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Families at risk and the role of the care system

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Chapter 2

Data sources

This chapter introduces information on the methodology used in this thesis. It describes the design of the study, the samples used in the thesis, its measures and the methods used to analyse data.

2.1 Study samples

This thesis involves five articles using four different study samples. We provide a description of each of them with a brief description of the samples in Table 2.1.

Sample 1 consisted of data from the baseline measurement wave of the Care4Youth community sample. Participants were recruited via randomly chosen primary schools in Kosice in eastern Slovakia and were approached from January until June 2017 using a two-stage sampling process. In the first stage, we contacted 11 primary schools, seven of which took part in our survey (response rate 63.6%). All schools were located in Kosice, the second largest city in Slovakia, and were mostly attended by children from families with a middle or high socioeconomic status. Six schools were state primary schools, four of them with attendance ranging between 557 and 687 children and two with attendance ranging between 276 and 171 children. One school was private, with an attendance of 147 children. In the second stage, 1599 parents or legal representatives of pupils were contacted. After being thoroughly informed about the consequences of participation in the study, parents were asked to provide us with a signed informed consent on behalf of their children and themselves (response rate 23.4%). We obtained data from a sample of 341 adolescents from the 5th to 9th grades and aged from 10 to 16 years old (response rate 94.3%, mean age 13.14 years, 44% boys). The study protocol was approved by the Ethics Committee of the Medical Faculty at Pavel Jozef Safarik University in Kosice (2N/2015). This sample was used in Chapter 3 and Chapter 4. In Chapter 4 we included 308 respondents due to missing answers in the questionnaires we were using.

Sample 2 involved data from the Health Behaviour in School-aged Children (HBSC) study that was conducted in 2018 in Slovakia. To obtain a representative sample, we used a two-step sampling procedure. First, 140 larger and smaller schools located in rural as well as urban areas from all regions of Slovakia were randomly selected from a list of all eligible schools in Slovakia and asked to participate in the study. The response rate (RR) of

schools was 77.9%. Second, we obtained data from 8,405 adolescents aged 11–15 years old (mean age = 13.43; 50.9% boys) by using online self-report questionnaires. The questionnaire on hopelessness was filled in only by 13- and 15-year-old pupils; therefore, we excluded respondents younger than 13 (N = 3716). After the exclusion of respondents with missing answers (N = 977), a final sample of 3712 Slovak adolescents remained (mean age: 13.9, 50.7% girls). The study protocol was approved by the Ethics Committee of the Medical Faculty at Pavel Jozef Safarik University in Kosice (16N/2017). We used this sample in Chapter 5.

Sample 3 consisted of professionals working with adolescents with emotional and behavioural problems (EBP) in the psychosocial care system. This system in Slovakia comprises three main types of care – preventive-counselling care, social care and health care. Preventive–counselling care is organised predominantly by the Ministry of Education, Science, Research and Sport. The second type, social care, is predominantly organised by the Ministry of Labour, Social Affairs and Family. The third type, health care is predominantly organised by the Ministry of Health. We obtained our sample of care providers following a two-step sampling. With the aim of reaching a representative sample of each type of institution providing preventive-counselling, social or mental health care in Slovakia, we first identified such providers in the Košice region, Slovakia. All of these providers were approached based on our existing connections from a previous quantitative project covering the system of care for adolescents suffering from EBP; they agreed to participate. Second, within each institution, all care providers working with adolescents were asked to participate in the study, and all of them agreed to do so. They received information about the study, were informed about the voluntary and anonymous basis of the participation and provided informed consent. The study protocol was approved by the Ethics Committee of the Medical Faculty at Pavel Jozef Safarik University in Kosice (2N/2015). This sample was used in Chapter 7.

Sample 4 included care providers from the institutions providing mental health care services for adolescents following a two-step sampling. With the aim of reaching all representatives of each type of institution providing mental health care services for adolescents in Slovakia, we first identified institutions of providers of mental health care services for adolescents in the Košice region, Slovakia. All of these providers were approached based on our existing connections from a previous quantitative project covering the system of care for adolescents suffering from EBP; they agreed to participate. Second, within each institution, all care professionals working with adolescents were asked to participate in the study, and all of them agreed. They received information about the study, were informed about the voluntary and anonymous basis of the participation and provided informed consent. The study protocol was

approved by the Ethics Committee of the Medical Faculty at Pavel Jozef Safarik University in Kosice (2N/2015). This sample was used in Chapter 6.

