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Irish Families Under Stress

**Service Evaluation
and Audit of a
Child and Family Centre**

Volume Five

Editor: Michael Fitzgerald

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IRISH FAMILIES UNDER STRESS

**SERVICE EVALUATION AND AUDIT OF A
CHILD AND FAMILY CENTRE**

VOLUME FIVE

EDITOR:

MICHAEL FITZGERALD

**EASTERN HEALTH BOARD
1996**

Contents

Page No.

Acknowledgements		i
Preface	Dr. D. Walsh	ii
Service evaluation and audit of Child and Family Centre		
Moukaddem S., Fitzgerald M., Barry M.		iii
 Chapter 1	 Issues on service evaluation	 1
	Outcome research	1
	Identifying factors that are related to effectiveness of service	4
	Attrition	4
	Attitudes and expectations	6
	Consumer satisfaction	8
	Linking research with practice	9
 Chapter 2	 Aims and plan of the study	 11
	Plan of the study and choice of instruments	13
	Areas to explore and plan of analysis	15
 Chapter 3	 Method	 17
	Sample	17
	Setting	18
	Procedure	18
	Questionnaire design and content	19
	Scales and instruments used in the study	19
	Child Behaviour Checklist	19
	General Health Questionnaire	21
	Quality of Life	22
	First Interview Questionnaire	23
	Health Visitor Questionnaire	23
 Chapter 4	 Results	 24
	First Interview Questionnaire	24
	Satisfaction with the service	27
	Child Behaviour Checklist	31
	General Health Questionnaire	37
	Quality of Life Questionnaire	44
	Studying the relation between children's behaviour problems and their mothers' mental health	48
	Studying the relation between children's behaviour problems and their quality of life	52
	Studying the relation between the mothers' mental health and their quality of life	56
	Correlations with satisfaction with the service	61
	Comparing attending and discharged groups	63

Chapter 5 Discussion		66
Treatment outcome		66
Mothers' mental health and quality of life		67
The relationship between the children's behaviour problems and their mothers' mental health		68
The relationship between the children's behaviour problems and their mothers' quality of life		69
Satisfaction with the service		70
Issues related to attrition		72
Clients' preparation for treatment		73
Methodology and measurement issues		74
Overall effectiveness of the clinic		78
Implications of findings for service delivery		79
Suggestions for future research		80
References		82
Appendix (Description of sample)		92
Adapted version of Lehman's Quality of Life Questionnaire		94
Audit of a Child and Family Centre		97
Irish Families Under Stress - Summary (1981 - 1996)		115
Tables and Figures		
Table 3.1	Attendance outcome	17
Figure 3.1	Patterns of referrals	19
Table 4.1	Satisfaction with the service (Health Visitor Questionnaire)	29
Figure 4.1	Classification on the CBC for the pre-treatment and post-treatment sets	32
Figure 4.2	Change of classification on the CBC from the pre-treatment set to the post-treatment	433
Table 4.2	Improvement rates from the pre-treatment set to the post-treatment set.	33
Figure 4.3	Distribution of t scores on the total behaviour problem scale for the pre-treatment and post treatment set	35
Table 4.3	Means, standard deviations and t-tests on the scales of the Child Behavior Checklist	36

Tables and Figures

Figure 4.4	GHQ classification for the pre-treatment and post-treatment sets	39
Figure 4.5	Change of classification on the GHQ from the pre-treatment set to the post-treatment set	40
Table 4.4	Means and standard deviations with t-tests for the pre-treatment and post-treatment GHQ scales	40
Table 4.5	Repeated measure ANOVA for the clinical and non-clinical categories on the GHQ	41
Figure 4.6	Changes on the GHQ scales from the pre-treatment set to the post-treatment set	42
Table 4.6	Mothers' responses on the QoL Global well-being measures and the subjective measures at pre-treatment	44
Table 4.7	Means and standard deviations for Quality of Life pre-treatment and post-treatment measures with t-tests results	45
Figure 4.7	Subjective Quality of Life measures for the pre- and post-treatment sets	46
Figure 4.8	Objective Quality of Life measures for the pre- and post-treatment sets	46
Table 4.8	Internal reliability of QoL indices	47
Table 4.9	Unpaired t-tests for the mothers whose children are 'clinical' (on the CBC) and mothers whose children are 'non-clinical'	50
Table 4.10	Unpaired t-tests for children whose mothers are 'clinical' (on the GHQ) and children whose mothers are 'non-clinical'	51
Table 4.11	Grouping the QoL results according to the childrens' classification on the CBC; means standard deviations and unpaired t-tests at pre-treatment	53
Table 4.12	Grouping the Quality of Life results according to the childrens' classification on the CBC; means standard deviations and unpaired t-tests at post-treatment	54
Table 4.13	Correlating the Total Behaviour Problem scale of the CBC (t scores) with the QoL measures	55
Table 4.14	Correlating the total score of the GHQ with the QoL measures	58

Tables and Figures

Table 4.15	Classifying Quality of Life results according to GHQ classification; t-tests for pre-treatment results	59
Table 4.16	Classifying Quality of Life results according to GHQ classification; t-tests for post-treatment results	60
Table 4.17	Factorial analysis on classification changes on the GHQ and Satisfaction with the Service Questionnaire	62
Table 4.18	Repeated measure ANOVA on Global well-being measure B of the QoL	65

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Preface

Dermot Walsh, Eastern Health Board / Health Research Board.

It is a pleasure to introduce Volume Five of *Irish Families Under Stress* by Dr. Michael Fitzgerald and his colleagues. Dr. Fitzgerald has been assiduous in carrying out and promoting research into his clinical clientele and their families in his work as Child Psychiatrist in the Dublin area. Dr. Fitzgerald has a very wide background of training and experience in child and family psychiatry and this is very evident in both his clinical and research work. Almost uniquely for a psychiatrist and researcher his interests, and their clinical applications, cover a great degree of territory from analytic and dynamic psychiatry to the biological and epidemiological. It is rare, in these days of specialisation, to meet such eclecticism and it is heartening to see such diverse orientations to research.

In *Families Under Stress* we are invited to enter the world of predominantly working class Dublin as seen from the perspective of children, their parents and their problems. In previous volumes Dr. Fitzgerald and his assistant colleagues have ranged widely through the panorama of social deprivation, its resultant symptomatology and consequences. It is of particular significance, I think, that Dr. Fitzgerald has imbued in all staff, and particularly those psychiatric trainees who have the good fortune to work with him, a sense of enquiry and intellectual curiosity as to causation in the social as well as physical sense. The overt manifestation of this curiosity is that virtually every trainee who has had a placement with him has been encouraged (and usually completed) some specific research project. This is what teaching (and training) is all about.

This fifth volume consists of a single piece of work concerned with the evaluation and audit of the Child and Family Centre in which Dr. Fitzgerald and his team operate. Specifically the work ranges widely from examination of the clientele on a variety of measures, the interrelationships between child symptomatology and maternal mental health and quality of life. Treatment outcome is evaluated and the factors relevant to that outcome are explored in depth. Finally the hard realities of the cost of its provision are set out in an audit section. This is a most valuable work as it is the first time that this exercise has been undertaken in child psychiatry in this country and gives some indication of what has to be faced when we provide adequate child services covering the whole of the nation.

Dr. Fitzgerald and his colleagues are to be commended for this most useful piece of work which is a model of what can and should be done in like services both in adult and child psychiatry throughout the country. This linking research with practice is so necessary in providing an increasingly complex network of psychiatry to ensure that in the long run we get value for money. Dr. Fitzgerald has pioneered research in child psychiatry in this country, not least in an area of the greatest importance and that is monitoring, evaluating and auditing what we provide and how the consumer perceives that provision.

Service evaluation and audit of a Child and Family Centre **Moukaddem S., Fitzgerald M., Barry M.**

Introduction

Research on child development and adjustment is a well-established field of enquiry within psychology. Yet only recently has the study of abnormal development in children benefited from the use of valid and reliable research methods (e.g. large sample sizes, control groups, blind experiments). Scientific rigour in all areas of clinical research is of vital importance given the increases in the audit and rationing of clinical services. The rationing of services is usually done on a cost-effectiveness basis. However, there is as yet little consensus on what constitutes effectiveness in a clinical service. There is danger of decisions being made in an unscientific manner (e.g. on the basis of opinion) rather than on the basis of valid and reliable research.

This study is concerned with evaluating the effectiveness of the clinical service provided by a Child and Family Centre in the urban Dublin area. Specifically, it evaluates the impact of services on both children receiving treatment at the centre, and their mothers. Effectiveness is measured along a number of dimensions. These include the adjustment of children themselves, and the mental health and life quality of their mothers. The attitudes of the mothers, and satisfaction towards the clinic's services are also examined.

The main objective of the study was to go beyond the traditional narrow indices of service effectiveness (e.g. attrition rates) to provide a comprehensive examination of the clinic services.

"When a unit does not know what it is doing, it cannot know whether it is doing it well" (McKee, 1989, p. 474).

Chapter One

Issues Regarding Service Evaluation

The main aim of this study is to evaluate the service provided by a child and family centre. This chapter identifies issues that are central to the design of a study with this aim. This is done by examining issues raised by previous research in the area of service evaluation. This chapter begins by discussing the two common approaches to service evaluation: experimental research and clinic based research. The inherent problems of each are discussed in an attempt to illustrate which have more practical relevance to the aims of this study. This is followed by identifying issues that affect the efficiency of service delivery, such as attrition and clients' attitudes and expectations. The last section discusses the relation between service evaluation and customer satisfaction.

Outcome Research:

Research on the effectiveness of psychotherapy in children and adolescents range from controlled experimental studies to studies of clinic-based and community-based interventions. Both areas have been subject to valid criticisms.

The main criticism made about controlled experimental studies is that the experimental conditions are different from the real life clinical settings. In investigating the effectiveness of treatment in children and adolescents, Weisz and Weiss (1993) reviewed over 250 controlled experimental studies ($N > 13,000$). In their review Weisz and Weiss noted that "most of these studies appear to have involved children, interventions, and/or treatment conditions that may not be very representative of conventional clinical practice" (p. 70). The authors identified several critical factors associated with these controlled studies; 1) children who were not referred for treatment have been selected for treatment; 2) the homogeneity of samples was based on one or two focal problems (on which treatment focused on) that are quite different from the broad range of problems that are seen and treated in clinics; 3) only one or two therapeutic techniques were used by the therapists who had recent training in the techniques, which is a situation that is quite different from that faced by clinic therapists; and 4) therapy was guided by manuals and/or was closely monitored for treatment integrity, luxuries that are difficult to find in service-oriented clinics. Weisz and Weiss (1993) conclude that "conditions in most child clinics may be different from (and less optimal than) the somewhat artificial conditions typically arranged

for controlled outcome studies" (p. 71). Persons (1991) presented a similar argument regarding psychotherapy in general.

Other differences between conventional clinical practice with children and child therapy outcome research have been noted by Kazdin, Siegel, and Bass (1990). When they surveyed 223 child outcome studies, Kazdin et al. found that therapy research, unlike child clinical practice, tends to (a) focus on children recruited from and treated in schools, (b) employ group interventions rather than individual treatment, (c) use behavioural and cognitive-behavioural methods (rather than the psychodynamic, eclectic, and family-oriented approaches more often favoured in clinics), (d) emphasize brief interventions averaging 8-10 weeks (vs. 27-55 weeks in clinical practice), (e) deemphasize involvement of parents and other family members, and (f) deemphasize consultation with teachers.

So it appears that the procedures and conditions associated with clinic-based therapy for children are rather different from those typically found in outcome research. Thus it is difficult to judge the extent to which the findings of outcome research can be generalised to the clinic-based interventions that are provided to disturbed children in the communities.

One of the main obstacles in outcome assessment with clinic-based and community-based interventions is that legal and ethical constraints prevent clinics from randomly assigning people who apply for treatment to a no-treatment control condition. One of the early approaches that attempted to address this problem was taken by Eysenck (1952) in a study of adult therapy effects. Eysenck's approach involved comparing the rates of improvement of treated groups to the rates of improvement in untreated groups. One of the earliest attempts in applying this approach to effects of treatment on children was carried out by Levitt (1957). Like Eysenck's (1952) article, Levitt's (1957) report stimulated a number of critiques (e.g., Barrett et al., 1978; Eisenberg and Gruenberg, 1961; Halpern, 1968; Heinicke and Goldman, 1960; Hood-Williams, 1960) that generalise to later studies that employed the same approach. Among these criticisms were: 1) a large number of children who formed the no-treatment base rate sample may not have been seriously disturbed as some had been referred initially only for diagnostic services; 2) it may not be accurate to assume that the no-treatment group received no intervention because for some children "the diagnostic process itself constitutes an intense, short-term therapeutic process" (Barrett et al., 1978, p. 412); 3) comparing improvement rates in treated and untreated children from studies conducted in very different years may be problematic because of time-linked shifts in case loads, types of children seen in clinics, therapeutic methods, and so on; and 4) for comparisons to be meaningful, treated and untreated children may need to be matched on such variables as maturational gradients, neuropsychological functioning, and

psychological factors (Halpern, 1968). Weisz and Weiss (1993) pointed to a main flaw in this approach which is that the base rate of improvement for treated and untreated individuals was estimated from different studies and thus different clinic settings, with different admission criteria and different population bases. "Because the comparisons were made across studies (rather than within studies), it was not possible to assess directly the demographic, developmental, or clinical similarity of the treated and untreated groups being compared" (Weisz and Weiss 1993, p.73).

These criticisms highlight the need for more direct and precise comparisons between treated and untreated children in clinic and community settings. One approach that attempted to meet this need was a study by Shepherd et al. (1966), who took 50 clinic children (all treated for the first time) and 50 non-clinic children selected through pairwise matching on age, gender, and behaviour/problem profile; the groups were then compared and shown not to be significantly different on such demographic factors as parents' age, employment of mother, presence of young children in the household, or on clinicians' blind ratings of overall severity of the child's disturbance. The main limitation of this study is that the children in the untreated sample were not actually referred for treatment. Mothers of these children, compared to the clinic mothers, showed significantly less distress over their children's problems and significantly more optimism that the problems were temporary. Moreover, there may have been other, undocumented differences between children and families who sought clinic treatment and those who did not. This study illustrates the importance of a clinic-referred control group.

One approach that addresses the problems associated with the use of non-referred children in control groups and with the use of separate dropout and therapy completer control groups is to compare treated and untreated children admitted to the same treatment facilities in the same period to untreated cases consisting of those who drop out prior to treatment. However, there still remains the important issue of whether dropouts and treatment completers differ from one another in important demographic or clinical variables. Hood-Williams (1960) suggest that treated groups may "represent the more serious, intractable problems, while at least a proportion of the untreated groups are minor or transient problems" (p. 84). Weisz and Weiss (1993) pointed out that "considerable research has failed to generate much evidence of reliable, consistent differences between child therapy completers and dropouts". However, the authors add: "the few differences that have been replicated at all tend to suggest that pretherapy prognosis may actually be slightly worse for children who remain in treatment" (p.75). Undoubtedly, such a trend imbalances the comparison between the two groups. One valid criticism with this approach is that the clinic dropouts do not constitute a true "no treatment" control group because the intake evaluation

they receive may constitute a therapeutic intervention (Barrett et al., 1978; Eisenberg and Gruenberg, 1961). It is also possible that the act of merely acknowledging that there is a problem for which help is needed may stimulate improved functioning and adaptation (Hood-Williams, 1960).

In sum, there are two types of treatment evaluation research; controlled experimental research, and clinic-based research. The main drawback with the experimental studies is that results do not generalise to real life clinic situations in order to be of practical help to practicing professionals. So ideally the researcher should aim for clinic based research since it is of more practical relevance, however, it is often difficult to assign accurate control groups.

Identifying Factors that are Related to Effectiveness of Service:

Attrition

Failure to attend appointments is a common problem across the various psychiatric and health services. In a comprehensive review, Baekland and Lundwall (1975) pointed out that 20-57% of general psychiatric clinics attenders fail to return after their first visit and 31-56% fail to attend more than four times. Cooper and Lynch (1975) found that 25% of paediatric appointments at a London teaching hospital were broken. Reports on attrition rates vary from one study to another. Gould et al. (1985) reported a drop-out rate of 11%, in relation to those who attend an initial interview but fail to attend a later evaluation interview. Novick et al. (1981) calculated an attrition rate of 85.4%, obtained by considering all cases of non-agreed termination of treatment at any stage of the referral/treatment-uptake process. In a study that examined 100 consecutive referrals to a child psychiatric unit, Cottrel et al. (1988) reported 16% failure to attend any appointment, and 40% dropout rate. For child psychiatric services, self-termination rates range from 28 to 59% (Ewalt et al., 1972; Farley et al., 1975; Ross and Lacey, 1961; Singh et al., 1982; Tuckman and Lavell, 1959).

Several factors have been associated with attrition in psychiatry clinics. Factors studied include sex and age of the child (Cohen and Richardson, 1970; Ewalt et al., 1972; Ross and Lacey, 1961; Singh et al 1982; Tuckman and Lavell, 1959; Williams and Pollack, 1964), socioeconomic status of the family as well as other demographic descriptors (Cohen and Richardson, 1970; Ewalt et al., 1972; Fischer, 1975; Gaines, 1978; Lake and Levinger, 1960; Litt, 1970; Ross and Lacey, 1961; Singh et al., 1982; Tukman and Lavell,

1959; Williams and Pollack, 1964), distance from the clinic (Gaines, 1978; Tuckman and Lavell, 1959), length of time on a waiting list (Cole and Magnussen, 1967; Gaines, 1978; Lake and Levinger, 1960; Litt, 1970), referral source (Cohen and Richardson, 1970; Gaines, 1978; Lake and Levinger 1960; Ross and Lacey, 1960; Tuckman and Lavell, 1959), clinical descriptions of the child (Cohen and Richardson, 1970; Cole and Magnussen, 1967; Levitt, 1958; Litt, 1970; Ross and Lacey, 1961; Singh et al, 1982), and parental attitudes toward the child or toward the treatment (Cohen and Richardson, 1970; Cole and Magnussen, 1967; Farley et al., 1975; Levitt, 1958; Singh et al, 1982).

In studying the factors associated with attrition, the cited studies do not provide a clear picture. Where one study does find a predictive factor for increased attrition rates, the next study finds the same factor to be unreliable. For example, while many studies have reported no significant differences between attenders and non-attenders in relation to social class (Cohen and Richardson, 1970; Ewalt et al., 1972; Gaines, 1978; Litt, 1970), others have reported that self-termination is related to lower socioeconomic levels (Fischer, 1975; Lake and Levinger 1960) or to higher socioeconomic levels (Singh et al., 1982). Many investigations have reported a significant relationship between self-termination and referral source (Lake and Levinger, 1960; Ross and Lacey, 1961; Tuckman and Lavell, 1959; Williams and Pollack, 1964), yet, a lack of an association has also been found (Cohen and Richardson, 1970; Gaines, 1978).

Gould et al. (1985) identified several factors that have led to these inconsistencies. One reason is that standardised interviews or questionnaires have rarely been administered (McAdoo and Roeske, 1973). Instead, case record reviews have been used in many of the studies (Cohen and Richardson, 1970; Cole and Magnussen, 1967; Levitt, 1958; Tuckman and Lavell, 1959; Williams and Pollack, 1964). Therefore, the assessment techniques often preclude any analysis on other than the most basic demographic descriptors (Tuckman and Lavell, 1959; Williams and Pollack, 1964). Furthermore, clinical descriptions of the children cannot be compared since different symptoms and diagnostic factors have been evaluated (Cohen and Richardson, 1970; Cole and Magnussen, 1967; Levitt, 1958; Litt, 1970; Ross and Lacey, 1961; Singh et al, 1982). Another point to make, is that the assessment period has varied. Information has been obtained from initial evaluations (Ewalt et al., 1972; Fischer, 1975; Gaines, 1978; Lake and Levinger, 1960; Singh et al., 1982), from termination records (Ross and Lacey, 1961), as well as from interviews at some time after the client dropped out (Farley et al., 1975).

In investigating the literature on attrition we do not emerge with a clear picture of what differentiates attenders from non-attenders or from dropouts. However, we do have a sense

of what factors are relevant, though any one of these factors has been subject to contradiction by various studies.

Considering how many factors have been associated with attrition, and considering all the demographic variables there are, it might be unrealistic to attempt to generalise one or more factors as a definite cause of attrition for all child guidance clinics. Moreover, even if we are referring to a specific population or sample, some factors are very difficult to control. When hypothetically discussing the relation between parents' attitudes and attrition rates, it is quite logical to expect parents with unrealistic expectations to have significantly higher dropout rates than parents with realistic expectations. However, if we investigate this hypothesis we might not find a significant correlation, for parents' expectations could be successfully made realistic in the patient's first session.

Attitudes and Expectations:

One area which is generally considered important is parents' attitudes and expectations towards the therapeutic service. This area encompasses parents' expectations with regard to the form, duration, and process of therapeutic service, and also their motivation and commitment to treatment.

How an individual perceives the agencies created to help deal with problems is one very important element in the complex social process of seeking help (Morris et al., 1973). Walker (1970), in a study of parental attitudes toward child guidance services in London, found that half of those interviewed had never heard of child guidance, and others were misinformed about the purpose of the clinics. Pritchard (1971) found that only 20% of Yorkshire housewives interviewed had accurate information about the kinds of problems dealt with in a child guidance clinic, 90% had heard of child psychiatrists but only half were fairly accurate about what child psychiatrists did.

Overall and Aronson (1964) found that clients whose expectations are less accurate are less likely to return and that such clients are less likely to be satisfied by the treatment received. In a study of a social services department, client satisfaction was found to be related to the fulfilment of expectations (McKay et al., 1973). Heine and Trosman (1960) pointed to the influence of clients' expectations on the kind of help offered. Clients whose expectations differed from those of the therapists' were less likely to be found suitable for therapy.

Referrers may be able to influence clients' expectations of the clinic. Rosenfeld (1964) points that a referrer could increase the confidence of clients in the agency. However, it has been noted that local authority social workers and school staff may also have misconceptions about child guidance clinics (Walker, 1970), and it has been suggested that families can pick up on the ambivalence of a referrer (Cobb, 1972).

One common source of referral is general practitioners. It has been pointed out that general practitioners do not sufficiently prepare their patients for the psychiatric consultation they are arranging (Skuse, 1975). Balint (1968) and Shepard et al. (1966) have commented on the difficulties experienced by a practitioner in expressing to his patient the need for a psychiatric opinion. In a study by Gath (1968), of 50 doctors who had referred patients to a Children's Department at the Maudsley Hospital in London, it was concluded that the doctors' role in the referral process had been largely passive. Bailey and Garralda (1988) replicated Gath's study (1968) and also interviewed mothers who were referred by general practitioners. Twenty years later, one would expect general practitioners to have become more aware of the importance of the role of the referrer. However, they reported that virtually no parents said that they had been given information about the clinic's procedure at the surgery, and the curious discrepancy between parents and doctors about who has actually instigated the referral (two-thirds of the parents named the doctor, whereas two-thirds of doctors noted parental requests), suggests that in many cases discussion of the referral itself may have been brief.

Several studies have looked at drop-out and continuance factors in treatment. Some research has focussed on the characteristics of the client which are related to continuance. These have included the client's expectations of their own role in treatment and the aspect of the problem most worried about (Ewalt et al, 1972), and the client's acceptance of responsibility for the problem (Nichols, 1955; Shyne, 1957; Levinger, 1960). Other studies have found the characteristics of the helper (Hollis, 1968; Shellow et al, 1963), the relationship between the client and the helper (Rosenfeld, 1964), and environmental factors (Mayer and Rosenblatt, 1964) to be related to discontinuance of treatment. Overall, the research shows that there are multiple factors affecting the complex interplay between the client and the therapist.

As mentioned earlier, a common assertion in the literature is that parents' acceptance of services is related to the extent of congruence between what they value and expect to receive from the clinic, and what they encounter (Baekland and Lundwall, 1975; Eiduson, 1968). Considering the importance of this issue, there is very little work done in relation to effectiveness of treatment in child psychotherapy. As Plunkett (1984) wrote, it is

surprising that there is virtually no sound empirical research in this area comparable to the research conducted on adult patients' expectations of psychotherapy (Baekland and Lundwall, 1975). Instead, much of the characterisation of parental expectations has been derived from studies best described as impressionistic (Richardson and Cohen, 1968; 1970; Cole and Magnussen, 1967; Lake and Levinger, 1960; Ross and Lacey, 1961) and post-treatment interviews (Maas et al., 1955; Richardson and Cohen, 1968; Shapiro and Budman, 1973).

There is a scarcity of research not only with regard to parents' expectations of treatment but also to follow-up studies concerning the effectiveness of treatment in child guidance. It has been difficult to control the numerous factors involved and to decide on the criteria of success. In a review of family research, Wells (1972) found only 18 studies which met minimum standards in terms of methodology and only two were really satisfactory. Moreover, it has been noted that unplanned short-term treatment does not necessarily mean treatment failure. Studies of clients' reasons for termination of treatment found that some families fail to continue because of an improvement in the child's problem (Inman, 1956; Levitt, 1958) or because they felt the treatment was completed (Shyne, 1957). Similarly McKay (1973) found that families may benefit from any activity by a person designated as a healer and that this may activate a person's belief that s/he is being helped.

Many studies have pointed out that continuance is not necessarily predictive of improvement (Levinger, 1960; Barbour and Beedell, 1955; Levitt et al., 1959). On the other hand, several studies have found a significant relationship between outcome as judged by the agency and kept appointments - the more appointments attended, the more likely the client was rated 'improved' (Maas et al., 1955).

Consumer Satisfaction:

One perspective for obtaining evaluation information is to solicit reactions from attenders. One of the advantages of this approach is that it provides a personal and unique view of the perceived effectiveness of a clinic's operations (Blach et al., 1977). El-Guebaly et al. (1983) observed that recently, increasing attention has been directed toward the need to assess the satisfaction of the recipient with the mental health services provided. The authors noted that "while a number of publications continue to advocate the evaluation of patient satisfaction, only a few attempts at this assessment have been reported" (p. 24). Gordon et al. (1979) observed that the patients' view of the care provided has so far been largely

estimated by means of interprofessional dialogue and by feedback from informal and unsystematic channels of communication.

In a review of patient satisfaction surveys, Fitzpatrick (1991) identified three reasons beside external pressures from governments, professional bodies, and health authorities why health professionals should take patient satisfaction seriously as a measurement: firstly, there is convincing evidence that satisfaction is an important outcome measure. It may be a predictor of whether patients follow their recommended treatments (Kinsey et al., 1975), and is related to whether patients reattend for treatment (Roghamann et al., 1979) and change their provider of health care (Weiss and Senf, 1990). Evidence has also begun to emerge that satisfaction is related to improvements in health status (Fitzpatrick et al., 1983; Fitzpatrick et al., 1987). Secondly, patient satisfaction is an increasingly useful measure in assessing patterns of communication, such as the success of giving information, of involving the patient in decisions about care, and of reassurance (Savage and Armstrong, 1990). Thirdly, patient feedback can be used systematically to choose between alternative methods of organizing or providing health care, such as length of consultation or arrangements for out of hour care (Bollam et al., 1988). Moreover, consumer satisfaction may be useful therapeutically, as some studies mention that many patients enjoy it, claiming that it is often the first time that anybody has enquired about their feelings and reactions to being a patient (e.g. Gordon et al., 1979).

