A SURVEY OF A TOTAL POPULATION OF CHILDREN OF SPECIFIED AGE IN A SPECIFIED GEOGRAPHICAL AREA OF THE PROVINCE OF NEWFOUNDLAND AND LABRADOR, TO DETERMINE PREVALENCE RATES OF CHILD PSYCHIATRIC DISORDERS

CENTRE FOR NEWFOUNDLAND STUDIES

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ABSTRACT

A total population of children of specified age in a designated geographical area in the Province of Newfoundland and Labrador were surveyed to determine prevalence rates of child psychiatric disorders. The study population consisted of all children age nine or ten years who were in attendance at any of six schools in the Goulds-Kilbride, Petty Harbour areas (416).

The following methods were used:

1) Parents were approached by mail for permission to screen the specified children for the presence of disorder. Positive response was obtained from the parents of 277 (66.58%).

2) The 277 children were then screened as follows:

   a) Questionnaire completed by Parents

   b) Questionnaire completed by Teachers

   c) Records search of relevant agencies to determine previous contacts

These steps identified 53 (19.1%) of the 277 children to be "at risk" of having a psychiatric disorder.

3) A random sample of the 'at risk' group together with an equal number of normal children, randomly selected and matched for sex and denomination of school attended, were then subjected to more extensive study as follows:

   a) Interview with Parents

   b) Interview with Child

   c) Psychological Testing

From the accumulated information on the individually assessed group, final global psychiatric diagnoses were established. From these results prevalence rates of psychiatric disorder were calculated for the positive response population. A corrected prevalence rate of 21.12% was obtained for definite psychiatric disorder of any degree. Emotional disorders were prevalent at a rate of 11.9% and mixed, conduct-emotional disorders were prevalent at a rate of 7.09%, contrary to expectation pure conduct disorder was absent in the current study. Emotional disorder was found to be more prevalent among children of mothers with certain neurotic symptoms, while mixed disorder was more common among children of fathers with neurotic symptoms.

A generally high frequency of individual items of deviant behavior was noted. Neurotic items of behavior were very common particularly among the children of large families. Boys were observed to show more conduct problems and girls more emotional problems. A tendancy was noted for children from lower classes to have lower tested I.Q. scores and for children of higher social classes to have higher tested I.Q. scores.

The method used in the current study was found to be applicable to local conditions and with further testing might well be a productive method for use in a provincial total population survey of the prevalence of child psychiatric disorder.

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St. Augustine's Elementary School, Kilbride

St. Kevin's Elementary School, Goulds

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St. Georges Elementary School, Petty Harbour } Amalgamated into Goulds Elementary, Goulds.

St. Edward's Elementary School, Petty Harbour } Amalgamated into Goulds Elementary, Goulds.

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CHAPTER ONE

INTRODUCTION

Definition of the Problem

This study aims:

(1) to determine the prevalence of child psychiatric disorder in a total population of children in a defined area in Newfoundland.

(2) To demonstrate that epidemiological methods of investigating child psychiatric disorder are both possible and productive in the Province of Newfoundland and Labrador, where they have not previously been used.

(3) To show how the results obtained provide a rational basis for the planning and development of new services for children.

The known facts prior to the present study may be stated briefly:

(1) The total population of children under fourteen years of age in this province was 194,585. (Census Canada, 1971)[1]

(2) Until the present study no attempt has been made to determine the prevalence rate of child psychiatric disorder in this population. Studies in other areas have produced prevalence rates ranging from 2% (Blacker, 1946) to 16% (Miller, 1971).

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[1]Census Canada Tract Bulletin Catalogue 95-731 (CT-1B) July, 1974. Authority of the Ministry of Industry Trade and Commerce, Statistics Canada Reproduction.

(3) Using these figures we can calculate that between 3,891 and 31,133 children in this province have a child psychiatric disorder.

(4) Up to the time of the study only one in-patient service exists in the province to meet the needs of these children. That single service has an in-patient capacity of thirteen children. In 1973 that service assessed 369 children and provided in-patient treatment for 73 cases.[2]

(5) It is therefore clear that we need more services; but, how much more? It is argued that such services should be rationally planned and for this it is essential to know the nature and extent of the problem. These questions could only be answered by a major epidemiological study of the children of the province. It was decided to carry out the present study in order to determine if such a major study is feasible in this province and by taking as representative a sample as possible to show on a small scale the benefits which might be obtained from the full scale investigation.

The Aim of the Study

The specific aim of the current study was to compute prevalence rates of child psychiatric disorder in the total population of nine and ten year old children who attend the six schools in the area, Goulds-Kilbride and Petty Harbour.

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[2]C. A. Janeway Child Health Centre. Annual Report, 1973.

The Methods Used in the Study

The steps used to arrive at these prevalence rates were as follows:

(1) Questionnaires completed by parents

(2) Questionnaires completed by teachers

(3) Records search of existing agencies to determine previous contact

The above procedures identified a group of children "at risk" of having a psychiatric disorder. A randomly selected sample of "at risk" children together with an equal number of randomly selected normal children were assessed more extensively as follows:

Individual assessment:

(1) Interview with the Child

(2) Interview with the Parent

(3) Psychological Testing

The individual assessments were carried out blindly.

From the results prevalence rates of child psychiatric disorder in the study population were completed.

Cross analyses of the accumulated data provided information concerning the etiology of disorder in the study population.

The Population Under Study

The area in which this study was conducted is Goulds-Kilbride, Petty Harbour. These communities are adjacent rural communities within twelve miles of St. John's, the provincial capital.

This particular area was chosen for the following reasons:

1) The area could be defined geographically in relation to the Enumeration Area boundaries of Census Canada, 1971; Enumeration Areas, 101-108

2) The six schools within the area service the children of the specified communities.

3) The communities chosen represent a cross section of life styles. Petty Harbour is a typical out-port fishing village. Goulds is primarily a family farming area. Kilbride, formerly populated by prosperous extensive farmers and professionals has, within the life of the study, seen a population boom due to housing development.

The representativeness of the schools in the area was supported to some extent by the experience of the School Medical Officer.[3]

[3]Personal Communication, C. Neville-Smith, Director of School Medical Service, September 1972.

CHAPTER TWO

THE DEMOGRAPHIC FEATURES AND SERVICES FOR CHILDREN IN GOULDS - KILBRIDE AND PETTY HARBOUR

Demographic Features

Population Characteristics

The geographic area from which the population was drawn was composed of three adjacent communities Goulds, Kilbride and Petty Harbour. Historic and geographic features ensure the independent identities of the three communities. Recent large scale land development for housing in Kilbride has served to accentuate these distinctions.

Kilbride, formerly populated by prosperous landowner farmers and professionals, has within the life of the study experienced rapid population growth due to suburban land development. Goulds, traditionally a family farming area has remained a farming area due to zoning regulations.

Unfortunately, Census Canada 1971, does not distinguish between Goulds and Kilbride as both were unincorporated at the time the Census was taken.

The Goulds Town Charter was granted in July, 1971. Kilbride is governed locally by the Provincial Department of Rural Affairs.

The community of Petty Harbour has been incorporated since 1969. The traditional mainstay of the community has remained the inshore fishery. The number of family fishing crews has diminished. However, fish processing remains a primary source of employment.

Census Canada 1971, provides a total population figure of 5,635, Goulds-Kilbride, 4,661 and Petty Harbour 940.[1,2]

The age distribution of this study population is presented in Table 1, which shows the influence of urbanization upon the demography of Goulds-Kilbride.

The age peak of Goulds-Kilbride comes at 5-9 years, 15.96% as compared to the Petty Harbour peak at 15-19 years of 12.76%. This is a feature which one would expect from the predominance of young families which occupy the new suburban developments.

Further support to this trend is found in the number of middle aged and elderly people to be found in these communities. 22.88% of the population of Petty Harbour are 45 years or older. In Goulds-Kilbride 18.83% of the population are 45 years or over. The difference of 4.05% is widened to 5.01% when those 55 years and above are considered.

Employment Characteristics

Census Canada 1971 lists the total labour force in the study area as 1,753, Goulds-Kilbride 1,455 and Petty Harbour 280.[3]

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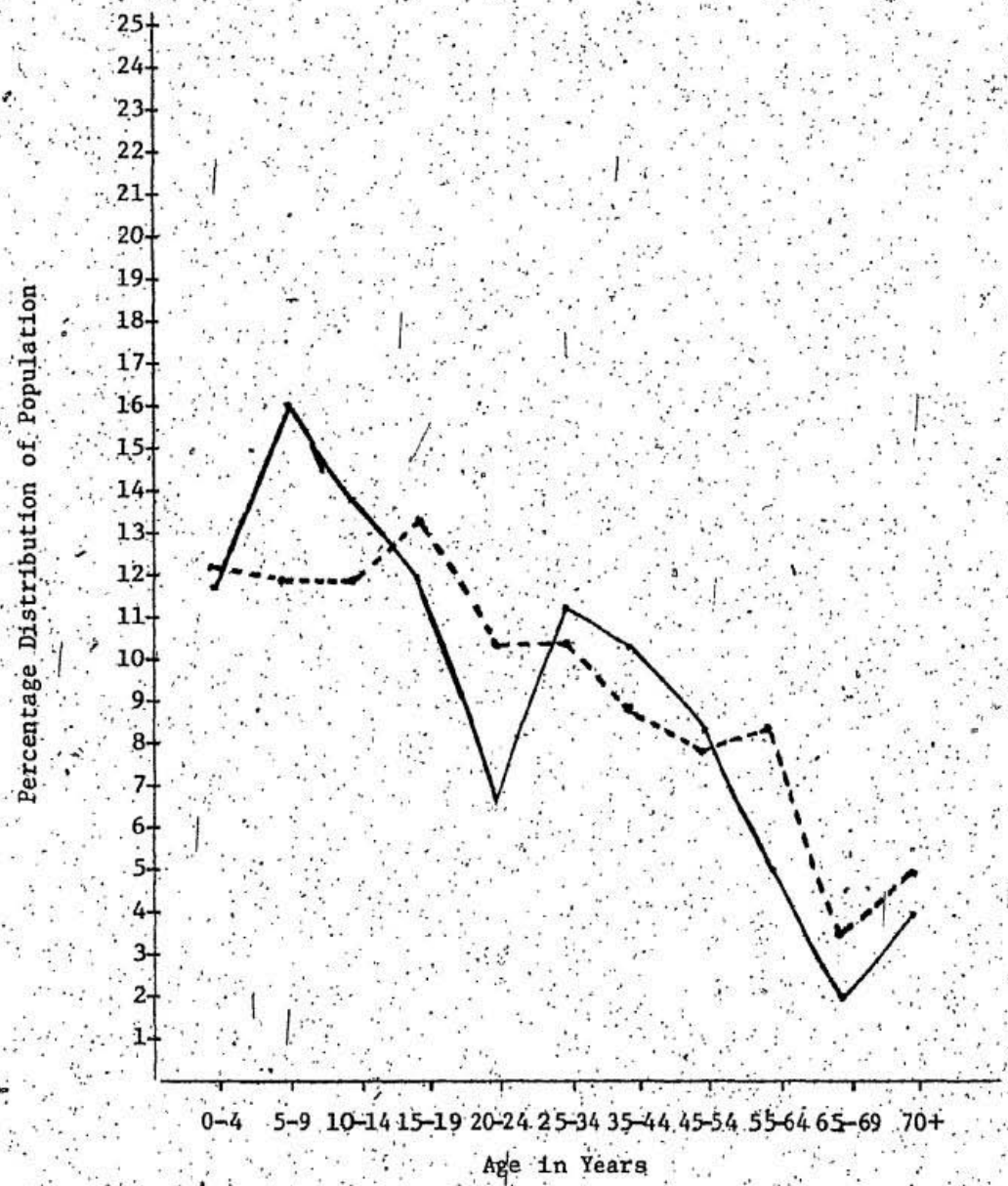
[1]Census Tract Bulletin. Catalogue 95-731 (CT-1B).

[2]Discrepancies in totals are due to the random rounding procedures employed in the generation of Census Canada population figures. Personal communication Mr. G. Courage, September, 1974.

[3]Statistics for labour force and occupation distributions are based upon randomly rounded totals of 5,615; Goulds-Kilbride 4,625 and Petty Harbour 990. Personal communication. Mr. G. Courage, Office of the Executive Council, Government of Newfoundland and Labrador, September, 1974.

TABLE 1

POPULATION BY AGE GROUPS, GOULDS-KILBRIDE, PETTY HARBOUR



Examination of Table 2 and Table 3 illustrates earlier comments concerning the retention of traditional patterns of life in Petty Harbour as compared with the more urban Goulds-Kilbride.

Both Goulds-Kilbride and Petty Harbour employ a high proportion of the population in farming, fishing and related processing occupations. For Petty Harbour the stated proportion, Groups (71, 73, 75, 77, 81, 82) together with 21.05% of its work force employed in Transport Equipment, Group 91, elevates the figure to 44.74%. This combination appears valid in view of the need to transport the inshore fishery catch to the processing unit in St. John's. This transport is provided by local drivers and equipment.

Services for Children

Educational Services

The educational system in the Province of Newfoundland and Labrador is administered by Religious Denominational groups.

The Avalon Consolidated School Board (Protestant) and the Roman Catholic School Board are the governing bodies responsible for education in the Goulds-Kilbride and Petty Harbour areas.

Facilities for primary, grades kindergarden - 2; elementary, grades 3-6; and junior high school, grades 7-8, are available in the local areas. High school students travel by bus to regional centers.

During the academic year (1972-73) in which this study began there were six schools operating in the area; two under the jurisdiction of the Avalon Consolidated School Board and four under the Roman Catholic School Board.

TABLE 2

OCCUPATION DISTRIBUTION FOR MALES
IN THE LABOUR FORCE

Number	Occupation Group	Goulds-Kilbride N = 990	Petty Harbour N = 190
11	Managerial, Administrative and Related Occupations	3.54	0.00
27	Teaching, Related Occupations	1.01	0.00
31	Occupations in Medicine and Health	2.53	2.63
21,23,25,33	Social Sciences and Related Fields, Religions, Natural Sciences, Engineering, Mathematics, Artistic, Literary, Recreation and Related Occupations	1.52	0.00
41	Clerical and Related Occupations	10.61	2.63
51	Sales Occupations	10.61	5.26
61	Service Occupations	5.56	13.16
71,73,75,77	Farming, Horticultural, Animal Husbandry, Fishing, Hunting, Trapping, Forest, Logging, Mining, Quarrying Gas and Oil Field and Related Occupations	8.59	10.52
81,82	Processing Occupations	4.56	13.16
83,85	Machining, Product Fabricating, Assembling, Repairing and Related Occupations	10.61	0.00
87	Construction Trades	13.63	7.89
91	Transport Equipment	10.10	21.05
	Other	10.10	13.16
	Unemployed	7.07	10.54

TABLE 3

GROUPED OCCUPATION DISTRIBUTION FOR MALES IN THE LABOUR FORCE

	Goulds -Kilbride	Petty Harbour
White Collar Occupations (Group Numbers 11,27,31,21,23,25,33,41,51)	29.82	10.52
Blue Collar Workers (Group Numbers 61,81,82,83,85,87,91)	44.46	55.26
Farming, Fishing and Related Occupations (Group Numbers 71,73,75,77)	8.59	10.52
Others and Unemployed	17.17	23.70

Table 4 will present the location, enrollment, staffing, pupil/teacher ratio, special education facilities and consultative services for each of the study group schools for the academic year 1972-73 and 1973-74.[4,5]

As Table 4 indicates schools B and D were integrated under the Avalon Consolidated School Board into a single new school in 1973-74. This represents a major improvement in conditions as the two former schools consisted of multi-grade classrooms. It also meant, however, that the children in Petty Harbour had now to travel by bus to school

[4]Statistics for Table 4 were obtained from the following sources: Personal communication, K. Veitch, Administrator, Roman Catholic School Board for St. John's. October, 1974.

[5]Avalon Consolidated School Board for St. John's, Newfoundland. Annual Report - 1972-73, 1973-74.

TABLE 4

THE DEMOGRAPHY OF EDUCATIONAL SERVICES IN GOULDS-KILBRIDE, AND PETTY HARBOUR

Location	School Letter	Avalon Consolidated						Roman Catholic					
		1972-1973			1973-1974			1972-1973			1973-1974		
		Pupils	Staff	Ratio	Pupils	Staff	Ratio	Pupils	Staff	Ratio	Pupils	Staff	Ratio
Kilbride	A							696	19	36.6/1	607	19	32/1
Goulds	B	141	4	35/1									
Petty Harbour	C							157	4	39.2/1	149	4	37.2/1
Petty Harbour	D	55	3	18.3/1									
Kilbride	E							631	21	30/1	436	14	31/1
Goulds	F							602	19	31.6/1	625	19	32.8/1
Goulds	B + D				255	9	29.3/1						
	Totals	196	7	28/1	255	9	29.3/1	2086	63	33/1	1817	56	32.4/1
	Special Education Teachers	0			1			4			4		
	Consultant Services	Nil in primary and elementary schools			Nil in primary and elementary schools			1 - Guidance 1 - Reading 1 - Math 1 - Music 1 - Religious Education 1 - Special Education			1 - Guidance 2 - Reading 1 - Math 1 - Music 1 - Religious Education 1 - Special Education		

in Goulds.

During the same academic year, 1973-74 the previously co-educational school E, under the Roman Catholic School Board transferred its entire female enrollment to the all girl school A.

These schools represent the only specifically designed service for children in Goulds-Kilbride and Petty Harbour.

Additional educational services for children with special requirements are provided by the Division of Special Services, Department of Education under Provincial Government jurisdiction.

These services include:

(1) School for the Deaf

(2) School for the Blind in Halifax, Nova Scotia.

(3) School for the Mentally Retarded

(4) Financial assistance to the privately run School for Autistic Children and Virginia Waters School of Physically Handicapped Children.

(5) Teachers are also provided for the tutoring of hospitalized children.[6]

Medical Services

One General Practitioner and two Public Health School nurses serve the medical needs of the Goulds-Kilbride and Petty Harbour area.

Consequently the local residents make use of the services for children which are available in St. John's.

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[6]Personal communication, C. K. Andrews, Director of the Division of Special Services, Department of Education, Government of Newfoundland and Labrador, September, 1974.

The services which are available for use are:

1) The C. A. Janeway Child Health Center. This is an acute care multi-service pediatric hospital of 248 bed capacity. It is intended to serve the entire child population of the Province of Newfoundland and Labrador.[7] The only Psychiatric service for children in the province operates as a department of this hospital.

2) Childrens Rehabilitation Center is an inpatient facility for the management of children with severe physical handicaps. In 1971 the bed capacity of this service numbered 42.[8]

3) School Medical Services. This service was designed to ensure that high standards of physical well-being are maintained among school children. The aim of the School Medical Officer, to provide consultative and preventive service, is hampered by high demand and limited staffing.[9]

4) Speech Therapists are also available in St. John's on a referral basis only. In 1971 two full-time Staff were assigned to duties attached to the School Medical Service.[10]

The medical services for children, as listed above, are augmented by the 17 pediatricians[11] and 94 General Practitioners[12] in the Metropolitan St. John's area.

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[7]Department of Health, Government of Newfoundland and Labrador. Annual Report, 1971: 82.

[8]Ibid.

[9]Ibid., pp. 31-32

[10]Ibid., pp. 35-38.

[11]Newfoundland Medical Association Specialist List, 1973 (unpublished).

[12]Personal Communication. K. Dormody, Supervisor of Public Services and Audit, Newfoundland Medicare Plan. September, 1974.

Child Welfare Services

The Provincial Government assumes the responsibility for providing the following services for the welfare of children:

1) Child Protection
2) Foster Home Care
3) Adoption Services
4) Child Welfare Allowances
5) Unmarried Mothers
6) Casework, Counselling Services, Care and Treatment for Delinquent Children.[13]

As of March 31, 1973 1,735 children were wards of the Director of Child Welfare. Of these, 316 were institutionalized and 1419 were fostered.

On the same date 428 of the 637 licensed foster homes were in use.

Tables 5 and 6 present the active caseload in Child Welfare and Corrections in the St. John's Region for a single month, March, 1973. This office services 27 communities and a catch population of 134,000.

The stated caseload is carried by a total of 10 workers and 1 supervisor.[14]

The Corrections program of the Division of Child Welfare operates three correctional institutions in addition to Probation services. As of March 31, 1973, 89 children under 16 years of age were

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[13]Department of Social Services and Rehabilitation, Government of Newfoundland and Labrador, Annual Report, 1973.

[14]Ibid., pp. 144, 146, 147.

TABLE 5

ACTIVE CHILD WELFARE CASES, MARCH, 1973

Category	Number
Children in Foster Homes	197
Children in Receiving Homes	88
Children in Other Placements	5
Unmarried Parents	21
Alleged Neglect	50
Adoptions pending	86
Adoptions finalized	100
Number of Foster Homes	97
Number of Receiving Homes	16
Child Welfare Allowances	43

TABLE 6

CORRECTION CASE LOAD MARCH, 1973

Category	Number
Number Juveniles on Probation	59
Number Juveniles in Group Foster Homes	21
Adults on Probation	4

resident in three institutions, 17 girls, 72 boys.

Two bachelorate level social workers comprise the total professional staff employed to service the children in these institutions.[15]

Institutional care is available for children who are severely handicapped, either physically or mentally. The total bed capacity of these institutions is 214.[16]

As is the case with the special education and medical facilities, the institutional programs offered by the Division of Child Welfare are intended to offer a province wide service.

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[15]Ibid., p. 125.

[16]Ibid., pp. 33-35.

CHAPTER THREE

A REVIEW OF PREVIOUS TOTAL POPULATION STUDIES OF THE PREVALENCE OF PSYCHIATRIC DISORDER IN CHILDREN

Early papers on the epidemiology of child psychiatric disorder grew out of the work of educators and other professionals who were interested in the health and development of children.

The pioneer investigation of Sir Cyril Burt in 1925 grew from a concern over the influence of World War I upon the health of English school children.[1] He used a case study method to investigate 391 children between the ages of 7 and 13 years. He found a total of 35.4% of the children examined to have some degree of emotional disturbance, 31.4% showed some symptoms of maladjustment while 4.0% were felt to be seriously maladjusted.

Haggerty (1952)[2] reports a study carried out by educators in 1923-24 in a Minneapolis school district. This early investigation was designed to obtain the incidence of undesirable behavior symptoms in a total population of elementary school children. The behavior of eight hundred children was assessed by their teachers. The teachers reported the frequency with which specific undesirable behaviors occurred in each child. Teachers also rated the child on a five point

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[1] C. Burt "The Backward Child." cited in Education and Mental Health by D. Wall (Holland, UNESCO, 1955) pp. 239-241.

[2] M. E. Haggerty "Incidence of Undesirable Behavior in Public School Children." Journal of Educational Research 12 (1952): 101-122.

scale for 37 items of behavior. Undesirable behavior was reported in 51% of the total group. The researchers devised a behavior score by the use of a weighting technique. The results of analyses based upon individual scores indicate that although no grade is free of behavior problems, neither does any particular stage of development exhibit a preponderance of behavior problems. More boys than girls were found to exhibit behavior problems. The frequency of the behavior problems was also found to relate to intelligence. At I.Q. 100 the number of problems are at their lowest. The frequency increases with deviation from the normal but more rapidly towards the lower end of the continium.

Wickman (1924-26)[3] studied the incidence of behavior problems in schools. The teachers were asked to compile lists of problem behaviors encountered in the classroom. The teachers rated the frequency with which the listed behavior occurred in their pupils. The teacher then assigned a global rating of adjustment to each child. The results indicated that up to 53% of pupils exhibited behaviors considered as serious by teachers. Despite this high frequency of individual items of deviant behavior only 7% were rated as seriously maladjusted.

Olsen (1930)[4] studied 1,537 first grade public school children in Minneapolis. Olsen's method employed experienced raters to assess the children on the Haggerty, Wickman et al. Behavior Rating Scales.

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[3]E. K. Wickman (1924-26) quoted in Teachers and Behavior Problems (New York, The Commonwealth Fund, 1938) pp. 1-40.

[4]Olsen (1930) cited in E. M. Bower Early Identification of Emotionally Handicapped Children in School (Illinois, Charles C. Thomas, 1960).

His results showed negative relationships between high average ability and problem tendency scores and achievement and problem tendency scores. Significant differences were found in the number of problem children found at the various schools. Within schools the over-age pupils showed the highest number of problems.

Rogers (1942)[5] studied 2,000 children in three Ohio schools to determine the proportion of children showing poor mental health. He utilized nine indices. A child was considered a "misfit" if his score on a particular index differed significantly from his classroom group. The indices used were: mental age, reading ability, school failure, truancy, behavior rating scales, personal index and observer ratings. Rogers methodology identified 12% of the children studied to have poor mental health and 30% showed a degree of poor adjustment. His study also identified the following trends:

1) Three times more boys than girls had serious mental health problems

2) The findings showed fifth grade children as most likely to be disturbed

3) Less maladjustment was found among children from high socio-economic backgrounds

4) The children least likely to be disturbed were those who most closely resembled their group

5) There was a significant difference in the amount of disturbance detected at the various schools

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[5]C. A. Rogers "Mental Health Findings in Three Elementary Schools." Educational Research Bulletin 21 (1942): 69-79, 86.

In 1953 The Committee on Maladjusted Children, Ministry of Education, Great Britain[6] sanctioned the commencement of three pilot investigations in Somerset, Berkshire and Birmingham. The purpose of the surveys was to provide an estimate of the number of British children in need of psychiatric care. The methodology of all three surveys was essentially the same. Random samples were drawn from the total school population in the county. The teachers were asked to make a questionnaire assessment of each child in terms of his emotional adjustment. Trained investigators then interviewed the children identified by the teachers and their parents. Finally the investigator completed a second questionnaire based on the accumulated information for each child.

The proportion of children requiring psychiatric care, in the total population as based on the estimates obtained in these surveys showed considerable variation; 5.4% in Berkshire, 7.7% in Birmingham and 11.8% in Somerset.

Lapouse (1958), began a series of epidemiologic investigations. The aim of these studies was to obtain a more complete knowledge of common and uncommon childhood behaviors and to relate these to other factors, such as; sex, age, race and socio-economic status. It was hoped that the information obtained would contribute to the ease and accuracy of measurement so that, psychiatrically ill children within the community might be more readily identified. These studies have

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[6]Report of the Committee on Maladjusted Children Department of Education and Science (London, Her Majesty's Stationary Office, 1955) pp. 1-172.

produced a wealth of information concerning the prevalence of individual items of deviant behavior. (Lapouse and Monk, 1959, 1964), (Lapouse, Monk, and Street, 1964).

Lapouse (1965)[7] re-examined the data collected in the above referenced studies, for the purpose of assessing the relationship between behavioral characteristics and adjustment in general. The analyses was based on data collected as follows:

In 1955 a sample of 482 children was selected by means of a random sample technique from houses in Buffalo, New York. The positive response rate from those approached was 94%. Interviews were carried out with the mothers of the selected children covering 200 items of behavior. These items covered current behavior, adjustment, performance, relationships, health, anxiety and demographic features. The interviews were scored by a weighted points method. The accumulated points could be grouped resulting in a score for the child on any of the issues listed above.

The results indicated a definite and statistically significant relationship between behavioral deviance and disturbances in adjustment.

Gildea et al.[8] (1958) studied the effect of three approaches to preventative mental health over a three year period. Their population involved the total population of third grade children attending 15 schools

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[7]R. Lapouse "The Relationship of Behavior to Adjustment in a Representative Sample of Children." American Journal of Public Health 55 (1965): 1130-1141.

[8]M. C. L. Gildea, H. R. Domke, I. N. Mensh, A. D. Buchmueller, J. C. Glidewell and M. B. Kantor "Community Mental Health Research: Findings after Three Years." American Journal of Psychiatry 114 (1958): 970-976.

in St. Louis County, Missouri data was collected prior to, during and after the implementation of each of the three plans. Positive co-relations were found between the degree of emotional disturbance and teachers reportings, school achievement, a group I.Q. test, sociometric data and mothers reports of symptoms. Positive co-relation was also found between maternal attitude to childrens problems and social class. More referrals to mental health workers were forthcoming on children from low and high class groupings and fewer on middle class children. More boys than girls were referred, likewise there were more boys than girls in the clinically disturbed group and more girls than boys in the normal group.

