EASTERN HEALTH BOARD

# Irish Families Under Stress

## Volume Four

EDITOR: MICHAEL FITZGERALD

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## Volume Four

Editor:

Michael Fitzgerald

Eastern Health Board
1995

## Contents

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## Foreword

**Professor Anthony Clare**
**Professor Psychiatry Trinity College Dublin**
**Medical Director St. Patrick's Hospital.**

This collection of research studies, clinical reports, personal essays and book reviews is a remarkable testimony to the productivity of Dr. Michael Fitzgerald and to the breadth of his professional interest, covering as it does such diverse topics as childhood stress, family disharmony, social change, alcohol and drug use, infantile gastroenteritis, major depression, abnormal eating patterns, language disability and immunization uptake in Ireland. Inevitably, given such diversity, some of these topics are considered with a degree of brevity. Others, such as Dr. Fitzgerald's particular interest, psychoanalytic psychotherapy, merit more consideration in depth. All repay careful reading.

Dr. Fitzgerald does not eschew controversy which makes the collection particularly stimulating. He has long argued the case for a strong and significant link between behavioural deviance in children and social deprivation, has campaigned strongly for an appropriate expansion of child psychiatry and psychology services in Ireland and, on the basis of his own findings and comparisons with equivalent studies abroad, makes a compelling plea for a greater priority to be afforded to preventive psychiatry.

Running through this collection is a concern for the family and it is to the credit of Dr. Fitzgerald that he places the issue of family dysfunction, disharmony and distress in a historical context. The picture he dispassionately paints of the current state of many Irish families will not comfort many and certainly serves to challenge those who somewhat blithely assume that apart from a handful of dramatic pathological cases all is well. The clustering of so many adverse factors in the case of so many of our children - poverty and debt, marital problems, parental mental illness, unemployment, housing difficulties, poor schools - poses a serious challenge to a society anxious to live up to the Constitutional imperative concerning the fundamental role played by the family in our society. Too many of our children grow up unloved and damaged in their own ability to love, marked with a profound lack of self-esteem and self-belief. It is to Dr.

Fitzgerald's great credit that notwithstanding the gloomy and distressing picture he paints concerning the experience of children and parents he is resiliently optimistic concerning what might be achieved were we to devote greater effort and resources to better preparation for marriage and family life and earlier intervention for families in trouble.

His call for the various Departments of State involved with the care and welfare of children to work together given the imminence of another divorce referendum is timely. There is, as he cogently argues, an urgent need for a new children's agenda which would put the child at the heart of society's priorities. This volume, in common with its predecessors, provides much information and comment to strengthen the argument and to hasten the day when politicians, planners, professionals and the public more appropriately confront the issue of child care and health in Ireland.

## Preface

**Mr. Michael Noonan T.D.**
**Minister for Health.**

The research findings in this volume will be an invaluable asset to all those both working and interested in the area of child and adolescent psychiatry. In recent years the increasing need to develop these services has become all too clear. The availability of child and adolescent psychiatric services is an integral component in the network of services required to underpin the implementation of the Child Care Act, 1991. As you are aware, the Government is fully committed to the speedy implementation of the remaining sections of the Child Care Act, particularly with those provisions that relate to the protection of children from abuse and neglect. Under the Health Strategy **Shaping a Healthier Future**, a major programme of investment in the child care services is underway to ensure that the Act is fully implemented.

Society is changing and we must be willing and able to meet its challenges. I am glad to say that the development of child and adolescent psychiatry has accelerated in recent years with the establishment of multi-disciplinary teams led by consultant psychiatrists in all health board areas. The Report of the Study Group on the Development of Psychiatric Services **Planning for the Future** published in 1984 accepted that the majority of children treated by the service are not mentally ill in the sense in which this term is used for adults but are emotionally distressed for a variety of reasons. The challenge which faces the child psychiatric team is to identify the causes of emotional distress in children and draw up suitable programmes which will ensure that the child can attain and maintain a good state of mental health. Research such as that carried out by Dr. Michael Fitzgerald and his team can go a long way in helping us to meet those challenges and in reaching the objective of providing a comprehensive modern day service.

## Commentaries

**Professor Marcus Webb**
**Professor of Psychiatry Trinity College Dublin**

Volume IV of Michael Fitzgerald's "Irish Families under Stress" is essentially in three parts. The first part summarizes the 133 papers which Dr. Fitzgerald has written, many with colleagues, on the psychological and psychiatric state of children, adolescents and their parents in Ireland in our time. There is a summary of each of the main areas of study, which include measurements of psychological and social distress, relationships between parents and children, the application of psychoanalytic psychotherapy, and particularly the impact of adverse family and community factors on the development and emotional life and conduct of children. Dr. Fitzgerald has provided a succinct summary of much of this work in a six-page account which seeks to point out what is required for the healthy development of children in Ireland. It is not surprising that a psychoanalyst looks for a close bond between mother and child, but also one in which praise and esteem-building interaction is fundamental. He stresses the gains that psychotherapeutic treatment of disturbed children can bring, but also he urges preventive strategies to improve the lives of growing children.

The second section of the volume deals with new studies which he has published on children and families, and this time he includes an international perspective in comparing child psychiatric in-patient treatment in Ireland with three other European countries.

The third section provides a number of thoughtful commentaries and position papers on psychoanalytic psychotherapy and the need for psychiatry to move back to link up psychological theory and practice with the burgeoning biological studies and treatments. This is a sound and sensible plea, particularly at this time when we are moving a little closer to understand how thought can influence physiological functions. Psychiatry should embrace such wide aspects of human condition.

We are indebted again to Dr. Fitzgerald's energy and commitment to improve the current lives and future of Ireland's children.

**Mr. Michael Walsh**
**Programme Manager, Special Hospital Care Programme**
**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 medial 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.

**Dr. Eric Fombonne**
**Senior Lecturer Child & Adolescent Psychiatry**
**Honorary Consultant The Maudsley Hospital.**

The volume of Irish Families under Stress edited by Michael Fitzgerald, testifies about the vitality of child and adolescent psychiatry research in Ireland. Indeed, this volume collates an impressive range of studies which, although they differ in their focus and methodologies, do provide a coherent contribution to the study of developmental psychopathology. Different developmental stages are covered, from behavioural deviance in preschool children, to emotional problems during school age, and to the study of eating attitudes, or suicidal behaviours amongst adolescent girls and boys. The breadth of coverage of the various disorders that child psychiatrists have to deal with is also evident in this volume where the reader will find studies of developmental disorders such as reading difficulties and autism, investigations of emotional disorders including depression, anxiety, obsessive compulsive disorders or fears, as well as studies of more specific constructs such as temperament in a clinical sample, personality disorders, or specific problems such as fire setting, sleep problems, or else of specific risk factors ranging from the chromosomal abnormality of the Fragile X syndrome to the impact of parental mental health on the developmental of children. Many of these studies capitalize on the strengths of epidemiological approaches to the study of child psychiatric disorders, and in this respect they are expanding on a solid empirical tradition which was establish 30 years ago in England. In particular, one obvious merit of this set of studies is that it relies on a combination of approaches focusing on both clinical samples and epidemiological samples, on a focus on specific disorders and risk factors, and on a multi level approach to the study of child psychopathology including the child, his or her immediate school and family environment, and the social influences which inevitably impinge on his development. Moreover, there is also an important focus on aspects of treatment and health services research in this volume. It has often been the case in past epidemiological studies of that the research findings had no direct clinical applicability or relevance. Rather than reflecting a lack of interest of epidemiologists for clinical issues, or alternatively a disinterest for research findings by clinicians, this state of affairs mostly reflects the precarity on the knowledge base of our discipline and the difficulty, for each disorder

that child psychiatrists deals with, to draw a straight line between the casual origins of psychopathological conditions to their successful treatment. While it remains a major difficulty in most instances, keeping a focus on the way psychiatric services are delivered to children and their families and researching into the evaluation of their efficacy and on the improvement of these interventions, remains an important task on our agenda. These concerns are met in this volume by the inclusion of a range of studies dealing with various descriptions of child psychiatric practices, assessment and audit of services, and studies on the value of psychotherapeutic interventions, which could all fall under the broad denomination of health services research. This provides the reader with an opportunity to at least speculate on the possible links between empirical findings from epidemiological studies and the optimization of clinical interventions to help the particular child standing in front of him.

As pointed out from the onset of this volume, Ireland has undergone dramatic and fast economic and social changes in the last three decades. With increased flows of people and products across European countries, these changes are likely to be irreversible, and even to acceleration the near future. As rightly argued by M. Fitzgerald, there is evidence that some substantial segments of the population are experiencing more pressures and stresses as a result of these changes. However, one is often confronted with a pervasive and optimistic view that, with these economic and social changes, in so far as they are signalling an increased wealth, should in the long run and on average be beneficial to most people, and to be followed by improvement in the mental health of the population at large. This naive expectation has been rejected by most recent research, which has pointed to increased rates of psychiatric disturbances, especially among the young people, over the last 30 or 40 years, in most countries which underwent a similar change. This is particularly true for conduct disorders and crime, alcohol use and substance abuse, suicide and depression. The facts that psychosocial disorders increased at a time where economic wealth increases as well, is a puzzling finding for which we still have few clues on the underlying processes. However, it makes the conclusion of this volume even more noticeable, and I share the view of the author that if anything, child psychiatrists and allied professionals will have to deliver more and better services to young people in the foreseeable future. The provision of baseline data for Ireland on psychiatric disorders in Irish children, their correlates, and on some key facets of the delivery of services was therefore welcome and this volume will undoubtedly help to foster the research and services which are needed.

**Professor Hilary Hoey**
**Professor of Paediatrics, Trinity College Dublin**
**Consultant Paediatrician, National Children's Hospital**
**Harcourt Street, and Our Lady's Hospital for Sick Children, Crumlin.**

Good health, normal growth, psychological and intellectual development occur only in the presence of a good psychosocial environment. Good child health is fundamental to the health of the general population.

This volume provides excellent and extensive epidemiological data on stress factors, psychological and psychiatric problems in Irish children, adolescents and their families. It demonstrates that a large proportion of Irish children and adolescents suffer from behaviour problems, intellectual impairment, anxiety, depression, psychopathology, delinquency, and from alcohol and glue sniffing.

The data clearly illustrates the higher prevalence of these problems in disadvantaged areas, and in urban areas where there is often loss of the extended family support and social isolation. These are also shown to be associated with an increase in psychosocial stress and in maternal psychiatric problems. The research demonstrates that the inability of parents to cope is an important factor in the hospitalisation of children, which in turn leads to further family stress. This is an important cause for the world wide increase in the number of paediatric hospital admissions despite the falling birth rate.

This Irish data is particularly relevant due to the fact that we have one of the highest ratios of children per population in Europe. There is now also a greater trend towards the loss of the extended family support structures, and an increase in the number of single parents throughout Ireland.

The research clearly demonstrates the need and cost effectiveness of good psychosocial support; psychiatric and behavioural assessment; and psychotherapy for children, particularly adolescents. The data shows that these services are particularly important both in socially deprived areas and in urban areas.

Dr. Michael Fitzgerald is to be congratulated for this extensive, scientific and extremely valuable research. It provides vital information which should be used by all who plan and provide health services for Irish children and adolescents.

**Dr. Vivian O'Gorman**
**Health Research Board**

I am happy to welcome Volume 4 of Irish Families Under Stress. This is the continuation of a series of presentations by Dr. Fitzgerald and colleagues focusing on Irish children, their families and the problems, individually and collectively, psychologically and socially, that they experience. These psychological problems are placed in a social, economic and cultural context. This presentation is the fruit of Dr. Fitzgerald and his colleagues' extensive investigations, clinically and epidemiologically, over recent years. The Health Research Board is happy to have supported much of Dr. Fitzgerald's very valuable work in this field.

The wide range of the investigative work and its interpretation is evident throughout this fourth volume, as it was in earlier presentations. The present volume comes in two parts. The first presents the results of various studies carried out in clinical, school and familial settings. The second part concerns itself with the contribution of psychoanalytic psychotherapy to psychiatry in Ireland. These are also some more philosophical considerations and, finally, some relevant book reviews.

It is salutary to reflect that from limited understanding of the usefulness of child psychiatry only a decade ago its importance for the mental health of children and their families, and for the prevention of the emergence of psychiatric disorders in adult life, is now generally acknowledged in Ireland. This realisation has been responsible for the considerable extension of child psychiatric services in this country in the 1990s, although still short of what is necessary at national level. There can be little doubt that the work of Michael Fitzgerald must take much credit for this progress.

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# IRISH FAMILIES UNDER STRESS (SUMMARY).

MICHAEL FITZGERALD.

Studies to determine the percentage of children in the community who have psychiatric disorders are critical in a country like Ireland with a high proportion of children in the population.

Ireland has a developing child psychiatric service and therefore epidemiological information is important in assessing the need for services as are the study of psychosocial and individual associations to behaviour and formal child psychiatric disorder. In the future psychotherapy is likely to play a much greater role in psychiatry in Ireland.

## ADOLESCENTS

### Psychological Stress in Female Adolescents.

In a study of 132 female adolescents attending inner city schools. 15% showed evidence of psychological stress, and attained a total problem score in the clinical range with 11% often crying; 11% often having stomach aches; 6% often using drugs or alcohol; 6% often wishing they were the opposite sex and 7% often having suicidal thoughts[1]. A study of 300 adolescents using the General Health Questionnaire found that 30% had six or more symptoms[2]. In a study of adolescents with spina bifida 38% showed evidence of formal psychiatric disorders on detailed interviewing[3].

### Ten year olds:

A study of 2029 fourth class pupils in an Irish urban area found that 20% of the boys and 11% of the girls were behaviourally deviant. 8% of the children were reading 36 months behind chronological age and 1% were found to be intellectually impaired[4].

### Social Support and Behaviour Problems in Children:

The levels of social support of Irish children were similar to levels of social support of American children of the same age. Social support from teachers and class males was associated with higher self esteem and developmental appropriateness[5].

### Mothers and Children: Ireland versus Malaysia:

Mothers in Malaysia had significantly lower rates of depressive and anxiety symptoms when compared to Irish mothers. This may have been due to the greater cohesion of Malaysian society. There were no differences in the rate of childhood behaviour problems[6].

## The Health Status of Mothers and the Hospitalization of Children:

The mothers of hospitalized children with gastroenteritis had significantly higher levels of psychological distress than the home care mothers. There was no difference in the levels of severity of the childrens illness[7]. There was a significant relationship between poor social resources and psychological distress of mothers[8].

## Depressed Children:

In a child psychiatric outpatient sample 14% of attenders were depressed[9]. A five year follow up of depressed children found that 50% were still depressed. At the five year follow up point 12% of these not originally depressed were depressed[10].

## Medical Doctors: Management of Ill Children:

Doctors who had special experience with gastroenteritis during training were more likely to hospitalize patients with gastroenteritis[11].

## A Study of Group versus Individual Therapy:

Group and individual psychotherapy showed statistically significant improvements. Those in individual therapy had interpersonal goals while those in group therapy had interpersonal goals at the beginning of treatment[12].

## Schizophrenia:

The diagnosis schizophrenia can be used too liberally and an example is Wittgenstein where this diagnosis was applied when in actual fact he suffered from depression[13].

## Paediatric Outpatients:

Considerable psychopathology was found in children, parents attending paediatric outpatients[14].

## Psychotherapy and the Health Service:

Psychotherapy reduces the utilization of medical services by 20% [15].

## Problem Solving Skills in children:

The lack of development of planning skills and negative attunement by parents was considered to be of importance in child rearing[16,17].

## A Follow Up Study of Boys with Delinquency:

When a group of 50 boys with delinquent behaviour were followed up it was found that 20% had drug problems with a 92% recidivist rate[18].

### Disadvantage and Psychiatric Problems:

Disadvantage and social disconnection were major factors associated with child and maternal psychiatric problems[19].

### Maternal Depression and Childhood Behaviour Problems:

There was no statistical association between maternal antenatal depression and child behaviour problems but there was a six times increased risk of behaviour problems in the child if mother was currently depressed. A screening study of mothers postnatally showed that 38% (19) showed evidence of depression. Twenty two per cent had financial difficulties; 10% were on antidepressants and 30% became pregnant sooner than they wanted to[20].

### Psychosocial Problems Antenatally in a Disadvantaged Area:

Fifty per cent of the women reported symptoms of unhappiness and depression with 11% feeling that life was not worth living. There was considerable evidence of financial and relationship problems[21].

### Psychological factors affecting the management of childhood illness:

An anxious mother was a factor in a doctors decision to hospitalise a child[22]. Other factors influencing the doctor were:

(a) Having had a bad experience of gastroenteritis.

(b) Being a male doctor.

(c) Being in single practice.

(d) Making a higher estimate of the severity of the gastroenteritis.

## PRIMARY SCHOOL CHILDREN

### (a) Girls:

Small scale screening studies showed considerable evidence of behavioural deviance particularly in urban disadvantaged areas. Barton and Fitzgerald found that there was over twice as much behavioural deviance in 10 and 11 year old girls in a disadvantaged school as compared to a highly privileged school. It was also of interest that 21% of the children in the disadvantaged school were absent from school for trivial reasons, while none of the children in the privileged private school were absent for trivial reasons[23]. There is little doubt that children living in disadvantaged areas are under much greater psychosocial stress than children living in affluent and privileged urban areas. It is also likely that parents in privileged families have greater interest in education and would generally not have children absent from school for trivial reasons. It is clear that privileged families and privileged schools have more resources of both a financial or human kind which have the effect of reducing stress and behavioural problems in children.

**(b) Boys:**

A study of 10 and 11 year old boys in a disadvantaged school showed a similar behavioural rate to those shown by the girls in a previous study. 22% (10) of the boys with behavioural deviance showed evidence of mild abnormality, 4% (2) moderate abnormality and 9% (4) marked abnormality[24]. This supports the link between increased rates of behaviour problems and disadvantage.

**(c)**

A study of 2029 ten year old children found a rate of 20% behavioural deviance in boys and 11% in girls using the Teachers Questionnaire[25].

**(d) Urban : Rural differences:**

It was found that over twice as many urban disadvantaged children showed evidence of behavioural deviance as against children in a rural town. In the urban group no significant difference was found between boys and girls with behaviour problems while a highly significant sex difference was found in the rural small town group. The observed incidence for boys at 18% (21) was three times that found for girls[26]. The most likely explanation is that the level of psychosocial stress is lower in rural counties. There is little doubt that disadvantaged urban areas are increasingly psychologically toxic to families and children[27].

**(e) Travellers children:**

In a study of 50 travellers children 27 out of 50 showed evidence of behavioural deviance using the Teachers Questionnaire[27]. This was greater than that found when travellers children were compared to a comparison group from the settled community, the Teachers questionnaire total score average for the travellers group at 9.96 was significantly above the total score average for the settled comparison group at 2.2. While acknowledging that the travelling people have a different culture, it would appear that they are possibly the most disadvantaged group in Irish society and have large families with an unsettled, alienated life style which would make the increased rate of behaviour problems in children not surprising.

**(f) Depression:**

Five per cent (4) of a group of boys in an urban disadvantaged school scored as depressed on the Depression Self Rating Scale[28]. There was evidence of co-morbidity in that three quarters of those children who were rated as depressed also scored deviantly in the antisocial domain of the Teachers questionnaire. There was also a high negative level of self esteem using the Coopersmith self esteem inventory and depression[29]. A study of depressive symptomatology in Irish female adolescents found that in a rural area 22% showed evidence of it[30].

**(g) Anxiety:**

3.5% (3) of a group of boys in an urban disadvantaged school scored above two standard deviations above the mean for the state anxiety scale of Spielberger and 5% (4) scored more than two standard deviations on the trait anxiety scale of the same instrument and these were taken as being indicative of high anxiety. There was also a

significant negative correlation coefficient between self esteem and state as well as trait anxiety[28]. Once again anxiety is not uncommon in normal school children and it is possible that strategies to boost self esteem by families and schools would be valuable particularly in the Irish context where negative attunement would appear to be a feature of the culture.

### (h) Autism:

A study of prevalence of childhood autism found a rate of 4.3 autistic children per 10,000 in the age range 8 - 10 years in the Eastern Health Board. These were evenly spread across the social classes and there was a male : female ratio of 1.3 : 1[31]. A study of sialyltranferase activity was found to be significantly increased in the serum of schizophrenic individually and unchanged in autistic serum[32].

### (i) Irish Childrens thoughts:

15% of a sample of 80 boys thought that their life was not worth living most of the time and 18.8% thought that their life was not worth living sometimes[28]. A study of suicidal thoughts in children (N = 50) attending a child psychiatric outpatients found that 15% had thought of killing themselves. 60% of the sample of children who had thoughts of killing themselves knew someone who had attempted suicide[33]. It would appear that very distressing thoughts are not uncommon and it behoves parents and teachers to tune into these thoughts in children so that they do not have to bear them alone and that the stress bringing them about should be identified.

### (j) Social difficulties:

A study of 95, 11 and 12 year old school children in a normal school in a disadvantaged area found that 13% had difficulties with peers, 17% had difficulties with adults and 11% had general social difficulties using the Social Difficulty Questionnaire[34]. There is evidence that children with peer difficulties are at risk for later problems and it would appear that social skills training programmes in school could have preventive possibilities.

### (k) Sleep Problems:

In a study of children attending a public health clinic (N = 101) with an average age of 4 years and 7 months twenty five per cent of the boys and thirty three per cent of the girls had sleep problems[35]. There is no doubt that sleep problems in childhood can cause very significant stress to a family. There are now simple behavioural programmes available which are particularly valuable for public health nurses and general practitioners in the management of sleep problems.

### (l) Reading:

Children attending a child psychiatric outpatients had significantly lower reading ages than a matched age comparison group in a normal school - the mean reading age of the normal school children was 10.8 years while the group mean for the psychiatric outpatients was 9.0 years and the special school children 7.9 years[36]. While low reading age can occur without psychiatric problems it is not uncommon to see both occur together.

### (m) Fire Setting:

A study of children attending a child psychiatric outpatients found that 19% (15) were fire setters. They set an average of 10 fires. The fire setting behaviour began on average at 7 years. Half of these children received a diagnosis of conduct disorder[37]. Fire setting behaviour can be the most serious of all childrens behaviour problems and it is important for doctors to ask about it as parents don't often mention it.

### (n) Childrens fears:

40% of children attending a child psychiatric outpatients had evidence of excessive fears[38].

### (o) Obsessive Compulsive Disorder:

A study of treatment approaches to O.C.D. in the 1990's suggest a multi modal treatment approach[39].

## PRE-SCHOOL

A study in a pre-school (N = 59) found a rate of 17% of children with behavioural deviance using the Behaviour screening Questionnaire[40]. This is similar to rates found in other countries. These children are at risk for later problems and deserve intervention. Another study showed that psychiatrically distressed preschoolers showed poor performance in performing tasks or accepting limits[41].

## ADOLESCENCE

### (a) Abnormal Eating Attitudes:

Using the Eating Attitude Questionnaire 13% of a sample (N = 50) of 16 year old female adolescents showed evidence of abnormal eating attitudes. 11% admitted to dieting, 7% to exercising strenuously to burn off calories, 11% to avoiding foods with high carbohydrate content, 15% described eating binges with feelings of loss of control, 4% used laxatives, 17% felt that food controlled their lives and 18% admitted to feeling anxious in relation to eating[42]. Clearly food issues cause considerable distress and western societies excessive preoccupation with thinness is probably a factor in this problem.

### (b) Psychological Stress in Female Adolescents:

A study found 7% to have admitted to being depressed[43].

### Sex differences in psychopathology between male and female adolescents:

In a study of 92 adolescents (average age 13.8 years) it was found that in using the General Health Questionnaire that 44% of the sample reported six or more symptoms and there was no significant difference between males and females. On the other hand

there was a significant difference between the mean scores for males and females, the females scoring significantly higher[44]. It is of interest that in child psychiatry that males have more psychological symptoms than females and here with adolescents there is no significant difference between males and females. Nevertheless the adult pattern is beginning to assert itself with females having higher mean scores than males. A study of the leisure activities of Irish adolescents found a high correlation between participation and interest[45].

**Coping and Psychological Stress in Adolescence:**

In this study it emerged that girls had more suicidal ideation than boys[46]. A problem solving intervention study for children with diabetes showed a positive response[47].

**Body Shape, General Health and Abnormal Eating Attitudes in Male Adolescents:**

Two out of 197, 16 year old boys showed evidence of abnormal eating attitudes. This was lower than a similar study in girls[42]. Thirty eight out of 197 boys showed 5 or more symptoms on the General Health Questionnaire. Three out of 107 boys showed excessive concern about being fat on the Body Shape Questionnaire[48].

**Formal Psychiatric Disorder:**

(a) A study of 45 10 and 11 year old children in a disadvantaged school found a rate of 18.6% (8). 7% (3) showed evidence of mixed order of conduct and emotions; 7% (3) showed depressive disorder and 5% (2) showed conduct disorder[23]. It demonstrated that about half those identified on screening questionnaires are false positives.

(b) A sample of 190 10 year old children selected from 2029 children screened for behavioural deviance found a rate of 16% showing evidence of formal child psychiatric disorder on detailed interviewing[25].

**Psychiatric Symptoms in Parents:**

(a) In a general practice study of 70 children there was a significant relationship between maternal depressive symptoms and behavioural deviance in the children[49].

(b) In a study of the mothers of 50 consecutive attenders at a child psychiatric outpatients 35 out of 50 showed evidence of formal psychiatric disorder using The Clinical Interview[50].

(c) In a pre-school study (N = 59) there was a significant relationship between depressive symptoms in mothers and behavioural deviance in children[51].

(d) When a consecutive sample of mothers with children attending the child psychiatric outpatients were compared with a comparison group of mothers of children attending a general practice significantly higher levels of hopelessness were found using The Hopelessness Scale[52].

(e) 72% of children of psychiatric inpatient mothers were found socially incompetent using the Child Behaviour Check List[53].

**Marital Disharmony:**

**(a)** In a general practice study there was a significant relationship between marital disharmony and behavioural deviance in children[54].

**(b)** In a study of 50 consecutive children attending a child psychiatric outpatients 21 of the mothers showed evidence of marital problems and there was a significant relationship between marital problems and anxiety and depressive symptoms in the mother[50].

**(c)** When marital adjustment and behaviour problems in children attending a child psychiatric outpatients population were compared with a control population in the community there were significantly higher rates of marital disharmony and behavioural problems in the children attending the child psychiatric outpatients[54]. It is important that general practitioners treat as soon as possible marital problems because of their effect on children. This is another example of preventive child psychiatry.

**Social Problems:**

Social problems of mothers were studied in 50 consecutive attenders at a child psychiatric outpatients. 74% of the mothers had significant social problems. There was a significant link between social problems and maternal mental illness in this study[50].

**Home Environment:**

When preschool children with behavioural problems were studied there was a significant relationship between low levels of warmth, affection and acceptance and a high score of behavioural deviance[55]. Clinical experience suggests that for children to develop healthily they need warmth, acceptance and affection.

**Bullying:**

A study of 2000 children found that 4% of males and 1% of females were bullied[56].

**Blood Lead:**

In a study of blood lead in children attending a child psychiatric outpatients and in the community there was no difference in the mean blood lead levels[57]. Of course toxic blood lead levels would have major physical and psychological effects.

**Adolescent Health:**

In a study of adolescents health, 1% rated their health as poor. 25% drink alcohol at least once weekly and 29% had visited their G.P. in the previous three months. 61% had taken medicine in the previous four weeks. 16% of boys and 3% of girls had tried glue sniffing. One quarter of Irish teenagers were weekly drinkers compared to one third of British teenagers[58].

## Family Relationships:

A study of the Family System Test found it to be a poor predictor of clinical status[59].

## Motivation:

It is of interest that children in an urban primary school show high intrinsic motivation to learning across 3rd to 6th standard. It was also of interest that behaviourally disturbed children showed higher levels of independent judgement as against dependence on teachers judgement. This may reflect a global mistrust of adults in their environment[60].

## Feelings of misery in Two Thousand and Twenty Nine Children:

A study of 10 year old (N = 2000) children found that 2.0% of the males and 3% of the females were miserable[34].

## Suicide and Parasuicide:

A study of suicide victims[61] in Dublin (N = 70) found that

(a) 70% were males.

(b) Average age 41 years.

(c) 80% of victims under 55 years.

(d) 37% married.

(e) 60% of economically active group in employment.

(f) 35% previously attempted suicide.

(g) 53% saw a doctor in previous month.

(h) 44% experienced hopeless feelings.

(i) Central Statistics Office statistically underestimated by a rate of 20%.

An eight year follow up of attempted parasuicide patients found that two out of 26 had died and 19% had more further suicide attempts[62]. A community study of parasuicide found that almost all had attended casualty[64,65].

## Lifetime Prevalence of Depressive Disorder:

In a study of the lifetime prevalence of depressive disorder of 33 consecutive patients attending the psychiatric department of a general hospital showed that 15 (45%) had a positive family history of depression and that the total number of relatives involved was 20 or 1 for 1.7 patients[66].

**Parental Bonding and Depression:**

On the EMBU (Enga Minnen Betraffande Uppfustran) a parental rearing practices instrument parents of depressed patients were more rejecting, more over protective and were more favouring of the subject than a comparison group. On the PBI (Parental Bonding Instrument) the mothers and fathers of adult depressed patients were more over protective and less caring than a comparison group[67].

**Disadvantaged Children:**

A study of 55 boys (average age 7 years and 9 months) in a disadvantaged area found a rate of 21% hyperactivity on the Activity Rating Scale, a rate of 31% had soft neurological signs, 35% had gross tooth decay and a behavioural deviance rate of 36% of the Teachers Scale[68]. This can be compared to a rate of 44% found in children attending a surgical outpatients in hospital in a disadvantaged urban area[14]. An analysis of their height and weight percentiles showed the height curve as being shifted to the left of the expected percentiles[68].

**Lone Parenthood:**

A study of married and unmarried mothers found that 60% of married mothers and 18% of single mothers wished to conceive at the time they became pregnant. 34% of the male partners of the single mothers did not want to know about the pregnancy while only 2% of the partners of the married mothers did not want to know about the pregnancy. The group of single mothers living alone were under considerable stress with three quarters of them having major financial problems as opposed to 19% of those living with their parents. There was no statistical difference between the two groups with regard to coping with their children[69].

**Personality Disorder:**

A study of the personalities of 50 child guidance clinic attenders found that 5 could be given a diagnosis of personality disorder[70].

**Expectations of a Child and Family Centre:**

In a study of the expectations of attending a child and family centre 40% of children expressed positive feelings about attendance, 30% expressed anxiety and apprehension about it and 30% had neither positive or negative feelings[71].

**Audit of a Child and Family Centre:**

77% of mothers were satisfied with the service. 70% of mothers received no information about the service prior to arrival[72].

**Burn Out:**

A study of stress in child psychiatric personnel showed that personnel with low scores on peer cohesion were found to be emotionally exhausted and to show greater depersonalisation of clients. Personnel working in residential child psychiatry were

more likely to be emotionally exhausted than personnel working in outpatient child psychiatry[73].

### Attitude to Authority:

In a study of attitude to authority in Irish adolescents 84% (76) expressed pro-authority feelings. There was also a negative correlation between level of psychological distress and positive attitude towards parents[44].

### Life Events:

Children referred for psychiatric assessment had a significantly increased number of life events when compared to non-referred children from a normal school. Failure of a class in school and increased number of arguments between parents were associated with an increased likelihood of referral[74].

### Psychoeducational Problems:

Males had significantly more behavioural and learning problems than females[75].

### Child Psychiatry Provision:

It is clear that there is very considerable numbers of disturbed children in Ireland and there are still areas of the country without child psychiatrists. Educational psychologists should spend part of their week based in child guidance clinics so that psychiatric problems can be dealt with[76].

### Prescribing in Child Psychiatry:

90% of Irish Child Psychiatrists prescribe psychotrophic drugs[77].

### Child Psychiatric Inpatient Treatment:

The prevalence of use of medication was lowest (8%) in Denmark and highest in Ireland (54%). Family therapy was undertaken with 25% of inpatient cases in Ireland[78].

### An Evaluation of a Child & Family Centre:

Significant improvement occurred in childrens behaviour with a 4% drop out rate.

### Paediatric Outpatients:

82% of parents were satisfied with OPD services[79].

### Preventive Psychiatry:

It is of critical importance to increase the priority given to preventive psychiatry and psychotherapy. The most cost effective time to intervene would be when children aged

3/4 years are showing signs of behavioural deviance. The children need high quality cognitively orientated preschool education and the mothers need parent training. There is a considerable need for the expansion of psychotherapy services in Ireland[81].

**Family Burden of a Child with Special Needs:**

When psychosocial stress in families with a child with special needs was compared to families with a child in a normal school it was found that there was significantly more stress in families with children with special needs. Parents in these families felt more incompetent, felt lack of attachment, were more restricted in their parent role, were more socially isolated, more depressed and had more marital stress. The child with special needs were more distractible, more moody, more demanding and more non-adaptible[82].

**Prosocial Behaviour:**

A study of prosocial behaviour in children attending a normal school found that Irish mean levels of prosocial levels of prosocial behaviour are similar to the United Kingdom mean scores. High trait anxiety was accompanied by lower prosocial behaviour scores and higher behavioural deviance ratings[83].

**Self Esteem:**

In a study of self esteem and behavioural deviance in children total self esteem was reduced in children attending the child psychiatric services. One component of total self esteem that is school self esteem was not reduced in children attending a day special school or were in an inpatient unit with a special school attached. This may have been due to children in the special school setting not being so different from each other as would be the case if these children were attending a normal school[83].

**Speech and Language:**

In a study of speech/language disability and behavioural deviance in a consecutive sample of 50 referrals to a child psychiatric outpatients, 63% showed evidence of behavioural deviance on the Parents Questionnaire (A2) and 44% showed evidence of speech/language problems[84].

**Temperament:**

When a consecutive sample of children attending a child guidance clinic were age, sex and school matched with children in a normal school it was found that children attending the child guidance clinic were significantly more likely to have difficult temperaments[85].

**Menarche:**

The mean age of Menarche in 836 Irish school girls was $12.5 \pm 0.06$. There was no statistical difference between social classes, number of siblings or place of the child within the family[86].

### Infant Care Practices:

When infant care practices were examined in mothers who had a child hospitalized and not hospitalized for gastroenteritis it emerged that families were the main source of advice for both groups. It was also of interest that 9% of hospital care mothers and 6% of home care mothers had no source of parenting advice. An average of 16% of mothers had problems feeding their children, 30% had settling problems at bedtime once per week or more and 35% had night wakening problems weekly. 22% of children posed some discipline problems. Most of the child care was provided by mother although fathers played with their children on average twice per week and mother three times per week[87].

### Families of Ill Children:

The study also found an association between psychological stress and low levels of leisure activity, low levels of shared leisure with partners, poor overall contacts, poor satisfaction with contacts and a disturbed intra familial environment[88].

### Maternal Mental Health:

A study of maternal illness in 185 mothers showed a rate of 33% (61). 13 had endogenous depression, 16 anxiety / depression, 24 reactive depression, 3 abnormal grief, 3 alcoholism and 2 personality disorder. There was a significant association between parental mental illness and child psychiatric illness. 60% of mothers with parental mental illness had a child with child psychiatric illness. Mothers with mental illness had poor social relationships[89].

### Antenatal Depressive Symptoms:

Fifty per cent of the women reported feelings of unhappiness and depression[90].

### Impact of Hospital Experiences on Doctors:

The impact of hospital experiences during training of general practitioners were studied in relation to their propensity to admit children with gastroenteritis to hospital. There was a significant excess of hospital referrals for gastroenteritis by these GP's with prior hospital training in an infectious diseases hospital and medical sensitization was considered to be a factor in that this specialized training had sensitized GP's to the potentially negative outcomes of gastroenteritis[91].

### Medication for Gastroenteritis:

25% of GP's are still using antidiarrhoeals and antiemetics in the treatment of gastroenteritis despite the general principle of fluids only for gastroenteritis[91].

### Child Hospitalization:

In a study of home or hospital care for childhood gastroenteritis it was found that being either a young child, a child of a single parent or a child of an anxious mother were factors which were equally likely and more likely than being a moderately sick child to result in referral to hospital[92].

**Pathways to Childhood Hospitalization:**

The ability of parents to cope emerged as important factors in the hospitalization of children[92].

**Immunization:**

In a study of children who had gastroenteritis and were treated either in hospital or at home it was found that 53% of the home care children had measles immunization which is similar to national levels while only 22% of the hospital care children had measles immunization before 18 months of age. Levels of immunization up take were satisfactory for both groups in the early post natal period but began to decline and diverge at about the six month period. This fall off represents the age old problem of health education, how to maintain health orientated behaviours beyond a point of intensive contact, in this case the perinatal period[93].

**Sudden Infant Death:**

Considerable amounts of psychosocial distress was found in a national Irish study[94].

**Attitude to Hospitalization:**

While the evidence of negative impact of long or frequent hospitalizations of young children is well documented, a study of the attitudes of Irish doctors to hospitalization found that only about half of those interviewed believed that hospitalization had negative effects, suggesting that research findings in this area do not appear to have had a major impact on the views of medical decision making[95,96].

**Mothers Consumption of Drugs and Alcohol:**

In a study of the consumption of alcohol and drugs in mothers of children attending a child psychiatric clinic it was found that 17% of the mothers were problem drinkers on a screening questionnaire - the Mast. 13% of the mothers were taking benzodiazepines daily while a further 7% were taking those drugs on an irregular basis. It is possible that these mothers are under more stress and have higher levels of problem drinking than women attending a general practice where a rate of 1.3% was found on a more sensitive screening instrument for alcohol problems the CAGE[97].

**Fragile X Chromosome:**

In the first Irish family studied with fragile X chromosome the proband with mental handicap and autism had on Cytogenetic study the fragile X in Tc 199 in 30 of his cells. His sister had fragile X chromosome in 25% of her cells and the younger sister had fragile X in 100% of her cells[98].

**Delinquency:**

In a review of the delinquency problem the principal of minimal intervention was evoked. The importance of scientifically evaluating all aspects of the legal, educational and health interventions in relation to delinquents was stressed. Institutional approaches have not generally been shown in effective and community approaches are

probably least detrimental. There should be increased emphasis on high quality pre-school education as well as parent training and support for mothers of at risk children[99].

### Disconnection and Disadvantage:

The issue of disconnection is particularly relevant to urban disadvantaged areas because socially isolated families are particularly at risk for psychological stress. Neighbours, clergy, voluntary groups and professionals should try to make social links with isolated families. Social linkage and social support can make a significant impact on psychological distress. It is not surprising that people who have supportive confiding relationships are less at risk[100].

### Mid Life:

The value and importance for the person in the middle years of linking with and guiding children and adolescents is generativity. This is particularly so for distressed children and adolescents who don't have anyone to take a positive interest in them as persons. A good experience of this nature for a child or adolescent may make the difference between success and failure in life[101].

### Planning Skills:

In a study of children it was pointed out that there is no reason to suppose that crime is generally more common now than in past centuries. The importance of helping children develop planning skills and experience success is underestimated. It is important for parents and educators to build up childrens self esteem. confident children are less at risk for psychological problems. Unfortunately negative attunement has been a feature of Irish child rearing[102].

### Relational Model of Psychoanalysis:

It is important to realize that there was a shift in psychoanalytical thinking from Sigmund Freud's energy and economic models of psychological functioning to the relational psychoanalysis which emphasizes the importance of problems in relationships as factors in the development of psychological distress and disorders[103].

### Cost Effectiveness of Psychotherapy:

Concern has recently been expressed that psychiatric educators may be "losing the mind". Brain science has not yet and probably never will fully explain the mind. There is little doubt that psychiatric training programmes do not give sufficient attention to psychotherapy. A review of the literature concluded that the effect of psychotherapy was to reduce the use of medical services by about 20%[104,105]. There is evidence that psychotherapy is more effective than no treatment and has a greater effect size than placebo.

### Supervision:

Insufficient attention has been paid to the supervisor/student relationship. If a supervisor is over concerned for the patient this suggests that the student is not tuned

into the patient in an empathic way. If the supervisor is performing well then his comments should be confirmed by the patients material. The use of the student for narcissistic aggrandisement by the supervisors must be guarded against[106].

## Technique of Psychoanalytic Psychotherapy:

The key elements of the technique of psychoanalytic psychotherapy are the analysis of the affect or pain that brings a patient and the analysis of the transference which allows the therapist to examine the forgotten feelings and attitudes developed in early life to important figures and transferred onto the therapist. These transference interpretations are most mutative that is, bring about the most change[107].

## Applied Child Psychoanalysis:

Psychoanalysis has a role to play in helping paediatricians and nurses understand and respond to the emotional impact of physical illness on children. This aspect of intervention has tended to lag behind technology in the twentieth century. After the resolution of a medical crisis the psychological needs of children in the very stressful environment of the hospital situation are just as important in the long term as the physical care of the child. Psychoanalytical thinking has been of considerable assistance to lawyers and child care professionals in thinking about the best interests of the child and giving particular importance to psychological parenthood[108].

## Psychoanalysis, Behaviour Therapy and Pharmacology:

In the past the disputes between psychoanalysts, behavioural therapists and psychopharmacologists were very unsatisfactory and not in the best interests of patients. There is little doubt that these three forms of treatment have their place either singly or in combination. Psychopharmacological drugs tend to have as their focus symptom relief while psychoanalytic psychotherapy tends to show its effect more slowly and on background personality factors as well as symptoms. It may be more useful to view them as having an additive or even mutually potentiating relation. Behaviour therapy has a place in enuresis, encopresis and behaviour problems[109]. A study of the suitability of socially disadvantaged women found a significant number were suitable for psychoanalytic psychotherapy[110].

## Balint Groups:

The Renaissance in General Practice, a phenomenon of the 1960's owed a great deal to the recognition of the enormous therapeutic potential in the doctor patient relationship. When problems occurred in this relationship it led to much unnecessary suffering, irritation and fruitless effort. Balint helped GP's to examine their countertransference feelings and to use these to increase their understanding of the neurotic problems of their patients which caused them and their patients so much suffering[111].

## Pregnancy:

It is important to recognise mothers at psychological risk during pregnancy. Mothers with over valued pregnancies, ambivalent pregnancies and historical sensitization are at risk. It is a good time to intervene psychotherapeutically as mothers are highly motivated before birth and in touch with unconscious conflict and unresolved problems from childhood which may interfere with the psychological task of pregnancy which

are emotional fusion with the foetus; differentiation of the foetus and self and progressive psychic separation of baby and mother[112].

### Existentialism:

Existentialistic philosophy is helpful in understanding alienation and man in a technological world. There are problems with it in that it denies the whole concept of mental illness, the biological basis of some mental illness and also genetic factors. Existential psychiatry establishes a dependent relationship that gratifies but can not be worked through because the transference is ignored[113].

### Hysterical Personality:

The patient with a hysterical personality thinks in a vague way with much feeling. This patient has difficulty in thinking clearly about feelings and behaviour. One of the aims of treatment is to help this patient to think clearly[114].

### Narcissistic Personality:

Empathy is very important in treating the patient with a narcissistic personality disorder. These patients are further hurt by too painful interpretation early in the treatment. If the therapist is empathic the patient will experience a transmuting internalization which will be strengthening to the personality because a new internal object will be set up which will counter some of the negative internal objects from childhood[115].

### Therapist Difficulties:

A study of a group of trainees conducting individual psychotherapy showed that the predominant categories of difficulty related to trainees feeling incompetent and threatened[116].

### Registration of Psychotherapists:

There is a need now for a working party of the Department of Health to be set up to examine and draw up guidelines for the statutory registration of psychotherapists. The public is entitled to know the form, duration and quality of training that people who call themselves psychotherapists and offer their services to the public have. This is particularly so because psychotherapy is not inert and has negative as well as positive effects[117].

### Psychotherapy Services:

Psychotherapy services in Ireland are largely available in urban areas. The largest number of practitioners would be in the Eastern Health board area. In the public health service therapists are generally employed under their core professional titles i.e., psychiatrist, psychologist, social worker or nurse and often psychotherapy is one of a number of treatment strategies. At the same time there is a growing number of nurse therapists who undertake behaviour therapy within the psychiatric service[118].

## Contribution of Psychoanalysis to Psychiatry:

The three theories most helpful in understanding mental illness are in the social domain, the biological domain and in the psychoanalytic domain. Psychoanalytic psychotherapy has a role in the treatment of patients particularly those with neurotic and personality problems. Psychoanalytic understanding is of assistance in management of a wider variety of psychiatric problems. It is very important for the clinician to be able to integrate psychoanalytic, biological and social understanding of the patient. While Kraeplin classified, Freud understood, both are required[119].

## Psychotherapy in Custodial Institutions:

Psychotherapeutic experience has shown that is is possible to work psychotherapeutically in custodial institutions. Indeed some acting out patients are only available for treatment in a secure setting. The treatment is still a voluntary one in that the patient does not have to have the treatment if he does not wish[120].

## Psychotherapy in a Psychiatric Outpatients:

A patient with neurotic depression failed to respond to antidepressants and hospitalization. It was only when childhood conflicts were dealt with in psychotherapy that they began to improve[121].

## Psychotherapy Training of Doctors:

It is necessary for far greater emphasis and resources be given to training of psychiatrists in psychotherapy and for medical psychotherapists to have a place in the delivery of services to the mentally ill in Ireland[122].

## Attitudes to Psychiatry:

Over the course of nurse training students become increasingly eclectic in their outlook and saw a place for ECT and compulsory detention of certain cases[123].

## The Boundary of Psychotherapy:

There is considerable overlap between all the different forms of psychotherapy but also sharp differences that must be acknowledged. It is also critical that the limits of psychotherapy be acknowledged so that biological factors can be addressed by biological psychiatrists[124].

## European Psychotherapy and Counselling:

The 1988 Higher Education Diploma Directive had as its objective "the abolition of obstacles to freedom of movement for persons services and capital". In training terms the amount of professional experience may not exceed 4 years[124].

## Future of Psychiatry:

An uncritical acceptance of Popperian empirical realism will lend to a marginalization of psychiatry[125 - 131].

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# THE CHILD AND THE FAMILY.

MICHAEL FITZGERALD.

Our forebears showed great foresight when they put forward the sentiment in the 1916 Proclamation about "cherishing all the children of the nation equally". The democratic programme of the first Dáil in 1919 was equally on the mark when it stated that "It shall be the first duty of the Republic to make provision for the physical, mental and spiritual wellbeing of the children". They were noble aspirations. Yet today we have an extremely unequal society as far as children are concerned. This is particularly true in disadvantaged urban areas where there are considerable numbers of children with behaviour problems. They feel that life is not worth living, they show evidence of poor school progress and of being victims of abuse both inside and outside the family. As Yeats said, "Things fall apart, the centre cannot hold". It is a phrase with great meaning when describing these tragic children whose worlds have fallen apart. They show persistent behaviour disturbances, including childhood anxiety and depression.

It is sad but accurate to report that child deprivation is nothing new. It has existed through the centuries. In the 1700s and 1800s thousands of unwanted infants were sent to the Dublin Foundling Hospital. Many of them died there. In the first seven years of the hospital's existence 4,000 children were admitted and more than 3,000 died. The hospital used to give £2 per year to women who were willing to nurse these infants, and there are several reports of infants being murdered after the women received the money. The bodies were found in graves with the hospital brand still on them. Such horrific incidents may not happen today, but the results of contemporary research are still highly disturbing.

For ten years I have studied psychological problems in children and adolescents in modern-day Ireland. Many of my studies focussed on disadvantaged areas and distressing results were found. For any of us zest for life is fundamental. Yet when we asked nine to eleven year olds if they felt life was worth living, 15 per cent thought that it was not most of the time, while a further 18 per cent thought it wasn't worth living sometimes.

In studying female adolescents, 15 per cent showed evidence of significant psychological stress - this in a normal inner city school. Eleven per cent admitted to often crying; 7 per cent to often thinking about killing themselves; 10 per cent to often being unhappy, sad or depressed and 6 per cent said they often used alcohol or drugs.

In a normal pre-school we found that 16 per cent of the children in a disadvantaged area were showing evidence of behaviour problems. The figures were higher in primary school. Eighteen per cent of ten and eleven year old boys were showing evidence of formal psychiatric disorder. The rates were higher still in the families of the unemployed. When we compared urban and rural schools we found that urban schools had over twice as many children with behaviour problems as their rural counterparts.

These studies reveal quite clearly the results of disadvantage. Children suffer the consequences of financial strain, marital problems, parental mental illness, less good schools. They live in a community where learned helplessness pervades. Such disadvantaged groups have a low sense of control over the forces that impact on their lives. Our research has shown that some of the parents have significantly higher levels of hopelessness than parents in the community generally.

It is clear that almost everything that impacts on parents will also impact on children. This happens in many different ways. If parents are spending considerable time dealing with financial arrears and rent, electricity bills and mortgages, they will have less time left for their children. Research by the Combat Poverty Agency shows that in dealing with moneylenders, 8 per cent of parents said that they took the stress out on their children, while 13 per cent said the children had to go without, because of moneylending.

Poverty and debt increase the social isolation of families. Children do not have money to go on holidays, attend music classes or generally engage in extracurricular activities. All of these would boost their self-esteem. Mothers have to carry a disproportionate burden of the stress related to poverty which they experience as a sense of shame, guilt, embarrassment and powerless. They have a sense of feeling excluded and having to suffer the unsympathetic comments from privileged groups. All of this increases the psychological stress on the mother. Indeed, some of our Irish studies have shown that over a quarter of these mothers show significant symptoms of anxiety or depression. The result is that poverty and disadvantage undermine parenting ability. Ultimately, this can lead to a higher rate of child behaviour problems.

So far I have concentrated on the role of social and economic deprivation in explaining child behaviour problems. But the issue is more complicated. Nietzsche might well say it is not surprising that children are disturbed at this time in history. They are, as he put it, "children of a fragmented, pluralistic, sick and weird period". But there are many more associations to explore.

The first issue to be considered is that of genetics. Indeed, there is an Irish saying, "*treise duchas na Oiliunt*" (heredity is stronger than rearing). While this is a sweeping statement, there is some truth in it in relation to certain disturbed children. For a start, there is evidence for a genetic component in a condition called childhood autism. This condition has, as its core feature, relationship difficulties. There is also a weak genetic component in a subgroup of children with conduct and delinquent problems which persist into adult life. Finally, genetic mechanisms may also play a part in the connection between social oddities in childhood and schizophrenic psychoses in adult life.

A second major issue came to prominence in the 1950s when John Bowlby claimed that maternal deprivation in infancy led to permanent damage to children. The issue proved to be much more complex. Subsequent research showed that the positive and negative experiences throughout childhood, adolescence and later life would have a considerable effect on the development of the person. The Bowlby theory had to be revised. It was pointed out in 1985 that markedly adverse experiences in infancy carried few risks for later development if the subsequent rearing environment was a good one. What is more, it was established that daycare children tended to be less apprehensive of new situations, were more peer orientated and more assertive. There was also no evidence of greater likelihood of psychiatric disorder. In the case of Bowlby and his thesis of maternal deprivation, the lesson is: beware of experts!

Some further issues in explaining child behaviour problems have been explored in a series of Irish studies. Firstly, in controlled studies we have shown significantly increased levels of marital disharmony in parents of disturbed children. It would appear that marital disharmony leads to poor supervision of children and to erratic parenting. It also creates a model of family discord based on aggression, inconsistency and hostility.

In another study we examined children of mothers who had been admitted to hospital as psychiatric patients. Over 50 per cent of their children showed evidence of social incompetence. It is possible that parental mental illness undermines a parent's ability, emotionally, to deal with their children's needs. It can impair the parent's ability to

model appropriate social behaviour for them. Interestingly, there is evidence that boys are more at risk than girls from the effects of parental mental illness.

Finally, when we studied the home environments of children, we found that families that had low levels of warmth, affection and acceptance had significantly higher rates of children with behaviour problems.

Looking at the Irish context, however, it is imperative to return to the issue of poverty and disadvantage. It is prevalent in a society such as ours with its class divisions. There is an Irish saying:

*An te ata Thuas oltar deoch air*
*An te ata Thios bualtear cos air*

which translates as "the top dog's health is always drunk, there are only kicks for the underdog". This saying identifies the two orbits within which children live out their lives. These orbits within which children live out their lives. These orbits are more distinct in urban areas. On the one hand there is a advantaged orbit, where children come from privileged circumstances, have good pre-school and school education and get good jobs, all of which bolsters their mental health. They marry successfully, parent their children successfully and their children continue in this orbit. The advantages are obvious. Eithne Fitzgerald has shown how a child from Foxrock is eighty times more likely to reach third-level education than a child from a disadvantaged area of Dublin.

