

IRISH FAMILIES UNDER STRESS

VOLUME 1

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CONTENTS

Section 1 - Epidemiology

PREFACE: Michael Walsh

- 1) Introduction - Michael Fitzgerald.

- 2) The Prevalence of Child Psychiatric Disorder in 10 and 11 year old boys
in an Urban Area.
Kieran Lynch Michael Fitzgerald Anthony Kinsella

- 3) The Incidence of Major Depressive Disorders in Children attending a Child
Guidance Clinic.
Helen Leader Michael Fitzgerald Anthony Kinsella

- 4) A Study of Behavioural Deviance in 10 and 11 year old Irish School Girls
in an Urban Area.
Yvonne Barton Michael Fitzgerald

- 5) Behavioural Deviance in an Irish Urban and Rural Town Sample.
Michael Fitzgerald Anthony Kinsella

- 6) An Epidemiological Study of Behavioural Deviance, Hyperactivity and Physical
Abnormalities in a Dublin Primary School Population.
Michael O'Rourke Michael Fitzgerald

- 7) A Psychosocial and Educational Study of Travellers Children.
Michael Fitzgerald Anne Pritchard Anthony Kinsella

- 8) A Study of Behavioural Deviance and Social Difficulties in 11 and 12 year
old School Children.
Deirdre Stone Michael Fitzgerald Anthony Kinsella

- 9) Self-Esteem and Behavioural Deviance in Child Populations.
Mary Murphy Michael Fitzgerald Lourda Fitzpatrick Anthony Kinsella
- 10) A Study of Emotions and Behaviour in Children Attending a Normal School in an Urban Area.
Mary Murphy Michael Fitzgerald Anthony Kinsella Mark Cullen
- 11) A Study of Behavioural Deviance and Social Competence in Children of Psychiatric In-Patient Females.
Zubie O'Leary Michael Fitzgerald Mary Naidu
- 12) Maternal Mental Health - Childhood Behaviour Problems and Social Disadvantage in Families of Children Attending a Child Guidance Clinic.
Fergus McNestry Michael Fitzgerald Anthony Kinsella
- 13) The Prevalence of Sleep Related Disorders and Bed-Wetting in Children Attending a Public Health Clinic.
Vinny Kapoor Michael O'Rourke Michael Fitzgerald
- 14) Psychological Distress and Attitude to Authority in a Sample of Irish Adolescents.
Hugh Williams Michael Fitzgerald Anthony Kinsella
- 15) Childhood Behaviour Problems and Maternal Depression in General Practice.
Diana Day-Cody Michael Fitzgerald
- 16) A Community Based Study of Unmarried and Married Mothers.
Katherine McDonnell Michael Fitzgerald
- 17) Marital Adjustment and Behaviour Problems in Children.
Clare Lucey Michael Fitzgerald

Pat. L. L.

18) A Study of Relationships between the Home Environment and Psychiatric Symptoms
in Children and Parents.

David Mulhall

Michael Fitzgerald

Anthony Kinsella

19) A Study of Temperamental Characteristics in Children.

Patrice Murphy

Michael Fitzgerald

20) Life Events and Psychiatric Referral in Children: Comparison with the
General Population.

Enda Dooley

Michael Fitzgerald

Section 2 - Psychotherapy

21) Why Psychotherapy?

Michael Fitzgerald

22) The Technique of Analytic Psychotherapy.

Michael Fitzgerald

23) The Effectiveness of Psychotherapy.

Michael Fitzgerald

24) Supervision of Trainee Therapists.

Michael Fitzgerald

25) The Balint Group in General Practice.

Michael Fitzgerald

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PREFACE

Michael Walsh

Programme Manager, Special Hospital Care Program, Eastern Health Board

Since his appointment as Child Psychiatrist with the Eastern Health Board in 1981 Dr. Michael Fitzgerald had made a major contribution to research in the various aspects of child psychiatry and behavioural problems in society in general, in addition to his clinical commitments. Dr. Fitzgerald's work in this area was very evident to me during my recent involvement in the Working Party on Child Psychiatry when almost all published resource/research material available was produced by Dr. Fitzgerald and his team.

This work is invaluable in the planning and delivery of child psychiatric services and social services generally. It provides a very effective mechanism for service evaluation, and is a very important element in the training of medical and paramedical staff.

It has been my pleasure to facilitate Dr. Fitzgerald in every possible way in this very important work and it is my desire to continue to do so in the years ahead.

INTRODUCTION

M. Fitzgerald

In his address to the Irish Division of the Royal College of Psychiatrists in November 1990, the President, Professor A. Simms emphasized to Irish psychiatrists the importance of conducting local epidemiological studies and of developing non-medical aspects of psychiatry. There is little doubt that Professor Simms was correct in his advice to Irish psychiatrists. This volume focusses on precisely the two areas regarded by Professor Simms as being of critical importance for Irish psychiatry in 1990's.

Epidemiological studies are of equal importance to planners, politicians and psychiatrists as well as psychologists, social workers and nursing personnel. Studies of psychosocial risk give us a better understanding of the nature and origin of different forms of psychiatric disorder. The rates of psychiatric disorder in Ireland are broadly similar to the United Kingdom e.g. autism and child psychiatric disorder. In a screening study, Fitzgerald M., Jeffers A. (1991) of over 2,000 urban Irish children, 20% of the boys and 11% of the girls showed evidence of behaviour problems. In the Eastern Health Board, the rate of autism was found to be 4/10,000. The Department Of Health Report (1984) Planning for the Future put considerable emphasis on the use of psychotherapy in out-patient clinics, day care services and in primary care. Professor Webb (1986) also stressed the importance of training in dynamic and behavioural psychotherapy. The behaviour therapy training for nurses in the Eastern Health Board is also of considerable importance. It is important that psychiatric registrars in training do not lag behind as regards psychotherapy training. Research has shown that psychotherapy is more effective than placebo and more effective than no treatment. There is still controversy about the cost benefit of psychotherapy. Vischi (1979) concluded that the effect of psychotherapy was to reduce the use of medical services by about 20%. It is critical now that a balance is found between the biological, social and psychotherapeutic approaches to psychiatric problems. It is also important that research efforts matches therapeutic efforts in psychiatry and that clinicians make use of research findings.

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**THE PREVALENCE OF CHILD PSYCHIATRIC DISORDER
IN 10 AND 11 YEAR OLD BOYS IN AN URBAN SCHOOL**

Kieran Lynch
Michael Fitzgerald
Anthony Kinsella

Summary

The total population of 10 and 11 year old boys in an urban primary school were studied using accepted questionnaire and interview methods. The prevalence of child psychiatric disorder was found to be 18.6%.

Introduction

Studies to determine the percentage of children in the community who have psychiatric disorder have varied considerably. Most investigations in the United Kingdom have suggested that between 5% and 18% of children have psychiatric disorder (Rutter et al, 1975). The few epidemiological screening studies on child psychiatric disorders carried out in Ireland so far have shown higher rates than in the United Kingdom (Leader, 1985; O'Rourke, 1985; Barton, 1985). As Ireland is a country with a high population and a developing child psychiatric service, accurate epidemiological information is essential to assess the need for services, to determine whether particular disorders are becoming more or less common, to establish age or sex differences in prevalence and to study casual processes.

Method

The research strategy used in this study was based on earlier surveys on the Isle of Wight. Psychiatric disorder was rated as present when, considered in relation to the process of the child's psychic development, abnormalities of behaviour, emotions or relationships were sufficiently marked and sufficiently prolonged to be causing persistent suffering or handicap in the child himself or distress or disturbance in the family or community, which was continuing up to the time of assessment.

The population studied were all 10 and 11 year old boys attending a primary school in an urban working class area. The sample size was 45. Children aged 10 and 11 were selected as the population for study, because the reliability and validity of psychiatric and psychological measures had already been established for this age group, and because it had been found that this was an appropriate age for studying the disorders in which we were interested (Rutter, 1970).

After permission was obtained from the school manager the roll book was examined and the names and addresses of all boys born in 1975 and 1976 were noted. The parents were contacted by letter and asked to take part in the study and to complete the enclosed Parent Questionnaires. 23 parents (51%) returned the questionnaire following the first request. 20 of the 22 remaining parents returned the complete questionnaire following a second request. 2 parents refused to take part in the study.

The teachers were then approached and asked to complete the Teacher Questionnaire. All 45 questionnaires were completed. Over the next six months the 43 children for whom permission had been obtained were interviewed in the school and the parents, mostly the mother, were interviewed at home.

The method of identification of children with psychiatric disorder was by means of the teacher and parent questionnaires, parental interview and psychiatric interview with the child.

The Teacher Questionnaire (Rutter Scale B₂) was in the form of 26 descriptions of behaviour against which the teacher was asked to indicate whether each description does "not apply", "applies somewhat", or "definitely applies" to the child in question. Each item is scored 0, 1 or 2 depending on the frequency with which the behaviour occurs. The cut-off point for this scale is 9. Depending on the score the scale was also rated mild, moderate or marked disturbance (Rutter, 1967).

The Parents' Questionnaire (Rutter Scale A₂) had 31 items, 23 of which are identical to those on the teachers questionnaire. The cut-off point on the Parent Scale is 13. These were also rated mild, moderate or marked disturbance depending on the score.

A separate Neurotic and Anti-social score is obtained from Scale A₂ and Scale B₂ and whichever score is higher determines how the child will be described. If the neurotic and anti-social scores are the same the child is regarded as being undifferentiated, having a mixed disorder of conduct and emotions.

Both questionnaires have been standardised for children of this age in the Isle of Wight and in London. The scales have been shown to have satisfactory reliability and validity (Rutter, 1970).

Parental Interview

One or both parents were interviewed by a Psychiatrist using the "modified interview with the parent". Initially the parent was asked whether she felt her child had any problems of behaviour or any nervous problems. If she mentioned any difficulties her view of them was obtained and a detailed description of the symptoms was obtained. The parent was then systematically asked about 36 areas of the child's behaviour, emotions and social relationships.

On completion the interview schedule was rated as showing no abnormality, dubious abnormality, slight definite abnormality, moderate abnormality or marked abnormality. The type of abnormality was also noted. The modified interview with the parent has been shown to be a most useful and reliable clinical tool in the assessment of child psychiatric disorder (Graham and Rutter, 1968).

Psychiatric Interview With The Child

The interview with the child was carried out by a psychiatrist (K.L.) in the school. The child was seen on his own. The first part of the interview was unstructured, the aim being to get the child relaxed and talking freely. The child was then asked more systematically about his life and activities outside the school, and the presence of psychiatric symptoms. The child's persistence in carrying out tasks and his degree of distractibility were also noted and scored. The interview was then rated as showing no abnormality, moderate abnormality or marked abnormality. The type of abnormality

Studies have shown that the short psychiatric interview with the child is a reasonably sensitive diagnostic instrument which gives rise to reliable and valid judgement on whether the child is exhibiting any psychiatric disorder (Rutter et al, 1970).

Inter-Rater Reliability

1 in 10 of the children were assessed by two psychiatrists (K.L. and M.F.). Although there were differences in their ratings of individual items there was total agreement in their overall judgement of the psychiatric state and the type of abnormality present (correlation coefficient of 1.0).

Results

Parent Questionnaire

On the Parent Questionnaire 18 children were above the cut-off point of 13. This gives a behavioural deviance rate of 41.8%. Eleven (25.5%) showed mild abnormality. Six (13.9%) showed moderate abnormality and 1 (2.3%) showed severe abnormality. (See Table 1).

TABLE 1
Parents' Questionnaire (Rutter Scale A)

N = 43			
Score		Number	Percentage
0 - 12	No Abnormality	25	58.2
13 - 20	Slight Abnormality	11	25.5
21 - 30	Moderate Abnormality	6	13.9
31 -	Marked Abnormality	1	2.3

} 41.8

Teacher Questionnaire

On the Teacher Questionnaire 16 out of 45 were above the cut-off point of 9. This shows a behavioural deviance rate of 35.5%. Ten (22.2%) showed mild abnormality, 2 (4.4%) showed moderate abnormality and 4 (8.8%) showed severe abnormality. (See Table 2).

Parental Interview

Following interview with the parents 10 out of 43 children were judged to be definitely disturbed. This shows a prevalence rate of disturbance of 23.2%. 6 (13.9%) were judged to have mild disturbance and 4 (9.3%) were judged to have moderate disturbance. Of the 10 disturbed children 7 showed a mixed conduct-emotional disorder (16.2%). Two showed emotional disorder (4.6%) and 1 showed conduct disorder (2.3%). Another 10 children were judged to be in the dubious range (23.2%). (See Table 3).

TABLE 2
Teachers' Questionnaire (Rutter Scale B)

N = 45			
Score		Number	Percentage
0 - 8	No Abnormality	29	64.5
9 - 15	Slight Abnormality	10	22.2
16 - 25	Moderate Abnormality	2	4.4
25 -	Marked Abnormality	4	8.8

} 35.5

TABLE 3
Parental Interview

N = 43		
	Number	Percentage
No Abnormality	23	53.5
Dubious Abnormality	10	23.2
Slight Definite	6	13.9
Moderate Definite Abnormality	4	9.3
Marked Definite Abnormality	0	0

} 23.2

Diagnosis on Parental Interview

- 7 Mixed Conduct/Emotional Disorder
- 2 Emotional Disorder
- 1 Conduct Disorder

Interview With Child

Of the 43 children interviewed 8 were judged to be definitely disturbed. This shows prevalence rate of disturbance to be 18.6%. Six (13.9%) showed mild disturbance. One (2.3%) showed severe disturbance. Of the 8 disturbed children 3 showed mixed conduct-emotional disorder (6.9%). Three showed depressive disorder (6.9%) and 2 showed conduct disorder (4.6%). Another 11 children (25.5%) were judged to be in the dubious range. (See Table 4).

TABLE 4
Interview With Child

N = 43		
	Number	Percentage
No Abnormality	24	55.9
Dubious Abnormality	11	23.5
Slight Definite Abnormality	6	13.9
Moderate Definite Abnormality	1	2.3
Marked Definite Abnormality	1	2.3

} 18.6

Diagnosis on Interview with Child

- 3 Mixed Conduct/Emotional Disorder
- 3 Depressed Disorder
- 2 Conduct Disorder

This is one of the few studies of child psychiatric disorder carried out on a non-clinic population in Ireland. It is limited in that the numbers are small and the population studied is a select population of high unemployment working class urban area. It is the first stage of a wider study that will look at the childhood population in different social classes and different geographic locations in Ireland.

TABLE 5
Association between pairs of instruments

	Abnormality		% Agreement	V Statistic
	Absent	Present		
R.A. and R.B.	21	11	74	+ 0.47 (P<0.01)
R.A. and P.I.	25	10	81	+ 0.65 (P<0.001)
R.A. and C.I.	24	7	72	+ 0.44 (P<0.025)
R.B. and P.I.	27	9	84	+ 0.64 (P<0.001)
R.B. and C.I.	28	8	84	+ 0.65 (P<0.001)
P.I. and C.I.	32	7	91	+ 0.73 (P<0.001)

Note: R.A. = Rutter Scale A R.B. = Rutter Scale B
P.I. = Parental Interview C.I. = Child Interview

This table shows the degree of diagnostic agreement between the four instruments used in the study. In 21 of 43 cases studied both the Rutter Scale A and the Rutter Scale B indicated no abnormality while in 11 cases both indicated the presence of abnormality their being agreement in 74% (32 of 43) of the cases. The V Statistic (Kendall and Stuart, 1979) measures the degree of association, between the pairs of instruments on a -1, +1 scale and is analogous to the correlation coefficient. The Rutter Scale A diagnosis is most highly correlated with the Parental Interview while the Rutter Scale B, Parental Interview and Child Interview are strongly correlated with one another.

Discussion

On the Child Psychiatric Interview the prevalence of psychiatric disorder in boys was found to be 18.6%. Using similar instruments the prevalence of psychiatric disorder in boys on the Isle of Wight was 13% and in boys in inner London the prevalence of psychiatric disorder was 18.3% (Rutter et al, 1975). The children in this study lived in an urban working class area with high unemployment and a high crime rate. These are children that are likely to show high rates of child psychiatric disorder.

Deviance rates on parental and teacher questionnaires are twice those found on parental and child interview. This suggests that using the recommended cut-off points these questionnaires are over inclusive and tend to select a large number of children who are not disturbed. While being extremely useful as screening instruments, researchers should be aware of their limitations. There was a significant correlation between the results obtained on the parent questionnaire, the teacher questionnaire, the parental interview and the interview with the child. (See Table 5).

Mixed conduct/emotional disorder is the most common diagnosis made followed by emotional disorder and then by ~~conduct disorder~~. The child psychiatric interview showed a high (6.9%) rate of depression amongst the disturbed children. This was something that did not seem to be picked up on the questionnaires or on the parental interview. This is in keeping with research which found that children often reported feelings of misery and despair and even suicidal thoughts of which parents and teachers were both unaware (Graham and Rutter, 1973).

The large number of children that fitted into the dubious categories have problems and show some signs of disturbance but are not severe enough to be classified as definitely disturbed. The findings suggest that for every child that is recognised as being disturbed there is another child that is extremely vulnerable. Any increased stress in this child's environment such as disturbed relationships within the family, parental mental illness, physical illness in the child or educational failure have the effect of increasing the disturbance from the dubious to the definite category (Graham et al, 1985).

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**THE INCIDENCE OF MAJOR DEPRESSIVE DISORDERS IN CHILDREN
ATTENDING A CHILD GUIDANCE CLINIC**

Helen Leader
Michael Fitzgerald
Anthony Kinsella

SUMMARY

The incidence of depression was examined in 49 children, aged 6 to 16 years, attending an out-patient Child Psychiatric Clinic. The children were given The Kiddie Schedule for Affective Disorders and Schizophrenia (KSADS) and The Depression Self-Rating Scale (DSRS). The mothers of these children were given The Leeds Scale for Depression and Anxiety. Seven children on the KSADS and nine on the DSRS scored for depression. There was a very high significant positive correlation between the results of these tests, (P 0.001). Thirty seven percent of the mothers scored as depressed. There was no significant correlation between maternal and childhood depression.

KEY WORDS

Childhood depression, The Kiddie Schedule for Affective Disorder and Schizophrenia (KSADS), Depression Self-Rating (DSRS), Maternal Depression.

INTRODUCTION

There is much controversy among Child Psychiatrists about the notion of a depressive illness occurring in children. According to Piaget (1954), children over the age of seven years should be capable of making judgements about their feelings and behaviour. Epidemiological studies on childhood depressive illness yield widely different results depending on the population of children studied (whether they are psychiatric in-patient, out-patient or general population studies) and also on the screening techniques used. Obviously the more stringent the criteria used - the fewer cases of depression will be diagnosed.

In a general population study, Rutter, (1976), found the prevalence of depression among 10 - 11 year olds to be 1.4% increasing to 4% among 14 - 15 year olds (Rutter et al., 1976). Of 103 non-psychiatric patients, Kashani and Simonds (1979), using DSM 111 Criteria found a prevalence of 1.9%. Weinberg et al., (1973) talked to parents of children 6 - 12 years referred to an educational diagnostic clinic and said 57% of these children were depressed. Albert and Beck (1975) studied 63 parochial school children in a classroom setting, using the short form of the Beck Depression Inventory and found that 33% of these children had moderate to severe depression. Kovacs and Beck (1977) found 14% of nine to 15 year olds in a psychiatric out-patient population were depressed. Pearce (1978) found the incidence of depression among 547 children attending a Child Psychiatric Clinic to be 23%. Looking at a group of 100 psychiatric in-patients using DSM 111 Criteria, Kashani and Simonds (1979) found the incidence of depression to be 13%.

When attempting to ascertain the incidence of depressive illness in childhood, one must bear in mind that childhood depression may not be directly expressed, but that it may be inferred from behaviour and symptoms. This does not invalidate the use in childhood of adult criteria, especially in the older child. It may be that those who are diagnosed as depressed using adult diagnostic criteria, constitute the group of children who are the most seriously affectively disturbed.

The primary aim of this study was to determine the incidence of depression in children referred to an out-patient child psychiatry facility. A secondary aim was to compare two different instruments - one being a very detailed semi-structured interview questionnaire and the other a self rating screening scale for child depressive disorder. A tertiary aim was to compare maternal depression with depressive disorder in childhood.

METHOD

The study was carried out on a psychiatric out-patient population in a working class Dublin suburb. Referrals to the Child and Family Centre in this area come from paediatricians, general practitioners and social workers in the area. Fifty new consecutive referrals of children aged 6 - 16 years were chosen for the study.

Children with serious or chronic medical illness were excluded. The form the research would take was explained to each mother and verbal consent was obtained from her. The diagnostic instruments used in the study were The Kiddie Schedule for Affective Disorders and Schizophrenia (KSADS), The Depression Self-Rating Scale (DSRS) and The Leeds Scale for the Assessment of Maternal Depression.

The KSADS is a modification of the Adult SADS (Endicott & Spitzer, 1978) developed by Chambers et al., (1978) and Ovrashel et al., (1982). The KSADS is a schedule which takes the form of a detailed semi structured interview and the timing and duration of symptoms is used to rate the severity of each symptom. Because of the detail of the information required, and because it is administered to young children, the schedule is also given in parallel to parents. The researcher uses his clinical judgement to arrive at the correct scoring for each question.

The DSRS devised by Birleson "is a self-rating questionnaire for child depressive disorder" (Birleson 1981). It is made up of 18 statements worded in a way which a child would easily understand. The child can answer "most of the time", "sometimes", or "never" to each question. Responses are scored in the direction of disturbance 0, 1 or 2. A score of 14 or more is evidence of child depressive disorder. The DSRS has been shown to have a high internal consistency, factorial validity and satisfactory stability (Birleson et al., 1987).

The Leeds Scales are self assessment scales for depression and anxiety, devised by Snaith et al. (1976). The results of these scales have been shown to significantly correlate with observer ratings for depression.

Each child in the study was initially seen by either an experienced Child Psychiatrist, Psychologist or psychiatric social worker depending on the nature of the presenting symptoms. This professional arranged for the child to complete the DSRS.

The following day the child was referred to an experienced Child Psychiatrist who was blind to the results of the DSRS. She administered the KSADS, first to the parents and then to the child. This researcher also invited the mother of each child in the sample to complete the Leeds Scales.

The results of the KSADS and DSRS were compared.

RESULTS

One child refused to answer questions and was excluded from the study, leaving a sample of 49 children and their mothers. Out of this sample seven (i.e. 14%) scored positively for depression on the KSADS. One of these cases fitted into the endogenous subtype. There was no case of psychotic depression. The depressed group included four boys and three girls. There was no significant difference between the mean ages of the children in the depressed and non-depressed groups.

Nine children, four girls and five boys scored positively for depression using the DSRS questionnaire. As with the KSADS there was no significant sex difference or age cluster. The χ^2 analysis for a 2 x 2 contingency table showed a very high significant positive relationship ($P < 0.001$) when the results of the KSADS and DSRS were compared. If a child showed a positive or negative result on one test, there was a very high probability (0.91) that the same result was found with the other test. Table 1 illustrates the relationship between the KSADS and DSRS. Of the seven children diagnosed as depressed on KSADS six were identified by the DSRS. Of the nine children diagnosed as depressed on the DSRS, six were picked up by the KSADS.

TABLE 1

Name of Child	Age	Sex	KSADS	DSRS	Maternal Depression
1	12	M	+	+	-
2	10	M	+	+	-
3	7	M	+	+	+
4	13	M	+	+	+
5	14	F	+	+	+
6	10	F	+	-	-
7	9	M	+	+	-
8	11	F	-	+	-
9	15	F	-	+	+
10	7	F	-	+	+

Eighteen mothers (i.e. 37%) scored positively for depression on the Leeds Assessment Scales. While there was an association between maternal and childhood depression, this association was not significant.

DISCUSSION

An incidence of 14% in an Irish Psychiatric Out-Patient population suggests that childhood depression is not a rare diagnosis. This incidence would be in keeping with other research in an out-patient population e.g. Kovacs and Beck (1977) had a similar finding.

The significantly close association between the results of the KSADS and the DSRS is interesting, given the different nature of both instruments. The KSADS takes a considerable length of time to administer and must be used only by a practiced and experienced person, whereas the DSRS can be completed in 5 - 10 minutes by the patient. While the DSRS may if anything, be over diagnosing depressive illness, it could be successfully used as a useful screening instrument.

In his studies Rutter et al., (1976) found 50% of mothers with children with psychiatric disorder to be depressed and only 10% of mothers of children without psychiatric disorder to be depressed. Therefore there is evidence to suggest that psychiatric disorder in mothers is strongly associated with psychological disturbances in children. It is therefore important when dealing with childhood depression to take account also of the possibility of maternal depression. Whether maternal depression is a cause or effect of childhood psychological illness would depend on each individual case and sometimes may be difficult to disentangle. However, a careful history of maternal mental health and a combined approach to treatment of both mother and child is indicated.

The notion of childhood depression is a relatively recent concept in psychiatry and more research is required before we can be more confident of its presentation, associations and treatment.

ACKNOWLEDGEMENT

We would like to thank Mark Cullen, Psychosomatic Unit, St. James's Hospital, for assistance with data analysis.

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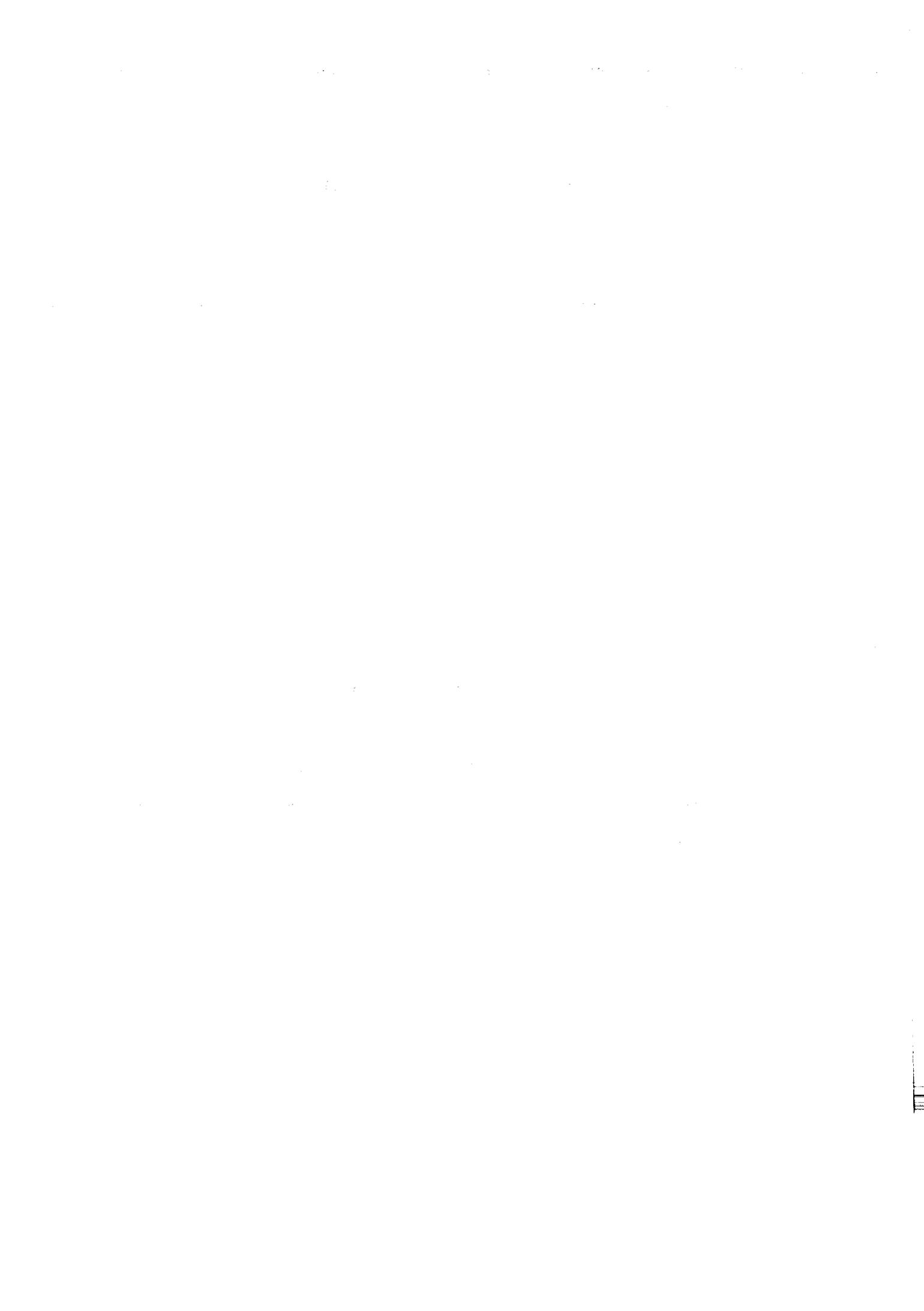
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BRIEF REPORT

A STUDY OF BEHAVIOURAL DEVIANCE IN 10 AND 11 YEAR OLD
IRISH SCHOOL GIRLS IN AN URBAN AREA

. Barton
. Fitzgerald

*DV
14/5/03*

*Social
Class*

*Pulvin
1986*

8

Summary

Ten and eleven year old Irish school girls from two contrasting socioeconomic urban areas were studied using behavioural rating scales. The rate of behaviour deviance was found to be more than six times greater among those from the lower social class background. Reasons for this have been suggested.

Introduction

The rate of behavioural deviance in Irish school children is not well documented. The clinical impression gained from working in two child psychiatric clinics, in the same city, one situated in a higher socioeconomic area, was that the majority of the children who attended both clinics were from a similar background, namely the lower social grouping.

Butter et al (1975) found that the rate of behavioural deviance in ten year old children in the Isle of Wight was 10.6%, whereas the rate for children of the same age in the Inner London Borough was 19.1%, this higher rate applying to both boys and girls and extending to both emotional and conduct disorders. Lavik (1975) similarly found for Norwegian adolescents that lower social class increased the rate of psychiatric disorder, this being more marked in urban areas.

Subjects and Methods

In setting up this study two sample sources were chosen from two different social class groupings. Sample 1 was drawn from a residential area where the housing was privately owned and the housing density was low. The children attended a private fee paying school in the area and lived within a ten mile radius of the school.

Sample 11 was drawn from an area where the housing was mostly corporation owned and the housing density was high. The children attended the local non fee paying state funded school and lived within a one mile radius of the school. The fathers' occupations were grouped according to 1971 Census of Population of Ireland as shown in the following table.

The instruments used to test behavioural deviance were a teacher's questionnaire (Rutter Scale B₂) and a parents' questionnaire (Rutter Scale A₂). The teachers' questionnaire consists of 31 items.

Each item is scored 0, 1, or 2 depending on the frequency with which the behaviour occurs, and its severity - for example the question on stealing is put as follows:

Does he/she ever steal things?

No scores 0

Yes occasionally scores 1

Yes frequently scores 2

Responses to the Scale items are then totalled and a total response score of 9 or above on the teacher's questionnaire and of 13 or above on the parents' questionnaire rated as deviant. A separate neurotic and antisocial score is obtained from Scale A₂ and Scale B₂ and whichever score is higher determines how the child will be described. If the neurotic and antisocial scores are the same the child regarded as being undifferentiated, having a mixed disorder of conduct and emotions. The neurotic subscore is obtained by summing the score on certain items for example "often worried, worries about many things".

Both questionnaires have been standardised for children in the ten to fourteen year old age group in the Isle of Wight and for children aged seven, ten and fourteen years in London (Isle of Wight studies 1964 - 1974). The scales have been shown to have satisfactory reliability and validity.

TABLE 1
Fathers' Occupations

SAMPLE 1		SAMPLE 2	
Higher Professional	= 22	Skilled	= 16
Lower Professional	= 16	Semi-skilled	= 5
Employers and Managers	= 16	Other non-manual	= 8
Salaried Employers	= 7	Intermediate non-manual	= 1
		Unemployed	= 10
		Unknown	= 15

Results

There was a lower response rate in Sample I; 38 out of 45 (84%) compared with that in Sample II; 55 of 59 (93%).

Table II shows the rate of behavioural deviance on the parental scale in the two samples: zero in Sample I and eleven (20%) in Sample II. This table also shows the rate of behavioural deviance on the Teacher's Scale (Rutter Scale B₂) two (5.25%) in Sample I and eighteen (32.7%) in Sample II. Statistical analysis using the chi squared test showed the increase in behavioural deviance in Sample II to be significant at a level of confidence greater than 0.5% in both scales. When the different types of deviancy on the Parental Scale were examined none of the children in Sample I were deviant, however in Sample II six children were rated as antisocial and five as neurotic.

