EASTERN HEALTH BOARD

# IRISH FAMILIES UNDER STRESS

## Vol 3

EDITED BY MICHAEL FITZGERALD

# IRISH FAMILIES UNDER STRESS

## VOLUME III

EDITOR: MICHAEL FITZGERALD

EASTERN HEALTH BOARD 1991


EASTERN HEALTH BOARD

SPECIAL HOSPITAL PROGRAMME COMMITTEE
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DR. FITZGERALD WAS THE FIRST IRISH-BORN MEDICALLY QUALIFIED PSYCHOANALYST WITH RECOGNITION BY THE INTERNATIONAL PSYCHOANALYTICAL ASSOCIATION FOUNDED BY SIGMUND FREUD TO RETURN TO PRACTISE IN THE REPUBLIC OF IRELAND, AND REMAINS THE ONLY PSYCHOANALYST WITH SUCH RECOGNITION IN PRACTICE HERE.

DR. FITZGERALD'S MAIN RESEARCH INTEREST IS IN PSYCHIATRIC EPIDEMIOLOGY.

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5 Dr. D. Walsh, Editor, Irish Journal of Psychiatry, for permission to reprint:

(i) **Blood Lead Level of Children attending an Urban Child Guidance Clinic.** Ir. J. Psych. 1987, 8: 2; 4 - 13.

(ii) **Book Review:** "The Inquiring Man: The Psychology of Personal Constructs." Bannister, D., Fransella, F. 1986. Croom Helm. in: Ir. J. Psych. 1987. 8: 1; 18.

6 The Editor, Irish Medical Journal, for permission to reprint **Prevalence of Childhood Autism in Ireland.** Ir. Med. Journal, 1984. 77: 5; 129 - 130.

7 The Editors of Journal of Irish Forum for Psychoanalytic Psychotherapy, for permission to reprint **A Study of Expectations of a Child and Family Centre.** J. Ir. Forum Psychoanalytic Psychotherapy, 1989. 1: 3; 15 - 23.

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(i) **The Impact of Hospital Experiences during Training on GP Referral Rates.** Ir. J. Psychol. Med., 1990. 7: 1; 22 - 25.

(ii) **Book Reviews:**

(a) "Instinctual Stimulation of Children," Vols. 1 and 2, by J. Weil. Internat. Univ. Press, 1989. In: Ir. J. Psychol. Med., 1990. 7: 1; 82.

(b) "Freud's Alter Ego," by V. Brome, 1982. in: Ir. J. Psychotherapy, 1983. 2: 2; 78 - 79.

(c) "Suicide." Barraclough, B. Croom Helm, 1987. In: Ir. J. Psychol. Med., 1989. 6: 1; 57.

8 (ii) (d) "Ordinary Ecstasy." Rowan, J., 1988. Routledge. In: Ir. J. Psych. Med., 1989. 6: 1; 58.

(e) "The Child and his Family." Anthony, E. J., Chiland, C., 1988. Wiley. in: Ir. J. Psychol. Med., 1989. 6: 1; 58.

(f) "The Oedipus Papers." Pollock, G. H., Ross, J. M. Internat. Univ. Press, 1988. in: Ir. J. Psychol. Med., 1989. 6: 1; 58.

(g) "Time Limited Psychotherapy." Mann, J., Goldman, R. A.P.P., 1987. in: Ir. J. Psychol. Med., 1989. 6: 1; 58.

(h) "Attachment and the Therapeutic Process." Editors: Sacksteder, J., Scwartz, D. Inter. Univ. Press, 1987. In: Ir. J. Psychol. Med., 1988. 5: 2; 104 - 105.

(i) "Research Linking to Social Sciences and Medicine - A Directory of Irish Work in the Eighties." P.S.I. Dublin, 1988. in: Ir. J. Psychol. Med. 5: 2; 106.

(j) "Mutative Metaphors in Psychotherapy." Cox, M., Theilgaard, A., 1987. Tavistock. in: Ir. J. Psychol. Med., 1988. 5: 2; 106 - 107.

(k) "Projection, Identification, Projective Identification." Sandler, J. (Ed.) 1987. Inter. Univ. Press. in: Ir. J. Psychol. Med., 1988. 5: 1; 42.

(l) "Autistic Barriers in Neurotic Patients." Tustin, F. 1986. Karnac. in: Ir. J. Psychol. Med., 1988. 5: 1; 42 - 43.

(m) "Child Psychiatry: A Developmental Approach." Graham, P. 1986. O.U.P. in: Ir. J. Psychol. Med., 1987. 4: 1; 31.



# PREFACE

MICHAEL WALSH

PROGRAMME MANAGER, SPECIAL HOSPITAL CARE PROGRAMME,
EASTERN HEALTH BOARD

SINCE HIS APPOINTMENT AS CHILD PSYCHIATRIST WITH THE EASTERN HEALTH BOARD IN 1981, DR. MICHAEL FITZGERALD HAS MADE A MAJOR CONTRIBUTION TO RESEARCH INTO THE VARIOUS ASPECTS OF CHILD PSYCHIATRY AND BEHAVIOURAL PROBLEMS IN SOCIETY IN GENERAL, IN ADDITION TO HIS CLINICAL COMMITMENTS. DR. FITZGERALD'S WORK IN THIS AREA WAS VERY EVIDENT TO ME DURING MY RECENT INVOLVEMENT IN THE WORKING PARTY ON CHILD PSYCHIATRY, WHEN ALMOST ALL OF THE PUBLISHED RESOURCE/RESEARCH MATERIAL AVAILABLE WAS PRODUCED BY DR. FITZGERALD AND HIS TEAM.

THIS WORK IS INVALUABLE IN THE PLANNING AND DELIVERY OF CHILD PSYCHIATRIC SERVICES AND SOCIAL SERVICES GENERALLY. IT PROVIDES A VERY EFFECTIVE MECHANISM FOR SERVICE EVALUATION, AND IS A VERY IMPORTANT ELEMENT IN THE TRAINING OF MEDICAL AND PARA-MEDICAL STAFF.

IT HAS BEEN MY PLEASURE TO FACILITATE DR. FITZGERALD IN EVERY POSSIBLE WAY IN THIS VERY IMPORTANT WORK, AND IT IS MY DESIRE TO CONTINUE TO DO SO IN THE YEARS AHEAD.

# COMMENTARIES

## (1)

### Professor M. Webb

Professor of Psychiatry, Trinity College Dublin

Dr. Michael Fitzgerald is to be congratulated on this further collection of his published works, with a number of colleagues, which relate particularly to distress among children, adolescents and their families. These papers represent a considerable body of work and provide valuable data on topics ranging from improved management of childhood gastroenteritis to psychoanalytic aspects of psychological adaptation to pregnancy. Included are papers which have relevance to the training of general practitioners, of trainee psychiatrists and of specialist psychotherapists. There is concern about the treatment of character disorders and about the uptake of immunisation among Irish children. These many interests of Dr. Fitzgerald demonstrate vividly not only his considerable application to the topic of Irish families under stress, but also his practical commitment, which is apparent in each of these papers, to improve the standard of psychiatric services in this country.

It is also as a teacher of both undergraduate and postgraduate students that Dr. Fitzgerald has been so



available to pass on his wisdom and knowledge, and we are indeed fortunate to have him working in Dublin. I am very pleased, therefore, for all these reasons, to introduce this further volume of papers by Dr. Fitzgerald and his colleagues.

## (2)

### Dr. Gerry O'Neill

Clinical Director
Eastern Health Board Child Psychiatric Services

I am very pleased to be asked to write a commentary on this, the third volume of Dr. Michael Fitzgerald's research on Irish families under stress. As a Child Psychiatrist working in Dublin for the past twenty years, mainly in the clinical field, many impressions have been accurately confirmed in this excellent piece of research. Some of the statistics seem quite alarming, for example, fifteen per cent of child guidance attenders feeling suicidal, and sixty per cent of children of psychiatrically ill mothers being themselves psychiatrically disturbed. The latter finding certainly suggests that child and adult psychiatry should work closer together in dealing with families where both parents and children are disturbed.

DR. FITZGERALD HAS CLEARLY AND REPEATEDLY BROUGHT TO OUR ATTENTION THE HIGH RATE OF DISTURBANCE AMONG CHILDREN IN DISADVANTAGED URBAN FAMILIES. SURELY, THEN, THIS IS THE AREA WHERE MAXIMUM EARLY INTERVENTION AND SUPPORT ARE NEEDED, IF WE ARE TO REDUCE THE LATER PROBLEMS OF CRIME, ADDICTION, PSYCHIATRIC ILLNESS AND POOR PARENTING, AND PREVENT THE CYCLE CARRYING ON TO ANOTHER GENERATION.

DR. FITZGERALD'S EXTENSIVE WORK HAS GIVEN A CLEAR IDEA OF THE RATES OF PSYCHIATRIC MORBIDITY FOR VARIOUS GROUPS OF IRISH CHILDREN WHICH CAN BE AN ACCURATE BASELINE FOR THE FUTURE. HOPEFULLY, PLANNERS OF SERVICES FOR CHILDREN IN IRELAND WILL TAKE NOTE OF HIS WORK AND THEREBY IN TIME IMPROVE THE QUALITY OF LIFE OF MANY OF OUR CHILDREN. AT THE PRESENT TIME IT CERTAINLY SEEMS THAT THE QUALITY OF LIFE FOR MANY LEAVES A LOT TO BE DESIRED. HOPEFULLY, DR. FITZGERALD WILL CONTINUE HIS RESEARCH AND CONTINUE TO INSPIRE MANY YOUNG RESEARCHERS TO FOLLOW IN HIS FOOTSTEPS.



# IRISH FAMILIES UNDER STRESS - SUMMARY

MICHAEL FITZGERALD.

STUDIES TO DETERMINE THE PERCENTAGE OF CHILDREN IN THE COMMUNITY WHO HAVE PSYCHIATRIC DISORDERS ARE CRITICAL IN A COUNTRY LIKE IRELAND WITH A HIGH PROPORTION OF CHILDREN IN THE POPULATION.

IRELAND HAS A DEVELOPING CHILD PSYCHIATRIC SERVICE AND THEREFORE EPIDEMIOLOGICAL INFORMATION IS IMPORTANT IN ASSESSING THE NEED FOR SERVICES, AS ARE THE STUDY OF PSYCHOSOCIAL AND INDIVIDUAL ASSOCIATIONS TO BEHAVIOUR AND FORMAL CHILD PSYCHIATRIC DISORDER. IN THE FUTURE PSYCHOTHERAPY IS LIKELY TO PLAY A MUCH GREATER ROLE IN PSYCHIATRY IN IRELAND.

## PRIMARY SCHOOL CHILDREN

(A) GIRLS: SMALL SCALE SCREENING STUDIES SHOWED CONSIDERABLE EVIDENCE OF BEHAVIOURAL DEVIANCE, PARTICULARLY IN URBAN DISADVANTAGED AREAS. BARTON AND FITZGERALD FOUND THAT THERE WAS OVER TWICE AS MUCH BEHAVIOURAL DEVIANCE IN 10 AND 11 YEAR OLD GIRLS IN A DISADVANTAGED SCHOOL AS IN A HIGHLY PRIVILEGED SCHOOL. IT WAS ALSO OF INTEREST THAT 21% OF THE CHILDREN IN THE DISADVANTAGED SCHOOL WERE ABSENT FROM SCHOOL FOR TRIVIAL REASONS, WHILE NONE OF THE CHILDREN IN THE PRIVILEGED PRIVATE SCHOOL WERE ABSENT FOR TRIVIAL REASONS. [1] THERE IS LITTLE DOUBT THAT CHILDREN LIVING

IN DISADVANTAGED AREAS ARE UNDER MUCH GREATER PSYCHOSOCIAL STRESS THAN CHILDREN LIVING IN AFFLUENT AND PRIVILEGED URBAN AREAS. IT IS ALSO LIKELY THAT PARENTS IN PRIVILEGED FAMILIES HAVE GREATER INTEREST IN EDUCATION, AND WOULD GENERALLY NOT HAVE CHILDREN ABSENT FROM SCHOOL FOR TRIVIAL REASONS. IT IS CLEAR THAT PRIVILEGED FAMILIES AND PRIVILEGED SCHOOLS HAVE MORE RESOURCES OF BOTH A FINANCIAL OR HUMAN KIND WHICH HAVE THE EFFECT OF REDUCING STRESS AND BEHAVIOURAL PROBLEMS IN CHILDREN.

(B) Boys: A STUDY OF 10 AND 11 YEAR OLD BOYS IN A DISADVANTAGED SCHOOL SHOWED A SIMILAR BEHAVIOURAL DEVIANCE RATE TO THAT SHOWN BY THE GIRLS IN A SIMILAR STUDY. TWENTY-TWO PER CENT (10) OF THE BOYS WITH BEHAVIOURAL DEVIANCE SHOWED EVIDENCE OF MILD ABNORMALITY, 4% (2) MODERATE ABNORMALITY AND 9% (4) MARKED ABNORMALITY.[2] THIS SUPPORTS THE LINK BETWEEN INCREASED RATES OF BEHAVIOUR PROBLEMS AND DISADVANTAGE.

(C) Large Scale Screening Study: A STUDY OF 2,029 TEN YEAR OLD CHILDREN FOUND A RATE OF 20% BEHAVIOURAL DEVIANCE IN BOYS, AND 11% IN GIRLS, USING THE TEACHERS' QUESTIONNAIRE.[3]

(D) Urban/Rural Differences: IT WAS FOUND THAT OVER TWICE AS MANY URBAN DISADVANTAGED CHILDREN SHOWED EVIDENCE OF BEHAVIOURAL DEVIANCE, AS AGAINST CHILDREN IN A RURAL TOWN. IN THE URBAN GROUP, NO SIGNIFICANT DIFFERENCE WAS FOUND BETWEEN BOYS AND GIRLS WITH BEHAVIOUR PROBLEMS, WHILE A HIGHLY SIGNIFICANT SEX DIFFERENCE WAS FOUND IN THE RURAL SMALL TOWN GROUP. THE OBSERVED INCIDENCE FOR BOYS, AT 18% (21), WAS THREE TIMES THAT FOUND FOR GIRLS.[4] THE MOST LIKELY EXPLANATION IS THAT THE LEVEL OF PSYCHOSOCIAL STRESS IS LOWER IN RURAL COUNTIES. THERE IS LITTLE DOUBT THAT



DISADVANTAGED URBAN AREAS ARE INCREASINGLY PSYCHOLOGICALLY TOXIC TO FAMILIES AND CHILDREN.

(E) Travellers' Children: IN A STUDY OF 50 TRAVELLERS' CHILDREN, 27 OUT OF 50 SHOWED EVIDENCE OF BEHAVIOURAL DEVIANCE, USING THE TEACHERS' QUESTIONNAIRE.[5] THIS WAS GREATER THAN THAT FOUND WHEN TRAVELLERS' CHILDREN WERE COMPARED TO A COMPARISON GROUP FROM THE SETTLED COMMUNITY. THE TEACHERS' QUESTIONNAIRE TOTAL SCORE AVERAGE FOR THE TRAVELLERS' GROUP, AT 9.96, WAS SIGNIFICANTLY ABOVE THE TOTAL SCORE AVERAGE FOR THE SETTLED COMPARISON GROUP AT 2.2. WHILE ACKNOWLEDGING THAT THE TRAVELLING PEOPLE HAVE A DIFFERENT CULTURE, IT WOULD APPEAR THAT THEY ARE POSSIBLY THE MOST DISADVANTAGED GROUP IN IRISH SOCIETY, AND HAVE LARGE FAMILIES WITH AN UNSETTLED, ALIENATED LIFE STYLE WHICH WOULD MAKE THE INCREASED RATE OF BEHAVIOUR PROBLEMS IN CHILDREN NOT SURPRISING.

(F) Depression: FIVE PER CENT (4) OF A GROUP OF BOYS IN AN URBAN DISADVANTAGED SCHOOL SCORED AS DEPRESSED ON THE DEPRESSION SELF RATING SCALE.[6] A CHILD PSYCHIATRIC OUTPATIENT POPULATION IN THE SAME AREA GAVE A TOTAL OF 14% (7) USING THE SAME INSTRUMENT.[7] THERE WAS EVIDENCE OF CO-MORBIDITY, IN THAT THREE-QUARTERS OF THOSE CHILDREN WHO WERE RATED AS DEPRESSED ALSO SCORED DEVIANTLY IN THE ANTISOCIAL DOMAIN OF THE TEACHERS' QUESTIONNAIRE. THERE WAS ALSO A HIGH NEGATIVE LEVEL OF SELF ESTEEM USING THE COOPERSMITH SELF ESTEEM INVENTORY AND THE BIRLESON DEPRESSION SCALE. A FIVE YEAR FOLLOW-UP OF DEPRESSED CHILDREN SHOWED THAT 50% WERE STILL DEPRESSED. AT THE FIVE YEAR FOLLOW-UP POINT, 12% (4) WHO WERE NOT ORIGINALLY DEPRESSED WERE ALSO FOUND TO BE DEPRESSED. CHILDREN WERE MORE LIKELY TO BE DEPRESSED IF THEIR MOTHERS WERE DEPRESSED.[8] IT IS CLEAR THAT DEPRESSION IS NOT UNCOMMON IN CHILDREN AND, INDEED, CAN

RUN A VERY PROTRACTED COURSE IN CHILD PSYCHIATRIC PATIENTS. IT IS CLEARLY A TOPIC OF INCREASING CONCERN TO CHILD PSYCHIATRISTS.

(G) ANXIETY: THREE POINT FIVE PER CENT (3) OF A GROUP OF BOYS IN AN URBAN DISADVANTAGED SCHOOL SCORED ABOVE TWO STANDARD DEVIATIONS ABOVE THE MEAN FOR THE STATE ANXIETY SCALE OF SPIELBERGER, AND 5% (4) SCORED MORE THAN TWO STANDARD DEVIATIONS ON THE TRAIT ANXIETY SCALE OF THE SAME INSTRUMENT, AND THESE WERE TAKEN AS BEING INDICATIVE OF HIGH ANXIETY. THERE WAS ALSO A SIGNIFICANT NEGATIVE CORRELATION COEFFICIENT BETWEEN SELF ESTEEM AND STATE, AS WELL AS TRAIT ANXIETY.[6] ONCE AGAIN, ANXIETY IS NOT UNCOMMON IN NORMAL SCHOOL CHILDREN, AND IT IS POSSIBLE THAT STRATEGIES TO BOOST SELF ESTEEM BY FAMILIES AND SCHOOLS WOULD BE VALUABLE, PARTICULARLY IN THE IRISH CONTEXT, WHERE NEGATIVE ATTUNEMENT WOULD APPEAR TO BE A FEATURE OF THE CULTURE.

(H) AUTISM: A STUDY OF THE PREVALENCE OF CHILDHOOD AUTISM FOUND A RATE OF 4.3 AUTISTIC CHILDREN PER 10,000 IN THE AGE RANGE 8 - 10 YEARS IN THE EASTERN HEALTH BOARD. THESE WERE EVENLY SPREAD ACROSS THE SOCIAL CLASSES, AND THERE WAS A MALE : FEMALE RATIO OF 1.3 : 1.[9]

(I) IRISH CHILDREN'S THOUGHTS: FIFTEEN PER CENT OF A SAMPLE OF 80 BOYS THOUGHT THAT THEIR LIFE WAS NOT WORTH LIVING MOST OF THE TIME, AND 18.8% THOUGHT THAT THEIR LIFE WAS NOT WORTH LIVING SOMETIMES.[6] A STUDY OF SUICIDAL THOUGHTS IN CHILDREN (N = 50) ATTENDING A CHILD PSYCHIATRIC OUTPATIENTS FOUND THAT 15% HAD THOUGHT OF KILLING THEMSELVES. SIXTY PER CENT OF THE SAMPLE OF CHILDREN WHO HAD THOUGHTS OF KILLING THEMSELVES KNEW SOMEONE WHO HAD ATTEMPTED SUICIDE.[10] IT WOULD APPEAR THAT VERY DISTRESSING THOUGHTS ARE NOT



UNCOMMON, AND IT BEHOVES PARENTS AND TEACHERS TO TUNE IN TO THESE THOUGHTS IN CHILDREN, SO THAT THEY DO NOT HAVE TO BEAR THEM ALONE, AND SO THAT THE STRESS BRINGING THEM ABOUT SHOULD BE IDENTIFIED.

(J) SOCIAL DIFFICULTIES: A STUDY OF 95 ELEVEN AND TWELVE YEAR OLD SCHOOL CHILDREN IN A NORMAL SCHOOL IN A DISADVANTAGED AREA FOUND THAT 13% HAD DIFFICULTIES WITH PEERS, 17% HAD DIFFICULTIES WITH ADULTS AND 11% HAD GENERAL SOCIAL DIFFICULTIES, USING THE SOCIAL DIFFICULTY QUESTIONNAIRE.[11] THERE IS EVIDENCE THAT CHILDREN WITH PEER DIFFICULTIES ARE AT RISK FOR LATER PROBLEMS, AND IT WOULD APPEAR THAT SOCIAL SKILLS TRAINING PROGRAMMES IN SCHOOL COULD HAVE PREVENTIVE POSSIBILITIES.

(K) SLEEP PROBLEMS: IN A STUDY OF CHILDREN ATTENDING A PUBLIC HEALTH CLINIC (N = 101), WITH AN AVERAGE AGE OF 4 YEARS AND 7 MONTHS, A QUARTER OF THE BOYS AND A THIRD OF THE GIRLS HAD SLEEP PROBLEMS.[12] THERE IS NO DOUBT THAT SLEEP PROBLEMS IN CHILDHOOD CAN CAUSE VERY SIGNIFICANT STRESS TO A FAMILY. THERE ARE NOW SIMPLE BEHAVIOURAL PROGRAMMES AVAILABLE WHICH ARE PARTICULARLY VALUABLE FOR PUBLIC HEALTH NURSES AND GENERAL PRACTITIONERS IN THE MANAGEMENT OF SLEEP PROBLEMS.

(L) READING: CHILDREN ATTENDING A CHILD PSYCHIATRIC OUTPATIENTS HAD SIGNIFICANTLY LOWER READING AGES THAN A MATCHED AGE COMPARISON GROUP IN A NORMAL SCHOOL - THE MEAN READING AGE OF THE NORMAL SCHOOL CHILDREN WAS 10.8 YEARS, WHILE THE GROUP MEAN FOR THE PSYCHIATRIC OUTPATIENTS WAS 9.0 YEARS, AND THE SPECIAL SCHOOL CHILDREN 7.9 YEARS.[13] WHILE LOW READING AGE CAN OCCUR WITHOUT PSYCHIATRIC PROBLEMS, IT IS NOT UNCOMMON TO SEE BOTH OCCUR TOGETHER.

(M) Fire Setting: A study of children attending a child psychiatric outpatients found that 19% (15) were fire setters. They set an average of ten fires. The fire setting behaviour began, on average, at seven years. Half of these children received a diagnosis of conduct disorder.[14] Fire setting behaviour can be the most serious of all children's behaviour problems, and it is important for doctors to ask about it, as parents don't often mention it.

(N) Children's Fears: Forty per cent of children attending a child psychiatric outpatients had evidence of excessive fears.[15]

## Pre-School Children

A study in a pre-school (N = 59) found a rate of 17% of children with behavioural deviance, using the Behaviour Screening Questionnaire.[16] This is similar to rates found in other countries. These children are at risk for later problems and deserve intervention.

## Adolescents

(A) Abnormal Eating Attitudes: Using the Eating Attitude Questionnaire, 13% of a sample (N = 50) of 16 year old female adolescents showed evidence of abnormal eating attitudes. Eleven per cent admitted to dieting; 7% to exercising strenuously to burn off calories; 11% to avoiding foods with high carbohydrate content; 15% described eating binges, with feelings of loss of control; 4% used laxatives; 17% felt that food controlled their lives, and 18% admitted to feeling anxious in relation to eating.[17] Clearly, food issues



cause considerable distress, and western societies' excessive preoccupation with thinness is probably a factor in this problem.

(B) Psychological Stress in Female Adolescents: One hundred and thirty-two female adolescents, attending two inner city schools, were studied using the Youth Self Report Questionnaire. Fifteen per cent showed evidence of psychological stress and attained a total problem score in the clinical range. Eleven per cent admitted to often crying; 11% admitted to often having stomach aches or cramps; 6% said that they often used drugs or alcohol; 6% said that they wished that they were of the opposite sex, and 7% said that they often had suicidal thoughts.[18] In another study, 7% admitted to being depressed.[19]

(C) Male : Female Adolescents: In a study of 92 adolescents (average age 13.8 years) it was found, in using the General Health Questionnaire, that 44% of the sample reported six or more symptoms, and there was no significant difference between males and females. On the other hand, there was a significant difference between the mean scores for males and females, the females scoring significantly higher.[20] It is of interest in child psychiatry that males have more psychological symptoms than females and here, with adolescents, there is no significant difference between males and females. Nevertheless, the adult pattern is beginning to assert itself, with females having higher mean scores than males.

(D) Coping and Psychological Stress in Adolescence: In this study it emerged that girls had more suicidal ideation than boys.[21]

(E) Body Shape, General Health and Abnormal Eating Attitudes in Male Adolescents: Two out of 107 sixteen year old boys showed evidence of abnormal eating attitudes. This was lower than a similar study in girls.[15] Thirty-eight out of 107 boys scored 5 or more on the General Health Questionnaire. Three out of 107 boys showed excessive concern about being fat, on the Body Shape Questionnaire.[22]

(F) Hostility, Self Esteem and General Health of Adolescents: A study of 300 twelve to fifteen year old adolescents, using the General Health Questionnaire, demonstrated that 30% had six or more symptoms.[23]

## Formal Psychiatric Disorder

(A) A study of 45 ten and eleven year old children in a disadvantaged school found a rate of 18.6% (8) of formal psychiatric disorder. Seven per cent (3) showed evidence of mixed order of conduct and emotions; 7% (3) showed depressive disorder and 5% (2) showed conduct disorder.[2] This shows that about half those identified on screening questionnaires are false positives.

(B) A sample of 190 ten year old children selected from 2,029 children screened for behavioural deviance found a rate of 16% showing evidence of formal child psychiatric disorder on detailed interviewing.[3]

(C) In a study of adolescents with spina bifida, a prevalance of 37.5% of formal psychiatric disorder was found on detailed interviewing.[24] There are increased rates of psychiatric problems in adolescents with neurological problems.



## Psychological Symptoms in Parents

(A) In a general practice study of 70 children there was a significant relationship between maternal depressive symptoms and behavioural deviance in the children.[25]

(B) In a study of the mothers of 50 consecutive attenders at a child psychiatric outpatients, 35 out of 50 showed evidence of formal psychiatric disorder, using the Clinical Interview.[26]

(C) In a pre-school study (N = 59) there was a significant relationship between depressive symptoms in mothers and behavioural deviance in children.[16]

(D) When a consecutive sample of mothers with children attending the child psychiatric outpatients' were compared with a comparison group of mothers of children attending a general practice, significantly higher levels of hopelessness were found, using the Hopelessness Scale.[27]

(E) Seventy-two per cent of children of psychiatric inpatient mothers were found socially incompetent, using the Child Behaviour Check List.[28]

## Marital Disharmony

(A) In a general practice study, there was a significant relationship between marital disharmony and behavioural deviance in children.[29]

(B) In a study of 50 consecutive children attending a child psychiatric outpatients, 21 of the mothers showed evidence of marital problems, and there was a significant relationship between marital problems and anxiety and depressive symptoms in the mother.[26]

(C) When marital adjustment and behaviour problems in children attending a child psychiatric outpatients population were compared with a control population in the community, there were significantly higher rates of marital disharmony and behavioural problems in the children attending the child psychiatric outpatients.[29] It is important that general practitioners treat as soon as possible marital problems, because of their effect on children. This is another example of preventive child psychiatry.

## Social Problems

Social problems of mothers were studied in 50 consecutive attenders at a child psychiatric outpatients. Seventy-four per cent of the mothers had significant social problems. There was a significant link between social problems and maternal mental illness in this study.[26]

## Home Environment

When pre-school children with behavioural problems were studied, there was a significant relationship between low levels of warmth, affection and acceptance and a high score of behavioural deviance.[30] Clinical experience suggests that for children to develop healthily they need warmth, acceptance and affection.



## Blood Lead

In a study of blood lead in children attending a child psychiatric outpatients and in the community, there was no difference in the mean blood lead levels.[31] Of course, toxic blood lead levels would have major physical and psychological effects.

## Adolescent Health

In a study of adolescents' health, 1% rated their health as poor. Twenty-five per cent drink alcohol at least once weekly, and 29% had visited their G.P. in the previous three months. Sixty-one per cent had taken medicine in the previous four weeks. Sixteen per cent of boys and 3% of girls had tried glue sniffing. One-quarter of Irish teenagers were weekly drinkers, compared to one-third of British teenagers.[32]

## Motivation

It is of interest that children in an urban primary school show high intrinsic motivation to learning across third to sixth standard. It was also of interest that behaviourally disturbed children showed higher levels of independent judgement, as against dependence on teachers' judgement. This may reflect a global mistrust of adults in their environment.[33]

## Screening Two Thousand and Twenty-nine Children

A study of 2,029 fourth-class pupils in an urban Irish primary school showed that 20% of the boys and 11% of

THE GIRLS WERE BEHAVIOURALLY DEVIANT. EIGHT PER CE
OF THE CHILDREN WERE READING THIRTY-SIX MONTHS BEHI
CHRONOLOGICAL AGE. ONE PER CENT OF THE CHILDREN WE
FOUND TO BE INTELLECTUALLY IMPAIRED.[34]

## SUICIDE

A STUDY OF SUICIDE VICTIMS[35] IN DUBLIN (N = 70) FOU
THAT

(A) 70% WERE MALES;

(B) THE AVERAGE AGE WAS 41 YEARS;

(C) 80% OF THE VICTIMS WERE UNDER 55 YEARS;

(D) 37% WERE MARRIED;

(E) 60% OF THE ECONOMICALLY ACTIVE GROUP WERE IN EMPLOYMENT;

(F) 35% HAD PREVIOUSLY ATTEMPTED SUICIDE;

(G) 53% SAW A DOCTOR IN THE PREVIOUS MONTH;

(H) 44% EXPERIENCED FEELINGS OF HOPELESSNESS;

(I) CENTRAL STATISTICS OFFICE STATISTICALLY UNDERESTIMATED BY A RATE OF 20%.

## SOCIAL SUPPORT AND BEHAVIOUR PROBLEMS IN CHILDREN

THE LEVELS OF SOCIAL SUPPORT OF IRISH CHILDREN WERE SIMILAR TO LEVELS OF SOCIAL SUPPORT OF AMERICAN



CHILDREN OF THE SAME AGE. LEVELS OF SOCIAL SUPPORT FROM TEACHERS AND CLASS MATES WERE ASSOCIATED WITH HIGHER SELF ESTEEM AND DEVELOPMENTAL APPROPRIATENESS.[36]

## A FOLLOW-UP OF DELINQUENTS

WHEN A GROUP OF 50 DELINQUENTS[37] WERE FOLLOWED UP, IT EMERGED THAT 20% HAD DRUG PROBLEMS.

## LIFETIME PREVALENCE OF DEPRESSIVE DISORDER

A STUDY OF THE LIFETIME PREVALENCE OF DEPRESSIVE DISORDER OF 33 CONSECUTIVE PATIENTS ATTENDING THE PSYCHIATRIC DEPARTMENT OF A GENERAL HOSPITAL, SHOWED THAT 15 (45%) HAD A POSITIVE FAMILY HISTORY OF DEPRESSION, AND THAT THE TOTAL NUMBER OF RELATIVES INVOLVED WAS 20, OR 1 FOR 1.7 PATIENTS.[39]

## PARENTAL BONDING AND DEPRESSION

ON THE EMBU (ENGA MINNEN BETRAFFANDE UPPFUSTRAN), A PARENTAL REARING PRACTICES' INSTRUMENT, PARENTS OF DEPRESSED PATIENTS WERE MORE REJECTING, MORE OVER-PROTECTIVE AND MORE FAVOURING OF THE SUBJECT THAN A COMPARISON GROUP. ON THE PBI (PARENTAL BONDING INSTRUMENT), THE MOTHERS AND FATHERS OF ADULT DEPRESSED PATIENTS WERE MORE OVER-PROTECTIVE AND LESS CARING THAN A COMPARISON GROUP.[40]

A STUDY OF 55 BOYS (AVERAGE AGE 7 YEARS AND 9 MONTHS) IN A DISADVANTAGED AREA FOUND A RATE OF 21% HYPERACTIVITY ON THE ACTIVITY RATING SCALE; A RATE OF 31% HAD SOFT NEUROLOGICAL SIGNS; 35% HAD GROSS TOOTH

DECAY AND A BEHAVIOURAL DEVIANCE RATE OF 36% ON TH
TEACHERS' SCALE.[41] THIS CAN BE COMPARED TO A RATE O
44% FOUND IN CHILDREN ATTENDING A SURGICAL OUTPATIENT
IN HOSPITAL IN A DISADVANTAGED URBAN AREA.[42] A
ANALYSIS OF THEIR HEIGHT AND WEIGHT PERCENTILES SHOWE
THE HEIGHT CURVE AS BEING SHIFTED TO THE LEFT OF TH
EXPECTED PERCENTILES.[41]

## Lone Parenthood

A STUDY OF MARRIED AND UNMARRIED MOTHERS FOUND THAT 60
OF MARRIED MOTHERS AND 18% OF SINGLE MOTHERS WISHED T
CONCEIVE AT THE TIME THEY BECAME PREGNANT. THIRTY-FOU
PER CENT OF THE MALE PARTNERS OF THE SINGLE MOTHERS DI
NOT WANT TO KNOW ABOUT THE PREGNANCY, WHILE THIS WA
TRUE OF ONLY 2% OF THE PARTNERS OF THE MARRIED MOTHERS
THE GROUP OF SINGLE MOTHERS LIVING ALONE WERE UNDE
CONSIDERABLE STRESS, WITH THREE-QUARTERS OF THEM HAVIN
MAJOR FINANCIAL PROBLEMS AS OPPOSED TO 19% OF THOS
LIVING WITH THEIR PARENTS. THERE WAS NO STATISTICA
DIFFERENCE BETWEEN THE TWO GROUPS WITH REGARD TO COPIN
WITH THEIR CHILDREN.[43]

## Personality Disorder

A STUDY OF THE PERSONALITIES OF 50 CHILD GUIDANCE
CLINIC ATTENDERS FOUND THAT 5 COULD BE GIVEN
DIAGNOSIS OF PERSONALITY DISORDER.[44]

## Expectations of a Child and Family Centre

IN A STUDY OF THE EXPECTATIONS OF ATTENDING A CHILD AND
FAMILY CENTRE, 40% OF CHILDREN EXPRESSED POSITIVE



FEELINGS ABOUT ATTENDANCE, 30% EXPRESSED ANXIETY AND
APPREHENSION ABOUT IT, AND 30% HAD NEITHER POSITIVE NOR
NEGATIVE FEELINGS.[45]

## Burn-out

A STUDY OF STRESS IN CHILD PSYCHIATRIC PERSONNEL SHOWED
THAT PERSONNEL WITH LOW SCORES ON PEER COHESION WERE
FOUND TO BE EMOTIONALLY EXHAUSTED AND TO SHOW GREATER
DEPERSONALISATION OF CLIENTS. PERSONNEL WORKING IN
RESIDENTIAL CHILD PSYCHIATRY WERE MORE LIKELY TO BE
EMOTIONALLY EXHAUSTED THAN PERSONNEL WORKING IN
OUTPATIENT CHILD PSYCHIATRY.[46]

## Attitude to Authority

IN A STUDY OF ATTITUDE TO AUTHORITY IN IRISH
ADOLESCENTS, 84% (76) EXPRESSED PRO-AUTHORITY FEELINGS.
THERE WAS ALSO A NEGATIVE CORRELATION BETWEEN LEVEL OF
PSYCHOLOGICAL DISTRESS AND POSITIVE ATTITUDE TOWARDS
PARENTS.[20]

## Life Events

CHILDREN REFERRED FOR PSYCHIATRIC ASSESSMENT HAD A
SIGNIFICANTLY INCREASED NUMBER OF LIFE EVENTS, WHEN
COMPARED TO NON-REFERRED CHILDREN FROM A NORMAL SCHOOL.
FAILURE OF A CLASS IN SCHOOL AND INCREASED NUMBER OF
ARGUMENTS BETWEEN PARENTS WERE ASSOCIATED WITH AN
INCREASED LIKELIHOOD OF REFERRAL.[47]

## Families Under Stress

Disadvantage and social disconnection were major factors associated with child and maternal psychiatric illness.[48]

## Psychoeducational Problems

Males had significantly more behavioural and learning problems than females.[49]

## Child Psychiatry Provision

It is clear that there are very considerable numbers of disturbed children in Ireland, and there are still areas of the country without child psychiatrists. Educational psychologists should spend part of their week based in child guidance clinics, so that psychiatric problems can be dealt with.[50]

## Child Psychiatric Inpatient Treatment

The prevalence of use of medication was lowest (8%) in Denmark and highest in Ireland (54%). Family therapy was undertaken with 25% of inpatient cases in Ireland.[51]

## Preventive Psychiatry

It is of critical importance to increase the priority given to preventive psychiatry and psychotherapy. The



most cost-effective time to intervene would be when children aged 3 - 4 years are showing signs of behavioural deviance. The children need high quality cognitively orientated pre-school education and the mothers need parent training. There is a considerable need for the expansion of psychotherapy services in Ireland.[52]

## Cross Cultural Study: Ireland and Malaysia

Mothers in Malaysia had a significantly lower rate of depressive and anxiety symptoms when compared to Irish mothers. This may have been due to the greater cohesion of Malaysian society. There was no difference in the rates of childhood behaviour problems between the two countries.[53]

## Family Burden of a Child with Special Needs

When psychosocial stress in families with a child with special needs was compared to that in families with a child in a normal school, it was found that there was significantly more stress in families with children with special needs. Parents in these families felt more incompetent, felt lack of attachment, were more restricted in their parent role, more socially isolated, more depressed and had more marital stress. The children with special needs were more distractible, more moody, more demanding and more non-adaptable.[54]

## Prosocial Behaviour

A study of prosocial behaviour in children attending a normal school found that Irish mean levels of prosocial behaviour are similar to the United Kingdom mean scores. High trait anxiety was accompanied by lower prosocial behaviour scores and higher behavioural deviance ratings.[6]

## Self Esteem

In a study of self esteem and behavioural deviance in children, total self esteem was reduced in children attending the child psychiatric services. One component of total self esteem, that is, school self esteem, was not reduced in children who were attending a day special school or were in an inpatient unit with a special school attached. This may have been due to children in the special school setting not being so different from one another as would be the case if these children were attending a normal school.[55]

## Speech and Language

In a study of speech/language disability and behavioural deviance in a consecutive sample of 50 referrals to a child psychiatric outpatients, 63% showed evidence of behavioural deviance on the Parents' Questionnaire (A2) and 44% showed evidence of speech/language problems.[56]



## Temperament

When a consecutive sample of children attending a child guidance clinic were age, sex and school matched with children in a normal school, it was found that children attending the child guidance clinic were significantly more likely to have difficult temperaments.[57]

## Menarche

The mean age of Menarche in 836 Irish school girls was 12.5 $\pm$ 0.06. There was no statistical difference between social classes, number of siblings or place of the child within the family.[58]

## Infant Care Practices

When infant care practices were examined in mothers who had a child hospitalised and not hospitalised for gastroenteritis, it emerged that families were the main source of advice for both groups. It was also of interest that 9% of hospital care mothers and 6% of home care mothers had no source of parenting advice. An average of 16% of mothers had problems feeding their children, 30% had settling problems at bed-time once per week or more, and 34% had night wakening problems weekly. Twenty-two per cent of children posed some discipline problems. Most of the child care was provided by mothers, although fathers played with their children on average twice per week and mothers three times per week.[59]

## Mothers' Health Status

The psychological health status of mothers who had a child admitted to hospital for gastroenteritis and who had a child with gastroenteritis treated at home were studied. The mothers of hospitalised children had significantly higher levels of psychological distress. There were no differences in severity of the children's illness between the two groups, as indicated by blind ratings of symptomatology from six infectious diseases' hospital doctors. Thus, hospitalisation of children for gastroenteritis was not contingent on medical symptomatology. Instead, the evidence indicates that the psychological status of the mothers may influence doctors' management decisions. Significant positive associations between poor psychological status and poor social resources illustrate the social context in which maternal vulnerability may influence child health care generally. The study also found an association between psychological stress and low levels of leisure activity, low levels of shared leisure with partners, poor overall contacts, poor satisfaction with contacts and a disturbed intra familiar environment. [60, 61].

## Maternal Mental Health

A study of maternal mental illness in 185 mothers showed a rate of 33% (61). Thirteen had endogenous depression; 16 anxiety and depression; 24 reactive depression; 3 abnormal grief; 3 alcoholism and 2 personality disorder. There was a significant association between parental mental illness and child psychiatric illness. Sixty per cent of mothers with parental mental illness had a child with child



psychiatric illness. Mothers with mental illness had poor social relationships.[62]

## Post-natal Depression

On the Edinburgh Post-Natal Depression Scale, 38% (19) scored above the cut-off point of 12. Twenty per cent (10) of the mothers were single; 22% per cent had marked difficulties with their financial commitments; 20% were on medication; 10% were on anti-depressants; 34% of the spouses of the married mothers were working; 30% became pregnant sooner than they wanted to.[63]

## Doctors' Decision Making

Over 2,000 children under two years of age are hospitalised annually in the Republic of Ireland. Fifty-seven general practitioners were randomly selected and presented with a series of "paper patients," each with a scenario about a young child presenting with gastroenteritis. A multiple regression analysis was carried out on their responses which accounted for 44% of the variance in decision making. In descending order of importance were

(1) Bad experiences with gastroenteritis;

(2) Higher estimates of the severity of gastroenteritis;

(3) Sex of the doctor (male);

(4) Single practice;

(5) If gastroenteritis management had changed since training;

(6) Age of doctor.[64]

## Impact of Hospital Experiences on Doctors

The impact of hospital experiences during training of general practitioners was studied in relation to their propensity to admit children with gastroenteritis to hospital. There was a significant excess of hospital referrals for gastroenteritis by those G.P.'s with prior hospital training in an infectious diseases' hospital, and medical sensitisation was considered to be a factor, in that this specialised training had sensitised G.P.'s to the potentially negative outcomes of gastroenteritis.[65]

## Medication for Gastroenteritis

Twenty-five per cent of G.P.'s are still using anti-diarrhoeals and antiemetics in the treatment of gastroenteritis, despite the general principle of fluids only for gastroenteritis.[66]

## Child Hospitalisation

In a study of home or hospital care for childhood gastroenteritis, it was found that being a young child, a child of a single parent or a child of an anxious mother were factors which were equally likely, and more likely than being a moderately sick child, to result in referral to hospital. [67, 68].



## Medical Factors and Childhood Hospitalisation

There was no difference in severity of gastroenteritis between those children treated at home and those treated in hospital.[69]

## Pathways to Childhood Hospitalisation

The ability of parents to cope emerged as an important factor in the hospitalisation of children.[70]

## Immunisation

In a study of children who had gastroenteritis and were treated either in hospital or at home, it was found that 53% of the home care children had measles immunisation, which is similar to national levels, while only 22% of the hospital care children had measles immunisation before eighteen months of age. Levels of immunisation up-take were satisfactory for both groups in the early post-natal period, but began to decline and diverge at about the six-month period. This fall-off represents the age-old problem of health education, how to maintain health orientated behaviours beyond a point of intensive contact, in this case the perinatal period.[71]

## Attitude to Hospitalisation

While the evidence of negative impact of long or frequent hospitalisations of young children is well documented, a study of the attitudes of Irish doctors to hospitalisation found that only about half of those

INTERVIEWED BELIEVED THAT HOSPITALISATION HAD NEGATIVE EFFECTS, SUGGESTING THAT RESEARCH FINDINGS IN THIS AREA DO NOT APPEAR TO HAVE HAD A MAJOR IMPACT ON THE VIEWS OF MEDICAL DECISION MAKERS.[72,73].

## Mothers' Consumption of Drugs and Alcohol

In a study of the consumption of alcohol and drugs in mothers of children attending a child psychiatric clinic, it was found on a screening questionnaire - the Mast - that 17% of the mothers were problem drinkers. Thirteen per cent of the mothers were taking benzodiazepines daily, while a further 7% were taking those drugs on an irregular basis. It is possible that these mothers are under more stress and have higher levels of problem drinking than women attending a general practice, where a rate of 1.3% was found on a more sensitive screening instrument for alcohol problems - the CAGE.[74]

## Fragile X Chromosome

In the first Irish family studied with fragile X chromosome, the proband with mental handicap and autism had, on Cytogenetic study, the fragile X in TC 199 in 30% of his cells. His sister had fragile X chromosome in 25% of her cells, and the younger sister had fragile X in 100% of her cells.[75]

## Delinquency

In a review of the delinquency problem, the principal of minimal intervention was evoked. The importance of



scientifically evaluating all aspects of the legal, educational and health interventions in relation to delinquents was stressed. Institutional approaches have not generally been shown to be effective and community approaches are probably least detrimental. There should be increased emphasis on high quality pre-school education, as well as parent training and support for mothers of at-risk children.[76]

## Disconnection and Disadvantage

The issue of disconnection is particularly relevant to urban disadvantaged areas, because socially isolated families are particularly at risk for psychological stress. Neighbours, clergy, voluntary groups and professionals should try to make social links with isolated families. Social linkage and social support can make a significant impact on psychological distress. It is not surprising that people who have supportive confiding relationships are less at risk.[77]

## Mid Life

One of the features of mid life is generativity, which is linking with and guiding children and adolescents. This is particularly important for distressed children and adolescents who don't have anyone to take a positive interest in them as persons. A good experience of this nature for a child or adolescent may make the difference between success and failure in life.[78]

## Planning Skills

In a study of children, it was pointed out that there is no reason to suppose that crime is generally more common now than in past centuries. The importance of helping children develop planning skills and experience success is underestimated. It is important for parents and educators to build up children's self esteem. Confident children are less at risk for psychological problems. Unfortunately, negative attunement has been a feature of Irish child learning.[79, 80.]

## Relational Model of Psychoanalysis

It is important to realise that there was a shift in psychoanalytical thinking, from Sigmund Freud's energy and economic models of psychological functioning, to the relational psychoanalysis which emphasises the importance of problems in relationships as factors in the development of psychological distress and disorders.[81]

## Cost Effectiveness of Psychotherapy

Concern has recently been expressed that psychiatric educators may be "losing the mind." Brain science has not yet and probably never will fully explain the mind. There is little doubt that psychiatric training programmes do not give sufficient attention to psychotherapy. A review of the literature concluded that the effect of psychotherapy was to reduce the use of medical services by about 20%.[82, 83, 84.] There is evidence that psychotherapy is more effective than no treatment, and has a greater effect size than placebo.



## Supervision

Insufficient attention has been paid to the supervisor/student relationship. If a supervisor is over-concerned for the patient, this suggests that the student is not tuned in to the patient in an empathic way. If the supervisor is performing well, then his comments should be confirmed by the patient's material. The use of the student for narcissistic aggrandisement by supervisors must be guarded against.[85]

## Technique of Psychoanalytic Psychotherapy

The key elements of the technique of psychoanalytic psychotherapy are the analysis of the affect or pain that brings a patient, and the analysis of the transference which allows the therapist to examine the forgotten feelings and attitudes developed in early life to important figures and transferred onto the therapist. These transference interpretations are most mutative, that is, bring about the most change.[86]

## Applied Child Psychoanalysis

Psychoanalysis has a role to play in helping paediatricians and nurses understand and respond to the emotional impact of physical illness on children. This aspect of intervention has tended to lag behind technology in the twentieth century. After the resolution of a medical crisis, the psychological needs of children in the very stressful environment of the hospital situation are just as important in the long term as the physical care of the child. Psychoanalytical thinking has been of considerable

ASSISTANCE TO LAWYERS AND CHILD CARE PROFESSIONALS IN THINKING ABOUT THE BEST INTERESTS OF THE CHILD, AND GIVING PARTICULAR IMPORTANCE TO PSYCHOLOGICAL PARENTHOOD.[87]

## Psychoanalysis, Behaviour Therapy and Pharmacology

In the past the disputes between psychoanalysts, behavioural therapists and psychopharmacologists were very unsatisfactory, and not in the best interests of patients. There is little doubt that these three forms of treatment have their place, either singly or in combination. Psychopharmacological drugs tend to have as their focus symptom relief, while psychoanalytic psychotherapy tends to show its effect more slowly, and on background personality factors as well as symptoms. It may be more useful to view them as having an additive or even mutually potentiating relation. Behaviour therapy has a place in enuresis, encopresis and behaviour problems.[88]

## Balint Groups

The renaissance in general practice, a phenomenon of the 1960's, owed a great deal to the recognition of the enormous therapeutic potential in the doctor/patient relationship. When problems occurred in this relationship, it led to much unnecessary suffering, irritation and fruitless effort. Balint helped G.P.'s to examine their countertransference feelings, and to use these to increase their understanding of the neurotic problems of their patients which caused them and their patients so much suffering.[89]



## Pregnancy

It is important to recognise mothers at psychological risk during pregnancy. Mothers with over-valued pregnancies, ambivalent pregnancies and historical sensitisation are at risk. It is a good time to intervene psychotherapeutically, as mothers are highly motivated before birth, and in touch with unconscious conflict and unresolved problems from childhood which may interfere with the psychological tasks of pregnancy which are emotional fusion with the foetus, differentiation of the foetus and self and progressive psychic separation of baby and mother.[90]

## Existentialism

Existentialistic philosophy is helpful in understanding alienation and man in a technological world. There are problems with it in that it denies the whole concept of mental illness, the biological basis of some mental illness and, also, genetic factors. Existential psychiatry establishes a dependent relationship that gratifies but cannot be worked through because the transference is ignored.[91]

## Hysterical Personality

The patient with an hysterical personality thinks in a vague way, with much feeling. This patient has difficulty in thinking clearly about feelings and behaviour. One of the aims of treatment is to help this patient to think clearly.[92]

## Narcissistic Personality

Empathy is very important in treating the patient with a narcissistic personality disorder. These patients are further hurt by too painful interpretation early in the treatment. If the therapist is empathic, the patient will experience a transmuting internalisation which will be strengthening to the personality, because a new internal object will be set up which will counter some of the negative internal objects from childhood.[93]

## Group versus Individual Psychotherapy

When individual and group psychoanalytic psychotherapy conducted by trainees were compared, both were found to be effective, but no difference was found between individual and group therapy in terms of improvement. Those in individual psychotherapy tended to have intrapersonal goals, while those in group therapy had interpersonal goals as their priority.[94]

## Therapist Difficulties

A study of a group of trainees conducting individual psychotherapy showed that the predominant categories of difficulty related to trainees feeling incompetent and threatened.[95]

## Registration of Psychotherapists

There is a need now for a working party of the Department of Health to be set up to examine and draw up guidelines for the statutory registration of



psychotherapists. The public is entitled to know the form, duration and quality of training had by people who call themselves psychotherapists and offer their services to the public. This is particularly so because psychotherapy is not inert, and has negative as well as positive effects.[96]

## Psychotherapy Services

Psychotherapy services in Ireland are largely available in urban areas. The largest number of practitioners would be in the Eastern Health Board area. In the public health service, therapists are generally employed under their core professional titles, i.e., psychiatrist, psychologist, social worker or nurse, and often psychotherapy is one of a number of treatment strategies. At the same time, there is a growing number of nurse-therapists who undertake behaviour therapy within the psychiatric service.[97]

## Contribution of Psychoanalysis to Psychiatry

The three theories most helpful in understanding mental illness are in the social domain, the biological domain and the psychoanalytic domain. Psychoanalytic psychotherapy has a role in the treatment of patients, particularly those with neurotic and personality problems. Psychoanalytic understanding is of assistance in the management of a wider variety of psychiatric problems. It is very important for the clinician to be able to integrate psychoanalytic, biological and social understanding of the patient. While Kraeplin classified, Freud understood; both are required.[98]

## Psychotherapy in Custodial Institutions

Psychotherapeutic experience has shown that it is possible to work psychotherapeutically in custodial institutions. Indeed, some acting out patients are only available for treatment in a secure setting. The treatment is still a voluntary one, in that the patient does not have to have the treatment if he does not wish.[99]

## Psychotherapy in a Psychiatric Outpatients'

A patient with neurotic depression failed to respond to anti-depressants and hospitalisation. It was only when childhood conflicts were dealt with in psychotherapy that improvement began.[100]

## Psychotherapy Training of Doctors

It is necessary for far greater emphasis and resources to be given to training of psychiatrists in psychotherapy, and for medical psychotherapists to have a place in the delivery of services to the mentally ill in Ireland.[101]

## Attitudes to Psychiatry

Over the course of nurse training, students became increasingly eclectic in their outlook, and saw a place for ECT and compulsory detention of certain cases.[102]



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# COMMON FACTORS IN PAEDIATRICS, OBSTETRICS, PSYCHIATRY.

MICHAEL FITZGERALD.

**IN RECENT** YEARS THE COMMON FACTORS IN PAEDIATRICS, OBSTETRICS AND PSYCHIATRY ARE BECOMING INCREASINGLY RECOGNISED. THE MIND IS THE BIGGEST COMMON FACTOR. MOTHERS AND BABIES HAVE MINDS. IT MUST NOT BE FORGOTTEN THAT PROFESSIONAL STAFF ALSO HAVE MINDS AND PERSONALITIES WHICH AFFECT, AND ARE AFFECTED BY, THEIR PATIENTS.

FOR A LONG TIME NOW, AN EXCESSIVE VALUE HAS BEEN PLACED ON OBJECTIVE SCIENTIFIC TRUTH. INTEREST HAS FOCUSED ON WHAT COULD BE OBSERVED. WE CAN OBSERVE BEHAVIOUR, BUT WE CANNOT OBSERVE INTERNAL MENTAL STATES. IT IS IMPORTANT TO INTEGRATE OBJECTIVE OR SCIENTIFIC TRUTH WITH SUBJECTIVE TRUTH. THEY SHOULD NEVER HAVE BEEN SEPARATED IN THE FIRST PLACE. THE GENERAL PRACTITIONER OF ONE HUNDRED YEARS AGO KNEW THE MEANING OF SUBJECTIVE TRUTH. IN RECENT YEARS IT IS BEING REDISCOVERED (JONES, 1977) BY SCIENTIFIC MEDICINE AND PSYCHOLOGY. SIGMUND FREUD IN THE DISCIPLINE HE FOUNDED, PSYCHOANALYSIS, HAS BEEN EMPHASISING SUBJECTIVE TRUTH SINCE THE TURN OF THE CENTURY.

Based on lecture to first Paediatric/Obstetric Psychiatric Conference, St. Brendan's Hospital, 12th November, 1982.

The disorders of the mother's mind during pregnancy and the baby's post-natally have received far less attention than the physical disorders of the baby. In the past, the physical danger to the mother and child was very great, with very considerable maternal and infant mortality.

With the increasing safety of child-bearing it might have been thought that much more attention would have been focused on the mental disorders of the pregnant state. This had not happened up to ten years ago. Today, research into the emotional aspects of pregnancy, childbirth and the neonatal period are a major growth area, (Davis, Richards, Roberton, 1983).

Perhaps the relative neglect of research into emotional factors and mental illness in the child-bearing and neonatal period has been due to the need for co-operation between two groups of specialised medical practitioners, obstetricians and paediatricians on the one hand, and on the other hand psychoanalysts, as well as midwives, developmental psychologists and social workers. These two major groups of health workers have had difficulty in communicating with each other.

It is possible that recent scientific advances in paediatrics and obstetrics have made interdisciplinary contact even more difficult.

It has been argued that the scientific model of pregnancy and childbirth is unable to put the woman's experience in terms of her whole life. There is a tendency to compartmentalise everything into concepts like pregnancy, neonatal period, etc.



The big issue for everyone in this area is to balance the psychological against the physical component of well-being. Are the psychologically upsetting rectal temperatures always necessary on a paediatric ward? Is it possible that physical medicine over-emphasises the physical issues and some extreme feminist groups and psychotherapists the opposite? Some of the feminist groups idealise the body and refuse to accept that it won't always work, and are then very shocked if childbirth does not go naturally. Professor F. Caplan, from Israel, who lectured in Ireland in 1982, emphasised that pregnant women who were prepared for all eventualities coped much better with problems when they arose. He called this "emotional innoculation."

In these days when the biochemical and psychological needs of premature and ill babies are so well studied and met, can we now be free to observe and think about the babies' emotional needs, which are expressed in physical ways? One of the issues of neonatal intensive care units is, how do you complement the technology with the more human instruments of care that are parents and staff? How are we to reduce the psychologically damaging effect of early hospitalisation? One cannot forget the striking links between early hospitalisation and later psychological problems, including child abuse. The close personal relationship between a regular nurse and baby can probably ameliorate some of this trauma. The regular nurse gets to know the baby and is able to tune into the baby's feelings and needs. She is able to understand the baby's distress and comfort him at critical periods, and by so doing to stand in for the mother. In reality, in a paediatric hospital a young child needs its mother if at all possible. How

OFTEN DOES IT HAPPEN THAT A CHILD HAS ITS MOTHER ALL THE TIME IN THIS STRANGE AND FRIGHTENING ENVIRONMENT? THE CHILD'S NEED FOR A REGULAR ATTACHMENT FIGURE IS AS GREAT AS THE CHILD'S NEED FOR FOOD. OF COURSE, SEPARATIONS ARE MORE SIGNIFICANT IN THE SECOND THAN IN THE FIRST SIX MONTHS OF LIFE.

ALL THIS BRINGS UP THE QUESTION OF WHO SHOULD TALK TO THE WORRIED MOTHER. WHO HAS THE TIME? SHOULD IT BE AN OBSTETRICIAN, PAEDIATRICIAN, GP, MIDWIFE, COUNSELLOR, PSYCHOANALYST, PSYCHIATRIST, NATIONAL CHILDBIRTH TEACHER, ANOTHER PREGNANT MOTHER, OR SOMEONE ELSE? IT IS INTERESTING TO NOTE THAT PREGNANT MOTHERS' COMPANIONS OR DOULAGH CAN REDUCE THE LENGTH OF LABOUR, AND ALSO HELP THE MOTHER TO PSYCHOLOGICALLY METABOLISE STRONG EMOTIONS OF HURT, ANGER, DISAPPOINTMENT AND GUILT, AS WELL AS JOY.

PREGNANT MOTHERS HAVE MANY FEARS, FANTASIES AND EXPECTATIONS. IN THE EARLY MONTHS OF PREGNANCY THEY CAN BE FILLED WITH DOUBTS, CONFUSION, REGRETS, ANXIETY, OR DISBELIEF THAT THEY ARE PREGNANT. THESE CONFLICTS CAN EXPRESS THEMSELVES THROUGH NAUSEA AND VOMITING. AGAIN, A WOMAN AT RISK WILL HAVE HAD A CONFLICTUAL RELATIONSHIP WITH HER OWN MOTHER IN CHILDHOOD. OTHER ANXIETIES INCLUDE FEAR THAT THE BABY IS DEAD OR MENTALLY HANDICAPPED, THAT THE BABY MIGHT FALL OUT OF THE WOMB, THAT THE BABY MIGHT TAKE OVER THE WOMAN LIKE A PARASITE, THAT THE MOTHER MIGHT HAVE DAMAGED THE BABY WITH HER FANTASIES, THAT THE BABY MIGHT DIE, OR BE IN DANGER, BECAUSE THE MOTHER HAD AN EARLIER ABORTION.

WHO TALKS TO THE MOTHER ABOUT THE PERSONAL MEANING OF INDUCTION TO HER? ONE WOMAN MAY BE ONLY MILDLY TROUBLED BY AN INDUCTION. ANOTHER MAY FEEL ROBBED OF HER CREATIVITY. IF THE MOTHER NORMALLY FEELS



INADEQUATE, INSECURE AND INCAPABLE OF ACHIEVEMENT, AND HAS BEEN IN GREAT RIVALRY WITH HER OWN MOTHER AND OTHER PEOPLE, SHE WILL REACT TO THE INDUCTION WITH A SENSE OF TOTAL FAILURE, RESENTMENT, DISTRUST AND DEPRESSION. I BELIEVE THAT THE MORE PSYCHOLOGICALLY DISTURBED WOMEN IN THE GROUPS I HAVE MENTIONED WILL NEED SPECIALISED PROFESSIONAL HELP, I.E., PSYCHOANALYTIC PSYCHOTHERAPY. PSYCHOANALYTIC PSYCHOTHERAPY IS MORE EFFECTIVE DURING PREGNANCY, AS THE PREGNANT MOTHER IS MORE IN TOUCH WITH UNCONSCIOUS PROCESSES. HOPEFULLY, THIS KIND OF WORK WILL REDUCE THE NUMBER OF CHILDREN WHO NEED TO ATTEND CHILD PSYCHIATRY CLINICS. TWENTY PER CENT OF CHILDREN IN THE INNER CITY AREA DEVELOP CHILD PSYCHIATRIC ILLNESS. MOTHERS' GROUPS AND THE NATIONAL CHILDBIRTH GROUPS, ETC., ALSO HAVE A SIGNIFICANT ROLE TO PLAY.

## PUERPERAL DEPRESSION AND "BLUES"

BETWEEN ONE-HALF AND TWO-THIRDS OF NEWLY DELIVERED WOMEN DEVELOP "THE BLUES," AND IT SHOULD BE REGARDED AS NORMAL. IT USUALLY OCCURS AROUND THE THIRD OR FOURTH DAY AND LASTS A FEW DAYS. ABOUT TEN PER CENT OF WOMEN BECOME DEPRESSED AROUND THE THIRD WEEK POST-NATALLY, DEVELOPING POST-NATAL DEPRESSION. THE FOLLOWING WOMEN ARE AT RISK OF PUERPERAL DEPRESSION:-

(A) THOSE WHO LOST THEIR MOTHERS BEFORE THE AGE OF ELEVEN YEARS;
(B) THOSE WHO HAVE HAD LIMITED CONTACT WITH MOTHER IN CHILDHOOD;
(C) THOSE WITH A PREVIOUS HISTORY OF DEPRESSION;
(D) THOSE WHO SHOW MARKED AMBIVALENCE ABOUT PREGNANCY;
(E) THOSE WITH UNSUPPORTIVE SPOUSES;
(F) THOSE WITH POOR HOUSING;
(G) THOSE WITH LACK OF CONFIDENCE;
(H) THOSE WITH HIGH ANXIETY AT THE END OF PREGNANCY.

## Recent Research on Neonatal Development

Our view of the new-born human has changed quite dramatically. He used to be seen as existing in an undifferentiated state or tabula rasa.

It is clear that the neonate has pre-adaptive potential for direct interaction with the mother. The focus of his gaze is most accurate on objects about eight inches away, the exact distance from his mother's eyes when he is held in the normal breast or bottle feeding position. The baby will look for longer periods at line drawings of a face than at dots. By the age of two weeks the baby will look longer at his mother's face than at a stranger's, and at mother longer again if she talks to him. The new-born will turn away from unpleasant odours and turn his eyes correctly to the source of sound. The infant's early capacity for organising his experience is suggested by the successful mastery of thumb-sucking. On the fifth day, numerous trial attempts will be made before the thumb enters the mouth, whereas by the tenth it will be a successfully executed pattern. Infants aged twelve to twenty-one days can consistently copy facial and manual gestures made by adults, (Rutter, M., 1980)

While the significance of mother's emphatic caretaking is entirely familiar, the role of the infant as an active force in interaction with mother has been less well appreciated. One study discovered that more than half of the observed interactions were initiated by the infant. Many researchers believe that the behaviours of the neonate are inbuilt in order to function as elicitors of maternal responsiveness. Over the last twenty years, researchers have become aware that neonatal organisation is far more complex than has



been believed. In the past it was believed that the infant was passively shaped by events.

It is interesting to note that many of the talented psychologists have been influenced by psychoanalysis. At present this shows itself in developmental psychologists' interest in internal mental states and in what is meaningful to the child.

## Staff Feelings

It is important not to forget the role of the emotions of the professionals in relation to the patient, or the professionals' need for support. The professionals sometimes cope with the strong emotions aroused by childbirth and its problems by distancing themselves emotionally from the mother. It is possible that technological advances have increased this distance between the mother and the professional. Anyone who has worked in an obstetric or paediatric unit will know the anxiety and stress of a personal responsibility for the life of the mother and infant.

Staff need time for thinking and reflecting as well as action, and more often they are not given the space to think and reflect about their work. In some countries, psychotherapists are getting involved in these units to help staff deal with the above issues, for example, by using part of the weekly staff meeting for this purpose. Sometimes in neonatal intensive care units, staff deal with their strong emotions about dying infants by avoidance, for example, of parents' visits; by denial, and by withdrawal of emotional investment in the sick baby; or by manic reparation,

FOR EXAMPLE, NURSES CONSOLING THEMSELVES THAT MOTHER WILL SOON BE PREGNANT AGAIN.

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# PSYCHOLOGICAL ADAPTATION TO PREGNANCY AND PSYCHOANALYTIC ASPECTS

MICHAEL FITZGERALD.

**IN RECENT YEARS** THERE HAS BEEN A SHIFT, FROM A PSYCHOLOGICAL POINT OF VIEW, FROM A FOCUS EXCLUSIVELY ON THE FEW HOURS OF LABOUR AND THE PREPARATION FOR THESE TO INTEREST IN THE ONGOING EMOTIONAL PREPARATION OF THE MOTHER FOR MOTHERHOOD. THIS HAS BEEN VERY WELL DEVELOPED BY RAPHAEL-LEFF (1982), WHOSE IDEAS I MAKE USE OF IN THIS LECTURE, PARTICULARLY HER PAPER ON THE "NEEDS OF MOTHERS-TO-BE."

