Pressure Points on Irish Families

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Chapter 1

INTRODUCTION

Michael Fitzgerald

Ill fares the land, to hast'ning ills a prey,
Where wealth accumulates, and men decay
— Oliver Goldsmith, The Deserted Village

Sacred Heart o' Jesus, take away our hearts o' stone, and give us hearts o' flesh!
— Sean O'Casey, Juno and the Paycock

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 the first duty of the government of the Republic would be 'to make provision for the physical, mental and spiritual well-being 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 wrote in The Second Coming, '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.

Professor Anthony Clare points out that 'the idea of Ireland as a tranquil, harmonious land, its people content and Catholic, its villages and towns havens of stability and social grace, cohabited uneasily with the notion of psychiatry and its implications of depression and disaster, psychopathology and pain. It is, in truth, a continuing contrast' (Keane, 1991).

There is a popular notion that Irish children have enjoyed sounder mental health than their Western neighbours. The 'Irish family' has enjoyed an image of solidity and cohesion and moral fortitude, and of being an institution safe from the turmoil,

disintegration and delinquency affecting modern families elsewhere. Does this image in any way approximate the reality? Indeed, did it ever?

There is also an opposite view of Ireland as a place where people were inherently prone to serious mental illness in adulthood, while their children were fortunate to be relatively free from psychological disturbance (Robertson and Fitzgerald, 2003). Can this be relegated to the category of Irish myths and legends, or are we indeed 'a breed apart'? The answer is yes.

Thus, overall, from the available epidemiological evidence, one can conclude that the modern Irish adult population is not remarkable in any way regarding its rate of severe mental illness, although there may be small isolated pockets of high prevalence, which might be remnants from a time in the early twentieth century and before when the prevalence of schizophrenia may have been slightly higher than it is today. These isolated areas of higher prevalence are not significant enough to have inflated the general prevalence rate in the wider community. Mental illness rates in children are the same as other parts of the western world.

AIMS

This book aims to examine the minds of Irish children and adolescents – those minds under major stress. It will explore why these children and adolescents are under stress from a personal, family, and wider societal perspective. It will explore this from a scientific perspective – exploring psychiatric, psychological and social perspectives but will eschew 'socio babble' and 'psycho babble'. It will give readers both lay and professional understanding of the different types of psychiatric problems that afflict Irish children and adolescents. It will help families to identify potential children and adolescents with psychiatric problems and in need of referral to their G.P. as well as the Child and Adolescent Psychiatric and Psychological Services. The book will also give information on interventions and the various treatments now available to children and adolescents under stress. The styles of parenting helpful for reducing stress in children and adolescents will be identified. The critical importance of early identification of children with Attention Deficit Hyperactivity Disorder, Autism and Asperger's syndrome and depressive conditions will be emphasised. In Ireland there is a history of serious delays in identification of these conditions with serious if not catastrophic results including suicide, death by misadventure, or indeed undiagnosed and untreated persons in childhood committing murder as adults. Critical factors associated with children under stress include genetic factors (grossly neglected in previous Irish books on this topic), marital disharmony, domestic violence, poverty, poor education, inadequate schools, bullying, sexual abuse, and gross family neglect as well as poor institutional care and the effects of violent television programmes on vulnerable children and adolescents at risk. The important defect of 'street drugs' on children will be examined. Racism is a factor of increasing importance and will be explored as well as the gross intolerance of traveller families. Interventions that will be focussed on will include psychotherapeutic – individual and family therapy approaches. There will also be emphasis on cognitive behavioural and psychoanalytic approaches. The hugely important and controversial psychopharmacological approaches will also be detailed. The critically important need to reduce child poverty and the unhelpful political agendas of recent years will be explored.

STRESS

Stress is a phenomenon, which occurs when the resources of the child are overwhelmed by the demands of the environment. It is associated with increased heart rate, hormonal changes, chemical changes in the body, a sense of fear or panic and helplessness, and a sense of not coping. The stress can be internal (e.g. homosexual panic in an adolescent) or more commonly external brought on by negative life events for example repeated hospitalisation of children, life threatening physical illness, death in the family, sexual or physical abuse or chronic neglect, bullying in schools, etc.. If it is chronic children can become aggressive, depressed, suicidal, hypervigilant, etc.. There is a false assumption that levels of stress have increased with modern technological societies. Anyone acquainted with the history of the past few thousand years will be aware of the stresses on children at most times in history. At the same time there would appear to be historical periods when stresses on families were lower than now. There is some suggestion of increased stress now possibly associated with family breakdown and other factors since the 2nd World War. Since the 2nd World War there have been increases in depression and increased numbers of children with psychosocial problems at the same time as this socio economic circumstances have improved. In the grossly divided Irish society the 'haves' and 'have nots' have not benefited equally and large numbers of children experienced very significant deprivation.

Chapter 2

SOCIAL CHANGE AND MENTAL DISORDER IN IRISH CHILDREN

Michael Fitzgerald

SOCIAL CHANGE IN IRELAND

In the year 2004, Ireland finds itself in a novel position. Having undergone rapid and dramatic social and economic change in the last decades of the twentieth century, the country has needed to 'grow up fast', so to speak. As life in Ireland has increasingly approximated that in its Western neighbours, the country, naturally, has all but shed its unique mythical and mystical image.

In all Western countries, including Ireland, social scientists have been very concerned about the effects of recent changes in the family and cultural trends on children. These changes are seen particularly in relation to the family – one of the so-called fundamental institutions – and have been most marked since the Second World War. The stability of the nuclear family appears precarious. Marriage and family relationships are sometimes regarded as optional, and even the phrase 'throwaway children' has even come into use. This relates to our consumer society where everything is disposable.

There has been a breakdown in the traditional gender-based division of labour (Furstenberg and Cherlin, 1991), and a dramatic increase in the number of mothers working outside the home. There is considerable role stress, particularly in mothers, between meeting the demands of children and those of the work environment; these are often contradictory and the workplace may be unsympathetic to the needs of working mothers. Huge emphasis is put on the idea of marital satisfaction: many people expect marriage to copper-fasten their happiness for the rest of their lives, which is grossly unrealistic and is probably a significant factor in the increasing marital breakdown. Children are left out of the equation. It is extraordinary how little emphasis there is on the children's needs in marital breakdown and divorce situations. It seems extremely difficult for the warring parties to keep the needs of their children even minimally in focus. The current changes are also seen in the battles between fathers' and mothers' rights over their children after marital breakdown. Clearly all this will impact on the children. The situation was different in Ireland in the past, where divorce was not an option and marital separation was relatively uncommon, particularly before the Second World War.

Children now have to face the major upheaval of dealing with reconstituted families and with step-parents, and of being in a family with biological children of other parents. The fact that children may have to go through a number of reconstituted families throughout the course of the lives increases the stress.

Another major stress on the working mother is the lack of – or great expense of – alternative childcare. Certainly for the slightly older pre-schooler there are considerable benefits of being in a high-quality pre-school group where there is low

staff turnover and significantly good interaction between the staff and children. Unfortunately, this is not the norm for children at the pre-school level in Ireland today.

Parental separation is probably the best option for children who are in extremely conflicted family situations where there is frequent domestic violence. They are probably better off remaining in families where there is mild marital disharmony, but there is a large category of moderate marital disharmony in which it is unclear where the children's best interests might lie. Certainly the child will wish to stay in such a family, and will not wish the parents to separate. In reality, the children are extremely rarely consulted about their wishes in these matters. Families have moved from a period where they spent their lives together no matter what happened – which in certain cases was certainly unhelpful for the children – to the present situation where the decision to separate is made far too quickly and to the detriment of the children. This view is based on observations of parents and children involved in family breakdown in Ireland. Nobody disputes that there has been a loosening of social norms over the past 50 years.

MENTAL DISORDER IN IRISH CHILDREN

The second commonly held belief regarding Irish mental health that this book wishes to explore is that there is a low rate of child, adolescent and family mental health problems among the Irish.

For the greater part of the last century (at least), the Irish family was idealised. The lack of divorce and the rural and traditional basis of Ireland's image perpetuated a vision of Irish children living in stable and harmonious families, and certainly not needing the attention of child psychiatrists. In fact, child and adolescent psychiatry, as a service, did not arrive in Ireland until the 1950s (Fitzgerald, 2003).

Over the past 20 years, enough epidemiological data has been collected within the Irish child psychiatric service to allow us to tackle the question of whether child and adolescent psychiatric disorders are more or less prevalent in Ireland than in its Western counterparts (Fitzgerald, 1991a–1991l, 1995a–1995e, 2003).

Professor Eric Fombonne, in a preface to Irish Families Under Stress in 1995, stated with regard to the view that 'these social and economic changes – insofar as they are signalling an increased wealth, should be followed by an improvement in the mental health of the population at large – this naïve expectation has been rejected by most recent research which has pointed to increased rates of psychiatric disturbances, especially among the young, over the last 30 or 40 years in most countries which underwent a similar change' (Fombonne, 1995).

As far as children are concerned, my own view, taking account of the increase in psychosocial disorders since the Second World War, is that the changes have in some ways been malignant for children from a psychological point of view. The great problem is to tease out cause and effect; this is something that we have not satisfactorily achieved yet.

There have been a number of other changes since the Second World War, including the following.

1. Increased life expectancy.
2. Economic growth and improvement in standards of living.
3. Substantial improvement in physical health, housing and other living conditions.
4. Increased leisure time.

5. Unemployed has fluctuated; it is rising in Ireland at present and society is massively divided, with a significant section of the population not having the money to participate in society.
6. Smaller families and an increased number of mothers of young children in employment.
7. The influence of the mass media has increased enormously, and our moral concepts and values have changed. The complexity of the influences on children and adolescents has increased enormously; this appears to stress and overwhelm the vulnerable.
8. Earlier onset of puberty and longer duration of education.
9. Increased expectations that are not always met. The ages of 16–27 appear to be particularly stressed and dangerous; people may 'drift' and lead unfocused lives. This factor is under-studied. Young males have difficulty finding a role in life.
10. Increased urbanisation.

Clearly all these factors impact on children, although it is often difficult to establish what the precise impact is. We are absolutely clear about the social and economic changes that have taken place, and we are equally clear about the increase in psychological disorders (conduct disorder, depression, etc.) in children since the Second World War. The difficulty is in trying to work out the mechanism whereby these broad cultural changes have led to the increased rates of psychosocial problems in children. What we have here is a fascinating 'experiment of nature' (Rutter and Smith, 1995).

A quick glance at the above list of social changes shows that the points mentioned in the previous paragraph are somewhat counter-intuitive. Who would have thought that improvement in health, housing, living conditions and the economy could be associated in any way with an increase in psychosocial problems?

One must consider the changes as challenges to children. Clearly the increase in psychosocial disorders suggests that, for some children, the challenges are greater than they can cope with.

This book explores the types of pressure points on Irish families associated with mental disorder in children and parents, paying particular attention to social, family and genetic factors. It demonstrates that, paradoxically, there have been increased pressures on Irish families since the Second World War, i.e. increased rates of depression and of psychosocial problems in children.

INFLUENCE OF GENDER ON CHILD PSYCHIATRIC PROBLEMS

In the Middle Ages, Paulo of Ceraldo recommended: 'Nourish the sons well. How you nourish the daughter does not matter as long as you keep her alive.' Unfortunately, these ideas long outlived the Middle Ages.

Many childhood problems are more common in males: autism, attention deficit hyperactivity disorder, conduct disorder, etc. A new book (Fitzgerald, 2004) demonstrates a link between autism in males and exceptional ability. Baron-Cohen (2003) discusses why females show better social skill and males are better systematisers, engineers, etc. Chromosomal, hormonal, and societal factors play a role in gender differences.

Behavioural and emotional problems tend to reach an almost equal ratio between male and female in teenage years; there is then a shift to the more adult pattern whereby psychological disorders are more common in females. One study of Irish adolescents

found a non-significant difference between males and females in psychological stress at the age of 15 (Williams et al., 1989).
Adolescent males probably complete suicide more because they are systematisers, and approach suicide in a more systematic way.

POSTMODERNISM AND POPULAR CULTURE

Parker et al. (1995) points out that the use of illicit drugs has become internalised or integrated into 'official' youth culture, and argues that this is shown by the way that youth magazines, music, fashion markets and popular language have incorporated drugs. It seems that drug culture is no longer a subculture but has been assimilated into popular culture. Advertisements are increasingly using drug-related imagery to sell their products. There was concern recently about the popularity of 'heroin chic' in the fashion world. There has also been a spate of popular books, movies and television shows that depict the drugs lifestyle.

Parker et al. also point to the collapse of distinctions between legal and illegal psychoactive markets, and relates this to postmodernism. Brinkley et al.'s (1998) study found a strong relation between the use of legal and illegal substances. Legal substances are being marketed using drug-related language and imagery in both advertisements and packaging. Not only are drugs becoming increasingly available, but marketing techniques are becoming more sophisticated. Concern has recently been expressed about the marketing of 'party packs' that contain an ecstasy tablet, a small amount of heroin to allow users to 'come down' from the effects of the ecstasy, and alcohol.

Chapter 3

FACTORS ASSOCIATED WITH CHILD AND PARENTAL SYMPTOMS AND DISORDERS

Michael Fitzgerald

APPROACHES TO PARENTING

'My children weary me', wrote Evelyn Waugh. 'I can only see them as defective adults; feckless, destructive, frivolous, sensual, humourless.' He might have written this on a bad day! The Greek teacher Protagoras (c.485–c.415 BC) described the contemporary approach to discipline: 'If he is willing, he obeys, but if not, they straighten him, just like a bent and twisted piece of wood, with threats and blows'. In the sixteenth century, Henry IV of France advised his son's tutors: 'I wish and command you to whip him every time that he is obstinate or does something bad … I know from experience that I myself benefited, for this age I was much whipped. That is why I want you to whip him and make him understand why.' To some degree, these quotations embody the traditional Irish form of parenting. It is a highly unsuccessful form.

In 'Whole Duty of Children', Robert Louis Stevenson wrote that:

A child should always say what's true
And speak when he is spoken to,
And behave mannerly at table;
At least as far as he is able.

What is powerful about this is that the phrase 'as far as he is able' is sensitive to child development. Freud put it well and accurately: 'If a man has been his mother's undisputed darling, he retains throughout his life the triumphant feeling, the confidence in success, which not seldom brings actual success with it.'
In a different vein, W.B. Yeats wrote in Remorse for Intemperate Speech:

Out of Ireland have we come,
Great hatred, little room,
Maimed us at the start.
I carry from my mother's womb
A fanatic heart.

STYLES OF PARENTING

Authoritarian Parenting

An unsatisfactory form of parenting is the authoritarian style. This is a 'fascist' style of parenting. It is highly controlling. Disciplinary techniques are harsh, and there is a lack of warmth in the home. Little attention is paid to the child as a person in his or her own right. The major focus is on the needs of the parents, not the children. Children reared with this type of parenting style tend to have poor school performance and show behavioural problems.

Professor Anthony Clare (1991) states that 'a child psychiatrist writing in 1976 on discipline in the Irish family commented: "The family home in Ireland is a novitiate for violence. Even from the cradle the child is made to feel rejection, hostility and open physical pain. The infant is left to cry in his cot because his mother does not want to "give in to him". Later he is smacked with the hand or a stick. He is made to go to bed early. He is not allowed to have his tea. He is put into a room by himself … and in order to invite this morale-breaking treatment from his parents, all the Irish child has to do is to be normal. It is the normality of childhood which sets parents' teeth on edge. They take no joy in childishness.' It is hardly surprising that this makes children self-doubting, insecure, angry, depressed and guilty, with low self esteem and uncertainty about themselves.

The historian Joe Lee noted 'the elusive but crucial psychological factors that inspired the instinct of inferiority' and 'shrivelled Irish perspectives on Irish potential'.

'Good Enough' Parenting

This is of the authoritative (as opposed to authoritarian) type. The children are treated warmly but set firm limits. Children reared with this kind of parenting style have higher self-esteem and achieve better.

There is flexible but effective monitoring of children, with sensitivity to their needs and age level. There is facilitation of appropriate behaviour, which leads to self-efficacy, and they are helped to develop problem-solving skills.

Praise for appropriate behaviour is very common. Parents get major pleasure from watching their children and adolescents develop. This kind of parenting can be done by homosexual parents.

Permissive Parenting

Another unsatisfactory type of parenting is the permissive type, whereby children are indulged and there are no limits. While 'spoiling' of children does exist, it is much less frequent than many people think. A small number of extremely affluent parents over-indulge and spoil their children. These children can become lacking in motivation, with little drive, ambition or sense of themselves, and become 'drifters' in society. Children reared under this parenting style are less independent and more immature in their behaviour.

Neglectful Parenting

This is another unsatisfactory parenting style. Children who suffer severe emotional neglect are more likely to be antisocial later. They tend to perform poorly academically.

MARITAL DISHARMONY AND CHILD PSYCHIATRIC PROBLEMS

The Evening Herald (19 September 2003) pointed out that 'some 16 per cent of young people … have parents who are separated or divorced, with a further 5 per cent having a widowed parent'. Irish studies have shown correlations between marital disharmony and child psychiatric problems (Fitzgerald and Jeffers, 1994; Lucey and Fitzgerald, 1989; McNestry et al., 1988). Of course, correlation is not the same as causality. It is possible that the effect on children is mediated through 'modelling', through insecure attachment bonds and through hostile and coercive parenting as a result of the marital disharmony. Children of 'warring parents' feel insecure.

It would appear that marital disharmony leads to increased irritability in the home; parents tend to have fewer shared interests and are less likely to operate as a unit. This may lead to inconsistent parenting, parents quarrelling with each other, and, often, the scapegoating of children. A child who is exposed to marital violence in the home has a 90 per cent chance of being disordered (Jeffers and Fitzgerald, 1991).

DOMESTIC VIOLENCE

Marital violence and disharmony are closely associated with child psychiatric disturbance. In an Irish study (Jefferson & Fitzgerald, 1991) a child who exposed to marital violence had a 90% chance of being disturbed. When children experience marital violence they become panicked and terrified. Chronic marital violence is grounds for separation and the separation is in the best interest of the child. Marital disharmony leads to increased levels of irritability in the home, parents tend to have less shared interests, and are less likely to operate as a unit. This tends to lead to an inconsistent parenting and scapegoating of particular children. Children also get pulled in on one side or the other with massively increased personal stress for them. In a ten year follow-up of a study from aged 11 to 21 one third of the children were disturbed as adults (Cleary, Fitzgerald, Nixon, 2004. From child to adult, UCD: Dublin). In separated families good contact with a non-custodial parent is very important. Parents are still parents after separation. While the marriage is over parenting continues. It is important that the continuing post-marital bickering does not poison the continuing parental duties of both parents. Children should not have to take sides. The continuous blackening of one parent by the other parent in the post-marital situation is very damaging. In the post marital situation forgiveness by the ex-marital partners is of critical importance even if it is extraordinary difficult and very often not possible to achieve. This post marital bickering should be kept away from the children and is a private matter between the two ex-marital partners. The best interests of the children must be kept in mind by both ex-marital partners as they are still parents. Unfortunately custody and access are often used by ex-marital partners as ways of getting at the other partner and as a way of getting further revenge and vengeance on the other partner. Tragically the children are very seriously traumatised by this situation. Children in families in this situation need on going counselling, mediation, and therapy in the best interest of the child. The child should have access to both parents unless there is a very serious and overwhelming reason not to give access to both parents. Access should be terminated if there is continuing violence to the child if the non-custodial parent is frequently drunk during the access or is overtly abusing drugs during the access arrangements. The child's wishes about access when the child is seen alone often give a good guide to what is best. Trying to sort out these issues in an adversarial court situation is hardly likely to put the child's interest first. A child advocate is certainly necessary in these situations.

PEER RELATIONSHIPS

Peer relationships are very important in terms of diagnosis, aetiology, and outcome of child and adolescent problems. At the diagnostic level lack of social know-how, lack of social nuance, are critical to a diagnosis of autism or Asperger's syndrome. These factors can also lead to severe victimisation and terrible bullying. Poor peer relations are often a factor in Attention Deficit Hyperactivity Disorder hyperactive type because of the impulsivity which leads to peers avoiding children with these problems. The rejection by peers can lead to depression and indeed suicidal behaviour in the person rejected. Sibling abuse within families is an underestimated cause of child disturbance. Adolescent (and pre-pubertal adolescents) are commonly introduced to street drugs by peers on the street. Indeed peers on the street are a very common source of supply. Delinquent peers are also critical to the development of sub cultural delinquency children and adolescents because they are introduced to delinquency and led into it on the street. This is likely to happen after children or adolescents are suspended from schools and 'thrown on to the street'. Treatment will involve forging relationships with non-delinquent peers and non-delinquent cultures. Indeed children with poor peer relationships in early life are particularly at risk of later psychological problems. Of course the advertising industry shamelessly exploits peer pressure. Children without the 'labels' on clothes are therefore not 'with it' which can lead to lowering of their self esteem and tremendous pressure on financially embarrassed parents to acquire these labels. Nothing is more distressing to a child or adolescent as to be seen as not 'with it' by their peers. In the family a sibling of a child with Learning Disability may be neglected as all the focus goes on the child with the Learning Disability. 'Circles of friends' in this situation can promote social inclusion. Sibling groups can also be helpful. Nevertheless it is not uncommon for family enrichment to occur in the long term in situations where there is a sibling with a Learning Disability.

EXAMINATION STRESS

In Ireland there is great stress on adolescents particularly during the final pre university examination or pre work examination – the Leaving Certificate. Parents and teachers often put massive pressures on pupils. Parents often want pupils to achieve their failed professional ambitions. Examination anxiety is also shamelessly exploited by the media to sell newspapers or to increase additional revenues from advertising radio programmes dealing with stress. Adolescents without adequate IQ are being pushed beyond their limits and can suffer mental disorder at this time including anxiety and depression or indeed hospitalisation. The suicide rate is not affected at this time. Adolescents with Attention Deficit Hyperactivity Disorder (often undiagnosed) and specific learning difficulties are also at risk at this time. Examination stress reduces adolescent's immunity and makes them more vulnerable to infections.

TRAVELLERS FAMILIES

Irish traveller families experience increased levels of deprivation and poorer health. The experience increased infant mortality, have twice the national rate of stillbirths, and reduced life expectancy as compared to the general population. A study by Heron, Barry, Fitzgerald, and MacLachlan (2000) found that almost half the traveller mothers they studied were psychologically stressed and 32% were on antidepressant medication. A study by Fitzgerald, Pritchard, and Kinsella (1988) found increased

rates of behavioural deviance in children in traveller families compared to a sample of children in a mainstream school. Clearly factors associated with deprivation and hostile responses to the families by the settled community aggravate the situation. They need improved living conditions, more outreach workers to help them, and improved medical care as well as more accepting attitudes by the settled community.

IMMIGRANTS

Racism has always been a problem in Ireland but it has increased (including probably racially motivated violence) with the increased number of immigrants into Ireland. These immigrants do not simply want to be tolerated but they want to be accepted as full human beings with equal rights with everybody else living in this island. The UNESCO declaration on racism states that 'any theory involving the claim that racial or ethnic groups are inherently superior or inferior, thus implying that some would be entitled to dominate or illuminate others who would be inferior; or which places a value judgement on racial differentiation, has no scientific foundation and is contrary to the moral and ethical principals of humanity'.

