EXPLORATORY STUDIES ~~INTO~~ of THE SERVICES FOR MALADJUSTED CHILDREN

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A B S T R A C T

Three exploratory studies in the field of the services for maladjusted children are described in this volume.

The first study is based on data obtained from child guidance clinics in those boroughs constituting the Outer London area.

Initially the data is presented as rates of referral of children to the thirty clinics concerned. An examination of these figures is then carried out in terms of the age and sex of the children and the source of referral.

Further refinements of this and other data collected about these areas enables the second stage of this study to progress. A causal analysis is carried out which seeks to explain why it is that the rates of referral to child guidance clinics and maladjusted schools vary from one area to another. The concept of social ethos is used as an independent variable and the number of clinic staff available as an intervening variable.

The second study addresses itself to the problem of why it is that some families who are referred to child guidance clinics co-operate with the clinics while others do not. An explanatory model based upon both sociological and psychological approaches is developed. This is tested using the techniques of causal analysis. Finally the causal links are examined in the light of the clients' expectations of the clinic and a role conflict model is used to illustrate the causal structure.

C O N T E N T S

CHAPTER 1

INTRODUCTION

This thesis describes three studies of the services for maladjusted children. Two of these studies are exploratory investigations of aspects of the services for such children which have only rarely been considered before. The investigations are carried out using specifically developed theoretical models and the relatively new techniques of causal analysis.

The concept of maladjustment is in many ways one of the most confusing terms to be found in official use today. The Underwood Committee[1] defined it negatively:

> "Maladjustment is not a medical term diagnosing a medical condition. It is not, as we have already mentioned to be equated with bad behaviour, delinquency oddness or educational subnormality. Nor is it the same as deviation from the normal. While it is true that many deviations are signs of maladjustment some may involve only one side of a child's development and may not affect his mental health.
>
> We can perhaps best approach the nature of maladjustment by saying that it is a term describing an individual's relationship at a particular time to the people and circumstances which make up his environment. In our view a child may be regarded as maladjusted who is developing ways that have a bad effect on himself or his fellows and cannot without help be remedied by his parents, teachers and other adults in ordinary contact with him."

This rather broad definition is restricted to a certain extent in The Handicapped Pupils in Special Schools Regulations of 1959[2] where maladjusted pupils are defined as:

> "Pupils who show evidence of emotional instability or psychological disturbance and require special educational treatment in order to affect their personal, social or educational re-adjustment."

Such broad terminology gives plenty of scope for creative development within the services. It also, unfortunately, gives plenty of room for abuse of those services.

The services for maladjusted children can be described under two headings.

1. Child Guidance Clinics

Child guidance clinics were first established between 1920 and 1930 in both the United States and Germany. In many ways they represented a new approach to the concept of mental health. In Germany the impetus was entirely due to the work of Alfred Adler who saw child guidance as part of the general philosophy of education. The influence of Adler disappeared owing to the closure of his clinics when Hitler first came to power.[3]

In America and later in Britain, the commitment to team work, which is the basis of the child guidance model, was a major innovation in the organisation of psychiatric services. From the very beginning the child guidance clinics were established with psychiatrists, psychologists, psychiatric social workers and child psychotherapists as a team.[4] At the present time, in this country, the director is usually a psychiatrist but some clinics are directed by social workers or psychologists.

The most common procedure, after a child has been referred to a clinic, is for the parents to be seen by the psychiatric social worker and the child to be seen by the psychiatrist. A case conference follows in which these two members of the team join with the psychotherapist and educational psychologist, who will have assessed the child, to form a diagnosis and a plan of treatment.

The treatment is usually of a psychotherapeutic nature, drugs are only occasionally used and the basic guidelines for treatment of the children are that they should be treated "not in isolation but in and with their families."(5)

Referrals to child guidance clinics come from two general sources; those associated with the schools which will be called "educational sources" and those not associated with the schools which we will call "non-educational sources". The educational psychologists in the clinic team are usually working in the schools and many children will be referred to the clinic from the schools at the instigation of the educational psychologist. Another group of children are referred to the clinics by the teachers or headmasters. Such referrals may or may not involve the educational psychologist - children are usually referred in this manner when their classroom behaviour is unsatisfactory.

A second group of children are referred via the school health service, by the school doctor, usually after a routine medical examination and consultation with the parents, or at the parents request.

Non-educational sources of referral tend to fall mainly into two groups. The largest of these is the general practitioner

who, as Gath[6] has pointed out, is often simply passively reflecting the demands of the parents to help with a difficult or worrying child.

The second group of non-educational referrals are the parents themselves. Not all clinics will accept direct referral by the parents, many demand that the parents ask a general practitioner to make the referral.

There are two types of clinic facilities available for the treatment of maladjusted children; child psychiatric clinics and child guidance clinics. The child psychiatric clinics are normally run by the department of child psychiatry in a general hospital. They receive their referrals from the hospital catchment area and they are financed by the hospital services. The child guidance clinics are one of the services provided by the local authority. At the present time they may be under the jurisdiction of the medical officer of health, the chief educational officer or the director of social services. The Seebohm Report[7] had no definite recommendations to make concerning the future organisation or development of the child guidance services.

2. Special School Facilities

Children who are unsuccessfully dealt with by a child guidance clinic may be "deemed" as maladjusted by a psychiatrist and placed in a school for maladjusted children. Such schools may be day or boarding schools. Boarding schools tend to be used either where the child is particularly disturbed or where the family situation is extremely bad. In addition to the boarding and day facilities some local authorities have part time classes for children who are considered to be maladjusted.

The studies which are about to be described are mainly concerned with the child guidance clinics themselves. Two of the studies are concerned with describing the provision and use of services within given geographical areas. The subjects for these two studies are the thirty child guidance clinics in the Outer London Boroughs. For practical reasons only the child guidance clinics have been considered and not the child psychiatric clinics. The child psychiatric clinics could not be included because their catchment areas cut across those of the local authority areas, hence direct comparison between groups would have been impossible.

The first study, described in Chapter 2, examinesthe rates of referral to the thirty child guidance clinics in terms of age and sex of the child and the source from which they were referred. This study is based upon more than 8,000 referrals over a period of two years.

The second study, which is described in Chapter 3, is an exploratory study. The same twenty boroughs are taken as the subjects of the study, but in this case the interest is focussed on the answers to two questions, firstly, why is it that different local authority areas have different provisions of services for maladjusted children and secondly, why is it that different areas have a different rate of usage of the services that they have provided for maladjusted children?

The third study, which is described in Chapters 4 and 5, is also an exploratory study. In this case the emphasis moves away from the influence of area factors towards the influences to be found within the individual family. In this study we seek to examine the factors which might explain why it is that some families who are referred to child guidance clinics co-operate with the clinics

and others refuse to do so.

Some of the children of the families who eventually co-operated with the clinic were considered to have improved as a consequence of their being treated by the clinic. Using these families as a basis, a limited analysis has been carried out on the relationship between various factors in the child's environment and the later improvement in his condition. The information that has been used for this analysis has been gathered from a very few cases and does not justify inclusion in the general text. However, as it is of interest and will be referred to at times it has been added as Appendix 6 of this thesis. Profiles of the families described in Chapters 4 and 5 and Appendix 6 are to be found in Appendix 3.

These studies are largely breaking new ground and although they address themselves to practical questions each has a theoretical basis which will be described as we proceed. Owing to the limited amount of research which has previously been done in this subject area there is little information to provide a context for the present study. However, where there are such studies they will be considered in the main body of the text.

CHAPTER 2

REFERRALS TO LOCAL AUTHORITY CHILD GUIDANCE CLINICS IN THE OUTER LONDON AREA

This study is based upon the children referred to the thirty local authority child guidance clinics in the Outer London area, between 1st January 1968 and 31st December 1969. Hospital clinics were ignored because it was beyond the means available for this study to include them.

The basic information was collected on a proforma which was so designed to enable the age and sex of the child and the agency from which he was referred to be included. A copy of this proforma is found in Appendix 1.

Two copies of the proforma were sent to each of the clinics involved in the study. One was for 1968 and one for 1969. The data for the two years was compared using a Chi squared test. The value of Chi squared was less than 0•6 so it was decided to amalgamate the data for the two years.

Because different clinics tend to use different administrative procedures when listing the agency which refers their clients, it was decided to create two categories of referring agent. These are the "educational referrals" which comprise all those children referred from sources under the education or school health departments and the "non-educational sources" which comprises all the other classifications.

The procedures that have been described reduced the data to a set of numbers for each clinic giving the number of boys and girls

of each age who were referred from educational and non-educational sources from each of the thirty clinics. These figures were then added together to give one set for the thirty clinics.

In order to express these figures as a "rate" it was necessary to calculate the number of children at risk in each area.

The Department of Education provided data on the numbers of boys and girls in each borough, and of each age, who were attending school during 1968 and 1969. These figures were accurate only for the age groups 5 to 14. The numbers for the two years were added together to make them comparable with the numbers of children referred to child guidance clinics.

Where a borough had more than one clinic the numbers of children referred to the clinics were added together to form a single total for that borough. This formed a set of twenty distributions covering the age, sex and source of referral for each of the twenty Outer London Boroughs.

For each distribution the number of children referred was divided by the number of children at risk to give a figure for the number of children referred per 1,000 children at risk. These figures are referred to as the "rates".

For the purpose of the analysis in this chapter the rates for the twenty boroughs were added together and divided by twenty to give the mean rate in each age group.

In the following chapter the number of children referred was calculated without consideration for age and divided by the total number of children at risk to give the rate of referral for the borough.

Diagrams 1 to 5 show the "mean rates" of referral for each age group from 5 to 14 years.

Diagram 1 shows the distribution of rates in each age group for the twenty boroughs. The most striking point about this distribution is its flatness. For the ages 6 to 13 inclusive the rate varies less than 0•8 cases per 1,000 children at risk. This is less than 10% variation.

Diagram 2 shows the same data but with the males and females separate. We see that the rate for boys is always greater than that for girls. The ratio of the sexes ranges between 2•1 boys for every girl at age 10, to 1•1 boys for every girl at age 13.

The general trend is that the rate for boys rises slowly up to the age of 10 and then declines. The rate for girls tends to rise slowly over the whole age range.

In diagram 3 the data for the children referred from educational sources is separated from the children referred from non-educational sources. The rate of referral for children referred from educational sources increases by 80% between the ages of 5 and 8. After this peak at 8 the rate slowly declines until it reaches a minimum at age 14, when it is lower than it was at age 5. The curvilinear distribution of referrals from educational sources contrasts with the linear distribution of referrals from non-educational sources. The referral rate from non-educational sources increases by 70% between the ages of 5 and 14.

Up to the age of 12 there tends to be fewer referrals from non-educational sources than the educational sources. After age 12 the rate of referrals from educational sources is surpassed by the rate from non-educational sources.

Diagram 4 shows the age distribution of male referrals with the sources of referral separate. We can see from this diagram that the pattern of referrals for boys from non-educational sources tends to be a rising trend. It increases 78% between the ages of 5 and 12 and hardly falls from this level at all.

In contrast, the rate of referral from the schools increases 62% between ages 5 and 9 and then declines to a level 26% below the original by the age of 14. At its peak level the educational rate for boys is 55% higher than the non-educational rate. Three years later, at age 12, it is the same as the non-educational rate after which it falls to a lower level.

Diagram 5 shows the distribution of female rates over the age range with the sources of referral separate. The distributions from the two sources of referral are very similar. Both show a trend which increases with age. The increase in the rate is 50% for both sources of referral between the ages of 5 and 13.

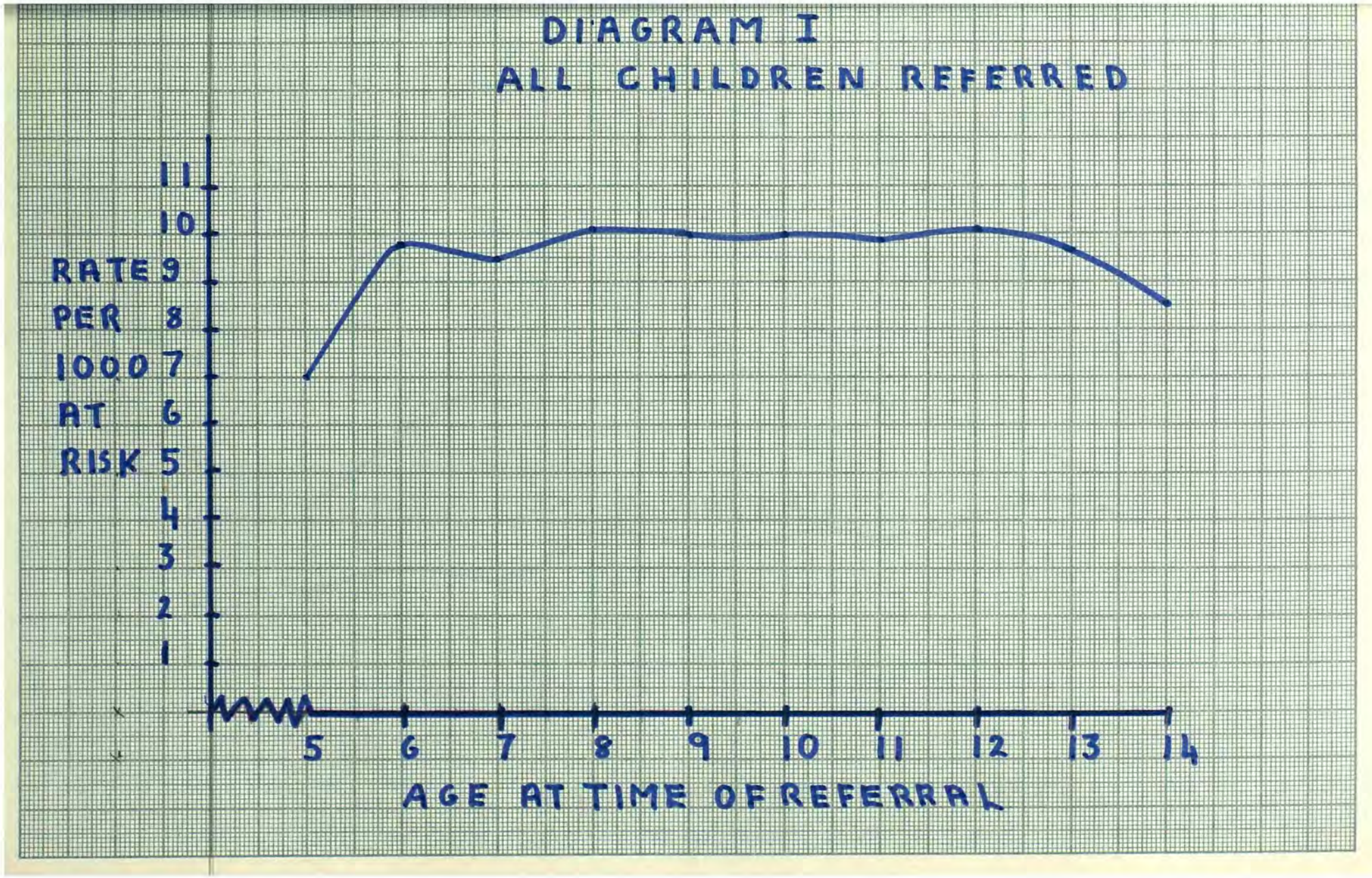


DIAGRAM I
ALL CHILDREN REFERRED
RATE PER 1000 AT RISK
11
10
9
8
7
6
5
4
3
2
1
5
6
7
8
9
10
11
12
13
14
AGE AT TIME OF REFERRAL

DIAGRAM II

MALE AND FEMALE REFERRALS

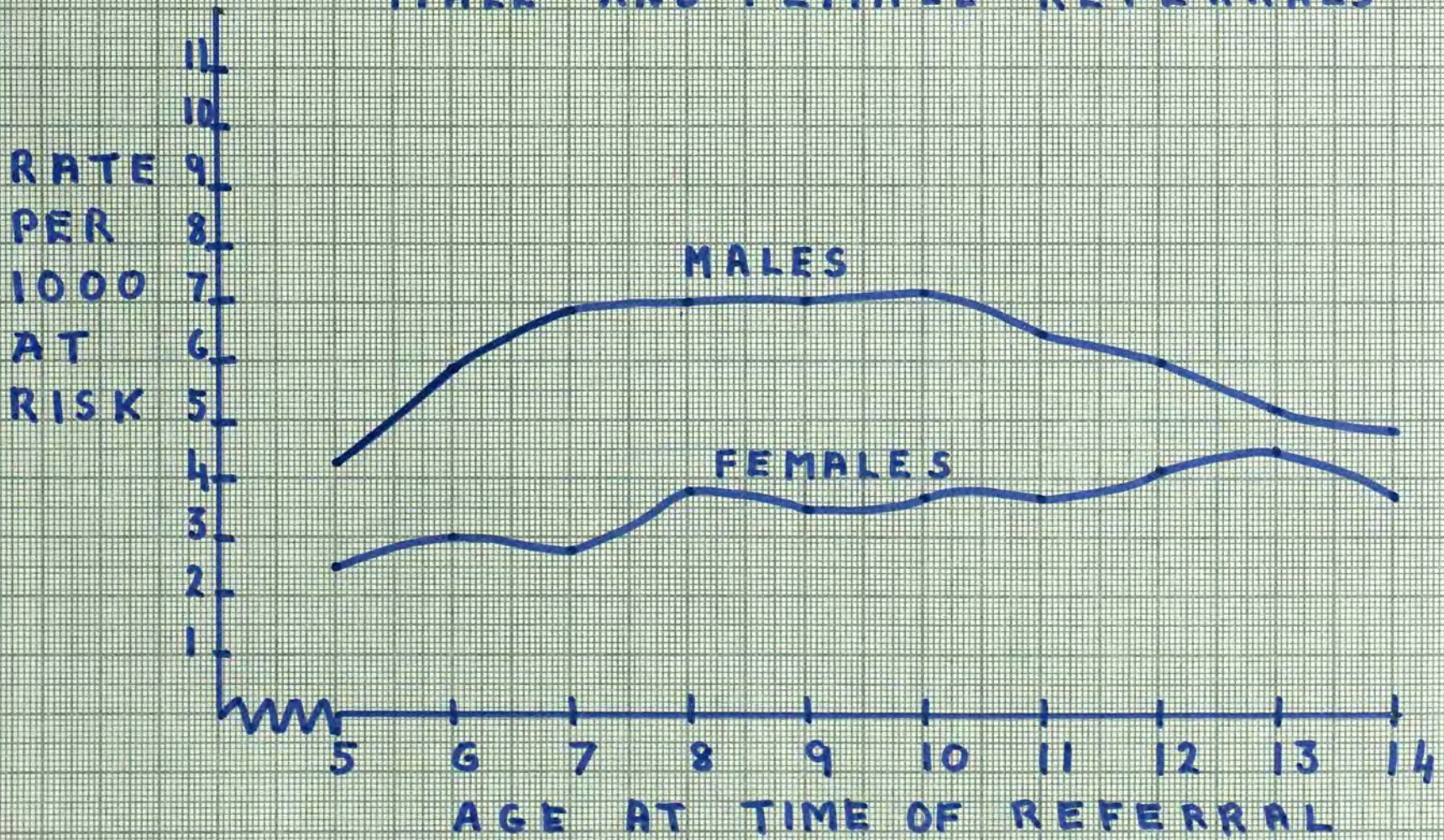


DIAGRAM III

EDUCATIONAL AND NON-EDUCATIONAL REFERRALS

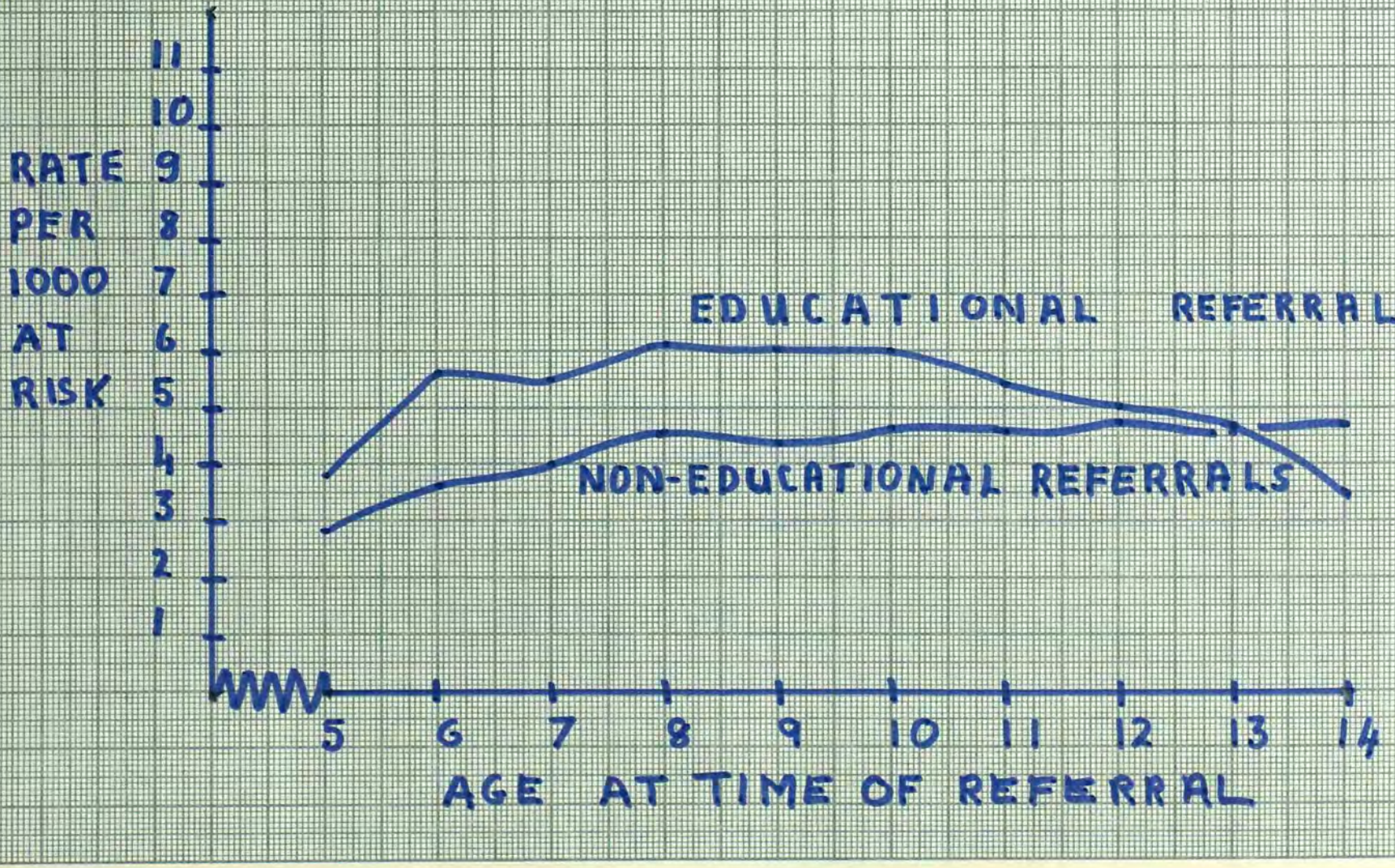


DIAGRAM IV

MALE REFERRALS

EDUCATIONAL AND NON-EDUCATIONAL SOURCES

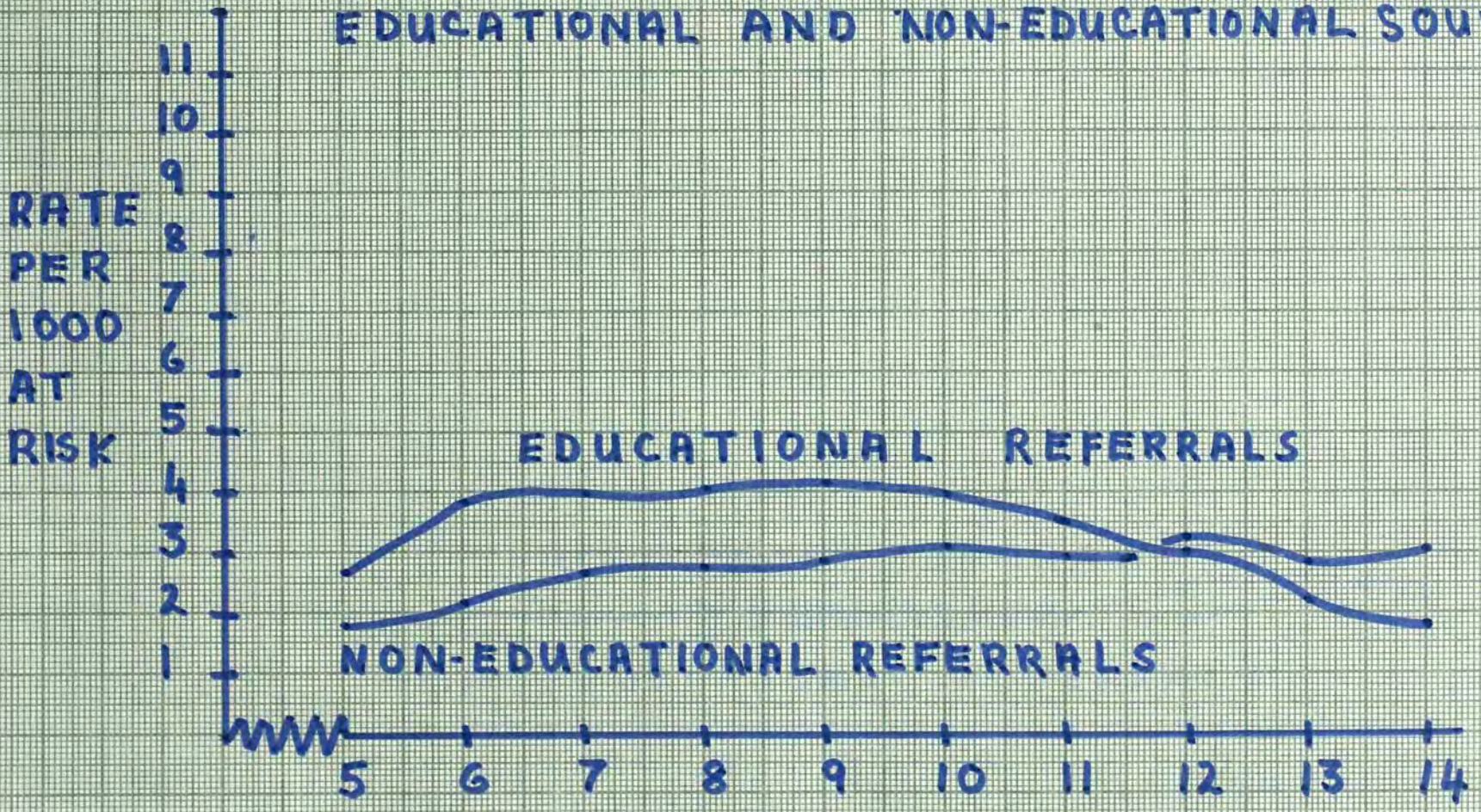
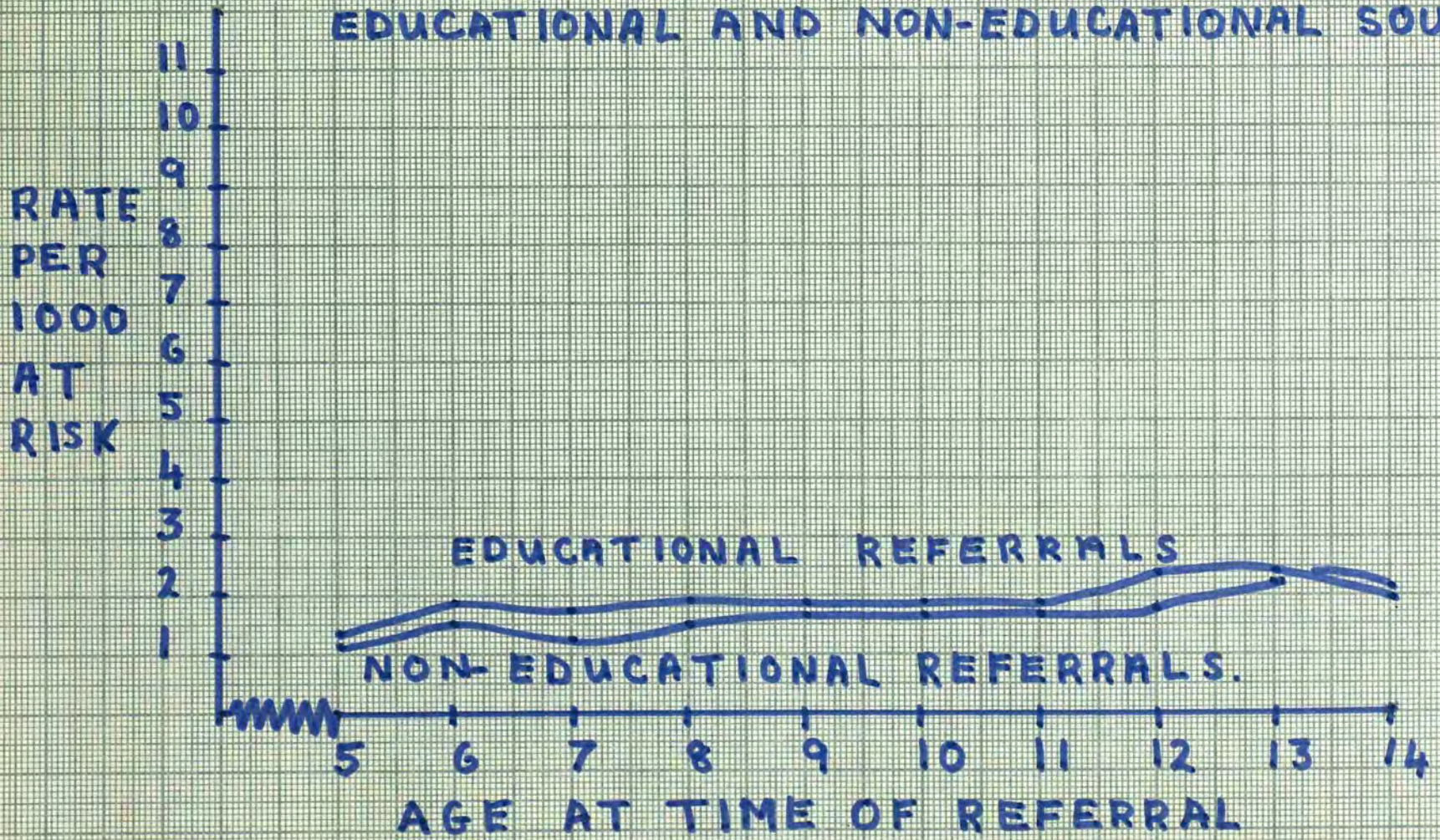


DIAGRAM V

FEMALE REFERRALS

EDUCATIONAL AND NON-EDUCATIONAL SOURCES



The first question we wish to ask of this data is how far is it comparable with that of earlier studies. Examination of the relevant literature has only found one study which is comparable with the present research. This study is referred to by Vernon[8] and was carried out by the British Psychological Society. Unfortunately it was not possible to trace the original data and that which is presented is taken from Vernon's report.