Of course, affluence can create its own problems. Abundance of money can lead to too rapid gratification of a child's needs. This can result in a lack of motivation, boredom and a lack of clear identity. Apart from such extremes, however, it would appear that the children of the middle class are least at risk within the orbit they inhabit: no disadvantage, no excess either. nevertheless, we know that in each class in a middle-class school there is a small number of disturbed children. These children tend to come from homes with family and marital conflict and/or serious parental mental illness.

The alternative orbit is the disadvantaged one. Children live in disadvantaged circumstances in the presence of considerable marital disharmony, parental mental illness, financial strain and the sense of helplessness and lack of hope. Such less well-off groups have earlier parenthood, larger families, lower usage of health clinics, are slower to seek medical advice and are less responsive to health education campaigns. The hidden costs of health have a much greater impact on these families. There is the time and effort required of parents to get health care for their children when there is no telephone and wages have to be lost to bring children to a health centre. In McGee and Fitzgerald's study of children hospitalised for gastroenteritis, they found that 33 per cent of mothers had difficulty in organising the finance to visit their children. Only 36 per cent had access to a family car. It was also of interest that the mothers of children most likely to be hospitalised for gastroenteritis were the least likely to have the resources, or access to facilities, to visit the hospital.

The highly influential Black Report published in Britain in 1980 is equally relevant to the Irish situation and is worth quoting. The first point is that children born to unskilled workers are four times more likely to die in the first year of life than those born into professional families. The second point is that boys in these families are twice as likely to die between the ages of one and fourteen, while girls are one and a half times more likely to die. The third point is that the children of professionals have a five year longer life expectancy. Clearly, all of these factors show the huge effect of disadvantage on children.

There is, perhaps, no more controversial an issue than that of how to tackle disadvantage, how to foster healthy and flourishing home environments for the

children. It is far more complicated than simply being an issue of money. Garret FitzGerald has pointed out that Gross Domestic Produce per head of population is 35 to 40 per cent lower in Ireland than in our near neighbours. While the basic rates of social welfare are relatively high, by comparison, and our politicians can take some credit for this, it should not deflect us from the attraction of a basic income system.

One obvious problem which needs to be tackled is the placement of families from disadvantaged areas in housing long distances from their family roots and friends. This has led to a negative psychological impact. When we compared Irish mothers with mothers living in Malaysia, we found a far lower rate of anxiety and depression in Malaysian mothers. This was most likely explained by their circumstances: they lived with their extended families and therefore had far more social linkage and support. The need to reduce such forms of isolation in Ireland is critical. There is a role for the whole community, including neighbours and clergy, in tackling this issue. Some of the Irish families, although in good-quality housing from a structural point of view, nevertheless feel alienated because they are so far from their friends and grandparents. They are effectively, psychologically, homeless. This problem has been complicated in recent years by the well-intentioned £5,000 surrender grant for tenants in local authority housing. This has led to families moving out of their areas. When those who move are those with leadership qualities the overall community competence is reduced.

A further complicating factor which needs to be examined is the segregation of public and private housing. It is my belief that from a psychological perspective we might have some less stressed families if there was adequate mixing. This would have the effect of raising the general level of community competence and support. It could also improve the social mobility of disadvantaged groups who are marginalised and isolated in ghettoised housing estates. A policy of mixing accommodation could also have the effect of reducing the suspicion between classes. It certainly would have the effect of boosting the esteem of some disadvantaged children; suddenly they would see that they could compete successfully with their more advantaged counterparts. In short, it is my experience that the private value of the middle class, with their separate housing, may not be in the public good, nor, especially, in the interests of the disadvantaged child.

One can hardly talk about children without discussing schools and their impact. It has been shown that less effective schools are twice as likely to show evidence of poor school attendance and to have children who leave school without scholastic qualifications. In contrast, even when children are reared in institutions, when they have positive school experiences they are three times as likely to plan their choice of career and marriage partner. So what can schools do in the preventative area?

For a start, at pre-school level, there is evidence that programmes which allow children to plan their environment help them to actively learn. A study has revealed that when children from such programmes were followed up at twenty-one years of age there were significant gains between disadvantaged children who had such programmes and those who had not. The gains included more of the students completing secondary school and going on to third-level education. Fewer of them were arrested and significantly fewer were on social welfare. These studies were undertaken in the US where it was shown that the programme was cost effective. These was a four dollar return on every dollar invested in the community. These were reduced demands on the community in terms of special education or costs to the legal authorities. Such schemes can obviously work and they show the value of preventative interventions at pre-school level.

Moving on to the primary level, Professor Kolvin has shown that direct intervention at this stage works. Group therapy for children showing evidence of behavioural problems is effective in reducing them. Again, such direct intervention programmes should be pursued. However, we are limited sadly by society's emphasis on training

illness rather than on prevention: over half of the health budget goes into the general hospital programme. It is a policy in need of reassessment and change.

At secondary school there is now much anecdotal evidence that a highly academic curriculum is not appropriate to weaker students. In this context the need for remedial care is of paramount importance. I would also suggest, however, that alterations being made to the curriculum emphasising the development of planning skills will help children plan for their future lives. That this will be productive is evidenced from studies among adolescents. These have shown that those with an ability to plan their lives were at much less risk of making unsatisfactory marriages and experiencing marital breakdown as adults.

Another area where weaker students could be helped would be in the development of social skills. It is also likely that various vocational skills, such as those covered by the vocational preparation and training programme, would be of more interest to them. It would probably also increase school attendance. I would also suggest that because children from disadvantaged areas have so little chance of getting to third-level education, universities and colleagues should consider outreach programmes. They should also set aside places for children from disadvantaged areas.

There would, of course, be costs attached to many of these measures. But the long-term benefits cannot be ignored. For example, there is an established link between education and usage of the health service, certainly in terms of the hospitalisation of children. It was shown in Israel that when parents had an extra year's secondary schooling, their children had less hospitalisation as infants. Put in simple terms, the moral is that we have to spend now to save later.

At this point the fundamental question of what is required for the healthy development of children must be examined. Firstly, if children are to develop healthily they need air and food as well as love and praise. From a psychological point of view, while love is not enough on its own it certainly goes a long way. Freud put it so well and so accurately: "If a man has been his mother's undisputed darling, he retains throughout life the triumphant feeling, the confidence in success, which not seldom brings actual success with it".

The second most critical need of a child is for praise. Unfortunately with the older generation in Ireland there was confusion between praise and spoiling. Consequently, very many Irish children have suffered from a lack of praise in childhood because of parental fears that if they were praised they would be spoiled. While there is no doubt that spoiling exists, it is much less frequent than people think.

The third need which children have is for boosts to their self-esteem. It is clear that those children with high self-esteem and self-confidence are more resilient in the face of problems. In various studies we have found that children with problems had low self-esteem. We also found that self-esteem at school was reduced in children with problems who attended normal school but not in similar children attending a special school. This was because in special settings children were performing on a level with their peers. They were also more likely to be in smaller groups and therefore getting more praise from their teachers. What is absolutely clear is that nothing succeeds like success. It is critical for parents and teachers to provide children with success experiences in so far as this is humanly possible.

What about the psychotherapeutic treatment of disturbed children, children whose worlds have fallen apart? The child psychiatrist aims to help the child put the parts back together again, to give the child an opportunity to develop a centre or identity for themselves. A central feature of disturbed children's problems is alienation. the child psychiatrist, through psychoanalytic psychotherapy, is trying to reduce this alienation. by forming a bond with the alienated child the psychiatrist helps the individual

understand the stresses that have brought about their current situation. Ibsen says, "Everything must be borne alone - despair, resistance and defeat". The child psychiatrist attempts to make sure that this does not happen.

The facts facing all of us in our professional lives are daunting, but clear: namely, that disturbed children and adolescents are hurt children and adolescents. They often respond to this hurt by taking revenge on their families, school and society. What is more, society often responds to them by taking further revenge which only aggravates the matter. It is our function to help these children and adolescents come to terms with their past hurts; to help them love and be loved. Then they are no longer, to quote Arnold in describing Beckett's characters, "tormented with what seems to be an arid desert like inability to love or be loved". We are trying to help them to live fully and to trust again. Our main task is to form long-term relationships with them over many years, whether in child psychiatry clinics or in local clubs and activities. If such long-term bonds can be formed with these children they can be helped through many difficult periods in their lives without damaging themselves or society.

It would be all too easy to forget that there have been certain gains for the Irish child in the last fifty years. For example, there has been increased awareness of the rights of children. The abolition of corporal punishment was also extremely important. There is a growing understanding of the importance of caring for children in small groups rather than large institutions. Lastly, our growing awareness of the needs of children to be cared for in the family context has been demonstrated by the increasing number of foster placements each year.

However, for the 1990s there is urgent need for a new children's agenda. The list of priorities is long. We need to evaluate scientifically the effectiveness of all aspects of the health care system for children. We need to prioritise all aspects of preventative health strategies. In education, our junior schools in particular could benefit from speech therapists' advice on children who have delays in language or who have speech problems. We also need an inspectorate of pre-school, daycare centres and children's homes to monitor standards of care. In the area of criminality and justice, the 1908 Juvenile Justice Act needs to be updated, and the age of criminal responsibility needs to increase from its current level of seven to fifteen years of age. And, while the Eastern Health board has well-developed psychiatric services, there are areas of the country where these require urgent development. It is critical that the Departments of Health, Education and Justice work together. Our ultimate objective has to be to make our society more child centred. We need to give all our children a sense of belonging, to cherish them, not just verbally but in reality. It will take more than constitutional rhetoric to achieve it.

# IRELAND: A CHANGING SOCIETY.

CARMEL DUGGAN.

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## INTRODUCTION

Irish society has undergone considerable change and development in the past thirty years. Economic restructuring has taken place, demographic changes have occurred and the population has become increasingly urbanised. These changes are on-going but they can be traced, in the first instance, to developments which occurred in the period from the 1950's to the 1970's. these developments include the end of protectionist policies, the setting up of various organisations to promote economic expansion and entry to the EEC in 1973.

Work force changes prior to 1970 have been documented by Humphreys (1983). These included a continued decline of the proportion of the work force engaged in agriculture, steady expansion of the service section and a fall off in industrial employment in the 1950's and early 60's, with some recovery in the late 60's. These changes occurred in the overall context of a declining work force.

The developments during the 1950's and 1960's wrought further charges. Rottman and O'Connell (1982) have identified two over-arching trends in the labour force transformation that occurred between the mid 1950's and late 1970's. These were a shift away from self-employment and onto wage labour and the increasing ratio of while collar and skilled manual work to semi-skilled and unskilled labour.

By 1975 22.2% of those in employment were engaged in agriculture, 31.4% were in industry and 46.6% were employed in the service section.

Demographic changes also occurred during this period. Between 1926 and 1961 there was a steady decrease in the total population, due to heavy out-migration. From 1961 onwards, the population began to increase from 2,884,000 in 1961 to 3,443,000 in 1979. Along with this overall increase in population there came an improvement in the age and sex structure although relative to other European countries the dependency ratio (i.e. the proportion under 15 and over 65 relative to those in the economically productive age group) remains high, at 69 for every one hundred in the active category compared with an EEC average of 53 (Courtney, 1986). In addition mortality has decreased and fertility rates have also decreased but this has been offset by an increase in marriage rates and a lowering of the age of marriage.

Along with overall demographic changes there has been a change in the spatial distribution of the population. In 1926 just 32.3% of the total population lived in urban areas. By 1981 that had risen to 55.4%. Much of this urbanisation has been concentrated in the Eastern region of the country and particularly in the Dublin area. While the proportion of all urban dwellers living in Dublin has been constant at around 53%, the proportion of the total population living in Dublin has risen from 17% in 1926 to 29.1% in 1981 (Ronayne, 1987).

## THEORISING CHANGE

Sociologists and others seeking to analyse these changes in Irish society have tended, in the main, to use one of two conflicting approaches. Exponents of modernisation theory (or convergence theory as it is sometimes called) argue that once a country has embarked on the path of economic development, it will inevitably, over a period, take on the features including the technology and socio economic organisation of developed societies. Modernisation theorists understand development as an evolutionary process "by which traditional (under developed) societies are transformed into the types of societies that characterise the economically advanced (developed) countries of the modern western world" (Commins, 1986).

Within this approach failure to modernise is understood in terms of personal deficiencies, for example lack of initiative or a clinging to traditional values. Economic categories who remain outside the modernisation process (for example small farmers) are considered, therefore, to be limited in their personal resources. This could have a negative effect on their mental health.

In contrast to this approach are those who take a structural perspective on change and development. Dependency theorists argue that all countries do not develop in the same economic context. Those countries of the Western world which are already developed occupy positions of great power in terms of world economics and it is in relation to these powerful countries that presently undeveloped (or in this perspective, underdeveloped) countries must develop. Dependency theorists see the underdevelopment of countries as a function of the power relations within the world economy (in simple terms, for example, the 3rd World is poor, precisely because its resources have been exploited by the developed nations).

The development of these countries must then occur within the context of these power relation developing countries are dependent on those already developed for technology etc. As a result these countries experience 'dependent development' and in consequence their pathway of development does not correspond to that of the already developed countries.

In this perspective the barriers to development are understood not as personal inadequacies, but as structural constraints. So for example the reasons why certain economic categories appear outside the development process are to be found in such structures and institutions as state policy, the law, the economy and so on.

## IDENTIFYING INEQUALITY

Whatever about their varying theoretical approaches, commentators on Irish economic and social change have invariable identified disadvantageous underlying trends within the overall processes of change and development.

These trends have produced increased differentiation within Irish society. The gap between the rich and the poor has widened, and the effects are manifest across society. In both urban and rural areas, there are categories of people who have been and continue to be increasingly marginalised by the on going processes of economic development. In terms of employment, housing, environment, education, health and so on these categories are compoundly disadvantageous and their disadvantage is reproduced across the generations, ensuring its perpetuation.

## DEMOGRAPHIC TRENDS

In 1954 the Commission on Emigration and other population problems was forecasting, in the assumed context of no economic development, that the population would barely exceed two and a half million today. That it now stands at over three and a half million has had "the most profound and devastating effect on values, attitudes and behaviour patterns" (Courtney, 1986).

Within that overall growth however are certain processes, which, when set in their social and economic context, result in a great degree of vulnerability for the effected categories.

Courtney (op cit) has traced the changes in demographic patterns in recent years. On the basis of census data he has identified an increase in the age specific marriage rate of almost 50% between 1961 and 1971. Paralleling this increase in marriage is a decline in the age of both brides and grooms. In 1959 the mean age at marriage was 31.2 years for men and 27.1 years for women. By 1967 this had fallen to 28.9 years and 25.8 years respectively (Hutchinson, 1972).

Since the mid seventies there has been a decline in the marriage rate and a decline in the numbers of going people getting married (Ronayne, 1987). Discussing these trends, Ronayne posits unemployment, economic recession, a fall in the popularity of marriage and the increasing acceptability of co-habitation as explanatory factors.

The high rate of increase in the marriage rate from 1960, however, was not experienced across society. In particular the small farmer of the west has been identified as a category with an extremely high and growing celibacy rate. In this part of the country the proportion of single farmers over the age of 45 has increased from 14% in 1926 to 28% in 1971 and this increase is much more pronounced among farmers with low acreages (Commins et al., 1979). Commenting on this 'family failure' and the disintegration of the western 'peasant society'. Hannan (1979) notes the social disintegration of those categories of small farmers who fail to modernise "their kin networks breakdown, the support that they may in previous decades have received from family members, is no longer available to them and they become more and more isolated both within their own families and extended families as well as within their own communities" (Hannan, 1979).

The demise of the western small holding economy which underwrites this demographic decline continues. As the economic viability of small farmers decreases so too does their 'life chances'. Increasingly they face the prospect of "a cheerless bachelorhood' (Hannan, 1979). It has been stated that a category of people with similar life chances may be regarded as a social class. Life expectations and marriage opportunity are examples of life chances.

Although Curtis and Varley's (1987) research has revealed social and psychological stability on the part of bachelor farmers in the area they studied, other studies (Brody, 1973; Scheper-Hughes, 1979) tend towards the consensus in the social sciences that in modern societies bachelors are more prone to physical and mental disorders than are married men (Davis and Strong, 1976). O'Hare and O'Connor (1986) argue however that it is social impoverishment rather than disturbed mental state which explains the high levels of long term dependency on psychiatric services shown by rural west of Ireland men. In a later paper (O'Hare and O'Connor, 1987) suggest that the social and economic circumstances of single farmers in the west render them vulnerable to psychiatric labelling and institutionalisation.

## BIRTH RATES

In 1946 Irish families were twice as large on average as those in European low fertility countries (Walsh, 1980). there was a slight decrease in the average family size between 1946 and 1961, with stability from then until 1971 (Clancy, 1984). Not until the early 1980's is there evidence of a downward trend. Between the mid seventies and 1986 the birth rate has fallen from an average of 21.7 per 1,000 to 17.4 per 1,000 (Ronayne, 1987). Courtney (1986) on the basis of a period analysis for a calendar reveals a decline in marital fertility of 35% between 1961 and 1981.

This decline in marital fertility removes from women the pressures associated with bearing and rearing a large number of children.

Within the overall decline in the birth rate however, there are other potentially disadvantageous trends. Both Courtney and Ronayne note the increase in non-marital fertility. In 1961 the proportion of all births registered to single women was 2%. By 1986 the figure was 9.6% (Ronayne). Most of this increase has been among younger aged (Ronayne, 1987) women. Between 1971 and 1984 the birth rate among single women in the age group 20 - 24 increased from 1.1% to 19.5% per 1,000. In 1973, 1,431 women were receiving the 'unmarried mothers allowance', by 1986 this figure was 12,039. In 1987 over half of those in receipt of this payment were under 26 years of age.

Research has consistently shown that single parent families are most vulnerable to poverty (Callan and Nolan, 1988). to housing stressful environments (SUS, 1988; Ronayne, 1987), and children of such families are over represented in residential child care settings (O'Higgins & Boyle, 1988). Courtney (1986) also notes the increase in extra-marital fertility (from 1.6% in 1960 to 7.8% in 1984) as well as suggesting a significant increase in the number of prenuptal conceptions, the latter especially noticeable among teenage prides and younger women generally.

O'Higgins (1973) while noting that marital desertion is most likely to result from a 'piling up' of adverse situations found that one third of the deserted wives included in her study of marital desertion in Dublin were pregnant at marriage.

Abortion is another issue concealed by aggregate demographic statistics. Although accurate information is difficult to come by, all the indications suggest a steady rise in the numbers of Irish women seeking abortion outside the jurisdiction. In 1977 2,183 women receiving abortions in England and Wales gave them addresses as Republic of Ireland. In 1984 this had risen to 3,946. It is widely accepted that these are conservative figures and that the numbers are increasing all the time.

## MORTALITY

At the other end of the life cycle, mortality rates have also fallen in recent years, and the Republic of Ireland now compares favourably with other countries in this regard. Increased longevity has also meant the disappearance of Ireland's previously high rates of female mortality and there has been a significant decline in infant mortality (Courtney, 1986). A detailed breakdown of Irish mortality rates by social class is not available, but international evidence suggests that the levels are higher among the lower socio-economic groups, especially in cases of prenatal and infant mortality. Courtney (op cit) also provides evidence of slightly higher rates of mortality in urban areas, a fact he attributes to differing life styles and environmental conditions.

## MIGRATION

Since the middle of the last century, emigration has been a feature of Irish life. During the 1950's it reached massive proportions, but subsequently declined following the economic expansion of the seventies. Since the early eighties, emigration has again been rising. Up to April 1982 1,000 had emigrated from the country in the year April 1986 the figure was 31,000. Because of the migratory flows which contribute to the overall trends, it is difficult to estimate exactly the numbers leaving he country in any one year.

Ronayne (op cit) has identified continuities and discontinuities between the current phase of emigration and that of the 1980's especially in regard to young people. Whereas previously it was mainly those from rural, semi and unskilled manual class backgrounds, with little formal education or experience work who left, there is now greater emigration among those with second and third level education, with professional and managerial back grounds.

There still remains however an outflow of young emigrants from working class back grounds who go mainly to London. These young people "unprepared, unskilled and inexperienced" constitute the clients group of many London hostels, night shelters and advice centres (Kelly, 1986).

## EMPLOYMENT AND UNEMPLOYMENT

The period of industrialisation led to a dramatic change in the structure of the Irish work force. The most noticeable and significant changes being the sharp decrease in agricultural employment and the simultaneous increase in employment in manufacturing industry. Proponents of modernisation theory would ensure that these changes in the structure of the labour force were evidence of development and convergence. However an analysis of the structure of industrial employment reveals processes and trends atypical of the developed economies.

Wichlam (1986) provides such an analysis. He acknowledges that manufactured goods now comprise a larger share of all exports than do agricultural products and that industries share of total G. A. P. has risen in the last 20 years. However, he argues, Ireland's industrial development can best be understood as 'dependent industrialisation'. This term was first proposed by Latin American sociologists to describe the development that was occurring in certain Latin American societies in the 1960's.

Dependent industrialisation is the result of under developed countries undergoing some development in the context of their unequal power relations with already developed societies. Dependent development in invariably instigated by manufacturing investment by multi national corporations. A feature of this development is that only the least skilled and lowest paid manufacturing activities are located in the dependent societies and much economic contact remains outside the national boundaries (Wichlam, 1986).

In Ireland over one third of the manufacturing work force is employed in foreign owned industry. These largely American and European firms were attracted by relatively cheap labour, tax concessions and government grants. For the U.S. firms access to the European markets was also an incentive. Although many of these foreign firms are in the high technology industries such as chemicals and electronics, not all of their employees are skilled. There is little research and development carried out in this country and in general it is only the less skilled operations that are moved to Ireland. The more skilled activities remain in the 'home' country of the multinational. Using the

electronics industry as a case study (Wichlam (1986) argues that the growth of such an industry does not necessarily mean that the Republic of Ireland is catching up with more developed countries. Furthermore, he argues there is evidence that white collar employment has been growing more slowly here than in the more advanced countries such as the U.S. and overall the social structure of this country remains most similar to the countries of the European periphery - Greece, Spain and Italy - than to the developed societies such as Britain and Germany.

Breatnach (1985) has discussed the implications of development based on multi national investment for the work force, especially in the context of rural Ireland. He suggests that branch plant development provides a limited range of skills for the work force, and furthermore these skills may be branch specific, leaving the workers little opportunity to seek employment elsewhere. In addition, as rural industries tend to be isolated, there is often little alternative employment available to the work force, thus making them dependent on their employer. This insecurity may have an effect on mental health. These factors render the work force very vulnerable in the context of employer worker relationships. As in the main, rural work forces do not have a history of trade unionism, they are poorly placed to counter this vulnerability.

Wichlam 1986 also notes the pattern of multi national industry siting in areas outside of Dublin - 'with its historic tradition of trade unionism'. This, together with the change in the ownership structure of industry - more industry here is now foreign owned, and it is the indigenous industries which have been most likely to collapse over the last decrease - means that "although overall (until the beginning of the current recession) more jobs have been gained than have been lost in industry, different groups of people have been involved".

This point is echoed by Ronayne (1987). He discusses the marginalisation of the semi skilled in the on-going trends in employment and unemployment and quotes Rottman and O'Connell (1982) to the effect that "Even in 1979, a substantial share of the work force was in residual classes stranded in the course of industrial development, especially farmers on marginal holdings and labourers without skills. People in these marginal categories have little opportunity to transfer to the more favourably placed categories; their childrens chances are little better, perpetuating marginality within families".

Despite the fact that high technology industries have not introduced a high level of industry related skills, it is the unskilled and semi skilled who have been excluded from the benefits of industrial development, and have been hardest hit by the collapse of the traditional industries. This is particularly noticeable in the Dublin area where the numbers involved in manufacturing decreased by over 14% between 1966 and 1981.

In contrast, much of the expansion in the service sector has also taken place in Dublin, but as the semi and unskilled work force of manufacturing industry is not transferable to while collar employment these trends have not been complimentary. Instead as has been noted elsewhere, an affluent and ostentatious service sector has grown up at the doorstep of multiply disadvantaged areas. The present development of the Dublin port area and the 'detenanting' of the local disadvantaged flats complexes in just one example of the varying experiences of social groups in the context of economic developments.

An analysis of young peoples participation in the labour force reveals that the decline in industrial employment among 15 - 24 year olds was greater than that for the labour force as a whole, and the increase in the numbers of young people in the service sector was smaller than the overall growth in that sector (Ronayne, 1987).

Wichlam (op cit) has investigated womens participation in the labour force. Because of the involvement of women in domestic duties, they have little chance of acquiring a

'good job' and are often instead concentrated in low paid, low skill and low prospect employment. Moreover the belief that in 'modern' Ireland many more women go out to work is a fallacy. The labour force in the Republic consists disproportionately of married men and single women.

## UNEMPLOYMENT

Those categories which have not been fully incorporated into economic processes of development - the young, the semi and unskilled and women - are also the most vulnerable to unemployment. Between 1975 and 1985 the percentage of the labour force unemployed increased from 9.3% to 17.4%. In 1989 it was 19%. For those between the ages of 15 and 24, however, the figures were 13.8% in 1978 and 25.5% in 1985. Female unemployment is consistently lower than male unemployment but it is accepted that many more women who would accept employment if it were available do not register themselves as unemployed. Wichlam shows for example that from the age of thirty onwards female labour force participation ranges from about 20% to 25%. Many of the non-participating women in this age range, would be presumably engaged in home duties and it is impossible to estimate what the degree of unemployment among them is.

But in both the U.K. and West Germany, where child care facilities are much more developed and, in Germany at any rate, the unemployment rate not so high, women are much more active in the labour force. In West Germany the participation rate of women aged between 30 and 50 is between 50 and 60%, while in the U.K. it ranges from 50 to over 70%.

A further worrying trend is in unemployment has been the steady increase in the proportion of long term unemployed. Between April 1980 and 1987 the number of people out of work increased by 170% but the number of long term unemployed increased by 24.5% (Ronayne, 1987).

An analysis of labour force survey data (considered more reliable than the live register) reveals that long term unemployment as a percentage of total unemployment has increased from 48.2% in 1966 to 65.2% in 1985. Within that, female long term unemployment has increased from 33.4% to 53.2% and long term unemployment among the young has increased from 41.6% to 57.3% (Ronayne, 1987).

The implications of unemployment for those affected is well documented. The importance of work is providing a self identity, social status, an outlet for skills and social interaction as well as means to an income is recognised by all commentators.

In its absence the quality of life is impaired and there can be severe health implications (see McHugh). Waun and Jackson (1984) found that unemployment over a period produced cumulative stress and anxiety in unemployed men between the ages of 20 and 60. In the Irish context, McCarthy and Ronayne found a mental state among the young employed comparable with that of attending psychiatric clinics.

Long term unemployment is further associated with declining living standards, a withdrawal of family support, often forthcoming in the initial stages, a steady deterioration of family relationships and greater likelihood of marital separation. (See Ronayne, 1987. For a full discussion of unemployment and social and personal well being). (See also Cullen et al., 1987).

## URBANISATION AND RURAL DECAY

The overall pattern of urbanisation in the past two decades has already been noted. Between 1926 and 1981 the proportion of the population living in urban areas increased from 32% to 55%. The proportion of total population living in Dublin has risen from 17% to just under 30%. This spatial redistribution of the population comprises two main trends: firstly the concentration of population in already existing urban areas. No new urban areas have been developed (McKeown, 1986). Secondly the depopulation of parts of the countryside, particularly along the west coast.

While these changes have been marked, Ireland's spatial distribution of population is marked by less urbanised than most of our European neighbours. Dublin and Cork are the only two centres of population with more than 100,000. Nevertheless the redistribution of the population along these lines has brought severe problems to certain areas, both urban and rural.

In the urban context, Bannon et al. (1981) was among the finish to document the problems associated with growth in the Dublin area.

The study examined the overall patterns of growth and decline and the spatial distribution of social and economic deprivation in Dublin. It identified a pattern of housing development which it categorised into six broad social areas: the inner city; a 'twilight' area; flatland; mature middle class suburbs; middle class areas; local authority estates.

Two of these areas the inner city and the local authority estates were considered to be areas of 'multiple disadvantage'. In the inner city these disadvantages include high levels of unemployment with those in employment dependent on low income occupations. Population loss of over one third between 1966 and 1981, a high proportion of the population living in rented accommodation in multi family dwellings that were seldom in good condition. A high dependency rate, over crowding especially in the case of large families and an overall poor environmental quality.

In the local authority estates, the problems included large youthful populations living in overcrowded conditions, high unemployment and a dependency on low pay among the employed, a high incidence of one parent families, many living in or near the poverty line. As with the inner city, a poor physical environment was also indicated.

The authors of this report recognise the wider context in which these problems arise:

> "The Dublin inner city represents a complex and intractable multi dimensional problem whose roots lie in the nature of the wider natural economic and social systems but whose consequences are felt intensely by the residents of the area".

They further note in their summary:

> "The scale of physical dereliction and human deprivation in Dublin remains a major concern not only to those directly concerned but to the population as a whole".

Bannon's (1981) survey was largely based on an analysis of census material collected on the basis of District Electoral Divisions. Typically each DED contains up to 4,000 households. In 1987, a study of deprivation in Dublin county, employed an analysis of enumeration areas, each comprising 300 to 400 households (SUS, 1987). This research provided a much fined grained analysis and allowed 'pockets of deprivation' to be identified.

Using a model of social need informed by three underlying concepts - socio economic position, dependency and housing - the study investigated the extent of deprivation in over 311 enumeration areas. Its findings reveal about 15% of EAs scoring poorly on the socio economic position dimension. What this means is that 48 out of 311 of the EAs in the study had less than the mean numbers of people per household in professional or managerial occupations or with higher education completed, and had more than the mean numbers in manual occupations, unemployed, with no post primary education.

Forty three EAs had very high dependency ratios as measured in terms of the proportion of the population aged less than 15, unemployed or not in paid employment. Fifty three EAs were identified as deprived on the housing dimension, in that they had a low proportion of owner occupied housing and a high average number of persons per room.

In addition 38 EAs were identified as suffering multiple aspects of social need in that they scored highly on all three diversions of social need.

As well as surveying social need across the county Dublin area, the research also investigated the 'neighbourhood' profiles (SUS, 1987, Volume II) of 24 neighbourhoods. This provided extremely detailed data for these areas and reveals many of the processes at work which contribute to social need.

High levels of dependency on state transfer payments are revealed in this survey as well as very low incomes. Across the 24 neighbourhoods an average of 37.2% were unemployed, but in several neighbourhoods the figure was rose to 45%, in several cases this level of unemployment was found among the principle earners. Similarly the findings reveal a high proportion in receipt of unmarried mothers or deserted wives allowances: ranging from just under 5% to 26.8% with an overall average of 12.5%. Only 7 of the 24 neighbourhoods had 25% or more of households in receipt of incomes greater than £150 per week. On average 43.9% of all households contained 5 or more people and 24% contained 6 or more.

The survey also looks at the impact of local authority housing policy in creating "ghettos of social deprivation'. In several neighbourhoods close to one quarter of local authority tenants had applied for the £5,000 Surrender Grant Scheme. (This scheme was discontinued in 1987). This implies that these tenants were in stable employment, with the result that those left behind are more likely to be unemployed - hence reducing the level of income to the area generally.

The level of ghettoization which occurs in certain aspects of housing policy including the surrender Grant Scheme, is well demonstrated by the case of Ballymun. During the year September 1985, 45% of all single parents housed by Dublin Corporation were accommodated in this area even though Ballymun accounts for only 10% of all housing available to Dublin Corporation. (Ronayne, 1987). More recently large numbers of single people have been housed there; lettings to single people increased from 7% in 1985 to 50% in 1986. As Ronayne points out, these trends reveal the opportunities for single people to acquire accommodation from the Corporation as a result of the Surrender Grant Scheme they also reflect the marginalisation of single people and single parents in public housing. The low income status of these groups have implications for the social vibrancy of the entire area and SUS had noted that in 1985 E.H.B. alone supplemented the income of households in Ballymun with £1,161,612 and the society of St. Vincent de Paul with £130,000. Over 100 people visited the Community Welfare Officer each week and the members of St. Vincent de Paul were in contact with 550 families each week.

## THE DECLINE OF RURAL IRELAND

The problems of urbanisation, together with the effects of economic recession are acutely experienced in many urban areas. But social deprivation is not a uniquely urban phenomenon.

The other side of the process of urbanisation has been the depopulation of large areas of the countryside, particularly west of the Shannon. The hardest hit areas have been those which relied on small holding as the main form of economic activity. As agriculture became more and more commercialised and as agricultural capital became concentrated at a national level, the small farms of the west became increasingly non-viable. The economic marginalisation of small farmers is well documented. Commins et al. (1978) has chronicled the decline of many rural areas particularly those in the west; populated continued to fall, even during periods of net immigration nationally, farm incomes in this region lag behind those of other regions and the gap between larger and smaller farmers is increasing, marriage rates are low and 'family failure' is increasingly a characteristic of these areas.

While the authors of this report recognise that the causes of the economic marginalisation of small farmers are structural and not individual, they tell what is essentially a modernisation approach; "a main thesis of the report is that rural the rural problems identified are dislocations and adjustments arising from the long-term processes of economic modernisation. That is, the major policy issues arising in Irish rural development are linked to a complex of technological, economic and social transformations that have, to various degrees worked themselves out in the more advanced countries of the western world".

Tovey's (1986) analysis of the dairy industry, however, would suggest that the problems of the small farmer are more endemic than Cummins and his colleagues admit. Tovey argues that small farmers were forced out of dairying - an activity recommended to relieve economic pressure on low average farmers - because of the technological barrier to their continued involvement: as the industry developed the technology needed to continue in production was outside the financial reach of small producers. She also argues that at the political level the interests of small farmers are not catered for by the farming organisations. These organisations, which enjoy a 'corporate' relationship with the state concern themselves mainly with the interests of the larger producers, although the small holders remain ideologically important - the concept of the small farm family, living and working on the land, still occupies a central place in Irish ideology (Duggan, 1986). The reality is somewhat different. The family failure of west of Ireland farms, has already been discussed. But even without this extreme occurrence the household based economy has changed drastically. The 'flight from the land' following the decline of intensive agriculture has meant that the children of farming families leave the land in large numbers. Machinery and other technology has replaced family labour. The role of the farmers wife has shrunk too. From being actively involved in several aspects of farming, many rural women now find themselves confined to home duties (Hannon & Katsiaouni 1977) and those who do remain active find their contribution goes unrecognised at a number of levels (Duggan, 1986). While Hannan & Katsiaouni note the greater satisfaction of farm wives whose family role are negotiated, they also note the dissatisfaction of those farm women who retain exclusive involvement with household duties.

O'Hare and O'Connor (1986) in gender in Ireland looking at rates of depression among rural women suggest that their limited social interaction which results from them predominant involvement in domestic duties leads to depression among rural women. These rarely show up in the statistics of the psychiatric services however, because a) women wait until their families are reared before they present with depression, b) they rely on their local GP rather than the psychiatric services, and c) factors such as

distance from the services, reluctance to discuss emotional problems etc. act as disincentives.

The lack of opportunities for social interaction is not restricted to framers wifes, it is a growing feature of rural areas where the traditional patterns of social visiting have broken down (Foster, 1984).

The decline of rural communities has also been described by Hannon (1979). Hannon suggests the social isolation experienced by certain categories, parallels their economic marginalisation. It is amongst these groups who have 'failed to modernise', failed to come to terms with the facts of modern farming, who have as a result 'sunk to mere substance level' that experience the greatest degree of social disintegration. Hannon's account is, like Commins et al., a modernisation approach to rural change. O'Neill (1988) however has outlined some of the processes at work in a rural community which sense to perpetuate disadvantage.

Drawing on his experience as a community worker in a Connemara community O'Neill has described the very poor economic infrastructure of the area (60% of farms are less than 15 acres), the high rate of emigration among the young (currently 68% of all school leavers leave the area), the very low participation rate in third level education, which is partly due to the lack of a tradition of such involvement, and the irrelevance of state training schemes in the absence of appropriate job in the area.

O'Neill has also discussed the difficulties which communities encounter when they seek to rectify some of these problems. Not least of these is the shortage of capital in such rural communities. But as well there is the bureaucratic insensitivity to the needs of these communities.

The decline of rural Irish communities is much lamented and the economic, social and psychological deprivation which has resulted is well chronicled. It would be over simplistic however to consider the decline as the end of a rural idyll. 'Traditional' rural communities were often characterised by rigid definition of gender and social rates (Hannan and Katsiaouni, 1977; Kane, 1976; Aversberg and Kinball, 1940), which along with the strict imposition of social and religious norms (Kane, 1976) was capable of placing the individual under severe stress. Lee (1984) has summarised accounts of the stifling and exploitative nature of family farming in Ireland in the past. He quotes O'Tuaithaigh (1982):

> "Of those who fled rather than have the bank of their youth thoroughly burgled, many went in order to escape the claustrophobic would of Irish small farm society".

In commentary on the disappearance, as a class, of the small farmer, Lee writes "the death knell of their class was sounded when the girls refused to linger any longer, flying rom the fate they saw staring at them in the wizened faces of their own mothers and unmarried aunts. It was ironically at the height of the official benediction of 'traditional' values, during the 1930's, that the flight of the girls from the small farms gathered irresistible momentum".

Lee's and others, conflict perspective on 'traditional' rural Ireland should not, however blind as to the very real personal and social deprivation that now features in so many rural communities. It must be pointed out too that there are few, if indeed any, communities that are totally blighted in this way. Most rural regions contain vibrant and innovative - elements within their populations.

Armstrong (1988) writing in the context of Northern Ireland argues that the spatial dimensions of rural deprivation must be addressed. The indications of deprivation - high unemployment, poor housing, lack of mobility etc. - he argues do not occur

randomly; "rather there is a particular group of people within the rural community who tend to suffer these deprivations in a compound way".

## STATE SERVICES

The social and personal problems produced in the wake of economic development and decline over the past two decades have implications for the provision of state services. Quite apart from the increased demand on social welfare payments, social deprivation and its consequences also produces an increased need for medical resources, social workers, child care services and, in the extreme juvenile justice agencies.

Despite increased spending in these areas in recent years, however, much of the resources currently in place are under severe pressure in dealing with their area of responsibility.

In November 1985 Dussing published his economic analysis the Irish Medical care resources. He identified there problem areas in the provision of medical care. The first of these related to the quality of care and concern was expressed int he report about the inequality of service and care between the public and private sectors, the failure of the services to reach the aged poor and possibly other disadvantaged or handicapped populations and the low level of involvement of working class women and children in certain medical and dental services.

Dussing also identified disparities in the regional distribution of medical and para medical resources and personnel. The disparities in the regional distribution - with almost half the countries specialists in the Eastern Health Board area - was excessive, leaving some regions distinctly undeserved. There were also wide disparities in the regional distribution of social workers and physiotherapists and it was noted that the north west was the area most undeserved by general hospital facilities. Dussing also identified as a problem area the varying eligibility of the population to free medical services. He advocated the extending of free G.P. services to all.

While Dussing has identified the lower socio economic groups and those living in remote rural areas as the categories most poorly served by the medical care services, other studies indicate that these are also the categories of greatest need. Foster (1984) has identified poor diet and limited opportunities for physical exercise among a community in North West Donegal. He also discovered high rates of smoking, and 40% of males in moderate or high drinking categories. Social networks had broken down, leaving the old socially isolated. In addition, anxiety or depression, particularly amongst women, was found to be a relatively common disorder. O'Hare and O'Connor, however, suggest that depression among rural women may be concealed to an extent because of the distance from the psychiatric services. They note Fosters finding that women may use G.P.s to deal with their depression, but also suggest that many rural women may be unhappy to discuss emotional matters.

In discussing the medical care needs of an urban based category, Ronayne (1987) also notes their difficulty in receiving care. The links between drug particularly heroin abuse and social deprivation have been well established (MRBI, 1984; National Youth Policy Report, 1984). A study of drug abuse in the north inner city found those involved to be poorly educated, poor employment record, likely to be unemployed, and to have been arrested (Dean et al., 1983). Dealy (1986) in a study of another socially deprived area, found the problems of addicts families to include emotional difficulties, financial problems, housing problems, family violence and the admission of children to care. Despite the evidence of these studies and the authors calls for comprehensive education, prevention and treatment programmes. Ronayne notes that in 1987, the

Government abolished the inner city fund for Dublin (valued at £300,000) and the Health Education Bureau.

The prevalence of children from lower socio economic backgrounds among those admitted to child care institutions has been noted by O'Higgins and Boyle (1988). These authors also found that the children of one parent families are vastly over represented among children admitted to care. While they note that in certain areas, the children of single mothers are more vulnerable to admission to care, they also found that one quarter of legitimate children in care are there because they are members of one parent families unable to cope, or because there is marital disharmony. This report also notes the apparent role of child day care facilities in preventory admission to care.

Despite their prevalence in the child care residential settings, however, there is little evidence that a period spent in care equips these children for a more stable adult life. The lack of after care facilities is frequently mentioned as a main stumbling block to the successful social reintegration of these young people. A survey carried out by the Eastern Health Board (1989) found over 20% of young homeless people to have had a previous experience of care. Duggan (forthcoming) revealed two thirds of admissions to an emergency service for boys out of home had already spent a period in residential care. The lack of after care support, proper day facilities, limited access to appropriate housing and poor employment prospects ensure the continued reproduction of homelessness among these children.

The increasing numbers of young people entering the juvenile justice system has been causing alarm for a number of years. In 1986, 34.8% of those convicted for recorded crimes or dealt with under the juvenile Liaison Schemes were under the age of 17. In 1987, the figure was 43.2%. During the same period the numbers admitted to the Juvenile Liaison Schemes increased by over one third (Report on Crime, 1987). In 1976 the daily average population of juveniles in prisons and places of detention was 195. In 1987 it had risen to 283 (Report on prisons and places of detention, 1987).

The value of prison as a deterrent to future crime is questionable to say the least, with approximately one third of all detainees having previous convictions leading to detention (161 d).

## SOCIAL DIFFERENTIATION

Sociologists and others who study Irish society, have consistently produced evidence of growing economic, social and related personal problems. Regardless of divergences in their approaches their conclusions are broadly similar: the economic marginalisation of certain social categorise in both urban and rural areas. More over that marginalisation is occurring along side the increasingly advantageous economic position of other social categories.

These trends, sometimes summarised in concepts such as 'a divided society' and 'a two tier' society, are in sociological terms described as processes of social differentiation. Differentiation is a characteristic of virtually all societies and is manifest of social, economic, political and cultural levels. In very traditional or undeveloped societies, social differentiation tends to be fixed: the caste system of Indian society is an extreme example. But of the myths which 'modern' societies relay to themselves is that the channels of movement between various social categories are open, or in other words opportunities for social mobility exist. The main vehicle of social mobility in these societies is seen as the educational system - as all have access to education, therefore all have access to the social resources which education can 'purchase'. Several recent Irish studies however, reveal this is not the case in Ireland. On the contrary, social

mobility is limited in the republic, and education, far from overcoming inequality actually compounds it.

Hannon, 1979; Bannon et al., 1981; Commins et al., 1978; Ronayne 1987; SUS 1987 these and virtually all other commentators have described the social differentiation which not only exists but is growing all the time. More over this differentiation is consolidated by the structures of Irish society.

Whelan & Whelan (1982) found social mobility in the Republic of Ireland to be more limited then in several other European countries. In particular 'long range mobility' was very rare with most movement between social classes not crossing the manual / non manual divide.

> "The overall picture remains are of a highly structured mobility regime where opportunities for upward mobility are restructured and the children of upper class parents still enjoy substantial advantages in access to higher level occupations".

These authors also investigated the role of education in promontory social mobility. Like several others commentators, they note the class structure of Irish education and the fact that the expansion of education and increased access to free secondary and third level education has not changed the social structure of enrollment to any great extent:

> "Occupational positions are passed from one generation to another, not, as in the part, through direct inheritance but through the medium of differential access to educational qualifications".

Clancy (1983, 1986) has also noted the social inequalities in participation in third level education, the predominance of working class boys especially in vocational schools and the lower retention rates of schools with a large working class enrollment. Hannon and Breen (1983) have pointed out the lower aspirations of schools with a predominantly working class intake, as well as the under provisioning for girls of the more commercially orientated and career relevant subjects.

Breen (1986) investigates social class disparities in the take up rate of senior cycle school subjects. He finds that general science and modern language subjects are more popular among the middle classes while technical and (among girls) commence subjects tend to be taken by working class pupils.

> "The distribution of pupils over the secondary / vocational / community and comprehensive sectors is strongly related to sex and class origins: as a result the curicula characteristics of these different school types become to some extent, the curicula characteristics of social classes".

The class bias of Irish education ensures the reproduction of inequality - occupation determines a wide range of social life chances: income, status, housing, health care, environment, personal control over resources, opportunities for ones children, health care and so on. That those who are already marginalised are being forced to reproduce that marginality in their own families ensures the continued stratification of Irish society (See Peillan, 1986).

The present situation, where low income (Cullan and Nolan), poor housing, unemployment, poor physical environment etc. are being concentrated within a compoundly disadvantaged 'underclass' (Dahnerdorf, 1989) is unlikely to change in the foreseeable future.

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# PSYCHOSOCIAL FACTORS ASSOCIATED WITH PSYCHOLOGICAL PROBLEMS IN IRISH CHILDREN AND THEIR MOTHERS.

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## INTRODUCTION

Relatively high rates of psychological distress for those from lower socio-economic groups have been found in a number of Irish studies, a pattern commonly observed in other countries. For example, a report for the Health Education Bureau found the rate of first admissions to Irish psychiatric hospitals and units to be three times as high for unskilled manual workers as for employers and managers (HEB, 1987). Similarly, Whelan, Hannan and Creighton (1991) showed that, in a nationally/representative household sample, the unemployed were five times more likely than the employed to exhibit symptoms which would lead to their being classified as non-psychotic psychiatric cases. This study paid particular attention to the psychological health status of women whose husbands were unemployed.

For Irish children, there is some evidence from small scale studies also pointing to an association between psychological and behaviour problems and socio-economic factors. Barton and Fitzgerald (1986) found higher rates of behaviour problems in children in a "disadvantaged" school than those from an "advantaged" one, and Fitzgerald and Pritchard (1988) show that among children of travellers the rate is even higher. Lavik (1975) found that lower social class increased the rate of psychiatric disorder. Other studies have shown higher rates of behaviour problems in children in urban compared with rural areas (Fitzgerald and Kinsella 1989, O'Connor, Ruddle and O'Gallagher, 1988).

Given the small samples available to most previous studies, a large scale exercise was undertaken to examine the prevalence of behavioural problems among school children in all 40 schools in a community care area in West Dublin. This area contains a large number of schools falling into what the Department of Education defines as the "disadvantaged" category, but also has a substantial number of schools which are not in that category. The Department of Education categorises the various types depending on the perceived needs of the majority of the children in the school. Schools with a large number of children from socially deprived backgrounds are categorised as "disadvantaged" and having need for a concessionary teacher. Children and their mothers were interviewed in depth, so the data provides a basis for analysis of the psychosocial factors associated with psychological problems in both. The results are reported in this paper, focusing on children in Section III and their mothers in Section IV. First, though, Section II describes the data to be employed in detail.

## II The Data

The sample area was a community care area in West Dublin. Compared with the Eastern Health Board area as a whole, this community care area has a below average proportion of its population in CSO social classes 1 and 2, that is the professional and

managerial classes, and an above average proportion in the semi-skilled and unskilled manual classes; the Eastern Health Board as a whole had 27 per cent of its population in the top two social classes in 1986 and 23 per cent in the bottom two, whereas the corresponding figures for the study area were 16 per cent and 30 per cent respectively (Dack, Lyons, Johnson, 1990). Relatively disadvantaged families generally lived in areas of high density local authority housing, with high levels of unemployment. In addition, there were new local authority housing estates in the area with services etc. in the early stages of development. However, the study area also contained significant numbers of relatively advantaged families, in private owner occupied housing, with children in well resourced schools.

All 40 primary schools in the area were approached and asked to participate in the study of all their 4th class pupils who would usually be about 10 years of age - and 39 co-operated. An assessment of each child in terms of behavioural deviance was obtained from the class teacher, using the Teacher's Scale B2 (Rutter, 1967). This is a questionnaire which has 26 descriptions of behaviour, covering the main emotional and behavioural problems of children as they might be seen in a school setting, against which the teacher is asked to indicate whether it "does not apply", "applies somewhat", or "definitely applies" to the child in question. These ratings are scored 0, 1 and 2 respectively, and the scores are added together to produce a total score on the scale. A score of 9 or more was taken as an operational definition of behavioural deviance. A previous study (Lynch, Fitzgerald, Kinsella, 1987) found an 84 per cent association between the Teacher's Scale B2 (cut off 9) and the formal Psychiatric Interview (v statistic + 0.64. $p < 0.001$). In addition, each child was administered two tests; the Standard Progressive Matrices, a non-verbal culture reduced test used to provide an indication of intellectual capacity (Raven 1983), and the MICRA-T Reading Test, standardised for use in Irish primary schools (Wall and Burke, 1988). In all, 2,029 children were screened in this way.

A sub-set of the children were then selected for in-depth individual study:

(1) One in three of those exhibiting a score of 9 or more on the Teacher's Scale and therefore exhibiting behavioural deviance, and

(2) A control group comprising every 16th child with a score of 8 or less on this scale, and therefore not behaviourally deviant.

This gave a total of 206 children for intensive individual assessment of whom 185 mothers and children were completed. There was refusal of co-operation in the other nineteen. Each child was interviewed in the home for approximately 3 hours by a psychiatrist. A standardised approach was used to assess child psychiatric disorder (Rutter, 1970). A series of set questions covering a wide range of possible emotional (e.g. miserable, worries, etc.) and behavioural (e.g. stealing, destructive, etc.) problems were asked in all cases. For each item information was sought systematically about severity and frequency of the behaviour and a comprehensive description was acquired. The interview has been shown to have satisfactory interrater reliability ($r = 0.81$). A similar semi-structured interview was used to assess social conditions and social supports - the Standardised Social Interview Schedule (Clare and Cairns, 1978). The Standardised Social Interview covers a number of areas or domains, e.g.:

(1) Income scored 0 satisfied, 1 minor dissatisfaction, 2 marked dissatisfaction, 3 severe dissatisfaction.

(2) Parental rôle satisfaction scored 0 satisfied, scored 1 minor dissatisfaction, scored 2 marked dissatisfaction, scored 3 severe dissatisfaction.

(3) Housewife rôle satisfaction scored 0 satisfied, 1 minor dissatisfaction, 2 marked dissatisfaction, 3 severe dissatisfaction.

(4) Mother's satisfaction with leisure activities scored 0 satisfied, 1 minor dissatisfaction, 2 marked dissatisfaction, 3 severe dissatisfaction.

Other areas covered included marriage and family relationships, housing, and occupation. Where possible, the questions in the interview were structured so as to allow for three kinds of rating to be made in each domain, ratings of the subject's objective circumstances, ratings of the subject's management of the social environment and ratings of the subject's satisfaction. The individual items were rated on a 4 point scale which ranges from "0" indicating satisfactory adjustment, to "3" indicating very poor adjustment and/or severe social difficulties. It's value has been demonstrated in several studies of patients in general practice (Cooper et al., 1975; Corney, 1984) and of patients with mixtures of physical and psychological symptomatology (Clare 1980) and in the effects of social problems on clinical outcome (Cooper et al., 1975). The mothers themselves were given a formal psychiatric assessment using The Clinical Psychiatric Interview (Goldberg and Blackwell, 1970). The Clinical Psychiatric Interview is a standardised semi-structured inventory designed for use in community surveys. The interviewer made a detailed and systematic enquiry about any psychiatric symptoms experienced during the previous week - somatic, fatigue, sleep disturbance, irritability, lack of concentration, depression, anxiety, phobias, obsessions and depersonalisation. The interviewer rated the abnormalities observed during the interview on 12, 5 point scales with 0 indicating absence of a symptom and 4 indicating a severe degree of clinical severity. The strength of the psychiatric assessment lies in its reliability and it has an overall reliability coefficient derived from the analysis of variance of +0.92. Mothers also completed The Malaise Inventory which consists of 24 Yes/No questions on their physical and emotional state. Five or more affirmative answers have been shown to be indicative of emotional disturbance (Rutter, 1970).