THE PURPOSE OF PREGNANCY IS NOT MERELY TO CREATE A BABY, BUT ALSO TO PRODUCE A MOTHER. A MOTHER IS NOT BORN WITH THE BIRTH OF HER CHILD. SHE IS ABLE TO MOTHER HER NEW-BORN ONLY IF SHE HAS DEVELOPED THE ROLE THROUGH IDENTIFICATION WITH HER OWN MOTHER IN CHILDHOOD AND THROUGH THE EXPERIENCE OF BEING MOTHERED BY PARENTAL FIGURES FROM INFANCY ONWARDS. MOST WOMEN DEVOTE THEIR PREGNANCY TO THE CULTIVATION AND PRACTICE OF THEIR MOTHERLINESS. IF THE PREGNANT WOMAN HAS HAD BAD EXPERIENCES AS A CHILD - IF SHE HAS BEEN DISREGARDED OR REJECTED BY, OR SEPARATED FROM HER MOTHER - THEN SHE IS GOING TO HAVE MUCH GREATER DIFFICULTY IN IDENTIFYING WITH THE MOTHERING ROLE, (RAPHAEL-LEFF, 1982).

Based on lecture to National Maternity Hospital, Dublin - 14th June, 1984.

MOST PREGNANT WOMEN ACHIEVE THIS PSYCHIC TASK OF IDENTIFICATION WITH MOTHERHOOD, AND ATTAIN THEIR OWN UNIQUE ADAPTATION TO THIS ROLE BY THE TIME THE BIRTH IS IN SIGHT. HOWEVER, THERE ARE WOMEN WHO CANNOT ACCOMPLISH THIS PREPARATION ALONE. IF THE EMOTIONAL TRANSITION TO MOTHERHOOD IS TO BE ACHIEVED BY THEM, SOME OF THESE WOMEN WILL NEED PSYCHOTHERAPEUTIC HELP.

IN A SOCIETY SUCH AS OURS, WHERE RESOURCES ARE BECOMING SCARCE, IT IS CLEARLY IMPORTANT THAT WE DETECT, AT AN EARLY STAGE, PREGNANT WOMEN WHO ARE AT HIGH RISK FROM A PSYCHOLOGICAL POINT OF VIEW, AND THAT WE DEVELOP PREVENTIVE STRATEGIES, THEREBY REDUCING THE COST OF TREATING ESTABLISHED CONDITIONS IN CHILD GUIDANCE CLINICS, ETC. I UNDERTOOK A RECENT STUDY OF A NUMBER OF NORMAL PRIMARY SCHOOLS IN A DISADVANTAGED AREA, AND FOUND THAT 20% OF THE BOYS WERE BEHAVIOURALLY DEVIANT OR SHOWING SIGNS OF PSYCHOLOGICAL DISTURBANCE.

THE READINESS WITH WHICH MANY WOMEN APPLY FOR ANTENATAL CARE FACILITATES EARLY SCREENING FOR THOSE IN NEED OF TREATMENT. MOREOVER, TIMELY PSYCHO-THERAPEUTIC INTERVENTION DURING PREGNANCY CAN MODIFY THE DEVELOPMENT OF PATHOLOGICAL INTERACTION BETWEEN MOTHER AND FOETUS INITIALLY, AND BETWEEN MOTHER AND BABY LATER ON. PREGNANT WOMEN ARE IDEAL CANDIDATES FOR BRIEF PSYCHOTHERAPEUTIC INTERVENTION, BEING HIGHLY MOTIVATED TO CHANGE BEFORE THE BIRTH AND, BY VIRTUE OF THEIR PREGNANCY, BEING UNIQUELY IN TOUCH WITH THEIR UNCONSCIOUS PROCESSES, UNCONSCIOUS CONFLICT AND UNRESOLVED PROBLEMS FROM CHILDHOOD WHICH PLAY A MAJOR ROLE IN LATER PSYCHIATRIC ILLNESS.

PREGNANCY IS A MAJOR LIFE EVENT OR CRISIS IN A MOTHER'S LIFE. WITH THE HIGH BIRTH RATE IN IRELAND IT IS NOT ALWAYS REALISED HOW MAJOR A LIFE EVENT PREGNANCY IS, PARTICULARLY IF IT IS NOT PLANNED. IT IS AT TIMES LIKE THESE THAT WOMEN ARE MOST OPEN TO CHANGE, AND



BRIEF PSYCHOTHERAPY, BY WHICH I MEAN TALKING TO THE WOMAN - ABOUT HER CONFLICTUAL RELATIONSHIP TO HER OWN MOTHER, HER CONFLICTS IN RELATION TO HER FOETUS, HER FEAR ABOUT THE HER MOTHERING ABILITY LATER ON, ETC. - CAN BRING ABOUT VERY SIGNIFICANT CHANGE, INCLUDING RESOLUTION OF CONFLICTS, CHANGE IN ATTITUDE TOWARDS HER OWN BABY, CHANGE IN HER VIEW OF HERSELF AS A MOTHER, ETC., AND THIS CAN BE BROUGHT ABOUT AT IN A VERY COST-EFFECTIVE WAY.

IT IS IMPORTANT THAT WORKERS IN ANTENATAL CLINICS ACQUIRE DIAGNOSTIC SKILLS, IN ORDER TO BE ABLE TO SCREEN WOMEN IN THEIR CARE AND REFER THOSE AT RISK FOR PSYCHOTHERAPEUTIC HELP.

## PREGNANT WOMEN AT RISK

AT A GROSS LEVEL, THESE ARE EASILY IDENTIFIED, FOR EXAMPLE, WOMEN WHO SHOW EXCESSIVE ANXIETY, AND HERE I AM NOT REFERRING TO INQUIRIES AND REQUESTS FOR INFORMATION, BUT TO DEPRESSION, DENIAL OR DETACHMENT, DELUSIONS, DEPERSONALISATION, DEREALISATION, AND EXAGGERATED WORRY OR CONCERN ABOUT LABOUR, FOETAL NORMALITY AND VIABILITY.

THERE ARE SUBTLE WARNING SIGNS INDICATING DISTURBANCE WHICH HAS NOT YET DEVELOPED INTO PSYCHO-PATHOLOGY AND IS THEREFORE MORE AMENABLE TO TREATMENT. IT IS THESE WARNING SIGNS THAT ANTENATAL CARE PROFESSIONALS SHOULD LEARN TO DETECT, NAMELY THE INABILITY TO ACCOMPLISH THE PSYCHOLOGICAL TASK APPROPRIATE TO EACH STAGE OF PREGNANCY.

THE NORMAL EMOTIONAL DEMANDS OF PREGNANCY NECESSITATE THAT A WOMAN GIVES IN TO THE PROCESS OF

PREGNANCY, REGRESSES, BECOMES MORE INTROSPECTIVE, MORE EMOTIONALLY LABILE, AND ALLOWS HERSELF TO GET IN TOUCH WITH THE PRIMITIVE EXPERIENCE OF PREGNANCY.

SUBTLE WARNING SIGNS WOULD INCLUDE A MARKED ABSENCE OF EMOTION, INCREASED OBSESSIONALITY IN PROFESSIONAL ACTIVITY IN THE PREGNANT PROFESSIONAL AND/OR FRANTIC SOCIALISING, DENIAL OF WORRIES, DENIAL OF ANXIETY OR CONCERN ABOUT THE PREGNANCY OR FUTURE MOTHERHOOD, AS WELL AS AN EXTREMELY PURITANICAL ATTITUDE TOWARDS ENJOYMENT, RELAXATION OR SELF-INDULGENCE. OBVIOUSLY, AS WITH OTHER FORMS OF DISTURBANCE ALREADY MENTIONED, PREGNANT WOMEN WITH SUCH RIGID DEFENSES ARE OBSTRUCTED IN THEIR INABILITY TO FULFIL THE EMOTIONAL WORK OF PREGNANCY.

## PERSONAL RISK FACTORS

MOST WOMEN EXPERIENCE SOME EMOTIONAL AND COGNITIVE CHANGES DURING PREGNANCY, SUCH AS DISTURBANCE OF MEMORY, ALTERED SPACIAL ORIENTATION, MILD NOMINAL APHASIA, UNCONTROLLABLE MOOD SWINGS, MAGICAL THOUGHT PROCESSES, SUPERSTITIOUS BEHAVIOUR PATTERNS, INSOMNIA AND ANXIETY. HOWEVER, OTHER PERSONAL RISK FACTORS MAY INTERFERE WITH THE PSYCHOLOGICAL ADAPTATION OF A PREGNANCY, AND THESE WOMEN MAY NEED PSYCHOLOGICAL HELP TO DEAL WITH THE STRESS AND STRAIN OF PREGNANCY.

<u>OVER-VALUED PREGNANCIES</u>: DURING THESE PREGNANCIES WOMEN OSCILLATE BETWEEN HOPE AND DISTRUST, ELATION AND DETACHMENT, IDEALISATION AND SUPREME EMOTIONAL INVESTMENT, FLUCTUATING WITH DREAD AND A CONVICTION OF FAILURE. MANY OF THESE WOMEN MONITOR THE PREGNANCY AND ARE CONVINCED THAT, IF THEY LOSE CONCENTRATION EVEN MOMENTARILY, THEIR LACK OF VIGILANCE WILL LEAD TO THE



DISAPPEARANCE OF THE FOETUS. UNTREATED, THESE WOMEN BECOME OVER-ANXIOUS MOTHERS WHO DISTRUST THEIR BABIES' ABILITY TO BREATHE THROUGH THE NIGHT, PRESENT AT CASUALTY CLAIMING NEAR-MISS COT DEATHS, AND OBTAIN MECHANICAL MONITORS AND ALARM SYSTEMS TO STRAP ONTO THEIR SLEEPING BABIES OVERNIGHT.

<u>AMBIVALENT PREGNANCIES</u>: AN EXAMPLE WOULD BE, A WOMAN HAVING HER BABY AFTER THE AGE OF THIRTY-FIVE AS A PRESSURISED "LAST CHANCE" CONCEPTION, MOTHERHOOD CONFLICTING WITH AN ESTABLISHED CAREER AND FAMILIAR IDENTITY. WOMEN IN FEMININE REVOLT MAY EXPERIENCE AMBIVALENCE ABOUT THEIR PREGNANCY, AND MAY FEEL THEY HAVE SOLD OUT THE WOMEN'S MOVEMENT. THEY DON'T HAVE ENOUGH SPACE IN THEIR MINDS TO CARRY OUT THE PSYCHOLOGICAL WORK OF PREGNANCY BECAUSE OF THESE PREOCCUPATIONS.

<u>LIFE EVENTS</u>: WHEN THESE LIFE CRISES COINCIDE WITH THE EMOTIONAL CRISES OF PREGNANCY, THEY DOUBLE THE LOAD, INTERRUPT THE PSYCHOLOGICAL WORK AND NATURAL PROCESSES OF PREGNANCY, AND PRESENT INTRUSIVE AND OFTEN CONFLICTING DEMANDS. AGAIN, THE WOMAN DOESN'T HAVE ENOUGH PSYCHOLOGICAL SPACE TO CARRY OUT THE WORK OF PREGNANCY.

<u>HISTORICAL SENSITISATION</u>: THESE WOMEN HAVE INCREASED ANXIETY DURING PREGNANCY, WHICH AGAIN CAN INTERFERE WITH PSYCHOLOGICAL ADAPTATION OF THE PREGNANCY. FOR EXAMPLE, A WOMAN WHO WAS HERSELF ADOPTED AS AN INFANT IS PARTICULARLY VULNERABLE DURING PREGNANCY, AS IT INVITES A SPLIT IN HER IDENTIFICATION BETWEEN HER NATURAL AND ADOPTIVE MOTHERS, AND A REVIVAL OF THE PRIMITIVE BELIEF THAT SHE CANNOT CONCEIVE BECAUSE HER ADOPTIVE MOTHER COULD NOT, AND CANNOT RETAIN THE INFANT BECAUSE HER NATURAL MOTHER COULD NOT.

EATING DISORDERS: FINALLY, THE GROUP OF WOMEN WITH EATING DISORDERS. HERE PREGNANCY WREAKS HAVOC WITH THEIR CONTINUOUS PREOCCUPATION WITH THEIR BODY IMAGE, SIZE AND ASEXUALISED APPEARANCE. IN ADDITION TO THEIR PSYCHOLOGICAL VULNERABILITY, THERE ARE THE PHYSICAL DANGERS OF FOOD REFUSAL, OBESITY, AS WELL AS THE POTENTIAL FUTURE FEEDING DIFFICULTIES OF THEIR OWN INFANTS.

## THE EMOTIONAL WORK AND SPECIFIC TASKS OF PREGNANCY

Table 1.

PSYCHOLOGICAL TASKS OF PREGNANCY (Raphael-Leff, 1982)

| | |
|---|---|
| 1. | Emotional fusion with foetus. |
| 2. | Differentiation of foetus and self. |
| 3. | Progressive psychic separation of baby and mother. |

AS TABLE 1 SHOWS, THE **FIRST TASK** OF THE PREGNANT WOMAN, FROM A PSYCHOLOGICAL POINT OF VIEW, IS THE ACHIEVEMENT OF EMOTIONAL FUSION WITH THE FOETUS AND PSYCHICALLY ACCEPTING THE EMBRYO AS AN INTEGRAL PART OF HERSELF, RATHER THAN A FOREIGN BODY. THUS, WOMEN WHO ARE UNABLE TO ACHIEVE EARLY FUSION IN PREGNANCY FIND DIFFICULTY IN EARLY BONDING AND ACCEPTING THIS SYMBIOTIC RELATIONSHIP WITH THE NEW-BORN LATER ON. (RAPHAEL-LEFF, 1983).



FEAR OF EXPERIENCING THIS UNION MAY RESULT IN THE DEFENSIVE NEED TO UNDERLINE THE WOMAN'S OWN NEED FOR SEPARATENESS IN THIS BIZARRE SITUATION OF TWO PEOPLE INHABITING THE SAME BODY. AS ONE PATIENT SAID IN HER FOURTH UNWANTED PREGNANCY, "THIS BABY HAS INVADED MY BODY, BUT MY HEAD IS MY OWN." ANOTHER WOMAN HAD A FANTASY AT THIS STAGE THAT PRECLUDED FUSION WHEN SHE SAID, "THE BABY IS LIKE A CANCEROUS GROWTH - INVADING MY BODY, GROWING, GOING ITS OWN COURSE, OUT OF MY CONTROL." IT IS IMPORTANT THAT WOMEN ARE GIVEN THE TIME AND SPACE TO MAKE THESE KINDS OF STATEMENTS AT THE ANTENATAL CLINIC.

OTHER WOMEN SOMETIMES MAKE COMMENTS LIKE, "IT WILL JUST HAVE TO FEND FOR ITSELF IF IT WANTS TO SURVIVE, I AM GOING TO GO ON AS I WOULD HAVE DONE IF I WASN'T PREGNANT." (RAPHAEL-LEFF, 1983).

CONFLICTS ABOUT THE RETENTION OF THE PREGNANCY MAY BE EXPRESSED SYMBOLIC ATTEMPTS TO EXPEL THE FOREIGN BODY. PHYSICAL SYMPTOMS SUCH AS EXCESSIVE VOMITING OR SEVERE FUNCTIONAL DIARRHOEA MAY BE UTILISED TO THIS END. IN EXTREME CASES, REJECTION OF THE PREGNANCY MAY ACTUALLY LEAD TO SPONTANEOUS ABORTION, HOWEVER, ONE SEES THE PREGNANT WOMAN'S REJECTION OF THE PREGNANCY MORE BY HER BEHAVIOUR. SHE MAY INDULGE IN NEGLECTFUL, DAMAGING OR DESTRUCTIVE BEHAVIOUR SUCH AS DRUG ABUSE, ALCOHOL AND NICOTINE ABUSE, UNBALANCED FOOD INTAKE OR DELIBERATE OR UNCONSCIOUS COURTING OF DANGER, INCLUDING PHYSICAL OVER-EXERTION OR HAZARDOUS ACTIVITIES.

THE FIRST STAGE SIMPLY CONSISTS OF THE WOMAN ACCEPTING THE FOETUS INSIDE HER AS PART OF HER.

THE **SECOND EMOTIONAL TASK OF PREGNANCY** IS THE GRADUAL DIFFERENTIATION OF FOETUS AND SELF WHICH OCCURS AFTER THE QUICKENING.

OUT OF THE FUSION OF THE INITIAL STAGE THE MOVING FOETUS HATCHES TO ACKNOWLEDGE THE FAMILIAR YET SEPARATE AND AUTONOMOUS. THE WOMAN USUALLY BEGINS ATTRIBUTING FEATURES, PERSONALITY, QUIRKS AND SOMETIMES EVEN A NAME, WHILE SHE NOW HATCHES INTO A PHYSICAL OBSERVANCE OF HER PREGNANT STYLE, DRESSING ACCORDINGLY, TELLING ACQUAINTANCES OF IT AND MODIFYING HER LIFESTYLE APPROPRIATELY.

SUBTLE WARNING SIGNS AT THIS STAGE MAY BE DETECTED IN AN INABILITY TO IDENTIFY WITH THE MOTHERING ROLE, DUE TO UNMITIGATED FEELINGS OF HOSTILITY OR ANGER TOWARDS HER OWN MOTHER. FOR EXAMPLE, A PREGNANT MOTHER SAID, "I DON'T WANT TO BE A MOTHER - MOTHERS ARE TYRANTS, MANIPULATORS, IT'S ALL A POWER TRIP, A BATTLE OF WILLS. I'D RATHER OPT OUT ONCE THIS PREGNANCY IS OVER AND LET SOMEONE ELSE DO THE DIRTY WORK." (RAPHAEL -LEFF, 1983).

ANOTHER WARNING SIGN IS THE IDEALISATION BY THE PREGNANT WOMAN OF HER MOTHER TO THE POINT OF CURTAILING HER OWN CAPACITY AS A MOTHER. FOR EXAMPLE, A WOMAN SAID, "MY MOTHER WAS SO FANTASTIC, SO PATIENT AND DEVOTED. I COULD NEVER BE ANYTHING LIKE HER, IF SHE WAS STILL ALIVE I WOULD JUST HAND HER OVER MY BABY, BUT AS THINGS ARE, I HAVE NOTHING MUCH TO OFFER THIS BABY."

A FINAL WARNING IN THE SPHERE OF DIFFERENTIATION, OR THE SECOND STAGE, IS THE INABILITY OF THE PREGNANT WOMAN TO HAVE A RANGE OF VARYING FANTASIES ABOUT THE FOETUS. THESE INCLUDE A NOTICEABLE POVERTY OF IMAGINATION CONCERNING THE BABY OR MAINTENANCE OF A



FIXED IDEA OF THE OUTCOME, FOR EXAMPLE, "IT'S GOING TO HAVE A CLEFT PALATE," OR "SHE'S GOING TO LOOK LIKE MY SISTER DID."

WHAT ARE THE CONSEQUENCES AFTER DELIVERY IF A WOMAN DOESN'T ACHIEVE THIS SECOND STAGE DURING PREGNANCY? WOMEN WHO HAVE DIFFICULTY IN ACHIEVING THIS DIFFERENTIATION DURING PREGNANCY TEND TO PROLONG THE EARLY SYMBIOTIC FUSION WITH THEIR INFANTS BEYOND ITS APPROPRIATE PHASE AFTER DELIVERY, MEETING ALL THE BABY'S NEEDS BEFORE THEY ARE EXPRESSED OR EVEN RECOGNISED BY THE INFANT, AND DISCOURAGING INDEPENDENT ACTION, WHICH CAN HAVE SERIOUS CONSEQUENCES FOR THE CHILD'S DEVELOPMENT LATER ON.

FINALLY, ANOTHER POINT ABOUT THE PREGNANT WOMAN'S ATTITUDE TOWARDS HER OWN MOTHER. IT IS GENERALLY FELT THAT BY THE THIRD TRIMESTER OF PREGNANCY MOST NORMAL WOMEN WILL HAVE ACHIEVED A RECONCILIATION WITH THEIR MOTHERS, AND WILL BE APPRAISING THEM MORE REALISTICALLY, RESOLVING THEIR MIXED FEELINGS ABOUT THEM AND RETROSPECTIVELY SEEING THEIR CHILDHOOD AS GOOD AND THEIR MOTHERS AS GIVING.

THE **THIRD STAGE OR THIRD EMOTIONAL TASK OF PREGNANCY** IS THE PSYCHOLOGICAL SEPARATION OF MOTHER AND BABY, CULMINATING IN THE PHYSICAL SEPARATION AT BIRTH.

WITH THE PROGRESSION OF NORMAL PREGNANCY, THE WOMAN MUST BEGIN PREPARING HERSELF FOR THE INEVITABLE SEPARATION FROM HER FOETUS. THIS COINCIDES WITH THE NUMBER OF WEEKS IN WHICH THE MOTHER BELIEVES THE BABY TO BE VIABLE OUTSIDE HER BODY IF BORN PREMATURELY. SHE COMPLETES THE PSYCHOLOGICAL SEPARATION FOR BIRTH, BECOMES CURIOUS ABOUT THE BABY AND FED UP WITH THE PREGNANCY. SHE ACCEPTS THAT THE BABY HAS A REALITY

OUTSIDE HERSELF AND THAT NO AMOUNT OF FANTASISING WILL ALTER ITS IDENTITY. (RAPHAEL-LEFF, 1983).

NOT SO THE DISTURBED MOTHER-TO-BE. THE WOMAN WHO HAS BEEN UNABLE TO COMPLETE THE SECOND STAGE, THE STAGE OF DIFFERENTIATION, MAY NOW BELIEVE THAT THE PREGNANCY WILL GO ON FOREVER. ALSO, THE WOMAN WHO HASN'T COMPLETED THE FIRST STAGE, THE STAGE OF FUSION, MAY NOW BE EMPHASISING THE BABY'S SEPARATENESS AND WILL ALSO BE ENUMERATING THE UNACCEPTABLE THREATS TO THE FUTURE BABY AND THE CONDITIONS UNDER WHICH SHE WILL TAKE THE BABY HOME FROM HOSPITAL.

AT THIS STAGE THE WOMAN WHO HASN'T COMPLETED THE FIRST TWO STAGES OF ADAPTATION TO PREGNANCY WILL BE FULL OF FEARS ABOUT THE LABOUR. IT APPEARS THAT SOME OF THESE FEARS CAN ALTER THE COURSE OF LABOUR, AND ONE FAIRLY COMMON THEME IS DUE TO THE REVIVAL OF A PRIMITIVE BELIEF THAT THERE IS A SINGLE CAVITY WITHIN THE BODY, HOUSING A CONFUSION OF FOOD, FAECES, FOETUS, INTERNAL ORGANS, URINE AND MILK.

THE FEAR, AS VERABLISED BY A PATIENT, IS THAT DURING CHILDBIRTH EVERYTHING INSIDE HER WOULD COME SPILLING OUT, LUNGS, LIVER, EVEN HER BRAINS. ASSOCIATED WITH THIS IDEA IS THE FEAR OF LOSING CONTROL, OF SPILLING OUT THE SECRETS OF THE MIND. ONE WOMAN STATED "THAT THE CHALLENGE OF LABOUR WOULD BE TO DO IT WELL, TO DISCOVER HER BREAKING POINT. THAT WAS THE TERRIBLE ATTRACTION OF IT, AS WELL AS THE GREAT FEAR THAT SHE WOULD REACH THE BREAKING POINT, AND BREAK AND GO UNDER AND BE DAMAGED AND NEVER RECOVER." (RAPHAEL-LEFF, 1982).

A FACTOR IN PROLONGED LABOURS MAY BE THE WOMAN'S DISBELIEF IN HER OWN ABILITY TO PRODUCE SOMETHING



HEALTHY, LIVE AND GOOD WITHIN HERSELF. ANOTHER PREGNANT WOMAN STATED THAT SOMETIMES SHE COULDN'T REALLY BELIEVE THAT SHE WOULD BE ALLOWED TO HAVE A BABY, SHE WAS SO AFRAID THAT IT WOULD JUST "GO POP" AND DEFLATE. BUT SOMETIMES, SHE THOUGHT THAT IF IT REALLY HURT, IF THE PAIN WAS REALLY BAD, THEN SHE WOULD HAVE EARNED THE BABY AND COULD TAKE IT HOME. IN SUCH CASES AS THESE THE DELIVERING MIDWIFE IS OF PRIME IMPORTANCE, REPRESENTING THE WOMAN'S OWN MOTHER, PERMITTING OR PROHIBITING BIRTH. SIMILARLY, WARM ENCOURAGEMENT ABOUT HANDLING AND NURSING THE NEW-BORN WILL GREATLY FACILITATE THE WOMAN'S INITIAL ACCEPTANCE OF HER OWN RIGHT TO BE A MOTHER.

## PRIMARY MATERNAL PREOCCUPATION

DONALD WINNICOTT (1958), A PAEDIATRITION AND PSYCHO-ANALYST, DESCRIBED A STATE TOWARDS THE END OF PREGNANCY AND FOR A FEW WEEKS AFTER DELIVERY CALLED "PRIMARY MATERNAL PREOCCUPATION." HE SAW THIS AS A STATE OF HEIGHTENED SENSITIVITY - ALMOST AN ILLNESS, THOUGH VERY MUCH A NORMAL STAGE - WHICH WAS NOT EASILY REMEMBERED BY MOTHERS ONCE THEY HAD RECOVERED FROM IT AND TENDED TO BE REPRESSED. IN THIS STATE, THE MOTHER IS LARGELY PREOCCUPIED WITH THE BABY. SHE IS SOMEWHAT OBLIVIOUS TO THE OUTSIDE WORLD AND TO NORMAL DUTIES. SOMETIMES THIS STATE IS MISDIAGNOSED BY PEOPLE AS EXCESSIVE ANXIETY. IN THIS STATE THE MOTHER IS ABLE TO BE EXTREMELY SENSITIVE AND TO TUNE IN TO THE BABY'S NEEDS, TO GET TO KNOW AND BOND TO THE BABY. WHERE ONE IS WORRIED IS WHERE THERE IS EVIDENCE THAT THE MOTHER HAS NOT DEVELOPED THIS STATE. I HAVE NOTICED SOMETIMES THAT VERY INTENSELY CAREER-ORIENTATED WOMEN CANNOT ALLOW THESELVES TO REGRESS AND TO GET PREOCCUPIED WITH THE BABY AT THIS TIME AS THEY SHOULD.

I REMEMBER ABOUT FIVE YEARS AGO I OBSERVED A MOTHER AND BABY FROM THE TIME OF BIRTH FOR ONE HOUR EACH WEEK FOR OVER A YEAR. THIS PARTICULAR MOTHER, WHO WOULD BE REGARDED AS PSYCHIATRICALLY NORMAL, WAS SLIGHTLY OBSESSIONAL AND PERFECTIONISTIC AND HOUSEPROUD. WHEN I VISITED DURING THE EARLY COUPLE OF WEEKS, SHE WOULD BE AT TIMES MORE PREOCCUPIED WITH GETTING HER HUSBAND'S LUNCH AND KEEPING THE HOUSE TIDY THAN WITH THE BABY. SHE HAD DIFFICULTY REALLY IN LETTING HERSELF GO. ANOTHER MOTHER DESCRIBED HOW, WHEN SHE WENT INTO A SUPERMARKET ABOUT A WEEK AFTER THE BABY WAS BORN, SHE FELT SHE WAS IN A KIND OF DREAMLIKE STATE, THAT THINGS SEEMED UNREAL AROUND HER AND THAT PEOPLE WERE "KIND OF LOOKING" AT HER. THIS KIND OF STATE DURING AND AFTER PREGNANCY IS PERFECTLY NORMAL, BUT IF THIS OCCURRED SIX MONTHS LATER, OR IN A NON-PREGNANT PERSON, ONE WOULD REGARD THE PERSON AS HAVING A PSYCHIATRIC ILLNESS. IT IS IMPORTANT THAT DURING THESE EARLY DAYS, AND DURING THIS SENSITIVE PERIOD, THE BABY IS LEFT WITH THE MOTHER AS MUCH AS POSSIBLE, AND THAT THE INSTITUTION OR THE INSTITUTIONAL RITUALS DO NOT INTERRUPT MOMENTS OF CLOSENESS AND SENSITIVITY BETWEEN MOTHER AND BABY.

## TREATMENT OF WOMEN WHO ARE NOT ADAPTING PSYCHOLOGICALLY TO PREGNANCY

THESE WOMEN SHOULD BE TREATED EITHER IN GROUP OR IN INDIVIDUAL THERAPY (RAPHAEL-LEFF, 1982).

INDEED, IT IS POSSIBLE THAT PUTTING THE CHAIRS IN THE ANTENATAL CLINIC WAITING-ROOM IN A CIRCLE MIGHT ALLOW A NATURAL SELF-HELP GROUP TO DEVELOP, MAKING GOOD USE OF THE WAITING TIME AND LEAVING FEWER DISGRUNTLED PATIENTS.



THE MORE FORMAL GROUP THERAPY WITH A GROUP LEADER IS AN EXCELLENT TOOL FOR PREGNANT WOMEN, FOR A NUMBER OF REASONS. THERE IS A BUILT-IN TERMINATION DATE AND THIS INVOLVES A SENSE OF URGENCY TO ACHIEVE PSYCHOLOGICAL GROWTH AND STABILITY BEFORE BIRTH. IT ALLOWS MANY STRANGE EXPERIENCES TO BE ASSIMILATED AND ABSORBED DURING PREGNANCY. IF THE WOMEN IN THE GROUP THERAPY ARE AT VARIOUS STAGES OF PREGNANCY, THEN IT WILL ALLOW SOME WOMEN TO REMEMBER SOME OF THE EARLIER STAGES OF PREGNANCY AND OTHER WOMEN TO ANTICIPATE LATER STAGES. IN A WAY, IT COULD BE ARGUED THAT EVERY PREGNANT WOMAN COULD BENEFIT FROM THE OPPORTUNITY TO DISCUSS HER CHANGING SENSE OF IDENTITY AND UNFAMILIAR FEELINGS. MIXED DISCUSSION GROUPS FOR PRIMAGRAVIDA AND MULTIPARA ALSO SERVE TO DISPEL THE CULTURALLY INDUCED, UNREALISTIC AND ROMANTICISED EXPECTATIONS OF MOTHERHOOD WHICH OFTEN LEAD TO POST-NATAL DEPRESSION, GUILT, DISAPPOINTMENT AND DESPAIR IN NEW MOTHERS, AND ARE AN IMPORTANT FACTOR IN PUERPERAL BREAKDOWN AND BABY-BATTERING LATER.

THE AIM REALLY IS TO HELP THE WOMEN TO SORT THEIR FANTASIES AND ANXIETIES FROM REALITY. IN SOME WOMEN THE AIM WOULD BE TO HELP THEM TO COME TO TERMS WITH THEIR OWN MOTHERS, TO HELP THEM TO SEE THEIR OWN MOTHERS MORE REALISTICALLY. FOR OTHER MOTHERS, THE AIM WOULD BE TO HELP THEM TO GET IN TOUCH WITH THE BABY. FOR OTHERS STILL THE AIM WOULD BE TO HELP THEM TO GET IN TOUCH WITH THEIR OWN STRENGTH, ETC. IN SUMMARY, THE AIM OF TREATMENT WOULD BE TO HELP THE MOTHERS TO COMPLETE THE PSYCHOLOGICAL TASKS OF PREGNANCY ALREADY OUTLINED.

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# THE PSYCHOSOCIAL SITUATION OF IRISH URBAN MOTHERS POST-NATALLY AND CHILDREN'S HEALTH

MICHAEL FITZGERALD; ELIZABETH SHAW.

THE PREVALENCE OF POST-NATAL DEPRESSION HAS BEEN FOUND TO BE 26.7% IN AN URBAN AREA OF DUBLIN. IN THE SAME STUDY, WHEN THE EDINBURGH POST-NATAL DEPRESSION SCALE WAS USED, 38 OUT OF 142 SCORED POSITIVELY FOR DEPRESSION ON THIS SCREENING INSTRUMENT, (O'NEILL, T., MURPHY, P., GREENE, V., 1990). A PAST PSYCHIATRIC HISTORY WAS FOUND TO BE A SIGNIFICANT RISK FACTOR.

PAYKEL ET AL. (1980) FOUND THAT MOTHERS WITH POST-NATAL DEPRESSION WERE INADEQUATELY HOUSED AND LACKED THE SUPPORT OF A HUSBAND OR CONFIDANT. GORDON AND GORDON (1960) NOTED THAT A RECENT MOVE, ABSENCE OF A HUSBAND AT THE TIME OF BIRTH AND LACK OF SUPPORT FROM HIM AND OTHERS, WERE IMPORTANT DETERMINANTS OF THE "MATERNITY PSYCHIATRIC SYNDROME." PITT (1985) EXAMINES THREE THEORIES THAT ATTEMPT TO EXPLAIN THE OCCURRENCE OF PUERPERAL MENTAL ILLNESS, AND CLAIMS THAT THERE IS SOME SUPPORT FOR ALL THREE:

(1) CHILDBIRTH IS A SIGNIFICANT STRESS IN ITS OWN RIGHT.

(2) THE CLOSE SIMILARITY OF PUERPERAL TO NON-PUERPERAL PSYCHOSES IN RESPECT OF A FAMILY AND PREVIOUS HISTORY OF MENTAL ILLNESS SUGGESTS THAT FOR THESE

DISORDERS CHILDBIRTH IS JUST ONE PRECIPITANT AMONG SEVERAL POSSIBLE OTHERS.

(3) IT HAPPENS THAT SOME WOMEN ARE PARTICULARLY VULNERABLE TO CHILDBIRTH, AS MANY MOTHERS WITH PUERPERAL DEPRESSION HAVE NEVER SUFFERED DEPRESSION BEFORE.

THIS STUDY EXAMINES IN DETAIL THE PSYCHOSOCIAL SITUATION OF A GROUP OF MOTHERS POST-NATALLY WHO HAD BEEN PREVIOUSLY STUDIED ANTENATALLY.

## METHODOLOGY

A CONSECUTIVE SAMPLE OF 50 MOTHERS WERE FOLLOWED UP AT HOME USING

(1) THE SOCIAL INTERVIEW QUESTIONNAIRE OF CORNEY AND CLARE (1985), A SATISFACTORY SCREENING INSTRUMENT FOR SOCIAL PROBLEMS;

(2) THE EDINBURGH POST-NATAL DEPRESSION SCALE (COX ET AL., 1987). THIS IS A WELL VALIDATED SCALE FOR THE DETECTION OF POST-NATAL DEPRESSION IN THE COMMUNITY;

(3) THE PARENTING AND CHILD HEALTH QUESTIONNAIRE, WHICH HAS QUESTIONS ON PHYSICAL ILLNESS, ACCIDENTS, IMMUNISATION, HOSPITALISATION, CHILD BEHAVIOUR, MOTHER'S PREGNANCY, MOTHER'S THOUGHTS AND FEELINGS, MOTHER'S ATTITUDE TO HEALTH AND VARIOUS ASPECTS OF THE PSYCHOSOCIAL ENVIRONMENT.



## RESULTS

RESPONSE RATE = 50 OUT OF 74.

AGES: 28% (14) AGED BETWEEN 18 AND 25 YEARS.
56% (28) AGED BETWEEN 26 AND 35 YEARS.
16% ( 8) AGED BETWEEN 36 AND 45 YEARS.

# SOCIAL QUESTIONNAIRE

1 ARE YOUR HOUSING CONDITIONS ADEQUATE FOR YOU AND YOUR FAMILY'S NEEDS?

| | | |
|---|---|---|
| ADEQUATE | 40 | 80% |
| SLIGHTLY INADEQUATE | 2 | 4% |
| MARKEDLY INADEQUATE | 3 | 6% |
| SEVERELY INADEQUATE | 5 | 10% |

2 HOW SATISFIED ARE YOU WITH YOUR PRESENT ACCOMMODATION?

| | | |
|---|---|---|
| ADEQUATE | 37 | 74% |
| SLIGHTLY INADEQUATE | 4 | 8% |
| MARKEDLY INADEQUATE | 4 | 8% |
| SEVERELY INADEQUATE | 5 | 10% |

3 HOW SATISFIED ARE YOU WITH YOUR PRESENT JOB?

| | | |
|---|---|---|
| NOT APPLICABLE | 45 | 90% |
| SATISFIED | 3 | 6% |
| MARKEDLY DISSATISFIED | 1 | 2% |
| SEVERELY DISSATISFIED | 1 | 2% |

4 DO YOU HAVE ANY PROBLEMS GETTING ON WITH ANY PEOPLE AT WORK?

| | | |
|---|---|---|
| NOT APPLICABLE | 45 | 90% |
| NO PROBLEMS | 3 | 6% |
| SLIGHT PROBLEMS | 2 | 4% |



5 HOW SATISFIED ARE YOU BEING A HOUSEWIFE?

| | | |
|---|---|---|
| NOT APPLICABLE | 5 | 10% |
| SATISFIED | 38 | 76% |
| SLIGHTLY DISSATISFIED | 4 | 8% |
| MARKEDLY DISSATISFIED | 2 | 4% |
| SEVERELY DISSATISFIED | 1 | 2% |

6 HOW SATISFIED ARE YOU WITH WORKING AND RUNNING A HOME?

| | | |
|---|---|---|
| NOT APPLICABLE | 45 | 90% |
| SATISFIED | 2 | 4% |
| SLIGHTLY DISSATISFIED | 1 | 2% |
| MARKEDLY DISSATISFIED | 1 | 2% |
| SEVERELY DISSATISFIED | 1 | 2% |

7 IS THE MONEY COMING IN ADEQUATE FOR YOU AND YOUR FAMILY'S NEEDS?

| | | |
|---|---|---|
| ADEQUATE | 13 | 26% |
| SLIGHTLY INADEQUATE | 22 | 44% |
| MARKEDLY INADEQUATE | 8 | 16% |
| SEVERELY INADEQUATE | 7 | 14% |

9 DO YOU HAVE DIFFICULTIES IN MEETING BILLS AND OTHER FINANCIAL COMMITMENTS?

| | | |
|---|---|---|
| NO DIFFICULTIES | 15 | 30% |
| SLIGHT DIFFICULTIES | 19 | 38% |
| MARKED DIFFICULTIES | 11 | 22% |
| SEVERE DIFFICULTIES | 5 | 10% |

10 ARE YOU SATISFIED WITH YOUR FINANCIAL POSITION?

| | | |
|---|---|---|
| SATISFIED | 11 | 22% |
| SLIGHTLY DISSATISFIED | 16 | 32% |
| MARKEDLY DISSATISFIED | 15 | 30% |
| SEVERELY DISSATISFIED | 8 | 16% |

11 HOW SATISFIED ARE YOU WITH THE AMOUNT OF TIME YOU ARE ABLE TO GO OUT?

| | | |
|---|---|---|
| SATISFIED | 32 | 64% |
| SLIGHTLY DISSATISFIED | 5 | 10% |
| MARKEDLY DISSATISFIED | 9 | 18% |
| SEVERELY DISSATISFIED | 4 | 8% |

12 DO YOU HAVE ANY PROBLEMS WITH NEIGHBOURS?

| | | |
|---|---|---|
| NO PROBLEMS | 43 | 86% |
| SLIGHT PROBLEMS | 1 | 2% |
| MARKED PROBLEMS | 2 | 4% |
| SEVERE PROBLEMS | 4 | 8% |



13 ANY PROBLEMS WITH GETTING ON WITH FRIENDS?

| | | |
|---|---|---|
| NO PROBLEMS | 50 | 100% |

14 ARE YOU SATISFIED WITH THE AMOUNT OF TIME YOU SEE YOUR FRIENDS?

| | | |
|---|---|---|
| SATISFIED | 40 | 80% |
| SLIGHTLY DISSATISFIED | 3 | 6% |
| MARKEDLY DISSATISFIED | 5 | 10% |
| SEVERELY DISSATISFIED | 2 | 4% |

15 ANY PROBLEMS WITH GETTING ON WITH CLOSE RELATIONS?

| | | |
|---|---|---|
| NO PROBLEMS | 46 | 92% |
| SLIGHT PROBLEMS | 1 | 2% |
| MARKED PROBLEMS | 2 | 4% |
| SEVERE PROBLEMS | 1 | 2% |

16 ARE YOU SATISFIED WITH THE AMOUNT OF TIME YOU SEE YOUR RELATIVES?

| | | |
|---|---|---|
| SATISFIED | 43 | 86% |
| SLIGHTLY DISSATISFIED | 4 | 8% |
| MARKEDLY DISSATISFIED | 3 | 6% |
| SEVERELY DISSATISFIED | - | - |

17 WHAT IS YOUR MARITAL STATUS?

| | | |
|---|---|---|
| SINGLE | 10 | 20% |
| MARRIED/CO-HABITING | 39 | 78% |
| SEPARATED | 1 | 2% |

18 DO YOU HAVE DIFFICULTY CONFIDING IN YOUR PARTNER?

| | | |
|---|---|---|
| NO DIFFICULTIES | 40 | 80% |
| SLIGHT DIFFICULTIES | 5 | 10% |
| SEVERE DIFFICULTIES | 1 | 2% |
| NOT APPLICABLE | 4 | 8% |

19 ARE THERE ANY SEXUAL PROBLEMS?

| | | |
|---|---|---|
| NO DIFFICULTIES | 40 | 80% |
| SLIGHT DIFFICULTIES | 5 | 10% |
| SEVERE DIFFICULTIES | 1 | 2% |
| NOT APPLICABLE | 4 | 8% |

20 DO YOU HAVE ANY OTHER PROBLEM GETTING ON TOGETHER?

| | | |
|---|---|---|
| NO PROBLEMS | 36 | 72% |
| SLIGHT PROBLEMS | 8 | 16% |
| MARKED PROBLEMS | 1 | 2% |
| SEVERE PROBLEMS | 1 | 2% |
| NOT APPLICABLE | 4 | 8% |

21 ARE YOU SATISFIED IN GENERAL WITH YOUR RELATIONSHIP?

| | | |
|---|---|---|
| SATISFIED | 38 | 76% |
| SLIGHTLY DISSATISFIED | 5 | 10% |
| MARKEDLY DISSATISFIED | 2 | 4% |
| SEVERELY DISSATISFIED | 1 | 2% |
| NOT APPLICABLE | 4 | 8% |



22 HAVE YOU RECENTLY BEEN SO DISSATISFIED THAT YOU HAVE CONSIDERED SEPARATION FROM YOUR PARTNER?

| | | |
|---|---|---|
| NO | 39 | 78% |
| SOMETIMES | 3 | 6% |
| OFTEN | 2 | 4% |
| YES (PLANNED OR RECENT SEPARATION) | 2 | 4% |
| NOT APPLICABLE | 4 | 8% |

23 HOW SATISFIED ARE YOU NOT BEING MARRIED OR IN A STEADY RELATIONSHIP?

| | | |
|---|---|---|
| SATISFIED | 5 | 10% |
| SLIGHTLY DISSATISFIED | 1 | 2% |
| SEVERELY DISSATISFIED | 1 | 2% |

24 DO YOU HAVE ANY DIFFICULTIES COPING WITH YOUR CHILDREN?

| | | |
|---|---|---|
| NO DIFFICULTIES | 30 | 60% |
| SLIGHT DIFFICULTIES | 7 | 14% |
| MARKED DIFFICULTIES | 3 | 6% |
| SEVERE DIFFICULTIES | 1 | 2% |
| NOT APPLICABLE | 9 | 18% |

25 ARE YOU SATISFIED WITH THE RELATIONSHIP WITH YOUR CHILDREN?

| | | |
|---|---|---|
| SATISFIED | 40 | 80% |
| SLIGHTLY DISSATISFIED | 1 | 2% |
| NOT APPLICABLE | 9 | 18% |

26 ARE THERE ANY PROBLEMS INVOLVING YOUR CHILDREN WITH REGARD TO SCHOOL?

| | | |
|---|---|---|
| NO PROBLEMS | 24 | 48% |
| SLIGHT PROBLEMS | 6 | 12% |
| MARKED PROBLEMS | 2 | 4% |
| NOT APPLICABLE | 18 | 36% |

27 DO YOU HAVE ANY PROBLEMS ABOUT SHARING HOUSEHOLD TASKS WITH OTHER ADULTS LIVING WITH YOU? (RELATIVES, NOT SPOUSE)?

| | | |
|---|---|---|
| NO PROBLEMS | 9 | 18% |
| SLIGHT PROBLEMS | 1 | 2% |
| MARKED PROBLEMS | 1 | 2% |
| NOT APPLICABLE | 39 | 78% |

28 DO YOU HAVE ANY DIFFICULTIES WITH THE OTHER ADULTS IN YOUR HOUSEHOLD?

| | | |
|---|---|---|
| NO DIFFICULTIES | 9 | 18% |
| SLIGHT DIFFICULTIES | 1 | 2% |
| MARKED DIFFICULTIES | 1 | 2% |
| NOT APPLICABLE | 39 | 78% |

29 ARE YOU SATISFIED WITH THIS ARRANGEMENT?

| | | |
|---|---|---|
| SATISFIED | 6 | 12% |
| SLIGHTLY DISSATISFIED | 3 | 6% |
| SEVERELY DISSATISFIED | 2 | 4% |
| NOT APPLICABLE | 39 | 78% |



30 DO YOU HAVE ANY LEGAL PROBLEMS?

| | | |
|---|---|---|
| NO PROBLEMS | 49 | 98% |
| SEVERE PROBLEMS | 1 | 2% |

31 DO YOU HAVE ANY DIFFICULTIES LIVING AND MANAGING ON YOUR OWN?

| | | |
|---|---|---|
| NO DIFFICULTIES | 1 | 2% |
| SLIGHT DIFFICULTIES | 1 | 2% |
| MARKED DIFFICULTIES | 1 | 2% |
| SEVERE DIFFICULTIES | 1 | 2% |
| NOT APPLICABLE | 46 | 92% |

32 HOW SATISFIED ARE YOU WITH LIVING ON YOUR OWN?

| | | |
|---|---|---|
| SATISFIED | 2 | 4% |
| SEVERELY DISSATISFIED | 2 | 4% |
| NOT APPLICABLE | 46 | 92% |

33 DO YOU HAVE ANY OTHER SOCIAL PROBLEMS?

| | | |
|---|---|---|
| NO PROBLEMS | 45 | 90% |
| SLIGHT PROBLEMS | 3 | 6% |
| SEVERE PROBLEMS | 2 | 4% |

# EDINBURGH POST-NATAL DEPRESSION SCALE

1 I HAVE BEEN ABLE TO LAUGH AND SEE THE FUNNY SIDE OF THINGS

| | | |
|---|---|---|
| AS MUCH AS I ALWAYS COULD | 29 | 58% |
| NOT QUITE AS MUCH NOW | 10 | 20% |
| DEFINITELY NOT SO MUCH NOW | 6 | 12% |
| NOT AT ALL | 5 | 10% |

2 I HAVE LOOKED FORWARD TO THINGS WITH ENJOYMENT

| | | |
|---|---|---|
| AS MUCH AS I EVER DID | 37 | 74% |
| RATHER LESS THAN I USED TO | 5 | 10% |
| DEFINITELY LESS THAN I USED TO | 5 | 10% |
| HARDLY AT ALL | 3 | 6% |

3 I HAVE BLAMED MYSELF UNNECESSARILY WHEN THINGS GO WRONG

| | | |
|---|---|---|
| YES, MOST OF THE TIME | 19 | 38% |
| YES, SOME OF THE TIME | 6 | 12% |
| NOT VERY OFTEN | 17 | 34% |
| NO, NEVER | 8 | 16% |

4 I HAVE BEEN ANXIOUS OR WORRIED FOR NO GOOD REASON

| | | |
|---|---|---|
| NO, NOT AT ALL | 16 | 32% |
| HARDLY EVER | 5 | 10% |
| YES, SOMETIMES | 20 | 40% |
| YES, VERY OFTEN | 9 | 16% |



5 I HAVE FELT SCARED OR PANICKY FOR NO GOOD REASON

| | | |
|---|---|---|
| YES, QUITE A LOT | 6 | 12% |
| YES, SOMETIMES | 13 | 26% |
| NO, NOT MUCH | 11 | 22% |
| NO, NOT AT ALL | 20 | 40% |

6 THINGS HAVE BEEN GETTING ON TOP OF ME

| | | |
|---|---|---|
| YES, MOST OF THE TIME I HAVEN'T BEEN ABLE TO COPE AT ALL | 7 | 14% |
| YES, SOMETIMES I HAVEN'T BEEN COPING AS WELL AS USUAL | 21 | 42% |
| NO, MOST OF THE TIME I HAVE COPED QUITE WELL | 6 | 12% |
| NO, I HAVE BEEN COPING AS WELL AS EVER | 16 | 32% |

7 I HAVE BEEN SO UNHAPPY THAT I HAVE HAD DIFFICULTY SLEEPING

| | | |
|---|---|---|
| YES, MOST OF THE TIME | 2 | 4% |
| YES, SOMETIMES | 11 | 22% |
| NOT VERY OFTEN | 3 | 6% |
| NO, NOT AT ALL | 34 | 68% |

8 I HAVE FELT SAD OR MISERABLE

| | | |
|---|---|---|
| YES, MOST OF THE TIME | 8 | 16% |
| YES, QUITE OFTEN | 9 | 18% |
| NOT VERY OFTEN | 14 | 28% |
| NO, NOT AT ALL | 19 | 38% |

9 I HAVE BEEN SO UNHAPPY THAT I HAVE BEEN CRYING

| | | |
|---|---|---|
| YES, MOST OF THE TIME | 3 | 6% |
| YES, QUITE OFTEN | 9 | 18% |
| ONLY OCCASIONALLY | 11 | 22% |
| NO, NEVER | 27 | 54% |

10 THE THOUGHT OF HARMING MYSELF HAS OCCURRED TO ME

| | | |
|---|---|---|
| YES, QUITE OFTEN | - | - |
| SOMETIMES | 4 | 8% |
| HARDLY EVER | 1 | 2% |
| NEVER | 45 | 90% |

THE CUT-OFF POINT FOR MOTHERS SHOWING A LIKELIHOOD OF SUFFERING FROM A DEPRESSIVE ILLNESS OF VARYING SEVERITY WAS 12. THIRTY-EIGHT PER CENT (19) SCORED IN THE POSITIVE RANGE.



## PARENT AND CHILD HEALTH QUESTIONNAIRE

1 HAS THE BABY BEEN FOR A GENERAL PHYSICAL CHECK-UP SINCE BORN?

YES: 44 88% NO: 6 12%

| | | | | |
|---|---|---|---|---|
| A | WHEN? | SIX WEEKLY | 43 | 86% |
| | | CAN'T REMEMBER | 6 | 12% |
| | | WHEN SICK | 1 | 2% |

2 HAS THE BABY RECEIVED THE BABY SHOTS? (THREE-IN-ONE)

YES: 32 64% NO: 15 30% DON'T KNOW WHICH ONES: 3 6%

3 HAS HE/SHE RECEIVED THE POLIO VACCINE?

YES: 10 20% NO: 40 80%

4 DID THE BABY HAVE ANY OF THE FOLLOWING ILLNESSES?

| | | | | | |
|---|---|---|---|---|---|
| A | COLDS | YES: 37 | 74% | NO: 13 | 26% |
| B | DIARRHOEA | YES: 9 | 18% | NO: 41 | 82% |
| C | RASH | YES: 27 | 54% | NO: 23 | 46% |
| D | COUGH | YES: 32 | 64% | NO: 18 | 36% |
| E | EAR INFECTION | YES: 8 | 16% | NO: 42 | 84% |
| F | ANYTHING ELSE | YES: 20 | 40% | NO: 30 | 60% |

| | | | |
|---|---|---|---|
| G | WHAT ELSE? | MEDICAL PROBLEMS, I.E. CHEST INFECTION: | 19 38% |
| | | NOTHING | 31 62% |

5 HAS THE BABY HAD ANY ACCIDENTS?

YES: 1 2% NO: 49 98%

6 HAS THE BABY BEEN IN HOSPITAL FOR ANY REASON?

YES: 4 8% NO: 46 92%

| | | | |
|---|---|---|---|
| A WHY? | GASTROENTERITIS | 3 | 6% |
| | JAUNDICE | 1 | 2% |
| | BRUISED ARM | 1 | 2% |
| | NOTHING | 45 | 90% |

7 HAS THE BABY BEEN IN CASUALTY IN HOSPITAL SINCE BORN?

YES: 6 12% NO: 43 86% CAN'T REMEMBER: 1 2%

8 IS THE BABY ON MEDICATION NOW?

YES: 5 10% NO: 45 90%

| | | | |
|---|---|---|---|
| A WHAT? | ANTIBIOTICS | 2 | 4% |
| | IRON | 2 | 4% |
| | CALPOL | 1 | 2% |
| | EAR DROPS | 1 | 2% |
| | NOTHING | 44 | 88% |
| B WHY? | CHEST INFECTION | 2 | 4% |
| | ANAEMIA | 1 | 2% |
| | TEETHING | 1 | 2% |
| | EAR INFECTION | 1 | 2% |
| | NOTHING | 45 | 90% |



8 C PRESCRIBED BY?

| | | |
|---|---|---|
| G.P. | 2 | 4% |
| HOSPITAL REGISTRAR | 1 | 2% |
| PUBLIC HEALTH NURSE | 1 | 2% |
| G.P.'S LOCUM | 1 | 2% |
| NOT APPLICABLE | 45 | 90% |

9 WHAT IS THE BABY FEEDING ON NOW?

| | | |
|---|---|---|
| BREAST MILK | 1 | 2% |
| MILLUMIL | 6 | 12% |
| COW'S MILK | 1 | 2% |
| CEREAL/MILK | 1 | 2% |
| MEAT (LIQUIDISED) | 1 | 2% |
| VEG. ( " ) | 1 | 2% |
| COW & GATE FORMULA + CEREAL | 38 | 76% |
| DID NOT ANSWER | 1 | 2% |

10 IS THE BABY ON A REGULAR TIME FOR EATING?

YES: 42 84% NO: 7 14% CAN'T ANSWER: 1 2%

| | | | |
|---|---|---|---|
| A WHAT IS IT? | 3-HOURLY | 32 | 64% |
| | 4-HOURLY | 11 | 22% |
| | NO SET PATTERN | 7 | 14% |

11 DOES THE BABY HAVE A REGULAR PATTERN OF SLEEPING?

YES: 39 78% NO: 10 20% DON'T KNOW: 1 2%

11 A WHAT? WAKING UP:

| | | |
|---|---|---|
| 6.00 - 7.30 AM | 8 | 16% |
| 7.30 - 9.00 AM | 18 | 36% |
| AFTER 9.00 AM | 14 | 28% |
| NOT APPLICABLE | 10 | 20% |

B SETTLING AT NIGHT:

| | | |
|---|---|---|
| 6.00 - 7.00 PM | 3 | 6% |
| 7.00 - 7.30 PM | 13 | 26% |
| 7.30 - 8.30 PM | 23 | 46% |
| NOT APPLICABLE | 11 | 22% |

12 WHEN DID YOU (MOTHER) GO FOR YOUR LAST PHYSICAL CHECK-UP?

| | | |
|---|---|---|
| RECENTLY | 1 | 2% |
| DON'T REMEMBER | 42 | 84% |
| NEVER | 6 | 12% |
| DIDN'T ANSWER | 1 | 2% |

A WOULD IT HAVE BEEN:

| | | |
|---|---|---|
| IN THE PAST YEAR? | 10 | 20% |
| 1 - 5 YEARS AGO? | 19 | 38% |
| 6 - 10 YEARS AGO? | 10 | 20% |
| MORE THAN 10 YEARS AGO? | 3 | 6% |
| NOT APPLICABLE | 8 | 16% |

13 WHEN WAS THE LAST TIME YOU WENT TO THE DOCTOR WHEN YOU WEREN'T FEELING WELL?

DATE GIVEN: 39 78% NEVER: 11 22%

A WHAT WAS THE PROBLEM?

| | | |
|---|---|---|
| MEDICAL PROBLEM | 25 | 50% |
| DEPRESSION | 8 | 16% |
| POST-NATAL CHECK-UP | 2 | 4% |
| NOT APPLICABLE | 15 | 30% |



14 HAVE YOU HAD ANY OF THE FOLLOWING ILLNESSES IN THE PAST THREE MONTHS?

| | | | | | |
|---|---|---|---|---|---|
| A COLDS | YES: | 12 | 24% | NO: | 37 74% |
| | DIDN'T REPLY: | 1 | 2% | | |
| B 'FLU' | YES: | 10 | 20% | NO: | 40 80% |
| C UPSET STOMACH | YES: | 15 | 30% | NO: | 35 70% |
| D BAD HEADACHES | YES: | 25 | 50% | NO: | 25 50% |
| E "NERVES" | YES: | 16 | 32% | NO: | 34 68% |
| F INSOMNIA | YES: | 11 | 22% | NO: | 39 78% |
| G ANY OTHERS | YES: | 12 | 24% | NO: | 38 76% |

| | | |
|---|---|---|
| H MEDICAL PROBLEMS | 5 | 10% |
| DEPRESSION | 7 | 14% |
| HYPERTENSION | 1 | 2% |
| NOT APPLICABLE | 37 | 74% |

15 ARE YOU ON MEDICATION NOW?

YES: 10 20% NO: 39 78% DIDN'T ANSWER: 1 2%

A TYPE:

| | | |
|---|---|---|
| ANTI-DEPRESSANT | 5 | 10% |
| TONIC | 4 | 8% |
| B.P. TABLETS | 1 | 2% |
| STEROIDS | 1 | 2% |
| NOT APPLICABLE | 39 | 78% |

B REASON:

| | | |
|---|---|---|
| DEPRESSION | 5 | 10% |
| ANAEMIA | 4 | 8% |
| HYPERTENSION | 1 | 2% |
| ARTHRITIS | 1 | 2% |
| NOT APPLICABLE | 39 | 78% |

15 C PRESCRIBED BY WHOM?

| | | |
|---|---|---|
| HOSPITAL DOCTOR | 1 | 2% |
| G.P. | 10 | 20% |
| NOT APPLICABLE | 39 | 78% |

16 HAVE YOU BEEN IN HOSPITAL IN THE PAST THREE MONTHS, OUTSIDE OF HAVING THE BABY?

| | | | | |
|---|---|---|---|---|
| YES: | 2 | 4% | NO: | 48 96% |

A WHY?

| | | |
|---|---|---|
| HAEMORRHAGE | 1 | 2% |
| "NERVES" | 1 | 2% |
| NOT APPLICABLE | 48 | 96% |

17 WHEN WAS THE LAST TIME YOU WENT TO THE DENTIST?

| | | |
|---|---|---|
| DATE GIVEN | 14 | 28% |
| DON'T KNOW/CAN'T REMEMBER | 32 | 64% |
| NEVER | 3 | 6% |
| DIDN'T ANSWER | 1 | 2% |

18 WHEN WAS THE LAST TIME YOU HAD A CERVICAL SMEAR?

| | | |
|---|---|---|
| DATE GIVEN | 2 | 4% |
| DON'T KNOW/CAN'T REMEMBER | 22 | 44% |
| NEVER | 25 | 50% |
| DIDN'T ANSWER | 1 | 2% |

A APPROXIMATELY WHEN?

| | | |
|---|---|---|
| 1 YEAR AGO | 1 | 2% |
| 2 YEARS AGO | 2 | 4% |
| 3 YEARS AGO | 1 | 2% |
| NOT APPLICABLE | 46 | 92% |



19 HAVE YOU FELT THE FOLLOWING WAYS IN THE PAST FEW WEEKS, MANY TIMES; A FEW TIMES; HARDLY AT ALL; OR NEVER?

A SO RESTLESS THAT YOU COULDN'T SIT LONG IN A CHAIR?

| | | |
|---|---|---|
| NEVER | 19 | 38% |
| HARDLY AT ALL | 5 | 10% |
| A FEW TIMES | 17 | 34% |
| MANY TIMES | 8 | 16% |
| COULDN'T ANSWER | 1 | 2% |

B VERY LONELY OR REMOTE FROM OTHER PEOPLE?

| | | |
|---|---|---|
| NEVER | 27 | 54% |
| HARDLY AT ALL | 4 | 8% |
| A FEW TIMES | 12 | 24% |
| MANY TIMES | 7 | 14% |

C BORED?

| | | |
|---|---|---|
| NEVER | 16 | 32% |
| HARDLY AT ALL | 6 | 12% |
| A FEW TIMES | 18 | 36% |
| MANY TIMES | 10 | 20% |

D DEPRESSED OR VERY UNHAPPY?

| | | |
|---|---|---|
| NEVER | 13 | 26% |
| HARDLY AT ALL | 12 | 24% |
| A FEW TIMES | 13 | 26% |
| MANY TIMES | 12 | 24% |

19 E UPSET BECAUSE SOMEONE CRITICISED YOU?

| | | |
|---|---|---|
| NEVER | 15 | 30% |
| HARDLY AT ALL | 7 | 14% |
| A FEW TIMES | 17 | 34% |
| MANY TIMES | 11 | 22% |

20 WAS THE BABY BORN

| | | |
|---|---|---|
| EARLIER THAN EXPECTED? | 1 | 2% |
| WHEN EXPECTED? | 27 | 54% |
| LATER THAN EXPECTED? | 8 | 16% |
| DON'T KNOW | 14 | 28% |

A ABOUT HOW EARLY?

| | | |
|---|---|---|
| LESS THAN 4 WEEKS | 1 | 2% |
| 4 OR MORE WEEKS | 2 | 4% |
| DON'T KNOW | 11 | 22% |
| NOT APPLICABLE | 36 | 72% |

21 ABOUT HOW MANY MONTHS WERE YOU PREGNANT WHEN YOU FIRST WENT TO THE DOCTOR?

| | | |
|---|---|---|
| 1 MONTH | 8 | 16% |
| 2 MONTHS | 17 | 34% |
| 3 MONTHS | 13 | 26% |
| 4 MONTHS | 6 | 12% |
| 5 MONTHS | 4 | 8% |
| 6 MONTHS | 1 | 2% |
| 7 MONTHS | 1 | 2% |



22 HOW MANY TIMES DID YOU GO TO THE DOCTOR WHEN YOU WERE PREGNANT?

| | | |
|---|---|---|
| USUAL G.P. AND CLINIC VISITS | 49 | 98% |
| NOT OFTEN | 1 | 2% |

23 WHERE DID YOU GO FOR PRE-NATAL CARE?

| | | |
|---|---|---|
| PUBLIC CLINIC | 49 | 98% |
| PRIVATE DOCTOR | 1 | 2% |

24 HOW MANY DAYS DID YOU STAY IN HOSPITAL?

| | | |
|---|---|---|
| 2 DAYS | 2 | 4% |
| 3 DAYS | 9 | 18% |
| 4 DAYS | 16 | 32% |
| 5 DAYS | 16 | 32% |
| 6 DAYS | 3 | 6% |
| 1 WEEK | 1 | 2% |
| 8 DAYS | 1 | 2% |
| 9 DAYS | 2 | 4% |

25 DID THE BABY COME HOME WITH YOU?

YES: 45 90% NO: 5 10%

A WHY?

| | | |
|---|---|---|
| PREMATURE | 2 | 4% |
| DEHYDRATION | 1 | 2% |
| SLOW FEEDER | 2 | 4% |
| NOT APPLICABLE | 45 | 90% |

26 WERE THERE ANY COMPLICATIONS DURING THE PREGNANCY?

YES: 14 28% NO: 36 72%

| | | | |
|---|---|---|---|
| A WHAT WERE THE PROBLEMS? | HYPERTENSION | 4 | 8% |
| | TOXAEMIA | 2 | 4% |
| | BREECH POSITION | 2 | 4% |
| | BABY IN DISTRESS/DIABETIC | 5 | 10% |
| | END OF PREGNANCY BLEEDING | 1 | 2% |
| | NOT APPLICABLE | 36 | 72% |

27 WERE THERE ANY COMPLICATIONS DURING THE BIRTH?

YES: 14 28% NO: 36 72%

| | | | |
|---|---|---|---|
| A WHAT WAS THE PROBLEM? | BREECH DELIVERY | 1 | 2% |
| | BABY DISTRESSED | 1 | 2% |
| | CORD AROUND BABY'S NECK | 2 | 4% |
| | EMERGENCY SECTION | 3 | 6% |
| | FORCEPS DELIVERY | 2 | 4% |
| | NOT APPLICABLE | 36 | 72% |

28 DID YOU GO BACK TO THE DOCTOR AFTER THE BABY WAS BORN?

YES: 27 54% NO: 23 46%

29 DID YOU HAVE INSURANCE THAT COVERED

| | | | | | |
|---|---|---|---|---|---|
| A PRE-NATAL CARE | YES: | 2 | 4% | NO: | 48 96% |
| B HOSPITAL COSTS | YES: | 1 | 2% | NO: | 49 98% |



30 DID YOU HAVE ANY OUT-OF-POCKET EXPENSES FOR

| | | | | | |
|---|---|---|---|---|---|
| A PRE-NATAL CARE | | | | NO: | 50 100% |
| B COSTS | | | | NO: | 50 100% |
| C HOSPITAL COSTS | YES: | 1 | 2% | NO: | 49 98% |

31 WHEN YOU WERE A CHILD, DID YOU GO TO THE DOCTOR?

| | | |
|---|---|---|
| REGULARLY | 13 | 26% |
| NOT VERY OFTEN | 32 | 64% |
| NEVER | 3 | 6% |
| CAN'T REMEMBER | 2 | 4% |

| | | | |
|---|---|---|---|
| A EXPLAIN: | WHEN SICK | 37 | 74% |
| | WHEN SICK AND CHECK-UPS | 12 | 24% |
| | JUST CHECK-UPS | 1 | 2% |

32 WHICH DOCTOR DID YOU GO TO WHEN YOU WERE YOUNG?

| | | |
|---|---|---|
| GENERAL PRACTITIONER | 49 | 98% |
| CHILDREN'S DOCTOR | 1 | 2% |

33 WHAT KIND OF MEDICAL PERSON DID YOUR FAMILY USE?

| | | |
|---|---|---|
| GENERAL PRACTITIONER | 50 | 100% |

34 WHERE WERE YOU USUALLY TAKEN FOR MEDICAL CARE?

| | | |
|---|---|---|
| DOCTOR'S OFFICE | 50 | 100% |

35 WOULD YOU SAY, AS YOU THINK BACK, THAT YOU WERE BASICALLY

| | | |
|---|---|---|
| A HEALTHY CHILD | 38 | 76% |
| SOMETIMES HEALTHY, SOMETIMES SICK | 7 | 14% |
| ALMOST ALWAYS SICK | 4 | 8% |
| CAN'T REMEMBER | 1 | 2% |

A OF "SICK," WHAT KIND OF ILLNESS WAS IT?

| | | |
|---|---|---|
| MEDICAL PROBLEMS (BRONCHITIS, PNEUMONIA, HEADACHES) | 5 | 10% |
| CONGENITAL DISLOCATED HIP | 2 | 4% |
| ULCERATIVE COLITIS | 1 | 2% |
| NOT APPLICABLE | 42 | 84% |

36 HOW MANY GRADES OF SCHOOL DID YOU FINISH?

| | | |
|---|---|---|
| PRIMARY SCHOOL OR LESS | 16 | 32% |
| SOME SECONDARY SCHOOL (1ST TO 3RD YEAR) | 32 | 64% |
| LEAVING CERTIFICATE COMPLETED | 2 | 4% |

37 DID YOU WORK WHEN PREGNANT WITH THIS BABY?

YES: 11 22% NO: 38 76% DIDN'T ANSWER: 1 2%

A WHAT MONTH DID YOU STOP WORKING?

| | | |
|---|---|---|
| 1 MONTH | 1 | 2% |
| 3 MONTHS | 2 | 4% |
| 4 MONTHS | 1 | 2% |
| 6 MONTHS | 1 | 2% |
| 8 MONTHS | 6 | 12% |
| NOT APPLICABLE | 39 | 78% |



37 B WHAT WAS YOUR JOB?

| | | |
|---|---|---|
| SEWING MACHINIST | 1 | 2% |
| PACKER | 1 | 2% |
| CLEANER | 2 | 4% |
| SOCIAL WELFARE OFFICER | 2 | 4% |
| RECEPTIONIST | 1 | 2% |
| HOSPITAL WORKER | 1 | 2% |
| ANCO COURSE | 1 | 2% |
| SALES ASSISTANT | 1 | 2% |
| NOT APPLICABLE | 40 | 80% |

C HAVE YOU EVER WORKED?

