), self-efficacy has particular significance in relation to adolescents. She suggested that progress in treatment with adolescents may be hindered by a sense of low self-esteem and self-efficacy, and therefore, recommended that counsellors use sessions to empower young clients, and enhance their sense of choice and self-esteem. This is also supported by results in the previous section on client factors, where the importance of empowering clients was discussed.

I frequently observed counsellors portraying themselves as allies, respecting clients goals and preferences, and acting as advocates for their clients in relation to school and family issues. The ADC counsellors appeared able to develop a sense of personal significance in their clients. I observed several introductory sessions where the ADC counsellor explained to the client that the programme was about working on what they (the young person) wanted to work on and not what others (e.g., referral agents or parents) wanted. To demonstrate this counsellors would encourage the youth to decide on the individual treatment goals that they wanted to work on. These as noted previously, then became the focus of subsequent counselling sessions.

Another way counsellors communicated that they were allies was by checking with clients before taking any actions, or before upcoming meetings:

Jane: *And like when mum would come, he would always, we’d talk about what we were going to talk about with her, so he could make sure it was alright, and that was all reassuring.*

Family therapy was a key component of the ADC programme, but the youth I spoke with generally appeared unenthusiastic. The respectful interaction described immediately above, involving reassurance that such contact was primarily for the benefit of the youth, may be one strategy to make family counselling more acceptable to adolescents.
(iii) A counsellor who listens to me and is not pushy

Perhaps the most important way a counsellor can convey respect and interest in what the client had to say was simply by listening carefully to the client. This was an characteristic that all of the participants mentioned as important, in particular that the counsellor listened to them, and did not just tell them what they should do.

EM:  How did you find [the ADC counsellor] compared to [your previous] counsellor?
Terry: She was a lot better eh. She listened to me she was like, she was the sort of person I wanted to talk to. ...Like you could really see that she was listening to me and she wanted to hear what I had to say. Unlike everyone else who just would sit there say something and then they'd start something else.

Here, Terry talked of his counsellor being ‘the sort of person’ he wanted to talk to, which could indicate that Terry decided she was ‘alright’ after ‘getting to know’ her. What appears to be important to note is that, for Terry, this judgment was apparently based on the ‘way’ he felt she ‘listened’ to him. It is not clear what specific verbal or non-verbal behaviours left Terry with this sense, but he perceived that she ‘wanted to’ hear what he had to say.

For Gerry, being listened to rather than being spoken to was one of the most helpful things about the ADC programme; for her, being listened to meant that the counsellor didn’t do all the talking.

EM:  How did you find the counselling?
Gerry: Really good. It was better than the other counselling as I did more of the talking. The previous one, she done all the talking, where as [my ADC Counsellor] got me to do the talking, and he worked things out from what I said. ... The other counsellor asked lots of questions that were confusing. It's better to let me talk and get the answers that way.

This group of adolescents didn’t always find it easy to put into words what they liked. However, they readily spoke of what they didn’t like, and it was possible to draw inferences from this about what they preferred. Youth were quite clear that counsellors who tried to tell them what was best for them were counsellors who were just not listening. This was something they felt quite strongly about, with nearly all the clients mentioning that they didn’t like what they called ‘pushy’ counsellors:
Martin: I didn’t like her [the G.P.]
EM: What didn’t you like about her?
Martin: Just the way she says, sort of pushes you into stuff. Just kept going on and on, and stuff. Like I was going to go up to this [residential school]. Yeah she just kept pushing and pushing and going on about it, every time I went to see her, she was going on about [this residential school], so in the end me and mum stopped going, yeah.
EM: When she pushes you what kind of reaction does that have, like...
Martin: You just get sick of it and annoyed.

Terry: ...but he [previous counsellor] just would tell me things that I should do, and I’d try to tell him that I’d already tried to do them and I can’t. But he just kept on going and didn’t even listen to what I had to say and everything. I’d start saying something and he’d butt in.

Similarly, Amy referred to a counsellor who had dictated to her family “what was best”, without listening, as “horrible, too pushy”. She described how her family would sit there, while the counsellor “reeled off” that they should do this and that, and how her brother’s response was “well that’s okay, but I just can’t do that”.

Earlier in this section it was noted that several ADC clients talked about how they liked their counsellor to self-disclose. However, if personal disclosures were used as a way to tell a client what they should do, it could have a negative effect:

Sue: He was pushy, too pushy. ... He doesn’t drink and he doesn’t smoke, like his kids, no offence to them, but they’re little angels, and I hate people that use examples. Like [the School Guidance Counsellor] does it really bad. He’s like, “Oh, my kid does this and my kid does that, so why don’t you do that ‘cause that worked?” And it’s like I’m a different person, like I don’t mind hearing about his kids and that, but I mean comparing me to them. It’s like, I’m a different person completely and he thinks he knows you but he doesn’t.

For Sue, comparing her to someone else, made her feel like she was not being listened to, and left her feeling misunderstood. Sue went onto explain how being listened to, was more about feeling supported, with her counsellor offering suggestions rather than telling her what she should or shouldn’t do:

Sue: Yeah it’s just at first. ... I wasn’t really keen on counselling as I thought we’d probably sit there and it would be, “Don’t smoke drugs, don’t drink alcohol.” But like it really surprised me how different it was, ‘cause he was more just supportive than all the no’s and do this and do that.
As well as not liking being told what to do and what not to do, the youth suggested that another indication that a counsellor wasn’t listening was if they asked too many questions. An excerpt from Gerry earlier, suggested she found it confusing when her previous counsellor asked her too many questions. Keith had a similar response:

Keith: *I had one counsellor and I got really sick of them... Well she’d go on and ask things and I wouldn’t understand how to, I didn’t understand how to talk to her like if you know what I’m talking about. So it was just hard to just go on about things like that.*

Comments from Ricky also suggest that, if counsellors are doing all the talking instead of listening, a potential consequence is that their clients are simply not understanding what is being said. He described how sometimes he didn’t really understand his counsellor and so he would just agree anyway towards the end.

In contrast Gerry mentioned above how it was better to get her “to do the talking” and for her counsellor to “work things out from what I said”. Similarly Jane talked about how she and her counsellor could work things out by letting her do the talking.

Jane: *...I found it quite hard to say what I was meaning to him, for a while. I’d say something briefly, but I wouldn’t ... but then he would always put it into words for me like I’d say something little and he’d say exactly what it really was.*

These comments appear to be related to a well recognised counsellor skill of ‘reflective listening’. It may also indicate that by listening a counsellor may help an adolescent ‘hear themselves’ (Braski, 1999).

It was interesting that, if clients felt they were being listened to, they were then prepared to listen to their counsellor. In response to his counsellor listening to him, Terry described how:

Terry: *Yeah, and I could sit down and listen to her for hours.*

Indeed, although clients wanted to be listened to, there was a general agreement that they did in fact want to hear their counsellor’s opinion or advice, but preferably in a way that they didn’t seem as if they were being told what to do:
EM: What makes a good counsellor?
Gerry: Someone who lets you have your own opinion, but he’d have some input too.

Sue: Just someone that is gonna listen to you. ... Just, like if you told them a problem or something, that they wouldn’t tell you what you need to do. They wouldn’t tell you what would be best to do. ...Yeah just suggestions, not sitting there raving on and on, do this, do that, just giving suggestions.

Indeed, a counsellor who just listened and said nothing was not necessarily ideal. In an interview Fiona said that one particular counsellor was ‘hard to relate to’: she found him “quiet and not that talkative”.

The primary message from these ADC clients was that they wanted to be listened to and not told what to do. Reflecting back to the previous section (7.1 ‘Client Factors), this could easily have been anticipated. The ‘Stages of Change’ model suggests that giving prescriptive advice on how to change before an individual has decided they want to change is likely to be ineffective or detrimental (Prochaska et al., 1992). It was suggested that most ADC clients when they initially signed up for the programme, had not yet reached a decision that they wanted to change their behaviour. Telling such clients what to do was, as predicted by the ‘Stages of Change’ model, likely to produce ‘reactance’ and be ineffective. As illustrated by Martin, Terry and Sue, Miller and Rollnick (1991) justly recommend that counsellors avoid trying to persuade clients to change. Instead they should ‘listen to’ the client and work out where their motivation lies, provide them with information and feedback on the consequences of their behaviour, and allow the client to decide on what actions they would like help with. This is supported in Sue’s comments above, that she preferred it when her counsellor gave her ‘suggestions’ rather than telling her what she should do.

From a developmental point of view listening to an adolescent rather then being dictated to, has particular relevance. A developmental task of adolescence is to achieve independence and autonomy. Church (1994) has suggested that when counselling is directive (i.e., telling a client what to do), adolescents feel as if their therapists are imposing their will on them and are, therefore, limiting their autonomy. This is also supported by this research: the ADC clients had a strong sense that being listened to meant that instead of a counsellor ‘telling them what to do’, they were attentive, helped to put into words what was going on for them, and after listening carefully, might offer suggestions for them to consider.
(iv) A counsellor who is different, uses my language, is ‘fun’

In the comments presented early in this section Sally talked about her
counsellor as more of a friend than a case manager, inferring perhaps that she
experienced her counsellor as different to what she expected from a helping
professional. Similarly Mike talked about his counsellor being unlike ‘school staff’. Other studies that have researched adolescents’ perspectives on mental health professionals have also found youth preferred counselling when it was, “more like
talking to a friend, not a professional” (Everall & Paulson, 2002, p. 83). It has been
suggested that a counsellor who presents as ‘different’ or ‘unique’ is modelling
individuation to the adolescent clients (Geldard & Geldard, 1999). Hence, a
counsellor who encourages and respects individuation in clients, is validating a
developmental need of adolescence.

Church (1994) also suggested a counsellor who portrays themselves as
different to other adult figures, may appeal to adolescents who developmentally are
striving for independence and separation. These developmental processes commonly
result in expectations that adults will attempt to exert control and power over an
adolescent, which consequently fosters mistrust of adults. Others have also noted
similar negative expectations of adults by adolescents (Le Surf & Lynch, 1999;
that their experience with adult figures were typically of being ignored,
misunderstood, disbelieved, dismissed, patronised, directed or punished. Tobler
(1991) noted as realistic the perception for youth to feel their views are often not
considered in decisions that affect them. Indeed, comments from ADC clients in this
study indicate such treatment from G.P.s, school guidance counsellors and other
counsellors was routine, which perhaps explains why trusting adults can be difficult
for these young people.

Whether it is because of individuation, or needs for independence and
separation, it appears counsellors who portray themselves as ‘different’ from other
adult figures or ‘unique’ may be better received by adolescents (Everall & Paulson,
2002). Interestingly in one introductory session I observed with an ADC counsellor
and a prospective client, was where the counsellor introduced himself and the
programme. He commented, “I’m not like your typical touchy feely counsellor”. To
this the new client Nicky replied “Yes I’d heard you’re not like normal counsellors’.
According to Nicky, others had also experienced this counsellor as ‘different’, a view echoed by Ann:

Ann: [the first ADC Counsellor] was different. I really liked my four sessions I had with him.

The style of interactions that the youth expressed a preference for, being treated with respect, made to feel important, and relating to the youth on ‘their level’. These preferences were often based on experiences they had had previously which they did not like. ADC counsellors were perceived as ‘different’ to what many of the adolescents were expecting from an adult counsellor. One client, however, expressed annoyance that her counsellor behaved so differently from what she was used to:

Jane: Yeah ‘cause I’m used to people fighting with me. ... That made it real annoying... He was always, ‘that’s fine, your choice’, ... I’d quite like him to yell.

Other ways that ADC clients found their counsellors to be different was the counsellors’ use of language and the degree of humour or enjoyment in the counselling session.

The excerpt below describes clients’ reaction to counsellors swearing:

Terry: Yeah, like everybody was real surprised when he swore.

Mel: I laughed when [the counsellor] swore, he looked too posh to swear.

These reactions reinforce the perception of ADC counsellors as ‘different’ to what clients were expecting. Other clients seemed surprised but not put off that the counsellor might use such language. The following excerpt is from a discussion with a client and his mother:

Terry: ...she spoke my language eh mum, she spoke how I would speak to a counsellor, just....
Mum: Like Terry would be really, really wound up and he would be swearing and ... he’d say, “I don’t give a b*gg*r,” or whatever, and she’d say, “All right so you don’t give a b*gg*r but how are we going to, ...” You know what I mean? So she didn’t have a go at him for swearing... She went with it and got him to talk more about what was happening for him.
EM: Is that what you mean by talking your language Terry?
Terry: Yeah.
Earlier it was noted that counsellors may risk being misunderstood if, instead of listening to the client, they did all the talking. Apparently another way clients could be assisted in understanding their counsellor was if the counsellor used what the clients considered to be ‘their language’. The language counsellors used could also influence how the client (and their parents) felt:

Mary (Parent):

[The ADC counsellor] swearing and expressing how angry she was about stuff, really put me and my daughter at ease.

A final style of interacting that several youth talked positively of, was the counsellor bringing humour to the session, or making it “fun”:

EM: What makes a good counsellor?
Keith: Well yeah, knowing what they're talking about but making it more fun, bringing a bit of character to it.

Amy: Someone cheerful, not boring, and that you felt comfortable going to see.

Jane: Understanding and helpful. Like always gives you help, and doesn’t get shitty when you stuff up, and someone who can make you laugh as well.

According to Ann, a good counsellor was able to have a bit of fun, and was easier to relate to than a counsellor perceived as too serious:

Ann: I hated that psychiatrist woman. She was too serious, uptight, too rigid.

The ability of a counsellor to lighten-up or be able to bring humour to the counselling session has been mentioned as a positive attribute by others (Geldard & Geldard, 1999; Hanna & Hunt, 1999). Hanna and Hunt (1999) suggest adults who can laugh at their own faults and idiosyncrasies and do not take themselves too seriously, are looked on differently by adolescents. This could then be another useful strategy for a counsellor to use, in seeking to portray themselves as different to other adult figures.
C) Someone Experienced in Life and Counselling

A final theme that emerged when ADC clients described the attributes they looked for in a counsellor related to counsellors’ level of experience. In the literature mixed findings occur in relation to treatment outcomes and level of counsellor experience. Not all of the research participants mentioned this as important but those that did all seemed to prefer a counsellor who was experienced in life and/or counselling.

In the section on counsellor self-disclosure several clients commented how they appreciated a counsellor who ‘shared’ their own experiences with them. This ‘sharing’ implies the youth perceived that the counsellor had similar experiences to their own to share. Ricky said from his experience, a counsellor who had experienced similar problems (e.g., substance abuse) to the clients was more effective. This view was shared by Jane:

EM:  Okay, what kind of person do you think makes a good counsellor?
Jane:  Understanding, and I reckon um people that have been there, kind of. Like ...I think that would be more helpful than having to learn it, 'cause you wouldn't have experienced it.

This preference for a counsellor who had been through similar life experiences is perhaps linked to appreciation of a counsellor who is able to ‘empathise’ with them. That is, a counsellor who is able to understand them and what they are going through is thereby more able to help them. Tim talked of feeling understood through the counsellors’ sharing of past experiences of travelling:

Tim:  [ADC counsellor] sort of, he listened to me. Like he came up to me and talked to me about a few things, you know. And he talked to me about Australia and he tried to understand and put himself where I was, you know, and things like that and sort of made it easier to talk to ...

For other clients, the perception of a counsellor who was capable of helping them appeared to be more about the credentials of the counsellor, i.e., whether he was an experienced counsellor:

EM:  If you had to choose someone for your counsellor who would you choose?
Andy:  ... Oh Okay, I'd probably choose [ADC counsellor]... 'Cause like he's just got, like he's got a better knowledge about counselling.
Sue: I don’t know, ...but I sort of, I think I found [ADC counsellor] really really, really easy to talk to. It was like even though I’d told [another ADC counsellor] most of my life, I don’t know, I just felt [this ADC counsellor] nicer to talk to... ‘cause he was like he knows his stuff...

Another client associated his counsellor’s training as signifying the counsellor being capable:

Alan: [the ADC counsellor] is a psychologist eh?.
EM: Yes.
Alan: [nodding in a that explains it kind of way] He’s clever, he always has a solution.

These comments fitted with Geldard and Geldard’s (1999) observation that adolescent clients have expectations that a counsellor will be knowledgeable, experienced in life and will have information regarding the client’s own specific problem. The importance of a counsellor being perceived as capable of helping is emphasised by MacDonald et al. (1995). They have suggested that adolescents are particularly sensitive to counsellors who lack skills; it is, therefore, important that counsellors are able to present themselves as knowledgeable and competent.

7.2.4 Summary

In listening to the youth talk about counsellor factors that helped them achieve change, there were many overlapping themes, but what these adolescent clients seemed to want did not seem unreasonable. They wanted a chance to get to know their counsellor, to decide if they were the sort of person they would like as their counsellor, and, importantly, whether they felt comfortable to open up and talk to them. They needed to feel like they could trust their counsellor, especially that they could trust their counsellor to keep matters discussed confidential. The youth suggested that when counsellors shared past experiences and were honest and ‘straight-up’, this helped them in developing trust. They also talked of appreciating it when they were treated in a caring, respectful manner. They had strong opinions about being listened to rather than being told what to do by their counsellor. Finally, they responded well to a counsellor who they perceived as different to other adult figures in their lives, and to someone who was experienced both in life and in counselling skills.
While these requests seem reasonable, what was perhaps surprising was the number of examples offered by clients past experiences with other adults and helping professionals where these expectations were not met. Many of the negative experiences seemed to stem from a failure on the part of the adult to recognise and attend to the developmental needs of adolescents. In contrast, their experiences of ADC counsellors had been positive, suggesting they were able to engage the youth through developmentally appropriate styles of counselling.

The positive association between the counsellor-client relationship and therapeutic outcomes achieved is well documented. Considering the conditions of referral for these adolescent clients, the formation of a positive relationship has particular significance, yet can be more difficult to achieve. Youth typically arrive with negative expectations "of having to spar with yet another adult who is going to tell them what to do, how to do it, and when to do it" (Braski, 1999, p. 544). The comments offered by these ADC clients may help counsellors understand better ways to interact with their adolescent clients to develop the type of relationship that is appropriate and helpful for these adolescents. If successful, the adolescent is more likely to engage in the counselling process, to open up to the counsellor, and be more receptive to suggestions offered by the counsellor.
7.3 Programme Factors – “It was the Journey”

In reviewing the youths’ comments from the previous two sections, compared to what is to be presented in this third section, it appears different phases of counselling have been highlighted. The first section (client factors) discussed the typical referral process for ADC clients, which highlighted the importance of the clients’ own motivation to make changes. The second section (counsellor factors) looked at the development of an appropriate adolescent client-counsellor relationship and how this can serve the change process. As such, the factors raised in these first two sections could be described as the pre-requisites for change to occur, or the beginning phase of counselling. In contrast, this third section focuses on what had been helpful to the youth in actually making changes. That is, it reviews the outcomes which the youth reported they had achieved, and explores the contribution of particular elements and content of the ADC programme that the youth considered as significant in achieving these changes.

The section begins with a brief overview of the ADC programme, providing some context to the relative emphasis given by the youth to the different components of the programme. There is a short section on the content of community-based counselling sessions that the youth found helpful, which highlights the variability among this group in terms of needs and preferences. However, the Journey aspect of the programme was most commonly referred to by the youth as being particularly helpful. The main focus of this section is, therefore, on the Journey. The importance placed on the Journey by the youth is examined, followed by a detailed review of how the youth perceived the Journey had assisted them in their efforts to make changes. Finally, there is a discussion on aspects of adventure/wilderness therapy (AT/WT) activities that appear to be important in order for therapeutic outcomes to be achieved, and how according to the youth these outcomes are transferred and maintained in their everyday lives.

7.3.1 Overview of ADC Programme

The basic format of the ADC programme has been described earlier (see Table 5, section 4.1.4), but it is probably useful to review this in order to provide context to the relative emphases of different elements of the programme that the youth described as helpful.
The ADC Programme is a multifaceted programme which combines community-based individual and family counselling with nine days of group-based wilderness therapy known as ‘the Journey’. The community-based counselling typically consists of weekly one-hour sessions of either individual or family-based counselling. The community-based sessions take place at the counsellor’s office in town, at school or at the clients’ home.

At the beginning of the programme there is an introductory session to explain the content and format of the programme, entry criteria, and limitations to the confidentiality agreement. Once informed consent has been obtained and the young person accepted onto the programme, the next couple of sessions focus on assessment issues and what the young persons’ counselling goals are to be. Counsellors seek to gain an understanding of the difficulties being experienced by the youth, as well as the resources and strengths available to the client to overcome the difficulties. At this stage agreement is reached on the specific goals the youth would like to work on. This is followed by a period of on-going assessment of the youths’ commitment towards achieving these goals.

In the two to three months that precede the Journey, the youth typically has weekly meetings with their counsellor in which they begin to work towards achieving counselling goals. These sessions may be one-on-one or involve family members or other relevant people (referral agents, school representatives, peers, other helping professionals, etc.). Immediately prior to the Journey the counsellor assesses the readiness of their client for the Journey, and prepares them for what to expect and how to get the most out of the experience.

The Journey is described by the programme providers as ‘short intensive group-based wilderness therapy’. It is short in that it is limited to nine days in duration; it is intensive being a residential-style experience involving up to 15 hours of contact time per day; it is a group intervention with between 8-12 youth participating in the daily activities, including group therapeutic discussions; and it is wilderness therapy as it incorporates living, working and recreating together in a wilderness setting. A significant proportion of time on the Journey involves daily routines: eating, sleeping, and completing chores (such as cleaning, cooking, gathering and chopping firewood) as are required in order to live in the environment. In addition there are a range of structured activities which include daily goal-setting, group discussions, tramping, climbing, kayaking, a three-day expedition, group
problem-solving activities, games, periods of quiet reflection and, on a few occasions, free time. There are up to 12 clients on a Journey, facilitated by three to four ADC counsellors alongside other staff as required (qualified climbing instructors, and other support staff). On the Journey counsellors are referred to as ‘leaders’; in most cases the clients have their regular ADC counsellor with them on the Journey.

Following the Journey, there is an emphasis on consolidating gains made on the Journey. This includes further family sessions and meetings with other key people, which focus on how the changes the young person has made can be supported. At the end of the programme, using the principles of narrative therapy, the counsellors assist the participants to ‘write their own story’ after which they are awarded a certificate of programme completion.

The above description contains the many features that make up the full ADC programme. I asked the youth to explain what it was that they had found most helpful about their counselling experience. They talked about the ADC programme as a whole being helpful (both the community-based counselling and the Journey). However, in terms of different components of the ADC programme, they tended to emphasise the Journey experience. No other elements of the programme such as the initial assessment, specific content covered in counselling sessions, different approaches used or the family counselling emerged as strong themes. Comments made in relation to these other programme elements tended to occur in response to probing, or single comments.

It initially surprised me that, despite the longer duration of time the community-based counselling encompassed, the youth had relatively little to say about the content of these sessions. The community-based sessions after all had spanned a significant period of time (on average six months), and provided opportunity for the adolescent clients and counsellors to regularly re-visit the goals identified at the outset, as well as additional therapeutic issues as they presented. The latter often involved ‘crisis’ management as problems at home, school or in relation to the community (e.g., illegal behaviour) arose. However, I later reflected that the Journey experience which they did speak a great deal about, was a far more intensive experience. In terms of contact time, it actually accounted for a far greater number of hours (counsellors interacted with clients for nine days, often eight to ten hour days, totalling over 72 hours of contact time, which compared to just 20 hours of community-based counselling). Further, it was clearly the prominent feature of the
programme, something reflected in the way it is introduced to the youth by the ADC counsellors, in being planned for and then later reviewed. The term ‘adventure’ in the title of the programme further underlines its prominence. As a distinguishing feature of the programme, it appeared often to be the reason many youth signed up:

EM:  Was there anything that attracted you to sign up for the programme?
David: No I just wanted to do it...the Journey sounded interesting to me.

Gerry: I had done counselling before and said to the school guidance counsellor I wanted to do something a bit different. The Journey made it different.

7.3.2 Content of the Community-Based Counselling

In this section the ‘content’ of the community-based counselling that the youth suggested had been significant to them is reviewed. I considered ‘content’ to include the issues covered as well as the actions, techniques or strategies employed by counsellors. The helpfulness of particular content of counselling sessions that follows, was described by research participants without specific prompting or questioning.

Of the core group of research participants, three clients described specific educational information they had received from their counselling in the community-based sessions as useful. This information included a description of the grieving process, and discussions on the consequences of abusing drugs and alcohol and engaging in criminal behaviour. Two youth mentioned interpersonal skills they had been taught which they felt had enabled them to interact more effectively with authority figures and to be less influenced by peers. Another client spoke of the great significance to him of his counsellor assisting him to get back into the regular school system. Another client expressed appreciation of her counsellor encouraging her into a work experience opportunity:

EM: Can you think of any particular sessions that stand out in your mind as particularly useful or helpful?
Sue: They all were, um,... I think it was when he said to me about going to the primary school for a day of work experience. And I actually did that and it was good 'cause now I do want to go and do things with children.

These comments reflect variability among clients as to what they perceived as helpful, which ranged from an increased understanding of the process of grief, to
facilitating an opportunity for work experience. The variability in what they had found helpful perhaps reflects the individual needs of the clients in terms of their presenting issues. That fewer themes reoccurred in relation to the content community-based counselling may reflect the individualised treatment clients received in relation to specific needs.