## III Psychological Problems and Psychosocial Factors

The Children.

Of the 2,029 children who were screened, 1,094 were boys and 935 were girls. Their ages ranged from 9 years 3 months to 12 years 11 months, with 90 per cent aged between 9 years 9 months and 11 years 2 months. In all, the rate of behavioural deviance (scoring 9 or more on the Teacher's Scale B2) was 19 per cent for children in disadvantaged schools as defined by the Department of Education and 8 per cent for advantaged schools. Twice as many males had behaviour problems as females. 2.5 per cent of children in disadvantaged schools were impaired in intelligence (Standard Progressive Matrices, Raven, 1983) as compared to 0.2 per cent of children in advantaged schools. In disadvantaged schools 37 per cent of the children were 18 months behind in reading (Micra-T, Wall and Burke 1988) as compared to 14 per cent in advantaged schools.

Focusing on the 185 children who were studied in depth, intensive psychiatric interviewing revealed that 16.3 per cent showed evidence of formal child psychiatric disorder. On this basis the Teacher's Scale test had an 11 per cent false negative rate and a 55 per cent false positive rate, which is what one would expect from this type of screening questionnaire.

Focusing on the socio-economic states of the families of these 185 children, 128 of the children had fathers who were employed, while 57 were unemployed and 11 were not living at home. Two-thirds of the group lived in owner occupied housing and one third were in rented accommodation, mostly local authority housing. The level of satisfaction with housing was high, with only 7.6 per cent expressing severe dissatisfaction with their housing. However, overcrowding was evident in 15 per cent of the families, largely where single mothers were living with their parents. Most

families had a television, half had a car and two-thirds had a telephone. Table 1 shows the level of satisfaction expressed by the mothers of these 185 children in a number of different areas. Satisfaction levels were highest in terms of social contacts and marital satisfaction, while about one-third of the mothers were quite or very dissatisfied with their income position and leisure opportunities.

Table 2 shows how the rate of psychiatric illness among the children varied across some of these economic and social background variables. As expected, the rate of illness was relatively high were the father was unemployed - twice as high as where he was employed. Local authority housing and absence of a car or a telephone were all associated with relatively high rates of psychiatric disorder. Rates of psychiatric illness also tended to be high where the mother expressed severe dissatisfaction with income, with social contacts, and where she did not have a confidant.

In order to move beyond bivariate relationships of this type, discriminant analysis was carried out with children categorised into those with and those without a psychiatric diagnosis. In discriminant analysis, if two items correlate highly and one is selected as having discriminant powers in terms of the dependent variable (here, whether the child has/has not a psychiatric illness), then the other item will not be selected as it would not provide additional discriminating power. The explanatory variables included were as follows: the child's age, sex and position in the family, the background of the children in the family, mother's and father's ages, the economic background variables described earlier, school type, the child's reading percentile, IQ (Raven, 1983), and measures of the mother's mental health and satisfaction. Her mental health was measured by the Malaise Inventory, while satisfaction as a housewife and either marital satisfaction or satisfaction as a parent were also included. Parental rôle dissatisfaction was found to be highly correlated with marital dissatisfaction, so the latter added little discriminant power when the former was included. Since both variables have been seen to be significantly associated with child disorders, it was thought useful to report the results of the two analyses, including one or other of these variables.

**Table 1:** The Social Context of Mothers

| | | % |
|---|---|---|
| Social Contact: | | |
| Satisfied | 139 | (75.1) |
| Minor Dissatisfaction | 20 | (10.8) |
| Marked Dissatisfaction | 12 | (6.5) |
| Severe Dissatisfaction | 14 | (7.6) |
| Marital Satisfaction: | | |
| Satisfied | 120 | (68.2)* |
| Minor Dissatisfaction | 13 | (7.4)* |
| Marked Dissatisfaction | 16 | (9.1)* |
| Severe Dissatisfaction | 10 | (5.7)* |
| Income Satisfaction: | | |
| Satisfied | 97 | (52.4 |
| Minor Dissatisfaction | 27 | (14 |
| Marked Dissatisfaction | 25 | (13.5) |
| Severe Dissatisfaction | 36 | (19.5) |
| Leisure Opportunity: | | |
| Satisfied | 74 | (40.0) |
| Minor Dissatisfaction | 54 | (29.2) |
| Marked Dissatisfaction | 28 | (15.1) |
| Severe Dissatisfaction | 29 | (15.7) |
| Confidant (Partner): | | |
| Absent | 40 | (22.1)** |
| Present | 141 | (77.9)** |
| N = 185 | | |

*N = 159 & % = 90.4

**N = 181 & % = 100

**Table 4:** Psychosocial and Educational Factors Differentiating Children with and without Child Psychiatric Illness

| Variables | Standard Canonical Discriminant Function |
|---|---|
| Employment Status | - |
| Income | - |
| Quality of Accommodation | - |
| Standard of Living | - |
| Maternal Age | - |
| Paternal Age | .32 |
| Family Number | .48 |
| Position in Family | - |
| Sex | .40 |
| Parental Rôle Dissatisfaction | .60 |
| Dissatisfaction with Housewife Rôle | .34 |
| School Type | - |
| Reading Percentile | -.49 |
| IQ Total | -.28 |
| Malaise Result (Mother's Mental Health) | - |

| | | |
|---|---|---|
| Canonical Correlation | .50 | |
| Wilks' Lambda | .74 | |
| Chi-Squared | 37.00 | $p < 0.001$ |

| | | % |
|---|---|---|
| % Classified correctly | Child Psychiatric Illness Present | 60.5 |
| % Classified correctly | Child Psychiatric Illness Absent | 77.8 |
| % Classified correctly | Total | 72.18 |

**N = 129**

Table 4 shows that an equation based on seven variables maximally distinguishes between children who are psychiatrically disordered and those who are not, and knowing the results of these variables it is possible to correctly classify 72 per cent of cases into those who are disordered and those who are not. The canonical correlation of .5 shows that 25 per cent of the variance between the two groups can be explained by these six variables. This difference is significant at the 0.1 per cent level.

Examination of the Standard Discriminant Function Coefficients show that, in order of importance, those most likely to have a psychiatric diagnosis are;

(i) Those children whose mothers score highly on dissatisfaction with parental rôle.

(ii) Those children who obtained a low reading percentage score.

(iii) Those children who were from families of 5 or more children.

(iv) Boys.

(v) Those children whose mothers were dissatisfied in their rôle as a housewife.

(vi) Those children whose father were older.

(vii) Those children who obtained a low score on IQ testing.

The analysis was repeated with the satisfaction as a parent variable replaced by the marital satisfaction one, and for the reasons mentioned above, the results are shown in Table 5 and Table 6.

**Table 5:** The Strength of Psychosocial and Educational Factors Associated with Child Psychiatric Illness

| Step | Variable entered | Wilk's Lambda | Significance |
|---|---|---|---|
| 1. | Marital Dissatisfaction | .84 | .0000 |
| 2. | Sex | .81 | .0000 |
| 3. | Number of Children | .78 | .0000 |
| 4. | Mother's Dissatisfaction with Housewife rôle | 75 | .0000 |
| 5. | Child's Reading Percentile | .74 | .0000 |
| 6. | Child's IQ Score | .72 | .0000 |

N = 129

**Table 6:** Psychosocial and Educational Factors Differentiating between those children with and without Child Psychiatric Illness

| Variables | Standard Canonical Discriminant Function |
|---|---|
| Employment Status | - |
| Income | - |
| Quality of Accommodation | - |
| Standard of Living | - |
| Maternal Age | - |
| Paternal Age | - |
| Family Number | .44 |
| Position in Family | - |
| Sex | .41 |
| Marital Dissatisfaction | .68 |
| Dissatisfaction with Housewife Rôle | .35 |
| School Type | - |
| Reading Percentile | -.42 |
| IQ Total | -.33 |
| Malaise Result (Mother's Mental Health) | - |

| | | |
|---|---|---|
| Canonical Correlation | .53 | |
| Wilks' Lambda | .72 | |
| Chi-Squared | 41.56 | $p < 0.001$ |

| | | % |
|---|---|---|
| % Classified correctly | Child Psychiatric Illness Present | 78 |
| % Classified correctly | Child Psychiatric Illness Absent | 82 |
| % Classified correctly | Total | 80 |

The results now show that marital dissatisfaction is the single most important factor in discriminating between disordered and non-disordered children. The equation is now more robust than when satisfaction as a parent was included, as shown by the higher value of the canonical correlation, with 30 per cent of the variance between the two groups now explained by the six variables selected by the analysis, and the percentage of cases classified correctly has also risen. Once again, children with reading difficulties and low IQs were most likely to have a psychiatric disorder, boys were more likely than girls, and those from large families also had an increased probability.

The direct measures of socio-economic disadvantage are father unemployed, absence of a car or a telephone, local authority housing, housing adequacy. However, as we shall see, they are strongly related to the marital or parental satisfaction of the mother, which are major influences on child mental health. It is to the factors affecting maternal psychological health that we now turn.

## IV Psychological Problems and Psychosocial Factors

The Mothers.

As described in Section II, the mental health of the 185 mothers was studied using the Clinical Psychiatric Interview (Goldberg and Blackwell, 1970) and the Malaise Inventory (Rutter, 1970). On this basis, 31 per cent were found to have a formal psychiatric diagnosis of depression. This is higher than would be expected in the general population, but not for the group under study. The women in this study were aged between 28 and 50, had at least one child, and all but one were married (at some time). The rate found is similar to that in other studies which have assessed prevalence of depression in mothers attending child guidance clinics (Rutter, 1970, Leader and Fitzgerald, 1985).

Clearly the fact that there was over sampling of those children with behaviour problems would have the effect of increasing the rate of psychiatric illness among the mothers.

Once again, on a bivariate basis the likelihood of being depressed was relatively high for those whose partners were unemployed, for those in households without a car or a telephone, and for those who were dissatisfied with their housing or with income. For example, 77 per cent of those who expressed severe dissatisfaction with their income were depressed, compared with only 21 per cent of those who were satisfied with income. Where the husband was in work, his level of satisfaction had no significant association with wife's depression. There was also a relatively high probability of depression for those with unsatisfactory social contacts and leisure. Three quarters of those who never had time with friends and hobbies were depressed, compared with 20 per cent of those who had ample time for leisure pursuits, and all those who were severely dissatisfied with their social contacts compared with only 20 per cent of those who were satisfied with their social contacts were depressed.

Discriminant analysis was again carried out, the two categories being women with psychiatric diagnoses and those without psychiatric illness. There were 157 cases available for analysis, excluding 28 who were "not married at present" and 17 for whom information was missing. Of these 157 cases, 30 were diagnosed as psychiatric cases. Fourteen explanatory variables were included in the analysis, those not already employed in Section III being dissatisfaction with neighbours, dissatisfaction with interaction with relatives this variable was similar to the other variables described on the standardised social interview schedule were 1 referred to minor dissatisfaction, 2 marked dissatisfaction and 3 severe dissatisfaction with the interaction with relatives.

**Table 7:** The Strength of Psychosocial Factors Associated with Maternal Mental Illness

| Step | Action Entered | Removed | Wilks' Lambda | Significance |
|---|---|---|---|---|
| 1. | Parental Rôle Dissatisfaction | | .9112 | .0004 |
| 2. | Leisure Dissatisfaction | | .8551 | .0000 |
| 3. | Employment Status of Husband | | .8312 | .0000 |
| 4. | Dissatisfaction with Interaction with Relatives | | .8176 | .0000 |
| 5. | Dissatisfaction with Income | | .8060 | .0000 |

| Canonical Function | Wilks' Lambda | Chi-Squared | D.F. | Sig. |
|---|---|---|---|---|
| .4403835 | .8060 | 29.213 | 5 | .0000 |

Table 7 shows that an equation based on five variables maximally distinguishes between those women who have a psychiatric diagnosis and those who do not, and it correctly classifies 72 per cent of cases.

**Table 8:** Psychosocial Factors Differentiating Between Mothers With and Without Maternal Mental Illness

| Variable | Mothers with Psychiatric Illness |
|---|---|
| Husband's Employment Status | -.51 |
| Income | -.30 |
| Quality of Accommodation | - |
| Dissatisfaction with Housewife Rôle | - |
| Family Number | - |
| Dissatisfaction with Neighbours | - |
| Dissatisfaction with their Relatives | .33 |
| Dissatisfaction with Parental Rôle | .65 |
| Dissatisfaction with their Leisure | .50 |
| Available Confidant | - |
| Sex of Child | - |
| Child's Total B2 score | - |
| Canonical Correlation | .44 |
| Wilks' Lambda | .80 |
| Chi-Square | 29.21 |
| P | <.0001 |

| | % |
|---|---|
| % classified correct Positive for Psychiatric Illness | 67 |
| % classified correct Negative for Psychiatric Illness | 74 |
| % classified correct Total | 72 |

Examination of the discriminant function coefficients show that, in order of importance, those most likely to have a diagnosis are:

(1) Those who score highly on dissatisfaction as parents. This is a summary value of situational handicaps to child rearing, problems with children other than the index child and dissatisfaction as a parent.

(2) Those whose husband's are unemployed.

(3) Those who score highly on dissatisfaction with leisure. This is a summary value for opportunity, management and satisfaction with leisure.

(4) Those who score highly on dissatisfaction with relatives. This is a summary value for opportunity, management, and satisfaction with relationships with relatives.

(5) Those with dissatisfaction with income.

The results of this discriminant analysis suggests that while employment status and income are important, stress in the form of difficulties with children and lack of supports in leisure activities and from relatives are key factors in distinguishing between those women who become depressed and those who do not.

As stated earlier parental rôle dissatisfaction and marital dissatisfaction were highly correlated ($r = .73$). If both were included in the same analysis the discriminating power of one would be cancelled out by the other and only one would appear in the final equation. As both variables have been shown to be highly significantly associated with depression using Chi-squared test of significance (parental rôle dissatisfaction Chi-Sq. 26.18 $p < 0.001$ and marital dissatisfaction Chi-Sq 18.07 $p < 0.001$), two analyses were performed, including these variables separately. A second discriminant analysis was performed using the same variables as above, but substituting marital dissatisfaction for parental dissatisfaction. Results are shown in Table 9 and 10.

**Table 9:** The Strength of Psychosocial and Educational Factors Associated with Maternal Mental Illness

| Variance Entered | Wilks' Lambda | Significance ($x^2$) |
|---|---|---|
| 1. Leisure Dissatisfaction | .91 | .0004 |
| 2. Marital Dissatisfaction | .89 | .0003 |
| 3. Employment Status of Husband | .87 | .0003 |
| 4. Dissatisfaction with Relatives | .85 | .0004 |
| 5. Teachers Child Behaviour Problem Scale Score (B2) | .84 | .0004 |
| 6. Income | .84 | .0007 |

| Canonical Function | Wilks' Lambda | Chi-Squared | D.F. | Sign. |
|---|---|---|---|---|
| .3993 | .8405 | 23.449 | 6 | .0007 |

**Table 10:** Psychosocial Factors differentiating between Mothers with and without Maternal Mental Illness

| | Mothers with Mental Illness |
|---|---|
| Employment Status | -.48 |
| Income | -.25 |
| Dissatisfaction with Income | - |
| Dissatisfaction as a Housewife | - |
| Family Number | - |
| Standard of Living | - |
| Dissatisfaction with Neighbours | - |
| Dissatisfaction with Relatives | .36 |
| Dissatisfaction with Marriage | .41 |
| Dissatisfaction with Leisure | .50 |
| Available Confidant | - |
| Sex of Child | - |
| Teachers Child Behaviour Scale (B2) | .27 |
| Canonical Correlation | .40 |
| Chi-Square | 23.45 |
| P | <.001 |

| | % |
|---|---|
| % classified correctly Maternal Mental Illness | 64 |
| % classified correctly No Maternal Mental Illness | 74 |
| % classified correctly Total | 71 |

An equation based on six variables maximally distinguishes between the two groups. The selection of The Teacher's Child Behaviour Scale (B2) in this case and not in the last equation is explained by the variance explained by this variable being also included in Parental Dissatisfaction. Once Parental Rôle Dissatisfaction is excluded from the included variables the discriminant power of The Teacher's Child Behaviour Scale (B2) increases. This equation is less robust than the previous one, with these six variables explaining 16 per cent of the variance between the two groups, however these variables as predictors of women mental health will correctly classify 71 per cent of cases. The importance of social relationships and income is evident.

## V Discussion

The results of the analysis reported here show that for Irish primary school children, the probability of psychiatric illness is positively associated with low IQ and reading difficulties, large family size, being a boy rather than a girl, and having a mother who is dissatisfied with her marriage and/or her rôle as a housewife. For the mothers of these children, depression is positively associated with having an unemployed husband, and with being dissatisfied with the level of family income, with their relations with their relatives and their neighbours, with the opportunities for leisure, and with their performance in their rôle as a parent. The stress of unemployment, financial difficulties, lack of social support and inadequate leisure opportunities appears to leave mothers prone to depression, which has the effect of undermining their parenting ability and makes it more likely that their children become disturbed.

The fact that children not living with both parents had a very high probability of being disordered highlights the difficulties involved in rearing children as a lone parent. In some cases, the fact that this situation follows on a period of marital disharmony leading to eventual separation is also a factor.

In addition to economic factors, the importance of social networks and interaction with relatives and neighbours for the psychological well-being of the woman is highlighted by the results. A previous study (McGee and Fitzgerald, 1988) showed that it was working class mothers who were more likely to be socially isolated, and the comforting myth of working class cohesiveness, social embeddedness and solidarity needs to be questioned. Particularly for mothers living in recently built local authority housing estates, opportunities for local social interaction may not have fully developed and there may be little sense of neighbourhood identity. It is also noteworthy that while the wives of unemployed men had high rates of depression, for those with husbands in work the level of husband's satisfaction with his employment had no significant association with depression. This suggests that, consistent with the findings of Whelan et al., (1991), it is the impact of unemployment on the family income which is the crucial variable for the wife's mental health.

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# AUDIT OF A CHILD AND FAMILY CENTRE.

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## INTRODUCTION

Interest in child development is by no means new. Yet only recently has the study in children benefited from advances in both clinical and scientific research (Weisz and Weiss, 1993).

There has been little research on the services offered, and in relation to Child Guidance units in particular there is a paucity of resource that presents information in an authoritative, systematic and disseminable fashion. The importance of auditing the services of Child and Family Centres is highlighted when considering McKee's (1989) remark: "When a unit does not know what it is doing, it cannot know whether it is doing it well".

The aim of this study is to redress the lack of research in describing the work of Child and Family Centres by reporting the audit of a clinic set in a Dublin rural area. This audit relates to both the referred cases and the staff's involvement with these cases.

## METHOD

The study focused on 52 consecutive referrals who had no previous contact with the Child and Family Centre, but may have had contact with other psychiatric services. Mothers of children referred to this clinic were interviewed at their homes about a week before their first appointment, and again 3-4 months later, irrespective of whether they have attended the centre, were still attending the centre, or have finished treatment. The pre-treatment interview investigated the mothers' attitudes and expectations towards treatment by administrating the First Interview Questionnaire. The questionnaire was designed and employed in a previous study investigating families expectations of a child and family centre (Fitzgerald and Keenan, 1991). The questionnaire is made of 28 open-ended questions probing into the following issues: referral source; information received from the referrer; expectations and fears about attending the child and family centre; type and length of treatment expected; stigma of attending a child and family centre; and length of time between referral and assessment at the child and family centre. The second interview investigated the mothers impressions of the service by administering the Health Visitor Questionnaire (Nicoll et al, 1986). The questionnaire explores various aspects of treatment such as: overall usefulness of the treatment; the mothers' coping with her child, her family, and herself; satisfaction with the type and amount of advice received; the mothers' handling of the therapy sessions; satisfaction with the frequency of visits.

The staff's involvement with these cases was audited over this 3-4 months period, in terms of time spent with these cases and also in terms of financial cost. The staff filled

time sheets for each case they were involved with, noting type of activity and the time they spent on each activity down to the nearest 15 minutes. The various activities noted were: assessment, individual therapy, family therapy, home visits, waiting time when clients did not attend their appointments, and administrative work which included phone calls, writing letters, and discussions of the cases. The staff were reminded to fill their time sheets two times a week on a regular basis. In calculating the cost of each case the salary of each member of staff was calculated per minute (to the nearest 6 digits) and multiplied by the time spent on each particular case. It should be stressed here that the resulting figures do not reflect the overall cost of these cases as they do not include the cost of the overheads. Also note that 22 clients were still attending four months after their first appointment.

### Setting

This child and family centre accepts self-referrals, unlike other clinics which require self-referrals to be referred by general practitioners. The staff that were involved with the referred cases included: 1 Consultant Child Psychiatrist, two non-consultant hospital doctors, two social workers, and one speech therapist. In some cases more than one member of staff was involved. The clinic has no inclinations to any particular forms of therapy or school of thought, but rather aims at a broad mode of family therapy which encompasses individual therapy. The Child and Family Centre was situated in a disadvantaged area with high unemployment rates. A high percentage of the clients were in houses that were Corporation owned and in an area of high housing density.

### Sample

As more than half of the mothers of the referred children were single mothers, the study focused only on the mothers as a source of information on the referred children. Out of the 52 referred children the number of boys referred (35 = 67%) was slightly more than double the number of girls referred (17 = 33%). The average age of children was 9, with ages ranging from 3 to 16 years of age. The average age of the mothers was 36, with ages ranging from 25 to 49 years of age.

## RESULTS OF CHARACTERISTICS

### Attendance outcome

The attendance outcome for the 52 cases was as follows; 22 cases (42%) were still attending at the time of the second interview (3-4 months after first interview), 22 cases (42%) were discharged at the time of the second interview, 2 (4%) cases had dropped out of treatment, and 6 cases (12%) did not attend any of their appointments. Table 1 shows the attendance outcome for the 52 cases.

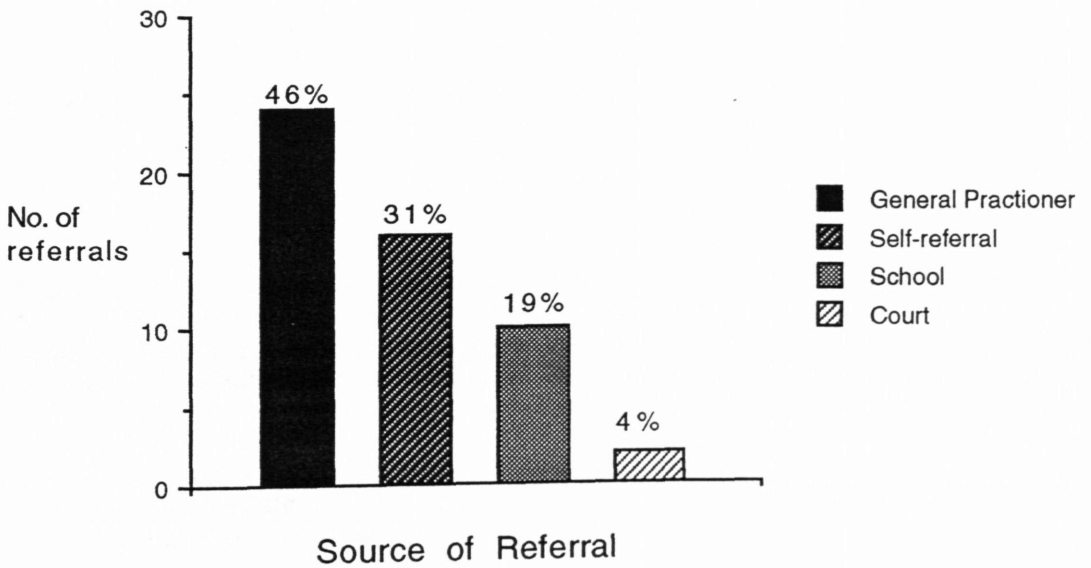
### Referring agencies

The biggest group referring were general practitioners who accounted for 46% of all referrals (24 families), followed by 31% (16 families) of self referrals, followed by school referrals accounted for 19% (10 families) of all referrals, followed by 2 court related cases (4%). Figure 1 shows the rate of referrals for this sample.

**Table 1. Attendance Outcome**

| | No. of cases | Percentage |
|---|---|---|
| Attending (after 3-4 months) | 22 | 42% |
| Discharged | 22 | 42% |
| Dropped out | 2 | 4% |
| Did not attend | 6 | 12% |

**Figure 1. Patterns of referrals**




## Attitudes and expectations towards treatment

The interviewer paid home visits to mothers of 52 consecutive referrals to the Child and Family Centre. The response rate to this questionnaire was 100%.

## Information received from the referrer

66% of the mothers received no information about the Child and Family Centre, while 31% said they were briefed about the clinic. Of the mothers that were doctor-referred (about half the sample), 80% said that they had received no information on the service.

### Children's' feelings about attendance

45% of the children were not told of the appointment at the time of the interview (the interviews were conducted 3-7 days prior to appointment). Of the children who were told about their appointment 41% were unhappy about the visit to the centre, 8% thought it was similar to a mental hospital, and 8% thought it was a place for punishment.

### Parents' feelings about attendance

When the mothers were asked whether they were upset or resentful about attendance, only 21% answered "Yes". 34% of the mothers felt that they have let themselves down as parents.

28% of the mothers saw the problem as being the child's while 72% saw the problem as being the family's.

30% of the mothers' partners were unhappy about the visit to the centre, while the remaining 70% had no objections.

### Receptivity to treatment

95% of the mothers thought that the clinic would advise better than a 'parent or a grandmother', while 4% did not hold that view.

When asked whether they thought the clinic will help, 63% of the mothers answered "Yes", 30% were 'hopeful', and 6% said "No".

### Expectations about attendance and treatment

77% of the mothers had no information on the clinic; 14% had a positive view, 11% had negative views, and 74% of the mothers had realistic expectations about the service. 85% of the mothers imagined the treatment would involve some form of "talking", while 15% had no idea what the treatment might involve. 95% of the mothers did not think that the centre would use any medication.

69% had no ideas about length of treatment, 14% of the mothers thought the treatment would take 1 month, 7% thought it would take about 3 months, and 7% thought it would take more than six months. One mother expected one visit would suffice as it was related to court procedures.

When the mothers were asked who they would see at the clinic, 34% responded "I don't know", 30% said "A doctor", 8% said "A psychiatrist", and 27% said "A psychologist".

When the mothers were asked what did they expect from the clinic regarding the child's problem, 4% answered "Assessment", 8% answered "I don't know", and 87% had general positive remarks ("help the child", "sort him/her out" etc.).

### Stigma about attending the clinic

12% of the mothers said that they would not tell family or friends that they are attending the clinic, while 87% said that they would.

### Time between wish for help and asking for an appointment

25% of the mothers said that they have requested an appointment within 1 week of wishing for help, 28% requested their appointments within 3 weeks, 25% within 1 month, 14% within 2 months, and 6% within 3 months or more.

### Expectations about waiting time at the clinic

When asked how long the mothers expected to wait at the clinic before they were seen, 42% said that they would be seen immediately, 35% said "I don't know", 19% thought that they would wait for an hour, and 3% thought that they would wait for about three hours. (In this centre clients are seen immediately, with rare exceptions).

### Preferences about therapy

33% of the mothers said that they would prefer to be seen alone, 60% preferred to be seen with the child, and 6% preferred to be seen with the whole family.

When asked weather the mothers had a preference to seeing a male or a female doctor, 87% had no preferences. Of the 5 cases that did have a preference, 4 preferred a female doctor and 1 preferred a male doctor. 1 mother gave no reason for her preference and the remaining 4 had reasons specific to the case (e.g. girl abused by male, or boy relating more to a male doctor).

### Convenience in attending the centre

When the mothers were asked whether they had to make any special arrangements in order to attend the centre, 82% said that they did not have to make any special arrangements, while 17% said that they did have to make arrangements (hiring a baby-sitter, taking time off work etc.).

### Efficiency of appointments

10% of the mothers said that they have received an appointment within 5 days of requesting an appointment, 49% received their appointments between 6 to 10 days, 23% between 10 days and 2 weeks, 4% between 2 and 3 weeks, and 13% between 3 weeks and 1 month.

10% of the mothers said that they would like 5 days notice, 80% said that they would like 1 week notice, and 10% said that they would like 10 days notice.

### Satisfaction with the service

For this questionnaire statements about treatment they received were read out to the mothers and they responded "Yes", "Possibly", "No", or "Not applicable (N/A)". Although some questions were straight forward in that one would not expect a "Not applicable" response, in some cases, the mothers felt that their children were referred for a 'report' rather than for treatment.

### Improving coping with the child

More than 50% of the mothers felt that the visits had improved their coping with their childrens' problems. However, more than 10% of the mothers felt that this issue was not applicable to their cases as they did not perceive that they needed help in this area.

### Improving coping with the family

Mothers who felt that the visits were useful for the family as a group was no more than 20% of all the mothers. About 65% of the mothers felt that they did not need help in that area.

### Benefit by the mother

25% of the mothers thought that the visits helped them and 29% thought that the visits helped them to 'understand their own reactions to things better'. Many of the mothers felt that the issue was not applicable to themselves.

### Usefulness of treatment

70% of the mothers thought that 'it helped to have someone to talk to', 48% of the mothers thought that the 'meetings were useful to them in seeing that other people may have similar difficulties'. A small percentage of the mothers felt that the visits were not useful (20%) and were a waste of time (11%).

### Overall benefit

77% of the mothers found the visits 'helpful on the whole', 13% didn't agree, and 9% answered "Possibly" (no mothers answered "N/A").

### Satisfaction with the therapy process

84% of the mothers found it 'very easy to talk to the social worker/doctor'. Only a small percentage of the mothers (16%) thought 'too many questions were asked' and 16% found it 'difficult to see the point of some of the things brought up'. And 10% thought that 'other family members should have had a chance to join in the discussions'.

### Wanting more advice

41% of the mothers 'would have liked more advice', and 32% of the mothers 'would like to have been told more about handling their children'.

### Handling therapy

18% of the mothers 'felt upset after the discussions', and 20% of the mothers 'worried about what had been discussed'.

### Frequency of visits

25% of the mothers felt that there not enough visits and only 4% of the mothers thought that 'fewer visits would have been more useful .

Table 2 shows the questions as asked to the mothers of the referred children along with the breakdown of responses.

## Table 2 Satisfaction with the service:

| | | | | |
|---|---|---|---|---|
| **Improved coping with child:** | | | | |
| It helped me to think of ways to cope with my child. | No 27% | Possibly 4% | Yes 57% | N/A 11% |
| It helped me to think of ways to understand my child more. | No 30% | Possibly 2% | Yes 54% | N/A 14% |
| It helped me to think of ways to cope with behaviour difficulties in my child. | No 27% | Possibly 9% | Yes 46% | N/A 18% |
| It helped me to understand my child better. | No 36% | Possibly 19% | Yes 36% | N/A 9% |
| It helped me to think of ways to cope with my child's sleep or eating problems. | No 11% | Possibly 2% | Yes 14% | N/A 73% |
| **Improved coping with family:** | | | | |
| It helped me to understand things about the whole family. | No 18% | Possibly 2% | Yes 21% | N/A 59% |
| The meetings were useful to us as a family group. | No 14% | Possibly 4% | Yes 9% | N/A 73% |
| **Benefit by mother:** | | | | |
| It helped me to understand myself more than before. | No 14% | Possibly 4% | Yes 25% | N/A 57% |
| It helped me to understand my own reactions to things better. | No 32% | Possibly 7% | Yes 29% | N/A 32% |
| **Usefulness of treatment:** | | | | |
| It was just talk and not really useful. | No 66% | Possibly 11% | Yes 21% | N/A 2% |
| It helped me to have someone to talk to. | No 20% | Possibly 5% | Yes 70% | N/A 5% |
| Discussions like that are just a waste of time. | No 77% | Possibly 9% | Yes 12% | N/A 2% |
| The meetings were useful to me in seeing that other people may have similar difficulties to me. | No 25% | Possibly 11% | Yes 48% | N/A 16% |

**Overall benefit:**

| | No | Possibly | Yes | N/A |
|---|---|---|---|---|
| I found it helpful on the whole. | 14% | 9% | 77% | 0% |

**Satisfaction with the therapy process:**

| | No | Possibly | Yes | N/A |
|---|---|---|---|---|
| Too many questions were asked. | 75% | 5% | 16% | 4% |
| It was difficult to see the point of some of the things brought up. | 70% | 7% | 16% | 7% |
| Other family members should have had a chance to join in the discussions. | 34% | 2% | 10% | 54% |
| It was very easy to talk to the worker (social worker or health visitor). | 7% | 7% | 84% | 2% |

**Wanting more advice:**

| | No | Possibly | Yes | N/A |
|---|---|---|---|---|
| I would have liked more advice. | 50% | 2% | 41% | 7% |
| I would like to have been told more about handling my children. | 43% | 16% | 32% | 9% |

**Handling therapy:**

| | No | Possibly | Yes | N/A |
|---|---|---|---|---|
| I sometimes felt upset after the discussions. | 77% | 4% | 18% | 0% |
| I worried over what had been discussed. | 73% | 5% | 20% | 2% |

**Frequency of visits:**

| | No | Possibly | Yes | N/A |
|---|---|---|---|---|
| There were not enough visits to be really useful. | 52% | 14% | 25% | 9% |
| Fewer visits would have been better. | 89% | 2% | 5% | 4% |
| The visits would have been more useful if they had been more frequent. | 55% | 13% | 25% | 7% |

**Convenience of visits:**

| | No | Possibly | Yes | N/A |
|---|---|---|---|---|
| I found the visits inconvenient. | 84% | 5% | 9% | 2% |

### Staff audit

Of the fifty two cases, six patients did not attend any of their appointments and of the 46 attenders two time sheets could not be located. The following is a breakdown of the types of activities the staff were involved in along with their costs.

### Case assessment

The average time spent on assessment per case was 80 minutes averaging to £20.42. The minimum time spent on assessment was 20 minutes costing £7.20. The maximum time spent on assessment was 2 hours costing £63.29. All 44 cases were assessed.

### Individual therapy

Of the 44 cases 25 had individual therapy. The average time of individual therapy for each case was 1 hour and 56 minutes averaging to £24.64. The minimum time per minute for the cases was 10 minutes averaging to £1.84. The maximum time was 3 hours and 45 minutes averaging to £63.29.

### Family therapy

Of the 44 cases 19 received family therapy. The average time of family therapy was 1 hour 34 minutes averaging to £27.81. The minimum family therapy received was 30 minutes costing £5.53. The maximum family therapy received was 3 hours 5 minutes.

### Home visits

Only four cases received home visits. The average time was 1 hour 33 minutes costing £28.57. The minimum received was 1 hour costing £23.42 while the maximum was 3 hours costing £38.62. These costs include travel expenses.

### Administrative work

Administrative work was recorded for 28 of the 44 cases. The average time spent was 34 minutes costing £9.65. The minimum time spent was 5 minutes costing £.87 while the maximum time was 2 hours 40 minutes.

### Non-attendance wasted time

Of the 44 cases 10 clients missed one or more appointments. The average cost was £34.28 (1 hour 42 minutes). The minimum cost was £10.54 (1 hour), while the maximum cost was £158 (3 hours 20 minutes).

Table 3 shows the type of activity the staff were involved in along with the number of cases receiving these activities, and the average, minimum and maximum time spent by staff and their cost.

### Overall costs

The sum of attendance for all the cases was 142. The overall cost for these cases was £2719.33 averaging £19.15 for one appointment. The average cost per case was

£61.79 (4 hours 1 minute of staff time). The minimum cost was £9.01 (25 minutes), while the maximum cost was £268.98 (10 hours 5 minutes).

As mentioned earlier these figures do not take into account the cost of the overheads as this report is more concerned with looking at the breakdown of activities of the staff. However, if we do take into account the budget out turn for this Child and Family Centre for the year 1991 (£285,824) along with the number of attendances for that year (5625), then the average cost per attendance is £50.81.

## Activities of the staff

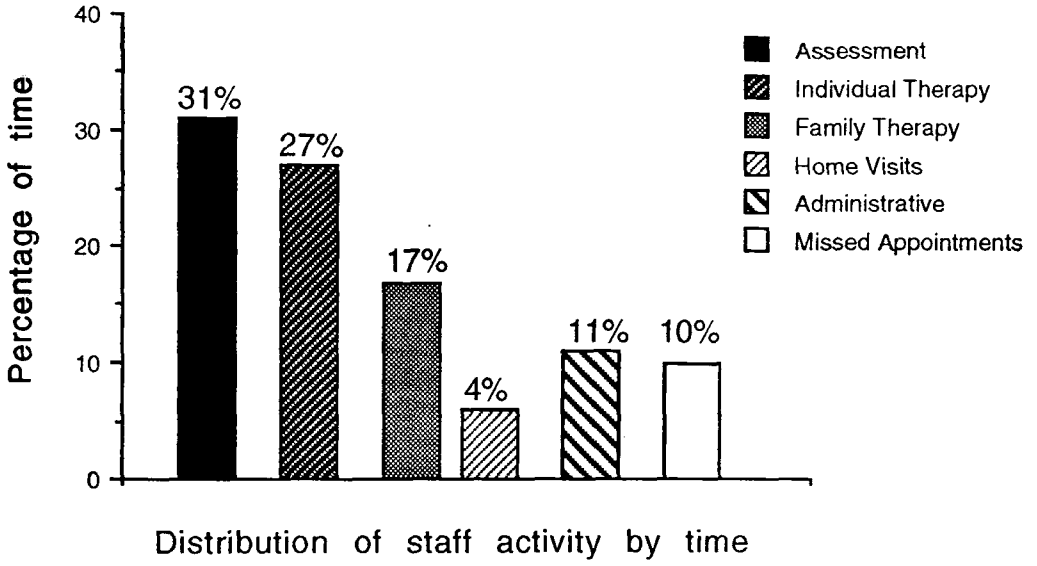
The breakdown of the staff's activities is as follows; the staff spend 31.34 % of their time on patient assessment, 27.30 % of their time on individual therapy, 16.82% of their time on family therapy, 3.52 % of their time on home visits, 11.41% of their time on administrative work, and 9.58 % of their time waiting for clients who do not attend their appointments.

Figure 2 shows the distribution of the staff's activities.

**Table 3. Breakdown of staff activity by time and cost**

| Type of activity | No. of cases | Ave./ minutes | Ave. cost | Min./ minute | Min. cost | Max./ minute | Max. cost |
|---|---|---|---|---|---|---|---|
| Case Assess. | 44 | 80 | £20.42 | 20 | £7.20 | 120 | £63.29 |
| Ind. Th. | 25 | 116 | £24.64 | 10 | £1.84 | 285 | £63.29 |
| Fam. Th | 19 | 94 | £27.81 | 30 | £5.53 | 245 | £75.68 |
| H.V. | 4 | 93 | £25.87 | 60 | £21.62 | 180 | £33.22 |
| Admin. | 28 | 43 | £9.65 | 5 | £0.87 | 160 | £48.65 |
| D.N.A. | 10 | 102 | £34.28 | 60 | £10.54 | 300 | £158.2 |

**Figure 2. Distribution of staff activity by time.**



## DISCUSSION

The results of the first interview are similar to those of Fitzgerald and Keenan (1991) who administered the same questionnaire to 46 consecutive referrals to the same Child and Family Centre. The two samples are similar with regard to: the amount of information received from the referrer, childrens' feelings about attending the clinic, length of time between referral and attendance at the Child and Family centre, and expectations of family versus individual assessment. One difference worth mentioning is that 87% of the mothers in this study were willing to tell their family or friends that they had attended a Child and Family Centre in comparison to 61% of the mothers in Fitzgerald and Keenan's study. At this point it is difficult to know whether this difference is a reflection of a genuine decrease in stigma in the community where the centre is situated.

About half of the mothers were doctor-referred. Of these cases 80% claimed that they have received no information on the service they were about to receive. While it would be difficult to confirm the validity of the mothers' responses, Ley and Spelman (1967) have shown that patients remember relatively little of their interview with a doctor, and it is possible that reports merely reflect a failure in retention of information. However, other research does not favour such explanations as Skuse (1975) suggested that general practitioners do not sufficiently prepare their patients for the psychiatric appointment they are arranging.

Overall, more than 70% of the mothers had no information on the service and did not know what to expect with regard to several aspects of the treatment, such as type of treatment or length of treatment. This number is very high considering the research that relates parents' expectations and attitudes towards the therapeutic process to treatment outcome. How an individual perceives the agencies created to help deal with problems is one very important element in the complex social process of seeking help (Morris et al., 1973). Overall and Aaronson (1964) found that clients whose expectations are less accurate are less likely to return and that such clients are less likely to be satisfied by the treatment received. It has been found that referrers may be able to influence clients' expectations of the clinic. A positive source of referral increases the confidence of the clients in the agency (Rosenfeld, 1964).

It is obvious from this study that there is a need for pre-treatment preparation of patients. It has been shown that the majority of patient preparation techniques do significantly improve the mental health of of the referred patients (Heitler, 1973). One approach would be for a social worker to visit the family after the referral has been made, and for the treatment preparation to be done in the home prior to the family attending the clinic. While this approach has the disadvantage of being time-consuming, and thus expensive, it saves waiting time for cases of non-attendance as the visitor can report to the centre whether or not the family will be attending their first appointment as many of the homes do not have a telephone.

### Satisfaction with the service

The majority of the mothers (77%) were satisfied with the service as a whole and recognised its usefulness (70%). 80% of mothers also reported satisfaction with issues related to the therapy process, such as finding it easy to talk to the therapist. These figures are consistent with the generally favourable results of previous client evaluation research (Denner & Halprin, 1974; Goyne and Ladoux, 1973; Heinemann and Yudin, 1974). However, although it seems that mothers were generally satisfied with the service, a closer examination of their responses reveals a more complex picture.

When mothers were asked whether they would have liked to have been told more about managing their children, 43% chose a "No" response. It is difficult to know whether

this result reflects the mothers' satisfaction with the advice they have received or that the mothers felt that they did not need advice in handling their children. Not all the mothers reported that they needed help in dealing with their children, as some of the mothers were apprehensive about the referral. For example, for two of the court referral cases, the children were referred to the centre for assessment. Both cases attended the centre more than once, but in both referrals the mothers did not think that their children needed help or that the mothers themselves needed help in dealing with their children. This point applies to other type of referrals as 11% of the mothers thought that the issue of needing help in dealing with their children was not applicable to themselves. Mothers who did not think that they needed the service in the first place are probably likely to be indifferent in their reporting about the quality of the service. The point to make here is that in assessing the quality of the service, it would be advisable to separate mothers who wanted help about managing their children from mothers who did not think they needed the service in the first place.

As pointed out earlier, this sample had very little information on the service they were about to receive. Considering the research that have found that clients whose expectations are less accurate are less likely to return and that such clients are less likely to be satisfied by the treatment received (Overall and Aaronson, 1964), this sample had very low attrition rates and generally high satisfaction with the service.

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# A Consumer Satisfaction Study Conducted in a Paediatric Outpatients in Hospital in The Republic of Ireland in 1990.

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A consumer satisfaction questionnaire was made available to a representative sample of patients booked into OPD over the course of a week. The questions focussed both on the waiting time for the appointment, waiting time in the OPD, and satisfaction with all aspects of the OPD and hospital departments including x-ray, laboratory and physiotherapy.

In the course of one week 447 patients were booked into OPD. 319 patients attended for their appointment. 140 questionnaires were distributed and 115 were completed.

13 patients were attending OPD for the first time. 101 patients were repeat attenders. The average waiting time was 25 minutes between the appointment and first being attended to. The average time between first being attended to and leaving the OPD was 24 minutes. 82% of parents were happy with OPD arrangements. 84% of parents were satisfied with the information they got on their childs condition.

The process of conducting the consumer satisfaction study brought immediate benefits for the patients by bringing about changes which they had indicated that they wished. It helped each member of the staff to focus on perception of the families attending OPD. This lead to intense staff discussions about improving the service. It is the kind of consumer study that needs to be repeated at intervals in all paediatric outpatients and indeed it appears from this study that simply the process of conducting the study actually helps to bring about improvements.

# CONSUMPTION OF ALCOHOL AND DRUGS IN MOTHERS OF CHILDREN ATTENDING A CHILD PSYCHIATRIC CLINIC.

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HANNAH MCGEE.

## SUMMARY

Maternal and child alcohol and drug consumption was examined in thirty consecutive families attending a child psychiatric clinic. Seventeen percent of mothers were problem drinkers by the MAST classification. Thirteen percent of mothers were taking benzodiazepines daily while a further 7% were taking those drugs on an irregular basis.

## INTRODUCTION

Alcohol and drug use are of particular concern in the context of the young family. Foetal alcohol syndrome [1,2] and cognitive impairment in children of alcoholic mothers has been described [3]. Maternal alcoholism has been related to conduct disorder in children while maternal depression and paternal alcoholism is related to the risk of depression in the child [4]. Reports that 16% of 15 year old boys claim to have drunk over twenty-five units of alcohol in the previous week are most alarming [5].

## METHODS

Thirty mothers and their children, consecutive attenders of an urban child psychiatric clinic were studied. Confidentiality was assured to mothers and their children who were interviewed separately. Mothers were asked to complete the Michigan Alcoholism Screening Test (MAST) questionnaire [6]. This is a twenty-five item questionnaire with scores from 0-25 with a scale >4 indicating problem drinking and a questionnaire pertaining to drug consumption over the previous month. (See Appendix I). Drugs were divided into three classes:

(i) Prescribed drugs e.g. antibiotics, oral contraceptives.

(ii) Over the counter preparations such as vitamins, and

(iii) Tranquillizers whether used or abused were classified separately.

Other variables recorded were:

(a) Age of child,

(b) Social class of family [7],

(c) Marital status of mother, and

(d) Number of children in the family.

Thirty children aged 5-16 years, who following clinical assessment by a child psychiatrist were categorized using the ICD 9 classification system (see Table I), completed a questionnaire [8] pertaining to smoking habits and alcohol and drug consumption. Children under 10 years were questioned by the interviewer - a psychiatric registrar. Older children completed the questionnaire themselves. The Rutter $B_{(2)}$ [9] a childrens behavioural questionnaire for completion by teachers, was requested by post from the teachers of the thirty children.

**Table I**

**Diagnostic Category of Children.**

| Diagnostic Category | Number of Children |
|---|---|
| Conduct disorder (312-1) | 14 |
| Adjustment Reaction (309) | 9 |
| Borderline mental handicap (317) | 2 |
| Anxiety disorder (313-8) | 1 |
| No psychiatric disorder | 4 |

## RESULTS

Four mothers scored at borderline or above on the MAST. Four mothers reported using benzodiazepines on a daily basis and 2 mothers used these drugs on an irregular basis. Fifteen of the mothers smoked cigarettes daily.

Mean age of the children was 9 years with a standard deviation of 3 years.

Twenty per cent of the children in this study admitted to smoking on at least one occasion. Ten percent drank alcohol at least once and 6% admitted to abusing drugs occasionally. The consumption of alcohol, drugs and cigarettes in children in this study was compared with that of a previous Irish study [8] of post primary children aged approximately 13 years. (See Table II).

**Table II**

Cigarette smoking. Consumption of alcohol and drugs by children in this study compared with results of an Irish urban study of 13 year old children carried out by the Economic & Social Research Institute in 1986.

| Behaviour | This study | ESRI study |
|---|---|---|
| Smoking (at least once) | 20% | 32% |
| Drinking (occasionally) | 10% | 45% |
| Drug Abuse | 6% | 8% |

The social class of the families was classified on the basis of parental occupation and the majority of families came from social class V and VI.

Almost 73% of the mothers were currently married. (See Table III).

## Table III

### Marital status of mother

| Number of mothers | Marital status |
|---|---|
| Married | 22 |
| Widowed | 2 |
| Single | 3 |
| Separated | 2 |
| Single but living with partner for at least the past year | 1 |

The mean number of children in the family was 3 with a standard deviation of 2.2. Sixty percent of the Rutter $B_{(2)}$ scales were completed by teachers and returned. Of the 20 Rutter Scales that were returned there was a high concordance with the ICD 9 diagnosis and the Rutter Scale classification of the behavioural disorder. See Table IV. Of eleven children diagnosed as suffering from a conduct disorder all scored positively on the Rutter Scale $B_{(2)}$ with 10 scores indicating an anti-social behavioural disorder and the remaining score indicating an undifferentiated behavioural disorder.

No statistically significant correlations were found between the variables using chi-squared tests i.e. in this study no direct correlation was shown between behavioural disorders in children and maternal alcohol and drug consumption. (See Table IV).

## Table IV

### Statistical relationship between the variables.

(i) Demographic details

| | |
|---|---|
| MAST score and number of children | x + 2.57 (ns) |
| MAST score and marital status | x - .10 (ns) |
| MAST score and age of children | person correlation + 0.11 (ns) |
| Rutter score and age of children | correlation + 0.46 (ns) |

(ii) Data Test scores

| | |
|---|---|
| MAST and Rutter score | correlation + 0.243 x + 0.97 (ns) |
| Rutter score and maternal use of tranquillizers | n = -.339 (ns) |
| MAST and tranquillizer use | n + 0.208 (ns) |

## DISCUSSION

The fact that 17% of mothers experienced problem drinking is significant. A study of general practice attenders using the CAGE which is a more sensitive instrument than the MAST found that the prevalence of problem drinking in women was 1.3% (10). The results of this study would imply that mothers of children attending a child psychiatric clinic have a very high prevalence of problem drinking.

Results from the children's questionnaire indicate that the prevalence of cigarette smoking, alcohol although not drug consumption are low especially when compared with the ESRI study. This may be because the children in this study were younger. Also the figures may be an underestimate as children may not have been convinced of confidentiality of the interview knowing that the interviewer would meet the mother alone subsequently. The children in the larger study completed the questionnaires anonymously at school.

The fact that no significant correlations could be drawn between the variables in this study may well be due to the relatively small numbers. Also the MAST may not be sensitive enough to detect more graded forms of excessive drinking. Another possibility is the relatively homogenous nature of the sample; all families were by definition problem families with referrals to a Child Psychiatric Clinic. Relationships between maternal and child substance abuse may be more apparent if the issue were examined in community samples.

In view of the findings of the relatively high level of problem drinking in mothers the authors suggest that questions pertaining to parental alcohol and drug consumption be asked routinely at assessment. Thus parents who have problems can be identified and referred for appropriate treatment. This would be an essential part of the overall therapy for the child.

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## Appendix One

### Questionnaire Pertaining to Drug Consumption in Mothers

How often have you used each of the following:

(1) Aspirin or other headache medications

(2) Aids for stomach or digestion problems

(3) Laxatives

(4) Cough, cold or sinus medicine

0. Never
1. Once weekly
2. Once-twice weekly
3. 3-4 times weekly
4. Daily

(5) Medication to pep you up or keep you going

(6) Medication to calm you down (tranquillizers)

(7) Antibiotics

(8) Medication for blood pressure or heart problems

(9) Vitamins, toxics or other dietary supplements

(10) Other prescription medicines

(11) Oral contraceptives

(12) Illicit drugs

(13) Other non-prescribed medicines or drugs

(14) Cigarettes

| Class | | | |
|---|---|---|---|
| | (1) | Prescribed Drugs | 7, 8, 10, 11. |
| | (11) | Over the Counter Preparations | 1, 2, 3, 4, 5, 9. |
| | (111) | Tranquillizers | 6. |

# CHILD PSYCHIATRIC IN-PATIENT TREATMENT IN DENMARK, FINLAND, IRELAND AND SWITZERLAND.

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## INTRODUCTION

Because our knowledge on the content of child psychiatric in-patient treatment are relatively poor, an epidemiological point-prevalence study on this issue was carried out in Finland in the beginning of 1988. The study was replicated with the same methodology in the autumn in Norway. The results of the comparison between Finland and Norway were interesting: there were many similarities in the child psychiatric practices in these countries, but clear dissimilarities, too. This comparison inspired the curiosity to extend the scope to some other countries, too.

The aims of this multinational epidemiological point-prevalence study are:

(1) To collect the basic knowledge concerning child psychiatric in-patient treatment in Denmark, Finland, Ireland, and Switzerland by exploring the treatment methods used, and by analysing the relationships between different kinds of treatment modes, and

(2) To compare the child psychiatric in-patient practices between these four countries.