The study compared the number of children referred to child guidance clinics in each age group. The research concluded that increasing numbers of children were referred in each age group between the ages of 5 and 7. The numbers then remained constant for each age from 7 to 9 and after age 9 fewer children were referred in each age group up to the upper age limit of 16.

There appears to be a belief among workers in child guidance clinics that the most common age of referral for children referred to a child guidance clinic is 8 or 9 years. As there is a general lack of figures on this subject it is quite likely that this belief stems from the study that has just been described, yet such a direct interpretation of these figures could be seriously misleading. These figures were collected in the mid-1950's when the children born between 1947 and 1949 were 8 to 9 years old. As this was a period of abnormally high birth rate, one would expect to have proportionately more children of this age being referred to child guidance clinics in the mid-1950's. It is quite probable that if this study had taken the numbers of children in each age group into account they would have found little difference in the proportion of children in each age group that were referred.

Of course, without the original figures this is purely speculative. However, one suspects the resulting age rate distribution would be very similar to the one seen in Diagram 1.

The second question that we can ask of the figures collected for the present study is how far do these patterns of referral reflect the actual incidence of disturbance within the population? In short, we cannot answer this question because there are no comparable studies of incidence in the population from which our figures are drawn. Even if we ignore this issue and just consider studies of incidence within the population there are considerable difficulties. Rutter[9], when he reviewed these studies came to the conclusion that there was no conclusive evidence concerning the incidence, prevalence, sex ratios or age distribution of disturbance in the population under 15.

The most exhaustive studies which have been carried out of the prevalence of disturbance in the population are those of Rutter who concluded, in the Isle of Wight study, that approximately 10% of the children in the 10 to 11 year age group were in fact disturbed, and he further concluded that about one in ten of these would be likely to be referred to a child guidance clinic. This overall figure of 1% of the child population being referred to child guidlance clinics (or 10% of the disturbed child population) is remarkably similar to that shown in Diagram 1.

In later parts of this study we will be examining some of the factors that seem to lead to children being referred to child guidance facilities. An important insight can be gained by comparing the male and female educational distributions with the findings of Jean Lawrence's study. Mrs. Lawrence found that

teachers experienced greatest difficulty in dealing with boys around the age of 8 years and girls around the age of 13 years. It is hardly fortuitous that these ages are the ages when we see the peak of referrals for boys and girls to child guidance facilities.

The idea that child guidance is one of several possible alternative resources that adults can use when they are unable to cope with children will be returned to again. It is well worth bearing in mind when considering figures such as those preceeding, that well staffed social, medical and educational agencies may have considerable impact on the numbers of children referred to child guidance facilities. For instance, one such alternative form of "treatment" would be the juvenile court. If we examine Diagram 4 we see that the rate of referral of boys from educational sources drops sharply after the age of 10. In 1968-69 this was the age at which children would first be eligible to appear before the juvenile courts. The majority of the boys referred by the schools are those showing anti-social tendencies and those are the ones most likely to appear before the courts. Hence it may be that the children who are referred to child guidance from educational sources prior to the age of 10 are the ones that would appear before the court after that age.

CHAPTER 3

THE PROVISION AND USE OF SERVICES FOR MALADJUSTED CHILDREN

INTRODUCTION

There is ample evidence for the view that the "ethos" of an area has considerable effect on both the services that are provided in that area and the type of problems that a person working in the area will encounter. The present study set out to discover how far it would be possible to explain the different provision of services for maladjusted children, and the uses made of these, in terms of the ethos of the area in which they are situated. Provision will be considered in terms of the child guidance services and usage in terms of the rates of referral to these services and to schools for the maladjusted child. The areas to be considered are the twenty Outer London Boroughs.

Theoretically the work that is closest to this present study is that of the ecological theorists. Generally speaking they have used ecological variables defining the characteristics of given areas to explain individual behaviour. In most instances the work has been concerned with delinquency. A study of this nature is described by Wallace and Maliphent[11]. Such studies as these tend to causally relate the physical attributes of the area to the individual behaviour. The present study differs in its emphasis. Here we are suggesting that the physical characteristics of the area are indicative of the values held by the people living in that area. No attempt is being made to suggest that the physical

characteristics of the area influence the individuals as such. Our argument here is that it is the value system of the individuals in the area which is of importance.

The concept of ethos is easy to grasp intuitively but difficult to measure in a practical manner. It really represents the social "atmosphere" of the area. As there is not a direct measure of ethos available, nor is it easy to conceive of such a measure, two indicators of this concept have been developed. The two indicators selected can be theoretically related to the concept of ethos and also to the dependant variables defining the provision and use of services.

The first indicator of ethos is the proportion of professional and managerial workers resident in the borough. In general terms where we find large proportions of such people we can expect a politically conservative local authority, operating a an 11+ system of educational selection rather than a comprehensive one. Housing is more likely to be "owner occupied" and the population density lower than in boroughs where the proportion of professional and managerial workers is lower.

These social and demographic variables are themselves merely a practical indication of the presence of middle class values. Such values tend to be held by the majority of persons occupying professional statuses though they are being rejected by growing numbers. The middle class value system tends to find its strongest expression among the lower middle classes, particularly in those areas where there are large numbers of professional persons to emulate.

One factor that is highly valued in this group is "education", another is "good behaviour". We can argue from this point that

adults in middle class areas would be less tolerant of deviant behaviour in their own children and in children around them. Partly, this lower tolerance will be a reflection of their values, but to a far greater extent it will be because such behaviour is more obvious. For instance, if most children in a school or classroom have middle class attitudes to education and learning, the disruptive behaviour of the child who appears to reject these values will be more obvious and tolerated to a lesser degree than he would be in an environment where the majority of children rejected these values.

The way that a deviant is perceived also tends to reflect the social class of the perceiver. The middle class person tends to see the deviant child as being "sick" and in need of treatment rather than being delinquent and in need of punishment. Consequently, we would expect a stronger tendency to use psychiatric facilities in middle class areas coupled with a more extensive provision in terms of clinics and staff. We would also expect to find a strong tendency to remove the disruptive child.

The second indicator of "ethos" is the proportion of commonwealth immigrants in the borough. The teacher in the classroom often encounters serious difficulties with those who are from different cultural backgrounds. A proportion of these difficulties will be due to the disruption caused by disturbed children. There is strong evidence that in the first years that any new group come into a culture, numbers of children will get into difficulties and express these difficulties in terms of disturbed behaviour.

We are unable to say to what extent this behaviour is truly indicative of a disturbed child and to what extent it simply

disturbs third parties who then refer the child because they are unable to deal with the problems created.

One clinic in an area with a large proportion of West Indians examined the names of the children in their referral book since 1945. They discovered that since the war three groups of foreign names appeared. First Irish, then Greek and finally West Indian. Each group of names was found to be most frequent at the times when the majority of new arrivals in the borough came from that part of the world. The first two groups of names, the Irish and Greek, appeared to decline about ten years after the peak of immigration from those areas and the remaining group of West Indians appeared to be following a similar trend.

Presently the explanation of deviance in immigrant groups tends to take one of two forms. In the first instance it may be explained in terms of genetic inferiority. Another approach is to explain it in terms of a cultural clash. Either way, the tendency is to try and "treat" the child by using "special education" and "treatment" rather than "punishment" and "correction".

It follows then that we would expect to find a more extensive provision of facilities for the treatment of the maladjusted child and a greater tendency to use these in the areas with larger proportions of immigrants. The process through which large numbers of immigrants in an area is reflected in terms of extra provision and use of services cannot be outlined with any certainty. One suspects that because of the sensitivity of this issue it is rarely discussed openly. Official reasons are unlikely to be phrased in any way which relates the provision of services in the area to the number of immigrants.

The majority of recent immigrants settle in areas with few resident professional people. Consequently, we would expect the two indicators of ethos to be related to each other. Most of the immigrants will go to the lower class boroughs and as we expect the immigrants to have an effect on the provision and use of facilities, we would expect most of the low class boroughs to have high provision and use. Conversely, we would expect the high class boroughs to have a higher provision and use than the low class ones because this would be a reflection of their social ethos. Much of the analysis of this data will be in order to investigate these complications and to see which of these divergent trends can be identified and separated.

THE DEVELOPMENT OF THE MEASURMENETS

In the introduction to this chapter a theoretical model was outlined. A description of the way the necessary data was collected and prepared for analysis follows.

The two indicators of ethos were developed as follows:-

1. The proportion of upper class persons (Variable named - Social Class)

The 1966 census data was re-arranged so that for each borough the proportion of upper class persons could be directly computed.

For the study "upper class persons" was defined as those being listed in the census as being members of socio-economic groups 1, 2, 3, 4, 13; these being professional people, employers, managers.

The boroughs were then ranked with those having the greatest proportion of upper class persons being given the highest rank. The ranking was then divided into two groups of ten - the top group being considered to be upper class boroughs and the bottom group lower class boroughs.

Social class is often considered to be a composite concept because so many things appear to be related to it quite strongly. In the introduction it was suggested that upper class areas would be marked by owner occupation, a low population density and an 11+ education system.

On the basis of this dichotomy:-

(a) 63% of the housing in the upper class boroughs is owner occupied compared with 52% in the lower class boroughs.

(b) The mean population density of the upper class boroughs is 13 persons per acre compared with 18 persons per acre in the lower class boroughs.

(c) Of the ten upper class boroughs seven were still operating an 11+ system of selection during the period of study compared with four of the lower class boroughs. Only one upper class borough was operating a fully comprehensive system compared with four lower class boroughs.

All the above figures follow the trends that we would expect. They are possibly not as dramatic as could be hoped for. We should, however, bear in mind that the eleven inner London boroughs have been excluded and these constitute the major bulk of the truly working class areas.

2. <u>The proportion of commonwealth immigrants</u> (Variable name - The proportion of immigrants)

The 1966 census gave the birth places of the population of each borough. For the present study this data was re-organised to form two categories. Those who were born in commonwealth countries and others. For each borough the proportion of commonwealth immigrants

was calculated. The boroughs were then ranked according to the proportion of commonwealth immigrants; those having most immigrants were given the highest ranking. The boroughs were then divided into two groups, on the basis of this ranking, those with high proportions of immigrants and those with low.

The boroughs ranked as being high immigrant had an average of 5•13% of the population born in commonwealth countries compared with 1•93% in those areas ranked as low immigrant areas.

These figures are probably very misleading in terms of the proportions of immigrant children in the schools. Unfortunately this data was not available. This deficiency is probably not serious because we would expect those boroughs with the highest proportions of commonwealth immigrants of all ages to also have the highest proportions of immigrants in the schools - so that the rankings would remain similar.

Three other variables were used in the analysis. These are analytical properties of the boroughs which are (theoretically) said to result from the differing ethoses of the area.

3. Provision of clinic staff (Variable name - Provision)

After consideration it was decided that the most suitable measure of therapeutic provision in an area was the number of clinic staff provided per 1,000 children at risk.

Two other approaches were rejected after consideration. The first of these was the number of clinics in the area. This was rejected because it was felt that it would be particularly sensitive to changes in the needs of the area. It takes a long time to establish a new clinic and is much easier to appoint staff within existing facilities.

The second approach that was rejected was to take specific staff positions and examine the data in terms of these. From this perspective we would ask how far the number of psychiatrists, social workers, therapists and psychologists in an area are reflections of the ethos of the area. This approach did not prove to be very useful, the reason being that each clinic tends to work in a specific way. Consequently, one clinic might feel that it needs a social worker to fulfil a given role while another would feel this could only be fulfilled by a psychiatrist.

The measure that was finally adopted was a development of this latter approach. For each borough the number of full time child guidance personnel was calculated. These figures being taken from the returns sent by the local authorities to the Department of Education.

The figures were divided by the number of children at risk to give the number of personnel provided for every 10,000 children. The boroughs were then ranked on the basis and then the ranking was divided into two groups. The high provision group has a mean of 2·82 full time workers for every 10,000 children at risk. The low provision group has a mean of 1·33 workers.

Two measures of the use of services have bee n adopted. These are the number of children placed as maladjusted and the rate of referral to child guidance clinics.

4. <u>The rate of placement as maladjusted</u> (Variable name - Placement)

As with the provision of services the use of facilities was first considered in terms of the number of schools provided for maladjusted children by the local authority and rejected for similar reasons.

The measure that was eventually used was based upon the number of children who were classified as maladjusted whether they attended day or boarding facilities.

The number of children placed as maladjusted in each borough was taken from the returns to the Department of Education. This figure was then divided by the number of children at risk.

The boroughs were then ranked according to the proportion of children being placed as maladjusted. The ranking was divided into two groups - high and low placement groups.

The high placement group has a mean of 3•12 placement per 1,000 children at risk. The low placement group has a mean of 1•38 per 1,000 children at risk.

5. The rates of referral (Variable name - Rate of Referral)

The data for these measures was collected and developed as described in the previous chapter. For the purpose of this study the rates were calculated as a single rate for all the children between the ages of 5 and 14. The educational sources of referral were separated from the non-educational sources in these calculations.

The boroughs ranked according to the rates of referral and the ranking divided to give high and low rate categories.

The group of boroughs in the high [redacted] rate category have a mean rate of 16•5 children referred per 1,000 at risk. Those in the low rate category have a mean rate of referral of 6•5 per 1,000 children at risk.

THE ANALYSIS

The analysis we are about to pursue will take the form of a "causal analysis"[39] The use of significance tests is not necessary.

as the data is population data and all differences are statistically significant. Because of the small numbers involved statistical measures of association are misleading apart from first order correlations. The data on which the study is based is population data and the purpose of the analysis is to try to estimate the relationship between population parameters. Consequently, significance tests have not been used and the major stress of the analysis will be on percentage differences which will be displayed graphically and subjected to visual inspection. A measure of correlation has been provided as a guideline.

The statistic that has been selected for use on this data is r (phi) - its characteristics and the reason for selecting it are described in Appendix 5.

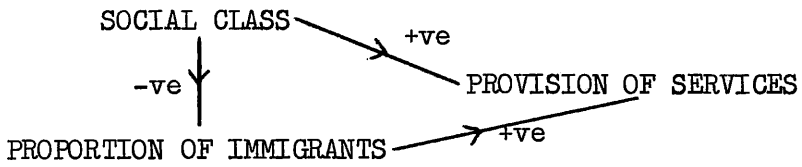
The theory presented in the foregoing paragraphs suggested that the two indicators of ethos ("social class" and "the proportion of immigrants") are in all probability related to each other. The following table shows the actual relationship.

TABLE 1

		Social Class of Borough	
		High	Low
Proportion of Immigrants in Borough	High	3	7
	Low	7	3

There is a clear strong negative relationship (r(phi) = 0•4) with the greates "proportion of immigrants" being found in the "lower class" areas.

In the theoretical presentation we argued that these two indicators both would tend to lead to an increased provision of services. This argument is presented diagramatically below.



However, because "social class" and the "proportion of immigrants" are related to each other in a manner whereby more "upper class" persons tends to mean less "immigrants" (and vice versa) we would expect the independent relationships between these two variables and the provision of services to be unclear. The first order relationships are shown in tables 2 and 3.

TABLE 2

		Social Class of Borough	
		High	Low
Provision	High	3	7
	Low	7	3

r (phi) = -0•4

TABLE 3

		Proportion of Immigrants	
		High	Low
Provision	High	8	2
	Low	2	8

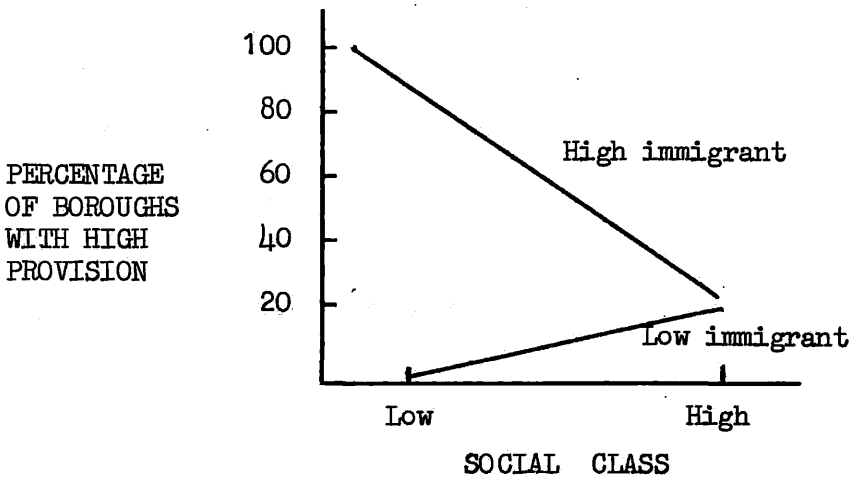
r (phi) = +0•6

Table 3 shows us that where there are large numbers of "immigrants" there also tends to be greater "provision of services". This is as we predicted. The relationship between "social class" and "provision of services" shown in Table 2 is not as we predicted it. In this case we find that it is the "low class" boroughs which have the highest provision. The r elationship is negative not positive as predicted. This may be due to the "low class" boroughs also being those with large proportions of "immigrants". The question we have to ask ourselves is - do the "high class" boroughs have higher "provision of services" than the "low class" ones when we take into account the "proportion of immigrants" in the population. This relationship is shown in the following table and diagram.

TABLE 4

		PROPORTION OF IMMIGRANTS			
		High		Low	
		Social Class		Social Class	
		High	Low	High	Low
PROVISION	High	1	7	2	0
	Low	2	0	5	3

DIAGRAM 6



The relationship is more complex than we predicted. In the "low immigrant" sub-group the boroughs which are "high class" tend to have higher "provision of services". In the high "immigrant" sub-group it is the "low class" boroughs which tend to have the highest "provision of services." In the "high class" boroughs there is a slight tendency for the boroughs with the greatest "proportion of immigrants" to be those with the highest "provision".

One way of interpreting this data would be to argue that the "upper class" boroughs tended to already have what was considered to be adequate provision before the arrival of the immigrants. The "lower class" boroughs would have had little, if any, provision for maladjusted children. Consequently, when they expanded their services it would have been in terms of establishing whole clinics. If, in fact, the most recently opened clinics were in areas with high rather than low "proportions of immigrants" we would be further justified in our argument that it is the "proportion of immigrants" in the area which is largely responsible for the increased "provision."

TABLE 5

YEAR CLINIC OPENED	PROPORTION OF IMMIGRANTS	
	High	Low
Before 1960	12	9
1960 and later	8	1

The interpretation of the above table is quite clear. Eighty-nine percent of the clinics opened since 1960 have been in areas

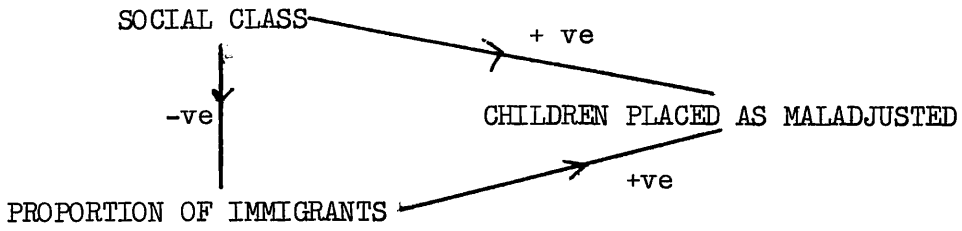
with high "proportions of immigrants". Before 1960, when the numbers of immigrants would have been relatively low, these areas only accounted for 57% of the [redacted] established clinics.

Without studying the actual decision making process we are unable to state conclusively that it is the increasing "proportion of immigrants" in the areas which are responsible for the increased "provision" of child guidance facilities. However, the evidence that is immediately available must lead us to consider this as a strong possibility.

We can conclude this phase of the analysis by suggesting that both of our indicators of ethos are related to increased provision of personnel in child guidance clinics. The relationship between "social class" and the "provision of services" is much weaker than that between "immigration" and "provision". Because "lower class" boroughs tend to be those with the highest "proportion of immigrants" the weaker relationship between "high class" and "provision" tends to be disguised.

The next phase in the analysis will consider the relationship between the two indicators of ethos and the "proportions of children placed as maladjusted". Once again we have argued that both the indicators of ethos will be positively related to the proportion of children placed as maladjusted. The theoretical role of "social class" in this model is that we suggest that the "upper class" groups will be less tolerant of deviant behaviour and thereby more likely to place children as maladjusted.

Our argument is depicted in a causal schema below.



The following tables show the actual relationships.

TABLE 6

		SOCIAL CLASS	
		High	Low
Placement as Maladjusted	High	5	5
	Low	5	5

r (phi) = 0

TABLE 7

		IMMIGRATION	
		High	Low
Placement as Maladjusted	High	8	2
	Low	2	8

r (phi) = +0·6

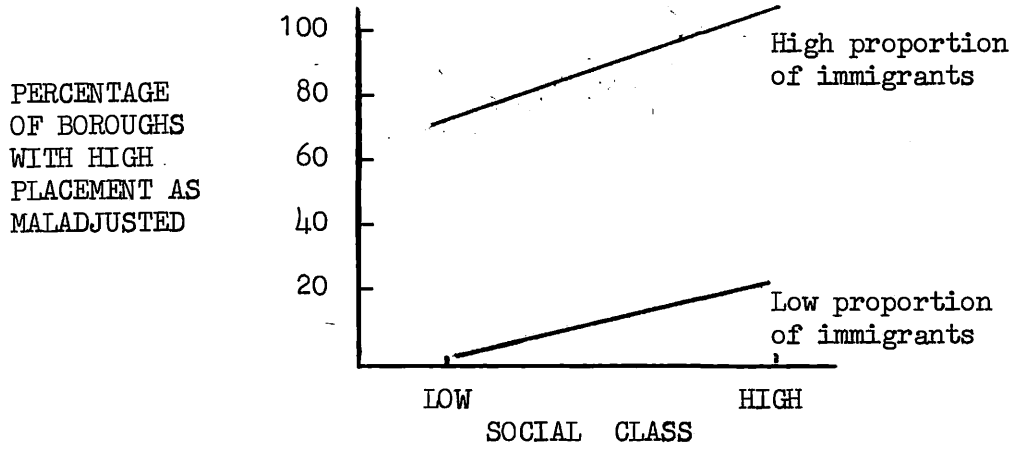
Table 6 shows that there is no relationship between "social class" and the numbers of "children placed as maladjusted". There is a strong relationship between the number of "immigrants" in the

area and the number of "children placed as maladjusted". This is shown in Table 7. Our experience when analysing the relationship between the two indicators of ethos and the provision of clinic staff showed that a positive relationship between social class and provision was disguised by the much stronger influence of the "proportion of immigrants" in the area. As only the dependant variable has been changed in this part of the analysis we would expect a similar situation to exist here. However, in this case we do not have a relationship at all between "social class" and the "numbers of children placed as maladjusted". Consequently we may expect to find a stronger relationship than that between "social class" and "provision" when we take account of the "proportion of immigrants" in the area. The tabulation and relevant diagram are shown below.

TABLE 8

		IMMIGRATION			
		HIGH		LOW	
		Social Class		Social Class	
		High	Low	High	Low
PLACEMENTS	High	3	5	2	0
	Low	0	2	5	3

DIAGRAM 7



Our expectations are fulfilled. A clear relationship exists. In both groups of boroughs, those with high and low "proportions of immigrants", it is the "high class" boroughs which tend to place more "children as maladjusted". Because the relationship is straightforward we can see the comparative strengths of the two indicators quite clearly. In both high and low "immigration" groups there are 30% more boroughs with high rates than low. In both high and low "class" groups the high "immigration" group has 70% more boroughs with high "placement" than low.

We have now been able to demonstrate that the two indicators of ethos are major determinants of the amount of professional time provided and also the numbers of children placed as maladjusted. As every child placed as maladjusted has to pass through a child guidance clinic we would expect to find some form of relationship between the "provision" of time and the "numbers of children placed as maladjusted". This relationship is shown in the following table.

TABLE 9

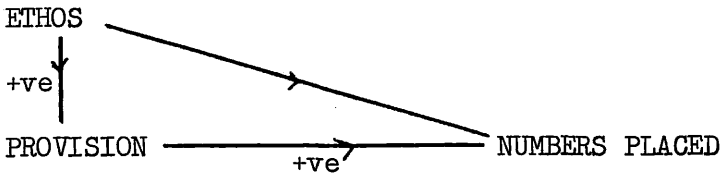
		PROVISION	
		High	Low
Proportion placed as Maladjusted	High	6	4
	Low	4	6

r (phi) = +0·16

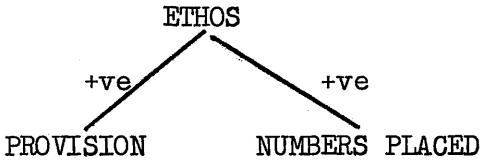
There is a relationship, though not a very strong one. The question we must answer is how is it effected by the two indicators of ethos. There seem to be two possibilities. In the first instance we might argue that the ethos determines the "provision" of clinic time and this in turn determines the numbers of children "placed" as maladjusted.

ETHOS ⟶ PROVISION ⟶ PLACEMENTS

Such a model as this does not fit in with our theoretical perspective in which we have argued that it is the ethos of the area which determines the numbers of children "placed". It is much more likely that a relationship holds in which the ethos acts to determine both the "provision" and the rate of "placements". However, because "provision" has an independent influence we would expect that the relationship between the ethos and the numbers of children "placed" as maladjusted would be less strong than when the provision was taken into account.



