

Research Project Reports and Professional and Ethical Issues Report

by

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Three placement project reports and one report addressing areas of professional and ethical issues in the practice of clinical psychology submitted in partial fulfilment of the requirements for the Doctor of Psychology (Clinical)

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TABLE OF CONTENTS

	Page
Index of Contents	ii
Statement of Authorship	v
Preamble	vi
<i>Report 1: Assessing Client Satisfaction and Perceptions of Treatment Outcomes in a Community Psychology Service</i>	1
Index of Contents	2
List of Tables	3
List of Figures	4
List of Appendices	5
Abstract	6
Introduction	7
Method	9
Results	12
Discussion	20
References	26
Appendices	27
<i>Report 2: Evaluation of an Early Intervention Group Program for Children with Developmental Delays</i>	31
Index of Contents	32
List of Figures	33
List of Appendices	34

Abstract	35
Introduction	36
Method	41
Results	45
Discussion	48
References	55
Appendix	57
<i>Report 3: Behavioural Treatment of Sleep Problems for a Child with an Intellectual Disability: A Case Study</i>	59
Index of Contents	60
List of Tables	61
List of Figures	62
List of Appendices	63
Abstract	64
Introduction	65
Method	71
Results	76
Discussion	78
References	83
Appendices	86
<i>Report 4: Professional and Ethical Issues in the Practice of Clinical Psychology</i>	89
Index of Contents	90

Abstract	91
Ethical Issues	92
Professional Issues	101
Summary and Conclusions	106
References	108

STATEMENT OF AUTHORSHIP

Except where explicit reference is made in the text of the portfolio, this portfolio contains no material published elsewhere or extracted in whole or in part from a thesis/portfolio by which I have qualified for or been awarded another degree or diploma. No other person's work has been relied upon or used without due acknowledgement in the main text and bibliography of the portfolio.

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PREAMBLE

The professional doctorate in psychology (clinical) is a program which has been developed to provide training in research and professional practice of clinical psychology. The program provides theoretical knowledge and practical experience in the assessment, diagnosis, and treatment of children, adolescents, and adults with psychological disorders through coursework, clinical practicum, practicum research projects, and a major dissertation component. Presented in this portfolio are research projects completed whilst undertaking clinical practicum. The first details an evaluation of a community psychology service; the second evaluates a developmental group provided by an early intervention service for children with developmental delays; and the third evaluates a behavioural intervention for a child with an intellectual disability demonstrating sleeping problems. Finally, a report addressing professional and ethical issues encountered whilst undertaking clinical practicum as a psychology doctoral student is presented.

Placement Report 1

Assessing Client Satisfaction and Perceptions of Treatment

Outcomes in a Community Psychology Service

Acknowledgements: Pomegranate House Community Psychology Services

TABLE OF CONTENTS

	Page
Index of Contents	2
List of Tables	3
List of Figures	4
List of Appendices	5
Abstract	6
Introduction	7
Method	9
Participants	9
Materials	10
Procedure	11
Results	12
Reasons for Seeking Treatment	12
Client Change Following Treatment	12
Ratings of Therapist	13
Ratings of Overall Service Experience	16
Reasons for Leaving Service	17
Comments about the Service	19
Discussion	20
Summary and Interpretation of Findings	20
Methodological Limitations	23
Conclusions and Recommendations	24
References	26
Appendices	27

LIST OF TABLES

Table	Title	Page
1.	Clients' Reasons for Seeking Treatment	12
2.	Means and Standard Deviations for Level of Distress, Worry, or Unhappiness Before and After Treatment	13
3.	Reasons Endorsed by Clients for Leaving Service	18

LIST OF FIGURES

Figure	Title	Page
1.	Participant ratings of satisfaction with therapist's treatment of problem.	14
2.	Participant ratings of therapist skills, knowledge, and competency.	15
3.	Participant ratings of therapist care, understanding, and compassion.	16
4.	Participant ratings of overall service experience.	17

LIST OF APPENDICES

Appendix	Title	Page
A.	Service Evaluation Questionnaire	27
B.	Letter to Past Clients	30

Abstract

This evaluation aimed to examine client satisfaction and perceptions of treatment from a community psychology service. Eighteen former clients who had accessed the service in the last 12 months completed a service evaluation questionnaire. Findings indicated that the majority of these past clients sought treatment for depression and/or anxiety, and that they perceived improvement in their symptoms following treatment. Approximately half of respondents were satisfied with the treatment they received, with 60% rating the overall service experience as having been worthwhile. Qualitative feedback from past clients highlighted the therapeutic relationship and practical considerations (e.g., affordability, short waiting list) as positive aspects of the service. Areas of dissatisfaction identified by clients included the type of treatment they received, changes in therapist, and age of therapist. Recommendations for future service provision are made in the context of these findings.

Assessing Client Satisfaction and Perceptions of Treatment Outcomes in a Community Psychology Service

To ensure high standards of psychological service provision are achieved and maintained, ongoing service evaluation is critical (Macran, Ross, Hardy, & Shapiro, 1999). As part of this evaluative process, it is becoming increasingly recognised that the perceptions of service users should be considered (Donabedian, 1992; Graham, Denoual, & Cairns, 2005; Macran et al., 1999; Stallard, 1996). Past views that clients had neither the insight nor the skills to assess therapeutic progress have been challenged (Macran et al., 1999), and it is now widely accepted that evaluation of psychological service delivery would be incomplete without the inclusion of clients' perspectives (Donabedian, 1992; Fischer, 2004; Mowbray, Bybee, & Collins, 2001).

Clients are no longer viewed as passive recipients in the therapeutic process, but rather as active participants who bring to therapy their own needs, wants, and expectations (Donabedian, 1992; Macran et al., 1999). As such, the perceptions of clients can significantly influence the outcomes and ultimately the success of therapy, making the views of clients equally important to those of the clinician in evaluating service provision (Fischer, 2004; Macran et al., 1999). In particular, clients' satisfaction with the treatment they receive is regarded as a key indicator in the evaluative process (Graham et al., 2005; Mowbray et al., 2001; Stallard, 1996).

Consumer satisfaction has been defined as "the extent to which service gratifies the wants, wishes, or desires for treatment" (Lebow, 1983, p. 730), and takes into account all aspects of service delivery including adequacy of treatment, cost, continuity, availability, accessibility, and satisfaction with process and outcomes. Stallard (1996) identified three important aspects of consumer satisfaction relating to

psychological service provision. Firstly, client satisfaction is a key objective of treatment. That is, a fundamental goal of any service encounter is for the client to feel satisfied, without which, it is unlikely treatment will continue or be successful (Macran et al., 1999; Stallard, 1996). Secondly, consumer satisfaction is a useful index of treatment outcome, and has been linked to client perceptions of improvement, effectiveness, and compliance with treatment (Donabedian, 1992; Fischer, 2004; Stallard, 1996). Finally, consumer satisfaction is important to quality assurance and service improvement, as it provides a means of assessing and monitoring service provision over time (Stallard, 1996).

For example, Stallard (2001) assessed parental satisfaction with services provided within a community child and adolescent psychology service. Parents who had finished contact with the service were sampled from cohorts in 1993 ($n = 65$), 1995 ($n = 73$), and 1997 ($n = 55$). These families were mailed the Parent Satisfaction Questionnaire approximately four weeks after their last contact with the service, and nonrespondents were followed up by the researcher to ensure questionnaires were completed. Findings demonstrated high levels of dissatisfaction, which resulted in quality improvement targets being implemented. Over time, these levels of dissatisfaction were shown to decrease. Whilst the study design was limited in that decreases in dissatisfaction could not be directly attributed to the changes implemented, it nevertheless reinforces the important role that consumer feedback can play in monitoring and ensuring quality mental health service provision.

Despite the benefits evaluation of consumer satisfaction holds in informing future practice and service provision, client feedback is not often utilised in the clinical setting (Graham et al., 2005). To address this concern, the purpose of the present study was to evaluate client perceptions of service provision from a local

community psychology service, Pomegranate House. Pomegranate House provides psychology/psychotherapy services to marginalised and financially disadvantaged people experiencing non-acute mental health issues and/or diagnosed psychiatric disorders. The primary therapeutic approach employed at Pomegranate House is psychodynamic psychotherapy, with services delivered by psychologists, psychotherapists, and postgraduate psychology and counselling students undertaking clinical placements. The current evaluation follows on from a previous evaluation of the service, with the present evaluation reviewing service provision from August 2005 to August 2006.

Specifically, aims of the present evaluation were to examine client satisfaction with treatment by their therapist as well as satisfaction with the service experience overall. Also, the present evaluation aimed to examine client feedback regarding reasons for attending the service, perceptions of change following treatment from the service, and reasons for leaving the service. Finally, the evaluation sought to obtain qualitative feedback from clients regarding positive and negative aspects of their experience at Pomegranate House, with the view to making recommendations for improving future service provision.

Method

Participants

A total of 87 questionnaires were distributed to past clients of Pomegranate House who had ceased service provision within the past 12 months. Only those clients who had ceased service provision within the past 12 months were selected, as previous clients had been surveyed in an earlier evaluation. Questionnaires were distributed to adult clients of the service, with child clients and their families being

excluded from the evaluation. In order to preserve anonymity, demographic information was not sought from respondents. Those clients sampled, however, included both males and females over the age of 18 years, from various referral sources (e.g., general practitioners, other health care providers, self-referrals). Of the 87 questionnaires distributed only 19 were returned, resulting in a response rate of 22%. One questionnaire was excluded from analyses due to missing responses, resulting in a total sample size of 18.

Materials

A self-report questionnaire (Appendix A) was designed for the purposes of the present evaluation, based on an adaptation of an existing questionnaire used in the previous evaluation of the service. Changes to the existing questionnaire were made through consultation with Pomegranate House staff to ensure their needs regarding client feedback were met. The questionnaire is not empirically validated and no psychometric data is available for the present or previous evaluation questionnaire.

The feedback questionnaire consisted of both quantitative and qualitative items addressing client satisfaction with the service. Items 1 and 2 addressed amount of service use and reasons for seeking treatment from the service. Items 3 and 4 assessed self-reported changes in client symptomatology following treatment. These items required clients to rate their level of distress, worry, and unhappiness before and after seeking treatment on a 5-point Likert scale ranging from *none at all* to *a great deal*. Items 5 to 7 assessed clients' perceptions of their therapist. Clients were asked to respond on a 5-point Likert scale ranging from *completely dissatisfied* to *completely satisfied* regarding satisfaction with treatment provided by therapist. They were also asked to rate therapist skill level, and level of care, understanding, and compassion of

therapist on a 5-point scale ranging from *very low* to *very high*. Item 8 asked clients to select from 10 available options regarding reasons for which they ceased service use. Options listed included “my psychologist and I agreed I did not need to come anymore”, “I felt better”, and “I had issues with my therapist”. The final quantitative item asked clients to rate overall, whether they believed accessing the service had been worthwhile. Clients were required to respond to this item on a 5-point Likert scale ranging from *definitely not* to *certainly*.

The final three items on the questionnaire sought qualitative responses from clients regarding their experiences at Pomegranate House. These included those aspects of the experience that they found useful, and those aspects they felt could be improved. Clients were also invited to make additional comments or suggestions for service provision.

Procedure

A list of clients who had accessed the service over the past 12 months, but were no longer “active” was obtained through computer records. From this list, intake forms completed by clients on their initial visit were searched to determine whether clients had consented to future contact for evaluative purposes. All intake forms contained an item asking clients whether they would consent to follow-up and those clients who had provided written consent were then sent a questionnaire package. Contained in the package was a letter inviting clients’ participation (Appendix B), the feedback questionnaire, and a stamped, self-addressed envelope. Clients were asked to complete the questionnaire and return it to Pomegranate House in the envelope provided.

Results

Reason for Seeking Treatment

Participants' primary reasons for seeking treatment from Pomegranate House are presented in Table 1.

Table 1

Clients' Reasons for Seeking Treatment

Reason	N	Percentage
Depression	8	44.4%
Depression and Anxiety	6	33.3%
Other	4	22.2%

Results showed that the most common reason for seeking treatment was depression, with 44.4% of clients listing depression as being their main reason for seeking help. The second most common reason for seeking treatment was co-existing depression and anxiety, as rated by 33.3% of respondents. Responses of the four remaining clients were categorised as 'other'. These responses included "to be normal", "low self-esteem", "to sort out where I was at", and "to overcome issues".

Client Change Following Treatment

Client self-ratings of distress, worry, or unhappiness prior to therapy and since completing therapy were used to assess treatment change. Ratings were made on a 5-point Likert scale ranging from 1 (*none at all*) to 5 (*a great deal*). Means and standard deviations for client ratings are presented in Table 2.

Table 2

Means and Standard Deviations for Level of Distress, Worry, or Unhappiness Before and After Treatment

	<i>N</i>	<i>M</i>	<i>SD</i>
Distress Before Treatment	18	4.67	.49
Distress After Treatment	18	3.17	1.10

The mean level of self-rated distress before treatment was 4.67, compared to 3.17 after completing treatment. Due to violation of the assumption of normality, nonparametric analysis was employed. Results from the Wilcoxon sign-rank test showed that clients' perceived level of distress, worry, or unhappiness after therapy was significantly lower than their perceived level of distress, worry, or unhappiness prior to treatment, $Z = -3.25$, $p < .001$.

Ratings of Therapist

Satisfaction with therapist's treatment of problem. Participants' ratings of satisfaction with their therapist's treatment of their problem ranged from 1 (*completely dissatisfied*) to 5 (*completely satisfied*), with a mean of 3.44 ($SD = .97$). Clients' satisfaction ratings are presented in Figure 1.

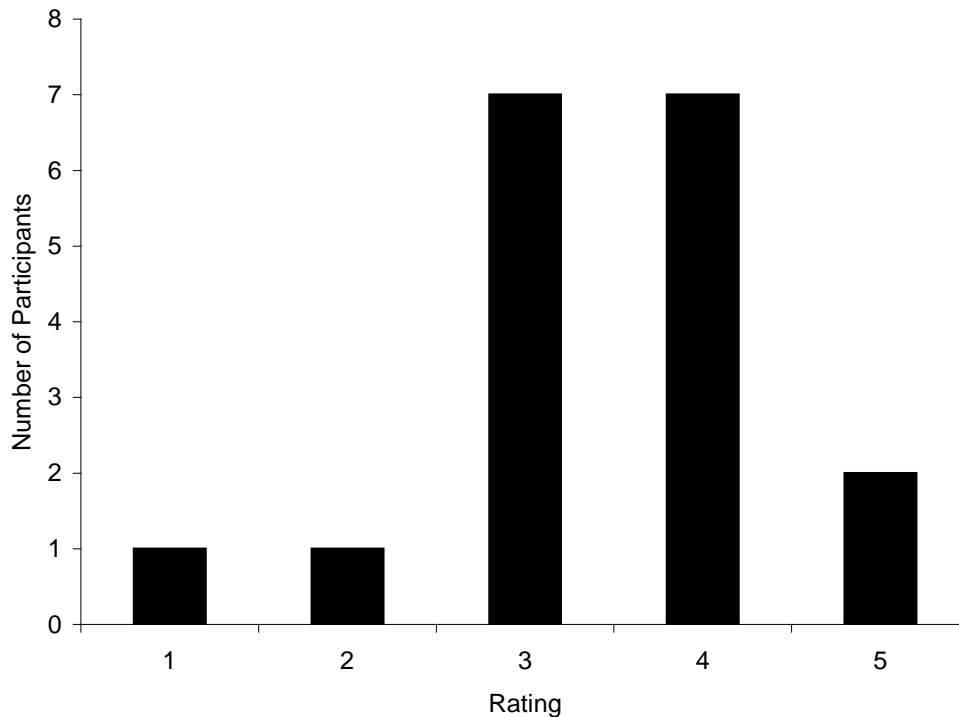


Figure 1. Participant ratings of satisfaction with therapist’s treatment of problem.

