THE UNIVERSITY *of* EDINBURGH

Edinburgh Research Explorer

Children's Concerns About Parents' and Significant Others' Health and Well-Being

Citation for published version:
Backett-Milburn, K 2005, Children's Concerns About Parents' and Significant Others' Health and Well-Being: ESRC End of Award Report. ESRC.

Link:
Link to publication record in Edinburgh Research Explorer

Document Version:
Publisher final version (usually the publisher pdf)

OPEN ACCESS

End of Award Report

Children's concerns about parents' and significant others' health and well-being

Background

ChildLine Scotland is the free, confidential, telephone counselling service for children and young people with any problem, however its data-base has been little researched. This project arose through collaboration between the Centre for Research on Families and Relationships (CRFR) and ChildLine Scotland (CLS) to explore this unique data base (CIDS). Children's concerns about the health and well being of others and the effect of these on their own lives form a significant minority of calls to CLS. However, qualitative studies with older children find that they say little about the health and illness experiences, behaviours or problems of their families and friends (Shucksmith and Hendry 1998, Borland et al 1998), even though surveys of young people suggest that they have adequate knowledge about health damaging behaviours and their own health maintenance (West and Sweeting 2002). Whether because of reticence, communication difficulties in families, lack of knowledge or interest, or researcher -child power relations, children's views on health issues affecting those close to them have proved difficult to elicit. There are, however, many interconnections between the health of significant others in children's lives and their own well-being, even though young peoples' concerns about their own health issues may not always coincide with those of adults. (Morrow 2000, Shucksmith and Spratt 2002). Both children and adults identify 'good parenting' as a key influence on children's health and well-being; and the effects of peers on young people's health relevant behaviours is a strong focus for researchers and lay people (Scott et al 2000, Backett-Milburn et al 2001). Against this background of communication challenges for researchers and parents, calls to CLS represent unsolicited communications from children and young people which, although in some cases reflecting current societal concerns and discourses, are unmediated by research methods and researcher interaction.

ChildLine Scotland's database

Every day 725 children and young people telephone CLS; approximately 400 get through to Counsellors, around 100 receiving counselling. Most calls are from children aged 11-15 years. This study focused on health relevant calls pertinent to children and young people's significant relationships. CLS considers that calls are representative of children's genuine concerns and their strategies for tackling these problems. Calls therefore reflect children's own agendas, supporting an approach which treats children and young people as competent reporters on their own lives. Children's calls may also contain information and levels of distress such that, in

fieldwork settings, researchers may have decided that, ethically, it was inappropriate to continue the interview (Alderson 1995).

Objectives

The overall aim of the study was to explore the concerns children themselves identify in relation to the health and well-being of parents and significant others. The **objectives** were:

a) to analyse the range and content of 11-15 year olds calls to ChildLine Scotland concerning the above concerns;

b) to examine in depth the reports of 11-15 year olds regarding these concerns and their impact on their lives;

c) to maximise insight into children's self-identified concerns about the health and well-being of parents and significant others by fully utilising Childline Scotland's unique database;

d) to ensure effective dissemination of findings into policy and practice through an integrated and targeted dissemination plan.

In meeting these objectives we worked closely as a research team to identify and attend to the practical and conceptual issues that emerged in conducting detailed academic research on this database for the first time. Excellent working relationships were maintained; these were essential, particularly for the Research Fellow who had to negotiate her position in the CLS office simultaneously with accessing and working with the database. Ethnographic observation was also carried out whilst the RF was based in the CLS counselling room, including participation in training and debriefing sessions, to enable reflexive attention to be paid to the nature of the data being constructed by CLS staff and Counsellors (see Methods). We carried out extensive dissemination to practitioners, policy makers and children through a series of targeted events and activities and accessible briefings (see Activities). A formal launch of the findings took place in May 2005. Details of dissemination and associated materials are annexed. All objectives have been met. Only one practical problem was encountered: the RF was appointed on an 80% FTE basis, as agreed with funders; consequently, the dissemination phase occurred after the planned twelve month contractual period necessitating an extension to contract.