Two standard components of the programme on which I specifically questioned the youth included the family therapy and the writing of the client’s story (based on principles of narrative therapy). I was interested in the youths’ perception of these particular components because they were viewed by ADC counsellors as particularly important. The emphasis on family therapy reflected awareness that adolescent psychotherapy/counselling research supports family involvement as an important element of effective interventions (Cormack & Carr, 2000; Grizenko, 1997; Huey et al., 2000). The results of the quantitative study (Part II of this thesis) provide some additional support for this view, in that the youth who had a parent or caregiver available and willing to complete assessment information had better treatment outcomes. In relation to clients writing their story at the end of the programme, little research exists on the therapeutic value of this activity, but it was noted that many of the ADC counsellors had received training sessions in the use of this activity and therefore used it in their work.

I was again surprised, however, that the research participants failed to mention either family therapy or the writing of their story unless prompted. In terms of family therapy, this apparent omission was particularly surprising considering that in the quantitative survey 48 percent of ADC clients had individual treatment goals of improving relations with family members (see Table 13).

When I asked specific questions on participant’s experience of family therapy, I received a mixture of responses. Most were ambivalent, some ‘didn’t mind’ it, or found it ‘quite good’. One client commented on how he found a session with his mum helpful because:

David: *I found out what my mum thinks about me.*

Two clients said they didn’t like the family therapy. One client found family therapy to be a negative experience:
Ricky: *It was alright at the start but then as time went on and [my ADC counsellor] got to know what was going on, he got the family involved, and that was shitty. Mum is the kind of person who is never wrong. She would butt in, I'd say one thing and she would say something else and it would turn into a big fight, and that was not pleasant.*

During my two years of data collection, I came across a handful of clients who described the family therapy as the most significant part of the ADC programme. For example, when I asked Neil what had been most helpful to him in giving up his use of marijuana, he described:

Neil: *Seeing Mum's reactions, how she felt about what I was doing to myself.*

However, these comments were relatively uncommon; more typical impressions I obtained from the youth were of ambivalence.

When I asked the participants how they had found writing their story, again there was a degree of ambivalence in responses. However, there were no solely negative comments, and two quite positive responses:

EM: *Writing the story at the end how was that?*
Jane: *Oh yeah, the story of your life ... That was real good 'cause I kind of got it all out on paper and looked at it and I suppose I liked reading it.*

Sue: *It was easy, I just love writing.*
EM: *Did it make you think about anything differently?*
Sue: *... once it was all together and I read it, ... it actually sort of made me think, it was good. I sort of thought, oh yeah it's over, you know, a couple of things have changed. But then when I wrote it, and actually thought about it, there was much more stuff that I liked about myself and that.*

These discrepancies between the importance awarded by research and the ADC counsellors compared to the apparent indifference signalled by the youth highlight areas worthy of further consideration. It raises the question of whether these elements of the ADC programme are in fact important. It may be that youth found these elements less effective compared to other elements. Indeed, not all research has found family involvement to be crucial (Clarke et al., 2003). Alternatively, they may have been important to the youth (as suggested in the number of family related counselling goals) but were simply topics that the youth felt less keen to talk about.
The low priority given by the youth to family involvement can perhaps be explained in terms of developmental issues. Unfortunately, answers to these questions are beyond the scope of this research, but the questions raised through listening to the youth perspective point to areas warranting further research attention.

While this section on the value of the community-based counselling sessions is comparatively short, I later reflected I may have created an artificial separation between the ‘content’ of the community-based counselling and other aspects and approaches (e.g., motivational/relationship aspects and theoretical approach). Previous sections have already covered several important aspects related to the community-based counselling. Section 7.1 highlighted the importance of a client readiness to make changes, and discussed how ADC counsellors could use early counselling sessions to influence the youths’ decision and commitment to make changes. Section 7.2 refers to the importance of client-counsellor relationship variables, much of which was based on events that occurred during community-based counselling. Further, in section 7.4 (Theoretical Explanations) which follows this section, there is a discussion of the possible impact of ADC’s theoretical approach on counselling based on comments made by the youth, which again points to the significance of events that occurred in the community-based counselling.

The brevity of this section should not necessarily be considered a reflection of the relative importance (or lack of it) placed by the youth. Indeed some of the content of the community-based sessions mentioned by the youth were referred to as ‘turning points’ for them.

7.3.3 The Journey

The Journey was presented to the youth as the main feature of the ADC programme, both by the ADC counsellors themselves and by promotional material received. When I interviewed the research participants who had completed the ADC programme, I was interested in learning whether they viewed their Journey experience as primary in assisting them to achieve positive changes. Further, I wanted to know if they felt their Journey experience had been significant, and whether they could identify what it was about their experience that had been helpful. From listening to the youths’ interpretations I hoped to gain a better understanding of how the Journey might ‘work’ to achieve therapeutic change.
7.3.4 Evidence of Importance

One of the first questions I had in relation to the Journey was how important it was to the youth in terms of assisting them in making therapeutic gains. The Journey is a costly part of the ADC programme, both in terms of personal and financial resources, but in the view of the programme staff is a cost that is justified.

In reviewing the data collected, the personal value the youth placed on the Journey became evident in several ways. It appeared to have been a very positive and memorable experience and was the topic they were most likely to talk spontaneously about. It was certainly the one element of the overall ADC experience they most commonly described as having had the greatest impact. Many of the positive outcomes reportedly achieved by the youth were attributed specifically to the Journey experience. While the youth described the Journey as a therapy experience, not dissimilar to the community-based counselling, several ADC clients believed the rate of therapeutic progress achieved was greater on the Journey.

The Journey – ‘It’s really cool’

The Journey emerged as the topic the youth were most at ease to talk about, and were most enthusiastic about. During interviews I noticed that the youth would appear to physically relax whilst talking about the Journey, but that they also became more animated when describing experiences such as the three-day expedition, the climbing or how well they got along with other members of the group.

In the conversations I had with the youth, all without exception reported their Journey experience as positive and helpful. The responses used to describe how they had found the Journey ranged from a simple “good”, to the more expressive replies such as “excellent”, “cool”, “awesome” or “exciting”. The quotes below are examples of such responses:

Jane:  *Exciting ‘cause I met like a different group of people.*

Terry:  *It was really quite fun I would say, everything was so hands on.*

David:  *It’s really cool, and that. Yeah good, good to talk and that, and go on cool walks and stuff.*

In trying to gauge whether this positive experience had actually been significant in terms of helping them to make changes, I reviewed the transcripts of the eight clients whom I had participated with on a Journey. Of these, one client, (Jane),
had even been sent home early from the Journey, having broken the terms of agreement of the Journey (e.g., she was judged as displaying insufficient commitment towards her counselling goals). She spoke positively about her experience nevertheless:

Jane: ...and the Journey is a good part, I wasn’t there long, but it would have been good.

Two clients described their experience as helpful, though weren’t able to give specific details of exactly how it had helped them. Another two reported that they felt the Journey had played an important role in their overall positive achievements, but that this occurred along with the other parts of the ADC programme. The remaining three attributed their main outcomes to the experiences gained on the Journey:

Sue: Oh yes. Well it was just my attitude that was getting me in trouble at school ....
EM: Has that changed? ...
Sue: Yeah, it’s like, I think if I’m going to be in a crabby mood then I’m not going to get much done. I’m not going to, like, especially now with exams, there is no time to be crabby.
EM: .. and so has that just happened gradually over the course of the programme or was there anything in particular that helped you?
Sue: It was definitely the Journey, me being polite and nice to others and getting it back just makes you feel better.

The personal outcomes attributed by these eight to their Journey experience were varied. The most commonly reported change was an improvement in their ability to interact with others. This included gaining control over anger, responding more appropriately to authority, and getting along better with friends and members of their family. Another set of outcomes could be described as general life or coping skills, including improved problem-solving skills, and an improved ability to persist with activities. A couple of clients also felt the Journey had been helpful in consolidating changes they had already started to make prior to the Journey, such as giving up crime and abuse of substances. More specific details of these reported outcomes will be presented throughout this section, as the youth described the ways the Journey was helpful to them in making changes.

It was not always easy for the youth to explain precisely how the Journey had helped them to achieve these outcomes, but there was a strong opinion that it had been significant. This was supported by a recent post-programme evaluation survey of a
different sample of ADC clients (Mossman, 2003). Twelve of 20 clients reported that the Journey was the single most significant event of the ADC programme in helping them to make positive changes.

The Journey - ‘Same as Counselling’

In exploring the value of the Journey to participants and whether it had been helpful, I asked the participants to compare the Journey to their community-based counselling sessions. I was curious to explore whether in their view the Journey was associated with different outcomes to those achieved during their community-based counselling. I was a little surprised that some didn’t think it really made sense to compare them as in their view they were more similar than different:

EM:  Okay. ... I'm just trying to compare the Journey to the counselling...
Andy: I wouldn't compare them, 'cause they were just the same.
EM:  Like just more of it kind of stuff?
Andy: Yeah,...

While some of the youth appeared to find the Journey “better”:

Ann: The Journey was like counselling but was fun too. Like on the Journey we talked about carrying around this big heavy pack and how it was good to get rid of the heavy load, and to me counselling was like throwing out small stones but on the Journey you got to throw out big stones.

According to the metaphor described by Ann, she experienced the Journey as similar to her community-based counselling, except that there was something about the Journey that enabled greater progress to be achieved (that she could ‘throw out the big stones’).

These comments from the youth challenge a common perception, especially amongst those outside of the field, that rather than an intentional ‘therapy-type’ experience, AT/WT provide just recreational experiences that on occasions may create beneficial effects. Indeed, despite the therapeutic purpose and content of the Journey being described to all ADC clients, several youth were themselves surprised to discover how therapeutically focused the Journey was:

Alan:  I thought it was going to be just rock climbing and tramping and stuff.
EM:  Like a school camp?
Alan: *Yeah that kind of thing… yeah it was a bit of a shock when I realised it was going to be more of the ‘sit down talking’ stuff.*

It could be that the Journey does in fact place more emphasis on the application of ‘therapy’ (the ‘sit down talking stuff’) than do other programmes that claim to be AT/WT interventions but are more recreational in nature.

These comments from the youth support Newes (2000) understanding of the type of participation necessary for an intervention to be considered ‘adventure therapy’. She suggested that participation in adventure or outdoor experiences alone cannot be assumed as sufficient to facilitate deep-level therapeutic growth and change, but that it is the processing (similar to counselling) of the actual experience with the client that promotes the therapeutic effect.

If mental health professionals continue to perceive AT/WT as merely recreational activity, as did some of these research participants initially, it is unlikely such programmes will gain credibility as alternatives to traditional approaches to counselling. Therefore, it may be important for the AT/WT field to communicate to others outside the field, that the recipients of one such intervention experienced this approach as more similar than different than that of community-based counselling.

What follows is a more detailed look at some of the youths’ constructions of the ‘therapy’ they received during their AT/WT experience.

### 7.3.5 How the Journey was Helpful

Many different elements make up a Journey experience, and this was reflected in the wide range of comments offered by the youth on what it was about the Journey that had been helpful. While there were differences among individuals over features that ‘worked best’, four aspects emerged as useful to a significant proportion of clients. These included:

A. The prolonged and concentrated nature of the nine day experience.

B. The group-based format.

C. The wilderness setting.

D. The challenging (and personally meaningful) Journey activities.

While these four features are presented in separate sections, it will become apparent from the discussion of each that, rather than acting in isolation, they combine together as important ingredients in the promotion of many of the beneficial effects noted by ADC clients.
A) The Prolonged and Concentrated Nature of the Nine-Day Experience – ‘You get to nut it out.’

In explaining how the Journey had been beneficial, several clients described how they felt therapeutic gains had occurred more rapidly for them on the Journey, as illustrated above by Ann in her comment about ‘getting rid of bigger stones out of your heavy back pack’. This accelerated therapeutic gain appeared to be linked to the extended duration and intensive nature of the Journey, aspects which emerged as a strong theme among ADC clients.

When I asked Andy how he felt the Journey had helped him to give up crime and use of cannabis, he summed up the felt benefits of this prolonged therapeutic exposure as follows:

Andy: *Um, ‘cause probably you get to nut it out.*

The value of the Journey as a chance to ‘nut it out’ made perfect sense to me when I considered the nine continuous days of therapeutic work. Yet while wilderness therapy interventions do typically extend over several days, the length of time is not commonly singled out as a contributing factor to therapeutic gains. The increased opportunities for therapeutic learning through more time interacting with group members has, however, been noted by Williams (2000) as one of the ways wilderness therapy interventions can be more effective than other approaches. These increased therapeutic opportunities were recognised by the ADC clients. However, in addition to interactions with group members, the youth also talked of the benefit of increased time for personal work, understanding of self, trying out and practising new ways of behaving and from one-to-one interactions with Journey leaders/counsellors.

What follows are the different features of the Journey that the youth identified as contributing to these increased therapeutic opportunities and chances to ‘nut it out’. They include the daily goal-setting coupled with opportunity to work progressively each day towards one’s overall Journey goals, regular time available for quiet reflection on personal issues, and the various opportunities for experiential learning.
(i) Daily goal setting

Daily goal setting was the activity most frequently referred to by the youth as contributing to their perceptions of high rates of therapeutic gain. They described what appeared to be a continuity or momentum that occurred over the nine day period, through working progressively on goals set, then achieved, from day to day. Ann told me how she felt she had "learnt stuff" on the Journey, and how "whatever you achieved up there each day, you then had to build on it the next day". She repeatedly mentioned that she had made more progress because of working on things each day, compared to what she could achieve in her usual hour long once-a-week community-based counselling sessions. Sue also described a similar sense of continuity gained from the daily goal setting, emphasising the benefits of being in a therapeutic environment for the week-long duration, particularly in relation to being able to maintain her changes.

Sue: ... ‘cause you’ve got your hour counselling, or how ever long, and then you just go back into that environment again and you just start it all up again, unless you’ve got major will power. But then with the Journey you’re there for the whole week and then by the end of that, by the end of those nine days you’ve adjusted to it like, you go home and you’re still the same [maintained the changes], that’s why it was better.

EM: So you felt different after the Journey and different enough that you actually felt like you’d changed?

Sue: Yeah... I think it helps doing it [goal setting] everyday the way we did.

The rate of progress the youth described from working on goals daily over a nine-day period could be similar to the rate of progress and outcomes one might expect to achieve from more ‘intensive’ therapy such as standard residential treatment. In fact, one client explained that she would recommend the programme to others because she felt it achieved outcomes similar to what she would expect from a residential A&D programme, but in a way that was also fun:

Sarah: Because it’s not hard out like [youth A&D residential programme], full on rehab. It’s fun but it helps you.

The ‘fun’ aspect of the Journey is something that will be revisited later on, but what is important to note here, is that Sarah felt the Journey experience was comparable to an intensive residential therapy in terms of being helpful.
The benefits of goal setting are well recognised. It is a strategy used to achieve behavioural change in many styles of counselling, and is a central feature of approaches such as solution-focused counselling and behavioural therapy. Indeed, goal setting is also an important aspect of the community-based counselling of the ADC programme. What appears to be different about the Journey is the intensity achieved in goal setting, daily for nine days in an atmosphere of generally positive emotion.

As well as benefiting directly through the attainment of the individual goals and the associated changes in behaviour, others talked of how they benefited from just learning the skill of ‘goal-setting’. Several clients described how they continued to set themselves goals and work towards them on their return from the Journey which resulted, as one client put it, in ‘getting control of your life’.

One theory that may explain the therapeutic benefits of the goal-setting described by the youth, is Bandura’s social learning theory which stresses the enhancement of ‘personal self-efficacy’ (Bandura, 1977, 1997). Setting and successfully achieving goals has been found to increase individuals’ belief in their own competencies (i.e., self-efficacy). In turn, increases in personal self-efficacy are associated with increased perseverance and effort towards goals and, therefore, increased likelihood of further success. This may explain the sense of momentum and rate of progress referred to by the ADC clients. Further, enhanced self-efficacy and the associated increases in achievements tends also to produce the perception of having ‘agency’ over one’s environment or, perhaps as described by the ADC client as ‘getting control of your life’. This in turn, according to Bandura, results in increased well-being and general improvements in overall mood state (Bandura, 1977, 1997), predicting a general positive affect, as well as the benefits of the behaviour change associated with the goals.

(ii) Time to think

While clients described aspects of the Journey and outcomes achieved as being similar to what might be expected from intensive treatment, the actual word ‘intensive’ was not used by the youth to describe their experience. In fact, perhaps because of the prolonged timeframe the Journey was experienced by some as less ‘intense’ moment by moment than their regular community-based counselling. In a conversation with Ann, she explained how she found her normal one-on-one
community-based counselling sessions quite “tense, very focused” and how she liked the Journey because she found it much easier to “relax and talk about stuff”.

During a typical day on the Journey, a great deal of walking occurred, either to or from activities, or as an activity in and of itself. During these walks I frequently observed the participants talking one-on-one with a leader. As suggested by Ann, these chats were relaxed and informal, and may or may not have been about personal or therapeutic issues. However, when I interviewed participants, these ‘personal chats’ were often referred to as having been helpful. In the previous section on counsellor factors, several youth referred to these ‘personal chats’ as a way to get to know their counsellor, and, according to Ann, for them to feel more at ease to open up, thus facilitating the counsellors getting to know the youth.

Other clients also appreciated the less intensive experience in that it provided time to think. This aspect of the Journey was what Ross felt had been particularly significant. He described his programme outcomes as improving the relationship with his parents, becoming more motivated and reducing his consumption of alcohol. These he attributed to the Journey, especially the element of:

Ross: ... being away from everything, time to think by yourself.

Having time to think could happen at any point during the day. There was quiet time for thinking when youth were walking, often single file, along narrow tracks on a tramp or on their way to an activity. There were also specific time set aside known as ‘reflection time’, where participants would sit alone, often in the bush, with their Journey log books, for 20-40 minutes. Some sat by streams, others spent times looking up at the glaciers, or leaned against beech trees in the old-growth forest. Most described the ‘reflections times’ positively:

Gerry: They were alright, it was good to have time to sit and think. To think about what was happening on the Journey, it was better because of it.

Sue: Yeah, but they were alright to think about whether you were achieving your goals or if you’ve been misbehaving. Like you’d think about it and it was like, It was good thinking time and that, that was all I did, write poems.

The comments above from Gerry and Sue suggest that they used the reflection time to process what was happening for them on the Journey. Another client Fiona,
found these reflection times sufficiently useful to continue with the practice on return to her normal life, where she described how she now would take “time out” in her bedroom to “think about things”.

Interestingly, some individuals experienced this quiet time negatively:

EM:  
*What else, the reflections, what did you think of the reflections?*
Andy:  
*I didn’t, I didn’t like them, being by myself.*

Terry:  
*Oh yeah that was alright, like the first part was alright, but then it got real boring...Like at the start it’s like yeah, but then you start to get real bored.*

Others like Ross, above, valued these times greatly. Jim expressed how the reflections were a particular highlight for him:

EM:  
*How was the Journey?*
Jim:  
*Awesome man [he seemed to brighten up when I asked about the Journey, sitting slightly higher in his chair, becoming more animated].*
EM:  
*What did you like about it?*
Jim:  
*The reflections, time to think [he speaks more quietly, more seriously].*

Hence, while the Journey appeared to provide periods of intensity with activities such as the group goal setting, the extended duration meant there was sufficient time to allow for thinking, periods of quiet where the youth could process the events that occurred for them. The value of this aspect of the Journey has also been noted in another qualitative study that looked at wilderness therapy programmes for adolescents. In this study Russell (1999) interviewed wilderness therapy participants and found that time alone was used to reflect on their lives, think about what was important, and make plans for the future.

(iii) Experiential nature

The experiential nature of the Journey was another aspect commented on by youth as providing therapeutic opportunities. The frequency of this element could also account for increased rate of therapeutic progress. However, before recounting the youths’ comments it is perhaps helpful to provide some context to the therapeutic opportunities that the youth referred to.

Before departing on one Journey, while ADC staff were getting the minibus ready for the trip, I overheard a garage attendant commenting to one of the ADC
counsellors, “I hope it goes well and you don’t have too many problems”. I found interesting the ADC counsellor’s reply, that on the contrary, the ADC clients were taken away “to have as many problems as possible”. I had imagined that all adventure programmes preferred to keep things running smoothly, and as hoped by the petrol attendant, ‘not have too many problems’. The ADC counsellor went on to explain that the behaviour that caused problems on the Journey was usually the same behaviour which resulted in the youth getting into difficulties at home or at school. Hence, this was exactly what they wanted to see emerge, as the aim of the Journey was to give the clients a chance to work on these behaviours in a safe environment and to try out new ways of dealing with problem situations.

Prior to the Journey, youth set specific goals on the new behaviours they wanted to practice on the Journey, and whilst living together and participating in Journey activities, there were many potential opportunities to work on these goals. When a client’s behaviour was observed to be inconsistent with their therapy goals, everybody stopped what they were doing and there would be a discussion about what was occurring. This process is described by Tim:

Tim:  Well it tended to help a lot just with my anger and stuff. They set up a few situations with um, like, where, there’d be conflict similar to here at school...I’d sit there and I’d argue, and some one would say “What are you doing to stop yourself doing that?” And they’d explain well that’s what’s getting you into trouble at school all that sort of thing. And then I’d think about it for a while and we’d talk about it and figure out a way I could deal with it...First five or so days, they’d be doing it and they got me with that every time they tried it...Then it stopped I just started to think about it a bit more and it was under control.

...They’d pull me up ... basically until you did it, until it was automatically in your head. Bang no they’re going to try and get me and you just didn’t bite. That’s some of the way it worked.

As described by Tim, clients are given immediate feedback on problem behaviour, and how they can try out new ways of behaving, i.e., learning through experiencing. Within the AT/WT field this is referred to as ‘experiential learning’, or ‘experiential therapy’, which Gass (1993) described as “learning by doing, combined with reflection” (p. 4). In Tim’s interpretation, the ‘experiential nature’ of the Journey provided a therapeutic opportunity for him to work on his behaviour. He clearly describes how he learned to control his anger through ‘doing it’ after having it
repeatedly pointed out to him. However, as with the goal setting, the extended period of time also appeared to be significant. It apparently took Tim ‘five or so days’ to begin to benefit from the set-up scenarios and to gain better control.

I witnessed many similar scenarios, of Journey participants being ‘caught in the act’ and being provided with concrete feedback of their behaviour. Learning and therapy opportunities were not always set up as described by Tim; sometimes the situation ‘just happened’. However, the leaders always appeared to be conscious of what the overall therapy goals were for each young person, so that when a relevant situation arose they could respond in ways that meant the young person might learn something useful from it. Group members were also encouraged to provide feedback to other group members, especially on behaviour related to individual goals announced to the group earlier that day. Journey leaders referred to these occurrences as ‘therapeutic opportunities’ or ‘real moments’ and aimed to maximise the learning that arose from them to help the youth understand their patterns of behaviour and consequences of that behaviour.

One of the ways of attending to therapeutic issues when they arose was what was called the ‘circle’. When an issue arose, a leader or any of the youth would call a ‘circle’, everyone stood facing each other in a circle, and the issue was discussed. The youth described how they found these circles ‘annoying’ because they usually interrupted activities that they were keen to participate in such as climbing or games. However, on reflection they generally accepted the need for them. Ann explained how they had ‘heaps’ of circles, and how at first they were a bit annoying, but then they were alright as it was a way for everyone to get a chance to say their thing. She felt she learnt stuff from them and it was also a fair way for people to get to say their thing. Gerry appeared to have arrived at a similar acceptance:

Gerry: I hated them! [smiling]. They were pretty boring, there was too many of them. But they were helpful, like they helped get stuff sorted out in people’s minds.

Therefore, while the learning opportunities were not always experienced as enjoyable, they were generally accepted as worthwhile.

While the circles provided therapeutic opportunities involving the whole group, sometimes learning apparently occurred on a one-to-one basis between the client and a leader. One client, Max, explained how he had learnt a strategy to help
control his anger in this way. He described a specific incident on the three-day expedition where he had become frustrated with other members of the group and how his counsellor had taken him aside and suggested in situations such as these that if he felt he couldn’t control his anger he should take some time out from the group. The leader was able to give Max immediate feedback on his behaviour, and provide a solution with which to manage the problem behaviour. Max reported how useful this had been for him, and how he now regularly used this strategy. His mother also commented that she had observed Max using this strategy, and described how life for him and the family was much better as a result.

Both Tim and Max described examples of learning new ways of behaving through being provided with a concrete example of the behaviour that was causing them problems as they were ‘experiencing’ it. This was able to happen because the youth had previously set goals around behaviour they realised they needed help with (i.e., they were committed to changing this behaviour); counsellors were aware of the young person’s goals and hence could point out the problem behaviour when it occurred. The concentrated, extended (and often stressful) experience of the Journey, also served to increase the likelihood of problem behaviours occurring.