YES: 36 72% NO: 3 6% NOT APPLICABLE: 11 22%

D WHAT WAS YOUR JOB?

| | | |
|---|---|---|
| SEWING MACHINIST | 7 | 14% |
| STORE SUPERVISOR | 2 | 4% |
| SALES ASSISTANT | 5 | 10% |
| SECRETARY | 2 | 4% |
| FACTORY WORKER | 7 | 14% |
| DOMESTIC WORKER | 8 | 16% |
| PRESSER | 1 | 2% |
| CIVIL SERVANT | 1 | 2% |
| MACHINE OPERATOR | 4 | 8% |
| HOSPITAL WORKER | 1 | 2% |
| ANCO COURSE | 1 | 2% |
| HAIRDRESSER | 1 | 2% |
| WAITRESS | 2 | 4% |
| COMPUTERS | 1 | 2% |
| SOCIAL WELFARE | 1 | 2% |
| PRINTING | 1 | 2% |
| NOT APPLICABLE | 5 | 10% |

38 Do you plan to work in the coming year?

Yes: 10 20% No: 39 78% Don't Know: 1 2%

A Doing what?

| | | |
|---|---|---|
| Anything | 4 | 8% |
| Social Welfare Officer | 2 | 4% |
| Domestic work | 1 | 2% |
| Packer | 1 | 2% |
| Receptionist | 1 | 2% |
| Sales Assistant | 1 | 2% |
| Not applicable | 40 | 80% |

A How much, approximately, is the family income?

| Weekly | | | Yearly | | |
|---|---|---|---|---|---|
| Under £20 | 1 | 2% | Under £1,000 | 1 | 2% |
| £58 - £77 | 1 | 2% | £2,000 - £2,999 | 1 | 2% |
| £78 - £96 | 13 | 26% | £3,000 - £3,999 | 1 | 2% |
| £97 - £115 | 11 | 22% | £4,000 - £4,999 | 14 | 28% |
| £116 - £134 | 8 | 16% | £5,000 - £5,999 | 8 | 16% |
| £135 - £154 | 4 | 8% | £6,000 - £6,999 | 12 | 24% |
| £155 - £173 | 2 | 4% | £7,000 - £7,999 | 3 | 6% |
| £174 - £192 | 2 | 4% | £8,000 - £8,999 | 3 | 6% |
| £193 - £231 | 1 | 2% | £9,999 - £9,999 | 3 | 6% |
| £232 - £238 | 1 | 2% | £10,000 - £11,999 | 1 | 2% |
| £289 - £480 | 2 | 4% | £12,000 - £14,999 | 2 | 4% |
| Did not reply | 4 | 8% | £15,000 - £24,999 | 1 | 2% |

40 Do you receive any public assistance such as

| | | | | | |
|---|---|---|---|---|---|
| A Food stamps | Yes: | 1 | 2% | No: | 49 98% |
| B Medical card | Yes: | 40 | 80% | No: | 10 20% |
| C Unemployment Assistance | Yes: | 25 | 50% | No: | 25 50% |
| D Welfare | Yes: | 32 | 64% | No: | 18 36% |



41 How old are you?

| | | |
|---|---|---|
| 18 - 25 | 14 | 28% |
| 26 - 35 | 28 | 56% |
| 36 - 45 | 8 | 16% |

42 Where were you born?

| | | |
|---|---|---|
| Dublin | 42 | 84% |
| Rest of Ireland | 6 | 12% |
| Abroad | 2 | 4% |

43 How many other children in your family?

| | | |
|---|---|---|
| 2 siblings | 4 | 8% |
| 3 " | 2 | 4% |
| 4 " | 1 | 2% |
| 5 " | 10 | 20% |
| 6 " | 7 | 14% |
| 7 " | 6 | 12% |
| 8 " | 3 | 6% |
| 9 " | 4 | 8% |
| 10 " | 3 | 6% |
| 11 " | 3 | 6% |
| 12 " | 4 | 8% |
| 13 " | 2 | 4% |
| 16 " | 1 | 2% |

43 A BREAK THEM UP

| | | | |
|---|---|---|---|
| YOUNGER BROTHERS: | 1 | 10 | 20% |
| | 2 | 8 | 16% |
| | 3 | 6 | 12% |
| | 4 | 7 | 14% |
| | 5 | 1 | 2% |
| NOT APPLICABLE: | | 18 | 36% |

B

| | | | |
|---|---|---|---|
| YOUNGER SISTERS: | 1 | 13 | 26% |
| | 2 | 8 | 16% |
| | 3 | 7 | 14% |
| | 4 | 5 | 10% |
| | 6 | 1 | 2% |
| NOT APPLICABLE: | | 16 | 32% |

C

| | | | |
|---|---|---|---|
| OLDER BROTHERS: | 1 | 10 | 20% |
| | 2 | 14 | 28% |
| | 3 | 9 | 18% |
| | 4 | 4 | 8% |
| | 5 | 1 | 2% |
| | 6 | 1 | 2% |
| | 7 | 1 | 2% |
| NOT APPLICABLE: | | 10 | 20% |

D

| | | | |
|---|---|---|---|
| OLDER SISTERS: | 1 | 6 | 12% |
| | 2 | 15 | 30% |
| | 3 | 12 | 24% |
| | 4 | 2 | 4% |
| | 6 | 4 | 8% |
| | 7 | 1 | 2% |
| NOT APPLICABLE: | | 10 | 20% |



44 HOW LONG DID YOU LIVE AT YOUR NATIVE ADDRESS?

| | | |
|---|---|---|
| 1 - 10 YEARS | 3 | 6% |
| 11 - 20 YEARS | 6 | 12% |
| 21 - 30 YEARS | 24 | 48% |
| 31 - 40 YEARS | 15 | 30% |
| 41 - 45 YEARS | 2 | 4% |

45 HOW LONG HAVE YOU LIVED AT YOUR PRESENT ADDRESS?

| | | |
|---|---|---|
| 1 - 10 YEARS | 37 | 74% |
| 11 - 20 YEARS | 6 | 12% |
| 21 - 30 YEARS | 7 | 14% |

46 ARE YOU PRESENTLY

| | | |
|---|---|---|
| MARRIED? | 39 | 78% |
| SEPARATED? | 2 | 4% |
| SINGLE? | 9 | 18% |

47 IF MARRIED, HOW MANY GRADES OF SCHOOL DID YOUR HUSBAND FINISH?

| | | |
|---|---|---|
| PRIMARY SCHOOL (1-8) | 9 | 18% |
| SOME SECONDARY (9-11) | 24 | 48% |
| LEAVING CERTIFICATE | 5 | 10% |
| SOME COLLEGE OR TECH. | 1 | 2% |
| COLLEGE GRADUATE | 1 | 2% |
| NOT APPLICABLE | 10 | 20% |

48 If married, what is the usual occupation of your husband?

| | | |
|---|---|---|
| Storehand | 5 | 10% |
| Taxi Driver | 2 | 4% |
| Sales Assistant | 2 | 4% |
| Forklift Driver | 2 | 4% |
| Carpenter | 2 | 4% |
| Warehouse Manager | 1 | 2% |
| Male Attendant in Nursing Home | 1 | 2% |
| Security Officer | 1 | 2% |
| Insurance Clerk | 1 | 2% |
| Labourer (E.S.B.) | 1 | 2% |
| General Labourer | 10 | 20% |
| Butcher | 1 | 2% |
| Metal Worker | 1 | 2% |
| Plumber | 1 | 2% |
| Busman | 1 | 2% |
| Builder | 1 | 2% |
| Army Chef | 1 | 2% |
| Bord Telecom Technician | 1 | 2% |
| Civil Servant | 1 | 2% |
| Presser | 1 | 2% |
| Barman | 2 | 4% |
| Not applicable | 11 | 22% |

49 If married, is he currently

| | | |
|---|---|---|
| Employed | 17 | 34% |
| Looking for work | 21 | 42% |
| On Sick Insurance | 1 | 2% |
| Not applicable | 11 | 22% |



50 What is your religious preference?

| | | |
|---|---|---|
| Catholic | 48 | 96% |
| None | 1 | 2% |
| Didn't answer | 1 | 2% |

51 About how often do you attend religious services?

| | | |
|---|---|---|
| Once a week or more | 17 | 34% |
| 2 - 3 times a month | 15 | 30% |
| Once a month | 5 | 10% |
| A few times a year, or less | 9 | 18% |
| Never | 4 | 8% |

52 Do you belong to any clubs or organisations?

Yes: 14 28% No: 36 72%

53 How often do you go out for eating, drinking or seeing a film?

| | | |
|---|---|---|
| Once a week or more | 23 | 46% |
| 2 - 3 times a month | 18 | 36% |
| A few times a year | 5 | 10% |
| Less than once a year | 4 | 8% |

54 Do you read any newspapers regularly?

Yes: 29 58% No: 21 42%

55 On average, how much T.V. do you watch?

| | | |
|---|---|---|
| More than 2 hours a day | 28 | 56% |
| Less than 2 hours, but daily | 19 | 38% |
| A few times a week | 1 | 2% |
| Rarely | 2 | 4% |

56 How often do you get together informally with relatives or friends?

| | | |
|---|---|---|
| Once a week or more | 24 | 48% |
| 2 - 3 times a month | 13 | 26% |
| A few times a year | 8 | 16% |
| Rarely, if ever | 5 | 10% |

57 Child care skills:

A Experience with babies around the house when growing up:

| | | |
|---|---|---|
| Little or none | 10 | 20% |
| Some | 13 | 26% |
| A great deal | 27 | 54% |

B Reading about baby care:

| | | |
|---|---|---|
| Little or none | 20 | 40% |
| Some | 19 | 38% |
| A great deal | 11 | 22% |

C Attending classes in pre-natal care or care of baby:

| | | |
|---|---|---|
| Little or none | 32 | 64% |
| Some | 9 | 18% |
| A great deal | 9 | 18% |



57 D Babysitting with other people's babies:

| | | |
|---|---|---|
| Little or none | 5 | 10% |
| Some | 12 | 24% |
| A great deal | 33 | 66% |

58 True or false:

A "A baby needs to be more warmly dressed than an adult."

True: 41 82% False: 8 16% Don't know: 1 2%

B "It is good practice to prop a bottle so that a baby can feed himself."

True: 24 48% False: 26 52%

C "Excitement can often cause a baby to spit up."

True: 44 88% False: 6 12%

D "If a baby is fat, you know he is healthy."

True: 8 16% False: 41 82% Don't know: 1 2%

E "The window on a baby's room should never be opened in the winter."

True: 25 50% False: 25 50%

58 F "AN OVERDOSE OF ASPIRIN IS A COMMON CAUSE OF POISONING IN CHILDREN."

TRUE: 43 86% FALSE: 7 14%

G "SOME BABIES OFTEN SPIT UP AFTER ALL THEIR FEEDINGS."

TRUE: 40 80% FALSE: 10 20%

59 DO YOU THINK ONE PERSON CAN CATCH THESE DISEASES FROM ANOTHER?

| | | | | | | |
|---|---|---|---|---|---|---|
| A 'FLU' | YES: 42 | 84% | NO: 5 | 10% | DON'T KNOW: 3 | 6% |
| B DIABETES | YES: 3 | 6% | NO: 38 | 76% | DON'T KNOW: 9 | 18% |
| C ALLERGIES | YES: 11 | 22% | NO: 32 | 64% | DON'T KNOW: 7 | 14% |
| D MEASLES | YES: 48 | 96% | NO: 1 | 2% | DON'T KNOW: 1 | 2% |

60 IF YOU NEED HELP OR ADVICE ABOUT YOUR BABY, ARE THERE PEOPLE AROUND TO HELP?

YES: 44 88% NO: 6 12%

A WHO ARE AROUND?

| | | |
|---|---|---|
| FRIENDS | 5 | 10% |
| FAMILY | 23 | 46% |
| PUBLIC HEALTH NURSE | 3 | 6% |
| FAMILY AND FRIENDS | 13 | 26% |
| NOT APPLICABLE | 6 | 12% |

61 ARE THERE OTHERS WHO TAKE CARE OF YOUR BABY EVERY DAY?

YES: 23 46% NO: 27 54%



61 A WHO HELPS YOU?

| | | |
|---|---|---|
| HUSBAND | 8 | 16% |
| MOTHER | 2 | 4% |
| FAMILY | 9 | 18% |
| FRIENDS | 2 | 4% |
| BABY MINDER | 3 | 6% |
| NOT APPLICABLE | 26 | 54% |

62 WOULD YOU SAY YOUR BABY IS

| | | |
|---|---|---|
| EASY TO CARE FOR? | 41 | 82% |
| MORE DIFFICULT TO CARE FOR? | 8 | 16% |
| DIDN'T REALLY KNOW WHICH | 1 | 2% |

63 HOW MANY CHILDREN DO YOU HAVE?

| | | |
|---|---|---|
| 1 CHILD | 10 | 20% |
| 2 CHILDREN | 11 | 22% |
| 3 " | 12 | 24% |
| 4 " | 7 | 14% |
| 5 " | 4 | 8% |
| 6 " | 1 | 2% |
| 7 " | 4 | 8% |
| 10 " | 1 | 2% |

64 HAVE ANY OF YOUR CHILDREN DIED SINCE BIRTH?

YES: 4 8% NO: 46 92%

65 HAVE YOU HAD ANY MISCARRIAGES?

YES: 13 26% NO: 37 74%

66 BEFORE THIS LAST PREGNANCY BEGAN, DID YOU REALLY WANT ANOTHER CHILD AT SOME TIME?

YES: 30 60% NO: 16 32% DON'T KNOW, DIDN'T CARE: 4 8%

67 DID YOU BECOME PREGNANT

| | | |
|---|---|---|
| SOONER THAN YOU WANTED? | 15 | 30% |
| LATER THAN YOU WANTED? | 5 | 10% |
| RIGHT TIME? | 20 | 40% |
| DON'T KNOW? | 10 | 20% |

68 HAVE YOU EVER OBTAINED ANY INFORMATION ABOUT FAMILY PLANNING FROM ANY DOCTOR OR AGENCY?

YES: 27 54% NO: 22 44% CAN'T REMEMBER: 1 2%

69 BEFORE YOU BECAME PREGNANT THIS LAST TIME, DID YOU EVER USE ANY METHOD TO DELAY OR PREVENT PREGNANCY?

YES: 22 44% NO: 28 56%

A WHAT METHOD DID YOU USE?

| | | |
|---|---|---|
| PILL | 17 | 34% |
| I.U.D. | 1 | 2% |
| CONDOM | 5 | 10% |
| RHYTHM (CALENDAR) | 1 | 2% |
| NOT APPLICABLE | 26 | 52% |



69 B WHICH ONE WERE YOU USING JUST BEFORE YOU GOT PREGNANT THIS LAST TIME?

| | | |
|---|---|---|
| PILL | 18 | 36% |
| I.U.D. | 1 | 2% |
| CONDOM | 5 | 10% |
| NOT APPLICABLE | 26 | 52% |

C HAD YOU STOPPED USING THIS METHOD BEFORE YOU BECAME PREGNANT?

YES: 23 46% NO: 1 2% NOT APPLICABLE: 26 52%

70 DO YOU EXPECT TO HAVE ANOTHER CHILD?

| | | |
|---|---|---|
| DEFINITELY YES | 11 | 22% |
| PROBABLY YES | 7 | 14% |
| UNCERTAIN | 4 | 8% |
| PROBABLY NO | 4 | 8% |
| DEFINITELY NO | 24 | 48% |

A HOW MANY MORE CHILDREN DO YOU THINK YOU WILL HAVE ALTOGETHER?

| | | |
|---|---|---|
| 2 CHILDREN | 4 | 8% |
| 3 " | 7 | 14% |
| 4 " | 4 | 8% |
| 5 " | 1 | 2% |
| 6 " | 2 | 4% |
| NOT APPLICABLE | 32 | 64% |

70 B About when do you expect to have your next child?

| | | |
|---|---|---|
| 1 year | 3 | 6% |
| 2 years | 9 | 18% |
| 3 years | 4 | 8% |
| 4 years | 2 | 4% |
| Not applicable | 32 | 64% |

71 Do you agree or disagree with the following statements:

A "I have great faith in doctors."

Agree: 28 56% Disagree: 22 44%

B "As long as you feel all right, there is no reason to go to a doctor."

Agree: 37 74% Disagree: 13 26%

C "In general, I think doctors do a good job."

Agree: 47 94% Disagree: 3 6%

D "There is much a person can do to keep from becoming sick."

Agree 47 94% Disagree: 8 16%

E "In general, I think most doctors are over-rated."

Agree 31 62% Disagree: 19 38%



71 F "If a person works at it, he can stay in good health."

Agree: 43 86% Disagree: 7 14%

G "When there are cold around, I am sure to get one no matter how much I try to avoid it."

Agree: 23 46% Disagree: 27 54%

H "I would rather not go to a doctor unless I had to."

Agree: 46 92% Disagree: 4 8%

I "Even if a person is not sick, he should see a doctor at least once at least once a year for a routine check-up."

Agree: 43 86% Disagree: 7 14%

J "If you are going to be sick, you will be sick, no matter what you do about it."

Agree: 47 94% Disagree: 3 6%

72 Would you consult a doctor if you had any of these illnesses?

A A temperature of $103^0$ for 2 days?

Yes: 41 82% No: 6 12% Don't know: 3 6%

72 B A REPEATED SHARP PAIN IN YOUR CHEST?

YES: 37 74% NO: 9 18% DON'T KNOW: 4 8%

C A SEVERE COUGH OR SORE THROAT?

YES: 32 64% NO: 17 34% DON'T KNOW: 1 2%

D "NERVES?"

YES: 24 48% NO: 23 46% DON'T KNOW: 3 6%

E FREQUENT INSOMNIA?

YES: 18 36% NO: 29 58% DON'T KNOW: 3 6%

F UNEXPLAINED WEIGHT LOSS?

YES: 31 62% NO: 17 34% DON'T KNOW: 2 4%

G ALLERGY?

YES: 26 52% NO: 17 34% DON'T KNOW: 7 14%

H BLOOD IN YOUR STOOLS?

YES: 20 40% NO: 12 24% DON'T KNOW: 18 36%



72 I GENERAL FATIGUE?

YES: 23 46% NO: 22 44% DON'T KNOW: 5 10%

73 HOW IMPORTANT IS IT TO YOU TO TAKE YOUNG CHILDREN TO A DOCTOR FOR REGULAR CHECK-UPS, EVEN WHEN THEY ARE FEELING WELL?

NOT IMPORTANT: 10 20% SOMEWHAT IMPORTANT: 19 38%

VERY IMPORTANT: 21 42%

74 WOULD YOU BRING YOUR CHILD TO THE DOCTOR IF HE/SHE HAD ANY OF THE FOLLOWING:-

A IF THE CHILD SEEMED TO BE FEELING POORLY FOR SEVERAL DAYS, AND HAD A TEMPERATURE OF ABOUT $102^{o}$?

YES: 47 94% NO: 2 4% DON'T KNOW: 1 2%

B IF THE CHILD SEEMED TO HAVE UNEXPLAINED MUSCULAR ACHES OR PAINS?

YES: 42 84% NO: 6 12% DON'T KNOW: 2 4%

C IF THE CHILD COMPLAINED OF A SORE THROAT FOR THREE DAYS, BUT HAD NO TEMPERATURE?

YES: 35 70% NO: 12 24% DON'T KNOW: 3 6%

D IF THE CHILD HAD AN EARACHE?

YES: 44 88% NO: 5 10% DON'T KNOW: 1 2%

## Discussion

The results show considerable psychological stress. The fact that the study was carried out in a disadvantaged area is clearly important for the increased levels of psychosocial stress. While 38% (19) of the mothers scored positively on the Edinburgh Post-natal Depression Scale, previous research in this country using this instrument and following the screening with a formal psychiatric interview suggested that about 30% would be false positives, (O'Neill et al., 1990). This would then give a similar figure to that found by O'Neill and colleagues in Dublin.

Examining the social situation, it is clear that there is very considerable financial stress, with only 22% (11) of the mothers being satisfied with their financial position. Only 26% (13) felt there was adequate money for the family needs. Fifty per cent (25) of the families were receiving unemployment assistance, and only 34% (17) of the spouses were employed. Eighty per cent (40) had a medical card.

There were also considerable difficulties on the social side, where only 64% (32) of the mothers were satisfied with the amount of time they had to go out. Twenty per cent had sexual problems, and 20% had difficulties in confiding in their partners. Twenty-four per cent were not satisfied with their relationship with their partners, and 20% had considered separation. Twenty per cent were single mothers. Forty per cent had some difficulties coping with their children, and 34% (17) were attending religious services once per week.

WHEN MOTHERS WERE ASKED IF THEY WANTED A CHILD BEFORE THIS LAST PREGNANCY, 32% (16) SAID "NO." CLEARLY, THERE IS A CONSIDERABLE NUMBER OF UNPLANNED AND UNWANTED PREGNANCIES. IT IS IMPORTANT THAT PUERPERAL DEPRESSION IS QUICKLY AND ENERGETICALLY TREATED, BECAUSE OF THE CLOSE LINK BETWEEN ADULT AND CHILD PSYCHIATRIC ILLNESS. IT IS ALSO CLEAR THAT THE MOTHERS WHO ARE UNDER PSYCHOSOCIAL STRESS ARE IN NEED OF CONSIDERABLE SUPPORT, DROP-IN CENTRES AND GOOD QUALITY PRE-SCHOOL PLAY GROUPS FOR THEIR CHILDREN.

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# SHOULD CHILDREN WITH MINOR MEDICAL PROBLEMS BE SENT TO HOSPITAL? A STUDY OF INFANT CARE PRACTICES WITHIN FAMILIES.

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## SUMMARY

THE ADMISSION OF CHILDREN TO HOSPITAL FOR MINOR MEDICAL PROBLEMS IS FREQUENTLY INFLUENCED BY FAMILY AND SOCIAL CIRCUMSTANCES. THIS STUDY COMPARED THE INFANT CARE PRACTICES OF FAMILIES OF CHILDREN ADMITTED TO HOSPITAL FOR GASTROENTERITIS (N = 76) AND FAMILIES CARING FOR CHILDREN WITH GASTROENTERITIS AT HOME (N = 76). MOTHERS OF CHILDREN WHO WERE ADMITTED TO HOSPITAL WERE MORE LIKELY TO USE MEDICAL SOURCES OF ADVICE ON PARENTING AND LESS LIKELY TO USE OTHER NON-FAMILY SOURCES THAN HOME CARE MOTHERS. THEY ALSO RECEIVED LESS SUPPORT IN THE EDUCATION/ENTERTAINMENT OF THEIR CHILDREN FROM FATHERS. THERE WERE MANY SIMILARITIES BETWEEN THE TWO GROUPS, INCLUDING THE HIGH LEVEL OF BEHAVIOUR PROBLEMS OF THE CHILDREN AND THE RELATIVELY LOW LEVEL OF INVOLVEMENT OF FATHERS IN CHILD CARE TASKS. BOTH OF THESE FACTORS SERVE TO INCREASE STRESS ON MOTHERS TO THE POINT WHERE THEY MAY BE UNABLE TO COPE WITH A SICK CHILD AT HOME.

## Introduction

Parenting is a life skill for which there is no training and few resources for advice and guidance.[1] Parenting styles show considerable continuity throughout childhood[2] and indeed the effects of parenting in one generation are clearly carried on to the next generation.[3] This overrides the impact of other influences such as material disadvantage or different family structures.[4] Some factors, such as high levels of stressful life events, have been shown to distract parents from taking care of their children.[5] In the health area, parents certainly influence the development of behaviour patterns in their children, for instance in areas such as nutrition and exercise,[6] which are important in terms of current health and ultimate longevity.[7] In illness, indifferent parenting styles are associated with less well controlled childhood illness.[8]

There is increasing discussion of the asymmetry of modern family arrangements in relation to the family work role.[9] Research suggests that women still shoulder almost all of the housework burden in families, regardless of their own job involvement.[10] While child centred tasks are shared more often than household tasks,[11] households with young children are particularly asymmetrical in their overall division of household tasks.[12]

An Irish study found little difference between groups of single and married mothers on a range of demographic, psychosocial and child development indices, but found that the sub-group of single mothers who lived alone were especially vulnerable to problems.[13]



One area in which non-medical factors such as parenting skills may influence disease incidence and management is that of infantile gastroenteritis. A recent study compared a group of children managed at home and a group managed in hospital for childhood gastroenteritis in the light of clinical concerns about the large number of admissions to hospital of children with this complaint for non-medical reasons. No differences were expected in terms of medical severity of the gastroenteritis. In the larger study, blind ratings by doctors specialising in gastroenteritis clearly showed that there were no such differences between hospital-managed and home care groups. An explanation was sought by examining social and family factors, as home care management of gastroenteritis would be associated with better parenting skills. Identification of differences in parenting between the two groups could provide a focus for the development of preventive strategies with young parents.

## Methods

Sample: The families of a group of 152 children under two years of age from an urban geographical region were interviewed about a recent childhood illness (gastroenteritis). The region was West Dublin; an area of approximately 300 square miles as defined by county boundaries to the west and by city postal districts to the east. A diagnosis of gastroenteritis by the doctor concerned was taken as the medical inclusion criterion. All children who had been admitted to the region's infectious diseases' hospital with gastroenteritis in the first quarter of 1987 were identified from hospital records (n = 78). An equal number of families who were known to have had a child with gastroenteritis in the

SAME PERIOD WHO HAD NOT BEEN ADMITTED TO HOSPITAL WERE IDENTIFIED BY CONTACT WITH GENERAL PRACTITIONERS AND HOSPITAL CASUALTY DEPARTMENTS. GENERAL PRACTITIONERS WERE INTERVIEWED FOR ANOTHER PART OF THE STUDY, AND WERE ASKED TO PROVIDE THEIR MOST RECENT CASE OF CHILDHOOD GASTROENTERITIS WHICH WAS MANAGED AT HOME. CASUALTY DEPARTMENT RECORDS IN THE CITY'S TWO LARGEST PAEDIATRIC HOSPITAL WERE EXAMINED FOR GASTROENTERITIS ATTENDANCES WHICH WERE MANAGED AT HOME IN THE SAME REGION AND TIME PERIOD. APPROACHES TO FAMILIES RESULTED IN A 97% RESPONSE RATE.[14]

PROCEDURE: QUESTIONS WERE ASKED ON A NUMBER OF ASPECTS OF PARENTING, INCLUDING PRIOR EXPERIENCE AND KNOWLEDGE, SOURCES OF ADVICE, PARENTING SKILLS MANAGEMENT AND THE ROLE DIVISION BETWEEN MOTHER AND FATHER. IT WAS AGREED THAT HOME CARE FOR CHILDHOOD GASTROENTERITIS, AS FOR ANY OTHER MINOR CHILDHOOD ILLNESS, WAS BEST.

STATISTICS: THE STATISTICAL PROCEDURES USED WERE CHI-SQUARE ANALYSIS FOR CATEGORICAL VARIABLES GROUP COMPARISON, ONE-TAILED T-TEST ANALYSIS FOR INTERVAL VARIABLES GROUP COMPARISONS AND PEARSON CORRELATION ANALYSIS FOR INTERVAL VARIABLE EXAMINATION OF SAMPLE CHARACTERISTICS.

## RESULTS

ON COMPARISON WITH THE CENSUS FIGURES FOR 1981,[15] TWO-PARENT FAMILIES WITH MORE THAN ONE CHILD WERE UNDER-REPRESENTED IN THE OVERALL SAMPLE (HOME SAMPLE: 58%; HOSPITAL SAMPLE: 58%; CENSUS PROPORTION: 70%, $p < .02$). TWO-PARENT FAMILIES WITH ONLY ONE CHILD WERE SLIGHTLY OVER-REPRESENTED IN THE HOME CARE BUT NOT IN THE HOSPITAL CARE SAMPLE (HOME CARE: 32%; HOSPITAL CARE:



25%; CENSUS PROPORTION: 23%, $p < .06$). SINGLE PARENT FAMILIES CONSTITUTED 9% OF THE CASES SEEN IN THE HOME SAMPLE AND 14% IN THE HOSPITAL SAMPLE, IN COMPARISON TO 3% OF ALL FAMILIES IN THE AREA ($p < .001$). THERE WERE NO SIGNIFICANT DIFFERENCES IN THE NUMBERS OF CHILDREN IN SINGLE PARENT FAMILIES IN THE HOME AND HOSPITAL SAMPLES.

PRIOR EXPERIENCE OF DIFFERENT FACETS OF PARENTING ARE SHOWN IN TABLE I. LEVELS OF EXPERIENCE WITH YOUNG CHILDREN ARE SIGNIFICANTLY HIGHER FOR THE HOSPITAL CARE MOTHERS, THE REVERSE HOLDING FOR PRE-NATAL CLASS ATTENDANCE AND READING ON BABYCARE. WOMEN WITH MORE EXPERIENCE OF YOUNG CHILDREN ARE MORE LIKELY TO BE YOUNGER ($r = -0.28$, $p = 0.01$), TO BE LESS WELL EDUCATED ($r = -0.25$, $p = 0.03$) AND TO HAVE HUSBANDS OF LOWER OCCUPATIONAL STATUS ($r = 0.21$, $p = 0.05$).

Table I.

EXPERIENCES RELATED TO CHILD CARE/PARENTING OF 152 STUDY MOTHERS

| MOTHER'S EXPERIENCE | HOSPITAL CARE % | HOME CARE % | p |
|---|---|---|---|
| Caring for young children | 88 | 75 | < 0.05 |
| Reading about child care | 50 | 80 | < 0.05 |
| Pre-natal class attendance | 36 | 63 | < 0.01 |

THERE WAS NO DIFFERENCE BETWEEN HOSPITAL CARE AND HOME CARE MOTHERS IN KNOWLEDGE OF ASPECTS OF CHILD CARE

WHEN TESTED BY A SERIES OF STATEMENTS AND ASKED TO INDICATE "TRUE" OR "FALSE" - SUCH AS: "A BABY NEEDS TO BE MORE WARMLY DRESSED THAN AN ADULT," "IF A BABY IS FAT YOU KNOW IT IS HEALTHY," OR "SOME BABIES SPIT UP ALL THEIR FEEDS."

FAMILIES WERE THE MAIN SOURCE OF PARENTING ADVICE FOR BOTH GROUPS OF MOTHERS. MEDICAL SOURCES WERE MORE EVIDENT FOR HOSPITAL CARE MOTHERS (12% VERSUS 3%, $p < .05$), AND NON-FAMILY CONTACT LESS EVIDENT (14% VERSUS 55%, $p < .001$). NINE PERCENT OF HOSPITAL AND SIX PERCENT OF HOME CARE MOTHERS HAD NO SOURCE OF PARENTING ADVICE.

INVOLVEMENT IN CHILD CARE TASKS BY MOTHERS AND FATHERS IS SHOWN IN TABLE II. MOST OF THE CHILD CARE WAS PROVIDED BY MOTHERS, ALTHOUGH THERE WAS SOME PATERNAL INVOLVEMENT IN ALL THE TASKS MENTIONED. FATHERS WERE MOST INVOLVED IN THE PLAY ACTIVITY OF THEIR CHILDREN. DIFFERENCES IN THE INVOLVEMENT IN CHILD CARE TASKS EXISTED FOR ONLY TWO OF THE ELEVEN DIMENSIONS FOR MOTHERS. HOME CARE FATHERS TOOK THEIR CHILDREN OUTDOORS SIGNIFICANTLY MORE OFTEN. BOTH MOTHERS AND FATHERS OF CHILDREN WHO WERE CARED FOR AT HOME WERE MORE LIKELY TO READ TO THEIR CHILDREN, ($p = .08$ FOR MOTHERS AND $p = .12$ FOR FATHERS). COMBINING THE NUMBER OF TIMES CHILDREN WERE TAKEN OUTDOORS, READ TO AND PLAYED WITH INTO AN INDEX OF "CHILD SOCIALISATION," HOME CARE CHILDREN WERE SIGNIFICANTLY MORE SOCIALISED THAN HOSPITAL CARE CHILDREN (15.3 VERSUS 12.7 EPISODES OF SUCH SOCIALISATION IN A WEEK, ($p = 0.004$). THE OVERALL INVOLVEMENT IN CHILD CARE TASKS OF MOTHERS WAS SIMILAR ACROSS THE GROUPS, (AVERAGE 74% FOR MOTHERS AND 20% FOR FATHERS).



Table II.

INVOLVEMENT IN CHILD CARE TASKS BY MOTHERS AND FATHERS

| TASKS | MOTHERS | | FATHERS | |
|---|---|---|---|---|
| | HOSPITAL CARE | HOME CARE | HOSPITAL CARE | HOME CARE |
| <u>No. of days involved weekly:</u> | | | | |
| getting child up in the morning | 5.7 | 5.9 | 1.1 | 1.0 |
| dressing child | 5.4 | 6.1* | 1.2 | 0.9 |
| preparing child's food | 5.6 | 5.8 | 0.9 | 1.0 |
| feeding child | 4.8 | 5.5* | 1.4 | 1.4 |
| changing nappies | 5.5 | 5.4 | 0.9 | 1.3 |
| putting child to bed | 4.9 | 4.8 | 1.4 | 1.6 |
| <u>No. of times weekly:</u> | | | | |
| bathing child | 4.8 | 4.2 | 0.4 | 0.6 |
| playing games | 3.0 | 3.4 | 2.1 | 2.6 |
| taking child outdoors | 3.0 | 3.2 | 1.2 | 1.7 |
| reading to child | 1.3 | 1.7 | 0.8 | 1.2 |
| babysitting without mother | N/A | N/A | 1.1 | 0.8 |
| taking up crying child at night | 2.6 | 2.0 | 0.7 | 0.6 |

N = 152; one-tailed t-test analysis.

* $p < .05$ (comparisons between mothers and between fathers).

## Discussion

In dealing with the problem of infantile gastroenteritis, parental inexperience (leading to anxiety and caution, yet an overall willingness and perceived ability to manage at home) may explain the greater preponderance of families with only one child whose children were cared for at home. It is likely that anything that undermines the family system will cause stress and reduce coping ability. A reduced level of paternal involvement with children may increase the burden on the mother and make her less capable of coping with an ill child. There is no need for fathers to become more involved in the management and care of their children.

Very few of the children in this study were re-admitted to hospital on a second occasion. It would appear that families learn, in hospital, about the management of gastroenteritis. Mothers expressed more confidence in the future management of a gastroenteritis episode following their child's stay in hospital. This suggests that a preventive educational strategy by general practitioners, public health nurses or health visitors might reduce hospital admissions. The impact of investment in families at preventative level has been outlined by Reif, who used family education as the investment domain and childhood hospitalisation as a measure of the impact of preventive spending.[16] For families in Jerusalem he showed that a third year at secondary school for at least one parent was associated with an average decline of 1.3 hospital days per infant per year.

The present study confirms that considerable stress is involved in rearing children, and that



significant numbers of children have behaviour problems. This may explain the high rates of psychiatric illness and disturbance in mothers, as demonstrated by Brown and Harris,[17] a situation probably aggravated by the asymmetry of parental relationships with the children. Health education in the management of a particular illness such as gastroenteritis might reduce the number of children admitted to hospital, which would be beneficial both in financial terms and in terms of the psychological well-being of the child. In the broader situation, more symmetrical sharing of child care by both parents might reduce stress on the mother and increase her coping ability in the management of a common childhood illness such as gastroenteritis.

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# PSYCHOLOGICAL HEALTH STATUS OF MOTHERS AND THE ADMISSION OF CHILDREN TO HOSPITAL FOR GASTROENTERITIS

MICHAEL FITZGERALD; HANNAH MCGEE.

**THE PREVALENCE** OF PSYCHOLOGICAL DISTRESS WAS MEASURED BY THE 30-ITEM GENERAL HEALTH QUESTIONNAIRE IN TWO POPULATIONS OF MOTHERS: THOSE WHO HAD CHILDREN HOSPITALISED FOR GASTROENTERITIS; AND THOSE WHO CARED FOR CHILDREN WITH GASTROENTERITIS AT HOME. SIGNIFICANT DIFFERENCES EMERGED, WITH MOTHERS OF HOSPITALISED CHILDREN REPORTING HIGHER LEVELS OF PSYCHOLOGICAL DISTRESS. THERE WAS NO DIFFERENCE IN SEVERITY OF THE CHILDREN'S ILLNESS BETWEEN THE TWO GROUPS, AS INDICATED BY BLIND RATINGS OF SYMPTOMATOLOGY FROM SIX INFECTIOUS DISEASES' HOSPITAL DOCTORS. THUS HOSPITALISATION OF CHILDREN FOR GASTROENTERITIS WAS NOT CONTINGENT ON MEDICAL SYMPTOMATOLOGY. INSTEAD, THE EVIDENCE INDICATES THAT THE PSYCHOLOGICAL STATUS OF MOTHERS MAY INFLUENCE DOCTORS' MANAGEMENT DECISIONS ON CHILDHOOD GASTROENTERITIS. SIGNIFICANT POSITIVE ASSOCIATIONS BETWEEN POOR PSYCHOLOGICAL STATUS AND POOR SOCIAL RESOURCES ILLUSTRATE THE SOCIAL CONTEXT IN WHICH MATERNAL VULNERABILITY MAY INFLUENCE CHILD HEALTH CARE GENERALLY. THE IMPACT OF MATERNAL PSYCHOLOGICAL STATUS ON DECISIONS ABOUT PAEDIATRIC CARE IS DISCUSSED.

LONG OR REPEATED ADMISSIONS OF CHILDREN TO HOSPITAL HAVE BEEN SHOWN TO BE ASSOCIATED WITH INCREASED RATES OF PSYCHIATRIC DISTURBANCE IN LATER CHILDHOOD AND ADOLESCENCE. IT HAS BEEN ESTIMATED THAT

4.3% OF THE CHILD POPULATION EXPERIENCES MULTIPLE HOSPITALISATION AND 40% OF CHILDREN WITH REPEATED HOSPITALISATION SHOW DISTURBED BEHAVIOUR IN LATE CHILDHOOD. THUS, SOME 1.7% OF THE TOTAL CHILD POPULATION SHOW DISTURBANCES WHICH HAVE ARISEN FROM REPEATED ADMISSIONS TO HOSPITAL. GASTROENTERITIS IS ONE RELATIVELY MINOR CHILDHOOD PROBLEM RESULTING IN MANY HOSPITALISATIONS. IN A LONGITUDINAL NATIONAL STUDY OF OVER 13,000 BRITISH CHILDREN IN THE EARLY 1970'S, 2.7% WERE ADMITTED TO HOSPITAL FOR GASTROENTERITIS AT LEAST ONCE IN THEIR FIRST FIVE YEARS, 1.5% IN THE FIRST YEAR ALONE.

MATERNAL PSYCHOLOGICAL HEALTH STATUS HAS BEEN SHOWN TO BE RELATED TO THE HEALTH OF CHILDREN; FOR INSTANCE, POOR PSYCHOLOGICAL HEALTH IS ASSOCIATED WITH INCREASED NUMBERS OF ACCIDENTS TO CHILDREN, THE RATIO BEING 2.2:1 FOR MOTHERS IN THE LOWER SOCIAL CLASSES AND 5:1 FOR THE MIDDLE CLASSES. CHILDREN OF WOMEN USING PSYCHOTROPHIC MEDICATION HAVE TWICE THE AVERAGE CONSULTATION RATE FOR RESPIRATORY ILLNESS AT GENERAL PRACTICE. MOTHERS ARE ALSO MORE LIKELY TO BRING A CHILD TO A CHILD GUIDANCE CLINIC IF THEY THEMSELVES ARE DEPRESSED. FURTHERMORE, IT HAS BEEN SHOWN THAT POOR MENTAL HEALTH IS ASSOCIATED WITH THE NURTURANT ROLE THAT WOMEN OCCUPY IN THEIR CARE OF SMALL CHILDREN; MOTHERS WITH SMALL CHILDREN TO LOOK AFTER ARE MORE LIKELY TO BE DEPRESSED THAN THOSE WITHOUT. THE LACK OF A CONFIDANT HAS ALSO BEEN SHOWN TO BE ASSOCIATED WITH INCREASING LEVELS OF DEPRESSION IN MOTHERS. FINALLY, MOTHERS WITH RECURRENT OR CHRONIC DEPRESSIVE DISORDER TEND TO BE LESS APPROPRIATELY RESPONSIVE TO THEIR CHILDREN, LESS LIKELY TO SUSTAIN POSITIVE INTERACTION, LESS ABLE TO PUT THEIR CHILDREN'S EXPERIENCES INTO A PERSONAL CONTEXT AND MORE OFTEN INVOLVED IN UNSUCCESSFUL ATTEMPTS TO CONTROL THEIR CHILDREN.



THE PRESENT STUDY IS PART OF A LARGER INVESTIGATION DESIGNED TO EVALUATE FACTORS INFLUENCING THE HOSPITALISATION OR NON-HOSPITALISATION OF CHILDREN FOR GASTROENTERITIS. THE STUDY EXAMINED VARIOUS NON-MEDICAL REASONS FOR THE DIFFERENTIAL TREATMENT OF TWO GROUPS OF CHILDREN WITH GASTROENTERITIS. AS PART OF THIS EXAMINATION THE PSYCHOLOGICAL HEALTH STATUS OF MOTHERS WAS INVESTIGATED.

IT WAS HYPOTHESISED THAT MOTHERS HAVING A CHILD ADMITTED TO HOSPITAL WOULD SHOW SIGNIFICANTLY HIGHER LEVELS OF PSYCHOLOGICAL DISTRESS ON THE GENERAL HEALTH QUESTIONNAIRE (GHQ) THAN WOULD MOTHERS MANAGING THEIR CHILDREN AT HOME.

## METHOD

SAMPLE: THE SAMPLE WAS DRAWN FROM A LARGE URBAN GEOGRAPHICAL REGION AND INCLUDED MOTHERS OF CHILDREN UNDER TWO YEARS OF AGE WHO HAD HAD A RECENT EPISODE OF GASTROENTERITIS. MOTHERS OF ALL SUCH CHILDREN HOSPITALISED IN THE FIRST QUARTER OF 1987 AT THE NATIONAL INFECTIOUS DISEASES CENTRE WERE INTERVIEWED AND WERE COMPARED WITH MOTHERS MANAGING CHILDHOOD GASTROENTERITIS AT HOME OVER THE SAME TIME PERIOD. MOTHERS IN HOME CARE SITUATIONS WERE IDENTIFIED IN TWO WAYS. FIRST, RESEARCHERS CONTACTED A RANDOM SAMPLE OF GENERAL PRACTITIONERS IN THE DESIGNATED AREA (AS PART OF THE LARGER STUDY). EACH GENERAL PRACTITIONER PROVIDED HIS OR HER MOST RECENTLY MANAGED HOME CARE CASE OF GASTROENTERITIS. SECONDLY, CASUALTY DEPARTMENT RECORDS FROM THE TWO MAIN PAEDIATRIC HOSPITALS IN THE AREA WERE ALSO USED TO IDENTIFY HOME MANAGEMENT CASES.

## Research Instruments

General Health Questionnaire: As part of an extensive interview tith mothers the 30-item GHQ was administered. This was scored using the two original scoring options; a dichotomous scoring system (0-1) and a 0-4 scoring system. The chronicity method of scoring was also used. This method has been shown to be a more valid measure of caseness since it differentially weighs the reporting of chronic and acute symptomatology.

Family or original relationships: Relationships of both parents with their own parents and the marital relationships of these grandparents were combined to provide an estimate of the general pattern of relationships in the parents' family of origin (values 0-12) - (see Appendix).

Leisure: Numbers of social outings were compiled, as in previous research, from information on social entertainments, club and religious involvements and visiting relatives and friends (values 0-8) - (see Appendix).

Shared Leisure: For those mothers in dyadic relationships, the overall level of sharing of social activities was calculated (values 0-6) - (see Appendix).

Social Contacts: The range of social contacts (that is, strangers, acquaintances, friends and relatives) was summarised using Henderson and colleagues' format (values 0-4) as was satisfaction with access to social contacts (values 0-8) - (see Appendix).



## Statistical Analysis

Statistical analysis aimed to assess group (hospital versus home care) differences and to examine the relationships among various dimensions under study (for example, psychological distress and satisfaction with social contacts).

Single variable group differences were examined with the student's t-test where data were in interval or ratio format (for example, age of child) and with the chi-square test where data were in nominal or categorical format (for example, single or two parent family). In both cases the more conservative two-tailed test of significance was used.

Pearson's product-moment correlation was used to examine single variable relationships between study variables.

Discriminant analysis, a technique based on multiple regression, was used for multivariate comparisons of hospital and home-care groups. Discriminant analysis identifies those study variables which best differentiate two groups from each other and provides an estimate of the degree of group differentiation possible by a combination of information from the variables measured.

Table I.

Comparisons of family aspects of children hospitalised for gastroenteritis and children managed at home for gastroenteritis

| | Mean Values | |
|---|---|---|
| | Hospital care sample (n=76) | Home care sample (n=76) |
| Age of child (months) | 10.2 | 10.7 |
| Medical severity of symptoms score (scale 0-7) | 5.2 | 5.0 |
| Two-parent family (% of sample) | 87.0 | 92.0 |
| Maternal age (years) | 26.3 | 28.2* |
| Number of other children in family | 2.3 | 1.9 |
| Basic education only (mother) (% of sample) | 55.0 | 28.0* |
| Basic education only (father) (% of sample) | 57.0 | 39.0* |
| Occupation of head of household (% professional) | 13.0 | 29.0** |
| State-provided housing (% of sample) | 67.0 | 38.0*** |
| Duration of residence (years) | 4.9 | 4.6 |
| Parenting skills score (scale 0-8) | 7.0 | 6.8 |
| Quality of marriage score (scale 0-40) | 28.5 | 29.8 |
| Child care provided by mother (% of sample) | 73.0 | 74.0 |
| Child care provided by father (% of sample) | 20.0 | 22.0 |
| Life events impact score (scale 0-100) | 50.0 | 44.0 |
| Family health status score (scale 0+) | 9.3 | 8.7 |
| Family health behaviours score (scale 0-9) | 2.6 | 3.2 |
| Maternal health attitudes score (scale 0-7) | 4.5 | 5.1** |
| Maternal GHQ-30 score (scale 0-30) | 10.0 | 7.5* |
| Maternal leisure score (scale 0-8) | 3.3 | 4.4** |
| Shared leisure score (scale 0-6) | 2.6 | 3.2** |
| Social contacts score (range) (scale 0-4) | 2.9 | 3.0 |
| Social contacts score (satisfaction) (scale 0-8) | 5.5 | 7.1* |
| Family of origin relationships score (scale 0-12) | 7.4 | 8.3* |

* $P < 0.05$; ** $P < 0.01$; *** $P < 0.001$, two-tailed tests



## Results

Seventy-eight hospital cases were identified in the study period; two mothers refused to be interviewed. Home care cases were then selected to provide another seventy-six cases for comparison. Again here, seventy-eight contacts provided seventy-six cases. Thus the overall response rate was 97%.

Interviews were conducted by a psychologist (HM) during or shortly after the child's episode of gastroenteritis, in the hospital or home care situation as appropriate. (Approximately half of hospital care mothers were seen at home following discharge, for logistic reasons.) There was no significant difference in the time interval to interview of hospital and home care mothers: (hospital care mothers interviewed at mean of fifteen days following resolution of symptoms; home care mothers interviewed at mean of eighteen days later.)

According to scores on the GHQ-30, mothers of hospitalised children were significantly more depressed by two of the three scoring combinations, the chronicity scoring system ($P = 0.03$) and the standard 0-4 scoring system ($P = 0.02$). The dichotomous scoring system showed a strong trend in the same direction ($P = 0.06$). Using Goldberg's "case" classification, those mothers scoring five or greater on the scale (0-1 ratings) were examined. Forty-eight per cent of hospital care and 31% of home care mothers fell above the cut-off point for psychiatric caseness ($t = 3.7$; $P = 0.05$).

One obvious reason for differential levels of distress and for differential referral in the two

GROUPS MAY BE THE DIFFERENTIAL MEDICAL SEVERITY OF THE CASES OF GASTROENTERITIS IN THE CHILDREN. HOWEVER, USING BLIND MEDICAL RATINGS OF SYMPTOMATOLOGY FROM SIX INFECTIOUS DISEASES' HOSPITAL DOCTORS, NO SIGNIFICANT DIFFERENCES IN THE MEDICAL SEVERITY OF THE HOSPITAL AND HOME CARE GROUPS EMERGED.

MANY VARIABLES WERE EXAMINED TO EXPLAIN THE NON-MEDICAL DIFFERENCES BETWEEN THE HOSPITAL AND HOME CARE GROUPS. TABLE I ILLUSTRATES THE DIFFERENCES AND SIMILARITIES BETWEEN THE TWO GROUPS. UTILIZING THIS WIDE RANGE OF INFORMATION, DISCRIMINANT ANALYSIS WAS USED TO FIND THE FACTORS WHICH MOST CLEARLY DIFFERENTIATED BETWEEN HOSPITAL AND HOME CARE MOTHERS.

THE MOST IMPORTANT VARIABLES TO EMERGE FROM THE DISCRIMINANT ANALYSIS WERE SOCIAL CONTACT AND SOCIAL RELATIONSHIP VARIABLES OUTSIDE THE NUCLEAR FAMILY. THE STUDIED VARIABLES DIFFERENTIATED BETWEEN THE TWO GROUPS WITH 71% ACCURACY. THE RELATIONSHIP OF THESE ASPECTS WITH PSYCHOLOGICAL DISTRESS ON THE GHQ-30 IS DEPICTED BY PRODUCT-MOMENT CORRELATIONS IN TABLE II. THUS, WHILE THE DIRECTION OF THE ASSOCIATION BETWEEN PSYCHOLOGICAL DISTRESS AND SOCIAL CONTACTS CANNOT BE ELUCIDATED BY THIS DATA, THE CORRELATIONS DRAW ATTENTION TO THE SIGNIFICANT ASSOCIATION OF DISTRESS AND SOCIAL CONTACT INDICES IN THIS POPULATION.

## DISCUSSION

THE PRESENT PAPER REPORTS ON THE PREVALENCE OF PSYCHOLOGICAL DISTRESS AS MEASURED BY THE GHQ-30 IN MOTHERS ACROSS TWO POPULATIONS - MOTHERS WHO HAD CHILDREN HOSPITALISED AND MOTHERS WHO DID NOT HAVE CHILDREN HOSPITALISED FOR GASTROENTERITIS. THE "CASE"



RATE OF 48% OF HOSPITAL CARE MOTHERS AND 31% OF HOME CARE MOTHERS DISPLAYING PSYCHOLOGICAL DISTRESS SUFFICIENT TO WARRANT A CLASSIFICATION OF SIGNIFICANT PSYCHIATRIC SYMPTOMATOLOGY IF SEEN BY AN EXPERIENCED CLINICIAN CAN BE COMPARED WITH A "CASE" RATE OF 35% OVER A PERIOD OF A YEAR FOR A GENERAL POPULATION OF HEALTH CENTRE ATTENDERS REPORTED BY CLARE.

COMPARING HEALTH CENTRE ATTENDERS (AS THE BEST AVAILABLE COMPARISON GROUP) WITH THE PRESENT SAMPLE, THERE ARE SIGNIFICANT DIFFERENCES BETWEEN MOTHERS WITH CHILDREN IN HOSPITAL AND THE GENERAL HEALTH CENTRE SAMPLE. MEANWHILE, ALTHOUGH LEVELS OF PSYCHOLOGICAL DISTRESS ON THE GHQ-30 APPEAR HIGH FOR HOME CARE MOTHERS, THEY ARE NOT ABOVE THAT OF HEALTH CENTRE ATTENDERS GENERALLY; IN BOTH CASES ABOUT ONE-THIRD ARE SIGNIFICANTLY DISTRESSED. IT IS ALSO NOTEWORTHY THAT AS THE LEVEL OF PSYCHOLOGICAL DISTRESS INCREASED THE LEVELS OF SHARED LEISURE ACTIVITIES GENERALLY, OVERALL CONTACTS, CONTACT SATISFACTION AND FAMILY OF ORIGIN VARIABLES DETERIORATED.

Table II

Product-moment correlations between social contact variables and scores for psychological distress on the 30-item General Health Questionnaire

| | Leisure activities | Leisure shared with spouse | Overall contacts | Contact satisfaction | Family of origin relationships |
|---|---|---|---|---|---|
| GHQ-30 Scores | −0.267* | −0.333* | −0.282* | −0.333 | +0.433* |

* $P < 0.05$; ** $P < 0.01$

THE STUDY ILLUSTRATES THAT LEVELS OF PSYCHOLOGICAL DISTRESS, AS MEASURED BY THE GHQ-30, MAY INFLUENCE MANAGEMENT DECISIONS ON THE ADMISSION OR OTHERWISE OF CHILDREN TO HOSPITAL FOR GASTROENTERITIS. IT SUGGESTS THAT MOTHERS OF CHILDREN WHO ARE HOSPITALISED FOR GASTROENTERITIS ARE MORE VULNERABLE AND POTENTIALLY NEED EXTRA PSYCHOLOGICAL HELP FROM PRIMARY CARE PHYSICIANS OR AT PSYCHIATRIC OUTPATIENT LEVEL.

THE INCREASED PSYCHOLOGICAL DISTRESS IN THE HOSPITAL CARE SAMPLE CANNOT BE EXPLAINED SIMPLY BY THE EFFECT OF THE GASTROENTERITIS EPISODE, SINCE THE MEDICAL SEVERITY OF THE HOSPITAL AND HOME CARE SAMPLES WAS SIMILAR. THIS STUDY ALSO ILLUSTRATES AN ASSOCIATION BETWEEN PSYCHOLOGICAL DISTRESS IN MOTHERS AND LOW LEVELS OF LEISURE ACTIVITY, LOW LEVELS OF SHARED LEISURE WITH PARTNERS, POOR OVERALL CONTACTS, POOR SATISFACTION WITH CONTACTS AND A DISTURBED INTRAFAMILIAL ENVIRONMENT. THE RESULTS ARE IN ACCORD WITH THE FINDINGS OF THE IMPORTANCE OF CONFIDANTS AS FOUND BY BROWN AND HARRIS. THEY SUGGEST THE IMPORTANCE OF HELPING DISTRESSED YOUNG MOTHERS TO INCREASE THE LEVEL AND QUALITY OF THEIR SOCIAL CONTACTS. DISTRESSED MOTHERS IN THIS STUDY MAY FEEL, OR BE SEEN BY DOCTORS AS BEING, LESS ABLE TO COPE WITH THE HOME MANAGEMENT F GASTROENTERITIS. THIS MAY ALSO APPLY TO OTHER CHILD MANAGEMENT ISSUES. IN THESE CIRCUMSTANCES IT IS OFTEN THE MOTHER, NOT THE CHILD, WHO IS PRIMARILY VULNERABLE AND IN NEED OF HELP FROM PRIMARY CARE PHYSICIANS OR AT OUTPATIENT LEVEL.

IT CAN BE CONCLUDED THAT IN ORDER TO PROMOTE MORE EFFICIENT CHILD HEALTH CARE MANAGEMENT IN THE HOME SITUATION, THE PSYCHOLOGICAL STATUS OF THE MOTHER AND THE CONSEQUENCES OF THIS NEED TO BE ADDRESSED AS A PRACTICAL ISSUE IN CLINICAL MANAGEMENT.



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# APPENDIX

THE FOUR RESEARCH INSTRUMENTS USED IN ADDITION TO THE GHQ (SCORING SHOWN IN PARENTHESES):

FAMILY OF ORIGIN RELATIONSHIPS:

(A) WHAT IS/WAS YOUR RELATIONSHIP WITH YOUR PARENTS?

MOTHER _____

FATHER _____

(B) WHAT IS/WAS YOUR HUSBAND'S/PARTNER'S RELATIONSHIP WITH HIS PARENTS?

MOTHER _____

FATHER _____

| | |
|---|---|
| NO RELATIONSHIP/CONTACT | (0) |
| COOL/RESERVED | (1) |
| AVERAGE | (2) |
| VERY CLOSE | (3) |

LEISURE:

(A) HOW OFTEN DO YOU GO OUT TO EAT, DRINK OR SEE A FILM?

EATING _____

DRINKING _____

FILM _____

(B) HOW OFTEN DO YOU ATTEND RELIGIOUS SERVICES?

(C) HOW OFTEN DO YOU GET TOGETHER INFORMALLY WITH FRIENDS AND RELATIVES?

| | |
|---|---|
| ONCE A WEEK OR MORE | (2) |
| 2-3 TIMES A MONTH | (2) |
| ONCE A MONTH | (2) |
| A FEW TIMES YEARLY | (1) |
| RARELY, IF EVER | (1) |

(D) DO YOU BELONG TO ANY SOCIAL CLUBS OR ORGANISATIONS?

YES _____ (2)

NO _____ (1)



SHARED LEISURE:

FOR COMPONENTS A - C OF THE LEISURE SECTION:

ON THESE SOCIAL OCCASIONS IS YOUR HUSBAND/PARTNER INCLUDED?

| | |
|---|---|
| ALWAYS | (2) |
| OFTEN | (2) |
| SOMETIMES | (1) |
| RARELY, IF EVER | (1) |

SOCIAL CONTACTS:

(A) APART FROM THOSE LIVING WITH YOU, ON AN AVERAGE DAY HOW MANY PEOPLE DO YOU SEE WHOM YOU KNOW JUST A LITTLE (TO NOD TO, SAY HELLO TO, ETC.)?

_____

IS THIS ABOUT RIGHT FOR YOU, OR DO YOU WISH YOU SAW FEWER OR MORE OF SUCH CASUAL CONTACTS?

FEWER _____ ABOUT RIGHT _____ MORE _____

(B) APART FROM THOSE LIVING WITH YOU, ON THE AVERAGE DAY HOW MANY PEOPLE DO YOU SEE WHOM YOU KNOW CASUALLY (TO HAVE A SHORT CHAT WITH?)

_____

IS THIS ABOUT RIGHT FOR YOU, OR DO YOU WISH YOU SAW FEWER OR MORE OF SUCH CASUAL FRIENDS?

FEWER _____ ABOUT RIGHT _____ MORE _____

(C) APART FROM THOSE LIVING WITH YOU, AND YOUR RELATIVES, ON AN AVERAGE WEEK HOW MANY PEOPLE DO YOU SEE WHOM YOU CONSIDER TO BE GOOD OR CLOSE FRIENDS (THOSE WHOM YOU COULD CALL ON WITHOUT BEING EXPECTED AND BE SURE OF A WELCOME AND VICE VERSA)?

_____

IS THIS ABOUT RIGHT FOR YOU, OR DO YOU WISH YOU SAW THEM MORE OR LESS OFTEN?

LESS _____ ABOUT RIGHT _____ MORE _____

(D) APART FROM THOSE LIVING WITH YOU, ON AN AVERAGE WEEK HOW MANY CLOSE RELATIVES DO YOU SEE?

_____

IS THIS ABOUT RIGHT FOR YOU OR DO YOU WISH YOU COULD SEE THEM MORE OR LESS OFTEN?

LESS _____ ABOUT RIGHT _____ MORE _____

| | |
|---|---|
| 0-5 PEOPLE | (0) |
| FEWER/LESS OFTEN | (0) |
| ABOUT RIGHT | (1) |
| MORE THAN 5 PEOPLE | (1) |
| MORE/MORE OFTEN | (2) |



# THE INFLUENCE OF NON-MEDICAL FACTORS ON CHILDHOOD HOSPITALISATION FOR GASTROENTERITIS

HANNAH MCGEE; MICHAEL FITZGERALD.

## INTRODUCTION

MANY HOSPITALISATIONS FOR CHILDHOOD GASTROENTERITIS ARE SEEN TO BE MEDICALLY UNNECESSARY. FOR PSYCHOLOGICAL AND SERVICE PLANNING REASONS, SUCH ADMISSIONS ARE OF CONCERN. THIS STUDY EXAMINED SUCH HOSPITALISATIONS WITH A VIEW TO FINDING METHODS OF SAFELY DECREASING ADMISSIONS.

CHILDHOOD HOSPITALISATION INVOLVES THE ACTIONS OF BOTH PARENTS AND DOCTORS. THUS BOTH GROUPS ARE INCLUDED IN THIS RESEARCH TO PROVIDE AN ADEQUATE QUANTITATIVE BASIS FROM WHICH TO MAKE PRACTICAL RECOMMENDATIONS. A LARGE HETEROGENEOUS GEOGRAPHICAL AREA WAS CHOSEN FOR THE STUDY (COMPRISING URBAN/RURAL, OLD/NEW HOUSING AND A MIX OF SOCIO-ECONOMIC NEIGHBOURHOODS).

## DOCTORS' STUDY

METHOD: FIFTY-TWO RANDOMLY SELECTED GP'S (PARTICIPATION RATE 91%) AND 28 CASUALTY DEPARTMENT DOCTORS (PARTICIPATION RATE 100%) WERE INTERVIEWED. DOCTORS WERE QUERIED REGARDING (A) THEIR MANAGEMENT OF A SERIES OF HYPOTHETICAL CASES OF GASTROENTERITIS

("PAPER PATIENTS") AND, (B) THEIR GENERAL MANAGEMENT OF AND VIEWS ON GASTROENTERITIS.

FOUR FACTORS DERIVED FROM EARLIER PILOT STUDY DISCUSSIONS WITH DOCTORS WERE COMBINED TO CONSTITUTE EACH PAPER PATIENT: AGE OF CHILD; MEDICAL COMPLAINTS; FAMILY CIRCUMSTANCES; AND MATERNAL REACTION. IN THE PAPER PATIENTS, CHILDREN COULD EITHER BE YOUNGER (3 MONTHS) OR OLDER (15 MONTHS); MEDICAL SYMPTOMS WERE REPRESENTED BY MILD, MODERATE OR SEVERE CASES OF GASTROENTERITIS; FAMILY CIRCUMSTANCES WERE REPRESENTED BY SINGLE PARENT WITH ONE CHILD; TWO-PARENT FAMILY WITH ONE CHILD; OR TWO-PARENT FAMILY WITH FOUR CHILDREN; EACH FAMILY WAS OF LOWER SOCIAL CLASS ENVIRONMENT, AND MATERNAL REACTION WAS EITHER "QUITE CALM" OR "QUITE ANXIOUS." EACH DOCTOR RATED A RANDOM SELECTION OF EIGHTEEN PAPER PATIENTS AND TWO FURTHER RANDOMLY SELECTED CASES FROM THESE EIGHTEEN, AS A CHECK ON CONSISTENCY IN MEDICAL JUDGEMENT.