Methods

The study had three main overlapping phases: piloting, setting up and conducting the study; analysis and coding; and dissemination. The applicants predetermined which of the existing categories in the CLS database (CIDS) would be likely to yield the required research information (table1, annex). These reflected a broad, socially based, definition of health and health concerns. Analysis was further restricted to records of calls in the 11 to 15 age range, reflecting the majority of calls placed to CLS. Four years of quantitative and qualitative data on parents' and significant others' problems, coded under predetermined categories, were extracted from CLS's database for further analysis, anonymisation and coding into QSR N6. Basic quantitative analysis was conducted on this entire dataset (N=9363 records) and in-

depth qualitative analysis was carried out on a 12 month cross-section of records (N=2386). The supporting statistical tables are presented in the annex.

Piloting, setting up and conducting the study

Sampling decisions and observations on the CIDS database

In the piloting exercise, two separate months for each of the four years leading up to March 2003 (N=8months) were examined. Detailed readings were made of 25% of each month's typed up records. Based on this, in the main sample we extracted 4 years (as above) of quantitative data, including simultaneous extraction of the qualitative narratives written by Counsellors. We also transcribed one month (July 2000, N=235) of archived written records, which are the original Counsellor notes of calls containing the richest, least filtered data. These materials gave insight into how much editing went into the narratives entered into the database.

Decisions about qualitative sampling were also based on the RF's ethnographic observations. Counsellors take written notes of the narrative during the call (including verbatim extracts, written down during or after the call) and then complete case record sheets directly after the call or at the end of their shift. Coding by Counsellors is therefore a retrospective process and subject to problems associated with recall. It was also evident that Counsellor coding, particularly of the narrative content, is, inevitably, a subjective process; discussions regularly take place between Counsellors and their Supervisors (always present in the counselling room) about the nature of calls and their appropriate coding. This is particularly applicable to 'main problem' coding where callers had discussed multiple issues. However, from the RF's observations, ChildLine's strict coding schedule seems to minimise subjective inaccuracy.

Further distance from the original interactions occurs through the Data Transferral Process. Here, the **narrative** content of case records written down by Counsellors is manually edited by administrative staff for entry into the CIDS database, a closely monitored process to ensure standardisation. The content entered is an abridged version of the original narrative the Counsellor wrote on the case record sheet; editing is usually minimal, not necessarily changing the narrative's meaning. However, different editing processes are applied to different types of caller records, sometimes removing the description of the outcome of the call and / or an evaluation of the call; the strategies that children have discussed; and the Counsellors' reflexive assessments of the call.

Although adequate for CLS's own monitoring purposes, aspects of the social construction of the CIDS database shape the data available for research. For instance, although recording information is always subservient to the demands of talking to the child, Counsellors are trained to elicit enough background information on callers to facilitate understanding of children's potential available support. These two requirements sometimes stand in tension and variations were observed in the extent to which Counsellors opened their interactions by trying to gather such information; more experienced Counsellors appeared better able to interweave such activity into the ensuing conversation. Although some demographic data (eg age and gender) are gathered for the majority of callers, other data are less uniform, such as family circumstances, SES and geographical location. Counselling practices are based on a person-centred approach but a relatively structured format is followed for most calls, adapted to the needs of individual callers. Supervisors are always present and may prompt and instruct Counsellors on live calls, particularly when difficult callers require close boundaries, concerning what they should say to the caller and

questions to ask. Further supervisory control was facilitated by the spatial configuration of the counselling room. Supervisors sit at a central station and Counsellor turrets are constructed in a circular formation, enabling complete visual access to one another. Some Counsellors saw the Supervisors' interventions as supportive, others sometimes experienced these as over-intense scrutiny.

Settling in and finding a place within ChildLine Scotland: conducting research within a voluntary organisation.

The research necessitated 8 months fieldwork within the CLS offices. Although the RF found CLS a very accessible, cooperative and surprisingly happy workplace, part of this study involved negotiating an existing culture, working within its constraints to set up research infrastructure, and establishing an identity within a busy environment of staff and volunteer Counsellors. The time taken to successfully establish the research in a busy work setting should not be underestimated. It is not just a matter of going in and accessing a database on a computer and we were fortunate in having a socially skilled RF, as well as a responsive co-applicant organisation.