The second alternative would be that both the numbers of children "placed" and the provision of services are determined by the ethos. In this case when we take the ethos into account we would not expect to find any relationship between the "provision of services" and the numbers of children "placed" as maladjusted.



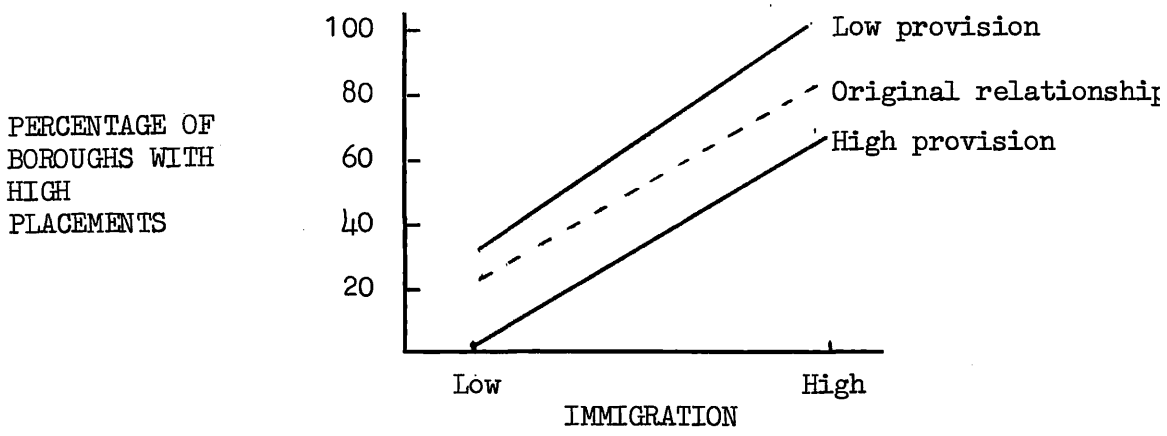
We are not able to directly test these hypotheses because to do so would require that we introduce both the indicators of ethos as control variables and the number here is too small to allow this. We have already been able to show that of the two indicators of ethos, "immigration" is the most powerful determinant both of the provision of services and the numbers of children "placed". Consequently, we will only use immigration in testing these hypotheses.

The relevant tabulation is shown in Table 10.

TABLE 10

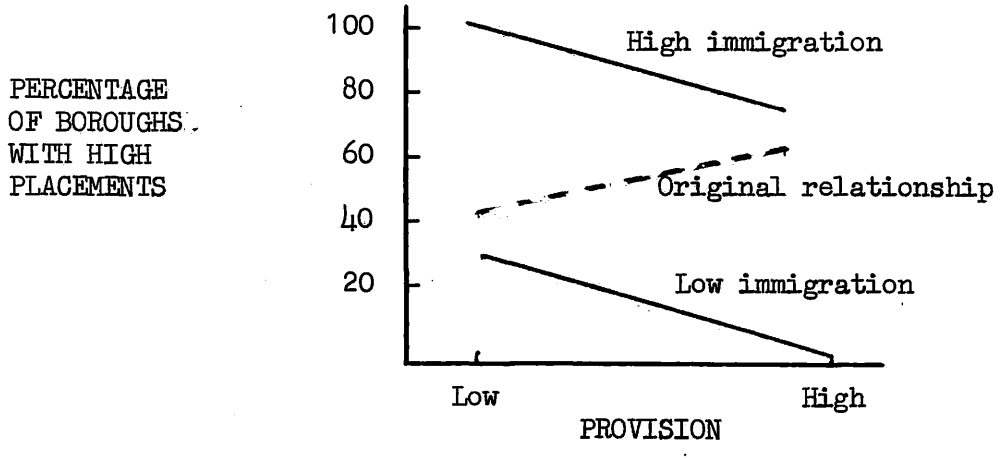
		PROVISION			
		HIGH		LOW	
		IMMIGRATION		IMMIGRATION	
		High	Low	High	Low
Placements	High	6	0	2	2
	Low	2	2	0	6

DIAGRAM 8



From the above presentation we can draw two conclusions. In the first place when we introduce "provision" as a control variable the relationship between "immigration" and the proportions "placed" as maladjusted does not decrease but is strengthened. The second conclusion explains the first. It is the areas with the lowest "provision" which have the highest rates of "placement". The reason why the opposite appeared to be the case originally was because of the strong relationship between "immigration" and both "provision" and "placement". "Immigration" once again has had the effect of distorting a relationship as the following diagram shows.

DIAGRAM 9



This relationship strongly suggests that where clinics are under-staffed there is a tendency to "place" more children as maladjusted than where there is more adequate staffing. We argue that if a clinic is overworked then it will be unable to treat larger numbers of children (through lack of time) and it would therefore be more likely to place these children as maladjusted. This argument, however, depends upon these clinics having proportionately more children referred than they have staff to deal with them. Unfortunately, the complex nature of the relationships prevents us adequately testing this assumption. The reasons for this will become clearer when we have examined the factors determining the rate of referral to the clinic.

We argued in the introduction that those areas with the largest proportion of "immigrants" would be most likely to have the highest "rates of referral" to the clinics. We also postulated that those areas with the most "upper class" people would also tend to have high "rates of referral". The relevant tables are given below.

TABLE 11

		SOCIAL CLASS	
		High	Low
RATES	High	2	8
	Low	8	2

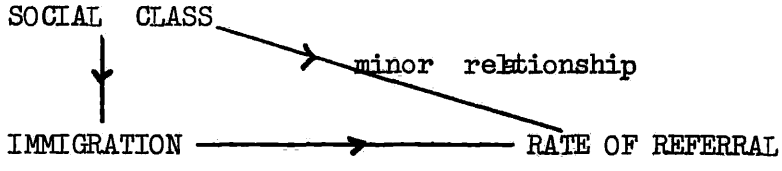
TABLE 12

		PROPORTION OF IMMIGRANTS	
		High	Low
RATES	High	7	3
	Low	3	7

r (phi) = 0·4

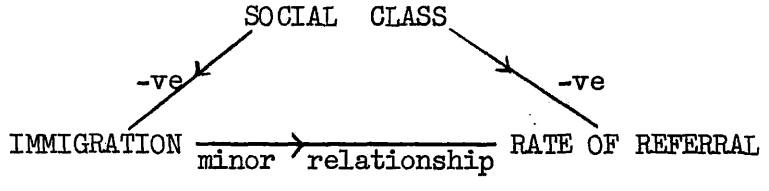
Two things are surprising about these tabulations. Firstly it is the lower "class" areas which have the highest "rates of referral" and not the upper "class" ones. Secondly, in absolute terms the relationship between "social class" and the "rate of referral is stronger than that between "immigration" and the "rate of referral". This suggests that "social class" is likely to be of more importance causally than "immigration".

We have two alternative ways of approaching the relationship between the two indicators of ethos and the "rate of referral". There is firstly the model that we have generally used up to now. Here we have aruged that the relationship between "social class" and the dependant variable is due to the fact that "social class" is related to "immigration" and "immigration" is related to the dependent variable. The direct relationship between "social class" and the dependant variable being of secondary importance.



This situation is depicted above with the "rate of referral" in the role of the dependent variable. If such a situation is the case the relationship between the intervening variable and the dependent variable is always stronger than that between the independent variable and the dependent variable.

In the present situation we must consider an alternative model. Such a model will treat "social class" as an extraneous variable which has the effect of creating the impression of a strong relationship between "immigration" and the "rate of referral" where there is not one at all.

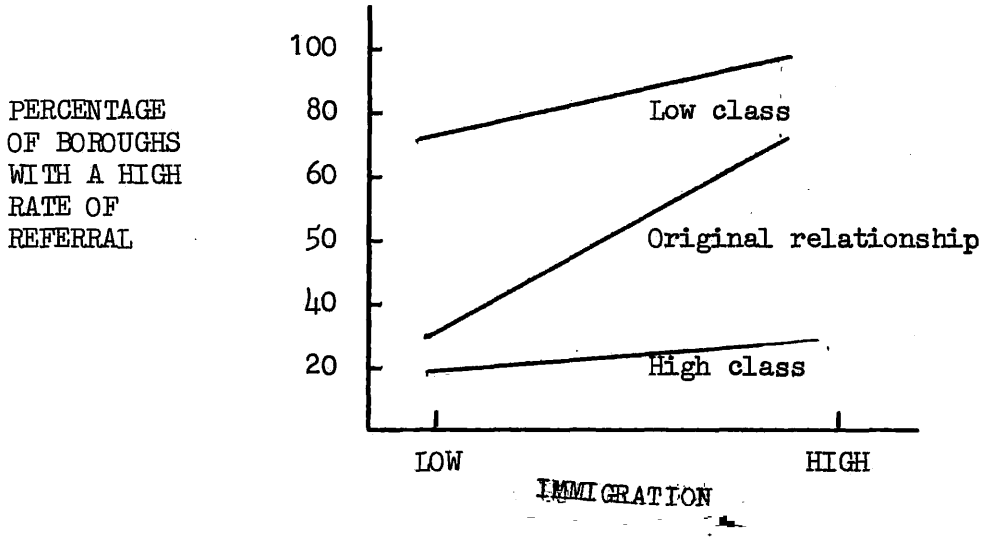


Our argument is as follows. We already know that there is a negative relationship between "social class" and the proportion of "immigrants" in the area. We have also discovered, contrary to our hypothesis, that there is a strong negative relationship between "social class" and the "rate of referral". We can therefore argue that the apparent relationship between "immigration" and the "rate of referral" is due to both of these variables being causally related to "social class". If we are correct when we introduce "social class" as a control variable we will find that the relationship between "immigration" and the "rate of referral" will be reduced.

TABLE 13

		SOCIAL CLASS			
		HIGH		LOW	
		Immigration		Immigration	
		High	Low	High	low
RATES	High	1	1	6	2
	Low	2	6	1	1

DIAGRAM 10



The relationship is clearly reduced. We can also see that if we were to introduce "immigration" as a control variable on the relationship between "social class" and the "rate of referral" this would make no difference to the original relationship.

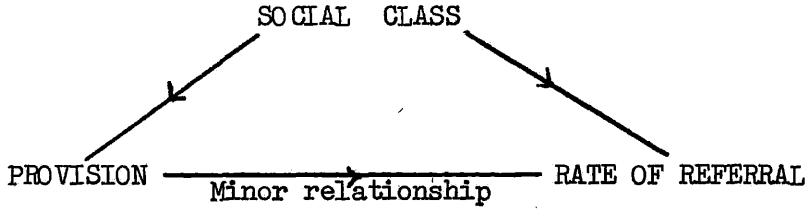
Before going on to explore the theoretical explanations for our results we need to ask - what is the role that the provision of clinic staff plays in this model? The question is essentially the same as that asked about the role of "immigration" in relationship to the

"rate of referral". Does "provision" act as an intervening variable between "social class" and the "rate of referral" or is the relationship between "provision" and the "rate of referral" due to the fact that both of these variables are causally related to social class? The fact that the relationship between "provision" and the "rate of referral" is weaker than that between "social class" and the "rate of referral" leads us to expect that the relationship is due to the influence of "social class" on the other two variables.

TABLE 14

		PROVISION	
		High	Low
RATE OF REFERRAL	High	7	3
	Low	3	7

r (phi) = 0·4

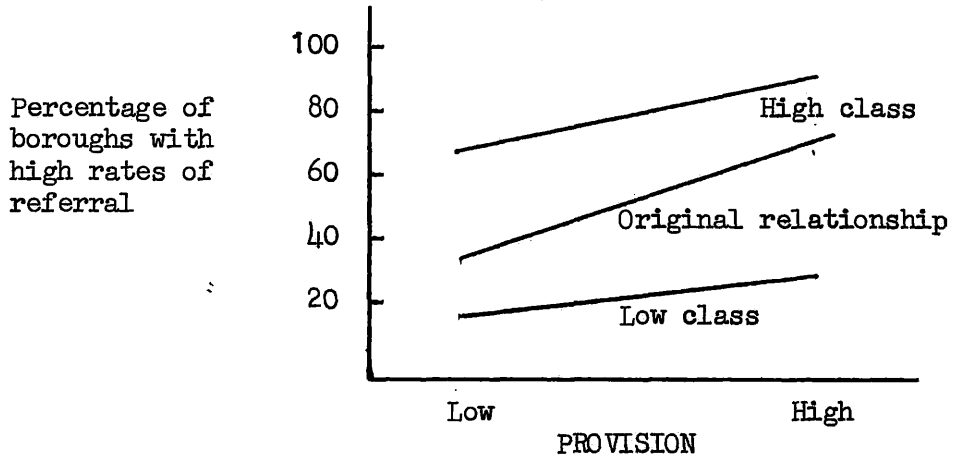


The following tables and diagram show this supposition to be correct.

TABLE 15

		SOCIAL CLASS			
		HIGH		LOW	
		PROVISION		PROVISION	
		High	Low	High	Low
RATE	High	1	1	6	2
	Low	2	6	1	1

DIAGRAM 11



At this point we can then say that the "provision" of services like the "proportion of immigrants" in the area is only weakly related to the rate of referral when we take into account that both these variables are related to "social class". It will be remembered that we have already demonstrated that the "provision" of services only has a weak causal relationship to social class and that this only becomes apparent when we take into account the role played by the proportion of "immigrants" in the area. The "proportion of immigrants" being causally the most important relationship.

The analysis of the rates of referral has diverged from the directions taken by the earlier analysis. Up to this point social class was seen to play a minor role. The process by which upper "class" areas tend to provide more expansive services and "place" more children as maladjusted only appeared once "immigration" had been introduced as a control variable. The analysis of the "rates of referral" has shown "social class" to be of major importance. It being the lower "class" areas which have the highest "rates of referral".

These findings need to be explained as they appear to contradict the theoretical model outlined in the earlier paragraphs. It is quite probable that there are two processes involved. Firstly, in "lower class" areas there tends to be a higher prevalence of disturbance which is related to the nature of the social and psychological environment of the lower class child. This would also be true for the immigrant child. Secondly, there is a cultural process which leads middle class people to define deviant behaviour in terms of sickness rather than badness or naughtiness, and therefore accept the role of child guidance clinics. Up to this point we have considered the cultural process in terms of the "ethos" of the area and demonstrated that the middle class ethos does lead to high provision of services and also to more children being placed as maladjusted.

Such middle class values are also held by some people who live and work in lower "class" areas. For our present purposes the most important group of these are the teachers and school medical officers. Because of their middle class orientation these people, we argue, would be more likely to refer children to the child guidance clinics than would people whose values are essentially working class.

We have already shown that social class is the dominant factor in determining the 'rates of referral' and that the lower 'class' areas have the highest rates. It would therefore appear that the prevalence of disturbance is more important than the cultural factors at this point. If, however, our argument is correct we would expect to find a much stronger relationship between social class and the rates of referral where middle class values are mostly dominant, in this case from the schools. We would therefore expect a stronger relationship between social class and the rate of referral for those children referred from educational sources than for those children referred from non-educational sources.

TABLE 16

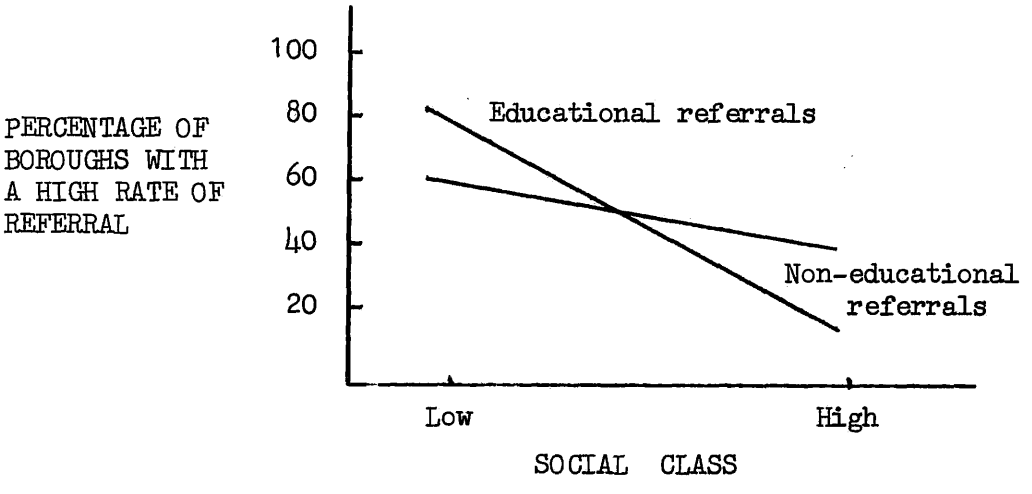
		REFERRALS FROM EDUCATIONAL SOURCES	
		Social Class	
		High	Low
Rate of REFERRAL	High	2	8
	Low	8	2

TABLE 17

		REFERRALS FROM NON-EDUCATIONAL SOURCES	
		Social Class	
		High	Low
RATE OF REFERRAL	High	4	6
	Low	6	4

As can be seen from diagram 12, the hypothesis is supported. The importance of the prevalence of disturbance is seen when we compare the 'lower class' and the 'upper class' boroughs on the basis of the sources of referral, the lower 'class' boroughs have the highest 'rates of referral'. However, the relationship is much stronger for the educational sources of referral than for the non-educational sources. This latter finding suggests that cultural factors do play the important role that we have postulated.

DIAGRAM 12



A similar argument can be postulated with regard to the "proportion of immigrant' children in the area. Again we would expect a stronger relationship between the 'rate of referrals' and the 'proportion of immigrants' in the area for the educational referrals than for the non-educational referrals.

TABLE 18

		REFERRALS FROM EDUCATIONAL SOURCES	
		Immigration	
		High	Low
RATE OF REFERRAL	High	8	2
	Low	2	8

r (phi) = 0·6

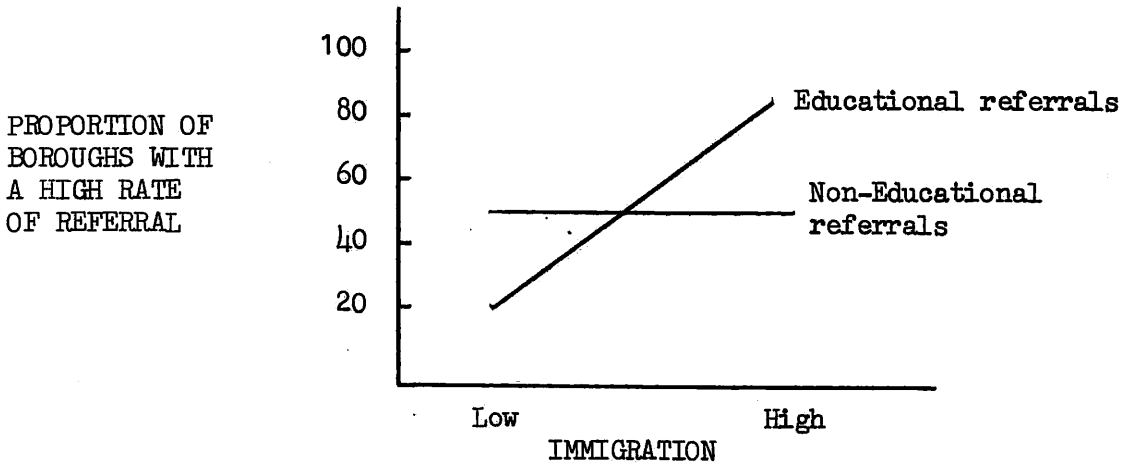
TABLE 19

		REFERRALS FROM NON-EDUCATIONAL SOURCES	
		Immigration	
		High	Low
RATE OF REFERRAL	High	5	5
	Low	5	5

r (phi) = 0

As diagram 13 shows, our hypothesis is supported. There is no relationship between non-educational referrals and the proportion of 'immigrants' in the area. A very strong relationship does exist between the 'proportion of immigrants' in the area and the 'numbers of children referred' to child guidance from the schools.

DIAGRAM 13



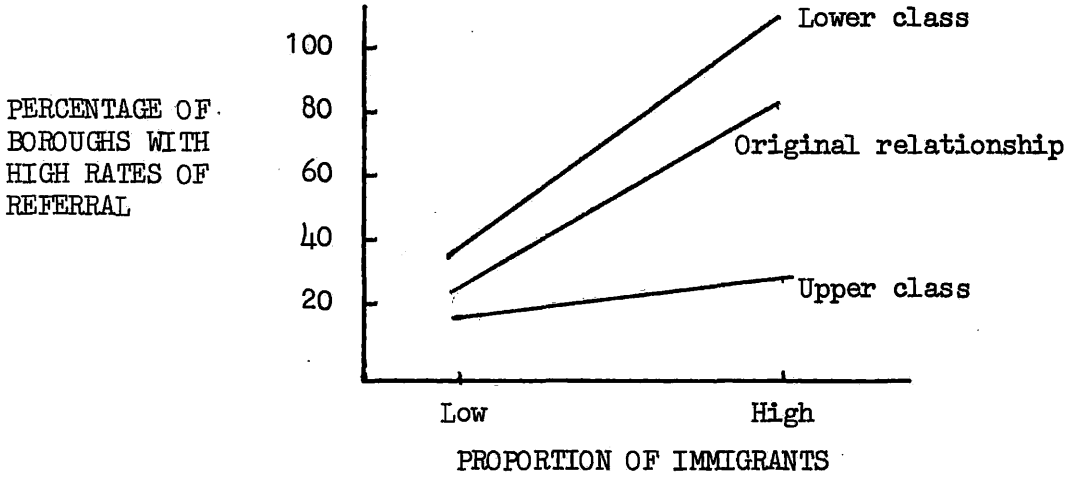
All that remains of the analysis now is to ask if the apparent relationship between the 'proportion of immigrants' in the area and the 'rate of referral from educational sources' is a genuine relationship or whether it is due to the fact that both the 'rate of referral' and the 'proportion of immigrants' in the area are due to the influence of 'social class', as was shown when we considered the total rates.

TABLE 20

		SOCIAL CLASS			
		HIGH		LOW	
		Proportion of Immigrants		Proportion of Immigrants	
		High	Low	High	Low
RATE OF REFERRAL FROM EDUCATIONAL SOURCES	High	1	1	7	1
	Low	2	6	0	2

The following diagram shows that the relationship is not a simple one at all but complex. In the 'upper class' areas the relationship between the 'proportion of immigrants' and the 'rate of referral' from educational sources is considerably reduced.

DIAGRAM 14



In the lower 'class' areas, however, the relationship is strengthened. What we are observing here is similar in form to that which we observed when we analysed the 'provision of services'. In this case, however, we see that in the low 'immigration' boroughs it is the low class areas which are most likely to have a high rate of referral and not the high 'class' areas as we found when we analysed the 'provision of services'. (See Diagram 6). The similarity lies in the interaction between low 'class' and high 'proportions of immigrants.' All the boroughs in this category have a high 'rate of referral' compared with only 33% of those in the high 'class' high 'immigration' sub-group.

SUMMARY AND CONCLUSIONS

This study set out with a theoretical model about the social atmosphere ('ethos') of an area and its effects on the provision and use of the services for maladjusted children. The concept of ethos was defined in terms of two indicators - the proportion of commonwealth immigrants in the area and the social class of the area. Three indicators of the provision and use of services were utilised. These were the numbers of full-time child guidance staff provided for every 10,000 children; the numbers of children placed as maladjusted for every 1,000 children; and the numbers of children referred to child guidance for every 1,000 children.

In the simple theoretical conception the two indicators of ethos were seen as independent variables whose values would determine the values of the indicators of the provision and use of services which were conceptualised as dependent variables.

The purpose of the analysis was not to establish whether or not the hypothesised relationships existed and to elicit information about causal sequences. In order to do this it was necessary to develop a more complicated model which took into account the possibility that each of the five variables would be related to the other. This meant that the final model had to be developed and tested during the analysis.

The analysis proceeded thus:-

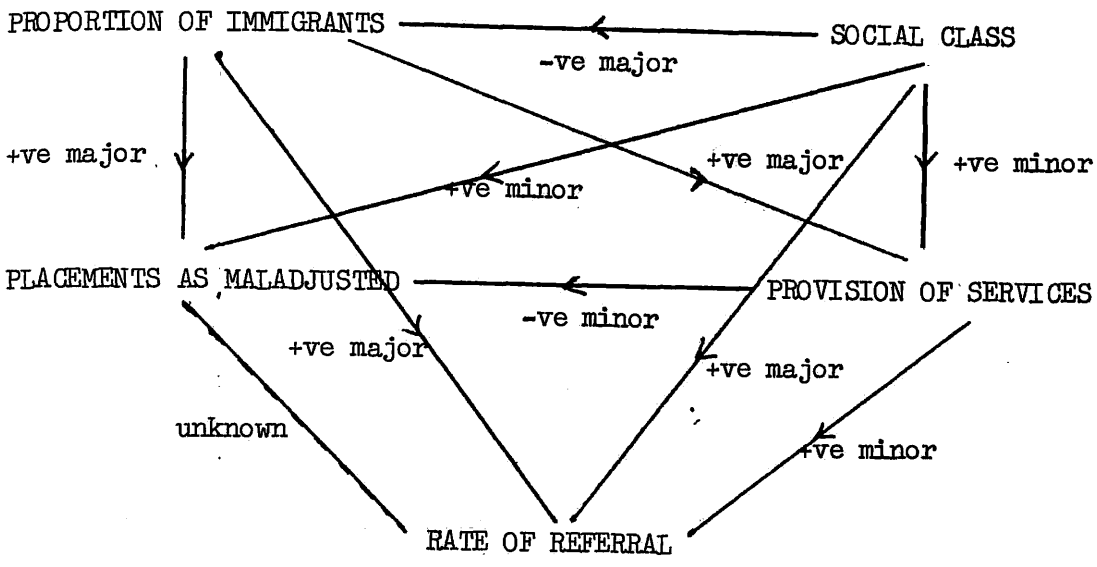
1. For each dependent variable hypotheses were established relating the dependent to the independent variables and the theoretical reasons for these relationships. The data was then analysed to establish the correctness of the hypotheses.

2. As the variables inter-relate to each other it was then necessary to re-examine the data to distinguish between those variables which had major causal significance and those which had minor causal significance. In order to do this the technique of sub-group analysis was used. Minor relationships are those which were clarified during this analysis.

3. The theory was modified in accordance with this analysis.

Diagram 15 shows the results of this analysis. The arrow denotes the direction of the relationship, the head pointing to the dependent variable and the tail to the independent variable. The sign denotes whether the relationship is positive (a high score on the independent leading to a high score on the dependent) or negative (a high score on the independent leading to a low score on the dependent). The final description of the relationship is whether it is a major relationship (a direct link between independent and dependent not affected by other variables) or minor (a relationship between the independent and dependent variable which is effected by a third variable acting either as an extraneous variable or an intervening variable). Pragmatically one could distinguish between major and minor variables by noting that major variables denote important theoretical links which are capable of being used predictively. This means that knowing the score on the independent variable one should be able to predict (within limits) the score on the dependent variable. With a minor relationship there is a link of theoretical importance but it is not strong enough to use for predictive purposes.

THE CAUSAL SCHEMA



Our analysis has shown that the two indicators of ethos do appear to relate quite strongly to the provision and use of services for maladjusted children. We started by analysing the 'provision' of services and found that the 'proportion of immigrants' in the area is a major determinant of the 'provision' of clinic staff. The relationship was complicated because 'social class' and 'immigration' were related to 'provision' in opposite ways. We had predicted that both high 'class' and high immigration would lead to high 'provision'. In fact it was only in the low 'immigrant' sub-group that high 'class' boroughs had higher 'provision' than the low 'class' ones (see Diagram 1). In the high 'immigrant' sub-group it was the low 'class' boroughs which had the highest 'provision'. The 'proportion of immigrants' therefore appears to have had the most dramatic impact on the low 'class' boroughs. The theoretical position taken by this study argues that these relationships reflect the tremendous problems existing in areas with large numbers of immigrant children. Cultural

pressures lead these problems of deviance to be defined in terms of 'sickness' rather than 'delinquency' with the consequent need to provide services to deal with the problem. In the working class areas the conception of deviancy in terms of delinquency would have been dominant up to the time when these problems first arose so that the services provided for maladjusted children would have been sparse and expansion would have to be in terms of whole clinics rather than additional personnel. The middle class areas would have already had provision as a result of their cultural values which would see deviancy in terms of sickness irrespective of the numbers of immigrants. Hence expansion would not be reflected in buildings in these areas. In order to further examine this problem we discovered the opening dates of the thirty clinics in the outer London area. This showed that 89% of the clinics opened since 1960 were in areas marked by a high proportion of immigrants.

