

**AN OUTCOME EVALUATION OF THE
PSYCHOTHERAPEUTIC MILIEU THERAPY
PROGRAMME OF THE WILLIAM SLATER
CENTRE FOR ADOLESCENTS AND YOUNG
ADULTS**

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Abstract

Adolescence is a significant developmental period during which individuals experience serious mental health problems. Research over the past two decades has demonstrated high morbidity, and at times, mortality for this age group. Adolescent depression has received much attention, since a significant proportion of adolescents have been found to suffer from depressive disorders or clinical levels of depressive symptomatology. This has led mental health professionals to develop effective intervention programmes for the youth. At present, numerous forms of therapeutic interventions exist for adolescents and young adults. A result of the increasing numbers of psychotherapeutic programmes for adolescents was a need to determine its efficacy. Programme evaluation methods have been increasingly utilised to evaluate the functioning and outcome of treatment programmes. It was this approach which informed the present study. The aim of this thesis was to conduct an outcome evaluation of the William Slater Centre for Adolescents and Young Adults' psychotherapeutic milieu treatment programme. This thesis arises from the drawbacks of a previous thesis which examined the structure, process and short-term outcome of the William Slater Centre's programme. The present thesis aims to obtain a profile and an indication of the functioning of a group of adolescents who were discharged from the William Slater Centre's 12-week therapeutic programme. A combination of quantitative and qualitative methods were used. The study is a limited, retrospective analysis of the existing records of the William Slater Centre. Post-discharge questionnaires were distributed to adolescent patients who had completed the 12-week therapeutic programme at intervals of 6 month, 18 month and 36 month post-discharge. The questionnaire was designed to determine the long-term efficacy of the Centre's psychotherapeutic programme. It includes a Beck Depression Inventory, a Youth Self-Report Scale and a General Health Questionnaire. Due to the small sample sizes of adolescents who returned the questionnaires at the three time periods, a sample of 83 adolescents who completed the 6 and 18 month post-discharge questionnaire formed the basis of the present study. The sample of 93 adolescents not responding to the questionnaires were also analysed. The analyses resulted in a discussion of the profile of adolescents who returned the questionnaires as well as a description of the adolescents

who did not return *any* of the post-discharge questionnaires. The scores of the Beck Depression Inventory are also analysed. The final part of the thesis provides a qualitative analysis of the comments of adolescents who completed the questionnaires. Results of the study found that adolescents discharged from the Centre's programme comprise a psychiatric population who have histories of psychological difficulties and who appear to be prone to further long standing problems. Qualitative analysis revealed adolescents need for ongoing psychiatric or psychological assistance. Quantitative analysis of the depression rating scales demonstrate that the majority of adolescents improved significantly since their initial assessment to the Centre. These findings are supported by the large number of adolescents reporting on their positive experiences of the Centre's therapeutic programme. The thesis demonstrates that strong outcomes are difficult to predict with a sample of depressed adolescents.

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INTRODUCTION

Adolescence has been identified as a critical period of development in an individual's life. Although this period of transformation received little attention previously, significant efforts have been made over the past two decades to address the challenges facing adolescents. Research has demonstrated that adolescence is a period where individuals indulge in health-damaging behaviours which may contribute towards morbidity and mortality. Of particular concern is adolescent depression which has been shown to have a host of co-morbidity factors associated with it.

It is now widely accepted that a significant proportion of adolescents suffer from depressive disorders or clinical levels of depressive symptomatology. Adolescent depression has been well documented in the past decade and research findings have alerted mental health professionals to develop effective intervention programmes for the youth and to plan appropriate adolescent services for early detection and treatment of depression.

At present, numerous forms of therapeutic interventions exist for adolescents and young adults. A result of the increasing numbers of psychotherapeutic programmes for adolescents was a need to determine its efficacy. Although social science research methods were found useful, the rise of programme evaluation provided an opportunity to focus on the efficacy of programmes and to consider a range of factors which impact on the functioning of programmes. The literature comprise numerous studies which have evaluated adolescent and adult therapeutic programmes. Studies have ranged from examining the structure, and process of programmes to conducting short- and long-term outcome evaluations of programmes.

The aim of this thesis is to conduct an outcome evaluation of an adolescent psychotherapeutic milieu treatment programme. A comprehensive evaluation of the William Slater Centre for Adolescents and Young Adults and its therapeutic programme was conducted in a previous thesis (Ahmed, 1997), focusing primarily on the structure

and process of the programme, with a brief look at the short-term impact of the programme. A shortcoming of the thesis was that an outcome evaluation was not conducted, whereby the long-term impact of the programme is evaluated. This is the aim of the present thesis. At the outset it is important to state that the aim is not to conduct a comprehensive outcome evaluation of the William Slater Centre's therapeutic programme. Instead, the study will focus on the William Slater Centre's existing records which document the progress of adolescents post-discharge.

Chapter one provides an overview of outcome evaluation with specific reference to psychotherapeutic treatments. The chapter highlights the difficulties encountered with treatment outcome studies. This is followed by a chapter providing background information regarding the William Slater Centre for Adolescents and Young Adults and its therapeutic programme as well as an outline of the aims and methodology of the present study.

Chapter three begins with a profile of the adolescents and young adults *at the time of their initial assessment* at the William Slater Centre, who later completed the 6 and 18 month post-discharge questionnaires. The intention is to provide a baseline from which to evaluate their progress at the follow-up time periods. This is followed by a description of these same adolescents at the follow-up periods, focusing on the results of their post-discharge questionnaires. Chapter five provides a profile of those adolescents who did not respond to *any* of the post-discharge questionnaires mailed to them, the aim being to determine whether there are any differences between the adolescents who responded to the post-discharge questionnaires and those who failed to complete any of the questionnaires.

The latter part of the thesis pertains to the quantitative analysis of depression rating scale scores of adolescents discharged from the programme. This analysis attempts to obtain a measure of treatment outcome for depressive symptomatology of adolescent patients who completed the 12-week programme, and who responded to the post-discharge questionnaires. The penultimate chapter takes a brief look at discharged patients'

perceptions of the William Slater Centre's therapeutic programme and their perceived progress. The thesis draws to a close with a brief discussion of the central themes arising from the above-mentioned chapters as well as the limitations of the present study.

CHAPTER 1

OUTCOME EVALUATION OF PSYCHOTHERAPEUTIC TREATMENTS

1. INTRODUCTION

This chapter provides an overview of outcome evaluation with specific reference to psychotherapeutic treatments. Follow-up studies of depressed adolescents are reviewed and the chapter concludes with the difficulties encountered with treatment outcome studies.

2. TREATMENT OUTCOME STUDIES

Over the past two decades, programme evaluation has been increasingly used in order to reflect on the range of psychotherapeutic treatments which exist. The evaluation of therapeutic programmes has usually involved the examination of the structure, process or outcome of programmes (Lieberman, 1983). A brief review of the literature on outcome evaluations of therapeutic treatments and programmes is provided in the present chapter.

Treatment outcome is a central part of the evaluation of therapeutic programmes. In psychotherapy outcome research it is important to determine whether therapeutic changes are maintained and whether they surpass the gains that may be associated with the passage of time without that particular treatment (Kazdin, 1986).

Hawton (1989) identified six reasons for the importance of long-term outcome studies of psychological treatments:

- (i) they aim to assess whether or not therapeutic effects evident at posttreatment are maintained;

- (ii) they examine the preventive effects of treatment, since prevention of further episodes of illness is an important objective of treatment for episodic psychiatric disorders and long-term follow up can determine whether this objective is fulfilled;
- (iii) they identify the problems patients encounter following treatment and possible coping strategies;
- (iv) they can allow early predictors of eventual outcome to be identified, - information that is important in deciding whether treatment should be continued and where more intensive or prolonged therapy is necessary;
- (v) they examine patients' long-term attitudes to treatment; and finally,
- (vi) long-term follow-up studies can detect whether a treatment can create new (iatrogenic) problems.

Research on the effectiveness of therapies for adolescents has lagged greatly behind that of research with adults. The earliest follow-up studies with adolescent psychiatric patients include the work of Carter (1942), Masterson (1958), and Beskind (1962), who surveyed adolescent patients discharged from adolescent and adult wards. Kivowitz, Forgotson, Goldstein, and Gottlieb (1974) followed up 98 adolescent in-patients for a period of two to nine years post discharge and found that psychotic patients did poorly over time while patients with neurotic disorders, adjustment reactions and personality disorders improved over time. The above-mentioned studies as well as later studies were restricted to within-sample, between-subject comparisons, without alternative-treatment or no-treatment control groups. Conclusions based on these studies are therefore restrictive since such designs are not controlled for the effects of maturation or of the natural course of psychiatric disorders and so cannot test the effectiveness of a specific treatment or programme.

In recent years major advances have been made in evaluating treatments for child and adolescent therapy (Kazdin, 1990). However, although interest in identifying effective psychotherapies for adolescent mental health problems has increased, there have been few attempts to integrate the empirical literature on psychotherapy outcomes with

adolescents (Mann & Borduin, 1991). Reviews on the evaluation of the impact of treatment on adolescents has been scant partly because of the failure of outcome studies to differentiate between children and adolescents (e.g. Kazdin, 1987; Weisz, Weiss, Alicke, & Klotz, 1987) and because attempts have only recently been made to design psychotherapy treatments solely for adolescents (Mann & Borduin, 1991). Tramontana (1980) is one of the few who reviewed 33 studies published between 1967 and 1977 on psychotherapy outcome studies with adolescents. The majority of these studies were found to be methodologically flawed, with only five found to be methodologically sound. Nevertheless there appeared to be support for psychotherapy over no-therapy conditions for adolescents. Mann and Borduin (1991) reviewed the methods and findings of adolescent psychotherapy outcome studies published between 1978-1988 and found that evaluations of individual psychotherapy with adolescents generally reveal positive short-term outcomes. Three meta-analyses that examined over 300 studies, encompassing diverse treatment methods and diverse children and adolescent problems, have indicated that the overall impact of child and adolescent psychotherapy is positive (Casey & Berman, 1985; Kazdin, Bass, Ayers, & Rodgers, 1990; Weisz et al., 1987). Later meta-analyses (Weisz & Weiss, 1993; Weisz, Weiss, & Donenberg, 1992) too found that psychotherapy may have significant beneficial effects with children and adolescents. Weisz, Weiss, Han, Granger, and Morton (1995) meta-analysis on treatment outcome studies with children and adolescents however found that psychotherapy effects were beneficial but were weaker than had been thought in previous meta-analyses.

Research into psychological treatments has focused primarily on the immediate short-term effects of treatment and little work has been done to examine the longitudinal effectiveness of therapies (Hibbs, 1995). The importance of long-term effects of treatment of adolescents is emphasised by Kazdin (1993). He notes that many of the gains demonstrated in psychotherapy have used a relatively brief time frame, for example, 5-6 months post-treatment. He adds that a longitudinal perspective of therapy is particularly important with adolescents since transition of this period of development can themselves create difficulties.

3. DEPRESSION OUTCOME STUDIES

In recent years, research has begun to approach depressive symptomatology during childhood and adolescence from a developmental perspective. One question stemming from this approach is the extent to which depressive symptoms are stable over time (Devine, Kempton, & Forehand, 1994). Because adolescence is a time of rapid change and development, a certain amount of diagnostic flux is expected and perhaps normative (Mattanah, Becker, Levy, Edell, & McGlashan, 1995).

Several follow-up studies have demonstrated that adolescents who experience depressive symptomatology tend to experience recurrences of these phenomena at some time later in adolescence or during adulthood and are at risk for future episodes of affective disorder (Kandel & Davies, 1986; Landolt, 1987; Strober & Carlson, 1982). Garber, Kriss, Koch, and Lindholm (1988) conducted a follow-up evaluation of 20 individuals who were psychiatric inpatients as adolescents, 11 of whom had an index hospitalisation diagnosis of an affective disorder. Approximately 8 years after discharge, seven of the eleven had experienced at least one episode of Major Depressive Disorder. This group reported significantly greater adjustment problems although they did not differ from the control group concerning overall adjustment.

In the Ontario Child Health Study (Fleming, Boyle, & Offord, 1993) one quarter of adolescents with a Diagnostic and Statistical Manual (DSM) - III-like major depressive syndrome went on to experience another episode during the 6 months preceding their 4-year follow-up assessments. Feehan, McGee, and Williams (1993) found that 44% of adolescents with an internalising disorder (i.e. emotional) at age 15 also had an internalising disorder at age 18. Mattanah et al. (1995) also found that internalising disorders have high persistence rates and that a diagnosis of an internalising disorder is a useful marker for later internalising problems. They examined diagnostic stability in an inpatient group of 70 adolescents followed up 2 years after hospitalisation. These studies suggest that internalising disorders are relatively stable in adolescence and do not respond well to psychotherapy.

