

**University College Dublin**

**FROM CHILD TO ADULT**

**A Longitudinal Study of Irish Children and their Families**

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Dublin.4.

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### **Note re Authorship**

This study was completed jointly by the authors and this is reflected in the alphabetical listing of names. The authors were assisted with aspects of the statistical analysis by Teresa Brannick and Suzanne Guerin.

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# **FOREWORD**

**The Minister of Social and Family Affairs, Ms Mary Coughlan**

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## **EXECUTIVE SUMMARY**

This report describes a longitudinal study of children and their families. The first phase of the study, conducted in 1990 on a sample of 185 children, revealed that a considerable number of children (16%) and approximately a third of mothers showed evidence of clinically significant psychiatric disorder. Disorder in the child was associated with the economic circumstances of the family, and maternal health was linked to disadvantage as well as dissatisfaction with domestic roles and inadequate social support. The second phase of the research, on which this report is based, included 97 young people, successfully contacted and interviewed for the study in 2000. The aim was to examine their subsequent health and social development and to determine whether childhood psychological and behavioural disturbance was associated with long-term outcome.

## **Results**

### **Social Development and Family Background**

- The average age of respondents was twenty-one years. Almost all were raised in the family home by both parents. All were unmarried; approximately a fifth now had children. They came mainly from semi-skilled manual backgrounds and a fifth of the mothers reported severe financial hardship during the participants' childhood.
- There were wide discrepancies in relation to educational attainment. Approximately one-third respondents had not completed second level education yet a high percentage (60%) of those who did finish secondary schooling went on to third level. Almost all were currently employed or engaged in full-time education or training.
- Approximately one-quarter of those interviewed, three-quarters of whom were male, had had some contact with the law but this was generally for minor offences.

### **Health and Well-being**

- In general, respondents were well-adjusted and happy. They demonstrated adequate levels of self-esteem and independence and were well integrated socially.
- There was no evidence of serious psychiatric disorder and only a small percentage were receiving treatment for psychological difficulties. However, symptom levels were

high amongst those interviewed, albeit below that required to establish a formal psychiatric diagnosis.

- There was little indication of serious drug misuse but a majority (55%) had used non-prescription drugs at some time. Alcohol consumption was high, especially amongst male respondents, and participants tended to underestimate their level of alcohol use.
- Respondents' mothers showed little evidence of formal psychiatric disorder despite the relatively high levels of disorder recorded for them in Phase One.

### **Childhood Health and Behaviour and Adult Outcome**

- An assessment of behavioural deviancy at age eleven was highly predictive of poor educational outcome and this likelihood increased with the accumulation of risk factors.
- Socio-economic disadvantage was a major risk factor for poor educational outcome. Respondents with a diagnosis and/or categorisation of deviancy were generally from economically disadvantaged backgrounds and these circumstances together considerably affected their educational progress.
- IQ was importantly related to educational achievement but economic factors modified its effects. Participants without economic disadvantage were able to reach higher educational levels even when they had equivalent or lower IQ levels.

### **Untraced Individuals**

- The relatively positive adult profile of participants which emerged from the study must be considered in the context of findings relating to untraced individuals. At age eleven this group had a significantly higher level of behaviour disorder than either participants or refusals. They subsequently had considerably higher levels of juvenile offending than other respondents.

### **Conclusions**

The young people studied for this report were, in general, healthy and happy and benefiting from increased educational and employment opportunities available in this country. For the majority of participants in this longitudinal study the high prevalence of psychiatric and conduct disorder, evident ten years previously, when they were aged eleven years, proved to be transitory and without long-term psychological consequences. However, early behavioural and or psychological disorder in the child did impact on educational progress, especially if this was

combined with economic disadvantage. Economic resources compensated for IQ deficiencies and children from better-off families, whatever their intellectual capacity, were more likely to access higher educational levels. Early behavioural difficulties are thus signalled here as key to understanding outcome, especially educational attainment. These findings are reinforced by the possibility that had the untraced group been included the impact of behavioural problems would most likely have been greater. Untraced individuals had higher levels of childhood disorder at Phase One, and considerably elevated offending rates, compared to study respondents (and refusals). The fact that the mothers interviewed were now, despite past diagnoses, relatively symptom free raises the possibility that at least some of the disorder seen in the mothers of ten years ago may have resulted from the stress inherent in coping with behavioural disturbance in the child. In the light of these findings it may be opportune to re-examine the association between economic disadvantage, behavioural difficulties and child health.

# CHAPTER 1: INTRODUCTION

## 1.1 Introduction

Knowledge and expectations about children and childhood are changing, as is the structure of families and family life. Traditional conceptions of childhood viewed all children as moving within similar, clearly defined, parameters. Evidence of diverse experiences of childhood were downplayed and there was little acknowledgement of the child's active involvement in his/her environment. The absence of child-centred research further contributed to an incomplete picture of childhood. For these reasons, the changing nature of childhood and children's lives in Ireland over past decades was, until recently, largely uncharted. Now a clearer view of Irish childhood is possible thanks to an emerging body of work focusing on both structural and experiential aspects of children's lives (Greene, Hennessy & Hogan, 2000; Cleary, Nic Ghiolla Phadraig & Quin, 2001a, 2001b). The way in which children emerge from childhood with a sense of identity is not linked to any single or definitive set of needs (Woodhead, 1990). They develop competence in a variety of different ways and are capable of negotiating adverse circumstances within and outside their family environment (Gilligan, 1993; Hogan, Halpenny & Greene 2002). Children's life prospects are not totally dependent on adults.

The young people studied for this report have grown to adulthood at a time of significant cultural and economic change and there has been much speculation about the effects of this change on children's lives. A link has been claimed between social change and the rise in conduct disorders and suicidal behaviour in recent decades (Rutter, Giller & Hagill 1998; Cleary, Corbett, Galvin & Wall, 2004). Yet the assumption that children are endangered by change, including family change, is unproven and some features of change may even be beneficial (Furstenberg, 1991). The majority of children (in Ireland and elsewhere) are without behavioural problems and emerge from childhood healthy and well-adjusted (Leader, Fitzgerald & Kinsella, 1985). It is difficult to generalise about social and other outcomes for children because children grow up in different social settings and create their own understandings of these environments (Greene 1994, p. 367). Yet there are important predictors of adult outcome for children such as socio-economic factors and family background. This report is an attempt to explicate these elements in a particular group of young Irish people.

## **1.2 Phase One of the Study**

The first phase of this study was undertaken in 1990 (for a full account see Fitzgerald & Jeffers, 1994). As part of this investigation over 2000 urban children were assessed for intellectual status and behavioural problems. A clear socio-economic and gender pattern was evident from the findings. The rate of behavioural deviance was higher for those attending disadvantaged schools and boys were twice as likely as girls to have these problems. A sub-sample of 185 children and their families was then studied in detail across a range of psychological, social and economic dimensions. A sizeable group (16%) of the children showed evidence of formal psychiatric disorder and this was related to economic circumstances, to the marital status of the parents and to the psychological functioning of the mother. One-third of the mothers were categorised as suffering from a psychiatric disorder and again this was associated with economic disadvantage as well as dissatisfaction with domestic roles and lack of social support. According to Fitzgerald and Jeffers (1994), maternal depression was linked to economic disadvantage and compounded by lack of social support. These features undermined the mothers' parenting ability, making it more likely that their children would become disturbed.

## **1.3 Phase Two: A Ten Year Follow-up of Children and their Families**

The present research project was commissioned by the Department of Family, Social and Community Affairs, under the Families Research Programme. The research was carried out in 2000 by a multi-disciplinary research team consisting of a psychologist, a psychiatrist and a sociologist. The purpose of the research was to follow up the cohort of young people (n=185) who were assessed in detail in Phase One of the study.

### **1.3.1 Aims of the Study**

This phase of the study proposed to investigate social and psychological outcomes for the group of 185 young people assessed for the original research project. The specific research aims were:

- To examine mental health status, educational and employment levels, alcohol and drug use and involvement in crime.
- To investigate whether the factors associated with childhood behavioural disturbance, identified in Phase One of the study, were connected to long-term outcome. These factors included gender, psychiatric diagnosis in the child and the mother, the child's IQ score, the marital status of the parents and the economic circumstances of the family.



#### **1.4 Outline of the Report**

The following report contains an outline of the methodology (Chapter 2) and a review of relevant literature (Chapter 3). The study findings are presented in Chapters 4, 5, and 6. The final chapter (Chapter 7) summarises and discusses the main findings of the study in the context of existing research findings.

## **CHAPTER 2: METHODOLOGY**

### **2.1 Introduction**

This chapter outlines the general methodology of the study, the research design, research instruments, and the interviewing procedures used. As this is a longitudinal study involving the follow-up of individuals interviewed and assessed ten years previously, the procedures used to locate the sample are also described.

The initial phase of this study was carried out in 1990 (Fitzgerald & Jeffers, 1994). In the original study, 2029 primary-school children in the Dublin area were assessed on a number of social, psychological and educational dimensions. Behaviour was measured using the Rutter B2 Questionnaire (Rutter 1967), completed by the teacher for each child, and IQ calculations were based on a non-verbal test, the Standard Progressive Matrices (Raven, Court & Raven, 1983). A sample of 185 children was extracted from this population and these children and their families were analysed in greater detail. In each family standardised instruments were used to assess the psychological health status of the child and his/her mother. The health status of the children was assessed using the Isle of Wight Parental interview on Child's Psychiatric State (Rutter & Graham, 1966). The mothers were administered the Clinical Psychiatric Interview (Goldberg, Cooper, Eastwood, Kenward & Shephard, 1970) and the Malaise Inventory (Rutter, Tizard & Whitmore, 1970). Information was also gathered on a range of social and economic items.

Sixteen percent of the children studied had a definite psychiatric diagnosis and this was related to maternal mental health and role satisfaction, socio-economic factors and the parents' marital status. A child was twice as likely to receive a diagnosis if his/her father was unemployed and children living with married parents were less likely to be disordered than those whose parents were separated. A higher IQ score also appeared to be protective for the child in terms of developing disorder. One-third of mothers were categorised as suffering from psychiatric disorder and this was associated with economic disadvantage, dissatisfaction with domestic roles and lack of social and recreational opportunities.

### **2.2 Ten Year Follow-up of Children and their Families: Aims of the Study**

The primary aim of the study was to investigate psycho-social outcomes in a cohort of children (n=185) first studied ten years previously. Another objective was to delineate those factors (both protective and potentially threatening) in a person's environment which best

predicted negative or positive psychosocial outcomes in adulthood. The specific research aims were:

1. To examine social and psychological outcomes in a sample of 185 young people.

The main outcomes of interest were:

- Mental and physical health
- Educational attainment and employment status
- Drug and alcohol usage
- Involvement in crime

2. To investigate if certain factors, identified in Phase One of the study, were associated with these outcomes. These included:

- Presence or absence of psychiatric disorder during childhood
- Presence or absence of psychiatric disorder in the mother or father
- The child's IQ score
- The social class and economic circumstances of the family
- The marital status of the parents

### **2.3 Research Design**

This study employed a longitudinal follow-up design, which involved the re-examination of a cohort of children and their mothers first assessed in 1990 across a variety of social and psychological dimensions. In 2000, these children and their mothers were located and, if they consented, re-interviewed. In the baseline study, the mother was the key informant while in the follow-up enquiry, the young person was the key informant although the mother was also interviewed.

### **2.4 Method of Data Collection**

Data was collected from each key informant and his/her mother during a structured interview using mainly standardised instruments. In addition to basic demographic characteristics, information was collected from the young person on:

- Psychological and physical health (including alcohol consumption and drug use)
- Education and employment status
- Social networks and relationships
- Self-esteem and Locus of Control
- Contact with the Law

The mothers' schedules included :

- Psychological health (self and family)
- Socio-economic and housing circumstances
- Marital relationship and parenting
- Social networks and relationships
- Alcohol, substance abuse and contact with the Law

## **2.5 Research Instruments**

Five main research instruments were used and these are described in detail in Appendix One. The SCID (Structured Clinical Interview for DSM-IV Axis Diagnosis) (First, Spitzer, Gibbon & Williams, 1996) was used to assess psychological functioning in both the key respondent and the mother<sup>1</sup>. The Beck Scale for Suicide Ideation (Beck & Steer, 1991) was employed to ascertain suicidal ideation and behaviour. Self-esteem was assessed using an instrument devised by Rosenberg (1965), the Rosenberg Self-Esteem Scale. The Arizona Social Support Interview schedule, devised by Barrera (1980), was administered to measure various indices of social support. Locus of Control was measured using a scale devised by Pearlin, Menaghan, Lieberman & Mullan (1981). The remaining areas of interest (employment, educational attainment, physical health, alcohol and substance misuse, criminal activity etc) were examined using a questionnaire devised for the study by the authors. A similar instrument was developed for the mothers' interview, which included questions relating to their marital and parenting role, and to the health and social and economic situation of their husbands (where relevant) and other children.

## **2.6 Pilot Interviews**

Before carrying out the main interviews, a number of pilot sessions were carried out. The purpose of the pilot procedure was to examine and refine questions and question order, as well as to test the acceptability of the interview content. Pilot interviews were carried out among a sample of young people and older women, matched for age with the participants in the study. Some minor modifications were made to the schedules following these interviews.

## **2.7 Locating the Sample**

The aim was to locate and interview as many individuals as possible who had participated in the first part of the study in 1990. As the young person was now the key respondent efforts were concentrated on trying to locate him/her. The mother was only interviewed if the key informant agreed to be interviewed. Preliminary checks were made, using the Telephone and

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<sup>1</sup> Training in the use of this instrument was provided by a psychiatrist (MF) who also monitored its use. The results were scrutinised by him and, independently, by another psychiatrist.

Thom's Directories, to determine whether individual families were still living at the same address. Once residence was satisfactorily established according to these criteria, key informants were contacted by letter in which the purpose and scope of the study were detailed and they were requested to contact the research team by phone or letter. A relatively small number of participants (n=19) responded to this initial contact. When no reply was forthcoming after a specified time period, participants were contacted by telephone (n = 30) or by calling to the house (n = 78). Various tracing methods were used for those families which had moved house. Neighbours proved to be a very useful source of information and twenty-six families were located in this way. The remaining untraced families (n=32) were then cross-checked with tenants on the Dublin Corporation housing register. If a match was found the Corporation forwarded a letter about the study. The researchers had negotiated this arrangement with Dublin Corporation's Housing department in order to protect the tenants' privacy. This method yielded no respondents.

## 2.8 Fieldwork

All interviews took place between April and December 2000. In almost all cases, the interview took place in the person's home and was carried out with only the participant and interviewer present. At the start of the interview a short summary of the study was provided and the confidentiality of the process emphasised<sup>2</sup>. The entire interview was conducted using a laptop computer. The researcher read the questions aloud to the participant and his/her answers were entered immediately. This method of administering the schedules presented no problems and respondents appeared to be quite at ease with the procedure.

### 2.8.1 Response Rate

Table 2.1: Details of participation and non-participation rates

	<b>Number of young people</b>	<b>% of Families Located (153)</b>	<b>% of Total Sample (185)</b>
Interviewed	97	63.4%	52.4%
Refusal	39	25.5%	21.1%
Emigration	8	5.2%	4.3%
Death	3	2%	1.6%
Location of young person unknown	6	3.9%	3.2%
Location of family unknown	32	—	17.3%

A breakdown of the response rate is shown in Table 2.1 above. Participation and non-participation rates are reported both as percentages of the total sample and of the sample of

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<sup>2</sup> Both the key informant and the mother were assured that information would not be divulged to either side.

families that were located. Of the original sample of 185 families, 83% (153 families) were contacted. Thirty-two families were not traceable. Of the 153 families who were contacted, 97 (63%) of the young people agreed to take part. This figure represents 52% of the total sample. Over a fifth (21%) of the total sample of young people refused to participate. Three people had died. Two of these deaths were drug related and the third a possible suicide. Eight had emigrated and six were no longer in contact with their families. Overall, the response rate compares well to other, similar, studies (see, for example, Dalgard, Bjork & Tambs (1995) who obtained a 50% response rate, and Serbin et al. (1998) who obtained a 47% response rate.

In addition to the 97 young people, 80 mothers were also interviewed. The discrepancy between the number of key respondents and mothers who were interviewed was due to a number of factors. Twelve mothers refused to take part, one was living abroad and could not be interviewed, and two young people requested the researchers not to contact their mother. In the remaining two cases, the mothers' whereabouts were unknown to the young people.

### **2.8.2 Respondents and Non-Respondents**

Based on data collected in from Phase One of the study respondents and non-respondents were compared in terms of gender, IQ score, behavioural deviance, psychiatric symptomatology, maternal mental state, family history of mental illness, economic background and employment status of the father. This analysis revealed a statistically significant difference between the two groups in relation to behavioural deviance (Rutter B2 Scale). Fifty-eight percent of non-participants had been categorised as behaviourally deviant compared with one-third of Phase Two respondents ( $\chi^2 = 10.662$ ,  $df = 1$ ,  $p < 0.01$ ). There was no significant difference between the two groups in relation to psychiatric diagnosis or the other variables analysed.

A further analysis was carried out to discriminate between those who refused to participate and the untraced group. There were no differences between those who participated and those who refused, on any of the variables investigated. There was, however, a significant difference between participants and the untraced group in terms of psychiatric diagnosis at Phase One ( $\chi^2 = 8.949$ ,  $df = 1$ ,  $p < 0.01$ ). Specifically, 59% of non-contacts received a psychiatric diagnosis at Phase One, compared with 30% of those interviewed. Additionally, 63% of non-contacts were categorised as behaviourally deviant during Phase One, compared with one third of Phase Two participants and this difference was also significant ( $\chi^2 = 8.063$ ,  $df = 1$ ,  $p < 0.01$ ).

These findings would ordinarily predict a higher level of negative outcomes amongst the non-contact. To explore this possibility we took the investigation a step further. The names of all

Phase One participants were checked against Garda files for a history of juvenile offending and this revealed important information about the various groupings. Only six (6%) of those interviewed had a recorded juvenile offence in contrast to 21% of the non-participants (i.e. refusals and non contacts together) and this difference was significant ( $\chi^2 = 8.486$ ,  $df = 1$ ,  $p < 0.01$ ). More crucially perhaps, juvenile offences were much more common among the untraced group. Almost 29% had a juvenile record, compared with just 13% for those who refused to participate. Differences between study participants and refusals were non significant but a significant difference was evident between participants and untraced individuals ( $\chi^2 = 13.403$ ,  $df = 1$ ,  $p < 0.01$ ). These findings are illustrated in Figure 2.1 and have important implications for the overall investigation.