Linking Research with Practice:

Weisz and Weiss (1993) point that "it has been certainly been one of the most frequently voiced complaints of practicing clinicians over the years that psychotherapy research is of little value to them" (p. 102). Other studies have also reported this view (Elliot, 1983; Kupfersmid, 1988; Luborsky, 1972; Orlinsky, and Howard, 1978; Parloff, 1984). It is particularly telling that, when clinical psychologists are asked to rank order the usefulness of various sources of information to their practice, research articles and books are generally placed at the bottom of the scale (Cohen, 1979, Cohen et al., 1986; Morrow-Bradley and Elliot, 1986). A number of researchers have voiced concerns about the clinical relevance of their work; as Morrow-Bradley and Elliot note, "With virtual unanimity, psychotherapy researchers have argued that (a) psychotherapy research should yield information useful to practicing therapists, (b) such research to date has not done so, and (c) this problem should be remedied" (p.188).

As pointed out earlier, much of the research on the effectiveness of psychotherapy in children and adolescents suffer from methodological problems. These problems diminish any practical usefulness of such research. In reviewing studies that are of practical relevance to the practicing psychologist, it is clear that there is a need for valid and reliable research in the area of child psychotherapy. This is particularly the case in Ireland, where there has been very little work carried out in this area.

Chapter Two

Aims and Plan of Study

This study examines the effectiveness of the clinical services offered by a Child and Family centre. Effectiveness is measured in terms of the behavioural problems exhibited by the children and by the mental health and life quality of the mother. The main areas of investigation are: 1) the relationship between the child and the mothers' state in order to discover which areas enhance the child's improvement, and 2) studying the clients' receptivity to treatment by focussing on the clients' attitudes and expectations.

In attempting to achieve the above aims, this study focuses on 52 consecutive referrals to a Child and Family Centre. Dublin mothers of children referred to the centre are interviewed at their homes before treatment and 3-4 months later, whether or not they are still attending the centre.

In order to study the effects of treatment on the referred child one needs to compare behaviour problems before and after treatment. Here one encounters issues of defining behaviour problems. Achenbach and McConaughty (1987) state that "Adults often seek help for their own discomfort, but children seldom do" (p. 81). Children are referred for help because adults see their behaviour as maladaptive, or harmful enough to warrant professional help. Wedge and Phelan (1989) state that for most children it can be argued that a period of disruptive, noisy, awkward behaviour occurs, is to be regarded as normal. So where should the line be drawn? In relation to the centre being evaluated, children are referred for one of the following reasons: 1) the child's mother is worried about one or several aspects of her child's behaviour, 2) the child's school finds the child to be maladaptive and difficult to cope with, or 3) in the case of separation cases the court requires a report on the child/children's mental health state. The last reason for referral usually constitutes about 5% of the referred cases. In the remaining cases the child's mother finds her child's behaviour to be worrying, or difficult to cope with or both. With regard to the treatment's success, the staff of the centre will be dealing with the mothers' perceptions of her child's behaviour/s. Part of the treatment may involve alleviating unrealistic fears about her child's behaviour/s or even bringing the mothers attention to other behaviours that deserve concern. Whichever the case may be, it is the mothers' perceptions that are focused on. For this reason, in studying the effects of treatment on the child we will be investigating behaviour problems in the child as perceived by his/her mother.

Part of the mother's overall mental health and well being is her concerns about her child's well being. In a paper relating maternal mental health with children's behaviour problems McNestry et al. (1988), point that "there is a large body of evidence to suggest that psychiatric disorders in mothers are strongly linked to psychological disturbances in children and that probably social factors feature significantly in the aetiology of both maternal illness and childhood disorders. The (study's) findings support this evidence and indicate that, to deal with children attending a Child Guidance Clinic effectively, it is necessary to enquire about maternal mental health and social and marital circumstances".

Studying the effect of treatment on the mother will involve investigating the mothers' overall mental health and quality of life, before the first appointment and 3-4 months later. This will also enable us to study the relationship between the mothers state and improvements in her child.

As pointed out in the previous chapter, there have been many factors associated with attrition. Although we do not emerge with a clear picture as to which factors are more significant, there is a general agreement on the importance of parents' attitudes and expectations in the success of the treatment they receive. So a crucial part of investigating the potentials of successful treatment, is investigating the parents' suitability/readiness to receive treatment. This involves studying parents' expectations with regard to the form, duration, the process of the therapeutic service, and also their motivation and commitment to treatment. As pointed out in the previous chapter, referrers have an influence on the clients' expectations, and it has been noted that the local authority social workers, and school staff may have misconceptions about child guidance clinics. Furthermore, it has been pointed out that general practitioners do not sufficiently prepare their patients for the psychiatric consultation they are arranging. So it is also important to inquire about the information received by the referrer.

One important component of the evaluation of publicly funded delivery systems is an assessment of the satisfaction of the clients who receive treatment, through their appraisals of both the clinical and the administrative aspects of their care. In the past, consumer evaluations of services have focused primarily on very general questions such as "Did you find the treatment helpful?". However, for such evaluations to become more useful in planning program policies and services, more specific aspects of the care received need to be assessed.

The growing body of knowledge in the area of consumer surveys points to the usefulness of monitoring this variable formally. The importance of assessing the clients' subjective

reaction to treatment has been emphasized by a number of recent studies (e.g. El-Guebaly et al., 1983).

Plan of study and Choice of Instruments:

In studying the effects of treatment on the child an instrument covers a wide range of behavioural problems in children is required, and one that is also sensitive to the frequency by which the behaviour occurred. The Child Behavior Checklist (CBC) is an instrument that has received a great deal of application in child mental health research and practice (Garrison and Earls, 1985). In "Assessment and Diagnosis in Child Psychopathology" (1988), Barkely states that "There can be little doubt that this is the most well-developed, empirically derived, behaviour rating scale currently available for assessing psychopathology and social competence in children. The item content is sufficiently broad to capture the majority of internalising and externalising disorders, to assess social competence, and to evaluate a diversity of psychopathological disturbances upon which to base an empirical taxonomy of childhood disorders" (p. 83). On this basis the Child Behavior Checklist (Achenbach, 1983) was chosen as an instrument for screening behaviour problems. The mothers of the referred children were questioned on 118 behavioural problems they perceive their children to have. As well as producing an overall score of behavioural problems, the 118 items were used to construct a core syndrome of items to be scored on the profile. These are: Withdrawn, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Delinquent Behaviour, and Aggressive Behaviour. Furthermore, Internalising and Externalising grouping of behaviour/emotional problems reflect a distinction between problems of Withdrawal, Somatic Complaints and Anxiety/Depression, on one hand, and delinquent and aggressive behaviour on the other.

In studying the mothers' mental health the General Health Questionnaire (GHQ) was employed. The GHQ was by Goldberg designed as a screening instrument for non-psychotic disorders and has, to date, been used in a wide range of studies (Boardman, 1987). Its validity in general practice populations has been well established (Goldberg, 1978). The GHQ focuses on the psychological components of ill-health and deals with distressing phenomena in normal every day functioning. Besides reflecting an overall mental health state the GHQ has four subscales: 'Somatic Symptoms', attempts to pick up perceptions of ill-health that do not necessarily have a physical diagnosis; 'Anxiety and Insomnia' subscale, measuring the extent to which the respondent worrying or losing sleep over worry; 'Social Dysfunction' subscale, with items relating to inability or lowered

competence in carrying out daily activities; and 'Severe Depression' subscale, identifying feelings of worthlessness and hopelessness.

Quality of Life has been generally used to refer to the sense of well-being and satisfaction experienced by people under their current life conditions. In the area of service evaluation, quality of life issues focus attention on how the service is influencing the lives of its clients in both positive and negative ways. Quality of life is usually evaluated with some combination of life satisfaction measures and objective indicators of external life circumstances. Lehman's scale (1983), which is an increasingly popular outcome measure of service evaluation was originally developed for chronically mentally-ill in community settings but it could be easily adapted for a non-chronic sample, making it most applicable for our study. It offers a structured interview format, collecting objective and subjective data covering six life domains in addition to measures of general well-being. The objective life domain measures include: family contact, social contact, number of leisure activities, and health, and the subjective life domain measures include: living situation, family relations, social relations, leisure, religion, finance, and health.

In investigating the families' suitability/readiness to receive treatment a First Interview Questionnaire (Fitzgerald and Keenan, 1991) employed in a previous study investigating family's expectations of a child and family centre was administered (Fitzgerald and Keenan, 1991). The questionnaire probes the following issues: whether the patient will attend his/her interview; referral source; information received from the referrer; expectations and fears about attending the child and family centre; expectations about type of professional who would interview them; type and length of treatment expected; expectations of family versus individual assessment; how the experience of coming to the child and family centre had affected the family; stigma of attending a child and family centre; and length of time between referral and assessment at the child and family centre.

In investigating the mothers' satisfaction with the service the Health Visitor Questionnaire (Nicol et al., 1986) was administered. This questionnaire was suitable in that it explores various aspects of treatment such as: the mother's coping with her child, her family, and herself; overall usefulness of the treatment; satisfaction with the therapy process; satisfaction with the type and amount of advice received; the mothers' handling of the therapy sessions; satisfaction with the frequency of visits; and the convenience of visits. Areas relating to treatment are thoroughly investigated, enabling the identification of the aspects which need to be improved on.

Areas to Explore and Plan of Analysis:

As outlined earlier, this study aims to look at three main areas:

- (1) Treatment received by the referred parties,
- (2) Attitudes and expectations of the referred and their effect on their attendance and treatment, and
- (3) Clients' satisfaction with the service.

Within these areas there are several aspects and hypotheses to explore.

With regard to studying the effects of treatment on the referred children and their mothers, the data of the CBC, GHQ, and QoL will be compared, before treatment and 3-4 months later. For each test two-tailed paired t-tests will be carried out to investigate significant differences between pre-treatment data and post-treatment data.

In examining the relation between childrens' behaviour problems and their mothers' mental health and life quality, the data on the CBC will be compared with that of the GHQ and QoL. One hypothesis to explore is that mothers of children with behaviour problems (those diagnosed 'Clinical' on the CBC) will tend to have significantly more mental health problems and significantly lower quality of life than mothers of children with fewer behaviour problems (those diagnosed 'Non-Clinical' on the CBC). This hypothesis could be investigated in two ways: 1) Grouping the mothers' according to their childrens' results on the CBC. The two groups would be: mothers of children diagnosed 'Clinical' and mothers of children diagnosed 'Non-clinical'. Then whether the two groups have significantly different scores on the GHQ and QoL will be investigated by applying unpaired t-tests. This will be carried out for both pre-treatment data and post-treatment data. 2) Another method of investigating this hypothesis is to correlate the overall results of the CBC with the various sections of both the GHQ and QoL, for data collected before treatment and 3-4 months later. Since the two methods rely on different procedures of classification, both methods will be applied.

Another hypothesis to explore is that a decrease in childrens' behaviour problems is associated with improvement in the mothers mental health and (possibly) life quality. This hypotheses is investigated by calculating the difference in overall scores on the CBC, the GHQ (overall scores and scores on the 4 categories), and the various categories of the QoL. For each test, the difference in overall scores will be taken as a measure of

improvement (or disimprovement). Employing two-tailed paired t-tests the results of CBC with GHQ and QoL will be compared.

With regard to studying the attitudes and expectations of the referred clients and their effect on their attendance and treatment, the following hypotheses are investigated:

Clients with negative expectations will have a significantly higher dropout and/or non-attendance rates than clients with positive or realistic expectations. Based on the data of the First Interview Questionnaire, the referrals will be categorised into two groups: 'Negative expectations', and 'Realistic expectations'. Then whether there are significant differences in attendance outcome between the two groups will be investigated.

It is hypothesized that clients who received no information on the clinic will have a significantly higher dropout and/or non-attendance rates than clients who received information on the clinic. Based on the amount of information the mothers claim to have received from their referrers, the referred clients will be categorised into two groups: 'Informed' and 'Not informed'. Then it will be investigated whether there are significant differences in attendance outcome between the two groups.

There are other factors that have been associated with non-attendance such as: marital status, distance from the clinic, child's agreement on attendance, and number of children living at home.

In investigating whether these factors have an effect on attendance outcome significant differences in attendance will be investigated with respect to each of the mentioned factors.

In studying the relation between clients' satisfaction with the service and the rates of improvement the following procedures will be followed: differences in the overall scores from the pre-treatment results and post-treatment results of CBC, GHQ, and QoL will be taken as a measure of improvement for each area these tests relate to. The 'improvement' on each test will then be correlated with the overall scores of the Satisfaction with the Service Questionnaire.

In investigating the relation between attitudes towards the clinic and satisfaction with the service the author will be investigating significant differences in dropout and/or non-attendance rates between clients with negative expectations and clients with realistic or positive expectations.

Chapter Three

Method

Sample:

The study focused on 52 consecutive referrals who had no previous contact with the Child and Family Centre, but may have had contact with other psychiatric services. As more than half of the mothers of the referred children were single mothers, the study focused only on the mothers as a source of information on the referred children. Out of the 52 referred children the number of boys referred (35 = 67%) was slightly more than double the number of girls referred (17 = 33%). The average age of children was 9 (std. dev.= 3.13), with ages ranging from 3 to 16 years of age. The average age of the mothers was 36 (std. dev.= 6.09), with ages ranging from 25 to 49 years of age. The attendance outcome for the 52 cases was as follows; 22 cases (42%) were still attending at the time of the second interview (3-4 months after first interview), 22 cases (42%) were discharged at the time of the second interview (these cases are regarded as completers), 2 (4%) cases had dropped out of treatment, and 6 cases (12%) did not attend any of their appointments. Table 3.1 shows the attendance outcome for the 52 cases.

Table 3.1 Attendance outcome for 52 cases.

	No. of cases	Percentage
Attending (after 3-4 months)	22	42%
Discharged	22	42%
Dropped out	2	4%
Did not attend	6	12%

The average number of attendances over the 3-4 months period was 2.3 visits (std. dev.= 2.50), ranging from one appointment to 11 appointments (only one case attended 11 times.

Setting:

The Child and Family Centre have a policy of giving appointments to any mother who asks for one. This is unlike other centres which would require clients to be referred by a general practitioner. There are four sources of referrals for an appointment at the centre; the biggest group referring were general practitioners who accounted for 46% of all referrals (24 families), followed by 31% (16 families) of self referrals, followed by school referrals accounting for 19% (10 families) of all referrals, followed by 2 court related cases (4%). Figure 3.1 shows the patterns of referrals.

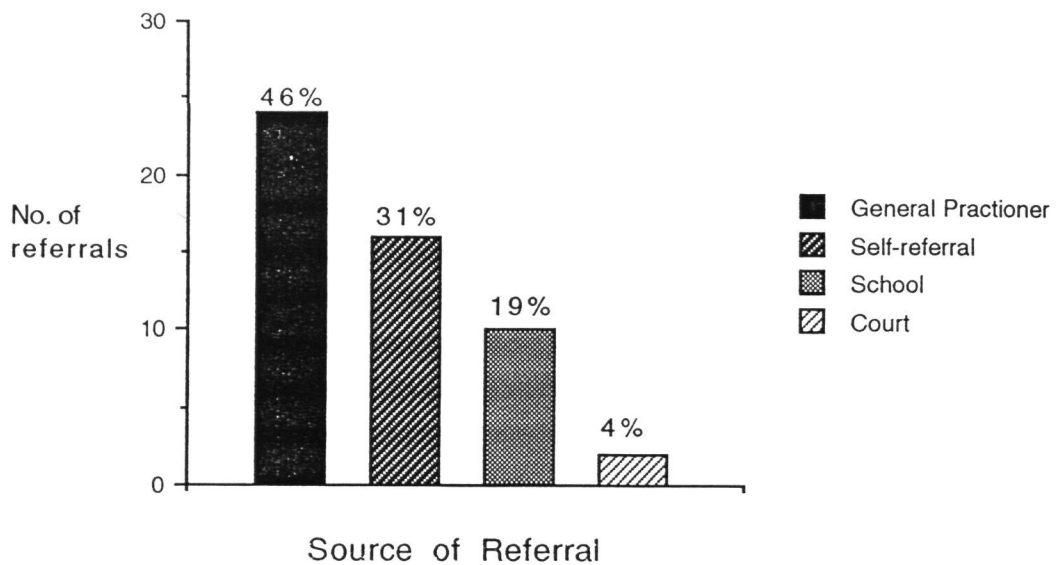
The breakdown of the child sample by reason of referral is as follows: 24 cases of conduct disorder, 6 enuretic cases, 5 cases related to late development, 3 children had speech problems, 3 cases with somatic complaints, 2 cases related to sexual abuse, 2 cases of neurotic symptoms, 2 cases related to witnessing violence at home, 2 cases where the mother was worried about the sexual orientation of her son, 2 cases related to bereavement, 1 eating disorder case, 1 case of child being bullied at school, and 1 case related to auditory hallucinations. For a brief description of each case see appendix (p.112).

The staff that were involved with the referred cases included; 1 Consultant Child Psychiatrist, two non-consultant hospital doctors, two social workers, and one speech therapist. In some cases more than one member of staff was involved. In the treatment of clients there was no inclination towards any particular form of therapy or school of thought but rather an eclectic approach aiming at "enhancing communication among family members" (Consultant Child Psychiatrist at this clinic). The Child and Family Centre was situated in a disadvantaged area with high unemployment rates. A high percentage of the clients were in houses that were Corporation owned and in an area of high housing density.

Procedure:

The mothers were interviewed in their own homes about 3 to 7 days prior to their first appointment, and interviewed again 3-4 months later, irrespective of whether they had attended the centre, were still attending the centre, or had finished treatment. The interview involved the interviewer reading the questions to the mothers and taking note of additional information the mothers offered. Interviews ranged between an hour and an hour and a half. Occasionally an interview might run for longer if the mother was unfamiliar with the type of questions asked, or in cases of distress where the mother would require a slower pace of interviewing.

Figure 3.1 Patterns of referrals.



Questionnaire design and content

Scales and Instruments Used:

- (1) Child Behavior Checklist (Achenbach, 1991).
- (2) The General Health Questionnaire (Goldberg, 1979).
- (3) Quality of Life (Lehman, 1983).
- (4) First Interview Questionnaire (Fitzgerald and Keenan, 1991).
- (5) Health Visitor Questionnaire (Nicol et al., 1986).

Child Behavior Checklist (C.B.C.L./4-18):

The C.B.C.L./4-18 was developed and revised by T.M. Achenbach at Burlington, University of Vermont. Achenbach and McConaughy (1987) saw that standardised tests did not capture behaviours or emotions as seen by those who interact with children. Many important behaviours such as arson or suicide attempts, were not observable. Achenbach thought that both D.S.M. III R (The American Diagnostic and Statistical Manual) and I.C.D.9 (The International Classification of Diseases) were limited with regard to childhood problems. They might categorise the child, but their criteria were shaped largely on adult psychiatric patients. As a result, Achenbach devised a Child Behavior Checklist

that would cover the largest area of behaviour problems rather than leave it to the informant to compose their own list. A wide range of areas are explored and leaving little danger of any problem behaviours being left out. This is particularly good in the case of problem behaviour, as some parents may feel uncomfortable or embarrassed trying to describe some behaviour. There are also spaces on the checklist for parents to add any extra information they think necessary.

The CBCL is designed to record, in a standardised format, the behavioural problems and social competencies of children, as reported by their parents and parent surrogates. The scales were constructed from analysis of parent ratings of 2,000 clinically referred children and normed on 1,300 non-referred children. It has been shown to yield valid results and to have a high test/re-test reliability (+0.89) and interparent correlation (+0.74) (Achenbach, 1978; Achenbach, 1984).

The C.B.C.L./4-18 is a standardised test that has 118 problem items. Parents are also asked to report problems that may not appear to be on the list. The items are scored on a profile that has versions for both boys and girls. These items are used to construct a core syndrome of items to be scored on the profile. They are: Withdrawn, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Delinquent Behaviour, and Aggressive Behaviour. Internalising and Externalising grouping of behaviour/emotional problems reflect a distinction between problems of Withdrawn, Somatic Complaints and Anxiety/Depression, on one hand, and delinquent and aggressive behaviour on the other. On the profile the Internalising group consists of the sum of scores of the problem items of the Withdrawal, Somatic Complaints and Anxious/Depressed scales. The Externalising grouping consists of the sum of the scores on the problem items of the Delinquent and Aggressive Behaviour scales.

Profiles for scoring the C.B.C.L./4-18 display scores for every problem item, as well as raw scores, T scores and percentiles for the syndrome scales, Internalising and Externalising. The total problem score is scored as a raw score and as a T score. Normal, borderline and clinical ranges are also designated for the scale scores.

In investigating changes over time it is important to consider changes in classification as well as investigating significant changes on the overall scores and subscales over time. The reason being is that if one relies solely on categorisation (i.e. 'clinical', 'borderline', or 'non-clinical') one will not be able to detect degrees of change within one category. For example, if a child is diagnosed 'clinical' before and after treatment, one still needs to know

whether there has been any improvement within this category. So the reader is reminded that the term 'clinical' is applied with caution.

General Health Questionnaire (G.H.Q.-28):

The General Health Questionnaire (Goldberg, 1972) was designed by Goldberg to be an easily-completed, self administered screening test, and to be used for detecting psychiatric disorders among those living in the community. It focuses on the psychological components of ill-health and deals with distressing phenomena in normal every day functioning. The version used here is the G.H.Q.-28 and is based on a four-factor solution of the G.H.Q.-60 (Goldberg, 1978). The G.H.Q.-28 has 28 items, and has four subsections.

The "Manual of the General Health Questionnaire" (Goldberg, 1978) suggests the following methods of scoring: "... for purposes of case identification the questionnaire should be scored in the usual way (0-0-1-1) using a threshold of 4/5 to obtain optimum discrimination. It was found that better correlation with independent clinical measures could be obtained for the subscales if they are scored 0-1-2-3" (p. 22). For the purposes of this study therefore, the 0-0-1-1 method will be employed to identify caseness (clinical or non-clinical), using the recommended threshold of 4/5. The 0-1-2-3 method will be used to compare the responses of the first interview with the responses in the second interview since this method is more sensitive to change of scores from interview to another, and also because it yields more information on subscales when closer examination of particular scales is required.

The inbuilt scales measure Somatic Symptoms (Q 1-7), Anxiety and Insomnia (Q 8-14), Social Dysfunction (Q 15-21), and Severe Depression (Q 22-28). Possible total scores, using the Likert method, range from 0 to 84, and for each of the 4 seven-item subscales, scores range from 0 to 21.

The respondent is asked to indicate how often recently he/she has been feeling a range of symptoms, for example "in perfectly good health", or "that life is not worth living". Respondents indicate their answers by choosing any one of the following four responses: 'better than usual', 'same as usual', 'worse than usual' and 'much worse than usual'.

The 'Somatic Symptoms' subscale, with items such as "been feeling in need of a good tonic" attempts to pick up perceptions of ill-health which do not necessarily have a physical

diagnosis; the 'Anxiety and Insomnia' subscale measures the extent to which the respondent is losing sleep over worry or feeling "scared or panicky for no reason", for instance, reflecting a state of heightened nervous tension. 'Social Dysfunction' items are related to inability or lowered competence in carrying out daily activities, and 'Severe Depression' items identifies feelings of worthlessness and hopelessness in questions such as 'have you recently felt that life is not worth living?'. Goldberg and Hillier (1979) report that the factor structure of symptomatology is similar for three independent sets of data collected over eight years, and that the subscales correlate well with total scores and with each other.

As with the CBC, in investigating significant changes over time it is important to investigate changes in classification as well as changes on the scores of the overall scale and the subscales.

Quality of Life:

Since our sample differed from the sample for which Lehman designed his questionnaire, it was necessary to alter Lehman's original questionnaire to suit the sample of this study. In adapting the schedule it was decided to retain the same basic structure as Lehman's scale (i.e. subjective and objective indices for various life areas, plus a number of general life satisfaction measures). The schedule, which consists of a structured interview format, collects objective and subjective data covering several life domains in addition to measures of general well-being. The objective data is obtained by asking direct questions about patients' lives, living conditions, how often they see people, how they spend their time etc. The subjective data is obtained by respondents rating their satisfaction on a 7-point scale ranging from 'delighted' to 'terrible', concerning different areas of their life. Measures of global well-being are obtained on a similar scale in addition to a semantic differential scale. In correlating various measures of this test with other tests the 7-point scale will be converted from a 7 point Likert scale to a seven point numerical scale (1-7). Changes are investigated by comparing pre-treatment scores with post-treatment scores.

The following areas were extracted from Lehman's Questionnaire: 4 objective life domain measures: 'Family contact' investigating frequency of contact with members of the mothers family; 'Social contact' investigating the mothers' frequency of contact with friends; 'Leisure activities' investigating frequency and type of activities the mothers engage in; and 'Health' investigating the mothers general health state. 7 subjective life domain measures investigating the mothers' feelings with regard to the following areas: 'Living situation',

'Family relations', 'Social relations', 'Leisure activities', 'Religion', 'Finance', and 'Health'. 2 Global well-being sections, the first relating to the mothers' feelings about life in general, and the other section relating to the mothers' feelings about specific aspects of her life such as boredom, hopefulness, finding life rewarding etc. The result is an interview schedule which takes on average 30-45 minutes to administer.

First Interview Questionnaire:

In investigating the families' suitability/readiness to receive treatment the First Interview Questionnaire was administered. The questionnaire was designed and employed in a previous study investigating families' expectations of a child and family centre (Fitzgerald and Keenan, 1991). The questionnaire is made of 28 open-ended questions probing the following issues: whether the patient will attend his/her interview; referral source; information received from the referrer; expectations and fears about attending the child and family centre; expectations about type of professional who would interview them; type and length of treatment expected; expectations of family versus individual assessment; how the experience of coming to the child and family centre had affected the family; stigma of attending a child and family centre; and length of time between referral and assessment at the child and family centre. In this questionnaire answers are not converted into categories or scores, rather they remain descriptive.

Health Visitor Questionnaire:

In investigating the mothers' satisfaction with the service we administered the Health Visitor Questionnaire developed by Nicol et al. (1986). The questionnaire is suitable in that it probes into various aspects of treatment. The instrument investigates the following areas: improvement in the mothers' coping with her child, her family, and herself; overall usefulness of the treatment; satisfaction with the therapy process; satisfaction with the type and amount of advice received; the mothers' handling of the therapy sessions; satisfaction with the frequency of visits; and the convenience of visits. Areas relating to treatment are thoroughly investigated, enabling us to locate aspects which need to be improved on. The questionnaire contained questions such as "Too many questions were asked", where the respondent can select 'No', 'Possibly', or 'Yes' (or in some cases 'Not Applicable'). To obtain an overall score the 3 categories are transformed to a 3 point Likert scale (1,2,3) enabling statistical correlations between means on this questionnaire and other questionnaires in this study.

Chapter Four

Results

First Interview Questionnaire:

The interviewer paid home visits to mothers of 52 consecutive referrals to the Child and Family Centre. The response rate to this questionnaire was 100%.

