Long-term mentoring for disadvantaged young people

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Overview

This volume comprises of three parts. Part 1, the literature review, examines the psychological impact that volunteering in a socially supportive role has upon the volunteer. It systematically reviews the evidence about such effects and the associated psychological, situational, or demographic variables.

Part 2 consists of the empirical paper. The study explores how young people change over the course of the mentoring relationship in terms of self-esteem, scholastic attitude, peer relations, and psychological well-being. The study uses a repeated measures multiple case design, following four mentor-youth pairs over a 15 month period.

Part 3 comprises of a critical appraisal of the research and the manner in which it was conducted. It considers four areas: the choice of outcomes that tend to be measured in mentoring research; what can be learnt from the psychotherapy literature; research designs in the mentoring literature; and the impact of mentoring on mentors themselves.

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Part 1: Literature Review

Abstract

Objectives: The review examines the evidence of what psychological impact volunteering in a socially supportive role has upon the volunteer. In addition, it reviews what psychological, situational, or demographic variables are associated with these impacts.

Methods: Studies were included if they examined adults who provided primarily emotional support in a voluntary capacity, and employed at least one quantitative psychological measure.

Results: The 14 studies reviewed fell into four categories: volunteers working with people with HIV/AIDS, with people with other physical health conditions, with people with mental health conditions, and older adult volunteers. There were three methodologically strong studies, which suggested that volunteers are not negatively affected by undertaking their role and may benefit from the experience, for example an increase in self-efficacy. Many of the other studies were less methodologically rigorous, employing cross-sectional designs, which make it difficult to determine the direction of causality. A few variables were associated with outcomes. For example, younger volunteers may be more at risk of being affected negatively. Also, the impact upon volunteers may differ depending on the group of people they work with.

Conclusions: The lack of methodologically strong studies limits the extent to which conclusions can be made. A greater number of rigorous, longitudinal studies are needed in the field.

Introduction

Volunteering is a major industry in the UK. Currently 24% of UK citizens formally volunteer at least once a month (Department for Communities and Local Government, 2010). In 2003, the average volunteer contributed over 100 hours of their time, totalling the equivalent of one million full-time workers, which, at the national average wage, was worth £22.5 billion (Home Office, 2004). Similarly, in 2008, 26.4% of the US population volunteered, on average for 50 hours each (Bureau of Labor Statistics, 2010). The Volunteering Compact Code of Good Practice (Home Office, 2005) defines volunteering as 'an activity that involves spending time, unpaid, doing something that aims to benefit the environment or individuals or groups other than (or in addition to) close relatives' (p.4).

Volunteers can undertake many different roles, from advocacy and campaigning to philanthropy and governance (Smith, 2000). One particular type is providing social support to individuals in need. Although there is a substantial body of research into volunteering, the majority of it examines the effectiveness of voluntary activities, focusing on outcomes for those who are provided for, i.e. the benefit to others. This review is interested in the impact of the volunteering on the volunteers themselves. More specifically, it focuses on the impact of volunteering in a socially supportive role.

Volunteers who provide social support for vulnerable people could in some way be affected by their work, particularly as the support-recipients may have difficulties and be in distress. This could potentially have a positive or a negative impact on the volunteers' well being. Volunteer well being is an area that the literature has rarely considered. The effects on volunteers of providing social support could be interesting from a psychological point of view and lead to further understanding of social support. In addition, such knowledge could potentially be useful for the voluntary sector in terms of retention and recruitment. The introductory section of this review considers the motivations for volunteering, its potential psychological impact on the volunteers, and possible effects providing social support to others.

The motivations for and psychological impact of volunteering

Altruism is commonly cited as a motivation for volunteering (Unger, 1991). It is seen as a product of evolution through reciprocal exchange (Fehr & Fischbacher, 2003), and altruistic social behaviours, such as helping others, have been associated with better mental health (Schwartz, Meisenhelder, Yunsheng, & Reed, 2003). Volunteers may have a number of motivations and there may be a tension between the altruistic desire to help others and the desire to benefit themselves. Hypotheses of why volunteers may choose to undertake their role have focused on their attitudes, values, personality, and motivations (Clary & Snyder, 1999; Thoits & Hewitt, 2001). Onomoto and Snyder (1995) proposed the 'Volunteerism process model', which includes five motives for entering a volunteering role: values, community concern, knowledge, personal development, and social relationships. The benefits a volunteer derives from their role may be reflected in their motivations (Fuertes & Jiménez, 2000). For instance if a volunteer's primary desire is to have more social relationships, they may search for this within their role and benefit in that manner. Alternatively, volunteering may be undertaken with the aim of acquiring knowledge and skills.

There is empirical evidence regarding the physical and psychological impact of being a volunteer. Volunteering among older adults is associated with reduced mortality rates (Oman, Thoresen, & McMahon, 1999), improved life satisfaction and psychological well-being (Fengler 1984) and greater self-esteem (Krause & Shaw, 2000). Volunteers report higher levels of well-being, independent of social integration (Morrow-Howell, Hinterlong, Rozario, & Tang, 2003). These large-scale studies, however, do not distinguish between the various activities undertaken by volunteers.

Providing social support to others

Social support is the perceived or actual social resources available to a person, and has been linked to physical and psychological health (Cohen, Gottlieb, & Underwood, 2000). Three types of social support are typically referred to: informational, instrumental (the provision of material aid), and emotional (e.g. Cohen, 2004). Two hypotheses have been proposed to explain the influence of social support on health. The stress-buffering hypothesis (Cohen & Wills, 1985) suggests that the resources others are perceived to be able to provide can moderate stress appraisal and that actual support may be able to provide solutions to the problem. This predicts that social support will only be effective when the recipient is experiencing stress. The main-effect hypothesis contends that social support is beneficial whether or not the recipient is under stress. The model advocates that the social network enhances the individual's sense of self and also applies pressure on them to comply with social norms, for instance engaging in positive health behaviours (e.g. Thoits, 1983).

Research on social support primarily focuses on the provision of support to people in the supporter's natural social network (i.e. family and friends). The majority of studies examine the effect on the recipient, but some explore the impact on the provider. For example, giving practical or emotional support to family members has been found to be associated with a number of positive indicators of psychological and physical health: longer life span (Brown, Nesse, Vinokur, & Smith, 2003; Brown, Consedine, & Magai, 2005), decreased negative mood (Gleason, Iida, Bolger, & Shrout, 2003), and better physical and mental quality of life, as mediated by improved self-esteem and control beliefs (Warner, Schüz, Wurm, Ziegelmann, & Tesch-Römer, 2010).

The provision of social support to those outside of one's natural social network, i.e. in a voluntary capacity, has received less research attention. Such volunteering opportunities are usually provided by structured programmes, for instance peer support or befriending programmes that involve working with people with mental health problems, young people at risk, youth offenders, or isolated older adults. In peer support programmes, an individual with experience of a particular difficulty provides support for another with a similar difficulty, be it in a one-to-one relationship or in a mutual help group setting. In befriending programmes, the functions of social support may include social relationships, social integration, and the development of self-esteem and self-efficacy, and providing nurturance and coping assistance (Heller & Rook, 1997).

There is evidence for the effectiveness of many of these types of interventions: the person receiving help tends to benefit. For example, befriending interventions have been demonstrated to have a modest ameliorating effect on depressive symptoms and emotional distress in recipients with a diagnosis of depression or under particular distress (Mead, Lester, Chew-Graham, Gask, & Bower, 2010). Though based on limited evidence, national clinical guidelines suggest that, as an adjunct to other treatments, befriending should be considered for people with chronic depression (National Institute for Health and Clinical Excellence, 2009). Similarly, many studies have considered the effectiveness of befriending/ mentoring for disadvantaged youth. Meta-analyses have shown that befriending interventions have a modest positive impact on youth and have investigated the influence of particular organisation and participant characteristics (DuBois, Holloway, Valentine, & Cooper, 2002; Rhodes 2008). The potential impact of befriending/ mentoring on the volunteers themselves, however, is rarely mentioned in the literature.

While the focus of research into the provision of social support by volunteers has mainly been on the recipient, it has been hypothesised that the supportive role may also have an impact on the volunteer. However, there is an absence of a strong theoretical framework underpinning this idea. Indeed, the wide range of social contexts within which these relationships are formed and developed makes it difficult to apply a single model. For example, some volunteering roles place emphasis on provision of instrumental support whilst some focus on informational support. The provision of emotional support, to a greater or lesser degree, may underpin many volunteering roles. Moreover, the relationship will be highly influenced by the personality characteristics of volunteers and recipients, which will govern the nature and level of support offered.

A full conceptualisation of the role and impact on the volunteer must be considered in relation to the role of health professionals; similarities and differences may be observed and the division between professional and non-professional helping may be less wide than is often considered (Barker & Pistrang, 2002). Both involve mutual respect, building a bond, and empathy. The volunteer relationship can be considered more reciprocal and because the role is voluntary the support recipient may feel an obligation to ensure the well being of the volunteer in a way they may not feel with a professional. The volunteer will have fewer of these relationships than a professional and so the success or failure of each may have more of an impact. Volunteers might be more likely to draw on and share their own experiences in an attempt to help (unlike professionals who rely on theory), which may leave them more open to being personally affected.

There have, though, been some hypotheses regarding the nature of the impact that providing social support might have on the provider. Weiss (1973, 1974) advocated that the expression of care for others lays the basis of social relationships and therefore that its absence leads to lowered self-esteem. As a result of his work with self-help groups, Reissman (1965) put forward the notion of the 'helper therapy principle'. This states that benefit is gained in the process of helping others, for instance through enhanced feelings of competence or social value. Moreover, Riessman suggested that helping another may even benefit the helper more than the person helped. A number of hypotheses attempting to explain this process have been suggested, emphasising the provision of social support as being fulfilling and increasing feelings of competence and self-efficacy, thus enhancing well-being and self-esteem (e.g. Kessler, McLeod, & Worthington, 1985). Krause, Herzog, and Baker (1992) suggest that the support provider may be encouraged by observing improvement in the recipient, as it implies that the helper may be able to overcome their own problems by seeking support, thus strengthening their feelings of self control. Furthermore, due to the hope of reciprocity, the provider may gain a sense that they are 'owed' this support (Bracke, Christiaens, & Verhaeghe, 2008). Krause and Shaw (2000) hypothesised that observing improvements in the circumstances of an other may bolster the helper's self-worth, as it would reflect well on the helper's skills and abilities. This suggests, for example, that a volunteer offering informational support would benefit in terms of self-esteem when the other progresses after responding to their advice.

As well as the positive outcomes, it may be that the provision of social support has a potential negative impact on the volunteer. Krause and Shaw (2000) suggested that providing support might have a deleterious effect: lack of improvement in the recipient implies the helper does not have the abilities to help productively, thus reflecting poorly on them. Belle (1990) suggested that providing support might be distressing for the helper if their resources are low. A lot of attention has been paid to the possibility of burnout among professionals whose role it is to provide social support (e.g. Ross & Seeger, 1988). While volunteers are likely to spend less time providing support, and thus it may be less of a burden, they are also less well trained and have fewer sources of supervision and support for themselves in the helping role.

Aims of the review

There has been considerable research into naturally occurring social support, focusing in particular on the effects on the recipient. While there has also been considerable investigation into the effectiveness of volunteering programmes that provide social support, minimal exploration of the impact on the volunteer has taken place. This review aims to appraise studies investigating how volunteering in a socially supportive role may affect the volunteers themselves. It addresses two questions:

1. What are the psychological impacts on the volunteer of providing support?
2. What psychological, situational, or demographic variables are associated with these impacts?

Method

Criteria for the inclusion of studies

There were several criteria regarding the nature of the volunteer activity and the study design:

1. The study must involve adults providing support in a structured programme or setting, rather than to a family member or friend.
2. The support given must be primarily social and emotional, rather than purely practical. The role should not be formally delivering a psychological therapy.
3. The role must be undertaken in a voluntary capacity.
4. The study must include at least one quantitative measure of the psychological impact of providing support. Due to the small number of relevant studies, no other restrictions regarding design were made.

Literature search strategies.

The PsychINFO, MEDLINE and CINAHL Plus databases were searched. No year limits were placed. Searches were restricted to English language peer reviewed journal articles.

An initial scope of the literature was conducted in order to identify relevant search terms. Based on this, the following search terms were used: "befriend*", "buddies", "buddy", "emotional support giv*", "emotional-support volunteer", "giv* help", "helper-therapy principle", "help-provider*", "mutually beneficial relationship", "peer navigation", "peer-support provider*", "peer supporter", and "provid* emotional support". The searches of the PsychINFO, MEDLINE and CINAHL Plus databases yielded 937, 827 and 487 results respectively. There was much overlap in these results.

The titles and abstracts of all papers were examined to initially establish whether they might meet the inclusion criteria. The vast majority of papers were excluded because they did not investigate volunteers at all or they solely examined the impact on the recipient of the support. Approximately 30 full papers were obtained and examined. Most of these were excluded, for example because the volunteer did not play an emotionally and socially supportive role. Nine papers met the criteria for inclusion.

The reference lists of relevant papers were examined and citation searches were carried out for the nine identified papers. This led to a further four studies which met the inclusion criterion. A repeat of this procedure was applied for the four new studies, identifying one further study.

Searches of major crisis hotline organisations were also conducted, such as “Befrienders Worldwide”, “Childline”, “crisis hotline”, “Lifeline International”, “National Sexual Assault Hotline”, “National Suicide Prevention Lifeline”, “Nightline”, and “Samaritans”. The searches of PsychINFO, MEDLINE and CINAHL Plus yielded 109, 109 and 18 results respectively, again with much overlap. None of these papers met the inclusion criteria.

Decisions about including and excluding studies.

In reference to the third inclusion criterion (that the role must be voluntary) stated above, two exceptions were made. In these two studies participants were provided with a modest stipend for their contribution. These papers were permitted because the participants were taking a supportive role and could not be considered professionals. In one (Schwartz & Sendor, 1999) it appeared that the participants spent less than five hours a week providing support. In the other (Rook & Sorkin, 2003) the participants were framed as volunteers throughout. In contrast, one excluded study (Kahn & Fua, 1992) recruited individuals with histories of alcoholism and were recently in recovery to train as alcoholism counsellors. The participants were not framed as volunteers but rather “students” or “trainees” who “graduated” from the training programme, after which they were “employed”.

Many studies were excluded because they did not specify and did not seem to be concerned with the type of volunteering activity, for instance Krause et al. (1992). Studies in which there was ambiguity regarding the extent of the socially supportive role played by the volunteer were excluded.

Results

A total of 14 studies met the criteria for inclusion. The results are presented in four sections: (1) eight studies investigating volunteers working with people with HIV/AIDS, (2) two studies considering people providing social support for those with physical health conditions, (3) two studies investigating volunteers working with people with mental health conditions, and (4) two studies which were defined by the support provider rather than the recipient and considered older adult volunteers. Each section provides an overview of the studies and concludes with a summary. Table 1 summarises the characteristics of the 14 studies reviewed. Table 2 lists the measures used in the studies.

Studies of Volunteers Providing Social Support to those with HIV/AIDS

Eight papers examined the effect of being a ‘buddy’ or volunteer for people with HIV or AIDS. While the papers did not give clear descriptions of what was expected of the volunteer, in each the volunteer played a socially supportive role for the person with AIDS. For instance, Guinan, McCallum, Painter, Dykes, and Gold (1991) described their participants as providing direct emotional support, while

Claxton, Catalán, and Burgess's (1998) volunteers from the Terrence Higgins Trust provided befriending and support on a one-to-one basis.

These studies on volunteers draw on the larger literature investigating burnout among health professionals. In the health literature, burnout is a term used to describe long-term exhaustion and lessened interest, typically arising from the stress of working with demanding populations, such as those with AIDS (Freudenberger, 1974). Less research has been conducted focusing on the role of the volunteer in working with this population. Nesbitt, Ross, Sunderland, and Shelp (1996) highlight the difference between the roles of the volunteer and the professional, underlining the volunteers' choice and freedom, and assert that the two need to be examined separately. The literature generally considers burnout from an economic perspective, due to the vast and cheap contribution that volunteers have made to people with AIDS and the source of care that is lost when volunteers drop out.

Six of the eight studies directly examined burnout. Five of these six used the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981). This conceptualises burnout as consisting of the volunteer's emotional exhaustion, feelings of a lack of personal accomplishment with negative self-evaluation and experiences of depersonalisation, characterised by callous and detached feelings towards their buddy. The other, Maslanka (1996), used the second edition of this measure (MBI-II; Maslach & Jackon, 1986), which includes the two additional scales measuring feelings of withdrawal and having a lack of boundaries between their volunteer role and the rest of their life. Five studies used the General Health Questionnaire (GHQ; Goldberg & Hillier, 1979) as a measure of volunteer psychological and social adjustment. One used the Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983). Nesbitt et al. (1996) and its follow-up Ross, Greenfield, and

Bennett (1999) also examined grief levels, for which they employed the Texas Revised Inventory of Grief (TRIG; Faschingbauer, Zisook, & DeVaul, 1987).

Five studies investigated the rewards and stressors associated with the volunteer role. Guinan et al. (1991) created a tool, later named the HIV Volunteer Inventory, to measure the rewards and stressors perceived by the volunteers. The HIV Inventory was used by three of the other studies. Maslanka (1996) designed an instrument to quantify rewards only.

One study (Williams, 1988) looked only at homosexual male volunteers, while the rest recruited both homosexual and heterosexual male and female participants. All but one study used a cross-sectional design, collecting questionnaire data at a single time point, with data analysed using correlations and, in some cases, multiple regression. The exception was Ross et al. (1999), which employed a prospective longitudinal design, using data from the Nesbitt et al. (1996) study as a baseline.

Main findings of studies

Williams (1988) examined how gay male volunteers, none of whom had AIDS but were by definition members of a high-risk group for HIV infection, were affected by the experiences of being a buddy to someone with AIDS. Just over a third (37%) of the sample described their volunteer experiences as largely positive, 11% as largely negative, and just over half as mixed. About a quarter responded that, at some point, they had regretted becoming a buddy, citing the difficulties in the individual relationship with their 'buddy' to whom they were designated, but also referring to the general stress of AIDS and associated feelings of helplessness. The greater the number of buddies a volunteer had, the more likely he was to be at risk of psychiatric symptomatology. However, it is difficult to interpret this finding because the reasons for having numerous buddies were not stated. It may be that volunteers had more than one buddy at a time, that their buddies died or that the relationship came to an end because it was not productive. A volunteer could be affected by any of these situations.

Raphael, Kelly, Dunne, and Greig (1990) found that volunteers were more likely to show evidence of psychological morbidity than the general population; 37% percent of their respondents reached the GHQ cut off (while only 16% of the general population are at this level). Poor psychological adjustment was associated with a greater likelihood of burnout. Individual factors were associated with outcomes: younger and less experienced volunteers were more likely to report psychological distress.

Guinan et al. (1991) examined the stressors and rewards reported by the volunteers and whether these were associated with burnout and psychological adjustment. The sample exhibited a similarly high level of psychological distress as the Raphael et al. (1990) sample. Many volunteers were also affected by feelings of burnout: around one in five of the volunteers reported emotional exhaustion and a sense of depersonalisation while nearly one in four reported a lack of personal accomplishment in their role.

To measure stressors and rewards Guinan et al. created the HIV Inventory. Each scale consisted of four factors. The stressor scale measured (1) emotional stress experienced by the volunteer, (2) negative aspects of the volunteer’s relationship with the person with AIDS, (3) the support available as perceived by the volunteer, and (4) a lack of training as perceived by the volunteer. The reward scale measured (1) the volunteers’ perception of their effectiveness in their role, (2) their feelings of emotional support, (3) their satisfying social experiences, and (4) the empathy they had and their getting to know and accept themselves.

Multiple regression analysis indicated that high levels of volunteer anxiety and insomnia and of emotional exhaustion were predictive of high stressor scores (notably feelings of being emotionally overloaded and unprepared for their role). It is unclear why the authors used measures of psychological distress and burnout to predict volunteer stress and rewards rather than the other way round. No other associations were found between the HIV Inventory and the other measures. Scores on the reward and stressor scales were positively correlated. Guinan et al. commented that this association may have been related to the volunteers' level of 'involvement' in the relationship, that is, that benefits arrive with an emotional cost. The association between volunteer 'involvement' and the level of benefit perceived by the person with AIDS was not reported but would be interesting to examine.

Maslanka (1996) looked at a sample of volunteers from the *Gay Men's Health Crisis* in New York, an agency that provides HIV/AIDS prevention, care and advocacy. Maslanka developed a tool to measure the rewards experienced by the volunteers. This consisted of the volunteer's sense of new values in their life, their self-efficacy and their sense of being a part of the organisation's community. The study explored the impact of perceived support (from staff and fellow volunteers) and volunteer motivation on rewards and burnout.

Maslanka's results demonstrated a complicated set of relationships between these variables. Receiving good support from staff and other volunteers was associated with decreased burnout, with higher self-efficacy and a new sense of values, all deemed to be positive outcomes. However, while higher self-efficacy was related to decreased burnout, a sense of new values was associated with an increased lack of boundaries, and so increased burnout. Thus the rewards gained through a new sense of values seem to be linked to problems maintaining boundaries between their voluntary work and the rest of their lives. Those volunteers whose motivation to volunteer was related to a desire to rethink their career were more likely to have greater self-efficacy and a new sense of values, but were also more likely to report burnout. The author did not comment on the influence that other motivations might have had, but advised that organizations should provide volunteers with realistic expectations for their role to help reduce the likelihood of burnout. Compared to older volunteers, younger volunteers were more likely to report burnout.

Bennett, Ross, and Sunderland (1996) explored the idea that rewards experienced by the volunteer might act as a buffer against stress and reduce burnout. They employed a cross-sectional design, requiring volunteers to complete the HIV Inventory (Guinan et al., 1991) and the MBI (Maslach & Jackson, 1981), a measure of burnout. In contrast to Guinan et al.'s findings, Bennett et al. identified many associations between the stressors/rewards and burnout; the HIV Inventory accounted for a fifth of MBI variance. This suggests that burnout is related to the balance between stressful and rewarding experiences and that rewards may protect against burnout.

Stressors were associated with increased burnout; all four stressor scales – lack of training, difficulties with interactions with their client, feeling emotionally overloaded, and lack of support – were associated with overall burnout and also specifically with volunteer emotional exhaustion. The first three were associated specifically with feelings of depersonalisation. Rewards were related to decreased burnout; those volunteers who reported feeling rewarded were less likely to experience burnout, due to feelings of personal accomplishment. The reward factors of personal effectiveness and empathy/ self-knowing appeared to be particularly important buffers.

Nesbitt et al. (1996) investigated the extent of volunteer grief and its relationship to stressors and rewards (as measured by the HIV Volunteer Inventory), psychological distress (as measured by the GHQ) and burnout (as measured by the MBI). They assumed that grief was purely negative. However, taken in the context of Guinan et al.'s findings of the association between stressors and rewards, it may be that grief is not wholly negative. Indeed, volunteer grief was not associated with burnout.

Higher levels of grief were correlated with both less time spent volunteering and shorter length of time as a volunteer; both associations can possibly be explained by volunteer self-selection. Regression analysis demonstrated that high grief levels were predicted by a short length of time spent as a volunteer, feelings of being emotionally overloaded, a lack of emotional support and increased social dysfunction and somatic symptoms. Lower levels of grief were associated with higher feelings of reward. In contrast to Williams' (1988) findings, Nesbitt et al. (1996) did not report any associations between psychological distress and the number of buddies a volunteer was placed with.

In a follow-up of the Nesbitt et al. (1996) study and using the same measures, Ross et al. (1999) investigated differences between those who were continuing to volunteer and those who had ceased. They examined whether baseline measurements of stressors and rewards predicted later drop out. Each of the stressor subscales was predictive of drop out, but there were no associations between drop out and the reward scales. Volunteers who experienced intense feelings of depersonalisation (a measure of burnout) at baseline were more likely to drop out.

Ross et al. asserted that, for volunteers, drop out and burnout should be distinguished. They suggested that burnout among volunteers should not be considered as significant a factor as it is with professionals, because of the greater financial latitude maintained by the volunteers with respect to their role. The concepts and occurrence of burnout and drop out, however, should not be ignored. This is confirmed by both burnout and grief being associated with both feelings of stress and reward at some point in the two studies. Ross et al. concluded that volunteer perception of the stress and rewards reaped from their role should be taken seriously.

Claxton et al. (1998) investigated demographic, situational and motivational factors associated with burnout, grief and psychological morbidity in order to identify those most at risk. Three quarters of volunteers fell within the moderate or high burnout range on one or more of the MBI subscales. Around one in four was considered to have significant levels of burnout. Only 2% of buddies were identified as depressed and 12% were classified as having high levels of anxiety. Some demographic factors were weakly associated with burnout: older volunteers, female volunteers, those less educated, and those who were unemployed or homemakers were less likely to report burnout.

Spending more hours per week with the buddy had both positive and negative associations with different MBI subscales: more hours per week was related to experiences of personal accomplishment (protecting against burnout) and also to feelings of emotional exhaustion (contributing to burnout). Feelings of closeness to the current buddy were associated with experiences of personal accomplishment and less depersonalisation (both protecting against burnout). However, while feeling close to their *previous* buddy was positive in that it was related to feelings of personal accomplishment, it was also negative in that it was associated with emotional exhaustion. Having a more physically ill buddy was purely negative: it related to volunteer emotional exhaustion and depersonalization. Volunteers who were dissatisfied with the training and support they received were more likely to experience psychological distress and burnout. A logistic regression model was not successful at distinguishing between volunteers who had high and low burnout scores. Only one independent variable was identified as statistically significant: those who endorsed the motivation ‘I wanted to find out more about HIV/AIDS’ were more likely to be in the high burnout category.