There is little doubt that neighbourly or community racism will have a major effect on a family. There is a model for this in relation to the families of the travelling community. It is particularly vile and sinister attack on a family. In school racism can manifest itself in the form of savage bullying. Unfortunately the majority of schools in Ireland have not taken full responsibility for bullying. There is a huge denial of bullying and racism. Institutional racism is also a problem. As Neil Crowley (2001) states in responding to racism in Ireland Veritas 'the 'mythical' Ireland of the welcomes merely served a denial of racism as a very unacceptable dimension to our make-up as a society'. Racism can only lead to increased levels of depression in families and increased levels of depression and psychosocial problems in children. We have to have zero tolerance for racism.

SERIOUS PHYSICAL ILLNESS IN CHILDHOOD

Serious physical illness to a child whether leukaemia, cystic fibrosis, cancer, etc. can leave a child and family 'shell shocked'. Families often go through phases of denial; then that the child will be magically cured; then a stage of sadness and anger or guilt; and hopefully finally a stage of adaptation and reorganisation of their lives. Sometimes families can get 'stuck' in a particular stage or indeed experience a pattern to the above. Family leisure can be curtailed; then there are increased medical and other expenses and effects on siblings. Effected children can become depressed; develop lower self-esteem, or behaviour problems. Good support for families and good communication with medical and paramedical staff is critical. Further family or individual counselling may be necessary.

LONE PARENTING

A study of lone parenthood conducted in Dublin in the 1980s (McDonnell et al., 1988) found that there was no significant difference between lone and married mothers in terms of mean age at first sexual intercourse, having more than one partner prior to pregnancy, reporting unavailability of family planning methods at the time, or reporting sexual, physical or other abuse in childhood. However, a significant difference was found for other parameters, as summarised in Table 2.1.

Eighteen per cent of the lone mothers in the study were living alone; the rest were living with their parents. Sixty-six per cent of the lone mothers living alone had major

financial problems, compared with 19 per cent of those living with their parents; 44 per cent of lone mothers living alone had major problems in the area of social contact. The lone mothers' problems with accommodation appeared to be due to overcrowding, as they frequently shared with several grown up-siblings as well as their parents. However, many of the lone mothers living with their parents felt that they would have difficulty coping both financially and socially if they moved out.

Table 2.1 Differences in circumstances of lone and married mothers in Ireland, 1980s

	Lone mothers	Married mothers
Wished to conceive at time of pregnancy	18%	60%
Initial negative feelings about pregnancy	56%	17%
Mother's parents initially hostile to pregnancy	78%	13%
Male partner showing no interest in the pregnancy	34%	2%
Major problems with accommodation	30%	9%

Source: McDonnell et al., 1988

FATHERS

The issue for a child is to have a good warm relationship with at least one parent. Fathers could do far more parenting than they do. Irish studies found that fathers were involved in only 20 per cent of child-care duties (McGee and Fitzgerald, 1988c). This is unsatisfactory and puts an excessive burden on mothers. The bonding in the delivery unit of the obstetric hospital is not as important as the father carrying out child-care duties during the rest of the child's life.

Children benefit from a good enough father and a good enough mother. The loss of a father or a very highly disturbed addicted or violent father has major impact on children, children's development both directly and indirectly through. The indirect effect is through the effect on mother and to poverty that father's behaviour may bring on the family. The direct effect on the child is through behaviour problems and depression. If a mother suffers chronic depression and there is a good enough father this can have a protective effect for the child. Indeed a good relationship with one parent can often protect a child from child psychiatric disturbance. Unfortunately sometimes mothers deny access to father to the children unjustifiably. On the other hand fathers tend to fade out of the picture or not pay or are not willing to pay sufficient maintenance. Once again the best interests of the child are ignored. The unemployed father not uncommonly suffers from identity problems as the breadwinner in the house and from demoralisation. Financial stress is often not uncommonly associated with unemployment and certainly poverty increases the likelihood of children showing evidence of child psychiatric problems. Nowadays there are a minority of fathers who opt for the task of the stay at home parent and do the major amount of parenting and house care. For some parents this is a very satisfactory arrangement.

DAY CARE AND CHILDREN

Poor-quality day care, with overcrowding, lack of stimulation and lack of space to play has negative effects on children. Affordable high-quality day care, with low density of children, adequate space and adequate stimulation is of great importance to Irish families. There is a major lack of this type of day care in Ireland.

The effects of day care must not be confused with the effects of residential care. Wolkind and Rushton (1994) state that there 'is evidence that (at least in 18 months olds) full-time day care may have greater insecurity-provoking effects than part-time day care'. Mothers who are stressed or depressed may benefit from having their children in high-quality day care.
Children reared in residential care tend to be more over-active and inattentive and have more behaviour problems. The later the age of entry into residential care, and the smaller the total number of care-givers per child, the better. This is also the case for children reared in orphanages in Eastern Europe.

PARENTING EXPERTS

The vast majority of parenting experts have been male: John Locke, Jean Jacques Rousseau, Benjamin Spock, T. Berry Brazelton, G. Stanley Hall, James Watson, Arnold Gesel, L. Emmett Holt, Mel Levine. Their theories have waxed and waned. Some of them have been parent-centred, others child-centred.
The psychologist John Broadus Watson, famous for his best-selling book *Behaviourism*, made the following idiotic statement in it:

"Give me a dozen healthy infants, well-formed, and my own specified world to bring them up in and I'll guarantee to take any one at random and train him to become any type of specialist I might select – a doctor, lawyer, artist, merchant-chief and, yes, even beggar-man and thief, regardless of his talents, penchants, tendencies, abilities, vocations, and race of his ancestors".

This is an example of bizarre behaviourism. Watson wanted to reduce child-rearing to standardised formulae. His comment on mothers – 'most mothers begin to destroy the child the moment it is born' – was also bizarre.
A theory of the tabula rasa or blank slate to describe the brain of the newborn is usually attributed to the philosopher John Locke. Locke actually stated: 'let us then suppose the mind to be, as we say, white paper void of all characters, without any ideas'. The child was therefore waiting to be socialised, and for the so-called blank slate to be filled up or imprinted upon by socialisation. Locke became very popular with sociologists and anthropologists.
It has been clear for quite a long time that the concept of the brain as tabula rasa is absurd. The child enters the world with a vast genetic programme that unfolds as the child grows, and in intimate association with the environment. How the child turns out depends on the interaction between nature and nurture and between the brain and its environment. The brain can't grow properly and develop properly functionally if its interaction with the environment is deficient.
Ann Hulbert has noted that each historical period finds one leading advocate of a strict parent-centred philosophy and a competing expert calling for a gentler child-centred approach. It is easy, therefore, to get the impression that experts are confused. As always, the truth lies somewhere between the two extremes.

CONCLUSION

In the Irish studies, family conflict, marital conflict, parental coercive behaviour, and negative, hostile parenting practices are of critical importance in the histories of troubled children. Negative, hostile, coercive parenting is toxic parenting. This kind of parenting pays no attention to the child's good qualities or good behaviour and

focuses only on the negative behaviour. The parent's reactions are probably related to parental mood rather than anything the child is doing.
The most important thing for parents to take from this book is that they should reward the child's behaviour, praise success liberally, and ignore minor infringements.

Chapter 4

AN IRISH STRATEGY TO PREVENT CHILD SEXUAL ABUSE

Maria Lawlor

Public awareness of child abuse in Ireland and internationally has increased exponentially since the 1960s, when Kempe and co-workers described the impact on children of physical abuse or non-accidental injury (Kempe et al., 1962; Kempe and Kempe, 1978). As we now know, both physical and sexual abuse in institutions was commonplace in Ireland at the time. As the devastating effects of physical abuse in the home were dawning on the professional community, it took longer for this to trickle out into the community. The educational system eventually took cognisance of the impact of physical abuse by teachers on their pupils, and in 1982 – a mere 22 years ago – corporal punishment in Irish schools was abolished. It is only now, in the twenty-first century, that the victims of institutional abuse are being seen as having been wronged and as being entitled to some form of redress.

Awareness of sexual abuse was growing in the USA in the 1970s. In the 1980s in Ireland it was an unmentionable topic for most citizens. However, children were beginning to disclose what was happening to them and the Rape Crisis Centre started seeing children who were disclosing sexual abuse. Two child sexual abuse (CSA) units were set up in Dublin in 1988 to help cope with the flood of referrals. For the vast majority of the population, sexual abuse was incredible. For those for whom it was credible, it was seen as shameful, stigmatising, and something that happened to other people.

CHILD ABUSE PREVENTION PROGRAMME

The Child Abuse Prevention Programme is a charity that was set up in 1989 by the author and Deirdre MacIntyre, clinical psychologist, to develop a preventive intervention to help address the problem of child sexual abuse in Ireland. This became known as the Stay Safe programme. It was developed in the late 1980s in Ireland as a result of therapeutic contact with a number of sexually abused children and their families in a residential psychiatric treatment centre. These children had been referred because of persistent suicidal behaviour, depression, refractory psychosomatic problems, severe behaviour and emotional problems and, in one or two cases, because of sexually abusive behaviour to smaller children. These children were experiencing many of the now well-documented effects of child sexual abuse (Beichtman et al., 1991; Finkelhor, 1984).

At that time, the medium- and long-term effects of sexual abuse were being increasingly acknowledged by victims and recognised by professionals (Beichtman et al., 1992). A striking features of the children and families undergoing treatment was that adults, parents and professionals had a range of difficulties about the whole problem of sexual abuse, as follows.

- Many adults were extremely reluctant to believe that other adults they knew, and sometimes loved and respected, would and could sexually abuse children.
- Some adults believed that the children themselves must in some way be responsible for the sexual abuse.
- Parents and professionals involved with children had great difficulty in recognising any hints from the children about sexually abusive experiences.
- Concerned adults did not know how to respond appropriately and supportively to the children even if they believed that child sexual abuse could possibly have occurred.
- Parents and professionals did not know what to do next in the child's best interest to help them, and did not have the slightest idea about where to go and who to approach for appropriate help.
- Adult victims of child sexual abuse had extreme difficulties in talking about their own childhood experiences of sexual abuse.

Other significant issues were some of the dynamics of sexual abuse, as follows.

- Sexual abuse was maintained by secrecy and threats.
- Victims felt they were to blame.
- Children did not have a language in which to communicate their abuse experiences, and the main adults in their lives – their parents, relatives and teachers – were not prepared to hear or to listen.

It would be fair to say that the whole area of child sexual abuse was fraught with difficulties, ignorance and fear for victims, families and many professionals.

As the 1980s progressed, the number of cases of child sexual abuse being brought to the attention of mental health professionals was increasing rapidly and treatment resources were limited. Given the extent and the serious effects of child sexual abuse, the development of primary and secondary preventive approaches seemed a worthwhile course to follow. Apart from being with their families, children aged between four and 12 years spend most of their time at school with teachers who could be confidantes to them about problems – including problems about abuse.

For parents and teachers to act as a resource to children, the parents and teachers clearly needed to know more about the signs and symptoms of child sexual abuse, how to respond appropriately and supportively to a child's disclosure, and where and how to mobilise appropriate advice and help. Teachers needed to know how, where and who to contact in social services if a child disclosed sexual abuse to them and if they had a suspicion or concern about child abuse. Teachers also needed to know what the outcome of their contact with the social services was likely to be.

The children needed to be told by parents and teachers to approach them about problems that made them feel upset, afraid or unsafe, and not to keep secrets about touches or anything that made them feel afraid or unsafe. Children needed to know that they could tell – and how to tell – adults if they felt upset, afraid or unsafe. They also needed to know that if they were asked to do something that made them feel afraid or unsafe they should say no, get away and tell an adult, and to keep telling until someone helped them.

It was clear that to have a primary and secondary preventive impact, a comprehensive approach was necessary. This approach would have to include teacher training, liaison between schools and social services, parent education and then the teaching of personal safety skills to children.

A review of available programmes at the time yielded some very short interventions (Nibert et al., 1989; Garbarino, 1987); some targeted children only (Garbarino, 1987). Most interventions were not suited to the Irish educational context and culture. The implementation of the Kidscape programme in the UK (Elliott, 1986) involved having additional adults in the classroom with the children's teacher. These additional school staff were not available in Irish primary schools. Few programmes took children's cognitive developmental levels into account (Conte et al., 1985).

A literature review at the time seemed to indicate that comprehensive programmes targeting children, families and schools were particularly effective (Kolko et al., 1987; Binder and McNeil, 1987). The more successful programmes teaching children to avoid abduction by strangers involved group training and behavioural training (Fryer et al., 1987a, 1987b) or video training and behavioural training (Poche et al., 1988). These clearly indicated that active teaching methods which included modelling and role play were likely to be more effective in teaching children personal safety skills. Indeed, the follow-up study by Finkelhor and co-workers of 2,000 10–16-year-olds indicated that young people who had been taught more comprehensive programmes found those programmes more helpful, had greater knowledge of child sexual abuse and – most importantly of all – were more likely to have used the skills taught to deal with threats and assaults and also were more likely to disclose than those who participated in brief programmes (Finkelhor and Djiuba-Leatherman, 1995; Finkelhor et al., 1995). It has also been found that the programmes with the most durable effects are those that include behavioural rehearsal, repeated presentations, standardised materials and trained instructors, and involve parents (Conte et al., 1985; Briggs and Hawkins, 1994; Wurtele et al., 1992).

DESIGN AND DEVELOPMENT ISSUES

To maximise the impact of a school-based child abuse prevention programme, a number of principles were considered essential to the development of the teaching materials. These were as follows.

1. The programme needed to be suitable for the Irish educational context and culture.
2. The programme needed to be suitable for the cognitive level of the child.
3. Learning strategies to maximise learning needed to be used. This included using modelling, role play, and multimedia presentation of materials.
4. A prosocial element was to be incorporated.
5. The mental health implications of the programme would be maximised by increasing children's self-esteem and their knowledge about self-protective strategies, and expanding their awareness of having a support structure and how to use it.

One of the aims of this programme was that children would tell adults about problems that they had, and that they should keep on telling until someone helped them. The purpose of this was to de-stigmatise having a problem and the 'telling of tales' about being hurt or upset. This could be of great benefit to a number of children, and especially to those who find it difficult to tell about problems of all kinds, as they may then be able to mobilise help to deal with their problems.

It was believed that when children realise that teachers are concerned about them feeling unsafe, afraid or upset, they may more readily see the teacher as a resource to whom they can turn when in difficulties.

The children are also taught how to assert themselves in a number of situations, and this may be protective for children in the short and long terms. They become aware that this mode of response is possible; they will have practised it in the school setting and may use it when a physically, sexually or verbally abusive situation arises and thus reduce victimisation on that occasion and subsequently.
Another mental health-related aim of this programme was that in some of the lessons the teacher would help children feel better about themselves by getting them to focus on the good and safe aspects of themselves and their lives, as well as helping them to develop problem-solving strategies.
Bullying is a common problem and is dealt with in some detail; children are encouraged to prevent victimisation by avoiding isolation as much as possible as well as being taught strategies to deal directly with it.
Every page of the children's workbook has a section for a parent's signature. The aim of this was to involve the parents in each lesson, with the intention that the parents would discuss the lesson content with their child and give the child an opportunity to confide in them as well as letting the child know that as parents that they are prepared to talk about such topics as touching, bullying and being upset, and are prepared to listen and help. Also, the parental involvement in the programme gives the parents an opportunity to find out exactly how much or how little their child knows about how to look after himself or herself, and they may then take the opportunity to advise them accordingly.
From a therapeutic point of view, for victims of abuse, it was considered useful to include the following.

- Reassuring victims of abuse that it was not their fault and that they are right to tell.
- Letting children know that they do not have to keep secrets that an adult may ask them to keep and that make them feel unsafe.
- Letting children know that adults are responsible for children and are responsible for helping them, thereby helping children to feel less alone when in difficulties.
- Teaching them that they should not be involved in hurting others.

Other issues in optimising impact on children were that:

- the programme be as relevant as possible by using information from research on sex offenders and about how they gain and maintain the cooperation of child victims (Conte et al., 1989)
- the children would enjoy the programme and teachers would enjoy teaching it.

STAY SAFE PROGRAMME COMPONENTS AND MATERIALS

Teachers nominated by the Irish National Teachers' Organisation (INTO) were involved to help design the lesson plans. To pay for the development of materials, a charity – the Child Abuse Prevention Programme (CAPP) – was set up. CAPP was involved in fundraising for the production of materials for the different programme components. The Eastern Health Board (EHB) Special Hospitals Programme made a contribution. Much goodwill was harnessed, and many people gave their time and services for free. The programme components developed included a teacher training course, a parent education module, arrangements for liaison between social services

and each school, and a two-tiered personal safety curriculum for the upper and lower age groups in primary schools. The following materials were developed:

1. a user's handbook for teachers
2. senior lesson plans book for senior cycle with 10 lessons; junior lesson plans book for junior cycle with 12 lessons
3. video for children called Pajo Says Take Care of Yourself
4. cassette tape with 'Stay Safe' song
5. templates for senior and junior children's workbooks
6. template of parents' booklet.

The development of the individual components of the Stay Safe programme are described in detail by MacIntyre et al. (2000).

EVALUATION OF THE STAY SAFE PROGRAMME

Given the complexity of the variables involved, the difficulty in effectively evaluating preventive interventions, and the reluctance and fears of teachers and society in general in the late 1980s and early 1990s in Ireland in addressing the problem of child sexual abuse, it was important to devise a good, implementable evaluation strategy. At the time there was no sex education in primary level schools in Ireland. Schools, teachers and parents were afraid to get involved in anything that concerned child sexual abuse. INTO and the National Parents' Council were supportive. The school managerial associations were reluctant to give support to an evaluation of the programme. However, once the rationale was explained to schools' boards of management, principals, teachers and parents, and once all parties saw and understood the non-threatening content of the teaching materials, a number of schools agreed to be involved in the evaluation of the programme.

Design of Evaluation

It was decided to evaluate the programme in two different ways. One involved evaluating the effect on children's behaviour of different levels of intervention; the other involved evaluating each individual component (teacher training, parent education, and teaching the children the programme) separately. This was done using knowledge/attitude questionnaires with teachers, parents and children on a pre- and post-test basis. This is reported in detail by Lawlor (1994) and MacIntyre and Carr (1999a).

Method

In all, 44 teachers, 637 parents and 1,558 children were involved. The children were from second and fifth classes. The second-class children had an average age of eight and the fifth class had an average age of 11 years. Forty teachers of second and fifth classes were asked to complete incident and concern record forms over one school year.

Teachers, parents and children completed knowledge and attitude questionnaires. The teachers collected records of approaches by children and teacher concerns over the evaluation period.

The numbers of approaches made by three groups of children to teachers about problems were recorded. The children and their teachers and parents had varying degrees of involvement in the programme. The control group had no involvement in

the programme; a second group had teacher training only; and a third group had teacher training, parent education, and were taught the curriculum.

Results

Children whose parents and teachers were also involved in the programme made significantly more approaches than those children with no teacher or parental involvement. Children with greater involvement in the programme made significantly more approaches to teachers about problems than did those where teacher training only had occurred. As one might expect, most of the approaches were about bullying and a small number were about sexual abuse. These results indicated that the programme was useful at a secondary preventive level.

The evaluation of the individual components of the programme study showed that children, parents and teachers made significant gains in knowledge and attitudes. The gains made in children's skills and knowledge were very substantial and significant. The children sustained these gains at three-month follow-up. Younger children made greater gains than older children.

Other outcomes were that teachers who taught the programme to the children in their classes reported that they had better relationships with the children and that teaching the programme had opened up channels of communication between the children and themselves. All the teachers reported that the children enjoyed the programme.

Conclusions of Evaluation

The evaluation study of the Stay Safe programme showed that it clearly influenced children to approach their teachers about problems. This is an important finding and indicates the effectiveness of the programme in impacting on children's behaviour at a secondary preventive level.

The children also learned the safety skills taught. As found by Finkelhor and Djiuba-Leatherman (1995) and Finkelhor et al. (1995), children who learn these skills are empowered to resist future sexual advances, hence the primary preventive impact of the programme. The Stay Safe programme was a comprehensive programme involving parents, had multiple lessons, and included lessons on a number of threatening situations including bullying. Finkelhor and co-workers in their nationwide US survey found that children who had been taught comprehensive programmes were more likely to have used the skills learned in those comprehensive programmes, felt better able to cope with and to deal with assaults and threats, and were more likely to disclose abuse than those who had been taught briefer programmes. These findings clearly indicate the positive mental health implications of being taught a comprehensive prevention programme. Other researchers (Conte, 1985; Briggs and Hawkins, 1994; Wurtele et al., 1992) have identified prevention programme features that are associated with more durable effects of child abuse prevention programmes. These features were all included in the original design of the Stay Safe programme

PROGRESS IN THE 1990S: WIDER IMPLEMENTATION AND FURTHER DEVELOPMENT OF MATERIALS

A steering committee was set up, chaired by the EHB. It included a Department of Education representative, a representative from Department of Health's Health Promotion Unit, and the two directors of CAPP. This steering committee meets quarterly.

When the evaluation was complete, the Minister for Education – at the time, Mary O'Rourke – took the unprecedented step of granting a Rule 60 day to allow all teachers to attend teacher training on recognising and responding to a child's disclosure, reporting abuse, and teaching the Stay Safe curriculum. In 1991 a team of six staff comprising three national school teachers and three social workers was seconded to CAPP to implement the programme in the eastern region. This was the first time in Ireland that multidisciplinary training of teachers had occurred in a systematic way.

Resistance to Stay Safe

A vociferous campaign was organised to oppose the Stay Safe programme. Parents Against Stay Safe (PASS) actively campaigned in local and national media, and travelled to disrupt parents' meetings throughout the country. One Holy Ghost father circulated a booklet to all schools opposing the Stay Safe programme. A number of articles were written in religious magazines opposing the programme. In response to the opposition, the Department of Education conducted its own evaluation of the acceptability of the Stay Safe programme to teachers, parents and pupils, and was very satisfied with the outcome.

National Implementation

In 1992, 14 more staff were recruited to ensure there was a multidisciplinary team of a teacher and social worker in place in all of the health board areas in the country, providing teacher training courses, liaison between schools and local social services, and parent education meetings in all primary schools. Teacher training was implemented nationally for all primary-level teachers from 1992 to 1995.

Further Development of Materials

The Stay Safe programme materials have developed over the years; there is now a four tier curriculum for primary schools with an upgraded new video. There is an Irish-language version of the programme for the Irish-speaking schools (Gaelscoileanna). Lessons plans have been developed for special schools for children with disabilities. These include specific adaptations and teaching materials for mentally handicapped children, deaf children and blind children (MacIntyre et al., 1986). Given that children with intellectual and physical disabilities are even more vulnerable than other children (Briggs and Hawkins, 1997), these developments are an important addition to the Stay Safe programme. The programme materials are available free to all national schools in Ireland from CAPP.

Further Evaluation of Stay Safe

Further evaluation of the Stay safe programme in 1995 showed that children who were taught Stay Safe were more likely to disclose sexual abuse and were more likely to make disclosures to their teachers. Teachers from schools where Stay Safe was taught initiated more referrals for evaluation of suspected sexual abuse. Following child sexual abuse assessment, there was a higher rate of confirmed sexual abuse among Stay Safe participants. These participants made more purposeful disclosures and in significantly more cases referral was due to the child telling someone about the abuse (MacIntyre and Carr, 1999b).