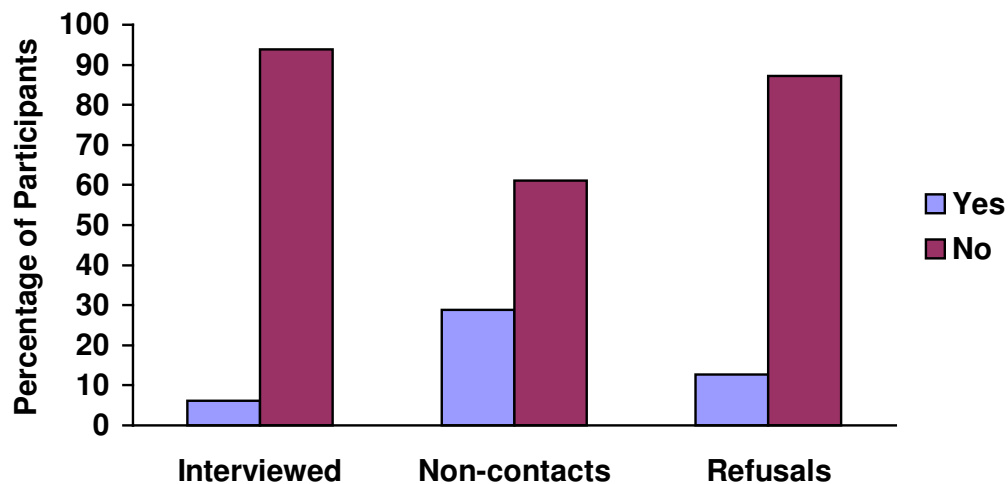


Figure 2.1: Record of juvenile offence among participants, refusals and non-contacts.

## 2.9 Statistical Analysis

Examination of SCID results was carried out according to its customised computer programme and the remainder of the data was downloaded onto the SPSS package for analysis. Modelling techniques were used to test the interrelations of key variables.

## 2.10 Summary

This section outlined the methodology of the study, a longitudinal analysis involving the follow-up of individuals initially interviewed ten years previously. The main aims of the study were to examine outcomes for the sample of young people who participated ( $n=97$ ) and to determine if factors identified in Phase One were associated with these outcomes.

Outcome measures which included psychological health and well-being, contact with the law, and educational and economic status, were assessed using standardised instruments. Of the

original sample (n=185), 153 young people and their mothers were located. Of these 63% agreed to participate and 26% refused. A comparison of participants and non-participants revealed a significant difference between the groups in relation to childhood psychological and behavioural disorder. An examination of Garda records revealed that considerably more of the untraced individuals (but not the refusals) had a juvenile record for offending.



## **CHAPTER 3: RISK AND PROTECTION FOR CHILDREN**

### **3.1 Introduction**

Frameworks for understanding children and childhood have developed in line with increasing clinical and academic knowledge of this area. Traditional conceptualisations, which viewed childhood transitions in terms of “a ladder-like progression through predictable stages, each of which has its set of tasks” (Rutter, 1989, p.45) are misleading. Childhood is not, as previously thought, a progression of certainty towards adulthood. Multiple pathways through childhood are available and a definitive set of needs do not exist (Hill & Tisdall, 1997). Economic and family background factors are important, as are educational experiences, but children’s life prospects are not totally dependent on adults. Children actively shape their own environments and are capable of negotiating change and adversity within families and elsewhere (Gilligan, 1993; Hogan, Halpenny & Greene, 2002). Although a link has been claimed between family transformation and the rise in conduct disorders over the last half century (Rutter, Giller & Hagill, 1998) this association is not conclusive (Furstenburg, 1991). Conclusions regarding mental health trends among children remain tentative (McArdle, Prosser, Dickinson and Kolvin, 2003), and the exact mechanism by which broad socio-cultural changes may have led to increased rates of psychosocial problems in children and young people is unclear. In studies of children in Ireland and elsewhere, the majority remain well adjusted and without behavioural or psychological problems (Leader et al 1985; Fitzgerald & Jeffers, 1994). Socio-cultural change may bring about either positive or negative alterations to children’s lives, and claims that childhood was a safer and happier period in former times are not supported by empirical findings (Lynch, 1998; O’Sullivan, 2001). It is also evident that children are resilient when faced with adverse conditions (Gilligan, 1993; Garmezy, 1993). Yet, while children may be, in general, adaptable and resilient some do emerge from childhood with negative attributes and the possible risk factors associated with this are considered below.

### **3.2 Risk and Resilience**

Children exposed to a variety of adverse experiences can suffer long-term damage or negative psychological outcomes (Brooks, 1994). Yet, studies have demonstrated a diversity of responses to events, even within similar environments and conditions (Rutter, 1989; Masten, Best & Garmezy, 1990; Hogan, Halpenny & Greene, 2002). Outcomes vary because individuals differ in terms of their susceptibility to risk and because there may be protective mechanisms which reduce risk (Rutter, 1985; Kolvin, Miller, Scott, Gatzanie & Fleeting,

1990). Data from a large U.S. study of high-risk children found that a secure attachment in infancy, along with good quality parent-child relationships in early childhood, serve as major protective factors (Grotberg, 1995). Problems are not irreversible and negative outcomes are dependent on whether risk experiences are intensified or ameliorated by subsequent experiences. Improvements in the child's economic situation can have a significant impact across a number of intellectual indicators, including IQ (Kolvin et al, 1990). Similarly, negative childhood experiences may be ameliorated by economic security and a supportive relationship in adulthood (Quinton & Rutter, 1985).

The occurrence of multiple difficulties is an important factor related to outcomes as is the meaning of events or situations for the individual (Brown & Harris, 1978; Lazarus & Folkman, 1984; Turner & Lloyd, 1995). A single stress generally has little effect on a child but an accumulation of adversity greatly increases the likely negative impact (Rutter & Quinton, 1977; Kolvin et al 1990) In Rutter's (1979) study, the presence of two or three risk factors resulted in a fourfold increase in the rate of psychiatric disorder and exposure to more than four stressors produced a tenfold increase in distress (Rutter, 1979; Turner & Lloyd, 1995).

Children are generally resilient even when faced with major stressful life events and difficulties (Garmezy, 1993) and the majority emerge from childhood as psychologically healthy and socially competent (Grotberg 1995; Kolvin et al., 1990). Even with the most severe stresses and adversities, it is unusual for more than half of all affected children to succumb to a maladaptive outcome (Rutter, 1979). Children's responses to stress varies over time and circumstances. In fact, children are capable of repeatedly altering their reactions to tension (Rutter, 1989). Resilience is influenced by protective features within the child's environment which ameliorate the impact of difficulties and/or help the child to develop a strong self-concept and thus resist stress (Rutter, 1987). Protective elements might also include positive events or turning points in people's lives such as educational success (Garmezy 1987).

Certain personality attributes, such as self-confidence and a sense of control over one's life, can also protect an individual from risk factors (Holahan & Moos, 1987). Children with adverse temperamental features are more likely to be the target of parental criticism and hostility (Rutter, 1987). Resilient youngsters have a strong belief in their ability to control their environment and this might involve seeking affirmation outside the family (Werner & Smith 1982). External locus of control, in combination with poor social support, increases the risk of developing psychological disorder (Dalgard & Haheim, 1998) and the use of avoidant coping strategies has also been shown to be a significant risk factor (Vaillant, 1977; Moos & Schaefer, 1984).

Social support is perhaps the best-documented factor associated with stress resistance and this may come from a variety of sources (Holahan & Moos, 1987; Dalgard & Haheim, 1998). DeWilde, Kienhorst, Diekstra and Wolters (1994) found that at-risk adolescents reported a low level of support from their families. Support from teachers and peers is associated with high self-esteem (Cauce, Felner & Primavera 1982; Stone, Fitzgerald and Kinsella 1990). However low academic achievement does not in itself result in a negative self-concept (Hayes & Kernan, 2001). The neighbourhood one lives in can provide protection, or increase risk (Aneshensel & Sucoff, 1996). In Kolvin et al's (1990) study the surrounding environment was almost as important in predicting delinquency as was family deprivation.

Trying to identify specific risk features for research purposes can be problematic because similar outcomes often arise from diverse risk factors and, conversely, comparable risk factors can lead to different outcomes (Magnusson, Stattin & Allen, 1985). The measurement of resilience is similarly challenging. Children may display competence in many areas of their lives yet still be vulnerable in less obvious, psychological terms (Luthar & Zigler, 1991). Resilience is also likely to fluctuate over time as it is not a stable attribute of the individual but rather a function of the interaction between the individual and environmental influences (Herronkohl, Herronkohl & Egolf, 1994).

### **3.3 Factors influencing the Child's Development**

As the above discussion indicates, the reasons why some individuals overcome adversity, while others succumb to maladaptive, less positive, outcomes lie partly in the study of the relevant environments (home, school, etc.) and of changes within those environments over time (Garmezy, 1988). The following sections consider some of these factors and sites of potential risk (or resilience) for the child.

#### ***3.3.1 Age and Gender***

The responses of children to stress and adversity will obviously be modified by their age and thus their capacity to understand the experience (Garmezy, 1985). Gender is also significant and males are vulnerable in terms of developing conduct and behavioural difficulties and for offending (Kolvin et al., 1990) Educational outcomes are clearly less positive for men in Ireland and elsewhere (Hearn, 1998; Cleary, Corbett et al., 2004). Males appear to be more vulnerable in certain situations (such as family discord) and boys are more likely than girls to develop emotional and behavioural difficulties in these circumstances (Rutter, 1987). This may be due to a number of factors. Hetherington, Cox and Cox (1982) found that parents were more likely to argue in front of their sons than their daughters. Maccoby and Jacklin's (1974) work indicates that boys are more likely to react to difficulties in a disruptive,

aggressive way and that this is likely to elicit negative reactions from parents and others. There are also varying cultural expectations for males and females in society and similar behaviour by boys and girls can have different consequences (Stevenson-Hinde & Hinde, 1986). Males and females have different ways of channelling emotional difficulties, which is, according to Chodorow (1978), a product of their differential emotional development in childhood. Young boys, she says, learn early in life to restrict the expression of emotion and this tendency is socially reinforced as they develop. The result is that males often experience difficulties expressing problems as they grow older. Females on the other hand are more likely to express feelings and to have channels in place to do so (Duncombe & Marsden, 1993).

### ***3.3.2 Psychological Health & Well-being in Childhood***

Early behavioural disturbance has been cited as one of the strongest predictors of later problems, including psychological difficulties, involvement in crime and antisocial behaviour (Rutter, 1989; Kolvin et al. 1990). Behavioural or conduct disorder is common in childhood and adolescence (Kolvin et al. 1990; Lawlor & James, 2000) and higher male than female rates are consistently found (Murphy, Fitzgerald, Kinsella & Cullen 1989; Martin 1997). Fitzgerald and Jeffers (1994) categorised almost a fifth of the Irish children they studied as behaviourally disordered with twice as many boys as girls classified in this way.

The fact that a child displays psychopathology in the early years makes it more likely that he/she will continue to experience difficulties into adulthood, although these difficulties may manifest themselves in various ways (Visser, Van der Ende, Koot & Verhulst, 1999). Disruptive behaviour makes it more likely that there will be an early exit from school and hence the individual is less likely to attain a stable occupational status (Fergusson & Horwood, 1998; Cleary, Corbett et al., 2004). Behavioural and other difficulties in childhood can be persistent (Fitzgerald, Jeffers & Kinsella, 1994). Children with conduct disorders at a young age are more likely to have higher rates of juvenile offending, substance use and mental health problems in later adolescence (Fergusson & Lynskey, 1998). Some children are vulnerable in this way and more generally exposed to risk (Nixon 2001; Halpenny, Keogh and Gilligan 2002).

Yet despite evidence of continuity between childhood and adult disorder only about a third persists into adulthood (Rutter, 1989). Teachers' assessments of deviant behaviour have been found to be reasonably reliable predictors of psychological outcome (Olin et al, 1998; Fergusson & Lynskey, 1998) but they can also be untrustworthy (Kolvin et al. 1990; Boyle et al. 1993). Such ratings are probably most accurate in relation to markedly deviant behaviour. Longitudinal data indicates that the risk of continuity is greatest for males who show a

combination of aggression, hyperactivity and poor peer relationships (Magnusson, 1988; Farrington, Loeber & Van Kammen, 1990). In Visser et al's (1999) study, the greatest predictive strength was found for aggressive and delinquent behaviour, attention difficulties and social problems. Continuity is likely for these individuals, according to Rutter (1989), because behavioural disturbance predisposes an individual to an increased likelihood of adverse environmental and psychosocial experiences in later life. In Fergusson and Horwood's (1998) study there were linkages between early conduct problems and later educational under-attainment and unemployment and this, they propose, is mediated by patterns of peer affiliations, substance use and problems with school authority. It also appears that conduct disorders are less amenable to treatment than internalising disorders such as depression (Visser et al 1999; Sheerin, Maguire & Robinson, 1999).

### ***3.3.3 Family background and experiences***

#### *3.3.3.1 Changing Family structures*

For most children the family is the context within which initial relationships and understandings are developed. The structure and dynamic of families and family life has altered considerably in recent decades and, although the extent of this change has been questioned, there is now a diversity of family types (Trost, 1990; Fahey and Russell, 2001). Children are increasingly reared in lone parent family units or in reconstituted families, although the majority of children still grow up in two-parent households (McKeown, Ferguson & Rooney, 2000). Existing evidence in relation to the effects of differing family type on children suggests that the nature of the household is not the most significant factor, but rather the quality of the relationships and the economic resources available to the family (Hobcraft & Kiernan, 2001).

Studies have shown that a higher proportion of children in lone-parent households have scholastic or emotional problems, compared to those living with both parents, but this is more likely to be due to economic circumstances than to parental marital status (McMunn, Nazroo, Marmot, Boreham & Goodman, 2001; Flanagan, 2001). McMunn et al.'s (2001) research indicated that the high prevalence of psychological and conduct problems among children of lone mothers was a consequence of socio-economic disadvantage, but this effect disappeared when receipt of state benefits, housing tenure and maternal education were taken into account. Early lone motherhood, in particular, is a risk factor for children as it is associated with educational and thus economic disadvantage in the mother.

The increased levels of participation in the labour force by mothers probably marks the most important change in the lives of Irish children over the last two decades. This transformation in women's roles has affected the balance of power within families, which in turn, has

influenced childcare practices. Fathers are becoming more involved in child rearing (Kiely, 2001) and family size has also decreased considerably. There is no evidence that having a mother working outside the home results in negative outcomes for the child. In fact, there is some evidence to the contrary. Hennessy's (2001) research shows that for the majority of children temporary non-parental care is a positive and enjoyable experience, and a Danish longitudinal study of children found that mothers' long term lack of employment was a risk factor for neglect and abuse of children (Christoffersen, 2000).

According to Kolvin et al. (1990), poor quality parental care makes a significant contribution to the prediction of offending in adolescence and adult life. Parenting skills undoubtedly impact on a child's life, but there is a good deal of flexibility in the type and form of parenting (Hill & Tisdall, 1997). The ability to engage in warm and loving relationships with children has been cited as a key factor (Fahlberg, 1994), and parental approval is predictive of higher levels of self-esteem in the child (Eccles, Wigfield & Schiefele, 1998). Yet, children are capable of negotiating difficult home environments and finding alternative sources of affirmation (Gilligan, 1993; Emond, 2002). In Horwitz, Widom, McLaughlin and White's (2001) follow-up study of children who were taken into care following abuse and neglect, this specific experience had little direct impact on lifetime mental health outcome. According to Kessler and Magee (1993), only some stressors such as family mental illness, discord, violence and divorce are significant predictors of adult psychological health for children.

Structural and family background features contribute to the prolongation of conduct disorders. Kolvin et al's (1990) work underlined the link between conduct disorder and economic disadvantage and this association is well established in the research literature (Kohlberg, LaCrosse & Ricke, 1972; Sroufe & Rutter, 1984). Behavioural disorder in childhood frequently results in poor educational attainment and this is connected to aspects of economic disadvantage and not simply impaired intelligence (Miech, Caspi, Entner & Silva, 1999). Other mediating factors are family discord and inadequate parenting (McArdle, O'Brien & Kolvin, 2002).

#### *3.3.3.2 Parental Mental Illness*

The association between parental mental disorder and negative outcomes in the child is well documented (Weissman, et al., 1984; Beardslee, Keller & Klerman, 1985; Fitzgerald and Kinsella, 1989; Day-Cody and Fitzgerald, 1989; Mohan, Fitzgerald & Collins 1998). According to Fitzgerald and Jeffers (1994), the link between maternal and child psychological health in their study resulted from the fact that maternal depression undermined parenting ability and made it more likely that the child would become disturbed. However, this relationship is not simple or straightforward and the impact of parental illness can be lessened

when other resources are available to the child. Maternal psychiatric disorder, as identified in the baseline study for this research project (Fitzgerald and Jeffers 1994), can be detrimental to the child's health and behaviour but this is usually associated with economic disadvantage. There is widespread evidence of successful coping amongst children with parents who are mentally ill. The main risk factor when a parent suffers from psychological disorder appears to stem from the associated family discord, especially when the hostility directly involves the child (Quinton & Rutter, 1985; Rutter et al., 1998). For the child, this difficulty can be offset by a mentally healthy parent and the maintenance of a good relationship with that parent. This is true also when a child loses a parent due to death or separation. These potentially damaging situations, if successfully negotiated, can even benefit the child in the long-term (Beardslee & Poderefsky, 1988).