## PROCEDURE

The study includes 10 child psychiatric in-patient units (representing 198 beds) in Denmark, 19 units (272 beds) in Finland, 4 units (55 beds) in Ireland, and 5 units (62 beds) in Switzerland. In Switzerland only a part of child psychiatric hospitals took part in the study, in the other countries the study covers all beds available for child psychiatric in-patient treatment.

Data on psychiatric treatment modes and psychic condition of child patients were collected by means of a questionnaire during the late spring in 1990 and 192 patients in Denmark, 240 patients in Finland, 50 patients in Ireland, and 46 patients in Switzerland.

The diagnoses (ICD-9) used in the study were done in the everyday routine of the hospitals. In Switzerland DSM-III-R classification was applied in some hospitals, these diagnoses have been omitted in this report (totalling 24 patients out of 46). As a consequence of that the diagnostic distribution of Switzerland is not representative.

## RESULTS

The sex structure of patients varied significantly. The proportion of boys was largest in Finland (78%), and smallest in Switzerland (52%). Denmark (62%) and Ireland (69%) were in between.

In the age structure there were also considerable variations. The mean age of all patients was nearly the same in Denmark and in Finland (10.0 and 10.7 years). The

same was true concerning Ireland and Switzerland but the patients were on average 3 years older (13.1 and 13.4 years).

In Ireland and in Switzerland over half of the boys were older than 12 years. In Finland more than half of the boys were between 8 and 12 years, and in Denmark the small boys (below 8 years) was the largest group, more than one third.

In each country the group of young adolescent girls was the most prominent one but in spite of that the differences between the countries were remarkable: Finland 40%, Denmark 50%, Switzerland 75%, and Ireland even 93%. In Ireland and in Switzerland all hospitalized girls were older than 8 years.

**Table 1. The diagnostic groups (ICD 9) of child psychiatric in-patients in Denmark, Finland, Ireland, and Switzerland (%) (24 Swiss patients with DSM-III-R diagnoses have been omitted).**

| Diagnostic group (ICD 9) | DEN | FIN | IRL | SWI |
|---|---|---|---|---|
| Autism (299) | 14 | 11 | 36 | 5 |
| Other psychoses (295 - 298) | 3 | 3 | 8 | 5 |
| Personality disorders (301, 3138C) | 5 | 1 | -- | -- |
| Conduct disorders (304, 312) | 14 | 6 | 38 | 18 |
| Emotional disorders (300, 307, 313 except 3138C) | 41 | 29 | 6 | 45 |
| Adjustment disorders (309) | 7 | 37 | -- | 23 |
| Attention deficit / Hyperkinetic disorder (314) | 7 | 2 | 4 | 5 |
| Other diagnoses | 10 | 10 | 8 | -- |
| Not known | -- | 1 | -- | -- |
| Number of patients | 192 | 240 | 50 | 22 |

In the diagnostic distribution there were striking differences between the four countries (Table 1). In Ireland the most important diagnostic groups were conduct disorders (35%) and autism (35%). The proportions were in the other countries considerably lower (respectively 6-18%, and 5-14%). Emotional disorders was the largest diagnostic group both in Switzerland (45%) and in Denmark (41%); in Finland it was the second largest (29%), and in Ireland the second smallest group (6%). In Finland the most prominent diagnostic group was adjustment disorders (37%), in Switzerland it was the second largest group (23%). In Denmark only 7% and in Ireland none of the patients were hospitalized due to these disorders. The proportions of attention deficit and hyperkinetic disorders (2-7%), and psychoses (3-8%) were almost the same in each country.

The planned duration of hospitalization was shortest in Denmark (mean 8 months). In Finland and in Switzerland the patients were expected to stay in hospital about one year (12, and 13 months). The nature of hospitalization was clearly different in Ireland, the mean planned duration being four years.

**Table 2. The applied treatment modes in child psychiatric hospitals in Denmark, Finland, Ireland, and Switzerland (%).**

| Treatment mode (Number of patients) | DEN (192) | FIN (240) | IRL (50) | SWI (46) |
|---|---|---|---|---|
| Primary caretaker | 99 | 96 | 16 | 67 |
| Parental guidance | 86 | 67 | 86 | 67 |
| Special education | 67 | 63 | 80 | 30 |
| Individual psychotherapy | 34 | 35 | 50 | 87 |
| Family therapy | 30 | 40 | 26 | 48 |
| ADL-training | 27 | 19 | 44 | 7 |
| S-I-therapy | 21 | 0 | 6 | 7 |
| Parental couple therapy | 18 | 8 | 8 | 7 |
| Speech therapy | 17 | 5 | 24 | 28 |
| Holding therapy | 14 | 6 | 10 | 2 |
| Individual psychotherapy of parent (s) | 11 | 7 | 4 | 17 |
| Group psychotherapy | 10 | 3 | 2 | 28 |
| Non-verbal group therapy | 5 | 31 | 54 | 37 |
| Non-verbal individual therapy | 5 | 16 | 16 | 37 |
| Treatment modes/patient | 4.6 | 4.1 | 4.5 | 4.8 |

The applied treatment methods resembled very much each others in Denmark, Finland, and Switzerland (Table 2). Primary care taker, parental guidance and special education with individual psychotherapy and family therapy formed the proper core of the treatment plan. In Ireland parental guidance, individual psychotherapy, and special education were also frequently used but with psychotropic medication, non-verbal group therapy and ADL-training. The use of all the other treatment modes was less frequent.

**Table 3. Prevalence of psychopharmacotherapies in child psychiatric hospitals in Denmark, Finland, Ireland, and Switzerland (%).**

| (Number of patients) | DEN (192) | FIN (240) | IRL (50) | SWI (46) |
|---|---|---|---|---|
| No medication | 92 | 83 | 44 | 72 |
| Medication | 8 | 17 | 56 | 28 |
| With one drug | 7 | 12 | 32 | 20 |
| With two drugs | -- | 3 | 16 | 4 |
| With three to five drugs | 0.5 | 2 | 8 | 4 |
| Regular medication | 7 | 13 | 44 | 24 |
| Medication as required | 2 | 8 | 20 | 11 |
| Acute medication | -- | -- | 2 | -- |

Chi-square: medication no/yes $p < 0.001$

The prevalence of medication varied enormously. It was lowest in Denmark (8%), and highest in Ireland (56%); the figures were in Finland 17% and in Switzerland 28% (Table 3). In Finland 5% and in Switzerland 9% of the patients were treated with 2 to 3 drugs, and in Ireland 24% with 2 to 5 drugs at the same time. In Denmark there were only one patient medicated with 3 drugs. Most of the drug prescriptions were regular, continuous medications.

**Table 4. Number of patients medicated with different types of drugs (first and secondary drug prescriptions, as regular, as required and/or as acute medication) in child psychiatric in-patient treatment in Denmark, Finland, Ireland, and Switzerland (% of medicated patients).**

| Drug group (Number of patients) | DEN (15) | FIN (41) | IRL (28) | SWI (13) |
|---|---|---|---|---|
| Neuroleptics | 27 | 63 | 71 | 69 |
| Psychostimulants | 27 | -- | -- | 23 |
| Antiepileptics | 27 | 12 | 18 | -- |
| Anxiolytics, hypnotics, sedatives | 14 | 22 | 29 | 15 |
| Antidepressants | 7 | 22 | 18 | 15 |
| Miscellaneous | 7 | -- | -- | -- |
| Prevalence of medicated patients | 8 | 17 | 56 | 28 |

In each country neuroleptics were the most frequently used drug group, from 27% (Denmark) to 71% (Ireland) of the medicated patients were treated with them. In Denmark psychostimulants and antiepileptics were used as often as neuroleptics. Psychostimulants were used in Switzerland, too but not in Finland and Ireland. The use of anxiolytics, hypnotics, and sedatives was most prominent in Ireland (29%), and the use of antidepressants most frequent in Finland (22%). These types of drugs were used in the other countries, too but less frequently.

**Table 5. The medicated symptoms in child psychiatric hospitals in Denmark, Finland, Ireland, and Switzerland (% of medicated patients).**

| Treatment mode | DEN | FIN | IRL | SWI |
|---|---|---|---|---|
| Aggressiveness and restlessness | 7 | 39 | 57 | 31 |
| Psychotic symptoms | 7 | 17 | 25 | 31 |
| Emotional and neurotic symptoms | 27 | 24 | 14 | 38 |
| MBD and inattentiveness | 33 | 2 | 0 | 15 |
| Depressiveness | 7 | 12 | 4 | 15 |
| Others | 20 | 12 | 18 | 0 |
| Number of medicated patients | 15 | 41 | 28 | 13 |

The most important target symptoms for medication were in Ireland and in Finland aggressiveness and restlessness, in Switzerland emotional and neurotic symptoms, and in Denmark inattentiveness and symptoms due to minimal brain dysfunction (Table 5).

## CONCLUSION

The study design (point-prevalence methodology) implies some uncertainties concerning the findings. The picture of the totality of child psychiatric in-patient treatment depends on several factors which may vary with time. In Finland e.g. the results on the diagnostic distribution of the in-patients were different in this and in the first study in 1988. However, the findings of this kind of point-prevalence study may show some main lines of clinical practices in different countries. Because only a part of child psychiatric units in Switzerland were involved in the study one should handle the Swiss findings with great care.

The sex and age structures, and diagnostic distributions were clearly distinct in different countries. As a consequence the duration of hospitalizations, and the applied treatment modes varied considerably between the four countries.

Main part of the patients in Ireland and Switzerland were young adolescents but they were hospitalized due to dissimilar reasons. The Irish in-patients who were in hospitals due to conduct disorders and autism, were more disturbed and more difficult than the patients in Switzerland where emotional and adjustment disorders were the principal diagnose groups. This distinction was reflected both in the length of the hospitalization and in the treatment measures used. Parental guidance, special education, and medication were in Ireland the three most frequently used treatment modes, individual psychotherapy, primary caretaker, and parental guidance in Switzerland.

The largest group of the in-patients in Finland were latency aged boys. In Denmark the sex and age structures were more even than in Finland. In both countries emotional disorders were an important reason for hospitalization, but the patients in Denmark seemed to be more disturbed than in Finland. In Finland adjustment disorders was the largest group of disorders, in Denmark instead of these there were more in-patients with autism, personality, conduct, and attention deficit disorders. The chosen treatment modes in both countries resembled very much each others, but in Denmark the spectrum of treatment methods was somehow wider and more versatile: sensoric integration, holding, and speech therapies, and ADL-training were more frequently used than in Finland.

# CHILDHOOD HOSPITALIZATION FOR PSYCHOSOCIAL REASONS: THE CASE OF GASTROENTERITIS.

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## ABSTRACT

Nonmedical factors are often important considerations when choosing treatment options for illness. High levels of childhood hospitalization are of concern for psychological as well as medical and economic reasons. This study compared medical and psychosocial attributes of children managed at home or in hospital for childhood gastroenteritis to identify factors differentiating type of care. Parents of children under two years with gastroenteritis managed at home (n = 76) or in hospital (n = 76) were interviewed. Medical details and a range of intra-family factors (e.g., parenting skills, marriage) and extra-family factors (e.g., neighbourhood, social contacts) were queried. Doctors (n = 6) rated the severity of symptomatology of each case based only on medical details. There was no difference in the medical severity of the gastroenteritis episodes for hospital and home care groups. Instead families were most clearly differentiated using discriminant analysis by social variables; specifically hospital care families had poorer scores than home care families on social contact indices. This highlights the necessity for focusing on the wider social context in efforts at decreasing the incidence of childhood hospitalization.

The social and family context is regarded as an important influence on the physical and psychological health of families. This has been documented for factors such as psychosomatic complaints, psychological distress, postnatal depression, child abuse, and preventive child health actions [1-5]. One important event with the potential for family disruption is childhood hospitalization. Evidence illustrates that young children who experience long or repeated hospitalizations have increased levels of psychological problems later in childhood and into adolescence [6,7]. Using Quinton and Rutter's [7] UK population data, some 1.7 percent of the entire child population are estimated to

have increased levels of psychological problems in the teenage years as a direct result of early hospitalization. A common childhood disorder experienced in the family context is gastroenteritis. Following respiratory disease it is also the second most common cause of pediatric medical hospitalizations in developed countries [8]. In one longitudinal national study of over 13,000 British children in the early 1970s, 2.7 percent were admitted for gastroenteritis at least once in the first five years of life, 1.5 percent in the first year alone [9]. Because of the large numbers of children hospitalized for gastroenteritis, an attempt to reduce referral rates is an important target of preventive child health efforts. Clinical experience suggests that social and family factors are influential in the management of gastroenteritis. This view has also been supported empirically [10-12].

This study compared families of children admitted to hospital for gastroenteritis with families managing their child's episode of gastroenteritis at home in order to identify the factors associated with such different forms of management. It was hypothesized that nonmedical factors would have a major influence on management decisions for gastroenteritis. Social and family variables were thus examined in order to consider their influence on medical care options. A wider range of variables was examined in this exploratory study to increase the likelihood of identifying the most salient nonmedical influences. The selection of these variables was influenced by factors identified in the general developmental literature. Family variables comprised assessments of marriage, parenting skills, integration of child into family, child care arrangements, family health, kin relationships, and the impact of life events while social variables consisted of measures of neighbourhood and leisure facilities and satisfaction, and range of satisfaction with social contacts.

The study thus sought to identify the influence of social and family factors in the management of gastroenteritis with a view to improving this management. Since both families and doctors are involved in gastroenteritis management decisions, medical decision making was also studied. This work is reported elsewhere [13].

## METHOD

### Sample

Children under two years old and with gastroenteritis as a primary or only medical complaint were the focus of the study as gastroenteritis is most common in this age group. A clinical diagnosis of gastroenteritis by the doctor concerned was taken as the working definition of gastroenteritis since the study focused on the management of children who are given a primary diagnosis of gastroenteritis. The study was based in a large heterogeneous urban region which had a mix of newly-established and well-established families and a mix of socio-economic groups. All gastroenteritis hospitalizations in this region are made to a major infectious diseases hospital centrally located in the area. Families of all eligible children admitted in a three-month period were identified from hospital records and mothers approached for interview. An equal number of families who managed a case of childhood gastroenteritis at home in the same time period was identified by two methods. General practitioners, randomly selected in the region and interviewed for another aspect of the study, provided their most recent home-management case of childhood gastroenteritis. Since many cases of childhood gastroenteritis are treated in casualty departments of children's hospitals, casualty department records for the region at this time period were also consulted to identify those attending casualty departments and then returning to home management for gastroenteritis.

In order to minimize the risk that differences between the two groups of children may be attenuated by differing treatment personnel, i.e., GP or casualty doctor, the study

aimed to balance the ratio of casualty doctor in GP cases in the home care group with the pattern found for the study region in the infectious diseases hospital. Hospital records analysis for the same time period in the previous year showed that 40 percent of referrals to the infectious diseases hospital from this area came via other hospitals in the area with the remaining referrals coming from GPs.

Seventy-nine children fitting study criteria were hospitalized with an admitting diagnosis of gastroenteritis in the three-month period. Two children from one family were hospitalized. The first of these children were chosen for study so that the characteristics of different families rather than different children would be studied. One child was rehospitalized during the three-month period and only the first episode of gastroenteritis was recorded for this child. Two mothers did not wish to take part in the study. Forty-six of the fifty-two randomly selected GPs in the region provided contact with the family of a child who had gastroenteritis recently but who had not been hospitalized. In two home care situations the case provided was in fact two children - two sets of twins, each with gastroenteritis. For these cases the information was collected with reference to one of the children only. Two mothers did not wish to take part in the study. The remaining home management cases were provided from casualty department records of the two major regional paediatric hospitals. Thirty cases from these were selected at random. This number provided an approximate 1:1.5 ratio of casualty and GP cases in the home care sample thus matching the ratio for the hospital care sample and avoiding hospital versus home differences based on sample origins. Overall there was a 97 percent response rate from the mothers approached.

## MEASURES

Extensive interviews with mothers covered the following topics: family structure, index child's history, parenting, marriage, home circumstances, occupation, income leisure, health, stressful life events, gastroenteritis, and hospitalization. The variables were assessed using a combination of measures from previous studies and, where appropriate, questions compiled for completeness in this study, reflecting both the exploratory nature of the study and the attempt to conduct research with face validity for these mothers.

Because of the large range of issues addressed in the study, it was felt that summary variables meaningfully combining measures would be useful in seeing overall difference patterns, if any, in the circumstances of those who had children hospitalized for management at home for gastroenteritis. These are divided into issues internal to the family (intra-familial factors) and wider community issues (extra-familial factors) are now outlined.

### Intra-familial Factors

***Integration of child into family*** - The integration of the child into the life of his/her parents consists of two aspects. The first is the influence of parents on their child. The index is combined from items relating to the birth of the child, feeding methods adopted, levels of age-relevant immunizations and parental relationships with the child. Higher values on the domain (0-9) rating, indicate more health-related planning for children by their parents, e.g., "Was N breast-fed partly or wholly, even for a few days?" (0) not breast-fed at all; (1) for less than one month; (2) for one month or more; (3) for three months or more. The influence of children on their parents was also considered. Items on temperament and early child behaviours were combined here to give a 0-9 rating, high values being associated with children who are easier to manage, e.g., "In comparison with what you know of other children of the same age, how would you rate your child as to the following issues? - activity level: the amount of physical activity during sleep, feeding, play, dressing, etc.?" (1) high; (2)

medium; (3) low. Linking the two ratings then provided an overview of the child into the life of the parents (values 0-18). It can be seen as a measure of child-environment fit in the family context.

***Parenting skills*** - Parenting as a variable was operationalized by combining the management of four distinct child management areas queried: bedtime, feeding, crying, and discipline. This was scored by the interviewer following discussion of the handling in each area by the parent (0-8 rating), e.g., "How would you rate the overall handling of bedtime for this child?" (0) satisfactory; (1) some handling problems; (2) considerable handling problems.

***Marriage*** - Marriage estimates are divided into two sections. The first is a summary of satisfaction with four marital areas queried: the sharing of interests, decision making, sexual relationship and general compatibility, e.g., "Generally speaking would you say that you get on well together?" (1) very dissatisfied; (2) dissatisfied; (3) neither; (4) satisfied; (5) very satisfied. The second variable summarizes friction within the marriage. This is calculated from the frequency of irritabilities and of quarrels, and the severity of these, e.g., "What about getting irritable with your husband/partner - how often do you get cross with him and him with you?" (0) less than monthly; (1) less than weekly; (2) one to two times weekly; (3) five to seven times weekly; (4) greater than once daily.

The satisfaction and friction scores are combined to provide an overall estimate of the marriage (values 0-40). Values of 20+ suggest a mainly satisfying marriage, a score of 20 represents neither a satisfying nor unsatisfying marriage and scores of less than 20 represent a marriage with more friction than satisfaction.

***Child care*** - Overall proportions of child care by mothers and fathers are calculated from a listing of child care tasks, e.g., number of times in an average week various individuals (mother, father, others) assist in caring for the index child. The 10-item Father Caretaking Questionnaire provided the basis for the list with items on feeding, birthing, and changing nappies (diapers) [14].

***Life events impact*** - The overall impact of life events on the family in the previous year, as measured by the Life Experiences Survey is calculated by subtracting the negative impact of events from the positive impact [15]. With a neutral situation being given a score of 50, scores lower than 50 indicate a family where the cumulative effects of life events have been negative over the year. The reverse is the case for scores over 50.

***Health status, behaviours and attitudes*** - Family health status is calculated using a combination of medical and psychological health problems, use of curative health services and medication, and advice given to family members by doctors in the past year, e.g., "In the past year has the doctor advised you to do any of the following - (1) get more rest or sleep?" (0) no; (1) yes. There is no upper limit on scores; higher scores indicate more health problems in the family in the previous year. Health behaviours are represented by preventive health actions undertaken by the family, the use of contraceptives (if applicable) and engagement in a number of healthy or unhealthy behaviours such as exercise and smoking (values 0-9). General health attitudes are summarized from views of personal control over family health and from a number of individual health and medical care attitudes (values 0-7), e.g., "How much control do you think you have over your family's future health?" (0) none at all; (1) very little; (2) some; (3) a great deal.

The General Health Questionnaire (GHQ) was used as a specific instrument to measure generalized psychological distress. The 30-item version of the scale was employed (values 0-30) [16].

***Family-of-origin relationships*** - Relationships of both parents with their own parents and the marital relationships of these grandparents are combined to provide an estimate of the general pattern of relationships in the parents' family-of-origin (values 0-12), e.g., "How would you describe your parent's marriage?" (1) breakdown/separation; (2) poor; (3) average; (4) good; (5) very good.

### Extra-Familial Factors

***Neighbourhood*** - Neighbourhood satisfaction is a composite of satisfaction with fifteen different aspects of the community (values 15-75), e.g., "Please rate your present satisfaction with the following aspects of neighbourhood - closeness to work for members of your household?" (1) unhappy; (5) happy.

***Leisure*** - Numbers of social outings are compiled as in previous research from information on social entertainments, club and religious involvements, and relative/friend visiting (values 0-8), e.g., "How often do you get together informally with friends or relatives?" (0) rarely, if ever; (1) a few times a year; (2) three times a month or more [17].

***Shared leisure*** - For those mothers in dyadic relationships, the overall level of sharing of the social activities outlined above is calculated (values 0-6), e.g., "On social occasions, do you attend with your husband/partner?" (0) never; (1) sometimes; (2) often; (3) always.

***Social contacts*** - The range of social contacts: strangers, acquaintances, friends and relatives is summarized using the Henderson et al. format (values 0-4) as is satisfaction with access to social contacts (values 0-8), e.g., "Do you wish you saw fewer or more of such casual friends or is it just about right?" (1) less; (2) about right; (3) more [18].

### Medical Ratings of Gastroenteritis Symptomatology

A detailed description of gastroenteritis episodes in terms of diarrhoea, vomiting, and other symptoms was taken from mothers. An overall assessment of the medical severity of the combined symptoms was felt to be the most appropriate way of comparing the medical problems experienced by the children. Such a complex collection of individual symptoms was not felt to be amenable to summary by a standard formula. Instead it was decided to have each case rated clinically. For this the medical details of each case (as were presented by the mother on one or more occasions to medical personnel) were recorded, along with the age of the child, on individual index cards. The number of times presenting to medical personnel was clear on the cards but no treatment information was provided such the hospital and home care cases could be distinguished. Social and psychological background information was also unavailable thus ensuring that cases were rated on the basis of the medical problem itself. The six gastroenteritis management doctors in the study hospital itself were provided with a set of these cards such that each card was rated twice and by two different doctors. Doctors Doctors were asked to rate the cards on a 1-7 point scale of severity; a higher score indicating a more severe medical case. The two doctors' scores for each case were combined and mean values recorded.

## PROCEDURE

Family information was obtained by interviewing mothers (or the primary carer, if different) of young children with gastroenteritis. Interviews were conducted by a psychologist (HM) during or shortly after the child's episode of gastroenteritis in the

hospital or home care situation as appropriate. Approximately half of the hospital care mothers were seen at home for logistic reasons. There was no statistical difference in the time interval to interview of hospital and home care mothers (hospital: mean 15 days; home: mean 18 days). The interviewer was aware of the status (hospital or home care) of the children.

## RESULTS

Inter-rater reliability between the two sets of doctors' ratings was r = 0.76. In terms of the medical severity of the gastroenteritis episode doctors' overall assessments on a 1-7 point rating scale of severity did not differ significantly between the two groups, (x = 5.16 for hospital care and 4.96 for home care groups, two tailed t-tests; p = .307, NS). Since the two groups did not differ in terms of the gastroenteritis episode it was necessary to examine other reasons to explain why some children were treated at home and some in hospital. Statistical comparisons between groups were made using t-test or chi-square (where appropriate) analyses. Demographic and amenity characteristics of the groups are outlined in Table 1.

A wide range of other family issues was investigated. The general pattern of difference between the two groups (Table 2) is that extra-familial factors differentiated, while intra-familial factors did not differentiate, the groups.

As seen from Table 2, hospital care families were significantly less satisfied with their neighbourhood, had fewer leisure experiences, engaged in less shared leisure and has fewer social contacts. Hospital care mothers showed significantly more general psychological distress as measured by the GHQ-30 and their health attitudes were also significantly more negative. The above differentiations of hospital and home care groups have been by single variable comparisons.

Table 1. Demographic and Amenity Characteristics of Hospital and Home Care Families

| | Hospital Care Families (n = 76) | | Home Care Families (n = 76) | |
|---|---|---|---|---|
| Summary Variables | X | SD | X | SD |
| Maternal age (X) | 26.3 | 5.1 | 28.2 | 4.9* |
| Paternal age (X) | 28.1 | 5.5 | 31.1 | 5.7 |
| Married/cohabitating (%) | 82 | | 89 | |
| Duration marriage (years) (X) | 5.3 | 4.6 | 5.4 | 4.2 |
| Number of children (X) | 2.3 | 1.4 | 1.9 | 1.0* |
| Education to age 14 only (maternal) (%) | 55 | | 28 | ** |
| Education to age 14 only (paternal) (%) | 57 | | 39 | * |
| Manual occupation (maternal) (%) | 29 | | 6 | * |
| Manual occupation (paternal) (%) | 17 | | 10 | |
| State-provided accommodation (%) | 67 | | 38 | *** |
| Amenities: family telephone (%) | 29 | | 56 | |
| family car (%) | 36 | | 58 | * |

*p < 0.5 **p < .01 ***p < .001

However, with multiple comparisons the likelihood of chance findings increases. The meaning of significant associations is also unclear in single variable analyses. Thus the study also utilized a comparison based on the differentiating power of combined variables. The procedure used was discriminant analysis; a multiple regression technique which identifies those variables which best differentiate between two groups and provides an estimate of the strength of the differentiation. The analysis was conducted using social and psychological variables as outlined in Table 2. Although there were also significant single variable differences between groups on demographic variables it was felt that these more structural variables, if predictive of location of care, would be so through social and psychological mechanisms, e.g., maternal age might differentiate between the groups because of an association with parenting skills. Discriminant analysis of hospital and home care families using the study summary variables resulted in a discriminant function which accurately classified 72 percent of hospital care and 71 percent of home care families. thus, a family could be identified as belonging to the hospital or home care group with 71 percent accuracy on the basis of the social and psychological measures taken in the study. The variable which best discriminated hospital and home care families was the overall level of social contacts of mothers, home care mothers having significantly more overall contacts.

Table 2. Comparisons of Family Summary Variables for Hospital and Home Care Gastroenteritis Groups

| | Hospital Care Families (n = 76) | | Home Care Families (n = 76) | |
|---|---|---|---|---|
| Summary Variables | X | SD | X | SD |
| Intra-Familial Factors | | | | |
| Integration of child into family | 13.1 | 2.9 | 13.4 | 3.1 |
| Parenting skills | 7.0 | 1.8 | 6.8 | 2.1 |
| Marital quality | 28.5 | 6.6 | 29.8 | 6.3 |
| Child care (%) - mother | 73.0 | 19.0 | 74.5 | 17.7 |
| - father | 19.5 | 18.9 | 21.8 | 18.4 |
| Impact of life events | 49.9 | 4.8 | 43.9 | 5.4 |
| Health: - status | 9.3 | 7.3 | 8.7 | 7.1 |
| - behaviour | 2.6 | 2.5 | 3.2 | 2.5 |
| - attitudes | 4.5 | 1.7 | 5.1 | 1.6** |
| Psychological distress (GHQ-30) | 9.9 | 7.0 | 7.5 | 7.1* |
| Family of origin relationships | 7.4 | 3.2 | 8.3 | 3.2* |
| Extra-Familial Factors | | | | |
| Neighbourhood | 52.7 | 7.8 | 55.5 | 7.8* |
| Leisure | 3.3 | 1.8 | 4.4 | 2.0** |
| Shared leisure | 2.6 | 1.2 | 3.2 | 1.4** |
| Social contacts - range | 5.5 | 3.0 | 7.1 | 3.4** |
| - satisfaction | 2.9 | 1.3 | 2.9 | 1.2 |

Two-tailed t-tests
*p < 0.5
**p < .01

The "best-fit" discriminant function based on the overall sample did not fully differentiate mothers into two family types. Thus, it was felt that an examination of subgroups within the sample might provide a clearer pattern of the underlying factors differentiating the two groups with the drawback that smaller samples would make the analysis less powerful. The more extreme cases in the two groups, i.e., those mild medical cases which were managed in hospital and those severe medical cases which were managed at home were selected for further study. Using medical ratings there were twenty-six severe cases of gastroenteritis managed at home (severity ratings 6-7) and seventeen mild cases of gastroenteritis managed in hospital (severity ratings 1-4). Applying discriminant analysis with these groups, 96 percent of the variability between the groups was found to be explained using the same summary variables as before. This second discriminant function classified 91 percent of mild cases and 100 percent of severe cases correctly. In this analysis, with almost total discriminability between the extreme groups in terms of hospital and home care management, social contact variables again emerged as the major differentiating factor. Social contact differences between the two groups of mothers are outlined in Table 3. For instance home care mothers were significantly more involved in leisure and religious activities and had more shared leisure with their partners. Furthermore 21 percent of hospitals and 8 percent of home care mothers reported having no good friend ($p < .05$) while hospital care mothers were significantly less happy with their contact with friends; 60 percent versus 3 percent wishing to see friends more often ($p < .01$).

Table 3. Leisure Activities of Hospital and Home Care Gastroenteritis Groups

| Activity | Hospital Care Families (n = 76) % | Home Care Families (n = 76) % |
|---|---|---|
| Get out often | 53 | 71* |
| - often accompanied by partner | 55 | 90* |
| Member of club | 11 | 22 |
| - often accompanied by partner | 2 | 5 |
| Attend religious service often | 55 | 75* |
| - often accompanied by partner | 48 | 70* |
| Meet friends often | 93 | 94 |
| - often accompanied by partner | 63 | 68 |
| Watch television daily | 84 | 94 |
| Read newspaper most days | 39 | 67** |

Two-tailed t-tests
*$p < 0.5$
**$p < .01$

When asked about the availability of a confiding relationship 13 percent of hospital and 5 percent of home care mothers reported having no such relationships ($p = .06$). Fourteen percent of hospital care mothers had only their partners to confide in, this contrasts with 5 percent of home care mothers ($p < .05$). When the family-of-origin relationships were studied it emerged that hospital and home care groups differed in the poorer relationships of both mothers with their own mothers ($p < .05$). Hospital care families also had significantly poorer personal resources from their original families in terms of quality of relationships within these families generally ($p < .05$).

## DISCUSSION

This study supports the clinical impression that children with gastroenteritis are being hospitalized for nonmedical reasons. It emphasizes the importance of the wider social context of children with gastroenteritis. Comparing families who managed at home with those whose children were sent to hospital, there was no difference in the overall severity of gastroenteritis. Thus the two groups were equally unwell. However families of hospitalized children differed on a range of demographic, amenity, social and psychological variables from home care families. Social contact indices were of most predictive value in differentiating the two groups; families of hospitalized children having fewer social contacts. It may be that having a wider circle of family and friends is protective since they can advise and encourage in the many difficult and worrying moments of child health problems and child are generally. In this situation having more of these contacts may have made the difference between managing a sick child at home and having the child referred to hospital. However since the relationships here are correlational caution must be exercised in assuming the direction of causality. The finding that low social contact is associated with increased use of hospital resources is, however, consistent with other research findings, e.g., increased use of casualty departments [19] and other hospital services [20]. Within the hospital context patients low in social contacts (although similar in demographic and medical terms) exhibit greater need for medication and longer hospital stays [21]. In the extreme, low social contact has been associated with increased mortality [17, 22]. The way in which levels of social contact may influence hospital referral needs to be clarified. It may be that doctors perceive low social contact as a risk factor in these cases, it might also be that families with low social contacts express a greater willingness to have their children hospitalized. This needs to be considered further. On a theoretical level findings of the association of social contacts and service use suggest the need for health care workers generally to encourage and facilitate the development of adequate social contacts for those they serve. Such endeavours should not be seen as laudable adjuncts to the "real" work of health care and health promotion but rather as crucial to a holistic approach to their work. On a practical level however, the facilitation of improved social contacts can involve macro-elements of society such as employment, income, and housing policies. This would require that health care personnel begin to work with other professions and also provide the evidence to justify particular policies on broad social issues from the perspective of maintaining and/or improving the community's health.

Findings here are tempered by the exploratory nature of the study including the use of some measures without psychometric scrutiny. Replication is warranted. However the study suggests the association of the wider social network with one aspect of the health care of young children, i.e., care for gastroenteritis. The results encourage the further examination of nonmedical influences on health care decisions. Research in this area could focus usefully on the whole range of health care decisions within families of young children and between these families and various health professionals in a longitudinal format. More detailed examination of factors influencing the clinical decisions of doctors is also warranted. Methods such as those used by Kirwan et al. to examine rheumatologists' assessment of arthritis severity would be useful for explicating the particular decision policies of different doctors and for teaching doctors to approximate "gold standard" decision policies derived from previous practice and

research [23, 24]. It will be increasingly necessary to focus on nonmedical influences on health care if health funding is to be used to optimal effect in the future.


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# MEDICATION AND THE MANAGEMENT OF INFANTILE GASTROENTERITIS.

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A recent U.K. study has outlined the continued use of medication, particularly antidiarrhoeals and antibiotics, in the management of infantile gastroenteritis, despite evidence of the ineffectiveness, or indeed negative effects, of such medication[1]. Of 100 infants hospitalised for gastroenteritis, oral rehydration therapy had not been recommended for 13 while 14 had been prescribed antidiarrhoeals and 16 antibiotics.

A recent Irish study of gastroenteritis management provides evidence on management patterns here[2]. Fifty-two randomly selected urban GPs and 28 paediatric Casualty Doctors were interviewed regarding gastroenteritis management (94% response rate). All doctors mentioned oral rehydration therapy as part of their general management strategy while 22 doctors (21 GPs and one hospital doctor) mentioned the occasional use of medication(s): antidiarrhoeals - kaolin (n = 6), Ioperamide (n = 3), diphenoxylate (n = 2) and dicyclomine (n = 1); antiemetics-domperidone (n = 5), metoclopramide (n = 3) and prochlorperazine (n = 2); and a traditional chloroform/morphine mix no longer available through pharmaceutical outlets (n = 2).

When asked more specifically about various categories of medication, usage was described as in Table 1. Antipyretics were widely used. As in the UK a small but significant number of doctors (particularly GPs) continue to use antidiarrhoeals, antiemetics and antibiotics, despite well-publicised contraindications. Such practice represents significant medication usage when considered over time and across the overall population of doctors managing infantile gastroenteritis in the primary care context. Why the difficulty with a general principle of fluids only for infantile gastroenteritis? Could this be indicative of ineffective and relatively costly management strategies in other areas of medical practice where procedural guidelines are a lot less clearcut than in the case of gastroenteritis?

**Table 1**

Medication use in the general management of infantile gastroenteritis

| Medication | | Use | | |
|---|---|---|---|---|
| | | Not used | Occasional Use | Frequent Use |
| | | % | % | % |
| Antipyretics: | (GPs) | 29 | 42 | 29 |
| | (Hos) | 21 | 68 | 11 |
| Antidiarrhoeals: | (GPs) | 71 | 25 | 4 |
| | (Hos) | 100 | -- | -- |
| Antiemetics: | (GPs) | 69 | 35 | 6 |
| | (Hos) | 93 | 7 | -- |
| Antibiotics: | (GPs) | 85 | 15 | -- |
| | (Hos) | 93 | 7 | |

GPs: general practitioners (n = 52)
Hos: Casualty Department Doctors (n = 28).

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# PSYCHOSOCIAL FACTORS INFLUENCING MEDICAL CHILDHOOD HOSPITAL ADMISSIONS.

MICHAEL FITZGERALD.

HANNAH MCGEE.

## INTRODUCTION

Over two thousand under two years of age are hospitalised annually in the Republic of Ireland for gastroenteritis.

Following on upper respiratory tract infections and tonsillitis/laryngitis, gastroenteritis is the third largest of this minor self-limiting paediatric disease category, comprising 1.4% of all consultations in a year to general practitioners (G.P.'s).

Concern regarding the hospitalisation of young children is warranted following on research evidence of the detrimental effects of long or repeated hospitalisation [2,3]. This study was initiated because one of the researchers (MF) made a clinical observation of a history of hospitalisation for gastroenteritis in many young children attending an urban child psychiatry clinic.

The study examined this childhood hospitalisation in a large heterogeneous urban area with a view to understanding the influence of psychosocial factors on referral and thus ultimately finding methods of safely decreasing admissions. The issue was addressed from the perspectives of both doctor and family.

## METHODOLOGY

### Doctors' Study

Fifty seven general practitioners were randomly selected and approached from a listing of those living and/or practising in the designated area (response rate 91%). The two major children's hospitals in the study area were contacted. In all 70 and 83% of the relevant casualty department doctors in each hospital were interviewed, with no refusals. A total of 28 hospital doctors were interviewed. Those doctors not seen were those off duty or busy at the time of the interview.

Each doctor was presented with a series (18) of "paper patients", each with a scenario about a young child presenting with gastroenteritis symptomatology. These vignettes or "paper patients" each contained four basic dimensions of information, age of child, presenting medical symptoms, family social background and mother's reaction to the situation. This allowed for later systematic investigation of the relative importance of various factors in doctors' decision making. Upon completion of the "paper patient" task, doctors were asked a range of questions about their management of, and views on, gastroenteritis and their work generally.

## Mothers' Study

### (1) Hospital Care Sample

All children under the age of 2 admitted to the study hospital (the infectious diseases hospital in the area) during a 3 month period with an admitting diagnosis of gastroenteritis, and from the settled West Dublin community, were selected for study.

### (2) Home Care Sample

G.P.'s in the study were asked for permission to contact the mother of their most recent patient under 2 years who had a diagnosis of gastroenteritis and who had been managed at home.

Casualty department records revealed 36 suitable children. Thus casualty department children were selected at random from the suitable cases to make up 76 home management interviews.

The mother's interview focused on family structure, the index child's developmental history, parenting experiences, levels of marital satisfaction, social support, occupation/income, leisure activities, health attitudes and behaviour, General Health Questionnaire [4], Life Experience Survey [5], detailed description of gastroenteritis episode and mother's attitude to hospitalisation.

## MEDICAL RATINGS OF GASTROENTERITIS SYMPTOMATOLOGY

The medical details of each case, excluding social data, were presented to 6 doctors in the hospital under study. doctors were asked to rate the severity of symptomatology for each patient on a 1 - 7 scale.

## RESULTS

Considering the "paper patients" presented to doctors, 21% of paper patient situations would result in hospitalisation for the child concerned. Considering the total sample of doctors interviewed, higher number of hospitalisation from "paper patients" were associated with higher reported levels of hospitalisation from the doctor's actual day to day work ($r = .608$, $p < .001$), with poorer experiences of gastroenteritis ($r = .292$, $p = .004$), with more severe ratings of gastroenteritis generally ($r = .296$, $p = .004$), with being a younger doctor ($r = -.220$, p .025) and with having fewer patient recalls to surgery ($r = -.303$, $p = .003$).

The overall pattern of hospital referrals for gastroenteritis illustrates that severe medical problems take precedence in hospital admission cases. However, moderate medical problems are only as likely to result in hospitalisation as are the better poles of the other three dimensions i.e. older children, children of experienced mothers and children of calm mothers. The figure illustrates that the three non-medical dimensions (age, social background and maternal reaction) are equally important to doctors in their general management decisions.

Regarding views on the influence of hospitalisation on small children, 50% felt there was a definite negative effect. Some further qualified this by saying "if less than one

year old" (1%) or "if older" (14%) while 5% felt the negative effects to be traumatic, 8% to be long term and 22% said there would be some negative effects. A further 29% felt there was little or no general effect of childhood hospitalisation with the remainder feeling reactions were too varied to generalize (3%) or that there can be fretting (18%). In relation to visiting arrangements in hospitals, 45% of doctors make no general recommendations to parents. Ten per cent specified that they did not think it necessary as they felt parents now realised the importance of visiting.

The 'doctor' factors influencing the decision to hospitalize were further examined using multiple regression. For general practitioners, six steps were produced in the analysis which explained a total of 44% of the variance in decision making. These steps in descending order of importance were bad experiences with gastroenteritis, higher estimates of the severity of gastroenteritis, sex of the doctor (male), single practice, if gastroenteritis management had changed since training and age of doctor.

For hospital doctors a series of seven steps were produced by multiple regression explaining 56% of the variance in gastroenteritis decisions. Here the important factors were a higher severity rating of gastroenteritis, more negative view of the effects of hospitalisation, if the Diploma Child Health had been taken, sex of doctor (female), length of time in medicine, if visiting recommendations were given and if there were any changes in the gastroenteritis management since training.

For general practitioners, from a total of 42 factors only 3 were sufficiently related to levels of hospitalisation to be included in the multiple regression equation. In all, 34% of the variance in childhood hospitalisation is explained by these variables. The major proportion of the variance explained, (88%), is accounted for by aspects of the doctor's background (i.e. bad experiences with gastroenteritis and team practice) with 12% coming from aspects of the patient (i.e. age of child). Thus G.P.'s having more bad experiences, less likely to be working in a team practice and seeing the age of the child as an important factor were more likely to hospitalise children for gastroenteritis.

As far as the hospital doctors were concerned in this analysis, 12 of 42 possible factors accounted for 88% of the variance in hospitalisation rates. These were 5 factors relating to doctors and 7 factors relating to children and their families (see Table 1). In the case of hospital doctors, family factors accounted for 54% of the variability with doctor factors counting for the remaining 34%.

Doctors with prior experience of working in an infectious disease hospital were significantly more likely to refer children to hospital; referring on average 5.8 versus 3.1 of 18 "paper patient" cases to hospital ($p = .015$). These doctors also estimated that they referred more patients from their own practice work to hospital (13% vs 5%, $p = .007$). Doctors who estimated the effects of hospitalisation to be more severe on children showed a tendency to hospitalise fewer vignette cases ($r = -.75$, $p = .064$).

## Mother's Study

In terms of medical problems, doctors' overall assessment of the severity of children's presenting symptoms did not differ significantly for the two groups ($x = 5.16$ for hospital care and 4.96 for home care, $p = .307$). Median values for the sample were identical (5.0) illustrating that the samples were similar in general severity patterns. Many variables were examined to explain the differences, now obviously non-medical, between the hospital and home care groups. (See Table 2 for an illustration of differences and similarities between the two groups). On a practical level hospital care families have fewer resources than home care families. For instance, fewer hospital care families had telephones (29 versus 56%) ($p < .01$) and cars (36% versus 58%) ($p < .05$) than home care families. Questioned specifically about their relationship with

their neighbours 23% of hospital care and 8% of home care mothers reported being on bad terms with, or of not mixing with, their neighbours ($p < .001$). Views on the effects of hospitalisation of young children were similar for hospital and home care mothers and were strikingly similar to those in a large Welsh study on parents' attitudes to hospitalisation. Attitudes to the hospitalisation of their child for the present episode of gastroenteritis were however significantly different for hospital and home care mothers ($p < .001$), hospital care mothers being significantly more in favour of hospitalisation. Twenty two percent of hospital care mothers and 7% of the others were/would be very happy having their child hospitalised and 58 versus 80% were/would be very unhappy. There is probably an element of cognitive dissonance in this.

Utilising this wide range of information, discriminant analysis was used to find the factors which most clearly differentiated between hospital and home care mothers. The most important variables to emerge from the discriminant analysis were social contact and social relationship variables outside the nuclear family. The studied variables differentiated between the two groups with 71% accuracy. For instance home care mothers were significantly more involved in leisure and community activities and had more shared leisure with their spouses/partners; 71% of home care mothers got out often while 53% of hospital care mothers got out often ($p < .05$). In terms of shared leisure 90% of home care mothers are often accompanied by their partner while 55% of hospital care mothers are often accompanied by their partner ($p < .05$).

Home care mothers had more casual contacts than hospital care mothers ($p = .003$) and met more acquaintances daily ($p = .008$). Only numbers of relatives contacted were the same for the two groups. In fact 21% of hospital care and 8% of home care mothers reported having no good friends ($p < .02$). Similar numbers of friends of both groups lived near enough to be able to visit easily (56% & 66%). Hospital care mothers were significantly less happy with their contacts with friends, 60% versus 3% wishing to see friends more often ($p < .001$). When asked about the availability of any confiding relationship, 13% of hospital and 5% of home care mothers reported having no such relationships ($p = .06$). 14% of hospital care mothers had only their partners to confide in, in contrast with 5% of home care mothers ($p = .04$). Hospital care families also had significantly poorer personal resources from their original families in terms of quality of their relationship with their families of origin ($p = 0.46$). Using the GHQ to measure general psychological well-being, hospitalised mothers were significantly more depressed than their home care counterparts ($p < .05$). Using Goldberg's (1972) "case" classification, those mothers scoring 4 and greater on the scale were examined. Forty-eight percent of hospital care and 31% of home care mothers fell above psychiatric cut-off point ($x = 3.7$, $p = .055$); these mothers would be seen as having a psychological symptoms meriting attention if they were seen in an assessment situation.

**Table 1**

Multiple regression analysis of the influence of non-medical factors on hospitalisation rates for gastroenteritis by hospital doctors.

| Factor | | $R^2$ (%) |
|---|---|---|
| Severity rating of gastroenteritis | (D) | 14 |
| Coping ability of parents | (P) | 21 |
| Parental attitudes to hospitalisation | (P) | 29 |
| Distance from G.P. / Hospital | (P) | 40 |
| Age of child | (P) | 49 |
| Type of feeding | (P) | 59 |
| Conservatism | (D) | 64 |
| Visiting recommendations provided | (D) | 68 |
| Number of children | (P) | 72 |
| Single parent | (P) | 79 |
| Sex | (D) | 83 |
| IQ of family | (P) | 88 |

N = 28. D: Doctors factors. P: Parent factors.

**Table 2**

Comparisons of family aspects of children hospitalized for gastroenteritis and children managed at home for gastroenteritis.

| | Hospital Sample n = 76 | Home Sample n = 76 | |
|---|---|---|---|
| - Age of child (months) | 10.2 | 10.7 | |
| - Medical severity of symptoms (0 - 7) | 5.2 | 5.0 | |
| - Two parent family (%) | 87 | 92 | |
| - Maternal age (years) | 26.3 | 28.2 | * |
| - Number of other children | 2.3 | 1.9 | * |
| - Basic education only (mother) (%)<br>(father) (%) 57 | 55<br>39 | 28<br>* | ** |
| - Family occupation (professional) (%) | 13 | 29 | ** |
| - State provided dwelling (%) | 67 | 38 | *** |
| - Duration of residence (years) | 4.9 | 4.6 | |
| - Parenting skills (0 - 8) | 7.0 | 6.8 | |
| - Quality of marriage (0 - 40) | 28.5 | 29.8 | |
| - Child care provided by mother (%)<br>father (%) 20 | 73<br>22 | 74 | |
| - Life events impact (0 - 100) | 50 | 44 | |
| - Family health status (0) | 9.3 | 8.7 | |
| - Family health behaviours (0 - 9) | 2.6 | 3.2 | |
| - Maternal health attitudes (0 - 7) | 4.5 | 5.1 | ** |
| - Maternal GHQ - 30 (0 - 30) | 10.0 | 7.5 | * |
| - Maternal leisure (0 - 8) | 3.3 | 4.4 | ** |
| - Shared leisure (0 - 6) | 2.6 | 3.2 | ** |
| - Social contacts (range) (0 - 4)<br>(satisfaction) (0 - 8) | 5.5<br>2.9 | 7.1<br>3.0 | * |
| - Family of origin relationships (0 - 12) | 7.4 | 8.3 | * |

* $p < .05$ ** $p < .01$ *** $p < .001$ Two tailed tests.

## DISCUSSION

### Doctor's Study

This empirical investigation confirms the findings of numerous surveys of the wide variability in doctors' referral rates. In this case analysis was conducted on a single disease, thus ruling out difficulties of the confounding of different problem combinations and referral rates. The results illustrate that doctors differ in their referral patterns for gastroenteritis both in an experimental situation and in their estimates of their own working practices. Referral rates from "paper patient" cases varied from none to 14 to 18 cases (78%) and in the doctors own work estimates from 0 - 95% of cases.

It was of interest that being either a young child, a child of a lone parent, or a child of an anxious mother were factors which were about equally likely (35% chance) to result in a hospital referral. These factors were more likely to result in hospitalisation than that of having a moderately sick child (16%). Having a severely sick child was, not surprisingly, the most likely single factor to result in a child's hospitalisation for gastroenteritis (38%). When all 3 non-medical factors are combined in the most serious scenario; i.e. a young child having a severe medical problem and an anxious lone mother, there was a 64% likelihood of hospitalisation. On the other hand the least serious scenario in these combinations was of an older child with a mild medical problem whose mother was calm and experienced with children and had a partner; in this case the likelihood of hospitalisation was 5%.

It is worrying that such a large number (29%) of doctors saw the hospitalisation of young children as having no appreciable negative effects on them. such views and practices do not concur with the view of Mrazek [6] - "Over the past generations the belief that hospitalisation early in life has a negative psychological effect on children has become an established clinical axiom".

It is also of interest that working in an infectious disease hospital during training increased the likelihood of a doctor hospitalising for gastroenteritis later on. This factor highlights the powerful influence of past experience on doctors. It appears that exposure during training may sensitize doctors to the potentially negative outcomes of gastroenteritis although deaths from gastroenteritis are now quite rare.

The fact that doctor factors are responsible for almost all the explained variance in G.P. referral patterns is an important findings. It illustrates the deciding role of the general practitioner in health service usage. While non-medical patient factors can be shown to influence G.P. decisions on gastroenteritis (as seen in "paper patient" analysis) the G.O.'s own background and experiences mostly determine management decisions. Thus it is that one G.P. cases to hospital. This study supports the finding that the doctor emerges as the single most important factor (over age, sex and social class of patients) in variations in health care decisions [7].

### Mothers' Study

The most important finding of this study is the fact that medical ratings of the severity of the children's gastroenteritis symptoms revealed no differences between hospital and home care groups. The parents in the hospital care families were younger, less educated and of lower occupational status than parents in the home care situation. They also had larger families than the home care group and material family circumstances such as housing and amenities were poorer overall for hospital care families.

In terms of general family leisure activities and social contacts, hospital care families were relatively insular. It is worrying that more many hospital care mothers report having no friends or confidants than do home care mothers. Overall hospital care families were more stressed, had larger demands on them and fewer resources as well as fewer social contacts. There was evidence also that mothers in the hospital care families were under greater psychological stress. Therefore at the time of the gastroenteritis episode they had fewer resources both within the family and from the neighbourhood on which they could draw in terms of social support.

Social contact variables were significantly related to demographic variables, those of lower educational and occupational status having poorer social contacts. Gavron [8] has shown that there is a lower level of social contracts in lower socio-economic families. She pointed to the myth of working class cohesiveness, social embeddedness and solidarity in relation to the young mothers studied. Instead she found upper class women enjoyed a wide circle of supportive friends.

It was clear from this study that the impact of hospitalisation on families was most difficult where there were already difficulties or relatively scarce time, finances or child help resources. It was ironic that those most likely to have their children hospitalised for gastroenteritis were those who, along a number of family dimensions, could least "afford" this option. For instance access to the hospital (via car and telephone) friends to help out was more limited for those mothers. it is important as well to note the similarities between the two sets of families. At this juncture a cautionary note is appropriate. Discriminant analysis was unable to fully differentiate hospital and home care families on the basis of a very wide range of information on families, (71% discriminability overall) leading one to the conclusion that family variables are not the only factors which differentiate between a hospital or home care decision. Other factors including large inter-doctor variability (as seen in this study) may operate. The day to day experience of the researcher (HM) was of meeting a substantial number of "misplaced" mothers/children by customary expectations: i.e. many mothers in poor personal and family circumstances who did manage a sick child at home and many mothers in good personal and family circumstances who had a child hospitalised for gastroenteritis.

The situation could be helped if there were clear gastroenteritis management instructions on a leaflet for distribution by doctors during a gastroenteritis consultation. This should have the effect of decreasing maternal anxiety and increasing compliance with specific instructions. It may also be valuable to educate medical staff about the non medical factors (such as sensitization) which influence their management decisions. On a broader front, the provision of opportunities for social contact to young families via social policies and provisions should help to reduce social isolation, a factor found to be associated with hospitalisation of children for gastroenteritis.