Information received from the referrer:

An average of 66% of the mothers received no information about the Child and Family Centre, while 31% said they were briefed about the clinic. Of the mothers that were doctor-referred (about half the sample), 80% said that they had received no information on the service.

Childrens' feelings about attendance:

An average of 45% of the children were not told of the appointment at the time of the interview (the interviews were conducted 3-7 days prior to appointment). Of the children who were told about their appointment 41% were unhappy about the visit to the centre, 8% thought it was similar to a mental hospital, and 8% thought it was a place for punishment.

Parents' feelings about attendance:

When the mothers were asked whether they were upset or resentful about attendance, only 21% answered "Yes". 34% of the mothers felt that they had "let themselves down" as parents.

An average of 28% of the mothers saw the problem as being the child's while 72% saw the problem as being within the family.

An average of 30% of the mothers' partners were unhappy about the visit to the centre, while the remaining 70% had no objections.

Receptivity to treatment:

An average of 95% of the mothers thought that the clinic would advise better than a 'parent or a grandmother', while 4% did not hold that view.

When asked whether they thought the clinic would help, 63% of the mothers answered "Yes", 30% were 'hopeful', and 6% said "No".

Expectations about attendance and treatment:

An average of 77% of the mothers had no information on the clinic; 14% had a positive view, 11% had negative views. 74% of the mothers had realistic views about the type of service the clinic offers. 85% of the mothers imagined the treatment would involve some form of "talking", while 15% had no idea what the treatment might involve. 95% of the mothers did not think that the centre would use any medication.

An average of 69% had no ideas about length of treatment, 14% of the mothers thought the treatment would take 1 month, 7% thought it would take about 3 months, and 7% thought it would take more than six months. One mother expected one visit would suffice as it was related to court procedures.

When the mothers were asked who they would see at the clinic, 34% responded "I don't know", 30% said "A doctor", 8% said "A psychiatrist", and 27% said "A psychologist".

When the mothers were asked what did they expect from the clinic regarding the child's problem, 4% answered "Assessment", 8% answered "I don't know", and 87% had general positive remarks ("help the child", "sort him/her out" etc.).

Stigma about attending the clinic:

An average of 12% of the mothers said that they would not tell family or friends that they were attending the clinic, while 87% said that they would.

Time between wish for help and asking for an appointment:

An average of 25% of the mothers said that they had requested an appointment within one week of wishing for help, 28% requested their appointments within three weeks, 25% within one month, 14% within two months, and 6% within three months or more.

Expectations about waiting time at the clinic:

When asked how long the mothers expected to wait at the clinic before they were seen, 42% said that they would be seen immediately, 35% said "I don't know", 19% thought that they would wait for an hour, and 3% thought that they would wait for about three hours. (In this centre clients are seen immediately, with rare exceptions).

Preferences about therapy:

An average of 33% of the mothers said that they would prefer to be seen alone, 60% preferred to be seen with the child, and 6% preferred to be seen with the whole family.

When asked whether the mothers had a preference to be seen by a male or a female doctor, 87% had no preferences. Of the five cases that did have a preference, four preferred a female doctor and one preferred a male doctor. 1 mother gave no reason for her preference and the remaining 4 had reasons specific to the case (e.g. girl abused by male, or boy relating better to a male doctor).

Convenience in attending the centre:

When the mothers were asked whether they had to make any special arrangements in order to attend the centre, 82% said that they did not have to make any special arrangements, while 17% reported having to make special arrangements (hiring a baby-sitter, taking time off work etc.).

Efficiency of appointments:

10% of the mothers said that they have received an appointment within 5 days of requesting an appointment, 49% received their appointments between 6 to 10 days, 23% between 10 days and 2 weeks, 4% between 2 and 3 weeks, and 13% between 3 weeks and 1 month.

An average of 10% of the mothers said that they would like 5 days notice, 80% said that they would like 1 week notice, and 10% said that they would like 10 days notice.

In sum, a high percentage of parents reported not receiving any information about the clinic. A high percentage of the parents were not stigmatised about attending the clinic and had a generally positive view about the service they were about to receive. These results also show that this clinic has a very short waiting list of two to three weeks.

Satisfaction with the service (Health Visitor Questionnaire):

For this questionnaire statements about treatment they received were read out to the mothers and they responded "Yes", "Possibly", "No", or "Not applicable (N/A)". Although some questions were straight forward in that one would not expect a "Not applicable" response, in some cases, the mothers felt that their children were referred for a 'report' rather than for treatment.

Improving coping with the child:

More than 50% of the mothers felt that the visits had improved their coping with their childrens' problems. However, more than 10% of the mothers felt that this issue was not applicable to their cases as they did not perceive that they needed help in this area.

Improving coping with the family:

Mothers who felt that the visits were useful for the family as a group was no more than 20% of all the mothers. About 65% of the mothers felt that they did not need help in that area.

Benefit by the mother:

An average of 25% of the mothers thought that the visits helped them and 29% thought that the visits helped them to 'understand their own reactions to things better'. Many of the mothers felt that the issue was not applicable to themselves.

Usefulness of treatment:

An average of 70% of the mothers thought that 'it helped to have someone to talk to', 48% of the mothers thought that the 'meetings were useful to them in seeing that other people may have similar difficulties. A small percentage of the mothers felt that the visits were not useful (20%) and were a waste of time (11%).

Overall benefit:

An average of 77% of the mothers found the visits 'helpful on the whole', 13% didn't agree, and 9% answered "Possibly" (no mothers answered "N/A").

Satisfaction with the therapy process:

An average of 84% of the mothers found it 'very easy to talk to the social worker/doctor'. Only a small percentage of the mothers (16%) thought 'too many questions were asked' and 16% found it 'difficult to see the point of some of the things brought up. Only 10% thought that 'other family members should have had a chance to join in the discussions'.

Wanting more advice:

An average of 41% of the mothers 'would have (generally) liked more advice', and 32% of the mothers 'would like to have been told more about handling their children'.

Handling therapy:

An average of 18% of the mothers 'felt upset after the discussions', and 20% of the mothers 'worried about what had been discussed'.

Frequency of visits:

An average of 25% of the mothers felt that there not enough visits and only 4% of the mothers thought that 'fewer visits would have been more useful'.

Table 4.1 shows the questions as asked to the mothers of the referred children along with the breakdown of responses.

Table 4.1 Satisfaction with the service (Health Visitor Questionnaire).

	No	Possibly	Yes	N/A
Improved coping with child:				
It helped me to think of ways to cope with my child	27%	4%	57%	11%
It helped me to think of ways to understand my child more	30%	2%	54%	14%
It helped me to think of ways to cope with behaviour difficulties in my child	27%	9%	46%	18%
It helped me to understand my child better	36%	19%	36%	9%
It helped me to think of ways to cope with my child's sleep or eating problems	11%	2%	14%	73%
Improved coping with family:				
It helped me to understand things about the whole family	18%	2%	21%	59%
The meetings were useful to us as a family group	14%	4%	9%	73%
Benefit by mother:				
It helped me to understand myself more than before	14%	4%	25%	57%
It helped me to understand my own reactions to things better	32%	7%	29%	32%
Usefulness of treatment:				
It was just talk and not really useful	66%	11%	21%	2%
It helped me to have someone to talk to	20%	5%	70%	5%
Discussions like that are just a waste of time	77%	9%	12%	2%
The meetings were useful to me in seeing that other people may have similar difficulties to me	25%	11%	48%	16%

	No	Possibly	Yes	N/A
Overall benefit:				
I found it helpful on the whole	14%	9%	77%	0%
Satisfaction with the therapy process:				
Too many questions were asked	75%	5%	16%	4%
It was difficult to see the point of some of the things brought up	70%	7%	16%	7%
Other family members should have had a chance to join in the discussions	34%	2%	10%	54%
It was very easy to talk to the worker (social worker or health visitor)	7%	7%	84%	2%
Wanting more advice:				
I would have liked more advice	50%	2%	41%	7%
I would like to have been told more about handling my children	43%	16%	32%	9%
Handling therapy:				
I sometimes felt upset after the discussions	77%	4%	18%	0%
I worried over what had been discussed	73%	5%	20%	2%
Frequency of visits:				
There were not enough visits to be really useful	52%	14%	25%	9%
Fewer visits would have been better	89%	2%	5%	4%
The visits would have been more useful if they had been more frequent	55%	13%	25%	7%
Convenience of visits:				
I found the visits inconvenient	84%	5%	9%	2%

Child Behavior Checklist:

This section contains results of the Child Behavior Checklist for the pre-treatment and post-treatment sets. The items on the CBC were scored using the procedure outlined in the manual (Manual for the Child Behavior Checklist, 1991; p.230). In classifying the children into 'clinical', 'borderline', and 'non-clinical', Achenbach's recommended thresholds were used.

At pre-treatment, 49 cases were within the age of 4-16. Of the 49 children, 25 children were classified 'Clinical' (51%), 3 children were classified 'Borderline' (6%), and 21 children were classified 'Non-clinical' (42%).

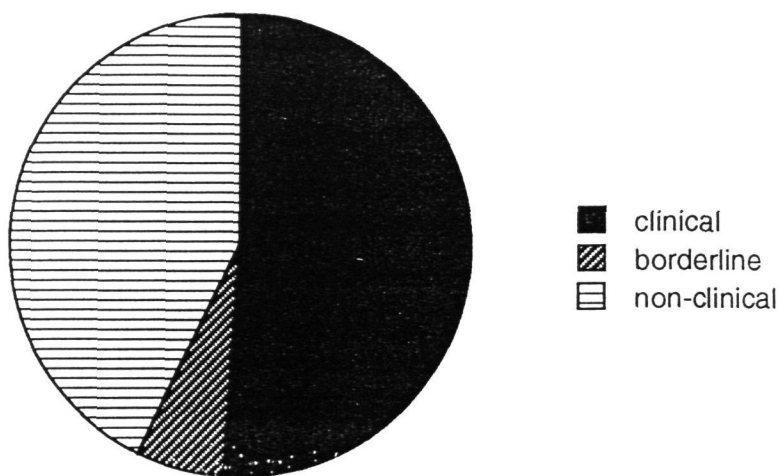
At post-treatment, results for 44 cases were available. Of this sample of 42 children, 6 children were classified 'Clinical' (13%), 2 children were classified 'Borderline' (4%), and 36 children were classified 'Non-clinical' (82%). Figure 4.1 shows the children's classification on the overall scores for both pre-treatment and post-treatment results.

In studying the change in categories between pre-treatment results and post-treatment results for the 44 children, 20 children (45%) were considered 'Improved' cases in that they have shifted either from 'Clinical' to 'Non-clinical' or 'Borderline', or from 'Borderline' to 'Non-clinical'. 6 children (14%) were considered 'No improvement' cases in that they have not shifted categories towards 'Non-clinical'. And 18 children (41%) remained within their 'Non-clinical' category. There were no reported cases of children shifting categories towards 'Clinical'.

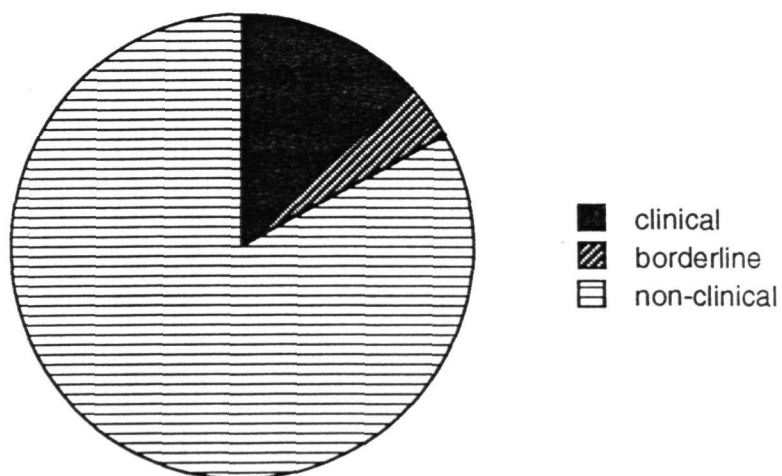
Figure 4.2 shows the improvement rates from the pre-treatment set to the post-treatment set.

Table 4.2 shows improvement in classification from pre-treatment to post treatment, on the CBC total behaviour problem scale and the subscales.

Figure 4.1 Classification on the CBC for the pre-treatment and post-treatment sets.



CBC pre-treatment classification



CBC post-treatment classification

Figure 4.2 Shows the change of classification on the CBC from the pre-treatment set to the post-treatment set.

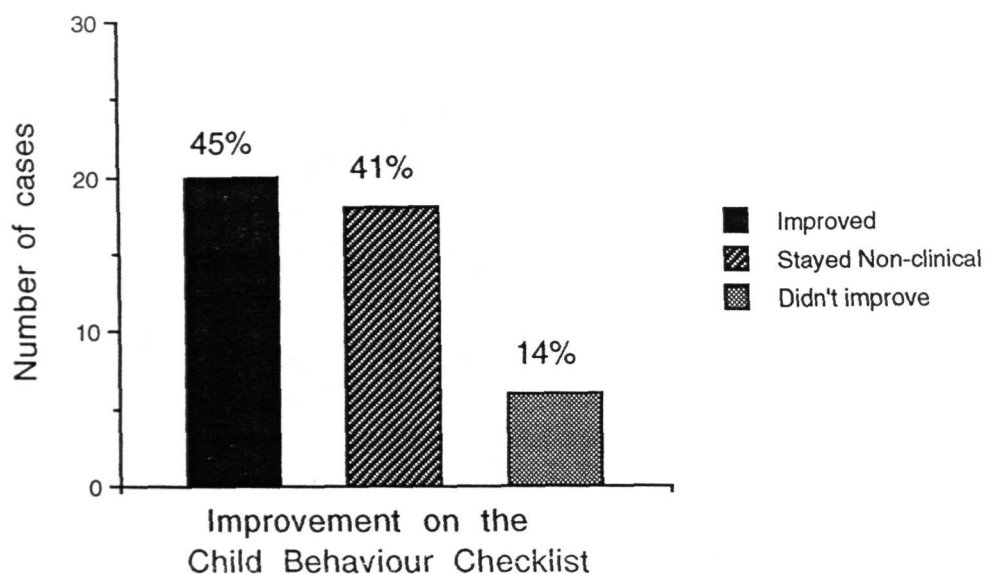


Table 4.2 Improvement rates from the pre-treatment set to the post-treatment set.

Scale	Improved	No change	Stayed Non-clinical	Worsened
Withdrawn	10 (23%)	4 (9%)	30 (68%)	0 (0%)
Somatic complaints	7 (16%)	0 (0%)	35 (80%)	2 (4%)
Anxious/depressed	5 (11%)	0 (0%)	35 (80%)	4 (9%)
Social problems	9 (20%)	2 (4%)	33 (75%)	0 (0%)
Thought problems	9 (20%)	0 (0%)	34 (78%)	1 (2%)
Attention problems	13 (30%)	5 (11%)	26 (59%)	0 (0%)
Delinquent behaviour	13 (30%)	1 (2%)	28 (63%)	2 (5%)
Aggressive behaviour	11 (25%)	0 (0%)	32 (73%)	1 (2%)
Internalizing scale	5 (11%)	5 (11%)	31 (70%)	3 (7%)
Externalizing scale	15 (29%)	6 (14%)	21 (50%)	3 (7%)
Total behaviour	20 (45%)	6 (14%)	18 (41%)	0 (0%)

Investigating significant changes on the CBC's scales:

In investigating whether there were significant changes on the scales of the CBC, paired t-tests were administered on the overall scales and also on the subscales. Figure 4.3 shows the distribution of T scores for the total behaviour problem scale for the pre-treatment and post-treatment data respectively. In correlating the results of the two sets (pre-treatment with post-treatment) the raw scores were used for the subcategories, and T scores were used for the Internalising, externalising, and overall categories as recommended in the CBC's manual (Manual for the Child Behavior Checklist, 1991; p.230).

There were significant decreases in scores on the all the CBC's scales except for the Internalizing scale. Table 4.3 shows the means, and standard deviations for both the pre-treatment and post-treatment sets, and also the results of the t-tests administered on the various scales.

In investigating whether the 2 groups, 'clinical' and 'non-clinical', were scoring significantly different from each other over time, a repeated measure ANOVA was administered on the t scores of the overall behaviour problem scale (the 'borderline' was excluded from this analysis due to small size of the group). This comparison was insignificant ($F(1, 44) = 0.95, p > .05$), suggesting that no differences in rates of improvement existed between the two groups.

Figure 4.3 Distribution of t scores on the total behaviour problem scale for the pre-treatment and post treatment set.

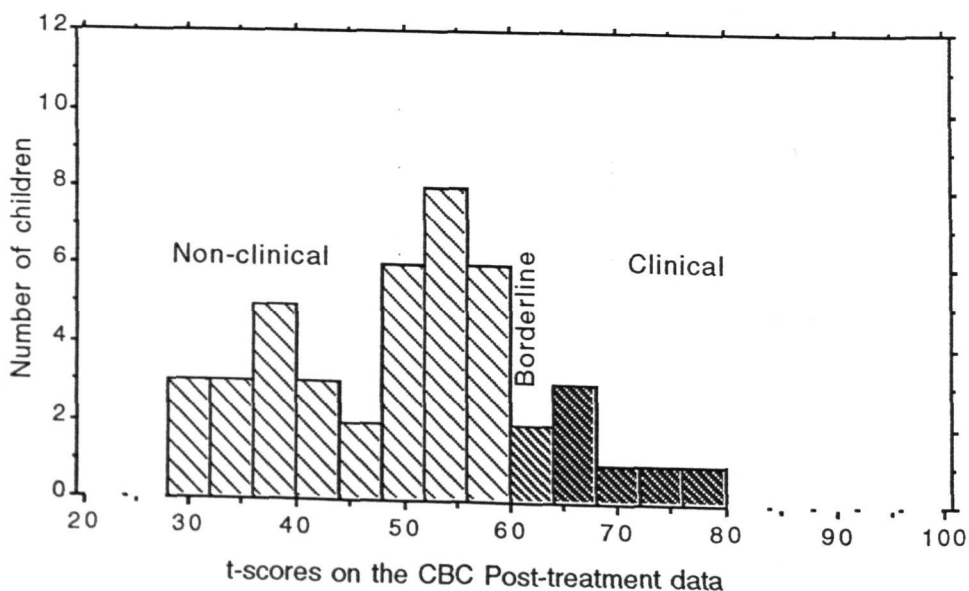
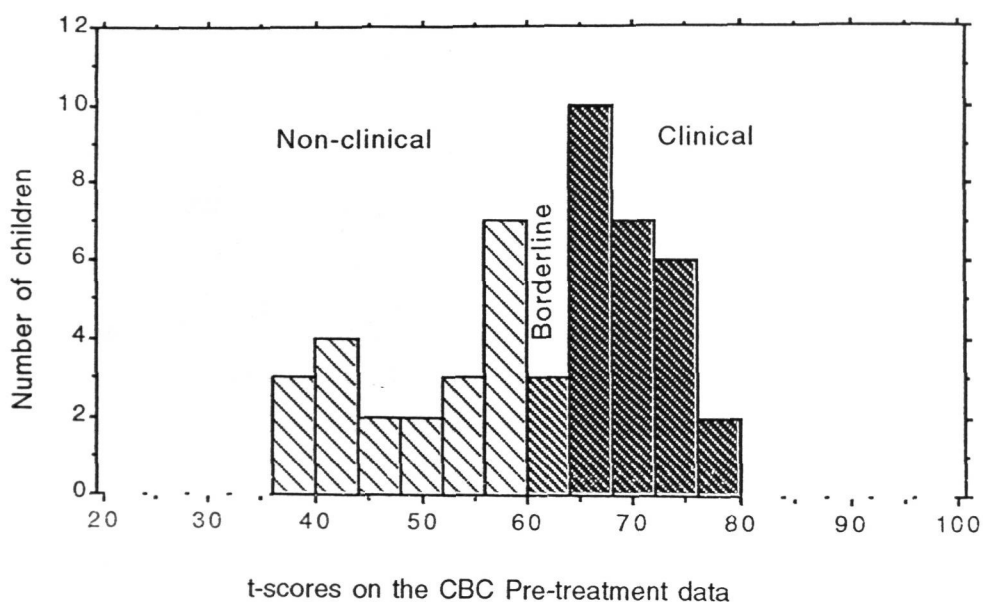


Table 4.3 Means, standard deviations and t-tests on the scales of the Child Behavior Checklist.

	Pre-treatment mean (S.D.)	Post-treatment mean (S.D.)	t-value
Withdrawn	5.41 (3.92)	2.93 (3.37)	6.44**
Somatic Complaints	1.78 (2.74)	.75 (1.62)	2.85*
Anxious/Depressed	6.88 (4.52)	3.93 (3.91)	6.75**
Social Problems	3.27 (3.31)	2.39 (2.55)	3.78**
Thought Problems	1.55 (1.89)	.68 (1.31)	4.28**
Attention Problems	7.18 (2.26)	4.55 (4.36)	5.62**
Delinquent Behaviour	2.86 (2.89)	1.41 (1.93)	3.81**
Aggressive Behaviour	11.31 (8.51)	6.87 (6.71)	6.59**
Internalizing Scale	54.27 (10.51)	51.71 (11.08)	1.88
Externalizing Scale	56.41 (11.98)	48.61 (11.34)	8.59**
Total Score	60.18 (11.52)	50.14 (12.01)	9.91**

(*p<.01; p<.0001)

GHQ (General Health Questionnaire-28):

As recommended in the GHQ manual (Goldberg, 1978), a threshold of 4/5 was employed. The following results emerged: At pre-treatment, 30 mothers (58%) were classified as 'clinical', and 20 mothers (42%) were classified 'non-clinical'. At post-treatment, data were available for 48 mothers. Of the 48 mothers, 14 mothers (29%) were classified 'Clinical', and 34 mothers (71%) were diagnosed 'Non-clinical'. Figure 4.4 shows the mothers' classification on the GHQ at pre-treatment and post-treatment.

In studying the change of classification for the 48 mothers from the pre-treatment set to the post-treatment set, 18 cases (38%) were identified as 'Improved' cases in that they were classified 'Clinical' on the pre-treatment set and then classified as 'Non-clinical' on the post-treatment set. 15 mothers (31%) stayed within their 'Non-clinical' classification, 11 mothers (23%) stayed within their 'Clinical' classification ('Didn't improve'), and 4 mothers (8%) shifted from a 'Non-clinical' classification to a 'Clinical' classification ('Became clinical'). Figure 4.5 shows the mothers' change of classification from the pre-treatment set to the post-treatment set.

Investigating significant changes on the GHQ scales:

In order to investigate whether there were significant overall changes across the 4 months period, two-tailed paired t-test were carried out on the scales of the GHQ. Table 4.4 shows the means and standard deviations for both the pre-treatment and post-treatment GHQ scales and also the t value for the t-tests for the various scales.

There were significant decreases of scores on the overall scale and on all the subscales of the GHQ. Figure 4.6 shows the pre-treatment and post-treatment overall scale and subscales at pre-treatment and post-treatment.

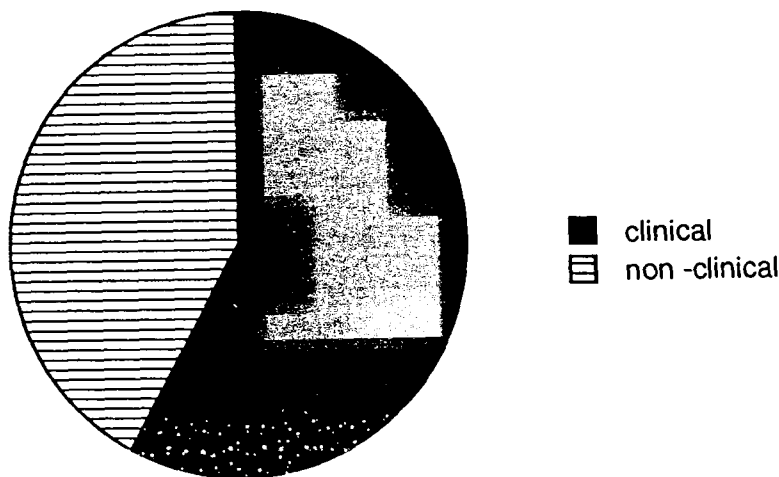
In investigating whether the 'clinical' cases were scoring significantly different than the 'non-clinical' groups over the 3-4 months, a repeated measures ANOVA was carried out for the two groups for the GHQ overall scale. There was a significantly higher change in the scores of the 'clinical' group than the 'non-clinical' group on the overall scale ($F(1, 48) = 16.16, p < .0001$). Table 4.5 shows the results of the repeated measures ANOVA for the clinical and non-clinical categories on the GHQ.

Note: When the GHQ was scored using the original method of scoring (0-0-1-1 as opposed to Likert's 0-1-2-3), there were significant decreases in scores on all the scales, with the

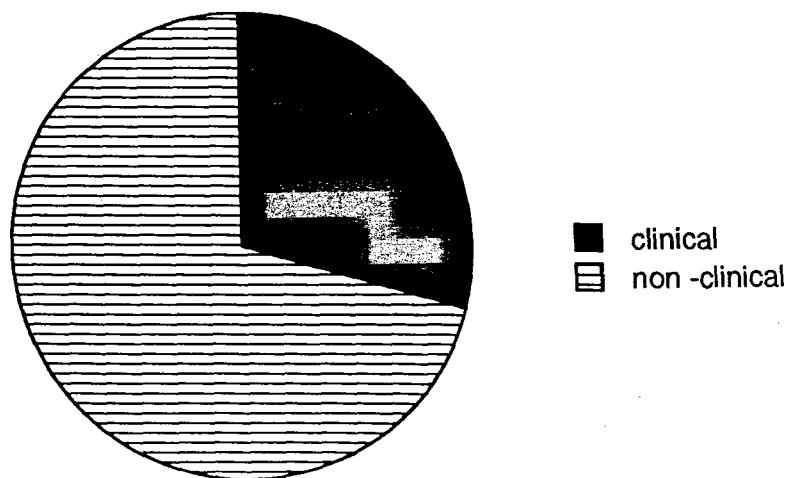
exception of the Somatic Complaints scale which had a significant increase in the scores. However, the skewing of the mean for that scale was emanating from three cases which when excluded from the analysis there was no longer a significant change in the overall score for that subscale.

In sum, there were significant decreases on all the GHQ total scales and also on all the subscales. There was a significantly higher change in the scores of the 'clinical' group than the 'non-clinical' group on the overall scale, the Somatic Complaints scale, and the Anxiety and Insomnia scale

Figure 4.4 GHQ classification for the pre-treatment and post-treatment sets.



GHQ pre-treatment classification



GHQ post-treatment classification

Figure 4.5 Change of classification on the GHQ from the pre-treatment set to the post-treatment set.