Despite empirical support linking parental mental disorder to negative outcomes in the child, this finding is contested. There are methodological problems about agreed definitions of mental disorder and the way in which this is measured in research studies. Greater emphasis has been placed on mothers' psychological health, which is usually measured objectively, while fathers' health status is often based on spouses' accounts. But perhaps more importantly, the causal pathway could be in either direction, a fact increasingly acknowledged by researchers (Mohan et al., 1998). Although the majority of research effort has focused on the direction of influence from the mother to the child, there is some evidence to support the opposite route (Hopkins, Campbell & Marcus, 1987; Sheeber & Johnson 1992). Naerde, Tambs and Mathiesen (2002) have presented evidence that the child's temperament and behaviour impacts on the mother's mental health from a very early age, especially in the absence of spousal support. The authors question the frequently documented belief that depressed mothers have distorted perceptions of their children's problems. These mothers may, in fact, be providing realistic accounts of their situations. In sum, it may be that parental disorder has a lasting impact on children or that parents' psychological status results from difficulties in the child or that both child and parental psychological problems originate from other stressful circumstances within families (Rodgers, 1990).

#### *3.3.3.3 Parental Substance Abuse and Involvement in Crime*

Another area of research has sought to identify intergenerational links between parents and children in relation to crime and substance abuse. A longitudinal study of males in the U.K found that a convicted father or sibling was highly predictive of a boys' later offending (Farrington, Barnes & Lambert, 1996) and Kolvin et al's (1990) work produced similar findings. There is some evidence that drug taking is cross generational and that similar processes operate when crime and substance abuse is evident in the home (Cleary, Corbett et al., 2004). However, the resilience of the child is a factor that must be considered in assessing

this risk, as are the social and economic resources available to the family. Risk is also dependent on the attitude and practices of the parent or parents and there is evidence that drug-taking parents often take great care to protect their children in these situations (Hogan & Higgins, 2001).

#### *3.3.3.4 Marital Discord*

Marital disharmony has been associated with behavioural deviancy in children (Lucey & Fitzgerald 1989; McNestry, Fitzgerald & Kinsella, 1988). Dooley and Fitzgerald (1984) found that an increase in marital discord in the home was associated with an increased likelihood of referral to child psychiatric services and this is apparent in very young children (Mulhall, Fitzgerald & Kinsella, 1988). Yet, as with other adverse circumstances, marital disharmony does not in itself necessarily result in psychological difficulties in the child. If he or she can draw on supportive relationships outside the home this can often ameliorate the effects (Rutter, 1989). There are also links between parental separation and adverse psychological and social outcomes for children (Chase-Lansdale, Cherlin & Kiernan, 1995), but again these are predicated on events surrounding the separation and the availability of parent or substitute support to the child (Hogan, Halpenny & Greene 2002). As Rutter (1989) has said, it is not the single event or factor that is important but rather the possible chain of negative events and features this sets in motion. Yet, although long-term adverse outcomes typically only apply to a minority of children experiencing parental separation, these children are more likely to experience long-term ill effects than children of two-parent families (Emery, 1999; Amato, Loomis & Booth, 1995). Separation has been linked with conduct problems and delinquency and with less positive educational outcomes (Kiernan, 1992; Kiernan 1997).

#### *3.3.4 Economic Factors*

Economic factors play a key role in determining the overall health and social status of individuals throughout their life-span and there is a well-established correlation between adverse socio-economic circumstances and the probability of behavioural and school-related problems in children (Kolvin et al., 1990; Nolan, 2001). Relatively high rates of psychological distress have been found in a number of Irish studies based on lower socio-economic groups (Barton & Fitzgerald, 1986; Fitzgerald, Pritchard & Kinsella, 1988; Fitzgerald et al., 1994).

In Kolvin et al's (1990) longitudinal study there was a clear relationship, especially for males, between offending and lower occupational status, and the likelihood of offending increased with the severity of deprivation in the family of origin. A number of studies have tried to pinpoint the risk elements in low-income families (Luthar & Zigler, 1991). These factors



include low status parental occupation, lone parenthood, large family size, and low level of maternal education (West & Farrington, 1977; Rutter & Quinton, 1977; Kolvin et al 1990). Economic factors are likely to explain the link between adverse outcomes for children and lone parenthood, as these families are more likely to be economically disadvantaged (Allan, 1999). Nolan (2001) cites parental unemployment and lone parenthood as reasons for the worsening financial position of households with children in Ireland despite improved levels of economic growth. Long-term unemployment and low income levels in the family were identified as a particular source of poverty for children. Nolan's research has charted growing levels of inequality amongst Irish children from the 1970s, a finding supported by Hayes and Kernan's (2001) recent analysis of educational outcome and Halpenny et al's (2002) study of children whose families are homeless. According to Fitzgerald and Jeffers (1994) unemployment and financial difficulties cause stress in families because they reduce the ability not just to obtain goods but also resources which may offer respite from a difficult environment. This kind of situation increases the mother's vulnerability to depression, which in turn may undermine her parenting ability, making it more likely that her children will develop difficulties.

### ***3.3.5 Educational success or failure***

School may act as an important risk or protective feature in the child's life (Garmezy, 1993; Hayes & Kernan, 2001). School offers the possibility of academic and social success and factors that will influence outcome include socio-economic and family background, IQ, the ability to learn and the school environment. It is recognised that attitudes to learning are shaped early and that academic success rests predominantly on a child's early knowledge of how to learn, as well as what is learned (Brazelton, 1992).

In Ireland all children have benefited from increased access to education but some groups have gained more than others (Clancy & Wall 2000; Clancy, 2001). Increasing retention levels are evident at second level from 1980 (from 60% to 81% in 1998) but socio-economic and gender differentials have emerged. Females are now outperforming males at most educational levels (Clancy & Wall, 2000; Cleary, Corbett et al., 2004), while males are much more likely to drop out of the school system (ESRI 1998).

Socio-economic factors appear to have a significant effect on educational participation and achievement and Clancy has described socio-economic background as a "powerful determinant of progress through the educational system" (Clancy 2001, p.58; Clancy & Wall, 2000; Hayes & Kernan, 2001). Hayes and Kernan (2001) found clear differences in academic achievement between disadvantaged and non-disadvantaged primary schools. At second level the increased participation rate of children from unskilled and semi-skilled groups (from 14%

in 1992 to 23% in 1998) is relatively small in comparison to other socio-economic groupings (Clancy & Wall, 2000). The majority of early school leavers come from lower socio-economic groupings and fewer than a quarter of entrants to higher education come from unskilled and semi-skilled backgrounds (compared to 75% for the highest social groupings). And it appears that less able middle class students have higher retention levels than working class students, a fact Clancy and Wall (2000) attribute to differential resources and parental expectations. The employment implications of a lack of educational attainment are demonstrated by the ESRI (1998) School Leavers' survey. Young people leaving school with no qualifications are six times more likely to be unemployed than those with a Leaving Certificate. There are links also between unemployment and mental and social adjustment (Fergusson, Horwood & Woodward, 2001).

Early childhood appears to be a crucial period for developing learning and intellectual abilities, therefore poverty at this stage has a substantial influence on educational achievement (Rutter, 1989; Guo, 1998). Hayes and Kernan's (2001) study of Irish primary school children has shown how children from poor backgrounds are disadvantaged from the pre-school stage despite the acknowledged importance of this period for cognitive development. Based on their study of Irish primary schoolchildren, Hayes and Kernan (2001) conclude that the cumulative effect of family disadvantages make it more likely that poor children will have a less positive educational outcome than other children. The early origins of scholastic difficulties are clear also from Kolvin et al.'s (1990) research in that pre-school deprivation was shown to have a powerful effect on later intellectual performance. At primary level, children from disadvantaged backgrounds scored lower on linguistic and other key measures (with IQ controlled) and the gap widened between these children and their classmates as they progressed through the school system.

Disadvantage can impact in various ways on school performance. Extreme disadvantage can have a significant negative impact on IQ, and conversely IQ as well as general scholastic functioning can improve with better economic conditions in the family (Cronbach, 1969; Garbarino, 1992; Kolvin et al 1991). Yet children do overcome economic obstacles and become successful in the educational system (Clarke & Clarke 1984; Kolvin et al. 1990). This appears to be strongly related to gender, peer group affiliation and the availability of successful role models (Jessor, Turbin & Costa, 1998).

There is a substantial body of literature evidence mapping the reasons why children from lower-economic groups may be disadvantaged in relation to other socio-economic groupings (Bernstein 1971; Bourdieu & Passeron, 1977; Lynch 1999). It is claimed that the Western educational system is dominated by middle-class frames of language and thinking and that children from this background have an automatic advantage in these settings. It does appear

that school and out-of-school life is more similar for middle-class children (Lareau 2000). School can engender feelings of marginalisation for children from different background environments (Keogh & Whyte, 2003). Parental expectations are also important, as is the ability to redress learning deficits (Hanafin, 2000). That school-based factors are not the only elements involved is underlined by Hayes and Kernan's (2001) finding that disadvantaged schools had better pupil-teacher ratios than other schools, similar equipment resources and that there were no obvious curriculum disparities. The clear differences in academic achievement between the two school categories reflect, as Hayes and Kernan (2001) note, established evidence regarding the lower academic achievements of children who are disadvantaged (Garbarino 1992; Kellaghan, Weir, O hUallachan & Morgan, 1995).

### **3.4 Summary**

Contemporary perspectives on child development favour flexibility and individuality rather than a definitive set of needs and outcomes. Economic and family background factors are important and there is an association between adverse social circumstances and the probability of behavioural and school-related problems in children. A higher proportion of children in lone parent households may experience difficulties compared to those living with both parents, but this may be related to economic circumstances rather than to family structure per se. Other family changes, such as mothers working outside the home, do not appear to have had adverse consequences for children, and the impact of parental separation is again dependent on the circumstances surrounding the separation. What is important for children is the quality of parenting they receive. Deficient parenting is more likely if one or both parents suffer from a mental disorder. Yet, children's life prospects are not totally dependent on adults and the majority of young people emerge from childhood well-adjusted and without behavioural or psychological problems. Outcomes vary for children because individuals differ in terms of their susceptibility to risk factors and also because of various protective mechanisms which reduce the impact of those factors. An accumulation of risks is more likely to adversely affect the child than a single event. The effects of such risks are likely to be mediated by age and gender. Education can be an important protective feature in a child's life, although there is considerable evidence suggesting that educational outcome itself is strongly associated with socio-economic factors, especially in the pre-school and early primary stage.

## CHAPTER 4: SOCIAL AND PSYCHOLOGICAL DEVELOPMENT

### 4.1 Introduction

In the initial phase of the study, 185 children and their mothers were studied across a range of social, psychological and economic variables. In Phase Two, 97 of these children, now young adults, were interviewed. Eighty mothers also participated in this part of the study. This section provides a descriptive account of the factors examined in the study.

The average age of participants was 21 years<sup>3</sup> (standard deviation = 0.48). Most respondents in both phases of the research were male although the distribution was more evenly distributed in Phase Two<sup>4</sup>. Almost all (91%) were single and non-cohabitating; the remainder were unmarried and living with a partner. Almost one-fifth (19%) of respondents had had children and two respondents were pregnant with their first child at the time of interview. Most young parents (n=14) were female but this difference was not significant. Over three-quarters (79%) of interviewees were still living in the family home.

### 4.2 Educational attainment and experiences

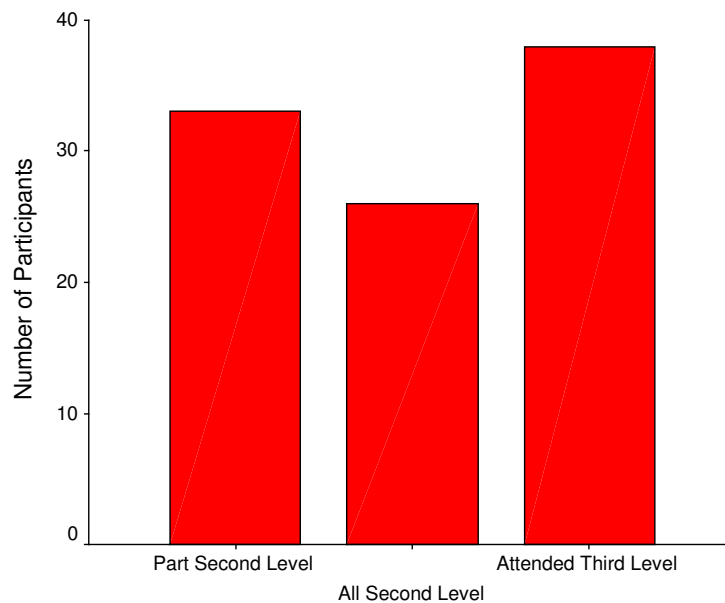


Figure 4.1: Highest educational attainment achieved by participants

<sup>3</sup> Mean = 2.1 years, sd=0.48.

<sup>4</sup> There were 107 males in Phase One and 50 males in Phase Two.

Almost one-fifth (19%) of respondents were still in full-time education. The remainder had completed schooling between thirteen and twenty-one years<sup>5</sup>. All had started secondary school but there was wide variation in relation to retention and educational attainment as shown in Figure 4.1. One-third had not completed second level education and 36% of the early school leavers undertook no further education. Almost 60% of those who completed second level went on to third level education. Table 4.1 illustrates the type of educational qualifications obtained by respondents.

Table 4.1: Educational Attainment (Highest educational qualification attained)

	Males %	Females %	Total group %
Leaving Certificate only	26	19.1	22.7
Junior Certificate/equivalent only	24	29.8	26.8
PLC Course, City and Guilds etc	34	40.4	37.1
Degree/diploma	10	10.6	10.3
No qualifications	6	-	3.1
Total	100	100	100

There were some gender differences in relation to educational variables but these differences were non-significant. The small number (3) of respondents who left school without qualifications were all male. Slightly more females (70%) than males (62%) completed second level education and approximately one-half (49%) of female respondents, in comparison to 30% of male interviewees, went on to third level education.

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<sup>5</sup> Mean = 17.4 years, sd = 1.89).

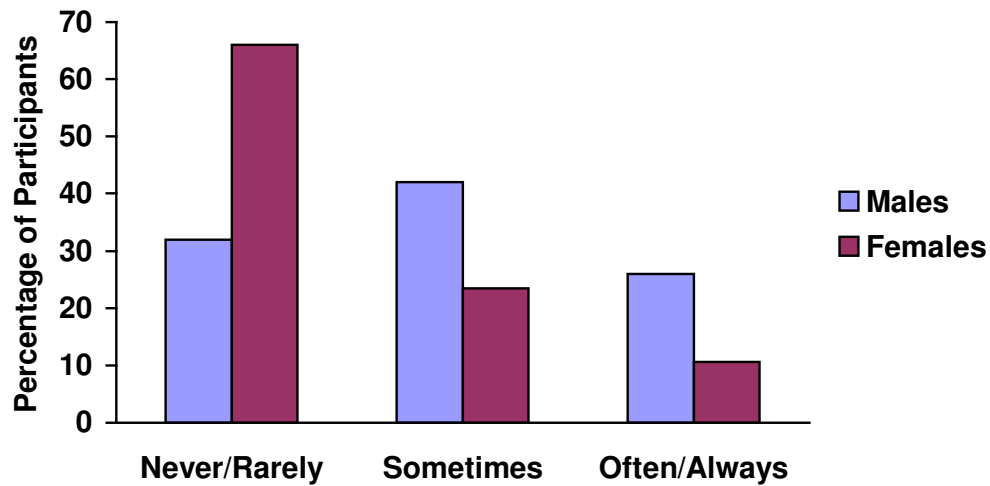


Figure 4.2: Reported Frequency of Trouble in School by Gender

Participants were asked about school experiences and behaviour and the majority (83%) felt that they had made good academic progress. Females rated their academic achievements as satisfactory slightly more often (93% and 82% respectively) and also reported satisfactory social development in school (97% and 90% respectively). Interviewees were asked to subjectively evaluate their behaviour in school and this was coded into three categories: never/rarely, sometimes, or often/always in trouble at school (Figure 4.2). Almost half (48%) of the group reported that they were rarely or never in trouble at school. Conversely, approximately one fifth (19%) said that they were often or always in trouble with teachers. Gender differences were significant in that more males (26%) than females (11%) stated that they were often/always in trouble and conversely more females (66%) than males (32%) said that they were rarely or never in trouble at school ( $\chi^2 = 11.386$ ,  $df = 2$ ,  $p < 0.01$ ).

### 4.3 Employment and work experiences

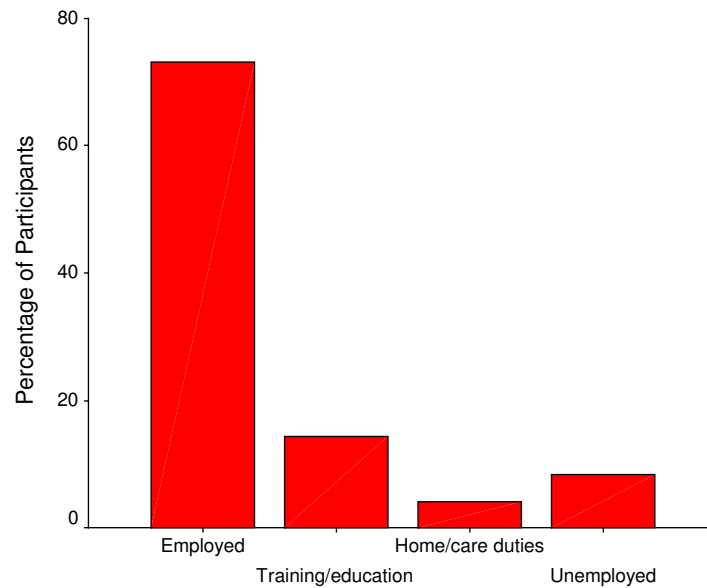


Figure 4.3: Employment situation of participants

As outlined in Figure 4.3, almost three-quarters (73%) of participants were in employment at the time of the study and over half of those not currently working were in full time education. More males than females were unemployed at the time of the study but this difference was not significant. The level of movement between jobs was unremarkable. The majority (59%) had been with their present employer for less than a year. Male respondents were in ongoing employment for a somewhat longer period than female respondents. When questioned about work experiences and aspirations, the great majority (90%) were satisfied with their present job. They also appeared, in general (64%), to be content with their working conditions. Relationships with work colleagues were almost universally rated as good (97%) and this was equally true for both male and female respondents.