The second stage of the analysis moved on to examine the rate of 'placement of children as maladjusted'. We argued that where there were large numbers of 'immigrants' we would expect to find high rates of 'placement as maladjusted'. We also postulated that upper 'class' areas would tend to 'place more children as maladjusted'. When this data was subjected to sub-group analysis we discovered that in both the high and low 'immigrant' sub-groups there was 30% more high class boroughs with high rates of 'placement' than low class boroughs. However, in each 'social class' group, there were 70% more high 'immigration' boroughs with high rates of 'placement' than low immigrant ones. The explanation put forward for these two relationships differs. We argue that the high 'placement' rate in high immigrant areas is the result of people trying to solve problems

created by large numbers of children who are 'acting out' - mainly in the class rooms. In the high class areas it is argued that the higher placement rate was due to the fact that the child who 'acts out' is more unusual and consequently more obvious. We also suggested that the toleration of such children would be much lower.

We originally suggested that there would be no relationship between the provision of services and the numbers of children placed as maladjusted. Any relationship that did exist, being due to the fact that both the numbers placed as maladjusted, and the services provided, would be causally related to the proportion of immigrants in the area. However, once we carried out the sub-group analysis we found that it was the areas with the lowest provision that tended to place most children as maladjusted (Diagram 8). This relationship, existing in both immigrant sub-groups (Diagram 9) can be explained in terms of the work load of the clinics. Clinics with less staff would be more likely to place children as maladjusted simply because they did not have time to deal with the more disturbed children adequately. As we pointed out during the analysis it was not possible to test this hypothesis because it would have needed several control variables to be introduced at the same time. An alternative hypothesis might be that the authorities guide their limited funds into specific areas, hence one authority might expand its clinic personnel while another might expand its special school facilities. If this is the case we would expect to find that those areas which had chosen to expand special school facilities at the expense of clinic facilities would have higher rates of placement as maladjusted.

The final stage of the analysis concerned itself with the 'rates of referral' of children to the clinics. This part of the analysis showed 'social class' to be of greater importance than 'immigration'. It was the 'social class' of the borough which was most strongly related to the 'rate of referral' with the unexpected result that the low class boroughs had the highest 'rates of referral'. Once we took 'social class' into account we discovered that neither 'immigration', or the 'provision' of services, were of major causal significance. We argued that this was probably due to the fact that there was a high prevalence of disturbance among the children in the lower social class areas and that the prevalence of disturbance would tend to lead to higher rates of referral(12). We suggested that the prevalence was of major importance, but that also middle class values would be of as great importance in determining the rate of referral. Not unexpectedly, we were able to show that in the lower 'class' boroughs it is the referrals from the schools that were dominant, while in the upper class boroughs it was the referrals from the non-educational sources.

The referrals from educational sources were further analysed and it was shown that in this sub-group 'immigration' played an important part (Diagram 14). Where there was a high proportion of 'immigrants' in a lower 'class' area all the boroughs had a high rate of referral. In low 'class' areas with low proportions of 'immigrants' only 30% of the boroughs had a high rate of referral. As with the analysis of the provision of services, 'immigration' did not play an important role in the referral rates of upper class area.

This study has a number of severe limitations. The first of these is concerned with the number of cases studied. Analysis of

group data of this nature is problematic. We have studied a population of twenty London boroughs, involving thirty Child Guidance Clinics who had some 8,000 children referred to them in the two year period. However, our analysis is based upon the twenty boroughs and not the 8,000 children. Hence, at several points in the analysis we were unable to come to satisfactory conclusions owing to the small numbers of cases.

The data that we used is population data and therefore not subject to sampling fluctuations. Significance tests, are, therefore, not relevant. However, because this is population data from a specific part of London one should be very cautions at making generalisations to other parts of the country.

This study can only be considered as an exploratory one, and as such it has pointed to significant areas of importance. Two points should be kept in mind when considering the results.

1. One should beware of making the jump from group data to individual behaviour.(13) The two indicators of ethos, 'social class' and the proportion of 'immigrants' appear to be significantly related to the three dependent variables. However, the fact that lower 'class' boroughs have higher 'rates of referral' is not the same as saying that it is lower 'class' children that are predominantly referred. Similarly, the fact that boroughs with high proportions of 'immigrants' have higher rates of 'placement' as maladjusted again does not necessarily mean that it is 'immigrant' children that are placed as maladjusted. We have suggested that both of these statements are in fact true. However, before we can be certain it would be necessary to examine the actual children who are being referred to the clinics. In the following chapters some steps in this direction are made.

2. The second reservation is related to the first. On several occasions we have referred to official decision making processes. The analysis that we have conducted particularly in the relationship to the proportion of 'immigrants', indicates that social pressures are effecting decision making processes. However, once again, there is no conclusive evidence to support these contentions. It would be misleading to let 'the facts speak for themselves'.

In conclusion we can say that the provision and use of services for maladjusted children is related to the social ethos of the area. Further studies seem to be necessary in three directions. Firstly, to examine the individual children referred to see if our general conclusions are in fact supported. This could probably be done in one or two boroughs. Secondly, to examine the decision making processes. Finally, and most important, studies need to be carried out to discover whether the provision and use of services for maladjusted children is related to the 'need' of the area, or whether in fact, this is no more than a fashionable way of dealing with problems. As we have already indicated much of the present theory is based upon the changing conception of deviance from delinquency to sickness. But is sickness the right term to use to describe problem children and are the present services for the maladjusted child the best way of dealing with them?

CHAPTER 4

FACTORS INFLUENCING THE FAMILY'S TENDENCY TO CO-OPERATE WITH A CHILD GUIDANCE CLINIC

INTRODUCTION

This section addresses itself to the question, "Why do some families who are referred to child guidance clinics co-operate with that clinic while others refuse to co-operate?"

Very few studies of these issues have been carried out in the field of child guidance whereas a number have been carried out in adult psychiatry.

Those carried out in adult psychiatry have considered two issues. Firstly, those workers who have followed Hollingshead's[14] work on class differences, and secondly, those who have been more concerned with the dynamics of therapeutic relationships.

Hollingshead's findings were replicated by Schaffer[15] who concluded that, (a) upper class patients were more highly motivated, (b) a cross class problem of communication existed and (c) therapists were prone to select patients with whom they could communicate.

In order to examine these issues more clearly Imber[16] created a situation where a third party sanctioned both the therapist and the patient to continue treatment. The patients had been randomly assigned to each therapist. Even after these procedures it was still apparent that working class patients were much more likely to drop out of therapy than middle class ones.

Many workers have tried to explain this phenomena by referring to the differing attitudes toward mental health found in the middle and working classes, suggesting that these lead to a lack of mutual

understanding. Such an approach has been taken by Bernstein,[17] Yamamoto,[18] Myers[19] and many others. Gursalin, after an exhaustive content analysis of the literature on mental health, was able to show that there is a close relationship between the middle class ethic and the ethic of mental health.

Some research has tried to go beyond such general statements and look at the actual dynamics of the helping relationship. This work, which has been largely reviewed by Goldstein, is concerned with the patients' expectations of the psychiatrist's personality. Where the psychiatrist was perceived by the patient not to conform with his expectations the patient was likely to drop out of treatment. A similar approach was taken by Overall and Aronson[21] who found that where their working class patients reported that they felt the therapist had a different approach from their own to the problem, drop out was quite likely.

Very few studies of these issues have been carried out in child guidance clinics; most of the work in this field being retrospective and purely descriptive.

The relationship between social class and tendency to remain in treatment in a child guidance clinic is not as consistent as that found in adult psychiatry. Neither Cohen[22] nor Baker[23] have found such a relationship. Other studies, however, did. Joelson,[24] studying the Pittsburg Child Guidance Centre found a strong relationship between social class and the tendency to remain in treatment over time even when the nature and severity of symptoms were held constant. A similar conclusion is reached by David[25] who carried out a large study of a family case-work agency in Toronto. He found that lower class families only remained in treatment over similar periods of time as upper class ones if their symptoms were

exceptionally severe. Similar findings were established by Ross and Lacey.(26)

Very few studies have looked at these issues in a more dynamic nature. Perhaps the outstanding piece of work of this tyoe is that of Cohen(22) who found that families that terminated treatment either before a diagnostic interview or immediately after differed from the rest of the clinic sample as follows:-

1. The terminaters had an orientation to the erasure of symptoms rather than a change in family relationship. This is a similar finding to that of Overall who concluded that patients who expected a direct medical orientated approach dropped out when faced with a 'talking cure'.
2. On the whole the terminators were families who were badly prepared and had little knowledge of the clinic.
3. Families without marriage problems tended to be in the first group, that is, the terminators.
4. Coercive referral made against the parents' will tended to drop out early and were in the first group.

Levitt(27) carried out a study which aimed to look more closely at the differences between close families who attended a clinic after referral and those who decided not. He analysed 61 variables to try to find factors which differentiated attenders from non-attenders. Five statistically significant differences were found but these did not 'hang together' in any meaningful way. The probability of getting five significant results in this analysis

was 0•25. so he concluded that these five results had occurred by chance.

This review of the relevant literature suggests that there is very little work previously done on which to establish a study of the kind proposed in this chapter. That which has been completed being pragmatic with only piecemeal theoretical explanations.

For the present study two theoretical models have been used. The first model is a stress model which argues that the families under the greatest stress will tend to be more anxious and consequently more highly motivated and co-operate with the clinic.

STRESS ———— MOTIVATION/ANXIETY ———— CO-OPERATION

This model has to be qualified on the basis of role theory. A family will tend to allow the clinic to help them resolve their difficulties (and so reduce the stress that they are experiencing) only if the family feels that the clinic personnel are the 'right' people to fulfill such a role.

These two theoretical perspectives will be integrated at two points during this study. In the following paragraphs, where the stress model is developed, the concepts based upon role theory will be used to define the areas over which the stress model is applicable. In particular we will argue that the level of stress in the family situation will not affect the parents' tendency to co-operate with the child guidance clinic unless this stress is seen by the parents to be relevant to the child.

The second point where the two perspectives will be brought together will be in the final discussion of the stress model where

the concepts based upon role theory will be used to illuminate the earlier findings.

The major difference between the stress model and the concepts based upon role theory, as they are used here, is that the model based upon role theory examines the situation through the eyes of the families who are referred. This procedure will be extended in the final chapter of this part of the study when a general description of the families' expectations will be given.

THE THEORETICAL DEVELOPMENT OF THE MODEL

It was decided after the completion of the pilot work that the most relevant indicator of the parents anxiety/motivation would be their concern about the child. However, nearly all the parents of children who are referred to a child guidance clinic are in some way concerned about their child. For many this anxiety only reflects their lack of knowledge of the clinic. For others it is due to lack of information as to why their child has been referred to a child guidance clinic.

After deliberation the decision was taken to use the concept of 'concern about the child's future' as the major indicator of the parents anxiety/motivation. It was argued that parents who were 'concerned about their child's future' were anxious and more highly motivated to co-operate with the clinic than those parents who were not concerned about their child's future. This indicator was selected for both pragmatic and theoretical reasons. Pragmatically attention was drawn to its relevance by the work of Shepherd (28) who discovered that many of the families interviewed were concerned about their child's future. Theoretically the concept makes sense

in terms of the general existential perspective that has been adopted. In these terms anxiety is the state which develops when the individual examines his present situation and then projects it into the future and imagines he will be unable to cope with it. An unpleasant present situation is imagined as likely to lead to a catostrophic future and the parents will welcome the intervention of someone who might prevent such a calamity.

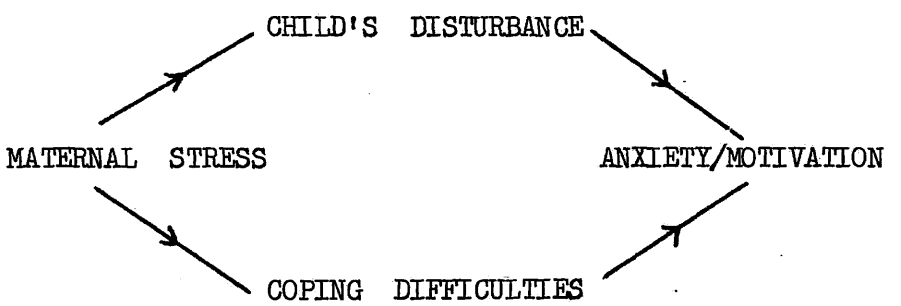
A second indicator of anxiety/motivation has also been used. This has been called stigma-fear. Those families who express stigma-fear are not expected to co-operate with the clinic. This indicator reflects the parents' fear of the psychiatric services Two aspects of this fear have been considered. The first of these is called 'stigma'. It is quite common in most societies to hold a belief that if a person comes into contact with something or someone that is considered to be 'bad' then that person is likely to become contaminated by the badness. The contamination is called stigmatisation. Probably the best indicator of the extent of this fear with regard to psychiatry is the efforts made to reduce it. In particular the changed terminology used in the 1959 Mental Health Act, where many terms were changed because of the derogatory associations, they had developed.

The second, and probably related aspect of this indicator is 'fear'. Here we are concerned with the families' fear that the clinic will do something unpleasant to themselves or the child. Again, ignorance plays an important part in developing this fear, though one should not forget that some people have things to hide and they would prefer not to let them be known.

Any person who has a strong feeling of stigma-fear is likely to reject the help of the clinic.

In this study the concept of stress has been used very loosely to describe any factor that would appear likely to threaten the physical or emotional wellbeing of the individual and will be used to cover a different aspect of the situation.

We are going to argue that maternal stress situations have aetiological significance in that these can and often do lead to the child becoming disturbed. A second line of argument will also be taken, being that where there is maternal stress the family will be less able to cope with the disturbed child. We will argue that the nature of the child's disturbance and the parents' inability to cope will be the factors that directly affect the parents' anxiety/motivation. This is depicted below.



If the parents do not see the child as being disturbed and if they are not experiencing any difficulties in dealing with the child then they are unlikely to develop the anxiety/motivation necessary for them to co-operate with the clinic. Such an argument rejects the idea that parents will come to child guidance clinics in order to resolve stress situations that are not seen to be caused by the child's behaviour.

Two indicators of maternal stress have been selected. The first of these is the marital situation. It is argued that where the family is experiencing marital difficulties the child is more likely to be disturbed and the family less able to tolerate either this disturbed behaviour or to cope with it.

The second indicator of family stress is defined as the 'mother's mental health'. Ideally we would have taken the father's mental health into account. Unfortunately time prevented this being done. Fortunately, in research studies there appears one consistant finding; that the mothers of children attending child guidance clinics tend to be more disturbed than mothers in the general population. No such consistency is to be found in studies which have measured the characteristics of the fathers. This allows us to feal that the omission of the paternal characteristics may not be so important.

Three recent studies in Britain have concluded that the clinic mothers are more disturbed than those of the general population. Sheppherd[28] contrasted a clinic group with a population group matched on the basis of symptoms, age and sex and conculded that the mothers of the clinic children tended to be in a worse state of mental health than those of control children. Wolfe[29] matched her clinic children on the basis of age, sex, father's occupation. The control group child was selected from the same school class as the subject. She concluded that over half the clinic mothers had personality disorders. Frommer[30] reported a similar proportion of disturbed mothers in a clinic sample of children under 5 years old.

Three American studies by Lauterbach,[31] Goldstein[32] and Liverant[33] have used the M.M.P.I. in order to compare the norms established for the parents of the children attending child guidance

clinics with the population norms. All three studies concluded that the norms for the clinic group lay between those for the normal population and those for the treated psychiatric population.

The effect of the mothers mental health in this model is expected to be similar to that of the marital situation. Where there are disturbed marriages the mother is also expected to show signs of disturbance. This relationship can be partly explained in terms of the dependent role of the woman in many marriages. When the marriages fail the wife is much more likely than the husband to feel that she has failed as a wife and mother and, because of her financial dependency, have anxieties about the future.

As with the disturbed marriage the disturbed mother is likely to affect her child and be less able to tolerate the child's behaviour or to cope with it.

It has been argued that the parents' ability to cope with the child's behaviour is an important factor in determining their anxiety motivation. Parents who are unable to cope with their child are likely to see it as a cause for anxiety and therefore will be motivated to accept outside help.

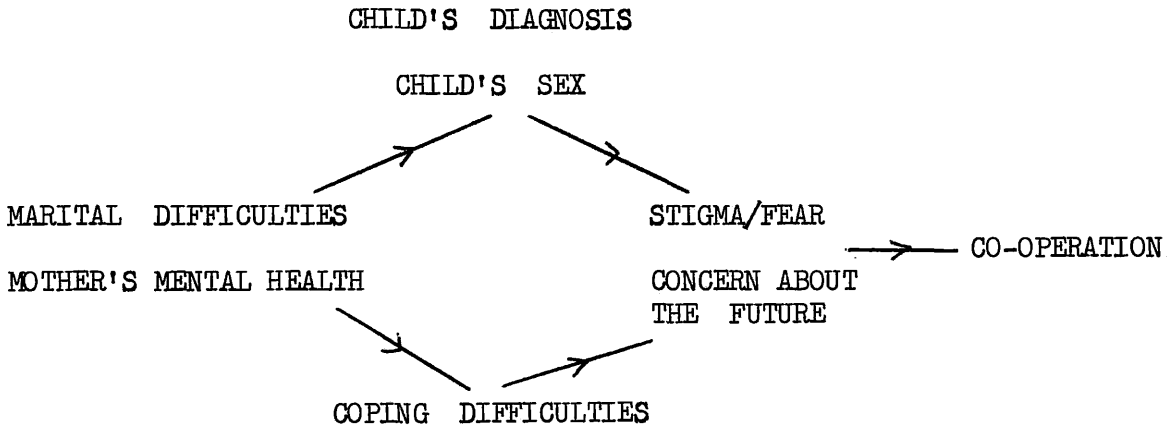
Two aspects of the child will be taken into account during this study. These are the child's behaviour and the child's sex.

The nature of the child's behaviour is indicated by the child's diagnosis. A diagnosis of anti-social behaviour refers to a child who is deviant in an active manner. Such children tend to disturb adults by behaving in a manner which is socially unacceptable. The neurotic child tends to be the very opposite to the anti-social child, he tends to be passive and withdrawn.

The role of the child's sex is mainly of cultural importance. An anti-social boy is socially more acceptable than an anti-social girl. A nuerotic girl more acceptable than a neurotic boy.

We have already noted the aetiological relationship between family stress and the child's diagnosis. When we combine the diagnosis with the sex of the child we see that cultural values will play a part in determining the parents' anxiety/motivation.

The crude model on which the analysis is based is shown below.



During the analysis further specification of these relationships will take place.

THE RESEARCH DESIGN

The research design adopted to test and expand the stress model described in the preceeding pages is relatively simple. The main requirement for any design that was adopted would be that the data on the families was collected before the family had any contact with the clinic. The basic aim being to see whether it is possible

to predict which families will co-operate with the clinic and which will not on the basis of the family situation and attitudes irrespective of the clinics behaviour.

The method of collecting the data is complex. Two types of approach have been used. Two standardised questionnaires were used in order to develop a reliable set of diagnoses - one being used for the child and another for the mother.

The main method of data collection was a structured non-schedule interview of the type recommended by Richardson(34). This form of interview allows for greater fluidity and depth than the schedule method. Instead of using a schedule with set questions which the interviewer completes, the interview is conducted on the basis of topic areas. The interviewer has a list of topics which he wishes to discuss with the respondent. He questions the respondent about each one until satisfactory answers are arrived at. The whole interview is tape recorded and the measurements that are eventually made are taken verbatim from the tapes.

In the next section the scales used and the way in which they were developed will be described. Then will follow a description of the way the sample was selected.

THE DEVELOPMENT OF SCALES AND MEASUREMENTS

In the preceeding sections of this study we dealt with the theoretical concepts and the indicators chosen to represent them. In this section we describe the scales that were developed to represent the indicators and the techniques used to measure them. The interview by which the data was collected will be described later.

A. Co-Operation with the Clinic

The data for this variable was collected from the clinic files approximately nine months after the families were interviewed.

A dichotomy was created which distinguishes between those families who co-operated with the clinic and those families who did not. Families were rated as unco-operative if:-

(i) they continually avoided the clinic's attempt to contact them.

(ii) if the clinic had closed the case as unco-operative.

B. Concern about the child's future

The data for this variable was collected during the family interview. A dichotomy was created which distinguished those families who were rated as being concerned about the child's future from those families who were not.

Families were rated as being concerned about the child's future if during the course of the interview they made statements about the child's future, e.g. "What will happen if he goes on like this" or "He could be dangerous as a man".

C. Stigma/Fear

This variable was rated on the basis of a dichotomy which distinghished those families who expressed strong stigma/fear from those who did not.

The information for this rating was collected during the family interview though no questions were asked about it. The ratings were based upon the spontaneous expression of the parents.

Stigma/fear was considered to be present if:-

(i) the parents expressed a fear of what might happen to the child as a consequence of referral. E.g. "He

(ii) If the parents expressed feelings towards the clinic or psychiatry which were phrased in commonly used derogatory terminology. E.g. "Do you want to see if I'm a nut?" or "He's not barmy."

(iii) If a strong fear was openly expressed. E.g. "I'm frightened of psychiatrists."

For the purpose of the final analysis only those families who expressed their fear directly (as in (iii) above) or who related it to the child (as in the examples given in (i) and (ii)) were included.

D. Child's Diagnosis

Michael Rutter's[9] parents' behavioural questionnaire was completed for each family in the sample. Rutter's findings show that his questionnaire will effectively discriminate between the children who have neurotic tendencies and those who have anti-social tendencies. He lists a number of questions which are effective discriminators of these two groups. Following Rutter's instructions, a diagnosis has been made for each child. The sample is divided into anti-social and neurotic children.

Coping Difficulties

A dichotomy is used to distinguish those families who are experiencing coping difficulties from those families who are not.

A family is considered to be experiencing coping difficulties if:-

(i) The parents consider themselves to be "at a loss" to know what to do about the child's behaviour.

(ii) If one of the parents makes a causal connection between the child's behaviour and their own health. E.g. "If this continues I will have a nervous breakdown."

Marital Difficulties

A dichotomy has been used to distinguish those families who are experiencing marital difficulties from those who are not.

A family was rated as experiencing marital difficulties if:-

(i) the parents were separated.

(ii) they stated that the marriage was bad during the course of the interview.

(iii) they said, during the interview, that they did not get on well.

When the interviews were rated there were four marriages that were considered suspect though there was not enough evidence to rate them as being in difficulties. When the clinic files were examined a check was made on the clinic's assessment of the marital situation of these four families and in each case the clinic felt that there was a marital problem. These four families were rated as being in difficulties.

Mothers Mental Health

A dichotomy is used to distinguish the disturbed from the non-disturbed mothers. During the interview Goldberg's mental health questionnaire (long version) was administered.(35) This was scored according to Goldberg's instructions. Following Goldberg, those mothers who scored thirteen or more were considered to be disturbed.

Two other variables will be mentioned during the study though they do not form a major part of the analysis. These are as follows.

Initiation of the Referral

A dichotomy is used to distinguish those families who directly sought help for a problem from those who had help suggested to them by a third party. A small number of families were seeking help for general difficulties with the child when they were referred to child guidance. These are rated as having sought help.

Severity of disturbance

This is an extremely difficult concept to rate. Studies in the United States by Levitt[27] and in Britain by Sheppard[28] seem to indicate that raters are only able to agree on rating severity in about 30% of cases. For our purposes here we have used Rutter's[9] Parents' Behavioural Questionnaire. Rutter has shown that a score of thirteen or more seems to differentiate most effectively between the children who are referred to child guidance clinics and those who are not. Rutter's questionnaire does ask the parents to make crude differentiations about the severity of behaviour and these are reflected in the final scores. In practice the higher scores tend to indicate greater disturbance as assessed in clinical situations. For the present study the sample is divided into those children who score 13 or more and children who score less on the questionnaire.

COLLECTING THE DATA

The data for this study was collected from two clinics located in an outer London borough. The social class distribution in the borough being very similar to than in London as a whole.

The Clinics

The borough in which the two clinics are located has special school facilities for children considered to be maladjusted as well as those who are of low intelligence. Both clinics have the use of a children's psychiatric ward in a nearby hospital.

Though the clinics are in the same borough they have different catchment areas. Clinic A was predominately staffed by men and described its approach as being eclectic. There is not attempt to select "suitable" cases. Clinic B was predominately staffed by women. The approach favoured by the staff was analytic and there was a very limited attempt to select suitable cases from those referred. Neither clinic used drugs as a form of treatment.

Selection of the subjects

Both clinics have a general policy that they would only inform their clients a few days before the date of an appointment. Neither clinic was prepared to change this to fit in with the research. New cases were generally selected on a Thursday and appointments sent out for the following Tuesday, Wednesday or Thursday.

New cases were always offered appointments by post. It was arranged that when the clinic sent the family an offer of an appointment they would send an accompanying letter which would explain that they were taking part in a research project. The clinics asked to write their own accompanying letter. Copies of these are found in Appendix 2.

A copy of the letter being sent to the client was forwarded to the researcher who would then write to the client stating the time that he would call and an alternative if they were not then available. Because of the shortage of time it was not possible

for the two alternatives to be very far apart.

The subjects were selected on the basis that they were each subsequent referral to the clinic of junior school age (5-10 years). In order to prevent contact with the clinic influencing their opinions the interviews were held before the family attended the clinic.

Family Interview

Most of these interviews were carried out with the mothers but in a number of cases the fathers were present as well. Where the parents were seen together there was always a period of time when the mother was seen alone. Many mothers took advantage of this to give additional information - particularly about their marriages.

All the interviews were carried out without the child being present. Wherever possible brothers and sisters were excluded from the room if they happened to be at home.

The interview can be divided into five stages.

In the opening minutes of the contact the interviewer would introduce himself and tell the families about the research project. He would then ask permission to record the interview.

The interview proper started when the parents were asked to complete Rutter's Parents Behavioural Questionnaire. This tended to ease the general atmosphere and bring the parents mind to bear on the different aspects of the child's behaviour.

After the questionnaire had been completed areas would be examined that had been opened up by the use of the questionnaire. The parents would be asked to elaborate on specific areas of the child's behaviour, giving examples of the ways that it affected them.

Having considered specific areas of behaviour, the interview would usually cover aspects of the parents' feelings, particularly about the child and the referral.

The preceeding discussion would usually lead to the subject of the clinic and information about the parents' expectations would be asked for.

Finally, the tempo of the interview would be reduced and the mother asked to complete Goldberg's Mental Health Questionnaire.

Very few of the interviews actually followed the form just outlined without deviation. In most cases the parents would bring up subjects in sequences that were meaningful to them. The interview would tend to follow the parents' direction. The interviewer only guiding the parents in order to cover all the relevant areas. A list of the topic areas covered is given in Appendix 4.

THE RESEARCH SAMPLE

Thirty-six families were offered appointments at the two clinics during the interviewing period. Twenty-four of these are included in the sample used for the analysis.

One family was excluded because the tape was found to be faulty.

Two families refused to take part in the research - one of these refused to visit the clinic.

Nine families were not contacted between the time they were offered an appointment and the time that they visited the clinic. Two of these families were offered earlier appointments. A mutually convenient time was not found when the interviewer could

visit the remaining seven families. Six of the families that were not contacted could not be offered alternative times before the date of their clinic appointment.

As far as can be ascertained from the clinic records the families that ware not included in the research sample do not differ appreciably in terms of age, sex or type of problem from those who are included in the sample. They appear to be equally likely to co-operate with the clinic.

The following table describes the sample in terms of the measures used. There are 15 boys in the sample and 9 girls. The mean age of the boys was 7·5 years and the mean age of the girls 7·3 years.