Summary and critique

There is consistent evidence from these studies that volunteers working with people with HIV/AIDS report higher levels of psychological distress than the general population. Of the seven papers that investigated burnout, only Guinan et al. (1991) and Claxton et al. (1998) reported the proportion of moderately or severely affected volunteers: between a quarter and a fifth of volunteers experienced at least moderate burnout, with many more experiencing some symptoms. Some volunteers experienced grief, but no details were given as to how many and to what extent.

The volunteers experienced their role as both rewarding and stressing, and indeed the two were positively correlated. Similarly, the number of hours spent with the person with AIDS had contradictory associations with different MBI subscales. Volunteer satisfaction with support was associated with reduced burnout and enhanced feelings of reward. It may have been fruitful to further investigate the impact of the amount and types of support volunteers were given. Support may be particularly important for experiencing rewards due to the especially emotive nature of working with this client group.

Younger, less experienced volunteers were more likely to report burnout or psychological distress. There is contradictory evidence regarding associations with volunteers' educational level. Correlations with demographic factors, however, were weak. Situational factors may also play a part. However, there was contradictory evidence regarding the associations found with having a number of different buddies, the length of volunteer 'career', and the amount of time spent volunteering per week. It appears that volunteers benefited from having motivations that could realistically be met by the organisation.

Several methodological issues need to be highlighted. The drawing of conclusions is limited by the cross sectional design employed by all but one of the studies: causal relationships cannot be asserted. For instance, Claxton et al. (1998) found that volunteer dissatisfaction with the training and support received was associated with experiences of psychological distress and burnout. It would be easy to conclude that it was because of the lack of training and support that they experienced later difficulties. However, it may be that those who had a propensity for psychological distress and burnout, or even were possibly experiencing some of those symptoms before starting their role, were more likely both to view training as inadequate and also to reject support. Even with conclusions such as volunteers reporting higher levels of distress than the general population, caution must be taken. It is important to consider the type of person who is attracted to volunteering, in particular with people with HIV/AIDS, and, of these, those who are inclined to take part in research.

Many of the authors commented on the issue of low response rates and that the postal questionnaire method, used in all but one study, created a self-selecting sample. Also, the manner in which the project was described to the participants, be it in relation to grief, drop out or whether described in neutral terms, may have influenced the make up of the sample according to the aim of the project.

There was a wide variety of measures used, each tapping differing and mostly negative experiences: grief, burnout, stressors, and psychological distress. While there is a degree of continuity of measures used across studies the differences, the heterogeneity makes it difficult to draw conclusions. The studies tended to use relatively established measures. The TRIG is one of the most commonly employed tools used to measure grief (Futterman, Holland, Brown, Thompson, & Gallagher-Thompson, 2010), the MBI is widely used and the GHQ is also prevalent across psychological literature and shows good reliability, with coefficients ranging from 0.78 to 0.95 (Jackson, 2007). The HIV Volunteer Inventory seems to have good face validity, but is not a widely used tool, partly because it is specific to this population. The stressor scale on this measure had good internal consistency but there were no significant correlations between the reward factors. The vast majority of the variance in the reward scale can be explained by just the *personal effectiveness* factor (Guinan et al. 1991). Maslanka's (1996) rewards measure is not explained in detail and is specific not only to the AIDS population but also to the organisation from which the volunteers were recruited.

Studies of Volunteers Providing Social Support for those with Other Physical Health Conditions

Two studies examined social peer support for people with physical illness: one for women with multiple sclerosis (MS) (Schwartz & Sendor, 1999) and the other for women with breast cancer (Giese Davis et al., 2006). In both studies the volunteer had experience of the diagnosis which the recipient of the support was living with, whether currently or in the past.

Schwartz and Sendor (1999) compared the quality of life of five women peer supporters with MS with those who they supported. The peer supporters were specifically selected for their ability to communicate with others and received training in non-directive active listening. They provided emotional and social support for 15 minutes a month, primarily by phone, to 67 participants who also had the disease. The peer supporters were given modest payment for their role. Quality of life was assessed by several measures split into three categories: role performance (a combination of social activity, fatigue, and role limitations), adaptability (the ability to engage in their physical and social environment, including self-efficacy), and well-being (for example, global satisfaction, mastery, depression, anxiety). Measures were completed at baseline and after one and two years, by both groups. A focus group was conducted three years after for the peer supporters, asking participants about their experiences in the programme.

Compared to those who received the support, the peer supporters reported greater benefits by a factor of 3.9 in psychosocial role performance, of 3.5 in adaptability, and of 7.6 in well-being. Of note were improvements in confidence, self-esteem, self-awareness and role functioning in comparison to those who were supported. They also reported relatively reduced fatigue, depression and physical role limitations. The majority of the gains occurred in the volunteers' second year in the role. The main themes that emerged from the focus groups were putting their problems into perspective, improving listening skills, gaining a stronger awareness of a higher power, and improved self-acceptance and self-confidence.

The authors hypothesised that benefits may have arisen due to the supporters being presented with new frames of self-reference and changes to internal standards and values. This hypothesis was based on it being *peer* support, suggesting that providing support for those without their condition would not lead to such improvement. They also suggested that the training in active listening may have enhanced the volunteers' support network.

Schwartz and Sendor employed a broad range of widely used measures, such as the Multidimensional Health Locus of Control Scale (Wallston et al., 1978). They also used the MS Self-Efficacy Scale (Schwartz, Coulthard-Morris, Zeng, & Retzlaff, 1996), a less common but, importantly, MS-specific tool. The longitudinal design and the comparison of support providers and recipients on the same measures are strengths of the study. The results, however, are based on a small number of peer supporters. The monthly volunteer group meetings of the peer supporters may have had a positive effect on the supporters, potentially limiting the validity of the study.

The second study, by Giese-Davis et al. (2006), examined peer support for women who had been newly diagnosed with breast cancer, provided by volunteers who, on average, were four years post diagnosis. They investigated the effect of the relationship on both the recipients of the support (referred to as Sojourners) and the supporters (referred to as Navigators). Contact between the pairs, primarily by telephone and involving expression of feelings and active coping, was one to four times per week over 3-6 months. Within a longitudinal design, a wide range of measures were completed, at baseline and after 3, 6, and 12 months. The measures assessed depression, cancer-related trauma symptoms, quality of life, cancer self-efficacy, the doctor-patient relationship, desire for cancer resource information, affect suppression, restraint and repressive-defensiveness and emotional self-efficacy.

The Navigators reported neither an improvement nor, importantly, a decline in the majority of the measures. There was, however, a decrease in satisfaction with their medical team (even though the programme aimed to facilitate positive interactions with their doctors, through training and supervision). Navigators also showed an increase in affect suppression, possibly because they wanted to protect the Sojourner from difficult feelings. There was also a non-significant increase in Navigator depression and trauma symptoms. Half way through the study, the authors noticed this and reacted by making supervision mandatory and employing a trauma specialist. Giese et al. advocated the need for supervision to protect the Navigators.

The study had a number of strengths and limitations. There appeared to be a thoughtfully broad range of advertising to generate the sample of the Navigators. The authors employed a number of cancer-specific measures, some of which were less and some more well-established, as well as a wide range of well-established general measures of psychological functioning. However, the study appeared to have a primary focus on evaluating change in the Sojourners rather than the Navigators. Since the Navigators had lower baseline distress levels than the Sojourners, it may be that the measures utilised did not pick up change in this group. There were not any measures that would have picked up improvements in Navigator self-esteem and self-efficacy outside of their relationship to cancer.

Data from five Navigators (out of a total of 30) could not be included as they did not complete follow-ups, and these five reported significantly higher depression symptoms, lower well-being, lower cancer-efficacy and less restraint of hostility at baseline. It may be that those who scored more negatively on these measures were negatively impacted by their supporting role and so were less likely to complete follow-ups, thus influencing the findings. In the focus group the Navigators suggested that their greater dissatisfaction with their medical team was due to their having less frequent contact as they were further out of treatment. Without a control group of participants at a similar stage post-diagnosis, it is difficult to draw firm conclusions about whether their supporting role impacted on this or whether it was simply an effect of time.

Summary and critique

It appears that volunteers with physical health conditions providing social support to their peers were not negatively affected by their role. Furthermore, the Schwartz and Sendor study suggested that providing support is related to a range of psychological improvements.

Strengths of both studies were their longitudinal design and their use of a wide range of established measures. However, while in the Schwartz and Sendor study both the providers and recipients of the support were at a similar stage in their diagnosis, this was not the case in the Giese et al. study and so the measures which focused on assessing change in the recipients may have been less applicable for the supporters. This may help to explain why the former study reported more positive results for those providing the support.

Studies of Volunteers Providing Social Support for those with Mental Health Conditions

Two studies examined social support for people with mental health conditions. Bracke et al. (2008) examined everyday supportive behaviours between peers at day activity centres for people with a history of chronic mental illness. Roberts et al. (1999) investigated the impact of receiving and providing support in peer support groups for people with serious mental illness. Both studies quantified the amount of support received and given by each individual member and examined whether this was related to psychological outcomes.

Bracke et al. (2008) examined peer support in rehabilitation day-centres which provided activity programmes for people with chronic mental health problems. They explored the relationships between support given, support provided, self-esteem, self-efficacy, and current mental health. The authors employed a cross-sectional design, with analysis across 51 day-centres and across 628 individual participants. Participants completed measures regarding the provision and receipt of (primarily social) support within the general milieu of the day centre. The authors were interested in the balance of support provided and received (i.e. if the individual could be considered a net provider or net recipient of support).

The total amount of supportive interactions (a combination of support received and provided) in each day-centre was associated with both self-esteem and self-efficacy. This suggested that supportive interactions were beneficial. Regression analyses indicated that the amount of perceived support received accounted for 14% of the variance in self-esteem and that a balance between support provided and support received was important for higher self-esteem. However, when self-efficacy was included into the equation, the effect was removed. Being a net provider of support predicted higher self-efficacy and an individual who received more support than they provided was likely to have lower self-efficacy. This effect was independent of self-esteem levels. The authors suggested that providing support bestowed feelings of competence and control. More detailed multivariate analyses demonstrated that receiving support accounted for improvement in self-esteem in women but not in men. For both sexes, providing support was related to higher self-efficacy, but to a greater extent for men than for women.

The authors rightly noted that direction of causality could not be demonstrated due to the correlational nature of the data. It may be reasonable to suggest that low levels of support received led to low self-esteem, but low self-esteem may also have lent to a negative perception of the level of support in the network. (However, the inclusion of the measure of mental health may partially have controlled for the influence of the latter.)

Roberts et al. (1999) measured the occurrence of helping behaviours in mutual-help groups and compared these to the group members' social and psychological adjustment. The 15 groups were run by GROW, International, an organisation for people with a history of serious mental illness. The study used a longitudinal design; participants were interviewed twice, on average 8 months apart. The interviewer also completed the Interviewer-Rated Adjustment Scale (created by the authors) to rate participants' behavioural expressions of symptoms and life distress. Participants also completed self-report measures of psychiatric symptoms and general distress (as measured by the Social Adjustment Scale-Self Report, Weissman & Paykel, 1974) and of social functioning (as measured by the Symptom Checklist, Derogatis, 1977). Individual interactions in the groups were coded using the Mutual Help Observation System, designed by the authors to assess supportive interactions. The Help Given scale was comprised of measures of Support Given, Interpretation Given, and Guidance Given (informational support). There were also corresponding indices for Help Received.

Multiple regression analyses indicated that giving help to others predicted improved self-reported social functioning and interviewer-rated psychosocial functioning. In particular, the giving of informational guidance, but not the giving of support or interpretation, predicted improvements in self-reported social functioning scores. The authors suggested that this concrete informational support may have been more related to the provider's own experience with a similar difficulty, and thus reinforced the provider's own learning. The only predictive factor in the receipt of help was that those who received more interpretive help reported improved social adjustment.

As the authors note, caution is needed in the interpretation of these results. For instance, it is possible that those who had the personal resources to help others in the group were the ones who were also able to adjust positively. The behavioural coding system was limited to interactions that took place within the group, while support may also have been given between members outside of the confines of defined group time. Also, only the quantity of helping interactions was considered, rather than their quality or their context. There is also potential bias in the sample, as it was those who were more heavily invested in the programme who were more likely to meet the inclusion criteria of having attended enough groups. Caution must be taken when generalising findings to less committed members, and, indeed, other self-help groups. The multi-method assessment approach, of using interviewer ratings and an observational measure, as well as participant self-report, should be applauded.

Summary and critique

It appears that people with mental health conditions benefit from providing social support to their peers. The Roberts et al. (1999) study suggests that providing support is related to a range of psychological improvements. Bracke et al. (2008) provide evidence that improved self-efficacy is associated with providing support to others. Both studies used rigorous methods but, again, the causation could not be determined in either study. While the participants in these two studies did provide social support, they may not have seen themselves as taking up the role of a ‘volunteer’, because they were in settings where support was potentially more reciprocal. This may or may not have an effect on the impact of providing support.

The measures the two studies used to quantify support provided and received differed in their complexity. Roberts et al. were ambitious and rigorous: observers used a coding system to rate participants’ provision and receipt of support over time. Bracke et al. created a simple self-report tool comprising of just eight questions and which was used at just one time point. The Bracke et al. study, however, did use well-established measures to assess change in the volunteer. While it is useful that Roberts et al. used self- and interviewer-report tools to assess change in the participants, it may have been informative to have included a wider range of measures looking at a greater number of aspects of participant well-being.

Studies of Older Adult Volunteers Providing Social Support

The final two papers come from what is a comparatively wide literature regarding volunteering amongst older adults. Widowhood, retirement, and other social role losses can often leave older adults without the opportunity to help others and the associated sense of personal meaning in life (Krause & Shaw, 2003). Volunteering roles can provide this opportunity.

Kuehne and Sears (1993) investigated older adult volunteers who undertook a predominantly emotionally supportive but also a practical role with children with chronic illnesses. With the view to creating a profile of committed volunteers, the authors examined differences between those volunteers who continued in their role beyond the initial nine-month commitment (n=7) and those who did not (n=12). The study used a cross sectional design with the volunteers completing an author-created questionnaire which asked about views of self, reasons for volunteering, and coping strategies and included an open-ended section. Volunteer life satisfaction was assessed using the Life Satisfaction in the Elderly Scale (LSES; Salamon & Conte, 1984), which consists of eight subscales: daily activities, meaning, goals, mood, self-concept, health, finances, and social contacts.

The data indicated that volunteers with altruistic motivations for beginning their role were more likely to have higher self-esteem. Also, the motivations of those who continued in the role were more likely to have been met by the organisation. These findings point to the importance of volunteers having realistic expectations. Those who continued in their role were more highly educated, had a higher income, and were more likely to volunteer for other organisations than those who left.

Those who continued also reported higher life satisfaction than those who did not. Among the seven volunteers who remained in their role, life satisfaction was associated with participation in other volunteer organisations, and length of time involved with this organisation. (These analyses were not performed for the group who discontinued their role.) Thus it seems that those who spent more time volunteering also enjoyed greater life satisfaction.

One cannot draw conclusions about causality of whether volunteering leads to greater life satisfaction or vice versa. The use of the open-ended questionnaire allowed for volunteers to report subjective experiences, but responses could not be quantified easily. The LSES looks at a wide range of areas, but is not a well-established measure and, in the light of the qualitative data, the authors claim that it was not able to capture the self-esteem of their sample accurately. Some of the LSES subscales were pertinent for the authors’ aims of building a profile of volunteers who continued in their role, but were less appropriate for examining volunteer change. A greater number of quantitative measures would have been useful. This, coupled with the relatively small sample size, suggests caution should be taken when drawing conclusions from this study.

Rook and Sorkin (2003) investigated the impact of involvement in the Foster Grandparent Program (FGP) on volunteer emotional health and social ties. The FGP is an organisation that pairs developmentally disabled children with older adult volunteers, providing one-on-one attention, nurturance and care for the child. The volunteers also engaged in daily social contact with their peers in the program. They received a “modest stipend” for their work, but the authors explicitly state the participants took on a “volunteer role” and refer to them in such terms throughout. Those in the control groups also received a smaller stipend.

The study examined the impact of the supportive role on the volunteer. The FGP group was compared with two control groups: a community sample of older adults (CS) and older adults in an alternative group programme (AGP). These groups were included to control for the opportunity to make friendships and for the personal characteristic ‘volunteerism’. Those who had expressed interest in the FGP were randomly assigned to either that group or the AGP group. The CS group comprised of individuals in the community who also were willing to perform volunteer work. This was done in an attempt to isolate the impact of providing support for the children. The study took a longitudinal design, with measures of emotional well-being and specific social characteristic networks taken at baseline (T1) and annually for two years (T2 and T3). Participants were interviewed to assess their number of social ties, using a name-eliciting question procedure (adapted from Fischer, 1982, and McCallister & Fischer, 1978). Measures of self-esteem, loneliness, number of chronic health problems, and depression were taken.

There were no significant differences in emotional health (self-esteem, loneliness, depression) between the three groups between baseline (T1) and two years later (T3). Both from T1 to T2 and from T1 to T3, the FGP group reported significantly more social ties, the majority of which were with people involved in the programme itself. Those in the FGP were more likely to form both exclusively negative and exclusively positive new social ties.

The authors provided several explanations for the lack of demonstration of emotional benefit. The volunteers' substantial time commitment (of 20 hours per week) and their interactions with supervisors may have meant that it began take on the role of work and limited the benefits derived. The nature of the research study necessitated that friends of the volunteers could not join the organisation, something that is very common in other programmes, possibly contributing to a lack of emotional health benefits. Circumstances meant that the volunteers were working with children who were lower-functioning than they had been expecting and the intensity and demands of the role may have detracted from the potential benefits. Indeed, there were high dropout rates, with some participants stating that they found the role more demanding than they had anticipated.

However, the study has a number of strengths. It was well designed, used considered control groups and had a relatively large sample size. Furthermore, it included randomisation between two of the groups. Three of the four measures are widely used, with the social ties tool also having been used in a number of other older adult studies. Measures were taken over the relatively long timeframe of two years. The authors gave due attention to attrition rates, something which is not uncommon in older adult volunteers due to problems associated with their age.

Summary and critique

It can be concluded that older adults volunteer who offer social support are not negatively affected by their role and may possibly derive benefits from it. The Kuehne and Sears (1993) study suggests that having altruistic motivations and realistic expectations for the volunteering role is associated with higher self-esteem. Also, those who continue in their role and who spend more time volunteering are likely to enjoy greater life satisfaction. The participants in the Rook and Sorkin (2003) study reported neither gains nor deleterious effects to their emotional health, but did foster more social ties compared to controls.

The Rook and Sorkin study used a rigorous, randomised longitudinal design with established measures and considered use of control groups. However, there were several aspects of the voluntary programme that may have explained why the participants did not derive the gains the authors had hypothesised. The Kuehne and Sears study used a far simpler, cross-sectional approach and causality could not be inferred. The authors employed only one quantitative measure and, despite it covering a number of areas of functioning, the study would have benefited from using a wider range of measures. Both studies, however, tried to take into account the life stage of the sample of the volunteers in their design.

Discussion

Summary of Findings

The psychological impact upon the volunteer

The 14 studies provided limited and varying evidence regarding the impact on volunteers of providing social support. The majority of studies had weak designs and provided limited evidence, but three had stronger designs.

The studies in the areas of AIDS accounted for over half of those in the review. They suggested that volunteers experience burnout and psychological distress, but also some degree of reward, and that some aspects of the role are simultaneously stressful and rewarding. However, these studies were all methodologically weak: all but one employed a cross-sectional design, none included a comparison group, and all but one used postal questionnaires as their sampling method. As a result, conclusions about what caused the volunteers' burnout and distress cannot be drawn, due to selection effects and poor sampling.

The strength of designs of the six studies examining volunteers working with other populations varied. Three in particular stood out in terms of methodological rigour (Schwartz & Sendor, 1999, Roberts et al., 1999, and Rook & Sorkin, 2003), in terms of their use of comparison groups and appropriate measures, and in the case of the Rook and Sorkin study, the randomised design. The Rook and Sorkin study suggested that volunteers were not negatively affected by undertaking their role while the other two reported improved volunteer psychosocial functioning. The other three of these six studies also described benefits to the volunteer, with the common theme being higher self-efficacy. The non-AIDS studies appeared to be less explicitly concerned with the potential negative impact of such a role and, as they did not assess burnout, it is difficult to conclude whether or not burnout is particular to those working with people with AIDS.

In all of the studies the volunteers were expected to engage with people who would be experiencing some distress. This may have had an emotional toll on the volunteer and may have limited the benefits that could be gained. Many studies, in particular those in the area of AIDS, did not describe in much detail what support the volunteers provided. It is likely that there was heterogeneity in the support they gave, dependent on the needs of the recipient population. Given the heterogeneity of the recipient populations across studies, it is likely their psychological needs would have differed, and in turn the emotional support provided to them. It is possible that the effect on the volunteer of giving support may differ depending on whether they provide support to peers or non-peers. Most of the AIDS studies did not specify the proportion of volunteers who were "peers" (i.e. homosexual/ bisexual). Future studies should be sure to be clear about the characteristics of their sample of volunteers.

What factors were associated with volunteer outcomes?

Only some of the studies, none of them among the methodologically strong three, looked at and found factors associated with volunteer outcomes. Nonetheless, a few themes emerged. Volunteers who were well supported by the organisation were less likely to burn out and more likely to experience rewards. Younger volunteers and those who were less experienced in volunteering appeared to be at greater risk of burnout and poor psychological and social adjustment. Such findings may have been as a result of a self-selecting sample and the direction of causation is unclear. Another common finding suggested that the extent to which the organisation could meet the hopes and motivations of the volunteer have a role in the extent of benefit experienced.

However, as Claxton et al. (1998) noted, demographic factors, regardless of their predictive value, should not be taken into account when advertising for and recruiting volunteers, for ethical and legal reasons. Furthermore, selection based on such factors would disregard other findings that it can be those who initially appear to have the least potential who turn out to be some of the best volunteers (Sainer & Zander, 1971).

Methodological Issues

Participants

All but one of the eight AIDS studies used postal questionnaires to obtain their sample, leading to small sample sizes relative to the target population. Bennett et al. (1996) and Nesbitt et al. (1996), drawing from the same sample, had a participation rate of 13%, while Ross et al. (1999) got follow up response to only 44% of those. The rates of the other four ranged from 42% to 58%. Relatively low participation rate leads to questions of how representative the sample was as they would have been particularly vulnerable to self-selection. The other studies were likely to have more representative samples as they had higher participation rates. For example, Roberts et al. recruited 84% of the 357 people they contacted.

There was great variability in the extent to which studies reported not only what the volunteers actually did but also in the descriptions of the training and supervision provided by the organisations. It is important that future studies give clear descriptions of these areas.

Research design

The cross-sectional design employed by the majority of the studies only allowed for measures of association, meaning causation cannot be assumed. With measurements taken at only one time point, there was no ability to assess change in an individual over time. Therefore, it is unknown whether reported differences in the volunteers compared to, for instance, a community sample, was an effect of undertaking their role or was characteristic of those who chose to volunteer. Five of the 14 studies used a longitudinal design, including the three noted as methodologically rigorous. These five looked at participants' scores at different time points, meaning change in scores could be more confidently attributed to the impact of their role.

Four of the 14 studies included an appropriate control group with which the volunteers could be compared. The Schwartz and Sendor (1999), Roberts et al. (1999), and Brake et al. (2008) studies all compared those who provided the support to their recipient peers while the Rook and Sorkin (2003) study included two control groups. This allowed for the key variable of the provision of support to be further isolated, as other variables would influence both groups. Comparisons to community samples (through the norms of standardised measures) within cross-sectional designs do not allow for conclusions about causation to be drawn.

Only one study, Rook and Sorkin (2003), had the benefit of a randomised design. Non-randomised designs have the potential problem of uncontrolled selection; there may be something different in the first place about those who choose to volunteer or who provide more support and this may be reflected in their scores.

Measures

The 14 studies used a wide range of measures. Many of these were standardised and well established while some did not have demonstrated psychometric characteristics. A number of the same, well-established measures were employed across the AIDS studies, such as the Maslach Burnout Inventory (Maslach & Jackson, 1981). This allowed for easier comparison across the studies. Among the other studies there was much variability both in the constructs the authors decided to assess and in the measures used in their assessment. This variability may partly be due to the differing participant populations studied. It was a strength of the studies reviewed that many employed measures and constructs specific to their particular populations. For example, Schwartz and Sendor (1999) used a self-efficacy scale specific to multiple sclerosis and Rook and Sorkin (2003) measured social ties, something which is pertinent to older adults. Two of the studies of AIDS volunteers, Guinan et al. (1991) and Maslanka (1996), created outcome measures specifically for their participants (although, in contrast to Guinan et al., Maslanka provided little detail about the process of creation of and items included in the reward scale). Many of the studies used some generic, established mental health measures and also some specific measures, determined by the characteristics of the populations and the volunteering organisations. This allowed for potential comparison across studies while also being sensitive to particular specific influences on particular populations. Some studies, however, were limited by relying on a small number of measures. For instance Raphael et al. (1990) and Bennett et al. (1996) each used just two.