Devine et al. (1994), who also concluded that depressive symptomatology during adolescence is relatively stable, found that an adolescent's level of depressed mood is predictive of his/her adjustment in multiple areas during young adulthood. Rao, Ryan, Birmaher, Dahl, Williamson, Kaufman, Rao, and Nelson (1995) reported on the adult psychiatric status and social adjustment of a group of adolescents with unipolar major depressive disorder compared with control subjects who had no history of psychiatric disorder when initially assessed. The conclusion of the study was that there is continued risk for recurrence and persistence of depressive episodes into adulthood resulting in psychosocial dysfunction. Although Mattanah et al. (1995) notes that systematic studies of diagnostic stability in adolescents are rare and none have used clinical samples, a prospective design, or repeated systematic assessments, the results of these studies highlight that adolescent depressed mood signals the possibility of longstanding difficulties and thus may require prompt attention. The clinical implications of these findings relates to the importance of prevention of later difficulties associated with depressed mood but also the prevention of the beginning of depressive symptoms in adolescents.

4. DIFFICULTIES WITH OUTCOME STUDIES

Little attention has been paid to long-term outcome studies for reasons such as the practical difficulties in organising these studies; the complex issues around interpretation of results; and the expense of funding long-term treatment research. Practical difficulties include the loss of subjects over time which may result from refusal to be seen, mobility, inability to trace them, or death. The inevitable increase in attrition as well as the ambiguities that can result from selective losses of cases are among the salient disincentives for conducting follow-up studies. The cost of following subjects over time is another factor which researchers consider when conducting longitudinal studies. There is also the difficulty of defining further episodes of disorders and determining whether the symptoms represent a recurrence or whether a new episode of illness emerged. Furthermore, the difficulty with a follow-up period is that it does not happen in a vacuum

and numerous influences other than the original treatment come in to play (Hawton, 1989; Kazdin, 1991).

However, despite the design of long-term outcome studies being inferior to short-term outcome studies, it is critically important to evaluate the impact of the intervention on subjects (Kazdin, 1991). Hawton (1989) suggests that given these limitations, researchers should plan outcome studies when initially designing treatment studies.

5. CONCLUSION

It is now widely accepted that a significant proportion of adolescents suffer from depressive disorders or clinical levels of depressive symptomatology and that the course of depressive disorders is of long duration in adolescents with a significant proportion of recurrent episodes. Since rates of depression appear to be on the increase among children and adolescents (Klerman & Weissman, 1989; Moreau, Mufson, Weissman, & Klerman, 1991; Ryan, Williamson, Iyengar, Orvaschel, Reich, Dahl, & Puig-Antich, 1992) it is clear that depression is a major challenge for researchers and clinicians (Reynolds, 1994). Long-term outcome studies therefore have important implications for adolescent mental health, especially in the planning of appropriate adolescent services for early detection and treatment of depression.

CHAPTER 2

**AN OUTCOME EVALUATION OF THE PSYCHOTHERAPEUTIC
MILIEU TREATMENT PROGRAMME OF THE WILLIAM
SLATER CENTRE FOR ADOLESCENTS AND YOUNG ADULTS**

1. INTRODUCTION

Prior to outlining the aim and methodology of the current thesis, a large part of this chapter is devoted to providing background information regarding the William Slater Centre for Adolescents and Young Adults and its therapeutic programme. The current thesis forms part of a larger evaluation study, the first part of which has been completed in a previous document (Ahmed, 1997). This chapter aims to provide the reader with a summary of the previous findings, and to outline the aim and methodology of the current study.

2. BACKGROUND DATA

An evaluation of one of the psychotherapeutic resources in Cape Town, namely the William Slater Centre for Adolescents and Young Adults (referred to throughout the remainder of the thesis as either the William Slater Centre or merely the Centre), was conducted in 1997. Three aspects of the milieu therapeutic programme were examined, namely (i) the structure of the programme; (ii) the process of the programme; and (iii) the short-term outcome of the programme. The results of these three aspects will be outlined below, without providing details of the methods adopted.

2.1. PROGRAMME STRUCTURE

The William Slater Centre is situated on the corner of Park and Milner Road, Rondebosch, an upper middle class area. It is housed in a fairly large building, resembling an old Victorian home, surrounded by spacious lawn and gardens. The

building does not show any exterior or interior characteristics that could allow for its identification as a psychiatric unit. The initial impression of the atmosphere of the Centre is that it is informal and relaxed and well-furnished and maintained for mental health hospital standards.

The personnel of the William Slater Centre comprises a multi-disciplinary team of mental health professionals, post-graduate trainees, voluntary facilitators, research staff, administrative staff and cleaning staff. Permanent staff include a psychiatrist who is the consultant-in-charge of the Centre, one full-time and one part-time psychologist, one social worker, and six psychiatric nurses. A range of post-graduate trainees receive education, training and supervision for varying lengths of time at the Centre.

The therapeutic programme is aimed at treating adolescents and young adults between the ages of 14 to 25 inclusive, presenting with any of the following psychological, emotional and/or behavioural problems: depression, anxiety, suicidal tendencies/attempts, difficulties with interpersonal relationships, adjustment problems, sexual abuse, physical abuse, eating disorders, school refusal, academic or vocational underachievement, acting out behaviour, and poor peer relationships. Individuals with conduct disorders, major behavioural disturbances, recalcitrant substance abuse, or psychotic illnesses are screened out telephonically by the psychiatrist, clinical psychologist or other clinical staff members. Adolescents have to be of average or above average intelligence and motivated to attend the programme. The two broad, interrelated goals of the programme are to achieve (i) symptom remission from psychiatric diagnoses, and (ii) optimal functioning or well-being in psychological and social domains (prosocial competence; interpersonal skills; ability to cope with stress and adversity). Adolescents' suitability and appropriateness for the psychotherapeutic programme are based on a full psychiatric evaluation conducted primarily by the psychiatrist and occasionally by the psychologist, social worker or psychiatric nurses. The psychiatrist often unilaterally took decisions about the suitability of patients for the programme.

The psychotherapeutic programme is a time-limited, psychodynamic, group-oriented milieu treatment programme, which extends over a twelve week period from 9:00 to 15:00 Mondays to Fridays. The programme's central treatment philosophy is based on milieu therapy, the underlying principle being that change is best effected by utilising peer group pressure in a therapeutic environment. Treatment is multimodal, with the highly structured programme including various forms of therapy and group activities. There is a maximum of 22 patients on the programme at any one time. On discharge from the 12-week programme, patients are encouraged to attend weekly ongoing outpatient group therapy sessions once a week, and family sessions and/or individual follow-up sessions, if needed. Patients in need of additional therapeutic support can continue their treatment on an outpatient basis, for an additional period of varying length.

2.2. PROGRAMME PROCESS

A retrospective analysis of the records of all adolescents assessed at the William Slater Centre was conducted for the 1997 study. During the period 01 April 1991 to 01 October 1996, 988 adolescents and young adults were assessed at the Centre. Of the 988 adolescents assessed, a total of 728 (73.6%) were found suitable for the programme, but only 320 (32.38%) adolescents completed the 12-week programme. A substantial number of adolescents (45.85%) were initially assessed at the Centre, but not admitted to the programme. Details regarding the reasons for this are discussed elsewhere (Ahmed, 1997).

The demographic data of the 320 adolescents completing the programme is as follows: the mean age was 18.1 and the sample was predominantly female (75.9%), English speakers (68.4%) and of the White racial group (63.1%). Several came from nuclear homes (42.2%), with the remainder coming from divorced/separated, single, or foster/adoptive homes. Sixty percent of adolescents were full-time secondary level students. Further data worthy of note include the fact that 63.8% had a history of psychiatric contact at their initial assessment, and 42.5% reported a family history of psychiatric illness. Almost 40% of the adolescents had attempted suicide prior to their

admission to the Centre. Of the adolescents completing the programme, 80.6% were diagnosed with some form of mood disorder. This data will be referred to in subsequent chapters.

2.3. SHORT-TERM PROGRAMME OUTCOME

A proper outcome evaluation was not the intention of the previous research; instead, an attempt was made to conduct a brief, short-term outcome evaluation of the programme. Analysis of three depression rating scale scores were conducted in order to obtain a measure of treatment outcome for depressive symptomatology of adolescent patients completing the 12-week programme. The measures included the Beck Depression Inventory (BDI) (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), a self-report scale, the Hamilton Depression Rating Scale (HDRS) (Hamilton, 1960), and the Montgomery-Åsberg Depression Rating Scale (MADRS) (Montgomery & Åsberg, 1979), the latter being clinician rating scales. At the Centre, a series of measures were taken at four intervals for each patient admitted to the programme. These occurred:

- (i) before the onset of the programme just prior to the initial assessment interview;
- (ii) during patients' first week on the programme;
- (iii) at patients' sixth week of the programme; and
- (iv) at discharge of patients' from the programme at week twelve.

Thus, only one measure was available prior to the onset of the programme and no measures were analysed post-treatment. Ideally, at least one measure prior to the onset of the programme and measures approximately six months post-treatment, would have been preferable. Although depression self-report measures were mailed to discharged patients at 6 months, 18 months and 36 months following discharge, this data did not form part of the previous thesis (but will be analysed in the present thesis).

Analysis of the BDI scores of patients completing the 12-week programme demonstrated that by the sixth week of treatment patients' BDI scores remained in the moderate

depression range and only in the very latter part of the treatment programme did the mean scores fall below the cutoff score of major depression. At discharge from the treatment programme, patients fell within the mild depression range. Results of the HDRS and MADRS similarly showed that adolescents remained in the depressive range for most of the programme, declining to the mild depression range at discharge. The findings from the short-term outcome of the Centre's programme found that there is significant improvement in the depressive symptomatology of adolescent patients completing the programme. These findings were consistent across three measures of depression. However, the absence of a control group cautions against conclusions regarding the impact of the therapeutic treatment programme on the alleviation of adolescent depressive symptoms. The numerous confounding variables and threats to internal validity (Campbell & Stanley, 1963) need to be taken into account in the interpretation of these findings. These are discussed in a later chapter.

While the results from the short-term outcome evaluation look very promising, namely that adolescents presenting for the Centre's milieu treatment programme significantly improve by the end of the 12-week period, caution is required in the interpretation of these findings. An important limitation is that only the short-term outcome of patients was determined without examining the progress of patients post-discharge. The present thesis therefore aims to evaluate the longer-term outcome of the William Slater Centre's therapeutic programme, with currently available data.

3. AN OUTCOME EVALUATION OF THE WILLIAM SLATER CENTRE'S PSYCHOTHERAPEUTIC PROGRAMME

At the outset it is important that the reader be cognisant of the limited scope of the present thesis. The thesis does not aim to comment on the long-term effectiveness of the William Slater Centre's psychotherapeutic treatment programme. The extent to which the programme impacted on the lives of adolescents and resulted in their progress or decline is not possible to ascertain. Instead, the thesis aims to obtain a profile and an indication of the functioning of a group of adolescents who were discharged from the 12-

week programme. Qualitative and quantitative methods were adopted, which was largely determined by the format of the post-discharge questionnaire which forms the basis of this study. It is important to stress that the study is a limited, retrospective analysis of the existing records of the William Slater Centre and the data presented in subsequent chapters is a reflection of the content of these records.

The post-discharge questionnaire. The William Slater Centre's post-discharge questionnaire was designed to determine the long-term efficacy of the William Slater Centre's psychotherapeutic programme. It was initially a two-page questionnaire which was adapted on three occasions during the period 1992-1995. In its most recent format it comprises a four page questionnaire, a Beck Depression Inventory (Beck et al., 1961), a Youth Self-Report Scale (YSR) (Achenbach & Edelbrock, 1987) and a General Health Questionnaire (GHQ) (Goldberg, 1978). A covering letter is attached requesting adolescents to complete the questionnaire in order that the staff of the William Slater Centre have some indication as to their progress since being discharged. As a result of the adaptations to the post-discharge questionnaire, there were inconsistencies in the data, with the addition or deletion of certain variables. The analyses conducted therefore included only the most consistent variables and the more recent changes and additions to the questionnaire (e.g. GHQ, YSR) were omitted as a result of the small sample sizes.