The youth talked of other examples of experiential learning through engaging in the daily chores associated with wilderness living. The group was responsible for organising themselves to clean showers and toilets, chop firewood, prepare and cook meals and do dishes. One client described how he was not used to doing chores like this:

Andy: *I thought it was pretty like, um pretty hard.*
EM: *Explain hard to me, hard as in...*
Andy: *Like all the work you had to do on the ADC and stuff like... Yeah, [pause], like some people might not be used to that, like how you had to, the routines [chores] and that.*

Being asked to do things that they were not used to, and didn’t necessarily want to do (especially by a figure of authority), was a potential source of friction for many of the ADC clients. Fiona had been referred to the ADC programme because of her drug use but also because she reacted badly to authority figures. As her counsellor described, she “would blow up over nothing”, resulting in disciplinary action at school. When I asked Fiona what she thought she had got out of the Journey, she explained that she was now better at dealing with authority. She said that she “stopped
and thought” now, thinking about the trouble she would get into if she did ‘blow-up’. In her view it was being asked to do the chores by the Journey leaders that had helped her to learn this skill.

The comment from Fiona that ‘I stop and think now’ was one I heard many times from ADC clients, and appears to describe an improvement in self-control or emotional regulation; this was evident also in comments by Tim and Max. This provides further support for the mechanism through which AT/WT interventions are thought to be effective, identified by Newes (2001b). She found that an AT/WT programme positively affected behavioural disinhibition in participants, which she found to be associated later with a reduction in recidivism in young offenders.

In describing his experience of the Journey, Andy provided the following comment:

Andy: Yeah, it’s like, you’re talking the talk here [at the office] and then like you’re walking the walk, at the Journey.

It is interesting that Andy appears to be contrasting an active (walking) style of learning on the Journey compared to a passive (talking) style of the community-based counselling. Proponents of AT/WT interventions have often argued the experiential nature of the interventions turns the therapeutic process into an active one rather than the passive style characteristic of many talk-based therapies. It has also been argued that passive ‘talk-based’ therapy requires youth to form abstract associations between what is being discussed in the office, and their lives with peers or family members outside (Gass, 1993). In contrast AT/WT interventions provide concrete opportunities for experiential learning, where learning becomes an active process where clients learn by doing and receiving immediate feedback rather than just talking or listening. This is supported by Eisenbeis (2000) who suggested that with AT/WT concepts that would otherwise retain a highly abstract character, such as such as ‘trust’ and ‘confidence’, can be directly and immediately experienced.

The experiential nature of therapy that occurs with interventions such as the Journey has been described as a unique characteristic of AT/WT (Crisp & O'Donnell, 1998). Others have likened the experiential learning of AT/WT interventions to the ‘here-and-now’ orientation of Gestalt therapy, which encourage clients to process events ‘in the moment’ while they are occurring (Adams & Sveen, 2000; Fletcher & Hinkle, 2002; Moote & Wodarski, 1997). Comparisons are also made to the active
participant-driven emphasis of person-centred approaches (Eisenbeis, 2000). Whether unique to AT/WT approaches or not, this style of learning is held to be particularly appropriate for adolescents, who may not have fully developed the cognitive abilities to think in an abstract way (Moote & Wodarski, 1997; Russell, 1999; Marx, 1988). This ability to think abstractly is required in order to relate ‘passive’ discussions that occur in the counsellor’s office to the adolescent’s life beyond the office.

There were many examples provided by ADC clients, of learning occurring on the Journey, especially when given immediate and concrete feedback after engaging in a behaviour that was inconsistent with therapy goals. This supports the premise that AT/WT interventions such as the Journey may be effective because of the opportunities for experiential learning and therapy. What is less evident in the literature is the potential importance of youth acknowledging that they needed help (i.e., becoming committed) with the specific behaviours that were the focus of ‘therapeutic opportunities’. It appeared the ‘therapeutic opportunities’ were not always enjoyable experiences, therefore, the commitment towards change by the youth may be especially significant.

B) Group-Based Format – ‘I’m not the only one with problems’

Another commonly reported outcome attributed to the ADC programme and in particular the Journey was an improvement in social skills. This ranged from gaining better control of anger, having more confidence, and an improved ability to get along with authority figures, members of their family and peers:

Gerry: I get on with more people now.
EM: Why’s that?
Gerry: I’m nicer now, and because I’m nicer, people like me.
EM: What helped you to be nicer?
Gerry: The Journey, making new friends.

Martin: Yeah I probably get on better with friends and that, I find it easier to talk to them and stuff yeah.

It is perhaps not surprising then that another strong theme to emerge from the youth on how the Journey was helpful, related to the social interactions provided by the group-based nature of the intervention. ADC clients mentioned several positive effects related to group-based experiences. They talked of feeling supported by the group, describing being able to gain a better understanding of themselves from
feedback provided by other group members. They also talked of the increase in confidence gained from the successful experience of meeting and getting on with a group of new people.

(i) Sharing experiences

Several youth talked about being part of a group of people who they perceived as going through similar challenging experiences. This they found helpful:

Ana: ...it was helpful because people were in the same shoes as you.

Jane: ...the Journey was helpful because everyone was on the same kind of pathway, and everybody was there to help everybody.

This sense of being with others who were in the ‘same shoes as you’, on the ‘same pathway’, appeared important to many. The Journey gave multiple opportunities for group members to form this opinion, through youth talking to each other informally and also through facilitated group discussions:

Hayden: ... what we talked about up there, hearing what others were talking about, what they've been through.

Nick: ...talking in the group about problems with doing drugs and crime, that was helpful. I didn't do crime any more after that.

There were several therapeutic effects noted by the youth from being in a group with whom they could relate well. Sue, similar to Jane, talked of how she appreciated the support and encouragement provided by the group:

EM: Of the Journey, what would be the most memorable thing that sticks in your mind?
Sue: Just everyone helping you. ... It's like I've never been somewhere with so much encouragement and help. It was just like everyone was just, ... Yeah, it was really good having lots of people there even though they are practically strangers, they just help you so much, it was cool.

For others, being with people who were ‘in the same shoes’ seemed to positively affect how they felt about themselves. One client described how this aspect of the Journey had been helpful to her through:

Rachael: ...knowing that I’m not the only one with problems.
Another client, Sandra, also gained the feeling that she was not the only one with problems and, for her, being among others who were attempting to make changes, or as Jane described ‘on the same pathway’, had a motivational effect:

Sandra: The group sessions on the Journey were really helpful. You got to hear other people’s things... [and realise] I’m not the only one with problems and if they’re willing to make changes then I can too.

While the overall impression from the youth was that the group experience was positive and beneficial, over the two year period of data collecting I did hear a few accounts of experiences that were less positive. There were a couple of clients who spoke of being frustrated by younger members of their group, while another client talked of being annoyed with a group member who was perceived as being less motivated towards change than the rest of the group. This may point to the importance of selecting a group of individuals who perceive themselves as more similar than different.

In understanding why for most youth the sense of similarity, acceptance and support was therapeutic, there are several possible explanations to consider. The use of a positive group culture is the basis for therapeutic community-type interventions, which aim to develop a group culture of positive pro-social values that provide encouragement and support for other members of the group in their efforts to make positive change. It is also similar to the premise behind systems-based treatment programmes such as Multi-systemic Therapy and Multidimensional Fostercare Treatment. These programmes aim to modify behaviour by systematically manipulating the context in which the ‘problem’ behaviour occurs, including the removal of problem-maintaining factors (such as deviant peer influences) and replacing these with new and pro-social environmental reinforcers. The Journey could similarly be viewed as creating a context involving supportive peers, who relate well to each other, and are mutually encouraging of change.

An alternative explanation for the therapeutic effect of a group-based intervention is provided by Ungar and Teram (2000) who interviewed 41 adolescents in therapy during the previous 12 months. As a result of these interviews they concluded that mental health in adolescents is socially constructed, with mental well-being associated with feelings of personal and social empowerment and a sense of acceptance from others. Therefore, the sense of belonging and acceptance described
by the ADC clients may have resulted in the youth ‘reconstructing’ their own self-worth. The realisation of youth that ‘I’m not the only one with problems’ is perhaps evidence that they had re-evaluated themselves in relation to others. Meeting others with similar problems may have enabled them to re-assess their own status, and positively influenced their own self-concept.

Developmentally, an adolescent’s peers are generally considered the greatest source of influence. Hence, a group experience which provides encouragement for positive change has the potential to exert powerful influence, as the youth strive to ‘fit in’ among their peers. In this respect the group environment of wilderness therapy programmes, such as the Journey, are developmentally appropriate, resembling in its social aspects their normal life, and thereby assisting in the transfer of learning (Moore & Wodarski, 1997).

(ii) Learning from group feedback

Learning from others in the form of personal feedback was quite a powerful effect noted by ADC clients, and usually associated with the Journey’s group-based format. On the Journey there were many opportunities for individuals to receive feedback from others, such as through goal setting activity. Here youth decided, and then announced to the rest of the group, what their ‘goal for the day’ was, and the group was encouraged to give feedback to one another on how well they were progressing towards these goals. At the end of the day structured group feedback occurred, where each participant received feedback from every other member of the group, including a rating on a ten-point scale, of the extent to which they were perceived to have attained their goal of that day. For Sue it appeared the group feedback provided a form of positive reinforcement:

Sue:  *I think it is good when they do the feedback ‘cause it lets you know what you’re doing right and wrong. So, if you want to achieve something you’ve got to have praise, you’ve got to know that you’re doing it right, yeah.*

Ann also found the feedback she received from group members on her progress towards goals very useful, but she recalled the overall positive feedback from the group on the last night an especially positive experience. Receiving positive feedback appeared to boost Ann’s self-esteem; she talked about how it “felt really
good” to have received the “good compliments”. This provides further support for the Journey providing a beneficial effect through its impact on participants’ self-worth.

For other youth the feedback they received appeared to help them gain better self-understanding:

Sonia: I got to know myself better. I learnt how others saw me and that helped with my communication skills stuff.

Tina: ...the chance to look at myself, see how others see me, and get to know myself better.

There are obvious overlaps between the therapeutic effect of feedback received from the group and other aspects of the Journey discussed previously, such as the daily goal setting and experiential learning opportunities. These features appear to combine together to help ADC clients develop a better understanding of themselves. Interactions created by engaging in Journey activities appeared to provide the opportunity and ‘substance’ for feedback.

The observations made by the youth find support in the AT/WT literature. An increased self-awareness developed through group interaction while engaging in activities has been noted by researchers as one of the main goals of AT/WT programmes (Bandoroff, 1989; Williams, 2000). Newes (2001b) has written that a theoretical tenet of AT/WT programmes is the opportunity for self re-evaluation. On the Journey individuals are made aware of the effect their behaviour has on others by group members or leaders. As a result they discover ‘how others see me’. Newes (2001b) has suggested that such feedback is the first step in enabling participants to begin regulating their own behaviour. From a developmental perspective, such self-evaluation may have extra significance for adolescence who are in the process of forming personal identity.

An alternative explanation of the youths’ comments can be provided by the principles and effects of traditional group counselling/therapy models (Adams & Sveen, 2000; Fletcher & Hinkle, 2002; Williams, 2000). For example, Williams (2000) explains the therapeutic effect of group-based AT/WT by relating it to the respected work of Yalom (1995) on group psychotherapy. According to Yalom (1995) what makes a group therapeutic is when the group achieves a ‘social microcosm’. This occurs when group members conduct themselves in an unguarded, unselfconscious manner, resulting in displays of their characteristic ‘acting out’
behaviour in front of the group. Acting out inevitably interferes with the functioning of the group and, therefore, the group is expected to exert pressure for such behaviour to cease.

Williams (2000) believed this ‘social microcosm’ occurs more quickly in the wilderness setting, which provides constant pressure to interact, under often stressful situations, with real consequences, whereas in a clinical setting therapy occurs in set blocks of time and under physically non-stressful conditions. He also noted that in a wilderness setting the interference of an individual’s ‘acting out’ on the functioning of the group was more evident, where the group relies on each other to achieve specific goals, as well as for safety, comfort and even survival.

I witnessed many such examples of group members being intolerant of ‘acting out’ behaviour from other group members. The safety of an individual attempting a climb up a cliff face is compromised if his or her belayer at the other end of the rope is not paying full attention, or fails to communicate effectively. I observed a group culture develop that made such inattentive behaviour unacceptable. Similarly, a client with a goal of ‘thinking of others’ who does not share in the completion of chores, provoked negative feedback from other group members. These examples of ‘acting out’ behaviour and resulting feedback are excellent examples of the ‘therapeutic opportunities’ which the Journey is designed to deliver.

It is interesting to note that, despite observing many such interactions on the Journey, the youth spoke more of the positive support and encouragement from group members, or what they learnt about themselves, than of discomfort from negative feedback about specific interactions. What is clear, however, is this feedback appeared significant in terms of self-evaluation.

(iii) Opportunities for successful inter-personal interactions.

ADC clients talked of having more confidence in their social skills following participation on the Journey. Increased confidence in their ability to get along with others appeared to be related to the opportunities provided by the Journey for successful interactions with group members and leaders.

Ann described how she became more confident interacting with her father, and that things had improved at home now that she communicated more assertively. She attributed this to the group discussions, from learning how to “speak out to the group about goals and stuff”. This ‘speaking out’ was another challenging aspect of the
Journey noted by several youth. There was an expectation that during group activities, like the goal-setting, youth would speak in front of the group to announce goals or give feedback. The self-consciousness common in adolescents, perhaps based on fears of not fitting in with peers, meant that being asked to speak was a challenge for some. Indeed a couple of clients disclosed how uncomfortable they felt being the ‘centre of attention’ in such situations. Some however, said that the repeated opportunity to practise this skill helped them overcome this fear:

EM:  ...with the goals and that, the group would give you feedback. How was that?

Andy: I got used to it. ‘Cause like I didn’t want to express like, ‘cause like I felt nervous but, I built up where I was like capable of telling the group. I just got used to it.

This is another example of an overlap between different aspects of the Journey. In this case the duration of the Journey and the challenge created by talking in front of a group of peers combined to provide opportunity to ‘build up’ to the point where Andy felt more confident to complete this task. Increased confidence to speak publicly may also assist adolescents in their efforts to achieve independence and autonomy. If able to speak up for themselves and put their point of view across, they are able to exert influence over decisions that effect them, and hence feel more control over their environment.

For some of the youth the idea of being placed with a group of people they didn’t know, and living, eating, working and interacting with them for nine days was quite daunting. They talked of initially being apprehensive about having social encounters with a group of unfamiliar people referring to group members as ‘complete strangers’ whom they perceived as potentially ‘scary’, ‘dangerous’, or ‘weirdos’:

Martin: I didn’t really want to go. I thought all dangerous people were going to be there.

Sue describes how she nearly decided not to go for this reason:

Sue:  ... I didn’t think everyone would be so nice. A couple of days into it we were all getting on really well in there and there sort of wasn’t anyone left out. And I just thought I bet you there is going to be someone left out or yeah.
EM:  *Um, 'cause that would a bit weird I would imagine like just um going away with a whole bunch of people you didn't know.*

Sue:  *Yeah, well when I seen them pull up outside, I felt my face really heat up, oh no... I sort of thought, "Should I tell him I don't want to go?"*

Yet, as Sue and others have described, despite their initial apprehensions they felt like they actually ended up getting on well with everyone.

Bandura's social learning theory and the concept of self-efficacy (Bandura, 1977, 1997) are again useful to explain the improved social skills and confidence mentioned by the youth. This theory suggests that the increased confidence described by Andy and Ann could be the result of successful interpersonal interactions experienced by these individuals. This theory also predicts that self-efficacy can be enhanced vicariously through seeing others, similar to yourself being successful in their achievements. In this way the similarity perceived among group members, seeing other members of the group interacting successfully, may also have aided in this process.

An additional point relevant to this discussion is that for self-efficacy to be enhanced, the success must not be too easily attained. Success without challenge is not likely to produce enduring self-efficacy (Bandura, 1997). It could be, therefore, that those youth who found the social interactions to be most challenging could potentially benefit the most from the challenge of, and success in social interactions.

The following comment was provided by John when he explained what it was about his ADC experience that had had the biggest impact on him:

John:  *Getting on with others on the Journey - not something I normally do.*

I took his comment 'not something I normally do' to suggest that 'getting on with others' was difficult for John, and therefore, as possible support for the idea that greater gains can be achieved when success was perceived as not easily attained. This may explain some of the individual differences among ADC clients on these aspects of the Journey they felt had had the most impact on them. For some, like Tim and Max, the challenge appeared to be gaining self-control. Others like John, Sue, Andy and Martin, had negative expectations around their ability to get on with others. They may have potentially benefited more, therefore, from the challenge of successfully interacting with peers. Certainly, John, Sue and Martin all talked about being able to 'get on better with others' as an outcome of their Journey experience.
C) Wilderness Setting – ‘Being away’

The environment in which wilderness therapy occurs (i.e., the wilderness) clearly sets it apart from most other forms of traditional therapy or counselling. There were a couple of aspects related to the wilderness environment that the youth commented on as helpful. Several noted positive effects from ‘being away’ and removed from their usual living situation, while for a few the natural wilderness was reported as a source of inspiration and even healing.

The terms ‘up there’ or ‘in there’ or ‘being away’ were frequently used by the youth to refer to their time on the Journey. This suggested the youth experienced the setting as removed and isolated. One client described this sense of remoteness:

Keith: ...and I know you got to take precautions and shit ‘cause it’s way out there and anything could happen.

Being in an environment that was ‘away’ from home was reported by a number of clients as significant. Ann talked of how “just getting away” had been very helpful, and went on to explain how she found it was much easier on the Journey to relax and ‘talk about stuff’. In describing how the Journey had been helpful to him, David noted a similar positive effect:

David: I don’t know, it was just being away from my Mum and brothers and that, that was good.

While clients were quite clear that ‘being away’ was helpful, it was less clear how this helped them achieve therapeutic goals. An exception to this was in relation to reducing or giving-up use of alcohol and drugs, the most common reason for referral for ADC clients. Several youth talked of the Journey as “going cold turkey”, and that this enforced drug-free time was helpful in realising that they could go without:

Sonia: ...being away on Journey and off marijuana. I realised I could quit if I wanted to and I did.

Martin: Probably like, ‘cause we didn’t take drugs or nothing on the camp. And it was sort of, if you didn’t need them then, you don’t need them now, sort of like that.

EM: Would that have been the longest time you’d have gone without that?

Martin: Yeah.
Hence, the Journey had been helpful by providing the opportunity for 'being away' from drugs and alcohol for a period. A similar effect occurred for some clients in relation to smoking tobacco. Jane explained how she realised from her short time on the Journey that “cigarettes ruled my life”. Several youth described how they cut down or quit smoking cigarettes following their time on the Journey.

The Journey environment, as well as being drug free, also provided a different social setting. For many ADC clients, their normal associates encouraged drug use and other types of behaviour which created problems in their lives. Grace described how, following her participation on the ADC programme, she stopped sniffing solvents, stopped self-mutilation, gained control over an eating disorder and felt much better about herself and life in general. When I asked what she felt had assisted in her many achievements, she talked about the different social environment provided by the Journey:

Grace: I'm not sure, but on the Journey we weren't around the people we normally hang around. You're in the middle of nowhere, having fun, my mood never dropped except for missing Mum once.

In addition to ‘being away’, some ADC clients also described a positive experience they received from living and being in an outdoor natural environment. Ann described how this appeared to have a profound effect on her, she talked of changing partly as a result of:

Ann: ...just being in such a beautiful place. Through being in nature, breathing clean air, the pure water and being surrounded by the mountains.

Ann’s reaction to being in the natural environment was perhaps more extreme than many ADC clients, but, most described the experience as positive:

EM: How did you find being in the wilderness?
Gerry: Pretty cool, [looking excited again], getting away from civilisation. Being in the wilderness.

Jane: Oh I loved it... I like nature, I like trees, and waterfalls and stuff.

Terry: The walking was bad. But just going around and seeing everything was good. Like you don’t get to see that everyday here, all the trees the mountains, like I didn’t even know what a glacier was before.
David: *Um going up to that oh, snowy glacier ... yeah it was a good memory, good scenery.*

There are several possible explanations for the beneficial effect of the wilderness environment noted by the youth. Comments about it being drug-free and away from normal associates appears to provide further support for the earlier hypothesis that the Journey is therapeutic by modifying the systems of influence that are supportive of problem behaviour (Bronfenbrenner, 1979). The wilderness setting provides a new environment, removed from these sources of influence, replacing it with a context that is supportive of behaviour change. Sikking, Gidlow and Perkins (1993) used similar explanations to explain the positive effects they noted to be associated with therapeutic outdoor programmes. They suggested these interventions were effective in modifying participants’ behaviour through removing them from their at-risk sub-culture. These authors noted that while the wilderness intervention may have created the conditions for change to occur, for these changes to be maintained on returning to the youths’ normal environment, the original systems of influence (youths’ at-risk sub-culture) that supported the problem behaviour would also need to be modified. With the ADC programme, this was sought with the follow-up work with family members or school staff, or through the youth choosing a different group of peers, ideally one that was supportive of the changes made.

An alternative explanation relates to the nature of the wilderness environment itself, which has been described as having intrinsically therapeutic effects. Researchers have suggested that simply being in an outdoor natural environment can have a healing effect (Flechther & Hinkle, 2002; Davis-Berman & Berman, 1994; Roszkal, Gomes & Kanner, 1995). Davis-Berman and Berman (1994) have described the wilderness as a ‘restorative environment’. They referred to the work of Kaplan and Kaplan (1984) which suggested that the wilderness can restore people to a state in which they are able to more fully function. When people are emotionally worn out from stresses occurring in their lives, being away can act as a break or respite. This may fit with the beneficial effect of ‘just getting away’ described by Ann and David.

A third possible explanation of the therapeutic effect of the wilderness environment is that this setting provides a simplified environment, away from the many distractions that exist in the busy and complicated everyday lives of the typical adolescent (Gass, 1993; Russell, 1999). The primitive nature of life associated with
the wilderness, where food, warmth and shelter take on new importance, may assist
the youth to gain a new perspective on their lives. Life becomes simplified, enabling
them to reflect on what is important, and ways they may want their lives to be
different (Gass, 1993; Russell, 1999; McKenzie, 2000). As such the wilderness setting
provides a place and time to think, away from distractions. Beneficial effects of
‘having time to think’ was discussed earlier: it could be that the time available in the
wilderness provides a particularly conducive environment for such reflection that is
necessary for the youth to realise and decide on changes they need to make.

D) The Challenging Journey Activities

The Journey involves participation in a number of activities including goal
setting, climbing, kayaking, tramping, group discussions or circles, periods of quiet
reflection alone, a three-day expedition, group problem-solving activities, games and
daily chores. In research on AT/WT programmes, particular attention is often given to
the specific content (activities) of such programmes. Therefore, I was curious as to
which of the Journey activities the youth described as having the greatest impact on
them.

Many of the Journey activities listed above have already been referred to (e.g.,
goal-setting, reflection times, circles, walks and chores). The goal setting appeared to
have been a significant activity for many participants, while other activities received
mixed ratings, although most were generally regarded as worthwhile. Two other
activities that appeared to have had a major impact on participants were climbing and
a three-day expedition, both of which involved physically demanding and emotionally
challenging elements. Other activities, such as games and group problem-solving
activities, seemed to be enjoyed as fun experiences but clients were less able to
recognise specific learning or therapeutic benefits.

(i) Climbing and the three-day expedition

The use of adventure activities such as climbing and tramping expeditions as
agents in the therapeutic change process is another clear distinction between AT/WT
and other counselling approaches. The climbing and the three-day expedition, were
the activities recalled most vividly by clients. During the interviews, participants
typically became quite animated when they recalled their experiences:
Gerry: *The tramp, I loved the tramp and the climbing... they were tough but fun.*

Ann: *The climbing awesome, I loved it.*

The challenging nature of these activities perhaps explains why these activities were so memorable to the clients. The arduous nature of three-day tramp was summed up by Keith:

Keith: *Feeling like I was going to die on that trip eh. [Said with a smile on his face].*

On the three-day tramp the youth carry a heavy pack containing food, clothes and shelter, walk long distances each day, prepare and cook all meals, and set up camp in variable weather. This physical challenge could also become an emotional one. I witnessed clients under what appeared to be emotional strain as they endured and persevered under difficult conditions. There were also emotional challenges involved in simply getting along with other members of the group in testing circumstances. The group were encouraged to work together as a team, with mutual decision-making involving trust, co-operation, communication and problem-solving skills. They were encouraged to take responsibility for themselves and others, and to work together to safely complete tasks such as river crossings and setting up camp for the night. If problems among group members arose (like the one described by Max earlier), everything halted and a circle would be called so issues could be worked through. The youth spoke of being frustrated when circles were called, as they could be left standing about, carrying their heavy pack, perhaps in poor weather, wanting only to get on and complete the activity. Journey leaders were usually quick to remind participants that the main purpose of the Journey was in achieving therapeutic goals, not simply completing activities. It is easy to see how the achievement of ‘social microcosm’ identified by William (2000), and discussed earlier, was facilitated under these conditions of physical and emotional challenge.

Keith also described the challenge provided by the rock climbing activity:

Keith: *Well that was pretty good that climbing thing. ... Rock climbing is a bit more of a fear thing for me. It’s pretty hard to rock climb eh...That front cliff just gave me the shits ’cause like the wind was blowing. Like once you’re up there the wind was quite strong you know. It’s like, “Shit I want to get the hell down from here.”*
The climbing involved emotional challenges of overcoming fear of heights and persevering at points where the person was sure they could go no further. There were also challenges of trusting and being entrusted, as group members were responsible for each other's safety as one belayed while the other climbed (under supervision of the leaders). The cognitive challenges ranged from working out the technical details of belaying to planning the route up the cliff face. The strength and agility required to complete the task provided physical challenge, but the main challenge described by Keith appeared to be one of managing his emotions.