TABLE II

	SAMPLE I	SAMPLE II	P
Rutter Scale (A ₂) (Parental Scale)	0	11 (20%)	p < 0.005
Rutter Scale (B ₂) (Teacher's Scale)	2 (5.25%)	18 (32.7%)	p < 0.001

Table III shows the types of deviancy rated on the teacher's scale. In Sample I one child (2.6%) was designated antisocial. There were no neurotic children and one child (2.6%) was designated as a mixed neurotic and conduct disordered child. In Sample II fourteen children (25%) were antisocial, two (3.66%) were neurotic and two (3.6%) were mixed

When Rutter Scale B₂ item 14 - absent from school for trivial reasons was scored sixteen (29%) of Sample II scored positively in this item, whereas none of the children in Sample I was rated on this item.

TABLE III

		SAMPLE I	SAMPLE II
Rutter Scale (B ₂)	Antisocial	1 (2.6%)	14 (25%)
Teachers' Scale	Neurotic	0	2 (3.6%)
	Mixed	1 (2.6%)	2 (3.6%)

Table IV shows that four children in Sample I out of a total of twenty-nine behaviourally deviant children were rated as deviant by both teacher and parent - a 13.8% overlap.

TABLE IV

SAMPLE II	PARENTAL SCALE A ₂		TEACHERS' SCALE B ₂		
	Antisocial	Neurotic	Antisocial	Neurotic	Mixed
01			*		
02	*				
03			*		
04	*		*		
05					
06					
07			*		
08			*		
09			*		
10	*		*		
11				*	
12				*	
13			*		
14			*		
15			*		
16		*		*	
17	*		*		
18					*
19					*
20	*				
21		*			
22		*			
23		*			
24		*			
25			*		

Rutter (1976) found that one in six of the most deviant children selected by one questionnaire used also selected by the other questionnaire: a 14.3% overlap. Statistical analysis showed no significant differences between the findings of this study compared with that of Rutter using Z test for a proportion.

Discussion

This study shows that the rate of behaviour deviance is higher in a lower social class urban area as compared with a similar urban area in England. In an Inner London Borough the rate of behavioural deviance was 19.1% (Rutter et al, 1975).

The rates of behavioural deviance in the higher socioeconomic urban areas are lower than was found in similar groups in the United Kingdom. In the Isle of Wight the rate of behavioural deviance was 10.6% (Rutter et al, 1975): In the United Kingdom the rates of behavioural deviance in the lower socioeconomic group compared with the upper socioeconomic group showed less difference than in the present study.

The explanation for the marked difference in behavioural deviance between the two social groupings may have been that all the children of Sample 1 came from extremely privileged families. The effect of private education on the rate of behavioural deviance may be a further explanation and is an area which requires further research.

This study confirms the original impression that there is more behavioural deviance in the lower deprived social grouping and this is a possible reason for more lower social class children attending child guidance clinics.

Further research might usefully look at the rate of behavioural deviance firstly in Irish school boys, secondly comparing a private and a state funded school in the same locality, thirdly some detailed studies of family psychiatric status, taking into account factors such as marital disharmony, parental psychiatric illness, rates of criminality and size of family, etc.

We would like to thank Mr. T. Kinsella of Dublin Institute of Technology for statistical assistance.

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BEHAVIOURAL DEVIANCE IN AN IRISH URBAN AND RURAL TOWN SAMPLE

1. Fitzgerald

1. Kinsella

1980 15
M. D. O'Keefe
New

Summary

Seven - eleven year old children in urban and rural schools were studied using the Rutter B₂ (teachers) questionnaire. A very highly significant difference was found between the urban and rural children.

Introduction

The difference in prevalence of behavioural deviance between an Irish urban and rural town area has not been well documented. There is the clinical impression that there is greater behavioural deviance in urban areas. These rates would have important implications for the developmental of the Child Psychology and Social Services. There is considerable knowledge of the rates of behavioural deviance in urban and rural town samples in the United Kingdom and it is important that similar methods are used in Ireland, so that valid comparisons are made^{1,2}. A rate of 19% was found in a large sample area of London using the Rutter B₂² (teachers) questionnaire. A previous study found that a rate of 36.4% of behavioural deviance on the Rutter B₂ (teachers) scale in a disadvantaged area of Dublin and 39.5% behavioural deviance on the Rutter A₂ (parents) scale in a similar area³.

A hypothesis based on clinical experience was set up: 'That there would be greater behavioural deviance in children in an urban area as opposed to a rural town area.'

Patients and Methods

Two schools in a disadvantaged area were approached and all children aged between 7 and 11 years had the Rutter B₂ scale (teachers) questionnaire administered. Two schools in a small town in rural Ireland were also approached and all children between the ages of 7 and 11 had the Rutter B₂ scale (teachers) questionnaire administered.

The Rutter B₂ scale (teachers) consists of 26 statements, e.g. "Bullies other children", and allows the teacher to score. 1. Does not apply. 2. Applies somewhat. 3. Certainly applies.

Response to the scale items were then totalled and the total response score of 9 or above on the teacher's questionnaire was rated as deviant.

The interrator reliability is satisfactory ($r = 0.72$).

The disadvantaged urban area was characterised by high density housing, over crowding and unemployment. The rural town area was represented by a small market town and some small industry, agriculture and service industries.

The study population consisted of 101 urban children of which 46 were boys and 55 were girls. The rural town population consisted of 250 children of which 113 were boys and 137 were girls.

Results

The response rate was 100%. The frequency count of the results are shown in Table 1 as a 3-way contingency table.

Using the likelihood ratio test method for contingency table analysis, a very highly significant difference was found between the urban and rural town children. 35% of the urban children exhibited behavioural deviance as against 11% of the rural town children. ($G^2 = 24.24$ (P 0.001)). Within the urban group no significant difference was found between boys (37%) and girls (33%). ($G^2 = 1.200$), while a highly significant sex difference was found in the rural town group. The observed incidence for boys as 18% was three times that found for girls ($G^2 = 9.32$ (P 0.001)).

TABLE 1

Distribution of behavioural deviance in the study groups.

Urban				Rural Town		
	Boys	Girls	Total	Boys	Girls	Total
Deviant	17 (37%)	18 (33%)	35 (35%)	21 (18%)	8 (6%)	29 (11%)
Not Deviant	29 (63%)	37 (67%)	66 (65%)	96 (82%)	129 (94%)	225 (89%)

Discussion

The hypothesis that there would be a greater rate of behavioural deviance in the urban as compared to the rural sample has been supported. A similar finding was found by Rutter (1974) in the United Kingdom. Rutter² suggested that marital disharmony, parental mental illness, social disadvantage and certain school characteristics were associated with behavioural deviance in children in both urban and rural areas. In so far as these factors may be regarded as contributing to casual influences (and there is evidence from other studies that they do)², it is suggested that the high rate of behavioural deviance in the urban sample could be due to a relatively higher proportion of urban families with marital difficulties, parental mental disorder, living in overcrowded houses and characterised by schools with a high turnover of staff and pupils. These views are supported by clinical experience and Kapoor et al⁵ finding of 27% overcrowding in a public health clinic sample in a disadvantaged Irish urban area and Leader et al⁶ finding that 50% of the mothers of a group of children attending a play-group in a disadvantaged Irish urban area showed depressive symptoms and 40% showed anxiety.

The results showed no significant sex effect for the urban disadvantaged while there was a significantly higher rate of behavioural deviance among the rural town boys. It is possible that girls in urban areas are less controlled and therefore more exposed to the same stresses as boys.

It is unlikely that genetic factors could explain the differences between the rates of deviance in an urban and rural area as one would have to explain if this was so, why these genetic factors should be more concentrated in an urban area. Differential migration from an urban to a rural area with the more disturbed individuals remaining behind would also have to be considered, but there is no evidence for this possibility.

It is also unlikely that a biological explanation in terms of some physical impairment in urban children leading to more behaviour deviance. Perinatal damage may sometimes lead to behavioural deviance but there is no convincing evidence that there is a major difference between urban and rural areas and this is a highly unlikely explanation of the difference between rural and urban areas.

Malnutrition is another possibility and there has been some evidence that children from low income families at least in England were not getting a proper diet (Lynch et al)⁷. In a recent study in the same disadvantaged Irish urban area as this study, O'Rourke et al³ examined the height and weight of children and demonstrated that "the height and weight percentiles shifted to the left of the expected percentiles". This indicated that as a group, the sample was of lower stature than expected while having similar weights to the standard sample. This may be a reflection of general inadequate nutrition with an excess of high carbohydrate and low protein foods.

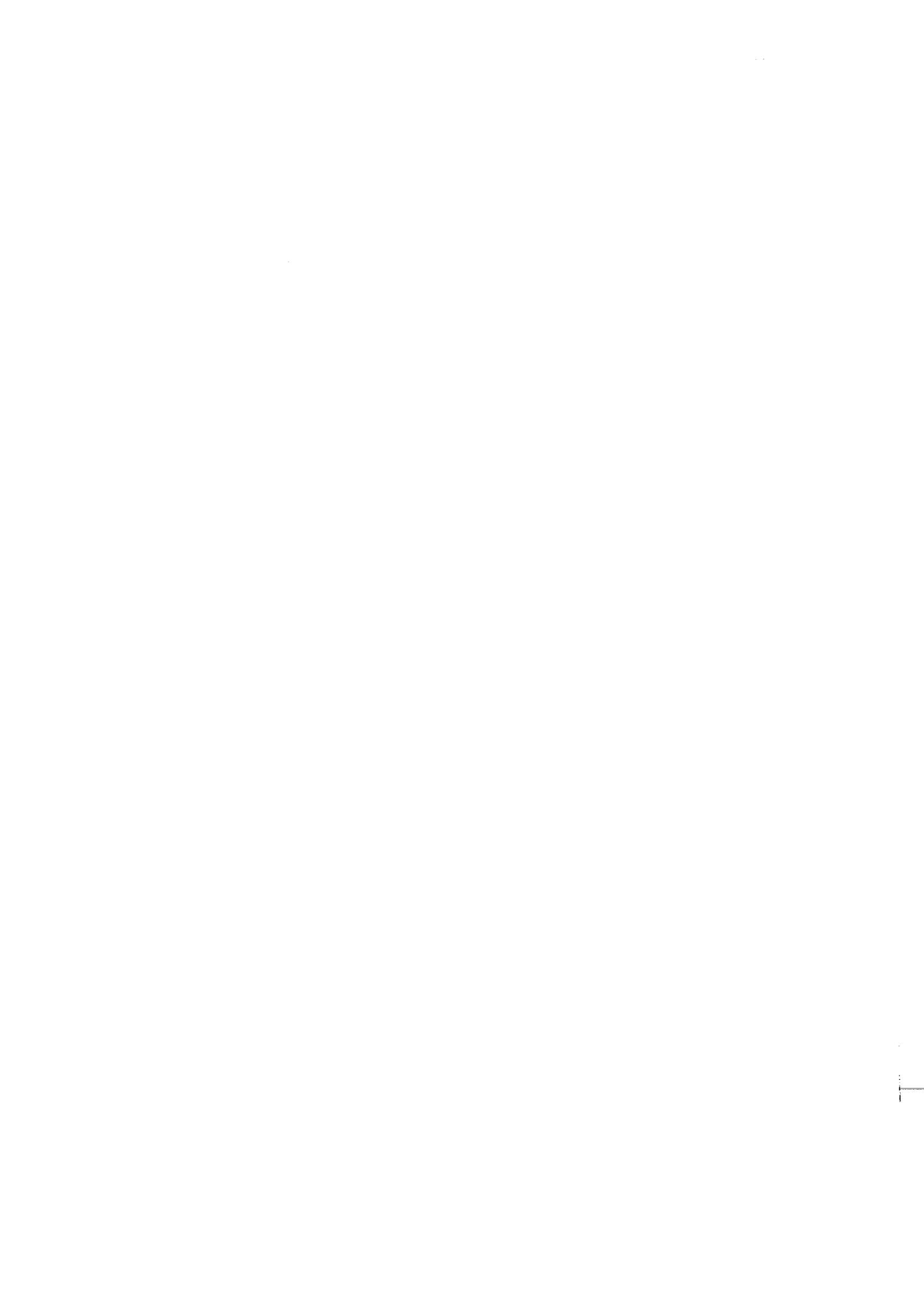
It is improbable that just one explanation will be found for the difference between the urban area children and the rural children in explaining the rates of behavioural deviance. Biological factors may well play some part with the findings to date indicating that psychological and social factors are at least important. How they interact remains uncertain and the question of what it is about life in an urban area which predisposes to the development of behavioural deviance has still to be answered.

Acknowledgement

We would like to thank Mark Cullen, Psychosomatic Unit, St. James's Hospital for data analysis.

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AN EPIDEMIOLOGICAL STUDY OF BEHAVIOURAL DEVIANCE, HYPER-
ACTIVITY AND PHYSICAL ABNORMALITIES IN A DUBLIN PRIMARY
SCHOOL POPULATION

Michael O'Rourke
Michael Fitzgerald

SUMMARY

This study has demonstrated a high prevalence of behavioural deviance, hyperactivity, crossed laterality, soft neurological signs, gross tooth decay and nasal abnormalities in a primary school population in a high-density housing, high unemployment area of Dublin.

INTRODUCTION

This study sought to find the extent of behavioural deviance, hyperactivity and abnormality on physical examination in a primary school population.

Behavioural deviance has been reliably measured (Graham and Rutter, 1968) and questionnaires devised for its measurement, these being designed for completion by parents and teachers. Hyperactivity has also been widely studied in different age groups. Routh et al adapted Werry et al's Activity Rating Scale, and this can be presented and later scored and compared to standardised results (Routh et al, 1974). Our sample consisted of fifty-five boys from two classes of the same standard in two primary schools in a working class area of high unemployment in Dublin.

The headmasters of the schools were contacted and they agreed to circularize the parents with a letter we prepared, asking their permission to include their children in the study.

The children were all examined by one of us (M O'R) during school hours and without further notice being given to the parents.

The examination consisted of: height and weight, full physical examination, hearing (using the stycar hearing test for high frequency words), vision, laterality (hand, foot and eye) and soft neurological signs (choreoathetoid movements, finger-spreading and mirror movements). The children were given the Rutter Child Scale A2 (Parents) and the Activity Rating Scale, as adapted by Routh, for their parents to complete and return to us via the headmaster, and the teachers were given the Rutter Child Scale B2 (Teachers) to complete on each child in their charge.

The results were tabulated by us, and the data subjected to computerised analysis.

RESULTS

In all, fifty-five children were examined. Permission was refused in only one case. Thirty-three activity scales (60%), forty-three parent questionnaires (78%) and all the teacher questionnaires were returned fully completed.

The basic statistics for age, height and weight are documented in Table 1.

TABLE 1
Age, Height and Weight of Children

	Maximum	Minimum	Range	Mean	Standard Deviation
Age:	8 yrs. 11 mths.	6 yrs. 2 mths.	2 yrs. 9 mths.	7 yrs. 9 mths.	6.9 mths.
Height:	133 cms	109 cms	24 cms	121.4 cms	4.58 cms
Weight:	28 kg	17 kg	11 kg	23.1 kg	2.59 kg

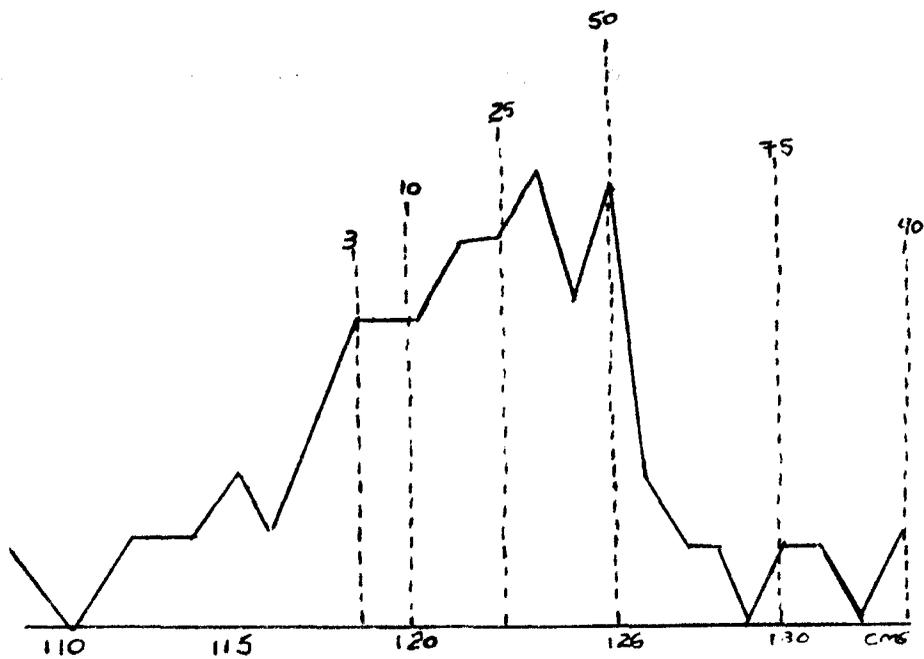


Figure 1 - The distribution of height (cms) superposed on the expected percentiles for an age-matched standard sample.

The standards for the standard sample in figures 1 and 2 are taken from Tanner et al (1986).

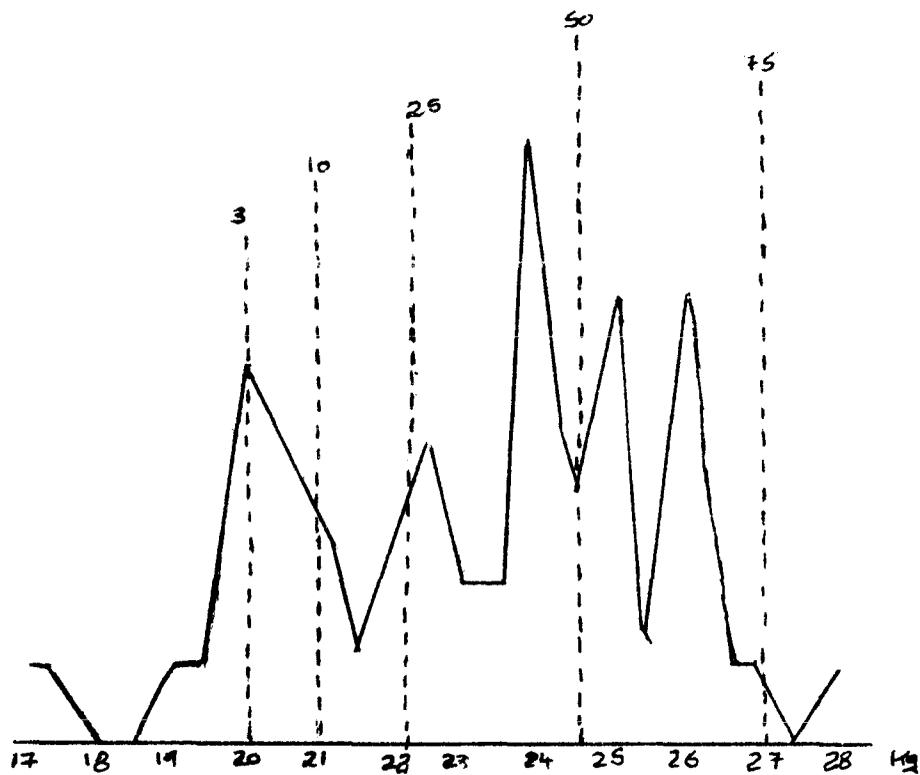


Figure 2 - The distribution of weight (kg) superposed on the expected percentiles for an age-matched standard sample.

Figure 1 and 2 compare the distribution of height and weight in this group with that expected in an age-matched standard sample.

To study the other parameters of the physical examination and the results from the questionnaires, we have grouped them into four degrees of abnormality. There was no abnormality found in the skeletal system heart sounds, chest auscultation or squint. Low levels of abnormality (i.e. less than 10% of those examined) were found on examination of abdomen and genitalia, skin and hair and vision. Intermediate levels of abnormality (i.e. greater than 10% and less than 20%) were found on examination of ears, throat and hearing. High levels of abnormality (i.e. greater than 20%) were found in the following parameters: hyperactivity (21.2%); soft neurological signs (30.9%); gross tooth decay (34.5%); behavioural deviance on the parent scale (39.5%); nasal abnormalities (41.8%); and crossed laterality (46.3%).

We cross-tabulated the observations to see which, if any, would correlate significantly. The significant correlations are documented in Table 2.

DISCUSSION

The group studied in this research project is an unselected sample of primary school children. The particular classes were chosen for study only because this age group provided the greatest number of children to study. The group's environment is one of high-density housing, over-crowding and unemployment. The physical examinations were carried out by one of us (M. O'R), in a standardised way and blind to the results of the questionnaires, which were scored at a later time. The questionnaires themselves have been long recognised as reliable for screening purposes (Graham and Rutter, 1968).

The significance of soft neurological signs and crossed laterality is controversial; however the concepts are standardised and well documented (Touwen and Precht1, 1970). The first item of interest in analysing the results of the physical examinations is the high prevalence of nasal abnormality, i.e. upper respiratory infection and/or nasal polyps, and gross tooth decay. While the upper respiratory infections might be expected in a young school population the findings that tooth decay, at a sufficiently advanced stage to be recognised merely by looking into the mouth, is present in one-

TABLE 2
Significant correlations found in this study

Behaviour deviance (teacher) correlated with:		
Skin/Hair	Pearson's R = -0.29	<u>P = 0.01</u>
	Chi square	<u>P < 0.08</u>
Hearing abnormality	Pearson's R = 0.23	<u>P < 0.05</u>
Vision abnormality	Pearson's R = -0.24	<u>P < 0.05</u>
The presence of any physical abnormality	Pearson's R = 0.31	<u>P < 0.1</u>
	Chi square	<u>P < 0.05</u>
Soft neurological signs correlated with:		
Nasal abnormality	Pearson's R = 0.25	<u>P < 0.05</u>
The presence of any physical abnormality	Pearson's R = -0.34	<u>P < 0.005</u>
	Chi square	<u>P = 0.01</u>
Hyperactivity correlated with:		
Ear abnormality	Pearson's R = 0.35	<u>P < 0.05</u>
	Chi square	<u>P < 0.05</u>
Teeth abnormality	Pearson's R = -0.29	<u>P < 0.05</u>
<u>Crossed laterality</u>	Pearson's R = -0.31	<u>P < 0.05</u>

Secondly, the analysis of the height and weight percentiles showed the height curve was shifted to the left of the expected percentiles. This indicated that as a group, the sample is of lower stature than expected while having similar weights to the standard sample. This may be a reflection of generally inadequate nutrition, with an excess of high carbohydrate, low protein foods.

Thirdly, the prevalence of behavioural deviance on both teacher and parent questionnaires, 39.5% and 36.4% respectively, are both extremely high, when it is considered that this is a school, rather than a clinical, population. These figures can be compared to the Aberdeen Validation Study, which showed 15% of general population boys aged 9 - 13 years were positive on the parent scale (Rutter et al, 1970).

Fourthly, the prevalence of crossed laterality of 46.3% and soft neurological signs of 30.9%, in a general population, questions both the validity of the tests and the normality of the population. This is discussed further below.

Fifthly, the finding of 21.2% hyperactivity, as defined by the Activity Rating Scale, is all the more striking when one considers that, (a) only those scores that were over two standard deviations above the mean for the age, were considered positive, and (b) that the lower response rate compared to Rutter's A2 and B2, might have been expected to give a bias towards lowering the prevalence.

The correlations found, though statistically significant, do not imply a casual association.

As noted above, behavioural deviance, as measured by the Rutter B2 (Teacher) scale, correlated positively with 'skin and hair' abnormality, which consisted of gross dirt, warts, rashes and bitten nails.

Some of these suggested an element of physical neglect. The high frequency deafness that may be picked up by the stycar method, also correlated with the Rutter B2 (Teacher) Scale results. These children may well be at a disadvantage in the classroom, leading to frustration and behaviour problems. It is recognised that in cases of serous otitis media, hearing loss can fluctuate considerably in the same individual, so that one normal audiogram, as obtained in school screening, does not rule out a problem with hearing in the classroom (Rutter and Martin, 1972).

When all the cases with some abnormality on physical examination were compared with those who had none we found that the presence of physical abnormality correlated positively with behavioural deviance, as measured on the Rutter B2 teacher scale. This is interesting in relation to the long established findings relating to physical illness and psychiatric problems in adults, which have led to the established practice of including a physical medical examination as part of any admission to psychiatric care.

The one negative correlation with behavioural deviance, as measured by the Rutter B2 (Teacher) Scale, was vision. Abnormality of vision was diagnosed when either both eyes failed to achieve 6/6, or when there was a discrepancy of at least one division between the eyes. It is difficult to explain why these children should show less behavioural deviance. There is the possibility that they may have been seated closer to the front of the classroom in order to see more clearly and that this tended to lessen their chance of expressing behavioural deviance. However, this theory is somewhat negated by the finding that behavioural deviance, as measured by the Rutter A2 (Parent) Scale is also negatively correlated to a significant level with vision.

Hyperactivity, as measured by the Activity Rating Scale, correlated positively with ear abnormalities. These consist of acute inflammation of the eardrum, old perforations, tympanosclerosis and otitis externa.

Hyperactivity also provided the only correlation with crossed laterality, a negative correlation. This is of interest, because whereas some cases of hyperactivity have been linked to minimal brain damage (Clements and Peters, 1962) it remains unclear why some individuals have their laterality crossed. It may be a reflection of some minimal unihemispherical damage, leading the otherwise non-dominant hemisphere to assume dominance. On the other hand, could it be the result of these individuals having been influenced at a sufficiently young age to forgo their natural dominance in favour of right laterality? Two facts drawn from this study support this last possibility; firstly, crossed eye laterality is much more common than crossed limb laterality (33% and 11% respectively), and secondly, the frequency prevalence of crossed laterality and full laterality (46% and 3.7% respectively)*. If one became right or left lateralised by random choice, one would expect each to be found at a level of around 50%. It seems significant then that we find 52% of our sample to be fully right lateral. This would suggest a random choice for dominance which is commonly interfered with to produce what we know as crossed laterality*.

*Crossed laterality is used to indicate the circumstance where eye, upper and lower limb preference usage are not all of the same side.

At the outset of this study, the question was put whether there would be a correlation between soft neurological signs and either of the measures of behavioural deviance or hyperactivity. The data failed to show such a correlation. Both the correlations with soft neurological signs were negative, and comprised of nasal abnormality and the presence of any physical abnormality.

Behavioural deviance, as measured by the Rutter A2 (parent) Scale, differed from the Rutter B2 (teacher) Scale results, in not providing any significant correlations other than the negative correlation with vision abnormality, mentioned above. This cannot be explained as being due to a relative lack of positive cases in the parent sample. It is recognised, however, that teacher questionnaire results tend to provide more useful information than parent ones. (Rutter 1970).

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Summary

The study compared aspects of behaviour, educational progress and social and emotional adjustment in two groups of children, travellers' children and a randomly selected comparison group matched for age and sex.

Introduction

The Irish travelling people are a small social subgroup bonded by a distinctive sub-culture. The population is growing rapidly, more than doubling in the last decade (Rottman, Tussing and Wiley, 1986). In 1981 the total population was 14,821 (Rottman, Tussing and Wiley, 1986). The age structure of travellers is radically different to the general population with extremely large numbers of infants and children and few older persons (Rottman, Tussing and Wiley, 1986).

Forty per cent of travellers are under 10 years, 50% are under 15 years (Rottman, Tussing and Wiley, 1986). Of the women aged 49 and over who would have completed their family 55% had 10 or more live births and 54% of the women aged 40 to 49 had 10 or more live births, demonstrating just how large many travellers families are. In 1963 the Commission on Itinerancy reported that almost all travellers were illiterate with only 114 children attending school regularly. In 1984, 4,000 children of school going age were enrolled (Dwyer, 1984), 40% of travellers children under 16 years did not attend school and 90% of adults were illiterate (Dwyer, 1984).

Subjects And Methods

Fifty consecutive primary school travellers' children and 30 consecutive primary school children from national schools were studied. The travellers group attended two inner city mixed national schools. This section of the city consisted of high

rise flats and there was an increasing unemployment and crime rate in the

a. The children were transported to school by mini-bus and there was a care worker escort on the bus.

The school from which the comparison group was drawn was mixed national school in South County Dublin with a total of 662 pupils on the register. During the course of the study, no parent was unemployed and table 1 gives an indication of the parents occupation for the comparison group.

TABLE 1
Social Class Group - Comparison Group

N.30	N	%
1. Professional	8	27
2. Skilled Manual	17	56
3. Semi-skilled	4	14
4. Unskilled	1	3

The comparison group was chosen according to their sequential position on the school register. The teachers were requested to answer a questionnaire on each individual child and also to administer to each child the Goodenough Draw-a-Man test. (Bawkin, 1948).

The school adjustment and achievement questionnaire was designed as a means of obtaining structured ratings for each child on key aspects of his or her educational progress and social and emotional adjustment in school. In part one, the following data was requested from the Head Teacher, the child's current class placement, educational history, school attendance and special educational help received, parental contact and predicted progress in secondary school. In part two of the questionnaire the Class Teacher was asked to assess each child's performance in language development, mathematical skills, reading and writing abilities. Two criteria were used in assessing performance (1) Normative reference assessment to determine how each pupil compared with norm or average standard, (2) Criteria referenced assessment to determine whether or not a pupil had mastered a specified

piece of learning regardless of how other pupils performed. The teacher was also asked to rate on a 40 point rating scale (not at all, somewhat, certainly, don't know) questions on the child's hearing, eyesight, control of hands, co-ordination and general health, (Cox & Jones, 1983).

The Class Teacher also completed the Child Scale B2 (Rutter 1967a) on each child. The checklist consists of 26 brief statements concerning the child's behaviour, which the teacher has to check according to whether each statement "certainly applies" (score 2), "applies somewhat (score 1) or "does not apply" (Score 0). A total score of maladjustment is obtained and this can be broken into sub-scale scores of neurotic and anti-social behaviour.

A total score of 9 or more may be taken as an indication of behaviour deviance (Rutter 1967a). The Child Scale has been shown to discriminate satisfactorily between children attending a psychiatric out-patient clinic and other (Rutter 1965 - 74).

The Goodenough Draw-a-Man test (Bawkin, 1948) was administered by the Class Teacher in a group situation. This test was designed to measure the level of mental development of children between the ages of 4 and 10 years. It makes three demands of the child (a) visualisation of the human figure, (b) organisation and interpretation, (c) reproduction by way of motor skills of visualised image, as seen and interpreted. Twenty eight criteria were used in the representation of features of the human figure (Harris, 1963). The score was determined by giving each child a basal age of 3 years and then for each 4 criteria met, the child was credited with one year. The sum of the two represented the child's age. There is significant correlation in the results of this test and the I.Q. and verbal part of the California Mental Maturity Test (CMMT) (Coleman et al, 1959).

Results

Attendance

The percentage school attendance of the 36 members of the travellers group who responded to this questionnaire was 72% which was significantly below the 92% attendance recorded for the 30 children in the comparison group.

The mental age as measured by the Goodenough method was 11.90 for the travellers groups. The mean was not significantly different from the comparison group.

Health

The teachers assessment of the groups general health indicate that the travellers groups were seen to have a higher rate of problems (see Table 2). There was no significant difference in terms of eye sight and hearing problems.

Parental Contact

There was a marked difference between the groups in relation to parental contact with the school. 42% of parents from the travellers group had made no contact which was significantly above the comparison group at 7%.

Behaviour

27 children in the travellers group were seen to exhibit behavioural deviance. 19 children in the anti-social range. 6 in the neurotic range and 2 undifferentiated (18 boys, 9 girls). The Rutter Total Score average for this group at 9.96 was significantly ($p < 0.001$) above the comparison group mean at 2.2. In the case of the Rutter Conduct score, the means were likewise significantly difference was found on the neurotic scale.

Speech

As shown in table 2 there was a significant difference in the quality of speech articulation in the two groups. 45% of the travellers were seen to have poor speech as opposed to only 10% of the comparison group. Speech difficulties included slurring of words, rapidity of speech and running words together.

Adjustment

In response to the question of overall levels of adjustment there was no significant difference in the teachers assessment of the children in both groups (see table 2).