Douglas and Mulligan (1961)[9] conducted a longitudinal study of children sampled from those born in one week in Great Britain in 1949. Information concerning the behavior and adjustment of these children was accumulated from the mothers, teachers, school doctors, school nurses and the children themselves. Based upon mothers reports of symptoms, this study demonstrates that children with fewer symptoms perform better on school achievement tests. They also obtained more grammar school places and are more favourably assessed by teachers and their achievement test scores improved with the passage of time. On the other hand, children with a higher number of symptoms, as reported by their mothers show a deterioration in achievement test scores

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[9]J. W. B. Douglas and D. G. Mulligan "Emotional Adjustment and Educational Achievement, The Preliminary Results of a Longitudinal Study of a National Sample of Children." Proceedings of the Royal Society of Medicine 54 (1961): 885-891.

over time. These same children are less likely to be admitted to grammar school, a finding which is unexpected based upon their achievement test scores.

Silver and Hagin (1972)[10] conducted a study of the entire first year enrollment of a Manhattan school for the academic years 1969-1970 and 1970-1971. The total number of children involved was 186. The purpose of the study was to identify children with possible emotional and cognitive disability and to provide them with preventative treatment. The children were examined individually for psychiatric, neurological, psychological and educational disabilities.

Diagnostic evaluations identified 12% of this population as suffering from a psychiatric illness, 25% were designated as psychiatrically well. The remaining 2/3 of the children exhibited mild and moderate symptoms indicating the presence of stress. Neurological examination of the children as based upon "soft signs" showed severe deviations from the normal in 7% of the children assessed.

Based upon the results given above, 56 children were selected for special tuition intervention in the school setting. When retested one year later on educational aspects these children were indistinguishable from the general population. A second retest following two years of intervention showed the functioning of subjects on the educational tests to be superior to the performance of previous second graders.

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[10] A. A. Silver and R. A. Hagin "Profile of a First Grade, A Basis for Preventive Psychiatry." Journal of the American Academy of Child Psychiatry II (1972): 644-704.

Ullman (1952)[11] studied a population of 810, 9th grade children in Prince Georges County near Washington, D.C. This number represents 97% of the enrollment in 27 classes. In addition to determining the nature and extent of child psychiatric disturbance, Ullman proposed to assess the reliability of teachers judgements as a means of identifying the disturbed child. He also compared the relationship between maladjustment as detected by teachers and the identification of maladjustment by classmates.

The method of investigation employed six indices as follows:

1) Teacher ratings of the childs adjustment level

2) Teacher ratings of the child on a forced choice test of adjustment

3) Childs self rated score on: California Test of Personality, (Self); California Test of Personality (Social): S.R.A. Youth Inventory Basic Difficulty Score

4) Classmates ratings of one another on a sociometric rank, converted to standard score

The prevalence rate of severe maladjustment found by Ullman as a result of the above investigations was 8%.

Ullman found an increased rate of maladjustment among males. He also found that teachers ratings and self descriptive data were each independently valuable tools for the detection of disorder. It appeared that, the ratings of teachers best predict maladjustment when the behaviors are observable and objective, the ratings were most reliable

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[11]C. A. Ullman, "Identification of Maladjusted School Children." United States Public Health Monograph 7 (1952): 1-41.

when teachers were confident about their responses and were not rating under conditions of stress or anxiety. Self descriptive data appeared to be the most useful indicator of maladjustment when aspects requiring subjective insight into feelings, attitudes and inner tensions were considered. Ullman concluded that the clearest and most accurate assessment of maladjustment could only be made when all of the assessment indices are employed.

Johnson and Kalvesten (1967)[12] studied a random sample of Swedish boys, age 7.5-16.5 years. The purpose of the study was to establish the nature and extent of the need for psychiatric treatment in Stockholm's child population and to gain some insight into the etiology of the disorders revealed.

The 222 male subjects were randomly selected from the Stockholm birth records. Data obtained on each child included somatic examination, psychological testing, interview with his parents, a home visit and the collection of information from the school.

The results were catagorized as follows:

symptom free	- 21%
mild symptoms	- 23%
moderate symptoms	- 31%
problem children	- 23%
institutional care	- 2%

Approximately 25% of Stockholm schoolboys were considered in need of psychiatric treatment (problem children plus institutional

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[12]G. Johnson and A. L. Kalvesten "Exerpt from 222 Stockholms Pojkar, Uppsalla, 1964." Acta Psychiatrica Scandinavica Supplementum Appendix I 195 (1967): 227-256.

cases). Only 44% of the boys studied could be designated as well adjusted. (symptom free plus mild symptoms).

Cullen and Boundry, (1966)[13] present a summary of the survey results of emotional disorder as it exists among the children of 1,000 West Australian families.

The families were sampled from four geographical locations, the total number of children concerned was 3,440.

Mothers of the study children were interviewed by two experienced and qualified interviewers. A simple questionnaire inventory was used to establish the current position of the child on 57 behavior disorders, evidence of persistence, i.e. 3 months duration was also required before the behavior was recorded. The disorders were classified into three groups Primary Behavior Disorders, Psycho-somatic Disorders, Disorders Associated with Social Standards.

In this survey, the results showed Psycho-somatic Disorders to be twice as prevalent as Primary Behavior Disorders.

In the order of diminishing prevalence the disorders rank as follows:

1) disorders of habit
2) sleep disorders
3) dysmennorhea

These three disorders made up 45% of the total. 35% of all disorders were related to:

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[13] K. J. Cullen and C. A. P. Boundry "The Prevalence of Behavior Disorders in the Children of 1,000 Western Australian Families." Medical Journal of Australia 2 (1966): 805-808.

4) fears

5) elimination disturbance

6) negativism

Infrequent occurrence of the following disorders made up the remaining 20% of the total variation.

7) withdrawn behavior

8) speech disorders

9) feeding disorders

10) showing off

11) disorders associated with social standards and masturbation

The number of children exhibiting disorder reached a peak at age 6-7 years. This remained constant until age 12 in boys and age 14 in girls at which time there was a falling off. The maximum prevalence of primary behavior disorders occurred in the 2-5 year old group. At ages 6-11 this gave way to a maximum prevalence of psychosomatic disorders. During the high school years there was an equal prevalence of both groups.

Pringle, Kellmer and Davie,(1965)[14] retraced 11,000 seven year olds who had been studied in 1958, as a part of the National Child Development Study. Information was collected on numerous aspects of the education, health, behavior and environment of these children.

Data concerning the childrens' behavior and adjustment was obtained from their teachers by use of a Bristol Social Adjustment Guide, (Stott, 1963). Teachers and parents were both asked about the

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[14]R. C. Pringle, B. N. Kellmer and R. Davie Studies in Child Development (1958, Cohort) 11,000 Seven Year Olds (London, Longmans, 1966) pp. 97-112, 153.

duration of the childrens settling down period when they first started school. Parents were also questioned about current aspects of the childrens behavior.

Mothers report an increased frequency of individual items of deviant behavior among boys.

When behavior in school was assessed, a highly significant difference between the sexes on the Bristol Social Adjustment Guides was evident. The proportion of maladjusted boys was twice that of girls and conversely, significantly more girls were stable than boys.

The overall proportion of maladjustment within this group of seven year olds is given at 13%.

It was found that the proportion of stable children decreases as does the socio-economic status of the childrens' fathers. A significant association between the age of school starting and the proportion of stable children was found to be consistent across occupational groups. Early starting children were significantly better adjusted than were late starting children.

Rutter, Tizard and Whitmore,(1970[15] carried out a large scale survey of the prevalence of psychiatric disorder in a total population of ten and eleven year old children. This was conducted as part of an enquiry into the education, health and behavior of children living on the Isle of Wight.

2,199 children, 10 and 11 years of age, were screened for disorder by the administration of parental and teacher screening

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[15]M. Rutter, J. Tizard and K. Whitmore Education Health and Behavior - Psychological and Medical Study of Childhood Development (New York, Wiley, 1970) pp. 147-267.

questionnaires and by the identification of administrative groups such as; foster children or children who had attended a psychiatric service. These screening techniques identified 286 children for further study. The individual assessment consisted of interviews with each child and his parents. These assessments were conducted by trained interviewers.

From the accumulated information on each child a diagnosis was formulated and classified in one of the following diagnostic categories; neurotic disorders, anti-social disorders, mixed anti-social neurotic disorders, developmental disorders, hyperkinetic syndrome, child psychosis and personality problems.

Of the 286 children identified by the screening 118 children were finally identified as having a psychiatric disorder. This provided a prevalence rate of 5.4%-6.8% when a correction factor was employed. Conduct disorders and mixed disorders were the most frequently diagnosed categories. Pure neurotic and anti-social disorders were diagnosed with approximately the same frequency. If the prevalence of the mixed disorders is pooled with that of the anti-social disorders a corrected prevalence figure of 4% is obtained. This pooling was felt to be legitimate in view of the numerous symptomatic features shared by these disorders. The corrected prevalence rate for neurotic disorders is 2.5%.

Raw frequencies in the remaining diagnostic categories were reported as follows:

Developmental Disorders	-8
Hyperkinetic Syndrome	-2
Child Psychosis	-2
Personality Disorder	-1

As is the case in numerous previously cited studies, psychiatric disorder was found more commonly in boys. This was particularly marked for anti-social disorders in which the proportion of boys to girls was 56:14 if pooled with the mixed group. In contrast neurotic disorders were more common among girls, however the margin was smaller, 17:26.

The most common subgroup of the neurotic disorders was the diagnosis of anxiety states. It was established in 30 cases. Of these 30, 16 were found to present with clinically significant phobias.

The pooled mixed disorders and pure conduct disorders were categorized according to place, severity, and type. The following list based on a total of 70 shows the distribution within the subcategories:

Anti-social but not Delinquent	-20
Trivial Delinquency	- 8
Delinquency confined to home	- 5
Socialized Delinquency	-20
Unsocialized Delinquency	-17

The duration of most neurotic and anti-social disorders was three years.

Rutter (1973)[16] provides the most recent input for this presentation of the literature. He applied the investigative methods designed for use in the 1970 Isle of Wight Survey to the total population of ten year olds residing in a London inner city borough, with the exception of children from immigrant families. The method differed only in that a single screening instrument was used, a revised edition

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[16]M. Rutter, "Why are London Children so Disturbed?" Proceedings of the Royal Society of Medicine 12 (1973): 1221-1225.

of the teachers questionnaire.

The prevalence of deviant behavior identified by the teachers screening was in the order of 19.1% compared with 10.6% selected by teachers forms in the Isle of Wight Survey. There were highly significant differences in the frequency with which neurotic and anti-social deviance occurred, both of which were more frequent in the London population. Rechecks were conducted and the validity of the questionnaire as a screening device for this population was confirmed.

Following the individual assessment of selected children and a random control group an 8% prevalence rate of child psychiatric disorder was confirmed. This compares with a stated rate of 4% on the Isle of Wight.

Boys were found to be disturbed at a prevalence rate of 12% and girls at a rate of 5%, both of these figures are double the findings on the Isle of Wight.

CHAPTER FOUR

THE METHOD OF THE PRESENT STUDY

The present study has employed the technique of multiple assessment of children in order to detect psychiatric disorder in childhood.

Psychiatric Disorder in Childhood as Defined in the Present Study

The definition of psychiatric disorder which is adopted in this study follows from a "clinical diagnostic" approach.[1]

"Psychiatric disorder was judged to be present when there was an abnormality of behavior, emotions, or relationships which was continuing up to the time of assessment and was sufficiently marked and sufficiently prolonged to cause handicap to the child himself and/or distress or disturbance in the family or the community."[2]

This definition is subject to qualification. It is meant to imply abnormality in the child's behavior at the time of assessment. It is not meant to imply that the child is himself abnormal.

Psychiatric disorder in childhood might be defined statistically by the symptom cluster method. (Shepherd, et al., 1966b), (Eynsenck and Rachman, 1971). This is a practical method from the conceptual, statistical and administrative points of view and has been partially employed in the current study. However, there are also significant disadvantages to symptom cluster methods. No consideration is given to the context in which the behavior occurs, nor to the extent of the

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[1]Rutter et al., Education Health and Behavior, p. 148.

[2]Ibid.

handicap imposed upon the child by his difficulties. This method does not permit the observer to view the child's problems in the context of his overall course of development.[3]

For these reasons the current study will use a method of diagnosis based upon information from both questionnaire and individual assessments.

Psychiatric Disorder in Childhood - Methods of Identification

The procedure for identification of child psychiatric disorder was carried out in two stages. Initially multiple screening techniques identified a group of children believed to be at risk of having a psychiatric disorder. The screening techniques were:

1) Questionnaire completed by the Parent
2) Questionnaire completed by the Teacher
3) Records search of existing agencies to determine previous contact

A sample of the children selected by the above procedure together with a comparative sample of unselected children were then subjected to more extensive individual examination as follows:

1) Interview with the Parent
2) Interview with the Child
3) Psychological Testing

On the basis of the accumulated information a diagnosis was established for each individually assessed child. From these results

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[3]M. Rutter "Classification and Categorization in Child Psychiatry" Journal of Child Psychology and Psychiatry 6 (1965): 149-150.

prevalence rates of child psychiatric disorder were calculated.

Screening Techniques

Multiple screening techniques were applied to a study population which numbered 416. The children in this study were nine or ten years of age as of December 31, 1972 and were in attendance at any one of six schools in the Goulds-Kilbride and Petty Harbour areas.

Parental Questionnaire

Previous research has confirmed the usefulness of a parental questionnaire as a valuable diagnostic instrument. Hafner et al. (1964), Kearsley et al. (1965), Shepherd et al. (1966), Berg et al. (1971).

The questionnaire used in the current study was designed for and employed in the 1970 Isle of Wight Survey. It has the measured potential of distinguishing the type of disorder manifested, in addition to discriminating between the disturbed and non-disturbed child.[4] The questionnaire solicits information on some 31 items concerning the child's health, education and behavior. Parents indicate frequency and/or severity of occurrence for each item by rating according to a scale which varies between '0' absent and '2' marked or severe. The configuration of scores also has the potential of differentiating the type of disorder evident.[5] (Appendix C)

The discriminative ability of this questionnaire was tested and found to be efficient. A cut off score of 13 was found to select 11.6%

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[4]Rutter et al., Education Health and Behavior pp. 155-158, 412-418.

[5]Ibid., pp. 412-418.

of a random general population sample, compared with 68.7% of consecutively referred clinic cases. During the Isle of Wight survey itself, a cut off point of 13 was found to detect 54.5% of children having a definite psychiatric diagnosis, compared with 6% of the general population.

Tests of reliability and validity were applied to this screening device.[6]

Inter-rater reliability was assessed by the comparison of independently completed parental evaluations. The product moment correlation between total scores was plus 0.64. Retest reliability within a two month period was in the order of plus 0.74.

The validity of the questionnaire diagnostic designations was confirmed by an agreement level of 80% with diagnosis made after individual assessment of a psychiatric clinic sample. Agreement between diagnostic designations by screening and individual assessments was also high, 78%.

Teachers Questionnaire

Numerous investigations have examined the usefulness of a teacher completed screening device and have found this method to be both reliable and valid. Wickman (1938); Haggerty (1952); Olsen (1930); Ullman (1952); Eisenberg et al. (1962); Mulligan et al. (1963); Mulligan (1963); Ross (1966); Stott (1963); Harth (1971). The efficiency of such a tool is increased when evaluations requested concerned specific observable behavior items, as opposed to information

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[6]Ibid., p. 413.

concerning feelings and attitudes. Reliability is also found to increase with an increase in the teacher's confidence in her ability to respond.

The teacher's scale used in this study consisted of 26 behavioral items 22 of which were identical to those on the parental questionnaire. The format of the questionnaire and weighted scoring technique was similar to that described for the parental questionnaire.[7] (Appendix D)

A cut-off score of 9 was found to be an efficient discriminator on the teacher's scale. At this level 80% of boys and 60% of girls from clinic samples were selected compared with 11% and 3% respectively from a randomly chosen sample of the general population.

The teacher's questionnaire was subjected to tests of reliability and validity.[8] Inter-rater reliability and test re-test reliability scores were plus 0.72 and plus 0.89 respectively.

For two clinic samples, a good agreement was found between teacher scale diagnostic designations and diagnosis based upon individual assessment. The level of agreement was 80% for neurotic children and 90% for anti-social children.

Response Rate to Screening

The Isle of Wight Survey obtained completed questionnaires from 99.8% of the study children. The initial response rate was 71.6%, completed questionnaires were obtained from 86.5% of the parents when

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[7]M. Rutter "A Childrens Behavior Questionnaire for Completion by Teachers, Preliminary Findings." Journal of Child Psychology and Psychiatry 8 (1967): 1-11.

[8]Ibid.

the non-responders were sent one mail out reminder.[9]

The spontaneous response rate in the current study, one month after initial contact with the parents was 24.5% (102). This was because a different method of approach to the parents had been employed. The Isle of Wight study used the children to take the questionnaires from school and give them to their parents and bring them back to their teacher the following morning. This was based upon much previous study, notably by Shepherd et al. (1971)[10] which had indicated this as the most efficient technique. Simply mailing the questionnaires to the parents had been found to result in a low response rate. The Human Experimentation Committee, Faculty of Medicine, Memorial University of Newfoundland directed that a mail out approach was to be used in this study. Following the low response rate to the mailed contact, telephone contact for the purpose of further explanation was made to the parents of 249 children. Personal visits were also made to the homes of 149 children. The visited group consisted of non-responders who had been positive in their reception of a telephone explanation but had been persistent in their apathy with regard to returning the forms, or non-responders who did not have a telephone.

As a result of these efforts, which were extremely time consuming, the final proportion of completed questionnaires was raised to 66.58% (277).

Table 7 illustrates the breakdown of the remaining non-respondent

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[9]Rutter et al. Education Health and Behavior p. 152.

[10]M. Shepherd, B. Oppenheim and S. Mitchell Childhood Behavior and Mental Health (New York, Grune and Stratton Inc., 1971) pp. 28-29.

population.

TABLE 7

NON-RESPONDERS

	Number	Percentage
I - Accepted telephone explanation, non-committed response	29	7.0%
II - Not contacted by telephone and/or visit	33	7.9%
III - Definite negatives	67	16.1%
IV - Positive attitude non-responders i.e. leaving province	10	2.4%
Total	139	33.4%

Teachers screening questionnaires were completed on all of the positive responders. These 277 children were also subjected to other screening procedures.

Records Search of Existing Agencies

Several administrative groups of children considered to be at risk of psychiatric disorder were identified:

1) 8 children with a record of attendance at a psychiatric service

2) 4 children with a record of having been in foster home care

3) children with a record of appearance before a juvenile court judge. This administrative group proved to be inapplicable in the local situation.

As a result of the screening procedures listed above 53, (19.13%) of the children screened were identified as "at risk" of having a psychiatric disorder. That is, they met any one of the following criteria:

1) Scored at or above the cut-off score of 13 on the parental screening questionnaire

2) Scored at or above the cut-off score of 9 on the teachers screening questionnaire

3) Identified on administrative grounds as a result of the records search of existing agencies.

Of these "at risk" children, a random sample (N = 30) was chosen for more intensive examination.

A comparison group, matched for sex and denomination of school was randomly chosen from the remaining positive responders.

The above samples were assessed blindly by use of standardized interviews, conducted separately with parents and children.

As was the case with the screening instruments, both the parental and the childs interviews were designed for use in the 1970 Isle of Wight Survey. Both have been modified slightly to meet local requirements. (Appendices E and F)

Parental Interview

The parental interview has an open ended semi-structured format. Initially it obtains demographic information about the child and his family. Spontaneous comment is encouraged from the parent on topics related to the education, health and behavior of the child. Information is requested in order to establish the childs status on a number of psychiatric symptoms. The interview also examines the child's personal

developmental history, the medical history and mental state of both parents, the emotional climate of the home and the educational background of family members.

Tests of the schedule from which the current interview was derived have been conducted by Graham and Rutter (1968).[11] Inter-rater reliability scores for 36 interviews was found to be high +0.81. It was found that raters agreed well on definite normality or definite abnormality, 60% and 78% respectively. However agreement was low at 22% for slight or trivial degrees of disorder.

Test re-test reliability with parents as informants and independent raters provided similarly high inter-rater co-relations for definite presence or absence of disorder, 78% and 55% respectively and the same low agreement level of 22% for trivial or slight disorder.

The current research also included a reliability test. The results represent independent assessments made by the researcher and a similarly qualified rater. Ratings were made on a sample of cases consecutively referred to a child psychiatric clinic. Each rater conducted 50% of the interviews and observed the remaining proportion. Inter-rater scores were found to agree as follows:

1) 89.8% agreement on individual items of deviant behavior
2) 100% agreement on global psychiatric diagnosis
3) 90% agreement on the degree of psychiatric abnormality evident.

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[11] P. Graham and M. Rutter "The Reliability and Validity of the Psychiatric Assessment of the Child: II Interview with the Parent." British Journal of Psychiatry 114 (1968): 581-592.

Child Interview

The individual assessment with the child consists of a psychiatric assessment which is essentially unstructured and open ended in format. There is also a brief neurological examination based on soft signs and the administration of Ravens Wide Range Colored or Standard Progressive Matrices and a Wide Range Achievement Test in Mathematics, Spelling and Reading. (Appendix F).

As with the other assessment tools tests of reliability and validity were conducted on the schedule from which the current schedule was derived. The results of two test re-test reliability studies and an Inter-rater reliability test were reported by Rutter and Graham (1968)[12] Findings showed high levels of agreement for definite and marked disorder, 90-95%. Less severe disorder was agreed upon in a range of 51%-63%.

Agreement on individual items of deviant behavior were considerably lower, but improved with adjustments to the scale.

The validity and sensitivity of this method was confirmed when diagnostic designations were compared to designations of the same children made independently by teachers and parents.

The current study tested the inter-rater reliability between the researcher and a similarly qualified rater. The psychiatric assessments were administered alternately by the interviewers to 10 children (6 patients of a child psychiatric service, 4 children

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[12]M. Rutter and P. Graham "The Reliability and Validity of the Psychiatric Assessment of the Child: I Interview with the Child." British Journal of Psychiatry 114 (1968): 563-579.

selected from the population at large).

The following levels of agreement were found between raters on independently scored assessments:

1) 87.5% agreement between raters on individual items of deviant behavior

2) 100% agreement between raters on global psychiatric diagnosis

3) 100% agreement between raters on the degree of abnormality evident.

Diagnosis and the Computation of Prevalence Rates

Upon completion of the individual assessments a psychiatric diagnosis, based upon the accumulated information was established. A child was considered to have a psychiatric disorder if at the time of assessment an abnormality of behavior, emotions or relationships was causing handicap, distress or disturbance to the child, his family or the community.

The diagnoses established in this study were classified according to a scheme derived by Rutter, Shaffer and Shepherd (1973) for use by the World Health Organization.[13] This is a multi axial scheme, the usefulness of which was confirmed by its application in a clinic setting and by its adaptability to computerization for research purposes.

This model is superior to previous work in that its phenomenological basis allows for thorough case assessment of a variety

[13]M. Rutter, D. Shaffer and M. Shepherd "An Evaluation of the Proposal for a Multi-axial Classification of Child Psychiatric Disorders." Psychological Medicine 3 (1973): 244-250.

which is more acceptable than a theoretically based model.[14]

The configuration of diagnostic designations established by the above procedures were then used to calculate prevalence rates of child psychiatric disorder as observed in the study population (N = 277).

Summary

The method employed in the current study was adapted from the multiple assessments technique derived for use in the 1970 Isle of Wight Survey.

The population studied (277 children) were screened for the presence of child psychiatric disorder as follows:

1) Questionnaires completed by parents
2) Questionnaires completed by teachers
3) Records search of existing agencies to determine previous contact

Previous investigations have found the screening questionnaires employed in the current study to be both reliable and valid when cut-off scores of 13 (parental questionnaire) and 9 (teachers questionnaire) are used.[15,16]

Children who scored above the stated cut-off score on either questionnaire or who were selected on administrative grounds were considered to be "at risk" of having a psychiatric disorder. N=53 (19.13%)

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[14]Rutter, "Classification and Categorization in Child Psychiatry." pp. 71-83.

[15]Rutter et al., Education, Health and Behavior pp. 155-158.

[16]Rutter, "A Childrens Behavior Questionnaire for Completion by Teachers, Preliminary Findings." pp. 1-11.

A randomly selected sample of 30 "at risk" children together with an equal number of unselected children matched for sex and denomination of school were then assessed blindly as follows:

1) Interview with the Parent.
2) Interview with the Child
3) Psychological Testing

The interview technique employed was open-ended and semi-structured in format. Preliminary testing and the Isle of Wight results themselves attest to the reliability and validity of these instruments as diagnostic tools.[17,18]

The current investigator subjected the adapted schedules (Appendices E and F) to tests of inter-rater reliability. For both interviews agreement levels were in excess of 87% for individual items of deviant behavior, global psychiatric assessment and degree of abnormality evident in the child.

Based upon the accumulated information a psychiatric diagnosis was established for each of the individually assessed children. A child was considered to be psychiatrically disturbed if he exhibited at the time of assessment abnormality of behavior emotions or relationships which was sufficiently severe and prolonged to cause handicap or distress to himself, his family or the community.[19]

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[17]Graham and Rutter "The Reliability and Validity of the Psychiatric Assessment of the Child: II Interview with the Parent." pp. 581-592.

[18]Rutter and Graham "The Reliability and Validity of the Psychiatric Assessment of the Child: I Interview with the Child." pp. 563-579.

[19]Rutter et al., Education, Health and Behavior p. 148

Diagnoses were classified according to a multi-axial scheme derived for the use of the World Health Organization.[20] From these results prevalence rates of child psychiatric disorder were calculated.

[20] Rutter et al. "An Evaluation of the Proposal for a Multi-axial Classification of Child Psychiatric Disorders." pp. 244-250.

CHAPTER FIVE

THE RESULTS

The Selection of Children with Psychiatric Disorder

The Selection of Children "At Risk" of Having a Psychiatric Disorder

Of the 277 children assessed by the screening techniques, 53 (19.13%) met the criteria necessary for designation to the "at risk" group.

As Table 8 demonstrates, the different screening instruments tend to designate different children to the "at risk" group, overlap is low.

Likewise, agreement rates were low for the 22 items of behavior common to both screening questionnaires. Table 9.

Among the six items agreed upon most frequently, there was a slight preference for emotional items, i.e., worry, fidgetness and solitary behavior. Among the six items agreed upon least frequently a more marked preference for conduct items was demonstrated, i.e. destructiveness, bullying, stealing, lieing, not much liked by other children.

This distribution of agreement levels between the scales is in marked contrast with the results of the Isle of Wight Survey.[1] On the Isle of Wight, conduct items were agreed upon most frequently while emotfonal items were agreed upon least frequently.

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[1]Rutter et al., Education Health and Behavior pp. 164-166.

TABLE 8

FREQUENCY OF SELECTION SOURCE
IN "AT RISK" GROUP

	Boys	Girls	Total
Parental Screening Questionnaire	14	11	25
Teachers Screening Questionnaire	14	3	17
Both	6	3	9
Administrative Group Only	0	2	2
Total	34	19	53

TABLE 9

PREVALENCE AND AGREEMENT RATES FOR BEHAVIORAL ITEMS - SCREENING INSTRUMENTS*

Item	% Parental Screening Instrument	% Teachers Screening Instrument	Percent Agreement
Nail Biting	65 (24.0%)	13 (4.7%)	(61%)
Disobedient	38 (14.0%)	52 (18.9%)	(57%)
Worry	109 (40.2%)	68 (24.8%)	(29%)
Fidgety	45 (16.8%)	53 (19.3%)	(28%)
Concentration Span	49 (16.2%)	37 (13.5%)	(23%)
Solitary	46 (17.3%)	56 (20.4%)	(21%)
Stammer	14 (5.1%)	15 (5.4%)	(20%)
Irritability	109 (40.2%)	35 (12.7%)	(18%)
Fears	109 (40.2%)	35 (12.7%)	(18%)
Miserable	51 (18.8%)	38 (13.8%)	(17.9%)
Fights	90 (33.0%)	33 (12.8%)	(17.9%)
Restlessness	83 (30.0%)	62 (22.6%)	(14%)
Fussiness	66 (24.3%)	23 (8.0%)	(13%)
Not Liked	16 (5.9%)	29 (10.5%)	(13%)
Lies	76 (28.4%)	17 (6.2%)	(10%)
Steals	18 (6.6%)	1 (0.3%)	(10%)
Bully	48 (17.7%)	19 (6.9%)	(8.9%)
Destructice	18 (6.7%)	5 (1.8%)	(4.0%)

*4 items: Tears on arrival at school, truanting, thumbsucking and mannerisms were rated as present in 3.5% or less of the total number of codings made. Missing values were not included in the calculation of proportions.