While it is understandable that the challenges provided by these activities made them among the more memorable experiences of the Journey, it appeared that it the successful accomplishment of these challenges also contributed to the experiences being therapeutic.

In a conversation with Fiona, she described how 'pleased' she was with herself having managed to complete a climb that she didn't think she could. The positive effect of successful accomplishments of these challenging activities on individuals' confidence and self-worth was supported by several youth:

Sue: *I thought I was going to die, but after I did them [the tramps] I was so proud of myself... yeah I was just like buzzing.*

EM: *Tell me about the climbing day?*
Terry: *At the start it was like real sort of like, just you didn't think you'd do it. Like at the start of it I didn't get very far. Then I got up the first one, and then, from then on it was real good eh, real easy and everything.*

EM: *How did you feel at end of the day?*
Terry: *Like I didn't want to go, it was that fun. But I felt like really good that you could achieve all that.*

The sense of being 'proud', 'pleased' and 'feeling good' described by Terry, Sue and Ann as a result of completing these challenging tasks once again support Bandura's theory of self-efficacy, which predicts an individual's confidence and self-esteem can be enhanced through successful accomplishments (Bandura, 1977; 1997). Indeed, it could be that the nature of these activities may be particularly effective at enhancing personal self-efficacy.

According to Bandura (1997) there are four principal sources of information that influence a person's self-efficacy beliefs: their own successes, vicarious experience through observing others succeeding, being verbally persuaded by others, and physiological arousal. The activities described above provide the opportunity for
all four sources of information. The youth can experience personal mastery over the
task, they see others succeeding, they have other group members and leaders
encouraging them to succeed, and they experience physiological arousal from the
physical/emotional challenge. This may explain why these accomplishments stood out
for many youth.

In addition to the positive effects of successful accomplishments, some youth
described more specific therapeutic learning from participating in such activities:

EM:  Has the programme had an effect on you in any way?
Gerry: It’s helped with my anger... I stop and think now.
EM:  How did the programme help you to do that?
Gerry: The tramp on the Journey, you had to work with others to do that. The
rock climbing and the belaying thing, you had to be trusting to do that.
EM:  How do you see being trusting as helping with your anger?
Gerry: If you’re trusting then you’re not angry and you’re getting on together.

Gerry attributed her positive gains in controlling her anger to a combination of
interacting with others (group effect) and the participation in the challenging and
adventurous activities. This again illustrates how the different aspects of the Journey
appear to work together to achieve positive effects.

Other clients gave examples of how they were able to use the learning
provided by their climbing experience metaphorically to make better sense of things
occurring in their daily lives. Fiona described how the day of climbing had helped her
to realise that “you can get over your fear of things by just trying it”. She described
how subsequently she had discovered that things that appeared difficult, like the
climbing, were, often easier than expected. Alan offered another helpful metaphor he
associated with the climbing activity:

   Alan:  ... that [the climbing] is about how high on the cliff face can you get,
            which is about how high can you get in life.

   Increased ability to persevere with difficult tasks, and associated benefits of
this positive attitude, were also noted by several youth in relation to the three-day
tramp. Gerry mentioned how she had learnt to ‘keep going’ and ‘stay positive’, while
others talked of learning to ‘stay with things and not give-up’, of gaining an
understanding of the concept of perseverance.
One of the rationales for AT/WT interventions is that participants can benefit from metaphorical learning that the activities provide, which according to the comments from Gerry, Fiona and Alan, does appear plausible. This was certainly the intention of the Journey leaders, who before, during and after the activities, would help clients to make connections and comparisons between what was occurring during these activities and therapeutic issues perceived as relevant to the youths’ lives at home. For example, when a client reached a point on the cliff and felt they couldn’t go any further, a leader would encourage them to stop and think and offer suggestions that would assist them to get a bit further up the cliff (which as noted by Fiona was often not as difficult as she thought it was going to be). The leaders would then get them to relate this experience to something they wanted to achieve back home, and think about what thoughts, images or feelings had helped them to achieve more than they had thought they were capable of. In this way they aimed to help the transfer of benefits and learning achieved from the activities, to assist the youth to be more successful in their every day lives at home. Comments from Gerry, Fiona and Alan provided support for the transfer of learning, although there were some clients that didn’t seem to benefit in this way:

EM: *How was the climbing?*
David: *Yeah that was good.*
EM: *Did you get anything out of that or was it just like a fun day?*
David: *Yeah, a fun day.*
EM: *You didn’t learn anything.*
David: *Na.*

There are several possible explanations in the AT/WT literature for those that experienced beneficial effects from these activities. Crisp (2003a) has suggested that AT/WT interventions serve as a useful metaphor for being able to tolerate adversity and endure seemingly unbearable situations, which he pointed out were important protective beliefs for youth with mental health concerns. Others have noted a positive effect associated with participation in AT/WT activities is the development of an ‘I can do it’ pattern of thought (Gass, 1993; Newes, 2000). It has been suggested that repeatedly overcoming the many challenges provided by AT/WT programmes results in cognitive restructuring, with automatic thoughts of ‘I can’t’ becoming ‘I can’ (Newes, 2000; Moote & Wodarski, 1997).
The comments from the youth, suggesting increases in confidence and self-esteem and the transfer of metaphorical learning provided by these activities, provide support for some of the more popular theories of how AT/WT interventions can be effective.

(ii) Group problem-solving activities and games

Over the nine days, the ADC clients regularly participated in group problem-solving activities and various games, where the group was given a task to complete or problem to solve, and was required to work together. The purpose of these activities varied. At times the leaders would use games as time-fillers to keep the group occupied and entertained. Sometimes the activities were used as ice breakers and a way to build group cohesion. Other activities had specific learning objectives such as effective communication, development of appropriate trust, leadership skills, stress management techniques or understanding the consequences of drug and alcohol abuse. Like the climbing and tramping, these activities relied on metaphors to link the learning and growth provided through the activity to situations in the youths' 'real-life'. Before listening to the youths' comments in relation to these activities, a description of one such group initiative is provided below.

The 'A&D Minefield' was a group activity that I found particularly interesting. At an intellectual level the activity appeared to have great potential. It incorporated the principles of motivational interviewing (Miller & Rollnick, 1991) and presented problems associated with using drugs and alcohol and the potential pitfalls that may be encountered when attempting to give up the use of such substances,

The activity begins with the decision balance exercise where group members discuss the pros and cons for them of using and not using drugs and alcohol. The reasons are written up on a white board. Reasons for not using substances tend to easily outweigh reasons for using. The 'good things' about using substances are written on pieces of A4 paper and rolled up and placed in rubber rings to form part of an obstacle course that takes up nearly the whole length of the room. Other obstacles include empty bottles or cans of alcohol, imitation joints or other items made to resemble particular drugs. The task is for a blindfolded individual to try to walk through the obstacle course without tripping up or knocking into any of the obstacles. Because the items are placed close together, completing the activity successfully
while blindfolded is virtually impossible, as several members of the group get to find out. The difficulty of the task is intended to represent the difficulties of giving-up the use of drugs and alcohol.

The next phase of the activity involves another member of the group being asked to complete the task blindfolded, but this time with someone guiding them through, shouting out directions, e.g., forward, left, right, stop, etc. With the person helping them, the traveller is quite likely to complete the activity or at least progress further through the course. This is intended to represent the idea that, with support of others, and accurate information, it is easier to avoid returning to use of substances.

The final phase of the activity involves another individual attempting the obstacle course but with two people giving advice: one person gives accurate, useful advice, while the other gives inaccurate advice, trying to ‘trip up’ the individual. The resulting confusion makes it even more difficult for the individual to complete the task. This is designed to illustrate how it is better to listen to people who want you to succeed, because those who don’t, or don’t care, may not give you accurate information.

There is then a group discussion around who the people to listen to about drug use are, and who should not be listened to. Clients are then asked to think about who these people might be for them back at home.

My impression observing this activity was that it was well thought-out and had potential to be very effective. It presented educational learning in an interactive and enjoyable way. I was, therefore, somewhat surprised that, during the interviews, none of the youth mentioned this particular activity (or similar ones) without being prompted. The following are some of the responses I received after asking how they had found the A&D minefield:

Sue:  *I loved that. I like that one, the cones, and like with the spoon and the knives and drugs and pills and you had to guide the person through.*

Gerry:  *That was weird, coming in and seeing all that stuff.*

Terry:  *I found that hard eh. I knocked over a bottle first thing.*

David:  *Yeah, that was cool.*

Martin:  *Oh, I thought it was quite fun.*
However, when I tried to explore if the activity had been a useful to them in terms of achieving therapeutic goals, only one client could come up with a explanation of how it was helpful:

EM:  *Was that useful?...*
Andy: *Yeah. Just to see like what kind of drugs like people are doing, and how all the drugs effect you and that.*

Most could not:

EM:  *Have you ever thought about it [A&D minefield] afterwards as far as being useful in sort of um, alcohol and drug type stuff back home?*
Sue:  *I haven’t really related back....*
Keith:  *Like I didn’t actually mind it, it was fun to do, but how was that supposed to...?*

From my adult perspective this had seemed to be a clever and potentially effective therapeutic activity, while from the youths’ perspective it appeared to be perceived more as a fun game. In terms of impacting on a client’s drug and alcohol use, it seemed that the effect of going ‘cold turkey’ whilst on the Journey had been more effective than the A&D minefield activity. This unexpected finding in relation to this type of group problem-solving initiative, which is a substantial part of many AT/WT programmes, raises some interesting questions about the aspects of an AT/WT activity that enable it to produce therapeutic outcomes. A discussion on what these aspects might be follows.

### 7.3.6 Therapeutic Activities Compared to Fun Activities

The objective of AT/WT interventions is to achieve therapeutic outcomes for participants. It is interesting to speculate from the comments provided by these youth as to the significant aspects of their experiences of AT/WT activities that resulted in therapeutic opportunities being realised.

In comparing the group problem-solving initiatives like the A&D minefield to the climbing and three-day expedition, it appears there may be several differences. The climbing and three-day expedition provided multi-dimensional (physical, emotional and cognitive) experiences that were ‘challenging’ to each individual. The A&D minefield activity on the other hand, was more of a contrived and intellectual/educational experience that is presented more as a group challenge.
Further the climbing and three-day expedition appeared to provide the opportunity for a ‘direct experience’ of ‘real-life’ therapeutic concepts such as perseverance, trust, communication, etc. ‘Feedback’ was provided via the successful accomplishment of the challenges. The A&D minefield activity experience required an abstract association of the therapeutic concept it represented. The youth did not directly experience the therapeutic concept (i.e., how to overcome the difficulties associated with giving up or reducing the use of drugs and alcohol) and hence feedback could not be provided on successful accomplishment of this therapeutic goal.

To expand this discussion to other therapeutic experiences referred to by the research participants, some common themes begin to emerge. Tim and Max described clear examples of therapeutic outcomes (gaining controlling over anger) as a result of the experiential nature of the Journey. The therapeutic opportunities they described were associated with the direct experience of a behaviour that they were motivated to change, combined with feedback from others on their progress, and for Tim in particular he noted this change in behaviour was not easy, but was personally challenging:

Tim:  *It’s annoying and bloody hard. Just like, the way that it is helpful is frustrating. Because it is what I have to deal with here [at school] which gets me angry, but they pull you up on it.*

The goal-setting was another activity youth associated with therapeutic outcomes. This activity also involved the direct experience of behaviour individuals were presumably committed to change (as the daily goals were chosen by the youth). In setting goals the youth were encouraged to choose ones that were not easily attained, and they were provided with feedback from group members on their level of achievement.

The interactions among group members was another activity commonly referred to as beneficial by youth, either through the experience of getting along well with others or the confidence gained through standing up in front of others and speaking out. It was noted that for several youth these interactions were personally challenging, but also involved direct experience, and feedback was provided based on the responses received following the interactions. All these examples of therapeutic opportunities appeared to involve ‘real life’ issues that mirrored the challenges the
youth faced in their everyday lives (e.g., perseverance in difficult situations, controlling anger, interacting with peers and figures of authority).

The reoccurring themes noted above (direct experience of real life issues, personally meaningful, individual challenge and feedback) perhaps point to the aspects that combine together to achieve therapeutic outcomes. Returning to the A&D minefield, reducing use of substances was a personally meaningful goal for many of the youth (according to individual treatment goals set by the youth at the start of the programme, see Table 13). It appeared, however, that the activity wasn’t able to provide a real-life, direct experience of a personally meaningful issue, but was more of an abstract experience. Understanding what it might be like if the participants tried to give-up or reduce their use of substances was based on discussion, not direct experience, and as such any feedback provided was also of an abstract nature. It could also have been that the group nature of the exercise limited the personal meaningfulness of the activity.

In considering what makes an experience ‘personally meaningful’, it may be relevant to reflect back on section 7.1. It was noted that the conditions of referral often resulted in youth typically arriving for counselling ambivalent towards change. Yet the youth recognised the importance of shifting to a point where they were ready and committed to making changes, which was associated with the realisation of the need for change. What is unique about the ADC treatment model compared to other AT/WT interventions is the way it combines two to three months of community-based counselling either side of the AT/WT intervention. Therefore, in the weeks/months leading up to the Journey there is opportunity and sufficient time for this shift in readiness to occur in the adolescent clients. The intention is that, by the time the youth participate on the Journey, they are already committed to making changes. It seems likely that therapeutic opportunities supplied by the Journey activities are more personally meaningful when clients are in this state of readiness. Others have noted the importance of readiness for change as a variable to consider in the selection of adolescent clients for these types of interventions (Pearce & Boyes, 2002; Sikking, et al., 1993). This was also supported in this study by comments from Tim, who recognised that the behaviour that was being pointed out to him was the same behaviour causing him problems at school, and one he realised he needed to change. It is also supported by comments from several ADC clients who, when asked who they
felt the programme would be most helpful to, suggested ‘it depends on the person, it will help if they want it to’.

It appears the ability of activities to achieve therapeutic outcomes may vary. However, before activities such as the A&D minefield are dismissed as being ineffective in this regard, it is important to consider an outcome that did result from their participation, that of an enjoyable fun, experience. The positive experience provided by such activities may be significant to promoting an overall therapeutic effect by the Journey.

The ‘fun’ aspect of the Journey was a very strong theme that emerged from the youth and appeared to have contributed to the Journey being experienced and remembered positively:

Sue:  *Coming up here [Journey] is the most fun thing I've ever done. It's going to be sad leaving tomorrow.*

In describing the value of the Journey and why youth would recommend the ADC programmes to other young people, youth appeared to give almost equal importance to both the ‘usefulness’ and ‘fun’ aspects:

Alice:  *It's good for you making changes and that, but you have fun, too.*

Tim:  *No, well it was everything, it was fun, it was hard, it was challenging, it was a good time... it was good, it helped a lot. It was worth it.*

That the Journey was found by the youth to be helpful, but also fun, appeared to be one way they distinguished (positively) the ADC programme from other counselling experiences. Certainly, earlier on Sarah had compared the Journey to a residential drug and alcohol rehabilitation programme, but differentiated it because it was ‘fun’.

A fun therapy experience may be important for two reasons. First, fun, enjoyment, and pleasure are emotional experiences that may assist youth to feel relaxed and comfortable and, therefore, more willing to discuss personal issues (Newes, 2000). Second, in New Zealand and internationally there is concern over low rates of help-seeking behaviour among youth with mental health concerns. Therefore, providing a therapy option that adolescents can experience as ‘fun’, ‘cool’ or ‘exciting’, may prove important in making a counselling programme appealing to
youth. There was evidence of some youth signing up for this ADC programme specifically because of the Journey component.

Understanding the characteristics of AT/WT activities that are associated with therapeutic outcomes is clearly an area where more research is needed. The youths' comments have raised some interesting issues for both AT/WT researchers and practitioners to consider. It should be noted, that this research compared just two types of activities, a group problem-solving initiative with the climbing/walking expedition; there are other types of activities that are commonly used by adventure therapists, such as ropes courses, that obviously require consideration.

7.3.7 Transfer and Maintenance of Journey Outcomes

The many outcomes reported by the youth, which included improved social interactions, enhanced self-regulation of emotional and behavioural responses, and the development of better problem-solving skills including the ability to persevere with difficult tasks, support many other studies which show that AT/WT programmes are effective in changing behaviour (Casey & Gillis, 1994; Gass, 1993; Hans, 2000; Hattie et al., 1997; Newes, 2000; Russell, 1999). However, a common criticism of AT/WT interventions is that the effects produced are not maintained in clients when they return to their everyday living environment (Bandoroff, 1989; Eggleston, 1996, 1997; Sikking et al., 1993). I noted with interest that, amongst the group of youth I interviewed, many described how the new skills developed on the Journey had in fact been transferred back to their home life.

Interviews occurred between three and six months following their Journey experience. When the youth reflected back on what they felt they had achieved from their Journey experience, they often used examples of outcomes that had transferred into their daily lives, to describe what the outcomes had been. For example, Martin described how he had learned to communicate more effectively on the Journey, and he illustrated this by referring to improved communication with his youth aid officer (and me):

Martin: I had to go court, I can't remember, it wasn't long after [the Journey],... and um, when I first met the cop, when I'd done something wrong, I would sort of not look at him and talk, but then [after the Journey], ... I'd look up and see... yeah 'cause I changed a wee bit. 'Cause I learnt how to talk to them. See how I'm talking to you..[Martin was making eye contact with me and talking openly].
Others described similar improvements in communication as a result of the Journey that they now experienced in their interactions with friends and members of their family:

EM:  *What do you think you learnt from the Journey?*

Sue:  *Heaps, um, the thing that it mainly affected, I suppose, was like my attitude. It’s like, ‘cause when [my ADC counsellor], every time, sort of, at the Journey, he’d mention to me, like about Dad and that, and it really sort of made me think, that I am quite horrible to him. So I changed my attitude in that way, and um, yeah and getting along with people and that,... it was definitely the Journey.*

Support for the transfer of skills was also provided by parents, who frequently commented on changes in behaviour observed following the Journey such as:

Jenny (Parent):
*He talks a lot more, before the Journey he was very closed off. He communicates more now and is more responsive.*

In addition to the transfer of improved social skills, other transferred skills reported by participants included the skill of setting goals, which had resulted in one client ‘getting control over my life’. The continued use of reflection times to help process stressful events, and the ability to ‘stop and think’ had also resulted in a continued improvement in self-control and anger management, particularly at school. As a result of ‘going cold turkey, on the Journey, there was also evidence of continued reduction or abstinence from alcohol and drugs on their return.

These comments from participants and parents are supported by the quantitative data that indicated significant improvements in overall mental health were not only maintained six months following the programme but in many cases had improved further, albeit with some relapse in alcohol and drug use and with individual treatment goals.

It is interesting to consider why the Journey may have been successful in helping the ADC clients to transfer and maintain their therapeutic learning in their everyday lives, when other AT/WT programmes have apparently been less successful. As mentioned previously, the ADC programme is different from many AT/WT programmes because of the community-based counselling that occurs either side of the Journey. The primary intention of the continuation of community-based counselling following the Journey is to help transfer and cement changes achieved on
the Journey. Within a week of returning counsellors aim to have a family session to discuss outcomes achieved and how parents/caregivers might support the changes made by the youth. One parent commented to me how this had been helpful, that she would remind her son about his achievements from the Journey if things seemed to be ‘slipping’. The youth themselves didn’t specifically mention whether the follow-up sessions with their counsellors had helped transfer Journey outcomes, but there were several clients who indicated that more follow-up sessions would be good. There were also several clients who indicated why such support might be needed:

Terry: *In a way, when you come back from the camps or Journeys or whatever. Yeah you change, but nothing else does. Like you get back from the Journey and your thinking [and] everything has changed. But then you realise it’s only you that has changed when you get back...Like at school I knew nothing had changed.*

Sadly, reactions from school teachers appeared to be an area where the youth felt their changes were least supported. This perhaps provides an argument for multi-systemic approaches that target a range of systems of influence on the client such as schools, peers and parents.

It could be that the transfer of Journey outcomes had been assisted through the use of metaphors by the leaders on the Journey, who encourage youth to relate the activities to events and issues present in their home life. One client commented that ‘everything I did up there, helped me to make sense of stuff back here’, suggesting at least some had transferred learning from activities. However, the youth’s reports in relation the A&D minefield activity suggested the use of metaphors alone could not account for the transfer.

Reflecting back on the youth’s comments, another aspect of the Journey experience that appeared to assist in their outcomes being long lasting was the prolonged exposure to this therapeutic environment. Several youth mentioned how changes occurred following the repeated exposure to therapeutic opportunities, and as a result they ‘adjusted’, ‘adapted’ and ‘got it under control’. As Tim described it, until it got to be “automatically in your head”. This suggests that prolonged exposure to ‘active’ therapy may be an important factor in achieving lasting change.

A final aspect that may impact on the maintenance of outcomes achieved could be the level of challenge posed by the activities and events on the Journey. One of the strongest themes that emerged from the youth in describing how they had
benefited from their Journey experience was the level of effort required. Tim described the experience as the 'hardest thing I've ever done'. This was a common sentiment: two thirds of the participants interviewed used the word 'hard' or 'challenging' to sum up their overall Journey experience. The remaining third described at least one element of the Journey as hard or challenging.

EM: *If you were going to give me a couple of words to describe what it [the Journey] was like what would they be?*
Andy: *Um, [pause] hard. Um, it was like you had to put in a lot of effort.*

Martin: *It was quite hard. Like there was a couple of times I just wanted to go home and that.*

Many comments from the youth referred to the aspects of the Journey that were experienced as 'hard', involving emotional, physical and cognitive challenges. Keith commented that he thought he was 'going to die' on the three-day expedition. As noted previously in relation to the improvement in social skills Bandura's social learning theory suggests, activities with the greatest challenge may also have the greatest potential to achieve lasting benefits. This theory predicts that for self-efficacy to be enhanced, the success must not be too easily attained: success without challenge is not likely to produce enduring self-efficacy (Bandura, 1997). It did appear that the activities and events described as challenging were associated with therapeutic changes, while those activities that were described as merely fun were not.

7.3.8 Summary

In relation to the content of the community-based counselling, only individual comments, rather than strong themes, emerged from the youth in relation to its value. This perhaps reflects the individualised nature of the treatment they received in this part the programme. However, several strong themes emerged from the youth in relation to how the Journey had assisted them in achieving therapeutic goals. Based on the youths' comments it was suggested that there are several ingredients to the Journey which, when combined together, achieve lasting therapeutic changes. These included the group-based format, a wilderness setting, an extended period of time, and participation in challenging activities that provide direct experiences of 'real' issues. The combination of these aspects appears to provide a unique and powerful experience of therapy.
There are several strengths to this approach which seem particularly suited to adolescents. The positive influence of peers provided by the group-based format, together with the active participation in ‘therapeutic opportunities’ for those who have not developed the ability to think abstractly, are developmentally appropriate. Further, the different elements of the Journey have the potential to meet the varied individual needs of each client, be they emotional or behavioural control, improved interpersonal skills or cognitive restructuring. The duration of the Journey, combined with the intentional focus on therapeutic issues, appears to produce outcomes similar to an intensive residential treatment, but in a way that is perceived by the youth as ‘fun’, ‘cool’, and worthwhile. Therefore, given concerns about low help-seeking behaviour amongst adolescents with mental health concerns, and the stigma attached to more traditional approaches to counselling which can be a barrier to participation (Dunnachie-McNatty, 2000), this approach may provide a valuable alternative to existing adolescent counselling and treatment programmes.

In the review of literature it was noted that AT/WT interventions are not well understood as a counselling approach compared to other more traditional approaches to counselling/psychotherapy. In listening to the youths’ perspectives and constructions of their Journey experience, it has been possible to gain an increased understanding of this approach. Their comments have helped to understand the aspects of AT/WT experiences that may be important in achieving and maintaining therapeutic goals.
7.4 Theoretical Explanations – ‘Making Sense’

The previous three sections have presented significant therapeutic change factors identified by the youth, which have included factors related to themselves, their counsellor and the Journey component of the programme. This final section investigates the extent to which ADC’s theoretical approach to counselling relates to, and can explain comments made by the youth. Reaching an understanding of what the theoretical underpinnings of the programme are was not a straightforward task. However, according to definitions developed by Hollanders and McLeod (1990), the ADC programme was considered to be a broad-based eclectic intervention based on a postmodern conceptualisation. The contribution of this postmodern perspective in the therapeutic change process is examined, and the need to understand this worldview in order to ‘make sense’ of comments and observations collected over the course of this research is discussed.