Respondents were asked about their financial circumstances and while 30% reported having some level of debt, overall the great majority (90%) stated that they had adequate spending money. Only four reported financial difficulties. Thirteen individuals were in receipt of welfare payments and these were primarily mothers (n=9) receiving lone parents allowance.

Table 4.2: Socio-economic classification of participants

Socio-economic Group	Frequency	%
Employers and Managers	3	3.1
Higher Professional	1	1.0
Lower Professional	6	6.2
Non-manual	36	37.1

Manual skilled	21	21.6
Semi-skilled	18	18.6
Unskilled	2	2.1
Others	10	10.3
<b>Total</b>	97	100

Table 4.2 categorises respondents according to socio-economic grouping, based on their present occupation, and shows that the largest proportion of the sample fell into the Non-manual category. Only four participants were included in the Employers/Managers and Higher Professional categories which partly reflects the age level of participants.

#### 4.4 Psychological Health Status

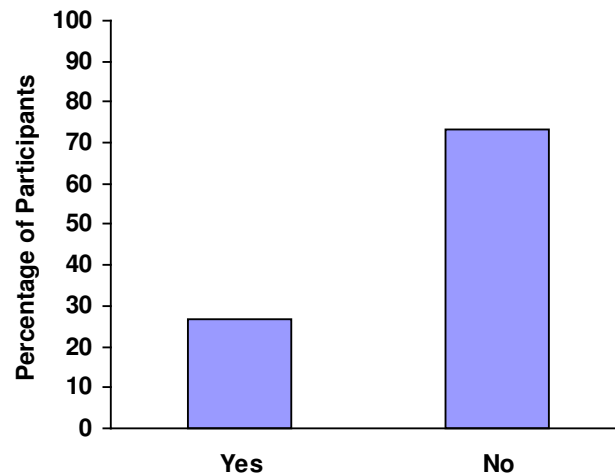


Figure 4.4: Treatment for psychological problems (in past and/or at present)

Twelve (12%) respondents reported that they had attended a doctor in the previous year because of an emotional or psychological problem (including depression, anxiety and eating disorders). Four individuals were in therapy at the time of the study and one participant was currently taking psychotropic medication. Eighteen percent reported having received treatment in the past (usually from a psychiatrist) for psychological difficulties. Slightly more females than males (21% in comparison to 16%) had received treatment, but this difference was not significant. Reasons for seeking treatment in the past were similar to those relating to present symptomatology i.e. depression, anxiety and eating disorders, as well as distress following various events or difficulties.



#### 4.4.1 Present symptomatology

Present psychological health status was assessed using the SCID (First et al 1996)<sup>6</sup>. This instrument provides a research diagnosis, which is generally well-correlated with clinical diagnosis. None of the respondents reached a level of definite clinical diagnosis but almost three-quarters (72%) presented with a *likely* diagnosis for disorder (i.e. significant symptoms below the threshold of diagnosis). Similar numbers of males (74%) and females (70%) received this categorisation. The largest *likely* diagnostic category was substance abuse. At least half of those who received a *likely* diagnosis were categorized within at least one other diagnostic grouping including mood, anxiety, or eating disorders. A number of respondents had five (or more) *likely diagnosis*. Figure 4.5 illustrates the various *likely* diagnostic categories<sup>7</sup>.

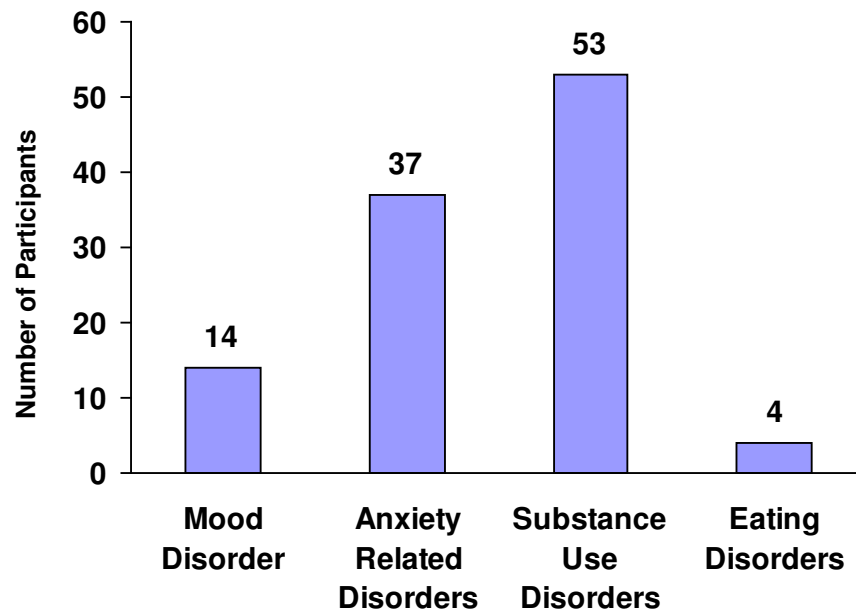


Figure 4.5: Frequency of Main (Likely) Diagnostic Categories

Over one-third (38%) received an anxiety-related (likely) diagnosis. More females (60%) than males (41%) received this categorisation but the difference did not reach statistical significance. Fourteen respondents (14%) received a *likely* diagnosis of a mood disorder, equally distributed between males (seven) and females (seven). Based on the SCID

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<sup>6</sup> See Chapter 2 and Appendix One for a full description of this instrument.

<sup>7</sup> A detailed breakdown of subcategories is contained in Appendix Two.

assessment six respondents had experienced a depressive episode in the past. Four individuals, all female, received a *likely* diagnoses of Eating Disorder.

#### 4.4.1.1 Substance Use

Alcohol consumption and substance abuse were included in the SCID assessment but additional questions were asked to determine participants' subjective evaluation of their drinking and drug use. A very high percentage (92%), an equal number of males and females, drank alcohol and heavy drinking was common. Thirty percent received a *likely* diagnosis of alcohol abuse, with a small and non-significant gender difference in favour of males. However there was a more significant gender difference in relation to another *likely* diagnostic category, alcohol dependence. Twenty-one individuals, more than a fifth (22%) of the total, received a *likely* diagnosis of alcohol dependence and this included sixteen (17%) males and five (5%) females ( $\chi^2 = 6.52$ ,  $df = 1$ ,  $p < 0.01$ ).

Ten percent of the group had some form of (likely) drug dependence and 4% received a likely diagnosis of drug abuse. Over half (55%) received a *likely* diagnosis of substance-related disorder (which included both alcohol and drugs) and again there was a slight preponderance of males (62% of those who received this diagnosis were male). One respondent in eight (13%) were categorized as having significant features of drug abuse and dependency<sup>8</sup>. Twelve respondents presented with a *likely* diagnoses of two substance-related disorders. Figure 4.6 presents the frequency of alcohol and drug dependence among the young people, based on the SCID measure.

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<sup>8</sup> **Substance dependence** refers to compulsive and repetitive use of alcohol or other drugs despite problems (withdrawal symptoms etc.) **Substance abuse** refers to repeated but not compulsive use or addiction (American Psychiatric Association (1994), Diagnostic and Statistical Manual of Mental Disorders IV).

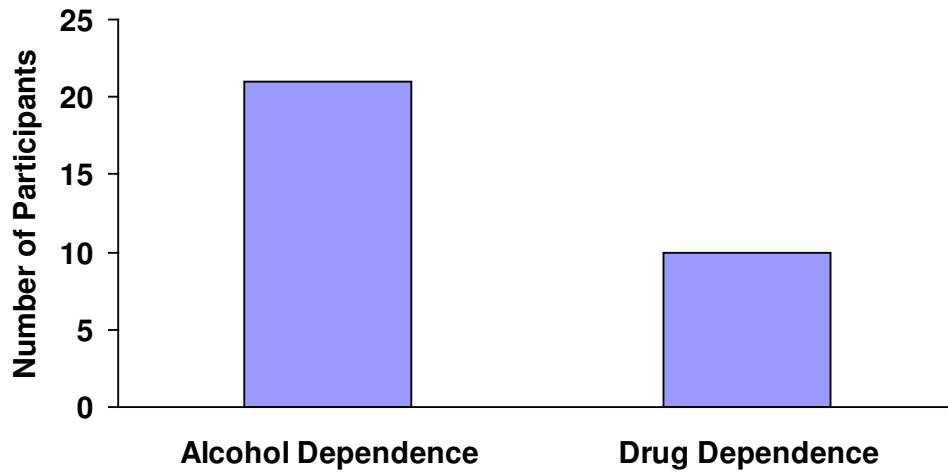


Figure 4.6: Frequency of alcohol and drug abuse and dependency among young people, based on the SCID measure.

Participants' subjective evaluation of their drinking was at variance with objective measures. When asked to rate alcohol consumption in a range from 'hardly drink at all' to 'drink heavily', just over half (52%) assessed their drinking as 'moderate.' None of the participants categorised themselves as heavy drinkers. Subjective evaluation of alcohol use is illustrated in Figure 4.7. Almost half (47%) of the participants were smokers.

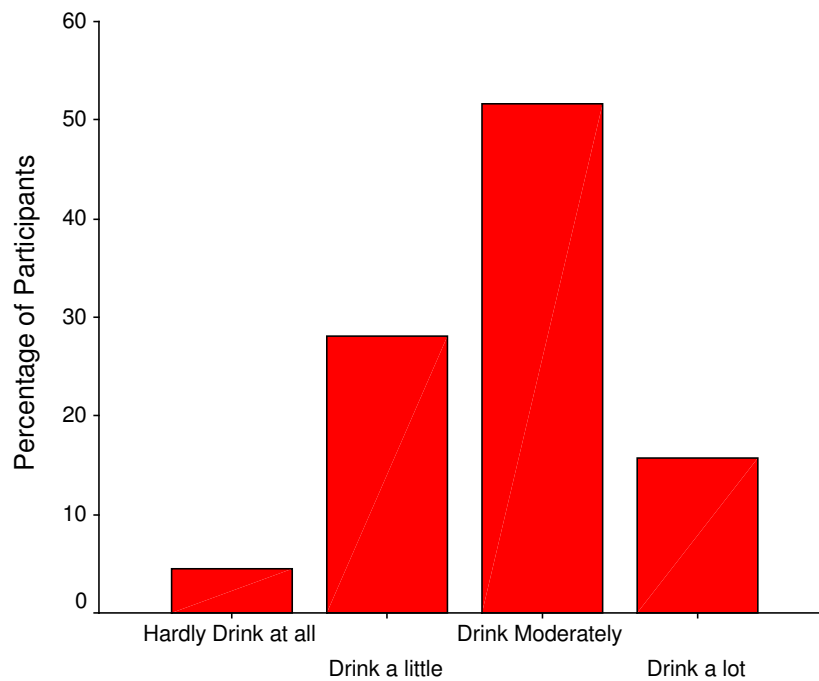


Figure 4.7: Participants' subjective evaluation of alcohol use.

#### 4.5 Suicide Ideation and Behaviour

Suicide Ideation was measured using the Beck Scale for Suicide Ideation (Beck & Steer, 1991) but both suicidal ideation and behaviour were uncommon. Ninety-four percent showed no evidence of either. Three individuals (two males and one female) displayed some signs of suicidal ideation and a further three people (two females and one male) reported that they had previously attempted suicide.

#### 4.6 Self-esteem and Locus of Control

Self-esteem was measured using the Rosenberg Self-Esteem Scale (Rosenberg, 1965)<sup>9</sup>. Overall levels were quite high. Average self-esteem scores for males were slightly higher than for females but this difference was not statistically significant (Figure 4.8).

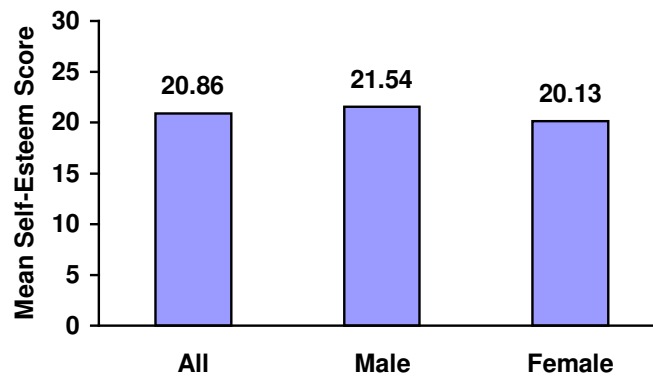


Figure 4.8: Mean Self-Esteem Scores for Participants<sup>10</sup>

Locus of control scores are illustrated in Figure 4.9 and represent quite high levels of control. Locus of control was measured using a 7-item scale developed by Pearlin et al. (1981). A score of 0, the lowest score possible, indicates no sense of control over what happens in one's life (an external locus of control). The maximum score is 21.

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<sup>9</sup> A score of 0 represents the lowest self-esteem point and a score of 30 the highest.

<sup>10</sup> Standard deviation of self-esteem scores were 4.28, 4.57 and 3.88 for all, males and females respectively.

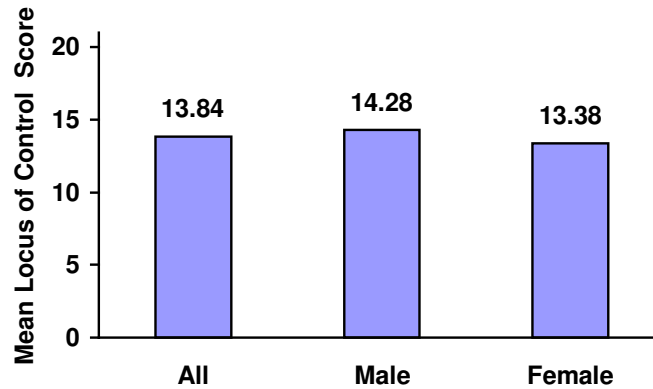


Figure 4.9: Mean Locus of Control Scores for Participants<sup>11</sup>

#### 4.7 Support Systems and Networks

To assess the impact of social and other forms of support, participants were questioned about friendship and support networks, community integration, and religious adherence. Social support was measured using the Arizona Social Support Interview Schedule (Barrera, 1980). The great majority of respondents (95%) reported that they had close friends and almost all (98%) were in regular contact (i.e. weekly) with their friends. Males reported having more close friends than females but this difference was not statistically significant. The majority of respondents also appeared to have access to emotional and practical support. Only seven individuals reported not having any confidant. Females were more likely than males (92% in contrast to 70%) to confide in others and also more likely (89% in comparison with 66%) to report needing a confidant in the recent past (Figure 4.10).

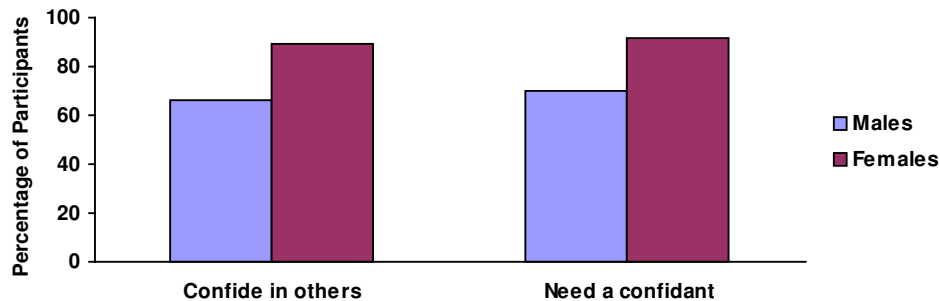


Figure 4.10: Percentage of Participants who reported that they did confide in others and needed a confidant, by gender

<sup>11</sup> Standard deviation of locus of control scores were 2.47, 2.56 and 2.32 for all, males and females respectively.

#### 4.7.1 Religion

Ninety-three percent (n=90) of participants professed to be Roman Catholics<sup>12</sup> but attendance at religious services was low. About one in ten (11%) attended church services regularly (i.e. at least once a month) and the majority 80% attended less often than four times per year. The main reason given for non-attendance was lack of interest. Yet, despite low church attendance, over three-quarters (83%) of the sample professed to believe in God and over 40% of these participants regarded religion as important in their lives (Figure 4.11).

Females interviewed were more likely to say that religion was important (49% in contrast to 38% of males) but these gender differences did not reach statistical significance (Figure 4.11). However there was a significant difference in relation to seeking moral guidance from their Church. Almost half (48%) of male respondents and 30% of female respondents would not refer to their Church's teaching when making moral decisions ( $\chi^2 = 10.174$ ,  $df = 2$ ,  $p < 0.01$ ) (Figure 4.11).

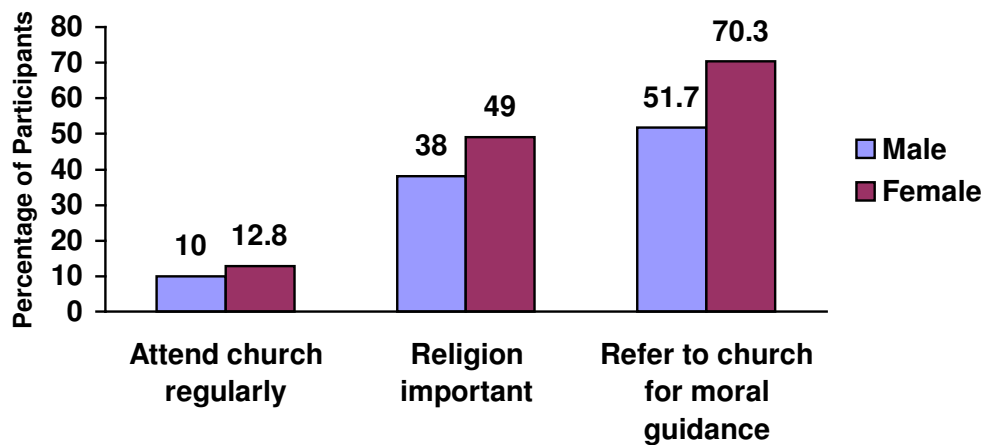


Figure 4.11: Attendance at Church, Importance of Religion and Reference to Church for guidance on moral issues

#### 4.8 Contact with the Law

One-quarter of respondents reported having been in trouble with the law at some point, the majority (79%) being male ( $\chi^2 = 9.741$ ,  $df = 1$ ,  $p < 0.01$ ). In all cases, trouble with the law involved only one incident and most incidents (63%) were relatively minor. Only two participants were involved in serious incidents. A small number (n=4) had been arrested and

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<sup>6</sup>Two respondents belonged to the Church of Ireland, and five individuals stated that they had no religion.

following this, one individual had been detained for a short period in a juvenile detention centre. This data must however be considered in the context of findings in Chapter 2 indicating that significantly more non-contacts than study participants had a record for juvenile offences.