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# IMMUNIZATION UPTAKE IN 1989.

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## SUMMARY

Evidence on current levels of immunization uptake in Britain and Ireland is presented and options for improvement outlined.

## INTRODUCTION

Despite extensive media campaigns in these islands levels of uptake of childhood immunization have remained a cause of considerable medical concern. There is a general consensus that the WHO European Regional target of 90% immunization cover by 1990[1] will not be achieved using current strategies. Recent English figures suggest DTP (diphtheria, tetanus and polio) uptake of 65 - 100% and measles uptake of 41 - 91% (average 69%) for 1983 - 1985[2]. In Ireland it is difficult to assess current levels of country-wide uptake of the various vaccines. Boland[3] estimates a 50% country-wide uptake of the much-publicised measles immunization with official sources[4] reporting 55% uptake. Meanwhile a 62% uptake of BCG was recorded over a number (n = 3) of centres5 and levels of DTP were reported to rise from a baseline of 54% to 84% in an eight year localised immunization promotion period[6].

The information presented here on immunization uptake is derived from a larger Irish study of hospitalisation for childhood gastroenteritis[7].

## METHOD

Information on the three routine immunizations for children under two years (BCG, DTP and measles) was collected in the course of a larger study based in the greater West Dublin area in the first quarter of 1987. One hundred and fifty-two families were interviewed, each with a child under two years having had a recent episode of gastroenteritis. Seventy-six of the children were admitted to an infectious diseases hospital with gastroenteritis and 76 were managed at home with GP or casualty department care. The time limit by which children were considered as having defaulted on immunization is relatively generous. For instance, measles immunization is recommended at 15 months old, unimmunized children were not considered to have missed their measles immunization until they were 18 months old. This was to allow for incidents such as minor illnesses which can cause immunization delays with families intending to provide appropriate immunization to children.

## RESULTS

Immunization levels for the two groups of children are reported in Table 1. The two groups studied did not differ in age (hospital group: mean = 10.2 months, standard deviation = 6.3 months; home group: mean = 10.7 months, standard deviation = 6.4 months). Immunization levels were however lower by t-test comparisons for the hospital care group ($p < .02$). The main reasons cited for not availing of immunization were childhood illness (cited by 42% of hospital and 21% of home care mothers) and fear (cited by 2% of hospital and 17% of home care mothers). Some 11% of hospital mothers suggested (incorrectly) that the child was too young for the immunization queried.

**Table 1**

Levels of immunization achieved by hospital care and home care children.

| **Immunization Level** | **Hospital Care** | **Home Care** |
|---|---|---|
| | % | % |
| BCG before age 3 months | 95 | 98 |
| +3:1 or 2:1 x 1 before age 5 months | 80 | 96 |
| +3.1 or 2:1 x 2 before age 7 months | 57 | 94 |
| +3.1 or 2:1 x 3 before age 11 months | 59 | 69 |
| + measles before age 18 months | 22 | 53 |
| No immunizations | 14 | 5 |
| N = 152 | N = 76 | N = 76 |

## DISCUSSION

The home care sample, expected to represent the typical young family (neither exceptionally capable or incapable in the management of gastroenteritis as a common childhood disorder), had measles immunization levels (53%) similar to national estimates quoted earlier. Levels of immunization uptake were satisfactory for both groups in the early postnatal period but began to decline and diverge at about the six-month period. This fall off represents the age-old problem of health education; how to maintain health-orientated behaviours beyond a point of intensive contact, in this case the perinatal period.

In the larger study from which this date is taken[7] the major factors differentiating those caring for their sick children in hospital rather than at home was social integration; hospital care families were less socially integrated than home care families. As with other aspects of the larger study those who were more socially integrated were adopting more health-orientated practices for their children; higher levels of immunization were associated with more maternal leisure activities ($r = .25$, $p < .05$) and more leisure shared with spouses ($r = .34$, $p < .01$). Such findings have been reported elsewhere[8]. This suggests that selective attention to groups at risk regarding immunization uptake could usefully focus on those who are socially isolated in the community. Such an outreach might initially appear to be an expensive use of scarce resources. However, many issues such as nutrition, early parenting and immunization can be addressed by the same services. Furthermore cost-benefit analysis of immunization uptake estimates a 10 : 1 benefit for measles[9] and an 11 : 1 benefit for pertussis[10]. Opportunities for opportunistic immunization promotion may also be available in the paediatric hospital situation. Figures reported here suggest that many children attending hospital have immunization delays and even in the U.S. where compulsory immunization by school age exists, 19% of hospitalised pre-school children in one study had a documented delay in immunization11.

Whatever the strategy adopted it is clear that current practice in Ireland and Britain cannot achieve the WHO target of 90% immunization cover by 1990. We need to look seriously at other options for achieving comprehensive immunization cover.


## ACKNOWLEDGEMENTS

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# THE ONSET OF MENARCHE IN AN EASTERN HEALTH BOARD POPULATION.

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## SUMMARY

Eight hundred and thirty six school girls were studied. The mean age of reported onset was 12.5 $\pm$ 0.06 with a standard deviation of 1.1 years. There was no statistical difference between social classes, number of siblings, or place of the child within the family.

## INTRODUCTION

The age of menarche is of importance to the physical and psychological well being of the adolescent girl (Rutter, 1976). Psychological trauma associated with premature or delayed puberty is well documented. The age of menarche is the most commonly utilized indicator of the age of puberty.

The age of menarche is not fixed but varies between populations and overtime (Tanner, 1976). Since it therefore cannot be assumed that the chronology of menarche will be the same between populations or even in the same population overtime or under different environmental circumstances, it is necessary to study each population separately and to make periodic re-examinations (Zacharias, 1970).

The age of menarche in Ireland was found to be 13 $\pm$ 0.02 years in 1973 (Tanner) and 13.5 $\pm$ 0.08 years in 1986 (Hoey). In France it was 13.2 years (Ray, 1972) while among Melanasians in New Guinea it was as late as 18.4 years (Malcolm, 1970).

Age of menarche has been associated with family size (Roberts, 1971). Roberts also showed no independent effect for social class or family position.

## METHOD

Schools in the catchment area were approached and all girls in each school age 10 - 17 years were approached. The questionnaire included present age, age of menarche, number of brothers and number of sisters, position in the family and both parents occupation. Written parental consent was necessary for the girl to answer the questionnaire. Eight hundred and thirty six girls participated in the study. The socio-economics group was classified by Father's occupation using the United Kingdom Registrar General Clarification (1970).

## RESULTS

Mean age of onset of menarche as reported by the girls was 12.5 $\pm$ 0.06 with a standard deviation of 1.1 years. Place within the family, number of siblings and socio-economic groupings are shown in the Table 1 - 3. Using chi-square analysis, none of the variables were significantly related to age of menarche.

## DISCUSSION

The age of menarche (12.5 years) was lower than that found by Hoey et al. (1986) and correlate with London (13.0), (Tanner, 1981) and American (12.8), (McMahon, 1973) figures.

The lack of social class influence on the age of onset suggests a reasonable degree of nutrition in these children.

Unlike the Roberts Study (1971) no association was found between age of menarche and family size. The results concur with Roberts in that and show that no independent effect for position of the child within the family and this has not been shown in Ireland previously.

Menarche has been getting earlier during the last 100 years by between three and four months per decade (Tanner, 1978). There is some evidence that this trend has stopped in some societies (Tanner, 1981; Zacharias, 1976) but not in others (Wyshak, 1982). It would appear to be continuing in Ireland if one compares the 1986 results (Hoey) with our own.

Studies of monozygotic and dizygotic twin girls and sisters indicate that the age of menarche is chiefly genetically determined under favourable environmental conditions (Tanner, 1962). In present Irish conditions the age of menarche would appear to be largely genetically determined.

In this study it was found that no case of either delayed or premature onset of menarche.

Clear cut relationships between age at puberty and psychiatric illness has not been demonstrated (Rutter, 1976). Howarth (1966) studied girls attending a psychiatric hospital and found an increased proportion of anxiety states in the years before menarche. In the Isle of Wight total population survey of 14 - 15 year olds, age of puberty did not differentiate between those with and without psychiatric disorder (Graham, 1977).

In the psychiatrically normal population, some girls feel pleased with the indication of their feminine status but for others it carries connotation of shame and fear (Rutter, 1976). These girls may suffer from temporary depression and transiently refuse to accept this very tangible proof of their femaleness (Group for the Advancement of Psychiatry, 1973).

Increasingly, girls are taking oral contraceptives and these two may have adverse emotional consequences (Annotation, 1970). Teenage pregnancies are also on the increase and there is good evidence that the puerperium is associated with a substantial increase in psychiatric disorder (Kendall, 1976).

In conclusion, the results may indicate that the age of onset of menarche in Ireland is continuing to fall to general European levels and associated problems of menarche must therefore be looked for in younger age groups.

**Table 1**

| Place in the Family | Number of Girls |
|---|---|
| 1 | 291 |
| 2 | 218 |
| 3 | 148 |
| 4 | 77 |
| 5 | 36 |
| 6 | 30 |
| 7+ | 36 |

| Number of Siblings | Number of Girls |
|---|---|
| 0 | 1 |
| 1 | 78 |
| 2 | 293 |
| 3 | 211 |
| 4 | 131 |
| 5 | 103 |
| 6+ | 119 |

| S.E.G. | Number of Girls |
|---|---|
| I + II | 272 |
| III + IV | 342 |
| V = VI | 222 |

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# HOPELESSNESS AMONG MOTHERS OF CHILDREN WITH BEHAVIOURAL DISORDERS.

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ANTHONY KINSELLA.

## ABSTRACT

In this study four questionnaires, The Eyeberg Child Behaviour Inventory, The General Health Questionnaire, The Guttman Scale and Beck's Hopelessness Scale were administered to the mothers of 50 consecutive children referred to a child guidance clinic. A control group of 30 mothers from the same area attending their General Practitioner were administered the same questionnaires. As expected the children who were referred to the Child Guidance Clinic scored higher on the Eyeberg Child Behaviour Inventory compared to the control group. There was a higher level of hopelessness among the mothers of children referred to the clinic compared to the control group. There were no differences between the two groups in the G.H.Q. scores and the neighbourliness scores. The relationship between the four parameters is discussed.

## INTRODUCTION

It has been demonstrated that mothers with disturbed children show increased rates of psychiatric illness[1]. The level of hopelessness in these mothers has not been studied. Hopelessness has been identified as one of the core characteristics of depression[2,3,4] and has been implicated in a variety of other conditions such as suicide2 and schizophrenia[5], alcoholism[6], sociopathy[3] and physical illness[7]. In this study the hypotheses that there would be increased feelings of hopelessness in mothers of children attending a Child Guidance Clinic was examined.

Brown and Harris[8] showed that social linkage is important for human psychological well-being. In view of this the level of neighbourliness in the study populations was also assessed.

## METHODS

This study was carried out in the Child and Family Centre in Ballyfermot Co. Dublin over a three month period commencing in January 1989. The study population consisted of a group of 52 mothers whose children (ages 2 - 16) had been referred to the centre. One mother refused to partake in the study and one was excluded because her child was less then two years. The final test population was 50. A breakdown of the referral problems in demonstrated in Table 1.

**Table 1**

Breakdown of Behaviour Problems of the Children Referred to the Child Care Clinic.

| Disorder | Number of Patients |
|---|---|
| Conduct disorder | 20 |
| Enuresis | 5 |
| Encopresis | 3 |
| Depression | 4 |
| Learning difficulties | 9 |
| Sexual abuse | 3 |
| School phobia | 1 |
| Night terrors/Somnambulism | 2 |
| Adjustment reaction | |
| Stress related symptoms | 5 |
| Marital disharmony | |

Two children had mixed disorders. There were 34 males and 16 females. The questionnaires involved are usually self-rating but because of literacy problems in some of the mothers an interview-style rating was used. Mothers were also asked the length of time they had lived in the area to the nearest year, the number of children in the family and the type of marriage i.e. married, separated, single parent, common-law (cohabitee), step-parent, or widowed.

The control population which consisted of 30 mothers from the same geographical catchment area attending their General Practitioner at a nearby Health Centre also completed the four questionnaires. These were also completed on an interview basis rather than a self-rating basis. The interviewee had the use of a clinic room one morning each week at the Health Centre and the study was carried out on the same morning each week over four weeks in May 1989. All mothers attending their G.P. who had children between the ages of 2 - 16 years were asked individually to participate in the survey. Of those who had children ten were excluded because they

each were first time mothers with a child less than two years. Two mothers refused. Four mothers who were also in the study population were excluded. The final sample population was 30. Prior to interview, the purpose of the survey was explained to each mother. These were also asked the length of time they were living in the area, the number of their children and their type of marriage. If there was more than one child in the family we selected the child who would most closely match the test group in age and gender when the Eyeberg questionnaire was being administered.

## MEASURES

The G.H.Q.-28 was used to measure the level of psychological stress. It consist's of 28 questions on recent changes in psychological and physical symptoms and ability to carry out normal activities. Many studies have shown it to be a valid and reliable measure for use in adult populations[9]. The respondent was asked if they had recently experienced a particular symptom or type of negative behaviour on a four point scale ranging from "less than usual" to "much more than usual". There were 28 questions in all. Replies of "rather more than usual" or "much more than usual" to a negative symptom meant a score of 1 with a possible total score of 28. A "less than usual response" attracted a score of 0 for each item.

The Eyeberg behaviour inventory is widely used in the assessment of behaviour problems in children. It's validity and reliability are well established[10]. It is used to assess the parents report of their child's behaviour. It is constructed to assess 36 items on two dimensions, firstly the frequency of it's occurrence and secondly it's identification as a problem. The frequency ratings range from, 1 never occurs to, 7 always occurs, which gives a possible score range of 36 - 252. The identification of each item as a problem gives an additional potential score of 36. Thus the overall score range is from 36 - 288.

One third questionnaire measuring women's neighbourliness is based on the Guttman scale as described by Paul Walien[11,12]. This scale is used for investigating factors accounting for individual differences in neighbourliness. There are twelve scale items. Eleven of these items have two responses, indicative of greater neighbourliness and designated G.N. with a score of 1, or an alternative response indicative of lesser neighbourliness and designated L. N. with a core of 0. One item has three possible responses with scores of G.N. (2), G.N. (1) or L.N. (0). The possible range of scores is 0 - 13.

The hopeless scale as constructed by Beck[13] was the fourth parameter studied. Beck designed this scale to reflect the respondents negative expectancies. It consist's of 20 true-false statements of which 9 are keyed false i.e. a false response to these items is assigned a score of 1. Eleven items are keyed true and a true response to each is assigned a score of 1. A response other than the keyed response is scored 0. Thus the possible score is from 0 - 20.

## RESULTS

Table 2 gives the mean value for each of the four parameters tested in both the study group and the control group. The standard deviation is shown in parenthesis beside each mean value. The unpaired (two sample) student t-test was used to assess the probability of each result which is indicated in the end column. There was a statistically significant difference between the scores of the study and control populations when measuring hopelessness ($p = 0.001$). There was also a significant difference between

them on the Eyeberg score ($p = 0.001$) which was as we expected. Scores on neighbourliness and the G.H.Q. demonstrated no statistical difference between the two populations. The mean duration that the mothers in the study group lived in the area was 12.7 years, standard deviation 11.9 years compared to a longer duration in the control group of 18.5 years (standard deviation 11.9 years). This difference was not statistically significant ($p < 0.039$).

**Table 2**

Scores of the test and Conduct Populations by the Four Instruments.

| Instrument | Problem (n = 50) | Control (n = 30) | T |
|---|---|---|---|
| G.H.Q. | 7.40 (6.90) | 7.07 (5.92) | +0.22 (p = 0.83) |
| Eyeberg | 123.00 (42.3) | 94.00 (24.6) | +3.42 (p + 0.001) |
| Hopelessness | 5.76 (4.45) | 2.47 (4.07) | +3.31 (p = 0.001) |
| Neighbourliness | 8.66 (3.36) | 9.00 (3.25) | -0.44 (p = 0.66) |

The T statistic is the unpaired (two sample) student t-test. The standard deviation is shown in parenthesis beside the mean values.

We also compared the type of marriage in the two groups. See Table 3. In this study 18% of the problem group were separated compared to 6.6% of the control group.

**Table 3**

Types of marriages in the two populations.

| Marriage | Study Group | Control Group | Total |
|---|---|---|---|
| Separated | 9 (18%) | 2 (6.6%0 | 11 |
| Married | 37 | 19 | 56 |
| Single parent | 2 | 5 | 7 |
| Common-law (Cohabitee) | 1 | 4 | 5 |
| Step-patent | 1 | 0 | 1 |
| Total | 50 | 30 | 80 |

## DISCUSSION

The importance of hopelessness in a variety of psychopathological conditions has been well established. In our study there was a significantly higher level of hopelessness among the study population. The Beck hopelessness scale used to measure this is a well established instrument. It has been evaluated in a number of studies and has been found to be reliable, sensitive and easily administered[13]. The study and control populations also differed in their Eyeberg questionnaires, with a significantly higher score in the study group. This confirmed the expected finding of a greater magnitude of behavioural disturbance among the children attending the C.G.C. Both groups were selected from the same geographical area, a relatively socially depressed suburb of south west Dublin which was socially homogeneous, therefore socio-economic factors, although not formally assessed should have been similar.

The two groups differed in the length of time they were resident in the area. While this was not statistically significant ($p = 0.037$), in a study with a larger population this may emerge as a more significant factor. They also differed in marital status, the study group having a higher percentage of marital separations (see Table 3). The impact of this on the behavioural disturbance in the child and the hopelessness in the mother is difficult to assess. We hypothesized that mothers in the study group would have a higher level of psychological stress as measured by the G.H.Q., however this was not true. Most of the reported data on the G.H.Q. is obtained from patients in consulting settings. Goldberg, Kay and Thompson[9] carried out a community based survey (a 1 :

23 random sample) comprising 213 south Manchester respondents. The mean score in females was 7.1. In a group of 240 consecutive primary care female attenders the mean score was 12.0. In our study mean scores of 7.40 in the study group and 7.07 in the control, were less than we expected. Our hypothesis that the mothers attending the clinic would feel more socially isolated and consequently score lower on neighbourliness was also untrue. We also expected that there would be a direct correlation between the duration of time living in the area and a higher neighbourliness score but this was not so.

Our most significant finding suggests that mothers of children attending a C.G.C. experienced higher levels of hopelessness than a control population. Whether or not these feelings of hopelessness in the mother are a cause or an effect of behavioural problems in her child, they can certainly exacerbate the situation by impairing her parenting skills. This aspect of the maternal psyche deserves study in greater depth. It's extent should be outlined more fully in similar populations. Therapeutic approaches to deal with these feelings of hopelessness should be developed and then applied and studied in order to determine their impact.

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# BEHAVIOURALLY DEVIANT PRE-SCHOOL CHILDREN AND DEPRESSED MOTHERS.

HELEN LEADER.

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While many studies have been carried out on the incidence of behaviour problems in school aged children, few researchers have studied the prevalence of behaviour problems in the pre-school child. The most extensive study in the area was carried out by Richman, Stevenson and Graham in 1975. They found the incidence of behaviour problems in pre-school children in a North London Borough to be 14.3%. Earls and Richman, 1980 studied behaviour problems in West Indian three year old children in the same borough and found a similar result. Richman also found that behaviour problems in the pre-school child tend to be closely associated with depression in their mothers. George Brown (1975) in his Camberwell Study, found the incidence of depression in working class women to be as high at 40%. He claimed that depressive conditions are often the result of aetiological factors of a directly sociological nature.

## METHOD

A pre-school play group was chosen in which to conduct our study. It was the most adjacent pre-school to the clinic in which the researchers worked, it's staff were already familiar to the researchers, which made for good co-operation between them. This pre-school was directed and staffed by experienced child care workers. It was situated in a working class Dublin suburb, five miles from the city centre and consisted mainly of local authority houses and a small number of privately owned dwellings. While new houses were still being built, this suburb commenced development twenty-five years ago, giving a certain cohesiveness to the community and containing many second and third generation families. There were no high-rise or low-rise flats in the area. Like with all other working class Dublin suburbs, there was a high and increasing unemployment and crime rate.

All three and four year olds attending this group were selected. The aim was to detect the incidence of behaviour problems in these children, and of depression and anxiety in their mothers.

The Behaviour Screening Questionnaire (B.S.Q.) devised by Richman and Graham was used to assess the children. This questionnaire was administered by the same researcher to the mother of each child. A total score of ten on this questionnaire was taken to indicate the 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 mothers of these children were asked to complete the Leeds Scales - these are self assessment scales for anxiety and depression, devised by Snaith, Bridge and Hamilton in 1970. The results of these scales have shown to significantly correlate with observer ratings for anxiety and depression. Three mothers were not seen - one was chronically ill and in hospital, one family had moved from the area to an unknown address and one mother remained unavailable, despite persistent home visits. The help of the pre-school leader was also enlisted, who scored the behaviour of each child on a rating scale. Information about family size, employment of father, physical health of parents and child as well as marital status and contentedness were also enquired about.

## RESULTS

The sample consisted of fifty-nine children, twenty-seven males and thirty-two females. There was a total of fifty-two mothers. Ten children i.e. nine boys (33.3%) and one girl (3.1%) were rated as behaviourally disturbed on the B.S.Q. Fifty per cent of the mothers were rated as depressed and forty per cent as anxious. Using the Pearson Product moment correlation coefficient (Greene and d'Oliviera [1982]), there was a strong correlation between anxiety and depression occurring together in a particular mother ($r = +0.66$ $P < 0.001$). Looking at the correlation between B.S.Q. scores over the whole sample with mother's depression and anxiety, the B.S.Q. was found to correlate statistically significantly with both. The B.S.Q. correlated with mother's depression ($r = +0.37$ $P < 0.01$). The B.S.Q. correlated with mother's anxiety ($r = +0.62$ $P < 0.01$). In the case of the problem group there was an even stronger correlation between B.S.Q. scores and mother's depression was, $r = +0.62$ $P < 0.05$. The B.S.Q. correlated with mother's anxiety was, $r = +0.65$ $P < 0.05$. Looking at individual questions on the B.S.Q. over the entire sample of children, the most frequently occurring difficulties experienced were with dependency, sleep, concentration and discipline. In the problem group, the overall score for each question was higher, with no question scoring significantly higher than others. The mean family size was 2.6 for the problem group and 2.8 for the overall sample. The only useful predictor of behaviour problems in the pre-school child was the child's sex. While other factors such as single parenthood, marital disharmony, unemployment of father and parental and child ill health tended to be associated more frequently with behaviourally disturbed children, the results were not statistically significant. The teacher's impression of the child's behaviour correlated negatively with parental rating on the B.S.Q.

## DISCUSSION

When the B.S.Q. was administered to fifty-nine pre-school children, 16.9% of them were rated as behaviourally disturbed. The overall percentage is somewhat higher than reported by other researchers using the same rating approach. It could be postulated that the sample of children was not representative of the general population of children in the area, but representative of a pre-school group and that more deviant children tend to attend pre-school facilities. The evidence against this is that on questioning, most mothers said they placed their children in the play group to enable them to play with peers and not because they were deviant. Richman (1980) found that children attending a pre-school facility were very little different from the general population in their likelihood of showing behaviour problems.

The high correlation between maternal psychopathology and behaviour problems occurring in her child may have many explanations. The child may have many explanations. The child may be responding to his mother's depression, or of course, it may be the child's behaviour problem that caused his mother to become depressed. Another explanation is that the child's behaviour problems and the mother's depression and anxiety may originate from the same outside source and may be compounded by mutual interaction.

Why were the boys in the sample showing behaviour problems nine times more often than girls? Richman found the ratio of behaviour problems in three year old boys and girls to be 1.5 : 1 respectively. We have been unable to satisfactorily explain this discrepancy, except by generally accepted theories. Shaffer et al., 1980, has found evidence linking male sex hormones to some aggressive behaviour. An active normally aggressive boy may be perceived as deviant by his mother, especially if he is depressed. Child rearing practices for boys and girls differ - parents tend to be more harsh and punitive in the treatment of boys and put emphasis on the development of complicancy and gentle behaviour in girls (Marcoby and Jacklin, 1980). boys tend to play outdoors more than girls and therefore may be more influenced by delinquent behaviour in their environment. Rutter, 1970 and Hetherington et al. (1977) found that boys seem to be more responsive to stress situations than girls. They are therefore probably more sensitive to the presence of a depressed or anxious mother as a stressor. Why were so many of the mothers in the sample depressed? It is because they had a child who was difficult to manage - but then a very large proportion of parents with so called "normal" children were also depressed or anxious. These women were at the vulnerable "life stage" that George Brown (1978) describes - they were young, had young children living at home and 19% were dissatisfied with their marriage and consequently would not have a confiding relationship with their husbands. Their lives would fit into George Brown's description of an "uneventful life" - where women have very little to look forward to - which unfortunately is often the plight of the working class mother. Other vulnerability factors were that they were urban women - Rutter and Quenton describe "inner city stresses" which greatly increase the prevalence of psychiatric disorders in women, particularly depression. Only two of these women worked, Grown (1978) thought work may be a protective factor, unemployment of spouse and financial difficulties have also been linked with maternal depression. One may postulate that the recent recession which is causing much economic hardship and unemployment as well as the increasing crime rate, where many women live in fear for their own and their children's lives are added vulnerability factors.

The teacher's impression of the child's behaviour correlated negatively with parental rating on the B.S.Q. Firstly, both teacher and parent used different types of measurement. Also various studies comparing children's behaviour in the classroom and at home showed that only about one in five children was identified as deviant by both parents and teachers.

It was our impression that much psychopathology and problem behaviour existed in our catchment area and that we were seeing very few of these disturbed families because the social factors that increase the risk of psychiatric disorder generally reduce the chances of reaching the psychiatric services. We feel clinics such as ours should put more emphasis on trying to detect more pre-school children with behaviour and emotional problems, because it is at this age that we can most successfully intervene before maladjusted patterns of behaviour become entrenched and more difficult to reverse.

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# CHILDHOOD DEPRESSION.

MICHAEL FITZGERALD.

Until relatively recently there was a prevailing assumption that depressive disorders rarely occurred in children. There was a belief that the psychological structure of the child was incapable of forming depression.

In the 1960's the idea of depressive equivalents or masked depression began to appear in the literature. It was argued that depressive conditions did occur in childhood but that they took a masked form in which somatic symptoms, enuresis, or conduct disturbances constituted depressive equivalents. However the boundaries of masked depression were never clearly defined and they gradually became extended to the point where almost any form of childhood and adolescent disorder could be considered as a masked depression. This lead to up to 61% of children attending child psychiatric out patients were being given a diagnosis of depression.

It is hardly surprising that there was a strong reaction to masked depression and an increased recognition developed that depressive conditions could meet adult criteria for depression and did appear in childhood. However, unlike what was observed with the concept of masked depression, using adult criteria led to a very restrictive approach to the problem and reportes of rates of depression in child and adolescent psychiatric out patients had even "decreased" to 0%. A debate then arouse as to the equivalence of childhood and adult depression. What became clear to people was that you could elicit adult type depression if you asked children about it. Bailly in the European Child and Adolescent Psychiatry Journal (1992) points out that the current American diagnostic and statistical manual that is DSM-3-R criteria represent a part synthesis of the two previously reported positions.

DSM-3-R classified as depressive disorders into major depression and dysthymia. There has to be at least five of nine symptoms of which either depressed mood or diminished interest or pleasure in everyday activities must be present. The symptom list includes either weight loss or gain, insomnia, agitation or retardation, poor concentration, feelings of worthlessness, and recurrent thoughts of death.

Dysthymia is used when the condition is present for at least one year and involves depressed or irritable mood and two of five symptoms including poor appetite, insomnia, low energy, low self esteem, poor concentration and feelings of hopelessness. The ICD 10 classification makes similar distinctions, categorizing depressive symptoms into depressive episodes, recurrent depressive disorder and dysthymia.

In considering childhood depression particularly using adult criteria we must consider the childs cognitive development. It is clear that young children differ from adult in their ability to experience symptoms of depression particularly the cognitive symptom of hopelessness. It is also clear that children may mislabel anger as depression. If children are to experience guilt, feelings of unworthiness and a sense of failure it is necessary that they appreciate the meaning of standards and are able to compare themselves with others and can understand the concept of failure to achieve a particular standard of performance.

Young children tend to have an over optimistic view of their competence and it is only during the early years of schooling that they begin to adjust their self perceptions as a consequence of past failure. Perhaps this tendency accounts for the finding that young children are less likely to have learned helplessness in response to a repeated (experimentally induced) task failure. Rutter (1988).

Kagan (1982) suggests that self concepts related to the capacity to feel guilt arise about the age of two years. However depressive cognitions involve more than a sense of specific task failure and require that the sense of failure be experienced as generalized and projected into the future.

Children as young as four or five years are aware that other people may feel proud or ashamed of them, but it is not until 8 years or so that they talk about being proud or ashamed of themselves. (Harter 1983). Self awareness in the form of marked self consciousness probably increases during adolescence. Anxieties about the future increase during the teenage period. Young children do no think much of the long term future nor do they conceptualize actions in terms of distant consequences. Probably it is only during later childhood and early adolescence that future perspectives come to the fore. It would seem that such perspectives may be important in the development of feelings of hopelessness about the rest of life. (Rutter, 1988). The age at which children are able to experience selective attachments to particular people is relevant because of the emphasis on the loss of love relationships as a factor associated with depression. This selective attachment usually becomes manifest during the second half of the first year of life. (Rutter, 1988).

## PRE-SCHOOL

Professor Graham (1991) points out that it is difficult or impossible to imply some classical features of depression such as low self esteem, hopelessness and recurrent thoughts of death to classify depression in the pre-school age group. Nevertheless there is no doubt that babies, toddlers, and other pre-school children can appear depressed over a significant period of time and that it is meaningful to think of their psychological problems in these terms. Characteristically, when depressed, infants and toddlers are apathetic and refuse food. They are miserable, unhappy, and irritable, and may spend a good deal of their time crying and rocking. Such children are often referred to paediatricians because of failure to thrive. Growth failure is often accompanied by non-specific diarrhoea. On examination, no physical abnormality is found to account for these symptoms but the child is fretful, insecure and unhappy. There is often evidence of mild developmental retardation. The picture may occur as a result of gross and obvious neglect or there may be more subtle reasons why the child is so disturbed.

Dr. Maureen Doherty (1992) has developed a Pre-school Depression Scale and in a study of depressive states in 11 psychiatrically hospitalized pre-schoolers aged 3 years to $5^1/_2$ years she found that 4 out of 11 met criteria for major effective disorder and that 4 out of 11 had a positive dexamethasone suppression test. She questioned the degree to which depression and anger are separate or associated affects.

Kashani (1979) found a rate of 0.9% major depression in children attending a child development clinic. These were children who had been referred for a variety of child development and behavioural problems.

Let us look now at what discriminates depressed from non-depressed children.

Harrington studied the Maudsley Hospital London item sheets of child psychiatric patients which are completed at the end of assessment and treatment. Harrington

carried out a discriminant analysis to establish which symptoms best discriminated between depressed and non depressed children. He was able to do this with 80% accuracy and found that the best discriminators were:

(1) Suicidal features.

(2) School refusal.

(3) Obsessions.

(4) Hypochondriasis.

A follow up study of children who attended the Maudsley Hospital as child psychiatric patients found that symptoms associated with adult criteria for depression i.e. disturbed sleep, disturbed eating, and suicidal features in children best predicted at follow up in adulthood depression.

Other studies have shown that social withdrawal and depression covary to almost 100%. When you have social withdrawal you must consider depression. It is interesting that Goodyear (1988) found that anhedonia that is lack of a sense of pleasure in life which is central to DSM-3-R classification of depression was not common in adolescence and that worthlessness, guilt and crying were also not particularly common in adolescent depression.

It is important to realise that the diagnosis of child and adolescent depression is often missed. Adolescents do not recognise themselves as depressed and parents and others don't notice it very clearly. What they do notice is a deterioration in school performance, or changes in their child's relationship with siblings or other family members including withdrawal, increased fighting and irritability.

Now a word about gender differences. As regards depression there is no difference between sexes during pre-puberty but adolescent girls out number boys by about 2 to 1.

Bailly (1992) in a study of French adolescents found that thoughts of death, somatic complaints, like asthma, diabetes, conduct disorder, dissatisfaction with appearance and school difficulties was significantly associated with depression only in males. He concluded that males were more susceptible to family problems because he only found a significant correlation between parental depression, anxiety or alcohol abuse and depression in males. Nevertheless females showed significantly more on the following that males:

(a) Weight loss or gain.

(b) Insomnia.

(c) Fatigue.

(d) Loss of energy.

(e) Poor concentration.

(f) Indecisiveness.

He found no significant sex difference in the prevalence of depression with males at 4.1% and females at 4.7% with DSM-3-R criteria. I found a rate of 4% as well using the Achenbach Child Behaviour Checklist.

Let us look now at predisposing factors to depression.

(a) **Biological Factors:**

Foreman and Goodyear (1988) had found raised mean salivary cortisol levels in a group of depressed children but later studies found no significant correlations between cortisol in major depressive disorders compared with conduct disordered or normal adolescents.

(b) Depressed children also show hyposecretion of growth hormone in response to the probe clonidine.

(c) The possibility of a common pathophysiology between major depression and attention deficit hyperactivity disorder is raised by similar rates of non-suppression using the dexamethasone suppression test. (30% M.D., 28% ADHD). Nevertheless, the DST has a lower specificity for children than for adult patients.

(d) Professor Graham (1991) points out that the evidence for neuro transmitter and endocrine abnormalities is weaker in children.

**(2) Family Histories of Psychiatric Disorder in Children with depression.**

These depressed children tend to come from families with histories of psychiatric disorder including effective disorder on the maternal side and on the paternal side mixed diagnosis including effective, anti social and substance abuse problems. Veluri and Fitzgerald (1993) in a study of the life time prevalence of depressive disorder in a consecutive series of adult patients attending a psychiatric department of James Connolly Memorial Hospital found that 45% had a positive family history of depression. The familial nature of depression is open as to whether the mechanism is genetic or environmental and there is no clear cut findings to elucidate this issue.

**(3) Temperament.**

It is unclear whether children with poor adaptability are more predisposed to depressive disorders. My clinical opinion is that they are.

**(4) Chronic Life Adversity.**

Children who are living in difficult and deprived circumstances are more at risk.

**Triggering or provoking events:**

(1) A Great Ormond Street study of adolescent depression has shown an increased number of life events before the onset of depression.

(2) Viral illnesses.

**Now I would like to look at depressive symptoms and depressive disorders in a series of Irish studies.**

Leader and Fitzgerald (1984) examined the incidence of depression in a consecutive series of 49 children age 6 to 16 years attending a child guidance clinic. They administered the Kiddie SADS which is a semi structured interview for effective disorders and schizophrenia. They also administered the Depression Self Rating Scale which is a screening instrument for depression. The mothers of these patients were also given the Leeds Self Rating Scales for anxiety and depression. 20% of children showed evidence of depression. There was a highly significant correlation between the results of the Kiddie SADS and the Depression Self Rating Scale. 37% of the mothers scored positively for depression on the Leeds Scales.

## The follow up study:

Five years later Fitzgerald & Jeffers (1994) carried out a follow up study and managed to make contact with 42 out of the 49 children originally assessed. These included 8 out of original 10 children identified with depression in 1984. They again used the same instruments for the children under the age of 16 but for those over the age of 16 they used the Standardised Psychiatric Interview. The mothers were again screened for depression using the Hospital Anxiety and Depression Scale which was an improved version of the Leeds. The children or adolescents who were depressed in 1984 and under the age 16 in 1989 had a 50% chance of being depressed in 1989. Children who were not depressed in 1984 had a 12% of being depressed in 1989. They found basically the same situation for those over 16 years of age. They found a significant correlation between depression in the mother and depression in the child at follow up. As the numbers in this study were small extrapolations can not be made. Nevertheless the findings were similar to other studies. The busy paediatrician will want to know how good was the short screening instrument the Depression Self Rating Scale in predicting depression at 5 years follow up. Indeed it is interesting that the Kiddie SADS and the depression self rating scale were equally good at predicting depression at five years follow up. 44% of the mothers were depressed initially and 15% were depressed at follow up. One other point was that the females were more likely to have persistent depression than the males but the numbers were small. There was no difference in the rate of depression when the mean age was 10 years or when it was 15 years at follow up.

## The effect of maternal depression on children:

In another study Murphy, Fitzgerald & Kinsella (1989) looked at depressive symptoms and their relationship to state and trait anxiety, as well as self esteem and behaviour problems. They found a significant negative correlation between self esteem and depressive symptoms. As expected there were significant positive correlations between state anxiety and trait anxiety. It has been suggested therefore that anxiety and depression are not distinct but part of a more general category of emotional stress called negative affectivity. Findings are generally against this construct. There was considerable co-morbidity for depression, anxiety and behaviour problems particularly anti social behaviour. Scores of more than two standard deviations above the mean were taken as indicative of high anxiety on the State Trait Anxiety of Speilberg's. 3.5% (3) scored above two standard deviations on the State Anxiety Scale. Of those who scored above these limits on the State Anxiety Scale (3) 2 scored also positively on the Depression Self Rating Scale and both of these also scored as behaviourally deviant on the Rutter B2 Scale - Conduct Disorder.

The significant relationship between self esteem and depression (-0.627) indicates a close association between these factors. Depression could either be a cause of low self esteem or low self esteem could be a vulnerability factor for depression. Certainly in the clinic domain one sees low self esteem as a low vulnerability factor for depression and depression lowering self esteem. It is of interest that Brown found that negative evaluation of the self was shown to predict depression in adults in response to a provoking agent. It is also of interest that the Offer Self Image Questionnaire has been shown to predict outcome of adolescents depression better than age, sex or social class.

## Depressive symptoms in female adolescents:

When Brown, Fitzgerald & Kinsella (1990) looked at psychological stress in 130 female adolescents average age 16 years using the Youth Self Report Questionnaire of Achenbach they found that 4% of the sample scored on the Depressed Subscale. When they looked at individual items we found that 34% of adolescents said it was sometimes true that they cried a lot and 11% said it was often true. 43% said that it was sometimes true that there moods or feelings change suddenly, while 29% said that this was often true. 22% said that it was sometimes true that they thought about killing themselves, while 7% said that this was often true, 51% said that it was sometimes true that they were unhappy sad or depressed, while 10% said that this was often true. A study (Williams and Fitzgerald, 1989) of $13^1/_2$ year old male and female disadvantaged adolescents using the General Health Questionnaire found that 44% reported 6 or more symptoms with no difference between males or females but the mean scores of the females were higher than the males which suggested that the switch over to the adolescent and adult pattern was taking place.

## Depressive symptoms and disorder in 10 year olds:

In a study of 2029 10 year olds Fitzgerald & Jeffers (1994) found that using Teacher Questionnaires when teachers were asked whether the children were miserable they said that this applied somewhat to 10% and definitely applied to 2%. When they interviewed the parents of a sample of children scoring positively and negatively for behaviour problems on the screening instrument and asked the parents about individual symptoms in their children they found that 4% of the children were chronically unhappy and 1.6% were depressed. When the children were given individual diagnosis using the ICD-9 classification system 1.1% emerged with endogenous depression. These children had symptoms of persistent depression with sleep disturbance, poor appetite, psychomotor retardation and they felt unloved and unwanted. These symptoms differed from the 1.6% with a disturbance of emotions specific to child and adolescents i.e. misery and unhappiness. (These had a longer duration and showed a lack of a close relationship in time and content to some stress). It is also of interest that 31% of the mothers in this sample of 190 had formal depressive disorder on interviewing which was significantly associated with marital discord, lack of a confidant, dissatisfaction with role and a wide variety of social contact variables as well as financial and housing problems. All these variables were equally significantly associated with child psychiatric disorder.

## Clearly depression has significant effects on children:

(1) Social modelling may play a role.

(2) It is interesting that children become self critical because of maternal criticism of them.

(3) Depressed mothers are less available and more irritable and find it difficult to tune into their child.

(4) Depressed mothers are more preoccupied with their own condition and critical of their babies and children.

(5) Infants react with distress and looking away when mother is still in a depression. With depressed mothers this is maintained even with strangers. This may be the beginning of learned helplessness. There is an interference with social interaction and this affects language and social responsiveness as well.

(6) Children of depressed mothers cry more.

(7) They have more insecure attachment.

(8) Depressed mothers are more controlling in their talk. Children of depressed mothers have more sleep problems, temper tantrums and behaviour problems, reading problems and performed less well at cognitive tasks at age five.

(9) When mothers depression remitted children's behaviour problems did not necessarily improve.

(10) High I.Q. and good temperament can be protective in this environment.

## Co-morbidity and Depression:

One of the most consistent findings from recent research into child and adolescent depression has been that it is very common for these disorders to occur in conjunction with other psychiatric problems including conduct and anxiety disorders as well as educational retardation and anorexia nervosa.

In Goodyear's et al. (1988) study he found that 40% of his depressed patients had co-morbidity with other psychiatric diagnosis. It is also of interest that Kovacs et al. (1988) found that the conduct disorder did not remit when the depression lifted but persisted and was often associated with long term behavioural problems. This suggested that the conduct disorder and depression had different prognostic implications. This supported the idea of co-occurence. It is also possible that co-morbidity could be explained by the fact that one disorder creates a risk of another or it could be explained by the fact that multiple diagnostic categories are reflecting a single underlying disorder.

## Treatment of Depression:

(1) Any specific stresses in the child's life have to be dealt with for example learning or language problems, intellectual deficits, bullying or reactions to disorders like diabetes, asthma, etc.

(2) The psychological therapy will focus in the first instance on communication problems within the family. The depressed child may be scapegoated and constantly criticized by family members. In Ireland parents are excessively critical of their children. Helping families to talk and identify positive aspects of each other and to reinforce each other in a positive way with praise (something that is greatly feared by many Irish parents) can be very helpful. The families

increased empathy and understanding of each others position can make a big different. Previous studies have shown that when the symptoms of depression remit and the child's interpersonal difficulties can remain and will need attention in their own right some times using individual psychotherapy. (Puigh-Antich et al., 1982).

Individual psychotherapy is very important. The children often have much bottled up anger and resentment at real or imagined wrongs done to them. This anger is turned inwards which increases their depression and ventilation of this is extremely important. I have often noticed that depressed patients have a sense of being unloved and undervalued. This can lead them to being withdrawn which only increases their depression. Some would see this as a social skills deficit. Helping to reality test their situation, to become more trusting and to engage more directly with people can be very helpful. Getting them to make positive statements about themselves to themselves is very important in countering the negative self statements that they make so often about themselves for example "I am no good nobody loves me" etc. Sometimes cognitive therapy for adolescents in a group setting a long the lines I have described can be helpful.

Finally if all this fails anti depressants should be considered i.e. Imipramine for the slowed up child or amitryptline for the agitated child. Unfortunately there is very little sound evidence for the efficacy of anti depressants in childhood. Puigh-Antich et al. (1987) found Imipramine no more effective than Placebo.

A number of reasons for the lack of effectiveness of anti depressants have been suggested including:

(1) Difficulty of sustaining satisfactory anti depressant blood levels and compliance problems.

(2) Problems in separating subgroups of depressives. Is it possible that those with more endogenous type depression might respond better?

(3) It maybe that there are greater placebo effects in childhood or weaker drug effects.

(4) Adolescent receptor sites may be altered explaining differences in response.

(5) Finally it may be that there is some immaturity in the noradrenergic system that is responsible.

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# A Study of the Lifetime Prevalence of Depressive Disorder in the First Degree Relatives of Patients with Major Depression.

Ramamohan Veluri.

Michael Fitzgerald.

## Summary

A consecutive sample of patients with a diagnosis of major depression was taken and the lifetime prevalence of depression in their first degree relatives was determined by Family History method of Research Diagnostic Criteria (FH RDC). A prevalence of 11 per cent was obtained. An attempt was made to explain the results. The Hospital Anxiety and Depression (HAD) scale was also administered to the same sample of patients and it was found that many more anxiety symptoms were revealed, which could not be detected at the clinical interview.

## Introduction

It is generally agreed that the life time prevalence of depression in the first degree relatives of probands with depressive illness is in the order of 15 per cent, as compared to 3 to 6 per cent in general population. It was shown to be 15 to 20 per cent in bipolar and 10 to 15 per cent in unipolar (Gershon et al., 1976).

Research Diagnostic Criteria (RDC) (Spitzer et al., 1978) is a widely accepted and extensively used instrument for diagnostic purposes in research. The present study attempts to find out the lifetime prevalence of depression in first degree relatives of depressive probands using FHRDC (Andreasen et al., 1977). The dormant anxiety symptoms in these patients using Hospital Anxiety and Depression (HAD) scale was also assessed (Zigmond & Snaith, 1983).

## Method

Consecutive cases of clinically depressed patients were taken and interviewed using Research Diagnostic Criteria to assess if they met the criteria for major depression. RDC was developed on the modification and elaboration of some of the diagnostic criteria developed in St. Louis and was successively revised. A major purpose of the RDC is to enable investigators to select relatively homogeneous groups of subjects who meet specific diagnostic criteria. The criteria for major depression are modified from Feighner criteria to make "the presence of a pervasive loss of interest or pleasure" the central feature. To make a diagnosis of major depression, any organic condition is to be excluded in the first place. Then it should meet all the features of subgroups A through F. A, B, C, & D involve symptoms, duration and treatment or help sought

during the dysphoric mood while E and F exclude schizophrenia and schizophrenia residual subtype.

The patients studied involved those attending the psychiatric department of a big general hospital in Dublin. They were seen at the out patient department, at the psychiatric unit and at the other departments during liaison work. All the cases were taken in a consecutive manner.

Family History method of Research Diagnostic Criteria (FHRDC) is the family history method of RDC to find the lifetime prevalence of a psychiatric disorder in first degree relatives of patients. This is administered to the patients or the other relatives to elicit information regarding other family members. This is in contrast to the family study method where the relatives are interviewed directly. Andreasen (1977) compared these two methods and found that FHRDC has respectable sensitivity for many major diagnoses. In this study FHRDC was administered to the patients during the first interview and again when they recovered from depression.

The Hospital Anxiety and Depression scale (HAD) was administered before the administration of Research Diagnostic Criteria interview. The HAD is a self-rating scale with half of the items directed towards anxiety and half towards depression. Patients were asked to make one of the four choices which indicated the severity of those symptoms. The anxiety and depressive scales are valid measures of severity of the emotional disorder. (Zigmond & Snaith, 1983).

## RESULTS

A total of 33 cases was studied with a mean age of 41 years. the male to female ratio was 12 to 21 or 1 to 1.75. There was a positive family history of depression in 15 patients (45% of the total patients) and the total number of relatives involved was 20 or 1 for 1.7 patients. The relative most involved was sister (35%) followed by mother (30%). The ratio of male to female relatives involved was 7 to 13 or 1 to 1.8. The mean age at first episode of depression among the cases was 32.

There were 9 bipolars and 24 unipolars in the sample. Among the relatives of the bipolars, the positive family history of depression was 5 or 15%. It was 15 or 8.1% among the relatives of unipolars.

There were 18 patients whose ages were below 40 years and 18 percent of their first degree relatives were involved.

On the HAD scale, anxiety and depression subscales were taken separately for the analysis of results. On the anxiety subscale, there were 2 non-cases, 3 doubtful cases and 28 definite cases.

## DISCUSSION

As mentioned above, it is generally agreed that the lifetime prevalence of depression in first degree relatives of depressive probands is in the order of 15%. Palmour et al. (1989) showed that the empiric risk figures in his study suggested that the first degree relatives of a person with affective illness have about 25-30 percent liability of major depression or manic depressive illness as compared to a population risk of 3 to 6 per cent. McGuffin et al. (1988) showed that the lifetime prevalence of depressive illness in first degree relatives of patients with depression was 38.9%. Compared to the two

recent studies mentioned above, this study showed a lower lifetime prevalence of 11 per cent in first degree relatives.

Even though it is not possible to generalise the results to Irish population as a whole, it seems that it is possible that genetic influences are less in this sample. It is also possible that certain other factors might have influenced the results. For example, the probands in this study were of younger age group and most of them (N = 19) were single and some (N = 2) did not have children. This led to a lesser total number of children of these probands, which might have affected the prevalence when first degree relatives are taken as a whole (parents, sibs and children).

The sample as a whole is from a low socioeconomic group of people, who were mostly unemployed for a considerable period. There were ongoing unsolvable problems which were acting as perpetuating factors and in some cases there were some significant life events which could be taken as precipitating factors. In fact, some of these cases started as reactive depression and progressed to meet the RDC criteria for major depression. From the figures of his study, Palmour (1989) felt that pedigree studies strongly suggested a high risk in families 'loaded' for affective disorder and a low risk in families with sporadic occurrence of the same illness. The possibility of a high proportion of these 'non-familial' type of depressive disorder in this sample might have reduced the lifetime prevalence in the first degree relatives of this study.

The higher prevalence of 16 per cent in relatives of bipolars is more than that of relatives of unipolars which is 8.1 per cent. This shows the trend of higher genetic influences in bipolars as shown in previous studies.

The ratio of females to males affected in the sample as well as in their relatives is approximately 2:1, which is in conformity with the previous studies. The relatives mostly involved were sister and mother and this may help in identifying the relatives at high risk and to provide them with help along the lines of primary prevention, e.g. educating them to reduce stress in their lives.

The results also show that a higher proportion of relatives (18%) of patients of lesser than 40 years of age were involved. This is in conformity with previous studies by Gershon et al. (1976) and Weissman et al. (1986).

As far as the findings on HAD scale are concerned, it was found that the symptoms of anxiety expressed by patients on this scale were much more prominent as compared to the depressive symptoms. These could not be detected at the clinical interview. Dr. Snaith in a personal communication expressed the thought that it might be that patients are more likely to report their more urgent depressive experience at interview. This suggests the importance of probing more for symptoms of anxiety in depressives, especially using a subjective rating scale like HAD.

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# A FOLLOW-UP STUDY OF DEPRESSIVE ILLNESS IN CHILDHOOD.

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## SUMMARY

In a study of 49 children attending a child guidance clinic in a socially disadvantaged urban area Leader et al., (1989) found an incidence of depression of 20%. This study is a follow up of those children after five years. At follow up half of the original eight depressed children were found to be depressed, along with four other children who were not originally depressed. A child who was depressed five years previously had a 50% chance of being depressed at follow up as compared to a 12% chance if not depressed 5 years previously. This study found children who were persistently depressed were more likely to have depressed mothers.

## INTRODUCTION

Depression in childhood has become a topic of considerable research interest over the past decade. There is evidence to suggest that children of depressed parents are at increased risk of developing depression (Weissman et al., 1984). In Irish children Leader et al., (1989) found no relationship between maternal depression and childhood depression. Studies that have attempted to assess the outcome of depression in childhood found a poor prognosis.(McGee and Williams 1988; Kovacs et al., 1984, I & II; Poznanski et al., 1976). The present study looks at the outcome of depression in a group of children who attended a child guidance clinic in a working class Dublin suburb. The relationship of maternal depression to outcome is assessed.

## METHODS

In a study (Leader et al., 1989) conducted five years previously a group of 49 consecutive attenders at a Child Guidance Clinic were assessed for the prevalence of depression in a clinic population and their mothers were assessed at the same time for anxiety and depression. In the current study these mothers were traced and sent a letter informing them of the nature of the present project. A psychiatrist then made a home visit and, having obtained verbal permission, interviewed both mother and child. As in

the original study (Leader et al., 1989) the instruments used for assessment were the Kiddie Schedule for Affective Disorders and Schizophrenia (Puigh Antich et al., 1983) and the Depression Self Rating Scale (Birleson 1981) for children under 16 years. As twenty-two of the group at follow up were over 16 years old these instruments were not suitable for them and they were assessed using The Clinical Psychiatric Interview which is a standardised, semi-structured inventory designed for use in community surveys and general practice. (Goldberg et al., 1970). Mothers were asked to complete the Hospital Anxiety and Depression Scale (H.A.D.) which is a self rating scale for measuring depression and anxiety (Zigmund and Snaith 1983). The interviewer was blind to the original diagnoses for both mothers and children. The K.S.A.D.S. is a semi-structured interview which is a modification of the adult S.A.D.S. The Depression Self Rating Scale (D.S.R.S.) was devised by Birleson to measure moderate to severe depression in childhood (Birleson 1981; Birleson et al., 1987).