TABLE 21

	CONCERNED	STIGMA/ FEAR	COPING	NEUROTIC	ANTI-SOCIAL	MARITAL DIFFICULTY	DISTURBED MOTHER
MALE	10	4	7	4	11	7	6
FEMALE	7	0	5	5	4	5	7
NOT RATED	7	20	12	-	-	12	11
Total	24	24	24	9	15	24	24

Total diagnosed 24

Despite the fact that the area in which the research was conducted has a social class distribution which is similar to that of London as a whole we found that there are only four families in this sample where the father is a white collar worker. These families do not

appear to differ appreciably from the rest of the families in the sample and as the number is small we will have to ignore class differences.

It has already been stated that the two clinics differ appreciably in the treatment philosophies that they present. They also draw their clients from different catchment areas with different referral agents. In spite of this the two clinics appeared to be very similar when the figures were examined. In the sample it turned out that there were 12 cases from each clinic. The sex distribution was roughly similar.

TABLE 22

	CLINIC A	CLINIC B
Males	7	8
Females	5	4

The number of families that co-operated with the clinic was identical for the two clinics.

TABLE 23

	CLINIC A	CLINIC B
Co-operative	7	7
Unco-operative	5	5

It appears possible to put a relatively simple interpretation on these similarities. Differences which appear fundamental to professionals who identify with certain philosophies appear as

irrelevancies to the client who has no means of telling one approach from another. In sum, we can argue that from the clients perspective the similarities outweigh the differences.

The fact that the samples from the two clinics are so similar is a very heartening finding. Two samples of 12 which are so similar must increase our confidence that the overall population of 24 is representative. For the purpose of the analysis the two samples will be amalgamated and treated as one sample of 24.

THE ANALYSIS

The data which is to be the subject of the analysis in this section is a sample of the families referred to two child guidance clinics. The purpose of the analysis to be carried out in this section is to test a number of hypotheses about the nature of the inter-relationship between variables. It is therefore of great importance that we should, as far as possible, try to eliminate the chance element in any results before we consider the possibility that the hypothesised relationship is valid for the population as a whole. Traditionally a level of significance of 0·05, that is a probability that the results would occur by chance on one occasion in twenty, is accepted as satisfactory level of significance. For the purpose of this analysis this convention will be adhered to. However, one should bear in mind that level of statistical significance is related to the size of the sample and that the larger the sample the smaller the differences and distributions required to reach statistically acceptable levels. Hence, statistically significant results are much more impressive in small samples than in larger ones and conversely, results that do not reach

acceptable levels of statistical significance in small samples may well be of theoretical importance.

Because of the small number of cases in our sample our correlations are sometimes not of a level which is statistically significant though they are in the predicted direction (this is particularly true when dealing with second order correlations). Even though the theoretical postulation of a relationship before the analysis of the data increases our confidence that the relationship is a valid one and not a chance one we still cannot accept as valid a correlation which is not statistically significant. However, it would be rash to reject relationships that might in later research prove to be of considerable importance, especially where the prevailing condition is such as to make it difficult to achieve an acceptable level of significance. Hence, where a correlation is in the predicted direction but marginally below an acceptable level of statistical significance it will be presented in the causal schema in a provisional manner.

The statistic r phi will be used in this section. This statistic and its relevant significant test is described in Appendix 6.

Before starting the analysis proper some questions can be answered which set the whole tone of the following section. Probably one of the most contentious statements made in the theoretical presentation was that the parents would only seek help for their difficulties if they felt that the child was disturbed. This counters the often made statement that parents come to child guidance to solve their own personal problems. If it was the case that parents initiate the referral for their child to solve their

own personal problems we would expect to find a strong relationship between the measures of maternal stress and the tendency to seek help.

TABLE 24

	MOTHERS DISTURBANCE	
	Yes	No
Asked for help	7	5
Help suggested	6	6

r (phi) = +0·08, d.f. 22, N.S.

TABLE 25

	MARITAL DIFFICULTIES	
	Yes	No
Asked for help	6	6
Help suggested	6	6

r (phi) = 0, d.f. 22, N.S.

We have also argued that it is the cultural incongruity of the clients behaviour which tends to determine the parents "concern about the child's future" and that it is this concern which will be most important in determining whether or not the parents will "co-operate" with the clinic to which they have been referred. We would therefore also argue that "concern about the child's future" would be likely to be a major factor in determining whether

or not the parents initiate the referral. This relationship is shown in Table 26.

TABLE 26

	CONCERN ABOUT THE CHILD'S FUTURE	
	Yes	No
Asked for help	10	2
Had help suggested	6	6

r (phi) = +0•35, d.f. 22, t = 1•76, Sig. 0•05

The statistically significant relationship gives us confidence that we can accept this hypothesis.

It is possible that the severity of the child's behaviour determines both the parents "concern about their child's future" and influences them in "initiating the referral".

The relationship between the severity of the child's behaviour and the parents "initiating the referral" is shown in Table 27.

TABLE 27

		SEVERITY (SCORE)	
		13+	12 or less
INITIATION	Asked for help	10	2
	Had help suggested	7	5

r (phi) = +0•27, t = 1•31, N.S.

The relationship between the "severity of the child's disturbance" and the parents initiating the referral is not strong enough to lead us to accept that the severity of the child's disturbance is of importance in determining whether or not the parents seek help for the child.

It is sometimes argued that the best prediction of whether or not the parents will co-operate with a child guidance clinic is simply that of the parents requesting help for their child. This position seems to ignore a vital aspect of the process of referral to a child guidance clinic. When a parent askes for help they usually approach either their general practitioner, a school doctor or a teacher. When they are referred to a child guidance clinic (which is a psychiatric facility) a new dimension is added to the situation. They are effectively going into the unknown. Under these conditions it is unlikely that the parents initiating the referral for the child is going to play an important role in predicting their response to the clinic. The relationship between the parents initiating the referral and their later co-operation is shown in Table 28.

TABLE 28

	ASKED FOR HELP	HAD HELP SUGGESTED
Parents Co-operated	8	6
Parents Unco-operative	4	6

r (phi) = +0•17, t = 0•8, N.S.

On the basis of this result the action of the parents in initiating the referral cannot be considered an important factor in understanding why the parents either co-operate or do not co-operate with the clinic.

Before continuing the analysis one other possible determinant of the parents eventual co-operation with the clinic will be considered. Even though the "severity of the child's disturbance" does not strongly influence the parents' tendency to "initiate the referral" for the child it is possible that once the parents have attended the clinic and had the situation explained to them by the staff the parents of the more severely disturbed children would be most likely to "co-operate". The relationship between the "severity of the child's disturbance" and "co-operation" is shown in Table 29.

TABLE 29

	SEVERITY	
	13+	12 or less
Parents Co-operative	8	5
Parents Unco-Operative	9	2

r (phi) = -0•19, t = 0•92, N.S.

The relationship is not significant and we can therefore reject the severity of the child's disturbance as a factor which will help us understand why some parents co-operate and others do not.

The major part of this analysis is concerned to try to explain why it is that some families "co-operate" with the clinic and others do not. We have postulated a theoretical model. The procedure will be to test and elaborate this model on a step by step basis.

The major hypotheses around which the model was constructed was that the two indicators of the parents' motivation/anxiety

would be the major determinant of whether or not a family would "co-operate" with the clinic. The first of these indicators was "concern about the child's future" and we argued that those parents who were "concerned about the child's future" would be much more likely to "co-operate" with the clinic than those families who were not "concerned about the child's future". The relationship is shown below.

TABLE 30

	CONCERN ABOUT THE CHILD'S FUTURE	
	Yes	No
Co-operative	12	2
Unco-operative	5	5

r (phi) = +0•38, t = 1•92, Sig. 0•05

There is a strong positive relationship here. Seventy percent of the families who are "concerned about their child's future" "co-operate" compared with 29% of those who are not "concerned about their child's future".

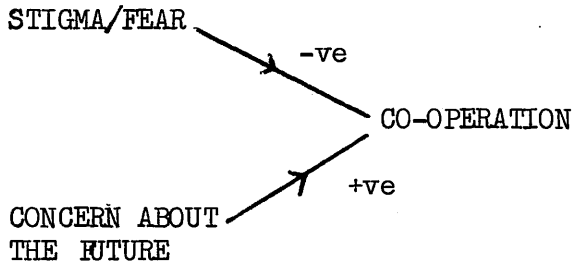
The second indicator of anxiety/motivation, "stigma/fear", is also postulated as a major intervening variable. In this case we are arguing that families who experience "stigma/fear" will not "co-operate" with the clinic. The relationship is depicted in Table 31.

TABLE 31

	STIGMA/FEAR	
	Yes	No
Co-operative	0	14
Unco-operative	4	6

r (phi) = -0·56, d.f. = 22, t = 2·6, Sig. 0·005

Whereas none of the families that experience "stigma/fear" "co-operate" with the clinic, 70% of those who do not experience "stigma/fear" do "co-operate". We can depict this relationship as follows:-



At this point it would be tempting to argue that "stigma/fear" acts as a supressor variable on the rleationship between "concern about the child's future" and "co-operation". In practical terms this is certainly the case. If we examine the relationship between "concern about the child's future" and "co-operation" in the two sub-groups of "stigma/fear" we find that where there is no "stigma/fear" there is a much stronger relationship between "concern about the child's future" and "co-operation" than there was when the "stigma/fear" cases were included.

TABLE 32

	STIGMA/FEAR			
	YES		NO	
	Concern about the future		Concern about the future	
	Yes	No	Yes	No
Co-operation	0	0	12	2
Unco-operative	4	0	1	5

r (phi) = 0

r (phi) = 0•65, t = 1•9, d.f. = 18, Sig. 0•05

Whereas when we include the cases of "stigma/fear" 70% of the families who are "concerned about their child's future" "co-operate" when the cases of "stigma/fear" are excluded 92% of the families who are "concerned about their child's future" "co-operate". Even though this relationship is pragmatically obvious, theoretically it does not make sense. For it to do so we would have to argue that "concern about the child's future" is in some way related to "stigma/fear". In order to make this convincing we would have also to show why "stigma/fear" had this effect. It is much more likely that both "stigma/fear" and "concern about the child's future" are the result of some third factor. We will return to this presently.

Up to this point of the analysis we have examined the two indicators of anxiety/motivation and shown that they relate strongly to the parents' tendencies to "co-operate" with the clinic. However, these arguments were not presented in a vacuum. We postulated that a second group of intervening variables, the child's characteristics and the parents inability to deal with the child, were

responsible for determining whether or not some parents developed anxiety/motivation. Consequently, the next stage of the analysis is to try to discover what the determinants of anxiety motivation are.

We have already started to ask about the factor that might determine both "concern about the child's future" and "stigma fear" in the first part of the analysis. At first no obvious theoretical reason presented itself until it was realised that all the children whose families expressed "stigma fear" were boys, and diagnosed as "anti-social". Further examination of these cases showed they were also very violent. It was postulated that "extreme violence" may well be a determinant of "stigma/fear". At this point the interview sheets for all the children diagnosed as being "anti-social" were examined and rated for violence. Six boys were given such a rating, all six families were concerned about the child's future. (Table 34)

TABLE 33

		Child Displaying Extreme Violence	
		Yes	No
Parents Expressing Stigma/Fear	Yes	4	0
	No	2	18

r (phi) = +0·77, t = 6, d.f. = 22, Sig. 0·005

During the examination of the case histories a theoretical argument presented itself. All these boys not only lost their tempers but did so in a manner which appeared to the parents to be "like a fit". This behaviour was so obviously unusual that the parents could not realistically ignore it or realise that it

would jeopardise the child's future. On the other hand, such overtly unusual behaviour raises in the parents' mind the possibility that the child is "mad", especially if the parents' background was such as to predispose them to "stigma/fear" in the first place.

All the families whose child was considered to be "violently anti-social" experienced "concern about the future" and 66% of them experienced "stigma/fear" and all the cases of "stigma/fear" were "violently anti-social" boys.

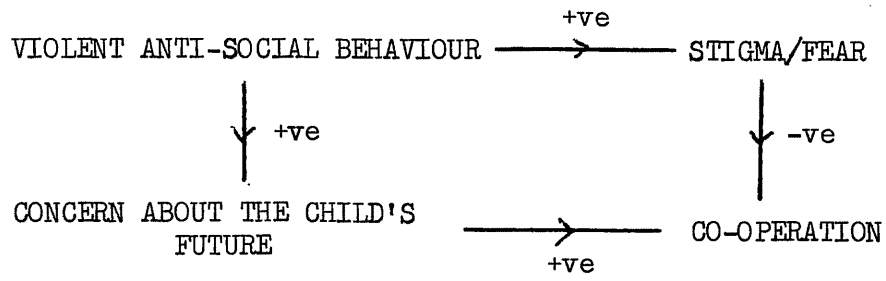
TABLE 34

		Child Displaying Extreme Violence	
		Yes	No
Parents concerned about the child's future	Yes	6	11
	No	0	7

r (phi) = +0·38, t = 2, d.f. = 22, Sig. 0·05

"Stigma/fear" appears to reduce the relationship between "concern about the child's future" and "co-operation" because both "stigma/fear" and "concern about the child's future" are the result of the parents' reaction to a "violently anti-social" boy. Such violence appears to be the major determinant of "stigma/fear" and an important factor in the development of a family's "concern about their child's future".

The proposed relationship between the four variables discussed so far is depicted below.



Extremely violent anti-social behaviour is a determinant of both concern about the child's future and stigma/fear. Its introduction as a control variable on the relationship between these other factors should reduce the original relationship between them.

The original relationship is shown in Table 35.

TABLE 35

		PARENTS EXPRESSING STIGMA/FEAR	
		Yes	No
Parents concerned about their child's future	Yes	4	0
	No	13	7

r (phi) = +0.29, t = 1.4, d.f. = 22, N.S.

A relationship does exist but it is not statistically significant. In Table 36 "extreme violence" is introduced as a control factor and the relationship disappears. The extraneous influence of "extreme violence" on the relationship between "concern about the child's future" and "stigma/fear" explains both the original relationship between these variables and shows why that relationship appeared to be theoretically meaningless.

TABLE 36

		EXTREME VIOLENCE			
		YES		NO	
		Parents concerned about child's future			
		Yes	No	Yes	No
Stigma/fear	Yes	4	0	0	0
	No	2	0	11	7

Phi = 0

We can now proceed further in developing our understanding of why some parents become concerned about their child's future.

First of all we will examine the effect of the characteristics of the child. Our general theoretical argument is that the child's characteristics, the diagnosis and sex, lead the parent to view and evaluate the child's behaviour in terms of culturally based expectations and that when the child does not conform to these the parents will become anxious. We further argue that any apparent relationship between the diagnosis and co-operation with the clinic or between the child's sex and co-operation with the clinic is due to the effect of the parents' anxiety/motivation. The relationship between the two sets of characteristics of the child and co-operation is given below.

TABLE 37

	SEX	
	Male	Female
Co-operative	7	7
Unco-operative	8	2

r (phi) = 0·38, t = 1·92, Sig. 0·05

TABLE 38

	DIAGNOSIS	
	Anti-social	Neurotic
Co-operative	8	6
Unco-operative	7	3

r (phi) = 0·13, t = 0·03, N.S.

There is a tendency for the families of girls to be more likely to co-operate than those of boys. Nearly 80% of the girls' families co-operate with the clinic compared with 46% of the boys. There is little difference, however, between the two diagnostic categories. Sixty-six percent of the families of neurotic children tend to co-operate compared with 53% of the families of children with an anti-social diagnosis.

According to our theory we would expect that these relationships will disappear when we examine them while controlling for the indicators of anxiety/motivation. By excluding the four cases

of stigma/fear we can in effect introduce them as a control factor. In as much as we know that all these four cases are male and did not co-operate, their removal from cell 'c' in table 37 controls them out. This reduces the correlation between "sex" and "co-operation" well below significant levels (see Table 39).

TABLE 39

	SEX	
	Male	Female
Co-operative	7	7
Unco-operative	4	2

r (phi) = 0·15, t = 0·06, d.f. 18, N.S.

This result demonstrates that the difference in co-operation between the two sexes is largely to be explained as being the result of the parents of boys being most likely to experience stigma/fear.

The theoretical model that we have presented has suggested that the importance of the child's sex and the child's diagnosis is mainly to be observed when these characteristics are taken together. Hence we postulate that the reaction to "anti-social girls" would be different from that to "anti-social boys". In order to examine the relation of these two sets of characteristics of the child to the "family's tendency to co-operate" we have to examine the relationship to "co-operation" for each sex in each diagnostic category. This relationship is shown, with "concern for the child's future" introduced as control factor, and the cases of "stigma/fear" excluded, in the following table.

TABLE 40

	DIAGNOSIS							
	ANTI-SOCIAL				NEUROTIC			
	Male		Female		Male		Female	
	Yes	No	Yes	No	Yes	No	Yes	No
Co-operative	3	1	4	0	3	0	2	1
Unco-operative	0	3	0	0	0	1	1	1

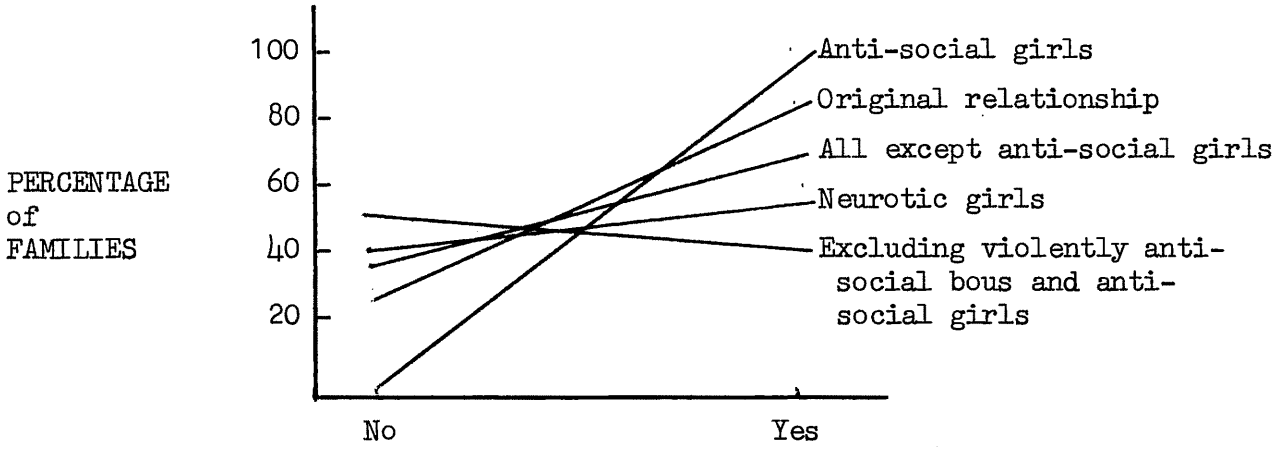
The trend in each of the tables is identical. Whether the child is male or female diagnosised as anti-social or neurotic, it is those families who are "concerned about the child's future" that are most likely to "co-operate" with the clinic. There are only three exceptions to this trend and these do not fit into any meaningful pattern. These three cases will be discussed further at the end of the analysis.

We are now in a position to examine those aspects of the "child's characteristics" that are related to the parents being "concerned about the child's future". We have already shown that violently anti-social boys tend to lead their parents to be concerned about their future.

Another relationship that seems to be as strong is that between the anti-social girl and the parents' concern about the child's future. Whereas all the parents of anti-social girls are concerned about their child's future only 65% of the rest of the parents are concerned and 60% of the rest of the parents of girls. These

relationships are depicted blow.

DIAGRAM 16



The above diagram which can be constructed from the preceeding table shows the proportions of those who are concerned about the child's future in various categories. It is quite clear from this table that when a girl shows anti-social characteristics the parents are likely to become concerned about her future. Unfortunately, as table 41 shows, this result is not statistically significant.

TABLE 41

	Anti-Social Girls	Other Children
Parents concerned about future	4	13
Parents not concerned	0	7

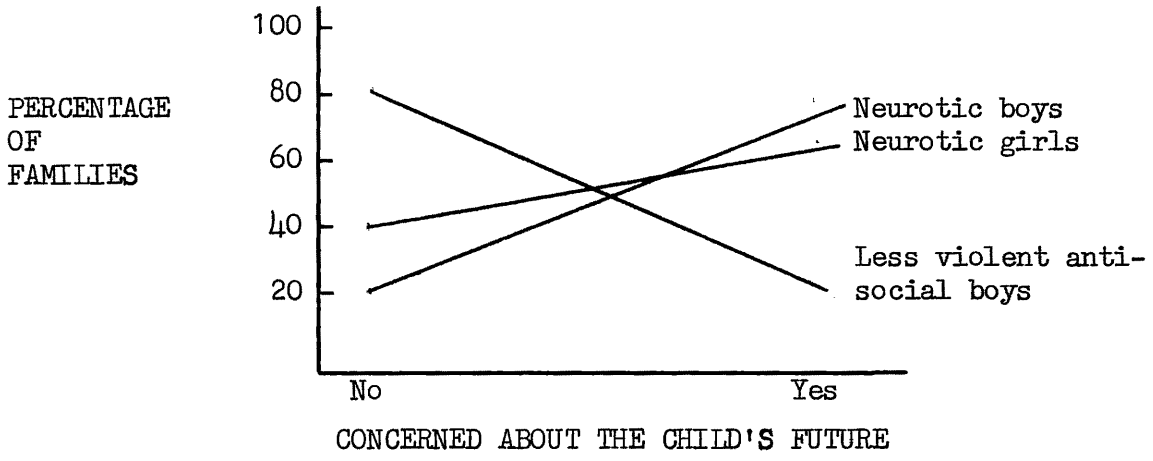
$r = +0{\cdot}29$, $t = 1{\cdot}37$, N.S.

It is, however, a result that should be borne in mind in any future replication of this study as it is both close to significance and theoretically meaningful. In order to demonstrate

another possible relationship we will treat this result as significant for the moment.

If we exclude the "violently anit-social boys" and the "anti-social girls" a possible third factor of importance to the development of the parents' concern about the child's future emerges. The following diagram can also be constructed from the previous table.

DIAGRAM 17

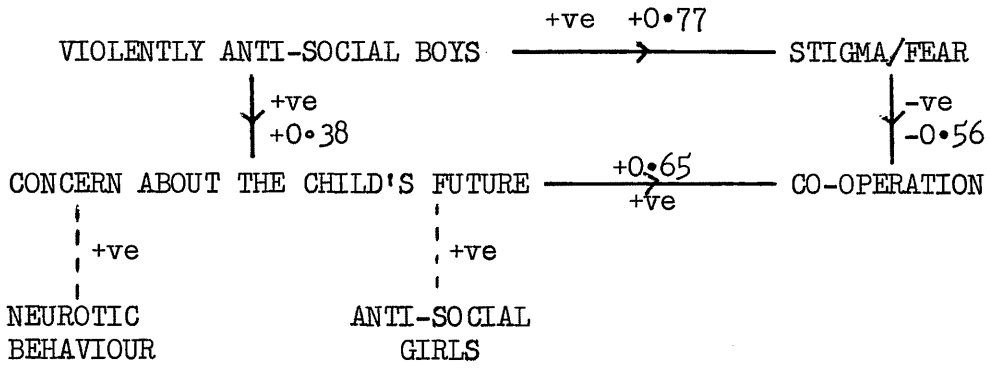


The new factor that emerges is that of neurotic behaviour. The parents of the remaining anti-social boys are not rated as being concerned about their child's future whereas the parents of "neurotic boys and girls" are more likely to be "concerned". As we would expect the parents of neurotic boys are more "concerned about their child's future" than the parents of "neurotic girls". However, the difference is too small to be accepted with confidence.

So fare we appear to have demonstrated the possible role the influence of cultural factors may have in determining whether or not the parents become "concerned about the child's future. There is one group of children, the less violent anti-social boys, where the parents are not concerned about their child's future. This

we would expect because these boys are to a certain extent fulfilling a role that is socially acceptable - that of the naughty boy.

The following diagram depicts the analysis as it has so far been developed.



(Dotted lines indicate relationships not statistically supported)

Up to this point we have not considered the other factor which we theoretically postulated would be related to the parents being "concerned about their child's future". This is their ability to "cope" with the child's behaviour.

The parents' ability to cope with the child's behaviour is significantly related to "co-operation" but not "concern about the child's future."

TABLE 42

	COPING DIFFICULTIES	
	Yes	No
Co-operative	9	5
Unco-operative	3	7

r (phi) = 0•34, t = 1•72, Sig. 0•05

TABLE 43

		COPING DIFFICULTIES	
		Yes	No
Concern about the future	Yes	10	7
	No	2	5

r (phi) = 0·8, t = 1·38, N.S.

Theoretically we are arguing that "coping difficulties" lead to parents becoming "concerned about their child's future" and that this "concern" determines whether or not they will "co-operate" with the clinic. If this argument is correct parents of children who are "concerned about the child's future" will "co-operate" whether or not they are experiencing difficulties in "coping" with their child.

The relationship between coping difficulties and co-operation (controlled for concern) is shown in the following table.

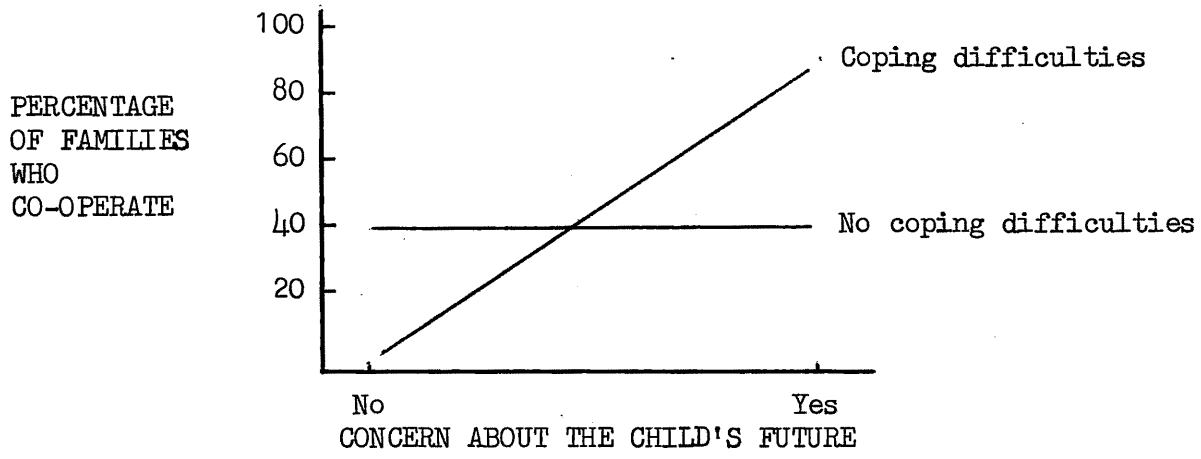
TABLE 44

	CONCERN ABOUT THE CHILD'S FUTURE			
	Yes		No	
	Coping difficulties		Coping difficulties	
	Yes	No	Yes	No
Co-operative	9	3	0	2
Unco-operative	1	4	2	3

There is obviously a complex relationship here. Where there is no "concern" neither of the families with "coping difficulties" co-operate with the clinic. Where there is "concern" and "coping difficulties" 90% of the families "co-operate".

This relationship is clearer when we examine the relationship between "co-operation" and "concern" about the child's future" for the two sub-groups of "coping" difficulties.

