

**THE DEVELOPMENT AND TESTING OF A MULTI-ETHNIC, LOW
LITERACY, FAMILY SUPPORT PROGRAMME FOR THE
PRIMARY PREVENTION OF CHILD ABUSE AND NEGLECT IN
THE CHILD UNDER FIVE YEARS**

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DECLARATION

I DECLARE THAT THIS WORK IS MY OWN ORIGINAL WORK.

**FULL ACKNOWLEDGEMENTS HAVE BEEN MADE OF SOURCES REFERRED TO
IN THIS TEXT.**

WENDY MAY LEWIS

NOVEMBER, 1995

DEDICATION

This study is dedicated to the average mother and woman who has the courage to live with caring in an unequal world, to both my parents for their belief in me and to my husband John and two daughters Melissa and Candice, who have given me the experience of family life, for which I am eternally blessed.

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ABSTRACT


The main aim of this research was to identify a family support programme which could be used as a primary prevention strategy against child abuse as a first positive step within the family, the basic unit of society, towards reducing community violence. The central focus of this intervention was that it should be appropriate for use in a multi-ethnic South African context and implementable by community health nurses or related lay health personnel with minimal training. No such programme was identified. The researcher attempted to integrate the most appropriate and scientifically substantiated features of existing programmes and develop a unique South African programme. This programme was developed and tested in a participatory manner with multiethnic communities. Community health nurse facilitators were trained and evaluated and the developed programme was then implemented by these facilitators in several sites. The influences of the developed programme were extensively evaluated. Changes in attitudes, feelings and behaviour of the child, the mother, the maternal-child interaction and the family system were explored.

A quasi-experimental design with pre and post testing of the experimental group and two control groups (control 1 received social support and control 2 receiving routine clinic nursing only) was utilized.

Completed analysis has yielded some exciting and provocative results. There are clear differences in each of the groups attitudes to their children. On the Mother-Child Relationship Evaluation (MCRE) positive gains in maternal-child relationship were established for the experimental group and this was greater than that of both controls

(t-test = 4.151 @ $\alpha = 0.0013$; $H=4.0734$ @ $\alpha = 0.04$ and $F=7.031$ @ $\alpha = 0.0004$). On the Family Assessment Device (FAD) some limited changes were observed in the experimental group over the controls ($F=3.33$ @ $\alpha = 0.05$). This is a positive outcome indicating that the family support programme evidenced significant changes in the participants relationships with their children and in their families and wider social life. Mothers and facilitators qualitative feedback reported positive interaction with young and older children and changed maternal and child attitude and behaviour. Despite the critical shortage of staff in community health settings facilitators continue to implement the programme voluntarily in their service settings.

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CHAPTER ONE

INTRODUCTION

Your children are not your children,
They are sons and daughters of life's longing itself.
They come through you but not from you.
And though they are with you yet they belong not to you.

You may give them your love but not your thoughts
For they have their own thoughts.
You may house their bodies but not their souls
For their souls dwell in the house of tomorrow, which you cannot visit,
not even in your dreams; you may strive to be like them, but seek
not to make them like you.
For life goes not backwards nor tarries with yesterday;
You are the bows from which your children as arrows are sent forth!
The archer sees the mark upon the path of the infinite and He bends
you with His might, that His arrows may go swift and far.
Let your bending in the Archer's Hand be for gladness
For even as He loves the arrow that flies,
so He loves also the bow that is stable!

Kahlil Gibran

1.2 HISTORICAL PERSPECTIVE

From the earliest recorded history of the ancient civilisations of Greece, Rome and China until the late nineteenth century parents have wielded absolute power of life and death over their children. Children have been legally bartered and sold, physically abused and mutilated and even murdered by their own parents. The "wall of Jericho" was believed to be magically strengthened by sealing the bodies of children in the walls and foundations (Vizard, 1987). The seventeenth century, **Stubborn Child Act**, enabled a rebellious child to be put to death (Kelly, 1983). During the industrial revolution children were forced to work long hours for a pittance and frequently and severely beaten for little reason (Miller, 1987).

The beginning of the nineteenth century saw the early efforts of European philanthropists to legally limit the abuse of children in the work situation. However the first reported attempt to actively protect a child was only in the late nineteenth century (Lazoritz, 1990; Starr, 1988) and child labour practices remain in many countries to this day. For example, approximately forty five thousand children are employed in match factories in India; Mexican children are widely employed as seasonal labourers; children, many under the age of six years work 11 to 12 hours a day as carpet makers in Pakistan (Shah, 1984).

The humanistic movement to protect the vulnerable from exploitation and abuse can be clearly seen in the worldwide legislative changes which have been

introduced during the twentieth century. However this very legislation has failed to recognise that the most frequent and severe abuse is that found in the home. The image of the home being a safe retreat from the hardships of the world, where families support and care for each other is frequently untrue and is a social stereotype which prevents those suffering this abuse from talking about it, thus indirectly protecting those perpetrating the abuse. Straus, Gelles, and Steinmetz, conducted the first national epidemiological survey of domestic assault and concluded that:

"...physical violence occurs at home between family members more often than it occurs between any other individuals or in any other setting except for wars and riots." (1980,p.32)

Indeed the data would seem to indicate that the most unsafe place to be is in your own home, particularly if you are a woman or a child.

The rights of parents to "discipline" their children is supported by the social and legal system and in many religions it is actively advocated. Judeo-Christian history has one of the most accurate historical records of child abuse in the writings of the Old Testament eg. Abraham's preparation to sacrifice his son Isaac is one example of an attempt at ritual infanticide (Franklin, 1977). Even today this biblical influence can be seen in the saying of "spare the rod and spoil the child" which is carried forward into our everyday language and beliefs and is derived directly from Proverbs:

"Withhold not correction from the child; for if thou beatest him with the rod, he shall not die. Thou shalt beat him with the rod, and shalt deliver his soul from hell" (23: 13 -14).

These harsh beliefs seem easier for people to accept than the many references to love and caring which are also advocated for example "Thy rod and thy staff they comfort me" (Twenty first Psalm) or "Love thy neighbour as thyself" (Ten Commandments). Understandably so when one looks at the historical perspective which has led to these social mores and stereotypes.

Anthropological studies of many primitive and advanced cultures almost universally reveal instances of extreme parental punitiveness. Abusive discipline of children is neither a new phenomenon nor is it associated with any cultural heritage (Kelly, 1983). Wauchope and Straus's study found that 90% of parents of 3-4 year olds report the use of physical punishment (cited in Vissing, Straus, Gelles and Harrop, 1991). Vissing et al (1991) found that 2/3 of American parents use verbal aggression, despite the fact that 70% of American adults believe that psychological problems can result from repeated yelling and swearing at children.

The right of parents to discipline their children is extended to other members with recognised authority in the society. Thus school teachers and hostel supervisors of child care institutions may be seen as having this right in many western

countries (Benthall, 1991). Sweden was one of the first countries to legally ban corporal punishment in families and schools in 1966 (Radbill, 1980; Starr, 1988) and Denmark followed in 1967 (Merrick, 1986). Since the 1960's liberation movement in China, the Peoples Republic of China has strictly forbidden physical punishment in schools and has introduced supportive legislature, which has resulted in a marked decrease in the incidence of child abuse (Vizard, 1987). In most countries the State itself is usually seen as having the right to use corporal punishment as a deterrent or punishment for wrongdoers.

We live in a violent society. At a macro-system level nations strive for power and supremacy, atomic warfare has been a constant threat of the postwar twentieth century. Within countries civil unrest is common. In South Africa this violence is particularly evident.

Not only have we a long history of "legal abuse" in the apartheid system but now in the present times of transition and change we have violence at all levels of the social system (Straker & Moosa, 1988). From this background of violence and family breakdown, at now more than any time in the past, it is time to start working with alternative methods, methods other than brute force and violence, in the solving of problems. Force, power and aggression have historically been shown to escalate violence at all levels. Family violence is a public health problem of some significance (Bullock, Sandella, & McFarlane, 1989; McKeel, 1985).

1.3 THE ROLE OF THE CHN IN CHILD ABUSE AND NEGLECT

In dealing with abuse or potential abuse and neglect within families in the community, the role of the nurse includes:

- a) case identification and reporting
- b) follow through of a nursing care plan eg. physical care, nutritional, psychological and social support
- c) assessment of physical and psychosocial development of parents and children
- d) anticipatory guidance of parents, particularly in area of normal growth and development of children
- e) provision of alternative methods of child rearing
- f) co-ordination of nursing interventions with the actions of other involved professionals

(Reinhardt & Quin, 1980).

However in reality nurses willingly give supportive advice on the physical aspects of child care but frequently and at all levels (from antenatal through to family planning and child health), ignore the extremely important emotional aspects of parenting (McKeel, 1985).

At a recent conference held by the International Society for the Prevention of Child Abuse and Neglect (ISPCAN), it was strongly recommended that:

- a) Public Health Nursing be preserved
- b) support groups for parents rather than cognitive, didactic groups be

formed

c) home visitation for new parents be mandatory

d) pregnancy prevention programmes for early adolescence be initiated

(ISPCAN, 1991)

Nearly a decade earlier McKeel (1985) had advocated that:

" The nurse working with abusive parents is an ideal person to teach realistic expectations of children, to encourage appropriate parenting, and to support and reinforce positively the parents as they learn new behaviour patterns" (p. 332).

Recent developments within the field of Public Health and Child Abuse treatment, reflect the practice of shared responsibility for detection, case management, treatment and preventive intervention. The nurse can be particularly effective when a multidisciplinary team functioning approach is used and multidisciplinary implementation is successfully initiated (Fore & Holmes, 1984; Kovitz, Dougan, Riese & Brummitt, 1984). Kovitz et al (1984), initiated such a team approach, utilizing an interactional model to conceptualize the aetiology, maintenance and amelioration of abusive family patterns, enlisting widespread community based support, input and representation at all levels and a flexible group decision-making model. They suggest that their success was largely due to three major factors a) Time was specifically allocated to community educational activities of an interdisciplinary nature b) to personal and professional development, and c) service volume demand pressure was reduced by intensive training and use of

volunteers and paraprofessionals. This study could be said to be guided by a comprehensive model of Primary Health Care which prioritises among others, the elements of education and maternal and child health, and the philosophy of community participation and interdisciplinary co-operation (WHO, 1978). This is a social model of health development and social justice and should form an integral part of all countries health systems.

This background of;

- (a) the community health nurse's understanding of health and the prioritisation of the prevention of disease and the promotion of health and the fact that she is frequently the family's first contact with the health system
- (b) the recognition of the vulnerability and needs of the child under five with the significance of the positive maternal contribution to the latter but also the importance of the interaction of the maternal-child dyad for the health of both, and
- (c) the presence of an existing extensive health care network serving multi-ethnic communities
- (d) the fact that research indicates that health personnel (district surgeon, community health nurses and hospitals) are the highest referral source of abuse for the child under five years and the second highest across all age groups of children (Meharchand, 1991) all contribute to the analysis that the community health nurse has a major role to play in the early identification of child abuse, and for the recognition of predisposing conditions which may lead to "high risk" categories, and most importantly for the provision of preventative interventions.

✓ 1.4 PROBLEM STATEMENT

Child abuse is recognised as a significant public health problem. Medical interventions by themselves have failed to reduce the incidence of child abuse. Howze & Kotch (1984) suggest that a holistic public health approach is needed to address this complex problem. The community health nurse works in a holistic manner, prioritising the prevention of disease and the promotion of health wherever possible, but also ensuring adequate treatment and rehabilitation (Mowat, 1982; Stanhope & Lancaster, 1992). She or he works from a positive rather than a negative conceptual model of health, being guided in her or his practice by the World Health Organisation's (WHO) recommendations and the comprehensive or longitudinal model of Primary Health Care as defined at the International Conference of Alma Ata (WHO, 1978). The WHO defines health as:

"a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (WHO, 1978, p.428)

The high incidence of child abuse in the community particularly in the child under five years, highlights the need for the introduction of a low cost primary prevention intervention. There is some evidence to suggest that preventive programmes may be more successful for families who have not yet begun or become entrenched in destructive patterns of interaction (Barth, 1991). The community health nurse is well placed to introduce such an initiative.

An overview of the South African population shows that approximately 75% of the population is african and of these, one third of those living in urban areas and two thirds of those living in rural areas are illiterate. The degree of illiteracy is also high among the coloured population, but low, being only 1% among the white or caucasian population (Wilson & Ramphele, 1991). The majority of South African families are functionally illiterate, poverty is prevalent and has been exacerbated by the political unrest and violence. South Africa is caught in a transitional process of political change leading to violence at all levels of the social system (Straker & Moosa, 1988). There is little or no life experience of democracy in daily living eg. ethnic groups are considered superior or inferior, as are male and female and adult and child. In considering the South African context we have the situation where a large proportion of the adolescent community has experienced limited/poor parenting, fragmented schooling and has also been exposed to family and community violence of the worst type. These adolescents are ill-equipped to be parents of the next generation. Families are in greater crisis now than at any time past.

The young child, particularly the infant and child under five years of age is recognised as being of particular vulnerability and significance for a number of reasons which highlight the importance of the primary caretaker.

(a) The human infant is distinct from the rest of the animal world in that he or she is completely dependent on other humans for basic survival for a prolonged period of time. Deficient or inadequate care of the infant may result in illness,

poor growth and development, and even death (Solnit, 1984).

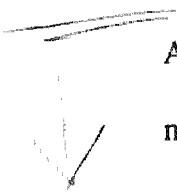
(b) This dependence continues for an extended period of time, during which the infant gradually develops and grows. Fifty percent of brain growth occurs in the first four years of life and eighty percent by the time the child is eight years old (Beck, 1967). Deficient or inadequate care may result in delay or retardation of developmental milestones which may have long term effects and seriously inhibit the infant's future physical, cognitive and social potential. The significance of the primary caretaker's role and the adequacy with which this is played, is thus of primary importance.

(c) The physical body of the human infant or young child is immature and fragile, and extremely vulnerable. Interactions which would not damage or hurt an older child may cause severe trauma to an infant or young child. For instance a rough shaking may cause a subdural haemorrhage in an infant due to a combination of a heavy head, weak neck muscles and a soft rapidly growing brain which is loosely attached to the thin skull wall (Dykes, 1986; Showers, 1992). Similarly a hard smack may fracture an infant's bone/s. The same actions may cause little ill effect to an older child or adult (Claussen & Crittenden, 1991).

(d) Population statistics for developing countries enable us to estimate that children under five years form approximately 1/5 of the total population (Brown & Brown, 1982). Children under five thus form a large vulnerable sector of the community.

(e) A considerable body of research highlights the fact that the highest incidence of child abuse and neglect occurs in the child under five years (This is discussed in more detail in the literature survey).

The importance of the primary caretaker, usually the mother, but maybe an aunt, cousin, grandmother, father or sibling, has been highlighted in the preceding discussion on the physiological vulnerability of the child. However this vulnerability also extends to the psychosocial growth and development of the child.



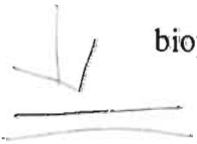
Although physiologically the child requires adequate basic nutrients to ensure normal brain growth, it is psychologically dependent on adequate stimulation to ensure normal cognitive development and adequate emotional support and care to nurture the development of a personality that is able to function in the real world. The social environment is the means by which most of these requirements are met and this is dependent on the family and the primary caretaker (Solnit, 1984).

The mother as the most frequent primary caretaker, thus plays a significant role in both the survival and the provision of an optimal environment for the adequate growth and development of her child. The maternal-child relationship during these first five critical years may have lasting influences on the child's later life.

The mother and child form an interacting dyad, each member of which influences

the other. The physiological characteristics and inherent personality, birth and environmental influences experienced by the child will influence both the mother and the child. The mother's personality and life experiences and the social support she receives will likewise influence both players in this intimate relationship.

It therefore becomes necessary when considering any intervention aimed at the child, to consider not only the role played by the mother, but also the biopsychosocial health status of the mother herself.



The community health nurse interacts with the mother and child dyad in the clinic situation, where the health status of both, and the growth and development of the baby is continuously assessed. Health promotive activities are encouraged. For example the mother may be provided with a family planning method or pap smear, the child is immunised, counselling on developmental stages and areas of concern is given and where necessary anticipatory guidance is provided. Frequent health consultation for the baby, especially for nonorganic conditions, has been shown to be symptomatic of early problems in the maternal-child relationship (Adler, Hayes, Nolan, Lewin & Raphael, 1991). The community health nurse is uniquely positioned for identification of early indicators of family dysfunction.

Home visiting is utilised by community health nurses as both a useful assessment tool, in order to assess the family situation and as a particularly powerful intervention for the provision of social and medical support for families in times

of stress or crisis and with families which may be considered to be either "at risk" or "high risk" (Jones, 1974; Mowat, 1982; Pawl, 1984).

The significant role psychosocial support contributes towards the promotion of health and prevention of disease is acknowledged in the provision and encouragement of social clubs for all age groups. In maternal and child health this takes the form of:

(a) neighbourhood social support groups. Here mothers who live in the same area or have children of a similar age, meet on a regular basis to discuss any common areas of interest or concern.

(b) skills activity support groups. Here mothers meet to learn new skills. This type of group is encouraged in communities where resources are scarce. Basic skills which will assist the family economics are learnt and include sewing, candlemaking, knitting and crochet, vegetable gardening and basic health care, nutrition and child care.

(c) encouragement of voluntary informal support groups among community members eg. savings clubs, burial clubs. Groups aimed socially and personally at enabling or empowering the community eg. skills training, civic action groups and so on.

The social support groups listed above have largely failed to provide anticipatory guidance in parenting skills.

The existing parenting family support programmes require sophisticated verbal ability and intellectual understanding and are frequently only available after some abuse has been reported (at a tertiary level), thus excluding a large majority who are in need of this service. This type of support programme has also traditionally been provided by social workers. A family support programme, based on programmes which have been shown to be effective, needs to be developed for multi-ethnic parents of low literacy. The programme would be appropriate as a primary intervention for child abuse and thus aimed particularly at certain criteria found to be significant in the aetiology of abuse.

Community health nurses would need to receive appropriate training to enable them to run such support groups and the effectiveness of such a programme on maternal and family dynamics would need to be evaluated.

1.5 MOTIVATION AND VALUE OF THE STUDY

The motivation for this study is the significant body of work which documents not only the high incidence of abuse and neglect in the child under five, but also the role the nurse plays in the reporting of this abuse (enlarged on in literature review).

Motivation has also grown from clinical work with families and the recognition that the community health nurse is in the unique position of frequently being welcomed into the home and the private lives of ordinary people, sharing with

them many of life's experiences, joy, sadness, loss, and crisis. She has the privilege of experiencing firsthand the human potential for courage and for change, frequently in the worst of environments and life's circumstances - a privilege afforded, in this way, to no other profession. This position provides a powerful potential for creating change and assisting people to help themselves.

The community health nurse works closely with individual clients and with the family, in both the agency or clinic setting as well as the home and community environment. She or he is thus in a pivotal position to implement a programme for the primary prevention of child abuse (Mowat, 1982).

Community and primary health care services form an existent network of permanent and mobile health services across most of South Africa and the present independent black homelands.

The value of this research thus lies in the pragmatic application of the findings. Should an effective preventive programme be found that is implementable by community health nurses it could be rapidly assimilated into community health nursing practice and introduced with little cost and on a large scale, into the existent service network.

✓ **1.6 OBJECTIVES**

The main aims of this research are;

(a) To identify or develop an intervention in the form of a structured family support programme which should be:

- * specifically for the primary prevention of child abuse and neglect.
- * for use by mothers with at least one child under five years of age.
- * appropriate for the scope of practice of the average community health nurse.
- * appropriate to multi-ethnic South African communities.
- * acceptable to those unable to read the written word, taking cognisance of the significant degree of illiteracy in South Africa, thus encouraging alternative methods of learning.

(b) To ascertain whether this programme could in fact be implemented by the average community health nurse in the South African setting.

(c) To evaluate the programme in the short-term and the long-term, by measuring the effects on selective maternal and family variables and maternal-child interaction.

A literature review of child abuse was undertaken and a profile of abuse and neglect drawn up. Primary, secondary and tertiary interventions for child abuse were assessed. None of the existing programmes were found to be appropriate for implementation as a primary preventative strategy in the South African multi-ethnic situation by community health nurses.

This led to the further exploration of various methods of intervention and the

development of a family support programme appropriate for the South African community health setting and the community health nurse's scope of practice. Having been designed for the specific use of the community health nurse, the course maximises the unique skills and contact she or he has with the client group. The community health nurse is seen as the facilitator of the group. A facilitator's manual was developed, giving detailed guidance, instructions and support to the facilitator.

This manual enables the community health nurse to run a 90 minute mother and child support group each week. The full course covers 10 weeks. The course is aimed at mothers of children under five years, with a low educational level, and includes a pictorial handout for mothers, depicting maternal child interaction scenarios in a multi-ethnic South African context.

In order to ensure that the designed intervention was implementable in a variety of settings and without extensive training, a short course teaching the necessary skills was offered free of charge to a variety of different community health service settings. This included the Local Authorities, the Natal Provincial Administration Primary Health Care Units and Kwa Zulu Polyclinics. The ability to rapidly train effective counsellors, particularly when they come from the culture and community that they service, is well documented (Anthony & Carkhuff in Ivey & Simek-Downing, 1980).

1.7 CONCEPTUAL FRAMEWORK

The **theoretical** framework and Nursing Model guiding the research was Orem's Self-Care model (Orem, 1985). There is some debate in the literature about the classification of Orem's model. Some authors classify it as a systems model (Riehl & Roy, 1980). Orem does refer to nursing systems, but not in the classical general systems terms of input, throughput and feedback. A "nursing system" is described as "...all the actions and interactions of nurses and patients in nursing practice situations" , and self-care and dependent-care are considered "... action systems" (Orem, 1980,p.92). Other authors classify Orem as a developmental model (Fawcett, 1984; Stanhope & Lancaster, 1992). Development has a very strong emphasis in Orem's model, where the influence of a progressive continuum and of critical life-stages is acknowledged as contributing to the individual's and group's self-care requisites (or self-care needs/demands). Yet other authors suggest that this model is eclectic in that use is made of several theories and emphasis is placed on developmental, interactionist and systems theories (Elliot, 1991). The eclectic nature of this theory is particularly suited to this research, which while primarily developmental in direction, has utilised interactionist educational theory in the development of the intervention support programme, and acknowledges the significance of the maternal-child interacting dyad as but one of the subsystems within a complex of intra- and extra- familial systems.

1.7.1 SPECIFIC ELEMENTS OF OREM'S SELF-CARE MODEL

This model sees the client as a psycho-physiological organism with rational powers functioning in a biological, symbolic and social manner (symbolic behaviours include "slips of the tongue, dreams and physical hysteria). Self-care is defined as:

"The production of actions directed to self or to the environment in order to regulate one's functioning in the interest of one's life, integrated functioning and well-being" (Orem, 1985,p.31).

Health is seen as a state of wholeness. This wholeness implies, not only that nothing has been lessened or omitted, but also the existence of a progressive development towards higher levels of integration (Orem, 1985). This view of health is conceptually similar to the W.H.O. definition already discussed (p.9).

The contribution of the environment is seen as both physical and psychosocial, and it is this very comprehensiveness that adds the dimension of a continuous development throughout the life-cycle. The concept of development includes the forming or changing of attitudes and values, the creative use of abilities, the adjustment of self-concept and bio-psycho-social development throughout the lifespan. Nursing is seen as a service mode of creative effort of one human being being able to help another. The relation of nurse to patient is a **complementary relationship**, in that the nurse seeks to help the client/patient assume

responsibility for her or his health-related self-care. The individual's need to take responsibility for self-care action is prioritised and the nurse plays a major role in assisting the client to do so. Orem (1985, p.15) refers to this as the "primary work" of nurses.

" Nursing has as its special concern the individual's need for self-care action and the provision and management of it on a continuous basis in order to sustain life and health, recover from disease or injury, and cope with their effects" (Orem, 1985, p.6).

Self-care involves a decision or choice. Self-care and care of dependents may be well intentioned, but may not be therapeutic. The word **therapeutic** is used to mean, support of life processes - remedial, curative, or contributing to personal development and maturity (Orem, 1985). Meeting one's therapeutic self-care demand (or that of another) is engaging in preventive health care and may involve seeking and actively participating in the care offered by health professionals. When it is effectively provided, self-care, organised around universal and developmental self-care requisites fosters positive health and well-being.

Self-care includes all those activities that maintain life, health and wellbeing.

Three categories of self-care are differentiated:

- 1) Universal self-care - ability to meet physiological and psychosocial needs or activities of daily living.
- 2) Developmental self-care - includes the developmental stages and events through

the lifespan.

3) Health deviations in self-care - which arise when health is threatened or compromised and include self-care demands, ability and deficits in areas of knowledge, skills, motivation and orientation. Good health is seen as a state of equilibrium. Ill-health occurs when there is a disequilibrium between self-care and reserve self-care ability, and the self-care requisites (Orem, 1985; Stanhope & Lancaster, 1992). The researcher notes that these are core concepts of systems theory.

The therapeutic self-care demand varies according to the self-care requisites from which it is made.

Primary prevention includes effectively meeting universal and developmental self-care requisites in well individuals, taking into account such life-cycle variables as age, environmental conditions and developmental state eg. childhood, adolescence and parenthood. This conceptualisation places the developed programme firmly in the area of primary prevention.

Following on from the three categories of self-care requirements are three categories of intervention, sometimes termed "typologies of nursing systems":

- 1) wholly compensatory - patient has no active role, the nurse acts, does or provides for the client
- 2) partly compensatory - nurse and patient interact actively, the nurse supports and guides the client

3) educational development- nurse and patient interact actively the nurse teaches and provides knowledge and skills. This is a supportive-developmental system. "It is the only system where a patient's requirements for assistance relate to decision making, behaviour control, and acquiring knowledge and skills' (Orem, 1985,p.100).

Orem (1985) suggests five general methods used by all helping professions:

- 1) Acting or doing for another
- 2) Guiding another
- 3) Supporting another (physical or psychological)
- 4) Providing an environment that promotes personal development in relation to becoming able to meet present or future demands for action
- 5) Teaching in order to develop knowledge or particular skills.

When multi-person units such as families are served by nurses the nursing systems are usually combinations of compensatory-supportive-educative nursing systems. All five helping methods may be in use at the same time. It is critical to recognise that learning cannot take place if the person being taught is not in a "state of readiness to learn", is unaware of a deficiency in knowledge, or is not interested in learning (Orem, 1985).

1.7.2 APPLICABILITY TO AREA OF RESEARCH

Orem's theory is particularly relevant to this research. There are some self-care

requisites common to all persons who constitute a group. The environment in which group members work or live affects the nature of the common self-care requisites as well as the methods for meeting them (Orem, 1985). This interrelationship between group members is of particular significance when working with groups which have the multidimensional complexity of also being family members eg mother's, and having another family member eg her child, present within the group. As is the case with the developed programme. The mother child dyad forms a family group within a mother's group and the developed programme includes all five of the nursing helping methods discussed above.

Orem (1985) outlines the purposes of nursing in the group and particularly in the family context as:

- * To promote the development by family or group members of the capability to view the family or group as a unit of structure and operation.
- * To promote the development or exercise of essential self-care or exercise of essential self-care or dependent-care capabilities.
- * To bring about the development and maintenance by family members, of cooperative efforts essential for group welfare by:
 - a) determining the interrelatedness of the therapeutic self-care demands of members.

- b) planning mechanisms for meeting individual and group needs and
- c) maintaining motivation and material resources.

Nursing actions to meet these therapeutic self-care needs and goals and to promote the well-being of the group as a unit, involve; organization, cooperative effort, interest motivation, knowledge and skills teaching. This research seeks to mobilise all of these nursing actions within the context of the developed family support programme.

1.8 FORMULATION OF HYPOTHESES

HYPOTHESIS ONE

The primary hypothesis is that the developed programme will meet the therapeutic self-care needs and goals of the mother and child as measured by positive changes in the maternal-child interaction.

The **first null hypothesis** is that the experimental and control groups would show no difference in maternal-child interaction patterns as measured by maternal attitude.

The **alternative hypothesis** is that the control and experimental groups would show different maternal-child interaction patterns, with the experimental group of mothers who participated in the developed intervention programme, showing increased usage of positive maternal-child interaction skills when compared to both the support group and the routine nursing service control group. **Increased**

positive maternal-child interaction is shown in the literature review to be a **primary prevention against child abuse** and this will be measured by assessing changes in maternal attitude.

An experimental intervention in the form of a family support programme aimed at enhancing maternal-child interaction was developed. The developed programme is the independent variable, the dependent variable was the extent to which maternal-child interaction was or was not enhanced. In order to distinguish between the effects of "group support" as opposed to the effects of the developed programme it was necessary to have one experimental group and two control groups. In the experimental group, the independent variable was the intervention programme designed to give specific learning material on maternal-child interaction and communication skills. In control group one the independent variable was an antenatal or other support group with no specific emphasis on maternal-child interaction. The second control group experienced only routine clinic and nursing services.

HYPOTHESIS TWO

The nursing intervention seeks to meet the self-care needs/demands of both the mother and the child and can be anticipated to affect the self-care needs of other significant family members and the family group as a system. This systems concept is the motivation for the researcher going beyond the first hypothesis and looking for any influence on the family, formulated in hypothesis two (a change in the equilibrium of one system will impact on interacting systems).

The **second null hypothesis** is that there will be no difference in the experimental and control group family relationships and functioning within families.

The **alternative hypothesis** is that there will be differences in the family relationships and functioning within families for the experimental family support programme group but not for the control groups.

HYPOTHESIS THREE

While the researcher felt that it was unlikely that any brief family support programme totalling only 15 hours intervention would have the power to influence **measurable** changes in the maternal-child interaction and maternal attitudes in the long-term, it was considered worthwhile to attempt this follow up. If the **first null hypothesis** is accepted, the researcher will follow up **only** maternal attitudes to participation in the support programme. If the **first alternative hypothesis** is accepted the researcher will follow up long-term to establish if the changes noted are persistent over time. In the latter instance a third null and alternative hypothesis will exist.

The **third null hypothesis** will be that the changes identified in the short-term evaluation of maternal-child interaction patterns will not continue to be measurable in the long-term.

The **alternative hypothesis** will be that the changes identified in the short-term evaluation of maternal-child interaction patterns will continue to be measurable in the long-term.

1.9 ADDITIONAL RESEARCH QUESTIONS

The formulation of additional research questions was guided by the literature review of child abuse and the existence of extensive community violence at the time of the study period.

RESEARCH QUESTIONS

QUESTION 1

Research detailed in the literature survey suggests that interventions are more effective when introduced to families who do not have entrenched dysfunctional behaviour patterns (Barth,1991). This research intervention aims at primary prevention, before such behaviours have become entrenched. The researcher looks at whether this primary intervention can influence potentially dysfunctional families to change their maternal-child interaction more than it influences functional families to change their maternal-child interaction. The independent variable in the intervention experimental group is the potential for dysfunction and the dependent variable is the change in maternal-child interaction patterns. The researcher suggests that is that there will be greater changes towards positive maternal-child interaction in those dyads identified as having a high potential for child abuse.

QUESTION 2

Research indicates that mothers with low self-esteem are frequently also depressed

and are at risk for abuse. Research on maternal support programmes has shown an increase in maternal self-esteem, which in turn has reflected positively on the family and community systems (literature survey). The independent variable is the developed programme and the dependent variable is the degree of change in maternal self-esteem. It is anticipated that the experimental mothers will show increased self esteem and this will be greater than any changes which might occur in either of the control groups.

QUESTION 3

High levels of community violence existed in South Africa during the time of the research which covered the 1992/93 pre-election period. The researcher felt that it was imperative to monitor the level of community violence in order to ascertain any influences this might have on the research. High levels of community violence and life stresses could influence the maternal-child relationship in the experimental groups and could prevent the measurement of any changes caused by the developed programme.

1.9.1 BRIEF DISCUSSION

The researcher envisages identifying appropriate instruments which will give quantitative statistics to enable her to accept or rejects the above hypotheses and answer the posed research questions.

Qualitative material will be gathered concurrently in order to assist the researcher

to both substantiate and understand the quantitative results (triangulation). The description and recording of the perceptions, attitudes and feelings of the subjective worlds of the programme participants is felt to an important aspect of this research and is supported by the guiding conceptual framework. Orem sees health comprehensively as including changing attitudes and values. Therapeutic self-care contributes to personal development and involves decisions and choices. The qualitative data encourages both the participant mothers and community health nurses to express their individual opinions and feelings about the developed programme.

1.10 DEFINITION OF TERMINOLOGY

The following definitions are given to clarify key terms utilized in this research.

1.10.1 NURSE:

This refers to any person registered as a nurse under the Nursing Act, 1978 (Act No.50 of 1978 as ammended).

1.10.2 CHILD:

This refers to any person under the age of 18 years. (The Child Care Act NO.74 of 1983).

1.10.3 CHILD ABUSE AND NEGLECT:

In South Africa, The Child Care Act,no.74 of 1983 as amended by the Child Care Amendment Act, no. 1346, 1991, requires compulsory notification by

dentists, medical practitioners, nurses and social workers of:

"injured children or children who suffer from nutritional deficiencies..."

"..the cause of which probably might have been deliberate.."

Ill-treating or abandoning a child is an offence, but this legislation does not define these terms implying child abuse. This legal definition is not considered comprehensive enough by the researcher who guided by the literature review sees child abuse as any physical, mental or sexual abuse, negligent treatment, or maltreatment of a child under the age of eighteen. For the purpose of this research child abuse and neglect will be defined as:

"a deficit in the positive two-way reciprocation of stimuli and response interactions between mother and child as determined by maternal attitude".

(Supported by the literature review of the ecological nature of child abuse, see also definition by Steele, 1980 on p.79).

1.10.4 MATERNAL-CHILD INTERACTION PATTERNS:

The parent is influenced by learning and past experiences to certain patterns of behaviour and response and parent-child interaction involves a dynamic two-way reciprocation of stimuli and responses (Nash, 1970, p. 450). For the purpose of this research parent-child interaction is measured by looking at four attitude measurement variables: acceptance, overprotection, overindulgence and rejection. Schaefer & Bayley (1963) found these four maternal attitudes influenced child behaviour from infancy to adolescence. The researcher attempts to identify a measurement instrument which will include the child's responses to the mother's attitude in order to reflect this reciprocal interaction.

1.10.5 SELF ESTEEM:

This covers the "feelings or conceptions of self, including the social self or the self capabilities" (Watson & Bell, 1990, p. 15).

For the purpose of this study, maternal self esteem was measured utilizing the Rosenberg Self Esteem Questionnaire.

1.10.6 PRIMARY PREVENTION:

The aim of prevention at each of the three levels, primary, secondary and tertiary, is to prevent the pathogenic process from evolving further.

" Primary prevention is aimed at intervention before pathological changes have begun during the stage of susceptibility."

(Stanhope & Lancaster, 1992, p.156).

It is applied to a generally **healthy** population and includes generalized health promotion as well as specific protection against disease (Shamansky & Clausen, 1980).

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION - CHILD ABUSE

Abuse of children has been well documented throughout history. It was in fact only the latter half of the nineteenth century that saw the development of a more compassionate, humane view of children and their needs. The first reported case of child abuse was in April 1874, the case of Mary Ellen, a nine year old American girl from New York who was protected from the severe maltreatment of her stepmother by a nurse, who reported the abuse to and enlisted the assistance of the Society for Cruelty to Animals (SPCA) there being no organisation at the time for the protection of children. This case led to the founding of the New York Society for the Prevention of Cruelty to Children (NYSPCC) in 1874 (Lazoritz, 1990; Radbill, 1980; Starr, 1988). In August 1948 Dr. John Caffey wrote an article on multiple fracture of the long bones of infants suffering from chronic subdural haematoma (Woolley & Evans, 1955). However it was not until 1961, that the term "battered baby syndrome" was first coined by Dr. Henry Kempe in an attempt to draw the attention of his colleagues and the general public, to the plight of these children (Finkelhor, Hotaling & Yiio, 1988; Helfer & Kempe, 1980; Radbill, 1980; Starr, 1988). Within four years all fifty states had introduced laws concerning the reporting of suspected cases of child

abuse. It is largely due to the continuing interest and research of Kempe that the interest of researchers from multiple disciplines has been aroused, and the incidence and aetiology of child abuse and neglect has been extensively researched over the last three decades. The 1980's onwards has seen an increased public and research awareness of the incidence of child sexual abuse.

2.1.1 CRITERIA FOR DEFINING CHILD ABUSE

The subject of child abuse is complex in that this covers not only a range of different types of abuse but also a continuum of different levels or degrees of abuse. The difficulties involved in developing a universal definition for child abuse hinder all areas of care.

The labelling of a given act as abusive or not, is often determined by the situation, circumstances, relationship of perpetrator, intentionality of the act, frequency of abuse, degree of perceived harm to the victim, moral, religious, societal, or cultural norms and mores. In reality child abuse is defined by the socio-cultural context within which it occurs. That which is considered abusive in one culture may not be considered to be so in another, or even within different groups of the same culture (Korbin,1980,b). Thus the Nguni customs of facial scarification, (which entails the slashing of the infant's face with a razor blade and rubbing of charcoal into these cuts to ensure scarring in the belief that this is as a prevention against ill-health in the child, in the adult is indicative of the cultural identity) or the custom of "Ukuphehlewe" (where a small rough stick

is inserted into the rectum of the young girl until bleeding occurs as a preventive against future promiscuity) would be considered abusive practice by western mothers. Likewise the western custom of sleeping apart from one's child, leaving the child to cry or not immediately feeding the young child on demand would be considered abusive by an Nguni mother. Disagreement is particularly strong within the grey areas in the middle of the continuum of permissive to abusive child care. Giovannono and Becerra found in their study of cross-cultural attitudes to abuse, that different cultural groups made similar ratings in their attitudes to physical injury and punishment (cited in Levinson, Graves & Holcombe, 1984). Garbarino and Gilliam see the different definitions as being determined by four factors: the intentionality of the act, the act's effect on the child, the society's value judgement made about the act and the standard on which the judgement is based (cited in Starr, 1988; cited in Gelles & Cornell, 1988).

These difficulties hinder the assessment of the prevalence of child abuse, the development of effective prevention and treatment programmes, the legal accountability of the perpetrator and the comparative value of much of the research. For the purpose of this research the definition in chapter one will be utilized.

2.2 TYPES OF ABUSE

Current clinical thinking suggests that some children who are physically abused are also likely to be sexually and psychologically abused (Burgess, Hartman &

Kelly, 1990).

2.2.1 PHYSICAL ABUSE

This involves the infliction of physical trauma to the body of the child. This is frequently referred to as "non-accidental injury", or the "battered baby syndrome". This can occur within a continuum from mild to severe and involves varying levels of violence and intentionality in the perpetrator (Kelly, 1983). This type of abuse, while frequently obvious because it leaves visible evidence of the trauma, need not necessarily be so. For example a child who has been punched in the belly may show no external signs of trauma, but may suffer internal injury (Silverman, 1980). A child who has been shaken might present with a severe whiplash injury (Dykes, 1986). Conversely a child who has been severely beaten may show only fairly mild bruising. The injuries include, bruises, welts, tie-marks, burns, cuts, puncture marks, pinch marks, bite marks, finger or fist marks, scars, head and eye injuries and bone fractures.

Many cultures regard corporal punishment as a normal and even necessary aspect of parenting. This is tacitly reinforced by state acceptance of physical punishment in institutions. Corporal punishment in schools is now illegal in many countries but is still emulated in some third world countries (Benthall, 1991). An American National survey in 1975 found that 77% of parents felt that spanking was a normal aspect of parenting and 71% felt that it was actually necessary and good

(Straus, Gelles & Steinmetz, 1980). A national survey by Straus et al in 1975, showed that three in every hundred parents had kicked, bitten or punched their child in the last twelve months (1980). Rivara (1985) found that in abused children under two years, the first incidence of abuse had occurred at a mean age of eight and a half months. Physical abuse occurred in 89% and neglect in 11% (the latter was more likely in the younger child). Studies cited in Garbarino (1977) show that 90% of parents report using physical force, 25% spank their children under six months and 50% spank under one year and that two thirds of police, clergy and educators condone spanking.

Corporal punishment that requires medical treatment is outside the acceptable range of normal punishment, and on the more severe end of the continuum. Few cultures would not label this as abuse. Yet as indicated by the preceding research many infants and young children are subjected to parental interaction which has a high potential for trauma requiring medical attention.

Lesions of the face, neck and genitalia are frequent in abused children of all ages but uncommon in normal children except those between 9 months and 3 years, of whom about 12% commonly had such bruising (Addy, 1985). These marks are frequently seen in different stages of healing and reflect the shape of the article used to inflict the injury (Bamford, 1981; Maurer, 1991; Schmidt, 1980). Approximately 10% of physical abuse cases involve burns (Gillespie in Schmitt & Kemp, 1975). These burns are inflicted by cigarettes, incense sticks, matches or lighters and irons, parts of the body may be immersed or splashed with boiling

water or held against a hot surface eg. stove plate, heater (Bamford, 1981). Seventy-two percent of burns are in children under five years of age (Feldman, 1989).

In a twenty year retrospective study of fatal child abuse, "shaking" was implicated in 13% of the fatalities (Showers, 1992). Follow up research by Showers established that at least 25% and as many as 50% of parents or prospective parents did not know that shaking an infant is dangerous (cited in Showers 1992). Central nervous system damage has a high morbidity and mortality (50% suffer permanent loss of vision) and usually occurs in the child under two years (Schmitt & Kempe, 1975; Schmitt, 1980).

There is a clear association between "near miss" cot deaths and Sudden Infant Death Syndrome (SIDS), and child/sibling abuse. One in ten SIDS deaths were found by Newlands & Emery (1991) to be directly due to abuse. Schmitt and Kempe (1975) warn that subdural haematoma due to birth injury will produce signs and symptoms within 24-48 hours of delivery, all other presenting subdural haematoma should be carefully investigated as being highly indicative of child abuse. Children suspected of being abused should have X-rays of long-bone, skull, rib and pelvis taken, as old injuries may well be identified to complement the evidence of existing soft tissue damage (Addy, 1985; Bamford, 1981; Silverman, 1980). McRae, Ferguson and Lederman found that 10 to 15% of children who suffered bone fractures, head traumas and subdural haematoma were later found to have died and Holler and Friedman suggest that 8-10% of

paediatric emergency room injuries are child abuse (cited in Kelly, 1983).

Caretakers may give drugs or poison to children to induce illness eg. laxatives and anti-diarrhoeal medication, or symptoms may be fabricated by the caretaker, subjecting the child to unnecessary and often invasive tests and medications. This type of abuse is known as Munchausen syndrome by proxy (Bamford, 1981; Schmitt & Kempe, 1975; Whaley and Wong, 1987).

2.2.1.1 Common Behavioral Indicators of Physical Abuse

Various authors report a collection of body language pointers to alert the observer to the possibility of physical abuse. This is crucial knowledge for health care workers, most particularly at a preventive or early intervention level. These pointers are significant to this research in that they substantiate the **interactive** nature of the behaviour between mothers and their children. It is this interaction between the maternal-child dyad which the researcher anticipates influencing in the primary prevention of child abuse.

The child may become wary of adult contact and of being touched. Hypervigilance or "frozen immobility" may accompany age inappropriate behaviour eg. the very "good" child who undergoes painful procedures without crying, struggling or holding their breath (Carley, 1985). Impaired ability for enjoyment and excessive apprehension when other children cry may be observed as may behavioral extremes such as aggressiveness or withdrawal and pseudoadult

role-reversal behaviour with adult and peers.

Sudden deterioration in school performance may occur or the child may appear afraid or slow to go home. Actual injury by parents or caretaker may be reported. This child is never absent even when sick or may be frequently absent.

(Burgess, Hartman & Kelly, 1990; Carley, 1985; Jones, 1977; Maurer, 1991; Martin, 1980; McQuiston & Kempe, 1980).

2.2.2 PHYSICAL NEGLECT

Neglect is the most common type of abuse (ratio 2:1) and the most likely to be implicated in child death (Downing, 1978). This is a lack of care, (physical, nutritional, medical or emotional) which results in damage or harm to the child. Neglect patterns are usually continuous and chronic and more frequent in very young children, 68% are under 5 years, and consequently very dependent on the care of adults for the basic necessities of life which ensure growth and development. It is more common in boys than in girls and in low birth weight and in illegitimate babies (Sadler, 1986). These children may present with "failure to thrive" (FTT), dehydration, failure to achieve normal developmental milestones, frequent infections and accidental injuries and/or neglect of the child's needs for medical care (Addy, 1985; Bamford, 1981; Schmitt & Kempe, 1975). Water deprivation or hypernatraemic dehydration in any child over two years of age is strongly indicative of abuse and neglect (Schmitt & Kempe, 1975). The child may be abandoned in public places or left unattended alone at home for long periods (Addy, 1985; Bamford, 1981). Schmitt and Kempe (1975) claim that over 50%

of failure to thrive cases are due to calorie deprivation associated with neglect. This is supported by Cantwell (1980). Up to 5% of all paediatric training hospital admissions are for FTT (Karniski, van Buren & Cupoli, 1986). This FTT is non-organic or environmental (NOFTT) in nature and strongly associated with **dysfunctional maternal-child interaction**, difficulty in parenting, isolation of parent from the child and subsequent emotional deprivation to the child (Ayoub & Milner (1985); Haynes, Cutler, Gray & Kempe, 1984; Karneski et al, 1986; Kristiansson & Fallstrom, 1987; Kempe, Cutler & Dean, 1980). As the severity of NOFTT increases so the maternal awareness decreases eg. strong denial and projection of the child's problems (Ayoub & Milner, 1985; Kotelchuck, 1982).

This data is particularly pertinent to South Africa. We have a large poor community trapped in the "poverty cycle" and a high infant mortality rate from diarrhoeal disease and failure to thrive. The researcher questions the influence of the poverty cycle has on the maternal-child relationship eg. powerlessness, vulnerability, physical weakness, poverty and isolation. Many of our infant deaths may be linked to non-organic failure to thrive and not simple economic poverty.

2.2.2.1 Behaviourial Indicators of Physical Neglect

As for physical abuse there are a number of pointers which may alert the nurse to the possibility of neglect. These include apathy, listlessness, tiredness, withdrawal and misery with a limited range of emotion. Indiscriminate affection may occur from a child who appears almost desperate for attention. In the young

child under five this may result in gross and fine motor developmental delay, poor language skills, distractibility, hyperactivity and even aggression.

The older child may present with failure to thrive, excessive appetite, poor impulse control, delinquency, alcohol or drug abuse. This child may attempt to stay at school and may even deny the caregiver's existence. Disturbed integrative process of thought are common (Martin, 1980; Maurer, 1991; McQuiston & Kempe, 1980).

2.2.2.2 Short and long term effect of physical abuse and neglect

The frequently disorganised and violent environment of the physically abused child leads to a minimum frustration tolerance and a need for instant gratification because anything beyond the present has little reality (Egeland, Sroufe & Erickson, 1983). The abused child perceives people as menacing and not associated with gratification, which leads to an inability to experience pleasure or to learn how to express gratitude (Harper, 1991). Due to the accelerated brain growth which occurs in the young child, accompanied by the nutritional deficit and/or physical injury the child is at risk for impaired intellectual growth. In short-term follow up several studies cited in Oates (1989) showed high levels of developmental retardation (up to 50%), language delay (38%) and emotional problems (62%). Abused and neglected children frequently tend to blame themselves for their problems (Ney, Moore, Mcphee & Trought, 1986).

Long-term follow up studies show prolonged problems experienced by abused and neglected children. In a four year follow up of early NNFTT infants, it was found that these children continued to grow slowly and maintain suboptimal growth patterns (Kristiansson & Fallstrom, 1987). Long term serious psychosocial problems are common and range from delinquency, criminality, mental illness and mental retardation, suicide attempts, psychosomatic complaints, depression, post traumatic stress disorder (PTSD), multiple personality, eating disorders, drug and alcohol abuse, low self esteem poor functioning at work, teenage pregnancy and prostitution (Jones, 1977; Finkelhor et al, 1988; Hamilton, 1989; Kluft, 1987). The parenting potential for these victims is not propitious and preventative intervention deserves urgent attention from all professionals working with families.

2.2.3 SEXUAL ABUSE

Sexual abuse is the involvement of the child in age inappropriate sexual behaviour designed for the gratification of the adult or older adolescent. It is inappropriate for the child's age level of psychosexual development and for his role in the family (Fore & Holmes, 1984). This type of abuse ranges from voyeurism, obscene phone calls, indecent exposure, to fondling or molesting, taking pornographic pictures, intercourse or attempted intercourse, rape or child prostitution" (Jacklin, 1992; Kempe, 1980; Lowery, 1987; Maurer, 1991; Stuckie, 1983). Physical signs include the presence of genital or oropharynx sexually transmitted diseases, injury, dilatation, pain, discharge or unexplained

bleeding or foreign bodies in the genitalia, urethra, bladder, vagina or anus (Fore & Holmes, 1984).

The perpetration of this type of abuse is closely related to culture and the specific gender power structures in that culture, is invariably perpetrated by males and most frequently by stepfathers (Levett, 1990). This may be within (intra) or outside (extra) the family. When intrafamilial it is known as incest. This is reported to occur more frequently in girl than boy children and is most frequently perpetrated by a **family member** or someone **well known** to the child (Addy, 1985; Dube & Hebert, 1988; Fore & Holmes, 1984). Greenberg reports that **1/3 of sexual abuse** cases had been **previously reported for physical abuse** (cited in Pierce & Pierce, 1985). This clearly highlights the need for health care workers to be aware of the interrelationship between the different types of abuse and the potential for the presenting type of abuse to mask multiple abuse patterns. The mean age for sexual abuse of children is 10.4 years (Pierce & Pierce, 1985). Sexual abuse of children who know their perpetrator, peaks at **5-6 years** of age, and again at puberty, where the perpetrator is frequently extrafamilial or a stranger (de Chesnay, 1989; Dube & Hebert, 1988). This type of abuse may or may not be accompanied by physical injury. Emotional abuse frequently accompanies sexual abuse in the form of threats of punishment for disclosure and family breakup, and the emotional feelings of helplessness, guilt over the abuse and decreased feelings of selfworth (Oates, 1989).

Pierce and Pierce (1985) found that 20% of the wives of sexually abused children

feared their spouse themselves, 20% did not believe the child's story, 16% tolerated the abuse of their daughter and 4% actually encouraged it. This is not a indicative of a close maternal-child relationship.

Phelan (1986) documents that incest by the biological father and the stepfather appear to take different forms. The biological father more frequently engages in full intercourse, more frequently is involved with multiple daughters and is more likely to have begun sexual activity during adolescence. Stepfathers most frequently begin sexual molestation in the preadolescent. Fifty percent of runaway adolescent girls have been sexually abuse, some with concurrent physical abuse (Kempe,1980; Pierce & Pierce, 1985).

While this research prioritises the maternal-child relationship it is important to take note of the above literature on sexual abuse for the following reasons:

a) While the male caretaker is the main roleplayer in sexual abuse, the mother frequently either does not believe her child or is aware of the abuse and plays a passive or active role in the triad of abuse (Pierce & Pierce,1985). This is indicative of a poor maternal-child relationship. An intervention which successfully improves the maternal-child relationship would have the potential for prevention of **all** types of abuse. b) An intervention which is successful in improving the maternal-child relationship might well have potential for influencing the paternal-child relationship. The influence of this on the primary prevention of particularly sexual abuse would be worthy of further study.

2.2.3.1 Common Behavioral indicators of sexual abuse

Behavioural indicators predictive of sexual abuse include the following:

- * Enuresis and Encopresis in the child with previous control.
- * Difficulty in walking or sitting.
- * Apparent psychosomatic headaches, abdominal pain, asthma, allergies, school and behaviour disorders are masked overt signs of sexual abuse.
- * Withdrawal, fearful, fantasy, crying or regression in behaviour.
- * Sudden reduction in assertiveness and in affective display to perpetrators (frequently the parents)
- * Anorexia, eating problems or other compulsive disorders.
- * Change in sleep patterns, fear of the dark, anxiety, impulsivity.
- * Bizarre, sophisticated eg. seductiveness, or unusual sexual knowledge or behaviour.

In the older child:

- * Low self esteem, depression, feelings of powerlessness, lack of trust self-destructive behaviour, alcohol and drug abuse and even attempted suicide.
- * Delinquency, truancy, deterioration of school work.
- * Unwilling to undress or change at school or preschool.
- * Reports, discloses sexual assault.

(Burgess, Hartman & Kelly, 1990; Beitchman, Zucker, Hood, da Costa & Akman, 1991; de Chesnay, 1989; Kolko & Moser, 1988; Lowery, 1987; Oates, 1989; Zimrin, 1986).

2.2.3.2 Short and long term effects of Sexual Abuse

Feelings of powerlessness and lack of trust are immediate effects of child abuse and follow the abused child into later life with serious consequences (Oates, 1989). The abused child is at high risk for future sexual victimisation and physical abuse (more battered wives) and are more likely to have daughters who are abused (Finkelhor et al, 1988). The sexually abused child frequently has poor self esteem, feelings of detachment, lacks ability to express emotions, has difficulty with authority figures, in relationships and in **parenting**, and tends to be isolated (de Chesnay, 1989; Lowery, 1987; Zimrin, 1986). She is at increased risk for personality disorders (eg. multiple personality disorder), for drug abuse, self destructive behaviour and suicide (Beitchman, Zucker, Hood, da Costa, Akman & Cassavia, 1992).

Problems with sexual functioning may take the form of aversion to sex, homosexuality or promiscuity (Finkelhor et al, 1988). Oates (1989) found that sexually abused adolescence girls (21%) and boys (6%) had been convicted of crime. The general crime prevalence rate for teenagers is 3.6% boys and 0.7% in girls.

In all types of abuse the long term effects are more severe when multiple and particularly ritualistic abuse occurs (Burgess, Hartman & Kelly, 1990).

2.2.4 EMOTIONAL ABUSE AND NEGLECT

This type of abuse is the most difficult to measure but current clinical thinking suggests that it frequently accompanies other types of abuse (Burgess et al, 1990). Claussen & Crittenden (1991) found that psychological abuse was present in almost all (91%) of physically abused children and was more related to the detrimental outcome of children than was the **severity** of the injury. A study by Briere & Runtz (1988) suggests that parental maltreatment of children is a multidimensional phenomenon, and both **physical** and **psychological** abuse types are typically present in the same families. This study highlights the significance of **both** parents in a pattern of " general parental abusiveness". The complex relationship of one type of abuse to another and the continuum of mild to severe clearly demonstrates why child abuse is so difficult to define.

Emotional abuse includes the psychosocial effects of abuse but may be an independent form of abuse. It includes the scapegoating, terrorizing, berating, verbal aggression and emotional rejection of the child. It includes abandoning children in public places and locking or threatening to lock a child in the cupboard, car boot or other frightening, dark place.

It includes inconsistent **parenting** where the child can never be certain of the caretaker's reaction or where a double-bind communication style exists (caretaker says one thing but means another; a no-win situation for the child).

Verbal aggression has long been thought to be undesirable, to lower the child's self-esteem and result in problematic behaviour (Ney et al, 1986). Recent

research strongly supports the fact that verbal aggression is detrimental to the child. In a well controlled study by Vissing, Straus, Gelles & Harrop (1991) involving 3,346 children, the effects of physical and verbal aggression were clearly differentiated. Verbal aggression was found not only to be extremely common, 2 out of 3 children being exposed to this form of abuse, but also, when it occurs, it occurs frequently, on average 12.6 times per annum. The most commonly verbally abused age group were children under 12 years, and tended to be boys. Where verbal abuse occurred in the under six's, it also occurred the most frequently on a per annum rating (ie.the **younger** the child the more **frequent** the abuse). The effects of verbal aggression were found to be independent of physical aggression. Verbal aggression was most closely associated with perpetration of **aggression** in children. Verbally aggressive parents tend to have aggressive children, regardless of whether the parents are also physically aggressive. The relationship between physical aggression and delinquency or interpersonal problems was also found to be minimal, unless the parents were **also** verbally aggressive (Vissing et al, 1991).

Emotional neglect concerns the failure to provide the child with adequate direct love, care, and attention. Direct attention involves verbal and non-verbal communication with the child. This lack in turn compromises the child's biopsychosocial developmental milestones (Bamford, 1981; Cantwell,1980). Verbal abuse appears to interfere with the child's ability to distance himself from the experience, making him angry at himself and pessimistic about his world, and frequently presents with psychosomatic symptoms (Bamford, 1981). Because

verbal abuse does not result in any physical wounds, it is not condemned by social norms to the same extent as are other types of abuse and it is more likely to be **passed on to the next generation** (Hjern, Angel & Hojer, 1991; Vissing et al, 1991). There is some evidence to suggest that early emotional/psychological abuse coupled with neglect and or physical abuse, may impair the child's total capacity for emotional response (Brothers, 1989).

2.2.5.1 Common Behavioral Indicators of Emotional Abuse and Neglect.

The behavioural indicators for emotional abuse may not be as obvious as are those for the other categories of abuse and are most readily observed in the child **under five**. As the community health nurse is frequently the first contact of the family with a professional caregiver for this age child it is absolutely essential that she or he is aware of these indicators. These are:

- * Failure to thrive or persistent hunger.
- * Speech delay and poor language skills.
- * Gross and fine motor development delays .
- * Poor relationship with peers.
- * Disturbed integrative process of thought.
- * Habit disorders and psycho-neurotic reactions (eg. sucking, biting, rocking)
- * Behaviour extremes accompanied by conduct disorders.
- * Indiscriminate affection with adults.
- * Reduced empathic capacity.

(Burgess, Hartman & Kelly, 1990)

2.2.6 STRUCTURAL ABUSE

State supported child abuse and neglect or structural violence has been detailed under the problem statement. The South African government apartheid system has lead to abuse and neglect of children as a result of ethnic discrimination and segregation (Eekelaar & Katz, 1977).

The high level of political transitional community and family violence, has resulted in many children suffering from post traumatic stress disorder (PTSD). The effects of which may be affective/emotional numbing, recurrent nightmares or flashbacks, hyperalertness, sleep disturbances, survivor guilt, memory difficulties and an avoidance of stimuli associated with the trauma (Finkelhor, Hotaling & Yiio, 1988).

2.3 MATERNAL BEHAVIOURS AS INDICATORS OF ABUSE AND NEGLECT

This research highlights the significance of the maternal-child interaction. It is therefore important to look at the interaction which occurs when abuse is present. Mothers who abuse their children frequently delay bringing the child for medical attention despite a major injury. They classically show relatively little concern for the physical or emotional pain of the child and appear to regard the entire accident as a nuisance to themselves rather than as a matter for deep concern for the feelings of their child (Baher, Hyman, Jones, Jones, Kerr & Mitchell, 1976).

Conversely they may present as being overprotective, never leave the child alone or allow him or her to speak independently (Addy, 1985). The history of the injury is often unexplained, vague and /or implausible and bizarre, being discrepant with the type of injury likely to be sustained by the type of explanation offered (Schmitt, 1980; Schmitt & Kempe, 1975). An indicator of possible abuse is the mother's behaviour both towards the affected child and also towards authority figures eg. police or welfare. Frequently the child is not permitted to speak for itself (Carley, 1985). Abusive mothers may also show cultural variance in behaviour eg. American abusing mothers tend to be bold, spontaneous and have many emotional responses, while Greek abusing mothers are shy, withdrawn and threat-sensitive (Kokkevi & Agathonas, 1987).

2.4 INCIDENCE OF CHILD ABUSE

This is difficult to determine, particularly since there is no one standard definition for child abuse. Incidence figures are usually taken from confirmed, reported cases of child abuse. Zellman's national survey indicated that 40% of mandated reporters had violated these laws at some time and this is supported by numerous other studies (Finkelhor & Zellman, 1991; Starr, 1988). Starr claims that two in three cases of known child abuse are not actually reported (1988, p. 124).

Conformity and agreement of the type or degree of abuse necessary for abuse to be reported, vary. Starr cites studies showing that the primary reasons for under reporting are: a) Similar personality characteristics between professional and abusing parent. This leads to a dramatic under-reporting of middle class, white

families and higher reporting of low-income minority families. Studies on physician's attitudes towards child discipline were related to reporting. Those personally condoning physical punishment as a form of discipline were less likely to report injury from this type of abuse. Starr (1988) and Finkelhor & Zellman (1992) support the influence of case characteristics on the reporting of child abuse and suggest that some practitioners need to recognise their own biases. An earlier study by Zellman grouped mandated reporters into four categories; (a) consistent reporters who always reported; (b) consistent nonreporters who never reported; (c) the uninvolved, who had never encountered a case of child abuse; and (d) a group termed "discretionary reporters," who sometimes did and sometimes did not" (cited in Finkelhor & Zellman, 1991). This latter group were the second largest group after consistent reporters and accounted for four-fifths of all those who admitted having ever failed to report. This group did not lack training and experience. This study suggests that much noncompliance occurs among well-trained and well-intentioned professionals. The failures to report are often good faith attempts to protect children in the context of overloaded child protection systems. This view is further supported by the fact that in 1985, most substantiated child abuse cases (75%) did not receive any service or intervention beyond the investigation (American Association for the Protection of Children [AAPC], cited in Finkelhor & Zellman, 1991). These authors suggest a possible solution to this would be to register or licence practitioners experienced in child abuse and then introduce a system of flexible reporting options for these practitioners. This would enable a more accurate record of the actual incidence of child abuse, while at the same time maintaining the confidentiality and the

present treatment.

The practitioner's attitude has been found to affect the type of intervention in child sexual abuse. A recent study comparing three groups involved with child abuse intervention (health visitors, psychiatric nurses and medical students), found that more than half gave a low estimated frequency of incest (1:500) whereas research indicates a 1: 60 incidence (Eisenberg, Owens & Dewey, 1987). This raises the concern that the low incidence expected may lead to insensitivity to the possibility of sexual abuse consequent for under-reporting. A study of physicians by Gelles (1982) found that, in line with the medical model which views individual pathology as responsible for disease, they ranked personality disorder as the most important cause of child abuse.

Reference has already been made to the legal situation concerning reporting of child abuse and neglect in South Africa and the obvious limitations and constraints therein (Child Care Amendment Act, No 86 of 1991). Thus the teachers, child care workers and the general public are not legally required to report incidence of child abuse. However in reality most educational authorities have an internal departmental requirement that incidents of this nature are reported to educational superiors for follow up.