RESULTS: MEDICAL CONSISTENCY IN THEIR DECISION MAKING WAS HIGH; 88% OF REPEAT CASES WERE DEALT WITH IN THE SAME MANNER AS THE ORIGINAL CASE, (I.E. HOME OR HOSPITAL CARE). PAPER PATIENT ANALYSIS ALLOWED SYSTEMATIC ASSESSMENT OF MEDICAL DECISIONS ON THE RELATIVE CONTRIBUTION OF MEDICAL AND NON-MEDICAL FACTORS IN MANAGEMENT DECISIONS FOR GASTROENTERITIS. RESULTS INDICATED THAT BEING A YOUNG CHILD, A CHILD OF A SINGLE PARENT OR A CHILD OF AN ANXIOUS MOTHER WERE FACTORS EQUALLY LIKELY TO RESULT IN HOSPITAL REFERRAL (IN 25%, 26% AND 25% OF CASES RESPECTIVELY). THESE FACTORS WERE MORE LIKELY TO CONTRIBUTE TO HOSPITAL REFERRAL THAN THAT OF HAVING A MODERATELY SICK CHILD (16% WOULD BE REFERRED). THE COMBINED EFFECT OF THESE ASPECTS OF THE THREE NON-MEDICAL FACTORS FACTORS WAS NOT CUMULATIVE, BUT WOULD RESULT IN A 40% REFERRAL



RATE. T-TESTS REVEALED THAT DOCTORS WITH EXPERIENCE OF GASTROENTERITIS MANAGEMENT DURING TRAINING REFERRED SIGNIFICANTLY MORE PAPER PATIENTS TO HOSPITAL THAN THOSE WITHOUT (32% VERSUS 17% REFERRED, $p = .02$).

DISCUSSION: RESULTS PROVIDE EMPIRICAL CONFIRMATION THAT NON-MEDICAL FACTORS ARE A MAJOR COMPONENT IN CHILDHOOD HOSPITALISATION FOR GASTROENTERITIS. FURTHERMORE, MATERNAL ANXIETY EMERGED AS A FACTOR AS POWERFUL IN DECISION MAKING AS MORE STRUCTURAL AND UNCHANGING FEATURES SUCH AS AGE OF CHILD AND FAMILY CIRCUMSTANCES. THUS, OF THE NON-MEDICAL FACTORS, IT APPEARS EASIEST TO ADDRESS IN A MEDICAL CONSULTATION. HIGHER REFERRAL RATES BY DOCTORS WITH PRIOR TRAINING SUGGEST SENSITIZATION TO GASTROENTERITIS AS A MANAGEMENT PROBLEM.

## MOTHERS' STUDY

METHOD: MOTHERS OF YOUNG CHILDREN HAVING A RECENT EPISODE OF GASTROENTERITIS WERE INTERVIEWED (PARTICIPATION RATE 97%). FAMILIES WITH CHILDREN ADMITTED TO HOSPITAL FOR GASTROENTERITIS ($N = 76$) WERE COMPARED WITH FAMILIES MANAGING THEIR CHILDREN AT HOME ($N = 76$) OVER THE SAME TIME PERIOD. THE LATTER GROUP CONSISTED OF ONE CASE FROM EACH OF THE INTERVIEWED GP'S AND THE REMAINDER FROM CASUALTY DEPARTMENT ATTENDANCE RECORDS OF THE SAME PERIOD. EXTENSIVE INTERVIEWS WITH MOTHERS COVERED: THE GASTROENTERITIS EPISODE AND ITS MANAGEMENT; GENERAL CHILD HISTORY; PARENTING INFORMATION; AND INFORMATION ON HOME ENVIRONMENT, MARRIAGE, FAMILY RELATIONSHIPS, NEIGHBOURHOOD, LEISURE ACTIVITIES AND HEALTH ATTITUDES, BEHAVIOURS AND STATUS.

RESULTS: MEDICAL RATINGS INDICATED THAT THE TWO GROUPS OF CHILDREN HAD MEDICAL SYMPTOMS OF EQUAL SEVERITY ($p<.30$). SINCE MEDICAL SYMPTOMATOLOGY DID NOT DIFFERENTIATE HOSPITAL AND HOME CARE GROUPS, THE PSYCHOSOCIAL INFORMATION WAS EVALUATED. T-TESTS IDENTIFIED INDIVIDUAL VARIABLES WHICH DIFFERENTIATED HOSPITAL AND HOME CARE FAMILIES, WHILE DISCRIMINANT ANALYSIS PROVIDED A HIERARCHICAL PROFILE OF DIFFERENTIATING FACTORS. FROM BOTH TECHNIQUES, SOCIAL CONTACT VARIABLES EMERGED AS THE MOST SALIENT DISCRIMINATOR OF THE TWO GROUPS; HOSPITAL CARE FAMILIES HAD FEWER SOCIAL CONTACTS.

DISCUSSION: IN THIS CONTEXT OF CHILD HEALTH CARE, SOCIAL CONTACTS OUTSIDE THE FAMILY RATHER THAN DEMOGRAPHIC OR INTRAFAMILY FACTORS DETERMINED THE LOCATION OF GASTROENTERITIS MANAGEMENT. HOWEVER, DESPITE EXTENSIVE FAMILY INFORMATION, DISCRIMINANT ANALYSIS SEPARATED HOSPITAL AND HOME CARE FAMILIES WITH ONLY 72% ACCURACY; THUS, ONE IN FOUR FAMILIES WOULD BE MISPLACED BY ITS BEST PREDICTIONS. THIS IMPLIES THE INFLUENCE OF OTHER FACTORS OUTSIDE THE FAMILY IN THE DECISION TO HOSPITALISE OR CARE FOR THE CHILD AT HOME. HERE THE FOCUS RETURNS TO THE DOCTOR.

## General Discussion

RESULTS FROM BOTH STUDIES WERE COMBINED TO PROVIDE INDICATORS FOR IMPROVEMENT IN THE PRESENT MANAGEMENT OF GASTROENTERITIS. MATERNAL ANXIETY EMERGED FROM THE DOCTORS' STUDY AS AN IMPORTANT DETERMINANT OF DECISIONS ON GASTROENTERITIS. IN THE MOTHERS' STUDY, THE IMPORTANCE OF SOCIAL CONTACTS PROBABLY REFLECTS IN PART THE ROLE OF SOCIAL CONTACTS IN ASSISTING YOUNG PARENTS IN THEIR CHILD REARING CAPACITY. ONE SUCH ROLE IS THE



ALLEVIATION OF UNCERTAINTY AND ANXIETY DURING CHILDHOOD ILL-HEALTH. TOWARDS AN IMMEDIATE PREVENTATIVE EFFORT, DOCTORS INTERVIEWED WERE OVERWHELMINGLY (78%) IN FAVOUR OF THE USE OF STANDARD WRITTEN ADVICE TO PARENTS REGARDING GASTROENTERITIS MANAGEMENT DURING THE MEDICAL CONSULTATION. THIS, IT WAS FELT, WOULD HELP TO ALLEVIATE SOME OF THE ANXIETIES OF MOTHERS IN THE MANAGEMENT OF GASTROENTERITIS. MORE GENERAL ATTEMPTS AT IMPROVING MATERNAL KNOWLEDGE AND CONFIDENCE THROUGH SOCIAL CONTACTS REQUIRE THE DEVELOPMENT OF RESOURCES SUCH AS DROP-IN CENTRES AND MORE INTEGRATED FAMILY HOUSING.

OTHER OPTIONS FOR IMPROVEMENT EMERGED, SUCH AS THE ADOPTION OF OUT-PATIENT FACILITIES FOR GASTROENTERITIS (AS IS USED SUCCESSFULLY ELSEWHERE) AND MORE GP-ORIENTATED TRAINING IN THE MANAGEMENT OF MINOR MEDICAL DISORDERS.

## Conclusions

IN SUMMARY, THE EVIDENCE ILLUSTRATED THE INFLUENCE OF NON-MEDICAL FACTORS ON MANAGEMENT DECISIONS REGARDING GASTROENTERITIS, AND PROVIDED SUGGESTIONS FOR IMPROVED MANAGEMENT OF THE PROBLEMS AT A NUMBER OF LEVELS.

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# THE IMPACT OF HOSPITAL EXPERIENCES DURING TRAINING ON GP REFERRAL RATES

HANNAH MCGEE; MICHAEL FITZGERALD.

## ABSTRACT

FINDINGS OF THE INFLUENCE OF HOSPITAL TRAINING EXPERIENCE IN A PARTICULAR MEDICAL SPECIALITY ON SUBSEQUENT GP REFERRAL PATTERNS TO THAT SPECIALITY ARE OUTLINED. SPECIALIST TRAINING APPEARS TO SENSITISE DOCTORS AND INCREASE THE REFERRAL RATE TO A GIVEN SPECIALITY. THE NATURE OF THIS SENSITISATION IN MEDICAL EDUCATION IS DISCUSSED.

## KEY PHRASES:

MEDICAL SENSITISATION; GENERAL PRACTICE; REFERRAL RATE.

## INTRODUCTION

IN A RECENT STUDY OF THE MEDICAL MANAGEMENT AND FAMILY CIRCUMSTANCES OF CHILDREN HOSPITALISED FOR GASTRO-ENTERITIS,[1] HOSPITAL REFERRAL RATES OF GENERAL PRACTITIONERS (GP'S) WERE EXAMINED.

IT WAS EXPECTED THAT EXPERIENCE GAINED IN AN INFECTIOUS DISEASES' HOSPITAL DURING MEDICAL TRAINING WOULD BOTH ALERT DOCTORS TO THE OFTEN UNNECESSARY

HOSPITALISATION OF CHILDREN WITH GASTROENTERITIS AND PROVIDE THEM WITH EXTRA EXPERIENCE IN JUDGING CLINICAL ASPECTS OF GASTROENTERITIS, SUCH AS LEVELS OF DEHYDRATION. THUS, IT WAS HYPOTHESISED THAT DOCTORS WITH PRIOR HOSPITAL EXPERIENCE OF GASTROENTERITIS MANAGEMENT WOULD MANAGE A GREATER PROPORTION OF CHILDREN WITH GASTROENTERITIS AT HOME. THIS HYPOTHESIS WAS TESTED USING DOCTORS' REPORTS OF THEIR OWN CLINICAL PRACTICE RESPONSES TO HYPOTHETICAL CASES OR "PAPER PATIENTS." PAPER PATIENT ANALYSIS HAS BEEN SHOWN TO VALIDLY REFLECT ASPECTS OF ACTUAL CLINICAL BEHAVIOUR. FOR INSTANCE, GOOD AGREEMENT WAS REPORTED BETWEEN HYPOTHETICAL CASE MANAGEMENT AND ACTUAL CLINICAL BEHAVIOUR FOR RESPIRATORY ILLNESS BY GP'S[2] AND FOR THE ASSESSMENT OF ARTHRITIS STATUS BY RHEUMATOLOGISTS.[3] THE USE OF PAPER PATIENTS HERE RULED OUT THE POSSIBILITY THAT DIFFERENCES IN REPORTED REFERRAL RATES WERE DUE TO THE DIFFERING PRACTICE POPULATIONS OF DOCTORS.

## METHOD

SAMPLE: THE STUDY WAS BASED IN THE GREATER WEST DUBLIN AREA, A LARGE HETEROGENEOUS AREA OF NEWLY-ESTABLISHED AND OLDER HOUSING, MIXED SOCIO-ECONOMIC NEIGHBOURHOODS AND URBAN AND SEMI-RURAL LOCATIONS. THE AREA SURVEYED WAS APPROXIMATELY FIFTEEN MILES MAXIMUM RADIUS FROM THE NATIONAL INFECTIOUS DISEASES' HOSPITAL LOCATED CENTRALLY IN THE REGION. THUS, DISTANCE TO HOSPITAL WAS UNLIKELY TO BE A DIFFERENTIATING FACTOR AMONG DOCTORS FOR HOSPITAL ADMISSIONS FOR THIS GROUP. GP'S SERVING THE AREA WERE CONTACTED FOR THE STUDY, SINCE THEY ARE THE FRONTLINE OF GASTROENTERITIS MANAGEMENT BY THE MEDICAL PROFESSION. FIFTY-TWO OF 57 RANDOMLY



SELECTED GP'S AGREED TO BE INTERVIEWED (91% RESPONSE RATE).

PROCEDURE: AS PART OF A GENERAL INTERVIEW, DEMOGRAPHIC, PRACTICE-RELATED, ATTITUDINAL AND GENERAL GASTROENTERITIS MANAGEMENT ISSUES WERE QUERIED. DOCTORS WERE SPECIFICALLY ASKED IF THEY HAD WORK EXPERIENCE IN HOSPITAL INFECTIOUS DISEASES' MANAGEMENT. EACH DOCTOR WAS ALSO PRESENTED WITH A SERIES OF CARDS, EACH WITH A SCENARIO ABOUT A YOUNG CHILD PRESENTING WITH GASTROENTERITIS SYMPTOMATOLOGY. THESE "PAPER PATIENTS" EACH CONTAINED FOUR BASIC DIMENSIONS OF INFORMATION: AGE OF CHILD; PRESENTING MEDICAL SYMPTOMS; FAMILY SOCIAL BACKGROUND; AND MOTHER'S REACTION TO THE SITUATION. DIMENSIONS WERE CHOSEN, UPON INITIAL DISCUSSION WITH A NUMBER OF DOCTORS, AS TO THOSE MOST RELEVANT IN MANAGEMENT DECISIONS ON GASTROENTERITIS. THE SPECIFIC INFORMATION USED ALLOWED THE COMPILATION OF A RANGE OF SCENARIOS: YOUNGER OR OLDER CHILD (ALL UNDER TWO YEARS OLD); MILD TO SEVERE MEDICAL SYMPTOMS; "MILD" TO "SEVERE" SOCIAL CIRCUMSTANCES; AND CALM OR ANXIOUS MATERNAL REACTION. A TOTAL OF 36 DIFFERENT SCENARIOS COULD BE CREATED FROM THE RELEVANT INFORMATION, I.E. AGE OF CHILD (X 2 OPTIONS), MEDICAL BACKGROUND (X 3 OPTIONS), AND MATERNAL REACTION (X 2 OPTIONS). BECAUSE OF TIME CONSTRAINTS ON DOCTORS, HALF OF THE SCENARIOS (N = 18) WERE RANDOMLY SELECTED FOR JUDGEMENT BY EACH DOCTOR. THIS RANDOMISATION ALLOWED FOR LATER SYSTEMATIC INVESTIGATION OF THE RELATIVE IMPORTANCE OF EACH OF THE VARIOUS FACTORS IN DOCTORS' DECISION MAKING, WHILE SEEKING TO ENSURE THAT DIFFERENT DOCTORS JUDGED AN EQUIVALENT RANGE OF CASES. SCENARIOS WERE PRESENTED TO DOCTORS AS COMPLETED DIAGNOSES, I.E. DOCTORS WERE TOLD TO ASSUME THAT THE CHILD WAS NOT SUFFERING FROM ANY MORE SERIOUS ILLNESS (SUCH AS MENINGITIS) AND TO CONSIDER THIS AS A CASE WHICH THEY

HAD DECIDED WAS ONE OF ACUTE GASTROENTERITIS. THEY WERE THEN ASKED TO DESCRIBE THEIR COURSE OF ACTION IF PRESENTED WITH THIS PARTICULAR PROBLEM. IF NECESSARY, QUESTIONS WERE ASKED TO ELICIT IF RECALL REQUESTS, WHERE MENTIONED, WERE TO BE BY TELEPHONE OR PERSONAL CALL, AND WHETHER THEY WOULD BE CONTINGENT ON SOME CRITERION OR NOT. FOR PRESENT PURPOSES, RESPONSES ARE DICHOTOMISED INTO HOSPITAL AND HOME REFERRALS.

## RESULTS

GP'S WITH AND WITHOUT EXPERIENCE IN AN INFECTIOUS DISEASES' HOSPITAL DURING MEDICAL TRAINING WERE COMPARED, (SEE TABLE 1). ALL THOSE HAVING HOSPITAL INFECTIOUS DISEASES' MANAGEMENT EXPERIENCE (N = 12) HAD ACQUIRED THIS AT THE NATIONAL INFECTIOUS DISEASES' CENTRE (THE HOSPITAL WHICH WAS THE FOCUS OF THIS STUDY). THOSE WITH A BACKGROUND OF HOSPITAL TRAINING IN INFECTIOUS DISEASES' MANAGEMENT WOULD SEND ALMOST TWICE AS MANY HYPOTHETICAL CASES OF GASTROENTERITIS TO HOSPITAL AS WOULD THEIR COUNTERPARTS (N = 40).

REPORTS OF THEIR OWN ACTUAL PRACTICE REFERRALS PARALLELED THIS, WITH THE "EXPERIENCED" GP'S REFERRING OVER TWICE THE PERCENTAGE OF CHILDREN AS THOSE GP'S WITHOUT SUCH HOSPITAL TRAINING. THUS, THE HYPOTHESIS THAT DOCTORS WITH PRIOR HOSPITAL EXPERIENCE OF GASTROENTERITIS MANAGEMENT WOULD MANAGE A GREATER PROPORTION OF CHILDREN WITH GASTROENTERITIS AT HOME WAS REFUTED. REFERRAL RATE DIFFERENCES WERE NOT ACCOUNTED FOR BY DEMOGRAPHIC FACTORS (I.E. AGE AND SEX OF DOCTOR), ASPECTS OF WORK PRACTICE (I.E. NUMBER OF CONSULTATIONS WEEKLY AND IF IN TEAM PRACTICE), OR ATTITUDINAL DIFFERENCES (I.E. VIEWS ON THE SEVERITY OF



GASTROENTERITIS, AND ON THE IMPACT OF HOSPITALISATION ON YOUNG CHILDREN.)

## DISCUSSION

DIFFERENCES BETWEEN DOCTORS WITH AND WITHOUT TRAINING EXPERIENCE IN THE INFECTIOUS DISEASES' HOSPITAL IN THIS STUDY WERE NOT EXPLAINED BY A RANGE OF MEASURED DEMOGRAPHIC, PRACTICE-RELATED OR ATTITUDINAL VARIABLES. ONE POSSIBLE EXPLANATION OF THE DIFFERENCES IS GREATER ACCESS TO INFECTIOUS DISEASES' HOSPITAL FACILITIES BY THOSE WHO ARE ALREADY FAMILIAR WITH THE HOSPITAL. WHILE THIS FACTOR MAY OPERATE IN MANY GENERAL HOSPITALS, WITH GP'S USING PERSONAL CONTACTS TO ACHIEVE ACCESS TO LIMITED RESOURCES, THE NATIONAL INFECTIOUS DISEASES' CENTRE OPERATES A CLEAR OPEN-DOOR POLICY OF ACCEPTING (VIRTUALLY) ALL PATIENTS REFERRED. THIS IS BECAUSE OF THE INFECTIOUS NATURE OF REFERRING SYMPTOMS AND THE NEED TO PROTECT COMMUNITY HEALTH. SINCE IT IS EXPECTED THAT DOCTORS IN THIS STUDY, ALL WORKING WITHIN TEN MILES OF THIS HOSPITAL, ARE AWARE OF THIS GENERAL POLICY IT IS EXPECTED THAT DIFFERENCES IN REFERRAL RATES ARE NOT EXPLAINED BY THIS FACTOR. AN ALTERNATIVE EXPLANATION OF THE SIGNIFICANT EXCESS OF HOSPITAL REFERRALS FOR GASTROENTERITIS, (EITHER BY PAPER PATIENT ANALYSIS OR PRACTICE ESTIMATES), BY THOSE GP'S WITH PRIOR HOSPITAL TRAINING EXPERIENCE IN AN INFECTIOUS DISEASES' HOSPITAL, IS THAT EXPOSURE TO THE PROBLEM DURING TRAINING MAY SENSITISE GP'S TO THE POTENTIALLY NEGATIVE OUTCOMES OF GASTROENTERITIS. THIS APPEARS SO, DESPITE THE FACT THAT DEATHS FROM GASTROENTERITIS IN WESTERN COUNTRIES ARE NOW VERY RARE, (E.G. 0.006% ANNUALLY IN THE REPUBLIC OF IRELAND IN THE 1980'S: COMBINED DEPARTMENT OF HEALTH REPORTS).

Table 1.

Demographic and referral pattern comparisons of doctors with and without training experience in an infectious diseases' hospital

Prior training experiences in an infectious diseases' hospital: Yes (n = 12)
No (n = 40)

| CHARACTERISTICS | $\bar{X}$ (S.E.) | $\bar{X}$ (S.E.) | Chi-square | t-test (two-tail) | Sigh. |
|---|---|---|---|---|---|
| DEMOGRAPHIC | | | | | |
| - sex (% female) | 25 | 12 | 0.32 | | NS |
| - age (% > 40) | 50 | 58 | 0.34 | | NS |
| PRACTICE | | | | | |
| - in team practice (%) | 42 | 52 | 0.44 | | NS |
| - no. consultations/week | 180 (26) | 187 (11) | | 0.30 | NS |
| ATTITUDINAL | | | | | |
| - severity of gastroenteritis (1-5)* | 2.2 (0.5) | 2.0 (0.2) | | 0.06 | NS |
| - impact of hospitalisation (1-5)* | 2.4 (0.4) | 2.8 (0.2) | | 0.44 | NS |
| REFERRAL RATE | | | | | |
| - % of paper patients referred (of 18 cases) | 32 (6) | 17 (3) | | 2.58 | .015 |
| - (estimated) referrals from own practice caseload (%) | 13 (8) | 5 (1) | | 2.93 | .007 |

$\bar{X}$: mean; S.E.: standard error; *: higher scores indicate a more negative view.



THE DISCREPANCY BETWEEN HOSPITAL REFERRAL RATES OF DOCTORS WITH AND WITHOUT MEDICAL EXPERIENCE IN AN INFECTIOUS DISEASES' HOSPITAL IS ALL THE MORE NOTICEABLE SINCE THERE WAS NO SIGNIFICANT DIFFERENCE BETWEEN THESE DOCTORS IN THEIR RATINGS OF THE SEVERITY OF GASTROENTERITIS AS A MEDICAL PROBLEM. IT APPEARS THAT BY BEING EXPOSED TO TRAINING IN AN INFECTIOUS DISEASES' CONTEXT, AND THUS PROBABLY TO THE MOST SEVERE CASES OF GASTROENTERITIS, DOCTORS BECOME SENSITISED TO THE NEED FOR CAUTION IN WHAT THEY STILL ACKNOWLEDGE, AT AN ATTITUDINAL LEVEL, IS A RELATIVELY MINOR DISORDER. THIS NOTION, ALBEIT POST HOC, OF THE SENSITISING (RATHER THAN HABITUATING) EFFECT OF PREVIOUS TRAINING ON DOCTORS' REFERRAL PATTERNS, FINDS RESEARCH SUPPORT ELSEWHERE WITHIN THE MEDICAL ARENA. ONE STUDY REPORTS THAT A DOCTOR IN A GROUP PRACTICE WITH POSTGRADUATE EXPERIENCE IN PAEDIATRICS AND DERMATOLOGY HAD HIGHER THAN AVERAGE REFERRAL RATES TO THESE DEPARTMENTS.[4] ANOTHER GENERAL PRACTICE STUDY FOUND THAT THE DOCTOR'S ATTITUDE TO PSYCHIATRY, RATHER THAN PATIENT CHARACTERISTICS, WAS A POWERFUL DETERMINANT OF HIS/HER PSYCHIATRIC REFERRAL RATE.[5] THUS, IT APPEARS THAT, WHILE GAINING CLINICAL EXPERIENCE IN A GIVEN MEDICAL SPECIALITY DURING HOSPITAL-BASED TRAINING, GP'S MAY BE SENSITISED TO THE POTENTIALLY DISASTROUS OUTCOMES FROM WHAT OFTEN ON INITIAL INVESTIGATION APPEAR TO BE MINOR PROBLEMS. THIS TYPE OF TRAINING, THEN, MAY INFLUENCE (BY INCREASING) THEIR PATIENT REFERRAL RATE IN THAT PARTICULAR MEDICAL SPECIALITY WHEN WORKING IN GENERAL PRACTICE.

SUCH BEHAVIOUR IS UNDERSTANDABLE FOR TWO REASONS. FIRST, THERE APPEAR TO BE A NUMBER OF UNIVERSAL COGNITIVE ERRORS OR BIASES IN THE CONTEXT OF JUDGEMENT AND DECISION MAKING GENERALLY.[6] ONE SUCH BIAS IS THE PHENOMENON OF AVAILABILITY, I.E. THE PROBABILITY OF AN

EVENT OCCURRING, (IN THIS CASE, AN EPISODE OF GASTROENTERITIS BECOMING SEVERE OR LIFE THREATENING), IS ESTIMATED BY THE EASE WITH WHICH PRIOR INSTANCES CAN BE RECALLED. OBVIOUSLY, FOR DOCTORS WITH PRIOR TRAINING IN A GIVEN AREA, SEVERE CASES ARE GENERALLY MORE READILY AND VIVIDLY RECALLED. THE SENSITISATION OF DOCTORS IS ALSO UNDERSTANDABLE WHEN ONE CONSIDERS THE VERY REAL DILEMMA FACED BY DOCTORS IN THEIR RESPONSIBILITY FOR THE HEALTH AND WELL-BEING OF THEIR PATIENTS. IN THE WORDS OF ONE DOCTOR:-

> "IF YOU ERR ON THE RIGHT SIDE, YOU ARE ACCUSED OF PLAYING SAFE. IF YOU ERR ON THE WRONG SIDE, JUST ONCE, YOU REGRET LIFE LONG."[7]

IN THE CONTEXT OF GASTROENTERITIS, FOR INSTANCE, THE COST OF IGNORING SYMPTOMS MAY INDEED BE HIGH, AS IS ILLUSTRATED BY AN ANALYSIS OF 145 UNEXPECTED DEATHS OF YOUNG ENGLISH CHILDREN IN THEIR HOMES.[8] SIXTY-ONE PER CENT OF THESE CHILDREN, IN COMPARISON WITH 23% OF A CONTROL GROUP, HAD HAD GASTROINTESTINAL SYMPTOMS IN THEIR LAST WEEK OF LIFE.

AS IS DESCRIBED HERE, EVIDENCE TO DATE ON THIS PHENOMENON OF MEDICAL SENSITISATION HAS COME FROM RESEARCH WITH OTHER AND VARIED PURPOSES. IF, AS IS SUGGESTED HERE, THIS IS A PHENOMENON OCCURRING AS A NATURAL CONSEQUENCE OF EXPOSURE TO ANY MEDICAL SPECIALITY, AND A FACTOR THUS POTENTIALLY INFLUENCING THE MANAGEMENT STYLES OF ALL DOCTORS (EACH IN DIFFERING SPECIALITIES), IT IS NOW APPROPRIATE TO ENCOURAGE IN FUTURE RESEARCH THE DIRECT EXAMINATION OF MEDICAL SENSITISATION ON MEDICAL, INCLUDING PSYCHIATRIC, EDUCATION.



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# ATTITUDES OF URBAN IRISH DOCTORS TO THE HOSPITALISATION OF YOUNG CHILDREN

HANNAH MCGEE; MICHAEL FITZGERALD.

**EVIDENCE** OF THE NEGATIVE IMPACT OF HOSPITALISATION ON YOUNG CHILDREN HAS BEEN WELL DOCUMENTED. A SAMPLE OF EIGHTY IRISH DOCTORS WAS STUDIED TO INVESTIGATE WHETHER THIS EVIDENCE INFORMS THE VIEWS HELD BY THOSE MAKING DECISIONS REGARDING CHILDHOOD HOSPITALISATION. IT WAS FOUND THAT ONLY ABOUT HALF OF THOSE INTERVIEWED BELIEVED THAT HOSPITALISATION CLEARLY HAS NEGATIVE EFFECTS ON YOUNG CHILDREN, SUGGESTING THAT RESEARCH FINDINGS IN THIS AREA DO NOT APPEAR TO HAVE HAD A MAJOR IMPACT ON THE VIEWS OF MEDICAL DECISION-MAKERS.

WIDESPREAD ATTENTION WAS FIRST DRAWN TO THE IMPACT OF HOSPITALISATION ON YOUNG CHILDREN SOME THIRTY YEARS AGO, BY ROBERTSON (1958) AND BY THE U.K. MINISTRY OF HEALTH'S (1959) PLATT REPORT. BOTH DOCUMENTS EMPHASISED THE NEGATIVE CONSEQUENCES OF HOSPITALISATION ON YOUNG CHILDREN. NUMEROUS STUDIES, INCLUDING A NATIONAL COHORT STUDY (DOUGLAS, 1975) AND A LARGE RANDOM COMMUNITY STUDY (QUINTON & RUTTER, 1976), HAVE CONFIRMED THESE CONTENTIONS. SPECIFICALLY, THEY HAVE ILLUSTRATED THAT LONG (I.E. GREATER THAN ONE MONTH) OR REPEATED HOSPITALISATIONS IN CHILDHOOD RESULT IN DISTURBANCES IN BEHAVIOUR THAT MAY PERSIST INTO THE TEENAGE YEARS. THESE EFFECTS CANNOT BE ACCOUNTED FOR SOLELY BY OTHER VARIABLES SUCH AS FAMILY CIRCUMSTANCES. FROM THEIR STUDY, QUINTON AND RUTTER ESTIMATED THAT A

potential 1.7% of the total child population may show disturbances of behaviour which have arisen from repeated admissions to hospital.

Drawing parallels with the U.K. situation, and given a birth rate of approximately 60,000 annually in Ireland, this would amount to over 1,000 older children in each age category with behavioural problems resulting from repeated hospitalisation while young.

Research evidence illustrates that detrimental effects of childhood hospitalisation can be avoided (e.g., Gillis, 1989; Prugh et al., 1953; Visintanier and Wolfer, 1975), and that interventions to achieve this may also accelerate children's rate of recovery (e.g., Ferguson, 1979; Skipper and Leonard, 1968). Overall, continuity of family links and a child-focused hospital environment augur for minimal disruption to hospitalised children.

Given this research evidence on childhood hospitalisation, it is of interest to see how, some thirty years on, Irish medical practitioners view the impact of hospitalisation on young children. As part of a larger study focusing on the home or hospital management of childhood gastroenteritis (McGee & Fitzgerald, 1988) Irish doctors were queried regarding the impact of childhood hospitalisation.

## Method

Sample: The sample of doctors interviewed comprised 52 general practitioners (GP's), randomly selected from the greater West Dublin area, and 28 doctors from the casualty departments of two urban paediatric hospitals



(where they routinely make primary case decisions regarding the admission of children to hospital.) Fifty-two of 57 GP's approached took part, as did all of the hospital doctors (94% response rate). In terms of the representativeness of the doctors surveyed, 22% were women in comparison with 25% of doctors working nationally, and 35% were 40 years old or over in comparison with 49% nationally, [Staff (of Irish Medical Times), 1987]. Comparing the GP's with Irish GP's generally, 40% were exclusively in private practice (average 25% nationally) and they had an average of 181 weekly consultations compared with the national average of 160 (Boland, 1987). Thus, the doctors in the sample were somewhat younger, busier and more private-practice orientated than Irish GP's as a whole. This may reflect the urban nature of the sample. However, in all the sample was not markedly different in constitution from the broad profile of Irish doctors. Thus, the findings may have some applicability to the general Irish medical population.

Procedure In the course of a thirty-minute interview doctors were asked their opinions on the influence of hospitalisation on young children, as follows:-

> What, in your opinion, are the effects, if any, of hospitalisation in general on young children?
>
> What, in your opinion, are the effects, if any, of hospitalisation for gastroenteritis on young children?

The questions were open-ended, to allow doctors to elaborate their beliefs regarding childhood hospitalisation.

## Results

The doctors' responses regarding the impact of hospitalisation on young children were coded on a post-hoc basis into ten categories, ranging from "no effect" to "traumatic effect"; no positive effects were mentioned by any of the respondents. The ten categories and the percentage of doctors giving each category of response to the question concerning the effects of hospitalisation in general can be seen in Table 1. Views on the effects of hospitalisation generally, and on the effects of hospitalisation for gastroenteritis, were the same for all but seven of the 80 doctors. In each of the seven cases where there was a difference, hospitalisation for gastroenteritis was seen as having less effect, mostly because of its usually brief duration. Because responses to the two questions were so similar, only doctors' views on the effects of hospitalisation in general on young children are considered further.

In all, 29% of doctors saw the hospitalisation of young children as having no appreciable negative effect (categories 1, 2 and 3 in Table 1). A further 21% felt that hospital experiences may have some negative effects (categories 4 and 10 in Table 1), while only 50% of the doctors felt that hospitalisation clearly had negative effects on young children (categories 4, 5, 6, 7, 8 and 9).

The belief that hospitalisation has a negative effect on young children (i.e., responses in categories 1, 2, 3, 4 and 10 versus those in categories 5, 6, 7, 8 and 9) was not associated with a range of demographic and practice-related variables: sex of doctor, ($X^2$ = 0.28; df = 1); age, (<40 or ≥40 years) of doctor, ($X^2$ = 0.73; df = 1); working in general practice or casualty department, ($X^2$ = 1.60; df = 1); or whether or not they possessed a child-focused postgraduate qualification - the Diploma in Child Health - ($X^2$ = 0.05; df = 1). In addition, Mann-Whitney "U" tests revealed that the group who believed hospitalisation had no effect did not differ significantly from the one that believed it had a negative effect in the number of years they had been in practice nor, in the case of GP's, the number of consultations weekly.



Table 1.

Percentage of doctors (n = 80) reporting each of a variety of effects of hospitalisation on children

| Category | Effect | % Doctors |
|---|---|---|
| 1 | No effect | 13 |
| 2 | Generally no effect | 14 |
| 3 | Little effect | 2 |
| 4 | Child can be fretful | 17 |
| 5 | Some negative effect | 22 |
| 6 | Negative effect if child under one year old | 1 |
| 7 | Negative effect if child older than one year | 14 |
| 8 | Negative effect if hospitalisation is long-term | 8 |
| 9 | Traumatic effect | 5 |
| 10 | Effects are very varied, unable to generalise | 4 |

## Discussion

The beliefs of the group of Irish doctors outlined here do not concur with Mrazek's (1984) view that:

> "Over the past generations the belief that hospitalisation early in life has a negative psychological effect on children has become an established clinical axiom." (page 211).

In this study the doctors' beliefs regarding the influence of hospitalisation on young children were not accounted for by a range of demographic, practice-related and educational variables. It is particularly interesting that the doctors who possessed a child-focused postgraduate qualification - the Diploma in Child Health - did not differ in their views from those who did not possess such a qualification; it may be that doctors' views on the impact of hospitalisation on young children derive from their fundamental approach to children and childhood, as their views do not show the influence of educational training.

It is disappointing that, in the face of clinical and research attention spanning thirty years, and consumer action - through groups such as the Association for the Welfare of Children in Hospital - of some fifteen years at least, relatively low levels of appreciation of the negative impact of hospitalisation still exist in medical circles. Research evidence such as that of Douglas (1975) and Quinton and Rutter (1976) does, of course, show that one short hospitalisation does not have detrimental effects in the long term for young children, but that subsequent hospitalisations can be damaging in the longer term. It is in this respect that any



hospitalisation during childhood needs to be seen as a vulnerability-inducing factor, even if not damaging in and of itself, and that decisions and recommendations concerning childhood hospitalisation can be taken with this caution in mind. It may be that research findings on the psychological impact of childhood hospitalisation, as on other topics, have not been made widely available in the context of a busy medical curriculum. Whether the relatively recent inclusion of psychology as a subject in undergraduate medical curricula will have an impact on doctors' attitudes in this regard remains to be seen.

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# A STUDY OF BEHAVIOURAL DEVIANCE AND MATERNAL DEPRESSIVE AND ANXIETY SYMPTOMS IN MALAYSIA (NEGRI SEMBILAN) AND IRELAND

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## SUMMARY

MOTHERS AND CHILDREN IN IRELAND AND NEGRI SEMBILAN (MALAYSIA) WERE STUDIED, USING QUESTIONNAIRES OF KNOWN RELIABILITY AND VALIDITY FOR MATERNAL DEPRESSION AND BEHAVIOURAL DEVIANCE IN CHILDREN. THERE WAS NO SIGNIFICANT DIFFERENCE BETWEEN THE RATES OF BEHAVIOURAL DEVIANCE IN EITHER CULTURE, ALTHOUGH THEY WERE CONSIDERABLY HIGHER THAN FOUND IN PREVIOUS SCREENING STUDIES. THE RATE OF ANXIETY AND DEPRESSIVE SYMPTOMS WAS SIGNIFICANTLY LOWER IN THE NEGRI SEMBILAN SAMPLE. IT WAS SUGGESTED THAT THIS MIGHT BE EXPLAINED BY THE GREATER COHESIVENESS OF THE NEGRI SEMBILAN SOCIETY.

## INTRODUCTION

CROSS-CULTURAL STUDY IN CHILD PSYCHIATRY IS A RESEARCH STRATEGY USING DIFFERENCES IN RATES OF BEHAVIOURAL PROBLEMS. IT CAN SUGGEST AETIOLOGICAL HYPOTHESIS WHEN OTHER RESEARCH STRATEGIES MIGHT BE UNSUCCESSFUL. THE RELATIONSHIP BETWEEN CULTURE AND PSYCHOPATHOLOGY HAS BEEN THE FOCUS OF MUCH SOCIAL AND BEHAVIOURAL SCIENCE RESEARCH, (OPLER, 1967). THE FOCUS OF THIS RESEARCH HAS BEEN LARGELY CONCERNED WITH THE INFLUENCE OF

CULTURE UPON THE FORM AND FREQUENCY OF MENTAL DISORDER IN TWO DIFFERENT SOCIETIES. AN UNDERLYING ASSUMPTION OF THIS RESEARCH IS THAT MENTAL DISORDER IS UNIVERSAL, AND THAT EACH CULTURE RECOGNISES ITS EXISTENCE BUT ATTRIBUTES DIFFERENT NAMES, SYMPTOMS AND EXPLANATIONS TO IT, (LEE, 1981).

IT HAS BEEN ARGUED THAT THE UNIVERSALITY OF MENTAL ILLNESS ALLOWS PSYCHOPATHOLOGICAL MANIFESTATIONS PECULIAR TO CERTAIN CULTURES TO BE SUBSUMED UNDER WESTERN BASED PSYCHIATRIC CATEGORIES, (YAP, 1969). SIMILARLY, IT HAS BEEN CONCLUDED FROM A REVIEW OF SEVERAL CROSS-CULTURAL STUDIES OF MENTAL HEALTH EPIDEMIOLOGY THAT MENTAL ILLNESS IS A SOCIAL REALITY AROUND THE WORLD, (OPLER, 1967). THE ARGUMENT THAT MANIFESTATIONS OF BEHAVIOURAL DEVIANCE ARE SHAPED BY CULTURAL FACTORS ASSUMES THE PRE-EXISTENCE OF BEHAVIOURAL DEVIANCE, BUT DOES NOT PROBE THE QUESTION OF WHAT IS REGARDED AS NORMAL BEHAVIOUR. TO DESCRIBE SOME INDIVIDUAL AS BEHAVIOURALLY DEVIANT IMPLIES THAT THERE IS A CORRESPONDING INDIVIDUAL WHO IS AN EXEMPLAR OF NORMAL BEHAVIOUR. IT ALSO SUGGESTS THAT THERE EXISTS IN ANY SOCIETY, AT ANY GIVEN TIME, A SET OF WRITTEN AND UNWRITTEN RULES THAT DISTINGUISHES BETWEEN NORMAL AND ABNORMAL INDIVIDUALS, ALTHOUGH THESE RULES MAY BE ALTERED FROM TIME TO TIME, (LEE, 1981).

A STUDY WAS UNDERTAKEN TO EXAMINE THE RATES OF BEHAVIOURAL DEVIANCE AND MATERNAL ANXIETY AND DEPRESSIVE SYMPTOMS IN TWO DIFFERENT COUNTRIES, MALAYSIA (NEGRI SEMBILAN) AND IRELAND, USING QUESTIONNAIRES DEVELOPED IN ENGLAND, (RUTTER ET AL., 1970; RUTTER, 1966 AND SNAITH, 1971). THE PREVALENCE OF BEHAVIOURAL DEVIANCE IN CHILDREN HAS IMPORTANT IMPLICATIONS FOR HEALTH AND PSYCHIATRIC SERVICES IN DEVELOPING AND DEVELOPED COUNTRIES.



## SUBJECTS AND METHODS

IN THE IRISH SAMPLE, TEACHERS WERE REQUESTED TO COMPLETE THE RUTTER B2 TEACHERS' SCALE (RUTTER, 1966) ON A CONSECUTIVE SAMPLE OF 46 BOYS AND 55 GIRLS, AGED BETWEEN 7 AND 12 YEARS. IN THE NEGRI SEMBILAN SAMPLE, TEACHERS WERE ASKED TO COMPLETE THE RUTTER B2 TEACHERS' QUESTIONNAIRE ON A CONSECUTIVE SAMPLE OF 36 NEGRI SEMBILAN BOYS AND 6 NEGRI SEMBILAN GIRLS. MOTHERS OF A CONSECUTIVE SAMPLE OF 24 NEGRI SEMBILAN SCHOOL GIRLS AGED 7 TO 12 YEARS WERE ASKED TO COMPLETE THE RUTTER A2 PARENTS' QUESTIONNAIRE, (RUTTER ET AL., 1970). MOTHERS OF 24 NEGRI SEMBILAN BOYS AGED 7 TO 12 YEARS WERE ALSO ASKED TO COMPLETE THE RUTTER A2 PARENTS' QUESTIONNAIRE. THE MOTHERS OF A CONSECUTIVE SAMPLE OF 55 IRISH GIRLS WERE ALSO ASKED TO COMPLETE THE RUTTER A2 PARENTS' QUESTIONNAIRE. THE MOTHERS WHO COMPLETED THE RUTTER A2 SCALE WERE ALSO ASKED TO COMPLETE THE LEEDS' SCALE FOR ANXIETY AND DEPRESSION, (SNAITH, 1971).

THE NEGRI SEMBILAN SAMPLE WAS TAKEN FROM A SMALL-TOWN RURAL SETTING. THERE WAS ONE LARGE INDUSTRY AND THERE WERE SOME GOVERNMENT EMPLOYEES, MAINLY IN THE LOWER GRADE. TOURISM ALSO PLAYED A CONSIDERABLE PART IN THE LIFE OF THE AREA. IT WAS BASICALLY A DISADVANTAGED RURAL AREA LOCATED IN THE NINTH STATE OF MALAYSIA - NEGRI SEMBILAN.

THE RUTTER B2 SCALE (RUTTER, 1966) CONSISTS OF 26 STATEMENTS, FOR EXAMPLE, "BULLIES OTHER CHILDREN," AND ALLOWS THE TEACHER TO SCORE (1), DOES NOT APPLY; (2), APPLIES SOMEWHAT; (3), CERTAINLY APPLIES. THE INTER-RATER RELIABILITY IS SATISFACTORY, (R = 0.72). THE RUTTER B2 SCALE HAS BEEN SHOWN TO DISCRIMINATE SATISFACTORILY BETWEEN CHILDREN ATTENDING A PSYCHIATRIC OUT-PATIENT CLINIC AND OTHERS. A CHILD IS CONSIDERED

TO BE BEHAVIOURALLY DEVIANT WHO HAS A SCORE OF 9 OR MORE AND CAN BE FURTHER CLASSIFIED INTO ANTI-SOCIAL, NEUROTIC AND UNDIFFERENTIATED.

THE RUTTER A2 PARENTS' SCALE (RUTTER ET AL., 1970) CONSISTS OF 31 QUESTIONS AND STATEMENTS ON THE CHILD'S HEALTH, HABITS AND BEHAVIOUR. A CUT-OFF POINT OF 13 ON THIS SCALE WAS FOUND TO BE THE BEST DISCRIMINATOR BETWEEN PATIENTS ATTENDING A CHILD PSYCHIATRIC DEPARTMENT AND OTHERS, AND THIS WAS THE CUT-OFF POINT USED IN THE PRESENT STUDY TO MEASURE BEHAVIOURAL DEVIANCE.

THE LEEDS' SCALE IS A SELF-ASSESSMENT SCALE FOR ANXIETY AND DEPRESSION, AND HAS BEEN SHOWN TO SIGNIFICANTLY CORRELATE WITH OBSERVER RATINGS FOR ANXIETY AND DEPRESSION, (SNAITH, 1971).

## RESULTS

THE RUTTER B2 TEACHERS' SCALE WAS AVAILABLE FOR 55 IRISH GIRLS, 46 IRISH BOYS, 36 NEGRI SEMBILAN BOYS AND 6 NEGRI SEMBILAN GIRLS. THE RUTTER A2 PARENTS' SCALE WAS AVAILABLE FOR 20 OUT OF 24 NEGRI SEMBILAN GIRLS AND 24 NEGRI SEMBILAN BOYS. FOUR OF THE GIRLS' QUESTIONNAIRES WERE INCOMPLETE. THE RUTTER A2 PARENTS' SCALE WAS AVAILABLE FOR 55 IRISH GIRLS. THE LEEDS' SCALE FOR ANXIETY AND DEPRESSION WAS AVAILABLE FROM 52 IRISH MOTHERS AND 43 NEGRI SEMBILAN MOTHERS.

### 1. PARENTS' QUESTIONNAIRES

THREE OUT OF 20 NEGRI SEMBILAN GIRLS HAD A SCORE OF 13 OR MORE, AND WERE THEREFORE BEHAVIOURALLY DEVIANT. FIVE OUT OF 24 NEGRI SEMBILAN BOYS WERE BEHAVIOURALLY



DEVIANT. ELEVEN OUT OF 55 IRISH GIRLS WERE BEHAVIOURALLY DEVIANT.

USING THE LIKELIHOOD RATIO TEST, NO SIGNIFICANT DIFFERENCES WERE FOUND BETWEEN THE RATE OF OCCURRENCE OF BEHAVIOURAL DEVIANCE IN IRISH AND NEGRI SEMBILAN GIRLS. ($X^2$ = 0.25, NS). NO SIGNIFICANT DIFFERENCE WAS FOUND BETWEEN SEXES, THE BEHAVIOURAL DEVIANCE RATE FOR GIRLS BEING 19% AND FOR BOYS 21%. ($X^2$ = 0.05, NS).

### 2. TEACHERS' QUESTIONNAIRES

FOURTEEN OUT OF 36 NEGRI SEMBILAN BOYS HAD A SCORE OF 9 OR MORE AND WERE BEHAVIOURALLY DEVIANT, OF WHICH 10 RECEIVED AN ANTI-SOCIAL SCORE, 3 A NEUROTIC SCORE AND 1 AN UNDIFFERENTIATED SCORE.

EIGHTEEN OUT OF 55 IRISH GIRLS AND 17 OUT OF 46 IRISH BOYS WERE BEHAVIOURALLY DEVIANT.

NO SIGNIFICANT DIFFERENCE WAS FOUND BETWEEN RATES OF BEHAVIOURAL DEVIANCE OF NEGRI SEMBILAN AND IRISH BOYS ($X^2$ = 0.03, NS) AND BETWEEN IRISH AND NEGRI SEMBILAN GIRLS ($X^2$ = 0.72, NS). WHEN THE OVERALL DEVIANCE RATES ARE COMPARED BETWEEN THE SEXES, NO SIGNIFICANT DIFFERENCE WAS FOUND BETWEEN THE 38% RATE FOR BOYS AND 31% RATE FOR GIRLS. ($X^2$ = 0.69, NS).

### 3. DEPRESSION AND ANXIETY QUESTIONNAIRES

TEN OUT OF 43 NEGRI SEMBILAN MOTHERS GOT A SCORE OF 7 OR MORE ON THE LEEDS' SCALE, WHICH MEANT THAT THEY WERE IN THE DEVIANT RANGE. SIX OUT OF THE 10 RECEIVED A POSITIVE SCORE FOR ANXIETY AND 4 OUT OF THE 10 A POSITIVE SCORE FOR DEPRESSION. ON THE LEEDS' SCALE, 26

out of the 52 Irish mothers received a positive score for depression, and 21 a positive score for anxiety.

A statistically significant difference occurred between the Irish and the Negri Sembilan rates of occurrence of anxiety and depressive symptoms. ($X^2$ = 6.06, $p<0.25$).

The $X^2$ value for depression on its own is 12.12 ($p<0.0005$), i.e., 14% showing signs of depression on the Negri Sembilan and 50% showing signs of depression the Irish. The $X^2$ value for anxiety on its own is 10.18 ($p<0.0005$), i.e., 9% anxious Negri Sembilan and 40% anxious Irish.

**Discussion**

It was of interest that there was no statistical difference between the rates of behavioural deviance in the Negri Sembilan sample and the Irish sample. There is some evidence that the teachers in both samples were identifying similar children as behaviourally deviant. The general comments made by the Negri Sembilan teachers were similar to comments made by Irish teachers, for example:-

1. "A very miserable looking boy wanting to be left alone."

2. "Lives in a world of his own, very difficult to get a response from."

3. "Quite a difficult child, tells a new story every time he is absent from school."



The rates of behavioural deviance in this screening study suggest considerable stresses in Negri Sembilan and Irish families. Alcoholism tends to be a stress factor in the Irish culture and in the Indian sub-sample of the Negri Sembilan.

It has been shown that in cross-cultural codes relating to infancy and early childhood there are a number of differences between Ireland and the Negri Sembilan, (Barry and Paxton, 1971). These may have an effect on the rates of behavioural deviance on children in both cultures.

As far as bodily restrictiveness is concerned, the Irish infant is confined to a limited space such as a bed or hammock in the first few months after birth, and the Negri Sembilan infant is limited by swaddling, heavy blankets or a small cradle. There are more hardening procedures, e.g. ear piercing, carried out on the Negri Sembilan children than the Irish children in early childhood. In Negri Sembilan a dot is placed on the child's face from the time he is born to avoid bad spirits, and this does not happen to the Irish infant. The weaning of the Negri Sembilan child is more severe than for the Irish. Toilet training is much earlier for the Negri Sembilan, possibly because the climate is very warm and there is therefore less need to urinate and it is easier to train the children. General indulgence and leniency is the same in both cultures. When one considers that Fitzgerald and Kinsella (1984) found that the rates of behavioural deviance are higher in urban than rural parts of Ireland, then the rates for the Negri Sembilan are therefore quite high for a rural area. The rates of behavioural deviance in this study using the Rutter B2 Teachers' Questionnaire are considerably higher than the rate of 19% found in an

URBAN AREA OF THE U.K. USING THE SAME QUESTIONNAIRE, (RUTTER ET AL., 1975). THIS SUGGESTS THAT THE CHILDREN STUDIED WERE UNDER VERY CONSIDERABLE STRESS. FURTHER STUDIES FOCUSING ON MARITAL DISHARMONY, PARENTAL PSYCHIATRIC ILLNESS, SIZE OF FAMILY AND PARENTAL CRIMINALITY WOULD PROBABLY GIVE SOME INDICATION OF WHY THE RATES ARE HIGHER IN THESE AREAS.

THE LOW RATES OF DEPRESSION AND ANXIETY IN THE MOTHERS IN THE NEGRI SEMBILAN SAMPLE MAY BE ASSOCIATED WITH THE GREATER SUPPORT FOR THE NEGRI SEMBILAN MOTHERS, AS NEGRI SEMBILAN FAMILIES TEND TO LIVE WITH THE EXTENDED FAMILY.



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# DELINQUENCY

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THE CONCERN ABOUT LEVELS OF JUVENILE DELINQUENCY IS NOTHING NEW AND, INDEED, IN 1818 A REPORT ON THE ENGLISH SCENE STATED

> "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 DOES APPEAR 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 ET AL., 1977). MORE RECENTLY RUTTER AND GILLER (1983) POINT OUT THAT THEFT AND VIOLENCE WERE MORE OF A PROBLEM ONE HUNDRED AND FIFTY YEARS AGO THAN THEY ARE TODAY.

THE GARDA SIOCHANA (1988) NOTE THAT THE TOTAL NUMBER OF PERSONS CONVICTED OF RECORDED CRIMES AND DEALT WITH BY WAY OF CAUTION UNDER THE JUVENILE LIAISON SCHEME WAS 12,763 IN 1987. OF THIS NUMBER, 5,520 (43.2%) WERE PERSONS UNDER 17 YEARS OF AGE. THE FIGURES FOR 1986 WERE 4,347 (34.8%). THERE WAS AN

INCREASE OF 36.5% IN THE NUMBER ACCEPTED INTO THE JUVENILE LIAISON SCHEME. THEY ALSO POINT OUT THAT THERE WERE 165 PERSONS UNDER THE AGE OF 14, AND 874 BETWEEN 14 AND 17, IN 1987. THE COUNCIL OF EUROPE (1987) ESTABLISHED THAT IRELAND HAD 54/100,000 INHABITANTS IN PRISON, AND THIS RANKED IRELAND THIRTEENTH AMONG THE MEMBER STATES OF THE COUNCIL OF EUROPE. IRELAND HAD A 46% INCREASE IN PRISON POPULATION FROM 1983 TO 1987.

IN THE CAMBRIDGE STUDY IN DELINQUENT DEVELOPMENT, THE PEAK AGE FOR THE NUMBER OF DIFFERENT PERSONS CONVICTED WAS 17 YEARS. WEST (1985) ESTIMATED THAT FOR ENGLAND AND WALES IN 1977, 22% OF THE MALES WOULD EXPECT TO ACQUIRE A CRIMINAL RECORD BEFORE THE AGE OF 21 YEARS. THE RATE FOR FEMALES WORKED OUT AT 4.7% BEFORE THE AGE OF 21 YEARS. AS PULKKINEN (1988) POINTED OUT, A SMALL GROUP OF PEOPLE ACCOUNTS FOR HALF OF ALL CONVICTIONS. HE ALSO POINTED OUT THAT IT HAS BEEN ESTIMATED THAT EVERYBODY AT SOME TIME BREAKS A LAW, AND THAT THE LIKELIHOOD OF BEING CAUGHT INCREASES WITH THE FREQUENCY OF DELINQUENT ACTS.

WEST AND FARRINGTON (1973) FOUND IN A SAMPLE OF LONDON BOYS THAT APPROXIMATELY 90% ADMITTED TO HAVE BEEN GOING TO SEE "X" RATED FILMS UNDER AGE, AND TO TRAVELLING WITHOUT A TICKET ON PUBLIC TRANSPORT. A FURTHER 82% PLAYED TRUANT AND ADMITTED TO BREAKING WINDOWS OF EMPTY HOUSES. IT IS CLEAR THAT ONLY A SMALL PROPORTION SHOW A PERSISTENT PATTERN OF DELINQUENCY. ONLY ABOUT ONE-QUARTER OF ADOLESCENT OFFENDERS CONTINUE TO OFFEND IN THEIR TWENTIES.



## THEORIES OF DELINQUENT DEVELOPMENT

THERE ARE MANY THEORIES ATTEMPTING TO EXPLAIN THE PHENOMENON OF DELINQUENCY. THE SOCIAL LEARNING THEORY ASSUMES THAT THE COMMISSION OF CRIMINAL ACTS VARIES INVERSELY WITH THE STRENGTH OF THE CONSCIENCE. THE SOCIAL CONTROL THEORY OF HIRSCHI (1969) ASSUMES THAT THE COMMISSION OF CRIMINAL ACTS VARIES INVERSELY WITH THE STRENGTH OF THE BOND TO SOCIETY. THE STRAIN THEORY POSTULATES THAT THE COMMISSION OF CRIMINAL ACTS DEPENDS ON THE DIFFERENCE BETWEEN A PERSON'S ASPIRATIONS AND ABILITY TO ACHIEVE GOALS OF STATUS OR MATERIAL SUCCESS. LABELLING THEORY POINTS OUT THAT CONVICTION WILL INCREASE DELINQUENT BEHAVIOUR. INDEED, FARRINGTON (1978) HAS SHOWN THAT THE FIRST APPEARANCE IN COURT TENDS TO BE FOLLOWED BY AN INCREASE IN DELINQUENT ACTIVITIES, AS WELL AS INCREASES IN HOSTILE ATTITUDES TOWARDS THE POLICE, AGGRESSIVE ATTITUDES AND BEHAVIOUR. NEVERTHELESS, BERG (1978) FOUND THAT COURT ADJOURNMENT WAS MORE SUCCESSFUL IN REDUCING TRUANCY THAN SOCIAL WORK INTERVENTION. WEST (1982) SHOWED THAT FOLLOWING THE FIRST CONVICTION THERE WAS A SIGNIFICANT TREND FOR BEHAVIOUR TO WORSEN, BUT THAT BOYS WHO AVOIDED CONVICTION TENDED TO IMPROVE. INDEED, THERE IS ALSO EVIDENCE THAT MORE SEVERE PUNISHMENT, FOR EXAMPLE, BY CUSTODIAL DETENTION RATHER THAN LESSER PENALTIES, LEADS YOUNGSTERS TO BE REARRESTED SOONER. THIS GOES AGAINST THE ALTERNATIVE THEORY, CALLED DETERRENCE THEORY, WHICH SUGGESTS THAT A CONVICTION SHOULD DECREASE DELINQUENT BEHAVIOUR, BECAUSE OFFENDERS WOULD BE MORE AFRAID OF THE POSSIBLE CONSEQUENCES OF OFFENDING. AS WEST (1985) POINTS OUT, THE SOCIOLOGICAL THEORIES SHARE THE ASSUMPTION THAT DELINQUENT BEHAVIOUR ARISES OUT OF UNFAVOURABLE SOCIAL CONDITIONS BROUGHT ABOUT BY AN INEGALITARIAN SOCIAL ECONOMIC SYSTEM AND SOCIAL CLASS STRUCTURE. HE ALSO POINTS OUT THAT "GLOBAL THEORIES

BASED ON SOME SINGLE PRINCIPAL, SUCH AS CLASS CONFLICT, ARE AT BEST VERY PARTIAL EXPLANATIONS."

SILBEREISEN AND NOACK (1988) HYPOTHESISED THAT PROBLEM BEHAVIOUR IN ADOLESCENTS FACILITATED THE ESTABLISHMENT OF CONTACT WITH PEERS. A STUDY OF DELINQUENT NETWORKS BY SARNECKI (1986) SHOWED THE JUVENILES APPEARED TO BE RECRUITED INTO DELINQUENT NETWORKS BY COMING INTO CONTACT WITH SOME INDIVIDUALS OF GREATER AGE AND DELINQUENT EXPERIENCE. HE ASSUMED THAT THESE WERE RESPONSIBLE FOR THE TRANSMISSION OF THE NORMS AND VALUES INVOLVED IN DELINQUENT BEHAVIOUR. IT HAS BEEN SUGGESTED THAT JUVENILE DELINQUENCY MAY INVOLVE TESTING THE LIMITS OF NORMAL BEHAVIOUR. PULKKINEN (1988) EMPHASISED THE WEAK SELF CONTROL AND "REVELLER'S" STYLE OF LIFE CARRIED OUT BY DELINQUENTS. HE POINTED OUT THAT THE "REVELLER'S" BEHAVIOUR WAS CHARACTERISED BY GATHERING WITH FRIENDS, DRINKING, SMOKING, HETEROSEXUAL INTERACTION AND WEAK TOLERANCE.

PULKKINEN (1988) POINTS OUT THAT SCIENTISTS WORKING WITH THE PROBLEMS OF DELINQUENCY DO NOT AGREE ABOUT THEIR OBSERVATIONS, LAWS AND THEORIES, BECAUSE THEY MAKE DIFFERENT PHILOSOPHICAL ASSUMPTIONS ABOUT THE NATURE OF THE WORLD. THESE ASSUMPTIONS REFLECT BASIC DIFFERENCES IN THE WAY THE THEORISTS VIEW THE SOCIAL ORDER AND THE NATURE OF HUMAN INTERACTIONS.

HEDIN ET AL (1980) EXAMINED AMERICAN AND IRISH YOUTHS' VIEWS ON REPUTATIONS AND DELINQUENCY. THE MOST STRIKING FEATURE WAS "HOW VERY SIMILAR THEY ARE." ONE AREA IN WHICH THEY WERE DIFFERENT WAS IN THE STUDENTS' THEORIES ABOUT THE CAUSES OF DELINQUENCY, WHERE THE AMERICANS EMPHASISED CHILD RELATIONSHIPS AND PSYCHOLOGICAL PROBLEMS, WHILE THE IRISH YOUTH EMPHASISED DEPRIVED ECONOMIC CIRCUMSTANCES.



## 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 NEGLECTING ATTITUDES AND ERRATIC OR HARSH DISCIPLINE.

KOLVIN (1988) FOUND A STRONG RELATIONSHIP BETWEEN DELINQUENCY AND THE MOTHER'S POOR CARE OF THE HOME AND THE CHILD DURING THE EARLY YEARS. HE POINTS OUT THAT POOR QUALITY OF PARENTING, AND POOR STANDARDS OF CARE OF THE HOME AND CHILDREN, APPEARED TO HAVE A MUCH CLOSER RELATIONSHIP WITH OFFENDING THAN DID MARITAL DISCORD OR BREAKDOWN. NEVERTHELESS, HE FELT THAT IT WAS LIKELY THEY ACTED BOTH SEPARATELY AND TOGETHER TO GIVE RISE TO AN ATMOSPHERE OF FAMILY STRESS AND GENERAL DISORGANISATION AND, FOR THE CHILD, A SENSE OF LACK OF PERSONAL RESTRAINTS. HE FOUND THAT THE RATE OF MALE CRIMINALITY IN THOSE DEPENDENT ON THE SOCIAL SERVICES WAS AT LEAST THREE TIMES HIGHER THAN FAMILIES WITHOUT THIS DEPENDENCY. HE ALSO FOUND HIGHER RATES OF CRIMINALITY IN YOUTHS COMING FROM OVERCROWDED HOMES AND A CLOSE RELATIONSHIP BETWEEN CRIMINALITY AND LARGE FAMILY SIZE. KOLVIN (1988) SHOWED THAT THE NATURAL FATHER WAS CONSTANTLY PRESENT IN ONLY 21% OF A GROUP OF DELINQUENTS, WHILE HE WAS PRESENT IN 57% OF A GROUP OF NON-DELINQUENTS. IT IS POSSIBLE THAT DELINQUENT PEERS AND VALUES ARE MORE APPROVED OF IN THE SUBCULTURE OF SCHOOLS FOR DELINQUENTS AND PRISONS.

FARRINGTON (1988) NOTES THAT THE DEGREE OF CRIMINAL POTENTIAL MAY DEPEND ON IMMEDIATE SITUATIONAL FACTORS, SUCH AS THE EXISTENCE OF AN OPPORTUNITY, THE IMMEDIATE LEVEL OF BOREDOM OR ANGER, PEER PRESSURE, THE

VALUE OF PROPERTY WHICH CAN BE STOLEN, AND THE PROBABILITY OF BEING CAUGHT.

FARRINGTON ET AL. (1988), HOME OFFICE STUDY U.K. (1990), HAS SHOWN THAT EMPLOYMENT DECREASES CRIME RATE, PARTICULARLY OFFENCES INVOLVING MATERIAL GAIN. FARRINGTON (1986) FOUND FOUR FACTORS THAT WERE INDEPENDENTLY IMPORTANT PREDICTORS:

(A) ECONOMIC DEPRIVATION, INCLUDING LOW INCOME AND POOR HOUSING;

(B) FAMILY CRIMINALITY, INCLUDING CONVICTED PARENTS AND DELINQUENT SIBLINGS;

(C) PARENTAL MISHANDLING, INCLUDING POOR SUPERVISION AND POOR CHILD REARING BEHAVIOUR;

(D) SCHOOL FAILURE, INCLUDING LOW INTELLIGENCE AND ATTAINMENT.

THE BEST INDEPENDENT PREDICTOR OF OFFENDING AT ANY AGE WAS THE MEASURE OF OFFENDING AT THE IMMEDIATE PRECEDING AGE. BOYS WHO BEGAN THEIR CONVICTION BEHAVIOUR AT THE EARLIEST AGES (10 - 12) TENDED TO BECOME THE PERSISTENT OFFENDERS.

AS DOUGLAS ET AL. (1968) POINTED OUT, TROUBLESOMENESS AT PRIMARY SCHOOL AS RATED BY TEACHERS WAS PREDICTIVE. AGGRESSIVENESS, INDISCIPLINE, DEFIANCE OF AUTHORITY, TRUANCY, INATTENTION, POOR PERFORMANCE IN SCHOLASTIC TASKS, AND RASH OR IMPULSIVE DARING ARE ALL IMPORTANT INDICES WHICH, COMBINED INTO A GLOBAL PICTURE OF TROUBLESOMENESS, CAN BE USED TO IDENTIFY A MINORITY AT HIGH RISK OF FUTURE DELINQUENCY.



ROBINS (1978) CARRIED OUT A THIRTY YEAR FOLLOW-UP OF CHILDREN REFERRED TO A CHILD PSYCHIATRY DEPARTMENT FOR BEHAVIOUR PROBLEMS SUCH AS THIEVING, INCORRIGIBILITY AND AGGRESSION, AND FOUND THAT 28% BECAME SOCIOPATHIC PERSONALITIES AS ADULTS, COMPARED WITH ONLY 2% OF ADULTS FROM THE SAME SCHOOL WHO HAD NOT BEEN REFERRED, AND 4% OF ADULTS WHO HAD BEEN REFERRED FOR OTHER REASONS, NOTABLY NEUROTIC SYMPTOMS. ROBINS FOUND THAT, IN ADDITION TO THE SOCIOPATHIC PERSONALITIES AS ADULTS, THERE WAS ALSO VERY CONSIDERABLE CRIMINALITY, ADDICTION, MARITAL DISCORD, VIOLENCE, SUICIDE, WELFARE DEPENDENCY AND CHILD NEGLECT OR ABUSE.