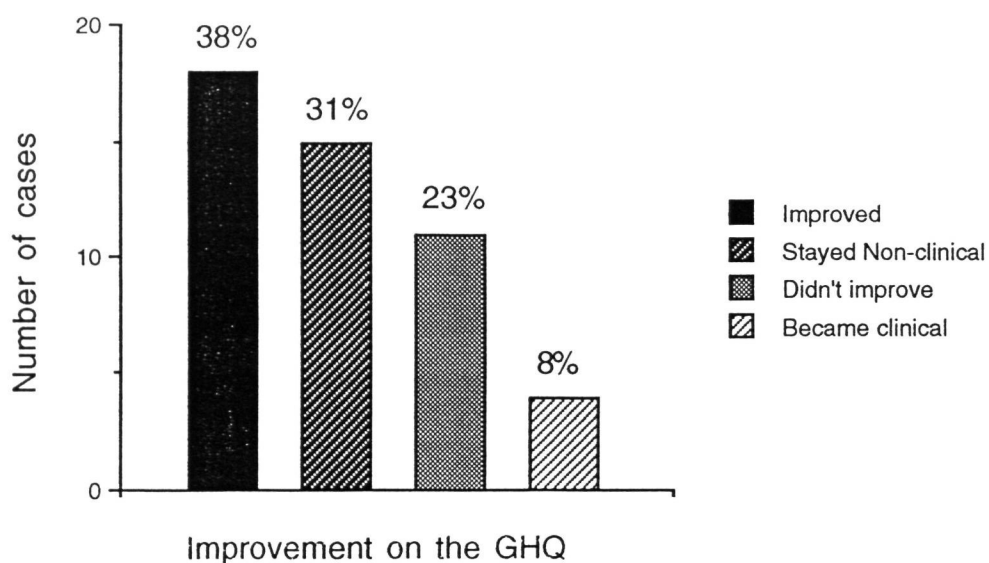


Table 4.4 Means and standard deviations with t-tests for the pre-treatment and post-treatment GHQ scales.

	Pre-treatment mean (S.D.)	Post-treatment mean (S.D.)	t-value
Total Scale	26.25 (13.65)	20.22 (12.22)	3.58**
Somatic Complaints	7.40 (4.47)	5.5 (4.33)	2.9*
Anxiety & Insomnia	7.71 (5.32)	5.58 (4.16)	2.86*
Social Dysfunction	8.25 (2.50)	7.31 (1.86)	2.95**
Severe Depression	2.89 (4.44)	1.83 (3.77)	1.80*

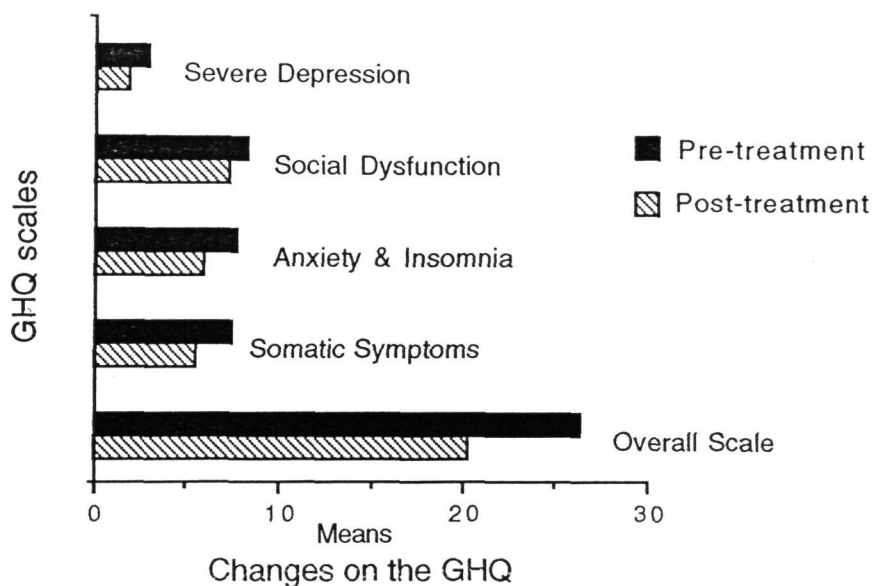
(*p<.01; **p<.0001)

Table 4.5 Repeated measure ANOVA for the clinical and non-clinical categories on the GHQ.

	Clinical (n=28) mean (S.D.)	Non-clinical (n=20) mean (S.D.)	F-test
Total Scale			
Pre-treatment	34.26 (11.45)	15.2 (5.58)	
Post-treatment	23.14 (14.08)	16.15 (7.59)	16.16**
Somatic Complaints			
Pre-treatment	10.11 (3.57)	6.14 (4.83)	
Post-treatment	3.7 (2.28)	4.6 (3.42)	17.38**
Anxiety & Insomnia			
Pre-treatment	10.5 (4.5)	3.8 (3.6)	
Post-treatment	6.64 (4.42)	5.58 (3.34)	8.89*
Social Dysfunction			
Pre-treatment	8.96 (2.86)	7.75 (2.07)	
Post-treatment	7 (6.86)	6.7 (1.34)	2.63
Severe Depression			
Pre-treatment	4.71 (5.21)	2.61 (4.5)	
Post-treatment	.7 (1.21)	.75 (2.05)	2.59

(*p<.01; **p<.0001)

Figure 4.6 Changes on the GHQ scales from the pre-treatment set to the post-treatment set.



Quality of Life Questionnaire:

This section shows the results of the QoL measures. In order to give a description of the sample the pre-treatment measures are first discussed, and then followed by a report on the change of scores from the pre-treatment to the post-treatment set.

For the Global well-being measures and for the subjective life domain measures, mothers were asked to respond to the questions by choosing one of seven categories on a satisfaction scale that best described them. The categories range from "terrible" to "delighted", with a median response of "mixed (feelings)". In order to give a picture of the sample the seven point scale will be collapsed into three categories: "Unsatisfied", "Satisfied", and "Mixed Feelings".

Global well-being section:

Measure A consists of the following question: "How do you feel about your life as a whole?". Measure B investigates life satisfaction on the following dimensions of the client's life: 'boring-interesting'; 'enjoyable-miserable'; 'useless-worthwhile'; 'full-empty'; 'discouraging-hopeful'; 'disappointing-rewarding'; 'brings out the best in me-doesn't give me a chance'.

On measure A, 22% of the mothers were "Dissatisfied" with their lives as a whole, and 44% were "Satisfied" (34% had mixed feelings). On measure B, 19% of the mothers were "Unsatisfied" with various aspects of their lives, while 44% were "Satisfied" (37% had mixed feelings).

Subjective life domain measures:

More than 70% of the mothers were generally satisfied about their living situation, family relations, social relations, religion in their lives, and their health state. Approximately 54% of the mothers were satisfied with the leisure and their personal safety. Table 4.6 shows the mothers' responses on the Global well-being measures and the Subjective life domain measures.

Objective life domain measures:

When the mothers were asked about the frequency of contact with their families, 25% of the mothers said they were in contact with at least one member of her family on a daily basis, 38% said they were in contact at least once a week, 19% said they were in contact at least once a month, 17% were in contact with members of their families less than once a month.

With regard to social contacts, 19% of the mothers were in contact with friends on a daily basis, 58% said they were in contact at least once a week, 10% said they were in contact at least once a month, 11% said they were in contact with friends less than once a month, 2% said they did not have any contact with their friends.

Investigating significant changes on the QoL measures:

In investigating significant changes over the 3-4 months, two tailed paired t-tests were administered on the QoL measures.

Significant changes occurred on only two of the QoL measures: the Global well-being measure A, and the Frequency of Social Contact measure (Objective measure). For both these measures there were significant increases of scores. Table 4.7 shows the means and standard deviations for the pre-treatment and post-treatment sets, with results of the t-tests. Figures 4.7 and 4.8 show the Subjective and Objective measures (respectively) for the pre- and post-treatment sets.

Reliability analysis on Quality of Life measures (Chronbach's alpha):

To have administered Lehman's questionnaire in its entirety would have resulted in a very long interview. The measures were therefore shortened by taking out some questions (refer to Appendix for adapted version of the questionnaire). Internal consistency reliability coefficients (Chronbach's alpha) were computed for each of the global well-being, subjective, and objective life domain scores. This was to establish the reliability of the shortened form of the adapted measures. This section reports the results for each domain followed by the number items in each domain and the number of cases for which the reliability test was administered on. Measures that do not appear in this section are measures that contained only one question. Table 4.8 shows the internal reliability coefficients for QoL measures.

Table 4.6 Mothers' responses on the QoL Global well-being measures and the subjective measures at pre-treatment.

	Dissatisfied	Mixed feelings	Satisfied
Global Well-being measures			
Measure A	22%	34%	44%
Measure B	19%	37%	44%
Subjective measures			
Living situation	15%	13%	72%
Family relations	9%	19%	74%
Social relations	12%	11%	77%
Leisure	23%	24%	53%
Religion	8%	12%	79%
Finance	51%	14%	35%
Safety	23%	23%	54%
Health	23%	1%	76%

Table 4.7 Means and standard deviations for Quality of Life pre-treatment and post-treatment measures with t-tests results.

	Pre-treatment mean (S.D.)	Post-treatment mean (S.D.)	t value
Global well-being measures			
Measure A	4.56 (1.37)	4.97 (1.12)	-2.12*
Measure B	4.84 (.98)	5.11 (1.23)	-1.96
Subjective Indices			
Family Relations	5.35 (1.31)	5.29 (1.06)	.44
Social Relations	5.14 (1.13)	5.26 (1.03)	-.70
Living Situation	4.83 (1.85)	4.93 (1.72)	-.42
Leisure	4.31 (1.52)	4.56 (1.55)	-1.50
Religion	5.21 (.82)	5.03 (.91)	.76
Finance	3.73 (1.51)	3.92 (1.74)	-.86
Safety	4.89 (1.06)	4.68 (1.19)	.68
Health	4.54 (1.33)	4.67 (1.02)	-.71
Objective Indices			
Family Contacts	3.71 (1.04)	3.92 (1.13)	-.188
Social Contacts	3.47 (.93)	4.11 (.92)	-3.91**
Leisure	1.7 (.22)	1.7 (.34)	-.08

(*p< .05; **p<.01)

Figure 4.7 Subjective Quality of Life measures for the pre- and post-treatment sets.

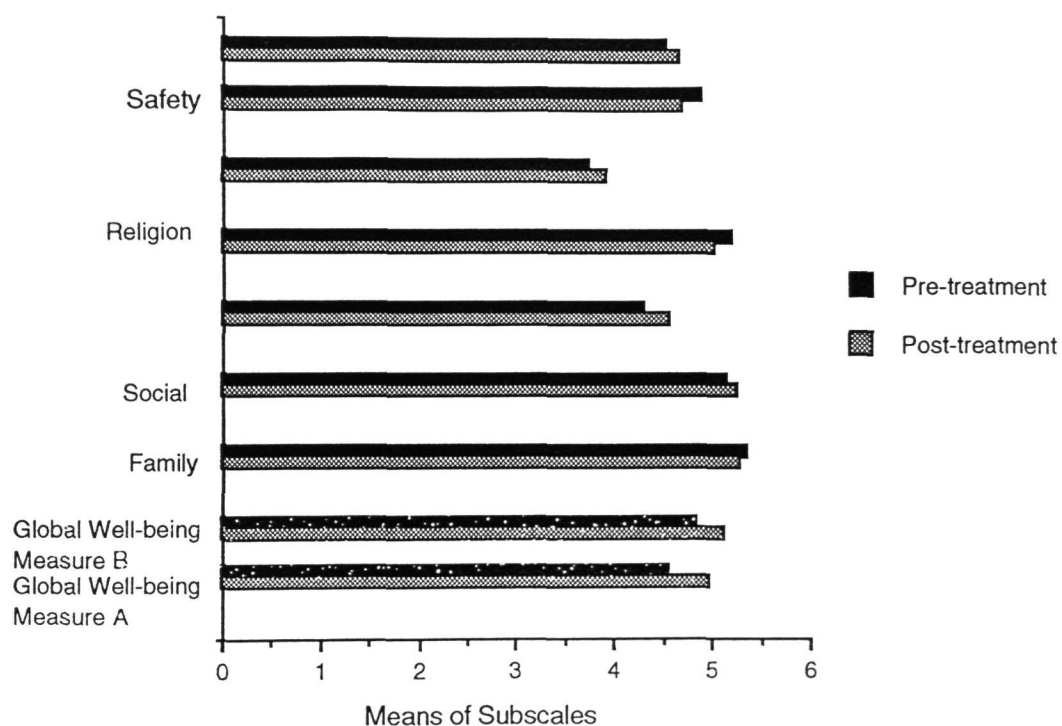


Figure 4.8 Objective Quality of Life measures for the pre- and post-treatment sets.

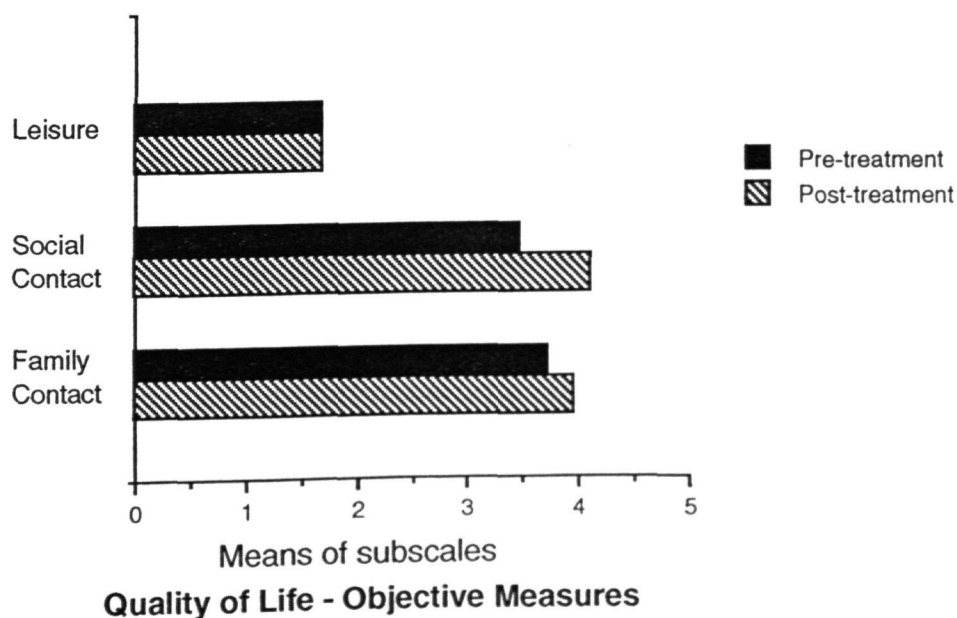


Table 4.8 Internal reliability of QoL indices.

Life Domain	No. of items	Chronbach's Alpha
Global Well-being measures		
Measure A	2	.67
Measure B	7	.84
Subjective Indices		
Living Situation	5	.81
Family Relations	5	.80
Social Relations	6	.76
Leisure	6	.76
Religion	5	.85
Finance	4	.79
Safety	5	.80
Health	7	.83
Objective Indices		
Social Contact	8	.87
Leisure	16	.86

Studying the relation between children's behaviour problems and their mothers mental health:

This section concerns itself with investigating relationships between outcomes for the children and their mothers.

In investigating whether children's behaviour problems are correlated with their mothers' mental health, the overall scores of the CBC were correlated with the overall scores of the GHQ. Significant positive relationships were observed both at pre-treatment ($R=.432$, $df=48$, $p<.01$) and at post-treatment ($R=.482$, $df=43$, $p<.0001$).

The relationship between the children and their mothers has two components: the effect of the mothers on their children, and the effect of the children on their mothers. In studying the effect of the children's behaviour problems on their mothers' mental health, the results of the GHQ were grouped into two groups according to the children's 'clinical' or 'non-clinical' classification (the number of 'borderline' cases were too small to be included in the analysis). In investigating whether the mothers of 'clinical' children had significantly different scores on the GHQ scales, unpaired t-tests were administered for both the pre-treatment and post-treatment sets. Table 4.9 shows the means and standard deviations with the t-tests results for the GHQ scales for both pre-treatment and post-treatment sets. In the pre-treatment set mothers of 'clinical' children had significantly higher scores than mothers of 'non-clinical' children on the GHQ overall score, on the Anxiety and Insomnia scale, and on the Severe Depression scale. In the post-treatment set, mothers of 'clinical' children had significantly higher scores on the overall scale and on all the subscales than mothers of 'non-clinical' children.

In determining whether the mothers of 'clinical' children were scoring significantly different than mothers of 'non-clinical' children over time, repeated measure ANOVA was carried out on the Overall score of the GHQ. No significant differences emerged ($F(1,44)=0.052$, $p>.05$).

In studying the effects of the mothers' mental health on their children's behaviour problems the children's CBC scores were grouped into two groups according to their mothers' classification on the GHQ and differences between the two groups were investigated. In investigating whether the children of 'clinical' mothers had significantly different scores than children of 'non-clinical' mothers, unpaired t-tests were carried out for both the pre-treatment and post-treatment sets.

On the pre-treatment set the two groups comprised of 28 children whose mothers were classified 'Clinical' on the GHQ, and 21 children whose mothers were classified 'Non-clinical' on the GHQ. The two groups had significantly different scores on the total score (Overall Behaviour Problem scale), on the Withdrawn and on the Anxious/Depressed scales. Children whose mothers were classified 'clinical' on the GHQ had significantly higher scores on these scales than children whose mothers were classified 'non-clinical' on the GHQ.

On the post-treatment set the two groups comprised of 13 children whose mothers were classified 'Clinical' on the GHQ, and 31 children whose mothers were classified 'Non-clinical' on the GHQ. The two groups had significantly different scores on the Overall Behaviour Problem scale, on the Thought Problems and on the Delinquent Behaviour scales. Children whose mothers were classified 'clinical' on the GHQ had significantly higher scores on these scales than children whose mothers were classified 'non-clinical' on the GHQ. Table 4.10 shows the means and standard deviations with the t-tests results for the CBC scales for both pre-treatment and post-treatment sets.

In determining whether the children of 'clinical' mothers were scoring significantly different than children of 'non-clinical' mothers over time, repeated measure ANOVA were carried out on the results of the total behaviour problem of the CBC. No significant differences emerged ($F(1,48) = 1.59, p > .05$).

In investigating whether the children and their mothers were improving at the same rate, the children's improvements were correlated with the mothers' improvements. Children's improvement was measured by calculating the difference from pre to post-treatment on the CBC overall scale. Similarly, the mothers' improvement was measured by calculating the difference from pre to post-treatment on the GHQ overall scale. The resulting correlation was not significant ($R = 1.58, df = 48, p > .05$).

It is important to note here that the range on the total score of the CBC (76) is close to that of the total score on the GHQ (84). (This correlation would not be as appropriate with the GHQ original method of scoring which would result in a smaller range (56) on the total GHQ scale).

These results suggest that while the children's behaviour problems and their mother's mental health are correlated, the children and the mothers did not improve at the same rate.

Table 4.9 Unpaired t-tests for the mothers whose children are 'clinical' (on the CBC) and mothers whose children are 'non-clinical'.

	Mothers of clinical children	Mothers of non-clinical children	
	Clinical mean (S.D.)	Non-clinical mean (S.D.)	
Pre-treatment	n= 25	n= 21	t values
Post-treatment	n= 6	n= 36	
<hr/>			
Total Scale			
Pre-treatment	30.56 (15.1)	20.3 (10.01)	2.65*
Post-treatment	32.83 (21.0)	18.89 (9.63)	2.71**
Somatic Complaints			
Pre-treatment	8.08 (4.77)	6.24 (3.71)	1.44
Post-treatment	9.17 (6.49)	5.11 (3.71)	2.21*
Anxiety & Insomnia			
Pre-treatment	9.12 (5.73)	5.57 (4.52)	2.30*
Post-treatment	9.16 (6.27)	5.17 (3.53)	2.27*
Social Dysfunction			
Pre-treatment	8.76 (2.87)	7.62 (2.04)	1.52
Post-treatment	9.33 (3.01)	7.08 (1.55)	2.83*
Severe Depression			
Pre-treatment	4.6 (5.38)	.91 (2.02)	2.97**
Post-treatment	5.17 (6.99)	1.53 (3.09)	2.17*

(*p<.05; **p<.01)

(Note: the number of mothers with children classified as borderline was too small to be included in the analysis).

Table 4.10 Unpaired t-tests for children whose mothers are 'clinical' (on the GHQ) and children whose mothers are 'non-clinical'.

	Children of clinical mothers		Children of non-clinical mothers		t-value
	mean	(S.D.)	mean	(S.D.)	
Total Score					
Pre-treatment	63.79	(9.13)	55.38	(12.79)	2.69*
Post-treatment	56.77	(10.18)	47.36	(11.76)	2.52*
Internalizing Scale					
Pre-treatment	56.5	(8.47)	51.29	(12.33)	1.76
Post-treatment	56.62	(10.22)	49.65	(1.22)	1.97
Externalizing Scale					
Pre-treatment	59.46	(12.05)	52.33	(10.85)	2.14
Post-treatment	53.62	(1.86)	46.52	(10.85)	1.96
Withdrawn					
Pre-treatment	6.43	(3.71)	4.05	(3.85)	2.19*
Post-treatment	4.31	(4.75)	2.36	(2.47)	1.70
Somatic Complaints					
Pre-treatment	1.96	(2.20)	1.52	(3.37)	.55
Post-treatment	1.31	(2.29)	.516	(1.21)	1.50
Anxious/Depressed					
Pre-treatment	8.25	(4.33)	5.05	(4.18)	2.60*
Post-treatment	5	(3.44)	3.48	(4.07)	1.18
Social Problems					
Pre-treatment	3.79	(3.35)	2.57	(3.20)	1.28
Post-treatment	3.39	(2.29)	1.97	(2.56)	1.72
Thought Problems					
Pre-treatment	1.89	(2.06)	1.10	(1.58)	1.48
Post-treatment	1.31	(1.49)	.42	(1.15)	2.14*
Attention Problems					
Pre-treatment	8.14	(5.30)	5.91	(5.05)	1.49
Post-treatment	6.39	(4.13)	3.77	(4.29)	1.86
Delinquent Behaviour					
Pre-treatment	3.36	(3.19)	2.19	(2.36)	1.41
Post-treatment	2.39	(2.66)	1	(1.39)	2.27*
Aggressive Behaviour					
Pre-treatment	13.29	(9.10)	8.67	(7.00)	1.93
Post-treatment	9.62	(8.29)	5.71	(5.68)	1.81

(*p<.01)

Studying the relation between children's behaviour problems and their mother's quality of life:

In studying the relation between the childrens' behaviour problems and their mothers' quality of life, the mothers' responses on the QoL were grouped into two categories according to their children's classification on the CBC; mothers of 'clinical' children and mothers of 'non-clinical' children (mothers of 'borderline' cases were excluded from the analysis due to small size (3) of the group). In investigating whether the two groups had significantly different scores on the QoL, unpaired t-tests were administered for all the QoL measures. At pre-treatment, mothers of 'non-clinical' children had significantly higher scores than mothers of 'clinical' children on only one measure: the Global well-being measure A. These results suggest that childrens' behaviour problems are related to their mothers' outlook towards life but not to other areas in the mothers' life quality.

At post-treatment, mothers of 'non-clinical' children had higher scores on three of the QoL measures: the Global well-being measure B, the Subjective Family Relations measure, and the Subjective Leisure measure. These results suggest that childrens' behaviour problems are related to their mothers' outlook towards life, to the mothers' family relations and leisure satisfaction. Tables 4.11 and 4.12 show the means, standard deviations and results of t-tests on QoL for the two groups at pre-treatment and post-treatment, respectively. Note that at post-treatment the number of mothers with 'clinical' children (6) was quite low.

The total behaviour problem scores (t scores) were correlated with the QoL measures both in the pre-treatment and post treatment set.

At pre-treatment, the total CBC had significant negative correlations with the following QoL measures: Global well-being measure A, and three of the Subjective measures; Family Relations, Leisure, and Health. These results suggest that childrens' overall behaviour problems are related to their mothers' outlook towards life, satisfaction with family relations, leisure time, financial situation, and health state.

At post-treatment, the total CBC had significant negative correlations with the following QoL measures: both Global well-being measures A and B, two of the Subjective measures; Family Relations and Leisure, and Objective Leisure measure. These results suggest that childrens' overall behaviour problems are related to their mothers' outlook towards life, satisfaction with family relations, leisure time, and the number of leisure activities in which the mothers engage in. Table 4.13 shows the correlations between the CBC total scale and the Quality of Life measures.

Table 4.11 Grouping the QoL results according to the childrens' classification on the CBC; means standard deviations and unpaired t-tests at pre-treatment.

	Clinical (n=25) mean (S.D.)	Non-clinical (n=21) mean (S.D.)	t value
Global well-being measures			
Measure A	4.2 (1.48)	5.14 (.87)	-2.57*
Measure B	4.76 (1.03)	5.02 (.88)	-.90
Subjective Indices			
Living Situation	4.6 (1.92)	5.33 (1.24)	-1.51
Social Relations	4.90 (1.28)	5.35 (1.00)	-1.33
Family Relations	5.12 (1.48)	5.75 (1.14)	-1.59
Leisure	4.2 (1.58)	4.81 (1.21)	-1.45
Finances	3.4 (1.38)	4.05 (1.36)	-1.59
Religion	4.92 (1.21)	5.29 (.85)	-1.16
Health	4.32 (1.27)	4.95 (1.31)	-1.66
Personal Safety	4.92 (1.15)	4.95 (1.12)	-.10
Objective Indices			
Frequency of Family Contacts	3.56 (1.04)	3.86 (1.01)	-.97
Frequency of Social Contacts	3.35 (1.01)	3.58 (.93)	-.81
Leisure	1.68 (.28)	1.74 (.23)	-.91

(* p< .05)

Table 4.12 Grouping the Quality of Life results according to the childrens' classification on the CBC; means standard deviations and unpaired t-tests at post-treatment.

	Clinical mean (S.D.)	Non-clinical mean (S.D.)	t value
Global well-being measures			
Measure A	4.25 (1.25)	5 (1.09)	-1.53
Measure B	3.83 (1.35)	5.24 (1.08)	-2.82*
Subjective Indices			
Living Situation	4.8 (1.10)	4.77 (1.86)	.03
Social Relations	4.97 (1.31)	5.19 (.99)	-.49
Family Relations	4.13 (1.63)	5.41 (.87)	-2.92*
Leisure	2.83 (1.84)	4.75 (1.21)	-3.22*
Finances	4.3 (1.99)	4 (1.70)	.36
Religion	4.75 (1.26)	5 (.80)	-.53
Health	4.08 (1.20)	4.70 (1.01)	-1.34
Personal Safety	4.33 (1.51)	4.83 (1.15)	-.86
Objective Indices			
Frequency of Family Contacts	3.5 (2.00)	3.93 (.96)	-.82
Frequency of Social Contacts	4.03 (1.17)	4.00 (.92)	-.09
Leisure	1.51 (.29)	1.70 (.34)	-1.22

(*p< .01)

Table 4.13 Correlating the Total Behaviour Problem scale of the CBC (t scores) with the QoL measures.