7.4.1 Theoretical Counselling Approaches of the ADC Programme

In section 2.3 of the literature review it became evident that some researchers believe that understanding and adhering to a theoretical approach is vitally important in the development and delivery of effective adolescent mental health treatment programmes (Kazdin, 2004; Weersing & Weisz, 2002). Of particular importance was using theory to identify causal mechanisms in order to produce therapeutic changes (Weersing & Weisz, 2002). However, other researchers have argued that in terms of treatment success, there is no basis for one counselling approach claiming to be more effective than an other (Lambert & Ogles, 2004; Wampold et al., 1997). Rather, a set of ‘common factors’ apply to all (or most) therapies and are responsible for therapeutic benefits (e.g., development of therapeutic alliance, opportunity for catharsis, acquisition and practice of new behaviours, and clients’ positive expectancies) and are the best predictors of success (Lambert & Ogles, 2004; Wampold, 2001). This section of the thesis reviews the theoretical underpinnings of the ADC programme. These theoretical principles are then compared to the therapeutic process factors identified by the youth. In so doing, the role theory may play in the outcomes achieved through participation on the ADC programme is examined.

The theoretical underpinnings of adolescent treatment programmes, especially those identified as empirically-supported treatments which have received significant
research attention, are relatively easy to describe. For example, the parent training and problem-solving skills training programmes developed to treat children and adolescents with disruptive behaviour disorders are typically behavioural or cognitive-behavioural while adolescent treatments for phobias such as imaginal and in vivo desensitisation and modelling would be described as purely behavioural. However, positing the theoretical underpinnings of the ADC programme was less straightforward. What follows is my assessment of the ADC theoretical approach based on what I observed, what the counsellors told me, and what was written in the ADC training manual.

ADC training manual

As a starting point to understanding the approaches and theoretical basis of the ADC programme, I consulted the 45-page ADC training manual (ADC, 2003). This manual was developed by the director of the programme with the assistance of other counsellors using relevant texts and research articles. It combines procedural information with descriptions of recommended counselling approaches. It has been revised four times since it was first put together, to reflect changes in the programmes procedures and emphases as the programme has evolved. Its primary purpose appears to be presenting the foundational aspects of the programme to new ADC counsellors. Newly recruited counsellors typically attend a two day workshop where the manual is used as a training resource over the two days. Over time, these foundational aspects of the programme are likely to be built on as the counsellors’ own experience and ways of working are privileged. The manual also serves as a description of the programme for funders. In this respect it forms part of the contract of services to be provided by the ADC programme staff. It is also the only complete description of ‘the programme’ available for interested parties such as myself. What follows is a summation of key aspects and basic content of the manual.

On the first page, an introductory paragraph described five approaches to counselling that are used in the programme:

Adventure Development Counselling draws on narrative, brief, brief systemic, multisystemic and motivational approaches to therapy. The focus of therapy is on assisting the individual to make positive and lasting change in their lives, congruent with their personal goals. (ADC, 2003, p. 2)
Directly below this paragraph is an acknowledgement that “different strategies will work with different clients at different stages” (ADC, 2003, p. 2).

To allow for an individualised approach whilst still retaining consistency in delivery of the programme, four underlying principles were then proposed. The manual reported that all strategies used by ADC counsellors should be based on these principles: (a) an empathetic relationship and development of trust; (b) highlighting of discrepancies in current behaviour and long-term goals, leading to the client arguing for change; (c) supporting self-efficacy and personal responsibility in the client and realising that the therapist can assist clients, but that the client is responsible for change; and (d) assisting the client to recognise that they have a choice of meanings to ascribe to an experience. These four principles in fact reflect a variety of theoretical approaches to counselling, including humanistic, cognitive-behavioural and postmodern approaches.

The first section in the training manual then describes the different “stages” of therapy (initial, early, middle and final stages) that should be anticipated, and the different strategies that may be useful during these stages. These stages of therapy are based largely on the stages of change (precontemplation, contemplation, determination, action, relapse and maintenance) described by the Transtheoretical model (Prochaska et al., 1982, 1992). Recommended strategies for the different stages appear to be drawn from both motivational interviewing approaches (Miller & Rollnick, 1991) and narrative therapy (Monk, Winslade, Crockety & Epston, 1997). Other sections in the manual include a discussion of selection issues, presentation of assessment procedures, and an overview of the principles of individual therapy and sessions with others (for example, school staff, referral agents and, in particular, family members or caregivers). Recommended strategies in sessions with others appeared to be based on narrative and brief approaches to therapy (Monk et al., 1997; de Shazer, 1985). Narrative and brief approaches to therapy whilst being integrated into other sections of the manual, also have dedicated sections of their own, as does the role of the Journey which is discussed at length. These are followed by shorter sections on developmental helping strategies, goal setting and the use of genograms for detailing family structure (ADC, 2003).

The manual presents the programme as multifaceted, with several standard elements such as assessment and information-recording procedures, development of individual treatment goals, family or caregiver involvement, participation on the
Journey and the writing of the client’s story. However, there is also provision for flexibility to enable the programme to be tailored to the individual needs of clients and their families. The content reflects an emphasis on postmodern approaches to counselling, but this is presented alongside and integrated together with other theoretical approaches.

Observations

In comparing the content of the training manual to data gathered through my observations of counselling sessions and conducting interviews with counsellors, it appeared that the approaches used largely conformed to those laid out in the training manual. During my observations, the counselling techniques most frequently used (or at least those I was able to identify) were drawn from narrative therapy, solution-focused brief therapy and motivational interviewing, and during the Journey, wilderness therapy. This reflected the approaches and content emphasised in the manual. There were a few minor discrepancies between observed practice and what appeared in the manual. Verbal reports by ADC counsellors indicated great importance was placed on family therapy. However, a discussion of family therapy only appeared in the training manual under ‘sessions with others’. This was presented as a standard element of the programme, to be adhered to “unless there are strong reasons to do otherwise”, which appeared consistent with the importance expressed by verbally by counsellors. The manual appeared to describe narrative and brief approaches to family therapy, while counsellors tended to refer to family therapy as a multisystemic approach, working with a clients’ wider systems of influence. Counsellors also reported being influenced by ‘Just Therapy’ (Waldergrave & Tamasese, 1993) and using CBT strategies such as problem solving skills and “helpful versus unhelpful thinking”, which were not specifically described in the training manual.

While the manual presented a fairly standard programme format which appeared to be adhered to in general, the individualised nature of the programme that was briefly referred to on page one of the manual came across strongly during observations. Content and approaches used across counselling sessions and with different clients appeared to vary greatly. This may have been partly a reflection of differences among the counsellors (e.g., level of experience, individual effectiveness, preferred style of counselling), but appeared largely to be in response to the varying
needs of the clients. As noted previously, there was large variability in the characteristics of clients referred to the programme, such as demographic characteristics (e.g., age range, gender, ethnicity), presenting issues (e.g., type, number and severity) and personal circumstances (e.g., living situation and educational status). While most clients had significant problems with substance misuse, a client with emotional difficulties living at home with two supportive parents was likely to have different needs to a youth who was engaging in criminal activities and currently in foster care.

The apparent need for an individualised treatment approach provides further support for the differences noted in section 5.4, between ‘real-world’ programmes like ADC which operate in a clinical practice setting, and the university-based treatment programmes which typically attempt to control for client variability factors. University-based programmes are typically developed on the basis of a particular theoretical perspective, for one particular problem area, with the corresponding treatment detailed in a training manual that is strictly adhered to. Hence, as noted in the introduction of this section, it is easier to describe the theoretical underpinnings of this type of programme. In contrast ‘real-world’ programmes (which are normally not bound by strict research-driven requirements) have to meet the needs of the wide variety of clients referred to them. As a result they are likely to have variability in content and approaches and are thus more difficult to describe in terms of a particular theoretical approach.

Despite the ADC programme having what appeared to be a relatively standardised format, the individualised approach to client need, together with differences in practise among counsellors, and its multi-component nature made it difficult to assess the relative contribution of theoretical approaches incorporated into its approach.

ADC director/counsellor perspective

Interviews with the director (the original developer of the ADC programme) supported the complexity of the task in hand. He agreed that putting recognised names to the theories and philosophies behind the programme was not straightforward. When I questioned him on the theoretical underpinnings of the programme, he described how the programme had started out from personal values and beliefs in relation to how people change and their social development, which had been based on years of
experience of working with young people. However, he noted that subsequently they became aware of theories that appeared to fit with their thinking (e.g., narrative therapy, motivational interviewing, multisystemic therapy and Bandura’s work on self-efficacy). He suggested that the “narrative stuff is probably where it started” and later clarified that:

**Cslr:** ...the biggest influence across the programme is a postmodern conceptualisation, coming from the understanding that everybody has different conceptions about the world.

Further discussions with the director and other ADC counsellors confirmed that this post-modern conceptualisation (i.e., reality is constructed) was the dominant philosophy behind most of the approaches used. This conclusion was supported by comments from many of the ADC counsellors that modernist approaches (i.e., that there is an objective reality) focusing on formal diagnosis and speculation about underlying causes were not considered helpful when working with adolescents with mental health concerns. This group ethos was also evident in the resistance encountered in the early stages of the research to my suggestion that standardised DSM-IV based psychometric instruments (e.g., diagnosis of substance use disorders) might form part of the methodology.

The emphasis on a postmodern perspective, and particularly the idea that multiple views on a presenting problem can exist, was illustrated by one counsellor who described that the focus of the first session was:

**Cslr:** ... typically finding out ‘who says you are a problem’ and working out ways to change this belief.

This reconstruction of the clients’ reality (a post-modern conceptualisation) appeared to be viewed as the essential ingredient in the therapeutic change process, ‘changing the clients belief that they are the problem’. However, the programme could not be described as based exclusively on a postmodern conceptualisation. Strategies and approaches from a modernist worldview were described in the training manual and incorporated into the programme (motivational interviewing, multisystemic approaches, problem-solving skills). In this respect the ADC programme is perhaps best described as a “broad-band eclectic” programme based on a postmodern conceptualisation. This is based on a definition of eclecticism developed
by Hollanders and McLeod (1999) (reviewed in section 2.3), i.e., a programme with a preferred metatheory (e.g., postmodern conceptualisation) but which is prepared to cross metatheoretical boundaries and make use of concepts and methods from other counselling metatheories (e.g., humanistic and cognitive-behavioural) wherever these seem useful.

7.4.2 ADC Postmodern Metatheoretical Conceptualisation

Having reached an understanding of the theoretical underpinnings of the ADC programme, the aim of this section is to investigate the extent to which this postmodern perspective can help explain the therapeutic change factors identified by the youth. However, prior to this it is necessary to briefly review what is meant by postmodern approach to counselling.

Postmodernism has been described as an intellectual movement that arose from the questioning, then rejection, of the fundamental assumptions of modernism, the intellectual movement that preceded it and now exists alongside it (Burr, 1995). At the core of postmodern thinking is the understanding that belief systems and apparent ‘realities’ are socially constructed, rather than ‘given’. As a result, different meanings can be constructed in relation to the same phenomenon (i.e., multiple ‘realities’). Key influences to meanings are culture, time and circumstance (Neimeyer, 1993). This involves acknowledging that there are no ‘right’ or ‘wrong’ ways, just different ways of seeing the world. The power relations with those who define what is right or wrong are then up for ‘deconstruction’ (McAuliffe & Eriksen, 1999).

These assumptions are present in ADC and other postmodern approaches to counselling. Reality is seen less as something ‘out there’, and more as socially constructed and, therefore, something that can be changed. As an illustration, consider the reasons most adolescents are referred to ADC, because of ‘substance use problems’. When viewed from a social constructionist perspective, the concept of a substance abuse problem may hold different meanings within different sections of society. To most adults, including parents, counsellors and programmes funders, a youth with a ‘substance use problem’ is probably using substances in a manner that is harmful; professionals might also expect that the person meets the DSM-IV criteria for a substance use disorder (either abuse or dependency). Adolescents so labelled would be regarded as in need of treatment, and would, therefore, deserve access to programmes such as ADC, which is in fact funded for precisely this purpose.
However, if ADC clients who meet the DSM-IV criteria for a substance use disorder are asked whether they have a 'substance use problem', the typical answer (although not always) is "no". From their perspective, their use of alcohol and cannabis is likely to be viewed as a 'solution', not a 'problem'. It is felt to assist them to fit in with peers, to reduce inhibitions and fears, and assist in creating highly enjoyable experiences. A more likely understanding of a 'substance use problem' is not being able to get hold of sufficient supplies! In other words, the same behaviour, when viewed by adults as a substance use problem, is not necessarily seen as a 'problem' to the youth. Neither meaning can be regarded as entirely 'objective' or 'true', rather each has been socially constructed.

A postmodern approach to counselling, therefore, aims to help the youth consider alternative meanings of what a 'substance use problem' might be, but without dismissing their original meaning. Many alternative meanings may be constructed and, if a meaning is constructed where the substance use behaviour is then viewed as a 'problem', it may be that there arises an acceptance of the need to change this behaviour.

The postmodern process of therapeutic change, therefore, becomes one of widening the range of meanings attributable to an experience, managing the development of more helpful meanings in relation to the difficulty the client is presenting with, and assisting the client to live with this new meaning. In this respect, the client is necessarily positioned as the 'expert' on the meanings they have developed on their lives (e.g., what a 'substance use problem' is), with the counsellor seeking understanding of these meanings from the clients before alternatives can be introduced. There is no point in trying to tell a youth to change his/her behaviour, if he/she doesn't see it as a problem. According to Monk et al. (1997), this contrasts with therapy based on a modernist worldview, where the counsellor tends to be viewed as the 'expert' who has privileged access to the 'truth'. The role of the modernist counsellor is to look for commonalities among people: to predict, interpret, classify and deploy ideas that are considered tried and true. Therapeutic change from a modernist perspective is often associated with the correction of faulty cognitions that do not correspond with 'reality' and are thus generating emotional stress (Neimeyer, 1993).
What follows is a discussion of some of the ways a postmodern conceptualisation has been incorporated into the ADC programme, and which appear to relate to significant aspects of therapeutic change identified by the youth.

**Relationship Aspects.**

The ADC clients offered several meanings of what a good client-counsellor relationship looked like to them in section 7.2. These included a relationship where they felt ‘listened to and respected’, where they perceived their counsellor as someone who was ‘there for them’ and ‘non-judgemental’. A postmodern approach to counselling can be used to explain these meanings of a good relationship developed by the youth.

**Client as expert ‘listened to and respected’**

The positioning of the client as ‘expert’ in postmodern approaches to counselling means they are encouraged to describe their meanings about life. The counsellor listens carefully in order to understand how the client is currently making sense of their life before exploring alternative, possibly more helpful, meanings available to the client. In doing so, counsellors tend to interact in just the way the youth prefer, i.e., being listened to and accorded a respectful attitude. Such an approach ensures avoidance of the relationship the youth clearly did not like where a counsellor was perceived as ‘pushy’ and who tried to tell them what was best for them, what they should do, and how they should behave.

**Egalitarian relationship - ‘there for me’**

In postmodern counselling, while the client is positioned as an expert, the counsellor is also seen as contributing their own expertise through managing conversations and creating a climate of intentional change. In this respect the counsellor positions him/herself as an equal partner, co-author, or collaborator with the client. This ‘partnership’ may explain the comments of some of the ADC clients of their perceptions of the counsellor being an ally, someone who was ‘there for me’. This egalitarian relationship style may also have contributed to youth feeling as though they could relate to and trust their counsellor. One way in which clients reported being able to gain sufficient trust in their counsellor and feel comfortable with self-disclosure was through hearing their counsellors’ own disclosures. This
sharing of experiences is arguably more acceptable in a postmodern egalitarian relationship. Monk et al. (1997) described how, in narrative therapy, a counsellor’s own experiences are viewed as resources available to be shared with their client. This sharing is thought to be strengthening for the client, knowing that other human beings including counsellors have had similar struggles. Certainly, in a relationship characterised by equal power a counsellor would treat with respect any questions directed at them by clients, which may assist the client in getting to know and developing trust in their counsellor.

Multiple realities – ‘not judged’

Postmodern thinking holds that there is no objective truth ‘out there’ to be discovered, rather, that there are multiple ways of making sense of life. From this perspective, no set of beliefs can be regarded as more ‘right’ than another, just different. This concept may account for several youths having commented how they perceived that their counsellor ‘did not judge me’ or ‘look down on me’. As discussed earlier, a client who said they did not have a substance use problem would not be told they were wrong. Instead, postmodern counsellors would be respectful of different positions taken by their clients, and not judge whether what a client is saying is correct, but, rather, attempt to widen the range of meanings attributable to an experience, and assist the youth to recognise they have a choice over which meaning they ascribe to it.

Motivational Aspects

The associations between postmodern approaches and motivational aspects identified by the youth are perhaps less clear than relationship aspects. It could be argued that many of the postmodern approaches to counselling assume a certain level of motivation, requiring clients to arrive wanting to find a solution to a presenting problem, and therefore, willing to consider alternative ways of perceiving their situation. However, as noted earlier (7.1 Client Factors) this is not necessarily the case with adolescent clients, many of whom were referred because others thought it best for them.
Motivating conversations

ADC clients described their motivation as a changeable state. This is also consistent with a postmodern perspective: meanings attributable to an experience can be changed and, therefore, motivation towards an experience or event is also changeable. As such it would not make sense to label a client unmotivated or resistant. Postmodern approaches to counselling endorse certain types of conversation (e.g., empowering narratives, a focus on competences, skills and client qualities) as those more likely to motivate and support clients towards change (Palmer, 2000). This study also noted that certain conversations appeared to influence a client’s motivation. It was found that the evaluation of pros and cons of the youths’ current behaviour, based on the principles of motivational interviewing, could indeed result in a shift in readiness to make changes. This recognition of the need for change was influenced in part by information and feedback provided by the counsellor. It is possible that the positive client-counsellor relationship fostered by the postmodern approaches described above result in youth being more receptive to listening to their counsellor’s feedback, which in turn contributed to increased motivation to make changes.

A preferred story as a motivator

The individual goal setting activities may also have impacted on the clients’ motivational state. Client-driven goal setting is an integral part of postmodern approaches to counselling. Encouraging clients to select their goals is consistent with the client being the expert on their lives and knowing what will work for them. These goals are then seen to play an important role in the construction of an alternative preferred story. The goals set by ADC clients were ‘personally’ meaningful to the client, not ones that the counsellor or others thought would be best for them. If these goals are presented as an alternative story, which is then viewed by the youth as preferable to their current story, (i.e., ‘what would be best for me’), then this could explain a shift towards readiness to make changes.

It appears that, for at least one client, this may have been the case. Sue explained she had been referred to the programme because her father and school guidance counsellor thought it was best for her. When I asked Sue whether she herself had a clear idea at the start what she wanted to achieve from the programme, she replied:

Sue:  No not really. I didn’t really know until we set the goals.
Therapeutic Change Process

To examine the extent to which postmodern approaches may have assisted clients in the therapeutic change process, it is perhaps helpful to re-consider the reasons these clients were first referred to the programme. Reasons for referral are recorded in clients’ individual files and are typically expressed using modernist terminology (i.e., DSM-IV diagnosis), so as to be consistent with the programme’s funding criteria. Of the eight clients who completed the programme and were formally interviewed, seven met the criteria for a DSM-IV substance use disorder, two had recently attempted suicide, three had symptoms of depression, three had been classified as ADHD, most were engaging in disruptive behaviour (including physical assaults [3], fire lighting [1], running away [1] and criminal behaviour which included stealing cars and robbery [4]), four were victims of sexual abuse, two were in foster care, and all were having educational difficulties at school or were no longer attending a regular high school.

The presenting problems were, therefore, serious and complex. Hence, coming from what was originally a modernist worldview, I had anticipated that the individual solutions reported would be similarly complex: perhaps that their counsellor had helped them to gain a better insight into the causes of their problem behaviour, had provided strategies and support systems to help control/overcome or cope with problem, and possibly helped to resolve complicated family issues.

When I asked the youth what they had achieved over the course of the programme, in contrast to the reasons for referral recorded in their files, the outcomes reported appeared to be quite simple and straightforward. Typical reports included, “I stop and think now”, “I can control my anger”, “I’m staying out of trouble”, “I get on with people”, “I’ve cut down/stopped my use of drugs and alcohol”, “I’m back at school”, “I’ve stopped doing crime”. There was also a simplicity to the clients’ explanations of how they achieved their outcomes: ‘It was me’, ‘I just decided’ or ‘I worked it out’. I didn’t hear any comments that suggested that achieving the reported outcomes had been emotionally demanding or involved great effort.

These apparently straightforward reports of outcomes, and explanations of how they were achieved puzzled me. They didn’t appear to correspond to the severe difficulties recorded in clients’ files which resulted in the referral. One explanation for the discrepancies between reasons for referral and reported outcome was that the
youth hadn’t in fact achieved what I had thought they needed to, they hadn’t changed and were simply putting a positive spin on their therapy experience. Yet the significance in real-terms of the outcomes reported by the youth was supported by parents’, referral agents’, and counsellors’ observations, as well as the quantitative data (YSR/CBCL) that indicated statistically and clinically significant outcomes that were found (as discussed in part II of the thesis).

An alternative explanation may be provided by a postmodern conceptualisation. O’Connell (2000) applied the social constructionist theory of knowledge to solution-focused therapy. He noted that, rather than trying to find a solution that fits the problem, the aim of a postmodern/solution focused counsellor is “to find a solution which fits the client” (O’Connell, 2000, p. 305). This view suggests that a complicated problem doesn’t require a complicated solution, and a longstanding problem doesn’t require a lengthy process to be solved. The changes made are the ones the client wants to make, rather than the ‘causes’ of the problem. This supports the explanations of change provided by the youth such as ‘It was me’. It also confirms clients reports that they felt like their counsellor was offering suggestions rather than telling them what to do, that they chose new meaning in relation to their presenting problem. ‘I worked it out’ demonstrates an expected outcome of a postmodern approach.

A strength-based focus is also central to many postmodern approaches to counselling, and I was interested in whether this may have made the process of therapeutic change easier for ADC clients. Postmodern counselling approaches aim to deconstruct clients’ stories or narratives that are unhelpful and limiting, and reconstuct more enabling stories. In this respect, an emphasis on client strengths and competencies becomes an integral part of the construction of a more helpful dominant story or solution (Monk, et al., 1997; O’Connell, 2000). Counsellors aim to strengthen examples of past successes or exceptions (de Shazer, 1985) that are consistent with the new story or solution.

During my observations of the clients as they proceeded through an ADC programme, a focus on clients’ strengths, competencies and qualities was clearly in evidence. This was obvious during both the community-based counselling and the Journey. One counsellor described this focus as ‘optimistic counselling’:
Cslr: ...from their perspective they are saying this glass is half empty. They're saying 'I've lost half of it'. While you're saying, 'you've got half of it you know, wow, most people don't start with that much. You are on a winner here, let's go for it'.

From my observations counsellors appeared to use every opportunity to highlight a client's strengths and competences, often providing evidence to the client of them being 'smart', 'quick', 'brave', 'strong minded', 'open and honest', 'great sense of humour', and 'a survivor':

Cslr: When you're ready you'll make the changes you need to. I don't know what it is about you, but I believe that you will. You're a survivor, you're brave and have a lot of courage.

In the above excerpt the counsellor also creates expectancy of change, as well as outlining the client's competences that may assist in the change process. Youths' stories of failure were frequently reframed by counsellors in a positive light:

Cslr: Now the big question, so how did School C go?
Vicki: I didn't pass [looking down, appearing ashamed or cross with herself]
Cslr: What was the highest mark you got?
Vicki: 45 in English.
Cslr: Well if you got 45 without working just think what you could have got if you worked, you must be pretty smart [Vicki smiles and starts to laugh].

The Journey provided opportunities not only to talk about strengths, but also to experience success and competence. These successes were witnessed by group members who were invited to provide feedback. Monk et al. (1997) argue that the participation of an 'audience' can help strengthen the new story. In section 7.3, there were numerous examples of clients succeeding in interpersonal interactions and in emotional and physical challenges. In explaining to me how the programme had been helpful Sam summarised this as one of the most helpful aspects of the programme:

Sam: Achieving stuff on the Journey that you would never otherwise achieve.

Helping clients to realise their strengths (qualities already a part of the client) and encouraging adoption of more helpful meanings in relation to their problems, arguably results in a process of 're-discovering' who they are, rather than requiring them to change their personality. It struck me that this 'process of change' may seem
easier and more straightforward to a young person than the more common modernist 'problem-focused approach'. The latter identifies and diagnoses client problems in light of possible causes (e.g., family dysfunction, personality disorder, genetic predisposition) as a means of resolving the current problem. In this approach there is a risk of inadvertently cementing those negative aspects of a clients' life which the counsellor is trying to resolve (Monk et al., 1997). These concepts may provide another explanation of the apparently simple solutions and straightforward outcomes reported by the ADC clients.

7.4.3 Complementary ADC Counselling Approaches

The above discussion of a postmodern conceptualisation describes the overriding philosophy behind the ADC programme. It is easy to see how it is applied through constructionist counselling approaches such as narrative therapy, brief therapy and solution-focused therapy. Whilst this philosophy underpins the ADC programme, there are occasions where other theoretical approaches are incorporated into the programme. These include the use of motivational interviewing strategies, multi-systemic approaches, and cognitive-behavioural strategies. There are also occasions where collaboration occurs with other helping professionals (e.g., psychiatrists, psychiatric emergency services) who operate within a modernist framework. These approaches and procedures appear mostly to be integrated into the postmodern framework, although sometimes they represent more of a departure from postmodernist conceptualisation. This section will explore the extent to which other counselling approaches may account for comments made by ADC clients.