FARRINGTON (1988) POINTS OUT THAT IT IS MORE FEASIBLE TO PREDICT, NOT DELINQUENCY IN GENERAL, BUT THE MORE PERSISTENT OR CHRONIC OFFENDERS WHO ACCOUNT FOR A SIGNIFICANT PROPORTION OF ALL CRIME.

BARNES AND O'GORMAN (1978) FOUND THAT IRISH DELINQUENT BOYS TENDED TO COME FROM THE HOUSEHOLDS OF SEMI-SKILLED AND UNSKILLED MANUAL WORKERS, AS WELL AS BEING BIASED TOWARDS LOW INTELLIGENCE, WITH 14% OF THEM IN A RANGE OF MENTAL HANDICAP AND MORE THAN HALF OF THEM IN THE DULL NORMAL RANGE. THEY ALSO NOTED "A MARKED SHIFT TOWARDS SHORT STATURE."

## SIZE OF DELINQUENT PROBLEM

AS RUTTER (1979) POINTS OUT, CRIMINAL STATISTICS ARE AFFECTED BY ALTERATIONS IN THE LAW, WITH CERTAIN BEHAVIOUR MOVING IN OR OUT OF THE AMBIT OF CRIMINAL LAW, WITH STATISTICS BEING AFFECTED BY THE LEVEL OF POLICE ACTIVITY, AND WITH THE OPPORTUNITY TO COMMIT CRIME BEING AFFECTED BY SOCIAL PHENOMENA LIKE THE INCREASE IN THE TOTAL NUMBER OF SELF-SERVICE STORES AND

MOTOR VEHICLES. OF COURSE, OFFICIAL RECORDS UNDER REPRESENT THE TRUE EXTENT OF CRIMINAL BEHAVIOUR, WITH LESS THAN 15% OF CRIMINAL ACTS RESULTING IN POLICE CONTACT.

IN EXAMINING THE SIZE OF THE DELINQUENT PROBLEM, IT IS IMPORTANT TO REALISE THAT THE DISADVANTAGED GROUPS ARE MORE LIKELY TO BE LABELLED THAN MIDDLE CLASS CHILDREN. ADOLESCENTS FROM HIGH STATUS HOMES ARE BETTER PLACED TO AVOID CONVICTION FOR THEIR MISDEEDS.

RUTTER AND GILLER (1983) NOTE THAT MUCH RESEARCH HAS SHOWN AN ASSOCIATION BETWEEN DULL INTELLIGENCE AND DELINQUENCY. WHEN KOLVIN (1988) STUDIED HIS HIGH RISK GROUP FOR DELINQUENCY, HE FOUND THAT 43% OF THOSE WHO DID NOT BECOME DELINQUENT HAD IQ'S ABOVE 100, COMPARED WITH 10% OF THOSE WHO DID BECOME DELINQUENT. HE ALSO SHOWED THAT FAMILIES' INTEREST IN MAINTAINING CONTACT WITH THE SCHOOL SEEMED TO REFLECT THEIR OFFSPRING'S ACHIEVEMENTS THERE - 83% OF PARENTS OF NON-DELINQUENTS, COMPARED WITH 48% OF PARENTS OF DELINQUENTS. AS RUTTER AND GILLER (1983) POINT OUT, THE RISK OF DELINQUENCY FOR A CHILD IS INCREASED IF HE IS EDUCATED IN A SCHOOL WITH A HEAVY PREPONDERANCE OF OTHER LESS ABLE CHILDREN. RUTTER ET AL. (1979) SHOWED THAT SCHOOLS DO MATTER, AND THAT THERE WERE DIFFERENCES IN RATES DEPENDING ON POST INTAKE INFLUENCES. HE SHOWED THAT THE DELINQUENCY RATES WERE PROBABLY AFFECTED BY SCHOOL FACTORS SUCH AS APPROPRIATELY HIGH EXPECTATIONS, GOOD GROUP MANAGEMENT, EFFECTIVE FEEDBACK TO THE CHILDREN WITH AMPLE USE OF PRAISE, THE SETTING OF GOOD MODELS OF BEHAVIOUR BY TEACHERS, PLEASANT WORKING CONDITIONS, AND GIVING PUPILS POSITIONS OF TRUST AND RESPONSIBILITY IN THE SCHOOL. MARRIAGE ALSO MATTERS, AND WEST (1982) HAS SHOWN THAT MARRIAGE DECREASES OFFENDING IF A MAN IS MARRIED TO A NON-DELINQUENT WOMAN.



## PROTECTIVE FACTORS FOR OFFENDING

KOLVIN (1988) FOUND THAT THERE WAS LESS LIKELIHOOD OF OFFENDING IF ADOLESCENTS HAD THE BENEFIT OF GOOD MOTHERING, OR IF THE BREADWINNER WAS EMPLOYED. HE ALSO POINTED OUT THAT BEING ELDER-BORN APPEARED TO MITIGATE THE ILL EFFECTS OF UNDERPRIVILEGE. OTHER PROTECTIVE FACTORS INCLUDED AN IQ ABOVE 100 AND BELONGING TO A YOUTH CLUB. AT AGE 15 THE PROTECTIVE FACTORS FOR GIRLS INCLUDED GOOD CONCENTRATION AND PERSISTENCE IN CLASS, A NON-HOSTILE ATTITUDE TO SCHOOL, A WILLINGNESS TO STAY ON AT SCHOOL, AND A FAMILY THAT MAINTAINED CONTACT WITH THE SCHOOL, AS WELL AS THE CONSTANT PRESENCE OF THE NATURAL FATHER.

HE ALSO POINTED OUT THAT THOSE RESILIENT TO OFFENDING IN THE PRE-ADOLESCENT PERIOD HAD A NUMBER OF PROTECTIVE FACTORS, INCLUDING:

(A) A CARE-GIVING ENVIRONMENT THAT PROVIDED GOOD SUPERVISION FOR THE CHILDREN;

(B) THE ABSENCE OF DEVELOPMENTAL DELAYS;

(C) RELATIVELY GOOD COGNITIVE DEVELOPMENT AND EDUCATIONAL ACHIEVEMENTS;

(D) POSITIVE TEMPERAMENTAL QUALITIES;

(E) POSITIVE RESPONSES FROM PEERS, AND ALSO AN INVOLVEMENT IN SOCIAL ACTIVITIES, SUCH AS MEMBERSHIP OF A YOUTH CLUB.

## Prevention of Delinquency

Rutter (1982) pointed out that a critical appraisal of primary prevention of children's psychosocial disorders indicates that our knowledge of this topic is limited, and that there are few interventions of proven value.

In Ireland, as in other countries, the crime rate is much larger in cities than in rural areas. In London those delinquents who moved out had a lower incidence of subsequent convictions but, of course, family relocation would only be possible in a small number of cases.

The Perry Pre-School Project (Berrueta-Clement et al., 1984) studied the effect of a child-initiated learning programme to help foster positive social development in a randomly assigned group of 3 and 4 year old deprived children. In this programme the teachers from the classroom also visited the home once a week to help the mother work directly with her own child. At age 19 significantly less youngsters had been arrested, had dropped out of school, or were on welfare, if they had this pre-school programme. The employment and literacy rates were also significantly higher in those attending the programme. An economic cost-benefit analysis revealed that for every dollar invested there was a return of six dollars in terms of reduced demands on services. The American Psychological Association regard this as one of the very few effective programmes. This programme has been criticised because people felt that the experimental group had moved more often to better neighbourhoods, but when this was re-examined it was found not to be true. It was also pointed out that two children from the experimental group had been moved to the control



group during the second year of the project. When the data was re-analysed with these children removed, the control group was worse off than when the children were left in. This study has been used as a basis for public policy decisions.

Nevertheless, Rutter and Giller (1983) point out that

> "There are no preventative programmes available which are likely to reduce crime to a major extent . . . it is obvious that the empirical findings do not justify any firm recommendations on what works in preventing delinquency."

Certain precautions will reduce the possibility of crime, for example, wheel locks on cars, impregnable telephone kiosks, etc.

## Intervention and Treatment of Delinquents

Rutter and Giller (1983) are correct when they state that

> "A policy of minimal intervention is most appropriate with first and minor offenders. Disapproval of delinquent behaviour should be firm and unequivocal, but such discipline is more effectively applied by parents and teachers than by the police or the courts. Informal community interventions of various kinds designed to increase the responsibility of the offender and of his family should be the first resort and often the second and

SUBSEQUENT RESORT FOR MINOR OFFENCES, BECAUSE THERE IS NO INDICATION THAT FORMAL PROCESSING IS MORE SUCCESSFUL AND BECAUSE OF THE EVIDENCE THAT A COURT APPEARANCE MAY MAKE THINGS WORSE."

THEY GO ON TO POINT OUT THAT WHEN A MORE INTENSIVE INTERVENTION IS REQUIRED, COMMUNITY PROGRAMMES ARE GENERALLY TO BE PREFERRED TO CUSTODIAL SENTENCES. IN SUCH COMMUNITY APPROACHES THE MAIN EMPHASIS SHOULD BE ON WORKING TO IMPROVE THE FAMILY ENVIRONMENT, TO MAKE THE PEER GROUP INFLUENCE LESS CRIME-DIRECTED, AND TO GIVE THE OFFENDER BETTER SOCIAL PROBLEM SOLVING AND VOCATIONAL SKILLS. THEY ALSO POINT OUT THAT

"RESIDENTIAL PLACEMENTS WILL BE NEEDED IN SOME INSTANCES BECAUSE OF THE SEVERELY DAMAGING QUALITY OF THE FAMILY ENVIRONMENT OR BECAUSE OF THE SERIOUSNESS OR DANGEROUSNESS OF THE OFFENDER'S ANTI-SOCIAL ACTIVITIES. IT IS NOT LIKELY THAT RESIDENTIAL EFFORTS WILL HAVE MUCH LASTING IMPACT ON RECIDIVISM, UNLESS THEY ARE COMBINED WITH EFFORTS TO IMPROVE THE HOME ENVIRONMENT, BUT ATTENTION TO THE QUALITIES OF THE INSTITUTION IS IMPORTANT IN ENSURING THAT THE SHORT TERM IMPACT IS BENEFICIAL. THERE IS A NEED FOR SOME SECURE FACILITIES, BUT IT IS NOT DESIRABLE TO ESCALATE THE AMOUNT OF SECURE PROVISION. PHYSICAL SECURITY IS MORE APPROPRIATELY SEEN AS SOMETHING THAT USUALLY IS NEEDED AS A SHORT TERM RESPONSE TO CRISIS AND THE NEEDS FOR WHICH CAN BE KEPT TO A MINIMUM BY MAINTAINING A HIGH QUALITY OF CARE IN NON-SECURE INSTITUTIONS."

THE HOME OFFICE IN THE UNITED KINGDOM POINTED OUT IN 1976 THAT THERE WAS NO EVIDENCE THAT THE BORSTAL SYSTEM WAS EFFECTIVE IN INFLUENCING LONG TERM



RECIDIVISM. OF TRAINEES RELEASED IN 1972, 64% WERE RECONVICTED IN TWO YEARS; THE FIGURE FOR BOYS UNDER THE AGE OF 17 YEARS ON SENTENCE WAS EVEN HIGHER, AT 79%. SHELDRICK (1985) POINTED OUT THAT IT SEEMED UNLIKELY THAT INSTITUTIONAL TREATMENT, RETRAINING OR PUNISHMENT WAS EFFECTIVE IN DECREASING DELINQUENCY. SHE FELT THAT IT WAS POSSIBLE THAT INSTITUTIONALISATION HAD A HARMFUL EFFECT BECAUSE OF THE ALIENATION, STIGMATISATION AND CONTAMINATION SUFFERED BY THOSE WHO WERE INCARCERATED IN PRISON ESTABLISHMENTS. IT IS POSSIBLE THAT A COMMUNITY APPROACH IS THE LEAST DETRIMENTAL ALTERNATIVE IN MANY CASES.

INTERVENTIONS MUST BE CAREFULLY PLANNED AS THEY MAY BE HARMFUL, AND MCCORD (1978) EXAMINED THE LONG TERM EFFECTS OF A TREATMENT PROGRAMME FOR BOYS CONSISTING MAINLY OF COUNSELLING AND COMMUNITY PROGRAMMES, AND FOUND THAT A TREATED GROUP FARED WORSE THAN THE CONTROL GROUP IN TERMS OF CRIMINAL BEHAVIOUR AND ALCOHOLISM, AS WELL AS SERIOUS MENTAL ILLNESS. O'MAHONY (1990) FOUND IN AN IRISH PRISON DRUG STUDY 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.

PATTERSON (1974) HAS USED BEHAVIOURAL FAMILY INTERVENTION PROGRAMMES, AND HELPS PARENTS TO BE POSITIVE AND USE NON-COERCIVE METHODS OF CONTROL; TO INTERACT MORE POSITIVELY AS A FAMILY; TO MONITOR THEIR CHILDREN'S ACTIVITIES BETTER; AND TO DEAL MORE DECISIVELY WITH DEVIANT BEHAVIOUR. HE HAD SOME SUCCESS IN REDUCING AGGRESSION AND STEALING.

CLEARLY, DELINQUENTS ARE NOT ALL THE SAME, AND THEREFORE THEY NEED INDIVIDUAL ASSESSMENT SO THAT THEIR SPECIFIC NEEDS CAN BE DEALT WITH. AS SHELDRICK POINTS

OUT, THEY NEED WARMTH, CONSISTENCY, FIRMNESS, HIGH BUT APPROPRIATE EXPECTATIONS AND CLEARLY DEFINED OBJECTIVES.

THERE IS NO CHEAP WAY OF DEALING WITH DELINQUENTS. IN THE UNITED KINGDOM IT WAS FOUND THAT PROBATION DAY CENTRES WERE NOT CHEAP OR CHEAPER THAN CUSTODIAL ESTABLISHMENTS. THE FIRST PRIORITY OF THE STATE MUST BE NOT TO DAMAGE THE DELINQUENT MORE. IF ALTERNATIVES TO PRISON ARE USED, THEY SHOULD BE USED FOR THOSE WHO WOULD HAVE GONE TO PRISON IN THE PAST. IN THE UNITED KINGDOM THERE HAS BEEN AN INCREASED RANGE OF PRISONS AND ALTERNATIVES TO PRISON, (VASS, 1990). VASS ALSO POINTS OUT THAT, IN RELATION TO COMMUNITY SERVICE, THERE MUST BE "TOLERANCE OF SOME RULE BREAKING AND, OVERALL, SOME DISCRETION AND ELASTICITY IN THE WAY OFFENDERS ARE TREATED." WE ARE STILL NOT CERTAIN WHICH TYPE OF OFFENDERS WILL RESPOND BEST TO A PARTICULAR PROGRAMME. DONNES (1988), IN COMPARING ENGLAND AND THE NETHERLANDS, STATES

> "THAT SOME MEANS HAS TO BE FOUND FOR SITUATING A MUCH MORE SPARING USE OF IMPRISONMENT WITHIN A REFORMED CRIMINAL JUSTICE SYSTEM. THE DUTCH JUDICIARY HAVE SHOWN GREAT COURAGE IN INSISTING ON HUMANE STANDARDS AND THE MINIMUM USE OF PAIN IN THE DISPENSATION OF CRIMINAL JUSTICE."

CUMMINS (1990) STATES THAT THE DEPARTMENT OF EDUCATION SPENDS ABOUT £4 MILLION ON THOSE CHILDREN AND ADOLESCENTS WHO OFFEND. ST. MICHAEL'S ASSESSMENT CENTRE IN DUBLIN DEALS WITH ABOUT 20 BOYS AT ANY ONE TIME. THEY ARE ADMITTED BETWEEN AGES 8/9 AND 16 YEARS (AVERAGE AGE, FOURTEEN YEARS). IT IS A REMAND AND ASSESSMENT CENTRE, BUT IS NOT SUITABLY USED AS A REMAND



CENTRE, AS THOSE ON REMAND INTERFERE WITH THE ASSESSMENT PROCESS. AFTER ASSESSMENT, CHILDREN AGED 13 - 15 YEARS (AVERAGE, 14 YEARS) CAN GO ON TO ST. LAURENCE'S SPECIAL SCHOOL, WHERE THERE ARE ABOUT 60 BOYS ON THE ROLE. ST. JOSEPH'S SPECIAL SCHOOL IN CLONMEL TAKES BOYS UNDER 12 YEARS AS A RULE, AND SOMETIMES 13 YEARS, AND THEY WILL BE KEPT TILL THEY ARE 16 YEARS. THEY HAVE APPROXIMATELY 75 BOYS ON THE ROLE. TRINITY HOUSE IN DUBLIN IS A VERY SECURE UNIT, AND TAKES 30 BOYS. IT COSTS OVER £50,000 PER YEAR TO KEEP ONE JUVENILE IN TRINITY HOUSE. FINALLY, OBERSTOWN REMAND AND ASSESSMENT CENTRE HAS BEEN SET UP IN DUBLIN FOR GIRLS AND HAS SPACE FOR 8, WHICH IS INSUFFICIENT. THERE NEEDS TO BE A SMALL EXPANSION OF SECURE ACCOMMODATION FOR OUT-OF-CONTROL BOYS AND GIRLS IN IRELAND. THESE SECURE UNITS WOULD REQUIRE PSYCHIATRIC, PSYCHOLOGICAL, SOCIAL WORK AND EDUCATIONAL PROVISION. JUVENILES SHOULD BE KEPT IN THESE CENTRES ONLY AS LONG AS IS FELT TO BE ABSOLUTELY NECESSARY. IT IS DIFFICULT TO ESTIMATE HOW MANY EXTRA SECURE PLACES ARE NEEDED - POSSIBLY 13 FOR BOYS AND 7 FOR GIRLS.

ONE OF THE PROBLEMS WITH ST. JOSEPH'S IN CLONMEL IS THAT IT IS TOO FAR FROM DUBLIN, WHERE A LARGE PROPORTION OF THE POPULATION RESIDES.

THE YEAR IN ST. LAURENCE'S SCHOOL IS TOO SHORT, AND THERE IS A NEED FOR HOSTEL PLACEMENTS, FOR EXAMPLE, FOR THOSE IN NEED OF THEM COMING OUT OF ST. LAURENCE'S SCHOOL, IN DUBLIN.

HISTORICALLY, WHEN THE REFORMATORIES CLOSED DOWN COMMUNITY HOMES WERE SET UP BY HEALTH BOARDS, BUT THESE COULD NOT COPE WITH THE MORE DISTURBED BOYS AND GIRLS WHO NEEDED ST. JOSEPH'S, CLONMEL, ST. LAURENCE'S OR TRINITY HOUSE.

## Delinquency: Planning for the Future in Ireland

We need to scientifically evaluate the effectiveness of all aspects of the legal, educational and health systems in dealing with delinquents. We need to prioritise all aspects of preventive strategies. We need to increase liaison and co-operation between the Departments of Health, Education and Justice. The Department of Health should co-ordinate services for adolescents so that each child and adolescent in difficulties has a key worker named by the Health Board. The 1908 Juvenile Justice Act needs to be re-examined and brought up to date; for example, the age of criminal responsibility needs to be brought from 7 years to 15 years, and whipping should not be a dispositional alternative. We need to set up as soon as possible the new Child Care Advisory Committee, as proposed in the new Children's Bill, 1988, to provide local co-ordination of services for children. We need to examine the use of family courts along the Scottish model. We need the secure unit for out-of-control, highly disturbed girls to be built as soon as possible. We also need extra places in a secure unit for out-of-control adolescent boys. We need the development of child and adolescent psychiatric services in rural parts of Ireland where they do not have them at present.

As the ethos of school has been shown to be important, schools with an unsatisfactory ethos need special help.

There should be increased emphasis on high quality pre-school education for "at risk" children, and mothers and fathers of these children need extra help with parenting.



There should be increased research into and use of intermediate treatment.

There is a need for an increased number of hostels. It should not be possible to send adolescents between 15 and 17 years to an adult prison, as it is at present. The age of entry into St. Patrick's Institution should be raised from 16 to 18 years. Currently, St. Patrick's is used for 16 - 21 year olds.

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# THE PERSONALITIES OF CHILD PSYCHIATRIC PATIENTS

IMELDA RYAN; MICHAEL FITZGERALD; ANTHONY KINSELLA.

> "TO ASSESS PERSONALITY IS TO MEASURE IT IN SOME WAY, CAPTURING THE TOTAL PATTERN AT ONCE, OR POSSIBLY FOCUSING ON CERTAIN DISTINCTIVE FEATURES OF THE PERSON'S BEHAVIOURAL TENDENCIES. NOT EVERY PSYCHOLOGIST BELIEVES THAT IT IS POSSIBLE TO CAPTURE SOMETHING SO UNIQUE AND POTENTIALLY ELUSIVE AS PERSONALITY IN A MEASUREMENT (WHETHER THAT BE BY TEST, SCALE OR QUESTIONNAIRE) AND EVEN THOSE WHO BELIEVE THAT IT CAN BE SO ASSESSED, DISAGREE ON THE METHOD IN WHICH THIS IS TO BE DONE."
> (RYCHILAK, 1981)

## INTRODUCTION

A DIAGNOSIS OF PERSONALITY DISORDER IS COMMONLY USED IN ADULT PSYCHIATRY. IT IS GENERALLY AGREED TO REFER TO A DISORDER MANIFESTED BY LIMITED ADAPTIVE FLEXIBILITY AND CERTAIN RELATIVELY FIXED INEFFECTUAL MODES OF BEHAVIOUR.

IN THE PAST THERE HAS BEEN LIMITED INTEREST IN THE PERSONALITIES OF CHILDREN ATTENDING CHILD GUIDANCE CLINICS. CHILDREN TENDED TO BE GROUPED INTO "NEUROTIC DISORDER," "CONDUCT DISORDER" OR "MIXED DISORDER OF CONDUCT AND EMOTIONS," - RUTTER ET AL. (1975). IN

RECENT YEARS A SMALL NUMBER OF AUTHORS HAVE TAKEN AN INTEREST IN THE PERSONALITY OF CHILDREN - WOLFF (1984) IN SCHIZOID PERSONALITY; WING (1981) IN ASPERGER SYNDROME, WHICH WOLFF (1984) WOULD SEE AS A VARIANT OF SCHIZOID PERSONALITY.

IT IS ACCEPTED THAT MANIFESTATIONS OF PERSONALITY DISORDER ARE GENERALLY RECOGNISABLE IN ADOLESCENCE, OR EARLIER, AND CONTINUE THROUGHOUT MOST OF ADULT LIFE. IT IS OF INTEREST TO SEE IF THEY CAN BE IDENTIFIED AT AN EARLIER AGE. THE FOLLOWING HYPOTHESES WERE DEVELOPED:-

1 THAT PERSONALITY TRAITS AND PERSONALITY TYPES IN CHILDREN CAN BE MEASURED BY MEANS OF PARENTAL REPORTING;

2 THAT PERSONALITY TRAITS CAN BE MEASURED AND FORM DISTINCT STATISTICAL CLUSTERS.

## METHOD

FIFTEEN PERSONALITY TYPES AS OUTLINED BY THE THREE MAJOR PSYCHIATRIC CLASSIFICATION SYSTEMS, ICD 9 (1979), DSM III (1980), GAP (1966), WERE MEASURED BY A 69-ITEM RATING FORM. THE 69 ITEMS WERE DERIVED FROM SEARCHING THE THREE CLASSIFICATION SYSTEMS, AND GETTING THE CONSENSUS OPINION OF THE PERSONALITY TRAITS USED BY EACH SYSTEM TO DEFINE THE VARIOUS PERSONALITY TYPES. IN THIS PARTICULAR QUESTIONNAIRE, A SCORE OF 0 WAS GIVEN IF A PARTICULAR FEATURE OUTLINED WAS NOT PRESENT; 1, IF THE FEATURE WAS DUBIOUS OR MINIMAL; 2, IF THE FEATURE WAS DEFINITELY PRESENT.



ALL INTERVIEWS WERE CONDUCTED BY INTERVIEWER I.R. USING A ONE-WAY MIRROR, ANOTHER RATER (M.F.) INDEPENDENTLY RATED 10% OF ALL CASES. THE INTER-RATER RELIABILITY WAS +0.80.

FIFTY CONSECUTIVE CASES REFERRED TO CHILD GUIDANCE CLINICS WERE RATED, USING AS INFORMANTS THE PARENTS WHO ATTENDED WITH THE CHILD. THERE WERE 31 BOYS AND 19 GIRLS IN THE STUDY. THE MEAN AGE WAS 8.7 YEARS AND THE AGE RANGE WAS 1 YEAR, 8 MONTHS TO 14 YEARS. THE INFORMANT IN 38 CASES WAS MOTHER AND IN 4 CASES FATHER, AND THERE WERE 8 CASES WHERE BOTH PARENTS WERE PRESENT AND GAVE INFORMATION.

THE RATING WAS DONE AT AN INITIAL STAGE IN THE INTERVIEW, AND THE RATER THEN WENT ON TO DO A FULL PSYCHIATRIC ASSESSMENT AND FORM A PSYCHIATRIC DIAGNOSIS. IN ALL CASES, THE INFORMANTS WERE ABLE TO IDENTIFY WITH THE ITEMS LISTED AND WERE ABLE TO RATE ACCORDING TO THE SCALE OUTLINED.

## RESULTS

FROM THE ANALYSIS OF RESULTS, 5 CHILDREN EMERGED WITH DISTINCT PERSONALITY PROFILES:-

2 CHILDREN OF THE HYSTERICAL PERSONALITY TYPE;
1 OBSESSIONAL PERSONALITY;
1 SCHIZOID PERSONALITY;
1 PASSIVE-AGGRESSIVE PERSONALITY.

IN THE REMAINDER OF THE GROUP, CHILDREN EMERGED WITH PERSONALITY TRAITS WHICH WERE NOT OF SUFFICIENT INTENSITY TO WARRANT A DIAGNOSIS OF PERSONALITY

DISORDER. IN THE YOUNGER AGE GROUP THERE WAS A PREDOMINANCE OF PASSIVE-AGGRESSIVE PERSONALITY TRAITS.

OF THE 5 CHILDREN WHO EMERGED WITH DISTINCT PROFILES, THEIR PSYCHIATRIC DIAGNOSOS ON ICD 9 WAS OF A NEUROTIC DISORDER FOR THE 1 HYSTERICAL AND 2 OBSESSIONAL CHILDREN; A MIXED DISORDER OF CONDUCT AND EMOTIONS FOR THE PASSIVE-AGGRESSIVE PERSONALITY; AND THE SCHIZOID PERSONALITY WAS CLASSIFIED AS A SCHIZOID PERSONALITY.

## DISCUSSION

THIS STUDY WAS DESIGNED TO LOOK MORE CLOSELY AT THE PERSONALITIES OF CHILDREN, AND TO SEE WHETHER OR NOT CHILDREN COULD BE SAID TO FIT ANY PARTICULAR PERSONALITY TYPE. THE STUDY IS NOT BASED ON ANY PARTICULAR THEORY, BUT IS DESCRIPTIVELY AND EMPIRICALLY BASED. THE MAJORITY OF CHILDREN WERE REPORTED AS HAVING PERSONALITY TRAITS BELONGING TO SEVERAL DIFFERENT PERSONALITY CATEGORIES, SUCH AS OBSESSIONAL, OPPOSITIONAL, HYSTERICAL, ETC., BUT THESE, WHEN MEASURED, DID NOT FORM ANY STATISTICAL CLUSTER. THE PREDOMINANCE OF PASSIVE-AGGRESSIVE PERSONALITY TRAITS IN THE YOUNGER AGE GROUP MAY HAVE BEEN A REFLECTION OF DEVELOPMENTAL PROCESSES AND NOT DUE TO ANY INGRAINED PATTERN OF BEHAVIOUR.

FIVE CHILDREN EMERGED AS HAVING DISTINCT PERSONALITY TYPES AND THE CORRELATION BETWEEN THIS AND THEIR DIAGNOSES, BASED ON ICD 9, HAS BEEN DISCUSSED PREVIOUSLY.

THE FIRST HYPOTHESIS STATED AT THE BEGINNING OF THE PAPER HAS BEEN SUPPORTED, I.E. THAT PERSONALITY



TRAITS AND PERSONALITY TYPES CAN BE MEASURED BY MEANS OF PARENTAL REPORTING. THE SECOND HYPOTHESIS - THAT PERSONALITY TRAITS CAN BE MEASURED AND FORM DISTINCT STATISTICAL CLUSTERS WAS **NOT** SUPPORTED.

A GENERAL PROBLEM WITH PERSONALITY QUESTIONNAIRES, IRRESPECTIVE OF WHO IS THE INFORMANT, IS THE PROPENSITY FOR RESPONSE SET. THESE ARE DEFINED AS TENDENCIES TO ANSWER TEST ITEMS IN CERTAIN WAYS, USUALLY REGARDLESS OF THE ITEM MEANING. TWO HAVE BEEN SINGLED OUT AS BEING ESPECIALLY IMPORTANT IN DISTURBING THE VALIDITY OF PERSONALITY QUESTIONNAIRES:-

### 1: <u>SOCIAL DESIRABILITY</u>

THIS IS THE TENDENCY TO ENDORSE ITEMS BECAUSE TO DO SO IS SOCIALLY ACCEPTABLE. EDWARDS (1957) SHOWED THAT THIS WAS AN IMPORTANT INFLUENCE ON RESPONSES TO THE MMPI. THIS WAS NOT REGARDED AS A MAJOR FACTOR IN THIS STUDY, AS INFORMANTS GAVE CAREFUL CONSIDERATION TO THE RESPONSE THEY GAVE, AND THE INTERVIEWER HAD THE SENSE THAT THEY WERE NOT SIMPLY GIVING SOCIALLY DESIRED RESPONSES, BUT WERE GIVING CAREFUL CONSIDERATION TO THEIR ANSWERS.

### 2: <u>ACQUIESCENCE</u>

THIS IS THE TENDENCY TO RESPOND "YES" OR TO AGREE WITH ITEMS, REGARDLESS OF CONTENT. GUILFORD (1959) HAS SHOWN THAT THIS OCCURS MOST OFTEN WHEN ITEMS ARE VAGUELY WORDED AND REFER TO GENERAL RATHER THAN SPECIFIC BEHAVIOURS. THE LATTER WAS BORNE IN MIND WHEN DESIGNING THE QUESTIONNAIRES AND, AS FAR AS POSSIBLE, CLEAR DESCRIPTIVE ITEMS FREE FROM AMBIGUITY WERE USED. THE AUTHOR WOULD AGREE WITH MANN ET AL. (1984) THAT RELATIVES, IN THIS CASE PARENTS, CAN BE USED AS

RELIABLE INFORMANTS, AND WE FEEL THAT THE ABOVE TWO FACTORS DID NOT INFLUENCE THE RATER'S RESPONSE, IN THAT IN EVERY CASE INFORMANTS THOUGHT CAREFULLY BEFORE GIVING THEIR RESPONSE AND GAVE A MAJORITY BORDERLINE/MINIMAL RESPONSE RATHER THAN ARBITRARILY OPT FOR THE TWO ABSOLUTE VALUES. IT IS INTERESTING TO NOTE THAT IN THE CASES (N = 8) WHERE BOTH PARENTS ACTED AS INFORMANTS, THERE WAS MARKED AGREEMENT BETWEEN PARENTS AS TO THE RESPONSE TO GIVE.

AS DISCUSSED, 5 CHILDREN COULD BE CLASSIFIED AS HAVING PERSONALITY DISORDERS, AND THIS WAS IN KEEPING WITH THEIR PSYCHIATRIC PRESENTATION IN THAT ONE GIRL WAS REFERRED DUE TO HYSTERICAL EPILEPSY AND ONE GIRL WITH HYSTERICAL PARALYSIS. ONE SCHIZOID PERSONALITY EMERGED. IN THE PAST THERE WAS A RELUCTANCE TO ASCRIBE SUCH A PERSONALITY TO CHILDREN, AS THIS TERM IMPLIED A HIGH RISK OF LATER SCHIZOPHRENIA. WOLFF (1984) ARGUES THAT THE TERM "SCHIZOID" IS APPROPRIATE BECAUSE THE CONDITION IN CHILDHOOD HAS FEATURES EXACTLY SIMILAR TO THOSE DESCRIBED IN THE PSYCHIATRIC LITERATURE FOR ADULTS. SHE STATES THAT THE DISADVANTAGES OF THE TERM LIE IN THE IMPLICATION THAT SCHIZOPHRENIA IS LIKELY TO SUPERVENE, WHEN THE RISKS OF SUCH A DEVELOPMENT ARE, IN FACT, UNKNOWN. SULA WOLFF ALSO, IN A RECENT STUDY, SHOWED THAT THE SCHIZOID PERSONALITY AS DIAGNOSED BY HER REMAINS REMARKABLY TRUE OVER TIME, AND CORRESPONDS TO THE GENERAL CLINICAL PICTURE PSYCHIATRISTS HAVE OF SCHIZOID PERSONALITY IN ADULT LIVES.

THIS STUDY SUPPORTS THE IDENTIFICATION OF PERSONALITY DISORDER, AND THE FINDINGS ARE IN AGREEMENT WITH WOLFF'S FINDINGS ON SCHIZOID PERSONALITY.



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# BLOOD LEAD LEVEL OF CHILDREN ATTENDING AN URBAN CHILD GUIDANCE CLINIC

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## SUMMARY

THE BLOOD LEAD AND ERYTHROCYTE PROTOPORPHRIN (EP) LEVELS OF CHILDREN ATTENDING AN URBAN CHILD GUIDANCE CLINIC WERE STUDIED. THE MEAN VALUES WERE SIMILAR TO GENERAL POPULATION STUDIES. THE ASSOCIATION BETWEEN "LOW" BLOOD LEAD LEVELS AND BEHAVIOURAL AND IQ SCORES IS REVIEWED. THE RELATIONSHIP BETWEEN SCIENTIFIC EVIDENCE AND SOCIAL POLICY IS ALSO DISCUSSED.

## INTRODUCTION

THE INTELLECTUAL AND BEHAVIOURAL SEQUELAE OF CHRONIC EXPOSURE TO LEAD AT HIGH LEVELS WERE FIRST NOTED BY BYERS AND LORD IN 1943.

BLOOD LEAD LEVELS GREATER THAN 60 UG/DL ARE UNIVERSALLY ACKNOWLEDGED AS TOXIC, AND IN MANY AREAS 5 - 10% OF CHILDREN HAVE LEVELS EQUAL TO OR GREATER THAN 30 UG/DL. INDEED, AT 30 UG/DL A NUMBER OF BIO-CHEMICAL SYSTEMS BECOME DERANGED. IN THIS RANGE, FREE ERYTHROCYTE PROTOPORPHRIN IS ELEVATED AND CNS ACTIVITY OF D-AMINO LEVULINIC ACID DEHYDRASE AND ADENCYCLASE ARE DEPRESSED. THE ATTENTION OF RESEARCHERS HAS FOCUSED MORE ON YOUNGER

CHILDREN, BECAUSE THEY ABSORB MORE LEAD FROM THE GUT AND ARE MORE VULNERABLE AT THE SAME INTERNAL DOSE.

THE RECENT DEBATE HAS FOCUSED ON THE SUGGESTION THAT CHILDREN ARE BEING ADVERSELY AFFECTED BY LEAD AT BODY BURDENS WELL BELOW THE ACCEPTED THRESHOLDS FOR FRANK POISONING.

THE SECOND NATIONAL HEALTH AND NUTRITION EXAMINATION SURVEY (1976 - 1980) FOUND THAT CHILDREN FROM ALL GEOGRAPHIC AND SOCIO-ECONOMIC GROUPS ARE AT RISK OF LEAD POISONING, (MAHAFFEY, 1982). AN ESTIMATED 3.9% OF CHILDREN IN THE UNITED STATES UNDER 5 YEARS OF AGE HAD BLOOD LEAD LEVELS OF 30 UG/DL OR GREATER, (ANNEST, 1983).

THE STUDY BY NEEDLEMAN ET AL. (1979) IS ONE OF THE FIRST TO ATTEMPT TO TAKE ADEQUATE MEASURES TO DEAL WITH THE MANY METHODOLOGICAL ISSUES THAT MADE WORK IN THIS AREA DIFFICULT. IT SHOWED A STATISTICALLY SIGNIFICANT DIFFERENCE IN FULL-SCALE IQ BETWEEN TWO GROUPS OF CHILDREN, CLASSIFIED AS "HIGH" OR "LOW" LEAD BY THEIR TOOTH LEAD LEVELS. THE DIFFERENCE OF 5 IQ POINTS REMAINED SIGNIFICANT AFTER ACCOUNTING FOR OTHER VARIABLES. FURTHER DATA SUGGESTED THAT BEHAVIOURAL PROBLEMS WERE DIRECTLY RELATED TO BODY BURDEN OF LEAD - THE HIGHER THE LEAD LEVEL, THE MORE LIKELY THE CHILD'S TEACHER WAS TO RATE THEM AS HAVING SOME SORT OF CLASSROOM RELATED BEHAVIOUR PROBLEM. RUTTER (1980), IN COMMENTING ON THIS STUDY, STATED THAT ALTHOUGH THE FINDINGS WERE SOMEWHAT CONTRADICTORY, THE EVIDENCE SUGGESTED THAT PERSISTENTLY RAISED BLOOD LEVELS IN THE RANGE ABOVE 40 UG/DL MAY CAUSE SLIGHT COGNITIVE IMPAIRMENT (A REDUCTION OF 1 TO 5 IQ POINTS ON AVERAGE) AND, LESS CERTAINLY, MAY INCREASE THE RISK OF BEHAVIOURAL DIFFICULTIES. THREE YEARS LATER, RUTTER (1983) STATED THAT THE NEW EVIDENCE SINCE 1980 HAD BEEN GENERALLY CONSISTENT IN POINTING TO



SIGNIFICANT EFFECTS AT THE LOW LEVELS OF LEAD EXPOSURE (BELOW 40 UG/DL) WHERE THERE WAS MOST DOUBT ON THE BASIS OF EARLIER STUDIES.

THESE CONCLUSIONS WERE NOT ACCEPTED BY THE EXPERT COMMITTEE ON PAEDIATRIC NEUROBEHAVIOURAL EVALUATIONS IN 1983, AND THEY STATE THAT THIS STUDY COULD NEITHER SUPPORT NOR REFUTE THE HYPOTHESIS THAT LOW LEVEL LEAD EXPOSURE HAD NEURO-PSYCHOLOGICAL EFFECTS, (HARVEY, 1984). IN THE SAME YEAR, THE ROYAL COMMISSION ON ENVIRONMENTAL POLLUTION STATED THAT THERE WAS CONTINUING UNCERTAINTY ABOUT THE EFFECTS OF LOW CONCENTRATIONS, PARTICULARLY ON CHILDREN. THEY HAVE SAID THAT THE FINDINGS OF THIS CANNOT BE ACCEPTED AS VALID BECAUSE OF SAMPLING AND STATISTICAL ERRORS IN DATA, (MARSHALL, 1983). IN A SEPARATE STUDY CARRIED OUT BY NEEDLEMAN (1981) ON A DIFFERENT SAMPLE OF 1,300 CHILDREN, BEHAVIOURAL RATINGS WERE AGAIN MADE. IN THIS STUDY, WHEN HE ADDED IN INFORMATION ABOUT SOCIO-ECONOMIC FACTORS, THE INCREASED BEHAVIOURAL PROBLEMS WITH INCREASED LEAD LEVELS DID NOT PERSIST. IT SEEMED THAT THE EFFECT WAS AS LIKELY TO BE DUE TO AN INCREASE IN DISADVANTAGEOUS SOCIAL FACTORS AS TO AN INCREASE IN LEAD, (SMITH, 1985).

SMITH ET AL. (1983) STUDIED A SAMPLE MADE UP OF THREE DISCRETE GROUPS OF CHILDREN REPRESENTING LOW, MEDIUM AND HIGH LEAD LEVELS, WITH EACH GROUP STRATIFIED BY SOCIAL GROUPING. THESE CHILDREN WERE TESTED AND THEIR MOTHERS INTERVIEWED TO COLLECT INFORMATION ON SOCIAL, DEVELOPMENTAL AND LEAD SOURCE VARIABLES. SOCIAL AND DEVELOPMENTAL VARIABLES WHICH WERE SIGNIFICANTLY RELATED TO OUTCOME MEASURES WERE CONTROLLED. BEFORE CONTROLLING FOR SOCIAL FACTORS, THERE WERE SIGNIFICANT DIFFERENCES BETWEEN THE LEAD GROUPS ON THE IQ SCORES, WITH THE LOW-LEAD GROUP SCORING HIGHER ON AVERAGE THAN THE HIGH-LEAD GROUP, WITH THE SCORES OF THE MIDDLE-LEAD GROUP

INTERMEDIATE. APART FROM THE READING TEST, THERE WAS A SIMILAR PATTERN OF RESULTS; THERE WERE NO SIGNIFICANT LEAD RELATED DIFFERENCES ON THE TESTS IN THE BATTERY. WHEN SOCIAL FACTORS WERE CONTROLLED, THE DIFFERENCES BETWEEN GROUPS REDUCED AND WERE NO LONGER STATISTICALLY SIGNIFICANT, ALTHOUGH THEY REMAINED IN THE SAME DIRECTION.

IT IS OFTEN SAID THAT THE OUTCOME MEASURES, FOR EXAMPLE, IQ AND BEHAVIOUR, ARE INDEPENDENT AND SHOULD BE TREATED AS MULTIPLE INDEPENDENT MEASUREMENTS FOR STATISTICAL PURPOSES. THIS IS NOT THE CASE, AS THERE ARE COMPONENTS OF PERFORMANCE WHICH ARE COMMON TO MANY TESTS, AND THERE ARE ASSOCIATIONS BETWEEN IQ AND SOME BEHAVIOURAL MEASURES. IT IS ALSO KNOWN THAT INTELLIGENCE AND ACADEMIC ACHIEVEMENTS (BEHAVIOUR LESS SO) ARE THEMSELVES LINKED TO SOCIAL FACTORS INDEPENDENTLY OF LEAD. THUS, IF CHILDREN ARE SELECTED FOR INCLUSION IN A STUDY MERELY ON THE BASIS OF THEIR BODY LEAD LEVEL, IT IS LIKELY THAT THE SAMPLE SELECTED AS HIGH-LEAD WILL BE MORE DISADVANTAGED, AND THEREFORE WILL PERFORM LESS WELL ON PSYCHOMETRIC TESTS THAN CHILDREN HAVING LOWER LEAD LEVELS. IN ORDER TO BEGIN TO MAKE INFERENCES ABOUT CAUSALITY, IT MUST BE DEMONSTRATED THAT ANY DIFFERENCES IN THE PERFORMANCE BETWEEN LEAD GROUPS ARE DUE SOLELY TO DIFFERENCES IN LEAD, AND ARE NOT ATTRIBUTABLE TO SOME OTHER VARIABLE WHICH IS ASSOCIATED WITH PERFORMANCE ON THE OUTCOME MEASURE. THE METHODOLOGICAL PROBLEM FACING THE RESEARCHER IS TO CONTROL FOR, THAT IS, TO REMOVE THE INFLUENCE OF THESE EXTRANEOUS VARIABLES, SO THAT ANY EFFECTS DUE TO LEAD ARE APPARENT, (SMITH, 1985). THE SEEMING CONFLICT OF LEARNED OPINION ON THE EFFECTS OF LOW LEAD LEVELS APPEARS TO BE DUE TO EXTRANEOUS VARIABLES NOT BEING CONTROLLED FOR.



IT IS CLEAR THAT IN MOST CASES (BEFORE SOCIAL FACTORS ARE CONTROLLED) THERE IS AN ASSOCIATION BETWEEN HIGHER BODY LEVELS OF LEAD AND POORER PERFORMANCE ON IQ TESTS, EVEN AT BLOOD LEVELS AROUND 13 UG/DL. THE ASSOCIATION IS NOT FOUND BY ALL RESEARCHERS, AND IT IS LESS OFTEN NOTED WITH BEHAVIOUR. WHERE A LINK BETWEEN LEAD AND BEHAVIOUR HAS BEEN REPORTED, IT APPEARS TO BE WITH BEHAVIOUR AS MEASURED BY SCALES SUCH AS THAT OF NEEDLEMAN ET AL. (1971), WHICH ARE CORRELATED IQ MEASURES (YULE ET AL., 1982). IT IS CLEAR THAT THERE IS, IN MOST STUDIES, AN ASSOCIATION BETWEEN BODY BLOOD LEVELS AND SOME SOCIAL FACTORS, ALTHOUGH NOT ALWAYS WITH THE SOCIAL CLASS (SMITH, 1985). IT SEEMS THAT TO A CERTAIN EXTENT, AT LEAST, LEAD DOES ACT AS A MARKER FOR SOCIAL VARIABLES, AS CONTROLLING FOR SOCIAL FACTORS HAS THE EFFECT OF REDUCING DIFFERENCES BETWEEN GROUPS ON OUTCOME MEASURES. THE EFFECT OF THIS MORE SPECIFIC AND PREDICTIVE SOCIAL INFORMATION IS THAT, WHEN SOCIAL VARIABLES WHICH HAVE BEEN SHOWN TO CORRELATE SIGNIFICANTLY WITH OUTCOME MEASURES ARE CONTROLLED, MORE OF THE VARIANCE IS EXPLAINED, AND DIFFERENCES WHICH CAN BE ATTRIBUTED TO LEAD ARE NO LONGER STATISTICALLY SIGNIFICANT, ALTHOUGH THEY REMAIN IN THE SAME DIRECTION, (SMITH, 1983).

THE IMPLICATION OF THIS IS THAT IF THERE ARE ANY FUNCTIONAL EFFECTS OF LEAD ON IQ, LEARNING OR BEHAVIOUR AT THESE LOW LEVELS, THEN THEY ARE SMALL, AND IT MAY NOT BE POSSIBLE TO DETECT THEM WITH ANY CERTAINTY, AMID THE MUCH LARGER EFFECT OF SOCIAL INFLUENCES.

WHILE IT IS POSSIBLE THAT THE RESIDUAL DIFFERENCES WHICH REMAIN BETWEEN LEAD GROUPS ARE DUE TO LEAD, IT IS ALSO POSSIBLE THAT THEY ARE DUE TO SOCIAL FACTORS NOT MEASURED, OR AT LEAST NOT CONTROLLED, IN THE DATA. THERE ARE SOME INDICATIONS, SUCH AS COMMON FINDING THAT VERBAL IQ IS MORE AFFECTED THAN PERFORMANCE IQ, AND THE

constancy of the 5 to 7 point IQ difference, that the latter may be the case, (Smith, 1985).

The Centres for Disease Control in the United States issued a statement in 1985 on preventing lead poisoning in young children. They stated that:

1 An elevated blood lead level, which reflects excessive absorption of lead, is defined as a concentration of lead in the whole blood of 25 ug/dl or greater.

2 Lead toxicity is defined as an elevated blood level with an EP level in whole blood of 35 ug/dl or greater.

3 Lead is most harmful to children between the ages of 9 months and 6 years.

4 Ideally, all children should be screened.

Another aspect of the recent controversy about the health consequences of lead in petrol has been described by Elwood and Gallagher (1984) as a blurring of the distinction between science and social policy. They point out that the social policy on lead in the U.K. was formulated on the basis of very poor scientific evidence, and that scientists must bear a heavy responsibility for the paucity of good, relevant evidence. They go on to state that what was more worrying was that, while the controversy about lead was conducted under the aegis of science, largely non-scientific considerations seem to have been paramount. They feel that serious questions were raised on the role of science and the scientist in society, particularly as to how science should relate to social policy. They conclude that confusing them reduces



the contribution that science can make to effective policy. At the same time the relation between science and value judgements were inextricably linked, (Rutter, 1982).

This study examines the usefulness of screening children for blood lead attending a Child Guidance Clinic.

## Patients and Results

A consecutive sample of 40 new referrals to a Child Guidance Clinic in a disadvantaged suburban area of Dublin were screened for lead toxicity. Venous blood was used, venepuncture being carried out using lead-free syringes, and the blood being transferred to lead-free containers using EDTA. These were refrigerated and transported to the City Analyst's Laboratory, where the levels of lead and Erythrocytic Protoporphrin (EP) were estimated.

For the purpose of comparison, the results of lead and EP analysis of 37 blood samples from primary school children from a similar suburb of Dublin were used.

## Results

Permission was refused in 1 of 40 children, leaving a total of 39 to be studied. Lead levels were as tabulated in Figure 1, and EP levels as in Figure 2.

Figure 1.

BLOOD LEAD LEVELS

| | Sample Group | | | Control Group | | |
|---|---|---|---|---|---|---|
| Level ug/dl | Number | % | Cum % | Number | % | Cum % |
| < 10 | 14 | 35.9 | 35.9 | 20 | 54.1 | 54.1 |
| 10 - 19 | 22 | 56.4 | 92.3 | 17 | 45.9 | 100.0 |
| 20 - 30 | 2 | 5.1 | 97.4 | 0 | 0 | 100.0 |
| > 30 | 1 | 2.6 | 100.0 | 0 | 0 | 100.0 |

Figure 2.

EP LEVELS

| | Sample Group | | | Control Group | | |
|---|---|---|---|---|---|---|
| Level ug/dl | Number | % | Cum % | Number | % | Cum % |
| < 20 | 18 | 46.0 | 46.0 | 30 | 81.4 | 81.4 |
| 20 - 29 | 16 | 41.0 | 87.0 | 7 | 18.9 | 100.0 |
| 30 - 35 | 3 | 7.7 | 94.7 | 0 | 0 | 100.0 |
| > 35 | 2 | 5.3 | 100.0 | 0 | 0 | 100.0 |

THE MEAN BLOOD LEAD VALUE FOR THE SAMPLE GROUP WAS 12.06 UG/DL, AND FOR THE CONTROL GROUP 9.54 UG/DL; THE MEAN EP VALUE FOR THE SAMPLE GROUP WAS 22.23 UG/DL AND THE CONTROL GROUP 16.8 UG/DL. STATISTICALLY SIGNIFICANT DIFFERENCES WERE OBSERVED BETWEEN THE SAMPLE AND THE CONTROL GROUPS FOR THE MEASURED PARAMETERS, (FIGURE 3).



Figure 3.

BLOOD LEAD AND EP LEVELS FOR THE SAMPLE AND CONTROL GROUPS

| | Sample Group | | Control Group | | Z | p |
|---|---|---|---|---|---|---|
| Blood Lead ug/dl | | | | | | |
| | $\bar{X}$ | 12.1 | $\bar{X}$ | 9.45 | 2.77 | < 0.005 |
| | S.D. | 4.88 | S.D. | 3.02 | | |
| | N | 39 | N | 37 | | |
| Blood EP ug/dl | | | | | | |
| | $\bar{X}$ | 22.2 | $\bar{X}$ | 16.8 | 2.77 | < 0.005 |
| | S.D. | 10.6 | S.D. | 3.01 | | |
| | N | 39 | N | 37 | | |

P < 0.005 = statistically significant differences between mean values

HYPOTHETICALLY, THESE DIFFERENCES COULD BE EXPLAINED BY THE EXISTENCE OF BEHAVIOURAL FACTORS IN THE SAMPLE GROUP, PREDISPOSING THEM TO GREATER LEAD INTAKES FROM THEIR ENVIRONMENT, OR IT COULD BE THE RESULT OF ENVIRONMENTAL LEAD DIFFERENCES BETWEEN THEIR RESIDENTIAL LOCATIONS, OR A COMBINATION OF BOTH.

BLOOD LEAD LEVELS VARY WITH A NUMBER OF FACTORS, THE MOST RELEVANT HERE BEING THE LEVEL OF LEAD IN THE LOCAL ENVIRONMENT AS AFFECTED BY TRAFFIC FLOWS AND DISTANCE FROM THE CITY CENTRE, HOUSING CONDITIONS, THE INCIDENCE OF PICA AND BLOOD LEAD AGE DIFFERENCES. FIGURE 4 GIVES DETAILS OF THESE FACTORS FOR THE SAMPLE AND CONTROL GROUPS.

Traffic density was greater for the sample group area, resulting in greater environmental lead levels. Dust lead concentrations adequately represent environmental lead levels, and results for these locations determined during a dust monitoring study between 1981 and 1984 (Murphy, 1985) show these differences, (Figure 4).

Mean dust lead and mean blood concentrations for population groupings vary linearly (Murphy, 1987), and from the equation it was possible to make a theoretical estimate of the blood lead concentration resulting from environmental and dietary sources to the sample group, (Figure 5).

Dust lead, as a representative of environmental lead, predicts a mean blood lead concentration of 10.4 ug/dl for the sample group; meaning that body lead intakes from environmental sources (dust and air mainly) together with that from food, which is relatively constant for most groups (Murphy, 1985), would give this blood lead value, and that the remaining difference (12.06 - 10.4 = 1.66 ug/dl) results because of other factors.

About a third of the residences of the sample group were built before 1945, which very likely means a greater occurrence of flaking paint, more paint coats on painted surfaces indoor and outdoor, and a greater likelihood of lead-based paints.

Blood lead concentration is found to vary with age in the non-industrially exposed (Annest, 1983), with increased levels in the 2 - 5 age group and a gradual decline to the teens. The sample group included a number of children of this age, and the blood lead age effect is



evident as a consequence, (Figure 4). Excluding the 1 - 6 age group from the calculation of mean blood lead gives a markedly different result, (Figure 5).

Since the incidence of pica is age-related, these two factors must be taken together in estimating the blood lead increment which results because of them. The incidence of pica occurs in at least 50% of children up to the age of 3. In the sample, 4 out of 16 (25%) of the age group 1 - 6 had pica, which is about average. Another phenomenon of younger age children is the adventitious ingestion of lead by hand-to-mouth activity, dirty sweets, etc. This could result in considerable dust intakes; one estimate is 20 - 200 mg/day, (Duggan and Williams, 1977).

Therefore, by excluding children of age 1 - 6 from the mean blood lead calculation and, secondly, by determining the blood lead fraction resulting from the environment and diet only, almost all (except 0.4 ug/dl) of the difference in mean blood lead concentration between the sample and control groups is explained. This remaining difference is not statistically significant, and therefore does not indicate a relationship between blood lead and hyperactive behaviour in the sample group.

## Discussion

One child had a lead level of 40 ug/dl, with an EP level of 76 ug/dl, and was referred to the Paediatric Service for management. Murphy (1985) studied children living in Dublin and found that blood lead concentrations ranged from a mean value of 147 $\pm$ 4.5 ug/dl for city centre children. The mean blood lead for this study was 12.06 ug/dl and was within this range. Murphy also studied Erythrocyte Protoporphyrin concentrations in city centre

Figure 4.

COMPARISONS BETWEEN THE GROUPS

| | | Sample Group | | Control Group | |
|---|---|---|---|---|---|
| Distance of locality from city centre: | | 6.0 km | | 4.1 km | |
| Number of nearby thoroughfares: | | 2 (1 major, 1 through road) | | 2 (1 major, 1 through road) | |
| Average traffic flow for busy nearby roads. Vehicles per hour: | | 2,058 | | 1,676 | |
| Mean surface dust lead concentration for outdoor environment: | | 519 ppm | | 429 ppm | |
| House Conditions: | Age | 11% pre-1945 | | All post-1945 | |
| | Lead pipes | No | | Not reported | |
| | Flaking paint | 1 (low lead in patient) | | No | |
| Incidence of pica: | | 5 | | 0 | |
| Blood Lead ug/dl: | Number | 39 | | 37 | |
| | Mean | 12.06 | | 9.54 | |
| | Range | 5.9 - 31 | | 4.6 - 15.3 | |
| | S.D. | 4.9 | | 3.02 | |
| Blood EP ug/dl: | Number | 39 | | 37 | |
| | Mean | 21.08 | | 16.84 | |
| | Range | 10 - 74 | | 10 - 24 | |
| | S.D. | 10.08 | | 3.01 | |
| Blood Lead ug/dl: | Age 1 - 7 | $\bar{X}$ 15.0 ± 5.97 n = 16 | Age 6 - 7 | $\bar{X}$ 9.30 ± 2.76 n = 22 | p* 0.005 |
| | Age 8 - 16 | $\bar{X}$ 10.0 ± 2.55 n = 23 | Age 8 - 10 | $\bar{X}$ 9.75 ± 2.45 n = 15 | p* N.S. |
| Blood EP ug/dl: | Age 1 - 7 | $\bar{X}$ 24.1 ± 14.4 n = 16 | Age 6 - 7 | $\bar{X}$ 16.4 ± 3.05 n = 22 | p* 0.01 |
| | Age 8 - 16 | $\bar{X}$ 20.0 ± 6.6 n = 23 | Age 8 - 10 | $\bar{X}$ 11.5 ± 4.39 n = 15 | p* N.S. |



CHILDREN, AND THESE VALUES RANGED FROM 19.5 ± 9.1 UG/DL FOR CITY CENTRE CHILDREN. THE MEAN EP OF 76 UG/DL PRESENTED WITH HYPERACTIVE BEHAVIOUR AND IT HAS BEEN HYPOTHESISED THAT LEAD IS RELATED TO HYPERACTIVITY IN CHILDREN. HOWEVER, THIS HYPOTHESIS IS NOT SUPPORTED BY PREVIOUS LEAD STUDIES AS VERY FEW, IF ANY, HAVE REPORTED SUCH AN ASSOCIATION, (SMITH, 1985).

STUDIES OF THIS NATURE USUALLY INCLUDE LARGE POPULATIONS, WITH MORE STRINGENT CONTROL IN THE CHOOSING OF SAMPLE AND CONTROL SUBJECTS. NOTWITHSTANDING THESE SHORTCOMINGS, THIS INVESTIGATION WAS SUFFICIENTLY THOROUGH IN DEMONSTRATING THE WEAKNESS OF THE HYPOTHESIS THAT LEAD LEVELS OCCURRING IN HYPERACTIVE CHILDREN ARE A CONSEQUENCE OF THEIR HYPERACTIVITY.

YOUNGER CHILDREN IN THE SAMPLE GROUP HAD A SIGNIFICANTLY GREATER MEAN BLOOD LEAD CONCENTRATION (15.0 UG/DL) THAN THE OLDER CHILDREN (10.0 UG/DL). THE REASONS PUT FORWARD FOR THIS ARE (I) THE HABIT OF PICA; (II) GREATER HAND TO MOUTH ACTIVITY; (III) A LESSER AWARENESS OF CHEWING AND EATING OBJECTS WHICH MAY BE UNHYGIENIC, E.G. DIRTY SWEETS AND CHEWING GUM; (IV) GREATER GUT ABSORPTION OF LEAD. SINCE THIS AGE GROUP WERE EXCLUDED IN THE CONTROL CALCULATIONS (SEE RESULT SECTION AND FIGURE 5), IT COULD BE ARGUED THAT AT LEAST SOME OF THE APPARENTLY LARGE DIFFERENCES IN MEAN BLOOD CONCENTRATION BETWEEN THE AGE GROUPS COULD BE DUE TO INCREASED LEAD INTAKES BECAUSE OF THE ABOVE FACTORS (I.E. I - III) POTENTIATED BY HYPERACTIVITY IN THIS 1 TO 6 AGE GROUP. EVIDENCE ON BLOOD LEAD LEVELS FROM SIMILAR AGED CHILDREN FROM OTHER STUDIES DOES NOT SUGGEST THAT HYPERACTIVITY IS A POTENTIATING FACTOR IN THIS CASE, (D.O.E. U.K. 1978 STARK ET AL, 1982: RICHARDSON, 1982). THE MOST COMPARABLE WAS A STUDY CARRIED OUT IN DUBLIN BY RICHARDSON (1982) WHO FOUND A DIFFERENCE OF 3.38 UG/DL

BETWEEN AGE 3 - 5 (17.86 UG/DL) AND AGE 6 - 8 (14.48 UG/DL) FOR CITY CENTRE CHILDREN. THE PRESENT STUDY GROUP INCLUDED SOME CHILDREN LESS THAN 3 YEARS OLD, WHICH COULD ACCOUNT FOR THE LARGER DIFFERENCES FOUND HERE THAN FOUND BY RICHARDSON.

HAVING EXCLUDED AGE GROUP 1 - 6 FROM THE CALCULATION OF THE MEAN FOR THE SAMPLE GROUP ONE IS LEFT WITH A RESULT WHICH IS ONLY 1.34 UG/DL GREATER THAN THE CONTROL POPULATION, AND NOT STATISTICALLY SIGNIFICANT.

CONSIDERING ALSO THAT THE SAMPLE GROUP LOCATION IS REGARDED AS SOCIO-ECONOMICALLY MORE DISADVANTAGED THAN THE CONTROL GROUP LOCATION, AND MINDFUL OF THE FACT THAT BLOOD IS TO SOME DEGREE A MARKER OF SOCIAL DISADVANTAGE, IT IS POSSIBLE THAT THE HIGHER ENVIRONMENTAL LEAD AND BLOOD LEVELS ARE COINCIDENTAL TO THIS GROUP, AND MUCH LESS LIKELY TO BE THE CAUSATIVE AGENT IN CHILD BEHAVIOUR PROBLEMS.

AS FAR AS CHILD GUIDANCE CLINIC CHILDREN ARE CONCERNED, THE HIGHEST PRIORITY FOR SCREENING SHOULD BE GIVEN TO YOUNGER CHILDREN WHO LIVE IN OR FREQUENTLY VISIT OLDER DILAPIDATED HOUSING, WHO LIVE NEAR SMELTERS OR OTHER INDUSTRIAL SOURCES OF LEAD, OR WHOSE PARENTS WORK WITH MATERIALS CONTAINING LEAD, FOR EXAMPLE, BATTERIES.

THE IRISH DECISION TO REDUCE THE LEVEL OF LEAD IN PETROL FROM 0.4 TO 0.15 GRAMMES PER LITRE SHOULD REDUCE THE BLOOD LEAD LEVELS, PARTICULARLY FOR THOSE CHILDREN WHO LIVE IN URBAN ENVIRONMENTS.

IN THE UNITED STATES, BETWEEN 1976 AND 1980, THE OVERALL MEAN BLOOD LEVELS DROPPED FROM 14.6 UG/DL TO 9.2 UG/DL, AND THIS CORRESPONDED WITH THE DECLINE IN THE



SALES OF LEADED GASOLINE DURING THIS PERIOD, (ANNEST, 1983).

AS FAR AS THE DEBATE IS CONCERNED ABOUT SCIENTIFIC EVIDENCE AND SOCIAL POLICY, IT WOULD APPEAR THAT SOCIAL POLICY DECISIONS HAVE TO BE TAKEN BEFORE THERE IS ABSOLUTE SCIENTIFIC EVIDENCE, EVEN IF THERE IS ONLY A RISK TO THE POPULATION IN THE MEANTIME.

Figure 5.

Comparing mean blood lead concentrations for the groups after controlling for environmental and age/lead related factors and the incidence of pica

| | Sample Group | Control Group |
|---|---|---|
| Theoretical estimate of blood lead based on a blood lead/dust lead relationship | 10.4 ug/dl | 9.61 ug/dl |
| Difference between actual and theoretical | 1.66 ug/dl | 0.07 ug/dl |
| Mean blood concentration excluding children with pica | 11.1 ug/dl | 9.54 ug/dl |
| Difference between the whole group and the group minus pica subjects | 0.96 ug/dl | 0.0 ug/dl |
| Excluding age group 1 - 6 in the sample population | 10.8 ug/dl | 9.54 ug/dl |
| Difference between the whole group and the group minus age 1 - 6 subject | 1.26 ug/dl | 0.0 ug/dl |
| Mean blood lead excluding age 1 - 6 subject minus theoretical blood lead mean from dust Pb/blood Pb relationship | (10.8 - 10.4) 0.4 ug/dl | |

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# THE PREVALENCE OF PHYSICAL AND SOFT NEUROLOGICAL SIGNS IN A CHILD GUIDANCE CLINIC AND NORMAL SCHOOL POPULATIONS

MICHAEL FITZGERALD; MICHAEL O'ROURKE; RACHEL WATERS.

## SUMMARY

AN EXAMINATION OF A CONSECUTIVE SAMPLE OF 40 CHILD GUIDANCE CLINIC REFERRALS SHOWED A HIGH PREVALENCE OF UPPER RESPIRATORY INFECTIONS (WHICH WAS PROBABLY SEASONAL), TOOTH DECAY, CROSS LATERALITY AND SOFT NEUROLOGICAL SIGNS. WHEN A PROPORTION OF THE SAMPLE WERE AGE AND SEX MATCHED TO A SCHOOLS' MEDICAL EXAMINATION GROUP, THE PREVALENCE OF SOFT NEUROLOGICAL SIGNS WAS FOUND TO BE SIGNIFICANTLY INCREASED IN THE CHILD PSYCHIATRIC SAMPLE.

> "SOUL AND BODY, AS IT SEEMS TO ME, ARE AFFECTED SYMPATHETICALLY ONE ANOTHER; ON THE ONE HAND, AN ALTERATION IN THE STATE OF THE SOUL PRODUCES AN ALTERATION IN THE FORM OF THE BODY AND, CONTRARIWISE, AN ALTERATION IN THE BODILY FORM PRODUCES AN ALTERATION IN THE STATE OF THE SOUL." (ARISTOTLE, "DE ANIMA").