The parental screening instrument showed a tendency to rate disorder present more frequently than did the teachers screening instrument. (Table 9) This was noted in 5/6 emotional items which were common to both questionnaires; i.e. worry, tearful, fearful, fussy, nailbiting. Similarly, the parental screening instrument detected more conduct disorder in 6/9 such items which were common to both questionnaires; i.e. destructiveness, fights, irritability, bully, lies, stealing.

The failure in the present study, of parents and teachers screening instruments to agree on global psychiatric assessment may have been influenced by the situation specific nature of childhood behavior.

The low agreement levels on behavioral items may be associated with the infrequent occurrence of conduct items. The specific, observable nature of conduct items is known to enhance their reliability as screening items, (Rutter et al., 1970), (Ullman, 1952).

The Efficiency of the Diagnostic Instruments

In the present study, the efficiency of the diagnostic tools was assessed in relation to the final, global diagnosis established for members of the intensively studied group. Table 10 provides a breakdown of final global diagnosis by selection source.

The parental screening questionnaire selected 48.71% of those finally diagnosed as having a psychiatric disorder compared with 12.27% of the general population.

In the present study the teachers screening instrument was less efficient. It selected 25.6% of those finally diagnosed as compared to

TABLE 10

FREQUENCY OF FINAL, GLOBAL DIAGNOSIS BY SELECTION SOURCE (INTENSIVELY STUDIED GROUP)

	Comparison Group	Parental Questionnaire	Teacher Questionnaire	Both Questionnaires	Administrative Group	Total
Normal Variation	19	2	0	0	1	21
Adaptation Reaction	0	1	0	1	0	2
Speech and Language Disorder	0	1	0	0	0	1
Stuttering	0	0	0	1	0	1
Emotional Disorder	11	4	5	1	1	22
Mixed Conduct-Emotional Disorder	2	9	1	1	0	13
						60

9.4% of the general population.

Accuracy of positive diagnosis was high for both screening instruments. The teachers screening instrument did not select any "false positives" and the parental screening instrument selected only 5% false positives.

In the current study the overall efficiency of both questionnaires is dubious in view of a 33% occurrence of "false negatives" among those with final, global psychiatric diagnosis.

This large proportion of "false negatives" is comprised primarily of emotional disorders (84.6%) and disorders of a dubious, slight or moderate degree. (84.5%).

This tendency of the screening instruments to miss emotional disorder may be related to the unreliability of questionnaire designations of emotional behaviors[2] which are inherently subject to interpretation on the part of the rater.

In the current study as in the Isle of Wight Survey[3] the parental interview was found to be the single most efficient diagnostic tool.

It selected 34 or 87.2% of those finally diagnosed as having a psychiatric disorder. The increased sensitivity of this instrument is reflected in its ability to detect 72.7% of the emotional disorders finally diagnosed.

The psychiatric interview with the child was also found to be an efficient diagnostic tool. It selected 31 (79.5%) of the children

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[2]Ibid., pp. 166-168.

[3]Ibid., p. 43.

ultimately diagnosed as disturbed and accurately selected 68.8% of the emotional disorders finally diagnosed.

Summary

In summary 19.13% (53/277) of the study population was considered to be "at risk" of having a psychiatric disturbance on the basis of multiple screening assessments.

The efficiency of each of the four diagnostic tools was evaluated. The parental interview was found to be the single most efficient and most sensitive diagnostic tool.

The screening instruments used separately were not efficient diagnostic tools particularly in relation to emotional disorders and disorders of a less than marked degree.

The Prevalence of Child Psychiatric Disorder

Prevalence Rates

The prevalence rates of psychiatric disorder provided in this paper are based upon the global findings for 60 individually assessed children. Selected according to the procedure outlined in Chapter Four, the individually assessed group can be broken down as follows (Table 11):

The current study has yielded a raw prevalence figure of 39 in 277 or 14.08%[4]. Of these children 13 were comparison children, thus allowing for a correction factor of 3/2. It is predicted that for every two children detected by the screening one will be missed.

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[4]This figure includes those children with a definite psychiatric disorder of any degree. (mild, moderate or severe.)

TABLE 11

COMPOSITION OF INDIVIDUALLY ASSESSED GROUP

		Total
Randomly selected "at risk" children	- 30	
Parents refused to participate	- 2	
		28 (1)
Comparison Group (Normal on screening)	- 30	
Assessed at Parental request (Normal on screening)	- 2	
		32
		60

(1) One parent permitted the assessment of the child, but was unwilling to permit the parental interview.

The corrected prevalence rate is then 21.12%. This corrected rate is in considerable excess of the rate of 6.8% established for the Isle of Wight population.[5] The single most common diagnosis made was emotional disorder. Contrary to expectation[6] pure conduct disorder was not diagnosed in this study.

However, conduct problems were frequently mixed with equally serious emotional problems. Table 12.

This finding is best illustrated by comparison of the prevalence of major diagnostic categories in the two studies. Table 13.

Although pure emotional disorders were most common in this study, mixed, conduct-emotional disorders were significantly more

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[5]Rutter et al., Education Health and Behavior pp. 200-201.

[6]Ibid.

TABLE 12

PREVALENCE OF DIAGNOSTIC CATEGORIES

Diagnosis	Frequency
Adaptation Reaction	2
Speech and Language Disorder	1
Stuttering	1
Conduct Disorder	0
Emotional Disorder	22
Mixed, Conduct-Emotional Disorder	13
Sub-Total	39
Normal Variation	21
Total	60

TABLE 13

CORRECTED PREVALENCE RATES OF MAJOR DIAGNOSTIC CATEGORIES

	Isle of Wight	Goulds-Kilbride, Petty Harbour
Emotional Disorder	43 (2.5%)	22 (11.9%)
Conduct Disorder	43 (2.5%)	0
Mixed, Emotional-Conduct Disorder	27 (1.5%)	13 (7.09%)
	N = 2,199	N = 277

severe in degree. Table 14.

Proportionately, mixed, conduct-emotional disorders were rated as marked in degree 53.8% of the time. This is approximately three times the proportion of marked pure emotional disorders. (18.2%)

Mixed conduct-emotional disorders and pure emotional disorders made up 28/34 children who were finally diagnosed. The remaining four children demonstrated symptom patterns as follows:

Stuttering	- 1
Speech and Language Disorder	- 1
Adaptation Reaction	- 2

The details of these cases are given in Appendix G.

The Prevalence of Psychiatric Disorder in Relation to Sex

The present study has found an increased prevalence of males in all diagnostic categories with the exception of adaptation reaction. Table 15.

This excess of males fails to reach statistical significance. It does, however, agree with a similarly non-significant tendency observed in the Isle of Wight Survey[7], Lapouse (1966), and Davie (1963).

The Prevalence of Psychiatric Disorder in Relation to Family Demography

The full range of demographic family features were tested for association with psychiatric disorder. (Appendix E pp. 130-134, 169-172, 195-238) None of the items showed a statistically significant degree of association.

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[7]Ibid., p. 182.

TABLE 14

FINAL DIAGNOSIS ACCORDING TO DEGREE OF ABNORMALITY

	Normal	Possible	Slight	Moderate	Marked	Total
Normal Variation	18	0	2	0	0	20
Adaptation Reaction	0	0	1	1	0	2
Speech and Language Disorder	0	0	1	0	0	1
Stuttering	0	0	0	0	1	1
Emotional Disorder	4	2	6	6	4	22
Mixed, Conduct-Emotional Disorder	0	1	2	3	7	13
Total	22	3	12	10	12	59

$X^2 = 53.11$ df = 20 $P < 0.0001$

Note: Degree of abnormality of psychiatric state as assessed from the parental interview

TABLE 15

PREVALENCE OF DIAGNOSTIC CATEGORIES BY SEX

	Male	Female
Adaptation Reaction	0	2
Speech and Language Disorder	1	0
Stuttering	1	0
Emotional Disorder	13	9
Mixed, Conduct-Emotional Disorder	11	2
Total	26	13

Comparable tests carried out on the Isle of Wight data[8] also failed to show statistical significance, with one exception.

The Isle of Wight results found significant association between sleeping arrangements and psychiatric disorder.[9] In the current study no such significant relationship was observed.

Neither did the current study confirm the Isle of Wight tendency for more psychiatrically disturbed children to come from broken homes.

The Prevalence of Psychiatric Disorder as Associated with Family Life and Relationships

The full range of enquiries into family life and relationships (Appendix E pp. to) were tested for association with psychiatric disorder in general and for associations with either emotional or mixed disorders in particular.

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[8]Ibid., p. 257.

[9]Ibid., pp. 260-261.

Only two items, both of which were of a neurotic nature showed a significant degree of association with general disorder.

The items were 1) misery and unhappiness which was reported to be present in 5% of the mothers of 20 normal children compared with 38.5% of the mothers of 39 disturbed children;[10] 2) excessive tearfulness was reported to be present in the mothers of 20% of 20 normal children as compared to 46.2% of 39 disturbed children.[11] Both items were more prevalent among the mothers of children with mixed disorders. However these differences were not statistically significant.

Significant associations were found between type of psychiatric disorder in children and weight and appetite loss in fathers.

Fathers of children with mixed disorders had shown weight loss in excess of eight pounds over six months in time, in 36.4% of 10 cases, a similar degree of loss was reported in the fathers of 5% (20) emotionally disordered children. Similarly, 45% of the fathers of children with mixed disorders, reported a significant degree of appetite loss compared with 5% of the fathers of children with emotional disorders.[12]

The statistical significance of appetite loss suggests that the association with weight loss is more likely to reflect a physical or emotional disturbance in the fathers of children with mixed disorders, than a reflection of increased voluntary dieting among the fathers of

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[10] X^2 test of association was significant at 0.05% level or better.

[11] X^2 test of association was significant at 0.05% level or better.

[12] X^2 test of association was significant at 0.05% level or better.

these children.

The Rutter study of 1966 found that associations such as those listed above are predictable in that the children of sick parents are at particular risk of developing a disorder themselves.[13]

The Prevalence of Psychiatric Disorder in Relation to I.Q.

The mean I.Q. scores obtained by study children on the Ravens, Colored or Standard Progressive Matrices were calculated for the three major diagnostic categories, and were tested for the significance of differences between means. Table 16.

T-tests were carried out, between emotional and mixed disorders and between both disturbed groups and the normal groups. No significant differences were found.

The results were consistently non-significant for males, females and the total group.

The results of Rutter's[14] work in this area showed significant differences between the mean I.Q. of the normal control population and both major diagnostic groups, neurotic and anti-social disorders.

The Isle of Wight results also demonstrated significant sex differences. Anti-social boys and neurotic girls both had I.Q. scores significantly lower than their respective normal controls. In the current study females with an emotional disorder tend to have a lower mean I.Q. score than children in the normal group, however, this result

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[13]Rutter, M. Children of Sick Parents, an Environmental and Psychiatric Study (London, Oxford University Press, 1966) p. 107.

[14]Rutter et al., Education Health and Behavior pp. 232-235.

does not approach statistical significance.

TABLE 16

I.Q. AND PSYCHIATRIC DISORDER

	Normal	Emotional Disorder	Mixed Conduct-Emotional Disorder
Males: Mean I.Q.	101.46	97.38	103.23
Standard Deviation	9.67	15.91	9.08
Number	13	13	13
Females: Mean I.Q.	99.50	96.33	105.50
Standard Deviation	15.73	12.44	7.77
Number	8	9	2
Total Group:			
Mean I.Q.	100.71	96.95	103.23
Standard Deviation	11.98	14.28	9.08
Number	21	22	13

The Prevalence of Psychiatric Disorder in Relation to Reading Ability

Reading retardation is a concept developed by W. Yule 1967.[15] By the use of a multiple regression equation a predicted reading level is established which takes into consideration the child's I.Q. and chronological age. By comparison of a child's predicted reading level and his observed reading level the degree of reading retardation, measured in months can be calculated.

In the current study the degree of reading retardation observed among the intensively studied group failed to show a statistically significant association with major diagnostic categories. Table 17.

[15]W. Yule "Predicting Reading Ages on Neales Analysis of Reading Ability." British Journal of Educational Psychology 37 (1967a): 252-255.

TABLE 17

READING RETARDATION AND PSYCHIATRIC DISORDER

	Percent Normal	Percent Emotional	Percent Mixed
Males:	N = 13	N = 13	N = 11
Reading at or above Predicted Level	76.9	53.8	45.5
Reading 1-6 months Retarded	23.1	46.2	54.5
Females:	N = 8	N = 9	N = 2
Reading at or above Predicted Level	62.5	33.3	0.0
Reading 1-6 months Retarded	37.5	66.6	100.0
Total Group:	N = 21	N = 22	N = 13
Reading at or above Predicted Level	71.4	45.5	38.5
Reading 1-6 months Retarded	28.6	54.5	61.5

These results differ remarkably from those of the Isle of Wight Survey [16] in which severe reading retardation (28 months or more) was related to a highly significant degree with anti-social and mixed disorders in both boys and girls, across all I.Q. categories.

In the current study both severe reading retardation and pure conduct disorder were absent. Although mixed conduct-emotional disorders were prevalent, the degree of reading retardation did not exceed six

[16] Rutter et al., Education Health and Behavior pp. 235-239.

months in any of the children so diagnosed.

Summary

The current study observed evidence of psychiatric disturbance in 39 of 277 children. Corrected for those likely to have been missed by the screening, the overall prevalence rate is 21.12%. This is more than triple the rate observed on the Isle of Wight, 6.8%. Emotional disorder was detected at a corrected rate of 11.9% and mixed disorder at a rate of 7.4%; both figures are approximately four times the prevalence observed on the Isle of Wight. Pure conduct disorder was absent in the present study.

In general, demographic family and social features were not significantly associated with disorder.

A significantly increased tendency towards psychiatric disorder was observed among children the mothers of whom displayed the neurotic symptoms of misery and unhappiness and excessive tearfulness. Mixed, conduct-emotional disorder was more common among children the fathers of whom displayed recent excessive weight and appetite loss. Otherwise, items related to family life and relationships showed no association with the presence or type of disorder observed in the children.

In the present study I.Q. was not significantly associated with the prevalence of psychiatric disorder, nor were there significant differences in mean I.Q. scores across types of psychiatric disorder.

Finally, reading retardation was not significantly associated with psychiatric disorder in the present study. In fact, none of the study sample were reading retarded to a degree greater than six months.

The Prevalence of Individual Items of Deviant Behavior

Numerous papers in the literature concern the prevalence trends of individual items of deviant behavior. These provide a major proportion of the information available concerning the epidemiology and etiology of child psychiatric disorder.

The remaining portion of this chapter will present, with reference to the literature, the prevalence trends of individual items of deviant behavior as they were observed in the current study sample.

The Prevalence of Individual Items of Deviant Behavior as Related to Psychiatric Disturbance

Contrary to the findings of Rutter et al. (1970), McCarthy (1969) and Quay and Quay (1965) very few items in the current study significantly differentiate the normal from the disturbed children. Table 18.

It is also noteable, that among the four scales employed no overall consistency was found among the items which did differentiate normal from disturbed.

The items; concentration span on the parental questionnaire and restlessness and concentration span on the teachers questionnaire were significantly exclusive to the disturbed population. However, these cannot be held as valid indicators of psychiatric disturbance in view of their failure to reach statistical significance on the parental and childs interviews.

Overall, the current study shows a high prevalence rate of deviant items of behavior in the population at large. For example, several items which showed a non-significant prevalence increase among 'normal' children in the present study, were significantly more

TABLE 18

INDIVIDUAL ITEMS OF DEVIANT BEHAVIOR - NORMAL VS. DISTURBED

A PARENTS SCREENING INSTRUMENT			
Item	Normal Percent N = 21	Disturbed Percent N = 39	X^2 Test Significance Level
Restless	14.3	53.8	0.006
Fidgety	4.8	35.1	0.02
Fights	23.0	59.0	0.01
Concentration Span	0.0	51.3	0.0003
B TEACHERS SCREENING INSTRUMENT			
	N = 21	N = 39	
Restless	9.5	41.0	0.02
Tearfulness	0.0	30.8	0.01
Concentration Span	0.0	28.9	0.01
C PARENTAL INTERVIEW			
	N = 20	N = 39	
Fidgety	5.0	33.3	0.03
Emotional State	15.0	46.2	0.03
Ideas of Reference	15.0	46.2	0.03
Temper Tantrums	21.1	61.5	0.008
Inadequate Number of Friends	10.0	50.0	0.006
Lies	5.0	30.8	0.05
D CHILDS INTERVIEW (*)			
	N = 21	N = 39	
Anxious Expression	42.9	78.9	0.01
Preoccupation with Anxiety Topics	9.5	38.5	0.03
Tearfulness	19.0	61.5	0.004
Unhappiness	14.3	46.2	0.02

* Items listed Appendix F pp. to

prevalent in the 'disturbed' group on the Isle of Wight. Table 19.

TABLE 19

INDIVIDUAL ITEMS OF DEVIANT BEHAVIOR WITH ELEVATED PREVALENCE RATES IN THE 'NORMAL VARIATION' CATEGORY

PARENTS SCREENING INSTRUMENT:		
Item	Normal Variation - Percent N = 21	Psychiatrically Disturbed - Percent N = 39
Bed Wets †	19.0	17.9
Thumbsucking †	14.3	2.9
Nailbiting †	38.1	28.2
Eating Difficulties †	23.8	18.4
TEACHERS SCREENING INSTRUMENT		
Truanting †	14.3	5.1
Fighting *	14.3	12.8
Worrying †	33.3	30.8
Nailbiting †	9.5	2.6
Bullies *	9.5	7.9
Frequently Absent †	23.8	15.6

*Items significantly more frequent in 'disturbed' group in Isle of Wight sample - both screening instruments.

†Items significantly more frequent in 'disturbed' group in the Isle of Wight sample on one screening instrument.

Lapouse (1966) and Ryle et al. (1965) both report high rates of deviant behavior in the population at large. In the current study, a number of individual deviant items were rated as present, at a rate in excess of 15% of the total number of assessments made. Table 20.

This elevated prevalence, in the population at large, precludes any reliable association between individual items of deviant behavior and overall psychiatric abnormality.

TABLE 20

INDIVIDUAL ITEMS OF DEVIANT BEHAVIOR IN THE TOTAL STUDY POPULATION AS BASED ON SCREENING ASSESSMENTS

Emotional Items	Percent	Habit or Behavioral Items	Percent	Conduct Items	Percent
Worrying	32.4%	Restlessness	26.6%	Fighting	22.6%
Irritability	26.4%	Fidgetness	18.1%	Lying	17.1%
Solitary	18.7%	Poor Concentration	15.8%	Disobedience	16.6%
Fears	16.9%				
Fussiness	16.3%				
Tearfulness	16.3%				

NOTE: The proportions given are based upon the total number of screening assessments made. Missing data was not included in the calculations.

The Prevalence of Individual Items of Deviant Behavior as Related to Sex

Unlike the Isle of Wight Survey[17] the current study found very few statistically significant sex differences for behavioral items as rated on the screening instruments. On the parental screening instrument no statistically significant associations were observed, while on the teachers screening instrument only three items, restlessness, disobedience and resentfulness showed significant differences. Each of these items was more common among boys. Table 21.

However the trend of sex preferences in this study are quite similar to the findings on the Isle of Wight. Developmental items such as, disorders of speech, stammering, bed wetting and soiling were more frequent among boys; as were the concentration and motor items of; restlessness and fidgetness. Irritability, interpersonal problems (not much liked by other children), fighting and stealing all tended to be consistently more frequent among boys. The essentially neurotic items of thumbsucking, worrying, tearfulness, habits or mannerisms, fearfulness and fussiness tended consistently towards increased frequency among girls.

The remaining items did not show statistically significant sex differences nor did they show consistent trend preferences.

Analysis of the sex differences as rated on the parental interview provide essentially the same results. Review of non-statistically significant trends show a predominance of males among items of habit or development and conduct items, and a trend towards more females

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[17] Ibid., pp. 205-207.

TABLE 21

INDIVIDUAL ITEMS OF DEVIANT BEHAVIOR IN RELATION TO SEX (SCREENING INSTRUMENTS)

Item	Parental Screening Instrument		Teachers Screening Instrument	
	Males	Females	Males	Females
Tempers	38.5	42.9		
Tears on Arrival at School	7.7	4.8	0.0	9.5
Truants	5.1	5.3	12.8	0.0
Restless	46.2	28.6	41.0*	9.5
Fidgety	30.8	10.5	20.5	4.8
Destructive	15.9	19.0	2.6	0.0
Fights	48.7	42.9	20.5	0.0
Not Liked	12.8	4.8	23.1	14.3
Worry	51.3	57.1	28.2	38.1
Solitary	12.8	31.6	30.8	28.6
Irritable	59.0	47.6	15.4	0.0
Tearful	28.2	47.6	17.9	23.8
Mannerisms	7.7	9.5	5.1	9.5
Thumb Sucking	5.1	9.5	2.6	4.8
Nail Biting	30.8	33.3	7.7	0.0
Disobedient	64.1	57.1	35.9*	9.5
Concentration Span	30.8	40.0	23.7	9.5
Fearful	15.4	28.6	18.4	23.8
Fussy	17.9	42.9	7.9	15.0
Lies	38.5	42.9	10.5	0.0
Bullies	28.2	38.1	13.2	0.0
Stammer	5.1	5.0	10.5	4.8
Other Speech Problems	7.7	4.8		
Stealing	10.3	9.5	2.6	0.0
Eating Difficulties	15.2	30.0		
Sleeping Difficulties	7.7	23.8		
Headache	41.0	52.4		
Stomach Ache	46.2	52.4		

TABLE 21 (continued)

Item	Parental Screening Instrument		Teachers Screening Instrument	
	Males	Females	Males	Females
Asthma	10.3	0.0		
Bed Wets	20.5	14.3		
Soils	2.6	0.0		
Absent			20.5	14.3
Unresponsive			2.6	4.8
Complains			0.0	4.8
Resentful			23.0*	0.0

*X^2 significant at 0.05% level or better

among neurotic or emotional items.

Four items showed statistically significant sex differences as rated on the parental interview. All four were items of conduct or habit and were more frequent among boys. Table 22.

TABLE 22

INDIVIDUAL ITEMS OF DEVIANT BEHAVIOR IN RELATION TO SEX (PARENTAL INTERVIEW)

Item	Percent Male N = 38	Percent Female N = 21	X^2 Test Significance Level
Overactive	47.4	14.3	0.02
Fidgety	34.2	4.8	0.02
Destructiveness	36.8	0.0	0.004
Fire Lighting	40.5	4.8	0.008

This tendency for conduct and behavioral problems to be more common in boys was also found by Rutter et al. (1970) and for girls to demonstrate predominantly neurotic symptoms by Lapouse and Monk (1959). Similar results were found by Davie (1968), Swift et al. (1969).

The findings in the literature are far from consistent in trend. Mensch et al. (1959) found that nervousness was among the items most frequently found in boys, as were fears and sleep disturbance and that girls were frequently rated for telling lies.

Ryle et al. (1965) on the other hand failed to find any sex differences in the ratings of symptoms.

The Prevalence of Individual Items of Deviant Behavior in Relation to School

The parental screening instrument failed to show any statistically significant associations between individual behavioral items and school.

The teachers' screening instrument did however, show significant associations for five items, all conduct items. Table 23.

On the child's interview no significant associations were observed between individual items of deviant behavior and school of attendance.

The parental interview showed significant associations with school on four items.[18] They were; soiling, squabbling, routines and disobedience towards mother. The parental interview also demonstrated a significant degree of deterioration in the behavioral and academic

[18]Associations X^2 test significant at 0.05% level or better.

TABLE 23

ITEMS OF DEVIANT BEHAVIOR IN RELATION TO SCHOOL
(TEACHERS SCREENING INSTRUMENT)

Items	Schools					
	A Percent N = 7	B Percent N = 5	C Percent N = 5	D Percent N = 5	E Percent N = 23	F Percent N = 14
Truanting †	0.0	25.0	60.0	20.0	0.0	0.0
Destructive *	0.0	0.0	20.0	0.0	0.0	0.0
Concentration Span *	0.0	20.3	20.0	60.0	21.7	0.0
Steals *	0.0	0.0	20.0	0.0	0.0	0.0
Bully *	0.0	20.3	20.0	20.0	0.0	7.1

† Items showing association at 0.01% level or better

* Items showing association at 0.05% level or better

standing of children who had experienced school changes.[19]

As previously mentioned during the life of the study, schools B and D were amalgamated and school E, formerly a co-educational School, transferred its entire female enrollment to school A.

Examination of Table 23 shows that for 3 of 5 items, schools B and D are among the schools with the highest prevalence. This suggests that the significance of these items may be related to a transient, situation specific phenomena related to school disruption. This is further supported by the failure of these items to show significance as rated on the more efficient parental interview.

The Prevalence of Individual Items of Deviant Behavior in Relation to Social Class

Previous epidemiological studies have revealed a tendency towards an increased prevalence of individual items of deviant behavior among lower class children, Douglas and Mulligan (1961).

Mensch et al. (1959) showed a sex related association with social class and psychiatric symptoms. Upper class boys were frequently anti-social and lower class girls frequently demonstrated comfort habits, nervousness and fears. Sarason et al. (1960) also found increased anxieties in lower class children as did Ziv et al. (1973).

However, the tendencies of the association are not consistent. Clausen and Williams (1963) found less anxiety among lower class children and Zigler and Phillips (1960) found an increased prevalence of anxiety items in middle class children. The Douglas studies of 1964 and 1966 found delinquent items of behavior to be more frequent

[19]Associations X^2 test significant at 0.001% level or better.

among lower class children and he found no association between lower class status and neurotic behavior.

The Isle of Wight results failed to show any significance of association between social class and individual items of deviant behavior.

The current study did not show significant association between social class as determined by the occupation of the head of the household and items of deviant behavior.

Only one screening item was significantly associated with social class. It was the teachers assessment of fussiness. Significant at the 0.04% level it showed most frequent prevalence 22.8% among children of professionally occupied parents. N = 9.

The parental interview provided 5 items which showed significant associations with occupation distribution. Table 24.

These items fail to demonstrate any specific trend of symptom type or trend in maximum prevalence.

The interview with the child produced two items which showed significant association with social class.[20] The items were, apathetic mood and decreased emotional expressiveness. Both items showed a x^2 significance level in excess of 0.01% level of probability and were considerably more prevalent in the occupation category; Long-Term Unemployment.

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[20]Items tested, Appendix F pp.282 to 283.

TABLE 24

ITEMS OF DEVIANT BEHAVIOR SIGNIFICANTLY ASSOCIATED WITH OCCUPATION GROUP

Item	Percent Professional N = 9	Percent White Collar N = 7	Percent Primary N = 5	Percent Blue Collar N = 26	Percent Long Term Unemployed N = 11
Hearing Problems†	33.3	0.0	0.0	8.0	0.0
Comfort Habits†	11.1	14.3	0.0	11.5	18.2
Ideas of Reference*	11.1	28.6	20.0	46.1	45.5
Bully*	33.3	14.3	0.0	0.0	0.0
Behavioral Change† After School Change	11.1	0.0	60.0	7.7	18.2

†X^2 test of association significant at 0.01% level or better

*X^2 test of association significant at 0.05% level or better.

The Prevalence of Individual Items of Deviant Behavior in Relation to I.Q.

On the Isle of Wight significant associations between I.Q. and individual items of deviant behavior were many and marked.[21]

The significant associations observed in the current study were not so frequent, however, several trends were observed. Table 25.

Five of the nine screening instrument items which were significantly associated with I.Q. were items of an emotional variety.

The item sleeping difficulty, which was significantly associated with I.Q. distribution in the current study, was one of the three items which did not demonstrate a significant association in the Isle of Wight Survey.[22]

[21]Rutter et al. Education, Health and Behavior pp. 220-230.

[22]Ibid., p. 224.