The strengths of questionnaires are that they can be anonymous; uniformity of information can be imposed; information on a variety of issues from a large group of people can be obtained; and respondents are able to put thought into their responses. According to Posavac and Carey (1992), programme participants who actually receive a service are often in an excellent position to evaluate aspects of the programme. Furthermore, they are the only ones who have access to their own feelings about the programme and about their current state at follow-up intervals. In addition, self-assessments have been found to be at least as accurate as other assessment approaches for a variety of behavioural and emotional dimensions (Shrauger & Osberg, 1981). They do however caution that certain types of patients seeking therapy cannot provide valid data, while many others can. The disadvantages include that they are not as flexible as

interviews; the completion and return rates of questionnaires may be problematic; and individuals may be better able to express themselves orally (King, Lyons Morris, & Fitz-Gibbon, 1987). Furthermore, asking adolescent patients to give a subjective evaluation of their experience in therapy is not highly reliable since responses may vary depending on their mood. However, it may yield quite reliable judgements if it focuses on current behaviour, such as further treatment sought and jobs held (Posavac & Carey, 1992), as is the case in the present study. A limitation of the William Slater Centre's post-discharge questionnaire is its length, which could partly account for the attrition rate. It is important to note that it is within these limitations that this study was conducted.

However, despite the restrictiveness of the post-discharge questionnaire, the data arising from the questionnaire has utility value. The usefulness of examining the existing records of discharged adolescent patients lies in the fact that these records are kept systematically at the Centre and the resulting analysis of these records may assist the staff of the William Slater Centre in reflecting on their functioning, on the therapeutic programme, and on the actual measures utilised to assess adolescents progress at post-discharge.

Since January 1992, the research unit of the William Slater Centre distributed post-discharge questionnaires to adolescent patients who had completed the 12-week therapeutic programme. These questionnaires were posted at intervals of 6 month, 18 month and 36 month post-discharge. Three research assistants who were not involved in the treatment programme telephonically contacted the adolescents or their families approximately two weeks prior to the designated time intervals, informing them of the questionnaire and confirming their current address. Adolescents were encouraged to return the questionnaires by mail and to notify the Centre of any changes in their address in the future. Self-addressed, stamped envelopes were included in order to reduce the attrition rate. Adolescents who failed to return their post-discharge questionnaires were contacted telephonically and in some instances were mailed a second post-discharge questionnaire.

3.1. ANALYSES CONDUCTED

A retrospective analysis of all patients who completed the programme during the period January 1992 and December 1995 and who were sent post-discharge questionnaires, was conducted. During this four year period a total of 245 adolescents completed the programme. Of these, 224 adolescents were sent post-discharge questionnaires at 6, 18 and 36 month intervals. Twenty-one adolescents were not sent questionnaires as a result of difficulties in locating them, given the mobility of this age group.

Of the total sample of 224 adolescents who were sent questionnaires, 131 (58.48%) responded in some way to the questionnaires at 6, 18 or 36 months. Twenty-nine (12.9%) adolescents returned the 6 month follow-up questionnaire only; 83 (37.05%) adolescents completed the questionnaire at the 6 and 18 month time periods; and 19 (8.48%) adolescents completed the questionnaire at the 6, 18 and 36 month time periods. A sample of 93 (41.5%) adolescents did not respond to any of the questionnaires. Due to the small sample sizes of adolescents who returned only the 6 month questionnaire as well as those who completed the questionnaire at the three time periods, a decision was taken to focus on the sample of 83 adolescents who completed the 6 and 18 month post-discharge questionnaire. This sample forms the basis of the present study. The sample of 93 adolescents not responding to the questionnaires were also analysed. The analyses conducted provided the following:

- (i) a profile of the adolescents who returned both the 6 and 18 month questionnaires *at the time of their initial assessment*;
- (ii) a profile of the same adolescents in (i) at the 6 and 18 month follow-up periods (i.e. the results of the post-discharge questionnaires);
- (iii) a description of the adolescents who did not return *any* of the post-discharge questionnaires sent to them at the 6, 18 or 36 month intervals;
- (iv) an analysis of the BDI scores of the adolescents who completed the post-discharge questionnaire at the 6 and 18 month intervals; and finally,
- (v) a qualitative analysis of the comments of adolescents who completed both the 6 and 18 month post-discharge questionnaires.

CHAPTER 3
**PROFILE OF ADOLESCENTS ASSESSED AT THE WILLIAM
SLATER CENTRE WHO COMPLETED THE 6 AND 18 MONTH
POST-DISCHARGE QUESTIONNAIRES**

1. INTRODUCTION

This chapter provides a profile of the adolescents and young adults *at the time of their initial assessment* at the William Slater Centre, who later completed the 6 and 18 month post-discharge questionnaires. The intention is to provide a baseline from which to evaluate their progress at the follow-up time periods. This is useful in order that one may monitor the progress of the adolescents and assess the changes evident at the follow-up periods. This chapter therefore provides a retrospective analysis of the data, which was captured at the time of the adolescent patients initial assessment to the Centre, prior to them being admitted onto the programme. Only data of those adolescents who later completed both the 6 and 18 month post-discharge questionnaires were analysed.

2. RESULTS AND DISCUSSION

Demographic and diagnostic data of patients who returned post-discharge questionnaires are presented in Tables 1 and 2. Only available data are included in these tables, with the missing data not documented.

Table 1: Demographic data of patients at the time of assessment who completed the 6 and 18 month post-discharge questionnaires (n=83)

	n	%
<i>Age</i>	16.8 ¹	
<i>Sex</i>		
Female	66	79.5
Male	17	20.5
<i>'Race'</i>		
White	57	68.7
Coloured	25	30.1
Asian	1	1.2
<i>Home Language</i>		
English	71	85.5
Afrikaans	12	14.5
<i>Living status</i>		
Parent(s)	65	78.3
Nuclear home	47	56.6
Single parent	18	21.7
Extended family	4	4.8
Independent	3	3.6
Reconstituted family	3	3.6
Foster/Adoptive	3	3.6
<i>Marital status</i>		
Single	83	100.0

Education

Secondary	56	67.5
Matric	17	20.5
Tertiary	5	6.0

Employment

Full-time student	61	73.5
Part-time employment	8	9.6
Unemployed	7	8.4
Full-time employment	3	3.6

¹Mean age

Inspection of the above table demonstrates that adolescent patients who completed the 6 and 18 month post-discharge questionnaires were predominantly White, English speaking, single females. In comparison to the demographic data of the total number of adolescents who completed the programme ($n=320$), this sample of adolescents could be considered fairly representative on the variables of sex, 'race', and home language (see Table 2). The mean age of the sample was 16.8, with a range of 14 to 24. A large proportion were full-time students completing their secondary level of education. More than half resided in nuclear homes at the time of their initial assessment at the Centre (56.6%), while 21.7% lived with one of their parents.

Table 2: Demographic data of adolescent patients who completed the William Slater Centre's 12-week programme (n=320)

	%
<i>Sex</i>	
Female	75.9
Male	24.1
<i>'Race'</i>	
White	63.1
Coloured	27.5
African	1.8
Asian	1.5
<i>Home Language</i>	
English	68.4
Afrikaans	16.5
Xhosa	1.3
Other	1.6

Table 3 provides further demographic and diagnostic data of the adolescent patients at the time of assessment.

Table 3: Demographic and diagnostic data of patients at the time of assessment who completed the 6 and 18 month post-discharge questionnaires (n=83)

	n	%
<i>In a relationship</i>	20	24.1
<i>Previous psychiatric contact</i>	55	66.3
<i>History of psychotropic medication</i>	22	26.5
<i>Family history of psychiatric illness</i>	36	43.4
<i>Physical abuse</i>	12	14.5
<i>Sexual abuse</i>	28	33.7
<i>Substance abuse</i>	22	26.5
<i>Suicidal ideation</i>	61	73.5
<i>Parasuicide</i>	39	47.0
<i>Eating disorder</i>	10	12.0
<i>Mood disorder¹</i>	72	86.7
<i>Axis II personality disorders/traits</i>		
Dependent personality disorder/traits	15	18.1
Histrionic personality disorder/traits	10	12.0
Borderline personality disorder/traits	7	8.4
Narcissistic personality disorder/traits	5	6.0
Avoidant personality disorder/traits	3	3.6

¹Includes MDE, Dysthymia, Adjustment disorder with depressed mood

The above table demonstrates that at the initial assessment at the William Slater Centre more than half of the adolescents experienced some form of prior psychiatric contact¹ and almost half of the adolescents reported a family history of psychiatric illness. Thus, it is clear that this sample (who later returned their post-discharge questionnaires), comprises adolescents with serious personal psychiatric histories and who have familial tendencies towards psychiatric illness. It is noteworthy that this sample once again does not differ to a large extent on these two variables, from the overall number of adolescents completing the programme ($n=320$), where 63.8% had a history of psychiatric contact, and 42.5% had a family history of psychiatric illness. What these results suggest is that the adolescents admitted onto and completing the therapeutic programme may be a screened psychiatric adolescent population. However, previous analyses of the Centre's data reveals that there is a lack of discrepancy on variables such as previous psychiatric contact and familial psychiatric history, between the adolescents not admitted to the Centre, and those who were admitted and completed the programme (Ahmed, 1997). Thus, the hypothesis that these adolescents are a screened psychiatric population is refuted. Nevertheless, the results from the above table demonstrate that the adolescents returning the post-discharge questionnaires comprise a sample with serious psychiatric histories.

Another striking finding from the above table is the very large proportion of adolescents who presented with histories of suicidal ideation as well as attempted suicide at the time when they were assessed. This data is similar to that of the overall number of adolescents admitted to the programme ($n=320$), where 37.8% had attempted suicide prior to their assessment at the Centre. What is clear from this data is that the sample of adolescents in question had previously experienced serious psychological difficulties. Little research exists in South Africa on the prevalence of suicide and parasuicide in adolescents, in either the general or psychiatric population. Schlebusch (1985) and Flisher, Ziervogel, Chalton, Leger, and Robertson (1993) comment on the growing concern both internationally and nationally around the extent of suicidal behaviour among adolescents.

¹ Previous psychiatric contact refers to outpatient psychiatric or psychological assessment, outpatient and/or inpatient treatment, and psychiatric or psychological hospitalisations.

Flisher et al. (1993) found that in a sample of 7340 high school students, 19% had seriously thought of harming themselves in a way that might result in death and 12.4% had informed someone that they intended to put an end to their life, while 7.8% actually attempted suicide. They conclude that suicidal thoughts can be regarded as a complex symptom that is associated with subsequent suicidal events and psychological dysfunction. Their study shows that a large segment of the adolescent population is vulnerable in this regard. Data on the extent of suicidal behaviour among South African adolescents in the community is important to obtain in order to inform preventive strategies (Flisher et al., 1993).

Table 3 indicates that at the initial assessment at the William Slater Centre, a third of the adolescents completing the post-discharge questionnaires reported a history of sexual abuse, with a smaller proportion reporting previous substance abuse. Once again, little South African research has been conducted on the prevalence of sexual abuse in psychiatric or general populations. The reported estimates of childhood sexual abuse range between 8% and 54% depending on the sample studied, the methodology used and the definitions adopted (Levett, 1990). Researchers have found an approximately 30% incidence of sexual abuse in hospitalised adolescent populations (Cavaiola & Schiff, 1988; Sansonnet-Hayden, Haley, Marriage, & Fine, 1987). A shortcoming of the investigations to date has been the use of predominantly small samples (McClelland, Mynors-Walls, Fahy, & Treasure, 1991; Miller, McClusky-Fawcett, & Irving, 1993; Shaunesey, Cohen, Plummer, & Berman, 1993), which makes for less conclusive interpretation of the data. In South Africa, although there appears to be a paucity of work in the area of sexual abuse, there are indications that childhood sexual abuse is widespread (de Villiers & Prentice, 1996; Levett, 1991; Mlotywa, 1992). In one of the few prevalence studies conducted, Levett (1989) found that 39 (41.5%) of a sample of 94 female university students reported 61 experiences of childhood sexual abuse. Haffejee (1991) examined sexual abuse in an Asian population and reported findings of 37 (22.8%) sexually abused children who were patients at the RK Khan Hospital, Durban. Westaway (1991) notes that there is no specific profile of the abused adolescent, but certain adolescents are at greater risk of abuse than others are. She concludes that

females are more likely to be abused in adolescence than males and argues that maltreated victims exhibit problems such as depression and suicidal ideation or self-mutilating behaviour. The correlation of these variables with sexual abuse in the present sample of adolescents has not been examined.