While most of the studies simply assumed that the volunteers provided support, two studies (Roberts et al., 1999, and Bracke et al., 2008) should be commended for creating tools to measure this. Roberts et al. created an intricate measure that provided an objective quantification of support given and received in peer support groups. In contrast, the tool created by Bracke et al. was less detailed, although the day centre setting was less amenable to objective quantification of support. Future studies would benefit from incorporating a measure of the support provided by the volunteer.

Conclusion and Future Directions

The studies reviewed provide limited evidence about the psychological impact that playing a socially supportive role has upon the volunteer. The methodological rigour of the studies varied, but there is some evidence of a benefit to volunteers as well as a potential psychological toll.

That volunteers report benefits is consistent with Reissman's (1965) notion of the helper therapy principle. The psychological toll on volunteers that is reported in the AIDS studies is coherent with the notion that voluntary roles may have a negative impact on the volunteer (e.g. Belle, 1990). However, further, more methodologically rigorous studies are necessary before firm conclusions can be reached as to exactly what these benefits and tolls are and why they arise.

The variable methodological rigour of the studies reviewed limits the extent to which conclusions can be drawn. However, some of the information they provide, for instance that many who volunteer with people with AIDS experience feelings of burnout, is nonetheless potentially useful to the organisations and how they look after their volunteers. Organisations should attend to the possible negative outcomes of volunteering and be aware that the support offered to volunteers may be of consequence in their experience of their role. Further research into the types of support that most enable volunteers is important.

Table 1:

Summary of studies

Author (Date)	**Support recipients**	**Sample of volunteers providing support**	**Design**	**Measures**
Bennett et al. (1996)	People with AIDS	Interfaith religious organisation, men and women N=174	Cross-sectional	MBI HIV Volunteer Inventory
Bracke et al. (2008)	People with mental health conditions	Individuals in day activity centres for people with chronic mental health difficulties N=628	Cross-sectional, across the individual and organisational levels.	Global Self-Esteem scale Abbreviated version of Self-Efficacy Scale Global Severity Index of the Brief Symptom Checklist Measure of levels of support given and provided, created by the authors
Claxton et al. (1996)	People with AIDS	N=267 (or 197 for some measures) from the Terrence Higgins Trust	Cross-sectional	HADS MBI Abbreviated version of Calvert Motivational Checklist
Giese-Davis et al. (2006)	People with physical health conditions	Women who had breast cancer (on average four years post-diagnosis) N=25	Longitudinal	CES-D PCL-C FACT-B CBI Medical Interaction Scale of the CARES BCRQ CECS WAI SESES-C
Guinan et al. (1991)	People with AIDS	Recruited from various AIDS agencies in Australia, men and women N=72	Cross-sectional	HIV Volunteer Inventory GHQ MBI

Author (Date)	Support recipients	Sample of volunteers providing support	Design	Measures
Kuehne and Sears (1993)	Children with chronic illnesses	Older adults, aged 58 and above N=19	Cross-sectional, comparing those who continued to volunteer to those who did not.	Author-created questionnaire re demographics, views of self and coping strategies along with an open-ended component re volunteer and own family experiences LSES
Maslanka (1996)	People with AIDS	Men and women from The Gay Men's Health Crisis in New York N=265	Cross-sectional	Measure of rewards, created by the author MBI, 2nd edition Measure of perceived social support from staff and from fellow volunteers, created by the author
Nesbitt et al. (1996)	People with AIDS	Interfaith religious organisation, men and women (from the same sample as Bennett et al. 1996) N=174	Cross-sectional	HIV Volunteer Inventory GHQ MBI TRIG
Raphael at al. (1990)	People with AIDS	Recruited from various AIDS agencies in Australia, men and women N=157	Cross-sectional	GHQ MBI
Roberts et al. (1999)	People with mental health conditions	Persons with a history of mental illness N=98	Longitudinal	SCL-90-R SAS-SR Interviewer-Rated Adjustment Scale (created by the authors) Mutual Help Observation System (created by the authors) PNI
Rook and Sorkin (2003)	Developmentally -disabled children	Older adults, aged 60 and over N=52	Longitudinal	Rosenberg Self-Esteem Scale 10 of the 20-item UCLA Loneliness Scale CES-D Name-eliciting question procedure

Author (Date)	**Support recipients**	**Sample of volunteers providing support**	**Design**	**Measures**
Ross et al. (1999)	People with AIDS	Interfatih religious organisation, men and women (from the same sample as Bennett et al, 1996, & Nesbitt et al., 1996) N=76	Cross-sectional in itself, but follow up of Nesbitt et al. (1996), so longitudinal	TRIG MBI HIV Volunteer Inventory GHQ
Schwartz and Sendor (1999)	People with physical health conditions	Women with a diagnosis of MS N=5	Longitudinal	Sickness Impact Profile Multidimensional assessment of fatigue scale Function and control subscales of the MSSE Internal subscale of the MHLC Relative profile scores of the WCCC Ryff Happiness Scale Satisfaction subscale of the QLI Depression, anxiety and social activity subscales of the AIMS
Williams (1988)	People with AIDS	Homosexual males volunteering with the Boston AIDS Action Committee N=54	Cross-sectional	A measure of how ‘out’ the volunteer was, created by the author. PSS GHQ

Table 2: List of measures

Measure	Author
AIMS - Arthritis Impact Measurement Scales	Meenan, Gertman, and Mason (1980)
BCRQ - Breast Cancer Resources Questionnaire	Giese-Davis et al. (2006)
Brief Symptom Checklist	Derogatis (1993)
Calvert Motivational Checklist	Calvert, Flynn, Fraser, and Long (1991, as cited in Claxton et al., 1998)
CARES - Cancer Rehabilitation Evaluation System	Coscarelli and Heinrich (1988)
CBI - The Brief Cancer Behavior Inventory	Merluzzi and Sanchez (1997)
CECS - Courtauld Emotional Control Scale	Watson and Greer (1983)
CES-D - Centre for Epidemiological Studies Depression Scale	Radloff (1977)
GHQ - General Health Questionnaire	Goldberg and Hillier (1979)
FACT-B - Functional Analysis of Cancer Therapy	Cella et al. (1993)
Global Self-Esteem scale	Rosenberg (1965)
HADS - Hospital Anxiety and Depression Scale	Zigmond and Snaith (1983)
HIV Volunteer Inventory	Guinan et al., (1991)
LSES - Life Satisfaction in the Elderly Scale	Salamon and Conte (1984, as cited in Kuehne & Sears, 1993)
MBI - Maslach Burnout Inventory	Maslach and Jackson (1981)
Maslach Burnout Inventory, 2nd edition	Maslach and Jackson (1986)
MHLC - Multidimensional Health Locus of Control Scale	Wallston, Wallston, and DeVellis (1978)
MSSE - MS Self-Efficacy Scale	Schwartz, Coulthard-Morris, Zeng, and Retzlaff (1996)
Multidimensional assessment of fatigue scale	Belza, Henke, Yelin, Epstein, and Gilliss (1993)
Name-eliciting question procedure	Adapted from Fischer (1982) and McCallister and Fischer (1978)
PCL-C - Posttraumatic Stress Disorder Checklist - Civilian Version	Weathers, Huska, and Keane (1991)
PNI - Personal Network Interview Schedule	Stein, Rappaport, and Seidman (1995)
PSS - Perceived Social Support Scale	Blumenthal et al., (1987, as cited in Williams, 1988)
QLI - Quality of Life Index	Ferrans and Powers (1992)
Rosenberg Self-Esteem Scale	Rosenberg (1965)
Ryff Happiness Scale	Ryff (1989)
SAS-SR - Social Adjustment Scale-Self Report	Weissman and Paykel (1974, as cited in Roberts et al., 1999)
SCL-90-R - Symptom Checklist	Derogatis (1977)
Self-Efficacy Scale	Sherer et al., (1982, as cited in Bracke et al., 2008)
SESES-C - Stanford Emotional Self-Efficacy Scale-Cancer	Giese-Davis et al., (2004)
Sickness Impact Profile	Bergner, Bobbitt, Kressel, Pollard, Gilson, and Morris (1976, as cited in Schwatz et al., 1999)
TRIG - Texas Revised Inventory of Grief	Faschingbauer, Zisook, and DeVaul (1987)
UCLA Loneliness Scale	Russell, Peplau, and Cutrona (1980)
WAI - Weinberger Adjustment Inventory	Weinberger (1990, as cited in Giese-Davis et al., 2006)
WCCC - Ways of Coping Checklist	Folkman and Lazarus (1988)

References

Barker, C. & Pistrang, N. (2002). Psychotherapy and social support: Integrating research on psychological helping. *Clinical Psychology Review, 22,* 361-379.

Belle, D. (1990). Poverty and Women's Mental Health. *American Psychologist, 45,* 385-389.

Belza, B. L., Henke, C. J., Yelin, E. H., Epstein, W. V., & Gilliss, C. L. (1993). Correlates of Fatigue in Older Adults with Rheumatoid Arthritis. *Nursing Research, 42*.

Bennett, L., Ross, M.W., & Sunderland, R. (1996). The relationship between recognition rewards and burnout in AIDS caring. *AIDS Care, 8,* 145-153.

Bracke, P., Christiaens, W., & Verhaeghe, M. (2008). Self-esteem, self-efficacy, and the balance of peer support among persons with chronic mental health problems. *Journal of Applied Social Psychology, 38,* 436-459.

Brown, S. L., Nesse, R. M., Vinokur, A. D., & Smith, D. M. (2003). Providing social support may be more beneficial than receiving it: Results from a prospective study of mortality. *Psychological Science, 14,* 320-327.

Brown, W. M., Consedine, N. S., & Magai, C. (2005). Altruism Relates to Health in an Ethnically Diverse Sample of Older Adults. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 60,* 143-152.

Bureau of Labor Statistics (2010). *Volunteering in the United States – 2009.* Retrieved August 5, 2010 from http://www.bls.gov/news.release/volun.nr0.htm

Cella, D. F., Tulsky, D. S., Gray, G., Sarafian, B., Linn, E., Bonomi, A., et al. (1993). The Functional Assessment of Cancer Therapy scale: development and validation of the general measure. *Journal of Clinical Oncology, 11,* 570-579.

Clary, E. G. & Snyder, M. (1999). The Motivations to Volunteer. *Current Directions in Psychological Science, 8,* 156-159.

Claxton, R. P. R., Catalan, J., & Burgess, A. P. (1998). Psychological distress and burnout among buddies: demographic, situational and motivational factors. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV, 10,* 175-190.

Cohen, S. & Wills, T.A (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin, 98,* 310-357.

Cohen, S., Gottlieb, B. H., & Underwood, L. G. (2000). Social relationships in health. In S.Cohen, L.G.Underwood, & B.H.Gottlieb (Eds.), *Social support measurement and intervention: A guide for health and social scientists* (pp. 3-25). New York: Oxford University Press.

Cohen, S. (2004). Social relationships and health. *American Psychologist, 59*, 676-684.

Coscarelli, A. & Heinrich, R. L. (1988). *Cancer Rehabilitation Evaluation System.* Santa Monica, CA: CARES Consultants.

Department for Communities and Local Government. (2010). *Citizenship Survey: April-June 2010.* London: Crown.

Derogatis, L. R. (1977). *SCL-90 Administration, scoring and procedures manual for the revised version*. Baltimore: Johns Hopkins University School of Medicine.

Derogatis, L. R. (1993). *BSI: Brief Symptom Inventory. Administration, scoring, and procedures manual.* Minneapolis, MN: NCS Assessments.

DuBois, D. L., Holloway, B. E., Valentine, J. C., & Cooper, H. (2002). Effectiveness of Mentoring Programs for Youth: A Meta-Analytic Review. *American Journal of Community Psychology, 30,* 157-197.

Faschingbauer, T. R., Zisook, S., & DeVaul, R. (1987). The Texas revised inventory of grief. In S.Zisook (Ed.), *Biopsychosocial aspects of bereavement* (pp. 111-124). Washington, DC: American Psychiatric Press.

Fehr, E. & Fischbacher, U. (2003). The nature of human altruism. *Nature, 425,* 785-791.

Fengler, A. P. (1984). Life satisfaction of subpopulations of elderly. *Research on Aging, 6,* 189-212.

Ferrans, C. E. & Powers, M. J. (1992). Psychometric assessment of the quality of life index. *Research in Nursing & Health, 15,* 29-38.

Fischer, C. S. (1982). *To dwell among friends: Personal networks in town and city.* Chicago: University of Chicago Press.

Folkman, S. & Lazarus, R. S. (1988). *Manual for the ways of coping questionnaire.* Palo Alto, CA: Consulting Psychologists Press.

Fuertes, F. C. & Jiménez, M. L. V. (2000). Motivation and burnout in volunteerism. *Psychology in Spain 4,* 75-81.

Futterman, A., Holland, J. M., Brown, P. J., Thompson, L. W., & Gallagher-Thompson, D. (2010). Factorial validity of the Texas Revised Inventory of Grief—Present scale among bereaved older adults. *Psychological Assessment, 22*, 675-687.

Giese-Davis, J., Bliss-Isberg, C., Carson, K., Star, P., Donaghy, J., Cordova, M. J., Stevens, N., Witenberg, L., Batten, C., & Spiegel, D. (2006). The effect of peer counseling on quality of life following diagnosis of breast cancer: An observational study. *Psycho-Oncology, 15,* 1014-1022.

Giese-Davis, J., Koopman, C., Butler, L. D., Joss, J., Classen, C., Roberts, J., et al. (2004). The Stanford Emotional Self-Efficacy Scale – Cancer: Reliability, validity, and generalizability. In I.Nyklícek, L.Temoshok, & A.Vingerhoets (Eds.), *Emotional Expression and Health: Advances in Theory, Assessment and Clinical Applications* (pp. 1053-1082). Hove, England & New York: Brunner-Routledge.

Gleason, M. E. J., Iida, M., Bolger, N., & Shrout, P. E. (2003). Daily supportive equity in close relationships. *Personality and Social Psychology Bulletin, 29,* 1036-1045.

Goldberg, D. P. & Hillier, V. F. (1979). A scaled version of the General Health Questionnaire. *Psychological Medicine, 9,* 139-145.

Guinan, J. J., McCallum, L. W., Painter, L., Dykes, J., & Gold, J. (1991). Stressors and rewards of being an AIDS emotional-support volunteer: A scale for use by care-givers for people with AIDS. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV, 3,* 137-150.

Heller, K. & Rook, K. S. (2010). Distinguishing the theoretical functions of social ties: Implications for support interventions. In B.R.Sarason & S.Duck (Eds.), *Personal relationships: Implications for clinical and community psychology* (pp. 119-139). Chichester, England: Wiley.

Home Office (2004). *Home Office Citizenship Survey: People, Families and Communities.* London: Home Office.

Home Office (2005). *The Volunteering Compact Code of Good Practice.* London: Home Office.

Jeffries, V. (1998). Virtue and the altruistic personality. *Sociological Perspectives, 41,* 151-166.

Kessler, R. C., McLeod, J. D., & Wethington, E. (1985). The costs of caring: A perspective on the relationship between sex and psychological distress. In I.G.Sarason & B.R.Sarason (Eds.), *Social support: Theory, research, and applications* (pp. 491-506). The Hague, The Netherlands: Martinus Nijhoff.

Kitzrow, M. A. (1998). An overview of current psychological theory and research on altruism and prosocial behavior. In R.Bringle & D.Duffy (Eds.), *With service in mind: Concepts and models for service-learning in psychology.* (pp. 19-34). Washington, DC: American Association for Higher Education.

Krause, N., Herzog, A. R., & Baker, E. (1992). Providing support to others and well-being in later life. *Journals of Gerontology, 47,* 300-311.

Krause, N. & Shaw, B. A. (2000). Giving social support to others, socioeconomic status, and changes in self-esteem in late life. *Journals of Gerontology Series B-Psychological Sciences and Social Sciences, 55,* S323-S333.

Kuehne, V. S. & Sears, H. A. (1993). Beyond the call of duty: Older volunteers committed to children and families. *Journal of Applied Gerontology, 12,* 425-438.

Maslach, C. & Jackon, S. E. (1986). *Burnout Inventory, second edition*. Palo Alto, CA: Consulting Psychologists Press, Inc.

Maslach, C. & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Organizational Behavior, 2,* 99-113.

Maslanka, H. (1996). Burnout, social support and AIDS volunteers. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV, 8,* 195-206.

McCallister, L. & Fischer, C. S. (1978). A Procedure for Surveying Personal Networks. *Sociological Methods & Research, 7,* 131-148.

Mead, N., Lester, H., Chew-Graham, C., Gask, L., & Bower, P. (2010). Effects of befriending on depressive symptoms and distress: systematic review and meta-analysis. *The British Journal of Psychiatry, 196,* 96-101.

Meenan, R. F., Mason, J. H., Anderson, J. J., Guccione, A. A., & Kazis, L. E. (1992). AIMS2. The content and properties of a revised and expanded Arthritis Impact Measurement Scales Health Status Questionnaire. *Arthritis & Rheumatism, 35,* 1-10.

Merluzzi, T. V. & Martinez Sanchez, M. A. (1997). Assessment of self-efficacy and coping with cancer: development and validation of the cancer behavior inventory. *Health Psychology, 16,* 163-170.

Morrow-Howell, N., Hinterlong, J., Rozario, P. A., & Tang, F. (2003). Effects of Volunteering on the Well-Being of Older Adults. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 58,* S137-S145.

National Institute for Health and Clinical Excellence (2009). *Depression: the treatment and management of depression in adults (update).*Retrieved August 5 2010 from http://www.nice.org.uk/nicemedia/live/12329/45888/45888.pdf

Nesbitt, W. H., Ross, M. W., Sunderland, R. H., & Shelp, E. (1996). Prediction of grief and HIV/AIDS-related burnout in volunteers. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV, 8,* 137-144.

Oman, D., Thoresen, C. E., & McMahon, K. (1999). Volunteerism and mortality among the community-dwelling elderly. *Journal of Health Psychology, 4,* 301-316.

Omoto, A. M. & Snyder, M. (1995). Sustained helping without obligation: motivation, longevity of service, and perceived attitude change among AIDS volunteers. *Journal of Personality and Social Psychology, 68,* 671-686.

Radloff, L. S. (1977). The CES-D Scale: A self report depression scale for research in the general population. *Applied Psychological Measurement, 1,* 385-401.

Raphael, B., Kelly, B., Dunne, M., & Greig, R. (1990). Psychological distress among volunteer AIDS counselors. *Medical Journal of Australia, 152,* 275.

Reissman, F. (1965). The helper-therapy principle. *Social Work 10,* 27-32.

Roberts, L. J., Salem, D., Rappaport, J., Toro, P. A., Luke, D. A., & Seidman, E. (1999). Giving and receiving help: Interpersonal transactions in mutual-help meetings and psychosocial adjustment of members. *American Journal of Community Psychology, 27,* 841-868.

Rook, K. S. & Sorkin, D. H. (2003). Fostering social ties through a volunteer role: Implications for older-adults' psychological health. *International Journal of Aging & Human Development, 57,* 313-337.

Rosenberg, M. (1965). *Society and the adolescent self-image.* Princeton, NJ: Princeton University Press.

Ross, M. W., Greenfield, S. A., & Bennett, L. (1999). Predictors of dropout and burnout in AIDS volunteers: A longitudinal study. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV, 11,* 723-731.

Ross, M. W. & Seeger, V. (1988). Short communication: Determinants of reported burnout in health professionals associated with the care of patients with AIDS. *AIDS, 2,* 395-398.

Russell, D. W., Peplau, L. A., & Cutrona, C. (1980). The revised UCLA Loneliness Scale: Concurrent and discriminant validity evidence. *Journal of Personality and Social Psychology, 39,* 472-480.

Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology, 57,* 1069-1081.

Sainer, J. & Zander, M. (1971). Guidelines for older person volunteers. *The Gerontologist, 11,* 201-204.

Schefczyk, M. & Peacock, M. (2010). Altruism as a thick concept. *Economics and Philosophy, 26,* 165-187.

Schwartz, C., Meisenhelder, J. B., Yunsheng M.P.H., & Reed, G. (2003). Altruistic social interest behaviors are associated with better mental health. *Psychosomatic Medicine, 65,* 778-785.

Schwartz, C. E., Coulthard-Morris, L., Zeng, Q., & Retzlaff, P. (1996). Measuring self-efficacy in people with multiple sclerosis: a validation study. *Archives of Physical Medicine and Rehabilitation, 77,* 394-398.

Schwartz, C. E. & Sendor, R. M. (1999). Helping others helps oneself: response shift effects in peer support. *Social Science & Medicine, 48,* 1563-1575.

Smith, D. J. (2000). Volunteering and social development. *Voluntary Action, 3,* 9-24.

Stein, C., Rappaport, J., & Seidman, E. (1995). Assessing the social networks of people with psychiatric disability from multiple perspectives. *Community Mental Health Journal, 31,* 351-367.

Thoits, P. A. (1983). Multiple identities and psychological well-being: A reformation and test of the social isolation hypothesis. *American Sociological Review 48,* 174-187.

Thoits, P. A. & Hewitt, L. N. (2001). Volunteer work and well-being. *Journal of Health and Social Behavior, 42,* 115-131.

Unger, L. S. (1991). Altruism as a motivation to volunteer. *Journal of Economic Psychology, 12,* 71-100.

Wallston, K. A., Strudler Wallston, B., & DeVellis, R. (1978). Development of the Multidimensional Health Locus of Control (MHLC) Scales. *Health Education & Behavior, 6,* 160-170.

Warner, L. M., Schuz, B., Wurm, S., Ziegelmann, J. P., & Tesch-Romer, C. (2010). Giving and taking - differential effects of providing, receiving and anticipating emotional support on quality of life in adults with multiple illnesses. *Journal of Health Psychology, 15,* 660-670.

Watson, M. & Greer, S. (1983). Development of a questionnaire measure of emotional control. *Journal of Psychosomatic Research, 27,* 299-305.

Weathers, F. W., Huska, J. A., & Keane, T. M. (1991). *The PTSD checklist-civilian version (PCL-C)*. Boston: Boston Veterans Affairs Medical Center.

Williams, M. J. (1988). Gay men as "buddies" to persons living with AIDS and ARC. *Smith College Studies in Social Work, 59,* 38-52.

Zigmond, A. S. & Snaith, R. P. (1983). The Hospital Anxiety and Depression Scale. *Acta Psychiatrica Scandinavica, 67,* 361-370.

Part 2: Empirical Paper

Long-term mentoring for disadvantaged young people

Abstract

Objectives: Youth mentoring involves a supportive relationship between a youth and a volunteer adult with the aim of promoting a range of positive developmental outcomes. The predominant paradigm in mentoring research involves large-N, pre-post designs. The present study examined a small number of child-mentor pairs over time in order to gain a more detailed understanding of patterns of change.

Method: A multiple case, longitudinal design was used, looking in depth at four children, aged 9 to 10 years. Data were collected at regular intervals over the first 15 months of the mentoring relationship from the child, their mother, and their mentor, using self-report measures of key domains of psychosocial functioning. The quality of the mentoring relationship was also measured.

Results: At baseline, all four children were functioning in the clinical range in at least one domain. Two of the children reported modest improvement over the course of the mentoring relationship, with reliable changes occurring mostly in the behavioural domains; however, this improvement was not reflected in the data provided by the parent. The scores for the other two children, as reported both by themselves and their mothers, were relatively stable over the 15 month period.

Conclusions: The wider literature suggests that more consistent improvements would have been expected; it may be that 15 months was not long enough for the influence of mentoring to be borne. A multiple case design offers a detailed view of patterns of change, providing the opportunity to identify potential moderating factors for particular individuals, which could improve the theoretical understanding of mentoring as well as its practical application. Further research using this paradigm could help define the role that mentoring should play within the helping services and which children would benefit most.

Introduction

Mentoring has increasingly been seen as a helpful intervention for vulnerable young people through the provision of a stable adult relationship outside of the young person's natural network. Mentoring traditionally involves an adult volunteer offering support and guidance to a young person through regular contact. There are a number of different types of mentoring, and the process can be defined differently depending on the origin and purpose of the relationship between the mentor and the mentee and where the meetings take place. This study is concerned with vulnerable young people who are paired, via a mentoring organisation, with an adult volunteer, in a community setting.

Rhodes defines formal mentoring as the pairing of a youth and a non-parental adult by an organisation to provide a supportive and caring relationship (Rhodes, Spencer, Keller, Liang, & Noam, 2006). The relationship usually evolves within a structured programme, with the primary aim of nurturing the youth. Intuitively, it would be thought that a trusting, non-judgemental relationship with a mentor could have a substantial positive impact on a young person with behavioural or emotional problems. Testimonial reports and qualitative studies (e.g. Spencer, 2007a) endorse this picture. Rigorous, large-scale empirical studies (e.g. DuBois, Holloway, Valentine, & Cooper, 2002), mostly based on the Big Brothers Big Sisters of America scheme (the US's largest and best-established mentoring organisation), have demonstrated that mentoring has a statistically significant positive effect on the adolescents' lives, but that this effect is modest.

Meta-analyses by DuBois et al. (2002) and Rhodes (2008) have demonstrated considerable variability in evidence of the effectiveness of mentoring programmes. Small, but significant, effects have been found in the domains of career/

employment, problem/ high-risk behaviour, and academic/ educational achievement. Possible effects have been found in the areas of social competence and emotional/ psychological wellbeing (DuBois et al., 2002).