Practical problems included the time taken to negotiate the purchase of a dedicated computer with ChildLine's London HQ, difficulties of an overburdened system that often crashed and required maintenance and installation of a new telephone system in the CLS offices. This meant that, for several months, the RF used a communal computer, trying to ensure this did not disrupt or alienate the regular workers but worrying that project files might be inadvertently deleted. Although the RF had security clearance and had signed ChildLine's confidentiality agreement, issues around making hard copies of records, printing from the computer at CLS and transferring data onto N6 continued to require negotiation within an organisation for whom security was, appropriately, a paramount concern. Ethical issues around confidentiality and security of data (the data in N6 were, in effect, doubly anonymised and password protected) needed to be regularly revisited. Further delays occurred because ChildLine HQ had problems with N6software, not licensed to CLS, being installed on a networked computer system. CLS Director and staff always attempted speedily to remedy problems but wider structures and systems seemed more intractable and anticipated fieldwork time was sometimes lost.

Doing the 'fitting in' work was also a challenge for the study. The RF decided to adopt a somewhat detached role, keeping interactions with the staff and volunteers to a friendly minimum. However, this strategy resulted in some personnel being suspicious of her presence and role. CLS discussed the research at a team meeting, put a note about it in the volunteer briefing book and sent an email and information leaflet to all staff. Nevertheless, the RF gradually became aware that some personnel were still unaware of the research. Despite CLS's best efforts, rumours circulated that the RF was a student, a computer consultant, a data input volunteer, from ChildLine HQ, and, perhaps worse, that she was monitoring the competence of counselling staff or the accuracy of their recording caller information. Although no hostility was experienced, finding out about these rumours helped to explain some of the stranger interactions and resulted in the RF giving a talk about the research at another team meeting.

Although emotional issues in doing research are increasingly acknowledged there has been little literature concerning the emotional impact of working with database records. Debriefing sessions, to work through problems or emotions arising from observation of children's 'live calls', were given by CLS to the RF as a matter of policy. However, this back-up support was not readily available when the RF was in researcher mode and occasionally the distressing nature of some of the material

impacted upon her. Although the RF had a background that the team felt prepared her for this work, she often found that the written word had a more profound effect that the spoken; emotions also experienced by CLS staff and the research team when they too read selections of the extracts.

Data Analysis and Coding

The analysis of the CIDS database was both qualitative and quantitative. In the first instance, the RF accessed and read samples of the records, as described above. This analysis was shared and discussed at full team meetings, approximately monthly.   More detailed work, reading and discussing selections of these data in order to agree the coding frame and key emergent themes, was carried out at several analytical team meetings, which involved the academic team and the policy officer from CLS, who herself had a research background.

Initially, the data were recorded using the codes assigned by the CLS system. These quantitative data were then analysed using the analytical and reporting functions in N6 for descriptive statistics, for example, cross tabulations for base data and the identification of patterns in qualitative data. These basic descriptive statistics (see Annex) helped to provide the framework for further in depth qualitative analysis.

More detailed qualitative analysis was conducted on the sub-sample of records (described above) to illuminate key emergent themes emerging from the coding and analysis. The narrative summaries in the CIDS records and archived notes varied from a paragraph to several pages. They contained information about people and events in the children's lives, some recollected quotations, and, occasionally, some Counsellor assessment.

The range of information was often rich, covering:
- children's talk and own analysis of often multi-layered concerns;
- their practical and emotional impacts;
- effects on children's everyday lives, for example on friendships or school experience;
- relationships and contexts in which the concern was embedded;
- communications around the concern, whether rows or support
- children's own strategies for getting by and what they might like to see happen.

Initially we worked with the CLS coding system which was not constructed with academic analysis in mind. However, these codes provided a useful starting point for theory testing and development and for establishing core patterns and hypothesised links within the data. We remained aware that using this coding system produced an unreflexively structured data set and that computer assisted data analysis packages only support the researcher's role and cannot replace the researcher's own intellectual and interpretive processes. Therefore, for the final in depth analysis, further anonymisation and coding of data using N6 were informed by manual analysis of the raw data (comprising the narratives / qualitative data) by the research fellow. This was supported by regular analytical meetings of the research team to discuss emergent themes; the PI and the CLS policy officer also made analytical readings of selected raw data to ensure reliability. These processes of manual analysis were integral to later on-screen thematic coding. Continuing iterative analysis was then carried out on these coded segments in order to unpack and further refine

understandings of the range of concerns expressed by callers and consolidate the emergent themes. Preliminary findings were presented to a purposively selected group of researchers and policy makers at the Scottish Executive, to incorporate their comments into the final analysis and recommendations.