TABLE 2

	Travellers Comparison		χ^2
Remedial Average or above average intellectual ability	13/31 (42%)	5/30 (17%)	3.54 (p 0.1)
Good physical co-ordination	26/32 (81%)	22/30 (73%)	1 (NS)
Good general health	31/50 (62%)	26/30 (87%)	4.43 (p 0.05)
Fluency of oral expression	37/50 (74%)	29/30 (97%)	6.56 (p 0.01)
Quality of speech articulation (good)	9/50 (18%)	7/30 (23%)	1 (NS)
Ability to follow instructions	27/49 (55%)	27/30 (90%)	8.93 (p 0.01)
Comprehension of reading	45/50 (90%)	29/30 (97%)	0.43 (NS)
Interest in reading	30/50 (60%)	26/30 (87%)	5.14 (p 0.05)
Good computational skills	30/50 (60%)	17/30 (57%)	1 (NS)
Understand maths concepts	26/50 (52%)	21/30 (70%)	1.1 (NS)
Level of adjustment (no significant problems)	27/50 (54%)	20/30 (67%)	1 (NS)
	18/50 (37%)	20/30 (67%)	1 (NS)

Discussion

The travellers' children in this study were only marginally behind the comparison group in terms of mental maturity and conceptual development. The comparison group was broadly representative of the settled community (see Table 1). It was not possible to use a control group because of the difficulty of matching for levels of deprivation, socio-economic status and employment status but nevertheless interesting differences were thrown up between the groups. The results are similar to research on learning capacities of travellers' children carried out at the University of Birmingham (Dennis, 1985). This may also indicate that the Goodenough Test is culturally free. As far as speech difficulties are concerned there may be cultured mediators to that style of speech. The reasons for the increase behavioural deviance may possibly include family instability and large family size (Travelling People Review Body, 1983). Their frequent exposure to malnutrition with its constant vulnerability may contribute to their problems of adjustment and development (Carroll, Kiely and Creedon, 1974). The settled community's attitude to travellers is more often hostile and resentful; constant pressure to move on, threats of eviction make them feel like outsiders. All these

factors together with their living conditions affect travellers self-esteem which may interfere with their educational performance (O'Dwyer, 1984). Further research might look at specific differences between deprived groups such as settled travellers and travelling travellers or between travellers and those in the lowest socio-economic group.

Recommendations

As parental contact with the travellers' school was very low (58%) specific intervention strategies are necessary to improve social and academic achievement in travellers' children. Pre-school, day care and health education programmes should be increased. Expansion of mobile clinics, family planning and parent training programmes are necessary so that the general health of travellers' children may improve.

Further research into travellers' lifestyle is required. This should involve a systematic collection of the experiences and findings of teachers, social workers and other personnel involved in work with travellers (O'Dwyer, 1984). This form of research would further assist educationalists in forming a planned curriculum of education to help meet their needs and also to retain their sense of identity and self-esteem (O'Dwyer, 1984).

It would also assist in educating the public as to the origins and culture of travelling people removing the discriminations, so that they can function as equal, self-respecting members of our society.

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A STUDY OF BEHAVIOURAL DEVIANCE AND SOCIAL DIFFICULTIES
11 AND 12 YEAR OLD DUBLIN SCHOOL CHILDREN

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INTRODUCTION

The incidence of significant social difficulties experienced by Irish school children is not well documented. It is considered that normal academic progress in school can be inhibited by a lack of proper social adjustment. This study focuses on social difficulties and behavioural deviancy in school children aged 11 - 12 years.

In a previous study, a rate of behavioural deviancy in Irish children was found to be 36.4% (O'Rourke and Fitzgerald, 1985), and 35.5% (Lynch and Fitzgerald, 1987). In Aberdeen, Lindsay developed, standardised and validated a self assessment questionnaire about social difficulty for adolescents (Lindsay and Lindsay, 1982). This questionnaire was used in this study.

SUMMARY

95 eleven and twelve year old school children were studied using a self-assessment questionnaire on social difficulties, and a teachers' questionnaire for measuring behavioural deviance.

11% of the children showed evidence of having general social difficulties. 17% of children described difficulties in their relationships with adults. 31% of boys and 9% of girls showed evidence of anti-social behaviour.

SUBJECTS AND METHODS

The study was carried out in an area of high unemployment and high density corporation housing where the majority of children were from families in the lower socio-economic groups i.e. partly skilled and unskilled manual workers (England, 1970). There were

other schools within a five mile radius of this school where the pupils were entirely middle class children living in a middle class area with no corporation housing. The parents of the school children were notified by letter of our intention to carry out the study. There were no refusals to partake in the study. Only the children in the 11 - 12 year age group were included in the study. The teachers were asked to complete a Rutter B2 questionnaire on behavioural deviance on each child involved in the study. The children were asked to complete Lindsay's questionnaire on social difficulties. This was done in the classroom in a group setting. It was easy to administer and took approximately 30 minutes to complete. Only the children present at school on the day the study was carried out were included. There were 95 children - 61 boys and 34 girls. 5 children were absent on the day.

The social difficulty questionnaire dealt with three areas of social interaction. These were social difficulties with peers, social difficulties with adults and general social difficulties. There were 46 questions; 26 dealt with peers, 11 dealt with adults and 9 dealt with general social difficulties. There were four possible answers to each question relating to the degree of difficulty experienced. For example:

- Q. How easily do you get embarrassed?
- A. (1) Very easily (2) Quite easily
(3) Not easily (4) Not ever

"Very easily" rated a score of three, down to a score of zero (0) for "not ever". The mean score was obtained for each question. Children who scored greater than one standard deviation above the mean were considered to have social difficulties in that area. Previous studies by Lindsay (1882) using this questionnaire including children of similar age and social background found it to be a reliable method of differentiating those with social difficulties from those without social difficulties.

The teachers completed a Rutter B2 questionnaire on all children involved in the study. This contained 26 questions covering neurotic and anti-social behaviour. Children were scored from 0 to 2 depending on the degree to which the behaviour occurred.

For example:

Q. Often worries/worries about many things.

Possible answers:

1. Doesn't apply - scored 0
2. Applies somewhat - scored 1
3. Certainly applies - scored 2

The total score was obtained and those scoring above a total of nine were rated as being behaviourally deviant. The child was then rated on a separate scale as being either neurotic or antisocial. If they scored equally on both antisocial and neurotic scores, they were rated as being undifferentiated, that is having a mixed disorder of conduct and emotions. Rutter's B2 scale has been standardised for children in the 10 to 14 year old age group in the Isle of Wight and for children aged 7, 10 and 14 in London. This scale has also been shown to be reliable and valid (Rutter, Isle of Wight Studies, 1976).

RESULTS

The results of the social difficulty questionnaire were similar to those in Lindsay's study of adolescents in an Aberdeen comprehensive school (Lindsay and Lindsay, 1982).

Table One - shows the mean score and standard deviations obtained in this sample and in the Scottish sample.

TABLE 1

Mean and standard deviation of three sections of questionnaire
Scottish Sample (n = 132)

	Peers	Adults	General
Mean	21.5	12.6	7.6
SD	7.7	4.8	2.8
Irish Sample (n = 95)			
Mean	19.3	13.6	8.8
SD	8.0	5.4	3.8

In the area of social difficulties with peers, 10 boys and 2 girls were considered to have poor peer relationships. In the area dealing with general difficulties, 4 boys and 6 girls indicated difficulties. 10 boys and 6 girls expressed social difficulties with adults.

Table Two - shows these scores as a percentage of the total Irish sample of 95 children, i.e. those with scores greater than one standard deviation above the mean.

TABLE 2

Percentage of Irish children exhibiting social difficulties as defined by Lindsay and Lindsay

	Male (m=61)	Females (m=34)	CHI Square Value
Peers	10 (16%)	2 (6%)	1.33 (Ns)
Adults	10 (16%)	6 (18%)	0.02 (Ns)
General	4 (7%)	6 (18%)	1.79 (Ns)

Table Three - shows the combined male/female scores as a percentage of the total Irish sample

TABLE 3

Overall percentage of sample exhibiting social difficulties as defined by Lindsay and Lindsay

Peers	13%
Adults	17%
General	11%

In each case, there is a strong positive correlation between the subscale (peers, adults and general social difficulties) for both boys and girls, indicating a tendency for high (and low) scores to occur together.

The Pearson product moment correlation co-efficient was used as the correlation measure.

Table 4 demonstrates this finding.

TABLE 4

Intercorrelations of component scales of Social Difficulty Questionnaire

Scales	Males (m=61)	Females (m=34)
Peers and Adults	+0.46 (p<0.001)	+0.41 (p<0.001)
Peers and General	+0.67 (p<0.001)	+0.59 (p<0.001)
Adults and General	+0.56 (p<0.001)	+0.59 (p<0.001)

On the Rutter scale 12% of boys were rated as being neurotic and 31% were rated antisocial. 9% of girls were rated antisocial. None of the girls were rated neurotic. 2 boys and 1 girl had a mixed or differentiated disorder of conduct and emotion.

Table Five - shows these results in actual numbers, rather than as a percentage.

TABLE 5

	Antisocial	Neurotic	Undifferentiated
Boys	19	7	2
Girls	3	0	1

DISCUSSION

The rate of behavioural deviance found in this study was similar to that found in previous studies in similar urban areas of Dublin (Lynch and Fitzgerald, 1987, and O'Rourke and Fitzgerald, 1985). They indicate quite a high rate of behavioural deviancy amongst school children from areas where there is a high rate of unemployment and high density corporation housing. The results probably marginally underestimate the level of social difficulty and behavioural deviance in the school because of the five children who were absent on the day on which the study took place. One could speculate that those children who were absent were from homes which were more socially disadvantaged than others.

The results of the Lindsay social difficulty questionnaire in this study were also similar to those found by Lindsay in school children from Aberdeen of similar age and socio-economic backgrounds (Table 1). This would indicate that the questionnaire is a useful screening method for social difficulties. It may also imply that children answer the questions honestly and do not give the socially desirable response.

An interesting feature that emerged in the study was the lack of a statistically significant correlation between the children's self-assessment and the teacher's rating of the children. One possible explanation is that the Rutter scale measures behaviour in the school environment whereas the social difficulty questionnaire measures behaviour in a wider context. Also, teachers may not detect the neurotic behaviour in children as

easily as antisocial behaviour which is more apparent. In 38 children (less than 50% of the sample), both the teacher and the child's self-rating concurred, i.e. they did not have social difficulties and were not rated as being antisocial, etc. However, in 48 children (more than 50%), the results of the teacher's assessment did not tally with the child's view of him or her self. The most striking difference was in the girls, where 11 girls (almost 30% of the females) who rated themselves as having social difficulties were considered to be "normal" by their teacher.

It is likely that children from more advantaged schools would have less social difficulties. Barton and Fitzgerald, showed that children in more advantaged schools had significantly less behavioural disturbances (Barton and Fitzgerald, 1986). Further studies should examine this possibility.

The percentage of children who did report social difficulties possibly indicates a need for a course in social skills training in schools. There is need for training teachers to detect social difficulties and neurotic behaviour in children. Finally it would appear that the social difficulty questionnaire could be useful as a measurement of improvement in social skills training in a child guidance clinic setting.

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Self-Esteem and Behavioural Deviance in Child Populations

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SUMMARY

Self-esteem and behavioural deviance were assessed in a normal school, a child psychiatric clinic, a special school and a child psychiatric in-patient clinic. Mean total self-esteem was lower in those attending the psychiatric services than in those attending the normal school.

INTRODUCTION

Self-esteem is related to many psychiatric disorders and it would be expected by most clinicians that children attending the psychiatric services would view themselves more negatively than normal children. A study by Thompson¹ of 2,000 eleven year olds in England indicated that self-esteem was lower among those who were rated as behaviourally deviant. Questionnaires measuring behavioural deviance have been shown to reliably distinguish those attending the psychiatric services from the normal population². High rates of behavioural deviance would be expected in out-patient clinics, special schools and child psychiatric in-patient units. It would therefore be expected that low self-esteem would be found in these groups.

This has, however, been disputed. Zimet and Farley³ found mean self-esteem scores of children entering psychiatric day treatment or referred for out-patient treatment to be comparable to a normal group. This finding is somewhat surprising.

The study here reported attempted to determine whether self-esteem was lower in psychiatric populations, and to assess the relationship between self-esteem and behavioural deviance.

MATERIALS AND METHODS

The subjects consisted of children attending a child psychiatric clinic, a special school and a child psychiatric in-patient unit. The child psychiatric clinic was located in a suburb of Dublin. A consecutive series of 17 referrals were assessed. The second group consisted of 15 children of a similar age attending a school for emotionally and behaviourally disturbed children. The third group consisted of all seven children of a similar age in an in-patient psychiatric unit at the time of the study. A control group consisted of 80 children of similar age and sex attending a normal school in a suburb of Dublin.

Each child was asked to complete the Coopersmith Self-Esteem Inventory⁴. This consists of a series of questions designed to measure self-esteem in general and in specific areas of life. The "school short form" consisting of 25 questions was administered to those under the age of ten years. The "complete school form" consisting of 58 questions was administered to the older subjects. This version has subscales which attempt to measure self-esteem in specific areas of experience such as home, school and social areas, and has a "lie" or defensiveness scale. The "short" form is included in the "complete" school form and consists of the items from the "complete" form which show the highest item-total score correlation. Total score correlation between both is 0.86⁴. The questionnaire has good construct validity and high internal consistency (KR 20: 0.81 - 0.86)⁴.

In the clinic population, the parents were asked to complete the Rutter A2 child (parents) scale. The teachers of the other groups were asked to complete the Rutter B2 child (teachers) scale. A score of 13 on the parents scale, and nine on the teachers scale was used by Rutter et al² as a measure of behavioural deviance, and was found by him to be a good indicator of psychiatric disorder. Subscales differentiated those rated as "behaviourally deviant" into "antisocial", "neurotic" and "undifferentiated" groups.

RESULTS

All questionnaires were returned. Prevalence of behavioural deviance in each groups as measured by the Rutter Child scale is shown in Table 1.

TABLE 1
RATES OF BEHAVIOURAL DEVIANCE IN EACH GROUP

Percentage rated as	Normal School	Clinic	In-patient Unit
Behaviourally deviant comprising -	40 %	53.8%	71.4%
1) Antisocial	33.7%	23 %	57 %
2) Neurotic	3.7%	15.3%	14.2%
3) Undifferentiated	2.5%	15.3%	—

In the out-patient clinic and special school, self-esteem scores were analysed separately for those above and below the age of ten years as the instrument used was slightly different. Mean total self-esteem scores for all groups and subscales scores for subjects over the age of ten years are given in Table 2.

Dunnett's T test⁵ for the difference of two means was used to compare group mean scores. No statistically significant difference was found when mean behavioural deviance scores were compared. Statistically significant differences in self-esteem scores are given in Table 2.

TABLE 2
COMPARISON OF MEAN SELF-ESTEEM IN ALL GROUPS

Variable	Normal School	O.P. Clinic		Special School		In-patient Unit	
	Mean	Mean	Significance of Difference	Mean	Significance of Difference	Mean	Significance of Difference
Total Self-esteem							
Age:							
>10 years	78.3	61.8	p < 0.01	66.9	p 0.05	64.3	p < 0.05
<10 year	78.3	59.2	p < 0.01	53.3	p 0.005	64.3	p < 0.05
"Lie" score	3.3	2.7	N/S	2.7	N/S	1.7	p < 0.05
Social Self-esteem	6.5	3.5	p < 0.001	3.6	p 0.001	3.7	p < 0.001
School Self-esteem	5.9	3.7	p < 0.001	4.6	N/S	5.1	N/S
Home Self-esteem	6.9	5.4	p < 0.001	5.8	p 0.05	5.7	p < 0.05
General Self-esteem	19.8	18.3	N/S	19.3	N/S	17.7	N/S

DISCUSSION

The rate of behavioural deviance obtained in the normal school was quite high: 40%. Instruments such as the Rutter A2 or B2 questionnaires generally overestimate the prevalence of psychiatric disorder in normal children. Previous research⁶ in a similar population using interview techniques and questionnaires found a similar rate of behavioural deviance on questionnaires, but a much lower prevalence of psychiatric disorder on psychiatric interview. The real prevalence of psychiatric disorder in a normal school in this previous study was 18.6%. The 40% rate here reported is also likely to be an over-estimate of the real prevalence of psychiatric disorder. It is probable that other factors such as class behaviour are influencing the teacher's ratings. This is supported by two findings: 84% of those rated as behaviourally deviant in the normal school were rated as "antisocial"; and secondly, no statistically significant difference was found between mean scores in the "normal" and the "abnormal" groups. The teachers in the normal school gave very high as well as very low ratings. Non-compliance or disruptive behaviour in class was probably the strongest influence on the rating patterns of the teachers in the normal school. This factor probably operated to a lesser extent in the other groups.

Total self-esteem was reduced in all groups attending the psychiatric services. The total self-esteem score was derived from four components: general self-esteem, home self-esteem, social self-esteem and school self-esteem. Since no significant differences in general self-esteem subscales scores were found between groups, the reduction in total self-esteem was due to reduction in the other components. The reduction in home self-esteem (slightly greater in the clinic group) could be a consequence of referral to the clinic, or of the factors causing referral. These same factors probably operated to a lesser extent or in a less acute fashion in the in-patient and special school group than in the clinic groups.

School self-esteem scores were significantly reduced in those attending the clinic. This could be due to poor performance in school, or the factors causing referral to the clinic. The absence of any change in school self-esteem in the special school and the in-patient and special school group than in the clinic group.

Social self-esteem was reduced in all study groups. Since it is equally reduced in all study groups, it is probably a consequence of attending the psychiatric services, or due to the causes of that attendance. The low defensiveness score of the in-patient is probably due to hospitalisation and the duration of psychiatric treatment.

These findings of reduction in self-esteem disagree with those of Zimet and Farley³. A different instrument was used in their study, and social class may have been different. However, the most likely cause of the difference in the findings is referral patterns. The findings of the study here reported would agree with the clinical impression of most psychiatrists in this country.

In those rated as behaviourally deviant in the normal school self-esteem scores were average. In the other groups, self-esteem scores were on average lower than in the children attending the normal school. This could be a consequence of the overestimation of "behavioural deviance" in the normal school groups, or it may indicate that self-esteem is an important factor in determining referral to the psychiatric services. Wide variations in both self-esteem and behavioural deviance scores were present within the groups attending the psychiatric services. No statistically significant relationship could be demonstrated between self-esteem scores and behavioural deviance scores within each group.

The conclusion of this study is that self-esteem is lower in those attending the psychiatric services, than in those attending a normal school.

Further studies could investigate self-esteem with detailed in-depth psychiatric interview and assessment of educational attainment.

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**A study of Emotion and Behaviour in Children attending
a normal school in an urban area**

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M. Cullen

SUMMARY

Anxiety, depression, self-esteem, behavioural deviance and prosocial behaviour were studied in children attending a normal school in a disadvantaged urban area, using self-rated and teacher-rated questionnaires. The prevalence of depression was rated as 5%. 15% described frequent suicidal thoughts. 40% scored as behaviourally deviant. Significant correlations were found between the variables studied. The rates of depression and behavioural deviance were higher than in comparable British populations.

INTRODUCTION

Epidemiological studies of children have shown various prevalences of psychiatric disorder. Studies using screening instruments have shown variations between urban and rural areas^{1,2} and have indicated differences between Irish and British populations^{1,3}. Studies using clinical interviews^{4,5} have shown that the actual prevalence of psychiatric disorder is lower than that found using self-rated or teacher-rated questionnaires. Studies of depression have found prevalences of between 1%⁴ and 33%⁶. The Isle of Wight study⁴ found a prevalence of less than 1% for depression, and a 1.5% prevalence of anxiety.

Various studies have found associations between psychiatric disorders such as depression and conduct disorder⁷. Correlations have also been found between scores on instruments designed to assess psychiatric disorder, adjustment or behaviour, such as anxiety and self-esteem⁸, or behavioural deviance and pro-social behaviour⁹.

3. The Coopersmith Self-Esteem Inventory consists of 58 questions which attempt to evaluate the self image in various areas of life¹². Reliability co-efficient is 0.87.

4. The Rutter B2 Teachers Scale consists of a series of 26 questions concerning observable behaviour designed by Rutter et al to assess maladjustment. Subjects scoring 9 or above are classified by Rutter as "behaviourally deviant". Subscales classify positive scores into "antisocial", "neurotic" or "undifferentiated" sub types. It has been shown to discriminate between those attending the psychiatric services and normal children. Test-retest reliability ($r = 0.89$) and inter-rater reliability ($r = 0.72$) are both high⁴.

5. The Prosocial Behaviour Questionnaire was designed by Weir and Duveen⁽⁹⁾ to measure prosocial behaviour. Prosocial behaviour is defined as an umbrella term for a number of inter-personal behaviours such as helping, sharing and co-operating, the common theme of which is concern for others. This scale correlates well with observed behaviour in classrooms. The reliability co-efficient is 0.91. All instruments have been shown to have validity.

RESULTS

All questionnaires were completed. Means and standard deviations for all variables are compared with data from U.S. and British studies and are shown in Table 1.

Table 1

Means and Standard Deviations of Variables and Comparison with Previous Data from Other Studie

Variable	STUDY GROUP			PREVIOUS RESEARCH		
	Mean	S.D.		Mean	S.D.	Significance
Depression D.S.R.S	7.4	3.6	Birleson (1981)	4.32	3.32	$p < 0.001$
State Anxiety	27.5	5.6	Spielberger (1970)	31.0	5.71	$p < 0.05$
Trait Anxiety	32.9	7.4	Spielberger (1970)	36.7	6.32	$p < 0.001$
Self-esteem	77.8	12.15	Simon et al. (1971)	70.4	15.4	$p < 0.001$
Prosocial Behaviour	24.3	11.0	Weir and Duveen (1981)	24.1	9.5	N/S
				24.3	9.5	N/S
				18.3	9.5	$p < 0.001$

Using a cut-off point of 13 on the Birleson Depression Self Rating Scale (DSRS), four boys, or 5% of the total sample, scored as depressed. 40% of the total sample (32 pupils) were rated as behaviourally deviant on the Rutter B2 behavioural deviance scale. 33.75% of the total sample (27 pupils) were rated as "antisocial", 3.75% of the sample as "neurotic" and 2.5% as "undifferentiated". 75% of those who scored as depressed (i.e. 3 out of 4) were also rated as behaviourally deviant, and all three were rated as antisocial rather than undifferentiated or neurotic.

Scores that were more than two standard deviations above the mean were taken as indicative of high anxiety. 3.5% (i.e. 3 pupils) scored above two standard deviations on the State Anxiety Scale, and 5% (i.e. 4 pupils) scored above two standard deviations on the Trait Anxiety Scale. Of those who scored above these limits on the State Anxiety Scale (3 in all) two scored as depressed, and both of these were also rated as behaviourally deviant - antisocial type. There were 4 pupils (i.e. 5%) who scored above two standard deviations on the Trait Anxiety Scale, and one of these scored as depressed, and "antisocial" on the Rutter scale. Two of the 4 were rated as antisocial only.

A normal Z test for the difference of two means was used to compare the results of this study with previous results on similar populations (see Table 1). The mean for the DSRS was significantly higher than that found by Birleson in children attending a normal school. Means for the State and Trait Anxiety were significantly lower, and for self-esteem significantly higher than in Spielberger's and Coopersmith's American samples. Means for prosocial behaviour were not significantly different from two of Weir and Duveen's three samples.

The data was cross-tabulated for significant correlations. These are given in Table 2.

DISCUSSION

5% of the subjects scored as depressed on the DSRS. A clinic population in the same area gave a prevalence of 14%, using the same instrument¹³. 40% of the subjects were rated as "behaviourally deviant" on the teachers' scale. This result is in accordance with previous studies of Irish populations^{1,3}. As these are self-rated and teacher

As in previous research there was a high correlation between prosocial behaviour and Rutter total scores. This finding is reasonable in that those scoring high in prosocial behaviour would score lower on the Rutter scale which attempts to measure behavioural deviance. Slightly less significant negative correlations were found between trait anxiety and prosocial behaviour, and positive correlations between trait anxiety and Rutter total scores. High trait anxiety was accompanied by lower prosocial behaviour and higher behavioural deviance ratings.

The number of significant correlations (9 in all) between the scores on the instruments used in this study supports previous evidence⁽¹⁶⁾ of close associations between depression, anxiety and self-esteem. The findings also suggest that measurements of behaviour correlate fairly well, and that high anxiety may be accompanied by behavioural problems.

The subjects in this study rated themselves as being less anxious, and having higher self-esteem than Spielberger's or Coopersmith's American samples. The studies (Spielberger and Coopersmith) were carried out on children of diverse social background, unlike the subjects in this study, so the difference may be due to social or cultural factors. No further conclusions can be drawn from the data available. Prosocial behaviour scores were comparable to Weir and Duveen's inner city samples.

A large difference occurred between the subjects of this study and Birleson's subjects who were attending a normal school (though Birleson's group was from mixed social backgrounds). The means score in this study was twice that obtained by Birleson in a normal school. This is further illustrated by a question in this instrument concerning what is classified by Birleson as "suicidal thoughts" i.e. asking subjects whether they thought that their life was worth living. In this study 15% thought that their life was not worth living "most of the time", and 18.8% thought that their life was not worth living "sometimes". The mean score for this question was 0.48. In Birleson's study the corresponding score for those attending the normal school was 0.03 and for his "maladjusted" group than to his normal group, having a higher prevalence of what he classifies as "suicidal thoughts". Other studies^{17,18} have found prevalences of suicidal thoughts of between 10% and 33% in a clinic population, though suicidal thoughts were defined

differently in this population. If the 5% prevalence of depression and this high prevalence of suicidal thoughts is valid, bearing in mind that this is a self-rated scale, the subjects in this study would appear to have a higher than expected level of depression. It is probable that social factors are playing a role in these findings, and that those attending schools in this disadvantaged area would appear to be showing more signs of stress of urban social disadvantage are pushing the subjects of this study closer to Birleson's maladjusted group, even though they are attending a normal school.

In conclusion, it would appear that the children in this disadvantaged urban area are under considerable stress, and this would be supported by the clinical experience of the authors (M.F. and M.M.) who have worked in child psychiatry in this area.



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Correlations between Variables

		Pearson's Correlation Coefficient	Significance (p value)
Depression (D.S.R.S.)	Self-esteem	-0.627	p < 0.001
	State anxiety	+0.455	p < 0.001
	Trait anxiety	+0.347	p < 0.001
Self-esteem	State anxiety	-0.327	p < 0.01
	Trait anxiety	-0.479	p < 0.001
State anxiety	Trait anxiety	+0.356	p < 0.001
Trait anxiety	Rutter score	+0.381	p < 0.001
	Prosocial behaviour	-0.295	p < 0.05
Rutter score	Prosocial behaviour	-0.679	p < 0.001

STUDY OF BEHAVIOUR DEVIANCE AND SOCIAL COMPETENCE IN
CHILDREN OF PSYCHIATRIC INPATIENT FEMALES

1 Papers



O'Leary
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SUMMARY

A study of behaviour deviance and social competence of children of 42 female inpatients was carried out at St. Loman's Hospital, Dublin between the 1st February 1985 and the 30th June 1985. A total of 92 children were studied. It was found that 5.4% of the children had deviant behaviour. In addition, 72.8% of the children were socially incompetent.

*Dublin
with special group*

INTRODUCTION

There is now screening information on the levels of behaviour deviance of children in normal settings in Ireland (Leader et al, 1985; Barton and Fitzgerald, 1986; Fitzgerald and Kinsella, 1987). However, the rate of behaviour deviance in the children of psychiatric inpatients is not known in Ireland. It has been shown that there are important associations between mental disturbance in the parents and psychiatric disturbance in the children (Beardslee, 1984; Cytryn et al, 1984; Weissman, 1984). The risk of behaviour problems is increased with most forms of parental mental illness (Quinton and Rutter, 1984). It seems to be greatest when the parents have a chronic or recurrent depression or emotional disturbance.

It was decided to study the children of psychiatric inpatient females to establish the rate of behavioural deviance and social competence.

METHODS

A consecutive series of mothers admitted to St. Loman's Hospital, with psychiatric illness was studied. It excluded those with senile dementia, alcoholism and mothers whose children were all over 16 years. 42 mothers were interviewed in St. Loman's Hospital.

These mothers had a total of 97 children. Data was unavailable on 5 of the children. The remaining 92 children were studied. All the mothers came from urban areas. The mothers were screened by the Hospital Anxiety and Depression Scale (HAD), (Zigmond and Snaith, 1983). The same researcher carried out all the interviews.

The HAD is a self assessment screening instrument. It was developed for detecting states of depression and anxiety in adult patients aged between 16 and 65 years. Scores of 7 or less indicate non cases, between 8 and 10 indicate doubtful cases. Scores from 11 onwards indicate definite cases. The HAD shows 1% false positive and 1% false negative for the depression subscale. The anxiety subscale shows 1% false negative and 5% false positives (Zigmond and Snaith, 1983). The mothers were also assessed using the Social Questionnaire (Corney et al, 1982). It has items on housing, occupation, finance, social and leisure activities, child-parent and marital relationships, relationships with relatives, friends, neighbours, workmates and legal problems.

In assessing the children, the Behaviour Screening Questionnaire (BSQ) was used for children aged 3 years (Richman et al, 1982). A total score of 10 on the questionnaire would indicate evidence of behaviour problems. The BSQ has been tested and proved to be a reliable method of assessing behaviour problems in the English pre-school child. It has been shown to detect 100% of cases who could be described as moderately or severely disturbed on clinical interview.

Children between the ages of 4 and 16 years were screened using the Child Behaviour Checklist (CBCL), (Achenbach and Edelbrock, 1983). It is a rating form designed to obtain reports of childrens' behavioural problems and social competencies as reported by their parents. This form has been shown to yield valid results and to have a high test/retest reliability.

RESULTS

The results demonstrated at 5.4% rate of behaviour deviance in children of female psychiatric inpatients and a 72.8% rate of social incompetence of the CBCL. 8.3% of the children who had behaviour problems were socially incompetent whereas 2.1% of the children who were socially competent had behaviour problems.

The Social Questionnaire demonstrated that 45% of the mothers complained of difficulties in coping with their children. The difficulties ranged from slight to severe problems. 2.4% of the mothers were working outside the home and 47.6% had primary and secondary education while none had third level education. 76.2% of the mothers were married. 16.7% were separated and 2.4% were widowed, while 4.7% of the mothers were single. The Social Questionnaire demonstrated a 50% rate of marital disharmony. In addition, 35.7% expressed dissatisfaction with their housing.

The rate of mothers showing definite anxiety symptoms with the HAD scale was 42.9%. 16.6% had scores in the doubtful range for anxiety symptoms. The same scale yielded 35.7% with definite scores on the depression scale, whereas 19% of them had scores in the doubtful range for depression.

DISCUSSION

mothers with social competencies

The high rate of social incompetence of 72.8% in the children of psychiatric mothers might be explained by the high rate of anxiety and depressive symptoms in the mothers. This could have interfered with the ability of the mothers to tune in emotionally to the children's needs and model appropriate social behaviour. This would be supported by the fact that 45.5% of the mothers admitted to having difficulties coping with their children.

Mothers who have symptoms of depression and anxiety may be preoccupied with their own thoughts and have limited time for their children. This may lead to inconsistent parenting which may reinforce socially incompetent behaviour in their children.

Mills et al, (1984) found that mothers with recurrent or chronic depressive illness

tended to respond less appropriately to their children and were less likely to sustain positive interactions. They were also less able in their attempts to control their children. Nelson et al, (1970) suggested that mental illness predisposed to tendencies to social isolation of patient couples. This may have an effect on the social competence of their children.

Family discord has been shown as a risk factor for child behaviour problems, (Rutter, 1981; Emery, 1982). In this study, it was found that 50% of the mothers admitted to having marital disharmony in the home. This may be a factor in producing behaviour problems and social incompetence in their children. This view is supported by Richman et al, (1982) in their general population epidemiological study. They found that psychiatric disorder in 3 year olds was strongly associated with family discord and disturbed parent/child relationship.

It would appear that the best interests of the children involved would be served by emphasis on early treatment of parental mental illness, marital disharmony and by supporting families under social stress.

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MATERNAL MENTAL HEALTH

CHILDHOOD BEHAVIOUR PROBLEMS AND SOCIAL DISADVANTAGE IN FAMILIES OF CHILDREN ATTENDING A CHILD GUIDANCE CLINIC

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Summary

This study investigates maternal mental health, behavioural problems in children and social adversity in families of children attending a child guidance clinic, using reliable and valid research tools. Thirty-eight per cent of mothers showed significant anxiety symptoms; 44% of mothers showed significant depressive symptoms and 50% showed no evidence of anxiety or depressive symptoms. There was a significant correlation between anxiety and depressive symptoms occurring in the same mother, or not at all. High levels of social (74%) and marital (42%) problems were found. Eighty per cent of the children showed evidence of behavioural problems.

Introduction

Brown et al (1975) in their Camberwell study found the incidence of depression in working class women to be 40%. They claimed that depressive conditions are often the result of aetiological factors of a directly sociological nature. Shepherd et al (1966) found that many mothers attending child guidance clinics saw themselves as suffering from depression and "nerves". They commented on the relationship between the disturbed child and the mother. Richman et al (1982) found behavioural problems in a pre-school child tended to be closely associated with depression in mothers. Irish studies have also looked at social adversity and mental depression (Fitzgerald, 1985; Leader et al, 1985).

Present Study

This study investigates mental health, behavioural problems in children and social adversity in families of children attending a child guidance clinic using detailed semi-structured clinical interviews in mothers in conjunction with child behaviour

Method

The group that was chosen for this study were the mothers of fifty consecutive attenders at a child guidance clinic. The clinic is situated in a large working class urban area, five miles from Dublin city centre, which consists mainly of local subsidised houses and a small number of privately-owned dwellings. This suburb was started twenty-five years ago, giving a certain cohesiveness to the community and contains many second and third generation families, although new houses are still being built. There are no high rise in the area. As with other working class Dublin suburbs, there is a high and increasing unemployment and crime rate (Leader et al, 1985).