	Pre-treatment		Post-treatment	
	(df)	R	(df)	R
Global Well-being measures				
Measure A	(48)	-.36**	(43)	-.33*
Measure B	(48)	-.10	(40)	-.51***
Subjective Indices				
Living Situation	(48)	-.21	(37)	-.3
Family Relations	(48)	-.30*	(43)	-.02*
Social Relations	(48)	-.12	(43)	-.08
Leisure	(48)	-.28*	(34)	-.43**
Religion	(47)	-.21	(27)	-.22
Finance	(48)	-.27*	(38)	-.13
Safety	(48)	-.06	(24)	-.45*
Health	(48)	-.28*	(40)	-.32
Objective Indices				
Family Contact	(48)	-.22	(35)	-.15
Social Contact	(48)	-.07	(34)	-.03
Leisure	(48)	-.08	(35)	-.40*

(*p< .05; **p< .01; ***p< .0001)

Studying the relation between the mothers' mental health and their Quality of Life:

The relationship between the mothers' mental health and their quality of life was investigated by employing two approaches: firstly, the total score on the GHQ scale was correlated with the various quality of life subscales at pre and post-treatment, and secondly, the mothers were grouped into two groups. 'clinical' and 'non-clinical' according to their GHQ classifications, and t-tests were administered on the various Quality of Life subscales in order to investigate whether the two groups had significantly different scores from each other - this procedure was carried out both at pre and post-treatment. In order to investigate whether the two groups (classified at pre-treatment) were scoring significantly different than each other over time, a repeated measures ANOVA was administered on the Quality of Life subscales. For all tests, results were considered significant at 95%.

In correlating the GHQ total scale with the Quality of Life subscales, at pre-treatment only two of the Quality of Life subscales did not correlate significantly with the total GHQ score: the Religion subjective measure, and the frequency of social contacts measure (objective measure). At post treatment, only one Quality of Life subscale did not correlate significantly with the total GHQ score: the Religion subjective measure. For all significant correlations low scores on the total GHQ score correlated with high scores on the Quality of Life subscales. Table 4.14 shows the correlations between the GHQ total scale with the Quality of Life subscales at both pre and post-treatment. These results suggest that the mother's mental health is related to several areas in the mothers' life quality.

When the mothers were grouped according to their GHQ classifications, at pre-treatment, 'clinical' mothers had significantly lower scores than 'non-clinical' mothers on the following Quality of Life scales: Global well-being measure A, the Health subjective measure, the personal safety subjective measure, and the frequency of family contacts objective measure. 'Clinical' mothers had significantly higher scores than 'non-clinical' mothers on one of the Quality of Life measures: the Religion subjective measure.

At post-treatment, 'clinical' mothers had significantly lower scores than 'non-clinical' mothers on the following Quality of Life measures: the Global well-being measures A and B, social relations subjective measure, family relations subjective measure, leisure subjective measure, finances subjective measure, health subjective measure, and the number of leisure activities measure. Tables 4.15 and 4.16 show the results of the t-tests on the Quality of Life measures as grouped by the GHQ classifications, at pre and post-treatment respectively.

Considering correlations that were significant at both pre and post-treatment, these results suggest that a 'clinical' (on the GHQ) mental health state in the mothers is negatively correlated with the mothers' outlook towards life, satisfaction (subjective) with social relations, leisure time, finance, health, and also the number of family contacts and leisure activities.

**Table 4.14 Correlating the total score of the GHQ
with the QoL measures.**

	Pre-treatment		Post-treatment	
	(df)	R	(df)	R
Global Well-being measures				
Measure A	(51)	-.64***	(47)	.70***
Measure B	(51)	-.40**	(44)	-.70***
Subjective Indices				
Living Situation	(51)	-.38**	(41)	-.16
Family Relations	(51)	-.26	(47)	-.57***
Social Relations	(51)	-.29**	(47)	-.64***
Leisure	(51)	-.37**	(38)	-.72***
Religion	(50)	.11	(29)	.13
Finance	(51)	-.29*	(41)	-.37**
Safety	(51)	-.40**	(27)	-.20
Health	(51)	-.59***	(44)	-.62***
Objective Indices				
Family Contact	(51)	-.40**	(39)	-.46**
Social Contact	(51)	-.14	(38)	-.40**
Leisure	(51)	-.34*	(39)	-.41**

(*p< .05; **p< .01; ***p< .0001)

Table 4.15 Classifying Quality of Life results according to GHQ classification; t-tests for pre-treatment results.

	Clinical (n=30) mean (S.D.)	Non-clinical (n=22) mean (S.D.)	t value
Global well-being measures			
Measure A	4.22 (1.54)	5.07 (.82)	-2.36*
Measure B	4.71 (1.03)	5.07 (.82)	-1.37
Subjective Indices			
Living Situation	4.67 (1.77)	5.36 (1.50)	.141
Social Relations	5.06 (1.32)	5.32 (.81)	-.83
Family Relations	5.2 (1.52)	5.67 (.89)	-1.28
Leisure	4.33 (1.49)	4.82 (1.44)	-1.18
Finances	5.58 (1.52)	3.93 (1.26)	-.88
Religion	5.35 (.72)	4.72 (1.32)	2.14*
Health	4.28 (1.17)	5.16 (1.35)	-2.50*
Personal Safety	4.63 (1.25)	5.36 (.66)	-2.50*
Objective Indices			
Frequency of Family Contacts	3.3 (.99)	4.27 (.83)	-3.75**
Frequency of Social Contacts	3.41 (1.01)	3.55 (.81)	-.56
Leisure	1.68 (.26)	1.79 (.23)	-1.58

(*p< .05; **p<.0001)

Table 4.16 Classifying Quality of Life results according to GHQ classification; t-tests for post-treatment results.

	Clinical mean (S.D.)	Non-clinical mean (S.D.)	t value
Global well-being measures			
Measure A	3.96 (1.53)	5.38 (.85)	-4.81***
Measure B	4.07 (1.12)	5.59 (.97)	-4.26***
Subjective Indices			
Living Situation	4.42 (1.51)	5.13 (1.78)	-1.23
Social Relations	4.45 (1.12)	5.59 (.79)	-4.02***
Family Relations	4.43 (1.08)	5.65 (.83)	-4.23***
Leisure	3.15 (1.47)	5.27 (1.04)	-5.21***
Finances	3.08 (1.53)	4.29 (1.73)	-2.18*
Religion	5 (1.10)	5.11 (.81)	-.301
Health	3.75 (1.09)	5.08 (.67)	-5.04***
Personal Safety	4.64 (1.12)	4.71 (1.26)	-.15
Objective Indices			
Frequency of Family Contacts	3.5 (1.51)	4.14 (.89)	-1.69
Frequency of Social Contacts	3.74 (.98)	4.27 (.86)	-1.72
Leisure	1.49 (.29)	1.80 (.33)	-2.98**

(*p< .05; **p< .01; ***p< .0001)

Correlations with Satisfaction with the Service Questionnaire:

In this section responses on the Satisfaction with the Service Questionnaire (Health Visitor's Questionnaire) were transformed into Likert-type scale (1-2-3), with higher scores reflecting higher satisfaction with the service. The means of the responses were computed to the nearest third digit, and responses of the 'Not Applicable' category were not included in the analyses.

Correlating 'Improvement' on the CBC with satisfaction with the service:

In this section responses on the Satisfaction with the Service Questionnaire were grouped into 3 groups depending on the change of classification on the CBC from the pre-treatment set to the post-treatment. The three groups were; the 'Improved' group referring to children whose classification changed from 'clinical' to 'borderline' or 'non-clinical' (or from 'borderline' to 'non-clinical'), children who stayed 'non-clinical', and children who did not improve (remained 'Clinical' or remained 'Borderline'). In investigating whether the three groups had significantly different scores, a Factorial ANOVA was administered on the results of the Satisfaction with the Service Questionnaire. The three groups did not have significantly different scores from each other over time ($F(1,41) = 2.87, p > .05$).

Correlating change of classification on the GHQ with satisfaction with the service:

In this section the mothers were grouped into 3 groups depending on their change of classification on the GHQ from the pre-treatment set to the post-treatment set. Mothers who remained within their 'non-clinical' category were classified as 'Stayed non-clinical', mothers whose classification changed from 'clinical' to 'non-clinical' were considered 'Improved' cases, mothers who remained 'clinical' were classified as 'No improvement' cases, and mothers whose classification changed from 'non-clinical' on the pre-treatment set to 'clinical' on the post-treatment set were classified as 'Worsened'. In investigating whether the groups had significantly different scores a Factorial analysis was administered on the results of the Satisfaction with the Service Questionnaire. In this analysis the 'Worsened' cases were not included due to the small size of the groups ($n = 4$).

Mothers who 'Stayed non-clinical' had significantly higher scores than mothers who were classified as 'No improvement'. Table 4.17 shows the means and standard deviations for the three groups.

Table 4.17 Factorial analysis on classification changes on the GHQ and Satisfaction with the Service Questionnaire.

	Satisfaction with the Service		
	Mean	(S.D.)	F-test = 4.62
GHQ classification			
Stayed 'non-clinical'*	13	2.63	(.31)
Improved*	15	2.56	(.47)
No improvement*	11	.12	(.53)

(* The Fisher PLSD for the 'Improved' vs. 'No improvement' was .36, and for the 'Stayed non-clinical' vs. 'No improvement' it was .37; significant at 95%).

Note: When the 'Worsened' cases were included in the 'No improvement' group, there were no significant differences between any two groups. Moreover, when the 'Worsened' group (n=4) was included in the analysis as a separate group, this group had significantly higher scores (mean =2.65, S.D.=.186) than the 'No improvement' group (significant at 95%).

Correlating satisfaction with the service with attendance outcome:

In this section the mothers responses were grouped into two groups; mothers who were still attending the centre at the time of the second interview (n=22), and mothers who had completed the treatment (n=19). In investigating whether the two groups had significantly

different scores on the Satisfaction with the Service Questionnaire a t-test was administered.

Mothers who were still attending the centre at 3-4 months had significantly higher scores than mothers who had completed the service ($t= 4.21$, $df= 39$, $p< .05$). Mothers who were still attending had a mean of 2.611 ($sd= 0.34$), while mothers who have completed the service had a mean of 2.34 ($sd= 0.51$).

In investigating whether the frequency of visits was related to the satisfaction with the service, the number of attendances for each case was correlated with the Satisfaction with the Service Questionnaire. The correlation was not significant ($R= +.23$, $df= 40$, $p> .05$).

Comparing attending with discharged groups:

The number of cases which dropped out or never attended were too small to carry out a repeated measure analysis or a factorial analysis on the data of the CBC, GHQ, and the QoL. However, statistical analysis was carried out for cases which completed the treatment and cases which were still attending at the time of the second interview (which was 3-4 months after their first appointment).

CBC results:

In investigating whether the two groups had significantly different scores on the overall scores of the CBC test, an unpaired t-test was carried for both the pre-treatment and post-treatment sets. The two groups did not have significantly different scores on either set (Pre-treatment $t=2.31$, $df= 39$, $p> .05$; post-treatment $t= 1.19$, $df= 39$, $p>.05$). In investigating whether the two groups were scoring significantly different than each other over time a repeated measure ANOVA was administered. There were no significant differences between the two groups ($F(1,39)= 2.49$, $p>.05$), suggesting that no differences in rates of improvement existed between the two groups.

GHQ results:

In investigating whether the two groups had significantly different scores on the overall scores of the GHQ test, an unpaired t-test was carried for both the pre-treatment and post-

treatment sets. The two groups did not have significantly different scores on either set (Pre-treatment $t=0.55$, $df=39$, $p>.05$; post-treatment $t=0.23$, $df=39$, $p>.05$). In investigating whether the two groups were scoring significantly different than each other over time a repeated measure ANOVA was administered. There were no significant differences for the two groups ($F(1,39)=2.49$, $df=38$, $p>.05$), suggesting that no differences in rates of improvement existed between the two groups.

QoL results:

As the QoL did not have an overall scale, statistical analysis was carried out on the scores of the Global well-being measures A and B. In investigating whether the two groups had significantly different scores on the two measures an unpaired t-test was carried for both the pre-treatment and post-treatment sets. For measure A the two groups did not have significantly different scores on either set (Pre-treatment $t=.06$, $df=39$, $p>.05$; post-treatment $t=.06$, $df=39$, $p>.05$). For measure B the two groups did not have significantly different scores on either set (Pre-treatment $t=2.60$, $df=39$, $p>.05$; post-treatment $t=0.157$, $df=39$, $p>.05$). In investigating whether the two groups were scoring significantly different than each other over time a repeated measure ANOVA was administered for each measure. For measure A there were no significant differences for the two groups ($F(1,39)=0.26$, $p>.05$). For measure B there was a significant difference for the two groups; the group that completed the service had improved significantly more than the group who were still attending. Table 4.18 shows the means and standard deviation for the two groups.

Although there were no significant differences between the attending and the discharged groups, it is important to note that the second interview was conducted 3-4 months after the first appointment, which is the average time of attendance at this clinic. That is, most of the cases in the 'still attending' group were due to have been discharged imminently. (Had the second interview been conducted 5-6 months after the first appointment, the number of clients still attending would be less).

Table 4.18 Repeated measure ANOVA on Global well-being measure B of the QoL.

	Pre-treatment mean (S.D.)	Post-treatment mean (S.D.)	F test
Group attending for more than 3-4 months (n= 22)	5.11 (1.00)	5.00 (1.11)	5.75*
Group that completed treatment (n=17)	4.58 (.90)	5.13 (1.39)	

* significant at 95%.

Chapter Five

Discussion

This chapter is comprised of several sections that highlight the main findings and discuss the interpretation and implications of the results of this study. Firstly, an overall review of the children and the mothers' assessment is presented. This is followed by discussing the relationship between the children's behaviour problems and their mothers' mental health and quality of life, and also discussing the relationship between the mothers' own general health and quality of life. The results of the mothers' satisfaction with the service and the implications of using customer satisfaction in evaluating treatment are then reviewed. This is followed by a discussion of the sample's attendance outcome in relation to attrition issues raised by previous research. An overall review of the delivery of the service of this particular child and family centre is then provided and the design of the study and the generalisability of this study's results are discussed. Finally the implications of this study's findings for service delivery are discussed and suggestions for future research are presented.

Treatment Outcome:

In relation to children's treatment outcome, significant improvements in behavioural problems were observed. The significant improvements occurred on the CBC's overall scale scores, and on all subscale scores with the exception of the Internalizing scale. There were no deteriorations in classification for 'Non-clinical' children.

Only one third of the children were classified as 'Clinical' or 'Borderline' at pre-treatment. This is due to the classification procedure of the Child Behavior Checklist where 'Clinical' or 'Borderline' classification would require a large number of behavioural problems. So, a child presenting with one critical behavioural problem, such as enuresis, would not be classified as 'Clinical' or 'Borderline' on the CBC. (Further discussion to follow).

With regard to mothers' states, significant benefits for the mental health of the mothers and their outlook towards their lives in general seem to have occurred.

At pre-treatment, more than half of the mothers were classified as 'clinical' on the GHQ. For this group there was a 64% improvement over time. Of the mothers who were

classified as 'non-clinical', there was 20% deterioration. Thus, although there was an overall improvement in classification, disimprovement did occur in a small proportion of the sample.

In investigating changes in raw scores, highly significant improvements were observed on the total GHQ score and also on all the GHQ subscales. However, these improvements occurred only for the 'clinical' group. This is not surprising considering the low cut-off point for the classification of 'non-clinical' on the GHQ. The maximum improvement which could take place for a mother classified as non-clinical at pre-treatment was 4 points (4 to 0).

On the quality of life questionnaire, significant improvements were observed on the general life satisfaction (Global well-being measure A) and on the Social Contacts measure (Objective measure). The improvement in outlook with life as a whole may be a result of the mother's own contact with the clinic, but this cannot be confirmed due to the lack of a control group. One possible explanation is that improvements in the behavioural status of children improved the overall well-being of mothers. However, as shown in the following sections, the children's improvement were not correlated with the mother's improvements.

As to the increased frequency of social contacts, it is difficult to hypothesize whether it is related to contact with the clinic, whether it was an indirect result of the mothers' mental health improvement, or the results of other contributing factors. One possible explanation is that the frequency of social contacts is a result of improvements in the mothers' mental health. However, as shown in the following section, there was no consistent relationship between the mothers' mental health and the number of social contacts.

Mothers' mental health and quality of life:

The relationship between mothers' mental health and quality of life was investigated in two ways. Firstly, GHQ classifications were related to QoL subscale scores (GHQ pre-treatment with QoL pre-treatment, and GHQ post-treatment with QoL post-treatment). Secondly, raw scores on the GHQ were correlated with QoL sub-scale scores, pre- with pre- and post- with post.

The first approach indicated that mothers with low mental health problems are more satisfied in their outlook towards life and are more satisfied about their health than mothers with a higher number of mental health problems. The second approach yielded more

specific results, showing that low mental health problems in mothers is associated with high satisfaction in the mothers' outlook towards life, family relations, social relations, leisure, finance, health, and also with a high number of family contacts and a higher number of leisure activities.

The relationship between the childrens' behaviour problems and the mothers' mental health:

According to the classification thresholds of the CBC and the GHQ, there was a higher percentage of mothers classified as 'clinical' (58%) than children classified as 'clinical' or 'borderline' (33%). On the whole this gives the impression that the mothers are more in need of help than their children. However, these classifications are the functions of the diagnostic categories of each test. That is, the percentage of cases diagnosed as 'clinical' in each test depends on the recommended thresholds of classification of each test. Another point to be made in relating the classification categories of the children and their mothers' is that the two questionnaires, the CBC and the GHQ, are not investigating the same areas. The CBC investigates the number and intensity of the children's behaviour problems (as judged by the mother) while the GHQ investigates the mother's mental health state. While we would expect the two areas to be related, we are not comparing like with like. The two tests also differ in that the GHQ is a self report while the CBC relies on the mother's perception of her child's behaviour problems. Another point too is that the two tests differ in their methods of investigation. The CBC has a 3 point Likert type scale but investigates 117 behaviour problem areas, while the GHQ-28 version employed investigates 28 mental health areas and a 4 point Likert type scale was used. So the two questionnaires also differ in their sensitivity to change of symptoms over time.

While childrens' behaviour problems correlated significantly with their mothers' mental health, both at pre and post treatment, children's improvements and mothers' improvements did not correlate significantly. Note that significant improvements in the mothers' mental health were observed. However, the fact that the children and the mothers' improvement are not correlated should not be unexpected. After all, the matching in classification at pre-treatment between child and mother was not perfect, indicating that one party was 'clinical' while the other wasn't. So in some cases improvement was occurring for one party since only one party was classified as 'clinical' and thus could show improvement.

The previous approach studied the general relationship between the childrens' behaviour problems and their mothers' mental health. Specifically, which areas do the children and their mothers affect each other was also investigated. In studying the effect of the mothers' mental health on their childrens' behaviour problems, it seems that children of 'clinical' mothers have significantly more behaviour problems than children of 'non-clinical' mothers.

In studying the effect of the childrens' behaviour problems on their mothers' mental health, it seems that mothers of 'clinical' children differ from mothers of 'non-clinical' children in that they are likely to have a lower overall mental health, have more problems with regard to anxiety and insomnia, and be more depressed.

In conclusion, the more behaviour problems children have the lower the mental health of their mothers, and vice versa. This effect was studied in both directions in order to investigate whether both parties were being affected by each other. It would have been possible for example, for mothers of 'clinical' children to show no significant differences on certain aspects of mental health than mothers of 'non-clinical' children, while children of 'clinical' mothers might have had significantly more behaviour problems than children of 'non-clinical' mothers. This would have implied that mothers' mental health problems increases the likelihood of their children having behaviour problems but not vice versa. As it is, the cause and effect is mutual.

The relationship between the childrens' behaviour problems and the mothers' quality of life:

In investigating the effects of the childrens' behaviour problems on their mothers' quality of life, the mothers' responses on the QoL were analysed according to their childrens' classification on the CBC. The results indicated that mothers of 'clinical' children had a lower life quality than mothers of 'non-clinical' only with regard to their outlook towards life (Global measure A). (This analysis was not applied at post-treatment as the number of mothers of 'clinical' children (6) was too low for a significant analysis).

In investigating the general relationship between the childrens' behaviour problems and their mothers' quality of life the scores of the total behaviour problem scale were correlated with the scores of the Quality of Life measures. In selecting the correlations that were significant at both pre-treatment and post-treatment, it seems that low number of behaviour

problems in children is correlated with a positive outlook towards life by their mothers, and a satisfaction with family relations and leisure activities.

Satisfaction with the service:

The majority of the mothers (77%) were satisfied with the service as a whole and recognised its usefulness (70%). 80% of mothers also reported satisfaction with issues related to the therapy process, such as finding it easy to talk to the therapist. These figures are consistent with the generally favourable results of previous client evaluation research (Denner & Halprin, 1974; Goyne and Ladoux, 1973; Heinemann and Yudin, 1974). However, although it seems that mothers were generally satisfied with the service, a closer examination of their responses reveals a more complex picture.

When mothers were asked whether they would have liked to have been told more about managing their children, 43% chose a "No" response. It is difficult to know whether this result reflects the mothers' satisfaction with the advice they have received or that the mothers felt that they did not need advice in handling their children. Not all the mothers reported that they needed help in dealing with their children, as some of the mothers were apprehensive about the referral. For example, for two of the court referral cases, the children were referred to the centre for assessment. Both cases attended the centre more than once, but in both referrals the mothers did not think that their children needed help or that the mothers themselves needed help in dealing with their children (in both cases the children were classified as 'non-clinical'). This point applies to other type of referrals as 11% of the mothers thought that the issue of needing help in dealing with their children was not applicable to themselves. Mothers who did not think that they needed the service in the first place are probably likely to be indifferent in their reporting about the quality of the service. The point to make here is that in assessing the quality of the service, it would be advisable to separate mothers who wanted help about managing their children from mothers who did not think they needed the service in the first place.

In investigating whether the mothers' satisfaction with the service was correlated with their childrens' improvements, the service satisfaction results were correlated with changes in classification on the CBC. No significant correlations emerged. This indicates that mothers' satisfaction with the service is not related to improvements in their children.

In investigating whether the mothers' satisfaction with the service was correlated with their own mental health improvements, the service satisfaction results were correlated with

changes of classification on the GHQ. The analysis showed that the mothers who did not improve (i.e. remained 'clinical') were less satisfied with the service than mothers who had improved, and also less satisfied than mothers who remained 'non-clinical' (did not disimprove). These results show that the mothers satisfaction with the service was related to their mental health improvement. However, when the mothers were asked whether visits helped them to understand themselves better, 57% thought that this issue was not applicable to themselves. These figures are high, considering that there were significant improvements in the mothers' mental health. It seems possible therefore, that mothers were apprehensive in admitting that they needed help. A reason for this might be that the mothers were uncomfortable about a possible link between their children's behaviour problems and their own mental health problems. On the other hand it could be that the main improvements were occurring in the mothers who did admit that the mentioned issue is applicable to themselves. That is, it is possible that the correlation between mothers' improvements and satisfaction with the service is mostly applicable to the mothers who accepted/wanted therapy. The ideal analysis would be to investigate whether there were significant differences in mental health improvement between mothers who did think that the visits were related to themselves and mothers who did not think that the visits were related to themselves. This grouping could not be applied in this sample since the mothers were not specifically asked whether they thought that the visits were related to themselves. Furthermore, one would have to ensure that all the mothers in question have received treatment, which is not the case in this sample.

One important result in considering the mothers' responses on the various aspects of the service is that the mothers who were still attending the service at the time of the interview showed significantly higher satisfaction rates than mothers who had been discharged at the time of the interview. One could conclude here that a social desirability effect was taking place in the mothers who were still attending the service. However, it is possible that the mothers who were still attending the service were genuinely more favourable to the service (than mothers who had been discharged) as a result of having received more attention. In relating satisfaction to improvement, the ideal design would be to only interview patients who were no longer attending the service in order to eliminate the effects of social desirability.

In sum, the mothers' satisfaction with the service was not related to their childrens' treatment outcome but rather to their own mental health improvement. This result is substantiated if we note that the mother and children improvement are not correlated.

While some research has related satisfaction to improvements in health status (Fitzpatrick et al., 1987; Savage and Armstrong, 1990), others have found only a weak relationship between the experience of clients and outcome (Llewelyn et al., 1988). It has been stated that "satisfaction assesses a dimension other than success" as rated by both the patient and therapist (El-Guebaly, 1983, p.28).

In conclusion, close examination of the mothers' responses on the various issues relating to the service indicate that we can not take their responses on face value due to inconsistencies in responses. Furthermore, since the mothers' satisfaction with the service was not related to their children's improvement, it is concluded that in evaluating the quality of the service it would be misleading to consider only satisfaction on its own as an outcome measure of the assessment of the quality of care. (Discussed in more detail later).

Issues related to attrition:

The number of cases that dropped out of treatment (2) and the number of cases that did not attend (6) were too small to allow for any meaningful statistical analysis.

Considering previous research on attrition (see Chapter 1) several factors predict much higher rates of attrition for this sample. These factors are: referral source (Cohen and Richardson, 1970; Gaines, 1978; Lake and Levinger 1960; Ross and Lacey, 1961; Tuckman and Lavell, 1959), sex and age of the child (Cohen and Richardson, 1970; Ewalt et al., 1972; Ross and Lacey, 1961; Singh et al 1982; Tuckman and Lavell, 1959; Williams and Pollack, 1964), clinical descriptions of the child (Cohen and Richardson, 1970; Cole and Magnussen, 1967; Levitt, 1958; Litt, 1970; Ross and Lacey, 1961; Singh et al, 1982), and the child and the parent's attitude towards attending the clinic (Cohen and Richardson, 1970; Cole and Magnussen, 1967; Farley et al., 1975; Levitt, 1958; Singh et al, 1982). So in relation to research on attrition, the above factors did not have any significant influences on attendance in this study.

Other factors that have been associated with attrition but were not applicable with regard to this sample are: the socioeconomic status of the family (Cohen and Richardson, 1970; Ewalt et al., 1972; Fischer, 1975; Gaines, 1978; Lake and Levinger, 1960; Litt, 1970; Ross and Lacey, 1961; Singh et al., 1982; Tuckman and Lavell, 1959; Williams and Pollack, 1964). This sample was homogeneous with regard to this factor, not allowing statistical comparisons as the clinic is situated in an area of high corporation housing density. Although the clinic also serves a more privileged area 6 miles away from the clinic,

they formed a minority of cases (6) of which very few members could be considered to belong to a different socioeconomic class.

Another factor that was not in effect with regard to this sample was the effect of time on a waiting list (Cole and Magnussen, 1967; Gaines, 1978; Lake and Levinger, 1960; Litt, 1970). This clinic had an average waiting list of 3 weeks. Most clients were seen within a very short time of asking for an appointment making it impossible to study this effect within the sample.

Another factor that has been associated with attrition is distance from the clinic (Gaines, 1978; Tukman and Lavell, 1959). With regard to the cases in this sample that lived 6 miles away from the clinic none of these cases were dropouts or non-attenders, however, this group formed less than 10% of our sample making it too small to draw any significant conclusions.

Clients' preparation for treatment:

The results of the first interview are similar to those of Fitzgerald and Keenan (1991) who administered the same questionnaire to 46 consecutive referrals to the same Child and Family Centre. The two samples are similar with regard to: the amount of information received from the referrer, childrens' feelings about attending the clinic, length of time between referral and attendance at the Child and Family centre, and expectations of family versus individual assessment. One difference worth mentioning is that 87% of the mothers in this study were willing to tell their family or friends that they had attended a Child and Family Centre in comparison to 61% of the mothers in Fitzgerald and Keenan's study. At this point it is difficult to know whether this difference is a reflection of a genuine decrease in stigma in the community where the centre is situated.