#### 4.9 Life Events & Life Satisfaction

Participants had experienced a variety of negative life events, some serious. This is illustrated in Figure 4.12.

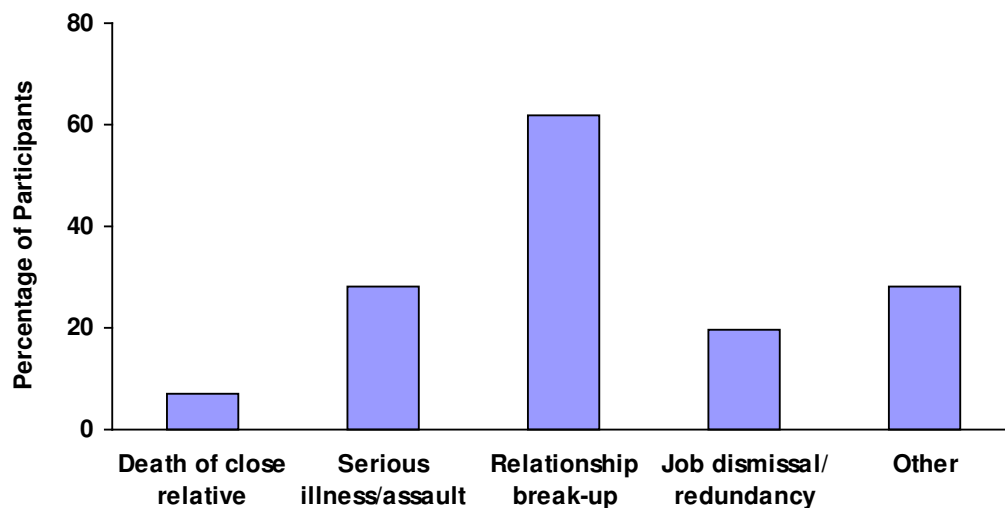


Figure 4.12: Life Events experienced by Participants

Over a quarter (28%) of those interviewed had suffered from a serious illness, injury or assault (physical or sexual). Eleven respondents reported having been mugged or physically attacked and three had been sexually assaulted. Twice as many males as females experienced a physical attack and/or a road accident but these differences were not statistically significant. There were no significant gender differences in relation to other life event categories. Approximately similar percentages of males and females reported a relationship break-up.

#### 4.10 Family Background and experiences<sup>13</sup>

The great majority (90%) of respondents had had both parents present for all their childhood. Nine respondents grew up in single parent families, in almost all cases because their parents were separated. Only one respondent was raised in a family where the mother had never been married. Three of the mothers were now widowed but this had occurred when the

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<sup>13</sup> The following data are based on both the respondents' and the mothers' interviews. Eighty mothers were included in Phase 2 of the study.

respondents were over 18 years. The average family size was 3.9 children and the range was from one to eight children.

#### **4.10.1 Socio-Economic Background of the Family**

Classification of socio-economic grouping was based on father’s occupation (or mother if a single parent) and this is presented in Table 4.3. The modal category is semi-skilled manual and over half of respondents (57%) were in manual, semi-skilled and unskilled categories.

Table 4.3: Socio-Economic classification of family of origin

<b>Socio-economic Group</b>	<b>%</b>
Employers and Managers	10.1
Higher Professional	1.3
Lower Professional	11.4
Non-Manual	11.4
Skilled Manual	19.0
Semi-Skilled Manual	25.3
Unskilled	12.7
Other	10.1
Total	80 <sup>14</sup>

This socio-economic status reflects the educational attainment of the parents. Just over 60% of mothers and almost one-half (48%) of fathers had left school by age 15 years and only a minority (7% of mothers and 11% of fathers) had attained Leaving Certificate level. Two parents had obtained a third level qualification. In relation to continuing education, 31% of mothers and 42% of fathers had returned to full or part-time education.

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<sup>14</sup> This information was obtained from the mother’s interviews hence n=80.



#### 4.10.2 Financial circumstances of the family

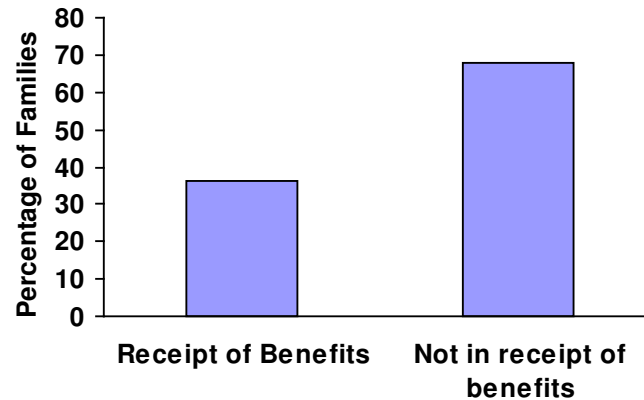


Figure 4.13: Family in receipt of benefits

In Phase One of the study economic disadvantage in the family had proved to be an important link with disorder in the child. In the current study over two thirds of mothers (69%) reported some level of financial difficulty while the index child was growing up, and one-fifth described more severe financial problems. Over one-third (36%) of families had been in receipt of benefits from the state, most commonly unemployment benefit, lone parent's allowance or deserted wife's allowance (Figure 4.13). A high proportion of fathers (44%) had been unemployed at some time during the index participant's childhood and over a third (38%) had been unemployed for more than six months<sup>15</sup>. Just over half (52%) of the mothers had worked when the index child was growing up but only six mothers had worked continuously.

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<sup>15</sup> The mean age of the children at this time was 7.6 years.

#### 4.10.3 Parental Mental Health

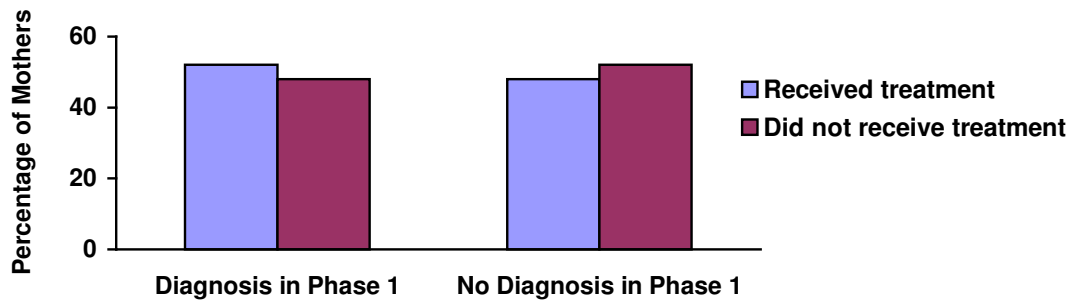


Figure 4.14: Mothers who received treatment for psychological problems by diagnosis in Phase One

Mothers' diagnoses proved to be a key variable in Phase One of this study when one-third of the mothers interviewed received a positive diagnosis. Among the sample of 80 mothers interviewed at Phase Two, a similar proportion (31%) had received a diagnosis ten years previously. Over half (52%) of this diagnosed group had subsequently received treatment for these difficulties, yet a similar percentage (55%) within the undiagnosed group had received treatment for a psychological problem<sup>16</sup>. In the present study the mothers' psychological health was assessed using the SCID (First et al., 1999) and none of the mothers had symptoms which reached a level of clinical disorder. However, there was, as with the respondents, a high level of sub-clinical symptomatology present. Over one-third (38%) presented with a *likely* diagnosis for disorder. The most common *likely* diagnoses were anxiety disorders (38%), mood disorders (8%) and alcohol abuse (5%). Thirteen (16%) mothers were currently taking psychotropic medication.

Based on mothers' reports, almost one-fifth (19%) of fathers had experienced psychological problems half of whom had received treatment while the index children were growing up. Over one-fifth (22%) of mothers reported fathers as having a drink-related problem either currently or in the past and three fathers had received treatment for alcoholism.

#### 4.10.5 Marital relationship, parenting roles and support systems

In Phase One of this study, satisfaction with marital and parenting roles was linked to psychological disorder in the mother. In Phase Two a high proportion (85%) of mothers

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<sup>16</sup> The mean age of the Index child during treatment was 8.6 years (Figure 4.14).

retrospectively reported a good or moderately good marital relationship during the childhood and adolescence of the index child. Eight mothers reported violence in their marital relationship and twelve mothers (15%) had separated from their spouses/partners<sup>17</sup>. Over two-thirds (70%) reported a high level of sharing in the marital relationship although the majority had received no assistance from their husband/partner with childcare or other household tasks.

The mothers were equally satisfied with their parental role. A high percentage (89%) were content with their role performance and only two expressed severe dissatisfaction. Over three-quarters (79%) reported no particular difficulties with any of their children.

When asked to name the most important adult in the early life of the respondent, mothers clearly regarded themselves as the key parent, as illustrated in Figure 4.15. Still, a substantial number of mothers (57%) reported a high level of involvement by fathers in the child's life and only a small minority (6%) reported no participation.

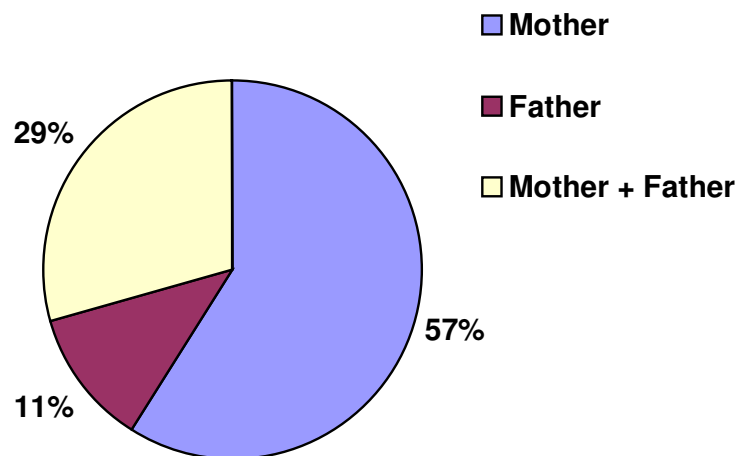


Figure 4.15: Mother's perception of key adult in index child's life

Despite the lack of support systems reported in Phase One of the study mothers now appeared to be well integrated socially, a majority (88%) reporting support from relatives and friends. Almost all (98%) described close friends whom they saw regularly (i.e. at least once or twice a week) and also reported good relations and regular contact with relatives (95%). Over three-quarters (78%) said that they were on very good terms with their neighbours.

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<sup>17</sup> Three had separated in the recent past.

#### 4.10.4 Respondents' relationship with parents

Table 4.4 gives participants' subjective assessment of their relationship with parents during childhood and adolescence. The great majority (94%) reported a good relationship with their mothers. A somewhat lower percentage (79%) reported a satisfactory relationship with fathers.

Mothers appeared to be the more usual confidants for respondents when they were growing up. Over half of the sample (54%), equally divided between males and females, felt that they could always or usually talk openly with their mothers. Approximately one fifth (21%) of female respondents and one-quarter of male respondents said that they could talk openly with their fathers.

Table 4.4: Respondents evaluation of relationship with parents

	Males %	Females %	All %
Relationship with Mother:			
Very good relationship	70	57.4	64.0
Quite good relationship	30	29.8	30.0
Difficult relationship	-	12.7	6.0
Relationship with Father:			
Very good relationship	57.8	46.5	52.3
Quite good relationship	31.1	37.2	34.0
Difficult relationship	11.1	16.3	13.6

To determine the level of childhood supervision respondents were asked if their parents generally knew their whereabouts when they were children. Over ninety percent (92%) of respondents said that their mothers knew where they were some, or all, of the time and 77% reported that their fathers knew their whereabouts. There were no significant gender differences in relation to supervision or in relation to physical punishment. Two-thirds reported that their mother had used physical punishment when they were children and over a fifth (22%) reported this to be a relatively frequent occurrence. Fathers were reported to have used less physical punishment and 41% of respondents had never been physically punished by their father.

#### 4.11 Summary

This section presents descriptive findings from a study of 97 individuals whose mothers had previously been interviewed ten years ago when the respondents were aged eleven years. In

this phase of the study all of the respondents were unmarried but almost one-fifth now had children. Over three-quarters were still living in the family home. Approximately one-fifth were still in full-time education but there was wide variation in relation to educational attainment. Almost one-third had not completed second level education. Females remained in the educational system for longer and were more likely to go on to third level education. Only a small proportion of participants was currently unemployed. There was no evidence of serious psychiatric disorder and only a small percentage of the group was receiving treatment for psychological difficulties. However, importantly, an assessment of psychological health status indicated a high degree of symptoms at a level which would suggest a likely, but not definitive, diagnosis of psychiatric disorder. The most common problems were substance misuse, anxiety and mood-related symptoms. The only significant gender difference in relation to psychological health was in the category of *likely* alcohol dependence where males predominated. Respondents demonstrated adequate levels of self-esteem and locus of control and appeared to be well integrated socially as well as having resources for intimacy and affirmation. Males were less likely to confide in others but this difference was not statistically significant. Religious observance was low yet over three-quarters of the sample said that they believed in God and 40% regarded religion as important in their lives. Almost one-quarter of those interviewed, mostly males, had had some contact with the law but this was overwhelmingly for minor offences and none of the respondents had been in prison.

Ninety percent of participants had been raised in the family home by both parents for all of their childhood. The children came generally from semi-skilled manual backgrounds and only two parents had a third level qualification. A fifth of mothers reported severe financial hardship during the key respondent's childhood. The respondents appeared, in general, to have had good relationships with parents especially mothers. Although over one-quarter of the mothers interviewed had received a psychiatric diagnosis in Phase One of the study there was now no evidence of clinical level disorder amongst them. Over half of mothers had received treatment in the intervening years but treatment rates were similar in the diagnosed and undiagnosed groups. Almost one-fifth of fathers had experienced psychological problems and about 10% had received treatment. Satisfaction with marital and parental roles, which had emerged as key variables in Phase One of the study, were re-examined, and mothers were now, in general, happy with their role performance in these areas.

# CHAPTER 5: HEALTH AND BEHAVIOUR IN CHILDHOOD

## 5.1 Introduction

The aim in this chapter is to examine two factors, diagnosis and/or categorisation of deviance, which emerged as important in Phase One of the study, and to relate these features to the present lives of the interviewees. A high degree of overlap was evident between the two variables in that over two-thirds ( $n = 20$ ) of those with a diagnosis were also categorised as behaviourally deviant. Over sixty percent (63%) of the behaviourally deviant group also had a psychiatric diagnosis at age eleven in contrast to 14% of the other respondents ( $\chi^2 = 24.21$ ,  $df = 1$ ,  $p < 0.01$ ).

## 5.2 Psychiatric Diagnosis

Almost 30% of respondents in the present study had received a formal psychiatric diagnosis in Phase One<sup>18</sup>. To examine the impact of having a diagnosis at age ten, participants with a diagnosis (twenty-nine) were compared with non-diagnosed participants (sixty-eight). Although there was a slight preponderance of males in the diagnosed group (65% of the diagnosed group vs. 54% of the others), these differences were not significant. The groups were similar in age and they were also comparable in terms of marital status, parental status, and living arrangements.

### 5.2.1 Education, Employment & Socio-economic Status

#### 5.2.1.1 Education & Employment

There were differences between the groupings in relation to educational attainment. A greater percentage of those without a diagnosis sat the Leaving Certificate examination, (74% in contrast to 48% in the diagnosed group), but this difference was not statistically significant. The groups differed significantly in terms of the age they completed full-time education ( $t = -2.327$ ,  $df = 75$ ,  $p < 0.01$ ). For those with a diagnosis, the mean age was 16.7 years (standard deviation = 1.6), while for those without a diagnosis, the mean age for completing the educational cycle was 17.8 (standard deviation = 1.9). Most importantly perhaps, almost half

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<sup>18</sup> The main diagnostic categories were conduct-related disorder and enuresis

(49%) of those without a diagnosis in Phase One had gone on to third level education in contrast to 17% of those with a diagnosis, and this difference was significant ( $\chi^2 = 8.352$  df = 1,  $p < 0.01$ ). This is illustrated in Figure 5.1 below. The relationship between diagnosis and educational attainment will be examined in greater detail in the next chapter (Chapter 6).

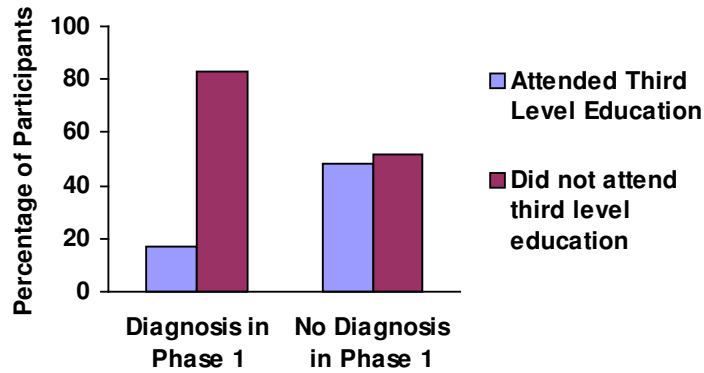


Figure 5.1: Percentage of Respondents who went on to Third Level Education, by Diagnostic Categorisation

On subjective reports of school behaviour, 55% of respondents without a diagnosis reported being rarely or never in trouble in school in contrast to 35% of the diagnosed participants. There was a significant difference between diagnosed (45%) and non-diagnosed (7%) groups on reports of frequent trouble in school ( $\chi^2 = 18.949$ , df = 2,  $p < 0.01$ ). This is illustrated in Figure 5.2.