The study group consisted of new cases that were currently being treated by the staff of the clinic. Patients were referred by general practitioners, public health nurses, teachers, social workers and a small number were self-referred. The staff of the clinic who were treating these cases included five psychiatrists, one psychologist and one social worker. Some of the children were also attending pre-school and school age groups, staffed by qualified child care workers. Children were attending for a variety of reasons: conduct and emotional disorders, disorders of sleeping, eating, elimination, personality and adjustment reactions.

Children who were under two and a half years and older than sixteen years were excluded from the study, as were those who were in institutional care.

Instruments

The Clinical Psychiatric Interview is a standardised, semi-structured inventory designed for use in community surveys and general practice. This was administered to all mothers in the study group. This schedule is divided into four sections. The first is unstructured and consists of sub-headings for brief recordings of the patient's present and past medical history. The second part is one detailed and systematically enquires about any psychiatric symptoms which the patient may have experienced during the preceding week. The third part of the schedule is unstructured and permits the interviewer to collect just enough information about the patient's personal family history as may be deemed necessary to assist him to make his clinical assessment. The fourth and last

non-referred children. It has been shown to yield valid results and to have a high test/re-test reliability (+0.89) and interparent correlation (+0.74) (Achenbach, 1978; Achenbach, 1984).

Results

Fifty mothers and 50 children were studied. The data were analysed using the Chi Square Test for Association with Yates' Continuity Correction. Leeds Scales: 25 mothers were found to be normal, 6 depressed only, 3 anxious only, and 16 both anxious and depressed. There was a significant correlation between anxiety and depression occurring in the same mothers together. (Chi Square = 17.56347).

On the clinical interview 15 mothers were found to be normal, 3 to be showing signs of depression only and 12 to be showing combined anxiety and depression. Table 1 indicates that the clinical interview detects different groups as regards scores, in the different categories, with no overlap between groups that are normal, depressed and anxious.

There is some overlap between the depressed group and the combined anxiety and depressed group. Thus, there are discreet groups of normal parents, anxious parents and parents who were depressed with or without anxiety. It indicates that the interview is effective at detecting different levels of psychiatric illness in relation to groups under study.

TABLE 1
Analysis of Clinical Interview

Group	Count	Mean Score	Standard Deviation	Standard Error	95% Confidence Interval for Mean
Normal	15	2.00	2.5635	0.6619	0.5804 - 3.4196
Anxious	20	13.40	6.4596	1.4444	10.3768 - 16.4232
Depressed	3	22.667	2.0817	1.2019	17.4955 - 17.8379
Anxious and Depressed	12	29.25	12.7002	3.662	21.1807 - 37.3193

Marital Problems

Twenty-one of the mothers showed evidence of marital problems and 29 did not.

section permits the interviewer to record abnormalities observed during the interview on twelve five point scales. The ratings represent the doctor's view of "manifest abnormalities" that he has observed at interview, as distinct from the patient's symptoms that have already been rated in the second part of the interview. The strength of the standardised psychiatric assessment lies in its reliability. The overall reliability co-efficient, derived from the analysis of variance, is +0.92 (Goldberg and Blackwell, 1970).

The Self-Report Social Questionnaire devised by Corney et al (1982) was administered to all mothers in the study. The questionnaire covers housing, occupation, finance, social and leisure activities, child, parent and marital relationships, relationships with friends, relatives, neighbours and work-mates and legal problems. It has been found to be readily acceptable, easy to complete and a useful screening device to detect social problems. Each social area is scored separately (Corney et al, 1982; Corney, 1985).

All mothers were asked to complete the Leeds Scales for anxiety and depression. The results of these scales have been shown to correlate significantly with observer ratings for anxiety and depression (Snaith et al, 1976).

The Behavioural Screening Questionnaire (BSQ) devised by Richman and Graham (1971) was used to assess the children in the age group two and a half to four years. It consists of twelve questions e.g. feeding, toilet training, tantrums. A total score of ten on the questionnaire was taken to indicate the possibility of a behavioural problem. The BSQ has been shown to be a reliable method of assessing behavioural problems in the English pre-school child. It has been shown to identify 100% of cases who would be described as moderately or severely disturbed on clinical interview (Richman and Graham, 1971).

The Child Behaviour Checklist (CBCL) was administered to all mothers in the study, of children between the ages of four to sixteen years. The CBCL is designed to record, in a standardised format, the behavioural problems and social competencies of children, as reported by their parents and parent surrogates. The scales were constructed from analysis of parent ratings of 2,000 clinically referred children and normed on 1,300

Social Problems

Thirty-seven mothers showed evidence of social problems and 13 mothers did not. Eight mothers had one significant social problem, nine mothers had two significant social problems, nine mothers had three significant social problems, five mothers had four significant social problems and two mothers had six significant social problems. Thus, 74% of mothers had significant social problems and 42% had significant marital problems and 58% had more than one significant social problem.

Children

Forty of the children scored as abnormal on the Child Behaviour Check-list and 10 as normal. In the abnormal subset four children scored as socially incompetent only, 24 children scored as behaviourally deviant only and 12 children were both socially incompetent and behaviourally deviant. A score greater than or equal to 10 on the BSQ was taken to indicate behavioural deviance. Six children were under four years of age and were rated as behaviourally deviant. The correlation between maternal mental health (Leeds) and childrens' behavioural status gave a chi-square result of 3.125 ($p < 0.1$). The correlation of social problems in mother and maternal health (Leeds) gave a chi-square value of 6.65 ($p < 0.01$). The correlation of marital problems in mothers and maternal mental health (Leeds) gave a chi-square of 5.25 ($p < 0.025$). The correlation of social problems and maternal health (clinical interview) gave a chi-square value of 3.35 ($p < 0.1$). The correlation of marital problems and maternal health (clinical interview) gave a chi-square value of 5.66 ($p < 0.025$).

Discussion

In this study high rates of depressive symptoms (44%) and anxiety symptoms (38%) using the Leeds Scale, in mothers of children attending a Child Guidance Clinic in a working class area have been noted. In this group there is also a high incidence of social (74%) and marital (42%) problems. It has been shown that there is an increased incidence of depression and anxiety occurring in mothers who also had significant social and marital problems. There was also a trend for more psychiatric disturbance in mothers as the number of social problems increased. Thus the findings are in

agreement with those of Brown et al (1975) and indicate the need to examine ways of dealing with the social and marital areas if maternal psychiatric disorders are to be treated effectively.

In regard to the children in this study it has been shown that there was a trend for more behavioural and social competence disorders in children of mothers with identified psychiatric disorders. It also appears that the same trends exist in the children of mothers with marital and social problems. Figure 1 shows a possible relationship between the factors under study.

Strong trends, just short of statistical significance, linked maternal mental illness and behavioural disorders in children. Less strong trends linked social and marital problems with behavioural disorders in children. Both social and marital problems were significantly statistically linked with maternal mental illness. Therefore, the apparent link between the factors under study is that social and marital problems are strongly associated with maternal mental illness and less so with behavioural deviance in children and maternal mental illness. Rutter (1976) found 50% of mothers with children with psychiatric disorder to be depressed and only 10% of mothers with children without psychiatric disorder to be depressed. He also found a greatly increased incidence of behavioural deviance in children living in a socially deprived inner London borough. Therefore there is a large body of evidence to suggest that psychiatric disorder in mothers is strongly linked to psychological disturbances in children and that probably social factors feature significantly in the aetiology of both maternal mental illness and childhood disorders. The findings support this evidence and indicate that, to deal with children attending a Child Guidance Clinic effectively, it is necessary to enquire about maternal mental health and social and marital circumstances. There are grounds for a close liaison between child guidance clinics and adult psychiatric departments as well as marriage guidance clinics and for quick and easy referral between these agencies. In this way the common problems which exist within the population can be dealt with more rapidly.

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**THE PREVALENCE OF SLEEP-RATED DISORDERS AND BED-WETTING
IN THE CHILDREN OF MOTHERS ATTENDING A PUBLIC HEALTH CLINIC**

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Summary

The prevalence of sleep-rated disorders and bed-wetting in a Dublin non-psychiatric child sample is studied and compared with that found in other centres. Relevant social and environmental factors are considered and discussed.

Introduction

The prevalence of sleep disorder in child psychiatric populations has been studied and documented (Anders and Fitzgerald, 1984). Similarly, associations have been drawn between frequency and chronicity of insomnia with the intensity of psychiatric symptomatology in adults (Sweltwood, 1980).

It is our clinical experience that many parents experience great difficulty with their children's sleep behaviour. However, they are not often referred with this as their main problem. Because of this, it was decided to study the prevalence of sleep-rated disorders in a non-psychiatric population of children.

It was decided to include the subject of nocturnal bladder control in the study for similar reasons. This subject has been well researched (Kolvin et al, 1973).

Method

The authors approached colleagues in the Community Care Service and arranged to interview mothers attending the developmental and other public health clinics. We collected data on 101 children under the age of 16 years, by interviewing the mothers about each of their children in this age group. The selection of the subjects in this way not only facilitated collection of the sample, but also provided a sample which could reasonably be expected to be without bias in the area of sleep disorder, as none of the mothers were approaching the clinic with this in mind. The data was obtained from 47 mothers.

A structured interview was devised by the authors for the study, to reflect previous research in the field, as well as looking at some local questions and data collected included; current sleeping behaviour, specific problems, sleeping history since birth, birth history, maternal tobacco and alcohol consumption during pregnancy, birth order, family size, sleeping arrangements, father's occupation and over-crowding.

Results

The definition of what constitutes sleep disorder can present some problems in the young infant whose patterns may be considered to be in an unstable state anyway, so it was decided to use the model used by Richman (Richman et al, 1975). This relies on the parents' perception of the problem, so that if certain behaviour is not a problem to the parent, sleep disorder cannot be diagnosed. A scoring system is used as follows: no problem = 0; problem once or twice per week = 1; problem occurring three times per week and either takes more than one hour to get to sleep or wakes at night for more than a few minutes and goes into the parents' room or bed = 2.

The 101 children were 45 boys and 56 girls with ages ranging from 4 months to 15 years, mean 4 years and 7 months. Twelve of the boys (26.7%) and twenty-one of the girls (32.2%) had sleep disorder as defined above. Only six of these scored 1, the remainder achieving a score of 2.

We asked about specific problems occurring more than once per week and we found thirty three children waking during the night other than for a routine feed, seventeen children sleep-talking, seven children with screaming episodes of night-terrors, and one child sleep-walking.

Gestation ranged from 35 to 43 weeks, mean 40.4 weeks. There were 80 normal deliveries, 11 Caesarian sections and 10 forceps-assisted deliveries. Ten children were recalled as having required oxygen after birth. The mothers of 10 children had had pre-eclamptic toxæmia.

The mothers of 54 children smoked during pregnancy, 28 smoking between twenty to forty per day and the mothers of 43 children drank alcohol during pregnancy. Twenty-eight of the children lived in overcrowded conditions, according to the International Classification of Diseases (ICK, 9) standard of 1.5 persons per habitable room. Thirty two (70.) of the fathers were employed, thirteen were unemployed, and the employment status of two fathers was unobtainable as the mothers were single parents without any contact with the fathers.

Twenty-three families (49%) had only one child, twenty-two families (45%) had between two and four children, one family had five children and two had six children. The large number of single child families can be accounted for by the number of mothers attending the developmental clinics with their first child.

Nine children slept on their own in a separate room, thirty-nine had their own bed or cot in a room shared with parents or siblings, thirty-one shared a bed with a sibling and twenty-two regularly shared the paternal bed.

Statistical analysis, using the chi-square test, failed to demonstrate a significant association at the 5% level between sleep problems and any of the following: abnormal delivery, toxæmia, length of labour, tobacco or alcohol consumption during the pregnancy, the sex of the child, bed-wetting, overcrowding or sleeping arrangements (including sharing a bed with parents).

Table 1 presents the number of children wetting the bed at least once per week.

TABLE 1

Breakdown by age and sex of the number of children wetting at least one night per week.

BOYS

Age	Total Number	Number Wetting	% Wetting
<1	14	13	92
<2	4	3	75
<3	2	1	50
<4	3	0	0
<5	3	2	66.6
<6	4	1	25
>6	15	3	20

GIRLS

Age	Total Number	Number Wetting	% Wetting
<1	14	12	86
<2	7	7	100
<3	11	9	81.8
<4	5	2	40
<5	8	3	37.5
<6	4	2	50
>6	7	1	14.2

We analysed two groups of these children using the chi-square test. The first excluded children of less than two years, at which age many parents begin toilet training, and the second excluded children of less than three years, at which age Richman found only 40% bed-wetting (Richman et al, 1975). The sex of the child was significant at the 5% level in the group excluding those less than 2 years, but did not achieve this level of significance when the two to three year old children were also excluded. A relationship between bed-wetting in the child and alcohol consumption during the pregnancy by the mother was demonstrated to approach significance (P 0.1) in the group of children over

2 years and it achieved significance at the 5% level when the two to three year old children were excluded.

A similar finding was noted in relation to abnormal delivery. Thus abnormal delivery was not significantly related to bed-wetting in the group of children where those less than 2 had been excluded, but achieved significance at the 5% level when the two to three year old children were also excluded.

Discussion

The finding of 33 children with sleep disorder out of a group of 101 is significantly higher ($P = 0.05$) than expected compared to those from a similar study in London (Anders and Fitzgerald, 1984) which showed the group with no psychiatric diagnosis to have a 19% prevalence of sleep problem.

TABLE 2

Comparison by age, of the prevalence of sleep problems of the London and Dublin groups.

Age Group	London Percentage	Dublin Number	P
A. Total Sample	19	33	< 0.05
B. < 5 years	24	36	< 0.1
C. 6 - 10 years	11.3	22.7	< 0.05
D. 11 - 15 years	21.1	16.6	NS

In Table 2 we have broken our sample to suit the groupings in the London study. This shows that there were significant sleep disorders in the Dublin group except for those aged 11-15 years. Our data showed a higher but not statistically significant prevalence in girls (32.2%) compared to boys (26.7%). This was also true for the London group.

Notable in the general information collected is the high prevalence of smoking during pregnancy (54%) and the proportion of those (52%) who smoked between 20 and 40 cigarettes per day. This must present a worry to all interested in obstetrics, paediatrics and health education generally.

The 52% alcohol consumption figure is similarly disturbing. The finding that neither of these groups had a significantly different prevalence of sleep disorder to the non-smoker or non-drinker gives no reason to be less distributed by the high prevalence. Moreover, it was found that maternal alcohol consumption during pregnancy was significantly associated with bed-wetting ($P < 0.05$). This will be referred to with the rest of the bed wetting results.

It was found that 28 of the children lived in over-crowded conditions, according to the ICD 9 standard of 1.5 persons per habitable room. This figure is high, especially considering the proportion of single-child families in the overall group (49%). Ten cases (66%) of over-crowding were single-child families. This illustrates the real problem of over-crowding in this area, that is, the necessity of families to share accommodation with other families. There were only two single parents out of 47; however at least 10 out of the 15 over-crowded families were over-crowded because of shared housing with other families.

The use of standard of 1.5 persons per habitable room has been criticised as far back as 1964 (Hersic, 1964) for the following reasons: it takes no account of sex or age composition of the household, room size or number of bedrooms. To this must now be added its failure to account for the number of family units in the accommodation.

The next point to be discussed is that of sleeping arrangements. Twenty-two of the 101 children regularly shared their bed with their parents. These were eleven boys and eleven girls.

Table 3 illustrates the age breakdown of these children.

There is a great dearth of information as to the extent of bed-sharing with parents in the English-speaking world. Of two reports which have studied this Oleinick et al. (1966) found 17% of children sleeping in their parents' room beyond 4 years. However, this cannot be equated to sharing the parental bed. The other study (Rosenfeld et al, 1982) found that upper middle-class parents in the USA commonly allow their ill or frightened children into the bed; however, of those who would be allowed to stay, approximately 30% did not

stay, another 30% stayed only until asleep and only 1% remained for the rest of the night. The children in this study are not comparable to either of these groups and reflect a more serious situation.

TABLE 3

Age and sex breakdown of children who regularly share the paternal bed.

BOYS		GIRLS	
Age	Number	Age	Number
<1	6	<1	7
<2	3	<2	2
9	1	<3	0
12	1	<4	1
		<5	1

The finding that sharing the parent's bed was not significantly associated with sleep disorder may be taken as a reflection both of the young age of most of those involved and of the situation where the parents were either colluding with or resigned to the continuance of the behaviour. The recognition that such a paternal attitude helps to maintain undesirable sleep patterns forms the cornerstone of a behavioural approach to treatment. The lack of significant association between sleep problems and adverse factors in pregnancy and early extra-uterine life adds to our confidence in the behavioural approach outlined by Richman for these disorders.

As enuresis tends to be seen as a psychiatric diagnosis, the term "bed-wetting" has been used in this study to describe the situation in the various age groups without implying a psychiatric condition. The difficulties of comparison of results in studies of bed-wetting have been well documented (De Jouge, 1973) and are due to substantial differences in the methods of investigation; the definition bed-wetting used in this study, one night wet per week or more, coincides with that of Hawkins (1962). The results of this study were compared to this. The comparison had to be limited to those children up to the age of three because of the low numbers available in the older age group.

TABLE 4

Comparison of the percentages wetting by age and sex in Hawkin's study and the present study

BOYS			
Age	Hawkins %	Dublin %	Cases
0→1	93	92	15
>1→2	70	75	4
>2→3	37	50	2
GIRLS			
Age	Hawkins %	Dublin %	Cases
0→1	76	86	14
>1→2	46	100	7
>2→3	31	81.8	11

The results for the males are similar, but there are more females wetting. This is the more striking because of the larger numbers of females than males.

In analysing the bed-wetting data for significant associations, it was decided to look at two groups as described above. This distinction produced two interesting associations which may reflect the difference between delay in maturation as opposed to biomedical or psychological differences. These were that bed-wetting was significantly related ($P < 0.05$) to abnormal delivery, and the drinking of alcohol during pregnancy by the mother in the group where children under three years were excluded, and that the relationship did not reach the 5% level of significance when the two to three year old children were included. It is recognised that alcohol is a sedative and a depressant drug. Two of the most popular books offering advice to women about their behaviour during pregnancy condone alcohol drinking in moderation during pregnancy: however, neither make any attempt to define what constitutes moderation (Llewellyn-Jones, 1971; Bourne, 1979). This should not be seen as an attempt to imply a casual association from a significant relationship in a small sample; however, the casual attitude of many doctors to un-necessary alcohol consumption in pregnancy is striking when many expectant mothers might be quite content not to consume the drug during pregnancy if requested not to do so. The cautionary attitude expressed in the publication which the Irish Health Education Bureau has recently issued must be welcomed (Health Education Bureau, 1982). However, it must also be noted that the much greater publicity given to the harmful effects of smoking, both

during pregnancy and for general health purposes, has resulted in no lesser prevalence of smoking in this sample than that of alcohol drinking where the degree of publicity is so much less.

Conclusions

This study has demonstrated a significant prevalence of sleep-disorder in the families of mothers seen in a public health clinic. These sleep disorders appear to arise without association with perinatal factors and be maintained by the parents' attitude to them. The study has documented the extent of over-crowding due to shared housing rather than large families, and recorded the number of children sharing the parental bed. It has also demonstrated an association between abnormal delivery and maternal alcohol consumption with bed-wetting in the sample obtained by excluding children less than three years old.

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PSYCHOLOGICAL DISTRESS & ATTITUDE TO AUTHORITY
IN A SAMPLE OF IRISH ADOLESCENTS

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Abstract

92 Adolescents (mean age 13.8 yrs) at a North Dublin school completed the GHQ - 30 and the attitude to authority scale. A high level of psychological distress (as measured by the GHQ - 30) was found, with 44% of the sample reporting 6 or more symptoms. The majority of students (84%) however expressed pro-authority feelings. A negative correlation was found between the level of distress and positive attitude towards parents. The possible clinical relevance is discussed

Keywords: Adolescents, Psychological distress, Attitude to authority

Introduction

Adolescence, the transitional period from childhood to adulthood is a stressful time. Rutter refers to adolescent turmoil, Erikson to identity crisis. Whatever its source, various studies show a considerable amount of psychological distress in adolescence, prevalence rates varying greatly (15% - 33%) depending on criterion used and populations studied as shown in Table 1 - adapted from D'Arcy & Siddique, (1984)¹

Adolescence is traditionally seen as a time of rebellion, rejection of adult standards with anti-authority feelings and behaviour. This popular view has not, however, been borne out by a number of recent studies (Rigby, 1987; Coleman & Coleman, 1984)^{2,3} who found an overall pro-authority attitude in the adolescent populations they studied.

The present study investigated two aspects of adolescence, namely, (1) level of psychological distress and (2) attitude to authority in a sample of Dublin working class adolescents, and in addition, tested the hypothesis that there would be a negative correlation between high levels of distress and pro-authority feelings.

TABLE 1
Rate Of Psychological Distress In Various Studies Of Adolescence

Author(s)	Setting	Sample	Measure of Distress	Rates
Krupinski et al. 1967	Australia	14 - 21 Yrs	Interview	15.7%
Place, 1987	Great Britain	14 - 17 Yrs	G.H.Q.*	16.2%
Graham & Rutter 1973	Great Britain	14 - 15 Yrs	Interview	21%
Albert & Beck, 1975	USA	11 - 15 Yrs	Becks Depression Inventory	33%
D'Arcy & Siddique 1984	Canada	14 - 17 Yrs	G.H.Q.**	27.5%

(* cut off point >_4)

(** cut off point >_6)

Method

Sample:

The study consisted of 92 adolescent students at a North Dublin Community School. Data was collected in May 1988. Prior to taking part, all first and second year students (total 110) brought a letter home to their parents explaining the function of the survey and seeking parental approval. No parents expressed disapproval or refused to allow their children to take part.

A total of 93 students completed the questionnaires. Eighteen students were absent on the day of the study and were therefore excluded. According to the school vice-President this was not an unusual absenteeism rate. Those who participated answered the questionnaires anonymously during call time and were supervised by teachers. In general, the children enjoyed answering the questionnaires and found little difficulty in completing them.

The mean age of the sample was 13.8 years (range 12 - 17 yrs). Sex distribution for the group as a whole was males 55, females 36, not stated 1 (this student was subsequently eliminated from the study). Breakdown of the various age groups was as follows: 12 years old = 2 (male 1, female 1); 13 years old = 29 (male 15, females 14); 14 year olds = 44 (males 27, females 17); 15 year olds = 14 (males 11, females 3). There was one 16 year old (female) and one 17 year old (male). As can be seen from the above, the majority (88 students) were between 13 years and 15 years old.

The students came from a lower socio-economic group background (ie socio-economic groups 4,5 and 6)⁴.

Measures

The General Health Questionnaire (GHQ - 30 Goldberg, 1972)⁵ was chosen to measure the level of psychological distress. This is a self administered questionnaire used for screening non psychotic psychiatric symptoms and it consists of questions on recent changes in social activities and psychological and physical symptoms. A cut off point of six or more symptoms was chosen. Numerous studies have shown the GHQ-30 to be a valid and reliable instrument in adult populations. Banks (1983)⁶ assessed the validity of the GHQ-30 against the PSE in 200, 17 year old adolescents and found it to be satisfactory. It has also been used to survey adolescent populations by D'Arcy and Siddique (1984)¹ and Place (1987)⁷.

In order to assess feelings towards authority, the Attitude Towards Authority Scale (Rigby et al 1987)² was used. This is a self administered questionnaire consisting of 30 likert type items which tap attitude towards 4 different institutional authorities (police, law, teachers and parents). A high score (ie scores greater than the neutral point, 90 for overall score) indicate pro-authority feelings.

In addition, favourable attitudes towards authority have been shown to correlate positively with self report and peer reported pro-authority behaviour (Rigby 1986, 1987)^{8,9}. In other words, pro-authority feelings predict pro-authority behaviour.

Results

Table 2 shows the level of symptom reporting for males and females on the GHQ-30. Overall 44% of students reported 6 or more symptoms. While there was a higher percentage of females (52.8%) than males (38.1%) reporting 6 or more symptoms this was not statistically significant.

The mean scores of the GH-30 are shown on table 3. The overall mean score for males was 5.02 (SD 4.88) while that for females was 8.72 (SD 7.64), the difference between the means being significant at 5% level ($P < 0.05$). There was also a positive trend between the mean scores and increasing age.

TABLE 2
Distribution Of GHQ - 30 Score By Sex

Score	Male	Female	Overall
0 - 5	34 (61.9%)	17 (47.2%)	51 (56%)
6+	21 (38.1%)	19 (52.8%)	40 (44%)
Totals	55	36	91

(Chi Square Test For Homogeneity Of Score Distribution $\chi^2 = 1.39ns$)

The number of students in the different age groups reporting 6 or more symptoms is also shown in table 3. There was no significant difference between males and females (with 6 or more symptoms) at the various ages. There was however a positive trend between the percentages of students reporting 6 or more symptoms and increasing age.

TABLE 3
GHQ - 30 Result Summary
Mean and Standard Deviation for Selected Age Groups
Cross Classified by Sex

Age	Male (n = 55)	Female (n = 36)	t-test
13 Yrs	3.87 (4.27)	6.43 (8.0)	+ 1.06 (ns)
14 Yrs	4.85 (4.19)	8.94 (6.68)	+ 2.20 (P<0.05)
15 Yrs	7.18 (6.94)	11.33 (5.51)	+ 1.09 (ns)
All Ages	5.02 (4.88)	8.72 (7.64)	+ 2.59 (P<0.05)

GHQ - 30 Scores for Selected Age Groups Cross
Classified by Sex

Age	Male	Females	
13 Yrs:			
Score 0 - 5	15	14	(x ² = 0.10 ns)
6+	4 (21.1%)	4 (22.3%)	
14 Yrs:			
Score 0 - 5	27	17	(x ² = 0.07 ns)
6+	15 (35.8%)	7 (29.2%)	
15 Yrs:			
Score 0 - 5	11	3	(Fisher's Exact ns)
6+	5 (31.2%)	2 (40.0%)	

The mean score for the sample on the Authority Scale was 107 which is greater than neutral point of 90 (Table 4). Mean scores in all sub scales (ie police, law, teach parents) were also greater than their neutral points. This implies that the group whole was pro-authority in attitude. In total, 76 students or 84% of the sample score greater than the neutral point, showing pro-authority feelings. There was no significant difference between the different age groups (Table 4). Nor was there any significant difference between the sexes, 81.8% of male and 86.1% of females were pro-authority attitude (Table 5).

TABLE 4

Total Attitude Towards Authority
Mean Scores and Standard Deviation for Selected Age
Group Cross Classified by Sex

Age	Male (n = 55)	Female (n = 36)	t-test
13 Yrs	106.67 (14.01)	115.36 (13.27)	+ 1.71 (ns)
14 Yrs	105.89 (19.03)	103.75 (16.65)	- 0.39 (ns)
15 Yrs	108.64 (26.48)	103.33 (21.96)	- 0.35 (ns)
All Ages	107.05 (19.36)	107.53 (16.14)	+ 0.13 (ns)

TABLE 5

Distribution Of Total Attitude To Authority
Score By Sex

Score	Male (%)	Female (%)	Overall (%)
0 - 89	10 (18.2)	5 (13.9)	15 (16.4)
90+	45 (81.8)	31 (86.1)	76 (83.6)

(Chi Square test for homogeneity of score distributions $\chi^2 = 0.29$)

Discussion

In the present study a high prevalence of psychological distress was found in the adolescents studies, 44% reporting greater than 6 symptoms on the GHQ - 30. There was no significant difference between the sexes, but the amount of distress tended to increase with age. This level of psychological distress is greater than the various studies cited, and in particular, the studies of Place (1987)⁷ and D'Arcy & Siddique (1984)¹, which used the GHQ - 30 as a measure of psychological distress (Table 1). Strict comparisons are not possible because of the different populations studied and differing study criteria. Our sample is not a random sample or representative of the population as a whole. The sample is over represented by lower socio-economic groups and is drawn from a deprived city suburb. This in itself might explain the high prevalence found in this study. Indeed, rates were similar to other screening studies of children in disadvantaged areas in Ireland Fitzgerald et al (1987)¹⁰. Rutter et al (1979)¹¹ have suggested that characteristics of individual schools (eg teacher-pupil ratio, teachers turn-over etc) influence the rate of disturbance in students. Such factors although not specifically reviewed in the present study, might also have influenced the high level distress found.

Although no significant correlation was found between the GHQ - 30 and the Attitude Towards Authority Scale, a significant negative correlation was found between the GHQ - 30 and attitudes towards parents, a subscale of the Attitude Towards Authority Scale. This suggests that those adolescents with positive attitudes towards their parents showed less psychological stress as measured by GHQ - 30.

For males, the negative correlation between the GHQ - 30 and attitude towards police suggests that disturbed males are more likely to have negative feelings towards the police. This equates well with our clinical impression that adolescents males, as compared to females, more often come into conflict with the police.

TABLE 6
Correlations of GHQ - 30 and Attitude to
Authority Scales

	Males (n = 55)	Females (n = 36)
Parent	- 0.296 (P<0.05)	- 0.483 (P<0.01)
Teacher	+ 0.099 (ns)	- 0.241 (ns)
Police	- 0.313 (P<0.05)	+ 0.081 (ns)
Law	- 0.167 (ns)	+ 0.052 (ns)
TOTAL	- 0.199 (ns)	- 0.204 (ns)

(Student's test for significant non-zero correlation coefficient (Pearson's Rho))

The scores of the present sample on the Attitude Towards Authority Scale are comparable with those of a similar age group of Australian adolescents. The Australian sample was drawn from two state schools in South Australia and consisted of 77 students (37 males, 40 females) with a mean age of 14.02 years (SD 1.21). Their mean score on the attitude to Authority scale was 109.11 for males and 108.7 for females.

Non significant correlation was found between the GHQ - 30 and the overall score on the Attitude Towards Authority Scale. However, when the sub scales (ie attitude to police, law, teachers and parents) are looked at separately, significant correlations are seen. For both sexes there is a negative correlation between the GHQ - 30 and attitudes towards parents (for males, P 0.05, for females P 0.01) (Table 6). For males there is a negative correlation between the GHQ - 30 and attitude towards police (P 0.05).

It is reassuring that the adolescent sample as a whole were pro-authoritarian in attitude. It has been shown that pro-authority feelings correlate well with behaviour (Rigby, 1986, 1987)^{8,9} Attitudes were consistent across the various sub groups, (ie police, law, teachers and parents) and showed no sex difference. This positive attitude was consistent with the findings of the Rigby et al (1987)² study of Australian adolescents, again bearing in mind the limits of such comparisons.

In conclusion, for the group of adolescent students studied, they showed a high level of psychological distress as measured by the GHQ - 30, but nevertheless overall they were positively orientated towards authority. It is interesting that the rates on this screening study were similar to high rates found on screening 10/11 years old in an earlier study by Barton & Fitzgerald (1986)¹². More wide reaching conclusions regarding the adolescent population as a whole are not possible from the present study but emphasise the need for a more detailed interview study in particular in disadvantaged urban Irish areas. If the findings of this screening study were substantiated, this would have considerable implications for the provision of services.