Until recent media publicity, many people were unaware of the prevalence and aetiological factors involved in child abuse. A recent statewide survey in Kentucky by Dhooper, Royse and Wolfe (1991) showed that while knowledge

levels about abuse were fairly good, many members of the public still thought that people who abused their children suffered from mental illness, were abnormal and intractable. One fifth knew someone who had abused a child but only one third had actually reported the case despite the respondents' belief that 90% of abused children suffer repeated injury.

The preceding discussion makes it very clear that both **professionals** and **members of the public** are strongly influenced by existing social stereotypes, and that this influences the reported incidence of child abuse. Society finds it difficult to accept the fact that normal everyday, respectable parents can intentionally and violently abuse their children.

Retrospective studies and survey have indicated much higher incidents of abuse. Retrospective studies on physical abuse have found that individuals report abuse of siblings more than of themselves, despite the fact that similar experiences of subjects and siblings are reported. Labelling these as abusive appears to some degree a function of whether the subject perceived the punitive experience as "deserved" or not. Even **severe** abuse is not recognised as such if the child perceives the punishment to be deserved (Rausch & Knutson, 1991).

2.4.1 UNITED STATES OF AMERICA

In 1975 the statistics were 550,000 cases of suspected child abuse and neglect. The incidence of child abuse in the 1970's was thought to be 500 new cases per

million of the population per year (Cross, 1973). Kempe claims that the incidence of physical abuse is considerably higher than this and closer to six to ten per thousand live births (Schmitt & Kempe, 1975).

Helfer and Kempe (1976) and Kempe (1980) list numerous research studies, which show that 60% to 70% of hospital admissions of children under three years and 28% to 34% of children under one year, were related to child abuse. In 1985, the American Humane Association found that 64% of major physical abuse and 37% of the minor incidence of physical abuse occurred in children under 6 years and that no gender differences were identified (cited in Starr, 1988). Professor Rostain from West Philadelphia hospital claims that 1/5 of all children seen in casualty are cases of intentional abuse and that in 1991 forty four children, primarily infants were murdered (personal communication, 1991).

Physical abuse is the primary cause of mortality in children aged six to twelve months of age (Schmitt & Kempe, 1975) and homicide is the only leading cause of death of children under 15 years, to have **increased** in incidence over the last 30 years and includes 18.5% of all deaths in this age range (Christoffel, 1988). Gil (1970) established that approximately half of the physical perpetrators were fathers and when single parents were removed from the analysis, this increased to two thirds.

The AAPC in 1985 found physical neglect to be the most common category of **reporting** (approximately 50%), followed by physical abuse (about 25%) and

sexual abuse made up a minority of 16% (Finkelhor & Zellman, 1991; Starr, 1988). A study of physically abused children under two years of age by Rivara (1985), found that 69% of these families abused more than the index child. Schmitt and Kempe (1975) claim 50% of sexual abuse occurs in children under 12 years. One in four girls between **birth and four years** will be victims of sexual violence (Finkelhor et al, 1990; Fore & Holmes, 1984). Adams and Fay, report that approximately 85% of children who are abused, are abused by someone well known to them, frequently a member of the child's own family (cited in Willows, 1991). These figures make sexual abuse more prevalent than accidents in the home during childhood.

Wyatt & Peters (1986) and later Haugaard & Emery (1989) claim, that on the whole the lower levels are being cited and these are underreporting the true incidence. In a crosscomparison of the methodologies used, they determine that data collection methods influenced the incidence rates. Personal interviews and multiple questions on the same topic lead to higher incidence figures than self-complete questionnaires. They conclude that face-to-face interviews appear to be the method of choice, allowing subjects to clarify misconceptions and their own experiences as abusive or not.

Of significance for this study is the high incidence repeatedly indicated above of **all** types of abuse occurring in the child **under five years**. The severe sequelae of abuse and neglect in this particularly vulnerable age group is of considerable concern for the community health nurse. Of particular note are the figures on the

reported neglect and this data together with the discussion of "non-organic failure to thrive" (NOFTT) (section 2.2.2) and emotional neglect (section 2.2.4) obligates health care workers to become actively involved.

2.4.2 UNITED KINGDOM

Violence as reflected in homicide rates, appears more prevalent in the United States than in the United Kingdom yet studies on cross-cultural variations in the definition of child abuse showed very little difference between that which is culturally classified as abusive when comparing the two cultures (Levinson, Graves & Holcombe, 1984).

In 1977 a select Committee of the house of Commons estimated that one in 10,000 children would be killed each year and 10 in 10,000 severely injured. Oliver reports that in a study over 21 years in north east Wiltshire, there were 513 abused children out of a total of 560 children born into 147 families and 41 deaths under eight years (Addy, 1985). This means that nine out of every ten children in this particular community were treated for abuse at some time during their childhood.

2.4.3 SOUTH AFRICA

Due to the paucity of information in South Africa, it is difficult to compare the incidence of child abuse from one centre to another. An interesting aspect of child

abuse in South Africa is that, primarily owing to the apartheid laws, hospitals and community health centres have tended to service specific cultures. The reported incidence thus reflects the prevalence of child abuse in the cultural group which feeds the health centre. Until the last decade it was believed that child abuse did not occur among the Zulu (Loening,1981). A similar situation of low child abuse incidence was thought to exist with children of Asian origin (Haffeejee,1991). Both writers highlight the significance of the current states of social and cultural transition as playing a crucial role in increased reports of abuse and discuss the possibility that societies in transition may manifest an increased incidence of abuse. Sexual abuse particularly remains underreported in South Africa. South African women are rarely willing to discuss this experience and many cultural taboos surround sexual matters and inhibit open discussion (Levett,1990). The contribution of the breakdown of cultural beliefs and traditions, and the stresses of a transitional state to an increased incidence of child abuse is supported by a number of authors (Mejiuni, 1991; Straker & Moosa,1988).

In Alexandra township in a 21 month survey during 1989 and 1990, 140 cases of abuse were reported. More children were seen for child abuse than there were cases of measles. The most common form of abuse was sexual abuse (81,5%), with an incidence of sexually transmitted disease of 50%. Physical abuse accounted for 9,3% and neglect for 7,1% (Howard,Marumo & Coetzee, 1991).

However, other studies on the Witwatersrand report a relatively low incidence of sexual abuse and a higher incidence of physical abuse and neglect (Hyslop,

Howard, De Villiers & Wagstaff, 1990). Of interest here is the increase in incidence over several years. The number of reported cases at Baragwanath Hospital, Soweto, for sexual abuse was 14 in 1986 and 132 in 1990 (Mkhasibe & Wagstaff, 1991). In Durban during the 12 month period of 1990, 199 cases of child abuse were seen at King Edward VIII Hospital. Here also the most common form of reported abuse was sexual abuse, which accounted for 79% of the cases, thirty three percent of these children were raped and 31% were diagnosed to have a sexually transmitted disease, while 28% suffered physical and emotional neglect (Loening, 1990).

In a six year study also in Durban at R.K.Khan Hospital, a total of 162 cases of child abuse were reported, of which 23% involved sexual abuse. Evidence of sexually transmitted disease was present in 39% of these children (Haffejee, 1991).

Another six year study in Tongaat from 1985 to 1990 found 229 reports of child abuse of which 30% were for sexual abuse (Jinabhai & Pillay, 1991). Children reported for child abuse to the Phoenix Child and family welfare Society in Durban over a two year period from 1987 to 1989 were 140 in number, 31% of which were for sexual abuse (Merharchand & Jinabhai, 1991).

A study by Singh in 1986, of abusing indian parents in Chatsworth found;

- * that married women between 21 and 25 years were the most violent
- * mothers were more abusive than fathers

- * children between 2 and 3 years of age were at the greatest risk
- * a predominance of the Hindu religion and high levels of: unemployment, poor education, residential mobility, community isolation.

These studies would seem to show that child abuse is present in all cultural groups in South Africa and that the number of reported cases would seem to be on the increase. This increased reported incidence will have been influenced by the recent nationwide educational campaigns initiated by Round Table and Child Welfare and the current state of political unrest and violence in South Africa. However this increase remains disturbing in that reported cases are for obvious reasons the more severe cases and thus measure only the very tip of the iceberg.

2.5 AETIOLOGY OF CHILD ABUSE

2.5.1 INTRODUCTION

Theoretical views of the aetiology of child abuse and neglect have changed considerably over the last fifty years. Research has not been able to show that there are any factors that are present in all abusing parents and yet absent from all non-abusing parents (Oates, 1979).

2.5.2 PSYCHOLOGICAL THEORIES

2.5.2.1 Introduction

Initially, in the early research into the aetiology of child abuse, there was strong support and belief in the psychological theories. These postulated that the abuser was mentally disabled or deranged. Researchers found it difficult to believe that a "normal parent" could wilfully and intentionally inflict such trauma and/or neglect on their own child.

2.5.2.2 Mental Illness

Yet 90% of abusing parents were found to be neither criminals nor insane (Schmitt & Kempe, 1975). In fact less than 5% have been found to have a psychosis or sociopathic personality (Spinetta & Rigler, 1972; Wooley & Evans, 1955). Dodds, Smith and Webber (1991), found no psychopathic or personality trends between known incestual fathers and controls of non-sexually abusive fathers.

Despite wide publicity concerning this myth, members of the public and even health professionals, find this difficult to accept (Dhooper, Royse & Wolfe, 1991). However, where mental retardation or psychosis is present in the parent, the risk of abuse is higher (Taylor, Norman, Murphy, Jellinek, Quinn, Poittrast & Goshko, 1991; Wooley & Evans, 1955). When considering the abuse cases involving extremely serious (life threatening) maltreatment of children, 50% of parents were found to have an emotional disorder or low IQ diagnosis on the Diagnostic and Statistical Manual for Mental Disorders of 1987, (DSM 111), (Taylor, Norman, Murphy, Jellinek, Quinn, Poittrast & Goshko, 1991).

2.5.2.3 Parental Personality

Several studies show that abusing parents do tend to have poor impulse control, are easily aroused and tolerate frustration poorly (Brunnquell, Crichton & Egeland, 1981; Casanova, Domanic, McCanne & Milner, 1992; Freeman & Heinrich, 1980; Steele, 1980). Gaenes, Sandgrund, Green & Power (1978), using the Minnesota Screening Profile for Parenting (MSPP), found that while abusive parents scored high on the tendency to become upset and angry, to feel isolated and lonely and to fear external threat and control - the variable of stress outweighed the significance of personality variables.

Disbrow, Doer & Caulifield (1977) found that abusive parents maintain a high state of arousal in response to their childrens behaviour, particularly aversive behaviour. This is particularly significant because studies by Bandura (1973) suggest that people who are emotionally aroused are more likely to respond in an aggressive manner. Starr (1988) postulates that the key factor in abuse is the level of emotional arousal, rather than personality type, particularly immediately preceding the abuse.

Some studies report low self-esteem and depression in abusing parents (Anderson & Lauderdale, 1982; Brunnquell et al, 1981; Evans, 1980; Heinicke, 1984; Oates & Forrest, 1985; Steele, 1980; Whipple & W-Stratton, 1991). Low self esteem

has also been correlated with physical and mental illness (Watson & Bell, 1990). Low self esteem may well be influenced by "learned helplessness", which has been positively correlated with the individuals past experiences of being unable to control the situation (Thornton, 1982). This state of situational loss of control is well demonstrated in Young's study, where in 88% of abusive families, neither parent took responsibility for decision making (cited in Garbarino, 1977). Abusive fathers may be especially passive individuals (Moore & Day, cited in Watson & Bell, 1990).

Other studies have failed to show that parental personality can be correlated to abuse (Gaines et al, 1978; Kelly, 1983). Kelly suggests that while psychological factors by themselves have not been found to consistently correlate with abuse, they do appear to influence the development of such events (Kelly, 1983).

2.5.3 SOCIO-CULTURAL THEORIES

2.5.3.1 Introduction

The psychological theories were followed by the socio-cultural theories which argue that child abuse is the result of characteristics universally found in our society rather than in individual personality patterns.

a) Social variables include stress, social isolation, poverty and societal violence. The acceptability of violence in society being a major contributor.

b) Demographic variables such as age and gender have been found to play a critical but not a determining role in child abuse. A high incidence of very young parents at the first pregnancy, low educational levels, high rate of single parents, inadequate prenatal and pregnancy complications are common in fatalities from child abuse (Schloesser, Pierpont & Poertner, 1992).

A five year review by Martin, J.A. (1984) of 66 studies of the treatment of abusing parents found that only 10 included both parents. This highlights the strong cultural expectations of men's and women's roles in childrearing. The role of the father in child rearing is undervalued and the responsibility for child rearing in the family rests with the mother, regardless of who the abusing parent may be.

Stress may be seen along a continuum from daily frustrations to unemployment, family conflict including spouse abuse (Straus, 1979; Straus, Gelles & Steinmetz, 1980; Vondra & Toth, 1989; Smith & Adler, 1991), unwanted pregnancy, illness, eviction, large families, transitional culture conflict and poverty.

Rockville found an estimated 3/4 of a million American women were battered each year by their husbands, boyfriends or ex-boyfriends, and in one study by Stark, 21 % of pregnant women were found to be battered (cited in Helton, 1986). Many studies cite stress as being strongly correlated with abuse (Gaenes et al, 1978; Garbarino, 1977; Gelles & Cornell, 1988; Meharchand & Jinabhai, 1991;

Spinetta & Rigler, 1972; Whipple & W-Stratton, 1991).

Various types of poverty have been studied. Poverty may take two forms. It may be economic poverty or social poverty.

2.5.3.2 Economic Poverty

Economic poverty has led to the continuing theoretical dispute of the classlessness of child abuse. Recent controlled studies have shown clearly that while parents from any social class are capable of abuse, nearly 50% of reported cases of abuse are from poor families (Meharchand & Jinabhai, 1991; Weston, 1980; Whipple & W-Stratton, 1991). This is supported by Straus et al who found an inverse relationship between income and parent-to-child violence (1980). Kelly, Grace & Elliot (1990), also found a negative relationship between family income and the acceptability of spanking as a method of discipline, as the income came down so the spanking increased.

2.5.3.3 Isolation

The stress produced by social impoverishment and isolation such as a poor network of friends or family, poor or no support from marital partner (Lynch, 1975; Oates et al, 1979; Disbrow et al, 1977; Whipple & W-Stratton, 1991) or the parents "perceived" feelings of loneliness and social isolation (Disbrow et al, 1977; Whipple & W-Stratton, 1991), may strengthen a family's predisposition to

violence. Women who perceived their social network as less supportive see their own infants as being more difficult to handle than other babies (Adler et al, 1991).

A well controlled study by Adamakos, Ryan, Ullman, Pascoe, Diaz & Chessare (1986) found, that good levels of social support for prenatally identified "at risk" mothers, lead to a reduction in stress, an improved positive Maternal-child relationship and increased stimulation with associated developmental advantages. This study also found that, of all the variables assessed, the level of maternal social support was the best predictor of stress in the mother-child relationship.

Life events such as moving house, divorce, death or separation while being recognised as being stressful, may be perceived as being more so by some people than by others. Mobility has been correlated with an increased incidence of abuse (Loening, 1990; Spearly & Lauderdale, 1983; Straker & Moosa, 1988; Starr, 1982).

2.5.3.4 Educational Level and Employment

The Straus et al (1980) study identified that parents with a standard 10 education were more at risk for abuse than parents with less or more than this level of education. Schloesser, Pierpont & Poertner (1992), also found a significant lower educational level in abusing mothers. Gelles & Edfeldt (1986) found that American parents with the highest (college) and the lowest (no high school) levels

of education, were the least likely to use violence. Male unemployment, particularly of a recent nature, has been found to lead to higher incidence of abusive behaviour. This was higher for males who worked part time than for fully unemployed or even disabled men (Krugman, Lenherr, Betz & Fryer, 1986; Starr, 1988; Steinmetz & Straus, 1974). Male status appears closely associated with employment, where the husband is unemployed and the wife employed, this is likely to have an even greater influence on his self-esteem. Unemployment may well put him in a dependent role for the first time and thus add to his level of perceived stress (Steinmetz & Straus, 1974).

Abusive mothers have also been found not only to be presently unemployed but to have never held down any job at all (Starr, 1982).

2.5.3.5 Family Structure

Schmidt and Kempe (1975) and Straus et al (1980) found that abuse was higher in single parent families than in intact families. Sack, Mason and Higgins found that this was not the case where the single parent family had never been married, indicating the significance of broken relationships rather than single status (cited in Starr, 1988).

The stress produced by a big family and small budget has also been postulated as a factor in the aetiology of child abuse. However the research indicates that while there is a rise in child abuse in five-child families, the highest incidence occurs in two or three-child families, the latter being 50% higher in two children

families as compared to a one child family (Straus et al, 1980).

A reduction in the time span between the birth of children or the "birth spacing" of children has also been associated with an increase in child abuse, particularly where this is found to be less than 18 months between the birth of children (Winikoff, 1983). Mothers less than 21 years old at the time of delivery have also been shown to be at risk for abuse (Lynch & Roberts, 1977.) However the notion that most abusing parents are very young is misleading. Hyman (1978) found the average age of abusing parents to be 28 years. Meharchand (1991) found the largest group of perpetrators to be in the age group 21 to 30 years.

2.5.3.6 Social - Learning Theory and family violence

It has been generally accepted that parents who themselves had been physically and emotionally abused, would abuse their own children. Some studies do support this, claiming that abused children are twice as likely to abuse their own children (Disbrow et al, 1977; Herrenkohl, Herrenkohl & Troedter, 1983; Smith & Adler, 1991; Straus et al, 1980; Whipple & W-Stratton, 1991).

It would seem that the presence of multiple abusive caretakers (Herrenkohl et al, 1983) and of family violence, particularly between parents (Straus, 1980) does predispose to abuse of one's own children.

Differences in intergenerational abuse are influenced by the age when the abuse

was inflicted and by the sex and relationship of the abuser (Straus, 1980). Several more recent studies show that abuse need not necessarily be perpetuated. Particularly where parents have learnt stress coping abilities and have a good support network, the abusive cycle is most likely to be broken (Gelles, 1982; Straus, Gelles, & Steinmetz, 1980). However a study by Korbin (1980,a), found that among women imprisoned for fatal child maltreatment, all had been abused as children, experienced little support in parenting and were exposed to multiple stresses.

2.5.3.7 Substance Abuse

Abuse of drugs and alcohol is frequently implicated in abusing parents (Cohen & Densen-Gerber, 1982; Behling, 1979; Young, 1964; Meharchand & Jinabhai, 1991; Whipple & W-Stratton, 1991). Taylor et al's (1991) study of severe cases of abuse found that when abusing parents were also involved with drugs and alcohol, 75% met the DSM 111 criteria for a diagnostic disorder and when abusive parents "suspected" of substance abuse were included this went up to 85% of the research sample.

2.5.4 CHILD - CENTERED

A great deal of child abuse revolves around the activities of daily living eg. sleeping, crying, feeding, toilet training, discipline, dressing, playing, and grooming. Parents who lack knowledge of the appropriate behaviour related to

age, fail to understand and/or misinterpret the child's behaviour and this leads to abusive "discipline" (Hamilton, 1989). Stress factors may also be found in the behaviour of the child. Variables long believed to contribute to a high risk are those which are associated with behaviour or attributes in the child which the parent might find "difficult " or "unpleasant". These include premature, twin, low birth weight (Nelson & Martin, 1985; Schloessner, Pierpont & Poertner, 1992) handicapped, adopted and step children, and behaviorally or emotionally demanding children. This latter behaviour is common in the young child under five years of age. As already noted, the incidence of reported abuse is high in this age group. Twins are also the most consistently high risk group for Sudden Infant Death Syndrome (SIDS) (Newlands & Emery, 1991). Where premature birth is accompanied by birth of twins, these children are at increased risk for abuse (Nelson & Martin, 1985)

2.5.4.1 Premature and Handicapped Children

Studies on prematurity and on handicapped children have failed to conclusively show that either of these conditions can be clearly confirmed as being consistently "high risk" for abuse (Benedict, White, Wulff & Hall, 1990). Some researchers claim the risk to a premature infant as being three times that of a normal infant (Klein & Stern, 1971). Others claim that this is not the case (Starr, 1988). The latter claim is based on an extremely comprehensive study undertaken by Starr (1982) which looked at all the ecological variables previously correlated with abuse and neglect. This study failed to find major relationships between most of

the variables which previous research had substantiated. This might well be as Starr suggests that when one looks at the whole one receives a different picture to when one looks at "parts of the whole". The researcher also queries the control group of this research. In this study the control group consisted of sociodemographically matched families taken from children admitted to the hospital emergency room. Most of the latter were admitted for respiratory or gastrointestinal problems. Given the increasing awareness of the high incidence of abuse presently being identified as a result of mass media awareness campaigns, the researcher questions whether the lack of significance of this study might well have been influenced by the fact that the control group consisted of a relatively high incidence of child neglect rather than a representative sample of non abusive or neglectful families .

2.5.4.2 Maternal - Infant Bonding

Of particular relevance are the studies of maternal-infant bonding (Lynch & Roberts, 1977; Martin, H.P., 1984; McBryde, 1951), early neonatal-maternal separation (Kennell & Klaus, 1976; Smith & Adler, 1991) and early infant learning (Aaronson, 1978) which all confirm that early separation, particularly within the first 48 hours of birth, places the maternal-infant bonding at risk, particularly if the separation from mother is greater than 24 hours.

Prematurity may in some cases lead to extensive maternal separation while in other cases this ensures that the mother and infant are hospitalised and given

extensive support for her maternal role and in handling her infant. These differences are frequently dependent on hospital policy. Hospitals in developing countries are frequently short of incubators and premature infants are "tandem" nursed by their mothers for warmth. This is a very different situation, more likely to lead to bonding than the high technological separation which a premature infant nursed in an incubator will experience. These factors might well account for the differences in research results in this area.

2.5.4.3 Unhealthy Children

There is however some evidence to suggest that "normal" children who suffer ill-health may be at higher risk of maltreatment (Lynch, 1975; Schmitt & Kempe, 1975). Mild rather than severely disabled children have been shown to be more at risk for abuse (Benedict et al, 1990). The relative importance of perinatal screening characteristics for child abuse, as determined by stepwise discriminant analysis, is shown below:

	Abusing families (N=62)	Non-abusing families (N=124)
1. Parents indifferent, intolerant or overanxious towards child	83.9	21.8 ^a
2. History of family violence	51.6	5.6 ^a
3. Socioeconomic problems ie. unemployment	85.5	34.7 ^a
4. Infant premature, low birth weight	24.2	3.2 ^a
5. Parent abused or neglected as a child	43.5	6.5 ^a
6. Step-parent or co-habitee present	35.5	4.8 ^a
7. Single or separated parent	38.7	8.1 ^a
8. Mother less than 21 years old at the time of birth	40.3	23.4 ^a
9. History of mental illness, drug or alcohol addiction	61.3	21.8 ^a
10. Infant separated from mother for greater than 24 hrs postdelivery	17.7	5.6 ^a
11. Infant Mentally or Physically handicapped	1.6	0.8
12. Less than 18 months birth spacing	22.6	15.3
13. Infant never breast-fed	46.8	40.3

^a Significant difference $p < 0.05$
(Browne and Stevenson, cited in Browne & Saqi, 1988)

Table 2.1 Significant variables in perinatal screening for child abuse

These factors have been further tested by Browne and Saqi (1988). They found this checklist to be insufficient to provide a causal model of child abuse as it addresses psychosocial variables only and ignores situational changes. In the 1988 research they found a significant number of families labelled as high risk at birth had changed to low risk two years later and vice versa. This clearly demonstrates the limitations of this model, which fails to consider the interaction between child, family and community (Browne & Saqi, 1988).

2.5.4.4 Precipitation of Abuse

On the whole then, it would seem that the abused child does not differ significantly from the non-abused child, except that in approximately 57% of the incidence of abuse, the actions or behaviour of the child, while in no way being markedly different from that of any other child, actually precipitated the abuse (Starr, 1988).

2.5.5 RELATIONSHIP - CENTRED

Which findings led on to an exploration of the relationship between parent and child. These studies show that there is a difference in the interaction patterns of

abusive versus nonabusive parents, and that these differences are more consistent than are the differences in stress, social isolation and personality disturbances (Starr, 1987). Abusive parents tend to show fewer responses to their child. These responses are more aversive and negative in nature and include punishment and restriction (Starr, 1982), with few positive interactions (Herrenkohl, Herrenkohl, Troedter & Yanushefski, 1984; Wood-Shumen & Cone, 1986; Whipple & Webster-Stratton, 1991). These studies would seem to suggest a parental interaction deficit, which may contribute to abuse. Starr (1982) in a comprehensive and well controlled study found that abusive mothers tended to see child rearing as a simple rather than a complex task and to deny the emotional complexity of parenting.

Studies by Kroth suggest that up to 25% of all girls have been exposed to destructive interactional patterns and disturbed sexual behaviour within their own families (cited in Willows, 1991). Incestuous families have been found to be characterised by low cohesiveness, lack of openness and expression of feelings. They do not encourage members to be independent and assertive and tend not to participate in outside social activities (Dodds, Smith & Webber, 1991). Non-organic failure to thrive (NOFTT), infants show a clear difference in maternal-child interaction (Haynes et al, 1984).

Failure to establish a meaningful relationship with parents has been found to lead to high "loneliness" scores in adults (Hojat, 1982). This is of concern in the light of the previous discussion of the contribution of social isolation to abuse.

Studies of psychiatric patients who are severely depressed, indicate that these mothers also view their children as more difficult, despite evidence that these skewed perceptions are not consistent with the childrens observed behaviour (cited in Gross, 1989).

Detailed studies on parent-child interaction and child-rearing practices have identified certain common features. Poor maternal-infant bonding (Schmitt & Kempe, 1975), rigid child rearing practices especially among lower income families which tend to be more parent centred (Curtis, 1983; Starr, 1967), unrealistic and inappropriate expectations, dependency needs and excessive demands and displacement of parental anger which leads to punishment excessive for the behaviour which precipitated it (Freeman & Heinrich, 1981; Schmitt & Kempe, 1975; Spinetta & Rigler, 1972). Many researchers conclude that abusing parents lack appropriate knowledge of child rearing - their attitudes, expectations and child-rearing techniques set them apart from non-abusive parents (Spinetta & Rigler, 1972). Present day treatment programmes for abuse have focused to a large extent on methods of strengthening the parent-child relationship.

2.5.5.1 Cross Cultural Childrearing Practices

The pattern of parenting and discipline contribute to the child's socialisation. Cross-cultural studies attempt to measure to what extent child rearing methods are culturally determined. Honig & Chung (1989) conducted a study of five cultural groups of mothers of children of one year and again at three years (Korea, India,

Sweden, France & America). All mothers were from low-income, low-education urban families. Across all five cultural groups mothers responded similarly to socially positive or negative interactions at both age groups. They returned positive emotional and physical actions for positive behaviour, and negative techniques for aggressive or autonomous actions in their children. Some behaviour evoked a narrow response regardless of culture eg. mothers reaction to child in danger. Mothers were sensitive to age differences using more distraction, protection, showing and modelling behaviour for one year olds and more verbal commands and explanations in three year olds. Within each cultural group particular techniques were preferred eg. American black mothers scheduled infants and rearranged the environment; Swedish mothers used the least corporal punishment (5% as compared to 50% in the American mothers); Korean mothers indulged one year olds more but were strict disciplinarians of three year olds. All cultures socialized girls and boys differently. Hong and Chung (1989) concluded that most maternal behaviour was more a function of child age and sex than culturally determined.

a) Traditional Families

A number of studies of traditional families of different cultures show similar family and child rearing patterns. Traditional families are close knit, with a strong sense of kinship. Boys are given more freedom and education than girls. Elders are respected and expect obedience from children. Children must be quiet and not bother adults with questions. Mothers work in the home and assume child

rearing and family responsibilities. Fathers have little to do with caregiving, demand respect and assume an authoritarian posture. Domestic and social activities are planned around his needs. The father is the primary link between the family and the community. Research; in Sudan (Grotberg & Bardin, 1989); in Africa (Goldberg, 1972); in Turkey (Sever, 1989) and in China, Malay and India (Roopnarine, Lu & Ahmeduzzaman, 1989).

b) Transitional Families

The transitional family shows many changes particularly in the work situation. The kinship system is still strong, but certain members are selected for special education to meet the needs of technology and industry. There is social movement from villages to urban areas. Extended families are left behind (Grotberg & Bardin, 1989) in the Sudan. Among working parents it was established that parent-child play and recreational activities are infrequent and fathers make little attempt to take over any caretaking in both India and Chinese-Malay (Roopnarine et al, 1989). This research also found significant differences in discipline between the Chinese-Malay, who were more likely to use physical punishment and the Indian who were more likely to use verbal feedback.

c) Modern Families

Modern families tend to promote the independence of individual family members and freedom of choice. Education is considered equally important for both sexes.

Both parents are involved in community affairs. Many mothers hold positions outside the home and many fathers help with household responsibilities (Grotberg & Bardin, 1989 in Sudan; Sever, 1989 in Turkey).

2.5.6 ECOLOGICAL MODEL

As a result of accumulated research over the preceding three decades a comprehensive, holistic ecological model for the aetiology of child abuse has become widely accepted. This recognises that there are multiple factors which may lead to child abuse. Some of these factors are contributed by the parent and their sociocultural environment, some are the contributions of the child and his biopsychosocial environment. These factors influence the type, frequency and quality of interaction in the family (family asynchrony) between the parent and the child and between the family, neighbourhood and community (Garbarino, 1977; Pardeck, 1989; Vondra & Toth, 1989). Steele describes child abuse and maltreatment as being :

"...an extremely complex group of human behaviours characterized by maladaptive interactions between infants and children of all ages and their caretakers." (1980,p.49)

As early as 1975 Kempe wrote of the aetiology of child abuse as being the "right parent,the right child and the right day" (Schmidt and Kempe,1975)

The complex relationship and interaction between these factors is clearly demonstrated in figure 2.1 on the following page.

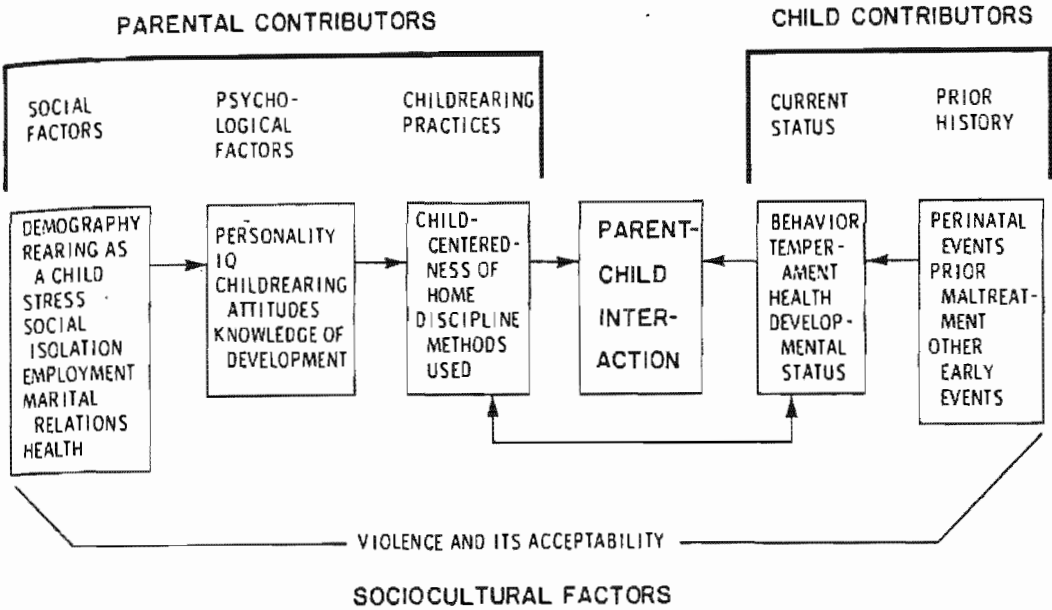


Figure 2.1 An ecological model of child abuse causation

(Starr, 1988, p.141)

Any intervention must therefore address the multiple problems associated with child abuse (Vondra & Toth, 1989). The cost of child maltreatment to individuals, families, communities and nations, both in terms of human suffering and the economic toll, is staggering. Maltreated children experiencing serious

physical injury require hospitalisation. Subsequent possibilities of rehabilitation, special education, foster care, counselling and support services, correctional facilities, reduced earning capacity and productivity, are all a heavy drain on human/economic resources. Daro, estimates that the cost to the state, of abused children in 1983, was about 7 billion dollars (cited in Dubowitz, 1990).

2.5.7 THE SOUTH AFRICAN PERSPECTIVE

Zulu society (like other Nguni tribes) was traditionally patriarchal and each kraal was run on a system of patriarchal power. The existence of a polygamous household meant that, although the relationship to the father implied respect and even fear, the father himself could not and did not concern himself much with the day-to-day discipline of his children. It was the wife who disciplined the younger children. African customary law conferred on the father similar powers to those held by ancient Roman fathers. He could, though instances were rare, thrash, starve or mutilate a transgressing wife or child (Olmesdahl, 1977)

In South Africa the labour and residential laws of the apartheid system have resulted in a large migrant labour force, separated from their families and isolated in hostels from the local urban and peri-urban communities. The extended family system has been eroded by this stringent policy of influx control which served to leave families without husbands, fathers and frequently without an income. Studies on American migrant farm workers indicate high rates of child abuse (Larson, Doris & Alvarez, 1987). Cross-cultural research by Finkelhor & Korbin

indicates that child abuse is less frequent when multiple caretakers, including extended kin, are involved with parenting (cited in Hamilton, 1989).

Later relaxation of these laws of influx control lead to the mushrooming of urban shack dwellings, accompanied by poverty, over-crowding, squalor and a breakdown of traditionally socialising regulatory mechanisms and controls.


In South Africa many mothers are forced to return to work prematurely. This is exacerbated by their migrant labour partners, many of whom strike up secondary relationships in the work area and default on providing financial assistance to their first family. In a recent study of black working women, it was found that 62% returned to work before the child was a year old and of these 50% did not have access to an extended family which could provide child care (Cock, Edmond & Klugman, 1986). Since creche facilities are extremely limited, the care of these children is severely compromised. In most cultures the father is not cast in the role of child rearer or minder. In South Africa in 1945, 90% of black mothers delivering in mission hospitals were married. By 1982, 90% were single and 22% of babies born were openly acknowledged as being unwanted (Larson, 1991).

The family in South Africa is in crisis. In some of our larger cities more than half of all marriages end in divorce (Wilson & Ramphela, 1991). In 1985, nearly 17 thousand black children under the age of one year died as compared to four and a half thousand white, asian and coloured children (Thomas & Mabusela, 1991). South Africa's black children are exposed from birth to a systematic process of violation, created and maintained by apartheid philosophy and legislation. Among

black people, the disintegration of family life is extensive. Children in such a situation grow up with little experience of parenting and being parented. They are ill-equipped to be the parents of the next generation. While many of these problems need to be addressed at a state policy level, we need to look at what can be done at a grass roots level as the health care system undergoes much needed reforms. From this background of violence and family breakdown, at now more than any time in the past is it time to start working with alternative methods, methods other than brute force and violence, in the solving of problems. Force, power and aggression have historically been shown to escalate violence at all levels. Parents need parenting skills now, more than at any other time in South African history.

2.6 PREVENTION


2.6.1 INTRODUCTION

 The concept of prevention is derived from a public health model and thus incorporates the concepts of epidemiology. The concepts of host, agent and environment, of prevalence, and of community or aggregate care as opposed to individual care, are thus dominant (Roberts & Peterson, 1984). In viewing community mental health, Albee (1982), proposed that the prevention of mental and emotional disorders should be viewed from a perspective of incidence which considers the contributing organic factors plus stress versus the existing coping skills, self-esteem and support groups available. This is a similar model to the

ecological model of child abuse. Possibilities for prevention of both child abuse and mental and emotional illness could thus be conceptualised in a similar manner.

There are three basic levels of prevention:

a) **Primary** prevention of child abuse, which involves the very earliest actions which are taken towards prevention of new cases. This intervention occurs before the "abuse" has occurred, with persons who have not been identified as having a disturbance (Resnick, 1985; Roberts & Peterson, 1984), or "prior to any direct indication of an abusive problem" (McKeel, 1984, p. 331). This can be achieved by: "...changing the environment so that negative conditions do not produce pathology or by strengthening an individual's resources to avoid pathology" (Roberts & Peterson, 1984, p 10). Primary prevention includes both **general health promotion** and **specific protection**.

 **General health promotion** includes all activities that improve the environment and enhance a healthy lifestyle, while **specific protection** refers to those measures taken to protecting individuals, families and communities from specific agents eg. immunization against target diseases, specific environmental protection measures ie. chlorination of water supply, or support programmes specific to lifestages. It focuses on the individual, the family and the community (Stanhope & Lancaster, 1992; van den Berg & Viljoen, 1989). The aim of primary prevention is the prevention of disease or psychosocial illhealth in the **prepathogenic** stage (van den Berg & Viljoen, 1989), and decreases the incidence.

At a **macro-level** or **general health promotion level** this includes prevention linked to broad social and economic reforms, the provision of work, educational opportunities, basic health services, housing and an income sufficient to accommodate basic living (Garbarino, 1986). This requires a Government, committed to a policy of social development for all its people, and prepared to address the issues of poverty, unemployment and racism. Legislation prohibiting the use of physical/corporal punishment, racism and sexism in schools, institutions and homes, gives weight to the unacceptability of these practices in a civilized society (Gil, 1969; Hamilton, 1989).

It includes mass media education to reduce and eliminate norms that legitimise and glorify violence in society and the family. Violence in entertainment is commonplace; one has only to look at current television programmes and popular reading, many of which portray violence together with humour eg. Carol Burnett Show, Bart Simpson, Jerry and Tweetie etc. This particular frivolous combination makes violence appear even more acceptable. American children are exposed to approximately 40,000 murders on television before graduation from high school (Donnelly, 1991). Violence in sport is also commonplace and widely accepted among both players and spectators. Schools find corporal punishment an acceptable method of discipline (direct communication with education departments).

Mass media education is also necessary to promote changes in the character of society by providing educational development in the form of:

* awareness of child abuse incidence eg. adult films such as the " Moore report" or "The Betrayal" which when shown on television in Minneapolis lead to the establishment of a public service campaign and a twenty-four hour hot-line (Byers, 1986)

* aetiology of child abuse

* awareness of available child abuse support services for both abused and abuser

* the provision of family educational and support services eg. parent education, family clinics, creches, health and welfare services

* education of health care and educational workers (eg. nurses, social workers and teachers) involved with children.

Gelles suggests that primary intervention aimed at altering the social structure and cultural attitudes about violence could reduce child abuse by 60% (Unpublished conference paper cited in Garbarino, 1986).

At a **micro - level** this includes actions taken to prepare for life crises and stresses and promote individuals and family motivation and responsibility for their own lives and their own health. This essentially involves **enabling** or **empowering** of individuals and groups within a developmental conceptual framework. It also includes actions ranging from;

* before conception eg. pre-conception counselling, genetic counselling & family planning covering planned parenthood and abortion counselling

* during pregnancy eg. antenatal care, support and education of both physical and psychological aspects of parenting

* perinatal care eg. provision of optimum condition for bonding, support for the

new family with family life education, home visiting support, crisis hotlines, self-care education for school and pre-school children (Martin, Scott, Pierron & Bauerle, 1984); Life skills programmes in schools, Sexuality education involving gender and power structures (Levett, 1990)

* long term introduction to community network of supports for family life, aimed at strengthening the coping skills of all members of the family, sufficient child care centres. These should be well controlled for standard of care as some research indicates early childcare might be harmful (Hamilton, 1989).

Meharchand in her 1991 South African study, identified the two highest reporting categories of child abuse as being the school in the child over five and health personnel in the child under five.

This gives strong support for the utilisation of these existing structures, where awareness of the problem is already recognised, for the introduction of primary prevention interventions. This has occurred in South Africa with the initiation of the Life skills programme in schools during 1989.

b) Secondary prevention, which in the absence of broad socio-economic change, involves the active identification and amelioration of the lives of "high risk" clients (also known as "at risk", "vulnerable" or "potential abusers"), prior to an established abuse pattern (McKeel, 1985).

"Secondary prevention emphasizes early diagnosis and prompt intervention to halt the pathological process, thereby shortening its duration and severity..... Screening procedures of any type..... are by definition secondary prevention"

(Roberts & Peterson, 1984; Shamansky & Clausen, 1980).

Early efforts should be made to identify potential abusers, to follow up reported cases and to provide support at this level in order to prevent and limit complications. Secondary prevention seeks to detect malfunction or disease early and to treat it promptly. Various screening tests may be used in this process, however it must be remembered that these tests should not be considered as "diagnostic" but merely as separating people who are "more likely" or "at higher risk" from those who are less likely or less at risk. The sensitivity of most screening tests is less than 100% and will include both "false positives" and "false negatives" (Stanhope & Lancaster, 1992).

At a microlevel intervention is aimed at the "at risk" mother or primary caretaker to provide secondary prevention for the child. For example, individual or group support and counselling, telephone helplines, home visits and intersectoral co-operative support from health and welfare departments. At risk mothers have been shown to describe "normal child behaviour as more negative, and to react more negatively than control mothers (Wood-Shuman & Cone, 1986).

At a macrolevel, secondary prevention would include the establishment of a National Child Abuse register in order to follow up and provide for families who have already maltreated one child and documentation of research in the form of a national research register to assist communication and co-operation between health care workers.

c) **Tertiary prevention**, which involves the ensuring of an adequate and effective intervention which aims at rehabilitation (Shamansky & Clausen 1980), of both the abused, the abusers and the family system. The purpose of rehabilitation is to prevent recidivism of the abusive parenting style. Gelles suggests that intervention implemented after an initial recognised incidence could reduce further incidence by 70% (Conference paper cited in Garbarino, 1986).

Most of these programmes attempt to improve the interaction relationship between parent and child, increase maternal support and coping and assist the abused child to overcome the sequelae of the abuse and promote physical, emotional, social and /or sexual development. Where the treatment compliance of the abuser is poor this may well include removal of the child and/or prosecution of the abuser.

Some preventive efforts have attempted to address all these areas of prevention, in an integrated and comprehensive manner eg. "Project Children" a successful rural child abuse/neglect programme in Indiana, addressed the community acceptance of the project, a hospital child protection team, parent-aide programme and community education (Sefick & Ormsby, 1978).

In the field of child abuse intervention, prevention has been introduced at all three levels and at each stage of the human lifecycle. This has been hampered however by a fragmented organisational structure at local, provincial and national level. Lack of national priority for children and families resulting in poverty, starvation, family disintegration and homelessness and the failure to provide adequate funding, leading to heavy case loads, prioritisation of "treatment" for known

abusive families and poor co-ordination of multi-disciplinary involvement of the disciplines working within the field of child abuse (police force, social worker, nurses and medical personnel). Most preventive work has thus been at a tertiary rather than primary level (Lachman,1991).

2.6.1.1 Relevance of Primary Prevention for Present Study

The nature of child abuse is such that it is frequently kept secret within the family. We know that only the severe cases of abuse tend to be reported. It is these reported cases that tend to be offered therapeutic intervention at a level of **tertiary** prevention.

Thus there are many children who having experienced abuse, have never worked through this experience of being poorly parented. As these people become parents themselves a primary preventive intervention to increase their interpersonal and communication skills and support network, and to introduce non-punitive methods of discipline, may be of particular significance for their own marriage and parenting potential.

We know that given the right time, place, circumstances and stresses, most people are capable of abuse and that where social support is reduced and multiple stressors exist, this potential risk is increased. This is of particular relevance when looking at prevention strategies, particularly if the aim is to provide a

widely appropriate intervention.

No preselection is made in primary prevention. Thus all members of the community are potentially exposed to prevention at a primary level. Client groups are given primary prevention according to the groups' characteristics, lifestages and needs. For example at a macrolevel a television programme on mothercraft and parenting skills could be seen by a wide population age and sex range, and at a microlevel, a similar programme may be run in an appropriate service setting such as an antenatal clinic. Both would be primary health promotive and problem preventive strategies.

By not preselecting "high risk" clients many people who might be missed if "high risk" screening were introduced will receive assistance, while still providing support for clients who are not considered "at risk", but given the right "time or circumstances" have this potential. There is also the additional benefit of avoiding the stigma or label which occurs when clients are identified as high risk. This would be just one more way of society giving negative feedback to people who have frequently had too much negative feedback already (Helfer, 1987). Prevention efforts can include measures to control destructive patterns or to replace these patterns with positive patterns that are incompatible with abuse (Garbarino, 1986).

2.6.2 PREVENTION PROGRAMMES

2.6.2.1 Introduction

Most efforts to date have of necessity involved the tertiary level of prevention. Historically prevention and therapeutic work with abusive parents has been emphasised, frequently to the exclusion of interventions directed at children (Vondra & Roth, 1989). This intervention has tended to involve group rather than individual treatment. Groups provide a mechanism whereby members can fulfil their needs for socialisation, identity and competence, receive support and identify with other parents with similar problems and experiences (Gilbert, 1988). Groups are offered for parents and more recently for the victim of the abuses. Very recently family group therapy has become available.

As noted in the earlier discussion, child neglect frequently manifests as "non-organic failure-to-thrive". The tertiary prevention is frequently a lengthy and costly hospitalisation of the child. Research has shown that long term hospitalisation of these children leads to negative developmental outcome at three years (Singh, 1986).

Physical abuse has also been strongly correlated with developmental delays, particularly where trauma to the face and head are involved or when prolonged hospitalisation is required (Vondra & Toth, 1989).

Treatment programmes here have attempted to provide stimulating preschool learning experiences together with, recognition of feelings, self esteem and peer

group relationship building (Culp, Heide & Richardson, 1987). Provision of these variables was found by Culp et al (1987) to result in positive advancement of fine and gross motor, cognitive, social and emotional development. The least change was noted in the area of verbal development.

When planning abuse prevention initiatives the provision of multiple services (interdisciplinary co-operation) addressing the parent-child-environment system is essential. And when considering intervention towards parents, the bidirectional nature of parent-child interaction must be acknowledged. Family or Parent Centres now exist in most large cities. Attempts are being made to provide support services and education to "high Risk" families, frequently using a multidisciplinary approach eg. Mount Hope Family Centre, University of Rochester (Vondra & Toth, 1989); the Parent Centre, Cape Town, South Africa.

2.6.2.2 International Prevention Programmes

a) Child Focused Programmes

There are a number of diverse educational programmes for the prevention of abuse. These are targeted at the child as primary preventive strategies. They are primarily aimed at providing knowledge and skills training for young children, to help them recognise potentially abusive situations and provide coping strategies in order to avoid or address potential situations. Many of them prioritising getting to know your feelings ("good and bad touches") and "keeping safe".

The effectiveness of these programmes has frequently not been subjected to evaluation. Those which have been evaluated have shown different short and long term results. The degree of protective behaviour actually learned, is also very dependent on the age of the child being exposed to the programme. An evaluation of the effectiveness of skills learned in a module utilising simulation techniques and aimed at "resisting stranger abduction", 6 months after implementation, was found to be extremely effective (Fryer, Kraizer & Miyoshi, 1987,a).

It is also not yet known whether the occupation of the person implementing the programme is significantly related to the effectiveness of the programme (Conte, Rosen & Saperstein, 1986). An evaluation of both teachers and parents as instructors of a personal safety programme for preschoolers suggests that both are effective. Evaluation showed significant knowledge gained and high levels of learned personal safety skills (Wurtele, Gillespie, Cuirier & Franklin, 1992).

As the school and the schoolteacher play an important role in the socialisation of the child, it is possible that this would be an effective level of primary prevention, utilising an existing service and with minimal additional training (Brassard, Tyler & Kehle, 1983). However, Conte et al (1986) warns that the teacher must receive additional training, must feel comfortable with her/his new role as "sex educator/ life skills educator", and must be aware of an appropriate multidisciplinary support network, in order to appropriately refer disclosures and problems.

Some programmes make use of comic books, puppet shows, videos and films. A number of films are available eg. "Strong kids, safe kids"; "Kids can say no"; "Feeling yes, feeling no" (Byers, 1986). Other programmes available include the "You're in Charge" Video programme, which introduces the concept that children have the right to say "No" if they are touched in a manner which makes them feel uncomfortable (Brassard, Tyler & Kehle, 1983) and "kidscape" a practical guide to talking to young children about keeping safe (Elliot, 1986).

i) Preschoolers

Borken and Frank (1986) developed a programme for preschoolers using the "Bubbylonian Encounter" puppet show. They emphasised :

- 1) the ability to distinguish between good and bad feelings and how to trust your own feelings
- 2) the concept of "private parts" and
- 3) the fact that the abuser may be known by the child. They evaluated this programme after four weeks and found that only 45% of the five year olds knew how to protect themselves if they were touched inappropriately.

ii) Preschool and Junior Primary

The "Cook County Illinois" prevention programme was evaluated by Conte, Rosen, and Saperstein (1986). They found that after just one week, only 50% of the concepts taught were remembered by children between the ages of six and

ten. The concepts that were remembered were:

- 1) What child abuse actually is.
- 2) Different kinds of touching.
- 3) Different ways to protect yourself.

Fryer, Kraizer & Miyoshi (1987,b) measured the critical "change in behaviour" in first and second graders who had participated in a "children need to know" personal training programme. They found that 78.3% had modified their behaviour. Children who had tested high on self esteem, knowledge and attitude on pretest showed the most significant behaviour change (92.3 %) on posttest. This programme showed a short term reduction in the vulnerability of participating children to potential abuse.

iii) Senior Primary

Garbarino (cited in Garbarino, 1986), examined the way elementary school children (second, fourth and sixth graders), responded to a "spiderman comic book" dealing with sexual abuse. He found that 85% to 96% (over the three grades) comprehended the sexual abuse message. The comic also left 50% of the second graders and 25% of the sixth graders feeling "anxious" and lead to several disclosures.

Plummer evaluated a three day programme which used concepts from "Illusion Theatre" and the film "No More Secrets". He found that at immediate post test

the fifth grade children knew the difference between physical and sexual abuse, understood that an assailant could be known to them and that both girls and boys are at risk. However eight months later the children had reverted to the idea that assailants are only strangers, promises should never be broken, that the child is at fault, and confused physical and sexual abuse (cited in Finkelhor, 1986).

The above selected studies demonstrate that while this type of programme can provide some protective behaviour and strategies for the prevention of child abuse it would seem that younger children are the least protected, and that over a longer time period much of the protection may be lost. Gilbert, Berrick, Duerr, Le Prohn & Nyman (1989) recommends that teaching should continue at primary school level and should include children, teachers, parents and community leaders in order to maximise the influence of these programmes.

In the light of the above conclusions, the researcher feels that it is important at this time to consider the moral and ethical implications of placing the responsibility for self protection firmly on the young child. Child focused programmes have gained momentum and are being widely introduced throughout schools in South Africa during the 1990's. While this is an important aspect of the primary prevention of child abuse, it should not be seen as pre-empting the responsibility of adults to protect, nurture and promote the health and well being of their children.

b) Carer-Focused Programmes

i) Perinatal period

There are multiple primary prevention programmes aimed at the perinatal period. The perinatal period is usually taken from nine months prebirth to 9-12 months after, but may sometimes be regarded as extending to the end of 2 years (Helfer, 1987). This period is optimal because it takes advantage of a "captive clientel", readily accessible to the health care system and frequently motivated - particularly in the case of first time parents.

Types of programmes include; mass education programmes; prepregnancy planning; antenatal, prelabor and labor assistance; rooming-in of mother and infant ; perinatal coaching programmes focused on skills training for the enhancement of mother-father-infant communication interactions; and home-bound follow up by public health nurses and lay health visitors (Helfer, 1987; Lally, 1984).

"...the perinatal period is a window of opportunity for enhancing parent-infant communication" (Helfer, 1987, P 575).

An example of a successful mass education programme is the "Don't Shake the Baby" campaign. Subsequent to this campaign, 49% of mothers said they would not now shake their infant and 91% thought all parents should receive this information (Showers, 1992).

ii) Social Support Programmes

A number of new family support programmes have proliferated over the last thirty years in order to promote child health and to prevent family dysfunction.

"....the need to create formal support systems that generate and strengthen informal support systems, that in turn reduce the need for the formal system" (Zigler & Weiss, 1985, p.175).

Many early intervention social support programmes initially addressed critical periods of brain growth and cognitive development, and thus tended to proliferate around early childhood education. For example, Headstart, in the early sixties, initially looked at evaluating with IQ tests, cognitive progress only. Subsequent longitudinal studies established that much more than cognitive ability had resulted. This intervention had influenced parent-child relationships, parental attitudes, parent development and coping, and in the child - long term school achievement, low teenage pregnancy rates and good employment records as adults, thus pointing to a broader set of evaluation variables, namely, family dynamics rather than individual life-cycles (Zigler & Weiss, 1985).

Subsequent to these research results, early support and cognitive intervention tended to involve multidisciplinary teams of paediatricians, psychologists, nurses, social workers, early childhood educators and lay community members eg. Brookline Early Education Project (BEEP) 1972 - 1979; Child and Family Resource Programme (CFRP) 1973-1981; Child Enrichment Project (CPEP) 1988-1989. All three programmes found on longitudinal evaluation, that

considerably more than cognitive development was achieved. The results of the first two programmes suggest that less well educated and low income families may require intense programmes with high **participation** in order to be effective (Zigler & Weiss, 1985). Barth (1991) suggests caution when considering the capacity for child abuse prevention services potential for change. The health services frequently receive primarily high risk clientele.

c) Tertiary Treatment programmes

Numerous treatment recommendations are available for abusing families. These fall mostly into the category of tertiary prevention. For example, mental health counselling, parenting classes, group therapy, lay therapy, home visitors, parent support groups and residential treatment (Beezley, Martin, & Alexander, 1976; Gilbert, Berrick, Duerr, Prohn & Nyman, 1989). Participation in counselling is poor unless required by law eg. recommendation of family court (Wolfe, Aragona & Kaufman, 1980). Numerous studies indicate, high levels of low self esteem, poor opinion of partners and resistance to discussing problems with others, in abusing parents (Anderson & Lauderdale, 1982; Brunnquell et al, 1981; Evans, 1980; Heinicke, 1984; Oates & Forrest, 1985; Steele, 1980; Whipple & W-Stratton, 1991). Treatment issues for abusing mothers should address their "inability to trust, poor self-esteem and limited social skills" (Wagner, 1991,p.100). This suggests that any intervention should seek to prioritise the development of positive self esteem and positive interpersonal relationship skills. Few studies have examined treatment compliance and evaluated therapy outcome.

i) Parent training

Parent training is one of the **major treatments** offered to remediate abuse (Elliot, 1986). A study by Rivara (1985) found a reluctance to accept treatment and **no** relationship between compliance of treatment and the incidence of reabuse. There is little evidence to suggest that **traditional** parenting classes can effectively change **severely abusive interaction** patterns.

The influences of parent training, for less severely abusive parents, has also been evaluated. Blythe (1983), analyzed 16 studies of treatment for mild to moderately abusing parents and stepparents in terms of methods and findings. Only two of these studies were group designs, half were evaluations of single case studies and the rest were assessments of ongoing programmes. Most studies gave very little details of significant variables eg. education level, age, marital status, income, social isolation etc. Only one study measured whether parents had mastered new parenting skills, but did not measure change in coping ability. Several studies observed parent-child interaction patterns. Ruger & Wooten (1982) found abusive parents developed both parenting skills and improved self discipline in the programme, Innovative Methods in Parent and Child Training (IMPACT).

Parent training included bibliotherapy, modelling, role-play practice of communication skills, anger management and relaxation exercises. Parenting programmes have been developed for the specific needs of certain clients. For example, foster parents have been trained in appropriate parenting skills utilizing one-way mirror observation, supported by discussion and foster parent support

groupwork (Gross, Schuman & Magid, 1978). High risk infants and toddlers have been placed in "therapeutic day care centres" where caretakers have modelled appropriate parenting and handling techniques for the biological parent (Phillips, 1982). Parent training has been found to be **effective** in changing parents' behaviour patterns and in some cases the children's behaviour.

ii) Cross-comparison evaluations of treatment programmes

In an assessment of eleven treatment programmes handling 1,724 parents, 30% were found to have "severely" abused or neglected their children **during the treatment programme** (cited in Dubowitz, 1990). The latter also discusses a federally funded evaluation carried out between 1974 and 1977 by the Berkeley Planning Association. This looked at five different treatment models:

- * individual counselling
- * group therapy
- * childrens programmes
- * family treatment and
- * lay therapy

The strongest predictor of recidivism was found to be the severity of the abuse. The most improvement was found in clients who did not abuse alcohol or drugs and was better for physical abuse than for neglect alone. The lay therapy model was not only the most effective model, but was also the only model to achieve success for **more than half** of the clients. None of the other intervention models achieved more than a 40% success rate.

A second national evaluation of a further 19 projects conducted in 1979 to 1981, utilizing the same five treatment models as the earlier evaluation, indicated that over 50% of the parents were still judged likely to maltreat their children in the future, despite having benefited from the programme in some way (eg. 57% showed improved knowledge of child development, 55% had increased understanding of their child's needs and 47% experienced greater self esteem). Sexual abusers had the lowest (19%) recidivism and child neglect the highest (66%).

Olds, Henderson, Chamberlin & Tatelbaum (1986) evaluated a programme for 400 high risk families, randomly assigning clients to four different permutations of treatment, involving paediatricians, social workers and nurses. The treatment groups offered permutations of :

- * sensory and development screening
- * transportation to prenatal and well baby clinics
- * nine home visits during pregnancy
- * home visiting by registered nurse (home health visitors) during the child's first two years of life.

The intervention group which included home health visiting was found to have a significant decrease in the incidence of child maltreatment in the **highest risk group** (only 4% maltreatment), when compared to the groups which did not include nurse home visiting (19% maltreatment). This group was also found to have improved family functioning and social control, less conflict and punishment and infants/children with a higher developmental quotient. The least positive

results were recorded in older, married women and the most in young, unmarried women.

iv) Specific Studies

An extensive **social work** study by Geismar, Lagay, Wolock, Gerhart and Fink (1972), involved an intervention programme based upon the family life improvement project (FLIP). This programme was based on the hypothesis that professional intervention by social workers can have a positive effect upon the social functioning of young families. Experimental and control multi-problem family functioning was compared with experimental and control non-problem family functioning in three areas, namely; 1) instrumental functioning 2) expressive and role behaviour functioning and 3) family relationship and unity and individual behaviour adjustment.

Both marital partners (literature indicates validity of reporting when there is a high degree of agreement between self reports and reports of others), were pre and post tested with the St Paul Scale of Family Functioning. The areas showing the most dysfunction on the pretest were, home and household practices, followed by family relationships and unity, economic practices, and individual behaviour and adjustment.

The results of this study showed that progress was frequently delayed by basic needs for housing, and employment. It also demonstrated that a single service programme such as FLIP was limited in the services they could provide. A

multiple service programme, bringing together a multidisciplinary service team could have been more effective.

An analysis of the change effected by FLIP in the experimental group, showed an increase over the control groups, particularly in instrumental functioning rather than in expressive or interpersonal areas of family functioning. Thus the most positive change was seen in areas of :

Care and training of Children

Health Conditions and Practice

Home and Household practice

Economic Practices

Social Activities

And of these the five areas, the most change was seen in the first three. Two of these (home and household practices and economic practices were highly dysfunctional on the pretest)

These are all areas more common to nursing rather than social work practice. Thus while this study highlights the need for a multidisciplinary team, one should also take note of the effectiveness of an intervention aimed at instrumental functioning, particularly in the areas noted which fall very definitely into the scope of practice of most community health or psychiatric nurses (commonly referred to as public health nurses/ home visitors or district nurses). This clearly supports the need for homebased visiting and support. The areas with the least change in family functioning were those of expressive and role behaviour and particularly in the area of family relationship and unity and individual behaviour

adjustment.

In a baseline **Public Health Nurses** study by Gray, Cutler, Dean, & Kempe (1976), vulnerable mothers were identified by observing the mothers during delivery of and interacting with their newborns. These observations were used to categorise the newborns into a low-risk and two high-risk groups. One high-risk group was provided with an intervention, including weekly public health nurse visits, and the other with no additional services. Follow up of children at 17 and 35 months showed 44% of high-risk and 8% of low-risk families with abnormal parenting. Quantitative analysis of high-risk intervention with non-intervention showed only one significant difference : a reduction in serious , inflicted injury. None of the children in the intervention group suffered injuries severe enough to result in hospitalization, compared to 10% of the non intervention group who were hospitalised. The nursing services provided to the high risk intervention group appeared to allow for early detection (76% prediction) and correction of abnormal parenting **prior** to the point of injury. The intervention led to a reduction in the **severity** of the abuse.

Haynes et al (1984), found that home health visitors were effective in NOFTT, but only if the intervention was initiated early and if the degree of hostility in the mother-child interaction was fairly mild. As previously discussed NOFTT is the most intractable pattern of maltreatment.

Lay Health visitors are a potentially powerful category of family and health

intervention. The use of able community members has been a largely untapped resource for family support, but research gives considerable credibility to the effectiveness of paraprofessionals.

Arch (1978), demonstrated the successful use of adult men and women as lay health visitors. These mature adults (average age 64yrs, black and white and average 8th grade education), were used to "parent" the abusing and neglectful parents. This foster grandparent-home visitor, attempted to surrogate parent the parent, model appropriate nurturant parenting behaviour, bolster the sibling relationship, and secondarily aid the child and provide stimulation techniques. A secondary benefit to the programme was the positive effects on the foster grandparents, who felt they had a new purpose in life and benefited financially with the receipt of a small stipendiary.

Gray and Kaplan (1980) studied a successful lay health visitor programme involving 550 families. Lay health visitors had to have been successful mothers or had extensive experience working with children and also possess qualities of flexibility and empathy. They were responsible to a nurse coordinator and paediatrician in the initial contact point of the postpartum ward of the hospital. All mothers delivering at the Colorado General Hospital and living in the Denver area were offered the service as a routine part of paediatric care. Barth (1991), in the Child Enrichment Project (CPEP), found lay visitors to be most successful with less severely abusive families, where the abuse had been of a shorter duration.

Rosenstein (1978), utilized trained American volunteers in Dallas, in a broad outreach programme. The aims were to inform the public about child abuse, to develop a one-to-one relationship with potential abusers and to find foster and adoptive homes in the community. The main indicator used to evaluate the success of this prevention effort was the increase in self-referrals, which rose from 8,5% in the first year to 51% in the 5th year.