As can be seen in Figure 1, 9 of the 18 participants provided a rating of 4 or 5. These results indicate that 50% of respondents were satisfied with their therapist’s treatment of their problem. A further 7 respondents reported that they were neither satisfied nor dissatisfied with their treatment, whilst the remaining 2 were dissatisfied to some extent.

Perceived levels of therapist skill, knowledge, and competence. Participants’ ratings of their therapist’s level of skills, knowledge, and competency ranged from 1 (*very low*) to 5 (*very high*), with a mean of 3.44 ($SD = 1.32$). Clients’ ratings of therapist skills, knowledge, and competency are presented in Figure 2.

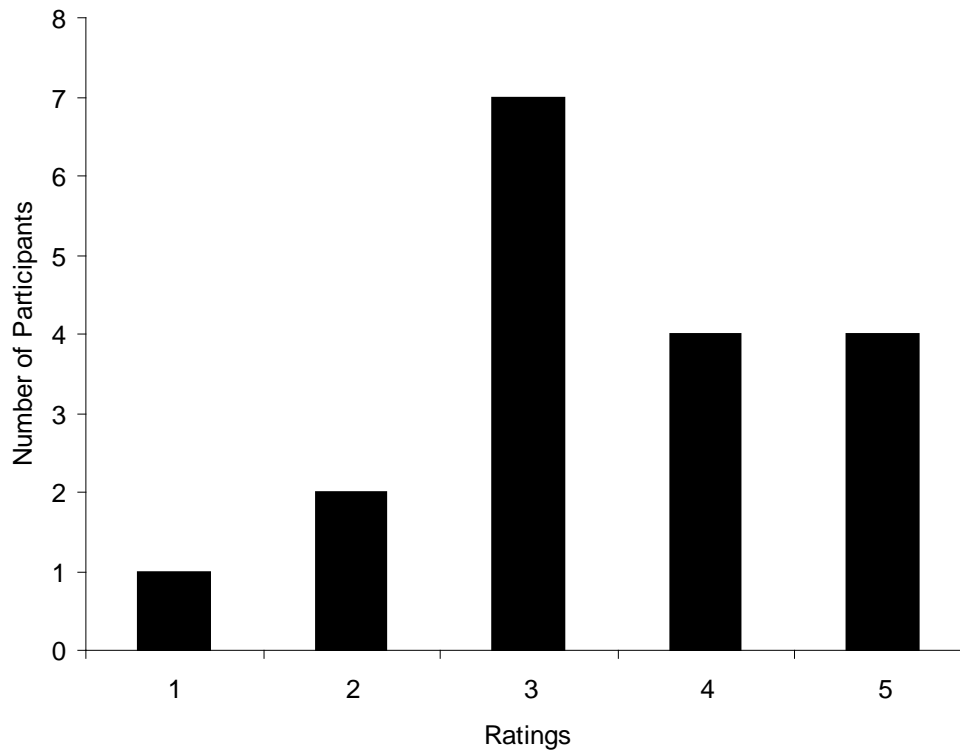


Figure 2. Participant ratings of therapist skills, knowledge, and competency.

As can be seen in Figure 2, 8 of the 18 participants provided a rating of 4 or 5. These results indicate that 44.4% of respondents viewed their therapist's knowledge, skills, and competency as being high to very high. A further 7 respondents reported that they were unsure about their therapist's level of knowledge, skill, and competency, whilst the remaining 3 perceived their therapist's level of knowledge, skill, and competence as being low to very low.

Perceived levels of therapist care, understanding, and compassion.

Participants' ratings of their therapist's level of care, understanding, and compassion ranged from 1 (*very low*) to 5 (*very high*), with a mean of 4.06 ($SD = 1.35$). Clients' ratings of therapist care, understanding, and compassion are presented in Figure 3.

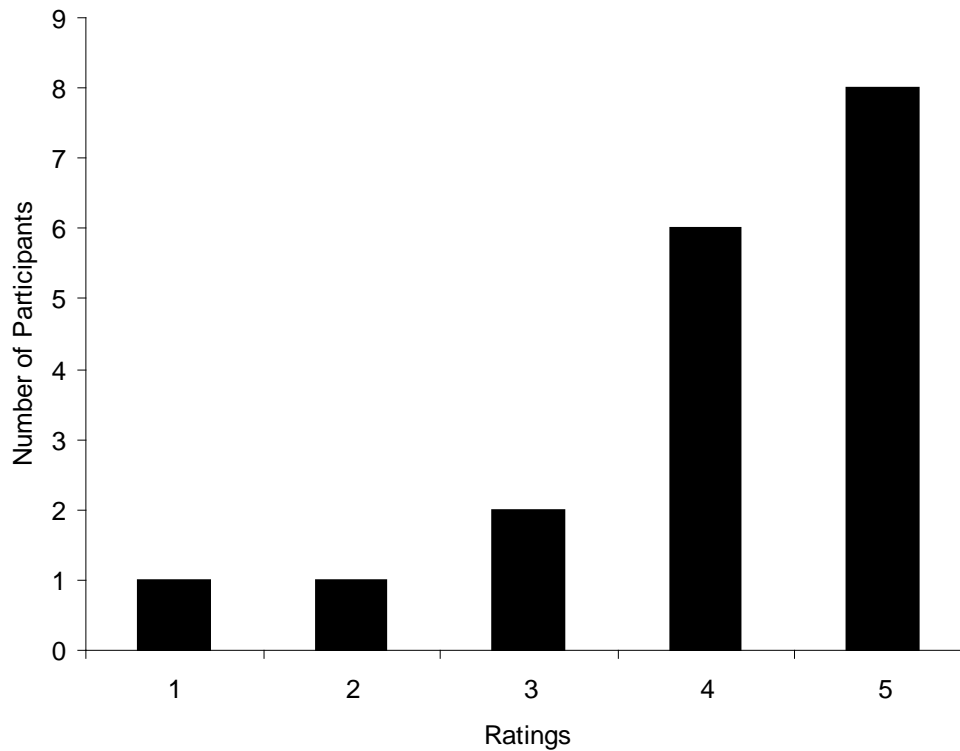


Figure 3. Participant ratings of therapist care, understanding, and compassion.

As can be seen in Figure 3, 14 of the 18 participants provided a rating of 4 or 5. These results indicate that 77.7% of respondents viewed their therapist's level of care, understanding, and compassion as being high to very high. A further 2 respondents reported that they were unsure about their therapist's level of care, understanding, and compassion, whilst the remaining 2 perceived their therapist's level of care, understanding, and compassion as being low to very low.

Ratings of Overall Service Experience

Participants were asked to rate whether they viewed coming to Pomegranate House as having been an overall worthwhile experience. Responses ranged from 1 (*definitely not*) to 5 (*certainly*), with a mean of 3.67 ($SD = 1.19$). Participants' ratings of their overall experience at Pomegranate House are presented in Figure 4.

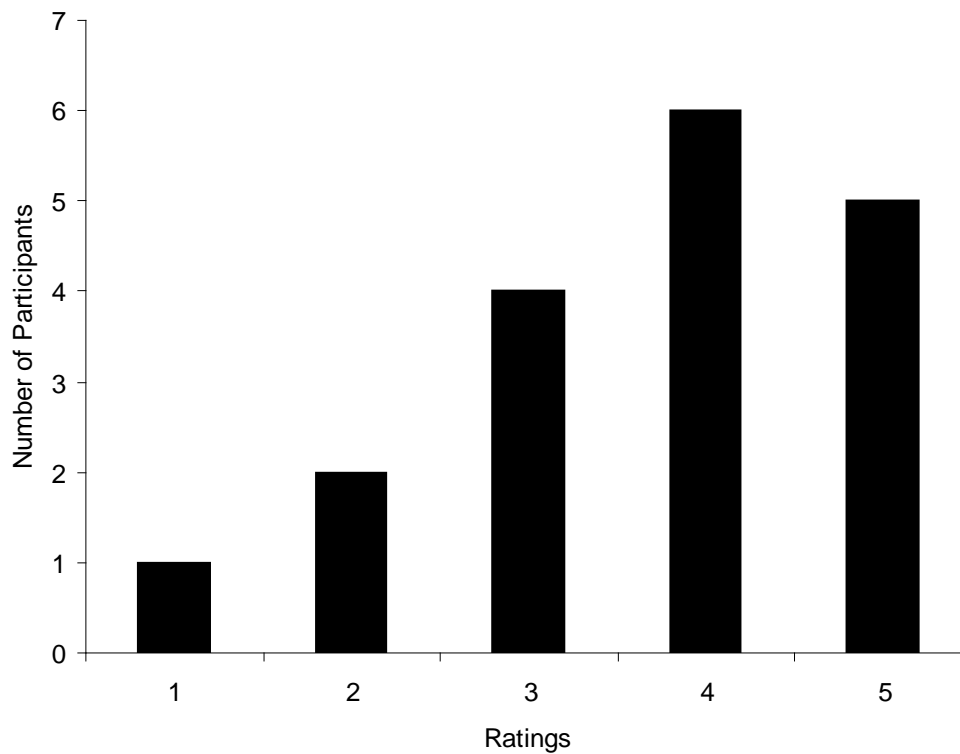


Figure 4. Participant ratings of overall service experience.

As can be seen in Figure 4, 11 of the 18 participants provided a rating of 4 or 5. These results indicate that overall, 61.1% of respondents viewed attending Pomegranate House as having been worthwhile. A further 4 participants indicated *perhaps* it had been worthwhile, whilst the remaining 3 participants did not view attending Pomegranate House as having been a worthwhile experience.

Reasons for Leaving Service

Participants were asked to select the reason(s) they ceased attending Pomegranate House from a list of 10 options. The reasons endorsed by clients for leaving Pomegranate House are presented in Table 3.

Table 3

Reasons Endorsed by Clients for Leaving Service

Reason	N	Percentage
I felt better	2	11.1%
Joint decision between client and therapist	6	33.3%
Found help elsewhere	2	11.1%
Not getting better	5	27.8%
Getting worse	1	5.6%
Issues with therapist	3	16.7%
Issues with treatment	3	16.7%
Too busy	3	16.7%
Too expensive	4	22.2%
Other	4	22.2%

The most common reason indicated by clients for leaving the service was a joint decision between the client and therapist, with approximately one third of clients citing this reason. This was closely followed by 27.8% of clients who reported that they did not feel they were getting better, whilst 22.2% cited the cost of attending Pomegranate House (i.e., too expensive) and other reasons for leaving the service. Those respondents citing other reasons included departure of therapist from service, and no rapport with therapist. One client indicated that they left the service as they felt they were getting worse.

Comments about the Service

Clients were asked to provide qualitative feedback regarding those aspects of the service that they found useful, and also suggestions for how the service could be improved/what would have made the experience more useful to them. Overall, the majority of comments were positive, with many providing thanks and praise to the service.

What did you find most useful about your experience at Pomegranate House?

A common theme among responses relating to useful aspects of the service was that clients benefited from the opportunity to talk about their problems without feeling that they were being judged. Examples included “it was terrific to talk to someone who did not judge you”, and “I felt I needed to unload a heavy burden and not be judged. I found that at Pomegranate House”. Clients also reported that feeling understood and having their feelings validated were an important part of their experience. For example, “I was reminded by my therapist that I was important...my feelings were valid”, and “the therapist took time to empathise with me”.

Having a relaxed and safe environment was another positive aspect of Pomegranate House expressed by clients. Examples included, “safe and caring environment”, “feeling relaxed and comfortable”, “a sense of security”, and “I felt relaxed and comfortable in my therapist’s room”. Other positive comments about the service included that it was affordable, and that one client was able to make an appointment immediately without having to wait. One client reported that they found “nothing” useful about the service.

What would have made the experience more useful? What would you have like done differently? The most common theme emerging in relation to how the service could have been more useful to clients was the view that therapists should have taken

a more active and directive role during sessions. Clients often requested a need for guidance, strategies, and feedback rather than just being listened to. For example, “I asked many times for ways/ideas for coping and was given none”, “more problem solving interaction”, “I could have been given more guidance to help towards making myself feel better”. Other clients reported feeling uncomfortable with the way the therapist interacted with them, such as “my therapist was too much of a therapist by saying ‘and how does that make you feel?’ I felt like I was in a movie”, and “I felt she mainly listened and didn’t speak...which is uneasy”.

One client reported a change in therapist as being a negative experience stating “I needed continuity and the belief someone would stay with me”, whilst another reported that they would have preferred a therapist closer to their own age writing, “I would have found it easier talking to a more mature age person”. One respondent stated that they felt their therapist did not listen and often confused names, including the client’s own.

Discussion

Summary and Interpretation of Findings

The purpose of the present evaluation was to examine client feedback regarding services provided by Pomegranate House. By assessing client perceptions of the service, this study aimed to identify positive aspects of the service and address gaps in service delivery and areas in need of improvement.

Findings from client feedback questionnaires indicated that the majority of respondents sought help from Pomegranate House for treatment of depression and/or anxiety. This suggests that individuals experiencing these types of symptoms

represent a key client group for Pomegranate House, and may be an important consideration in planning future service provision.

In regard to treatment change, clients' self-ratings of distress, worry, or unhappiness after therapy differed significantly from ratings of perceived distress, worry, or unhappiness prior to therapy. This indicated that clients' perceived significant improvement in symptoms after having sought help from Pomegranate House; however, this finding must be interpreted cautiously due to methodological limitations.

With regards to respondents' perceptions of their therapists, approximately half of respondents were satisfied with their therapist's treatment of their problem and believed their therapist's level of knowledge, skill, and competency to be of a high to very high level. In contrast, almost eighty percent of respondents viewed their therapist's level of care, understanding, and compassion to be of a high to very high quality. These findings indicate that whilst clients viewed their therapists as being caring and compassionate, this did not necessarily translate into satisfaction with the treatment they received or perceptions of therapist's knowledge and skills as being highly regarded.