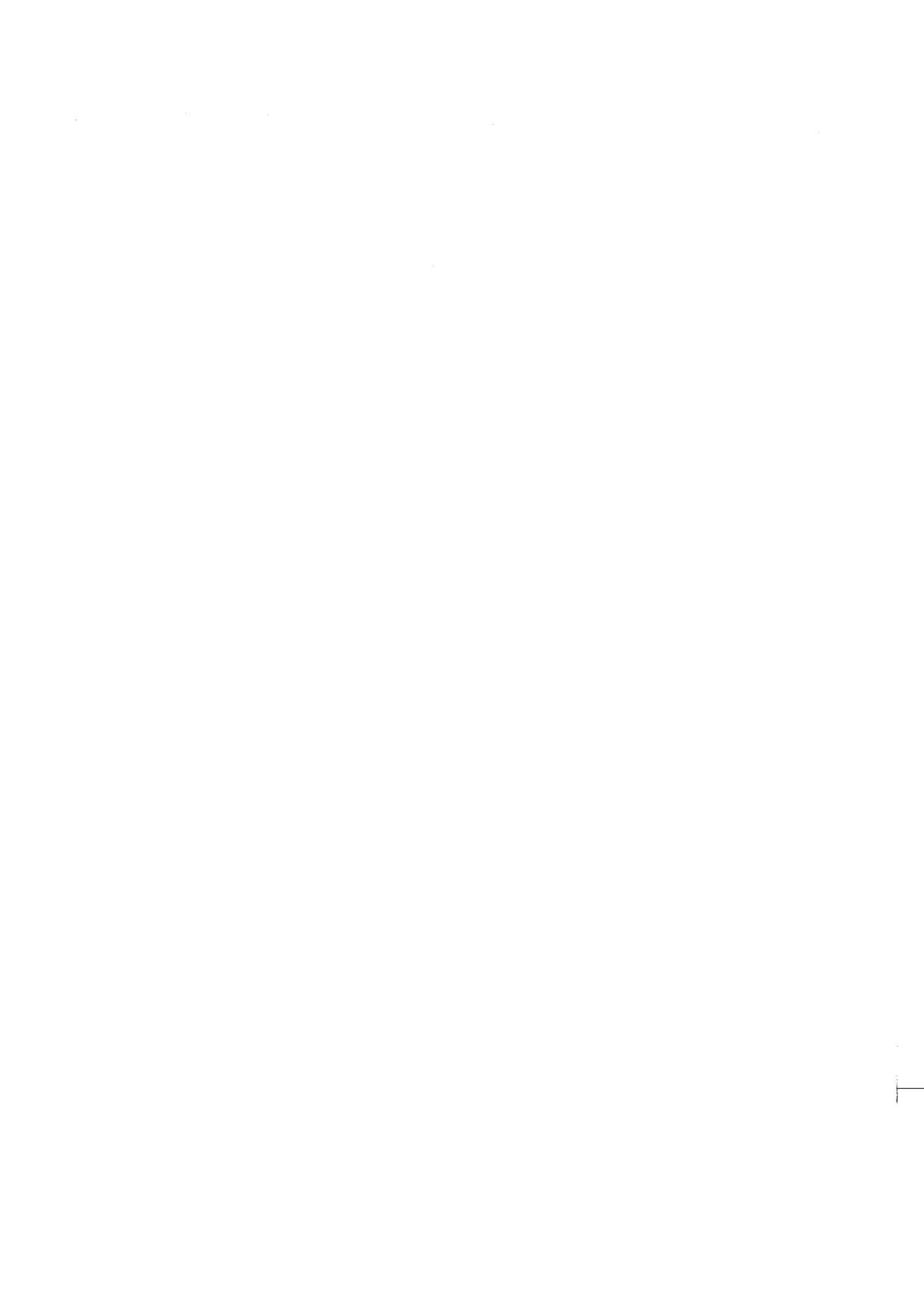
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**CHILDHOOD BEHAVIOURAL PROBLEMS AND
MATERNAL DEPRESSION IN GENERAL PRACTICE**

Diana Day Cody
Michael Fitzgerald

Abstract

Childhood behavioural problems and social competence in children of mothers attending a Dublin general practice were studied; they were found to have a prevalence of 30%, and to be associated with maternal depression, and marital disharmony. This relationship is explored, and the possible implications for management in a general practice discussed.

Keywords: General Practice Study. Depression. Childhood Behavioural problems.

Introduction

In recent years there has been a greater awareness of the need for general practitioners to receive special training in child psychiatry.¹ The family doctor is well placed, due to his specialist knowledge of child development and its atypicalities, and his access to the family's circumstances, to recognise at an early stage, when intervention may be required.² He is also advantageously placed to initiate treatment or referral to appropriate agencies.

Behavioural problems have been estimated to have a prevalence of 19.1% for 10 and 11 year olds, living in a London borough,³ whilst the prevalence of behavioural problems in three year old pre-school children living in a North London borough has been found to be 14.3%.⁴ Behavioural problems in both pre-school and older children have been positively correlated with psychiatric problems in the mother.^{5,6} In the Isle of Wight Study, 50% of the mother who had children with a psychiatric disorder, had themselves a psychiatric diagnosis, depression being the most common. A recent study⁷ of behavioural deviance in children age seven to 11, attending hospital medical or surgical out-patient departments, showed that 44 had deviant scores, and that 32% of their mothers had significant symptoms of depression.

Further research has also shown that affective illnesses in parents increases the risk of psychopathology in the children, this can take the form of affective illness, anxiety symptoms, dysthymia, conduct disorder and substance abuse.⁸

For the purpose of the present study the following hypothesis, based on clinical experience was set up, that there would be an association between maternal depression and behavioural problems in the children of women attending their general practitioner.

Method

The study was conducted in a general practice in a North Dublin suburb, which is situated approximately five miles from the city centre, and consists of both working class and middle class housing estates. There are no high rise flats within the area, but in common with other working class Dublin suburbs there is a high rate of unemployment and increasing criminal rates. The practice consists of 1,400 families. 900 of whom had one or more children in the age group 3-16, the average family size in the practice was three. Every second mother who attended one of two general (medical) weekly clinics in a four month period August to November 1985, and who children aged between three and 16 was asked to participate. She filled in a self rating questionnaire regarding depressive and anxiety symptomatology and a marital adjustment scale. She also completed age-appropriate questionnaires for each child within the test age group, designed to identify behavioural problems.

The Leeds Scales⁹, which are self assessment scales for depression and anxiety were used. These were devised by Snaith, Bridge and Hamilton and the results have been shown to correlate significantly with observer ratings for anxiety and depression. A cut off point of greater than or equal to seven was selected on each scale, which has been shown to yield results of significance.

Marital adjustment was estimated on those women who had had a steady partner for at least two years, using the Locke-Wallace Short Marital Adjustment Test.¹⁰ This consists of 15 multiple choice items and has a reliability co-efficient of 0.9; a score of 100 or more has been shown to correlate with a good degree of marital adjustment.

The Behaviour Screening Questionnaire, devised by Richman and Graham,¹¹ was used to assess those children in the age 3-4 group. This comprises of 12 questions regarding eating and sleeping patterns, excretion, temper tantrums etc. The inter-rater reliability is satisfactory, $R = 0.94$. A score of 10 or more indicates the possibility of a behavioural problem, and this was the cut off used in this study.

The Rutter A2 Scale¹² was used for children in the family aged 6-11. This consists of 31 questions relating to the child's behaviour, habits and health. It is completed by the parent and each item is rated as, "certainly applies", "somewhat applies", or "does not apply". A score of 13 or more has been found to be the best discriminator between children attending a child psychiatric department and others, this was the cut off point used in our study.

The Children's Behavioural Check List, (C.B.C.L.), is a parent's questionnaire relating to those children aged 4-16. It can be administered as an interview, as in this study, or can be self administered. Analyses of parents ratings of 2,300 clinically referred children and was normed on 1,300 non referred children, it has been shown to yield valid results and have high test/re-test reliability (0.89), and high inter parent reliability (0.74).¹³ There are separate sub scales for Social Competence which look at such items as peer group relationships, academic difficulties, and general social behaviour, and Behavioural Difficulties which looks at specific difficulties such as "demands a lot of attention", psychosomatic symptoms" etc.

Agreement was very good between tests of childhood behaviour for overlapping age ranges. Children whose behaviour was assessed by two tests were rated as having behavioural problems if this was indicated by one of the tests. The statistical methods employed in analysing the data were Fisher's Exact Test, and Chi-Square test, results were taken at the two-sided 5% significance level.

Results

Screening

The response rate was 100%, the total sample consisted of 33 mothers who had 70 children (36 female and 34 male). Of the mothers, one-third were rated as being depressed on the Leeds Scales. Nine of the 29 married mothers examined using the Locke Wallace Marital Adjustment Test had high scores; these nine women also scored depressed on the Leeds Scales. The 20 with normal marital adjustment were all non depressed. This relationship was examined using Fisher's Exact test and found to be significant, $p < 0.001$. More of the children whose mother's rated their marriage as being unsatisfactory had behavioural problems when compared to those children whose mothers were satisfied with their partners. Fisher's Exact Test yielded $p < 0.001$ (Table 1).

TABLE 1 - Marital adjustment and behavioural problems in children

	Locke-Wallace Marital Scale		N(%)
	≤ 100 (poor degree of adjustment) n(%)	> 100 - (well adjusted) n(%)	
Children - non disturbed	1 (11.1%)	19 (95.0%)	20 (69.0%)
Children - behavioural problems	8 (88.9%)	1 (5.0%)	9 (31.0%)
TOTAL	9 (100.0%)	20 (100.0%)	29 (100.0%)

Fisher's Exact Test $p < 0.001$ significant at the 0.1% level (2-tailed)

Thirty per cent of the total group of children were rated as being "behaviourally disturbed" on one or more of the instruments. Ten children were in the pre-school group, and of these two were scored as being "behaviourally deviant" on the B.S.Q. The male/female ratio in the group identified as being "behaviourally disordered" was 3:2, however, this male preponderance failed to reach statistical significance when examined using chi squared (Table 2). Sixty of the children were studied using the C.B.C.L. and a total of 19, ie 32% were rated as being "behaviourally deviant". This broke down into two sub-groups, 11 scoring on Social Competence alone and a further 8 scoring on both the Social Competence and Behavioural sub-scales. Interestingly in our study no child scored deviantly on the Behavioural scale alone. All of the children who rated as having a behavioural disturbance on the A2 Scale were also identified using the C.B.C.L.

TABLE 2 - Behavioural problems/Sex of child

	Behavioural problem n (%)	No behavioural problem n (%)	N(%)
Male	13 (61.9%)	21 (42.9%)	34 (48.6%)
Female	8 (38.1%)	28 (57.1%)	36 (51.4%)
TOTAL	21 (100.0%)	49 (100.0%)	70 (100.0%)

Chi-squared = 2.14 1 degree of freedom N.S.

A significant relationship between maternal depression and behavioural disturbance in her children was found (Table 3)

TABLE 3 - Maternal depression and behavioural disturbance in her children

	Mother - depressed n (%)	Mother - non-depressed n (%)	N(%)
Mothers with any behaviourally disturbed children	10 (90.9%)	9 (40.9%)	19 (57.6%)
Mothers with no behaviourally disturbed children	1 (9.1%)	13 (59.1%)	14 (42.4%)
TOTAL	11 (100.0%)	22 (100.0%)	33 (100.0%)

Fisher's Exact Test $p = 0.009$

Discussion

The working hypothesis set up was supported, children of mothers attending the practice exhibited a high prevalence of behavioural disturbance and the mothers reported a high rate of depression.

The figure for behavioural problems in our group of 3-16 year old children was higher than that reported by other sources.⁵ The relationship between maternal depression and behavioural disorders in the children showed a statistically significant association. Fifty per cent of our mothers who had behaviourally disturbed children, rated themselves as being depressed on the Leeds Scale, which is similar to the findings of the Isle of Wight Study.⁵ Depressive symptomatology in young women was studied by George Brown,¹³ who identified a lack of a confidante as being one of his "vulnerability" factors. In our study, those women who were dissatisfied with their marital relationship, or were separated or widowed, rated themselves more frequently as being depressed. Depression and marital discord are strongly associated,¹⁵ this in turn is related to psychopathology in the children.¹⁶ One explanation for this is that marital discord is associated with reduced affection, and conflicts in decision making including child rearing practices.

The relationship between maternal depression and behavioural difficulties in children is complex, it is possible that the mother's depression and the children's problems have arisen from the same source. However, our finding that it was particularly the social competence of the children of depressed mothers that was affected is interesting. It may be that mothers who suffer from depression tend to respond to their children less appropriately, either by neglect or by over concern, and also have more difficulties in controlling their children, and that this in turn leads to the child relating poorly to his peer group, and in functioning socially. Social competence is a readily observed phenomenon, and our study would suggest that when it is lacking in a child it should alert the doctor to the possibility of a depressive illness in the mother which may benefit from treatment.

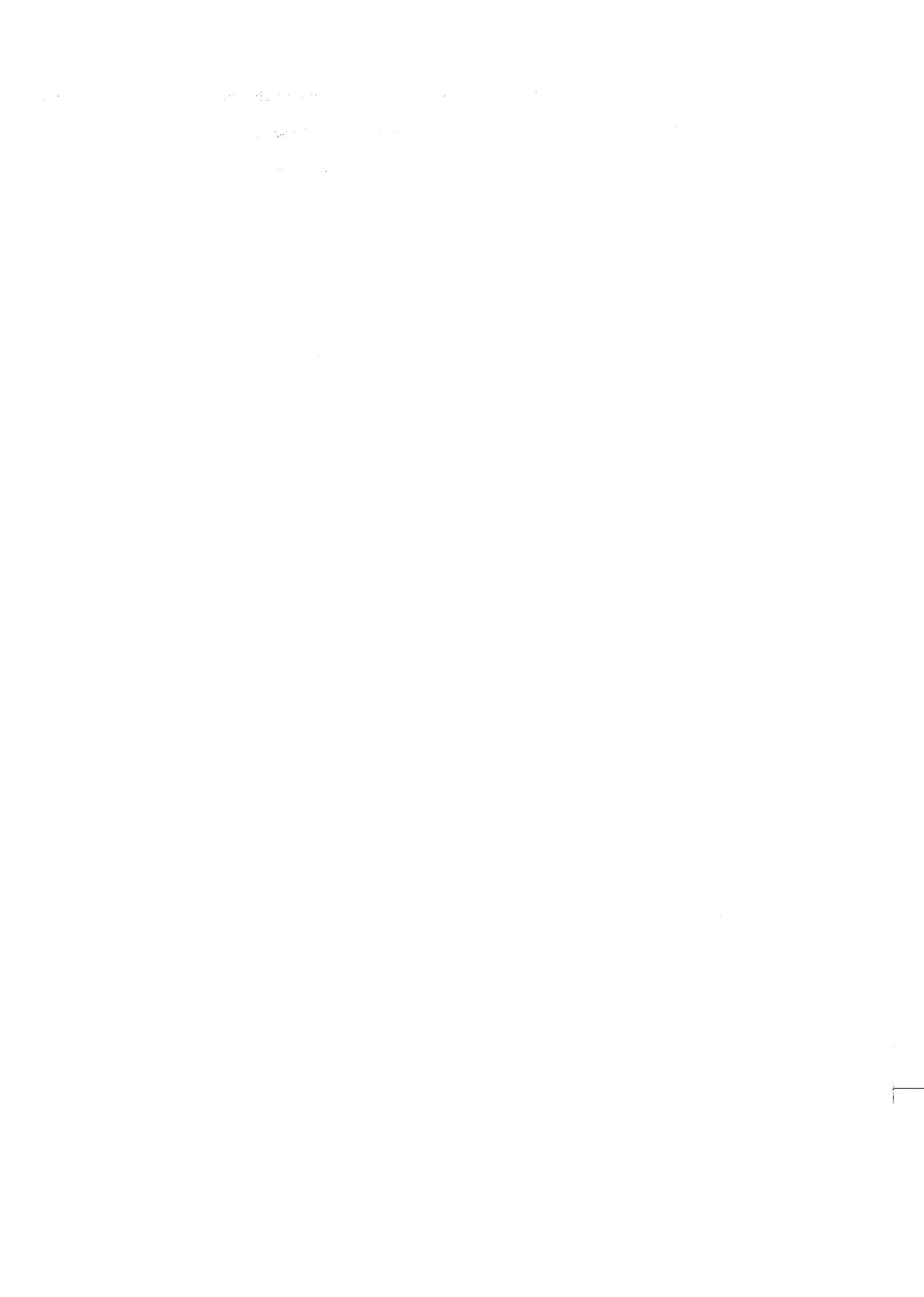
The overall rate of behavioural problems in our sample was high, and it should be noted that the area in which our study was carried out suffers from considerable financial and social stresses. Over three quarters of the husbands were unemployed, and most of the families had on-going financial worries. A bias towards a higher rate of behavioural disorders has been shown in other studies,¹⁴ and factors such as criminality, marital disharmony, parental psychiatric history, and family size have all been implicated.

In our study some of the causes of behavioural problems may be due to a developmental delay, in keeping with this theory is that, of the children examined using the C.B.C.L. all of those that were identified as "cases", scored pathologically on the Social Competence sub scale.

Our sample may not be representative of mothers and children living in the area, since it was drawn from mothers attending the family doctor, and so may not reflect the true prevalence of behavioural disorders, or maternal depression in this community. However, none of the mothers were presenting with solely psychological symptoms, most were attending for general medical problems, and none had attended a psychiatrist.

In order to test whether our results would also relate to the community in this area, it would be necessary to replicate this study using randomly assigned cases from the GP's register of patients.

From our study we conclude that in mothers attending their general practitioners, depression is associated with behavioural problems in their children.



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A COMMUNITY BASED STUDY OF UNMARRIED & MARRIED MOTHERS

K. McDonnell
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T. Kinsella

ABSTRACT

This study examined a group of 50 unmarried mothers, living in an urban underprivileged area in Ireland, under the headings of: demographic details, background factors, material and social supports, the prevalence of psychiatric disturbance, and how they perceived their babies. The findings were then compared with those of a control group of 53 married mothers from the same community.

Difficulties encountered by both groups were very high levels of unemployment, financial difficulties and a high prevalence of psychiatric morbidity. There was also a high incidence of single pregnancies in the families of both groups. Significant differences between the unmarried and married groups of mothers lay in the areas of: inadequate accommodation, desire to conceive at the time of conception and paternal interest in the pregnancy.

The group of single mothers living alone emerged as a particularly vulnerable group, specifically in the areas of finances, social contact and psychiatric disturbance.

INTRODUCTION

The numbers of illegitimate births, with their legal and other implications of disadvantage, have been rising steadily in this country over the past decade. This does not take into account the premarital conceptions that result in either marriage or abortion.

In 1985, there were 5268 (8.5%) illegitimate births and 3888 terminations in the U.K. on mothers giving an Irish address¹. The average number of adoption orders (1120/year) has been relatively stable since 1976, meaning that approximately 80% of unmarried mothers are keeping their babies yearly. In 1985 11,530 women were in receipt of the unmarried mothers allowance^{1,2}.

Theories as to the cause resulting in single parenthood have been changing over the years, ranging from being viewed as a manifestation of "disturbance" in itself, to factors such as large family size, "broken homes" in families or origin, poverty and poor education³. In recent years it has been noted that illegitimacy has not been related to socio-economic grouping⁴, but that psychological and attitudinal shifts have occurred with earlier age of menarche and increased sexual activity among young people, especially in urban areas⁵.

Marriages resulting from illegitimate conception are on the decline with the increased awareness that such marriages are prone to breakdown⁶.

Concern over the implications of single parenthood arises from reports that such mothers and their children are disadvantaged in a variety of ways. Social, economic and educational disadvantage has been reported by Crellin et al⁴. Material disadvantage has also been noted by Marsden⁹ and by Ferri¹⁰. The latter also noted that illegitimate children tend to be less well-adjusted and lower achievers than their legitimate counterparts, although stressing that this effect was not associated with the family situation per se, but with the factors associated with it.

Further concern arises from the finding that 33% of children coming into care in this country are those of unmarried mothers¹¹. The majority of these are less than 12 months of age, representing about 18% of children kept by their mothers for that particular year. The commonest reason for this was maternal illness (32%) stressing the vulnerability of this group in times of crisis.

We undertook this study to discover the areas in which unmarried mothers, in a community setting, perceived the greatest difficulties to determine whether these problems, in this particular type of community, were related to urban underprivilege or single parenthood per se.

SUBJECTS AND METHODS

69 consecutive mothers attending routine developmental clinics in an urban underprivileged area were interviewed. The interview consisted of 6 self-rated questionnaires, all of which were fully complete in the presence of the same author. This yielded 52 married mothers and 4 unmarried mothers. The rest were excluded because they were either separated or co-habiting. 47 unmarried mothers attending General Practices in the same area with children of the same approximate age were then interviewed at home, again by the same author. The practices were selected on a judgemental basis to be broadly representative of practices in this particular area. All questionnaires were fully completed. Only one mother refused to participate with the study.

The 6 questionnaires were:

(1) "A Parental Bonding Instrument"¹², which is a 25 item questionnaire based on the two main dimensions of the parental contribution to bonding i.e. care and overprotection, yielding 2 scales. The questionnaire is filled in as the individual remembers her father/mother up to the age of 16 years. The care scale involves affection, empathy and warmth versus coldness, indifference and neglect (scored 0 - 36). The overprotection scale involves allowance of independence and autonomy vs control and intrusiveness (scored 0 - 39). (Test-retest reliability: $r = 0.628$, ($p < 0.001$) for care scale, $r = 0.628$, $p < 0.001$ for overprotection scale. Concurrent validity: $r = 0.77$, $p < 0.001$ and $r = 0.49$, $p < 0.001$ resp).

(2) The second questionnaire comprised a series of direct questions as to: age of first sexual intercourse, availability of family planning methods at the time, whether or not there was a premarital pregnancy in an older sibling, whether peers exerted a greater influence than parents in teenage years, the number of sexual partners a mother had prior to pregnancy and attitudes towards the pregnancy itself (either positive or negative) with regard to the mother herself, her partner/husband and her own parents.

These two questionnaires gave background information on the mothers in the study.

(3) A "Social Problem Questionnaire" (SPQ) examined financial and social supports and difficulties with scoring in the following categories: housing, finances, work (including housework, social contact with friends and relatives, relationships, coping with children, domestic problems (for those living with parents), legal problems and difficulties living alone. These were scored as to whether the mothers had nil/minor problems versus major problems in each domain. The SPQ has been shown to be a useful screening device to detect the presence or absence of social problems, with satisfactory co-efficients of agreement between questionnaire and interview^{13,14}.

(4) The fourth questionnaire surveyed how the mother perceived her baby under the following headings: ease/difficulty feeding the baby, ease/difficulty settling it down and whether or not the baby was felt to be difficult, irritable or demanding. All questions were self-rated as nil, minor, major or severe for each category.

(5) The thirty item "General Health Questionnaire" (GHQ) was designed to be a self administered screening test aimed at detecting psychiatric disorders among respondents in community settings such as primary care. It has been shown to have acceptable validity with high specificity and sensitivity. (Concurrent validity $r = 0.7$ ($n = 244$ threshold score 4/5. Test-retest reliability (with standardised psychiatric interview $r = 0.9$ ($n = 20$))^{15,16}.

(6) The "Vineland Social Maturity Scale" was used as a standardised method for the quantitative assessment of social maturation of the child. Social age and social quotient can be computed, (satisfactory reliability and validity)¹⁷.

RESULTS

This study consisted of 50 single mothers, mean age 23 yrs (SD 3.7 yrs), and a control group of 53 married mothers, mean age 29 yrs (SD 5.6 yrs). The married woman had a mean of 3.1 children vs a mean of 1.2 children in the single group.

43.4% of husbands of the control group were unemployed. Of the one third of fathers who were still in contact with the single mothers, 61% were unemployed. Less than 10% of both groups of mothers were themselves employed outside the home.

SOCIO-DEMOGRAPHIC FACTORS

There was no significant difference between the single (S) and married (M) mothers for a) mean age at first sexual intercourse S = 19 years, M = 20 years; b) having more than one partner prior to pregnancy, S 10%, M 17%; c) reporting unavailability of family planning methods at the time in S 64%, M 57%; d) mean size of family of origin S 5.2, M 6.3; e) having one older sibling with a premarital pregnancy S 34%, M 34%; f) reporting sexual, physical or abuse in childhood S 12%. M 3.7%; g) reporting psychiatric illness in partners S 3.7%, M 4% and h) considering peers to have exerted greater influence on them than parents S 34%, M 28.3%.

However, significant differences were seen between the two groups for a) wishing to conceive at the time of pregnancy S 18%, M 60% ($P < 0.001$); b) having initial negative feelings about the pregnancy S 56%, M 17% ($P < 0.001$); c) parents being initially hostile to pregnancy S 78%, M 13% ($P < 0.001$) and d) male partner showing no interest in pregnancy S 34%, M 2% ($P < 0.001$).

PARENTAL BONDING (PBI)

With regard to their own parenting, the parents of both groups of mothers were scored as being caring and not overprotective. Mean care score for mothers of the single group was 28.8/36 and for mothers of the control group was 28.5/36 (NS). Mean care score for fathers of the single group was 26/36 and for fathers of the control group was 31/36 (NS).

Mean overprotection score for mothers of the single group was 15.2/39 and for mothers of the control group was 15.5/39 (NS). Mean overprotection score for fathers of the single group was 16.5/39 and for fathers of the control group was 18.9/39 (NS).

MATERIAL AND SOCIAL SUPPORTS (SPQ)

Table I shows that 30% of the single group vs 9.4% of the married group felt that they had a major problem with accommodation ($P < 0.05$), but there was no significant difference for reporting major financial problems or lack of social contact.

64% of the single group had no steady relationship, although only 6% saw this as a major problem. Of those with a steady relationship 16% were having major difficulties. This compares with 13% of the married controls who were having major marital problems (NS).

COPING WITH CHILDREN

There was no significant difference between the unmarried mothers and the married coping with their children (NS), in terms of considering their babies to be extremely demanding, finding their babies to be very difficult to settle and considering their babies to be either extremely irritable or difficult (NS).

SOCIAL MATURITY OF THE BABIES

There were no differences between the scores on the Vineland Social Maturity Scale (an estimation of social competence) between the babies of the two groups of mothers.

PSYCHIATRIC MORBIDITY (GHQ)

40% of the single mothers and 35.8% of the married controls scored as being psychiatrically disturbed (NS). Within the single group a significant correlation was found between GHQ scores and absence of plans for a future with the baby's father.

SINGLE MOTHERS LIVING ALONE

18% of the single mothers in the study were living alone, the rest were living at home with their parents. Table II shows that 66% of single mothers living alone had major financial problems, compared with 19% of those living at home ($P < 0.01$) (Table II) and that 44% of single mothers living alone had major problems in the area of social contact, compared with 0.17% of those at home ($P < 0.05$).

There were insignificant differences shown between the groups in relation to many major problems with accommodation and coping with their children.

22% of single mothers living alone considered their babies to be extremely difficult compared with 2.4% of those living at home ($P < 0.05$), but there were no significant differences between those living alone and those at home with regard to perceiving their babies as being extremely irritable, demanding or very difficult to settle.

66% of single mothers living alone vs 34% of those at home were scored as being psychiatrically disturbed but this difference is not statistically significant.

TABLE I
SOCIAL PROBLEM QUESTIONNAIRE (SPQ)
(% with major problem in each domain)

	Single n = 50	Married n = 53	χ^2 1 df	P
Housing	30%	9.4%	5.7	$P < 0.005$
Finances	28%	37.7%	-	NS
Social Life (excluding family)	22%	20.8%	-	NS

TABLE II
SINGLE PARENTS ONLY

(1) SPQ	(% with major social problems)		χ^2	P
	Living Alone n = 9	Living at Home n = 41		
Housing	44%	27%	1.09	NS
Finances	66%	19%	8.13	$P < 0.01$
Social Life (excluding family)	44%	0.17%	4.59	$P < 0.05$
Coping with Children (2) GHQ	11%	0.05%	0.50	NS
Probable Psychiatric Cases	66%	34%	3.25	approaching significance at the 5% level

DISCUSSION

This study was conducted in an urban area which consisted predominantly of corporation housing with high levels of unemployment. Among husbands of the control group the unemployment level was 43.4% compared with a national average of 18.9% in May 1987¹⁸. Among the fathers who were still in contact with the single mothers this level was even higher at 61%. Other characteristics of the area are high levels of vandalism and crime. Academic achievements in the community is low, most children leaving school at 15 years and very few going on to third level education. Finances are managed on a day to day basis and there is widespread use of money lenders and aid from local welfare officers.

Pregnancy among unmarried mothers in the area studied is very common with 34% of both study and control groups reporting such an event in an older sibling. No differences were found between the two groups of mothers in terms of their personal backgrounds suggesting that shared cultural influences play a major role in influencing the incidence of single pregnancies. Family planning methods were notably unavailable to the majority of both groups of women at the onset of sexual activity, where young people still feel intimidated by their local GP/chemist, and lack the resources to search further afield.

Psychiatric morbidity was high in both groups of mothers, suggesting that this was due to problems common to people living in the area as a whole (i.e. urban underprivileged living) rather than to single parenthood per se. Absence of plans for a future with the baby's father in the single group was however a significant contributory factor. The control group of married mothers were older and more experienced than the single group, and one would expect this to heighten the differences between them, but similar percentages in both groups were having major financial and social difficulties (Table I). This supports the idea that the general level of deprivation in the area is such that the fact of being single adds little to their already substantial difficulties. The majority of single mothers in the study were living at home and as such were protected from the major hardship experienced by those living alone (Table II).

A significantly greater number of single mothers had major problems in the area of accommodation (Table I). This was predominantly due to overcrowding, as the single mothers were frequently sharing with several other grown-up siblings as well as their parents, compared with the married controls, 88% of whom were living with their husband and children only. Despite obvious overcrowding however, many of the single mothers living at home felt they would have difficulty coping both financially and socially if they moved out. This was supported by the group of single mothers living, 66% of whom were experiencing major financial problems and 44% of whom had major problems with lack of social contact (Table II). 66% were also suffering from psychiatric problems (Table II). Three of the single mothers in the study had moved back home because of inability to cope.

The usual concept of the single mother, of poverty and social isolation still applies to the single mother living alone. This community based study has highlighted a second group where the single mother is living at home in the extended family situation. It is the acceptance by the family that has improved the situation for the single mother. Financially she and her child can survive and have some hope of a reasonable social life. However, in an area such as the one studied, her prospects are still very limited, with widespread unemployment and limited opportunities for self-improvement. Independence will mean definite hardship.

Dependence on state support is widespread and contributes to a feeling of lack of control over one's life and future. This in turn is associated with loss of feelings of responsibility for the consequences of one's actions, an example of which is single pregnancy. Being an unmarried mother is no longer a thing of shame and there is even a minor financial incentive in staying single. Young men take pride in having fathered a child as a status symbol among peers, however many feel that from there on, responsibility for the child lies with the mother and the state.

It is the widespread social problems that result from unemployment and social attitudes towards education and state support that emerge as the major problems in an area such as this, and single parents living alone and their children are its main victims.

We would like to thank Mr. Mark Cullen of the Psychosomatic Unit, St. James's Hospital for assistance with data processing.

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on pre-school populations and Rutter⁸ on adolescent populations. Emery⁹ comments on the powerful influence of conflict between the marital couple in the genesis of such disorders. More recently Wallerstein and Kelly¹⁰, assessing the influence of parental divorce on children, indicated that pathological outcomes are more likely where conflict between the couple continues after the divorce. Kauffman¹¹ suggests that in an intact family, parental discord may exert a more pernicious influence than impending or actual separation. It is suggested that the influence of marital conflicts in the genesis of childhood psychopathology is greater for male children. However, no age association is demonstrated. Rutter¹² has also stated that where marital discord co-exists with poverty, illness, poor housing, parental violence and unemployment, the effects are not merely additive but multiplicative. That is the occurrence of two such factors together, more than doubles the probability that the child will develop a behaviour disorder. When three or more factors co-exist the deleterious effect is many times greater. Cross Cultural Studies¹³ have suggested a tenuous link but rural studies³ have supported this finding. This study further investigates the association between marital discord and childhood behaviour disturbance.

MATERIALS AND METHODS

Forty-eight consecutive cases attending a community based psychiatric clinic in Ireland were selected to enter a controlled trial. The eligibility criteria was that the biological parents of the child were married and living together with the child. The group consisted of 29 males and 19 females whose ages ranged from 2 - 16 years. The mother of each child was asked to complete three self-report questionnaires and a demographic data sheet. Fathers did not complete the questionnaires as their attendances at the clinic was unreliable. A control population of mothers was also selected by searching the school register of each child attending the clinic and obtaining the name and address, from the register, of the next child of similar sex and age living with his parents. These homes were visited and the mothers asked to complete the same questionnaires and demographic data sheet. There were forty control cases. It was not possible to obtain a control for every clinic case. Five clinic mothers refused permission for their child's school to be contacted; for the three others the distance involved in contacting the relevant schools was too great.

MARITAL ADJUSTMENT AND BEHAVIOUR PROBLEMS IN CHILDREN

C. Lucey

M. Fitzgerald

SUMMARY

Previous research has suggested links between marital unhappiness and behaviour problems in children. A survey was carried out in a community based Child Psychiatric clinic in Ireland to investigate these links. Methods used involved self report questionnaires administered to mothers of fifty-eight children attending the clinic. A control group was selected for comparison. Tests of correlation indicate significant associations between marital adjustment and behaviour problems for both clinic and control populations. Some possible mechanisms are suggested.

INTRODUCTION

Since Bowlby's¹ work on infant attachment and response to separation experience much attention has been focused in the literature on the importance of continuing relationships in the growth and development of children. Where as early work focused on the parent child and subsequent emphasis has focused on family influences, in particular the effect of marital discord on child development.

The Isle of Wight² and Inner London Borough³ studies of child psychiatric morbidity illustrated the role of marital tension in the genesis of child psychopathology. Rutter⁴ showed that family discord and disharmony are associated with antisocial problems in childhood. He suggested that this association applies to homes which have not been broken by divorce, death or separation and he postulates that it is the unhappiness of the strained marital relationship that is the relevant factor. West and Farrington⁵ supported this finding and showed that delinquency was much more common when there was marital disharmony or serious parental conflict than when family relations ran smoothly. Portor and O'Leary⁶ have shown that marital discord is associated with anxiety states in children. This concurs with work by Richman⁷

INSTRUMENTS:

1. Demographic Profile

The demographic profile assessed the current age of the both parents, age at marriage, number and ages of children, the family housing standard as defined in the Multiaxial Classification of disease¹⁴, psychiatric history of both parents and the employment status of the father.