Karniski, van Buren & Cupoli (1986) placed NOFTT infants in volunteer foster homes in the Medical Placement Home Programme (MPHP) in Florida. The biological parents were encouraged to maintain contact with the volunteer family and frequently developed a relationship with the foster parents, gaining support, parental skills and confidence. The programme was found to be most successful as measured by :

- a) infant weight gain (double the average hospital catch up rate)
- b) cost of service (decrease of 20% on normal cost of hospitalisation)

Barth, Hackman & Ash (1986) found that experienced mothers developed supportive relationships with mothers at high risk for abuse. Lines (1987), in Adelaide, Australia, found that parent aids (with only 15hrs training), very effectively reduced recidivism in abusing parents. Recidivism with professionals normally 8% and with parent aids dropped to 3%. The results were still positive on a five year follow up. Hornick & Clarke (1980) showed similar results. In this study 74% of clients were still in treatment with lay therapists after one year, as compared to 50 % in the standard professional social work group.

Several other studies lend support to the use of trained lay workers, taken from the client population, in the provision of mutual aid support groups (Burke, 1982; Carkhuff, 1968; Cohn, 1979a; Feldman, 1989; Martin, H.P. 1984). When lay workers are used, they do need to be given training. Seagull (1987) found that interventions were not successful where no training had been given. Much of the success of lay home visitors might well be attributed to the matching of client and home visitor, thus facilitating rapport. Wyatt & Peters (1986), found that ethnic matching between interviewer and subject facilitated rapport.

v) Overview

The previous research suggests that parent education, skills development, and most particularly home visiting and lay health worker support, achieve the best client outcomes. Zigler & Weiss (1985), found social support to not only moderate life stresses but also to assist coping ability. Social support influences parental attitudes and parent-child interaction and plays a crucial role in family coping, wellbeing and child development (Crockenberg, 1981; Cochran & Brassard, 1979). Lack of social support has been shown to be an important factor in the aetiology of child abuse.

These studies provide support for the use of community based nurses and lay health visitors in the prevention of child abuse. Research by Baher et al, (1976), gives support to the health visitor as a **case finder**, and recognises the significance of an interdisciplinary team in the prevention of child abuse. The complexity of the epidemiology of child abuse would seem to demand a broad

based, **comprehensive** strategy, which incorporates all three levels of prevention, and the principles of Primary Health Care as defined in 1978 at Alma Ata, most particularly; multidisciplinary team work, intersectoral co-operation (provision of jobs, housing and basic health facilities in order to break the poverty cycle) and Community participation (Donnelly, 1991).

✓ 2.6.2.3 Prevention Programmes in South Africa

Prevention of child abuse at the macro level, has as its main objective the changing of social and government attitudes and awareness, to address the needs of children and families. Activists in this area motivate for changes in the legislation which will enhance child protection and facilitate treatment options for the perpetrators.

For example:

In South Africa the Child Care Act no.74 of 1983 has been amended by the Child Care Amendment Act, no.74 of 1991. These changes are frequently motivated for by active community health and welfare workers. A report in July 1991 on a commission of enquiry into the protection of child witnesses, in which Key recommended that the child be protected from being touched or otherwise harassed by the abuser in court, and further advocated that a professional represents the child to ensure that the child is not subjected to secondary abuse in the courtroom, should lead to appropriate legislation changes in court room procedure (Project 71, 1991).

a) South African Child-Focused Programmes

The Department of National Health and Population Development developed a national plan for family life in 1987 and assigned the implementation to the South African Welfare Council and the regional welfare boards. (Health Promotion:information Bulletin, 1992)

Family Life programmes with particular emphasis on parenting, sexuality and protection awareness are in the process of being introduced into the schools at a national level.

The Natal Education Department is utilizing the South African Pre Primary and Primary School programme called "Education for Life", initiated and tested by Craig (1991). This programme was found to effectively introduce concepts of "feeling safe", to Pre Primary school children. Children were able to respond correctly to questions about "private parts", difference between "good and bad touches", not having to share one's body and were able to shout "No" if someone upset them in any way (Craig, 1991). This course is based on the principles and philosophies of democratic parenting, such as respect, responsibility and self worth, described in parent education. (These include such programmes as Systematic Training in Effective Parenting (STEP) and Parent Effectiveness Training (PET)). This programme is available for all interested preschools, funded by Liberty life /Round Table in a video and handbook format. This can

also be purchased by private individuals at a current cost of R58. This video programme covers the necessary knowledge and skills to deal with abuse and "feel safe" for the under five. Five modules are covered. 1) Aspects of sexuality and building of positive self-esteem 2) Exploration of conflicting feelings 3) Listening to your body. Communication and Assertiveness 4) Decision-making skills and Communication with unfamiliar persons 5) Problem-solving and responsibility for getting help. (Round Table advert, 1992)

A manual of suggested content and structure of school education for life programmes for use by school teachers at pre-primary, junior and senior primary schools is available from Southern African Society for the Prevention of Child Abuse and Neglect (SASPCAN), Pietermaritzburg. This is sponsored by the Beare Foundation. Six themes are explored: 1) Family Safety 2) Personal Safety and Body Integrity 3) Good and Bad Touching and Feelings 4) Childrens right to protect self 5) Assertiveness "No" and 6) Secrets - Who to tell? (Walters, 1991)

Leach is at present adapting the Kinly Sturkie Model for use in the treatment of sexually abused children (tertiary prevention). This involves group work with the eight structured themes of: 1) Believability 2) Guilt and Responsibility 3) Body Integrity and Protection 4) Secrecy and Sharing 5) Anger 6) Powerlessness 7) Other life crisis tasks and symptoms and 8) Court Attendances (Personal contact, 1992).

Other interventions have been the attempts different disciplines have made, to

work together in the formation of the "Child Protection unit", where police,

social and health care workers co-operate for the protection of the child in most South African Cities. The Bara/Soweto Child Abuse Liaison Group, was initiated in 1986. This consists of a multidisciplinary and community group, whose aim is to equip members with the skills to identify and manage child abuse effectively. They run a ten week training course known as "Friends of Families" (Mlotywa, 1992).

Voluntary organisations have become involved in mass media education. The Round Table have taken the prevention of child abuse and the care of children in distress as a major project. Bumper stickers, posters, newsletters, child line and many other media ploys have been highlighted over the last two years in a massive attempt to raise public awareness to the problem of child abuse.

b) South African Carer-Focused Programmes

At a micro level the primary service being offered for the primary prevention of child abuse are the various parenting education courses offered primarily by the Welfare and Psychological services. On the whole these courses are offered on payment of a fee. The Psychological services offer brief courses on understanding behaviour and behaviour modification and discipline for parents with problem children and some offer preventive short courses, on the same theme for parents

of children under five. Several lay support organisations offer mothercraft,

breastfeeding and parenting support, advice, counselling and teaching of communication skills eg. La Leche League.

At secondary and tertiary prevention levels more specialised services are offered. These may take several forms, from individual to family therapy, lay "victim" or "abuser" self-help support groups, to removal of either the abuser or abused from the family system to a "place of safety" (eg imprisonment or protective care respectively). Support for marital and social problems is also provided by these organisation eg. Family and Marriage Society of South Africa (FAMSA), The South African Institute of Marital and Family Therapy (SAIMFT), The local Child and Family Treatment Unit. Community and Psychiatric Health services at national and local level and private services, offer support and guidance of a limited nature on the prevention, handling and treatment of childhood behaviour problems, marital, family and sexual problems.

i) Group Model

Bernstein and Grey have tested a Group model, originally described by Hildebrand and Forbes in 1987, with dysfunctional, abusive families in the University of Natal's Austerville Community Project (1988). This model covers four stages.

1) Stage one - Constituting the group and establishing Needs. This is a pre-intervention phase, aimed at generating interest in order to recruit group members

and establish needs.

2) Stage two - Establishing the Content. Encourage the creation of a safe environment by modelling openness, honesty and self-disclosure. Baseline information and family concerns listed. Self-esteem questionnaire administered.

3) Stage three - Group Process. Provision of information as appropriate to expressed needs. Frequently covers areas such as: child development, sex education, principles of effective parenting and structural family therapy concepts such as boundaries and alliances. Group members are encouraged to use information to discuss and deal with individual family conflict and to integrate knowledge and skills, in order to improve functioning. Skills training consists of interpersonal, communication and assertiveness skills. The parenting skills cover effective listening and communication skills in accordance with the STEP programme. This covers three levels, functional, interactional and educational. The functional level includes roleplaying and homework assignments. The interactional level provides support from group members discussion of members effective coping methods. In the educational level, the group leader provides information and skills.

4) Stage four - Evaluation and Future Planning. Group progress and future planning assessed. Self-esteem Questionnaire readministered.

Most welfare organisations offer the course "Systematic Training for Effective Parenting" (STEP) for the child under ten or "Stepteen" for the teenager. This is an American based programme shown to produce important change in parents and children.

2.6.3 PARENTING PROGRAMMES

2.6.3.1 Introduction

As has been discussed these programmes are offered by a number of welfare organisations and are applicable at all three levels of prevention.

There is increasing recognition that the **most effective** and **efficient** means of intervention for children is through the **parenting system** (Winans & Cooker, 1984). Much research indicates that parents play a vital role in childrens attitudes and behaviour (Mckay & Hillman, 1979; Sumerlin & Ward, 1981). Nearly all the major parent-training programmes work primarily with parents as change agents (Wantz & Recor, 1984). The ultimate goal of parent education is to improve the parent-child relationship (Williams, Omizo & Abrams, 1984).

The consistency of interactional differences between abusive, at risk and non-abusive parents, suggests that observation of the interaction could be useful in diagnosing abuse and in evaluation of the success of treatment outcome (Starr, 1987).

The teaching of parenting skills has been the focus of intervention, frequently at secondary and tertiary level (Blythe, 1983; Gross et al, 1978; Rosenstein, 1978; Wantz & Recor, 1984). Thus abusing and neglectful parents have been

encouraged/coerced to participate in "Parenting Education/Support programmes" in an attempt to improve/modify deficits in the parent-child relationship. The main emphasis has been on changing the parents unacceptable behaviour. High risk parents have also been targeted for this type of intervention. At these levels there have been varying reports of success, often dependent on the severity of breakdown in the parental-child relationship, more effective results being obtained in less severely entrenched abusive relationships (Barth, 1991; Henry, 1981; Phillips, 1982; Sefick & Ormsby, 1978). Spinetta & Riegler (1972), found that the greater the personality problems of the parent, the more resistant they were to treatment. An immature personality was found to be of greater significance for parental dysfunction, than were emotional problems (Heap, 1991).

Non-problem families have also been exposed to this type of education, frequently with considerable success, but usually on the payment of a fee (Wantz & Recor, 1984).

2.6.3.2 Different Parenting Programmes

There are four basic approaches to parent training;

- a) The Behavioral Approach (A.B.C. of Behaviour. Acceleration & Deceleration)
- b) The Interpersonal Communications Approach (P.E.T. & Developmental Play)
- c) The Adlerian Approach (S.T.E.P.)

d) Bibliotherapy (Child rearing books used as references)

a) Behavioral Approach

There is widely published research support for behaviour modification programmes, particularly in children under five years (Henry, 1981), in retarded, emotionally and/or behaviourally disturbed children (Dolly & Page, 1981), in childrens homes (O'Keefe, 1978), in poverty stricken ghettos (Phillips, 1982) and in fostered children (Pen, 1978). The majority of studies have however investigated the application of a particular technique to a specific problem behaviour eg. timeout, verbal praise. While well supported by empirical research, they tend to focus on the "observable behaviour" of children rather than parents attitudes and feelings and parent-child communications (Fine, 1980; Henry, 1981).

The Family Empowerment Training programme (FET), utilizes behaviour training to help empower parents and provide self-help support (Schatz & Bane, 1991).

The Early Intervention Program (EPI) is a programme designed to help prepare children specifically for school entry. It is designed to include both parents and child and combines both treatment and evaluation of treatment aspects. Parents are trained by previously trained parents, in behaviour management and self-help skills teaching. Effectiveness of parental action is recorded by graphing both the child's and the parents actions (Frangia & Reisinger cited in Roberts & Peterson,

1984).

2) Interpersonal Communications Approach

Parent Effectiveness Training (PET) has been extensively researched and shown to lead to positive changes in both parents and children (Fine, 1980; Nystul, 1982). Parents experienced increased acceptance and empathic understanding of their children and an increase in self esteem and children experienced increased self-esteem, improved school grades and decreased disruptive behaviour (unpublished doctoral dissertations cited in Fine, 1980)

This approach introduces a democratic interpersonal relationship between parents and children which embodies mutual respect and collaboration, social equity of the worth and needs of both and an environment conducive to mutual growth and development (Fine, 1980).

The PET programme, developed by Gordon, emphasises the teaching of techniques of communication skills eg. "active listening" (silence, door-openers/open ended questions and reflective listening), "I- Messages", and a humanistic, existential, caring approach eg. limits "value-loading", blaming and criticising, encourages democratic problem-solving. An interaction between parent and child in which both attain gratification (Geismar et al, 1972; Gordon, 1970; Fine, 1980). These Rogerian principles should not be underestimated. In a recent well-controlled study on extremely high risk families (pregnant mothers who had

been confirmed abusers with earlier children or had their children removed because of this abuse) the "caring relationship" outranked the provision of even direct physical assistance and provisions in significance (Pharis & Levin 1991).

PET and Behaviour Modification utilised together led to an increase in physical contact and increased problem-solving in the dyadic relationship, while PET alone did not lead to this increase (Schultz, Nystal & Law, 1980).

A recent study found no difference between PET and STEP. Both programmes lead to positive changes in parental attitudes, improved family functioning and marital and child relationships (Noller & Taylor, 1989), however the STEP programme is more cost effective.

Several other interpersonal communication programmes have shown promise.

Developmental Play, which seeks to stimulate or rebuild the bonding relationship between parent and child. Both group activities and one-to-one child-adult play is encouraged. Touching and body contact, a sense of fun and mutual enjoyment is encouraged. This approach has been successfully used with disturbed children and to enrich the growth experience of normal children (Brody, 1978).

The Innovative Methods in Parent and Child Training (IMPACT), found that abusive parents developed both parenting skills and improved self-discipline (Ruger & Wooten, 1982). This programme also highlighted the significance of

"informal Discussion" and the need to "begin where the client is".

The Human Relations Enrichment Course (HREC), which is a three day course of concentrated parent-child communication skills training for parents is currently available in South Africa (personal communication, 1991).

Haim Ginott, like Gordon, emphasised humanistic communication and recognition of mutual needs and choices in the parent-child relationship. He also stressed democratic principles in the form of the "real" expression of values, feelings and expectations rather than authoritarian criticism of the other person. Parent training proceeds through four recognisable phases. First that of "recitation" where parents vocalise problems and gain increasing support from the acceptance by group members on one hand and increased discomfort on the other hand by exposure to other group members problems. Secondly, where group members are "sensitised" to their own and their childrens' feelings. Thirdly, group members learn the basic "concepts" of interpersonal exchanges and principles for understanding the influence of feelings on acts of behaviour. Phase four involves active teaching and practice of "coping skills" (Fine, 1980; Ginott, 1965). Faber and Mazlish have extended this work to include cartoons and dialogue of real parenting problems, thus making the acquisition of these parenting skills available to the literate man in the street (Faber & Mazlish, 1980).

In the Parent Involvement Program (PIP), Glasser applies reality therapy to parent education with a strong emphasis on developing warm interpersonal

communication and a behavioral focus of problem identification and resolution which includes nonpunitive parent-child interaction (Fine,1980).

Transactional Analysis is another interpersonal approach which focuses on relationships between people; in parent education this focus becomes the parent-child dyad and may focus on either the development and growth of the child or the parent (Sirridge, 1980).

c) Adlerian Approach

The most commonly utilised "parenting Programme " in South Africa is STEP and STEPTEEN (Systematic training for Effective Parenting). This programme was developed by Dinkmeyer and McKay in 1976 and is strongly influenced by the Adlerian work of Dreikurs and by the Rogerian work of Gordon (the latter developed PET or Parent Effectiveness training in 1970).

The STEP programme includes many of the skills taught in the PET programme eg. communication skills, limits blaming and criticising and also emphasises problem solving, extending the negotiation skills to include the concepts of natural and logical consequences and democracy to include a family council, avoidance of a power struggle and the recognition of and active response to childrens needs (Dinkmeyer & McKay, 1976).

The STEP programme has been shown to lead to attitude and behaviour change

in both parents (more able to accept and trust children) and children (better self-concept and improved internal locus of control), and to an increase in parenting skills (Hammett, Omizo & Loffredo, 1980); Winans & Cooker, 1984; Schultz et al, 1980; Summerlin & Ward, 1981; McKay & Hillman, 1979; Williams, Omizo & Abrams, 1984; Hammett et al, 1981).

Some studies however have shown inconclusive results. For example Jackson and Brown failed to substantiate improvement in STEP children's self concept (1986), found to be positive by Summerlin & Ward (1981) and also found to be positive by Hammett et al in learning-disabled children (1981).

STEP parents perceive their childrens behaviour more positively (McKay & Hillman, 1979) and are more democratic and encouraging of increased verbalisation in the parent-child interaction (Nystul, 1982). Croak and Glover have shown that changes in parental attitude in the parent-child relationship lead to attitudinal and behavioral changes in the child (1977).

The effects of this Adlerian based programme on children's behaviour, has shown significant change in the childrens behaviour, as perceived and assessed by the parent (Wantz & Recor, 1984). Where parent training and child group counselling have occurred concurrently this has shown to be particularly effective (Phillips, 1982; Wantz & Recor, 1984.)

While the Behavioral Approach seeks to modify the child's behaviour, and

frequently looks at specific behaviours, the Adlerian Approach seeks to modify the child's motivation by developing self esteem, cooperation, independence and responsibility. Ultimately this should lead to broad behaviour change (Fine, 1980).

Winans and Cooker showed that the STEP programme lead to an increase in marital satisfaction (1984). Thus while the programme is aimed at the parent-child relationship, it may also lead to positive changes within the family system.

These programmes are aimed at middle class, American, literate parents, and involve fairly advanced metacognition abilities and skills. Homework and pre- and post- reading of the training manual are expected. Most groups look at the child from four years and over. The supporting research is primarily from studies of this socio-economic group.

d) Bibliotherapy

Parents who are fortunate enough to be literate and have access to a library, are able to make use of this written source of knowledge and information on parenting principles and skills. Most of the above parenting methods and many programmes designed specifically for independent use by parents and teachers are available in this format. This frequently excludes the majority of South African parents. Of particular interest to this current research is a self help programme which was designed only in a brochure format to assist mothers to effectively

utilise "time- out" and "differential attention" to modify their childrens mealtime behaviour (McMahon & Forehand cited in Roberts & Peterson, 1984).

Parent education is aimed at sharing information, skills, support functions and frequently value clarification, and is distinct from parent therapy which requires a skilled therapist and individual counselling for psychological problems. Parent education is an educational and social process rather than a medical procedure. The model assumes that it is lack of knowledge, experience, skill and/or motivation, rather than, illness, which is the basis of maladaptive behaviour (Christensen & Thomas, 1980).

These programmes are primarily aimed at middle class, American, literate parents, and involve fairly advanced metacognition abilities and skills. Homework and pre and post reading of the training manual are expected. Most groups look at the child from four years and over. The supporting research is primarily from studies of this socio-economic group, and much of this research is in the form of unpublished dissertations (Fine, 1980). Research on other groups have not been shown to be as successful eg. Jackson & Brown, 1986 study on military bases.

2.6.3.3 Basic Principles of Parenting Programmes

As can be seen from looking at the content of these programmes, intrinsic to the programme is a basic democratic respect for the **value** of people, regardless of age. This concept of "equality" of human value across the lifespan should not be

misinterpreted as "permissiveness" but rather as "freedom with order" (Christensen & Thomas, 1980) or in the language of the nineties, as "rights with responsibilities". The primary goal of childrearing from this conceptualisation is to motivate in the child an internal locus of behaviour control which will enable the child to function effectively in the sociocultural community to which she or he belongs.

2.6.3.4 Relevance of Parenting Programmes to the South African Profile

Looking back at the profile of South African family life it becomes obvious that these programmes have limitations.

a) Social Class

Research has well documented that lower socio-economic groups have a different parenting style ie. more corporal punishment, less verbalisation and problem-solving attempts to middle and upper class parenting ie. more verbalisation, democratic problem-solving and less use of corporal punishment. There is increasing cross-cultural evidence suggesting that early training in obedience adversely effects intellectual development, particularly the ability to solve problems, and that creative thinking in children is positively associated with more permissive child rearing patterns (Grotberg & Bardin, 1989). South Africa has a large illiterate, transitional, lower socio-economic sector in it's total population.

b) Violence and Criminal Behaviour

Research has also correlated physical violence with lack of physical affection and the ability to experience pleasure. Vissing et al (1991), found that verbal aggression is strongly associated with aggression in children. The lack of a nurturing, touching relationship is seen as one of the main contributing factors in criminal behaviour (Brody, 1978). Several researchers claim that witnessing violence in one's family of origin is the most consistently demonstrated background among wife abusers, delinquents and violent criminals (Finkelhor et al 1988; Gelles & Edfeldt, 1986; McCord, 1983). Violence is present at all levels of South African Society.

c) Parent-Child and Parenting Interaction patterns

Research on the parent-child interaction of abusive and non-abusive families show that when socio-economic and income levels are controlled in the regression equation, maltreatment was frequently associated with more negative and hostile behaviour and less affectionate - positive and less frequent interactions (Herrenkohl et al, 1984).

Further research on the parent-child interaction of abusive and non-abusive families indicate less speech and stimulation and more passivity (Herrenkohl et al, 1984) and distorted affective communication (Gaensbauer & Sands, 1979) in the abusive families. Any intervention to promote and support family functioning

must take these factors into account.

Schaefer (1987), found that high academic performance and motivation is positively correlated with permissive child rearing practices. Sever (1989), explored the change in Turkish women's child rearing practices over three generations of social change, finding a decrease in authoritarian control and an increase in emphasis on independence, open expression and expression of affect. The shift from traditional to modern or permissive child rearing practices can be taught. Grotberg & Bardin (1989), successfully implemented a home visiting programme using psychology students to teach urban Sudanese mothers how to change their child rearing practices in order to enhance the development of their young preschool children. Regardless of income level or family cultural patterns, positive changes were noted in child development, the parent-child relationship, parental tolerance to child and increased verbalisation. This gives promise for the South African situation.

d) Isolation and reduced Social Support

Abusing families frequently have no telephone or an unlisted number, no friends, make no or little use of available social services, have no family pets and keep to themselves (Garbarino, 1977; Seagull, 1987). In South Africa, most families do not have telephones, social services are not available for the majority and family life has frequently been disrupted family members being abruptly and violently killed and /or separated by dissentous politics and the violence.

2.6.4 ANALYSIS OF SITUATION

Thus while programmes developed for the teaching of parenting skills have been shown to be successful interventions in literate, western societies who can also afford to pay for this service, in their present forms, they have limitations for a multi-ethnic South African society.

This research has sought to address this problem by taking the principles of the parenting programmes discussed and presenting them in a form appropriate to the identified needs of a multi-ethnic community with low literacy, a high number of children under five years, a high number of single parents, multiple stressors eg. poverty, unemployment, transitional changes and structural and political violence, who are thus vulnerable and at risk for family dysfunction. The economic constraints need to be addressed by ensuring the ability to include the programme in an existing service setting or utilising trained lay workers as volunteers. Given the history of violence in South Africa this initiative should be instituted at a primary prevention level and made widely available.

It was with this purpose in mind that the researcher initiated the development of the support programme (Chapter 4). The researcher was committed, not only to developing the programme, but also to training competent nurse facilitators and evaluating the programme in the multi-ethnic South African community. It was anticipated that the need might be as great for other developing countries and that this baseline work could be utilised fruitfully to demystify life skills and improve maternal-child and family relationships in any developing country.

CHAPTER THREE

METHODOLOGY

THE TESTING OF A FAMILY SUPPORT PROGRAMME FOR COMMUNITY HEALTH NURSES IN THE PRIMARY PREVENTION OF CHILD ABUSE.

3.1 INTRODUCTION

The aims of this research are:

- * The development of a structured family support programme for families with children under five years, appropriate to a multi-ethnic low literate South African population, based on the child abuse literature, research on prevention in this area and educationally sound and appropriate principles.

- * The training and selection of community health nurse volunteers willing to implement this programme in their own communities of practice, in order to ascertain whether this developed programme could in fact be implemented by the average community health nurse in the South African setting.

- * An evaluation of both the structured support programme and the short-term effects of the programme on selected family variables and maternal-child interaction.

- * A long-term evaluation to establish whether any changes noted in the maternal-child relationship remain consistent over time and to further enquire into the participants retrospective attitudes to the programme.

The high incidence of child abuse and neglect, particularly in the child under five years, is discussed in the literature review, as is the complex relationship between different types of abuse where several types of abuse may concurrently occur. The ability to train effective professional, para-professional and lay counsellors is well documented.

Family support programmes have been shown to lead to behaviour and attitude changes in the parent-child relationship, with a decrease in the use of punitive methods of discipline and an increase in effective, non-punitive practices. This has been found to be particularly the case with families who do not have long term, entrenched punitive behaviour patterns.

This highlights the need for the introduction of a low cost support programme into an existing service setting.

3.2 PROGRAMME DEVELOPMENT

This is covered in detail in chapter four. In the interests of maintaining clarity and the context of the research a brief overview is provided below.

3.2.1 BRIEF OVERVIEW OF DEVELOPED PROGRAMME

A basic instruction manual was developed for the use of a facilitator, with detailed instructions, thus necessitating limited training only. In accord with the UNICEF information for action issue paper on health education (Jan.1986), appropriate visual aids for semi-literate audiences were developed and tested.

This resulted in a multi-ethnic "comic book" presentation of 90 different graphics. These graphics showed typical, common multi-ethnic parent-child interaction sequences and child behaviours. The comic book, with its ability to convey humour, satire and abstract information is an effective medium for semi-literate groups and an extremely effective medium for reaching children (Flavier, 1990; UNICEF & Aga Khan, 1986).

As photographs have also been found to be a successful medium, particularly for semi-literate, rural populations, these were also incorporated in a cost effective format (UNICEF & Aga Khan, 1986).

Principles of participatory and experiential learning were included as much as

possible and relevant tools were utilised where appropriate. eg humour, cultural/spiritual beliefs etc. (Flavier, 1990; UNICEF & Aga Khan, 1986). This was not only to promote the learning experience but also to increase the positive interaction and touch between parent and child (supported by Ruger & Woosten, 1982).

The learnt control of the aggressive behaviour sequence (discussed in section 4.3.4.1) was encouraged by relaxation, singing and play. Playing with children and providing stimulating toys from recycled waste was utilised to increase the age appropriate parent-child interaction. The concern of most parenting programmes to avoid verbal aggression, has now been substantiated by research, and positive verbal skills were considered as essential. Appropriate simple and basic principles of the PET, STEP programmes were utilized with some of the modifications made by Faber and Mazlish and with age related relevant behaviour modification skills and provision of information on normal child development.

3.3 RESEARCH DESIGN

The research questions and objectives provide guidance for the research design (Roberts & Burke, 1989). The research design describes the researchers planning and gives structure or order to the research process (Seaman & Verhonick, 1983).

In this research an attempt was made to develop a structured support programme based on the specific criteria outlined under the research objectives and on

relevant research in this area. Graphic material and experiential-learning sessions were tested in multi-ethnic communities across the lifespan, and the adaptations made are discussed under programme development. The ability of the average community health nurse to implement this programme was assessed by advertising a short course offering training as a facilitator directly to organisations employing community health nurses. The support programme was then evaluated on several criteria of process and outcome evaluation.

A quasi-experimental design was used to evaluate the relationship between variables in an experimental group and in two control groups in four different sites. The research was initially concerned with the short-term changes in the interpersonal variables between mother and child and sought to measure cognitive and attitudinal changes in the mother. A long-term follow up of these changes was conducted. A quasi-experimental research design is appropriate to the natural field setting utilized in this study (Roberts & Burke, 1989; Santrock, 1983). While control groups are utilised, randomisation was not always possible. A nonequivalent control group design or comparison group was thus used.

In an attempt to ensure that the groups were as similar as possible and thus limit the influence of extraneous variables which could influence the dependent variable, the researcher selected three groups from the facilitator community health nurse's clinical practice in each of the four sites. All participating mothers came from the same geographical area and were of a similar socio-economic status and ethnicity, attended maternal and child health clinic, had children under

five years and were under thirty five years of age.

Initially a six-cell design without randomisation was utilised. This consisted of the pretest and posttest of the experimental group and two control groups (Roberts & Burke, 1989; Seaman & Verhonick, 1983). With the addition of the long-term follow up this became an eight cell design (clarified on p.274). The time interval between pretest and posttest was foreseen to be at least three months for each of the three groups in each site.

There are three threats to validity in the quasi-experimental design. These are:

a) History b) Maturation and c) Testing effect.

The effect of history refers "...to extraneous variables that occur between the testing periods and influence the action of the independent variable on the dependent variable" (Roberts & Burke, 1989, p.162).

The researcher attempted to control internal validity or causality by utilising a questionnaire indicating life stresses which had occurred during the time interval between pretest and posttest (Hypothesis 5). The social readjustment Rating Scale was given posttest to the experimental group with instructions to score the life changes only after the intervention programme was complete. Subjects pre and posttest scores could then be analysed and any influence of the variable "life changes" could be assessed.

Internal validity was also improved by the care taken to ensure that all subjects shared the phenomenon under study, namely a maternal-child relationship, and that experimental subjects were as similar in characteristics as is possible in a quasi-experimental design.

Triangulation was also utilised to reduce bias. Use was made of a) formal closed ended questionnaires b) an interview c) open ended questionnaire, and d) informal evaluation by facilitator of observed changes in clients.

Maturation was not considered by the researcher to pose a major threat as the time interval between pre and post testing was relatively short. The testing or sensitisation effect (in experimental design called the Hawthorne effect), was also thought by the researcher not to pose a major threat. The rationale for this was that with four lengthy questionnaires to complete there would be little recall of previous responses. Attempts were also made by the researcher to relieve boredom in this session by allowing for short "tea breaks" and most clients remained attentive throughout.

The researcher attempted to limit subjectivity and thus strengthen external validity or generalisability by encouraging and supporting the clinic sister in the administration of the questionnaires and by limiting contact with the experimental subjects over the three months to two contacts (however the researcher was **available** for comments or support at all times). Only the one test was administered in an interview situation by the researcher. This was the Family

Stress CheckList. This looked at the potential for child abuse of the client. This was scored before working with the raw scores of the questionnaires which looked to determine changes in parent-child relationship and the potential influence of the developed programme to exclude any possible bias in the researcher. The researcher anticipated that the quality of the research would be high and that this would counteract some of the threat to external validity brought by the nonprobability sampling.

Sample size was felt by the researcher to be a threat to external validity. The nature of the study required that the experimental groups be a small group experience. This limited the possible number to between five and ten subjects. In order to increase external validity the researcher attempted to implement the research in four sites in order to increase the sample size. The limitation of this was that the characteristics of the subjects over the four sites, while fulfilling the research criteria, included fairly extensive socio-economic, ethnic and language differences, and thus they could not be regarded as homogenous.

Sampling bias existed in that only mothers and children who utilised the formal health services were part of this study. This will limit the generalisability of the study to the population of all mothers and will reduce external validity. Sampling error is present as nonprobability sampling cannot represent a completely accurate sample of the population under study. Attempts were made to assess the extent this existed by looking closely at the characteristics of the experimental and two control groups.

All of the formal questionnaires used in this study have some established validity and reliability. This will be discussed under each specific test as will the use of these tests in the multi-ethnic South African Context.

3.4 SAMPLING

The accessible population for the research support programme facilitators included all Kwazulu-Natal community health nurses employed and working in this field during 1992 and 1993, who were motivated to attend the three day facilitators training course and who were either given permission by their employing bodies or signed leave in order to be able to attend.

For the evaluation of the developed programme as a primary prevention for child abuse, the accessible population was that part of the target population who met the population criteria and were accessible to the researcher. For the purpose of this research this comprised of the mothers fulfilling the population criteria who attended the clinic services of the community health nurses who accepted and completed the three day facilitators' training course of the developed programme, and whose employing body gave consent for participation in the research.

To a large extent, it was the employer who directed the sampling process of these community health nurses who became the facilitators, and this also determined the study sites.

Nonprobability sampling was utilised for the pilot study and in all four sites where the research was implemented. Nonprobability sampling strives to be representative of the population under study by using the "... judgment of the researcher to select those subjects who know the most about the phenomenon " (Robert & Burke, 1989, p. 217). The form of nonprobability sampling used was convenience or accidental sampling. This was used in the pilot study and all four experimental sites. "Convenience sampling takes advantage of a group of subjects that fall within the population of interest and are conveniently located or readily accessible to the research team" (Roberts & Burke, 1989, p. 218).

The special techniques used in the nonprobability sampling differed in the sites and will be clarified when discussing each site. In one site it was possible to attempt matching of experimental and control groups. "Matching is a special technique used to construct a comparison group by filling it with persons who are similar to each subject in the other group by predetermined variables" (Roberts & Burke, 1989, p. 219). In most sites subjects were randomly assigned to either the experimental or the control groups.

All the sites sampled differed from each other. The sites covered rural, urban and periurban communities which had differing levels of literacy, language usage, ethnicity and socio-economic class.

The minimum sample size for any group was set at five and the maximum at ten. The researcher hoped to have six to eight subjects in each of the three groups in

each site. This number was thought to allow for sufficiently small groups to ensure the dynamics of small group work, while also fulfilling minimum guidelines for adequate sampling. Roberts & Burke (1989, p.227) suggest that .."Most researchers agree that there should be at least five of each type of subject in the sample and recommend at least ten, with twenty to thirty per type preferred." The optimal number sampled is also related to the design of the research and how the data will be analysed (Roberts & Burke,1989).

3.4.1 THE SAMPLING PROCEDURE FOR CHN FACILITATORS

The sampling procedure for the **community health nurse facilitators** occurred in two phases:

a) In sampling phase one all provincial and local authority services employing community health nurses in KwaZulu/ Natal and the larger private primary health care clinics and hospitals, as listed in the 1992 Hospital and Nursing Year Book, were identified. Those centres within traveling distance of the University of Natal, Durban were identified. Twenty two clinics and/or community services were sent invitations to participate in the three day facilitators workshop with the understanding that there was no financial charge but that participants should be prepared to voluntarily participate in the research by implementing the developed support programme in their own clinical practice.

In addition the Natal Professional Community Nurses Society was given

notification of the course and a brief presentation concerning the course was made at one of their professional meetings.

Thirteen community health nurses responded positively, were accepted and permission for their attendance was confirmed by their employing body. On day one of the facilitators course twenty one community health nurses arrived and eighteen finally completed the full three days.

b) In Sampling phase two all of the eighteen community health nurses who had completed the three day course volunteered to facilitate a research group and left full details of contact addresses and telephones. Final sampling of facilitators was convenience. Those facilitators who had clearly demonstrated understanding of the programme skills **and** who were also available during the next six months to facilitate a group were selected. Many community health nurses were unable to participate because they were taking leave during this time and this would have meant an interruption of the developed programme which needed to run over two and a half months and initially required several months to set up. Of the original group of eighteen trained facilitators, only five were available for an unbroken stretch of five to six months. The programme of ten weekly sessions took two and a half months to complete. Two months were allowed to plan and gather the pretest questionnaires of the experimental and two control groups and a further two weeks after completion of the programme, was allowed for the gathering of the posttest questionnaires.

The five potential sites identified were: 1) PILOT STUDY SITE 2) SITE ONE
3) SITE TWO 4) SITE THREE 4) SITE FOUR

3.4.2 SAMPLING IN EACH SITE

a) SITE ONE

i) Brief overview of Site One

This site was a small geographic section of a large subtropical coastal city. The area is naturally divided on both sides by a major road and a freeway. The other two aspects are bordered by commerce and industry. The subjects were drawn from mothers who lived in this area and attended the local maternal-child health clinic. The attendance at this clinic according to the city's annual report is approximately four thousand per annum, making it one of the busier clinics in the city. There are no breakdown figures published for each subsection of the city. The estimated population from the most recent population census for 1991, suggests seven and a half thousand people. Ethnically this includes approximately 58% Indian, 23,6% White, 10,5% Black and 7,8% Coloured.

The city itself has a full complement of highly developed educational, medical, transport, communication and environmental health services. The terrain of this specific site is steep and hilly. This could be seen as an advantage, allowing cool breezes to cool the frequently hot summer days and providing magnificent sea views.

This site was developed initially as a site for relatively wealthy white landowners,

because of the magnificent views and proximity to the inner city. Over the years it has become more cosmopolitan. Several large flat and simplex developments have increased the number of both elderly and young married couples in the area and the proximity to the University has increased the young student population in the area.

The clinic now serves all ethnic groups and the population ranges from landowners and tenants to household employees. Socio economic levels are typical middle class. Of interest to this study is the yearly publication of the child abuse and neglect figures for the city, which showed that 85% of reported cases for abuse in the city were for the child five years and under, and 59% were under three years and under. The majority (47%) came from White families (Site Professional Nurse, 1993; City's Annual Report, 1992).

ii) Research Sampling of Site One

Nonprobability convenience sampling was used. The community health nurse group facilitator gathered the names of interested mothers with children under five over the months of August and September, as these mothers attended clinic. These names were then divided randomly into two groups. One group became the experimental group and the other group was formed into a "neighbourhood group", which became the social support control group one. The "neighbourhood group" is a concept which has been utilised to encourage mothers in the area to form their own health support group with the encouragement of the community

health nurse working in the area. This is encouraged in order to supplement the home visiting case load of community health nurses, which of necessity have been reduced to only birth notification and problem follow ups (City Health Annual Report, 1992). The second clinic attendance control group two was randomly chosen from recent clinic attendance files.

iii) Sampling realisation in Site One

The community health nurse facilitator commenced both the experimental and control group one's sessions, with a full morning pre-session in which permission and the pretest questionnaires were completed. For control group two, permission and pretest questionnaires were completed by home visits after clinic cards had randomly been drawn from the clinic records (every tenth client card which fulfilled the research criteria). Post test questionnaires were completed in a similar manner. The experimental group requested to meet the researcher and this occurred during one of the programme sessions, when the subjects interviews for the Family Stress Checklist occurred and again during the morning post test questionnaire session. There were fifteen participants in this site, being five in the experimental and in each control group. All participants completed all pre and post test questionnaires.

Sampling realisation of site one for the **long-term post-test** evaluation testing hypothesis 6 was disappointing. The researcher attempted to access the experimental and control group one's participants (ten in total). Only three

participants were successfully traced. Two of the experimental group had immigrated. All the control group one had moved without forwarding an address, one of whom has immigration.

b) SITE TWO

i) Brief overview of Site Two

The original Nguni inhabitants were settled in 1980 after being forcibly removed during the construction of the national freeway. This is a trust area bounded on both sides by KwaZulu. This entire area has been plagued by political violence over the last few years.

This site comprises approximately 92 hectares of land situated in the undulating hills of the KwaZulu/Natal coast, 27 km from the nearest town and about 4 km east of the local Mission Hospital. While the fairly close proximity to a town might prompt one to class this as a periurban area, the limitations of infrequent and costly transport and poor roads leave this community isolated from urban support and the lifestyle is traditionally rural. A large river cuts through the hills, and together with springs, five boreholes and forty water pumps provides water for the community. The climate is mild, subtropical, coastal with a high rainfall suitable for agriculture. There are approximately 330 households covering 50% of the land area, primarily concentrated on hills but spreading down towards the river valley which is subject to seasonal flooding. The average household is

estimated at 7,5 persons and the estimated population is approximately 2475 people (Department of Development Aid; Residents' Committee).

Income levels are low and formal employment is minimal. Subsistence agriculture is supplemented by cane growing, candle and block making, roadside vegetable stalls and pensions. There is a well established and active resident's committee. Residents have a low educational and literacy level and are mainly Zulu speaking. Many households are female headed.

There is one gravelled main access road, no electrical supply or telephones and no refuse collection or piped water. Sewerage is managed by pit latrines. There is only one School (Standard 1-8), one creche, two churches and a small trading store. A Mobile Clinic service visits twice a month. This stops at the school site and is within fifteen to thirty minutes walking distance of most homesteads. The Mission Hospital provides care between mobile visits.

Housing is primarily the traditional round "kraal", constructed from mud, cement and wattle with corrugated iron and thatch roofing. Each homestead may be made up of several round, one roomed huts, each serving a different function eg. sleeping, cooking, food storage (Site Development Plan; Community Health Nursing Manager from Mobile Clinic; Personal observation).

ii) Research Sampling of Site Two

For this particular site nonprobability convenience sampling was used. The trained programme facilitator was also the Community Nursing Manager for the Mobile Clinic service and had been looking for volunteers to train as Community Health Workers (there is limited antenatal and family care in this area). This group of volunteers were very keen to be involved. Those mothers and children fulfilling the research population criteria were identified from this group of volunteers, and randomly allocated to the experimental and social support control groups. The experimental group met on a regular two weekly basis and participated in the designed programme. The social support control group met on a regular basis and training as community health workers was begun at these meetings. Mobile Clinic attenders formed the second control group, experiencing normal clinic health service only.

iii) Sampling realisation in Site Two

This community had a low educational level and this is shown in the analysis and presentation of data. Only zulu was spoken and literacy was low. The experimental and social support groups thus completed the pre and post test questionnaires with the assistance of the researcher and three community health nurses who supervised, clarified questions and translated from english to zulu. The clinic control group completed the questionnaire as they were randomly selected during actual mobile clinic visits (every third client attending clinic who

fulfilled the research criteria). The interviews for the Family Stress Checklist were conducted by the researcher with the assistance of the facilitator who acted as the translator and took two hours to complete. The completion of the pretest questionnaires took six hours and the post test questionnaires took five hours.

There were eighteen participants, eight being in the experimental group and five in each control group, who qualified for the study. The sampling was planned to be six to eight in each group. However two participants refused to be part of the social support group and insisted on joining the experimental group. A further four participants who fell outside the criteria of 35 years, one of whom had nine children, also insisted on participating in the experimental group and in completing all questionnaires, both pretest and posttest. The facilitator felt she was unable to dampen such enthusiasm and allowed them to do so. The researcher has taken the test results from those who fulfilled the criteria for the research but has accepted that the participation of four extra people in the experimental group will have influenced the group and its process and consequently will consider the qualitative feedback given by these participants when this is under discussion. The researcher would also like to support the community health facilitator who made the decision to accept the extra participants. Had she refused to do so this might well have reflected poorly on the remaining participants and would certainly have been contrary to the conceptual framework of considering the subjective norms of the community. The entire tone of the group might have become negative, rather than positive, a core aspect of the intervention itself.

Posttest results were obtained for the entire experimental group, four of the five support control group and three of the clinic control group. The final number of subjects used in the statistical calculations thus became $n=8 \times 4 \times 3$. There was one subject who dropped out of the social support group. The clinic control group were extremely difficult to trace. This is because the clinic service being provided is only a mobile service which usually includes no home visiting. Each of the clinic attenders then had to be traced to their homes, and found at home, no easy task. Consequently, only three of these subjects finally completed the posttest questionnaire.

Sample realisation of site two for the **long-term post-test** evaluation testing hypothesis 6 was also disappointing but more promising than in site one. Five of the original eight experimental participants were traced and three of the four subjects from control group one.

c) SITE THREE

i) Brief overview of Site Three

This site is situated approximately 20 km inland. It is subtropical with gently undulating hills between large level tracts of land, through which runs a large river. It is geographically part of a larger town. The town is largely divided by the ethnicity typical of the apartheid South Africa. Population figures are 29928 White, 20648 Asian, 7009 Coloured and 43000 Black. Most of the Asian

population is found in this study site. The site is boarded by a black residential area on one side and a coloured residential area on the other.

This community has a good infrastructure of services, roads are tarred, water is piped to the houses as is electricity and there are several schools shops, a library, community hall, police station and comprehensive clinic service.

Houses are primarily of brick and tile or corrugated iron and range from exotic architect designs to small square western type homes. There is a mixture of large wealthy landowners and poor "low cost" housing estates. Employment is primarily in the large industrial park and in the commercial area of the town. The extended, patriarchal family system is predominant in the area and literacy levels vary across socioeconomic level and caste distinction. English is widely spoken.

ii) Research Sampling of Site Three

Nonprobability convenience sampling was used. The community health nurse facilitator identified interested mothers from among those who attended the clinic over the months of August, September and October. This became the experimental group. The social support control group one consisted of an existing antenatal group who fulfilled the study criteria. The clinic control group two were randomly chosen from those mothers who attended the clinic.

iii) Sample realisation of Site Three

The experimental and antenatal/neighbourhood control groups filled in the pretest questionnaires at an arranged all morning presession meeting. The clinic control group completed the questionnaires at their normal clinic visits. Posttest questionnaires were not completed on any of the participants for reasons discussed later under analysis of results. The participants totalled sixteen, six in the experimental group and five in each of the control groups ($n=6 \times 5 \times 5$).

d) SITE FOUR

i) Brief overview of Site Four

This site is comprised of Nguni residents, and covers approximately 2141 dwelling sites. It is a periurban township in fairly close proximity (approximately 25 km) to a large industrial park and well developed town. It is regarded as a developing estate by this town and many of the services are provided by this local authority in consultation with the civic organisations, National and Provincial health and the Independent Development Board.

The topography is steep and the climate subtropical. It is approximately 17 km inland from the coast. The access road is narrow and winding and while transport is readily available it is also costly. The main road is tarred and in fairly good repair. Secondary roads are dirt and in poor repair. Electrification is currently

being planned in the form of metred boxes and the "card " holding system. The latter requires the householder to pay for the electricity consumption used. A "credit card" is issued which allows the user to utilise electricity up to the paid amount. Water is provided by standpipes throughout the area. Major civic buildings do have piped water, water reticulation for 690 sites, funded by the Independent Development Trust, was completed in 1992, and a further 400 during 1993/1994.

Housing is primarily of wattle and mud with some usage of cement blocks and corrugated iron roofing. Traditional round homes exist but western square styles are more common. There is no refuse disposal. Services are provided for health and welfare in the area. There is an active community centre, and a health clinic. Unfortunately these are not situated together but are approximately a kilometre apart. There is a community library, several schools and small shops (Site Community Health Nurse; Mayor's Minute, 1992-93; Personal Observation). There is a high level of unemployment, accompanied by alcoholism and crime in this area. Violence occurs from time to time and there is a strong police presence in the area. Many homes may only be reached by foot and clinic staff are wary of entering certain parts of this community. The clinic staff have developed a demonstration garden and run educational programmes and women's clubs from the clinic (Clinic Community Health Nurse). Subsistence gardens are encouraged to supplement family incomes.

ii) Research Sampling of Site Four

Nonprobability convenience sampling was again used in this site. The age group of the women's club was over 35 years and thus fell out of the research criteria. Clinic attendance was fragmented and infrequent. The community health nurse facilitator was, however, very keen to initiate the programme and attempted to start a second women's club which would fulfil the research criteria which would form the social support control group one. The clinic control group two was randomly chosen from clinic attenders. The experimental group was initiated with clinic attenders who were motivated during normal clinic attendance and who agreed to join such a group.

iii) Sample realisation of Site Four

This community was similar to site number two, being zulu speaking, with low educational levels and limited literacy. The experimental group completed the pretest questionnaires with the facilitator translating in a preprogramme morning session. The clinic control group completed the questionnaire as they were randomly selected during actual clinic visits (every third client attending clinic who fulfilled the research criteria). The social club control group one, for reasons to be clarified later, was never brought together in a pretest session nor were the posttest questionnaires completed by any of the participants. The participants totalled eight, five in the experimental group and three in the only control group (clinic control) which completed the pretest questionnaires ($n=5 \times 3$).

3.5 SELECTION OF RESEARCH INSTRUMENTS

3.5.1 INSTRUMENTS MEASURING MATERNAL-CHILD INTERACTION

The instrument chosen here must be appropriate for testing Hypothesis one

Two potential instruments were identified a) the MSPP and b) the MCRE.

a) Michigan Screening Profile of Parenting (MSPP)

This is a 30-item self-report inventory designed to measure attitudes regarding child rearing and parental self-awareness and self-control. Clients respond to each item on a 7-point scale ranging from strongly agree to strongly disagree. There are four subscales. These subscales include a) Emotional Needs Met b) Relationship with Parent c) Expectations of Children d) Dealing with others and e) Coping (Baher, 1976; Howing, Wodarski, Gaudin & Kurtz, 1989; Schneider, 1982). This is a widely used instrument but the researcher wanted to look more specifically at details of parent-child interaction.

The Michigan Screening Profile of Parenting does not claim to be an instrument for identification of potential abusers, but rather an instrument for identifying parent-child interaction problems (Schneider, 1982). The researcher felt after perusal of the questions falling into each subscale or cluster, that it was weighted to the factors identified and discussed in the literature review concerning child abuse, it did not specifically fulfil the criteria for prediction of child abuse (was also longer than the Family Stress Checklist (FSC) ultimately used by the

researcher to identify parental abuse potential) and also did not give sufficient details of specific parent-child interaction, a necessary prerequisite to identify any changes in maternal attitude after the experimental intervention.

b) The Mother-Child Relationship Evaluation (MCRE)

This instrument was the researcher's choice (Annexure J). The instrument attempts to provide an objective estimate of a mother's relationship to her child based on a four-attitude profile. Krech and Crutchfield (1948) define attitude as "an enduring organisation of motivational, emotional, perceptual, and cognitive processes with respect to some aspects of the individual's world" (p.152). Roth feels that in the mother's world, this implies a universe which is the mother's child, and attitude is "...an intervening variable which mediates between the manner in which a mother relates to her child and the present and previous experiences leading to the psychodynamics of the mother" (Roth, 1980, p.1)

The experimental data for the MCRE was based on a sample of 80 mothers forming a relatively homogeneous group of middle-class mothers from the same community between 25 and 35 years of age.

The scales of the MCRE were defined to reflect Symond's definitions of four maternal attitudes: acceptance (A), overprotection (OP), overindulgence (OI), and rejection (R). These maternal attitudes have been found to influence child behaviour from infancy through to adolescence (Schaefer & Bayley, 1963). Each

scale consists of 12 items for a total of 48 items on the instrument. The scales are rated on a five-point Likert scale from strongly agree to strongly disagree. Items 1 to 30 are values of 5-4-3-2-1 and items 40 to 48 are values 1-2-3-4-5. Raw scores for each scale range from 12 to 60.

The scales are defined using three variable from Symond's system and each scale is discussed in terms of these three variables. These three variables are;

- 1) parental attitudes
- 2) dynamic factors of the parent's personality
- 3) child's responses to the attitude.

The parental attitude variable looks at behaviours and attitudes which are indicative of each of the four scales. The dynamic factor of the parent's personality variable looks at both immediate and unconscious factors eg. stability of the marriage, pleasure in the child, emotionally secure or insecure parental childhoods etc. Finally the child's response variable looks at the child's behaviour which is indicative of each of the four scales eg. adjustment difficulties, positive responses to socialisation, withdrawal etc. (Roth, 1980). These will be referred to in more detail where necessary during the analysis of the results.

This instrument is particularly relevant when looking at a parenting support programme because it is based on the research and parent-child relationship theory of Symonds (Roth, 1980). The relevance of this is that Symond's writing

refers to the child's response to denial of love and expression of hate by the parents. Symonds suggests that the child "attempts to win affection" (p.24) by 1) Attention-getting behaviour, 2) "inflicting the most acute pain"... "at the point of greatest parental self esteem" 3) Remaining helpless and 4) Retaliation and Revenge (p.25-28). This is very close indeed to the concepts of Dreikurs on the goals of children's misbehaviour, namely the goals of 1) Attention 2) Power 3) Inadequacy and 4) Revenge (Dinkmeyer & McKay, 1970), which are extensively used to help parents understand their children's behaviour in the Dinkmeyer and McKay parenting programme (STEP). The latter is currently one of the most frequently used parenting programmes in South Africa.

Reliability was established by a split-half Pearson product moment correlation and reliability coefficients were .57 for Acceptance, .53 for Overprotection, .41 for Overindulgence and .47 for Rejection. This moderately low estimate of reliability should be taken in context of the split-half methodology which thus compared only six test item scores (Roth, 1980).

Validity was tested by looking at the intercorrelation between scales. A high negative correlation between the acceptance and nonacceptance scale was anticipated and was shown to be -.55. The Overprotection (OP), with a correlation coefficient of -.68, was the most closely related to nonacceptance attitude. Overindulgence (OD) followed with a correlation coefficient of -.47, and then Rejection (R) with a correlation coefficient of -.45 (Roth, 1980). The relatively moderate correlation of this instrument needs to be considered when

discussing the research results of this study.

3.5.2 INSTRUMENTS MEASURING FAMILY FUNCTIONING

Three potential instruments were identified a) the Family APGAR b) the Home observation and c) the McMaster Family Assessment. This must be appropriate for testing Hypothesis two.

a) Family APGAR Questionnaire

This instrument is a rapid assessment of five components of family functioning, That of Adaptation, Partnership, Growth, Affection and Resolve. It is a self-report questionnaire scored on a scale of almost always, sometimes and hardly ever (Smilkstein, 1978). The researcher felt that as this involved only five questions and responses, it had limitations for effectively measuring family functioning in the present study. This instrument could however be useful, particularly for standard use in a busy community health centre.

b) Home observation for measurement of the environment inventory

This is a 100-item observation interview procedure designed to assess primarily the quality of stimulation of the child's early environment. It has two variations, one for the child from birth to three and one from three to six. Many of the subscales look specifically at maternal-child relationship eg. emotional and verbal responsiveness, avoidance of restriction and punishment, maternal involvement with

the child, independence from parental control and pride, affection and thoughtfulness (Caldwell, 1980). While this would have been useful in this research because it looked at the maternal-child relationship and at the quality of stimulation of the environment, particularly as the intervention programme was hoping to stimulate maternal-child contact and play, it was felt by the researcher to be too time consuming as it involves both objective observation and a self-report inventory and would require the use of both age variations in order to cover children under five years.

c) The McMaster Family Assessment Device (FAD)

This instrument was the researchers choice. It is based on the McMaster Model of Family Functioning, a clinical model describing structural organisational properties of the family group and the patterns of transactions among family members that have been found to distinguish between healthy and unhealthy families (Annexure K). This makes this instrument clinically relevant. The model identifies six dimensions/scales of family functioning. These include:

- 1) Problem Solving - refers to the family's ability to resolve problems. Seven steps of effective problem solving are identified.
- 2) Communication - refers to the exchange of information among family members. With particular emphasis on clear verbal messages.
- 3) Roles - focuses on whether the family has established patterns of role behaviour.

- 4) Affective Responsiveness - assesses the extent to which individual family members are able to experience affect over a range of stimuli.
- 5) Affective Involvement - focuses on the extent to which the family members are interested and involved with each other's activities.
- 6) Behaviour Control- Refers to the way the family expresses and maintains standards for the behaviour of its members.
- 7) General Functioning - assesses the overall health/pathology of the family.

The questionnaire consists of 53 items of common statements one would make about one's family. Subscales Problem Solving and Affective Responsiveness, both entail five items, subscale Communication entails six items, subscale Affective Involvement entails seven items, subscale Roles entails eight items, subscale Behaviour Control entails nine items and General Functioning entails twelve items.

Items are scored on a four point scale from strongly agree to strongly disagree. The first two scales are scored 1-2-3-4 and the rest are scored 4-3-2-1 (Epstein, Baldwin & Bishop, 1983).

Reliability and Validity was established by examining the development and testing of the instrument. The items were developed from an original item set of 240 items, being 40 from each of the six dimensions. These were then reduced until the smallest subset of items which taken together produced a scale with the

highest reliability was achieved (Cronbach's alpha). The item selection stopped when the scale reliability was over the minimum of $\alpha = .70$. The most highly intercorrelated items were placed in a subset category of General Functioning (Epstein, et al, 1983).

The seven scale instrument was tested on 503 subjects from clinically unhealthy and clinically healthy populations in order to establish reliability. As discussed above Chronbach's alpha was over the minimum of .70, and ranged from .72 to .92. This establishes that this instrument has good internal consistency (Roberts & Burke, 1989).

The content validity was established by drawing the items and scales from a sound theoretical base eg. based on McMasters Model of Family Functioning. This model is also based on sound clinical practice.

The criterion or predictive validity was established by discriminant analysis, which was found to be highly statistically significant ($p < .001$) for both the non-clinical group (67%) and the clinical group (64%) (Epstein et al, 1983; Karbacoff, Miller, Bishop, Epstein & Keitner, 1990).

The FAD has been studied together with two other instruments which tap family functioning and this would suggest construct validity. These are the Philadelphia Geriatric Satisfaction Scale (PGSS) and the Locke Wallace Marital Satisfaction Scale (LWMSS). The regression analysis demonstrated that the FAD had

predictive or concurrent validity and that it was a more powerfully predictive instrument than the LWMSS scale for predicting family functioning (Epstein et al, 1983). The FAD also compares favourably with the Family Unit Inventory and Faces II (Miller, Epstein, Bishop & Keitner, 1985).

There is evidence that the FAD has some cross-cultural validity, having being used successfully in North America, Hungary and the United Kingdom (Cited in Akister & Stevenson-Hinde, 1991). It has also been used successfully in intact families with young children to identify those families in need of early intervention (Akister & Stevenson-Hinde 1991). The latter researchers recommend that it be used by Health Visitors as a screening tool to identify families who could benefit from support.

This instrument was considered by this researcher to be particularly relevant to this study. The subscales related well to the basic principles of the intervention programme and covered the skills and learning experiences weighted therein, namely, Problem Solving, Affect or Feeling, Communication, Roles and Behaviour Control (enlarged on in Chapter 4). The researcher felt that the high degree of correlation of the subscales (Cronbach's Alpha was over .70) would strengthen the study findings of this research should there be a correlation between the results of the FAD and the MCRE, particularly in the light of the moderate correlation between subscales found in the latter and discussed above. Should a strong correlation be established between the FAD and the MCRE, this would help establish the concurrent or predictive validity of the MCRE.

3.5.3 INSTRUMENTS FOR PREDICTING CHILD ABUSE POTENTIAL

This must be appropriate for examining Research Question 1.

Three potential instruments were identified a) Potential Screening 20-item Scale b) the Child Abuse Potential and c) the Family Stress Checklist.

a) Potential Screening Scale of Twenty Items

This was developed by Avison, Turner & Noh, and looks to be a promising predictive instrument for the prediction of child abuse potential. Sensitivity is .79 and specificity is .77 (Avison, Turner & Noh, 1986). This instrument has the advantage of not carrying a child abuse "label" and accompanying "value-judgement" and would be useful for screening in a community health setting where this was a factor to be considered (eg. could be used by all categories of staff with guidelines and referral protocols and not confined to highly trained specialists only). The specificity and sensitivity are lower than the Family Stress Checklist and it is more time consuming to administer. As the researcher already had four self administered questionnaires to be answered by respondents, this was a critical factor in the decision not to utilise this instrument.

b) Child Abuse Potential Survey (CAP)

This is a 160-item self-report inventory to be completed by the parent. Factors measured include distress, rigidity, problems from child and family, unhappiness, loneliness and negative concept of self and others. Respondents are asked to agree

or disagree with each item. This instrument is specifically designed to detect physical abuse (Milner, 1989; Phyllis, Howing, Wodarski, Gaudin & Kurtz, 1989). Crowe and Zeskind (1992) found that nonparent adults who had a high score response on CAP, had similar physiological responses to infant crying as parents with histories of physically abusive interaction with their children. This would seem to support the theories of physiological arousal and the aggressive arousal sequence (discussion in section 4.3.4.1). This, together with the length of the instrument was felt to be a limitation by the researcher, despite the fact that this instrument has been widely tested to establish reliability and validity. The limitation of specificity for physical abuse was of particular significance for this research in the light of the research already discussed which particularly emphasises the interrelationship of different types of abuse and the particular significance of emotional abuse within this complex syndrome. Much of the research intervention focuses specifically on skills of communication and relationship interaction and thus aims at prevention of more than physical abuse.

c) The Family Stress Checklist (FSC)

This instrument was chosen for use in this study. It sensitively predicts child abuse as clarified below, it is simple and straightforward to administer and it offered the researcher the opportunity to interview each participant on a one to one basis. This was thought to be valuable to lend triangulation of method to the research which up to this stage relied heavily on self report questionnaires only. It was originally known as the Carroll-Schmidt Checklist. The latter was a family

checklist which had been used to evaluate parents known to have abused or neglected their children. The potential for predicting families "at-risk" for abuse has been tested and the scale found to be a sensitive and accurate predictor of child abuse and non-organic failure to thrive (Murphy, Orkow & Nicola, 1985). A total of 587 women was interviewed antenatally, during the first and second trimesters of pregnancy. These families were followed up two to two and a half years later. This instrument is highly recommended as a predictive tool for use in social work practice (Carroll, 1978).

The FSC has ten subscales or factors (refer Annexure I). Each of these subscales is determined by asking questions from a suggested question list for each subscale. One or more questions may be necessary in order to accurately score the subscales. This method of questioning has also been found to be successful by Femina, Yeager and Lewis (1990).

The checklist may be completed individually or by both parents. Maternal and paternal scores were found to correlate significantly (90%). The test is scored:

No Risk score 0

Risk score 5

High Risk score 10

In earlier use of this instrument, the subscales were scored with different weighting and the maximum raw score was 40 (Carroll, 1978). For the purposes of this research the more recent scoring method will be utilised (Orkow, 1985). This data is considered to be at nominal level and the standard error of the mean

was used to establish the variance between the high abuse potential and the low abuse potential groups. Individual scores can range from 0 to 100. Respondents scoring 0-10 are considered as having a low potential for abuse. Scores of 11-24 a medium-low risk. Scores from 25-30 were considered medium-high. Scores of 31 -39 as high and scores of 40 and over as very high risk.

The sensitivity for abuse-neglect was 80%. The specificity or predictability of which parents who will **not** be likely to neglect-abuse was 89.4%. The predictive value for a positive is 52.5% and for a negative 96.8% (Murphy et al, 1985).

3.5.4 INSTRUMENT MEASURING SELF ESTEEM

This must be appropriate for examining Research Question 2.

Several instruments were identified however the Rosenberg Self Esteem was indisputably the most appropriate in the context of this research.