Given the extent of anecdotal evidence for the effectiveness of the mentoring relationship, it should be asked why only modest effect sizes have been found. It may be that variations in outcomes and the corresponding statistical influence of less successful relationships conceal a potentially greater (though probably still modest) overall positive effect of the mentoring relationship (Rhodes & DuBois, 2006). There is substantial variability in outcomes both across and within programmes; some pairings lead to a negligible or negative effect, while some are successful (Grossman & Rhodes, 2002). Research has also shown variation in the ways mentoring organisations run (DuBois et al., 2002). It is also plausible that such a relationship can have only limited influence on many vulnerable youth.

As research has, in the main, focused on outcomes, there has been little investigation into the process behind the mentor-mentee relationship. However, Rhodes has put forward an integrative model to explain these underlying processes (Rhodes, 2005; Rhodes et al., 2006). The model contends that any potential for a positive shift relies on the formation of a strong bond between the mentor and mentee. Rhodes suggests that the growth of trust, empathy, and mutuality between the pair can lead to the mentee's social-emotional, cognitive, and identity development. The model proposes that improvement in any one of these areas, mediated by peer and parental relationships and the longevity and quality of the mentoring relationship, can in turn lead to positive outcomes in traditional measures such as scholastic achievement, emotional well-being, and behaviour.

Rhodes posits that social and emotional development can occur through simple enjoyment of the companionship, via corrective emotional experiences (with the mentor potentially acting as an alternative or secondary secure attachment figure), and through the growth of emotional regulation abilities. Drawing on attachment theory (Bowlby, 1988), Rhodes proposes that the mentoring relationship has the potential to provide the young person with an experience of a caring other and that this experience may generalise to modify their experience of others. Rhodes also suggests that the mentoring relationship encourages the youth to take new perspectives on their other relationships, thus helping them gain interpersonal understanding and be more likely to seek emotional support when under stress. Such gains by the youth could potentially improve their family and peer relations, conduct, emotional symptoms, and self-esteem.

The model suggests that cognitive growth can be promoted through the provision of new learning experiences and intellectual challenges and through supporting the youth with these, in line with Vygotsky's (1978) zone of proximal development. Mentors may also encourage scholastic achievement. It may also be that improvements to youths' interpersonal skills leads to improved perceptions of and relationships with their teachers, something that is related to higher academic success, scholastic engagement, and behavioural adjustment (Reddy, Rhodes, & Mulhall, 2003). In this way, Rhodes suggests that the mentoring relationship can directly or indirectly improve cognitive growth.

Rhodes suggests that the youth's relationship with the mentor can aid the formation of the youth's identity. Harter (1988) advocates that a child's global self worth is based on both how they perceive their abilities and also whether they view important others as supporting and accepting them. With the mentor acting as a model, an advocate, and providing new opportunities and experiences, the youth can construct a new sense of self. A more positive identity and feeling accepted by the mentor could predict improvements such as the youth's self worth, among others.

The proposed theoretical underpinnings of mentoring, together with evidence from a number of qualitative studies (e.g. Morrow & Styles, 1995; Spencer, 2007a, b), assert the importance of the quality of the relationship between the mentor and the mentee. It has been shown empirically that a strong emotional connection is associated with better outcomes (DuBois & Neville, 1997; Grossman & Rhodes, 2002; LoSciuto, Rajala, Townsend, & Taylor, 1996). Data from interviews with successful pairs indicate that the quality of the relationship is important: Spencer (2009) found that authenticity, empathy, collaboration, and companionship all appeared to be important processes behind the flourishing matches. The same study also suggests that it often takes time for the mentee to reveal more of themselves, to engage in the relationship, and thus to gain from it. There has been some investigation of the change in outcomes over time, but the evidence is mixed. A qualitative study by Styles and Morrow (1992) indicates that benefits from mentoring are rarely borne out in the first six months. Grossman and Rhodes (2002) provide some empirical evidence that fewer gains are seen early in the relationships. The DuBois et al. (2002) meta-analysis found no significant difference in outcomes between relationships lasting less than and more than a year.

It seems that a trusting relationship is a requisite for successful outcomes in mentoring. Since time is necessary for such a relationship to develop, it may be that the realisation of positive outcomes is not linear. An investigation of the process of the mentor-mentee relationships over time could therefore be instructive. Zand et al.

(2009) advise that such information could also give an idea of what underlies the process of change in the mentee.

The predominant paradigm in mentoring research has relied solely on data pre and post the intervention. These pre-post designs are limited in their capacity to observe processes of change (Laurenceau, Hayes, & Feldman, 2007) and are generally seen in studies with a large sample size. Such designs are affected by the problems brought about by the uniformity myth assumption (Kiesler, 1966); they presume that all participants are a part of a homogeneous group that changes in a gradual and linear fashion. The approach used in the current study draws on an alternative paradigm and is in line with the current thinking in psychotherapy research about the value of investigating the patterns of change processes as they unfold over time (Laurenceau et al., 2007). Change process research involves measures being taken regularly over the course of an intervention and takes into account that there may be individual characteristics which relate to the effectiveness of an intervention. It thus allows for conclusions to be drawn about different types of participants and so is not affected by the problems associated with the uniformity myth assumption

The current study uses a multiple case design, examining a small number of cases in depth and monitoring change over several time points. Taking a number of measurements over the course of the mentoring relationship has the potential to provide greater clarity to the pattern of change in the young person and can identify periods of improvement or worsening. Concentrating on detailed individual trajectories can provide insight into how and when change occurs and may point to the influence of mediators and moderators of any changes. This may highlight factors necessary for a beneficial mentoring relationship, for example, giving an idea of the minimum length of time that a mentoring relationship should last and what factors are important for positive outcomes to be realised.

The aim of this study was to gain a detailed understanding of what changes occur at what points during the first 15 months of the mentor-mentee relationship. Outcomes, assessed by child and parent questionnaires, were tracked in a small number of mentor-mentee pairs and examined in the context of relationship factors, as measured by child and mentor ratings. There were two central research questions:

1. How do young people change over the first 15 months of mentoring in terms of the key developmental domains of self-esteem, scholastic attitude, peer relations and psychological well-being? Do changes in some domains occur earlier or later than in others?
2. Are patterns of change associated with the evolving characteristics of the mentor-mentee relationship? That is, do certain relationship qualities need to be present before changes can occur?

Method

Ethical Considerations

Ethical approval was obtained from the UCL Research Ethics Committee (see Appendix 1). Information sheets were given to and consent obtained from the child, their parent and the mentor (see Appendix 2). It was clearly explained each time the children were asked to complete questionnaires that their responses would be kept confidential and any reports would be anonymised. Part way through the study, the mentoring organisation through whom participants were recruited changed the term they used from ‘befriending’ to ‘mentoring’; while the former term is found in the consent forms and mentor questionnaire pack, this study uses solely the latter term.

Setting

Participants were recruited from a voluntary-sector organisation in London which matched volunteer mentors with disadvantaged children, aged between five and sixteen years, from single parent families. Each mentor and child pair was expected to spend on average three to four hours a week together for a minimum of two years. The organisation provided initial and on-going training for their volunteers, with continual support from an allocated caseworker.

Referrals for mentoring could be made by schools, social services, other organisations, or by parents themselves. The mentoring organisation operated on the principle that secure relationships are the basis for emotional well being and stressed the importance of the development of a genuine relationship between the mentor and the child.

Design

A multiple case longitudinal design was used in order to examine the patterns of change over time (Laurenceau et al., 2007). Data were collected from the child and the mentor every three months over a 15-month period and from the child's mother every six months over the same period. The trajectory of change was examined for each child.

Ideally, baselines measure would have been taken three months before the beginning of the intervention to ensure that the variables were stable. However, due to practical constraints of the setting (e.g. uncertainty about when each mentor–child pair would begin to meet), this was not feasible. Also, Rhodes' theory suggests that minimal change would be expected during the first few months, as it takes time for the relationship to be established. The first three month period therefore could be considered a period of baseline measurement.

Participants

Child-mentor pairs were eligible for the study if the child was 9-12 years old, and both the child and the parent with whom the child lived were English speaking. A narrow range of ages was sought in order to limit the heterogeneity of the sample and to ensure that the measures were developmentally appropriate

Matches were eligible if they were newly matched by the organisation within the time frame of the study or if the one-year anniversary of their match fell within this time. Already established pairs were included with the hope of observing the extent of changes later in the relationship. Overall, data were collected from twelve young person-mentor pairs. Seven pairs were followed from the beginning of their relationship and five from one year after their relationship had begun.

Complete data sets were obtained for only four of the pairs, specifically the first four matched pairs who were newly matched by the organisation at the beginning of the study. There was a limited time frame within which new matches could be followed and 15 months of data obtained. It was considered that there was not enough data longitudinally for the other three new matches; data were obtained for no more than nine months in each case. Incomplete data were obtained for those pairs who were followed from a year into their relationship. It was, in particular, difficult to get responses from the volunteers in these pairings. This may have been because they felt that they had given a lot of their time to the organisation already and did not wish to give any more or because completing questionnaires was not part of their routine. Multiple case designs typically rely on intensive data from a small number of cases, for example the excellent study Bennun and Lucas (1990) had a sample of six. Given this and the large quantities of data for each pair, a sample size of four pairs was considered sufficient.

Results are presented for the four newly matched pairs for whom there were complete data sets. Each pair was approached by the senior case worker and all consented to taking part in the study. All four of the children lived at home in a single parent family (all were living with their mother). At study entry, all four were in primary education. Child 1 and Child 2 were brothers, and thus Parent 1 and Parent 2 are the same person. Three of the children were white British and one mixed European/ Asian. All of the four mentors were white and were in full-time employment. Table 1 shows the characteristics of the children and their respective mentors.

Table 1. Child and mentor characteristics.

Child-mentor pair	Sex	Age	Referral source	Referral reason
Child 1	Male	10	Social Services	Mother's health problems prevent her being able to do activities
Mentor 1	Female	30s		
Child 2	Male	9	Social Services	Mother's health problems prevent her being able to do activities
Mentor 2	Female	30s		
Child 3	Male	10	Social Services	As a part of Child Protection Plan, behavioural problems, history of domestic violence
Mentor 3	Male	20s		
Child 4	Female	10	Social Services	Mother’s lack of social support networks and history of domestic violence
Mentor 4	Female	50s		

Note: Child 1 and Child 2 are brothers.

Measures

The child and their mother completed measures assessing the domains of scholastic competence and perception, peer relationships, behavioural conduct, emotional symptoms, family relations, and self-worth, along with an idiographic measure of the child's problems. The measures were selected on the basis of being well established and of having been used in previous mentoring studies. In addition, both the mentor and the child completed a measure assessing the quality of their relationship. All questionnaire packs for the child, parent, and mentor can be seen in Appendix 3.

Self-Perception Profile for Children/Adolescents (SPPC)

The SPPC (Harter, 1985; 1988) measures young people's self-esteem. It comprises six domains: Scholastic Competence, Social Acceptance, Athletic Competence, Physical Appearance, Behavioural Conduct, and Global Self-Worth. For each item two statements are provided, for example "Some children often *forget* what they learn BUT Other children can remember things *easily*". The child is asked to indicate which statement they believe is more like them and to what extent. Each domain consists of six such questions. Items are scored on a scale of 1 to 4, with higher scores indicating higher perceived competence. Harter (1985) showed that the scale has good internal consistency (alpha coefficients ranged from 0.73-0.86).

In this study, the child completed four of the domains: Athletic Competence and Physical Appearance were not included because they are less relevant to mentoring interventions. A teacher version of the scale, which parallels the child profile, was adapted for the parent to complete. This parent version excluded the Global Self-Worth domain and two questions in the Social Acceptance domain, as they were less easily adapted.

Strengths and Difficulties Questionnaire (SDQ)

The SDQ (Goodman, 1997) measures important domains of child psychopathology and the child's personal strengths. It consists of 25 items, divided into five subscales: emotional symptoms, conduct problems, hyperactivity/ inattention, peer relationship problems, and prosocial behaviour. The questionnaire is made up of statements, such as “I usually do as I am told”, and the participant indicates whether this is “Not True”, “Somewhat True” or “Certainly True” of them. Each item is scored from 0 to 2, with each subscale score ranging from 0 to 10. A higher score on the prosocial behaviour subscale indicates a greater strength in that domain. Higher scores in the other subscales indicate greater difficulties; the scores in these subscales can be combined to generate a Total Difficulties score. The SDQ has been shown to have good concurrent validity (Goodman, 2001; Muris, Meesters, & van den Berg, 2003) and reliability (Cronbach's alpha of .73, test-retest reliability of .62; Goodman, 2001). Although the self-report version was created for use by 11 to 16 year olds, support has been demonstrated for its validity and reliability in 8 to 13 year olds (Muris, Meesters, Eijkelenboom, & Vincken, 2004). In the present study, the child completed the child version of the SDQ and the parent completed an informant-rated version. The SDQ scores can be classified as normal, borderline, or abnormal; roughly 10% of a community sample falls in the abnormal range and a further 10% in the borderline range (Goodman, 1997; Goodman, Meltzer, & Bailey, 1998).

Multidimensional Students’ Life Satisfaction Scale (MSLSS)

The MSLSS (Huebner, 1994) measures children’s life satisfaction in the domains of family, school, friends, self, and living environment. Example items are: “I enjoy being at home with my family” and “School is interesting”. The child is asked to indicate how often they have had such a thought; responses are on a Likert scale, with the options “Never”, “Sometimes”, “Often” or “Almost Always”. Scores of 1 to 4 are assigned respectively, with negatively-worded items scored in reverse.

Higher scores indicate higher levels of satisfaction. Internal consistency and test-retest reliability both fall in the .70 to .90 range (Greenspoon & Saklofske, 1997; Huebner, 1994; Huebner, Laughlin, Ash, & Gilman, 1998). Factor analyses have supported the dimensional, hierarchical model of the MSLSS (Huebner, 1994; Huebner et al., 1998).

In this study, in the interest of brevity, only the family and school subscales were used, as 'self' and 'friends' were tapped by other measures and 'living environment' was considered less relevant to mentoring. Also in order to reduce the length, four items (out of seven in the family scale and of eight in the school scale) with the highest factor loadings on each subscale were chosen.

Personal Questionnaire

The Personal Questionnaire is a simplified version of the Shapiro Personal Questionnaire (Elliott, Mack, & Shapiro, 1999). This is an idiographic tool that has been used in psychotherapy research, and which focuses on participants' self-defined problems. It allows for the severity of individual problems to be quantified and for change to be traced over time.

In discussion with the child, particular problems or difficulties affecting them in any area of their life were identified. Ideally, between two and four problems were named, for example "I don't try enough new things". The parent also completed the process for what they thought were their child's problems. The problems are rated as "Not a problem", "A bit of a problem", "A moderate problem", or "A big problem". Responses are given a score of 1 to 4 respectively, with higher scores indicating that the matter is more of a problem.

In this study, if the child found it difficult to think of a problem, their parent's ideas or hypothetical problems of other children were used as examples. Suggestions were also generated by the researcher based on the difficulties the child expressed in the answers they gave to the preceding measures.

Quality of mentoring relationship

The quality of the mentor-child relationship was assessed using the *Mentor-Youth Alliance Scale* (MYAS; Zand et al., 2009) and five items from the empathy subscale of the *Relationship Inventory* (RI; Barrett-Lennard, 1986). In addition, mentors were asked how regularly and for how long they had seen the child and what activities they had done. They also completed individual items, with a response on a seven point Likert scale, asking: what the pair usually spend their time doing (with responses varying from ‘mostly doing things’ to ‘mostly talking’); how easy or difficult it is to communicate; how easy or difficult is it to talk about sensitive topics; how they feel the mentoring is going; and how rewarding the mentoring has been for them, the mentor.

The MYAS was created specifically to measure the quality of mentoring relationships from the viewpoint of the mentee. It consists of two factors, caring and acceptance, each containing five items. Ten statements, such as “My mentor is happy when good things happen to me”, are rated on a four-point Likert scale according to how strongly the participant agrees. Higher scores indicate a higher quality relationship. The measure shows good internal consistency (Cronbach’s alpha of .92) and moderately strong concurrent validity, with a correlation of .30 with an adult relationship scale (Zand et al., 2009). In the present study, the wording of the statements was modified to create a version for the mentor to complete, so that both perspectives were obtained.

The RI empathy scale was used to assess mentor and child views of the degree to which the mentor understood the child. Statements, such as “My mentor nearly always knows what I mean", are rated on a four-point Likert scale according to how strongly the participant agrees. Higher scores indicate a higher level of empathy. The five items with the highest factor loadings on the original 16-item scale (Cramer, 1986) were used; items were slightly reworded to ensure age-appropriateness. An earlier version of this empathy scale, containing 16-items, demonstrated good validity and alpha coefficients above 0.80 (Gurman, 1977).

Inter-correlations between the two MYAS subscales and the empathy scale were high (above 0.80 for child and mentor), and therefore were combined into a single index of relationship quality.

Procedure

The procedure relates to the new four new matches, the results of whom are presented in this study. Measures were collected from the child at the start of the mentoring relationship (baseline) and then every three months; from parents at baseline and then every six months; and from the mentor starting at three months and continuing every three months. The data final collection point for the child and mentor was at 15 months and for the parent was at 12 months. Table 2 shows which measures were completed by the child, the parent, and the mentor at which time points. The measure of relationship quality was not completed at baseline because this was before the pair had met or too soon after for the measure to be meaningful. The parent completed the same measures as the child with two exceptions: the MSLSS was omitted because it assesses the child's satisfaction with their own life rather than another's view of this, and the relationship quality measure was omitted because it could only be rated from the perspectives of those involved.

The researcher met with the child and mother face-to-face in their home, giving assistance where necessary. The only exception was that the caseworker

Table 2. Measures completed by participants at each time point.

Time point	Child	Parent	Mentor
Baseline	Self-esteem Strengths and Difficulties Personal Questionnaire Life Satisfaction	Self-esteem Strengths and Difficulties Personal Questionnaire	-
3 months	Self-esteem Strengths and Difficulties Personal Questionnaire Life Satisfaction Relationship measure	-	Relationship measure
6 months	Self-esteem Strengths and Difficulties Personal Questionnaire Life Satisfaction Relationship measure	Self-esteem Strengths and Difficulties Personal Questionnaire	Relationship measure
9 months	Self-esteem Strengths and Difficulties Personal Questionnaire Life Satisfaction Relationship measure	-	Relationship measure
12 months	Self-esteem Strengths and Difficulties Personal Questionnaire Life Satisfaction Relationship measure	Self-esteem Strengths and Difficulties Personal Questionnaire	Relationship measure
15 months	Self-esteem Strengths and Difficulties Personal Questionnaire Life Satisfaction Relationship measure	-	Relationship measure

administered the baseline measures, when meeting with the child and parent before the mentoring relationship had started. The researcher was not present at baseline in order that the child was not introduced to too many new adults in a short period, given that they were soon to meet with the mentor for the first time also.

Analysis

The data were analysed using a multiple single-case design approach, drawing on examples such as Parry, Shapiro, and Firth (1986) and Bennun and Lucas (1990). The Reliable Change Index (Jacobson & Truax, 1991) was used to establish whether any changes between baseline and the final time point exceeded the variation that would be expected due to measurement unreliability. Where a measure had published clinical norms, considerations of clinical significance were drawn upon, particularly movement from the clinical to the non-clinical range. The SDQ was the only measure to provide clinical norms. Table 3 summarises the scoring on each measure, indicating the meaning of high and low scores.

Results

The intensive, longitudinal data are presented for each of the four children in turn. Within each case the perspectives of the child, parent, and mentor are considered sequentially.

All four children met with their mentor weekly for around three to four hours and tended to do things such as eating out, going to the cinema, a museum, or the park or activities like ice-skating. The meetings between the pairs were still ongoing at the time of the final data collection.

Child 1

Child 1 presented as a slightly shy 10 year-old boy. He appeared happy to be involved in the research and seemed confident in his ability to complete the

Table 3. Summary of scoring on each measure.

	Score			Clinical Ranges			
				Child		Parent	
Measure	Minimum	Maximum	Score indicative of problem[a]	Borderline	Abnormal	Borderline	Abnormal
Self-esteem							
Behavioural Conduct	1	4	Low	-	-	-	-
Scholastic Competence	1	4	Low	-	-	-	-
Social Acceptance	1	4	Low	-	-	-	-
Global Self-Worth	1	4	Low	-	-	-	-
Strengths and Difficulties							
Emotional Symptoms	0	10	High	6	7-10	4	5-10
Conduct Problems	0	10	High	4	5-10	3	4-10
Hyperactivity/Inattention	0	10	High	6	7-10	6	7-10
Peer Problems	0	10	High	4-5	6-10	3	4-10
Total Difficulties	0	40	High	16-19	20-40	14-16	17-40
Prosocial Behaviour	0	10	Low	5	0-4	5	0-4
Life Satisfaction							
Family	1	4	Low	-	-	-	-
School	1	4	Low	-	-	-	-
Personal Questionnaire	1	4	High	-	-	-	-
Relationship measure	1	4	Low	-	-	-	-

[a] Low: low score on the measure indicates problematic functioning; High: high score on the measure indicates problematic functioning.

questionnaires. He did not need much assistance and was unafraid to ask when he required it. He was referred by Social Services because his mother's health problem relating to Child 1 can be seen in Tables 4, 5, and 6 respectively.

At the start of the mentoring relationship, Child 1 identified the main problem that he wanted to change as "I'm not always so good at talking to people", which he rated as a 'moderate problem'. However, his baseline scores on related measures (Social Acceptance and Peer Relations) suggest he felt socially accepted and had good peer relations. That his problem statement was socially related and yet he rated himself positively on the social relations aspect of the other measures is not necessarily inconsistent, however, as the SDQ and self-perception measures tap the degree to which a child feels popular rather than their social skills.

At baseline, Child 1 rated himself in the abnormal range on the Conduct Problems and Hyperactivity/ Inattention subscales of the SDQ. Although the other SDQ domain scores were well within the normal range, the Total Difficulties score fell in the borderline range. His Life Satisfaction scores indicated he was content with school and his family. His esteem in relation to his behavioural conduct and scholastic competence was moderate and he indicated positive feelings of social acceptance and global self-worth.

The mother of Child 1 provided a slightly different picture. At baseline, while she did not indicate particular problems with his self-esteem, she rated him as falling within the abnormal range for all the SDQ domains, including having difficulties in prosocial behaviour. On the Personal Questionnaire, his mother suggested he was "sometimes too angry" and not "self confident enough". She rated these as a 'moderate problem' and 'a bit of a problem' respectively.

Over the course of the first 15 months of his mentoring relationship, Child 1's scores showed a modest increase across all of the self-esteem domains, although with some fluctuations; however, none of the changes from baseline to 15 months were reliable. The Conduct Problems and Hyperactivity/ Inattention subscales of the SDQ moved from the abnormal to the normal range and, as a result, the Total Difficulties score moved to within the normal range. All three of these were reliable improvements. The Emotional Symptoms and Peer Problems subscales remained in the normal range and he reported reliable improvements in his prosocial behaviour (which was already in the normal range at baseline). He reported his difficulty with talking to people as no longer being a problem. There was, however, a reliable decrease in his satisfaction with his life at school.

His mother did not report the same degree of consistent improvement, but did indicate some change for the better. From her point of view, the self-esteem domains remained relatively consistent across time, as did his emotional symptoms, conduct problems, and lack of prosocial behaviour. The only reliable change reported was in the Hyperactivity/ Inattention scale, which moved from the abnormal to the normal range. The Peer Problems domain also moved to the normal range and, as result of these improvements, the Total Difficulties score decreased to just within the abnormal range. Consistent with her scores on these measures, her perception of her son's problems of anger and lack of self-confidence remained relatively steady.

Both the child and the mentor rated the quality of their relationship consistently highly. On the additional questions, the mentor indicated that communication between the pair was relatively easy, and that over time sensitive topics became slightly easier to talk about. Generally the mentor felt the relationship to be going well and found the experience rewarding.

Overall, the shape of change for Child 1 is far from dramatic, but both the mother and the child indicated some modest, reliable improvement. Both indicated that his hyperactivity and inattention improved over time, but while he indicated his conduct problems were no longer a difficulty, she still considered them problematic. While it is perhaps unsurprising for a mother to perceive problems with conduct where her child does not, it is worth noting that at baseline they agreed there was a difficulty.

Child 2

Child 2 came across as an enthusiastic, energetic boy who was young for his 9 years. He appeared to enjoy the attention provided by the researcher, but when it came to completing the measures he seemed to lose confidence and became quieter. He always wanted the questions to be read out to him and frequently needed to be reminded of the different answer options open to him. He would persevere without complaint and would immediately galvanise upon the measures being completed. Child 2 was referred by Social Services for the same reason as his brother, Child 1: his mother's health problems restricted his opportunity to do activities. The self-report, parent, and mentor data relating to Child 2 can be seen in Tables 7, 8, and 9 respectively.

At the beginning of the mentoring relationship, Child 2 named his problems as "I don't try enough new things", which he identified as 'a bit of a problem', and "I get angry too much", which he saw as being 'a big problem'.

Child 2's esteem in relation to his behavioural conduct was very low and in relation to his scholastic competence was moderate. He indicated positive global self-worth and feelings of social acceptance. On the SDQ, he reported few emotional symptoms and good peer relationships. His Conduct Problems and

Hyperactivity/Inattention scores were in the abnormal range, and his Total Difficulties score was in the borderline range. He rated his prosocial behaviour highly. His baseline Life Satisfaction scores indicated he was moderately satisfied with school and more content with his family.