TABLE 25

ITEMS OF DEVIANT BEHAVIOR BY I.Q.
(SCREENING INSTRUMENTS)

A: PARENTAL QUESTIONNAIRE							
	Proportion of Total (N = 60)						
Item	I.Q. 127 or more	I.Q. 120-126	I.Q. 111-125	I.Q. 100-110	I.Q. 90-100	I.Q. 80-89	I.Q. 79 or less
Bed Wets *	0.0	1.7	8.3	1.7	1.7	3.3	1.7
Mannerisms *	0.0	0.0	1.7	1.7	0.0	3.3	1.7
Sleep Difficulty†	1.7	1.7	5.0	0.0	1.7	0.0	3.3
B: TEACHERS QUESTIONNAIRE							
Nail Biting*	0.0	1.7	0.0	0.0	0.0	1.7	0.0
Fears †	0.0	1.7	8.5	1.7	5.1	1.7	1.7
Lies †	0.0	1.7	1.7	1.7	0.0	1.7	0.0
Unresponsive†	0.0	1.7	8.5	1.7	5.1	1.7	1.7
Complains †	0.0	0.0	1.7	1.7	1.7	1.7	1.7
Tears on Arrival at School †	0.0	0.0	0.0	0.0	1.7	0.0	1.7

(*) X^2 test significant at 0.05% level or better

(†) X^2 test significant at 0.01% level or better

Four screening items, bed wetting, sleeping difficulty, fears and lies had their maximum prevalence rates in the I.Q. category 101-111.

Only one item showed an increased prevalence in the lower I.Q. category, 80-89, mannerisms. In contrast, the Isle of Wight results found a consistent trend for an increased prevalence of deviant items in the lower I.Q. categories.[23]

The analysis of deviant items as assessed on the parental and child's interviews differed very little in relation to I.Q. from the results of the screening instruments.

Table 26 shows that again two somatic items, soiling and hearing problems were significantly associated with I.Q. in the current study, but not so in the Isle of Wight results.

Of the items significantly associated with I.Q. on the individual assessments only one, the parental interview assessment of hearing problems demonstrated a maximum prevalence in the lower I.Q. category 80-89. On the individual assessments no single I.Q. category demonstrated a consistent tendency towards increased prevalence of deviant behavior items.

The Relationship between Social Class and I.Q.

The present study failed to demonstrate a significant relationship between I.Q. and social class as determined by parental occupation. Table 27.

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[23]Ibid., p. 230.

TABLE 26

INDIVIDUAL ITEMS OF DEVIANT BEHAVIOR BY I.Q. (INDIVIDUAL ASSESSMENTS)

A Parental Interview

Items	Percent of Total						
	I.Q. 127 or more	I.Q. 120-126	I.Q. 111-125	I.Q. 100-110	I.Q. 90-100	I.Q. 80-89	I.Q. 79 or less
Hearing problems*	1.7	0.0	3.4	1.7	6.9	0.0	0.0
Soiling†	0.0	1.7	0.0	0.0	0.0	0.0	0.0
Fear of changing* Cloths	0.0	0.0	5.3	7.1	5.3	0.0	1.8
Jealousy*	1.7	0.0	6.8	8.5	1.7	0.0	0.0
Relationship with teacher†	0.0	1.7	6.9	6.9	1.7	0.0	1.7
Fire lighting†	0.0	1.7	5.1	1.7	0.0	1.7	0.0
Wandering	1.7	0.0	6.8	0.0	6.8	0.0	1.7

B Childs Interview

Items	Percent of Total						
	I.Q. 127 or more	I.Q. 120-126	I.Q. 111-125	I.Q. 100-110	I.Q. 90-100	I.Q. 80-89	I.Q. 79 or less
Mannerisms†	0.0	0.0	1.7	6.7	3.3	0.0	3.3
Decreased emotional expressiveness†	0.0	0.0	1.7	5.0	1.7	1.7	1.7
Distractability†	0.0	1.7	1.7	3.3	1.7	1.7	3.3

†χ^2 Significant at 0.01% level or better. *χ^2 Significant at 0.05% level or better.

TABLE 27

I.Q. SCORE ACCORDING TO OCCUPATION GROUP

Ravens I.Q. Score	Percent Professional N = 9	Percent White Collar N = 7	Percent Blue Collar N = 26	Percent Primary N = 5	Percent Long Term Unemployment N = 11
I.Q. 127 or more	11.1	0.0	0.0	0.0	0.0
I.Q. (120-126)	0.0	0.0	3.8	0.0	0.0
I.Q. (111-119)	44.0	57.1	30.8	40.0	8.3
I.Q. (100-110)	33.3	28.6	23.1	20.0	33.3
I.Q. (90-100)	11.1	14.3	26.9	20.0	33.3
I.Q. (80-89)	0.0	0.0	15.4	0.0	8.3
I.Q. (79 or less)	0.0	0.0	0.0	20.0	8.3

However, trends observed in the data support the Isle of Wight findings that lower class children tend to have lower I.Q. ratings.[24]

In the current study a decreased frequency of lower class children was observed in the I.Q. categories 127 or more and 120-126. Further a decreased frequency of higher class children was observed in the I.Q. categories; 79 or less and 80-89.

The Prevalence of Individual Items of Deviant Behavior in Relation to Family Size

Thirteen items of deviant behavior demonstrated significant associations with family size. Of these, eight items were of an emotional variety. Ratings made on the Parental interview were predominant among the significant items. Table 28.

[24] Ibid.

TABLE 28

INDIVIDUAL ITEMS OF DEVIANT BEHAVIOR BY FAMILY SIZE

Item	Only Child	1 Sibling	2 Siblings	3 Siblings	4+ Siblings
A PARENTAL QUESTIONNAIRE	Percent Total N = 60				
Bed Wets *	0.0	3.3	0.0	5.0	10.0
Tears on Arrival at School *	0.0	1.7	1.7	0.0	3.3
Sultry †	0.0	3.4	1.7	3.4	10.3
B TEACHERS QUESTIONNAIRE	Percent Total N = 60				
Complains *	0.0	1.7	0.0	0.0	6.8
C PARENTAL INTERVIEW	Percent Total N = 59				
Headache *	0.0	0.0	5.1	0.0	11.9
Bed Wets *	0.0	3.4	0.0	6.8	10.2
Tearful *	1.7	3.4	8.5	15.3	44.0
Self Deprecation *	1.7	1.7	1.7	6.8	6.8
Fear of Animals *	0.0	1.8	0.0	0.0	1.8
Fear of Insects †	1.7	5.1	1.7	0.0	5.2
Fear Thunder and Lightning *	0.0	5.2	0.0	0.0	6.9
Teased *	1.8	1.8	7.1	1.8	15.8
Relationship with Adults †	0.0	0.0	1.7	0.0	0.0

* X^2 test significant at 0.05% level or better

† X^2 test significant at 0.01% level or better

It is notable that the highest prevalence rate of any item occurs among children from large families. With one exception, self-deprecation, the highest prevalence rate is shared with the second largest family size category, three siblings.

These findings concerning the prevalence of deviant items are in general agreement with the results of previous studies. Ellis and Beechley (1951), Nye (1952), Rutter et al. (1970) and Mitchell et al. (1966) all found a slight overall increase of deviant behavior among children from large families.

However the predominance of neurotic items among those showing significant association is in sharp contrast to the results of previous studies. Sewall (1930), Urgel-Semen (1952), Hawkes et al. (1958) and Tuckman and Regan (1967) all found a decrease of neurotic symptoms among the children of large families and a corresponding increase in the prevalence of anti-social behavior.

Although individual items show an increased association with family size the number of significant associations continues to be far less than the quantity found in the Isle of Wight analysis.

This set of results must be qualified by the fact that in the present study mean family size, across each of the major diagnostic categories is in excess of four children. Table 29. Most of the studies referenced in the above presentation consider families of four children to be large.

Summary

In the current study sample, a generally high frequency of deviant behavioral items were observed.

The overall high prevalence rate and lack of consistency among the items which distinguish the normal from the disturbed populations rule out any of the individual items as reliable predictors of psychiatric disturbance.

TABLE 29

MEAN FAMILY SIZE ACROSS MAJOR DIAGNOSTIC GROUPS

	Normal	Emotional	Mixed
Mean number of Children	5.7	4.4	5.2
Standard Deviation	3.7	2.5	2.5
Number of Subjects	21	22	13

Individual items showed few significant associations with sex. However, the non-significant tendencies observed were consistent across all diagnostic instruments. It was observed that items of a conduct and habit variety were more common among males while emotional items were more common among females.

Tests of association between schools and the distribution of individual items of deviant behavior suggested a situation specific increased prevalence of conduct items as rated by teachers. This increased prevalence was noted in association with school disruption.

The items of deviant behavior which were significantly associated with social class did not indicate trends of symptom type, nor did any one social class show a predominance among the maximum prevalence rates.

The results of the present study did not demonstrate an association between increased frequency of deviant behavior and low I.Q. Although the analysis based upon the screening instruments demonstrated a tendency towards highest prevalence in the I.Q. category 101-111 this

finding was not consistent across other diagnostic instruments.

An examination of the relationship between I.Q. and Social Class revealed a non-significant trend for lower class children to have lower tested I.Q. scores and higher class children were found to dominate the higher tested I.Q. categories.

Finally the present study observed a significantly increased frequency of children from large families in the ratings on a number of neurotic items of deviant behavior.

CHAPTER SIX

THE DISCUSSION

At its inception the current study had three major objectives. They were:

1) To compute prevalence rates of psychiatric disorder in a total population of school age children in the Province of Newfoundland and Labrador.

2) To arrive at these prevalence rates by the use of valid epidemiologic methods. If workable these methods might then be used in a later, province wide, total population study.

3) From the information obtained improvements to existing services and the establishment of new services could be planned in relation to the nature and extent of documented need.

This chapter will discuss the extent to which each of these objectives has been reached.

The Prevalence of Psychiatric Disorder in Newfoundland Children

The prevalence rate of psychiatric disorder computed in the current study was 21.12% of 277 children. This figure is approximately three times the 6.8% rate observed in the Isle of Wight Survey.

There is evidence to suggest that the 277 children to whom this figure applies are a sample of essentially normal children. The mean I.Q. rating of the sample is well within the average range. Table 29 and the frequency of children known to have an increased risk of

psychiatric disorder is low. Table 30.

TABLE 30

FREQUENCY OF HIGH RISK CHILDREN (NOTE)
AMONG THE POSITIVE RESPONDERS

	Frequency
Children with a History of Attendance at a Psychiatric Service	- 8 (2.8%)
Children with Chronic Physical Handicap	- 9 (3.2%)
Children with Low Tested I.Q. Rates (79 or below)	- 7 (2.4%)

N = 277

(Note) Rutter et al, Education Health and Behavior p. 153.

Other studies of Newfoundland children have confirmed the tendency towards an increased prevalence of psychiatric disorder among lower I.Q. and chronically handicapped children.

Hollett (1974)[1] conducted a study of thirty children in Special Classes and thirty children performing at the bottom of regular classes. This sample of children generally had I.Q. tested scores of less than 85. Psychiatric disorder as detected by at least one diagnostic tool was observed in 59.2% of the group. The diagnostic instruments employed were similar to those in the current study and were derived from the Isle of Wight diagnostic methodology.

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[1]L. Hollett "A Comparison of the Academic, Psychiatric, Physical, Social and Family Characteristics of Children Attending Special Classes with a Specified Group of Children Attending Regular Classes of the St. John's Educational System." MSc. Thesis (Memorial University of Newfoundland, 1974).

Dickson (1975)[2] conducted a study of the prevalence of psychiatric disorder in a total population of children with chronic physical handicap, hemophilia. Using the Isle of Wight diagnostic methodology she observed a prevalence rate of 20.8% n = 24.

These facts, coupled with the likely increase of psychiatric disorder among the non-responders, indicate that 21.12% may well be a minimum prevalence rate.

The observed prevalence rate in the current study is dominated by a high rate of emotional disorder, 11.9%. 81.8% of these emotional disorders were rated as less than marked in degree. This suggests that the increased prevalence may reflect an increase in the amount of transient fluctuations in the psychic state of otherwise normal children.[3]

The verification of this tendency would require further investigation of a follow up variety.

Another finding in the current study was the absence of pure conduct disorder. It appears that Newfoundland children do not frequently display conduct problems and when they do informal methods of coping are employed.

This finding is illustrated clearly in the age distribution of children declared delinquent by the courts in 1973. Table 31.

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[2]Personal communication, M. Dickson, March, 1975.

[3]A. Boulton "The Anxious Child." British Medical Journal September (1972): 690-692.

TABLE 31

AGE OF CHILDREN DECLARED DELINQUENT WARDS, 1973
(PROVINCIAL FIGURES)[4]

Under Twelve Years	21
12 - 14 years	169
14 - 16 years	315
Total	505

Further, an attempt to review the records of Juvenile Court as a screening device proved inappropriate. In the St. John's area the referral of children under twelve years of age is so rare that official records on such cases are not maintained.

Reference to some of the cases of mixed disorder which were observed in current study reflect the types of coping methods which are employed in lieu of official intervention.

One boy, diagnosed as a stutterer also demonstrated serious associated conduct problems. His behavior included break and entry and the theft of money and goods. Although this offence was sufficient to warrant official charges it had been dealt with by an unofficial Police visit to the home of the child.

In several other instances of conduct problems family members had intervened with the injured party on behalf of the child.

In only one mixed disorder case had psychiatric help been sought, neither had any of the study sample children made an unofficial

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[4]Department of Social Services and Rehabilitation, Annual Report, 1973 p. 123.

appearance at Juvenile Court.

In view of the marked increase in the frequency of charged delinquency after twelve years (Table 31) it would be valuable to study the prevalence of psychiatric disorder in a sample of older children. It is probable that the etiology of conduct disorder in older children includes a tendency towards mixed disorder as a younger child.

The Test of The Methodology

The prevalence rates observed and the configuration of disorders evident in the current study leave little doubt as to the immediate need and value of a total population study.

It was originally hoped that the current study would provide a valid test of methodology for a later total population study. However, in view of the low response rate to screening efforts and the inefficiency of the screening instruments as diagnostic tools the results of the current study are not generalizable.

It is therefore imperative to obtain a sample which will provide valid and reliable pilot results.

Some administrative alterations may well improve the response rate to screening attempts.

The current study was required to employ a postal method of approach to parents. A study by Shepherd, Oppenheim and Mitchell in 1971[5] demonstrated that this method is the least efficient approach in terms of response. Table 32. The inclusion of additional postal

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[5]M. Shepherd et al. Childhood Behavior and Mental Health pp. 28-29.

steps further decreased the spontaneous response rate from a predicted 65% to an observed 25%.

TABLE. 32

APPROACH METHOD RESPONSE RATES

	Total	Number/ Lost en Route	Completed Returns	Non-Responders
Sample I Method - Sent by Post Directly to Parent, Postal Return	100	11 (11%)	55 (55%)	34 (34%)
Sample II Method - Sent by School to Parents - Postal Return	100	6 (6%)	85 (85%)	9 (9%)
Sample III Method - Sent by School, Thru Child, Returned via Child and School	137	Nil	131 (96%)	6 (4%)

It was also demonstrated in the current study, that a personal approach to parents served to elevate the response rate by 41%. The study population appeared more hesitant and skeptical than negative to the project. This study was the first survey of child behavior, and as far as could be determined the first survey of any kind attempted in the area. The population was totally unfamiliar with survey methods. This was reflected in the numerous requests for verbal assurances of anonymity and autonomy despite the fact that these assurances had been given in writing.

It is likely that other study samples which might be selected will be equally skeptical and unsophisticated in their appreciation of

survey techniques. It would seem that a better response rate could be obtained if personal canvassers, preferably people known to the population were to follow up those who did not respond to a survey instrument distributed through the schools.

However, in the current study this skepticism of survey techniques was also shared by the school authorities.

Several years prior to the current study in another geographical location, hostile public response had been aroused when a school survey had been conducted without the knowledge of the parents concerned.

As a consequence of this previous study, school principals, clergy and P.T.A. leaders were unwilling to give public support to the current project.

The present study provides proof that studies of this type can be conducted in a non-threatening manner. Hard core negative response was relatively low.

It is hoped that this will encourage school authorities to support similar investigations in the future.

A second methodologic problem which was evident in the results of the current study was the inefficiency of the screening instruments. The parental screening instrument detected only 48.71% of those finally diagnosed as having a psychiatric disorder and the teachers instrument detected 25.6%. Further, the teachers instrument detected a lower frequency of disorder present in 11/15 individual conduct and emotional items of deviant behavior which were common to both questionnaires. (Table 9).

It is possible that the inefficiency evident in the teachers ratings is due in part to the high pupil/teacher ratio present in the study schools (Table 4) and further by the fact that two of the study schools were operating multi-grade classrooms for a period during the life of the study.

It is probable that the absence of previous exposure of the raters to survey instruments contributed to the observed inefficiency. It is also likely that the increased frequency of emotional disorders and mixed disorders with a major emotional component, contributed to the inefficiency. Items concerning emotional symptoms are inherently subject to interpretation by the rater.

This type of inefficiency could be reduced by providing more specific coding instructions and by making an experienced investigator readily available for consultation.

It is also likely that the inefficiency of the screening instruments could be improved by modification of the cut-off scores on the screening instruments.

When the screening assessment of positive psychiatric diagnosis was compared to the final diagnosis accurate assessments had been made in 25/26 cases.

In view of this high degree of accuracy it is possible that the cut-off scores are too high for local conditions and are consequently producing an excess of type II error.

As part of a pilot project for a total population study the assessment of appropriate cut-off scores for the screening instruments would be essential.

Services for Children

Only when such a pilot and total population studies are complete should organizers attempt to extend and establish treatment facilities.

Prematurely designed services may be both inappropriate and harmful.

For example, if later studies verify the predominance of mild and moderate neurotic disorders, and the reduced sensitivity of parents and teachers to these problems is confirmed, then the major treatment task will be one of edueation. Parents and teachers will need sensitizing to the indicators of transient distress, and will also require education in how best to be supportive to the distressed child.[6]

If on the other hand a significant prevalence of conduct disorders in children over twelve years is detected, very different treatment orientations will be required. In view of the severity and prognosis of such disorders, early detection of those children now masked by parents and authorities will be essential. Effective intervention in such cases would likely require intensive, long-term individual treatment.[7] Such facilities are not available in this province at present, but could be expertly designed if appropriate to the needs of the children.

The time for conducting a total population study in this province is long overdue. The current study has demonstrated, that

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[6]A. Boulton The Anxious Child pp. 690-692

[7]P. Barker "Antisocial Behavior." British Medical Journal July (1972): 34-36.

with some modifications the available epidemiologic techniques are workable.

Nothing further is required but the interest and initiative of the professionals in the community. Anxious children need not suffer unnoticed and potentially salvageable children need not be permitted to drift into severe and permanent conduct disorders.

Summary and Conclusions

The specific aim of the current study was to detect the prevalence of child psychiatric disorder as found in a total population (416) of nine and ten year old children who attend school within the geographical area of Goulds-Kilbride, Petty Harbour Newfoundland.

Attempts were made to screen the total population for disorder according to the following steps:

1) Questionnaire completed by Parents
2) Questionnaire completed by the Teacher
3) Records search of existing agencies

The final response rate to these screening efforts was low; 66.58% (277). Of the 277 children assessed 53 (19.13%) were found to be "at risk" of having a psychiatric disorder.

A randomly selected sample of the "at risk" children together with an equal number of randomly selected normal children (matched for sex and denomination of school attended) were then assessed blindly as follows:

1) Interview with the Parent
2) Interview with the Child

3) Psychological Testing

From the accumulated information on the individually assessed children an overall psychiatric diagnosis was established for each child. Based upon these final global diagnoses prevalence rates of child psychiatric disorder were computed.

Evaluations of the methodology found the screening instruments to be inefficient diagnostic tools if used alone. The individual interview with the parent was found to be the single most efficient diagnostic tool. It selected 87.2% of those finally diagnosed as having a psychiatric disorder.

Thirty-nine of 277 children were observed to have a definite psychiatric disorder of some degree. Corrected for those likely to have been missed by the screening this provides a corrected prevalence rate of 21.12%. The major diagnostic categories observed were emotional disorder, 11.9% and mixed, conduct emotional disorder 7.09%. Other diagnoses established were as follows: stutter - 1, speech and language disorder - 1, adaptation reaction - 2.

A significantly increased tendency towards emotional disorder was observed among children the mothers of whom displayed certain neurotic symptoms. A similarly increased tendency towards mixed disorder was observed among children the fathers of whom displayed recent excessive weight and appetite loss.

The present study observed a generally high frequency of individual items of deviant behavior in the population at large.

A significantly increased frequency of emotional items of deviant behavior was observed among children from large families.

Individual deviant items showed a consistent sex trend preference. Conduct items were more common in boys while emotional items were more common in girls.

Social class was significantly associated with certain individual items of deviant behavior however no consistent trend of symptom type was noted nor did any one social class show a consistently high prevalence of deviant behavior.

A tendency was observed for children from lower classes to have lower I.Q. scores and for children of higher social class groups do have higher tested I.Q. scores.

From the results of the current study it can be concluded that a total population survey of child psychiatric disorder in the Province of Newfoundland and Labrador is both necessary and feasible.

Based upon the evidence obtained in the current study it is likely that the true prevalence rate of child psychiatric disorder is in excess of the observed 21.12%. Precise information concerning the nature and extent of these disorders is essential to the rational planning of new services.

The current study has demonstrated that the epidemiological techniques available, with some preliminary modification and testing would be productive tools for application in a total population study.

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APPENDIX A

DEFINITION OF TERMS USED IN THE STUDY

1) Child Psychiatric Disorder -- Child Psychiatric disorder was judged to be present when there was an abnormality of behavior, emotions or relationships which was continuing up to the time of assessment and was sufficiently marked or sufficiently prolonged to cause handicap to the child himself and/or distress or disturbance in the family or the community. (Rutter, M. et al., 1970).

2) Tri-axial scheme of Classification of Child Psychiatric Disturbance. (M. Rutter, D. Shaffer, and M. Shepherd, 1973).

CLINICAL PSYCHIATRIC SYNDROME

0.0	Normal Variation
1.0	Adaptation Reaction (Include pre-school management problems)
1.1	Battered baby syndrome.
2	Specific developmental disorder.
2.1	Hyperkinetic disorder
2.2	Speech and language disorder
2.3	Other specific learning disorder
2.4	Abnormal clumsiness ("Developmental dyspraxia")
2.5	Tics
2.6	Enuresis (as isolated disorder)
2.7	Encopresis (as isolated disorder)
2.8	Stuttering
3.0	Conduct Disorder
4.0	Emotional ("neurotic") disorder
5	Psychosis
5.1	Infantile (Childhood Autism)

5.2 Disintegrative
5.3 Schizophrenia
5.4 Other

6.0 Personality Disorder

7 Psycho-somatic Disorder

7.1 Failure to thrive
7.2 Obesity
7.3 Ulcerative Colitis
7.4 Peptic ulcer
7.5 Asthma
7.6 Migraine
7.7 Abdominal Pain
7.8 Other psycho-somatic syndrome

8 Other Clinical Syndrome

8.1 Acute confusional state
8.2 Dementia
8.3 Gilles de la Tourett's syndrome
8.4 Any other clinical syndrome

8.5 Manifestation of Mental Subnormality Only (but not including any of the listed syndromes).

9 N.K.

INTELLECTUAL LEVEL

Tests Administered:

Ravens Colored Progressive Matrices

Ravens Standard Progressive Matrices

I.Q. Score	Code
127 or above	0
111-127	1
100-111	2
89-99	3
80-89	4
79 or below	5
Untestable	8
Not Known	9

ASSOCIATED PHYSICAL DISORDER (PAST YEAR)

00	No known associated physical disorder
01	Disorder of the Kidney or Genito-urinary tract
02	Metabolic or Endocrine Disorder
03	Disorder of the Circulatory System
04	CNS disorder above the brain stem (excluding epilepsy)
05	Epilepsy or on acute convulsants
06	CNS disorder at brain-stem or below
07	Phenylketonuria
08	Very short stature (below 3rd. percentile)
09	Obesity (above 97th. percentile)
10	Neoplasm
11	Leukaemia
12	Asthma
13	Ulcerative Colitis
14	Disorder of Special Sense Organs (excluding squint)
15	Other somatic disorder

APPENDIX B

CORRESPONDENCE WITH PARENTS

April 5, 1973.

Michelle Williams
c/o Unit 1 - C
Janeway Child Health Centre
Pleasantville
St. John's, Newfoundland
722-5100 Ext. 216

Dear _____

I would like to ask for your help in securing some information which I think will be very important to Newfoundland. The information is about our nine and ten year old Newfoundland children.

I have worked for two years at the Janeway Children's Hospital helping to treat children with emotional or behavioral problems. During this time I have come to realize that our very small department must be missing many children who could benefit from treatment. In order to set up realistic services it is important to know how big the need actually is. I am now able to do some research to find out what our needs are. The survey which I am doing now is the first step in what I hope will be a province wide survey in a few years.

There are many characteristics which fit together to make each child a special person. We all know children who are shy and quiet, or talkative and active, or rough and tumble by nature. Very often children of all these types are found in a single family.

However, there are times when the nature of the child's personality can cause problems with friends, at home or in school. When this happens things can be done to help the child if the right people and services are available. It is uncommon that such problems develop. The rate is about 6 in 100 children. Because it is uncommon it is important to obtain the information on all the normal children so that we can be sure that we have not missed the ones who can be helped, that is why I need your aid.

I am asking every parent in the Goulds, Kilbride, Petty Harbour area; who has a nine or ten year old child, to fill out a short form. I am asking the help of the parents because they naturally know the child better than anyone else. Some of the questions cannot be answered by anyone other than the parents because like any information about health these things are personal.

Because some of the questions are personal your child's name will not appear on the form, I will be the only one who can identify the form, this is confidential and will be treated with due respect.

If you agree to help in this survey I would also like to ask your child's teacher to fill out a short form about his behavior in school and to review the records of various services such as medical records. Teachers will not be told any of the replies which you have made.

At the end of this screening survey, any child who appears to be in need of treatment will be given that opportunity, provided the parents wish that the child be treated. This would, of course, require that the professional people have an interview with the parents and the child in order to plan the best form of treatment.

I will also hope to write a report on my findings when the entire survey is completed. In this report I will talk only in general terms; identifiable individual examples will not be used.

I have discussed the plan of this survey with many people; Doctors, Nurses, School Boards, Supervisors of Government Departments, Clergy, School Principals, Teachers, and certain staff members of the Janeway Hospital. These people have all agreed that the study is needed and is worthwhile.

It is possible that we do not know about some children who have a disorder which we can help. This survey will find these children and we can offer the needed help.

The questions on the form are also very useful for picking out children who may develop a disorder. This survey will allow the professionals in this field to offer early treatment.

We think that this survey has a lot to offer parents and children, but success will depend upon your help.

If you are willing to participate please return the attached consent in the envelope provided. Time is important. When I receive your consent I will send the form immediately. I will be very grateful if you answer quickly.

If you would like any more information, please call me in care of the Janeway Hospital, 722-5100 Ext. 216.

I thank you in advance for your help.

Yours sincerely,

Michelle Williams.

I UNDERSTAND THE PURPOSE OF THE SURVEY AND I AM WILLING TO HAVE _____ INCLUDED IN IT. I WOULD LIKE TO HAVE A FORM SENT TO ME.

DATE: APRIL___ 1973

SIGNED: _____

c/o Unit 1C,
Janeway Child Health Center,
Pleasantville,
St. John's, Newfoundland

_____, 1973

Dear _____,

Thank you for returning the consent form indicating that you are willing to allow your child to participate in this study. Enclosed you will find the form which you requested. Please complete the form and return it to me. A stamped envelope is enclosed.

I remind you that the answers which you give to these questions are completely confidential, they will not be shared.

If you have any questions about the form please telephone me. The telephone number is 722-5100 ext 216.

Thank you again for your help. Please mail the completed form as soon as possible, time is important.

Yours sincerely,

Michelle Williams, B.A.

APPENDIX C

PARENTAL SCREENING INSTRUMENT

The parental screening instrument was scored according to a weighted points technique as follows:

SECTION	RATING	SCORE
Health Problems	Never	0
	Occasionally, but not as often as once per week	1
	At least once per week	2
Habits	None	0
	Yes - mild	1
	Yes - severe/frequent	2
Behavior	Doesn't Apply	0
	Applies Somewhat	1
	Certainly Applies	2

The scores were summed in order to obtain an overall score for psychiatric disturbance. A child was considered to be "at risk" of having a psychiatric disorder if his score on the parental screening was 13 or more. (Rutter, M. et al., 1970) By summing the scores for certain items on the questionnaire a subscore for emotional disorder (items; C,G,V,6,15) and conduct disorder (Items; III,3,13,17,18) could be calculated. The child was assigned a screening diagnosis on the basis of the configuration of these sub-scores.