Findings

Selected statistical data, illustrating the analysis carried out to meet objective (a), are presented in a series of tables in the Annex, these
- form the background for the qualitative analysis;
- describe frequencies of types of call (main and subsidiary reasons);
- provide breakdowns regarding parents' or significant others' health issues;
- provide cross tabulations against a range of relevant variables, such as age and gender.

Where appropriate, some of the tables will be referred to in the next section where we present the richer qualitative material

The nature and complexity of children's concerns about parents' health and well-being

Concerns about the health and well-being of parents, and related issues, were present across all of the predetermined categories selected for analysis, except for the categories of solvent abuse and eating problem (table 3, Annex). The vast majority of concerns were about alcohol misuse or drug misuse (or both) and almost exclusively focussed on children's worries about how these impacted on their own lives and well-being.   The more open ended category of 'health' and third party calls (where children called about the problems of other people), both contained much smaller numbers of expressed concerns about a wide range of traditional and non-traditional parental health and well-being problems. However, such calls tended to be about serious and often life threatening illness, such as cancer and heart complaints. Lack of information had, for many, led to confusion and anxiety about death; some children had not been 'officially' informed of their parents' illness but had overheard others talking about it. These calls were characterised by a search for reassurance or information.

Children's calls were seldom about a single issue; they detailed multiple issues and problems in their lives. Importantly, children phoned primarily because of the impact of these issues on themselves; concern about their parents was unlikely to be the main reason for calling CLS. Parental health and well-being problems formed part of a complicated web of issues being experienced by the child. This insight provides one explanation of previous difficulties in accessing these issues, as past research often asked directly about parents or family members, rather than the child's experiences of these issues. Equally, the overwhelming complexity could itself be

the trigger for these calls, in much the same way that patients often save up several health problems when going to the doctor.

Concerns about alcohol misuse, drug misuse, domestic violence, family relationship problems, depression and mental health problems and bereavement frequently featured concurrently in a call, in multiple combinations (either two or more). Alcohol misuse was the most common concern to appear in combination with others, suggesting some interaction between this and other health and well-being concerns. For example, 34% of all calls analysed in which concerns were expressed about parental drug misuse also cited alcohol misuse as a problem (table 15, Annex).

Children's narratives also showed a detailed understanding and need to make sense of the circumstances they perceived had led to the onset of their parent's health and well-being problems. Children in the 11-15 age group lucidly articulated complex understandings of their parents' lives and the place of parental health and well-being issues within these. Many spoke of how a parent's emotional difficulties triggered the onset of negative health behaviours. A recurrent theme was parental alcohol misuse following bereavement (of spouse, close family member, relative or significant other) or separation or divorce. Children often related their parent's depression to both the emotional impact of such life events and the onset of alcohol misuse; occasionally discussing how problems with one parent's health and well-being could trigger the onset of stress and/or depression in the other parent. There were some gender differences in children's accounts of what triggered negative parental health behaviours. Although commonly reported as a trigger for domestic violence, some children identified parental alcohol misuse as resulting *from* their parent's status as a victim of domestic violence, but this was only ever the case for mothers. Unemployment, redundancy, financial pressures and work related stress were given by some children as reasons triggering either depression, alcohol misuse or both amongst fathers, rarely as triggers for mothers.

Impact on children's lives

Physical abuse was the primary negative outcome of parental health and well-being problems throughout and across all the health and well-being concerns analysed (30% of all main reasons coded for calling, 12.4% of additional reasons). 46% of children who reported domestic violence to a parent said they were themselves also experienced such violence, echoing other research. Compassion for parents' problems often sat alongside children's obvious anger at the violence they experienced. A minority of callers, usually the younger ones, stated that they were 'hit for nothing', tending to seek explanation for the physical abuse within their own behaviour.

Table 9 (Annex) shows that the level of physical abuse varied across the different categories of health and well-being concerns and high levels clustering within categories that are perhaps not considered to represent 'traditional' health / well-being issues. Physical abuse was concurrently reported by children in 40% of all calls about parental alcohol misuse. However, although still high, levels were slightly lower for bereavement, drug misuse, family relationship problems and depression and mental health, ranging from between 23% to 35%. Whilst it is not possible to state that there is direct link between parental health and well-being problems and the physical abuse of children, these figures suggest a relationship. Children commonly stating that the violence began when the parent began misusing alcohol or happened when the parent had consumed alcohol. Children's descriptions suggested that physical abuse was often extremely violent and, for many, frequent.