IT HAS BEEN SHOWN THAT THERE IS CONSIDERABLE PHYSICAL ILLNESS IN PATIENTS ADMITTED TO AN ADULT PSYCHIATRIC UNIT, (MAGUIRE AND GRANVILLE - GROSSMAN, 1968). AT THE AGE OF 7 YEARS SOFT NEUROLOGICAL SIGNS ARE A GOOD PREDICTOR OF LATER PROBLEMS IF DISTURBED

BEHAVIOUR IS ALSO PRESENT, (SHAFFER, SCHONFELD, O'CONNOR, STOKMAN, TRAUTMAN, AND SHAFFER, 1985B). A BLIND STUDY USING STANDARDISED MEASURES AMONG ADULT PSYCHIATRIC IN-PATIENTS (QUITKIN ET AL, 1976) INDICATED THAT SOFT SIGNS ARE FOUND MORE OFTEN IN SCHIZOPHRENICS WITH A HISTORY OF SOCIAL DIFFICULTIES IN CHILDHOOD, AND IN PATIENTS WITH LABILE MOOD DISORDERS. THE ORIGINS OF NEUROLOGICAL SOFT SIGNS ARE UNKNOWN, BUT THERE IS SOME EVIDENCE THAT THEY ARE GENETICALLY DETERMINED. NICHOLS AND CHEN (1981) FOUND 66% CONCORDANCE IN MONOZYGOTIC TWINS AND 29% IN DIZYGOTIC TWINS. SUCH SIGNS INCLUDE INVOLUNTARY MOVEMENTS OF A CHOREIC OR ATHETOID TYPE, MOTOR ABNORMALITIES SUCH AS SYNKINESIS, DYS-DIADOKOKINESIS AND GENERAL CLUMSINESS. THE PRACTICE OF INCLUDING A MEDICAL EXAMINATION WITH THE INITIAL ASSESSMENT OF A CHILD PRESENTING AT A CHILD PSYCHIATRIC CLINIC REMAINS CONTROVERSIAL. IT HAS BEEN ASSERTED THAT THE RELATIONSHIP A CHILD DEVELOPS WITH THE INTERVIEWER WOULD BE CONTAMINATED BY FEELINGS OF SHAME OR EXCITEMENT DURING THE PHYSICAL EXAMINATION, (MCDONALD, 1965; CRAMER, 1980). ON THE OTHER HAND, A PHYSICAL EXAMINATION OF THE CHILD PRESENTING AT A CHILD PSYCHIATRIC CLINIC HAS BEEN REGARDED AS ESSENTIAL FOR A FULLER APPRAISAL, (HILL, 1985). THIS STUDY SEEKS TO DOCUMENT THE LEVEL OF PHYSICAL ILLNESS, INCLUDING SOFT NEUROLOGICAL SIGNS, IN CHILDREN PRESENTING AT A CHILD PSYCHIATRIC CLINIC. IT ALSO COMPARES A SUB-SAMPLE OF THESE CHILDREN WITH AN AGE AND SEX MATCHED PUBLIC HEALTH EXAMINATION.

## METHODS

A CONSECUTIVE SAMPLE OF 40 NEW REFERRALS TO A CHILD GUIDANCE CLINIC FOR CHILDREN WITH BEHAVIOUR DISORDERS WERE EXAMINED PHYSICALLY. A PROPORTION OF THE WHOLE



CLINIC GROUP WAS TAKEN AND AGE AND SEX MATCHED WITH SCHOOL CHILDREN FROM A SOCIALLY AND ECONOMICALLY SIMILAR URBAN AREA, AND DATA BEING RANDOMLY DRAWN FROM THE SCHOOL MEDICAL EXAMINATION. IN THIS PAPER THE SCHOOL GROUP WILL BE REFERRED TO AS CONTROLS, AND THE CORRESPONDING CHILDREN FROM THE CLINIC AS THE CHILD GUIDANCE CLINIC GROUP. THE MEDICAL EXAMINATION CONSISTED OF A FULL PHYSICAL EXAMINATION, HEARING AND VISION TESTS BY THE STYCAR METHOD AND AN EXAMINATION FOR SOFT NEUROLOGICAL SIGNS. ALL THE CLINIC PATIENTS WERE EXAMINED BY M. O'R. AND ALL THE CONTROLS BY R. W.

## RESULTS

ONE CHILD OF THE 40 REFUSED TO BE EXAMINED. THUS, THE SAMPLE CONSISTED OF 39 CHILDREN IN THE CLINIC EQUIVALENT GROUP, OF WHICH 18 WERE MATCHED WITH CONTROLS.

Figure 1.

| | MAXIMUM | MINIMUM |
|---|---|---|
| AGE yrs | 16 | 1 11/12 |
| HEIGHT cms | 167 | 84 |
| WEIGHT kg | 60 | 10 |

Figure 1 demonstrates the range in values of age, height and weight.

There were 17 cases (43.6%) in the child guidance clinic groups and 8 cases (20.5%) in the control group with soft neurological signs, ($p < 0.01$).

## Discussion

It was possible to substantiate Levy's (1929) finding that a full physical examination created an opportunity for the child to elaborate on his perception of himself and his body, with the exception of one case where the physical examination was refused. The objections to physical examinations outlined earlier were not substantiated and the physical examination did not interfere with the relationship between the psychiatrist and the child. Indeed, the positive findings are further evidence of the value of carrying out physical examination in child psychiatric patients.

Figure 2.

| | CONTROLS | | CLINIC EQUIVALENTS | | P |
|---|---|---|---|---|---|
| | Maximum | Minimum | Maximum | Minimum | |
| AGE yrs | 12.2m | 5.1m | 12.3m | 5.1m | N.S. |
| HEIGHT cms | 144 | 100 | 147 | 100 | N.S. |
| WEIGHT kg | 36 | 10 | 38 | 10 | N.S. |

Figure 2 demonstrates the matching on age, height and weight of the controls and the child guidance clinic. The following sub-sections of the physical examination showed no abnormality: skeletal, heart, abdomen and eyes.



Figure 3

PHYSICAL ABNORMALITIES (Numbers)

| | Controls | Child Guidance | P |
|---|---|---|---|
| Skin/hair | 3 | 1 | N.S. |
| Skeletal | 0 | 0 | N.S. |
| Ears | 2 | 7 | 0.1 |
| Hearing | 1 | 4 | N.S. |
| Nasal | 1 | 11 | 0.01 |
| Throat | 4 | 4 | N.S. |
| Teeth | 5 | 6 | N.S. |
| Heart | 0 | 0 | N.S. |
| Respiratory | 0 | 2 | N.S. |

Figure 3 demonstrates the level of physical abnormality in the control and child guidance clinic groups.

THE HIGH PREVALENCE OF UPPER RESPIRATORY INFECTION IN THE WHOLE CLINIC EQUIVALENT GROUP WAS PROBABLY RELATED TO THE TIME OF YEAR (AUGUST TO FEBRUARY) IN WHICH THE REFERRALS WERE SEEN. WHEN THE RECORDS WERE EXAMINED, IT WAS FOUND THAT MOST OF THE CONTROLS HAD BEEN EXAMINED IN THE MONTH OF JUNE. THIS SEASONAL VARIATION IS THE LIKELY REASON FOR THE SIGNIFICANT ($p > 0.01$) INCREASE IN CASES WITH NASAL ABNORMALITY IN THE CHILD GUIDANCE CLINIC GROUP.

THE HIGH PREVALENCE OF TOOTH DECAY (30.8%) IN THE WHOLE CHILD GUIDANCE CLINIC GROUP, CORRESPONDING TO A SIMILAR PREVALENCE IN THE CONTROL GROUP, DEMONSTRATES THE NEED FOR PREVENTIVE DENTAL CARE IN BOTH GROUPS.

SOFT NEUROLOGICAL SIGNS WERE PRESENT IN 43.6% OF THE CHILD GUIDANCE CLINIC GROUP. IT MAY BE THAT, IN THE LONG TERM, THIS 43.6% OF THE CHILD GUIDANCE CLINIC GROUP WITH PSYCHIATRIC PROBLEMS AND SOFT SIGNS ARE MORE AT RISK FOR LONG TERM PROBLEMS, AND THEREFORE NEED DETAILED LONG TERM CLINICAL MONITORING. THESE SOFT NEUROLOGICAL SIGNS COULD THEREFORE HAVE POTENTIAL VALUE FOR PREVENTIVE CHILD PSYCHIATRY.



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# PREVALENCE OF CHILDHOOD AUTISM IN IRELAND

PAUL MCCARTHY; MICHAEL FITZGERALD; MARIE ANN SMITH.

## SUMMARY

BY CONTACTING ALL THE AGENCIES WHO WOULD HAVE KNOWLEDGE OF AUTISTIC CHILDREN IN THE EASTERN SECTION OF IRELAND, A RATE OF 4.3 AUTISTIC CHILDREN PER 10,000 CHILDREN IN THE AGE GROUPS 8, 9 AND 10 YEARS WAS OBTAINED. THESE FINDINGS ARE SIMILAR TO THOSE FROM OTHER EUROPEAN COUNTRIES. THEY WERE SPREAD EVENLY ACROSS THE SOCIAL CLASSES. HOWEVER, USING THE MULTI-AXIAL CLASSIFICATION SYSTEM, IT BECAME APPARENT THAT WHEN WE SPLIT OFF THOSE AUTISTIC CHILDREN WHO WERE ALSO PROFOUNDLY MENTALLY HANDICAPPED, OR THOSE WHOSE DISORDER WAS UNDERSTANDABLE IN TERMS OF SOCIAL OR BIOLOGICAL FACTORS, THE AUTISM LOCATED VERY DEFINITELY IN THE MORE AFFLUENT SOCIAL GROUP.

THE USE OF THE MULTI-AXIAL CLASSIFICATION IS POSSIBLY ONE WAY OF REFINING THE DIAGNOSIS OF NUCLEAR AUTISM.

IRELAND HAS A HIGHER NUMBER OF PSYCHIATRIC BEDS PER HEAD OF POPULATION THAN ANY OTHER COUNTRY FOR WHICH STATISTICS HAVE BEEN GATHERED, THE FIGURES BEING 415 PER 100,000 POPULATION IN IRELAND[1] AS AGAINST 171 PER 100,000 IN ENGLAND. THIS MAY REFLECT THE INADEQUACIES OF DOMICILIARY FACILITIES IN IRELAND, OR THE USE OF PSYCHIATRIC HOSPITALS FOR THE GERIATRICALLY INFIRM AND MENTALLY HANDICAPPED. OF COURSE, IT MIGHT ALSO REFLECT

A HIGHER PSYCHIATRIC MORBIDITY IN IRELAND AND, INDEED, THERE HAVE BEEN STUDIES IN THE PAST DECADE WHICH HAVE SUGGESTED QUITE A HIGH RATE OF SCHIZOPHRENIC BREAKDOWN IN YOUNG IRISH MALES. MORE RECENTLY PUBLISHED WORK, HOWEVER, THROWS DOUBT ON THE RELIABILITY OF THESE EARLIER STUDIES AND, IN FACT, TENDS TO DEMONSTRATE A SCHIZOPHRENIC INCIDENCE RATE NOT UNLIKE THAT FOUND IN THE UNITED KINGDOM.[2] CONNOLLY[3] HAS SHOWN THAT THE INCIDENCE OF DOWN'S SYNDROME IN IRELAND, AT 1.70 PER 1,000 LIVE BIRTHS, IS SIMILAR TO THAT REPORTED FROM THE UNITED KINGDOM OF 1.61 PER 1,000 LIVE BIRTHS[4] AND TO THE REPORT OF 1.66 PER 1,000 LIVE BIRTHS IN A SURVEY OF THE INTERNATIONAL LITERATURE ON THE SUBJECT, (COMMUNICATION BY VAN DEN BERGH, H.)

A PREVALENCE STUDY OF CHILDHOOD AUTISM WAS CARRIED OUT, WITH A VIEW TO CLARIFYING THE EXTENT OF CHILD PSYCHIATRIC MORBIDITY IN IRELAND. THE METHOD OF DATA COLLECTION USED IN THIS STUDY WAS DEVELOPED BY BRASK IN ARRHUS[5]. BRASK CONTACTED ALL THE CHILD PSYCHIATRISTS AND INSTITUTIONS IN HER AREA. THIS WAS IN THE ASSUMPTION THAT THEY WOULD KNOW ANY CHILD WITH AS SERIOUS A DISORDER AS CHILDHOOD AUTISM. USING THIS METHOD, SHE ARRIVED AT A SIMILAR PREVALENCE RATE TO THAT OF WING AND LOTTER IN MIDDLESEX[6]. THESE INVESTIGATORS HAD DONE A MUCH MORE EXHAUSTIVE SURVEY, IN WHICH EVERY CHILD AGED 8, 9 OR 10 YEARS IN MIDDLESEX (A TOTAL OF 78,000 CHILDREN) HAD BEEN SCREENED.

## METHOD

A LETTER WAS SENT TO EVERY CONSULTANT CHILD PSYCHIATRIST IN IRELAND, AND ALSO TO EVERY INSTITUTION WHERE IT WAS FELT THERE WAS EVEN THE REMOTEST CHANCE THERE MIGHT BE AN AUTISTIC CHILD WHO HAD BEEN BORN IN THE EASTERN HEALTH



BOARD AREA. MOST OF THE CHILDREN IN THIS AREA ARE CATERED FOR LOCALLY, BUT THE AUTHORS WERE AWARE THAT CERTAIN CHILDREN HAD BEEN PLACED IN OTHER PARTS OF THE COUNTRY; HENCE OUR COUNTRYWIDE SEARCH. THESE LETTERS WERE FOLLOWED UP BY PHONE CALLS.

ONE OR OTHER OF THE AUTHORS VISITED EACH OF THE CENTRES WHEREIN WE HAD LOCATED AUTISTIC CHILDREN. CASE NOTES WERE PERUSED, THE CHILD WAS OBSERVED IN VARIOUS ACTIVITIES OVER THE COURSE OF A FEW HOURS, AND DISCUSSIONS WERE HELD WITH THE MORE EXPERIENCED NURSING AND TEACHING PERSONNEL.

ALL CHILDREN WHO WERE AGED 8, 9 OR 10 YEARS ON 18TH APRIL, 1978 WERE INCLUDED IN THIS STUDY. WE, THEREFORE, STUDIED ALL AUTISTIC CHILDREN WHOSE BIRTHDAYS LAY BETWEEN 19TH APRIL, 1965 AND 18TH APRIL, 1968.

AFTER DISCUSSION OF THE FINDINGS, WE INCLUDED IN OUR STUDY ALL THOSE CHILDREN WHOM WE CONSIDERED FULFILLED THE FOLLOWING CRITERIA:-

(1) ONSET BEFORE 30 MONTHS.

(2) A PROFOUND AND GENERAL FAILURE TO DEVELOP SOCIAL RELATIONSHIPS.

(3) MARKED DELAY IN THE DEVELOPMENT OF LANGUAGE SKILLS AND SUBSEQUENT MARKED ABNORMALITY IN THE COMPREHENSION AND USE OF EITHER VERBAL OR NON-VERBAL LANGUAGE.

(4) AN INSISTENCE ON SAMENESS: USUALLY INFERRED FROM THE PRESENCE OF RITUALISTIC OR COMPULSIVE PHENOMENA AND THE INTENSE DISTRESS INDUCED BY INTERFERENCE IN SAME.

## Type of Data Collected

This was essentially a head count exercise, and so the data collected were primarily that which would enable us to make a clinical diagnosis of childhood autism. A detailed investigation and description of the sample awaits Phase II of our study.

## Multi-axial Classification

This system of descriptive classification is being used increasingly in child psychiatry, and we used it to describe the cohort of 28 children located.

(1) Clinical Psychiatric Axis: Using the criteria outlined, all of the children were clearly autistic on the axis.

(2) Intelligence Axis: There was a group of these same children in whom the degree of mental handicap was as of important significance as was the clinical psychiatric state. Indeed, the child's place on this axis can pose a particular difficulty when assessing some of the features necessary for making the clinical psychiatric diagnosis.

(3) Biological/Social Axis: With certain of the children we were so impressed with the importance of factors in these axes that we described a third sub-group. These would be autistic children in whom such factors as, e.g., death of a parent, growing up in an institution, etc. would seem to have been of major aetiological significance.



## Results

There were 65,000 children born in the Eastern Health Board area of Ireland in the three years that concerned us. The population movement in the subsequent ten years was negligible. Twenty-eight children were located. This gave a prevalence rate of 4.31 per 10,000 children.

The Multi-Axial Classification system divided the 28 children into the following sub-groups:-

(1) Classical nuclear autism, 50%.

(2) Autism plus profound mental handicap, 29%.

(3) Autism plus equally significant biological and/or psycho-social factors, 21%.

It was interesting to compare these results with the Middlesex and Arrhus studies.

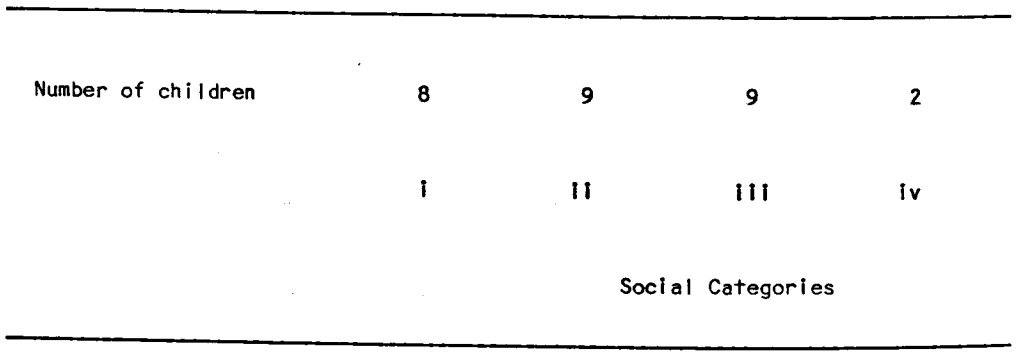
Table 1.

| | | Middlesex | Arrhus | Dublin |
|---|---|---|---|---|
| Rate per 10,000 | NUCLEAR AUTISM | 2.1 | | 2.2 |
| | TOTAL | 4.5 | 4.3 | 4.3 |
| | Age of onset less than ..... years | 3 | 6 | 2½ |

## Social Status

The three Dublin sub-groups defined by the Multi-Axial Classification system were examined in terms of parental social status, and also of sex distribution: Fathers were placed on a 4-point scale of socio-economic position in society, ranging from the successful business and professional person in category one, to the unemployed bricklayer in category four. See Histogram 1.

Histogram 1.

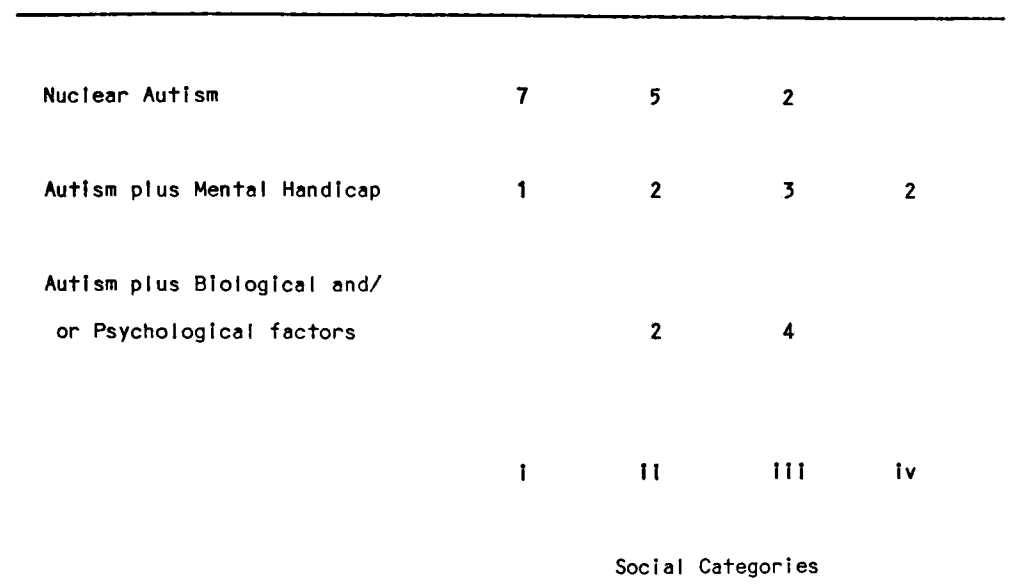



This shows the 28 children in a fairly broad scatter across the social groups, with 8 children in category I, 9 in category II, 9 in category III and 2 in the lowest category, i.e. IV.

When the samples are broken down into the three broad groups that the Multi-Axial Classification had identified, the children diagnosed as "nuclear autism" come mainly from the upper social brackets. See Histogram 2.



Histogram 2




Interestingly, the Histogram shows that the group who had been previously categorised as profoundly mentally handicapped tended to be in the lower social categories. Those whose autism was accompanied by significant factors in the biological and/or social axes of the Multi-Axial Classification tended to fall in between. These diagnostic sub-divisions were made before looking at social class.

## Sex Distribution

There were 16 boys and 12 girls, i.e. a sex ratio of 1.3 : 1. In the Danish Study, the ratio was 1.4 : 1. Both findings were low, relative to Lotter's Middlesex Study where a ratio of 2.55 : 1 had been found.

In the nuclear group, the ratio changed in our study to 1.8 : 1. This is still low, however; in Lotter's

NUCLEAR GROUP THE RATIO WAS ACTUALLY 2.75 : 1. SEE HISTOGRAM 3.

Histogram 3.

| | BOYS | GIRLS |
|---|---|---|
| Nuclear Autism | 9 | 5 |
| Autism plus Mental Handicap | 3 | 5 |
| Autism plus Biological and/or Psychological factors | 4 | 2 |

## SPEECH

OUR FINDINGS ARE IN KEEPING WITH THOSE OF BOTH LOTTER AND BRASK. SEE TABLE 2.

Table 2.

Percentage of patients who are mute

| | |
|---|---|
| Total Cohort | 54% |
| Nuclear Autism | 43% |
| Autism plus Profound Mental Handicap | 75% |
| Autism plus Biological and/or Social factors | 50% |



## DISCUSSION

AUTISM IS SUCH A SEVERE CONDITION THAT IT IS NOT LIKELY TO BE MISSED BY THE MEDICAL SERVICES. IN LOTTER'S [6] TOTAL POPULATION STUDY ONLY ONE CHILD WAS FOUND WHO HAD BEEN UNKNOWN TO THE MEDICAL SERVICES. IT COULD BE THAT THE INCIDENCE OF AUTISM IS HIGHER IN IRELAND BUT THAT THE SCHOOLS, NOT HAVING A SCHOOL PSYCHOLOGICAL EDUCATIONAL SERVICE, TEND TO COPE UNWITTINGLY WITH THE BRIGHTER AUTISTIC CHILDREN. HOWEVER, THIS SEEMS HIGHLY UNLIKELY WHEN ONE CONSIDERS THE NUMBERS OF MUCH LESS SERIOUSLY DISTURBED CHILDREN WHO ARE REFERRED TO THE CHILD PSYCHIATRIC SERVICES BY THE SCHOOL MEDICAL SERVICES. IT COULD ALSO BE ARGUED THAT THERE WAS A TENDENCY FOR AUTISTIC CHILDREN, SINCE THEY ARE IN THE SOCIO-ECONOMICALLY MORE SUCCESSFUL GROUPS OF THE POPULATION, TO BE IN PRIVATE SCHOOL SETTINGS. THESE SCHOOLS ARE NOT VISITED BY THE SCHOOL MEDICAL SERVICES AS A ROUTINE MATTER.

ONCE AGAIN, HOWEVER, BECAUSE AUTISM IS SUCH A SEVERE CONDITION TEACHERS AND, INDEED, PARENTS WITH THESE CHILDREN SEEK ADVICE FROM PRIVATE CHILD PSYCHIATRY, AND ALL CHILD PSYCHIATRISTS IN PRIVATE PRACTICE WERE CONTACTED IN THIS STUDY.

WHEN KANNER[7] PRODUCED HIS INITIAL STUDY, IT WAS THOUGHT THAT HIS COMMENTS ON SOCIAL GROUPINGS WERE BIASED, BECAUSE OF THE SPECIFIC INTAKE WITH WHICH HIS ACADEMIC DEPARTMENT DEALT. THIS SCEPTICISM HAS CHANGED OVER THE YEARS, WITH MANY OTHER STUDIES SHOWING THE TENDENCY OBSERVED BY KANNER. IN IRELAND, THE PROVISION OF SERVICES TO MENTALLY HANDICAPPED AND PSYCHOTIC CHILDREN IS INDEPENDENT OF CLASS. ALL OUR MENTALLY HANDICAPPED AND AUTISTIC CHILDREN ARE KNOWN AND ARE TREATED BY THE SAME SERVICES. THESE FIGURES, THEREFORE,

CLEARLY INDICATE A TENDENCY FOR AUTISM TO BE FOUND MORE FREQUENTLY IN THE MORE AFFLUENT IN THIS SOCIETY.

IT SHOULD BE BORNE IN MIND THAT ALL THE CHILDREN INCLUDED IN THIS STUDY WERE IN SPECIAL INSTITUTIONS AT THE AGE OF 8, 9 AND 10 YEARS, AND HAD CLEARLY BEEN PSYCHOTIC BEFORE THE AGE OF THIRTY MONTHS; IN OTHER WORDS, THEY HAD AN ILLNESS OF AT LEAST SIX YEARS' DURATION AT THIS STAGE.

IN BRASK'S STUDY, THE ACCEPTED AGE OF ONSET WAS "UNDER TEN YEARS." SHE WAS SEEKING ALL PSYCHOTIC DISORDERS WITH A MINIMUM DURATION OF TWO YEARS, BUT WHEN SHE EXAMINED HER DATA IN TERMS OF THE AUTISTIC SYNDROME, THE AGE OF ONSET WAS TAKEN TO BE UNDER SIX YEARS. IN FACT, SHE FOUND THAT THREE-QUARTERS OF HER CHILDREN HAD AN ONSET OF UNDER THIRTY-SIX MONTHS.

BEARING IN MIND THAT, IN DUBLIN, WE COUNTED ONLY THOSE CHILDREN WHOSE AGE OF ONSET WAS UNDER THIRTY MONTHS IT IS, PERHAPS, A LITTLE SURPRISING THAT WE FOUND AS MANY AS WE DID. HOWEVER, BRASK ONLY COUNTED THOSE CHILDREN RESIDING IN HER AREA; POSSIBLY SOME, ESPECIALLY THOSE WITH HIGHER IQ'S, MAY HAVE BEEN SENT TO INSTITUTIONS ELSEWHERE.

THIS STUDY SUPPORTS THE GENERAL EVIDENCE THAT MAJOR PSYCHIATRIC ILLNESSES ARE NO MORE COMMON IN IRELAND THAN ELSEWHERE.



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# FIRST IRISH FAMILY WITH THE FRAGILE X SYNDROME

MIGUEL A. DE ARCE; MICHAEL FITZGERALD.

## INTRODUCTION

ALTHOUGH THE FRAGILE X SYNDROME WAS FIRST DESCRIBED IN 1977 (HARVEY ET AL.), AND THE CONDITIONS REQUIRED FOR ITS DETECTION IN CULTURED LYMPHOCYTES WERE DETERMINED BY SUTHERLAND THAT SAME YEAR (SUTHERLAND, 1977) THERE HAD NOT BEEN ANY FAMILY FORMALLY REPORTED IN THIS COUNTRY UP TO 1984. THIS IS ALL THE MORE SURPRISING SINCE THE SYNDROME APPEARS TO BE QUITE FREQUENT, (PREVALENCE 0.55/1,000 MALES) (SHERMAN ET AL., 1984). IF THIS FIGURE CAN BE APPLIED TO THE IRISH POPULATION, AND ASSUMING NO DECREASE IN THE VIABILITY OF FRAGILE X CONCEPTUSES, APPROXIMATELY 20 BOYS PER YEAR ARE BORN WITH THE FRAGILE X IN THIS COUNTRY.

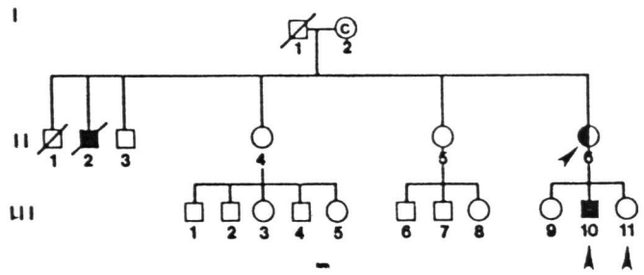
WE REPORT HERE THE FINDING OF THE FIRST IRISH FAMILY WHERE THE FRAGILE X CHROMOSOME IS SEGREGATING TOGETHER WITH MENTAL RETARDATION.

## FAMILY HISTORY

THE INDEX CASE IS A SIX-YEAR OLD BOY, WHO WAS DIAGNOSED IN A SURVEY IN SEARCH OF THE FRAGILE X CHROMOSOME IN MENTALLY RETARDED CHILDREN WITH AUTISTIC FEATURES, CARRIED OUT IN A SPECIAL SCHOOL FOR AUTISTIC AND MENTALLY RETARDED CHILDREN.

Of his two sisters (see Figure 1) aged seven and three years respectively, and developing normally, the younger is a carrier, (also 25% fragile X).

Figure 1.




Cytogenetic studies were carried out on the three children. One hundred cells were studied in each case. The proband and her younger sister showed the fragile X in TC 199 in 30 and 25% of their cells respectively. Of the younger sister's fragile X chromosomes, 80% were early replicating, as demonstrated by R-banding with Bromodeoxyuridine, (Figure 2).

The older sister can be excluded as a carrier, since no fragile X was found in 400 metaphases. This would have detected fragile X present with a frequency of 1% or more, with a probability of 99%, (De Arce, 1983). The mother also showed the fragile X, but with lower frequency (1%). Her intelligence has not been formally tested, although she is apparently normal and has reared three children. She had a brother "very slow at school," who died at the age of 28, unmarried.



Two of the mother's sisters have had a total of eight children, all of them holding jobs at present and of apparently normal intelligence. The mother has another brother working in the U.S.A., who is a bachelor. The medical history on the paternal side is unremarkable.

Figure 2.

Both sisters of the proband are reported to be bright, cheerful children who are doing well at school and do not have problems associating with their classmates.

Physically there is little remarkable about the boy, except perhaps a prominent forehead. He moves freely and displays a high activity level. He is described as "fidgety" and manneristic, and persists in "doing his own thing." His attention span is very short, 15 seconds maximum. He never played with toys, and avoids eye contact, particularly when speaking. His speech is spontaneous and echolalic. Expressive language is well developed but the content is often irrelevant. His cognitive functioning suggests a

MODERATELY HANDICAPPED RANGE OF INTELLIGENCE, AS JUDGED WITH THE McCARTHY SCALES. WHEN EXCITED, HE STANDS ON HIS TOES HOLDING HIS BODY RIGID AND SHAKING HIS HANDS. THIS BEHAVIOUR LASTS FOR 10 - 15 SECONDS AND USED TO OCCUR 12 TO 15 TIMES PER DAY, ALTHOUGH THE FREQUENCY IS DECREASING SPONTANEOUSLY. NEUROLOGICALLY THERE WERE NO ABNORMAL FINDINGS.

## DISCUSSION

THERE WAS ONLY ONE POSITIVE CASE OF FRAGILE X FOUND IN A SEARCH CARRIED OUT ON 14 AUTISTIC CHILDREN ATTENDING A SPECIAL SCHOOL FOR AUTISTIC CHILDREN. THE PROPORTION OF AUTISTIC CHILDREN HAVING THE FRAGILE X HAS NOT BEEN ACCURATELY ESTABLISHED SO FAR, AND THE NATURE OF THE ASSOCIATION STILL REMAINS TO BE DETERMINED. A STUDY OF THE FREQUENCY OF FRAGILE X IN AUTISTIC CHILDREN WITH DIFFERENT DEGREES OF AUTISM, SUCH AS IN THE THREE CLASSES SUGGESTED BY McCARTHY, FITZGERALD AND SMITH (1984), COULD CONTRIBUTE TO CLARIFY THE RELATIONSHIP.



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# ADOLESCENTS AND THEIR HEALTH

PATRICK DEVITT; MICHAEL FITZGERALD; ANTHONY KINSELLA.

## SUMMARY

TWO HUNDRED TEENAGERS (100 GIRLS AND 100 BOYS), ATTENDING TWO SECONDARY SCHOOLS IN A DUBLIN NORTH CITY SUBURB, WERE REQUESTED TO COMPLETE A HEALTH QUESTIONNAIRE.

ONE PER CENT RATED THEIR HEALTH AS POOR, 60% ADMITTED TO HAVING TAKEN MEDICINES, THREE-QUARTERS COMPLAINED OF HEADACHES AND A THIRD HAD TIME OFF SCHOOL FOR ILLNESS IN THE PREVIOUS FOUR WEEKS. TWENTY-FIVE PER CENT DRANK ALCOHOL AT LEAST ONCE WEEKLY, 33% FELT DEPRESSED AT LEAST ONCE PER WEEK AND NEARLY A THIRD WERE SMOKERS.

MOST CHILDREN FELT RESPONSIBLE FOR THEIR OWN HEALTH, WITH THREE-QUARTERS AGREEING THAT GOOD HEALTH WAS DUE TO SENSIBLE LIVING.

THE FACT THAT THERE IS A PERCEPTION THAT TEENAGERS HAVE FEW MEDICAL PROBLEMS COULD EXPLAIN THE LACK OF RELIABLE INFORMATION CONCERNING THEIR HEALTH NEEDS, INTERESTS AND ATTITUDES. (BEWLEY 1982, BEWLEY ET AL. 1984). THIS KIND OF INFORMATION IS IMPORTANT TO THOSE PROFESSIONALS CONCERNED WITH HEALTH PROMOTION.

THIS STUDY AIMS TO ESTABLISH THE SELF-REPORTED VIEWS OF A SAMPLE OF ADOLESCENT GIRLS AND BOYS ABOUT THEIR HEALTH AND PSYCHOLOGICAL STATE.

## METHODS

THE STUDY WAS UNDERTAKEN IN APRIL/MAY 1988 AT TWO SECONDARY SCHOOLS, ONE FOR BOYS AND ONE FOR GIRLS, IN A DUBLIN NORTH CITY SUBURB. THESE SCHOOLS WERE ADJACENT TO EACH OTHER AND THE POPULATION CAME FROM AN AREA OF MIXED PRIVATE AND COUNCIL HOUSING. ALL CHILDREN WERE FROM THE INTERMEDIATE CERTIFICATE YEAR. ONE HUNDRED BOYS AND ONE HUNDRED GIRLS WERE SURVEYED.

THE GENERAL HEALTH QUESTIONNAIRE CONTAINED 40 QUESTIONS, MOST OF WHICH WERE MULTIPLE-CHOICE AND SOME OF WHICH WERE OPEN-ENDED. THE QUESTIONNAIRE WAS DESIGNED BY MACFARLANE ET AL., 1987, AND INCLUDED SEVERAL QUESTIONS THAT HAD BEEN USED IN PREVIOUS STUDIES BY BEWLEY ET AL. (1984) AND FROGEL (1976).

THE FOLLOWING ARE EXAMPLES OF QUESTIONS:-

DO YOU CONSIDER YOURSELF TO BE:

- IN POOR HEALTH?
- IN FAIR HEALTH?
- IN GOOD HEALTH?
- IN EXCELLENT HEALTH?

HAVE YOU EVER TRIED GLUE SNIFFING?

- YES?
- NO?



THE QUESTIONNAIRE WAS ANONYMOUS AND SELF-ADMINISTERED, AND WAS DISTRIBUTED BY TEACHERS IN THE SCHOOLS.

## RESULTS

ALL 200 ADOLESCENTS COMPLETED THE QUESTIONNAIRE. GIRLS' AGES RANGED FROM 14 YEARS, 4 MONTHS TO 17 YEARS, 1 MONTH, AND BOYS' AGES FROM 14 YEARS, 11 MONTHS TO 17 YEARS, 3 MONTHS. THE AVERAGE AGE FOR THE GIRLS WAS 15 YEARS, 10 MONTHS AND FOR THE BOYS 16 YEARS, 1 MONTH.

## GENERAL HEALTH

ALTHOUGH 36% OF THE GIRLS AND 28% OF THE BOYS AT THE TIME OF THE QUESTIONNAIRE FELT THEY HAD SOME HEALTH PROBLEM, ONLY 1% FELT THEIR HEALTH WAS POOR AND 16% THAT IT WAS ONLY FAIR.

## VISITS TO G.P.

TWENTY-NINE PER CENT OF THE ADOLESCENTS HAD VISITED THEIR G.P. IN THE PREVIOUS THREE MONTHS, WITH COLDS AND 'FLU' BEING THE COMMONEST COMPLAINT, STOMACH PROBLEMS BEING THE NEXT COMMONEST, FOLLOWED BY HEADACHES, AS CAN BE SEEN IN TABLE 1.

Table 1.

MAIN COMPLAINT AT TIME OF QUESTIONNAIRE

| Complaint | Girls (number) | Boys (number) |
|---|---|---|
| Colds | 6 | 6 |
| Headaches | 5 | – |
| Asthma | 4 | 4 |
| Skin Problem | 3 | – |
| Overweight | 3 | 1 |
| Joints | 2 | 3 |
| Eye Problem | 2 | – |

## Time Off School

More girls (41%) than boys (24%) had time off school in the previous four weeks. [$X^2 = 6.52$ ($p<0.025$)]. The most frequent reason given by both boys and girls was 'flu'; periods and eye problems were the second most common reasons given by girls, followed by headaches and asthma for girls.

## Medicines

Eighteen per cent of the adolescents were taking medicines at the time of the survey, mainly for asthma, hay-fever or headaches. Sixty-one per cent had taken medicine in the previous four weeks.



## Smoking, Alcohol and Drugs

While 95% of the adolescents felt that smoking was harmful to their health and 90% felt that passive smoking was harmful, 29% were smokers and 50% had a parent who smoked.

Significantly more boys (82%) than girls (67%) had consumed alcohol [$X^2 = 13.95$ ($p<0.001$)] at least once weekly, with parties or discos being the favourite locations. There was no significant correlation between those who smoked and those who consumed alcohol.

More girls than boys, 16% as against 3%, [$X^2 = 8.9$ ($p<0.005$)], had tried glue sniffing, with 99% feeling that it was harmful to their health.

By contrast, more boys (18%) than girls (3%) had tried other drugs.

## Depression

Girls admitted to more depression than boys. [$X^2 = 6.18$ ($p<0.1$)]. See Table 2.

## Attitudes to Health

Twenty-eight per cent of the adolescents agreed with the statement that "What happens to your health is a matter of luck." Eighty-six per cent agreed that "There are many things you can do to be healthy and avoid illness." Seventy-four per cent agreed "That good health is largely due to sensible living." Forty-eight per cent agreed

THAT "IF YOU WAIT LONG ENOUGH YOU WILL GET OVER MOST ILLNESSES."

NINETY-SEVEN PER CENT OF THE GIRLS AND 79% OF THE BOYS WENT TO THEIR MOTHER FIRST FOR ADVICE WHEN THEY WERE LAST ILL.

Table 2.

DEPRESSION

| DEPRESSED | GIRLS | BOYS |
|---|---|---|
| Every day | 14 | 5 |
| Once per week | 20 | 22 |
| Once per month | 27 | 21 |
| Occasionally | 28 | 30 |
| Never | 11 | 22 |
| MAIN CAUSES | | |
| School | 8 | 15 |
| Boredom | 12 | 17 |
| Parents/Family | 9 | 2 |
| Exams | 9 | 3 |
| Boyfriends | 7 | 0 |
| Girlfriends | 0 | 2 |



## OTHER PROBLEMS

GIRLS (34%) HAD MORE SKIN PROBLEMS THAN BOYS. [$X^2 = 4.97$ ($p<0.05$)].

EIGHTY-THREE PER CENT OF THE BOYS AND 65% OF THE GIRLS FELT THEY WERE OF NORMAL WEIGHT. [$X^2 = 8.42$ ($p<0.025$)].

MORE GIRLS THAN BOYS NOTICED OTHER PEOPLE'S BAD BREATH.

## DISCUSSION

THE TEENAGE YEARS ARE AN IMPORTANT MILESTONE IN TERMS OF PERSONAL DEVELOPMENT. IT IS DURING THIS TIME THAT LATER ATTITUDES TOWARDS HEALTH AND LIFE IN GENERAL ARE FORMED. FACTORS INFLUENCING THE EVOLUTION OF THESE ATTITUDES INCLUDE THE ATTITUDES OF PARENTS, TEACHERS, FRIENDS AND POSSIBLY HEALTH EDUCATION PROGRAMMES.

AS FAR AS DEFINITION OF GOOD HEALTH BY ADOLESCENTS IS CONCERNED, IT IS NOTEWORTHY THAT ONLY 1% OF THE TEENAGERS REGARDED THEIR HEALTH AS POOR, YET 32% HAD SOME HEALTH PROBLEM AT THE TIME OF THE QUESTIONNAIRE. THIS SUGGESTED THAT THE TEENAGERS' DEFINITION OF HEALTH MAY NOT INCLUDE SUCH TEMPORARY EPISODES.

IT IS INTERESTING THAT NEARLY 90% WENT TO THEIR MOTHERS FIRST FOR ADVICE ON ILL HEALTH. IT WOULD APPEAR THAT MOTHERHOOD IS STILL REGARDED AS THE REPOSITORY OF COMMON SENSE AS APPLIED TO HEALTH MATTERS.

THE HEALTH EDUCATION MESSAGE THAT SMOKING AND ILLICIT DRUGS ARE HARMFUL TO HEALTH APPEARS TO HAVE BEEN

ABSORBED, ON AN INTELLECTUAL LEVEL AT LEAST. NINETY-NINE PER CENT THOUGHT SMOKING WAS HARMFUL AND 99% THOUGHT THAT GLUE SNIFFING WAS HARMFUL. IT WAS ALSO OF INTEREST THAT 90% WERE AWARE OF THE HARMFUL EFFECTS OF PASSIVE SMOKING. DESPITE THIS KNOWLEDGE, NEARLY ONE-THIRD SMOKED.

THE QUESTIONNAIRE DID NOT SEEK TO DETERMINE WHAT PROPORTION TOOK DRUGS REGULARLY, BUT A QUARTER CONSUMED ALCOHOL ON A WEEKLY BASIS.

IT IS WELL ESTABLISHED THAT FEMALES ARE MORE FREQUENT USERS OF THE HEALTH SERVICES AND SUFFER MORE MINOR PSYCHIATRIC ILLNESS. INTERESTINGLY, THIS PATTERN SEEMS TO HAVE BECOME ESTABLISHED EVEN AS YOUNG AS 15 YEARS OF AGE. GIRLS WERE MORE DEPRESSED, HAD MORE TIME OFF SCHOOL, SUFFERED MORE SKIN PROBLEMS, REGARDED THEMSELVES AS MORE OVERWEIGHT AND SUFFERED MORE HEADACHES THAN BOYS.

OVERALL, IRISH TEENAGERS HAD SIMILAR ATTITUDES AND HABITS TO THEIR BRITISH COUNTERPARTS. ONE EXCEPTION WAS THAT ONLY A QUARTER OF IRISH TEENAGERS WERE WEEKLY DRINKERS, COMPARED WITH A THIRD OF BRITISH TEENAGERS. (MACFARLANE ET AL, 1987).



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# PREVALENCE OF PSYCHOLOGICAL DISTRESS IN IRISH FEMALE ADOLESCENTS

KATHERINE BROWN; MICHAEL FITZGERALD; ANTHONY KINSELLA.


## SUMMARY

FEMALE ADOLESCENTS (N = 132) ATTENDING TWO INNER CITY DUBLIN SCHOOLS COMPLETED THE YOUTH SELF REPORT QUESTIONNAIRE (YSRQ).

OF THIS GROUP 15.4% OBTAINED A TOTAL PROBLEM SCORE IN THE CLINICAL RANGE. A HIGHER PROPORTION, 23%, OBTAINED A SCORE IN THE CLINICAL RANGE ON ONE OR MORE PROBLEM SUBSCALES OF THE YSRQ.

NO ONE SCORED ABNORMALLY ON THE SOCIAL COMPETENCE SCALES. A NUMBER OF INTERESTING AND THOUGHT-PROVOKING RESPONSES TO INDIVIDUAL QUESTIONS WERE OBTAINED.

THE POSSIBLE CLINICAL RELEVANCE OF THESE FINDINGS AND IMPLICATIONS FOR FUTURE PLANNING IN SCHOOLS ARE DISCUSSED.


## INTRODUCTION

DESPITE WIDESPREAD AND INCREASING INTEREST IN ADOLESCENT PSYCHOPATHOLOGY, ONLY A LIMITED NUMBER OF STUDIES WORLDWIDE HAVE ADDRESSED THE PREVALENCE OF

PSYCHOLOGICAL DISTRESS AMONG COMMUNITY SAMPLES OF ADOLESCENTS (GRAHAM AND RUTTER, 1985). KRUPINSKI, BAIKIE, STROLLER ET AL. (1967) REPORTED SOME TYPE OF PSYCHIATRIC DISORDER IN ABOUT 16% OF THE ADOLESCENT POPULATION AT HEYFIELD IN AUSTRALIA BUT, UNFORTUNATELY, DIAGNOSTIC CRITERIA WERE NOT SPECIFICALLY DEFINED.

IN THE ISLE OF WIGHT STUDY (GRAHAM AND RUTTER, 1985; RUTTER, GRAHAM AND CHADWICK ET AL., 1976; GRAHAM AND RUTTER, 1973) PSYCHIATRIC DISORDERS WERE FOUND TO BE MORE COMMON IN ADOLESCENCE THAN IN MIDDLE CHILDHOOD, AND THE ONE YEAR PERIOD PREVALENCE WAS ESTIMATED AT 21%.

MORE RECENTLY, D'ARCY AND SIDDIQUE (1984) AND KASHANI ET AL. (1987), IN CANADA AND THE U.S.A. RESPECTIVELY, USING A VARIETY OF INVESTIGATIVE APPROACHES (INCLUDING THE GENERAL HEALTH QUESTIONNAIRE, DIAGNOSTIC INTERVIEW SCHEDULE FOR CHILDREN AND PARENTAL INTERVIEWS), REPORTED RATES OF PSYCHOLOGICAL DISTRESS AMONGST NON-CLINICAL SAMPLES OF ADOLESCENTS OF 27% AND 19%, RESPECTIVELY.

HOWEVER, RUTTER ET AL. (1976), KASHANI ET AL. (1987) AND MANN, WAKELING, WOOD ET AL. (1983) ALL ACKNOWLEDGE THE LIMITATIONS OF INSTRUMENTS USED IN CHILD AND ADULT PSYCHIATRIC DIAGNOSES WHEN APPLIED TO THE ADOLESCENT POPULATION.

PLACE (1987) FOUND THAT SCREENING INSTRUMENTS TEND TO BE BEHAVIOUR SPECIFIC, AND THAT THE GHQ, WHILE ONE OF THE BEST VALIDATED SELF REPORT INSTRUMENTS, IS LESS SENSITIVE THOUGH MORE SPECIFIC IN THE ADOLESCENT AGE GROUP. HE ALSO FOUND THAT MULTIPLE SOURCES OF INFORMATION APPEAR TO BE LESS VALUABLE THAN FOR THOSE



AT A YOUNGER AGE, AND THAT A SELF REPORT INVENTORY IS MORE ACCURATE THAN INFORMATION FROM OTHER SOURCES.

THE YOUTH SELF REPORT QUESTIONNAIRE (YSRQ) WAS DESIGNED BY ACHENBACH AND EDELBROCK (1987) TO RECORD IN A STANDARDISED FORMAT THE COMPETENCIES AND BEHAVIOURAL PROBLEMS OF CHILDREN AGED 11 - 18 YEARS AS REPORTED BY THE CHILDREN THEMSELVES.

THE PRESENT STUDY AIMS TO ASSESS THE PREVALENCE OF PSYCHOLOGICAL DISTRESS IN A COMMUNITY GROUP OF DUBLIN FEMALE ADOLESCENTS, USING THE YSRQ. BY DOING SO, WE WISH TO HIGHLIGHT THE PARTICULAR PROBLEMS EXPERIENCED AND TO COMPARE THE RESULTS OBTAINED WITH THE FINDINGS USING OTHER SCREENING INSTRUMENTS.

## METHODOLOGY

### THE SAMPLE:

THE STUDY POPULATION WAS DRAWN FROM THE FIFTH YEAR PUPILS OF TWO INNER CITY CONVENT SCHOOLS, AND THE DATA WERE COLLECTED IN FEBRUARY, 1989. THE AIMS OF THE STUDY WERE EXPLAINED TO THE PUPILS, WHO IN TURN WERE ASKED TO SEEK PARENTAL CONSENT BY TAKING HOME A SPECIALLY PREPARED LETTER FOR PARENTS TO SIGN AND RETURN. ALL 141 PUPILS APPROACHED WERE WILLING TO PARTICIPATE, AND NO PARENTS EXPRESSED ANY RESERVATIONS ABOUT THEIR DAUGHTERS' CO-OPERATION.

A TOTAL OF 132 PUPILS COMPLETED THE QUESTIONNAIRE; THE OTHER NINE WERE ABSENT ON THE DAY OF THE STUDY, AND THEREFORE EXCLUDED. A FURTHER FIVE PUPILS PRESENT ON THE DAY THAT THE QUESTIONNAIRE WAS ADMINISTERED, BUT ABSENT ON THE INITIAL MEETING, WERE ALSO EXCLUDED. COX

(1977) has shown a higher level of behavioural disturbance among non-attenders at school which should be borne in mind.

The questionnaire was administered by the author (K.B.) in groups of 25 - 30 pupils per sitting during a 40-minute class period. The pupils were asked to complete the questionnaire without discussion with peers, and were assured of the anonymity and confidentiality of their responses. They were permitted to clarify any queries or misunderstandings with the author (K.B.), and approximately 20% availed of this opportunity.

The Instrument:

The Youth Self Report Questionnaire (YSRQ), designed by Achenbach and Edelbrock (1987), is a self report inventory adapted from the Child Behaviour Checklist previously designed by Achenback and Edelbrock (1979). Its aim is to record in a standardised format the competencies and behavioural problems of children aged 11 - 18 years.

The 17 competence items consist of questions concerning activities, social involvement and academic performance. Eight items concerning participation in organisations, number of friends, contact and relationships with friends, are scored on the "Social Scale." A further eight items concerning involvement in sports, work and other recreational activities, are scored on the "Activities Scale." Summing these two with a score for General Academic Performance yields the "Total Competence Score." This can then be compared with normative data obtained from 686 randomly selected U.S.A. adolescents.



The remainder of the questionnaire consists of 112 items designed to identify psychological and behavioural problems over a six month period. Both a "Total Problem Score" and scores for six subscales are thus obtained. These six distinct groups of symptoms are based on statistical analyses of the responses of 927 adolescents referred to the Mental Health Services in the U.S.A. The six subscales thus identified are: "Somatic;" "Depressed;" "Unpopular;" "Thought Disorder;" "Aggressive;" and "Delinquent."

Reliability as shown by Achenbach and Edelbrock (1987) is satisfactory, with a test retest correlation of 0.69 between total YSR problem scores over a six month interval for youths referred to a Community Mental Health Centre.

Validity Assessment using measures of Content Validity and Criterion Related Validity show that:

(i) Competence scores, while useful in determining strengths and weaknesses, should not be used in determining clinical status.

(ii) Problem Scores, i.e., both the Total Problem Score (TPS) and the scores on the six subscales, are found to be a useful indicator of psychological distress, provided that suitable cut-off points are used (i.e. scores greater than/equal to 89th percentile of the normative sample for the TPS and a score greater than/equal to 98th percentile for the individual narrow band problem subscales). This method classified 10.5% of the non-referred adolescents as being in the clinical range.

## Results

Demographic Variables:

Altogether 130 valid questionnaires were completed.

The mean age of the sample is 16.42 years with a range of 2.98 years and a standard deviation of 0.63 years.

The socio-economic groupings show the predominance of working class background with 74% of the total, and 85% of those whose socioeconomic group was identified as coming from SE Groups IV or V as defined by O'Hare (1982). Only 6.1% of the group studied were from SE Groups I or II, with 6.9% coming from SE Group III.

YSRQ

(A) In this study all of the participants obtained Competence Scores within the normal range. This included scores on the "Total Competence Scale," "Activities Scale" and "Social Scale." The mean raw score obtained in the "Total Competence Scale" was 18.2, while the results for the "Activities Scale" and the "Social Scale" were 7.9 and 7.1, respectively.

Normalised "T Scores" are based on percentiles of the raw scores obtained by the normative sample (Achenbach and Edelbrock, 1987). As a whole the group scored very highly, with only 13% obtaining scores below the 31st percentile of the normative sample, as defined by Achenbach and Edebrock (1987).



(B) On the behaviour problem items, the percentage of the group studied scoring in the clinical range is shown for both the Total Problem Score and each of the different subscales. See Table 1.

Table 1.

BEHAVIOUR PROBLEM SCORES

| | No. | Sample (%) |
|---|---|---|
| Total problem score ≥ 89% Centile | 20 | 15.38 |
| One of more subscales ≥ 98% Centile | 30 | 23.0 |
| Somatic subscale ≥ 98% Centile | 15 | 11.53 |
| Depressed subscale ≥ 98% Centile | 5 | 3.85 |
| Unpopular subscale ≥ 98% Centile | 2 | 1.53 |
| Thought disorder subscale ≥ 98% Centile | 27 | 20.77 |
| Aggressive subscale ≥ 98% Centile | 3 | 2.3 |
| Delinquent subscale ≥ 98% Centile | 4 | 3.0 |

A percentage (15.8%) of the group studied scored in the clinical range for the Total Problem Score. A higher 23% was obtained when all those scoring in the clinical range for any of the six subscales were considered. The percentage of the group scoring in the clinical range for any of the six subscales is itemised with the highest scores being obtained on the "Thought Disorder" and "Somatic" subscales. The Mean Total Problem Score of the group studied was 52.

As the age, sex and socio-economic groupings of the group studied were relatively homogenous, no

CORRELATION OF THESE RESULTS WITH DEMOGRAPHIC VARIABLES WAS FEASIBLE. EQUALLY, SINCE ALL OF THE STUDY POPULATION OBTAINED COMPETENCE SCORES WITHIN THE NORMATIVE RANGE, NO CORRELATION WAS POSSIBLE HERE.

RELATIONSHIPS BETWEEN THE TOTAL PROBLEM SCORE (TPS) AND VARIOUS SUBSCALES ARE SHOWN IN TABLE 2.

WHILE ONLY 4 SCORED ON THE CLINICAL RANGE ON THE TPS ALONE, A MUCH LARGER NUMBER SCORED IN THE CLINICALRANGE ON EITHER THE "SOMATIC" (3) OR "THOUGHT DISORDER" (10) SUBSCALES ONLY. HOWEVER, NOBODY SCORED HIGHLY ON ANY OF THE OTHER FOUR SUBSCALES IN ISOLATION.

FOR THOSE 20 WHO SCORED IN THE CLINICAL RANGE ON THE TPS, THE NUMBER OF THOSE WHO ALSO SCORED HIGHLY ON ANY OF THE SIX SUBSCALES IS LISTED, I.E. 9 ON THE "SOMATIC" SUBSCALE, 14 ON THE "THOUGHT DISORDER" SUBSCALE, 4 ON THE "DEPRESSED" SUBSCALE, 2 ON THE "UNPOPULAR" SUBSCALE, 3 ON THE "AGGRESSIVE" SUBSCALE AND FOUR ON THE "DELINQUENT" SUBSCALE.

ONLY IN ONE INDIVIDUAL WERE SCORES IN THE CLINICAL RANGE FOR ALL SUBSCALES AS WELL AS THE TPS OBTAINED. HIGHEST CORRELATION WAS BETWEEN HIGH SCORES ON THE TPS AND HIGH SCORES ON THE "SOMATIC" AND "THOUGHT DISORDER" SUBSCALES. FOUR RESPONDENTS SCORED HIGHLY ON BOTH THE "SOMATIC" AND "THOUGHT DISORDER" SUBSCALES BUT NORMALLY ON THE TPS.

THE RESPONSES OF THE GROUP STUDIED TO A NUMBER OF QUESTIONS CONCERNING SUBJECTIVE FEELINGS AND PREOCCUPATIONS ARE SHOWN IN TABLE 3.



Table 2.

ABNORMAL SCORES ON TOTAL PROBLEM AND INDIVIDUAL SUBSCALES

| | Total Problem Score (Abn) | Somatic (Abn) | Thought Disorder (Abn) | Depressed (Abn) | Unpopular (Abn) | Aggressive (Abn) | Delinquent (Abn) |
|---|---|---|---|---|---|---|---|
| 1. Total | 20 | 15 | 27 | 5 | 2 | 3 | 4 |
| 2. Only | 4 | 3 | 10 | - | - | - | - |
| 3. Combination of T.P.S. and others | 20 | 9 | 13 | 4 | 2 | 3 | 4 |

1. Total scoring highly.
2. Number scoring highly on individual scale only.
3. High score on T.P.S. and associated high score on any of subscales.

Table 3.

RESPONSES OF SAMPLE TO CERTAIN QUESTIONS FROM YSRQ

| Question Number | | Response (valid per cent) Sometimes true | Often true |
|---|---|---|---|
| 9 | I can't get my mind off certain thoughts. | 50.4 | 23.3 |
| 12 | I feel lonely. | 50.0 | 8.6 |
| 13 | I feel confused or in a fog. | 45.7 | 10.1 |
| 14 | I cry a lot. | 34.4 | 11.5 |
| 45 | I am nervous or tense. | 57.7 | 20.0 |
| 50 | I am too fearful or anxious. | 32.3 | 14.6 |
| 54 | I am overtired. | 52.7 | 20.9 |
| 56 | Physical problems without known medical cause: | | |
| | (a) Aches or pains; | 42.5 | 9.2 |
| | (b) Headaches; | 43.3 | 19.7 |
| | (c) Stomach aches/cramps. | 33.1 | 11.0 |
| 87 | My moods or feelings change suddenly. | 43.5 | 29.8 |
| 91 | I think about killing myself. | 22.3 | 6.9 |
| 96 | I think about sex too much. | 36.4 | 14.7 |
| 99 | I am too concerned about being neat or clean. | 51.9 | 24.4 |
| 103 | I am unhappy, sad or depressed. | 51.1 | 9.9 |
| 112 | I worry a lot. | 50.0 | 35.4 |



Some of the questions and responses concerning activities and social relationships of the group studied are shown in Table 4.

## Discussion

In the present study a prevalence rate of 15.4% for psychological distress was found in a group of Irish female adolescents studied.

While this figure is lower than prevalence figures found using other investigative instruments listed in the introduction, it is substantially higher than the 10.5% cited by Achenbach for a group of non-referred adolescents using the YSRQ. However, the group studied here is not representative of the population as a whole. It is composed entirely of girls and is drawn from two deprived inner city areas being over-represented by lower socio-economic groups. Rutter and Hersov (1977) in a later study found that the incidence of psychiatric disturbance was substantially higher amongs youngsters living in cities. Leslie (1974), among other researchers, has also noted a sex difference in psychiatric disturbance, boys being more vulnerable in their early teens in contrast to girls, where the rate of disturbance increases in later adolescence.

Both of these factors as well as possible cultural differences must be considered, therefore, and do not allow strict comparisons to be drawn with other studies.

Of considerable interest in this study is the predominance of high scores obtained on the "Thought

DISORDER" SUBSCALE, AS WELL AS THE RESPONSES OF THIS STUDY POPULATION TO A NUMBER OF DIFFERENT QUESTIONS.

ACHENBACH CLAIMS THAT THE "THOUGHT DISORDER" SUBSCALE RESEMBLES THE "SCHIZOID" SCALE OF THE CHILD BEHAVIOUR CHECKLIST AND THE SCHIZOTYPAL PERSONALITY/ PSYCHOTIC DISORDERS OF THE DSM III-R.

THE "THOUGHT DISORDER" SUBSCALE IS COMPRISED OF 12 QUESTIONS ADDRESSING CERTAIN ASPECTS OF AN INDIVIDUAL'S BEHAVIOUR AND COGNITIONS, I.E. TROUBLE CONCENTRATING, TROUBLE SITTING STILL, POOR SCHOOL WORK, DAYDREAMS, SECRETIVENESS, STRANGE BEHAVIOUR, STRANGE THOUGHTS, STORING UP THINGS, PREOCCUPATION WITH CERTAIN THOUGHTS, HEARING THINGS AND TENDENCY TO REPEAT ACTIONS.

SOME OF THESE QUESTIONS, HOWEVER, ARE OPEN TO CONSIDERABLE VARIATIONS IN INTERPRETATION. FOR EXAMPLE, RESPONDENTS, ASKED TO ELABORATE FURTHER IF THEY GAVE A POSITIVE RESPONSE TO SEEING OR HEARING THINGS, REFERRED TO HEARING CONVERSATIONS, NOISES, EVENTS AT HOME AND TO SEEING THINGS IN DREAMS, IMAGININGS AND NOTICING OTHER PEOPLE'S REACTIONS.

POSITIVE RESPONSES TO THE OTHER QUESTIONS ALSO FOCUSED ON THE INDIVIDUAL'S SENSITIVITY AND PERCEPTION OF THEIR THOUGHTS OR ACTIVITIES AS DIFFERENT FROM OTHERS. ACCORDINGLY, ONE WOULD BE VERY CAUTIOUS ABOUT CLASSIFYING SOME OF THESE INDIVIDUALS IN THE CLINICAL RANGE ON THIS PARTICULAR SUBSCALE, USING THE PRESENT SCORING SYSTEM. THE FINDINGS ELICITED IN OUR STUDY MUST CERTAINLY RAISE DOUBTS ABOUT THE VALIDITY OF THIS "THOUGHT DISORDER" SUBSCALE AS APPLIED TO THIS GROUP OF IRISH ADOLESCENTS STUDIED.



THE RESPONSES OF THIS SAMPLE TO A NUMBER OF INDIVIDUAL QUESTIONS MERITS FURTHER CONSIDERATION.

TABLE 3 SHOWS THE RESPONSES TO A NUMBER OF QUESTIONS CONCERNING SUBJECTIVE FEELINGS AND PREOCCUPATIONS. IT INDICATES THE DEGREE OF VULNERABILITY AND SUBJECTIVE UNHAPPINESS EXPERIENCED BY A LARGER NUMBER OF "NORMAL" ADOLESCENTS. ERIKSON'S (1965) CONCEPT OF "IDENTITY VERSUS CONFUSION" IS CERTAINLY SUBSTANTIATED. AS CAN BE SEEN, UP TO 50% OF THOSE SAMPLED COMPLAINED OF AT LEAST "SOMETIMES" FEELING LONELY, CONFUSED, NERVOUS, SAD, OVERTIRED AND OF "SOMETIMES" BEING MOODY, PREOCCUPIED BY CERTAIN THOUGHTS AND WORRYING A LOT.

IT IS GENERALLY ACCEPTED THAT THE INCIDENCE OF DEPRESSION AND BIPOLAR AFFECTIVE ILLNESS IS THE SAME DURING ADOLESCENCE AS FOR ADULT LIFE. RYAN AND PUIG-ANTICH (1986) SUBSTANTIATED THIS, WHILE HILL (1986) STRESSED THE IMPORTANCE OF UNDERSTANDING THE PATHOPLASTIC EFFECT OF ADOLESCENCE ON PSYCHIATRIC DISORDER IN THIS AGE GROUP.

HOWEVER, 22.3% OF THE STUDY POPULATION HERE RESPONDED THAT THEY "SOMETIMES" HAD THOUGHTS ABOUT KILLING THEMSELVES, WHICH IS AN INDICATOR OF THE LEVEL OF DISTRESS AND DESPERATION EXPERIENCED BY THIS "NORMAL" SAMPLE OF ADOLESCENTS.

TABLE 4 SHOWS THE RESPONSES TO A NUMBER OF QUESTIONS CONCERNING ACTIVITIES AND SOCIAL RELATIONSHIPS. PETERSON AND EVANS (1983) DESCRIBE THIS PERIOD OF LATE ADOLESCENCE FROM 15 - 18 YEARS, WHEN ADOLESCENTS ARE ACTIVELY ENGAGED IN THE EMOTIONAL PROCESS OF SEPARATING THEMSELVES FROM THEIR FAMILIES AND ENDEAVOURING TO BECOME INDEPENDENT ENTITIES.

HENCE, SELF ASSERTION IS ESPECIALLY SHOWN TOWARDS THOSE ON WHOM THE RESPONDENT HAD FORMERLY RELIED FOR EXTERNAL CONTROL, I.E. APPROXIMATELY TWO-THIRDS OF THOSE QUESTIONED "SOMETIMES" DISOBEYED THEIR PARENTS WHILE ONLY ONE-THIRD "SOMETIMES" DISOBEYED AT SCHOOL.

PEER GROUP RELATIONSHIPS ARE OF THE UTMOST IMPORTANCE IN ASSISTING SEPARATION FROM ONE'S FAMILY. BY SELECTIVE ASSOCIATIONS WITH VARIOUS PEER GROUPS, ADOLESCENTS ARE LIKELY TO EXPERIMENT WITH SOCIAL IMAGES AND SEEK CONFIRMATION OF ASPECTS OF THEMSELVES. AS CAN BE SEEN FROM TABLE 4, HOWEVER, ADOLESCENTS EXPERIENCE CONSIDERABLE DOUBTS AND UNCERTAINTY IN THIS AREA AND UP TO 50% CLAIM THAT THEY "SOMETIMES" OR "OFTEN" KEEP FROM GETTING INVOLVED WITH OTHERS.

EXPERIMENTATION AND IMPULSIVITY ARE OTHER WELL KNOWN TRAITS OF THIS AGE GROUP AND, GIVEN THE SETTING IN WHICH THE STUDY WAS CONDUCTED, THE FIGURE OF 25% OBTAINED AS A POSITIVE RESPONSE BY THOSE WHO "SOMETIMES" OR "OFTEN" USE ALCOHOL OR DRUGS IS PROBABLY AN UNDERESTIMATE.