STRICTLY CONFIDENTIAL

FOR OFFICE USE ONLY

SCALE A

TO BE COMPLETED BY PARENTS

Code _____ Date of Birth _____

HOW TO FILL IN THIS FORM

The questionnaire asks about various kinds of behaviour that many children show at some time. Please give the answers according to the way your child has been during the PAST 12 MONTHS.

HEALTH PROBLEMS

Below is a list of minor health problems which most children have at some time. Please tell us how often each of these happens with your child by putting an "x" in the correct box.

	Never	Occasionally, but not as often as once per week	At least once per week	FOR OFFICE USE ONLY
A. Complains of headaches	☐	☐	☐	☐
B. Has stomach-ache or vomiting	☐	☐	☐	☐
C. Asthma or attacks of wheezing	☐	☐	☐	☐
D. Wets the bed or pants	☐	☐	☐	☐
E. Soils or loses control of bowels	☐	☐	☐	☐
F. Has temper tantrums (that is, complete loss of temper with shouting, angry movements, etc.)	☐	☐	☐	☐
G. Had tears on arrival at school or refused to go into the building	☐	☐	☐	☐
H. Truants from school	☐	☐	☐	☐

HABITS. Please place an "X" in the box by the correct answer.

		FOR OFFICE USE ONLY
I. Does he/she stammer or stutter? .. .. .. ☐ No. ☐ Yes—mildly. ☐ Yes—severely.		☐
II. Is there any difficulty with speech other than stammering or stuttering? .. .. .. ☐ No. ☐ Yes—mild. ☐ Yes—severe.		☐
If "Yes", please describe the difficulty: _____		
III. Does he/she ever steal things? .. .. .. ☐ No. ☐ Yes—occasionally. ☐ Yes—frequently.		☐
If "Yes" (occasionally *or* frequently), does it involve		☐
☐ minor pilfering of pens, candles, toys, small sums of money, etc.		
☐ stealing of big things		
☐ both minor pilfering *and* stealing of big things		
Is stealing done	Is stealing done	☐ ☐
☐ in the home	☐ on own	
☐ elsewhere	☐ with other children or adults	
☐ both *in the home and elsewhere*	☐ sometimes on own, sometimes with others	
IV. Is there any eating difficulty? .. .. .. ☐ No. ☐ Yes—mild. ☐ Yes—severe.		☐
If "Yes", is it		
☐ faddiness		☐
☐ not eating enough		
☐ eating too much		
☐ other, please describe: _____		☐
V. Is there any sleeping difficulty? .. .. .. ☐ No. ☐ Yes—mild. ☐ Yes—severe.		☐
If "Yes", is it difficulty in		
☐ getting off to sleep		☐
☐ waking during the night		
☐ waking early in the morning		
☐ other, please describe: _____		

Below are a list of descriptions of behaviour often shown by children. After each statement there are three columns – "Doesn't Apply", "Applies Somewhat", "Certainly Applies". If your child definitely shows the behaviour described by the statement place an "x" in the box under "Certainly Applies". If he or she shows the behaviour described by the statement, but to a lesser degree or not so often, place an "x" under "Applies Somewhat". If, as far as you are aware, your child does not show the behaviour, place an "x" under "Doesn't Apply".

Please put one "x" against each statement.

STATEMENT	Doesn't Apply	Applies Somewhat	Certainly Applies	FOR OFFICE USE ONLY
1. Very restless, has difficulty staying seated for long	☐	☐	☐	☐
2. Squirmy, fidgety child	☐	☐	☐	☐
3. Often destroys own or others' property	☐	☐	☐	☐
4. Frequently fights or is extremely quarrelsome with other children	☐	☐	☐	☐
5. Not much liked by other children	☐	☐	☐	☐
6. Often worried, worries about many things	☐	☐	☐	☐
7. Tends to be on own—rather solitary	☐	☐	☐	☐
8. Irritable. Is quick to 'fly off the handle'	☐	☐	☐	☐
9. Often appears miserable, unhappy, tearful or distressed	☐	☐	☐	☐
10. Has twitches, mannerisms or tics of the face or body	☐	☐	☐	☐
11. Frequently sucks thumb or finger	☐	☐	☐	☐
12. Frequently bites nails or fingers	☐	☐	☐	☐
13. Is often disobedient	☐	☐	☐	☐
14. Cannot settle to anything for more than a few moments	☐	☐	☐	☐
15. Tends to be fearful or afraid of new things or new situations	☐	☐	☐	☐
16. Fussy or over-particular child	☐	☐	☐	☐
17. Often tells lies	☐	☐	☐	☐
18. Bullies other children	☐	☐	☐	☐

ARE THERE ANY OTHER PROBLEMS?

Signature: Mr./Mrs. _____

THANK YOU VERY MUCH FOR YOUR HELP

APPENDIX D

TEACHERS SCREENING INSTRUMENT

The teachers screening instrument was scored according to a weighted points technique as follows:

Teacher Rating	Score Value
0 - Doesn't Apply	0
1 - Applies Somewhat	1
2 - Certainly Applies	2

A child was considered to be "at risk" of having a child psychiatric disorder according to the teachers assessment if the sum of the score values was 9 or more. (Rutter, M, 1967b).

By summing the scores for certain items a sub-score for emotional disorder (Items: 7,10,17,23) and conduct disorder (Items: 4,5,15,19,20,26) could be calculated for the "at risk" children. The "at risk" child was then assigned a screening instrument diagnosis on the basis of the configuration of these sub-scores.

STRICTLY CONFIDENTIAL

FOR OFFICE USE ONLY

SCALE B

TO BE COMPLETED BY TEACHERS

Name of Child _____ Boy/Girl _____ School _____

Code _____

Date of Birth _____ Grade _____

Below are a series of descriptions of behaviour often shown by children. After each statement are three columns:— "Doesn't Apply", "Applies Somewhat" and "Certainly Applies". If the child definitely shows the behaviour described by the statement place a cross in the box under Column 2 "Certainly Applies". If the child shows the behaviour described by the statement but to a lesser degree or less often place a cross in the box under Column 1 "Applies Somewhat". If, as far as you are aware, the child does not show the behaviour, place a cross in the box under Column 0 "Doesn't Apply".

Please complete on basis of child's behaviour IN THE PAST 12 MONTHS.

Put ONE cross against EACH statement. Thank you.

STATEMENT	0 Doesn't Apply	1 Applies Somewhat	2 Certainly Applies	FOR OFFICE USE ONLY
1. Very restless, has difficulty staying seated for long	☐	☐	☐	☐
2. Truants from school	☐	☐	☐	☐
3. Squirmy, fidgety child	☐	☐	☐	☐
4. Often destroys or damages own or others' property	☐	☐	☐	☐
5. Frequently fights or is extremely quarrelsome with other children	☐	☐	☐	☐
6. Not much liked by other children	☐	☐	☐	☐
7. Often worried, worries about many things	☐	☐	☐	☐
8. Tends to be on own—rather solitary	☐	☐	☐	☐
9. Irritable. Touchy. Is quick to 'fly off the handle'	☐	☐	☐	☐
10. Often appears miserable, unhappy, tearful or distressed	☐	☐	☐	☐
11. Has twitches, mannerisms, or tics of the face or body	☐	☐	☐	☐
12. Frequently sucks thumb or finger	☐	☐	☐	☐
13. Frequently bites nails or fingers	☐	☐	☐	☐

STATEMENT	0 Doesn't Apply	1 Applies Somewhat	2 Certainly Applies	FOR OFFICE USE ONLY
14. Tends to be absent from school for trivial reasons	☐	☐	☐	☐
15. Is often disobedient	☐	☐	☐	☐
16. Cannot settle to anything for more than a few moments	☐	☐	☐	☐
17. Tends to be fearful or afraid of new things or new situations	☐	☐	☐	☐
18. Fussy or over-particular child	☐	☐	☐	☐
19. Often tells lies	☐	☐	☐	☐
20. Has stolen things on one or more occasions in the past 12 months	☐	☐	☐	☐
21. Unresponsive, inert or apathetic	☐	☐	☐	☐
22. Often complains of aches or pains	☐	☐	☐	☐
23. Has had tears on arrival at school or has refused to come into the building in the past 12 months	☐	☐	☐	☐
24. Has a stutter or stammer	☐	☐	☐	☐
25. Resentful or aggressive when corrected	☐	☐	☐	☐
26. Bullies other children	☐	☐	☐	☐

Is there anything else unusual about this child's behaviour?—or are there any other comments you would like to make?

Signature: Mr./Mrs./Miss

THANK YOU VERY MUCH FOR YOUR HELP

APPENDIX E

PARENTAL INTERVIEW

The Parental Interview as presented in this Appendix is exact in terms of content. However, due to thesis format restrictions the lay-out of the schedule has been altered.

Originally a booklet format was used. Questions and their corresponding answers and/or codings were located on facing pages rather than on consecutive pages as presented here.

PARENTAL

INTERVIEW

CODE: _____

INTRODUCTION TO PARENTS

Thank you for arranging to let me talk to you today.

As you know I am presently conducting a survey with many of the children . . . . .'s age who live in this area.

The questions which I would like to ask you concern the education, health and behaviour of children but in more detail than was included on the form which you so kindly completed for me.

We are hoping that the information which we will gather as a result of these questions will help us to pick-up some children who might benefit from some extra help with either education, health or behaviour.

Of course, all the answers which you give are confidential.

If, for some reason you would prefer not to answer any of the questions, please just say so and I will just record "not known".

N.B. Throughout this document the expression "he" when used herein and where the context requires, shall include the singular and plural, the masculine and feminine genders.

First of all I would like to get some details on yourself and the children.

How many children are there here? (sharing cooking facilities)
Record:

Who is the oldest?

I-1 Name	Sex	Age	Occupation	(Present/last grade & school) Education	Living in Household	Step/foster Adopted, Own Child

I-2 Altogether then there are ... children living here.

I-3 Have you any other children living away from home?

I-4 Then there is you, could you tell me your age?

☐☐ Age of wife

I-5 And your husband, how old is he?

☐☐ Age of husband

(If either dead:)

	Year of Death	Reason
Husband		
Wife		

I-6 How long have you been married now?

☐☐

Have either of you been married before?

I-7a [ ][ ] Number of marriages for husband

I-7b [ ][ ] Number of marriages for wife

(If no) Then all the children are your own, that is none of them are adopted or foster children.

(If yes) Are any of the children of a former marriage or marriages or are any of them adopted or foster children?

I-8 Total number of children in X's household regardless of age.

[ ][ ]

I-9 How many children have been born alive to X's mother?

[ ][ ]

Ordinal Position of X

(This should be rated according to the child's position in the family to all other children with whom he has shared the household for a period of 6 months or longer. Children residing in a foster home or residential setting should be rated in the natural family provided they have not been residing elsewhere for more than one year.)

I-10

0 - Only child
1 - Eldest
2 - Middle
3 - Youngest
4 - Other
5 - Twin
9 - Not known

[ ]

(If X's father/mother is alive and living in household, omit the following.)

If X's father/mother is dead:

I-11 When did he/she die? (if not already known)

I-12 When did you remarry? (if applicable)

If X's father/mother is alive but not living in the household ask:

Are you divorced?
Legally separated?
Living apart?

When did he/she stop living with you? Year ____

Does he/she see the children at all?

How often has he/she seen them during the past year?

I-13 Parental Situation: Status of Natural Parents of X

0 - Married and living together (include common law marriage)
1 - Unmarried
2 - Separated
3 - Divorced
4 - Widowed
5 - Other
6 - Adopted or fostered within 1 year of birth
9 - Not known

I-14 X Now Living With:

0 - Two natural parents
1 - Adopted child
2 - Natural mother only
3 - Natural mother and other parent substitute
4 - Natural father only
5 - Natural father and other parent substitute
6 - Other relatives
7 - Other non-relatives
8 - Institution
9 - Not known

Could you tell me your husband's occupation?

How long has he been working at this job?
(If job commenced during past year inquire?)

I-15 Paternal Employment

0 - Regularly employed
1 - Seasonally employed
2 - Casually employed
3 - Temporarily unemployed
4 - Long-term unemployment
9 - Not known

Home Circumstances

Now I need to know a little about the physical setting in which you live.
Is it a house or apartment which you have?

Do you own this place or are you renting?

Apart from you and your own family, is there anyone else living in your home, such as a boarder or relatives?

Has there been during the past 3 months?

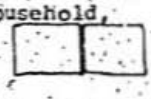
I-16a
0 - House unshared
1 - House shared with other household
2 - Apartment - in complex
3 - Apartment - in house
4 - Semi-detached house
5 - Other
9 - Not known



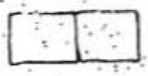
I-16b
0 - Own home
1 - Private rental
2 - Agency rental
9 - Not known



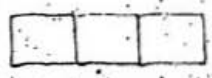
I-17 What is the total number of persons living in the household, sharing the facilities?



I-18 How many rooms are there in the house altogether?
Living room. Bedrooms. Kitchen.



I-19 Room/person ration expressed to one decimal place.



How do you arrange the rooms for sleeping?
Does X share his/her room or bed?

I-20 Sleeping Arrangements

0 - Child sleeps alone/own room
1 - Child sleeps with parents/own bed
2 - Parents room/parents bed
3 - Sleeps with sibs/own bed
4 - Sleeps with sibs/shares bed
5 - Shares bed with sibs/parents room
6 - Other arrangements/own bed
7 - Other arrangements/shares bed
9 - Not known



Facilities in House

Do you have - a fixed bath?
a kitchen?
running hot water?
running cold water?
an indoor toilet?
an outdoor toilet?

Do you share any of these facilities with anyone else?

Code: 0 - Present, not shared
1 - Shared
2 - Not present
9 - Not known

I-21a Bath
I-21b Kitchen
I-21c Running hot water
I-21d Running cold water
I-21e Indoor toilet
I-21f Outdoor toilet



Are you satisfied with your housing conditions?

What is this area like to live in?

I-22 How many years have you lived here now?



I-23 Satisfaction with housing and/or area

0 - No disatisfaction
1 - Slight disatisfaction
2 - Moderate dissatisfaction
3 - Marked disatisfaction
9 - Not known



Children's Health: G.P. CONTACTS

I need to find out some things about the health of each of the children, during the past year.

Has . . . . had to see a doctor for any reason?
(If yes) Why was this?

Has he/she been to see a doctor for any other reason?

What about check-ups?

Or to get regular prescriptions?

Has He been in any accidents?

Or anything else?

Has he taken any medicine during the past year which was prescribed by a doctor?

Has he had to take anything to help with sleep or for worrying during the past year?

(Record answers for each child probing to obtain clear information on contacts and reasons for the same. Determine whether the child has taken sedatives or stimulants?)

Code: 0 - No
1 - Yes
9 - Not known

I-24	Name	Medical Contact	Dubious Psychiatric	Psychiatric	Sedative or Stimulant
a.					
b.					
c.					
d.					
e.					
f.					

HOSPITALS AND CLINIC CONTACT (obtain information for each child)

Has . . . . ever had to go to the hospital during the past year?

Why was this?

To a clinic?
Emergency?
Inpatient
Special Tests?
How long was he/she there?
When was this?
Which hospital was it?
Have you ever had to take . . . . to see a specialist about behaviour or nerves or the like?

(Record hospital contacts during past year for each child - probe as indicated above.)

Code: 0 - None
1 - OP
2 - IP
9 - Not known

I-25 Name	Contact for Med. Reason	Contact for Dubious Psychiatric Reason	Contact for Psychiatric Reason	Contact for Psychiatric Reasons During Life to Date
a.				
b.				
c.				
d.				
e.				
f.				

(Again for each child)

Has he/she had to go to hospital for any reason when younger?

Has he/she ever been admitted to hospital?

(If yes) What for?
When?
How long did he stay?
Which hospital?
How did he react?

Has he ever been to a special clinic such as hearing clinic or speech therapy?

If Yes: What was it for?

When?

How many visits did the child make to the clinic?

Code: 0 - No contacts
1 - OP Contact
2 - IP Contact
3 - Not applicable
9 - Not known

I-26	Name	Medical Reason	Dubious Psychiatric	Psychiatric Reason
a.				
b.				
c.				
d.				
e.				
f.				

SEPARATIONS

You mentioned that . . . (child concerned) was admitted to hospital when he was . . . years old. (if applicable)

Has . . . ever been away from you or your husband for any (other) reason?

Such as: Your going to hospital i.e. pregnancy.

Your husband going to hospital?

Has he/she ever gone to stay with relatives or friends for a period of time?

Has your husband ever worked away from home?

During separation (if applicable) how was he/she cared for?

How did he/she react to separation?

To reunion?

How long was this separation?

How old was he/she?

(Note any separation of one week's duration or longer; for each such separation, record details as above.)

I-27 Separation - During Child's Life Span to Date

0 - None
1 - Father only 4/52 or more
2 - Mother only 4/52 or more
3 - Mother and father at different times, 4/52 or more
4 - Mother and father at same time, 4/52 or more
9 - Not known

I-28 Admissions - During Child's Life Span to Date

0 - No admissions
1 - Admission to hospital for only 1/52 or longer
2 - Admission to hospital and/or to an institution or to foster care for 1/52 or longer
9 - Not known

As I mentioned earlier we are particularly interested in obtaining some information about not only health and education of children but behaviour as well.

A. SPONTANEOUS COMPLAINTS

Is there anything in particular about . . . . . 's education, health or behaviour which has concerned you?

(If parent does not voice any spontaneous complaints, proceed to Section C - Systematic Inquiry.)

OR

(During this time the parent should be encouraged, do not probe. Continue to prompt with:)

Are there any other difficulties? (until the parent says no.)

(Record verbatim the parental description as far as possible)

List of difficulties:

Do you think that the difficulties which . . . has are more than most boys and girls his age experience, less or about the same?

A-1 Presence of Difficulties

0 - None
1 - Present but less than most
2 - About same as most
3 - Present and more than most
9 - Not known

What do you think is the cause of these difficulties?
Record verbatim:

A-2 Cause of Difficulties

0 - No difficulties
1 - Factors in child (other than heredity)
2 - Factors in school
3 - Factors in heredity
4 - Handling by parents
5 - Stress outside school
6 - Normal developmental phenomena
7 - Physical disorder in child
8 - Other (specify)
9 - Not known

B. DETAILED DESCRIPTION OF SPONTANEOUS COMPLAINTS

(It is necessary to obtain a detailed account of each item of behaviour formerly mentioned by the informant. The interviewer must not accept such statements as "he is jealous" or "he worries" but must determine the type of manifestation, the circumstances of the behaviour, severity, frequency and date of onset.)

I need to know some specific things about the behaviour which you mentioned earlier. (Taking each aspect of behaviour individually, probes could be as follows:)

What exactly does he/she do?

Would you describe it?

Does this happen at school, at home, away from home (friends, relatives)?

When was the first time you noticed it?

How often does it happen now?

What seems to bring this on?

What usually makes it better?

During the past year, have you noticed any improvement?

Or worsening? In what way?

For each item note: Example

Severity

Course over past year

Precipitant)
)Circumstances
Ameliorating)

Date of onset

Context

Coding for each item of behaviour:

Significant Abnormality for Child's Age

0 - No abnormality
1 - Possible (minor or doubtful)
2 - Definite
9 - Not known

B-1

B-2

B-3

B-4

B-5

(If any further coding required - number B-1/1, B-2/1, B-3/1 etc.)

C. SYSTEMATIC INQUIRY INTO RECENT BEHAVIOURAL & EMOTIONAL STATE

I am now going to ask some questions about numerous items of behaviour which children often show in various combinations and to various degrees.

(Proceed through questioning, omitting those already covered if any, and do not probe on items which have not been evident during the past year.)

For each item probe and note: Example, Severity, Precipitant factors, Ameliorating circumstances, Onset date, Context.

For judgment of abnormality code: 0 - No Abnormality noted
1 - Possible (dubious or minimal)
2 - Definite
9 - Not known

C-6 Does he/she ever have headaches?
(If yes) Are they severe headaches?

Does he/she ever become sick with them or do they affect his sight?

C-7 What about stomach aches? Does he/she ever complain of that?
(If yes) Does he/she ever vomit with them?
What time of the day is it most common?

Is there any change in frequency from week days to week-ends or holidays?

C-8 Does he/she ever have any trouble with breathing - such as asthma?
(If yes) How often does he have these attacks?

How do you have to deal with them in order to make it better?

C-6

C-7

C-8



C-9 Does he/she have any problem with his sight that you have noticed?

(If yes) When did you first find out about this problem?

Has he/she ever had his eyes checked?

(If yes) Does he/she wear glasses?

Were glasses prescribed?

C-10 How about his/her hearing?

Have you ever thought that he perhaps couldn't hear you?

Does he/she turn the radio, T.V., stereo on loudly, or do you ever have to repeat things for him ?

Has his hearing ever been checked?

(If yes) When? By Whom?

C-11 I need to know a little about his/her eating habits?

Have you ever been worried about this?

That he/she might be eating too much or too little or the wrong kinds of foods?

(If yes) Has he/she lost or gained weight?

C-12 How about eating inedible things?

C-9

C-10

C-11

C-12

C-13 What about his/her sleeping?

Do you have any trouble with it?

When he/she goes to bed, does he settle quickly?

Ever have any trouble getting him off to sleep or with him waking at night or in the morning quite early?

Do you ever have trouble awakening him/her?

What about nightmares? Or walking and talking in his sleep? Can you tell me about that?

C-14 Do you ever have any problem with him/her wetting the bed?

(If no) Does he/she ever have any accidents?

(If yes) How often does this happen?

Has he/she always wet the bed?

Was there ever a time when he/she didn't wet the bed?

What is the longest period which he has gone without wetting?

C-15 Does he/she ever wet his clothes during the day?

(If no) Does this ever happen as an accident?

(If yes) How often does he/she ever wet his pants?

Has he/she always done this or was there a time when he/she was dry all day?

What is the longest period during which he has been dry?

Does this happen away from home, such as at school or when visiting or playing away from home?

C-16 Does he/she ever soil himself or dirty his pants?

(If yes) Is there a particular time of the day when this happens?

How often does it happen?

Are there usually actual pieces of feces in his/her pants or is it mostly stains?

Has this always happened?

What is the longest period during which he was clean?

Circumstances?

C-13



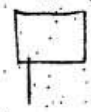
C-14



C-15



C-16



C-17 How active is he/she?

Would you say that he/she is unusually overactive or restless?

(If yes) How does he/she show this?

Can you get him/her to sit still when he is expected to. Such as at mealtime?

What is the longest time that you have seen him sit still with something interesting to do. Such as a T.V. show?

(If child is unable to sit still) Does he get upset if you insist that he must stay quiet?

C-18 Is he/she a fidgety child?

(If yes) How does he/she show this?

When does he/she fidget?

Are there times when there is no fidgeting?

C-19 What is his/her concentration like?

Would he spend as long as 3/4 hour at a stretch doing something interesting?

C-20 Do you find him/her to be more clumsy than other children?

Does he/she bump things or himself frequently?

What do you think causes this?

C-17

C-18

C-19

C-20

C-21 Is he/she right or left handed?

What about his feet? For example, when he hops on one leg which one is it?

If I were to kick a ball with him, which foot would he/she use?

C-22 What about his speech, does he speak as well as other children his age?

Does he/she ever have trouble expressing his ideas, such as finding the right words?

Does he/she have any trouble with pronunciation?

What about having a lisp? Stutter? Or using baby talk?

C-23 Does he/she have any habits? Such as blinking?

Or tics and mannerisms such as twitching or his/her face or shoulders?

C-24 Does he/she ever suck his thumb?

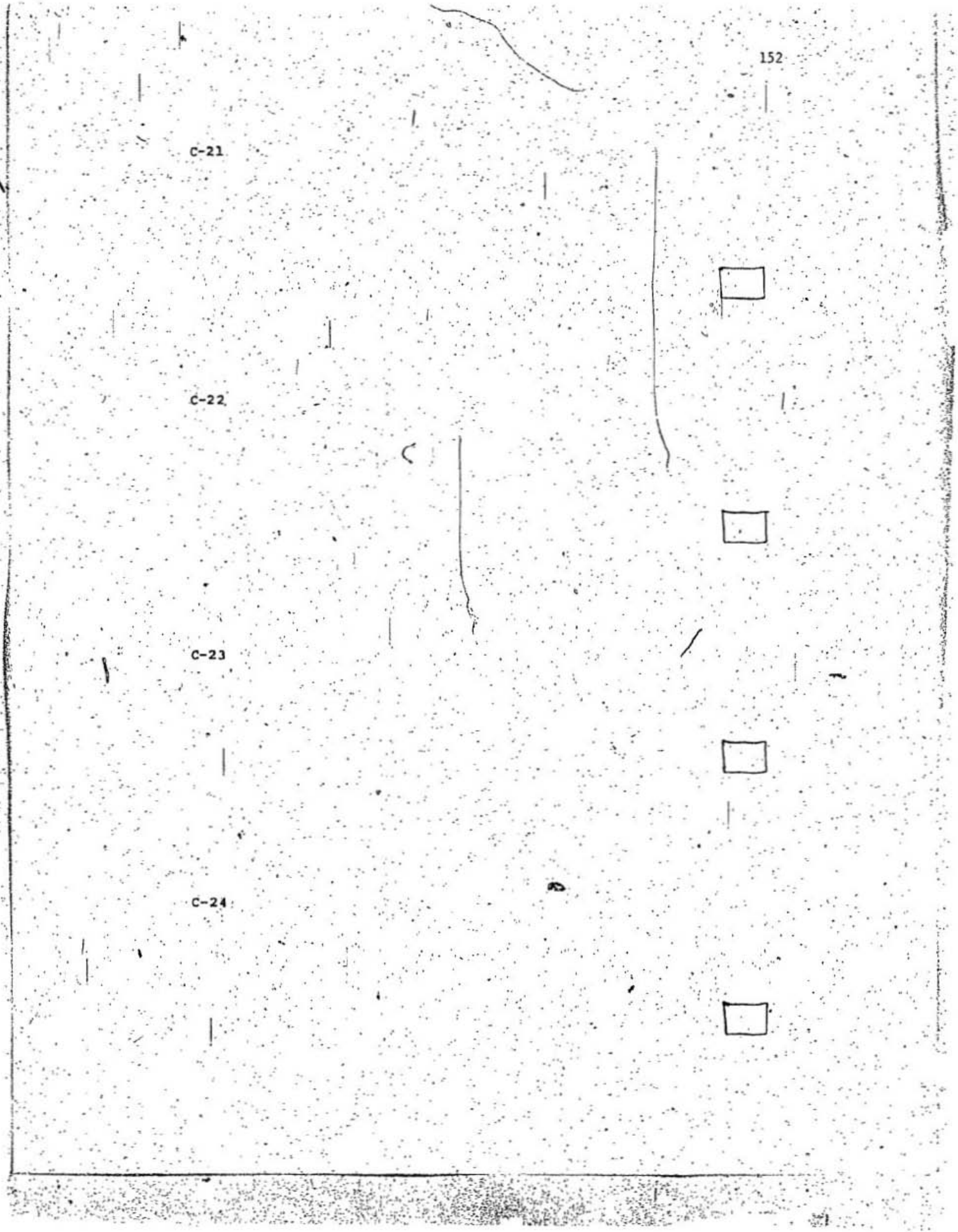
Does he suck anything else such as shirt collars, pencils or things like that?

(If yes) What does he suck?

How often?

Do you notice it at any particular time i.e. when going to sleep or worrying?

When did he/she start sucking his thumb?


C-21
C-22
C-23
C-24

C-25 Does he/she bite his/her nails?
Or chew on other things such as the tops of pencils?
(If Yes) What does he/she bite?
How often?

Does he/she bite her nails right down?
Do they ever bleed because of this?

Do you notice this at a particular time?
When did it start?

C-26 Does he/she have any other habits such as rocking while standing?

Or rocking while sitting?
Rocking while lying down?
What about banging his head? Has this ever happened?
(If yes) When did this begin?

Does it still happen?
How often?
In what situations?

C-27 Have you ever known him/her to have attacks of things?
(If yes) When was the last time this happened?

Would you describe the attack?
How many times did it happen during the past year?
What did you do about it?