The narratives contained accounts of their injuries and the implements parents used; the use of belts, baseball bats, golf clubs, knives by parents was not uncommon. Mothers were reported as being almost as likely (32% of cases) as fathers (40%) to be responsible for the physical abuse. Children also sometimes talked about how the non-abusive parent did little or nothing to intervene in the abusive parent's behaviour. 18% of calls which expressed concerns about parental health and well-being also contained children's accounts of sexual abuse, predominantly by fathers. This was often related by children to the death of the child's mother or the father's separation or divorce, coinciding with alcohol misuse. Nevertheless, some children's narratives showed that they sought out and recognised the 'good' in their parents, for example, accounts of 'good times' or 'past times' before the physical abuse began. Others, however, expressed feelings of hate, rage and violence towards their parents.

A range of wider impacts were described, for example effects at school when children hid the signs of abuse or truanted or were bullied because they were poorly clothed, smelly or dirty. Neglect of basic needs, such as adequate food and clothing, was occasionally reported as reasons for children stealing from shops or getting part time jobs to buy for food for themselves or younger siblings. Some reported taking on adult caring responsibilities for siblings as well as parents. However, some explicitly said they called ChildLine not to add to their parents' existing problems by burdening them with their worries.

Concerns about friends

In comparison to parents, there were fewer calls about the health of friends. Children expressed worries that behaviours such as smoking or drinking might lead to other forms of substance misuse or serious future health complications, such as cancer; and about peer pressures to engage in negative health behaviours. Girls, in particular, discussed eating problems (bulimia and anorexia nervosa) of friends, giving special emphasis to the distorted views of bodily image that their friends held. Discussions of the eating problems of female friends were often contextualised in the multiple personal problems friends were experiencing within the home (e.g. family relationships, physical abuse, parental divorce etc.).

Getting by

Children described a range of strategies for getting by in difficult circumstances. Friends emerged as a key source of informal support for children in difficult circumstances, particularly where physical abuse was an issue. 20% of children had talked to friends about their problems; friends sometimes offered refuge and protection where there was a risk of physical harm. Sometimes, though, callers reported losing or withdrawing from friendships for fear of them finding out about what was happening at home. Other strategies included trying to take care of themselves and others (working to buy food, stealing food, taking care of siblings or adults, doing household chores etc.) and staying away from home, either by walking the streets, staying with friends or relatives, or sleeping rough. Some children thought about getting out, either through running away or fantasising about being taken into

care. Some children did run away or went into care as a way of getting out of family problems.

Support from adults and statutory services

Informal support was often sought from parents themselves but very few children reported seeking help from statutory services, or that they disclosed their problems to other authority figures such as teachers.   The records suggested that sometimes adult interference had made matters worse. Children also emphasised that they were sometimes not listened to or taken seriously. Callers were also afraid of disclosing to other adults because of possible repercussions within the home; their being taken into care; losing autonomy over their lives; confidences being breached. Although the data base does not have uniform data for all callers it seemed that about 14% of children had told no-one about their problems.

References
Alderson, P (1995) *Listening to Children: Children, Ethics and Social Research.* Barnados: Barkingside.
Backett-Milburn K, Cunningham-Burley S, Davis J (2003) Contrasting lives, contrasting views? Understandings of health inequalities from children in differing social circumstances. *Social Science and Medicine*, 57, 4,613-623.
Borland, M. Laybourn, Hill, M. and Brown, J. (1998) *Middle Childhood: The Perspectives of Children and Parents.* Jessica Kingsley: London.
Nutley et al (2003) *Models of research impact: a cross-sector review of literature and practice.* Learning and Skills Research Centre, London.
Scott, S. Jackson, S. Backett-Milburn, K. (2000). The impact of risk and risk anxiety on the everyday worlds of children. *ESRC Children 5-16 Programme, final report*. ESRC: Swindon.
Shucksmith J and Hendry LB (1998*) Health Issues and Adolescence: Growing Up and Speaking Out.* Routledge: London.
Shucksmith J and Spratt J (2002) Young people's self identified health needs. *Report prepared for Young People and Health Initiative. Health Education Board for Scotland, www.hebs.com/research/cr/*
West P and Sweeting H (2002) The health of young people in Scotland: Quantitative dimensions. *Report prepared for Young People and Health Initiative. Health Education Board for Scotland. www.hebs.com/research/cr/*

Activities

Dissemination

Objective d) was 'to ensure effective dissemination of findings into policy and practice through an integrated and targeted dissemination plan'. As a collaborative research project it was also important to CLS that one outcome would be to influence policy and practice for children and young people, this being part of the justification for allowing researcher access. CRFR has a dedicated research liaison team with expertise in disseminating and making research accessible. We used a combination of targeted messages and face to face discussion with practitioners and policy

makers; this having been evaluated as a key way of communicating research findings (Nutley et al, 2003).