Child 2's mother also identified anger as a problem, stating that "He has anger management problems" and this was 'a moderate problem'. She also suggested that "He isn't self-confident enough", which she rated as 'a bit of a problem'. In contrast to her son, she did not report any problems in the self-esteem domains at baseline. Otherwise, their views were consistent. On the SDQ, she did not identify emotional symptoms, or peer problems, and rated his prosocial behaviour in the normal range. Scores on the Hyperactivity/ Inattention subscale were in the abnormal range and the Conduct Problems and Total Difficulties subscales in the borderline range.

Over the duration of the relationship, Child 2 relatively consistently rated his problem of not trying enough new things as 'a bit of a problem'. His view of his anger fluctuated, and at 15 months was still considered 'a big problem'. There was a reliable improvement in his perception of his behavioural conduct, with it reaching moderate levels at 15 months. Scores on the other self-esteem domains were consistent across time. His scores on the Conduct Problems and Hyperactivity/ Inattention domains of the SDQ moved from the abnormal to the borderline range, but these were not reliable changes. His scores showed a trend to the normal range in the Total Difficulties subscale, but, again, this was not a reliable change. His Life Satisfaction scores remained relatively stable.

From his mother's point of view, Child 2's anger levels remained 'a moderate problem', but she came to consider his lack of confidence no longer a problem. She reported minimal change in self-esteem domains. While her ratings of her son’s Total Difficulties remained in the borderline range, there were fluctuations in the domains which made up this score. The Hyperactivity/ Inattention score shifted from the abnormal to the normal range but the Conduct Problems score moved from the borderline to abnormal range. Her view of his prosocial behaviour also diminished; her scores placed him in the borderline range. None of the changes from the baseline to 12 months were reliable.

Child 2 indicated that he found the quality of the mentoring relationship consistently good. However, over time, Mentor 2 viewed the relationship as becoming increasingly difficult. This is reflected both in her scores on the relationship quality measure and in her responses to the other questions. She indicated she found him increasingly difficult to communicate with and that sensitive topics were always very difficult to talk about. This may be reflected in her report that their time together largely revolved around doing activities rather than talking. Over time, she considered the quality of the relationship to have diminished. The researchers’ communication with the mentoring organisation revealed that Mentor 2 had stated that her expectations of being mentor to a 9 year-old boy were not met in this relationship.

In general, Child 2 and his mother reported little change over the 15 months. The only score showing reliable change was the improvement in the child’s esteem about his behavioural conduct. The most notable aspect of the data is Mentor 2’s negative view of the relationship.

Child 3

Child 3 presented as a personable and eager 10 year-old. He enjoyed the social interaction with the researcher and would freely initiate conversation before and after the questionnaires were completed. He was quick to understand the instructions to the measures and worked through them silently and swiftly, but carefully. He clearly wanted to do his best but for its own sake rather than for the receipt of praise. He was referred by Social Services due to a history of domestic violence, because of his behavioural problems, and as a part of a Child Protection Plan. The self-report, parent, and mentor data relating to Child 3 can be seen in Tables 10, 11, and 12 respectively.

At the start of the mentoring relationship Child 3 considered his problems to be “Not doing my work at school” and “I get into fights with other children”, both of which he saw as ‘a moderate problem’. At baseline, he indicated that he was only sometimes satisfied with his life at school but was more content with his family life. Child 3’s scores suggest he had moderate self-esteem across the domains, but, of these was least satisfied with his behavioural conduct. He scored within the normal range on all of the SDQ domains. It is not necessarily contradictory for him to have scored in the normal range in the Conduct Problems and yet to name one of his difficulties as getting into fights, as only two of the questions on that SDQ subscale refer to aggressive behaviour. Similarly, the questions regarding his behavioural conduct self-esteem are general and do not directly refer to aggressive behaviour.

Child 3’s mother stated that “He is easily distracted” and “He doesn’t think before he does things”, both of which she rated as being moderate problems. She also was concerned that “He enjoys creating difficult situations, e.g. winding brother up unnecessarily”, something she rated as being a big problem. She agreed with her son regarding his moderate perception of his behavioural conduct. She rated his self-esteem in relation to scholastic competence and social acceptance competence highly. Unlike her son, she identified difficulties within the domain of Hyperactivity/

Inattention, but, in accordance with his view, her scores in the other domains all fell within the normal range.

At six months Child 3 identified a further problem: “I react without thinking”. At this six month mark, he rated this as a moderate problem and by 15 months it had become ‘a bit of a problem’. At 15 months, he no longer deemed the other two problems he cited as problematic. His scores on the other measures were stable, apart from a reliable decrease in his satisfaction with family life.

Over the 12 months Child 3’s mother did not report much change in the specific problems she identified. Her view of her son’s self-esteem in relation to his behavioural conduct remained low and in relation to his scholastic competence remained high. Her scores indicated a reliable decrease in his feelings of social acceptance. Her scores of her son’s Conduct Problems and Total Difficulties moved from the normal to the borderline range, but these changes were not reliable.

Both Mentor 3 and Child 3 rated their relationship to be of high quality throughout. The mentor considered communication between the pair to be easy and indicated that it was possible to talk about sensitive topics.

The results suggest there was little change for Child 3 over the course of the relationship. The only reliable changes were with negative outcomes. The only trend towards improvement was with the child’s scores in his identified problems.

Child 4

Child 4 initially presented as a shy and wary 10 year-old but soon became talkative and open. She was quick to make jokes and she seemed to present in an overly animated manner. She appeared keen to complete the questionnaires and would often pause to tell a story to illustrate a response to a question. Child 4 was referred by Social Services because of the mother’s lack of social support networks and a history of domestic violence. During the period of data collection, Child 4 attended psychotherapy between once and three-times weekly. The self-report, parent, and mentor data relating to Child 4 can be seen in Tables 13, 14, and 15 respectively.

At baseline, she identified two main problems: “When I can't listen in lessons because my friend is talking to me”, which she rated as a moderate problem, and “I hate children bullying me then I get the blame”, which she rated as a big problem. She talked of regularly being bullied by a number of children at her school. At three months she identified a new problem: “When I come back from school I'm very moody and sometimes take my anger out on members of my family” as a big problem. At six months she included “I'm scared of my strict new school”, which she rated as a moderate problem.

Before the mentoring relationship had begun, Child 4 reported very low feelings of social acceptance, but moderate esteem in the other domains. On the SDQ, she scored in the borderline range in the Emotional Symptoms subscale and in the abnormal range in the Peer Problems and Total Difficulties subscales. She reported no difficulties in the other domains. She indicated being moderately satisfied with her family life but unsatisfied with school life.

Child 4’s mother reported a greater number of difficulties in her child’s life. In particular, she identified “Her behaviour is not good”, “She feels unhappy”, and “She feels nobody likes her”, rating all as big problems. She scored her daughter in the abnormal range in the Emotional Symptoms, Conduct Problems, Peer Problems, and Total Difficulties domains, and in the borderline range in the Hyperactivity/ Inattention domain. She perceived her daughter’s esteem regarding her behavioural conduct to be moderate, but rated her esteem in relation to scholastic competence and social acceptance as lower.

During the course of the study, Child 4 decided she would move to a secondary school that the children who were bullying her were not to attend. She started this school in the period between the 9 and 15 month data collection points. By 15 months all four of the problems she had identified had ameliorated. She reported that the problem of being moody after school and directing anger at her family and of getting the blame after children bullied her were no longer issues. She indicated that not listening in lessons due to friends talking to her and being afraid of her strict new school had become only a bit of a problem. It is notable that the improvements in these areas occurred towards the latter stages of the study, after she had moved school. Between the 9 and 12 month points her satisfaction with her school life reliably changed from being very low to very high. Her satisfaction with family life also improved, though not reliably. On the SDQ, she reported reliable improvements in the Peer Problems subscale (which moved steadily from the abnormal to normal range), and in the Conduct Problems and Prosocial Behaviour subscales (both of which remained in the normal range). The Total Difficulties subscale moved from the abnormal to the normal range, with more of a jump between 9 and 12 months, but this change was not reliable. Her scores indicate a steady, reliable improvement in her feelings of social acceptance and remained relatively consistent in the other domains.

Child 4's mother indicated that there was improvement in all three of the problems she identified with her daughter, rating each as only 'a bit of a problem' by 12 months. However, this improvement was generally not exhibited in the other measures. Her ratings of her daughter remained in the abnormal range on the

Emotional Symptoms, Peer Problems, and Conduct Problems subscales of the SDQ and moved to the abnormal range on the Hyperactivity/ Inattention subscale. The Total Difficulties subscale score also increased, but this change was not reliable. The only reliable change was the mother's reporting her child's prosocial behaviour (already in the normal range at baseline) to have improved. She reported little change in her view of her daughter's self-esteem. It appears inconsistent that the mother reported that the problem "she feels nobody likes her" came to be seen as only 'a bit of a problem' and yet she indicated that her self-esteem around social acceptance and her peer problems did not ameliorate.

It is noteworthy that Child 4's self-report data indicates that the majority of her improvement happened prior to the 12 month data collection point. Therefore, the discrepancy between Child 4 and her mother's views cannot be explained by the child self-report data continuing until 15 months when for the mother it stopped at 12 months.

Both Mentor 4 and Child 4's scores indicate a high quality of the relationship throughout the 15 months. Mentor 4 reported that it was very easy to communicate and talk about sensitive topics and felt that the relationship was going well.

Child 4 reported moderate improvement over the course of the mentoring relationship. A lot of this improvement was related to peers, social acceptance, and school, for which the change of school could have been a factor. Other areas also improved, however, and the change of school doesn't exclude mentoring as an important influence. Child 4's concurrent individual therapy may also have been a confounding factor. The inconsistency between the child's and the mother's views is striking.

Summary

At baseline, all of the children apart from Child 3 rated themselves in the abnormal range for at least two of the domains on the Strengths and Difficulties Questionnaire. All of the mothers scored at least one of these domains in the abnormal range. Child 1 and Child 4 reported modest improvement over the course of the mentoring relationship, but this improvement was not reflected in the data provided by the parent. The scores for Child 2 and Child 3, as reported both by themselves and their mothers, were relatively stable over the 15 month period.

Discussion

The findings

Overall, across the four children in this study, the main picture was of modest improvement in two children and no indication of benefit in the other two. However, there was no suggestion of deterioration. All four children and all but one of the mentors reported that the quality of relationship between the child and the mentor was strong. In the one relationship that, from the mentor's point of view, did not go well, there appeared to be no negative impact on the child.

Before the start of the mentoring relationship, the data from three of the four children and all of the mothers indicated that the children were functioning in the clinical range on at least one domain. Child 1 scored himself in the abnormal range on the Conduct Problems and Hyperactivity/ Inattention subscales. Both of these reliably improved, as did his prosocial behaviour, while his satisfaction with school decreased. Overall, the self-reported difficult areas were perceived by Child 1 to have improved. Child 4 scored herself in the abnormal range on the Conduct Problems and Peer Problems subscales. Both of these reliably improved, as did her prosocial behaviour and her satisfaction with school. Her perceived difficulties with

Table 4

Child 1: Self-report data

Measure	Month 0	3	6	9	12	15
Self-esteem						
Behavioural Conduct	2.17	2.5	3.5	3.17	3.17	2.83
Scholastic Competence	2.50	2.33	3.17	3.00	3.50	3.00
Social Acceptance	3.71	3.00	3.83	4.00	3.83	3.83
Global Self-Worth	3.33	3.5	3.5	3.83	3.83	3.67
Strengths and Difficulties						
Emotional Symptoms	1	1	0	0	0	0
Conduct Problems	6††	3	2	2	1	2*
Hyperactivity/Inattention	8††	6†	5	6†	3	4*
Peer Problems	1	1	1	0	1	0
Total Difficulties	16†	11	8	8	5	6*
Prosocial Behaviour	6	9	10	10	10	10*
Life Satisfaction						
Family	3.50	3.50	4.00	2.75	3.50	4.00
School	3.00	1.75	2.25	1.25	2.25	2.00*
Personal Questionnaire [a]						
Problem 1	3	1	1	2	1	1
Quality of Relationship	n/a	3.67	3.73	3.67	3.73	3.87

[a] Problem 1: I’m not always so good at talking to people.

† Borderline range

†† Abnormal range

* Indicates reliable change from baseline to 15 months

Table 5

Child 1: Parent Data

	Month		
Measure	0	6	12
Self-esteem			
Behavioural Conduct	2.50	3.00	2.83
Scholastic Competence	3.00	2.67	2.83
Social Acceptance	2.50	3.00	2.75
Strengths and Difficulties			
Emotional Symptoms	5[††]	3	5[††]
Conduct Problems	6[††]	2	5[††]
Hyperactivity/ Inattention	10[††]	6[†]	5*
Peer Problems	4[††]	-	2
Total Difficulties	25[††]	-	17[††]
Prosocial Behaviour	5[†]	-	5[†]
Personal Questionnaire [a]			
Problem 1	3	2	2
Problem 2	2	2	2

[a] Problem 1: He is sometimes too angry; Problem 2: He isn't self confident enough.
[†] Borderline range
[††] Abnormal range
* Indicates reliable change from baseline to 12 months

Table 6

Child 1: Mentor Data

	Month				
Measure	3	6	9	12	15
Quality of Relationship	3.58	3.67	3.58	3.58	3.46
Spend time mostly talking	4	2	4	3	4
Easy to communicate	4	6	6	6	6
Easy to talk about sensitive topics	2	4	3	4	4
Mentoring going well	7	7	7	7	6
Mentoring rewarding	7	7	7	7	6

Table 7

Child 2: Self-report data

Measure	Month 0	3	6	9	12	15
Self-esteem						
Behavioural Conduct	1.00	2.17	2.17	1.83	2.33	2.33*
Scholastic Competence	2.33	2.67	2.33	2.33	2.50	2.33
Social Acceptance	3.83	3.00	3.67	3.50	3.83	3.67
Global Self-Worth	3.50	3.83	3.67	3.33	3.67	3.83
Strengths and Difficulties						
Emotional Symptoms	1	3	2	1	2	1
Conduct Problems	5††	4†	5††	5††	4†	4†
Hyperactivity/Inattention	8††	6†	6†	6†	4	6†
Peer Problems	2	3	2	2	1	1
Total Difficulties	16†	16†	15	14	11	12
Prosocial Behaviour	8	8	7	6	7	6
Life Satisfaction						
Family	3.50	2.75	2.75	2.00	2.75	3.00
School	2.50	2.50	2.50	2.25	2.25	3.00
Personal Questionnaire [a]						
Problem 1	n/a	2	2	3	2	2
Problem 2	n/a	4	3	4	2	4
Quality of Relationship	n/a	3.67	3.53	3.27	3.47	3.53

[a] Problem 1: I don't try enough new things; Problem 2: I get angry too much.

† Borderline range

†† Abnormal range

* Indicates reliable change from baseline to 15 months

Table 8

Child 2: Parent Data

	Month		
Measure	0	6	12
Self-esteem			
Behavioural Conduct	3.00	2.67	2.83
Scholastic Competence	2.83	3.00	3.00
Social Acceptance	3.25	3.00	2.75
Strengths and Difficulties			
Emotional Symptoms	3	2	3
Conduct Problems	4†	4†	6††
Hyperactivity/ Inattention	7††	5	4
Peer Problems	1	3	2
Total Difficulties	15†	14†	15†
Prosocial Behaviour	7	5†	5†
Personal Questionnaire [a]			
Problem 1	2	1	1
Problem 2	n/a	3	3

[a] Problem 1: He isn't self confident enough; Problem 2 (not identified until 6 months): He has anger management problems.

† Borderline range

†† Abnormal range

Table 9

Child 2: Mentor Data

	Month				
Measure	3	6	9	12	15
Quality of Relationship	3.10	2.23	-	2.13	1.82
Spend time mostly talking	3	1	2	1	1
Easy to communicate	3	1	1	1	1
Easy to talk about sensitive topics	1	1	1	1	1
Mentoring going well	4	2	3	2	1
Mentoring rewarding	6	2	3	2	1

Table 10

Child 3: Self-report data

Measure	Month 0	3	6	9	12	15
Self-esteem						
Behavioural Conduct	2.33	2.67	2.50	2.83	3.00	2.67
Scholastic Competence	3.00	2.67	2.67	2.83	3.17	3.33
Social Acceptance	2.83	2.83	2.67	2.50	3.00	3.00
Global Self-Worth	3.33	3.00	3.00	3.00	3.17	3.00
Strengths and Difficulties						
Emotional Symptoms	0	0	1	1	0	1
Conduct Problems	3	4†	3	2	3	2
Hyperactivity/Inattention	2	5	5	4	2	4
Peer Problems	3	2	2	1	1	2
Total Difficulties	8	11	11	8	6	9
Prosocial Behaviour	7	8	8	8	9	10
Life Satisfaction						
Family	3.50	4.00	3.50	2.25	2.25	2.25*
School	2.00	3.00	2.00	2.25	2.25	2.25
Personal Questionnaire [a]						
Problem 1	3	2	2	2	1	1
Problem 2	3	2	2	2	2	1
Problem 3	n/a [b]	n/a [b]	3	2	2	2
Quality of Relationship	n/a	3.40	3.87	4.00	3.73	3.87

[a] Problem 1: Not doing my work at school; Problem 2: I get into fights with other children; Problem 3: I react without thinking.

[b] The parent did not suggest this as a problem until 6 months.

† Borderline range

* Indicates reliable change from baseline to 15 months

Table 11

Child 3: Parent Data

	Month		
Measure	0	6	12
Self-esteem			
Behavioural Conduct	2.33	2.33	2.67
Scholastic Competence	4.00	3.83	3.67
Social Acceptance	4.00	3.50	2.75*
Strengths and Difficulties			
Emotional Symptoms	0	0	0
Conduct Problems	2	2	3†
Hyperactivity/ Inattention	9††	10††	10††
Peer Problems	1	3†	2
Total Difficulties	12	15†	15†
Prosocial Behaviour	9	6	7
Personal Questionnaire [a]			
Problem 1	3	4	4
Problem 2	3	3	4
Problem 3	4	3	3

[a] Problem 1: He is easily distracted; Problem 2: He doesn't think before he does things; Problem 3: He enjoys creating difficult situations, e.g. winding brother up unnecessarily.

† Borderline range

†† Abnormal range

* Indicates reliable change from baseline to 12 months

Table 12

Child 3: Mentor Data

	Month				
Measure	3	6	9	12	15
Quality of Relationship	-	3.67	3.65	4.00	3.85
Spend time mostly talking	-	4	4	4	4
Easy to communicate	-	5	6	6	7
Easy to talk about sensitive topics	-	4	5	5	6
Mentoring going well	-	6	6	7	6
Mentoring Rewarding	-	7	6	6	7

Table 13

Child 4: Self-report data

Measure	Month 0	3	6	9	12	15
Self-esteem						
Behavioural Conduct	2.67	2.83	3	2.83	2.83	3.17
Scholastic Competence	2.67	3.67	3.17	2.83	2.83	2.5
Social Acceptance	1.00	1.83	2.17	2.50	3.00	2.33*
Global Self-Worth	3	2.5	2.83	3.17	3.5	2.83
Strengths and Difficulties						
Emotional Symptoms	6†	8††	5	7††	5	6†
Conduct Problems	3	4†	3	2	1	0*
Hyperactivity/Inattention	3	5	5	5	4	3
Peer Problems	8††	6††	5†	4†	2	3*
Total Difficulties	20††	23††	18†	18†	12	12
Prosocial Behaviour	6	9	8	9	9	10*
Life Satisfaction						
Family	2.5	3.25	2.25	3.25	3	3.25
School	1.5	1	1	1	3.75	3.75*
Personal Questionnaire [a]						
Problem 1	3	4	4	3	3	2
Problem 2	4	4	4	4	1	1
Problem 3	n/a	4	2	4	4	1
Problem 4	n/a	n/a	3	4	3	2
Quality of Relationship	n/a	3.00	3.67	3.47	3.40	3.47

[a] Problem 1: When I can't listen in lessons because my friend is talking to me; Problem 2: I hate children bullying me then I get the blame; Problem 3 (not identified until 3 months): When I come back from school I'm very moody and sometimes take my anger out on members of my family; Problem 4 (not identified until 6 months): I'm scared of my strict new school.

† Borderline range

†† Abnormal range

* Indicates reliable change from baseline to 15 months

Table 14

Child 4: Parent Data

	Month		
Measure	0	6	12
Self-esteem			
Behavioural Conduct	2.33	2.00	2.67
Scholastic Competence	1.83	1.33	2.00
Social Acceptance	1.75	2.00	1.50
Strengths and Difficulties			
Emotional Symptoms	4††	7††	7††
Conduct Problems	6††	8††	5††
Hyperactivity/ Inattention	6†	8††	10††
Peer Problems	8††	7††	8††
Total Difficulties	24††	30††	30††
Prosocial Behaviour	7	10	10*
Personal Questionnaire [a]			
Problem 1	4	4	2
Problem 2	4	2	2
Problem 3	4	4	2

[a] Problem 1: Her behaviour is not good; Problem 2: She feels unhappy; Problem 3: She feels nobody likes her.

† Borderline range

†† Abnormal range

* Indicates reliable change from baseline to 12 months

Table 15

Child 4: Mentor Data

	Month				
Measure	3	6	9	12	15
Quality of Relationship	3.80	4.00	3.65	3.87	3.93
Spend time mostly talking	4	5	4	5	4
Easy to communicate	7	7	7	6	7
Easy to talk about sensitive topics	7	6	6	6	6
Mentoring going well	7	7	6	6	7
Mentoring rewarding	7	7	7	7	7

emotional symptoms did not improve. The mothers' scores, however, did not always reflect the views of their children. The other two children did not report even these modest changes.

The results are partially consistent with the literature, which has demonstrated that mentoring relationships have modest effects (Dubois et al., 2002; Rhodes, 2008). Overall, more marked improvements were expected. Mentoring theory suggests that social and emotional problems should be most amenable to such an intervention (Rhodes, 2005; Rhodes, et al., 2006), while the empirical evidence indicates modest effects across all domains, with no particular domain appearing to benefit from mentoring more than the others (Dubois et al., 2002). Instead, the current study found reliable changes mostly in the behavioural domains such as attention and conduct problems.

Mentoring theory predicts that little change over the early months but that later youth outcomes will improve (Rhodes et al., 2006): it may take sic months or more for the relationship to establish (e.g. Grossman & Rhodes, 2002). However, the results revealed no pattern. There was neither reduced nor increased change in the first three months in comparison to other three-month periods.

The outcomes should also be considered in the light of normal maturation for children of this age. Bongers, Koot, van der Ende, and Verhulst (2003) investigated the normal development of child and adolescent problem behaviour from ages 4 to 18. They found that externalising behaviour (a category akin to the SDQ's Conduct Disorders domain) steadily decreases through childhood. Therefore, improvements seen in the conduct problems of the children in this study are congruous with, and may in part be accounted for by, the normal improvement that occurs. Bongers et al.

also found that girls' internalised problems tend to increase between the ages of ten and twelve. In this way, the emotional symptoms scores of Child 4, a girl, remaining in the borderline range at both baseline and at study completion may be considered a good outcome. Of note, whilst Bongers et al. showed that social problems also tend to decrease over this time, the improvements in this domain for Child 4 seem in excess to this normal maturation.

One of the primary aims of the study was to examine the time points at which change is initiated. The expectation, based on the literature, that change would begin to occur after the first six months of mentoring (Grossman & Rhodes, 2002) was not borne out; over the 15-month period there were no clear pattern to the changes. However, this is consistent with the notion put forward by the Rhodes et al. (2006) model that mentoring may take a long period of time to have an effect. It is possible that 15 months is not a long enough time period to observe substantial and definable patterns in these changes. Unfortunately, there has been little in depth research into such long term mentoring relationships. It may also be that the methodology employed in this study was not robust enough to truly capture whether patterns of change in the young person were associated with evolving characteristics of their relationship with their mentor.

The naturalistic design of this study meant it was prone to the influence of confounding factors. Thus, it is important to consider the possible external factors that may have had an impact on outcomes, apart from the mentoring relationship. Clearly, the attendance of Child 4 in intensive psychotherapy throughout the 15 months, as well as her seemingly important move to secondary school, is likely to have impacted on her scores. Nevertheless, whilst one cannot ignore the influence of extra-mentoring factors on outcomes, this does not necessarily preclude the effect of the mentoring relationship. Indeed, it is plausible that both the mentoring relationship and change of school were necessary for Child 4's improvement, and that neither was sufficient in isolation.

It is possible that the potential abundance of recognised and unrecognised confounding factors in such children's lives accounted for the variability of outcomes obtained; great variability is found not only across mentoring programmes but also between individuals within single programmes (DuBois et al., 2002; Rhodes, 2008). It therefore follows that it may be challenging to identify how mentoring may help individual children, due to the variation in the children's circumstances. Far from being exclusive to mentoring, the mechanisms of any intervention are likely to be complicated and conceivably differ for different recipients (Kazdin, 2009). Thus, two children could respond positively to mentoring for differing reasons, as illustrated by the two brothers (Child 1 and Child 2) who had markedly different outcomes, despite their common environment.

It is unlikely that the limited outcomes across the four children are related to the characteristics of the mentoring organisation itself. DuBois et al.'s (2002) meta-analysis found that variation in mentoring organisations is linked to variability in youth outcomes: the presence and quality of particular aspects of the organisation is influential. In this case, the organisation fulfilled a number of important criteria, such as close supervision of the mentors and an expectation of regular and enduring contact with the child. Nonetheless, conclusions drawn from this small sample should be considered in relation to this organisation rather than generalised to others.