Did he ever have a faint? fit? seizure? convulsion?
Petit Mal? (in each case repeat inquiry)

C-28 Do you think that he/she is most of the time a happy child or do you think that he is more often sad than happy?

(If unhappy) How does he/she show this?
How often is he/she like this?
Are there particular things which make him unhappy?

How miserable does he/she get?

C-25

C-26

C-27

C-28

C-29 Does he/she cry about things?

Do you think this happens more, less or about as often as with other children?

(If more) What sorts of things cause the crying?

Do you ever find that he/she cries for no reason?

Do you ever find that he/she goes away on his own to cry?

C-30 Has he/she ever tended to blame himself for things which you wouldn't really consider important?

C-31 Has he/she ever seemed so down in the dumps that he felt life wasn't worth living?

Has he/she ever threatened to harm himself?

Has he ever actually tried to do this?

Have you ever been worried that he might do such a thing?

C-32 Has he/she ever seemed to have the idea that people are against him?

(If Yes) Has he ever accused other people of things unnecessarily?

Has he ever expressed a fear that people were trying to harm him?

C-29

C-30

C-31

C-32

C-33 Has he/she ever behaved in a strange or unusual manner?
(If yes) Could you tell me about that?

C-34 Is he/she the type of child who worries about things?
(If yes) What does he/she worry about?

How often does this happen?
Does he worry more now than before, is this getting more serious?

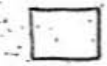
Does he/she ever worry so much that it interfered with his ability to function i.e. study? sleep? play?

C-35 Does he/she worry about his health at all?
Did he/she ever say that he might have an illness of some kind?

Does he ever have morning stomach pain?

C-36 Does he/she ever get irritable or cross with other people?
Do you find that he/she sulks?
(If yes) How does he/she show that he is cross?
What sorts of things cause him/her to behave this way?

C-33



C-34



C-35



C-36



C-37 Does he/she ever have temper tantrums?
(If yes) Can you describe them to me?
Does he scream? Or throw things?

How often does this happen?
What seems to cause them?
How do you usually deal with these?
How long do these episodes usually last?
Does this happen at other places besides home?

C-38 Do you find that he/she is fussy or particular?
Such as about what he eats, or how it is cooked, or his clothes?
How does he show this fussiness?

C-39 Are there things which he insists upon doing in a certain way?

C-40 Does he/she sometimes find himself doing things which seem silly, like touching things? Or washing his hands over and over again?

C-37





C-38



C-39



C-40



C-41 to C-51

Does he/she seem frightened in certain places or in certain situations?

For example: Some children become worried and upset before they go to school in the morning. Does this ever happen with him?

What about changing for gym at school in front of other people?

Or being in a crowd?

Or going to new buildings?

Meeting new people?

Being left alone in the house?

Frightened of the dark?

Some children are afraid of animals, is he/she?

What about insects?

Thunder and lightening?

Others?

(Obtain full details for each listed fear. Any spontaneously reported fears?)

Note: Example
Severity
Frequency
Course over past year
Precipitants
Ameliorating factors
Date of onset

Code each as follows:

0 - None
1 - Dubious
2 - Specific anxiety
3 - Situation specific panic attacks
4 - Avoidance because of anxiety
9 - Not known

C-41 Going to School

C-42 Changing Clothes

C-43 Being in Crowd

C-44 New Buildings

C-45 Meeting New People

C-46 Being Left Alone

C-47 The Dark

C-48 Animals

C-49 Insects

C-50 Thunder and Lightening

C-51 Other

C-52 to C-55
Does he have friends?
Does he/she mix with many children, or just a few, or one special friend?

How old are his friends? At home? In school?

Are his friends only friends at home or does he/she see them in school as well?

How often does he/she see his/her friends at home?
How often does he/she see his/her friends in school?

Record: Example
Severity and frequency
Course over last year
Precipitants
Ameliorating factors
Onset date
Circumstances

C-56 Is he/she a member of a crowd or a group of children who usually play together?

Is he a member of an organized group i.e. girl guides, boy scouts; organized sports?

When was the last time he/she participated with the group?

NUMBER OF PEER CONTACTS (past week)

		None	One	2-3	4-6	7+	Not Known
C-52	Home Friends	0	1	2	3	4	9
C-53	School Friends	0	1	2	3	4	9
C-54	Special Friend	0	1	2	3	4	9

C-55 Age of Peers

0 - Same age
1 - Younger
2 - Older
9 - Not known

C-56 Member of Gang or Organized Group

0 - Non - membership
1 - Dubious membership
2 - Definite membership (home group)
3 - Definite membership (school or organized group)
4 - Definite membership (both groups)
9 - Not known

C-57, C-58

Where does he/she usually meet his/her friends?
Do the other children seek him/her out; call for him/her?

Does he ever visit the home of friends?
Does he ever bring friends to your home?

C-59, C-60

What do you think of his/her friends?
Do you talk about this?

Have you ever had to ask . . . . not to play with certain children for any reason?

Were these his friends at "home" or at "school"?
(If yes) Did he/she do as you asked?

C-57 Visit to Friends House (past month)

0 - No visits
1 - Visit to home of "home" friend
2 - Visit to home of "school" friend
3 - Visit to home of "overlap" friend
9 - Not known

C-58 Visit of Friends to Child's Home (past month)

0 - No visits
1 - Visit to home by "home" friend
2 - Visit to home by "school" friend
3 - Visit to home by "overlap" friend
9 - Not known

C-59 Parental Approval of "Home" Friends

0 - No parental comment or approval only
1 - Parental disapproval but no restriction
2 - Parental disapproval with effective restriction
3 - Parental disapproval with ineffective restriction
9 - Not known

C-60 Parental Approval of "School" Friends

0 - No parental comment or approval only
1 - Parental disapproval but no restriction
2 - Parental disapproval with effective restriction
3 - Parental disapproval with ineffective restriction
9 - Not known

C-61 All in all how would you say that he/she gets on with other children?

Is he/she a good mixer or do you think that at times he would prefer to be on his own?

Do you think that with other children he is usually the leader or one of the followers?

C-62 Does he ever get teased by other children?

Do you think he gets teased more, less or about as often as other children?

(If yes) What does he usually get teased about?

Who usually teases him in this way?

What does he do when this happens?

C-63, C-64

Does he/she ever get bullied or picked upon by other children?

Do you think that he gets bullied more than most children, less than most or about the same?

Does he/she ever bully or pick upon younger children?

Has he/she ever gotten into trouble for this behaviour?

C-61 Overall Adequacy of Peer Relationships

0 - No abnormality reported
1 - Possible abnormality
2 - Definite abnormality
9 - Not known

C-62 Teased by Peers

0 - Not teased
1 - Teased but no more than other children
2 - Teased somewhat more
3 - Teased a lot more than others
9 - Not known

C-63 Bullied by Peers (past year)

0 - Not bullied
1 - Bullied but no more than most
2 - Bullied somewhat more
3 - Bullied a lot more
9 - Not known

C-64 Bullying other Children

0 - Doesn't bully other children
1 - Bullies but no more than others
2 - Bullies occasionally, no hitting
3 - Bullies other children marked by hitting
9 - Not known

C-65 Everyone feels lonesome once and a while. Does this ever happen to her/him?

(If yes) How often does that happen?

At what sorts of times?

C-66 to C-68 (If no sibs, omit this question)

How does he/she get on in general with his brothers and sisters?

Most families squabble among themselves, does he/she?

Is there anyone in particular with whom he squabbles?

Does the squabbling ever become serious enough for blows?

Is there anyone of his brothers or sisters to whom he is particularly attached?

Do you think he/she is particularly jealous of one of the other children?

(If yes) How does he show the jealousy?

When did he start to be jealous of this child?

C-65 Loneliness

0 - Never felt
1 - Occasionally
2 - Frequently
9 - Not known

C-66 Squabbling

0 - Does not squabble
1 - Squabbles as part of group
2 - Squabbles (is the initiator)
3 - Squabbles (is the recipient)
9 - Not known

C-67 Jealousy

0 - No jealousy reported
1 - Mild, general sibling jealousy
2 - Moderate jealousy of one or more sibs
3 - Marked jealousy of one or more sibs
9 - Not known

C-68 Relationship with Siblings

0 - No abnormality noted
1 - Possible abnormality
2 - Definite abnormality
9 - Not known

C-69, C-70

How do you find that . . . . . gets on with you?

Will he/she usually obey you when you speak to him/her?

Do you find that he/she is an affectionate child with you?

(If yes) How does he/she show you that he loves you?

C-71, C-72

How about with your husband, does . . . . . get on better, worse, or about the same with him as he/she does with you?

Do you think he/she would obey your husband quicker than you? Or slower? Or about the same?

Is he/she affectionate with your husband?

(If yes) How does he/she express this?

C-69 Undue Disobedience to Mother

0 - None reported
1 - Possible
2 - Definite
9 - Not known

C-70 Affection

0 - Does not express affection
1 - Affection verbally expressed
2 - Affection non-verbally expressed (giving gifts, doing tasks)
3 - Affection expressed verbally and non-verbally
9 - Not known

C-71 Undue Disobedience to Father

0 - None reported
1 - Possible
2 - Definite
9 - Not known

C-72 Affection

0 - Does not express affection
1 - Affection verbally expressed
2 - Affection non-verbally expressed
3 - Affection expressed verbally and non-verbally
9 - Not known

C-73, C-74

How do you find that he gets along with other adults, such as neighbors and teachers?

Have you ever received complaints about him/her?

(If yes) What were the complaints about?

How often were complaints received?

From whom were the complaints heard?

C-75 Have you ever found . . . to be a destructive child over his/her belongings?

Has he ever damaged other peoples things?

Have you ever received complaints that he/she is destructive?

How often does this happen?

C-76 Many children are fascinated by fire and sometimes light matches and play with fire; did you ever know him/her to do this?

(If yes) How often did this happen?

Was he/she on his own or with other children?

Where did the event take place?

Did the fire do any damage?

How did you deal with that?

C-73 Relationship with Adults

0 - No abnormality noted
1 - Friendly but not cheeky with adults
2 - Over friendly, cheekiness reported
3 - Definite disinhibition with adults
9 - Not known

C-74 Relationship with Teachers

0 - No abnormality reported
1 - Possible abnormality (all teachers)
2 - Definite abnormality (all teachers)
3 - Possible abnormality (specific teacher)
4 - Definite abnormality (specific teacher)
9 - Not known

C-75 Destructiveness

0 - None reported
1 - Possible destructiveness
2 - Definite destructiveness of own property
3 - Definite destructiveness of others' property
9 - Not known

C-76 Fire Lighting

0 - Never
1 - One occurance out of curiosity, no damage
2 - One occurance, serious damage
3 - Two or more occurances, no damage
4 - Two or more occurances, serious damage
9 - Not known

C-77 Have you ever found . . . telling lies?
What sort of lies were they?
In what circumstances?
Does he/she lie to other people?

C-78 Have you ever had any trouble with him/her bringing home things which don't belong to him/her?
Has he/she ever stolen anything at home?
(If yes) How often?
Did it happen at home? School? Shops?
Was he/she on her own or with other children?
How did you deal with this?
What did he/she do with the things he/she had stolen?

C-79 Have you ever had any trouble with him/her playing hooky from school?
Has he/she ever wandered away from home and stayed away late?
(If yes) When?
In what circumstances?
Was he/she on her own or with someone else?
Where did he/she go?

C-80 Many children threaten to run away from home. Has he/she ever done this?
(If yes) Has he/she ever actually prepared to go or actually left?
(If yes) When?
How often has this occurred?
In what circumstances?
Where did he/she go?

C-77 Lying

0 - Never
1 - Occasional (fib or white lie)
2 - Frequent (fib or white lie)
3 - Occasional serious lie
4 - Persistant serious lying
9 - Not known

C-78 Stealing

0 - None reported
1 - Occasional minor pilfering
2 - Frequent minor pilfering
3 - Infrequent serious theft
4 - Frequent serious theft (no police)
5 - Frequent serious theft (police contacted)
9 - Not known

C-79 Truanting or Staying away late

0 - Never
1 - Once for a period of less than 5 hours
2 - Once for a period of more than 5 hours
3 - Twice or more for less than 5 hours
4 - Twice or more for more than 5 hours
9 - Not known

C-80 Running away from home

0 - Never
1 - Threatened only
2 - Threat coupled with preparation
3 - Actual abscondance for less than 5 hours
4 - Abscondance for more than 5 hours
9 - Not known

C-81 Has he/she ever given you any cause to suspect smoking?
Drinking? Drugs?
(If yes) When?
How often?
What circumstances?
How dealt with?
On own or with others?

C-82 Has he/she ever been in any trouble with the police?
Has he/she ever been to court for any reason?
(If yes) Obtain details:

C-83 (If Girl) Have her periods started yet?
When did they begin?
OR Are there any other signs of puberty yet, such as breast development or body hair?
(If Boy) Has he begun to develop body hair yet?
In his armpits? Around his privates?

C-84 Has he/she taken any interest in the opposite sex?
How shown?
Are there any difficulties for you or him/her with this?

C-81 Smoking, Drinking, Drugs

0 - No experience of any of above
1 - Possible experience, peer group related
2 - Definite experience, one alone
3 - Definite experience, two or three
9 - Not known

C-82 Police Contact

0 - Never
1 - Police contact only
2 - Police contact and court appearance
3 - Court appearance only
9 - Not known

C-83 State of Puberty

0 - Prepubertal (no signs reported)
1 - Pubescent
2 - Pubertal (if girl, periods begun)
9 - Not known

C-84 Describe details:

C-85 Have you ever told him/her anything about sex, or where babies come from?

Do you think he/she knows?

Where did he/she find this out, do you think?

C-86, C-87

I would like to ask you some questions concerning . . . education and schooling.

Which school does he attend?

Do you think that . . . . is doing as well as other children his/her age with their school work, not so well as other children or better than other children?

How does this compare with his performance last year?

C-85 Sex Information

0 - No information
1 - Information gleaned from parents
2 - Information gleaned from peers
3 - Information gleaned from school
4 - Other
9 - Not known

C-86 School Attended

0 - Not attending school
1 - Attending special service school i.e. Vera Perlin, C.P. School School for the Deaf
2 - Primary School
3 - Elementary School
4 - Junior High School
5 - High School
6 - Special Class in Regular School
7 - Other, specify:
9 - Not known

C-87 Parental Evaluation of Performance

0 - Average performance
1 - Exceptional performance
2 - Good performance (better than ever)
3 - Below average previous performance
4 - Below average performance of other children his/her age
5 - Poor performance, failure
9 - Not known

C-88 Have you ever had any contact with his/her school or teacher?

Was this at a PTA meeting, or Parents Night or at another time?

Who made the move to get in touch, you or the teacher?

C-89 Has he/she ever had any difficulties at school which you know about? (past year)

Behavioural problems - having to be disciplined because of rule infraction?

Academic problems - such that he has needed extra help in some area?

C-90, C-91 (IF YES TO C-89)

What was done about these difficulties?

What was the course of the problem as a result of intervention?

C-88 Parent-Teacher Contact

0 - No contact
1 - General PTA only
2 - Parents Night only
3 - Interview precipitated by school
4 - Interview precipitated by parent
5 - Combination of above
9 - Not known

C-89 Parental Knowledge of Problems

0 - No difficulties
1 - Difficulties of behavioural sort
2 - Difficulties of academic sort
3 - Combination of both
9 - Not known

C-90 Form of Management of Difficulty

0 - No difficulties reported
1 - Nothing done
2 - Referral to school medical office
3 - Referral to Public Health Nursing
4 - Referral to other medical source
5 - Referral to guidance department
6 - Recommended additional tuition
7 - Special class placement
9 - Not known

C-91 Efficacy of Management

0 - No difficulties
1 - No referral
2 - Referral without pursuit
3 - Worse
4 - No change
5 - Slightly improved
6 - Much improved
7 - Recovered
9 - Not known

C-92 to C-94

Has . . . ever attended any school other than this present one?

(If yes) What were the names of the other schools?

Why did he/she change schools?

Compared to this present school, did the child get on better, worse or about the same since move, behaviourally or academically?

Record: Number of and Names of various schools

C-92 Reason for School Change

0 - No school change since started school
1 - Natural progression through local educational system
2 - Family moved to different school district
3 - Parent precipitated change because of disatisfaction with child's academic progress or the school itself.
4 - School precipitated change in attempt to effect appropriate placement
5 - Other, specify:
9 - Not known

C-93 Comparative Achievement - Academic

0 - No preceptible difference
1 - Deterioration of academic performance
2 - Improvement of academic performance
9 - Not known

C-94 Comparative Achievement - Behaviour

0 - No perceptible difference
1 - Deterioration of behaviour
2 - Improvement of behaviour
9 - Not known

D. PERSONAL HISTORY

D-95 I need to know some things about . . . .'s personal history, your pregnancy and delivery.

Did you have any complications with the pregnancy or delivery?
Probe: Were instruments used?
Any exposure to infections ie. V.D.
Vaginal
German measles

Diabetes?
Toxemia of pregnancy?
Threatened abortion?
Breech delivery?
Placenta previa?
Cording of baby?
Prolonged labour?
Induced birth?
Caesarian section?
Rh factor?
Twinning?
First birth?

D-96 Was he/she born at home or in hospital?
(If at home) Who attended the birth?
(If in hospital) Which hospital was it?

D-97 Was he/she a full term baby?
Premature?
How many weeks?
Late? How many weeks?
Who decided the baby was premature? (mother, doctor, other)

D-95 Complications of Pregnancy

0 - No abnormality
1 - Dubious
2 - Definite
9 - Not known

D-96 Location of Birth

0 - Home alone
1 - Midwife or doctor attending at home
2 - Hospital admission
3 - Other, specify:
9 - Not known

D-97 Maturity

0 - Full term
1 - Premature (1-3 weeks)
2 - Premature (4+ weeks)
3 - Post mature (1-3 weeks)
4 - Post mature (4+ weeks)
9 - Not known

D-98 How much did the baby weigh when he/she was born?

Where was he/she weighed?

D-99 How was your health during and after the baby was born?

Did you have to take any medicine while you were pregnant?
(If Yes) What was the medicine for?
Was it prescribed by a doctor?
How long did you take the medicine?

NEONATAL PERIOD

D-100.1 Did he/she have any problems breathing or sucking or keeping food down?

(If Yes) Did he ever appear to turn blue?

Were there times when he appeared to be gagging?

D-100.2 Did he have any convulsions shortly after birth?

D-98 Weight at Birth (record)

D-99 If health poor give details:

NEONATAL PERIOD

D-100.1 Description

0 - No abnormalities
1 - Dubious abnormality
2 - Definite abnormality
9 - Not known

D-100.2 Convulsions

0 - None
1 - Dubious form of behaviour
2 - Definite, present during neonatal period
9 - Not known

D-100.3 Was he/she jaundiced in the time after birth?
(If yes) How long did it last?

Was it necessary for the baby to get transfusions?

D-101 Was he/she a breast fed child or bottle fed?
(If combination ascertain the duration of each feeding method.)

When was he/she weaned?

Were there any difficulties with weaning?

Were there any difficulties with feeding in general?

D-102 Did you find him to be a placid or active child in infancy?

Did he cry a lot, more than usual?

How did he react to you when he was offered comfort or attention such as when you came to change him?

D-100.3 Jaundice

0 - Not present
1 - Dubious
2 - Present but not warranting transfusion
3 - Present and needing blood transfusions
9 - Not known

D-101.1 Feeding (Method)

0 - Breast fed
1 - Bottle fed
2 - Combination of breast and bottle feeding
9 - Not known

D-101.2 Feeding Abnormality

0 - No abnormality evident
1 - Abnormality with feeding (lasting more than 1 month)
2 - Abnormality with weaning
9 - Not known

D-102

0 - No report of abnormality
1 - Mother felt that child did not respond
2 - Mother did not remember

MILESTONES

D-103.1 I need to know a few items about his/her development.

Can you tell me how old he/she was when he could sit alone on a flat surface?

Record:

D-103.2 How old was he/she when he could walk on his own, without help?

Record:

D-103.3 How old was he/she when he could say single meaningful words?

Record:

D-103.4 How old was he/she when he used 2-3 word phrases?

Record:

D-103.5 How old was he/she when he could stay dry all day and all night?

Record:

D-103.1 Sitting

0 - No abnormality (sat unsupported before age of ten months)
1 - Abnormality evident
9 - Not known

D-103.2 Walking

0 - No abnormality (walked unsupported before age of 20 months)
1 - Abnormality evident
9 - Not known

D-103.3 Single Meaningful Words

0 - No abnormality (words with meaning used before 24 months)
1 - Abnormality evident
9 - Not known

D-103.4 Word Phrases

0 - No abnormality (2-3 word phrases used before age of 30 months)
1 - Abnormality evident
9 - Not known

D-103.5 Urine Continence

0 - No abnormality (fully continent of urine before the age of 5 years)
1 - Abnormality evident
9 - Not known

D-103.6 How old was he/she when he could keep his bowels controlled by day and by night?

Record:

D-103.7 How does he/she compare on these things to the other children in your family.

Earlier? Slower? Or about the same?

D-104.1,.2,.3

Did he/she have any disorders of eating or sleeping or disorders of any other kind during the first two years of life?

(If yes) What sort of difficulty was it?

How long did it last?

How was it dealt with?

D-103.6 Feces Continence

0 - No abnormality (fully continent of feces before the age of 4 years)
1 - Abnormality evident
9 - Not known

D-103.7 Comparison with Sibs

0 - Development comparable to sibs
1 - Development more favourable than sibs
2 - Development less favourable than sibs
3 - No siblings
9 - Not known

D-104.1 Disorder of Eating

0 - None reported
1 - Disorder evident (duration of one month or more)
9 - Not known

D-104.2 Disorder of Sleeping

0 - None reported
1 - Disorder evident (duration of one month or more)
9 - Not known

D-104.3 Other Disorders

0 - None reported (other than eating & sleeping)
1 - Disorder evident (duration of one month or more)
9 - Not known

E. FAMILY HEALTH

The next group of questions which I would like to ask concern the health of you and your husband. These questions are important because of the effect which parents' health has upon their children.

For each of these questions, responses should be probed with such questions as: 1. Examples
2. Severity and frequency
3. Course over last year
4. Precipitating circumstances
5. Ameliorating factors
6. Date of onset

E-105.1,.2,.3

What has your husband's general health been like during the past year?

Has he had to see a G.P. for any reason?

(If so probe as above)
Check-ups?
Regular prescriptions?
Accidents?

E-105.1 G.P. Visits for Medical Reasons

0 - No visits to G.P.
1 - Visits for non medical reasons
2 - Visits for medical reasons
9 - Not known

SPECIFY:

E-105.2 G.P. Visits for Dubious Psychiatric Reasons

0 - No visits to G.P.
1 - No visits for dubious psychiatric reasons
2 - Visits for dubious psychiatric reasons
9 - Not known

SPECIFY:

E-1-5.3 G.P. Visits for Psychiatric Reasons

0 - No G.P. Visits
1 - No visits for psychiatric reasons
2 - Visits for psychiatric reasons
9 - Not known

SPECIFY:

E-106.1,.2,.3

I've asked about contacts with G.P.'s; but what about hospitals?

Has your husband had to attend a clinic for anything in the past 5 years? Either as an outpatient or as an inpatient?

For things such as: accidents at work?
check-ups?
special tests?
to see a psychiatrist?
some other specialist?

(If Yes) Why was this?

When did it take place?

(If Hospitalized) How long was he in hospital?
Which hospital was it?

HOSPITAL/CLINIC CONTACT

E-106 Note details of any contact:

Code as follows:
0 - No contact
1 - Contact for these reasons: O.P. only
2 - I.P. contact only
3 - Both O.P. and I.P. contact
9 - Not known

E-106.1 Medical Contact

☐ Past 12 months

☐ Past 5 years

E-106.2 Dubious Psychiatric

☐ Past 12 months

☐ Past 5 years

E-106.3 Definite Psychiatric

☐ Past 12 months

☐ Past 5 years

E-107 Has your husband been off work during the past year because of illness?
(If Yes) When?
For how long?
How often occurred?
What was the trouble?
How managed?

Has he been off work for any other reason during the past year?
(If Yes) When?
For how long?
How often occurred?
What was the trouble?
How managed?

E-108 Has your husband had to take any pills or medicine of any kind during the past year?
(If Yes) What for?
How long taken?
Ever take pills to help with sleep?
Tonics?
Nerve pills of any kind?
(For depression or worrying?)

E-107 Illness - Work Loss

00 - Never or less than one week
96 - Not applicable, husband retired
97 - Not applicable, husband away altogether
98 - Not applicable, unemployment for another reason
99 - Not known

Number of weeks lost during the past year:

Due to illness

Due to unemployment for other reasons

E-108 Medications (duration more than one week)

0 - No medication taken
1 - Medication for medical reasons
2 - Medication for dubious psychiatric
3 - Medication for definite psychiatric
9 - Not known

E-109.1,.2

Is your husband the sort who worries?
Does he worry about the children?
Or his work?

Does he worry about his health? (During past year).
Has he ever wondered if he might have an actual disease?
(If Yes) What did he do?
Has he worried about other things?

(If Yes for any worry)

Has worry ever interfered with what he is doing?
Does it affect his concentration or work?
Or how he is at home?
Does worry ever interfere with his sleep?

E-110 Does he have any special sorts of fears?
Such as a fear of going out or of being alone, or of anything else?

(If Yes) Has he shown that he is afraid of . . . during the past year?
Has it interfered with his daily life such as stopping him from doing things?
i.e. going out? staying home?

E-111 Is he an anxious sort of person?
Have you ever known him to have periods of anxiety or panic?
(If Yes) Description?
Frequency?
Precipitating factors
Ameliorating factors
When was last episode?

E-109.1 Overall Worrying/Ruminations

0 - None
1 - Dubious
2 - Definite
9 - Not known

E-109.2 Hypochondriasis

0 - None
1 - Dubious
2 - Definite
3 - Delusions of a physical disorder
9 - Not known

E-110 General Fear, Anxiety or Nervousness

0 - None
1 - Dubious
2 - Definite
9 - Not known

E-111 Non-Situational Panic Attacks

0 - None
1 - Dubious
2 - Definite
9 - Not known

DEPRESSION

E-112.1,.2,.3,.4

Has he ever seemed to be depressed or miserable or fearful?

Has he ever said that life didn't seem worth living?
(If yes) How did he show this?
Did these feelings interfere with his daily activities or how he is with you or the children? Or his work?

Has he ever blamed himself for unimportant things?

Have you ever worried that he might harm himself?

Has he ever attempted to harm himself?

Has he ever felt that people were against him?

Or that they were looking at him, as people sometimes think when they are feeling low?

Has he ever been jealous of you or the children?

E-112.1 Misery/Unhappiness

0 - None
1 - Dubious
2 - Definite
9 - Not known

E-112.2 Suicidal Thoughts

0 - None
1 - Suicidal thoughts, method not formulated
2 - Method formulated
3 - Active steps but no attempt
4 - Suicide attempt
9 - Not known

E-112.3 Self-Deprecation

0 - None
1 - Tendency to run self down
2 - Self blame for trivia
9 - Not known

E-112.4 Tearfulness/Crying

0 - None
1 - Some
2 - Definite
9 - Not known

E-112.6,112.7

Could you tell me what your husband's appetite is like?

Have you noticed any change in his appetite recently?

What about his weight, has he lost lately?

E-112.8 How about his sleep, how has that been?

Any difficulty getting to sleep?
Waking during the night?
Waking early in the morning?

E-112.5 Feelings of Reference

0 - None
1 - Dubious
2 - Definite
9 - Not known

E-112.6 Loss of Weight

0 - None
1 - Loss of 0-7 lbs.
2 - Loss of 8+ lbs.
9 - Not known or gained

E-112.7 Loss of Appetite

0 - None
1 - Dubious
2 - Definite
9 - Not known

E-112.8 Sleep Disturbance

0 - None
1 - Dubious
2 - Definite
9 - Not known

OBSESSIONS

E-113.1,113.2

Do you find that your husband is a fussy or overparticular person?
How does he show this?
Is he particular about germs and cleanliness?
Does he tend to check things which he knows he has already done; such as check the stove or lights before going out, or the lock on the door at night?

Does he have a particular routine or order for doing things from which he will not deviate?

(If Yes) Example?
Severity?
Frequency?
Degree to which it interferes with family life?