2. Locke Wallace Marital Adjustment Test:

The Locke Wallace Marital Adjustment Test¹⁵, self report questionnaire was completed by each mother. Using a scaled analogue graph the respondent indicates her overall level of marital happiness. The poles and midpoint of the scale are clearly marked as "very unhappy", "happy" and "perfectly happy". The respondent also answers a 15 item questionnaire with a range of answers from "always agree" to "always disagree". Questions included issues such as couples agreement over finances, mutual recreation and interests, demonstration of affection, friends, satisfaction with sex life, conventionality, philosophy of life, attitudes to inlaws and overall satisfaction with their present partner.

3. RUTTER A : Parent's Scale:

The Rutter A parent's self report scale is valid and reliable symptom questionnaire for 16 - 13 age range². Each symptom is scored on a 0 - 2 scale indicating its absence, occasional presence or frequent presence. A score of 13 or greater indicates clinical disturbance.

4. EYBERG - Child Behaviour Inventory:

The Eyberg Child Behaviour Inventory is a valid and reliable parental report, behavioural symptom questionnaire suitable for children in the 2 - 16 age range^{16,17,18}.

The inventory has two scales. An intensity scale and a problem scale. The mothers are asked to rate the intensity of a wide number of potential problems on a seven point axis from never present to always present. This yields an intensity scales score. The mothers are also asked to indicate on a yes/no axis if the symptom behaviour is a problem for them. This yields the problem score.

There were no significant differences in the profiles of both Clinic and control groups. The psychiatric status of parents in both groups differed slightly. In the Clinic population 18.8% of the parents had attended specialist psychiatric services by comparison with 4% of the control parents. While this difference in proportion was not statistically significant the results support previous research¹⁹, suggesting that rates of psychiatric disorders are higher among children of mentally ill parents.

Parents in the Clinic population married at a younger age than parents in the control population.

2. Mean Scores for Each Instrument in Clinic and Control Groups.

Instrument	Clinic Control		p
	N = 48	N = 40	
Locke Wallace	96.6	110	p < 0.03
Rutter A	16.9	6.4	p < 0.001
Eyeberg	99.8	49.2	p < 0.001

Test of mean = student T test

The Clinic population mean scores on each of the self report Questionnaires were significantly different from the mean scores obtained by the Control population. The Clinic population were on average less well maritally adjusted and had more problems with their children than the control population. For each questionnaire these differences reached statistical significance.³

For both populations a negative and statistically significant correlation exists between the Locke Wallace Marital Adjustment Test and the Rutter A. Parent questionnaire. This indicates that for both Clinic and Control family, greater marital adjustment is associated with fewer childhood problems. Similarly a negative correlation was also demonstrated between the Locke Wallace Marital Adjustment Test and the Eyberg Child Behaviour Inventory. Again this indicates that greater marital adjustment is associated with fewer childhood problems.

For the Clinic and Control population the Rutter A. Parent Questionnaire positively correlated with the Eyberg Child behaviour inventory intensity score indicating that both Questionnaires detected childhood behaviour problems. These correlations were statistically significant. Similarly, a positive correlation was obtained between the Rutter A. Parent Questionnaire and the Eyberg Child Inventory behaviour problem score. This correlation was only significant for the Clinic population.

RESULTS

1. Demographic Profile of Child and Control Groups

	Clinic N = 48	Control N = 40
Family Housing Standard	79.2%	80.0%
Mean Family Size	4.4 members	4.6 members
Mean Duration of Marriage	15.8	12.7 years
Mean Father age at marriage	20 years	24 years
Mean Mother age at marriage	20 years	21 years
Father employed	62.5%	70.0%

DISCUSSION

The results indicate that marital adjustment correlates with childhood behaviour for both clinic and control populations. As correlation does not equate with causality this finding makes no suggestion as to the nature of the association or causal direction. This result was independent of the demographic profile of the groups. Both groups were subjected to similar demographic stressors. However the Clinic population did differ in two areas. The clinic parents had greater psychiatric morbidity. This finding

supports previous work illustrating an association between parental mental health and childhood psychiatric disturbance¹⁹. The Clinic parents married at younger age than the control population. However, it is not clear to what extent this influenced partner choice or later behaviour problems in children.

The instruments used had a mixed utility. The Marital Adjustment Test was a crude measure of marital happiness. It viewed marriage as a static entity and not as an interactive process and so made no assessment of adaptability and capability of change. However it did detect marital unhappiness in the clinic group and marital unhappiness in the clinic group and marital contentment in the control group and so did give an overall broad estimate of marital adjustment. The Rutter A is a well known, reliable and valid instrument and the Eyberg Child Behaviour Inventory compares favourably with it. Positive correlations were obtained with both Clinic and Control populations. For the Control group the problem scale correlation could have occurred by chance. It may be that the Eyberg intensity scale with its broader range of possible responses is the axis most useful in screening procedures.

Emery⁹ has comprehensively reviewed the mechanisms by which marital turmoil affects children. He suggests several possible hypothesis. These include disruption of attachment bonds; modelling; parent discipline and a stress response paradigm. He also illustrates that a deviant child can place an undue strain on a marriage and may cause it to malfunction. In addition to these Patterson²⁰ has suggested a systems theory model in which discord creates the setting for sequences of coercive family interaction in which hostile or coercive behaviours serve to perpetuate aggressive encounters. It is unlikely that any single hypothesis fully explains the relationship between marital and child problems. Future studies using semi structured interviews with parents and children focusing on marriage, mental illness and social factors could lead to greater understanding of this relationship. Careful evaluation of this interaction will have broad implications for prevention and treatment and allow professionals to meet the needs of both parents and children.

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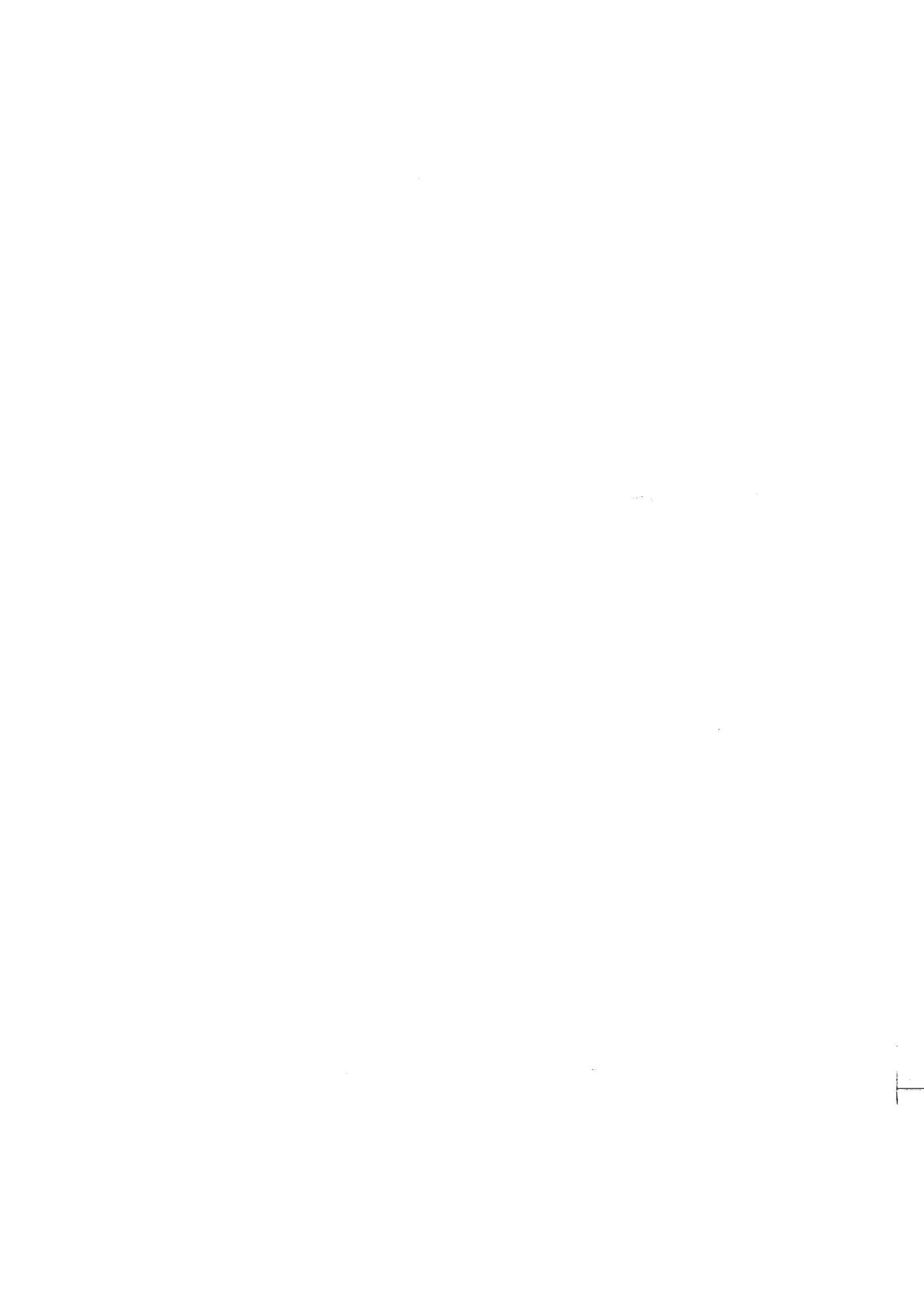
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Correlation between each Questionnaire for Clinic and Comparison Groups

Instrument	Clinic N = 48	Comparison N = 40
Locke Wallace Marital Adjustment Test: Rutter A ₂	-0.25 p < 0.05	-0.35 p < 0.02
Locke Wallace Marital Adjustment Test: Eyberg	-0.17	-0.36 p < 0.02
Rutter A ₂ : Eyberg - Intensity Score	+0.67 p < 0.001	+0.41 p < 0.005
Rutter A ₂ : Eyberg Problem Score	+0.36 p < 0.005	+0.16

Test of correlation : Pearson Product Moment correlation



A STUDY OF THE RELATIONSHIPS BETWEEN THE HOME ENVIRONMENT
AND PSYCHIATRIC SYMPTOMS IN CHILDREN AND PARENTS

David Mulhall

Michael Fitzgerald

Anthony Kinsella

SUMMARY

Data from children attending a pre-school playgroup and their mothers demonstrated relationships between the child's home environment using The Home Observation For Measurement Of The Environment Inventory, maternal psychiatric symptoms using The Hospital Anxiety Depression Scale and the presence of behavioural disorder in the child using The Behaviour Screening Questionnaire. The Home Observation for Measurement Of The Environment Inventory was found to be useful in identifying children at risk for behaviour problems.

INTRODUCTION

It is generally agreed that deficits in the home environment have a negative influence on the child and attempts have been made to counter this using the Head Start Programme in the United States with some success. (Herber and Garber³). The Home Observation for Measurement of the Environment (H.O.M.E.) inventory has become one of the most widely used measures of deprivation in the home environment. Caldwell and Bradley² have used it for determining which children were at risk for school failure. The present study attempts to evaluate in an Irish context the relationship between the home environment, maternal psychiatric symptoms and behavioural problems.

METHOD

A pre-school playgroup was chosen in which to conduct the study. This playgroup was situated in a working class urban area, consisting mainly of local authority housing of domestic scale with no flat developments.

Although new housing was being built, the development commenced 25 years ago and contained many 2nd and 3rd generation families. There was a high and increasing unemployment and crime rate in the area.

All children between the ages of 36 months and 48 months were selected for study except where siblings were attending the pre-school playgroup when the eldest was selected. A total of 52 children was studied. The study involved a home visit of 1 hours duration to complete The Home Observation of the Environment Inventory.

The H.O.M.E. inventory (Caldwell and Bradley¹) pre-school version was used and contains 55 items clustered in the following eight sub-scales.

1. Learning Stimulation

Sample item: Child has toys permitting free expression.

2. Language stimulation

Sample item: Parent encourages child to talk and takes time to listen.

3. Physical environment

Sample item: Interior of house not dark or perceptually monotonous.

4. Warmth and acceptance

Sample item: Parent answers child's questions or requests verbally.

5. Academic stimulation

Sample item: Child is encouraged to learn to read a few words.

6. Modelling

Sample item: TV is used judiciously.

7. Variety of experience

Sample item: Child is taken on outing by family member at least every other week.

8. Acceptance

Sample item: No more than one instance of physical punishment during past week.

All items on this Inventory received binary scores - yes or no. This gives a total score ranging between 0 and 55.

The Behaviour Screening Questionnaire (B.S.Q.) devised by Richman and Graham⁶ was administered to the mother of each child by the same researcher as carried out the home assessment. (D.M.). A total score of 10 on this questionnaire was taken as indicating a possibility of a behaviour problem. The B.S.Q. has been tested and proven to be a reliable method of assessing behaviour problems in the English pre-school child. It has been shown to detect 100% of cases who would be described as moderately or severely disturbed on clinical interview. The following is a sample item: "how often has X had an accident - soiled - in the past four weeks?" Possible answers are, none, scoring 0, twice a week or less, scoring 1, three times a week or more, scoring 2.

The Hospital Anxiety and Depression Scale (H.A.D.) was also administered to the mother during the home visit by the same researcher (D.M.). This instrument has been found to be reliable in the setting of a hospital medical out-patient clinic and is now being used in studies in the community in the U.K. Its advantage is that it is brief and acceptable to patients and differentiates between anxiety and depression. The anxiety and depressive scales are also valid measures of severity of the emotional disorder (Zigmond and Snaith⁷).

RESULTS

Family Demography

A total of 52 children was studied (28 females, 24 male). The average family size was 2.5 children. 39 (75%) mothers were married and 13 (25%) were either single or separated. 29 (74%) fathers were in full time employment and 7 (13.5%) mothers were in full time employment. A total 13 (25%) of the parents had a history of psychiatric illness. This included 10 (19.2%) of mothers and 3 (5.8%) of fathers. Both parents had a history of psychiatric illness in 1 (1.9%) case. There was overcrowding (1.5 persons per room) in 4 (7.7%) families.

Home Observation for Measurement of the Environment (H.O.M.E.)

There was a highly significant relationship between the total raw score on the H.O.M.E. scale and caseness (score of 10 or more) on Behavioural Screening Questionnaire. The lower score on the H.O.M.E. representing increasing levels of deprivation. See Table 1

On subscale 4 - Warmth and Affection (H.O.M.E.). There was again a significant correlation between a low score and B.S.Q. caseness ($p < 0.037$). See Table 1B.

On subscale 8 - Acceptance (H.O.M.E.) a low score again related to B.S.Q. caseness ($p < 0.025$). See Table 1C.

On subscale 3 - Physical environment (H.O.M.E.), a low score showed a relationship to B.S.Q. caseness which did not approach significance ($p < 0.07$). See Table 1D.

TABLE 1

1A		BSQ non case	BSQ case	Analysis of Variance	
	Total H.O.M.E. raw score :	41.86	36.44	F 4.449	$p < 0.04$
1B	H.O.M.E. subscale 4	-	Pearson correlation coefficient 0.2505		$p < 0.037$
1C	H.O.M.E. subscale 8	-	BSQ caseness χ^2 5.14		$p < 0.025$
1D	H.O.M.E. subscale 3	-	BSQ caseness Pearson correlation coefficient 0.02093		$p < 0.068$

Hospital Anxiety and Depression Scale

When a score of 11 or more was taken on the H.A.D., 10 (19.2%) of mothers scored in this range and were probable cases in anxiety and 10 (19.2%) scored in the range 8 - 10 on H.A.D. and were possible cases of anxiety. On the depression sub-scale of the H.A.D., 4 (7.7%) scored 11 or more on the H.A.D. and were probable cases of depression and 2 (3.8%) scored 8 - 10 on the H.A.D. and were possible cases of depression. There was a significant relationship between probable depressive caseness on the H.A.D. and B.S.Q. caseness (X^2 6.18 $p < 0.025$). There was also a significant relationship between anxiety (probable caseness) on the H.A.D. and the history of previous psychiatric illness (X^2 3.25 $p < 0.01$). There was also a significant correlation between depression (probable caseness) on the H.A.D. and previous psychiatric illness. (X^2 3.25 - < 0.01).

Behavioural Screening Questionnaire

The Behavioural Screening Questionnaire demonstrated 9 positive cases (17.9%). 6 (25%) were boys and 3 (10.7%) were girls, a ratio of 2.35 : 1.

DISCUSSION

The finding of 9 (17.3%) children with behavioural deviance is similar to a previous survey carried out by Leader, Fitzgerald and Kinsella in 1985⁴ when the rate was 16.9%. There is a suggestion that the children attending the pre-school playgroup were probably similar to the general population of children because mothers stated that placement in the play school was to enable the children to play with peers and not due to behavioural problems. Richman (1980)⁶ found that children attending a pre-school facility were very little different from the general population in their likelihood of showing behavioural problems.

The correlation between maternal depressive symptoms and behaviour problems occurring in her child may have a number of explanations. The child may be responding to mother's depression or indeed, it may be the child's behaviour problem that has caused his mother to become depressed. Another explanation is that the child's behaviour problems and mother's depression may originate from the same outside source

and may be compounded by mutual interaction. Clinical experience would suggest that mothers who are depressed have difficulty in tuning into their children's emotions and tend not to set consistent limits for them.

There is also a role for the adult psychiatrist in dealing with mother's depression because in this study there was a significant correlation between depressive symptomatology and behaviour problems in children. A previous study by Leader, Fitzgerald and Kinsella⁴ showed a similar correlation. Philips⁵ emphasized this group as providing an important opportunity for prevention in the practice of psychiatry.

Clinical experience would support the findings from the H.O.M.E. Inventory that low levels of warmth and affection in the family, deficiencies in the physical environment and low levels of acceptance in the family were associated with problems in children. Psychiatrists have the ability to intervene at the level of warmth and affection in the family and acceptance within the family. Intervention at the level of the physical environment is a matter for the Department of the Environment and individual families living in a disadvantaged area.

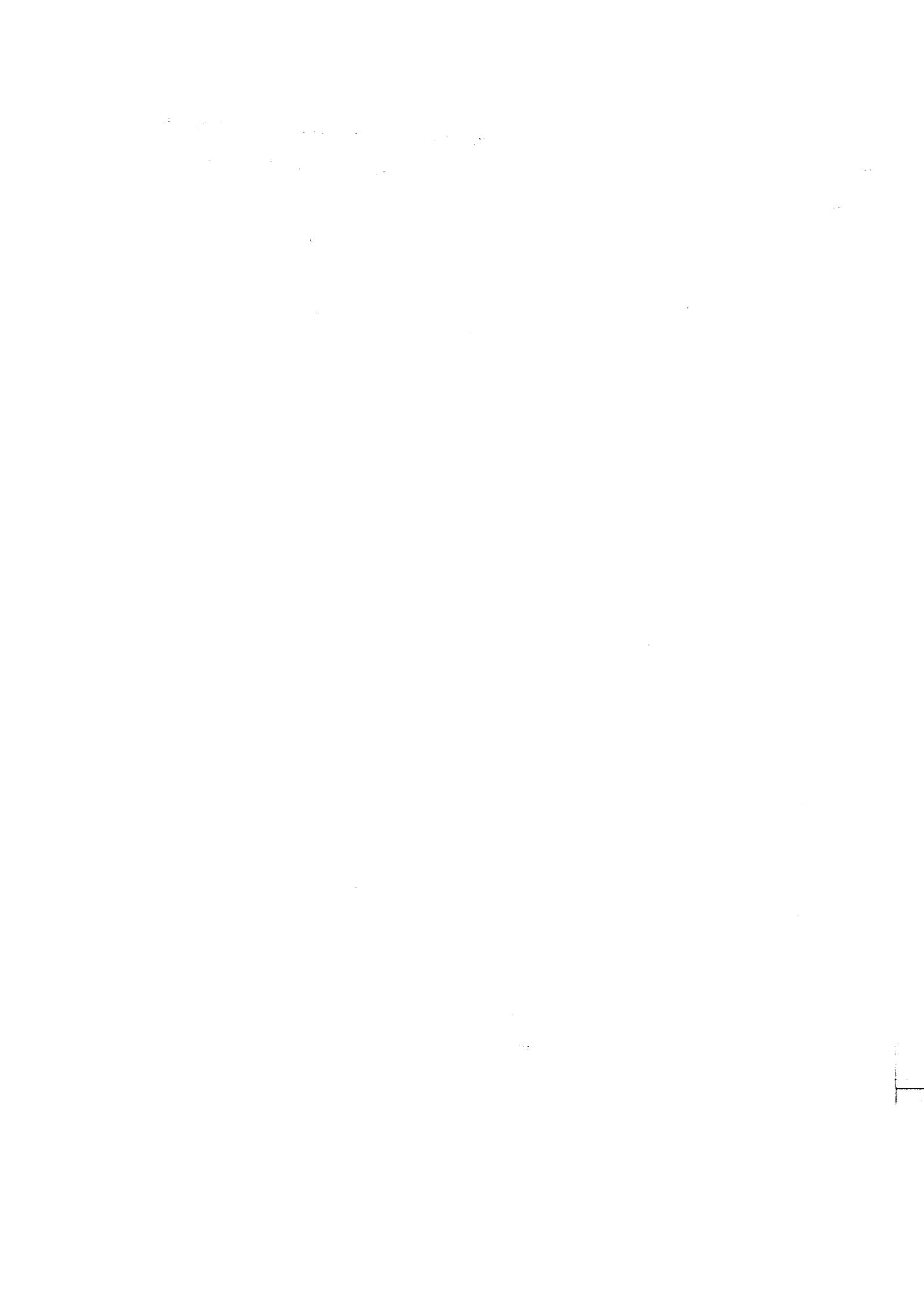
This study demonstrates that the H.O.M.E. Inventory could be useful in identifying children at risk for behavioural problems. Low scores on this inventory are correlated with significantly increased rates of behaviour problems in pre-school children. This has implications for preventive child psychiatry and various intervention strategies. There is a need for research into the effectiveness of direct work with these at risk children and also on parent training with mothers of at risk children in Ireland.

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Review

A STUDY OF TEMPERAMENTAL CHARACTERISTICS IN CHILDREN

between the ages of three and seven attending a Child
Guidance Clinic as compared with a control group

Patrice Murphy
Michael Fitzgerald

Temperament has been defined in terms of a relatively small number of simple, non-motivational, non-cognitive, stylistic features of which emotionality, activity and sociability are the best validated. Rutter (1967).² Allport (1961)³ suggested that temperament involved those aspects of personality that were "largely hereditary in origin". Buss & Plonin (1975)⁴ pursued this definition and developed a theory of personality development that proposed four general personality traits and components of each as possible temperaments - emotionality, activity, sociability and impulsivity (EASI). The New York Longitudinal Study of temperament, Thomas and Chess^{5 7} has focused on the stylistic differences in behaviour that begin early in life "with no implications as to aetiology". Similarly, McDevitt and Carey¹ state that temperament refers to the "behavioural style of the child in interaction with the environment". In spite of the very wide range of approaches to the description of individual differences in childhood, there is considerable agreement among the studies that from about three years on there is some consistency of individual differences from year to year.

Much of the interest shown in early differences between children arises from the hope that prediction of vulnerability to later disorder will become possible. A number of studies involving very different samples of children and using very different methods of assessing individual differences, have now demonstrated constellations of individual differences and later behavioural problems. Wolkind and De Saslis⁸ have shown that interview measures of temperament predict the later development of emotional and behavioural disorders in high risk samples. Bates⁹ has derived similar results using questionnaire measures. Carey¹⁰ has shown an association between "difficult" temperamental features and a higher rate of accidents, sleep difficulties and of infantile colic.

Methodology

The instrument used in this study was the Behavioural Style Questionnaire redevise by McDevitt and Carey (1978)¹. This questionnaire is specifically designed for determining temperamental characteristics in three to seven year old children and was based on the conceptualisation of temperament introduced by Thomas et al,^{5 7} in the New York Longitudinal Study.

This questionnaire consists of a hundred items in question form which can be completed by the mother in twenty-five to thirty minutes and scored in fifteen minutes. A six point rating scale ranging from "almost never" to "almost always" is employed.

Rating instructions given to the mother include:

- (1) To consider only the child's recent and current behaviour.
- (2) To judge her own impressions of the child.
- (3) To consider each item independently.

In addition, information was provided about how to rate accurately using extremes when appropriate, basing judgements on first impressions and attempting every item.

A clinical method of scoring was developed following procedures introduced by Carey (1970)¹⁰. The tester checks off the response for each item (1 - 6) on the scoring sheet, arranged by category. Item responses are totalled and divided by the number of items rates. This procedure is repeated for each of the nine categories. Diagnostic clusters are defined in terms of mean and standard deviations. The three diagnostic clusters of the New York Longitudinal Study (difficult, easy, slow to warm up) are retained approximately as defined by them; all others being designated as intermediate, high or low.

The hypothesis in this study was that there would be a significant difference in the number of children attending a Child Guidance Clinic who fell into the difficult and intermediate high temperamental categories, as compared with a control group matched for age, sex and school attended.

The Behavioural Style Questionnaire was completed initially by mothers of fifty children between the ages of three and seven, referred consecutively to the Child Guidance Clinic regardless of their diagnosis. All the children had undergone psychiatric assessment.

The fifty controls were matched according to age, sex and school attended; their mother's completing the same questionnaire.

Nobody declined to partake in the study but questionnaire on nine children from the psychiatric group and three children from the control group were unable to be completed by virtue of the reasons such as change of address, death of the mother or separation of the parents.

It was found that in some cases the questionnaire took longer than twenty-five minutes to complete and in other cases mothers were unable to read well enough to understand the questions. In these cases explanation of the items in the questionnaire was required, otherwise the instructions were the same as those suggested by McDevitt and Carey.

Results

(1) The sample consisted of:-

26% (13) girls

74% (37) boys

(2) The Age distributions was as follows:-

16% (8) aged 3 years

14% (7) aged 4 years

22% (11) aged 5 years

22% (11) aged 6 years

26% (13) aged 7 years

(3) The distribution in Diagnostic Clusters was as follows:-

	Psychiatric Group	Control Group
Difficult <i>more</i>	28% (14)	14% (7)
Slow to warm up	2% (1)	2% (1)
Intermediate high	28% (14)	22% (11)
Intermediate low	22% (11)	32% (16)
Easy <i>less</i>	20% (10)	30% (15)

By utilisation of the chi-square test the findings are:

- (1) When the difficult and intermediate high categories are grouped together, there is a significant difference between the psychiatric and control group.

Chi-square 4.025 (p 0.050)

- (2) No significant difference was found between the psychiatric and control group in the number of children falling into the 'Easy' or 'slow to warm up' categories.

Discussion

Actually
This study demonstrates that there is a significant difference in the number of children a Child Guidance Clinic with a variety of diagnosis who fall into the difficult and intermediate high temperamental categories as compared with a control group matched for age, sex and school attended. It appears that children's temperament has an affect on the way people respond to them. Lee and Bates¹¹ found that temperamentally difficult infants elicited more confrontations with their mothers as well as a greater tendency for these to result in conflict. Rutter¹² found that children with adverse temperamental features were more likely to be the target of parental criticism. Stevenson-Hinde and Hinde¹³ found that children with more negative mood were more likely to have mothers who were irritable and teachers who were reactively hostile. These factors may be relevant to the children developing child psychiatric problems.

W.C.
The issue of how personality differs from temperament is of some importance. Hall and Lindzey¹⁴ defined personality as "that which gives order and congruence to all different kinds of behaviour in which the individual engages". Rutter² points out that Sroufe¹⁵ has placed emphasis on integrative and organising functions and, by implication, on cognitive and motivational as well as dispositional components. He points out as well as dispositional components. He points out as well that these non-behavioural aspects provide the clearest differentiation from temperament. Personality differs, also, in its concern with meaningful patterns of behaviour that may be evident in a lack of behavioural generalisation across situations². Dunn and Kendrick¹⁶ found that girls who had an intense, warm playful relationship with their mothers were more likely to have a poor relationship with their siblings. Instead of a generalisation of warm relationships, jealousy leads to an inverse association. Clearly there is much more

to personality than just a collection of temperamental traits². Murray and Kluckhohn¹⁷ conceived a personality as an organising and integrating force, a force that exhibited both coherence and flux, and which grew out of life experiences as well as basic needs.

Rutter² claims that the view that temperament, personality and personality disorder can be viewed interchangeably or alternatively that they can be viewed in a sequential fashion with one leading to the next is mistaken. He feels that it is possible that the temperamental characteristics may have fairly direct neurobiological correlates but that this has yet to be demonstrated. His conclusion is that "personality refers to the coherence of functioning that derives from how people react to their given attributes, how they think about themselves, and how they put these together into some form of conceptual whole. There is no one way of measuring personality. Some aspects may be dealt with in terms of dimensional traits such as obsessionality but others are best thought of in terms of processes involving cognitive, emotional and social mechanisms. Personality disorders, as traditionally conceived, include several categories that are most appropriately considered as variance of conditions such as affective disorder, autism and schizophrenia. However, there remains a substantial group of disorders that are characterised by a persistent, pervasive abnormality in social relationships and social functionings generally. These personality disorders are clinically important in terms of both their incidence and their chronicity".

It is clear that individual differences between children must be taken into account in attempts to understand patterns of family interaction. Such differences are of great importance in their influence on the way people behave towards children, on the way children cope with changing circumstances and stressful experiences and on their perception of and thus their reactions towards those experiences. This study supports the importance of assessing individual differences in temperament when making assessment of disturbed children and adolescents and when looking for possible aetiological factors in behavioural deviance. It is possible that if these temperamentally difficult children were recognised early, and a preventative programme was instituted, that the subsequent risk of behavioural deviance would be decreased.

Acknowledgements

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**LIFE EVENTS AND PSYCHIATRIC REFERRAL IN CHILDREN:
COMPARISON WITH A GENERAL POPULATION**

E. Dooley
M. Fitzgerald

Summary

This study compared life events in two groups: referrals to a Child Psychiatric Clinic and a randomly selected control group matched for age and sex. The referral group had significantly more life events occurring and higher mean stress scores. In the 5 - 12 year old section, failure of a class in school, increase in number of arguments with parents and decrease in number of arguments between parents were all associated with increased likelihood of referral.

Introduction

In the last 15 years, much attention has been devoted to the importance of life events as precipitators of both physical and psychological illness (Holmes and Rahe, 1967; Brown and Harris, 1978; Masuda and Holmes, 1979). Most of this work has been done in relation to adult populations. Holmes and Rahe devised the Social Readjustment Rating Scale and this was subsequently applied to children by Coddington (1972a, 1972b).

Social readjustment includes both the amount and duration of change in a child's accustomed pattern of life, resulting from various life events. It measures the intensity and length of time necessary to accommodate to a life event, regardless of the desirability of this event. Social readjustment is quantified in life change units (L.C.U.). The amount of readjustment a child has undergone during a specific time period is determined by summing the life change units and thus we have a simple measurement of the environmental factors that impinge upon him.

In children, Coddington developed a questionnaire for life changes. This questionnaire had specific types of questions for various age groups from pre-school to senior high school. Most work on the effect of life events in children has studied the effect of these events in the development of physical illness (Heisel, 1972, 1973; Padilla, 1976; Beautrais, 1982b; Aagaard, 1979). There has been much less work published on the effect of life events in precipitating psychiatric illness in children, and most of work has tended to focus on a particular age-group or particular behaviour (Cohen-Sandler, 1982; Beautrais, 1982a). Kashani et al (1982) compared life events in three groups of 7 - 12 year olds and found that hospitalized children had a significantly greater number of life events and mean score of life events than children in a general population.

The purpose of this study was to compare life events in children referred to a child psychiatric out-patient centre with those in children of a general population. In this, it was hoped that stressful events associated with referral would be noted before further intervention complicated the history.

Patients and Methods

The total sample consisted of 100 children from 2 groups. Fifty consecutive referrals to the Child and Family Centre were matched with 50 children selected randomly from local schools.

Of the 50 referrals, 33 were male and 17 female. They ranged in age from 1.9 years to 16 years. Eight of the referrals were in the preschool age group, 33 in the primary (5 - 12 years) school group and 9 were in the early secondary (12 - 16 years) age group.

Procedure

The Coddington Life Event questionnaire was administered to the parents. Coddington's Elementary and Junior High school groups correspond well regarding age with our Primary School and early Secondary school groups. Though designed for an American population it was felt that this type of questionnaire was suitable for our population. Monaghan et al (1979) showed a high degree of agreement between Coddington's rating and the

ratings of a mixed group of British professionals. As our sample was 100 per cent Roman Catholic the item relating to "becoming a fully fledged member of a church" was expanded to include the child receiving First Holy Communion or Confirmation. All the parents agreed to participate in the study. The interviewer asked the questions of the parents and clarified any difficulties regarding the items. The questionnaire was administered at the time of the initial assessment in the clinic or as soon after as was possible. The year prior to applying the questionnaire was taken as the period applicable to the questionnaire items. The study was therefore retrospective. Only first-time referrals to the clinic were included.