## RESULTS

Three families could not be traced, and four parents refused to cooperate. Forty-two children and their mothers were assessed. The children followed up were aged 10 to 20 years, with a mean age of 15.4 years. This included twenty-five males and seventeen females. Of the original group of ten with depression (as rated by both KSADS and DSRS), one had left the country and one parent refused to cooperate.

Eight children who were originally depressed were assessed, (five males and three females). Five of these were found to be depressed using KSADS, and three scored for depression on DSRS only. At follow up four children (50%) were still depressed. Depression at follow up was as likely if initial depression was diagnosed by K.S.A.D.S. or D.S.R.S. Children who were depressed initially and at follow up (Gp A Tab.1) had a mean age of 16 years and consisted of three females and one male. Two of their mothers were depressed originally and at follow up. This compared with those who were depressed initially and not at follow up (Gp B Tab.1). This group had a mean age of 15.5 years and all four were male. One mother was depressed originally and none at follow up.

At follow up four (12%) of the thirty four children who were originally not depressed were found to be depressed (Gp C Tab. 1). They had a mean age of 14.5 years and consisted of two males and two females. One of their mothers was depressed originally and two were depressed at follow up. Thirty children did not score for depression on both occasions. (Gp D Tab. 1). They had a mean age of 15.5 years and consisted of sixteen males and thirteen females. Forty four per cent (44%) of their mothers were depressed originally and 15% were depressed at follow up.

Group C has a slightly lower mean age than the other groups. On an analysis of variance using F ratio test this age difference was not significant. In both 1984 and 1989 the rate of depression is 19.5%.

**Table 1**

Depression Over Time

| Group | Mean age | Male/Female ratio | % mothers depressed initially § | % mothers depressed at follow up § |
|---|---|---|---|---|
| Gp A | 16 yrs | 1/3 | 50% | 50% |
| Gp B | 15.5 yrs | 4/0 | 25% | 0% |
| Gp C | 14.5 yrs | 2/2 | 25% | 50% |
| Gp D | 15.5 yrs | 16/13 | 44% | 15% |

Group A (depressed initially* and at follow up)

Group B (depressed initially* not depressed at follow up)

Group C (not depressed initially* depressed at follow up)

Group D (not depressed initially or at follow up)

* = as rated by either K.S.A.D.S. or D.S.R.S.

§ = this difference in maternal depression is significant at the 10% level ($p<0.10$) using McNemar's X. There was no significant difference in the rate of maternal anxiety in both years.

## DISCUSSION

The results of this study adds to the considerable body of evidence that depression in childhood can be relatively persistent. This study shows that a child who was depressed 5 years previously had a 50% chance of being depressed at follow up, compared with a 12% chance if he was not depressed 5 years previously. These results concur with those of Poznanski et al., (1976) who followed up 10 of an original group of 14 depressed children. Kovacs et al., (1984 I & II) reported a similar poor prognosis for those with major depressive disorder.

The results also suggest that there are sex differences in persistence of depressive symptoms. All 3 females who were originally depressed were depressed at follow up, whereas only one male of 5 originally depressed was depressed at follow up. The female predominance shown is in keeping with that reported for adult depression (Boyd and Weissman 1981) and concurs with Albert and Beck (1975) who report a change in sex ratio of depression during adolescence.

Rutter (1979) reported a marked increase in depression in children at age 14 years as compared to 10 years. Overall depressive disorders in adolescence were much more frequent in girls than boys. The fact that this study showed no difference in rate of depression in the group when mean age was 10 years or when mean age was 15 years deserves comment. The smaller number of girls in the present group could explain the lack of overall increase in rate of depression. Also the original group of eight depressed children included three who were found to be depressed on D.S.R.S. and not on K.S.A.D.S. The D.S.R.S. is a self rating scale and these cases could be

classed as false positives. If these cases are excluded there is a real increase in rate of depression over five years. However, Birleson et al., (1987) found a high incidence of dysthymic features in a group of children with false positive scores on the D.S.R.S and Kovacs et al., (1984) showed that 69% of children with dysthymic disorder had a major depressive episode within 5 years of diagnosis. Since two of the three children who scored for depression on D.S.R.S. alone originally, fulfilled R.D.C. criteria for major depression at follow up these findings could indicate that these false positives from Leader et al., (1989) studied were in fact dysthymic disorders. D.S.R.S. may be a useful tool for predicting risk of future depressive illness, this study suggests that it is a useful screening instrument for identifying childhood depression. It could be useful for use in a large population studies and in longitudinal studies.

The evidence that children of depressed parents are at risk for psychological dysfunction is well documented (Rutter 1966). Numerous studies have shown a strong aggregation of major depression in the first degree relatives of depressed probands (Weissman et al., 1984; Gershon et al., 1982). Originally Leader et al., (1989) found no correlation between mothers depression and childhood depression. She found a significantly higher rate of depression in mothers overall than was found at follow up. This difference could be explained by the fact that different instruments were used to assess depression on each occasion. Leader using the Leeds scale (Snaith et al., 1976) and found a rate of almost 40%. The follow up study used the more recent H.A.D. which differentiates more clearly between anxiety and depression. This difference in rates of depression using these scales has been reported previously (Mulhall et al., 1988; Leader et al., 1985). Mulhall et al., (1988) using the H.A.D. found a 7.7% rate of depression in mothers of children attending a pre-school in the same socially deprived area. This was almost half the rate found by Leader et al., (1985) in an earlier study using the Leeds scale on a group of mothers of children attending the same play school. These results would seem to indicate that the H.A.D. scale has a greater specificity for depression and is a useful instrument for use in out patient population.

The finding that children were more likely to have a persistence of depression if their mother's depression is persistent is interesting. These results are similar to those of Apter et al., (1982). They studied 18 children of depressed parents at age 10 years and 14 years. Only 2 of the original 12 depressed children were asymptomatic at follow up. Weissman et al., (1987) found children of depressed parents to have a higher rate of depression, substance abuse and poorer social functioning. When the issue of genetic and environmental factors and childhood depression were examined Hammen et al., (1987) compared this issue by comparing the incidence of depression in children of depressed mothers, chronically ill mothers and normal mothers. With the effects of chronic stress controlled for they found few differences between groups but they did find particular impairment for children of unipolar depressed mothers. Future research should focus on whether depressed mothers who are adequately treated for depression have less depressed children at follow up than mothers whose depression is inadequately or unsuccessfully treated.

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# THE INCIDENCE OF FIRE SETTING AND ASSOCIATED PSYCHOPATHOLOGY OF CHILDREN ATTENDING A CHILD PSYCHIATRIC OUTPATIENTS.

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## SUMMARY

Fire setting can be a serious form of anti-social behaviour. A study of 79 consecutive out-patient attenders at a Child Guidance clinic found a rate of 15 (18.9%). The number of fires set ranged from 1 to 20 (mean 9.9). Conduct disorder was found in 8 (53.3%) of the fire setters.

## INTRODUCTION

Fire setting is a form of antisocial behaviour that can have serious consequences. It may arise as a result of experimentation with matches or as a deliberate destructive activity. American figures suggest that a third of all fire setting is done by children[1].

According to the Federal Bureau of Investigations's[2] Uniform Crime Reports, 54.6% of all arsonists arrested in the United States during the 1970's were under 18 years of age, 11% were under 10 years.

Stewart and Culver[3] in a study of 46 children who had been admitted to Psychiatric Unit and whose problems included fire setting found that only 11 were admitted solely for their fire setting behaviour. They found a prevalence of fire setting among inpatients of 14.3% and a connection to conduct disorder. They followed up 30 subjects one to five years later and found that seven were still setting fires but that there is no reliable way as yet to tell whether a child will stop setting fires or continue.

A study[4] of 104 fire setters attending a Child guidance Clinic in London found that they formed part of a subgroup of severe conduct disorders and were characterized by a peak age of 8 years; high boy/girl ratio and marked psychosocial disturbance.

The incidence in the United Kingdom of fire, in particular school fires, set by children and teenagers has considerably increased in the past 10 years. There is no general population data available on fire setters.

Despite the above facts, little definite evidence exists to distinguish child fire setters from their non-fire setting peers[5].

## METHOD

Seventy-nine children attending The Psychiatric Registrar or Social Worker from the 1st of July 1988 to the 1st October 1988 were studied.

For the purpose of the study, a fire setter was defined as a child between 4 and 16 years old who has set at least one fire without permission or supervision.

The children attending who did not fire set were used as a control group.

To diagnose a child's primary psychiatric condition, the I.C.D.9 Multi-Axial classification[6] system was used.

## RESULTS

All 79 were Irish; 22 (27.9%) were girls and 57 (72.1%) were boys. The mean ($\pm$ S.E.M.) age was 9.5 ($\pm$ 0.5) years and all were in S.G.III - VI (British Registrar General).

Fifteen of the 79 (18.9%) were fire setters (F.S.); 2 (2.5%) observed other gang members fire setting while the remaining 62 (78.6%) were non fire setters (N.F.S.). All the fire setters and observers were male.

Among the F.S., fire setting behaviour began between 4 and 9 years old (mean $\pm$ S.E.M. = 6.9 $\pm$ 0.5). The number of fires set ranged from 1 to 20 (mean 9.9). Six (40%) were fire setting within the previous six months, 1 (6.6%) between 7 and 12 months prior to the study and 7 (46.6%) had not fire set within the preceding 2 years. In the latter group average duration of fire setting was one year. Nine (60%) of the children set fire for excitement. Seven (77.87%) of these did their fire setting exclusively on waste ground with 6 - 8 peers and heightened their excitement by running through the small fires. These children generally used matches or cigarette lighters to light paper and used the inside of rubber tyres. Two (22.2%) of these 9 also set one fire each at home. One for reason of curiosity synged a carpet, the other burned the curtains of his bedroom when confined there for disciplinary reasons. Of the remaining 6, one (6.6%) repeatedly set small fires at home (the parents felt out of fascination) while the other 5, fire set them out of revenge. All were alone and set fires exclusively at home. Three of these five set fire to their bedrooms when confined there for disciplinary reasons; all causing negligible damage. One boy, with a poor father-son relationship, set his father's pillow on fire. One boy with disciplinary problems at school, set his books on fire when forced to study at home. The mean (S.E.M.) age of the 'Revenge' group was 5.7 $\pm$ 0.6 and of the excitement group was 7.6 $\pm$ 0.6. This was significant at $p<0.05$.

The cost of fire damage was negligible in 9 of the cases and never exceeded £50 in any instance.

A disorder of conduct specific to childhood was the primary diagnosis in 8 (53.3%) of the F.S. as compared to 15 (24.2%) of the N.F.S. Using the chi square analysis and a Yeats correction (chi square = 3.6, D.F. = 1, $p<0.05$). This was significant. All other psychiatric diagnoses were similar in both groups.

None of the F.S. or observers had a history of sexual abuse while 4 (6.5%) of the N.F.S. had a history of definite sexual abuse; 2 (3.2%) probable sexual abuse and 2 (3.2%) possible sexual abuse. However, this difference between the two groups did not reach statistical significance.

In the F.S. group, 2 (13.3%) had a definite history of physical abuse and 2 (13.3%) had a history of probable physical abuse. This did not differ significantly from the N.F.S. group ($p<0.55$).

Poor performance in school occurred in 11 (73.3%) of the F.S. and in 23 (37.1%) of the N.F.S. This was significant with Years correction at $p<0.024$ (chi square = 5.0, D.F. = 1).

There was no significant difference between F.S. and N.F.S. as regards paternal alcoholism (40% : 27.4%), family breakdown (46.5% : 43.5%), enuresis (20% : 22.5%), mean number of siblings (3.2 : 2.7), psychosis (0% : 1.6%).

## DISCUSSION

The findings of the F.S. being exclusively male is consistent with larger studies[7] where males outnumber females by 8 : 1. Boys are more likely than girls to set multiple fires, be motivated by excitement and to set fires on waste ground. Showers and Pickerell[7] found that 39% of fire setters presented with fire setting to a county Mental Health Centre and 33% presented with behavioural problems.

Larger studies have found that about one third of fire setters are 4-8 years old; one third 9-12 years old and just over one quarter are adolescents. The breakdown was 73% in the 4-5 years old, 27% in the 9-12 years old, and interestingly there were no adolescent fire setters. Perhaps adolescents fire setters are more likely to get into trouble with the law and may be dealt with in state institutions.

Revenge has been found to be more common in 9-12 years old than in younger or older children[7] but revenge was noted to be more common in younger children. Showers and Pickerell[7] also found the financial cost of fire damage to be higher in the younger age groups. This was not found in this study.

It is of importance to note that only one of the fire setters volunteered information about his fire setting behaviour. Fire setting information was elicited only on direct questioning of parents and children in all other instances. Most of the parents were not worried about their children fire setting and felt it was a transient phase and part of peer group behaviour. Even those parents whose children fire set at home and alone did not volunteer this information. This suggests that unless a child and his family are directly asked about fire setting behaviour, it will be missed in most instances.

The findings of this study failed to corroborate results of other studies that have suggested correlation between fire setting and enuresis or cruelty to animals, large family size[8], adoption[9] or psychosis. The 'sexual roots' of pyromania which derived from highly selected observations that compulsive masturbation, impotence and fetishism were associated with fire raising[11] have been recently re-affirmed in certain prison populations[12].

However modern clinical studies have failed to replicate either link[13]. It would appear therefore that a sexual aspect of the problem is regarded as being much less important nowadays than in the past. It is more helpful to consider the fire setters as neglected angry children who express their sense of anger and alienation through fire setting. Of course modelling and group pressure would appear to play a part in certain cases.

However the study supported the finding of Showers and Pickerell[7] that fire setters tend to have conduct problems and have poor performance at school. In addition, it

was found that there was a high incidence of paternal alcoholism and physical abuse among the fire setters.

Although, not reaching statistical significance, 40% of our F.S. had fathers who abused alcohol as compared to 27.4% of N.F.S. Showers and Pickerell found that fire setters were significantly more likely to have fathers who abused alcohol or drugs. It is possible that with large numbers this would have been found in this study as well. Although not reaching statistical significance the F.S. group tended to cluster with variables such as one parent families, physical abuse and the more disadvantaged areas.

The absence of sexual abuse in F.S. correlates with Showers and Pickerell. The triad of fire setting, enuresis and cruelty to animals which in earlier years received widespread attention has once again been refuted.

It is of note, that despite the recent increase in school fires, none of the F.S. set fires in the school area. In contrast to Showers and Pickerell, the cost of damage due to fire setting was not high.

In no case was the child referred for his fire setting to the Clinic and the children were treated for their primary diagnosis. As their other behavioural problems were resolved so did their fire setting behaviour receded.

Fire setting behaviour in children needs to be elicited by direct questioning or else it will be undiagnosed. It appears to be one part of peer group behaviour certainly among S.G III - VI in the Dublin area and doesn't appear to duly worry parents. It appears to be a transient activity and from questioning the cohort, many non-psychiatric boys of the same age engage in the activity.

Fire setting is significantly correlated with conduct and poor performance at school.

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# A Psycho-Educational Study of Normal School Children.

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## Summary

Anxiety, depression, self esteem, reading ability, behavioural deviance, and pro-social behaviour were measured in a normal school population, using self rated and teacher rated questionnaires. The prevalence of depression was five percent. Fifteen percent had frequent suicidal thoughts. Forty percent scored as behaviourally deviant. Significant correlations were found between self esteem and depression, self esteem and trait anxiety, and state anxiety and depression. Reading age was related to anxiety, pro-social behaviour and behavioural deviance, and prosocial behaviour and behavioural deviance were inversely related.

## Introduction

Epidemiological studies of psychiatric disorder in normal children have shown close associations between psychiatric disorders and physical abnormality [1], and between psychiatric disorders themselves, such as behavioural deviance and reading retardation [2,3] and behavioural deviance and depression [4]. The strength and significance of these associations have differed in most studies, as have the prevalences found for the disorders themselves. The prevalences found have varied with the instruments used, with clinical interviews [2,5] producing much lower prevalences than self rated or other questionnaires [6].

Studies of depression have found prevalences between 2 percent [5] and 33 percent [6]. The Isle of Wight study [2] found a prevalence of depression of less than 1 percent and a 1.5 percent prevalence of anxiety. Studies of behavioural deviance in Irish populations using teacher-rated questionnaires have found rates of up to 40 percent [1]. In clinical practice, anxiety and depression frequently co-exist and are closely related to self-esteem. This study attempted to measure the prevalence of depression in a normal school population, and to assess the relationships between depression, reading difficulties, behavioural deviance, prosocial behaviour, anxiety and self esteem.

## METHOD

All children in the age group 9 - 11 years in a school in a high density, high unemployment area of the city were selected for the study. The sample consisted of eighty boys, which was the total number in this age group. Each pupil completed questionnaires measuring anxiety, depression, and self esteem.

Reading age was measured on each subject by the Marino Reading Age Test. The same rater measured reading age on each subject. Scales measuring prosocial behaviour and behavioural deviance were completed by the teachers on each pupil. The questionnaires were completed as follows: The State Trait Anxiety Inventory which was devised by Spielberger [7] is a research tool to measure state anxiety and trait anxiety in pre-adolescent children. It consists of two twenty-item questionnaires measuring - first, State, and then, Trait anxiety. This scale correlates well with other measures of anxiety. Reliability co-efficients are 0.82 and 0.78.

The Birleson Depression Self Rating Scale (DSRS) is an eighteen item questionnaire based on clinical criteria for depressive disorders [8]. This scale correlates well with clinical criteria. Reliability co-efficient is 0.80.

The Coopersmith Self Esteem Inventory consists of fifty-eight questions which attempt to evaluate the self image in various areas of life [9]. Reliability co-efficient is 0.87.

The Rutter B2 Teachers Scale rates behavioural deviance, and has sub-scales classifying positive scores into "antisocial", "neurotics", or "undifferentiated" sub-types [2].

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.

The Prosocial Behaviour Questionnaire is designed by Weir and Duveen to measure this [3]. This scale correlates well with observed behaviour in classrooms. Reliability co-efficient is 0.91. All instruments have been shown to have validity.

## RESULTS

The sample consisted of eighty boys aged 9 - 11 years, and all questionnaires were completed. Means and standard deviations for all variables are compared with data from previous research and are shown in Table 1.

Using a cut off point of 14 on the Birleson Depression Self Rating Scale (DSRS), 4 boys, or 5 percent of the total sample scored as depressed. Forty percent of the total sample (32 pupils) were rated as behaviourally deviant on the Rutter B2 behavioural deviance scale. 33.7 percent of the total sample (27 pupils) were rated as "antisocial", 3.75 percent of the sample as neurotic, and 2.5 percent as undifferentiated. 75 percent 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. 3.75 percent (i.e. 3 pupils) scored above two standard deviations on the State Anxiety Scale, and 5 percent (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 percent) who scored above two standard deviations on the Trait Anxiety Scale, and one of these scored as depressed, and two of these 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 DSRS was significantly higher than that found by Birleson in normal children. Means for state and trait anxiety were significantly lower than in Spielberger's samples. Both of these were significant at the level of p less than 0.001.

The self esteem and prosocial behaviour scores were both significantly higher than in the corresponding British and American populations.

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

**Table 1.**

**Means and Standard Deviations of Variables and Comparison with Previous Data from Other Studies.**

| STUDY GROUP | | | PREVIOUS RESEARCH | | | |
|---|---|---|---|---|---|---|
| **Variable** | **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 | 9.5 | Weir & Duveen (1981) | 18.3 | 9.5 | $p < 0.001$ |

**Table 2**

**Correlations between Variables**

| | | Pearson's Correlation Coefficient | Significance Level 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 | $p < 0.001$ |
| Reading Age | Rutter Score | -0.404 | $p < 0.001$ |
| | Prosocial Behaviour | +0.612 | $p < 0.001$ |
| | Trait Anxiety | -0.276 | $p < 0.05$ |
| Prosocial Behaviour | Rutter Score | -0.679 | $p < 0.001$ |
| | Trait Anxiety | -0.293 | $p < 0.05$ |
| Rutter Score | Trait Anxiety | +0.381 | $p < 0.01$ |

## DISCUSSION

Five percent of the sample scored as depressed on the DSRS. The mean score on the scale obtained in this study was almost twice that obtained by Birleson in a normal population [8]. This 5 percent prevalence appears high if compared to an out-patient clinic prevalence of 14 percent in the same area, using the same instrument [10].

On the Rutter B2 Teachers Scale, 40 percent were rated as behaviourally deviant. This is higher than that found in British studies [2], but in accordance with previous studies in similar Irish populations [1]. A previous study [11] using both clinical interview and questionnaires in a similar population found a 2 percent prevalence of depression on clinical interview. Deviance rates on clinical interview were half those obtained on questionnaires. It is possible that self rated questionnaires might over-diagnose depression. This misdiagnosis could be due to the inclusion of self esteem and anxiety components in the questionnaire.

Seventy five percent of those rated as depressed were also rated as behaviourally deviant, and all of these were rated as antisocial. This figure is much higher than Puig-Antich's findings of one third of those who were depressed being deviant, but this disparity could be due to the small numbers who were rated as depressed in this study, or to misclassification by the Rutter B2 scale.

### Anxiety

3.75 percent scored above two standard deviations on the state anxiety scale. It is difficult to draw conclusions from this, but overall scores on the state anxiety scale were more closely correlated with scores on the Depression scale (DSRS) than with scores on the trait anxiety scale (Correlation co-efficients +0.46 and +0.35 respectively). The likely causes are instrumental overlap or mixed states of anxiety and depression. The two cases which scored above two standard deviations on the state anxiety scale, and as depressed on the DSRS would seem to have mixed anxiety/depressive states. Five percent scored above two standard deviations on the trait anxiety scale. High scores on trait anxiety would be expected in anxiety disorders, though 5 percent can not be regarded as a prevalence for anxiety. The different prevalences and correlation coefficients of state and trait anxiety would support their validity as independent instruments.

All those who were rated as anxious or depressed and behaviourally deviant on the Rutter scale were classified as antisocial rather than as neurotic or undifferentiated. A proportion of these may therefore be regarded as having been misclassified by this instrument. This is in agreement with the Isle of Wight study [2] that 31 percent of diagnosed neurotics were designated as antisocial rather than neurotic by this scale. It was suggested that antisocial behaviour was more likely to attract the attention of the teacher than neurotic behaviour. However, other workers have suggested that this misclassification is due to the preponderance of antisocial items in the questionnaire [12]. Those whom the teachers rated as neurotic did not score as depressed or high in the anxiety scales. So it is difficult to determine what the neurotic sub-scale was measuring in this population.

### Correlation between Variables

The high correlation between total self esteem and depression (-0.627) indicated a close association between these factors. Depression would be either a cause of low self esteem, or, low self esteem could be a vulnerability factor for depression. Alternatively, the association could be due to the inclusion of self esteem items in the

instrument used for assessing depression. The correlation between self esteem and the Birleson Depression scale is lower than the correlation between this measure of self esteem and the children's form of the Beck Depression inventory found by Kaslow et al. [13]. The Birleson Depression scale appears to include fewer questions relating to self esteem, than the Beck Depression inventory.

The correlation coefficient of self esteem and trait anxiety was -0.479. This is less than the correlation coefficient (-0.655) found between Castaneda's anxiety scale and the Coopersmith self esteem inventory [14]. Correlations between the Castaneda anxiety scale and the Spielberger scale were 0.727. The Spielberger anxiety scale therefore does not appear to be as closely related to the Coopersmith Self Esteem inventory as the Castaneda anxiety scale. Ingham et al. [15] suggested that there is a complex relationship between anxiety, depression and self esteem, with similar correlations between them. In this study the correlation with anxiety was not as high as with depression. The instruments used would probably affect the correlation coefficients obtained in any particular study.

Reading age varied inversely with trait anxiety. It is likely that high levels of anxiety interfere with learning at school. The absence of a significant association between self esteem and reading age seems to indicate a specific effect of anxiety on reading performance. Reading age was not directly related to scores on the DSRS, but those who scored as depressed tended to have lower reading ages.

Reading age correlated closely with prosocial behaviour (0.612) and slightly less closely with Rutter total scores. These correlation coefficients are higher than those obtained by Weir and Duveen [3], as also is the correlation coefficient between total Rutter score and prosocial behaviour scores. Rater differences such as teachers' personality theories could be responsible for this [16]. Slightly less significant correlations were found between trait anxiety and prosocial behaviour, and trait anxiety and Rutter total scores. As in previous research [3] there was a high correlation between prosocial behaviour and Rutter total scores. In their two studies of prosocial behaviour, Weir and Duveen [3] comment that in the first study, neurotic deviant children had average prosocial behaviour ratings, whereas in their second study neurotic deviant children had reduced prosocial behaviour ratings. In this study, neurotic deviant children had average prosocial behaviour ratings.

One item on the Birleson Depression scale deserves special comment. This is that 15 percent thought that their life was not worth living "most of the time", and 18.8 percent thought that their life was not worth living "sometimes". The mean score for this question was 0.48. In Birleson's study the mean for the control group was 0.05. The mean for the depressed group in his study was 0.65 and for a maladjusted group was 0.45. The pupils in this study therefore appear to be closer to Birleson's maladjusted group than to his normal subjects; having a higher prevalence of what he classifies as "suicidal thoughts". Other studies [17,18] have found prevalences of suicidal thoughts of between 10 percent and 33 percent in a clinic population, though suicidal thoughts were more rigourously defined in these studies. This high prevalence suggests that suicidal thoughts are fairly common in this age group.

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# SOCIAL SUPPORTS AND BEHAVIOURAL PROBLEMS IN CHILDHOOD.

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## SUMMARY

This study found that the social support perceived by the children was within normal levels and that there was no association between this and disturbed behaviour as rated by parents. Other factors are operating in the development of psychiatric problems in the children, and that good parent child and peer relationships, although present, did not exert a protective effect.

## INTRODUCTION

The relationship between friendship and psychological well-being has been recognised in both adults and children. Brown and Harris (1978) identified the lack of a confiding relationship with a husband or another intimate as a vulnerability factor in the development of depression.

Rutter (1979) demonstrated that children living in disharmonious homes who had a good relationship with one parent, were less likely to show antisocial disorder than children who had poor relationships with both parents. In Kauffman et al.'s study, (1979) there was a positive association between the quality of children's psychological health and their peer relationships and that these exerted a protective effect.

Good relationships are necessary for healthy mental development, promoting self esteem, social skills and emotional attachments. (Field et al., 1984; Harter, 1983; Hartup, 1983).

In this study we examined the association between social supports in terms of relationships with parents, teachers, friends and classmates and disturbed behaviour reported by parents. We also compared developmental appropriateness, social skills and self esteem assessed by the Cornell Interview with disturbed behaviour. The significance of these findings is discussed.

## METHODS AND MATERIALS

The subjects were a series of consecutive referrals to a child psychiatric clinic in the Dublin area. The children were between 7 and 11 years and predominantly from lower socio-economic groups. Informed consent was obtained from the parents or parent accompanying the child. Assessments were carried out when the children first attended the clinic.

The Eyberg Child Behaviour Inventory (E.C.B.I.) (Eyberg and Ross, 1978) was completed by the child's parent(s). This is an easily administered test which both identifies problem behaviour and rates its intensity. Problem identification ranges from 0 to 36. Behaviour intensity is rated from 0 to 7 with an overall score range of 36 to 252.

The children were interviewed alone using the Cornell Interview of Children's Perceptions of Friendships and Peer Relationships (Kernberg). This is a semi-structured interview consisting of 84 questions relating to developmental appropriateness, social skills and elf esteem. The children are rated on three global subscales on a scale of 0 to 6.

The children were also asked to complete the Social Support Scale (Harter, 1985), which is designed to document the perceived support and regard which parents, teachers, classmates and friends manifest towards the child. The questionnaire consists of 24 items divided into four subscales. Each item is scored on a scale of 4 - 1 where 4 represents the highest level of support and and 1 the lowest level. The items for a given subscale are grouped together and the means calculated.

The results were analyzed using the Pearson Product Moment correlation coefficient and the unpaired two sample Student t-test (Osborn, 1979): both of these procedures were designed for small samples.

## RESULTS

Twenty children, thirteen boys and seven girls participated in the study (N = 20). Two children were excluded as their parents withheld consent. The ages ranged from 7 to 11 years with a mean age of 8.2 years for boys and 9.7 years for girls. See **Table 1** for the means scores on the subscales of three instruments.

There were no significant associations between the scores on the social support subscales (parents, teachers, friends, and classmates) and problem identification and behaviour intensity.

There was a positive correlation between social support from classmates and social skills and self-esteem and between social support from teachers and self esteem and developmental appropriateness.

When the three subscales of the Cornell Interview are compared with each other - developmental appropriateness correlated positively with social skills and self esteem.

There was a positive correlation between problem identification and behaviour intensity. See **Table 2** for correlation values.

**Table 1**

Mean Scores & Standard Deviations for Subscales of the Instruments used.

| **Cornell Interview** | **Mean** | **Standard Deviation** |
|---|---|---|
| Development Appropriateness | 3.450 | 1.050 |
| Social Skills | 3.350 | 1.226 |
| Self Esteem | 2.60 | 1.27 |
| **Eyberg Child Behaviour Inventory** | **Mean** | **Standard Deviation** |
| Problem Identification | 12.70 | 6.92 |
| Behaviour Intensity | 128.40 | 33.10 |
| **Social Support Scale** | **Mean** | **Standard Deviation** |
| Parents | 3.455 | 0.533 |
| Teachers | 3.025 | 0.764 |
| Classmates | 2.720 | 0.876 |
| Friends | 2.975 | 0.885 |

**Table 2**

Correlation Values of Subscales
{cut off point + 0.433 (5%); + 0.549 (1%)}

| | Developmental Appropriateness | Social Skills | Self Esteem | Behavioural Intensity |
|---|---|---|---|---|
| Social Skills | 0.689 | | | |
| Self Esteem | 0.653 | 0.836 | | |
| Classmates | | 0.483 | 0.517 | |
| Teacher | 0.457 | | 0.476 | |
| Problem Identification | | | | 0.742 |

When we compared our means scores on the social support subscales with the mean scores for U.S. studies: there was no statistical significant difference found (p + 0.57, p + 0.97, P = 0.87, p + 0.67).

## DISCUSSION

There was no association between social support as perceived by the children in terms of relationship's with parents, teachers, friends and classmates and disturbed behaviour. Rutter (1979), and Kauffman et al., (1979), have demonstrated that parent child and peer relationships respectively are protective against stress. But the absence of an association does not mitigate against our findings as other factors like temperament, IQ, marital disharmony and the absence of parental mental illness also have a role in protecting children and it is possible that these are operating in this group.

When we compared the means on the social support scale in this study to the population means obtained from U.S.A. studies, there was no statistical difference present. This validates our results as well as demonstrating that Irish children have the same degree of social support as their American counterparts.

Support and regard from teachers and classmates as perceived by the child are positively correlated with self-esteem, social skills and developmental appropriateness in the child. This is an interesting finding as it implies that favourable relationships in the school environment promote feelings of personal positive regard as well as social interaction and emotional maturity. It could however be argued that these factors are necessary to develop relationships with more distant figures like teachers and classmates.

When the three subscales in the Cornell Interview are compared with each other, there is a positive association between developmental appropriateness and social skills and self esteem. This is an expected finding as the literature on development appropriateness suggested that as children grow older peer relationships develop sequentially and become autonomous, interdependent friendships with mutual acceptance and support (Selman, 1980; Youniss, 1980). There is no association between the subscales on the Cornell Interview and disturbed behaviour as measured on the E.C.B.I. These results suggests that behavioural problems may develop independently of self esteem, developmental appropriateness and social skills. Indeed Zimet and Farley (1985) have shown that mean self esteem scores of children attending psychiatric day care are comparable to a normal group.

The Cornell Interview is an easily administered test, acceptable to raters and children and we would recommend further work confirming its predictive value in the assessment of childhood friendships.

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# SELF ESTEEM, READING ABILITY, AND BEHAVIOURAL DEVIANCE IN CHILD POPULATIONS.

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## SUMMARY

Reading age, self-esteem and behavioural deviance were assessed in a normal school, a child psychiatric clinic, a special school and a child psychiatric in-patient unit. Reading age was significantly lower than controls in the special school and to a lesser extent in the child psychiatric clinic. Total self-esteem was reduced in all groups, compared with normal children. Specific reductions of the 'social' components of self-esteem occurred in all study groups. 'Home' self-esteem and 'school' self-esteem were particularly low in the clinic group. High rates of behavioural deviance were present in the study groups. The findings are discussed.

## 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. This assumption has recently been disputed [1].

Various studies have found self-esteem to be closely associated with school performance, and to be a good indicator of future reading performance [2, 3, 4].

The association between reading difficulties and antisocial behaviour has provoked much research over many years, with some researchers finding associations between specific reading retardation and antisocial behaviour, [5] and others [6], between problem behaviour and general reading backwardness. The original hypothesis that behavioural deviance develops as a response to poor school performance would appear to suggest a mediating role for self-esteem. Thompson's [7] study of eleven year olds found low self-esteem among those who were behaviourally deviant, but by the age of fifteen years self-esteem had increased.

This study attempted to compare self-esteem in normal and psychiatric populations and to assess the relationships between self-esteem, reading difficulties and behavioural deviance.

## METHOD

The population studied were: a chid psychiatric clinic, a special school fir disturbed children, and a child psychiatric in-patient unit. The child psychiatric clinic was located in a suburb of Dublin. Successive referrals (17 in all) during a defined period with all diagnoses were interviewed. The second group consisted of fifteen children of a similar age attending a school for disturbed children. The third group consisted of all children [7] in an in-patient psychiatric unit at the time of the study. The control group was of eighty children attending a normal school close to the clinic. The special school and the in-patient unit were drawn from a wider population, in which the clinic and the school were included.

Each child was asked to complete the Coopersmith Self-Esteem Inventory [8]. This consists of a series of questions designed to measure self-esteem in general and in specific areas of life. It has been found to have high internal consistency (Kuder Richardson reliability estimates KR20: 0.81 - 0.86), [8], and construct validity. The school short form consisting of twenty five questions was administered to those under the age of ten years. The complete school form consisting of fifty eight questions was administered to the older subjects. This version had sub-scales which attempt to measure self-esteem in specific areas of experience such as home, school, and social areas and has a 'lie' or defensiveness score. The short form is included in the longer form and consists of the items from the longer form which show the highest item-total score correlation. Total score correlation between both is 0.86 [7]. Reading age was measured on each subject using the Marino Reading Age Test. In the Isle of Wight study [5], an attainment in reading accuracy which was twenty eight months or more below chronological age was defined as 'reading backwardness'. These criteria were used in this study.

Behavioural deviance was assessed using either the Rutter A2 (parents) rating scale (on the clinic population) or the Rutter B2 (teachers) scale on the in-patient and control groups. A cut-off point of thirteen on the parents' scale, and of nine on the teachers' scale was used to diagnose behavioural deviance. Subscales differentiated those rated as deviant into 'neurotic', 'antisocial' and 'undifferentiated' [5].

All questions were analysed for significant differences between groups. (See Table I).

## RESULTS

All questionnaires returned were analysed. Rutter scales were unavailable on those attending the special school.

40% of the normal school pupils were rated as behaviourally deviant. 33.7% were rated as antisocial, 3.7% as neurotic and 2.5% as undifferentiated. Of those referred to the Child Psychiatric Clinic, 53.8% were rated as behaviourally deviant. 23% were designated as antisocial, 15.3% as neurotic, and 15.3% as undifferentiated. 71.4% of the in-patients were rated as behaviourally deviant (57% were antisocial, 14.2% as neurotic). There was no statistically significant difference between mean scores for each group on either total scores or on the neurotic or antisocial sub-scales.

7.5% of the controls fitted the criteria for reading backwardness. 50% of those attending the clinic fulfilled these criteria, as did 57.1% of the in-patients and 73.3% of those attending the special school. Because the data was analysed separately for those over and under the age of ten years, it was found that in all groups, the prevalence of reading backwardness was much higher in those over the age of ten years. Mean reading age was significantly lower than controls in the special school. This was

statistically significant at the level of $p < 0.001$. Reading age was also reduced in the clinic population at a lower level of significance ($p < 0.05$).

In the normal school, 33.7% were rated as antisocial. 28% of these fitted the criteria for reading backwardness. 76.4% of those in the study groups who were rated as antisocial also fitted these criteria. Only one of those who were rated as neurotic fitted the criteria. Self-esteem scores were analysed separately for those above and below the age of ten years, as the instrument used was slightly different. Dunnett's T test was used to compare the group mean scores. Total self-esteem was lowest in those over the age of ten years attending the psychiatric clinic and those under the same age attending the special school ($p < 0.001$).

The mean score of those less than ten years attending the clinic was also reduced ($p < 0.01$). Total self-esteem of the older children attending the special school and the in-patient group was also reduced at a lower level of significance ($p < 0.05$). The mean of the social self-esteem sub-scale was reduced in all groups compared with controls ($p < 0.001$). School sub-scale scores were significantly lower than controls in the clinic group ($p < 0.001$). the home self-esteem sub-scale scores were reduced in all groups, but the level of significance attained was higher in the clinic group ($p < 0.001$) than the special school and the in-patient unit. The 'lie' scale scores were significantly lower in the in-patients ($p < 0.05$).

## Table I

Comparison of Group Means with Controls

| Variable | Group | Group Mean | Comparison Mean | Significance p value |
|---|---|---|---|---|
| Reading Age | O.P. clinic | 9.0 | 10.8 | $p < 0.05$ |
| | Special school | 7.9 | 10.8 | $p < 0.001$ |
| Total Self-esteem | O. P. clinic (< 10 years) | 59.2 | 78.3 | $p < 0.01$ |
| | Special school (< 10 years) | 53.3 | 78.3 | $p < 0.001$ |
| | O. P. clinic (> 10 years) | 61.8 | 78.3 | $p < 0.001$ |
| | Special school (> 10 years) | 66.9 | 78.3 | $p < 0.05$ |
| | In-patient unit | 64.3 | 78.3 | $p < 0.05$ |
| Lie score Defensiveness | In-patient unit | 1.7 | 3.3 | $p < 0.05$ |
| Social self-esteem | O. P. clinic | 3.5 | 6.5 | $p < 0.001$ |
| | Special school | 3.6 | 6.5 | $p < 0.001$ |
| | In-patient unit | 3.7 | 6.5 | $p < 0.001$ |
| School self-esteem | G.P. clinic | 3.7 | 5.5 | $p < 0.001$ |
| Home self-esteem | G.P. clinic | 5.4 | 6.9 | $p < 0.001$ |
| | Special school | 5.8 | 6.9 | $p < 0.05$ |
| | In-patient unit | 5.7 | 6.9 | $p < 0.05$ |

## DISCUSSION

The rate of behavioural deviance in the normal children was quite high: 40%. The rate of behavioural deviance in the clinic group was intermediate between the control group and the in-patient group. It is probable that because of specific referral of those with behavioural deviance to the special school, rates would have been higher in this group. No statistical difference was found between mean scores of the study groups and the control group. This appears to have been due to rating patterns; the teachers in the normal school gave very low as well as extremely high ratings; the parents of the clinic patients and the teachers of the in-patients tended to give intermediate ratings to all subjects. This resulted in similar mean scores. In the normal classroom, those who were behaviourally deviant would appear more abnormal and attract higher ratings than in an in-patient unit or the home environment. The rates of behavioural deviance obtained on questionnaires are generally over-estimates compared to the prevalence of psychiatric disorder found on clinical studies [9].

The high rate of reading backwardness in the special school is probably due to environmental and referral factors. There are several possible causes for the increased prevalence of reading backwardness in the child psychiatric clinic. It could be due to referral patterns, such as referral by teachers, referral for reading difficulties or behavioural deviance, or the reading difficulties being secondary to whatever disorders precipitated referral to the clinic. Since reading ability in the in-patient group was not statistically different from controls, reading backwardness did not appear to increase the likelihood of admission to the in-patient unit.

Total self-esteem was reduced in all study groups. This finding disagrees with Zimet and Farley [1]. The findings in this study, however, would be consistent with clinical impression. The total self-esteem score was derived from four components: general self-esteem, home self-esteem, social self-esteem and school self-esteem. Since the general self-esteem sub-scale scores were not significantly different from controls, the reduction in total self-esteem was due to reduction in the other components.

Home self-esteem was reduced in the clinic group to a greater extent than in the other groups. This could be a consequence of referral to the clinic (an identified patient might perceive himself more negatively than his siblings) or could be due to such factors as family discord. The same factors probably operated to a lesser extent or in a less acute fashion in the special school and in-patient groups.

School self-esteem scores were significantly reduced in those attending the clinic. As reading age was slightly reduced in this group, these factors could be associated. Firstly, reading difficulties may cause reduced self-esteem. Secondly, reduced self-esteem could be responsible for the reading difficulties. Alternatively, some other factor could be responsible for both, or that the presence of both or either increases the possibility of referral to the clinic. None of these explanations are mutually exclusive. The absence of any change in school self-esteem in the special school and in-patients is probably due to the abnormal peer group.

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

In all the study groups, reading backwardness was closely associated with behavioural deviance. In the clinic group, the cases with reading backwardness were predominantly undifferentiated. In the in-patient group, 75% were antisocial and 25% neurotic, though small numbers were involved. In the special school group, only those

over the age of ten years fitted the criteria for reading backwardness. This suggested that the reading difficulties increased with age.

A major difference between the antisocial members of the control group and those in the study groups, was that those in the control group had a 7% rate of reading backwardness, whereas in the study groups the rate was 72%. Self-esteem was average in antisocial pupils in the control group, but was reduced in antisocial pupils in the study groups.

In the Isle of Wight study [5], those with pure antisocial disorder were differentiated from those with antisocial disorder and reading retardation. This is supported by the findings of this study, which also suggests that in those with both disorders, low self-esteem is present. The findings also tend to support the hypothesis that self-esteem tends to return towards normal with age.

It also appears likely that those with antisocial disorders and reading difficulties have a higher rate of referral to the psychiatric services than those with antisocial disorder alone, and those with reading difficulties alone have a higher rate of referral than those with behavioural disorders alone.

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# MOTIVATION TOWARDS LEARNING AND BEHAVIOUR DEVIANCE IN EIGHT TO ELEVEN YEAR OLD CHILDREN ATTENDING AN URBAN PRIMARY SCHOOL.

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## ABSTRACT

Motivation towards learning was assessed in a class of 3rd, 4th and 5th standard, using a self report scale [1]. Results for children identified as behaviourally deviant were compared with those of their non-disturbed peers. The findings show no significant difference on motivational scores between both groups; behaviourally deviant children differing from their non-disturbed peers only on an informational subscale of judgement.

## INTRODUCTION

Studies [2,3] have shown a significant association between behavioural disturbance and learning difficulties. Behaviourally deviant children perform less well in school than their non-disturbed peers; though the direction of any causal relationship is not clear [4].

It seems reasonable to assume that behaviourally deviant children might not be well motivated towards learning. To examine this, it was hypothesized that behaviourally deviant children would show less intrinsic motivation towards learning than their non-disturbed peers.

## METHOD

The population under study were children of both sexes, attending 3rd to 5th class, in an urban primary school. The sample size was 86. Forty five were females and 41 were males, and their ages ranged from eight to 11 years with a mean of 9.85 years. These children were selected because the reliability and validity of the measuring instrument had already been established for this age group [1,5].

With the co-operation of the school, parents were contacted by letter to gain permission for their children to take part in the study.

A Self Report Scale [1] assessing motivation was administered to the classes separately. Each child completed the questionnaire independently. The class teacher was then approached and asked to complete the Rutter Teacher Questionnaire [5] for each pupil in their class.

The Self Report Scale: [1] of intrinsic versus extrinsic orientation in the classroom; motivational and informational components, is in the form of a 30 item questionnaire of which six items tap into each of five subscales. These are, preference for challenge versus preference for easy work, curiosity/interest versus teacher approval, independent mastery versus dependence on teacher, independent judgement versus reliance on teachers judgement, and internal criteria versus external criteria for success or failure. The first three subscales define a motivational factor, whereas the last two define a cognitive/informational factor.

Each question was read aloud to the class, and the child then decided which of four possible answers was most true for him. Depending on his or her choice the child may score between one and four for each item, a score of one indicating a maximum extrinsic orientation and a score of four indicating a maximum intrinsic orientation, for that particular item. By averaging the scores on each subscale each child will have five mean scores ranging from one to four, which will depict the child's profile, across the five dimensions.

Teachers questionnaire [4] (Rutter Scale B2); is in the form of 26 descriptions of behaviour against which the frequency of behaviour is scored, as it applies to the child in question.

Statistical analysis: the difference between the means of behavioural deviant and non-deviant groups were tested on each of five subscales, using Student's T-test (2 tailed). In addition, a two way analysis of variance was performed to identify the effects of grade, sex and their interaction.

## RESULTS

The individual profiles on the self report scale were averaged for each class, giving a mean and standard deviation for each of the five subscales, across grades 3 - 5. Thirty two children were assessed as showing behavioural deviance. The distribution of these children over 3rd to 5th class was as below, see Table 1. The motivational score for this group were also averaged, by class, giving a mean and standard deviation on each subscale.

A comparison of the means between the deviant group and the non-disturbed peer group shown no significant difference between the groups on the motivational subscales, see Table 2. Only on the informational subscale of judgement did a significant difference occur between both groups, see Table 3. There was a significant grade X sex interaction on the subscale of judgement ($p < 0.001$). The size of the sex difference depended upon grade with males scoring more highly than females in grades four and five, see Table 4.

Table 1 - **Behavioural Deviance by Class**

| | | Non Disturbed | Disturbed | All |
|---|---|---|---|---|
| Class | 3 | 19 | 10 | 29 |
| | 4 | 25 | 6 | 31 |
| | 5 | 10 | 16 | 26 |

Number of disturbed and non-disturbed by class using the Teachers Questionnaire [4].

Table 4 - **Grade X Sex Interaction on Judgement Subscale**

| | Judgement | | |
|---|---|---|---|
| | 3 | 4 | 5 |
| Male | 1.38 | 2.82 | 2.60 |
| Female | 1.60 | 1.61 | 1.85 |
| Difference (female - male) | +0.22 | -1.21 | -0.76 |
| t statistic | +0.74 | -4.94 | -2.74 |
| | ($p > 0.10$) | ($p < 0.001$) | ($p < 0.01$) |

Comparison of means on judgement subscale for both sexes in each class.

## DISCUSSION

The findings do not support the hypothesis that behaviourally deviant children show less intrinsic motivation towards learning than their non-disturbed peers. This would suggest that the mechanism by which behaviourally deviant children do less well in school, does not involve a lowering of motivation.

These findings cast doubt on the theory [4] that behavioural problems arise because of loss of self esteem due to learning difficulties.

It is known that other factors such as parental deviance, family discord and social disadvantage are associated with both learning difficulties and behavioural deviance [6]. The children in this study lie in an urban working class area with high unemployment and a high crime rate. Although we did not examine these variables it seems reasonable to assume that some of these factors are prevalent in this environment. If this is so, then the results would seem to suggest that these factors do not exert their effect on school performance by lowering motivation.

Thus motivation in the classroom, which may be defined as the need to achieve [7], appears very resilient. It seems to persist even in the presence of factors, associated with learning difficulties.

When comparing children identified as disturbed with the non-disturbed group, it was interesting to find that the only subscale on which a significant difference occurred, was on that of judgement, with disturbed children showing a greater reliance on their own rather than on teachers judgement. It seems maladaptive that they should do this as it is

not likely that at this grade level they have internalized sufficient knowledge and information with which to make autonomous judgements. Rather it may be that this reliance on their own judgement might reflect a global mistrust of significant adults in their environment. It may be that early learning in the family and social milieu might account in some way for this phenomenon.

The interaction between grade and sex on the subscale of judgement indicates that with increasing grades the difference between male and female children increases. This finding is in agreement with the fact that there is a higher prevalence of behaviour deviance among male than female children for this age group [4].

In summary, children identified as behaviourally deviant do not show low intrinsic motivation towards learning. They differ from their non-disturbed peers only on the subscale of judgement (with a significant difference between the sexes). Further study is needed to confirm this finding and to elucidate the mechanisms involved.

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# A 10 YEAR DESCRIPTIVE FOLLOW-UP STUDY OF 50 DELINQUENT BOYS.

MARY KELLY.

BERNADETTE MACKEY.

MICHAEL FITZGERALD.

Studies have repeatedly shown a consistent relationship between juvenile delinquency and large family size, marital disharmony, alcohol abuse in parents, and overall social deprivation. A consistent relationship has also been shown with delayed reading age, below average scores on intelligence and achievement tests, conduct disorder of childhood, and parental aggressive behaviour. Among the many follow up studies of delinquents are those of Kolvin, West and Robins.

The aim of the following study was to assess 50 delinquent boys 10 years after their first admission to a national treatment centre for young male offenders, with the above associations in mind.

## METHOD

Fifty (50) consecutive admissions from a well-defined geographical catchment area to a national treatment centre for young male offenders, during the period 1979 - 1980 were chosen for this study. Each admission file was reviewed and all relevant details taken. Each individual boy was contacted by letter, informing him of the study. A second letter was sent when difficulties in contracting individuals were encountered. Home visits were carried out, and additional information was obtained confidentially from other relevant agencies.

## RESULTS

Forty-nine (49) of these boys were referred from the District Courts. One (1) referral was by a community care social worker. Of these fifty (50) boys, twenty (20) were referred because of poor school attendance, and thirty (30) were referred because of antisocial behaviour i.e. stealing, assault and malicious damage.

The average family size was 8.5, range 3 - 17 (the national average family size was 4.7, during the period 1979 - 1980). Two (2) of the boys were adopted. In four (4) cases, father or head of household was deceased. In eight (8) cases parents were separated. The total number of cases from one-parent families was 14 (28%). Seventeen (17) (34%) of the fathers were unemployed (the national unemployment rate in 1979 was 7.1%). Forty-five (45) (90%) were described as living in corporation housing and five (5) (10%) in private homes.

Offord has identified possible protective factors against conduct disorder, among them being (1) a good relationship with parent/adult, (2) compensatory good experiences, i.e., school competence or skill development, (3) improvement in social circumstances, (4) employment, (5) voluntary change to a less deviant peer group.

The Perry Pre-School Project and Weikert's High Scope Programme have been shown to be effective in the long term, in social and school adjustment and reduced criminal involvement. The Perry Pre-School Project involved the provision of a daily pre-school programme to black children from low income homes. The duration of the pre-school programme lasted 2 years and also involved weekly home visits. Follow up was made periodically until the age of 19, at which time this group had a better education level, better employment history and less criminal involvement than a control group.

Weikert's High Scope Programme similarly involved a well structured cognitively orientated pre-school curriculum coupled with home visits. Follow-up at 21 years showed significant gains fro disadvantaged children involved in this programme.

Similarly the Syracuse University Family Development Research Programme aimed primarily at black single mothers has shown on follow up that their children showed improved self esteem and school performance and were involved in ewer and less severe offences. The programme provided support with regard to child-rearing, family relationships and social functioning over a 5 year period.

Kolvin also has shown effectively in his book "Help Starts Here" that direct intervention in the form of group therapy with at risk primary school children with behavioural problems was effective.

The provision of support at community level to first time mothers as was provided is Community Mother's Programme (Van Leer et al) and which has since been replicated in other countries has shown to be worthwhile and effective.

Volunteer mothers who themselves have undergone a training programme are involved in befriending vulnerable mothers in the community. Thus attempts are made to build on the resources and self esteem of these parents through a combination of support, encouragement and education. It has been shown that these volunteer mothers befriending schemes have significant effects on the emotional and behavioural status of children.

To return to the findings, the study has shown a clear association between social disadvantage and offending behaviour. A clear link has been shown in many studies between social disadvantage and offending behaviour. In discussing preventative measures therefore, attention must be given to measures which will effectively improve the social circumstances in which children grow up in, e.g., adequate housing, social supports, and employment.

## CONCLUSION

Given the overall poor outcome in this study, it behoves us to seek effective measures to prevent similar outcomes. The research literature to date identifies possible risk and protective factors for conduct disorder. It also suggests that efforts should be mainly directed at pre-school children.

It would surely be more appropriate therefore, and in the interests of society, that funding be directed towards intervention strategies at pre-school level, rather than custodial strategies at a later age when it is possibly too late to ameliorate already existing damage.