DIAGRAM 18



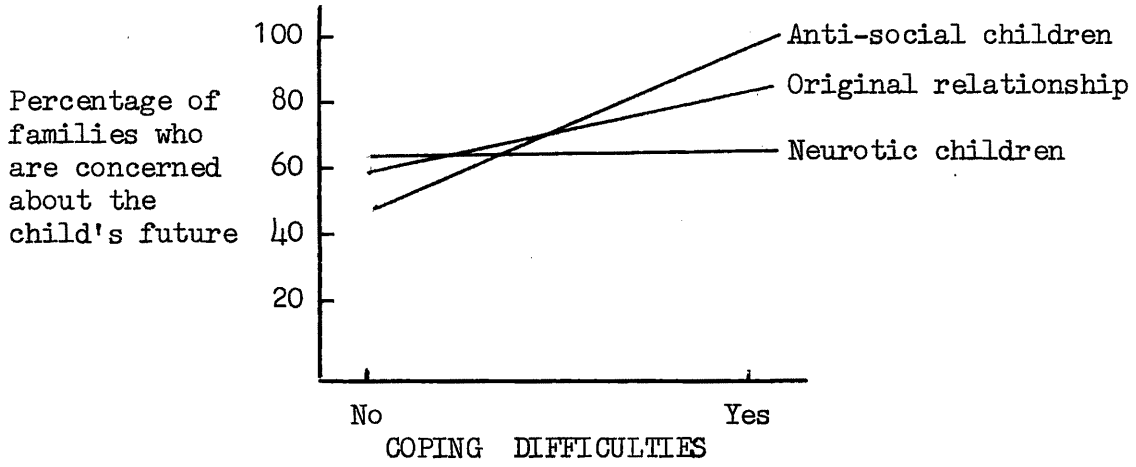
The above diagram shows quite clearly that "coping" difficulties have no effect on the family's tendency to "co-operate" unless the family is also "concerned about the child's future".

In order to understand this relationship more fully it is necessary to examine the nature of the relationship between "concern about the child's future" and "coping" difficulties. In particular we want to know about the relationship for children with different characteristics. The following table and diagram shows the relationship between "coping" difficulties and "concern about the child's future for the two diagnostic categories.

TABLE 45

		DIAGNOSIS			
		Anti-Social		Neurotic	
		Coping Difficulties		Coping difficulties	
		Yes	No	Yes	No
Concern about the future	Yes	6	5	4	2
	No	0	4	2	1

DIAGRAM 19



The above presentation shows quite clearly that parents of "neurotic" children are "concerned about their child's future" irrespective of any difficulties that they may have in coping with the child. For anti-social children, however, coping difficulties on the part of the parents seem to be a factor in determining whether or not the parents become "concerned about the child's future". Our foregoing analysis has already shown us that the parents of "anti-social girls" and "violently anti-social boys" tend to be concerned

about their child's future - and we have explained this in terms of cultural factors. The preceeding results raise an alternative explanation based on the fact that anti-social children are most difficult to handle. This raises the parents' anxiety and they consequently become more "concerned about their child's future".

If the alternative explanation is correct then we would find a strong relationship between coping difficulties and "concern about the child's future" for each of the three groups of anti-social children.

TABLE 46

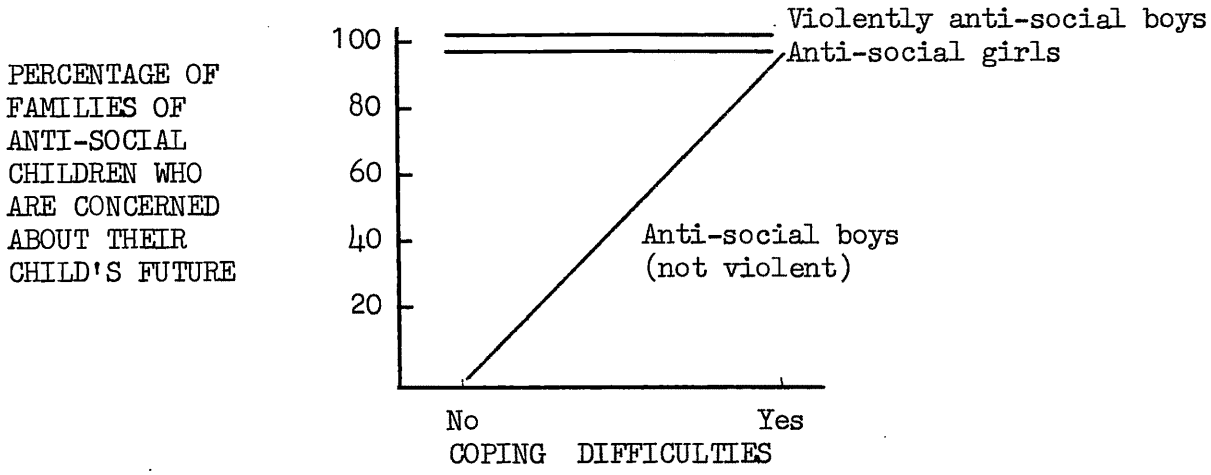
ANTI-SOCIAL CHILDREN

		EXTREMELY VIOLENT BOYS		OTHER BOYS		GIRLS	
		Coping difficulties		Coping difficulties		Coping difficulties	
		Yes	No	Yes	No	Yes	No
CONCERN	Yes	3	3	1	0	2	2
	No	0	0	0	4	0	0

The data shown in Table 46 rejects the second hypothesis and clearly supports the first. Of the four "anti-social girls" two of the families experience "coping" difficulties and all four "concern" about the child's future. For the "violently anti-social boys" only three of the families experience "coping" difficulties but all six families are concerned. For the rest of the "anti-social boys" four families are not concerned and do not experience "coping" difficulties and one is experiencing "coping" difficulties and is "concerned". This is shown in the

the following diagram.

DIAGRAM 20



The diagram shows that the parents of "anti-social girls" and those of "violently anti-social boys" experienced "concern" about their child's future irrespective ofwhether or not they experienced difficulties in "coping" with the child.

For the remaining "anti-social" boys the parents are only "concerned about the child's future" if they are unable to cope with him.

We will return to this issue again when we have discussed the aetiological factors in our model.

During the construction of the theoretical model we proposed two independent variables that were indicators of stress. These two indicators were "marital difficulties" and "the mother's mental health". In addition we proposed that the mother was more likely to be disturbed where there were marital difficulties. The argument being that where a marriage was in difficulties a mother who was potentially disturbed would develop overt signs of disturbance.

The relationship, as the following table shows, is very strong and very clear.

TABLE 47

		MARITAL DISTURBANCE	
		Yes	No
Mothers disturbance	Yes	10	2
	No	3	9

r = 0•59, t = 0•32, Sig. 0•005

The next part of the analysis will examine the aetiological significance of these two indicators of family stress.

It seems to be a well accepted theory that where there are marriage difficulties the children will be disturbed. Such disturbance is usually expressed in "acting out" by the children. Rutter( ) has recently given further support on this contention. In our sample we too find a strong relationship between the parents having marital difficulties and the children being diagnosed as anti-social.

TABLE 48

		MARITAL DIFFICULTIES	
		Yes	No
Diagnosis	Anti-social	10	5
	Neurotic	2	7

r (phi) = 0•42, t = 2•6, Sig. 0•01

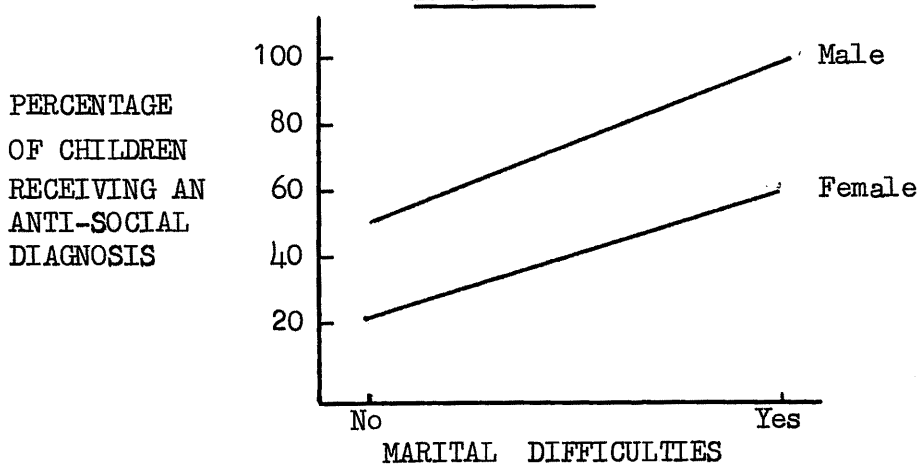
We can examine this relationship for both boys and girls.

TABLE 49

	SEX			
	MALE		FEMALE	
	Marital difficulties		Marital difficulties	
	Yes	No	Yes	No
ANTI-SOCIAL	7	4	3	1
NEUROTIC	0	4	2	3

The tables and the following diagram show that both boys and girls are more likely to receive an anti-social diagnosis if the parents are experiencing marital difficulties. When marital problems are taken into account boys appear more likely to receive an anti-social diagnosis than girls and there is clearly a number of anti-social diagnoses which are not applicable in terms of the parents' marriage difficulties.

DIAGRAM 21



In spite of these reservations the relationship is clearly strong enough to support the aetiological role of marital difficulties in the child's disturbance.

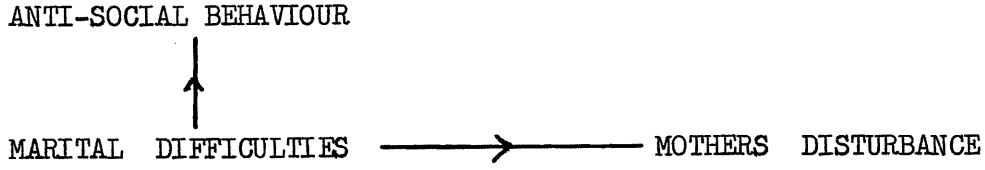
We also argued for the significance of a second aetiological factor. That between the mother being disturbed and the child being disturbed if that child was a girl.

TABLE 40

	MOTHERS DISTURBANCE	
	Yes	No
Female	7	2
Male	6	9

$r = 0 \cdot 24$, $t = 1 \cdot 1$, N.S.

Fifty-four percent of the children whose mothers were rated as being disturbed at the time of referral were girls, compared with 18% of the children whose mothers were not disturbed at the time of referral. In fact 78% of the girls have disturbed mothers. This relationship is not strong enough to be given causal significance. The adeiological model as it has presently been developed is depicted below.



The final aspect of the aetiological model that we have to explore is the relationship between the "mothers disturbance" and

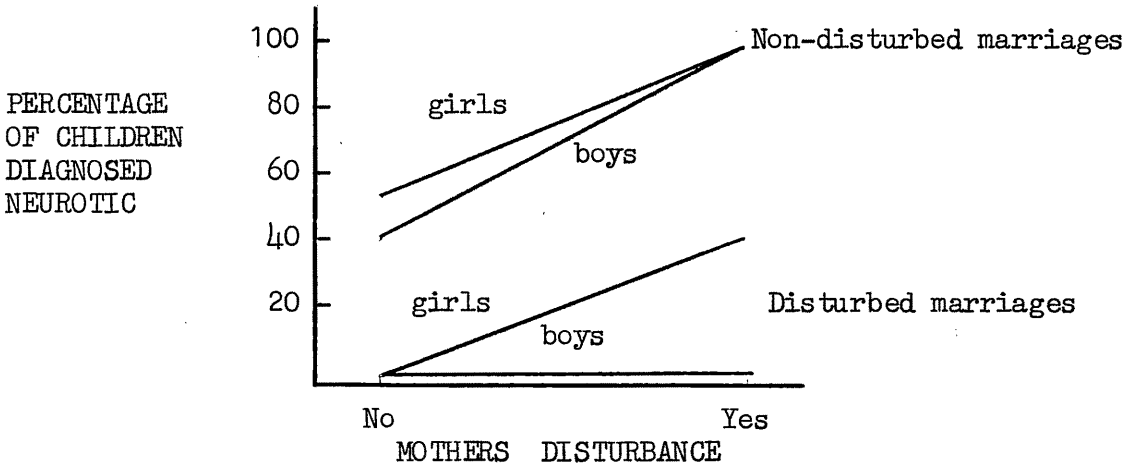
the child's "diagnosis". We would assume that a "mother who is herself disturbed" would be likely to have a disturbed child. Furthermore, we would expect that as most of the women in this sample would be considered to be neurotic we would expect their children to be neurotic themselves. The mothers teaching the neurotic behaviour and attitude to the child during their every day contact.

This relationship is difficult to examine within this sample because of other confounding relationships. In the first place "disturbed mothers" are found in "disturbed marriages" and these tend to indicate that a child will receive an "anti-social" diagnosis. Secondly, "disturbed mothers" tend to be seen with daughters at the clinic and these are more likely to receive a "neurotic diagnosis". In order to examine this hypothesis we must take into account not only the sex of the child but also the state of the marriage.

TABLE 51

	SEX							
	MALE				FEMALE			
	Marital Difficulties				Marital Difficulties			
	Yes		No		Yes		No	
	Mothers disturbed		Mothers disturbed		Mothers disturbed		Mothers disturbed	
	Yes	No	Yes	No	Yes	No	Yes	No
Neurotic	0	0	1	3	2	0	2	1
Anti-Social	5	2	0	4	3	0	0	1

DIAGRAM 22

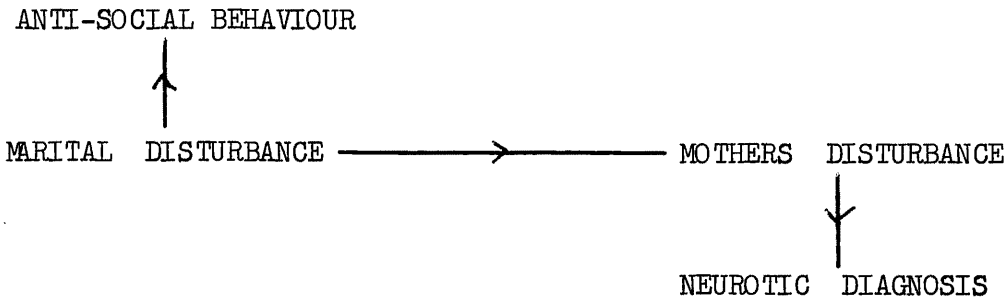


In spite of the small cell totals consistant relationships appear. Boys from "disturbed marriages" are likely to be diagnosed as anti-social whatever the rating of motherd disturbance. Girls, however, tend to be more likely to be diagnosed as neurotic than boys if the marriage is disturbed and the mother is disturbed.

Where the marriage is not rated as being "disturbed" boys and girls are equally likely to receive a neurotic diagnosis or an anti-social one if the mother is not disturbed. If the mother is disturbed, however, then all the boys and all the girls from families not rated as being in marital difficulties receive neurotic diagnoses.

An important point follows from this part of the analysis. Girls and boys are equally likely to be diagnosed as being either neurotic or anti-social once we take into account the aetiological significance of the two indicators of family stress.

We can summarise the aetiological aspects of the model as follows:-



We are now in a position to conclude this part of the study by relating the aetiological model to the earlier part of the analysis. We have been able to show that "coping" difficulties are not of causal significance. They are related to the parents' "concern about the child's future" but they are only a necessary condition for this "concern" for the anti-social boy who is not particularly violent. In a similar manner, "mothers disturbance" is related to "coping" difficulties.

TABLE 52

		MOTHERS DISTURBANCE	
		Yes	No
Coping difficulties	Yes	9	4
	No	3	8

r (phi) = +0·42, t = 2·1, Sig. 0·05

There is almost certainly a causal link here. In fact, the way that coping difficulties was defined partially links it to mothers disturbance by definition. However, we would expect the disturbed mother to have difficulties in coping with her child.

Though we can accept this as a causal link its significance for the general model is not great, as coping difficulties do not appear to play an important role.

The major aspect of the argument is that the indicators of maternal stress, through their aetiological significance, determine the nature of the child's characteristics and that these in turn determine the nature of the parents anxiety/motivation.

FAMILY STRESS ⟶ CHILD CHARACTERISTICS ⟶ ANXIETY MOTIVATION

If this meodel is correct we would not expect to find a significant relationship between the indicators of family stress and those of anxiety-motivation. Any relationship would be explained by the role played by the child's characteristics intervening between the other variables.

In Tables 49 and 50 the relationship of the "marital situation" to the parents "concern about the child's future" and "stigma/fear" is shown.

TABLE 53

		MARITAL DIFFICULTIES	
		Yes	No
Concern about child's future	Yes	9	8
	No	3	4

r (phi) = 0•09, N.S.

TABLE 54

		MARITAL DIFFICULTIES	
		Yes	No
Parents express stigma/fear	Yes	3	1
	No	9	11

r (phi) = +0•2, t = 1•05, N.S.

Neither of the results are statistically significant and we can accept that there is no relationship between the parents' "marital difficulties" and the two indicators of anxiety motivation.

In tables 55 and 56 we examine the relationship between the "mothers disturbance" and the indicators on anxiety/motivation.

TABLE 55

		Mothers Disturbance	
		Yes	No
Concern about child's future	Yes	10	7
	No	3	4

r (phi) = 0•14, t = 0•6, N.S.

TABLE 56

		Mothers Disturbance	
		Yes	No
Stigma/fear	Yes	2	2
	No	11	9

r (phi) = 0•03, N.S.

The other determinants of the parents becoming conerned about their child's future are far less clear - none of the hypothesised ones reaching statistical significance. There are indications, however, that anti-social behaviour on the part of girls and general neurotic behaviour in either boys or girls may well be of theoretical significance.

Another factor may well lie in the parents experiencing difficulties in coping with the child. This factor may well work in conjunction with "concern" though it does not appear to have an important role in the development of concern about the child's future.

The only point where coping difficulties might play a significant role is in relation to less violent anti-social behaviour in boys. Here we saw that the parents only became concerned when they were also experiencing coping difficulties.

More success was achieved with the maternal stress indicators which were expected to determine the nature of the child's behaviour. As predicted we discovered a strong relationship between anti-social behaviour and the parents experiencing marital difficulties and this was true for both boys and girls. We also found the expected relationship between the mothers disturbance and neurotic behaviour though this was only apparent once the confusing influence of the parents marital situation was taken into account. This relationship is therefore not statistically significant.

There is no appreciable relationship between the mothers' disturbance and the indicators of anxiety/motivation. Consequently we can conclude that the indicators of maternal stress are not determinants of the parents anxiety/motivation.

Before going on to discuss the families who did not co-operate in more detail it will be useful to summarise the results of the analysis described in this chapter.

The original model was as follows:-

MATERNAL STRESS → CHILD CHARACTERISTICS → ANXIETY/ MOTIVATION → CO-OPERATION

The linear development of the model has been supported in that we have been able to show that each variable is only causally related to those variables within its own classification or to its immediate antecedent or dependent variables. For example, anxiety/motivation is only related to child characteristics and co-operation, and the child characteristics only to maternal stress and anxiety/motivation.

More specifically we have been able to demonstrate strong relationships between the parents expressing stigma/fear, their concern about the child's future and their eventual co-operation. These variables together explain 71% of the variance in co-operation.

Our attempts to explain the basis of the parents' anxiety/motivation have been less successful. We have been able to show that extreme violence on the part of anti-social boys is likely to lead to both the parents expressing stigma/fear and being concerned about their child's future. Extreme violence explaining 60% of the variance in stigma/fear.

FURTHER EXAMINATION OF THE FAMILIES WHO DID NOT CO-OPERATE WITH THE CLINIC

In the following pages we will discuss the model that we have developed by examining some aspects of the case histories in detail. We will use the perspective of "role theory" to elaborate the analysis.

The model shows that the two indicators of the parents motivation/anxiety can be used to predict which families are likely to co-operate with the clinics and which are unlikely to. There are 13 families in this sample who were concerned about their child's future and not rated for stigma/fear, 12 of these families co-operated with the clinic giving a correct prediction of 92%. There are 11 families who were either rated for stigma/fear or not concerned about their child's future and 9 of these did not co-operate with the clinic, giving a correct prediction of 82%.

On this basis we can calculate the probability of achieving these results by chance.

TABLE 57

	Expected Co-operation	Expected Non-Co-operation
Actual Co-operation	12	2
Actual Non-Co-operation	1	9

Scotts Measure = 75% better than chance

$X^2 = 13{\cdot}4$, Sig. 0·01 (exact tables)

In the following pages we will look at some of the families in more detail. First of all we will consider those rated for stigma/fear.

A. is a six year old boy. The school has threatened to expell him because he has attempted to prevent other children from going into school by terrorising them. At home his behaviour is uncontrollable. His mother describes his behaviour as being "almost like a fit" when he will throw things at everybody in sight.

B. is a seven year old boy. At school he is quiet but at home he tends to go round "smashing things up" and "really goes red with temper".

C. is a ten year old West Indian boy. He has been referred by the school for "fighting like an animal". His mother does not have any difficulties with him but knows that others do.

D. is an eight year old West Indian boy. He has been referred by the school because of his uncontrollable behaviour. His mother felt that he could be dangerous if he was a man.

Each of these cases expresses stigma/fear.

A. "Psychiatrists frighten me."

B. "My kids not going round there, he's not barmy."

C. "I don't want to say to the child he's mad."

D. "I don't want them to treat him as a mad child - he's not mad he's a sensible child."

Three of these families positively express concern. The fourth denies that there is any problem to be concerned about (C). This family is very defensive about the situation. When the tape was replayed it was discovered that a young child - ostensibly playing in the corner of the room, was repeating over and over again "He can't help it mummy, you said so". This mother also spent a lot of time talking about the positive side of the child's future,

how bright he was, and how he would probably go to university (apparently realistic assessments) and then countered these comments with, "I don't want it to affect his future."

The two motivational variables are theoretical counstructs which can be treated as indicators of the parent's state of mind. The parent does not feel or think in terms of, "I am not worried about the future so I will not co-operate", nor is it likely that they think in terms of fear. From the parent's point of view they are likely to ask a number of questions about the situation and react in terms of the way they answer these.

The first question that the parents are likely to ask concerns the role and functions of the child guidance clinic:-

(a) What is child guidance for?

(b) Does my child fit into that category?

The second question concerns the way in which they consider that these roles and functions can be fulfilled:-

(a) What treatment are they likely to give?

(b) What do I consider to be acceptable?

The parents are not likely to co-operate with the clinic unless they feel that the answers to part (a) and (b) of each question are acceptable to them.

Excluding the four cases that expressed stigma there are five cases who were not rated for "concern". In each case we can explain their failure to co-operate with the clinic by taking into account their approach to the first of these questions.

D. is a six year old boy. He was referred by the school (for aggressive and disruptive behaviour) without the parents being consulted. Before the referral arrived there had been a radical

change in the child's behaviour at home, following the end of the school term. The parents hoped that this sudden improvement would continue. They did not attend the clinic at all.

In this case the parents saw the role of child guidance as being to deal with the behaviour problem. As this had suddenly changed there was obviously no point in going to the clinic.

L. is a seven year old boy. He was referred by the school because his school work was not up to his intelligence. The mother accepted that this was in fact true. However, she denied that it was due to the child. She felt that it was the result of the bad school. "He's seven, he should be sitting at a desk." She also admitted that his behaviour was not as good as could be desired but blamed this on the "bad influences" in the area. The family attended the clinic but denied that there was any problem for the clinic to deal with.

Q. is an eight year old West Indian boy. He was referred by the school because he would not speak to the teachers. The mother said that she could understand their anxiety but was not worried because he spoke to people he knew. At home he tended to be of a violent disposition and was also enuretic. His mother felt that none of these factors warranted any concern because in the West Indies there were many "grown people" who were very similar.

In cases L and D the parents accept the behaviour but not the role of the clinic in dealing with it. In case L the parents see it as being due to the external factors and therefore not amenable to "treatment". In case Q the mother sees the behaviour as being quite "normal" and therefore not requiring "treatment".

W. is an eight year old girl. She was referred by the mother because of her recent refusal to be separated from her mother and her refusal to go to sleep at night. The mother was under extreme stress as the result of marital difficulties and recent deaths and illnesses of relatives. She felt that the "child needs help" and this would be one burden less for her to carry.

The clinic did not feel that the child needed any treatment and suggested that the mother came for help with the marital problem. The mother only attended twice.

In the above case the referral is obviously made in order to treat the child to relieve the mother's burden. The attempt on the part of the clinic to treat the parents rather than the child steps outside the role that the mother wanted the clinic to play.

T. is a ten year old boy. He was referred by the local hospital for enuresis. His referral to the hospital had been made by the general practitioner at the request of the mother. The child was disobedient and tended to have regular temper tantrums at home.

The mother was not in agreement with the referral. The clinic was obviously for problems of "the mind" and "I don't think his mind is causing it. I think its a matter of discipline, unless its physical."

In this case the mother has defined the problem in such a way that the clinic is not the correct agent for treatment. She did not think that the clinic could help "unless they talked about the right things". In this mother's mind the right things would be "right and wrong".

In this final case the situation is defined firstly in a way that makes the child guidance the wrong form of treatment. Secondly, the restrictions the mother puts onto the nature of the treatment which is acceptable are such that it would be unlikely that any clinic would fit her demands.

In each of these cases we see how the lack of "concern about the child's future" is related to a definition of the situation which excludes child guidance as a treatment agency. Only one family (Q) is not worried at all, the remaining four are concerned about the child "now". The parents of the three anti-social boys (D, Q, T) are not experiencing any difficulty in coping with the child. The families of the two children who are diagnosed as neurotic (L and W) are experiencing coping difficulties.

The interviewer felt that in four of these cases (L, Q, T, W) the families were being very defensive and that there was considerable fear of the clinic. In this case the definitions of the situation that they were presenting could be rationalisations to justify their refusal to co-operate. Such rationalisations would be sufficient because the behaviour is not severe enough to force the parents to confront it. Hence they are concerned but not concerned about the future.

In the four families that are marked by stigma/fear which is openly expressed the intensity of the behaviour is such that a simple definition of the situation (as in the cases above) is unlikely to be sufficient. In one case the refusal to co-operate is straightforward:-

B. "My kid's not going round there, he is not barmy."

In the other three cases it is the possible treatment that is being rejected. In two cases the only treatment being accepted

by the family is drugs, which neither clinic uses.

A. "He needs someone to give him something, a tranqualliser..... something that will make him relax..... they won't get much by talking."

The clinic recommended psychotherapy. This mother has a strong fear of psychiatrists. Her fear is obviously so great that she refused to co-operate after the first visit in spite of intense coping difficulties. She had instigated the referral herself through a welfare worker whom she described as being "interested and sympathetic".

G. "I don't want them to put him in an abnormal school. I won't allow it. That's going to make him mental. They should give him a drug."

This father did not really accept that the child's behaviour was a problem. He felt it was natural for the child to rebel and that it was the teachers who could not keep discipline.

In the final case the stigma/fear has obviously been hightened by the action of a teacher.

C. "One day the teacher said to him - you're too naughty, we got a place to put kids like you... I had a friend who had a child and she was naughty in school and they sent the child up there to the hospital and there was nothing wrong with her."

The clinic recommended that this child be sent to the hospital and that he might afterwards go to a special school. The mother only attended once.

In only one of these cases is the parent having difficulty in coping with the child (A). In all the rest they state that they

do not have any difficulty though they are aware that other people do have such problems with their children. In these cases we see how the restriction of the treatment possibilities reflects the stigma/fear dimension which is much more apparent in these cases.

There is only one case in which there is concern and no apparent stigma/fear where the family refuses to co-operate with the clinic.

F. is a nine year old girl. The reason why she was referred was that she often refused to go to school and would not sleep at nights. The parents had been divorced and the mother had remarried. The mother defined her main hope from attending the clinic as being "to get her name changed".

The mother was worried about the sleeping because "she lays there for two hours. It's beginning to worry me when she lays there and thinks. I don't like her thinking. She thinks which parent she would rather be with."

Though the mother complained that it was the school situation which was the basis of the referral she also said that she was prompted when "she came back from her father one day and said that she wanted to go and live with him."

It appears that this mother was trying to use the clinic as part of a struggle to wrest the daughter from her father. The clinic recommended psychotherapy for the child. The mother did not attend again.

It is almost certain that this is a further case of stigma/fear though less overt. The mother wanted to use the clinic for one purpose. The clinic's suggestion of therapy for the child would obviously lead the child to openly consider her feelings which is the thing the mother was attempting to prevent.

The preceeding paragraphs have considered the relationship of stigma/fear to violent anti-social behaviour. They have also considered in some detail the ways in which the parents express (or justify) their refusal to co-operate with the clinic by defining the situation in a way which often makes the clinic's role either very difficult or impossible. When these families arrive at the clinic the clinic do not know that such a procedure is in fact taking place. Of the ten cases that refused to co-operate, seven were referred by the school. None of these families accepted the referral willingly though all but one complied with the wishes of the authorities and attended the clinic.

The families who were referred by the school and refused to co-operate do not appear to be greatly different in their general perspective from those who initiated the referral themselves and later refused to co-operate. In each case the role of the clinic is defined by the parents and if the clinic does not appear to fit in with that definition then the family does not co-operate.