About half of the mothers were doctor-referred. Of these cases 80% claimed that they have received no information on the service they were about to receive. While it would be difficult to confirm the validity of the mothers' responses, Ley and Spelman (1967) have shown that patients remember relatively little of their interview with a doctor, and it is possible that reports merely reflect a failure in retention of information. However, other research does not favour such explanations as Skuse (1975) suggested that general practitioners do not sufficiently prepare their patients for the psychiatric appointment they are arranging.

Overall, more than 70% of the mothers had no information on the service and did not know what to expect with regard to several aspects of the treatment, such as type of treatment or length of treatment. This number is very high considering the research that relates parents' expectations and attitudes towards the therapeutic process to treatment outcome (see Chapter 1). It would have been useful to have investigated whether realistic attitudes towards the service were related to improvement, however, the number of mothers who had realistic information on the service was too low for meaningful statistical comparisons.

It is obvious from this study that there is a need for pre-treatment preparation of patients. It has been shown that the majority of patient preparation techniques do significantly improve the mental health of the referred patients (Heitler, 1973). One approach would be for a social worker to visit the family after the referral has been made, and for the treatment preparation to be done in the home prior to the family attending the clinic. While this approach has the disadvantage of being time-consuming, and thus expensive, it saves waiting time for cases of non-attendance as the visitor can report to the centre whether or not the family will be attending their first appointment as many of the homes do not have a telephone.

Methodology and Measurement Issues:

One common criticism in evaluation of psychotherapy research is that the categorisation of clinical versus non-clinical cases, and of changes in the categorisation, is somewhat arbitrary (Garfield and Bergin, 1978). If the clinical threshold for a particular test is low, as is the case with the GHQ, then we are likely to get a high percentage of clinical cases. In this study more than half the mothers were classified as clinical on the GHQ. In contrast, only one third of children were classified as clinical on the CBC, a measure with a relatively higher clinical threshold. The somewhat arbitrary nature of thresholds also makes the detection of improvements difficult, if change in classification is the sole criterion employed. When the clinical threshold is too low, the evaluation may underestimate the benefits of the therapy, as movement from clinical to non-clinical would require vast improvements in behaviour. When the clinical threshold is too high the evaluation may overestimate the benefits of the therapy, as movement from clinical to non-clinical would require only few improvements in behaviour. For this reason close attention was paid to investigating improvement by employing two approaches; looking at changes in classification and also investigating significant changes in the childrens overall number of behaviour problems. However, both approaches suffer from an important drawback: both approaches detect improvement only in children with a high number of behaviour

problems. The improvement of children with one major behaviour problem, such as firesetting or enuresis, is not detected. Such cases would not be classified as 'clinical' in the first place. The assumption with this approach is that worrying or major behaviour problems in children are accompanied by others behaviour problems, which may not be the case for many referred children. The CBC currently assumes each behaviour problem has an equal impact on the child's adjustment. This is unlikely to be the reality for individual cases, with some problems (e.g. 'firesetting') having a greater impact than others (e.g. 'stores up things he/she doesn't need'). The CBC could be made more sensitive to important changes in the child's behaviour by having the mother weight each behaviour problem in terms of it's impact on the child's overall adjustment, rather than in isolation.

This Child and Family Centre has a policy of attending to every referred case, be it a self-referral or through a G.P. All cases are treated with the same urgency and are seen within 2-3 weeks of the date of referral, with the exception of suicide cases which are seen immediately. During weekly staff meetings, the particulars of each case are described, and allocation of cases to staff depends on the availability and suitability of the staff (e.g. psychiatrists are typically involved with cases where medication might be required). The distinction between 'clinical' and 'non-clinical' is not clear cut, and 'categorisation' as such, is not an issue that is deliberated upon. In drawing up a treatment plan, the staff aim to address the parent's concerns and work with the presenting problem/s. Cases are viewed more in terms of 'duration of treatment' than in terms of 'severity'. A 'suicide' case could be discharged after three visits while an 'enuretic' case might take twelve visits. Moreover, cases are discharged when both staff and the parent of the referred child agree that the mother can handle her child without the clinic's frequent support. The child might be still fall under the classification of 'clinical' on the CBC, as he/she did before attending the centre, but the case would be considered a success if the mother is better equipped to deal with her child's behaviour problem/s. So in dealing with each case over time, the involved staff subject a looser criteria of 'classification' and 'improvement' than the one measured in this study.

Since the staff used a looser criteria for classification than the one imposed by the CBC, a direct comparison between the CBC's 'clinical vs. non-clinical' classification against the Clinic's record would not be very definitive. However, in relation to uncovering behaviour problems in children, the CBC differs from the staff's assessment in that the CBC inquires about 118 behaviour problems, while the staff's assessment involves noting the information presented by the parent and then inquiring about the existence of other behaviour problems. Each staff would differ in their assessment approach. Some staff would have a list of child behaviour problems that they have devised, and they would go

through this list in every assessment, while other staff would vary the extensiveness of their inquiry depending on each case. Since inquiring about 118 behaviour problems takes about 30-45 minutes, the staff tend to collapse specific behaviour problems into more general problem areas. In this respect the CBC could be viewed to be more extensive and likely to uncover more behaviour problems than an assessment that does not employ a comprehensive list as the CBC. However, in all the 52 cases there was only one case in which the involved staff was unaware of the existence of a behaviour problem that was uncovered by the pre-treatment interview when the CBC was administered (child smears and plays with bowel movement). This shows that the staff were extensive in their assessments of the cases in this study.

In investigating the mothers satisfaction with the service there are a few points to be made in relation to the Health Visitor's Questionnaire. Although the questionnaire seems thorough in that it taps into various areas of treatment, the response format ("No" , "Possibly", "Yes", or "Not applicable") may be lacking sensitivity. In addition to the loss of precision this response format also produces results with ambiguous interpretations. For example, 43% of mothers chose a "No" response when asked if they wished for more information on handling their children. It is difficult to know how many of the mothers who responded with "No" were actually satisfied with the amount of advice they have received and how many thought that they did not need advice in the first place.

In correlating improvement (children and mothers) with the mothers' satisfaction with the service, the mothers' responses on the Health Visitor's Questionnaire were transformed into a Likert type scale ranging from 1 to 3. Because this was a small range, the overall satisfaction score (mean of all responses) was calculated to the nearest third digit. However, this is still an approximation of responses which were generalised in the first place. In order to achieve a more accurate picture of the mothers' satisfaction with the service, it would be necessary to administer an open ended questionnaire allowing for specific responses to particular situations. Since many of the responses would be too specific to generalise into an overall score, making it impossible to conduct any statistical correlations, it would be useful to administer another questionnaire having a Likert type scale with a larger range than the one used in this study.

The analysis of the mothers' responses of their satisfaction with the service highlighted the need for a more thorough and precise investigation in order to achieve an accurate picture of the mothers' satisfaction. However, even if we do achieve an accurate picture of the mothers' experience of the service, it would still be misleading to consider the mothers'

responses as the sole reflection of the effectiveness of treatment. There are few points to be made in relation to this:

- 1) The mothers' satisfaction with the treatment process could be misleading if the mothers had unrealistic expectations as to what treatment might constitute. In this sample most mothers had no previous experience with child guidance clinics and also did not know that this centre even existed.
- 2) The mothers' receptivity to treatment should also be taken into account. In some cases the mothers were resentful about having to attend the clinic and thought that neither they nor their children needed any type of help. These negative attitudes may produce a low level of satisfaction with the service, irrespective of its' quality. Court referrals are usually apprehensive about receiving treatment even if they did need help, fearing a less than favourable report on the mother's fitness in keeping her children. Also, for some of the school referrals the mothers were resentful for having to attend the clinic. In some of these cases the teacher did not allow the child into class until he/she was assessed at the clinic. The mothers saw this as a reflection of the teacher's inability to discipline the class and were resentful that their child could not attend school until he/she was seen at the clinic.

This study focused on a Child and Family centre that employs a broad therapeutic approach. So this study does not evaluate a specific treatment, but rather it evaluates the eclectic approaches employed by the staff involved with the referred cases. Kazdin (1988) identified 230 different forms of therapy that are in use with children. While many of these are used only rarely, the most commonly used theoretical models for therapy were psychodynamic (59% of respondents), behaviour modification (55%), and cognitive (49%). When Kazdin et al. (1990) asked the therapists to indicate which therapeutic approaches were "effective most or all of the time", they found that individual and family therapy were rated effective 79% and 59%, respectively. Effectiveness ratings were relatively high for behaviour modification (62%), psychodynamic therapy (52%), and cognitive therapy (50%). However, most child therapists surveyed by Kazdin, et al. (1990) described themselves as eclectic. The point here, is that in a non-specialised clinic setting, it is the presenting problem that dictates the type of treatment to be received. So as much as it would be useful to evaluate the effectiveness of a specific approach, it would not give us a picture of the overall functions of a clinic that deals with a wide array of problems.

One shortcoming of this research is the lack of a control group. While significant improvements were observed in both the childrens' behaviour problems and the mothers

mental health it could not be confirmed that these improvements would not have occurred without the treatment they received. In "Effects of psychotherapy with children and adolescents" (1993), Weisz and Weiss noted that "children who drop out of treatment may be an acceptable (though not ideal) naturally occurring control group for outcome research" (p. 75). Considering the low drop out rates of this clinic it would take 4 years for a group of 50 drop outs to form. However, as discussed in the first chapter, since it is difficult to assign no-treatment control groups in community settings, treatment outcome research with uncontrolled groups is quite common. This is even more the case with children and adolescent treatment outcome research where research in general is scarce

For practical reasons, the interval between pre and post treatment interviews were set at 3-4 months. While this period is sufficient to detect improvements in certain behavioural problems (e.g. enuresis), it is likely to have been too short to detect improvements in some behaviour problems (e.g. conduct disorder). Setting a longer interval between pre and post interviews, such as one year, can might also miss immediate effects of treatment, in that some problems may have improved and then disimproved within a one year period (e.g. sleeping problems), giving the impression that the intervention had no effect on the child's behaviour. Ideally, one should aim for two post-treatment interviews (3 repeated measures) to account for various changes in the different types of behavioural problems in children.

Overall Effectiveness of the Clinic:

On the whole, significant positive improvements were observed in both the children and their mothers. Although we can not take the mothers' satisfaction with the service as a measurement of the clinic's effectiveness, it should be noted that a high percentage of the mothers were satisfied with the overall service and also with various aspects of the treatment provided by the staff of the clinic. The clinic also had very low dropout rates (4% of all attenders dropped out of treatment), and also a short waiting list (2-3 weeks) in comparison to other Child and Family Centres. As mentioned earlier, considering previous research on attrition we would have expected a higher dropout rate in this centre.

As this study was longitudinal, the sample acted as their own control group, allowing for the detection of change over time. However, the design does not control for the possibility of change caused by factors other than intervention (e.g. natural remission of problems due to maturation). This flaw could possibly be remedied by interviewing a sample of children with behaviour problems receiving no intervention. Again, this was precluded by time and resource constraints.

Considering the very long waiting lists of other child and family centres (6 months in some centres), it should be welcome news that this centre has such a short waiting list. However, whether this is a reflection of the clinic's efficiency is a different matter. It may well be that a short waiting list reflects the staff's organizational skills but it could also be related to the fact that most of the community members which this centre was designed to serve are not even aware of the clinic's existence. If a considerable effort was made to inform the community members of the availability of this service, then the waiting list might not be so short.

Implications of Findings for Service Delivery:

The findings of this study point to a strong relationship between the childrens' behaviour problems and their mothers' mental health. Moreover, the administered questionnaires point to a higher percentage of improvement in the children than in the mothers. While this difference may be more a function of the diagnostic categories of each test, nevertheless, these findings point the fact that the mothers' are in need of help. At this point we do not know whether the childrens' conditions were a reaction to their mothers' conditions or whether the opposite is true (we assume it is both ways). For this reason it could not be established whether the mothers' condition will ease as their children improve or whether the children whose mothers did not improve will regress to their pre-treatment condition. This highlights the importance of the mother's condition in successfully treating referred children. It is suggested here that child therapists monitor the mothers condition and if needed refer for treatment. While this may be a common procedure in many child and family centres the importance of this procedure should be reaffirmed.

In relation to enhancing the clients' receptivity to treatment this study has shown that there is a need for pre-treatment preparation. It has been shown that the majority of patient preparation techniques do significantly improve the mental health treatment of the disadvantaged (Heitler, 1976). Fitzgerald and Keenan (1991) sees that it is worthwhile for child and family centres to train their referrers in these preparation of family techniques, such as attending to the clients' fears and grounding her/him in realistic expectations toward the service. This will apply to general practitioners, community care doctors, paediatricians, adult psychiatrists, social workers, and public health nurses. An alternative approach would be for a social worker to visit the family after the referral has been made, and for the treatment preparation to be done in the home prior to the family attending the clinic. This would be a much more time-consuming approach, and expensive particularly in a climate of economic stringency. All pre-treatment preparation interviews would include

discussions of the reasons for referral, and the assessment and treatment procedures to which the family would be exposed in the child and family centre.

A point of caution should be made here. Although efforts should be made in reaching those members of the community who are in need of the services but are unaware of its availability, such efforts should only be made if the centres' capabilities are being considered. A sudden overload of cases will render the centre understaffed, and will undoubtedly affect the effectiveness of the involved staff.

Suggestions for future Research:

The efficacy of the clinic in actually dealing with children's behaviour problems could be better assessed with a more sophisticated design (i.e. larger sample, non-intervention control group, more frequent interviews, larger study period). Interviewing both the staff and clients would provide multiple perspectives which could help identify areas that require further attention. The measures employed should also have a greater sensitivity to important changes in individual cases by allowing greater input from the person completing them. In investigating factors related to attrition, it would be more practical to select a Child and Family Centre with substantially higher rates of non-attendance and dropout than the 12% and 4% (respectively) of the studied centre.

In studying the customers' satisfaction with the service, a social desirability effect seemed to be taking place with clients who were still attending the centre at the time of the interview. In attempting to eliminate this social desirability effect, one approach would be to question the clients only after they have been discharged or considered dropouts. However, if the interviewer does not interview until the client has been discharged, some clients would have visited the centre a considerably higher number of times than other clients and thus be more favourable towards the service as a result of having received more attention. Moreover, even when interviews are conducted only after clients have been discharged the effects of social desirability could not be totally eliminated as many clients are aware that they might want to return to the centre at some time in future.

As pointed out earlier, this study shows that it is misleading to consider client satisfaction as a sole outcome measure of the assessment of the quality of care. This is not to diminish from the importance of the clients' opinions as they provide invaluable feedback to the staff involved in assessing clients' needs and in grounding the client in more realistic expectations. However, considering the increased need for service evaluation by health

board officials who are pressurised to make decisions on cutbacks, it is essential that these decisions are based on valid and reliable investigations rather than on shallow impressions.

Future service evaluations must be based on valid and reliable research so that the scarce resources available are used in the most beneficial way. The recommendations made in this study may in some way further this goal.

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Appendix

Description of sample:

1 - Boy, 10;	Hears voices, mother on medication for auditory hallucinations;
2 - Boy, 14;	Skips school;
3 - Girl, 12;	Slow child, obsessive handwasher;
4 - Boy, 12;	Court case, no complaints from mother;
5 - Boy, 9;	Steals at home, no other problems;
6 - Boy, 14;	Throws fits;
7 - Boy, 8;	Enuretic, physically abused by previous neighbours;
8 - Boy, 9;	Doesn't eat well, football coach told him to lose weight, no problems on CBC;
9 - Girl, 13;	Sexually abused by teacher 4 years earlier;
10 - Boy, 7;	Mother worried that son acts feminine;
11 - Girl, 11;	Grandparents died during six months previous to referral, shivers in bed;
12 - Boy, 13;	Skips school, disruptive, anxious, ran away from home;
13 - Boy, 7;	Uncommunicative in school, no other problems ;
14 - Girl, 7;	Put back a class, prefers to play with younger children;
15 - Girl, 4;	Introverted, mother worried that her daughter has been affected by witnessing domestic violence;
16 - Girl, 4;	Lovable child, plays with genitals in public, fears sexual abuse of a neighbour girl;
17 - Boy, 8;	Court case, no complaints from mother;
18 - Girl, 3;	Enuretic, mother acquiring about effects of divorce on child;
19 - Girl, 12;	Lethargic, poor relations with adoptive aunt;
20 Boy, 12;	Temper tantrums, poor school work, mother and child do not connect;
21 Girl, 9;	Slow learner, doesn't eat well, unhappy;
22 Boy, 12;	Disruptive, over-sensitive;
23 Girl, 7;	Mother worried that her child gets teased about her colour (child isn't coloured);
24 Boy, 8;	Poor concentration, lacks confidence, sudden changes in mood, teased by other children;
25 Boy, 8;	Perfect child, gets headaches, on medication;

- 26 Boy, 9; Difficult to manage, swallows all sorts of stuff, enuretic, teased by mates;
- 27 Boy, 12; Enuretic, functions on one-to-one basis only, attitude problems, prefers playing with older children;
- 28 Boy, 9; Poor school work, jealous of mother going out with men;
- 29 Boy, 5; Child witnessed mothers' physical abuse by previous husband;
- 30 Boy, 14; Girl shop-lifts, doesn't want to go to school but wants to work;
- 31 Boy, 7; Slow learner, no other problems;
- 32 Boy, 8; Discipline problems in school, used to have nightmares but not disclose content;
- 33 Boy, 15; Obsessed with getting cancer and losing his hair;
- 34 Boy, 6; Mother worried that son likes to wear girl's clothes, stable home;
- 35 Girl, 14; Witnessed fathers' fatal heart attack six months previously and has been feeling nauseas since;
- 36 Girl, 12; Fidgety, lives in boarding school, plays with children younger than her;
- 37 Boy, 10; Slow learner, mother has panic attacks;
- 38 Boy, 8; Speech problems;
- 39 Girl, 11; Disruptive, mother is single with five children;
- 40 Girl, 6; Behaviour problems in school, depressed mother;
- 41 Boy, 14; Tongue-tied, no other problems, stable home;
- 42 Boy, 14; Skips school, mother is single;
- 43 Boy, 6; Enuretic, mother is single and has a good relationship with child;
- 44 Boy, 8; Bullied at school, occasionally gets into fits with a weird laughter;
- 45 Girl, 9; Slow in school, demands attention, cries a lot;
- 46 Girl, 6; Enuretic, no other problems;
- 47 Boy, 13; Somatic problems, mood changes, tension between parents;
- 48 Boy, 9; Speech problems, lives with stressed mother who has five children;
- 49 Boy, 5; Takes frustrations out on mother, parents separated,
- 50 Boy, 5; Disruptive, single mother with a minor offences record;
- 51 Girl, 9; Obsessed with somatic pains since a fall the previous month, frightened of teacher (teacher has attended a psychiatric hospital and had complaints from 28 parents);
- 52 Boy, 4; Disobedient at pre-school, mother thinks he's bored, he has calmed down since he has been reading.

Adapted version of Lehman's Quality of Life Questionnaire:

For the Global well-being Measure A and for all the Subjective measure questions, statements were read out and clients would chose one of the following responses: terrible, unhappy, mostly dissatisfied, mixed (equally satisfied and dissatisfied), mostly satisfied, pleased, or delighted. The responses were then transformed to a 7-point scale (1-7).

Global Well-being section:

"How do you feel about life as a whole?" (B1 and L1).

In Measure B clients were asked to choose on a 1-7 scale "Which box (1-7) for each pair of words best describes what you think about your life in general? ; 'boring-interesting'; 'enjoyable-miserable'; 'useless-worthwhile'; 'full-empty'; 'discouraging-hopeful'; 'disappointing-rewarding'; 'brings out the best in me-doesn't give me a chance'".

Subjective Indices:

Living situation:

"How do you feel about your living arrangements?".

Family relations:

"How do you feel about your family in general?";

"How do you feel about the way you and your family act toward each other?";

"How do you feel about the way things are in general between you and your family?".

Social Relations:

"How do you feel about the things you do with other people?";

"How do you feel about the amount of time you spend with other people?";

"How do you feel about the amount of friendship in your life?".

Leisure:

"How do you feel about the way you spend your spare time?".

Religion:

"How do you feel about your religious faith?".

Finance :

"How do you feel about the total amount of money you get?";

"How do you feel about how much money you have to spend for fun?".

Safety:

"How do you feel about your personal safety?".

Health:

"How do you feel about your physical condition?";

"How do you feel about your emotional well-being?".

Objective Indices:**Family relations:**

"Not including the relatives you live with, how often do you get together with a member of your family?". Clients choose one of the following responses: once a week; at least once a week but not daily; at least once a month but less than weekly; less than once a month but at least once a year; not at all in the past year. (Scored 5, 4, 3, 2, 1 respectively).

Social Contact:

In this section the following statements describing the clients were read out and clients would choose one of the following responses: about daily, about weekly, about monthly, less than monthly, never (scored 5, 4, 3, 2, 1 respectively):

"Try to make friends with others?";

"Sit and talk with friends?";

"Spend time with someone you consider more than friend (e.g. boyfriend, girlfriend, best friend)?".

Leisure:

This section begins with the following question: "Which of the following things have you done during the past week?". Clients choose one of the following responses: "No", "Yes my on own", or "Yes with others" (scored 1, 2, 3 respectively) to the following statements:

1. Went for a walk;
2. Went to a movie or a play;
3. Watched TV;
4. Went shopping;
5. Went to a restaurant or a coffee shop;
6. Went to a bar;
7. Read a book, magazine, or newspaper;
8. Listened to a radio;
9. Played cards;
10. Went for a ride in bus or car;
11. Prepared a meal;
12. Worked on a hobby;
13. Played sport;
14. Went to a meeting of some organization or social group;
15. Went to a park;
16. Went to a library.

Health:

"In general what would you say your health was like?"

Clients choose one of the following responses; Excellent, Good, Fair, Poor (scored: 4, 3, 2, 1 respectively).

Audit of a Child and Family Centre

Moukaddem S., Fitzgerald M., Barry M.

Introduction:

Interest in child development is by no means new. Yet only recently has the study in children benefited from advances in both clinical and scientific research (Weisz and Weiss, 1993).

There has been little research on the services offered, and in relation to Child Guidance units in particular there is a paucity of resource that presents information in an authoritative, systematic and disseminable fashion. The importance of auditing the services of Child and Family Centres is highlighted when considering McKee's (1989) remark: "When a unit does not know what it is doing, it cannot know whether it is doing it well".

The aim of this study is to redress the lack of research in describing the work of Child and Family Centres by reporting the audit of a clinic set in a Dublin rural area. This audit relates to both the referred cases and the staff's involvement with these cases.

Method:

The study focused on 52 consecutive referrals who had no previous contact with the Child and Family Centre, but may have had contact with other psychiatric services. Mothers of children referred to this clinic were interviewed at their homes about a week before their first appointment, and again 3-4 months later, irrespective of whether they have attended the centre, were still attending the centre, or have finished treatment. The pre-treatment interview investigated the mothers' attitudes and expectations towards treatment by administering the First Interview Questionnaire. The questionnaire was designed and employed in a previous study investigating families expectations of a child and family centre (Fitzgerald and Keenan, 1991). The questionnaire is made of 28 open-ended questions probing into the following issues: referral source; information received from the referrer; expectations and fears about attending the child and family centre; type and length of treatment expected; stigma of attending a child and family centre; and length of time between referral and assessment at the child and family centre. The second interview investigated the mothers impressions of the service by administering the Health Visitor Questionnaire (Nicole et al, 1986). The questionnaire explores various aspects of treatment such as: overall usefulness of the treatment; the mothers' coping with her child, her family,

and herself; satisfaction with the type and amount of advice received; the mothers' handling of the therapy sessions; satisfaction with the frequency of visits.

The staff's involvement with these cases was audited over this 3-4 months period, in terms of time spent with these cases and also in terms of financial cost. The staff filled time sheets for each case they were involved with, noting type of activity and the time they spent on each activity down to the nearest 15 minutes. The various activities noted were: assessment, individual therapy, family therapy, home visits, waiting time when clients did not attend their appointments, and administrative work which included phone calls, writing letters, and discussions of the cases. The staff were reminded to fill their time sheets two times a week on a regular basis. In calculating the cost of each case the salary of each member of staff was calculated per minute (to the nearest 6 digits) and multiplied by the time spent on each particular case. It should be stressed here that the resulting figures do not reflect the overall cost of these cases as they do not include the cost of the overheads. Also note that 22 clients were still attending four months after their first appointment.

Setting:

This child and family centre accepts self-referrals, unlike other clinics which require self-referrals to be referred by general practitioners. The staff that were involved with the referred cases included; 1 Consultant Child Psychiatrist, two non-consultant hospital doctors, two social workers, and one speech therapist. In some cases more than one member of staff was involved. The clinic has no inclinations to any particular forms of therapy or school of thought, but rather aims at a broad mode of family therapy which encompasses individual therapy. The Child and Family Centre was situated in a disadvantaged area with high unemployment rates. A high percentage of the clients were in houses that were Corporation owned and in an area of high housing density.

Sample:

As more than half of the mothers of the referred children were single mothers, the study focused only on the mothers as a source of information on the referred children. Out of the 52 referred children the number of boys referred (35=67%) was slightly more than double the number of girls referred (17=33%). The average age of children was 9, with ages ranging from 3 to 16 years of age. The average age of the mothers was 36, with ages ranging from 25 to 49 years of age.

Results of Characteristics:

Attendance outcome:

The attendance outcome for the 52 cases was as follows; 22 cases (42%) were still attending at the time of the second interview (3-4 months after first interview), 22 cases (42%) were discharged at the time of the second interview, 2 (4%) cases had dropped out of treatment, and 6 cases (12%) did not attend any of their appointments. Table 1 shows the attendance outcome for the 52 cases.

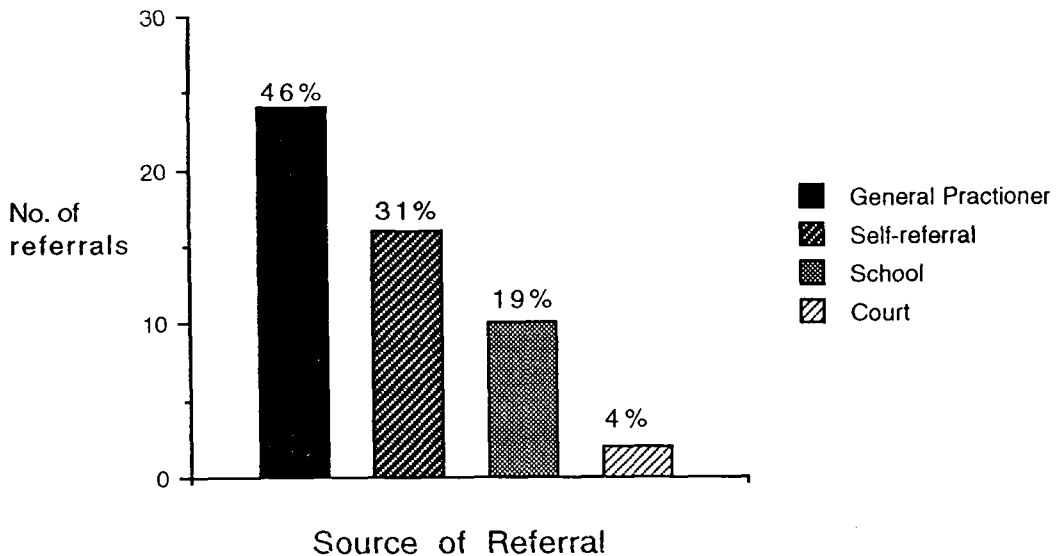
Referring agencies:

The biggest group referring were general practitioners who accounted for 46% of all referrals (24 families), followed by 31% (16 families) of self referrals, followed by school referrals accounted for 19% (10 families) of all referrals, followed by 2 court related cases (4%). Figure 1 shows the rate of referrals for this sample.