Methodological limitations

A number of methodological limitations need to be addressed. Firstly, as mentioned, there were a number of confounding factors. While it is impossible to completely control for external confounding factors, the study was limited by a lack of systematic assessment of such confounds. As suggested, it may have been that there were reasons outside of the mentoring relationship, unknown to the researcher, which could account for Child 3's lack of improvement. Some events that had affected the children, for example changing school or attending psychotherapy, did come up in conversation. However, it is highly unlikely that everything worthy of note was mentioned and it is plausible that distressing events, which would be most relevant to the study, would be the least likely to be brought up.

A recommendation for future research would be to include a systematic way of checking for such confounds. A tool such as the Children's Life Events Inventory (CLEI; Monaghan, Robinson, & Dodge, 1979) could be employed. The CLEI is a 40-item self-report measure that gauges both positive and negative experiences. It has items enquiring about events such as 'death of brother or sister', 'loss of job by parent', and 'outstanding personal achievement'. This could be completed at each time point, ideally by both the child, with the assistance of the researcher, and the parent.

Secondly, the appropriateness of the outcome measures needs to be questioned. The outcome measures were chosen on the basis of their reliability and validity, as well as their established use in other studies in this field. While self-report measures do have limitations, for instance being prone to social desirability effects, obtaining the child's view is important: such assessments are necessary to measure certain factors such as the child's self-esteem. However, observations by the researcher suggested that the scores might not have accurately reflected the children's behaviour and feelings about themselves. At times, the questionnaire responses contradicted not only other responses but also the content of their informal conversations with the researcher. Failure to understand the questions is unlikely to have contributed to this, as each of the children appeared content when they did ask for clarification. It may be that they felt able to vocalise thoughts but not able to put them in writing, or vice versa. Furthermore, it is possible that not all children around the age of nine and ten have the requisite reflective abilities to accurately complete such questionnaires. However, it may also be that the contradictions in their responses accurately reflected the confusion they felt or the turbulence that defined certain aspects of their lives.

There were similar self-report difficulties with the Personal Questionnaire. Its strength is that it is an idiographic tool, but it was not always easy for the children to formulate their problems, even with assistance from the researcher. It is plausible that those who found it easier to identify problems were those with greater reflective abilities and, as such, these children would be more likely to improve. However, while some of the children appeared to find it easier than others to formulate problems, there was no apparent relationship between this ease and whether or not the problems persisted.

The domains of functioning assessed by the outcome measure also need to be considered. Outcome studies of mentoring have focused on the behavioural and academic domains (DuBois et al., 2002), while other domains have been comparatively neglected. Rhodes' model (Rhodes, 2005; Rhodes et al., 2006) sets out a framework through which these positive outcomes come about: via social-emotional development, cognitive development, and identity development. Yet domains related more to the child's internal world are measured less often. It is understandable why this had come about: academic and behavioural outcomes are easier to to define and thus more easily observable and measured. It may be that the changes that occur in the young people are subtler than those that could be captured by the measures employed in this study.

In the main, children who participate in mentoring programmes do not have major psychological problems and the aim of mentoring programmes is not to reduce psychological problems. One domain that might be particularly relevant to mentoring is the child's attitude to relationships. In describing her model, Rhodes refers to attachment theory (Bowlby, 1988), the importance of the young person's internal model of how to relate with others, and how the mentoring relationship may be able to positively influence this. Thus, development of a young person's internal model of relationships may be an important outcome in itself as well as holding the potential to enhance other areas of his or her life. However, there do not appear to be appropriate measures for assessing children's in depth views of their relationships, possibly because of their less developed reflective ability. However, a measure such as the Relationship Profile Test (RPT; Bornstein & Languirand, 2003), adapted to be appropriate for children, might be applicable. The RPT is self-report measure that assesses the flexibility of a person to defer short-term gratification in favour of longer-term relationships, something which is said to result from the confidence and self-directness gained from appropriately authoritative parenting (Lee & Robbins, 1995). Given that the aim of the study was to investigate the process of change, it may have been beneficial to have a greater focus on attempting to assess the internal world of the young person. This would be a relatively new area in this literature, but one which future research may benefit from considering.

Quantifiable measures may not be the best way to capture the often ill-defined constructs of the young person's inner world. It may be that a qualitative approach would be more illuminating, gaining the child's point of view more clearly.

However, there is also likely to be a limit to what extent, particularly younger, children would be able to verbalise their experiences. A semi-structured interview, perhaps revolving around some of the items in a measure such as the RPT (Bornstein & Languirand, 2003), may better capture, or add to the understanding of, the outcomes of mentoring and the process behind it.

Rhodes' model (Rhodes, 2005; Rhodes et al., 2006) also places importance on quality of mentoring relationship between the mentor and the young person and yet this also has rarely been assessed in the literature. The measure of the quality of the mentoring relationship used in this study, the MYAS (Zand et al., 2009), was limited in that there appeared to be ceiling effects, with high scores from the start, and thus it did not give a sense of relationship development. Despite its reliability and validity having been previously demonstrated, these effects may be related to inadequacies in the measure itself: it may not have provided a fine-tuned assessment of relationship quality. The ceiling effects may also be related to the nature of self-report: the children may have been reluctant to share negative thoughts about their mentor. The high scores may also have been related to these children in particular. It is plausible that their previous inexperience of attentive or supportive relationships with an extra-familial adult resulted in unexpectedly high scores from an early stage. It may have been useful to include questions about improvement or otherwise in the relationship over the past three month period, in order to provide a comparison. However, such questions would be more applicable to the mentors, who would have greater ability to resituate themselves in the past. The ceiling effects seen with this measure limited examination of the study's second hypothesis, regarding whether patterns of change would be associated with the evolution of the mentor-mentee relationship.

A strength of the study design was that it allowed for data to be collected from three perspectives: the child, the parent, and the mentor. The main emphasis was on the child, but, in retrospect, further data could have been obtained from the other perspectives. Data were only collected from the parent every six months in order not to burden their time; three-month intervals would have been preferable, and possibly more informative. The mentor's perspective on the child's behaviour was not sought, as they did not see the child in their everyday context. However, even though the mentors' views may not have been representative of the wider picture, their perspective may have been informative. In addition, were a measure such as a child version of the RPT (Bornstein & Languirand, 2003) to be employed, the outcomes of a version adapted for the mentor may be instructive. It also would have been helpful to obtain the teacher's perspective regarding peer relations and scholastic achievement, but this was beyond the scope and the resources of the study.

A further limitation was the matter of a lack of a solid baseline. Theory dictated that outcomes would be stable while the mentoring relationship was being established but would then improve (Grossman & Rhodes, 2002). This would allow the first three-month period to act as a baseline. However, the hypothesised pattern was not revealed, thus calling into question whether or not the first three months could be considered a baseline period. Without a baseline, it is uncertain to what extent the changes can be attributed to the mentoring relationship. Future studies would be improved by incorporating a baseline prior to the first meeting of the mentor and the young person.

Clinical and research implications

Despite its limitations, the multiple single case design used in this study has the potential to offer new insight into the effects of mentoring. It is rare to find studies in the field that include three perspectives. Obtaining results from the child, parent, and mentor is a strength of the study, providing a rich set of data, and should be encouraged and expanded in future research. The design addresses the issue of the uniformity myth (Kiesler, 1966), allowing for individual cases to be looked at in depth, over time, rather than presuming that participants belong to a homogenous group on which an intervention will have a uniform effect. It offers a detailed view of the pattern of change in outcomes, providing an opportunity to identify factors that may mediate change for particular individuals (Kazdin, 2009; Laurenceau et al., 2007).

Understanding the mechanisms of influence of mentoring is important both theoretically (Haynes & O'Brian, 2000) and practically. Even if stronger evidence is found for mentoring bringing about positive outcomes, explanatory power is important (Kazdin, 2009; Elliott, 2010), whilst being mindful of the individual variation between children. Moreover, it has been argued that the study of simpler, more informal helping such as mentoring might help elucidate the mechanisms behind more formal helping interventions such as psychological therapies (Barker & Pistrang, 2002).

Practically, further research could help illuminate for whom and in what way a mentoring intervention can be most beneficial. This would help focus the resources of mentoring organisations and mean that not only those who are helped by such an intervention can benefit, but also that those who are less likely to be helped by it can be offered a more applicable intervention.

Mentoring may not bring about substantial alterations to children's behaviour or internal world as it represents just one of many influences on a child's life. However, mentoring offers something that psychotherapies and other formal, professional services are not designed to deliver: it provides the opportunity for a healthy and reciprocal relationship outside of the family. It may be that mentoring comes to occupy a place in the therapeutic disciplines as something that can complement and supplement services provided by professionals, rather than take the place of such services.

It is evident that mentoring has an, as yet incompletely defined, role in providing positive support for some children, the benefit of which is likely to be realised over a longer time period than was feasible in this study. Future research is vital in order to supplement the current evidence-base for the effects of mentoring, to allow community and psychological services to plan child programmes accordingly.

References

Barrett-Lennard, G. T. (1986). The Relationship Inventory now: Issues and advances in theory, method and use. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 439-476). New York: Guilford Press.

Bennun, I. & Lucas, R. (1990). Using the partner in the psychosocial treatment of schizophrenia: A multiple case design. *British Journal of Clinical Psychology, 29,* 185-192.

Bongers, I. L., Koot, H. M., van der Ende, J., & Verhulst, F. C. (2003). The normative development of child and adolescent problem behavior. *Journal of Abnormal Psychology, 112*, 179-192.

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development.* New York: Basic Books.

Bornstein, R. F. & Languirand, M. A. (2003). *Healthy dependency*. New York: Newmarket.

Cramer, D. (1986). An Item Factor Analysis of the Revised Barrett-Lennard Relationship Inventory. *British Journal of Guidance and Counselling, 14*, 314-325.

DuBois, D. L., & Neville, H. A. (1997). Youth mentoring: Investigation of relationship characteristics and perceived benefits. *Journal of Community Psychology, 25,* 227-234.

DuBois, D. L., Holloway, B. E., Valentine, J. C., & Cooper, H. (2002). Effectiveness of mentoring programs for youth: A meta-analytic review. *American Journal of Community Psychology, 30,* 157-197.

Elliott, R. (2010). Psychotherapy change process research: Realizing the promise. *Psychotherapy Research, 20*, 123-135.

Elliot, R., Mack, C. & Shapiro, D.A. (1999). *Simplified Personal Questionnaire Procedure.* Network for Research on Experiential Psychotherapies website: http://experiential-researchers.org/instruments/elliott/pqprocedure.html

Goodman, R. (1997). The Strengths and Difficulties Questionnaire: A research note. *Journal of Child Psychology and Psychiatry, 38,* 581-586.

Goodman, R., (2001). Psychometric properties of the Strengths and Difficulties Questionnaire (SDQ). *Journal of the American Academy of Child and Adolescent Psychiatry, 40,* 1337-1345.

Goodman, R., Meltzer, H., & Bailey, V. (1998). The Strengths and Difficulties Questionnaire: a pilot study on the validity of the self-report version. *European Child Adolescent Psychiatry, 7*, 125-130

Greenspoon, P. J. & Saklofske, D. H. (1997). Validity and reliability of the Multidimensional Students' Life Satisfaction Scale with Canadian children. *Journal of Psychoeducational Assessment, 15,* 138-155.

Grossman, J. B. & Rhodes, J. E. (2002). The test of time: Predictors and effects of duration in youth mentoring programs. *American Journal of Community Psychology, 30,* 199-219.

Gurman, A. S. (1977). The patient's perception of the therapeutic relationship. In A.S. Gurman & A. M. Razin (Eds.), *Effective Psychotherapy: A handbook of research* (pp. 503-543). New York: Pergamon.

Harter, S. (1985). *Manual for the self-perception profile for children.* Denver, CO: University of Denver.

Harter, S. (1988). *Manual for the self-perception profile for adolescents.* Denver, CO: University of Denver.

Haynes, S. N. & O'Brien, W. O. (2000). *Principles of behavioral assessment: A functional approach to psychological assessment.* New York: Plenum.

Huebner, E. S. (1994). Preliminary development and validation of a multidimensional life satisfaction scale for children. *Psychological Assessment, 6,* 149-158.

Huebner, E. S., Laughlin, J. E., Ash C., & Gilman, R. (1998). Further validation of the Multidimensional Students' Life Satisfaction Scale. *Journal of Psychological Assessment, 16,* 118-134.

Jacobson, N. S. & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59,* 12-19.

Kazdin, A. E. (2009). Understanding how and why psychotherapy leads to change. *Psychotherapy Research, 19*, 419-428.

Kiesler, D. J. (1966). Some myths of psychotherapy research and the search for a paradigm. *Psychological Bulletin, 65*, 110-136.

Laurenceau, J. -P. Hayes, A. M., & Feldman, G. C. (2007). Some methodological and statistical issues in the study of change processes in psychotherapy. *Clinical Psychology Review, 27,* 682-695.

Lee, R. M. & Robbins, S. B. (1995). Measuring belongingness: The Social Connectedness and Social Assurance scales. *Journal of Consulting Psychology, 42*, 232-241.

LoSciuto, L., Rajala, A. K., Townsend, T. N., & Taylor, A. S. (1996). An outcome evaluation of across ages: An intergenerational mentoring approach to drug prevention. *Journal of Adolescent Research, 11,* 116-129.

Monaghan, J. H., Robinson, J. O., & Dodge, J. A. (1979). The Children's Life Events Inventory. *Journal of Psychosomatic Research, 23*, 63-68.

Morrow, K. V. & Styles, M. B. (1995). *Building relationships with youth in program settings: A study of Big Brothers/Big Sisters.* Philadelphia: Public/Private Ventures.

Muris, P., Meesters, C., & van den Berg, F. (2003). The Strengths and Difficulties Questionnaire (SDQ): Further evidence for its reliability and validity in a community sample of Dutch children and adolescents. *European Child and Adolescent Psychiatry, 12,* 1-8.

Muris, P., Meesters, C., Eijkelenboom, A., & Vincken, M. (2004). The self-report version of the Strengths and Difficulties Questionnaire: Its psychometric properties in 8 to 13-year-old non-clinical children. *British Journal of Clinical Psychology, 43*, 437–448.

Parry, G. Shapiro, D. A., & Firth, J. (1986). The case of the anxious executive: A study from the research clinic. *British Journal of Medical Psychology, 59,* 221-233.

Reddy, R., Rhodes, J., & Mulhall, P. (2003). The influence of teacher support on student adjustment in the middle school years: A latent growth curve study. *Development and Psychopathology, 15*, 119–138.

Rhodes, J. E. (2005). A model of youth mentoring. In D. L. DuBois & M. Karcher (Eds.), *Handbook of youth mentoring* (pp. 30–43). Thousand Oaks, CA: Sage.

Rhodes, J. E. (2008). Improving youth mentoring interventions through research-based practice. *American Journal of Community Psychology, 41,* 35-42.

Rhodes, J. E. & DuBois, D. L. (2006). Understanding and facilitating the youth mentoring movement. *Social Policy Report, XX,* 3-19.

Rhodes, J. E., Spencer, R., Keller, T. E., Liang, B., & Noam, G. (2006). A model for the influence of mentoring relationships on youth development. *Journal of Community Psychology, 34,* 691-707.

Spencer, R. (2007a). "I just feel safe with him": Emotional closeness in male youth mentoring relationships. *Psychology of Men and Masculinity, 8,* 185-198.

Spencer, R. (2007b). "It's not what I expected": A qualitative study of youth mentoring relationship failures. *Journal of Adolescent Research, 22,* 331-354.

Spencer, R. (2009). Understanding the mentoring process between adolescents and adults. *Youth Society, 37,* 287-315.

Styles, M. B. & Morrow, K. V. (1992). *Understanding how youth and elders form relationships: A study of four linking lifetimes programs.* Philadelphia: Public/Private Ventures.

Vygotsky, L.S. (1978). *Mind in society*. Cambridge, MA: Harvard University Press.

Zand, D. H., Thomson, N., Cervantes, R., Espiritu, R., Klagholz, D., LaBlanc, L., & Taylor, A. (2009). The mentor–youth alliance: The role of mentoring relationships in promoting youth competence. *Journal of Adolescence, 32,* 1-17.

Part 3: Critical Appraisal

This part reflects on particular issues that arise in Part 2. It focuses on four areas: the choice of which outcomes tend to be measured in mentoring research; what mentoring research can learn from the psychotherapy literature; the forgotten variable of the mentor; research designs in the mentoring literature; and the impact of mentoring on mentors themselves.

The choice of outcomes that are measured in mentoring research

The majority of studies investigating the effectiveness of mentoring, be they performed by independent researchers or the mentoring organisation themselves, have evaluated behavioural and academic outcomes (see DuBois, Holloway, Valentine, & Cooper, 2002). Although, the behavioural and academic domains are clearly relevant, they may also be chosen as the focus because they are relatively easy to define and measure. A further motive underlying this focus is the importance for mentoring organisations to prove their worth in quantifiable terms in the behavioural and academic domains; such outcomes are deemed overtly beneficial to society. Demonstration of effectiveness is necessary to procure government funding and private donations. This view was evident in conversations with the fundraiser from the organisation through which the participants for the current study were recruited and with whom the results would be shared. He stated that he was looking forward to having some “pithy statistics” to headline his marketing literature. Tersely presented evidence of behavioural change and scholastic improvement are eye catching for potential funders.

But are the goals of mentoring organisations primarily to bring benefit in these domains? Some mentoring programmes have explicit aims. For instance, the prevalent school-based programmes seek to enhance scholastic attitude and academic achievement, while programmes for youth offenders endeavour to reduce conduct problems (e.g. Jolliffe & Farrington, 2007).

However, the aims declared by more general mentoring programmes are often vague, for instance saying that they provide adult support and guidance to help young people have productive lives. It is unclear *precisely* what it is that mentoring is trying to achieve, and therefore what outcomes should be measured. This is because often the youth themselves will not have explicit goals, and if they do there will be great variation from person to person.

Domains other than the behavioural and academic have been considered: a number of studies have assessed young people's self-esteem while some have measured their relationships with parents and peers (see DuBois et al., 2002). However, investigation of these domains has been comparatively neglected. Some measures chosen to assess peer and parental relations have been relatively crude, while some have been more robust, for instance the Grossman and Tierney's (1998) use of the parent component of the *The Inventory of Parent and Peer Attachment* (IPPA; Armsden & Greenberg, 1987).

It can be argued that greater attention should be paid to outcomes related to the internal worlds of the youth, particularly given the role of psychological factors in the proposed conceptual models of mentoring. Based on limited empirical evidence and longstanding theory, Rhodes' (2005; Rhodes, Spencer, Keller, Liang, & Noam, 2006) model proposes that a caring, supportive relationship promotes youth social-emotional, cognitive, and identity development.

Rhodes draws upon attachment theory (Bowlby, 1988), assuming that many of the youths who acquire mentors are insecurely attached, as a result of early unreliable and insensitive care giving. These early experiences provide the young person with an internal model of relationships, which, at an unconscious level, brings a tendency to view others with insecurity and mistrust. This pattern endures unless they are given a corrective experience, changing their perception of relationships, an experience that mentors may offer.

These assertions are based on evidence of young people reporting improved perceptions of the adults in their lives after receiving mentoring (e.g. Grossman & Tierney, 1998). Qualitative research has also explored relational changes that can occur as a consequences of the mentoring dyad: in one study, boys described their greater ability to seek emotional support as a result of the mentoring relationship (Spencer, 2007) while in another the young people suggested that, through the mentoring relationship, their relationships with peers and family had improved and they had gained in self-confidence (Maldonado, Quarles, Lacey, & Thompson, 2008). These studies suggest that some subtle changes around the mentoring process may lead to changes in the child's natural social network.

The investigation of these nuances is important for deepening the theory of the mechanisms of change that underlie mentoring. It may be difficult to transfer these ideas to empirical measurement, although the assessment of the more subtle internal changes that may occur in the young people would be illuminative. One measure in the general psychotherapy literature that attempts to gauge more subtle changes is the Relationship Profile Test (RPT; Bornstein & Languirand, 2003). This assesses the participant's internal view of the other in relation to themselves rather than asking about specific relationships, for instance with caregivers or peers. Items include "It is important that people like me", "I prefer making decisions on my own, rather than listening to others' opinions", and "Other people want too much from me", with participants required to indicate to what extent the statement is like them.

However, even if the scale is adapted to be appropriate for young people, the items are relatively abstract and may be too difficult for younger children to grasp and answer in a meaningful way.

Measures that seek to assess more subtle changes in the young person's internal world should be more widely used, focusing on domains such as self-perception and relational attributes. This need not be instead of the more traditional behavioural and academic outcomes, which are important for the evaluation of programmes. They would, however, help provide a deeper understanding of the process behind effective relationships. This theoretical approach may help shape the goals of mentoring programmes and elucidate for whom they can be of most benefit.

When considering what measures should be employed the question of to whom they are given should also be addressed. All the studies in the field that seek data beyond administrative records obtain the view of the young person, but most do not attain further perspectives (see DuBois et al., 2002). It can be unwise to rely on just one perspective (Patton, 2002) and a strength of the current study was that it sought multiple perspectives: from the child, the parent, and the mentor. This allows for the 'triangulation' of findings (Patton, 2002), and the potential for greater confidence in the findings.

Evaluations based on self-report are prone to social desirability effects and bias, but the youth perspective is essential for the assessment of self-esteem. The notion that the parental view would necessarily be more objective and therefore based in reality is questionable: often the parent would have referred their child for mentoring and therefore would have hope and expectation about its effects, which might influence their reports. The current study frequently revealed differences between the child and parent reports. Such differences in perspectives, however, are common and do not mean that one perspective is not of value; weight needs to be given to both views.

The mentor's perspective of the child's behaviour is also a potentially valuable source of information. It is questionable to what extent the mentors can make an accurate assessment given that they see the child for only a few hours a week in the prescribed situation of one-to-one attention, often in the context of an activity. Nonetheless, over time the child may change within this framework, though it is unknown whether these changes would be generalisable. It may be useful, for instance, to give the mentors an adapted version of the RPT (Bornstein & Languirand, 2003): particular items, for example 'I am comfortable asking for help', could be taken and modified.

The mentors' reports, though, would also be prone to reporter-bias, especially given that the time and effort they volunteer is considerable. It could be that an unconscious desire to feel their investment to be worthwhile would allow self-deception regarding, for instance, the child's self-esteem. The results may also be prone to social desirability effects, despite declarations of confidentiality and anonymity. These issues of potential bias may have arisen in the current study in the mentors' assessment of their relationship with the children. Given their endeavours in forming the relationships, it is likely, for instance, that they would have wanted to believe that the child was able to talk about difficult things with them. Further perspectives would have been valuable, but were beyond the scope of the current study. The child's teacher also would have provided a useful angle on the child's scholastic attitude and peer relations, particularly for a child in primary education who spends the majority of their time with a single teacher.

In the mentoring organisation linked to the current study, a caseworker overlooked each pair throughout their relationship, providing supervision for the mentor and conducting biannual reviews with the family. The caseworker therefore had a unique, more objective view on the relationship, which may have been valuable particularly because they would have had experience of a number of relationships to provide comparison. However, it may be that the case worker's view of the relationship quality would to an extent be reflected in what the mentor was willing to talk about in supervision.

Psychotherapy research and mentoring

While mentoring and psychotherapy clearly differ, they are both relationship-based interventions. Thus an understanding of what constitutes an effective therapeutic relationship may inform the mentoring literature. This falls in line with the argument that there is an unwarranted division between the research literature on 'formal' psychotherapy and 'informal' social support (Pistrang & Barker, 2002).

Spencer (2004) notes that a factor common to all psychotherapies, and the foundation of Person Centred Therapy, is a relationship based on empathy, authenticity, positive regard, and congruence (Rogers, 1959). Spencer proposes that these qualities are essential to a mentoring dyad. Psychotherapists and mentors have some other features in common: both should be able to appropriately support and challenge and both are separate from the natural social network of those they are paired with.

The limits to the similarities between psychotherapy and mentoring should of course be emphasised. Therapeutic interventions are far more theory driven, and thus potentially more uniform, while there is little known about what actually happens in mentoring relationships and their constitution may be more variable. Mentors receive far less training, and expectations of what they can achieve should not be overestimated (Spencer, 2004). Generally a therapy will focus on a potential or presenting problem, and would have stemmed from a referral stating this. As a result, to a greater or lesser extent, the therapist and the client agree about the purpose of therapy, with shared goals. In contrast, when a young person is allocated a mentor, there may or may not be a specific aim for the intervention and it may be seen as preventative. The mentor and young person may or may not have a shared view of the purpose of mentoring. A therapy is likely to be more time limited while, because of the length and the voluntary nature of mentoring, it could be argued that mentors invest more of themselves into the relationship. This would be emphasised by mentors usually being paired with only one young person, whereas a therapist will have a number of clients. The mentor, in part due to not relying on theory and in part due to the higher reciprocity and mutuality of the relationship, is more likely to share his or her own experiences and offer advice. Because mentors give of themselves, in contrast to professional therapists providing a theory-based service, mentors may feel the intervention represents them personally to a greater extent. Therefore, the flourishing or otherwise of the relationship and indeed the young person may affect them more. The reciprocity and mutuality of the mentoring relationship makes it more ‘real’.