Overall ratings of the service experience indicated that sixty percent of participants viewed attending Pomegranate House as having been worthwhile. Whilst this finding showed that the majority of clients saw their experience at Pomegranate House as having been beneficial, a significant portion of clients were either unsure of whether their experience had been worthwhile, or did not view attending Pomegranate House as having been useful. Further to this, findings regarding the reasons clients ceased service use indicated that in most cases the decision to cease therapy had been jointly made between themselves and their therapist. However, of almost equal

importance was a perception held by clients that they were not improving. These findings may be indicative of a split between those clients who viewed their treatment as having been a positive experience and therefore ended it on mutual terms, and those who viewed the experience negatively and ceased treatment as they did not find it beneficial.

In regards to qualitative feedback provided by respondents, most responses were positive. Aspects of the service that were identified by respondents as having been useful centred around the nature of the therapeutic relationship. Being given the opportunity to talk about their problems to an understanding, non-judgemental person in a safe environment was important for clients. This is consistent with the earlier finding that a majority of clients saw their therapist as being caring, understanding, and compassionate. Secondary to this theme were more practical aspects of the service such as affordability and a short waiting period.

The major areas of service delivery that clients highlighted as needing improvement related to the type of treatment they received. Many respondents indicated a desire for a more proactive approach, such as the therapist providing guidance or strategies to help them cope with their difficulties. This finding is consistent with earlier findings relating to therapist treatment and skill levels, and may reflect a mismatch between clients' expectations of treatment and the nature of services provided by Pomegranate House. This finding is particularly concerning given the impact that this may have on the development of a strong therapeutic alliance. Recent research indicates that congruence between clients' treatment preference and the type of treatment they receive influences the development of a therapeutic alliance (Iacoviello, McCarthy, & Barrett, 2007). Given that the quality of the therapeutic alliance is a robust predictor of therapeutic outcome, a discrepancy

between the type of treatment clients expect and the type they receive could impact on the formation of this alliance, and ultimately treatment satisfaction and outcomes (Iacoviello et al., 2007).

Other areas of dissatisfaction included change in therapist and the age of therapist. Whilst these types of difficulties are generally considered unavoidable in any service delivery, in the case of change in therapist there is evidence to suggest that this does not impact on progress or outcome in the longer term (Flowers & Booraem, 1995).

Methodological Limitations

Findings from this evaluation must be interpreted cautiously due to a number of methodological limitations. In relation to the questionnaire used, this was designed specifically for the present evaluation and as such, no information was obtained regarding its psychometric properties. Furthermore, changes made to the questionnaire meant that comparisons could not be made with results from past evaluations. In future evaluations, it is recommended that a standardised questionnaire be employed to improve validity. By employing a consistent, standardised questionnaire this would also allow comparisons to be made across evaluations and thus enable an ongoing evaluative process of service delivery (Graham et al., 2005; Stallard, 1996).

The sampling procedure, poor response rate, and subsequently small sample size obtained in this evaluation also raise significant concerns regarding the generalisability of the findings. The sampling procedure used in the current evaluation was subject to a self-selecting bias, and it is possible that differences in perceptions of service delivery exist between respondents and nonrespondents (Lebow, 1983;

Stallard, 1996). The small sample size obtained in the current evaluation limited the types of statistical analyses that could be employed, and due to the lack of representativeness of the sample, also limits the conclusions that could be drawn from the study findings. Given these methodological limitations, future evaluations would benefit from considering alternative methods of assessing clients' perceptions of service delivery (e.g., interviews, focus groups) in addition to self-report questionnaires, in an attempt to minimise biases in responding and improve sample size (Stallard, 1996). Furthermore, if self-report questionnaires are used researchers should actively follow up with nonrespondents to obtain a more balanced picture of clients' perceptions (Stallard, 1996).

Conclusions and Recommendations

Key findings from the current evaluation indicated that the majority of past clients viewed their experience at Pomegranate House as having been worthwhile. In particular, being given the opportunity to talk about their problems to a non-judgemental, understanding, caring, and compassionate therapist was important to clients and highlights a valuable aspect of the service provided by Pomegranate House.

With regards to gaps in service delivery, for some clients there appeared to be a mismatch between their expectations of therapy and the type of treatment they received. In particular, some clients were seeking more proactive strategies to help them manage their difficulties and were disappointed that this was not provided. To address this gap in future service provision, Pomegranate House could provide clients with education relating to the type of treatment they offer so that clients are better informed about what to expect from the service. Also, in order to meet the needs of a

variety of clients it would be worthwhile considering integrating other therapeutic techniques (e.g., cognitive behavioural therapy) into practice, given the predominant psychodynamic orientation of service provision at Pomegranate House.

There are a number of methodological limitations in the present study that have been highlighted for consideration in future evaluations. In particular, careful thought should be given to the means by which feedback is obtained, especially in the case of self-report questionnaires. The present evaluation demonstrates the valuable contribution that evaluation of consumer satisfaction can have in informing future practice and service provision. For this reason, ongoing service evaluation is recommended to ensure that high standards of service provision at Pomegranate House are achieved and maintained.

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Appendix A

Service Evaluation Questionnaire

POMEGRANATE HOUSE
Evaluation Survey

What do you think of us?

The feedback you can provide about our service is very important. It helps us to know what we are doing well and tells us where we need to improve. We would appreciate it very much if you could take the time to fill out our survey. Anything you write will be anonymous.

1. How many sessions did you attend at Pomegranate House (*please tick*)?

- 1-2
 3-5
 5-10
 10-15
 15-20
 more than 20

2. What was the main reason you sought treatment?

.....

.....

.....

3. **Prior to therapy**, how much distress, worry, or unhappiness was that problem or issue causing you (*please circle*)?

None at all	A little bit	Moderate	Quite a bit	A great deal
1	2	3	4	5

4. **Since completing therapy**, how much distress, worry, or unhappiness has that problem or issue caused you (*please circle*)?

None at all	A little bit	Moderate	Quite a bit	A great deal
1	2	3	4	5

5. As a result of coming to therapy, do you feel that you are managing differently (*please circle*)?

Definitely Not		Perhaps		Certainly
1	2	3	4	5

6. How satisfied were you with your therapist's treatment of your problem (*please circle*)?

Completely dissatisfied			Neither		Completely satisfied
1	2	3	4	5	

7. How would you rate your therapist's level of skills, knowledge, and competence in the treatment of your problem (*please circle*)?

Very Low		Unsure		Very High
1	2	3	4	5

8. How would you rate your therapist's level of care, understanding, and compassion in the treatment of your problem (*please circle*)?

Very Low		Unsure		Very High
1	2	3	4	5

9. Why did you decide to stop coming to Pomegranate House (*please tick boxes that apply to you*)?

- I felt better.
- My psychologist and I agreed I did not need to come any more.
- I found help elsewhere.
- I felt I was not getting better.
- I felt I was getting worse.
- I had issues with my therapist.
- I had issues with the type of treatment I was receiving.
- I was too busy to come.
- I could not afford to keep coming/cost of therapy was too expensive.
- Other.....

10. Overall, do you think that coming here has been worthwhile (*please circle*)?

Definitely not		Perhaps		Certainly
1	2	3	4	5

11. What did you find most useful about your experience at Pomegranate House
(please comment)?

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12. What would have made the experience more useful. What would you have liked
done differently (please comment)?

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13. Are there any additional comments or suggestions you have for our service?

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**Thank you for taking the time to complete the survey.
Please return the survey using the envelope provided.**

Appendix B

Letter to Past Clients

26th July 2006

Dear Past Client,

Pomegranate House is currently undertaking an evaluation of the service, and we are asking past clients of the service for their feedback. Any feedback you can provide about the service is very important in helping us know what we are doing well and where we need to improve. We would appreciate it if you could take the time to fill out the enclosed survey.

Your involvement in this survey is completely voluntary. If you agree to participate, the survey should take no more than ten minutes to complete. You may omit any question you prefer not to answer. Any information you provide is anonymous and considered confidential.

If you chose to participate in evaluating our service, please return the completed questionnaire using the reply paid envelope provided. If after receiving this letter, you have any questions or would like additional information, please feel free to contact us on 5320 2260.

Yours Sincerely,

Rachel Jamieson
Probationary Psychologist
Pomegranate House

Placement Report 2

Evaluation of an Early Intervention Group Program for Children with Developmental Delays

Acknowledgements: Pinarc Support Services

TABLE OF CONTENTS

	Page
Index of Contents	32
List of Figures	33
List of Appendices	34
Abstract	35
Introduction	36
Method	41
Participants	41
Materials	42
Procedure	43
Results	45
Pre and Post Comparisons on Screening Measure	45
Parent Evaluations	46
Discussion	48
Summary and Interpretation of Findings	48
Methodological Limitations	51
Conclusions and Recommendations	53
References	55
Appendix	57

LIST OF FIGURES

Figure	Title	Page
1.	Total scores on Brigance Preschool Screen for each child pre and post participation in developmental group.	45
2.	Parent ratings of children's social, fine motor, gross motor, and cognitive skills following participation in developmental group.	47

LIST OF APPENDICES

Appendix	Page
Developmental Group Parent Evaluation Form	57

Abstract

This evaluation aimed to examine the effectiveness of an early intervention group for children with developmental delays. Seven children (aged 3:2 to 4:7 years) identified as having a developmental delay and their parents participated in the group. The Brigance Preschool Screen was used to assess developmental skills before and after participation in the group. Parents also completed an evaluation questionnaire assessing their perceptions of the group. Results regarding changes in developmental skills of children following participation in the group were inconclusive. However, findings regarding parental perceptions and overall satisfaction with the group were positive. All parents reported that they felt their child benefited from participating in the group and rated skills across social, fine motor, and cognitive domains as having improved following the group. Recommendations for the planning and evaluation of future developmental groups are considered.

Evaluation of an Early Intervention Group Program for Children with Developmental Delays

Early childhood is considered a critical time for developmental progress, which is characterised by broad variation in the rates, timing, and patterns of skill development. Whilst these patterns vary, a general order in the progression of these skills, or milestones, is recognised (The National Joint Committee on Learning Disabilities [NJCLD], 2007; Reddihough, Marraffa, Rowell, Carne, & Ferguson, 2008). For some children, the acquisition of such skills and abilities may be different or delayed in comparison to other children. These delays may be transient and resolve through the course of development; however, for other children such delays will persist and present ongoing challenges in their developmental functioning (NJCLD, 2007; Reddihough et al., 2008).

Developmental delays can present in one or more areas including speech and language, cognition, motor skills (fine and gross), social, and emotional development (Hamilton, Goodway, & Haubenstricker, 1999; Reddihough et al., 2008). Furthermore, certain biological and environmental factors have been identified which place children at a particularly high risk of developmental delay. In terms of biological factors, these include low birth weight/preterm birth, genetic conditions (e.g., Down's Syndrome, Fragile X), chronic illness, and otitis media (middle ear infection; Frankel & Gold, 2007; Hamilton et al., 1999; Hill, Brooks-Gunn, & Waldfogel, 2003; NJCLD, 2007), whilst poverty, parental substance abuse, parental mental health problems, single parent status, and numerous stressful life events are among the environmental factors which have been identified as placing children at risk of developmental delay (Glascoe, 2005; Guralnick, 1998; Hamilton et al., 1999;

NJCLD, 2007). Children with developmental delay are also at risk of future negative outcomes such as school failure, learning disabilities, and unemployment (Glascoe, 2005). Given the potential negative outcomes for children presenting with a developmental delay, or at risk for developmental delay, interventions targeting this developmental age group are critical.

Early intervention refers to a variety of educational, psychological, or therapeutic interventions for children presenting with, or identified as being at risk for developmental delay (White, Bush, & Casto, 1985). Whilst there is a lack of consistent agreement as to how these interventions should be delivered (Hill et al., 2003; White et al., 1985), they typically take the form of group or program-based early education, or individualised interventions delivered in the home setting. Early intervention programs typically consist of varied activities targeting a range of developmental skill areas (e.g., fine and gross motor skills, cognition, language, social, and emotional skills; Hill et al., 2003; NJCLD, 2007). The premise underlying this approach is that intervention provided during these early years of life will prevent or minimise developmental delays and subsequent manifestations of disability, thereby improving developmental outcomes and future learning opportunities (Frankel & Gold, 2007; Simeonsson, 2000).

Whilst early intervention provides promising benefits for children demonstrating developmental delay, some debate exists as to the overall efficacy of such interventions. Research to date indicates strong short-term effects for interventions delivered within the first 5 years of life. For example, in a review of the literature, White et al. (1985) reported that in 94% of past studies substantial immediate benefits of early intervention for developmentally delayed, at-risk and disadvantaged children were found in areas of cognitive, academic, social, and

attitudinal development. Similarly, a review by Guralnick (1998) concluded that early intervention programs for children at risk or with diagnosed disabilities demonstrated consistent effectiveness in reducing a decline in cognitive development (approximately 8 to 12 IQ points) that occurs in the absence of early intervention. However, in all studies reviewed by Guralnick, intellectual ability was assessed either during or shortly after the program or within the first 5 years of life, and therefore conclusions regarding long-term outcomes could not be made.

Research regarding the long-term effectiveness of early intervention have been fewer and findings less consistent. The fore-mentioned review by White et al. (1985) reported that of those past studies considering long-term effects, 41% reported that gains attributed to early intervention were maintained, 18% concluded that gains were not maintained, and 41% did not find sufficient evidence to draw any conclusions regarding long term effectiveness. More recent studies have however produced more promising findings.

For example, Smith, Groen, and Wynn (2000) examined the effectiveness of intensive early intervention for children (aged between 18 and 42 months) with a pervasive developmental disorder. Children were randomly assigned to either an intensive treatment group ($n = 15$) or a parent training group ($n = 13$). Children in the intensive treatment group received on average 24.52 hours per week of individual treatment for one year, with hours being gradually reduced over the next 1 to 2 years. In the parent training group, parents received training in using the treatment approach with their children in their own homes over a 3 to 9 month period. Children were assessed at intake and/or at follow-up (age 7 or 8 years) with a variety of standardised measures assessing intellectual functioning, language functioning, adaptive functioning, socioemotional functioning, and academic achievement, whilst class

placement, and progress in treatment were also recorded. At follow-up, results showed that children in the intensive treatment group performed significantly better than the parent training group on measures of intelligence, visual-spatial skills, language, and academic functioning, but not on adaptive functioning or behavioural problems. These findings provide some support to suggest that gains for children in the treatment group were maintained in some developmental areas at age 7 to 8 years; however, this was not systematically tested in this study.