Table 1. Attendance Outcome.

	No. of cases	Percentage
Attending (after 3-4 months)	22	42%
Discharged	22	42%
Dropped out	2	4%
Did not attend	6	12%

Figure 1. Patterns of referrals.



Attitudes and expectations towards treatment:

The interviewer paid home visits to mothers of 52 consecutive referrals to the Child and Family Centre. The response rate to this questionnaire was 100%.

Information received from the referrer:

66% of the mothers received no information about the Child and Family Centre, while 31% said they were briefed about the clinic. Of the mothers that were doctor-referred (about half the sample), 80% said that they had received no information on the service.

Childrens' feelings about attendance:

45% of the children were not told of the appointment at the time of the interview (the interviews were conducted 3-7 days prior to appointment). Of the children who were told about their appointment 41% were unhappy about the visit to the centre, 8% thought it was similar to a mental hospital, and 8% thought it was a place for punishment.

Parents' feelings about attendance:

When the mothers were asked whether they were upset or resentful about attendance, only 21% answered "Yes". 34% of the mothers felt that they have let themselves down as parents.

28% of the mothers saw the problem as being the child's while 72% saw the problem as being the family's.

30% of the mothers' partners were unhappy about the visit to the centre, while the remaining 70% had no objections.

Receptivity to treatment:

95% of the mothers thought that the clinic would advise better than a 'parent or a grandmother', while 4% did not hold that view.

When asked whether they thought the clinic will help, 63% of the mothers answered "Yes", 30% were 'hopeful', and 6% said "No".

Expectations about attendance and treatment:

77% of the mothers had no information on the clinic; 14% had a positive view, 11% had negative views, and 74% of the mothers had realistic expectations about the service. 85% of the mothers imagined the treatment would involve some form of "talking", while 15% had no idea what the treatment might involve. 95% of the mothers did not think that the centre would use any medication.

69% had no ideas about length of treatment, 14% of the mothers thought the treatment would take 1 month, 7% thought it would take about 3 months, and 7% thought it would take more than six months. One mother expected one visit would suffice as it was related to court procedures.

When the mothers were asked who they would see at the clinic, 34% responded "I don't know", 30% said "A doctor", 8% said "A psychiatrist", and 27% said "A psychologist".

When the mothers were asked what did they expect from the clinic regarding the child's problem, 4% answered "Assessment", 8% answered "I don't know", and 87% had general positive remarks ("help the child", "sort him/her out" etc.).

Stigma about attending the clinic:

12% of the mothers said that they would not tell family or friends that they are attending the clinic, while 87% said that they would.

Time between wish for help and asking for an appointment:

25% of the mothers said that they have requested an appointment within 1 week of wishing for help, 28% requested their appointments within 3 weeks, 25% within 1 month, 14% within 2 months, and 6% within 3 months or more.

Expectations about waiting time at the clinic:

When asked how long the mothers expected to wait at the clinic before they were seen, 42% said that they would be seen immediately, 35% said "I don't know", 19% thought that they would wait for an hour, and 3% thought that they would wait for about three hours. (In this centre clients are seen immediately, with rare exceptions).

Preferences about therapy:

33% of the mothers said that they would prefer to be seen alone, 60% preferred to be seen with the child, and 6% preferred to be seen with the whole family.

When asked weather the mothers had a preference to seeing a male or a female doctor, 87% had no preferences. Of the 5 cases that did have a preference, 4 preferred a female doctor and 1 preferred a male doctor. 1 mother gave no reason for her preference and the remaining 4 had reasons specific to the case (e.g. girl abused by male, or boy relating more to a male doctor).

Convenience in attending the centre:

When the mothers were asked whether they had to make any special arrangements in order to attend the centre, 82% said that they did not have to make any special arrangements, while 17% said that they did have to make arrangements (hiring a baby-sitter, taking time off work etc.).

Efficiency of appointments:

10% of the mothers said that they have received an appointment within 5 days of requesting an appointment, 49% received their appointments between 6 to 10 days, 23% between 10 days and 2 weeks, 4% between 2 and 3 weeks, and 13% between 3 weeks and 1 month. 10% of the mothers said that they would like 5 days notice, 80% said that they would like 1 week notice, and 10% said that they would like 10 days notice.

Satisfaction with the service (Health Visitor Questionnaire):

For this questionnaire statements about treatment they received were read out to the mothers and they responded "Yes", "Possibly", "No", or "Not applicable (N/A)". Although some questions were straight forward in that one would not expect a "Not applicable" response, in some cases, the mothers felt that their children were referred for a 'report' rather than for treatment.

Improving coping with the child:

More than 50% of the mothers felt that the visits had improved their coping with their children's problems. However, more than 10% of the mothers felt that this issue was not applicable to their cases as they did not perceive that they needed help in this area.

Improving coping with the family:

Mothers who felt that the visits were useful for the family as a group was no more than 20% of all the mothers. About 65% of the mothers felt that they did not need help in that area.

Benefit by the mother:

25% of the mothers thought that the visits helped them and 29% thought that the visits helped them to 'understand their own reactions to things better'. Many of the mothers felt that the issue was not applicable to themselves.

Usefulness of treatment:

70% of the mothers thought that 'it helped to have someone to talk to', 48% of the mothers thought that the 'meetings were useful to them in seeing that other people may have similar difficulties. A small percentage of the mothers felt that the visits were not useful (20%) and were a waste of time (11%).

Overall benefit:

77% of the mothers found the visits 'helpful on the whole', 13% didn't agree, and 9% answered "Possibly" (no mothers answered "N/A").

Satisfaction with the therapy process:

84% of the mothers found it 'very easy to talk to the social worker/doctor'. Only a small percentage of the mothers (16%) thought 'too many questions were asked' and 16% found it 'difficult to see the point of some of the things brought up. And 10% thought that 'other family members should have had a chance to join in the discussions'.

Wanting more advice:

41% of the mothers 'would have liked more advice', and 32% of the mothers 'would like to have been told more about handling their children'.

Handling therapy:

18% of the mothers 'felt upset after the discussions', and 20% of the mothers 'worried about what had been discussed'.

Frequency of visits:

25% of the mothers felt that there not enough visits and only 4% of the mothers thought that 'fewer visits would have been more useful .

Table 2 shows the questions as asked to the mothers of the referred children along with the breakdown of responses.

Table 2. Satisfaction with the service (Health Visitor Questionnaire).

	No	Possibly	Yes	N/A
Improved coping with child:				
It helped me to think of ways to cope with my child	27%	4%	57%	11%
It helped me to think of ways to understand my child more	30%	2%	54%	14%
It helped me to think of ways to cope with behaviour difficulties in my child	27%	9%	46%	18%
It helped me to understand my child better	36%	19%	36%	9%
It helped me to think of ways to cope with my child's sleep or eating problems	11%	2%	14%	73%
Improved coping with family:				
It helped me to understand things about the whole family	18%	2%	21%	59%
The meetings were useful to us as a family group	14%	4%	9%	73%
Benefit by mother:				
It helped me to understand myself more than before	14%	4%	25%	57%
It helped me to understand my own reactions to things better	32%	7%	29%	32%

	No	Possibly	Yes	N/A
Usefulness of treatment:				
It was just talk and not really useful	66%	11%	21%	2%
It helped me to have someone to talk to	20%	5%	70%	5%
Discussions like that are just a waste of time	77%	9%	12%	2%
The meetings were useful to me in seeing that other people may have similar difficulties to me	25%	11%	48%	16%
Overall benefit:				
I found it helpful on the whole	14%	9%	77%	0%
Satisfaction with the therapy process:				
Too many questions were asked	75%	5%	16%	4%
It was difficult to see the point of some of the things brought up	70%	7%	16%	7%
Other family members should have had a chance to join in the discussions	34%	2%	10%	54%
It was very easy to talk to the worker (social worker or health visitor)	7%	7%	84%	2%
Wanting more advice:				
I would have liked more advice	50%	2%	41%	7%
I would like to have been told more about handling my children	43%	16%	32%	9%
Handling therapy:				
I sometimes felt upset after the discussions	77%	4%	18%	0%
I worried over what had been discussed	73%	5%	20%	2%

	No	Possibly	Yes	N/A
Frequency of visits:				
There were not enough visits to be really useful	52%	14%	25%	9%
Fewer visits would have been better	89%	2%	5%	4%
The visits would have been more useful if they had been more frequent	55%	13%	25%	7%
Convenience of visits:				
I found the visits inconvenient	84%	5%	9%	2%

Staff audit:

Of the fifty two cases, six patients did not attend any of their appointments and of the 46 attenders two time sheets could not be located. The following is a breakdown of the types of activities the staff were involved in along with their costs.

Case Assessment:

The average time spent on assessment per case was 80 minutes averaging to £20.42. The minimum time spent on assessment was 20 minutes costing £7.20. The maximum time spent on assessment was 2 hours costing £63.29. All 44 cases were assessed.

Individual Therapy:

Of the 44 cases 25 had individual therapy. The average time of individual therapy for each case was 1 hour and 56 minutes averaging to £24.64. The minimum time per minute for the cases was 10 minutes averaging to £1.84. The maximum time was 3 hours and 45 minutes averaging to £63.29.

Family Therapy:

Of the 44 cases 19 received family therapy. The average time of family therapy was 1 hour 34 minutes averaging to £27.81. The minimum family therapy received was 30 minutes costing £5.53. The maximum family therapy received was 3 hours 5 minutes.

Home Visits:

Only four cases received home visits. The average time was 1 hour 33 minutes costing £28.57. The minimum received was 1 hour costing £23.42 while the maximum was 3 hours costing £38.62. These costs include travel expenses.

Administrative Work:

Administrative work was recorded for 28 of the 44 cases. The average time spent was 34 minutes costing £9.65. The minimum time spent was 5 minutes costing £.87 while the maximum time was 2 hours 40 minutes.

Non-attendance Wasted Time:

Of the 44 cases 10 clients missed one or more appointments. The average cost was £34.28 (1 hour 42 minutes). The minimum cost was £10.54 (1 hour), while the maximum cost was £158 (3 hours 20 minutes).

Table 3 shows the type of activity the staff were involved in along with the number of cases receiving these activities, and the average, minimum and maximum time spent by staff and their cost.

Overall Costs:

The sum of attendance for all the cases was 142. The overall cost for these cases was £2719.33 averaging £19.15 for one appointment. The average cost per case was £61.79 (4 hours 1 minute of staff time). The minimum cost was £9.01 (25 minutes), while the maximum cost was £268.98 (10 hours.5 minutes).

As mentioned earlier these figures do not take into account the cost of the overheads as this report is more concerned with looking at the breakdown of activities of the staff. However, if we do take into account the budget out turn for this Child and Family Centre for the year 1991 (£285,824) along with the number of attendances for that year (5625), then the average cost per attendance is £50.81.

Activities of the Staff:

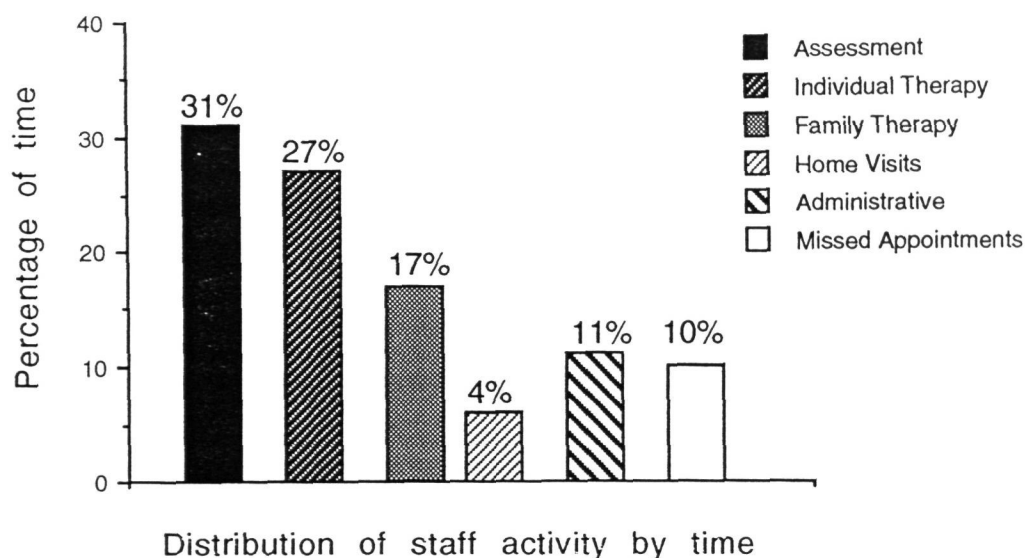
The breakdown of the staff's activities is as follows; the staff spend 31.34 % of their time on patient assessment, 27.30 % of their time on individual therapy, 16.82% of their time on family therapy, 3.52 % of their time on home visits, 11.41% of their time on administrative work, and 9.58 % of their time waiting for clients who do not attend their appointments.

Figure 2 shows the distribution of the staff's activities.

Table 3. Breakdown of staff activity by time and cost.

Type of activity	Number of cases	Average minutes	Average cost	Minimum minute	Minimum cost	Maximum minute	Maximum cost
Case Assess.	44	80	£20.42	20	£7.20	120	£63.29
Ind. Th.	25	116	£24.64	10	£1.84	285	£63.29
Fam. Th	19	94	£27.81	30	£5.53	245	£75.68
H.V.	4	93	£25.87	60	£21.62	180	£33.22
Admin.	28	43	£9.65	5	£0.87	160	£48.65
D.N.A.	10	102	£34.28	60	£10.54	300	£158.2

Figure 2. Distribution of staff activity by time.



Discussion:

The results of the first interview are similar to those of Fitzgerald and Keenan (1991) who administered the same questionnaire to 46 consecutive referrals to the same Child and Family Centre. The two samples are similar with regard to: the amount of information received from the referrer, childrens' feelings about attending the clinic, length of time between referral and attendance at the Child and Family centre, and expectations of family versus individual assessment. One difference worth mentioning is that 87% of the mothers in this study were willing to tell their family or friends that they had attended a Child and Family Centre in comparison to 61% of the mothers in Fitzgerald and Keenan's study. At this point it is difficult to know whether this difference is a reflection of a genuine decrease in stigma in the community where the centre is situated.

About half of the mothers were doctor-referred. Of these cases 80% claimed that they have received no information on the service they were about to receive. While it would be difficult to confirm the validity of the mothers' responses, Ley and Spelman (1967) have shown that patients remember relatively little of their interview with a doctor, and it is possible that reports merely reflect a failure in retention of information. However, other research does not favour such explanations as Skuse (1975) suggested that general practitioners do not sufficiently prepare their patients for the psychiatric appointment they are arranging.

Overall, more than 70% of the mothers had no information on the service and did not know what to expect with regard to several aspects of the treatment, such as type of treatment or length of treatment. This number is very high considering the research that relates parents' expectations and attitudes towards the therapeutic process to treatment outcome. How an individual perceives the agencies created to help deal with problems is one very important element in the complex social process of seeking help (Morris et al., 1973). Overall and Aronson (1964) found that clients whose expectations are less accurate are less likely to return and that such clients are less likely to be satisfied by the treatment received. It has been found that referrers may be able to influence clients' expectations of the clinic. A positive source of referral increases the confidence of the clients in the agency (Rosenfeld, 1964).

It is obvious from this study that there is a need for pre-treatment preparation of patients. It has been shown that the majority of patient preparation techniques do significantly improve the mental health of the referred patients (Heitler, 1973). One approach would be for a social worker to visit the family after the referral has been made, and for the treatment preparation to be done in the home prior to the family attending the clinic. While this approach has the disadvantage of being time-consuming, and thus expensive, it saves waiting time for cases of non-attendance as the visitor can report to the centre whether or not the family will be attending their first appointment as many of the homes do not have a telephone.

Satisfaction with the service:

The majority of the mothers (77%) were satisfied with the service as a whole and recognised its usefulness (70%). 80% of mothers also reported satisfaction with issues related to the therapy process, such as finding it easy to talk to the therapist. These figures are consistent with the generally favourable results of previous client evaluation research (Denner & Halprin, 1974; Goyne and Ladoux, 1973; Heinemann and Yudin, 1974). However, although it seems that mothers were generally satisfied with the service, a closer examination of their responses reveals a more complex picture.

When mothers were asked whether they would have liked to have been told more about managing their children, 43% chose a "No" response. It is difficult to know whether this result reflects the mothers' satisfaction with the advice they have received or that the mothers felt that they did not need advice in handling their children. Not all the mothers reported that they needed help in dealing with their children, as some of the mothers were

apprehensive about the referral. For example, for two of the court referral cases, the children were referred to the centre for assessment. Both cases attended the centre more than once, but in both referrals the mothers did not think that their children needed help or that the mothers themselves needed help in dealing with their children. This point applies to other type of referrals as 11% of the mothers thought that the issue of needing help in dealing with their children was not applicable to themselves. Mothers who did not think that they needed the service in the first place are probably likely to be indifferent in their reporting about the quality of the service. The point to make here is that in assessing the quality of the service, it would be advisable to separate mothers who wanted help about managing their children from mothers who did not think they needed the service in the first place.

As pointed out earlier, this sample had very little information on the service they were about to receive. Considering the research that have found that clients whose expectations are less accurate are less likely to return and that such clients are less likely to be satisfied by the treatment received (Overall and Aronson, 1964), this sample had very low attrition rates and generally high satisfaction with the service.

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Irish Families Under Stress (Summary).

Michael Fitzgerald.

Studies to determine the percentage of children in the community who have psychiatric disorders are critical in a country like Ireland¹ with a high proportion of children in the population.

Ireland has a developing child psychiatric service and therefore epidemiological information is important in assessing the need for services as are the study of psychosocial and individual associations to behaviour and formal child psychiatric disorder. In the future psychotherapy is likely to play a much greater role in psychiatry in Ireland.

ADOLESCENTS

Psychological Stress in Female Adolescents:

In a study of 132 female adolescents attending inner city schools. 15% showed evidence of psychological stress, and attained a total problem score in the clinical range with 11% often crying; 11% often having stomach aches; 6% often using drugs or alcohol; 6% often wishing they were the opposite sex and 7% often having suicidal thoughts². A study of 300 adolescents using the General Health Questionnaire found that 30% had six or more symptoms³. In a study of adolescents with spina bifida 38% showed evidence of formal psychiatric disorders on detailed interviewing⁴.

Ten year olds:

A study of 2029 fourth class pupils in an Irish urban area found that 20% of the boys and 11% of the girls were behaviourally deviant. 8% of the children were reading 36 months behind chronological age and 1% were found to be intellectually impaired⁵.

Social Support and Behaviour Problems in Children:

The levels of social support of Irish children were similar to levels of social support of American children of the same age. Social support from teachers and class mates was associated with higher self esteem and developmental appropriateness⁶.

Mothers and Children: Ireland versus Malaysia:

Mothers in Malaysia had significantly lower rates of depressive and anxiety symptoms when compared to Irish mothers. This may have been due to the greater cohesion of Malaysian society. There were no differences in the rate of childhood behaviour problems⁷.

The Health Status of Mothers and the Hospitalization of Children:

The mothers of hospitalized children with gastroenteritis had significantly higher levels of psychological distress than the home care mothers. There was no difference in the levels of severity of the children's illness⁸. There was a significant relationship between poor social resources and psychological distress of mothers⁹.

Depressed Children:

In a child psychiatric outpatient sample 14% of attenders were depressed¹⁰. A five year follow up of depressed children found that 50% were still depressed. At the five year follow up point 12% of these not originally depressed were depressed¹¹. There was a relationship between personality and depression¹².

Medical Doctors: Management of Ill Children:

Doctors who had special experience with gastroenteritis during training were more likely to hospitalize patients with gastroenteritis¹³.

A Study of Group versus Individual Therapy:

Group and individual psychotherapy showed statistically significant improvements. Those in individual therapy had interpersonal goals while those in group therapy had interpersonal goals at the beginning of treatment¹⁴.

Schizophrenia:

The diagnosis schizophrenia can be used too liberally and an example is Wittgenstein where this diagnosis was applied when in actual fact he suffered from depression¹⁵.

Paediatric Outpatients:

Considerable psychopathology was found in children, parents attending paediatric outpatients¹⁶.

Psychotherapy and the Health Service:

Psychotherapy reduces the utilization of medical services by 20%¹⁷.

Problem Solving Skills in children:

The lack of development of planning skills and negative attunement by parents was considered to be of importance in child rearing^{18,19}.

A Follow Up Study of Boys with Delinquency:

When a group of 50 boys with delinquent behaviour were followed up it was found that 20% had drug problems with a 92% recidivist rate²⁰.

Disadvantage and Psychiatric Problems:

Disadvantage and social disconnection were major factors associated with child and maternal psychiatric problems²¹.

Maternal Depression and Childhood Behaviour Problems:

There was no statistical association between maternal antenatal depression and child behaviour problems but there was a six times increased risk of behaviour problems in the child if mother was currently depressed. A screening study of mothers postnatally showed that 38% (19) showed evidence of depression. Twenty two per cent had financial difficulties; 10% were on antidepressants and 30% became pregnant sooner than they wanted to^{22,62}.

Psychosocial Problems Antenatally in a Disadvantaged Area:

Fifty per cent of the women reported symptoms of unhappiness and depression with 11% feeling that life was not worth living. There was considerable evidence of financial and relationship problems²³.

Psychological factors affecting the management of childhood illness:

An anxious mother was a factor in a doctors decision to hospitalise a child²⁴. Other factors influencing the doctor were:

- (a) Having had a bad experience of gastroenteritis.
- (b) Being a male doctor.
- (c) Being in single practice.
- (d) Making a higher estimate of the severity of the gastroenteritis.

PRIMARY SCHOOL CHILDREN

(a) Girls:

Small scale screening studies showed considerable evidence of behavioural deviance particularly in urban disadvantaged areas. Barton and Fitzgerald found that there was over twice as much behavioural deviance in 10 and 11 year old girls in a disadvantaged school as compared to a highly privileged school. It was also of interest that 21% of the children in the disadvantaged school were absent from school for trivial reasons, while none of the children in the privileged private school were absent for trivial reasons²⁵. There is little doubt that children living in disadvantaged areas are under much greater psychosocial stress than children living in affluent and privileged urban areas. It is also likely that parents in privileged families have greater interest in education and would generally not have children absent from school for trivial reasons. It is clear that privileged families and privileged schools have more resources of both a financial or human kind which have the effect of reducing stress and behavioural problems in children.

(b) Boys:

A study of 10 and 11 year old boys in a disadvantaged school showed a similar behavioural rate to those shown by the girls in a previous study. 22% (10) of the boys with behavioural deviance showed evidence of mild abnormality, 4% (2) moderate abnormality and 9% (4) marked abnormality²⁶. This supports the link between increased rates of behaviour problems and disadvantage.

(c)

A study of 2029 ten year old children found a rate of 20% behavioural deviance in boys and 11% in girls using the Teachers Questionnaire²⁷.

(d) Urban : Rural differences:

It was found that over twice as many urban disadvantaged children showed evidence of behavioural deviance as against children in a rural town. In the urban group no significant difference was found between boys and girls with behaviour problems while a highly significant sex difference was found in the rural small town group. The observed incidence for boys at 18% (21) was three times that found for girls²⁸. The most likely explanation is that the level of psychosocial stress is lower in rural counties. There is little doubt that disadvantaged urban areas are increasingly psychologically toxic to families and children²⁸.

(e) Travellers children:

In a study of 50 travellers children 27 out of 50 showed evidence of behavioural deviance using the Teachers Questionnaire²⁹. This was greater than that found when travellers children were compared to a comparison group from the settled community, the Teachers questionnaire total score average for the travellers group at 9.96 was significantly above the total score average for the settled comparison group at 2.2. While acknowledging that the travelling people have a different culture, it would appear that they are possibly the most disadvantaged group in Irish society and have large families with an unsettled, alienated life style which would make the increased rate of behaviour problems in children not surprising.

(f) **Depression:**

Five per cent (4) of a group of boys in an urban disadvantaged school scored as depressed on the Depression Self Rating Scale³⁰. There was evidence of co-morbidity in that three quarters of those children who were rated as depressed also scored deviantly in the antisocial domain of the Teachers questionnaire. There was also a high negative level of self esteem using the Coopersmith self esteem inventory and depression²⁹. A study of depressive symptomatology in Irish female adolescents found that in a rural area 22% showed evidence of it^{31,32}.

(g) **Anxiety:**

3.5% (3) of a group of boys in an urban disadvantaged school scored above two standard deviations above the mean for the state anxiety scale of Spielberger and 5% (4) scored more than two standard deviations on the trait anxiety scale of the same instrument and these were taken as being indicative of high anxiety. There was also a significant negative correlation coefficient between self esteem and state as well as trait anxiety³⁰. Once again anxiety is not uncommon in normal school children and it is possible that strategies to boost self esteem by families and schools would be valuable particularly in the Irish context where negative attunement would appear to be a feature of the culture.

(h) **Autism:**

A study of prevalence of childhood autism found a rate of 4.3 autistic children per 10,000 in the age range 8 - 10 years in the Eastern Health Board. These were evenly spread across the social classes and there was a male : female ratio of 1.3 : 1³³. A study of sialyltransferase activity was found to be significantly increased in the serum of schizophrenic individually and unchanged in autistic serum³⁵. Social support variables were important in relation to family burden and the person with autism³⁴.

(i) **Irish Childrens thoughts:**

15% of a sample of 80 boys thought that their life was not worth living most of the time and 18.8% thought that their life was not worth living sometimes³⁰. A study of suicidal thoughts in children (N = 50) attending a child psychiatric outpatients found that 15% had

thought of killing themselves. 60% of the sample of children who had thoughts of killing themselves knew someone who had attempted suicide³⁶. It would appear that very distressing thoughts are not uncommon and it behoves parents and teachers to tune into these thoughts in children so that they do not have to bear them alone and that the stress bringing them about should be identified.

(j) Social difficulties:

A study of 95, 11 and 12 year old school children in a normal school in a disadvantaged area found that 13% had difficulties with peers, 17% had difficulties with adults and 11% had general social difficulties using the Social Difficulty Questionnaire³⁷. There is evidence that children with peer difficulties are at risk for later problems and it would appear that social skills training programmes in school could have preventive possibilities.