However, given the parallels that do exist between the therapeutic and mentoring relationships, the established psychotherapy literature could be drawn upon, in particular considering the transactions between mentors and youths, focusing more on individual relationships. A major finding in the psychotherapy research is that the alliance between the therapist and the client is the best predictor of client outcomes. The measure of alliance at a single time-point in therapy (generally assessed early on) has a robust moderate association with later outcomes (e.g. Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Several researchers have argued for the quality of the alliance as a common factor across treatments (e.g. Norcross, 2010; Safran & Muran, 2000). A meta-analytic review by Shirk and Karver (2003) indicated that the influence of the alliance was as important in therapy with children and adolescents as it was with adults, and that this was consistent across developmental levels and therapeutic contexts. Similarly, in the mentoring literature, there is growing empirical evidence for the importance of the quality of relationship between a young person and their mentor. Stronger emotional connections between the mentor and the mentee are related to better outcomes, while less close relationships have little influence (DuBois & Neville, 1997; Grossman & Rhodes, 2002; Parra, Dubois, Neville, Pugh-Lilly, & Povinelli, 2002; Rhodes, Reddy, Roffman, & Grossman, 2005).

However, the mentoring studies that have examined the quality of the relationship have not used measures with established psychometric properties (Nakkula & Harris, 2005), with the exception of the *Youth–Mentor Relationship Questionnaire* employed by Rhodes, et al. (2005). Zand et al. (2009) criticise the *Youth–Mentor Relationship Questionnaire* on the basis that it contains only one item tapping positive features of the mentoring relationship. However, they appeared to disregard that the creation of the measure involved discarding over fifty positively framed items, as they held no predictive power (Rhodes, 2002). Whichever view is taken, both the *Mentor-Youth Alliance Scale* (MYAS; Zand et al., 2009), used in the current study, and the *Youth–Mentor Relationship Questionnaire* are somewhat unsophisticated measures. Both only allow the relationship to be looked at from the perspective of the youth. In addition, the MYAS has only two subscales, caring and acceptance, while the *Youth–Mentor Relationship Questionnaire* has none. In the current study, the empathy scale of the *Relationship Inventory* (RI; Barrett-Lennard, 1986) was added to the MYAS. The RI has been used across literatures and is designed to look at the relationship from the perspectives of each party. Even with this addition, the results of the current study suggested a ceiling effect to the measure, particularly from the child's point of view, and it may not have been able to pick up more subtle relationship changes. However, the mentor-youth relationship is a difficult concept to assess. There may be value to adapting an established measure of therapeutic alliance, but the differences between the therapist-client and mentor-mentee relationships may be too great for it to be applicable. However, this assumes that the factors that make up an effective therapeutic alliance – a collaborative relationship, an affective bond, and an ability for the dyad to agree on treatment goals (Martin, Garske, & Davis, 2000) – also constitute an effective mentoring relationship. Given the differences in the two relationships, this may not be the case.

A further robust finding in the psychotherapy literature, which has relevance to mentoring, is that the skill of the individual therapist accounts for greater variability in outcomes than specific technique or theoretical orientation. This association is present in both clinical trials (e.g. Kim, Wampold, & Bolt, 2006) and naturalistic settings (Lutz, Leon, Martinovich, Lyons, & Stiles, 2007; Wampold & Brown, 2005). Baldwin, Wampold, and Imel (2007) demonstrated that outcomes were related to variation in therapists' ability to form an alliance, but not that of clients. This underlines the importance of the therapist in creating an effective relationship. As with therapists, mentors will vary in their skills and abilities to perform their role. The variation in mentors is rarely considered in the literature.

The forgotten variable of the mentor

If outcomes are conceptualised as resulting from the mentoring relationship, then greater consideration needs to be given to the mentor's role within it. As previously described, mentors have less training and less of a theoretical framework to guide their approach. Even with the supervision that the better mentoring organisations offer, this is likely to lead to great variation in what mentors actually offer in their relationship with the young person. More detailed examination of what mentors do and how mentors might differ would offer more insight into the process and mechanism of change and may help identify the factors that differentiate effective mentors from less effective ones.

Future studies could explore the types of social support given by mentors. Which type or types of support do the volunteers view their role as providing: instrumental, informational, or emotional support? Do the young people agree? Is the type of support given related to the characteristics of the volunteer? Or is it more related to the characteristics and needs of the young person? This would provide a more insightful understanding into the relationship and a greater understanding of to what extent the mentoring relationship is comparable to a therapeutic alliance. It may demonstrate that there is huge variation in mentoring relationships, which would allow consideration of whether some relationships with some young people are more beneficial.

As already noted, such investigation would remain prone to potential methodological problems. It may be unwise to trust self-report by the volunteer, given social desirability effects. An alternative would be for a researcher to observe and analyse meetings between the young person and the mentor. This could be done in person, which may feel intrusive, and influence the content and manner of conversation, but would allow for visual observation. Otherwise audio recordings could be taken, as is the norm in psychotherapy process research. Either way, given the length of meetings between mentors and young people, the process would be highly labour intensive.

Research designs in mentoring research

The need for greater focus on the individual mentoring relationship can be realised in the multiple case design used in the current study. This is in line with the current zeitgeist for practice-based evidence, where research and evaluation can occur within a real-world framework (Barkham & Mellor-Clark, 2003). The larger randomised controlled designs such the evaluations of the Big Brothers/ Big Sisters programme (e.g. Grossman & Tierney, 1998), look to provide evidence upon which to base practice. A strength of these studies is their large numbers of participants from many sites across the USA, but while they are performed under real-life conditions, its parameters for inclusion mean that the context and length of relationships are often quite specific.

A multiple case design can allow focus on the idiographic rather than treating all youth (and indeed mentors) as one homogenous group, leaving results prone to the effects of the uniformity myth (Kiesler, 1966). The design permits a greater depth of research that cannot be carried out across the large scale randomised controlled trials, due to the intensity of resources required. As such, patterns of change in outcomes and in the mentor-mentee relationship can be observed (providing appropriate measures are employed). This is in line with the psychotherapy literature growing to regard the therapeutic alliance as a complex, non-linear attribute (Hayes, Laurenceau, Feldman, Strauss, & Cardaciotto, 2007), the evolution of which should be tracked over time (Kramer, de Roten, Beretta, Michel, & Despland, 2009).

The multiple case design should not be regarded as an alternative to larger scale studies, but rather as complementary, if potentially very labour intensive. It places a focus on individual pairs and gives a place to research that is not tightly controlled. In the current study, this approach was congruent with the needs of the mentoring organisation, which wanted more comprehensive evaluation systems in place. This type of design can encourage such smaller organisations to conduct research and help assess and develop their practice.

The impact of mentoring on mentors

Understandably, the mentoring literature tends to regard the relationship dyad as unidirectional in terms of the mentor's influence on the young person, rarely considering that the mentor too may be affected. According to the 'helper-therapy principle' (Reissman, 1965), a person can benefit through the process of helping others, for instance via enhanced feelings of competence or social value. The mentor may gain an increased sense of efficacy and pride from their role, attained from feelings of being looked up to and of helping someone (Rhodes, 2002). In one of the few studies that considered the impact on the mentor, male mentors reported in interviews that they welcomed the opportunity to connect more with their own emotional lives as well as feeling they became more able to emotionally support others outside of the mentoring relationship (Spencer, 2007).

In the current study, one of the items in the mentor questionnaire asked how rewarding they found mentoring. Three of the four mentors reported experiencing their role as 'very rewarding'. However, over the 18 months, one found it decreasingly rewarding to the point of it being 'not at all rewarding'. This suggests that, just as there is great variation of impact on individual youth (Dubois et al., 2002), there is variation in the experience of the mentor, with the potential for both positive and negative outcomes. Greater attention should be given to the mentor's experience, given the evidence that the quality of the relationship with the young person is of importance (Goldner & Mayseless, 2009; Grossman & Rhodes, 2002). Rhodes (2002) calls for the recognition of the mutual benefits that arise from the mentoring relationship and volunteering in general, at both the individual and societal levels, while acknowledging the potential costs that come with it.

Conclusion

There is extensive evidence for mentoring having a modest effect on youth, but investigation of its underlying process is under-researched. It is important to continue to look beyond the randomised controlled trial paradigm to designs that can provide a greater depth of understanding. This can be aided by employing measures more adept at tapping aspects of the youth's internal world and by gaining the perspectives of a number of sources. The consideration of parallels with psychotherapy and drawing upon the psychotherapy literature may also be of use.

References

Armsden, G. C. & Greenberg, M. T. (1987). The inventory of parent and peer attachment: Individual differences and their relationship to psychological well-being in adolescence. *Journal of Youth and Adolescence, 16*, 427-454.

Baldwin, S. A., Wampold, B. E., & Imel, Z. E. (2007). Untangling the alliance–outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology, 75*, 842-852.

Barker, C., & Pistrang, N. (2002). Psychotherapy and social support: Integrating research on psychological helping. *Clinical Psychology Review, 22*, 361-379.

Barkham, M., & Mellor-Clark, J. (2003). Bridging evidence-based practice and practice-based evidence: Developing a rigorous and relevant knowledge for the psychological therapies. *Clinical Psychology and Psychotherapy, 10*, 319-327.

Barrett-Lennard, G. T. (1986). The Relationship Inventory now: Issues and advances in theory, method and use. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 439-476). New York: Guilford Press.

Bornstein, R. F. & Languirand, M. A. (2003). *Healthy dependency.* New York: Newmarket.

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development.* New York: Basic Books.

DuBois, D. L., & Neville, H. A. (1997). Youth mentoring: Investigation of relationship characteristics and perceived benefits. *Journal of Community Psychology, 25,* 227-234.

DuBois, D. L., Holloway, B. E., Valentine, J. C., & Cooper, H. (2002). Effectiveness of mentoring programs for youth: A meta-analytic review. *American Journal of Community Psychology, 30,* 157-197.

Goldner, L. & Mayseless, O. (2008). The quality of mentoring relationships and mentoring success. *Journal of Youth Adolescence, 38*, 1339-1350.

Grossman, J. B., & Tierney, J. P. (1998). Does mentoring work? An impact study of the Big Brothers/Big Sisters program. *Evaluation Review, 22,* 403-426

Grossman, J. B. & Rhodes, J. E. (2002). The test of time: Predictors and effects of duration in youth mentoring programs. *American Journal of Community Psychology, 30,* 199-219.

Hayes, A. M, Laurenceau, J. P., Feldman, G., Strauss, J.L., & Cardaciotto, L. (2007). Change is not always linear: the study of nonlinear and discontinuous paths of change in psychotherapy. *Clinical Psychology Review 27,* 715-723.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 36*, 139-149.

Jolliffe, D. & Farrington, D. P. (2007). *A rapid evidence assessment of the impact of mentoring on re-offending: A summary.* London, UK: Research Development and Statistics Directorate, Home Office.

Kiesler, D. J. (1966). Some myths of psychotherapy research and the search for a paradigm. *Psychological Bulletin, 65*, 110-136.

Kim, D.-M., Wampold, B. E., & Bolt, D. M. (2006). Therapist effects in psychotherapy: A random-effects modeling of the National Institute of Mental Health Treatment of Depression Collaborative Research Program data. *Psychotherapy Research, 16,* 161-172.

Kramer, U., de Roten, Y., Michel, L., & Despland, J.-N. (2009). Early change of defense mechanisms and coping in short-term dynamic psychotherapy: Relations with symptoms and alliance. *Clinical Psychology and Psychotherapy, 16,* 408-417.

Lutz, W., Leon, S. C., Martinovich, Z., Lyons, J. S., & Stiles, W. B. (2007). Therapist effects in outpatient therapy: A three-level growth curve approach. *Journal of Counseling Psychology*, *54*, 32-39.

Maldonado, N. L., Quarles, A., Lacey, C. H., & Thompson, S. D. (2008). Mentoring at risk adolescent girls: Listening to 'little sisters'. *Mentoring & Tutoring: Partnership in Learning, 16*, 223-234.

Martin, D. J., Garske, J. P., & Davis, K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*, 438-450.

Nakkula, M. J., & Harris, J. T. (2005). Assessment of mentoring relationships. In D. L. DuBois & M. J. Karcher (Eds.), *Handbook of youth mentoring* (pp. 100–117). Thousand Oaks, CA: Sage.

Norcross, J. C. (2010). The therapeutic relationship. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble (Eds.) *The heart and soul of change: Delivering what works in therapy* (2nd ed.) (pp. 113-142). Washington, DC: American Psychological Association.

Parra, G. R., DuBois, D. L., Neville, H. A., Pugh- Lilly, A. O., & Povinelli, N. (2002). Mentoring relationships for youth: Investigation of a process-oriented model. *Journal of Community Psychology, 30*, 367-388.

Patton, M. (2002). *Qualitative research and evaluation methods* (3rd edn). Thousand Oaks, CA: Sage Publications.

Reissman, F. (1965). The helper-therapy principle. *Social Work 10,* 27-32.

Rhodes, J. (2002). *Stand by me: The risks and rewards of mentoring today's youth.* Cambridge, MA: Harvard University Press.

Rhodes, J. E. (2005). A model of youth mentoring. In D. L. DuBois & M. Karcher (Eds.), *Handbook of youth mentoring* (pp. 30-43). Thousand Oaks, CA: Sage.

Rhodes, J. E., Reddy, R., Roffman, J., & Grossman, J. B. (2005). Promoting successful youth mentoring relationships: A preliminary screening questionnaire. *Journal of Primary Prevention, 26*, 146-167.

Rhodes, J. E., Spencer, R., Keller, T. E., Liang, B., & Noam, G. (2006). A model for the influence of mentoring relationships on youth development. *Journal of Community Psychology, 34,* 691-707.

Rogers, C. R. (1959). A theory of therapy, personality and interpersonal relationships. In S. Koch (Ed.), *Psychology: A study of a science* (pp. 184-256). New York: McGraw-Hill.

Safran, J. D. & Muran, J. C. (2000). *Negotiating the therapeutic alliance.* New York: The Guilford Press.

Shirk, S. R., & Karver, M. S. (2003). Prediction of treatment out come from relationship variables in child and adolescent therapy: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 71*, 452-464.

Spencer, R. (2004), Studying relationships in psychotherapy: An untapped resource for youth mentoring. *New Directions for Youth Development, 2004*, 31-43.

Spencer, R. (2007). "I just feel safe with him": Emotional closeness in male youth mentoring relationships. *Psychology of Men and Masculinity, 8,* 185-198.

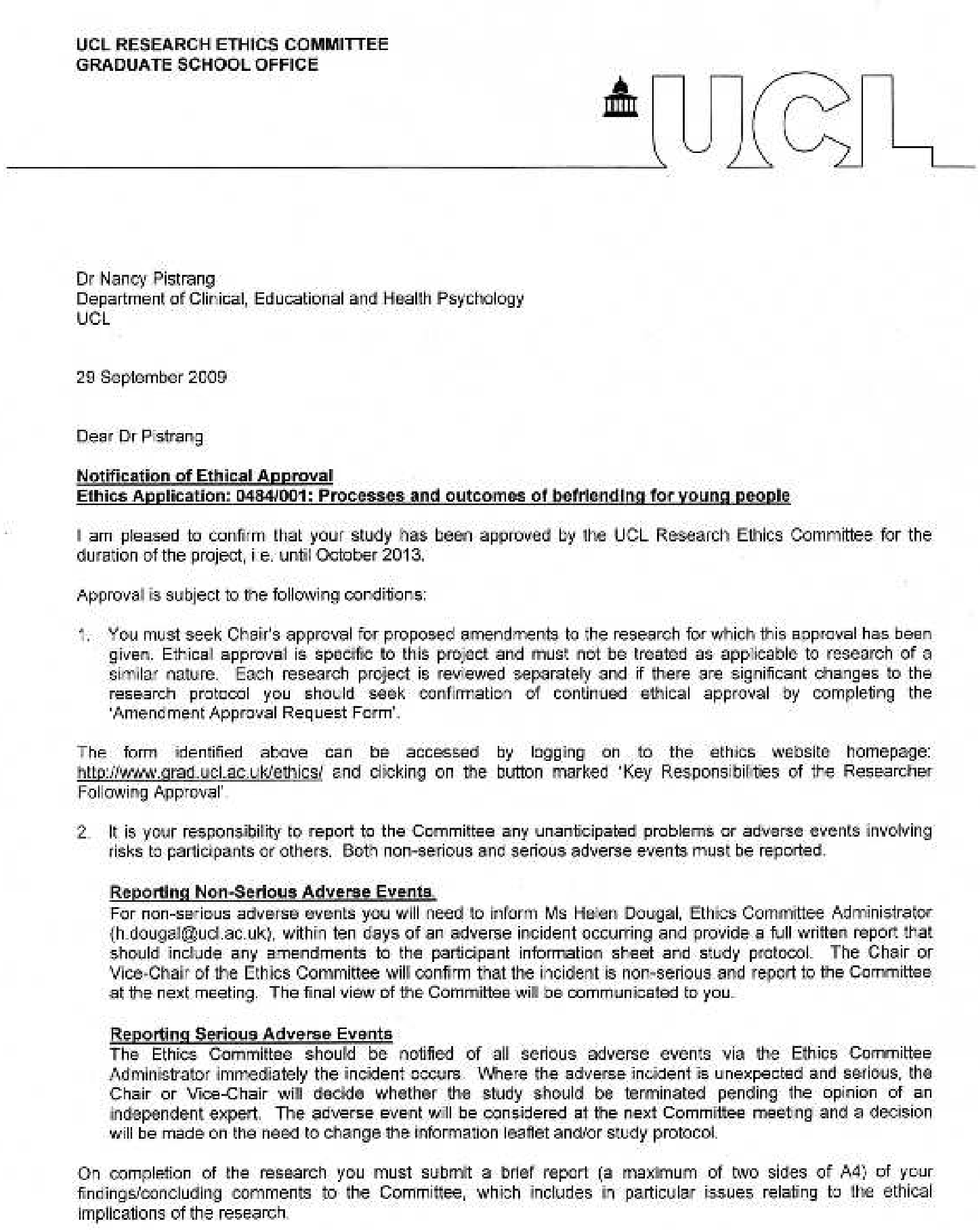
Wampold, B. E., & Brown, G. S. (2005). Estimating variability in outcomes attributable to therapists: A naturalistic study of outcomes in managed care. *Journal of Consulting and Clinical Psychology, 73,* 914-923.

Zand, D. H., Thomson, N., Cervantes, R., Espiritu, R., Klagholz, D., LaBlanc, L., & Taylor, A. (2009). The mentor-youth alliance: The role of mentoring relationships in promoting youth competence. *Journal of Adolescence, 32,* 1-17.

Appendices

Appendix 1

Notification of Ethics Approval



UCL RESEARCH ETHICS COMMITTEE
GRADUATE SCHOOL OFFICE

Dr Nancy Pistrang
Department of Clinical, Educational and Health Psychology
UCL

29 September 2009

Dear Dr Pistrang

Notification of Ethical Approval
Ethics Application: 0484/001: Processes and outcomes of befriending for young people

I am pleased to confirm that your study has been approved by the UCL Research Ethics Committee for the duration of the project, i.e. until October 2013.

Approval is subject to the following conditions:

1. You must seek Chair's approval for proposed amendments to the research for which this approval has been given. Ethical approval is specific to this project and must not be treated as applicable to research of a similar nature. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing the 'Amendment Approval Request Form'.

The form identified above can be accessed by logging on to the ethics website homepage: http://www.grad.ucl.ac.uk/ethics/ and clicking on the button marked 'Key Responsibilities of the Researcher Following Approval'.

2. It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. Both non-serious and serious adverse events must be reported.

   Reporting Non-Serious Adverse Events.
   For non-serious adverse events you will need to inform Ms Helen Dougal, Ethics Committee Administrator (h.dougal@ucl.ac.uk), within ten days of an adverse incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Chair or Vice-Chair of the Ethics Committee will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

   Reporting Serious Adverse Events
   The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator immediately the incident occurs. Where the adverse incident is unexpected and serious, the Chair or Vice-Chair will decide whether the study should be terminated pending the opinion of an independent expert. The adverse event will be considered at the next Committee meeting and a decision will be made on the need to change the information leaflet and/or study protocol.

On completion of the research you must submit a brief report (a maximum of two sides of A4) of your findings/concluding comments to the Committee, which includes in particular issues relating to the ethical implications of the research.

Yours sincerely

Sir John Birch
Chair of the UCL Research Ethics Committee

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Appendix 2

Participant information and consent forms

Child Information form

DEPARTMENT OF CLINICAL, EDUCATIONAL AND HEALTH PSYCHOLOGY

An evaluation of befriending

Information Sheet for Young People

We are inviting you to take part in this research project. You should only take part if you want to – if you don't want to, that's OK. Before you decide whether to take part, it's important to read this information sheet carefully (the researcher or someone at [name of organisation] can read it out to you if you want). You can talk it over with other people too. Please ask us if there is anything you are not sure about or if you would like more information.

Who are we?
We are from University College London and we are working together with [name of organisation]. Our names are at the bottom of this sheet.

What is the project about?
We are trying to find out how befriending can help young people. We want to learn about this from young people themselves, and also from their befrienders and parents.

Who is being invited to take part?
We are asking young people who have been matched with a befriender at [name of organisation] to take part. We're also asking their befrienders and parents to take part.

What will I be asked to do?
We will ask you to fill out some questionnaires about yourself and what you think about having a befriender. The questions will be about things like how you feel about yourself, what you think of school, and how you get along with other people your age. We will also talk to you about what it is like having a befriender. We'd like to meet with you a few times over the next couple of years while you are with [name of organisation], so that we can see how things are going. The questions will be private and will take about 30 minutes.

What will happen afterwards?
What you tell us will be kept confidential (private). This means it is between you and us, and your parent and befriender won't see it. However, if you tell us something that makes us worry about your safety, we would have to tell other people. We will make sure your information is kept private by using identification numbers in place of your name. With your permission, we will audio-record our conversations so that we have a record of what we talked about, but we will take out any information that can identify you. We will then type up what was said and we will delete the recordings. When the study is over, we will write up a report and you will be given a summary of it.

Are there any benefits of taking part?
Young people have told us that it can be interesting to fill in the questionnaires and to talk about what it is like having a befriender. We hope that we will learn some important things about befriending from this research. This should help [name of organisation] and other young people in the future.

Are there any risks of taking part?
We do not think that there are any risks of taking part. We will be asking you about your feelings and things about your life. If you feel upset at any point or do not want to continue, it is OK for you to stop.

Do I have to take part?
No, you don't have to take part. It's up to you to decide.

What do I do now?
If you have any questions, please ask one of the researchers or someone at Friendship Works. If you decide to take part, we will ask you to sign a consent form.

The researchers are:

Dr Nancy Pistrang <n.pistrang@ucl.ac.uk>
Dr Chris Barker <c.barker@ucl.ac.uk>
Matthew Evans <matthew.evans@hotmail.com>

Department of Clinical, Educational and Health Psychology
University College London
Gower Street, London, WC1E 6BT

Telephone: 020 7679 5962

Thanks for reading this information sheet! You can keep this copy.

This study has been approved by the UCL Research Ethics Committee (Project ID number 0484/001).

Child Consent Form:

DEPARTMENT OF CLINICAL, EDUCATIONAL AND HEALTH PSYCHOLOGY

UCL

Consent Form for Young People

An evaluation of befriending

Please circle your answer to the questions below:

Have you read (or had read to you) the Information Sheet for Young People?	Yes	No
Has someone explained this project to you?	Yes	No
Do you understand what this project is about?	Yes	No
Do you understand that some of things you say may be in our reports, without people knowing who you are?	Yes	No
Do you understand it's OK to stop taking part at any time?	Yes	No
Are you happy to take part?	Yes	No

If any answers are 'no' or you **don't** want to take part, **don't** sign your name!

If you would like to take part, please sign your name

Your name	**Date**	**Signature**

This study has been approved by the UCL Research Ethics Committee [Project ID Number: 0484/001]

Parent Information Sheet:

DEPARTMENT OF CLINICAL, EDUCATIONAL AND HEALTH PSYCHOLOGY

An evaluation of befriending

Information Sheet for Parents

We are inviting you and your child to take part in this research project. You should only participate if you want to; choosing not to take part will not disadvantage your child in any way. Before you decide whether you want to take part, it is important to read the following information carefully and discuss it with others if you wish. Please ask us if there is anything that is not clear or if you would like more information.

Who are we?
We are researchers from University College London and we are working together with [name of organisation]. Our contact details are at the bottom of this sheet.

What is the project about?
The purpose of this research is to get a detailed picture of how befriending may help young people. There are a number of studies of befriending (sometimes called mentoring), but few have looked at long-term befriending and how change occurs over time. We hope to learn more about this by getting the views of the young people, their befrienders and their parents.

Who is being invited to take part?
We are asking young people who have been matched with a befriender at [name of organisation] to take part, as well as their befrienders and parents.

What will my child and I be asked to do?
We will ask you each to fill out questionnaires that ask about how your child is doing (e.g. at school, with friends, at home) and any areas in which you would like to see change. We will also ask you each to take part in an informal interview so that we can hear about your experiences of befriending. Because we are interested in how befriending develops over time, we will ask you to fill out questionnaires several times over the next couple of years while your child is with [name of organisation]. They should not take longer than 30 minutes to fill out and you will be able to do them at a time and place convenient to you.