IN CONCLUSION, THE PREVALENCE OF PSYCHOLOGICAL DISTRESS FOUND IN THIS GROUP OF ADOLESCENTS STUDIED USING THE YSRQ IS BROADLY IN KEEPING WITH PREVIOUS STUDIES IN DIFFERENT POPULATIONS AND USING DIFFERENT INSTRUMENTS. RESPONSES TO VARIOUS QUESTIONS CERTAINLY CONFIRM AND EMPHASISE THE WELL-KNOWN OBSERVATIONS CONCERNING THIS PERIOD OF TURMOIL. INDEED ITS EXTENT AND DISRUPTION OF THE ADOLESCENT'S LIFE IS PROBABLY CONSIDERABLY UNDERESTIMATED, GIVEN THE FINDINGS IN THIS STUDY. FURTHER RESEARCH IN THIS AREA IS CERTAINLY INDICATED TO HELP TO MORE FULLY IDENTIFY THE NEEDS OF THIS VULNERABLE AGE GROUP. HOWEVER, WITH THE INFORMATION AVAILABLE TO DATE, A COMPREHENSIVE SERVICE



CAPABLE OF DEALING WITH ADOLESCENTS' CONCERNS AT BOTH SCHOOL AND COMMUNITY LEVEL COULD BE DEVELOPED.

Table 4.

SOME YSRQ ITEMS CONCERNING SOCIAL RELATIONSHIPS

| Question Number | | Response (valid per cent) Sometimes true | Often true |
|---|---|---|---|
| 22 | I disobey my parents. | 65.4 | 6.9 |
| 23 | I disobey at school. | 36.6 | 6.9 |
| 25 | I don't get along with other kids. | 19.4 | 1.6 |
| 38 | I get teased a lot. | 25.2 | 5.3 |
| 39 | I hang around with kids who get into trouble. | 10.7 | 1.5 |
| 41 | I act without stopping to think. | 61.8 | 13.3 |
| 42 | I like to be alone. | 57.3 | 22.9 |
| 48 | I'm not liked by other kids. | 14.6 | 3.1 |
| 63 | I prefer company of older kids. | 41.2 | 12.2 |
| 64 | I prefer company of younger kids. | 9.2 | 1.5 |
| 71 | I am self conscious or easily embarrassed. | 43.5 | 41.2 |
| 75 | I am shy. | 48.9 | 26.0 |
| 89 | I am suspicious. | 60.3 | 16.9 |
| 105 | I use alcohol or drugs. | 19.4 | 6.2 |
| 110 | I wish I were of the opposite sex. | 29.8 | 6.1 |
| 111 | I keep from getting involved with others. | 35.9 | 13.7 |

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# THE MEASUREMENT OF ADOLESCENT ADAPTIVE PROCESSES IN THE CLINICAL INTERVIEW

Louise Tansey; Michael Fitzgerald; Anthony Kinsella.

**A STUDY** is described measuring the clinical usefulness of Adolescent Adaptive Process Scales. These processes are measured in three groups of adolescents in which psychopathology is also measured using a standardised psychiatric interview. Inter-rater reliability is calculated between two raters, and mean score comparisons are made between the groups using the t-test method. In the study, a higher inter-rater reliability and some preliminary evidence of construct validity are found for these scales. The findings indicate that these scales could constitute a useful clinical tool in psychotherapy, research and teaching. They also provide scope for future work in the field.

## Introduction

The clinical interview constitutes the main tool for both assessment and treatment in psychiatry. It was shown both reliable and valid by Rutter, (Graham and Rutter, 1968). In spite of vast literature on the use of the therapeutic interview, there has been little systematic study of psychiatric interviewing for assessment purposes until 1981, (Rutter and Cox, 1981). Their interview focused on the diagnostic appraisal of children, (Hill, 1985).

THE AIM OF THE PRESENT STUDY WAS TO MEASURE NORMAL PROCESSES IN DIFFERENT GROUPS OF ADOLESCENTS. THE SCALES USED WERE DEVELOPED AND SHOWN TO BE RELIABLE BY BEARDSLEE, (BEARDSLEE ET AL., 1985). THEY ARE DERIVED FROM THE STUDY OF EGO PSYCHOLOGY, AND ATTEMPT TO MEASURE ASPECTS OF PERSONALITY DEVELOPMENT RATHER THAN PSYCHOPATHOLOGY IN THE GROUP. BY THE CONCURRENT USE OF A STANDARDISED PSYCHIATRIC INTERVIEW, (GRAHAM AND RUTTER, 1968), THE RELATIONSHIP BETWEEN PSYCHOPATHOLOGY AND THEIR DEGREE OF ADAPTATION WAS OBSERVED. THE HYPOTHESIS WAS THAT THE GROUP SCORING LOWEST ON ADAPTATION WOULD SCORE HIGHEST ON PSYCHIATRIC DISTURBANCE.

## METHODOLOGY

THREE GROUPS OF ADOLESCENTS PARTICIPATED IN THE STUDY: ADOLESCENTS WITH A MAJOR PSYCHIATRIC DISORDER; A NON-PATIENT CONTROL GROUP; AND A GROUP WITH A PHYSICAL DISABILITY. THE PSYCHIATRIC SAMPLE WERE SELECTED FROM A NUMBER OF CONSECUTIVE ADMISSIONS TO A RESIDENTIAL UNIT FOR EMOTIONALLY DISTURBED CHILDREN OF AVERAGE INTELLIGENCE, EXCLUDING THOSE SUFFERING FROM MAJOR PSYCHOSIS OR ORGANIC BRAIN DAMAGE. THE CONTROL GROUP WERE SELECTED FROM A SECONDARY SCHOOL REGISTER AND MATCHED WITH THE PSYCHIATRIC SAMPLE BY AGE, SEX AND SOCIAL CLASS. THE SPINA BIFIDA TEENAGERS WERE SELECTED FROM A NORMAL SECONDARY SCHOOL AND MATCHED SIMILARLY WITH THE OTHER GROUPS. SOCIAL CLASS WAS DETERMINED BY HEAD OF HOUSEHOLD, USING THE IRISH SOCIAL CLASS SCALE, (AILEEN O'HARE, 1982).

THE INSTRUMENTS USED WERE THE RUTTER DIAGNOSTIC INTERVIEW AND ADOLESCENT ADAPTIVE PROCESS SCALES. THE ADAPTIVE PROCESSES COMPRISE 15 PROCESSES DERIVED FROM



EGO PSYCHOLOGY TO MEASURE EGO FUNCTIONS DEEMED PRESENT IN ALL ADOLESCENTS, (TABLE 1). EACH PROCESS HAS A FIVE-POINT SCALE MEASURED WITH THE AID OF AN ACCOMPANYING MANUAL. IN THE MANUAL, EACH PROCESS IS DEFINED FOLLOWED BY A DEFINITION OF EACH RATING ON A FIVE-POINT SCALE, WITH EXAMPLES OF EACH GIVEN, (TABLE 2).

Table 1.

FIFTEEN ADAPTIVE PROCESSES

| | |
|---|---|
| A. | Amount of committable energy available for school tasks. |
| B. | Amount of committable energy available for non-school activities and interests. |
| C. | Commitment and persistence. |
| D. | Creative involvement. |
| E. | Degree of synthesis. |
| F. | Flexibility in thought, feeling and action. |
| G. | Impulse regulation. |
| H. | Inner experience of interpersonal relationships. |
| I. | Playfulness and openess to inner experience. |
| J. | Profundity of thought content. |
| K. | Self as actor. |
| L. | Self understanding. |
| M. | Social exploration and affiliation. |
| N. | Stress tolerance. |
| O. | Variety of thought content. |

Table 2.

ADAPTIVE PROCESSES SCALE EXAMPLE: IMPULSE REGULATION

**Definition:** This scale focuses on impulses mainly of an aggressive and/or sexual nature, and their regulation by the adolescent. At lower points on the scale the adolescent is controlled by his/her impulses, while at higher ones the adolescent controls and regulates his/her impulses. With the ability to obtain distance from impulses comes the ability for internally controlling and delaying, rather than having the environment (parents, authority figures, institutions) be the source of control.

1. **Minimal:** The subject is almost completely a victim of any impulse, unable to delay or control gratification.

2. **Little:** The subject is occasionally able to control impulses and delay gratification, but is impulsive and labile most of the time.

3. **Moderate:** The subject is generally able to control impulses and impose delays of gratification on them. This is done with effort by the subject, or there are discontinuities in control.

4. **Considerable:** The subject shows flexible control of impulses; successful postponement of gratification is possible, and occurs without discontinuities in control.

5. **Extreme:** The subject is dominated by his or her attempts to control his/her impulses.

IN THE CLINICAL PSYCHIATRIC INTERVIEW EACH CANDIDATE WAS SCORED ON RUTTER'S SCALE FOR PSYCHOPATHOLOGY AND BEARDSLEE'S FOR ADAPTATION. BOTH INTERVIEWS WERE CONDUCTED BY THE SAME INTERVIEWER AND THE TRANSCRIPTS WERE USED BY A SECOND RATER TO MEASURE INTER-RATER RELIABILITY. THE SECOND INTERVIEWER WAS BLIND TO BOTH THE DIAGNOSIS AND GROUP MEMBERSHIP OF THE SAMPLE. PRIOR TO CONDUCTING THE INTERVIEW ON ADAPTIVE PROCESSES THE INTERVIEWER FAMILIARISED HERSELF WITH



THESE BY READING CAREFULLY THROUGH THE MANUAL. THE AREAS EXPLORED CLOSELY RESEMBLED THOSE OF THE RUTTER INTERVIEW, WITH A GREATER FOCUS ON THE ADOLESCENT'S ACCOUNT OF HIS INNER EXPERIENCE.

## RESULTS

RAW DATA ARE INCLUDED IN TABLE 3 AND STATISTICAL CALCULATIONS IN TABLES 4 AND 5. TWENTY-NINE ADOLESCENTS WERE INTERVIEWED. TEN OF THESE WERE IN THE PSYCHIATRIC GROUP, 11 IN THE MATCHED CONTROL AND 8 IN THE SPINA BIFIDA GROUP.

ON THE RUTTER SCALE THE MAJORITY OF THE PSYCHIATRIC GROUP WAS DIAGNOSED AS A MIXED DISORDER OF CONDUCT AND EMOTION, OF MODERATE OR SEVERE DEGREE. ONE CASE FELL INTO THE SLIGHT BUT DEFINITE CATEGORY. IN THE CONTROL GROUP OF 11, 2 ADOLESCENTS FELL INTO THE CATEGORY OF CHILD PSYCHIATRIC DISORDER. ONE WAS OF SLIGHT BUT DEFINITE SEVERITY, WHILE THE OTHER WAS MODERATE. IN THE SPINA BIFIDA SAMPLE 3 OUT OF THE 8 WERE CASES, 2 SLIGHT BUT DEFINITE AND 1 OF MODERATE SEVERITY.

Table 3.

SOCIODEMOGRAPHIC CHARACTERISTICS OF IRISH SAMPLE

| | Secondary School | Psychiatric | Spina Bifida |
|---|---|---|---|
| **Male** | 4 | 3 | 6 |
| Female | 7 | 7 | 2 |

**Group Total:** 29. **Sex Ratio:** Female 16; Male 13. **Age Range:** 12 - 16 years.

On the measurement of inter-rater reliability using the Rutter interview, there was a 90% agreement on diagnosis with an 80% agreement on severity. In the Adaptive Process Scales, reliability in terms of per cent agreement within a half step of the scales and exact agreement was measured. The former was a measure of the number of times the two raters did not differ by more than 0.5 points in the scale. With reference to Table 4, Scale A, 100% agreement between the raters in the Irish sample indicated that they did not differ by more than 0.5 points in the scale in any of the samples. The average score on the present study was high. These scores compared favourably with the results of the American study, and are demonstrated in Table 4.

As hypothesised, the average score on the Adaptive Process Scales in the control group was higher than in the psychiatric group. The average score in the Spina Bifida group fell between the normal group and the psychiatric. The difference between the psychiatric and normal groups was significant, at a 0.001 level of significance. The difference between the Spina Bifida and psychiatric groups was significant, at a 0.005 level. The individual scores for each process in the three groups were further analysed. In 8 of the 15 processes, there was a highly significant difference between the psychiatric and the normal groups, providing preliminary evidence of a construct validity for the scales.

## Discussion

In adolescents it seems easier to describe pathological manifestations than normal processes. In the present



Table 4.

INTER-RATER RELIABILITY COMPARING IRISH AND AMERICAN STUDIES

| Scale | Per cent agreement within 0.5 point (American) | Per cent agreement within 0.5 point (Irish) | Per cent agreement exact (Irish) |
|---|---|---|---|
| A. Amount of committable energy (school) | 0.92 | 1.0 | 0.9 |
| B. Amount of committable energy (non-school) | 0.7 | 0.8 | 0.6 |
| C. Commitment and persistence | 0.88 | 1.0 | 0.8 |
| D. Creative involvement | 0.77 | 1.0 | 0.6 |
| E. Degree of synthesis | 0.92 | 1.0 | 0.8 |
| F. Flexibility of thought and feelings | 0.76 | 1.0 | 0.9 |
| G. Impulse regulation | 0.91 | 1.0 | 0.9 |
| H. Inner experience of relationships | 0.8 | 1.0 | 0.7 |
| I. Wit, humour, playfulness | 0.79 | 0.9 | 0.6 |
| J. Profundity of thought | 0.84 | 0.9 | 0.9 |
| K. Self as actor | 0.88 | 0.8 | 0.8 |
| L. Self understanding | 0.88 | 0.8 | 0.6 |
| M. Social explorations and affiliations | 0.88 | 0.9 | 0.6 |
| N. Stress tolerance | 0.92 | 1.0 | 0.69 |
| O. Variety of thought content | 0.92 | 0.9 | 0.5 |
| Average score: | 0.85 | 0.93 | 0.73 |

Table 5.

AVERAGE SUB-SCALE AND TOTAL SCORES FOR ADAPTIVE PROCESSES IN THE THREE GROUPS

| | Group | | | T-test method | |
|---|---|---|---|---|---|
| Sub-scale | Normal (n = 11) | Spina Bifida (n = 8) | Psychiatric (n = 10) | Normal versus psychiatric | Spina Bifida versus psychiatric |
| A | 2.73 | 2.56 | 1.75 | p 0.005 | p 0.005 |
| B | 3.36 | 2.44 | 2.60 | p 0.025 | ns |
| C | 3.36 | 2.56 | 2.25 | p 0.001 | ns |
| D | 2.59 | 2.25 | 2.60 | ns | ns |
| E | 3.64 | 2.75 | 2.10 | p 0.001 | ns |
| F | 3.32 | 2.88 | 1.75 | p 0.001 | p 0.002 |
| G | 3.59 | 3.13 | 1.95 | p 0.001 | p 0.001 |
| H | 3.36 | 3.19 | 2.40 | ns | p 0.005 |
| I | 3.32 | 2.56 | 2.75 | ns | ns |
| J | 2.55 | 2.81 | 2.10 | ns | ns |
| K | 3.23 | 2.56 | 2.40 | ns | ns |
| L | 3.05 | 2.63 | 2.10 | ns | ns |
| M | 3.36 | 2.81 | 2.45 | ns | ns |
| N | 3.50 | 3.19 | 2.05 | p 0.001 | p 0.001 |
| O | 2.91 | 2.50 | 2.05 | ns | ns |
| TOTAL | 47.86 | 40.81 | 33.31 | p 0.001 | p 0.005 |



STUDY THE NORMAL PROCESSES OF ADOLESCENCE ARE EVALUATED, THEIR INTER-RATER RELIABILITY MEASURED, AND THE ASSOCIATION BETWEEN ADAPTATION AND PSYCHOPATHOLOGY IDENTIFIED.

THE INTER-RATER RELIABILITY IN THE MEASUREMENT OF THE ADAPTIVE PROCESSES GAVE AN AVERAGE SCORE OF 0.93 IN THE IRISH GROUP, WHICH COMPARES FAVOURABLY WITH THE RESULTS OF THE AMERICAN STUDY, (BEARDSLEE ET AL., 1985). RESULTS SHOWING A HIGHLY SIGNIFICANT DIFFERENCE BETWEEN THE PSYCHIATRIC AND THE NORMAL GROUPS IN 8 OF THE 15 PROCESSES ALSO PROVIDE SOME PRELIMINARY EVIDENCE OF CONSTRUCT VALIDITY FOR THE SCALES. THIS SUPPORTS THE ORIGINAL FINDINGS OF BEARDSLEE ET AL. IN THEIR STUDY.

A HIGH PREVALENCE OF PSYCHIATRIC DISORDER WAS FOUND IN THE SPINA BIFIDA GROUP, AT 37.5%. PREVIOUS STUDIES ON HANDICAPPED CHILDREN FOUND A FIVE-FOLD INCREASE IN PREVALENCE AMONGST HANDICAPPED CHILDREN WITH NEURO-EPILEPTIC CONDITIONS AND A THREE-FOLD INCREASE IN HANDICAPPED CHILDREN WITH LESIONS BELOW THE BRAIN STEM, (GRAHAM AND RUTTER, 1968A).

IN THE SPINA BIFIDA GROUP IN THE PRESENT STUDY, 6 OUT OF 8 OF THE SAMPLE HAD LESIONS ABOVE THE BRAIN STEM. THE PREVALENCE RATE OF 37.5% IN THIS GROUP IS STILL HIGH COMPARED TO THE 34% PREVALENCE FOUND BY RUTTER IN A GROUP OF CHILDREN ALL OF WHOM HAD NEURO-EPILEPTIC CONDITIONS. A POSSIBLE EXPLANATION FOR THIS MIGHT BE THE INCREASED AGE OF THE PRESENT SAMPLE, ALL OF WHOM WERE TEENAGERS.

THE RESULTS OF THE PRESENT STUDY HIGHLIGHT THE CLINICAL USEFULNESS OF THE PROCESSES MEASURED. THE ADAPTIVE PROCESS SCALES ARE MEASURES OF EGO FUNCTION

WHICH ALLOW THE ASSESSMENT OF THE DEVELOPING PERSONALITY OF THE INDIVIDUAL. THESE MEASURES COULD BE VERY USEFUL CLINICALLY IN THE ASSESSMENT OF THE SUITABILITY OF PATIENTS FOR THE PROCESS OF PSYCHOTHERAPY.

HOWEVER, IN INTERPRETING THE INTER-RATER DATA, IT IS APPARENT THAT AGREEMENT IS CLOSER WHEN PROCESSES WITH A MORE OBVIOUS BEHAVIOURAL COMPONENT ARE ASSESSED, E.G., IMPULSE REGULATION, AND LESS WHERE A MORE PURELY INTRA PSYCHIC PROCESS, E.G., SELF UNDERSTANDING, IS ASSESSED. A SIMILAR OBSERVATION MIGHT BE MADE ABOUT THE INTER-GROUP COMPARISONS, (TABLE 5.) THIS SUGGESTS THAT, AS WITH THE RUTTER SCALES, OUTWARD BEHAVIOUR IS STILL EASIER TO MEASURE THAN FEELINGS/ATTITUDES.



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# DISCONNECTION AND PSYCHIATRY

MICHAEL FITZGERALD.

**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. PEOPLE FEEL DISCONNECTED FROM NATURE AND LIVE IN OVER-CROWDED, 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 WHICH GAVE THEM A SENSE OF SOLIDARITY WITH THEIR COMMUNITY IN THE PAST. 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.

THE MODERN CITY INCREASES ANOMIE AND THE DISCONNECTION OF HUMAN BEINGS FROM ONE ANOTHER. THE LOWER-PAID AND UNEMPLOYED APPEARED TO BE INCREASINGLY VULNERABLE TO THESE PSYCHOLOGICALLY TOXIC ASPECTS OF OUR CITIES. SOCIAL FORCES, PARTICULARLY IN CITIES, ARE IN FAVOUR OF INDIVIDUALISM, COMPETITIVENESS AND SELF-INTEREST, WHICH ALL MAKE PEOPLE FEEL ALONE, UNATTACHED AND UNCARED FOR AS HUMAN BEINGS.

WHAT IS "TRUE VALUE" IS NOW DEFINED BY ECONOMISTS, TECHNOLOGISTS AND ADVERTISING AGENCIES. 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 THEIR 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."

OF COURSE, THIS LAMENTATION OVER DISCONNECTION IS NOTHING NEW. AS 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 PRINCIPAL (THE GERM AS IT WERE) OF PUBLIC AFFECTIONS. IT IS THE FIRST LINK IN THE SERIES IN WHICH WE PROCEED TOWARDS A LOVE TO OUR COUNTRY AND TO MAN KIND."

FOR BURKE, "THE AGE OF CHIVALRY IS GONE. THAT OF SOPHISTERS, ECONOMISTS, AND CALCULATORS HAS SUBSEEDED." THE "CALCULATORS" DO NOT REALISE THE PRESERVATIVE POWER OF STRONG GROUP ATTACHMENT. (MAHONEY, 1955).

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 ANT HILLS 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, THEN 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 FURTHER RESPONSIBILITY TO HUMAN BEINGS; NO FURTHER RESPONSIBILITY TO CONNECT WITH HUMAN BEINGS; TO REACH OUT TO THE ALIENATED AND DISCONNECTED. (BLOOM, 1979).

ANOTHER FORM OF DISCONNECTION - A DISCONNECTION FROM SOCIAL INSTITUTIONS, OBJECTS AND IDEAS SUCH AS SOCIETY, COUNTRY AND COLLECTIVE SENTIMENT - WAS CALLED BY DURKHEIM "EGOISTIC." 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.

IT IS STILL 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."

In the United Kingdom it was also found by Brown (1978) that one of the vulnerability factors of depression in working-class women was the quality of their social connections. Women who had a close, confiding relationship with another person were much less likely to experience depression in response to stressful life events. Only four per cent of those who had major stressful life events and who had a confiding connection with another became depressed, compared to thirty-eight per cent of those who were disconnected and without a close, confiding relationship. Fitzgerald and McGee (1989) showed that children with gastroenteritis were more likely to be hospitalised if mother had poor social linkage.

Durkheim's studies on anomie, that is, when the controlling normative structure of society is disorganised and the individual begins to feel disorientated, 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 (1897) 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 forty years, that is, a weakening and disrupting of the "conscience collective" which was the system of social norms which 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 less religious beliefs and rites to bind the society together, and it is worth noting that Durkheim (1912) stated "that religion is something essentially social." The church traditionally met people's needs for consolation but, 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, nevertheless they are but "a drop in the ocean" in terms of what is needed.

Now materialism and individualism are worshipped without balance, and the recognition of the importance of solidarity and social linkage is forgotten. Tocqueville noted that there was 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 they have been hurt by other human beings, particularly in childhood. Children who have been hurt 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.

In dealing with bureaucracy, the disadvantaged can sometimes still feel like that. This 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." 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 HE STATED: "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 "URBANITES" FIND THEMSELVES TODAY. W. H. AUDEN CALLED THE PERIOD AFTER THE SECOND WORLD WAR "THE AGE OF ANXIETY." THIS IS STILL RELEVANT TO OUR TIME, AS IRISH PEOPLE HAVE BEEN SHOWN TO HAVE HIGH LEVELS OF ANXIETY SYMPTOMS. THE ANXIETY NOW IS LESS ABOUT NUCLEAR OBLITERATION THAN THAT WHICH COMES FROM DISCONNECTION AND DISTRESS OF 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."



UNFORTUNATELY, IN THE SECOND HALF OF THE TWENTIETH CENTURY, PEOPLE'S NEEDS AND WANTS ARE BEING DEFINED BY ADVERTISING AGENCIES IN TERMS OF CONSUMER GOODS. THE ADVERTISERS OFFER PEOPLE "MASKS" OR "PERSONA" WHICH HAVE BEEN CHOSEN BY THE DOMINANT COMMERCIAL INTERESTS. UNFORTUNATELY, PEOPLE OFTEN CONFORM TO THE WISHES OR MODELS THE ADVERTISING AGENCIES OFFER.

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 ROCHEFOUCAULT 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, THEN PEOPLE WILL HAVE TO BE DIRECTLY RESPONSIVE TO THE NEEDS OF THOSE THEY MEET EACH DAY. 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 ONLY BE A DECENT LIFE FOR PEOPLE 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, AND ROUSSEAU POINTED OUT IN HIS "SECOND DISCOURSE ON INEQUALITY" THAT THEY ENSLAVE THEMSELVES IN THE UPWARDS SPIRAL OF THEIR OWN NEEDS. THEY ARE AT RISK OF A FORM OF PROMETHEANISM OR, AS

ROUSSEAU PUT IT, "THE PRIVILEGED FEW GORGED THEMSELVES WITH SUPERFLUITIES."

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, BUT THIS WOULD TAKE ANOTHER PAPER TO DISCUSS.

FOR CENTURIES THERE HAVE BEEN THOSE WHO HAVE ARGUED AGAINST THE VALUES OF COMMERCE, AND THERE ARE GROUNDS FOR HOPE IN THAT AYER (1990) HAS ARGUED "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 IN THE 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."



IN THE EIGHTEENTH CENTURY ROUSSEAU SAID THAT "KEEPING CITIZENS APART HAS BECOME THE FIRST MAXIM OF . . . . . POLITICS." IN THE TWENTIETH CENTURY THE FIRST MAXIM OF POLITICS SHOULD BE IN BRINGING PEOPLE TOGETHER, FOR EXAMPLE, BY HOUSING THEM CLOSER TO THEIR CONNECTIONS, I.E., FAMILIES OF ORIGIN, AND NOT IN DISCONNECTED NEW TOWNS.

THE ARTISTS AND WRITERS HAVE BEEN ABLE TO FIND SOME SOLIDARITY IN THE TWENTIETH CENTURY. IGNATIEFF (1990) POINTS OUT THAT JOYCE'S DUBLIN "TAKES US BEYOND EASY LAMENTS ABOUT ALIENATION OF MODERN LIFE, WHICH HAS ENABLED US TO FIND A LANGUAGE FOR THE NEW PLEASURES OF LIVING AS WE DO."

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# ISSUES DURING THE MIDDLE YEARS

MICHAEL FITZGERALD.

THERE ARE NEGATIVE AND POSITIVE ASPECTS TO THE COURSE OF LIFE DURING THE MIDDLE YEARS.

ON THE NEGATIVE SIDE THERE IS AN INCREASE OF MENTAL HEALTH PROBLEMS, INCLUDING DEPRESSION, ALCOHOLISM AND SUICIDE.

COLLEGE EDUCATED MEN TEND TO BE MORE DEPRESSED, SHOW MORE EVIDENCE OF PSYCHOLOGICAL IMMOBILISATION, HAVE MORE DRINKING PROBLEMS AND MORE READILY TURN TO DRUGS FOR TENSION RELIEF, BUT THEIR SELF ESTEEM REMAINS INTACT. IN CONTRAST, SECONDARY SCHOOL EDUCATED MEN TEND TO PLUMMET ONLY IN THE AREA OF SELF ESTEEM, (TAMIR, L. M., 1987).

IN THE MIDDLE YEARS, THERE IS A MAJOR SHIFT IN THINKING AND TALKING OF "TIME SINCE BIRTH" TO "TIME LEFT TO LIVE," (NEUGART, B., 1979). PENSION FUNDS AND RETIREMENT BENEFITS TAKE ON MUCH GREATER IMPORTANCE. THOUGHTS ABOUT RETIREMENT BECOME MUCH MORE PROMINENT.

Based on a paper prepared for the Twenty year Anniversary of Graduation Meeting of the University College Galway Medical Class of 1970, at Ennis, Co. Clare. November 9th, 1990.

THE MIDDLE-AGED BECOME CONCERNED WITH THEIR EMOTIONAL AND FINANCIAL LEGACY TO THEIR CHILDREN. BECAUSE OF THE DEATH OF PARENTS, THE MIDDLE-AGED GO TO THE "HEAD OF THE LINE." THEY BECOME AWARE THAT THEY ARE NEXT IN LINE FOR THE GRAVE.

THE TASKS OF MIDDLE LIFE INCLUDE TAKING STOCK OF ONE'S LIFE, REAPPRAISING WORK AND MARRIAGE, ENSURING THAT ONE IS REMEMBERED WITH AFFECTION BY BECOMING A MENTOR TO THE YOUNGER GENERATION AND LEAVING AN IMPRINT ON FUTURE GENERATIONS THROUGH GENERATIVITY.

SAMUEL OSHERSON (1980) EMPHASISES THAT THE MIDDLE-AGED HAVE TO COME TO TERMS WITH NOT HAVING ACHIEVED THEIR CHILDHOOD DREAMS AND THAT THIS MEANS A SENSE OF LOSS ITSELF. THIS MAY HAPPEN LESS WITH WOMEN, BECAUSE IN THE PAST THEY MAY HAVE SET OUT WITH LESS CAREER EXPECTATIONS AND ARE THEREFORE MORE SATISFIED AT MIDDLE AGE.

THE TAKING CARE OF ELDERLY PARENTS CAN BE QUITE A STRESS. CARE-GIVING INVOLVES MORE STRAIN WHEN THERE IS A CLOSE PERSONAL BOND WITH THE PERSON BEING CARED FOR, (CANTOR, M., 1983). THE CARE-GIVERS HAVE TO ACHIEVE A BALANCE BETWEEN UNDER AND OVER INVOLVEMENT. THOSE OVER INVOLVED CAN EXPERIENCE CONSIDERABLE RESENTMENT, AND THOSE UNDER INVOLVED CONSIDERABLE GUILT. MODELL (1989) POINTS OUT THAT THE PERSON DURING THE MIDDLE YEARS HAS TO COPE WITH THE LOSS OF SELF-DECEPTIVE ILLUSIONS, FOR EXAMPLE, ABOUT IMMORTALITY, AND TO CONFRONT DEATH.

DEATH ANXIETY CAN INHIBIT CREATIVITY BUT, FOR THE POET ROBERT LOWELL, POETRY WAS THE ALTERNATIVE TO PSYCHIC DEATH AND, IN A SENSE, ALL ART IS A TRANSFORMATION. AS STEPHEN SPENDER SAID, THE GREATNESS OF THE ARTIST CONSISTS IN HIS CAPACITY TO TRANSLATE THE



HARSH, UNPOETIC MATERIAL OF THE WORLD INTO POETRY. DURING THE MIDDLE YEARS PEOPLE WHO DO NOT HAVE THIS CAPACITY TO TRANSFORM REALITY, FOR EXAMPLE, THROUGH THE USE OF SYMBOLS, HAVE A GREATER SENSE OF FUTILITY. THESE WOULD INCLUDE EXCESSIVELY CONCRETE PEOPLE LIKE OBSESSIONAL PERSONALITIES. AS ERICKSON (1959) POINTS OUT, PSYCHOLOGICAL DEVELOPMENT OCCURS FROM BIRTH TO DEATH, THE MIDDLE LIFE TASK BEING GENERATIVITY, THAT IS, GUIDING AND ESTABLISHING THE NEXT GENERATION. FOR KOHUT (1977) "THE TRAGIC MAN" IN MID LIFE HAD NOT FULFILLED HIS NUCLEAR AMBITIONS. THE TRAGIC MAN WAS WELL DESCRIBED BY JOHN CHEEVER, IN HIS NOVEL "THE SWIMMER."

IN THE FIRST HALF OF THE TWENTIETH CENTURY THERE WAS AN EMPHASIS ON MAN BECOMING INNER-DIRECTED AND AUTONOMOUS FROM SOCIETY.

IN THE SECOND HALF OF THE TWENTIETH CENTURY THERE IS MORE AN EMPHASIS ON NARCISSISM AND "PLAYING THE GAME." THE EMPHASIS IS ON DOING THAT WHICH WILL BRING ADMIRATION IN THE MIDDLE YEARS. THE MIDDLE-AGED PERSON BECOMES VERY PATHETIC AND DEPRESSED IF THE ADMIRATION AND PUBLIC SUCCESS ARE NOT FORTHCOMING.

THE UNREALISED MIDDLE-AGED AMBITIONS MAKE THE INDIVIDUAL AWARE OF FINITE TIME. THESE MAY THEN BE DISPLACED ON TO THE SYMBOLIC EXTENSIONS OF THE SELF, FOR EXAMPLE, FAMILY OR GROUP. THIS SHIFT FROM SELF TO OTHERS LEADS TO THE TRANSFORMATION OF INFANTILE NARCISSISM INTO THE MATURE GOALS OF NORMAL ADULTS. (MICHELLS, 1981).

THERE IS A SHIFT FROM GUILT IN THE EARLY YEARS TO A SENSE OF TRAGEDY IN THE MIDDLE YEARS.

The Locus Coeruleus at the base of the fourth ventricle is a centre involved in arousal, anxiety and fear. Seventy per cent of the cells that use the neurotransmitter epinephrine are concentrated in the Locus Coeruleus. There is a reduced synthesis in middle age and an increase of monamine oxidase, which is responsible for the metabolism of norephrine. There is an increase of an inert waste product of norephrine, neuromelanin, in the cells. There is a decrease in the number of intact cells in the Locus Coeruleus. This may be related to a mellowing of the personality, a decrease in anxiety and a move to a more mature defenses in the middle years.

People in the middle years maintain a view of themselves as somewhat younger than they actually are, to defend against the harsh reality of time. They have a narcissistic reluctance to accept their limitations and a wish to avoid their mortality. They want to remain young and cared for. The descending narcissist turns to face lifts or sports (Perry, 1989). A person's perception about his body fails to keep up with small changes during the middle years. These changes have to be incorporated into the self representational world and evoke the three signal anxieties of fear of loss of love, power, self-regard and, in addition, fear of loss of core identity. When these losses are faced up to, there is then grief work to be done.

There is also a loss of "fluid intelligence," the capacity to memorise, but there is an increase in "crystallized intelligence," i.e. the capacity to conceptualise issues and put them in perspective. People during the middle years become "less smart but more wise," (Perry, 1989).



Clearly, life events affect intrapsychic structure throughout life and it is important, as Michells (1980) stated, to recognise that "it would be a great error to infantomorphize" adult psychological processes, as it was to "adultomorphize" childhood in the last century.

As Pearl King (1980) pointed out, older patients have more a sense of "becoming" than of "being" and they reflect Kierkegaard's observation that "life can only be understood backwards."

It is instructive to examine Henri Matisse's creative development during the middle years of his life, between 1917 and 1928. He was aged between forty-seven and sixty-one during that period. He was faced with a decision to continue repeating himself, which would have brought him recognition and material success, with the alternative of taking a risk and seeking new experiences, (Vieterman, M., 1987). As his children were no longer at home, he took off to Nice without his wife, to replace the world that had become burdensome to him. His mother, who had always encouraged his painting and, indeed, he said that every painting was for her, died in 1918. This confronted him with his own mortality, and he went to Nice in an attempt to master her death. He coped with his mother's death by actively abandoning his wife, rather than passively mourning his mother. He rediscovered his life force and creative potential through the inspiration provided by a series of talented and attractive models who took the role for him of transitional objects, (Vieterman, 1987).

Since the creative artist needs conflict, this was provided for him by the flight from his wife and the associated loneliness and discomfort of his life in

Nice in the first year. In mid-life, there is a preoccupation with the internal world and, not surprisingly, he began to paint interior scenes, for example, the "Interior of a Room Painted at Nice in 1918." As he began to come out of this empty, depressing period, humans began to appear again in his painting, for example, in 1921 he painted "The Interior in Nice, a Woman in a Green Dress leaning at the Window." It is likely that his new models helped him out of his empty depression of the "interiors" period.

## Positive Aspects of the Middle Years

It is realised now that there is more plasticity in the brain than was previously thought. Dormant connections in the brain can be activated. Some dendrite structures disappear and other new ones are formed. It is clear that because of this morphological plasticity, there is still a capacity for learning.

There is a shift from the immature defenses of adolescence to the mature defenses of the middle years. The immature defenses include (a) acting out, (b) projection, (c) schizoid fantasy and hypochondriases. The hypochondriacal defense was shown by a number of later very successful people, including Florence Nightingale, founder of modern nursing, Mary Eddy of Christian Science and Bertha Pappenheim, a patient of Sigmund Freud who later became a leader of the German women's movement. Man shifts to the mature defenses of the middle years including, (a) suppression (b) altruism, (c) sublimation, (d) anticipation and humour. As usual, Sigmund Freud was on the mark when he quipped that "a young whore makes an old nun." One also sees that delinquency and criminality in adolescence are



replaced by intellectualisation in middle years, and the emergence of the jail-house lawyer.

For many people the middle years can be the best years of their lives, a period of relative stability when they have the benefit of wisdom and experience. People during the middle years, according to Gasset (1958), are the "dominant generation and natural leaders of society." They are more reflective, tolerant and realistic.

When the individual negotiates the middle years successfully, he begins to integrate the contradictions in life, becomes less work focused and accepts the limitations of life. He can see shades of grey in the decision-making process. Riegel (1973) has pointed out that the highest level of cognitive functioning, that is, dialectical thought, is achieved in mid life. Men and women develop more rounded personalities in mid life. Women become more assertive and independent, while men become more sensitive and nurturant. There is a degree of disengagement from work and the inter-personal aspects of work become more important. There is a shift of focus from the children to a focus on the marriage, from father and mother to husband and wife. Connections become very important, and it is clear that the most socially active are the least stressed, and those most isolated the most stressed.

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# A STUDY OF EXPECTATIONS OF A CHILD AND FAMILY CENTRE

MICHAEL FITZGERALD; OLIVER KEENAN.

AT A TIME OF RE-ORGANISATION OF PSYCHIATRIC SERVICES, IT IS IMPORTANT TO STUDY THE EXPECTATIONS OF FAMILIES ATTENDING CHILD AND FAMILY CENTRES, BASICALLY COMMUNITY RESOURCES, (PLANNING FOR FUTURE, 1984). IT HAS BEEN STATED THAT THERE IS A LACK OF CHILD AND FAMILY CENTRE RESEARCH INTO CLIENT OPINION, AND THAT THE VIEWS AND NEEDS OF THE CLIENTS WERE CRUCIAL TO ANY CONSIDERATION OF THE COMMUNITY ROLE IN THESE SERVICES, (WHITMORE, 1974). IT HAS BEEN EMPHASISED THAT THERE IS A NEED TO "DEVELOP QUANTITATIVELY AND QUALITATIVELY ADEQUATE COMMUNITY PROVISION" IN THE PSYCHIATRIC SERVICES, (EDITORIAL, 1985).

IT HAS BEEN SHOWN THAT HOW THE PATIENT PERCEIVES AN AGENCY IS ONE OF THE VERY IMPORTANT ELEMENTS IN THE COMPLEX SOCIAL PROCESS OF SEEKING HELP, (MORRIS ET AL., 1973). PATIENTS DIFFER IN THEIR EXPECTATIONS OF WHAT A PROFESSIONAL HELPER MIGHT DO TO HELP THEM. MOST PATIENTS RETAIN SOME CHILDHOOD HOPE OF MAGICAL SOLUTIONS, A WISH THAT BECOMES MORE INTENSE WHEN A PERSON EXPERIENCES DISTRESS. MANY FAMILIES ALSO HAVE UNREALISTIC EXPECTATIONS OF WHAT A CHILD AND FAMILY CENTRE CAN DELIVER. SUCH EXPECTATIONS OCCUR NOT ONLY AMONG THE UNEDUCATED OR UNSOPHISTICATED FAMILIES, MANY OF WHOM MAY SIMPLY LACK INFORMATION; THEY OCCUR FOR DIFFERENT REASONS AMONG FAMILIES WHO, ON THE BASIS OF THEIR EDUCATIONAL EXPERIENCE, HAVE HEARD OR READ A GOOD

DEAL ABOUT CHILD AND FAMILY CENTRES. IT HAS BEEN STATED THAT THE BELIEFS OR EXPECTANCIES ABOUT THERAPY WHICH THE PATIENT BRINGS TO THERAPY MAY INFLUENCE THE RESULTS OF THERAPY, AND THAT THE GREATER THE DISTRESS OR NEED FOR RELIEF, THE GREATER THE EXPECTANCY OR LIKELIHOOD OF SUCH RELIEF, (FRANK ET AL., 1955).

AS FAMILIES' EXPECTATIONS MAY HAVE CONSIDERABLE BEARINGS ON THEIR APPROACH TO CHILD AND FAMILY CENTRES, AND FUTURE RELATIONSHIPS WITH THE MULTI-DISCIPLINARY TEAM WITHIN SUCH A CENTRE, IT WAS DECIDED TO STUDY THESE EXPECTATIONS IN AN IRISH CONTEXT.

## METHOD

A CONSECUTIVE SAMPLE OF NEW REFERRALS TO A CHILD AND FAMILY CENTRE WERE STUDIED. THE CHILD AND FAMILY CENTRE WAS SITUATED IN A DISADVANTAGED AREA WHERE HOUSING WAS CORPORATION-OWNED AND HOUSING DENSITY WAS HIGH. THERE WAS HIGH UNEMPLOYMENT IN THE AREA. ONE OF THE AUTHORS (O.K.) INTERVIEWED EACH NEW REFERRAL BEFORE ASSESSMENT. THE FOLLOWING INFORMATION WAS DOCUMENTED:-

1. AGE AND SEX OF REFERRED CHILD;
2. EMPLOYMENT STATUS;
3. MARITAL STATUS OF PARENTS;
4. SIZE OF FAMILY;
5. REFERRAL SOURCE;
6. INFORMATION RECEIVED FROM REFERRED;



7. EXPECTATIONS AND FEARS ABOUT ATTENDING THE CHILD AND FAMILY CENTRE;
8. EXPECTATIONS ABOUT TYPE OF PROFESSIONAL WHO WOULD INTERVIEW THEM;
9. TYPE AND LENGTH OF TREATMENT EXPECTED;
10. EXPECTATIONS OF FAMILY VERSUS INDIVIDUAL ASSESSMENT;
11. HOW THE EXPERIENCE OF COMING TO THE CHILD AND FAMILY CENTRE HAD AFFECTED THE FAMILY;
12. STIGMA OF ATTENDING A CHILD AND FAMILY CENTRE.
13. LENGTH OF TIME BETWEEN REFERRAL AND ASSESSMENT AT THE CHILD & FAMILY CENTRE.

ALL MOTHERS WERE ASKED THE SAME QUESTIONS IN THE SAME WAY. IN ADDITION TO THE 11 QUESTIONS BEING ASKED OF MOTHERS THE CHILD, IN THE PRESENCE OF MOTHER, WAS ASKED ABOUT HIS EXPECTATIONS AND FEARS ABOUT ATTENDING THE CHILD AND FAMILY CENTRE, AS WELL AS ABOUT INFORMATION RECEIVED FROM REFERRER.

## RESULTS

A CONSECUTIVE SAMPLE OF 46 NEW REFERRALS WERE STUDIED, AND THE RESPONSE RATE WAS 100%. THIRTY OF THE 46 CHILDREN WERE MALE, AND 16 WERE FEMALE. THE AGE RANGE WAS FROM 2 TO 15 YEARS, WITH AN AVERAGE AGE FOR BOYS OF 9.6 YEARS, AND FOR GIRLS, 7.1 YEARS.

The size of the families varied from 1 child to 11 children, with an average family size of 3.8 children. Thirty-nine (85%) of the parents were living together and 7 (15%) were separated. Sixteen (38%) of the fathers were unemployed.

The sources of referrals were:-

1. General Practitioners, 16.
2. Community Care Medical Services, 16.
3. Social Services, 7.
4. Self-referral, 1.
5. Legal agencies, 2.
6. General Hospitals, 4.

## Information Received from Referrer

Fifty-five per cent of the parents received no information about the Child and Family Centre from the referrer and, of the referred children, 48% were told nothing about the Child and Family Centre and did not know why they were coming. Of the 52% of children who were given some information, it was not always accurate, e.g., "the doctor is going to examine my ears," while another child felt that he was coming to a play school, and a third was going to change his behaviour.



## Feelings about attendance at a Child and Family Centre

Forty per cent of the children expressed positive feelings about attendance. Thirty per cent of the remainder were negative about coming, and this manifested itself in feelings of anxiety and apprehension about the Child and Family Centre. The final 30% expressed neither negative nor positive feelings about coming.

## Expectations and fears about attending a Child and Family Centre

Forty-five per cent of the parents denied any special thoughts about the Child and Family Centre before attendance. None of the parents thought it would be a mental hospital or place of punishment.

## Type and length of treatment expected

Forty-eight per cent of the parents identified the type of treatment as "talking," and correctly assumed it would probably take months to effect any change. Eight per cent of parents felt that medication would be used and 44% did not know what form of treatment would be offered. When mothers were asked how long they felt the treatment would take, the answers ranged from one hour to three years.

### Expectations about the type of professional by whom they would be interviewed

Ninety-one per cent of parents expected to see a doctor at the Child and Family Centre.

### Expectations of family versus individual assessment

When mothers were asked if they would rather be seen alone or with the family, 48% expressed the wish to be seen alone, as they felt that some matters should not be discussed in front of the children. The other 52% would have liked to have been seen as a whole family, as they felt that this would help the child's problem.

### Effects on family of attending Child and Family Centre

Twenty-four per cent of mothers felt resentful at having to attend a Child and Family Centre, and were angry that they were not able to handle their children without assistance. It was also noted by the interviewer that this initial anger dissipated during the research interview which took place immediately on their arrival at the Clinic for the first interview. One parent expressed the view at the end of the research interview that "this is a very friendly place."

### Stigma of attending a Child and Family Centre

Sixty-one per cent of the mothers were willing to tell their family or friends that they had attended a Child and Family Centre. They felt that there was no stigma



attached to it. The remaining 39% would not tell anyone because of a psychiatric stigma.

### Length of time between wish for help and referral

When parents were questioned about the time lapse between their first wish for help and actual referral, this ranged from four days to seven years. The average length was four months.

### Length of time between referral and attendance at Child and Family Centre

The average length of time between being referred and attendance at first appointment was twenty days.

## Discussion

In this study, 40% of the families had positive feelings towards the Child and Family Centre, which suggested that they had hope that they would be helped. It has been shown that the arousal of hope leads to a decrease in symptoms of emotional distress and demoralisation, (Pritchard, 1974). This expectation of improvement is a non-specific therapeutic factor.

It is of interest that some of the patients relaxed during the research interview, and it has been shown that patients' perception of therapists' empathy is a significant predictor of good outcome. It has also been shown that when patients saw the therapists as feeling "uncertain," the outcome tended to be significantly poorer, (Tovian, 1977).

THE PROPORTION OF THOSE REFERRED WHO HAD NEVER HEARD OF A CHILD AND FAMILY CENTRE WAS SIMILAR TO AN EARLIER ENGLISH STUDY, (WALKER, 1970).

IT HAS BEEN SHOWN THAT 3 OUT OF 10 FAMILIES WERE UNABLE TO STATE THEIR EXPECTATIONS IN RELATION TO THEIR ROLE IN A CHILD AND FAMILY CENTRE, (MASS, 1955). IN THIS STUDY, 45% DENIED ANY THOUGHTS ABOUT THE CHILD AND FAMILY CENTRE BEFORE ATTENDING, AND THOUGHT THAT IT WOULD BE "JUST LIKE ANY OTHER CLINIC."

THE THERAPEUTIC APPROACH IN CHILD AND FAMILY CENTRES IS BROADLY PSYCHOTHERAPEUTIC, AND CLINICAL EXPERIENCE HAS SUGGESTED IN THE PAST THAT PATIENTS FROM SOCIO-ECONOMIC GROUPS 3 - 5 DO NOT SEE THEIR PROBLEM AS HAVING A PSYCHOLOGICAL BASIS THAT CAN BE HELPED BY PSYCHOTHERAPY. IT HAS BEEN SHOWN THAT PATIENTS FROM SOCIO-ECONOMIC GROUPS 3 - 5 WILL STAY IN THERAPY LONG ENOUGH FOR THE THERAPEUTIC PROCESS TO OPERATE, WHEN ROLE EXPECTATIONS OF PATIENTS AND THERAPISTS ARE MORE CONGRUENT, (HEITLER, 1976). IT HAS BEEN SHOWN THAT TELEVISION AND THE PRESS HAVE PROVIDED MUCH INFORMATION TO THE PUBLIC ABOUT THE PSYCHOTHERAPEUTIC PROCESS, AND THEREFORE THE DIFFERENCES BETWEEN HIGHER AND LOWER SOCIAL STATUS HAVE CONSIDERABLY REDUCED, (KLADUSHIN, 1968, WHAL, 1976). THE FACT THAT PATIENTS IN THIS STUDY FROM LOWER-CLASS DISADVANTAGED FAMILIES THOUGHT THAT "TALKING" TREATMENT WOULD MOST LIKELY BE GIVEN IN 48% OF CASES, SUGGESTED THAT THEY HAD SEEN THE PROBLEMS OF THEIR CHILD AS HAVING A PSYCHOLOGICAL BASIS.

IT HAS BEEN SHOWN THAT LOCAL AUTHORITY SOCIAL WORKERS AND SCHOOL STAFF MAY HAVE MISCONCEPTIONS ABOUT CHILD AND FAMILY CENTRES, (WALKER, 1970, ROSENFELD, 1964) AND THAT FAMILIES CAN PICK UP THE AMBIVALENCE OF A REFERRER, (WALDRON-SKINNER, 1976). IT IS CLEAR FROM



THIS STUDY THAT THERE IS A NEED FOR PRE-TREATMENT PREPARATION OF PATIENTS FROM DISADVANTAGED AREAS. IT HAS BEEN SHOWN THAT THE MAJORITY OF PATIENT PREPARATION TECHNIQUES DO SIGNIFICANTLY IMPROVE THE MENTAL HEALTH TREATMENT OF THE DISADVANTAGED, (HEITLER, 1973). IT WOULD SEEM WORTHWHILE FOR CHILD AND FAMILY CENTRES TO TRAIN THEIR REFERRERS IN THESE PRE-TREATMENT PREPARATION OF FAMILIES TECHNIQUES. THIS WILL APPLY IN PARTICULAR TO GENERAL PRACTITIONERS, COMMUNITY CARE DOCTORS, PAEDIATRICIANS, ADULT PSYCHIATRISTS, SOCIAL WORKERS, AND PUBLIC HEALTH NURSES.

AN ALTERNATIVE APPROACH WOULD BE FOR A SOCIAL WORKER TO VISIT THE FAMILY AFTER THE REFERRAL WAS MADE, AND FOR THE TREATMENT PREPARATION TO BE DONE IN THE HOME PRIOR TO THE FAMILY ATTENDING THE CLINIC. THIS WOULD BE A MUCH MORE TIME-CONSUMING APPROACH, AND EXPENSIVE PARTICULARLY IN A CLIMATE OF ECONOMIC STRINGENCY. ALL PRE-TREATMENT PREPARATION INTERVIEWS WOULD INCLUDE DISCUSSIONS OF THE REASONS FOR REFERRAL, AND THE ASSESSMENT AND TREATMENT PROCEDURES TO WHICH THE FAMILY WOULD BE EXPOSED IN CHILD AND FAMILY CENTRES.

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# RESPONSE TO THE WORKING PARTY REPORT ON CHILD AND ADOLESCENT PSYCHIATRIC SERVICES IN THE EASTERN HEALTH BOARD AREA, DECEMBER 1989.

Colette Halpin; Michael Fitzgerald.

**The Child** and Adolescent Section of the Royal College of Psychiatrists (Irish Division) welcomes the publication of this Report. This Report contains many positive recommendations for the future development of the Child and Adolescent Psychiatric Services in the Eastern Health Board region which are largely in agreement with the recommendations made to the Working Group on behalf of this Section in 1988.

## Catchment area re-organisation

There is uncertainty and a certain amount of confusion among the members of our Section as to the exact reasons for the re-organisation of the catchment areas as proposed. Under the proposed re-organisation the two main catchment areas that would be affected are Community Care Areas 6 and 4 (ref 2.7, 2.8). The Child and Adolescent Section point out that Community Care Area 6 has been served by the Eastern Health Board from the point of view of Child and Adolescent Psychiatric Services for many years, and it is in this area that there are two special schools and a number of residential treatment centres. Likewise, there is a well established Child and Adolescent Psychiatric

service in Community Care Area 4 which is part of the St. John of God Service.

Another point of importance is that the Report treats the St. John of God services as if they were one (ref 2.3). In practice these two services, i.e. the Orwell Road and Cluain Mhuire services, operate as two distinct clinical and organisational entities, under the auspices of the St. John of God Brothers. Given the amount of professional investment over the years in the development of these services, and as they exist, it is difficult to see how the re-organisation of the catchment areas could be clinically beneficial. We disagree with this proposal.

**Consultant Staffing**

The Report quotes the Royal College recommendation on Consultant norms in Child Psychiatry, (ref 2.11). However, the figure quoted of 2 per 200,000 is recommended by the College as an "irreducible minimum" and does not include Consultants who would work in specialist areas, in residential treatment units, in paediatric hospitals, or Consultants who would have teaching commitments, as do many in the Eastern Health Board region. Given this, plus the socio-economic factors applicable to this area, The Child and Adolescent Section believe that the ideal Consultant requirement would be even greater than the Royal College recommendations. However, when the permanent Consultant post quota in the Eastern Health Board region is increased to seventeen, there will be five Consultants working in full-time specialist areas, i.e. residential treatment units/C.S.A.V. units. A number of Consultants also have part-time/sessional



commitments to special schools, paediatric hospitals, etc. Taking all of this into account, the increase by two permanent posts will not bring the Consultant ratios up to the minimum norms recommended by the Royal College of Psychiatrists.

The Child and Adolescent Section agree with the recommendation that Consultant Child and Adolescent Psychiatrists should have an increased input and access to paediatric hospitals. The Central Remedial Clinic, Clontarf and the Cerebral Palsy Clinic, Sandymount, (ref 2.14, 2.15).

The proposal to have Our Lady's Hospital, Crumlin (ref 2.15) served by two Consultant teams is one that could lead to confusion. However, with careful negotiation and planning a comprehensive and efficient service could be developed. This should take the form of a Department of Child Psychiatry within the Hospital which would have as a central figure one Consultant responsible for the co-ordination and delivery of the psychiatric service to the hospital.

With regard to the Consultant posts in child sexual abuse validation unit, the recommendation that these two posts be made permanent is welcome, (ref 4.5). However, the original submission by the Child and Adolescent Section recommended the creation of two posts in each of the two paediatric hospitals. While it is important to provide an assessment and validation service for the victims of sexual abuse, it is important also to recognise that the treatment of these victims and their families (which it is recommended should take place at the Community Child Guidance Clinic) is often a lengthy and detailed process that may need to continue over several months, or years.

Due regard should be given to this need when considering Consultant staffing levels.

## Educational Psychology Service

The Child and Adolescent Section agree with the recommendation of the Report for a better educational psychology service (ref 2.22). This Section has, for a long time, been concerned about the lack of an educational psychology service at primary school level in this country. It is, however, the opinion of this Section that the educational psychology service should be set up under the Departments of Health and Education with educational psychologists working in child guidance clinics. This opinion has been voiced both to the Department of Education and Health in a letter from the Section in August 1989.

## Location of Services

The Report recommends that more use be made of Health Centres for holding child psychiatric clinics (ref 2.17). At present many Community Health Centres are not designed, or equipped, for this purpose. Nevertheless, there are some child guidance clinics working satisfactorily in these settings, for example, Kildare. Planning for the Future stressed the importance of Milieu therapy in Child and Adolescent Psychiatry and the need to give consideration to good design and furnishings, play rooms, group therapy rooms and audio-visual systems.

It is not absolutely necessary to work within these clinics in order to build up links with Primary



Care Personnel. Existing Child and Adolescent Psychiatry services can maintain satisfactory working relationships with Community Care without actually working within the same building.

With regard to the Child Guidance Clinic at St. James' Hospital, this clinic does function as a community based clinic at present in that it is situated in quite a central location in its catchment area. It is difficult to see why this Report feels it is necessary to re-locate this clinic (ref 2.19).

## Co-Ordination Group

The Child and Adolescent Section strongly support the principle that there should be effective co-ordination and liaison between the three different services. (2.25). There is a point which requires clarification, that is, when the Report refers to the Heads of Services: Is it the Clinical Directors to whom it is referring? It is vital that such experienced clinicians be part of such a group.

## Training and Research

The recommendations of the Report with regard to training and research in Child and Adolescent Psychiatry (2.28) are welcome, in particular the recommendation that there be a Professorial Chair in Child Psychiatry, however, this should not be at the expense of a Chair in Adult Psychiatry.

## Residential Facilities

In the opinion of the Child and Adolescent Section the present provision of residential facilities is not adequate for in-patient treatment of psychiatric disorders in children and adolescents. At present, the two facilities for in-patient treatment i.e. Warrenstown House/Court Hall and the Orwell Road Residential Unit accept national referrals in addition to those from their catchment areas. The present Mater catchment areas has no in-patient placement for a child as a crisis intervention. We repeat our previous recommendation that there be an in-patient unit for treatment of disturbed adolescents adjacent to St. Vincent's Hospital, Fairview, where such adolescents could then attend the Day Hospital Programme at St. Joseph's, Richmond Road, when their conditions permit. The facilities for residential treatment of intractable conduct disorders in boys, and particularly girls, are severely deficient. The Working Group's recommendation for additional residential facilities for medium and long term treatment of such children is welcomed (ref 2.29). There is also a need for a small secure unit for the treatment of severely conduct disordered girls.

The Department of Health should give due consideration to the fact that an alternative model of intervention such as earlier intervention in the form of day programme facilities, i.e. day hospitals, workshops, etc., may allow for earlier treatment and possibly prevention of the need for residential treatment in a number of cases.

With regard to the comments of the Report on the residential treatment of autistic children and adolescents, (ref 3.5), the Child and Adolescent



Section agree with the recommendations of the Report, however, the statement regarding autistics with "major" disturbance requires clarification. It is unclear as to whether this statement refers to autistics with major psychiatric disturbance or those autistic children who are more seriously mentally handicapped.

## Age of Adolescents

The Report recommends that for planning purposes the age range covered by the service should be twelve to sixteen years of age, (ref 3.2). The Child Care Bill 1988, when it is passed, will re-define the upper age limit of the Child as eighteen years. This will have implications for the Child and Adolescent Psychiatric Services.

## Areas outside the Eastern Region

It was not the brief of this Working Group to examine the needs of the areas outside the Eastern Health Board region. The Group calls on the Department to examine the needs of the rest of the country for a Child and Adolescent Psychiatric Service in areas where there are none, (ref 2.12). This is an extremely urgent matter and should be attended to as soon as possible. Child and Adolescent Psychiatric Services should be set up in each Health Board area around the country, however, this should not be at the expense of already overstretched services in the Eastern region.

## Mental Handicap

The Report did not address the needs of psychiatrically disturbed mildly mentally handicapped children who are usually treated by the Child and Adolescent Psychiatric Services. The Report also fails to address the problem of psychiatrically disturbed mentally handicapped children and adolescents who need residential treatment.

Based on response by Royal College of Psychiatrists (Irish Division) Child and Adolescent Psychiatry Section.



# ASPECTS OF PSYCHOTHERAPY AND COUNSELLING PROVISION IN IRELAND

Michael Fitzgerald.

**PSYCHOTHERAPY** services in Ireland tend to be more urban than rural based. Counselling services, particularly marital counselling services, are more evenly distributed throughout the country. However, in Ireland, like the United Kingdom, there is a concentration of services in large urban areas such as Dublin. It is also possible that the public demand for these services is greater in urban than in rural areas. The issue of individuals being stigmatised who avail of these services is probably greater in rural than in urban areas. Nevertheless, the demand and acceptance of these services is an example of the increasing self-confidence of Irish people, and the wish to no longer suffer in silence. Treating Irish people psychotherapeutically is basically similar to treating English people psychotherapeutically. A cross-cultural difference evident clinically is that the super ego of the Irish person tends to be more harsh than the super ego of English patients. Irish patients would appear to be more self-critical and to have more negative thinking. It would be interesting to study this in a scientific way cross-culturally.

Based on paper presented to the Second European Society for Psychotherapy Research Meetirg, Berne, Switzerland, September, 1989.

IRISH PEOPLE ENGAGE IN PSYCHOTHERAPY WITH THE SAME COMMITMENT AND POSSIBLY EVEN MORE PERSISTENCE THAN PEOPLE IN OTHER COUNTRIES. THERE IS AN EXPLOSION OF INTEREST IN AND KNOWLEDGE ABOUT PSYCHOTHERAPY. CLEARLY, THE BROADCAST MEDIA, BOOKS, ARTICLES AND "WORD OF MOUTH," PARTICULARLY IN "PSYCHOTHERAPY AREAS" LIKE SOUTH DUBLIN, HAVE STIMULATED INTEREST. THE GROWTH IN DEMAND AND PROVISION IN RECENT YEARS HAS BEEN PARTICULARLY NOTICEABLE IN THE PRIVATE SECTOR. AT THE SAME TIME, THE AMOUNT OF COUNSELLING AND PSYCHOTHERAPY BEING PROVIDED BY THE PUBLIC HEALTH SYSTEM IS INCREASING, WITH IN-THE-CORE PROFESSIONAL GROUPS (PSYCHIATRISTS, PSYCHOLOGISTS, SOCIAL WORKERS AND NURSES) PROVIDING PSYCHOTHERAPY AS ONE ASPECT OF THEIR SERVICES TO THE PUBLIC. IN ADDITION, THERE ARE NURSE BEHAVIOUR THERAPISTS AND DRUG COUNSELLORS, AS WELL AS COUNSELLORS IN OTHER AREAS. IT IS LIKELY THAT PROGRESS WOULD HAVE BEEN MORE RAPID HAD THERE BEEN A SHARP AND DISTINCTIVE DEFINITION OF WHAT PSYCHOTHERAPY IS, AND A REGISTER OF COUNSELLORS AND PSYCHOTHERAPISTS.

PSYCHOTHERAPY HAS BEEN DEFINED AS A TALKING TREATMENT, WHERE PEOPLE TALK OUT THEIR PROBLEMS AND UNDERSTAND THE MEANING AND ORIGIN OF THEIR PROBLEMS IN THE CONTEXT OF A GOOD RELATIONSHIP WITH A THERAPIST. THIS PROCESS IS OFTEN, THOUGH NOT ALWAYS, A HEALING ONE. THERE IS CLEARLY A DIFFICULTY IN PRECISELY DELINEATING THE FIELD OF PSYCHOTHERAPY AND THEREFORE ONLY INDICATIVE REGISTRATION IS POSSIBLE. IF LEGISLATION WERE PASSED, IT WOULD THEN BE UNLAWFUL TO IMPLY THAT ONE WAS A PSYCHOTHERAPIST UNLESS ONE WERE ON A REGISTER OF PSYCHOTHERAPISTS. FUNCTIONAL REGISTRATION WOULD ONLY BE POSSIBLE WHERE IT WAS POSSIBLE TO DEFINE PRECISELY WHAT THE SCOPE OF THE WORK WAS, FOR EXAMPLE, DENTISTRY.



THERE IS LITTLE DOUBT THAT ALL THE CORE PROFESSIONALS DO NOT POSSESS FORMAL PSYCHOTHERAPEUTIC TRAINING, AND THEY HAVE NOT ALWAYS MADE THIS CLEAR. THE PROBLEM HAS BEEN THAT THERE ARE GENERAL PSYCHOTHERAPEUTIC SKILLS THAT ALL THE CORE PROFESSIONALS HAVE, AND THEN THERE ARE THE MORE SPECIFIC AND COMPLEX SKILLS THAT ONLY THOSE WHO HAVE UNDERTAKEN SPECIALISED COURSES OF TWO TO FIVE YEARS' DURATION WILL HAVE ACQUIRED. THE MAJOR ORIENTATIONS IN IRELAND ARE PSYCHOANALYTIC, ROGERIAN, BEHAVIOUR, FAMILY, AND HUMANISTIC. THERE IS A NEED TO EXPAND THE PSYCHOTHERAPEUTIC ASPECTS OF CORE PROFESSIONAL GROUPS IN THE PROVISION OF SERVICES TO THE PUBLIC WITHIN THE PUBLIC HEALTH SECTOR. AT PRESENT, CERTAIN EUROPEAN PSYCHOTHERAPY GROUPS ARE TRYING TO PREVENT NON-CORE PROFESSIONALS PROVIDING PSYCHOTHERAPY SERVICES. WITH THE INCREASING DEVELOPMENTS IN THE COMMUNITY PSYCHIATRY AREA, THE TIME IS OPPORTUNE FOR THE EXPANSION OF THE PSYCHOTHERAPY SERVICES.

# THE STATUTORY REGISTRATION OF PSYCHOTHERAPISTS

MICHAEL FITZGERALD.

A PUBLIC DEBATE IS BEGINNING INTO THE TRAINING OF PSYCHOTHERAPISTS. QUESTIONS ARE BEING ASKED ABOUT THE STATUS OF THE TRAINING WHICH HAS BEEN UNDERTAKEN BY CERTAIN PSYCHOTHERAPISTS. THE PUBLIC IS TO BE FORGIVEN FOR BEING CONFUSED BETWEEN THE ENORMOUS NUMBER OF PSYCHOTHERAPIES NOW AVAILABLE. THERE IS CLEARLY A NEED FOR SOME ORDER TO BE BROUGHT TO THE SITUATION. FOSTER (1971) STATED "I HAVE BECOME CONVINCED THAT IT IS HIGH TIME THAT THE PRACTICE OF PSYCHOTHERAPY FOR REWARD SHOULD BE RESTRICTED TO MEMBERS OF A PROFESSION PROPERLY QUALIFIED IN ITS TECHNIQUES, AND TRAINED." HINSHELWOOD (1985) POINTS OUT THAT THE MEDICAL PROFESSION WAS REGULATED IN 1858 BY A STATUTORY INSTRUMENT THAT REQUIRED ALL PRACTITIONERS TO BE REGISTERED. IN THE MIDDLE OF THE NINETEENTH CENTURY, ABOUT A QUARTER OF THOSE PRACTISING AS DOCTORS WERE NOT TRAINED. IT IS INTERESTING THAT IN IRELAND TODAY WE DON'T KNOW HOW MANY PSYCHOTHERAPISTS ARE TRAINED. WHILE THERE IS SOME DIFFICULTY IN ARRIVING AT A "FUNCTIONAL" DEFINITION OF PSYCHOTHERAPY, THERE IS A VIEW THAT WE SHOULD FOCUS ONLY ON AN "INDICATIVE" DEFINITION, THAT IS, ON WHO CALLS HIMSELF A PSYCHOTHERAPIST.