OBSESSIONS

E-113.1 Compulsive Thoughts

0 - None
1 - Dubious
2 - Definite
9 - Not known

E-113.2 Obsessional Rituals

0 - None
1 - Dubious
2 - Definite
9 - Not known

MOTHER'S HEALTH

Now I need to obtain much the same information for yourself as I did for your husband concerning health.

These questions are very important because perhaps mother's health is more important to children than father's.

For each of the following questions probing should include:

1. examples
2. severity and frequency
3. course over last year
4. precipitating and ameliorating factors
5. date of onset

E-114 What has your own general health been like during the past year?

Have you had to see a G.P. for any reason at all?
(If Yes) Check-ups?
Regular prescriptions?
An accident?

E-114

E-114.1 G.P. Visits - Medical Reasons

0 - No visits to G.P.
1 - Visits for non medical reasons
2 - Visits for medical reasons
9 - Not known

E-114.2 G.P. Visits - Dubious Psychiatric

0 - No visits to G.P.
1 - No visits for dubious psychiatric reasons
2 - Visits for dubious psychiatric reasons
9 - Not known

E-114.3 G.P. Visits for Psychiatric Reasons

0 - No G.P. visits
1 - No visits for psychiatric reasons
2 - Visits for psychiatric reasons
9 - Not known

E-115 I have asked about contacts with G.P.'s, but what about hospitals and clinics?

Have you had to attend a clinic for anything during the past 5 years?

(If Yes) As an inpatient or outpatient?
For things such as: Accidents at work?
Check-ups?
Special Tests?
To see a psychiatrist?
To see some other specialist?

(If Yes) Why was this?
When did it take place?

(If Hospitalized) How long were you in hospital?
Which Hospital was it?

HOSPITAL/CLINIC CONTACT

E-115 Note details of any contact:

Code as follows:
0 - No contact
1 - Contact for these reasons O.P. only
2 - I.P. contact only
3 - Both I.P. and O.P. contact
9 - Not known

E-115.1 Medical Contact


During past 12 months


During past 5 years

E-115.2 Dubious Psychiatric


During past 12 months


During past 5 years

E-115.3 Definite Psychiatric


During past 12 months


During past 5 years

E-116 Have you been off work during the past year because of sickness?

(If Yes) When?
For how long?
How often occurred?
What was the trouble?
How manage daily routine?

Have you been off work for any other reason during the past year?

(If Yes) When?
For how long?
How often occurred?
What was the trouble?
How managed?

E-117 Have you had to take any pills or medicine during the past year?

(If Yes) What for?
How long taken?
Who prescribed?
Ever taken pills for sleep difficulty or depression or worrying, nerve pills? Tonics?

E-116.1 Illness - Work Loss

00 - Never or less than one week
96 - Not applicable, Mother unemployed
97 - Not applicable, Mother not employed for other reason
99 - Not known

E-116.2 Number of Weeks Lost During Past Year

Due to Illness ☐

Due to Other Reasons ☐

E-117 Use of Medications (duration more than 1 week)

0 - No medications taken
1 - Medications for medical reasons
2 - Medications for dubious psychiatric reasons
3 - Medications for definite psychiatric reasons
9 - Not known

☐

E-118 Would you say that you are the sort of person who worries?

Do you worry about the children?
Or your work?

Have you worried about your health at any time during the past year?

Have you ever wondered if you might have an actual disease?
(If Yes) Did you do anything about it?
Do you worry about other things?
(If Yes for any worry)
Has worry ever interfered with what you are doing?
Has it ever affected your concentration or work?
How are you with the other people at home?
Has worry ever interfered with your sleep?

E-119 Do you find that you have any particular fears?
i.e. of going out, or being alone, or anything else?

Have you been afraid of this during the past year?
Has this fear interfered with your daily living?
Does it keep you from doing things?

E-120 Are you an anxious sort of person?
Do you ever have times when you feel anxious or panicky?
(If Yes) Description?
Frequency?
Precipitating factors
Ameliorating factors
When last episode?

E-118.1 Overall Worrying/Ruminations

0 - None
1 - Dubious
2 - Definite
9 - Not known

E-118.2 Hypochondriasis

0 - None
1 - Dubious
2 - Definite
3 - Delusions of physical disorder
9 - Not known

E-119 General Fear, Anxiety or Nervousness

0 - None
1 - Dubious
2 - Definite
9 - Not known

E-120 Non-Situational Panic Attacks

0 - None
1 - Dubious
2 - Definite
9 - Not known

DEPRESSION

E-121- Do you ever sometimes feel miserable or depressed?

Do you ever feel so badly that you feel like crying?
Do you cry?

Have you ever felt that life doesn't seem worth living?
(If Yes) Have you ever wished you were somewhere else?
Have you ever wished that you were anywhere else?

Have you ever felt so badly that you felt like harming yourself?

Do you think that you might?
(If Yes) How?
Have you ever actually attempted to harm yourself?

Have you ever felt that people were against you?
Or that people were looking at you as we sometimes do when we are feeling down in the dumps?

Do you ever find yourself feeling jealous of your husband or the children?

DEPRESSION

E-121.1 Misery/Unhappiness

0 - None
1 - Dubious
2 - Definite
9 - Not known

E-121.2 Suicidal Thoughts

0 - None
1 - Suicidal thoughts, method not formulated
2 - Suicidal thoughts, method formulated
3 - Method formulated, actual steps taken
4 - Suicidal attempt
9 - Not known

E-121.3 Self-Deprecation

0 - None
1 - Tendency to run self down
2 - Self blame for trivia
9 - Not known

E-121.4 Tearfulness/Crying

0 - None
1 - Some
2 - Definite
9 - Not known

E-121.5 Feelings of Reference

0 - None
1 - Dubious
2 - Definite
9 - Not known

E-121 cont'd

Could you tell me a little about your appetite, is it good?

Have you noticed any change in your appetite lately?

What about your weight, has it changed recently?
Lost or gained?

How about your sleep, is it giving you any trouble?

Any trouble getting to sleep?

Waking during the night?

Waking early in the morning?

E-121.6 Loss of Weight

0 - None
1 - 0-7 lbs. lost
2 - Loss of 8+ lbs.
9 - Not known or gained

E-121.7 Loss of Appetite

0 - None
1 - Dubious
2 - Definite
9 - Not known

E-121.8 Sleep Disturbance

0 - None
1 - Dubious
2 - Definite
9 - Not known

OBSESSIONS

E-122 Do you think that you are a fussy or particular person?
(If Yes) How do you show this?

Are you fussy about germs or cleanliness?

Do you find yourself redoing things you know you have already done, such as check the stove or doors?

Do you ever find that you repeatedly do things which seem silly, like touching things even though you don't want to?

Do you have a particular daily schedule to which you stick faithfully?

(If Yes) Probe for example
severity & frequency
degree to which daily life is regulated because of this behaviour.

OBSESSIONS

E-122.1 Compulsive Thoughts

0 - None
1 - Dubious
2 - Definite
9 - Not known



E-122.2 Obsessional Rituals

0 - None
1 - Dubious
2 - Definite
9 - Not known



F. FAMILY LIFE

F-123 Another aspect which influences children is general family life routines and relationships.
I'd like to find out a little about how jobs are divided in the family?

Does your husband ever help with the children?

Who usually does the shopping, do your husband and the children participate in this?

How much does the rest of the family help with the housework? (For participation questions enquire as to frequency during the past week?)

Who usually makes decisions for the family, such as when you need to buy things for the home?
Are there any recent decisions which you think should have been made differently?

Do you and your husband talk much about day to day things, such as the news or your work?
What about talking over problems; are there things which you would like to discuss but cannot?

F-123 Describe pattern of family life and informants attitude noting: Example
Severity & Frequency
Course over past year
Precipitating and Ameliorating factors
Date of onset

IRRITABILITY WITH CHILD

F-124 Most children do things or want to do things with their parents, what does X like to do with you both?
When it is necessary to reprimand him/her who usually does it?

Most children do somethings which get on their parents nerves, what does . . . do that buggs you?
When this happens do you find that you become irritable with him/her?

How often would you say that happens?
When was the last time?
When this happens do you find that you lose control a little and bellow at him?
How does that make you feel?
How long would it carry on?
Do you ever become so irritated that it becomes more than bellowing?

(Obtain frequency and degree during past 3 months)

What about your husband? How often does he become irritable with . . . ?

IRRITABILITY WITH CHILD

F-124.1 Mother to child - Description:

F-124.2 Father to child - Description:

F-124.3 Irritable Acts

0 - Once a month or less
1 - More than once per month/up to once per week
2 - 2-4 times per week
3 - 5-7 times per week
4 - More than daily
9 - Not known

IRRITABILITY BETWEEN PARENTS

F-125 In most families there is usually some irritability between members.

How often would you say that you and your husband become irritable with each other?

What would you/he say?

What would you/he do?

What would it usually be about?

What things make you cross with him?

Him cross with you?

How often do you become cross with him?

How often he with you?

Q

F-125 Irritability - wife to husband
Description and Frequency (3 months):

Irritability - husband to wife
Description and Frequency (3 months):

F-125.1 Irritability of Wife to Husband

0 - Once/month or less
1 - More than once/month up to once/week
2 - 2-4 times/week
3 - 5-7 times/week
4 - More often than daily
9 - Not known/not applicable

F-125.2 Irritability of Husband to Wife

0 - Once/month or less
1 - More than once/month up to once/week
2 - 2-4 times/week
3 - 5-7 times/week
4 - More often than daily
9 - Not known/not applicable

F-126 Most families have quarrels or arguments from time to time. By this I mean other than the sort of irritability which we have been discussing.

Can you tell me what usually happens when you quarrel?
How long do they usually last?

When was the last time that you had such a quarrel?
What sorts of things do you usually say to each other?
Call each other names or make comments about each others families?

What about shouting or hitting?
Have you ever slept apart because of a quarrel?

(These probes are not necessary in full detail if their is clearly no applicability. However, the interviewer must check for difficulties in all ranges of severity i.e. from quarrels to fights using a flexible approach.)

F-127 Marital Relationship

It is necessary here to get the informant as involved as possible in the subject of his/her marriage. The free use of neutral probes will elicit feelings and attitudes.

How do you usually spend the evenings when you stay at home these days? What do you do?

Are there things which you and your husband particularly enjoy doing together such as:
Watching T.V.? Talking? Playing games(sports)? Hobbies?

Do you have an opportunity to get out together?
What do you do?
In general how would you say that you get on together?

F-126 Quarrels

(Must involve: shouting and/or
violence and/or
denigration of each other and/or
denigration of each others families and/or
not speaking for at least 1 hour and/or
negative talk for at least ½ hour.)

Describe:

No. of times during past 3 months when there was a quarrel. ☐

Nights slept apart through strain because of quarrels. ☐

F-127 Marital Relationship

Describe:

Coding: ☐

0 - No difficulties reported
1 - Dubious marital discord
2 - Definite marital discord
9 - Not known

F-128 Father's Occupation

I need to know a few more details concerning the occupation and education of the people in the family. Starting with your husband.

(Ask the following questions irrespective of current situation i.e. death of or separation from individual in question. Questions should be phrased appropriately)

What exactly is(was) your husband's job?
What precisely does he do?
Is he in charge of other people?
(If Yes) How many?
Did he have any further education after leaving school?
What sort?
Has he got a second job?
(If Yes) get details:

Does his work ever take him away from home overnight?
(If Yes) How often during an average month would he be away overnight?
Is that the same all year round?

F-128.3 Occupation Paternal Grandfather

What was your husband's father's job?
Is(was) he in charge of others?
(If yes) How many?

Did his work take him away from home overnight?

FATHER'S OCCUPATION

F-128.1 Working Hours

0 - Ordinary working hours
1 - Rotating shifts excluding nights
2 - Rotating shifts including nights
3 - Regular night work
4 - Unemployed
5 - Other
9 - Not known

F-128.2 Husband Away from Home

0 - Never or rarely away from home
1 - Away during week, return on weekend
2 - Away for less than one week/average month
3 - Away for more than one week/on average month on average for any reason
9 - Not known

128.3 Occupation Paternal Grandfather

0 - Never or rarely away from home
1 - Away during week, return on weekends
2 - Away for less than 1 week/month on average
3 - Away for more than 1 week/month on average for any reason
9 - Not known

DESCRIBE:

F-129 Father's Education

How far did your husband get in school?

Did he have any difficulties with reading or speech?

Did he have any trouble getting along in school?
i.e. Getting into fights?
Not getting on with teachers?
Not getting on with rules?

F-129 FATHER'S EDUCATION

F-129.1 Father's Education (completed)

0 - Grades 1-6
1 - Grades 7-9
2 - Grades 10-11
3 - University attendance
4 - University degree
5 - Technical school
6 - Fisheries College
7 - Other - specify:
9 - Not known

F-129.2 Academic Difficulties

0 - None
1 - Slight (failure of one grade)
2 - Definite (numerous failures)
9 - Not known

F-129.3 Other School Difficulties

0 - None
1 - Slight (minor infractions)
2 - Definite (major infractions leading to disciplinary action or expulsion)
9 - Not known

F-130 Mother's Occupation

I would now like to know about your work?
Have you had a job outside the home during past two years?
(exclude work done at home)

Do you have a job now?
Is it an all year round job?
Is it a full time or part time job?
(If applicable) When did you give up your job?

F-130 cont'd

What is your job?
What exactly do you do?
Are you in charge of others?
(If yes) How many?
Did you have any special education after leaving school?

What sorts of hours do you work?
Are you usually at home when . . . comes from school?
(If no) Who usually cares for him/her until you get home?

F-130.1 Employment Status (during past two years)

0 - Not employed, or employed for less than 1 month part time
1 - Employed for a period of 1 to 6 months
2 - Employed part time, six months or more
3 - Employed full time for period of 1 to 6 months
4 - Employed full time for six months or more
9 - Not known

F-130.2 Arrival Home After Work

0 - Mother has not worked for as long as one month
1 - Works, always at home when child returns from school
2 - Works, usually at home when child returns from school
3 - Works, sometimes at home when child returns from school
4 - Works, hardly ever home when child returns from school
9 - Not known

F-130.3 Care of Child

0 - Not applicable
1 - Inconsistent baby sitter (less than 18 years)
2 - Consistent baby sitter (less than 18 years)
3 - Inconsistent mother substitute (adult)
4 - Consistent mother substitute (adult)
5 - No special arrangement
9 - Not known

F-130.4 Maternal Grandfather's Occupation

What was your father's job?
Is(was) he in charge of others at all?
(If Yes) How many?
Did he have any special training after leaving school?
(If Yes) What?
Did his work ever take him away from home overnight?

F-131 Could you tell me how far you went in school?

Did you have any difficulties with speech or reading or anything else?
Did you have any difficulties getting along in school?
Such as: with the other children?
In getting on with teachers?
Or keeping the rules?

F-130.4 Maternal Grandfather's Occupation

0 - Never or rarely away from home
1 - Away during week, returns on weekends
2 - Away for less than 1 week/month on average
3 - Away for more than 1 week/month on average
9 - Not known

DESCRIBE:

F-131.1 Mother's Education (completed)

0 - Grades 1-6
1 - Grades 7-9
2 - Grades 10-11
3 - University attendance
4 - University graduation
5 - Technical college
6 - Fisheries College
7 - Other - specify:
9 - Not known

F-131.2 Academic Difficulties

0 - None
1 - Slight (failure of one grade)
2 - Definite (failure of numerous grades)
9 - Not known

F-131.3 Other Difficulties in School

0 - None
1 - Slight
2 - Definite (leading to disciplinary action or expulsion)
9 - Not known

F-132 Siblings Education

And finally, how are the other children in the family doing in school?

Have any of them had trouble learning how to read or speak?

Or in keeping up with the class progress?

Are they failing tests during the year?

Or failing grades?

Have any of the children been placed in a special class in school?

F-132 Siblings Education

0 - No siblings, or no difficulties with sibs
1 - One or more sibs have failed a grade
2 - One or more sibs have failed several grades
3 - One or more sibs have been placed in special education classes
4 - Other sibling(s) attending specialty school (i.e. Mentally retarded, C.P. etc.)
9 - Not known



F-133 CONDITIONS OF INTERVIEW

Describe:

F-133.1 Informant

0 - With mother alone
1 - With father alone
2 - With both parents together
3 - Any other informant
4 - Parents with child present
5 - Other informant with child present
6 - Other (specify)

F-133.2 Interview Setting

0 - Home of the subject
1 - House other than home of subject i.e. relatives house
2 - School setting
3 - Hospital setting
4 - Other (specify)

F-134 Duration of Interview

Minutes [ ]

Comments on Informant
(rapport, co-operative attitude, quality of information)

INFORMANT(S) _____

_____

INTERVIEWER _____

DATE OF INTERVIEW _____

NAME OF CHILD _____

CODE OF CHILD _____

EVALUATION OF PSYCHIATRIC STATE

G-135 Overall Assessment

0 - No abnormality
1 - Dubious abnormality
2 - Slight but definite abnormality and handicap
3 - Moderate abnormality and handicap
4 - Marked abnormality and handicap

G-136 Type of Abnormality

0 - No abnormality
1 - Anxiety or phobia state
2 - Depression
3 - Other neurotic disorder
4 - Mixed antisocial - neurotic disorder
5 - Antisocial
6 - Hyperkinetic syndrome
7 - Other - specify:
9 - Not known

SPECIFIC DIAGNOSTIC EVIDENCE:

CONCLUSION

As I mentioned in the beginning, there were a great many questions to which I needed to obtain the answers.

I want to thank you very much for being so patient and allowing me to use so much of your time.

Is there anything which you can think of that we haven't talked about which you think might be important?

After all these questions that I have asked you, is there anything which you would like to ask me?

(Answer questions concerning the nature of the study if necessary) i.e. Study of 9 and 10 year old children in schools to see if any extra services need to be established to help children.

If asked about available services give an outline of those available. Indicate that if necessary information obtained in the study will be made available for service needs if the parent is agreeable. Do not make evaluative assessment of need for service at this time.

Reassure if necessary about confidentiality.

Do not leave things behind.

APPENDIX F

CHILD

INTERVIEW

CODE: _____

Section 1 INTRODUCTION

The interviewer should introduce herself using first name as well as surname to the child and parent.

It should be explained to the child that he has come to see you for only a short while and that he will be returning home when the interview is complete.

He should be told that the time we spend together will be spent in conversation, playing games and performing some tasks.

At least 5 minutes should be allowed to be spent in waiting area.

Description of interview room i.e. location and that of washroom should be given.

Description of Child

Appearance:

Manner:

Style of dress:

Parent-child Interaction and Separation:

Describe if relevant i.e. parent present

Section II UNSTRUCTURED INTERVIEW

The first fifteen minutes of the interview are unstructured. The aim is to relax the child, put him at ease and to encourage him to talk freely.

Can you tell me your name?
What name do you like to be called?
May I call you . . . . . ?

Can you tell me how old you are?
Do you know when your birthday is?

What is the name of your school?
Which grade are you in at . . . . . School?

Can you tell me what games you like to play?
Who do you usually play with?

What else do you like to do besides games?

Do you have any brothers or sisters?
Can you tell me their names? (record)

What do you want to be when you grow up?

During this general conversation and throughout the interview note the degree of relationship which the child can form in such a setting; the level and lability of his mood; his conversational speech; and the range of emotions evident. The number and content of spontaneous remarks should also be noted.

The interview should be geared to the child's age, apparent intelligence and interests.

The examiner must be flexible in his approach to each child.

Section III SYSTEMATIC QUESTIONING

Peer Relationships

Do you have any friends?
Can you tell me their first names? (record)

What do you like to play or do with ... ... ?

Anything else?

How old are ... ... ?

When was the last time you played with them? Yesterday, last week, last month?

How often would you like to see your friends?

Do you see them and play with them enough?

1. Number of Peer Contacts

	None	One	2-3	4-6	Not known	
same sex	0	1	2	3	9	☐
opposite sex	0	1	2	3	9	☐

2. Frequency of Peer Contacts

0 - Observed and desired frequencies equal
1 - Observed frequency less than desired
2 - Desired frequency less than observed
9 - Not known

☐

3. Comparative Age of Peers to Child

0 - Child-peer group age consistent
1 - Peer group preponderantly older
2 - Peer group preponderantly younger
9 - Not known

☐

Do you have enough friends or would you like to have more?

How about at school, do you have friends there?

Do your friends at home go to your same school?

Do you ever see your school friends outside of school time?

Do you ever go to visit them at their house?
Do they ever come to visit you?

Do you have any special friend, like a friend that you could tell a secret to?
(If yes) Is that friend a "home" friend or a "school" friend?

4. Adequacy of Number of Friends

0 - No. of friends adequate - would not like more
1 - No. of friends adequate - would like more
2 - No. of friends inadequate - would like more
3 - No. of friends inadequate - would not like more
9 - Not known

5. Correspondence between "Home" Friends & "School" Friends.

0 - Same friends each setting
1 - Different friends each setting (without overlap)
2 - Different friends each setting (with overlap)
9 - Not known

6. Visits to Friends Home

0 - No visits made to friends in specified time span
1 - Visit to home of "school" friend
2 - Visit to home of "home" friend
3 - Visit to home of "overlap group" or visit to home of two friends from other foci of concern
9 - Not known

7. Visit of Friend to Child's Home

0 - No visits to child's home of friend within specified time span
1 - Visit of "home" friend to child's home
2 - Visit of "school" friend to child's home
3 - Visit of two friends from different foci of concern
9 - Not known

Most boys and girls get into fights with their friends sometimes. Do you ever get into fights?

When you do get into fights what are they usually about?

Do you think you get into those kinds of fights more often than most children, less often than most children, or about the same?

When was the last time that you got into a fight? Yesterday, last week, last month?

8. Frequency of Fights

0 - Never
1 - Less often than most children
2 - About the same as most children
3 - More often than most children
9 - Not known

9. Time Span since Last Fight

0 - No fights
1 - One day since last fight
2 - One week since last fight
3 - One month since last fight
4 - 5 weeks or more
9 - Not known

Who is usually the winner when you get into fights?

What about bullying, do you ever get bullied or picked on by the other children?

Do you think you get bullied more often than most children, less often, or about the same?

How does it make you feel when you get bullied or picked upon? (If this appears to be anxiety provoking to the child, pursue and record.)

10. Bullied by Peers

0 - Not bullied
1 - Bullied but no more than others
2 - Bullied somewhat more
3 - Bullied a lot more
9 - Not known

What about being teased, do you ever get teased by other children?

Do you get teased more by your "home" friends or your "school" friends?

Do you get teased more often than most children, less often, or about the same?

What do you usually get teased about?
(If child seems anxious about teasing, pursue and record verbatim.)

How does this teasing make you feel?

11. Teased by Peers

0 - Not teased
1 - Teased but no more than other children
2 - Teased somewhat more than most
3 - Teased a lot more than most

12. Overall Relationship with Peers

0 - No difficulty in relationships
1 - Slight difficulties in relationships
2 - Marked difficulties in relationships
9 - Not known

Most boys and girls and grown ups too feel lonely at times.
Do you ever feel lonely?
(If yes) How often does that happen?

What are the things that make you lonely?

What do you usually do when you feel lonesome?

13. Loneliness

0 - Never felt
1 - Felt infrequently
2 - Felt occasionally
3 - Felt often
9 - Not known

You told me earlier that you have .. brothers and .. sisters;
What is it like to live with them?

Most children in families squabble at times, does that ever happen with your brothers and sisters?

How often do you get into the squabbles?

What are the squabbles usually about?

Who usually wins?

Do you think that there are more squabbles in your family than most, fewer or about the same?

Out of all your brothers and sisters is there one with whom you squabble most often?
Why?

Is there one that you like best of all?
Why?

14. Frequency of Squabbles

0 - Never
1 - Less often than most families
2 - About the same as most families
3 - More than most families
9 - Not known



15. Time span since last Squabble

0 - Never
1 - One day
2 - One week
3 - 2-4 weeks
4 - 5 weeks or more
9 - Not known



16. Relationship with siblings overall

0 - No difficulties or trivial difficulties with siblings
1 - Slight difficulties or abnormalities in relationships
2 - Marked difficulties or abnormalities with relationships
3 - No siblings
9 - Not known



(If rating on Numbers 8 & 14 show higher frequency rates - Probe)

You have told me about the fights and squabbles that you get into. Who usually starts the fights?

Who usually wins?

Are they "real" fights or "friendly" fights?

Do you like fighting?

17. Overall Aggression

0 - Not evident
1 - Evident to a mild degree
2 - Evident to a moderate degree
3 - Evident to a marked degree
9 - Not known

18. Nature of Aggression

0 - Not evident
1 - Passive
2 - Verbal
3 - Physical aggression (defensive)
4 - Physical aggression (offensive)
9 - Not known

Most children get into trouble for things at some time. What sorts of things get you into trouble?
Probe: at school?
at home?
outside?

How does it make you feel when you get into trouble?
(If this appears anxiety provoking, pursue and record.)

Are there some things which you have gotten away with which might have gotten you into trouble?
What usually happens when you get into trouble at home?
Record:

On the whole, do you think that you get in trouble more often than most boys and girls, less or about the same?

19. Antisocial activities reported at school.

0 - None
1 - Minor disciplinary infringements only
2 - Occasional definite antisocial behaviour
3 - Frequent definite antisocial behaviour
9 - Not known

20. Antisocial behaviour reported at home

0 - None
1 - Minor disciplinary infringements only
2 - Occasional definite antisocial behaviour
3 - Frequent definite antisocial behaviour
9 - Not known

21. Antisocial behaviour reported outside

0 - None
1 - Minor disciplinary infringements only
2 - Occasional definite antisocial behaviour
3 - Frequent definite antisocial behaviour
9 - Not known

22. Reported frequency of antisocial behaviour

0 - No reported antisocial behaviour
1 - More frequent than most children
2 - Less frequent than most children
3 - About the same as most children
9 - Not known

If I was a "good fairy" and I told you that you could have three wishes. Each of the wishes would come true and you can wish for anything at all.

What would your wishes be?

Record: 1.

2.

3.

Let's pretend now that I am going to send you to an Island.

Do you know what an Island is.

Can you tell me? (If child isn't clear explain - A piece of land with water all around, like a piece of soap floating in a sink only much bigger.)

Well, now you are sent to this Island. On the Island there is a nice house for you to live in.

It is warm, and you can have anything that you want to eat and also lots of toys and things to do.

This is a nice place to be and you are allowed to take just one person with you to share the Island.

Who would you take?

Record:

23. Criticism of Mother by Child

0 - No critical remarks
1 - One or two critical remarks
2 - 3 or more critical remarks
9 - Not known



24. Criticism of Father by Child

0 - No critical remarks
1 - One or two critical remarks
2 - 3 or more critical remarks
9 - Not known



25. Criticism of Siblings

0 - No critical remarks
1 - One or two critical remarks
2 - 3 or more critical remarks
9 - Not known



26. Rejection of Mother

0 - No observable rejection
1 - Possible rejection
2 - Marked rejection
9 - Not known

27. Rejection of Father

0 - No rejection noted
1 - Possible rejection
2 - Definite rejection
9 - Not known

28. Rejection of Siblings

0 - No rejection noted
1 - Possible rejection
2 - Definite rejection
9 - Not known

You told me earlier that you go to . . . . . School.
Which grade are you in? (record)

What is it like to be in Grade ...?

How is the work?

Do you think that you find the work easier than most children, harder, or about the same?

Of all the subjects in school, which one do you like best? (record)

Which subject do you dislike most? (record)

What is your teacher's name? (record)

What is . . . . like all in all? (record)

Of all the teachers that you have had which one did you like best of all?

Have you ever gone to any other school?

(If Yes) What was the name of the school?

Why did you change schools?

Is this school nicer than the other one, not as nice, or about the same?

27i. Reported academic difficulties

0 - None - less difficult than most
1 - Slight or about the same as most
2 - Definite - more difficult than most
9 - Not known

28i. Criticism of school or teacher

0 - No critical remarks
1 - One or two critical remarks
2 - 3 or more critical remarks
9 - Not known

29. Rejection of school or teacher

0 - None
1 - Possible
2 - Definite
9 - Not known

30. Relationship with Teachers

0 - No abnormality
1 - Slight difficulties
2 - Marked difficulties
3 - Definite abnormalities
9 - Not known

Most people, both grown-ups and children have things that worry them.

Things which are worries are things that make you feel sad and that are hard to forget.

What sorts of things do you worry about? (record)

(If there is evidence of worrying pursue):

Is the worrying ever so bad that you can't get to sleep at night?