Rosenberg Self Esteem (RSE)

The researcher was looking for a short questionnaire with good reliability. There was considerable concern over the length of the first two questionnaires already accepted for use and an awareness that the subjects would experience test fatigue should the subsequent questionnaires utilised be too long or complex. The Rosenberg Self Esteem questionnaire was chosen for use in this study (Annexure L).

This is a simple self administered questionnaire for assessing self esteem. It is a 10-item Guttman scale. Respondents are asked to strongly agree to strongly disagree. Statements are scored on a four-point scale. Items 1, 3, 4, 7, and 10 are scored 4-3-2-1, and items 2, 5, 6, 8, and 9 are scored 1-2-3-4. The scale is based on "contrived items" which yield a 6-point scale. Contrived items are obtained from a combination of responses and each scale item individually rated as positive or negative for self esteem, according to set criteria for each scale item (Rosenberg, 1979; Crandall, 1973).

Scale Item One is contrived from 3, 7, and 9.

Scale Item Two is contrived from 4 and 5.

Scale Item Three, Four and Five are scored positive or negative based on responses to 1, 8, and 10.

Scale Item Six is contrived from 2 and 6.

The RSE is frequently scored according to a Likert format and appears to yield similar results (Rosenberg, 1979). In a review of twenty five self-esteem instruments, Crandall (1973) rated the Rosenberg Self Esteem Scale as the fourth best measure of self esteem and accepts the widely tested construct validity of the instrument.

The self-esteem instruments rated first to third were all longer instruments (eg. Tennessee Self-Concept Scale is a 100 -item instrument) and thus not suitable for use in this research.

Reliability has been established by several studies. Test-retest reliability has

been demonstrated ($r=.85$ to $r=.88$, studies cited in Rosenberg, 1979).

Construct reliability has been established by ascertaining that the instrument is related to other tests measuring similar theoretical constructs. It has been found to bear a clear relationship with tests measuring depression (the 6-item Guttman scale of depressive affect) and a strong relationship with tests measuring anxiety (Rosenberg, 1979).

There is evidence for concurrent or predictive **validity** as the RSE correlates with other self-esteem instruments such as the Coopersmith Self-Esteem Inventory (Rosenberg, 1979).

3.5.5 INSTRUMENT FOR MEASURING LIFE STRESS

This must be appropriate for exploring Research Question 3. A number of studies cited in Holmes and Rahe (1967, p.213 & 215), provide powerful evidence that stressful life events contribute to the natural history of many diseases by evoking psychophysiological reactions. While the epidemiology of child abuse is of a complex multifactorial sociopsychophysiological nature the role of precipitating stress is well documented. Given the current violent transitional political era of South African history, and the physiological aggression arousal cycle the researcher felt it was imperative that some measure of the research participants life stresses was documented. Particularly in the event of possible conflicting

research results, the researcher wanted to ensure that major social stresses and life events were documented and available for discussion while at the same time not unduly weighting both this aspect of the study and the length of participant self report questionnaires. A short simple instrument was anticipated, and the researcher found this in the Social Readjustment Rating Scale.

The Social Readjustment Rating Questionnaire (SRRQ)

This is a 43 ranked item list of life events giving a mean value for each ranking. The 43 life events were derived from sixteen years clinical experience with over 5000 patients whose life event clusters at the time of disease onset were studied. Two major categories of items were identified, those of the lifestyle of the individual, and those indicative of the occurrences (social and interpersonal) involving the individual. One theme common to all these life events was the need for the involved individual to adapt or utilise coping behaviour (Holmes & Rahe, 1967). This is of particular applicability to this research, as the abusive caretaker has been found in some studies to be immature and lacking in these coping skills (Brunnquell et al, 1981; Gelles, 1988; Straus et al, 1980). Life skills which assist the caretaker to cope, adapt or manage the maternal-child dyad could thus be considered as primary prevention interventions to reduce the level of stress with which the individual will react to these life events and thus reduce their "abuse-risk" potential.

After identifying these major life events Holmes and Rahe (1967) took a

convenience sample of 394 subjects and asked them to subjectively rate these life events. The data analysis of this showed a high consensus concerning the subjects relative ordering of life events. Pearson's r was found to be above 0.90 for all groups between age, sex, marital status, religion and social class, and to be 0.82 between black/white ethnic groups (Masuda & Holmes, 1967a) and 0.94 and 0.92 between Orientals and whites and between first and third generation Americans respectively (Masuda & Holmes, 1967b). Results of $r = 0.70$ or more are considered necessary to demonstrate internal consistency of a tool (Roberts & Burke, 1989). The measure of association utilised (the Pearson r) demonstrated a correlation of greater than 0.70 and this instrument could thus be said to have content validity and to reliably measure life event stresses. The SRRQ has also been subjected to cross-cultural examination (internal consistency mentioned above). Masuda and Holmes (1967b) compared Japanese and American subjects responses and found a significant concordance between attitudes towards most life events with some interesting differences reflecting cultural variation. Death of a spouse was rated by both as requiring the most adjustment of all events. This was of significance for this research which attempts to recognise the complexity of South African society and included groups of different ethnicity. Of relevance to the research were the changes made to the questionnaire before administration to the Japanese subjects. This involved only translation and adaptation of the bond loan figure (Masuda & Holmes, 1967b). A similar adaptation was made to the questionnaire by the researcher. The bond figure was changed to be appropriate to the South African context (refer Annexure M). Translation into zulu was carried out in a person to person interview which allowed for clarification of

terminology. Finally in the experimental group with the lowest literacy level and income the translation of a bond figure was considered inappropriate and the questions was merely asked as to whether any loan at all was held.

Further examination of the reliability of the SRRQ was demonstrated in that Kendall's coefficient of concordance was found to be 0.992 for the rank ordering of all three measures of central tendency. Furthermore the correlation coefficients of item scoring between the different subgroups on Pearson's r and Spearman's rank order r was found to be almost identical (Masuda & Holmes, 1967a). This lead Masuda and Holmes to suggest that in subjective magnitude estimates of psychosocial events one is dealing with a ratio scale (1967a). This is supported by other researchers in the field of subjective psychophysical evaluation (cited in Masuda & Holmes, 1967a, p.224). The rating results were then applied to psychophysical phenomena to generate a ratio scale (Holmes & Rahe, 1967; Masuda & Holmes, 1967a). A full copy of the Social Readjustment Rating Questionnaire is documented in annexure M.

Of further interest to this research is the fact that the SRRQ has been utilised by Starr (1982), in a well controlled and comprehensive study of child abuse, to evaluate the role of stressfull events as contributors to abuse. In this study the SRRQ was modified to omitt the ratio weightings suggested by Holmes and Rahe (1967). The reason given for this was that Starr (1982) felt that ratings are subjective events and that unitary values would be more meaningful as indicators for subjective stress preceding the abuse. The researcher found this surprising in

the light of the argument made by Holmes and Rahe (1967) for weighting the scores as a ratio, the established between-group socio-economic variables correlation (Holmes & Rahe, 1967) and the cross cultural correlation (Masunda & Holmes, 1967b). This might well account for the fact that the only life stress events found to be significant in this study by Starr (1982) were childbearing problems in the last month and a recent stressful death. In the light of this the researcher will retain the ratio scoring suggested by Holmes and Rahe (1967).

3.5.6 INSTRUMENTS FOR SUBJECTIVE EVALUATION

The researcher wanted a subjective evaluation from the intervention programme participants and the community health nurse group facilitators and this is aimed at substantiating and enhancing the quantitative results of the hypothesis and research questions. This took the form of an open ended questionnaire covering both the participants attitudes and some observed behaviours. This data was gathered in order to substantiate and give meaning to the quantitative data. The significance of the need for participants to be able to express their individual opinions regarding their experience of the programme was felt to be important for two reasons.

First, it was felt to be an important means of debriefing both the facilitators and the participants. The researcher was available for detailed discussion of problem areas and participants were able to anonymously criticize the experience if they so wished. The facilitator was encouraged to be openly critical of the programme

limitations as she perceived them in order to assist the researcher to address any problems experienced.

Secondly, the researcher was of the opinion that the gathering of additional qualitative data would strengthen the validity of the results by triangulation and introduce the "humaneness" or caring component back into a study which was beginning to feel coldly clinical and experimental.

Three open ended questionnaires were completed for this evaluation. One by the participants and two by the facilitator. The facilitators were requested to return all drawings made by the participants to the researcher.

a) Final Evaluation Questionnaire by Parents

This was an open ended self report questionnaire consisting of only seven items. The participants were asked to rate their feelings about the course, give details of; what they liked and disliked about the course, any changes noticed in their children or themselves and any changes in the the way they thought or interacted with their child. Finally they were invited to make any further comments concerning the experience. A copy of this questionnaire is annexured (refer Annexure N).

b) Detailed Feedback on Course Questionnaire

This was a more detailed report which asked for specific data from the facilitator regarding each session. The facilitator was asked to elaborate about any problems she encountered both during each session and with the support material of the session and to give details of the problems discussed and observed among the group participants' during each session. Details on the participants use of the learned skills, areas of concern and voluntary input were requested and the participator was reminded to return all participants' drawings to the researcher (refer Annexure O).

c) Final Evaluation Questionnaire by Participating CHN

This was an open ended self report questionnaire consisting of five items and closely related to the questionnaire filled in by the participants. Facilitators were asked to rate their feelings about the course and what they liked and disliked most about the programme. They were asked about changes observed in the group and given the opportunity to give further comment. This questionnaire was limited in that it could not be anonymous. A copy of the questionnaire is annexured (refer Annexure P).

d) Drawings produced by Participants

The researcher had observed during the initial testing of the sessions that the

drawings participants produced varied greatly. During the course training community health nurse facilitators the drawings completed by the trainees who later made disclosures of abuse were noted as being different from the rest of the group. While this is not the researcher's area of expertise nor is this a qualitative study, it was felt that it would be useful to retain this material and at least document any major themes.

e) A Long-Term Final Evaluation Questionnaire by Mothers

This questionnaire was similar to the short-term evaluation questionnaire found in e) above. It consisted of twelve questions which attempted to identify i) the existence or not of continued social support ii) to what extent the skills learnt in the course were still in use iii) behaviour changes in the mother, in the child and in the maternal-child interaction and finally iv) a subjective valuation of the course. A copy of the questionnaire is annexured (refer Annexure Q).

3.6 DATA COLLECTION

General guidelines for data collection were drawn up by the researcher (Refer Annexure F).

3.6.1 DATA COLLECTION PROCEDURE

The purpose of the study, the amount of time commitment being requested, the

confidentiality of all data and the reassurance that subjects will be allowed to withdraw without any adverse loss of service or health support was explained to each subject in all three groups of every site. Informed consent giving permission for the research was signed by every subject, experimental and control. The instructions for each instrument were explained. The pilot study was initiated utilising these same guidelines.

The pretest instruments were administered starting with the demographic data of the participant and her children found on the first page of the Maternal-Child Relationship Evaluation and followed by the McMaster Family Assessment Device and the Rosenberg Self Esteem Scale. These were administered by either or both the researcher and/or facilitator of each site.

The experimental and control programmes commenced and ran weekly over ten weeks, in as consecutive a manner as possible.

The researcher met with each participant in privacy during the course of the sessions to administer the Family Stress Checklist and again assure the subject of confidentiality.

On completion of the tenth session the posttests were administered starting with the Maternal-Child Relationship Evaluation, the McMaster Family Assessment Device, the Rosenberg Self Esteem Scale, the Social Readjustment Rating Scale and the clients Subjective Evaluation. These were to be administered by either the

researcher or the facilitator of each site.

The facilitator of each site completed a report on each session and an evaluation of the experience at this time.

Qualitative data of the subjective maternal and facilitators' feelings, perceptions and attitude of the experimental intervention were also collected (Annexures N and P). An objective qualitative process evaluation of the maternal and child interaction and the group interaction and specific negative and/or positive outcomes and problems with the programme material was completed by the facilitators (Annexure O).

A long-term evaluation was collected in mid 1995, approximately two and a half years after the programme implementation. This was only conducted in the two sites which completed the intervention programme. This involved the Maternal-Child relationship Evaluation, the Rosenberg Self Esteem Scale and a subjective evaluation of maternal attitudes to the experimental intervention (refer Annexure Q). An attempt was made to access all clinic cards of the experimental participants in order to screen them for any recorded maternal-child problem over this time period. The child abuse reporting agencies for site one and two were contacted in order to establish whether any of the participants had been reported for child abuse in this time period.

Four data collection techniques were used in this study. Self administered

questionnaires, interviews, objective observation and maternal drawings.

3.7 PILOT STUDY

i) Choice of site for the Pilot Study

This particular site was chosen for the pilot study for several reasons. Most of the mothers in this group had some tertiary educational experience, which was primarily secretarial. They thus fell outside of the "standard ten" educational limit of the study. All other requirements of the study were met. This was not seen as a disadvantage for a pilot study however, but rather as an advantage. The programme material had been pretested in low literacy, multi-ethnic context already and the major purpose of the pilot study was to identify possible problems with the research questionnaires, the programme presentation, and problems or difficulties experienced by the facilitator. It was felt that a more literate group would actually assist in identifying some of these problems. The community health nurse was highly motivated, intended immediately initiating the programme in her area of practice and was particularly keen to be part of the research. She had discussed it with clinic mothers and already had an existing support group, as an antenatal group, which met weekly.

Finally there was the problem that there was a limited number of only five potential sites. In order to ensure, particularly in the light of the political unrest

and the transitional stage in South African history that at least one site had a chance of completing the programme, the researcher felt strongly that it was advisable to try and implement the study in all of the remaining four sites which fulfilled the study requirements.

A further advantage of utilising this site as a pilot study, was the opportunity this offered for the researcher to practice the interview technique of the Family Stress checklist and to become proficient in this before interviewing in the four study sites. It was also possible to time the length of the questionnaires in the actual clinical setting.

ii) Brief overview of Pilot Study Site

This is an urban area. It was developed as a low cost housing scheme for the caucasian population group. It is bordered by a black urban residential development, by poor asian housing, and by industrial and commercial business. The inhabitants are primarily young, english speaking married couples with children. Most families are headed by a male who is employed in the neighboring industry and commerce. Water is piped to every household, electricity, telecommunication and postal services are good, garbage collection is once a week and sewerage is managed by septic tank. Roads and transport are good, and direct access to neighbouring cities and towns is possible via an excellent freeway system. The area is well served by preschools, schools, shops and services. The local authority provides a full time comprehensive clinic service (Site Professional

Nurse, 1992).

iii) Sampling of Pilot Study

Nonprobability sampling was used. The pilot study site fulfilled the control criteria of the research and completed all the research questionnaires, but for the purpose of this study only the relevant information from the experimental group will be discussed. This additional data will be collated when this research is complete and a comparison between the more literate group will be carried out at that time.

The semistructured interview with the Family Check List took twelve to fifteen minutes to complete and required no modification.

The remaining data collection took approximately forty five minutes per subject. Some of the American vernacular was queried and minor adjustments made to clarify these questions.

The facilitator's evaluation feedback of the programme was extended to be more comprehensive in nature and took on the format described above under Instruments for Subjective Evaluation.

This complete pilot study was found to be particularly useful in identifying support data which needed to accompany the facilitator's manual. As a result of

this pilot study support information in the following areas were added to the manual:

- * Basic information on behaviour principles
- * Instructions to the group facilitator
- * Basic Requirements per session of the developed programme
- * Cross referencing of each session with the comic book pages
- * Cross referencing of comic book and facilitator's demonstration flip chart pages

The following appendices were added:

- * Appendix 2 - Why is playing with your child important?
- * Appendix 3 - Common management and behaviour problems
- * Additional to Appendix 4 - Useful recipes for creative play.
- * Appendix 5 - Zulu, Xhosa, Tswana, English and Sotho songs
- * Appendix 6 - Useful reference books for further reading

3.8 DATA ANALYSIS

In order to measure any differences or changes in the pre and post test results, all tests will be analysed with a t-test initially and then with an analysis of

variance (ANOVA) for all three group. The strength of association between the Roth Maternal-Child Relationship Evaluation and the McMaster Family Assessment Device will be calculated with the Spearman's correlational statistic.

3.9 ETHICAL ASPECTS

According to Roberts & Burke (1989), there are three basic human rights which should be observed by the researcher. These are:

- * The right to freedom from risk or injury
- * The right to privacy and dignity
- * The right to anonymity" (p.190).

Every effort was made to ensure that both subjects and participating nurse facilitators and sites remained confidential.

Special care was taken during the facilitators' training course to ensure that the group of community health nurses supported each other. The researcher was available at the end of each session and day for private discussion and support. This was necessary as it was anticipated that subconscious emotions and feelings might surface and that disclosures might well occur.

During the study itself, in order to ensure the "right to freedom from risk or injury", the subjects were given the "free choice" to voluntarily withdraw at any time with the assurance of no detrimental labelling or loss of clinic service. The time commitment was clearly explained. The researcher was initially available to

all groups to answer questions and clarify the research. The researcher was also available during the ten week course as a support for the facilitator and groups. Finally the researcher was available at the final evaluation in order to provide a debriefing in which all participants were able to express their feelings about the programme experience freely in writing and verbally on a personal level if this was desired. All subjects were thanked for their participation in the study.

The "right to anonymity" was preserved in two ways. In site one the nurse facilitator numbered clients from the three groups. The names of the subjects were never divulged to the researcher. In all other sites the researcher numbered the clients' raw data and this number was the only record which was fed into the computer. All original names were kept confidential together with the signed consents.

The right to privacy and dignity was observed for the interview, where the Family Stress Checklist was completed. All interviews were held in a separate room. Where language was a problem the subjects were asked to choose the translator they preferred. Where language was not a problem only the researcher was present.

Permission was requested from the Provincial Authorities and the Local Authorities where facilitators had been sampled. This involved a two phase process. In order for permission to be granted from the Provincial Authority the research proposal had first to be approved by the Medical School Ethics and

Professional Standards Sub-Committee. Only when this had been approved could permission be requested from the employing bodies. Letters were then sent to nursing service managers notifying them of the course available to their staff, the purpose of the research and the dates and venue (Refer Annexure A and B).

The facilitators training course was completed and the researcher identified those facilitators who were competent, motivated and available during the study time span. Letters were written to Chief Nursing Service Managers in all five sites, enclosing copies of the research proposal, questionnaires and procedures to be followed to ensure informed consent. All subjects were promised anonymity both verbally and in writing. General guidelines for data collection were drawn up (Annexure F). Written information was given, interpreted and explained before being signed by all participants to ensure informed consent (Annexure G1 for Control group consents). The information given to the experimental subjects was more detailed (refer Annexure G2). Brief written information was supplied to the group facilitator to supplement the verbal briefing and physical presence and support of the researcher (refer Annexure H).

3.10 LIMITATIONS OF THE STUDY

Many community health nurses lack the skills of group work. It is only recently with the introduction of the four year comprehensive nursing training that the student nurse is now taught these skills within the psychiatric nursing curriculum. Many community health nurses, particularly those working in inaccessible rural

areas, have not had the privilege of being able to participate in in-service training and keeping abreast of changing needs. A possible limitation to the study could be that these nurses might in fact, be unable to cope with this new material.

Further limitations to the study are the radical changes which the South African health system is presently experiencing and the current economic recession. These major political changes have led to massive cutbacks in health expenditure and an attempt to allocate much of these reduced funds to primary health care. However as a result of staffing cutbacks much of this health care emphasises primary medical care rather than primary health care. This has meant that the existing services are now carrying their earlier work load of health care delivery, plus a new primary medical care work load - with a reduction of staff. As this type of intervention is initially time consuming this might become problematic.

The cost-effective benefits of preventive work are not readily evaluated. Primary prevention is delivered to individuals and groups not seen to have a problem, and consequently funding for programmes more immediately measurable tend to take preference.

This study not only attempts to increase maternal knowledge, but also attempts to change maternal beliefs, attitudes and behaviour. In the present state of political unrest and violence, this might well prove not to be possible.

The limitations of sampling have already been discussed. Other limitations

recognised at this stage are:

a) Researcher

The limitations that the researcher experiences are that she is english speaking and caucasian. This limits her interaction among the zulu speaking subjects particularly. Despite attempts to be crossculturally sensitive, this may well have been problematic, not in the programme evaluation stage, but in the programme development stage. Interviewer bias may well have been introduced at this stage. The subjects may have wanted to please the researcher, who might have been seen by them as a member of the then dominant white culture.

b) Facilitator

In the pilot study and in three of the sites, the facilitator was of the same language group and ethnicity as the subjects. In two of the study sites the facilitator actually lived in the area of her practice and was a recognised and respected member of the community. This was seen as an advantage in that it allowed the facilitator to commence with a knowledge base and understanding of the subjects that would allow her to flexibly adjust the programme to meet their specific needs and to be culture-sensitive. In the one study site four, this was not the case. The facilitator was caucasian and all three groups were asian. This was seen as a possible limitation as ethnic, cultural and religious differences were present. As the facilitator and participants were eager to participate, the

researcher included this site in the study. The researcher was of the opinion that this site might well provide interesting data concerning the cross-cultural group work and could therefore be considered worthy of study.

c) Experimental subjects

In all groups except site four, the experimental subjects were homogenous for ethnicity, culture, religion, language, socioeconomic standard and educational level. In site four, this was not the case. The subjects who volunteered to participate in the programme were heterogenous and thus of different religious beliefs, educational levels, castes and socioeconomic. This was also the group which was lead by a crosscultural facilitator. While this was seen to be a possible serious limitation, the facilitator and subjects requested to continue as part of the research and were accepted.

CHAPTER FOUR

PROGRAMME DEVELOPMENT

THE DEVELOPMENT OF A FAMILY SUPPORT PROGRAMME FOR COMMUNITY HEALTH NURSES IN THE PRIMARY PREVENTION OF CHILD ABUSE AND NEGLECT AND EXPANSION OF THE INITIAL CONCEPTUAL MODEL

4.1 INTRODUCTION

The researcher initially made every effort to find a developed programme which could be utilized by community health nurses, specifically in the primary health care setting as an intervention appropriate for the **primary prevention** of child abuse and neglect, particularly for the child five years and under.

International letters were written to Professor Rostain and to Dr O'Sullivan at the Child Guidance Clinic in Philadelphia enquiring about current primary prevention interventions for child abuse in the community. No success was achieved.

University departments of Social Work, Psychology and Nursing were approached

throughout South Africa as were many clinical settings. While there was a general feeling from the clinical setting that Medunsa the Medical University of South Africa and the University of the Witwatersrand had worked in the field of maternal-child relationships and parenting programmes, the researcher was unable by an interlibrary search, by direct telephone communication or by correspondence to elicit any information in this regard. The researcher identified that there are video presentations available, and several centres are working on variations of the STEP programme.

The Parent Centre in Cape Town has since produced a leader's manual for Positive Parenting (September, 1993). This is an excellent facilitator's manual, based entirely on the STEP programme. It is aimed at a fairly high level of literacy and professionalism in the facilitator and in the group. Dreikurs "goals of misbehaviour" as presented in the Dinkmeyer and McKay STEP programme are utilised, as are homework, recorded notes and recommended readings (Positive Parenting, 1993). This was not available at the time of initiating this research, but would not have been utilised even had this been the case. The researcher was looking for a programme which would have potential at the "grass roots" level and which could ultimately be effectively utilized by trained lay health workers with limited literacy. The Parent Centre's Positive Parenting Programme uses language, scenarios, real life examples and peoples' names which come from the average middle class caucasian population, it is also priced fairly high. The researcher was looking for a grassroots or basic core programme which reflected the multi-ethnic nature of South African society.

There is also an active "Human Relations Enrichment Course" which is gaining popularity (personal communication with Dr N Jolly, Port Elizabeth). This is a three day course in which communication skills are experientially practised until competence has been achieved. This may be adapted to a multi-ethnic experience and is more of a basic skills approach and could be used at a grass roots level.

At grass roots level the only material the researcher was able to access was the "International Child Development Programme" endorsed by the World Health Organisation (WHO). This requires a two week training course and provides very limited pictorial and written support (personal observation of material and communication Mr S de Waal, Trained Course Facilitator). The researcher did not have the funds to travel to the United Kingdom to undergo this training, and was looking for more than this course has to offer.

The researcher identified some original work which had been initiated by Carole Friedman. This work utilized the basic core concepts of the STEP programme over three to four experiential, grass roots sessions. The concepts explored were those of "Self Worth", "Communicating Feeling", "Listening" and "Togetherness" (the latter is a more appropriate concept of "community togetherness" rather than the STEP "Family Meeting", particularly for a society which has had little experience of democracy). The language, roleplays and experiential nature of these sessions are descriptive of the language and lifestyles of the people. This work also introduced the spiritual support of prayer. This is particularly relevant to many people, but most particularly to the black

community in South Africa. Social and business meetings are frequently opened and closed with a prayer and it is in integral part of any occasion of socio-cultural-political significance.

The researcher requested permission to utilise these initial core sessions as a base to develop a programme aimed specifically at increasing positive maternal-child interaction, maternal self-esteem and child intellectual stimulation, as a primary prevention for child abuse and neglect. She felt it was crucial to the programme to utilise the everyday lifestyles and language of South African people; to support the programme with visual graphics in an economically viable format that could be taken back into the family. These could act as both a memory prompt for participating parents, and a new learning experience for homebased family members. The use of graphics could be used to address the problem of limited literacy and could serve to demystify the skills of effective communication and positive parenting. This method has been used successfully by Faber and Mazlish (1980) for parenting the under five's in western middle class caucasian parents, and was seen by the researcher to also be an ideal medium for overcoming the obstacle of illiteracy.

4.2 SELF-DEVELOPMENT OF RESEARCHER

a) The researcher attended a ten day course in Family Therapy. The benefits of this were the exposure to the theory and literature of family therapy in the context of the current South Africa and a reaffirmation of the conceptual base developed

in Orem's theory of nursing. This embraces a model of self-care which includes the concepts of the nurse's prevention being aimed at facilitating this self care and conceives as the individual, family and community as interacting systems. The researcher became aware of the significance of working with more than one family member and utilizing a group context to facilitate change. In Family Therapy the focus of health and pathology moves from an individual level to a systems level (Love, 1989). Family therapy has three main approaches, a) Psychoanalytic where the subconscious directs the dynamics of family members; b) Integrative where support is provided for individuals and family and c) Communicative-Integrative where personality is perceived in terms of the social interaction both within the family system and within their communication processes (Love, 1989). The last approach guides this research. The family is seen as an intimate and powerful social system. The Communicative-Integrative approach looks specifically at interventions describing the process of interaction eg. how messages are sent and received. Doane, Hill and Diamond (1991), found that family therapy using a play therapy approach led to increased attachment, bonding and nurturing behaviour in schizophrenic patients and strengthened family and patient coping.

b) The researcher attended, in the role of a parent, a ten session programme of the Systematic Programme for Effective Parenting (STEP). This is a training course for parents "...based on a philosophy of child training.." (Dinkmeyer & McKay, 1976 p.4). The core concepts of this programme are briefly outlined in chapter two of this study and these were found to be particularly useful.

The group was a homogenous group of largely professional caucasian middle-class parents. The researcher retained an ethical approach by revealing that she was a parent, but was also a researcher looking at the feasibility of utilising this training programme, and was accepted by the group on these terms. Some group members were single parents and some were married couples. They were participating in the programme because they were experiencing difficulties with the behaviour of their children. There were aspects of the programme with which parents voiced difficulty despite their advantaged educational background and their obvious commitment to the programme. The researcher made note of these.

These were:

i) The American usage of both language and situational context was voiced as being difficult. The taped American accent and colloquial language was difficult to follow. The American context of the situation was not always understood and required additional explanation by the group facilitator.

ii) Understanding children's behaviour was generally found to be a difficult task. The research worker saw the need to modify their approach. The "four goals of misbehaviour" namely, attention, power, revenge and inadequacy, were easy to remember cognitively. However in order to identify these goals the parent was required to identify the way this behaviour made **them** feel.

Thus the feeling of annoyance will accompany attention seeking, anger will accompany power seeking, hurt and a desire to retaliate will accompany revenge

seeking and despair will accompany displays of inadequacy (Dinkmeyer & McKay, 1976). Once the parent has identified the way she or he feels, they are required to recognise the goal for misbehaviour and to change their own reaction response. The response the parent can make is twofold and entails a) an alternative response/s to those usually used for correction of misbehaviour and b) response/s which encourages positive goals or behaviour in the child (Dinkmeyer & McKay, 1976).

iii) Parents were able to rapidly learn the skills of positive communication eg. attention for positive behaviour, ignoring of negative behaviour, avoidance of power struggle, encouragement rather than false praise, listening reflectively with full attention and the skills of giving verbal feedback concerning their feelings (Dinkmeyer & McKay, 1976). However parents tended to be hindered in their responses by trying to decide what the child's goals were and which response was therefore the most appropriate.

iv) Despite the very obvious disagreement of the programme with corporal punishment, there were still some participants who felt this was still their first and easiest reaction. The researcher felt that this gave a feeling of secrecy or taboo to the subject which sometimes appeared to negatively influence the openness of the group when discussing their parent-child interaction.

v) Participants became very close during these ten weeks. This resulted in group members supporting each other's feelings, disclosures and actions. On completion

of the course all participants wanted to keep meeting. This was discouraged by the facilitator.

Group changes noted by the researcher:

- i) Despite the existing tendency for a generally middle class democratic parenting style among the participants there was a marked move to a more empathic understanding of the child's world by most participants.
- ii) Participants were highly motivated to read, study and attempt the training skills. Despite this there was a general feeling of still needing support for skill usage at the end of the course.
- iii) The use of the skills learnt was only expressed as being applied to the children in the family. There was no mention of a benefit or extension to other areas of participants lives. This might well not preclude this having happened.
- c) Thirdly the researcher contacted the child guidance clinic and discussed the programme run by them called "You and Your Toddler", a two hourly, three session course for parents of children under five years (The Children's Assessment Centre, 1992).

Session one covers how behaviour is learnt, positive and negative consequences or the ABC of behaviour, reinforcement, routines or limits and modelling.

Session two covers specific skills and management of specific problems. Distraction, ignoring, use of "NO", correction or showing the child how to correct the situation, "time-out", logical consequences, deprivation and smacking. Session three covers the biopsychosocial development of the child under five.

While recognising that behaviourism has been found to be one of the most successful treatment methods, the researcher was concerned that the goal of parenting should not be that of "training" as one would an animal species, nor was the intervention at a level where pathologies were anticipated. Most importantly the researcher did not want to influence mothers to "manipulate" or "control" their families. The researchers goal was to provide skills which would **enable** the mother to **care** for her family and for herself, thus providing an optimal nurturant environment for child-rearing.

d) The researcher contacted a skills trainer of the "Behaviour Enrichment Course" (Dr N Jolly, April 1991) and discussed at some length the skills training utilized by this approach and the results they were finding. This course was being used at grass roots level and was achieving considerable results in the learning of skills. The focus of the course is on skills learning with repeated practice until competence is achieved.

The researcher recognised the practicality of this and the importance of ensuring that mothers were actually able to effectively implement the skills they were exposed to. Again the researcher wanted to provide more support to the maternal-

child dyad than the learning of skills.

4.3 INITIAL CONCEPTUAL FRAMEWORK

A developmental model, is used, which implies that the individual and the system are capable of growth and change in a progressive and forward continuum. The human organism does not exist only in reaction to the environment but seeks to actively harness energy in order to facilitate this forward progress. Mankind is seen as determined to control the direction of life, and this ability to do so, contributes to the developmental experience.

Developmental models included in the programme development, of necessity look at those theories most appropriate to the rapid development which occurs in the child under five and the lifestage and developmental implications of the life crisis of parenthood. Erikson's psychosocial theory of development and Piaget's cognitive development theory are of particular significance and relevance to understanding the development of the intervention programme.

Theories of learning are appropriate in order to understand:

- a) how behaviour is learned eg. Social Learning Theory of Bandura; Miller and Dollard's Theory of Imitation and Skinner's Operant Conditioning Approach.
- b) the most effective methods of encouraging learning, influencing attitude and

motivating behaviour changes in the client group which encompasses current health education theories.

4.3.1 HEALTH EDUCATION MODELS

Ideally, health education should be a participatory process through which people develop an understanding of their health needs and problems, why these exist, and how they can be prevented. There are several approaches to health education.

The **Educational Approach** seeks to provide information which may include exploration and clarification of relevant beliefs and values (Tones, 1981). A severe limitation of this approach is that many people are not in a position to be able to make an "informed choice" and no attempt is made to look at factors which enable people to utilise this knowledge in an appropriate way.

Tones (1981) criticises those who adopt this model as doing so either because they have either a naive understanding of the dynamics of health-related behaviour or because they believe it is unethical to use persuasion to motivate individuals to adopt a healthy lifestyle.

The **Radical Approach**, which looks for the root cause of health problems in social, economic and political factors and seeks to generate public awareness and concern in order to promote community action (Tones, 1981).

The **Self Empowerment Approach** has gained support particularly since the declaration of Alma Ata in 1978 recognised the contribution of individuals to self-help, and of the community in assessing planning, implementing and evaluating their own health needs.

The **Decision Making Approach**, which utilizes four phases of assessment, planning implementation and evaluation. This is a useful model for transcultural health education but control tends to be in the hands of the service provider rather than the community (Nolde & Smillie, 1987).

The **Prevention Approach**, a medical model which recognises the significance of the social environment and the individuals lifestyle and seeks to prevent disease or illhealth by developing "healthy" behaviours and changing "unhealthy" practices.

Health education is one of the core elements that make up the primary health care approach as conceived of, and promoted by the World Health Organisation (W.H.O.) and United Nations Children's Fund (UNICEF) (Walt, 1985). The most frequently used health education approach among health care workers has been the Knowledge-Attitudes-Practices (KAP) model. This is an application of the Health Belief Model or Health Promotion Model which was developed in the early 1950's and derived from the Value Expectancy Approach for predicting behaviour (Redman, 1988). This model was developed to provide an explanation as to why some people take specific action to avoid illness while others fail to

protect themselves. Unfortunately the success of the educational efforts of health care workers has frequently been shown to be poor. A common complaint is that members of a community ignore advice and continue to practise health damaging behaviours even if they know that they are harmful. It is easy to condemn the community and put the blame on traditional beliefs or backwardness. The real reason for failure is often that the health education contained irrelevant information, promoted unrealistic changes, was directed at the wrong people and/or used inappropriate methods (Hubley, 1988; Orem, 1985; Pearson, 1986).

The model has been strongly criticised as being too simplistic, and ignoring the complex psychosocial contributions which influence behaviour. It has also, particularly in developing countries, lead to "victim blaming" eg. the women gave the children the wrong food, failed to boil water etc.

Since the 1970's there has been a shift to community responsibility and this has been accompanied by the growing interest in promoting self reliance and a shift from a medical viewpoint to a growing interest in lay competence. With changing disease patterns, social expectations and technology, the frame of reference has moved away from professional control to recognise alternative non-professional resources and skills within a community eg. support and self-help groups. Research in the literature review also highlights this trend.

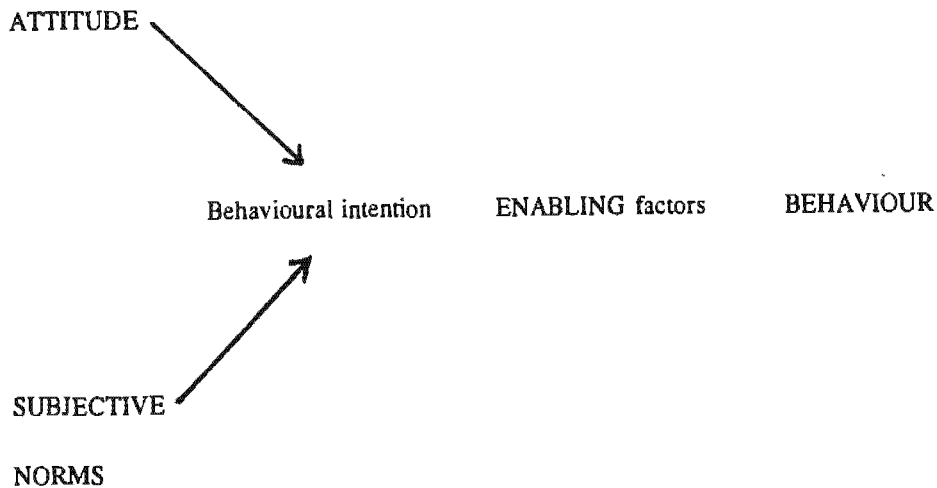
This has lead to new approaches in community health education, all of which attempt to a greater or lesser degree both to involve the active participation of the

community in the learning process and to move away from a medical to a social model. The BASNEF approach attempts the latter. It provides a good rationale for understanding behaviour, is particularly appropriate to developing countries and has been shown to provide extremely effective health education (Hubley, 1988). While it is derived from the PRECEDE model of Green (Stanhope & Lancaster, 1992, p.187) and from the theory of Reasoned Action developed by Ajzen and Fishbein as an application of Value Expectancy theory (Hubley, 1988) it is quite different from the Health Belief Model. Value Expectancy Theory sees behaviour as motivated by the "value" (benefit/advantage) people themselves attribute to the performance of the given behaviour. It is the persons's own judgement of what is a good or bad outcome, that is the key to behaviour motivation. Aijzen and Fishbein (1980), suggest that the term "attitude" , which is determined by the individual and sociocultural beliefs held, be used to encompass a person's overall judgment of a behaviour as either good or bad, and worth carrying out or not. The BA of the BASNEF model indicates Basic Attitude.

The SN of the BASNEF model indicate subjective norms. This encompasses the overall perceived social pressure. The person will have to balance out conflicting pressures from different people, of different significance in one's social network. The person is most likely to conform to their subjective perception of the wishes of those persons in the social network who are the closest to them or are considered the most significant. Whether or not a person forms a behaviour intention to perform a behaviour will depend on the weight placed on basic

attitude as against subjective norms. Whether the behaviour is actually performed, once the behavioral intention has been formulated, may well depend on the EN or enabling factors of the BASNEF model. With the best intentions in the world, unless one has access to the appropriate resources eg. skills, knowledge, equipment, finance etc., it is sometimes impossible to perform the desired behaviour.

The BASNEF approach is a problem-solving approach. In order to utilize this model it is necessary to apply the process of the decision making model eg. assess, plan, implement and evaluate. But in this model the client is included in the process. By this inclusion, the process of this model becomes that of self empowerment and would concur with the conceptual framework of comprehensive primary health care as described at Alma Ata (W.H.O., 1978) which is essential for community health nursing practice in South Africa today. Hubley (1988) has found it useful in helping individuals/groups to change their behaviour and it would seem to have potential as a model for parent education in a developing country like South Africa. The BASNEF approach recognises the complex relationship between the individual, family and community (Hubley, 1988). In this research the BASNEF model is also seen to be of potential significance for self-help and lay competence and to concur with Orem's theory which forms a core theoretical guide for this study. The process of this model is summarised on the following page.



Flow diagram of BASNEF Approach

For the purposes of this research a combination of the "Self-empowerment", "Educational" and the BASNEF Approach, is utilised.

4.4 CORE PRINCIPLES FOR PROGRAMME DEVELOPMENT

Any parenting programme for a multi-ethnic South African Society, must of necessity consider the needs of the country's black majority, who have suffered structural abuse and are economically and socially disadvantaged as a result of long term discrimination and prejudice. Weaver (1982), identifies one of the survival techniques for self preservation in the apartheid system as aggression or rage, which is often repressed, internalised and later inappropriately displaced.

4.4.1 EMPOWERMENT PRINCIPLE

Empowerment at an individual or community level has a reciprocal relationship. Thus empowering the individual influences the family and ultimately the community and vice versa (Gutierrez, 1990).

When families are forced to cope consistently with powerlessness, as many are in the South African context of apartheid which has led to oppression, and poverty, they embrace values that ease their frustration and give them a sense of power for example fatalism, spirituality, cooperation, strength, autonomy, toughness, cunning and power. Many of these values whilst ensuring survival, do not encourage the harmony and co-operation necessary for group function and leave the family vulnerable to conflict and family dysfunction (Pinderhughes, 1983).

If we are to reject a culture of dependency on experts and promote individual choice and self-care, we need to weaken the belief that the doctor-patient relationship is crucial to healing. "We need to substitute a healing process which is self-generating and re-generating rather than one that is controlled by others" (Rappaport, 1985, p.16). Alternative ways of dealing with problems of living need to be made accessible (Rappaport, 1985).

Empowerment develops a sense of consciousness in people and stimulates a feeling of control (Freire, 1970). Empowerment is a particularly important goal

and process of all parenting programmes. In the light of the above, particularly so for illiterate and/or black families. Freire (1970) supports the significance of literacy for empowerment. The process of relationship building and understanding "where the client is", is essential for empowerment (Ruger & Wooten, 1982: Weaver, 1982), as is the acknowledgement and understanding of existent family strengths and the provision of opportunities for the client to be in charge rather than to be controlled (Weaver, 1982).

The empowerment approach requires that the individual or group must be actively involved in understanding, assessing, analyzing, choosing, planning, acting and evaluating themselves. They must believe that they can influence their own lives, obtain needed resources and feel good about themselves (Shatz & Bane, 1991). In order to be effective, parents need to feel self-worth and self-esteem. The aim of the research parenting support programme is to provide parents with the opportunity to experience power and practice skills within the context of the support group. This is supported by Hasenfield (1987) and by Pinderhughes (1983) as a strategy for empowerment. Clients may be empowered by encouragement to creatively remember forgotten skills, personal strengths and potential or by current support networks (Guetierrez, 1991). This has potential for parenting programmes. Empowerment may be achieved when community mental health groups work collaboratively with self-help groups, "... not on a dependency on experts model but rather on the power and dignity of people" (Rappaport, 1985, p.21).

4.4.2 POSITIVE COMMUNICATION PRINCIPLE

The concern of most parenting programmes to avoid verbal aggression has now been substantiated by research, and positive verbal skills are considered essential for effective parenting. Parenting programmes frequently rely on the parent-child attachment bond to promote non-punitive methods for influencing behaviour. The high incidence of verbal aggression, the undermining effect this has on the parent-child relationship and the positive relationship of verbal aggression to aggression in the child, needs to be considered in context. Labelling a child is frequently used in verbal aggression eg. "stupid", "no-good", and can lead to acting out of this expected role (Vissing et al, 1991).

Non-verbal communication should be congruent with verbal communication and positive attending and influencing skills should be emphasised (Ivey & Simek-Downing, 1980).

4.4.3 SOCIAL AND CULTURAL SENSITIVITY PRINCIPLE

Previously mentioned research has highlighted the importance of sensitivity to the clients' reality and current frame of reference as being crucial to effective parenting teaching (Ruger & Wooten, 1982; Schatz & Bane, 1989; UNICEF, 1986; Zigler & Weiss, 1985). Cultural sensitivity is a continuum of this general interpersonal sensitivity. One needs to consciously, temporarily, put aside one's own values and preconceptions and openly enquire about the values and

preconceptions of others. Cultural sensitivity includes knowing the cultural content, openness to finding out what is not known, and observing of appropriate social niceties and etiquette (Lieberman, 1989).

Rather than attempting to change attitudes which are detrimental (eg. corporal punishment is culturally appropriate), try and understand the parent and family's feelings and perceptions of what is best, and then give information (eg. on child development and expectations of ability), together with awareness of the feelings of significant others (eg. child's feelings and frame of reference). Lieberman (1989), found this culturally sensitive approach led to improved child development. The control group in this research who received didactic information only, showed little change. Slaughter found that culturally sensitive mother-discussion groups was a more effective support intervention method than home-visiting in low income, black mothers (cited in Zigler & Weiss, 1985). This is of particular interest to the researcher in the light of the previous studies discussed which strongly support the effectiveness of home visiting as a support intervention. The researcher anticipates that the results of this study which looks at the developed group programme, in different ethnic groups and socioeconomic levels, will contribute to our understanding of support programme effectiveness in different settings in a meaningful way.

It is essential that the developed programme needs to be socioculturally sensitive and allow for exploration of existing beliefs and attitudes. This is congruent with the BASNEF conceptual framework which guides this study.

4.4.4 RESEARCH-BASED PRINCIPLE

4.4.4.1 Effective Techniques from Behaviour Theory

Most parenting programmes make some use of knowledge gained from behaviour theory, and much of the research by the early behaviourists Pavlov, Skinner, Watson, Thorndike, and Dollard and Miller remains influential today. The aim of parenting programmes is to improve the parent-child relationship by establishing clear and effective communications patterns which guide the relationship. The contribution of behaviour theory is the recognition that behaviour occurs in a sequence, frequently determined by the situational variables which serve to reinforce it. Most behaviour is learned. Behaviour can therefore be unlearned or changed. Behaviour is influenced by the antecedent (what happens before the behaviour) and the consequences (what happens after the behaviour) (Liebert & Spiegler, 1970). For example, the child asks for a sweet, mother says "no", child throws temper tantrum, and child gets given the sweet. The child has learned that making a fuss or throwing a temper tantrum, has desirable results. Mother has learned to give in to the child to avoid embarrassment. The behaviour sequence can be interrupted at both the antecedent and the consequence/s stages. The former requires active management or control of the situation and the latter requires reactive management. Most parenting programmes try and teach active management at the antecedent stage as the method of choice, but also provide guidance for reactive management by changing the consequences.

When looking at programmes for the prevention of child abuse, it is also helpful

to look at contributions from behaviour modification interventions of value in the **aggression behaviour sequence**. The aim is to prevent the negative consequences of aggressive behaviour which results from a loss of control in a spiral of heightening arousal and which result in child abuse. Goldstein, Krasner & Garfield (1987), suggest six intervention steps in the aggression sequence. These are tabulated below:

<u>STEP</u>	<u>INTERVENTION</u>
1. Arousal-heightened interpretation of external stimuli	Anger control training
2. Heightened affective arousal	Relaxation training
3. Malcommunication	Communication training Negotiation training Contracting
4. Mismanagement of contingencies	Management training
5. Prosocial skills deficiencies	Prosocial Skills training
6. Prosocial value deficiencies	Prosocial values training

(Goldstein, Krasner & Garfield, 1987, pg.5)

The research on child abuse has shown that it is the adult's **perception** of the event which is of significance in influencing the degree of stress or heightened arousal actually experienced. To this end the intervention looks at promoting understanding in the parent of child development and parental awareness that the child's unwanted behaviour may in fact be initiated by developmental stages through which the child will pass, rather than by the child's cognitive decision to annoy, control and manipulate the parent. This is of particular relevance to the developed intervention. The latter is aimed at primarily the child under five years. This is a time of rapid developmental change. While the STEP programme looks at the unconscious social goals identified by Dreikurs to explain the reasons for children's behaviour or misbehaviour, the developed programme excludes these concepts, looking rather to enhancing positive parental interaction, influencing skills and control of the affective arousal sequence. Responsibility for the behaviour of **adults** towards children and the ability of adults to learn skills to control their behaviour is prioritised, rather than teaching of children how to protect themselves eg relaxation training and client self-management of the physiological cues of anger-arousal (cognitive and attending skills, language and imagery skills) have been shown to be easily and effectively taught (Goldstein et al, 1987).

4.4.4.2 Effective techniques from communication theory

Communication theory is relevant to this research in programme development in two areas.

First, the control of communication skills and networks is traditionally in the hands of the dominant, literate culture. This disempowers the poor and illiterate, denying them access to knowledge and skills (Ramirez, 1990). This research aims at providing visual material which will provide a "memory aid" for the knowledge and skills learnt, thus demystifying them in an appropriate and acceptable form for illiterate ordinary people at grass roots level.

Secondly, the communication theories which are relevant to interpersonal communication are also influential in both understanding existing parenting programmes and the development of the experimental programme.

Psychoanalytic theory studies the communication dimensions of symbols and symbolic behaviours eg. slips of the tongue, dreams, and language induced hypnosis and the physical behaviour of hysteria respectively, as communicative of psychological processes (Smith & Williamson, 1977). Traditionally, psychodynamic approaches have been used as core practice models for treatment of child abuse. A limitation of utilising this model in isolation is that it has not been shown to be very effective (Pardeck, 1989). Alfred Adler introduced the idea that all behaviour has a social purpose and this concept was developed

further by Dreikurs, who identified four unconscious goals motivating misbehaviour in children, namely, attention, power, revenge and inadequacy (Dinkmeyer & McKay, 1976; Dreikurs & Grey, 1970). While this theory has been utilised as a base for parenting programmes eg. Systematic Training for Effective Parenting (STEP)), it was not utilised in this format in the developed programme. The rationale for this was that the programme was aimed at a primarily peasant population with limited formal education, who were neither necessarily familiar with the western scientific concepts of causality nor versed in the metacognitive skills this type of thinking entails. In the light of the literature review understanding of an ecological aetiology of child abuse, a more comprehensive model incorporating the social and cultural environment of the family and community systems rather than an individual intrapsychic model was considered by the researcher to be more appropriate and in congruence with the core conceptual framework provided by Orem's Nursing Theory. This conceptualisation is also more in line with the Comprehensive Primary Health Care Model of Practice for community health nurses. This involves a flexible, social model of health including client inclusion, consultation and active participation and a broad interdisciplinary focus (W.H.O., 1978).

Recognition of the contribution of psychoanalytic theory was, however, given in the psycho-socio-cultural dimension. It was recognised by the researcher that in many cultures, illness and behaviours are believed to be influenced by the supernatural, ancestor spirits or resultant of moral transgression (UNICEF & Aga Khan, 1986). For this reason particularly, the researcher attempted where

feasible, to ensure that the group facilitator was of the same culture, socioeconomic level and lived in the same community as the group members. The importance of this is reinforced by the quote, "Meaning is not in words but in people" (Birk, cited in UNICEF & Aga Khan, 1986, p.19). An educator who has good rapport with the client group, speaks the same language, dialect, vocabulary and slang, is advantaged. It was this particular advantage that the researcher attempted to maximise.

General systems theory sees information and feedback as part of the interrelationship between various elements within a system. This is of significance to this research which acknowledges the importance of the maternal-child dyad as but one of the subsystems within the intra- and extra familial systems.

Humanistic theory contributes to communication theory, emphasising the concern for values, respect and freedom. This influence is shown strongly in Gordon's, Parent Effectiveness Training (PET)(Gordon, 1970), STEP (Dinkmeyer & McKay, 1976), Ginot's and Faber & Mazlish's work (Faber & Mazlish, 1982). Concepts such as democracy, mutual respect, honest /congruent expression and acceptance of feelings are emphasised. The significance of active listening and nonverbal communication skills is emphasised, as are the importance of general semantics. General semantics is the study of the powerful relationship between words and behaviour. The way we verbalise or utilise speech influences the inferences and responses we communicate, and in order to have healthy communication, a person must acknowledge the communication of others (Smith

& Williamson, 1977). This is observed in parenting programmes where the verbal skills of communicating negative feedback without damaging the self esteem of the recipient and active listening are taught eg. PET, STEP.

4.4.4.3 Significant research on Child Abuse and Neglect and Transcultural Parenting

The literature review in chapter two details the relevance of this research to the present study.

4.4.4.4 Learning and Education Theory

a) Teaching Strategies

The programme follows the BASNEF health education model which attempts to look at the adults underlying values from an experiential and emotional rather than from a cognitive level of understanding (Hubley, 1988). Didactic presentations giving knowledge on child abuse at parent evenings were found to produce little evidence of learning (Berrick, 1988). Gilbert, Berrick, Duerr, Le Prohn & Nyman (1989) assessed seven didactic programmes aimed at providing knowledge to parents on preschoolers' cognitive and moral development and found them all to be ineffective. However a similar programme for primary school parents which combined didactic information with communication skills using small group discussion, exercises and roleplay was found to be highly

effective, leading to increased parent-child communication about sex and values on sexuality (Huston, Martin, Foulds, 1990). This study further found that when parents were given the information and skills to communicate effectively in the home environment, this led to a change in the children's sexual behaviour and the consequences thereof. This is significant in the light of the fact that formal sexuality education in schools has been shown to have a limited measurable effect on children's sexual behaviour (Huston et al, 1990). Thus this approach is of note for this study as it attempts to utilise a combination of teaching strategies not only to promote learning in both the parent and child, but also to empower the parent to utilise new skills and knowledge in the context of the home environment. Further support for a combination of methods is provided by a study which used didactic methods, roleplay and discussion to successfully increase the knowledge of three groups, primary school children, parents and teachers (Binder & McNiel, 1987). Kleemeier, Webb, Hazzard and Pohl (1988) were also successful when they utilised a combination of methods.

The developed programme needs to use a teaching strategy which will not conflict with the conceptual framework of the study and is appropriate for the client group in order to ensure optimal learning. The nature of the interaction led the researcher to choose group work as being the most appropriate teaching strategy. The rationale for this was the characteristics of group work. In group work:

- * the educational aim is to raise awareness, facilitate attitude change and decision making and foster mutual support

- * members are active participants and may plan and choose the content
 - * the educator guides or facilitates learning experiences
 - * learning is through enquiry and discovery and can take place outside the group in the client's own home
 - * co-operation between members is promoted and new ideas welcomed
 - * group members are frequently highly motivated because learning is based on the groups interests and problems
- (Ewles & Simmet, 1985).

b) Learning Aids

Abusing and vulnerable parents are typically impaired in their ability to perceive and accurately interpret their child's affective state. Pictures, videotapes and audiotapes have been utilised to train parents in the skill of accurately recognising anger, hurt, joy, fear, pleasure and pain (Martin, 1984). The researcher utilised the same concept in the developed programme.

Comic books and graphics and pamphlets have also been shown to lead to successful learning. Garbarino (1987) found that the messages in the "Spiderman" comics were understood by both parents and children and led to both children knowing where to get help and parents who were more likely to believe their children and to take action. The photonovel has been found to be particularly successful in reaching semi-literate, rural populations living in media-scarce environments, whilst the comic book is the most effective for children (UNICEF

& Aga Khan, 1986).

Videotapes have also been shown to increase parents' knowledge of alternative to physical punishment, increase understanding of normal child development and change parental attitudes to their children's misbehaviour (Golub, Espinosa, Damon, Card & 1987).

Simulation techniques were found to be highly effective with preschool and first and second graders in giving them skills to resist stranger abduction (Fryer, Kraizer, Miyoshi, 1987a)

Educational aids do not in themselves ensure learning; the material needs to be discussed in order to enhance learning (Donahue, 1986).

c) Factors in the Learner

First time parents frequently have both the greatest need and the best potential for health education to have the greatest impact (Taylor & Beauchamp, 1988). In providing a primary prevention intervention aimed at the under five, it was anticipated that at least some of the parents would be first time parents. They therefore would be likely to have less entrenched behaviour patterns of child rearing and consequently be more receptive of the intervention strategy.

Those parents who are not first time parents might well be experiencing problems

with parenting and this could be their motivation for volunteering to participate in this study.

d) Factors in the Facilitator

Bandura's Social Learning Theory is particularly relevant to the developed programme. The facilitator is expected to rolemodel the behaviour she is facilitating to both the participating child and mother in order to encourage "observational " learning. For the same reason, individual participants roleplay interaction sequences for the group. Bandura found observational learning to be rapidly assimilated and well retained and to entail both verbal and visual cognitive coding processes (Bandura, 1969). In order to facilitate recall of this acquired learning, visual and simple verbal responses are presented in the form of the comic book.

4.4.5 INTERACTION PRINCIPLE

Given the large number of vulnerable children under five and the long distances often to be travelled, the possibility of a simultaneous parent-child interaction was explored. This has been found to be successful when children and parents are each given a separate group intervention (Wantz & Recor, 1984). In many treatment programmes serving abusive families the intervention is aimed at the parent system alone, and where more extensive services are provided, separate intervention for the caretaker/parent and for the abused child are run

simultaneously (Blythe, 1983). The researcher considered the possibility of combining the group so that children and parents are actively able to participate. The purpose of this was to allow participant roleplaying, stimulation activities and pleasant touching practice, real observation of actual developmental stages and the opportunity for the children to learn some of the skills. The researcher believed that all aspects of the programme should be able to be discussed openly in front of both parent and child and that this would effectively role model the core relationship principles eg. congruence, openness, reflection of feelings, democratic respect and acceptance and effective communication.

This is conceptually similar to Filial Therapy that was developed by Guerney to train parents to serve as play therapists for their own children who had serious adjustment problems (L'Abote & Milan, 1985). It differs in that Filial Therapy is remedial whereas the developed programme is preventive. Developmental play has been used successfully to enrich the lives of emotionally disturbed children (Brody, 1978), foster-parent programmes (Gross, Shuman, Magid, 1978), and normal biological parents (Brody, 1978; Gross et al, 1978).

The only preventive parenting programme the researcher was able to identify which simultaneously works together with the parent-child interaction is the Parent-Child Relationship Enhancement Programme (PCRE) (L'Abote & Milan, 1985). This is a preventive programme which works on relationship-building skills eg. empathic responding and nonverbal attention, combined with parent assertion skills eg. limit setting and I-Messages. This covers ten weeks of two

hourly sessions where skills are learned through play sessions that parents conduct with their own children, first during group sessions and later at home. The findings suggest that including children in the parent education provides more effective skills training than when parents alone are given education (L'Abote & Milan, 1985).

Utilisation of a programme which primarily involved developmental play was felt by the researcher to require more advanced facilitation skills than the average community health nurse would initially possess. This would require a longer training period for the facilitator and entail greater emphasis on theory. This would in essence "professionalise" these skills once again.

Given the historically violent social situation in South Africa, parents needed to start from their current experience and explore new possibilities for parenting in a non-threatening and supportive environment. The concept of play as a significant variable in the healthy development of the child is not widely recognised in traditional families (Roopnarine et al, 1989). The rapid brain growth of the child under five years and the frequently compromised nutritional status of poor families in South Africa would highlight the necessity for early cognitive stimulation. To introduce the concept of interactive play and not facilitate this aspect at the same time would have been negligent clinical practice in the eyes of the researcher.

As discussed in the literature review, a large majority of South Africans families

are traditional or transitional and are unaware of the benefits of this potential parenting role. For both black facilitators and participants this might well require a major shift in cognitive thinking. For these reasons the researcher suggests that an awareness of the importance of play would be accepted more readily and would be less intrusive if it was introduced as merely one of the natural experiences of the programme rather than as the main therapeutic theme.

Song and music on the other hand is used extensively among many South African communities as a source of solace and joy. The researcher anticipated that the caucasian groups might well find the interactive songs more problematic than the other ethnic groups. The songs followed wherever possible the theme of each session. An appendix of additional songs in English, Zulu, Xhosa and Sotho was added to the manual for easy reference. It was anticipated that any socio-cultural song, particularly if well known to the group could be substituted by the facilitator.

4.5 PROGRAMME DEVELOPMENT

4.5.1 INITIAL OUTLINE OF PROGRAMME DEVELOPMENT

The researcher wanted to provide a step by step programme which would be simple to use. A concerted attempt was made to provide support for the facilitator for typical responses. At the same time the programme should be as flexible as possible in order to fully utilise the knowledge which the facilitator possesses of

the community and permit her sensitivity to the unique needs of each group.

The first three sessions are based on original unpublished material developed by C. Friedman in the 1980's from the core concepts of the STEP programme, and tested in her clinical social work practice with the urban poor. The utilisation of prayer was retained but with firm guidelines that this should only be used when appropriate. This was felt to be acceptable in the light of the comprehensive conceptual framework of health promotion guiding this study. Much emphasis has been placed on cultural and social sensitivity, thus the researcher considered it would be inappropriate not to harness the spiritual aspect of mankind where this was appropriate. Certainly in South Africa prayers are frequently accepted as a social protocol before the commencement of community meetings (Personal experience of researcher 1990-1994). The theme of the prayer when used was encouraged to be the same as the theme for each session.

The format of presentation is in line with this study's emphasis on maternal-child interaction and all the activities pertaining to the child are additional eg. interaction graphics, songs, touching, play and toy making from waste. The concept of continued "home activity" during the intervening week between sessions was also introduced in line with most other parenting programmes which encourage the use of skills and practice in the home environment. The family's retention of the comic book for their own use eg. learning, colouring, for reference, would appear to be a unique aspect of this research as is the toy-making from waste materials (also taken home to respective families). The latter

is conceptually in line with primary health care concepts of appropriate technology (WHO, 1978).

The researcher attempted to reinforce learning by repetitively reintroducing the skills learnt throughout the ten sessions in a continuous cyclical manner. Boredom was prevented by utilising different learning strategies and a variety of visual aids. Sessions gradually moved from the cognitive and emotional world of the adult to that of the child. This was a conscious effort to commence from the adult position of the mother and to gradually encourage the development of an empathic understanding of the child's world. The programme repeatedly went from adult to child and back again in order to retain this empathy.

The researcher developed the programme so that it would provide the opportunity and "trigger material" for new experiences together with the opportunity to explore the feelings and thoughts these experiences produced in an empathic and supportive environment, but accepts that it is the right of every mother and family to make the ultimate choice of parenting style and their own prioritisation of skill usage. Much of the "trigger material" challenged existing stereotypes and produced heated discussion. For this reason there is little attempt made to actively condemn smacking. This is contrary to the STEP and PET programmes and writings but was felt to be important considering the empowerment principle of self help and the conceptual framework of this study (Orem, 1985). The option or choice is there for the parents to decide for themselves and basic information on the effective use of punishment is included in the manual's introduction on

behaviour principles in order to facilitate this.

4.5.2 THE BROAD OBJECTIVES FOR THE INTERACTIVE SESSIONS

Were to:

- a) Start from the mother's current possibly egocentric position and perspective and assist the development of an empathic awareness for her child's world.
- b) Increase the knowledge of the mother concerning the current and potential appropriate biopsychosocial stage of development of her child.
- c) Assist the mother to apply this knowledge of development in the context of the everyday behaviour of her child. So that her expectations for the child would fall within normal parameters eg. utilise the power of lighthearted laughter as recommended by Flavier (1991), the founder of the International Institute of Rural Reconstruction from his thirty year experience of working with the poor.
- d) Empower the mother to gain confidence in her self-worth by decreasing her need for the child to fulfil her own need for love and attention (de Mause, 1974). This was provided by the social support of the group initially, the encouragement of the continued contact and functioning of the group on the completion of the course (Hamilton, 1989) and by discussion of community support resources in the last session.

e) Increase the mothers personal self-esteem and growth by increasing the control/power she has over her actions (Garbarino, 1977) by :

- * teaching the mother verbal and non-verbal skills to direct the parent-child relationship (Hamilton, 1989). This was ensured by teaching the skills of effective listening, recognition of own and others feelings, effective expression of ideas, exploring alternatives and learning from natural and logical consequences.