In considering the results, we took the population as a whole and also according to age and sex.

Results

Analysis was conducted on both the stress scores in life changes units (L.C.U.) based on Coddington's values, and on the number of life events occurring. As well as the total sample being analysed, further analysis was carried out according to sex, and also according to age based on the questionnaire groupings.

Table 1 presents the means and standard deviation of the L.C.U. scores. There was a significant difference between the mean scores of the 50 referrals and 50 controls, with the referrals scoring higher. There was also a significantly higher mean score for the total female referrals when compared to the female controls. The primary school and early secondary school referrals also had significantly higher mean L.C.U. scores as did the primary and early secondary school female referrals when compared to female controls. All other sub-groups of referrals, with the exception of pre-school males, had higher mean L.C.U. scores compared to their corresponding control group, though scores were not significantly different at the five per cent level.

Table II presents similar analysis of the number of events in the various groups.

TABLE II
Analysis of Groups on Number of Life Events

Group	Referrals			Controls			p
	Mean	n	S. Deviation	Mean	n	S. Deviation	
Total Sample	4.2	50	1.93	3.42	50	1.68	0.05
Total Males	4.3	33	2.17	3.7	34	1.80	N.S.
Total Females	4.1	17	1.39	2.9	16	1.46	0.05
Pre-School Total	2.9	8	1.53	2.9	2	1.12	N.S.
Pre-School Males	2.4	5	1.55	3.0	8	1.60	N.S.
Pre-School Females	3.7	3	1.52	3.2	6	2.12	N.S.
Primary School Total	4.6	33	2.04	3.75	32	1.67	0.1
Primary School Males	4.8	23	2.24	4.0	23	1.81	N.S.
Primary School Females	4.3	10	1.57	3.0	9	1.05	0.05
Secondary School Total	3.8	9	1.09	2.7	10	1.64	0.02
Secondary School Males	3.8	5	1.30	2.8	5	1.30	N.S.
Secondary School Females	3.75	4	0.96	2.6	5	2.07	N.S.

Significant differences were found between the total referral and control groups, and also between total female referral and control groups. The Secondary School total ($p < 0.02$) and Primary School female sub-group ($p < 0.05$) also reached statistical significance while the Primary School total was significant at the $p < 0.1$ level. The only exception to the trend was the pre-school group which showed a slight excess of the life events in the control group. This was due to the pre-school male referral group having fewer events occurring compared to the corresponding control group. As in the case of the mean L.C.U. score for this group, there is no clear explanation for this anomaly.

Having analysed the overall scores and number of life events occurring in the groups, further examination was carried out on the questionnaire to see what, if any, events occurred more frequently.

The pre-school, primary school and early secondary school groups were each examined separately as items on the questionnaire do not co-incide. In analysing the results a one-tailed test of significance was used.

The results are shown in Tables III, IV and V.

TABLE III
Pre-School Group

Item	Referrals (8)		Controls (8)		p
	n	%	n	%	
Beginning Nursery School	3	37.5	5	62.5	N.S. ($X^2 = 0.25$)
Change in Parent's financial status	2	25	4	50	N.S. ($X^2 = 0.266$)
Loss of job by Parent	-	0	2	25	N.S. ($X^2 = 0.214$)
Mother beginning to work	2	25	-	0	N.S. ($X^2 = 1.214$)

TABLE IV
Secondary School Group

Item	Referrals (33)		Controls (32)		p
	n	%	n	%	
Failure of a class in School	8	24	2	6	0.05 ($X^2 = 2.769$)
Increase in number of arguments with Parents	12	36	4	12.5	0.05 ($X^2 = 3.790$)
Decrease in number of arguments between Parents	6	18	-	0	0.025 ($X^2 = 4.410$)
Change in Child's acceptance by peers	5	15	-	0	0.05 ($X^2 = 3.333$)
Serious illness requiring hospitalization of Parent	11	33	7	22	N.S. ($X^2 = 1.284$)

TABLE V
Secondary School Group

Item	Referrals (9)		Controls (10)		p
	n	%	n	%	
Change in Parent's financial status	2	22	6	60	N.S. ($X^2 = 1.44$)
Increase in number of arguments between parents	6	66	4	40	N.S.
Serious illness requiring hospitalization of Parent	3	33	1	10	N.S.
Becoming involved with drugs or alcohol	2	22	-	0	N.S.
Suspension from school	2	22	-	0	N.S.

Both the pre-school and early Secondary school groups were too small for significant differences to become apparent. In the primary school group, 4 events showed significant differences and a fifth showed a marked excess in the referral group, though not reaching a statistically significant level.

In the pre-school sample, more of the control group began nursery school, and had either a change in financial status or loss of job by the parents. More of the referrals had a mother begin working in the year prior to being seen.

As in the pre-school sample, the secondary school sample had an excess of finance related events (change in financial status of parents) occurring in the control group. Events with either physical (hospitalization) or psychological (arguments) trauma to the parents occurred more commonly in the referral group as did involvement with drugs or alcohol and suspension from school.

The numbers involved in each case were too small to be statistically significant.

In the primary school group, both an increase in the number of arguments with parents (36 per cent) and a decrease in the number of arguments between parents (18 per cent) occurred significantly more frequently in the referral group. Hospitalization of a parent (33 per cent) and a failure of a class in school (24 per cent) also occur more frequently, as did change in child's acceptance by peers (15 per cent).

Discussion

This study has shown that referrals to a Child Psychiatric Clinic have a significantly higher number of life events occurring in the year prior to assessment, when compared to children of similar age and sex in the general population. They also have a higher mean stress score in life change units. In this, the results agree with those of Kashani et al (1981).

Because consecutive referrals were studied, the numbers in the pre-school and secondary school group were too small for statistically significant differences in individual items to become apparent between the referral and control groups.

Comparing the two primary school groups, significantly more of the referrals had failed a class in school in the previous year. There was also a significant difference in the child's acceptance by his/her peers, in all cases with a deterioration in the relationship. These differences may point to a gradual withdrawal of interest in school and friends as a precipitator of referral.

It is interesting to note that significantly more of the primary school referrals had an increase in arguments with their parents (36 per cent) together with a decrease in arguments between the parents (18 per cent). One possible explanation is that as the child's difficulties become more manifest, the parents tend to minimize their own problems and concentrate their attention on the child.

Hospitalization of a parent with serious illness occurred more frequently in the referral group (33 per cent v. 22 per cent) though the differences was not significant.

There was no significant difference in the occurrence of the three most commonly scored items - beginning another school year (91 per cent in referrals, 94 per cent in controls), change in parents' financial status (58 per cent in referrals, 50 per cent in controls), and outstanding personal achievement (39 per cent in referrals, 44 per cent in controls).

It is notable that the questionnaire weightings give a higher L.C.U. value to death of a parent compared to divorce of parents. Many professionals now feel that divorce or separation of parents may require more adjustment by a child than death of a parent. This may indicate that the relative weightings of various life events in life change units needs to be reviewed.

In conclusion, while there may be other events occurring both in the family and the child's general environment which may be important in causing a particular referral, certain risk factors have been noted in this study, especially in the primary school group, which are occurring prior to any intervention and which may help with possible identification of children at risk for breakdown. Further prospective study on a larger population would be helpful in confirming the usefulness of these findings.

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WHY PSYCHOTHERAPY?

M. Fitzgerald

The pressures on the medical curriculum leave little time for formal training in psychiatry and still less for supervised training in psychotherapy. It is a most useful medical skill which if used more by the profession could result in less medication and hospital admissions. The need for formal training in psychotherapy and the desirability of more ready access to it are argued.

Concern has recently been expressed that some psychiatric educators may be "losing the mind". Reiser¹ recently put it as follows: As the neurobiological database, therapeutic armamentarium, scope of interest, and philosophical views of psychiatry expand and competitive pressures for time in residency training are intensified, teaching in the mental sciences and opportunities for residents to develop solid psychodynamic diagnostic and therapeutic skills are rapidly disappearing. However, brain science does not yet, and probably never will, fully explain the mind. The author urges psychiatric educators not to "give up the mind", or worse yet, loose it by "default". This refers to the current American situation. There is some evidence that a more middle ground is being found in Ireland with the development of the current psychotherapy training programme. There is further opportunity if the current proposals by the Irish Psychiatric Training Committee and the Royal College of Psychiatrists regarding psychotherapy training and services are implemented.

Definition

Psychotherapy in its widest sense is synonymous with the doctor/patient relationship. There are three generally recognised levels of understanding of psychotherapeutic skills. The basic level covers the understanding required by all health professionals. The intermediate level requires more substantial training in psychotherapy as would be

required by a broadly trained psychiatrist. The third level would refer to the consultant with a special interest in psychotherapy who would to have had extensive training in psychotherapy. Psychotherapy in its informal sense can be seen as including a wide range of techniques which can be described rather than defined e.g. counselling. Formal analytical psychotherapy has as a central feature the developmental of the transference relationship within which the therapist offers the patient a series of interpretations relating to the transactions within this relationship and to present and past experiences. Other important psychotherapies include behaviour therapy and family therapy.

Indications and scope of psychotherapy

Psychotherapy may be used as a primary treatment method, or in conjunction with other treatments. It has a wide application, and is of particular importance in the brief and effective treatment of patients with adjustment reaction, including atypical grief; selected patients with psychosomatic disorders; various behavioural disorders; and post traumatic conditions including the sequelae of accidents, rape, assault and sexual abuse. Psychotherapy may be used as a component in the treatment of a wide range of psychiatric illnesses, to mitigate against secondary effects of the disorder or the influence of precipitating and perpetuating factors. Referrals to psychotherapists from psychiatric colleagues are often patients who present the most difficult management problems. It is valuable in the management of physical illnesses where patients have difficulty in adjusting to or accepting irremedial handicaps or distressing symptoms. Psychotherapy may contribute to management of severely disadvantaged groups of patients e.g. the chronic mentally ill, and some elderly patients. The increased emphasis on interpersonal factors in hospital, medical and general practice, and the concern with interview techniques, has led to demands for training in these areas. There is a growing awareness of the need of staff support, especially for nurses and for staff working in community health programmes.

"Planning for the future"

This report of a study group on the development of the psychiatric services states:

- 1) The psychiatric service should be community oriented i.e. it should enable people to avail of full range of services while continuing to live in their own homes.
- 2) It envisaged a more dynamic role for out-patient clinics, incorporating a referral, assessment, diagnostic and a treatment service including psychotherapy and behaviour therapy for all categories of psychiatric patients.
- 3) That day care services should provide individual and group psychotherapy, family therapy and behaviour therapy.
- 4) Notes that G.P.'s undertake the medical treatment of a large proportion of diagnosed mental illness and recommends that general practitioners should have supervised clinical experience to develop skills in interviewing and supportive psychotherapy. It also regards it important that general practitioners try to understand the psychology of mentally ill patients and deal with the underlying problems without undue reliance on drug therapy.
- 5) It states that children from broken or unhappy marriages may require specialist psychotherapeutic help.

Specialisation in psychiatry

Webb³ states in the proceedings of a symposium of the Postgraduate Medical and Dental Education in Ireland that there is a need to improve training in the specialities within psychiatry and he mentions dynamic and behavioural psychotherapy as one of these specialities. Comhairle na nOspideal⁴ agrees with the concept of sub-specialisation in general psychiatry and believes that the trend should, to a reasonable extent, be facilitated in the future organisation of psychiatric services throughout the country.

Langsley⁵ et al state that sub-specialisation is not only inevitable in psychiatry as in other medical specialties but also holds several advantages for psychiatrists and patients alike. First and foremost, sub-specialisation (e.g. psychotherapy) would elevate the level of psychiatric care received by many patients. Even if patients continued to be treated largely by general psychiatrists, emerging sub-specialisations would increase the tendency for general psychiatrists to obtain consultation. They also point that the tendency of some general psychiatrists to see themselves as qualified to treat any type of psychiatric problem with an eclectic blend of generic psychotherapy and non specific psychopharmacology may be counteracted by rising expectations that sub-specialty consultations should not be uncommon in community practice.

Benefits of Psychotherapy?

The literature claiming that the costs of out-patients psychotherapy may be offset by savings in medical expenditures began with a West German study of persons who had psychoanalysis or psychoanalytic psychotherapy and whose use of hospitalisation for a five year period was less than that of a control group⁶. This study and the subsequent literature reviewed by Vichi⁷, who concluded that the effect of psychotherapy was to reduce use of medical services by about 20%. Another study showed that patients receiving family crisis therapy were less likely to be admitted to hospital in the 18 month follow-up period and if they did that their admissions were shorter. Crisis intervention was found to be cheaper, costing on average 1/6 as much as hospitalisation at 6 months⁸. Nevertheless Clare et al⁹ noted "a disappointing lack of counselling impact on surgery attendances, psychotropic drug prescribing and overall response and caution against excessive zeal and expectations in this area". Another study examined patients with obstructive airways disease and found that patients who were treated with psychotherapy had fewer admissions than a control group¹⁰. A more recent study demonstrated that counselling offered by general practitioners significantly reduced the prescription of psychotropic medication without an increase in time spent with patients¹¹. A review of economics studies of psychotherapy concluded that it might be possible to justify the provision of psychotherapy services on economic grounds but that considerably more research needed to be done in this area¹¹.

PRACTICAL POINTS

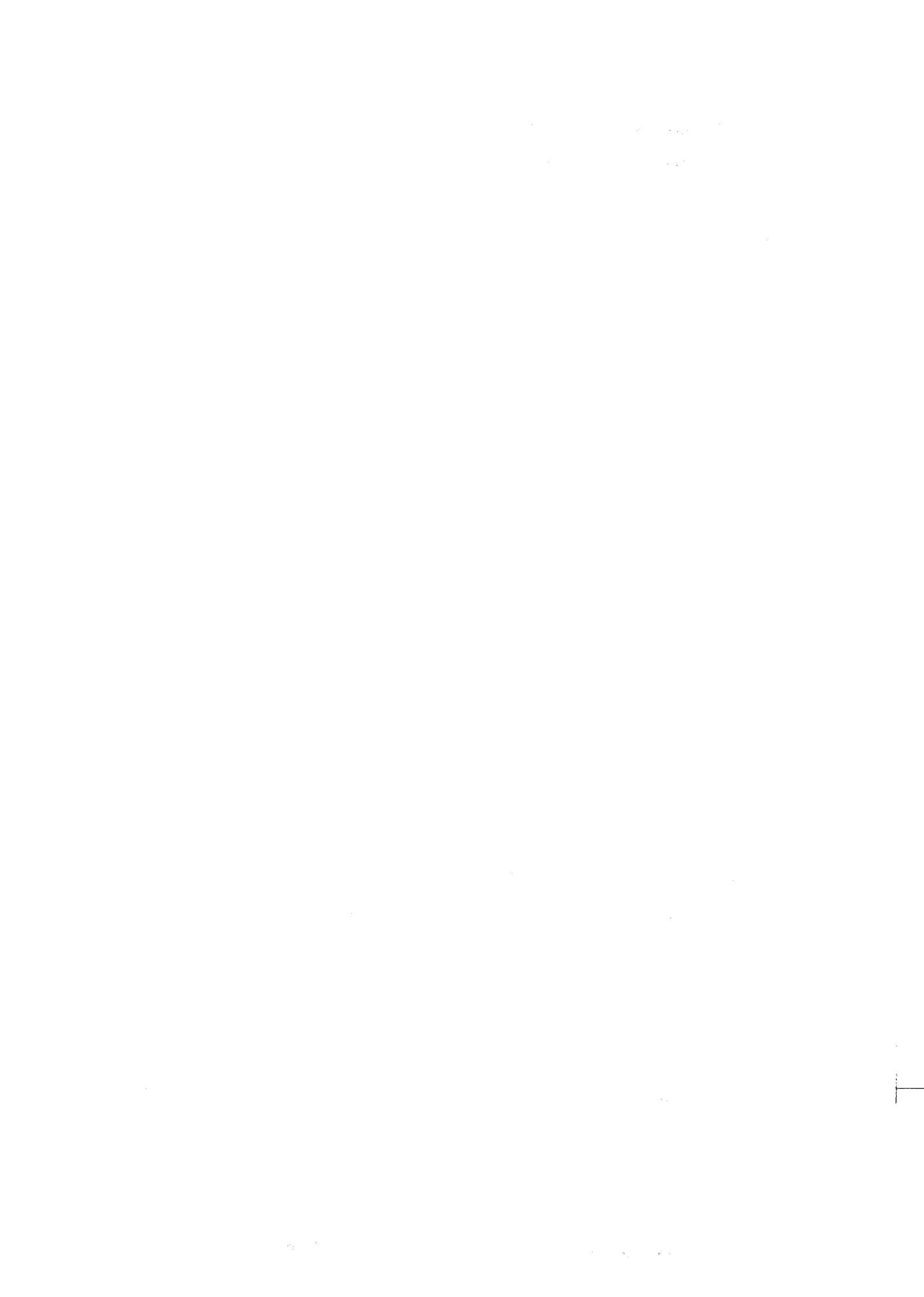
- . Psychotherapy in its widest sense is synonymous with the doctor/patient relationship.
- . Referrals to psychotherapists from psychiatric colleagues are often patients who present the most difficult management problems.
- . There is a need to improve training in dynamic and behavioural psychotherapy.
- . A recent study demonstrated that counselling offered by general practitioners significantly reduced the prescription of psychotropic medication without an increase in time spent with patients.

Way forward

Despite this controversy in the literature there are still sufficient grounds to support the Royal College of Psychiatrists as well as the Irish Psychiatric Training Committee and Higher Psychiatric Training Committee views that psychotherapy services and training be developed in the Republic of Ireland. The most practical way of achieving this would be to restructure consultant posts to take in a special interest dimension and to develop Senior Registrar Training with a special interest in psychotherapy.

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The Technique of Analytic Psychotherapy

M. Fitzgerald

Psychotherapy involves the following elements proceeding from superficial to deep elements:

1. Unburdening of problems to a sympathetic listener.
2. Ventilation of feelings within a supportive relationship.
3. Discussion of current problems with non-judgemental helper.
4. Clarification of problems, their nature and origins, within a deepening relationship.
5. Confrontation of defences.
6. Interpretation of unconscious motives and transference phenomena.
7. Repetition, remembering and reconstruction of past.
8. Regression to less adult and less rational functioning.
9. Resolution of conflicts by re-experiencing and working them through.

The first task of analytic psychotherapist is to establish whether the patient is suitable for analytical psychotherapy. Patients are considered suitable if they have:

1. An ability to achieve and maintain a positive therapeutic alliance.

2. Ability to work through the terminal phase.

Patients who have achieved substantial mastery of ambivalence in the early mother/child relationship can achieve this, and patients who have consolidated genuine one to one relationship with both parents before the onset of the genital oedipal situation are more suitable. This simply amounts to good enough mothering.

3. Suitable patients have a capacity to distinguish internal and external reality, particularly in respect of the regressive revival, in the transference neurosis of a triangular oedipal conflict.

4. Suitable patients have a capacity to tolerate anxiety and depression.

5. They also have a capacity to renounce without bitterness or sense of devaluation the realistically unavailable and to actively approach and attempt to attain available objects and realistic ideals (Zetzel, 1966).

Less suitable patients will show a number of the following:

1. Absence or a significant separation from the parents in the first four years.
2. Serious pathology in one or both parents, often associated with an unhappy or broken marriage.
3. Serious and or prolonged physical illness in childhood.
4. Absence of meaningful or sustained object relations with either sex.

Patients attending a psychotherapist nowadays will show a variety of neurotic symptoms and character problems. As well as showing symptoms of anxiety or depression they will often have relationship difficulties, work difficulties, psychosexual difficulties or have a sense that their life is empty and meaningless. As Anthony Storr (1980) has pointed out many of them will come with problems of living.

At the initial meeting the therapist and patient have to decide whether they can work together. If the patient immediately dislikes the therapist it is less likely that this patient will be able to form a good psychotherapeutic alliance. One patient noticed the art work that a therapist had on the walls and felt that such a therapist could never understand her and what she valued. The patient was probably right. It is often useful for a patient to see a number of psychotherapists before making up their minds to work with a particular one.

The setting is also important with meetings taking place at the same time in the same place for the same duration each week, providing the patient with a containing environment which helps to foster trust in the patient. If a decision is made to start treatment the patient is told about the technique of free association and the patient is asked to report whatever comes into their mind, however trivial, irrational or disturbing it might seem. The therapist gives the patient the notion that it is a joint search for understanding. The therapist's attitude is one of evenly suspended attention, tuning in equally to the manifest and latent meanings of what the patient is saying or has said in the past as well as tuning in to the therapist's own associations, fantasies and feelings. The therapist provides a corrective emotional experience for the patient which can be seen as a kind of "re-parenting" as described by Sutherland (1976). This involves the recognition and correction of transference distortions.

AFFECT

It is helpful to try to establish at each session what the patient is worried about and what their main conflict is at each meeting. Following the anxiety of the session helps the therapist to work out what is most important on any particular day. It also has the advantage of countering excessive intellectualization something that an obsessional patient for example will be prone to engage in. It is important then to trace the routes of the patient's anxiety on any particular day in so far as it relates to the therapist, to current preoccupations or people in the external world and to establish the childhood origins of this anxiety. When the therapist traces the relation to the therapist as well as current external world and to childhood then he has a complete interpretative statement for that particular day. Anxieties are often

over determined and have multiple routes or reasons for them and it is something critical to explore them as treatment progresses. Following the anxiety of the session also has the benefit of refocusing a therapist if they get lost in the patient's material and are unable to establish what's important or what the patient is concerned about on any particular day. It allows the therapist to 'retune' to the patient. This 'retuning' to the patient is extremely important because what most patients have suffered is parents who were unable to be in 'tune' into them in childhood.

THEMES

As the therapist reviews the sessions he discovers what the themes are for the patient. These themes will often run throughout the psychotherapy or throughout phases of the psychotherapy. Establishing what the main themes are has an organizing quality both for the patient and for the therapist and gives a sense of continuity to the sessions. It helps to 'knit' the sessions together. In a way psychotherapy is like knitting a pattern and the pattern or autobiography of the patient will develop and become clearer as the sessions progress. Psychotherapy is partially about helping the patients to speak their life history. The issue of themes also links up with the issue of core conflicts for each patient. It becomes clear quite quickly with most patients what their core conflicts are. It is helpful for the therapist to ask himself or herself what the conflicts are on any particular day and again it will help the therapists to focus on what is most important. These may include an oedipal conflict, anger at a rejecting mother, etc.

CONTRADICTIONS

It is worth the therapist noting contradictions that appear in the patient's material. This helps the therapist to establish what the conflict might be on any particular day. The contradictions should be seen as nodal points in a session and particular attention should be given to them.

It is also worth noting that the beginnings and endings of sessions are linked and it is useful for therapists to have in their minds how the previous sessions ended. They may then see a very useful link being made by the patient between the ending of the previous session and the beginning of the next and it can be very helpful to patient to point out the connection. This also gives the feeling of continuity to the sessions and helps the patient to see that each session is connected to the next one.

Dream analysis is extremely important and the royal road to the unconscious. Dreams have to be given a special importance in sessions. The interpretation of a dream will often bring a rather 'dead' session to life. The therapist has the sense when they interpretate dreams that they are on solid ground and in touch with the unconscious and current anxieties and conflicts. There will also often be a reference to the therapist in a disguised way in the dream and its important for the therapist to make interpretations involving the dream and the transference i.e. interpreting an aspect of the dream in relation to them. E.g. a patient had a dream where she was dialling a telephone number and couldn't get through to the number. This dream without going into all the details reflected the patient's anxiety of whether she would get through to her therapist or not. About a year later she had a similar dream but in this later dream she did manage to get through to the number she was dialling, which showed the movement of the treatment and that she was getting through to her therapist. Dreams will also contain reference to external current reality and to childhood anxieties, conflicts or experiences. It is also useful to look for the hidden wish in each dream.

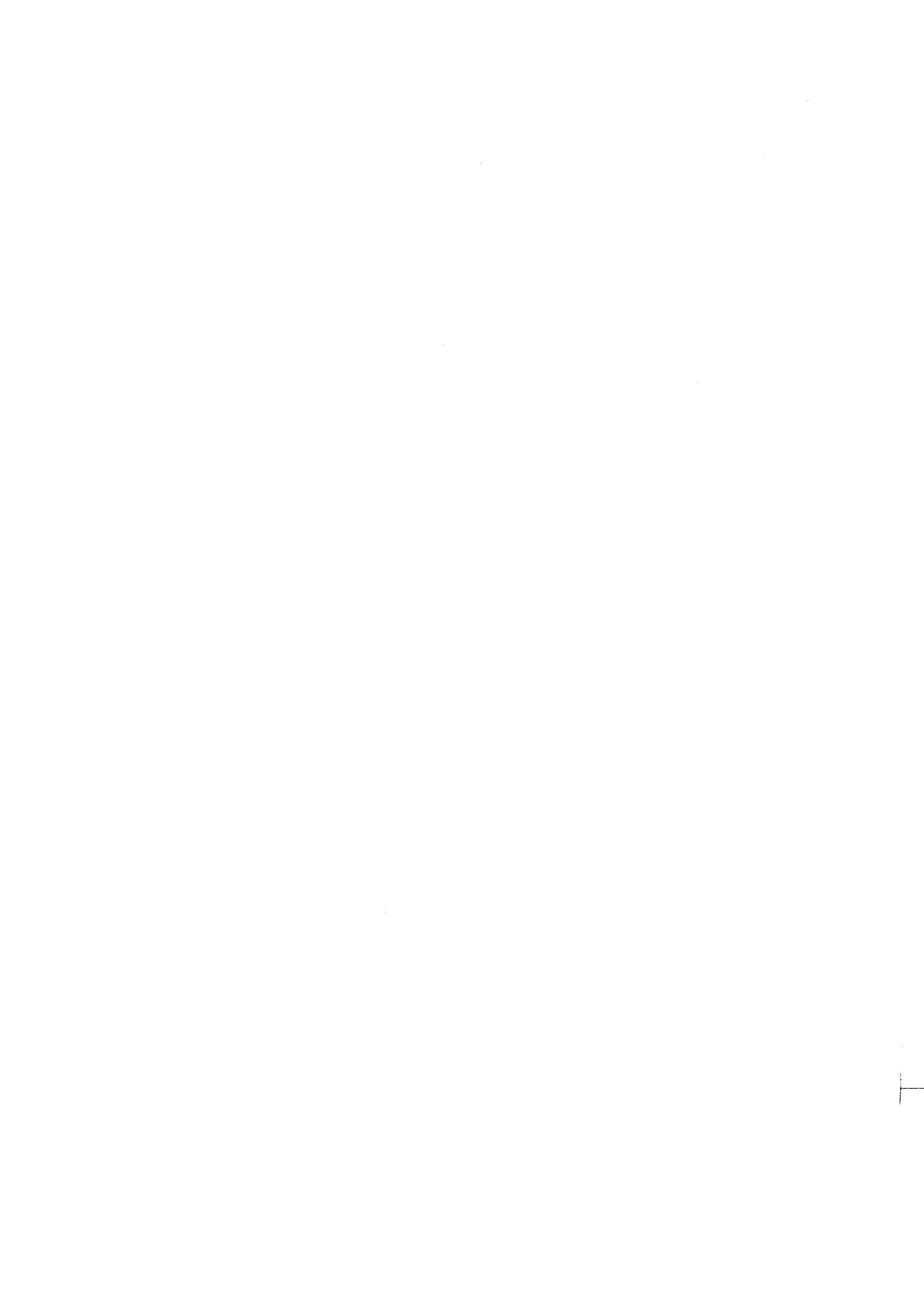
Transference is a tool for investigating the forgotten past and feelings and attitudes developed in early life to important figures as transferred on to the therapist. There is then a re-actment with the therapist which has been called the private theatre of transference by Pontalis (1974). Strachey (1934) called these interpretations mutative interpretations as they aimed to modify the patient's over strict super-ego. Repetition in the transference enables the vividness of the patient's past disturbed family relationships to be mutually experienced and examined by the patient and the therapist. This has the effect of deepening the therapy and increasing insight.

Transference is always operating during psychotherapy sessions but the therapist has to decide when it is most appropriate to be interpreted and which transference figure the patient is experiencing him or her at any particular time i.e. mother, father, sibling, etc. Patients will usually have had distorted relationships with important figures in childhood and the working out and understanding of these distorted relationships with the therapist is a major function of the psychotherapy. This is also a significant part of the reasons patients have difficulties in relationships outside the sessions and significant reason why they have come into treatment in the first place. The focus on therapist/patient relationship places it at the centre of the psychotherapeutic process. In a sense the patient's past life comes alive in the setting of the psychotherapeutic relationship and can be worked on in the here and now. The classical analytical psychotherapist has a commitment to resolving these distortions, exploring the unconscious, making it conscious and exploring what psychic reality is for the patient. This psychic reality is coloured by the experiences patients have had in childhood, by their own constitutional endowment and their own fantasies which have coloured external reality both in the past and in the present. As stated earlier the therapist is assisting the patient to differentiate internal and external reality.

The countertransference of the therapist is now regarded as extremely important because of the information it gives about the patient and the assistance it gives to the therapist in formulating interpretations. The therapist has to learn to tolerate and not to act out his countertransference feelings. The therapist has to be prepared to respond to the roles the patient draws him in to and this has been called free floating responsiveness by Sandler (1976). It parallels free floating attention. The countertransference is now seen as a major therapeutic tool ego - a therapist had a sense in a session of feeling dreadful and this was a session before the holiday break. The therapist gradually realized that the patient had projected into him how she was feeling i.e. she was making him feel the left out child with the holiday coming up rather than feeling that way herself. There was no hint of this in the patient's material and it was left for the therapist to see that he had been feeling in good form all that day and that this feeling that was aroused in him belonged to the patient and not to himself. A therapist has to be careful that if for example he comes to assessment in an angry mood that he doesn't attribute this to the patient.

TIMING

The timing of interpretation is very important and it is important not to prematurely interpret. For an interpretation to be effective it must be emotionally relevant, the patient must be fairly close to it and it must bring about emotional rather than intellectual insight. Intellectual insight has little value. If an interpretation is accurate it will have a "ring of truth" or it will help the patient to bring up new material from childhood or possibly a forgotten dream. This is called validation of an interpretation. If a patient never validates a therapist's interpretation it suggests that the therapist is not in tune with the patient or possibly that the patient is not suitable or maybe non-psychologically minded. Interpretations bring about a change in a patient's sense of self and this change can be frightening and therefore the therapist has to move at a pace the patient can tolerate. Some patients can only take cognitive change and alterations in their views of themselves in 'small doses' otherwise if they are given too much they may panic and break off treatment. It is a general rule that the therapist should analyze resistance before content and ego before id and that he should begin with an examination of surface material and proceed from that point to deeper issues. Analysing resistance gives a lot of information about the patient and their personality and can be very helpful in helping the patient to understand themselves and blocks between the patient and therapist. These blocks will also reflect blocks that the patient had with significant figures in childhood.



THE EFFECTIVENESS OF PSYCHOTHERAPY

M. Fitzgerald

It is apparent that patients who consult a psychotherapist do so under pressure of considerable emotion. It is also clear that professionals who discuss the effectiveness of psychotherapy do so with more than a dispassionate interest.

The greatest stimulus to research in evaluating the effectuacy psychoanalytic psychotherapy in the past 30 years was Eysenck's (1952) paper on the effects of psychotherapy. The outcome problem in psychotherapy research has been well reviewed by Malan (1973). Eysenck claimed that psychoanalytic psychotherapy was no better than the passage of time, i.e. that two-thirds of neurotic patients improve whether treated or not. He later reinforced this view adding further evidence in 1960 and 1965. All these articles resulted in a flood of critical comments, mostly pointing out the weakness in the evidence he was presenting, but until recently none of the criticisms were based on a proper re-examination of the original data.

The first possibility of making sense of this apparently null result occurred as early as 1956, in the form of a brief article by Desmond Cartwright. He re-examined the figures in Barron and Leary's (1955) semi-controlled study of dynamically orientated individual and group therapy. He showed that although there was no difference in the average improvements between the treated patients and the waiting list controls, there was a significantly greater variation in the treated patients, which must imply that some patients had shown significantly greater improvement, while others had shown greater deterioration.

One of the problems with the Eysenck Papers were that many people had accepted his figures and his survey of the literature and provided you didn't examine his figures or his survey of the literature it is impossible not to accept his conclusion that the effectiveness of psychotherapy had no evidence in its favour - it was only possible to say that his data was full of weaknesses.