Do worries ever make it hard for you to think about other things, like in school; because the worries won't go away?

31. Overall worrying

0 - None
1 - Dubious
2 - Definite
9 - Not known

Do you ever worry about your health?

(If Yes) Have you ever felt that you might be physically sick?

What did you think the problem was?

Do you ever worry that you might become sick?

32. Hypochondriasis

0 - None
1 - Dubious
2 - Definite
9 - Not known

Do you ever feel nervous all over, or scared for no particular reason?

(If Yes) When did that happen last? 1 day, 1 week, 1 month?

Can you tell me about it, what it was like?

What were you doing to make this happen do you suppose?

33. Non-situational anxiety or panic

0 - None
1 - Dubious
2 - Non-situational specific anxiety
3 - Non-situational panic attacks
9 - Not known

Do you ever notice that you get scared or worried at certain things or in certain places? (record)

Are there certain things that frighten you? (record)

For example: Some children find going to school in the morning very hard.

34-1 Do you ever feel frightened about going to school?

34-2 How about changing into and out of your gym clothes in front of other children?

34-3 Or writing examinations in school?

34-4 Or being in a crowd?

34-5 Being in the dark?

34-6 Lots of boys and girls your age are afraid of animals - cats? dogs? mice?

34-7 How about insects and bugs?

34-8 Does thunder and lightening frighten you?

If the child reports fear obtain details and record them.
i.e. What does he do in the fearful situation.
It might also be useful to have the child imagine the anxiety provoking situation.

34. Situation Specific Anxiety

0 - None
1 - Dubious
2 - Specific anxiety
3 - Situation specific panic attacks
4 - Avoidance of situation because of anxiety
9 - Not known

Do you ever get so fed up with things that you feel unhappy or miserable?
(If yes) Can you tell me about those times. How do you feel? What causes these feelings?

Do you ever feel like crying?
Do you ever actually cry?
(If yes) Is there anyone that you can talk to when you feel that way?

Do these feelings ever get so that you want to run away?

Did you ever try to run away?
(If yes get details; why; where; with whom; why return?)

Do you remember the last time that you felt this miserable or unhappy?

35. Misery or Unhappiness

0 - None
1 - Slight
2 - Marked or very often
9 - Not known

36. Support when Unhappy

0 - None
1 - Minimal (immediate family)
2 - Minimal (other)
3 - Adequate (immediate family)
4 - Adequate (other)
9 - Not known

37. Running away

0 - Never
1 - Single effort
2 - 2-3 efforts
3 - 4 or more efforts
9 - Not known

38. Success of abscondance

0 - Not applicable
1 - Effort interfered with
2 - Threat without follow through
3 - Abscondance with spontaneous return
4 - Abscondance with search
5 - Abscondance for more than 5 hours
9 - Not known

Did you ever feel so unhappy that you wished you were somewhere else?
(If yes) Did you ever wish you were anywhere else?

(If yes) Have you ever felt like harming yourself?

(If yes) When? Can you tell me what you did when you felt that way?

39. Suicidal Ideas

0 - None
1 - Suicidal thoughts only
2 - Thoughts of method of suicide
3 - Active steps taken but no actual attempt
4 - Suicidal attempt
9 - Not known

Have you ever felt that what happens to you is not as important as the things which happen to other people.
That you don't matter very much?

40. Self-Depreciation

0 - None
1 - Slight
2 - Moderate
3 - Marked
9 - Not known

Most people dream at night. Do you ever dream?

Are they usually nice dreams or not nice dreams?

Can you tell me about one of your dreams?

Do you ever have difficulty getting to sleep at night?
(If yes) How long are you usually awake after you go to bed?

Do you ever find that you wake up during the night and have difficulty getting back to sleep?
(If yes) What do you think about when you are awake like that?

41. Disturbance of Sleep

0 - None
1 - Dubious
2 - Possible
3 - Definite
9 - Not known

Did you ever notice that you feel better in the morning than you do in the evening, or better in the evening than you feel in the morning?
(If Yes To Either) Why do you think that is so?

42. Diurnal Variation of Mood

0 - None
1 - Dubious
2 - Definite
9 - Not known

Can you tell me how your appetite is? Good? Average? Poor?
(If poor) How long has it been since your appetite was average or good?

Have you lost any weight in the last little while?
(If yes) How much?

When was the last time you weighed yourself?
Record:

How much did you weigh at that time?
Record:

43. Loss of Appetite

0 - None
1 - Dubious
2 - Definite
9 - Not known

Do you ever have trouble with your bowels? i.e. constipation or diarrhea?

(If yes) For how long?

44. Persistant Constipation

0 - None
1 - Dubious
2 - Definite
9 - Not known

Observations should be made throughout the interview for psychomotor retardation, depressed affect, preoccupation with depressive or anxiety topics, preoccupation should be evaluated in terms of comments spontaneously made by the child, the frequency of these should be noted as with the content and a coding made in the observation section of this schedule.

45. Obsessional Ruminations

0 - None
1 - Slight
2 - Marked
9 - Not known

Do you ever find yourself doing things which appear silly such as touching things like the walls or the doors?

Or washing your hands over and over again?

46. Obsessional Rituals

0 - None
1 - Slight
2 - Marked
9 - Not known

Sometimes when people are sad, they get to feeling that other people are looking at them; talking and laughing.

Do you ever feel like that?

(If yes) When was the last time that happened?

Do you think they were really talking (laughing) at you?

47. Ideas of Reference

0 - No ideas of reference
1 - Dubious
2 - Definite ideas of reference recognized as unfounded
3 - Delusional ideas of reference
9 - Not known

Do you ever have nasty thoughts in your head that won't go away?

Do you think that these silly/nasty thoughts are not your thoughts?

Do you ever feel like someone else has control of your thoughts and that you are not in charge of them?

Do you ever feel that some one is taking your thoughts away?

Do you ever hear voices when there isn't anyone else around?
(If yes) Is the voice a man's voice or a woman's voice?

Is it a voice which you recognize?

Where does the voice come from?

Can you tell me what it says?

Do you ever see things or people in places where you know they can not really be?
(If yes) When do you usually see these things?

Do they ever talk to you?
(If yes) What do they say?

48. Disturbance of Thought

0 - None
1 - Questionable
2 - Definite
9 - Not known

49. Evidence of Auditory Hallucinations

0 - None
1 - Questionable
2 - Definite
9 - Not known

50. Evidence of Visual Hallucinations

0 - None
1 - Questionable
2 - Definite
9 - Not known

Do you ever feel like you want to laugh for no particular reason?

What do you do when you feel that way?

Did you ever feel all of a sudden as if you wanted to cry?

When there wasn't really anything to cry over?

51. Disturbance of Mood

0 - None
1 - Questionable
2 - Definite
9 - Not known

Do you ever feel like you might like to do something but have trouble deciding whether or not you should?

(If yes) Can you give me an example?

52. Disturbance of Volition

0 - None
1 - Questionable
2 - Definite
9 - Not known

Can you tell me what day it is today and the date?

Where are you now? Place? City? Country?

Where were you just before I saw you?

Can you tell me where you live?

When they told you that you were coming to see Mrs. Sullivan, how did you go about getting from ,... to ...., ?

If you wanted to go from .... to ...., how would you get there?
(In this question try to use familiar land marks which would require the use of two modes of transportation.)

Can you tell me my name?
(If the child cannot respond, give name and repeat question after an interval of other questions.)

53. Disorientation of Time

0 - None
1 - Dubious
2 - Definite
9 - Not known

54. Disorientation of Place

0 - None
1 - Dubious
2 - Definite
9 - Not known

55. Disorientation of Person

0 - None
1 - Dubious
2 - Definite
9 - Not known

Section IV NEUROLOGICAL

We've talked for quite a while now. Perhaps you would like to do some things for me?
First of all I am going to measure you to see how tall you are.

Now we will find out your weight.

(Both height and weight should be recorded on a percentile chart.)

During this neurological examination, obvious signs should be noted i.e. abnormal posture, wasting of hands, tremors, tics, muscle spasm, myokymia (persistant quivering of the muscles), choreoathetotic movements (ceaseless occurrance of a wide variety of rapid, jerky, uncoordinated movements.)

Cranial Nerves

a) Olfactory

Do you ever have any trouble smelling or tasting your food?
(Test each nostril separately with a different odor - coffee and lemon may be used.)
Do these odors smell the same or different?

56. Olfactory

0 - No abnormality noted
1 - Questionable abnormality
2 - Definite abnormality
9 - Not known

b) Optic

(Observations should be made during this part of the examination for squint or ptosis (drooping of the upper eye lid) or nystagmus and recorded for later coding.)

Do you ever have any trouble with your eyes? i.e. Pain? Blurring? Diplopia?
(If yes) Pursue:

When was the last time this happened?

How often does it happen? Daily? Weekly? Monthly?

Have you ever gone to the doctor about your eyes?

What did he do about it?

57. Vision

0 - No abnormality reported
1 - Physical abnormality complained of in past 12 months
2 - Physical abnormality treated
9 - Not known

(After this discussion the child is presented with the eye chart and is asked to read it from the prescribed distance, first covering one eye then the other. Any abnormality in recounting the letters i.e. B for D should be noted.)

58. Vision-Reading Chart

0 - Normal 6/9 Schnellen Chart #8
1 - 20/200 (Schnellen #1)
2 - 20/100 " #2
3 - 20/70 " #3
4 - 20/50 " #4
5 - 20/40 " #5
6 - 20/30 " #6
7 - 20/25 " #7
8 - 20/15 " #9
10 - 20/13 " #10
11 - 20/10 " #11
9 - Not known

VISUAL FIELDS

(Facing the child at eye level, test the peripheral fields and blind spot by confrontation in all four quadrants by comparing with the examiner.
Also test for visual sensory competition by repeating the excercise but simultaneously stimulating on both sides.)

At each test child should be asked:

Tell me when you can see my finger, even though you are looking at me?

For the extinction test, the child should be asked:

Which finger can you see?

Which one did you see first?
(If child is uncertain, the test can be repeated.)

59. Visual Fields Abnormality

0 - None noted
1 - Possible
2 - Definite
9 - Not known

60. Visual-Sensory Competition Abnormality

0 - None noted
1 - Possible
2 - Definite
9 - Not known

I am now going to shine this funny light in your eye.
Will you look straight at that spot on the wall behind me?
Try not to pay any attention to the light.

(Observations should be made of the optic disc, the retina, the vessels, and the macula in turn.)

61. Fundi Abnormality

0 - None observed
1 - Questionable
2 - Definite
9 - Not known

Now I want you to follow my finger, watch it as I move it. Good girl/boy.

(Move the finger both in horizontal and vertical directions.)

62. Reflex Gaze

0 - No abnormality noted
1 - Possible abnormality
2 - Definite abnormality
9 - Not known

Would you look up for me please, and down, and to the right, and now to the left? Good boy/girl.

63. Spontaneous Gaze

0 - No abnormality noted
1 - Possible abnormality
2 - Definite abnormality
9 - Not known

64. Nystagmus

0 - Not noted
1 - Possible
2 - Definite
9 - Not known

(If nystagmus is noted during the examination, please record description.)

Would you look up for me please until I tell you to stop (60 sec).
Good girl/boy!

65. Ptosis

0 - None noted
1 - Possible
2 - Definite
9 - Not known

66. Squint

0 - None noted
1 - Possible
2 - Definite
9 - Not known

Trigeminal Motor Functions

(Resistance should be applied to the jaw and the child asked the following. Pressure also applied to test sideways deviation.)

Would you open your mouth for me? Good.

Now, I have this little stick which I want you to bite for me.
(Face should be touched in order that contraction of the temporalis and masseter muscles can be felt.)

67. Trigeminal Motor Functions

0 - No abnormality noted
1 - Possible abnormality
2 - Definite abnormality
9 - Not known

Motor Functions of the Facial Nerve

(The child should be observed for assymetry of the face when he smiles or speaks and when he bares his teeth.
Test to be included are:)

Will you raise your eyebrows for me; and screw up your eyes?
(Demonstrations may be given)

(The child might also be asked to close his eyes and his resistance to your opening them noted.)

Good!

68. Evidence of Facial Weakness

0 - Not noted
1 - Possible
2 - Definite
9 - Not known

(The child is asked to differentiate the taste of several stimuli which are applied to the tongue by moistening the Q-tip in the stimulus solution. The child is allowed a glass of water between the stimulii in order that the traces of the last be eliminated.)

The stimuli to be used are:

1. salt solution - salty
2. sugar solution - sweet

69. Taste Sensation

0 - No abnormality noted
1 - Possible abnormality (identified one solution)
2 - Definite abnormality (no identification or discrimination of taste)
9 - Not known

Hearing

(The child should be asked about difficulties.)

Do you ever have any trouble with your ears?
(If yes) Can you tell me about it? (record verbatim)

When was the last time that happened?

What did you do when it happened?

Does it happen very often?

Does your hearing ever seem foggy?

What about your ears themselves, do they ever pain?

How about earaches, do you ever have them?

(Record relevant information from specific questions.)

70. Complaints of Hearing

0 - None
1 - Spontaneous only
2 - Specific only
3 - Spontaneous and specific
9 - Not known

(Before actual testing it is important to eliminate bias by checking the child's ears for evidence of wax; the condition of the tympanic membrane and evidence of infection. This may be done by use of the otoscope.)

I am going to look in your ears now with this little eye glass. It won't hurt. I'll just look.

71. Otoscopy

0 - No abnormality
1 - Possible abnormality
2 - Definite abnormality
9 - Not known

AUDITORY ACUITY

(The child is to be seated with his back to the examiner and is asked to indicate when he can hear the ticking of a watch.
The watch is to be slowly moved from outside of hearing range closer to the ear and the distance at which the sound is perceived recorded in inches.
This test should be repeated for the other ear.)

RIGHT EAR: LEFT EAR:

(The child is now presented with a game situation of word repetition.
The distance between the examiner and child should be 20-25 feet and the words pronounced in a low voice, with the mouth hidden in order that by the absence of visual cues, possible high tone auditory deficit be eliminated.)

Word Said	Child's Response
fat	
cat	
rat	
scat	
pat	
bat	
sat	
hat	

72. Auditory Acuity

0 - No abnormality noted
1 - Possible abnormality
2 - Definite abnormality
9 - Not known



Renne's Test

(A tuning fork is struck and the base placed upon the mastoid process while the ear is occluded. The child is asked to indicate when the sound disappears. The still ringing fork is then placed in front of the ear and the child is asked if he can still hear the ringing.
If so air conduction is better than bone conduction.)

73. Renne's Test

0 - No abnormality noted
1 - Possible bone conduction preference
2 - Definite bone conduction preference
9 - Not known

Webers Test

(The base of a ringing fork is placed on the centre of the child's forehead. He is asked:)

Where does the sound seem to come from, the centre of your head or is it louder in one of your ears?

(If yes) Can you tell me which ear?

74. Webers Test

0 - No abnormality noted
1 - Possible abnormality
2 - Definite abnormality
9 - Not known

I'm going to ask you to do some other things for me now.

Would you kick the bean bag over towards the wall (window)?

Do you know how to hop on one leg?

Can you show me? or Will you try?

(Note taken of the leg employed for later coding on laterality.)

75. Gross Motor Movement

0 - Within normal limits
1 - Possible abnormality
2 - Definite abnormality
9 - Not known

Do you think you can pretend to play the piano on my hand?

I'll show you.

Will you take your pointing finger and touch it on your nose for me?

First eyes open, then closed.

Can you touch your fingers with your thumb for me, like this, one right after the other?

(A brief demonstration can be given.)

Now I want to pretend that you are dancing on your heels, but the trick is that you have to sit down while you do it.

I'll show you, now you do it.

(Demonstration should be brief.)

76. Co-ordination of fingers

0 - Within normal limits
1 - Possible clumsiness
2 - Definite clumsiness
9 - Not known

77. Co-ordination of Limbs

0 - Within normal limits
1 - Possible abnormality
2 - Definite abnormality
9 - Not known

78. Evidence of Ataxia

0 - No abnormality noted
1 - Possible abnormality (difficulty with tapping items only)
2 - Definite abnormality (difficulty with finger-nose test marked)
9 - Not known

I have some paper and pencils here. Will you draw me a picture?

(If the child asks as to the content of the picture, he should be encouraged with "Anything that you like".)

(While the child is drawing, several measures may be made for later coding:

1. distractability - tested by examiner coughing, moving about the room, opening a drawer or briefcase.
2. hand used for drawing should be recorded.
3. speech and language may be assessed in terms of adequacy of description, grammar and articulation by asking the child to describe his pictures, i.e. "Would you tell me about it?"

Now I would like you to draw me a picture of a man.

(This should be preserved for later coding in the psychological evaluation.)

Cerebral Functioning

Now we are going to play a word game. I will point to some things in the room and you can tell me what they are? i.e. book, chair, table, shirt, door, wall, picture, body parts.)

79. Nominal Dysphasia

0 - Within normal limits
1 - Possible
2 - Definite
9 - Not known

Now I am going to think about one of the things which we just named and I want you to guess which one it is.
It's like a game of 'I Spy' except you already have the clues.

80. Receptive Dysphasia

0 - No abnormality noted
1 - Possible abnormality
2 - Definite abnormality
9 - Not known

I want you to see if you can make the shapes which I am going to show you now, out of these matches?

(The child is presented with the following shapes: triangle, diamond, the letter 'L', cross.
Scoring should only take accuracy into account.)

81. Constructional Ability

0 - All shapes age comparable
1 - Shapes (△ ◇ L) comparable but X considerably distorted
2 - Shapes (△ ◇) comparable but L and X distorted
3 - Three or more shapes distorted
9 - Not known

Motor Impersistance (inability to sustain a voluntary motor act)

We are now going to play a game of funny face statues.
I want you to see how long you can close your eyes and open your mouth with your tongue stuck out, OK?

Eyes closed -------

Mouth open -------

Tongue Protruding ----

82. Constructional Apraxia

0 - No abnormality noted
1 - Possible abnormality noted
2 - Definite abnormality
9 - Not known

83. Motor Apraxia

0 - No abnormality noted
1 - Possible abnormality
2 - Definite abnormality
9 - Not known

If you were going to play at being a secretary and you had to mail a letter, what would you do?
Record verbatim:

Here is some paper and an envelope, will you show me how you would get it ready to mail?

84. Ideational Apraxia

0 - Not noted
1 - Possible abnormality
2 - Definite abnormality
9 - Not known

85. Ideamotor Apraxia

0 - Not noted
1 - Possible abnormality
2 - Definite abnormality
9 - Not known

Now that you have the envelope, will you write your own name and address on it and then we can really mail it to you?

(Note hand used for later coding on laterality.)

86. Executive Dysphasia

0 - No abnormality noted
1 - Possible abnormality
2 - Definite abnormality
9 - Not known

87. Language and Speech

0 - No abnormality noted
1 - Possible abnormality
2 - Definite abnormality
9 - Not known

Now I want you to write or print the letters of the alphabet for me?

(Note indicators of perceptual difficulty for later psychological coding i.e. letter formation, up-down, right-left distortion.)

Here is a ball will you throw it to me?

Handedness:

I have a telescope in my case, have you ever looked through one, here have a look.

Eyedness:

Now I want to play some football (if boy)/ ballerina (if girl).

Stand on one foot. Kick on one foot.

(This should be compared to previous record and if there is a discrepancy, repeat.)

Footedness:

88. Laterality

0 - Consistently right or left
1 - Hand differing from eye-foot orientation
2 - Eye differing from hand-foot orientation
3 - Foot differing from eye-hand orientation
9 - Not known

Child is asked:
Which is your right hand?
Point to my left hand?
Touch your left foot with your hand.

89. Right-Left Confusion

0 - No abnormality noted
1 - Right-left confusion
9 - Not known

90. Overall Evaluation of Cerebral Functioning

0 - No abnormality noted
1 - Possible abnormality (as indicated by a score of possible on 1 or 2 subtests)
2 - Definite abnormality (as indicated by scores of possible or definite on 3 or more subtests)
9 - Not known

Now I want you to relax your arm for me.
(Taking the child's arm, move it to determine the amount of voluntary relaxation, encourage the same. Then taking each limb and applying a quick jerky movement, determine if resistance is normal, increased or diminished comparing both sides.)
(If there is increased rigidity, determine if the nature of the rigidity is "clasp-knife", "lead pipe" or "cogwheel".)

91. Tone Code: 0 - No abnormality noted
1 - Increased rigidity
2 - Decreased rigidity
9 - Not known

91-1 Right Arm
91-2 Left Arm
91-3 Right Leg
91-4 Left Leg

Increased rigidity type

92. Code: 0 - No increase in rigidity
1 - Cogwheel type
2 - Lead Pipe type
3 - Clasp-knife type
9 - Not known

92-1 Right Arm
92-2 Left Arm
92-3 Right Leg
92-4 Left Leg

Placing each of the child's limbs in a flexed position.
Test power to move limb against resistance.

Now I want you to push against my hand and move your arm/leg.
Again.

93. Power

0 - No abnormality - full power
1 - Movement can be overcome by resistance
2 - Movement cannot meet resistance
3 - Total paralysis or flicker
9 - Not known

93-1 Right Arm
93-2 Left Arm
93-3 Right Leg
93-4 Left Leg

Reflexes

Now I am going to use this little rubber hammer to make you do some funny things - like kick when you don't mean to.

Have you ever seen one before?

It won't hurt- I'll show you what to do and then you can try it on me. OK?

94. Reflexes

0 - No abnormality
1 - Absent
2 - Flicker
3 - Increased
4 - Increased with clonus
9 - Not known

	RIGHT	LEFT
Knee jerk	94-1	94-2
Ankle jerk	94-3	94-4
Radial jerk	94-5	94-6
Grasp Reflex	94-7	94-8

OBSERVATION OF CHILD DURING INTERVIEW

95. Anxiety

		Abnormality			
		None	Slight	Marked	Not Known
95-1	Expressions	0	1	2	9
95-2	Preoccupations	0	1	2	9
95-3	Tearfulness	0	1	2	9
95-4	Fears	0	1	2	9
95-5	Worries	0	1	2	9

96. Mood

96-1	Unhappiness	0	1	2	9
96-2	Apathy	0	1	2	9
96-3	Retardation	0	1	2	9
97.	Muscular Tension	0	1	2	9
98.	Habitual Mannerisms (Describe)	0	1	2	9
99.	Fidgetiness	0	1	2	9

100. Spontaneity of Talk

0 - At least 4 spontaneous comments
1 - 1-3 spontaneous comments
2 - No spontaneous comments
9 - Not known

101. Emotional Expressiveness

0 - Happiness and sadness observed appropriately
1 - Emotions expressed guardedly
2 - No observable emotional expression
9 - Not known

102. Emotional Responsiveness to Interviewer

0 - Emotionally responsive in manner appropriate to interview setting
1 - Marked excess of emotional responsiveness i.e. crying
2 - Limited emotional response to interviewer
3 - Markedly lacking in emotional responsiveness to interviewer, guarded, difficult to contact
9 - Not known

103. Rapport

0 - Good rapport established and held

1 - Difficult to establish or hold rapport for any reason; belligerence, uncooperativeness; negativism

2 - Rapport with child not obtained or severely limited

9 - Not known

104. Gross Activity Level

0 - No abnormality - child sits on chair throughout interview except when instructed otherwise

1 - Definitely underactive; very little spontaneous movement

2 - Tendency to increased activity; occasional spontaneous movement

3 - Child definitely and markedly overactive. Finds it difficult to stay still when expected to do so

4 - Child definitely and markedly overactive; quantitative and qualitative distortion in activity level

9 - Not known

105. Attention Span and Persistance (judged from interview as a whole)

0 - Persists at tasks given until completed (if momentarily distracted, voluntarily returns to task)

1 - On some tasks needed occasional prompting in order to assure completion

2 - Needed frequent prompting and reminding in order that tasks be completed

9 - Not known

106. Distractibility (attention should be paid to child's response to both incidential & usual stimuli)

0 - Not distracted (or only rarely) by onset of incidental or usual stimuli when attention engaged in a task

1 - Occasionally distracted by usual stimuli and/or repeatedly distracted by unusual stimuli

2 - Easily distracted by usual and/or slight unusual stimuli such that attention is diverted from task at hand

9 - Not known

107 Disinhibition

0 - Some reserve - as normal with a strange adult

1 - Treats examiner in an easy friendly manner with little or no reserve. Rather disinhibited for interview situation.

2 - Treats examiner as a long standing friend of his own age. Markedly disinhibited and overfriendly for interview situation; may be cheeky, make unprompted remarks, ask questions

3 - Disregard for interview or his instructions; proceeds with own interests. Makes unprompted remarks or spontaneous questions of a cheeky, not friendly sort; disregard is self-centered or overfriendly

9 - Not known

Section V PSYCHOLOGICAL EVALUATION -

Administer Raven's Colored or Standard Progressive Matrices to the child on an individual basis as per instructions given.

Wide Range Achievement Test should also be administered in its entirety.

Scoring of each test should be done according to the methods recommended.

RAVEN"S COLORED OR STANDARD PROGRESSIVE MATRICES SCORE:

WIDE RANGE ACHIEVEMENT TEST SCORE:

Section VI OVERALL JUDGEMENT OF PSYCHIATRIC STATE

108. 0 - No abnormality
1 - Dubious abnormality
2 - Slight but definite abnormality and handicap
3 - Moderate abnormality and handicap
4 - Marked abnormality and handicap

109. Type of Abnormality

0 - No abnormality
1 - Anxiety or phobia state
2 - Depression
3 - Other neurotic disorder
4 - Mixed antisocial neurotic disorder
5 - Antisocial
6 - Hyperkinetic syndrome
7 - Psychotic syndrome
8 - Other - specify:
9 - Not known.

SPECIFIC DIAGNOSTIC EVIDENCE:

I have asked you quite a lot of questions.
Is there anything that you would like to ask me?

(If there are questions, attempt an age appropriate answer and as far as possible, provide the answer which the child is likely to expect.)

(Shaking hands) Thank you very much for coming and being so very helpful.

DATE OF INTERVIEW: _____

NAME OF INTERVIEWER: _____

NAME OF CHILD : _____

CODE: _____

APPENDIX G

MINOR DIAGNOSTIC CATEGORIES - CASE DETAIL

Stuttering

One boy had been a mild stutterer from age four years when a traumatic household accident was said to have precipitated the stutter.

The stuttering had increased upon admission to school, it had become situation specific and had progressed to an incapacitating degree in that setting. The stutter was predominanted by tonic but also demonstrated clonic features.

The boy was failing in school and within an eighteen month period had developed a full range of conduct problems. His symptoms included, disobedience, destructiveness, fire-lighting, lying, stealing and consequent police contact, frequent truanting and smoking. He had marked relationship problems with siblings and peers. His friends were generally older and not approved of by his parents. With the onset of these conduct problems the boy had become tearful and showed persecutory ideas. He also began to display some stuttering at home.

Speech and Language Disorder

One boy had been diagnosed as having an expressive language aphasia at age 4 years.

He was treated regularly with speech therapy up to the age of seven years until relatively fluent speech had been obtained.

The child had been having academic problems throughout his school career, in particular reading difficulties.

In the current study, his tested non-verbal I.Q. was within the normal range.

Attempts were made to improve his academic problems by special class placement (2 years), this was unsuccessful. Some academic improvement was forthcoming when the boy was placed in a regular class and given private tutoring.

Psychiatric symptoms displayed by the boy were of a mixed, conduct-emotional variety and were moderate in degree.

He had frequent temper tantrums and lied frequently. He had mild relationship problems with his siblings, i.e. squabbling and jealousy and complained of loneliness. His mother found him to be an extremely demanding child.

Adaptation Reaction

Two girls were diagnosed as demonstrating adaptation reactions.

The first girl demonstrated a grief reaction following the death of her father, eighteen months prior to the assessment. Her symptoms were many and included, sleeplessness, tearfulness, the onset of multiple fears, pica, worrying, fussiness, loneliness and separation anxiety. The symptoms had shown a considerable improvement over time. This child had long standing academic problems which were effectively dealt with by special class placement.

The second girl showed moderate anxiety and emotional symptoms which varied in response to chronic physical and mental illness which were evident in both of her parents.

She displayed somatic complaints of headache, stomach ache, visual problems and fainting spells, none of which were found to have medical causation. She was described as a worrier, hypochondriacal, and overly particular. She was fearful of school and had relationship problems with one specific teacher. She also displayed marked relationship problems with one sibling.