CURRENT SITUATION

The Child Abuse Prevention Programme (CAPP) has a full-time coordinator who has been involved since the initial evaluation of the programme, a full-time seconded teacher and a half-time secretary. CAPP also has 40 part-time teachers who provide parent education on a demand-led basis throughout the country. CAPP provides ongoing teacher training to teachers who have qualified since the early 1990s, and has also provided a co-teaching service to teachers who did not feel able to teach the curriculum to the children on their own. This has helped increase the uptake in areas of greater resistance. CAPP is based in Bridge House in Cherry Orchard, and is funded by the ERHA and by the Department of Education and Science.

IMPLEMENTATION RATES

Clearly the programme needs to be repeated through primary school, as children are likely to forget what they have learned without revision and reinforcement. Given the emotive nature of child abuse, and child sexual abuse in particular, it is difficult for teachers to hear, recognise and respond to a disclosure of child abuse, and they need ongoing support with this. Since 1990 many teachers and parents have used CAPP as a support and a resource.

Uptake of parents' meetings has increased steadily over the years. The latest figures on implementation in 2002 are that 98 per cent of primary school teachers (in 3,331 schools) have been trained, 86per cent of schools (2,875 schools) have held parents' meetings, and 77 per cent of schools nationally (2,548 schools) teach the Stay Safe programme. This level of uptake is very heartening. Table 4.1 provides a regional breakdown of these figures.

Table 4.1 Uptake of Stay Safe by region

Health Board	Number of Schools	In-service Training	Parent Education	Teaching Stay Safe
ERHA	638	98%	95%	92%
MHB	256	99%	89%	82%
SEHB	403	98%	92%	82%
NEHB	333	97%	86%	76%
SHB	527	97%	85%	72%
MWHB	356	97%	83%	70%
WHB	520	99%	86%	69%
NWHB	298	98%	67%	59%
Total	3,331	98%	86%	77%

There are a number of areas in the country where uptake is lower than in others, but every year in these areas the uptake has been gradually increasing. The highest implementation rate is in the eastern region, and the lowest in parts of the NWHB. The challenge at this stage is to ensure that schools continue to implement the programme and that it is repeated in schools for the same children at different ages. The introduction of Social, Personal and Health Education (SPHE) to the national school curriculum should facilitate the continuation of the teaching of Stay Safe to the children.

Although child abuse prevention is supposed to be part of the curriculum for primary-level schools, each school can choose to do just one lesson from the Stay Safe

programme or to do the whole programme. A current challenge is to ensure that the programme is taught in full to all children.

Chapter 5

BEHAVIOUR PROBLEMS AND DELINQUENCY

Michael Fitzgerald

BEHAVIOUR PROBLEMS

A behaviour pattern in childhood is a problem when it causes distress to the child, the family or society, and is persistent.

PRE-SCHOOL

A study of children in pre-school found that 17 per cent had behaviour problems (Cheasty et al., 1996).

PRIMARY SCHOOL

A very large study of 2,029 children in Dublin in fourth class of primary school found that 16.6 per cent were behaviourally deviant. Twice as many boys as girls were found to have behaviour problems. About three-quarters of those with problems were conduct-disordered; 7 per cent of those with problems had a mixed disorder of conduct and emotions. Of the total sample, truanting definitely applied to 0.4 per cent, destructiveness to 2.3 per cent, fighting to 4.8 per cent, disobedience to 6.1 per cent, lying to 3.3 per cent, stealing to 1.1 per cent and bullying to 2.9 per cent. In addition, 5.3 per cent were described as being resentful or aggressive when corrected.
With regard to gender differences:

- 0.8 per cent of the boys and none of the girls were truanting
- 3.8 per cent of the boys and 0.5 per cent of the girls were destructive
- 6.4 per cent of the boys and 3.2 per cent of the girls were fighting
- 9.8 per cent of the boys and 1.8 per cent of the girls were disobedient
- 4.5 per cent of the boys and 1.8 per cent of the girls were lying
- 1.8 per cent of the boys and 0.4 per cent of the girls were stealing
- 7.6 per cent of the boys and 2.6 per cent of the girls were resentful or aggressive when corrected
- 4.4 per cent of the boys and 1.1 per cent of the girls were bullying.

Children in disadvantaged schools, on reaching adulthood, were twice as likely to have children with behaviourally deviance as those in advantaged schools. The rate of behavioural deviance was 22 per cent in children in disadvantaged schools and 8 per cent in advantaged schools.

URBAN–RURAL DIFFERENCES

Studies conducted in Ireland in the 1980s showed that 35 per cent of urban children studied exhibited behavioural deviance, as against 11 per cent of Irish rural town children (Fitzgerald and Kinsella, 1987).

DELINQUENCY

Concern about perceived high levels of juvenile delinquency is nothing new: indeed, in 1818 a report on the English scene stated that 'the lamentable depravity which, for the last few years, has shown itself so conspicuously among the young of both sexes, in the Metropolis and its environs, occasioned the formation of a society for investigating the causes of the increase of juvenile delinquency' (West, 1982).

It appears that violent assaults were at their highest point during the middle of the eighteenth century. It also appears that the crime rate fell steadily during the nineteenth century and, indeed, up to and after the First World War (Gurr, 1977). Rutter and Giller (1983) have also pointed out that theft and violence were more of a problem 150 years ago than they are today.

It is of interest that the increase in psychosocial disorders after the Second World War was sudden and 'not the continuation of trends established earlier in the century' (Rutter and Smith, 1995). When one examines trends in the nineteenth and twentieth centuries as a whole, one finds 'a U-shaped curve, with high rates of crime and disorders in the early part of the nineteenth century, especially in larger cities, falling rates in the latter half of the nineteenth century and the early part of the twentieth century, followed by a large increase after the Second World War' (Rutter and Smith, 1995). Another change has been the converging trend of rates of antisocial behaviour of boys and girls. Up to about 90 per cent of London boys engage in minor delinquent acts.

The Irish Times (20 September 2003, p. 6) found that 69 per cent of 15- to 17-year-olds were concerned about the level of crime and street violence. At 57 per cent, Ireland was becoming more racist. Forty-nine per cent felt that they would never be able to afford a house or apartment in Ireland. Thirty-five per cent worried about the state of the economy.

Only a small number of delinquent acts are recorded, and of course disadvantaged children and adolescents are much more likely to be labelled as having committed a delinquent act than their middle-class counterparts.

Associations with Delinquency

Sheldrick (1985) points out that delinquency is associated with poverty, large family size, parental criminality, marital conflict, poor parental supervision, cruel, passive or neglectful attitudes, and erratic or harsh discipline. In addition, coercive or hostile parenting is of critical importance.

It appears that 'parental negativity focused on the individual child seems to be more a risk factor for antisocial behaviour than is general family discord' (Rutter et al., 1998, p. 176). Reversal of delinquent careers has been shown to occur when adolescents move from a large city to a rural setting, and when they marry a non-delinquent spouse (Rutter et al., 1998, p. 179). Aetiology is usually multifactorial: a single factor on its own will have only a small effect. Other associations include parental alcoholism, drug abuse, unemployment, and low IQ. Indeed, there is an overlap between drug and alcohol abuse and delinquency. A ten-year follow-up in Ireland of

delinquent behaviour showed that 20 per cent had drug problems and that there was a 92 per cent recidivist rate (Kelly et al., 1999).

Other associations to delinquency include untreated ADHD and television violence. ADHD is commonly missed in Ireland and the children go on to develop ODD, delinquency and drug abuse. If vulnerable children with behaviour problems from disturbed backgrounds view a vast number of violent acts on television, results include an increased number of violent acts and an increased level of adolescent aggression. Such movies also provide unsatisfactory role models.

Clearly boys are more vulnerable to being convicted than girls. Antisocial girls who become mothers tend to drop out of criminal activities. Nevertheless, women are accounting for much higher rates of officially recorded crimes than in the past. Hormonal difficulties as well as reading difficulties are probably relevant. Most problems in childhood are more common in boys than girls.

Housing policies that put severely disadvantaged families together without supports and without an infrastructure simply provide delinquent peer groups, and are very negative.

Genetics and Crime

There is no doubt that the rise in crime in the second half of the twentieth century has to be attributed to environmental influences. The gene pool could not have changed sufficiently to account for it.

Genetic factors are more important when 'antisocial behaviour … persists into adult life than when such behaviour is confined to childhood and adolescents' (Rutter et al., 1998: 131). The aggressive trait has a heritability of about 40–50 per cent.

In the early twentieth century it was common for Irish people to say about people with psychological and physical disorder, 'it's all in the blood'. In the second half of the twentieth century there was more truth in this than people realised.

Protective Factors against Delinquency

For children, protective factors include a good temperament, good peer relationships, not being in contact with delinquent peers, having above-average IQ, belonging to a youth club, having good concentration, being willing to stay in school, and having a family who remain in contact with the school. The presence of the natural father is also helpful, as is adequate fathering and mothering experience in the parents.

In relation to older adolescents with delinquency, marrying a supportive partner and being in a stable environment have been found to be helpful. Having a mentor outside the home or being successful at sport. can also be helpful. Any experience of success tends to breed more success. A good relationship with one parent is also most helpful. The issue of parental separation as a causative factor has been greatly exaggerated: the real issues occur before and after the separation; the separation per se is just one part of a complex situation.

A school can also be protective against delinquency if it has an ethos of high expectations, good management, effective feedback to the children with ample praise, the setting of good models of behaviour by teachers, pleasant working conditions, and giving pupils positions of trust and responsibility (Rutter et al., 1979). Schools with a high rate of teacher turnover and a preponderance of less able children are less protective.

Prevention of Delinquency

The Community Mothers' Programme was developed in Dublin. Volunteer mothers were trained to provide support and advice, and selected first-time mothers in each community were trained by a family development nurse, who was then available to provide ongoing support if needed. This is a promising approach. It would appear from this study that families who are socially isolated from both their extended family and their neighbours are most at risk. It appears that the issue of parental support in the task of parenting is critical.

The US Head Start programme focused on cognitive development and school performance; while the initial IQ gains did not persist, there were long-term gains in terms of better social functioning.

The intervention most quoted in relation to the prevention of delinquency is the High Scope Perry Preschool Study, which stands out with respect to its focus on very high-risk families, the quality of its programme, a low attrition rate, and the length of its follow-up to age 27. The children attended special classes for 2½ hours daily for 30 weeks, and there was a home visit by a teacher once per week. Some of the children attended for one year; most for two years. The focus was on active learning, encouragement of children's independence, the development of self-esteem, the teaching of problem-solving and task persistence. Emphasis was placed on good home–school integration, small classes, and specially trained and supervised teachers.

The results were certainly impressive in several important respects. The High Scope group had fewer arrests than a no-intervention group. Teenage pregnancy was lower. None the less, Rutter et al. (1998, p. 337) point out that: 'Expectations of modifiability need to be realistic. There are clear grounds for thinking that criminal behaviour is open to modification, but indications are that reductions and future offending are likely to be relatively small (e.g. 12 per cent).'

Scientific evaluation of interventions is critical, and seriously neglected in Ireland.

Intervention and Treatment for Delinquency

Roger Doyle (2003) points out that a new statistical technique called meta-analysis 'convincingly demonstrated that rehabilitation does work … the method combines the results of many studies, thereby averaging out extraneous and idiosyncratic factors.' The evidence shows that: certain behavioural modification programmes for violent offenders and for medium-risk sex offenders have been particularly effective, achieving reductions in recidivism of 50 per cent or more as compared with controls. Programmes targeting juvenile offenders – including mentoring, skills instruction and, for teenage mothers, intensive home visiting to reduce child abuse – attained high success rates in preventing crime.

Doyle also notes that 'one of the leading researchers in criminal behaviour, James McGuire of the University of Liverpool in England, notes that, in general, punishment is not effective and may actually increase crime rates. Boot camps, three-strikes laws, so-called scared-straight programmes and the death penalty are proving ineffective in preventing recidivism.'

The only sensible policy is one of minimal intervention, minimal court processing and minimal incarceration. Incarceration generally only makes things worse and leads to an increase in delinquent activities. In New Zealand there are family group conferences that consist of 'the offender, their immediate and extended family, the victim, and victim's representatives, the police, and social workers. The aim of the conference is for the offender and their family group to come up with an appropriate

plan that will meet the needs of the victim' (Rutter et al., 1998: 358). There is no doubt that this has value in the Irish context as well.

The Justice System

The protection of the rights of adolescents in custody is a matter of very serious urgency, and needs to be dealt with in the Irish context. Parents should immediately go to the place of custody and remain there until the adolescent is discharged.

If adolescents appear in court, it is critical that families draw up their defence in great detail. This can then be handed to the legal people. Barristers may have multiple cases going at the same time, and may drop out of less valuable cases at the last minute. Families have to realise that the maximisation of income is the critical factor in the legal process, therefore to be successful they must do most of the defensive work and preparation themselves. It is important not to put naïve faith in the legal system.

If the family have very detailed, carefully typed-out defences for their adolescent, the legal team will be able to provide some presentational input for the court and they will be more successful. If it is not possible for the family to type out their defence, it should be handwritten clearly and legibly, with headings, so that the barrister who has to pick it up at the very last minute can follow it easily and know the relevant questions to ask in order to mount the best possible defence.

If the family don't organise things, the solicitor and barrister will omit critical factors. The legal people will come from a different social class to disadvantaged adolescents, and it will be difficult for them to have any real empathy or understanding of the adolescent's circumstances or indeed care.

Persons with Offence Histories

The Irish Independent (23 September 2003, p. 1) pointed out that 'one in every eight prisoners left school at 12 or younger and more than half have serious literacy problems'. The judicial system is insensitive to the needs of these unfortunate disadvantaged adolescents. Custodial sentencing is dehumanising, and the harsh sentencing favoured by right-wing groups only further dehumanises the people concerned. These adolescents are simply statistics, numbers, victims of a divided society, victims of right-wing fiscal policies and an uncaring hierarchy. In courts they are prisoners, delinquents, etc.; there is little evidence that they are recognised as human beings (except in rare cases). During the twentieth century, probably the most dangerous place for an adolescent to be was in the custody or 'care' of the state.

The concept of a caring judicial system is a contradiction in terms: conviction and punishment are its main interests. The fact that the punishments and custodial sentences meted out actually aggravate the situation doesn't bother the majority of persons in the justice system in the slightest.

It is likely that many people in prison shouldn't be there. Even if a person commits a delinquent act, he or she is still a human being. In the environs of the courts, cynicism is deep. In the criminal system, the best interests of the adolescent are given short shrift. The justice system is inherently coercive and insensitive. The following is an example:

Outrage as man jailed for not paying dog licence … The gentleman in question was 'a single man who was of limited education, and had been unemployed for a number of years'. Michael O'Dowd, who knew him, stated that 'he just did not understand the system and he did offer to pay the fine in instalments. It is disgraceful that something was not worked out before he was hauled off to prison.' (Irish Examiner, 30 March 2003, p. 7)

This is an example of justice in Ireland. The situation in some other Western countries may be less bleak; for example, Downes (1988) notes that the 'Dutch judiciary have shown great courage in insisting on humane standards and the minimum use of pain in the dispensation of criminal justice'.

The evidence of thousands of years supports the notion that the individual should not be too trusting of the state, as thus Raftery and O'Sullivan's The Inside Story of Ireland's Industrial Schools (1999). A naïve faith in the state is a dangerous thing.

Interventions must be carefully planned, as they may be harmful. McCord (1978) examined the long-term effects of a treatment programme for boys consisting mainly of counselling and community programmes, and found that the treated group fared worse than the control group in terms of criminal behaviour and alcoholism, as well as serious mental illness. O'Mahony (1990), in an Irish prison drug study, found that an untreated group of addicts who were merely detoxified in prison were more likely to be abstinent than a treated group, contrary to expectations.

We must use alternatives to prison wherever possible. Persons in prisons need more psychotherapy and treatment of conditions such as ADHD.

Delinquency: Some Issues for the future in Ireland

Policy must not depend on vague sociological cocktail-party-type discussions. There has been a great lack of scientific evaluation of services for persons with delinquency in Ireland. The wearer of a pin-striped suit is believed to possess special knowledge in Ireland, but this is not in fact the case.

There is vast heterogeneity in delinquent behaviour, and there is no 'magic bullet' (Rutter and Giller, 1983, p. 386). For the early-onset group with overlap with hyperactivity, early intervention and early treatment of ADHD and programmes during the preschool years (examples of which are given above) have promise. Direct intervention with children in school does work.

Criticism by teachers in schools is damaging. Nothing succeeds like praise, and giving children experience of success. Unfortunately, 'mindless' criticism of pupils is still all too common in Irish schools. The Irish education system has a long and inglorious history of harsh treatment of children in school (Suffer the Little Children by Mary Raftery and Eoin O'Sullivan, New Island: Dublin, 1999).

There should be increased research into alternatives to prison. Imprisonment should be kept to a minimum.

ADOLESCENT SCHOOL BULLYING: AN UNACKNOWLEDGED TRAUMA

Awareness of bullying as a common phenomenon has been steadily increasing over the past ten years in Ireland, and much of the focus has been on workplace bullying. A number of books on bullying have been written by Irish authors, including Coping with Bullying in School (1993) and Bullying: A Community Approach (1994b) by Brendan Byrne, ABC of Bullying (1998) by Marie Murray and Colm Keane, and others.

A further contribution to awareness of this issue was made in the 1990s by a national survey on the extent of school bullying by Mona O'Moore of the Trinity College Anti-Bullying Centre, which indicated that approximately 17 per cent of Junior Cycle post-primary pupils report being bullied in school, with substantially higher levels in primary school. A survey of second-year pupils in over 45 of the north-eastern region's second-level schools indicated a victimisation rate in school varying from a low of 10 per cent to a high of over 46 per cent. All too often the impact of school bullying comes to national awareness only when the media in Ireland and Britain

report on young people – mainly second-level pupils – attempting and committing suicide as a result of bullying.

The prevalence of bullying in schools varies from 8 to 46 per cent (Wolke, 2000); in second-level schools it varies from 18 to 26 per cent for occasional bullying and from 5 to 10 per cent for frequent bullying, as shown by studies in Ireland, the UK and Norway (James et al., 2002; Roland, 2000; Whitney and Smith, 1993; Ahmed and Smith, 1990; O'Moore, 1997).

In 1993 the Department of Education released Guidelines on Countering Bullying Behaviour in Schools. In the past few years a number of parents' groups have been set up in various parts of the country in response to the impact of school bullying on their children. Indeed, increasing numbers of parents and young people are taking legal cases against the Department of Education and Science because of their experience of non-resolution of school bullying problems.

Apart from the 1993 guidelines, the only countrywide approach to dealing with the problem of bullying is the Stay Safe Child Abuse Prevention Programme, which has been implemented on a national basis since 1993. The Stay Safe programme addresses the problem of bullying in primary schools through the curriculum and, when requested, through the provision of training to primary school teachers and parents on the problem of child abuse and bullying. However, there has been no systematic or concerted effort throughout the country to address the problem of school bullying with students in second-level schools.

To facilitate communication about bullying, it is important that a clear and shared definition be used. A commonly used definition of bullying is as follows:

Bullying is aggressive behaviour by an individual or group against others. It can be verbal, psychological, physical, racist or sexual in nature, is usually deliberate, and may often be repeated.

Examples of the various types are described below.

1. Physical bullying: Hitting or beating; kicking; pushing; pinching; tripping; choking; spitting; stealing; vandalising or damaging property.
2. Verbal bullying: Name-calling, jeering, teasing, taunting, slagging; threatening; daring others to do things they know to be dangerous or wrong.
3. Psychological bullying: Excluding; isolating; demeaning; ridiculing; malicious gossip; spreading rumours; passing notes; using peer pressure to intimidate; threatening gestures or looks.
4. Sexual bullying: Unwelcome sexual comments; unwelcome touching; spreading rumours about a person's sexual orientation.
5. Racist bullying: Discrimination; prejudice; comments about colour, nationality, ethnic or traveller background.
6. Relational bullying: Manipulating relationships as a means of bullying, e.g. ignoring; excluding from the peer group; ostracising; spreading rumours; breaking confidences; huddling together to exclude others; talking sufficiently loudly that the victim can hear their name being mentioned; demeaning dismissive looks; abusive messages, notes, letters, or drawings; abusive text-messages, emails and phone calls.

CONSPIRACY OF SILENCE

A major international obstacle for parents, teachers and professionals in addressing the issue of bullying is that many victims of bullying, particularly adolescent victims,

are reluctant to tell anyone about it. We know from two studies in Ireland that only one in five students who were frequently bullied told their teachers about it (O'Moore et al., 1997), and only one in three told their parents (James et al., 2002). The hidden nature of bullying makes it difficult for professionals (in both health and education), parents and students to respond effectively to it. Young people need encouragement to tell, and adults need to know how to respond effectively when they are told. As adult involvement is almost always necessary to resolve persistent bullying problems, parents and teachers need to cooperate in order to deal effectively with bullying as it arises.

EXTENT AND IMPACT OF BULLYING IN SCHOOL

A survey carried out as part of the development of the Cool School Anti-Bullying Programme for 45 second-level schools in the North Eastern Health Board (NEHB) Region of Ireland (Counties Meath, Louth, Cavan and Monaghan) found that 19 per cent of the young people were victims of bullying – the lowest reported rate in a school was 10 per cent and the highest was 46 per cent. These findings are of concern not only because of the extent of the problem and the effects on the victims, but also because of the increasing efforts being made nationally to keep young people in the educational system for as long as possible.

A recent study carried out with students in second-level schools in the NEHB Region on the emotional impact of bullying on victims found that many young people feel very angry, depressed and anxious about being bullied (James et al., 2002). As the frequency of bullying increased, the students felt worse. Students who experienced psychological bullying and social exclusion were the most distressed. These effects are noteworthy as the impact of psychological bullying is not commonly recognised in society: many people perceive bullying as being predominantly physical in nature.

When asked about the persistence of bullying, half of the victims said it was this that made them feel suicidal. Indeed, one in five victims reported feeling very suicidal as a result of victimisation (James et al., 2002).

Bullying is known to have damaging effects on the mental health of victims. Being bullied has been found to be linked with depression and sadness (Salmon et al., 1998; Neary and Joseph, 1994; Rigby, 1996; Byrne, 1994b), poor health (Slee, 1995), anxiety and a variety of somatic symptoms (Faust and Forehand, 1994) and low self-esteem (Salmon et al., 1998; Lagerspetz et al., 1982; Stanley and Aurora, 1998; Rigby and Slee, 1992). Young people involved in bullying as victims and as bully/victims have significantly more mental health problems than those not involved in bullying (Kaltiala-Heino et al., 2000).

BULLYING AND SUICIDAL IDEATION

To exacerbate the situation, the presence of psychological symptoms increases the victim's vulnerability to further bullying (Hodges and Perry, 1999). If the bullying increases in frequency, the consequent worsening of its effects may lead to lower self-esteem, depression and hopelessness, all of which are recognised predictors of suicide attempts. Slee (1995) found that a tendency to be bullied was significantly associated with severe depression and suicidal ideation, and Rigby (1996) found that victims of bullying were twice as likely as non-victims to feel suicidal.

The link between bullying and suicidal ideation deserves society's serious attention, particularly in the context of an increasing suicide rate among adolescents (Kelleher et al., 1995) and because bullying is a common phenomenon.