CHAPTER 5

GENERAL DESCRIPTION OF THE EXPECTATIONS OF THE FAMILIES REFERRED TO THE CLINICS

Twenty-one of the twenty-four families, that is 87% of this sample, had no knowledge or information about the clinic or its workings, when they first attended. Twenty-two of the families in the sample had been referred to the clinic by third parties; none of them had been prepared in any way for their contact with the clinic.

Of the twenty-four families, twenty-one denied any knowledge of the clinic or its procedures. Of these twenty-one cases, three had apparently talked to friends who knew something (E, F and W) of the clinic. Two of the families who claimed some knowledge of the clinic had attended before (H and O). One family claimed to know all about the clinic (L) but appeared to be guessing.

There are probably two reasons why the referring agents fail to prepare their clients. Firstly, many of them probably know very little about the clinic themselves; secondly, they are apprehensive of the reaction they may get from their clients.

One mother who had been before (H) described the head master's approach to the problem. "The headmaster was very tactful - he didn't like to suggest that she should see someone." Several of the families had been put under pressure by the school to attend the clinic. The referral was not made, however, until they agreed to go. "This headmaster and the last one had suggested seeing a psychiatrist. Maybe there is something I don't know about. I'll give it a try and see what happens..... I don't really want to go....

I'll go to please them." (C). Some families, however, were not consulted at all. "We got a letter from the school. The headmaster said they had referred him to child guidance." (D). "We got a letter from the school. They said that his work was not up to his intelligence, so they were referring him to child guidance." (L). These three families did not co-operate with the clinic.

Even when a family presses for help, they are not told a great deal about the clinic. Very often, the referring agent appears to have been ambivalent about making the referral. "We took her to the doctor about school.... He gave her a tranquillizer... I went again about the younger child and the doctor asked about her. He suggested child guidance.... I wonder if I ammaking a fuss about nothing?" (I). "The last time I saw the doctor she said, 'I don't think we'll bother with child guidance'.... The next thing I know, I've got a letter." (F). "When we went to the school they said he had a terrible temper. The next time they said he was all right. On the third visit they asked if we'd like to see a psychiatrist."(G).

"We went to a school medical and were told there was nothing to worry about. Then we got this letter saying we should go back in two months. When we went the doctor asked if she was still frightened of noise. She (the doctor) said she wanted to dig down and find out why." (R).

The impression that this data gives is that many of the families were going into a situation that they did not understand, and even to a certain extent did not really comprehend what was the purpose of going.

During the course of the interview, all the families were asked what changes they would like to see in their child. All the families who had initiated the referral were able to state a specific change that they would like to occur. Only four of the twelve to whom help had been suggested, could make a similar statement.

The changes that the parents wanted in the children can be divided into three major groups. The major distinction is between those families who wanted a positive change, and those familes who wanted a negative change. The third group is a miscellaneous category.

Seven of the families wanted their children to change in a positive manner. Statements were considered to be positive if they appeared to be about the child and his growth. The parents' wishes were: that the child should be happier (H and I); be the same as before (less fearful) (W); be less fearful (R); be more active - get his trousers torn (X); stay in his own bed and be more like others - calmer (D). Six of these children have a neurotic diagnosis.

Statements were considered to be negative if they were essentially phrased in terms of, "I would like him to stop" certain ways of behaving. The things that the parents wanted stopped were: destructiveness (V); tantrums and bed-wetting (G and T); lying and stealing (N); naughtiness (S); temper, stealing and destructiveness (A). All these children have an anti-social diagnosis.

Obviously, to stop certain types of behaviour involves doing or being, certain other things. The above classification was

made on the way the parents expressed themselves. Apparently, the parents of anti-social children tend to see things in a more negative manner than do the parents of neurotic children. This may be related to the life situation of these parents of anti-social children, who tend to be involved in bad marriages and who are themselves more disturbed.

Three families were classified as being in the miscellaneous other category, their hopes being: to get her name changed (F); to find out if she wants her mum (U); to put him in a boarding school (O).

The remaining eight families did not express any such specific change that they would like to see. There is no relationship between the parents being able to state how they would like their child to change and the family co-operating with the clinic.

The picture our data has presented so far is a group of families who have not been prepared for their attendance at the clinic, claim to know very little about it and, in several cases, don't even have a reason for going.

Some of these families were prepared to venture a guess about the clinic and its methods. They believe it would be "talking". Of the three families who talked to friends, one said, "You hear so many different things." (E). The others tended to agree, "It's personal" (W). The other person's friend apparently said, "I don't envy you going up there - they want to know everything, and in the end you're guilty because you go to work and you should wet-nurse. I walked out." (F). This mother comments, "I'm not like that. If it would help my child I would tell them which brand of toilet paper I used." However, she reserved her judgment - "I won't go back if I don't feel it's doing any good."

Families (F) and (W) each only attended the clinic once. It is quite possible that they are ach using their friend's comments as a vehicle to express their own anxiety about the situation. Both these families were rated as expressing limited stigma/fear.

From the other comments made, it is not at all apparent that the families do, in fact, expect it to be personal. This is in spite of the fact thatthey all agreed that they would be involved in treatment except one case - "They will talk to him and know from his answers what's worrying him." (L). "I thought that they would see her and ask a lot of questions and analyse from the answers that maybe she needs her mum. I would not like that." (U). "If they talk to him about the right things, it might work." (T - the right things apparently being about right and wrong). "Not treatment - just that someone might talk to him - get through to him." (N). "They put you to sleep, don't they? Or maybe they'll just ask him things." (S). "We can only guess. I don't know whether they work in a psychiatric way where they probe them - 'Have you got a fear of your father? Have you got a fear of your mother? Have you got a fear of bangs? Does your father beat you? Does you mother scream at you?'" (R). "The main reason we want to go to child guidance is that she is so deep; she has a chip on her shoulder and we hope they will get it out." ( ).

The situation that has been described so far is one of considerable ignorance. Not surprisingly, ignorance breeds fear and in these rather stressful conditions the worst fears of must of the parents begin to come to the surface.

Many of the ratings of limited stigma/fear are, as expected simply expressions of this fear. This mild fear is not related

to eventual co-operation with the clinic. Apart from the fears already mentioned in the discussion, these determine the stigma. "I was told that he might be put in hospital. I would not like that." (D). "I don't want him to go into hospital. I have no confidence in them."(O).

Two families also expressed a fear of E.C.T. - "I don't want them to try things out on her - like E.C.T." (I). "They won't give her shock treatment?" (R).

Only one parent directly objected to the use of drugs. "I don't want drugs." (K) This particular woman has been living on various tranquillizers and anti-depressants for several years. The fears were also expressed in a more round about way. "My husband is allergic to psychiatrists - he was a little sad that I had done it." (X). "My husband thinks I'm making a fuss over nothing. I don't think there is anything mentally wrong with her, but people do know she's different." (I). "I am <u>not</u> ashamed." (W) Several of the mothers raised the possibility that if the wrong person was going to see the psychiatrist, it should be them and not the child. In two cases the anxiety was more apparent. "Is all this to find out if I'm a nut?" (S). One mother told about her experience with a specialist to whom she had been referred for thyroid trouble. The doctor suggested referral to a psychiatrist, and she replied, "I'm not mad." The doctor replied, "I didn't say you were mad." "Psychiatrists are ~~the~~ for mad people." "No, they are not." When she told her general practitioner about the suggestion he said "You what?" and refused to give her a referral. This mother was one of the highest scorers on the Goldberg Scale.

This mild stigma does not eventually affect whether or not the parents co-operate.

CHAPTER 6

CONCLUSIONS

Because of the tentative nature of these studies they can only really be considered as explorations of their subject matter rather than final statements about the nature of the social processes involved. In reviewing each of the studies we will examine both their strengths and their weaknesses.

The study of the use and provision of services can most effectively be criticised because the data has been collected at the wrong level of analysis. The two independent variables, the proportion of professional people resident in the area and the proportion of immigrants resident in the area, have been used to explain the various dependent variables; that is the numbers of child guidance staff per child at risk, the number of children referred to child guidance per child at risk, and the number of children placed in maladjusted schools per child at risk. All these variables are measurements of group phenomena yet the theoretical processes and mechanisms which we have used to link and explain the relationship between the independent and the dependent variables are in the realm of individual behaviour and this we have not attempted to measure.

On this basis most of our theoretical conclusions could be rejected. However, this research was developed around theories of individual behaviour and the hypothesis at the group level was postulated from these which suggests that the theories have a degree of validity. However, to fully validate them a study at the in-

dividual level is now necessary. Of course, such a study would only have to consider one or two geographical areas rather than the twenty geographical areas described in the present paper.

There are other criticisms which can be made of the methodology of this study. Because the data is population data the question of sampling fluctuations within a sample of twenty does not arise. However, with such small numbers random influences in the population might have an inordinate effect. This is important because such random variables might give a false impression of the theoretical trends underlying the distributions. For instance, one borough might have a more extensive provision of services than can be predicted from its ethos simply because a particular officer has managed to influence the local authority in the direction which suited his specific interest. To a certain extent we are guarded against such influences because we have used dichotomies. Hence, provided a borough is not at the point of division between the high and low categories, so that this influence moves it from one group to another, such an effect will not be noticed. On the other hand using dichotomies does make the relationship between variables appear to be stronger than they would be if interval or ordinal scales were used. This is because there is far less room for variability in a dichotomy than in any other type of scale. Preliminary investigations using other methods of scaling this data show that the relationships were not reduced by much more than 10%. This point alone must give us some confidence in the results.

The final criticism that we can make of the study of the provision and use of services is that it is probably going to be very difficult to generalize the results to the rest of the country. The

study has been carried out on an urban population. However, it is also the population of London which is very different in many ways from the population in other parts of the country. If attempts are going to be made to generalize this model then these factors must be taken into account. For instance, the influence of the proportion of Commonwealth immigrants would probably be much weaker if we considered the country as a whole and we may discover that social class becomes a dominant factor.

The study of the provision and use of services really set out with one question in mind - how far is the provision and use of services for maladjusted children congruent with the needs of those children. In other words we are asking if decisions taken about individual children are based upon an objective assessment of the child's needs or if they are dominated by social and organizational factors.

We can first consider these issues in relationship to the pattern of referrals from the schools (Diagrams 8, 9, 10). A very distinct peak is noticed in the pattern of referrals of boys from the schools around the age of nine and a less pronounced one for girls around the age of thirteen. As was noted earlier there is very little conclusive evidence about the age prevalence of disturbance in the child population. However, none of the studies Rutter reviewed have a peak at these ages, most in fact have a flat distribution with occasional peak years. However, these two peaks are clearly related to the peaks that Jean Lawrence found in her studies of teachers. The teachers that she studied found most difficulties with boys of the age of nine and girls of the age of thirteen. It appears probable that referrals to child guidance from the schools may be saying as

much about the teachers' difficulties as about the childrens. Such an interpretation is given further credibility when we compare the patterns of referrals from schools with those from non-educational sources. Here the pattern corresponds much more closely with the studies of the population prevalence but the peaks are missing. This study leads us to one of two conclusions, either that many of the boys around the age of eight and girls around the age of thirteen who are referred to child guidance clinics do not need to be referred because of their behaviour or a greater proportion of the boys around the age of eight and girls at around the age of thirteen who are disturbed are being referred to child guidance. Whichever of these hypotheses is valid it has important implications which need to be pursued.

The next aspect of this study that has raised important points concerns itself with the influence of the proportion of immigrants in the area upon the provision of child guidance facilities and the numbers of children classed as maladjusted. As we have already pointed out, we cannot logically claim to have proved a causal relationship exists though we have evidence that such a relationship may well be found if more detailed studies were carried out.

Assuming that such a relationship does exist we need to ask certain questions about the relevance of child guidance which is based on white middle class values, as a treatment agency for non-white working class children. If in fact the expansion of child guidance is being carried out surreptitiously without admitting the real reason why such developments are taking place it is more than likely that the staff involved are not adequately prepared to deal with the difficulties of children from different cultures.

It is often argued that child guidance, like other psychotherapeutic agencies, is only effective in dealing with the neurotic child and not with the anti-social child. We have limited evidence from the second study which is presented in Appendix 6 to suggest that this may in fact be true but not because child guidance is ineffective with the anti-social child but because anti-social behaviour appears to be a reaction to the home situation, particularly the parents' marriage and unless this improves there is unlikely to be any improvement in the child. In Appendix 6 there is some suggestion that where there are no marital difficulties the child receiving an anti-social diagnosis is as likely to improve as the child receiving a neurotic diagnosis. A similar form of argument implicating the environmental factors may be used with regard to the immigrant child who appears to react in an anti-social manner to a disturbed environment. Unless one can deal more directly with the environmental disturbance there is little hope of helping the child whose reaction may appear to be irrational though it is possibly justified.

The anti-social child from a disturbed background is the one that the clinic is most likely to find difficulty in helping. In the second study all four immigrant children received an anti-social diagnosis compared with only eleven of the twenty non-immigrant children. We also find that all four of the children recommended for placing as maladjusted had received an anti-social diagnosis and that two of these were immigrant children. Although the numbers are small they do fit in with the wider patterns found in the first study where a strong relationship was shown between the proportion of immigrants in the area and the numbers placed as maladjusted.

If the relationships we have described are reflecting the point that large proportions of immigrants are being placed as maladjusted we should seriously examine alternative ways of intervening in these situations. We should quite clearly take into account the one aspect of the immigrant child's difficulties is going to be a feeling of being different. To compound this by sending him to the "mad school" or "nut school" as most schools for the maladjusted are locally known, can only be asking for more trouble later.

When considering causal models it is important to realise that some very weak relationships may be of great theoretical importance. Social class seems to play such a role in this model. Where weak the distinct relationships appear between the provision of services and the number of children placed as maladjusted. Such relationships only appear, however, when the proportion of immigrants in the area is taken into account. Given the fact that most immigrants are concentrated in relatively few parts of the country we would expect social class to appear as a much more important variable. The implications of this point are most important with regard to the number of children placed as maladjusted. There is some evidence that working class areas have a higher incidence of disturbance than middle class ones. Rutter has found this in his recent work. It may also be implicit in our own study where we found that lower class areas have much higher rates of referral even when the proportion of immigrants and the provision of services is taken into account. If the upper class areas are placing more children as maladjusted we must ask the obvious question. Are the upper class areas providing a service which is responding to the

need of the child or are we observing the social processes we suggested on the basis of our theoretical model which predicted that the upper class areas would place more children because the lower incidence of disturbance would make the disturbed child more obvious and less tolerated. Either way it appears that some children are being misplaced and we do not know the consequences of this.

The question raised above is typical of all the questions raised by this study of the use and provision of services for the maladjusted child. How are the services for maladjusted children responding to the objective assessment of the child's needs and how far do social processes based on the needs and values of third parties in official positions affect these services. This study started with a perspective and a theory based on the latter of these positions. The results tend to suggest that a more detailed study would not only be rewarding but is also important.

In the second exploratory study, that concerned with the factors influencing the family tendency to co-operate with the child guidance clinics, can most easily be criticised because of the small number of subjects upon which it was based. It was argued at the beginning of the study that we could increase our confidence in the representativeness of the sample if we found relationships in our analysis which had already been established elsewhere. There are in fact three such relationships which appear to fulfill these requirements.

A. There is a strong relationship between our measurement of marital difficulties between the parents and anti-social behaviour amongst the children. This relationship has been established and confirmed by Rutter.( )

B. The second relationship which appears quite clearly in our sample is that nearly 55% of the mothers in this sample are considered to be disturbed on the basis of Goldberg's questionnaire. This proportion is very similar to that found in other studies (28•29)

C. Rutter, in a sample of 782 boys and 48 girls referred to the Maudsley Hospital, found that 70•8% of the boys and 66•6% of the girls scored 13 or more on the parents behavioural question. If we accept these figures as norms for the questionnaire we could calculate expected frequencies for our sample:

	Boys		Girls	
	13+	4•4	13+	12 or less
Expected frequency	10•6	4•4	6	3
Actual frequency	10	5	7	2

These results are close enough to give us further confidence in the representative nature of our sample.

On the basis of these three relationships we can have considerable confidence that our sample is not unique and can be used as a basis for generalisation.

The first important group of findings in this study concerns the role of those aspects of the family situation which might indicate that the child was living in a stressful environment. Notably, the marital situation and the mother's disturbance, that is the two indicators of maternal stress. Earlier studies have related these two indicators to the nature of the family's contact with the clinic.

Cohen's study, conducted in the United States, showed that there was a tendency for parents with marital difficulties to co-operate with the clinic. In the present study it has been argued that such a relationship is not causally meaningful, in fact the finding is that families with marital difficulties are less likely to co-operate with the clinic than families without such difficulties. The observations from this data suggest that the parents tend to accept child guidance only when they perceive the clinic has a direct role to play with regard to the child. The parents do not accept the role of child guidance clinics in helping them to solve their own difficulties.

Most of the families with marital problems were referred to the clinic because of the child "acting out" at school. These families were rarely able to see a problem, were not concerned about the child's future and did not co-operate with the clinic.

Sheppard's study implicitly seems to suggest that the mother's mental health may be an important factor in determining which families are referred to, and attend a child guidance clinic. The study now being described is unable to directly approach this question. However, within the sample it is possible to demonstrate that where the mother is disturbed the family were not more likely to have sought out help for their child than those families where the mother does not show signs of disturbance.

Disturbed mothers tend to have slightly more concern about their child's future than those who are less disturbed. However, this is very slight and not of statistical significance. Consequently, it has been argued that the mother's disturbance is not of causal significance in determining whether or not a family co-operates with the clinic.

The conclusion has been drawn that the marital situation and the mother's disturbance are not of causal significance in determining which parents co-operate with the clinic and which do not. Nor is there any evidence in the present data to suggest that they are causally significant in determining whether or not help is sought for a child. The significance of these two factors is almost entirely related to their aetiological role in determining whether a child develops neurotic or anti-social behaviour patterns.

How the parents react to these behaviour patterns probably depends upon cultural values. Even though the relationships in our sample were not statistically significant, parents do appear to become more anxious and are more likely to co-operate with the clinic if the child's behaviour is not of a culturally acceptable pattern. Such overtly unacceptable patterns are neurotic behaviour in boys and anti-social behaviour in girls. When the child's behaviour is outside such culturally determined role expectations then the parents start to become concerned about the child's future and are more likely to co-operate with the clinic staff.

This approach, which explains the parents' anxiety in terms of the cultural meaning given to the child's behaviour is not the whole story. The parents can become, and do become, concerned about their child's future in different situations.

For instance, most anti-social behaviour in boys appears to take place outside the home and the parents can easily question any information about the child's behaviour they get from a third party. However, such a protest of denial is not so easy once

the child starts to manifest his behaviour at home and consequently parents of anti-social boys start to become concerned about their child's future if the behaviour not only becomes apparent at home but the parents have difficulty in coping with it. On the whole parents of anti-social children appear to have less difficulty in coping with their child's behaviour than do the parents of neurotic children.

Parents of violently anti-social boys will become concerned about their child's future even if they are quite able to cope with the child. Again, the parents are not able to deny the descriptions of the child's behaviour because it is so obvious. However, in this case the behaviour is so dramatically abnormal that the parents are likely to become very concerned.

The difference between the parents of the violently anti-social children and the other parents that are concerned about their child's future is that the parents of the violently anti-social boys experience considerable stigma/fear. Many of the other families experience stigma/fear as well but not so blatently as the parents of the violently anti-social children. It was argued that the extent of the stigma/fear was related to the degree of obvious abnormality the child displayed. Certainly within this sample the greatest stigma/fear was attached to the children whose behaviour was the most dramatically disturbed.

From a practical point of view it may well be that the child guidance will be more successful if greater preparation was given to families before they attended the clinic. None of the families in this sample could be considered to be adequately prepared for their visit to the clinic and few had any realistic expectations

of what was going to happen to them. If we assume that there is a valid reason for the referral being made then there appear to be two points where intervention could be successful. In the first instance all the families except one attended for a diagnostic interview. Such interviews may be more successful if they spent more time dealing with the parents' anxiety and fears and less on diagnosing the presenting problem. However, many of the families who attended for a diagnostic interview felt that they were being coerced into doing so and would obviously be very defensive. The majority of these families had quite good relationships with the school and this is where the intervention could probably be made more successfully.

The most important factor in predicting whether or not a family will co-operate was shown to be "concern about the child"s future". Our analysis has indicated that the determinants of this may well be cultural rather than environmental. Whether or not the parents become concerned about their children's future appears to depend on whether or not the child's behaviour deviates from the parents' conception of normal behaviour. This hypothesis appears to explain some of the results in the causal analysis though it has not been tested directly. During the interview parents were asked in what way they felt their child differed from other children. Surprisingly very few of the parents could answer this, most saying that they either did not know other children well enough or that there were no differences. Most parents presented their perceptions of their child either in relationship to themselves in terms of difficulties in coping, or in isolation. However, the feel of the interview and comments

made at other points when the question of the child's normality is not being raised (and feelings of stigma/fear are not being aroused) strongly suggests a culturally based point of reference. It appears that this hypothesis can only be tested fully in a less intrusive manner.

Our analysis suggests that the failure of child guidance to deal successfully with the children referred from the schools is not in the nature of the problem but in the attitudes of the parents to the problem and this may be a consequence of the process of referral. This suggests that the techniques of child guidance needs to be changed. Child guidance was the first clinical area to break away from the strict disease concept and develop the roles of para-medical disciplines. It now appears that it requires to develop itself even further and take into consideration the extent to which its isolation from the everyday activity of the community is hampering its work. In particular this study suggests, as did the earlier one, that members of the team should be prepared to come into the community much more and meet the problems in the areas where they exist, particularly in schools. It appears that the clinic team should take a more active role in school counselling, not only with the staff of the schools, but also in order to carry out much of their clinical work.

Even though the two studies described are exploratory studies they have provided a wealth of information which needs to be pursued in far greater detail. Apart from such specific points these studies illustrate quite clearly that the research workers need to integrate the difference "levels of analysis". In

particular, ecological studies of the type described in Chapter 3 need to be coupled with studies of individuals as was done in Chapters 4 and 5. Studies using individual perspectives such as role theory and grounded theory also need to be coupled with studies using the technique of causal analysis. Until this is done our understanding will always be incomplete and confused.

APPENDIX 1

(reduced in size)

AGE AT TIME OF REFERRAL	REFERRED FROM																				TOTAL	
	A TEACHER HEAD-MASTER		B SCHOOL PSYCHO-LOGICAL SERVICE		C SCHOOL MEDICAL OFFICER		D SCHOOL DOCTOR		E OTHER EDUCA-TIONAL		F GENERAL PRACTI-TIONER		G PARENTS DIRECT		H CHILDRENS DEPART-MENT		J COURT PROBATION		K OTHERS NOT EDUCAT-IONAL		L	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Under 2																						
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8																						
9																						
10																						
11																						
12																						
13																						
14																						
15																						
16																						
TOTAL																						

APPENDIX 2

COPIES OF LETTERS TO THE FAMILIES

A. Typical letter from the Clinic, which would accompany the appointment

Dear .....,

You will have received a letter from me offering you an appointment to see one of our social workers, ..., next ..... At present this clinic is taking part in a research project to look into how the child guidance services, for both children and parents can be improved. The research is being carried out by the London Hospital under Professor Pond.

We are therefore asking parents if they would be willing to meet Mr. Cartwright, the research worker, before their first appointment at the clinic. Mr. Cartwright will probably be contacting you to arrange to see you at home. If you do not want to take part please let him know. Your decision will in no way affect your appointment at the clinic.

Yours sincerely,

B. Typical letter from research worker to parents

Dear .....,

I unedrstand from the staff of the ..... that your son ..... has been referred to them.

In order for us to carry out our research project it is necessary for us to talk to as many people as possible, before they actually go to the clinic. Even if they do not intend to keep the appointment we would like to talk to them.

I will be in your area on ....., in the morning and again on ..... in the evening and will be able to call on you then. If neither of these times are convenient will you please telephone me and let me know.

You are under no obligation to take part in this project. If you do agree to participate I can give you the strongest assurance that all the information given will be treated in the strictest confidence.

Yours sincerely,

A P P E N D I X 3

BRIEF CASE HISTORIES

In the following pages brief outlines will be given of each of the 24 cases. Each case is preceded by a capital letter.

A. A was a six year old boy who was referred by a welfare worker at the mother's request. He had an anti-social diagnosis, and his mother scored 30 on the Goldberg scale.

The child had a history of violent aggression. He was nearly expelled from his school because of uncontrollable behaviour; in particular, he had attempted to prevent other children attending school through a campaign of terror.

At home he was equally violent; his mother feared for the safety of his young stepsister. She claimed that he virtually wrecked the house in which they lived; she was also troubled because of his enuresis.

A's father was killed in a road accident before he was born, and he was brought up alone by his mother. His mother eventually re-married; A openly resented this fact and there was a continual conflict between the child and the step-father, and the marriage was on the verge of breakdown.

He had a younger step-sister who was weak and continually demanding attention. Mother feels torn between the conflicting demands of the three others; she openly developed nervous eczema. She felt that she could not take it any more.

The mother expressed an open fear of psychiatrists, "They know what you are doing if you tell lies - if you cut something - they frighten me." She wanted two things from the clinic;

firstly, some drugs to tranquillize the child, and secondly, advice. She did not feel that talking would achieve anything.

The mother attended the clinic only once, where psychotherapy was recommended. After this she did not attend for any further appointments. She had deliberately avoided contact with the social worker who tried to visit her. A was recommended for a part-time place in a maladjusted school.

B. B was a seven year old boy who had an anti-social diagnosis. His mother scored 19 on the Goldberg scale. This child was referred by the school because he had a "mental block." At school he sat and was quiet. This was the opposite to his behaviour at home. At home he had violent temper tantrums, was disruptive and told lies. He also had a tendency to twitch and to stutter. Mother was concerned about the behaviour. It was quite clear that this was a response to the father who had been critical to the child since he was very young. His father always compared the child unfavourably with his brother. When the father was not at home, most of the symptoms disappeared. The father rejected the referral very strongly. "My kid's not going round there - he's not barmy." Mother and child attended the clinic once, but felt unable to come again because of the father's reaction.

C. C was a ten year old boy. He had an anti-social diagnosis. Mother scored 0 on the Goldberg scale. The family were West Indian. The child was referred by the school because, "He fights like an animal." Mother, however, did not see a problem. She encouraged him to fight because she could not always be around to defend him

"when the white kids tried to beat him up". Mother denied that she was at all concerned about the child. She did feel, however, it would be nice if he was less naughty and did not get his clothes torn so often. She said that she did not have any problems with him, but was aware of the fact that neighbours and teachers found him difficult to control. She blamed most of these difficulties on the fact that she lived in a Tower Block, and this very active boy felt that he was trapped. During the course of this interview it was discovered that a young child was repeating over and over again in the background that, "He can't help it, mummy - you said so." The clinic also felt that the mother was concerned but was not prepared to admit it. She said that she would go to the clinic to please the teachers because they were so worried. She strongly reacted against any ideas of special schooling or hospitalisation. She felt these would be tantamount to saying that the child was mad. The clinic suggested that first the boy should be hospitalised, then in all probability sent to a special school.

D. D was a six year old boy who had an anti-social diagnosis. Mother scored 11 on the Goldberg scale. The child was referred from the school without the parents being consulted. They knew, however, that the referral was made because of his behaviour in school. His younger sister was due to start school in the following term and mother had decided to send her to a different school, "Because of his reputation." At home he was always in trouble. Mother felt that she could not trust him to go out by himself because of what he might get up to. She said that the other children always dared him to do things, and he could never resist.

Most of his friends were girls; he was always fighting - mainly with girls. He got on very badly with his younger sister.

During the course of the interview the mother spoke a lot about his past. His sister was born when he was two years old. At that time they were living in one room. He was a very demanding child and one day she nearly strangled him, "I nearly strangled him when he was two. I really marked his throat. I was very worried and went to see the doctor about it. She put it down to where we were living."