Considering the long term effects of early intervention participation by children at risk for developmental delay, Hill et al. (2003) randomly assigned 416 children identified at birth as being premature and low birth weight (LBW) into a intensive treatment group, whilst 666 matched children receiving standard treatment served as a control condition. Children in the intensive treatment group received high-quality centre-based care throughout their second and third years of life (full-day care, 50 weeks per year). Cognitive and behavioural outcome measures were collected at 1, 2, 3, 5, and 8 years of age. At age 8, significant treatment effects were shown on overall and verbal IQ scores for children who attended more than 400 days of the intensive intervention, indicating that high levels of participation in early intervention for at risk children produce larger and longer-lasting effects. However, this study examined children identified as being at risk of cognitive delay, not those identified as having a developmental delay specifically. Also, the intensive nature of this and the previous intervention may not be realistic, practical, or affordable options for service providers (e.g., having available funding, staffing, facilities etc.) or for parents who do not want their children in full-time care.

Whilst early intervention appears to be beneficial, findings on the long-term effects of such interventions remain somewhat limited. Other aspects important to the

success of early intervention programs have, however, been considered. In particular, family/parental involvement in early interventions has been associated with increased benefits to interventions and shown to be an important component of treatment success (Frankel & Gold, 2007; Hamilton et al., 1999; Simeonsson, 2000; White et al., 1985).

Examining the effectiveness of parental involvement in motor skill development for children at risk of developmental delay or school failure, Hamilton et al. (1999) randomly assigned at risk preschool children to an experimental and control group. Children in the experimental group ($n = 15$) participated in an 8-week motor skill intervention program that consisted of 45 minute lessons delivered each week by their parents. The control group ($n = 12$) participated in a standard motor skill program, consisting of movement songs and play activities delivered by parents, but without direct instruction. The Test of Gross Motor Development (TGMD) was used to assess children's performance on five object-control skills (i.e., kicking, throwing, bouncing, striking, and catching) at pre- and post-test. Results showed that at baseline both groups performed at or below the 20th percentile on the TGMD, indicating clear motor skill delay. However, at post-test 60% of the experimental group performed at or above the 75th percentile on the TGMD, demonstrating significant gains in motor skill development following the intervention. In contrast, little or no change was found for the control group. The authors concluded that these findings provide support for the inclusion of parents in the instructional process of early intervention programs for children at risk for developmental delay.

In summary, early childhood represents a critical developmental period, where problems or delays in skill areas such as speech and language, cognition, fine and gross motor skills, social, and emotional development can have lasting negative

outcomes. As such, early interventions intending to prevent or reduce subsequent delay or disability are indicated. Whilst the immediate and short-term benefits of early interventions are well established, it is less clear as to whether these effects are lasting. One factor in particular which has been identified as being important to the success of early interventions is parental involvement. As such, the present evaluation aimed to examine the effectiveness of a developmental playgroup run through an early intervention centre for children identified as having a developmental delay or disability. It was hypothesised that the scores of children on a developmental screening tool (Brigance Preschool Screen) would increase following participation in the developmental playgroup. Given that parents also participated in the developmental playgroup, this evaluation also aimed to examine parental satisfaction and perceived benefits of the playgroup for both themselves and their child.

Method

Participants

Seven children aged from 3:2 years to 4:7 years participated in the developmental playgroup. Two of the children were female and the remaining five were male, including a set of identical male twins. Children had been referred to the early intervention service with identified developmental delay, and had been identified by staff within the service as appropriate for the developmental playgroup program. Children in this program were assigned to various groups according to ages, types of delays/disabilities, and ability to attend on particular days. Thus, the present group was aimed at 4-year-old children (with the exception of one child aged 3:2 years who could not attend on other days) preparing for entry to kindergarten, with mild developmental delays. One male child had a diagnosis of Attention-

deficit/hyperactivity disorder (ADHD); however, no other children had any formally diagnosed disabilities or disorders (e.g., Down's syndrome, autism). Mothers of four of the children who participated in the group completed the group evaluation questionnaire.

Materials

Brigance Preschool Screen. The Brigance Preschool Screen is a standardised screening tool assessing child development over a range of skill areas including fine and gross motor, language, general knowledge, preacademic, and graphomotor development. It is intended for use with children between the ages of 2:9 years through to 4:8 years, and is divided into specific three-year-old (ages 2:9 to 3:8 years) and four-year-old (3:9 to 4:8 years) versions. Both versions comprise of 11 subtests that measure knowledge of personal data (3 to 4 items), knowledge of body parts (9 items), gross motor skills (3 items), object identification (3 items), repetition of sentences (3 items), visual-motor skills (3 items), number concepts (3 items), building tower with blocks (5 items), colour matching/identification (5 items), picture vocabulary (5 to 6 items), and grammar (2 items). The Brigance has been shown to have high internal consistency, good test-retest and inter-rater reliability, and adequate construct validity (Emmons & Alfonso, 2005; Hamilton, 2006; Mantzicopoulos, 1999).

Parent evaluation form. An evaluation form (see Appendix) was developed in order to obtain feedback from parents regarding their perceptions of the developmental group. The evaluation form consisted of 14 items in total. Items 1 and 2 asked parents to indicate whether they believed the group was beneficial, and whether they believed their child enjoyed the group. Items 3 and 4 required parents to

list those aspects of the group that their child liked/disliked, and the ways in which they felt their child benefited from the group. Items 5 through 8 asked parents to rate changes in their child's skills in a range of areas (social skills, fine motor skills, gross motor skills, cognitive skills) on a 5-point Likert scale ranging from *much decreased* to *much improved*. Items 8 and 10 assessed parents' perceptions of their child's readiness for kindergarten following participation in the group, whilst item 12 asked parents to list what they had gained from the group, and item 13 asked for suggestions on how the group could be improved. The final item (i.e., would you like to attend next year?) was included to assist in planning for groups in the following year.

Procedure

Prior to commencement of the developmental playgroup, children's developmental skills were assessed using the Brigance Preschool Screen. Baseline measures were not obtained for three of the children, due to these children being admitted into the group at late notice.

The developmental playgroup was run each Monday for two hours over an 8-week period. Playgroups were conducted by a registered psychologist, a psychology doctoral student, and a teacher's assistant. At various times during the program other professionals from the early intervention service (e.g., speech pathologists, occupational therapists, physiotherapists) also attended to observe children for referral to individual therapy. At least one parent or caregiver was required to attend with their child, whilst siblings were also welcome. In some cases, the same parent attended each week, whilst others varied depending on parent availability. Similarly, sibling attendance varied depending on factors such as carer arrangements, pupil free school days etc.

The structure of the playgroup was designed to simulate a kindergarten setting, beginning with greetings and introductory mat time, following onto various structured and unstructured play activities, snack time, and finishing with mat time (reading a story, singing songs, and saying “goodbye”). Integrated into this program were tasks specifically targeting various developmental skill domains. These included fine motor skill activities (e.g., cutting, drawing, pasting, threading beads, painting, eating using utensils, drinking from a cup), gross motor skill activities (walking, climbing, managing steps, ball skills, trampoline, bicycles), cognitive and language skills (e.g., naming objects, colours, listening/looking/attending, general knowledge/learning tasks), and social skills (interactive play, sharing, taking turns, group mat time, group snack time). Parents were encouraged to assist and interact with their children on various tasks, and where required, parents were provided with guidance and assistance from staff on how to do this.

At the conclusion of the 8-week program, parents were invited to have their child reassessed on the Brigance Preschool Screen. Parents consenting for their child to be reassessed were asked to nominate a suitable time on a sign up sheet to meet with the psychology doctoral student for this assessment to take place. All parents consented, resulting in all children being assessed on the Brigance at completion of the program. Parents were also asked to complete an evaluation form for the group. Four parents completed and returned this form.

Results

Pre and Post Comparisons on Screening Measure

Total scores (out of 100) on the Brigance Preschool Screen for each child before and after participation in the developmental group are presented in Figure 1.

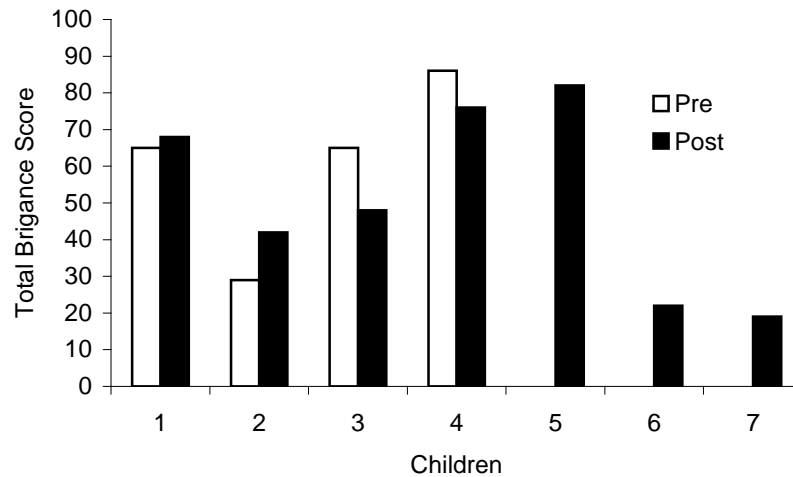


Figure 1. Total scores on Brigance Preschool Screen for each child pre and post participation in developmental group.

As can be seen in Figure 1, total scores on the Brigance Preschool Screen increased for Child 1 and 2 after participation in the developmental group, however, total scores for Child 3 and 4 decreased after taking part in the group. A paired-samples t-test examining the impact of the developmental group on these total Brigance scores was not significant, $t(3) = .41, p = .71$. Baseline scores were not obtained for Child 5, 6, or 7, and as such, pre and post comparisons could not be made for these participants.

Parent Evaluations

Perceived enjoyment and benefits of group. Parents of 4 children from the group completed the parent evaluation form. All parents indicated that they felt the developmental group was beneficial and that their child enjoyed the group. Parents listed the climbing room, small group size, playing, cut and paste/craft activities, and singing songs as among those aspects of the group that their child enjoyed. In terms of the ways in which parents perceived the group to have assisted their child, parents reported that the small group size was less intimidating and therefore enhanced their child's confidence, provided practice engaging in a group and taking turns, provided exposure to varied activities, and encouraged children to focus on tasks and develop attentional skills.

All parents indicated that they felt their child was better prepared for attending kindergarten as a result of having taken part in the developmental group. Parents reported that gaining experience in listening, order, waiting, sitting on the mat, and being in a group environment had assisted in their child's readiness for kindergarten. In terms of parental gains, parents reported that spending time with their child engaging in activities they would not often do at home, and observing their child's interaction with other children were of benefit to them as parents.

With regards to recommendations for future groups, one parent suggested including more activities that encourage interaction between children, whilst another suggested changing the layout of the climbing room to reflect an obstacle course, thereby encouraging children to participate in all tasks. No suggestions were made in the remaining two forms. Finally, all parents indicated that they would be interested in attending a developmental group with their child in the following year.

Perceived changes in areas of skill development. Parents' rated their child's social, fine motor, gross motor, and cognitive skills following participation in the developmental group ranging from 1 (*much decreased*) to 5 (*much improved*).

Parents' ratings of their child's skills in each of these areas are presented in Figure 2.

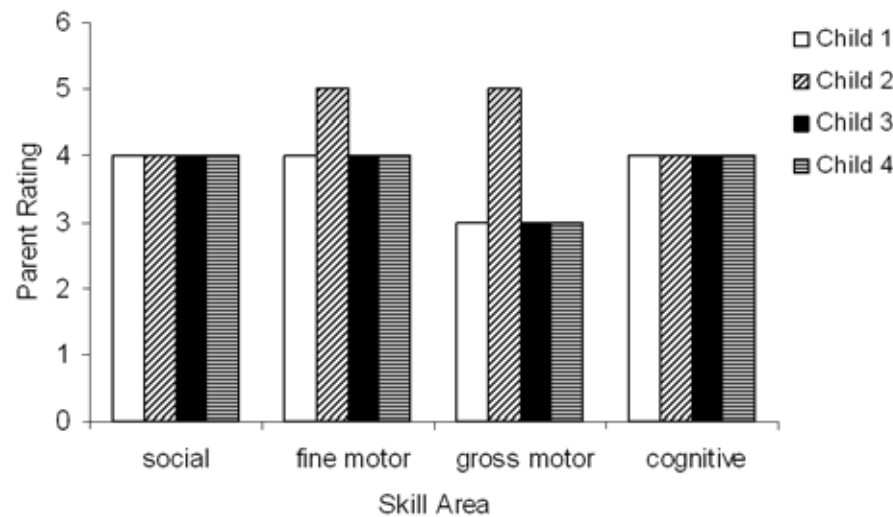


Figure 2. Parent ratings of children's social, fine motor, gross motor, and cognitive skills following participation in developmental group.

All parents rated their child's social skills as somewhat improved following participation in the developmental group. Three of the parents rated their child's fine motor skills as somewhat improved following the group, whilst one parent rated their child as much improved. In terms of gross motor skills, three of the parents rated their child's skills in this area as unchanged, whereas one parent rated their child's motor skills as much improved following the group. Finally, all parent's rated their child's cognitive skills as somewhat improved at completion of the developmental group.

Discussion

Summary and Interpretation of Findings

This evaluation aimed to examine the effectiveness of an early intervention developmental playgroup for children identified as having developmental delay. It was hypothesised that scores of children on a developmental screening tool (Brigance Preschool Screen) would increase following participation in the group; however, this was not supported by the study findings. Only two of the children who participated in the group demonstrated increases in their performance on the Brigance Preschool Screen following the group. Of particular concern was the finding that two of the children obtained lower scores on the Brigance after participating in the group, indicating that these children demonstrated greater delays in development at conclusion of the group than they did prior to the group. Unfortunately, baseline measures were not obtained for the other three children who took part in the developmental group and thus it is unclear as to how participation in the group impacted on their skill development. Also, the use of a t-test on a sample of this size would require a large effect size to produce any significant results. Based on these very limited findings, no conclusive statements can be made regarding the effectiveness of the developmental group.

A second purpose of this study was to examine parental satisfaction and perceived benefits of the developmental group for their child. Overall, parental perceptions of the developmental group were very positive. All parents reported that they felt participation in the group was beneficial to their child's development, and that their child enjoyed taking part in the group. Among the benefits identified by parents was providing children with exposure to a group environment and experience

interacting with other children, and the opportunity to participate in activities across varied skill areas.

In addition to the perceived benefits of the group to their child's development, parents also reported that they felt their child was better prepared for kindergarten as a result of having taken part in the group. Again, experience in a group environment, interacting with other children, and introducing children to some of the expectations of the kindergarten setting (e.g., listening, sitting at matt, taking turns) were identified by parents as aspects of the group that promoted their children's readiness for kindergarten. Parental satisfaction with the group was further supported by reports that all parents were interested in their child taking part in the group again in the following year.