In 1998 a study of younger adolescents by O'Sullivan and Fitzgerald found that almost half of them gave school factors, including bullying, as the main reason why someone might want to kill themselves. There have been occasional reports in the mass media in Ireland and abroad linking suicide in young people with school bullying. Indeed, it was the suicide of three young people in Norway in the early 1980s that prompted the Norwegian government to fund substantial research into the development of intervention programmes to address bullying in schools (Olweus, 1993). It is clear that bullying needs to be addressed and that preventive and effective intervention measures should be put in place in a systematic fashion.

An audit of referrals to the NEHB's adolescent psychiatric day programme showed that 25 per cent of attendees had experienced significant bullying (unpublished Regional Child Psychiatric Report, 1997), and all of these had originally presented with either self-harm or suicidal ideation. Understandably, the families of victims also become very distressed, and these effects resulted in an increased demand for mental health services.

IMPACT OF BULLYING ON HOSPITAL, GP AND CHILD PSYCHIATRIC HEALTH SERVICES

The Health Services are an additional, rarely documented area on which bullying impacts. Some young people are admitted to hospital with psychosomatic problems, and school bullying may be an important contributory factor in some cases. Young people are sometimes referred to Accident and Emergency departments with the physical effects of bullying, including broken bones.

A number of adolescents referred to Accident and Emergency Departments with parasuicidal behaviour and self-harm have had experiences of bullying in school. General practitioners frequently see young people presenting to them with somatic, emotional and behavioural problems, depression, suicidal feelings and behaviour, and school refusal. In some cases bullying is likely to be a contributory factor, and in some it may be the main factor in their symptomatology.

When young people demonstrate suicidal behaviour they are frequently referred to specialised psychiatric services for assessment and treatment. Depending on the severity of the effects, long and costly treatment may be necessary. The costs in terms of direct contact between therapist and patient were measured for just two of a number of cases referred to the NEHB Child Psychiatric Service involving the effects of school bullying. The details were as follows.

1. An outgoing, good-looking, intelligent, academically able 14-year-old girl was being bullied physically and psychologically at school for a number of months. She became depressed and made a number of suicide attempts. She was suffering from post-traumatic stress disorder symptoms, depression, low self-esteem and severe anxiety symptoms. Her parents had to take significant amounts of time off work to be with her, as she needed 24-hour supervision. Her mother became depressed because of the persistent nature of the bullying and its effects on her daughter. The mother also required treatment for depression from her GP and assessment by the local adult mental health service. The child psychiatric service provided much-needed individual psychotherapy, group therapy, family therapy, parental counselling and liaison with the new school to which this girl moved. The family attended the child psychiatric service for 18 months. This case took up over 110 hours of therapist time in the Child Psychiatric Service, with an overall cost of €6,500.

2. A young girl was referred to the Child Psychiatric Service as she was unable to walk, and was very reluctant to speak. She had stopped eating at home and was admitted to the paediatric unit. She refused to communicate for quite some time and it was only at the end of a three-month admission that she was able to disclose that she had been kicked in the groin by a boy at school who told her that he would kill her if she told anyone about it. She had become so disturbed by this event that she went into a state of hysterical paralysis, anorexia and depression. This case involved 81 hours of therapist time for outpatient child psychiatric treatment and a three-month admission to the local paediatric unit, at a total cost of €43,000.

The costs in these cases do not include the money involved in parents missing work, and the figures do not reflect the tremendous distress and impact that the victimisation of one family member has on the others. Neither do the costs include the time spent by parents going to the Gardai to make statements, the Gardai processing these complaints, referral to the Director of Public Prosecutions and onwards.

Bullying can have extremely costly consequences: the London Chamber of Commerce estimated that bullying and harassment cost UK industry £2 billion per year. The economic argument for investing in preventive measures is very persuasive.

LONG-TERM EFFECTS OF BULLYING

The long-term effects of bullying on self-esteem and interpersonal relations have been documented. These effects include depressive symptoms and poor self-esteem in adulthood (Olweus, 1993; Farrington, 1993). Many adults who have been victimised as children in school, whether by peers or by teachers, have clear and vivid memories of these events. Indeed, as recently witnessed by the reports about institutional abuse and by the Laffoy Commission, many people who underwent physical and sexual abuse at the hands of their teachers suffered the traumatic effects for many years afterwards.

There is lots of evidence of the persistence of aggressive behaviour from childhood to adolescence and to adulthood (Farrington, 1993). The bully in primary school, if unchecked, is likely to continue to bully in second-level and beyond, to the workplace and elsewhere.

ADDRESSING THE PROBLEM OF BULLYING

A number of interventions have been developed to address the complex problem of bullying. Olweus' studies in Norway and Smith and co-workers' studies in Sheffield indicate that more comprehensive and longer programmes are more successful (Olweus, 1993; Whitney and Smith, 1993; Whitney et al., 1994). A whole-school approach needs to be taken, and schools with greater input and support are more effective. There have been similar findings with school-based child abuse prevention programmes, where a comprehensive approach, involving teachers and parents and teaching children a specific and longer curriculum, is more effective (Finkelhor and Djiuba-Leatherman, 1995).

A number of steps have been taken in Ireland that help to point in the direction of effective action. The Department of Education's 1993 Guidelines on Countering Bullying Behaviour in Schools recommend the development of a whole-school anti-bullying policy; a school ethos that encourages disclosure; awareness-raising among teachers, students and parents; adequate supervision; agreed procedures; a programme of support; involvement with local agencies; and evaluation of the overall effectiveness of the policy. Although these guidelines are far-seeing, there has been poor uptake in their implementation. This is seemingly due to the absence of a

number of essential factors, namely teacher time to deal with the problem; resources; teacher training and effective reporting; responding strategies; and teacher support structures. All of these are essential for the full implementation of the guidelines. Most schools take an ad hoc approach is to the problem of bullying; unfortunately, in autumn 2003 – ten years after the release of the guidelines – it seems that there is an increase in the level of aggression and bullying in schools.

The Health Strategy launched by Minister Micheál Martin and the NEHB's own Health Strategy both emphasise the importance of prevention of disorders and advancement of social gain. A Department of Health document that has been adopted as government policy, Get Connected: Best Help for Adolescents, emphasises the promotion of adolescent mental health. Perhaps now, in the twenty-first century, there will be some commitment to and investment in the prevention of mental health problems in children and adolescents.

THE COOL SCHOOL PROGRAMME: A RESPONSE TO THE PROBLEM OF SCHOOL BULLYING

This section describes an anti-bullying programme that has been developed and evolving since 1998 in the NEHB Child Psychiatric Service by a multidisciplinary team including a consultant child psychiatrist, a principal psychiatric social worker, a research psychologist, two education officers with teaching backgrounds, and a group therapist.

The programme has been funded mainly by the NEHB Child Psychiatric Service. It was supported by the NEHB Health Promotion Unit and by Noel Dempsey, Minister for Education and Science and by the Department of Education and Science.

The Aims of the Cool School Anti-Bullying Programme

The Cool School Programme facilitates the formation of policy and the development of strategies and procedures to combat school bullying in line with the 1993 Department of Education guidelines. Its curricular and policy development components fit neatly under the umbrella of the Social and Personal Health Education Programme for Irish schools.

The Cool School Programme addresses the problem of bullying at a multi-systemic level, i.e. at a whole-school level, at the staff and management level, and at a class and individual level, including therapeutic input for persistent victims and bullies. Its aims are:

- to support schools to develop effective strategies to prevent and combat bullying behaviour
- to reduce the extent and effects of bullying
- to increase students', teachers' and parents' knowledge and awareness of the extent, effects and dynamics of bullying
- to promote early disclosure
- to encourage bystanders to intervene
- to provide a therapeutic input to persistent victims and to vulnerable students
- to develop intervention strategies for persistent bullies.

The Whole-School Approach

The Cool School Programme takes a whole-school approach, involving:

1. administration of a student questionnaire to survey the extent and nature of bullying in the school; compilation of a report on the results and feedback to the school on the extent of bullying, where it happens and how often
2. in-service training for the teachers
3. work with self-nominated school subcommittees
4. educational meetings for parents
5. delivery of curriculum to students by teachers
6. therapeutic groups for persistent victims of bullying, run by the Cool School group therapist in partnership with a member of the school staff; individual work has been done with persistent bullies with a view to developing a module for use by guidance counsellors in schools.

The programme has also been involved in the development of a range of resources, including:

- a teacher-training programme
- two booklets for teachers – Responding to Bullying: First Steps for Teachers and Investigating and Resolving Bullying in School: Further Steps for Teachers
- an information book for parents on how to deal with bullying – Adolescent School Bullying: What Parents Need to Know (this was due to be completed by summer 2004)
- a curriculum for students
- a website with information for students, parents and teachers – www.coolschoolbullyfree.ie.

Additional resources currently being developed include a curriculum to address relational bullying this is being piloted in November 2003. Relational bullying is the type of bullying practised more commonly by girls. It includes the damaging and manipulation of relationships, the spreading of rumours and deliberate exclusion. It is much more easily denied and deniable than physical bullying and can be very difficult for teachers to detect.

A computerised assessment tool is being developed to assess the emotional recognition ability, empathic capacity, perspective taking ability of bullies and those involved in bully/victim situations. It is planned to have this completed by summer 2004.

Teachers' In-Service Training

The aims of the teachers' in-service training are:

- to raise awareness about all aspects of bullying
- to define bullying and distinguish between bullying problems and discipline problems in schools
- to feed back the results of the survey on bullying in their school
- to establish a consensus among the teachers about unacceptable behaviours
- to offer strategies to deal with bullying
- to recruit a subcommittee to be involved in tackling the problem, supported by the Cool School team.

Teacher training involves two separate workshops for all teachers in the school. The task of the first workshop is to identify unacceptable behaviours – physical verbal and psychological – across the whole school community, i.e. student to student, student to teacher, teacher to student, teacher to teacher, parent to teacher, teacher to parent.

The task of the second workshop is to elicit an appropriate response to bullying from the staff. Teachers are asked what they can do as individuals to intervene in bullying

situations in their school, what agenda they would set for their school if they were part of an anti-bullying team, and what resources they would require from management. Management are asked what resources they would be willing to provide for an anti-bullying programme in their school. At the end of the teacher training the teachers are invited to volunteer to be involved in an anti-bullying subcommittee to develop the school's anti-bullying policy in consultation with the rest of the staff, with students and with parents.

Work with Subcommittees

The Cool School team then engage with these subcommittees to facilitate them in developing procedures for disclosure of bullying and procedures for responding, reporting, investigating and recording incidents. This includes the introduction and delivery of a non-hostile sanction system, which is individual to every school. An important issue in working with students is negotiation of confidentiality with victims who disclose bullying but are reluctant to allow any action to be taken. Another issue is how to interview victims and bullies in the most effective manner possible. Throughout this process there is an overall emphasis on consultation with colleagues.
Work with sub-committees with the Cool School Programme involves:

- giving advice about how to raise awareness with the students and parents
- how to plan and run an anti-bullying week
- what to include in an anti-bullying policy document
- how to evaluate the policy
- providing ongoing support to the subcommittee.

The Cool School Programme and Parents

Parent education meetings are held in each school. These focus on awareness-raising work, which includes:

- defining bullying
- describing the warning signs and effects of bullying
- offering coping strategies for students and parents
- offering advice on how best they can support their child who has been victimised or who has been using bullying behaviour
- offering advice on how to approach schools if a child has been bullied
- inviting parents to contribute to the overall school policy.

Therapeutic Work with Victims and Bullies

Therapeutic groups for the victims of bullying have been run by Child Psychiatric Service therapists in 2002 and in 2003 in schools, with a teacher as co-therapist. Six to eight young people are involved in each group, and each group has lasted for eight sessions. Prior to the group therapy there is an initial interview with the parents and the young person. The group offers self-esteem-enhancing activities, peer support, opportunity to make new friends, peer exchange of coping strategies to deal with bullying situations, social skills training, assertiveness skills, age-appropriate games and activities, and an interview is held after the group to review its progress with the young people and their parents. Feedback from the young people has been very positive; they all tried out some of the new strategies taught and found them useful.
A number of young people engaged in persistent bullying have been referred and a course of individual sessions has been given to them. These include anger management strategies and cognitive problem-solving strategies. Over the next year it

is planned that a therapeutic module that can be used by counsellors in schools will be developed.

Students' Curriculum

The students' curriculum offers a set of five lesson plans. It is suggested that these lessons be taught to all students at the start of the programme, and thereafter to first-year and third-year students every year. The lesson content is as follows.

- What is bullying?
- Asking for help.
- Standing up for yourself.
- Bystanders, how can we help?
- Making a class agreement.

This curriculum is being developed further to include lessons on relational bullying. These are currently being piloted and evaluated.

Research

Research and development are intrinsic parts of the Cool School programme. As described above, an analysis of the emotional response to bullying has been carried out. Evaluation of the programme is ongoing. An evaluation of the curriculum in 2003 indicated that it helped increase the students' level of knowledge about bullying and about how to tell, increased the likelihood of students telling teachers about being bullied, and increased the likelihood of student bystanders intervening if they liked the person who was being bullied. The teacher-training component of the programme has been reported by 85 per cent of teachers as being very helpful and useful.

Another area of research is into the levels of teacher bullying by and of students and how this relates to levels of pupil–pupil bullying in schools. It can only be assumed that in schools where bullying behaviour is commonly experienced by the staff, this impacts on the students and on the ethos of the school.

Uptake of the Programme

Over the past four years the Cool School Programme has been developed and has been implemented on a gradual basis, starting in Co. Meath and expanding into Co. Louth and then Counties Cavan and Monaghan. There are 56 second-level schools in the NEHB Region, and by October 2003 a total of 46 schools (82 per cent) had become involved with the programme. The Cool School team did a lot of work in persuading some of these schools to become involved; others were immediately enthusiastic and engaged readily.

Implementation of the programme was somewhat impeded by the competing demands of in-service times and days, teachers' industrial action that resulted in a number of days of school closure in 2002, and the packed curriculum in second-level schools. As of autumn 2003:

- 46 schools (82 per cent) have had a student survey done and have had a report and feedback given to them
- 38 schools (68 per cent) have had in-service teacher training
- 32 schools (57 per cent) have set up anti-bullying subcommittees
- 22 schools (39 per cent) have written a draft of their anti-bullying policy
- 20 schools (36 per cent) have had a parent awareness workshop
- 19 schools (34 per cent) have taught an anti-bullying curriculum
- 14 schools (25 per cent) have held an anti-bullying awareness week.

All these figures are expected to be significantly higher by the end of the school year 2003/04.

SOME FUTURE THORNY ISSUES IN SCHOOL BULLYING

Bullying is an endemic problem in society, in organisations, in schools and in families, and can potentially occur in any social group. On the positive side, much of society has moved from believing that bullying does you no harm at all to some understanding that it can have a negative impact. Policies are being developed in workplaces and schools. However, to make anti-bullying policies work, the people to whom they apply have to believe that the policies have relevance, that they do actually apply to them, and that they will be and are being unequivocally implemented.

Parents in Ireland are sometimes very frustrated with the response they get from schools when a child discloses that he/she has been bullied at school. This has resulted in a number of legal cases taken by parents against the Department of Education and Science. However difficult it is to bring up the subject of your child being bullied by another pupil, it is extremely difficult for parents to raise the issue of a teacher bullying a child. Teachers who are inclined to use more coercive methods of teaching and to misuse their power in the classroom are more likely to have students in their classes who feel they are being bullied by the teacher. This is really a hidden problem and an area generally unmentioned in the bullying literature and elsewhere.

Another issue that impacts greatly on teachers is that the level of psychosocial problems experienced by young people has been increasing over the past 50 years (O'Connor, 2002). Aggression by young people seems also to be increasing, particularly among girls. The phenomenally increased levels of alcohol consumption and drug abuse no doubt have fuelled the impact and extent of youth aggression over the past ten years, funded partly by the Celtic Tiger. The suicide rate among young Irish people is alarmingly high.

One suspects that the level of aggressive behaviour and bullying in schools is on the increase. From a teacher's point of view, this means that control and discipline are more difficult to maintain. The extent to which teachers in Ireland are targeted for bullying by pupils is another well-kept secret. Bullying behaviour by pupils is certainly recognised by teachers, but is rarely reported in Ireland or elsewhere. A study of 575 teachers in the USA in 1980 described them as 'a new endangered species' suffering from a form of 'combat neurosis' (Bloch and Bloch, 1980). Increased levels of aggression in young people obviously have an impact on the working conditions of teachers. Also, it is likely to be difficult for teachers who are being bullied by their pupils to intervene effectively in bullying problems between the pupils.

The problem of bullying is not easily dealt with, and there are no simple answers. However, multi-systemic measures need to be – and can be – put in place to keep the problem of school bullying under control. Implementing measures that are likely to work involves a commitment on the part of parents, teachers and pupils to make them work, and on the part of politicians to give leadership in prioritising the problem of bullying and allocating the necessary resources. Schools need help and ongoing support to implement measures that are likely to impact in any meaningful way on the level of school bullying and in the prevention of recurrent incidents.

In the interests of suicide prevention, reduction of youth aggression, prevention of mental health problems and improvement of schools' atmosphere, parents, teachers, students, general practitioners, mental health professionals, politicians and allocators

of health and education resources need to know about the different types of bullying, its dynamics and effects and how to deal with and prevent it. Can we afford as a society to ignore the problem of school bullying?

APPENDIX FOR PARENTS – IS MY CHILD BEING BULLIED?

It must be remembered that even one bullying incident can have a detrimental effect on a young person. The following checklist refers to the general characteristics of bullying behaviour and can be referred to if you suspect that your child is a victim of bullying. Use this checklist along with the warning signs to establish whether bullying is taking place.

Bullying Checklist

1. Is verbal, psychological or physical aggression being used?
2. Is the person feeling upset?
3. Do they feel helpless in the face of what is happening to them?
4. Is there an imbalance of power because of a wide discrepancy in age, size, strength or ability to articulate?
5. Is this behaviour happening in the same place, at the same time, or being carried out by the same person or group?
6. Is the bullying behaviour being planned or organised in some way?
7. Is the aggression unprovoked? Very often young people who are bullied say that they were picked on without reason, and that they did nothing to provoke it. (Some young people may unwittingly provoke the bullying through their own behaviour.)
8. Is the situation too much for them to handle alone?

Approaching the School

Telephone the school and request an appointment with the principal or your child's class tutor. Prepare for the meeting by making a note of the circumstances from your child's point of view. Focus on:

- Who? Names of children involved and of witnesses. Your son/daughter may not be the only one being bullied, and several pupils may be bullying.
- What? The nature of the incident(s) and the behaviours involved.
- When? Dates and times of incidents.
- Where? Location of incidents, e.g. corridors, classrooms, school bus.
- Why? Are you or your child aware of any reasons for the bullying?

At the meeting:

- Ask to have the incident investigated.
- Ask what support the school can offer your son/daughter, e.g. counselling or supervised mediation between the parties if appropriate.
- What action will be taken to protect your child from retaliation?
- How will the situation be monitored, for how long and by whom?
- Ask to be kept informed about progress. Set a date for this. Establish whom you should contact and when.

FEARS

Fear is focused on a specific object or situation, while anxiety has a more diffused quality with anticipatory elements. Being fearful definitely applied to 2 per cent of the

children in an Irish study; being anxious applied to 3.3 per cent (Jeffers and Fitzgerald, 1991).
In a recent study of fears in children attending an Irish Child and Family Centre for child psychiatric problems, it emerged that 62 per cent had an excessive level of fear (Scully et al., 2003). The most common fears of child psychiatry clinic attenders were:

1. being criticised
2. being kidnapped
3. making mistakes
4. death of a family member
5. being adopted.

Relaxation therapy is helpful; family therapy can also be helpful as part of a multi-modal intervention. If the fear is part of a more extensive child psychiatric problem, intensive psychoanalytic psychotherapy will also have a role.
Desensitisation to the feared situation is one form of treatment of fears. In this, a child is gradually exposed to a feared stimulus – for example, being separated from the mother – until the fear is eradicated.

SCHOOL REFUSAL AND DEVIANT BEHAVIOUR

In this case the child refuses to go to school in the morning, complaining of abdominal pain or other physical symptoms, is fearful and distressed, or shows evidence of depression. The child may fear that the mother will not be there when he/she returns from school. He or she may be the victim of bullying in school, or there may be other school or family stresses. It is critical to get the child back to school quickly, in a very firm way. Family therapy or individual therapy is usually relevant; specific learning or other educational difficulties may also need to be addressed.
In a study of 2,029 fourth-class primary-school children (Jeffers and Fitzgerald, 1991), one-fifth of those who were behaviourally deviant were emotionally disordered, and 6 per cent of those who were deviant had a mixed disorder of conduct and emotions. Being definitely worried applied to 2.7 per cent of the children. Tears on arrival at school or school refusal occurred in 0.4 per cent of the children.
In terms of boy–girl comparisons, 4.6 per cent of the girls were definitely worried, compared with only 1.1 per cent of the boys. 2.3 per cent of the girls and 1.8 per cent of the boys were definitely fearful; this was a non-significant difference. 4.1 per cent of the boys and 2.4 per cent of the girls were apathetic. Tears on arrival at school or school refusal occurred for 0.5 per cent for boys and 0.4 per cent for girls; this difference was non-significant (Jeffers and Fitzgerald, 1991).

RESEARCH ON ADOLESCENT SUBSTANCE USE IN IRELAND

Alcohol and Drug Use and Misuse

In the past decade the use and abuse of substances has become recognised as a major national and international problem. It is useful to make a distinction between use and misuse of substances, as this reflects a more realistic view of adolescent substance use. It also allows for the identification of factors that differentiate between those whose use is problematic and those who use substances in a more positive way.
The assertion that there is such a thing as non-problematic adolescent drug use is a contentious one. It questions the assumption underlying the vast bulk of drug research and drug-related policy – that all drugs are bad. There is a marked dissonance

between policy on the one hand and services on the other. While the emphasis is on repression and abstinence at policy level, many services adopt a harm-reduction approach and a goal of non-problematic or controlled use rather than abuse.

Research on Adolescent Substance Use in Ireland

Children or adolescents who engage in drug abuse may show signs of disturbed sleep, complain of various physical symptoms, and be moody and impulsive, with low frustration tolerance. They may also be anxious or depressed, and lose friends. They may have accidents, miss school, or their school performance may deteriorate.

Many of the signs of early drug abuse are rather non-specific. The parent may find drugs in the house or in their child or adolescent's possession. This requires sensitive, empathic and non-judgemental intervention by parents. Severe initial criticism by a parent will aggravate the situation and make the adolescent more angry and distant. Interviews by professionals dealing with these matters should start with minor and socially acceptable issues and gradually, as the interview progresses, move on to more serious matters including drug use, contact with the law, etc. More often than not, use of a variety of illegal drugs, including alcohol and smoking, will be found. Conduct disorder, depression and anxiety, as well as attention deficit hyperactivity disorder (ADHD), may need to be treated concurrently.

Brinkley et al. (1998) carried out a study by questionnaire, to which 570 girls (58 per cent of sample) and 409 boys (42 per cent) in Dublin responded. The majority of pupils were born in 1982 or 1983, and were 14 or 15 years of age at the time of the study. The mean age was 14.38.

Cigarettes

Pupils who reported that they smoked were asked to state at what age they had started smoking. The average age at which pupils first smoked cigarettes was 10.8 years (standard deviation (SD) = 2.1). The mean age at which boys started smoking (10.4 years) was significantly lower than the mean age among girls (11.0 years) ($t(363) = 3.27$, $p < .001$).