The two children shared the same bedroom until the subject was about four years old. He had monster nightmares; these ceased when he was moved from his sister. Quite recently the mother had been expecting another child. The boy was very interested and said he would like another sister. Mother had a miscarriage; the boy was never told of this. The miscarriage occurred during the last week of the school term. Since that week, "When he's been off from school - he's been different. What he will be like when he goes back, I don't know." Because they had never talked about the miscarriage to the child, they did not seem to feel that he could know anything about it. Consequently, it did not seem to have occurred to them that it could have been an important factor in such a sudden change of behaviour. The family did not attend the clinic. The change in behaviour seems to have been relatively permanent. Both parents and school reported that it had been sustained over the following year.

E. This is a five year old boy. He had a neurotic diagnosis. Mother scored 4 on the Goldberg scale. This boy was referred by

the school because he was inattentive and withdrawn. At home he had difficulties in dressing himself; his speech was indistinct and very difficult for the parents to understand. The clinic felt he was a child of low intelligence; they recommended that the family give him maximum encouragement in all he did. They felt the main problems were educational, and he was referred to the Educational Department for further consideration.

F. This was a nine year old girl. She had a neurotic diagnosis. Mother scored 7 on the Goldberg scale. The referral had been made several months earlier by the school doctor at the mother's instigation. The main problems that we presented were that the child did not sleep well and did not like going to school. The mother felt that most of the problem was due to the fact that the child was deaf in one ear - also that she had a teacher with a bad stutter. Because the child could not understand the teacher, the mother claimed that the teacher turned on the child. Mother had been divorced from the child's father and had remarried. There was a certain amount of pulling between the parents. Mother said she would come to the clinic to get help to change the child's name. The clinic felt that the child was suffering and suggested that they worked with the child's anxiety and depression. The mother was very defensive about any possibility of opening up the child's feelings. Her original reason for making the referral was that, "She came back from her father one day and said that she wanted to go and live with him." Underlying the mother's concern seems to be a similar fear. "She can't get to sleep at night; she lies there for two hours. It is beginning to worry me because

when she lies there she thinks, and I don't like her thinking. She thinks about the family situation and which parent she would rather be with." It seems that the clinic's suggestion of working through the situation would be the last thing that this mother wanted.

G. This is an eight year old boy. He had an anti-social diagnosis. The mother scored 10 on the Goldberg Scale. He was a locally born child of West Indian parents. He was referred by the school because of his uncontrollable temper. At home he tended to be violent and destructive; he also suffered from enuresis. The marriage situation was poor, and the parents had been to marriage guidance. The mother was concerned about the boy's behaviour because she felt that "When he is a grown man he could be dangerous." The father did not feel there was any problem. The father felt that it was natural for a child to rebel, and the reason why the teachers were having such problems with him was that they did not know how to keep discipline. He felt that things were all the wrong way round. The doctor refused to give the boy treatment for enuresis, which father believed to be an illness. The school, however, wanted to give treatment to the child because of their own failure to keep discipline.

The father said that if they were to give any treatment, then they should give drugs and nothing else. He refused to accept the possibility of either special schooling or hospitalisation. The parents attended the clinic once and did not return again.

H. H was a seven year old girl. She had a neurotic diagnosis. The mother scored 45 on the Goldberg scale. The child was referred by the school who said that she was tense and nervous. The mother had only had one problem with the child, which was her enuresis. This had stopped dramatically one day when the mother broke down and lost her temper with the child. Mother was not particularly concerned about the child's symptomatology. The child tended to be sick before going into new situations. Mother tended to ignore this, "Because I'm like that." She felt that the leg aches about which thechild complained, were physical. Mother felt that the child, "will be all right in the future because she is not stupid." When the school recommended the referral, the mother was quite surprised. "I never thought that she needed someone." Neither parent objected, however, "If we say no, it doesn't help her." This family attended the clinic seven times. When the case was closed, there had been some real improvement in the eyes of both the family and the school. Mother, however, felt that her own difficulties had not been helped at all.

I. This was a five year old girl. She had a neurotic diagnosis. Mother scored 21 on the Goldberg scale. This child was referred by the general practitioner at the instigation of the mother. The prime problem was that she would cry and create whenever she was taken to school. The doctor tried tranquillizers without success. She also tended to be destructive, disobedient, and did not mix well. Mother did not feel particularly affected by the behaviour, though she said, "I don't know how to handle this; it is so unlike my family." The parents were concerned particularly because she,

"doesn't seem to know how to correct herself - make herself liked." Mother was worried about the future, particularly about her education. Mother said that she, "doesn't think there is anything mentally wrong with her, but other people do know she is different." She also said, "People say she will be all right - I want someone to tell me that she is." Mother wondered "if I am making a fuss about nothing." The family visited the clinic seven times over a period of five months. When the case was closed, both parents were happy with the improvement in the child's behaviour.

J. This was a nine year old girl. She had an anti-social diagnosis. Mother scored 26 on the Goldberg scale. This referral was made by the general practitioner at the father's request as a result of a suggestion by the headmaster. Father had visited the school hoping to get the headmaster to intervene to prevent a series of attacks and threats that had been made against his daughter by an older girl. These attacks were part of a feud that had developed between the two families. This was the result of an argument between the fathers. The parents had been concerned about the child before these incidents, but had done nothing. In this situation they tended to act to prevent attacks rather than to help the child directly. The felt, "If she carries on like this, we don't know where she'll be." Her mother had been totally unable to cope with the situation. "It's made my nerves bad; I've been to the doctor." This family attended the clinic on five occasions. During this period the marital situation deteriorated, and the father got into trouble with the police for "fiddling on the Social Security." During the interview, the

father complained bitterly that other families were getting all sorts of benefits that were being denied them because he had been in prison. The clinic felt that this child was reacting to family problems and could be best helped in the environment of a school for maladjusted children.

K. This was a six year old girl. She had an anti-social diagnosis. Her mother had spent several years in mental hospitals for what she called "depression". The official diagnosis was schizophrenia. She was not very forthcoming during the interview. The child seemed to dominate the mother (father was in prison for child molesting). On the first visit, the mother thought the interviewer was the rent collector and would not open the door. The child stood outside and threatened to kill her if she did not open the door. On the second visit (during the interview) the child came into the room and attacked the mother with a knife because she would not agree to buy her a new paint brush. Mother had kept the child away from school for six months for various reasons, even though the child wished to go. A welfare worker visited the mother to discuss this with her, and suggested the referral as "K was a bit disturbed." The child was taken into the psychiatric ward of a hospital and remained there for some time. At the time of discharge, the mother was extremely reluctant to take her back, though she did so eventually. The mother's health appeared to be deteriorating as the time approached for her husband's discharge from prison. The clinic lost contact with the family almost immediately after the child was discharged. It is believed that the child is now in care, but the clinic had not been able to firmly establish this at the time of follow-up.

L. This was a seven year old boy. He had a neurotic diagnosis. The mother scored 0 on the Goldberg scale. The boy was referred by the school because his work was not up to his intelligence. His parents were not consulted. At home he tended to be disobedient and had temper tantrums that got his mother down. The marriage was not obviously bad, but there were a lot of side remarks during the interview, "I'm a secretary; I see things quicker than my husband." Mother agreed that the child's work was not up to standard, but felt this was simply because of the poor quality of the school, "He's seven. He should be sitting at a desk." She also blamed the school for his behaviour which she attributed to the bad influences he had received from the children there. During the first interview at the clinic the family denied that there were any problems. No further attendance took place.

M. This was a ten year old boy. He had a neurotic diagnosis. His mother scored 17 on the Goldberg scale. This child was referred by the general practitioner at the request of the parents. The main complaints being that he would not sleep in his own bed and that he was disobedient. He also tended to have temper tantrums in the morning before going to school. The child was ascertained as E.S.N. three years earlier. The father felt that the school which he attended had "brought him on a bomb." The school had been actively involved in trying to help the family with earlier problems. These included a mother-in-law who had actively tried to turn the child against her parents. The parents had been concerned about the child for years. The referral was made because they felt they could no longer cope. They recently had a new baby

who suffered from fits (as did M until the age of three) and who needed constant attention. They found they could not control M. "We have to be really nasty if we want him to do anything." The father said, "I got to the point that I thought I would have a breakdown." The parents felt that if they could get him over the "fear" that made him want to sleep in their bed, they could cope. The clinic took him into the children's psychiatric ward where his problems were not apparent. However, when he returned home, he insisted on sleeping in his parents' bed again. The psychiatrist told them that the boy would be all right provided they were strong enough. At this point, the father, who had been unemployed, got a job elsewhere, and the family moved. They contacted the services in their new area.

N. This was a nine year old girl. She had an anti-social diagnosis. The mother had a score of 26 on the Goldberg scale. This child was directly referred by the mother because of her lying and stealing. The father had recently left hom after failing in an attempt to start a motor business, and throughout the period before the follow-up there was continuous reference to the family joining him whenhe had "made it". He did not seem to be able to hold on to any job for long. After the father left, the child became difficult at school and at home. A whole series of incidents had taken place: she had been collecting money under false pretences, wreaked a warehouse, gone off with strange men, and told a neighbour that her child had just been run over. Her lying and general disobedience started before her father left home. Mother had little difficulty in coping with the child but was very concerned. "The

way she is going on, she is going to end up in serious trouble - she just laughed at the policeman." Mother and child came to the clinic on six occasions. During this time N did not speak a single word. However, mother said she seemed to take some notice of what was being said. The family left the area (mother felt that the area was the cause of many of the problems) and further reports from mother and the new school said that N's behaviour had improved and that she was doing much better at school.

O. O was a five year old boy. He had an anti-social diagnosis. Mother scored 60 on the Goldberg scale. This child was epileptic and had violent temper tantrums. Mother was at the end of her tether, "It's nerves with me. The doctors say that I've got nervous anxiety." "Cigarettes - the only thing I can turn to. The other day I put my hand round this throat; it was only John who pushed me away." She was very concerned, "I can't get through to him; I can't do no more. He's got to have this help. I'm not sure of my responsibilities, but I feel that if he does not have this help, he will do damage."

This family was well known to the authorities who, if mother was to be believed, were not very sympathetic. The events leading to the referral were described as, "I had glandular fever recently, and I couldn't cope with O. My daughter had to stay at home. She's losing a lot of time from school. She's suffering now; she feels that she cannot put up with life." As a result of this an area case conference was called and a referral made from the conference to the clinic. The child was placed for a short period of time in the children's ward of a psychiatric hospital.

Whilst he was there, the number of fits he had diminished considerably. He was rarely violent at all. Whenever members of the family appeared, all the previous symptoms became apparent. The clinic felt that he was quite clearly reacting to a disturbed family situation. At the time of follow-up a placement was being sought in a boarding school for maladjusted children.

P. P was a nine year old boy. He had an anti-social diagnosis. His mother scored 0 on the Goldberg scale. The referral had been made one year before the interview, after a stealing incident in school. Consequently, the parents were surprised to receive the appointment at this point in time. Neither parent was concerned about the child's behaviour, nor did they experience much difficulty in coping. However, the boy was considered by the mother to be playing her up a lot; she felt it was time he settled down, grew up and stopped being a baby. The husband did not feel therewas anything wrong with the boy at all. The mother appeared to completely dominate this household. She made a lot of remarks in the interview about her superiority to her husband. She was very defensive indeed during the course of the interview; the interviewer felt that there was a big skeleton in this particular cupboard.

This family visited the clinic on sixteen occasions. Over this period of time some general improvement took place in the child's behaviour. The child terminated the treatment after several months' attendance at the clinic.

Q. Q is an eight year old boy. He had an anti-social diagnosis. His mother scored 28 on the Goldberg scale. The parents are West

Indian, and mother and the children had only arrived in Britain nine months previously. He was referred by the school because he refused to talk to the teachers. Mother said that she would go to the clinic because she understood that the teachers were worried as they did not know where they stood with him. From the mother's point of view he was quite normal. At home he was quite talkative. He had a violent temper and was also enuretic. The mother gave examples of children who were much older in the West Indies and who behaved in a very similar fashion. The marital situation was very poor. The parents attended the clinic once, but did not return. Many appointments were made, but these were not kept. About six months after the first child was referred, his brother was also referred for aggressive behaviour in school. The clinic had persisted in trying to contact the family, and at the time of follow-up they had managed to get the parents to agree to some form of treatment. However, this had not materialised when the actual follow-up took place.

R. This was a six year old girl. She had a neurotic diagnosis. Mother scored 34 on the Goldberg scale. The child was referred by the school doctor because the parents had taken her to him on a number of occasions as she was frightened of noise and would not go to school. She was tense and nervous. She once picked her finger until the nail came off. Most afternoons she would refuse go go to school. Mother had to try and persuade her. This affected the mother, "This gets me down - trying to find something to say to get her back in the afternoon. I've been through enough in my life without having a baby do this to me as well." The

parents have been concerned about her for four years and have been regularly in contact with welfare and medical agencies. This family visited the clinic twice before leaving the area. They claimed that there was some general improvement in the child's behaviour. The clinic felt that if this, in fact, was true, it was quite likely to be short-lived.

S. S is a six year old boy. He had an anti-social diagnosis. His mother scored 5 on the Goldberg scale. This child was referred after the mother had been putting considerable pressure on the general practitioner and school for about six months. She was ostensibly referring the child for nightmares. This is what she told the doctor, the school and the clinic. During the course of the interview she spent five minutes talking about nightmares, and over an hour talking about the child's general behaviour and the effect it had on her. The child is very aggressive and always in trouble for fighting, "They're always knocking here whenever there's a fight - 'Go and see Stephen's mum.' Many are the rows I've had over him." He is also agressive towards his mother. The doctor gave him medicine because he is having eating difficulties, "but he spat it out all over me - nice child." On a couple of occasions he had taken matches, and mother has had to go and extinguish the various items he set light to.

Mother said that she used to get all worked up then, "All my face used to go. I used to think to myself, 'My nerves have gone again'. If I get all worked up, my face goes numb all down one side." In spite of the fact that mother could not control the child and was severely affected by him, she hardly mentioned these

problems to any official agency. She feels that, "Something has got to be done about him." and that "I don't know what I'Ll do if they don't succeed." She expected if 'they' were successful, her son would be less naughty. During her visits to the clinic, mother hardly seemed to mention these difficulties at all. Her presenting problem was nightmares and her expected mode of treatment for the child was hypnosis. Both clinic and interviewer suspected that there were also considerable marital difficulties, though these were mainly denied. For a period the parents appeared to co-operate. The mother attended the clinic three times, after which she did not reappear.

T. T was a ten year old boy. He had an anti-social diagnosis. Mother scored 10 on the Goldberg scale. The main basis of the referral was regular bed-wetting which had started eight months earlier; it was accompanied by outbursts of temper and disobedience. Mother had asked the doctor to refer the boy to the hospital as she felt that the enuresis was due to some physical complaint. The temper tantrums she believed to be due to a lack of discipline on her husband's part. The hospital suggested that the clinic was the best place to deal with the problem. Mother was not experiencing difficulty in coping, "Gets me down a bit, trying to dry the sheets in the winter." "Sometimes the tantrums make me a bit bad-tempered." Mother is concerned because she feels something is wrong, but her concern is very limited, "I've been worried since last October."

Mother did not really see that there was a role for the clinic. "I don't think his mind is causing it. I think it's a matter of

discipline, unless it's physical." In consequence, mother did not think the clinic could help - "unless they talked about the right things" - the right things to talk about being matters of right and wrong.

This family were experiencing marital difficulties. The mother only appeared at the clinic once.

U. U is a six year old girl. She has an anti-social diagnosis. She lived with an aunt who scored 1 on the Goldberg scale. The parents and the aunt were West Indians. The parents were separated and the 'aunt' who was actually a friend of the mother's, was looking after the child. It was the child's choice that she should live with the aunt. However, her recent behaviour, such as lying and disobedience, had led the aunt to wonder if she actually wanted to continue staying with her. The aunt had asked the school to ask the child, because she felt she was not being told the truth by the child. After an incident at school it was agreed to make a referral to the clinic. What the incident was, was never discovered. The aunt was very concerned about the child because she could not understand why she was behaving like this. She was very worried. The child attended the clinic three times and left to join her mother. The interviewer felt that the aunt really wanted to get rid of the child and was trying to force the child into wanting to leave.

V. V was a six year old boy. He had an anti-social diagnosis. The mother scored 28 on the Goldberg scale. This family had been to child guidance some years earlier with an elder child. The mother knew about the clinic and was able to make the referral

directly by herself. She wanted the child referred because of his temper tantrums and destructive behaviour. He was also stealing from his parents and from other people. The immediate reason for the referral was that he had broken into the house next door and done a considerable amount of damage, including urinating on the furniture, and trying to set fire to the carpets. Mother was having difficulty in coping with the child. She said she was frightened of letting him out of her sight, and that she collects him from school and then tries to lock him in the house. She had to leave the other children to look after themselves while she looked after V. She felt that she was getting short-tempered.

The parents really became concerned after the child had started to damage other people's property. They wondered about the future for him. "What is he going to be like in later life?" "If it's something in him, I want it done now before he's 17 and they can get him into court, and things like that." The house in which the family were living was probably the worst encountered in all the interviews done on this research. This was partly due to the child, and also due to the fact that the parents had waited over a year for an improvement grant. The father said they could't do anything because if they did, the grant would be reduced.

The marital situation was poor. The clinic felt that the child was reacting to a disturbed family situation. They did not recommend any treatment for the child but suggested that the parents worked with the clinic. The parents accepted this situation. Then father decided he no longer wished to remain with the family; he decided to get a divorce. At the time of the

follow-up, the clinic was still actively involved in working through the problems associated with this position. Both the parents were in contact.

W. This was an eight year old girl. She had a neurotic diagnosis. Mother scored 29 on the Goldberg scale. She was referred by the school doctor at the instigation of the mother. The main problems were the child's sudden refusal to be separated from her mother and her inability to sleep. Both had occurred quite recently. The referral was a last resort.

Mother believed that the child's problems were a reaction to her own difficulties. Her father had just died of cancer and her uncle had just had it diagnosed. Her husband had told her that he would stay with her even though he loved someone else. The mother felt that, "Sometimes I think it's me that needs a psychiatrist." It was quite clear that mother felt that the treatment should be for the child, "I'don't feel ashamed; I want something done for her." "She needs help and they are the only people." The clinic recommended treatment of the marriage problem. The mother attended the clinic twice and did not attend again.

X. This was a ten year old boy. He had a neurotic diagnosis. Mother scored 0 on the Goldberg scale. He was referred by the school doctor after the mother had asked for help as he was becoming hard to live with. While she was with the school doctor for the medical, she started to cry. "I started piping my eyes. I was disgusted with myself. I can't stand not being able to get on with him. My mother's my best friend. I want the same relationship with him as with my mother."

Mother described him as being lethargic and fearful but "like Jekyll and Hyde really; he's not lethargic outside the house." She said that he sat on the couch and did nothing, or went up to his bedroom where she could not see him.

Mother said that she had been concerned for years, ever since he stopped talking to her about school. He would soon be going to a boys' school, and she did not want to risk his being miserable all his life, "When he goes to a boys' school, they don't like pretty little boys whom the teachers like. He's good at maths, but that's all. It happens to click - nothing to be proud of." Mother had been down to the school but, "No joy!" All I get told is that he's a nice little boy. I know that. I know that he is good looking. I wish he was not. It would make him practice survival." Mother felt that his behaviour was making her aggressive towards him. He was affecting her. She was "up and down now." She was "trying to give up because I'm beginning to feel ill myself." She described herself and her son as being "different as chalk and cheese." She was "willing to accept that it is me - he cannot cope with my personality."

The clinic felt that the family were involved in a power struggle. Family therapy was suggested. At the time of the follow-up sixteen sessions had taken place. The notes did not state any improvement in the situation.

APPENDIX 4

TOPIC AREAS FOR THE INTERVIEW

The child's behaviour

About each item to which a positive response on the Rutter Questionnaire is given ask:-

When does it happen?

Where does it happen?

What exactly occurs?

How often does it occur?

Who does it affect?

How does it affect them?

In what ways does it affect them?

How do they feel about it?

How do the parents feel about it?

When did it start?

When did the parents start getting worried?

What have they tried to do about it?

Are they worried - what worries them?

What about the future?

The parents' perspective

Have the parents any idea about the cause of the behaviour?

Do they agree?

Do they think there is something wrong with the child or do they feel the child is reacting to the environment?

Do they feel the child is "getting" at them?

Does the mother feel she has more difficulty in carrying out her other tasks now?

Has the child's behaviour affected their marriage?

How do they get on together?

Has this changed recently?

Do they go out much together?

Could things be much better?

The child in relation to his friends and school

Has the child any friends?

What are they like?

In what way is the child different from his friends and siblings?

How is the child doing at school?

Has the mother been to the school?

What are the teachers like?

What is the headteacher like?

Does the school know about the problem?

What have the school done or said about it?

Do the parents agree with the school?

The process of referral

Who initiated the referral?

Who actually made the referral?

On what grounds was it made?

Were the parents consulted about the referral?

Did they expect it?

Did they think it necessary?

Did they agree to it being made?

How do they feel about it?

Have they any anxieties?

The Clinic

Do they know how a child guidance clinic works?

Has anyone told them anything?

Have they ever tried to find out?

If so, what and how?

Do they expect the clinic to succeed?

In what ways do they expect the child to change if the clinic is successful?

How will this alter other people's lives - whose?

How do they think the clinic will do this?

Is there any form of treatment the clinic will not accept?

Does the mother expect to be involved?

How does the father feel?

Will he attend the clinic?

How often do they expect to go?

How often do they expect the child to go?

General

What is the husband's occupation?

What was (is) the mother's?

What is the birth order in the family?

What do they think about where they are living?

A P P E N D I X 5

STATISTICAL TECHNIQUES USED

When the data described in this thesis was first gathered a number of different statistical techniques were considered for the analysis. In particular Goodman-Kruskal's[38] statistic gamma was considered in some detail. However, gamma is unstable with small cell frequencies and was eventually abandoned because of this. Eventually the statistic r (phi) was utilised. This statistic is most useful in a fourfold table as its formula is identical to that of the product moment correlation, hence it can be interpreted in exactly the same way as one would interpret a normal product moment correlation.

The formula for r (phi) is:-

$$r\ (phi) = \frac{bc - ad}{\sqrt{(a+b)\ (c+d)\ (b+d)}}$$

A further advantage of this statistic is that it has a significance test which can be referred to the t-Distribution. The formula for the significance test is:-

$$t = r \sqrt{\frac{n - 2}{1 - r^2}}$$

As will be noted in the thesis in the chapters on the provision and use of services, where population data is being utilised, the significance tests are inappropriate. In the

chapters on the factors influencing the parents' tendency to co-operate with the child guidance clinic, these tests have been used(38).

APPENDIX 6

FACTORS RELATING TO THE OUTCOME OF THE FAMILY'S CONTACT WITH THE CLINIC IF THE FAMILY CO-OPERATES

This part of the analysis is concerned with the child's improvement. Fourteen cases agreed to co-operate with the clinic. In six of these cases it was noted in the case histories that the child or the situation had improved between nine months and one year later. In two of these cases there was considered to be marked improvement, and in the remaining four cases there was some improvement.

One case out of the fourteen co-operating families was not considered by the clinic to warrant any further treatment (E). It was felt that this child required help from the education authorities and that the clinic did not have the role to play at that point in time.

The variable that relates most strongly to improvement is the sex of the child. Seventy percent of the girls whose families co-operated showed some improvement between nine months and one year later. This compares with 17% of the boys.

The second factor that is of importance is the diagnostic category. It is usually assumed that the more neurotic children are more amenable to psychotherapy than anti-social children.

TABLE 1

IMPROVEMENT - DIAGNOSIS

		DIAGNOSIS	
		Anti-Social	Neurotic
IMPROVEMENT	Yes	3	3
	No	5	2

We find some support for this contention here. Our confidence is further strengthened if we examine the two cases in the neurotic category that do not show any improvement (M and S). These two cases are the only two families who are still actively in therapy with either the clinics. In one of them the family has left the area (M) and was known to be in contact with the clinic in their new area. In the other case, the family is still in active family therapy.

It seems quite possible then that some improvement may well either have taken place in these families or can be expected in the future.

Sex and diagnosis are related variables; consequently, it would appear prudent to examine the relationship of sex to improvement holding the diagnosis constant.

TABLE 2

IMPROVEMENT - SEX : DIAGNOSIS

		DIAGNOSIS			
		Anti-Social		Neurotic	
		Male	Female	Male	Female
IMPROVEMENT	Yes	1	2	0	3
	No	3	2	2	0

In the anti-social category there appears to be little difference in improvement rates for the two sexes. In the neurotic group the girls showed considerably greater improvement than the boys. However, we should keep in mind at this point that the two boys who are rated as showing no improvement are the two cases who are still in therapy.

It is possible then that any differences between the sexes in tendency to improve in treatment may be the result of the fact that neurotic children tend to improve more than anti-social children, and girls tend to have a neurotic diagnosis in far greater proportion than boys when they are referred to the clinic.

We would expect the maternal stress indicators to affect the improvement rate. In particular, having shown that anti-social children come from bad marriage situations, much of their behaviour may be a reaction to this situation. It is unlikely that these children will improve unless there is evidence that the marriage situation itself improves. The clinic files did not note in any

of the cases in this sample that the marriage situation had in fact improved.

TABLE 3

IMPROVEMENT? - MARITAL SITUATION

		MARITAL DIFFICULTIES	
		Yes	No
IMPROVEMENT	Yes	2	4
	No	4	3

If we examine Table 3 we see a tendency for higher rates of improvement to occur within those families with the better marriages.

Anti-social children tend to come from those families experiencing marital difficulties. If we examine the relationship between improvement and the marital difficulties in each diagnostic category we see a factor that may well explain a large proportion of the differences in improvement between children from the two diagnostic categories. Where there are no marital difficulties, two out of three anti-social children improve. Where there are marital difficulties, one out of five anti-social children improve.

In the neurotic children there is no distinct trend. The one child from the family experiencing marital difficulties does, improve. There are two children who do not improve, who come from families who are not experiencing marital difficulties. These two children are the children who are still in treatment.

TABLE 4

IMPROVEMENT? - MARITAL DIFFICULTIES : DIAGNOSIS

		DIAGNOSIS			
		Anti-Social		Neurotic	
		MARITAL DIFFICULTIES		MARITAL DIFFICULTIES	
		Yes	No	Yes	No
	Yes	1	2	1	2
	No	4	1	0	2

Those children who improve also tend to come from families who are experiencing the least difficulty in coping with them.

TABLE 5

IMPROVEMENT - COPING DIFFICULTIES

		COPING DIFFICULTIES	
		Yes	No
IMPROVEMENT	Yes	2	4
	No	7	0

Whereas all four of the children who improved from families who were not experiencing coping difficulties, only 22% of those children from families who were experiencing coping difficulties also improved.

We can conclude this brief analysis by saying that roughly half the children who actually co-operated with the clinic tended to show some improvement nine months to one year later. These children tended to come from families where there were no marital difficulties; their parents were also having less difficulty in coping with them.

There was a strong tendency for girls to show a higher rate of improvement than boys, though much of this may have been explained as being due to the fact that girls tend to have a neurotic diagnosis and neurotic children tend to be much more likely to improve than anti-social children. It was suggested that one of the reasons why anti-social children do not improve is that their behaviour is a reaction against the bad marriage situation. Where anti-social children tend to come from good marriage situations, it is possible that their rate of improvement may well be the same as that of neurotic children.

Of the seven cases that co-operated with the clinic and had not shown any improvement between nine months and one year later, only two were no longer involved in any form of treatment programme. One of these (S) ceased attending the clinic after three visits. The whereabouts of the other of these cases (K) was not known at the time of follow-up. It was thought, however, that she might be in care. Two more of these cases (O and J) have been recommended for placement in schools for the maladjusted. In one case (V) the family were still in contact with the clinic and working through a poor situation: the child was not in treatment. Of the remaining cases, one (X) was still in treatment with the clinic; the other (M) had left the area but was known to be in treatment.

Six cases were rated as having improved, and in only two of these (H and I) is the evidence clear cut and uncontroversial. In two others (P and N) the reports show that some improvement has taken place. In case R the family claimed that the child had improved dramatically after two visits. The psychiatrist felt that if this was the case, it was going to be short-lived. In the final case (U) improvement can only be judged from the fact that the child left the situation which had been causing other people anxiety, and returned to her own mother.

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