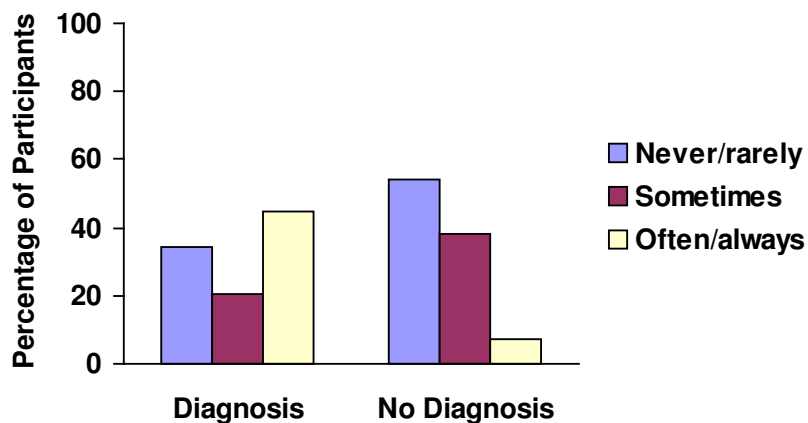


Figure 5.2: Percentage of Respondents who reported Frequency of Trouble in School, by Diagnostic Categorisation

There were no important differences in relation to employment. This is not unexpected in the context of the respondents' ages and the buoyant economic situation in the period between the two study phases. Three-quarters of both groups were in full-time employment at the time of the study. Similar proportions (13%) in both groups were in receipt of social welfare benefits. In terms of socio-economic status, more from within the diagnosed group (35% in contrast to 15% of the non-diagnosed group) were in semi-skilled and unskilled categories while the non-diagnosed grouping tended to predominate in the lower professional and non-manual categories (51% in contrast to 24%).

### **5.2.2 Social Supports & Networks**

Respondents with a past diagnosis had a smaller social network (mean = 7.24, standard deviation = 2.32) than those without a diagnosis (mean = 8.79, standard deviation = 2.53), and this difference was significant ( $t = 2.930$ ,  $df = 95$ ,  $p < 0.01$ ).

More individuals with a diagnosis reported not believing in God (31% vs. 12%) and attended Church services less frequently. Over half said that religion was unimportant to them (58%) in comparison to those without a diagnosis (41%).

### **5.2.3 Psychological Health**

There was little difference between those with and without a psychiatric diagnosis in childhood in terms of present psychological status. There were no differences between the groups on the number of *likely* diagnoses obtained on the SCID. There were no significant differences in relation to suicidal ideation/behaviour nor in respect to consumption of alcohol. Only 10% of those with a past diagnosis ( $n = 3$ ) and 13% of the others ( $n = 9$ ) had experienced recent (i.e. in the past year) psychological problems. More respondents with a past diagnosis (28% in contrast to 15% of the non-diagnosed group) had previously received treatment for psychological problems but this difference was not statistically significant and, in fact, slightly more of the non-diagnosed (three in comparison to one) were receiving treatment at the time of the study.

As indicated in the introduction to this Chapter, the diagnosed group was more likely to be categorised as behaviourally deviant<sup>19</sup>. Over two-thirds (69%) of those with a diagnosis in contrast to 18% without a diagnosis were categorised as behaviourally deviant. Analysis of the symptom profiles of all respondents revealed an interesting and significant difference between the groups in the number of hyperactive and conduct symptoms displayed at that age

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<sup>19</sup> Measured by Rutter B2



( $U = 572.0$ ,  $N1 = 29$ ,  $N2 = 68$ ,  $p < 0.01$ ;  $U = 358.0$ ,  $N1 = 29$ ,  $N2 = 68$ ,  $p < 0.01^{20}$ ), with the diagnosed group showing higher levels of both symptoms.

#### 5.2.4 Self-Esteem & Locus of Control

There were no significant differences between those with a diagnosis and those without on the measures of Self-Esteem and Locus of Control.

#### 5.2.5 Family Background & Experiences

There were few differences between the two groups of families in terms of socio-economic status but economic disadvantage was more common in the diagnosed group. The Index of Poverty<sup>21</sup> used in Phase One did not reveal any difference between diagnosed and non-diagnosed groups. Nor did fathers' unemployment history. However, there was a significant difference in relation to an important indicator of childhood economic disadvantage, i.e. whether the family had been in receipt of state benefits. Almost 60% of families of those with a diagnosis had been in receipt of benefits in contrast to just over a quarter (28%) of the other families and this difference was significant ( $\chi^2 = 6.851$ ,  $df = 1$ ,  $p < 0.01$ ). This is illustrated in Figure 5.3.

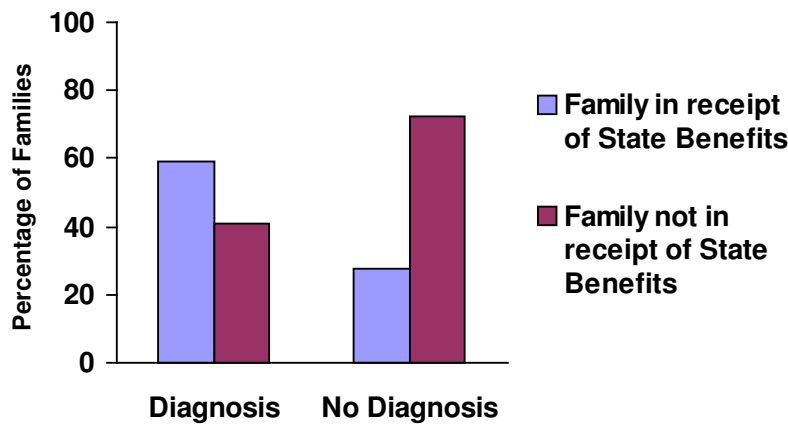


Figure 5.3: Percentage of Families in receipt of State Benefits, by Diagnostic Categorisation of Key Respondent.

A significant difference emerged in relation to one measure of psychological health (The Malaise Inventory (Rutter et al 1970)), the mothers of diagnosed children having higher scores than the other mothers ( $U = 575.5$ ,  $N1 = 28$ ,  $N2 = 67$ ,  $p < 0.01$ ). However, the more

<sup>20</sup> Mann-Whitney Test

<sup>21</sup> Computed on the basis of presence or absence of specific material goods (Telephone, car etc)

comprehensive psychiatric assessment (Clinical Psychiatric Interview, Goldberg et al., 1970) revealed no differences between the two groups, which might imply that symptoms were minor and transitory rather than long-term in nature.

In relation to current psychological health, 41% of mothers of diagnosed respondents and 22% of mothers of non-diagnosed respondents had experienced emotional problems in the year prior to interview but this difference was not significant. A similar percentage of mothers in both groups had attended for therapy while their children were growing up, and the same number (three) in each group had been hospitalised for psychiatric reasons. Neither were there differences between the mothers in relation to alcohol problems. Two mothers in the diagnosed group and four mothers in the comparison group reported a problem with alcohol at some time.

A similar number of fathers (19% in both groups) had had psychological difficulties in the past and eight fathers (one father of a child with and seven fathers of children without a diagnosis) had received treatment while their children were growing up. There were no differences between the two groups in relation to paternal alcohol use but three of the fathers of diagnosed respondents had misused drugs in contrast to the undiagnosed group where no father had abused drugs.

Almost the same proportion of mothers in both groups (six in the diagnosed group and eleven in the non-diagnosed group) reported problems with their children when they were growing up. A high percentage in both categories (96% of mothers of diagnosed children and 86% of the others) reported parental role satisfaction.

### **5.2.6 Contact with the Law**

Almost 40% of those with a diagnosis and 19% without a diagnosis reported contact with the Law for minor offences (Figure 5.4). Although this did not reach statistical significance, a definitive trend is evident.

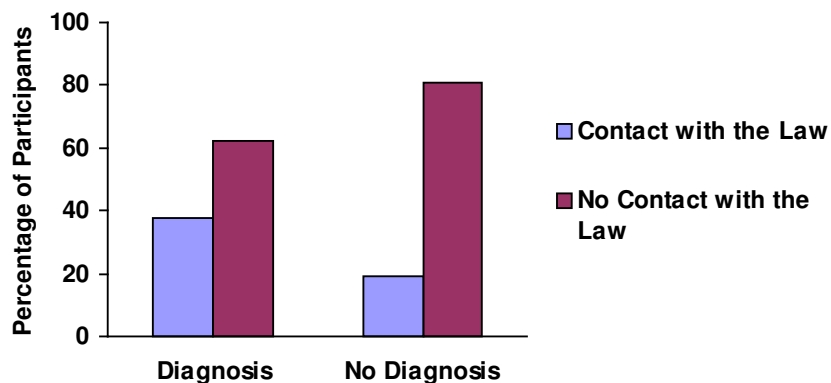


Figure 5.4: Percentage of Respondents who reported Contact with the Law, by Diagnostic Categorisation

### **5.3 Behavioural Deviancy**

In Phase One of the study, behaviour was assessed using Rutter's B2 Instrument (Rutter, 1967). To measure the impact of an assessment of behavioural deviancy at age eleven, respondents who were categorised in this way (n=30) were compared with the non-deviant group (n=65). There were more males than females (69% in contrast to 31%) in the deviant group. Although this difference was non-significant there was clear trend which reflects other research findings. Background factors such as marital and parental status in the two groupings were similar.

#### ***5.3.1 Education, Employment & Socio-economic Status***

##### *5.3.1.1 Education and Employment*

There were important differences between the two groups in relation to educational attainment. Sixty-six percent of the behaviourally deviant group left secondary school before completing the Leaving Certificate compared with only 19% in the non-deviant group and this difference was significant ( $\chi^2 = 21.25$ ,  $df = 1$ ,  $p < 0.01$ ). This is illustrated in Figure 5.5. A related variable, age at leaving school, provided another significant differential between the groups ( $t = -5.108$ ,  $df = 75$ ,  $p < 0.01$ ). For the behaviourally deviant group, the mean age for completing school was 16.14 years (standard deviation = 1.38), while for the others the mean age was 18.12 (standard deviation = 1.76). Participation in third level also varied considerably. Approximately fifty percent (51%) of the non-deviant group went to third level education in contrast to 16% of the group classified as behaviourally deviant and this was also statistically significant ( $\chi^2 = 11.115$ ,  $df = 1$ ,  $p < 0.01$ ). The relationship between diagnosis, behavioural deviancy and educational attainment will be explored further in the next chapter (Chapter 6).

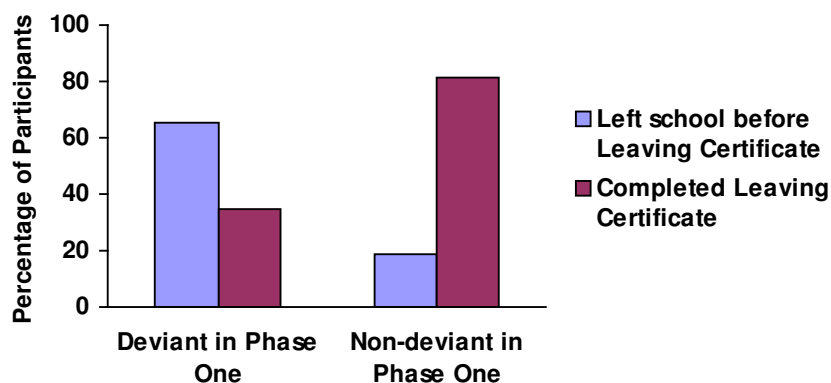


Figure 5.5: Percentage of Respondents who left secondary school before their Leaving Certificate, by Categorisation of Behavioural Deviance.

Subjective school experiences also varied between the deviant and non-deviant groups but here the differences were not significant. Over one-third (34%) of the behaviourally deviant group reported frequent problems in school in contrast to 11% of the remaining respondents.

There were no important differences in relation to employment status of the two groups. Almost 80% of the behaviourally deviant group and 71% of the comparison group were in full-time employment at the time of the study. Similarly there were no important differences between the groups in relation to socio-economic status. A higher percentage of the non-deviant group (54% in comparison to 34%) were in non-manual and higher groupings but this difference did not reach statistical significance. Conversely, more of the behaviourally deviant group than the others (28% in contrast to 17%) were in the semi-skilled and unskilled category, but, again, these differences were non-significant.

### 5.3.2 Social Supports & Networks

There were no significant differences between the behaviourally deviant and comparison groups in relation to social support and networks.

Religious adherence was also similar for both groups. Somewhat fewer in the behaviourally deviant group believed in God (75% in contrast to 86%); they attended church services less often (3% attended at least monthly in contrast to 15% of the comparison group), and more (57% in contrast to 40%) declared that religion was unimportant.

### 5.3.3 Psychological Health

Similar numbers in both groups (12%) had had psychological difficulties in the past year and although more from the behaviourally deviant group had received treatment (25%, in contrast to 15% of the non-deviant group) this difference was not significant. There were no

differences between the two groups on the number of *likely* diagnoses obtained on the SCID or in relation to substance (including alcohol) misuse. Suicidal behaviour and ideation was similarly absent in both groups.

#### 5.3.4 Self-esteem & Locus of Control

There were no significant differences between the groups in relation to Self-esteem or Locus of Control.

#### 5.3.5 Family Background & Experiences

Family background was similar. The marital status of mothers in both groups was similar and a comparable percentage of fathers (45% of fathers of the behaviourally deviant children and 40% of other fathers) had been unemployed during the key respondent's childhood. However, in line with the analysis of the diagnosed group, a significant difference emerged in relation to receipt of benefits by the family. Almost sixty percent (58%) of the deviant groups' families (in contrast to 27% of the others) had been in receipt of benefits while the child was growing up ( $\chi^2 = 7.235$ ,  $df = 1$ ,  $p < 0.01$ ). This is illustrated in Figure 5.6.

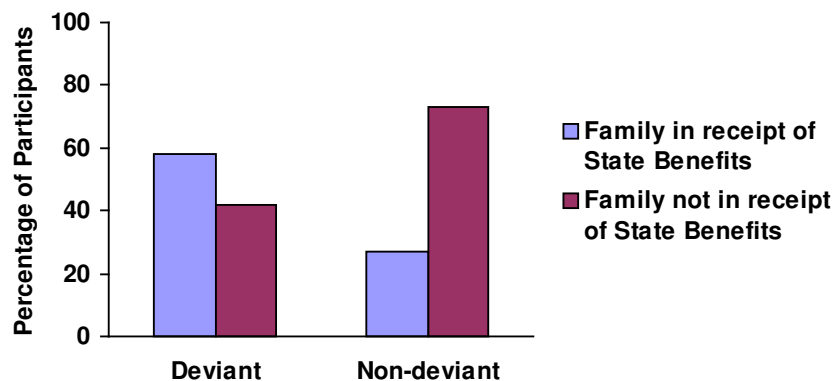


Figure 5.6: Percentage of Families in receipt of State Benefits, by Categorisation of Behavioural Deviance of Key Respondent.

Not unexpectedly (and in line with the analysis of diagnosis) the re-examination of mothers' mental health in Phase One, based on the Malaise Inventory (Rutter et al 1970), revealed a significant difference between the behaviourally deviant and non-deviant groups ( $U = 629.5$ ,  $N1 = 32$ ,  $N2 = 65$ ,  $p < 0.01$ )<sup>22</sup>. However, there was no important difference between the groups in relation to mothers' subsequent psychological health i.e. during the key

<sup>22</sup> The mothers of those in the behaviourally deviant group had a mean Malaise score of 7.03 (standard deviation = 4.44) in contrast to a mean score of 4.48 (standard deviation = 4.63) amongst other mothers.

respondent's late childhood and adolescence. One-third of mothers of behaviourally deviant respondents (in comparison to 25% of the others) had experienced psychological problems in the year prior to interview. A similar percentage of mothers in both groups (25% in the behaviourally deviant group and 21% in the other group) had received psychiatric treatment while their children were growing up and slightly more of the mothers of non-deviant than of deviant respondents (four and two respectively) had been hospitalised for this. There were no differences in relation to alcohol abuse.

A comparable number of fathers in both groups (ten in comparison to five) had had psychological difficulties in the past and figures for alcohol misuse were also similar (20% and 27% respectively).

Approximately the same percentage of mothers in each group expressed satisfaction with their parental role.

### 5.3.6 Contact with the Law

There were important differences between the groups in relation to contact with the law. Fifteen (47%) of the deviant group, in contrast to nine (14%) of the non-deviant group had been in trouble with the police and this difference was statistically significant ( $\chi^2 = 12.563$ ,  $df = 1$ ,  $p < 0.01$ ). This is illustrated in Figure 5.7.

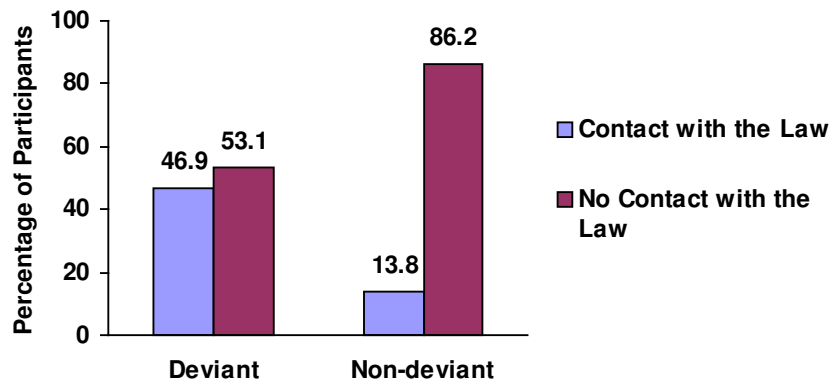


Figure 5.7: Percentage of Respondents who reported Contact with the Law, by Categorisation of Behavioural Deviance

## 5.4 Summary

This section examined the impact of two childhood difficulties – psychiatric diagnosis and categorisation of behavioural deviancy. There was considerable overlap between the two

categories in that over two-thirds of those with a diagnosis were also classified as behaviourally deviant. Educational attainment emerged as important in relation to both indicators. Almost half of those without a diagnosis in Phase One had gone onto third level education in contrast to less than one fifth of those with a diagnosis. Furthermore, over half of those with a diagnosis did not sit their Leaving Certificate examination, in contrast to just over a quarter of individuals without a diagnosis. There was also a significant difference in the age at which the two-groups completed full-time education and whether they had frequently been in trouble at school. There was evidence of economic disadvantage in the families of the diagnosed group in that they were more likely to have been in receipt of state benefits when they were growing up.