Of the total number of adolescents who completed the 6 and 18 month post-discharge questionnaires, 86.7% were diagnosed with some form of mood disorder at the initial assessment. Thus, only 11 adolescents had diagnoses other than mood disorder. Although this figure seems high, it closely resembles the total number of adolescents diagnosed with a mood disorder who completed the 12-week programme (80.6%). Previous analyses have demonstrated that the presence of a mood disorder at the assessment interview(s) did not necessitate admission to the Centre's programme. Furthermore, staff at the William Slater Centre alluded to the unilateral decision making of the psychiatrist around patient diagnoses as well as the changing of clinical staff's diagnostic impressions of patients (Ahmed, 1997). This could largely account for the high number of adolescents diagnosed with mood disorders. Nevertheless, it is important to bear in mind that depression is a serious form of psychopathology in adolescents and may be a precursor to serious mental health problems and psychosocial dysfunction in adolescents. Furthermore, depressive episodes may lead to potential or actual life-ending outcomes (Reynolds, 1994). Thus, given the high number of adolescents presenting with suicidal ideation and suicidal attempts at the William Slater Centre, it is important not to dismiss the adolescents presenting with mood disorder or depressive symptomatology.

<p style="text-align: center;">CHAPTER 4</p> <p style="text-align: center;">PROFILE OF ADOLESCENTS AT THE 6 AND 18 MONTH</p> <p style="text-align: center;">FOLLOW-UP PERIODS</p>
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1. INTRODUCTION

Having provided an indication of the profile of adolescents who completed the 6 and 18 month post-discharge questionnaires *at the time of their initial assessment*, this chapter provides a description of these same adolescents, focussing on the analysis of their post-discharge questionnaires.

2. RESULTS AND DISCUSSION

The results presented below begin with a profile of the adolescents who returned the 6 and 18 month post-discharge questionnaires, followed by responses to questions with regard to their progress since being discharged.

Table 4: Demographic and diagnostic data of patients who completed the 6 and 18 month post-discharge questionnaires ($n=83$)¹

	n	%	n	%
	6 month		18 month	
<i>Living status</i>				
Parent(s)	63	75.9	58	70.0
Independent	11	13.3	16	19.2
Extended family	4	4.8	4	4.8
Place of safety	4	4.8	4	4.8
Foster/Adoptive	1	1.2	1	1.2
<i>Marital status</i>				
Single	82	98.8	82	98.8
Married	1	1.2	1	1.2
<i>Education</i>				
Secondary	44	53.0	30	36.2
Matric	20	24.1	25	30.1
Tertiary	19	22.9	28	33.7
<i>Employment</i>				
Full-time student	59	71.1	43	51.8
Full-time employment	10	12.1	12	14.5
Part-time employment	8	9.6	19	22.9
Unemployed	6	7.2	9	10.8

¹Demographic data such as sex, 'race' and home language has been excluded from this table since this data has remained constant.

There were no major changes in the living status or marital status at the 6 and 18 month periods than at the time of the initial assessment. The number of adolescents in secondary education decreased over the two time periods while the numbers in matric and tertiary education increased. These results are expected as adolescents progress through schooling and further education. In keeping with these changes, similar trends are evident with regard to their employment status. Decreasing numbers of adolescents were full-time students at the follow-up periods, while adolescents involved in full-time and part-time employment increased.

Table 5 presents further data of adolescent patients who completed the post-discharge questionnaires.

Table 5: Further data of adolescent patients who completed the 6 and 18 month post-discharge questionnaires (n=83)¹

	n	%	n	%
	<i>6 month</i>		<i>18 month</i>	
<i>In a relationship</i>	66	79.5	47	56.6
<i>Admitted to an inpatient or outpatient psychiatric unit since leaving WSC²</i>	11	13.3	10	12.0
<i>On medication</i>	16	19.3	18	21.6
<i>Suicidal thoughts since leaving WSC</i>	28	33.7	36	43.4
<i>Suicide attempt since leaving WSC</i>	8	9.6	12	14.4
<i>Hospitalised as a result of suicide attempt</i>	7	8.4	11	13.3

¹Data on physical abuse, sexual abuse and substance abuse is not included since only the more recent revised post-discharge questionnaire included questions on these variables. Data on eating disorder, mood disorder and Axis II personality disorder is also not available since no clinical assessments were conducted at the follow-up time periods.

²William Slater Centre

While a substantially large number of adolescents were engaged in a relationship at the 6 month follow-up period than at the initial assessment, this number decreased at the 18 month follow-up period. It could be hypothesised that adolescents feel confident in committing to a relationship when leaving the Centre's programme but have difficulties in maintaining these relationships for an extended period of time. The fluctuation in the numbers engaged in relationships at the various time periods could possibly be attributed

to the developmental phase of adolescence. Devine et al. (1994) commented on the possibility that depressed mood during adolescence may influence relationships indirectly, for example through social isolation and a failure to develop social skills necessary for forming relationships. It could be hypothesised that the latter is applicable to this sample of adolescents, a large proportion of whom were diagnosed with some form of mood disorder at their initial assessment to the Centre.

The number of adolescents receiving psychiatric contact since leaving the William Slater Centre's programme declined from 11 to 10 over the 6 and 18 month period. Given that more than half of the adolescents had received some form of previous psychiatric contact at their initial assessment at the William Slater Centre, it is noteworthy that less than 15% sought psychiatric help after their discharge. This could possibly be attributed to three factors: firstly, that several continued with their psychotropic medication. The number of adolescents who were taking psychotropic medication increased slightly from the 6 month to the 18 month time periods. Most of these adolescents had a history of psychotropic medication at the initial assessment period. Thus, adolescents appear to continue to rely on their medication post-discharge, which is desirable for mood disordered illnesses. Secondly, the small number of adolescents seeking psychiatric help could be explained by the fact that several considered themselves to have access to an adequate support system outside of the William Slater Centre, although the nature of this support system is unknown. Thirdly, some adolescents were involved in ongoing therapy. Fleming et al. (1993), who conducted a follow-up study in a community sample of depressed adolescents in Ontario, found high levels of psychiatric and psychosocial impairment. They too found that a high number (i.e. more than 80%) of clinically depressed adolescents did not seek treatment for emotional or behavioural problems (Reynolds, 1994).

Of the sample of 83, only 25 adolescents did not seek any form of psychiatric or psychological assistance since leaving the William Slater Centre. They were not involved in any form of inpatient or outpatient therapy, were not hospitalised, and were not on psychotropic medication. Analysis of their files at their initial assessment to the

Centre revealed that 15 adolescents had previous psychiatric contact (11 outpatient, 4 inpatient), 5 had previously received psychotropic medication, and 8 had a family history of psychiatric illness. The majority therefore did not have distinct personal or familial psychiatric histories, and this could possibly account for them not seeking psychiatric help after being discharged. It could be hypothesised that for some of these adolescents the Centre's therapeutic programme was an adequate intervention which resulted in them not seeking follow-up treatment at post-discharge.

While a large proportion of adolescents had suicidal ideation at the time of the assessment at the Centre ($n=61$), there was a fall off in these numbers at the 6 month follow-up time period ($n=28$), with slightly less than half the number experiencing suicidal ideation. There was however a slight increase in the number of adolescents feeling suicidal at the 18 month follow-up period ($n=36$). With regard to suicide attempts, although there is a significant decline in the number of parasuicide cases in the follow-up period in comparison to the large number of adolescents who presented with parasuicide at assessment, it is of concern that upto 15% of the adolescents proceed with attempting suicide post-discharge. Furthermore, the majority of these adolescents were hospitalised as a result of their suicide attempt, which provides an indication of the extent of the suicide attempt. Schlebusch (1985) found that a significant number of adolescents who attempted suicide had a previous history of parasuicide; had received some psychological or psychiatric treatment before; and came from a family history of mental disorder or parasuicide. He added that adolescents who attempt suicide may go on to complete the act, particularly in adulthood, and many patients who commit suicide have a history of previous attempts. Hawton and Catalán (1982) too found a positive association between the number of attempts a patient makes and the chances of such a person having received psychiatric treatment or having been admitted to a psychiatric facility. These findings are of particular relevance to the present sample of adolescents who presented with personal and familial psychiatric histories as well as previous suicide attempts. These findings highlight that these adolescents are vulnerable to long-term psychiatric difficulties and are likely to experience recurrences of their condition in later adolescent and adult life. It is important to caution that although these findings are noteworthy, the

data is derived solely from self-reports of adolescents. Thus, no collateral data confirming adolescents' suicide attempts or psychological states is available.

Although the number of adolescents attempting suicide and having suicidal ideation may appear to be small, it is important that these figures be taken seriously. Suicidal behaviour is currently recognised as the second leading cause of death among adolescents and young adults worldwide (Stivers, 1988). Over the last 20 years the rate of suicide in adolescents has risen by 150% (Deykin, Alpert, & MacNamarra, 1985; Neiger & Hopkins, 1988; Sudak, Ford, & Rushforth, 1984) and this incremental global trend is supported by local data (Schlebusch, 1985). In South Africa 10.7% of all deaths in the 15-19 year age group during the period 1984-1986 were attributed to suicide (Flisher, Joubert, & Yach, 1992).

Given that a large proportion of adolescents were diagnosed with a mood disorder while on the therapeutic programme, prospective data on the natural course and short-term outcome of major depressive disorders is useful to review here. Furthermore, one of the most documented facts about adolescent depression is that they often co-occur with other symptoms (Berman & Jobes, 1991; De Wilde, Kienhorst, Diekstra, & Wolters, 1993) and depressed mood appears to be a strong predictor of suicidal ideation, implying mortality or significant morbidity (Fergusson & Lynskey, 1995; Kandel, Raveis, & Davies, 1991; Lester & Miller, 1990). In the present study, clinical assessments were not conducted at the follow-up periods, hence there is no indication of the recurrence of mood disorder in these adolescents. What is however evident from the post-discharge questionnaires is that the adolescents experience ongoing psychological or psychiatric difficulties. Longitudinal research shows that adolescent depressive disorders have a protracted course and there is a high tendency for recurrence (Kovacs, Feinberg, Crousse-Novak, Paulauskas, Pollock, & Finkelstein, 1984; Kovacs, 1985).

Garland and Weiss (1995) hypothesise that there are two groups of adolescents, one where there is a later onset, quick recovery and more mild course of depression and another group of childhood depressions where there is an early onset, heavy genetic

loading, poor treatment response and longer duration of the depressive illness. A notable finding of Rao et al. (1995) study is that depressed adolescents with no further episodes during the transition to adulthood may expect to function well in adult social roles whereas those with depressive episodes during this time may have significant psychosocial dysfunction in adulthood which may persist despite remission from depressive episodes. Their work emphasises the importance of early-onset depression and shows that depressed adolescents with a recurrent course are at high risk for persistent psychosocial morbidity in adulthood. These findings are of particular importance to the present study where ongoing psychiatric difficulties appear to be evident in the sample of adolescents, a large proportion of whom were diagnosed with a mood disorder. Although Mattanah et al. (1995) note that systematic studies of diagnostic stability in adolescents are rare and none have used clinical samples, a prospective design, or repeated systematic assessments, they argue that the literature highlights that adolescent depressed mood signals the possibility of longstanding difficulties and thus may require prompt attention. The findings of Rao et al. (1995), Mattanah et al. (1995), as well as the present study have implications for adolescent mental health services and highlight the importance of early identification and treatment.

The overarching impression one gets from the present findings as well as the previous chapter is that the post-discharge group of adolescents comprise a psychiatric population who have histories of psychological difficulties and who appear to be prone to further long standing problems. It could be hypothesised that many will continue to experience difficulties in future and may require further psychiatric or psychological intervention. Of interest is a comment by Barker (1974) who raised the notion that adolescent admission is a 'passport to further help' rather than 'a complete treatment in itself'. Although this view suggests that adolescent units are not of clear therapeutic value and is at odds with others who recommend an increase in the number of adolescent in-patient beds (Steinberg, 1982 in Turner, Dossetor, & Bates, 1986), it nevertheless suggests that recurrence of problems or disorders is highly probable for the adolescent population and that once off treatments for this age group are not adequate. These views are supported

by the work of Angst, Merikangas, Scheidegger, and Wicki (1990) who found that adolescents might have episodically intense periods of depression interspersed with periods of improvement. Other studies too report high risk for future episodes of affective illness (Garber et al., 1988; Keller, Beardslee, Lavori, Wunder, Drs, & Samuelson, 1988). Hence there is a strong likelihood of further psychiatric or psychological interventions later in life. These findings have important implications for an outcome study such as the present one, where one should perhaps not necessarily expect the therapeutic treatment programme to have dramatically positive effects.

Table 6 presents further data arising from the post-discharge questionnaire.