- * teaching the mother control of "impulse" and "aggression" (Goldstein et al, 1987; Hamilton, 1989) in line with child abuse literature which indicates the high state of emotional arousal and with aggressive arousal sequence literature eg. relaxation skills, recognition of feelings.

- * allowing frequent and repetitive practice of new skills within the group sessions.

- * facilitating the use of sincere encouragement rather than inappropriate praise.

f) Improve the positive maternal-child interaction as a primary prevention for child abuse potential by actively encouraging interactive play, singing and involvement of the child in the group session, by encouraging the use of non-punitive methods of discipline, positive reinforcement and empathy with the child's world by actively eliciting experiences and discussion of the feelings experienced by smacking.

g) Encourage the child's self esteem and positive development by exposure to a warm, supportive and stimulating environment of parenting which will allow the child to master it's personal and social world (Willows, 1991).

h) Identify vulnerable mothers and provide additional support and referral if necessary eg. Depressed mothers are limited in their ability to provide effective child rearing (Wagner, 1991).

4.5.3 OUTLINE OF DEVELOPED SESSIONS

The developed programme entails ten weekly sessions of approximately 90 minutes each. Each session carries a core theme. Continuity and reinforcement of previously learnt skills are ensured by a cyclical repetition of previously learnt skills throughout successive sessions.

Sessions are given "titles" which describe these core themes. An attempt was made to make these titles fun titles. This was for two reasons. First in our largest and poorest communities we have a very high teenage pregnancy rate, and this would appeal to this maternal age group. Secondly, this same community frequently has large families including both children under five and teenagers. The researcher hoped and anticipated that these would be relayed back to the teenagers, together with reinforcement from the graphics.

4.5.4 SPECIFIC SKILLS TAUGHT DURING PROGRAMME

The four major areas in which specific skills were taught were:

a) I AM A SPECIAL PERSON

skills - * show love

- * show respect

- * show discipline by teaching and guiding

b) GAINING CO-OPERATION

skills - * model the behaviour you want

- * show "how to" do things

- * give attention to the behaviour you want

- * describe the situation

- * give information

- * "say it with a word"

- * talk about feelings

c) FIRST AID TO A CHILD IN DISTRESS

skills - * non-verbal attention

- * listening

- * naming feelings

- * "fantasy wishes"

d) ALTERNATIVES TO PUNISHMENT

skills * ignore negative behaviour

- * attention, or distraction
- * show how to be helpful and make amends
- * strong disapproval
- * say what you expect
- * give a choice
- * take action
- * experience the consequences

Some of the above words and ideas was derived from work and ideas from Faber and Mazlish, (1980), and adapted to the South African context. These researchers have worked on the ideas of parenting programmes from the viewpoint of the child psychologist Haim Ginott and give guidance specifically for the young child. While the terminology used is sometimes similar, this was not an attempt to copy their work but rather to use the everyday language which we all use and which the researcher knew could not be improved upon.

Additional skills the development of which ran throughout the programme were:

- * recognition of feelings
- * development of sensitivity and empathy to the world of significant others
- * effective giving and receiving of messages
- * interactive social and cognitive play and stimulation
- * the development of a social support group and recognition of this need

4.5.5 THE DEVELOPMENT OF THE SUPPORT PROGRAMME

GRAPHICS

These were drawn up to complement each session of the programme as it was developed and aimed at being appropriate for the child of five years and under.

There were several guidelines used to draw the graphics. The researcher was guided by the messages and principles of the programme. Graphics thus depicted interactions and descriptions of salient points of each session. It was essential that a multi-ethnic perspective was created and graphics included indian, caucasian, coloured and black facial features. The background was planned to be as simple as possible so as not to distract from the message of the skill depicted, but attempted to include both rural and urban environments and modern and traditional clothing (no specifically traditional clothing was used eg. sari or skins and beads). The guidelines for low visual literacy were followed, namely, a) no complexity b) no unimportant details c) no unusual angles and d) no depth perception (UNICEF & Aga Khan, 1986). The situations attempted to cover a range of those likely to commonly occur in any cultural group in a family with children under five years eg. bathing, holding, dressing, eating, working, relaxing/playing, preschool, going to the doctor, and dangerous games. Interaction between the mother-child dyad dominated the graphics but interaction between the father-child dyad and siblings is also shown. Graphics covered common areas for a mother and child and ranged from the kitchen, bus stop, home, garden and outside yard to the shops.

The researcher wanted this initiative to be as low cost as possible in order to make it viable to photocopy and give to each family to take home. Photonovels have been found to be less expensive than comic books because the latter are usually coloured (UNICEF & Aga Khan, 1986). Future use of the graphic comic book by photocopying would be more likely if diagrams were black and white and easily reproducible at minimal cost. The use of a black and white format also made it possible to encourage the use of the comic book for stimulating play. It was anticipated that children could colour this in. This would not only lead to practice in hand-eye co-ordination, but also reinforcement in the children of the learning of the skills demonstrated in the graphics. By using a black and white comic book, the danger of misinterpretation of culture-specific colours was avoided. Shaded line drawings and block-out photos (photos without a background) have been found to be the most effective (UNICEF & Aga Khan, 1986).

The researcher drew initial stick diagrams and filled in words to support the interaction sequence. The services of a graphic artist were employed to draw these up appropriately. The researcher gathered examples of multi-ethnic graphics from the Early Resource Learning Centre, WHO health bulletins, newspapers, magazines and comic books. Many of these graphics were being used with some success as educational aids in preschools and primary health care centres. Graphic work by Faber and Mazlish (1980) was particularly helpful. By being guided by South African multi-ethnic visual material, the researcher hoped to be able to avoid the problem of the existent educational and cultural gap differences between

herself and the clients for whom the programme was being designed. Cultural and educational differences can also be a positive influence. UNICEF and Aga Khan (1986) record that illiterate peasants may be more impressed by the credibility of modern education and authority.

The researcher and graphics designer worked closely together in order to create the required South African feel in the graphics. The initial problems experienced was the need for the "body language" or non-verbal communication, particularly the facial expression, body posture and hands, to show very explicitly the communication skills being taught. Nearly all graphics had to be redrawn at least once to ensure this. Another problem experienced was the appropriateness of clothing. Headscarfs and longer dress lengths were more important in some graphics than in others. The UNICEF & Aga Khan (1986) guidelines suggest that pictures should be as realistic as is possible and that facial features, clothing and buildings should be familiar to the client group.

Gender awareness led to ensuring that children were both male and female. While this programme is directed primarily at mothers, the significant role and potential contribution of the father needed to be acknowledged (Carlsmith, 1964; Dreyer & Wells, 1966). This was done with two graphics depicting the father-child dyad. This was restricted because in traditional societies there is still considerable role definition and the researcher did not want to be offensive in any way. The verbal responses of the graphics were written in a hand script in the style of a typical comic book. Only the page headings and skills being demonstrated were in typed

script.

Testing of these graphics was carried out in several ways among black, caucasian and coloured population groups. Initially a small convenience sample of five caucasian and five black mothers in the age range of twenty five to thirty five was individually consulted and each was asked to describe the interaction from pictures alone (no written input on graphics). A similar convenience sample of eight caucasian and six black children ranging in age from three to twelve was asked to do the same. Feedback and suggestions from this participatory study were then used to adapt the graphics where necessary.

The participants were exposed to large single graphics on A4 paper with a single picture per page initially. When asked by the researcher all participants were able to spontaneously describe the basic non-verbal messages and the mood of the graphics interaction sequences. No prompting was required. The children, (even the three year old) were all able to do this to with ease and required no assisted explanation. The adults, particularly those who were less familiar with books and had less schooling, needed to have a sample descriptive explanation demonstrated by the researcher. Once this was done they were able to describe the graphic interaction effectively and with understanding. The words were necessary for full understanding of the skill being taught.

The researcher then reduced the graphics to half and then quarter size. This had no effect on the children's ability to interpret the graphics, but did have an effect

on the adults. The older, 35yr old participants, particularly those with less schooling seemed to find it progressively more difficult to interpret the graphics as the size was reduced. This was of some concern to the researcher. As only two participants fell into this category, the researcher tested the effect of size on interpretation yet again when the graphics and sessions were tested together later in the coloured community as described below.

4.5.6 THE TESTING OF THE COMPLETED PROGRAMME AND GRAPHICS

The completed graphics were tested together with the seven sessions which were being presented to mothers and children for the first time. This was implemented in the same coloured periurban community in which Friedman had tested the original three sessions which were modified, with her consent to the prerequisites of the present programme.

Prior permission was obtained from the local authority and the local community health clinic sister. The waiting room of the clinic was used. Volunteers waiting to attend the clinic service participated in the sessions. This gave immediate feedback of the sessions as they developed, and the extent to which the graphics supported each session. This was an artificial situation in that there was little consecutive follow through from one session to the next and no attempt was made to present the entire programme. Some mothers did experience more than one session. Mothers were asked to give input about each experience, were debriefed

after each session and thanked for their participation. The community health clinic sister was offered the opportunity of attending the facilitators' training course.

No problems were experienced with any of the sessions. The size of the graphics continued to influence the older, less educated participants' ability to describe the graphics. One grandmother who was bringing her grandchild to the clinic was able to describe the A4 graphic but when this was quarter size found the same graphic difficult to describe and was unable to describe a different graphic at the small size until it was seen again at the A4 size. This might well have been caused by unfamiliarity and limited exposure to graphic material (visual illiteracy) and might have improved with practice. Recommendations for nonliterate visual material does suggest that pictures in a series may not be recognised as a series but rather seen as independent individual pictures (UNICEF & Aga Khan, 1986). A further exploration of the effect of size on interpretation of graphics would make an interesting future study. For the purpose of this study the researcher felt advised to retain the graphic at the largest possible size that would still make this an economically viable learning tool and memory prompt. Graphics were reduced to half, third or quarter size as appropriate to produce a comic book which could be coloured in. The final product covered only fourteen back to back A4 pages. UNICEF and Aga Khan (1986) recommend that the ideal size of a pamphlet is sixteen pages as this is the most economical format for high speed printing presses and the most appropriate length to ensure the readers attention span.

In order to ensure that initial learning from the graphics was not limited by the

graphic size, particularly as this research was aimed at mothers or primary caretakers with limited educational levels, the researcher produced an economical flipchart with all the graphics drawn at A4 size for use by the facilitator in the group session. This was a manageable size to hold on her lap and could be seen easily by all members of a small group seated in a circular arrangement. The page numbers of the comic book and the flipchart were collated and these details added to the manual for easy reference as a result of problems the pilot group facilitator experienced. The researcher also made use of black and white photographs (with the permission and consent of parents) to illustrate emotional responses and feelings of children and adults.

The programme with graphics took approximately seven and a half months to develop and a further three months testing, redrawing and redrafting. A total of ten and a half months.

Each facilitator was given a spare copy of the roleplay and situation sheets of the manual as a separate addition. This was done to assist the facilitator in her session preparation as much as possible and also because some of the community health nurse facilitators did not have access to photocopy facilities in their sites. Each facilitator was supplied with sufficient and spare comic books for all the experimental group participants.

4.5.7 DISCUSSION OF INDIVIDUAL SESSION DEVELOPMENT

The humorous titles discussed in section 4.4.3 are listed below:

SESSION ONE - " I AM A SPECIAL PERSON"

SESSION TWO - " COMMUNICATING HOW YOU FEEL"

SESSION THREE -" DO YOU KNOW HOW TO LISTEN"

SESSION FOUR -" DOES SMACKING WORK"

SESSION FIVE -" TAMING THE LITTLE MONSTER"

(gaining the child's co-operation)

SESSION SIX -" FIRST AID TO A CHILD IN DISTRESS"

(listening to the feelings behind the words)

SESSION SEVEN -" TOOLS OF THE TRADE"

(recognising the skills mothers already possess)

SESSION EIGHT -" I'M BIG ENUFF"

(problem solving and recognising developmental ability)

SESSION NINE -" IT'S OK I CAN HANDLE IT"

(independence, setting limits and avoiding a power struggle)

SESSION TEN -"THE LAST WORD"

(Praise, reward, punishment and togetherness)

The developed sessions were all based on a similar **format** in order to make the sessions as simple as possible for the facilitator to follow. This was:

- * **FEEDBACK** from the previous week's session and family interactions, including discussion and active problem solving of any problems experienced.
- * **MATERIALS** required for the current session.
- * **TIME** anticipated for the session.
- * **AIM** of the session clarified.
- * **OPENING PRAYER** - only if appropriate for the group. It was anticipated that this would be inappropriate for some groups. The spiritual input should be appropriate to the belief system of the group, whether this is Christian, Islamic, Jewish or agnostic.
- * **CHILDREN'S INTERACTION SONG AND GAMES** - to introduce/reinforce the concept of play and positive maternal-child interaction. This method was used to introduce an orientation to the child, provide cognitive stimulation, actively demonstrate positive attention and love, precipitate laughter and fun and to practice skills being learnt.
- * **EXPERIENTIAL LEARNING** - roleplaying, drama, graphics, problem solving,

drawing, toy making and games. This covers the core content and skills teaching of each session and includes the facilitators input, possible group input and group discussion and problem solving.

* SESSION END - making of toys and appropriate utilization of these. Summary of skills to be practised over the week.

SESSION ONE - "I AM A SPECIAL PERSON"

This is the first group meeting and mothers and children might or might not know each other. All members of the group will possibly be feeling "ill-at-ease", vulnerable and unsure of what they are about to experience (Ewles & Simnett, 1985).

Icebreaker strategies of "getting to know each other" activities were utilised to address this (refer group introduction, drawings and group icebreaker game Support Programme Manual, p.1 & 2). These icebreaker activities attempt even at this early stage to include the children in the activities and to utilise song to reduce tension and as a tool promotive of positive maternal-child interaction.

This session looks at feelings of self-worth from the mother's egocentric position. As clarified repeatedly in the literature review, it is important to start from the initial point of "where the person is" and attempt to actively address this by roleplaying a story situation which involves an adult experience common in everyday life. The participants are asked to actively empathise with the feelings

in the story with an experiential exercise. This also serves as an initial introduction to the "skill of listening to and recognising feelings in others". Discussion and examples of participants real life experience are utilised to roleplay non-verbal communication skills which actively demonstrate an appreciation of a person's self worth (giving and receiving "messages of worth"). The session ends on a positive note with an exchange of a gift of a personalised note of self-worth to each group member and from each mother to her child.

Graphics demonstrating nonverbal behaviours of "giving and receiving of worth" were not shown in this initial stage, but retained to be introduced in session two, when the group came back together again. The primary reason for this was that the researcher did not want to load this introductory session with too much material.

SESSION TWO - "COMMUNICATING HOW YOU FEEL"

This continues to adapt Friedman's work to the core interaction conceptual principle of this study. The major emphasis of this session is the discussion of feedback on giving and receiving feelings of worth and continued roleplay of these and an extension of this to the communication skills of giving and receiving feedback of negative feelings which involves the verbal skills of "I-messages" and "you-messages".

The roleplay now moves from the mother to the teenager. This roleplay was used

in Friedman's work and was retained for several reasons. First this age level is closer to the mother's chronological age than the child under five and thus takes her gradually and progressively into the world of the child. Secondly adolescence is stereotyped in most communities as being a "problem time". The rebelliousness of this stage is therefore familiar to all community members and management of this was thought by the researcher to contribute considerably to the perception of the "power" of the skills being taught. Finally it was anticipated that with the large family size frequently found in developing countries, there would be some mothers who either had children under five and teenage children (which might at this time be problematic) or who lived in an extended family home which included adolescents.

Recognition of a range of different feelings was introduced and explored within the group progressing from physical tactile feeling through to emotional feelings. This recognition of feelings is reinforced in a repetitive manner throughout the sessions, gradually moving from the cognitive and emotional world of the adult to that of the child. This session takes the mother through adolescence and introduces the younger child actively for the first time, both from the examples coming from the participant mother and child and from the situation examples offered for roleplay in this session.

The graphics and comic book interaction sequences are introduced for the first time in this session. These all depict the inter-relationship of the mother and child of five years and under. The graphics developed for this session covered the

verbal and non-verbal communication of feelings (p.1-7 of comic book of developed programme). The use of songs and games continue to encourage an atmosphere of relaxation, fun and interaction between both group members and mother and child. The session ends with mother-child dyads taking the comic book home and encouragement to practice "I-messages" at home.

SESSION THREE - "DO YOU KNOW HOW TO LISTEN"

This is the last session which draws extensively on the work of Friedman. The main theme of the session is effective listening. This theme carries through in all the children's song, adult-child game play and adult group member activities. A relaxation script is appended to the manual and active relaxation is introduced for the first time. Listening to the words and to the feelings behind the words is taught. Graphics describing these skills are introduced and discussed (comic book p.8-13). The session ends with the mother and child making a picture book for the child. Homework entails practising listening to and recognising the feelings of friends and family and discussion of appropriate use of the picture book and positive reinforcement of desired behaviour.

The following six sessions are the original work of the researcher based on many of the concepts of Dinkmeyer and McKay (1976) and Faber and Mazlish (1980) with the addition of unique material which to the current knowledge of the researcher is not available elsewhere. The final session includes a small contribution of Friedman's work.

SESSION FOUR - "DOES SMACKING WORK"

This takes the recognition and understanding of feelings from the initial superficial level of a skill to be learnt to a deeper level. It attempts to challenge stereotypes and initiate empathic feelings for the world of the child. The session is confrontational to the major issue of smacking as a means of discipline. The feelings produced by smacking are experienced from the sensitive viewpoint of gender violence and the feelings and reaction this generates in the mother. The researcher wished to use the power of this issue to produce strong feelings. Most parenting programmes do not openly discuss this significant aspect of child rearing. As mentioned under the self development of the researcher, it was felt that this actually prevented openness within the group. This conflicted with the researcher's empowerment conceptual framework which requires the nurse to assist the client in her self care deficit. By providing a supportive environment the facilitator promotes personal development which will enable the individual to meet future demands for action by allowing each parent to make their own choices (Orem, 1985). Furthermore, this step is in congruence with the BASNEF model of health education which requires the researcher to look at basic attitude, subjective norms and enabling factors which influence behaviour (Hubley, 1988). For this reason the researcher made an active decision to rather bring the topic out into the open and deal with it within the support of the group interaction.

The researcher attempted to utilise the symbolic attachment of the hand as both giver of love and tenderness and the symbol of power. This was felt to be

particularly relevant in the light of South African history where the clenched fist has been symbolic of the power of the black resistance movement.

The role play reverted back to the position of the adult and how violence made the mother react. Built into this roleplay was the cyclical repetition and practice of the verbal skills of giving I-messages and the continued observation of the escalation of negative aggression that is produced from you-messages.

The comic book is used to show a typical situation in every mother's life, that of shopping with a tired toddler and a power confrontation. Feelings around this are explored and the photographs of a mother's violent face and a miserable, crying child are shown to bring realism of these raw emotions to the discussion (comic book p.25).

The graphics on imitation (comic book p.14) are also discussed in the context of the observational learning which occurs from contact with rolemodels in the family (Bandura, 1969).

The sense of touch is used extensively throughout this session. In order to end the session on a positive note and effectively debrief any charged emotions, the mother-child dyad end the session on a fun note, making a "sensory" card and discuss its function in child stimulation. Homework includes practice of touching, giving and receiving of positive messages of self-worth.

SESSION FIVE - "TAMING THE LITTLE MONSTER"

The sessions up to here have weighted the skills of effective communication and demonstrated the loss of control and escalation of aggression when ineffective communication is used. This session looks at non-punitive methods of engaging the child's co-operation and the skills this entails. It takes the parent to the other end of the life span and uses an analogy of an elderly, handicapped parent to present the home from the perspective of the child. The use of analogies has been found to be extremely effective in making a point meaningful (Flavier, 1990). This particular analogy is utilised because of the ready acceptance of the respect due to and the awareness of the vulnerability of the elderly in most peasant communities.

The format of this session was changed slightly . The toy-making was initiated directly after the maternal-child interaction game. The purpose of this was to give the children something to play with while the mothers discussed the issues. Learning from rolemodels is repeated to reinforce the basic concept introduced in the previous session and this theme is further developed to look at "labelling" and "acting out". Graphics are used extensively to demonstrate the skills of modelling, showing or teaching and describing and informing the child of the behaviour the parent considers desirable (Comic book pp. 14 - 17). The session is ended with a play session obstacle course made from waste cardboard boxes. The concepts of balance, control and cognitive spatial perception are encouraged and the use of a cardboard box lined with newspaper as a cooking "hot box" is

discussed. The week's homework consists of active practise, enlisting the child's co-operation utilising the skills discussed and continuing to play interactively with the toys made in this and other previous sessions.

SESSION SIX - "FIRST AID TO A CHILD IN DISTRESS"

At this stage of the programme, the researcher anticipated that a strong group support would have developed, any attrition would have occurred and the mothers would have moved into a position of being receptive to direct information on the child and a focus shift to prioritise the child would be acceptable. This and subsequent sessions shifted to make this distinction.

Session six looked at helping group members to recognise their children's distress and how to manage this effectively. This entailed more specific practice to reinforce previous learning on recognising feelings, most particularly in the child under five (comic book p.8-13). These previous graphics were reviewed and the facilitator mimed and acted while the group actively responded. Mothers did more drawings and children drew for the first time. Differences in the drawings and their relevance to effective communication were discussed. Different emotions were mimed with the face covered in an attempt to demonstrate the vital significance of the face in correctly interpreting and understanding feelings. Scenarios and maternal reactions to the photographic infant faces (eg crying, afraid, happy etc.) were discussed. Different options for maternal reactions were problem solved and the concept of "wishes in fantasy" and "first aid to child in

distress" from Faber and Mazlish (1980) was introduced (comic book p.18-21).

The session ended with more interactive toy making.

SESSION SEVEN - "TOOLS OF THE TRADE"

This session is used to reinforce the skills learnt over the previous six sessions and to develop an awareness of and self- confidence in the skills that all group members now possessed, and the ability they each have to direct their own lives. Non-punitive alternatives were initiated from the group which problem-solved the management of a number of real life scenarios. Consequences of behaviour and the choices we make, were introduced with graphic support (comic book p.22-24). The sessions ended with toymaking and homework including the concepts of "choice" and "consequences".

SESSION EIGHT - "I'M BIG ENUFF"

This is aimed at giving detailed information on the developmental stage of the child and age appropriate psychosocial behaviour, expectations and management strategies. The facilitator needed to take the age group of the children in the group into consideration and to prioritise these and/or any particular age related problems which had arisen from the group work. This was supported with graphics and the crying infant photograph (comic book p.25 -26). This could be a long session as it depended on the range of age of children in the group and the number of problems brought up, and had few distractions for the children in the

form of roleplaying or games. It was anticipated that there might well be some discipline problems experienced and the management of these within the group would be excellent practice of the skills learnt. The session was closed off with an additional mother-child action song and time permitting, further stimulating interactive toymaking from waste.

SESSION NINE - "IT'S OK I CAN HANDLE IT"

Continues reinforcement of previously learnt skills and involves extensive active roleplaying. The main aim of this session is to help parents learn the skills of limit setting, avoiding power struggles and encouraging independence in their children. The concept of parenting choices and "problem ownership" is introduced and problem solving around a number of common issues encouraged. Feelings of self-worth are reinforced and further toymaking, playing and interacting with children encouraged.

SESSION TEN - "THE LAST WORD"

This is the last session and entails final participant roleplay and discussion of praise, punishment and togetherness (comic book p.27). The concept of community support suggested by Friedman is introduced rather than the family meeting as utilised in the American parenting programmes. A large support system collage is made by each mother and child. The group is encouraged to continue meeting as a group and final debriefing of any problems is completed.

Each mother-child dyad takes home their comic book for family use.

Finally it is anticipated that the community health nurse who facilitated the programme will continue to see the participants at regular intervals and encourage any continued group support activities. Any maternal-child dyad identified as vulnerable or high risk during this programme will continue to receive the necessary additional support or referral as the situation demands.

4.6 FACILITATORS TRAINING

4.6.1 CURRENT NURSING ROLES AND SKILLS OF FACILITATORS

Nurses already provide biopsychosocial developmental assessment and anticipatory guidance in the clinic situation. They already provide family support in the clinic and in many areas by homevisiting and by developing community support groups.

As already mentioned in this research, the role of the public health nurse, district nurse or as she is known in South Africa the Community Health Nurse, has been found to be crucial in the early identification and reporting of abuse in the child under five and in the supportive care given to high risk families. McKeel (1985) and ISPCAN (1991) advocate that the nurse is the ideal health worker to provide parental support and guidance.

It is however also documented that many nurses find it difficult both to enquire into personal relationships and explore the emotional aspects of parenting (McKeel, 1985; Orkow, 1985)

In order to address this potential deficit in the community health nursing practice, the training of the community health nurse facilitators will need to ensure competence in this area as well as in basic counselling and interview skills and some experience of group work.

While these skills are important, the researcher also wanted to tap into the existent skills, sociocultural awareness, community knowledge and professional expertise of the community health nurse. The rationale for this was the need to maximise the potential of the existing health service providers to provide a more efficient, effective and preventive focused practice. Certainly with the current change in health policy towards Primary Health Care, this becomes even more significant.

The nurse group facilitator will be expected to rolemodel what she expects from the parent. Namely:

- * appropriate language usage
- * unconditional, non-judgmental caring, positive regard
- * democratic respect and acceptance of other feelings, attitudes, beliefs and behaviours

- * congruence and genuineness of words, actions and information consistency towards all group members
- * effective communication skills and concreteness, including listening skills and positive and negative feedback
- * encouragement of self-exploration within the safety of the group (no false "praise")
- * empathy
- * cognisance of developmental stages, particularly from birth to five years
- * encouragement of the presence of children in the group demonstrating the same mutual respect for their needs within the group

Five of these skills are basic to facilitating a therapeutic interpersonal relationship (empathy, positive regard, genuineness, concreteness and self-exploration) (Aiken & Aiken, 1973), and should be within the normal range of skills to be expected from a professional nurse.

4.6.2 SKILLS TAUGHT IN EXISTING TRAINING FOR PARENTING FACILITATORS

Rosenstein (1978), trained lay volunteers in a family outreach programme for high risk families. Essential skills and knowledge were identified.

The skills considered essential were:

- * listening and responding

- * problem identification
- * parenting skills
- * casework skills

The knowledge considered essential was:

- * the roles and characteristics of abusive and neglectful parents
- * knowledge of family communication systems and stages of family development
- * stages of normal child development
- * management of family crisis
- * awareness of cultural differences

From the skills listed above it could be expected that the community health nurse would possess all these skills with the exception of parenting skills. Similarly, she should have a good knowledge base in most of the areas considered essential. The two weakest areas anticipated were the specific knowledge of the roles and characteristics of abusive and neglectful parents and the management of family crisis. The latter would normally be referred to a community psychiatric nurse or social worker. The everyday scope of practice of these nurses covers child development, family practice and cultural awareness, and there should be competence in both knowledge and clinical practice in these areas. The extension of the community health nurse to include facilitation and anticipatory parental guidance would seem to be a necessary step in the proactive prevention of child abuse and neglect. Nursing education has attempted to address this by

introducing the "four year" comprehensive undergraduate course which includes general nursing, psychiatry, midwifery and community health nursing. Nurses who trained before this time might require additional training.

Hamilton (1989), emphasises the need for training of parents for the prevention of child abuse and neglect. Prioritising social skills, communication theory, positive reinforcement, knowledge of age-appropriate development (particularly psychosocial), anger management and empathy for one's children. Parents should be encouraged to allow themselves and their children the freedom to be imperfect and to make mistakes.

The effectiveness of support groups both self-help and home health visitor have been shown to reduce isolation, a major factor contributing to child abuse (Arch, 1978; Barth et al; 1991; Grey & Kaplan, 1980; Hamilton, 1989; Haynes et al, 1984; Rosenstein, 1978; Zigler & Weiss, 1985). It would seem important then for any intervention to encourage the participating group to maintain regular contact and to continue to emotionally support each other. This should be built into the developed programme and was included in the final session ten, where community support and togetherness are workshopped.

4.6.3 PLANNING AND IMPLEMENTATION OF FACILITATORS TRAINING

As mentioned in chapter three, the size of the group of facilitators which

responded and was accepted for the training course was thirteen. The final number present on day one was twenty one, and eighteen completed the three day course. This created a problem in that the researcher had planned on using a small group format and this had to be adjusted to accommodate a much larger group.

The limitation of this was that no practice facilitation could be implemented for trainees and this aspect of the training had, of necessity to be left to be addressed at a later date with the five facilitators who finally actually implemented the programme. A further limitation (both ethical and economic) was the supply of programme material to participants who had completed the course. Initially the researcher had thought to offer this material to all facilitators demonstrating competence on completion of the course. As a result of the much larger numbers and elimination of facilitation practice periods this was no longer possible. All participants were given the comic books to take home and encouraged to contact the researcher for a manual, should they be desirous of utilising the programme in the future.

A core programme of essential data was developed for the training programme. This covered the roles and characteristics of abusive parents, cross-cultural factors, the role of the community health nurse in the context of comprehensive primary health care, community involvement and child abuse prevention at primary, secondary and tertiary levels. Basic behaviour and communication theory and a brief overview of current parenting programmes.

This core content was interspersed between sessions of the developed programme and periods for questioning and clarification were offered. The facilitators were thus taken from theory to experiential learning and back again.

The researcher conceptualised that it was essential for all the potential facilitators to have experienced each of the ten programme sessions on a personal basis and to experience their own and the group's interaction and responses. The researcher rolemodeled the facilitator role.

A needs assessment approach was used in this training programme. This entailed frequent questioning and responding, and with the consent of the participants, the administration of a simple questionnaire, the Eyeberg Child Behaviour Inventory (refer Annexure C) (Eyeberg & Ross, 1978; Kelly, 1983). The core content was adapted according to the groups needs. The facilitators course was run over three consecutive, eight hour Fridays.

4.6.4 EVALUATION OF FACILITATORS TRAINING

4.6.4.1 Competence of trainee facilitators

The researcher identified from the needs assessment that there was already a strong knowledge base and awareness of many of the characteristics of child abuse and neglect and of the "Rights of the Child". This does credit to both nurse educators as well as the media publicity campaign which has nationally

highlighted the problem of child abuse both on radio, television, and in newspapers and fund-raising campaigns. As a result of this awareness, only the more specific roles and characteristics of abusive and neglectful parents needed to be covered.

The role of the community health nurse was less well perceived. The concept of Comprehensive Primary Health care was also surprisingly poorly understood. More time was spent on this in order to ensure that the trainees were comfortable with their roles and with the appropriateness of this intervention in a Comprehensive Primary Health Care Approach. This is of some concern to the researcher and would suggest that in-service education, particularly in this transitional period of South African history, would appear to be crucial to maintaining the professional confidence and competence of community health nurses.

There appeared to be a rather wide variance of knowledge concerning child development (particularly psychosocial development), whilst understanding of basic behaviour principles also varied, as did the perception of the significance of play.

As a result of this and the pilot study feedback, the researcher decided to include appendices to the developed manual to address this weakness and give support to the four experimental group facilitators (refer to last pages of developed manual).

The Eyeberg Child Behaviour Inventory, a 36 item questionnaire, was used to ascertain the needs of this particular group. This instrument was designed to be behaviourally specific to assess the parental report of behaviour problems in children. It has reliability coefficients of 0.86 (test-retest) and 0.98 for internal consistency. It is used for both the assessment and the study of the treatment effects on behaviour problems in children (Eyeberg & Ross, 1978; Kelly, 1983).

The results indicated the most common problem child behaviour management areas for this particular group of community health nurse trainees (twenty of the initial twenty one participants were parents and completed this questionnaire).

Of the thirty six possible behaviour problems, the following eighteen were a problem for more than half the parents, occurring "often" to "always".

These were:

- 1) Refuses to obey until threatened with punishment (85%).
- 2) Refuses to go to bed on time (80%).
- 3) Dawdles or lingers at mealtime (75%).
- 4) Careless with toys and other objects (70%).
- 5) Refuses to eat food presented (70%).
- 6) Teases or provokes other children (65%).
- 7) Gets angry when doesn't get own way (65%).
- 8) Dawdles in getting dressed (55%).
- 9) Cheeks adults (55%).
- 10) Verbally fights with peers (55%).

11) Verbally fights with siblings (55%).

The following seven were rated as problematic by 50% of the participants -

Lies/ Acts defiant when told to do something/ Fails to finish tasks/ Physically fights with siblings/ Physically fights with peers/ Destroys toys/ Whining.

The researcher used these findings to practically implement her conceptual framework and give the potential facilitators a meaningful experience of the developed programme. This was accomplished by prioritising these problems during the roleplay and discussions of the developed programme. Discussion during the sessions led to three disclosures of past physically abusive behaviour. All three incidents of abuse had occurred when the children were considerably younger. The said children were all presently teenagers and not currently at risk. These folk were given support, empathy, and understanding by the entire group which became a cohesive unit after day one of training. Support services were discussed.

The ability of the trainees was assessed during their participant roleplaying. All participants were given the opportunity to roleplay and practise skills, utilising both the programme scenarios and scenarios from their own real life experiences. As mentioned, owing to the large group size, trainees were unable to actually practice group facilitation skills during this three day course.

Finally the participant trainees completed the Knowledge of Behaviour Principles Test, a 50 item questionnaire (Refer Annexure D), in order to identify whether

a basic understanding of behaviour principles existed (Kelly, 1983; O'Dell, Tarler-Benlolo & Flynn, 1979). This was not the optimal evaluation test to give as the support programme encompassed much more than behaviour modification and there had in fact been only a short introduction on basic behaviour modification theory and techniques. The researcher wanted to test to what extent this basic introduction was sufficient to complement the existing training of the community health nurses, and if the additional data supplied by the programme appeared to have any influence. A pre and post test would have given a more accurate picture and was a limitation of this aspect of the study. In order to ensure competence of facilitators an evaluation test more specifically related to the content of the developed programme should be developed and utilised in the future.

The results of this test indicated that 77% of the trainees had an adequate understanding of behaviour principles (mean score was 61% on the test). This was of particular interest to the researcher because as mentioned this particular test looked only at behaviour modification principles. This was only one of the areas to which the trainees had been exposed. The experiential awareness and empathy for the world of the child which had developed in the trainee facilitators was suggested in a number of the "incorrect" answers which were given. This was noted particularly in the following responses:

Question 3 - Problem behaviour in young children, was answered as being due either to a lack of communication or to a stage which the child will outgrow

rather than as "accidentally taught by the child's family", this might well be indicative of the influence of the developmental and communication skills learnt.

Question 10 - which requests the respondent to choose the "best type of punishment" from four alternatives, was answered by all respondents as "clearly express your disapproval" rather than as "remove to boring situation", which was again one of the skills taught during the sessions eg. A child of under five needs to know both what is expected and that which is disapproved of, or not desired before punishment is attempted. While the behaviour principle of "time out" is most effective in behaviour modification, the humanistic school of thought gives support to improving positive interpersonal relationships in the guidance of behaviour rather than merely "training" as one would for a domesticated animal.

Question 26 on physical punishment was answered by 50% of respondents as - mild and immediately following undesirable behaviour, by 44% as ineffective and undesirable and by 16% as the correct behaviour modification response of "following the undesirable behaviour and at full intensity". These responses again would indicate the possibility of empathic understanding following the support programme experience. This was of particular interest to the researcher as she observed that the sessions which received the most animated responses and comments from the group were sessions four and six, "Does Smacking Work" and "First Aid to a Child in Distress".

Question 30 was answered "correctly" as for behaviour modification by only 16%

of trainees. Sixty one percent answered that the "boys would grow out of it". This again demonstrates the strong developmental focus of the programme.

Question 31 was answered by 88% of respondents with an interest in exploring the child's feelings or with utilizing distraction. Only 16% answered "correctly" with "reward when crying stops".

The four participants who did not score adequately on this test were the same participants who demonstrated difficulties in practical utilisation of the skills. These participants require further input before facilitating a support programme. As discussed in chapter three under sampling of facilitators, the final choice of facilitators was nonprobability, and while dependent on competence, was primarily dependent on logistics. The five trainees who finally participated as facilitators in the pilot and four experimental sites all scored adequately on this test (mean of 64%) and demonstrated practical understanding of the skills during the sessions. The two sites which finally successfully completed the support programme, had facilitators with a mean score of 78%, which was considerably higher than the score for the remaining facilitators and requires discussion in the study's final results and recommendations.

4.6.4.2 Trainee Facilitators evaluation of training course

Participants were asked to complete an evaluation of the three day training course (refer Annexure E). In this evaluation 88% of the participants rated the course

highly as a worthwhile programme and 12% as a moderately worthwhile programme. There were no negative ratings.

Only one respondent noticed no changes in the group, their family or children, yet this same respondent rated the course highly and requested more courses of the same nature. Sixty six percent of the participants noticed some changes in the group, their family or their children and 27% noticed a lot of changes.

Things Liked by participants:

All participants had some positive feedback to give. The course was described as "creative, practical, simple and realistic". The most mentioned aspects enjoyed were the toy making from waste (55%), the understanding of participant's own and the feelings/perspective of children and "I-messages" (33%) and the group discussion, roleplay and graphics (27%).

Things disliked most by participants:

Several participants found the three days too intensive and would have liked shorter sessions, and in their service setting as part of their in-service training. The distance travelled was also a problem for several participants (some faced two to three hour trips to and from the course which ran from 0830 hrs to 1630 hrs). One participant wanted the course to be shorter and saw the play material as superfluous. Of note here was that only eighteen participants completed the

course. There was an attrition rate of three from the original number of twenty one. The researcher was only able to contact one of these three. The reason given by this nonparticipant was length of journey (two hour) and the child play. This was of interest in the light of the emphasis placed in current undergraduate nursing programmes on the importance of developmental play and the discussion (refer 4.3.5 on the interactive principle) on the poor perception of transitional communities on the significance of play. This would indicate a need for in-service education in this area.

Those participants who were childless missed not having a child of their own to observe. Despite the open invitation to bring their children, only one participant actually did so. One participant would have liked to have done so had travel distance been less, and actively verbalised sadness at their non-participation.

Additional comments made:

More than half of the participants made an additional comment that this type of training should be more widely available, both during basic nursing training and later in-service training. It should also be offered to teachers at creches, preschools, schools and other health care workers. All participants volunteered to participate in the research and left contact details with the researcher.

4.7 FACILITATORS PREPARATION

The facilitators should demonstrate competence and willingness to organise and direct the developed programme. She or he will be expected to have become familiar with material presented in the developed programme and be familiar with the cross-referencing of material. This involves the introductory instructions and appended support literature, preparation of the basic requirements for each session, familiarity with the content of each session, including the link between the manual, comic book and graphics flipchart. There should be a conscious awareness of the facilitator's role now being played rather than the group member role experienced during the training.

For the purposes of this study and for the reasons mentioned below under the evaluation of the facilitator's training, this material together with the research requirements, was worked through on a one to one basis with each site facilitator who initiated this programme in their clinical practice and participated in the study.

CHAPTER FIVE

ANALYSIS AND DISCUSSION OF RESEARCH FINDINGS

5.1. SOCIODEMOGRAPHIC FINDINGS

5.1.1 BRIEF ANALYSIS OF SOCIODEMOGRAPHIC FINDINGS BETWEEN SITES

It is necessary to briefly look at the sociodemographic similarities and differences between sites (refer summary Table 5.1 on following page). Particularly in the light of the non-completion of sites 3 and 4. This brief discussion is followed by specific sociodemographic clarification of the data realisation for analysis.

a) Maternal age over the four sites was within the study criteria for mothers who were under 35 years of age. The mean maternal age in all four sites was very similar (29.3 yrs, 30yrs, 27.81yrs, 38.81 respectively). The overall mean maternal age for all four sites was 29.5 years. Of interest and worthy of comment is the range in maternal age. The three groups which were taken from poor black and asian community sites all had some younger mothers while in the caucasian

site all mothers were twenty five years or over. This is likely to reflect both the economic and the cultural lifestyle of these sites. The caucasian group was a middle income group while the other three were lower socio-economic, lived below the poverty data line, and showed evidence of the developing country trend of early childbearing.

Table 5.1 Summary table of mean maternal age, years married and educational status across all four sites.

SITES	Mean Maternal Age	Mean number of years Married	Mean Educ.Standard of schooling completed
1	29.3 yrs	5.8 yrs	Std. 10
2	30 yrs	6.9 yrs	Std. 5.3
3	27.8 yrs	8.6 yrs	Std. 5.6
4	30.8 yrs	11 yrs	Std. 6.5
MEAN	29.5 yrs	8 yrs	Standard 6.85

b) The family size of sites 1 and 2 fell within the range of one to five children (refer Table 5.2 overleaf). In site 1 the majority of families (60%) were two children families. There was only one family of five children and this fell into the experimental group. This site tended to have a small family size with relatively older mothers. In site 2 most families (60.1%) had three to four children. In site

3, 75% of families had two to three children and in site 4, one third (37.5%) were two children families. Site 4 had a limited number of only eight participants. This is a very small sample and possibly not representative of the larger community. Of interest is the fact that while this group presented on the whole with fairly small families (25% one child and 37.5% two), it also had some of the largest families (25% six children).

Table 5.2 Summary of the number of children in the family for each site expressed as a percentage for the sum of all groups in the site.

NO	SITE 1	SITE 2	SITE 3	SITE 4	Tno
1	(5) 33.4%	(2) 13.3%	(3) 18.75%	(2) 25%	(12)22%
2	(9) 60%	(2) 13.3%	(4) 25%	(3) 37.5%	(18)33%
3		(5) 33.4%	(8) 50%		(13)24%
4		(4) 26.7%	(1) 6.25%	(1) 12.5%	(6)11%
5	(1) 6.66%	(2) 13.3%			(3)6%
6				(2) 25%	(2)4%
T =	(15) 100%	(15) 100%	(16) 100%	(8) 100%	(54)100

The varying family size across sites is clearly demonstrated in the summary table above). The trends of childbearing can be seen more explicitly on looking at the age range of children in these families. Given the maternal age limit of thirty five

and given that the mean age for all groups was 29.5 years, one can infer that for those mothers with five or six children, childbearing would have commenced in the late teens with a pregnancy every two years to achieve this family size. Had the researcher looked at an older maternal range, family size could have been expected to be much larger, particularly in the rural site. This trend can be seen in the two over age participants (excluded from analysis) who were 39 and 40 years old and had five and nine children respectively.

c) Age of children. Site 1 included primarily small families (50% under two years) with most (82.2%) of the children fairly closely spaced and under five years (refer Table 5.3 overleaf). Site 2 showed a spread from infancy to eighteen years with 43.4% under five years and 56.6% between six and eighteen years indicating the spread of childbearing years in developing or third world communities which was found in this sample site. Site 3 was similar to site 2 in that a spread from infancy to adolescence can be seen. This site sampled asian subjects from a lower economic periurban site and the spread of childbearing is demonstrated as for site two. The largest groupings being in the three to five (38.6%) and six to ten year (28%) age group (together total 66.6% of the sampled children). Site four shows a similar spread across ages as do site two and three. This is in line with the previous mention above of the connection between maternal age and continuous childbearing in developing regions. This site is a black, periurban lower socioeconomic area. Most children fall into the three to five and eleven to eighteen age range (29.2%). There is a slight difference in this group compared to the other three groups in the large number of children falling

into the eleven to eighteen category (29.2%). This would suggest that for this periurban site there were more early adolescent pregnancies than in the other three sites.

Table 5.3 Summary of the ages of children across all four sites.

Child's Age	Site 1	Site 2	Site 3	Site 4	Total
0-2 yrs	(14) 50%	(7) 15.2%	(7) 18%	(4) 16.6%	(32)23.4%
3-5 yrs	(9) 32.2%	(13)28.2%	(15)38.6%	(7)29.2%	(44)32.1%
6-10 yrs	(3) 10.7%	(17) 37%	(11) 28%	(6) 25%	(37)27%
11-18 yrs	(2) 7.1%	(9) 19.6%	(6) 15.4%	(7) 29.2%	(24)17.5%
Total	28 100%	46 100%	39 100%	24 100%	137 100

d) **Gender** spread across sites uniformly showed slightly less male than female children (refer Table 5.4 below).

Table 5.4 Summary of gender of children in sampled sites

	SITE 1	SITE 2	SITE 3	SITE 4
MALE	46%	48%	48.72%	45.83%
FEMALE	54%	52%	51.28%	54.17%

e) **Marital status** varied across sites. All participants in sites 1 and 3 were married. This would seem to be indicative of the cultural influences (caucasian and asian) which strongly disapprove of children out of wedlock. Site 1 had a mean years married of 5.8 yrs and a range of 2-9 yrs. Site 3 had a range of 3-12 yrs marriage and an overall mean of 8.62 yrs. This is of note in that this site had the youngest maternal age (27.81yrs) and also the longest years of marriage. This would seem to be congruent with the Indian culture where marriages occur commonly in young adolescence.

Sites 2 and 4 were very different to the above. This would also appear to be indicative of cultural influences. These groups were both of the Nguni culture where there is not the same pressure to marry as in western and eastern cultures. The difference between a traditional marriage, western marriage or living together also tended to be obscured in these sites. For both these sites rather than spend time on the complexities of marriage perceptions, the researcher took all those who had been cohabitating for more than a year as "married". This gave a picture in site 2 of 73 % and site 4 of 37.5% who were considered married and the remaining were single mothers with children. Years of marriage ranged in site 2 from 2-11yrs together and in site 4 from 5-18yrs together. Of particular note in this respect is site 4, where only two of the eight participants were married. Despite the small sample size this meant that 62.5 % of the mothers in this site were not living with a permanent male partner in the household.

f) **Educational** levels varied from no education at all to a standard ten educational

level (12 years schooling) which was the cut off point for this research. From this it can be seen that site one consists of mothers with a fairly high level of schooling but no tertiary education. Site two has a fairly wide variation of educational levels; of particular note is that the majority of mothers have standard five or less education (66.6%) and the remaining 33.4% all have standard eight to ten (refer Table 5.5 below). It would appear that those who did not drop out of school before standard five all continued to standard eight and upwards. It would be interesting to know how many of the latter dropped out of school because of pregnancy, particularly in the light of the data above which shows the wide spread of children's ages within the families in this site. Sites 3 and 4 showed a similar pattern to site two, most mothers (56.3% for site 3 and 50% for site 4) completing standard five or less schooling and there is a wide spread of childrens ages within the family.

Table 5.5 Summary of educational status across sites

Educ.std.	SITE 1	SITE 2	SITE 3	SITE 4
0 - 3		(5)33.3%	(5) 31.3%	
4 - 5		(5) 33.3%	(4) 25.0%	(4) 50.0%
7 - 8	(3) 20%	(1) 6.7%	(5) 31.3%	(3) 37.5%
9 - 10	(12) 80%	(4) 26.7%	(2) 12.4%	(1) 12.5%
TOTAL %	(15) 100%	(15) 100%	(16) 100%	(8) 100%

g) Religion and Ethnicity.

As mentioned in the detailed discussion of the sites, sites 2 and 4 were nguni, zulu speaking communities, site 1 was caucasian and english speaking and site three was asian and english speaking.

Site 1, 2 and 4 were all christian. Site 3 was mixed christian, hindu and moslem. Religion needs to be considered initially because of the inclusion of this aspect in the intervention programme. Site 1 felt uncomfortable about including religion and this part of the intervention programme was left out in this site. Site 2 and 4 utilised the religious aspects of the intervention programme, felt comfortable with it and this was well accepted.

Site 3 did not utilise the religious aspects of the intervention programme because of the difference in religious affiliation within this group. The limitations of mixed ethnicity (facilitator caucasian), different religious affiliation and the Asian caste system created major difficulties within this group. These will be discussed later when the non completion of sites 3 and 4 is discussed.

5.1.2 SOCIODEMOGRAPHIC FINDINGS FOR DATA REALISED.

a) Maternal Age - This ranged from 22yrs to 35yrs. The mean of the experimental group and control group 2 (clinic), were very close (30.5 & 31.5 yrs). Control group 1 (support) were a little younger with a mean age of 27.7yrs (refer summary Table 5.6 overleaf).

b) Number of years married- This ranged from 2 to 11yrs. The mean number of years married of the experimental and control group 1 (support) were very similar (6.4 & 6.5 yrs) and the control 2 (clinic) was slightly less.

Table 5.6 Summary of sociographic findings for the three groups of the research design.

GROUP	Mean Maternal Age	Mean years of marriage	Mean of School Standard of Educat.	No. of children under 5	Gender of under 5's	Mean age of under 5's
Exper.	30.5 yrs	6.4 yrs	Std. 7.8	17	F=9 M=8	2.76
Contr1	27.7 yrs	6.5 yrs	Std. 4.46	14	F=7 M=7	3
Contr2	31.5 yrs	5.6 yrs	Std 7.46	12	F=7 M=5	2.83
TOTAL	X=29.9 yrs	X=6.1 yrs	Standard X=6.57	T=43	F=23 M=20	X=2.86

c) Educational level- This ranged from nil schooling to standard ten (12 years formal schooling). The mean educational standard achieved was very similar for the experimental and control group 2 (clinic)(7.8 & 7.46), but considerably less for control group 1 (support) (4.46).

d) Number of children under five - there are a number of children under five as may be noted from the summary Table 5.6. and this was to be expected as it was a prerequisite of the research. The experimental group was the largest group $n=13$ and as was to be envisaged had the largest number of under fives (17). The experimental mothers had a total of three infants under 1yr. These did not participate in the intervention. This left a total of 14 children and 13 mothers who participated in the intervention programme. The mean age of children under 5yrs was similar for all three groups (2.76, 3, & 2.83). The spread of male to female, being slightly less male, was similar for all three groups.

e) Family size - This ranged from 1-5 children per family. There were a total of 36 children in the experimental group, 20 in control group 1 and 18 in control group two.

Table 5.7 Ages of all children in the family for the three research groups.

AGE	Experi. Group	Control 1 (support)	Control 2 (clinic)	Total
0-2	(9) 25%	(7) 35%	(6) 33%	22
3-5	(8) 22%	(7) 35%	(6) 33%	21
6-10	(10) 28%	(5) 25%	(5) 28%	20
11-18	(9) 25%	(1) 5%	(1) 6%	11
Total	(36) 100%	(20) 100%	(18) 100%	74

The larger number in the experimental group is the result of the larger sample size (n=13). As can be seen from the table above the experimental group has an almost equal distribution of children under and over five. The two control groups however have more children under five (70% & 66%) than over five (30% & 34% respectively). The number of older children in the family is of particular interest to the researcher who was keen to ascertain whether the graphic comic book would be read by the older children in the family.

5.1.3 CLARIFICATION OF DATA ANALYSIS

This was an eight cell design which included the experimental group, control 1 (which received social support) and control 2 (which received only normal clinic attendance) in a pretest - posttest - posttest (refer Table 5.8 below).

Table 5.8 Eight cell research design.

GROUPS	Pretest Data	Posttest 1 Data	Posttest 2 Data
Experimental group	X	X	X
Control group 1 (support control)	X	X	X
Control group 2 (clinic control)	X	X	No data gathered

In the initial analysis, data from site 1 and site 2 was combined to form three data

sets, the experimental group, the control group 1 and the control group 2. At this stage of the analysis graphs are marked 1=experimental, 2=control 1 (support), and 3=control 2 (clinic).

In order to understand and explain the results more fully - these data sets were broken down further to gain insight into the changes or gains established in the initial analysis. Data from sites 1 and 2 are separated to enhance understanding of the gains established. Graphs at this stage are marked according to the comparisons being made. From this point on where site 1 and 2 are combined they are called "combined group" and where the sites are divided they are named for experimental or control **and** for which site they represent.

There were 15 respondents from site 1 (8x4x3) and 15 from site 2 (5x5x5). The total sample size was $n=30$. The experimental group was $n=13$, the control 1 (support) group was $n=9$ and the control 2 (clinic) group was $n=8$. Combining site 1 and site 2, increased the sample size and the power to reject the null hypothesis and avoid a type one error. Another technique of improving the power (the chance of rejecting a false null hypothesis and accepting a true alternative hypothesis) is to compute the **difference** between the pre and post tests, which allows one to conduct a t-test and analysis of variance with confidence. The rationale for this is that the differences between scores more often approximates a normal distribution than does the original measure (Mosteller & Rourke, 1973).

It was important to check for normality of distribution as outliers could lead to

"significant" result when the rest of the data showed little effect. A stem and leaf display was used to indicate the distribution of the variable, show outliers, groupings and peculiarities. The stem and leaf diagram below indicates a "non-normal" looking distribution.

n=5

2 5

1 5

0 0,0,5

n=8

3 0,0,

2 0,0,

10,0,5,5,

The small sample size and precarious assumption of normality meant that the researcher should take cognisance of the need to substantiate results from parametric analyses by also computing non-parametric analysis that do not rely on the presumption of the data falling within a normal distribution eg not rely heavily on the explicit parameters of the distribution. The parametric t-test and F-test are regarded as more powerful than other statistical tests (Roscoe, 1969). In addition to a parametric t-test, nonparametric tests such as the Mann-Whitney ranks test, which is almost as powerful as the t-test (95% relative power) (Roscoe, 1969) and the most robust or sturdy of the non-parametric tests (Mosteller & Rourke, 1973) was utilised.

The Signs test was computed as it does not require normality of distribution and it offers some protection against very large differences by weighting all measures equally (Mosteller & Rourke, 1973). The latter is not as powerful as the Mann-Whitney rank test.

The Kruskal-Wallis analysis of variance was also utilised. This is a non-parametric one-way analysis of variance using ranks rather than original measurements and thus appropriate for use with nonnormal data.

5.2 ANALYSIS ACCORDING TO INSTRUMENTS

5.2.1 MOTHER-CHILD RELATIONSHIP RESULTS (Hypothesis 1 and 3)

The Mother-Child Relationship Evaluation (MCRE)

This test has been enlarged on in chapter three. It is a 48 item instrument divided into four subscales of 12 items each. These subscales are acceptance (A), overprotection (OP), overindulgence (OI) and rejection (R). Raw scores for each scale range from 12 to 60. The higher the scale score the greater the attitude and the lower the scale score the lesser the attitude. Due to the relatively high error estimate, it is recommended that scores between the 25th and 75th percentile should be interpreted with caution (Roth, 1980). Both **short-term (A)** and **long-term (B)** data analysis were initiated.

A) SHORT-TERM ANALYSIS OF MCRE (Hypothesis 1)

Summary statistics were computed for the **difference** between the pre and post test scores. Minimum scores were -1.23 and maximum were 4.91 with a range of 6.15. The mean was 1.07 and the standard deviation was 1.53. The median was less than the mean indicating a slight positive skew. There was some approximation of normality from the computation of the differences between pre and posttest scores, but normality could not safely be assumed. Non-parametric tests were primarily used. These scores were used to compute a Signs test, a Mann-Whitney Ranks test, t-tests, various one-sample analysis of variance (ANOVA) and several Kruskal-Wallis analyses.

a) Signs test

A Signs test was carried out on the pre and post test scores of the combined experimental groups from sites one and two. This was found to be significant. The Z score = 2.2188 and the two-tailed probability of equalling or exceeding Z is 0.0265.

b) t-test

Finally a t-test was conducted. Results indicated that $t = 4.151$ at a significance level of 0.0013. Therefore the null hypothesis (H_0) may be rejected at the standard $\alpha = 0.05$ level as these results can be seen to be highly significant

and to support the results of the signs and rank tests. The intervention clearly led to a change in the maternal-child relationship.

c) Kruskal-Wallis one-way-analysis of variance

This non-parametric analysis was conducted before the analysis of variance (ANOVA). This is a robust version of the one-way ANOVA, utilising ranks in order to reduce the effects of highly deviant scores. This was initially conducted on the combined experimental sample ($n=13$) and combined four control samples ($n=17$). This was a measure of the gains between the pre and post scores. The test statistic computed $H = 4.0374$ at a significance level of 0.04. A significant result. Figure 5.1 overleaf graphically indicates these gains on the MCRE.

Box and Whisker Plots
for Factor Level Data, MCRE Gains

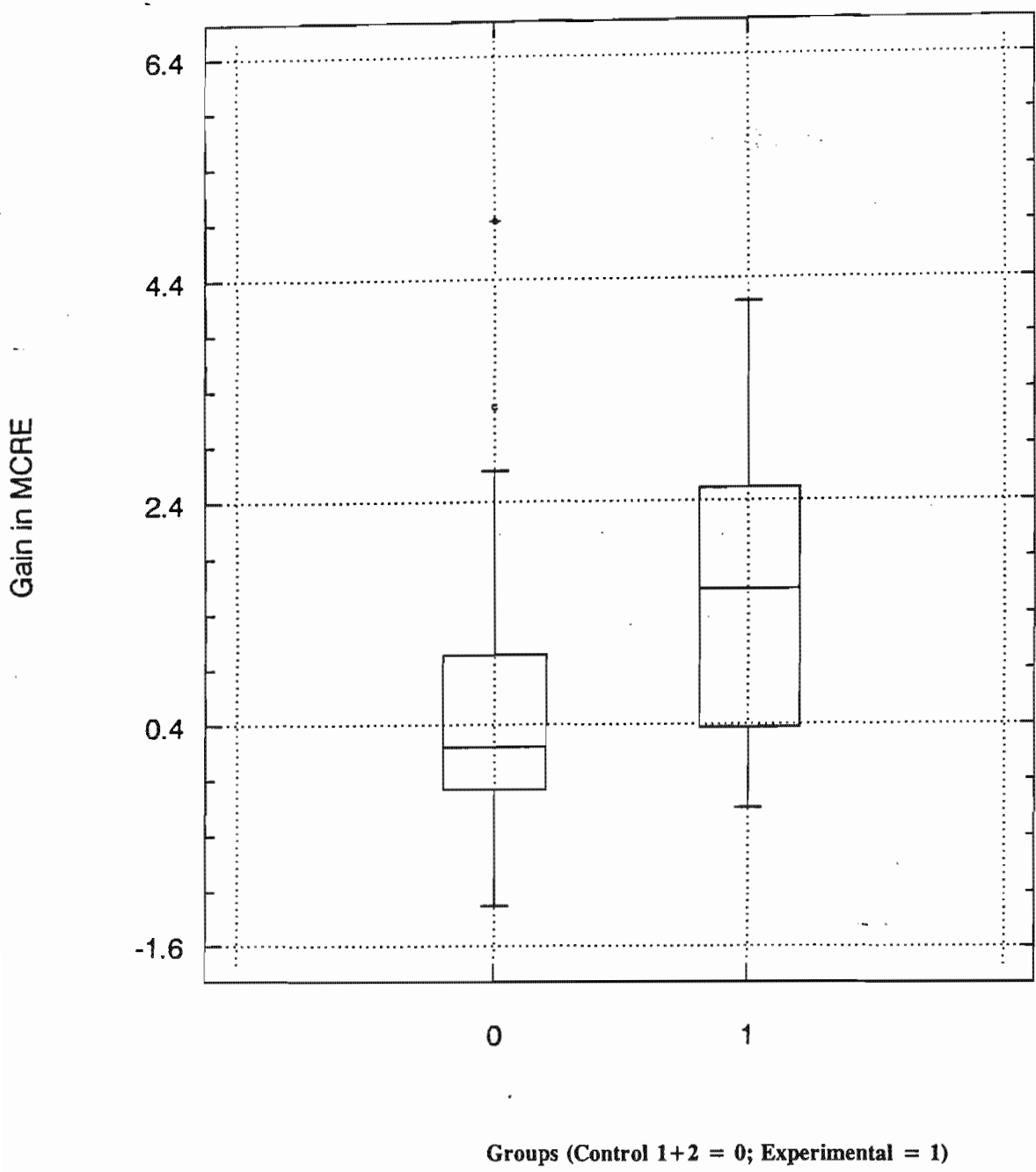


Figure 5.1 Gains from pretest to posttest for the MCRE for the control and experimental groups.

A further analysis of variance was computed for **all** groups. This gave an H statistic of 17.4106 at a 0.003 level of significance that is very obviously, a significant result. Figure 5.2 graphically demonstrates the gains and the differences between each of the six groups and clearly shows the outliers and non-normal distributions that plague conventional statistical tests such as ANOVA.

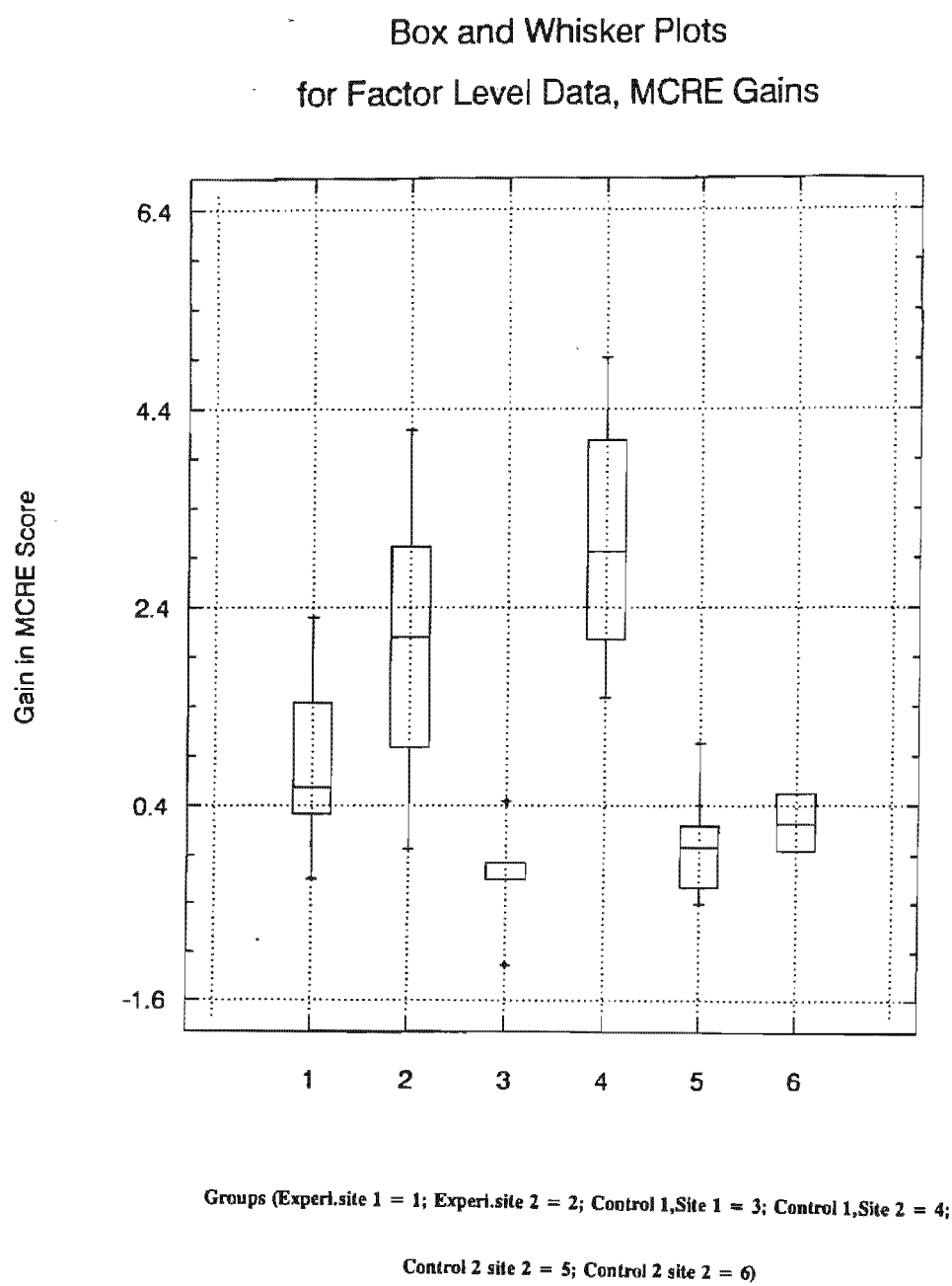


Figure 5.2 Gains from pretest to posttest for the MCRE for all six groups

Yet further analysis identified that despite significant gains between experimental and control groups (Figure 5.1) and within the total sample (Figure 5.2), analysis of the groups (experimental, control 1 and control 2) indicated no significant gains. Figure 5.3 illustrates this graphically. The experimental and control group 1 (support) have marked gains over control group 2 (clinic).