Pupils who smoked were asked to indicate how many cigarettes on average they smoked each day. The mean number of cigarettes smoked was 4.2 (SD = 5.7). Although a higher proportion of girls reported smoking than boys, boys smoked more cigarettes on average than girls. The mean number of cigarettes reported by boys was 4.7, compared to 3.9 for girls.

The majority of smokers said they smoked because they wanted to try (78 per cent). The next most common reasons were 'because my friends smoke' (38 per cent) and 'because it relaxes me' (23 per cent). Some significant gender differences emerged, with a higher proportion of girls citing 'wanted to try' as a reason ($\chi^2(1) = 25.3$, $p > .001$) and a higher proportion of boys saying that they smoked 'because my friends smoke' ($\chi^2(1) = 3.9$, $p > .05$) and 'because it relaxes me' ($\chi^2(1) = 7.4$, $p > .01$).

According to the Irish Times (18 September 2003, p. 7), 'some 42 per cent of young people smoke; and the level of smoking increases with age'.

Alcohol

In the Brinkley et al. study, 25 per cent of pupils reported that they never drink alcohol, 59 per cent reported that they sometimes drink and 16 per cent said that they drink regularly. These differences were not statistically significant ($\chi^2(2) = 2.1$, $p > 0.1$). There were no gender differences in the proportion reporting that they drink regularly.

Pupils were asked to specify how often they had drunk any of a list of six alcoholic drinks. The type of drink that pupils drank most often was alcoholic 'soft' drinks (75 per cent of those who drink alcohol) and lager, stout or cider (72 per cent). The least common types of alcohol used by pupils were spirits, spirits with mixers, and wine. Significant gender differences were found for two of the types of drink listed. A higher proportion of boys than girls reported that they drank lager, stout or cider ($\chi^2(4) = 13.9$, $p < .01$), and a higher proportion of girls than boys drank alcoholic 'soft' drinks ($\chi^2(4) = 19.4$, $p < .001$).

The mean age at which pupils reported that they had their first alcoholic drink was 11.6 years. The mean age at which boys started drinking (10.8) was significantly lower than the mean age among girls (12.3) ($t(521) = 3.5$, $p < .001$). Half of the boys who drink alcohol reported having had their first drink at 11 years or younger, compared to just over a third of girls.

The mean amount of alcohol consumed on an average occasion was 3.6 units (SD = 2.7). Boys reported drinking significantly more on average than girls (mean for boys was 4.0 compared to 3.4 for girls; $t(588) = -2.9$, $p < .01$). Twenty-six per cent of boys reported that when they drink they consume six or more units, compared to 17 per cent of girls.

The most common location for drinking is outside – on the street, in a park, on the beach or in another open area (61 per cent of those who drink). The next most common location is in someone else's home, which was reported by over half of pupils who drink alcohol (56 per cent). Approximately a third of those who drink said that they drink in their own home (33 per cent) or at a disco or club (30 per cent). Significantly more girls than boys reported that they drank at someone else's home ($\chi^2(1) = 6.2$, $p < .01$) and in pubs ($\chi^2(1) = 7.1$, $p < .01$).

The Irish Times (9 October 2003, p. 7), in reviewing a study on Irish drinking culture and drinking-related harm (Ramstedt and Hope, 2003), stated that Ireland has the most binge-drinkers in Europe. It also noted that 'Irish drinkers are more likely to engage in binge-drinking compared with other European countries; half of men binge-drink at least once a week; 16 per cent of Irish women engage in binge-drinking; out of 100 drinking occasions, 58 end up in binge-drinking for men and 30 per cent for women [and] as a direct result of alcohol, 11.5 per cent of men had "got into a fight" and 6.3 per cent had had an accident'.

As quoted in the Irish Independent (9 October 2003, p. 5), the National Safety Council stated that "we have a chronic drink-driving problem in this country". This was shown by the fact that 11,000 people were prosecuted in 2001 for drink-driving offences, of whom more than 6,800 received convictions. On the same page, the Irish Independent notes that Irish people 'drink more – we binge more – and now we are becoming more aggressive'.

The Evening Herald (18 September 2003, p. 4) states that 'one in ten young people now take drugs on a regular basis and 99 per cent of Dublin youngsters report they are easy to get hold of'. It reports that three out of five youngsters aged 15 to 17 now drink alcohol, while the average age for starting to drink is 15½ years, and the average number of drinks consumed 'on a good night' is eight.

Substance Use and Misuse

According to Brinkley et al., cannabis was the most commonly used illicit drug, with 29 per cent of pupils having used it either in the last year or in the last month (15 per cent last month; an additional 14 per cent last year). The next most commonly used drugs were the solvents (glue, aerosols, butane gas, petrol, etc.), which had been used

by 14 per cent of pupils (8 per cent last year, 7 per cent last month; values are rounded up or down). All other illicit drugs had been used by 5 per cent or less of the sample. In total, 18 per cent of the sample had used an illicit substance other than cannabis, and a significantly higher proportion of boys than girls had done so (22 per cent of boys compared to 16 per cent of girls, $\chi^2(1) = 5.0$, $p < .05$).

Pupils who had used an illicit substance were asked to indicate at what age they had first used the substance. The lowest mean age of onset was reported for glue (12.4 years, SD = 1.63) followed by cannabis (12.5 years, SD = 1.48), magic mushrooms (12.6 years, SD = 2.4), LSD (12.8 years, SD = 2.4), ecstasy and tranquillisers (both 13.3 years, SD = 0.9 and 0.8) and amphetamines (13.5 years, SD = 0.7). Significant gender differences were found in the age of first use of cannabis and amphetamines. Boys had a lower mean age of first use of cannabis (12.2 compared to 12.7; $t(215) = 2.5$, $p < .05$), while girls had a lower mean age of first use of amphetamines (12.8 compared to 13.7; $t(19) = –2.6$, $p < .05$).

Pupils who had used illicit drugs were asked to indicate their reasons. The majority of pupils who had used drugs (80 per cent) reported that they had taken drugs because they wanted to try. This was the reason most commonly given, followed by 'I like the effects' (44 per cent) and 'my friends take drugs' (30 per cent). 'I feel better when I take drugs' and 'there are drugs in the places I go' were both given as reasons by just under a quarter of those pupils who had used drugs (23 per cent each). Seventeen per cent of pupils who had used drugs gave as a reason that drug-taking is a tradition among young people. A significantly higher proportion of girls than boys said that they had used drugs because 'I wanted to try' ($\chi^2(1) = 6.1$, $p < .05$).

Availability and Accessibility

Pupils who smoked were asked to indicate how they usually obtained cigarettes. Sixty-one per cent said that they bought their cigarettes and 60 per cent said that they obtained them from a friend. Forty-three per cent said that cigarettes were shared around a group of friends, 18 per cent said that they took them from home without their parents' permission and 18 per cent said that they obtained them from a brother or sister.

Pupils were asked, if they drank, to indicate how they usually obtained alcohol. The majority of those who use alcohol indicated that they obtained it from a friend (60 per cent). Just under a half of pupils (47 per cent) said that they bought it, while 38 per cent said that it was shared around a group of friends. Thirty-one per cent of pupils said that they took it from home, 22 per cent said that they obtained it from a brother or sister, and 17 per cent said they got it from one or both parents.

The availability of illicit substances was examined. Pupils were asked if they had ever been offered any of a list of illicit drugs. Sixty per cent of the total sample had been offered at least one illicit drug. A higher proportion of boys than girls had been offered an illicit substance (66 per cent compared to 56 per cent, $\chi^2(1) = 10.2$, $p < .01$). Cannabis was the most accessible drug, with over half of the respondents having been offered it (54 per cent), followed by ecstasy (30 per cent), solvents (21 per cent), LSD (20 per cent), amphetamines (18 per cent) and magic mushrooms (13 per cent). Tranquillisers had been offered to 10 per cent of the sample, while 9 per cent reported having been offered substances other than those listed (other substances named by respondents included petrol, tobacco, benzodiazepines (Roche) and amyl nitrate (poppers).

The most common places in which pupils were offered drugs were on the street, at a rave or disco and at a friend's home. While 'on the street' was the place where the

most pupils had been offered each of the substances, there were some differences between substances. Cannabis and solvents had been offered to some pupils at a friend's home or at school. For the three 'party' drugs – LSD, amphetamines and ecstasy – the proportion of pupils that were offered them 'at a rave or disco' was similar to the proportion that were offered them 'on the street'.

The majority of respondents reported that they would know where to obtain cannabis. Pupils who had used cannabis and ecstasy were asked to indicate how they usually obtained the substances, and some differences emerged. In relation to cannabis, the most common sources were 'from a friend' (64 per cent of pupils who had used cannabis) and 'shared around a group of friends' (62 per cent). Thirty-eight per cent said that they usually buy it and a quarter said that they usually get it from a stranger. Fifteen per cent said that they usually get it from a brother or sister and 6 per cent said they took it from home without their parents' permission. In relation to ecstasy, friends were again the most common source (59 per cent of pupils who used ecstasy had obtained it 'from a friend', and 15 per cent 'shared around a group of friends').

Some striking differences emerged between the five cities in the perceived availability of illegal substances. The highest percentage of pupils who had been offered at least one illegal substance was found in Dublin, while the lowest rate of drug offers was reported by youth in Groningen and Rome.

The majority of pupils (71 per cent) reported that they had been offered an illicit substance and would know where to obtain cannabis. While the street was one of the most common places where pupils had been offered illicit substances, the majority of pupils who had used an illicit substance had obtained it from a friend or group of friends. This dispels the myth of young people being tempted into drug use by 'pushers'. The reality is that while drugs are readily available on the streets, it is the young people's friends and peer group that are the most common suppliers.

Mark Morgan, referring to the fact that the main source of supply is friends, noted that 'For policy-makers this shows clearly that prevention starts with friends and that you can't blame the supply of drugs for the drugs problem' (Irish Times, 8 November 1997).

Attitudes to Substance Use

Pupils were asked to indicate on a five-point scale whether they thought a list of events were likely to occur if they drank alcohol. Pupils think that they are more likely to experience positive events after drinking alcohol than negative events. The most common expected outcomes are that an individual would have a lot of fun (83 per cent of sample reported it was likely or very likely) and would feel happy (80 per cent of sample). Almost two-thirds of the sample said that it was likely or very likely that they would feel relaxed (65 per cent), and over a half said that it was likely or very likely that they would forget their problems (56 per cent).

Pupils were asked what in their opinion were the effects of a list of substances. The most commonly cited effects of cannabis, alcohol and tobacco were relaxation and pleasure. While a high proportion of pupils did not know the effects of ecstasy, cocaine or heroin, among those who did dependency was cited most commonly as the effect of heroin and cocaine, while hallucination and pleasure were the most commonly cited effects of ecstasy.

Associations Between Problem Behaviours

The relation between various forms of problem behaviour was examined. Moderate correlations were found between alcohol and both cannabis use and tobacco use.

Moderate correlation was also found between tobacco use and number of delinquent behaviours and between cannabis use and number of delinquent behaviours.
Looking in more detail at the link between delinquent behaviour and various forms of substance use, a significant relationship was found between the number of delinquent behaviours and level of involvement with both alcohol and cannabis.

Socio-Economic Factors

A particular pattern emerged in relation to smoking, with pupils in the high socio-economic schools reporting high rates of infrequent use and pupils in the low socio-economic schools (or schools in disadvantaged areas) reporting high rates of frequent use. Pupils in the middle socio-economic group reported the lowest rates of smoking. These differences were found to be significant ($\chi^2(4) = 21.1$, $p < .001$).
Looking at cannabis use, a slightly different pattern emerged. Pupils in schools assigned to the low socio-economic group had the highest rates of both 'last year' and 'last month' use of cannabis. Schools in the middle and high socio-economic groups had similar rates of cannabis use. These differences were found to be significant ($\chi^2(4) = 9.4$, $p < .05$).
Significant differences also emerged in relation to inhalant use ($\chi^2(4) = 10.6$, $p < .05$). Schools in the low socio-economic group had the highest reported rates of 'last year' use of inhalants, but the highest rates of 'last month' inhalant use were reported in schools assigned to the higher socio-economic group. Reported use was lowest in the middle socio-economic group.
Looking at availability, the highest rate of drug offers was reported by pupils in the schools in the low socio-economic group (65 per cent of pupils had been offered at least one illicit substance). Pupils in the high socio-economic group reported the lowest rates of drug offers (54 per cent), while pupils in the middle socio-economic group reported moderate rates of drug offers (58 per cent). These differences were found to be significant ($\chi^2(2) = 8.4$, $p < .05$).

Type of School

The results show that rates of substance use are higher in mixed schools, and suggest that this may be due to diminished gender differences. Compared to single-gender schools, rates of smoking among boys in mixed schools were closer to those of girls, and rates of cannabis use and binge-drinking among girls were closer to those of boys. Differences were found for boys' smoking behaviour, with a higher proportion of smokers in mixed schools (daily smoking – 25 per cent of boys in mixed schools; 12 per cent of boys in single-gender schools). The other differences were for female pupils only. Girls in mixed-gender schools reported higher rates of cannabis use than girls in single-gender schools (33 per cent of girls in mixed schools, 21 per cent of girls in single-gender schools). Girls in mixed schools also reported a higher rate of binge-drinking (47 per cent of girls in mixed schools, 23 per cent of girls in single-gender schools).

Cannabis Smoking in the Five Cities Study

Males first smoked cannabis at a younger age than females (12.8 and 13.2 years respectively), and were more likely to have used cannabis than females. A third of male and a fifth of female cannabis users had first used by the age of 12 years. The age of initiation into cannabis use was in a narrow range between 12.6 years (Dublin) and 13.9 years (Rome), with Groningen (12.8 years), Newcastle-upon-Tyne (12.9 years) and Bremen (13.4 years) intermediate.

McArdle et al. (2002c) showed that for females, traditional family, sport and studying were independently associated with reduced drug use. Delinquent behaviour was linked with high rates of drug use.

Comparison with Other Cities

- Of the five cities that participated in the study (Bremen, Groningen, Newcastle, Rome and Dublin), youth in Dublin had some of the highest rates of substance use and delinquent behaviour.
- Pupils in Dublin reported one of the highest rates of regular smoking, with 16 per cent of young people reporting daily smoking compared with 16 per cent in Bremen, 13 per cent in both Newcastle and Rome, and 11 per cent in Groningen.
- Pupils in Dublin reported the highest rate of regular alcohol consumption, with 16 per cent reporting regular use of alcohol, compared with 15 per cent in Newcastle, 9 per cent in Groningen, 2 per cent in both Bremen and Rome. Dublin youth reported one of the lowest rates of abstinence from alcohol, and reported drinking more on an average drinking session than young people in the other cities.
- Dublin youth reported the highest rates of cannabis use. Twenty-eight per cent of pupils in Dublin reported having used cannabis either in the last year or the last month, compared with 27 per cent in Newcastle, 21 per cent in Bremen, 15 per cent in Groningen and 11 per cent in Rome. Dublin youth also reported the lowest age of first use of cannabis, and one of the highest rates of use of illicit drugs other than cannabis, with use of inhalants being particularly high in comparison to the other cities.
- Availability of illegal substances was highest in Dublin. Sixty per cent of pupils in Dublin had been offered an illicit substance, compared with 44 per cent in Newcastle, 43 per cent in Bremen, 37 per cent in Rome and 35 per cent in Groningen.
- Dublin youth reported the highest rates of graffiti writing, vandalism, public nuisance, fighting in public and persistent criminality. Rates of fighting in public and causing a public nuisance were twice as high as those in the other cities.

Attitude to and feelings towards substance use

It is useful to look at how young people themselves perceive substance use. For example, the results show that young people do not see cannabis use as a dangerous activity: indeed it is seen in a more favourable light than the use of cigarettes. This points to the discrepancy between the message adopted by many prevention programmes that ‘all drugs are evil’ and the adolescents’ own perception of drugs and drug use. In light of both the level of substance use and young people’s perception of such use, there is a clear need for a harm-reduction element in prevention strategies.
Pupils’ perceptions of the consequences of alcohol use are particularly striking, and show that young people have a very positive attitude to alcohol.

POSTMODERNISM AND POPULAR CULTURE

Parker et al. (1995) point out that the use of illicit drugs has become internalised or integrated into ‘official’ youth culture, and argues that this is shown by the way that youth magazines, music, fashion markets and popular language have incorporated drugs. It seems that drug culture is no longer a subculture but has been assimilated into popular culture. Advertisements are increasingly using drug-related imagery to sell their products. There was concern recently about the popularity of ‘heroin chic’ in the fashion world. There has also been a spate of popular books, movies and television shows that depict the drugs lifestyle.

Parker et al. also point to the collapse of distinctions between legal and illegal psychoactive markets, and relates this to postmodernism. Brinkley et al.'s (1998) study found a strong relation between the use of legal and illegal substances. Legal substances are being marketed using drug-related language and imagery in both advertisements and packaging. Not only are drugs becoming increasingly available, but marketing techniques are becoming more sophisticated. Concern has recently been expressed about the marketing of 'party packs' that contain an ecstasy tablet, a small amount of heroin to allow users to 'come down' from the effects of the ecstasy, and alcohol.

Chapter 6

READING PROBLEMS, ATTENTION DEFICIT HYPERACTIVITY DISORDER, AUTISM, EMOTIONAL PROBLEMS, EATING PROBLEMS AND TREATMENT.

Michael Fitzgerald

READING AND BEHAVIOUR PROBLEMS

It is interesting that a child is more likely to have a psychiatric disorder if there is a low reading score or a low score on IQ testing. In an Irish study of 2,029 10- and 11-year-olds, a quarter of the children were reading at 18 months behind chronological age; however, 36.8 per cent of children in disadvantaged schools were reading at this level. This is almost three times the level found in children in advantaged schools (13.7 per cent) (Jeffers and Fitzgerald, 1991). Significantly more males (8.1 per cent) than females (4 per cent) received the impaired reading grade. Of boys, 27.2 per cent were 18 months behind; the figure for girls was 22.4 per cent.

Graham et al. (1999) have noted that:

There is a strong link between conduct disorder and educational failure, especially specific retardation in reading ability. It is probable that many children who fail in school become discouraged and low in self-esteem, and take to delinquency to obtain rewards they are missing elsewhere. It is also possible that underlying personality factors such as impulsiveness and excitability both impede learning and predispose to aggressive and antisocial behaviour.

It is critical that children have a full child psychiatric and educational psychological assessment, and that attention deficit hyperactivity disorder, autism, mild mental retardation or specific reading difficulties be identified if they are present. A speech and language assessment is also necessary if there are any speech and language problems. Only then can the proper intervention be undertaken and the inappropriate blame of pupils by teachers and parents stop. In turn, then and only then can improvements occur in the child's self-esteem, academic performance and behaviour.

GENETIC FACTORS

There is an Irish saying 'treise duchas ná oiliunt' (heredity is stronger than rearing). In the past 20 years the importance ascribed to genetic factors in the aetiology of psychiatric disorder has increased dramatically. It has been pointed out that there is now 'extensive evidence that many associations previously attributed to environmental influences are at least partly genetically mediated' (Rutter et al., 1998). This reflects the shift from vague sociological theories. The social work profession has a very poor understanding of psychopathology and scientific research.

Matt Ridley (Daily Telegraph, 9 March 2003, p. 18) points out that 'genes are at the root of nurture as well as nature, and they make culture and language possible …

despite similarities with chimpanzees, humans are genetically programmed to learn a language and its culture'. It was Francis Galton, over 225 years ago, that first used the phrase 'nature and nurture'. The issue is not nature versus nurture, however, but nature and nurture. There may be a genetic predisposition to a condition, but a suitable environment will be required in order for it to manifest. (Of course this is not necessarily the case with highly heritable conditions such as autism (~93 per cent heritability), which will probably manifest whatever the environment.)

As Michel Rutter (2001) points out, the categorisation of genes into 'good' and 'bad' is quite misleading. Many genes have rather varied effects on several functions, and these may include both adaptive and maladaptive consequences. For example, an anxious, emotionally hyper-responsive temperament constitutes a risk for anxiety disorders, but a protection against antisocial behaviour. Rutter concludes that 'whether or not a particular genetic susceptibility will actually lead to a disease will depend in part on environmental risks. Not only are the risks probabilistic, but they are also contingent upon circumstances.' He also discusses the human genome, describing it as 'the book of life'. However, it is 'a book in which we have identified all the words, and how they fit together, but we have little notion as to the meaning of the words' (Rutter, 2001, pp. 232–5).

CHILD AND ADULT ATTENTION DEFICIT HYPERACTIVITY DISORDER

In children, attention deficit hyperactivity disorder (ADHD) is characterised by inattentiveness and poor concentration in class, tasks not being completed, avoidance of homework, and poor memory, including being generally forgetful and losing things. It also has hyperactive–impulsive elements including being always 'on the go', being restless, leaving one's seat in the classroom, climbing excessively, butting into conversations and generally interrupting. Some persons mainly have inattentiveness problems; others have hyperactive–impulsive problems; a third group have combinations of the two. In up to about 60 per cent of children with ADHD, problems persist into adulthood.

ADHD causes enormous stress to the child himself/herself, to the family, to the school, and to society generally. It is not caused by watching too much television or by the pace of modern life. Genetic factors play a major role in its aetiology.

COMORBID DISORDERS

The most common comorbid (i.e. accompanying) disorders include oppositional conduct (temper tantrums, argumentativeness, deliberately annoying people, etc.), mood disorders and anxiety disorders. When one follows the lifetime trajectory of children diagnosed with ADHD, one finds a number of comorbid problems including oppositional defiant disorder (ODD) in up to 60 per cent, conduct disorder in up to 45 per cent, criminal behaviour in up to 25 per cent, and emotional, depressive, anxiety and personality disorders in up to 40 per cent. They are also more likely to have road traffic accidents and to commit speeding offences. Curran and Fitzgerald (1999) found rates in an Irish prison population that were much higher than in the general population.

ADHD causes great distress to the child himself or herself, in that it gives rise to low self-esteem and gives the child the experience of academic failure and, often, of dropping out of school. Peers tend to shun children with ADHD because of their impulsivity. If it remains untreated in adolescence, drug abuse and delinquency, up to

the level of criminal behaviour and imprisonment, can result. This very poor outcome tends to occur only in those that are untreated or have a more severe form of the disorder.

PSYCHOLOGY

ADHD is characterised by rapid premature response to stimuli, an aversion to delay, and a preference for rapid actions and immediate gratification. In reading a book, a person with ADHD will inspect a sentence for a shorter period than a person without ADHD. They also show evidence of problem-solving deficits, poor planning, and poor working memory. They have diminished frontal lobe functioning of the brain.

AETIOLOGY

The exact cause of ADHD is unknown. However, ADHD is one of the neuropsychiatric disorders with the most evidence for a genetic aetiology, with heritability ranging from 50 to 90 per cent.

Simply to blame the parents, as happened for much of the second half of the twentieth century, is very unfair and unhelpful. This happened more with professionals who took the family therapy approach or the psychoanalytic psychotherapy approach. The theories they operated with were rather simplistic in blaming the parents or the family dynamics and not taking account of the complexity of the situation. By 'complexity' I mean genes and the temperament of children.

MANAGEMENT OF ADHD IN CHILDHOOD AND ADOLESCENCE

Early intervention is of critical importance. If ADHD is left untreated and a high level of negative emotion is expressed in the family and at school – i.e. school suspensions, punishment by teachers, ostracisation by other pupils – the outcome can be negative as the child gets older, with increasing conduct disorder, depression, delinquency, substance abuse and antisocial personality disorder.