Table 6: Further data of patients who completed the 6 and 18 month post-discharge questionnaires (n=83)¹

	n	%	n	%
	<i>6 month</i>		<i>18 month</i>	
	<i>Yes¹</i>		<i>Yes¹</i>	
<i>Adequate support system outside</i>	48	57.8	61	73.5
<i>Been in individual or group therapy during the past year</i>	38	45.7	30	36.1
<i>Refer adolescents in need of psychological intervention to the William Slater Centre</i>	52	62.6	71	85.5
<i>Coping with your life</i>				
<i>Yes</i>	49	59.0	68	82.0
<i>Unsure</i>	18	21.7	1	1.2
<i>Sometimes</i>	4	4.8	3	3.6
<i>No response</i>	12	14.5	11	13.2
<i>William Slater Centre have an impact on your life</i>				
<i>Yes</i>	52	62.7	68	82.0
<i>Unsure</i>	9	10.8	13	15.6
<i>No response</i>	22	26.5	2	2.4

¹Applicable to first three items only

The above table demonstrates that adolescents continue to seek psychiatric or psychological assistance. Less than half of the adolescents reported utilising individual or group therapy in the period following their discharge from the Centre. The

questionnaire did not specify whether therapy was obtained outside the William Slater Centre or whether it formed part of the post-discharge therapeutic programme. More than half of the adolescents felt that they had an adequate support system outside of the Centre. These findings suggest that the adolescents were able to utilise external resources following their discharge from the programme. Furthermore, the findings highlight adolescents need for ongoing support following their discharge. Several studies have emphasised the importance of continuing therapy after discharge. Gossett, Lewis, and Barnhart (1983) reported on 68 boys and 52 girls from 12-19 years old who were admitted to a private psychiatric facility. They found that adaptive outcome at follow-up related to less severe psychopathology at admission; average to above-average intelligence; length of hospital stay greater than three months; participation during hospitalisation in a programme that included an educational component; and continuing therapy after discharge. The first year after discharge was particularly notable for variability of functioning. Research has found that continued therapy after discharge is associated with better functioning and is important to maintain given the possibility that functioning is variable in the immediate postdischarge period. Furthermore, supportive peer and family relationships may be associated with better functioning at follow-up (Curry, 1991). One study even found that parental involvement in the treatment process is related to positive outcome. Waugh and Kjos (1992) outcome study of 50 adolescents with behavioural and emotional problems in a partial hospitalisation programme found that parental involvement during the treatment process is related to greater improvement in school and home functioning as well as reduced pathology. Adolescents discharged from the William Slater Centre's programme appeared to utilise available resources in the post-discharge period and these findings highlight the need for a post-discharge supportive therapy network, especially in light of the recurrence of depressive disorders as well as the number of adolescents presenting with suicidal ideation and suicidal attempts at follow-up periods.

Table 6 shows that at the 6 month follow-up period, 41% of adolescents felt unable to provide a clear comment on whether they were coping adequately with their life. This figure declined at the 18 month follow-up, with 82% feeling that they were coping well

with their life. These findings once again suggest that adolescents appear to be experiencing long-term difficulties and that these are possibly episodic in nature. It could be hypothesised that these adolescents are not coping adequately and are likely to be experiencing difficulties at present or in the future. These findings lend support to the importance of ongoing therapy for adolescents following discharge from the therapeutic treatment programme.

At the 6 month follow-up time period, more than 60% of adolescents considered the William Slater Centre's programme to have had an impact on their life. This figure increased to 82% at the 18 month follow-up period. The remaining adolescents were either unsure or did not respond to the question. Adolescents appear to consider the benefits of the William Slater Centre's programme more favourably after an extended period of being discharged. However, there appeared to be a discrepancy in these findings and that of a subsequent question where adolescents were requested to rate the impact of the William Slater Centre's programme on their lives at present. A scale of 0-10 was provided where 0 implied that the programme had no impact on their life and 10 signified that the programme had a significant impact on their life. The mean score at 6 months was 6.8 and at 18 months was 6.4. The mean score of 6.8 at 6 months correlates with the number of adolescents reporting a positive impact at 6 months on the previous question. However, these figures may be misleading since only 25 scores were available for analysis of the total sample of 83 at the 6 month follow-up period, as a result of this scale being included in later post-discharge questionnaires, as well as adolescents choosing to not complete the scale. Instead, adolescents provided detailed descriptions of their current state and views of the programme in the open-ended part of the questionnaire (see Chapter 6). Of note is that the high percentage of adolescents (82%) who considered the Centre's programme to have a positive impact on their life at the 18 month time period, does not coincide with the low mean of 6.4 at 18 months on the scale score. (A total of 56 adolescents provided a score at the 18 month follow-up period). This discrepancy could partly be attributed to the different response formats, which resulted in a low mean score, while the categorical data yielded more positive results. Once again, the qualitative data presented in Chapter 6 provides a richer description of

their experience of the programme and of their perception of their progress at the follow-up time periods.

Adolescents were asked to rate their progress since being discharged from the William Slater Centre on a scale of 0-10, where 0 implied that there had been no significant change in their life and 10 signified that their life had improved to a large extent. The average scores at 6 months was 7.0 (with 67 adolescents responding to the question) and at 18 months 7.4 (with 81 adolescents responding). In general, the large number of adolescents felt that their lives had improved since being discharged from the William Slater Centre's programme.

The gains made on the programme are reflected in their response to the question on whether they would refer adolescents to the Centre. More than half of the adolescents reported that they would refer adolescents to the Centre's programme. By the 18 month period, an even larger proportion (85.5%) of adolescents were willing to refer adolescents in need of psychological intervention to the Centre. These findings suggest that adolescents consider the Centre's therapeutic programme more favourably after an extended period of being discharged.

CHAPTER 5

PROFILE OF ADOLESCENTS WHO DID NOT RESPOND TO ANY POST-DISCHARGE QUESTIONNAIRES

1. INTRODUCTION

Having provided a profile of the adolescents who completed the 6 and 18 month follow-up questionnaire, the following chapter examines the remainder of the sample, namely those adolescents who did not respond to *any* of the post-discharge questionnaires sent to them at the 6, 18 or 36 month time periods. This chapter provides a profile of these adolescents and young adults at the time of their initial assessment at the Centre. In this way it is possible to determine whether there are any differences between the adolescents who responded to the post-discharge questionnaire and those who failed to complete any of the questionnaires. Providing a profile of these adolescents would enable one to determine whether those returning the post-discharge questionnaires represent the typical adolescent seen at the William Slater Centre. Furthermore, it can clarify whether there were any significant features of the sample of adolescents who completed the questionnaires as opposed to those not responding to any of the questionnaires. It is important that the staff of the Centre have a profile of the adolescents not returning any of the questionnaires in order for them to begin addressing the high attrition rate and to increase their attempts to access these adolescents at the follow-up periods.

All records of adolescent patients who successfully completed the William Slater Centre's 12-week programme and who did not respond to *any* of the post-discharge questionnaires sent to them at either of the 6, 18 or 36 month time periods, were retrospectively analysed.

2. RESULTS AND DISCUSSION

Table 7 presents the results of adolescents who did not respond to the post-discharge questionnaires.

Table 7: Demographic and diagnostic data of patients who did not respond to the post-discharge questionnaires (n=93)

	n	%
<i>Age</i>	17.9 ¹	
<i>Sex</i>		
Female	74	79.6
Male	19	20.4
<i>'Race'</i>		
White	53	57.0
Coloured	29	31.2
Asian	4	4.3
African	2	2.2
<i>Home Language</i>		
English	68	73.1
Afrikaans	18	19.4
Xhosa	1	1.1
Other	1	1.1

Living Status

Parents	59	63.4
Extended family	10	10.8
Reconstituted family	8	8.6
Single parent	8	8.6
Foster/Adoptive	7	7.5
Independent	1	1.1

Education

Secondary	65	69.9
Matric	18	19.4
Tertiary	9	9.6
Primary	1	1.1

Employment

Full-time student	62	66.6
Part-time student	13	14.0
Unemployed	13	14.0
Full-time employment	5	5.4

¹Mean age

Inspection of the above table demonstrates that the adolescents who did not respond to any of the post-discharge questionnaires are not demographically different from those who returned the questionnaires.

Table 8 presents further data of patients not responding to any of the post-discharge questionnaires.

Table 8: Further data of patients who did not respond to the post-discharge questionnaires (n=93)

	n	%
<i>In a relationship</i>	29	31.2
<i>Previous psychiatric contact</i>	51	54.8
<i>History of psychotropic medication</i>	15	16.1
<i>Family history of psychiatric illness</i>	41	44.1
<i>Physical abuse</i>	15	16.1
<i>Sexual abuse</i>	51	54.8
<i>Substance abuse</i>	35	37.6
<i>Suicidal ideation</i>	65	69.9
<i>Parasuicide</i>	24	25.8
<i>Eating disorder</i>	8	8.6
<i>Mood disorder¹</i>	71	76.3
<i>Axis II personality disorders/traits</i>		
Dependent personality disorder/traits	13	13.9
Histrionic personality disorder/traits	11	11.8
Borderline personality disorder/traits	5	5.4
Narcissistic personality disorder/traits	3	3.2
Avoidant personality disorder/traits	2	2.2

¹Includes MDE, Dysthymia, Adjustment disorder with depressed mood

The above table demonstrates that adolescents who did not respond to the questionnaires did not differ much from those who responded to the questionnaires. The most noteworthy differences between these two groups were on the variables of sexual abuse, parasuicide and mood disorders. Those adolescents not responding to the questionnaires presented with fewer parasuicide attempts at assessment and slightly fewer were diagnosed with mood disorder than those adolescents who did respond to the questionnaires. Of note is that adolescents who did not respond to the questionnaires

were more likely to have had a history of sexual abuse than those adolescents who responded to the questionnaires. Literature demonstrates that sexual abuse has both short-term and long-term consequences (Browne & Finkelhor, 1986). Adolescents with a history of sexual abuse have been found to exhibit a range of behaviours and disorders including substance abuse (Cavaiola & Schiff, 1988; Jeffrey & Jeffrey, 1991); suicidal ideation and attempts (Cohen & Mannarino, 1988; Deykin, Alpert, & MacNamarra, 1985; Jeffrey & Jeffrey, 1991; Shaunesey et al., 1993); self-destructive behaviour (Browne & Finkelhor, 1986); personality disorders (Ludolph, Westen, Misle, Jackson, Wixom, & Wiss, 1990; Westen, Ludolph, Misle, Ruffins, & Block, 1990); eating and sleeping disturbances (Miller & McClusky-Fawcett, 1993; McClelland et al., 1991); depression, anxiety and low self esteem (Jeffrey & Jeffrey, 1991); running away, truancy, scholastic difficulties and early marriages (Kurtz, Kurtz, & Jarvis, 1991; Herman, 1981). This highlights the varied clinical presentation and multiple symptomatology associated with sexual abuse. There is however no simple or clear-cut relationship between early experiences of sexual abuse and psychological problems in adulthood (Levett, 1995). Given the above research findings, it is likely that this sample of adolescents not returning any of the post-discharge questionnaires may have differed in their ratings of the William Slater Centre's therapeutic programme as well as their progress since being discharged. Although this data cannot be ascertained, what is clear is that this sample is demographically similar to those adolescents who responded to the post-discharge questionnaires. The literature nevertheless highlights the significance of follow-up of adolescents presenting with early sexual abuse histories.

It can be hypothesised that the absence of follow-up data for the adolescents who did not respond to any of the questionnaires may not have influenced the overall findings of this study. The sample of adolescents not responding to the questionnaires is as typical of the William Slater Centre's patient as those who did return their questionnaires. It was not considered vital to conduct statistical tests of significance since the intention was merely to determine whether there were some difference between the two groups of adolescents and strict comparisons of the groups was not necessary.

CHAPTER 6

DEPRESSION RATING SCALE AS A MEASURE OF OUTCOME

1. INTRODUCTION

As evident from previous chapters, adolescent depressive disorders are particularly prevalent in the cohort of adolescents assessed at and admitted to the William Slater Centre's psychotherapeutic programme. A large proportion of adolescents returning their post-discharge questionnaires were initially diagnosed with some form of mood disorder at the Centre. Given the high percentage of adolescents with affective disorders at the William Slater Centre, as well as the concern about adolescent depression (Harrington, 1994) and the need for effective intervention and preventive strategies, the present chapter aimed at examining depression as an indicator of programme outcome.

A retrospective analysis of the BDI scores was conducted in an attempt to obtain a measure of treatment outcome for depressive symptomatology of adolescent patients who completed the 12-week programme, and who responded to both the 6 and 18 month post-discharge questionnaires. Only the BDI scores were analysed since the sample sizes of adolescents completing the GHQ and YSR were too small. The HDRS and MADRS were not administered at post-discharge.