Kellner (1965) carried out a re-investigation of the literature and pointed out the existence of a number of controlled studies of all kinds of psychotherapy which Eysenck had missed. He also began the process of exposing some of the oversights, common to writers of polemics, as opposed to dispassionate critique. Kellner made the following points 1) that in suggesting how strongly the evidence favoured behaviour therapy over psychoanalytic psychotherapy, Eysenck had accepted without criticism, Wolpe's figure of 90% improvement rate, which excluded patients who broke off treatment prematurely, while writing about psychoanalyses as follows "as regards the psychoanalytic results, we have classed those who have stopped treatment together with those who have not improved. This appears to be reasonable because a patient who fails to finish his treatment and has not improved, is surely a therapeutic failure. If a patient broke off treatment from behaviour therapy Eysenck did not include those in the results. If Eysenck had included cases that broke off the treatment from behaviour therapy the 90% improvement rate would have obviously been reduced.

Eysenck's style is also shown by an examination of the Phipp's clinic studies. One of those who came up with a null result was quoted by Eysenck but another result by Jerome Frank was positive and was not quoted.

Kellner summarised that on comparing Eysenck's paper with the published evidence on the efficacy of psychotherapy, he could only conclude that Eysenck's review of the literature was incomplete, that both the selection of his evidence and the presentation were biased and that his conclusions on the effectiveness of psychotherapy were misleading.

In 1971 Bergen again re-examined Eysenck's figure. Bergen made a thorough survey of the literature and he calculated improvement rates from Eysenck's original figures. He concluded 1) that as far as spontaneous improvement rates were concerned, these varied from one diagnosis to another but appeared to be far smaller than the rates deduced from the Landis (1938) and Denker (1946) studies, which Eysenck had used as a base line. Bergen listed fourteen studies, from which he deduced a median rate of about 30%. Kolvin (1981) found 25% from child psychotherapy studies.

Bergen also noted in his review of the literature that Eysenck dichotomized therapeutic results into improved and unimproved. Where the author concerned had four categories of improvement, this was easy; where he had only three, Eysenck halved the middle group, assigning one half to improved and one half to unimproved. Now it happens that in one of the two important studies purporting to give the figures for spontaneous remission, mainly that of Landis, there were three categories. Eysenck classed the whole of the middle category as improved, using an inflated value of 72% improved instead of 52%. Bergen wrote that the conclusion that Landis' 72% base line was curiously high, and this was further supported by the fact that his rates for alcoholics and psychopaths were 64% and 75% respectively, a figure way out of line with clinical reality. Bergen felt that this was the most devastating critique of all regarding Eysenck's papers.

Bergen concluded that the spontaneous improvement rate was in the neighbourhood of 30% and that for all forms of psychotherapy other than psychoanalysis it was about 65% and that the overall rate for psychoanalyses was 83%. He emphasised that this did not provide strong, but modest evidence in favour of psychoanalytic psychotherapy. Bergen also concluded that when this was put together with a strong cumulative evidence for the deterioration effect, then the conclusion that under the right conditions psychotherapy has a positive effect became considerably reinforced.

Wright (1976) showed that the effects of psychotherapy were clearer if one studied the patient at nine months follow-up rather than at the end of treatment. At the end of treatment a patient may be somewhat upset by the treatment and therefore not show the positive effects of the treatment. The follow-up increments have been shown in studies where there has been 30 or more psychotherapy sessions. These increments that follow-up are consistent with the theoretical view that psychotherapy effects a central or underlying or structural aspect of personality functioning rather than just directly altering behaviour.

The multi-centre study carried out by the National Institute of Mental Health (1987) on the effectiveness of cognitive behavioural therapy and interpersonal therapy as well as drug treatment of depression found that after sixteen weeks there was no significant differences in reduction of depressive symptoms or in overall functioning between either of the psychotherapies or imipramine treatment. Some 60% of the patients who received either psychotherapy or drug therapy had a full mental health recovery.

A consumer based evaluation of psychoanalyses was made by Lawrence D. Philips (1986) Director, Decision Analysis Unit, London School of Economics in the Times. He stated that "scientific method was applied by my analyst: interpretations were based on shared data mainly discussions, events and behaviour that occurred during the session, not only on past memories to which only I had fallible access. Inconsistency, contradictions, lapses of memory, slips of the tongue, all provided data for making inferences and for analysing, along with reports of dreams and associations. Many interpretations were offered as hypothesis which later behaviour both in the analytic sessions and outside either confirmed or rejected. An ability to see one's self as other might see one was valued as the scientist values the ability to view the world objectively. Instead of rhetoric about the (stupendous confidence trick) with its (audacious assertions), Times' readers are entitled to a dispassionate and scientifically based valuation of psychoanalysis as it is practised today. Dr. Denis Friedman (1986) of the Priory Hospital stated that it was not acceptable "to discredit more than half the patients in psychoanalysis in the United States who are either themselves practising psychiatrists or psychologists. Surely the fact that this is the treatment of choice for the cognoscenti familiar with the many other therapeutic strategies speaks for itself".

Sherperd (1984) argues that the effect of psychotherapy is little more than a placebo effect. He gives weight to a meta-analytic study of outcome of psychotherapy by Prioleau (1984) which states that "for real patients there is no evidence that the benefits of psychotherapy are greater than those of placebo treatment". Block and Lambert (1985) commented that the treatment in this study was quite unrepresentative of conventional clinical practise and that only 8 of the 24 studies included had patients. Many of the therapists had limited clinical experience and ranged from elementary school teachers to psychiatrists. The average duration of the treatment were unlike standard dynamic psychotherapy. Greenberge (1983) noted "overall, the characteristics and heterogeneity of the few studies selected for review suggest that they are unsuitable as a basis for drawing sweeping inferences about out-patient psychotherapy". Dynamic psychotherapists would agree with that conclusion.

Block and Lambert (1985) point out researchers in psychotherapy should attempt a) to test whether a specific form of treatment has any particular advantage over an established treatment for a target clinical sample b) tease out certain characteristics of the treatment under study, including certain qualities in the therapists and to note their effect on outcome and c) to examine the influence on outcome of other factors such as the patient's ability to form relationships, and his motivation for change.

It is unfortunate that the style of the debate in the mid 1980's is conducted in a similar manner to the 1950's.

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SUPERVISION OF TRAINEE THERAPISTS

M. Fitzgerald

The supervisor is the most critical person in training of any psychotherapist. The complexities and pitfalls of supervision are not as well recognised as they should be. A trainee will tend to practise like his supervisor for the rest of his professional life. Different types of patients will present different problems to both the trainee and supervisor.

After a session between patient and trainee the trainee has to write out the sequence of the session in so far as is possible to remember it. This record then will be the main focus of the work between the trainee and supervisor. The sequence is crucial and what is most important for all is the order in which the material of the session has unfolded. This also permits the supervisor an opportunity to empathise with both the patient and trainee as to their unfolding interactional experiences and to sense on some level the anxieties, the moments of relief, the periods of confusion or understanding - and whatever that the trainee and patient may have felt separately.

The hysterical patient will try to modify the frame of reference that the trainee has set up. This kind of patient will try to manipulate the trainee. The trainee must not allow the patient to manipulate him in this way and needs to confront the patient with what they are doing. This requires confrontation which requires the use of constructive aggression. If the trainee has not come to terms with aggression in his or her own life they maybe unable to confront the patient with their manipulation. If the trainee has had a very domineering mother, who didn't allow expression of anger or aggression or to stand up to her, transference of these feelings onto the patient can occur. The trainee is not able to confront the patient in the same way that he was not able to confront his mother in childhood. The trainee will require the support of the supervisor in confronting the patient

with acting out behaviour. If the trainee is anxious, frightened or insecure in his role as a therapist he may be unable to confront the patient with her absences from treatment. If the trainee has very low self-esteem and values himself very little then it is likely that he will also value his psychotherapeutic work very little and it is important for the supervisor to point this out to him. The trainee may take the patient's attitude as confirmation of how useless he is as a person and how useless psychotherapy is. At this point the trainee is not in touch with reality or with the value of psychotherapy but is only in touch with reality or with the value of psychotherapy but is only in touch with his feelings about himself which developed in childhood. The trainee is more vulnerable in this situation if he has never been praised for his achievements in childhood. Nevertheless praise from the supervisor to the trainee is not sufficient in itself and these issue may need to be taken up in personal psychotherapy of the trainee. Nevertheless if the trainee has good experience in dealing with a difficult patient he will gradually begin to value his psychotherapeutic work more with the support of the supervisor.

Another form of resistance that the trainee may have to confront is silence and once again the trainee must find out what the silence means. It may mean that the patient is angry with the trainee, has something upsetting to hide that they feel the trainee wouldn't be sensitive to or has critical thoughts about the trainee. It is necessary for the trainee to explore all these possibilities with the patient to enable the patient to communicate. The supervisor must point out to the trainee that they must not be critical of the patient which could lead to them becoming like a super-ego figure from the childhood of the patient. The silence is also often mishandled by the trainee asking irrelevant questions which of course the patient will be very pleased with as it then helps them to avoid the reason for the resistance in the first place. It is the aim of the trainee to undo blocks in communication between the patient and them. Of course the same thing may happen between the supervisor and trainee. The supervisor and trainee. The supervisor may collude with the trainee and avoid the trainee's blocks. Blocks that trainees have with patients will often be reflected in the relationship to the supervisor. The supervisor has to pay attention to

what is going on between the trainee and himself. What goes on between the trainee and the supervisor is a mirror of what goes on between the trainee and the patient. Most of the ingredients of the problems trainees will have will also come up in the supervisory interaction. The supervisor needs to be experienced to tune in to all these nuances between himself and the trainee.

The most critical factor in the trainee's interventions is to know how the trainee is represented in the patient's material in the transference. The trainee has to be helped to ask himself or herself the question - how does the patient see me now? The trainee has to ask themselves whether the patient is seeing them as if they were a sibling or father or mother.

If the trainee is not handling the patient properly or not really understanding what is going on, the patient will often make unconscious supervisory efforts to help the trainee to understand better. An example of where the trainee missed the real issue is the following. A male patient started off the session by saying there were two things that he wanted to get off his chest. He didn't want things discussed with this therapist's colleague who lived in the same house and who was a social worker. The patient went on to say that his mother had a stroke and later when he went home from visiting his mother in hospital he said that he was reading the Bible and the notion of a traitor occurred to him. At the very end of the session the patient again said it was easier to talk when one was with a social work therapist. The therapist on all these three occasions did not explore the meaning of trust with the patient and the patient kept coming back to it over and over again, trying to get the therapist to pay attention to what was worrying him. It emerged that this patient had seen some other therapist who had spoken in a rather denigrating way with a friend of his and this was one of the origins of the mistrust. If the therapist picked up at the very beginning of the session on these fantasies and mistrust the therapist could have resolved them with the patient and the patient would not need to have been bringing them up over and over again.

Another problem that will arise is a lack of knowledge of the trainee. If the trainee is not aware of the significance of schizoid or paranoid traits and their meaning and origins in childhood then the trainee will not be able to deal with them effectively in treatment. The supervisor here should give the trainee the knowledge or at least guide them in their reading.

The kind of trainee that a supervisor may have difficulty in dealing with, will be the schizoid, obsessional trainee. Obsessional trainees are typically out of contact with their feelings and go in to psychotherapy training in order to get in touch with their feelings. Unfortunately, once they get involved in psychotherapy they continue on intellectualising. They are often extremely rigid and defensive and it is extremely difficult to get through to them. Some trainees will be so damaged that they can't be helped and will probably be better occupied not working with people but working in a laboratory or doing some scientific activity where for example obsessional traits would be extremely highly valued. Again, of course, obsessional people tend not to be creative and there is a need for a lot of creativity in psychotherapy. In this case the supervisor will probably have to draw attention to certain traits in the trainee and to these defenses particularly when they are not able to get in touch with their patients. When a trainee of this category talks about a patient they will give no real sense of the patient and will have no feeling for the patient.

The supervisor may become aware of an approaching supervisory crisis when he becomes more preoccupied with the patient than with the trainee. This occurs particularly when the trainee is not able to tune to the patient when the patient is clearly in distress and is not being attended to by the trainee. At the same time it is important that the trainee intervenes actively when there is gross acting out or when there is psychotic depression or serious suicidal ideas. In some of these cases the patient needs to be hospitalised and requires the intervention of a psychiatrist and medication. Sometimes if the psychotherapy can be continued as an in-patient this provides continuity and the combination of a biological and psychotherapeutic approach can be useful to certain patients.

Sometimes trainees become overly preoccupied with certain theories and stop listening to their patient. The trainee may also become excessively theoretical when he loses confidence in his own intuitive ability and indeed theories can for a period create a block between the trainee and the patient. The supervisor has to help the trainee to trust himself again, to trust his feelings and 'tune' into the patient's feelings.

Another side effect of supervision is that the trainee can't tune into the patient because he is preoccupied with what the supervisor said or may say in the future. This is probably something that cannot be fully eliminated of during the supervision. The supervisor has to tell the trainee not to remain preoccupied all the time with what is said in supervision but to pay attention to what is going on between the trainee and the patient. One often notices that the trainee's performance is poorer the day after supervision.

Trainees develop very powerful transferences for supervisors. They tend to idealise them and to place them on a pedestal. When this happens the trainee often has hostility towards the supervisor which is not expressed and which is covered by the idealisation. Naturally the trainee will react to a supervisor in the same way that he reacted to his parents in childhood. If the trainee has a strong and severe super-ego as many Irish trainees have this super-ego will be projected on to the supervisor and the sessions may become terrifying for the trainee. The supervisor must take up issues of idealisation and fear that may become evident in the supervisory sessions. Ideally at the end of the supervisory process the trainee should view the supervisor as he or she really is with their assets and faults. Nevertheless, this does not necessarily happen and the trainee continues to feel that the supervisor is on a higher plane and may continue to idealise him for years after the supervision has terminated. It is evident that some weaker trainees remain submissive to supervisors for years after the supervision has terminated. Supervisors sometimes collude with this idealisation as it is very gratifying for them and makes them feel very powerful and pathologically increases their self-esteem and narcissism. Another unfortunate side effect is when the trainee at a later stage becomes a supervisor they tend to prefer the supervisory task in a similarly unsatisfactory way.

The supervisor is because he becomes internalised in the trainee and has a major influence on the trainee's work. After qualification, therapists continue to 'talk' to their internalised supervisor. The supervisor becomes part of their minds in a way similar to the way their mother and father. The good and bad effects of the supervisor become fossilised in a web in the trainee's mind and will remain, directing the trainee during the rest of their professional careers. This happens because the supervisor has an emotionally intense relationship with the trainee over an extended period of time. This is also why lecturers and academic discussions have much less effect over the longterm.

During a normal supervision when the trainee is performing reasonably well, the supervisor has no preoccupation with the patient and supervision is an enjoyable experience where the supervisor is helping to point out to the trainee points that they have missed, issues that they should have explored further and minor problems in their ways of relating to the patient when the trainee is of the more borderline personality type. When all the supervisors and staff of a training institution have the same anxiety about a trainee this has serious implications for the qualification of such a trainee. Ideally this kind of thing should be identified during the first year of training or at preliminary interview for the course. A small number of trainees are accepted for all courses who are unsuitable. It is unfortunate that persons sometimes attracted to psychotherapy training have had excessive severe traumas in their early life which have damaged the ego's too severely to be able to become therapists. They may not be aware of coming to training only for treatment purposes. Nevertheless it is true that persons who are mildly neurotic probably make the best therapists. These mild problems sensitise people to what is going on within themselves and then they are able to 'tune' in to ill people or people with problems of living.

Interruptions or irregularities can have a serious effect on supervision. If the supervisor doesn't like the trainee or if the trainee makes the supervisor anxious cancellation of sessions can take place. The meaning of these missed sessions must be taken up by the supervisor with the trainee. The missing of

a supervisory session by a trainee can be a form of acting out and the trainee can be expressing his anger towards the supervisor in this way or non-verbally stating that the supervisor isn't helping the trainee sufficiently. The trainee may have problems with authority and be anti-authority and express it by missing sessions. The trainee equally maybe frightened of coming to the sessions and be too anxious to come and therefore miss them. This again must be taken by the supervisor and personal therapist. The process of supervision cannot be interrupted anymore than the process of treatment. If it is interrupted or irregular, all the nuances get lost and it becomes difficult to follow the sequence of what is going on between the trainee and the patient.

It is also important to realise that the supervisor's primary responsibility is with the patients that the trainee is treating. The supervisor's primary responsibility is not with the training organization. This is of a secondary nature. Nevertheless the training organization can interfere with the relationship between the supervisor and the trainee. The supervision is not confidential between the trainee and the supervisor and this interferes with the trust between this trainee and supervisor. The trainee may remain preoccupied with what the supervisor is going to tell the training organization and therefore not be honest and open with the supervisor. In an ideal world the supervisory process between the trainee and supervisor should have no outside interference but this is not possible in a formal psychotherapy training program. In one sense it could be argued that the best supervision occurs post-qualification when there is no outside institutional interference.

Supervisors should not tell trainees about their own personal problems, marital problems, relationship problems, and so on. If the supervisor gives the trainee too much personal information about themselves this can interfere with the supervision. If the supervisor admits to being depressed, this can have a negative effect and the trainee may become preoccupied not with what is going on between him and the supervisor but with the supervisor themselves and how they can be helped. Under optimal circumstances the supervisor should take up a neutral position in so far as this is possible.

Trainees are very vulnerable and can be very easily exploited consciously or unconsciously by the supervisor. Supervisors who are critical about other staff members can have equally bad effect on trainees and some supervisors use the supervisory process to gather a clique of trainees around them who will accept their views. This again is an abuse of the supervisory process.

The supervisor will offer a formulation which is related to the material brought by the trainee to the supervisory session. This formulation can be validated. If the patient brings material which illuminates in an unique and unexpected manner the formulation offered by the supervisor then this will validate it and the new material will organize things in the patient's mind that were previously unorganized. This will also have the effect of organizing the material in the trainee's mind.

The new material will lead to a deepening of what the supervisor and trainee know about the patient. Another validation of the supervisor's formulation comes about when the trainee reports material that he had forgotten in the earlier part of the supervisory session. In the case of the patient described earlier in this paper where the trainee hadn't sufficiently identified the patient's mistrust at the beginning when he was presenting material to me, said after I hypothesised this that there was further support for what I was saying towards the end of the session. Supervision is a gradually unfolding process.

The supervisor must also be careful to look for countertransference based difficulties. The supervisor should evaluate himself after he has made a number of non-validated hypothesis about the material the trainee is presenting. The supervisor should also examine critical comments from the trainee as these may contain 'a grain of truth' and may touch on an area of disturbance within the supervisor. The supervisor should make consistent efforts to identify clues of the presence of countertransference factors in his supervisory work. If there is tension in the relationship between the supervisor and trainee the supervisor must examine himself to see if he is adding to this tension. Likewise the supervisor must examine himself if there is no progress in the treatment between

the trainee and patient. The third situation where the supervisor must examine himself is where there is deterioration in the treatment situation between trainee and patient.

The type of supervision that is progressing poorly is where the trainee makes relatively barren, uninformative presentations to the supervisor and the supervisor responds with relatively terse general interventions. These barriers tend to defend against inner turmoil and catastrophe - usually an underlying psychotic disturbance in a part of the personality - they are strongly maintained and difficult to modify in the supervisory situation. This kind of unsatisfactory supervisor will make no use of the validating process and will accept the most vague and general forms of confirmation of his formulation and will tend to accept similarly ill defined formulations and intervention on the part of his trainee.

When the supervision is going well it will serve the growth of both participants - trainee and supervisor. Growth prompting supervisory work often requires tolerance and some degree of aggression and anxiety in both the trainee and supervisor and will be especially required when there is painful confrontations and self realisations on the part of the trainee who truly cannot learn without periods of regression, disorganization and it is hoped subsequent re-constitution at a higher level of functioning. Sometimes trainees who are so defended are not able to allow this period of regression and are therefore not able to grow because of too severe defense mechanisms.

Some supervisors make the mistake of focussing too much on a single idea or theory and others only focus on the content of the session but ignore all interactional factors.

Nevertheless the supervisory process cannot be used for personal therapy. There are matters that can only be worked out in personal therapy, not in supervision. To work effectively the supervisor and trainee must be in reasonably good psychological health and not suffering from severe anxiety, depression or

Other factors that interfere with the trainee/supervisor relationship occur when the supervisor becomes envious of a usually younger trainee and becomes antagonistic towards the trainee because the trainee's basic attitude towards his therapeutic work is at variance with the supervisor and unresolved competitive conflicts between the supervisor and trainee can be disruptive. The supervisor may also have difficulties in relation to aggression and be upset by some of the material that the trainee is bringing. On the other hand the trainee may equally be envious of the supervisor and fear the supervisor's knowledge and perceptiveness. If the trainee is in personal therapy there is also the danger of displacement of conflicts and issues centred within their own personal therapeutic experience which get shifted on to and enacted within the supervisory relationship. Some supervisors act out during supervision and use the trainees as a vent for their aggression and for narcissistic gratification and use the student as a kind of audience before which the supervisor acts out. It is critical as well that the supervisor maintains respectful attitude towards other forms of treatment.

The supervisor has the satisfaction of assisting in the growth of new therapists who are entering the field. In addition however, by virtue of the added distance between the supervisor and the patient, and because the supervisor's responsibilities are quite different in supervision as compared to therapy (they are not entirely and immediately devoted to the therapeutic needs of the patient and may take a wider scope), supervisors have a special opportunity for growth and creativity. (Langs, 1979) Langs also believes that it is no coincidence to realise that it seems likely that Freud's discovery of transference was greatly facilitated by his supervisor/like role in observing the therapeutic work of Breuer. Langs also points out that much of his own creative work and discoveries had been aided from the supervisory situation. He felt that it was a setting rich in potential for research and insight and that it deserved far more extensive utilisation.

When a student completes supervision he goes into a state of self-supervision and he must maintain this self-supervisory attitude for the rest of his professional life and use the predictive validating methodology described and also be very sensitive to the patient's unconscious supervisory efforts.

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THE BALINT GROUP IN GENERAL PRACTICE

Michael Fitzgerald

Summary

The development of a psychotherapeutic approach to general practice since the 1920's by Michael Balint is described. The importance of getting in touch with patient's feelings and conflicts is emphasised. The aim of the approach is to help the patient understand the meaning of the problems they present to the doctor to listen to the hidden reasons for the patient's visits to him. A Balint group is described.

The Balint Group In General Practice

There has been considerable interest and effort in the development of a technique for psychotherapeutically influencing the patient, which is germane to General Practice since 1920s¹⁻¹². The issue remains important because epidemiological studies that have surveyed General Practice, show that this approach picks up far more psychiatric cases than a search of hospital records and General Practitioners refer only about 5% of their adult psychiatric patients to hospitals¹³. It has also been shown in the UK that GPs fail to detect about one third of their patients' psychiatric disorders¹⁴. For each disturbed child referred to a Child Guidance Clinic, there are 5 equally disturbed children not referred¹⁵. In addition GPs who practice the Balint approach have taken a special interest in patients with psychosomatic problems. Balint was always interested in emotional and relationship problems of General Practice and commenced Seminars for GPs in Budapest in the late 1920s. He restarted this work in the late 1950's, in London, when many GPs were anxious about their future role within the order of medicine, and it was widely recognised that medical teaching and medical practice had been neglecting the emotional aspects of General Practice. In addition Balint¹⁵ as well as Mallan¹⁶ had a major impact on psychiatry with the development of short term psychoanalytic psychotherapy in the context of post World War II Britain. Balint in particular

The Renaissance in General Practice, a phenomenon in the 1960's owed a great deal to the recognition of the enormous therapeutic potential in the doctor/patient relationship, a factor of which Balint¹ had opened the eyes of the profession and which he had begun to examine. It became clear to Balint that the most common "drug" prescribed in General Practice was the doctor himself and the chief aim of Balint's¹ initial work was to describe certain processes in the doctor/patient relationship - the undesirable and unwanted side effect of the "drug" doctor, which caused the patient and his doctor unnecessary suffering, irritation and fruitless effort. Balint¹ was trying to describe the diagnostic signs to enable G.P.'s to recognise those pathological processes or side effects in himself in good time; in short a kind of pharmacology of the doctor. He realised very quickly the disquieting revelation that very little was known about the timing and dosage needed for this oldest of all "drugs", the doctor himself. Balint¹ felt it was very important for each doctor to know what kind of patient he was unsuccessful with or what his blind spots were. Stein¹² felt that coming to terms with the feelings that the patients stirred up in doctors was a significant part of a doctor's maturity.

At the time Balint commenced his group, General Practitioners had no established methods for training them in psycho-diagnosis and psychotherapy. He felt that the research he wanted to do could only be conducted by G.P.'s while doing their every day work undisturbed and unhampered, sovereign masters of their own surgeries. He organised G.P.'s into groups with himself as leader. He resisted a teacher/pupil relations with the G.P.'s but aimed at developing a free give and take atmosphere in which everyone could bring up his problems in the hope of getting some light on them from the experience of others in the group. G.P.'s were requested not to bring detailed written case histories, as it was felt that this would involve a good deal of secondary elaboration of the clinical material which was exactly what Balint wished to avoid. From the beginning Balint's intention was that a G.P.'s report should include as full an account as possible of his emotional responses to his patient or even his emotional involvement in his patient's problems. A frank account of this, the emotional aspect of the doctor/patient relationship could only be obtained if the atmosphere of the discussion was free enough to enable the

G.P.'s to speak spontaneously. The problem with a carefully pruned written report was that there was a weeding out of most of the remnants of the emotional processes in the mind of the reporter, or of his critics, thereby giving disproportionate emphasis to intellectual processes. Balint wanted to avoid the ending up with a detailed written clinical report with a kind of detached scientific assessment of the patient with all the emotional feelings extracted.

Balint¹ emphasised the importance of listening as distinct from traditional medical history taking. He emphasised the importance of intervention at the early "unorganised" phase of the patient's illness. It became clear that a doctor's feelings for his patient often interfered with the treatment which lead to a poor outcome. Nevertheless, if the doctor could be trained to understand the meaning of his emotional reactions to the patient, then the treatment was often enhanced. Balint¹ pointed out the danger of complying automatically in diagnostic work with the rules of "elimination by appropriate physical examination" as a protection against missing a possible organic illness, and the fact that this rule was achieved only as a price of establishing a "ranking order of illnesses and of patients attached to them." He also emphasised the danger involved of "elimination by appropriate physical examination" on finding an irrelevant physical sign and helping the patient to "organise" his illness around it sometimes with calamitous consequences. It was clear that missing a psychological problem, could have equally serious effects to missing a physical one.

The importance of not trying to reassure a patient before it was clear what the patient's visit was about, was something that came up in these early Balint Groups.

The initial approach that Balint¹ used was to bring patients back for long interviews at the end of surgery, but this was felt to interfere with the normal flow of general practice. This led to the development of the flash type of interview that could be used in the normal 5 to 15 minutes available for a general practice consultation⁸. The Flash consists of a spontaneous mutual awareness of something important in the patient. For the doctor to experience a flash of insight, he has to allow himself the discomfort of abandoning his own ideas of what should be happening and tune into the patient's distress.

Often a flash concerned the relationship between the doctor and the patient, but even if it does not, the relationship is changed by the flash. The main characteristics of the flash technique are the intensity of contact between the patient and the doctor; the freedom the technique gives to the patient to use the doctor in his own way, the freedom the technique gives to the patient to use the doctor to make his own observations and to escape from theory and interrogation; the freedom it gives the doctor to be used i.e. to give himself without anxiety that the patient will abuse his time; the discipline it imposes on to the doctor during the brief interviews to observe both the patient and his thoughts and feelings. The doctor gives the patient one ear, but the other is listening to his own emotional reactions to the patient. The doctor's task is to observe how the patient talks, acts, thinks and behaves, and why this causes him pain, what he is like, what he seems, in an obscure and confused way, to share with his doctor; what really makes him want his doctor's attention. The Flash technique allows the doctor to cut across the massive amount of data that he has about the patient.

Aims of the Balint approach

It is hoped that the changes that occur in the doctor/patient relationship in the Consulting Room will generalise to other relationships outside it. A reduction is aimed for in the patient's symptoms, e.g. depression or anxiety. This approach also aims at reducing emotional tensions between the patient and people in his family and at work.

In addition the Balint Group for G.P.'s has the following functions:

- (A) Support.
- (B) The development of new strategies in a context of general practice and the development of a science of practice.
- (C) To allow the G.P. to reassess his practice techniques.
- (D) It has an educational element, particularly in relation to psychosocial problems and can be a useful element in a G.P.'s continuing medical education.

Petroni¹¹ has suggested an additional aim of personal care where each G.P. brings to the group any personal concerns relating to his own life and explores any issues relating to any member of the group including the leader or his practice.

The relevance of psychotherapeutic approach to general practice developed by Balint was studied in an Irish context so that the appropriateness of such an application could be ascertained.

An Irish example

The Balint Group met for approximately two years at two weekly intervals and the meeting lasted 1½ to 2 hours each. Each G.P. told the story of his patient in his own way. The ensuing presentation was acceptable because something of value emerged which probably would not have been achieved in any other way. It is possible, with exhaustive detail and the rigid presentation format, to squeeze the life and feeling out of a presentation. This technique departed from the traditional bedside teaching, but it did so in a secure knowledge that the absence of the patient himself was no loss - the central subject of this study, the doctor/patient relationship, was present and mirrored in the group/doctor interaction. Free from the constraints of a formal and logical presentation, the reporting doctor was able to represent and almost impersonate his patient. The following is an example of a typical case and a discussion and understanding that ensued.

The doctor described how he was called out late at night to see a child who had had an asthmatic attack. The doctor examined the child, but felt the child did not need antibiotics, which the father was insisting on the doctor prescribing. The doctor explained to the father that they were not required in this instance. The G.P. became aware of some irritation and anger at the father's persistence. The Balint group were then able to point out to the G.P. that the feelings that were welling up within him gave him an understanding of how it felt for this child to live with this father and the kind of feelings that this father stirred up in the child. This understanding had the effect of reducing the doctors sense of irritation.

Another G.P. had seen a patient for a number of years with tiredness, headaches and pains in her neck. No physical abnormalities were found. Initially, she was slow to trust him and had a fear of intimacy. The group suggested that something

traumatic might have happened earlier in her life. Gradually, she began to trust the G.P. over a number of sessions and was able to tell him of a secret of her trauma that she had withheld for fifteen years. The relationship with the G.P. was changed by this disclosure and further discussions could take place on the basis of exploring her real psychological conflicts.

The Group helped a G.P. cope with a young mother, who presented over a long period with complaints that she could not stop her baby crying, could not give him enough to eat and could not keep him happy. The group focused on the mother's uncertainty about her ability to be a mother and helped the G.P. to give the mother space to express her anxieties about herself in the first instance and then to support the mother in her mothering role. The meaning of the early losses that the mother experienced in her childhood were explored and understood. This helped to make the doctor/patient relationship more effective and the increased understanding that the Group was able to give the G.P. helped him.

Some G.P.s described the Group as time consuming but useful personally, the fact that some G.P.s were at different stages in their careers was a source of some conflict. There seemed to be a need for groups for trainees and groups for senior G.P.s. Another point of stress was that feelings of participants stirred up in a Balint Group are much more intense than a G.P. would normally expect in a teaching/learning situation and attention needed to be directed to these feelings by the leader. A re-evaluation of old styles of practice arouses very considerable anger.

The Group was a learning experience and it is usually not possible to learn from such an experience and the rethinking of their practice without some pain being involved. The Group challenged some idealised fantasies the G.P.s had about themselves and the notion that their old style of general practice was the only way. The switch over from the old to the new style of general practice involved the G.P.s tolerating some uncertainty about their styles of practice and their identity as practitioners during the change over period. It is important for the leader to attend to these as well as rivalries between participants. It would be probably be preferable if the Group be led by a psychotherapeutically oriented G.P. This leader would be easier for G.P.s

to identify with. In practice this is often not possible as it is one of the core psychotherapeutic professionals who takes the role of Group leader. A decision was taken by the leader to apply very few group dynamic principles but to focus on the doctor/patient relationship in the consulting room and the reactions of individual doctors in the group to history of the patient presented. Some G.P. training groups focus more on group process and this had the advantage of giving the G.P.s some further personal understanding of themselves. The disadvantage might be that it would take the focus off the doctor/patient relationship and make the group more group therapy experience. Likewise, the personal care and personal concerns of the G.P.s were not dealt with. There would appear to be a need for separate groups to be set up to focus on these issues, and of course these groups would also have secondarily a beneficial effect on the doctor/patient relationships.

It is also became clear that G.P.'s were more successful when they got involved with patients, hesitated in the prescription of psychotropic medication, and coped with the tensions and countertransference feeling without rejecting the patients by referring them onto someone else. The countertransference feelings were seen as giving the doctor information about the patient. The possibility of a mismatch between doctors and patients was also discussed. Sometimes a Balint Group can help a G.P. to resolve these mismatch issues. At other times it became clear that referral was appropriate, and that patients resolved these mismatch issues by transferring to another doctor.

One G.P. summarised the effect of the Balint Group on him as follows: "The Group discussions made me a better 'talking doctor' and the patients appreciated this. We thus had a more effective relationship". This was what was set out to be achieved.

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