Table 2.2 Characteristics of the samples used in this PhD thesis

Sample	*Chapter*	*Final sample size*	*Gender*	*Data source*	*Country/ Region*	*Research question*
S1	Ch3 Ch4	341 adolescents	50.9% boys	Care4Youth community sample	Kosice (eastern Slovakia)	RQ1 RQ2
S2	Ch5	3712 adolescents	49.3% boys	HBSC study	Slovakia	RQ3
S3	Ch7	49 care providers	8.2% male	Care4Youth qualitative study	Kosice (eastern Slovakia)	RQ5
S4	Ch6	12 care providers	100% female	Care4Youth qualitative study	Kosice (eastern Slovakia)	RQ4

2.2 Measures, variables and procedures

This section provides an overview of the measures, variables and procedures used in the samples contributing to the thesis. Table 2.2 introduces information on measures used in the quantitative studies of this thesis (Chapter 3, Chapter 4 and Chapter 5). Table 2.3 provides information on the variables used in qualitative studies (Chapter 6 and Chapter 7).

The setup of qualitative studies (Chapter 6 and Chapter 7) included specific procedures. For collecting data in both of these studies we used semi-structured interviews with a predefined set of topics represented by open-ended questions. Interviewers added some more detailed questions in the process of interviewing, if they were needed. These topics covered two main aspects of the psychosocial care of adolescents – the legislative and financial framework and work with the client. Each interview was conducted by one to three interviewers (the principal investigator conducted all the interviews; others alternated). These interviews were performed face-to-face and were recorded and transcription was prepared.

Table 3 Overview of measures used in quantitative studies of the thesis (Chapters 3, 4, and 5)

Measure	*Research question*	*Chapter*	*Data source*	*Role in analysis*	*Short description*
Family-related adversity	RQ1 RQ2 RQ3	Ch3 Ch4 Ch5	Care4Youth questionnaire Care4Youth questionnaire HBSC questionnaire	Independent Independent Independent	Variable measuring adverse event in family – death of a parent, divorce, parental substance abuse and violence
Perceived parenting style	RQ1	Ch3	Care4Youth questionnaire	Mediator	Variable measuring parenting practices – parenting, supervision and discipline
Family activities	RQ1	Ch3	Care4Youth questionnaire	Mediator	Variable measuring frequency of family joint activities
Positive youth development	RQ1 RQ2	Ch3 Ch4	Care4Youth questionnaire Care4Youth questionnaire	Dependent Dependent	Variable measuring aspects of positive youth development – competence, confidence, connection, character and caring
Psychological distress	RQ2	Ch4	Care4Youth questionnaire	Mediator	Variable measuring the level of psychological distress represented by occurrence of symptoms, such as lack of concentration, lack of sleep, stress, sad feeling and absence of joyful emotions and ability to face problems
Hostility	RQ2	Ch4	Care4Youth questionnaire	Mediator	Variable measuring the level of hostile thoughts and attitudes
Hopelessness	RQ2 RQ3	Ch4 Ch5	Care4Youth questionnaire HBSC questionnaire	Mediator Mediator	Variable measuring occurrence of hopeless ideas about future
Fighting	RQ3	Ch5	HBSC questionnaire	Dependent	Variable measuring frequency of involvement into physical fights in the last 12 months

Table 4 Overview of variables used in qualitative studies of this thesis (Chapters 6 and 7)

Measure	*Research question*	*Chapter*	*Design/ Data source*	*Short description*
Roles of psychosocial care providers	RQ5	Ch7	Care4Youth interviews	Questions about different aspects of the care provided by the institution, including questions about the competencies of providers, setup of the work with clients, methods they used in their work, theoretical background they have and cooperation with other institutions. We used rather general questions which did not directly regard the perceived roles to prevent socially desirable answers by care providers.
Roles of parents in the process of psychosocial care for adolescents	RQ4	Ch6	Care4Youth interviews	The guide for the semi-structured interview included various questions about the different aspects of the care provided by the institution, including questions on competencies of providers, setup of the work with clients, methods they used in their work, theoretical background they have, cooperation with other institutions, perceived barriers and facilitators of care, and provider's suggestions of what might help to improve the care for adolescents. We selected questions on the role of the parent in this process and include them in the analysis.