2. MEASURES

Beck Depression Inventory. The Beck Depression Inventory is a widely-used, well-studied clinical and research measure of depressive symptoms, used for both adult and adolescent populations (Ambrosini, Metz, Bianchi, Rabinovich, & Undie, 1991; Barrera & Garrison-Jones, 1988; Robbins, Alessi, Colfer, & Yanchyshyn, 1985; Strober, Green, & Carlson, 1981; Teri, 1982). In recent years, the BDI has become one of the most widely accepted instruments for the assessment of depression in mental health patients (Piotrowski, Sherry, & Keller, 1985). It has been utilised in studies based on large-scale screenings of community or school-based samples as well as in clinical settings with

adolescents (Archer, Maruish, Imhof, & Piotrowski, 1991) and on normal populations (Steer, Beck, & Garrison, 1985). It has been researched and validated for the adolescent population (Robbins et al., 1985; Strober et al., 1981).

The Beck Depression Inventory comprises 21 questions with four choices of answers. The total BDI score (the sum of the individual items) ranges from 0 to 63. Cutoff scores used in previous studies on adolescent populations are as follows: 0 to 9 non depressed; 10 to 15 mild depression; 16 to 23 moderate depression; 24+ severe depression. A total BDI score of 16+, has been validated to be a cutoff score for major depressive disorder in adolescents (Strober et al., 1981). According to Tarnopolsky, Hand, McLean, Roberts, and Wiggins (1979), instruments should be re-validated in different settings or when used in different populations. Although validation studies of the BDI are dated, recent research conducted at the William Slater Centre found the BDI to be a useful measure of depressive symptoms in the psychiatric adolescent population (Berard & Ahmed, 1996).

In the present evaluation, only one self-report measure of depressive symptoms, namely the Beck Depression Inventory, was utilised to determine the progress of patients admitted onto and discharged from the therapeutic programme. The literature indicates a tendency for adolescents to be considered valid reporters of internal states such as feelings associated with depression, thus the accepted use of self-report measures for adolescent depression (Kendall & Morris, 1991). Furthermore, depression rating scales can be viewed as objective and credible when ratings are obtained at stipulated time periods rather than in retrospect. Self-report rating scales, in particular, impose uniformity on the information obtained (King et al., 1987).

3. METHOD

An adaptation of the single-group, interrupted time-series design was used. Ideally, this design comprises a *series* of measures before, during and after the programme, thereby enabling one to determine whether measures taken after the programme are a continuation of earlier patterns or whether they mark a decisive change (Weiss, 1972).

At the Centre, a series of measures were taken at four intervals for each patient admitted to the programme. These occurred:

- (i) before the onset of the programme just prior to the initial assessment interview;
- (ii) during patients' first week on the programme;
- (iii) at patients' sixth week of the programme;
- (iv) at discharge of patients' from the programme at week twelve²;
- (v) at 6 month post-discharge;
- (vi) at 18 months post-discharge; and
- (vii) at 36 months post-discharge from the programme.

Thus, only one measure was available prior to the onset of the programme and upto three measures were available for analysis post-treatment. The time lapse between the initial assessment and admission to the programme ranged from two weeks to three months. Three research assistants, who were not involved in the treatment programme, independently administered the BDI at assessment, and at week numbers one, six and twelve of patients' stay on the programme. The BDI was mailed to adolescents at 6 month, 18 month and 36 month post-discharge.

A retrospective analysis of all patients who completed the post-discharge questionnaires including the BDI during the period January 1992 and December 1995, was conducted. Initially, a total of 131 files were examined, several of which had missing scores for the BDI. This was a consequence of different time periods in which the rating scales were initiated and adolescents failing to complete the scales. As a result, analyses were conducted on samples with the maximum number of complete records.

² Occasionally rating scales were administered in the penultimate week of patients' stay on the programme.

4. RESULTS AND DISCUSSION

4.1. MEANS AND STANDARD DEVIATIONS OF BDI

Table 9 presents the means, standard deviations and ttest for the available BDI scores at the 6 and 18 month follow-up time periods.

Table 9: Means, standard deviations and ttest for BDI scores at 6 month and 18 month follow-up ($n=80$)

	N	Mean	Std. dev.	t value	df	p
6 month	80	10.46	10.63	0.955	79	0.05
18 month	80	9.44	9.43			

This table demonstrates that there is no significant difference in the scores at the 6 and 18 month intervals on the BDI.

Table 10 shows the means and standard deviations of the BDI at the six time periods, while the time-series graph (Figure 1) represents this table graphically.

Table 10: Means and standard deviations of the BDI at six time periods – Assessment, Week 1, Week 6, Week 12, Month 6 and Month 18 ($n=71^1$)

	Mean	Standard deviation
Assessment	26.3	12.4
Week 1	23.6	12.5
Week 6	21.3	12.5
Week 12	13.6	10.1
Month 6	10.5	10.7
Month 18	8.9	8.7

¹71 patient records were available with scores at the six time periods

COMPARISON OF BDI SCORES AT SIX TIME PERIODS

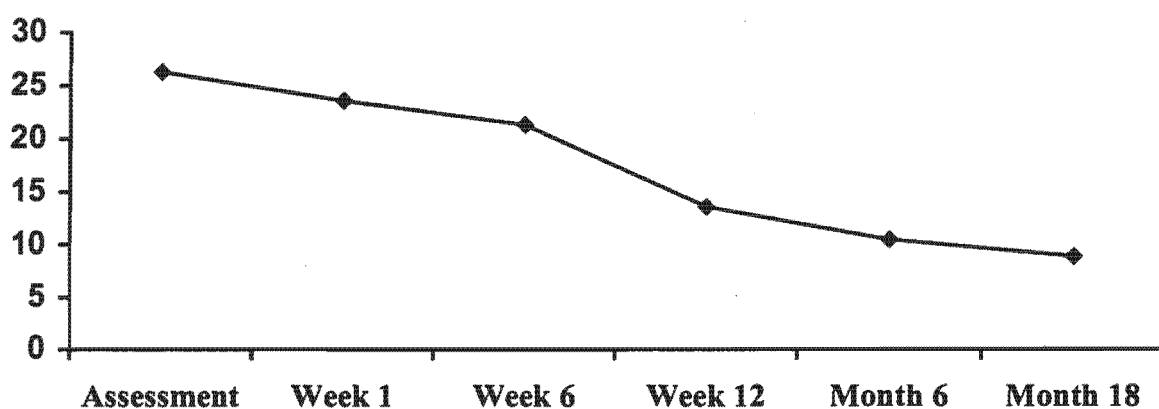


Figure 1: Time-series graph for the BDI at six time periods ($n=71$)

A repeated measure, one-way analysis of variance (ANOVA) was conducted on the BDI scores. The results are depicted in Table 11 below.

Table 11: Repeated measure, one-way ANOVA, fixed effects

Source	df	MS ¹	dfError	MSError	F
Within groups	5	3745.68	355	69.73	53.716

¹Mean Squares

Critical value at $p < 0,00$

The ANOVA indicates that there is significance for the main effect factor of time ($F=5.35$; $p < 0,00$). This implies that patients scores on the BDI significantly improved over the course of the 12-week period as well as at the 6 and 18 month follow-up periods.

Figure 1 indicates that patients fluctuated between the moderate to severe range of BDI cutoff scores during the waiting period. By the sixth week of treatment, patients BDI scores remained in the moderate depression range. It is only in the very latter part of the treatment programme that the mean scores fell below the cutoff score of major depression. At discharge from the treatment programme, patients fell within the mild depression range and these scores declined to below the mild range by the 18-month follow-up period. As one would expect from a therapeutic treatment programme, the most noteworthy effect occurred during the 6 to 12 week period of the programme.

Given the high mean BDI scores at the initial assessment, further analysis was conducted on patients who scored within the severe depression range (i.e. 24+) at any of the four time periods (i.e. Assessment, Week 1, Week 6, or Week 12). Of the sample of 47, 42 adolescents scored 24+ at the initial assessment. At discharge the number of patients within the severe depression range declined to 12, demonstrating a phenomenal improvement in patients from the time of assessment. At the post-discharge time period

of 6 months, 9 patients fell in the severe depression range, with this number decreasing to 7 at the 18 month interval (See Table 12). Seventeen adolescents were moderately depressed at 6 months post-discharge and 14 at 18 months. Of note is the adolescents who scored 24+ at the post-discharge intervals with some reaching scores as high as 42.

Table 12: Number of patients with BDI scores of 24+ ($n=71$)

ASSESS- MENT	WEEK 1	WEEK 6	WEEK 12	MONTH 6	MONTH 18
42	35	27	12	9	7

In summary, the BDI rating scale demonstrates scores of severe or major depression at assessment, with mild depressive scores at discharge and at post-discharge. The most significant improvements as recorded by this scale, occurs in the latter part of the programme and at post-discharge.

These findings suggest that the majority of adolescents did not have a recurrence of mood disorder at the post-discharge follow-up periods. Although the number of adolescents scoring in the moderate and severe depression range on the BDI appear to be small, it could be implied that these adolescents have depressive symptomatology which is in need of psychological or psychiatric intervention. It is important to note that according to Emslie, Weinberg, Rush, Adams, and Rintelmann (1990), self-report instruments do not take into account the presence of a cluster of symptoms needed to make a diagnosis of depression. Reynolds (1994) argues that depression measured by self-reports provides an estimate of severity in adolescent depression on condition that the measures have empirically established cutoff scores. However, it is possible for individuals with a depressive disorder to score below the cutoff because of the potential for symptom variability (Stewart, McGrath, & Quitkin, 1992). Another important comment worthy of note is that conclusions about the effectiveness of treatment may vary greatly depending on when assessments are conducted and this is of particular importance with depressive

illness which has a protracted course with a high tendency for recurrence (Kazdin, 1990). What these research findings highlight is that the scores of depression rating scales should not be equated with a formal diagnosis of depression. The analysis of the BDI scores therefore provides an indication of the severity of depression and depressive symptomatology rather than a formal diagnosis of mood disorder.

What can clearly be stated from the findings of this chapter is that there is significant improvement in the depressive symptomatology of adolescent patients as measured by the BDI, completing the William Slater Centre's therapeutic programme. A limitation is that there is only one measure of depression and a clinician's perspective is not available. The improvement in depressive scores is very promising and demonstrates that the therapeutic programme has a positive impact of adolescents presenting with major or severe depression. It is however important to note that what cannot be assumed is that the therapeutic treatment programme was responsible for the alleviation of adolescent depressive symptoms. The absence of a control group in this study clearly cautions against this conclusion.

In addition to the lack of a control group, there are numerous confounding variables, which prevent conclusive findings with regard to the role of the therapeutic programme in the alleviation of adolescent depressive symptomatology. An exhaustive account of the possible confounders is a complex undertaking and therefore will not form part of this thesis. Instead, the approach taken is to briefly comment on the threats to internal validity³ (Campbell & Stanley, 1963), a significant disadvantage of the time-series design.

Maturation: Improvements in depressive symptoms may have occurred solely as a result of the passage of time between the administrations of the rating scales, and not as a result of the programme itself. Determining how much of the change was due to maturation

³ Threats to internal validity refers to eliminating explanations of change not due to the programme in an attempt to demonstrate that the programme caused the changes.

requires testing other groups of adolescents or testing over a greater number of time periods (Posavac & Carey, 1992).

Testing: Administration of the same rating scales at the six time periods may have differed simply as a function of patients' increased familiarity with the scales. Thus, improvement in depressive scores, particularly in the latter part of the programme and at post-discharge, could be a result of patients' familiarity with the rating scales. Furthermore, the transparency of the questionnaire may have led adolescents to respond to the items of the BDI in a socially desirable manner.

Regression to the mean: Regression implies that extreme scores in a particular distribution will tend to move towards the mean of the distribution as a result of repeated testing. The implication for the present chapter's findings is that significant depressive scores are likely to be less significant at the next administration of the rating scales. Thus patients who were most depressed at the initial assessment were inclined to be less depressed at the end of the 12-week programme and at post-discharge. However, this does not imply that they were at a healthy level of functioning at discharge. In fact they could still have been more depressed than the general adolescent population. The number of adolescents presenting with suicidal ideation and suicidal attempts at the follow-up periods as well as the fact that several were uncertain about their ability to cope with their life, possibly lends support for this hypothesis.

History: It is likely that events, not related to the programme, which occurred between the administration of the rating scales, could have affected patients and thus resulted in improved depression scores. For example, stressful home or school environments could have improved, a particular stressor may have been eliminated or the intensity of the stressor reduced, or adolescents may have taken medication. Problems related to history can be remedied by testing additional groups at additional time periods, being sensitive to unexpected events and changes. This was however not tracked in the present study.