(k) Sleep Problems:

In a study of children attending a public health clinic (N = 101) with an average age of 4 years and 7 months twenty five per cent of the boys and thirty three per cent of the girls had sleep problems³⁸. There is no doubt that sleep problems in childhood can cause very significant stress to a family. There are now simple behavioural programmes available which are particularly valuable for public health nurses and general practitioners in the management of sleep problems.

(l) Reading:

Children attending a child psychiatric outpatients had significantly lower reading ages than a matched age comparison group in a normal school - the mean reading age of the normal school children was 10.8 years while the group mean for the psychiatric outpatients was 9.0 years and the special school children 7.9 years³⁹. While low reading age can occur without psychiatric problems it is not uncommon to see both occur together.

(m) Fire Setting:

A study of children attending a child psychiatric outpatients found that 19% (15) were fire setters. They set an average of 10 fires. The fire setting behaviour began on average at 7

years. Half of these children received a diagnosis of conduct disorder⁴⁰. Fire setting behaviour can be the most serious of all childrens behaviour problems and it is important for doctors to ask about it as parents don't often mention it.

(n) Childrens fears:

40% of children attending a child psychiatric outpatients had evidence of excessive fears⁴¹.

(o) Obsessive Compulsive Disorder:

A study of treatment approaches to O.C.D. in the 1990's suggest a multi modal treatment approach⁴².

PRE-SCHOOL

A study in a pre-school (N = 59) found a rate of 17% of children with behavioural deviance using the Behaviour screening Questionnaire⁴³. This is similar to rates found in other countries. These children are at risk for later problems and deserve intervention. Another study showed that psychiatrically distressed preschoolers showed poor performance in performing tasks or accepting limits⁴⁴.

ADOLESCENCE

(a) Abnormal Eating Attitudes:

Using the Eating Attitude Questionnaire 13% of a sample (N = 50) of 16 year old female adolescents showed evidence of abnormal eating attitudes. 11% admitted to dieting, 7% to exercising strenuously to burn off calories, 11% to avoiding foods with high carbohydrate content, 15% described eating binges with feelings of loss of control, 4% used laxatives, 17% felt that food controlled their lives and 18% admitted to feeling anxious in relation to eating⁴⁵. Clearly food issues cause considerable distress and western societies excessive preoccupation with thinness is probably a factor in this problem.

(b) Psychological Stress in Female Adolescents:

A study found 7% to have admitted to being depressed⁴⁶.

Sex differences in psychopathology between male and female adolescents:

In a study of 92 adolescents (average age 13.8 years) it was found that in using the General Health Questionnaire that 44% of the sample reported six or more symptoms and there was no significant difference between males and females. On the other hand there was a significant difference between the mean scores for males and females, the females scoring significantly higher⁴⁷. It is of interest that in child psychiatry that males have more psychological symptoms than females and here with adolescents there is no significant difference between males and females. Nevertheless the adult pattern is beginning to assert itself with females having higher mean scores than males. A study of the leisure activities of Irish adolescents found a high correlation between participation and interest^{49,50}. The values⁴⁸ of adolescents reflected those of society at large.

Coping and Psychological Stress in Adolescence:

In this study it emerged that girls had more suicidal ideation than boys⁵¹. A problem solving intervention study for children with diabetes showed a positive response⁵².

Body Shape, General Health and Abnormal Eating Attitudes in Male Adolescents:

Two out of 197, 16 year old boys showed evidence of abnormal eating attitudes. This was lower than a similar study in girls⁴⁵. Thirty eight out of 197 boys showed 5 or more symptoms on the General Health Questionnaire. Three out of 107 boys showed excessive concern about being fat on the Body Shape Questionnaire⁵³.

Formal Psychiatric Disorder:

- (a) A study of 45 10 and 11 year old children in a disadvantaged school found a rate of 18.6% (8). 7% (3) showed evidence of mixed order of conduct and emotions; 7%

(3) showed depressive disorder and 5% (2) showed conduct disorder²⁵. It demonstrated that about half those identified on screening questionnaires are false positives.

- (b) A sample of 190 10 year old children selected from 2029 children screened for behavioural deviance found a rate of 16% showing evidence of formal child psychiatric disorder on detailed interviewing²⁷.

Psychiatric Symptoms in Parents:

- (a) In a general practice study of 70 children there was a significant relationship between maternal depressive symptoms and behavioural deviance in the children⁵⁴.
- (b) In a study of the mothers of 50 consecutive attenders at a child psychiatric outpatients 35 out of 50 showed evidence of formal psychiatric disorder using The Clinical Interview⁵⁵.
- (c) In a pre-school study (N = 59) there was a significant relationship between depressive symptoms in mothers and behavioural deviance in children⁵⁶.
- (d) When a consecutive sample of mothers with children attending the child psychiatric outpatients were compared with a comparison group of mothers of children attending a general practice significantly higher levels of hopelessness were found using The Hopelessness Scale⁵⁷.
- (e) 72% of children of psychiatric inpatient mothers were found socially incompetent using the Child Behaviour Check List⁵⁸. There was also a relationship between maternal depression and childhood behavioural problems^{59,60}.

Marital Disharmony:

- (a) In a general practice study there was a significant relationship between marital disharmony and behavioural deviance in children⁶³.
- (b) In a study of 50 consecutive children attending a child psychiatric outpatients 21 of the mothers showed evidence of marital problems and there was a significant

relationship between marital problems and anxiety and depressive symptoms in the mother⁵⁵.

- (c) When marital adjustment and behaviour problems in children attending a child psychiatric outpatients population were compared with a control population in the community there were significantly higher rates of marital disharmony and behavioural problems in the children attending the child psychiatric outpatients⁶³. It is important that general practitioners treat as soon as possible marital problems because of their effect on children. This is another example of preventive child psychiatry.

Social Problems:

Social problems of mothers were studied in 50 consecutive attenders at a child psychiatric outpatients. 74% of the mothers had significant social problems. There was a significant link between social problems and maternal mental illness in this study⁵⁵.

Home Environment:

When preschool children with behavioural problems were studied there was a significant relationship between low levels of warmth, affection and acceptance and a high score of behavioural deviance⁶⁴. Clinical experience suggests that for children to develop healthily they need warmth, acceptance and affection but not over protection⁶¹.

Bullying:

A study of 2000 children found that 4% of males and 1% of females were bullied⁶⁵.

Blood Lead:

In a study of blood lead in children attending a child psychiatric outpatients and in the community there was no difference in the mean blood lead levels⁶⁶. Of course toxic blood lead levels would have major physical and psychological effects.

Adolescent Health:

In a study of adolescents health, 1% rated their health as poor. 25% drink alcohol at least once weekly and 29% had visited their G.P. in the previous three months. 61% had taken medicine in the previous four weeks. 16% of boys and 3% of girls had tried glue sniffing. One quarter of Irish teenagers were weekly drinkers compared to one third of British teenagers⁶⁷.

Family Relationships:

A study of the Family System Test found it to be a poor predictor of clinical status⁶⁸. Unfair, harsh discipline by parents was predictive of later development of depression⁶¹.

Motivation:

It is of interest that children in an urban primary school show high intrinsic motivation to learning across 3rd to 6th standard. It was also of interest that behaviourally disturbed children showed higher levels of independent judgement as against dependence on teachers judgement. This may reflect a global mistrust of adults in their environment⁶⁹.

Feelings of misery in Two Thousand and Twenty Nine Children:

A study of 10 year old (N = 2000) children found that 2.0% of the males and 3% of the females were miserable³⁷.

Suicide and Parasuicide:

A study of suicide victims⁷⁰ in Dublin (N = 70) found that:

- (a) 70% were males.
- (b) Average age 41 years.
- (c) 80% of victims under 55 years.
- (d) 37% married.

- (e) 60% of economically active group in employment.
- (f) 35% previously attempted suicide.
- (g) 53% saw a doctor in previous month.
- (h) 44% experienced hopeless feelings.
- (i) Central Statistics Office statistically underestimated by a rate of 20%.

An eight year follow up of attempted parasuicide patients found that two out of 26 had died and 19% had more further suicide attempts⁷¹. A community study of parasuicide found that almost all had attended casualty⁷³. There was high over protection scores amongst parents of children who attempted parasuicide⁷⁴. There were considerable rates of suicidal ideation in children in normal school^{75,76,77}. Most parasuicides attended casualty⁷⁸.

Lifetime Prevalence of Depressive Disorder:

In a study of the lifetime prevalence of depressive disorder of 33 consecutive patients attending the psychiatric department of a general hospital showed that 15 (45%) had a positive family history of depression and that the total number of relatives involved was 20 or 1 for 1.7 patients⁷⁹.

Parental Bonding and Depression:

On the EMBU (Enga Minnen Beträffande Uppfostran) a parental rearing practices instrument parents of depressed patients were more rejecting, more over protective and were more favouring of the subject than a comparison group. On the PBI (Parental Bonding Instrument) the mothers and fathers of adult depressed patients were more over protective and less caring than a comparison group⁸⁰.

Disadvantaged Children:

A study of 55 boys (average age 7 years and 9 months) in a disadvantaged area found a rate of 21% hyperactivity on the Activity Rating Scale, a rate of 31% had soft neurological signs, 35% had gross tooth decay and a behavioural deviance rate of 36% of the Teachers Scale⁸¹. This can be compared to a rate of 44% found in children attending a surgical outpatients in hospital in a disadvantaged urban area¹⁶. An analysis of their height and

weight percentiles showed the height curve as being shifted to the left of the expected percentiles⁸¹.

Lone Parenthood:

A study of married and unmarried mothers found that 60% of married mothers and 18% of single mothers wished to conceive at the time they became pregnant. 34% of the male partners of the single mothers did not want to know about the pregnancy while only 2% of the partners of the married mothers did not want to know about the pregnancy. The group of single mothers living alone were under considerable stress with three quarters of them having major financial problems as opposed to 19% of those living with their parents. There was no statistical difference between the two groups with regard to coping with their children⁸².

Personality Disorder:

A study of the personalities of 50 child guidance clinic attenders found that 5 could be given a diagnosis of personality disorder⁸³.

Expectations of a Child and Family Centre:

In a study of the expectations of attending a child and family centre 40% of children expressed positive feelings about attendance, 30% expressed anxiety and apprehension about it and 30% had neither positive or negative feelings⁸⁴.

Audit of a Child and Family Centre:

77% of mothers were satisfied with the service. 70% of mothers received no information about the service prior to arrival⁸⁵.

Burn Out:

A study of stress in child psychiatric personnel showed that personnel with low scores on peer cohesion were found to be emotionally exhausted and to show greater

depersonalisation of clients. Personnel working in residential child psychiatry were more likely to be emotionally exhausted than personnel working in outpatient child psychiatry⁸⁶.

Attitude to Authority:

In a study of attitude to authority in Irish adolescents 84% (76) expressed pro-authority feelings. There was also a negative correlation between level of psychological distress and positive attitude towards parents⁴⁷.

Life Events:

Children referred for psychiatric assessment had a significantly increased number of life events when compared to non-referred children from a normal school. Failure of a class in school and increased number of arguments between parents were associated with an increased likelihood of referral⁸⁷.

Psychoeducational Problems:

Males had significantly more behavioural and learning problems than females⁸⁸.

Child Psychiatry Provision:

It is clear that there is very considerable numbers of disturbed children in Ireland and there are still areas of the country without child psychiatrists. Educational psychologists should spend part of their week based in child guidance clinics so that psychiatric problems can be dealt with^{89,90,91}.

Prescribing in Child Psychiatry:

90% of Irish Child Psychiatrists prescribe psychotropic drugs⁹².

Child Psychiatric Inpatient Treatment:

The prevalence of use of medication was lowest (8%) in Denmark and highest in Ireland (54%). Family therapy was undertaken with 25% of inpatient cases in Ireland⁹³.

An Evaluation of a Child & Family Centre:

Significant improvement occurred in childrens behaviour with a 4% drop out rate⁹⁴.

Paediatric Outpatients:

82% of parents were satisfied with OPD services⁹⁵.

Preventive Psychiatry:

It is of critical importance to increase the priority given to preventive psychiatry and psychotherapy. The most cost effective time to intervene would be when children aged 3/4 years are showing signs of behavioural deviance. The children need high quality cognitively orientated preschool education and the mothers need parent training. There is a considerable need for the expansion of psychotherapy services in Ireland⁹⁶.

Family Burden of a Child with Special Needs:

When psychosocial stress in families with a child with special needs was compared to families with a child in a normal school it was found that there was significantly more stress in families with children with special needs. Parents in these families felt more incompetent, felt lack of attachment, were more restricted in their parent role, were more socially isolated, more depressed and had more marital stress. The child with special needs were more distractible, more moody, more demanding and more non-adaptable⁹⁷.

Prosocial Behaviour:

A study of prosocial behaviour in children attending a normal school found that Irish mean levels of prosocial levels of prosocial behaviour are similar to the United Kingdom mean scores. High trait anxiety was accompanied by lower prosocial behaviour scores and higher behavioural deviance ratings⁹⁸.

Self Esteem:

In a study of self esteem and behavioural deviance in children total self esteem was reduced in children attending the child psychiatric services. One component of total self esteem that

is school self esteem was not reduced in children attending a day special school or were in an inpatient unit with a special school attached. This may have been due to children in the special school setting not being so different from each other as would be the case if these children were attending a normal school⁹⁸. Preliminary results suggest that parental self esteem and locus of control has an impact on childrens scores⁹⁹. An inverse relationship was found between anxiety and self perception¹⁰⁰. Disturbed preschool children were less competent at performing tasks¹⁰¹.

Speech and Language:

In a study of speech/language disability and behavioural deviance in a consecutive sample of 50 referrals to a child psychiatric outpatients, 63% showed evidence of behavioural deviance on the Parents Questionnaire (A2) and 44% showed evidence of speech/language problems¹⁰².

Temperament:

When a consecutive sample of children attending a child guidance clinic were age, sex and school matched with children in a normal school it was found that children attending the child guidance clinic were significantly more likely to have difficult temperaments¹⁰³.

Menarche:

The mean age of Menarche in 836 Irish school girls was 12.5 ± 0.06 . There was no statistical difference between social classes, number of siblings or place of the child within the family¹⁰⁴.

Infant Care Practices:

When infant care practices were examined in mothers who had a child hospitalized and not hospitalized for gastroenteritis it emerged that families were the main source of advice for both groups. It was also of interest that 9% of hospital care mothers and 6% of home care mothers had no source of parenting advice. An average of 16% of mothers had problems feeding their children, 30% had settling problems at bedtime once per week or more and

35% had night waking problems weekly. 22% of children posed some discipline problems. Most of the child care was provided by mother although fathers played with their children on average twice per week and mother three times per week¹⁰⁵.

Families of Ill Children:

The study also found an association between psychological stress and low levels of leisure activity, low levels of shared leisure with partners, poor overall contacts, poor satisfaction with contacts and a disturbed intra familial environment¹⁰⁶.

Diabetics with poor H₆ A₁ levels exhibited lower self esteem¹⁰⁷. Twenty five per cent of mothers of diabetic children reported high levels of stress on the General Health Questionnaire¹⁰⁸. A cognitive behavioural intervention significantly improved children with diabetes self efficacy¹⁰⁹.

Turner girls showed lower levels of self esteem and social interpersonal involvement^{110,111}.

Maternal Mental Health:

A study of maternal illness in 185 mothers showed a rate of 33% (61). 13 had endogenous depression, 16 anxiety / depression, 24 reactive depression, 3 abnormal grief, 3 alcoholism and 2 personality disorder. There was a significant association between parental mental illness and child psychiatric illness. 60% of mothers with parental mental illness had a child with child psychiatric illness. Mothers with mental illness had poor social relationships¹¹².

Antenatal Depressive Symptoms:

Fifty per cent of the women reported feelings of unhappiness and depression¹¹³.

Impact of Hospital Experiences on Doctors:

The impact of hospital experiences during training of general practitioners were studied in relation to their propensity to admit children with gastroenteritis to hospital. There was a

significant excess of hospital referrals for gastroenteritis by these GP's with prior hospital training in an infectious diseases hospital and medical sensitization was considered to be a factor in that this specialized training had sensitized GP's to the potentially negative outcomes of gastroenteritis¹¹⁴.

Medication for Gastroenteritis:

25% of GP's are still using antidiarrhoeals and antiemetics in the treatment of gastroenteritis despite the general principle of fluids only for gastroenteritis¹¹⁵.

Child Hospitalization:

In a study of home or hospital care for childhood gastroenteritis it was found that being either a young child, a child of a single parent or a child of an anxious mother were factors which were equally likely and more likely than being a moderately sick child to result in referral to hospital¹¹⁶.

Pathways to Childhood Hospitalization:

The ability of parents to cope emerged as important factors in the hospitalization of children¹¹⁵.

Immunization:

In a study of children who had gastroenteritis and were treated either in hospital or at home it was found that 53% of the home care children had measles immunization which is similar to national levels while only 22% of the hospital care children had measles immunization before 18 months of age. Levels of immunization up take were satisfactory for both groups in the early post natal period but began to decline and diverge at about the six month period. This fall off represents the age old problem of health education, how to maintain health orientated behaviours beyond a point of intensive contact, in this case the perinatal period¹¹⁶.

Sudden Infant Death:

Considerable amounts of psychosocial distress was found in a national Irish study^{117,118}.

Attitude to Hospitalization:

While the evidence of negative impact of long or frequent hospitalizations of young children is well documented, a study of the attitudes of Irish doctors to hospitalization found that only about half of those interviewed believed that hospitalization had negative effects, suggesting that research findings in this area do not appear to have had a major impact on the views of medical decision making^{119,120}.

Mothers Consumption of Drugs and Alcohol:

In a study of the consumption of alcohol and drugs in mothers of children attending a child psychiatric clinic it was found that 17% of the mothers were problem drinkers on a screening questionnaire - the Mast. 13% of the mothers were taking benzodiazepines daily while a further 7% were taking those drugs on an irregular basis. It is possible that these mothers are under more stress and have higher levels of problem drinking than women attending a general practice where a rate of 1.3% was found on a more sensitive screening instrument for alcohol problems the CAGE¹²¹.

Fragile X Chromosome:

In the first Irish family studied with fragile X chromosome the proband with mental handicap and autism had on Cytogenetic study the fragile X in Tc 199 in 30 of his cells. His sister had fragile X chromosome in 25% of her cells and the younger sister had fragile X in 100% of her cells¹²².

Delinquency:

In a review of the delinquency problem the principal of minimal intervention was evoked. The importance of scientifically evaluating all aspects of the legal, educational and health interventions in relation to delinquents was stressed. Institutional approaches have not

generally been shown in effective and community approaches are probably least detrimental. There should be increased emphasis on high quality pre-school education as well as parent training and support for mothers of at risk children¹²³.

Disconnection and Disadvantage:

The issue of disconnection is particularly relevant to urban disadvantaged areas because socially isolated families are particularly at risk for psychological stress. Neighbours, clergy, voluntary groups and professionals should try to make social links with isolated families. Social linkage and social support can make a significant impact on psychological distress. It is not surprising that people who have supportive confiding relationships are less at risk¹²⁴.

Mid Life:

The value and importance for the person in the middle years of linking with and guiding children and adolescents is generativity. This is particularly so for distressed children and adolescents who don't have anyone to take a positive interest in them as persons. A good experience of this nature for a child or adolescent may make the difference between success and failure in life¹²⁵.

Planning Skills:

In a study of children it was pointed out that there is no reason to suppose that crime is generally more common now than in past centuries. The importance of helping children develop planning skills and experience success is underestimated. It is important for parents and educators to build up childrens self esteem. confident children are less at risk for psychological problems. Unfortunately negative attunement has been a feature of Irish child rearing¹²⁶.

Relational Model of Psychoanalysis:

It is important to realize that there was a shift in psychoanalytical thinking from Sigmund Freud's energy and economic models of psychological functioning to the relational

psychoanalysis which emphasizes the importance of problems in relationships as factors in the development of psychological distress and disorders¹²⁷.

Cost Effectiveness of Psychotherapy:

Concern has recently been expressed that psychiatric educators may be "losing the mind". Brain science has not yet and probably never will fully explain the mind. There is little doubt that psychiatric training programmes do not give sufficient attention to psychotherapy. A review of the literature concluded that the effect of psychotherapy was to reduce the use of medical services by about 20%^{128,129}. There is evidence that psychotherapy is more effective than no treatment and has a greater effect size than placebo. A child psychiatric intervention showed effectiveness at 3 month follow up^{130,131}.

Supervision:

Insufficient attention has been paid to the supervisor/student relationship. If a supervisor is over concerned for the patient this suggests that the student is not tuned into the patient in an empathic way. If the supervisor is performing well then his comments should be confirmed by the patients material. The use of the student for narcissistic aggrandisement by the supervisors must be guarded against¹³².

Technique of Psychoanalytic Psychotherapy:

The key elements of the technique of psychoanalytic psychotherapy are the analysis of the affect or pain that brings a patient and the analysis of the transference which allows the therapist to examine the forgotten feelings and attitudes developed in early life to important figures and transferred onto the therapist. These transference interpretations are most mutative that is, bring about the most change¹³³.

Applied Child Psychoanalysis:

Psychoanalysis has a role to play in helping paediatricians and nurses understand and respond to the emotional impact of physical illness on children. This aspect of intervention has tended to lag behind technology in the twentieth century. After the resolution of a

medical crisis the psychological needs of children in the very stressful environment of the hospital situation are just as important in the long term as the physical care of the child. Psychoanalytical thinking has been of considerable assistance to lawyers and child care professionals in thinking about the best interests of the child and giving particular importance to psychological parenthood¹³⁴. Multi-modal treatments have a place in treating patients with obsessional personalities¹³⁵.

A modification of the Anna Freud Diagnostic Profile has been made to make it quantitative¹³⁶. The three models (a) Circumflex, (2) Beavers, (3) McMaster are not entirely satisfactory in differentiating clinical from non-clinical families¹³⁷.

Psychoanalysis, Behaviour Therapy and Pharmacology:

In the past the disputes between psychoanalysts, behavioural therapists and psychopharmacologists were very unsatisfactory and not in the best interests of patients. There is little doubt that these three forms of treatment have their place either singly or in combination. Psychopharmacological drugs tend to have as their focus symptom relief while psychoanalytic psychotherapy tends to show its effect more slowly and on background personality factors as well as symptoms. It may be more useful to view them as having an additive or even mutually potentiating relation. Behaviour therapy has a place in enuresis, encopresis and behaviour problems¹³⁸. A study of the suitability of socially disadvantaged women found a significant number were suitable for psychoanalytic psychotherapy¹³⁹.

Balint Groups:

The Renaissance in General Practice, a phenomenon of the 1960's owed a great deal to the recognition of the enormous therapeutic potential in the doctor patient relationship. When problems occurred in this relationship it led to much unnecessary suffering, irritation and fruitless effort. Balint helped GP's to examine their countertransference feelings and to use these to increase their understanding of the neurotic problems of their patients which caused them and their patients so much suffering¹⁴⁰.

Pregnancy:

It is important to recognise mothers at psychological risk during pregnancy. Mothers with over valued pregnancies, ambivalent pregnancies and historical sensitization are at risk. It

is a good time to intervene psychotherapeutically as mothers are highly motivated before birth and in touch with unconscious conflict and unresolved problems from childhood which may interfere with the psychological task of pregnancy which are emotional fusion with the foetus; differentiation of the foetus and self and progressive psychic separation of baby and mother¹⁴¹.

Existentialism / Literature:

Existentialistic philosophy is helpful in understanding alienation and man in a technological world. There are problems with it in that it denies the whole concept of mental illness, the biological basis of some mental illness and also genetic factors. Existential psychiatry establishes a dependent relationship that gratifies but can not be worked through because the transference is ignored¹⁴². Literature is helpful to psychiatrists because they have similar concerns to poets and writers¹⁴³.

Hysterical Personality:

The patient with a hysterical personality thinks in a vague way with much feeling. This patient has difficulty in thinking clearly about feelings and behaviour. One of the aims of treatment is to help this patient to think clearly¹⁴⁴.

Narcissistic Personality:

Empathy is very important in treating the patient with a narcissistic personality disorder. These patients are further hurt by too painful interpretation early in the treatment. If the therapist is empathic the patient will experience a transmuting internalization which will be strengthening to the personality because a new internal object will be set up which will counter some of the negative internal objects from childhood¹⁴⁵.

Therapist Difficulties:

A study of a group of trainees conducting individual psychotherapy showed that the predominant categories of difficulty related to trainees feeling incompetent and threatened¹⁴⁶.

Registration of Psychotherapists:

There is a need now for a working party of the Department of Health to be set up to examine and draw up guidelines for the statutory registration of psychotherapists. The public is entitled to know the form, duration and quality of training that people who call themselves psychotherapists and offer their services to the public have. This is particularly so because psychotherapy is not inert and has negative as well as positive effects¹⁴⁷.

Psychotherapy Services:

Psychotherapy services in Ireland are largely available in urban areas. The largest number of practitioners would be in the Eastern Health board area. In the public health service therapists are generally employed under their core professional titles i.e., psychiatrist, psychologist, social worker or nurse and often psychotherapy is one of a number of treatment strategies. At the same time there is a growing number of nurse therapists who undertake behaviour therapy within the psychiatric service^{148,149,150}.

Contribution of Psychoanalysis to Psychiatry:

The three theories most helpful in understanding mental illness are in the social domain, the biological domain and in the psychoanalytic domain. Psychoanalytic psychotherapy has a role in the treatment of patients particularly those with neurotic and personality problems. Psychoanalytic understanding is of assistance in management of a wider variety of psychiatric problems. It is very important for the clinician to be able to integrate psychoanalytic, biological and social understanding of the patient. While Kraeplin classified, Freud understood, both are required¹⁵¹.

Psychotherapy in Custodial Institutions:

Psychotherapeutic experience has shown that it is possible to work psychotherapeutically in custodial institutions. Indeed some acting out patients are only available for treatment in a secure setting. The treatment is still a voluntary one in that the patient does not have to have the treatment if he does not wish¹⁵².

Psychotherapy in a Psychiatric Outpatients:

A patient with neurotic depression failed to respond to antidepressants and hospitalization. It was only when childhood conflicts were dealt with in psychotherapy that they began to improve¹⁵³.

Psychotherapy Training of Doctors:

It is necessary for far greater emphasis and resources be given to training of psychiatrists in psychotherapy and for medical psychotherapists to have a place in the delivery of services to the mentally ill in Ireland¹⁵⁴.

Attitudes to Psychiatry:

Over the course of nurse training students become increasingly eclectic in their outlook and saw a place for ECT and compulsory detention of certain cases¹⁵⁵.

The Boundary of Psychotherapy:

There is considerable overlap between all the different forms of psychotherapy but also sharp differences that must be acknowledged. It is also critical that the limits of psychotherapy be acknowledged so that biological factors can be addressed by biological psychiatrists¹⁵⁶.

European Psychotherapy and Counselling:

The 1988 Higher Education Diploma Directive had as its objective "the abolition of obstacles to freedom of movement for persons services and capital". In training terms the amount of professional experience may not exceed 4 years¹⁵⁷.

Future of Psychiatry:

An uncritical acceptance of Popperian empirical realism will lend to a marginalization of psychiatry^{158 - 164}.

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