With regards to ways in which parents felt they had gained or benefited from the group themselves, again exposure to varied activities and the opportunity to observe their children interacting with other children was seen as important. Parents reported that spending time with their child engaging in activities they would not often do at home was particularly useful. It may have been that the developmental group provided exposure to activities that parents could not provide in the home environment (e.g., lack of resources, financial constraints). Alternatively, the group may have provided parents with new ideas for activities they could engage in with their child at home to further enhance their skills and development.

Parents also provided suggestions as to how groups could be improved in the future. These suggestions focussed on extending activities already included in the group to further enhance children's skills. For example, one parent suggested having more activities to encourage interaction between children, whilst another commented on ways the climbing room could be arranged to further enhance participation. No

areas of dissatisfaction or recommendations to remove activities were made by parents, further highlighting their overall satisfaction with the group.

Finally, parents were asked to rate their child's skills across four developmental domains (social, fine motor, gross motor, and cognitive) following participation in the group. All parents rated their child's social skills and cognitive skills as somewhat improved. All parents identified their child's fine motor skills as having improved following the group, whilst one parent perceived their child's fine motor skills to be much improved. This same parent rated their child's gross motor development as much improved, whilst the remaining three parents rated their children's gross motor skills as unchanged. None of the parents perceived their child's skills to have decreased across any of the developmental skills areas.

It should be noted that whether parents perceived a change in their child's skills following the group would have been influenced by the area(s) in which the child was presenting with delay. For example, Child 2 had been referred to the group with concerns regarding motor development and thus skill development in this area was targeted in the group. However, other children were not referred with specific delays in gross motor skills, and therefore it is not unexpected that parents did not perceive changes in this area (i.e., development in this area was already age appropriate at commencement of group).

Also, parents may have had an expectation that their child would improve as a result of attending the group. This expectation may have influenced or biased parents' perceptions of changes or improvements in their child's developmental skills. That is, parents may have perceived an improvement in their child's skills as this is what they expected would be gained from the group. Equally plausible, however, is the possibility that parents noticed or were aware of more subtle changes in their child's

skills that were not detected through the use of the screening tool. For example, a parent may have observed their child's use of scissors or their ability to attend to a story to have improved, yet these specific skills are not assessed on the Brigance Preschool Screen.

Overall, findings regarding the effectiveness of the developmental group based on pre and post scores on a developmental screening tool were, at best, inconclusive. A more promising finding, however, was the overall satisfaction with the group reported by parents. Parents reported many benefits of attending the group, and all noted changes in their child's developmental skills that they attributed to attending the group. Whilst parents' perceptions of their child's improved skills may have reflected some bias, it is also possible that parents noticed developmental changes that were not measured by the Brigance Preschool Screen. Furthermore, the fact that parents perceived the group to be effective and worthwhile may be particularly important given that parental involvement has been found to be a key component to the success of early intervention programs (Frankel & Gold, 2007; Hamilton et al., 1999; Simeonsson, 2000; White et al., 1985). If parents perceive the group to be beneficial then it is likely they will also be more willing to take part in the group and be supportive of their child's participation.

Methodological Limitations

A number of methodological limitations were present in this evaluation, and as such, findings must be interpreted cautiously. First and foremost, the failure to obtain baseline measures for three of the children in the group severely limited the pre and post comparisons that could be made. In planning for future groups, adequate time should be allowed to enable baseline measures to be obtained for all children. It may

even be worthwhile to consider making pre-group assessments a mandatory requirement for inclusion in the groups. Without obtaining adequate baseline data, it is impossible to make any pre and post comparisons to establish the efficacy of the group.

On a similar note, future evaluations would benefit from the use of a control group. A number of possible factors may have impacted on children's performance on the Brigance at follow-up. For example, some children were also receiving individualised therapy (e.g., speech therapy, occupational therapy, physiotherapy) at the time of participating in the group, which either alone or in conjunction with the group may have led to improvements in various skill areas. Also, the present study does not take into account naturally occurring developmental changes. That is, given that early childhood is a time of rapid development, even those children experiencing developmental delay will make some natural progression in development and the use of a control group would assist in accounting for this.

A final limitation in terms of the design of the developmental group may have been the frequency and duration over which groups took place. Past research has suggested that intensive early intervention programs are the most effective in producing long term changes for children presenting with, or at risk of developmental delay (Hill et al., 2003; Smith et al., 2000). Given that the current group took place for two hours each week over an 8-week period, the intensity of this program may not have been sufficient to produce any significant change. Whilst a more intensive intervention may have been desirable, this was not possible or realistic in this case due to organisational constraints (e.g., budget, resources, staffing etc.).

Finally, with regards to the parent evaluations, these were limited in that only 4 were completed. It would have been preferable for all parents to complete these

evaluations in order to obtain more varied perspectives of the group. Also, the evaluation form used was designed specifically for the present study and as such, no information was obtained regarding its psychometric properties and it is not empirically validated.

Conclusions and Recommendations

Findings regarding the efficacy of the early intervention group were inconclusive. Evaluation of the effectiveness of the group was severely hampered by a lack of baseline data, and subsequently, limited pre/post comparisons could be made. Future evaluations of such groups need to ensure that baseline data is available for most if not all of participants, and this should be considered as an important component when planning for groups. Similarly, future research would benefit from the use of a control group in order to account for other factors that may influence developmental outcomes such as concomitant therapies and natural developmental progression.

Parental evaluations of the group were very positive overall. Whilst these findings were limited by the small amount of parents completing the form and the untested psychometric properties of this questionnaire, this finding is nevertheless promising given the important role that parents play in the success of early intervention programs (Frankel & Gold, 2007; Hamilton et al., 1999; Simeonsson, 2000; White et al., 1985). Future evaluations would be well advised to consider the role and views of parents in early intervention programs and consider ways in which parental participation can be supported to ensure treatment success.

Whilst methodological issues in the present evaluation limit interpretation of the findings, program evaluation remains an important consideration when planning

and conducting early intervention programs. As such, those providing early intervention services should ensure that formal evaluation processes take place, in order to be confident that programs are delivered in an effective and evidence based manner for children with developmental delays.

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Appendix

Developmental Group Parent Evaluation Form

1. Did you feel that attending the developmental group was beneficial for your child?
Yes / No
2. Did your child enjoy coming to the developmental group? Yes / No
3. What did your child enjoy/dislike about the developmental group? Please comment.

.....

4. In what ways has the developmental group assisted your child?

.....

5. How would you rate your child's *social skills* (e.g., playing with other children, sharing, taking turns, group mat time, snack time) **now**, compared to before attending the developmental group (*please circle*)?

1	2	3	4	5
<i>Much Decreased</i>	<i>Somewhat Decreased</i>	<i>Unchanged</i>	<i>Somewhat Improved</i>	<i>Much Improved</i>

6. How would you rate your child's *fine motor skills* (e.g., using scissors, pencil grip, pasting, painting, threading, hand-eye coordination) **now**, compared to before attending the developmental group (*please circle*)?

1	2	3	4	5
<i>Much Decreased</i>	<i>Somewhat Decreased</i>	<i>Unchanged</i>	<i>Somewhat Improved</i>	<i>Much Improved</i>

7. How would you rate your child's *gross motor skills* (e.g., ball skills, climbing, bike riding, walking, managing stairs) **now**, compared to before attending the developmental group (*please circle*)?

1	2	3	4	5
<i>Much Decreased</i>	<i>Somewhat Decreased</i>	<i>Unchanged</i>	<i>Somewhat Improved</i>	<i>Much Improved</i>

8. How would you rate your child's *cognitive skills* (e.g., information, naming objects, colours, expressing oneself, broad understanding of expectations) **now**, compared to before attending the developmental group (*please circle*)?

1	2	3	4	5
<i>Much</i>	<i>Somewhat</i>	<i>Unchanged</i>	<i>Somewhat</i>	<i>Much</i>
<i>Decreased</i>	<i>Decreased</i>		<i>Improved</i>	<i>Improved</i>

9. Do you feel your child is better prepared for kindergarten as a result of attending the developmental group? Yes / No

10. If so, in what ways do you feel your child is better prepared for kindergarten after attending the developmental group? Please comment.

.....
.....

11. What have you as a parent/carer gained from attending this group (e.g., what has been useful, enjoyable)?

.....
.....

12. What aspects of the group do you think could be changed/improved?

.....
.....

13. Are you interested in attending a developmental group with your child in 2006?
Yes/No

Thank-you for your time!

Please return this form in the envelope provided.

Placement Report 3

Behavioural Treatment of Sleep Problems for a Child with an Intellectual Disability: A Case Study

Acknowledgements: University of Ballarat Psychology Clinic

TABLE OF CONTENTS

	Page
Index of Contents	60
List of Tables	61
List of Figures	62
List of Appendices	63
Abstract	64
Introduction	65
Method	71
Participants	71
Materials	72
Procedure	73
Results	76
Developmental Behaviour Checklist	76
Sleep Diary	76
Discussion	78
Summary and Interpretation of Findings	78
Methodological Limitations	80
Conclusions and Recommendations	81
References	83
Appendices	86

LIST OF TABLES

Table	Title	Page
1.	Time to Bed, Time Asleep, and Time Awake in Morning during Baseline and Intervention	77

LIST OF FIGURES

Figure	Title	Page
1.	Number of night time wakings during baseline and intervention phases.	78

LIST OF APPENDICES

Appendix	Title	Page
A.	Sleep Diary	86
B.	Bedtime Routine	87
C.	Bedtime Rules	88

Abstract

This case study examined the use of a behavioural intervention in managing sleep difficulties of a 7-year-old girl with an intellectual disability. A second purpose of this case study was to explore the effects that treatment of sleep problems would have on daytime challenging behaviours. A sleep diary was provided to the child's mother to record sleeping patterns at baseline and during the intervention phase. Developmental Behaviour Checklists were also completed by the child's mother and teacher to assess challenging behaviours. Findings suggested some improvement in bedtime settling and episodes of night waking during the intervention phase; however, insufficient data were available to determine whether these trends were significant. Likewise, insufficient data were collected to make any inferences about effects of the behavioural intervention on daytime behaviour. Due to the child's mother withdrawing from the service during the intervention phase, follow up data was unable to be obtained and findings remain inconclusive. Factors likely to have impacted on the implementation of this behavioural intervention are raised for consideration in future treatment planning.

Behavioural Treatment of Sleep Problems for a Child with an Intellectual Disability:
A Case Study

Sleep problems are highly common in children with intellectual or developmental disabilities, with prevalence rates ranging from 30% to 80% reported across various studies (Bartlett, Rooney, & Spedding, 1985; Didden, Korzillius, van Aperlo, van Overloop, & de Vries, 2002; Quine, 1991; Wiggs & Stores, 1996a). Furthermore, rates of sleep problems in children with intellectual disabilities are significantly higher than those found in typically developing children (Quine, 2001; Richdale, Francis, Gavidia-Payne, & Cotton, 2000). The course is often chronic, sometimes continuing into adulthood (Richdale et al. 2000; Robinson & Richdale, 2004).

Among the most common types of sleep problems experienced by children with intellectual disabilities are difficulties initiating sleep (settling) and difficulties maintaining sleep (night waking; Durand, Gernert-Dott, & Mapstone, 1996; Quine, 1991, 2001). For example, Quine (1991) found that in a sample of 200 children with intellectual disabilities, 67% presented with night waking problems, whilst 51% experienced settling problems. Other types of sleep problems commonly experienced among children with intellectual disabilities include early morning waking, co-sleeping, teeth grinding, nightmares, night terrors, sleep talking, sleep walking, and bedwetting (Quine, 2001; Wiggs & Stores, 1996a).

Whilst sleep problems clearly affect the nature and quality of a child's sleep, sleeping disturbances among children with intellectual disabilities have also been shown to have a negative impact on family functioning and to be associated with more daytime behaviour problems in the child (Didden et al., 2002; Richdale et al.,

2000; Quine, 1991). For example, Richdale et al. (2000) examined the relationship between children's sleeping problems and parent stress and coping, and child behaviour problems among 52 children (aged 2 to 19 years) with intellectual disabilities and their families (ID group). Twenty-five typically developing children (aged 2 to 17 years) and their families served as a comparison group. Parents completed a sleep questionnaire, the Developmental Behaviour Checklist (DBC), and the Parenting Hassles Scale (PHS). Results showed that, for the ID group, having a sleep problem was significantly associated with behaviour problems, higher levels of parental stress, and greater hassle frequency and intensity in parents. Similar findings have also been reported elsewhere (e.g., Didden et al., 2002); however, these must be interpreted with some caution given that the correlational nature of this research prevents the direction of causality between child sleep problems and behaviour problems and parental factors to be established.

Given the potential negative impacts sleep problems have for children with intellectual disabilities and for their families, treatment to address sleeping difficulties is indicated. Traditionally, pharmacological approaches to treating sleep problems in children with intellectual disabilities have been common, despite limited evidence of long-term efficacy and the risk of potential side effects (Bramble, 1997; Phillips & Appleton, 2004; Wiggs & Stores, 1996a). Behavioural interventions, on the other hand, offer a safe and effective alternative to medication and are becoming increasingly recognised as a successful way to treat sleeping problems among children with intellectual disabilities (Durand et al., 1996; Schreck, 2001; Thackeray & Richdale, 2002; Weiskop, Richdale, & Matthews, 2005).

Common components of behavioural interventions for sleep difficulties in children include extinction and graduated extinction as well as the establishment of

bedtime routines (Schreck, 2001; Weiskop et al., 2005). Extinction involves the removal of reinforcement (typically attention from parents in the context of sleep problems) to decrease behaviour and has been used to address settling problems, night waking, and cosleeping (Schreck, 2001; Weiskop et al., 2005). Graduated extinction procedures are based on the same extinction principles, but reinforcement is removed gradually rather than being ceased entirely from the onset (Schreck, 2001). The approach has been argued to be less stressful and more acceptable for parents than standard extinction (Lancioni, O'Reilly, & Basili, 1999). Finally, establishing a set bedtime routine (e.g., bath, put on pyjamas, brush teeth, read story, go to bed) provides structure and predictability for children with an intellectual disability, thereby providing a cue for sleep and assisting in developing good sleep habits (Christodulu & Durand, 2004; Schreck, 2001).

In a study designed to evaluate the effectiveness of behavioural interventions in reducing the frequency of night waking and bedtime disturbances (settling difficulties), Durand et al. (1996) employed a multiple baseline across subjects design to treat four children with developmental disabilities exhibiting sleep difficulties. Two of the children (7-year-old girl and 11-year-old boy) were exhibiting frequent night waking with the remaining two (2-year-old girl and 12-year-old boy) experiencing bedtime disturbances. Interventions were tailored specifically to each child, but all included establishment of a consistent bedtime routine and the use of graduated extinction. Parents were asked to keep sleep diaries throughout their child's treatment to monitor changes. Results showed a percentage decrease in the frequency of night waking and bedtime disturbances for the children in this study; however, the sole reliance on parent reports without any objective measures of sleep quality was a limitation.