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# SCREENING FOR ABNORMAL EATING ATTITUDES IN MALE DUBLIN ADOLESCENTS.

COLETTE HALPIN.

MICHAEL FITZGERALD.

## ABSTRACT

The Eating Attitudes Test, 40 item version (EAT 40), Body Shape Questionnaire (BSQ) and General Health Questionnaire, 30 item version (GHQ 30) were administered to a sample of 107 Dublin adolescent males. 2.8% scored above the cut off point on the EAT 40. 2.8% also scored highly on the BSQ. Only one respondent scored highly on both. 35.5% of the sample scored highly on the GHQ indicating the presence of psychological distress. All high EAT 40 and BSQ scores also scored above the cut off point on the GHQ. These results contrast with a recent study using the EAT 40 in a similar population of Dublin adolescent schoolgirls, in which 13% of the sample scored highly.

## INTRODUCTION

A recent study of eating attitudes using the EAT 40 questionnaire in a sample of Irish female adolescents, demonstrated that 13% exceeded the cut off score, thereby expressing concern about their eating habits and weight. Johnson and Sabine et al [2] in their recent study of a large sample of London schoolgirls, found between 6.8% and 14.1% scored positively on the EAT questionnaire. There is no similar study of eating attitudes in Irish males. This study attempts to address this deficiency.

## METHOD

*The Study Sample:*

The chosen sample consisted of all 5th year students in a large Dublin boys' secondary school. The school is situated in an established large suburban area of Dublin. For confidentiality reasons, the school authorities were reluctant to allow the author to obtain information on individual parental occupations. However, they informed us that approximately 75% come from middle to upper middle class homes. Approximately 25% of the boys came from disadvantaged homes.

The aims and content of the study were explained to the boys by the author (CH). They brought home explanatory letters to their parents in order to obtain consent to partake in the study. It was stressed that all information would be anonymous and independent of the school principal or teachers.

*Questionnaires Used:*

Three questionnaires were administered to the boys in two separate groups during one 40 minute afternoon class period for each group.

### (1) Eating Attitudes Test (EAT 40):

The EAT 40 is a 40 item self report questionnaire first designed by Garner and Garfinkel [3]. It covers a broad range of attitudes and symptoms some of which are characteristic of Anorexia Nervosa. It is a screening instrument and not a diagnostic tool. It has been used widely in non-clinic populations e.g. college populations [4, 5], family planning clinic attenders [6] , London schoolgirls [2] , female patients in a general practice[7].

### (2) General Health Questionnaire (GHQ):

The 30 item version of the GHQ [8] was chosen to measure the level of general psychiatric morbidity.

### (3) The Body Shape Questionnaire (BSQ):

This is a 34 item self report questionnaire devised by Cooper et al [2]. It is a measure of concerns about body shape and in particular the experience of feeling fat. Each individual item is scored on a 1-6 sliding scale with 6 representing the most symptomatic score. The validity of the BSQ has been tested in both clinical and non-clinical samples [2] . It was found to correlate significantly with high EAT scores. In a non-patient sample the mean score for a "concerned" group was 109 and 55.9 for an "unconcerned" group. Patients with Bulimia Nervosa and Anorexia Nervosa showed mean scores of 129.3 and 136.9 respectively.

## RESULTS

*The Study Population:*

A total of 107 boys in all completed the 3 questionnaires. This sample represented 89.2% of the total number of 5th year students in the school. Those who did not partake were absent on the day. The boys ranged in age from 14 years 5 months to 17 years 10 months. The mean age was 16.12 years.

The questionnaires were administered during an afternoon class period, which had been prearranged with the school principal. One author (CH) was present in the classroom while the boys filled out the questionnaires. They were asked to complete them without reference to their peers. They were allowed to ask questions regarding any misunderstandings. Ten boys availed of this opportunity. The school principal assisted in supervision of the group by visiting the classroom on a number of occasions during the 40 minute period. Cooperation was excellent and no spoiled questionnaires were returned.

Three boys scored above the cut off point of 30. Figure 1 shows the frequency positive scores on each individual EAT item. The mean EAT score for the group was 8.62.

72% reported that they liked their clothes to fit tightly (Q18), 47% disliked trying new rich foods (Q39), 45% reported early morning wakening (20), 30% liked eating the same foods every day (Q21), 30% disliked eating with others (A1), 32% felt they display self control around food (Q32), and 25% felt they did not enjoy eating at restaurants (Q27).

12% admitted to being terrified of being overweight (Q4), 12% said they exercise strenuously to burn off calories (Q16), 6% think about burning calories on exercise, 8% said they particularly avoid foods with a high carbohydrate content (Q10), whereas 3% admitted to engaging in dieting behaviour (Q37), 6% also felt they give too much time to thought of food (Q34), 1 respondent admitted to taking laxatives (Q28).

**Table 1**

**Eating attitudes and concern about body shape in stressed adolescents**

| EAT 40 | GHQ 30 | BSQ |
|---|---|---|
| 35 | 25 | 89 |
| 30 | 11 | 71 |
| 33 | 9 | 119 |
| 14 | 15 | 105 |
| 29 | 18 | 162 |

EAT = Eating Attitudes Test

GHQ 30 = General Health Questionnaire

BSQ = Body Shape Questionnaire.

GHQ 30 Scores

38 (35.5%) of the 107 respondents scored above the cut off point of 5. The mean GHQ 30 score was 5.21.

BSQ Scores

The BSQ scores ranged from 34 - 162 with a mean score of 48.86. Three respondents scored a total greater than 100.

All three high scores on the EAT 40 questionnaire also scored above the cut off point of the GHQ 30, as did the three high scores on the BSQ. However, only one of the respondents scored positively on all three questionnaires. Table 1 shows the profile of the five high scoring respondents on all three measures.

## DISCUSSION

The results of this study must be interpreted with caution because of the small numbers and the difficulties in population screening for rare disorders. Williams et al [10], in their comment on the EAT 40 highlight the fact that it is only of limited use in case identification. While it is not a diagnostic tool it has been shown to distinguish between an anorectic group and a control group without the disorder [4]. Other studies show that EAT 40 positive scores do have abnormal and exaggerated eating attitudes [5, 11]. These limitations are further borne out by Johnson Sabine et al [2] in their study of a large cohort of schoolgirls.

They found that 24% of the sample were clinical cases of Anorexia Nervosa ? Bulimia and that 59% were dieting. They stress the need for prospective studies of EAT positive dieters to determine whether they become "cases" in the long term. The relevance of this for male adolescents is that eating disorders in males and females appear to constitute parallel syndromes as pointed out by Steiger in his recent review of eating disorders in males [13]. Therefore, it is reasonable to extrapolate that the high EAT scores in this study represent a group of males whose eating attitudes may merit further assessment.

It is of interest that 2.8% of the respondents from our sample scored positively on the EAT 40 compared with 13% of a similar female sample; the mean score for males being 8.62 and 16.45 for females.

The fact that all 5 respondents who were high EAT 40 or BSQ scores also exceeded the cut off point on the GHQ is noted. The overall finding that 35.5% of the sample scored above the cut off point on the GHQ is similar to a previously studied population of Irish adolescents [12].

This study merely represents a starting point for the study of eating attitudes in Irish males. There is a need for further studies of larger groups and follow up interviews with positive scorers to further assess their eating habits and psychiatric status.

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# SCREENING OF ABNORMAL EATING ATTITUDES IN AN UNSELECTED POPULATION OF 16 YEAR OLD DUBLIN SCHOOLGIRLS.

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MICHAEL FITZGERALD.

## INTRODUCTION

The Diagnostic and Statistical manual[1] of Mental Disorders, Third Edition, reports that as many as 1 in 250 females will experience eating disorder symptoms at some time during adolescence. It has been repeatedly noticed that abnormal eating patterns and Anorexia Nervosa (A.N.) are most common in females and have their peak onset during the mid teenage period[2,3]. Furthermore there is growing evidence that these problems are increasing in frequency[4,5,6,7,8,9,10].

Despite these observations there have been few epidemiological studies of the prevalence of abnormal eating attitudes/eating disorders amongst female adolescent populations in general and Irish female adolescent populations in particular. This study attempts to address this deficiency. It entailed the administration of eating attitudes Test 40 questionnaire (EAT 40) to an unselected population of 16 year old Dublin school girls in an attempt to detect and document abnormal eating patterns within the group.

## MATERIALS & METHOD

The study population was drawn from the fifth year pupils (average age $15^{11}/_{12}$) of a Dublin secondary school. The school is located in a socially disadvantaged area of the city.

The aims of the study were explained to the pupils, who, in turn, were asked to seek parental consent by taking home specially prepared letter for parents to sign and return. It was stressed that the study was being conducted anonymously and independently of schools and teachers. All 56 pupils approached were willing to participate and all obtained written parental consent. Subsequently 55 pupils completed the questionnaire and gave demographic details (Date of Birth, fathers and mothers' occupation).

The questionnaire was administered to the pupils by one of the authors during an afternoon class period. The pupils were asked to complete the questionnaire without discussing their answers amongst themselves and were assured of the anonymity and confidentiality of their responses. They were permitted to clarify any misunderstandings in relation to the test items with the author (MH) and a small number (7%) availed of this opportunity.

## THE EATING ATTITUDES TEST 40 (EAT 40)

The EAT 40 questionnaire i a 40 item measure of the symptoms in Anorexia Nervosa (AN). It is presented in a 6-point forced choice self report format wherein each extreme response in the anorexic direction is scored as worth 3 points while the adjacent alternative responses are weighted as 2 points and 1 point respectively. A total cut-off score of 30 points has been determined for the entire 40 items[11]. Amongst clinical populations, scores of 30 point or more on the EAT 40 questionnaire are significantly associated with a clinical diagnosis of Anorexia Nervosa whilst amongst non-clinical populations similar scores identify a group with serious eating and weight concerns. Thus the EAT 40 questionnaire has been shown to be a valid objective and economical index of behaviours and attitudes frequently observed in anorexia nervosa, and it has also proved useful in identifying eating disturbances in non-clinical samples[11,12,13,14].

## RESULTS

55 girls (98% of those enroled) co-operated in the study. From parental occupation the social class of the study population was determined - (11 and 111, 6%, IV, 44%, V, 24%, unemployed 13%, not know or deceased 13%). The study had an average of 15 years eleven months.

A cut-off score of 30 points has been established for the EAT 40 questionnaire[11].

The mean score for the group was 16.45%. 13% of scores exceeded the cut-off score, representing 7 of the 55 respondents.

The following is the results of respondents scoring positively i.e. either 1, 2 or 3 points, (where each extreme response in the anorexic direction is scored as 3 points etc., as previously outlined above) on all 40 EAT items. Thus 42% of respondents reported feelings of terror in relation to being overweight (Q 4), whilst 31% described feelings pre-occupied with a desire to be slimmer (Q 15). 24% admitted to a pre-occupation with the thought of fat on their bodies (Q 25) and 16% believed that they gave too much time and thought to food (Q 34). 17% felt that food controlled their lives (Q 31), 18% admitted to becoming anxious prior to eating (Q 3) and 7% described extreme guilt feelings after eating (Q 4). 11% of respondents admitted to dieting (Q 37) and 7% to exercising strenuously to burn off calories (Q 16). 11% avoid foods with sugar (Q 29) and 11% avoid foods with a high carbohydrate content (Q 10). 15% describe eating binges with feelings of loss of control (Q 7) and 4% describe laxative consumption (Q 28).

## DISCUSSION

There are potential limitation as well as obvious advantages to the self report format of the EAT. Self report measures rely on the assumption that respondents will accurately describe their symptoms. It is however difficult to estimate the biasing effects of inaccurate or distorted reporting on the questionnaire responses. Nor can the findings of this study be taken as representative of all Dublin school girls due to the selective nature of the sample. The 13% prevalence rate of high EAT 40 scorers discovered in this population can only be cautiously compared with the findings of other studies. Reports by Button and Whitehouse of the use of the EAT 40 in a population of older college students found that 6.3% were high scorers[13]. Garner and Garfinkel identified 38% of dance students and 12% of normal control students as high EAT scorers[12]. man et al. reported 7% of an unselected population of 15 year old London schoolgirls

as high EAT scorers on a shortened version (EAT 26) of the original EAT 40 questionnaire[15].

It has been shown in follow-up clinical interviews of non-clinical high EAT scorers that the majority do not satisfy the diagnostic criteria for anorexia nervosa. Nonetheless the majority have been shown to experience abnormal eating patterns and attitudes sufficient to interfere with normal psychosocial functioning[11,12,13]. It is therefore inappropriate to assume that high EAT 40 scorers in non-clinical populations are diagnostic for anorexia nervosa[12,13,16]. Rather in non-clinical settings, the EAT 40 may be regarded most suitably as a screening instrument and those high EAT scorers as representing a group with serious eating and weight concerns.

In summary this study identifies 13% of the study population as high (i.e. above cut-off point) scorers on the EAT 40 questionnaire. Despite the difficulties and dangers inherent in inter study comparisons, the result is not out of keeping with previously reported prevalences amongst non-clinical populations in Canada and in the U.K. It is possible, as reported in other studies of non-clinical high scores, that this study's high scoring individuals are experiencing considerable psychosocial distress which in turn represents a very real source of psychological morbidity within the teenage school girl population.

Finally the study demonstrates that it is possible to obtain information on the psychological health of school girls by questionnaire without undue disruption of the school programme.

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# A Pilot Study Of Speech/Language Disability and Behaviour Disturbance in a Sample of Referrals to a Child Psychiatric Clinic.

Michelle Murphy.

Michael Fitzgerald.

A sample of 50 consecutive referrals to a child and family centre between March 1983 and July 1983 were chosen as the subjects. These children were given an appointment for administration of a speech and language screening assessment as well as a behavioural questionnaire. The speech therapist (M. M.) made home visits during which she administered the Rutter A2 behaviour questionnaire to the parents, 32 out of 50 parents cooperated. The following instruments were used:

(1) Bankson Language Screening Test.

(2) Reynell Developmental Scale.

(3) English Picture Vocabulary Test.

(4) Boehm Test of Basic Concepts.

(5) North Western Syntax Screening Test.

(6) Detailed Phonological Assessments and Analysis.

(7) Symbolic Play Test.

(8) Battery of Dysfluency Assessments, and

(9) Rutter A2 Behaviour Questionnaire.

In this study 19 out of the 32 children studied had language delay and of these 14 also had behaviour problems. This study suggested that screening children attending a Child & Family Centre in a disadvantaged area for speech and language problems would be productive. It also appeared possible that speech and language problems are not been given sufficient attention in routine referrals to Child & Family Centres.

# PSYCHOLOGICAL DISTRESS AMONG DUBLIN FEMALE ADOLESCENTS.

MICHAEL FITZGERALD.

MARIE HORGAN.

## INTRODUCTION

Despite widespread and apparently increasing interest in adolescent psychopathology only a limited number of studies worldwide have addressed the prevalence of psychological distress amongst community samples of adolescents [1].

Krupinski, Baikie, Stoller [2] reported psychiatric disorder in 16% of the adolescent population of Heyfield, Australia. Unfortunately diagnostic criteria were not specifically defined. In the Isle of Wight study [1,3,4] psychiatric disorders were slightly more common in adolescence than in middle childhood and considering various sources of data collection the one year period prevalence of psychiatric disorders in adolescence was estimated at 21%.

More recently, Mann, Wakeling et al.[5] in the U.K., D'Arcy and Siddique [6] in Canada and Kashani, Beck et al. [7] in the U.S.A. using a variety of investigative approaches reported rates of psychological distress amongst non-clinical populations of adolescents of 19%, 27% and 19% respectively.

The study reported here attempts to document by means of a self report questionnaire the nature and prevalence of psychological distress in an unselected sample of 16 year old Dublin schoolgirls.

## METHOD

The study population was drawn from the fifth year pupils (average age $15^{11}/_{12}$) of a Dublin secondary school. The school is located in an established working class area of the city.

The aims of the study were explained to the pupils who in turn, were asked to seek parental consent by taking home a specially prepared letter for parents to sign and return. It was stressed that the study was being conducted anonymously. All 56 approached were willing to participate and all obtained written parental consent. Subsequently 54 pupils completed the questionnaire and gave the following demographic information: (1) date of birth and (2) occupation of father.

The questionnaire was administered to the pupils by the author (MH) during a morning class session. the pupils were asked to complete the questionnaire without discussing answers amongst themselves and were assured of the anonymity and confidentiality of their responses. They were permitted to clarify any misunderstandings in relation to the best items with the author (MH) and a small number (5%) availed of this opportunity.

## THE YOUTH SELF REPORT QUESTIONNAIRE - (YSRQ) [8]

The YSRQ was designed by Achenbach and Edelbrock (8) to record in a standardised format behavioural problems and social competencies of children aged 11 - 18 years as reported by the children themselves.

The behaviour problem items were scored on 3 step response scale. The social competence items comprised information on the amount and quality of the child's participation in port, hobbies, games, activities, organizations, job/chores and friendships. It also had items of how the child got along with others, works by himself and on how well he functions at school.

The YSRQ is scored on the YSR profile which consists of social competence scales reflecting the child's activities and social relationships as described above and behaviour problem scales which categorise problem behaviours under 6 distinct headings as follows: somatic, depressed, unpopular, thought disorder, aggressive, delinquent.

Research with YSRQ indicates good stability in self ratings over a six month period and statistically significant agreement with ratings by parents and clinicians.

## RESULTS

(1) The Study Population:

Fifty-four girls (96%) of those enroled) completed the questionnaire. The social class of the study population was as follows: (Classification and Occupation) [9] - Social Class II and III, 6%; Social Class IV, 44%; Social Class V, 24%; unemployed 13% and not known 13%. The average age of the study population was fifteen years and eleven months.

(2) YSRQ Results:

In this study no deviant scores were obtained on the social competence scales.

On the behaviour problem scales 18.5% (10) of the sample scored deviantly (i.e., above the normatively derived cutting points) on one or more scales.

One pupil scored deviantly on all 6 scales, one scored deviantly on 3 scales, two scored deviantly on 2 scales and five pupils score deviantly on 1 scale only.

Thus 17% (9) of the sample scored deviantly on the somatic scale, 7% (4) scored deviantly on the depressed scale, 2% (1 pupil each) scored deviantly on both the aggressivity and delinquency scales.

Twenty-two questions from problem behaviour questionnaire set have been selected and the pupils analysed and illustrated graphically. The results yield informative and interesting data on the anxieties and preoccupations of the study population.

## DISCUSSION

This study identified 18.5% (10) of the study population as deviant scorers on one or more of the YSRQ problem behaviour scales. No participant scored deviantly on the social competence scales.

With regard to the overall level of psychological health amongst adolescents, data from cross-cultural studies indicate that a fairly large number of adolescents (about 20%) suffer some form of psychological distress. Thus the results of this study are in keeping with previously reported figures in countries other than Ireland.

Nonetheless a strict comparison is neither intended nor is it feasible, due to the diversity in populations studied and differences in the instruments used to measure psychological distress.

There was a tendency for deviant scores to predominate in the somatic and depressed scales of the problem behaviour profile. This is in keeping with the recognized tendency for psychologically distressed females to somatize and to experience depression/anxiety rather than to present with anti-social or delinquent behaviour.

In summary the study reports the use of the YSRQ in an attempt to identify and document the prevalence of psychiatric morbidity amongst an unselected, non-clinical adolescent female sample. Its findings are broadly in keeping with those known to date from a variety of cross-cultural sources.

## ACKNOWLEDGEMENTS

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# Part II

# CHILD PSYCHOANALYTIC PSYCHOTHERAPY.

MICHAEL FITZGERALD.

## INTRODUCTION AND HISTORY

Three women are associated with the birth of child psychoanalysis and psychotherapy, Anna Freud, Hermine Hug-Hellmuth and Melanie Klein. Anna Freud died in 1982, Melanie Klein died in 1960 and Hermine Hug-Hellmuth was murdered by her nephew in 1924. While there is no doubt that Sigmund Freud was the "Father" of psychoanalysis and psychotherapy, child psychoanalysis and child psychotherapy had three "Mothers". The psychoanalytic study of childhood was conducted initially through adult patients. Josef Breuer and Sigmund Freud in 1893 discovered that "hysterics suffer mainly from reminisces". Adult psychoanalysis than set about discovering new information about childhood trauma through reconstructing childhood events.

In 1909 Sigmund Freud published The Analysis of a Phobia in a Five Year Old Boy. The case material that Freud based his analysis of the little boy was collected by his father. Freud believed that underlying this phobia was a conflict over sexual urges.

After the publication of the Three Essays on the Theory of Sex by Freud in 1905 psychoanalysts began direct observation of children which confirmed some psychoanalytic theories at that time and also provided alternative hypothesis. As Anna Freud (1966) pointed out, analysed nursery school teachers and those working with delinquents continued this work in the 1920's and 1930's. Indeed psychoanalytic ideas which emphasized honesty, openness and freedom began to have increasing influence on child rearing practices.

In the 1920's papers on child psychoanalysis with children began to be published using psychoanalytic theory but using a technique modified from adult psychoanalysis. Anna Freud set out the therapeutic principles. She wished to eliminate suggestion as a element of the treatment and achieved this by not using her authority. She avoided the use of abreaction as a therapeutic tool. She kept management of the patient to a minimum except where they were seriously harmful forces at work. She considered that the following were major features of this therapy:

(a) The analysis of resistance which is resistance to the work of child analytic psychotherapy and to increased self knowledge.

(b) The analysis of the transference which is the transference of feelings, attitudes and experience of parental figures which are transferred onto the therapist and others around the child in the present.

(c) The interpretation of unconscious material, that is bring to the child's mind matters that have been repressed, memories, wishes and desires that the child is not aware of and which are currently causing conflict.

## PHILOSOPHY OF CHILD ANALYTIC PSYCHOTHERAPY

The two main assumptions of psychoanalysis are:

(1) The principle of psychic determinism or causality, and

(2) The importance of the unconscious in the understanding of the human mind.

The principle of psychic determinism states that nothing in the mind is arbitrary or undermined or happens by chance. All mental events have meanings and causes and are determined by the ones that preceded it. A person cannot therefore dismiss dreams, obsessive thoughts or slips of the tongue but must ask themselves "What caused it?", "Why did it happen?". Dreams follow the same principle of psychic determinism and psychoanalysis traditionally looks for hidden wishes beneath the remembered dream.

The second main assumption focuses on the importance of unconscious factors in understanding the human mind and that only a small amount of mental activity is conscious at any one time. Psychoanalysis is fundamentally about the study of the unconscious, about the study of how deep seated, unconscious factors determine the feelings, attitudes and patterns of behaviour of children and adolescents. The unconscious contains earlier childhood memories and childhood wishes as well as many desires and fantasies that would be unacceptable to the conscious mind for example sexual and aggressive wishes or impulses. While the conscious mind takes reality into account the unconscious mind is governed by the pleasure principle by that I mean that all that matters is pleasure. It is hardly surprising that the contents of the unconscious are therefore repressed because if they become conscious they would cause the individual anxiety. In central Europe around the end of the 19th century and in Ireland in the first half or more of the 20th century sexual impulses were connoted as "bad" and so a large amount of psychological energy was expended on keeping these impulses repressed and in the unconscious. The problem of repressed anger could be seen in a child who began to steal because he could not express anger at an ill father who was neglecting him. He repressed the anger at the father and began to steal as a symptom of his distress. In treatment it was possible to make the anger conscious and to give him insight into the problems between himself and his father. He was able to express his anger directly at his father and the symptoms of stealing ceased.

In short psychoanalysis is a branch of the science of the mind developed by Sigmund Freud. It is basically the analysis of the human psyche. Psychoanalysis is:

(a) A method of investigating the mind.

(b) A theory of human behaviour.

(c) A technique for the treatment of emotionally disturbed children and adolescents. Child analytic psychotherapy is a technique that applies psychoanalytic theory.

The form of treatment is useful to children who are anxious or depressed or in psychological turmoil. It is also of value to children who are in conflict because of physical illness or who having difficulty coming to terms with disability. It is also helpful in treating children with unresolved grief reactions because of the death of a parent, reactions which can make the child more vulnerable to adult depression in later life if not dealt with satisfactorily. It can help children who are having difficulty resolving stress due to some overwhelming trauma for example a serious accident or other traumatic life event.

It is not for everyone and everybody does not need it. It will not reverse biological brain pathology. It is a treatment of the mind rather than the brain that is taking a dualistic view. To be helpful the problem must have a psychological basis. In general patients with mental handicap, schizophrenia and autism would not be treated with psychoanalysis as a first line treatment. These patients would benefit from another form of therapy called behaviour therapy which is based on learning theory - elements of which would include social skills training or rewarding positive behaviour. In addition psychopharmacology approaches would be relevant to children with schizophrenia. At the same time in recent years there has been some new interests in applying child psychoanalytic psychotherapy to patients with mental handicap.

The philosophy of change in child psychoanalytic psychotherapy is about psychic change which is taken as a major sign of emotional growth. This change is shown in the child by clearer thinking with insight into the causes of the child's problems and feelings. The child can know put a meaning on their feelings and is not bewildered by them. An observer looking at the child has the sense of a more contained child, less at the mercy of his or her instincts or feelings. I believe that the child identifies or models himself or herself on the calm, contained therapist. The good experience with the therapist is taken in by the child and strengthens the child's personality. The therapists calm accepting voice becomes absorbed into the child's mind and laid down in memory traces. This voice counters critical parental voices from the past. This has the effect of boosting the child's self esteem. In the same way the child's good experience with the therapist increases the child's capacity to trust and form relationships with other children and people in general. This helps the child get back on the developmental course and one observes him or her as being more like the other children. One observes emotional growth happening again just as in non-disturbed children. One observes a smile coming on to the child who had a frozen frightened face. The child plays better and works better in school and relates better to peers. The child is better able to cope with every day stresses. One also notices a softening of the super ego or conscience and therefore less signs of inappropriate guilt.

Changes is brought about by a good quality trusting therapeutic relationship and by the therapist making the unconscious conscious. The child is free to put the unspeakable into words and with that the burdens on the child lightens - "a problem shared is a problem halved". Young children in particular have a tendency to blame themselves for everything that happens for example if a parent gets sick the child may say that it was because that they were naughty. This fantasy of the child can cause enormous distress and guilt and be undetected for a long time by the parent. The child can feel that he or she is very "bad" and that the expression of anger is both "bad" and dangerous. the exploration by the therapist of the many fantasies that children have about themselves is critical to the progress of therapy and to change. Children will also have fantasies about the therapist and will transfer or put onto the therapist feelings that they had about a rejecting father or mother and then perceive the therapist as rejecting even though the therapist has been very reasonable and sensitive throughout the treatment. The therapist has to help the child to see that these fantasies about the therapist are inappropriate and refer to powerful figures from outside the treatment. The feelings described are called transference feelings and the resolution of these feelings is very important for change to come about. It is important for the child to understand where these feelings have come from. Then they will be able to see the therapist and other adult figures in their life more realistically. In the treatment the child also has a corrective emotional experience by that I mean the therapist behaves differently to other figures in the child's life outside of the treatment or in the child's past. Then the child can begin to see that not all adults are like their rejecting critical parents or other figures that they have had that experience with. This development of trust and hope is absolutely critical for the child's future happiness and successful negotiation of lifes hurdles.

Change is more likely to be maintained if the problems have been properly worked through in the psychoanalytic sense. This means covering the same ground many times

and uncovering the many ramifications of conflict and fantasies as they appear in the child's clinical material with the therapist. There are many reasons why a child develops a particular symptom and all these need to be explored in so far as it is possible.

Work with parents is also important and can be a form of psychoanalytic child development education. It helps the parents to understand what the child has been through and emphasises the child's need for empathy, security and an accepting environment. The sessions with parents also have the role of protecting the child's treatment and supporting the parents in the demanding task of bringing the child for treatment. Some parents suffer very considerable guilt about having a disturbed child and others experience envy of the child's treatment and attention that the child is receiving. These are matters that need to be attended to if the treatment is not to be prematurely terminated. The confidentiality of the child's material has to be respected otherwise the child will mistrust the therapist. Some parents who have major psychological problems themselves will need formal psychotherapeutic help in their own right or marital problems and may need marital therapy.

When unconscious impulses for example sexual or aggressive impulses seek discharge they put the child into conflict with his or her super ego (conscience) and the outside world. A pathological solution to this conflict is the development of a compromise formation (symptom) for example phobia, obsessional symptom (e.g. hand washing) or a conversion symptom (e.g. paralysed limb). A phobia is a condition where there is an avoidance of a specific situation or object, although not dangerous, which causes anxiety to the child. Here the defense mechanism of displacement can occur where for example a fear of father can be displaced onto a fear of animals. In school phobia what can emerge is not a fear of school but a fear of leaving mummy or a fear that mummy will die if the child goes to school.

I remember one situation where the child had a school phobia because he was afraid of mother stabbing herself while he was at school. This came as a great surprise to mother but she had attempted suicide in the past. In obsessive compulsive neurosis the child is dominated by repetitive unwanted thoughts or actions or rituals for example hand washing. There tend to occur in conscientious meticulous and hard working children. These children tend to have harsh super egos (conscience) and a very poor toleration of strong feelings. These neurosis are a pathological solution to strong sexual or aggressive impulses which are unconscious. In analysis one becomes aware that these children have isolated thinking from feeling. They tend to intellectualize and the therapist is trying to help them to get in touch with their feelings and unconscious impulses. One can also analyse the defense mechanism of undoing which attempts to ritualistically "remove" the enough, who are sensitive enough to the needs of the child. This means that the child has more good experience with the parents than negative experience. The child's personality is built on this good experience. When the child is reared with sensitive parents he or she lays down within himself or herself a strong foundation for their personality. This makes them strong and more able to withstand the "slings and arrows" of life. The child strengthens their personality by identifying with solid sensitive parents. There is major modelling on the parents personality. What the child models on is not only the parents as they are but the parents as the child perceives them. The small child will tend to project aggressive and other feelings onto the parents and will therefore perceive them as more threatening and dangerous that they are. It is this model of the parents that he or she will identify with. the child's super ego or conscience is modelled on the parents and other significant figures in their environment.

In the past conscience development tended to be very harsh in Irish children and adults and caused enormous guilt and anxiety when the standards of conscience were not met. If the parents and others for example teachers are extremely negative to children, the children develop very low self esteem which makes them vulnerable to anxiety and

depression and other conditions. Unfortunately in Ireland there has been a fear of praising children and an idea that continuous criticism was good for them. Nothing could be further from the truth. A child with low self esteem is very prone to psychological problems. Critical parents, critical teachers and other voices are internalized in the child and echoes throughout the rest of their lives often very serious consequences for their happiness. It leaves children in a very anxious, offensive act for example hand washing to undo the guilt about masturbation.

Children also show conversion symptoms where unacceptable mental content is changed into physical phenomena for example headaches were a child was unable to express anger at mother for being over controlling and instead developed a headache. Another example would be a child who develops abdominal pain because he is in conflict with someone in his environment. Children can also develop other conversion symptoms for example gait disturbances, tremors, convulsions and paralysis because of stress in their environment. The development of the conversion symptom happens unconsciously.

Reaction formation is another defence mechanism were the child converts unacceptable feelings into acceptable ones and in the process keeps the unacceptable ones unconscious for example a child who had repressed feelings of hate for his mother became over concerned for her welfare and was over attentive to her.

In modern psychoanalysis the importance of interpersonal factors has greatly increased. The earlier psychoanalysis puts major stress on factors within the child i.e., with the child's instincts for example aggressive instinct where the conflict arises when the demands of the super ego which approximates to the standards of conscience is in conflict with the instinctual wish. While this still holds the cause of psychological problems in childhood and adolescence are now perceived as being more complex and multi-faceted. Nowadays crucial importance is given to the levels of empathy or sensitivity between the parents and the child. To grow healthily a child needs parents who are good, unhappy, negative and pessimistic with a very poor quality of life. I have never know a child who grew up healthy who was continually criticized and neglected or completely unwanted.

In Ireland it has been shown that children from large families are more at risk from psychological problems. It is more difficult for parents to be sensitive to each member of a large family. The economic stresses also undermine parents by distracting them from the needs of their children and anything that impacts on parents will also impact on the children because if the parents are distracted by the multiple stresses of disadvantage, mental illness or marital breakdown they will have much less mental energy to tune into the needs of their children and their children are more likely to become psychologically stressed. To grow healthily children need a secure environment, reasonable limits and parents who are in tune with their needs and developmental stage or level of maturity. Age is a critical factor in determining what is appropriate to demand of a child for example to demand that a six month old child is toilet trained is too much. At the same time a child will also be damaged if normal demands are not made at the appropriate time. Over indulgence or spoiling is as damaging as neglect or rejection. Sometimes children and adolescents from extremely wealthy families who over indulge their children have children who have difficulty in developing definite identities of themselves or knowing what they want or what true value is.

One of the first tasks of healthy development is the acquisition of basic trust which will grow in the child in a good enough family. Children who are physically abused, sexually abused or suffer serious neglect grow up very mistrustful and fearful of people. Child psychotherapy takes a very long time to reverse this mistrust of people and indeed and element of it probably always persists.

## APPLICATION OF PSYCHOANALYTIC PSYCHOTHERAPY

The basic technique of child analytic psychotherapy is a play technique. In play children symbolize their conflicts and anxieties. Adult patients are able to free associate that is said freely what comes into their mind. Small children cannot do this and of course play is their normal way of expressing themselves. The child psychotherapist treats the child's play and verbal discourse in the same way that the adult therapist treats the patients free association of ideas.

The child psychotherapy takes place in a room without dangerous objects. The surfaces are washable. This kind of room will allow the child the freedom to express himself or herself. Each child will have an individual box of toys which will only be used by him or her. The box will usually contain bricks, toy cars, animals and figures of various sizes. It is also traditional to have paper, pencils, crayons, glue, scissors, string and running water. The aim is to have material that will allow the child to express themselves as freely as possible. Children get quite attached to the room and insecure if they are changed. The change of room can remind children of many previous changes that may have occurred in their life and that may have distressed them. If a room change occurs it may bring to mind old upsetting changes in the childs past and these will need to be explored in detail with the child if they have occurred.

The basic mode of communication with the child is through interpretation where the therapist tries to understand the patients communications and make sense of them and communicates these insights to the child in a language that the child will understand. The therapist conveys to the child that he or she is interested in the child's worries and is there to help them understand them. The timing of interpretation is important and therefore an effort is made not to give an interpretation until the child is ready for example there may be evidence in a child's material that they have a death wish towards a parent or sibling but the therapist initially will only focus on the anger at mother or sibling or say something initially like "some children can be very angry with their brothers and sisters or with their mother". It can also be of considerable relief for children to realise that they are not the only ones who have these wishes. Before coming to treatment children often feel they are the only ones in the world with these feelings which greatly increases their suffering. As described earlier transference interpretations are among the most important because they increase the child's self knowledge and help him or her to see the feelings they are transferring onto the therapist and people in the outside world that were originally felt towards parental figures. If a child felt that they were responsible for a parent's death then the experience of this would be highly significant for the child and the unburdening would be of major importance. Psychosomatic symptoms may be interpreted depending on the child and the cause of them as a conflict with a parental figure or sibling or as a way of getting some love or care in a family where this is only available to a sick member.

It would be usual for a child coming to a first session to have fears or fantasies about the treatment. The child may feel that they are coming because they are "naughty" and may see it as a punishment. If they have been mistreated for most of their life they will have much mistrust and very little hope of help. They may expect to be let down again. Siblings may have mentioned the word "mad" in relation to coming for therapy and this may cause the child great anxiety. Sometimes they will have been told that they are going to get their eyes tested and are therefore completely confused. These prior fantasies or explanations need to be explored by the therapist with the child or the child will feel totally confused. The major part of treatment is opening up clear lines of communication and openness and dealing with fantasies so that the world makes sense to the child.

One of the major other tasks of the therapist is to overcome resistance that is the resistance or reluctance of the child to communicate or cooperate with the therapist.

The child does not want to talk about something or wants to shut out something that makes him or her anxious or guilty.

Termination is considered when the child is back on developmental course, is functioning well at home and school and is not showing evidence of significant psychological pain.

The first visit to a child psychotherapist will involve a detailed history of the child and his or her family. The therapist will enquire about mothers pregnancy with the child and developmental milestones, language development, feeding behaviour, experience of preschool and school. In addition the child's temperament which can have major effects on the child development will be enquired about. Detailed histories would also be taken of the parents life story and especially their marital relationship if this was relevant as well as parental personality type and history of mental illness. The family atmosphere in the earlier part of childhood and currently would also be of critical importance. The child would then be interviewed alone using the play technique as well as verbal communication to assess the child's conflicts and suitability for child psychotherapy. If treatment was considered appropriate the child would be seen once or more times per week the sessions would last under one hour.

There is research evidence that psychotherapy is more effective than no treatment. Some of the positive effects of psychotherapy are not seen immediately and indeed some of the improvements continued to occur between 18 months and three years after the children finish treatment with psychotherapy. For children the overall improvement with psychotherapy has been put between 67 and 78%. The spontaneous improvement rate that is the improvement rate without treatment has been put at about 25%. It is likely that child psychotherapy considerably speeds up the rate of improvement. There is much less research on child psychotherapy as compared to adult psychotherapy.

## TRAINING

The Irish Forum for Child Analytic Psychotherapy undertakes the only formal child analytic psychotherapy training in Ireland. Information is available from the Director Dr. M. Fitzgerald, Irish Forum for Child Psychotherapy, 43 Rock Road, Blackrock, Co. Dublin.

## WHERE TO GO

Information for perspective clients about where to find the therapist using this approach could be acquired from in the first instance their local General Practitioner. It is also available from many Child and Family Centres run by the Health Boards run throughout the country. The Irish Forum for Child Psychotherapy at 43 Rock Road, Blackrock, Co. Dublin would also provide a list of names.

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# MEASURING PROGRESS IN PSYCHOANALYTIC PSYCHOTHERAPY: A PILOT STUDY.

JOHN SHEEHAN.

MICHAEL FITZGERALD.

Six patients in individual psychoanalytic psychotherapy and ten patients in group psychoanalytic psychotherapy were assessed using two self-report questionnaires. The questionnaires were administered pre-therapy, after three months and after six months. A statistically significant improvement occurred in both groups but important differences were found between the groups.

Since Eysenck's (1952) controversial charge that psychoanalytical psychotherapy has no value, researchers in psychotherapy have rallied to refute this claim. Numerous studies have been conducted (Lambert et al., 1986) concerning both outcome and process. The positive effects of both individual and group therapies have been documented (Smith et al., 1980). The purpose of the present study was to attempt to measure change or progress in patients under going psychoanalytical psychotherapy either on an individual basis or as part of a group.

## METHODS

### The Therapists and their Supervision

Six therapists participated in the study. All were trainees in psychoanalytical psychotherapy. Five were involved in individual therapy. They were in their second year of a two-year university course leading to a Masters degree in Psychotherapy. The sixth trainee was in his first year of a five-year group psychoanalytical psychotherapy course run by the Institute of Group Analysis, London. Demographic data were collected from each therapist and included age, sex, qualifications, previous personal analysis and previous supervision. Of the trainees in individual psychotherapy, the mean age was 38 years (range 30 - 47). Two were male, the other three female. Two were medical doctors, two were social workers and one was a clergyman with a Masters degree. Four had no previous experience of psychoanalysis but one had been in analysis for three years. Each trainee was supervised on a weekly basis by a supervisor. The trainee in group psychotherapy was a 32 year old male doctor with no previous experience in psychoanalysis. He had regular supervision by a fully-trained group psychoanalyst.

### The Patients' Characteristics

Sixteen patients participated in the study, ten in the group and six in individual therapy. All were outpatients. All of the patients in individual therapy were referred for psychoanalytical psychotherapy by a consultant psychiatrist attached to the Department of Psychiatry in a Dublin teaching hospital. four out of the six were private patients. All of the patients in the group were referred either by a consultant psychiatrist or a registrar in Psychiatry. the patients were all attending the local community-based psychiatric service. None were private patients. Demographic data, including age, sex, marital status, education, occupation, duration of presenting complaint, past psychiatric history and medication were recorded. Diagnosis, as made by the referring consultant or registrar, was based on the International Classification of Diseases-9.

### The Therapeutic Method

The therapeutic method employed by the trainees both in individual and group therapy was psychoanalytical psychotherapy. The golden rule of free association was adhered to and emphasis was placed on interpreting the resistance and the transference. Dream interpretation and parapraxes were highlighted. In the individual cases, sessions lasted for 50 minutes and occurred on a weekly basis at the same time and in the same place. The group sessions were longer, lasting 90 minutes each but occurring at the same time and in the same place each week. The group used the integrative approach devised by Foulkes (1975).

An attempt was made to validate the treatment. A transcript of a session with a client was made by each trainee. A tape recording was also made of a group session and a supervisor (MF) assessed both the transcripts and the recording. The fact that all the therapists were trainees attending their supervisors regularly helped to ensure the integrity of the treatment.

The group was held on a weekly basis over a six-month period. All patients were informed of the duration of the group before they started and the methods of psychoanalytical psychotherapy were explained to them. The patients in individual therapy were told about the study either before they started or just after starting treatment. The duration of therapy was, however, an issue between themselves and their therapists and the therapy did not have to terminate after the six-month assessment. Consent was obtained from all patients prior to the commencement of the study.

## INSTRUMENTS

To measure change or progress two different instruments were used, the General Health Questionnaire-30 (GHQ-30) (Goldenberg, 1972) and the Self-Development Project List-90 (SDPL-90) (Braaten, 1989). Both are self-report questionnaires.

The GHQ-30 is a screening instrument for psychiatric disorder in patient and community samples. It detects psychopathology (Huppert et al., 1989) and has been used extensively in various cultures and in different linguistic groups (Chan and Chan, 1983).

The SDPL-90 was devised by Professor Braaten in Norway. It is an instrument to measure individualized outcomes. It consists of 90 questions relating to individual goals which after factor analysis are reduced to five areas, three interpersonal and two intrapersonal. The interpersonal areas are dependency, intimacy and social assertiveness. The intrapersonal ones are self-individuation and self-acceptance. The

aim is to detect the patient's individual goals or priorities. The patient completes the 90 questions by assigning a value between zero and four to each question. Zero represents no importance and four extreme importance to the patient. As therapy progresses, problems are worked through and goals change. Hence serial measurements reflect the individual's changing goals and priorities during treatment.

Both the GHQ-30 and the SDPL-90 were administered to each patient pre-therapy or just after starting therapy, after three months and after six months. The three-month assessment was arbitrarily defined as Mid-treatment and the six-month assessment as End-of-treatment although patients in individual therapy could continue in therapy after six months. For patients who dropped out, the three-month score was taken as End-of-treatment score.

The effect of psychotherapy was determined by the statistical analysis of the change in GHQ-30 Mean scores using repeated analysing the number of patients who changed their main goal in the SDPL-90 during therapy using Fisher's Exact test. The Chi-square test, the t test, Fisher's Exact test and the median test were used to analyse the demographic data.

## RESULTS

Comparing the patients in individual therapy with those in group therapy, no significant differences were found with regard to demographic details (Table 1).

Regarding diagnoses, three patients in individual therapy had depressive neuroses, one was alcohol-dependent, one had a depressive personality and one an adjustment reaction. One patient had both a depressive neurosis and an anankastic personality. In the group, five patients were diagnosed as having depressive neuroses, one an anxiety neurosis, one simple schizophrenia, one neurasthenia and two hysterical personality disorders.

The attrition rate was 50 percent in both samples. The mean number of weeks completed in therapy for those who dropped out was 17 (range: 14-19). Of the three people in individual therapy who dropped out, two did so because they were dissatisfied with their treatment and one because she felt better. In the group, five did not complete the six months' therapy. Two left because they were dissatisfied, one patient got a job and another got a place on a night course which has held on the same evening as the group. The fifth person was referred to a day hospital and he stopped attending the group of his own volition.

All the patients in individual therapy completed their questionnaires. Two of the participants in the group did not return their questionnaires at three months, although they completed the six-month questionnaires.

The GHQ-30 results were analysed in several ways. The changes in GHQ-30 mean scores between Pre- and End-of-therapy for all 16 patients are shown in Table 2. The pre-, three-month and six-month results are shown in Table 3.

Patients were subsequently divided into those who completed six months' therapy (Completers) and those who terminated prematurely (Dropouts). Their Pre-, three-month and six-month GHQ-30 readings are illustrated in Table 4. Finally, the Pre- and End-of-treatment results of the Completers in both samples were pooled and compared with those of the Dropouts (Table 5).

Table 1

**Demographic Details of Patients in Individual and Group Therapies.**

| Variable | Individual (n = 6) | Group (n = 10) | p value |
|---|---|---|---|
| Age | | | |
| Mean | 29.8 yrs | 36.4 yrs | NS |
| Range | 16 - 41 | 24 - 48 | |
| Sex | | | |
| Male | 3 | 4 | NS |
| Female | 3 | 6 | |
| Marital status | | | |
| Single | 5 | 5 | NS |
| Married | 1 | 5 | |
| Education | | | |
| Non/Primary | 1 | 3 | |
| Secondary/Third Level | 5 | 7 | NS |
| Occupation | | | |
| Unemployed | 2 | 3 | |
| Employed/Housewife | | | NS |
| Student | 4 | 7 | |
| Duration of complaint | | | |
| Mean | 6.3 yrs | 7.8 yrs | NS |
| Range | 9 mths-20 yrs | 2 mths-16 yrs | |
| Past psychiatry history | 4 (66.6%) | 8 (80%) | NS |
| Psychotropic medication | 2 (33.3%) | 8 (80%) | NS |

NS = Not Significant.

Table 2

**GHQ-30 Mean Scores (Standard Deviation): Pre- and End-of-therapy.**

| | Pre | End | Change |
|---|---|---|---|
| Individual n = 6 | 12.5 (4.9) | 3.3 (4.0) | 9.2 |
| Group n = 10 | 18.6 (8.0) | 8.8 (9.1) | 9.8 |

Patients significantly improved with psychotherapy ($F = 9.44$, d.f. = 1, $p + 0.009$). No statistically significant difference between therapies ($p = 0.923$).

Table 3

**GHQ-30 Mean Scores (Standard Deviation): Pre-treatment, Three Months and Six Months.**

| | Pre | 3 months | 6 months |
|---|---|---|---|
| Individuals n = 6 | 12.5 (4.9) | 5.7 (6.1) | 5.3 (4.9) |
| Group n = 10 | 18.8 (7.6) | 6.0 (7.3) | 12.2 10.6) |

Significant improvement in patients between Pre- and three months ($F = 21.44$, d.f. = 1, $p = 0.001$). Group therapy patients deteriorated between three and six months but not significantly ($p = 0.212$).

**Table 4**

**BHQ-30 Mean Scores (Standard Deviation): Those who Completed Six Months and Those who Terminated Prematurely.**

| | Completed 6 months | Pre | 3 months | 6 months |
|---|---|---|---|---|
| Individuals n = 6 | Yes (Completers) | 10.7 (4.9) | 9.3 (7.1) | 4.7 (2.6) |
| | No (Dropouts) | 14.3 (5.1) | 2.0 (1.7) | 6.0 (2.6) |
| Group n = 10 | Yes (Completers) | 15.4 (8.6) | 6.3 (10.5) | 11.2 (11.8) |
| | No (Dropouts) | 22.2 (5.3) | 5.8 (3.8) | 13.2 10.6) |

**Table 5**

**GHQ-30 Mean Scores (Standard Deviation) of Completers and Dropouts, Pre- and End-of therapy.**

| | Pre | 3 months | 6 months |
|---|---|---|---|
| Completers | 13.6 (7.4) | 8.8 (10.3) | 4.8 |
| Dropouts | 19.0 (6.8) | 4.1 (3.5) | 14.9 |

Significant improvement ($F = 13.42$, d.f. = 1, $p = 0.003$) occurred in patients between Pre- and End-of-treatment. Tend for Dropouts to improve more ($p = 0.087$). No difference in level of psychopathology between Completers and Dropouts ($p = 0.894$).

Patients in individual therapy consistently scored lower on the GHQ-30 than those in group therapy. This reached statistical significance ($p = 0.031$). It affirms that those in individual therapy had less psychopathology, both at the beginning and at the end of treatment than those in the group therapy.

Regarding the SDPL-90 results, two patients out of six (33.3 per cent) in individual therapy changed their main priority between the start and end of treatment. Four out of nine patients (44.4 per cent) in group therapy changed their principal goal over the same time. No significant difference was found between these results. The most frequently observed priority of the patients in individual therapy was self-acceptance, an intrapersonal goal. fifty per cent had self-acceptance as their principal goal and 83 per cent had it as either their first or second goal. Concerning the group, the most prevalent goal was assertiveness at 60 per cent, an interpersonal goal.

## DISCUSSION

Approximately 250 different forms of psychotherapy have been identified (Herink, 1980). With such an array of therapies, one must ask about efficacy. However, research in psychotherapy is difficult. Definitive answers are difficult to obtain. Furthermore, no consensus exists regarding the measurement of outcome.

The aim of our study was to attempt to measure change or progress in patients in psychoanalytical psychotherapy. The results showed that the patients in both samples improved and that the improvement was statistically significant (Table 2, $p = 0.009$). However, by examining the Pre- and three-month GHQ-30 results (Table 3), one sees that a significant improvement occurred even in that time period ($p = 0.001$). It suggests that symptom reduction (for example, anxiety, depression) occurs early in therapy.

The change in GHQ-30 mean scores between Pre- and End-of-therapy (Table 2) was virtually identical for patients in individual therapy (9.2) and group therapy (9.8). The difference between therapies was not significant ($p = 0.923$). One could falsely conclude that because there was no statistical difference there was no clinical difference. The SDPL-90 results dispel that notion.

The SDPL-90 results illustrate interesting differences between the patients. Those in individual therapy had predominantly intrapersonal goals whereas those in group therapy had interpersonal goals at the start of therapy. Conversely, the least priority of those in individual therapy when assessed pre-treatment was an interpersonal goal, dependency, and for those in group therapy, it was self-acceptance, an intrapersonal goal. One can only speculate about the bias at the referral stage. Perhaps patients with intrapersonal problems readily accept individual therapy whereas those with interpersonal problems seek group treatment. These factors probably affect the choice of therapy offered by the referring psychiatrist.

A number of unexpected results are of particular interest. Patients in group therapy deteriorated between three months and the End-of-treatment. The change was not significant (Table 3, $p = 0.212$). One can postulate that the deterioration was related to the psychiatric status of the patients who were chronically ill and obviously very needy individuals. The group was time-limited which is not typical of group psychoanalytical psychotherapy. Normally a group would be of longer duration. Another possibility is the inexperience of the therapist and his handling of the issues around termination.

A paradoxical finding was the improvement in the Dropouts. This may have been a flight into health as the improvement was not maintained at six months (Table 4). Another possibility is that the improvement was due to the therapy. The mean number

of weeks in therapy for the Dropouts was 17 which is probably longer than occurs in some forms of Brief Psychotherapy.

Frank et al. (1957) outlined several factors associated with high dropout rates which included lower social class, less education, less integration into society and less readiness to talk about their feelings. In those who dropped out of the study, there was a wide educational spread. One had no formal education, two had primary education, two had secondary education and two had third-level education. Hence, less education did not predict attrition in this study.

Could the improvement in GHQ-30 scores be due to a spontaneous remission in symptoms? this is a valid question as no control group was employed. However, the mean duration of illness for those in individual therapy was 6.3 years and 7.8 years for those in group therapy. Spontaneous remission must be highly unlikely.

In conclusion, it must be emphasized that the study was small - a pilot study - and caution must be exercised in drawing major conclusions. The sample size was small; the therapists were trainees; self-report questionnaires were employed; the therapies had different time-limits and the therapies themselves were different. However, it was possible to measure change during therapy using two self-report questionnaires each of which provided useful but different information about the patients. We hope that the study will stimulate further research in this area.

## ACKNOWLEDGEMENTS

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# PSYCHOTHERAPY IN IRELAND.

MICHAEL FITZGERALD.

There has been a major expansion in interest in all forms of psychotherapy in Ireland in the past 15 years. This growth is a reflection of professional development e.g. many new courses of Masters standard and consumer demand.