Children with severe ADHD or with very difficult temperaments are not liked by either peers or adults, including teachers and parents, who react negatively to them. This leads to their developing a great sense of injustice, to diminishing self-esteem and self-confidence, to a negative self-image and to a sense of hurt that leads to further aggression. Indeed, I have often seen patients with severe ADHD who, when treated with medication, evoke much more positive reactions from peers and adults in their environment because of the reduction of their ADHD symptoms.

The most serious diagnostic error at present is to miss ADHD diagnosis when conduct disorder is also present. This means that the ADHD is not treated and the person could later end up in prison. McArdle et al. (2002b) point out that 'most apparent cases of conduct disorder are in fact hybrid conditions including symptoms of hyperactivity and true conduct disorder. True conduct disorder should be diagnosed not only by positive symptomatology but also by absence of hyperactivity symptoms.'

The combined approaches of psychological and pharmacological treatments were better at dealing with oppositional and aggressive symptoms. In a large-scale study in the USA, combined medication and psychological treatments of the core symptoms of ADHD were no less effective than treatment with medication alone.

TREATMENT

Children with ADHD should sit at the front of the class, beside a child who has good concentration and away from distraction; the same quiet environment should be

present during study time at home. The outcome is determined to a considerable extent by levels of criticism at home and at school. If the level of criticism is high, then the outcome is much poorer.
Young children in primary school should be given rewards or points each day by the teacher for staying in their seat, completing homework, having their desk tidy, etc. A home programme of reward systems for doing homework, not hitting siblings, etc. is also often helpful, and can be negotiated with the child or adolescent.

MEDICATION

Two groups of drugs are prescribed: those that are licensed, such as Ritalin, and those that are not licensed, such as Clonidine. Unlicensed drugs are commonly used throughout the world and often have major beneficial effects on children. These medications tend to be used in more complex situations. 'Unlicensed' means that the pharmaceutical company has not approached the governmental licensing board for a licence. They are used by doctors in the same way as licensed drugs, and will have many publications for their use throughout the world.
Methylphenidate (Ritalin) is the most common drug used to treat ADHD at present. This is a stimulant drug that has been around for many years. It is safe, but of course it has to be monitored, and is not without side-effects. Common side-effects include insomnia, decreased appetite, irritability or gastrointestinal disturbances. Less common side-effects include depression, dizziness, lethargy and fatigue. A new once-daily methylphenidate called Concerta is available, and is becoming more popular.
A new drug, Atomexitine, is the first non-stimulant medication available for the treatment of ADHD. In Ireland it is available on a named patient basis, but it is licensed for children and adults in the USA, where over a million persons have been prescribed it. Because ADHD is often associated with ODD, which is characterised by temper tantrums, blaming others for mistakes, and general negativistic behaviour, sometimes Clonidine has to be added. Clonidine was originally prescribed as an anti-hypertensive medication, and requires monitoring with ECG and specialist follow-up. It has to be stopped slowly because there is a risk of rebound hypertension.
Another medication that is sometimes used is Risperidone. This is licensed for children with learning disability and for psychotic conditions. It is sometimes necessary to use it in very severe cases of ADHD and ODD, or more severe conduct disorder.

CONSEQUENCES OF ADHD

If people with ADHD can survive adolescence in school without tremendously negative effects arising from criticism and rejection, they can potentially be very successful in later life, like John Lennon, who had ADHD and ODD. Lennon had a capacity for tactlessness and aggression, and showed evidence of restlessness, novelty-seeking and rebelliousness (Coleman, 2000). He was not a good student: he was anti-authority, and found education extremely boring. He was highly disruptive in class, worked erratically, was forgetful and was constantly losing things. He was impulsive, moody and hyperactive, and had severe temper tantrums. His performance put him at the bottom of the class, and he truanted. In adult life he was promiscuous and abused drugs and alcohol. Because of his poor concentration, he was not a safe driver.
On the positive side, Lennon had a great imagination and the capacity to hyper-focus on what interested him. He also had the heart of gold that is typical of persons with

ADHD, and the creative energy typical of artists of genius. His music saved him from the life of a drifter.

The consequences of untreated ADHD are very great, including school failure, school drop-out, drug abuse, delinquency, and other criminal behaviour. It is imperative, then, that it be recognised early: it is often evident at the age of three or four. Medications such as dexamphetamine are licensed from the age of three. Others showed the consequences of Attention Deficit Hyperactivity Disorder were Kurt Cobain, Lord Byron, Richard Brinsley Sheridan, and Oscar Wilde.

AUTISM AND ASPERGER'S SYNDROME

Autism is a condition that shows itself early in life when a child may stop babbling, be thought to be deaf, not respond to its name, toe-walk, show lack of eye contact, have poor peer relations, show lack of ability to point jointly with the parent or to share, have a delay in language development, be obsessed with lining up cars or trains, and have 'preservation of sameness'. The term 'Asperger's syndrome' is often used for persons with higher IQ and these features. The National Autistic Society (2001) in the United Kingdom estimated the total number of people with autism spectrum disorders as 91 per 100,000; this ratio would give us about 35,000 in the Republic of Ireland. These disorders are approximately eight to ten times more common in boys than in girls.

Doherty et al. (2003) have shown that this is a lifelong condition and that there are major effects on caregivers, with psychological stress in parents, interference with family leisure, increased expenditure by families, social isolation of the family, problems getting babysitters, etc. Children and adolescents with these conditions need social skills training and behavioural interventions (e.g. a reward for socially appropriate behaviour, programmes aimed at improving the children's understanding of other minds, training in understanding emotions and reading the non-verbal behaviour of other people, as well as specialised educational programmes for persons with autism spectrum disorders). These are often given in a special class in the mainstream school.

Persons with Asperger's syndrome are often in mainstream classes but will need extra educational input including resource teaching and special help in dealing with playgroup activities, where they tend to have the greatest difficulty and are often bullied. Persons with Asperger's syndrome can also show special talents, particularly in engineering and mathematics.

The key to correct diagnosis of any developmental disorder is a clear early developmental history. A multidisciplinary approach (comprising neurological, speech and language, and educational viewpoints) is essential if confused partial diagnoses are to be avoided (Fitzgerald and Corvin, 2001). It is of note that W. B. Yeats, President Eamon de Valera, Einstein, and Lewis Carroll had Asperger's syndrome.

SUPPORT FOR PEOPLE WITH AUTISM AND THEIR FAMILIES

As Doherty et al (2003) have pointed out, the vast majority of individuals with autism will require lifelong care studies have shown that parents find it more difficult to cope as their son or daughter with autism grows older, and have greater need for expanded services.

With the young autistic child, the unrelenting care-giving demands are the main source of stress for parents; later, behaviour management, self-help skills training, and appropriate school placement emerge as stressors. As the individual with autism

reaches adolescence and adulthood, behavioural problems are often exacerbated as the person increases in size and strength, and the discrepancy between sexual and social maturity becomes apparent. Stigma may therefore become more pronounced, as society will see the behavioural anomalies typical of autism as far less acceptable in a fully-grown adult than in a child. Cumulative stress effects may lead to psychological 'burnout' for some parents, especially as they come to realise that their adult son or daughter has progressed as far as potential allows.

The chronic difficulties inherent in being a 'perpetual parent' lead most to opt for professional help in caring for their child. An adaptable service responding to the changing needs of the individual with autism can make the difference between coping and not coping with these difficulties.

Most autistic adults will eventually need full-time residential care. Accepting this can be a cause of great distress to many parents, who may struggle with feelings of failure and guilt.

SERVICES FOR AUTISM IN IRELAND

Education is by far the most powerful source of improvement for individuals with autism. The importance of quality service provision cannot be overstated. Individualised specialist education for children with autism is now being provided in mainstream schools in Ireland. The provision of this education in an integrated setting may, in the long term, prove to be a valuable step forward.

The Department of Health Report on Services for Persons with Autism (1994) specifies that services should:

1 be specific to the triad of impairments characterising autism [social interaction, communication, imagination]
2 be tailored to individual needs
3 involve parents as partners
4 be localised.

Also, staff working with individuals with autism should be trained and knowledgeable about autism, and should be supported by multidisciplinary teams representing areas of knowledge including psychiatry, psychology, speech and language therapy, and social work.

The report recommends that an individual education plan (IEP) based on multidisciplinary assessment be drawn up for each client immediately after diagnosis. It suggests that services for people with autism should be sufficiently wide-ranging to encompass all developmental levels from infancy to adulthood, and all levels of disability from mild to severe.

The report goes on to stress that support for the family should be an integral part of any treatment plan, and that parents should be involved in treatment from the start. Regular respite care and home support are advocated in order to alleviate the burden of care on families. Finally, the report recommends special attention for adolescents with autism, including family support and forward planning to ensure that the transition from school to adult services proceeds smoothly.

STUDY OF EFFECTS ON FAMILIES

A study of the psychosocial effects on the families of 100 individuals with autism in Dublin and Kildare was started in 1991. The results were published in 1997. A further study (Doherty et al., 2003) followed up 85 of the 100 participants. The participants with autism in the latter study ranged in age from eight to 33 years; 66 were male and

19 female. Thirty-six lived at home, and 49 in residential care (of whom 27 were in residential care for persons with autism).

Only 26 per cent of the primary caregivers surveyed reported satisfaction with their opportunities for leisure. One-third reported minor difficulties, and 43 per cent had marked or severe difficulties in finding opportunities for leisure. Fifty-one per cent of caregivers reported that their social contact was adequate; 19 per cent reported minor difficulties and 31 per cent felt that the extent of their social contacts was markedly or severely inadequate. However, although two-thirds of services provided respite care to clients, only half of caregivers availed of this. Most caregivers did not express a need for more respite care.

A number of caregivers volunteered information about their psychological health. Five female and three male parents had suffered psychological problems; these included recurrent panic attacks, depression and alcoholism. Seventy-nine per cent of caregivers did not attend a support group. Of these, 37 per cent said that they would like to attend a support group and 63 per cent said that they would not.

Most caregivers felt that the participant's disability had had a severe (28 per cent) or a moderate (30 per cent) effect on siblings. Only 12 per cent felt that it had had no effect on siblings. A small number of caregivers noted psychological and behavioural difficulties in their other children that they believed were related to the experience of having a sibling with autism. Only 2 per cent of siblings attended a support group; according to their parents, 76 per cent of siblings did not want to. Nine per cent of parents did not know the siblings' feelings on the issue.

In terms of social support, one-third of caregivers felt that they had some support from their family in the care of their disabled son/daughter, and a further third felt 'very supported' by their family. With regard to practical help, 61 per cent of caregivers reported that family members never or rarely looked after the person with autism to give them a break.

Thirty-nine per cent felt some support from friends, and 20 per cent felt very supported by friends. In 77 per cent of cases, friends never looked after the person with autism. Only 1 per cent had a friend who regularly took care of their son or daughter with autism. Many caregivers mentioned that they would not expect friends to look after the person with autism because 'they wouldn't be able to cope with him' or 'it's not their job, it's mine'.

DISCUSSION

The study's findings have clear implications for future service provision. The Department of Health (1994) recommendations need to be consistently implemented, with standardised individual assessment and planning for all clients, regardless of age. A standard education programme for autism is needed to ensure that the wide-ranging needs of these individuals are consistently met. The views expressed by caregivers provide valuable pointers on the road to improvement. Although there has been great progress in the relationship between parents and professionals, the desire for more parental involvement indicates that more work is needed in this area, i.e. there is a need for more partnership between parents and staff in the care and education of individuals with autism. This may encourage parents to share the responsibilities that they currently feel are theirs to shoulder alone. Previous studies have emphasised the value of parents as co-therapists (Schopler and Mesibov, 1994). This allows for an interchange of resources, knowledge and skills between staff and parents, as well as ensuring a continuum in the care and education of the individual with autism. A move

towards ‘parents as parents’ is clearly desirable. Also, improved staff training and education, particularly in heterogeneous services, is essential.

The fact that many caregivers chose not to avail of respite care, while reporting dissatisfaction with their opportunities for leisure, reflects the unwillingness of some caregivers to accept help even when help is warranted. This has also been found in previous studies (Holmes and Carr, 1991).

Parents’ worries about continuity of service provision and future care for their son/daughter with autism need to be addressed: service providers must recognise that adequate service provision is a life-long need for most individuals with autism, and one that must be tackled early in the individual’s life.

The findings regarding siblings warrant future research. Is the tiny number of siblings attending support groups attributable to the lack of sibling support groups provided by services, or are parents unwilling to ‘pathologise’ normally developing siblings by encouraging attendance at a support group? Knowledge of siblings’ own views regarding support groups would provide some guidance here. Most parents were not attending a support group themselves, so perhaps parental and sibling attitudes to support groups would be a fruitful area of further enquiry.

The level of participants that had not received a clinical diagnosis clearly needs to be addressed. An essential prerequisite of adequate service provision is a definite diagnosis, which delineates the child’s unique abilities, disabilities and specific service needs.

Doherty et al. (2003, p. 162) highlight the potential value of individualised family service plans (IFSPs) co-developed by caregivers and staff. The IFSP should contain:

- a statement of the child’s current level of development, based on objective assessment
- a statement of the family’s resources, priorities, and concerns for enhancing the child’s development
- a statement of the major outcomes expected to be achieved for the child and family
- a statement of the steps to be taken to support the transition of the child from home to school, and onwards to adult services.

Doherty et al. (2003, p. 162) recommend the use of the Wing Autistic Disorder Interview Checklist (WADIC) (Wing, 1996) in future research.

EMOTIONAL PROBLEMS, EATING PROBLEMS, SUICIDAL BEHAVIOUR AND PSYCHOTHERAPEUTIC TREATMENT

Anxiety Disorders

Factors associated with anxiety include genetic factors, family disharmony, coercive and harsh parental criticism, and traumatic events. Dynamic, behavioural or family psychotherapies, or medications such as Sertraline, may be helpful.

Obsessive-compulsive disorder is an anxiety disorder characterised by intrusive repetitive thought or compulsive actions, like checking or hand-washing a fixed number of times. Behaviour therapy, including response prevention rewards for not engaging in rituals, may be helpful; medications such as Sertraline may sometimes be necessary.

Post-traumatic stress disorder (PTSD) happens after a traumatic event, and shows evidence of the traumatic event being re-experienced: frightening dreams; lack of interest in daily activities with a feeling of detachment from others; sleep difficulties; irritability; difficulty in concentrating; hyper-vigilance, and exaggerated startle

response. Irish studies have focused on road traffic accidents and the effects of the Omagh bomb (O'Brien et al., 1999; McDermott et al., 2003). O'Brien et al. (2003) found that after a road traffic accident a higher percentage of those at risk for PTSD had experienced personal threat, i.e. believed they were going to die.

By December 1997, 3,585 people had been killed in the Northern Ireland conflict and over 40,000 injured (Fay et al., 1999). Young people have always been among those at greatest risk, with those aged 19–20 having the highest death rate for any age group. The death rate steadily rises with increasing age from birth, substantially so from 12 to 14 years, with 257 deaths having occurred in the under-17 year age group.

McGrath and Wilson (1985) reported that 20 per cent of 10–11-year-old children in Northern Ireland had been in or in close proximity to a bomb explosion. In addition, just over 20 per cent experienced the injury or death of a friend or relative, while 12 per cent felt that the area they lived in was unsafe.

On Saturday, 15 August 1998 the largest single atrocity of the Northern Ireland conflict took place in Omagh, a market town with a population of 26,000. At 3.10 p.m., a bomb exploded in the town centre. Twenty-nine people, in addition to two unborn children (twins), were killed; 382 were injured and 135 were hospitalised. Twenty-six families were bereaved. Of those killed, the youngest was one year old, one was aged eight years and 12 were aged 17 or under.

McDermott et al. (2001) showed that 45 per cent of 8–13 year old boys reported higher levels of PTSD than girls (49 per cent). In the 14–18 years age group, males reported higher levels than females (89 per cent compared to 79 per cent).

As expected, children with direct and indirect exposure to the bomb reported higher levels of distress than those not exposed. The more direct the exposure, the higher the level of distress. Girls reported more difficulty with intrusive memories than boys. Various forms of psychotherapy, including cognitive behaviour therapy, dialectic psychotherapy, eye movement desensitisation and reprocessing interventions, can be helpful.

Depression

In the study of 2,029 fourth-class primary-school children mentioned above (Jeffers and Fitzgerald, 1991), 2 per cent were definitely miserable and 3 per cent were definitely apathetic. In terms of gender differences, 2.5 per cent of the girls and 1.6 per cent of the boys were definitely miserable. For depression there is no difference between the sexes before puberty, but adolescent girls outnumber boys by about 2 to 1 (Jeffers and Fitzgerald, 1991).

Brown et al. (1990) looked at psychological stress in 130 Irish female adolescents (average age, 16 years). They found that 4 per cent of the sample scored on the depressed subscale of the Youth Self Report Questionnaire. When they looked at individual items they found that 34 per cent of adolescents said it was sometimes true that they cried a lot, and 11 per cent said it was often true. 43 per cent said that it was sometimes true that their moods or feelings changed suddenly; 29 per cent said that this was often true. 22 per cent said it was sometimes true that they thought about killing themselves; 7 per cent said this was often true. 51 per cent said that it was sometimes true that they were unhappy, sad or depressed; 10 per cent said this was often true.

Fitzgerald et al. (1994a) carried out a five-year follow-up study of depressed children. They found that the children or adolescents who were depressed in 1984 and under the age of 16 in 1989 had a 50 per cent chance of being depressed in 1989. Children who were not depressed in 1984 had a 12 per cent chance 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. 44 per cent of the mothers were depressed in 1984, and 15 per cent at follow-up. Mother's depression at follow-up increased the likelihood that the child would be depressed at follow-up.

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.

Factors associated with depression include bullying, family stress, coercive parenting, genetic factors, loss experiences including death and divorce of parents, and significant deprivation and poverty. Treatments include psychotherapy (dynamic, behavioural/cognitive), family therapy and antidepressants.

Abnormal Attitudes to Eating, Anorexia Nervosa and Obesity

In an Irish study using the Eating Attitude Questionnaire (Fitzgerald and Horgan, 1991a), 13 per cent of a sample (n = 50) of 16-year-old female adolescents showed evidence of abnormal eating attitudes. Eleven per cent admitted to dieting; 7 per cent to exercising strenuously to burn off calories; 11 per cent to avoiding foods with high carbohydrate content; 15 per cent described eating binges with feelings of loss of control; 4 per cent used laxatives; 17 per cent felt that food controlled their lives; and 18 per cent admitted to feeling anxious in relation to eating.

In a study of 197 Irish 16-year-old boys (Halpin and Fitzgerald, 1992), two showed evidence of abnormal eating attitudes. Three out of 107 boys showed excessive concern about being fat on the Body Shape Questionnaire.

An Irish Times/TNSmrbi Youth Poll (20 September 2003, p. 1) found that 'some 42 per cent of young females say they are always trying to lose weight, with more than half of them knowing someone with an eating disorder such as bulimia or anorexia'.

Anorexia Nervosa

As evidence of an eating disorder, the Diagnostic and Statistic Manual IV (American Psychiatric Association, 2000) identifies:

1. refusal to maintain body weight
2. intense fear of gaining weight
3. disturbance in the experience of body weight, size or shape
4. primary or secondary amenorrhoea.

Bulimia nervosa is characterised by a preoccupation with eating and a craving for food. Self-induced vomiting follows overeating binges. This tends to commence in late adolescence.

The great majority of persons with anorexia nervosa developed the condition between 14 and 19 years of age. Early onset anorexia nervosa has been shown to have an onset from 7.7 years to 13.7 years. The onset can be sudden or gradual. Sometimes there is a precipitating event; sometimes a chance remark to an isolated girl about her appearance and need to lose weight can start the process. The media's emphasis on shyness plays a part.

Initially anorexia can be rather hidden, and indeed the girl can present to her GP with constipation or amenorrhoea. Gradually it becomes more evident, and family conflict becomes more intense. Girls may use purgatives, appetite suppressants, or self-induced vomiting. Others over-exercise grossly.

Outpatient treatment should be tried first unless the situation is very severe and the person is severely depressed or suicidal, in which case inpatient treatment is required. Treatment such as chlorpromazine can be used. Antidepressants are also sometimes needed if the person is depressed.

Initially they require a firm approach to weight gain. A target weight should be set between 90 and 110 per cent of the mean weight for the patient's height and age. They would be expected to gain 1.5–2 kg per week. As treatment progresses, family therapy and individual therapy are required. There is some evidence that family therapy is better for the younger patient and individual therapy for the slightly older patient. One-third make a full recovery, one-third make a reasonable recovery but remain preoccupied with appearance, and one-third run a more chronic course. About 5 per cent commit suicide. Anorexia is a condition with a potentially fatal outcome, and therefore has to be taken very seriously. Clearly the stress on the family is enormous.

Obesity

Obesity is a major problem in Irish children (and adults). It has major health implications. The Medical Director of VHI Health Care has described the issue of childhood obesity in Ireland as a health 'time bomb', and said that problems were being stored up for future healthcare provision (Medicine Weekly, 24 September 2003, p. 6). A recent study has shown that the average Irish school child eats 50 per cent less fresh fruit and vegetables than they did five years ago, and that they spent 15 hours per week watching television.

According to Roche (2003), childhood obesity presents long-term health risks, particularly cardiovascular. She also notes that type 2 diabetes is increasingly evident in childhood and adolescents. She notes the psychological effects of childhood obesity, including problems in peer interaction, bullying, and low self-esteem. It is certainly increasing in prevalence.

Obese children are more likely to become obese adults. Preventive interventions such as the promotion of healthy lifestyle practices are critical. These will include healthy eating practices and exercise. Roche also points out that there is a global epidemic of obesity, with approximately 22 million children under five years of age worldwide being overweight. She notes a United Kingdom study which showed that more than one-third of six-year-olds, and almost half of 15-year-olds, were considered to be overweight or obese.

Therapeutic Interventions with Children

A number of psychotherapeutic interventions can be helpful with children and adolescents. These include child psychoanalytic psychotherapy, which focuses on helping children to understand themselves, understand their dreams, understand the traumas of life that have afflicted them, and take control of their lives.

Lacanian psychoanalysis is a controversial form that is beyond the scope of this book. The more tradition form of psychoanalysis aims to give the patient an empathic understanding of themselves. For young children play is central to analytic psychotherapy; it is through play that they externalise their conflicts. Children that can benefit from these treatments include those who have been abused, those with conduct or aggression problems, anxiety, parasuicide, depression, psychosomatic symptoms, separation and loss, and children of divorced couples. Fonagy and Target (1996), in a study of 763 cases, show child psychoanalysis to be 'particularly effective

for seriously disturbed children under 12 years suffering from a variety of psychiatric disorders, particularly those which involve anxiety'.

Influence of Gender on Child Psychiatric Problems

In the Middle Ages, Paulo of Ceraldo recommended: 'Nourish the sons well. How you nourish the daughter does not matter as long as you keep her alive.' Unfortunately, these ideas long outlived the Middle Ages.

Many childhood problems are more common in males: autism, attention deficit hyperactivity disorder, conduct disorder, etc. A new book (Fitzgerald, 2004) demonstrates a link between autism in males and exceptional ability. Baron-Cohen (2003) discusses whether females show better social skill and males are better systematisers, engineers, etc. Chromosomal, hormonal, and societal factors play a role in gender differences.