More recently, Thackeray and Richdale (2002) examined the effectiveness of a behaviour intervention program implemented by parents who had received training in the use of reinforcement, instruction giving, partner support strategies, bedtime routine, and standard extinction. Parents of three children (aged 5 to 10 years) with an intellectual disability and sleep difficulties (all children had settling difficulties, two had co-sleeping difficulties, and two had night waking difficulties) participated. A delayed multiple baseline across subjects design was employed, and treatment measures included sleep diaries, actigraphy, a diary of daytime behaviour, and direct observation. At post-intervention, all children were falling asleep independently, co-sleeping had been eliminated, and night waking reduced for one child. Sleep diaries and actigraph data demonstrated changes in sleep quality, with improvements in sleep length, sleep latency, and morning wake times found. These changes were maintained at 3-month follow up. Findings regarding daytime behaviour were somewhat inconsistent, showing variation across behaviours and settings. The authors concluded that whilst affects on daytime behaviour remain unclear, extinction proved to be an effective technique for reducing sleep problems in children with intellectual disabilities.

Finally, Weiskop et al. (2005) evaluated the efficacy of a parent training program incorporating the same behavioural components (reinforcement, instruction giving, partner support, bedtime routine, extinction) used in Thackeray and Richdale's (2002) study to decrease sleep problems in children with autism and Fragile X syndrome. Participants included five children with autism and one with Asperger's disorder (four males and two females; mean age = 5 years, 6 months) and their parents; and seven children with Fragile X syndrome (six males, one female; mean age = 4 years, 9 months) and their parents. A multiple baseline across subjects design

was used and parents were asked to complete sleep diaries to monitor their child's sleep behaviours. At post-intervention, sleep data showed improvements in sleep problems with settling problems, night waking, and co-sleeping all reduced, and most parent goals for treatment met. These changes were maintained at follow-up. The authors concluded that the outcomes of the behavioural intervention were clinically significant.

Not only has the use of behavioural interventions been shown to improve sleep problems, but it has also been suggested that treatment of sleep problems can have added effects on daytime behaviour of children with intellectual disabilities and improved sleep and reduced stress in parents (Thackeray & Richdale, 2002; Wiggs & Stores, 1996b, 2001). Wiggs and Stores (1999), for example, examined whether treatment of children's sleep problems would reduce daytime challenging behaviour in children with severe learning disabilities. Using a randomised control design, 15 children in the intervention group received an individually tailored behaviour program and support phone calls to parents from the therapist. Children's behaviour was assessed using the Aberrant Behavior Checklist (ABC) at baseline, 1-month, and 3-month follow up. Results showed that successful treatment of sleep problems was not associated with changes in children's daytime behaviour for the intervention group. Both groups showed improvements in behaviour at follow-up, as rated by both parents and teachers. The authors concluded that non-specific effects of participating in the study, rather than resolution of sleep problems per se, may have had benefits to children's daytime behaviour. However, further research would be needed to clarify this.

Using the same sample, Wiggs and Stores (2001) examined the effects of behavioural treatment for sleep problems in children with intellectual disabilities and

challenging behaviours on parental functioning. Parents completed self-report measures of satisfaction with sleep, stress, sleepiness, locus of control, and perceived control. Results showed that successful treatment of children's sleep problems had a positive impact on mothers, and to a lesser extent, fathers. Mothers reported reduced stress, increased control, increased satisfaction with their own and their child's sleep, and improved ability to cope with their child's sleep following the intervention. Fathers reported increased satisfaction with their own and their child's sleep, but felt less control after treatment. Wiggs and Stores concluded that the successful treatment of sleep problems for children with intellectual disabilities and challenging behaviours have added benefits to parents, with these effects being different for mothers and fathers.

Overall, research supports the use of behavioural interventions to treat sleep problems in children with intellectual or developmental disabilities. Extinction and graduated extinction techniques in particular have been shown to be effective in improving children's sleep problems when used in conjunction with other behavioural strategies (e.g., establishing bedtime routine). Successful treatment of children's sleep problems have also been reported to have added benefits for parental functioning, though these effects may differ between mothers and fathers. Less evidence exists regarding the effects of successful treatment of sleep problems in reducing challenging daytime behaviours in children, with further research needed to clarify this.

In the present case study, the use of a behavioural intervention in managing sleep difficulties of a 7-year-old girl with an intellectual disability will be presented. The case study aimed to examine the effects of a behavioural intervention program in reducing sleep difficulties, and also to explore the effects that treatment of sleep

problems have on daytime challenging behaviours. It was hypothesised that implementation of a behavioural intervention would lead to a reduction in settling difficulties, night time waking, and early morning waking. Also, it was hypothesised that successful treatment of sleeping problems would lead to a reduction in daytime challenging behaviours.

Method

Participants

Sally (pseudonym), a 7-year-old girl with a mild intellectual disability, was referred to the clinic with sleeping and behavioural problems. With regards to sleeping problems, Sally's mother reported that she had difficulty putting Sally to bed and getting her to stay in bed (settling difficulties), that Sally would often get out of her bed during the night (night waking), and that Sally would wake early in the morning. Sally had concurrent diagnoses of Attention-Deficit/Hyperactivity Disorder (ADHD) and anxiety. She was prescribed Ritalin for the treatment of ADHD, and Catapres for sleeping difficulties. Sally had good verbal skills, though literacy skills were limited.

Sally lived with her mother (27 years) and younger half-brother (2 years) in an Office of Housing home. Sally had not had contact with her biological father since birth. Sally's mother had a diagnosis of depression for which she had been prescribed antidepressants, but was taking irregularly. The home environment lacked structure, routine, and consistency, and Sally's mother presented as having limited parenting skills. Sally's mother was not working and received a pension as her main source of income. The family have had extensive involvement with welfare services in the past, and continue to rely heavily on services for support.

Sally attended a special development school 5 days per week and accessed respite services 5 to 7 days per month. Neither school nor respite staff reported any concerns regarding Sally's behaviour in these settings, and aside from occasional bed wetting, no sleeping problems had been identified at respite.

Materials

Sleep diary. Sally's mother was provided with a sleep diary (see Appendix A) that she was asked to complete prior to and during implementation of the behavioural intervention. In this sleep diary Sally's mother was asked to record the date, the time that Sally went to bed, the time that Sally feel asleep, the number of times Sally woke up and got out of bed during the night, and the time that Sally got out of bed in the morning.

Developmental Behaviour Checklist. The Developmental Behaviour Checklist (DBC; Einfeld & Tonge, 1994) is a 96-item checklist designed to assess behavioural difficulties in children with intellectual disabilities aged between 4 and 20 years. The DBC requires parents to rate behaviours occurring within the past 6 months on a scale ranging from 0 (*not true as far as you know*) to 2 (*very true or often true*). The DBC yields 5 subscale scores (disruptive/antisocial, self absorbed, communication disturbance, anxiety, social relating) and a Total Behaviour Problem Score. A clinical cut off score is used to determine significant behaviour problems.

The corresponding Developmental Behaviour Checklist-Teacher Version (DBC-T; Einfeld, Tonge, & Parmenter, 1998) was given to Sally's classroom teacher to complete. The DBC-T consists of 94-items requiring teachers to rate the behaviour of their pupil on a 0 (*not true as far as you know*) to 2 (*very true or often true*) scale for the past 2 months. As with the parent version, corresponding subscale and Total

Behaviour Problem Scores are derived from the DBC-T. Adequate reliability and validity have been reported for both versions of the DBC (Einfeld & Tonge, 1994; Einfeld et al., 1998).

Procedure

Assessment. The assessment phase began by conducting a parent interview with Sally's mother. This occurred over two visits to the family home. The purpose of this interview was to gain detailed information about Sally's family, developmental, medical, and educational history, current skills and functioning, past treatment or management strategies, as well as undertake a functional assessment of Sally's behaviour (i.e., description of behaviour, history of behaviour, antecedents and consequences of behaviour). The clinician then assisted Sally's mother to complete the DBC-P (by reading questions), as Sally's mother had some difficulty reading the DBC-P due to limited literacy skills.

Telephone interviews were then conducted with Sally's assistant principal and classroom teacher regarding Sally's behaviour at school and any concerns the school staff may have. The writer also provided Sally's classroom teacher with a copy of the DBC-T, which the teacher completed and returned via mail. A telephone interview was also conducted with the coordinator at Sally's respite facility, to assess whether Sally presented with any behavioural issues at respite.

Two weeks prior to the date set to commence intervention, the writer provided Sally's mother with a copy of the sleep diary to be completed each night to provide a baseline measure. The writer reviewed and discussed the sleep diary with Sally's mother and reinforced the need for this to be completed on a nightly basis. However, the diary was only completed by Sally's mother for three nights prior to intervention.

Intervention. Prior to commencing the intervention, the family's current bedtime routine was discussed and reviewed with Sally's mother. A structured routine starting from dinner through to Sally's bedtime was developed, and created in a pictorial format (see Appendix B) for use with Sally. In developing this routine, consideration was given to factors that may influence Sally's settling difficulties and early morning waking. It was decided that Sally's current bedtime of 7:00pm to 7:30pm would be shifted to 8:30pm. This time was considered more age appropriate and therefore likely to assist with settling difficulties (as Sally would be more likely to be tired) and early morning waking. This bedtime also enabled a specific period of time to be scheduled where Sally and her mother were able to spend time alone (i.e., while younger brother was in bed).

The clinician then discussed behavioural intervention options (graduated extinction or standard extinction) with Sally's mother. It was decided that standard extinction would be the best intervention option, as Sally's mother may not have had the capacity to understand the details or consistently implement the graduated technique. The clinician then provided training and information to Sally's mother on how to implement the routine, and how to manage Sally's behaviour once the intervention had commenced, including the need to be aware of the potential for an extinction burst. This was outlined as follows:

1. Follow bedtime routine as set out on routine board (see Appendix B).
2. Put Sally to bed at 8:30pm.
3. Remind Sally of the bedtime rules (see Appendix C).
4. Leave bedroom.
5. Ignore crying or calling out.

6. If Sally gets out of bed, return her to bed immediately with minimally interaction.

Continue each time Sally gets out of bed.

To address early morning waking, it was also recommended that Sally's mother place an alarm clock in Sally's room, to serve as a cue for Sally to know when she could get up in the morning (i.e., when the alarm goes off you can get out of bed).

The clinician then met with Sally, her mother, and the family's support worker at the family home to review the bedtime routine and rules. The clinician went through the routine board and rules with Sally to ensure she was able to understand and follow these. The clinician then modelled to Sally's mother how to engage and involve Sally in marking off tasks on the routine board as each activity is completed to assist Sally in following the routine. A date was then arranged to commence the intervention when the support worker could also be present to assist Sally's mother in implementing the routine and behavioural strategies. Sally's mother was asked to complete the sleep diary throughout the intervention phase.

The clinician attempted to maintain regular phone contact and home visits during the intervention phase; however, often Sally's mother was not at home for scheduled appointments and did not return the clinician's phone calls. Sally's mother made recordings in the sleep diary for two nights during the intervention phase, but discontinued use of the behavioural intervention and routine when her support worker was no longer present to assist. Sally's mother disengaged from the service shortly after and subsequently, follow-up measures were not completed.

Results

Developmental Behaviour Checklist

Results of the DBC completed by Sally's mother placed Sally's Total Problem Behaviour score at the 100th percentile when compared to other children of her age and disability level. Considering the subscale scores, Sally was placed at the 100th percentile for the Anxiety subscale, the 98th percentile for both the Disruptive/Antisocial and Self-Absorbed subscales, and the 96th percentile for both the Communication Disturbance and Social Relating subscales. All of Sally's scores on the DBC were well above the clinical cut off score, indicating significant behavioural problems across all domains as rated by Sally's mother.

In comparison, results of the DBC-T completed by Sally's classroom teacher placed Sally's Total Behaviour Problem Score at the 32nd percentile when compared to other children of her age and disability level. This score was well below the clinical cut off point and did not indicate any significant behavioural problems as rated by Sally's teacher. Considering the subscale scores, Sally was placed at the 32nd percentile for both the Anxiety and Social Relating subscales, the 30th percentile for the Communication Disturbance subscale, the 28th percentile for the Self-Absorbed subscale, and the 62nd percentile for both the Disruptive/Antisocial subscale. Sally's score on the Disruptive/Antisocial subscale was the only score to exceed the clinical cut off point (60th percentile) as rated by her teacher.

Sleep Diary

Data obtained from the parent sleep diary for three nights during baseline phase and two nights during intervention phase are presented in Table 1 and Figure 1.

Table 1 shows the times at which Sally went to bed, the times by which she had fallen asleep, and the times she woke in the morning as recorded by her mother.

Table 1

Time to Bed, Time Asleep, and Time Awake in Morning during Baseline and Intervention

	Time to Bed	Time Asleep	Time Awake
Baseline Night 1	7:30pm	11:00pm	5:00am
Baseline Night 2	7:00pm	11:20pm	4:55am
Baseline Night 3	7:10pm	12:05am	5:30am
Intervention Night 1	8:30pm	10:00pm	5:15am
Intervention Night 2	8:30pm	9:15pm	5:30am

At baseline, Sally's bedtime was recorded as being between 7:00pm to 7:30pm. For the two nights during the intervention phase Sally's bedtime was reported to have increased to 8:30pm, as set out in her bedtime routine. With regards to the time Sally fell asleep at night, this was reported to be after 11:00pm and as late as 12:05am at baseline, becoming earlier during the intervention phase at 10:00pm and 9:15pm. This indicates that for the two nights the intervention took place, Sally fell asleep quicker than she had been prior to intervention. Little change was observed between the time Sally woke up in the morning at baseline or intervention, with Sally waking at around 5:00am to 5:30am before and during the intervention phase.

The number of times that Sally woke during the night for the three nights during the baseline phase and two nights of intervention phase are presented in Figure 1.

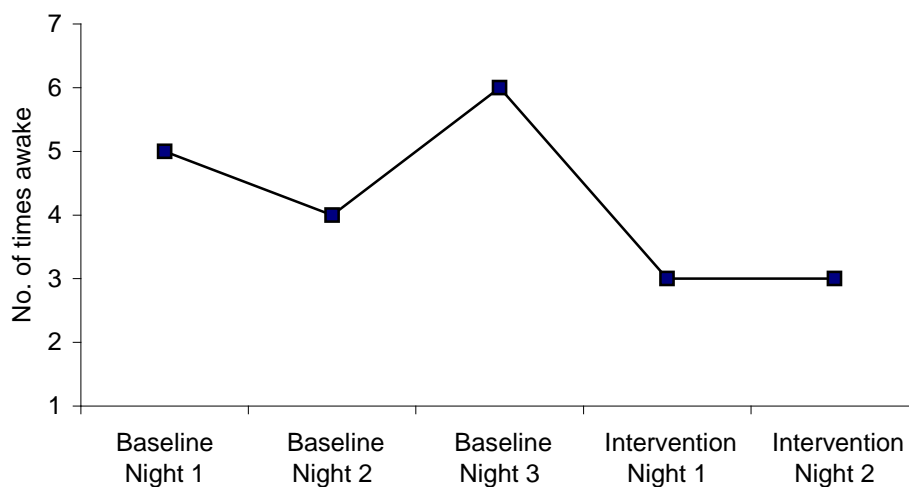


Figure 1. Number of night time wakings during baseline and intervention phases.