The Journey is a good example of a programme component integrating postmodern and modernist approaches. The Journey, like the broader ADC programme itself, is underpinned by a postmodern theoretical perspective. It is presented to the youth as an opportunity to 'try out' their alternative preferred stories and corresponding ways of behaving and thinking, which can be witnessed publicly by the rest of the group. This 'trying out of different ways of behaving' was supported by Andrews's comment that on the Journey he got the chance to 'walk the walk' (see section 7.3.5). The Journey provides opportunities for individual experiences and social interaction through which the youth can extend and strengthen their current ways of thinking and behaving. The positive effect of these interactions could be
explained in terms of the postmodern approach, but could equally be explained by the principles of group therapy (modernist).

The goal setting and challenging activities on the Journey provided multiple opportunities for mastery and success. The value of the goal setting on the Journey was another strong theme identified by the youth. While consistent with the postmodern strength-based focus, these successful experiences can also be seen to increase confidence and the likelihood of future successes, as indicated by cognitive and behavioural theories of human change (Bandura 1977, 1997).

The action-orientated learning provided by the Journey with the provision of immediate and concrete feedback of ‘problem behaviour’, was noted by the youth as being particularly helpful. It has been argued this style of learning is more appropriate for adolescents who may not have fully developed their abstract thinking abilities, (a modernist perspective). In this respect the Journey may cater better for all developmental levels, compared to (typically office-based) postmodern linguist forms of therapy. It appears the Journey is an integration of counselling approaches that are presented to the youth as an opportunity for self-discovery.

Motivational interviewing as an approach to counselling is also heavily incorporated into the ADC programme. The motivational interviewing manual describes the approach as a directive form of person-centred (i.e., humanistic) counselling (Miller & Rollnick, 1991). However, the director of the ADC programme suggested that it also can be considered postmodern when one:

\[\text{Csllr: } \ldots \text{considers the idea that motivation isn't fixed, that through dialogue motivation can either increase or decrease.}\]

The value of motivational interviewing as a counselling approach has been discussed at length (7.1 Client Factors). It appeared particularly useful in helping clients to recognise a need to make changes, based on a re-assessment of what is best for them (e.g., decision balance, information and feedback, and increasing client understanding). The language used by the counsellor tends to be grounded in postmodern approaches, i.e., conversations around alternative stories and the goals they would like to work on. The recognition, and then addressing, of an adolescent clients’ initial ambivalence (identified as an important aspect in the therapeutic change process) is consistent with the theoretical principles inherent in motivational interviewing. It appears this approach is compatible and complimentary to a
postmodern approach. Attending to an adolescent's motivation towards counselling is an important aspect of treatment considering the high drop-out rate typically found in adolescent counselling (Pelkonen et al., 2000; Robbins et al., 2003). Therefore, motivational interviewing may play a key role within ADC, building a commitment to change in the client, which in turn may increase the effectiveness of other approaches such as narrative and wilderness therapy.

Multisystemic approaches to therapy also appear to be incorporated within the ADC programme. Multisystemic therapy (MST) is in fact a specific programme rather than a broad approach. However, increasing popularity and research evidence of its effectiveness has encouraged it being viewed as an approach. MST is based on the social-ecological theory of behaviour change (Bronfenbrenner, 1979), combined with findings from empirical research on the correlates and causes of problems (Huey et al., 2000) and would, therefore, perhaps be best described as a modernist approach. Within the MST framework a structural reality is seen to exist, one which requires assessment of the difficulties the youth is experiencing in terms of the various systems that the youth operates within (e.g., school, legal, economic and family systems, as well as biological, cognitive and emotional). Within a modernist perspective, problems are not seen as socially constructed, and therefore 'fixing' a specific problem is very much part of the overall goal of treatment (e.g., providing access to education, good nutrition, increasing financial resources available to a family, medication, etc.).

The relevance of MST approaches based on ADC clients comments was difficult to assess. Family therapy is an important aspect of MST, as the family is regarded as a potentially powerful influence over an adolescent. Within the ADC programme, family therapy is similarly seen as important because of its potential to influence the youth. However, when conducting family therapy, ADC counsellors typically adopt postmodern counselling approaches. Hence, this may be another example how different theoretical approaches can be integrated into a postmodern framework.

While the ADC counsellors felt that family therapy and involvement was essential, the youth did not articulate that their experiences of family therapy were particularly significant. On the other hand, it was interesting to note that nearly half of ADC clients choose an individual treatment goal (i.e., alternative stories) that entailed improved relations with family members, suggesting family-related outcomes were
important to the youth. Similarly, while not commented on by youth during interviews, school-related individual treatment goals were also very common. The content of these goals perhaps supports the value of targeting wider systems of influence, including the family and school, consistent with a MST approach.

A final example of what appears to be more of a departure from postmodern metatheory are the occasions when ADC counsellors make the judgement that it is ‘in the best interest of their client’ to seek help from other helping professionals. This may include referral for a psychiatric assessment if there were concerns that the client was displaying psychotic symptoms. ADC counsellors would also enlist the help of psychiatric emergency services if a client signalled intent to self-harm, or had made a recent attempt. If a client appeared severely and chemically dependent on drugs or alcohol, the ADC counsellor may also refer the client for a residential detoxification before continuing with the ADC counselling at a later date. On these occasions the ADC counsellor worked collaboratively with other services, or referred the young person on, but usually with the expectation of continuing to work with the young person at a later date.

7.4.4 Developmental Considerations

While a postmodern conceptualisation has been suggested as the overriding philosophy behind the programme, another reoccurring theme requires mention, the developmental perspective. Throughout the previous three sections (7.1 to 7.3), the developmental appropriateness of the programme frequently emerges in interpreting the youths’ comments on their ADC experience. Many comments made by the youth appeared to have specific relevance to adolescence. These included their initial ambivalence towards change as a result of being referred by others (as opposed to self-referral typical in adults); their desire to be listened to rather than being told what to do (related to a developmental need for autonomy, which if not met, could impact on the therapeutic relationship with their counsellor), and the importance of peers and action-orientated learning on the Journey. These all appeared related to developmental characteristics and tasks of adolescence.

It has been recognised that a major weakness within the adolescent psychotherapy/counselling field is a neglect of developmental considerations when developing treatment programmes for adolescents. The majority of adolescent treatment programmes that have been researched, particularly those promoted as
empirically supported treatments (ESTs) tended to be either ‘downward adaptations’ of treatments developed for adults, or ‘upward’ adaptations of programmes developed for children. Only a handful had been developed specifically for adolescents. This research provided many examples of how the developmental needs specific to adolescents appear likely to impact on the effectiveness of counselling programmes, providing further evidence for the need for the adolescent psychotherapy/counselling field to take a developmental approach to treatment.

Overall, the counselling approaches incorporated within the ADC programme appeared appropriate for adolescents. Motivational interviewing has been developed to work with clients who are initially ambivalent towards change, something characteristic of adolescents (DiGiuseppe et al., 1996; Tobler, 1991). Wilderness therapy provides an action-orientated approach that provides concrete examples of behaviour, easily understood by those who predominant thinking style is concrete (Moote & Wodarski, 1997; Russell, 1999; Marx, 1988). The Journey also provides interactions with a group of peers, which is particularly relevant to adolescents. Ungar and Teram (2000) have argued that postmodern approaches (the core theoretical perspective of ADC) are particularly appropriate for high risk adolescents. A postmodern approach positions the adolescent client as the expert in their lives, and requires that the counsellor listen carefully to what they have to say and place importance on what is heard. Such a style is consistent with developmental needs for autonomy and individuation. Further, the construction of a new, preferred story coincides with the adolescent task of personal identity formation. Each of these different approaches, therefore, appears to offer a developmentally appropriate, yet unique contribution to the formation of therapeutic relationships, enhancing motivation and the therapeutic change process.

7.4.5 Concluding Comments on the Role of Theory

Researcher perspective

As this qualitative enquiry concludes, I can reflect back on the ‘post-positivist’ researcher who embarked on this qualitative enquiry, and note how theory has played an important role in enabling me to ‘make sense’ of the youths’ comments. Of particular importance was the postmodern conceptualisation that underpins the ADC experience, in allowing me to make sense of the youths’ views on those factors which had been helpful to them. There are several examples throughout the data collection
and analysis where my post-positivist view of the world was challenged. Perhaps one of the more salient examples was when I asked a youth how he had managed to stop his criminal behaviour (see section 7.1.5). His reply was similar to what others had given me: ‘Because I worked out that crime wasn’t worth it’. Having actually sat in on the session where his counsellor had encouraged him to consider the consequences of crime, my reaction at the time was, ‘no, you didn’t work it out, it was your counsellor who made you realise this’.

From my initial post-positivist perspective, together with very limited knowledge of counselling theories, I understood counselling as something that was ‘done to’ clients. Indeed, my goal was to research what the counsellors ‘did’ to the client, and in so doing understand the best way to help adolescents with mental health concerns. In the above instance my reaction was to conclude that this client was not telling the truth, but was claiming credit for having worked out that crime wasn’t worth it. Given that I had directly observed the counsellor exerting influence over the client, that was exactly the kind of thing that I was interested in researching.

It was only through reading and beginning to understand what a postmodern approach to counselling involved that I was able to start making sense of comments like this. I realised the goal of the counsellor was to assist the client in understanding the choice they have over the meanings attributable to an experience, but that these meanings must come from within (i.e., be constructed by the client, not imposed by the counsellor). Therefore, the postmodern style adopted by ADC counsellors appeared to have been successful, in that it had at least helped this client to construct and take responsibility for a more adaptive meaning relative to crime. Conversations managed by his counsellor had helped him to work out, ‘that crime wasn’t worth it’. Taking a postmodern perspective had also enabled me to ‘work it out’.

Opening myself up to an alternative worldview, understanding the postmodern conceptualisation behind the ADC programme, had been essential for me as a researcher to ‘make sense’ of the qualitative data collected.

Client perspective

The role of theory in explaining the therapeutic change process, however, is less clear-cut. The different theories of counselling inherent to the ADC programme were useful in explaining many of the youths’ comments on what they had found helpful. This provided support for the effectiveness of, in particular, a postmodern
approach to counselling with adolescents and considerations of the unique developmental characteristics of adolescents. This apparent association between theory and the significant factors in the therapeutic change process identified by the youth, therefore, points to an important role of theory in explaining therapeutic change. This is consistent with those who argue that understanding the theoretical mechanisms that result in therapeutic change is key to developing effective treatment programmes (Kazdin, 2004; Weersing & Weisz, 2002).

Throughout the discussion of the qualitative data, however, it became evident that theoretical perspectives other than postmodern could be applied equally well in explaining the effectiveness of the programme. For example, the positive effects that were noted from positioning the client as ‘expert’ could also be related to a humanistic approach to counselling; the positive benefits from the social interaction on the Journey would be predicted by the principles of group therapy, while setting and achieving personally meaningful goals is common to many theoretical counselling approaches. In fact, things identified by the youth as important, ‘attending to motivation’, ‘appropriate client-counsellor relationship’, and ‘the value of an intensive, action-orientated, group-based intervention’, could be explained in terms of ‘non-specific’ programme factors or ‘common factors’ just as easily as by reference to a postmodern theory of counselling. Therefore, while postmodern approaches appear to result in a counselling style that is appropriate and effective with adolescents, it can not be concluded that this is the only approach capable of explaining such effects.

It could also be argued that the effectiveness of the programme had as much to do with the inbuilt flexibility that enables a variety of counselling approaches to be used as its adherence to one theoretical approach. The review of literature on the effectiveness of adolescent counselling programmes (2.2 Treatment Effectiveness) revealed different types of treatments were more effective with different presenting problems (internalising, externalising and substance use disorders). Therefore, a range of approaches may be required to meet the widely varying needs of ADC clients and their families. Certainly the differing accounts given by each of the research participants on what they had found most helpful (see section 7.3.1) support an individualised, multifaceted approach.

There is a danger that fitting theories to youth reports, whilst an interesting academic exercise, may result in losing sight of the main purpose of the qualitative enquiry. While the understanding of theoretical mechanisms that can explain
therapeutic change is a valuable goal of research, the purpose of this enquiry was not to test existing theories, but to increase understanding from the adolescent client’s perspective, on what had assisted them in making positive life changes. Therefore, rather than evaluating which theory best fit the youths’ comments, what is needed is to focus on the actual thoughts and comments offered by the youth.

7.4.6 Summary

Based on what was observed, what the counsellors told me, and what was set out in the ADC training manual, my assessment was that the ADC programme could be considered a broad-based eclectic intervention based on a postmodern conceptualisation. Support was found for the effectiveness of this programme format and approach when counselling adolescents. Understanding these theoretical approaches was also critical in enabling the researcher to make sense of comments made by the youth. However, it was concluded that rather than a programme’s strict adherence to any one theoretical approach, what is important is the commitment to listen to clients, and give priority to the needs and preferences expressed by these youth.

In summary, when listening to the perspectives offered by the ADC participants, different phases in the therapeutic change process were evident. The importance of attending to their readiness to make changes, and the factors that facilitated a developmentally appropriate client-counsellor relationship appeared important precursors to change. However, once the decision to change had been made, approaches such as wilderness therapy that are intensive, enjoyable, action-orientated and group-based, appear particularly helpful. The therapeutic change factors identified as significant by the youth were in fact addressed and provided for in the therapeutic experiences they received whilst participating on an ADC programme.
PART IV:
SUMMARY OF FINDINGS,
IMPLIEDATIONS, RECOMMENDATIONS
AND CONCLUSION
CHAPTER EIGHT: 
SUMMARY OF FINDINGS, IMPLICATIONS AND CONCLUSION

In brief, this research sought to evaluate an established New Zealand adolescent counselling programme, and to contribute to the understanding of factors associated with successful treatment outcomes. To address these research objectives, data were collected using quantitative and qualitative methods over a two year period from adolescent participants, their caregivers, and the staff of three programmes in separate South Island geographical regions.

Standardised quantitative data assessing mental health and other individual and contextual variables were collected from 89 clients who were accepted onto an ADC programme between July 1999 and December 2000. For the 54 adolescents who completed the programme, the measures were collected three times: immediately prior to, immediately after, and then again six months after the end of the programme. In addition, detailed qualitative information was collected from a group of 14 clients as they progressed through an entire ADC programme. This involved regular observations of their counselling experiences, and in-depth interviews following their participation. Where possible, quantitative and qualitative data were also collected from the clients’ parents, their counsellor and referral agents.

This final chapter summarises the major findings that emerged from this extensive collection of data and discusses the implications and recommendations arising from these findings, for both assisting adolescents with mental health concerns, and for ongoing research into effective adolescent mental health treatments.

8.1 Summary of Findings

<table>
<thead>
<tr>
<th>Research Question One</th>
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<tr>
<td>Do ADC adolescent clients demonstrate significant improvement in their mental health?</td>
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9 Table 3 in Chapter 4 lists the measures of mental health selected as treatment outcome variables. Improvement in mental health was defined as reductions in the frequency and severity of mental health disorders and problem behaviours (including drug and alcohol use), as well as improved functioning in other psychological and social domains.
Overall this research found statistically and clinically significant improvements on multiple measures of mental health gathered from multiple informants. These gains were largely maintained when reassessed six months after completion of the programme. Therefore, it seems reasonable to conclude that ADC clients achieved significant and stable improvements in their mental health following participation on an ADC programme.

**Evaluation of Specific Treatment Outcomes**

In terms of the primary measures of treatment outcome, both the youths’ (YSR) and parents’ (CBCL) reports of behavioural functioning revealed statistically and clinically significant improvements following completion of the programme. This was evident on the following indicators:

- Total problem behaviour.
- Internalising behaviour.
- Externalising behaviour.

Improvements were in fact not only maintained at the six-month follow-up point but also, on half these measures, there had been continued improvement at the six-months point to a statistically significant degree. This improvement was true for both males and females, and across different ethnic groups. Effect sizes calculated on the measures indicated that participants on ADC programme achieved gains in treatment outcome comparable to, or greater than, those of many well-established and empirically supported treatments.

Other measures of mental health also indicated statistically significant post-programme improvements, including:

i. youth reports of perceived academic performance;
ii. attainment of individual treatment goals;
iii. reduced consumption of substances;
iv. counsellors’ assessment of presence of DSM-IV substance use disorders;
v. counsellors’ ratings of global functioning.

There was also evidence of significant improvements in family functioning following the programme, according to both youth and parent reports. At six-months follow-up, most of these improvements remained significantly improved compared to pre-programme levels, family functioning, and on youths’ reports of *current use* of
drugs and alcohol. A summary of these results were presented in Table 19 (section 5.2).

**Research Question Two**

Is it possible to identify characteristics of clients, contextual factors or treatment variables that are significantly associated with completion of treatment and greater levels of therapeutic change?

Two aspects of successful treatment outcome were adopted: programme completion, and level of improvement in mental health. Several client factors (including severity of problem behaviour and number of previous interventions) and contextual factors (parent/caregiver involvement, community support) were found to be significantly associated with successful treatment outcome.

**Prediction of Programme Completion**

Two predictor variables significantly distinguished between programme completers and early terminators:

- Clients most likely to complete the programme had relatively lower / less serious levels of target behaviour (CBCL), as reported by *parents*.
- Clients who completed had participated in fewer previous interventions.

**Prediction of Greater Levels of Therapeutic Change**

Amongst those who completed the programme, predictors of more positive treatment outcome (improvements in YSR total problem behaviour) immediately following completion were:

- Youth who reported a higher number of problem behaviours (in contrast to the result above based on parent report).
- Having a parent willing and available to complete a CBCL.

Gains in treatment outcome at six-months following completion were significantly associated with:

- Higher levels of pre-programme total problem behaviour, as above.
- Having fewer concurrent community agencies and services involved with the client during the programme.
Although the results of the discriminant function analysis and the multiple regression were statistically significant, the practical significance of the predictor variables was limited. Furthermore, all models left a fairly large proportion of variance unaccounted for (51-82%), with the greatest variance by any one predictor (youth reports of pre-programme problem severity) reaching only 24 percent. It was concluded that the features of clients which might predict better outcomes from the programme remained largely unidentified.

**Research Question Three**

What treatment methods or other factors do participants perceive to be most helpful in assisting them to make changes in their lives?

From the comments offered by youth who had participated in the programme, several themes emerged that appeared to assist in the achievement of therapeutic change. These spanned personal, counsellor and programmatic factors. In the early phases of counselling the importance of personal motivation and a readiness to make changes appeared critical, as was a developmentally appropriate and acceptable client-counsellor relationship. However, once the youth were committed to making changes in their lives, programmatic elements such as wilderness therapy, given its action-orientated, intensive, challenging, enjoyable and group-based nature, were perceived as particularly helpful.

**Client Factors in the Therapeutic Change Process**

In recognising their own role in the therapeutic change process, the youth talked of the importance of realising the need for changes and becoming committed to making those changes. Based on comments from the youth, it was noted that:

- The majority of adolescent clients approached counselling initially with ambivalence towards change, this ambivalence seemingly associated with referrals originating in a third party’s judgement of their ‘need’ for help, rather than the adolescent’s.
- Their level of motivation towards making changes was, however, not a stable ‘trait’, but rather a changeable ‘state’ which was able to be influenced.
• Many came to accept the need for change through a re-evaluation of what ‘was best for them’. A decision to change was facilitated by weighing up the consequences of their behaviour, receiving feedback and information from significant others, including their counsellor, and forming a clearer understanding of themselves and what they wanted.

• These clients’ recognition of their role, and ownership of their achievements, validated the ADC programme philosophy of encouraging the client to be responsible for changes.

The Perceived Role of the Counsellor

The contribution of the ADC counsellor in the therapeutic change process was noted by the youth. Getting to know their counsellor was perceived as an important first step in the development of a therapeutic relationship. Several preferred counsellor characteristics emerged as assisting the youth to engage with their counsellor and to achieve therapeutic outcomes. These included a counsellor who was:

• Trustworthy (someone who would keep disclosures confidential, was prepared to talk about themselves, and was honest and ‘straight-up’).

• Treated them ‘right’ (respectful in a friendly way; as an ally; listened to them rather than telling them what they should do; used their language; was ‘fun’).

• Was experienced in general life experiences, as well as in counselling skills.

The youth were keen to talk about, and had strong opinions on, what makes a good counsellor. Their perspectives may provide worthwhile information for counsellors, especially on how to engage more effectively with their adolescent clients.

Beneficial Programme Factors

While no dominant themes emerged from research participants in relation to the content of community-based counselling sessions, individual clients did talk of the significance of certain elements. The variability of these reports seemed to reflect the varying needs of ADC clients and the individualised treatment package they received.
The following content covered in counselling sessions were mentioned by individuals as helpful:

- Increased understanding of grief processes.
- Greater awareness of potential negative consequences of continued use of drugs and alcohol, and also of engaging in criminal activities.
- Learning effective interpersonal strategies with authority figures and peers.
- Assistance with educational and career development.

The research participants were, however, almost unanimous in perceiving the 'Journey' component of the ADC programme as positive and beneficial. Some youth felt that a greater rate of therapeutic progress was made possible on the Journey compared to in community-based counselling. Several valuable aspects of the Journey were identified based on comments from the youth. These aspects included:

- The prolonged and concentrated nature of the nine day experience (daily goal-setting, time to reflect, increased opportunities for experiential therapeutic opportunities).
- The group-based format (sharing experiences, receiving feedback from others, opportunities for successful personal interactions).
- The wilderness setting (restorative effect of being in nature, 'getting away from it all').
- The individual Journey activities that provided multi-dimensional challenges.

Activities that provided personal challenge, the direct experience of 'real life' issues that the youth were committed to change, and where feedback was received, were associated with therapeutic outcomes. Group problem-solving activities that relied on abstract association of therapeutic issues seemed less effective. Pre-Journey work assisted clients in recognising the need to make changes, as a means to maximise the benefit of the therapeutic opportunities as they arose on the Journey. Counselling following the Journey may have assisted in the maintenance and transfer of Journey outcomes into the clients' everyday lives.

The Role of Theory in Counselling

Based on descriptions provided by counsellors, and on the training documentation, the ADC programme was considered to be a broad-based eclectic programme based on a post-modern theoretical conceptualisation. Support was found
for the effectiveness and developmental appropriateness of ADCs postmodern theoretical approach, as were other programme approaches such as motivational interviewing and wilderness therapy, when applied from within this theoretical framework. It was argued that a strength-based emphasis within post-modern counselling approaches may facilitate the process of therapeutic change for clients. Understanding the programme's theoretical framework was found to be essential in enabling the researcher to 'make sense' of the qualitative data. However, it was concluded that rather than a strict adherence to a single theoretical approach, what seemed to be more important was the commitment to active listening to clients, respecting and responding to their preferences and wishes and allowing sufficient flexibility in delivery of the programme so as to tailor the programme to the clients' unique and varied needs.

8.2 Implications and Recommendations

A number of potential implications emerge from the results summarised above, both for the providers of ADC programmes as well as others seeking to work more effectively with adolescents with mental health concerns.

Fundamentally, the outcome evaluation data (relating to Research Question One) provide evidence that the overall approach was reasonably effective. They suggest to others working with similar adolescents that aspects of the ADC model of counselling may be worth considering for incorporation within other services.

The quantitative analysis of successful treatment outcome (Research Question Two) identified client characteristics associated with poorer outcomes. ADC counsellors might, therefore, conclude that greater attention, through selection and the targeting of treatment, is warranted with clients displaying these identified characteristics.

The qualitative enquiry (Research Question Three) provided additional useful information on critical aspects of ADC clients' treatment experience, including their perspectives on how to increase treatment effectiveness. The process variables identified as contributing to successful treatment outcomes will be of interest to researchers and other programme providers searching for effective ways of counselling adolescents with mental health concerns.
Other implications and recommendations with relevance to those working with adolescent mental health concerns, and for those researching this particular group, are presented below.

8.2.1 Implications for Mental Health Work with Adolescents

NZ Adolescent Counselling Context

The ADC programme is an established New Zealand mental health service targeting adolescents whose problems constitute priority areas for mental health services. Such priorities were formulated within the National Mental Health Strategy, which requires that mental health services (including alcohol and drug services) are delivered to the three percent of 0-19 year olds most severely affected with mental illness (Mental Health Commission, 1998).

The ADC the programme was found to achieve significant and stable improvements in the mental health of its clients, and therefore, obviously has positive implications in relation to this country's Mental Health Strategy. In an environment of relatively scarce financial resources, funds should be directed toward programmes with demonstrated success. While the outcomes reported here are favourable for the ADC programme, it is essential that all mental health services currently being offered in New Zealand should also be subjected to similar evaluations.

The Need for Individualised, Multifaceted and Flexible Treatment Programmes.

The current sample of adolescent clients was characterised by a spectrum of multiple and severe mental health problems, usually accompanied by unstable living situations and inconsistent family or caregiver support. According to research overseas (Audit Commission-UK, 1999) and here in New Zealand (Horwood & Fergusson, 1998), these characteristics are common to adolescents referred for mental health treatment.