A matter of considerable current concern is the lack of interest in formal psychotherapy by the psychiatric profession. I recently founded the Irish Standing Conference on Psychotherapy and only 10% (of 300) psychotherapists were medically qualified. This process could be reversed if there were senior registrar posts in psychotherapy and consultant psychotherapist posts available in the Republic of Ireland. There are none. The fact that the recent Green Paper on Mental Health in Ireland did not even mention the word psychotherapy is also worrying.

These trends must be reversed because psychotherapy reduces the cost of medical services by 20% and only 50% of psychiatric patients are susceptible to biological approaches.

It is essential that training programmes as fostered by the psychotherapy specialist advisory section of the Royal College of Psychiatrists are fostered.

# DEVELOPMENTS IN EUROPEAN PSYCHOTHERAPY AND COUNSELLING.

MICHAEL FITZGERALD.

Psychotherapists and counsellors became concerned that changes in the European Community regulations for the professions in 1992 might adversely effect them. Many reputable psychotherapy and counselling organisations began to consider a European Association to look after both the interests of profession and the public. It was feared that the European Commission and its committees could pass legislation issued by interested parties that would be enforceable throughout the European community with very little national consultation. Nevertheless it was also felt the European Directives would give opportunities for the psychotherapy profession to take the initiative, to become recognised and competent authorities and therefore to be in a position to advice the European Commission and National Governments.

It became clear that it was necessary for both National and European Associations to monitor the following elements of the EC structure including:

(1) The European Parliament and its Committee on the Environment, Public Health and Consumer Protection, its Committee on Economics and Monetary Affairs, its Committee on Legal Affairs and its Committee on Drug Abuse.

(2) The EC Commission.

(3) The Council of Ministers.

(4) The Economic and Social Committee and a number of Directorate Generals including DG5 Employment, Labour Relations and Social Affairs; DG11 the Internal Market; DG12 Science Research and Development; DG3 Freedom of Movement of Doctors, etc.

It became clear that professions with greater financial resources had their own independent offices monitoring these departments in Brussels. An example of the kind of document that comes from the Commission of the EC was the proposal for a Council Directive on the Liability of Suppliers of Services published in Brussels on the 20th of December 1990. This had relevance for psychotherapists and shifted the onus of proof of safety and responsibility from the recipient or patient to the provider of services. In 1988 a Higher Education Diploma Directive was published which focussed on the mutual recognition of diplomas with in the EC. This directive related to article three of the Treaty of Rome which defines one of the objectives of the community as "the abolition to obstacles to freedom of movement for persons, services and capital". In the definition of a Higher Education Diploma the Council did accept equivalent trainings to their formal ones. They also discussed that the differences in length of training may be compensated for by evidence of professional experience i.e. actual involvement in the pursuit of the profession in a member state. The length of professional experience required may not be in any circumstances exceed 4 years. Some people who go to another state may have to go through an adaptation period or aptitude test.

Each country in Europe will have a competent authority which will look at credentials and diplomas of migrants to see if they meet the requirements of that country. It is hoped in Ireland that the Irish Standing Conference for Psychotherapy will be recognised as a competent authority to assess incoming migrants psychotherapy qualifications. There is also a differentiation between independent private practice and practicing in a hospital setting where one is usually a member of a team and where there is very considerable supervision of treatment. The notion of acquired rights is also quite important in Europe and therefore people who are in established private practice would be seen as having acquired rights which would be recognised.

There is great variation in Europe about how psychotherapy and counselling is organised. There is an official register of psychotherapists in Holland since 1986. Only official psychotherapists can do psychotherapy in public hospitals. In Germany psychotherapy treatments are covered by the compulsory health insurance scheme. Psychotherapists who wish to provide treatments which can be reimbursed in the frame work of public health insurance schemes but must be qualified medical practitioners or psychologists. There are approximately 4,000 medial psychotherapists in Germany and there are 3,200 psychological psychotherapists with 750 therapists dealing with children and young people. It is of interest that child psychotherapists and those working with young people may also be professional educationalists. In France there is no regulation and no definition of what a psychotherapist is. The psychotherapy situation in the United Kingdom is similar to the psychotherapy situation in Ireland.

In 1990 the Executive Committee of the Dutch Association for Psychotherapy took the initiative for founding a European Association for Psychotherapy (EAP). I was invited to the first meeting which took place in Amsterdam in December 1990 and at least one member from the other European countries were also invited. A Steering Committee was formed to look at issues of training and regulation of psychotherapy in Europe. Regular meetings have taken place in either Amsterdam or Brussels. I invited Dorothy Gunne to also represent a different psychotherapy strand to myself at these meetings. The discussions have been very valuable to psychotherapists in this country. Dr. B. Martindale stated in February 1994 that "The Dutch initiative is as foundering and now confined to a few individuals".

A second organisation also called The European Association for Psychotherapy was set up in Austria. This organisation supports the Strasbourg Declaration on Psychotherapy 1990 which states in accordance with the aims of the World Health Organisation (WHO), the non-discrimination accords valid in the framework of the European Community (EC) and intended for the European Area (EEA), and the principle of freedom of movement or persons and services, the persons named below are in agreement on the following points.

(1) Psychotherapy is an independent scientific discipline, the practice of which amounts to an independent and free profession.

(2) Training in psychotherapy takes place at an advanced, qualified and scientific level.

(3) The multiplicity of methods of psychotherapy is assured and guaranteed.

(4) In a process of psychotherapy, training is carried out in full and includes theory, self-experience and practice under supervision. Adequate knowledge is gained of further processes of psychotherapy.

(5) Access to training is through various preliminary qualifications, in particular in human and social sciences.

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Of course having two European Organisations with the same name is a problem and this is reflected in Dr. Alfred Pritz, Executive Officer EAP (Austria) statement in March 1994.

"The EAP is keen to ensure that a truly co-operative effort across the whole of Europe will secure the future of the profession of psychotherapy in Europe. Psychotherapy is formally established as an independent profession in Austria and Switzerland where national umbrella organisations regulate the profession. A similar situation exists in the United Kingdom although no psychotherapy law has been adopted as of yet.

The Austrian, Swiss and British umbrella organisations are now working actively together through the European Association for Psychotherapy and a start has been made on agreeing minimal training standards in psychotherapy in Europe. We are also working closely with the European Commission and some interesting developments have been achieved.

We believe that it is essential for us all to work together (with Brussels based EAP) and we would welcome opening lines of communication directly with your organisation to overcome the potential danger of fragmentation of the field".

This new movement is gathering pace and has involved many individuals from Eastern Europe. It will probably be a broadly based organisation and this is probably shown by the fact that its annual meeting in 1994 will be held in London on June 24/26 with the British Association of Counselling, United Kingdom Council for Psychotherapists and European Association for Counselling.

In 1990 I believed that if the psychotherapy profession was to develop in Ireland it would be necessary for the major strands of psychotherapy to come together. I decided to set up an Irish Standing Conference on Psychotherapy and the first meeting was attended by Ger Murphy a Humanistic Psychotherapist, Ruth O'Donnell a Family Therapist and Ed McHale a Family and Marital Therapist. At the following Dorothy Gunne represented the constructivist psychotherapists and Aidan Lawlor the behaviourists. The current strands of psychotherapy represented by the Standing Conference are:

(1) Analytical Psychotherapy.

(2) Family Therapy.

(3) Constructivist Psychotherapy.

(4) Behavioural and Cognitive Psychotherapy.

(5) Humanistic Psychotherapy.

The Irish Standing Conference on Psychotherapy organises national meetings and also has had discussions with the Department of Health about the development of psychotherapy in Ireland.

Early in 1991 I received an invitation to attend a meeting in London to establish a European Federation of Specialists in Psychoanalytic Psychotherapy. This meeting took place on February 6th 1991 in London and led to the foundation of this Federation. Its aim was to benefit the public by promoting the development of both psychoanalytic psychotherapy services and the training of therapists to a high standard and to promote research in psychoanalytic psychotherapy. At a later stage I invited

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*in London and is a Consultant Psychiatrist with the*
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*He is a Senior Lecturer in Child and Adolescent Psychiatry at*
*The University of Dublin and also teaches at*
*The Royal College of Surgeons of Ireland.*
*He is a Psychoanalyst with the*
*International Psychoanalytical Association.*

Tom McGrath to be an alternative representative from Ireland. More recently Dr. Louise Tansey and Dr. Mary Smith have agreed to represent the child section of this Federation. The Federation is setting high standards for individual group and child psychotherapy. The child psychotherapy programme of the Irish Forum for Child Psychotherapy follows the European training guidelines set down by the EFPP. The Irish Institute of Psychoanalytic Psychotherapy course will equally follow the guidelines laid down by the EFPP. The EFPP now has members from most of the EC countries and European Free Trade Counties. The current guidelines operate until 1995 when new guidelines will come into force for training in psychoanalytic psychotherapy. This will lead to increased harmonization of psychoanalytic psychotherapy training within Europe.

# PSYCHOTHERAPY IN IRELAND - PAST, PRESENT AND FUTURE.

MICHAEL FITZGERALD.

Irish Psychiatry is in danger of losing the mind. As Reiser points out, this giving up of the mind or worse still losing it by 'default' will have very serious consequences for Irish Psychiatry, and lend it to becoming marginalized and not relevant to psychiatric illness outside of schizophrenia, severe depression, including manic depressive psychosis.

Psychiatrists are trying to make psychiatry into an exact science, something which physicists abandoned about 1936. Another difficulty is that reality and truth are defined in such a narrow reductionistic way which bears no relationship to the complexity of human phenomena. In science you have to explain some higher level in terms of a lower level. This will not be possible to do with extremely complex phenomena. Using a broad definition of science, psychoanalysis fits well into the behavioural sciences and indeed, Professor Klein, Professor of Psychometrics, points out that "it has been shown that psychoanalytic theory could be regarded as a collection of separate hypothesis rather than one theory, and that these hypothesis could then be put to the scientific test". He goes on to state that there is a 'sizeable proportion of important Freudian concepts have been shown, therefore, to have empirical foundation'.

There is general agreement that approximately 70% of patients with psychotherapy improve, while the spontaneous improvement rate is 25 - 30%. Psychotherapy significantly reduces inpatient stays. Recent psychotherapy studies have shown better outcome from patients having more intensive psychotherapeutic treatment. It is naive to state that whatever can be achieved, can be achieved with brief psychotherapy.

Currently the risks for psychiatry were as pointed out by Sir Denis Hill, when he stated that "there is a risk that a psychiatry dominated by physical methods of treatment, and promoting little but physiological research related to them, will regress to unpsychological attitudes to mental disorder such as existed at the beginning of the century". The other current danger was recently pointed out by Van Praag, when he warned "against the potential dangers of 'objectivitation' and coarsening of diagnosis, a pre-occupation with the obvious, and misregard for the subjective constituents of the psychopathological spectrum". There are dangers when the attitude of the Neuroscientist, who is trained to purge events of all human emotion, adopt a formal impersonal style to the patient who is perceived as having a problem at the neurochemical brain level, is taken on by the psychiatrist. Only about 50% of relevant factors in psychiatry are biological, and the other 50% are psychological and social.

The fact that Irish Psychiatrists pay minimal attention to psychotherapy is shown by the fact that there are no Senior Registrar training posts in psychotherapy and no Consultant Psychotherapy posts, which are part of Psychiatry in England, Northern Ireland, etc. In addition, only a small number (approximately 10% of 280) of Psychotherapists in Ireland have a medical qualification.

If Irish Psychiatry is to remain relevant to the great majority of persons with psychiatric problems, it will have to change its attitude to many psychiatric problems, and psychiatrists in training must spend 30% of their training period studying and practicing psychotherapy.

The explosions of interest in non-medical psychotherapy and counselling is due to public demand, and the lack of interest of the medical profession in psychotherapy.

Psychiatrists should heed Professor R. Cawley's recent warning that psychiatry is under threat because there is not sufficient emphasis on the relationships with the patient, and it has a dogmatic attitude against psychoanalysis.

# THE BOUNDARY OF PSYCHOTHERAPY.

MICHAEL FITZGERALD.

The Irish Forum for Psychoanalytic Psychotherapy was set up to provide a coherent focus for those throughout Ireland, who had a serious interest in the advancement of the study and practice of this form of knowledge. It is not a training or accreditation body. Since its foundation in 1986 it has organised meetings, lectures and clinical discussions, both in the North and South of Ireland. It was felt that a Journal would further the aims of the Forum and stimulate scientific inquiry and writing in this area.

It is important that the qualifications of psychoanalytic psychotherapists who teach in Departments of psychiatry, Psychology, and the social sciences are as high as possible, and that these teachers have a formal training in the field. In the past, future teachers had acquired knowledge of psychoanalytic psychotherapy in a hap hazard way. This is no longer satisfactory in the lat 1980's, but now with the development of formal training programmes in both north and south of Ireland, this deficiency should be corrected in the 1990's. The core role of assessment, diagnosis and suitability should be recognised as part of these training programmes. It is interesting to quote Sir Aubrey Lewis, who stated many years ago ".... (but) It is unseemly that a Post Graduate Institute, if it holds that psychoanalysis may be valuable in the training of some psychiatrists, should shut itself off from that work, or profit by it without taking responsibility for it, as we have profited - and how much we have profited .... means must be found, therefore, whereby those pupils of the Post Graduate Institute for whom psychoanalysis is judged, a useful and necessary part of training, should be able to get it under University Auspices .... ".

It is also of critical importance to establish the limits of this form of treatment. In the past it has been both undervalued and over-valued. It now has to find its place within the wide range of treatment options available. An accommodation is being developed with psychopharmacology and behaviour therapy. Indeed many of the current therapies have evolved from psychoanalysis, e.g. Group Therapy, Family and Marital Therapy, Social Therapy, Psycho Drama and Gestalt Therapy. In the past many therapists, who belonged to other schools of psychotherapy were hostile to each other, which must have been very confusing for the public and students of psychotherapy. The over lap between all psychotherapies is becoming increasingly recognised, for example, support, ventilation of feelings, discussion of current problems with non-judgemental helpers. Nevertheless there are also sharp differences which are now often neglected in these discussions, for example interpretation of unconscious motives and unconscious family life, transference phenomena, dream analysis, as well as repetition remembering and reconstructing the past of a patient.

There is little doubt that Freud would have been intrigued by new findings in the neurosciences, including the work on receptors, but it is also likely, he would have warned against biological reductionism. Analytic therapists also have to be careful of analytic reductionism. Therapists have to resist taking an exclusively one sided approach, because of the stress and conflict that has to be tolerated in establishing the value of each disciplines contribution.

# DEVELOPMENTS IN PSYCHOANALYTIC PSYCHOTHERAPY IN IRELAND - A PERSONAL VIEW 1981 - 1993.

MICHAEL FITZGERALD.

There has been an 'explosion' of interest in psychoanalytic psychotherapy in Ireland in the past 13 years. This growth has been due to professional developments and consumer demands. It is interest that in a recent interview that Adam Limentani (1994) pointed out that Freud was interested in this 'explosion' and told his followers in 1923 "you must do something about this 'explosion' of demands for psychotherapy that is about to happen! You will see what is going to happen". Limentani went on to state that Freud was right. Clearly this 'explosion' was much delayed in Ireland partly because Ireland is an island at the periphery of Europe and also because no member of the medical profession, the dominant profession in this area was willing to take the lead until recently. In addition there has been dissatisfaction by patients with the lack of psychotherapy services being provided by the medical and psychiatric profession. The medical profession particularly in the past have been trained using the medical biological model which has been the dominant paradigm. The advisers to government are drawn from doctors with this paradigm as indeed have ministers for health on at least two occasions in recent years. This has led to a lack of understanding of non medical approaches to treatment. In addition the development of psychotherapy has also been inhibited by the lack of support for Senior Registrar posts in psychotherapy and Consultant Psychotherapist posts within the Health Service. In addition an interest in psychotherapy will not advance doctors careers.

There are about 300 psychotherapists in Ireland of which 10% are medically qualified. These include psychoanalytic psychotherapists; cognitive and behavioural; family and marital; constructivist and humanistic. There are well over 1,000 counsellors, many of these are guidance counsellors and a small group of practitioners who call themselves counsellors but would be indistinguishable from psychotherapists. Counselling tends to focus on career guidance, non directive measures and discussion of problems with a non judgemental listener. Psychoanalytic psychotherapy tends to focus on the unconscious and the transference. The majority of psychotherapists work in the private sector as would counsellors with a clinical orientation. Guidance counsellors tend to work in school and drug and alcohol counsellors work both within the public health service and in private practice. The public have come to realise that there is not a pill for every ill as they were promised in the 50's, 60's and the early 1970's.

Nevertheless in 1981 on my return to Ireland I began to realise that there was an interest in the psychotherapeutic aspects of general practice by some General Practitioners. This interest lead me to conduct a Balint Group for General Practitioners in the West of Dublin at a late evening time after their general practices closed for a number of years. This was a particularly rewarding experience and lead me to found The Irish Balint Society which focuses on the application of psychoanalysis to general practice. The first chairman was Dr. John Dillon and the first Treasurer was Dr. Kiaran Lynch. I then considered that other medical specialities would be also interested in the application of psychoanalysis. I therefore founded the Irish Paediatric Obstetric Psychiatric Society in 1982 which had Dr. P. McKenna Rotunda Hospital as first Chairperson and Dr. Elizabeth Griffin Our Lady's Hospital for Sick Children as the first treasurer. This society held annual meetings at the National Maternity Hospital, Coombe Hospital, etc., with enormous interest from Paediatricians, Obstetricians, Nurses, Social Workers, and all those associated with the paediatric and obstetric hospitals. Even now there is still much to be done in the application of psychoanalysis to these professional domains.

As a Psychoanalyst and a Consultant Child Psychiatrist working with disturbed families it came to my notice that there was an excessive emphasis on Family Therapy and on systems approaches with a relative neglect of the intrapsychic processes in disturbed children. This lead me in 1982 to initiate the Child Psychoanalytic Psychotherapy Group. This group held meetings many times a year on all aspects of psychoanalysis and child psychotherapy and were attended by professionals working with children and adolescents. Then in 1986 I founded The Irish Forum for Child Psychotherapy with the assistance of Fr. Paul Andrews, Dr. Mary Smith and Dr. Louise Tansey. The first meeting took place in Broc House. At this point I felt that discussions about child psychoanalytic psychotherapy while laudable in themselves were insufficient. I felt that there was a need for a training course in child psychoanalytic psychotherapy and I was ably supported by Fr. Paul Andrews, Dr. Mary Smith and Dr. Louise Tansey in the development of the first Child and Adolescent Psychotherapy Diploma course which commenced in October 1990. About this time I was travelling regularly to Europe having being invited to represent the Irish view point and to found a European Association of Psychotherapy. During these discussions I began to realise that academic attachments would play a large role in most future courses. I then approached Professor Marcus Webb and the Faculty of Health Sciences at Trinity College Dublin and initiated the process of converting the Diploma in Child and Adolescent Psychotherapy into a Master's Degree. This was successfully achieved and the course now operates as a Master's Degree in Child and Adolescent Psychotherapy from October 1993. As far as Child and Adolescent Psychotherapy is concerned I was also approached in 1992 by child care workers who worked in various children's homes in the Eastern part of Ireland to initiate an introductory course in Child and Adolescent Psychotherapy of one years duration. The first co-ordinator was Sally Phalan and the current co-ordinator is Marych O'Sullivan. There is now an invitation to repeat this course in the West of Ireland.

Since I also have an interest in adult psychoanalytic psychotherapy I set in train a similar process and founded the Irish Association for Psychoanalytic Psychotherapy in 1982 with Dr. John Alderdice as the first Treasurer and Dr. C. P. Noone as the first Chairperson. This association held meetings to discuss topics related to adult psychoanalytic psychotherapy. Then around the time of The New Ireland Forum Dr. Alderdice suggested that the Forum would be a good word to have in the title of an Irish organisation which I agreed and this lead to the formation of the Irish Forum for Psychoanalytic Psychotherapy. Dr. J. Alderdice was the first Secretary, Mary Pyle as the first Treasurer in 1985, and myself as the first Chairperson in 1985. I also had an opportunity to supervise E.H.B. Registrars in Psychiatry in all the catchment areas of Dublin and Kildare from 1986 to 1991.

The IFPP then began to concern itself after a period of continuing discussions on psychoanalytic psychotherapy with accreditation issues. The criteria for membership of the IFPP began to be gradually harmonized with Europe. A grandparent clause allowed professionals with different trainings in the past and experience of working in the area of psychoanalytic psychotherapy to also become members. The IFPP became recognized as the major place for discussions on theoretical, clinical and professional issues in relation to psychoanalytic psychotherapy in Ireland. It organised many highly successful lecture series. Another activity associated with the IFPP was the founding of the Journal. I saw a need for this as a way of giving members an opportunity to express themselves creatively in print and founded the Journal in 1986 with Dr. John Alderdice. Then the IFPP began discussions about setting up psychoanalytic psychotherapy training. A training institute was set up in 1993 called The Irish Institute of Psychoanalytic Psychotherapy of whom the founding members were Felicity Casserly (Treasurer), Nessa Childers, Michael Fitzgerald (Co-chairperson), Rita McCarthy, Ann Murphy (Co-chairperson), Ellen O'Malley Dunlop, Mary Pyle (Co-ordinator of Training Course), Ross Skelton (Examinations Secretary) and Patricia Skar (Secretary). This course has its first intake of 15 students in October 1993. The course is basically an integrative/integrated dynamic psychotherapy course with all the

major psychoanalytic and analytic thinkers emphasized. It has in addition a group psychotherapy training experience as well as an infant observation experience something which has become essential for anybody becoming a psychotherapist since the 1960's.

On my return to Ireland in 1981 I was contacted by Cormac Gallagher who was at that time working in the Department of Psychiatry, St. Vincent's Hospital, Elm Park as a psychologist. During the course of meetings continuing on to 1982 I suggested to him a psychoanalytic psychotherapy training course and put a model of such a course on paper for the first time. He then discussed it with Professor Noel Walshe who expressed an interest in it. Following on this Professor Ivor Browne and Vincent Kenny also became interested in setting up a parallel course in constructivist psychotherapy. A meeting took place on the 13th of May 1983 with Noel Walshe, Cormac Gallagher, Vincent Kenny, Mary Darby and myself to discuss proposals for courses in psychotherapy. There followed then many meetings through 1984 and early 1985 and the first course in adult psychoanalytic psychotherapy with a Master's Degree associated from U.C.D. began on the 15th of October 1985. There were at least 17 meetings leading up to the commencement of the course. For many years I have had the opportunity to supervise trainee psychiatrists and others in psychotherapy in most Eastern Health Board areas e.g. Kildare and West Dublin at St. Loman's Hospital, North County Dublin at Artane Day Centre, North West Dublin at St. Lawrences Road, South Dublin at Vergemount Hospital and St. James's Hospital.

The training course under direction of the Institute of Group Analysis in London has been another very successful initiative here in Dublin. The original Irish organising committee were Mary Darby, Therese Brady, Cormac Gallagher, Noel Walshe, Michael Fitzgerald, James Kelly and Conall Larkin.

Another welcome development is the M.Phil in psychoanalytic studies initiated by Ross Skelton and David Berman.

**Now to turn to the Northern Ireland situation.**

In 1981 I was invited to a meeting with Professor George Fenton Professor of Psychiatry Queen's University Belfast and Professor Joe Meehan Professor of Psychiatry Trinity College Dublin about the issue of psychotherapy training within the Department of Psychiatry in Belfast. This lead to my appointment as a tutor in psychotherapy in the Department of Psychiatry, Belfast City Hospital. Since that appointment I have supervised Senior Registrars in Psychiatry initially and later Senior Registrars in psychotherapy on a regular basis. They have travelled down from Belfast for the supervisory sessions. More recently I have had the pleasure in supervising a Senior Registrar in Child Psychiatry who was undertaking the Diploma in Child and Adolescent Psychotherapy in Dublin from Belfast. From these small beginnings evolved a dynamic Department of Psychotherapy. I took part in a number of discussions with Dr. Alderdice and Dr. Adams during the period of development of the Master's Degree in Psychotherapy at Queen's University Belfast. Unlike the situation in the Republic of Ireland where developments in psychotherapy in the Public Health Service are very few and far between, Dr. John Alderdice supported by Dr. C. Adams has made been great strides in the Public Health Service in the delivery of psychotherapy services to disadvantaged patients who otherwise would not be able to avail of psychotherapy. The combined output of graduates for all the Irish courses (Masters or equivalent) is now well over 100.

A major development in Northern Ireland occurred in 1991 when Dr. John Alderdice, Dr. Clare Adams and others founded the Northern Ireland Institute of Human Relations. Its aim was to integrate efforts to develop psychoanalytically informed activities and to act as a focus for those who were working in this field in Northern

Ireland. I was pleased to be elected an Honorary Foundation Member of the Institute. Another major development in 1989 in Northern Ireland was the foundation of the Association for the Study of Psychoanalysis by Dr. Tom Freeman and associates. This has been a highly active group now for many years and I have had the honour of speaking to the group and I am also pleased to be an Honorary Member of The Association which had Dr. R. Ekins as its first Secretary.

More recently I have become aware that the issue of training programmes had been adequately dealt with and that there is no further scope for further post graduate training programmes in psychoanalytic psychotherapy. The issue now seemed to me to be the development of psychotherapy as a profession in its own right, a profession that will not be an annex on any other profession and a profession whose training requirements will be harmonized with the training requirements in other European countries. In the past I felt that the psychoanalytic psychotherapy could not go it alone because of the small numbers involved and so I founded The Irish Standing Conference on Psychotherapy in 1990 which embraces all the major psychotherapy organisation in Ireland. I found a full and immediate support for this conference from all the major psychotherapy training organisations e.g. family therapy, psychoanalytic psychotherapy, constructivist psychotherapy, humanistic and integrative psychotherapy, and behaviour and cognitive psychotherapy. The Irish Standing Conference for Psychotherapy has organised since its foundation many highly successful national conferences on psychotherapy the most recent of which had Professor Anthony Clare as a speaker. Other speakers in the past have included Mary Bennotti MEP and Dr. Ruth Barrington Department of health. In recent years the Department of Health has consulted the Irish Standing Conference on Psychotherapy on major mental health issues. The Irish Standing Conference on Psychotherapy has links with the European Association of Psychotherapy. On the 3rd of July 1992 the European Association for Psychotherapy was incorporated in Brussels and I was one of the 15 signatories to the document of incorporation. The EAP is basically an umbrella organisation of national umbrella organisations within each country within the Ec. At about the same time I was invited to attend the first meeting of the European Federation for Psychoanalytic Psychotherapy which was playing a similar role with a narrower focus on psychoanalytic psychotherapy in London in 1991. The EFPP criteria are now being used by the Institute of Psychoanalytic Psychotherapy and the Child and Adolescent Psychotherapy Training Programme.

The current situation is relatively healthy with regard to psychotherapy but more needs to be done to establish psychotherapy as a profession in its own right, and in getting reimbursement for psychotherapy provided by psychotherapists. I have had a meeting with the Voluntary Health Insurance to discuss this matter. I put to them that psychotherapy could be argued for purely on economic grounds, i.e. that it reduces general medical service demands by 20% and reduces inpatient hospital stays. (Taller et al., 1994; Anchor 1989). The research is also very clear that it is more effective than placebo and more effective than no treatment. (Fitzgerald 1987; Malan 1973). In addition it speeds up the rate of recovery of patients with many psychological problems. There is also evidence that some patients with serious psychological problems gain a benefit which is additive from a combination of pharmacological and psychotherapeutic interventions. The additive effect is due to differential effects of the two treatments. In addition there is a growing interest in psychotherapy integration. (Stricken and Gold 1993; Karasu 1982; Marmor J. and Woods S. 1980; Wolfe and Goldfried 1988). There is also some evidence that group and individual therapy work in different ways. (Sheehan and Fitzgerald 1994).

I have also got agreement from the Irish Standing Conference on Psychotherapy to write to the Minister for Health about the setting up of a Psychotherapy Council of Ireland which would be a statutory body and deal with issues of registration and practice in Ireland. In 1993 the Profession of Psychotherapy is mature enough for this development and it is important that it present an assertive and confident front. The

Irish Standing Conference on Psychotherapy is setting up of a voluntary Register while awaiting a statutory register being inaugurated.

Dr. Fitzgerald is the only psychoanalyst recognised by the International Psychoanalytic Association in Republic of Ireland.

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# IRISH PSYCHIATRY: THE PROBLEM OF ACHIEVING A BALANCE.

MICHAEL FITZGERALD.

Irish psychiatry is at a crossroads even though this would not be generally recognised by the profession. It will become marginalised unless it finds a serious place for formal psychotherapy along side psychopharmacological and social approaches the current dominant modes of intervention in psychiatry.

Clearly psychopharmacology has had some success with the treatment of severe mental illness for example manic depressive psychosis and schizophrenia since the introduction of chlorpromazine a major tranquillizer to psychiatry in the early 1950's. While the so called "pharmacological revolution" has had modest success it certainly has not succeeded in providing "a pill for every ill". Later in the 1950's the anti depressant drug Imipraime was introduced with some success. Lithium has helped some patients with recurrent manic depressive disorder. Nevertheless side effects have been a considerable problem over the years. In recent years psychopharmacological advances have been very modest in terms of patient benefit with the exception of the newer anti depressants which have lower levels of side effects.

Social psychiatry has also had its successes in recent years with its deinstitutionalization programmes which are continuing but there is now a need for a major shift of emphasis in psychiatry to formal psychotherapy.

The philosophy of the logical positivists which values empirical propositions based on actual observations has had a major influence on Irish psychiatry. The positivistic psychiatry, with its uncritical acceptance of Popperian empirical realism has defined acceptable knowledge in an excessively narrow reductionistic way. The view is that all that can be known in psychiatry is commensurate with what can be measured. There is very little space for the theory of psychoanalysis and derived psychotherapeutic techniques or for interpretations given to patients that resonate with the dialectic of experience and have the ring of truth. Positivistic psychiatry has particularly focussed on biological psychiatry and the "mind machine". The "mind machine" does not resonate with patients. The biological psychiatrist is more comfortable with so called objective "macho" knowledge which Karl Popper calls "It is known" but have difficulty with subjective knowledge which Karl Popper calls "I know". Psychiatrists have difficulties in combining the rational and romantic view or both masculine and feminine perspectives. The masculine has largely dominated Irish psychiatry. The conflict is not new because the enlightenment of the 18th century emphasised rational thinking and devalued imaginative and emotional life. Irish psychiatry will be greatly enriched if it took on board formal psychotherapy to a much greater degree than it does at present. The Irish Standing Conference on Psychotherapy recently identified 280 psychotherapists but only 10% were medically qualified. It is clear that medical psychotherapy is providing only a very small proportion of the formal psychotherapy being provided in Ireland. The concerns expressed by Sir Denis Hill who was a Professor of Psychiatry at the Institute of Psychiatry are very relevant to Irish psychiatry. He stated "there is a risk that a psychiatry dominated by physical methods of treatment, and promoting little but physiological research related to them, will regress to unpsychological attitudes to mental disorder such as existed at the beginning of the century". Psychiatrists will return to becoming physicians in psychological medicine and the patients that they will treat will either have manic depressive psychosis, schizophrenia or Alzheimer's disease while a considerable proportion of

patients with other psychiatric disorder will be treated by non-psychiatrists. It is of interest that 15 to 20% of the population have psychiatric problems at any one time. Psychiatrists are in danger of "loosing" the mind, of loosing interest in the meaning of the internal world of their patient with the excessive focus on the brain pathology.

As with drug treatment psychotherapy can also have negative effect but the evidence is that psychotherapy is far more effective than is realized. Eysenck stated in 1952 that psychotherapy did not result in significantly higher rates of improvement than spontaneous remission. When Bergin reanalysed this paper he showed that there are many major flaws including non comparable comparison groups, a multitude of arithmetic errors and misinterpretations of original data. Bergin showed that the improvement rate for patients treated with psychotherapy was 65%. Studies of spontaneous improvement have put the rate at about 30% for untreated patients. In a more recent re-analysis of Eysenck's data it has been shown that psychotherapy accomplishes in about 15 sessions what spontaneous remission takes two years to achieve. Another recent study by Howard showed that there was a positive relationship between the amount of psychotherapy and the amount of patient benefit i.e. by eight sessions approximately 50% (of 2,400 patients) had improved and by 26 sessions 75% had improved. There is also evidence in relation to the effects of psychotherapy that the effect size for psychotherapy of patients with depression is greater than the effect size of placebo. In addition there is some evidence that psychological interventions with physically ill patients reduces medical utilization.

As we approach the 21st century it is important that psychiatrists avoid the dangers of single minded approaches that avoid complexity and uncertainty in favour of more "simple" models. It is critical that Irish psychiatry achieves a balance between biological and social approaches and formal specialist psychotherapy.

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# THE END OF PSYCHIATRY?

MICHAEL FITZGERALD.

The prediction of the end of psychiatry is an uncertain enterprise as is the prediction of suicide and many other events in the psychiatric domain. Of course to make any prediction it is necessary to be able to state what the current situation is which with psychiatry is something that is impossible to do exactly. One is therefore left in a state of uncertainty, a state well recognised by physicists for many years. If psychiatrists had been more uncertain about pharmacology over the past 50 years we might now not be facing the possible end of psychiatry as we know it.

For too long descriptive and biological psychiatry has been the only type of psychiatry of importance while 'lip service' has been paid to psychotherapeutic approaches. The dominance of biological psychiatry is responsible for psychiatry becoming increasingly marginalised. It will lead to psychiatrists largely treating a group of chronic patients with schizophrenia, manic depressive psychosis and Alzheimer's disease (assuming that some other medical speciality does not take some of these patients) while a considerable proportion of psychiatric disturbance will be treated by non-psychiatrists. A recent study estimated psychiatric disturbance to be about 20% of the population at any one time. (Robins and Regier, 1991). Sir D. Hill was concerned that psychiatry would "regress to unpsychological attitudes to mental disorder such as existed at the beginning of the century". Unfortunately his concerns are now coming true with the increasing marginalization of psychiatry as psychiatrists turn back into physicians in psychological medicine.

Even at this late stage it is still possible to prevent the demise of psychiatry by using "'the life support'" that is available, that is, a linking up of the psychotherapies to biological and descriptive psychiatry. To be meaningful it would mean that about 40% of the trainees time in psychiatry would be spent learning theory and practice of psychotherapy and that consultant psychiatrists would in future practice formal psychiatry at least two days per week. Psychiatry would then resonate with the spirit of the age and become meaningful and relevant to the broad range of patients with formal psychiatric disturbance.

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# OF SOUND MIND.

MICHAEL FITZGERALD.

DAVID BERMAN.

J. R. Smythies[1] states that Canon C. E. Raven told him that Wittgenstein "suffered from paranoid delusions". Smythies then elaborates on a "speech disorder known as schizophreneze". Smythies says that he attend[ed] the weekly meetings of Wittgenstein's disciples and found the "thoughts produced" by this group "very like the thoughts and mode of thinking that troubled my schizophrenic patients".

On 12th November 1993, we interviewed Professor Normal Moore about Smythies' claims[2]. Moore was professor of psychiatry at Trinity College, Dublin, and the leading Irish psychiatric clinician of his day. In the late 1940s, Wittgenstein had been referred to Moore for 'another opinion' by Dr. Maurice Drury, a psychiatrist working at St. Patrick's Hospital in Dublin, and a friend of Wittgenstein. Drury, according to Moore, "was worried" about Wittgenstein, who was on one of his extended visits to Ireland. Unlike Smythies, who had "no personal contact with Wittgenstein", Moore saw Wittgenstein about five or six times in St. Patrick's Hospital. Moore categorically stated to us that Wittgenstein was not a schizophrenic. Moore described Wittgenstein when he saw him as a "depressed and sad man", who was "down with depressed affect" and "gloomy", that he spoke "slowly" and was "slowed down".

There is extensive evidence of Wittgenstein's depressive moods, as is clear from Ray Monk's careful biographical study of Wittgenstein. Thus Monk[3] quotes Wittgenstein writing to Rush Rhees: "First suffered terrible depressions". Later Monk[3] talks about Wittgenstein's "depression as Christmas approaches". There is no doubt that Wittgenstein was a sensitive, highly strung personality, whose interpersonal relations could be difficult; and indeed Moore describes him as such. But Moore was certain that Wittgenstein showed no signs of schizophrenia. We think this evidence is important, as Moore seems to have been the only psychiatrist to interview and perhaps treat Wittgenstein in a professional capacity.

Smythies' evidence that Wittgenstein suffered from thought disorder or paranoid delusions amounts to little more than gossip or hearsay. The only person who was schizophrenic in the inner Wittgenstein circle, according to Monk[3], was Yorick Smythies, who "suffered from paranoid schizophrenia and became a patient of Maurice Drury. He died in tragic circumstances in 1981".

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# Book Reviews

# AN OUTLINE OF PSYCHOTHERAPY FOR MEDICAL STUDENTS AND PRACTITIONERS. EDS. MAXWELL H. (1986 WRIGHT).

MICHAEL FITZGERALD.

This book provides an excellent description of individual, group and family therapy with also a brief chapter on behaviour therapy. In the foreword, Professor S. Hirsch makes a number of important points. He points out that Psychotherapy has been shown to be a powerful technique in terms of the following outcome criteria return to work, resumption of sexual activity, lessening of anxiety and depression scores, lower relapse rates, or, in the case of liaison psychiatry, improvements in the patients physical functioning.

He goes on to point out that today "we are witnessing an exploding interest in psychotherapy on the part of the public and the growing appreciation by the medical profession at all levels of what it has to offer". He also points out that the Royal College of Psychiatry requires all psychiatrists in training to obtain experience in psychotherapy because it realises that psychotherapeutic skills are essential in the treatment of patients. The book deals with issues of definition, technique, psychoanalytic concepts, suitability, defense mechanisms, conflicts, e.g. independence - and the balance technique in general practise.

It is clearly important that medical students are introduced to the technique of analytic psychotherapy and that modern psychoanalytic theory is integrated with biological developments in psychiatry. Ideally every medical student should take on a patient for brief psychotherapy. Medical students are very interested in treatment. Because medical students are often interested in facts and lists, it is important that psychoanalysts should make an effort in medical schools to teach elements of abstract thinking as has been pointed out by Asch in the Journal of the American Psychoanalytic Association. This book does identify the particular concepts that are relevant to medical students. It has also to be recognised that certain psychoanalytic concepts can raise anxieties in medical students, particularly because of the phase of life that they are passing through. Therefore the dosage of psychoanalytic concepts has to be carefully measured up for them.

# DYNAMICS OF PSYCHOLOGICAL DEVELOPMENT. A. THOMAS AND S. CHESS, NEW YORK: BRUNNER / MAZEL, 1980.

MICHAEL FITZGERALD.

This book attempts to provide "a fresh overview of human developmental theory" (p. xix). The authors have attempted to integrate the data and concepts from the biological sciences, developmental psychology and psychiatry. The model they put forward is a dynamic interactionist one. They examine in detail observed behaviour resulting from the interaction between temperamental characteristics, parental behaviour and social experience. They are very critical of the one sided environmentalist view and drive reduction and the stimulus-response models.

The book is based on a review of over 400 references as well as the author's New York longitudinal study which followed the behavioural development of 130 subjects from early infancy to early adult life. They emphasis that "it is fruitless to pose the question of whether biology or culture is more important in individual psychology, just as the argument over heredity versus environment is fruitless". (pp. 18 - 19).

This is an excellent book which I can recommend to child psychiatrists, psychologists and social workers. It brings together in a very readable way, an enormous amount of research in child development in recent years. It gave me great pleasure to read this book. the authors deal particularly well with biological and general social factors. They value the methodology of academic psychology and indeed the best parts of the book are those which deal with observed behaviour.

A psychoanalyst would be critical of their discussion of psychoanalytic concepts. They speak of a "Rational unconscious" (p. 202) which is a contradiction in terms from the psychoanalytic point of view. They also discussed the defence mechanisms which the psychoanalysts have delineated but do not agree that they are necessarily unconscious. This misuse of the term defence mechanism is confusing. H. P. Laughlin (1979) states that defence mechanisms "must operate outside conscious awareness". The fact that the new born has a greater degree of perceptual competence, neurobehavioural organization and learning competence, than previously realised could just as easily point to a greater degree of cognitive organisation earlier in the child's life as M. Klein (1975) has pointed out. We do not know for certain what goes on in the cognitive life of a small infant. We may be attributing too much or too little.

The authors decry the use of "speculative hypothetical entities to fill in gaps in our knowledge" (p. 195). It is difficult to see how knowledge could have progressed without the setting up of these "speculative hypotheses" (p. 195). They are also critical of "reason by analogy", but this was all many earlier researchers had available to them.

They state "that they see no alternative but to consider psychoanalysis in terms of Freuds own formulation". This is equivalent to saying that one can only consider behavioural psychology in terms of Pavlov's work (Pavlov, 1941). This completely ignores the development in theory and technique of psychoanalysis over the past 40 years. Two of the major contributors to child psychology, Klein (1975) and Winnicott (1965), are not even mentioned in the index of this book.

The authors of this book have taken a much greater interest in constitutional factors than psychoanalysts have. The reason psychoanalysts give for not being more interested in constitutional factors is that they could not alter them. At the same time it is important for a psychoanalyst to keep constitutional factors more in mind as they are then in a better position to make a fuller assessment of the patient. If an analyst gives a psychodynamic interpretation for something that is constitutional, then a patient will feel misunderstood. It is a great burden for a patient to have a psychotherapist who does not understand him.

It appears that in the mid 1950s the authors were trying to get Americans away from the idea of the perfect mother and that the mother was responsible for all the child's ills. Earlier in Britain, Winnicott (1949) was talking to the British about "the ordinary devoted mother" and emphasizing the same point.

I would agree with the authors when they are critical of linear unidirectional continuity. They consider that experience at any age period is important but not all decisive for later functions.

Finally I feel that who ever reads this book can't fail to be stimulated by it.

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## PRIORITIES IN PSYCHIATRIC RESEARCH. EDITED BY MALCOLM LADER. JOHN WILEY & SONS, 1980.

MICHAEL FITZGERALD.

This book, based on the proceedings of a conference of the same title organized by the Mental Health Foundation at Balliol College, Oxford, during September 1979, presents an overview of psychiatric research, with particular reference to future developments. The aim of the conference was to assist the Foundation in its formulation of priorities for research, by the assessment of the potential of various areas of psychiatric research to advance understanding of the nature and causes of mental illness and its subsequent treatment.

The book contains chapters by major British research workers in psychiatry among them Richard Rodnight on biochemistry, Norman Kreitman on epidemiology, Philip Graham on child psychiatry, Sidney Crown on psychotherapy and Gwyne Jones on behavioural approaches. The best chapter in the book was by George Brown on sociology and psychiatry. This was not surprising as George Brown's research on depression and life events has been probably the most important research carried out in Britain in the past 10 years. Robert Kendall was convincing when he pointed out that psychiatrists cannot hope to do fundamental research and should confine themselves to clinical and epidemiological issues. The Rodnight chapter on biochemical research was excessively optimistic about the future contributions of biochemical research. Robert Kendall on the same topic was more accurate when he commented that we were not on the brink of any breakthrough. The competition for research funds between epidemiologists, biochemists, sociologists, etc. was very evident in this book and they all promise significant advances in the next decade.

Except for the first chapter on biochemistry, this book would be of considerable interest to psychologists and social workers and the book as a whole is essential reading for all trainees in psychiatry. It provides many good ideas for those interested in undertaking research. This book will not be of interest to the truly original person and as Peter Sainsbury says "no ordering of priorities can take account of true originality" (page 220). It is impossible to read this book without one's excitement and enthusiasm for research being rekindled.

## ON LOVING, HATING AND LIVING WELL. INTERNATIONAL UNIVERSITIES PRESS. NEMIROFF R. A., SUGARMAN A., ROBBINS A. (EDS). (1992).

MICHAEL FITZGERALD.

This book contains the public psychoanalytic lectures by Ralph Greenson who was Marlyn Monroe's psychoanalyst. This is a superb book but also it could be read with interest at night and is quite suitable for the bedside table. The book displays a deep insight into human beings, is written in a clear and concise way and highly readable. One of the key textbooks of my psychoanalytic education was The Technique and Practice of Psychoanalysis by Ralph Greenson and remains one of the most important books that any psychiatrist could read. I believe Greenson was the most outstanding clinician after Sigmund Freud. Greenson's writings are more important now than ever with psychiatrists developing a tunnel vision with a narrow focus on biological aspects of psychiatry and psychopharmacology. While the growth of psychoanalysis and psychoanalytic psychotherapy is enormous in both Britain and Ireland outside of psychiatry, within the psychiatric profession its status is severely threatened. This is the most unfortunate aspect of the current psychiatric scene. Greenson has an excellent chapter on why people hate psychoanalysis and this could be easily retitled why psychiatrists hate psychoanalysis.

Greenson makes many excellent points in his book including his experience that the final resolution of the transference neurosis depends to a great extent on the transference neurosis being replaced by a real relationship. This is my experience as well. He has a very insightful chapter called "You Only Live Twice" which was written after he had his heart attack. He anticipated the problems of the age of narcissism with his chapter on beyond sexual satisfaction focussing on the emptiness of promiscuity and super sex. It has been a great pleasure to review this book.

# CHAOS.
## MAKING A NEW SCIENCE. JAMES GLEICK. CARDINAL, 1989.

MICHAEL FITZGERALD.

The Prologue to this book makes the following rather passionate statement i.e. "that the twentieth - century science will be remembered for just three things: relativity, quantum mechanics and Chaos. Chaos theory had become the century's third great revolution in the physical sciences. Like the first two revolutions, Chaos cuts away the tenets of Newton's physics".

It remains to be seen whether these claims for Chaos will be substantiated when the history of science in the twentieth century is written. The book suggests that the first Chaos Theorists had an eye for pattern especially pattern that appeared on different scales at the same time. They were also interested in "randomness and complexity, for jagged edges and sudden leaps". There is no doubt now that cardiologists are taking an interest, at least at research level, in Chaos theory. Physiologists have "found surprising order in the Chaos that develops in the human heart, the prime cause of sudden, unexplained death".

The book also contains a discussion of inner rhythms in schizophrenia. The author discusses the fact that schizophrenic patients and their relatives, when they try to watch a slowly swinging pendulum, their eyes cannot track the smooth motion. The schizophrenic's eyes jump about disruptively in small increments, over-shooting or under-shooting the target and creating a constant haze of extraneous movements. Physiologists have felt that this was due to some random disturbance afflicting the brains of schizophrenics. Huperman developed a computer model of this phenomena and found both order and Chaos. He noted that in some regimes, the eye would track smoothly; then, as the degree of non-linearity was increased, the system would go through a fast period-doubling sequence and produce a kind of disorder that was indistinguishable from the disorder reported in the medical literature. There then followed a discussion about whether the non-linearity could stabilize the system or disrupt it, depending on whether the non-linearity was weak or strong and there was some suggestion that this might correspond to a single genetic trait. Chaos theory is being taken seriously in some quarters in medicine. The book is worth reading. The contribution of this theory to psychiatry is still to be clearly defined.

## REVIEW OF GENERAL PSYCHIATRY. 3RD EDITION.

Howard H. Goldman, editor. East Norwalk Connecticut: Appleton and Lange, 1992.

MICHAEL FITZGERALD.

This book is designed as a companion text to be used by medical students, psychiatrists in training and physicians in conjunction with more comprehensive works. The chapters have been pared to essential content. The test largely conforms to the DSM-111-R in its classification of disorders, use of diagnostic criteria and format. While all the contributors to the book work in North America and the psychiatry presented has an American flavour to it, nevertheless there are many references to work published in Europe, for example on the social and cultural aspects of mental illness. While child development was well covered, conduct disorder and the epidemiological aspects of child psychiatry received very limited discussion. Nevertheless, on balance the editor has achieved his aims and the book can be recommended. Indeed, consultant psychiatrists in a hurry who want a general overview of unfamiliar topics could benefit from a copy.

# MIND WAVES, A COLLECTION OF PAPERS BY PHILOSOPHERS, PSYCHIATRISTS, PSYCHOANALYSTS AND OTHER SCIENTISTS. EDS. BLACKMORE C., GREENFIELD S. (1987). BASIL BLACKWELL.

MICHAEL FITZGERALD.

Some of the oldest philosophical questions surround the "mind-brain" problem and a recent book called Mind Waves edited by Blakemore and Greenfield brings together philosophers, psychiatrists, psycho-analysts and other scientists, to carry out an examination of this problem in a series of fascinating papers.

There is a discussion about how behaviourism came to a halt, because the humble laboratory rate proved too resourceful, too thoughtful, too rich in in-sight to be treated as if it were a mindless machine. The authors point out that most behaviourists had denied the necessity of postulating mental states but the need to see behaviour in terms of intentions kept intruding.

The psychology of behaviour then returned to its nineteenth-century roots in the current fashion for "cognitive" explanations of the actions of animals as well as people. Brain researchers of all sorts have been forced to take seriously mentalistic explanations of behaviour and most of them see perception, intention, thought, and will to be legitimate subjects of interest for the rapidly growing subject of neuroscience.

The editors in the preface make the common mistake in discussing the dualism of Descartes. If they had re-read Descartes they would have seen that he discussed repeatedly the relationship between mind and body. Descartes has been scapegoated by workers in the psychosomatic field by their insistence on continually blaming him for the split between mind and body.

Some of the problems in psychiatry have been caused by the isolation of one group of research workers from another. The psycho-analysts tend to work in their area isolated from the biological researchers and the philosophers.

Many unsatisfactory lines of research would not have commenced if the various groups related more closely to each other. An example of this would be the "Laingian explanations of madness in terms of errors in society".

These errors would not have been made if Laing had been aware of the growing evidence for physiological disturbances in brain function in schizophrenia. Nevertheless Gordon Claridge is critical of this new "organic" phase in schizophrenia because he claims that those working in the field have rarely matched their conceptualisations and explanations of schizophrenia to the complexity of the condition.

In a chapter on psychoanalysis and science, Anthony Storr feels that adopting an objective, mechanistic stance towards human beings actually deprives the observer of an important source of understanding. He fails to see that the psychoanalyst uses intuition and empathy during an analytic session when he is collecting data to make an interpretation.

Once the data is collected, then the analyst becomes objective and formulates an interpretation initially in terms of hypothesis which is then examined with the patient.

At the end of this process interpretation will be accepted or rejected on the basis of the weighing up of evidence by analyst and patient.

Brian Farrell has an interesting chapter on psychoanalytic explanation, with special reference to historical material and he points out that when psychoanalysis is used with care, it "can nevertheless often help to explain what is puzzling, and helps us to see things in new and interesting ways". He also points out that it is best to use it with biographical work where sufficient material is available for analysis.

## SHARED EXPERIENCE - THE PSYCHOANALYTIC DIALOGUE

Edited by Moligliano and Robutti, London; Karnac. 1992.
Pp.233. £18.95p

MICHAEL FITZGERALD.

This book focuses on new directions in psychoanalysis with an emphasis on interpersonal interactions and a detailed study of these interactions. It emphasises the psyche of the patient and analyst - a two person psychological model. There is less focus on older psychoanalytic concepts of drive discharge, unveiling the patient to himself and the intrapsychic or one person psychological model. The focus is no longer on the so called analyst's neutrality but of building up new meanings with the patient. The patient and analyst are working together in the new model. The analyst cannot help but reveal himself through his interventions within this "'biperson field'" and therefore the analytic dialogue is the outcome of both parties and not just the product of the patient. The analyst's interpretation results from his reviewing his own thoughts, feelings, contributions and the patients input both verbal or non-verbal. The newer models of psychoanalysis view patients as seeking human contact and psychopathology as a result of relational factors e.g. in narcissism and hyperchondriasis. Negative therapeutic reaction and premature termination are seen in the same way.

All psychoanalytic treatments are research because each patient brings something unique that has not been exactly described previously and which the analyst has to work with in a creative way without imprisoning himself in some theoretical model that those not fit with the patient. This is the style of the work of the authors of this book. Eric Brenman in his forward points out that the rest of the analytic psychoanalytic world has moved in this direction. Unfortunately psychiatrists are not always aware of the theoretical and technical changes that have occurred in psychoanalysis since Sigmund Freud.

This book will enrich any psychiatrist who reads it and will help him or her to have a more balanced view of the patients problems (and their own) particularly in this current "'age of biology, of the brain and the mind machine'". Indeed biology is only likely to explain at most 40% of the variance in relation to the causes of psychiatric problems. Psychoanalysis and books such as this are critical in bringing about a more holistic understanding of human beings at this time.

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