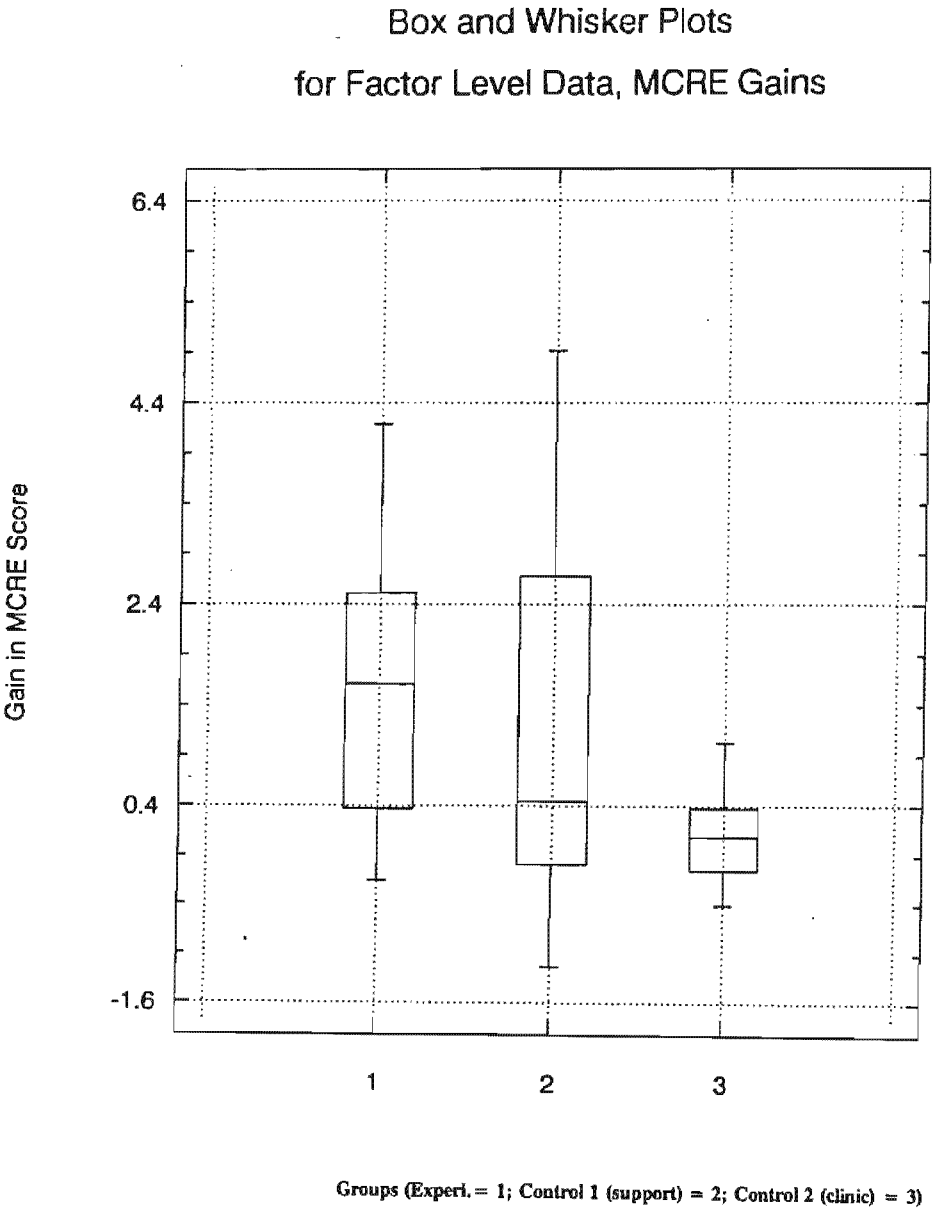


Figure 5.3 Gains from pretest to posttest for the MCRE for the groups; experimental, control 1 and control 2.

The researcher then split the control group 1 (for site 1 and site 2) and computed a further analysis of the combined experimental, split-site control group 1 (support) and the combined control groups 2 (clinic). This computation showed the "bestgroup" gains from pre to post test. $H = 15.5738$ at a significance level of 0.0013. This is clearly demonstrated graphically on the box and whisker graph (refer figure 5.4). Of particular note is the highest gain which occurred in the site two control group 1 (marked 3 on plot). This was higher than the experimental group (marked 1 on plot), which also shows gains. The site one control group 1 (marked 2 on plot) and both sites combined control group 2 (marked 4 on plot) show relatively no gains. This indicates that the combined experimental group (marked 1) showed gains over the combined control group 2 (clinic) (marked 4) and that in site one the control group 1 (support) showed no gains (marked 2). However the site two control group 1 (marked 3) shows significant gains.

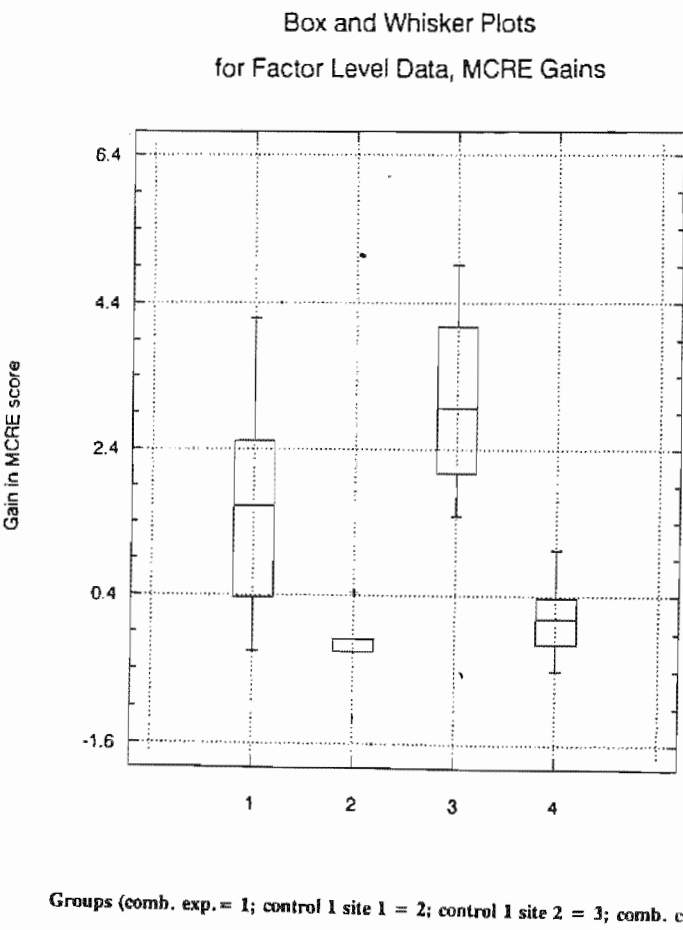


Figure 5.4 Bestgains from pretest to post test for the MCRE, with control group 1 divided into

d) One-Way Analysis of Variance (ANOVA)

This was computed for variation between and within groups and gave an F statistic of 7.031 at a significance level of 0.0004, a powerful support of the Kruskal-Wallis results discussed under (c) above. Further ANOVA analysis of the experimental and control groups failed to show significant results. Guided by this and the results from the Kruskal-Wallis computations the researcher split the two control group 1's (support) into site one and site two, and recomputed the "bestgains" ANOVA against the combined experimental group and combined control 2 (clinic) groups. This supported the findings for the similar computation of the Kruskal-Wallis analysis. This ANOVA result gave an F-ratio of 9.771 at a significance level of 0.0002; a highly significant result requiring further discussion as indicated above.

The above findings show clear evidence that changes have occurred during this study. The researcher was interested in delving more deeply into the gain changes observed and observing the changes which occurred particularly between the scale of **acceptance** and the **other three non-acceptance scales** of the MCRE. The computed scores for these scales showed interesting features. The medians and means were fairly close for all four scales being 3.4 & 3.3 respectively for acceptance, 2.6 for both in overindulgence, 2.7 & 2.8 in overprotection and 2.6 for both in rejection. The variance was relatively small being 0.1 for acceptance and overindulgence, 0.23 for overprotection and 0.07 for rejection.

The pre and post test gains in **acceptance** are clearly demonstrated by the series

of box and whisker plots below and follow the similar unusual pattern identified just observed in the MCRE gains. Figure 5.5 shows the control groups compared with the experimental groups. This ANOVA was significant at a 0.02 level of significance (F-ratio 5.62).

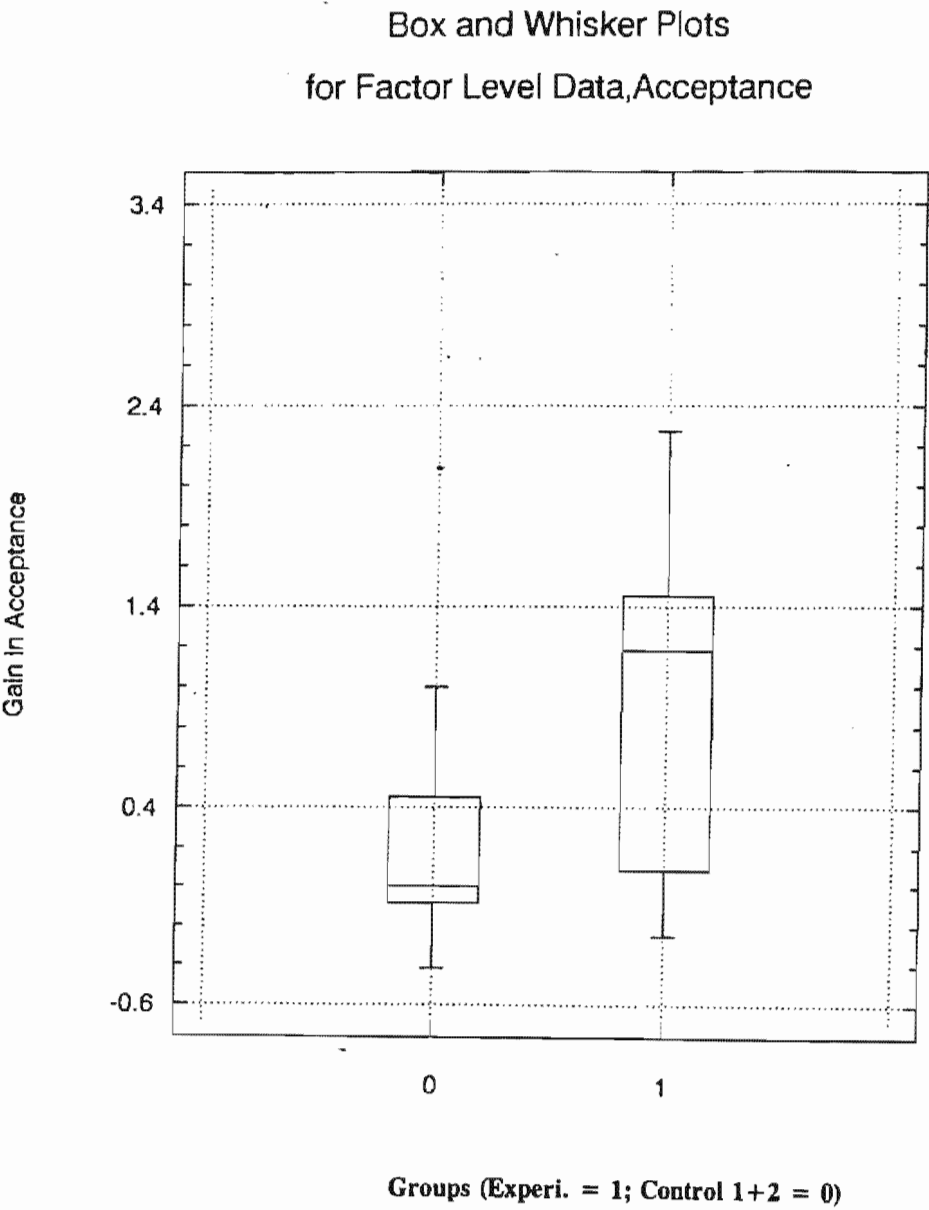


Figure 5.5 Gains for ACCEPTANCE in combined control groups and experimental groups for the MCRE.

The gains for the combined experimental groups, the combined control group 1, and the combined control group 2 were computed. Yet again the control group 1 (support) appears to have more gain than the experimental group and both vary from the control group 2 (clinic). The ANOVA was significant at 0.02 level of significance (F-ratio 4.29). Figure 5.6 graphically shows the gains in the three groups.

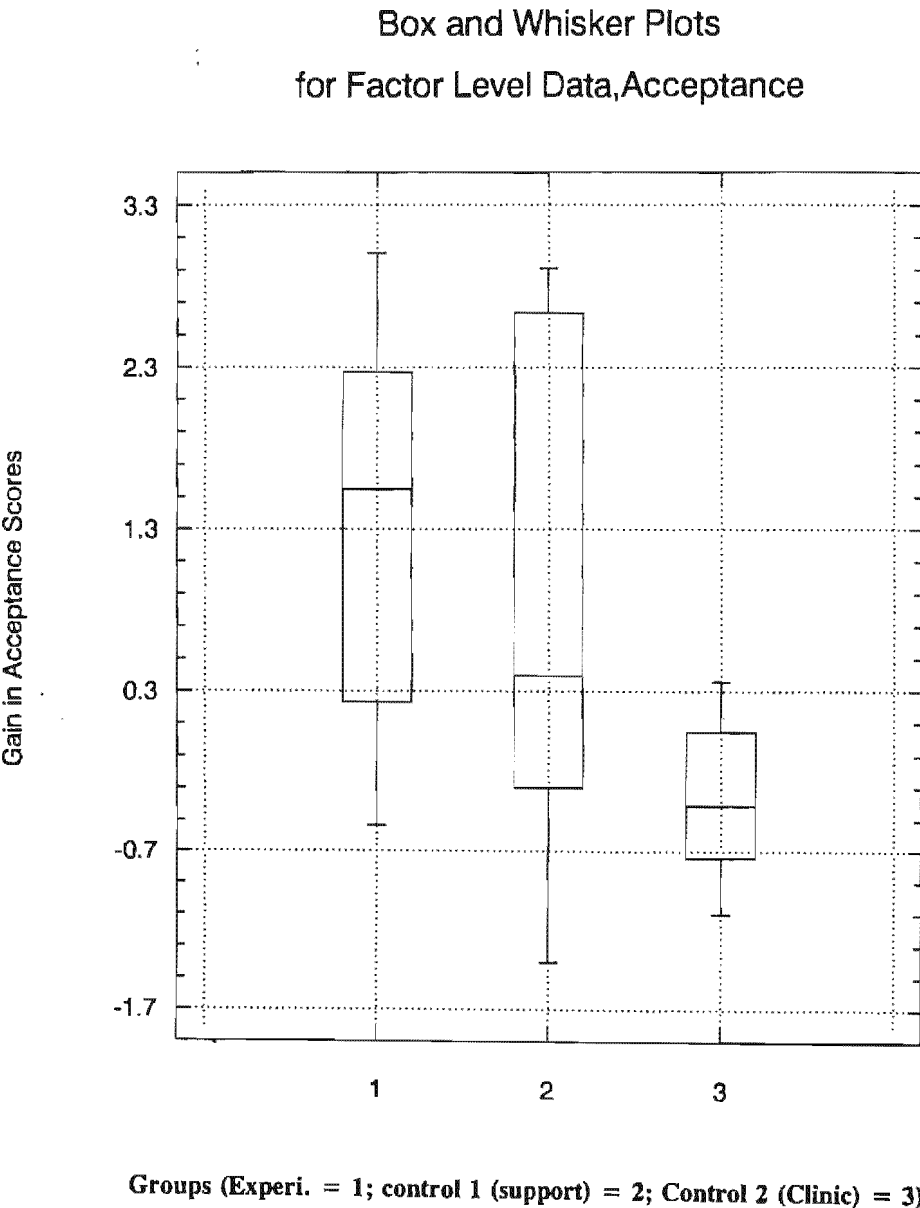
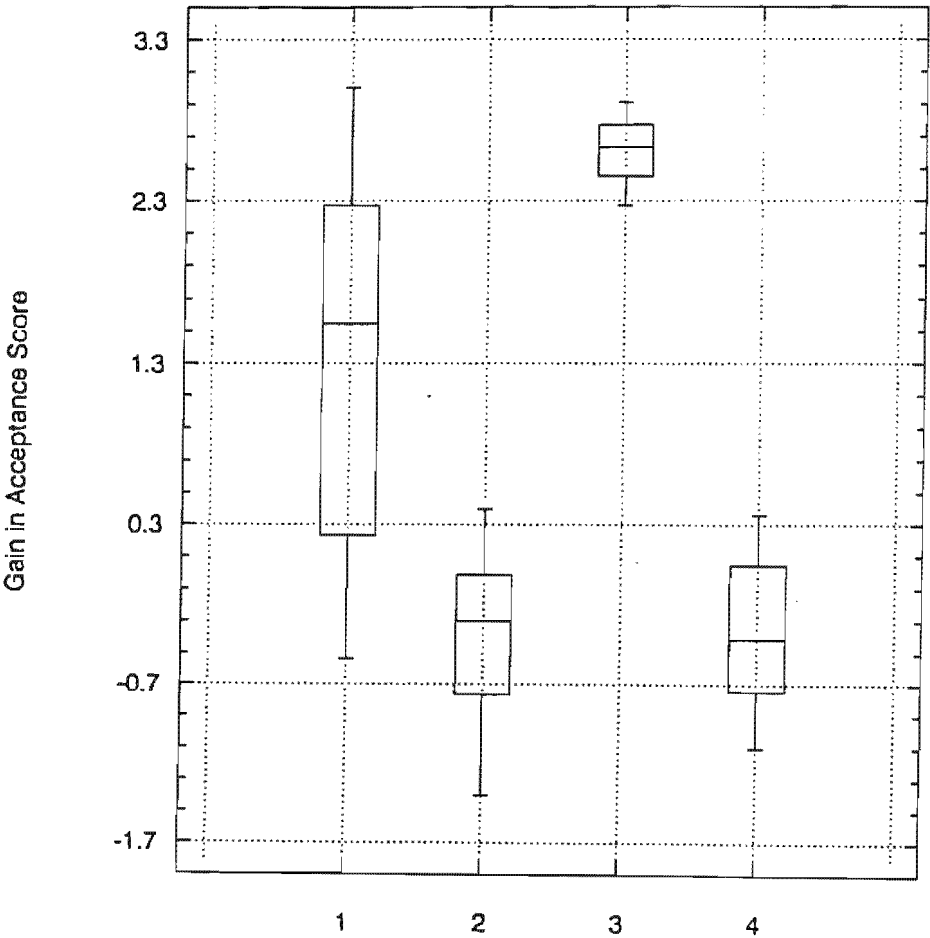


Figure 5.6 Gains for ACCEPTANCE for the experimental, control 1 and control 2 groups for the MCRE.

The "best gains" group (figure 5.7) with the split-site control group 1 (support) against combined experimental and combined control group 2 (clinic), shows dramatically both the gain in acceptance in the experimental group (marked 1) over the clinic control 2 (marked 4) and the dramatic gain in the control group 1 (support) in site two (marked 3). The ANOVA was significant at 0.00 level of significance (F-ratio 12.97)

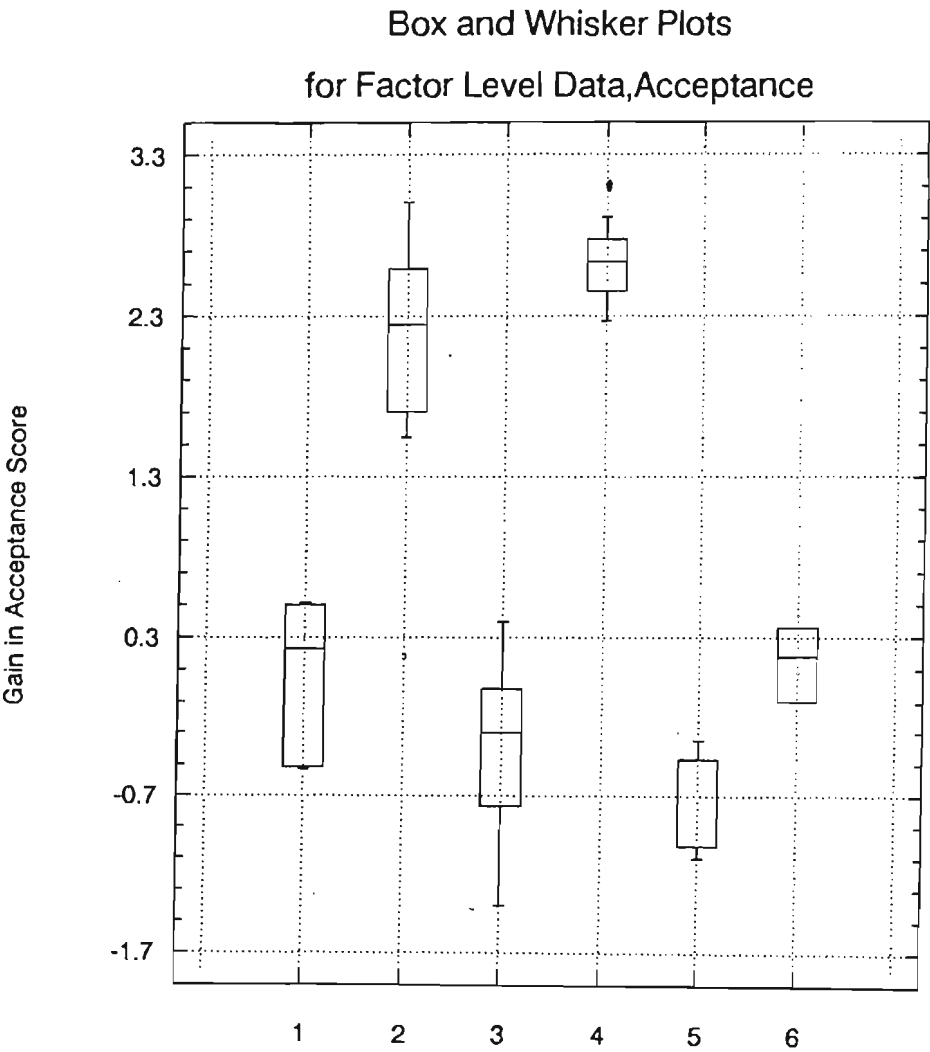
Box and Whisker Plots
for Factor Level Data,Acceptance



Groups (Combined Experi. = 1; Control 1,Site1 = 2; Control 1,Site 2 = 3; Combined Control 2 = 4)

Figure 5.7 Bestgains plot for ACCEPTANCE. The combined experimental, split-site cont.group 1, and combined cont. group 2 for the MCRE.

Finally the gains in acceptance for each of the six groups (figure 5.8) clearly shows the gain in site one experimental group (marked number 1 on the plot) against site one control 1 group (marked 3) and against site one control group 2 (marked 5). Likewise the unusual pattern of site two is demonstrated. The control 2 (marked 4) showing more gains than the experimental group (marked 2) and both showing more gains than the second control group (marked 6). The ANOVA was significant at a 0.00 level of significance (F-ratio 24.63).



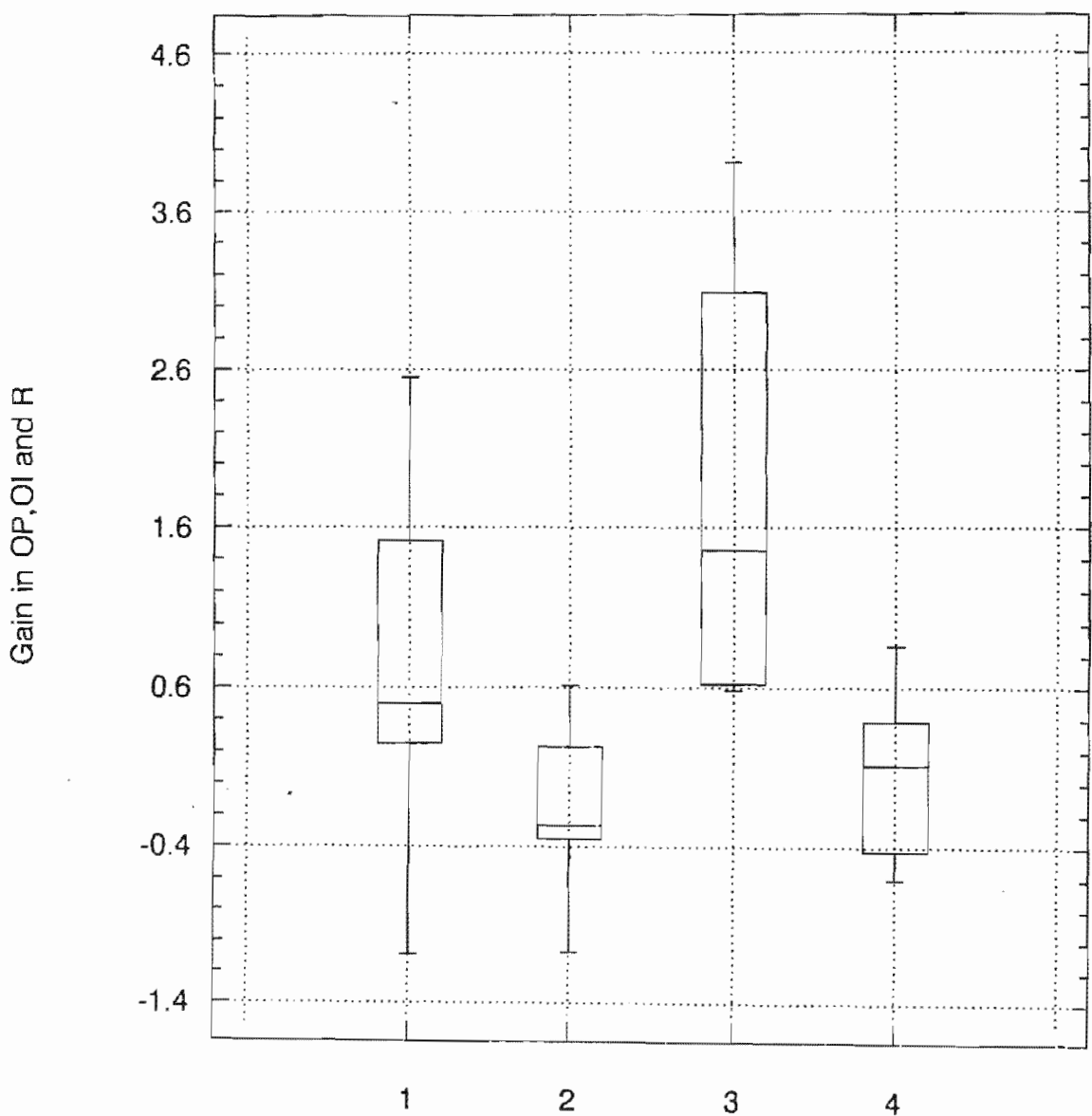
Groups (Exp.Site 1 = 1; Exp.Site 2 = 2; Contr.1,Site 1 = 3; Contr.1,Site 2 = 4; Contr.2,Site 1 = 5; Contr.2,Site 2 = 6)

Figure 5.8 Gains in ACCEPTANCE for each of the 6 groups for the MCRE.

The researcher then looked at the **non-acceptance** scales. Namely the overprotection, overindulgence and rejection scales. Roth (1980) had found a negative correlation between the acceptance and non-acceptance scales. An ANOVA was computed in order to observe if the pretest and posttest difference between the scales within the (OI), (OP) and (R) groups was significant. The F-ratio was not significant for the difference in groups (experimental, control one, & control two).

Similarly the difference between and within all six groups was found to be insignificant. However the "**bestgroup**" identified earlier, namely, the combined experimental, split-site control group 1 (support), and combined control group 2 (clinic), was found to be **significant** with a F-ratio of 3.893 at a 0.02 significance level. This is graphically shown on the box and whisker plot overleaf (figure 5.9). The site one control group 1 (marked 2) and the combined control group 2 (marked 4), have remained unchanged and the combined experimental (marked 1) and site two control group 2 (marked 3) show considerable gains.

Box and Whisker Plots
for Factor Level Data, OI,OP and R



Groups (Comb.Exper. = 1; Contr.1, Site 1 = 2; Contr.1, Site 2 = 3; Comb. Contr.2 = 4)

Figure 5.9 Bestgains in NON-ACCEPTANCE for combined exper. group, split-site control group 1 and combined control group 2, for the MCRE.

While the ANOVA of all six groups was shown not to be significant, it is useful to look at the graphic presentation as it demonstrates the relationship between the groups and most particularly the large gains yet again in the site two control group 1 (support) (marked 4 in figure 5.10). This needs further exploration in an effort to explain these unexpected results.

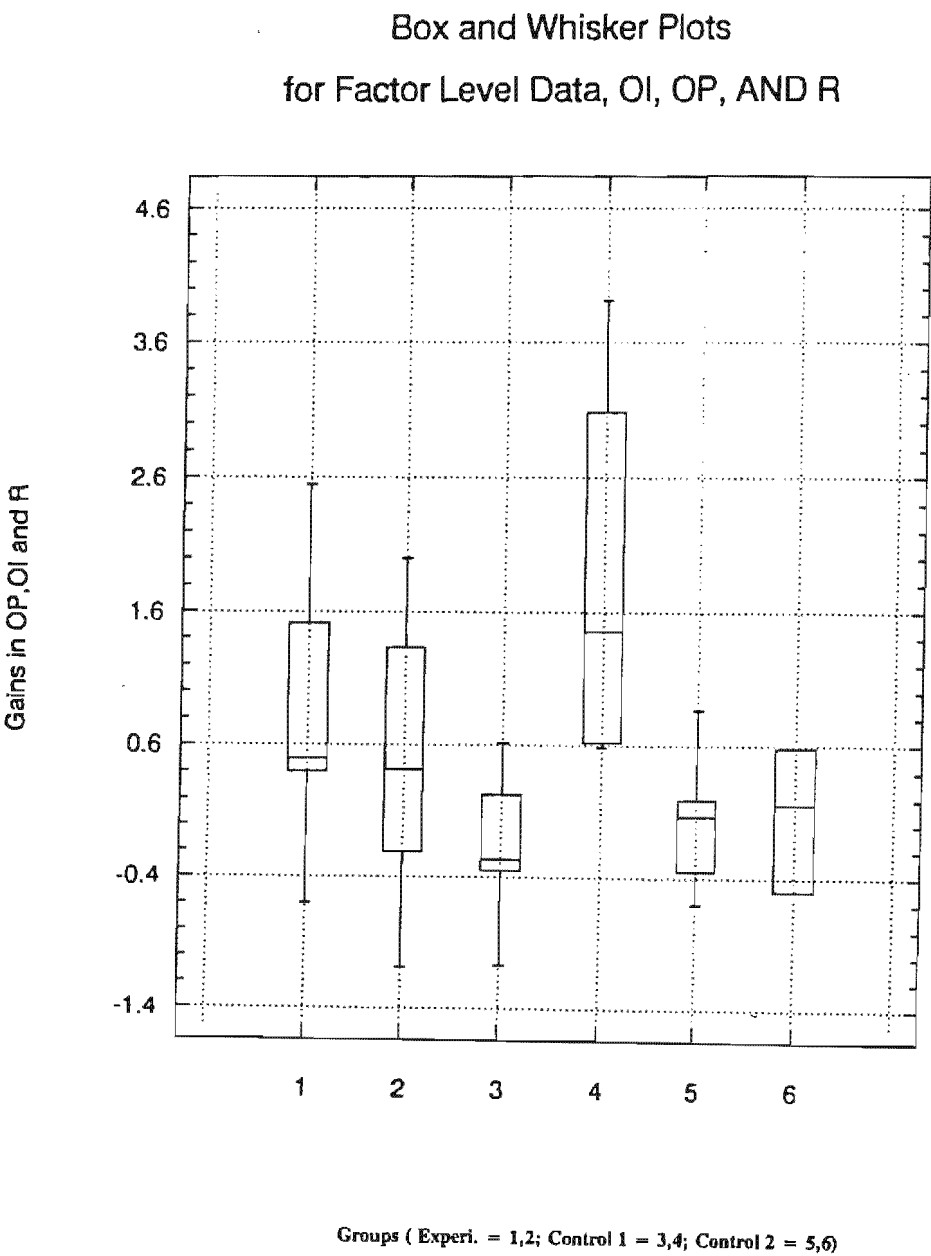


Figure 5.10 Gains in Non-Acceptance for all six groups for the MCRE.

Finally the researcher computed separate ANOVA on the gains for each of the individual non-acceptance scales. This was considered necessary because rejection was felt by the researcher to measure a slightly different variable to overprotection and overindulgence. This proved to be fruitful as shown by the box and whisker plots below in figure 5.11. These clearly show the changes in rejection and the minimal changes in overprotection and overindulgence. The gains for the combined nonacceptance scales were influenced by the changes in rejection. The ANOVA between all six categories for (R) was $F=18.58$ and for the best group $F=12.97$ both at $\alpha=0.000$.

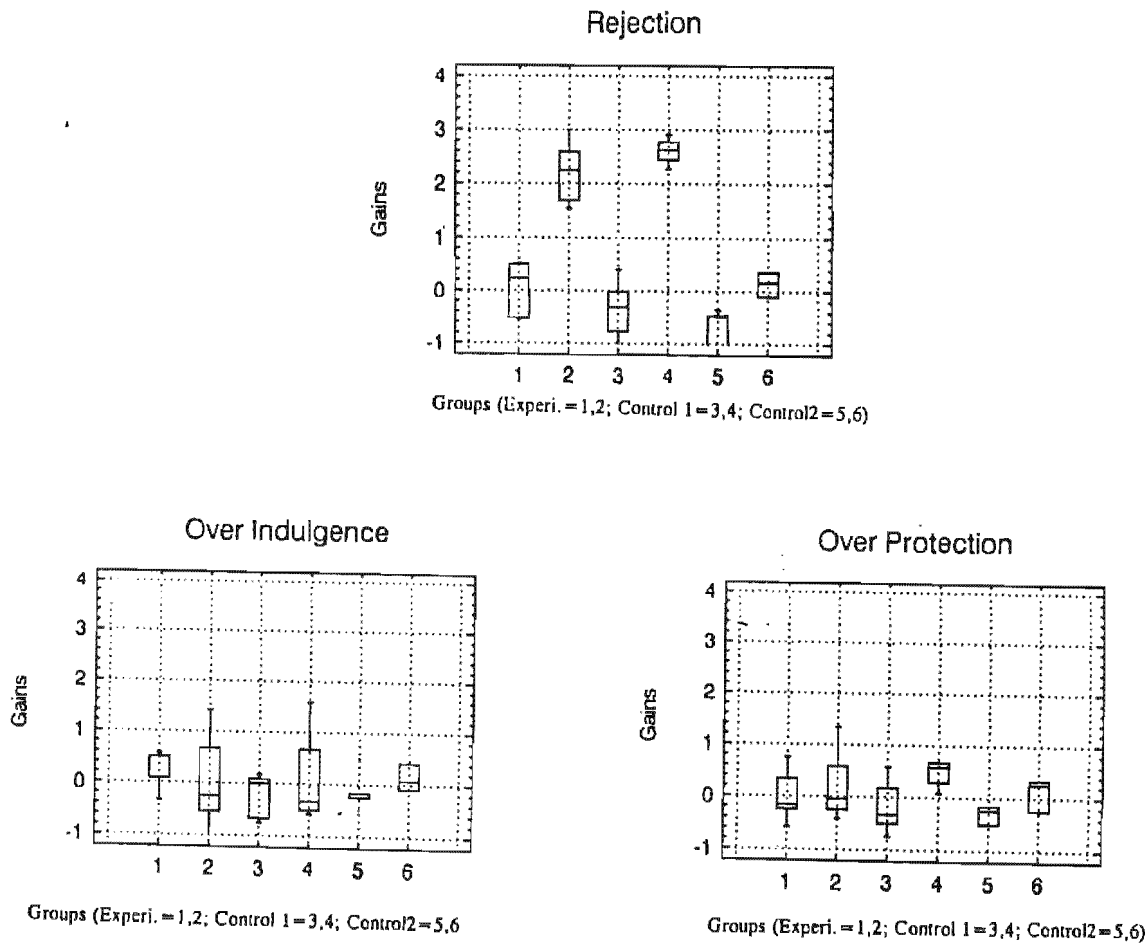


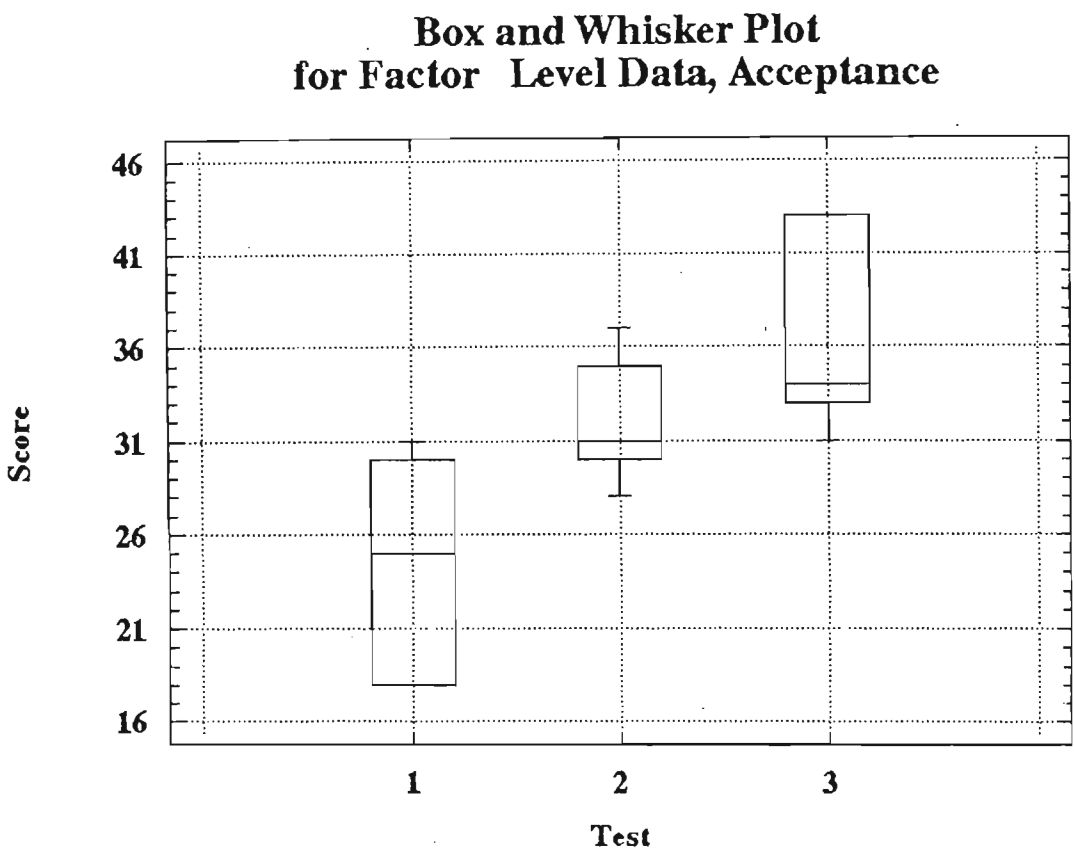
Figure 5.11 Summary of change in individual non-acceptance scales for all six groups in the MCRE.

B) LONG-TERM ANALYSIS OF MCRE (Hypothesis 3)

Sample size was even smaller in the long-term evaluation. Non-parametric tests only were computed. The experimental participants from site one and site two were combined to form a data set of $n=8$. A Kruskal-Wallis analysis of variance between the combined score of the gains at pretest, at posttest 1 and at posttest 2 was computed. This was found to be **insignificant**. There was no significant difference between and within the three groups. The **shortterm** analysis had shown **significant gains** in the experimental group from **pretest to posttest 1** on the MCRE. Further investigation was indicated. Site one and site two data was **separated**. A Spearman rank correlation between the pretest and the posttest 2 gains was computed for each site. Site one was not significant (0.3149). Site two was significantly negatively correlated (-0.7005).

Site 2 was looked at in more depth. Summary statistics of both posttests of site 2 indicate that the means and medians are similar (means =18.5 and 18; medians = 17.4 and 17.1), but the variance differs (27.1 and 43.09), indicating a greater spread in the longterm posttest data. This spread can be seen visually in Figure 5.12 below. The researcher separated out the acceptance and the non-acceptance sum of scores. The ANOVA on non-acceptance scales was not significant. The shortterm follow up had shown a **significant** difference between the gains from pretest to posttest for non-acceptance scales (Figure 5.11) but this has not followed through to the longterm posttest. The ANOVA on **acceptance** was computed and found to be significant at 0.0104 level of significance ($F = 6.838$). The significant differences in acceptance between the pretest and posttest 1 and

between the pretest and posttest 2 are shown in the box and whisker plot in Figure 5.12 below.



Experimental Groups Site 2 (pretest=1; posttest 1 = 2; posttest 2 = 3)

Figure 5.12 Gains in ACCEPTANCE for Pretest 1 to Posttest 1 to Posttest 2.

A Spearman rank correlation between the two posttest gains of site 2 was computed. This was found to be **strongly significant** (0.7476).

The **null hypothesis 3** must be accepted for **site one** (there was no longlasting measurable gain for this group). This could also be a function of the small sample size ($n=3$). The qualitative feedback these same mothers provided contradicts this finding. The null hypothesis may be rejected for **site two** and the **alternative hypothesis 3** accepted (ANOVA for the MCRE in Acceptance was significant as was the correlation between the gains in the two post tests).

5.2.1.1 Discussion of First Null and Alternative Hypothesis: Maternal-Child relationship

The first null hypothesis is that the experimental and control groups would show no difference in maternal- child interaction patterns as measured by maternal attitudes.

The alternative hypothesis is that the experimental and control groups would show different maternal-child interaction patterns, with the experimental group of mothers who participated in the developed intervention programme, showing increased usage of maternal- child interaction skills when compared to both control groups one (social support) and control groups two (basic clinic service).

The data analysis provides interesting material for discussion. The Maternal-Child Relationship Evaluation (MCRE) was widely tested and strongly rejected the null hypothesis that there was no difference in the maternal-child interaction pattern between the experimental and control groups. This rejection of the null hypothesis

was supported by the computed difference between the pre and post test scores on the MCRE which was found to be highly significant for the Signs test and the t-test. Similarly the t-test for difference or gains in the total sample was found to be powerfully significant. The Kruskal-Wallis one-way-analysis of variance between the experimental and combined control groups, between all six category of group and between the "bestgains" group (split-site control 1 (support) groups) were all significant as was the ANOVA for all groups and the bestgains groups.

The graphic box and whisker plots show the pattern of these differences or gains clearly. There was significant gain between the experimental group and the combined controls (Figure 5.1) but not in the three group computation (experimental, control 1, control 2, in Figure 5.3). The "bestgains" group explains this apparent conflict (Figure 5.4). In this box and whisker plot the combined experimental group (marked 1) shows considerable gains over the combined (clinic) control group 2 (marked 4). The control group 1 in site 1 (support) (marked 2) shows no gains over the combined (clinic) control 2 (marked 4). However the site 2 (support) control group 1 (marked 3) shows large gains, even higher than the combined experimental group (marked 1). This picture is supported by figure 5.2 where all six categories are shown. Marked improvement in the maternal-child relationship in the experimental groups (marked 1 & 2) is demonstrated over the two (clinic) control 2's (marked 5 & 6). Control 1 of site 1 (social support) (marked 3) shows no gain over control 2 of site 1 (marked 5) and once again the site 2 (support) control group 1 (marked 4) shows the largest

gains. This specific pattern of gain is repeated when the acceptance (A) scale alone of the MCRE is examined. The acceptance score were examined particularly as an indicator that a positive maternal-child relationship change had occurred. Results were significant for all four relationships (experimental and control; all six categories; experimental and two controls and bestgroup).

There can be no doubt at all that the developed programme had a positive effect on maternal-child relationships in both experimental groups in both sites and that the researcher can accept the alternative hypothesis with confidence. In site one the developed programme was clearly demonstrated to have more influence than the two controls. In this site the researcher can claim to have demonstrated that support alone (shown in previous research to be highly significant in the prevention of child abuse) will not provide this positive change in the maternal-child relationship.

What then of the even more dramatic changes which occurred in the site two support control group? The programme was developed for use at a grassroots level and this site fell more into this category than did site one. As has been seen from chapter five this relationship continues throughout the non-acceptance scales of the MCRE (The non-acceptance scales showed a significant result only for the bestgains group) and further on into the results of the Family Assessment Device (FAD).

Clearly this support control group (marked 3) shows a large increase (Figure

5.9). The researcher has considered possible reasons for this outcome. It is of note that the level of education for this group was considerably lower for the **entire** group than were the experimental and other control groups (refer Table 5.6).

In the light of the mass move of participants from this second control group in site two, it is possible that the remaining control group was "contaminated" by the experimental group. If this was the case then this group will have been exposed to the developed programme via a lay facilitator and this would be highly significant. For obvious reasons this is a sensitive issue and was left till the long-term evaluation to investigate.

In the **longterm posttest evaluation** only two of the original four clients of the site two, control group 1 (support) were accessed. The other two had returned to school out of their home area and were inaccessible. Of these two subjects, one had indeed received information from her neighbour who was a participant in the experimental group. This client insisted on completing the longterm questionnaire and listed the skills so that she could give information on the skills she was using and how much she appreciated them. She felt that she had in fact done the course, gained the skills and had noticed a difference in her family relationships. It is impossible to draw conclusions from only two subjects. A t-test on the shortterm and longterm posttests **and** on the pretest and long-term posttest indicated that there was no significant gains for these two subjects, this is helpful in that the large gains identified in this group can be attributed primarily to the

two subjects who were not accessed for longterm follow up and this highlights the problem of making any assumptions with this small group. The subjects from control group 1 site 1 (support) were all inaccessible.

5.2.2 FAMILY RELATIONSHIP (Hypothesis 2)

The McMaster Family Assessment Device (FAD)

This instrument has been described fully in chapter three. It is a clinically relevant instrument which looks at seven different areas of family functioning to distinguish healthy and unhealthy families (eg problem solving, affective responsiveness and involvement, communication, roles, behaviour control and general functioning.)

Similar computations were carried out on the FAD as were followed above for the MCRE. Standard scores were computed for the difference between the pre and post test scores in order to approximate normality. Minimum scores were -17.98 and maximum were 3.947 with a range of 21.93. The mean was -0.77, being higher than the median (-0.55) giving a positive skew to the distribution. This distribution has several nonnormal features and nonparametric tests would appear to be a prerequisite. These scores were used to compute a Signs test, t-tests, various one-sample analysis of variance (ANOVA) and several Kruskal-Wallis analysis.

a) Signs test

A Signs test was carried out on the pre and post test scores of the combined experimental groups from site one and two and found to be insignificant.

b) t - test

This was computed and similarly found to accept the null hypothesis that there was no significant change.

c) Kruskal-Wallis analysis of variance

This non-parametric analysis was conducted before the analysis of variance (ANOVA) as for the MCRE. This was particularly important owing to the evidence of deviance identified earlier. The first computation was between the experimental and control groups and found to be insignificant. The box and whisker graph on the next page shows the two medians as being almost the same (refer Figure 5.13).

Box and Whisker Plots
for Factor Level Data, FAD Scores

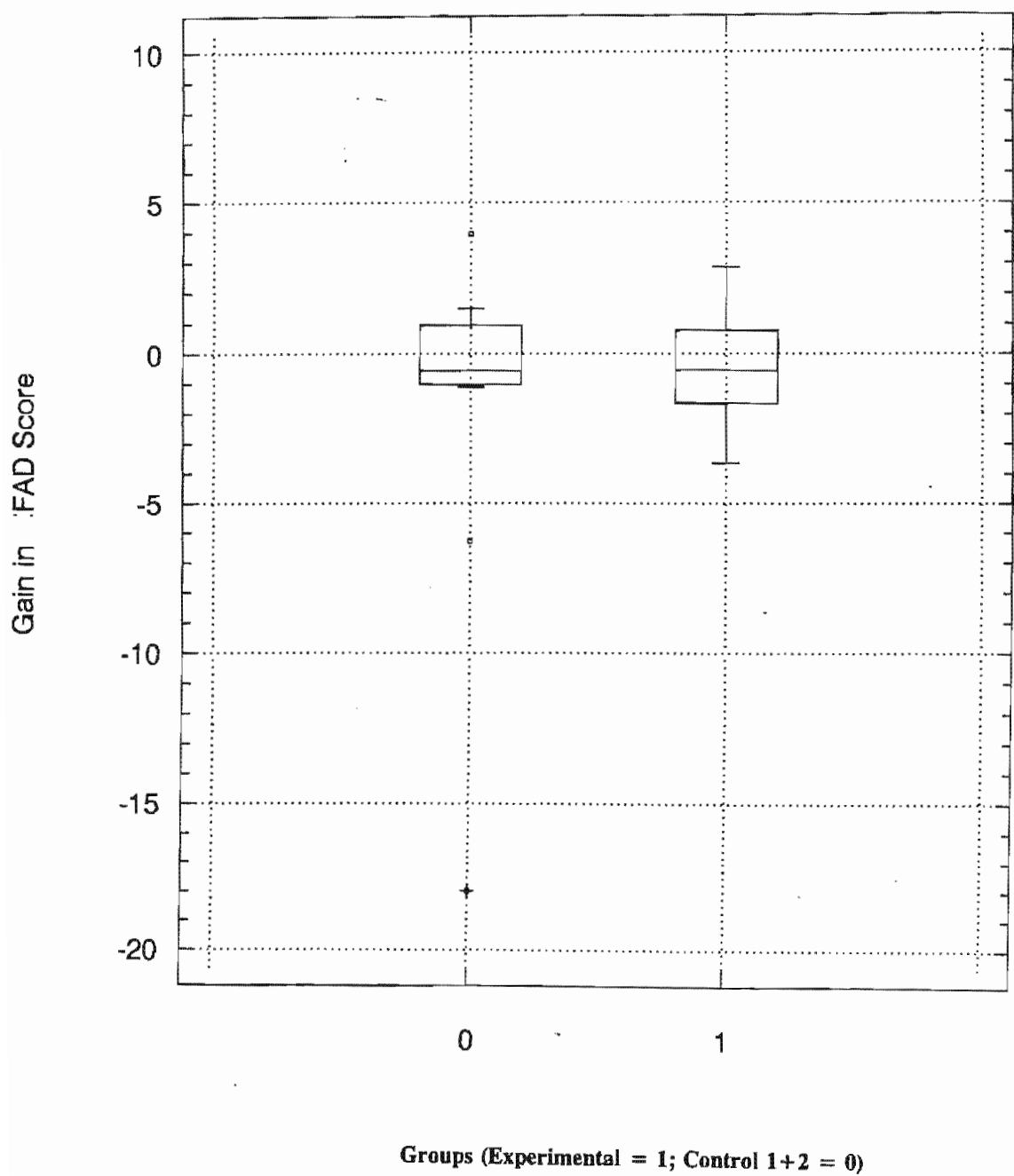


Figure 5.13 Gains in FAD for experimental and control groups.

A further computation of the Kruskal-Wallis analysis of variance by each of the six groups was however found to be significant, giving a H statistic of 14.1087 at a 0.01 level of significance. The range in the control group 2 (clinic) in site 2 (marked 6) is graphically demonstrated as are the gains in the second experimental and second control group of site two (marked 6, 2 & 4 respectively in figure 5.14).

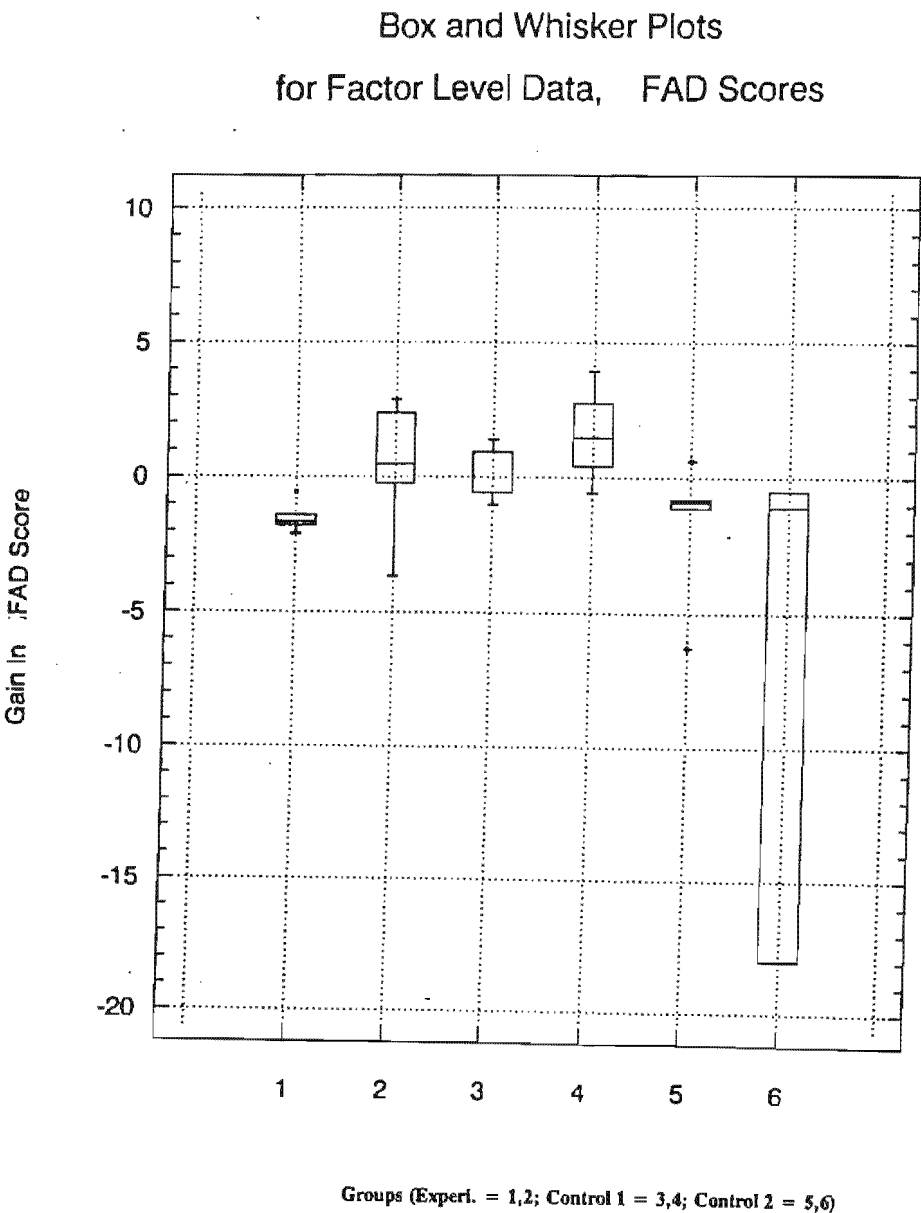


Figure 5.14 Gains in all six groups for the FAD

Kruskal-Wallis analysis of all three groups was likewise significant with an H statistic of 6.515 at a 0.03 significance level. The groups are shown graphically below for easy reference and clearly show the gains in the experimental and control group 1 (refer figure 5.15). It is of note that the gains in this instrument are considerably less than those shown for the MCRE.

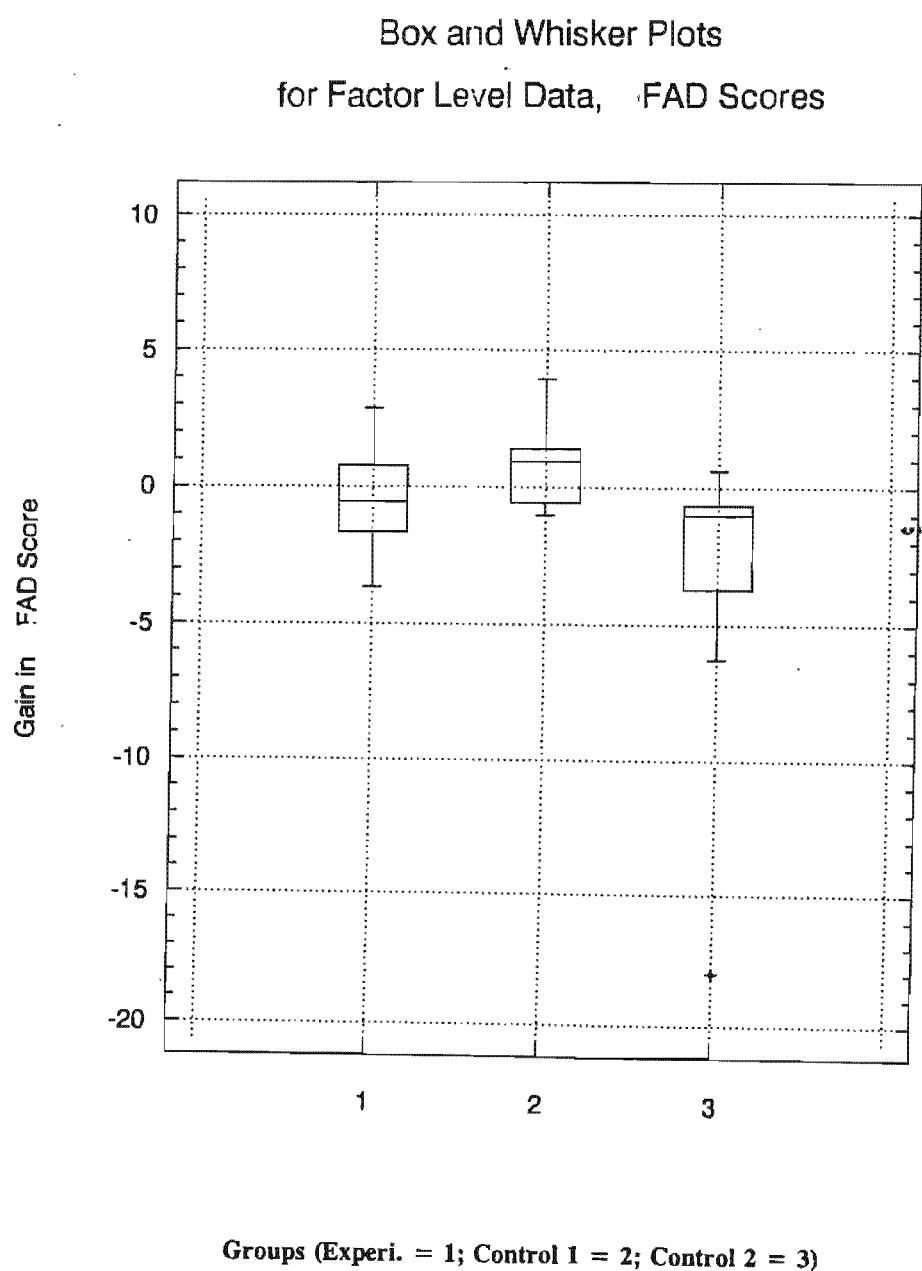


Figure 5.15 Gains in experimental and control groups one and two.

Finally to complete the picture of the relationship between group differences or gains, the "bestgains" group was computed (the combined experimental, split-site control group 1 (support) and combined (clinic) control group 2). This was similarly found to be significant with $H = 7.4142$ at a 0.05 level of significance (refer Figure 5.16). This box and whisker plot shows a similar picture to the similar plot for the MCRE but with less powerful gains. While the experimental group and both control 1 groups show gain over control group 2, the highest gain occurred in control group 1 of site two (marked 3).