Education also emerged as significant in relation to those classified as behaviourally deviant at age eleven. Again, this group was less likely to sit their Leaving Certificate or to go on to Third Level education, and they were more likely to finish their education at an earlier age. Families of these children were more likely to be in receipt of benefits from the state. Finally, those classified as behaviourally deviant at age eleven were more likely to be in trouble with the law at a later stage. To assess the comparative strengths of these factors in relation to educational outcome they were subjected to more detailed analysis. The findings are presented in Chapter 6.

## CHAPTER 6: EDUCATIONAL ATTAINMENT

### 6.1 Introduction

Educational attainment emerged from preliminary analysis as an important variable with wide differentials across groupings and proved to be the most robust outcome measure for the respondents' age and stage of development. In this chapter, the relationship between educational attainment and other study factors is explored further. Bi-variate analysis is used initially to examine the relationship between educational attainment and other, potentially important, variables. For this examination participants were divided into three groups: respondents who had completed part of second level (n=33), those who had completed all of second level but did not go on to third level (n=26) and those who did go on to third level education (n=38)<sup>23</sup>. In the second part of this chapter, log linear models are used in an attempt to develop a predictive model for educational attainment.

### 6.2 Educational Attainment: Descriptive Variables

#### 6.2.1 Personal factors

Somewhat unexpectedly, no significant interaction between educational attainment and gender was identified. However, as noted in the preceding chapter (Chapter 5) this lack of gender difference might be explained by differential gender contact rates. The contact rate between Phase One and Phase Two of the study was 60% for females and just 46% for males. There was a significant association between educational attainment and parenthood in that those respondents who had gone on to third level education were less likely to have children and those who only completed part of second level were more likely to have children ( $\chi^2 = 11.496$ ,  $df = 2$ ,  $p < 0.01$ ). There were no significant differences across the education groups in relation to social network. Another potential source of social support, religious belief, also proved to be non-significant in relation to educational level. The association between education and satisfaction with various aspects of the respondents' lives (work, finances, housing and leisure opportunities) was similarly non-significant. This was also true for self-esteem and locus of control.

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<sup>23</sup> Where expected cell counts fall below five in more than 25% of cells, education level was recoded into two categories (those who had completed all or part of second level (n=59) and those who had gone on to third level (n=38).



### 6.2.2 Employment

The association between current employment status (and job satisfaction) and educational level did not prove to be statistically significant. There were however significant differences between the groups in relation to their current socio-economic grouping ( $\chi^2 = 17.973$ ,  $df = 2$ ,  $p < 0.001$ )<sup>24</sup>. The relationship between education level and socio-economic status is in the expected direction in that those with third level education are likely to be in the professional and managerial socio-economic groups. This is illustrated in Table 6.1. Examination of the mean ranks confirms that a linear trend exists, with those leaving school after only part of the secondary cycle showing the lowest socio-economic status.

Table 6.1: Educational level and participants' socio-economic status

	Second level part		Second level all		Third Level	
	Frequency	%	Frequency	%	Frequency	%
Employers/managers	–	–	–	–	3	8.6
Higher professional	–	–	–	–	1	2.9
Lower professional	–	–	1	4.2	5	14.3
Non-manual	8	28.6	9	37.5	19	54.3
Manual skilled	9	32.1	8	33.3	4	11.4
Semi-skilled	9	32.1	6	25.0	3	8.6
Unskilled	2	7.1	–	–	–	–

### 6.2.3 Psychological Health Status in Phase Two

None of the respondents had received a clinical research diagnosis (based on the SCID assessment) therefore this factor was examined at the level of *likely* diagnosis. There was no significant association between this categorisation of diagnosis and educational attainment. Neither was there a relationship between educational levels and respondents' reports of an emotional problem and/or receiving treatment for psychological problems in the intervening years.

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<sup>24</sup> Ten respondents were not in employment because they were still in full-time education.

### 6.2.4 Contact with the Law

Table 6.2: Educational level and contact with the law

	Second level part		Second level all		Third level	
	Frequency	%	Frequency	%	Frequency	%
Contact with the Law	15	45.5	5	19.2	4	10.5
No contact with the Law	18	54.5	21	80.8	34	89.5

Table 6.2 illustrates the results of an analysis of the relationship between participants' education level and whether they had been in trouble with the law. The significant relationship evident here ( $\chi^2 = 12.151$ ,  $df = 2$ ,  $p < 0.01$ ) reflects the association already detected in the preceding analysis (Chapter 5). It is clear that respondents who completed only part of second level education were more likely to have offended. A significant difference was also found between educational attainment and frequency of involvement with the law ( $\chi^2 = 12.747$ ,  $df = 2$ ,  $p < 0.01$ ). This is illustrated in Table 6.3. Inspection of the mean ranks suggested a linear trend with those completing less education being in trouble more frequently.

Table 6.3: Education level and frequency of contact with the law

	Number of times in contact with the law	
	Mean	SD
Second level part	.91	1.47
Second level all	.31	.68
Third level	.11	.31

## 6.3 Childhood Characteristics and Educational Outcome

In this section factors identified as important in Phase One of the study are examined in relation to educational outcome. These include respondents' and mothers' diagnosis, categorisation of behavioural deviance and respondents' IQ (assessed in Phase One of the study) and economic disadvantage during the respondents' childhoods.

### 6.3.1 Respondents' Psychological Health and Behavioural Status

As indicated in the previous chapter (Chapter 5) a diagnostic categorisation at age eleven proved to be an important indicator of educational outcome. This is further illustrated in

Table 6.4. There was a significant association between educational attainment and this factor ( $\chi^2 = 9.2$ ,  $df = 2$ ,  $p < 0.01$ ).

Table 6.4: Diagnosis (Phase One) and present educational level.

	Diagnosis		No Diagnosis	
	Frequency	%	Frequency	%
Second level part	15	51.7	18	26.5
Second level all	9	31.0	17	25.0
Third level	5	17.2	33	48.5

Almost half of those without a diagnosis went on to third level, in contrast to 17% of those with a diagnosis. A similar trend was evident for those with a deviant categorisation (Table 6.5). A significant difference emerged in relation to educational attainment ( $\chi^2 = 21.9$ ,  $df = 2$ ,  $p < 0.001$ ) between the deviant and the non-deviant group (measured by the Rutter B2 instrument). Two-thirds of those with a behaviourally deviant categorisation on this instrument did not complete second level, compared with 19% of the non-deviant group.

Table 6.5: Behavioural Deviance/Non-deviance (Phase One) & Education Level

	Deviant		Non-Deviant	
	Frequency	%	Frequency	%
Second level part	21	65.6	12	18.5
Second level all	6	18.8	20	30.8
Third level	5	15.6	33	50.8

An examination of the mean ranks for each group suggests that those who had completed part of second level education had a higher number of deviant symptoms than other participants. This finding reflects the outcome of the analysis of educational level and a categorisation of behavioural deviance in Phase One. Inspection of the mean ranks indicated that those who had achieved lower educational levels had higher deviant scores. This is illustrated in Table 6.6<sup>25</sup>.

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<sup>25</sup> The educational level attained by the participants and their score on the Rutter B2 was examined using a non-parametric test as scores based on this instrument are not normally distributed within the sample

Table 6.6: Educational level & Mean/Standard Deviation Scores (Rutter B2 Scale)

	Rutter B2 Scores	
	Mean	SD
Second level part	9.97	7.99
Second level all	6.00	7.25
Third level	2.84	3.87

### 6.3.2 Intellectual Capacity (IQ score)

Table 6.7 below illustrates the mean and standard deviation IQ scores across education levels. There was a significant difference across the groups on IQ assessed in Phase One of the study ( $F_{\text{obs}}(2,86) = 5.565, p < 0.01$ ). Those who entered third level had higher IQ scores than those who had completed either all or part of the second level cycle only.

Table 6.7: Educational Level & Mean and Standard Deviation IQ scores

	IQ score	
	Mean	SD
Second level part	30.78	8.56
Second level all	31.08	11.59
Third level	38.19	7.77

When IQ scores were re-categorised into above and below average (Table 6.8) a significant difference between IQ categorisation and educational outcome was apparent ( $\chi^2 = 15.452, df = 2, p < 0.01$ ). Those with above average IQ were very likely (over 57%) to go on to third level while those (over 51%) with below average IQ tend to leave the educational system without completing second level.

Table 6.8: Educational Level by IQ Categories.

	Above Average IQ		Below Average IQ	
	Frequency	%	Frequency	%
Second level part	10	20.4	22	51.2
Second level all	11	22.4	13	30.2
Third level	28	57.1	8	18.6

### 6.3.3 Mother's Diagnosis

In Phase One of the study mothers' psychological health status proved to have an important association with psychiatric diagnosis in the child. The relationship between results on the

Clinical Psychiatric Instrument (Goldberg et al., 1970) and educational attainment is illustrated in Table 6.9.

Table 6.9: Maternal diagnosis in Phase One and Respondents' Educational level at Phase Two

	No diagnosis		Diagnosis	
	Frequency	%	Frequency	%
Second level part	18	27.7	15	46.9
Second level all	16	24.6	10	31.3
Third level	31	47.7	7	21.9

Despite the importance of the diagnostic variable in Phase One, there was no significant association in this phase of the study between the education level attained at follow-up and whether the mother received a diagnosis of psychiatric disorder in Phase One. However, the trend is in the expected direction in that almost 50% of those with non-diagnosed mothers (in Phase One) went on to third level education. The other assessment of mothers' psychiatric status in Phase One (The Malaise Inventory (Rutter et al 1970)) proved to be similarly non-significant. Educational attainment was also analysed in relation to mothers' treatment for psychological difficulties between the two phases of the study but there was no significant relationship between this and the young person's educational level. Paternal psychological health also proved to be non-significant.

It was not possible to examine the relationship between educational level and parental marital status as the majority of mothers were married in both phases of the study. There were no differences in relation to parental educational attainment. The quality of respondents' relationships with their parents was also examined but no major differences were evident across the groups.

#### **6.3.4 Socio-economic Background**

The socio-economic status of the participants' family of origin is compared across education levels in Table 6.10.

Table 6.10: Educational Level & Family's Socio-economic Status (SES)

	Second level part	Second level all	Third level

	Frequency	%	Frequency	%	Frequency	%
Employers/managers	2	7.4	–	–	6	18.2
Higher professional	–	–	–	–	1	3.0
Lower professional	1	3.7	3	15.0	5	15.2
Non-manual	3	11.1	2	10	4	12.1
Manual skilled	3	11.1	5	25	7	21.2
Semi-skilled	10	37.0	5	25	5	15.2
Unskilled	5	18.5	3	15	2	6.1
Other	3	11.1	2	10	3	9.1
Total	27	100	20	100	33	100

Given the small sample size (n=80) and the large number (eight), of categories in the SES variable it is not surprising that there were no significant differences between the groups. But again, the trend is in the expected direction with 36% of those with third level education coming from families in the Professional categories. An analysis of paternal unemployment (during the respondents' childhoods) produced no significant association. However there was an important difference between the groups in relation to another indicator of economic disadvantage i.e. whether the family was in receipt of state benefits ( $\chi^2 = 15.162$ ,  $df = 2$ ,  $p < 0.01$ ). This data is contained in Table 6.11.

Table 6.11: Educational Level & Family in receipt of State Benefits

	Received state benefits		Did not receive state benefits	
	Frequency	%	Frequency	%
Second level part	16	55.2	11	21.6
Second level all	9	31.0	11	21.6
Third level	4	13.8	29	56.9

Respondents from families who received state benefits completed only part of second level while those from families not in receipt of state benefits were more likely to go onto third level. To assess the impact of disadvantage further, the Index of Poverty used in Phase One of the study was examined for each family and the results are illustrated in Table 6.12 below.

Table 6.12: Educational Level & Poverty Indicators (Phase One)

	Mode for Poverty Index
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Second level part	6.00
Second level all	7.00
Third level	8.00

As Table 6.12 demonstrates, there was a significant difference across the groups on this measure of poverty ( $\chi^2 = 10.950$ ,  $df = 2$ ,  $p < 0.01$ ). Inspection of the mean ranks indicated that those who had completed more education had higher scores on this scale, indicating less poverty at Phase One. In developing the predictive model in the following section, receipt of state benefits is included as the most robust indicator of socio-economic status.

#### **6.4 A Predictive Model of Educational Attainment.**

The two-way analyses above identified four factors from Phase One of the study as statistically related to educational attainment. These factors were: The family being in receipt of state benefit, Respondents' IQ categorisation, Diagnosis and Categorisation of deviancy. In addition, three of the four factors (Diagnosis, Deviancy and Receipt of Benefits) proved to be interrelated in that respondents with a diagnosis tend to have a deviant categorisation (on the Rutter B2 Scale) and come from families who were in receipt of state benefits. The respondents' IQ categorisation was independent of the other three variables. A predictive model for educational attainment was developed, based on these key variables, using Log Linear and Logit Models<sup>26</sup>.

##### **6.4.1 Loglinear Saturated Model**

Saturated models contain all possible effect parameters, that is, all individual effects of the independent variables and all interaction effects. A fully saturated model is therefore a perfect representation of the data. Thereafter effects with small estimated values can be deleted. This process was completed for all study variables and the findings are illustrated in Table 6.13.

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<sup>26</sup> These models are used when independent and dependent variables are categorical. In a logit model the value of the dependent variable is based upon the 'log odds'. It is the variation of this measure which is explained by the independent variables. In the present analysis, the dependent variable is educational attainment and the independent variables are: Family in Receipt of State benefit, IQ categorisation, Behavioural Deviance and Presence of a Psychiatric Diagnosis. The sample size is reduced to 76 when the five variables are considered simultaneously.

Table 6.13: Main Parameter Estimates for Saturated Logit Model

Variables	Coefficient	Standard Error	Z-Value
<b>Main Effects</b>			
Education level (E) 1	.22499	.19	1.158
2	-.1769	.21	-.815
Deviance (U) 3	.42236	.19	2.174
4	-.21542	.21	-.993
Receipt of state benefits (R) 5	.28875	.19	1.49
6	.07358	.22	.339
Diagnosis (D) 7	-.1686	.19	-.868
8	-.0487	.21	-.225
IQ Categories (I) 9	.3566	.194	1.836
10	.0186	.216	.0857
<b>First Order Interaction Effects</b>			
E by U by R 11	-.0147	.19	-.0757
12	-.078	.21	-.3600
E by U by D 13	.0712	.19	.367
14	-.1724	.21	-.794
E by U by I 15	-.0265	.19	-.1365
16	.2234	.21	-1.030
E by R by D 17	-.0559	.19	-.287
18	-.0239	.21	-.110
E by R by I 19	.002	.19	-.010
20	-.086	.21	-.398
E by D by I 21	.0055	.19	.028
22	.0616	.21	.284
Number of Cases = 76			
Goodness-of-Fit test statistics			
Likelihood Ratio Chi Square = .00000; DF = 0, P = 1.000			
Pearson Chi Square = .00000; DF = 0, P = 1.000			

The direct effect of three independent variables, categorisation of deviance, family in receipt of State benefits and IQ level emerged as important. Psychiatric diagnosis did not provide any additional explanatory power and was therefore eliminated from the analysis.



### 6.4.2 Loglinear Unsaturated Model

Table 6.14: Parameter Estimates for Specified Logit Model

Variables	Coefficient	Standard Error	Z-Value
Main Effects			
Education level (E) 1	.3471	.213	1.626
2	-.1821	.253	-.718
Deviance (U) 3	.6316	.205	3.07
4	-.3697	.247	-1.49
Receipt of state benefits (R) 5	.3813	.205	1.86
6	.1973	.200	.982
IQ Categories (I) 9	.3625	.201	1.796
10	.1405	.190	.736
Goodness-of-Fit test statistics			
Likelihood Ratio Chi Square = 8.73531; DF = 8, P = 0.365			
Pearson Chi Square = 6.52279; DF = 8, P = 0.589			

At this stage various unsaturated models were tested. Independent variables and interaction effects, which have large estimated values (Coefficient and Z-Value) form the basis of the unsaturated model presented below (Table 6.14). Inspection of the Coefficients and the Z-values indicate that the categorisation of behavioural deviance has a slightly stronger influence than family in receipt of State benefits or IQ categorisation. The results of the analysis are summarised in Table 6.15.

Table 6.15: Log Linear Model: Categorisation of Deviance, Family in receipt of State Benefit, and IQ categorisation, by Level of Education achieved

			Partial Second Level	Complete Second Level	Third Level
Deviant	State Benefit – Yes	IQ Below A	85%	12%	3%
		IQ Above A	69%	16%	15%
	State Benefit – No	IQ Below A	68%	14%	18%
		IQ Above A	35%	11%	53%
		IQ Below A	43%	46%	10%

Non-Deviant	State Benefit – Yes	IQ Above A	25%	42%	33%
	State Benefit – No	IQ Below A	24%	37%	39%
		IQ Above A	8%	19%	72%

As Table 6.15 illustrates, respondent's categorisation of deviance, family in receipt of State benefits and IQ all have a significant, independent, direct effect on educational achievement and these differences are clearly evident at all three levels of education. Eighty-five percent of respondents who were classified as behaviourally deviant, whose family were in receipt of state benefits during their childhood, and who were below average in IQ, did not complete second level education. Conversely, only 8% of those outside these categories failed to complete second level schooling. Overall, all non-deviant sub-categories are less likely to leave school without completing second level education. The differences in relation to third level education are stark. Eighty-five percent of the deviant group who were in receipt of benefits and with a below average IQ did not complete second level in comparison to 43% of non-deviant respondents who had similar attributes (i.e. below average IQ and family in receipt of state benefits). A categorisation of deviancy therefore, assessed at age eleven, is a very sensitive predictor of educational attainment.

Two other factors, family in receipt of state benefit and IQ categorisation, also have significant predictive powers, but are somewhat less important than a deviant classification. Respondents with below average IQ are less likely than those with above average IQ to pursue third level education. Those groups in receipt of state benefit are more likely to leave the educational system without completing second level. However, those in receipt of state benefit with above average IQ present a similar pattern of educational attainment as those with a below average IQ but with families not in receipt of state benefit. This finding indicates that socio-economic advantage can benefit individuals educationally. A similar pattern is evident for both the deviant and non-deviant groups but the deviant group is less likely to complete second level and go on to third level education.