Clearly then, treatments need to be sufficiently broad in scope to address the full range of presenting problems, be of variable length and intensity to cater for differences in the level of severity of each client's problems, and be sufficiently flexible in the delivery of the programmatic components (such as family therapy) to adapt to unstable family and living situations of clients. These requirements were met by the ADC programme, through its individualised, multifaceted and flexible approach to treatment, which undoubtedly contributed to its success.
It is of concern that these identified treatment needs do not appear to match the conditions of delivery of the empirically supported treatments (EST) which have become the main focus of international research. These EST programmes have been developed for clients with single disorders, and tested on those of lower severity. They tend to be delivered in a rigidly standardised format in terms of number and content of sessions, and often with the requirement that consistent family support is available throughout. Hence, while some of the EST programmes may have multiple components (i.e. multifaceted), generally they could not be described as either ‘flexible’ or ‘individualised.’ This raises questions over the ability of these treatments, if more broadly implemented, to meet the needs of the average youth and their families in need of mental health services, such as those clients referred to the ADC programme.

Conditions of Referral and an Adolescent Clients’ Readiness to Change

The qualitative enquiry revealed that many of the ADC clients came to the programme because adults (rather than the youth themselves) thought the programme was in the youth’s best interest. As a result many arrived for treatment with ambivalent feelings about personal change. Indeed, this characteristic of ambivalence is common to adolescents referred for treatment (DiGiuseppe et al., 1996; Shirk & Russell, 1998). Consequently, treatments for this group must pay special attention to adolescents’ ‘stage of readiness’ to make changes. Counsellors need initially to focus on strategies to assist the adolescent to recognise the need for change before any attempt is made to introduce treatment strategies directed at change itself. Results from this study suggest that, for some, this engagement phase, of building commitment to making changes, can take several weeks, and there needs, therefore, to be sufficient time to allow for this work.

Motivational Interviewing approaches (Miller & Rollnick, 1991) used by ADC counsellors appeared particularly well-suited to address the initial ambivalence of clients. The ADC counsellors appeared to have developed an effective approach that demonstrated respect for the wishes of the adolescent clients, but nevertheless was able to influence, encourage and adapt to changes in client motivation.

As an illustration, many ADC clients were referred because others judged them to have a substance abuse ‘problem’. Typically the clients themselves regarded their substance use as non-problematic, and as a result were not particularly inclined
to commit themselves either to ceasing or even reducing their use of alcohol or drugs. As a means of engaging with the youth, an ADC counsellor might instead suggest that a more acceptable goal to the youth be ‘to become more educated about the safe use of such substances’. This approach creates opportunity to then apply motivational interviewing strategies, such as encouraging the weighing up of positive and negative consequences of substance abuse. As a result of such considerations the young person’s readiness to change their level of consumption may be positively influenced. By approaching the issue in this manner, counsellors respect clients’ wishes and goals, but also create the opportunity for the clients to re-consider and change their goals.

This way of working with adolescents has potential implications for securing programme funding. Client treatment goals, in the initial phases of treatment particularly, will not always be consistent with funding criteria (i.e., they may be educative rather than therapeutic change goals). Programme funders may need to be informed of the rationale for counsellors working in this seemingly indirect fashion.

The Value of Questioning, Listening and Responding to Youth.

This research revealed that, when asked, adolescent clients tended to voice strong opinions about the types of counselling experiences they preferred, and those they did not. Preferences expressed by ADC adolescent clients appeared in many ways to be quite reasonable: to be listened to, to have discussions kept confidential, to be treated respectfully and honestly, and to have confidence that the counsellor was sufficiently experienced and able. Surprising, and alarming, was the frequency with which research participants commented that other counselling experiences had fallen short of these expectations. Many disclosed having prematurely terminated previous counselling arrangements, while some had held generally negative views about helping professionals.

Such negative expectations are potentially destructive of counselling engagement. Hence, a simple but important implication arising from this research is the importance of exploring the perspectives and preferences of the adolescent clients, and then acting to reassure them and build their confidence about the process.
Balancing Adolescent Preferences and Needs with Acceptable Counselling Practice.

Whilst it may be necessary for a counsellor to listen to adolescent preferences and adapt their style so as to be acceptable to their clients, they obviously must also balance this goal with ethical and professional counselling standards (New Zealand Association of Counsellors, 2004). Some of what ADC clients indicated was desirable and/or effective practice, have implications for such standards.

- Accepted practice allows the counsellor and client to jointly establish the goals and purpose of counselling. Counsellors traditionally respect a client's wish not to change, or to refuse help. Yet, as noted above, adolescent clients can be ambivalent about addressing what may be harmful and sometimes life-threatening problems, and there is thus legitimacy in at least trying to influence the prospective client to recognise the desirability of change.

- Counsellors are often cautioned against making personal disclosures out of concern for maintaining appropriate client-counsellor boundaries, as well as to ensure the focus of the sessions is always on what will benefit the client. Yet these ADC clients clearly expressed a preference for their counsellors to 'open up' and share personal stories with them.

- It is an ethical requirement that counsellors maintain confidentiality unless there are imminent safety concerns for the client or others (New Zealand Association of Counsellors, 2004). Confidentiality was highly valued, and appeared to have particular significance to these adolescent clients. However, in counselling adolescents this requirement becomes complicated. Important third parties, such as parents and referral agents, tend to be very interested and concerned for the well-being, safety, general progress, and emerging needs of the client.

- Closely related to the issue of sharing information with third parties is the active involvement of these parties in the counselling process. A current emphasis in the treatment of adolescent mental health in New Zealand is inter-service collaboration (Mental Health Commission, 1999; Ministry of Health, 2000). Adolescent clients, however, are often reluctant to engage with additional parties, tending to react negatively to having too many adults 'telling them what to do'.
Adolescent clients obviously have the same rights as adults, and should receive standards of counselling that are both ethical and professional. These issues above may require further attention so that optimal guidelines for practice can be developed for counsellors of adolescents. In general ADC counsellors sought a middle road in relation to the above issues: while respectful of clients’ goals, they sought nevertheless to encourage adoption of goals that addressed presenting problems; while maintaining a sound professional approach, counsellors were not averse to disclosing personal stories to clients; similarly, while respecting the clients’ needs and wishes for confidentiality, they sought to negotiate acceptable ways, when necessary, of sharing information and working with third parties. Their success in steering this middle line may explain why ADC counsellors frequently were described by their clients as ‘different’ from other helping professionals they had had contact with.

Modifying the Context of the Problem-Behaviour.

Modifying the context within which problem-behaviours typically occur is the means by which some of the more successful adolescent treatment programmes aim to achieve change (See MST and MDFC reviewed in section 2.3.3). As a model of treatment the ADC programme also seeks to influence the various contexts and inter-related systems that serve to elicit and/or maintain clients’ problem behaviour.

The community-based counselling sessions provided the opportunity to influence the context of the clients’ problem-behaviour, with sessions often including participation from significant others such as peers, parents and referral agents (including school teachers). However, as noted above, facilitating this involvement in a way that is acceptable to youth (i.e., not forced on them) can be a challenge.

The wilderness therapy component of the programme provided an additional means of altering context, something the research participants reported to be both helpful and enjoyable. For example, they commented how the Journey had assisted them to gain control of their use of substances through being in an environment free of drugs and alcohol where there was opportunity to “go cold turkey”. Some youth also mentioned positive effects from having their usual associates (who tended to maintain clients’ problem behaviour) replaced by peers who were supportive of positive change.

This research confirms the value of modifying the context within which clients’ problems typically occur. Programme providers generally should consider the
ways in which context can be influenced, particularly ways that are acceptable to youth.

**Increasing Help-seeking Behaviour and Client Retention.**

As in most countries, concerns exist locally over low levels of help-seeking behaviour amongst youth with mental health disorders (Horwood & Fergusson, 1998; Inder, 1997; McGee et al., 1990). Because the ADC programme has over its 15 years of operation generally succeeded in both attracting and retaining in treatment its adolescent clients, identifying key aspects of the ADC experience that produce this outcome is likely to be of interest to providers of other programmes also.

One way in which the ADC programme appears to have been successful is in reducing the stigma associated with participation. The programme is promoted as a ‘development’ experience, rather than ‘treatment’. It is also touted as an ‘adventure’. These themes are made explicit through the name of the programme, and through the programme’s promotional material, which feature photographs of rock-climbing and other adventurous activities.

A number of youth indicated that they had signed up for the ADC programme specifically because of these aspects. Following participation, their comments that the Journey was ‘exciting’, ‘cool’ and ‘awesome’, indicated that the experience matched their expectations. Certainly, spending nine days in the wilderness engaged in adventurous activities is likely to be more appealing than a similar period spent in ‘talking therapy’ in an institutional setting. This high level of satisfaction with their overall programme experience was supported by all research participants reporting that they would recommend the programme to other young people.

The enjoyable nature of the experience may also have helped to retain clients. A strong theme that emerged from the research participants, in relation to their Journey experience, was that while it had been sufficiently intensive and prolonged, and that therapeutic gains could be made and maintained, it had also been ‘fun’.

These findings imply that the inclusion and promotion of programme activities that are viewed and experienced positively by youth may help to reduce the stigma attached to seeking mental health services, increase help-seeking behaviour, and help to retain adolescents in treatment programmes.
Promotion of Wilderness Therapy as More Than a Recreational Experience

While wilderness therapy appealed strongly to the youth, the enjoyable and exciting aspect of the approach may, however, cause other observers to regard it as less than a genuinely ‘therapeutic’ intervention. This was not an issue for the youth themselves, who were clear that the experience had been therapeutic, and described the experience as “similar” to the community-based counselling.

However, if mental health professionals were to view this approach as merely ‘fun and games’, as a recreational rather than therapeutic experience (as a few of the research participants had initially been expecting), wilderness therapy will be dismissed as a viable adjunct or alternative to traditional approaches to counselling. It will be important, therefore, that representatives of the AT/WT profession seek opportunities to inform those outside the field about the effectiveness of this approach in achieving clinically significant outcomes.

The Benefits of a Strengths-based Focus

This study produced evidence that a treatment approach that focuses on clients’ strengths, and provides opportunities to experience success, may be particularly useful with adolescent clients.

It would seem self-evident that a young person in the process of forming a personal identity ought be encouraged to focus on positive personal qualities, rather than dwelling continuously on the less appealing aspects of their life. ADC counsellors not only discussed with clients their strengths and competences, but also provided clients with multiple opportunities to experience mastery and success. This occurred through realistic goal-setting (during the Journey and community-based counselling) and then encouragement and support to successfully accomplish the many challenging activities that made up the Journey. The value of these activities, in terms of positive experiences gained, and resulting changes in self-perception and behaviour, were mentioned by many ADC clients.

Bandura’s theory of self-efficacy (1977, 1997) seemed particularly useful in explaining the therapeutic value of these experiences. The theory predicts that successful achievement results in enhanced confidence, and consequently increased likelihood of success. This can result in a sense of personal agency and general well-being. For adolescents at a developmental phase which entails moving away from dependency on adults and gaining greater control over their lives, experiences of
accomplishment, competence and a corresponding increase in personal agency may be particularly beneficial.

It was noted that a 'problem-solving' focused approach is commonly used in the treatment of adolescents with mental health concerns. This approach identifies and diagnoses a client's problems in light of possible causes (e.g., childhood trauma, parental dysfunction, personality disorder) as a step towards resolving the problem. However, this approach arguably risks reinforcing those very aspects of a client's life which the counsellor is trying to resolve. Workers assisting adolescents with mental health concerns should seek, therefore, to always consider how clients might be helped to recognise their own strengths, and to find ways of allowing them to experience success and mastery.

A Developmentally Appropriate Context

A major weakness identified in the literature on adolescent psychotherapy and counselling is a neglect of developmental considerations. Most of the empirically supported treatment programmes (ESTs) that have been delivered to adolescents, have been either 'downward adaptations' of treatments developed for adults, or 'upward' adaptations of programmes developed for children. Only a handful had been developed specifically for adolescents. However, an overriding theme that has arisen throughout this research is the unique developmental characteristics of adolescents, characteristics that appear to influence treatment outcome. Some of these key characteristics are:

- A critical phase early in adolescent treatment is to address ambivalence. Adolescents who receive treatment are typically referred by others, and as a result they tend to start out less ready or committed to making changes. The ADC programme used motivational interviewing strategies for this purpose, and allowed sufficient time for adolescent clients to reach the point where they were committed to making changes.

- The need to achieve individuation and autonomy: for counsellors to elicit a positive response in their clients they need to listen carefully to what adolescents have to say and place importance on what is heard. The postmodern approach to counselling adopted by the ADC programme positioned the clients as the 'expert' in their own lives. This meant the
clients were treated in a developmentally appropriate way, with counsellors encouraging their clients to describe their own meanings about life, and listening carefully in order to understand how the client was currently making sense of their life.

- Being in the process of forming a personal identity: the strength-based focus of ADC, as mentioned above, together with the construction and writing of the clients alternative or new life ‘story’ at the end of the programme, may be particularly appropriate for adolescents.

- Peers represent the most important source of influence to adolescents: to increase the effectiveness of treatments it may be necessary to enlist the support of these peers. The ADC programme did this through the wilderness therapy component of the programme, where counsellors acted as facilitators as clients interacted with peers. The feedback received from their peers reportedly helped them to modify their behaviour, and gain a better understanding of themselves.

- The level of cognitive development in adolescents: implies the effectiveness of simple ‘talking’ therapies, especially those that rely on clients to form abstract associations, may have limited value. The wilderness therapy component was also able to address this developmental characteristic. It provided opportunities for the direct experience of real-life, here-and-now examples of problem behaviour that could be easily recognised. The immediate feedback provided by others meant alternative behaviours could readily be grasped by clients whose level of cognition tended towards the concrete.

In summary, one of the more important implications arising from this research is in proving the need for treatments to be developed specifically for this age group.

8.2.3 Implications and Recommendations for Researchers

This research did not set out to test theories or establish causal relationships; rather, the focus was exploratory and discovery-orientated. Many of the research findings summarised and discussed above thus identify areas for replication and validation through further research. Further implications and recommendations for future research are discussed below.
This research has contributed to several gaps and/or limitations in existing research on the treatment of adolescent mental health. Most notably, through the collection of data in a field setting on an established programme, evidence is presented that is applicable to 'real-world' clinical practice. The difficulties and frustrations associated with conducting research in such a setting have been discussed at length in section 5.4. They included the struggle to collect complete sets of data (particularly in relation to parent report data), resulting in reduced validity and ability to generalise findings. Further, the length of this treatment programme and limited numbers of referrals made it more difficult to collect data on a sufficiently large sample to allow for more sophisticated statistical analysis. There were also ethical and practical limitations associated with withholding treatment to youth with serious mental health problems, which precluded the use of a no-treatment control group. This limited the ability to draw firm conclusions on the impact of the ADC programme on participants.

On reflection, however, having completed such an exercise, despite the difficulties and limitations, my view is that this type of field-based research is essential. Throughout this study the poor fit between programme conditions described in much of the published research (particularly that which has sought to identify empirically supported treatments), and the real-world conditions and characteristics associated with the ADC programme and its clients, became increasingly evident.

For research to be more clinically relevant, it must also focus on counselling approaches in common use but which perhaps have been less amenable to experimental research. These include approaches such as person-centred, postmodernist and wilderness therapy approaches, most of which currently have received little empirical validation. Popular programme formats such as eclectic or multi-modal programmes, and long-term treatment programmes, also require more attention. It is important that research is carried out on what is relevant, not what is easiest to evaluate. Researchers must adapt and develop their methodologies to address the relevant treatment questions that will serve to enhance this field of endeavour.

This study addressed another persistent shortfall in adolescent counselling and psychotherapy research (Kazdin 2004; Weisz & Kazdin, 2003) by gathering evidence on the maintenance of treatment effects over the longer term. Obviously, when
treatment effects are not maintained much beyond the programme end date, then questions must be raised over the value of that treatment. This research indicated that some clients of the ADC programme did not simply maintain the gains made in overall mental health, but in fact continued to make further improvements over the six-months’ follow-up period. Admittedly, individual measures of mental health showed differing patterns of maintenance and/or relapse, which points to the need to measure multiple indices of mental health over both the short and long-term.

In addition to its focus on a “real-world” clinical programme, this research also constituted one of the first systematic attempts to specifically evaluate adolescent mental health treatment in New Zealand. Some impressive longitudinal studies have been conducted in New Zealand, which have provided valuable information on rates of prevalence and risk-factors associated with the development of adolescent mental health (McGee et al., 1990; Fergusson et al., 1993; Feehan et al., 1994; Horwood & Fergusson, 1998). However, very few evaluations have been published on outcomes of New Zealand adolescent mental health treatment programmes. There is a similar dearth of local studies on client or programmatic factors that are associated with successful treatment outcomes. Consequently, those responsible for providing adolescent mental health services here have had to rely on overseas research to guide selection of treatments that might be effective. The extent to which such international research is directly applicable to New Zealand adolescents of course remains unclear. This research sets a positive precedent then for future research, hopefully stimulating a greater focus on the effectiveness of New Zealand adolescent mental health services.

One obstacle to further research, however, is the absence of any nationally representative norms on measures of adolescent mental health. The current study had to make use of norms derived from North American and Australian youth populations. Researchers could be greatly assisted were there a nationally representative survey on youth mental health, similar to that recently carried out in Australia (Sawyer et al., 2000). Such a survey while assessing the national prevalence of mental health disorders, might also provide norms on readily administered measures such as the CBCL, YSR and CGAS. Valuable data would thereby be generated to measure the clinical significance of programme treatment effects. Such a survey would also help programme providers to better identify and focus efforts on
priority groups (i.e., the most severely affected three percent of 0-19 year olds with mental illness).

Another significant contribution made by this research, it is hoped, is increased understanding of factors associated with successful treatment outcomes. This has been identified as a serious gap in the literature both locally and internationally. Real improvements in treatment effectiveness will probably be derived from sharper understanding of exactly how treatments work (Kazdin, 2004). In this case, quantitative results pointed to the moderating effects of several client and contextual variables on ADC treatment outcome, although admittedly only a relatively small proportion of the variance in treatment outcome was accounted for. More practical and perhaps more significant findings came from the qualitative enquiry, which sought the views and perceptions of the adolescent clients themselves. When asked, they usually had strong opinions on the factors that had or had not “worked” for them in achieving change.

Failure to consider this perspective has been noted as a limitation of previous research with adolescent mental health issues (Butson, 2002; Le Surf & Lynch, 1999). This research demonstrated the value of listening and giving priority to the ‘voice’ of the youth, whose comments sometimes supported, and sometimes challenged commonly-accepted tenets of research and counselling practice. On the other hand, differences among clients as to which factors were personally significant highlighted the complexities associated with understanding and achieving effectiveness in therapeutic change with youth. The challenge now is for researchers and practitioners not only to more fully accept the importance of the youth perspective, but to respond by following up, with further research, the valuable perspectives these youth can provide.

Understanding how wilderness therapy may effect positive change, was another issue identified as needing research attention (Newes, 2000; Russell, 1999) and has been addressed in this research. The findings of the qualitative enquiry revealed that different types of AT/WT activities appear to have different outcomes. While group problem-solving activities promoted the sense of an enjoyable experience, the youth associated therapeutic outcomes from activities that provided the direct experience of immediate, “real” and personally meaningful issues, individual challenge, and personal feedback.
More of such process-orientated research is needed on AT/WT interventions, particularly in order to gain a better understanding of programme characteristics necessary for therapeutic outcomes to be achieved, and to understand the contribution to therapeutic change made through activities that are intrinsically enjoyable.

Other recommendations for researchers that have arisen as a result of this research study include the following. Currently, much adolescent treatment research relies heavily on parent reporting of youth problem behaviour. However, discrepancies arise between the self-reports of youth and those of the parents. This suggests that researchers should be particularly cautious when conducting and interpreting research results that rely solely on one or the other of these data sources. It is recommended that reports are collected from multiple informants (e.g., youth, parent, counsellor). Ideally, these sources are also accompanied by direct behavioural observations, as well as official records such as school/training attendance, criminal records, and referrals to other mental health services. This battery of data sources assists in verifying self-reports, and leads to more accurate interpretation of research findings.

There were also reliability problems in relation to youth self-report of substance-use. This research found that, when asked to retrospectively describe their pre-programme levels of use, the youth tended to report higher levels of use than they did when they were asked at the pre-programme stage. It was thought that the retrospective reports may have been more accurate, implying that reliance on current use reporting may result in an underestimation of the effectiveness of programmes such as ADC. Obviously, further research is required to verify the validity and utility of retrospective self-reporting as an additional or alternative method of data collection.

Finally, effort is needed to develop assessment measures of mental health that are compatible with strengths-based approaches to mental health issues. Ideally, researchers would begin to move from a “problem” focus towards the measurement of competence and, emotional and spiritual well-being. Of particular relevance to adolescent mental health would be measures that captured elements such as success in work placements, career-related training courses, and improved attendance or performance at school. Assessing youth mental health in this way would also be more compatible with the New Zealand governments’ current commitment to a more holistic understanding of mental health (Ministry of Heath, 2002; 2004).
Advantages of a Mixed-Methods Research Design

This research demonstrated that it is both possible and desirable for a researcher to use a mixed methods research design that incorporates different theoretical perspectives. Within this study, each method and perspective displayed its own strengths, and was able to answer different questions. This resulted in what were effectively two stand-alone studies (Part II and Part III), consistent with the 'complementary strengths’ approach to mixed methods research (Tashakkori & Teddlie, 2003).

The quantitative study involved the use of standardised measures of treatment outcome. As a result, the findings on outcomes and factors associated with these outcomes could be compared and contrasted to published research, the majority of which is based on a similar post-positive perspective. The qualitative enquiry provided an inductive approach to understanding the therapeutic change process based on the often-neglected but important perspective of the adolescent clients themselves. The theoretical perspective associated with this methodology privileged the knowledge offered by the youth and enabled the construction of new ways of understanding how counselling might have worked.

The main advantage of using this mixed method research design was, therefore, was the ability to fulfil quite distinct research objectives. Unlike some mixed methods studies the intent was not to combine the data sets from each approach as a means of increasing understanding of a particular issue. While not part of the overall research design it is, however, interesting to note that there were several instances where data collected using one approach were able to inform the findings of the other.

The quantitative information collected on the effectiveness of the programme was able to provide a particular context within which the qualitative data could be interpreted. For example, evidence of clinical improvements in mental health gave important context to comments from the ADC clients on what they thought had been beneficial. At times the two approaches revealed findings that were consistent; for example, both studies found support for the effectiveness of the programme in assisting youth to reduce or give up their use of drugs and alcohol. On other occasions different findings were evident. In the qualitative study youth were seen to emphasise different treatment outcomes than had been apparent from the quantitative data. These included improved relationships with family members and peers as a result of
enhanced social skills, gaining better self-control (which they often associated with getting into less trouble in and out of school), ceasing criminal behaviour, feeling better about themselves, and the attainment of significant events such as returning to school or moving from a foster care arrangement back into the family home. These outcomes had not been selected for evaluation in the quantitative study.

The two approaches also pointed to different understandings of ADC process variables. For example, the quantitative investigation of factors associated with successful treatment outcome indicated the importance of problem severity and third party involvement. Analysis of youths' interview data on the other hand indicated the significance of variables (perhaps less amenable to quantitative assessment) such as the effect of motivation and aspects of the client-counsellor relationship.

Sometimes discrepancies in data sets provided useful insights for consideration. For instance, the ambivalence reported by youth towards family therapy could be contrasted with the value of parental involvement, as revealed through the quantitative analysis. The qualitative data also provided possible explanations of apparent negative effects of increased community support noted in the multiple regression analysis.

As noted above, combining data sets from each approach was not part of the planned research design, and as such the implications of these overlaps are best viewed as potentially worthwhile considerations for future research.

Both the quantitative and qualitative methodologies revealed the complexities involved in seeking to understand how treatment works to improve the mental health and well-being of adolescent clients. For progress to be achieved in this important but complex area, it is recommended that researchers take advantage of all the methodological tools and perspectives that are available to them. Incorporating both quantitative and qualitative approaches into this study enabled an increased understanding of 'what works for youth'.
8.3 Conclusion

As indicated by its title, this thesis constitutes an attempt to shed a little more light on the question of ‘what works’ with youth. Having fairly comprehensively considered all of the collected data, a few concluding remarks are perhaps in order.

At the outset, the goal of this project was to identify programme elements (content, format, etc.) that were associated with good outcomes. Clearly, many elements of the ADC programme format, together with its mix of counselling approaches, emerged as effective, both as strategies for engaging the clients and then enabling them to make positive changes.

This fairly straightforward conclusion, however, needs to be considered in light of the realities of these young people’s lives. One of the most potent and memorable aspects of this project, for me, was an appreciation of the difficult conditions under which many of these young people sought to make headway through life. Many were making their way without support or positive role modelling from parents. Others had developed maladaptive coping strategies, regardless of the supports available to them. For whatever the reason, all were habitually making poor choices that put them at risk of injury, abuse from others, even death, creating further stress and complications in their lives. As a result, many youth had previously been seen by other helping professionals, but too frequently this had only served to confirm negative expectations held by the youth and engendered further alienation.

These factors, coupled with the stage of life these youth are at (where adults’ attempts to exert influence is increasingly resisted), combined to create major barriers to both engaging the young person and assisting them in a process of change. Consequently, when these youth started on the ADC programme, they often posed a significant challenge to the counsellors. They typically arrived with considerable ambivalence, and at times could be openly oppositional.

All this brought into focus what is for me an important conclusion about ‘what works’ with youth. I refer in particular to the staff of the programme, and I am now inclined to the view that, probably nothing will ‘work’ with youth unless this part of the equation is right.