2.3 Analyses

For the study reported in Chapter 3, we performed a series of analyses to explore the associations of crisis in the family and of family functioning with positive youth development, using linear regression analysis. We repeated these analyses with adjustment for gender, age and perceived socioeconomic status of the family (SEP). In these exploratory analyses, we also examined the moderating effect of perceived positive parenting, perceived poor supervision and family activities on the association between crisis in the family, and positive youth development was examined by adding in each of the listed interactions (perceived positive parenting × crisis, perceived poor supervision × crisis, and family activities × crisis) separately into a regression model. Next, based on this exploration, we conducted final analyses on the mediation by family functioning of the relation between crisis in the family and positive youth development for all respondents. We did so by assessing the mediation effect of all variables separately and then building a serial mediation model using the PROCESS macro model 6 (Hayes, 2017). These analyses

were all controlled for gender, age and SEP, and all indirect effects were subjected to follow-up bootstrap analyses, with 5,000 bootstrap samples and bias-corrected 95% confidence intervals. All statistical analyses were performed in IBM SPSS v 23.

For the study reported in Chapter 4, we assessed the associations of family-related adversity, psychological distress, hopelessness and hostility with PYD using multivariate linear regression models adjusted for gender, age and perceived socioeconomic status of the family (SEP). We then explored the parallel mediation effects of all the proposed mediators – experienced psychological distress, hopelessness and hostility – which allowed us to assess the effect of every mediator controlled for the effects of the other two mediators. The mediation analysis was done using the PROCESS macro model 4 (Hayes, 2017) and was controlled for gender, age and SEP. It was performed on 5,000 bootstrap samples. The indirect effect was calculated using the *a*b* product method, and the bootstrapped 95% confidence intervals (*CI*) for the indirect effect of *ab* were provided as a test of the indirect effect. All analyses were performed in IBM SPSS v. 23 for Windows.

For the study reported in Chapter 5, we assessed the associations of family-related adversity, hopelessness and fighting using multivariate linear regression models adjusted for gender, age and SEP. Next, we assessed the association of each family adversity (death of a parent, substance abuse problems of a parent, conflicts or physical fights between parents, divorce of parents), hopelessness and fighting using multivariate linear regression models adjusted for gender, age and SEP. All regression analyses were performed on 5,000 bootstrap samples. Fourth, we explored whether hopelessness mediated the association of family-related adversity with fighting. Finally, we ran the same analysis of the mediation effect of hopelessness in the association of each of the family adversities (death of a parent, substance abuse problems of a parent, conflicts or physical fights between parents, divorce of parents) with fighting. The mediation analysis was done using the PROCESS macro model 4 (Hayes, 2017) and was controlled for gender, age and SEP and was performed on 5,000 bootstrap samples. The indirect effect was calculated using the a*b product method, and the bootstrapped 95%-confidence intervals (CI) were calculated. All analyses were performed in SPSS v. 23 for Windows.

In the study reported in Chapter 6 we analysed data in two steps. First, each team member read the transcripts of the interviews and created codes for parts of interviews independently. Second, team members met and shared their codes and interpretations with the aim of achieving consensus. In the case of differing opinions, the discussion continued until consensus was reached. For the coding and analysis process we used the MAXQDA software. After the coding system was completed, codes regarding the role of a parent in any part of the process of care were

clustered into subthemes and four main themes in line with the setup of thematic analysis. Coding and creation of subthemes and themes were done separately for each of the three types of care. Afterwards, we put the codes, subthemes and themes from preventive-counselling, social and health care together and looked for overlap. In the case of some differences, we searched for the code, subtheme and theme that would cover all the nuances. Finally, a thematic map was created.

In the study reported in Chapter 7 we analysed data using Foucauldian discursive analysis (FDA). First, we identified the *discursive objects*. We interpret as *discursive objects* the providers' roles in the care for adolescents and focused on the parts of the interview providing information roles might be drawn. Second, we identified different discourses in the background of these roles. By *discourse* in FDA we mean sets of statements constructing objects and arraying subject positions that facilitate and limit and enable and constrain what can be said, by whom and when (Parker, 1992; Parker 1994). Third, we identified the different *subjective positions* that providers adopted within roles. While a role is something that can be expected to fulfil, a *subjective position* is something providers identify themselves with and is related to the specific rights and duties for those who are identified with the *subjective position.* Finally, we explored the *practices* of providers that are bound and allowed within the various discourses they are based on. Once the analysis was done, we explored whether the identified discourses in the roles led to subjective position and practices in line with transformational tendencies.

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