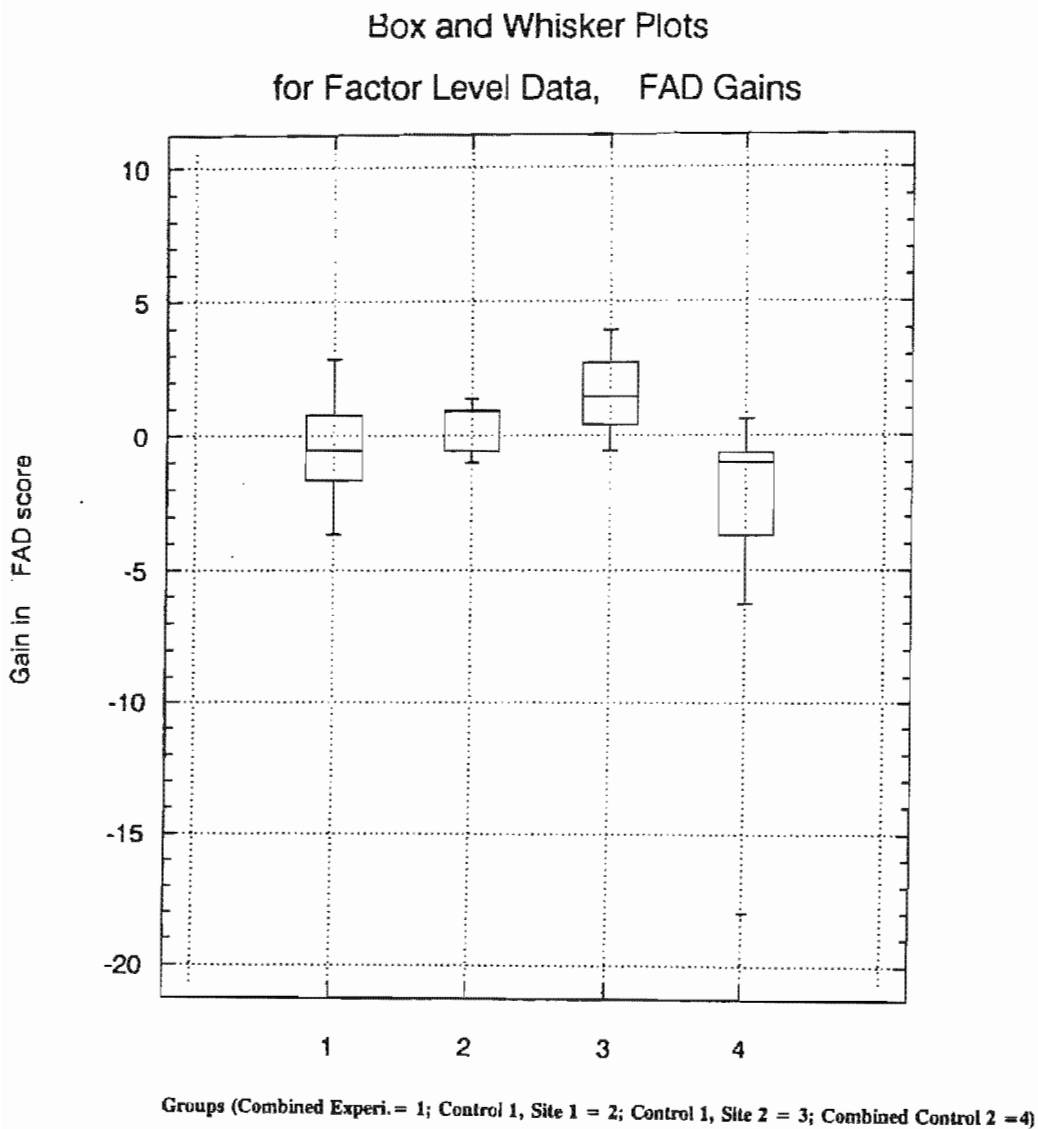


Figure 5.16 Gains in bestgains group for the FAD.

d) One Way Analysis of variance (ANOVA)

This was computed for the difference between pre and post test for experimental and control groups; all six groups and best group (eg split-site control group 1) - and all were found to be insignificant. However the three groups (experimental, control 1 and control 2) were computed and found to be significant with an F-ratio of 3.33 at a 0.05 level of significance. (This supports the results of the Kruskal-Wallis analysis shown in Figure 5.15).

This failure of the gains to be supported by the ANOVA in all, except the last of the analyses above, might well be a function of the non-normal distribution of the data scored for this test. However this needs careful discussion in the light of the box and whisker plot which clarifies the gains in the experimental group of site two and both support groups, but indicates little change in the experimental group in site one (refer Figure 5.14 above).

These results would seem to give support to reject the null hypothesis albeit not the same powerful degree of support provided by the changes in the MCRE. The programme intervention has been shown to lead to some changes in the family relationship of site two with the control group 1 having displayed greater change.

When a Spearman Rank Correlation was computed to establish the association between the gains in the MCRE and the FAD. Neither the gains nor the pretest scores of the MCRE and the pretest scores of the FAD were shown to have any significant correlation.

5.2.3 CHILD ABUSE POTENTIAL (Research Question 1)

The Family Stress Checklist

This instrument has been used in this study to examine the abuse potential of the experimental participants and is fully described in chapter three. Respondents score 0-10 for low abuse potential, 11-24 for medium-low risk and 25-30 for medium-high risk. Those participants with scores over forty are considered high risk. Only the participants in the experimental group were scored for this test. The summary table below indicates the percentage scores for site one and site two. The researcher was able to obtain only two responses from site three (of 30 and 65) and none in site four (these are followed up later).

Table 5.9 Summary of Family Stress Checklist Scores

SITES	0-10	11-24	25-30	TOTAL
ONE	3	2		N=5
	60	40		100%
TWO	2	4	2	N=8
	25	50	25	100%
ONE + TWO	5	6	2	N=13
	38.47	46.15	15.38	100%

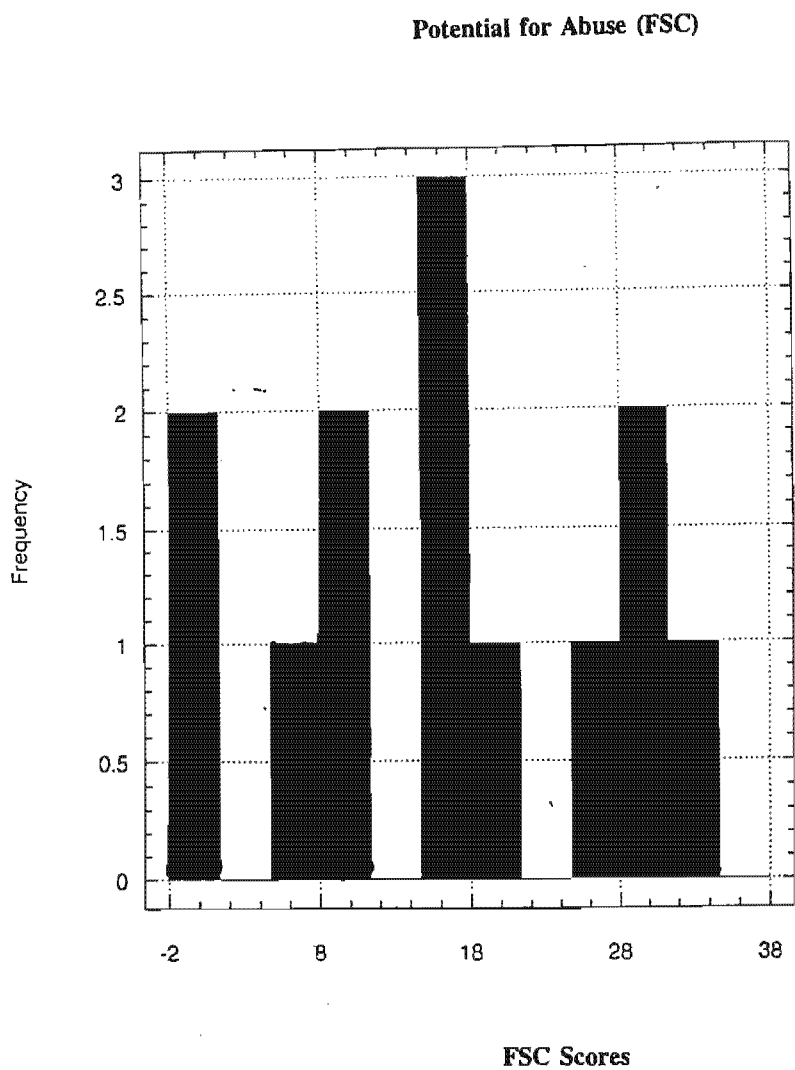


Figure 5.17 Bar Chart of Family Stress Checklist Scores

As can be seen from the above, most participants scored in the medium-low range of potential for abuse. The Spearman Rank Correlation showed no significant correlation between the Family Stress Checklist and the MCRE, the FAD, the Rosenberg Self-Esteem and the Social Readjustment Scale.

The question being asked in hypothesis three was whether those mothers who had a higher abuse potential would have more positive changes in the maternal-child relationship than mothers with a lower abuse potential. The gains in Acceptance and the abuse potential were subjected to a Spearman Rank Correlation. A correlation of 0.55 between the FSC and gains in Acceptance (A) at a 0.05 level

identified. This means that those participants who scored higher on the FSC (had a higher abuse potential) also had a greater gain on the acceptance scale. This computation consequently allows the researcher to conclude that there will be a greater change in positive maternal-child interaction in those dyads identified as having a higher potential for child abuse. The change has occurred in the maternal-child acceptance gains which were specifically targeted in the developed programme.

5.2.4 SELF ESTEEM (Research Question 2)

This questionnaire can be scored as a sum of the Likert scale and according to Rosenberg (1979) this yields similar results to the contrived item method of scoring. This was utilised for easy computation. Low self esteem is recognised as a score of twenty and under. The maximum score for positive self esteem is forty. There was very little difference in sample means between the experimental and control groups in both the pretest and post test results. Most respondents scored a moderate self esteem. The mean for combined groups on pretest was 28.7 and on post test was 29.8 and the scores ranging from 22 to 40. An ANOVA was computed on the difference or gains in self-esteem and found to be insignificant for experimental versus controls, all three groups and all six groups. There appeared to be no evidence that the intervention had lead to a general gain in self esteem. This is contrary to previous research in this area.

However the researcher is prepared to concede that there was some evidence of

changes in the feelings of self worth in the experimental mothers evidenced in the qualitative data analysis (discussed below). This does provide room for further enquiry and perhaps future research. Of further interest was that while mothers who had good self esteem did not gain in self esteem, those mothers who scored near the low range (about 24) for self esteem all did increase their self esteem scores in the posttest 1 and this increase was maintained in the posttest 2.

5.2.5 MEASUREMENT OF LIFE STRESS (Research Question 3)

Social Readjustment Rating Scale (SRRS)

The SRRS was utilised to monitor the stresses in the mothers lives which might influence the measurement of changes on the maternal-child relationship.

The Social Readjustment Rating Scale (SRRS) is a 43 ranked item questionnaire of life events as detailed in chapter three. The potential score ranges from 11 to 1466. The latter score would include all the life events and thus would be a rare occurrence. The scores of participants ranged from 12 to 314 in the experimental groups, with a mean of 133 in site one and 122 in site two. The most common events occurring in both sites were death of a close family member and a change in living conditions. Site one showed a range of problems from sexual difficulties, problems with in-laws, mortgage loans to changes in sleeping or social habits while site two experienced injuries, marriages, loss of work, changes in health and living conditions and Christmas. There was no significant difference in this pattern in the control groups.

A Spearman rank correlation was conducted to look at the relationship of life stresses as measured by the SRRS to the MCRE and FAD. There was no significant correlation found. Similarly there was no correlation between self esteem and life events (SRRS) and between life events and the Family Stress Checklist. This is of particular interest as many of the participants experienced fairly high scores on the SRRS. This is graphically indicated by the histogram of life events SRRS featured on the following page (refer Figure 5.18).

Contrary to expectations the high levels of community violence and life stresses do not appear to have influenced the measurement of the changes caused by the developed programme.

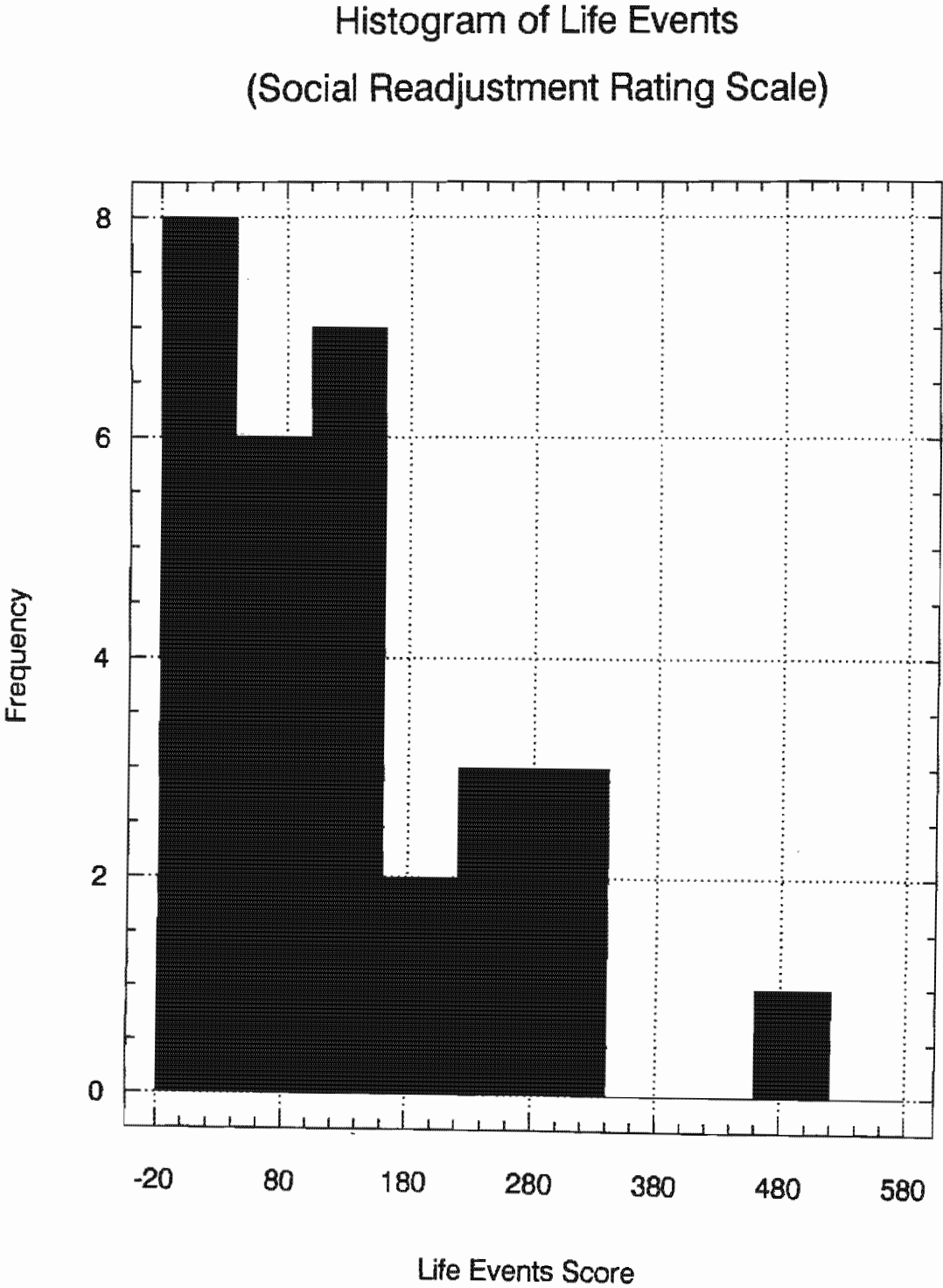


Figure 5.18 Histogram of Social Readjustment Scale (Life Events)

5.3 QUALITATIVE RESULTS

A) SHORTTERM POSTTEST EVALUATIONS

a) Final Evaluation Questionnaire by Parents

The researcher included the comments of all site one and two participants, including the two extra over age mothers in site two (10 + 5 =15).

Q1 How I felt about the course:

One participant from site one rated herself as feeling only "mildly glad" to have participated in the developed programme. All other participants (93.3%) were "very glad" they had taken part in the developed programme.

Q2 What I liked most about the course:

Site one and two responded differently to this question. Site one prioritised:

- * the social aspect as being important (60%) eg making new friends, support of mothers with same aged children and mixing socially.
- * learning communication which was relevant for children and people throughout the lifespan.

Comments included:

"meeting with other mums with children of the same age with similar problems,

before I felt unique"

"Helped me to handle people in general. Made me realise that I have rights too.

The I-messages were excellent".

"I learnt a lot for future reference"

Site two responded that they liked everything about the course. This group were hampered by limited ability to read and write and none could speak english. Detailed written communication was difficult and tended to be limited to single words.

Q3 What I disliked most about the course.

Site one responded:

- * time problems. Some wanted the course alternate weeks and others wanted longer, weekly sessions.

- * one participant disliked meeting in a different venue each week.

Site two had no dislikes at all. There was no negative feedback either on the evaluation form or via verbal feedback to the facilitator or researcher.

Q4 Changes noticed in my family or child/children:

In both sites parents claimed to have noticed changes in their children. Most (66%) claimed to have noticed "a lot" of change and the rest (34%) to have noticed a few changes.

Comments included:

" behaviour has definitely improved"

"children behave differently now"

Q5 Changes noticed in myself:

* Many participants (66%) mentioned an improved relationships and communication with their children, a further 40% mentioned improved adult relationships particularly with their male partners and older teenage children.

* Four of the five participants in site one (80%) claimed to feel more confident:

A typical comment was:

" I feel better about myself and more confident with my children"

"My relationship with my husband and family has improved very much"

"Now I understand"

Site two

During the interview for the FSC when the facilitator translated for the researcher, despite the fact that the researcher did not ask **any** questions about the course and how it was affecting the participants, this information was repeatedly and insistently volunteered. This information has been added in here because this was the only means this group of participants could find to inform the researcher

of the way they felt and had been influenced by the programme. This language barrier was a limitation of the research. The most commonly used words were:

"I've changed"

"I'm different"

"I'm better now that I can say how I feel"

"I still smack but learning still to communicate"

"I'm better now"

"now changed, improved relationship of both parents with children - happy because two elder sons had left home because they did not like discipline, now did not need to smack all the time with other children".

"Now I see well what to do "

Q6 Changes noticed in the way I think and /or interact with my child:

Many of the participants (80%) claimed to have changed the way they interacted with their children.

Comments included:

"I stop to think before I discipline."

"Before I did the first thing to come to mind which wasn't always best for him".

"Before I wanted to shout at them. I stop to think first now"

"think before react"

"used to smack and feel guilty - now act

" less aggressive"

"improved understanding of feeling"

"playing and communication now"

"don't hit because I know how they feel"

"I was very furious and had a problem communicating, I used to smack a lot"

"I was very aggressive but now very understanding"

"I can now live well with my neighbours and I understand them."

"At first we were not friends at all, I was so cheeky to them and they did not like me. Now we are all happy."

"I make time to play with my children"

Q7 Further comments

There was very little response to this question. Two of the participants advocated continuing availability of the programme to other mothers and two admitted a desire to facilitate such a programme.

Comments made:

"I feel parents need all the help they can"

"Before I went on this course I was not sure that I was doing the right thing for my children - my thoughts have now been cleared up"

"I feel there are many Moms that could benefit from a "course" like this. I am grateful and thank you for the time and "advise" ".

"I would be interested in presenting the course if you need people to do so."

Verbal feedback was also given at this final feedback. The site one mothers

requested more extensive written material to support the programme's comic book. This was the most educated group, English was their first language. They fulfilled the research criteria of standard ten or less education and there were no literacy problems (a similar request for additional written material was made by the pilot group, a caucasian, well educated group discussed earlier in chapter three). There was no recidivism in this group.

The researcher anticipated that there would be a negative response to the multi-ethnic comic book in this caucasian group. This was not the case. The participants in this group had become close friends and continued to meet after the programme completion despite several home moves some distance away.

The site two mothers had no requests and were vocally appreciative about the programme they had completed. There was no recidivism in this group despite the fact that the programme ran over the Christmas period and that this was an area with considerable political violence and pre-election unrest. Participants voiced their appreciation of the comic book and the indirect influence this had had on their families. Some participants were still using smacking but vocalised that they were smacking less and were actively using other parenting and communication skills. Some of the adolescent children were "correcting" their mothers when they failed to utilise their new skills and had identified the "I am a special person" and "listening skills" from the comic book graphics.

b) Final Evaluation Questionnaire by participating CHN

This was a brief feedback similar to the above questionnaire for the participants but adapted appropriately to the facilitator (refer annexure P). Both facilitators briefly responded to this and gave indepth feedback on the following questionnaire that specifically requested more detailed information. Both facilitators enjoyed initiating this programme and felt it to be very worthwhile. Site two facilitator found the facilitation stimulating and intended to continue offering the programme. There was nothing disliked specifically. Site two would have found it helpful to have the manual in zulu to prevent having to translate all the time. The intimacy of sharing ideas and problems and discussing these with parents was particularly enjoyed. Both facilitators noted changes in the group.

c) Detailed feedback on course questionnaire

There were no problems experienced with any of the sessions or with the use of the manual and graphics.

SESSION ONE - Site one mothers verbalised that they were very shy and were unable to relax because they were interacting with their "misbehaving" children. Site two found mothers enthusiastic and motivated, their most verbalised problem was the expectation by their husbands that they should be submissive.

SESSION TWO - Site one mothers were still tense and tended to watch their

children but were beginning to actively participate. Site two remained relaxed and participant. The most common verbalised problem for this group was the "anger and guilt they felt build up inside" instead of communicating how they really felt. This went so far as to make them feel physically ill at times. Participants felt that if they voiced their feelings, children might respect and listen to them.

SESSION THREE - Site one mothers were still guarded and watchful of their children. Site two mothers enjoyed roleplaying. Verbalised problems were related to the difficulty of listening when parents are busy people.

SESSION FOUR - Site one mothers are more relaxed and children are starting to play with one another. Facilitator remarked that mothers "only after the fourth session began to enjoy the meetings". Mothers verbalised that smacking did not work for them but that "biting" a child had stopped it biting other children (two mothers). Site two felt that smacking made the child more aggressive and they had problems with anger and guilt followed by feeling sorry. Some still felt that they would use smacking.

SESSION FIVE - Site one ran smoothly. Site two had a lengthy discussion about the workload that mothers carried and the difficulty of encouraging children to help.

SESSION SIX - Site one experienced no problems. Site two discussed that children were frequently left to cry as a means of punishment. Parents feel guilty

if children then get hurt. The group then decided that parents must be accountable for their children.

SESSION SEVEN - Site one participants who did not have older children were unable to discuss the needs of this age of child. Site two participants expressed fear of giving information to children as they did not know when the child was old enough for this. Children were confused because parents were inconsistent, sometimes telling them they were too small and yet other times expecting them to be "big".

SESSION NINE - Site one experienced some discussion of behaviour problems and the group participated in problem solving management of these and gave support. Site two verbalised that children of five were too young to be given choices and discussed the concept of self-worth in relation to children.

SESSION TEN - Both sites ran smoothly. Site one facilitator remarked that she really enjoyed facilitating these sessions, most particularly "the input mothers and children present at each session". She had also personally learnt and used the "I-messages" successfully. Mothers made the toys but felt they were of an inferior quality to the bought ones in their homes. Mothers also felt stressed at times by the interaction of the younger two year olds during the sessions. Some mothers also felt that the two year olds were "too young" to participate in the "sing-along". The participants requested that the researcher give them feedback about the study outcome when this is complete.

Both sites found that they used their new skills on others. Site one used "I-messages" on husbands and found it to be "very effective". Site two "confessed" that they used the communication skills to help them improve their relationships more with their spouses and older children, particularly teenagers, than with their young children.

Both facilitators felt that they had really enjoyed the experience and utilised the skills in their own lives. Both the mothers and themselves had benefitted. Site one noted that there were other mothers in the community that would have liked to participate in the course. Mothers verbalised that "their children were responsible for the choices they as children made". The facilitators summed up with "this is a very interesting assignment to have completed", "this was very interesting and stimulating" and "I think this is a most constructive way of improving communication skills and assertiveness in people - far more than in a normal clinic."

Site two wanted to run the programme for children of all age groups, particularly teenagers also and to have ongoing groups.

B) LONGTERM POSTTEST 2 EVALUATION BY PARENTS

The quantitative data has shown differences in the long term measurable changes for the maternal-child relationship in site 1 and site 2. The longterm qualitative data will be looked at as for individual sites in line with these findings (refer

Annexure Q). This evaluation attempted to gather more details of skill usage than the first evaluation.

Q1 Do you still see any members of the parenting group:

and

Q2 Does the group ever meet as a group:

Site 1 - no participants were in contact with each other. There were two reason for this, a) geographical relocation and b) mothers returning to work.

Site 2 - All participants met on a weekly basis. This was primarily because they were all working as community health workers in the community now, but many also saw each other socially.

Q3 Are you still using the skills you learnt during the positive parenting course:

Site 1 - All were still using the skills. The skills used most frequently differed for all three participants. These were "giving a choice", "positive attention and I-messages" and "respecting and requesting rather than telling".

Site 2 - All were still using the skills. All listed the skills which helped them to "communicate more effectively" as being the most used.

Q4 On whom do you use these skills:

Site 1 - All repondents listed their children who now ranged up to seven years of age. This group had not extended the usage of these skills to other age groups to any great extent in the shortterm or longterm evaluation.

Site 2 - Four of the five participants had extended the skills to all age groups. It

is interesting that it is the participants with the least education who have taken these skills and applied them laterally to interpersonal communication in general.

Q5 - Briefly describe any situation where you have used this/these skill/s effectively:

Participants in site 1 and site 2 found this a difficult question. Some left this out and others gave general descriptions of communication or described a specific situation consistent with the skill they had prioritised.

Q6 - Please mark the skills you have used since the course:

Site 1 - The least used skill was "fantasy wishes" the skills used most frequently by all participants were "positive attention for behaviour", "distraction" and "giving a choice".

Site 2 - The least used skills were "relaxation skills" and "ignoring negative behaviour". The most frequently used skills were "communicating love", "touching your child", "teaching behaviour", "describing the situation", "listening skills", "talking about feelings (I-messages)" and "giving a choice".

Q7 - Changes noticed in child/children:

All participants in both sites had noticed some changes in their children.

Q8 - Please give examples of any changes noticed in your children's behaviour and/or attitude:

Only one respondent did not answer this. Answers for both sites were very

similar and covered; decreased aggression, increased helpfulness, talking about problems and awareness of the mother of the child's facial expression.

Q9 - Specific ages in which changes are noticed:

Site 1 - again this site referred to their children who were all under seven years.

Site 2 - this site was also consistent in referring to children, teenagers and adults.

Q10 - Please give an example for each area of change you have marked in Q 9:

All participants in both sites gave appropriate examples to support the age for which the change had been noted.

Q11 - Please describe any changes in the way you think and/or interact with your children:

Site 1 - mothers gave more time for play and listening to their children, before used to just smack but now talk and explain first, giving children attention and respect achieves more than shouting.

Site 2 - participants felt that they were "better mothers", can talk to their children, can share ideas with children, have more positive feelings towards them, and feel confident in managing the family.

Q12 - Please describe any changes noticed in yourself since completing the course:

Site 1 - mothers here said they were less frustrated and more patient and tolerant than they had been before the course.

Site 2 - mothers said they were more understanding, they told their children what they expected. Before the course they thought hitting was "good" for a child now they use other methods before hitting.

Q13 - Are you happy you did this course:

Mothers from both sites were happy they had participated in the course. Reasons listed ranged from the family being happier, to understanding their children and the pleasure the new skills had given them when meeting and speaking to people.

Q14 - Please list any parenting needs which you still have:

The only comment here was that " the course should be available to husbands also".

It would appear that mothers remembered and were using the skills taught in the course as evidenced by their ability to give specific examples to substantiate the questions asked. The most interesting factor to come out of this rather detailed questionnaire was the consistent failure of site 1 mothers to use these skills in other areas of their life and the equally consistent extension of usage of site 2 mothers to all areas of their social and work life. This might well help to explain why despite the small sample size there was measurable consistency in the change over time in the maternal-child acceptance in site 2 but not in site 1.

No longterm evaluation was made by the participating community health nurses. Both nurses are currently still involved in training in this area, despite the

demands made by a changing health care system.

5.4 DOCUMENTATION OF NONANTICIPATED FINDINGS

Research does not necessarily proceed by hypothesis and statistical analysis alone. The qualitative data above in the opinion of the researcher gives a power and a depth of understanding quite lacking in the quantitative data. This concept is analogous to the discipline of Nursing. On one hand the scientific, natural, medical and social sciences and on the other the human, caring element, so crucial to the art of nursing. Together these form a foundation for practice, the "the whole being greater than the sum of the parts".

The researcher requested that the participants drawings made during the first session of the intervention programme be retained. The serendipitous findings of these drawings are now recorded.

5.4.1 DRAWINGS BY PARTICIPATING RESPONDENTS

The drawings made by the participants of themselves and their families were gathered and returned to the researcher. These were examined for any recurring theme which appeared to run through the pictures. Several themes were identified.

a) Site One Themes

- * only family group's drawn, no environmental details, hobbies or work activities
- * very few hands drawn in
- * patterns of contact between family members shown
- * facial features either present or missing

Individual graphic features which appeared unusual compared to the group

Client 1 - Mother and father full facial features but all four children have no mouths or noses, despite all having eyes and hair.

Client 3 - Mother and daughter have full facial features. Father missing from picture. Son has no face at all. The only hands (detailed fingers) in the picture are the mothers left hand and the sons right hand, both very large.

b) Site Two Themes

- * families drawn, mother features primarily with her children (few fathers)
- * gardens, gardening utensils and vegetables/crops
- * houses and churches
- * facial features (present or absent)
- * hand and finger details (present or absent)

Individual graphic features which appear unusual to the group

Client 3 - No facial features. Hands prominent.

Client 5 - Children have no facial features. Hands and fingers very prominent.

Client 6 - No facial features

Client 9 - Mother and daughter have full facial features no face on son. All hands and fingers prominent.

Client 10 - No mouth on either face. Hands and fingers prominent.

c) Interesting Associations

An interesting phenomenon is noted here. The Family Stress Checklist of the graphics with unusual features were noted. These are tabulated below for each site.

Table 5.10 Family Stress Checklist and unusual graphic features.

CLIENT NUMBERS OF SITE ONE	1	3
FAMILY STRESS CHECKLIST SCORES	15	25

CLIENT NO. OF SITE TWO	3	5	6	9	10
FAMILY STRESS CHECKLIST	30	15	20	30	30

The remaining scores in site one for the FSC are 0,0,5. The remaining scores in

site two are 10,10,15,30.

AS can be seen from the above tabulation the clients with unusual features also tended to demonstrate a higher FSC score. Of note is the high number of raised FSC scores in site 2 and the number of clients who drew prominent hands and limited facial features. Additional observations that are worthy of note:

Site One

Client 1 scored 215 in the SRRS.

Additional notes made by the researcher when interviewing for the FSC, commented that child number 4 was perceived by the mother to be "a very difficult child". This had been an unwanted and difficult pregnancy.

Additional note on client 3 by CHN facilitator.

"Client needs a lot of support. Father works on weekends and family seldom go out"

Additional note made on administration of FSC by researcher.

Mother referred constantly to her own rearing by a single father who was "so strict" - said with loss of eye contact and obvious distress.

Also of note for this client is the Social Readjustment Rating Scale score. This client scored the highest in the experimental group with a score of 284 life stresses.

Additional note on client 4 by community health nurse facilitator.

"Child's behaviour improved dramatically during course". This comment confirmed by mother on her feedback form as well.

There was no additional information of note for **Site Two**.

d) Brief Discussion

The Draw-A-Person Test (DAP) (for adult subjects) has been commonly used by psychologists since Manchover's publication of Personality Projection in the Drawing of the Human Figure (Swensen, 1957). The researcher wished to briefly examine the serendipitous findings above. Two evaluations of research on the DAP were consulted, that by Swensen (1957) and by Roback (1968). Much of the research appeared to be conflicting. The areas of particular interest for this research were study's which looked at facial features, mouths and hands and fingers.

Face - Manchover stated that "the face is the most expressive part of the body" (cited in Swensen, 1957, p.439) and that subjects who deliberately omit facial features in drawings were "evasive of interpersonal relationships" (cited in Roback, 1968, p.4). Omitting facial features is a graphic expression of avoiding social problems. A study by Margolis supports this (cited Swensen, 1957).

Eyes - Manchover stated that " people with a tendency to shut out the world will draw a figure with the eyes closed " (cited in Swensen, 1957, p.443). No research

examining omission was identified.

Mouth - Manchover looked primarily at the direction of the lips and not at the presence or absence of the mouth.

Hands/Fingers - Manchover believed that speared fingers reflected paranoid aggression (Roback, 1968).

Few well controlled research studies have been published to clarify the position of the DAF test. Despite this it remains in clinical use. A study on human figure drawing as related to self-esteem found no significant empirical evidence to support Manchover's hypothesis that body-image indicators correlate with self-esteem (Prytula & Thompson, 1973). Yet other research indicates a significant relationship between the drawing of well formed hands and positive self-esteem (Coopersmith, Sakai, Beardslee & Coopersmith, 1976).

More recent literature in this area concentrates on the drawings of children rather than of adults and studies proliferate particularly in the area of child abuse.

In the absence of empirical data giving support for interpretation of adult drawings the researcher is left to hypothesise. Is the absence of facial features in the children in mothers who scored higher on the FSC significant? Is the presence of a detailed hand and fingers in relation to one child, yet in the same mother figure, absent fingers and hand in relation to the other child an indicator of potential interpersonal problems with these children?

The researcher cannot make firm deductions from the above material. These mothers were drawing a picture of themselves and their families. This was not a straight Draw-A-Picture Test. In clinical interpretation there are many factors which support final diagnosis and treatment intervention. These drawings contribute to our understanding of the participants in this programme and further investigation of this projective technique would make interesting study.

5.4.2 EVALUATION OF HUMAN FACTORS

Site three and four both had problems in implementing the study. Some of these were unfortunate and could not have been foreseen and others had been anticipated as potentially problematic.

a) Site Three

The caucasian facilitator and asian participants commenced well. In September the community health nurse facilitator organised a morning of permission signing and questionnaire completion and received support in the form of cakes and teas from a local firm. This went well, as did the first and second sessions. On the third session no participants arrived at all. The community health nurse followed this up with home visits. The initial reasons for non attendance were the high cost of transport to get to the clinic, lack of time because of the demands of housework and a problematic choice of day. Although Friday was the most convenient day for the clinic staff it was a religious day for some and for others

there were weekend preparations to be done. The session day was changed to a Tuesday but with a continued poor response of only two participants. One participant found work and was no longer able to attend. Further enquiry by the facilitator both in home visit form and at clinic attendance could gain no further information. Participants said they wanted to come but tended not to arrive. After the ten week period allowed for the intervention no further change had occurred. The researcher then conducted a series of home visits with the facilitator in the first week of December. Only two participants (subject 1 and 3) were found at home. These two women share a home and were sisters-in-law. These participants were interviewed for the Family Stress Check list and Social Readjustment rating scale at this time and asked for feedback about their nonattendance and to evaluate the two sessions attended. There was initial reistance and guarded responses which eased as time progressed. Subject one received a score of sixty five on the abuse potential and subject three a score of thirty. Both these scores were of concern. The latter falling into the moderate to high potential and the former into the very high risk category. On the Readjustment Rating Scale subject one scored a mean value of 11 and subject three a mean value of 171. The score for subject one needs to be evaluated in the light of the subject's later diagnosis of schizophrenia discussed below, which might well have lead to less items being perceived and scored. Particularly in the light of subject three scoring fairly high for stressful life events and recording the death of a close family member and changes in health, financial and work situations. In the evaluation of the two sessions participated in, the two subjects appreciated having fun, playing with and learning good things about their children

the most. Subject one felt that session one made her feel "more special than she actually was" and subject three felt that the sessions had "shown her how to care for her family". Neither gave any negative feedback.

A brief investigation of this home environment found a small four roomed home accommodating seven people. The lounge cum kitchenette also served as the bedroom for the aged grandmother. The other two rooms served as bedrooms for each couple with their child and there was a small bathroom. Both mothers were young (20yrs) and had one child of three years of age. Subject one had standard two and subject three had a standard three level of education. The grandmother was in a neck brace and was covered with scars from previous fractures requiring pinning. This was said to be caused by "falling" and by subject one who was prone to outburst of violence. There were no marks on either of the two children. Both husbands were unemployed and the family complained of no formal income at all. Yet the family looked well nourished and the childrens clinic cards recorded normal growth and development for both children. Further enquiry elicited that subject three was taking in washing and charing intermittently to bring in money. During the home visit subject three's husband returned with a catch of a large fish. The nearby river was then admitted to be a major source of nutrition for the family. This family was extremely guarded about both the apparent violence in the family and their income and appeared to see the health and welfare service as a potential for financial resources which may well have accounted for the guarding in this area and for the continued profession of interest in a course which was then never attended.

Subject three acted as the main voice of the family and repeatedly showed interest in attending the developed programme. The major obstacle to her attendance was the inconsistent nature of the work she did and the very real problem of the cost of transport to get to the clinic which was approximately ten kilometres away.

Subject one appeared to have problems of communication and orientation to time and person. In the light of this and the history of family violence, subject one was referred for psychological assessment. This subject was finally diagnosed as schizophrenic and referred to the social worker for application of a disability grant. Both subjects continue to get support and to visit the clinic.

Discussion between the community health nurse facilitator and the researcher and evaluation of the two sessions that were completed, elicited the following information. The facilitator experienced some problems in eliciting group participation and cohesion. The first three subjects were all Hindu. Subject one and three have been discussed in detail above and subject two had found work and was unable to attend. Subjects four to six had a higher educational level (std 8-10) and were different from the first three in the group in religion and socioeconomic standing. Subject three to six owned their own houses and transport and had a higher income level than the first three subjects. Subject four was Christian, subject five was Hindu but of a higher caste than the first three subjects and subject six was Moslem. The heterogeneity of the group might well have contributed to the failure of this group to participate in the designed programme. A further possible problem might well have been the caucasian

ethnicity of the facilitator. This should be viewed from the perspective of apartheid South Africa where white people were frequently perceived as controlling the supply and delivery of resources. This might well have created a false "desire to please response" from the participants, particularly in the asian culture where bargaining for resources is recognised as being a skilled art. Finally the researcher recognised that for at least half of the experimental group, financial constraints linked to transport did exist and to walk to the clinic required a high degree of motivation. General inconsistent attendance appeared to be a problem in this site. These observations will be discussed in relation to similar constraints which existed for the sites which did successfully complete the developed programme in the discussion in chapter six. The antenatal support group was also inconsistent about attending the antenatal classes. This did not influence the running of the antenatal group as the sample taken for this study was only a small sample of a much larger group held during antenatal clinic services.

b) Site Four

This site is a black periurban site plagued with problems. The crime rate is high and there are some areas where the black community health nurse facilitator was unable to visit for fear of being attacked. The first time the researcher entered the area she was stopped by the police, asked for details of her business, told not to stay unattended in the area and accompanied to the clinic. Subsequent visits were made in nursing uniform.

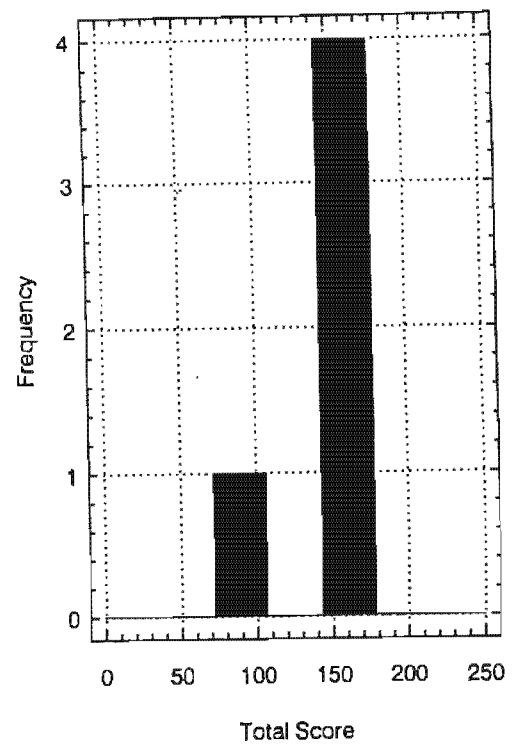
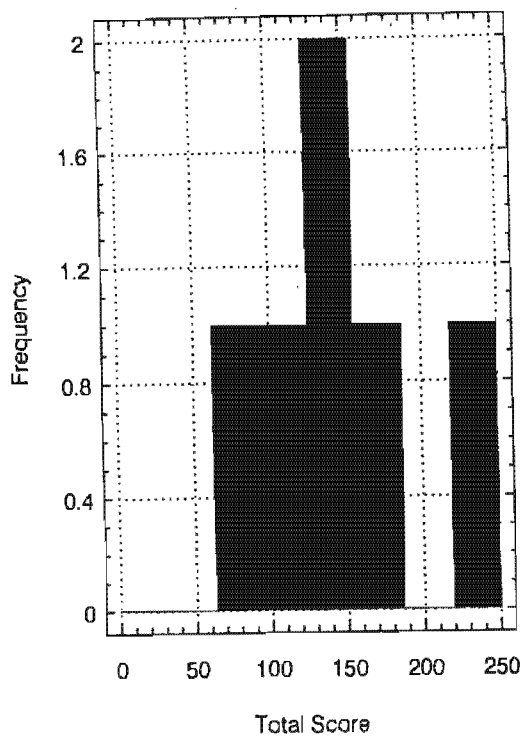
This facilitator experienced personal and community problems which influenced her ability to commence and to continue the programme. She had arranged to start the first session in the first week of October. This was postponed because of a family death which necessitated her being away for two weeks and returning to a backlog of work. Session one was ultimately run on the 10th November and session two on the 17th November. The clinic was broken into on the 24th November, when the perpetrators drove a car into the door and prefabricated wall and cleaned everything out of the clinic. This was followed by three of the five experimental group finding fulltime work in December and being unable to continue attending. The remaining two subjects lived in areas that the facilitator felt were unsafe to home visit. The researcher made four visits to support and assist this facilitator over this time period. Finally by mutual discussion it was decided to terminate the research process. Pretest material was available for only the experimental and clinic control group as the antenatal support group had been stopped owing to all the events which had plagued the clinic. Due to the inaccessibility of the subjects no follow up home visits were made. The data gathered from this site was only utilised to compare the pretest scores of these subjects with the pretest scores of the other sites in order to identify any perceivable variance within the subjects.

The self esteem pretest scores for site one and site two and again for site three and site four are shown below. The histograms show that self esteem was similar in all sites with sites one and two showing some participants with higher self esteem than were found in sites three and four. This is shown as a frequency

percentage of contrived scores which gives a picture of the entire group as a group.

Self-Esteem Site 1+2

Self-Esteem Site 3+4



**Figure 5.19 Histograms of pretest Self Esteem on sites 1 + 2,
and sites 3 + 4.**

5.5 CRITICAL ANALYSIS OF RESEARCH FINDINGS

The major problem experienced with the data analysis was the small sample size and non-normal distributions for which non-parametric tests were used.

Despite these limitations powerfully significant results were obtained which enabled the researcher to reject the first and second null hypotheses. Research question 1 supported the researchers expectations and research questions 2 and 3 yielded results contrary to the researchers expectations. These results in all humility are only a beginning. It is accepted that this programme needs to be made widely available which would make possible an evaluation utilising larger sampling.

It is important when looking at the quantitative results supporting the hypotheses, to look also at the qualitative feedback from the participants and facilitators. The researcher found that this was where the "human factor" was found. The participants had been reduced to figures with the statistical analysis, but with the qualitative analysis they became human once more. The researcher was astounded at the enthusiasm, gratitude and openly demonstrated joy which was expressed. This far surpassed the expectations. The power of people's own words to describe their feelings about the programme and the changes in their lives, overshadowed the hard scientific evidence produced by the quasi-experimental design. What numbers can compete with the words; "I'm different," "I feel better about myself and more confident with my children", "now I understand" and "my child's behaviour has definitely improved" ?

What numbers can compete with the "confessions" that not only have these skills been learnt, but that they were being applied to other areas of the participants lives as evidenced by the words "I can live well with my neighbours and I

understand them" and "My relationship with my husband and family has improved very much".

The effectiveness of the comic book as a powerful educational tool being taken back into the family and providing a secondary educational impact is evidenced by the comments concerning teenagers "correcting" their mothers for not using the "listening" and "self-worth" skills they had seen in the comic book. The full extent and influence of this secondary learning and the impact on the behaviour of those who become "teenage mothers" would have been interesting to follow up.

If the primary aim of the researcher was to provide a primary intervention at family level as a means of addressing the violence endemic in South Africa and for the prevention of child abuse and neglect most particularly in the child under five, it would appear from these quantitative and qualitative analysis that this programme is a good starting point. Physical violence has been shown to occur more in the family than in any other setting except for wars and riots (Straus et al, 1980). It is crucial in the prevention of community violence to start with the family. This is better expressed by one of the participants themselves, who on completion of the programme said "I don't hit because I know how they feel".

The researcher followed up the maternal-child relationship (MCRE), the maternal self esteem (RSE) and subjective maternal attitudes in the longterm and these have been discussed in context. A further effort was made to establish that no child

abuse had been reported for any of the programme participants. The appropriate reporting authorities for child abuse in each site were approached. None of the participants had been reported. A further effort was made to screen the clinic cards of all participants for any record of "problem" maternal-child interaction. This was completed and none was found.

The complex nature of child abuse and neglect makes isolating the different types difficult. Certainly if participants practice the programme skills this should influence the physical, verbal and emotional maternal-child interaction. The researcher's conceptual framework demanded that the maternal-child dyad could not be viewed in isolation. It was therefore important to look at whether the programme's influences extended into the family system. The qualitative data above suggests that this is the case. The researcher subjected the FAD to data analysis to see if this could be substantiated. As previously mentioned several insignificant results were obtained followed by significant Kruskal-Wallis analyses of variance for treatment group, all six categories and bestgroup. These clearly demonstrated that while the experimental group did show improved family functioning, so did the control groups 1. The site two control group 1 showing the most gain of all (in the light of the longterm evaluation of this control group in site 2 no clear deductions can be made). This might well be demonstrating the power of family support to influence family functioning. This has been well established in the literature as been significant and these results would seem to support this notion.

In summary then it would seem that the developed programme lead to significant positive changes in the maternal-child dyad and to some smaller degree influenced healthy family functioning. The support control 1 groups showed no change in maternal-child relationship in site one but dramatic changes in this variable in site two. The site two experimental and two social support groups (Sites 1 & 2) showed significant changes in family functioning compared to the two clinic control groups 2 and the site one experimental group. This is interesting in the light of the longterm evaluation which showed that the mothers from site 1 consistently did not attempt to use these skills with the broader family members - they were kept for the children.

This leaves one tempted to postulate as to what the possible reasons could be for this unexpected gain in the social support control in site two. It has been shown that there was contamination between at least one of the experimental group members. This is one of the problems of working in a small closeknit rural community. This leaves the researcher with the intriguing possibility that the developed programme might be appropriate for use by lay health workers. This exiting possibility invites further research.

The serendipitous findings of the maternal drawings were of particular interest to the researcher. The attention to detail which appeared in some pictures which at the same time had facial features missing was quite striking. The inconsistent use of hands and fingers was also striking. The researcher does not intend to draw any conclusions or assumptions from this data. It is of however of interest to note

the association tabulated in table 5.15 between the higher scores for the FSC and both the lack of facial features and the presence of hands and fingers. This would appear to be a potential area worthy of further research.

CHAPTER SIX

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

TO THE NEW WOMEN OF AFRICA

Proud mothers of the coming age,
'Tis good to find you now engage
Your minds and time your lives to raise
Above the level of bygone days.

'Tis good to see you play your part
With spirit and undaunted heart;
It gives young Afric's throbbing soul
A glimpse of bright and glorious goal.

God bless you, Mothers of our Race,
God cause to shine on you His face;
And give you strength and all you crave
To bring forth sons and daughters brave.

(Dennis C Osadebay)

6.1 INTRODUCTION

This research initially sought to understand the aetiology of child abuse and neglect and to explore the availability of interventions for the primary prevention thereof. The researcher identified a number of programmes that were being used at different levels of prevention. None of these fulfilled the criteria required by the researcher. It was essential that the intervention should be simply presented. It should be multi-ethnic and appropriate to South African consumers. In order to fulfil this requirement it must take cognisance of the marginalised education system created by the apartheid system which has left large numbers of South Africans functionally illiterate and disempowered. It should be appropriate to the most vulnerable and powerless and yet flexible enough to allow socio-cultural extension and application throughout the lifespan. It should comply with the Alma Ata principles of community acceptability, accessibility and affordability. The principles of equity and community participation should guide the programme as should prioritisation of those most in need. It should be appropriate for implementation by community health nurses as a primary prevention in the service setting in a manner which harnesses the unique knowledge base and skills she or he possesses and allows her or him to work with groups while not negating the importance of the individual. Finally it should encourage the community health nurse in her self-development as a facilitator to be sensitive to unique group and community needs and to encourage the embryonic development of a social support system. In such an atmosphere of mutual socio-cultural trust, each group member can experience feelings of worth; share and problem solve mutual and individual life hurdles; and acquire knowledge and practice in new and

possibly alternative communication and child management skills. No such programme was identified.

The researcher in all humility and awareness of the challenge being faced, sought to build from and on the existing knowledge base of parenting programmes and to develop a grass roots programme unique to the South African context which attempted to fulfil the criteria listed above.

This has been developed utilising existing programmes as basic material. Concepts, interaction sequences, and skills have been adapted primarily from Dinkmeyer and McKay (STEP) and Friedman's adaptation thereof, Filial Therapy and the work of Faber and Mazlish in the under five. These have been combined together with concepts of experiential learning, child development and counselling psychology into the simplest possible, grass roots programme which sought to demystify basic life skills and empower group members.

Much of the suggested material for roleplaying has come from the researchers own clinical crosscultural nursing experiences over fourteen years and from her familiarity with her own and other young children over seven privileged years of informally teaching mothers how to play with their children. The material for the graphics came from diverse sources of the multi-ethnic South African media, from Faber and Mazlish and from the crosscultural participatory community members who tested and directed the shape, format and to some extent the content.

The programme was implemented by offering Community health nurses training in the utilisation of the programme and this training was evaluated. Five community health nurses attempted to implement the programme. One as a full pilot study in order to identify and make possible correction of any further problems. This group as mentioned previously, was not included in the data analysis as the educational level was over standard ten. It was however extremely useful in that it did provide the anticipated feedback which in turn smoothed the implementation in the study sites. This pilot study did complete the full pre and post test questionnaires and the full programme intervention. Now that this research study is complete, it will be interesting at some future date to compare this study's results to those of the pilot site which fell into a higher educational category.

The programme effects were measured by exhaustive data analysis and has yielded some exciting and provocative results.

6.2 DISCUSSION

There are clear indication, that this was a worthwhile intervention. The triangulation of research methods has produced strong evidence in favour of the potential contribution to be made by this particular grass roots intervention. This is heartening for those researchers who are seeking to initiate similar grass roots programmes within a primary health care focus in the interests of empowering women and mothers to actively manage their lives in a self-directed manner.

The statistical analysis and qualitative feedback have individually and in combination clearly shown an improved maternal-child relationship. This improved relationship was initially assessed by measuring attitude change. This was in the belief that attitude measures "...an enduring organisation of motivational, emotional, perceptual and cognitive processes with respect to the individuals world" (Crutchfield, 1948,p.152). The mother's world includes the child, family environment, community system and the present and past psychodynamic experiences of the mother.

According to the BASNEF model of health education which guided this study, behaviour change is influenced by the complex interaction between the maternal attitude and the subjective norms held by the mother. This leads to the formulation of an intention for behavioral change. However behaviour change is possible only if "enabling factors" such as appropriate skills, economic and/or knowledge resources, are available.

The programme successfully provided sufficient "enabling factors" (eg. actively taught skills) to initiate the behaviour change documented. The developed programme also explored and questioned socio-cultural beliefs and "subjective norms" which influence attitudes to parenting and maternal-child relationship. Behaviour change was thus directly facilitated.

This was evidenced in the qualitative data where mothers insistently volunteered that they had "changed" and were "different". The latter was also supported by

reports from mothers supported by the CHN facilitators of observed behaviour change in the child (sometime dramatic). Further evidence of the extension of attitude into changes in behaviour and the influence of this changed behaviour on the family and community social system was supported initially by the statistical changes in the McMaster Family Assessment Device which supported that family functioning had improved in a positive direction. This was further supported by the sometimes open and sometimes embarrassed "admission" that the learnt skills had changed the marital interpersonal relationship, the relationship with older and teenage children and relationships with neighbours eg. "I can now live well with my neighbours and I understand them". Individual claims to have changed would not have been as powerful were it not for the number and variety of claims that were made. Participants tend to socially conform and the very diversity of the changed relationships was felt by the researcher to be impressive. Further evidence of the persistence of these changes in the longterm were provided by the consistent gains over time found in the positive maternal-child relationship in the posttest 2, site 2 and by the longterm subjective feedback given by mothers.

Thus while the researcher attempted to influence and measure attitude change, the core purpose of this study was to encourage a positive maternal-child relationship with all the positive behaviours associated with this, for the primary prevention of child abuse.

The conceptual framework which included concepts of interacting systems and of self-care and was guided by Orem's theory was found to be particularly relevant

for this research. The nursing intervention from Orem's Theory sought to meet the self-care needs/demands of both the mother and the child and to promote the development of essential self-care and dependent-care capabilities.

The changes in attitude, feeling and behaviour facilitated by the developed programme demonstrated an improved maternal-child relationship. These changes represent a core aspect of the dependent-care needs which the child requires from the mother eg maternal love and nurturance. This was clearly demonstrated in the qualitative feedback with words such as "less aggressive"; "play and communicate now"; and "don't hit because I know how they feel".

Orem's Model has a strong developmental focus. This aspect is supported by the developmental nature of the intervention programme which gives specific information on child development. It was further supported by the expectation that mother and child would experience self growth during the programme. This was evident in the change in behaviour which was reported to have occurred in the participating children (66% "a lot" & 34% "a few" changes). Despite there being no statistically significant change in the quantitative self esteem measure, mothers's did report positive changes in feelings and attitudes towards themselves eg. "I feel better about myself and more confident about my children" and "...made me realise that I have rights too". Further evidence of self growth in the facilitator was recorded on their evaluation feedback. The researcher felt that this verbalisation was substantiated by the fact that both facilitators not only verbalised that they had enjoyed the facilitation and utilised the skills in their own lives, but

they were also prepared, despite the enormous work load this research had added to their work schedule and despite continued work pressure, to continue offering the course in their service settings.

The researcher encountered considerable scepticism from a number of sources, this was unanticipated and of interest to the researcher. This seemed to primarily stem from two issues. Firstly, disciplinary guarding of infringement of perceived professional roles. The question most commonly asked was: "Was this an appropriate intervention for nurses to be making?" The researcher felt that the real threat was in the demystifying and simplification of "professional" skills and jargon which could be seen to pose a threat to certain professionals. Secondly there was a strong leaning among medical colleagues towards Maslow's Theory of Needs. In this instance it was felt that poor illiterate families that did not yet have basic needs met could not be open to a programme that looked at meeting higher self actualising and personal growth needs.

These challenging professional attitudes can be strongly refuted by these research results. Despite the extreme poverty and hardship evidenced in site two, and with lower level basic needs barely met (food and water scarce, 38.46% single parent maternal headed families, and housing/shelter being poor); there was evidence of dramatic changes in both the experimental group and in the social support control group in this site. Maslow's Theory predicting that lower level needs must be met before higher level needs can be addressed did not hold true for this research.

It was of considerable interest to the researcher that the Social Readjustment

Rating Scale which measured life stresses showed no correlation to the scores on the MCRE, FAD, Self-Esteem test or FSC. This would seem to support previous research on child abuse which has found no direct causal relationship between life stress and child abuse and which support an ecological causal model of child abuse.

The non-completion of sites three and four provided some interesting material for analysis. On comparing site two and four there were limited differences in "real terms". Site four was a peri-urban environment with considerable endemic community violence and psychosocial pathology. Similarly, although site two was more rural in nature, political violence pre-election was severe in this area. There were several political "massacres" in the area over this time period. The life events as measured by the SRS showed that death and injury were also common features of this community. Despite this the community health nurses in both sites were prepared and keen to facilitate a group. Site two was extremely successful as has been recorded in considerable detail. Site four was not. Detailed evaluation of the psychological and social factors which prevented this completion have been discussed. A similar problem existed with site three. Once again details of the psychosocial problems have been enlarged on already. Do these two "failures" outweigh the two "successes"? The researcher would suggest that this is not the case. The lessons from these two incomplete sites are clear. Community health nurses are prepared and committed to work closely with the community even when their own safety is jeopardised. The time period of this research fell over a particularly difficult and violent time period in the history of South Africa. With

the new post election non-racial democracy has come a commitment to discourage community violence. This is good news for health care providers. Despite this optimism for the future, it is only realistic to acknowledge that worldwide periurban areas are acknowledged as being violent; this does not mean that nurses should not continue to provide appropriate primary health care in these areas. Hopefully with the new commitment to primary health care, many of the social injustices which provoked violence will be remedied. Improved education, health care, basic services and subsidised medical care and nutrition programmes for mothers and children under six years will contribute to this process. Can we consider "parenting" and "life skills" programmes to be included in the concept of PHC? This is answered by the following quote:

"...the provision of safe water and improved sanitation; better housing; the reduction of the work load of women in villages; elementary health education of children and adults and through schools, through direct community action and the mass media - and of course the promotion of responsible parenthood which should be integrated into primary health care itself"

(Labouisse, Executive Director of UNICEF cited in WHO Chronicle, 1978, p.420)

What then of site three? The lesson to be learnt here is the very one the researcher has emphasised in the developed programme. It is essential for the

facilitator to be in close contact and socio-culturally aware of her community of practice. This does not necessarily preclude crosscultural experiences however. The significance of community participation at all four stages of assessment, planning, intervention and evaluation cannot be underestimated. Any intervention in the community must be prioritised by the community themselves rather than "imposed" by the health system experts.

The homogenous quality of the group could well be an important factor, particularly in community health nurses who may be unskilled in group work. Zigler and Weiss (1985) had similar experiences with failures and suggest that the high rate of attrition in programmes that require substantial participation by low-income mothers may be an indication that this is not an acceptable intervention mode. This study has shown that it is possible to complete such a programme with dynamic positive results. Site two had limited services and were excited and overjoyed to be offered new skills. There was no attrition despite long distances in hot, hilly terrain to reach the mobile service point where the course was based. This study extends the work of Olds (section 2.6.2.2), by providing knowledge of the effectiveness of support programmes in **different** settings.

There is evidence to suggest that the quality of the implementation (including the training and supervision of the intervention programme) influences the success (Zigler & Weiss, 1985). In this study, all five facilitators had the same training programme experiences. Yet the two facilitators who successfully implemented the programme received a mean score of 78% as compared to the mean score of

the unsuccessful facilitators of 57% (The Knowledge of Behaviour Principles).

The researcher sees the quality of the community participation and the personality and training of the community health nurse herself as being crucial to the success of the programme. At the end of chapter three the researcher showed concern under "limitations" as to whether community health nurse would be able to effectively implement the developed programme. This research indicates that it is not only possible but that they are strongly motivated to do so.

6.3 RECOMMENDATIONS

a) Faciliators Training

In the light of this it is crucial that facilitators being trained to run such a programme are competent to do so. The researcher attempted to provide effective training in a brief course of only 24 hours. Some facilitators might well require longer than this to become competent. Competence should be ascertained during the training.

It is also important to ensure that facilitators feel comfortable with this role. Several researchers have identified this as a potential problem (Conte et al, 1986; Wurtele et al, 1992).

The problem of disclosures needs to be recognised by the trainer of these facilitators and by the community health nurse facilitators themselves. Brief management of disclosures and support systems for referral should be included in any training course of this nature. When disclosures occur they need to be followed through with support and counselling.

Finally there is no reason why this programme should not be available for use by any lay or professional health care worker who is motivated and willing to undergo short, intensive training. Certainly there are many professionals who may be able to utilise the material effectively without undergoing additional training and it should be made available to them.

b) Developed Programme

This programme has been shown to provide more than does support alone and is an effective primary prevention for child abuse. There appears to have been little difficulty in learning communication, interaction and child management skills. The programme was enjoyed and beneficial even to those on whom it was not entirely focused because of their higher educational level. It would appear to be entirely appropriate for implementation at grass roots. Most (61.65%) of site two participants had less than a standard five educational standard.

c) Research

The power of the qualitative data has impacted to such a degree on the researcher, that had she the choice to redo this study the research methodology would be entirely participatory and of a qualitative nature. Further studies of this programme should be of this nature and include more direct measurement of variables in the children. Use could be made of children's drawings before, during and after the programme.

The literature review identifies more than 50% of failure to thrive (FTT) as being non-organic FTT. In a developing country such as South Africa it is crucial to recognise that the poverty cycle disempowers families and mothers and that FTT may well be NOFTT. This is critical to both intervention and treatment. Further research could explore the possibility of integrating this type of programme into existing nutrition education programmes for FTT infants at district level.

d) Dissemination

The fact that two participants actually volunteered to run such a programme themselves was of considerable interest. The literature review gives considerable weight to the ability to train lay community members effectively. This is of particular relevance where the community health nurse may be working cross-culturally. By utilising trained lay community members, the attrition rate may be reduced and "ownership" of the programme by the community is more likely to

occur, a self-empowering concept. This research should be extended to include appropriate training and testing of lay community members to utilise the basic manual and comic book. Both the latter should be translated into the most appropriate language for the facilitator and participants. The eleven South African official languages should be a prerequisite for local use. Most particularly because where participants are working with a second language (eg. english), one immediately reduces the level of understanding that the participant would gain if the comic book was in her first language. Similarly, the feedback that the comic book has a "secondary" impact in the home, is an indicator that any verbal literacy potential should be harnessed to encourage this to occur.

The facilitator's manual and comic book should be made available at a low cost in order to be accessible to those in the most need. It should be made available through UNICEF for international utilisation in developing countrys.

6.4 CONCLUSION

In the researcher's opinion the developed programme has been clearly shown to have a powerful positive impact on the maternal-child relationship. This is an effective primary prevention intervention and should be widely implemented in existing service settings at a district level of primary health care.

The community health nurse is in a unique position at the first level of health care delivery. It is her privilege and role to be in this position and it is critical for

effective primary health care delivery in South Africa today that her expertise is both recognised and maximised in the interests of this critical aspect of community health.

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ANNEXURES A - E :

TRAINING PROGRAMME

ANNEXURES F - Q :

EVALUATION OF DEVELOPED PROGRAMME

ANNEXURES A - E :

TRAINING PROGRAMME

ANNEXURES F - Q :

EVALUATION OF DEVELOPED PROGRAMME

ANNEXURES A - E

TRAINING PROGRAMME

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TRAINING PROGRAMME

29 May 1992.

Chief Nursing Service Manager

Dear Ms

**re: THREE DAY COURSE ON PARENTING FOR COMMUNITY HEALTH NURSES.
"Positive caring for the under fives"**

I am enclosing details of the above course which is being offered during June/July 1992 at the University of Natal, Durban.

It would be appreciated if you would circulate this information to your staff and consider allowing interested Community Health Nurses to attend this course.

The course will be run on:

THREE CONSECUTIVE FRIDAYS from 0800 hrs to 1600 hrs.

26 June

3 July

10 July

There is no charge for the course. However as this is part of a research study it would be appreciated if you would consider allowing those nurses who do attend, to implement the skills they will have acquired from the course, in your service setting.