Other factors, which could have contributed to the significant improvement in depressive scores, include the anti-depressant medication which adolescents were taking. The role of anti-depressant medication in the treatment of adolescent depression is however fairly inconclusive and the extent to which medication contributes to improvement in depressive symptomatology is unknown. Another factor is that patients who completed the 12-week programme and the post-discharge questionnaires chose to complete it, and their improvement, as measured by the rating scale, may not represent the effect of the programme on everyone that the programme was designed for.

In studying treatment results it is important to note that the alleviation of symptoms alone does not reflect a cure, and what is of equal (or greater) significance is the ability of individuals to develop a meaningful life in the community (Blackman, Eustace, & Chowdhury, 1991). Thus, while depression rating scales demonstrate improvement in depressive symptoms and severity of depression, it does not provide an indication of the overall functioning or general psychosocial adaptive functioning of the adolescent. The latter is of particular importance to the present thesis given that one of the primary aims of the William Slater Centre is the improvement of the overall functioning of adolescents.

The results from this chapter nevertheless are very promising, demonstrating that adolescents presenting for the Centre's milieu treatment programme significantly improve by the end of the 12-week period as well as at post-discharge. It is however essential that these positive findings be interpreted in light of the above-mentioned threats to internal validity. These obvious and hidden confounders are multiple and complex in their relationship and qualitative data therefore becomes imperative. Caution is required in the interpretation of these findings, with particular reference to the conclusions of preceding chapters, and the findings of the following chapter.

CHAPTER 7

PATIENTS' PERCEPTIONS OF THE PROGRAMME AND THEIR PERCEIVED PROGRESS AT FOLLOW-UP

1. INTRODUCTION

The perspective of programme participants on therapeutic treatments have been valued to a lesser extent to that of the perceptions of staff members. Although patient ratings provide a rich source of data from those directly experiencing the programme, these are subjective (Ellsworth, 1983). Weiss (1972) notes that participants may like or dislike a programme for reasons not related to its goals. Adolescents, in particular, are noted to not always be the best source of information (Loeber, Green, & Lahey, 1990) and preference is given to data obtained from significant others in their lives, for example from parents and teachers (Ellsworth, 1983).

Taking these limitations into account, this chapter provides a qualitative analysis of the comments of adolescents who completed the 12-week therapeutic programme as well as the 6 and 18 month post-discharge questionnaires. At the end of the questionnaire adolescents are encouraged to comment on any aspect of the programme or on their progress since being discharged.

2. RESULTS AND DISCUSSION

The method of 'open coding' as described by Strauss and Corbin (1990) formed the basis of the analysis of the semi-structured part of the post-discharge questionnaire. Open coding involves a line-by-line analysis of transcripts to label phenomena, identify concepts, and group concepts into categories. The analysis of the data resulted in the following categories being identified, each of which will be discussed below:

- (i) Emotional growth
- (ii) Acquisition of skills
- (iii) Positive and negative aspects of the programme

(i) Emotional growth

The overarching impression from the comments of adolescents was that the William Slater Centre's programme had significantly contributed towards them improving their sense of self-worth. Many commented on their improved self-confidence, assertiveness and maturity since their discharge from the programme:

- *I was taught how to develop and grow with myself*
- *I feel that I have a lot of self confidence now because I'm happy with who I am*
- *It made me more assertive, mature and enabled me to overcome most of my problems.*

Furthermore, the majority of adolescents noted that the most useful aspect of the programme was acquiring the skill of self-reflection. Many reported that the programme was instrumental in changing their perspective on themselves as well as achieving a better understanding of their self and others:

- *William Slater has greatly influenced my life and my understanding of other people*
- *I hated Slater while I was there - because of other patients, some staff, etc., but in retrospect I suppose it was beneficial. I'd have to say that I learnt a great deal about myself which helps to confront life now*
- *You can't change or better yourself unless you know and understand yourself.*

Some noted that reflecting on themselves enabled them to recognise their strengths and to acknowledge their shortcomings:

- *Slater has increased my ability to acknowledge my downfalls and shortcomings and in effect to deal with them accordingly.*

Adolescents also alluded to the fact that they learnt to take responsibility for themselves and their lives and hence became more independent individuals as a result of the programme:

- *I have learnt to accept negative feedback in a more positive way. I am taking responsibility for myself and feel much more positive.*

Of significance is adolescents awareness of the need for prospective patients to the Centre to be motivated to attend the programme and to improving their condition:

- *Slater only helps the people who want to be helped ... the experience is valuable and enriching*
- *I found William Slater useful because I was mature enough at the time*
- *Slater's a traumatic experience that not everyone can benefit from – some people just don't have the maturity to realise that they have to take responsibility for themselves*
- *Slater helped me. But you have to be prepared to work bloody hard and I think that people need to be made more aware of this*
- *I would ...consider age as a criteria, psychological and emotional maturity is inevitable to take most advantage of what this programme has to offer.*

(ii) Acquisition of skills

What was clearly apparent from the comments of adolescents is the value of life skills which forms part of the therapeutic programme:

- *It helped me incredibly not just with my depression but it also taught me life skills and other things like dealing with my individual feelings.*

Several highlighted the fact that they feel better equipped to cope with their difficulties and to deal with challenges they were faced with:

- *Slater has given me the skills to cope with life successfully*
- *Slater helps people/adolescents learn to cope or realise the underlying factors of their problems and teaches you to cope with those problems if not solve them*
- *My coping skills have improved, I have learnt to start taking responsibility for myself and it has helped me face some of the difficulties in my life.*

Some added that they continued to have difficulties applying the skills they learnt to everyday life:

- *It has given me ways and means to cope, but I'm not sure how to apply it.*

Adolescents reported improved interpersonal relationships as a result of the skills acquired on the therapeutic programme:

- *I have improved my relationships with people.*

(iii) Positive and negative aspects of the programme

The overwhelming majority of adolescents commented on the positive impact which the William Slater Centre's therapeutic programme had on their lives;

- *It was a remarkable and unforgettable turning point in a positive direction*

with some acknowledging the benefits of milieu therapy:

- *It is an environment where other people of the same age will be going through similar feelings*
- *At Slater you feel less abnormal around other teenagers with the same problems. The support and acceptance of your peers is very comforting*
- *... the best was gaining understanding and support from others in similar situations*
- *It gives one opportunity to deal with difficult situations in a caring and supportive environment. Most of all it encourages openness and honesty of feelings which is essential for understanding and healing.*

However several adolescents held opposing views on the programme. One of the most striking criticisms of the William Slater Centre's programme is the lack of ongoing support or therapy after the discharge of adolescents. The stark transition from a supportive environment to their home environment post-discharge was considered problematic for many adolescents and is in need of attention:

- *... it is too artificial... when you leave it's hard to readjust to life without constant company/support of friends*

- *I'm just disappointed that you go from having immense support and then suddenly ... you lose most of that support too quickly.*

Adolescents emphasised the importance of ongoing therapy and highlighted the shortcomings of the Centre in this respect:

- *It took me a long time to go back to therapy and I felt awful before I realised that therapy was not over. A referral from William Slater to a therapist might have helped.*

Adolescents also expressed difficulties in returning to the William Slater Centre after their discharge:

- *I think it is difficult for people to 'return' to William Slater for help because while one is mostly received in a 'gentle', attentive way (it) feels somehow that one is intruding upon a haven.*

Some however have been able to continue therapy and utilise the experience of the therapeutic programme to further their emotional growth:

- *Slater had a very positive impact on my life, because although I did not deal with some issues while I was there, it has helped me to trust and confide in subsequent therapy.*

A minimal number of adolescents were uncertain about the gains made from the Centre's therapeutic programme:

- *Isolated incidents of great benefit... otherwise generally very difficult – detrimental even*

- *at other times I do wonder if it helped me at all. It all depends on what is happening in my life at that present moment*
- *I think it helped me with more insignificant issues, not with anything major*
- *It has had a impact but sometimes I do things that does not look that way. Like taking a overdose. Maybe I'm just not using the program properly or maybe I am afraid to face life and its realities,*

while others held strong opinions on the failure of the programme:

- *All it really did was fill a 3-month gap of my 1994 year, that's all*
- *Slater needs work, it's falling apart.*

Adolescents also expressed frustration at not being cured of their primary diagnosis, and it appears that the programme did not sufficiently educate adolescents with regard to the subsequent course of their illnesses:

- *I feel it helped me with certain family problems and relationships but I don't feel it solved my bulimia problem*
- *My depression was not solved through therapy*
- *I never really learnt how to ... deal with my learning problem*
- *Although I'm not sure we found any concrete reasons for my depression I have learnt many practical ways of coping with my emotions.*

3. CONCLUSION

The findings of this chapter highlight the varied views of adolescents discharged from the Centre's therapeutic programme. Although the majority of adolescents reported on their positive experiences of the programme, several commented on their uncertainty or pessimism about the progress made since their discharge. Of significance is adolescents highlighting the acquisition of life skills as an essential aspect of the therapeutic programme as well as the prerequisite that individuals be motivated to attend the programme. Perhaps the most noteworthy finding is the importance of ongoing therapy or support after adolescents are discharged. Adolescents' comments in this regard should alert the staff of the William Slater Centre to providing a formal support structure during the post-discharge period. Of interest is that these comments were made despite the outpatient group therapy sessions which are designed for post-discharge patients, held at the Centre. It appears that adolescents are inadequately educated with regard to the objectives of the Centre's programme.

CHAPTER 8

DISCUSSION AND CONCLUSION

1. INTRODUCTION

This thesis aimed to conduct an outcome evaluation of the William Slater Centre's psychotherapeutic milieu programme. This was accomplished by examining existing records of post-discharge questionnaires which were sent to adolescent patients at various intervals following their discharge from the Centre. From the outset, the study was limited by the measures adopted by the Centre, which did not allow for a comprehensive outcome evaluation of the long-term efficacy of the programme. Instead, analysis of the questionnaires resulted in an indication of the profile of adolescent patients at the post-discharge intervals as well as a glimpse of their functioning since their discharge from the Centre's programme. What was envisaged is that, despite the limitations of the present study, the data arising from the questionnaire could provide guidelines with regard to the improvement of the William Slater Centre and its therapeutic programme. The outcome of the study may assist the staff of the Centre in reflecting on their own functioning within the therapeutic programme as well as on the measures utilised to assess adolescents progress at post-discharge.

This concluding chapter aims to briefly outline the findings of the previous chapters and to discuss the limitations of the present study, in the hope that these would be beneficial to the future functioning of the William Slater Centre's therapeutic programme.

2. DISCUSSION

2.1. SUMMARY OF FINDINGS

The William Slater Centre for Adolescents and Young Adults is one of the few psychiatric units which provides intensive psychotherapeutic treatment for emotionally and psychologically disturbed adolescents. A previous study concluded that the facilities

at the William Slater Centre are adequate and well-maintained and that the environment is conducive to milieu therapy, the central philosophy on which the Centre's programme is based. The staff comprise a multi-disciplinary team of experienced health professionals. The profile of adolescents assessed and admitted to the Centre suggests that more clarity is required with regard to the selection criteria for admission to the programme. There appears to be a lack of discrepancy between those adolescents admitted to the programme and those failing to be admitted. The majority of adolescents completing the programme had a history of psychiatric contact; a family history of psychiatric illness; and a diagnosis of mood disorder. Several presented with previous parasuicide attempts prior to their admission. The brief short-term outcome evaluation found significant improvements in the depressive states of adolescents by the end of the 12-week therapeutic programme. The extent to which this is a result of the programme itself is difficult to ascertain (Ahmed, 1997).

The overarching impression one gets from the present study is that adolescents who were followed up after their discharge from the William Slater Centre's therapeutic programme comprise a fairly disturbed psychiatric sample by the fact that they presented with personal and familial psychiatric or psychological histories at their initial assessment to the Centre. Furthermore, the majority of adolescents were diagnosed with some form of mood disorder at their initial assessment. The literature, as well as the findings of the present study, lends support to the hypothesis that these adolescents appear to be vulnerable to long-term psychiatric difficulties. It is likely that they will experience recurrences of their condition in later adolescent and adult life.

While there appears to be significant improvement in adolescents depressive symptomatology, as measured by a rating scale, with the most effect occurring in the latter part of the programme and being sustained at post-discharge, findings from the study as well as from the literature highlight the importance of ongoing support at post-discharge. Adolescents expressed a clear need for ongoing psychiatric or psychological assistance. This is of particular importance given the known recurrence of depressive disorders and its associated comorbidity. The nature of adolescent depression, with its

protracted course and tendency for recurrence, makes strong outcomes difficult to predict.