What will happen to the information that is collected?
All the questionnaires and interviews will be made anonymous; names and any identifying information will be removed so that you and your child cannot be identified. With your permission, we will audio-record the interviews and then transcribe (write up) what was said. We will delete the recordings after they have been transcribed. All written information will be stored securely and will be destroyed five years after the project has ended. All data will be collected and stored in accordance with the Data Protection Act 1998.

Everything that you and your child tell us will be kept confidential; only the research team will have access to what has been said. The only time confidentiality would be broken is if we were worried that your child or somebody else was at risk of harm, and we would need to let the appropriate services know. However, we would try to talk to you about this before we spoke to anyone else.

Once the project is over, the results will be written up and may be submitted for publication in a professional journal. Reports will not reveal the identity of anyone who took part. A summary of the findings will be given to those who took part in the project.

Are there any benefits of taking part?
We hope that you and your child will find it interesting to fill in the questionnaires and to talk to us about what it is like having a befriender. The research should give us a better understanding of how befriending works, and therefore it should be helpful to [name of organisation] and to young people in the future.

Are there any risks of taking part?
We do not think there are any risks to taking part. It is possible that you or your child may feel uncomfortable answering questions about any difficulties your child has experienced (e.g. problems at home or with friends). If this should happen, you do not have to answer the questions.

Do my child and I have to take part?
No, neither of you has to take part. It is up to you both to decide. If you do decide to take part, you are still free to withdraw at any time and without giving a reason.

What do I do now?
If you would like to take part, or if you have any questions, please tell one of the researchers or someone at [name of organisation]. Before taking part, we will ask you and your child to sign a consent form.

The researchers are:

Dr Nancy Pistrang <n.pistrang@ucl.ac.uk>
Dr Chris Barker <c.barker@ucl.ac.uk>
Matthew Evans <matthew.evans@hotmail.com>

Department of Clinical, Educational and Health Psychology
University College London
Gower Street, London, WC1E 6BT

Telephone: 020 7679 5962

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Mentor Information Sheet:

DEPARTMENT OF CLINICAL, EDUCATIONAL AND HEALTH PSYCHOLOGY

An evaluation of befriending

Information Sheet for Befrienders

We are inviting you to take part in this research project. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important to read the following information carefully and discuss it with others if you wish. Please ask us if there is anything that is not clear or if you would like more information.

Who are we?
We are researchers from University College London and we are working together with [name of organisation]. Our contact details are at the bottom of this sheet.

What is the project about?
The purpose of this research is to get a detailed picture of how befriending may help young people. There are a number of studies of befriending (sometimes called mentoring), but few have looked at long-term befriending and how change occurs over time. We hope to learn more about this by getting the views of the young people, their befrienders and their parents.

Who is being invited to take part?
We are asking young people who have been matched with a befriender at [name of organisation] to take part, as well as their befrienders and parents.

What will I be asked to do?
We will ask you to fill out questionnaires that ask about your relationship with the young person whom you are befriending. We will also ask you to take part in an informal interview so that we can hear about your experiences of befriending. Because we are interested in how befriending develops over time, we will ask you to fill out questionnaires several times over the next couple of years while you are with [name of organisation]. They should not take longer than 30 minutes to fill out and you will be able to do them at a time and place convenient to you.

What will happen to the information that is collected?
All the questionnaires and interviews will be made anonymous; names and any identifying information will be removed so that you cannot be identified. With your permission, we will audio-record the interviews and then transcribe (write up) what was said. We will delete the recordings after they have been transcribed. All written information will be stored securely and will be destroyed five years after the project has ended. All data will be collected and stored in accordance with the Data Protection Act 1998.

Everything that you tell us will be kept confidential; only the research team will have access to what has been said. The only time confidentiality would be broken is if we were worried that someone was at risk of harm, and we would need to let the appropriate services know. However, we would try to talk to you about this before we spoke to anyone else.

Once the project is over, the results will be written up and may be submitted for publication in a professional journal. Reports will not reveal the identity of anyone who took part. A summary of the findings will be given to those who took part in the project.

Are there any benefits of taking part?
We hope that you will find it interesting to fill in the questionnaires and to talk to us about what it is like being a befriender. The research should give us a better understanding of how befriending works, and therefore it should be helpful to [name of organisation] and to young people in the future.

Are there any risks of taking part?
We do not think there are any risks to taking part. If you feel uncomfortable answering any questions, you do not have to answer them.

Do I have to take part?
No, you don't have to take part; it is up to you to decide. If you do decide to take part, you are still free to withdraw at any time and without giving a reason.

What do I do now?
If you would like to take part, or if you have any questions, please tell one of the researchers or someone at [name of organisation]. Before taking part, we will ask you to sign a consent form.

The researchers are:

Dr Nancy Pistrang <n.pistrang@ucl.ac.uk>
Dr Chris Barker <c.barker@ucl.ac.uk>
Matthew Evans <matthew.evans@hotmail.com>

Department of Clinical, Educational and Health Psychology
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Gower Street, London, WC1E 6BT

Telephone: 020 7679 5962

Thanks for reading this information sheet! You can keep this copy.

This study has been approved by the UCL Research Ethics Committee (Project ID number 0484/001).

Mentor Consent Form:

DEPARTMENT OF CLINICAL, EDUCATIONAL AND HEALTH PSYCHOLOGY

Informed Consent Form for Befrienders

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Title of Project: **An evaluation of befriending**

This study has been approved by the UCL Research Ethics Committee
[Project ID Number: 0484/001]

Thank you for your interest in taking part in this research. Before you agree to take part the person organising the research must explain the project to you.

If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you to decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

Participant's Statement

I ……………………………………………………………………

- have read the notes written above and the Information Sheet, and understand what the study involves.
- understand that if I decide at any time that I no longer wish to take part in this project, I can notify the researchers involved and withdraw immediately.
- understand that interviews may be audio-recorded, and consent to anonymised quotations from the interviews being used in reports.
- consent to the processing of my personal information for the purposes of this research study.
- understand that such information will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 1998.
- agree that the research project named above has been explained to me to my satisfaction and I agree to take part in this study.

Signed: Date:

Appendix 3

Participant questionnaires

Child Questionnaire:

Friendship Works Questionnaires

Child Version – follow up

[Organisation Logo]

Name: ______________________________ Date: ____________

My Big Friend

We would like to know how things are going with your Big Friend. Sometimes things go well, and sometimes not so well. <u>There are no right or wrong answers</u>. Please tell us what you really feel.

Step 1: READ each sentence, and decide whether it is true or false for you.

Step 2: CIRCLE the word next to the sentence that tells HOW TRUE OR FALSE the sentence is for you.

Example: If you think your Big Friend sort of likes to talk about sports, you would circle the words "Sort of true" like this:

EXAMPLE	My Big Friend likes to talk about sports.	Very false	Sort of false	[✓ Sort of true]	Very true

Now circle one answer for each sentence:

1.	I would feel sad if something bad happened to my Big Friend.	Very false	Sort of false	Sort of true	Very true
2.	I look forward to the time I spend with my Big Friend.	Very false	Sort of false	Sort of true	Very true
3.	My Big Friend nearly always knows exactly what I mean.	Very false	Sort of false	Sort of true	Very true
4.	My Big Friend is happy when good things happen to me.	Very false	Sort of false	Sort of true	Very true
5.	My relationship with my Big Friend is important to me.	Very false	Sort of false	Sort of true	Very true
6.	My Big Friend can tell what I mean even when it's hard for me to say it.	Very false	Sort of false	Sort of true	Very true
7.	My Big Friend cares about me.	Very false	Sort of false	Sort of true	Very true

Turn the page to continue this set of questions. ⇨

8.	I enjoy talking with my Big Friend.	Very false	Sort of false	Sort of true	Very true
9.	My Big Friend usually understands what's bothering me without me saying it straight out.	Very false	Sort of false	Sort of true	Very true
10.	I try to follow my Big Friend's advice.	Very false	Sort of false	Sort of true	Very true
11.	I trust my Big Friend.	Very false	Sort of false	Sort of true	Very true
12.	My Big Friend understands me.	Very false	Sort of false	Sort of true	Very true
13.	My Big Friend cares about me, even when I do things s/he does not approve of.	Very false	Sort of false	Sort of true	Very true
14.	I feel comfortable with my Big Friend.	Very false	Sort of false	Sort of true	Very true
15.	My Big Friend usually can tell what I'm feeling.	Very false	Sort of false	Sort of true	Very true

All finished? Well done!
Turn the page for the next set of questions.

What I Am Like

People are all different, and we would like to find out what you are like – what kind of a person you are. There are no right or wrong answers.

On the next few pages, there are sentences describing different types of children. Here is an example:

	Really true for me	**Sort of true for me**				**Sort of true for me**	**Really true for me**
Example	☐	☐	**Some children would rather play outdoors in their spare time**	**BUT**	**Other children would rather watch T.V.**	☑	☐

Instructions

Step 1: For each sentence, decide whether you are more like the child on the left side or more like the one on the right side.

Step 2: Once you have decided which kind of child is most like you, tick a box to show whether that is only *sort of true* for you or *really true* for you.

For each sentence, you ONLY TICK ONE BOX – just like the example above. Sometimes it will be on one side of the page, and other times it will be on the other side of the page. Don't tick both sides - just the ONE BOX most like you.

Turn the page to begin this set of questions. ⇨

	Really true for me	**Sort of true for me**				**Sort of true for me**	**Really true for me**
1	☐	☐	**Some children feel that they are very *good* at their school work**	**BUT**	**Other children *worry* about whether they can do the school work assigned to them**	☐	☐
2	☐	☐	**Some children find it *hard* to make friends**	**BUT**	**Other children find it's pretty *easy* to make friends**	☐	☐
3	☐	☐	**Some children often do not like the way they *behave***	**BUT**	**Other children usually *like* the way they behave**	☐	☐
4	☐	☐	**Some children are often *unhappy* with themselves**	**BUT**	**Other children are pretty *pleased* with themselves**	☐	☐
5	☐	☐	**Some children feel like they are just as *clever* as other children their age**	**BUT**	**Other children aren't so sure and *wonder* if they are clever**	☐	☐
6	☐	☐	**Some children have *a lot* of friends**	**BUT**	**Other children *don't* have a lot of friends**	☐	☐
7	☐	☐	**Some children usually do the *right* thing**	**BUT**	**Other children often *don't* do the right thing**	☐	☐
8	☐	☐	**Some children *don't* like the way they are leading their life**	**BUT**	**Other children *do* like the way they are leading their life**	☐	☐
9	☐	☐	**Some children are pretty *slow* in finishing their school work**	**BUT**	**Other children can do their school work *quickly***	☐	☐

Turn the page to continue this set of questions. ⇨

	Really true for me	Sort of true for me				Sort of true for me	Really true for me
10	☐	☐	Some children would like to have a lot more friends	BUT	Other children have as many friends as they want	☐	☐
11	☐	☐	Some children usually act the way they know they are *supposed* to	BUT	Other children often *don't* act the way they are supposed to	☐	☐
12	☐	☐	Some children are *happy* with themselves as a person	BUT	Other children are often *not* happy with themselves	☐	☐
13	☐	☐	Some children often *forget* what they learn	BUT	Other children can remember things *easily*	☐	☐
14	☐	☐	Some children are always doing things with *a lot* of children	BUT	Other children usually do things by *themselves*	☐	☐
15	☐	☐	Some children usually get in *trouble* because of things they do	BUT	Other children usually don't do things that get them in trouble	☐	☐
16	☐	☐	Some children *like* the kind of person they are	BUT	Other children often wish they were someone else	☐	☐
17	☐	☐	Some children do *very well* at their schoolwork	BUT	Other children *don't* do very well at their schoolwork	☐	☐
18	☐	☐	Some children wish that more people their age liked them	BUT	Other children feel that most people their age *do* like them	☐	☐

Turn the page to continue this set of questions. ⇨

	Really true for me	Sort of true for me				Sort of true for me	Really true for me
19	☐	☐	Some children do things they know they *shouldn't* do	BUT	Other children *hardly ever* do things they know they shouldn't do	☐	☐
20	☐	☐	Some children are very *happy* being the way they are	BUT	Other children wish they were *different*	☐	☐
21	☐	☐	Some children have *trouble* figuring out the answers in school	BUT	Other children almost *always* can figure out the answers	☐	☐
22	☐	☐	Some children are *popular* with others their age	BUT	Other children are *not* very popular	☐	☐
23	☐	☐	Some children behave themselves very well	BUT	Other children often find it hard to behave themselves	☐	☐
24	☐	☐	Some children are *not* very happy with the way they do a lot of things	BUT	Other children think the way they do things is *fine*	☐	☐

All finished? Well done!

Turn the page for the next set of questions. ⇨

Family and School

We would like to know what thoughts you've had about family and school over the last few weeks.

Step 1: READ each sentence, and decide how often you've had the thought in that sentence.

Step 2: CIRCLE the word next to the sentence that tells HOW OFTEN you have had that thought.

Example: If you almost always think life is great, you would circle the words "Almost Always" like this:

EXAMPLE	I think life is great.	Never	Sometimes	Often	[✓ Almost always]

Now circle one answer for each sentence:

1.	I like spending time with my parents.	Never	Sometimes	Often	Almost always
2.	I wish I didn't have to go to school.	Never	Sometimes	Often	Almost always
3.	I enjoy being at home with my family.	Never	Sometimes	Often	Almost always
4.	My family gets along well together.	Never	Sometimes	Often	Almost always
5.	I look forward to going to school.	Never	Sometimes	Often	Almost always
6.	I like being in school.	Never	Sometimes	Often	Almost always
7.	School is interesting.	Never	Sometimes	Often	Almost always
8.	My parents and I do fun things together.	Never	Sometimes	Often	Almost always

All finished? Well done!
Turn the page for the next set of questions.

Strengths and Difficulties

Everyone is good at some things, and not so good at other things. We call these things strengths and difficulties. We would like to find out some of your strengths and difficulties. There are no right or wrong answers.

On the next few pages, there are sentences describing strengths and difficulties that some children have. Here is an example:

		Not True	Somewhat True	Certainly True
EXAMPLE	**I usually try to follow the rules at school.**	☐	☑	☐

INSTRUCTIONS: For each sentence, tick a box to show whether it is NOT TRUE for you, SOMEWHAT TRUE for you, or CERTAINLY TRUE for you.

If you are not absolutely certain, it's OK – just make a good guess, based on how things have been for you over the last few weeks. Remember, there are no right or wrong answers.

		Not True	Somewhat True	Certainly True
1	**I try to be nice to other people. I care about their feelings.**	☐	☐	☐
2	**I am restless. I cannot stay still for long.**	☐	☐	☐
3	**I get a lot of headaches, stomach-aches or sickness.**	☐	☐	☐
4	**I usually share with others (food, games, pens etc.)**	☐	☐	☐

Turn the page to continue this set of questions. ⇨

		Not True	Somewhat True	Certainly True
5	I get very angry and often lose my temper.	☐	☐	☐
6	I am usually on my own. I generally play alone or keep to myself.	☐	☐	☐
7	I usually do as I am told.	☐	☐	☐
8	I worry a lot.	☐	☐	☐
9	I am helpful if someone is hurt, upset, or feeling ill.	☐	☐	☐
10	I am constantly fidgeting or squirming.	☐	☐	☐

Turn the page to continue this set of questions. ⇨

		Not True	Somewhat True	Certainly True
11	I have one good friend or more.	☐	☐	☐
12	I fight a lot. I can make other people do what I want.	☐	☐	☐
13	I am often unhappy, down-hearted, or tearful.	☐	☐	☐
14	Other people my age generally like me.	☐	☐	☐
15	I am easily distracted. I find it difficult to concentrate.	☐	☐	☐
16	I am nervous in new situations. I easily lose confidence.	☐	☐	☐
17	I am kind to younger children.	☐	☐	☐
18	I am often accused of lying or cheating.	☐	☐	☐
19	Other children or young people pick on me or bully me.	☐	☐	☐
20	I often volunteer to help others (parents, teachers, children).	☐	☐	☐
21	I think before I do things.	☐	☐	☐
22	I take things that are not mine from home, school, or elsewhere.	☐	☐	☐

Turn the page to continue this set of questions. ⇨

		Not True	Somewhat True	Certainly True
23	**I get on better with adults than with people my own age.**	☐	☐	☐
24	**I have many fears. I am easily scared.**	☐	☐	☐
25	**I finish the work I'm doing. My attention is good.**	☐	☐	☐

All finished? Well done!
Turn the page for the next set of questions. ⇨

Things I Want to Change

Step 1: Think of the problems that you had when befriending started. They are written on the lines below. You can write new problems, too, if you like. If you have more than four problems, write down the ones that are most important to you.

EXAMPLE: My problem is. . . <u>I'm too shy</u>.

Step 2: Circle a number for each problem to show how big a problem it has been over the last few weeks.

EXAMPLE: My problem is. . . <u>I'm too shy</u>.

1	2	[✓ 3]	4
Not a problem	A bit of a problem	[✓ A moderate problem]	A big problem

1. My problem is. . .____

1	2	3	4
Not a problem	A bit of a problem	A moderate problem	A big problem

2. My problem is. . .____

1	2	3	4
Not a problem	A bit of a problem	A moderate problem	A big problem

3. My problem is. . .____

1	2	3	4
Not a problem	A bit of a problem	A moderate problem	A big problem

4. My problem is. . .____

1	2	3	4
Not a problem	A bit of a problem	A moderate problem	A big problem

All finished? Well done!
Thank you very much for your help.

Parent Questionnaire:

[Name of Organisation] Questionnaires

Parent Version

[Organisation Logo]

Name: ________________________________ Date: ____________

Child's Name: ____

Instructions to caseworker: Discuss with the parent what problems they hope mentoring will help their child with. There can be up to four different problems. It is important that these be worded as *problems* rather than as goals.

Example: "My child is too shy" (rather than "My child needs to be more outgoing").

Things to Change

We would like you to think about what problems your child has that you hope mentoring will help with. Write these problems on the lines below (if there are more than four problems, choose the ones that are most important). Then rate each one by circling one number to show how big a problem it has been over the last few weeks.

EXAMPLE: My child is too shy.

1	2	[✓ 3]	4
Not a problem	A bit of a problem	[✓ A moderate problem]	A big problem

Problem 1: ____

1	2	3	4
Not a problem	A bit of a problem	A moderate problem	A big problem

Problem 2: ____

1	2	3	4
Not a problem	A bit of a problem	A moderate problem	A big problem

Problem 3: ____

1	2	3	4
Not a problem	A bit of a problem	A moderate problem	A big problem

Problem 4: ____

1	2	3	4
Not a problem	A bit of a problem	A moderate problem	A big problem

Turn the page for the next set of questions.

What My Child Is Like

The sentences below describe different types of children. For each sentence, first decide whether your child is more like the description on the left or more like the description on the right. Then decide if this description is "Sort of true" or "Really true". Please put only ONE tick on each line.

	Really true	Sort of true				Sort of true	Really true
Example	☐	☐	**My child would rather play outdoors in their spare time**	**OR**	**My child would rather watch T.V.**	☑	☐

	Really true	Sort of true				Sort of true	Really true
1	☐	☐	**My child is very good at their school work**	**OR**	**My child can't do the school work assigned to them**	☐	☐
2	☐	☐	**My child finds it hard to make friends**	**OR**	**My child finds it pretty easy to make friends**	☐	☐
3	☐	☐	**My child is usually well-behaved**	**OR**	**My child is often not well-behaved**	☐	☐
4	☐	☐	**My child is just as clever as other children their age**	**OR**	**My child isn't as clever as other children their age**	☐	☐
5	☐	☐	**My child has a lot of friends**	**OR**	**My child doesn't have a lot of friends**	☐	☐
6	☐	☐	**My child usually does The right thing**	**OR**	**My child often doesn't do the right thing**	☐	☐
7	☐	☐	**My child is pretty slow in finishing their school work**	**OR**	**My child can do their school work quickly**	☐	☐

Turn the page to continue this set of questions.

	Really true	Sort of true				Sort of true	Really true
8	☐	☐	My child usually acts appropriately	OR	My child would be better if they acted differently	☐	☐
9	☐	☐	My child often forgets what they learn	OR	My child can remember things easily	☐	☐
10	☐	☐	My child is always doing things with a lot of children	OR	My child usually does things by themself	☐	☐
11	☐	☐	My child usually gets in trouble because of things they do	OR	My child usually doesn't do things that get them in trouble	☐	☐
12	☐	☐	My child does very well at their schoolwork	OR	My child doesn't do very well at their schoolwork	☐	☐
13	☐	☐	My child does things they know they shouldn't do	OR	My child hardly ever does things they know they shouldn't do	☐	☐
14	☐	☐	My child has trouble figuring out the answers in school	OR	My child almost always can figure out the answers	☐	☐
15	☐	☐	My child is popular with others their age	OR	My child is not very popular	☐	☐
16	☐	☐	My child behaves themself very well	OR	My child often finds it hard to behave themself	☐	☐

Turn the page for the next set of questions.

Strengths and Difficulties

The sentences below describe strengths and difficulties children can have. For each one, please think about your child and tick the box for "Not True", "Somewhat True", or "Certainly True". It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of your child's behaviour over the last few weeks.

	Not True	Somewhat True	Certainly True
EXAMPLE **Tries to follow the rules at school**	☐	☑	☐

		Not True	Somewhat True	Certainly True
1	**Considerate of other people's feelings**	☐	☐	☐
2	**Restless, overactive, cannot stay still for long**	☐	☐	☐
3	**Often complains of headaches, stomach-aches or sickness**	☐	☐	☐
4	**Shares readily with other children (treats, toys, pencils etc.)**	☐	☐	☐
5	**Often has temper tantrums or hot tempers**	☐	☐	☐
6	**Rather solitary, tends to play alone**	☐	☐	☐
7	**Generally obedient, usually does what adults request**	☐	☐	☐
8	**Many worries, often seems worried**	☐	☐	☐
9	**Helpful if someone is hurt, upset or feeling ill**	☐	☐	☐
10	**Constantly fidgeting or squirming**	☐	☐	☐

Turn the page to continue this set of questions.

		Not True	Somewhat True	Certainly True
11	Has at least one good friend	☐	☐	☐
12	Often fights with other children or bullies them	☐	☐	☐
13	Often unhappy, down-hearted or tearful	☐	☐	☐
14	Generally liked by other children	☐	☐	☐
15	Easily distracted, concentration wanders	☐	☐	☐
16	Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
17	Kind to younger children	☐	☐	☐
18	Often lies or cheats	☐	☐	☐
19	Picked on or bullied by other children	☐	☐	☐
20	Often volunteers to help others (parents, teachers, other children)	☐	☐	☐
21	Thinks things out before acting	☐	☐	☐
22	Steals from home, school or elsewhere	☐	☐	☐
23	Gets on better with adults than with other children	☐	☐	☐
24	Many fears, easily scared	☐	☐	☐
25	Sees tasks through to the end, good attention span	☐	☐	☐

Thank you very much for filling out these questionnaires!

Mentor Questionnaire:

Volunteer Questionnaire: 3-monthly review

We'd like to know how the mentoring match has been going ***during the last three months***. We know that some matches go well, and others not so well, and that things sometimes vary over time. There are no right or wrong answers – we want to hear what it's really like for you.

Section A – Meetings with your match

1. During the last three months, how often have you met with your child/young person?

Twice weekly / Weekly / Fortnightly / Monthly / Other (please state) ....

2. What is the usual length of your visit? (Please state approximate number of hours):

_________ hours

3. What kinds of things have you done together?

____

____

Section B – About your meetings

For each of the following questions, please circle one number. Each question pertains to the last three months.

1. How do you usually spend your time together?

Mostly doing things 1 2 3 4 5 6 7 Mostly talking

2. How easy or difficult is communication with your friend?

Very difficult 1 2 3 4 5 6 7 Very easy

3. How easy or difficult is it to talk about sensitive topics?

Very difficult 1 2 3 4 5 6 7 Very easy

4. Overall, how do you feel the match is going?

Very badly 1 2 3 4 5 6 7 Very well

5. How rewarding has mentoring been for you?

Not at all rewarding 1 2 3 4 5 6 7 Very rewarding

Section C – Your relationship with your friend

Please circle a response, ranging from Very false to Very true, for each of the following questions. Again, these questions pertain to the last three months.

I would feel sad if something bad happened to my young friend.	Very false	Somewhat false	Somewhat true	Very true
I look forward to the time I spend with my friend.	Very false	Somewhat false	Somewhat true	Very true
I nearly always know exactly what my friend means.	Very false	Somewhat false	Somewhat true	Very true
I am happy when good things happen to my friend.	Very false	Somewhat false	Somewhat true	Very true
My relationship with my friend is important to me.	Very false	Somewhat false	Somewhat true	Very true
I can tell what my friend means even when s/he has difficulty in saying it.	Very false	Somewhat false	Somewhat true	Very true
I care about my friend.	Very false	Somewhat false	Somewhat true	Very true
I enjoy talking with my friend.	Very false	Somewhat false	Somewhat true	Very true
I usually understand the whole of what my friend is meaning.	Very false	Somewhat false	Somewhat true	Very true
I care about my friend, even when s/he does things I do not approve of.	Very false	Somewhat false	Somewhat true	Very true
I understand my friend.	Very false	Somewhat false	Somewhat true	Very true
I feel comfortable with my friend.	Very false	Somewhat false	Somewhat true	Very true
I usually sense or realise how my friend is feeling.	Very false	Somewhat false	Somewhat true	Very true

Any comments: Please feel free to write any comments here or on the back of the page (e.g. what has been most/least enjoyable, any difficulties you've encountered).