As can be seen in Figure 1, Sally woke during the night between 4 to 6 times prior to the intervention. This decreased slightly during the two nights of intervention to 3 times per night. This suggests a trend towards decreased night waking during the intervention phase; however, further data would be needed to clarify this.

Discussion

Summary and Interpretation of Findings

The present case study aimed to examine the effectiveness of a behavioural intervention program in reducing sleep difficulties of a 7-year-old girl with a mild intellectual disability. It was hypothesised that implementation of the behavioural intervention would lead to a reduction in settling difficulties, night time waking, and early morning waking. From the limited data available, results suggested some improvement in settling and night time waking during the intervention phase. Data from the two nights of intervention demonstrated a decrease in the time between Sally

going to bed and the time at which she fell asleep, and also a decrease in the number of times Sally woke up during the night. These suggest some improvement in bedtime settling and episodes of night waking; however, insufficient data were available to determine whether these trends were significant.

In contrast, the behavioural intervention did not appear to have any affect on early morning waking. The times at which Sally woke in the morning at baseline and during the two nights of intervention were comparable. Sally's mother reported that she did not arrange an alarm clock as recommended and it is therefore likely that this part of the intervention was not properly implemented. Alternatively, it is likely that the intervention was not maintained long enough for an effect to be observed on early morning waking.

This case study also aimed to assess the effects of treatment of sleep problems on daytime behaviour, hypothesising that successful treatment of sleeping problems would lead to a reduction in daytime challenging behaviours. Unfortunately, insufficient data was collected to make any inferences about effects on behaviour and as a consequence this hypothesis was unable to be tested.

Results from the DBC completed by Sally's mother and by her teacher at baseline demonstrated inconsistencies. Sally's mother rated Sally's behaviour as being highly problematic across a range of behavioural domains, whilst Sally's teacher only rated one behavioural domain (Disruptive/Antisocial) as being above the threshold for clinical significance. Past research indicates that teachers and parents perceive child behaviour differently, and that this is likely to be explained by the different perspectives parents and teachers have in assessing child behaviour, variations in child behaviour across settings (e.g., school versus home), or some combination of the two (Culp, Howell, Culp, & Blankemeyer, 2001). However,

because Sally's mother withdrew from the service, follow-up measures using the DBC were not completed and therefore comparisons in behaviour before and after the intervention could not be made.

Methodological Limitations

A number of methodological problems were encountered that considerably limit any interpretations or conclusions that can be drawn from this case study. First and foremost, insufficient data were obtained from the sleep diaries to establish a baseline of sleeping patterns or to measure the effects of the behavioural intervention on Sally's sleeping behaviour. Whilst Sally's mother had agreed to complete sleep diaries when commencing the program, she was not able to follow through with this consistently. Also, whilst some initial success in implementation of the routine and behavioural strategies was observed when the family's support worker was present, Sally's mother was not able to maintain this program on an ongoing basis and eventually disengaged from the service. This occurred despite phone calls and weekly home visits offered by the clinician. Sally's mother's withdrawal from the service also prevented collection of follow-up data to be undertaken.

Whilst the reasons for withdrawal from the program were not specifically examined, past research indicates that factors including parental psychopathology (particularly maternal depression), single parent status, socioeconomic disadvantage, and life stress have been associated with poor participation/high treatment drop out rates and poor treatment outcomes for parent training programs to treat child behavioural problems (Reyno & McGrath, 2006). The family stress model of economic hardship (Conger et al., 1992, 2002) has been proposed as a way to explain the relationship between low income, parenting practices, and child adjustment. This

model postulates that economic pressure increases parental distress and depressed mood; depressed mood then negatively influences parenting practices (less nurturing and overly harsh or punitive), subsequently impacting on child adjustment and development of externalising child behaviour problems.

Given that many of these factors were present in Sally's home environment, it is likely that they significantly impacted on Sally's mother's ability to implement and maintain this program. Furthermore, for behavioural interventions to be successfully implemented they require a high level of motivation and consistency (Reyno & McGrath, 2006), which was potentially too demanding for Sally's mother to undertake. In this instance, it may have been more beneficial to address Sally's mother's own personal issues and mental health concerns through individual counselling, prior to or in conjunction with the behavioural intervention.

Alternatively, a more intensive program that provided Sally's mother with ongoing in home support to implement the program and strengthen her own skills and coping resources may have been useful.

Conclusions and Recommendations

Findings regarding the efficacy of the behavioural intervention in treating sleep problems and addressing daytime challenging behaviours for a 7-year-old girl with a mild intellectual disability were inconclusive. There was limited evidence to suggest that improvements in settling and night time waking occurred at the commencement of the intervention; however, insufficient data were available to determine whether these changes were clinically significant. Furthermore, no data was available to determine whether treatment outcomes were maintained over time. Due to

Sally's mother withdrawing from the service prior to completion of the program, assessments of daytime behaviour following intervention were not undertaken.

A number of factors (maternal depression, single parent status, socioeconomic disadvantage, and life stress) identified from past research had a likely impact upon Sally's mother's ability to successfully implement the behavioural intervention. When designing future interventions, greater consideration may need to be given to parental factors that may impact on treatment success and ways to address these. This might involve including an individual parental support or counselling component, or providing a more intensive model of in home support during the intervention phase. Given the high rates, chronic course, and negative affects of sleeping problems for children with intellectual disabilities, it is important that interventions are carefully planned and individualised to ensure better treatment outcomes.

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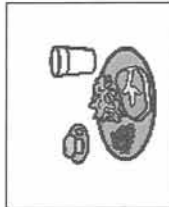
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Appendix B

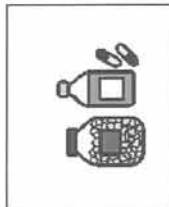
Bedtime Routine

Bedtime Routine

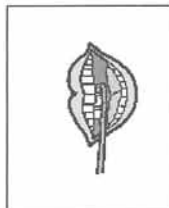
6:00 Tea



6:25 Medicine



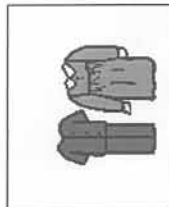
6:30 Brush Teeth



6:35 Shower



6:50 Pyjamas



7:00 Quiet Play Time



7:30 Jimmy Bedtime



8:00 Mummy and Sally time



8:25 Toilet



8:30 Sally Bedtime



Appendix C

Bedtime Rules

1. Jimmy's (younger brother) bedtime is 7:30pm
2. Sally's bedtime is 8:30pm
3. Be quiet in your room (no talking or yelling out)
4. Stay in your own room
5. Stay in bed until the morning (6:00am)

Report 4

**Professional and Ethical Issues in the Practice
of Clinical Psychology**

TABLE OF CONTENTS

	Page
Index of Contents	90
Abstract	91
Professional and Ethical Issues in the Practice of Clinical Psychology	92
Ethical Issues	92
Ethical Issues in Supervision	93
Professional Issues	101
Challenges in Undertaking Research in the Clinical Setting	102
Summary and Conclusions	106
References	108

Abstract

As a provisional psychologist undertaking clinical placements, a number of ethical and professional issues relevant to practice in the area of clinical psychology are encountered. In this report, ethical and professional issues raised whilst undertaking clinical placements as part of a professional doctorate in clinical psychology will be discussed. In particular, ethical issues related to competency as a provisional psychologist and supervision as well as professional issues relevant to the scientist-practitioner model will be examined. These issues will be considered in the context of relevant ethical guidelines, literature, and will also include reflection on my own personal experiences as a provisional psychologist undertaking a doctoral degree in clinical psychology.

Professional and Ethical Issues in the Practice of Clinical Psychology

Ethical Issues

The Australian Psychological Society (APS) Code of Ethics (Australian Psychological Society [APS], 2007) sets the standards by which ethical and professional conduct by psychologists in Australia are judged. The Code of Ethics details and promotes ethical principles of the profession, serving as a guide to both psychologists and the general public as to what constitutes ethical and professional behaviour on the part of psychologists (APS, 2007). Ethical principles detailed in the Code are considered the minimum standards by which psychologists conduct their professional practice and have been developed to ensure that the welfare of clients and the integrity of the profession are protected (APS, 2007).

The APS Code of Ethics (APS, 2007) is founded on three general ethical principles: (A) Respect for the Rights and Dignity of People and Peoples; (B) Propriety; and (C) Integrity. The first general principle, *Respect for the Rights and Dignity of People and Peoples*, stipulates that psychologists must respect the rights and dignity of others. This includes regarding people as intrinsically valuable, promoting equity, and protecting people's human, legal, and moral rights. The second general principle, *Propriety*, requires psychologists to be competent in the services they provide and incorporates principles of beneficence, non-maleficence, and responsibility to clients, the profession of psychology, and society as a whole. Finally, *Integrity*, reflects the need for psychologists to be of good character and to recognise the high level of trust intrinsic to their professional role. Psychologists must honour this position of trust and exercise their power appropriately, acting with probity and honesty at all times.

A series of Ethical Guidelines were recently developed to complement the Code of Ethics (APS, 2007). These guidelines serve to further clarify the general principles and specific standards set out in the Code, aiding in their interpretation and application in contemporary areas of psychological practice. In the next section, ethical issues relevant to provisional psychologists undertaking clinical placements, namely professional competency and ethical issues in supervision, will be considered. These issues will be discussed in the context of the APS Code of Ethics and Guidelines on supervision, with reference to relevant literature in the area and reflection on personal experiences as a provisional psychologist undertaking clinical placements as part of the requirements of a doctoral degree.

Ethical Issues in Supervision

Competency in the delivery of psychological services is an important ethical standard to which all psychologists must adhere. Section B.1 of the APS Code of Ethics (APS, 2007) states that psychologists must "...bring and maintain appropriate skills and learning in their areas of professional practice" and that psychologists must "...only provide psychological services within the boundaries of their professional competence". For provisional psychologists undertaking a clinical placement, however, the issue of professional competence does present an important ethical dilemma. Provisional psychologists are, by virtue of their role, not fully competent in the area in which they are practising. They are practising as students, and are therefore delivering a service as a learning opportunity for themselves, in order to increase and develop their own skills and competence. Consequently, this creates discordance between their role as a student and the varied professional roles they may be expected to undertake on placement.

To overcome deficits in their own proficiencies, provisional psychologists rely heavily on the process of clinical supervision. Clinical supervisors are responsible for training, guiding, supporting, and encouraging provisional psychologists to assist them in developing the necessary skills to successfully undertake the placement, and eventually work independently as a psychologist (Ramos-Sánchez et al., 2002). The supervisory relationship, therefore, constitutes one of the most important factors in the process of supervision and skill development of provisional psychologists (Ladany, Ellis, & Friedlander, 1999).

Whilst the supervisory relationship is a critical factor in the success of the supervision process it is, however, a power disproportionate relationship (Burke, Goodyear, & Guzzard, 1998; Nelson, Barnes, Evans, & Triggiano, 2008). As well as providing clinical guidance, supervisors also play an evaluative role that automatically places trainees in a more vulnerable and subordinate position (Gross, 2005; Ladany & Friedlander, 1995; Ramos-Sánchez et al., 2002). This is likely to create dissonance for provisional psychologist who are on the one hand expected to seek advice and to discuss their weaknesses and limitations in supervision, whilst on the other hand knowing that the success of their placement will ultimately be decided by their supervisor. This power differential may in turn result in provisional psychologists not disclosing problems or raising concerns with their supervisor, for fear of the consequences this might have on the outcome of their placement (Gross, 2005; Ladany, Hill, Corbett, & Nutt, 1996).

For example, Ladany et al. (1996) examined nondisclosures in supervision for 108 trainee therapists. Results of self-report surveys indicated that 97.2% of supervisees withheld information from their supervisors, with common content of nondisclosures including negative reactions to the supervisor, clinical mistakes, and

evaluation concerns. Among the most common reasons for nondisclosures were negative feelings about the nondisclosure, a poor alliance with the supervisor, deference to the supervisor, the supervisor's agenda, impression management, and fear of political suicide. These findings support the suggestion that students do withhold information in supervision to avoid conflict and present themselves in a positive light, and that these are likely to be attributed to the power imbalance and evaluative nature of the supervisory relationship.

Given that evaluation concerns are an unavoidable aspect of the supervision process, it has been recommended that this be clarified and normalised for trainees (Ladany et al., 1996). In fact, Sections 7.2 and 7.6 of the APS Ethical Guidelines on Supervision (APS, 2007) make specific reference to the need for supervisors to explain the supervision process to supervisees, including alerting supervisees to the dual role supervisors face as both mentor and evaluator, and the difficulties inherent in this. The Guidelines also state that whilst it is possible to reduce the influence of this power differential in supervision, it should not be ignored.

As a student on clinical placements I found that the power imbalance and evaluative process of supervision created some internal conflict for myself. For placements where I found the supervisory relationship to be a positive, open, and supportive one, this dilemma was easily overcome. In these supervisory relationships I felt comfortable and confident to address any concerns or difficulties I had, in the knowledge that this would be seen by my supervisor as a necessary part of my skill development and the supervision process, and that it would not be used as a negative evaluation against me. However, in those supervisory relationships that I did not feel well supported by or trusting of my supervisor I found it very difficult to discuss difficulties I was having or to ask for help for fear that this would be seen as a

weakness in my ability and would be used against me negatively in evaluation processes.

In fact, rather than this power imbalance being discussed with me in supervision as the ethical guidelines recommend, in one supervision experience I encountered I was forced to raise the ethical dilemma this evaluative process created for me with my supervisor. In this instance, I was being asked to provide input at a team meeting that would have been in direct opposition to my supervisor's own opinion. The expectation that I provide my clinical opinion, which would directly challenge my supervisor's own, in front of other professionals created tension for me as I did not want to act in a way that might be damaging in my placement evaluation. The conflict this created for me was not readily acknowledged by my supervisor, nor was it openly discussed with me in supervision until I raised the issue myself.

A further aspect of the supervision process highlighted by this discussion is the importance of the strength and quality of the supervisory relationship, or alliance, and the various ethical implications this has. The supervisory alliance refers to the collaborative relationship between supervisor and supervisee, which endeavours to promote change in the supervisee through mutually agreed upon tasks and goals and a strong emotional bond (Bordin, 1983). In fact, research indicates that supervisory relationships characterised by a strong emotional bond are associated with greater satisfaction (Ladany, Ellis, et al., 1999), and that negative experiences in the supervisory relationship can have detrimental and long lasting effects for supervisees in terms of their emotional functioning and professional development (Nelson & Friedlander, 2001; Ramos-Sánchez et al., 2002).