Behavioural and emotional problems tend to reach an almost equal ratio between male and female in pre-teenage years; there is then a shift to the more adult pattern whereby psychological disorders are more common in females. One study of Irish adolescents found a non-significant difference between males and females in psychological stress at the age of 15 (Williams et al., 1989).

Chapter 7

SOCIAL LINKAGE, DISCONNECTION AND POVERTY

Michael Fitzgerald

The issue of disconnection is important in relation to the pressure points on Irish families. The disconnected lack a feeling of connection to their true selves and to the society to which they belong. They do not feel part of a community, but are lonely individuals in a crowd.

Nowadays many people feel disconnected from nature and live in overcrowded, deprived, urban housing estates a long way from their roots. The disconnection is aggravated by a fall-off in religious practice, which means that more people are becoming disconnected from group religious practices that gave them a sense of solidarity with their community in the past. This is very much part of current Ireland. People's connections with their fellow human beings are now based more on financial transactions than on any deeper commitment to the needs of human beings for one other.

In Irish cities today there is increased anomie. The lower-paid and unemployed appeared to be increasingly vulnerable to the psychologically toxic aspects of our cities. Social forces, particularly in cities, are in favour of individualism, competitiveness and self-interest, which make people feel alone, unattached and uncared for as human beings. There is even a political party that fosters these social forces – 'greed is good'.

Economists, technologists and advertising agencies now define 'true value'. In Ireland, an example is 'A credit card is all you need'. This is the geist or spirit of our age, 'the age of narcissism' and 'the age of the schizoid', with the concept of reciprocity being absent. What the disconnected really need is to be given a sense of belonging to a community. Indeed, some of the rich are also disconnected, with high walls around their houses 'in their own grounds' and their obsession with materialism and consumerism, which only increases their sense of emptiness and futility. They don't understand Durkheim's point that the true 'spirit' of human life is 'the spirit of collectivity'.

Unfortunately, in the early years of the twenty-first century, people's needs and wants are being defined by advertising agencies in terms of consumer goods. The advertisers offer people 'masks' or 'personae' which have been chosen by the dominant commercial interests. Equally unfortunately, Irish people often conform to the wishes or models the advertising agencies offer. These are empty promises and offer poor 'sustenance' to the individual.

THE NEEDS OF PEOPLE

Martin Luther King stated: 'I have the audacity to believe that people everywhere can have three meals a day for their bodies, education and culture for their minds and dignity, equality and freedom for their spirits' (Scally, 2003, p. 67). If Martin Luther King were alive and he visited Ireland today, he certainly would not find these

aspirations fulfilled. He would observe homelessness, a very large number of citizens unable to read, and a highly divided society.

Of course, this lamentation over disconnection is nothing new. Edmund Burke put it so well: 'To be attached to the subdivision, to love the little platoon we belong to in society, is the first principle (the germ as it were) of public affections. It is the first link in the series by which we proceed towards a love to our country, and to mankind.' For Burke, 'the age of chivalry is gone. That of sophisters, economists, and calculators, has succeeded.' The 'calculators' do not realise the preservative power of strong group attachment. The current Irish government is a government of 'calculators'.

The psychologically toxic aspects of cities was well recognised by Rousseau in the eighteenth century, and what he said is still very relevant to disadvantaged urban areas today. According to Rousseau, men 'are made not to be crowded into anthills but to be dispersed over the earth which they should cultivate. The more they come together, the more they are corrupted – man is, of all the animals, the one who can least live in herds.'

Rousseau stated that cities 'are the abyss of human species' and that 'the young people, exhausted early, remain small, weak, and ill formed'. Rousseau was also correct when he stated that private self-interest should be subordinated to the good of society as a whole. Many people feel that once they have paid their taxes and given money to charity, they have no further responsibility; that they have fulfilled the duties of 'the age of calculators'. It is unfortunate that they feel they have no responsibility to connect with human beings; to reach out to the alienated and disconnected.

Another form of disconnection – a disconnection from social institutions, objects and ideas such as society, country and collective sentiment – was called 'egoistic' by Durkheim. In Durkheim's (1897) study of suicide he pointed out that in times of dislocation, stress and anxiety the person finds himself without group support and is likely to take his own life out of desperation.

Durkheim's studies on anomie (i.e. when the controlling normative structure of society is disorganised and the individual begins to feel disoriented and that his life is meaningless) are still enormously relevant. The anomic 'normless' factor operates where the social norms are upset by rapid change in the interior of society, and this has happened in Ireland. Durkheim felt that there was a relationship between poverty and suicide, as 'the means for accustomed ends are gone'. There has been increased anomie in Ireland over the past 40 years, i.e. a weakening and disrupting of the 'conscience collective' – the system of social norms that reflected the commonality of beliefs, sentiment and feeling in the society. There has also been a weakening of social solidarity, particularly in the new towns. It is possible that, with the decline of religion, there are fewer religious beliefs and rites to bind the society together, and it is worth noting Durkheim's (1915) observation that 'religion is something essentially social'. The church traditionally met people's needs for consolation; with the decline of religious participation, the fulfilment of this need has passed to the wider community. While various voluntary agencies, counsellors and therapists are attempting to fulfil this need, they are but 'a drop in the ocean' in terms of what is needed. (On the other hand, religious practitioners are often unable to be helpful, as is shown by the experience of parents of children with autism.)

In an Irish study by Coulthard and Fitzgerald (1999a), carers reported significantly more support from their personal beliefs than from organised religion. Formal churches to which they belonged did not help them cope, were rarely there as a

resource, and generally did not have an outreach to these isolated families. It could be that the clergy need to be educated as to the spiritual support they could give to such people in their parish communities. This might be just an occasional visit to acknowledge the existence of the child with autism in that family. Carers in this study who sought comfort in prayer had significantly better health than those who did not.

Now materialism and individualism are worshipped without balance ('greed is good'), and the importance of solidarity and social linkage is forgotten. Alexis de Tocqueville noted that there is a risk of an unsocial, alienated outcome if 'each man is forever thrown back on himself alone, and there is a danger that he may shut up in this solitude of his own heart'.

People disconnect themselves from other human beings because other human beings have hurt them, particularly in childhood. Children who have been hurt, abused, neglected, harshly parented do not develop basic trust early in life, and are more likely to become alienated adults and to fear social involvement. This is well described in Kafka's novels, where the people in authority are shown as arbitrary and unpredictable, impossible to figure out and impossible to find strategies of dealing with. This is how the current justice system must appear to adolescents being processed by it; in dealing with bureaucracy, the disadvantaged in general can sometimes still feel like that. It is well summarised in the opening sentence of The Trial: 'Someone must have been telling lies about Joseph K. for without having done anything wrong he was arrested one fine morning' (Kafka, 1925). As Bradbury (1988) points out, this novel 'seems to belong so centrally to our bleak experience of the modern world'. Citati's (1990) description of Kafka is an excellent description of an alienated man – 'he was surrounded by a "wall of glass". There he stayed behind the very transparent glass, walking gracefully, gesticulating, speaking.'

Albert Camus in The Rebel well described the search of man for connection: 'When the time of exile began, the endless search for justification, the aimless nostalgia, the most painful, the most heartbreaking questions, those of the heart which asks itself "Where can I feel at home?".' This sense of 'never feeling at home' is a situation in which alienated Irish 'urbanites' find themselves today. It is hardly surprising that there is such a high rate of youth suicide in Ireland today. W.H. Auden called the period after the Second World War 'the age of anxiety'. This is still relevant to our time. The anxiety now is less about nuclear obliteration than a result of disconnection and distress in life. People who have been hurt and who have disconnected from others have difficulty in trusting love, in allowing themselves to love and to be loved, and in so doing allowing themselves to connect again. In the first Epistle to the Corinthians, St Paul states 'I may speak in tongues of man or of angels, but if I am without love, I am as a sounding gong or a clanging cymbal. I may have the gift of prophecy, and know every hidden truth; I may have faith strong enough to move mountains; but if I have no love I am nothing. I may dole out all I possess, or even give my body to be burnt, but if I have no love I am none the better.'

The recent study undertaken by the Combat Poverty Agency, 'Against All Odds', found that some families were unable to engage in any activities outside their homes because of low incomes, lack of social supports and fear of crime: 'They rely on internal supports rather than social capital.' This is precisely the kind of background from which children are more likely to develop behavioural problems. There is little doubt that these families need the social capital that Kevin Johnson (2003) describes:

building social capital may well be a new term describing existing activity. However, if it recognises the importance of empowerment, engagement, accessibility, networks,

trust, resources, influence and citizenship, then it may make an important contribution to creating a more inclusive, equal, fair, supportive and inter-cultural society. If it is understood and accepted by politicians, social and economic analysts, the social partners and those working in local communities, then it may allow us all to move towards building a better society.

Building a better society from the point of view of children means making sure that families are not socially isolated and that they have sufficient finance to participate fully in our society.
Johnson has pointed out that:

building social capital has become common parlance and is used to refer a range of activities such as volunteering, sports clubs, peace building, political participation, informal social networks and to trust in others and institutions. This received currency through the work of Robert Putnam, who notes an increasing individualisation in society and a diminution of the importance of community. He puts forward concepts such as bonding (relationships within communities), bridging (relationships between communities), and linking (to resources and institutions). Social capital is seen as the 'glue' that holds networks together.

It is against a background of low 'social capital' that children of disadvantaged families are more likely to express behaviour problems.
Isolated families are in critical need of social support from their neighbours, from voluntary organisations and from professionals. Clearly mothers are more vulnerable to depression if they live at home with children and have very poor social supports. Over the years many housing estates were built in Dublin in rather isolated areas without services.

THE NEEDS OF OTHERS

One of the problems modern men and women have is in their definition of what true value is, and what they really need. As La Rochefoucauld said, 'there are few things we should keenly desire if we really knew what we wanted'. Clearly, everyone should have the basic necessities of food, housing, clothing and sexual outlets. Everybody also has a need for love, respect, honour, dignity and solidarity with others (Ignatieff, 1990). When people meet others' needs for these, there is a reduction in the sense of disconnection and an increase in the sense of belonging. If there is to be a further reduction in the sense of disconnection, people will have to be directly responsive to the needs of those they meet each day. Irish people will need to 'reconnect'. Then we will have a truly caring society, and not the kind of 'caring' offered by financial institutions when they are only interested in 'the bottom line' and how much profit they can make from us. There can be a decent life for people only if their basic survival needs are met, as well as their need for love, belonging, dignity and respect.
The extremely affluent in our society are also at risk of disconnection: Rousseau pointed out in his Second Discourse on Inequality that they enslave themselves in the upward spiral of their own needs, and that the privileged few gorge themselves with superfluities. This is very much the situation with the privileged few in Ireland and their right-wing political allies. They show the lack of sensitivity epitomised by the 'Let them eat cake' remark supposedly made by Marie-Antoinette on being told that the people had no bread.

Of course, we must also realise that being connected is by no means uncomplicated, and can bring many different stresses – 'squinting windows' and excessive dependency on people can have an equally detrimental outcome. These days, the 'squinting windows' of certain sections of the media have replaced the 'squinting windows' of neighbours.

For centuries there have been those who have argued against the values of commerce. Ayer (1990) offers grounds for hope, arguing that 'the average man is more humane, more pacific and more concerned with social justice than he was a century ago'. Ayer is absolutely correct when he states that 'it is normally incumbent upon humanists to do everything in their power to bring about the material and social conditions in which the great majority of people will have a fair opportunity of finding satisfaction in their lives'. This should be the responsibility of every man and woman, as well as the politicians. It is critical that people develop a 'fellow feeling' and greater cohesion than is the case at present. This seems to happen in times of war or during great sporting occasions like the World Cup, but does not survive these events. Ignatieff (1990) points out that 'the possibility of human solidarity rests on this idea of natural human identity. A society in which strangers would feel common belonging and mutual responsibility to each other depends on trust, and trust reposes in turn on the idea that beneath difference there is identity.'

THE POLITICS OF EXCLUSION

Current government parties are devoting their efforts to increasing the divisions in society, which occurred particularly during the 'Celtic Tiger'. Indeed in the eighteenth century Rousseau said that 'keeping citizens apart has become the first maxim of … politics'. In the twenty-first century the first maxim of politics should be to bring people together, for example by housing them closer to their connections, i.e. families or origins, and not in disconnected new towns. In recent years in Ireland, Fianna Fáil and the Progressive Democrats have followed Rousseau's maxim in 'keeping citizens apart' and dividing the society.

The democratic programme of the first Dáil in 1919 was correct when it stated that the first duty of the Government of the Republic would be 'to make provision for the physical, mental and spiritual well-being of the children'. Right-wing Irish governments have regarded this statement, and the aspiration in the 1916 proclamation to cherish all the children of the nation equally, as jokes. For the disadvantaged groups described by Lonergan (2003), the quote from W.B. Yeats comes to mind: 'things fall apart, the centre cannot hold', and families are left floundering without help or hope.

For several years the government has practised 'the politics of exclusion' to great electoral success. Unfortunately for people who are disadvantaged, have disabilities or are mentally ill, this is likely to remain a dominant political persuasion for some years to come.

A JUST SOCIETY WITH POVERTY?

As Gaffney (1992) has pointed out, 'Poverty creates sadness'. John Lonergan asks the question: 'Why do we support and sustain a system that pays one group in society €2,000 per day for their services [I assume he means lawyers] while at the other end of the social ladder we expect people on social welfare to live on as little as €100 per week?' (p. 68). He goes on to state that 'there is an appalling lack of respect for the person throughout our society and as usual the biggest suffers are our most vulnerable and broken, the old, the sick, the mentally ill, the unemployed, the poor, the homeless,

the addicted, minority groups, refugees, the travelling community, those suffering from disability, the socially disadvantaged, wrongdoers, and many other groups and individuals' (p. 69). Lonergan also states that 'we are a very divided, fragmented, unjust society … every child must have a fundamental right to a bed, food, clothes, medical care, full education, work and other basic human rights. We are a long way from achieving this objective – is it even on our agenda?' (p. 70).
Lonergan (2003) notes that:

the reality is that for many thousands of our children, again mostly those born into poverty and social disadvantage, equal opportunity is an unobtainable dream … these children quickly pick up the vibes that they are second-class citizens and their self-esteem suffers accordingly. Little wonder then that many of them drop out of formal education at a very young age. They have few work opportunities and they quickly become disillusioned and disconnected from the mainstream society. They are destined to carry the 'loser' label throughout their lives. (p. 71)

According to Lonergan, 'those of us who have become affluent and successful have also become very hardhearted and self-righteous' (p. 71). He points out that 'many people are destined to live their lives in "ghettos" with little support services and demoralising and dehumanising cultures and environments. Add to this the fact that homeless children sleep on the streets in cardboard boxes. Also, is it just a coincidence that over 75 per cent of all Dublin-born prisoners come from small pockets in six separate postal districts of Dublin city?' (p. 72). Lonergan states that we have a two-tier educational system: he could have added that we also have a two-tier health system.
Jeffers and Fitzgerald (1991) found that children who were at home with parents who were markedly dissatisfied with their income were more likely to have child psychiatric problems. A high proportion of the factors that Jeffers and Fitzgerald studied were associated with disadvantage. It would appear that the material and financial environment is quite important. A child was twice as likely to be disordered if his or her father was unemployed.
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 for their children. Debt causes financial stress that can be taken out on children.
Harvey (2003) points out that 18 per cent of Irish people live below the poverty line defined as 60 per cent of average income, and 4 per cent live below the poverty line defined as 40 per cent of average income – the 'very poor'. He notes that in Ireland 12 per cent are at risk of persistent poverty (being poor for more than three years at a time). In addition, 'Ireland is one of the most unequal countries of the European Union judged by the proportion of what the top 20 per cent earn compared to the bottom 20 per cent', and '10 per cent of Irish people live in a jobless household'. All these factors are correlated with child behaviour problems. Psychosocial disorders in children have been increasing since the Second World War; the factors listed here probably provide some of the background to these increases.
Father Peter McVerry (in Scally, 2003) states that 'during the five years of Ireland's greatest economic growth, from 1996 to 2001, five years of unparalled prosperity, the number of homeless people in our country almost doubled' (p. 59). He points out that

'people on low incomes live in a different world to that of the decision makers' (p. 63).

McVerry comments on the Irish government's decision 'to cut 54 million from the overseas aid budget'. In doing this, the government did not 'hear the cries of street children orphaned by AIDS, or the mourning of mothers as they buried their children who died from lack of food or lack of medicine' (p. 65). McVerry concludes: 'we live in a very divided society, and indeed in a society that is becoming more and more divided. All the decisions in our society are made by those who are on one side. Those on the other side are excluded and marginalised' (p. 66). Once again, the Fianna Fáil/Progressive Democrats 'politics of exclusion' is evident.

The situation is aggravated because 'we have the most expensive potatoes, chickens, eggs, and antibiotics. It is the most expensive place also … to buy a cup of coffee or a hamburger' in Europe. These are very serious matters for people who are unemployed or seriously disadvantaged financially (Begg, 2003: 35).

Sister Stanislaus Kennedy discusses 'the 17 per cent of our children who still live in consistent poverty and the 8 per cent of our adult population who live in chronic poverty'. She is concerned about 'consumerism, exploitation, greed and ostentatious wealth that is in clear evidence', and the 'extreme individualism which drives out solidarity and compassion' (Kennedy, 2003: 14).

Right wing-governments obviously run society for the rich and not for the common good. Sister Stanislaus Kennedy states that 'the existence of an alienated underclass, bereft of any sense of participation in or belonging to the wider community' is tolerated as a price worth paying for right-wing electoral success and additional benefits to the rich in society' (p. 17). Scally (2003) writes about those at 'the margins of our society who have not found the Celtic tiger, not even a Celtic pussycat' (p. 2).

The fact that the current government won a second election on the basis of 'greed is good' suggests that it is tapping into something new in the Irish psyche. There is clearly a lot of support for the 'greed is good' notion, and it would appear that this philosophy is likely to be politically successful in the short term. This shows more clearly the changes that have occurred in Ireland, which are certainly not in the best interests of the children or the many young adults who commit suicide.

THE PSYCHOLOGICAL EFFECTS OF POVERTY ON FAMILIES

Poverty and debt increase the social isolation of families. Children do not have the 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 powerlessness. They have a sense of feeling excluded and having to suffer unsympathetic comments from privileged groups. All this increases the psychological stress on the mother. Indeed, some of our Irish studies have found 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.

AFFLUENCE

Of course, affluence can create its own problems. Abundance of money can lead to excessively 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, or with definite genetic vulnerability.

THE EVIDENCE AND EFFECTS OF DISCONNECTION IN IRELAND: MOTHERS AND CHILDREN

A study of 190 Irish mothers (Fitzgerald and Jeffers, 1994) found that one-third of the mothers were considered to have markedly inadequate opportunity for leisure activities. A child whose mother was satisfied with her leisure activities had a one in four chance of being disturbed, while a child whose mother was severely dissatisfied with her leisure activities had a one in two chance of being disturbed (Jeffers and Fitzgerald, 1991, p. 81).

In this group of 190 mothers in Dublin, 22 per cent reported they did not confide in their partner and 18 per cent had no confiding relationship at all. Fourteen per cent were dissatisfied with the extent of their social supports. Over a quarter described dissatisfaction with their opportunity for relating to their neighbours.

In the same study of the 190 Irish mothers of children of 10 years, a quarter described marked difficulties in keeping contact with their relatives, the commonest reason given being geographical distance. A slightly smaller number made constructive efforts to keep in contact. One-fifth of the total sample expressed dissatisfaction over their contact with relatives. A very small percentage complained of too much contact with their relatives (Jeffers and Fitzgerald, 1991,p. 96).

It is clear that mothers are more vulnerable to depression if they are at home with children and have poor social supports. The findings indicate that mothers whose social supports are poor are twice as likely to have children with a psychological disorder. It is unfortunate that there is no integration of adult and child psychiatry: the treatment of maternal depression is a perfect example of preventive child psychiatry.

Living in a large housing estate is no protection against social isolation. Many women felt unwanted in their neighbourhood. This feeling seemed to reduce self-esteem and led to poorer management of their relationships with neighbours. With respect to leisure activities and social contacts, those with low income reported having reduced opportunity for social outlets. It was also found that they tended to manage any opportunity poorly and they did not consciously plan their leisure time.

It has been shown that suicide and parasuicide are highest in the disconnected, i.e. the divorced and single and those where a disconnection occurred in childhood through a broken home. Barraclough (1987) points out that there is an excess of migrants among suicides, and that migration appears to have weakened the social bond of those suicides who have moved.

Mothers in advantaged areas tend to be more cohesive than women living in disadvantaged areas. They tend to have more money, which gives them access to cars, telephones, and babysitters. These in turn make it possible for them to spend more time away from their children, and allow them time for themselves. This would appear to have the effect of reducing depression and improving parenting. Mothers fitting the ‘advantaged’ description display a ‘planful competence’ in their lives. They are aware that they need time for themselves away from the home, and make a conscious effort to break from being ‘housebound housewives’. ‘Advantaged’ women are more likely to have an opportunity to avail of advice and support from relatives, and more likely to manage this relationship better.

The alternative orbit is the disadvantaged one. As we have seen, children live in disadvantaged circumstances in the presence of considerable marital disharmony,

parental mental illness, financial strain and a sense of helplessness and lack of hope. Such less well-off groups have earlier parenthood, larger families and 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 in order to bring children to a health centre. In Fitzgerald and McGee's (1990) study of children hospitalised for gastroenteritis, they found that 33 per cent of mothers had difficulty in organising the finance to visit their children. 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.

HOUSING ISSUES AND SOCIAL DISCONNECTION

David Begg points out that housing is in crisis (Scally, 2003, p. 34). One-third of young people have to make a choice between having a family and buying a house. There are 54,000 people on the social housing waiting list; increasing female labour force participation is, in turn, increasing demand for child care but this is either not sufficiently available or very expensive.

Those living in rented local authority accommodation are twice as likely to have disturbed children. Many housing estates built since 1975 are situated on the outskirts of Dublin, distant from the mother's home of origin. This practice of placing families from disadvantaged areas in housing long distances from their family roots and friends needs to be tackled. Many mothers commented on a lack of available advice from mothers and older sisters: advice that had seemed to be available to their own mothers.

When we compared Irish mothers with mothers living in Malaysia, we found far lower rates of anxiety and depression in the Malaysian mothers (Fitzgerald et al., 1986). 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 Irish families, although in good-quality housing from a structural point of view, feel alienated because they are so far from their friends and grandparents. Psychologically, they are effectively 'homeless'. When the competent parents who move out of disadvantaged areas are those with leadership qualities, the overall community competence is reduced.

A further complicating factor that 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 would certainly boost the self-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 values of the middle class, with their separate housing, may not be for the public good; in particular, it may not be in the interests of the disadvantaged child.

Professional and voluntary agencies must help people to develop a sense of control of their lives and reduce the sense of learned helplessness that sometimes pervades

socially disadvantaged areas. There is an Irish saying: ‘An té atá thuas óltar deoch air; an té ata thíos buailtear cos air’ (‘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 are more distinct in urban areas. On the one hand there is the advantaged orbit, where children come from privileged circumstances, have good preschool 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 80 times more likely to reach third-level education than a child from a disadvantaged area of Dublin (M. Fitzgerald, 1991a).