What impressed as so critical is that personnel delivering services have to be not just competent in a wide range of skills, but also to be credible to the youth. To gain the client’s cooperation, youth counsellors need a blend of energy, genuineness, firmness, patience and perseverance. What also seemed crucial was a willingness to
go the extra mile and to be able to recognise, and then focus on, the qualities and positive attributes of these young people. As one young person suggested, 'not just anybody' could be a good counsellor.

During my observations I noted these characteristics were abundantly evident in ADC staff. Not only were they competent mental health professionals, but they approached their work with a level of commitment and dedication that I found inspiring. As a result they were able to gain the trust of these youth, life stories and experiences were shared, and a sense of collaboration was forged. In most cases the outcome was the young person choosing to make some positive changes to their life course. And according to the youth, once this decision was made, change seemed to come about fairly readily.

In conclusion, a great programme with inadequate staff is unlikely to achieve good results, while good staff may be limited by the inadequacies of a programme's framework. However, recruiting and retaining effective counsellors and setting them to work within a programme structure such as ADC, clearly is one approach that works!
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Newes, S. (2001a). The application of empirically-supported treatment criteria to adventure-based therapy research: Where do we stand and why should we care? Unpublished manuscript.


Sydney: National Drug and Alcohol Research Centre, University of New South Wales.


Westermeyer, J. (1997). Substance related disorders. In R. Ammerman & M. Hersen (Eds.), Handbook of Prevention and Treatment With Children and
Adolescents. *Interventions in the Real World Context* (pp. 604-628). Toronto: John Wiley & Sons, Inc.


APPENDIX A:
TESTING SCHEDULE
<table>
<thead>
<tr>
<th></th>
<th>Pre-Test</th>
<th>Post Test</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Youth</strong></td>
<td>• Client characteristics form</td>
<td>• Client characteristics form</td>
<td>• Client characteristics form</td>
</tr>
<tr>
<td></td>
<td>• YSR (Behavioral Checklist)</td>
<td>• YSR (Behavioral Checklist)</td>
<td>• YSR (Behavioral Checklist)</td>
</tr>
<tr>
<td></td>
<td>• A&amp;D - DSM-IV assessment (KSADS)</td>
<td>• A&amp;D - DSM-IV assessment (KSADS)</td>
<td>• A&amp;D - DSM-IV assessment (KSADS)</td>
</tr>
<tr>
<td></td>
<td>• A&amp;D – Level of consumption (Current Use)</td>
<td>• A&amp;D – Level of consumption (Current Use &amp; Retrospective Reporting)</td>
<td>• A&amp;D – Level of consumption (Current Use &amp; Retrospective Reporting)</td>
</tr>
<tr>
<td></td>
<td>• Brief FAM (Family Functioning)</td>
<td>• Brief FAM (Family Functioning)</td>
<td>• Brief FAM (Family Functioning)</td>
</tr>
<tr>
<td></td>
<td>• Individual treatment goals</td>
<td>• Individual treatment goals</td>
<td>• Individual treatment goals</td>
</tr>
<tr>
<td><strong>Parent</strong></td>
<td>• CBCL (Behavioral Checklist)</td>
<td>• CBCL (Behavioral Checklist)</td>
<td>• CBCL (Behavioral Checklist)</td>
</tr>
<tr>
<td></td>
<td>• Brief FAM (Family Functioning)</td>
<td>• Brief FAM (Family Functioning)</td>
<td>• Brief FAM (Family Functioning)</td>
</tr>
<tr>
<td><strong>Counsellors</strong></td>
<td>• CGAS (Global Functioning)</td>
<td>• CGAS (Global Functioning)</td>
<td>• CGAS (Global Functioning)</td>
</tr>
</tbody>
</table>
APPENDIX B:
DETAILS AND COPIES OF TESTING INSTRUMENTS
Client Characteristics

Clients ID or Name: ____________________________

Please fill out the following form with information that is available to you. (If information is unknown please write unknown next to questions).

A: Referral Information
   i) Who made referral:
   ii) Primary reason for referral:
   iii) Secondary reason for referral (where applicable):

B: Other Interventions (circle those applicable)
   i) Previous treatment / therapy:
      Individual / Family / Parent / In-patient / Out-Patient group / Special Education / Other
   ii) Concurrent treatment / therapy in addition to ADC:
      Individual / Family / Parent / In-patient / Out-patient group / Special Education / Other
   iii) Other agencies involved previously:
      CYFs / Youth Justice / Truancy / School / Community Workers / Other
   iv) Other agencies involved concurrently:
      CYFs / Youth Justice / Truancy / School / Community Workers / Other

C: Client Characteristics
   NB: If information is different now from how it was at the start of the programme (e.g. living situation) please make a note of how things have changed.

1. Family situation (circle those applicable)
   i) Clients living situation:
      a) number of parents or caregivers at home? single / two / living alone / other ______________
      b) relationship to client? family / caregiver / other ______________
      c) who else lives at home? no. of bothers & sisters ______________
   ii) Parents / caregiver occupation:
       a) Mother / female caregiver ______________
       b) Father / male caregiver ______________
   iii) Family issues / stress:
       (circle those applicable) 1. housing 2. finance 3. legal 4. medical 5. cultural 6. safety or violence 7. educational / occupational 8. social networks 9. separation 10. other ______________
iv) History of antisocial behaviour in clients parents, (circle those applicable to the clients parents):

1. Recent illicit drug use
2. Alcoholism
3. Psychiatric illness
4. Criminal offending

2. Childhood physical and/or sexual assault/abuse (circle those applicable)

i) Level of childhood sexual abuse (CSA): no CSA / non-contact CSA / contact CSA / contact CSA with penetration

Is this level of CSA: confirmed / suspected

ii) Childhood physical assault / punishment: never / seldom / regular / extreme

Is this level of CPA: confirmed / suspected

iii) Childhood emotional abuse: never / seldom / regular / extreme

3. School situation (prior to programme) (circle those applicable)

i) Attending – regularly / irregularly or Not Attending - permanent / temporary

ii) School behaviour: 
   a) truanting: Y/N
   b) suspensions: Y/N
   c) disciplinary: Y/N

4. Onset of clients 'problem behaviour': Age of first official notification ___________ yrs

5. Criminal behaviour: Y/N
   If 'yes' age of first official notification ______ yrs

6. Gang involvement: Y/N

7. Peers: 
   i) Influence of peers on client: little / moderate / greatly
   ii) Behaviours of peers A&D / truanting / offending

8. Health (current/past medical diagnoses, medication, treatment) - please indicate if health issues have been formally diagnosed or are self-report:
### Alcohol Quantity & Frequency

<table>
<thead>
<tr>
<th>How often do you usually drink alcohol?</th>
<th>How much do you typically consume per single drinking occasion? (ask for beer, wine, spirits incl pre-mixed drinks)</th>
<th>How often would you consume the equivalent of 5 or more standard drinks on one drinking occasion?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Now...</td>
<td>(for spirits include size of bottle and % alcohol)</td>
<td>(times per week/month, etc)</td>
</tr>
<tr>
<td>(times per day/week/month, etc)</td>
<td>(for spirits include size of bottle and % alcohol)</td>
<td>(times per week/month, etc)</td>
</tr>
</tbody>
</table>

Post Programme / Follow-Up – Ask for pre-programme consumption

| (times per day/week/month, etc)        | (for spirits include size of bottle and % alcohol)                                                              | (times per week/month, etc)                                                        |

NB: One standard drink = 10g alcohol = stubbie/can/300ml glass of beer (4%) = 100ml glass of wine (12%) = 30ml of spirits (40%), pub measure/double nip, neat or with mixer; 750ml bottle of wine (12%) = 7.5 standard drinks; 750ml bottle of spirits (40%) = 25 standard drinks.

**Estimate the average number of st. drinks consumed per week:**
- Now: 
- Prior to ADC programme: 

### Drugs and other Substances

<table>
<thead>
<tr>
<th>List drugs used (including those no longer used)</th>
<th>How often do you use these drugs? (per week/month)</th>
<th>How much do you usually use?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug</td>
<td>Duration of Use</td>
<td>Now...</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prior to ADC...</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Now...</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prior to ADC...</td>
</tr>
</tbody>
</table>
## Individual Treatment Goals

1. Treatment Goal  
   (describe):

```
   0  1  2  3  4  5  6  7  8  9  10

(Behavioural Descriptor) (Behavioural Descriptor) (Behavioural Descriptor)
```

2. Treatment Goal  
   (describe):

```
   0  1  2  3  4  5  6  7  8  9  10

(Behavioural Descriptor) (Behavioural Descriptor) (Behavioural Descriptor)
```

3. Treatment Goal  
   (describe):

```
   0  1  2  3  4  5  6  7  8  9  10

(Behavioural Descriptor) (Behavioural Descriptor) (Behavioural Descriptor)
```

4. Treatment Goal  
   (describe):

```
   0  1  2  3  4  5  6  7  8  9  10

(Behavioural Descriptor) (Behavioural Descriptor) (Behavioural Descriptor)
```

5. Treatment Goal  
   (describe):

```
   0  1  2  3  4  5  6  7  8  9  10

(Behavioural Descriptor) (Behavioural Descriptor) (Behavioural Descriptor)
```

6. Treatment Goal  
   (describe):

```
   0  1  2  3  4  5  6  7  8  9  10

(Behavioural Descriptor) (Behavioural Descriptor) (Behavioural Descriptor)
```
APPENDIX C:
CONSENT APPROVALS
14 June 1999

Elaine Mosman
C/o Assoc.Prof. Bob Manthel and Judi Miller
Department of Education
UNIVERSITY OF CANTERBURY

Dear Elaine

The Human Ethics Committee advises that your research proposal "The Adventure Development Counselling (ADC) Research Study" has been considered and approved.

Yours sincerely

[Signature]

Isobel Phillips
Secretary
31 August 1999

Ms S E Mossman
Education Department
University of Canterbury
Private Bag 4800
CHRISTCHURCH

Dear Elaine

The Adventure Development Counselling (ADC) Programme: An evaluation of its effectiveness and investigation of factors contributing to successful outcome in the treatment of adolescent's problem behaviours (including drugs and alcohol use)
Investigators: E Mossman Supervisor: Prof R Mauthei
Protocol number: 98/10/109

Thank you for letter of 5 August 1999 regarding changes to the above study. The care you have taken to meet the concerns raised by the Committee is appreciated.

As consent has already been obtained from some participants for Part I of the study, it has been agreed that recruitment may continue in this way.

The information sheets as per the national guidelines for ethics applications are preferred and you may find them helpful, but the choice is yours.

Our best wishes for a successful study. A copy of your report at the conclusion of the project would be appreciated.

Yours sincerely,

Sally Cook
Ethics Committee Administrator
APPENDIX D:
INFORMATION SHEETS AND CONSENT FORMS
(QUANTITATIVE STUDY - PART II)
Adventure Development Counselling Research Study - Part I

INFORMATION FOR ADC CLIENTS

You are invited to participate as a subject in the Adventure Development Counselling Research Study.

The aim of this project is to find out how effective the Adventure Development Counselling (ADC) programme is with adolescents.

Your involvement in this project will be to agree to release assessment / evaluation information collected by ADC staff to the researcher. Your participation in this project is voluntary and you are free to withdraw at any time.

The results of the project may be published, but you may be assured of the complete confidentiality of data gathered in this investigation: no material that could possibly identify you will be used in any reports based on this study.

The project is being carried out by Elaine Mossman who is conducting her PhD at the Education Dept, University of Canterbury. She can be contacted at (03) 355 4386. She will be pleased to discuss any concerns you may have about participation in the project.

The project has been reviewed by the University of Canterbury Human Ethics Committee.
Adventure Development Counselling Research Study - Part I
INFORMATION SHEET FOR PARENTS / CARE GIVERS

You son/daughter has been invited to participate as a subject in the Adventure Development Counselling Research Study.

The aim of this project is to find out how effective the Adventure Development Counselling (ADC) programme is with adolescents.

If you agree to their participation in this project, they will be asked to release assessment / evaluation information collected by ADC staff to the researcher. Their participation in this project is completely voluntary if you agree to their participation you may change your mind at any time.

The results of the project may be published, but you may be assured of the complete confidentiality of data gathered in this investigation: no material that could possibly identify them will be used in any reports based on this study.

The project is being carried out by Elaine Mossman who is conducting her PhD at the Education Dept, University of Canterbury. She can be contacted at (03) 355 4386. She will be pleased to discuss any concerns you may have about your son/daughters participation in the project.

The project has been reviewed by the University of Canterbury Human Ethics Committee.
ADVENTURE DEVELOPMENT COUNSELLING
PROGRAMME CONSENT FORM

I approve of ____________________________ taking part in the Adventure
Development Counselling selection process and if selected, in the Adventure Development
Counselling Programme.

I understand that the Programme will involve individual counselling, family sessions and a
nine day outdoor group therapy experience.

I agree to information being passed on to the Specialist Education Services Adventure
Development Counselling team by the referral agency/school.

I understand that I will be involved in the Specialist Education Service evaluation and agree
for this information to be released to Elaine Mossman of University of Canterbury for
research and evaluation purposes.

I understand that confidentiality will be maintained in the following ways:
• All information received from the participants, family, and schools or other referral
  agencies, will be restricted to the therapeutic team working with the young person.
• No information will be passed to another person without the consent of the person who
  initially provided the information.
• Any written reports, published articles or the formal evaluation report will not identify
  individual participants, parents, or schools.
• Photographs will only be used with the permission of the participant.

The information collected is held at the offices of the Specialist Education Service, whose
addresses are:

Specialist Education Services
442 Moray Place
PO Box 5147
Dunedin

Specialist Education Services
190 Forth St
PO Box 887
Invercargill

Specialist Education Services
Cnr Amargh St & Fitzgerald Ave
PO Box 4629
Christchurch

Signatures

Parent(s)/legal guardians: ________________________________________

__________________________________ Date: ________

(Both legal guardians must have knowledge of the programme and agree to the participation
of their son/daughter)

I wish to take part in the Adventure Development Programme.

Participant: _______________________________ (This must be signed by the
  participant)
APPENDIX E:
TESTING FOR EFFECTS OF MISSING DATA
### Table A1:
Indepdendent t-tests to assess the effect of missing data.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Completers</th>
<th>Early Terminators</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X (SD)</td>
<td>n</td>
<td>X (SD)</td>
<td>n</td>
</tr>
<tr>
<td>Age</td>
<td>14.4 (1.2)</td>
<td>41</td>
<td>14.7 (1.1)</td>
<td>12</td>
</tr>
<tr>
<td>Treatment Outcome</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tot Prob (YSR)</td>
<td>65.5 (10.5)</td>
<td>40</td>
<td>61.5 (8.3)</td>
<td>12</td>
</tr>
<tr>
<td>BFAM (Youth)</td>
<td>57.9 (11.2)</td>
<td>39</td>
<td>52.7 (8.6)</td>
<td>11</td>
</tr>
<tr>
<td>CGAS</td>
<td>53.7 (7.7)</td>
<td>33</td>
<td>55.8 (9.2)</td>
<td>6</td>
</tr>
<tr>
<td>Alcohol amt/week</td>
<td>8.8 (10.3)</td>
<td>32</td>
<td>13.2 (13.4)</td>
<td>9</td>
</tr>
<tr>
<td>Cannabis Freq/week</td>
<td>1.8 (5.2)</td>
<td>36</td>
<td>2.0 (2.1)</td>
<td>9</td>
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<tr>
<td>Counselling Stats</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tot No. Sessions</td>
<td>18.6 (5.8)</td>
<td>41</td>
<td>18.2 (14.7)</td>
<td>12</td>
</tr>
</tbody>
</table>

### Table A2:
Chi-Square analysis to assess the effect of missing data on categorical variables.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Completers</th>
<th>Terminated Early</th>
<th>ch^2</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Male</td>
<td>27</td>
<td>65.9</td>
<td>10</td>
<td>83.3</td>
</tr>
<tr>
<td>Female</td>
<td>14</td>
<td>34.1</td>
<td>2</td>
<td>16.7</td>
</tr>
<tr>
<td>Attend School</td>
<td>35</td>
<td>85.4</td>
<td>9</td>
<td>75.0</td>
</tr>
<tr>
<td>Not Attending</td>
<td>6</td>
<td>14.6</td>
<td>3</td>
<td>25.0</td>
</tr>
<tr>
<td>NZ European</td>
<td>31</td>
<td>75.6</td>
<td>4</td>
<td>33.3</td>
</tr>
<tr>
<td>Non NZE</td>
<td>10</td>
<td>24.4</td>
<td>8</td>
<td>66.7</td>
</tr>
</tbody>
</table>

NB: In some cases pre-test data were missing rather than post-test or follow-up, hence the varying numbers for incomplete data.
APPENDIX F:

FRIEDMAN ANOVA RESULTS FOR A&D CONSUMPTION
Table A3:
Results of Friedman ANOVA and Wilcoxon Matched Pairs for alcohol and cannabis consumption following participation on ADC programme

<table>
<thead>
<tr>
<th></th>
<th>Pre-Programme Reporting</th>
<th>Retrospective Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Score</td>
<td>Significance</td>
</tr>
<tr>
<td>Average Quantity of Alcohol Consumption</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friedman ANOVA</td>
<td>$\chi^2(2) = 7.14$</td>
<td>.028</td>
</tr>
<tr>
<td>Wilcoxon MPairs Test</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre to Post</td>
<td>Z = 1.88</td>
<td>.060</td>
</tr>
<tr>
<td>Post to Follow-up</td>
<td>Z = 2.78</td>
<td>.005</td>
</tr>
<tr>
<td>Pre to Follow-up</td>
<td>Z = 1.25</td>
<td>.212</td>
</tr>
<tr>
<td>Average Frequency of Cannabis Use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friedman ANOVA</td>
<td>$\chi^2(2) = 6.16$</td>
<td>.046</td>
</tr>
<tr>
<td>Wilcoxon MPairs Test</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre to Post</td>
<td>Z = 2.72</td>
<td>.007</td>
</tr>
<tr>
<td>Post to Follow-up</td>
<td>Z = 2.35</td>
<td>.019</td>
</tr>
<tr>
<td>Pre to Follow-up</td>
<td>Z = .089</td>
<td>.929</td>
</tr>
</tbody>
</table>
APPENDIX G:
INFORMATION SHEETS AND CONSENT FORMS
(QUALITATIVE STUDY- PART III)
Adventure Development Counselling Research Study - Part II

INFORMATION FOR ADC CLIENTS

You are invited to participate as a subject in the Adventure Development Counselling Research Study.

The aim of this project is to find out how effective the Adventure Development Counselling (ADC) programme is with adolescents.

Your involvement in this project will be to agree that an independent researcher interview and observe your participation at various stages through out the ADC programme. This could involve 6-8 one hour interviews, and observations through out your participation in the programme. Your permission is also sought to interview your counsellor, parents/caregivers, and the person who referred you onto this programme for their opinion on the effectiveness of the programme. Your participation in this project is voluntary and you are free to withdraw at any time.

The results of the project may be published, but you may be assured of the complete confidentiality of data gathered in this investigation: no material that could possibly identify you will be used in any reports based on this study.

The project is being carried out by Elaine Mossman who is conducting her PhD at the Education Dept, University of Canterbury. She can be contacted at (03) 355 4386. She will be pleased to discuss any concerns you may have about participation in the project.

The project has been reviewed by the University of Canterbury Human Ethics Committee.
Adventure Development Counselling Research Study - Part II
INFORMATION SHEET FOR PARENTS / CARE GIVER

You son/daughter has been invited to participate as a subject in the Adventure Development Counselling Research Study. We would also like to invite you to participate in the study.

The aim of this project is to find out how effective the Adventure Development Counselling (ADC) programme is with adolescents.

Your involvement in this project will be to agree that an independent researcher interview you about your observations of the effectiveness of the programme on your child. This could involve 2-4 one hour interviews. Your permission is also sought to interview and observe your child’s participation on the programme. Both your and your child’s participation in this project is voluntary and you and they are free to withdraw at any time.

The results of the project may be published, but you may be assured of the complete confidentiality of data gathered in this investigation: no material that could possibly identify yourself or your child will be used in any reports based on this study.

The project is being carried out by Elaine Mossman who is conducting her PhD at the Education Dept., University of Canterbury. She can be contacted at (03) 355 4386. She will be pleased to discuss any concerns you may have about your or your son/daughters participation in the project.

The project has been reviewed by the University of Canterbury Human Ethics Committee.
Adventure Development Counselling Research Study - Part II

PARTICIPANT CONSENT FORM

I have read and understood the description of the above-named project. On this basis I agree to participate as a subject in the project, and I consent to publication of the results of the project with the understanding that anonymity will be preserved. I understand also that I may at any time withdraw from the project, including withdrawal of any information I have provided.

Signed: ............................................................. Date: ......................

==================================

PARENT / CAREGIVER CONSENT FORM

I have read and understood the description of the above-named project. On this basis I agree to my own participation and the participation of my son/daughter as a subject in the project, and I consent to publication of the results of the project with the understanding that anonymity will be preserved. I understand also that I may at any time withdraw my permission for their participation in the project, including withdrawal of any information already provided.

Signed: ............................................................. Date: ......................
Adventure Development Counselling Research Study - Part II
INFORMATION FOR ADC COUNSELLORS

You are invited to participate in the Adventure Development Counselling Research Study.

The aim of this project is to find out how effective the Adventure Development Counselling (ADC) programme is with adolescents.

Your involvement in this project will be to agree that an independent researcher interview you and observe your participation at various stages throughout the ADC programme. This could involve 6-8 one hour interviews, and observations throughout the programme. Your participation in this project is voluntary and you are free to withdraw at any time.

The results of the project may be published, but you may be assured of the complete confidentiality of data gathered in this investigation: no material that could possibly identify you will be used in any reports based on this study.

The project is being carried out by Elaine Mossman who is conducting her PhD at the Education Dept, University of Canterbury. She can be contacted at (03) 355 4386. She will be pleased to discuss any concerns you may have about participation in the project.

The project has been reviewed by the University of Canterbury Human Ethics Committee.
Adventure Development Counselling Research Study - Part II

ADC COUNSELLOR CONSENT FORM

I have read and understood the description of the above-named project. On this basis I agree to participate as a subject in the project, and I consent to publication of the results of the project with the understanding that anonymity will be preserved. I understand also that I may at any time withdraw from the project, including withdrawal of any information I have provided.

Signed: .................................................. .................. Date: ..................
Adventure Development Counselling Research Study - Part II

INFORMATION SHEET FOR REFERRAL AGENCY

A student/client of yours has been invited to participate as a subject in the Adventure Development Counselling Research Study. We would also like to invite you to participate in this study.

The aim of this project is to find out how effective the Adventure Development Counselling (ADC) programme is with adolescents.

Your involvement in this project will be to agree that an independent researcher interview you about your reasons for referring this client to the programme and your observations of the effectiveness of the programme on this client. This could involve two one hour interviews. Your participation in this project is voluntary are free to withdraw at any time.

The results of the project may be published, but you may be assured of the complete confidentiality of data gathered in this investigation: no material that could possibly identify yourself or the client will be used in any reports based on this study.

The project is being carried out by Elaine Mossman who is conducting her PhD at the Education Dept, University of Canterbury. She can be contacted at (03) 355 4386. She will be pleased to discuss any concerns you may have about your participation in the project.

The project has been reviewed by the University of Canterbury Human Ethics Committee.
Adventure Development Counselling Research Study - Part II

REFERRAL AGENCY CONSENT FORM

I have read and understood the description of the above-named project. On this basis I agree to participate as a subject in the project, and I consent to publication of the results of the project with the understanding that anonymity will be preserved. I understand also that I may at any time withdraw from the project, including withdrawal of any information I have provided.

Signed: ................................................................. Date: ....................
What kind of person do you think makes a good counsellor?
- How did you find your counsellor - Other co-leaders
- Respect? Confrontation? Open-up to?
- Did the relationship change over time?

The Journey
- Word to describe?
- How important do you think it was?
- Most memorable bits?
- What about -
  - Group - not knowing, effects...
  - Goal setting - group feedback
  - Circles - gp discussions
  - Climbing
  - The tramp
  - Games - problem solving activities
  - A&D minefield
  - Reflections
  - One on one check-ins
  - co-leaders - how long to trust?
- What did you learn from the Jn? - Is this different from your other counselling?
- Since the Jn have things changed? - Do you do things differently now as a result of going on Jn? Like what?

ADC

Signing-Up
- Anything in particular attractive about ADC?
- Expectations - what did you want it to do for you? WHY
- what did you think it was going to be like? (what Info)

How was it?
- What was most helpful? What was least helpful?
- Any specific 'moments' or 'points' that stand-out as significant?
- What about - Info
  - Assessment Info
  - One on One (goal setting, problem solving.....)
    (how did you decide on your goals?, Tell me about a good session that you can remember)
  - Family sessions
  - (Journey)
  - Follow-up Session
  - Story

What Effect?
- Has the programme had an effect on you in anyway?
- What were your goals? How did you decide on them?
- Everyone different but what about -
  - School
  - Home
  - Friends
  - Relationships
  - How you feel about yourself

How was this achieved?

How come? - Tell me more? - Give me an example - memorable bits - In what ways has that made a difference - Lasting effect?
APPENDIX H:
INTERVIEW GUIDE – TREE DIAGRAM