Considering factors that affect the supervisory alliance, Ladany and Friedlander (1995) examined the degree to which trainees' role difficulties would be

predicted by the strength of the supervisory relationship. Specifically, role difficulties were categorised as either role conflict (engaging in behaviours that are incongruent with each other or with trainee's beliefs) or role ambiguity (trainee unclear about their role expectations in supervision). Results of questionnaires completed by 123 trainee counsellors found that the supervisory working alliance was significantly related to trainee's perceptions of role conflict and ambiguity. That is, trainees who reported a strong supervisory alliance tended to experience less role conflict and ambiguity, whilst trainees who reported weak supervisory alliances encountered more role conflict and ambiguity. These findings highlight the importance of the supervisory alliance and the implications this can have with regards to trainees' experiences of role difficulties.

Also exploring factors related to the supervisory alliance, Ladany, Lehrman-Waterman, Molinaro, and Wolgast (1999) examined the relationship between supervisor ethical behaviour, the supervisory alliance, and supervisee satisfaction. Results of questionnaires completed by 151 trainee therapists found that 51% of supervisees reported at least one ethical violation by their supervisors, with ethical guidelines least frequently adhered to including performance evaluation and monitoring of supervisee activities, confidentiality issues, the ability to work with alternative theoretical perspectives, and lack of supervision session boundaries and respectful treatment. With regards to the supervisory alliance, supervisees whose supervisors reportedly adhered less to ethical guidelines had weaker supervisory alliances and supervisees reported less satisfaction with supervision.

In the context of my own experiences on clinical placements, two ethical issues related to the strength of the supervisory relationship – role conflict in

supervision and provision of supervision sessions – will now be considered with reference to the APS Code of Ethics.

With regards to role conflict and the supervisory relationship, in one particular supervision experience I encountered significant role conflict when my own theoretical perspective and the theoretical perspective of my supervisor did not match. This led to disagreement in supervision as to the best way to approach particular client issues, and left me feeling particularly conflicted as to how to best provide services to my clients. I was forced to weigh my ethical obligation to act competently and provide services that I saw as being in the best interests of my clients and their welfare (APS, 2007), against the knowledge that I was in a subordinate position whereby challenging or disagreeing with my supervisor's advice may negatively impact my placement outcomes. This also created further weakening of an already weak supervisory alliance, making it difficult to resolve these issues in supervision. Had the supervisory alliance been stronger in this instance, it may have been easier to explore alternative perspectives and reach mutually agreed upon treatment goals for my clients.

A second ethical dilemma students can face on clinical placements involves the provision of regular supervision sessions. The Psychologists Registration Board of Victoria's (2005) current supervision guidelines for provisional psychologists stipulate that provisional registrants practising in the profession for more than 20 hours per week must undertake at least 2 hours of supervision per fortnight, whilst those practising for a minimum of 15 hrs per week should undertake at least 1 hour of supervision per fortnight. Additionally, the University of Ballarat's (2004) guidelines for clinical placements whilst undertaking the Doctor of Psychology indicate that the supervisor and trainee should meet for a formal, scheduled supervision session of 1

hour's duration on a weekly basis. This is also stipulated in the placement contract completed by the supervisor and trainee prior to commencement of the placement.

Not only is the frequency and duration of supervision important for clinical experience and registration purposes, but supervision arrangements are also identified as an important ethical issue in the APS Code of Ethics. Section 5.3 of the APS Ethical Guidelines on Supervision (APS, 2007) states that, "...psychologists supervising students on placement have the responsibility to ensure that they are sufficiently available to provide an effective supervision arrangement according to the agreed supervision contract". Section 7.8 of the guidelines also recommends that, "at a practical level, supervisors inform their supervisees of the times when they are available, and how they can be contacted in an emergency, or any alternative arrangement for support".

As a student undertaking clinical placements I found that having these supervision arrangements met was very important to the overall success of the placement and the quality of the supervisory relationship. Having a mutually agreed upon supervision time, which both myself and my supervisor attended on a regular basis, was very important to my professional development. Also, when my supervisor was not able to make this arrangement for some reason (e.g., sick leave, holidays), this was discussed with me and rescheduled for another time. I found this to be particularly important during my earlier placements when I was less experienced and initially lacked confidence. In those instances, it was very reassuring to know that there was always a dedicated time to talk about any issues, ideas, or problems I was having. These arrangements fostered a strong supervisory alliance, and made me feel supported and satisfied with my supervisory experience.

However, research indicates that some trainees do not have their supervision requirements met (Gross, 2005; Ladany, Lehrman-Waterman, et al., 1999). Examples of this include supervisors not scheduling regular supervision times, not being present for scheduled supervision times, or cutting short the time allocated for supervision (Ladany, Lehrman-Waterman, et al., 1999; Nelson & Friedlander, 2001). In such instances, this is likely to create negative supervisory relationships, where trainees feel unsupported and dissatisfied with the supervision experience (Gross, 2005; Nelson & Friedlander, 2001). Also, not having supervision requirements met has implications for provisional psychologists who rely upon the supervision process to ensure they are meeting ethical standards of competence in their clinical practice. In instances where provisional psychologists are not having their supervision needs met, they may miss out on opportunities to develop their skills and competency, or may find themselves in situations where they are delivering services to clients that may be beyond their level of professional competence and expertise.

To tackle some of the ethical dilemmas encountered in supervision, it has been recommended that both supervisors and supervisees receive education and training regarding the expectations of clinical supervision and ethical issues inherent in this process (Ladany, Lehrman-Waterman, et al., 1999). For many supervisors, knowledge about how to provide supervision comes from their own experiences of being supervised, rather than through any form of systematic training. Supervisors may adopt an “ad lib” approach to their supervision style, rather than basing supervision practices on informed knowledge about effective supervision methods and relevant ethical practices (Ladany, Lehrman-Waterman, et al., 1999). Similarly, students undertaking clinical placements often have little understanding of the supervision expectations and enter the process a “blind” participant. Ensuring teaching programs

include specific components on supervision is important to teach current students (and future supervisors) of relevant practical and ethical issues in supervision. Likewise, extending such training to supervisors of students will be important to ensure they are aware of the clinical and ethical expectations of them as supervisors.

In summary, provisional psychologists rely on the process of supervision to develop and enhance their professional skills, and to ensure that they meet ethical standards of competency in their clinical practice. A strong determinant of the success and outcomes of the supervision process is the strength and quality of the supervisory relationship. Research has demonstrated that factors such as role difficulties and ethical behaviour of supervisors are associated with the strength of this relationship and satisfaction with supervision. As a doctoral student undertaking clinical placements I encountered a number of ethical dilemmas related to the supervisory relationship and reflected upon how these issues impacted upon my own professional practice and competency. Future consideration should be given to provision of training to both supervisors and supervisees around relevant clinical and ethical issues in supervision and the expectations of them as participants in the supervision process. In the next section, professional issues relevant to the practice of clinical psychology will be discussed in the context of the scientist-practitioner model.

Professional Issues

The *scientist-practitioner model* has been widely adopted, both in Australia and overseas, as the dominant approach to training in clinical psychology (Baker & Benjamin, 2000; Geffen, 1993; Stricker, 2000, 2002). As the name suggests, the scientist-practitioner model proposes that training in clinical psychology integrate science and practice to produce psychologists who are capable in the areas of both

psychological research and clinical work (Barlow, Hayes, & Nelson, 1984; Drabick & Goldfried, 2000; Jones & Mehr, 2007). There are three primary expectations for the roles of psychologists trained under the scientist-practitioner framework (Barlow et al., 1984; Jones & Mehr, 2007). Firstly, the scientist-practitioner should be a consumer of research, keeping up-to-date with relevant research findings and incorporating them into their clinical practice (Barlow et al., 1984; Drabick & Goldfried, 2000). The second role of the scientist-practitioner is to be an evaluator of their own interventions, by using empirical methods to assess client progress, treatment efficacy, and overall program success (Jones & Mehr, 2007). The final role is that of a researcher, whereby the individual actively engages in producing new data and research within the clinical setting for dissemination to the scientific community (Barlow et al., 1984; Drabick & Goldfried, 2000; Jones & Mehr, 2007).

Despite the promise this framework holds for both research and practice in clinical psychology, a number of limitations of the scientist-practitioner model have been identified. In particular, it has been well documented that very few clinicians trained in the scientist-practitioner model actually go on to produce research after graduating (Lampropoulos, Goldfried, et al., 2002; Long & Hollin, 1997). In the next section, challenges faced by psychologists producing research in the clinical setting will be considered, with reference to my own personal experiences as a provisional psychologist undertaking research within the clinical placement setting.

Challenges in Undertaking Research in the Clinical Setting

Clinicians face a number of practical and ethical limitations in conducting research in the clinical setting, which make fulfilling the ideologies of the scientist-practitioner model challenging (Lampropoulos, Goldfried, et al., 2002). On a practical

level, clinicians often lack the time, funding, and resources required to undertake research (Asay, Lambert, Gregersen, & Goates, 2002; Lampropoulos, Goldfried, et al., 2002). From the initial point of designing a study through to publication, research is a very time consuming process (David, 2006). As a doctoral student undertaking a thesis and completing research projects whilst on placement I understand only too well the amount of time that research imposes both on one's professional and personal life. For practising clinicians, the competing demands of caseloads and work pressures mean that they may be unwilling or unmotivated to make the additional effort required to undertake research, especially if this is outside the parameters of their job description (Drabick & Goldfried, 2000; Lampropoulos, Goldfried, et al., 2002).

Not only can research be time consuming, but it can also be a costly process. For psychologists working in a clinical setting, they may not get access to funding opportunities available to their colleagues in research institutions and the time required to undertake research may also decrease their ability to generate income (Drabick & Goldfried, 2000; Lampropoulos, Goldfried, et al., 2002). Similarly, research often requires additional resources (e.g., assessment tools, questionnaires), that clinicians may not have access to within their workplace and may not be able to afford to purchase (Barlow et al., 1984).

For example, whilst on placement I completed a clinical placement report that involved evaluating a developmental playgroup. As there was only one psychologist working in that particular organisation, there were limited psychological assessment tools available for use in the evaluation. As I did not have sufficient time to borrow additional resources from the university, I was limited to those resources available in that particular workplace and consequently, employed a screening tool developed for use by teaching staff.

Another issue that is likely to affect whether or not practitioners undertake research, are the values and attitudes towards research existing within their workplace (Abrahamson & Pearlman, 1993; Lampropoulos, Goldfried, et al. 2002). If clinicians work in a clinical setting where research is actively encouraged and supported by their employer (including allocation of time and resources to undertake research), then they are more likely to participate in research and espouse the role of scientist-practitioner (Abrahamson & Pearlman, 1993). However, if the employer or the culture of the workplace is resistant to or unsupportive of research then it is unlikely to be pursued by the clinician (Abrahamson & Pearlman, 1993; Asay et al., 2002).

As a student undertaking research projects whilst on clinical placements I experienced varied levels of support in different placement settings and from different placement supervisors. Whilst all placement organisations and supervisors were generally happy for me to complete a project, given that it was a requirement of my degree, some were more actively involved and supportive than others. For example, in one placement setting where a scientist-practitioner framework was not practised, I was generally left to my own devices to complete the project, and had to approach staff for their input. In contrast, in another placement setting where my supervisor was also trained in a scientist-practitioner approach, the supervisor was actively involved in making suggestions around the study design and in facilitating the project. Whilst completion of these projects was a requirement of my degree and therefore may not necessarily reflect the realities for practitioners attempting to undertake research in the clinical setting, they do provide some insight into how a supportive workplace can assist in this process.

It is not only practical limitations that create challenges for clinicians in applying the scientist-practitioner model, but there are also ethical implications that

need to be taken into consideration. Specifically, the primary concern of all psychologists is to ensure the welfare of their clients (Barlow et al., 1984), as outlined in the APS Code of Ethics (APS, 2007). Consequently, research is typically seen as being of secondary concern (Larner, 2001). When practitioners do attempt to undertake research they must carefully consider the ethical implications this would have for their clients. For example, it would be unethical for a clinician to withhold treatment from a client in the same way a researcher would withhold treatment from participants in a control group. Practitioners have a duty of care to their clients, and their goal at all times is to relieve their client's distress wherever possible (Barlow et al., 1984).

There are, however, research methods that can be successfully and ethically applied in the clinical setting. Single case designs, for example, are intended specifically for studying the individual, making them well suited to the needs of practitioners (Galassi & Gersh, 1993; Lundervold & Belwood, 2000). As part of a placement research project I employed a single-case design to evaluate a behavioural intervention for sleeping problems in a child with an intellectual disability. By gathering data on sleeping patterns before and during implementation of the behavioural intervention I hoped to assess changes in sleeping difficulties as a result of the intervention. Unfortunately, this evaluation was largely unsuccessful as insufficient data was collected by the child's mother to make any pre or post comparisons. In this instance, although the mother did not complete sleep diaries as requested, I could not simply refuse to provide further treatment, as this would have been unethical. Whilst this evaluation was not particularly successful, it does highlight the potential of single-case designs being used in the clinical setting, whilst also

reflecting upon some of the difficulties practitioners encounter when undertaking research.

Given the challenges faced by practitioners in undertaking research in the clinical setting, it is perhaps unsurprising that many psychologists do not undertake research after completing their training (Lampropoulos, Goldfried et al., 2002; Long & Hollin, 1997). However, there is more to fulfilling the role of scientist-practitioner than simply undertaking research. Through consuming research findings, applying them to their clinical work, and adopting an evidence-based practice approach, clinicians are enacting the scientist-practitioner model (Lampropoulos, Spengler, Dixon, & Nicholas, 2002). Perhaps the most important element of the scientist-practitioner ideology is not whether clinicians conduct research, but that clinicians adopt an enquiring and analytic approach to their practice, thinking and acting as scientists in their everyday work (Barlow et al., 1984; Carter, 2002; Lampropoulos, Spengler, et al., 2002). By acting in this way, psychologists emulate the scientist-practitioner approach and overcome any limitations or professional issues associated with this model.

Summary and Conclusions

In summary, this report reflected upon a number of ethical and professional issues I encountered as a provisional psychologist undertaking clinical placements. With regards to ethical considerations, issues related to the competency of provisional psychologists and the importance of clinical supervision were discussed, with specific reference to the need for training of both supervisors and supervisees to overcome some of the difficulties faced in the process of supervision. In terms of professional issues, the scientist-practitioner model was presented as the predominant framework

guiding training and practice in clinical psychology. Whilst the model presents a number of challenges for practitioners in undertaking research in the clinical setting, it was suggested that by bringing a scientific mindset to our everyday work, clinical psychologists can enact the scientist-practitioner model.

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