Chapter 8

CONCLUSION

'A SOCIETY IN DENIAL' – THE NEED FOR CHANGES

Michael Fitzgerald

In Ireland at the present time, there is denial at a societal level of the needs of the poor, of people with disabilities, and of the sick. This denial is shown in the voting patterns of large numbers of Irish people at election time. They vote for policies supporting the 'haves', and against policies supporting the 'have-nots'. In the privacy of the polling booth their personal consciences seem to be easily dismissed as they put their hand on their wallets and not on their hearts. Their actions make them responsible to themselves in the following five years for the behaviour of the government they elect, which of course is entirely predictable. The societal denial is the denial of this responsibility.

POLITICAL CYNICISM AND FAILURE

There is a political or 'macro' bullying of disadvantaged families in Ireland. St Vincent de Paul states that 'hundreds of thousands of children live in families whose income is less than €150 per week' (Kenny, 2003). This is all not surprising when we have a political party, the Progressive Democrats, whose unspoken agenda, which is clear from its policies, is clearly that 'greed is good', with its dismissal of all the 'have-nots' in Irish society. Progressive Democrat policy in relation to the disadvantaged can be summed up in the phrase attributed to Marie Antoinette – 'let them eat cake'. When the Labour Party (a so-called left-wing party) was in government, deprived hard-pressed disadvantaged children a primary education by giving free third-level education to the rich. This was a brutal attack on children who desperately needed these funds. Sean O'Casey's reference to 'hearts of stone' once again comes to mind.

Kenny (2003) quotes the Director of Merchants Quay Ireland (a charity that offers special services to the homeless and drug users) as being 'greatly concerned by the increased number of homeless and drug users … a clear indication of a failure of government policy to meet the needs of the most marginalised'. An editorial in the Irish Times states that 'the gap between rich and poor in our society is growing. An estimated 300,000 children are not eating properly. This is an unacceptable situation in one of the richest countries in the world.' Fianna Fáil–Progressive Democrat budgets of recent years have hugely aggravated this division. The big decision for many Fianna Fáil–Progressive Democrats at dinner is the vintage of the wine they will purchase; the target for the poor is to have basic food to eat.

Fintan O'Toole (2003a) writes about the Fianna Fáil–Progressive Democrat government creating 'a climate in which [it] … does its best to keep the poor poor. There is something almost psychotic about the way … the government lashes into the most vulnerable. The speed and energy with which cuts in community employment

schemes, rent allowances, dietary allowances, and back to education schemes [are introduced] … suggest that it is almost a relief to be able to take off the mask of consensus politics and get back to the great pleasure of kicking the poor.' O'Toole calls Ireland a 'poor country with lots of rich people'. He also discusses the '10,000 [disabled] children waiting for assessment' (O'Toole, 2003b).

At the same time the government gave high tax breaks to the rich people in the horse-racing industry. Vincent Browne (2004) correctly notes the 'vast untaxed earnings … from the bloodstock industry' in Ireland, and refers to 'the egregious abuse of wealth, one replicated throughout society in so many different spheres'.

Naomi Lyons Sweeney (2004) states that 'with already 640 homeless families in Dublin, including 1,400 children, it is easy to doubt the government's real commitment to social inclusion'. There is a link between poor education and poor health. A devastating commentary on our educational service is fact that according to the Organisation for Economic Cooperation and Development, '25 per cent of Irish adults aged 16–65 have very low literacy' (OECD, 1997). This amounts to about half a million Irish adults. Of course it leads to a high level of employment problems, poverty, and ill health due to poverty; all of this makes children much more vulnerable to childhood behaviour problems and problems at school, and the cycle is repeated in the next generation.

Further evidence of the problems of schools in disadvantaged areas is the fact that one in ten high-risk (disadvantaged) children miss school 30 days per year (Walsh, 2003). John Carr points out that 'for many pupils this is the start of a drift towards early school drop-out, educational failure, and a life of continuing disadvantage. Some will turn to crime and drug abuse. If this cycle of poverty and disadvantage is to be broken then the government must fully resource its own legislation in this area' (Walsh, 2003). Some hope!

Justine McCarthy (2003) describes the welfare cutbacks by the Fianna Fáil–Progressive Democrat government as brutal and life-sapping for some of the State's most vulnerable citizens. She goes on to say that 'people are frightened. They are frightened that they will not make ends meet or that their children will suffer or that if they fall sick, they will be left out on a trolley. There are numerous and disparate fears among those who depend on the Welfare System … but there is a common fear: they are scared that they are being abandoned.' Ireland is not a child-centred society and a recent public appointment had children on the board of the appointments. It is a misuse of children to get them to do adult tasks.

McCarthy (2004) states that Irish stallion breeding is reckoned to be worth €100 million per year, but no tax is payable on these fees. She also notes that 'the other identifiable collective enjoying tax exemption is the arts fraternity. Though the €37.2 million cost to the State since its introduction in 1969 is paltry compared to stallion fees, it is a perversity in the present climate to favour production-line novelists over dying children. The Taoiseach's author daughter, Cecelia Ahern, seems like a nice person who probably would not mind contributing some of her lotto-figure publishers' advance to the national coffers, if she were allowed.' On the other hand:

Charities … are caught for VAT on phones, computers, advertising, consultancy, stationery, construction, electricity, you name it. Research by Ernst and Young has estimated the annual VAT take from charities at €18 million. The Irish Charities Tax Reform Group, an umbrella body for 135 charitable organisations, argues that charities are increasingly taking responsibility for providing services that ought to be provided by the State … St Vincent de Paul incurs €2 million a year on VAT –

enough to build an entire social housing project – what kind of crazy country have we? (McCarthy, 2004)

Clearly a duty of care to the sick, people with disabilities and the poor is not considered important or politically relevant, while looking after the financial wealth of stallion owners is seen as enormously important.

The Progressive Democrats and Fianna Fáil have waged an undeclared war on the poor, people with disabilities and patients in A&E hospital departments and elsewhere in the health service for the past six years. The only hope of change is that persons living in poverty will vote in huge numbers at every election. Unfortunately, low turn-out for voting, which is not uncommon in disadvantaged areas of Ireland, has catastrophic consequences for the poor. It leads to politicians ignoring them.

Labour's Liz McManus is quoted as stating that 'it is absolutely clear now that the Minister and the government simply lied to the Irish people in the run-up to the general election' (Sunday Tribune, 18 August 2002). In relation to the 'Celtic Tiger', a report by Matt Cooper describes how the government 'squandered our boom' (Sunday Tribune, 11 August 2002). This was tragic for the poor in particular.

It is hardly surprising that young people lack interest in politics and that fewer and fewer of the electorate are voting. The Irish Independent (27 July 2002) reported that before the general election, on 13 May 2002, the Finance Minister stated that 'no cutbacks whatever have been planned secretly or otherwise' and then after the election, on 26 July, 'the Cabinet sanctioned savings of €300 million and set up a Committee to look for even more cuts'. The Sunday Independent (28 July 2002) claimed that Fianna Fáil 'stole' the election – 'If this were the private sector it would be called fraud and deception'.

THE NEED FOR A PATIENT-CENTRED HEALTH SERVICE

In relation to the 2003 and 2004 government decisions on the reform of the nation's health and disability services, it is clear that at a time when the services were just about recovering from their last reorganisation they were suddenly plunged into another. Gaius Petronius Arbiter wrote wisely in 66 AD: 'I was to learn later in life that we tend to meet any new situation by reorganising, and a wonderful method it can be for creating the illusion of progress while producing confusion, inefficiency, and demoralisation'. Nothing could be truer about the current reorganisation. The mandarins' endless reform packages for the health service have a strong Alice in Wonderland flavour, exacerbated by the fact that the senior politicians in the Department of Health often have no previous direct personal experience of delivering any aspect of the health service, and come from law, education or economic backgrounds. It's a bit like putting an aeroplane's passengers in the pilots' seats. The result is guaranteed catastrophe.

The most favoured outside experts are 'bean counters' or businessmen brought in as consultants at vast expense. The primary qualification appears to be never having delivered any aspect of the health service. This leads to crazy top-down planning, to the bewilderment of the healthcare professionals meeting the patients/clients face to face. These professionals often feel completely irrelevant to the planning of the health service. There is no possibility of a decent health service unless there is bottom-up planning and the professionals who deliver the service directly to the people are seen as the most important, rather than being ignored.

In the health service, having a meeting is often a substitute for doing something meaningful like seeing a client. Very many of the health service meetings with

management (which are extremely frequent) about resources are a waste of time, as these meetings have no capacity to create resources from thin air. They are actually an attack on people on waiting lists, because they reduce the resources available for seeing clients face to face. It appears that there is huge wastage of taxpayers' money. The endless futile reorganisations cause endless further meetings and further wastage. If useless and pointless meetings were outlawed, health service delivery could improve overnight by at least 15 per cent.

The other waste of resources occurs when two fully qualified professionals see the same family. This is a gross waste of money except in certain very complex family and child situations where multidisciplinary involvement is necessary.

Fergus Bowers (Irish Medical Times, 8 September 2003) states that:

all of the glossy reports and strategy documents on health cannot hide the fact that at the coal-face, where doctors have to treat patients, the system is in serious disrepair. It is bad enough being one of the 28,000-plus patients on waiting lists for in-patient treatment. But when a patient finally gets into hospital, they may be faced with disgusting hygiene conditions or equipment that breaks down halfway through a crucial procedure. Some hospitals and Health Boards are attempting to 'gag' consultants and prevent them from making public how bad things really are. It is only because of the public statements of some hospital consultants that the public have been informed of the true state of the health service.

Consultants, along with their clinical role, have a right to advocate for patients. A worrying trend has developed within this government. It promised a 'world class' health service, but when returned to power, implemented serious cuts. Then it decapitated the Freedom of Information Act. It now wants to have all inquiries held in private. As regards the health service, it is a government in denial. It may even have given up caring, believing that the public can no longer be shocked at the failings in the service. Now that is a scandal.

A vote for the government parties in the last election was a vote for this, even though all would deny it. As noted above, the denial and lack of responsibility that people take for the consequences of their vote is the biggest problem, and while it persists there can be little hope of better times for the poor, the sick, and those with disabilities. The politicisation of the civil service eliminates another independent voice for society, and it is inevitable that this will happen when political parties are in power too long.

Over the past 30 years, social work practice in Ireland has become preoccupied with risk management. It is not rare for social workers to have a poor understanding of the psychopathology of individuals, which is at the centre of an understanding of families. They are using simplistic, outdated and vague sociological theories that are often grounded in ideology rather than science. It is hardly surprising, then, that they appear rather rudderless and 'all over the place' and it is very difficult to follow their discourse.

As Alexander Pope wrote, the proper study of mankind is man. Psychopathology and the individual will have to be put at the centre rather than the periphery of social work studies if the current situation is to be changed. There is almost no scientific evaluation of the benefits of the vast amount of taxpayers' money that is paid to social workers in the social services. Unfortunately, many social workers have an anti-scientific posture that makes formal logical scientific evaluation almost impossible; a

lot of their decisions are based on the 'hearsay' type of evidence as well as on 'sociobabble'.

While child psychiatry shows the effectiveness of interventions at three months' follow-up (Moukaddem et al., 1998), these all disappear at one year's follow-up (Leeson et al., 1999). This is a devastating scientifically based criticism of child psychiatric services in Ireland. The situation needs to be attended to urgently; changes in the practice must be instituted and further scientific follow-up studies completed. Quite a number of the current child psychiatric practices are out of date (especially in terms of time wasted, as outlined above).

An example of the wastage of taxpayers' money in child psychiatry is the exclusive use of family therapy or behaviour therapy with children who have conditions with 60 to 90 per cent heritability, e.g. ADHD. While family therapy can be a help in more severe situations, it should not be the sole treatment. Unfortunately, clinics that use exclusively family therapy approaches are caught in a 'time warp'. Ignoring the biological components of child psychiatric problems, coupled with inadequate treatment of ADHD, for example, can later lead to drug abuse and other serious social interactional problems, up to and including imprisonment.

Although I have worked with a number of superb psychologists, it is not rare for psychologists to go their own way and pursue their own professional agenda. A refocus on distressed children and family needs would help greatly. In terms of speech therapy, the Irish universities in the twentieth century (with the exception of Trinity College Dublin) failed to provide the courses that were needed to increase the number of speech therapists, and this has left huge numbers of Irish families without a speech therapy service. It is critical that each professional's work output be quantified in terms of number of children and parents seen, to ensure that taxpayers' money has a proper return.

Sections of the health service are inflexible, rigid, obsessional, tied to the past and unresponsive to change. If the health service is to be responsive it will have to be much more flexible, with much more fluent boundaries and much more openness to change and response to clients' needs. In reality, health service procedures are hindering instead of helping patients. The service is often more staff-centred than patient-centred, and more staff-sensitive than patient-sensitive. Many staff are driven by exaggerated fears of being sued – staff that operate in a state of paranoid anxiety in relation to patients and clients will naturally malfunction, and indeed will precipitate the problems that they are trying to avoid. Nobody is more insensitive to patients than insecure, anxious staff.

CONCLUSION

While in the past Ireland was seen as a country of 'saints and scholars' (never an accurate picture, but a myth that many people like to hang on to), it is now a country where greed is good and wealthy citizens see their duty as being only to themselves and their kin, and feel no responsibility for the disadvantaged or the wider community. Whereas in the past there was a fear of Ireland becoming financially bankrupt, there is now a danger of moral bankruptcy. I'll conclude this book as it started, with the words of Sean O'Casey: 'Sacred Heart o' Jesus, take away our hearts o' stone, and give us hearts o' flesh!'

PRACTICAL SOLUTIONS, RECOMMENDATIONS, AND PLANNING FOR THE FUTURE MENTAL HEALTH OF IRISH CHILDREN

1. Primary school screening of all children to identify those with behavioural and emotional problems, developmental disorder, and specific learning problems.
2. Early intervention for those identified.
3. Reduction and elimination of the large number of Irish children experiencing child poverty.
4. An increased emphasis on the role of father, grandparents, and extended family networks.
5. Much increased emphasis on the development of problem solving skills and communication skills (especially about emotional matters) in schools.
6. All schools and teachers to take responsibility for bullying in their schools and all to have anti-bullying policies and intervention strategies to deal with bullying.
7. Increased development of psychological and psychiatric services in school with particular emphasis on group work for behaviourally disordered children and parenting programmes for parents.
8. The identify of isolated families in the community by G.P., other health care professionals, and voluntary agencies. Since these families are particularly at risk they should be offered support and extra community services.
9. Expansion of the Community Mothers Scheme and the High Scope Early Intervention Scheme.
10. In preschool the identification and intervention with the 17% of the children showing preschool problems.
11. Evidence based child psychiatry and psychology to be used when ever available. If not available then this type of research should be done.
12. There needs to be greater liaison between the health agencies and between health and education agencies.
13. Increased ‘drop out’ centres for adolescents run on voluntary basis with no barriers to admission but with good referral paths for children with psychiatric disturbance meeting specialist care.

Appendix

USEFUL ADDRESSES AND TELEPHONE NUMBERS

(1) Adoptive Parents Association.
Telephone Number: 825 6961.

(2) Al-Anon, Al Ateen, Dublin.
Telephone Number: 873 2699.

(3) AWARE, 72 Lower Lesson Street, Dublin 2.
Telephone Number: 830 8449.

(4) Bereavement Counselling Service, Dublin Street, Baldoyle, Dublin 13.
Telephone Number: 839 1766.

(5) Bodywhys (Help, support and understanding for anorexia and bulimia nervosa), P.O. Box 105, Blackrock, Co. Dublin.
Telephone Number: 283 5126.

(6) Boyle Family Life Centre, Roscommon.
Telephone Number: 1800 638 888.

(7) CARI (For children, families and groups affected by sexual abuse), 110 Drumcondra Road, Dublin 9.
Telephone Number: 1890 924 567.

(8) Childline.
Telephone Number: 1800 666 666.

(9) Child Bereavement (Northern Ireland).
Telephone Number: 028 90 403000.

(10) Cruse Bereavement Care (Northern Ireland).
Telephone Number: 028 90 792419.

(11) Focus Ireland, 14a Eustace Street, Dublin 2.
Telephone Number: 671 2555.

(12) Foyle Research and Rescue.
Telephone Number: 01 504 3138000.

(13) Gamblers Anonymous.
Telephone Number: 021 71 351329 or 028 90 249185 (Northern Ireland).

(14) GROW (Promoting better mental health).
Telephone Number: 873 4029.

(15) Homeless persons (Eastern Region Health Authorities) Charles Street West, Dublin 7.
Telephone Number: 1800 724 724.

(16) Irish National Eating Disorders Association, Central Office, P.O. Box 8114, Dublin 6.
Telephone Number: 412 6690.

(17) Irish Society for Autism, 16 Lower O'Connell Street, Dublin 1.
Telephone Number: 874 4684.

(18) Legal Aid Board.
Telephone Number: 028 90 246441 (Northern Ireland).

(19) Mental Health Association of Ireland.
Telephone Number: 284 1166.

(20) Nar-Anon.
Telephone Number: 874 8431.

(21) Narcotics Anonymous.
Telephone Number: 208 4107.

(22) National Youth Federation.
Telephone Number: 872 9933.

(23) National Women's Council of Ireland.
Telephone Number: 661 5268.

(24) Network of Rape Crisis Centres of Ireland.
Telephone Number: 091 563676.

(25) Northern Ireland Mental Health Association.
Telephone Number: 028 90 328474.

(26) Oasis House Refuge, Waterford.
Telephone Number: 051 370367.

(27) Overeaters Anonymous.
Telephone Number: 451 5138.

(28) Parental Equality, 54 Middle Abbey Street, Dublin 1.
Telephone Number: 872 5222.

(29) Parentline (Parents under stress) Carmichael House, North Brunswick Street, Dublin 7.
Telephone Number: 873 3500 or 1890 927 277.

(30) Qanda, The Association for Phobias in Ireland, 140 St. Lawrence's Road, Clontarf, Dublin 3.
Telephone Number: 833 8252 / 3.

(31) Rainbow Programme.
Telephone Number: 042 71235.

(32) Samaritans, 112 Marlborough Street, Dublin 1.
Telephone Number: 1850 60 90 90.

(33) Schizophrenia Ireland, 38 Blessington Street, Dublin 7.
Telephone Number: 860 1620.

(34) Victim Support, Haliday House, 32 Arran Quay, Dublin 7.
Telephone Number: 878 0870.

(35) Women's Aid, 47 Old Cabra Road, Dublin 7.
Telephone Number: 1800 341 900.

(36) Women's Refuge (ERHA), Dublin 6.
Telephone Number: 496 1002.

SUICIDE BEREAVEMENT SUPPORT GROUPS:

(1) Carlow: Carlow Suicide Bereavement Support Group, Dr. O'Brien Centre, Dublin Road, Co. Carlow.
Telephone Number: 0503 51277.

(2) Cavan: Cavan Family Support Group, Family Resource Centre, Main Street, Co. Cavan.
Telephone Number: 049 71363.

(3) Cork: Friends of the Suicide Bereaved, P.O. Box 162, Co. Cork.
Telephone Number: 021 249318.

(4) Cork: community Centre, Fermoy, Co. Cork.

(5) Cork: Irish Friends of the Suicide Bereaved, The Planning Office, St. Finbarr's Hospital, Co. Cork.
Telephone Number: 021 36722.

(6) Cork: Youghal Suicide Bereavement Support Group, League of the Cross Hall, Grattan Street, Youghal, Co. Cork.
Telephone Number: 024 95561.

(7) Dublin: The Bereavement Counselling Service, Dublin Street, Baldoyle, Co. Dublin.
Telephone Number: 839 1766.

(8) Dublin: Herber, C/o Irish Hospice Foundation, 64 Wellington Road, Dublin 4.
Telephone Number: 660 3111.

(9) Dublin: Northside Counselling Centre, Bunratty Drive, Bonnybrook, Dublin 17.
Telephone Number: 848 4789.

(10) Dublin: Suicide Bereavement Group, Institute of Psychosocial Medicine, 2 Eden Park, Dun Laoghaire, Co. Dublin.
Telephone Number: 837 0433.

(11) Dublin: Suicide Bereavement Support Group, Spiran House, 213 North Circular Road, Dublin 7.
Telephone Number: 873 4318.

(12) Dublin: Tallaght Suicide Bereavement Support Group, Tallaght Hospital, Belgard Road, Tallaght, Dublin 24.
Telephone Number: 414 2482.

(13) Dublin: Dochas, The Oratory, Blanchardstown Centre, (Yellow Entrance), Dublin 15.
Telephone Number: 820 0915.

(14) Dublin: Dochas, Ballymun Health Centre, Dublin 9.
Telephone Number: 086 8569283.

(15) Galway: Tuam Day Hospital, Hermitage Court, Dublin Road, Tuam, Co. Galway.
Telephone Number: 093 24693.

(16) Galway: Department of Psychiatry, University College Hospital, Galway.
Telephone Number: 091 544458.

(17) Kilkenny: Bereavement Support Group, 27 Riverview, Kilkenny.
Telephone Number: 056 626421.

(18) Kerry: Kenmare Bereavement Support Group, C/o The Presbytery, Kenmare, Co. Kerry.
Telephone Number: 064 41222 or 086 8145856.

(19) Kildare: Bereaved by Suicide Foundation, Aspect House, 5 Whitethorn Grove, Celbridge, Co. Kildare.
Telephone Number: 627 5102 Help Line, Free Phone: 1800 201890.

(20) Kildare: Kildare Suicide Bereavement Support Group, Parish Centre, Church of Irish Martyrs, Ballycain, Naas, Co. Kildare.

Telephone Number: **045 895629.**

(21) Laois: Community Mental Health Centre, Bridge Street, Portlaoise, Co. Laois.
Telephone Number: **086 8157320.**

(22) Longford: Community Mental Health Centre, Dublin Road, Co. Longford.

(23) Mayo: Solace, Suicide Bereavement Support Group, The Family Centre, Castlebar, Co. Mayo.
Telephone Number: **094 25900.**

(24) Offaly: Community Mental Health Centre, Wilmer Road, Birr, Co. Offaly.

(25) Offaly: Cloghan House, Arden Road, Tullamore, Co. Offaly.

(26) Roscommon: Boyle Suicide Bereavement Support Group, Family Centre, Boyle, Co. Roscommon.
Telephone Number: **079 62144 or 079 63000.**

(27) Tyrone: Paths, Postgraduate Centre, Tyrone County Hospital, Omagh, Co. Tyrone.
Telephone Number: **048 82245211 Extn. 5479.**

(28) Westmeath: Mullingar Suicide Bereavement Support Group, Bethany, Bishopsgate Street, Mullingar, Co. Westmeath.
Telephone Number: **044 42746.**

(29) Westmeath: Community Mental Health Centre, Grace Road, Mullingar, Co. Westmeath.

(30) Westmeath: Health Centre, District Hospital, Athlone, Co. Westmeath.

(31) Wexford: H.O.P.E. Suicide Bereavement Support Group, Community Health Centre, Summerhill, Co. Wexford.
Telephone Number: **053 23899.**

(32) Wexford: The Bereavement Care Service, St. Brigid's Centre, Roches Road, Co. Wexford.
Telephone Number: **053 23086.**

(33) Waterford: Cairdeas.
Telephone Number: 1850 201249.

(34) Wicklow: Suicide Bereavement Support, Holy Redeemer Parish Centre, Bray, Co. Wicklow.
Telephone Number: 286 8413.

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