Qualitative analysis highlights adolescents positive experiences of the Centre's therapeutic programme and the gains made, with few voicing their uncertainty or pessimism about the programme. However, the findings of the study stress the importance of addressing the attrition rate and the need to follow up adolescent patients not responding to the post-discharge questionnaire, especially given that they do not differ demographically from those responding to the questionnaires. Furthermore, they constitute a sample of adolescents who presented with histories of sexual abuse at their initial assessment to the Centre. The follow-up of this sample is of particular importance given the short- and long-term consequences of sexual abuse.

2.2. DRAWBACKS OF THE WILLIAM SLATER CENTRE

As mentioned earlier, the present thesis is limited by its reliance on self-report data to evaluate the outcome of adolescent patients. The questionnaire is dependent on adolescents judgement of their well-being. Information about psychopathology occurring since discharge was based on the adolescent patients reports, thus it may have been less accurate than desired. Mann and Borduin (1991) criticise researchers who rely solely on self-report measures and exclude observational measures in evaluating treatment effects. They note that researchers who exclusively use self-report measures must assume that respondents are accurate in their reports of events and perceptions. While adolescents assertions that they do or do not have an emotional problem is probably a valid indicator of experienced distress (Offer, Howard, Schonert, & Ostrov, 1991), another significant drawback of the present study is that there is no indication of whether adolescents would have met formal diagnostic criteria of psychiatric disorders. Usually, clinical assessments are conducted at follow-up periods in order to determine whether there is a recurrence of the disorder or whether new disorders are present. This is lacking in the present study. Another consideration is the actual time periods after discharge when the questionnaires were mailed. Kazdin (1991) notes that conclusions about the effectiveness

of a treatment may vary greatly depending on *when* outcome is assessed. This is particularly relevant with regard to adolescent depressive illnesses which are known to have a long, protracted course, and adolescents should therefore ideally be followed up for longer than 18 months post-discharge (Kovacs et al., 1984; Kovacs, 1985).

Another limitation of the study is that no attempts were made to contact adolescents who did not respond to any of the questionnaires and there was no control group. Hence, the findings of the study are biased and may explain the overwhelming number of positive comments from adolescents about the Centre's programme. Posavac and Carey (1992) argue that programme participants with the most favourable impressions of a programme are most likely to co-operate, although some very angry people may write lengthy criticisms.

The most significant drawback of the present study is that only one measure of depression and one source of data was used. Literature on outcome studies have repeatedly demonstrated the use of varied measures and varied sources of data. Although many outcome studies have been designed with the assumption that treatment outcome can be reasonably reduced to a single variable, researchers have frequently found psychotherapy outcome to be complex and multifactorial (Lambert, 1983). An adequate evaluation of outcome therefore requires the use of a wide set of measures and a multidimensional model of the effects of treatment (Basham, 1986). Follow-up studies vary in outcome measures with some using simple 'improved/not improved' scales or consumer opinions (Wells, Morris, Jones, & Allen, 1978), while others assess outcome by focusing on further treatment needs, family functioning (Framrose, 1975), diagnosis and continuing morbidity (Welmer, Welmer, & Fisher, 1979). Mann and Borduin (1991) criticised researchers for using only outcome measures that were directly related to the focus of their experimental treatment. They argue that although it is important to demonstrate that a treatment achieves specific goals, it is also important to assess domains other than the skills taught by one treatment. Kazdin (1990) too supports this notion, focusing on the importance of prosocial functioning. He comments that the effects of treatment are usually measured by the extent to which the problems identified

at the outset of treatment are reduced, while prosocial functioning of the adolescent is rarely assessed at pretreatment or used as a basis to examine outcome. Prosocial functioning refers to the presence of positive adaptive behaviours and experiences such as participation in activities, and social interaction. With adolescents, adjustment may depend on positive adaptive behaviours or skills and while treatments may appear effective in reducing symptoms they may vary in the extent to which they promote and develop prosocial behaviours. He argues that prosocial behaviour warrants further attention in the evaluation of treatment outcome.

Kazdin (1990) also notes that evaluations of treatments typically focus on statistically significant differences in outcome measures, but it is important to examine the extent to which treatment has produced an effect that is of practical significance and that makes a difference in the individual's life. Several measures of clinical significance have been proposed for psychotherapy outcome research, such as the extent to which treatment returns patients to normative levels of functioning, the degree to which improvement is perceptible to significant others in the person's life, and the elimination of the presenting problem. Relatively few psychotherapy studies incorporate measures designed to evaluate the clinical significance of change.

Moss and Mann (1980) are of the opinion that in studying treatment results, the alleviation of symptoms alone does not reflect a cure. Of significance is the ability of the patient to develop a meaningful life in the community. They argue that diagnosing adolescents involves not only a DSM diagnosis but also an examination of psychosocial adjustment (e.g. the patient's family, school and community functioning). The follow-up criteria should include the psychosocial functioning of discharged patients and whether or not they are able to function successfully in the community (Blackman et al., 1991). In an attempt to assess social and global functioning, objectives such as the Level of Functioning Scale and the Adolescent Functioning Scale have been used in adolescent follow-up studies (Blackman et al., 1991) as well as the Social Adjustment Inventory of Children and Adolescents (SAICA) and the Global Assessment Scale for Children (C-GAS) (Mufson et al., 1994).

3. CONCLUSION

The above mentioned limitations of the present study have particular relevance to the staff of the William Slater Centre who may consider redesigning the post-discharge questionnaire, taking into account the importance of multiple sources of data as well as the need to determine adolescents overall functioning in their environment. The attrition rate also needs attention since the majority of adolescents not responding to the Centre's questionnaires have initial assessment diagnoses of adolescent depression and do not demographically differ from those adolescents responding to the questionnaires. The findings of the present study highlight the protracted course of the depressive illness and demonstrates the potential for long-term psychiatric morbidity in this population. This in turn emphasises the need for ongoing supportive therapy and alerts to the importance of dealing cautiously with this psychiatric group of adolescents. It is hoped that the present evaluation may assist the staff of the William Slater Centre in reflecting on the follow-up of adolescent patients post-discharge.

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APPENDIX A

The William Slater Centre's post-discharge questionnaire

POST DISCHARGE QUESTIONNAIRE

MONTH: 6 12 18 3yr 5yr

Name: _____ Date: _____

If your address or telephone number has changed or will be changing soon, please write your new address/telephone number below.

New address: _____

Telephone no: (W) _____ (H) _____

Marital status (please circle): Single / Married/ Divorced / Widowed

If you are single, are you in a relationship: Yes / No

If yes (please circle): Heterosexual relationship / Homosexual relationship

How long have you been in this relationship? _____

At present where are you living:

- On your own
- With mother / father / both parents (please circle)
- With stepmother/ stepfather
- Foster/ Adoptive parents
- Extended family - eg aunts, uncles, grandparents
- Place of safety

Education:

- No formal education
- Primary education only
- Secondary education excluding matric
- Matric
- Tertiary - Technikon (Trade)
- Tertiary - Diploma
- Tertiary - Degree

If tertiary education completed, please provide details of the course you did/ are doing:

Employment:

- Full-time employment
- Part-time employment
- Full-time student/scholar
- Self-employed
- Unemployed

Please provide details of employment - eg what are you doing, in what capacity are you working. If unemployed how do you get an income?

Since leaving William Slater have you been admitted to an inpatient or outpatient unit for psychological care? Yes / No

If yes, for how long were you hospitalised: _____

Reason: _____

Have you ever *thought* about taking your own life since leaving William Slater?

Yes / No

Have you ever *attempted* to take your own life since leaving William Slater?

Yes / No

If yes, were you admitted to hospital: Yes / No

Do you use any of the following: Cigarettes / Cannabis (Dagga) / Mandrax/ LSD /

Do you use any other substances? Yes / No Please specify: _____

If yes, why: To escape from ones problems / To relax / Peer pressure / Boredom /
Other reason (please specify) _____

Do you drink alcohol: Yes / No If yes, how frequent: _____

Why: To escape from any problems / To relax / Peer pressure / Boredom /
Other reason (please specify) _____

Do you have any bulimic symptoms at present (ie do you binge and purge)? Yes / No

Do you diet excessively or starve yourself? Yes / No

Have you experienced any sexual abuse episodes since your discharge from William Slater?

Yes / No

Details: (if possible) _____

Are you on any medication? Yes / No

Details: _____

Do you feel that you have an adequate support system outside (eg family, friends, partner)?

Yes / No

At present or during the past year have you been in individual or group therapy?

Yes / No

Overall, do you feel that you are coping with your life?

Yes / No

How do you feel you've progressed since leaving William Slater? Please indicate on the scale below:

0 1 2 3 4 5 6 7 8 9 10

There has been
no significant
change in my life

My life/ conditions
have improved slightly

My life has
improved
to a large
extent

Do you feel that your stay at William Slater has had any impact on your life?

Yes / No / Unsure

Comments: _____

If you had to rate the impact of the William Slater programme on your life *at present*, how would you rate it?

0 1 2 3 4 5 6 7 8 9 10

The programme has
had no impact on my
life

The programme impacted
on my life

The programme
had a significant
impact on my
life

Should you come across adolescents in need of psychological intervention would you refer them to William Slater? Yes / No

If yes / no please give reasons: _____

Thank you very much for completing this questionnaire. The information you have provided us will assist us in ensuring that the programme offered at William Slater is of benefit to adolescents in need of psychological intervention. Thank you.

General Comments:

APPENDIX B

The Beck Depression Inventory

B.D.I

ASSESSMENT

NAME: _____ DATE: _____ WEEK: 1 6 12

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling **OVER THE PAST FOUR WEEKS INCLUDING TODAY**. Circle the number beside the statement you picked. Be sure to read all the statements in each group before making your choice.

Please remember to complete *both sides of the pages*. Thank you.

1. 0 I do not feel sad.
 1 I feel sad.
 2 I am sad all the time and I can't snap out of it.
 3 I am so sad or unhappy that I can't stand it.

2. 0 I am not particularly discouraged about the future.
 1 I feel discouraged about the future.
 2 I feel I have nothing to look forward to.
 3 I feel that the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
 1 I feel I have failed more than the average person.
 2 As I look back on my life, all I can see is a lot of failures.
 3 I feel I am a complete failure as a person.

4. 0 I get as much satisfaction out of things as I used to.
 1 I don't enjoy things the way I used to.
 2 I don't get real satisfaction out of anything anymore.
 3 I am dissatisfied or bored with everything.

5. 0 I don't feel particularly guilty.
 1 I feel guilty a good part of the time.
 2 I feel quite guilty most of the time.
 3 I feel guilty all of the time.

6. 0 I don't feel I am being punished.
 1 I feel I may be punished.
 2 I expect to be punished.
 3 I feel I am being punished.

7. 0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted in myself.
3 I hate myself.
8. 0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.
9. 0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.
10. 0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.
11. 0 I am no more irritated now than I ever am.
1 I get annoyed or irritated more easily than I used to.
2 I feel irritated all the time now.
3 I don't get irritated at all by the things that used to irritate me.
12. 0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.
13. 0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than before.
3 I can't make decisions at all any more.
14. 0 I don't feel I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance and they make me look unattractive.
3 I feel that I am ugly or repulsive looking.

- 15 0 I can work about as well as before.
 1 It takes an extra effort to get started at doing something.
 2 I have to push myself very hard to do anything.
 3 I can't do any work at all.
- 16 0 I can sleep as well as usual.
 1 I don't sleep as well as I used to.
 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
 3 I wake up several hours earlier than I used to and cannot get back to sleep.
- 17 0 I don't get more tired than usual.
 1 I get tired more easily than I used to.
 2 I get tired from doing almost anything.
 3 I am too tired to do anything.
- 18 0 My appetite is no worse than normal.
 1 My appetite is not as good as it used to be.
 2 My appetite is much worse now.
 3 I have no appetite at all any more.
- 19 0 I haven't lost much weight, if any, lately.
 1 I have lost more than 5 pounds.
 2 I have lost more than 10 pounds.
 3 I have lost more than 15 pounds.
- 20 0 I am no more worried about my health than usual.
 1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
 2 I am very worried about physical problems and it's hard to think of much else.
 3 I am so worried about my physical problems, that I cannot think about anything else.
- 21 0 I have not noticed any recent change in my interest in sex.
 1 I am less interested in sex than I used to be.
 2 I am much less interested in sex now.
 3 I have lost interest in sex completely.