I am including a brief research proposal in order to clarify the objectives of this research and will be happy to furnish any further details you may require. Thanking you in anticipation.

Yours faithfully,

Mrs. W.M. Lewis
(Community Health Nursing)

29 May 1992.

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(Community Health Nursing)

"POSITIVE CARING FOR THE UNDER FIVES"

(A SHORT 3 DAY COURSE ON THE SKILLS OF EFFECTIVE COMMUNICATION AND NON-PUNITIVE METHODS OF DISCIPLINE FOR THE YOUNG CHILD)

THIS COURSE IS BEING OFFERED FREE OF CHARGE TO ANY COMMUNITY HEALTH NURSE WHO IS NOT ONLY INTERESTED IN THIS AREA BUT WHO WOULD BE PREPARED WITH THE PERMISSION OF THE EMPLOYING AUTHORITY TO CONSIDER RUNNING SUCH A COURSE WITHIN HER SCOPE OF PRACTISE. IT IS PART OF A RESEARCH STUDY ON A FAMILY SUPPORT PROGRAMME FOR COMMUNITY HEALTH NURSES IN THE PRIMARY PREVENTION OF CHILD ABUSE AND NEGLECT.

This course has been developed as a primary prevention strategy. The emphasis is on helping nurses teach parents or parent substitutes to understand the psychosocial and physical development of the young child and to learn new skills of communication, thus encouraging effective parenting and engaging the co-operation of the child without resorting to violence.

Having been designed for the specific use of the Community Health Nurse, the course maximises the unique skills and contact she/he has with this client group. A facilitators manual is provided which gives detailed guidance and support. This would enable the Community Health Nurse to run a 90 minute mother and child support group each week. The full course would cover ten weeks.

The course is specifically designed for mothers of children under five years, with a low educational level, and includes a six page pictorial handout for mothers. This covers maternal-child interaction scenarios in a multi-ethnic South African context.

Training in this course is being offered for a limited number of Community Health Nurses during June/July 1992.

The course will be held on three consecutive Fridays from 0800 hrs to 1600 hrs. [26 June, 3 July, 10 July]

RATIONALE FOR RESEARCH

The high incidence of child abuse in the community and the reality of family and community violence, highlights the need for the introduction of a low cost support programme into an existing service setting. Existing family support programmes require sophisticated verbal ability and cognitive skills.

BRIEF BACKGROUND TO STUDY

The significance of the maternal-child relationship and the vulnerability of the child under five years is well recognised in the practice of Midwives and Community Health Nurses.

PTO/

***NOTICE OF THREE DAY COURSE
FOR COMMUNITY HEALTH NURSES***

DATES:

26 June 1992

3 July

10 July

VENUE:

UNIVERSITY OF NATAL
KING GEORGE V AVENUE
DURBAN
4000

ENQUIRIES:

MRS. W. LEWIS
8161075 / 8162499
(After hours 7643057)

A RESEARCH STUDY - NO PAYMENT REQUIRED.

International and local statistics indicate that a substantial number of reported cases of physical abuse and neglect fall into this age group, 60 - 70 % of all reported cases of physical abuse and neglect occur in the child under five years of age. These reported cases tend to be severe.

It is also well established that nearly all perpetrators are parents or parent substitutes.

Studies of child rearing practices show that parents commonly use physical modes of correcting the young child (62% of parents in children under one year and 97% of parents in children under four years.)

Family support programmes have been shown to be an effective therapeutic intervention strategy, particularly in families where the abusive pattern of interaction is not entrenched.

DIRECT ENQUIRIES TO:

MRS. W. LEWIS
Department of Nursing
University of Natal
King George V Avenue
Durban
4000.

PHONE 8161075 or 8162499 for further information.

"POSITIVE CARING FOR THE UNDER FIVES"

(A SHORT 3 DAY COURSE ON THE SKILLS OF EFFECTIVE COMMUNICATION AND NON-PUNITIVE METHODS OF DISCIPLINE FOR THE YOUNG CHILD)

THIS COURSE IS BEING OFFERED FREE OF CHARGE TO ANY COMMUNITY HEALTH NURSE WHO IS NOT ONLY INTERESTED IN THIS AREA BUT WHO WOULD BE PREPARED WITH THE PERMISSION OF THE EMPLOYING AUTHORITY TO CONSIDER RUNNING SUCH A COURSE WITHIN HER SCOPE OF PRACTISE. IT IS PART OF A RESEARCH STUDY ON A FAMILY SUPPORT PROGRAMME FOR COMMUNITY HEALTH NURSES IN THE PRIMARY PREVENTION OF CHILD ABUSE AND NEGLECT.

This course has been developed as a primary prevention strategy. The emphasis is on helping nurses teach parents or parent substitutes to understand the psychosocial and physical development of the young child and to learn new skills of communication, thus encouraging effective parenting and engaging the co-operation of the child without resorting to violence.

Having been designed for the specific use of the Community Health Nurse, the course maximises the unique skills and contact she/he has with this client group. A facilitators manual is provided which gives detailed guidance and support. This would enable the Community Health Nurse to run a 90 minute mother and child support group each week. The full course would cover ten weeks.

The course is specifically designed for mothers of children under five years, with a low educational level, and includes a six page pictorial handout for mothers. This covers maternal-child interaction scenarios in a multi-ethnic South African context.

Training in this course is being offered for a limited number of Community Health Nurses during June/July 1992.

The course will be held on three consecutive Fridays from 0800 hrs to 1600 hrs. [26 June, 3 July, 10 July]

RATIONALE FOR RESEARCH

The high incidence of child abuse in the community and the reality of family and community violence, highlights the need for the introduction of a low cost support programme into an existing service setting. Existing family support programmes require sophisticated verbal ability and cognitive skills.

BRIEF BACKGROUND TO STUDY

The significance of the maternal-child relationship and the vulnerability of the child under five years is well recognised in the practice of Midwives and Community Health Nurses.

PTO/

Below are a series of phrases that describe children's behavior; Please (1) circle the number describing how often the behavior *currently* occurs with your child, and (2) circle either "yes" or "no" to indicate whether the behavior is *currently* a *problem*.

	How often does this occur with your child?							Is this a problem for you?	
	Never	Seldom	Sometimes	Often	Always			Yes	No
1. Dawdles in getting dressed	1	2	3	4	5	6	7	Yes	No
2. Dawdles or lingers at mealtime	1	2	3	4	5	6	7	Yes	No
3. Has poor table manners	1	2	3	4	5	6	7	Yes	No
4. Refuses to eat food presented	1	2	3	4	5	6	7	Yes	No
5. Refuses to do chores when asked	1	2	3	4	5	6	7	Yes	No
6. Slow in getting ready for bed	1	2	3	4	5	6	7	Yes	No
7. Refuses to go to bed on time	1	2	3	4	5	6	7	Yes	No
8. Does not obey house rules on his own	1	2	3	4	5	6	7	Yes	No
9. Refuses to obey until threatened with punishment	1	2	3	4	5	6	7	Yes	No
10. Acts defiant when told to do something	1	2	3	4	5	6	7	Yes	No
11. Argues with parents about rules	1	2	3	4	5	6	7	Yes	No
12. Gets angry when doesn't get his own way	1	2	3	4	5	6	7	Yes	No
13. Has temper tantrums	1	2	3	4	5	6	7	Yes	No
14. Sasses adults	1	2	3	4	5	6	7	Yes	No
15. Whines	1	2	3	4	5	6	7	Yes	No
16. Cries easily	1	2	3	4	5	6	7	Yes	No
17. Yells or screams	1	2	3	4	5	6	7	Yes	No
18. Hits parents	1	2	3	4	5	6	7	Yes	No
19. Destroys toys and other objects	1	2	3	4	5	6	7	Yes	No
20. Is careless with toys and other objects	1	2	3	4	5	6	7	Yes	No
21. Steals	1	2	3	4	5	6	7	Yes	No
22. Lies	1	2	3	4	5	6	7	Yes	No
23. Teases or provokes other children	1	2	3	4	5	6	7	Yes	No
24. Verbally fights with friends his own age	1	2	3	4	5	6	7	Yes	No

International and local statistics indicate that a substantial number of reported cases of physical abuse and neglect fall into this age group, 60 - 70 % of all reported cases of physical abuse and neglect occur in the child under five years of age. These reported cases tend to be severe.

It is also well established that nearly all perpetrators are parents or parent substitutes.

Studies of child rearing practices show that parents commonly use physical modes of correcting the young child (62% of parents in children under one year and 97% of parents in children under four years.)

Family support programmes have been shown to be an effective therapeutic intervention strategy, particularly in families where the abusive pattern of interaction is not entrenched.

DIRECT ENQUIRIES TO:

MRS. W. LEWIS
Department of Nursing
University of Natal
King George V Avenue
Durban
4000.

PHONE 8161075 or 8162499 for further information.

TRAINING COURSE FOR COMMUNITY HEALTH NURSES

Three full, eight hour days.
3 July, 10 July, 17 July.

Only a maximum of 10 community health nurses will be accepted for this course. It is hoped that at least 3 of these will be motivated to implement the research within their own communities.

A number of Local Authorities have responded with requests to participate.

Community Health Nurses working in Primary Health Care have also shown interest in attending the training course and would be an excellent locus to implement the research. However the Natal Provincial Administration requires this research to have been accepted by the Medical Ethics Sub-Committee before they will allow any staff to attend the training course.

IMPLEMENTATION OF RESEARCH BY COMMUNITY HEALTH NURSES.

August/September/October/November 1992

**EYEBERG ASSESSMENT OF CHILD
BEHAVIOUR PROBLEMS**

(Eyeberg & Ross, 1978)

Below are a series of phrases that describe children's behavior; Please (1) circle the number describing how often the behavior *currently* occurs with your child, and (2) circle either "yes" or "no" to indicate whether the behavior is *currently* a *problem*.

	How often does this occur with your child?							Is this a problem for you?	
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[illegible]

**Knowledge of Behavioural Principles
as applied to children**

(Odell, Tarler-Benlolo & Flynn, 1979)

Directions

Please use pencil.

Read each question and each of its four possible answers. Sometimes more than one answer could be correct under certain circumstances; however, you should select the best answer or the answer that is most generally true. Completely fill in the square beside that answer with a pencil.

Example:

- ✓ ☒ Probably the most important influence in a young child's life is his
- ☐ Toys
 - ☐ Television
 - ✓ ☒ Parents
 - ☐ Friends

Please do not consult others while deciding how to answer the question.

Be sure to fill in only one square for each question.

Be sure to answer every question even if you must guess.

1. Desirable and undesirable behavior are most alike in that they are:
 - ☐ The result of emotions and feelings.
 - ☐ Habits and therefore difficult to change.
 - ✓ ☒ Ways the child expresses himself.
 - ☐ The result of learning.
2. Probably the most important idea to keep in mind when first changing behavior is:
 - ☐ To use both reward and punishment.
 - ☐ To reward every time the desired behavior occurs.

- ☐ To be flexible about whether or not you reward.
 - ✓ ☒ To be sure the child understands why you want the behavior to change.
3. Most problem behavior in young children is probably:
- ☐ A reaction to deeper emotional problems.
 - ✓ ☒ Due to lack of communication in the home.
 - ☐ Accidentally taught by the child's family.
 - ☐ Due to a stage which the child will outgrow.
4. A child begins to whine and cry when his parent explains why he can't go outside. How should the parent react?
- ☐ Ask the child why going outside is so important to him.
 - ☐ Explain that it is a parent's right to make such decisions.
 - ☐ Explain again why he should not go outside.
 - ☐ Ignore the whining and crying.
5. Which of the following is most important for parents in controlling their child's behavior?
- ☐ The rules the parents make about behavior.
 - ✓ ☒ The parents' understanding of the child's feelings.
 - ☐ The behaviors to which the parents attend.
 - ☐ Being strict, but also warm and gentle.
6. In changing a child's behavior a parent should try to use:
- ☐ About one reward for every punishment.
 - ☐ About one reward for every five punishments.
 - ☐ About five rewards for every punishment.
 - ☐ Practically all rewards.
7. Which of the following is the least likely way for children to react to the person who punishes them?
- ☐ The child will try to avoid the punisher.
 - ☐ The child will have admiration and respect for the punisher.
 - ☐ The child may copy the punisher's methods and do similar things to playmates.
 - ☐ The child will associate the punishment with the punisher.
8. Which of the following statements is most true?
- ☐ People usually fully understand the reasons for their actions.

- ☐ People are often unaware of the reasons for their actions.
 - ☐ People's actions are mostly based on logic.
 - ☐ It is necessary to understand the reason for a person's behavior before trying to change the behavior.
9. If you are trying to teach a child to talk, you should first:
- ☐ Reward the child after speaking a sentence.
 - ☐ Reward the child for saying a word.
 - ☐ Reward the child for any vocalization.
 - ☐ Punish the child if he did not speak.
10. If punishment is used for a behavior such as playing football in the house, which type is probably best to use?
- ☐ Make the child do extra homework.
 - ☐ Clearly express your disapproval.
 - ☐ Remove the child to a boring situation each time.
 - ☐ A reasonable spanking.
11. A child has been rewarded each time he cleans his room. In order to keep the room clean without having to use a reward, the next step should probably be to:
- ☐ Have a talk about how pleased you are and then stop giving the reward.
 - ☐ Give the reward about one out of five times.
 - ☐ Give the reward almost every time.
 - ☐ You must always reward it every time.
12. Parents who use lots of rewards for good behavior and few punishments will probably tend to have children who:
- ☐ Do not understand discipline.
 - ☐ Will not cooperate unless they are "paid."
 - ☐ Take advantage of their parents.
 - ☐ Are well-behaved and cooperative.
13. When should a child who is just learning to dress himself be praised the first time?
- ☐ When he gets his foot through the first hole in his underwear.
 - ☐ When he gets his underwear completely on.
 - ☐ When he asks to do it himself.
 - ☐ When he has completely finished dressing himself.

14. Which of the following is most effective in getting a child to do homework?
- ☒ "When you finish your homework, you can watch T.V."
 - ☐ "You can watch this show on T.V. if you promise to do your homework when the show is over."
 - ☐ "If you don't do your homework tonight, you can't watch T.V. at all tomorrow."
 - ☐ Explain the importance of school work and the dangers of putting things off.
15. Three of the following responses refer to forms of punishment which are mild and effective. Which one is not?
- ☐ Ignoring the undesirable behavior.
 - ☐ Sending the child to a dull room for a few minutes.
 - ☐ Taking away something the child likes (such as dessert after supper).
 - ☐ Scolding.
16. Each time Mother starts to read, Billy begins making a lot of noise which prevents her from enjoying her reading time. The best way for Mother to get Billy to be quiet while she reads is to:
- ☐ Severely reprimand him when this occurs.
 - ☐ Pay close attention and praise and hug him when he plays quietly while she is reading and ignore his noisy behavior.
 - ☐ Call him to her and explain carefully how important it is for her to have a quiet time for herself each time this occurs.
 - ☐ Tell him that he won't get a dessert after dinner if he continues.
17. Which of the following is the most effective form of punishment in the long run for reducing a child's undesirable behavior?
- ☐ Scolding him every time he does it.
 - ☐ Occasionally spanking him when he does it.
 - ☐ Sending him to his room for five minutes every time he does it.
 - ☐ Sending him to his room all afternoon every time he does it.
18. A young child often whines and cries when he is around his mother. In trying to find out why he cries, his mother should probably first consider the possibility that:
- ☐ He is trying to tell her something.

- ☐ He needs more of her attention.
- ☐ She is somehow rewarding his crying.
- ☐ She is not giving him enough attention.

19. A good rule to remember is:

- ☐ Do not reward with money if possible.
- ☐ Catch a child doing something right.
- ☐ Reward good behavior and always punish bad behavior.
- ☐ Punishment is always unnecessary.

20. If a child very gradually receives rewards less and less often for a behavior, what is most likely to happen?

- ☐ He will soon stop the behavior.
- ☐ He will be more likely to behave that way for a long time.
- ☐ He will not trust the person giving the rewards.
- ☐ None of the above.

21. Which of the following is true about punishment?

- ☐ Punishment teaches respect.
- ☐ Punishment should be delayed until it can be carefully determined that it is really necessary.
- ☐ Punishment can teach a child new behaviors.
- ☐ Some punishments can result in a child becoming aggressive.

22. In a reading group, the teacher gives each child candy plus praise for each correct answer. Which of the following statements is most true?

- ☐ The candy is a bribe and doesn't belong in a school setting.
- ☐ At first, the children work to earn the candy and may later work for the praise alone.
- ☐ Children shouldn't be "paid" for doing their school work.
- ☐ It probably doesn't make much difference whether or not candy is used because the children who want to learn to read will do so and the others won't.

23. A boy loves football. What is most likely to happen if, each time he is playing nicely with his sister, his father invites him to play football?

- ☐ He will always be asking his father to play football.
- ☐ He will play nicely with his sister more often.

- ☐ He will be annoyed with his father for interfering with his activities.
 - ☐ He will be encouraged to teach his sister to play football.
24. To record, graph and note the direction of the change of a behavior is:
- ☐ A minor, optional step in a behavior-change program.
 - ☐ An important step in a behavior-change program.
 - ☐ A procedure employed only by scientists for research.
 - ☐ Time consuming and complicated. Therefore, these procedures should only be used in special cases.
25. A father is teaching his son to hit a thrown ball with a bat. Which of the following methods will probably most help his son to learn to hit?
- ☐ Let him try to hit the ball without saying anything, so the child can learn on his own.
 - ☐ Occasionally tell him what he is doing wrong.
 - ☐ Occasionally tell him what he is doing right.
 - ☐ Tell him almost every time he does something right.
26. Which of the following is most true about physical punishment?
- ☐ It should immediately follow the undesirable behavior and at full intensity.
 - ☐ It should be mild and immediately follow the undesirable behavior.
 - ☐ It should begin in a mild form and, if that doesn't work, intensity should gradually be increased.
 - ☐ It is ineffective and inappropriate.
27. Punishment, as a way to get rid of an undesirable behavior, is best used when:
- ☐ You are very upset.
 - ☐ You want to teach the child the right way to behave.
 - ☐ The behavior may be dangerous.
 - ☐ Scolding doesn't seem to be effective.
28. Which of the following is not an important step in a behavior-change program?
- ☐ Make certain the child feels ashamed for his misbehavior.

- ☐ Decide on a particular behavior that you wish to change.
 - ☐ If necessary, break the selected behavior down into smaller steps.
 - ☐ Select a proper time and situation for measuring the behavior.
29. If you want your child to develop proper study habits, you should:
- ☐ Encourage him to do his homework.
 - ☐ Help him to see school as pleasant.
 - ☐ Reward him whenever he studies.
 - ☐ Give him good reasons why he will need school.
30. Two brothers fight constantly. Their parents decide to praise them when they play together nicely. However, they still continue to fight. Punishment may be necessary. What is probably happening?
- ☐ They don't want their parents' praise.
 - ☐ The benefits of fighting are stronger to them than their parents' praise.
 - ☐ They have too much anger toward each other to control.
 - ☐ They are at a stage they will grow out of.
31. A child often cries over any small matter that bothers her. How should her parents react to best reduce her crying?
- ☐ Reward when she reacts without crying.
 - ☐ Use a mild punishment when she cries.
 - ☐ Try to find out what is really troubling the child and deal with that.
 - ☐ Provide her with something interesting so she will stop crying.
32. Mrs. Thomas found out that spanking her seven-year-old son, Bob, did not seem to stop him from using "naughty" words. A friend suggested that rather than spanking him, she should send him to be by himself. The room he is sent to should be:
- ☐ His own room, so he will still have something to do.
 - ☐ Small and dark.
 - ☐ As uninteresting as possible.
 - ☐ A large room.
33. If you want your child to say "please" and "thank you" at the table, it is probably most important to:
- ☐ Reprimand him when he forgets to say them.
 - ☐ Explain why good manners are important.

- ☐ Remember to compliment him when he remembers to say them.
 - ☐ Praise other members of the family when they use these words.
34. Which reward is probably best to help a 12-year-old child improve his arithmetic skills?
- ☐ A dollar for each evening he studies.
 - ☐ A dime for each problem he works correctly.
 - ☐ Ten dollars for each A he receives on his report card in arithmetic.
 - ☐ A bicycle for passing arithmetic for the rest of the year.
35. A major problem has been getting Leon to bed in the evening. His mother has decided to change this and wants to measure the relevant behaviors. Which is the best way for her to do this?
- ☐ Each evening, record whether or not he goes to bed on time.
 - ☐ Chart his behavior all day long, up to and including bedtime to try to find out what causes his not wanting to go to bed.
 - ☐ Each week, make a note of how easy or difficult it has been to get him to bed.
 - ☐ Ask Leon to keep his own record each week.
36. Mr. Jones agreed to pay his son, Mike, 25¢ each time he carries out the trash. If Mr. Jones forgets to give Mike the money for a few days, what is most likely to happen?
- ☐ Mike will continue to take out the trash because he realizes how important this is.
 - ☐ Mike will stop taking out the trash.
 - ☐ Mike will begin to do extra chores, as well as take out the trash, so his father will notice how well he's doing and remember to give Mike the money.
 - ☐ Mike will start to misbehave to take out his anger about not being paid.
37. A father tells a child she cannot go to the store with him because she didn't clean her room like she promised. She reacts by shouting, crying and promising she will clean the room when she gets home. What should the father do?
- ☐ Ignore her and go to the store.

- ☐ Take her to the store but make her clean her room when they return.
 - ☐ Calm her down and go help her clean her room.
 - ☐ Talk to her and find out why she doesn't take responsibility.
38. The first step in changing a problem behavior is to:
- ☐ Reward the child when he is behaving nicely.
 - ☐ Punish the child for misbehavior.
 - ☐ Carefully observe the behavior.
 - ☐ Seek help from someone who is more objective.
39. In changing a behavior it is most important to use:
- ☐ Methods which have been tested by others.
 - ☐ Consequences which are rewarding to the child.
 - ☐ Consequences which are punitive to the child.
 - ☐ Rewards which do not bribe the child.
40. Johnny has just torn up a new magazine. Of the following choices, which is the best way for his mother to discipline him?
- ☐ Tell him he will be spanked by his father when he gets home.
 - ☐ Punish him then and there.
 - ☐ Explain to Johnny about the wrongness of his action.
 - ☐ Angrily scold Johnny so that he will learn that such an act is bad and upsetting to his mother.
41. Stan is doing a number of things that greatly disturb his parents. It would be best for them to:
- ☐ Try to eliminate quickly all of these undesirable behaviors at once.
 - ☐ Select just a few behaviors to deal with at first.
 - ☐ Select the single behavior they find most disruptive and concentrate on changing that.
 - ☐ Wait for 28–30 days before beginning to try to change his behaviors to make certain they are stable and persistent.
42. Which would be the best example of an appropriate way to praise Mary?
- ☐ Good girl, Mary.
 - ☐ I love you, Mary.

- ☐ I like the way you helped me put the dishes away.
 - ☐ I'll tell your father how nice you were when he comes home.
43. Listed below are four methods used to change behavior. Which is usually the best technique to get Frank to stop sucking his thumb?
- ☐ Punish the undesired behavior.
 - ☐ Ignore the behavior.
 - ☐ Reward him for desirable behavior in the situation in which he usually misbehaves.
 - ☐ Explain to the child why the behavior is undesirable.
44. Jimmy sometimes says obscene words, but only in front of his mother. She has been shocked and makes her feelings clear to him. How should she react when he uses obscene words?
- ☐ Wash his mouth out with soap.
 - ☐ Ignore him when he uses obscene words.
 - ☐ Tell him how bad he is and how she doesn't like him when he uses those words.
 - ☐ Explain to him the reason such words are not used.
45. If you want to make a behavior a long-lasting habit, you should:
- ☐ Reward it every time.
 - ☐ First reward it every time and then reward it occasionally.
 - ☐ Promise something the child wants very much.
 - ☐ Give several reasons why it is important and remind the child of the reasons often.
46. Punishment will not be effective unless you:
- ☐ Prevent the child from escaping while you punish him.
 - ☐ Throw all of your emotions into the punishment.
 - ☐ Follow it with a careful explanation of your reasons for the punishment.
 - ☐ Have tried everything else.
47. The most likely reason a child misbehaves is because:
- ☐ He is expressing angry feelings which he often holds inside.
 - ☐ He has learned to misbehave.
 - ☐ He was born with a tendency to misbehave.
 - ☐ He has not been properly told that his behavior is wrong.

48. Which of the following is probably most important in helping a child behave in desirable ways?
- ☐ To teach him the importance of self-discipline.
 - ☐ To help him understand right and wrong.
 - ☐ Providing consistent consequences for his behavior.
 - ☐ Understanding his moods and feelings as a unique person.
49. A baby often screams for several minutes and gets his parents' attention. Which of the following is probably the best way for his parents to reduce his screaming?
- ☐ If there is nothing physically wrong with the child, ignore his screaming even though the first few times he screams even louder.
 - ☐ Distract the child with something he finds interesting whenever he screams.
 - ☐ Ignore all noises and sounds the child makes.
 - ☐ None of the above. Babies usually have good reasons for screaming.
50. How often a behavior occurs is probably mostly controlled by:
- ☐ The person's attitude about his behavior.
 - ☐ What happens to him at the same time the behavior occurs.
 - ☐ What happens to him just before the behavior occurs.
 - ☐ What happens to him just after the behavior occurs.

KEY:	1. d	12. d	23. b	34. b	45. b
	2. b	13. a	24. b	35. a	46. a
	3. c	14. a	25. d	36. b	47. b
	4. d	15. d	26. a	37. a	48. c
	5. c	16. b	27. c	38. c	49. a
	6. d	17. c	28. a	39. b	50. d
	7. b	18. c	29. c	40. b	
	8. b	19. b	30. b	41. c	
	9. c	20. b	31. a	42. c	
	10. c	21. d	32. c	43. c	
	11. c	22. b	33. c	44. b	

***FINAL EVALUATION BY TRAINEE
PARTICIPATING COMMUNITY HEALTH NURSE FACILITATORS***

How I felt about the course:

A worthwhile Health Education Programme

A moderate Educational Programme

A disappointing Educational Programme

An ineffectual Educational Programme

What I LIKED most about the programme:

What I DISLIKED most about the programme:

Changes noticed in the group members in my family or child/children:

A lot

A few

None

Further comments I would like to make:

ANNEXURES F - Q

EVALUATION OF DEVELOPED PROGRAMME

GENERAL GUIDELINES FOR DATA COLLECTION PROCEDURE

* Each community health nurse facilitator has a copy of the facilitators manual, and sufficient of the graphic comic books for each of her group members (refer developed programme).

* Brief written information to support the verbal instructions of the researcher were given to each participating community health nurse facilitator (refer Annexure H).

* The purpose of the research, the appreciation of the subjects willingness to participate and possible benefits, clear guidelines as to what is being asked of the subject concerning time, participation and questionnaires and reassurance that should the subject decide to withdraw from the research she would not be disadvantaged in any way by any health service provider, is explained to each subject. The confidentiality and anonymity of the research data is to be assured and consent forms are to be signed by every subject participating in the study (refer Annexure G1 & G2).

* The questionnaires will be given to all subjects in the same sequence.

This sequence shall be:

- 1) The Roth Mother-Child Relationship Evaluation
(Which includes basic demographic information.)

- 2) The McMaster Family Assessment Device

- 3) The Rosenberg Self esteem Scale

These three instruments will be both pre and post tested for all groups.

- 4) The Social Readjustment Rating Scale (posttest only).

* The graphic drawings of the mothers will be retained and given to the researcher.

* The Family Stress Checklist is to be completed by the researcher in a semi-structured questionnaire form for all subjects of the experimental groups. Privacy and confidentiality is to be assured.

* Evaluation questionnaires are to be completed by mothers and by community health nurse facilitators.

* Long-term evaluation two and a half years after intervention programme completion will be undertaken.

INFORMATION TO BE GIVEN TO RESEARCH SUBJECTS

1. This is a research study to evaluate the effectiveness of a "PARENTING COURSE "in the community setting.
2. In order to evaluate the effectiveness or ineffectiveness of this course it is necessary to compare mothers taking the course with mothers not taking the course.
3. Mothers will thus be asked to fill in some questionnaires. The purpose of these will be to help us understand how you think of yourself and your family and subsequently to ascertain whether the "parenting course" as compared to the normal clinic services leads to any changes at all.
4. Please answer the questions as honestly as possible.
5. All information given will be kept strictly confidential.
6. Your assistance and co-operation with this research is much appreciated. THANK YOU!

I ACKNOWLEDGE THAT I UNDERSTAND AND GIVE MY CONSENT TO VOLUNTARILY PARTICIPATE IN THIS STUDY.

NAME IN FULL: DATE:

PLACE:

11. INFORMED CONSENT FOR INCLUSION IN A CLINICAL TRIAL*

1. I NAME:

hereby consent to the following procedure and/or treatment being conducted on the person indicated in (4) below.

2. I acknowledge that I have been informed by:

Mrs Wendy May Lewis

concerning the possible advantages and possible adverse effects which may result from the abovementioned procedure and/or treatment and of the ways in which it is different from the conventional procedure and/or treatment. The information which I was given and which I acknowledge I understand is shown on the reverse side of this form.

3. I agree that the above procedure and/or treatment will be carried out and/or supervised by:

Mrs Wendy May Lewis

4. I acknowledge that I understand the contents of this form, including the information provided on its reverse and as the

SUBJECT	PARENT	GUARDIAN	OTHER (SPECIFY)
---------	--------	----------	-----------------

freely consent to the above procedure and/or treatment being conducted on:

NAME:

5. I am aware that I may withdraw my consent at any time without prejudice to further care.

SIGNED	SUBJECT:	DATE			
SIGNED	WITNESS:	DATE			
SIGNED	INFORMANT:	DATE			
SIGNED	RESEARCHER:	DATE			

* With the exception of the names and signatures in paragraphs 1, 4 and 5, please provide the above information.

INFORMATION TO BE GIVEN TO ALL RESEARCH SUBJECTS

1. This is a research study to evaluate the effectiveness of a "PARENTING COURSE" in the community setting.
2. In order to evaluate the effectiveness or ineffectiveness of this course it is necessary to compare mothers taking the course with mothers not taking the course.
3. Mothers will thus be asked to fill in some questionnaires. The purpose of these will be to help us understand how you think of yourself and your family and subsequently to ascertain whether the "parenting course" as compared to the normal clinic services leads to any changes at all.
4. Please answer the questions as honestly as possible.
5. All information given will be kept strictly confidential.
6. Your assistance and co-operation with this research is much appreciated. THANK YOU!

CLIENTS PARTICIPATING IN "PARENTING COURSE"

1. There will be 10 consecutive meetings (one a week) on "positive parenting for the under five"
2. As this is for research purposes we would really appreciate your participation. However should you desire to withdraw at any time you are free to do so, and will experience no disadvantage or discrimination whatsoever from any health service.
3. Each group meeting will last approximately 90 minutes.
4. Each week new communication skills will be learnt and practised.
5. These new skills will help you to listen, understand and talk to your child/children.
6. These new skills may also help you to communicate better with other people in your life.
7. At the end of these 10 weeks, your group will be given the option to keep meeting as a neighbourhood group, should you so desire.
8. You will be asked to answer some simple questions about you and your child/children, before and after the course.

***BRIEF INFORMATION ON RESEARCH
FOR PARTICIPATING COMMUNITY HEALTH NURSES***

The Community Health Nurse working in maternal and child health assesses the health, growth and development (bio-psycho-social) of the infant/child, the primary caretaker and the family. She establishes an appropriate nursing care plan, wherever possible, prioritising preventive and promotive activities, and including curative and rehabilitative activities when necessary.

Community clients routinely receive support from the nurse at clinic visits, home visiting and neighbourhood groups.

The control groups will receive only the above support.

The experimental groups will experience 10 once-a-week sessions lasting 90 minutes each. Here clients will experience the same support as in the neighbourhood group mentioned above, but will also receive intensive skills training on effective communication and non-punitive methods of discipline, accompanied by anticipatory guidance on age appropriate behavior for the child under 5 years and common management of common childhood problems.

ALL CONTROL AND EXPERIMENTAL CLIENTS MUST HAVE THEIR CLINIC CARDS MARKED TO SHOW THAT THEY ARE PART OF THIS RESEARCH (small red cross).

ALL THREE GROUPS WILL CONSIST OF THE SAME NUMBER OF CLIENTS (approximately 7).

The two control groups will consist of:

1. One group of normal clinic attenders
2. One group of normal clinic attenders who also attend a neighbourhood group/antenatal class.

LIST OF QUESTIONNAIRES FOR THE RESEARCH ON
"PARENTING SKILLS"

During the Parenting Course only:

1. FAMILY STRESS CHECKLIST - Completed by RESEARCHER
OR C.H.N. IMPLEMENTING THE RESEARCH

Before and after the Parenting Course:

2. MOTHER-CHILD RELATIONSHIP EVALUATION
3. MCMASTER FAMILY ASSESSMENT DEVICE
4. ROSENBERG'S SCALE TO MEASURE SELF ESTEEM

After the course only:

5. SOCIAL READJUSTMENT RATING SCALE
6. EVALUATION BY:
 - A) MOTHERS
 - B) COMMUNITY HEALTH NURSE
 - C) DETAILED REPORT BY C.H.N.

FAMILY STRESS CHECKLIST

This questionnaire will need to be filled out by the researcher or Community Health Nurse participating in the research.

All information is confidential and will remain such. To facilitate this each checklist will be initially marked with the clients name in **PENCIL**. This will later be removed and substituted with a code which will remain and will not be traceable back to the service setting.

The client is scored on ten areas of possible stress. Each point is scored on a scale of 1 to 10. "No Risk" is scored (0), "Risk" is scored (5) and "High Risk" is scored (10).

A list of possible questions to use to enable the clients to be consistently rated on the checklist is given.

The definition for each category of No Risk, Moderate Risk and High Risk are given to help clarify these categories.

The final checklist for scoring each client is provided.

Solbritt Murphy, Bonnie Orkow and Ray M. Nicola

Table 1. Family Stress Checklist*

	No Risk, Score 0	Risk, Score 5	High Risk, Score 10	
	M F	M F	M F	M F
1. Parent beaten or deprived as child	Infrequent spankings. Consistent "parenting"	Frequent spankings, some bruises; received intermittent "parenting"	Severe beatings; repeated foster homes. No helpful parent model in childhood	
2. Parent has criminal or mental illness record	Not present	Present, but demonstrates rehabilitation	Current psychosis; chronic pattern of psychiatric problems	
3. Parent suspected of abuse in the past	Not present	Official report of mild abuse; child not placed in foster care	Official report of serious abuse; children placed in foster care or died	
4. Parent with low self-esteem, social isolation, or depression	Not present	Intermittent coping skills; no current lifelines or unreliable ones	Severely depressed. No lifelines in past or present	
5. Multiple crises, or stresses	Not present	Moderate environmental and/or marital problems	Chaotic life style, severe environmental and/or marital problems	
6. Violent temper outbursts	Not present	Damages property	Attacks people	
7. Rigid, unrealistic expectation of child's behavior	Not present	Afraid of spoiling child, unrealistic expectations	Intolerance of normal behavior; very strict parent	
8. Harsh punishment of child	Not present	Current frequent spankings or use of belt, not in head area	Physical punishment of baby prior to crawling; sadistic and/or dangerous punishment	
9. Child difficult and/or provocative or perceived to be by parents	Not present	Child triggers abuse by intermittent provocative behavior	Child triggers abuse by constant provocative behavior (i.e., seen as having no good points)	
10. Child unwanted, or at risk of poor bonding	Not present	Risk factors present, but bonding adequate	Risk factors present, and bonding poor	

* Developed by B.D. Schmitt and C.A. Carroll-Child Protection Team at the University of Colorado Health Sciences Center. Abbreviations used: M = mother, F = father. Reproduced with permission of the authors and published from *The Child Protection Team Handbook*, B.D. Schmitt (Ed.), pp. 107-108. Garland, New York (1978).

(Questions are not asked in any order, nor are all questions necessarily asked of each client.)

1. *Parent beaten or deprived as a child.*

- How did your parents treat you when you were a child?
- How did your parents get you to behave when you were growing up?
- Did both parents treat you the same?
- Was the treatment fair?
- Who are you living with now? When a child?
- Do you want to raise your child differently than you were raised?
- Were your brothers and sisters treated the same as you were?
- Did your parents treat you differently when you became a teenager?

2. *Parent has criminal or mental illness history (category used for mental breakdown as well as transient situational stresses).*

- Have you ever seen a counselor before?
- Did you have any problems in school? (Did you see a school counselor?)
- Have you had any contact with other agencies, e.g., mental health, welfare, legal?
- Tell me about your partner—are you together? What type of work does he do? (Pay particular attention to issue of how he gets to work, driver's license? police involvement? If wife/girlfriend describes her partner's behavior as weird, ask if he has ever had any treatment for that.)
- Was there anyone who took a particular interest in you when you were growing up?
- Do you/your partner drink? Is that a problem?

3. *Parent suspected of abuse in the past.*

- How do you discipline a child?
- Do you have any problems getting a child to cooperate?
- Does your partner agree with you that "Johnnie" has/does not have a problem?
- Have you ever seen a social worker/been to a social agency about the behavior problem (give examples: school social worker, mental health, welfare)?
- How do you handle the situation when you get mad at a child?
- Did you babysit when you were younger? How was that experience?
- (If patient is a stepparent) How was it to become a "parent" overnight?

4. *Parent with low self-esteem, social isolation, or depression.*

- If you were not talking to me about your concerns, who would you be talking to? (Observe general appearance. Does client look sad or at a loss to talk.)
- With whom do you spend most of your time?
- What do you do for fun?
- Do you like the way life is going for you?
- What is a typical day like for you?
- Do you think you/your partner will be a good mother/father? Do you think you/your partner is a good father/mother?

5. *Multiple crises or stresses.*

- Who is in the home? Does everyone get along? How are things going for you? (Observe client's interaction in the clinic with child/other parents/professional staff.)
- How does your partner feel about this pregnancy?
- Does your living situation work for you? (Observe types of requests client makes of staff, e.g., emergency food order, housing emergencies, clinic walk-in with sick child.)
- What is most stressful in your home?

6. *Violent temper outbursts.*

- When you/your partner get angry, what do you do?
 - What does your partner do when you get angry?
 - What do you do when he gets angry?
 - Do you have a bad temper? And your partner?
 - Do you find you and your partner hitting each other when you get angry?
 - What happens in your home when you/your partner drink too much?
-

Table 2. Questions Used by Social Work Staff to Complete Parenting Checklist (*Continued*)

7. *Rigid, unrealistic expectations of child's behavior.*

- How is cooperation handled in your home?
- If interviewing while children in playroom or office are screaming, ask client what the screaming of kids does to her.
- Do you feel you know enough about how children grow and develop?
- Would you like to know more about raising children? (It is difficult to imagine what it will be like caring for a newborn if one has never had the experience.)
- Who has talked to you about raising children?
- What would you do if a child you were caring for began to cry?

8. *Harsh punishment of child.*

- How do you discipline your child?
- Do you or your partner use the same methods to get your child to cooperate?
- Are you satisfied with the discipline methods you use?
- What is the most important thing in raising a child?
- Do you want to raise your child differently than you were raised? What changes have you made?

9. *Child difficult/provocative or perceived to be by parents.*

- Is your child difficult to handle? (Observe mother's interaction with the child.)
- What does your child do that irritates you? Do you think he does that on purpose?
- In what ways is your partner involved with your child (children)?

10. *Child unwanted or at risk for bonding.*

- Was this pregnancy planned?
 - Do you want to be a mother/father?
 - How is life going to be different once this baby is born? Are you making plans for those changes?
 - Have you baby clothes? Thought of names?
 - Do you own maternity clothes?
 - When did your partner/family find out you were pregnant?
 - If you were not pregnant now, what would you be doing?
 - What had you been planning for yourself for next year?
-

Implementation of a family stress checklist

Table 3. Defined Specific Categories on Parenting Checklist*

Category	Risking	Definition
#1 Parent beaten or deprived as child	NORMAL	Two-parent or one parent figures in the home (can be step, foster, or adoptive parents) with physical punishment not primary means of discipline.
	MODERATE RISK	Two-parent home or one-parent figure raising dependent children primarily alone with physical punishment primary means of discipline.
	SEVERE RISK	Children in the home removed voluntarily or involuntarily due to physical violence, sexual abuse, psychological neglect or physical neglect. This should include teens who repeatedly run away from home and see themselves as not having parent figure on whom they can depend.
#2 Parent has criminal or mental illness record	NORMAL	History free of legal offenses or encounters with mental health professionals.
	MODERATE RISK	Minor traffic violations or record of minor juvenile or adult crime (speeding, minor theft) or contact with mental health professionals for situational stress or for preventive illness; demonstrating no ongoing propensity for dysfunctional behavior.
	SEVERE RISK	History of driving under the influence of alcohol, theft, burglary, larceny, violence, felonies or hospitalized for mental breakdown or evaluation of mental competence. Chronic pattern of emotional problems with or without any attempt made to change that behavior.
#3 Parent suspected of abuse in the past	NORMAL	Babysitting or step-parenting experience free of mistreatment to children under care.
	MODERATE RISK	Babysitting, step-parenting, or parenting experience involves professional or lay referral to child welfare for suspected mistreatment; child not removed due to minor nature of complaint and parents' willingness to engage in corrective treatment.
	SEVERE RISK	Babysitting, step-parenting, or parenting experience where child welfare authorities felt child in question needed to be removed from home due to seriousness of abuse or neglect and parents' unwillingness/or inability to cooperate for necessary change.
#4 Parent with low self- esteem social isolation, or depression	NORMAL	Has sense of self (plus friends/family) which gives support for their success at daily functioning.
	MODERATE RISK	Has some successes in their lives but this is intermingled with failures in daily living tasks. Friends/family/partner currently not supportive or helpful toward person.
	SEVERE RISK	Not able to perform daily living tasks due to clinical signs of depression. Has never been happy. Has never perceived themselves as able to depend on anyone for emotional and physical support.
#5 Multiple crisis or stresses	NORMAL	Daily stresses of living evident but patient coping adequately.
	MODERATE RISK	Problems evident in marital (partner) relationship, child-parent relationship, and other relationships which patient not handling. Patient experiences job losses, financial strains, housing location concerns, or legal problems. Signs of stress evident.
	SEVERE RISK	Multiple run-ins with authority (evictions, collection agencies, fired from jobs); dysfunctional marriage (alcoholism, violence, infidelity); inability to relate or make use of environmental options for personal benefit.
#6 Violent temper out- bursts	NORMAL	Has developed techniques for handling anger which do not harm other persons or property.
	MODERATE RISK	When angered punches walls, throws dishes, or in any way strikes out at objects; or is not able to rationally handle anger.
	SEVERE RISK	Fights by slapping, punching, kicking others, or instigates fights with others.
#7 Rigid, unrealistic ex- pectations of child's behavior	NORMAL	Understands basic developmental needs of infants and children and attempts to meet those needs by nurturance and physical comfort.
	MODERATE RISK	Minimal understanding of children's needs coupled with fear of being unsuccessful parent.
	SEVERE RISK	Feels that infants and children intentionally misbehave out of malice and must be physically or psychologically dominated at all times to insure "respect."

Table 3. Defined Specific Categories on Parenting Checklist* (Continued)

Category	Risking	Definition
=8 Harsh punishment of child	NORMAL	Physical punishment not used or used as tertiary strategy to withdrawal of privileges and "time-out." When child is punished physically, no implements (spoon, paddle, stick) used.
	MODERATE RISK	Physical punishment used as primary means of discipline. Implements used but not in the head or spinal column area.
	SEVERE RISK	Physical punishment alone used even for infants, with no restraints as to implement used or duration or severity of blows.
=9 Child difficult and/or provocative or perceived to be by parents	NORMAL	Child's behavior not viewed as destructive or dysfunctional for family but as normal part of growth process.
	MODERATE RISK	Child's behavior seen as occasionally destructive and provoking anger in parents which results in physical punishment of child.
	SEVERE RISK	Child's behavior viewed as intentional to disrupt family life and happiness and seen as correctable only by physical discipline carried out routinely.
=10 Child unwanted or at risk for poor bonding	NORMAL	Pregnancy planned and parenting desired; or pregnancy itself not planned but childrearing looked upon as positive life change.
	MODERATE RISK	Pregnancy not desired and initially rejected but changes being made in lifestyle to accommodate new addition to family.
	SEVERE RISK	Pregnancy not desired. Infant not desired and viewed as necessary burden on lifestyle. No positive statements made about pregnancy or childrearing. No identification with fetus.

THE MOTHER-CHILD RELATIONSHIP EVALUATION

by
Robert M. Roth, Ph.D.

Published by
WESTERN PSYCHOLOGICAL SERVICES
A Division of Manson Western Corporation

Name:	Age:	Years Married:	Date:
Address:			Telephone Number:
No. of Children:			
Name	Age	Gender	
Child Presented:			
Educational Level:			

DIRECTIONS:

To better understand you and your child, and your relationship with your child, please express your opinions or your feelings about the statements which follow, when you turn this page. There are no "right" or "wrong" answers, only your opinions or feelings. Let your personal experiences decide your answers. Keep in mind the child for whom you are seeking help.

Do not spend too much time on any one statement. If you are in doubt, circle the opinion or feeling closest to express your feelings at this time. BE SURE TO ANSWER ALL STATEMENTS.

Read each statement carefully, then draw a circle around the opinion or feeling to the right of the statement which comes closest to your opinion or feeling.

If you STRONGLY AGREE with the statement or feeling, circle the letters SA; if you AGREE, circle the letter A; if you are UNDECIDED, circled the letter UN; if you DISAGREE, circle the letter D; and if you STRONGLY DISAGREE, circle the letters SD. You will have time to answer all the statements. When you finish, please turn in your booklet. NOW TURN THE PAGE AND BEGIN.

<u>Strongly</u> <u>Agree</u>	<u>Agree</u>	<u>Undecided</u>	<u>Disagree</u>	<u>Strongly</u> <u>Disagree</u>
<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>

40-A	A child should not get angry at its mother	SA	A	UN	D	SD
41-A	Young children, like toys, are for their parents' amusement	SA	A	UN	D	SD
42-A	Child-bearing is a responsibility of marriage	SA	A	UN	D	SD
43-A	There are certain right ways of raising a child, no matter how the parents feel	SA	A	UN	D	SD
44-A	Children should be seen but not heard	SA	A	UN	D	SD
45-A	A mother should control her child's emotions	SA	A	UN	D	SD
46-A	Since thumbsucking is an unhealthy habit, it should be stopped by all means	SA	A	UN	D	SD
47-A	It is not too helpful for a mother to talk over her plans with her child	SA	A	UN	D	SD
48-A	A child should please its parents	SA	A	UN	D	SD

END

Please see that you have answered all statements then turn in your booklet.

THE MCMASTER FAMILY ASSESSMENT DEVICE

This is a list of 53 statements a person could make about her/her family. Read each one and mark next to it whether you:

	<u>Strongly Agree</u>	<u>Agree</u>	<u>Disagree</u>	<u>Strongly Disagree</u>
1. We usually act on our decisions regarding problems			SA	A
2. After our family tries to solve a problem, we usually discuss whether it worked or not	SA	A	D	SD
3. We resolve most emotional upsets that come up	SA	A	D	SD
4. We confront problems involving feelings	SA	A	D	SD
5. We try to think of different ways to solve problems	SA	A	D	SD
6. When someone is upset the others know why	SA	A	D	SD
7. You can't tell how a person is feeling from what they are saying	SA	A	D	SD
8. People come right out and say things instead of hinting at them	SA	A	D	SD
9. We are frank with each other	SA	A	D	SD
10. We don't talk to each other when we are angry	SA	A	D	SD
11. When we don't like what someone has done, we tell them	SA	A	D	SD
12. When you ask someone to do something, you have to check that they did it	SA	A	D	SD
13. We make sure members meet their family responsibilities	SA	A	D	SD
14. Family tasks don't get spread around enough	SA	A	D	SD
15. We have trouble meeting our bills	SA	A	D	SD
16. There's little time to explore personal interests ..	SA	A	D	SD
17. We discuss who is to do household jobs	SA	A	D	SD
18. If people are asked to do something, they need reminding	SA	A	D	SD
19. We are generally dissatisfied with the family duties assigned to us	SA	A	D	SD

20. We are reluctant to show our affection for each other ...	SA	A	D	SD
21. Some of us just don't respond emotionally	SA	A	D	SD
22. We do not show our love for each other	SA	A	D	SD
23. Tenderness takes second place to other things in our family	SA	A	D	SD
24. We express tenderness	SA	A	D	SD
25. We cry openly	SA	A	D	SD
26. If someone is in trouble, the others become too involved ..	SA	A	D	SD
27. You only get the interest of others when something is important to them	SA	A	D	SD
28. We are too self-centred	SA	A	D	SD
29. We get involved with each other only when something interests us	SA	A	D	SD
30. We show interest in each other when we get something out of it personally	SA	A	D	SD
31. Our family shows interest in each other only when they can something out of it	SA	A	D	SD
32. Even though we mean well, we intrude too much into each other's lives	SA	A	D	SD
33. We don't know what to do when an emergency comes up	SA	A	D	SD
34. You can easily get away with breaking the rules	SA	A	D	SD
35. We know what to do in an emergency	SA	A	D	SD
36. We have no clear expectations about toilet habits	SA	A	D	SD
37. We have rules about hitting people	SA	A	D	SD
38. We don't hold to any rules or standards	SA	A	D	SD
39. If the rules are broken, we don't know what to expect ...	SA	A	D	SD
40. Anything goes in our family .	SA	A	D	SD
41. There are rules about dangerous situations	SA	A	D	SD
42. Planning family activities is difficult because we misunderstand each other	SA	A	D	SD
43. In times of crisis we can turn to each other for support	SA	A	D	SD

44. We cannot talk to each other about the sadness we feel ...	SA	A	D	SD
45. Individuals are accepted for what they are	SA	A	D	SD
46. We avoid discussing our fears and concerns	SA	A	D	SD
47. We can express feelings to each other	SA	A	D	SD
48. There are lots of bad feelings in the family	SA	A	D	SD
49. We feel accepted for what we are	SA	A	D	SD
50. Making decisions is a problem for our family	SA	A	D	SD
51. We are able to make decisions about how to solve problems .	SA	A	D	SD
52. We don't get along well together	SA	A	D	SD
53. We confide in each other	SA	A	D	SD

ROSENBERG SELF ESTEEM

This is a list of 10 statements a person could make. Read each one and mark next to it whether you:

	<u>Strongly Agree</u>	<u>Agree</u>	<u>Disagree</u>	<u>Strongly Disagree</u>
	<u>SA</u>	<u>A</u>	<u>D</u>	<u>SD</u>
1. On the whole I am satisfied with myself	SA	A	D	SD
2. At times I think I am no good at all	SA	A	D	SD
3. I feel that I have a number of good qualities	SA	A	D	SD
4. I am able to do things as well as most other people	SA	A	D	SD
5. I feel that I do not have much to be proud of	SA	A	D	SD
6. I certainly feel useless at times	SA	A	D	SD
7. I feel that I'm a person of worth, at least on an equal plane with others	SA	A	D	SD
8. I wish I could have more respect for myself	SA	A	D	SD
9. All in all, I am inclined to feel that I am a failure	SA	A	D	SD
10. I take a positive attitude towards myself	SA	A	D	SD

SOCIAL READJUSTMENT RATING SCALE

PLEASE MARK WITH A CROSS ANY OF THESE "LIFE EVENTS" WHICH HAVE HAPPENED TO YOU OVER THE PAST 12 MONTHS.

MEAN VALUE	Rank	Life Event
100	1.	Death of spouse
73	2.	Divorce
65	3.	Marital separation
63	4.	Jail term
63	5.	Death of close family member
53	6.	Personal injury or illness
50	7.	Marriage
47	8.	Fired at work
45	9.	Marital reconciliation
45	10.	Retirement
44	11.	Change in health of family member
40	12.	Pregnancy
39	13.	Sex difficulties
39	14.	Gain of new family member
39	15.	Business readjustment
38	16.	Change in financial state
37	17.	Death of close friend
36	18.	Change to different line of work
35	19.	Change in number of arguments with spouse
31	20.	Mortgage over R80 000
30	21.	Foreclosure of mortgage or loan
29	22.	Change in responsibilities at work
29	23.	Son or daughter leaving home
29	24.	Trouble with in-laws
28	25.	Outstanding personal achievement
26	26.	Wife begin or stop work
26	27.	Begin or end school
25	28.	Change in living conditions
24	29.	Revision of personal habits
23	30.	Trouble with boss
20	31.	Change in work hours or conditions
20	32.	Change in residence
20	33.	Change in schools
19	34.	Change in recreation
19	35.	Change in church activities
18	36.	Change in social activities
17	37.	Mortgage or loan less than R80 000
16	38.	Change in sleeping habits
15	39.	Change in number of family get-togethers
15	40.	Change in eating habits
13	41.	Vacation
12	42.	Christmas
11	43.	Minor violations of the law

FINAL EVALUATION BY PARENTS

How I felt about the course:

Very glad I took it

Mildly glad

Somewhat disappointed

Very disappointed/ A waste of time

What I LIKED most about the course:

What I DISLIKED most about the course:

Changes noticed in my family or child/children:

A lot

A few

None

Changes noticed in myself:

Changes noticed in the way I think and/or interact with my child/children:

Further comments I would like to make:

TO BE COMPLETED BY GROUP FACILITATOR.
DETAILED SUBJECTIVE FEEDBACK REPORT ABOUT THE COURSE.

SESSION ONE

FACILITATOR

Did you experience any problems with this session? YES/NO
If so elaborate:

Any problems with the use of this manual? YES/NO
If so elaborate:

SESSION

Note any verbalised problems expressed at this time by group members:

Note any non-verbal interaction problems you notice:

With the group:

With any mother-child dyad:

SESSION TWO

FACILITATOR

Did you experience any problems with this session? YES/NO
If so elaborate:

Any problems with the use of this manual? YES/NO
If so elaborate:

SESSION

Note any verbalised problems expressed at this time by group members:

Note any non-verbal interaction problems you notice:

With the group:

With any mother-child dyad:

SESSION THREE

FACILITATOR

Did you experience any problems with this session? YES/NO
If so elaborate:

Any problems with the use of this manual? YES/NO
If so elaborate:

SESSION

Note any verbalised problems expressed at this time by group members:

Note any non-verbal interaction problems you notice:

With the group:

With any mother-child dyad:

SESSION FOUR

FACILITATOR

Did you experience any problems with this session? YES/NO
If so elaborate:

Any problems with the use of this manual? YES/NO
If so elaborate:

SESSION

Note any verbalised problems expressed at this time by group members.

Note any non-verbal interaction problems you notice:

With the group:

With any mother-child dyad:

SESSION FIVE

FACILITATOR

Did you experience any problems with this session? YES/NO
If so elaborate:

Any problems with the use of this manual? YES/NO
If so elaborate:

SESSION

Note any verbalised problems expressed at this time by group members:

Note any non-verbal interaction problems you notice:

With the group:

With any mother-child dyad:

SESSION SIX

FACILITATOR

Did you experience any problems with this session? YES/NO
If so elaborate:

Any problems with the use of this manual? YES/NO
If so elaborate:

SESSION

Note any verbalised problems expressed at this time by group members:

Note any non-verbal interaction problems you notice:

With the group:

With any mother-child dyad:

SESSION SEVEN

FACILITATOR:

Did you experience any problems with this session? YES/NO
If so elaborate:

Any problems with the use of this manual? YES/NO
If so elaborate:

SESSION

Note any verbalised problems expressed at this time by group members:

Note any non-verbal interaction problems you notice:

With the group:

With any mother-child dyad:

SESSION EIGHT

FACILITATOR

Did you experience any problems with this session? YES/NO
If so elaborate?

Any problems with the use of this manual? YES/NO
If so elaborate:

SESSION

Note any verbalised problems expressed at this time by group members.

Note any non-verbal interaction problems you notice:

With the group:

With any mother-child dyad:

SESSION NINE

FACILITATOR

Did you experience any problems with this session? YES/NO
If so elaborate:

Any problems with the use of this manual? YES/NO
If so elaborate:

SESSION

Note any verbalised problems expressed at this time by group members:

Note any non-verbal interaction problems you notice:

With the group:

With any mother-child dyad:

SESSION TEN

FACILITATOR

Did you experience any problems with this session? YES/NO
If so elaborate:

Any problems with the use of this manual? YES/NO
If so elaborate:

SESSION

Note any verbalised problems expressed at this time by group members:

Note any non-verbal interaction problems you notice:

With the group:

With any mother-child dyad:

Was any mother or child of concern to you for any reason
whatsoever? YES/NO

Please elaborate if so:

Did any mother mention that she had used these communication
skills with older children or other adults? YES/NO

If yes, please enlarge on how effective this was found to be:

Any other problems or perceptions you would like to make?

PLEASE ENCLOSE ALL DRAWINGS MADE BY GROUP MEMBERS

WITH GRATEFUL THANKS FOR ALL YOUR INPUT AND ASSISTANCE

***FINAL EVALUATION BY
PARTICIPATING COMMUNITY HEALTH NURSE***

How I felt about the course:

A worthwhile Health Education Programme

A moderate Educational Programme

A disappointing Educational Programme

An ineffectual Educational Programme

What I LIKED most about the programme:

What I DISLIKED most about the programme:

Changes noticed in the group members:

A lot

A few

None

Further comments I would like to make:

LONG-TERM FOLLOW-UP EVALUATION QUESTIONNAIRE

EXPERIMENTAL PARTICIPANTS ONLY

PLEASE MARK YOUR ANSWERS CLEARLY AND GIVE AS MUCH DETAIL AS POSSIBLE IN YOUR RESPONSES - THANKING YOU.

Q1 DO YOU STILL SEE ANY MEMBERS OF THE PARENTING GROUP? YES/NO

IF NO - PLEASE GIVE REASONS FOR THIS

IF YES - PLEASE ENLARGE:

HOW MANY OF THE GROUP?

HOW FREQUENTLY?

REASONS FOR MEETING?

Q2 DOES THE GROUP EVER MEET AS A GROUP? YES/NO

IF NO - SUGGEST REASON FOR THIS

IF YES

A) - HOW OFTEN DO YOU MEET AS A GROUP?

1) DAILY

2) WEEKLY

3) EVERY TWO WEEKS

4) MONTHLY

5) OTHER - SAY HOW FREQUENTLY

B) - WHAT IS THE PURPOSE OF MEETING?

Q3 ARE YOU STILL USING THE SKILLS YOU LEARNT DURING THE POSITIVE PARENTING COURSE? YES/NO

IF NO - GIVE REASONS FOR THIS

IF YES - GIVE THE SKILL/S YOU USE MOST FREQUENTLY.

Q4 ON WHOM DO YOU USE THIS/THESE SKILL/S?

- 1) ADULTS
- 2) TEENAGERS
- 3) CHILDREN BETWEEN 5 - 12 years
- 4) CHILDREN UNDER FIVE

Q5 BRIEFLY DESCRIBE ANY SITUATION WHERE YOU HAVE USED THIS/THESE SKILL/S EFFECTIVELY

Q6 PLEASE MARK THE SKILLS YOU HAVE USED SINCE THE COURSE

relaxation skill.....	never	sometimes	frequently
non-verbal attention.....	never	sometimes	frequently
communicating love.....	never	sometimes	frequently
communicating respect.....	never	sometimes	frequently
playing with your child.....	never	sometimes	frequently
touching your child.....	never	sometimes	frequently
positive attention for behav..	never	sometimes	frequently
teaching behaviour.....	never	sometimes	frequently
modelling behaviour.....	never	sometimes	frequently
ignoring negative behaviour...	never	sometimes	frequently
distraction.....	never	sometimes	frequently
describing the situation.....	never	sometimes	frequently
say what you expect/inform...	never	sometimes	frequently
listening skills.....	never	sometimes	frequently
recognising feelings.....	never	sometimes	frequently
naming the feelings.....	never	sometimes	frequently
fantasy wishes.....	never	sometimes	frequently
talk about feelings(I-messages)	never	sometimes	frequently
giving a choice.....	never	sometimes	frequently
taking action.....	never	sometimes	frequently
strong disapproval.....	never	sometimes	frequently
experiencing the consequences.	never	sometimes	frequently

Q7 CHANGES IN MY CHILD/CHILDREN?

- A lot
- A few
- None

Q8 PLEASE GIVE EXAMPLES OF ANY CHANGES YOU HAVE NOTICED IN YOUR CHILDREN'S BEHAVIOUR AND/OR ATTITUDE

Q9 ARE CHANGES NOTICED IN:

CHILDREN UNDER FIVE
CHILDREN BETWEEN 5 - 12 YEARS
TEENAGERS
OTHER ADULTS IN THE HOME
OTHER ADULTS OUTSIDE THE HOME

Q10 PLEASE GIVE AN EXAMPLE FOR EACH AREA OF CHANGE YOU HAVE MARKED IN QUESTION 9.

Q11 PLEASE DESCRIBE ANY CHANGES NOTICED IN THE WAY YOU THINK AND/OR INTERACT WITH YOUR CHILD/CHILDREN.

Q12 PLEASE DESCRIBE ANY CHANGES NOTICED IN YOURSELF SINCE COMPLETING THE COURSE.

Q13 ARE YOU HAPPY THAT YOU DID THIS COURSE - YES/ NO.

IF YES - GIVE REASON/S

IF NO - GIVE REASON/S

Q14 PLEASE LIST ANY PARENTING NEEDS WHICH YOU STILL HAVE.

LONG-TERM FOLLOW-UP EVALUATION QUESTIONNAIRE

CONTROL GROUP ONE PARTICIPANTS ONLY

PLEASE MARK YOUR ANSWERS CLEARLY AND GIVE AS MUCH DETAIL AS POSSIBLE IN YOUR RESPONSES - THANKING YOU.

Q1 DO YOU STILL SEE ANY MEMBERS OF THE ANTENATAL GROUP? YES/NO

IF NO - PLEASE GIVE REASONS FOR THIS

IF YES - PLEASE ENLARGE:

HOW MANY OF THE GROUP?

HOW FREQUENTLY?

REASONS FOR MEETING?

Q2 DOES THE GROUP EVER MEET AS A GROUP? YES/NO

IF NO - SUGGEST REASON FOR THIS

IF YES

A) - HOW OFTEN DO YOU MEET AS A GROUP?

1) DAILY

2) WEEKLY

3) EVERY TWO WEEKS

4) MONTHLY

5) OTHER - SAY HOW FREQUENTLY

B) - WHAT IS THE PURPOSE OF MEETING?