Involving children, policy makers, practitioners and decision makers

To reflect children's voices we collaborated with the Children's Parliament. Groups of school children of similar ages to those in the research were asked to consider some aspects of the findings. The groups were facilitated by a youth worker and recorded in a variety of ways by the children themselves and two other workers. The comments (also incorporated into dissemination materials, see annex) very much reflected the concerns of the children who called ChildLine, with additional information children's views of adult helpers.

To draw out policy and practice implications, we conducted an informal feedback session at the Scottish Executive and then an informal seminar was held with interested practitioners to discuss the research. Practitioners' insights regarding research implications are valuable and the seminar included an excellent level of discussion and useful development of issues, particularly in child protection and supporting parents (see dissemination materials). However, the research team was mindful of being influenced by practitioners' own agendas, consequently, the final list of recommendations included only those with a direct link to the research findings.

Key decision makers from all sectors, along with MSPs, were invited to the launch at which the Children's Commissioner for Scotland responded to the research findings; non-attendees were sent the dissemination materials. Invitees included all Directors of Social Work and Education from each Scottish local authority and Chief Executives of all of the Health Boards, with an invitation to send a representative. We were disappointed with the lack of attendance from Social Work Directors at this event and social workers at the practitioners event, so special effort was made to highlight the child protection implications of the research and draw these to the attention of social work departments in each local authority in Scotland. This resulted in several requests for further information.

Making research accessible: all publications from the research are available on www.crfr.ac.uk, hard copies available from CRFR. Attention was drawn to the findings by information bulletins and via the press.

Press Work
A press strategy was planned in conjunction with the University of Edinburgh and ChildLine Scotland's Press Offices; coverage was considerable. Most stories concerned the abuse and neglect that children were suffering. Anne Houston, Director of CLS, featured on STV news and was interviewed by Real Radio; SAGA FM; Wave FM and Forth FM. The RF was interviewed by Beat 106; Clyde FM and Kingdom FM; Professor Kathryn Milburn participated in a live discussion on Radio Scotland's Gary Robertson Show. The story also featured in The Sunday Herald, The Scotsman; Metro; Children Now and online at BBC Scotland; Third Force News (on-line version) and Inside Scotland.

Outputs

Several presentations have been given; dissemination materials developed (see annex); we are presently working on an overview paper and a methodological paper for academic journals (see Report Form).

- 'Children's concerns about the health and well-being of their significant others: key findings', Scottish Executive, Edinburgh, 31/01/2005.
- 'But what about me? Exploring children's concerns about the health and well-being of their significant others': policy and practitioner conference, Glasgow Caledonian University, 8/03/2005.
- 'Children's concerns about the health and well-being of their parents' and significant others', ChildLine Scotland, Glasgow, 16/03/2005.
- 'But what about me? Exploring children's concerns about the health and well-being of their parents' and significant others', Research Launch Conference, Edinburgh City Chambers, 16/05/ 2005.
- 'But what about me? Children's concerns about the health and well-being of their significant others', CRFR seminar series, University of Edinburgh, 31/05 2005

Impacts

These are described in full in the activities section. We have targeted and reached a wide range of policy/practitioner and lay audiences (see annex); academic papers are in preparation

Future research priorities

Funding has been obtained for further work on the CLS database:
Backett- Milburn, Ogilvie–Whyte, Houston, Wales. Children and young people's concerns about their sexual health and well being. Scottish Executive, £45,227 (2005-2006).

This report has highlighted the need to explore further the emotional impacts on researcher of working with sensitive materials/data. Greater research attention is needed to the *resilience processes* involved in children 'getting by' in difficult family circumstances. In this, it is important to investigate and value the positive role of children's friendships, which have been shown to be crucial for these callers to ChildLine. Given increasing research partnerships, the challenges and practicalities of working with, for example, a voluntary organisation need to be reflexively addressed.