### 6.5 Summary

This section explored the relationship between educational attainment and factors which emerged as important from preceding analyses. Neither gender nor current mental health status proved to be important in relation to educational attainment. However socio-economic

status, based on current employment, was strongly associated with educational outcome. So also was involvement with the law.

Despite the importance of maternal diagnosis when the children were aged eleven, there was no significant relationship between this variable and educational attainment. There was an important association however between educational level and a diagnosis of psychiatric disorder and/or categorisation of behavioural deviance for the child. A significant relationship was also evident between respondents' IQ and educational outcome. The socio-economic categorisation of the family of origin did not prove to be important but another indicator of economic disadvantage, receipt of state benefits, was significantly related to educational outcome.

Four factors assessed in Phase One of the study (diagnosis, behavioural deviancy, IQ and family in receipt of state benefits) were identified as key to understanding educational outcome. When subjected to multivariate statistical techniques categorisation of deviance, IQ and family in receipt of state benefits all proved to have a significant, independent and direct effect on educational achievement. In particular, a categorisation of deviance, assessed at age eleven, proved to be an extremely sensitive predictor of educational attainment. IQ proved to be important in terms of educational attainment but this was associated with economic factors. Specifically, socio-economic advantage clearly benefits individuals in accessing third level education.

## **CHAPTER 7: DISCUSSION AND CONCLUSIONS**

This investigation was longitudinal in nature, and focused on a group of children and their families, at two points in time. The first phase of the study, conducted in 1990 on a sample of 185 children, concluded that 16% of children and approximately one-third of mothers showed evidence of formal psychiatric diagnosis. Childhood diagnosis was related to maternal mental health and to the economic circumstances of the family. Maternal psychological status was similarly associated with economic factors as well as dissatisfaction with marital and parenting roles and social isolation.

The second phase of the research, on which this report is based, includes ninety-seven young people who were successfully contacted and interviewed for the study. Eighty mothers were also re-interviewed. The aim of the study was to investigate a range of psycho-social outcomes for these young people and to relate those outcomes to factors identified as important in the first stage of the study. The relevant factors included respondents' diagnosis, behavioural deviancy, IQ score, maternal psychiatric diagnosis and the economic circumstances of the family. The psycho-social outcomes of interest in the young adult group included psychological adjustment, educational and employment status, involvement in crime and alcohol and drug use. Mothers were interviewed to re-assess their mental health status and to provide information on family circumstances during the participants' childhood and adolescence.

### **7.1 Social Development and Family Background**

The mean age of the participants was twenty-one years and the majority in both phases of the study were male but gender was more evenly distributed in the present phase. They were largely homogeneous in terms of area of residence, accommodation type (over three-quarters still living in the parental home) and marital status (primarily single). Approximately one-fifth now had children. Almost all of the participants had been raised in the family home by both parents and they appeared, in general, to have good relationships with their parents. The participants were predominantly from semi-skilled manual backgrounds and only two parents had a third level qualification. A fifth of mothers reported severe financial hardship during the participant's childhood. There was wide variation in relation to educational attainment. Approximately one-third had not completed second level education. While females remained in the educational system for longer, gender differences were non-significant. Almost three-quarters of the sample were in employment, the majority being reasonably satisfied with their life and work situations. Religious observance was low yet over three-quarters of participants

professed to believe in God and 40% regarded religion as important in their lives. Almost one-quarter of those interviewed, three-quarters of whom were male, had had some contact with the police but this was mainly for minor offences, and none of the respondents had been in prison. Overall, the profile of the participants' lives which emerged from the study was one of economic and social stability.

## **7.2 Health and Well-Being**

There was no evidence of serious psychiatric disorder and only a small percentage of the group were receiving treatment for psychological difficulties. However, an assessment of psychological health status indicated a not insignificant level of symptoms, below diagnostic level. The prevalence for clinical level disorder is lower than that found in another Irish study of a similar population and may reflect differences in assessment methods (Lawlor & James, 2000). The most common symptoms were anxiety-related and the only significant gender variations related to alcohol misuse with males predominating. Alcohol consumption was high, especially amongst males respondents, and participants tended to underestimate their level of alcohol use. Respondents demonstrated adequate levels of self-esteem and locus of control and appeared to be well integrated socially as well as having sources of intimacy and affirmation. However, as in Lawlor and James's (2000) study, males were less likely to confide in others.

It is of interest that participants, including those with a psychiatric disorder at age eleven, came across as well-adjusted, psychologically healthy and competent individuals. This is in line with the majority of longitudinal studies which demonstrate, in general, a successful transition to adulthood for most individuals (Rutter, 1989). The generally positive results relating to psychological health must however be considered in terms of the possible bias that may have arisen due to sample attrition. Twenty percent of the young people could not be located and a further 21% refused to participate in the current phase of the study. As is the case with all longitudinal studies, respondents who participated in this phase may not be representative of the original sample and might be characteristic of those with the most favourable outcomes. There are some reasons for believing this might be the case.

A comparison of respondents and non-respondents revealed significantly higher levels of psychological and behavioural dysfunction among the untraced group (but not refusals) at age eleven. Almost 50% of the original sample of children who were judged vulnerable because of psychiatric disorder and/or behavioural deviance at age eleven were lost to follow-up. A small number of individuals from the original sample were not contactable because they were no longer in communication with their families. In most cases neither the young people nor their families could be traced, despite extensive inquiries, including the accession of public

housing records. Thus, psychiatric morbidity and/or behavioural deviancy identifies a mobile group, either of the young people or of their families (or both). Additional analysis carried out for the study suggests that this untraced group may be more vulnerable than study participants. Non-contacts had considerably higher rates of offending than study participants (and refusals) in the intervening years.

### **7.3 Maternal Health & Child Well-being**

Mothers' psychological health was identified in Phase One as importantly associated with childhood mental health. Then, almost a third of the mothers interviewed were diagnosed with a psychiatric disorder. Now mothers were generally healthy with no evidence of clinical-level disorder and treatment levels in the intervening years were similar for all mothers. Again, in contrast to Phase One of the study, mothers were satisfied with their marital and parenting roles. The association between maternal and child mental health is not apparent in this phase of the research which disputes a fairly consistent finding in the literature (Downey & Coyne, 1990; Weissman, Warner, Wickramaratne, Moreau & Olfson, 1997). Both adult depressive conditions and childhood psychiatric diagnosis and/or behavioural deviancy have been considered as conditions which tend to persist. The present study shows this not to be the case. Of the 50% of vulnerable children identified at Phase One and interviewed for this stage of the study the majority were doing better than might have been predicted. Mothers had similarly recovered and had not required more intensive psychiatric care in the intervening years.

This discrepancy could be due to methodological differences in that many studies concentrate on patient groups and focus exclusively on psychological outcomes (Weissman et al 1997). In this research sampling was based on random selection and other outcomes, such as educational attainment, were included. The findings reflect other longitudinal examinations of maternal/child interactions which suggest that maladaptive outcomes in children are dependent on the nature of the mother's illness, her environment and outcomes examined in the child. The life-stage which includes the care of young children is a potentially stressful phase for women (Brown & Harris, 1978; Cleary, 1997a; Christoffersen, 2000). The mothers in this study were, when assessed in Phase One, almost all full-time mothers and many were restricted (some severely) by lack of money and support. These results point to the transience of much psychiatric symptomatology amongst the general, female, population, the origins of which are often more social than biopsychiatric (Cleary, 1997b). There may be some support here for the view that the relationship between maternal and child well-being is more reciprocal than previously considered (Naerde, Tambs & Mathiesen 2002; Conrad & Hammen 1989). Mothers of children with behavioural problems experience considerable

stress and at least some of the disorder seen in the mothers of ten years ago may have resulted from the strain of coping with this.

Yet, maternal psychological health did have an affect on the child's later life in that the educational attainment of children whose mother had a psychiatric disorder in Phase One were less likely to be successful educationally. And, of course the same proviso, cited above, is relevant here also in that the healthiest individuals (and their mothers) from the original sample may have been included in the present study.

#### **7.4 Childhood Behavioural Problems**

There was a good degree of overlap, as expected, between behavioural deviance and psychiatric diagnosis. None of the respondents showed evidence of current clinical level disorder and there were few differences in relation to current symptoms between the two groupings. However the deviant/diagnosed group were more likely to leave school early and less likely to go on to third level education. Approximately half of the non-disordered had gone on to third level education in contrast to less than a fifth of the categorised groups. They also differed significantly in relation to their school experiences. The diagnosed/deviant group were more likely to offend against the law and were more probably from an economically deprived background.

Early behavioural problems have been cited as one of the strongest predictors of later problems, including educational underachievement, and there is support for this in the present study. Fergusson and Horwood (1998) and Rutter (1989) have described the cycle of disadvantage set in motion by early behavioural problems. Disruptive behaviour makes it more likely that there will be an early exit from school and the individual is then less likely to attain a stable occupational status. Fergusson and Lynskey's (1998) and Kolvin et al's (1990) findings that young people with conduct disorders have higher rates of juvenile offending are reflected in this study. And, as in Olin et al's (1998) research, teacher's assessments of behaviour have good predictive value in identifying children at risk at an early stage.

#### **7.5 Behavioural Deviance, Economic Disadvantage and Educational Outcome**

Educational attainment emerged in this study as the strongest outcome variable. Mental health status and offending against the law demonstrated weaker associations. There were few gender differences except for a relationship between parenthood in females and less favourable educational outcome which supports existing findings (NESF, 1997; McCashin, 2000). Early school leavers were more likely to have offended against the law. Socio-economic status was strongly associated with educational achievement and economic disadvantage (the most sensitive measure of which was receipt of state benefits) predicted

lower educational attainment. This reflects the findings from other longitudinal studies (Kolvin et al., 1990). Mother's mental health was unrelated to educational outcome. Four variables emerged from the analysis as key to understanding outcome in terms of educational attainment. These factors, economic disadvantage, categorisation of deviancy, and another assessment of childhood functioning, IQ, all proved to have significant, independent, and direct effects on educational outcome. Thus, respondents with a categorisation of behavioural deviancy were less likely overall to be successful educationally but this likelihood increased with the accumulation of risk factors. Individuals with this classification from a disadvantaged background (i.e. family in receipt of state benefits) and a lower than average IQ were highly unlikely to complete second level schooling, in marked contrast to those participants who were not in any of the categories. IQ was important but was associated with the presence or absence of economic disadvantage. Thus respondents with an average IQ, without a deviant classification and with no evidence of economic disadvantage in their background were twice as likely to complete second level as those disadvantaged individuals with a deviant categorisation. At third level, economic factors had an even greater impact with better off individuals much more likely to reach this level than disadvantaged participants, even with similar IQ levels.

This link between economic disadvantage and educational outcome has been similarly identified in two recent studies of the Irish educational system (Hayes & Kernan, 2001; Clancy, 2001). Hayes and Kernan's (2001) work highlights the early emergence of educational inequities along socio-economic grounds and Clancy's (2001) study demonstrated the impact of these inequalities on third level access. Lower socio-economic groupings are significantly underrepresented in the third level educational sector. This study reflects Clancy's finding that middle-class students, even when educationally less able, are more likely to reach third level than individuals from other social categories.

## **7.6 Conclusions**

In this follow-up study of young people the relatively high prevalence of psychiatric disorder and behavioural deviancy, evident ten years previously proved, in general, to be transitory and without any long-term psychological impact. Similarly, mothers previously diagnosed as suffering from psychological problems had now recovered and the absence of disorder raises the possibility that at least some of the complaints seen in the mothers of disturbed children may have resulted from the stress of coping with this disturbance. The results imply a lack of association between maternal mental disorder and long-term psychological difficulties in the child. Whether the non-contactable group were similar or dissimilar in outcome can only be speculative. There is a possibility that the untraced group might exhibit more negative



outcomes than the present sample and thus would have altered the relatively healthy psychological and social profile presented by the study participants.

Yet the findings of this study clearly indicate that behavioural problems in the child do have long-term effects. Behavioural deviancy in childhood impairs individuals in terms of educational achievement and this situation is exacerbated in the context of economic disadvantage. Early behavioural difficulties are signalled here as key to understanding outcome especially educational attainment. Economic factors and IQ also have significant predictive powers although they are somewhat less important than the classification of deviancy. Economic factors are more essential than intellectual capacity in terms of educational attainment. The trajectory of the student with behavioural problems from a disadvantaged background, with possible learning difficulties, falling through the educational net is apparent here (Miech et al., 1999). This finding is reinforced by the likely possibility that had all of the original sample been included, the impact of behavioural problems would probably have been even greater.

The children interviewed for this study have benefited from the economic prosperity and widening educational opportunities available to them as they grew to adulthood. However the link between economic and educational disadvantage, especially for at risk groups, along with the shadow cast by a possibly more vulnerable group of untraced individuals, implies that inequities remain. In the light of these findings it may be opportune to re-focus on the role of economic disadvantage in the development and prolongation of behavioural difficulties in the child.

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## **APPENDIX 1**

### ***Structured Clinical Interview for DSM-IV Axis I Diagnoses (SCID)***

The SCID (First et al., 1996) is a semi-structured clinical interview, which permits categorisation into DSM-IV diagnoses. The instrument covers the major areas of psychopathology: Mood Disorders, Anxiety Disorder, Substance Use Disorders, Psychotic Symptoms, Somatoform Disorder and Eating Disorders. In this study, a computer-administered screening version of the SCID [Referred to as the SSPQ-X or SCID Screening Patient Questionnaire Extended Program for Windows (First, Gibbon, Williams & Spitzer, 1999)] was used. The schedule contains 497 questions, although fewer questions are usually administered, as there is an automatic branching program that skips questions if a patient reports not having certain symptoms. The length of time taken to complete the schedule varies from 20-40 minutes. The SSPQ-X was administered to the participants using a Laptop Computer. Questions were read aloud to the respondent as they appeared on-screen and the answers entered by the interviewer simultaneously onto the computer. Training for the SCID was provided by a psychiatrist (M.F.) who also monitored the interviews and the completed schedules. The programme provides three report options: complete summary of patient responses, concise summary of possible diagnoses, and long summary of diagnoses. When the computer analysis was completed, the computer-generated diagnoses were checked by M.F. and another psychiatrist familiar with the instrument. The final diagnosis was based on their assessment plus the computer-generated results.

### ***Beck Scale for Suicide Ideation (BSSI)***

The BSSI (Beck & Steer, 1991) is a 21-item instrument that is used to detect and measure the severity of suicidal ideation in adults and adolescents. Each item consists of three statements scaled from 0 to 2 points, reflecting increasing gradations of the severity of suicide ideation. The first 19 items measure various facets of suicide ideation: the wish to live, the wish to die, reasons for living or dying, frequency and duration of suicidal ideation, and active suicidal behaviour. The first five items act as a screening instrument, and only those respondents who have contemplated suicide attempts are administered the remaining questionnaire. The severity of suicidal ideation is calculated by summing the ratings for the various items. The total BSSI score can range from 0 to 38 points.

### ***Rosenberg's Self-esteem Scale***

This is a ten-item scale developed to provide a uni-dimensional measure of global self-regard, or self-esteem (Rosenberg, 1965). Responses to the items are reported along a four-point scale, ranging from strongly agree, agree, disagree, to strongly disagree. Responses can be scored using a simple summing scale or as an agree/disagree dichotomy. Test-retest reliabilities have been reported to range from 0.85 (Silber & Tippett, 1965) to 0.92 (Rosenberg, 1965), while internal consistency coefficients ranging from 0.72 (Rosenberg, 1965) to 0.74 (Ward 1977) have been reported.

### ***Arizona Social Support Interview Schedule (ASSIS)***

The Arizona Social Support Interview Schedule (Barrera, 1980) was developed to measure available and utilised network size, and also satisfaction with, and need for, support. Six aspects of support are included: private feelings, material aid, advice, positive feedback, physical assistance, and social participation. For each of the support functions, respondents are asked to name those individuals who are perceived as being available to provide each of the support functions (perceived network size) as well as those who have *actually* provided support. Satisfaction for each type of support is rated on a 7 - point scale and need is rated on a 5-point scale. Negative interaction (conflict network) is also measured in that interviewees are asked to name individuals who make them angry or upset. The instrument has been tested for reliability and results have revealed moderately satisfactory to good reliability (Bowling, 1991). Test-retest reliabilities range from 0.88 over three days to 0.70 over a period of one month (Barrera, 1980; Valdenegro & Barrera, 1983). Internal consistency reliabilities for support satisfaction and support need are lower: from 0.33 to 0.52.

### ***Locus of Control***

Locus of control was measured using a 7-item scale developed by Pearlin et al. (1981). A score of 0, the lowest score possible, indicates that the person feels they have no control over what happens in their life (an external locus of control). Conversely, a maximum score of 21 indicates that the person feels in full control of events in their life (an internal locus of control).

## APPENDIX 2

### Frequency of SCID Diagnostic Categories<sup>27</sup>

Diagnostic SCID Categories	Frequency	Percent
<b>Anxiety-related Disorder: Total</b>	37	38.1
<b>Subcategories:</b>		
Obsessive Compulsive Disorder	14	14.4
Agoraphobic Avoidance	12	12.4
Panic	5	5.2
Specific Phobia	10	10.3
Post-Traumatic Stress Disorder	6	6.2
Social Phobia	8	8.2
Current Generalised Anxiety Disorder	6	6.2
<b>Mood Disorder: Total</b>	14	14.4
<b>Subcategories:</b>		
Depressive Episode	6	6.2
Dysthymic Disorder	2	2.1
Hypomanic Episode	3	3.1
<b>Substance Related Disorder: Total</b>	53	54.6
<b>Subcategories:</b>		
Alcohol Abuse	29	29.9
Alcohol Dependence	21	21.6
Hallucinogenic Abuse	2	2.1
Hallucinogenic Dependence	1	1.0
Cannabis Abuse	1	1.0
Cannabis Dependence	8	8.2
Cocaine Abuse	1	1.0
Cocaine Dependence	-	-
Opioid Abuse	-	-
Opioid Dependence	1	1.0
<b>Eating Disorder: Total</b>	4	4.1
<b>Subcategories:</b>		
Anorexia Nervosa	3	3.1
Bulimia Nervosa	3	3.1

<sup>27</sup> The sum of the diagnoses within the subcategories may not add up to the overall total for a category as some individuals may have presented with a likely diagnosis for more than one disorder within a category.