TRADITIONALLY, IF SOMEONE HAD A SYMPTOM THEY CONSULTED THEIR GENERAL PRACTITIONER, WHO TRIED TO ESTABLISH WHETHER THE SYMPTOM HAD A PHYSICAL OR A PSYCHOLOGICAL BASIS. IF THE G.P. RULED OUT A PHYSICAL



CAUSE, THE PATIENT WAS THEN REFERRED ON TO A PSYCHOTHERAPIST. WHILE THIS STILL HAPPENS, THERE ARE MANY PEOPLE WHO NOW DIRECTLY REFER THEMSELVES, AND THEREFORE THE SCREENING FOR A PHYSICAL PROBLEM IS LESS LIKELY TO TAKE PLACE. IF THE PATIENT WERE DISCUSSED IN ADVANCE OF TREATMENT WITH THE GENERAL PRACTITIONER, THEN THIS SCREENING FOR PHYSICAL ILLNESS WOULD NOT BE LEFT OUT. THE BEST SOLUTION WOULD BE FOR PSYCHOTHERAPISTS OF VARIOUS STYLES, GENERAL PRACTITIONERS AND PSYCHIATRISTS TO WORK IN GROUPS. THEN THE PHYSICAL ASPECTS COULD BE DEALT WITH AND PATIENTS WHO REQUIRED PSYCHOTROPHIC DRUGS COULD RECEIVE THEM, OR COMBINATIONS OF PSYCHOTROPHIC DRUGS AND PSYCHOTHERAPY. INDEED, SOMETIMES PATIENTS REQUIRE PSYCHOTROPHICS FOR THE TREATMENT OF A SYMPTOM AND, AT THE SAME TIME OR LATER, PSYCHOTHERAPY TO DEAL WITH A PERSONALITY OR INTERPERSONAL ELEMENT TO THEIR PROBLEM.

PROSPECTIVE PATIENTS DON'T ALWAYS REALISE THAT THEY SHOULD SEE A NUMBER OF PSYCHOTHERAPISTS TO FIND THE ONE WITH WHOM THEY WOULD FEEL MOST COMFORTABLE. IF THERE WERE A REGISTER AVAILABLE TO THE PUBLIC, WITH NAMES AND DETAILED DESCRIPTIONS OF THE PSYCHOTHERAPY AS WELL AS DETAILED DESCRIPTIONS OF TRAININGS, THEN THIS WOULD HAVE THE EFFECT OF INCREASING THE KNOWLEDGE OF PROSPECTIVE PATIENTS AND AIDING THEM IN MAKING A DECISION ON A PARTICULAR THERAPY.

THE NEED FOR STATUTORY REGISTRATION IS EVEN MORE IMPORTANT BECAUSE OF THE CLEAR NEGATIVE EFFECTS OF A WIDE VARIETY OF PSYCHOTHERAPIES. LIEBERMAN, YALOM AND MILES (1973) HAVE SHOWN THAT THE DISREGARDING OF A PERSON'S NEED FOR DEFENCES CAN LEAD TO PSYCHIATRIC CASUALTIES. THEY ESTIMATED THE CASUALTY RATE TO BE ABOUT 9% FROM TECHNIQUES SUCH AS ENCOUNTER GROUPS.

YALOM AND LIEBERMAN (1971) HAVE SHOWN THAT AGGRESSIVE THERAPISTS, WHAT THEY CALL "AGGRESSIVE STIMULATORS," HAD THE MOST CASUALTIES IN GROUP THERAPY. THESE THERAPISTS WERE CHALLENGING, CONFRONTING, IMPATIENT, AND INSISTED ON IMMEDIATE SELF-DISCLOSURE AND EMOTIONAL EXPRESSION. RICKS (1974) SHOWED THAT THERAPISTS WHO DEVOTED MORE TIME, ENERGY AND INVOLVEMENT TO BOYS WHO HAD ADOLESCENT PROBLEMS, AND PAID ATTENTION TO HOPEFUL ELEMENTS IN WHAT WAS BEING SAID BY THESE PATIENTS, HAD BETTER OUTCOMES. GARFIELD AND BERGIN (1978) POINT OUT THAT NEGATIVE PSYCHOTHERAPY OUTCOMES SHOW THAT THERAPY HAS POWERFUL CONSEQUENCES, AND CLINICIANS AND RESEARCHERS SHOULD GIVE EARNEST AND IMMEDIATE ATTENTION TO THE SELECTION AND TRAINING OF THERAPISTS, AS WELL AS THE ROLE OF LICENSING AND CONTINUING EDUCATION POLICIES FOR PSYCHOTHERAPISTS. OTHER CAUSES OF NEGATIVE EFFECTS PROBABLY INCLUDE INAPPROPRIATE TREATMENT FOR A PARTICULAR PROBLEM AND A MISMATCH BETWEEN A PATIENT AND A THERAPIST. IT IS ALSO INTERESTING THAT THERE IS EVIDENCE THAT EXPERIENCED THERAPISTS HAVE A LOWER DROP-OUT RATE FROM THERAPY.

A FIRST STEP IN DEALING WITH THE ABOVE PROBLEMS COULD BE FOR THE DEPARTMENT OF HEALTH TO CONVENE AN IRISH STANDING COMMITTEE ON PSYCHOTHERAPY TO EXAMINE THE VARIOUS THERAPIES AND TRAININGS OFFERED. AN ALTERNATIVE WOULD BE FOR PSYCHOTHERAPISTS TO BEGIN TO REGULATE THEMSELVES, AND TO SET MINIMUM TRAINING REQUIREMENTS AND DRAW UP LISTS OF THERAPISTS WHO WOULD HAVE MET THESE MINIMUM REQUIREMENTS. THEY COULD FORM A CO-ORDINATING COMMITTEE WHICH COULD HAVE SECTIONS DEALING WITH THE MAJOR TYPES OF PSYCHOTHERAPY AVAILABLE IN IRELAND, E.G., ANALYTICAL PSYCHOTHERAPY, HUMANISTIC AND INTEGRATIVE PSYCHOTHERAPY, CONSTRUCTIVIST, MARITAL, FAMILY AND GROUP PSYCHOTHERAPY, AS WELL AS BEHAVIOURAL



PSYCHOTHERAPY. EACH SECTION COULD SET MINIMUM TRAINING REQUIREMENTS AND QUALIFICATION PROCEDURES. A PSYCHOTHERAPY COUNCIL COULD BE SET UP ALONG THE LINES OF THE MEDICAL COUNCIL, WITH A REGISTER, A CODE OF PRACTICE AND ETHICS, GUIDELINES FOR CONTINUING PROFESSIONAL DEVELOPMENT AND A MECHANISM FOR DEALING WITH COMPLAINTS. IT WOULD BE FUNDED THROUGH A LEVY ON MEMBERS. THESE MATTERS HAVE INCREASED URGENCY NOW WITH THE IMPENDING INTEGRATION OF EUROPE 1992, AND IT IS IMPORTANT THAT TRAINING RULES AND STANDARDS OF PRACTICE IN DIFFERENT EUROPEAN COUNTRIES ARE IN LINE WITH ONE ANOTHER. IN IRELAND, LEGISLATION MAY HAVE TO BE ENACTED TO PROTECT TITLES.

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# STRESS IN CHILD PSYCHIATRIC SERVICE PERSONNEL

Greta Murphy; Eileen Smith; Richard Wynne;
Michael Fitzgerald; Nadia Clarkin.

## Introduction

In recent years there has been a growing interest in the quality of working life, health and well-being among those involved in the provision of Health Care Services. Consequently, there has been a substantial amount of literature and research studying stress levels and particular stressors for specific professions, (Freudenberger, 1974; Maslach, 1976; Meiler, 1983). However, most of this research has been conducted abroad, particularly in the United States of America. Nevertheless, some of the issues raised through this research are also important in the Irish context, for example, irregular working hours.

From studying the relevant literature in this area and from personal work experience, the authors became aware of certain factors and special demands which are specific to those who work in a Child and Adolescent Service, for example, fear of unprovoked physical attacks by disturbed children.

THE OBJECTIVES OF THE STUDY WERE AS FOLLOWS:-

1 TO COMPARE AND CONTRAST STRESS AND SUPPORT AMONG THE SERVICE PERSONNEL;

2 TO COMPARE STRESS LEVELS BETWEEN RESIDENTIAL AND DAY CARE WORKERS;

3 TO ESTABLISH RISK FACTORS FOR STAFF STRESS;

4 TO ESTABLISH WHAT ARE GENERALLY BELIEVED TO BE THE MOST STRESSFUL AND MOST SUPPORTIVE WORKING ENVIRONMENTS.

THE HYPOTHESES WERE:-

1 THAT THOSE PROFESSIONALS WORKING IN RESIDENTIAL CHILD AND ADOLESCENT PSYCHIATRY WOULD SHOW HIGHER LEVELS OF STRESS;

2 THAT PEERS WOULD BE THE MAJOR SOURCE OF SUPPORT; THOSE EXPERIENCING HIGH PEER COHESION WOULD BE LESS LIKELY TO SUFFER FROM STRESS;

3 THAT WORKERS WITH HIGH SUPERVISOR SUPPORT WOULD BE LESS STRESSED;

4 THAT THOSE WORKING IN A POOR PHYSICAL WORK ENVIRONMENT WOULD BE MORE STRESSED;

5 THAT WHERE SUPERVISORS GAVE CREDIT FOR IDEAS CONTRIBUTED BY STAFF, LESS STRESS WOULD BE FOUND;



6 THAT STAFF IN NON-MANAGEMENT POSITIONS WOULD BE MORE STRESSED, I.E., THOSE WITH GREATER AUTONOMY WOULD BE LESS STRESSED;

7 THAT WHERE ACTIVITIES WERE POORLY PLANNED, WORKERS WOULD BE MORE STRESSED.

## METHOD

A CHILD AND ADOLESCENT PSYCHIATRIC SERVICE IN AN URBAN AREA OFFERED A GOOD CROSS-SECTION OF PROFESSIONALS. THEY INCLUDED:-

| | | |
|---|---|---|
| 1 | RECEPTIONISTS | (5) |
| 2 | PSYCHOLOGISTS | (3) |
| 3 | PSYCHIATRISTS | (12) |
| 4 | TEACHERS | (12) |
| 5 | CHILD CARE WORKERS | (8) |
| 6 | DOMESTIC STAFF | (7) |
| 7 | NURSES | (39) |
| 8 | NURSE ATTENDANTS | (7) |
| 9 | SPEECH THERAPISTS | (2) |
| 10 | SOCIAL WORKERS | (4) |

QUESTIONNAIRES WERE CIRCULATED AMONG ALL WORKERS IN THE CHILD AND ADOLESCENT SERVICE, WHICH INCLUDED:

TWO RESIDENTIAL CENTRES;
FOUR SPECIAL SCHOOLS;
THREE CHILD AND FAMILY CENTRES.

SERVICES PROVIDED BY THE CHILD AND ADOLESCENT SERVICE WERE AS FOLLOWS:-

1 SPECIAL EDUCATION FOR EMOTIONALLY DISTURBED, AUTISTIC AND MENTALLY HANDICAPPED CHILDREN AND ADOLESCENTS.

2 RESIDENTIAL ASSESSMENT AND TREATMENT FOR ACUTE EMOTIONALLY DISTURBED, AUTISTIC AND MENTALLY HANDICAPPED CHILDREN AND ADOLESCENTS.

3 FAMILY THERAPY.

4 PSYCHOTHERAPY AND INDIVIDUAL COUNSELLING.

5 SPEECH THERAPY.

6 THERAPEUTIC GROUPS FOR CHILDREN AND ADOLESCENTS.

7 PSYCHOLOGICAL SERVICE.

8 PARENTING SKILLS TRAINING.

THE QUESTIONNAIRES CONSISTED OF:

1 THE MASLACH BURN-OUT INVENTORY 1981 (MBI) (MASLACH C., JACKSON, S., 1981);

2 WORK ENVIRONMENT SCALE (WES), (MOOS, R. 1981).

3 BASIC DEMOGRAPHIC DATA.



THE MBI IS DESIGNED TO MEASURE THREE FEATURES OF THE BURN-OUT SYNDROME:

EMOTIONAL EXHAUSTION;

DEPERSONALISATION OF CLIENTS;

PERSONAL ACCOMPLISHMENT.

THESE FEATURES ARE DESCRIBED BY MASLACH AND JACKSON (1981) AS FOLLOWS:-

"THE EMOTIONAL EXHAUSTION SUBSCALE ASSESSES FEELINGS OF BEING EMOTIONALLY OVEREXTENDED AND EXHAUSTED BY ONE'S WORK. THE DEPERSONALISATION SUBSCALE MEASURES AN UNFEELING AND IMPERSONAL RESPONSE TOWARDS RECIPIENTS OF ONE'S SERVICE, CARE, TREATMENT OR INSTRUCTION.

THE PERSONAL ACCOMPLISHMENT SUBSCALE ASSESSES FEELING OF COMPETENCE AND SUCCESSFUL ACHIEVEMENT IN ONE'S WORK WITH PEOPLE."

ITEMS ON THE MBI ARE WRITTEN IN THE FORM OF STATEMENTS AROUND FEELINGS AND ATTITUDES. THE INVENTORY RATED EACH STATEMENT ON A FREQUENCY CATEGORY. THIS WAS DONE TO REDUCE THE TIME TAKEN TO COMPLETE THE QUESTIONNAIRE, WHICH WAS QUITE LENGTHY.

## Reliability (Maslach, C. and Jackson, S. 1981)

Internal consistency was estimated by Chrombach's coefficient alpha (N = 1316 for frequency). The reliability coefficients for the subscales were as follows:

.90 for Emotional Exhaustion;

.79 for Depersonalisation;

.71 for Personal Accomplishment;

The Standard Error of Measurement is:

3.80 for Emotional Exhaustion,

3.16 for Depersonalisation,

3.73 for Personal Accomplishment.

The test-retest reliability coefficients for the subscales were:

.82 for Emotional Exhaustion,

.60 for Depersonalisation,

.80 for Personal Accomplishment.



## Validity

Within the home setting, a knowledgeable observer would be the person's spouse, so spouse evaluations were collected using a questionnaire survey of 142 policemen and their wives (Jackson and Maslach, 1981; Maslach and Jackson, 1979). The wives were asked to indicate the frequency of their husband's behaviours that were predicted to be reflective of the Emotional Exhaustion and Personal Accomplishment dimensions of the MBI (because the wives did not see their husbands working with people on the job.) They were not asked to rate behaviours reflecting depersonalisation. Each wife's ratings were compared with her husband's.

MBI scores and the resulting correlations were in line with the predictions. Policemen who scored high on Emotional Exhaustion were rated by their wives as coming home upset and angry, tense or anxious, physically exhausted, and complaining about problems at work. Policemen who scored high on Personal Accomplishment were rated by their wives as coming home in a cheerful or happy mood, and doing work that was a source of pride and prestige for the family.

## Discriminant Validity

(1) It might be argued that the scores on the MBI are subject to distortion by a social desirability response set, because many of the items describe feelings that are contrary to the professional ideals. To test this idea, 40 graduate students in Social Welfare were asked to complete both the MBI and the Crowne-Marlowe (1964) Social Desirability (SD) Scale. If reported Burn-out is not influenced by a social desirability response

SET, THEN THE SCORES ON THE MBI AND THE SD SCALE SHOULD BE UNCORRELATED. THE RESULTS SUPPORTED THIS HYPOTHESIS, AND NONE OF THE MBI SUBSCALES WERE SIGNIFICANTLY CORRELATED WITH THE SD SCALE AT THE .05 LEVEL.

(2) THE WORK ENVIRONMENT SCALE (WES) IS DESCRIBED BY MOOS AND INSEL (1981) AS A SCALE WHICH ASSESSES THE SOCIAL CLIMATE OF ALL TYPES OF WORK UNITS. IT FOCUSES ON THE MEASUREMENT AND DESCRIPTION OF THE INTERPERSONAL RELATIONSHIP BETWEEN MANAGERS AND EMPLOYEES; ON THE DIRECTIONS OF PERSONAL GROWTH AND DEVELOPMENT WHICH ARE EMPHASISED IN THE WORK UNIT; AND ON THE BASIC ORGANISATIONAL STRUCTURE OF THE UNIT.

THE WES IS A 40-ITEM, TEN SUBSCALE QUESTIONNAIRE, MEASURING RELATIONSHIP, PERSONAL GROWTH, SYSTEM MAINTENANCE AND SYSTEM CHANGE DIMENSIONS. THE TEST-RETEST RELIABILITIES ARE ALL IN AN ACCEPTABLE RANGE, VARYING FROM A LOW OF 0.69 FOR CLARITY TO A HIGH OF .83 FOR INVOLVEMENT.

(3) IN ADDITION TO BASIC DEMOGRAPHIC DATA, THE THIRD SECTION OF THE QUESTIONNAIRE INCLUDED THE FOLLOWING OPEN-ENDED QUESTIONS:-

(A) WHAT DO YOU FEEL IS THE MOST STRESSFUL SITUATION ON THE JOB FOR YOU?

(B) HOW DO YOU FEEL STRESS AT WORK CAN BE ALLEVIATED?

(C) WHAT ARE THE MAJOR SUPPORTS WHICH HELP YOU FUNCTION BEST AT WORK?

(D) ANY OTHER COMMENTS?



## RESULTS

OF THE 117 QUESTIONNAIRES CIRCULATED, 99 WERE RETURNED, 3 OF WHICH WERE BLANK. THIS REPRESENTS AN 85% RETURN RATE.

DEMOGRAPHIC BREAKDOWN IS AS FOLLOWS:-

### SEX AND MARITAL STATUS

77 WERE FEMALE, 16 WERE MALE. (6 MISSING),

44 WERE SINGLE, 41 MARRIED, 0 DIVORCED, 3 SEPARATED, AND 5 FELL INTO THE "OTHER" CATEGORY.

### WORKING HOURS

59 WORKED REGULAR HOURS, 31 WORKED SHIFT HOURS AND 6 WORKED PART-TIME. (3 MISSING).

### WORK EXPERIENCE

47 WERE IN THEIR PRESENT POSITION UP TO TWO YEARS, 26 UP TO FIVE YEARS, 14 UP TO TEN YEARS, 8 TEN YEARS OR MORE. (4 MISSING).

## Health and Absenteeism

Self-reported state of health was as follows:

37 in "excellent" category, 58 in "very good" category. Categories "poor" and "very poor" were unused. (4 missing).

71 had been absent from work in the previous year for one week or less, 9 for two weeks or less, 5 for two to four weeks and 4 for over four weeks. (9 missing).

Reasons for absence were:

'flu' 24; colds 12; infection 8; back problems 5; stomach bugs 5; menstrual problems 2; tension headaches 1; migraine 0; others not listed 15; (9 missing).

## Training

83 of the sample had undergone training, 13 had not. (3 missing).

The length of training was as follows:

| | |
|---|---|
| Up to two years | 10 |
| Up to three years | 37 |
| Up to five years | 12 |
| Five years or more | 23 |
| (17 missing) | |

65 felt that their training was relevant, 18 did not. (16 missing).



In order to ascertain whether residential workers experienced more stress than non-residential child care workers, a T-test (one tailed) was performed on the three dimensions which make up the stress measure.

Table 1.

T-test between residential and non-residential workers on three dimensions of Burn-out Inventory

| Dimensions | df | t-test result |
|---|---|---|
| Emotional Exhaustion | 81 | - 1.88* |
| Depersonalisation of Clients | 83 | - 1.07 N.S. |
| Personal accomplishment | 77 | - 0.47 N.S. |

$p < .05$

When looking at emotional exhaustion the residential group's result was negative and statistically significant ($t = -1.88$, $p < .05$), indicating that residential staff were significantly more emotionally exhausted than non-residential staff at the .05 level. T-tests for the dimensions of the depersonalisation of clients and personal accomplishment were found to be not significant.

The Work Environment Scale is a 40-item scale which taps ten different conditions of the Work Environment. These ten conditions of the WES have scores ranging from 0 to 4, where 0 = low and 4 = high. It was decided to examine the following conditions and the effect of stress on them:-

A **Peer Cohesion:** TO SEE IF THOSE WITH HIGH PEER COHESION WERE LESS STRESSED THAN THOSE WITH LOW PEER COHESION.

B **Supervisor Support:** TO SEE IF THOSE WITH HIGH SUPERVISOR SUPPORT WERE LESS STRESSED THAN THOSE WITH LOW SUPERVISOR SUPPORT.

C **Physical Conditions:** TO SEE IF THOSE WHO WORKED IN A POOR PHYSICAL ENVIRONMENT WERE MORE STRESSED THAN THOSE WHO WORKED IN A GOOD PHYSICAL ENVIRONMENT.

D **Innovative Ideas:** TO SEE IF THOSE GIVEN FULL CREDIT FOR IDEAS CONTRIBUTED WERE LESS STRESSED THAN THOSE WHO WEREN'T CREDITED FOR IDEAS.

E **Task Orientation:** TO SEE IF THOSE WHOSE TASKS WERE WELL PLANNED WERE LESS STRESSED THAN THOSE WHOSE TASKS WERE POORLY PLANNED.

To analyse these a one-way analysis of variance, using the Ducan range test to test for multiple comparisons between means, was used. The significant levels used for the Ducan was the .05 level.

The results are described in the matrices. The group means are ranked in order from smallest to largest. The "*" denotes a significant difference between the means in the row and the column where the "*" appears. The values in the columns and the rows represent the scores of the conditions of the work environment scale.



Table 2.

A – PEER COHESION

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. | Emotional Exhaustion: | | Work Environment Scale scores | | | | |
| | mean | group | 4 | 3 | 2 | 1 | 0 |
| | 13.0 | 4 | | | | | |
| | 13.8 | 3 | | | | | |
| | 15.7 | 2 | | | | | |
| | 19.3 | 1 | | | | | |
| | 22.8 | 0 | | | | | |
| 2. | Depersonalisation of clients: | | Work Environment Scale scores | | | | |
| | mean | group | 4 | 3 | 2 | 1 | 0 |
| | 2.7 | 4 | | | | | |
| | 4.1 | 3 | | | | | |
| | 4.8 | 2 | | | | | |
| | 5.5 | 0 | | | | | |
| | 6.3 | 1 | | | | | |
| 3. | Personal Accomplishment: | | | | | | |
| | No two groups are statistically significant at the 0.5 level | | | | | | |

As far as peer cohesion was concerned, those who scored 0 on this condition showed a significantly greater level of Emotional Exhaustion than those who scored 3 and 4. Those who scored 1 showed greater Depersonalisation of Clients than those who scored 4.

There were no significant differences between any of the groups on the measure of Personal Accomplishment.

IT IS CLEAR THAT THOSE WHO SCORED LOW ON PEER COHESION WERE MORE EMOTIONALLY EXHAUSTED AND SHOWED GREATER DEPERSONALISATION OF CLIENTS THAN THOSE WHO SCORED HIGH ON PEER COHESION.

Table 3.

B - SUPERVISOR SUPPORT

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. | Emotional Exhaustion: | | Work Environment Scale scores | | | | |
| | mean | group | 3 | 4 | 1 | 2 | 0 |
| | 12.4 | 3 | | | | | |
| | 13.9 | 4 | | | | | |
| | 15.7 | 1 | | | | | |
| | 17.6 | 2 | | | | | |
| | 23.9 | 0 | | | | | |
| 2. | Depersonalisation of clients: | | Work Environment Scale scores | | | | |
| | mean | group | 3 | 4 | 1 | 2 | 0 |
| | 2.7 | 3 | | | | | |
| | 3.5 | 4 | | | | | |
| | 4.1 | 1 | | | | | |
| | 6.4 | 2 | | | | | |
| | 8.1 | 0 | | | | | |
| 3. | Personal Accomplishment: No two groups are statistically significant at the 0.5 level | | | | | | |



## C - PHYSICAL CONDITIONS

ON EMOTIONAL EXHAUSTION, DEPERSONALISATION OF CLIENTS OR PERSONAL ACCOMPLISHMENT, NO TWO GROUPS ARE STATISTICALLY SIGNIFICANTLY AT THE .05 LEVEL.

Table 4.

D - INNOVATION

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. | Emotional Exhaustion: No two groups are statistically significant at the .05 level. | | | | | | |
| 2. | Depersonalisation of clients: | | Work Environment Scale scores | | | | |
| | mean | group | 1 | 4 | 3 | 2 | 0 |
| | 2.6 | 1 | | | | | |
| | 3.5 | 4 | | | | | |
| | 4.7 | 3 | | | | | |
| | 5.9 | 2 | | | | | |
| | 6.0 | 0 | | | | | |
| 3. | Personal Accomplishment: No two groups are statistically significant at the 0.5 level | | | | | | |

## DISCUSSION

THIS STUDY SHOWS THAT THE INTER-PERSONAL ENVIRONMENT IS A VERY SIGNIFICANT FACTOR IN THE DEVELOPMENT OF "BURN-OUT." AS HAS BEEN SHOWN, THOSE WITH LOW SCORES ON PEER COHESION WERE FOUND TO BE EMOTIONALLY EXHAUSTED AND SHOWED GREATER DEPERSONALISATION OF CLIENTS. THIS INTER-PERSONAL FACTOR WAS FURTHER EMPHASISED WHEN THE

OPEN-ENDED QUESTIONS WERE ANALYSED. FORTY-FIVE PER CENT OF THE SAMPLE CITED COLLEAGUES AS THE MAJOR SOURCE OF SUPPORT.

WORKERS IN RESIDENTIAL CARE WERE MORE LIKELY TO BE EMOTIONALLY EXHAUSTED THAN THEIR DAY CARE COLLEAGUES. OF THE SAMPLE, 7% PIN-POINTED LONG HOURS AS BEING THE SOURCE OF GREATEST STRESS. THIS SPECIFICALLY RELATED TO THE RESIDENTIAL WORKERS.

LOW SUPERVISOR SUPPORT WAS ASSOCIATED WITH HIGH EMOTIONAL EXHAUSTION AND DEPERSONALISATION OF CLIENTS. THIS WAS CORROBORATED BY THE RESULTS OF THE OPEN-ENDED QUESTIONS. NEXT TO COLLEAGUES, "RECOGNITION" WAS CONSIDERED TO BE THE MAJOR SUPPORT WHICH HELPED PEOPLE FUNCTION BEST AT WORK (16%).

IT IS INTERESTING THAT THERE WAS NO RELATIONSHIP FOUND BETWEEN THE PHYSICAL WORK ENVIRONMENT AND THE DEVELOPMENT OF "BURN-OUT," REFUTING THIS HYPOTHESIS. IT COULD BE VIEWED THAT THIS SUPPORTS THE FINDING THAT THE INTER-PERSONAL IS THE CRITICAL ENVIRONMENT WITHIN THE SERVICE.

THERE WAS HIGHER DEPERSONALISATION OF CLIENTS AMONG WORKERS WHO WERE NOT GIVEN FULL CREDIT FOR IDEAS CONTRIBUTED. HOWEVER, STIFLING OF INNOVATION DID NOT INCREASE EMOTIONAL EXHAUSTION OR REDUCE PERSONAL ACCOMPLISHMENT.

WHERE TASKS WERE POORLY PLANNED, HIGHER EMOTIONAL EXHAUSTION AND DEPERSONALISATION WERE FOUND.

GRADE ANALYSIS SHOWED THAT ON PERSONAL ACCOMPLISHMENT RECEPTIONISTS WERE THE HIGHEST SCORING GROUP. THERE WAS NO SIGNIFICANT DIFFERENCE BETWEEN



GRADES ON THE EMOTIONAL EXHAUSTION OR DEPERSONALISATION SCALES. A POSSIBLE EXPLANATION FOR THIS WAS RELATED TO THE ACTUAL WORK CONTENT. IT COULD BE ARGUED THAT RECEPTIONISTS' WORK IS MORE QUANTIFIABLE, POSSIBLY MORE TASK-ORIENTATED THAN THAT OF THE TEACHERS, NURSES, PSYCHIATRISTS, CHILD CARE WORKERS AND SPEECH THERAPISTS WITH WHOM RECEPTIONISTS WERE MOST AT VARIANCE ON THE PERSONAL ACCOMPLISHMENT SCALE.

Table 5.

E – TASK ORIENTATION

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. | Emotional Exhaustion: mean | group | Work Environment Scale scores 3 | 4 | 2 | 1 | 0 |
| | 10.9 | 3 | | | | | |
| | 12.5 | 4 | | | | | |
| | 16.8 | 2 | | | | | |
| | 18.6 | 1 | | | | | |
| | 19.1 | 0 | | | | | |
| 2. | Depersonalisation of clients: mean | group | Work Environment Scale scores 3 | 4 | 1 | 0 | 2 |
| | 3.1 | 3 | | | | | |
| | 3.5 | 4 | | | | | |
| | 4.4 | 1 | | | | | |
| | 4.6 | 0 | | | | | |
| | 6.1 | 2 | | | | | |
| 3. | Personal Accomplishment: No two groups are statistically significant at the 0.5 level | | | | | | |

Table 6.

GRADE

1. Emotional Exhaustion:

No two groups are statistically significant at the 0.5 level

2. Depersonalisation of Clients:

No two groups are statistically significant at the 0.5 level

3. Personal Accomplishment:

| mean | group | Work Environment Scale scores 1 10 4 7 8 6 3 2 5 9 |
|---|---|---|
| 27.0 | 1 | |
| 34.7 | 10 | |
| 35.4 | 4 | * |
| 35.7 | 7 | * |
| 35.7 | 8 | |
| 36.0 | 6 | |
| 36.7 | 3 | * |
| 37.0 | 2 | |
| 38.0 | 5 | * |
| 42.5 | 9 | * |

1 = Receptionists
2 = Psychologists
3 = Psychiatrists
4 = Teachers
5 = Child Careworkers
6 = Domestic Staff
7 = Nurses
8 = Nurse Attendants
9 = Speech Therapists
10 = Social Workers




## Summary

NINETY-NINE STAFF OF A CHILD PSYCHIATRIC SERVICE WERE STUDIED USING THE MASLACH BURN-OUT INVENTORY AND WORK ENVIRONMENT SCALE.

A POSITIVE INTER-PERSONAL ENVIRONMENT - PEER COHESION - WAS FOUND TO REDUCE THE LIKELIHOOD OF "BURN-OUT."


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# ATTITUDES TO PSYCHIATRY AND ATTITUDINAL SHIFT IN PSYCHIATRIC NURSING STUDENTS - A PILOT STUDY

PATRICK O'BRIEN; MICHAEL FITZGERALD.

## SUMMARY

MEASURES OF ATTITUDES TO PSYCHIATRY AND ATTITUDINAL SHIFT OVER A THREE-YEAR PERIOD IN PSYCHIATRIC NURSING STUDENTS ARE REPORTED IN THIS SMALL DESCRIPTIVE PILOT STUDY. THE RESULTS INDICATE AN OVERALL FAVOURABLE VIEW OF PSYCHIATRY AND A DEFINITE SHIFT IN ATTITUDE IN RELATION TO DIFFERENT ASPECTS OF THE SUBJECT AS MORE EXPERIENCE WAS GAINED. IN RELATION TO DEFINITE SHIFTS TOWARDS THE MEDICAL MODEL OR THE MORE PSYCHO-SOCIALLY ORIENTED MODELS, THE RESULTS WOULD APPEAR TO BE SOMEWHAT INCONCLUSIVE, WITH AN OVERALL LEANING TOWARDS A MORE ECLECTIC PHILOSOPHY. RESULTS WERE NOT SUBJECTED TO STATISTICAL ANALYSIS, IN VIEW OF THE VERY SMALL NUMBER OF SUBJECTS INVOLVED.

## INTRODUCTION

THE ATTITUDE OF MEDICAL AND NURSING PERSONNEL WITHIN THE PSYCHIATRIC DISCIPLINE TOWARDS PSYCHIATRY AND VARIOUS ASPECTS OF PSYCHIATRIC PRACTICE IS OF INTEREST AND FUNDAMENTAL IMPORTANCE. WORTHY OF EQUAL CONSIDERATION IS THE QUESTION OF ATTITUDINAL SHIFT (IN A POSITIVE OR NEGATIVE DIRECTION) AMONGST MENTAL HEALTH WORKERS IN KEEPING WITH PSYCHIATRIC TRAINING, AND

ESPECIALLY CLINICAL EXPOSURE TO THE MENTALLY ILL. PSYCHIATRIC DISORDER HAS ALWAYS BEEN HIGHLY STIGMATISED IN SOCIETY, AND IT IS OFTEN SUGGESTED THAT SUCH STIGMATISATION IS LARGELY ATTRIBUTABLE TO SOCIETAL IGNORANCE AND/OR PREJUDICE IN RELATION TO THE NATURE OF MENTAL ILLNESS, WITH RESULTANT APPREHENSION AND SOMETIMES FEAR. ONE WOULD LOGICALLY EXPECT, THEREFORE, THAT THE MORE INFORMATION GLEANED ABOUT THE NATURE OF MENTAL ILLNESS - ITS CAUSES AND TREATMENT - COUPLED WITH INCREASING DIRECT EXPOSURE TO THOSE SUFFERING FROM SUCH ILLNESS, THE GREATER THE FAVOURABLE IMPRESSION WOULD BE.

SUCH ATTITUDES TO PSYCHIATRY AND ATTITUDINAL SHIFTS IN RELATION TO EXPOSURE TO THE SUBJECT HAVE BEEN INVESTIGATED BY A NUMBER OF WORKERS, WHO HAVE LOOKED MAINLY AT MEDICAL STUDENTS DURING BRIEF PSYCHIATRIC EXPOSURE WHILST UNDERGOING CLINICAL TRAINING PROGRAMMES (BURRA, KALIN ET AL., 1982; AUGOUSTINOS, SCHRADER ET AL., 1985; GHARDIRIAN AND ENGELSMAN, 1982). THE ATTITUDES OF OTHER GROUPS, SUCH AS OCCUPATIONAL THERAPISTS, HAVE ALSO BEEN INVESTIGATED AND REPORTED, (BURRA, KALIN ET AL., 1982). THE ATTITUDE OF NURSES TOWARDS MENTAL ILLNESS HAS ALSO BEEN REPORTED IN A NUMBER OF STUDIES, (COHEN AND STRUENING, 1962, 1964; WELLER AND GRUNES, 1988; WILKINSON, 1982; WILLIAMS AND WILLIAMS, 1961.) THE ATTITUDES OF TWO LARGE GROUPS OF CONSULTANT PSYCHIATRISTS, WHO WERE MEMBERS OF EITHER THE BIOLOGICAL PSYCHIATRY OR PSYCHOTHERAPY SECTION OF THE ROYAL COLLEGE OF PSYCHIATRISTS, WERE ALSO TESTED, AND THE RESULTS SHOW THE EXTENT TO WHICH THEIR ATTITUDES TO PSYCHOTHERAPY OR DRUG THERAPY TEND TO OVERLAP, (WILKINSON AND WILLIAMS, 1986).

A POSITIVE CHANGE IN THE ATTITUDES OF SUBJECTS TOWARDS PSYCHIATRY HAS BEEN DEMONSTRATED IN THE



MAJORITY OF REPORTED STUDIES, (BAKEWELL ET AL, 1971; LAU AND OFFORD, 1976). SUCH A CHANGE, HOWEVER, WAS NOT DEMONSTRATED IN TWO CLASSES OF OCCUPATIONAL THERAPY STUDENTS EXPOSED TO A COURSE OF PSYCHIATRY, (BURRA, KALIN ET AL., 1982). ANOTHER INTERESTING QUESTION IS WHETHER SUCH POSITIVE CHANGE IS LASTING. BURRA AND KALIN (1982) DEMONSTRATED THAT CHANGE TENDED TO BE TRANSITORY RATHER THAN PERMANENT. APART FROM THE GENERAL ATTITUDE TOWARDS PSYCHIATRY IN GLOBAL TERMS, (E.G., POSITIVELY OR NEGATIVELY PREDISPOSED), IT IS OF INTEREST AND CRUCIAL IMPORTANCE TO ASCERTAIN ATTITUDES TOWARDS DIFFERENT MODALITIES OF TREATMENT, AND TO IDENTIFY THE SIGNIFICANT FACTORS WHICH SHAPE AND MOULD THOSE ATTITUDES. FOR INSTANCE, ONE STUDY (AUGOUSTINOS, SCHRADER ET AL., 1985) SHOWED A SIGNIFICANT CHANGE IN THE MEDICAL MODEL DIRECTION FOLLOWING EXPOSURE TO PSYCHIATRY IN FIFTH YEAR MEDICAL STUDENTS UNDER PSYCHIATRIC TRAINING. INTERESTING QUESTIONS TO ASK WOULD BE TO WHAT EXTENT ARE ATTITUDES INFLUENCED BY IDEOLOGIES HELD AND EXPRESSED BY TEACHERS TO THE COURSE, AND BY CLINICAL STAFF WITH WHOM THE STUDENTS OR JUNIOR STAFF MEMBERS WORK CLOSELY? DO STUDENTS, FOR INSTANCE, WHO ARE EXPOSED TO A MEDICAL MODEL ORIENTED SETTING IN TERMS OF THEIR THEORETICAL TEACHING AND CLINICAL EXPERIENCE, VIEW PSYCHIATRY GENERALLY FROM THIS PERSPECTIVE IN THE FUTURE, OR ARE THEY LIKELY TO MAKE UP THEIR OWN MINDS FOLLOWING EXPOSURE TO A VARIETY OF DIFFERENT EXPERIENCES BASED ON DIFFERENT THEORETICAL PERSPECTIVES AND PHILOSOPHIES? NURSING RESEARCH IN THIS AREA (STRAUSS ET AL., 1964) SUGGESTS THAT NURSES ARE MOST LIKELY TO ADOPT THE IDEOLOGY OF THE MEDICAL STAFF WITH WHOM THEY WORK. THEIR PRACTICE MAY CHANGE, THEREFORE, IN DIFFERENT CLINICAL SETTINGS, AND THIS SUGGESTS THAT NURSES ESPECIALLY MAY BE IN A LESS ADVANTAGEOUS POSITION TO INFLUENCE CHOICE OF A GIVEN APPROACH OR TREATMENT MODALITY. THE FACT THAT A NURSE

OPERATES WITHIN THE FRAMEWORK OF A GIVEN "MODEL" OF PSYCHIATRY IS NOT, OF COURSE, NECESSARILY A RELIABLE INDEX OF HIS OR HER OWN INDIVIDUAL IDEOLOGY - EXPERIENCE WOULD SUGGEST THAT PEOPLE TEND (WHERE POSSIBLE) TO MOVE TO AN AREA IN WHICH CLINICAL PRACTICES ARE IN ACCORDANCE WITH THEIR OWN IDEOLOGY AND PREFERENCE.

## Subjects and Methods

THE SUBJECTS CHOSEN FOR THIS STUDY COMPRISE A SMALL GROUP (N = 8) OF PSYCHIATRIC NURSING STUDENTS IN A DUBLIN PSYCHIATRIC HOSPITAL. THE AIM WAS TO ATTEMPT TO MEASURE THEIR INITIAL ATTITUDES TO PSYCHIATRY AT THE COMMENCEMENT OF A THREE-YEAR COURSE (BASELINE INFORMATION) AND TO ASCERTAIN WHAT, IF ANY, ATTITUDINAL SHIFT TOOK PLACE AS THEY BECAME PROGRESSIVELY EXPOSED TO PSYCHIATRIC PRACTICE AS THE COURSE PROGRESSED. A SERIES OF STANDARDISED QUESTIONNAIRES WERE USED, AND THESE WERE ADMINISTERED TO THE STUDENTS AT THE BEGINNING OF THE COURSE (DURING THEORETICAL INTRODUCTORY BLOCK PRIOR TO ANY CLINICAL EXPERIENCE), HALF-WAY THROUGH SECOND YEAR AND HALF-WAY THROUGH THIRD YEAR. THE PURPOSE OF THE RESEARCH AND PROCEDURE FOR COMPLETING THE QUESTIONNAIRES WAS EXPLAINED BY A NURSE TUTOR, WHO ALSO INFORMED THE STUDENTS THAT ANONYMITY AND CONFIDENTIALITY WERE ASSURED, THAT THERE WERE NO RIGHT OR WRONG ANSWERS PER SE, AND THAT RESPONSES WOULD NOT AFFECT THEIR GRADES. ADMINISTRATION AND COMPLETION OF ALL QUESTIONNAIRES WAS SUPERVISED BY THE SAME TUTOR, UNDER THE SAME CONDITIONS, AND CONFERRING ON RESPONSES WAS PROHIBITED. THE SUBJECTS CONSISTED OF FIVE FEMALES AND THREE MALES, AND THE MEAN AGE WAS 19.5 YEARS. THERE WAS A 100% COMPLIANCE RATE.



## The Questionnaires

THREE QUESTIONNAIRES WERE USED, ALL THREE BEING ADMINISTERED SIMULTANEOUSLY IN FIRST, SECOND AND THIRD YEAR.

**QUESTIONNAIRE 1** - THE TREATMENT ATTITUDES IN PSYCHIATRY SCALE (TAPS) - A MODIFIED 21-ITEM QUESTIONNAIRE FOR MEASURING ATTITUDES TO PSYCHOTHERAPY AND DRUG THERAPY. THIS MODIFIED VERSION WAS DEVELOPED BY WILKINSON AND WILLIAMS (1986). IT IS A MODIFICATION OF THE MACANDREW AND ROSEN SCALES, WITH EACH STATEMENT FOLLOWED BY A 10 CM VISUAL ANALOGUE SCALE ANCHORED AT ONE END BY "STRONGLY AGREE" AND AT THE OTHER END BY "STRONGLY DISAGREE."

**QUESTIONNAIRE 2** - THIS IS A 30-ITEM LIKERT-TYPE SCALE, DESIGNED TO MEASURE MEDICAL STUDENTS' ATTITUDES TO PSYCHIATRY - THE ATP-30, ATTITUDES TOWARDS PSYCHIATRY SCALE. THIS TOOL WAS DEVELOPED AND VALIDATED BY BURRA, KALIN ET AL. (1982) AND THE GLOBAL MASS REFERRED TO AS "ATTITUDES TO PSYCHIATRY" WAS TEASED OUT INTO EIGHT RELATED ATTITUDINAL OBJECTS:-

(1) PSYCHIATRIC PATIENTS;
(2) PSYCHIATRIC ILLNESS;
(3) PSYCHIATRISTS;
(4) PSYCHIATRIC KNOWLEDGE;
(5) PSYCHIATRIC CAREER CHOICE;
(6) PSYCHIATRIC TREATMENTS;
(7) PSYCHIATRIC INSTITUTIONS, AND
(8) PSYCHIATRIC TEACHING.

**Questionnaire 3** - The Libertarian Mental Health Ideology Scale (LMHIS). This scale measures attitudes towards two popular, and sometimes competing, conceptual frameworks in psychiatry: the medical model and the psychosocial model. This scale was developed by Nevin and Morrison (1980) and used in the attitude assessment of mental health professionals and students. It comprises four factor subscales:-

Mental Illness Mythology (MIM);

Anti-Medical Model (AMM);

Social Deviance Control (SDC), and

Anti-coercive Treatment (ACT).

Subscales: The MIM and AMM subscales attempt to distinguish between a psychosocial and a medical position in the conceptualisation of the nature of mental illness and its aetiology. The psychosocial end of the MIM subscale expounds the belief that mental disorder should not be subsumed under the category of "illness," but instead should relate to personal and social issues, rather than medical ones. The medical end of the AMM subscale describes the belief that mental/behavioural problems are organic or biochemical in nature. The SDC and ACT subscales deal with civil, ethical and legal issues of psychiatry, differentiating between a "libertarian" position and a more "authoritarian" approach. Generally, the Libertarian end of the SDC and ACT subscales stresses the position that compulsory treatment and hospitalisation are unjustifiable, and that the institution of psychiatry



serves to legitimise the established order through the control of social deviance. The questionnaire items are arranged in Likert form, with five response categories: strongly agree; slightly agree; neither agree nor disagree; slightly disagree; strongly disagree.

## Results

The following comprises a representative cross-section of statements and responses for each of the three questionnaires during first year and third year respectively. The first year responses reflect baseline attitudes at commencement of the course, and third year responses are a comparison in an attempt to measure attitudinal shift. Responses for end of second year are not included.

N = 8; A = Agree; D = Disagree.

### Questionnaire 1 - (TAPS)

| | 1st Year | 2nd Year | |
|---|---|---|---|
| There is too frequent use of Psychotrophic Drugs | 3(37.5%) | 5(62.5%) | A |
| A well controlled study of the results of psychotherapy over a 5-year period is needed | 7(87.5%) | 7(87.5%) | A |
| The use of psychotrophic drugs has facilitated the management of the hospitalised mentally ill and aids in creating a state more favourable to psychotherapy | 5(62.5%) | 7(87.5%) | A |

| | 1ST YEAR | 2ND YEAR | |
|---|---|---|---|
| PSYCHOTROPHIC DRUGS CONSTITUTE A MAJOR BREAK-THROUGH IN OUR ATTEMPTS TO HELP THE MENTALLY ILL | 7(87.5%) | 8(100%) | A |
| PSYCHOTHERAPY IS AN UNKNOWN QUANTITY AMONG MEDICAL TREATMENT METHODS | 3(37.5%) | 2(25.0%) | D |
| PSYCHOTHERAPY IS THE TREATMENT OF CHOICE IN ALL PSYCHIATRIC DISORDERS | 4(50.0%) | 6(75.0%) | D |
| THE USE OF PSYCHOTROPHIC DRUGS SHOULD BE DEFINITELY DISCOURAGED IN PSYCHIATRIC TREATMENT BECAUSE OF THEIR DOUBTFUL VALUE AND THE DANGER TO THE PATIENT | 7(85.5%) | 6(75.0%) | D |
| PSYCHOTHERAPY IS THE ONLY TREATMENT OF EMOTIONAL PROBLEMS WHICH OFFERS ANY HOPE OF SUCCESS | 4(50.0%) | 2(25.0%) | D |
| THE USE OF PSYCHOTROPHIC DRUGS HAS BROUGHT MAN'S CONTROL OF MENTAL ILLNESS TO A POINT SIMILAR TO MAN'S CONTROL OF PAIN | 4(50.0%) | 2(25.0%) | D |
| PSYCHOTROPHIC DRUGS HAVE THEIR PLACE IN PSYCHIATRY | 6(75.0%) | 8(100%) | A |
| ENOUGH IS NOW KNOWN ABOUT PSYCHOTHERAPY TO GUARANTEE THAT WE ARE ON THE RIGHT TRACK | 2(25.0%) | 5(62.5%) | A |
| PSYCHOTROPHIC DRUGS ARE BEING USE TOO FREQUENTLY AND WITH LITTLE THOUGHT TO THE INDIVIDUAL PATIENT | 2(25.0%) | 5(62.5%) | A |



## QUESTIONNAIRE 2 - (ATP-30)

| | 1ST YEAR | 2ND YEAR | |
|---|---|---|---|
| PSYCHIATRY IS A RESPECTED BRANCH OF MEDICINE | 7(87.0%) | 6(75.0%) | A |
| PSYCHIATRIC HOSPITALS ARE LITTLE MORE THAN PRISONS | 8(100%) | 8(100%) | D |
| IT IS QUITE EASY FOR ME TO ACCEPT THE EFFICACY OF PSYCHOTHERAPY | 3(37.5%) | 6(75.0%) | A |
| PSYCHIATRIC TEACHING INCREASES OUR UNDERSTANDING OF MEDICAL AND SURGICAL PATIENTS | 7(87.0%) | 4(50.0%) | A |
| PSYCHIATRY HAS VERY LITTLE SCIENTIFIC INFORMATION TO GO ON | 5(62.5%) | 5(62.5%) | A |
| WITH THE FORMS OF THERAPY NOW AT HAND MOST PSYCHIATRIC PATIENTS IMPROVE | 6(75.0%) | 7(87.0%) | A |
| PSYCHIATRIC TREATMENT CAUSES PATIENTS TO WORRY TOO MUCH ABOUT THEIR SYMPTOMS | 5(62.5%) | 4(50.0%) | D |
| PSYCHIATRISTS GET LESS SATISFACTION FROM THEIR WORK COMPARED WITH OTHER SCIENTISTS | 6(75.0%) | 3(37.0%) | D |
| PSYCHIATRIC HOSPITALS HAVE A SPECIFIC CONTRIBUTION TO MAKE TO THE TREATMENT OF THE MENTALLY ILL | 8(100%) | 7(87.5%) | A |
| PSYCHIATRY HAS VERY LITTLE SCIENTIFIC INFORMATION TO GO ON | 5(62.5%) | 5(62.5%) | A |
| PSYCHIATRY IS SO UNSCIENTIFIC THAT EVEN PSYCHIATRISTS CAN'T AGREE AS TO WHAT ITS BASIC APPLIED SCIENCES ARE | 6(75.0%) | 2(25.0%) | D |

| | 1ST YEAR | 2ND YEAR | |
|---|---|---|---|
| IN RECENT YEARS, PSYCHIATRIC TREATMENT HAS BECOME QUITE EFFECTIVE | 8(100%) | 7(87.5%) | A |
| MOST OF THE SO-CALLED FACTS IN PSYCHIATRY ARE REALLY JUST VAGUE SPECULATIONS | 6(75%.0) | 6(75.0%) | D |
| THE PRACTICE OF PSYCHIATRY ALLOWS THE DEVELOPMENT OF REALLY REWARDING RELATIONSHIPS WITH PEOPLE | 7(87.5%) | 8(100%) | A |
| PSYCHIATRIC PATIENTS ARE OFTEN MORE INTERESTING TO WORK WITH THAN OTHER PATIENTS | 8(100%) | 7(87.5%) | A |
| PSYCHIATRY IS SO AMORPHOUS THAT IT CANNOT REALLY BE TAUGHT EFFECTIVELY | 6(75.0%) | 3(37.5%) | D |
| PSYCHIATRY IS A RESPECTED BRANCH OF MEDICINE | 7(87.5%) | 6(75.0%) | A |
| PSYCHIATRIC ILLNESS DESERVES AT LEAST AS MUCH ATTENTION AS PHYSICAL ILLNESS | 8(87.5%) | 6(75.0%) | A |
| PSYCHIATRIC ILLNESS DESERVES AT LEAST AS MUCH ATTENTION AS PHYSICAL ILLNESS | 8(100%) | 8(100%) | A |
| IT IS INTERESTING TO TRY TO UNRAVEL THE CAUSE OF MENTAL ILLNESS | 7(87.5%) | 7(87.5%) | A |

**QUESTIONNAIRE 3 - (LMHIS)**

| | | | |
|---|---|---|---|
| THE PROCESS OF DIAGNOSING MENTAL ILLNESS IS BASICALLY A MORAL ACT DEPENDENT ON THE PREVAILING CULTURAL MORES OF SOCIETY | 3(37.5%) | 4(50.0%) | A |



| | 1ST YEAR | 2ND YEAR | |
|---|---|---|---|
| IT IS IMPOSSIBLE TO REALLY UNDERSTAND THE THOUGHT PROCESS OF THE SCHIZOPHRENIC | 3(37.5%) | 5(62.5%) | A |
| MENTAL HEALTH PROFESSIONALS SHOULD INCREASE THEIR EFFORTS IN EDUCATING THE PUBLIC THAT "MENTAL ILLNESS IS AN ILLNESS LIKE ANY OTHER" | 7(87.5%) | 8(100%) | A |
| THE LABEL "MENTAL ILLNESS" IS APPLIED TO PERSONS WHO DISPLAY SOCIALLY OFFENDING BELIEFS, CUSTOMS OR BEHAVIOUR | 4(50.0%) | 4(50.0%) | A |
| MENTAL PATIENTS ARE GENERALLY MORE DANGEROUS THAN PERSONS WITHOUT APPARENT BEHAVIOURAL DISORDERS | 4(50.0%) | 6(75.0%) | D |
| THE USE OF SHOCK THERAPY ON MENTAL PATIENTS, EVEN WITHOUT THE CONSENT OF THE PATIENT, CAN BE JUSTIFIED IN AT LEAST SOME EXTREME CASES OF DEPRESSION | 6(75.0%) | 4(50.0%) | A |
| MENTAL PATIENTS CAN JUSTIFIABLY FEAR THE POWER OF PSYCHIATRISTS AND PSYCHOLOGISTS JUST AS PEOPLE THOUGHT TO BE WITCHES COULD FEAR THE POWER OF THE INQUISITION | 6(75.0%) | 5(62.5%) | A |
| MENTAL ILLNESS MOST LIKELY HAS A STRONG GENETIC COMPONENT | 5(62.5%) | 5(62.5%) | A |
| THE PSYCHOTIC PATIENT IS GENERALLY INCAPABLE OF SELF-DETERMINATION OR FREE CHOICE | 4(50.0%) | 7(87.5%) | A |
| MENTAL ILLNESS IS AN ILLNESS LIKE ANY OTHER | 5(62.5%) | 7(87.5%) | A |
| SCHIZOPHRENIC THOUGHT DISORDER IS BEST CONSIDERED WITHIN A CONTEXT OF BIOCHEMICAL PATHOLOGY | 3(37.5%) | 6(75.0%) | D |

| | 1ST YEAR | 2ND YEAR | |
|---|---|---|---|
| INVOLUNTARY HOSPITALISATION SHOULD BE PROHIBITED | 7(87.5%) | 6(75.0%) | D |
| THE LABELLING OF NON-CONFORMING BEHAVIOUR AS MENTAL ILLNESS SEEMS TO LEGITIMISE THE ESTABLISHED SOCIAL ORDER | 4(50.0%) | 5(62.5%) | A |
| NO PERSON SHOULD BE DEPRIVED OF THEIR CIVIL RIGHTS BECAUSE OF THEIR MENTAL HEALTH STATUS AS DIAGNOSED BY MENTAL HEALTH PROFESSIONALS | 4(50.0%) | 7(87.5%) | A |
| THE SEGREGATION OF POTENTIALLY VIOLENT PATIENTS IN LOCKED CLOSED WARDS IS A NECESSARY FORM OF PSYCHIATRIC TREATMENT | 4(50.0%) | 1(12.5%) | D |
| THE STATE HOSPITAL SYSTEM SERVES AS AN INSTRUMENT FOR THE CONTROL OF SOCIAL DEVIANCE | 2(25.0%) | 4(50.0%) | A |
| THE LABELLING OF INDIVIDUALS AS MENTALLY ILL HAS THE EFFECT OF STIGMATISING THEM IN THE COMMUNITY | 8(100%) | 5(62.5%) | A |
| MENTAL ILLNESS IS A MYTH | 5(62.5%) | 6(75.0%) | D |
| BEHAVIOUR DISORDERS CAN USUALLY BE FOUND TO HAVE A BIOLOGICAL ORIGIN | 4(50.0%) | 3(37.5%) | A |
| COERCIVE TREATMENT IS SOMETIMES NECESSARY SINCE MENTAL PATIENTS ARE OFTEN NOT IN A POSITION TO FULLY APPRECIATE THEIR BEST INTERESTS | 7(87.5%) | 7(87.5%) | A |
| SOCIETY ACCORDS ITS MENTAL HEALTH PROFESSIONALS TOO MUCH POWER | 5(62.5%) | 7(87.5%) | D |



## DISCUSSION

THE RESULTS AS OUTLINED ARE CLEAR AND ONLY A BRIEF COMMENT WILL BE MADE ON A FEW OF THEM. THEY GENERALLY INDICATE AN OVERALL REASONABLY FAVOURABLE OPINION OF PSYCHIATRY IN ITS VARIOUS FACETS AND, IN RELATION TO MANY AREAS, SHOW A SIGNIFICANT ATTITUDINAL SHIFT BETWEEN THE FIRST AND THIRD YEAR OF TRAINING. THERE WERE, HOWEVER, A NUMBER OF CONTRADICTORY RESPONSES, AND THERE WAS CONSIDERABLE OVERLAP BETWEEN THOSE FAVOURABLY DISPOSED TO A PSYCHOTHERAPEUTIC APPROACH ON THE ONE HAND, AND A BIOLOGICAL APPROACH ON THE OTHER. THESE RESULTS SUGGEST A MORE PRAGMATIC AND ECLECTIC VIEW IN RELATION TO TREATMENT MODALITIES AND GENERAL APPROACH TO THE MENTALLY ILL, AND THIS MIGHT NOT BE TOO SURPRISING IN VIEW OF THE FACT THAT THE CLINICAL EXPERIENCE OF THE STUDENTS WOULD HAVE EXPOSED THEM TO A MULTI-DIAGNOSTIC AND PREDOMINANTLY LOWER SOCIO-ECONOMIC PATIENT PROFILE. SUCH A MIXTURE WOULD NOT BE LIKELY TO LEND ITSELF TO A PREDOMINANTLY PSYCHOTHERAPEUTIC APPROACH; IN FACT, THE MEDICAL MODEL ETHOS WOULD TEND TO BE DOMINANT; THE STUDENTS WOULD HAVE BEEN ACCUSTOMED TO A HIGH RELIABILITY ON MEDICATION, SOME ECT AND TRADITIONAL USE OF OCCUPATIONAL, SOCIAL AND RECREATION THERAPY. PSYCHOTHERAPY, COUNSELLING AND OTHER FORMS OF PSYCHOLOGICAL INTERVENTION, WHILST SEEN ON A SMALL SCALE, WOULD NOT BE THE NORM. ACCORDINGLY STUDENTS, PLUS QUALIFIED CLINICAL STAFF (MULTI-DISCIPLINARY), WOULD TEND TO CONDITION TO THE MEDICAL MODEL IDEOLOGY. BEARING THIS IN MIND, IT IS SATISFYING TO SEE THE FAVOURABLE ATTITUDES EXPRESSED TOWARDS PSYCHOTHERAPY AND, INDEED, THE RESERVATIONS EXPRESSED IN RELATION TO PHYSICAL METHODS (VIZ A VIZ, DRUGS). SUCH RESULTS COULD AT LEAST ARGUABLY BE EXPLAINED BY THE VERY STRONG EMPHASIS PUT ON THE IMPORTANCE OF PSYCHOLOGICAL METHODS

OF TREATMENT DURING THE PSYCHIATRIC AS OPPOSED TO THE PHYSICAL LECTURES; IN THE CLINICAL AREAS (HOSPITAL WARDS AS DISTINCT FROM THE COMMUNITY AREAS), THE SAME EMPHASIS WAS UNLIKELY TO BE REFLECTED IN THE ASSESSMENT, PLANNING AND DELIVERY OF CARE - IN OTHER WORDS, EXPOSURE TO PSYCHOLOGICAL TECHNIQUES AND THEIR IMPORTANCE WOULD HAVE BEEN EXPERIENCED IN LECTURES AND TUTORIALS (PSYCHIATRIC AND PSYCHOLOGICAL ASPECTS OF THE SYLLABUS), BUT NOT IN CLINICAL PRACTICE.

THE PHILOSOPHY OF THE NURSING SCHOOL AND, INDEED, A REQUIREMENT OF THE NURSING BOARD WOULD BE THAT STUDENTS BE GIVEN A BALANCED PERSPECTIVE ON ALL APPROACHES IN TERMS OF UNDERSTANDING THE NATURE AND MANAGEMENT OF PSYCHIATRIC DISORDER. HOWEVER, IT MUST BE REALISED THAT UP UNTIL 1988 (ONE YEAR BEFORE THOSE STUDENTS QUALIFIED) THE WHOLE SYLLABUS AND CURRICULUM WAS PREDOMINANTLY MEDICAL MODEL ORIENTED, WITH A GROSSLY DISPROPORTIONATE PERCENTAGE OF LECTURES DEVOTED TO SUBJECTS SUCH AS ANATOMY, PHYSIOLOGY, PHYSICAL PATHOLOGY, MICROBIOLOGY AND SO FORTH, WITH VERY SCANT AND MINIMAL ATTENTION BEING GIVEN TO MORE RELEVANT TOPICS. THE 1987 NEW CURRICULUM MARKED A SIGNIFICANT IMPROVEMENT IN THIS STATE OF AFFAIRS, AND HAS MORE OF A PSYCHOSOCIAL ORIENTATION, WITH GREATER EMPHASIS ON SOCIOLOGICAL ASPECTS, COUNSELLING SKILLS AND A TENTATIVE MOVE TOWARDS THE PSYCHOLOGICAL APPROACH.

WITH SPECIFIC REFERENCE TO THE QUESTIONNAIRE FINDINGS, THE SUGGESTION THAT PSYCHOTHERAPY IS AN UNKNOWN QUANTITY AMONG MEDICAL TREATMENT METHODS (38%) MAY BE EXPLAINED BY THE HITHERTO CLINICAL EXPERIENCE ALREADY DESCRIBED. INTERESTINGLY, THERE WAS 100% AGREEMENT THAT PSYCHOTROPHIC DRUGS HAVE THEIR PLACE IN PSYCHIATRY, WHILST AT THE SAME TIME UNDERSTANDABLY SUGGESTING THAT SUCH DRUGS ARE OVER-USED (62.5%). IT



IS ALSO INTERESTING AND GRATIFYING THAT 75% SAID IT WAS EASY FOR THEM TO ACCEPT THE EFFICACY OF PSYCHOTHERAPY IN THE THIRD YEAR - AN INCREASE FROM 37.5% AT THE BEGINNING OF THE COURSE. IT IS PERHAPS SOMEWHAT SURPRISING THAT THE SURVEY SHOWS ONLY 50% OF THE SAMPLE SAYING THAT PSYCHIATRIC TEACHING INCREASES ONE'S UNDERSTANDING OF MEDICAL AND SURGICAL PATIENTS, COMPARED TO 87% IN FIRST YEAR; ALL THE MORE SO, SINCE PSYCHIATRIC NURSING STUDENTS SPEND TWO MONTHS ON GENERAL HOSPITAL SECONDMENT DURING SECOND YEAR, AND IT IS MANDATORY FOR ALL GENERAL NURSING STUDENTS TO SPEND A MINIMUM OF SIX WEEKS ON PSYCHIATRIC PLACEMENT DURING THEIR COURSE - HOPEFULLY TO ENABLE THEM TO BETTER UNDERSTAND PHYSICALLY ILL PEOPLE. IT IS INTERESTING TO FIND THAT 100% OF RESPONDENTS AGREED THAT THE PRACTICE OF PSYCHIATRY ALLOWS THE DEVELOPMENT OF REALLY REWARDING RELATIONSHIPS WITH PEOPLE - THIS WOULD SUGGEST THEIR INVOLVEMENT IN INTERPERSONAL RELATIONSHIPS AND PSYCHOLOGICAL ASPECTS OF WHICH STUDENTS MAY NOT APPRECIATE THE SIGNIFICANCE AT THE TIME - PERHAPS SPRINGING FROM THE MORE CASUAL NON-STRUCTURED INFORMAL INTERACTIONS WHICH THEY (THE STUDENTS) MAY UNDER-RATE IN TERMS OF PATIENT/CLIENT THERAPEUTIC POTENTIAL. THERE WAS A SIGNIFICANT DROP, FROM 75% IN FIRST YEAR TO 50% IN THIRD YEAR, IN THOSE WHO FELT THAT "SHOCK THERAPY" (ECT), EVEN WITHOUT THE CONSENT OF THE PATIENT, CAN BE JUSTIFIED IN AT LEAST SOME EXTREME CASES OF DEPRESSION. THIS IS PERHAPS SURPRISING, SINCE ONE MIGHT REASONABLY EXPECT THAT ONCE ECT HAD BEEN "DEMYTHOLOGISED" (IF THAT IS POSSIBLE) BY KNOWLEDGE AND CLINICAL EXPERIENCE, NURSES WOULD BECOME MORE ACCEPTING OF ITS USE IN SEVERE CLINICAL DEPRESSION. OF COURSE, THE CONVERSE ARGUMENT COULD BE USED, AS APPEARS TO HAVE HAPPENED IN THIS RESPONSE. ANOTHER POSITIVE OUTCOME OF THE STUDY IS THAT PSYCHIATRIC PATIENTS ARE PERCEIVED AS NOT BEING MORE

DANGEROUS THAN PERSONS WITHOUT APPARENT BEHAVIOURAL DISORDER - THIS, OF COURSE, WOULD RUN CONTRARY TO A MORE WIDELY HELD MISPERCEPTION BY LARGE SECTIONS OF THE GENERAL PUBLIC. IN RELATION TO VIEWS HELD ABOUT THE PATHOGENESIS OF SCHIZOPHRENIC THOUGHT DISORDER, IT IS PERHAPS UNUSUAL THAT 75% OF RESPONDENTS PERCEIVED IT IN THE CONTEXT OF A NON-BIOCHEMICAL PATHOLOGY IN THIRD YEAR. ONE WOULD HAVE THOUGHT THAT THEIR KNOWLEDGE OF NEURO-BIOCHEMISTRY AND THE DOPAMINE HYPOTHESIS WOULD HAVE PROMPTED THEM TO RESPOND TO THE CONTRARY.

THE PREDOMINANT FINDING (87%) THAT NO PERSON SHOULD BE DEPRIVED OF THEIR CIVIL RIGHTS BECAUSE OF THEIR MENTAL HEALTH STATUS IS INTERESTING, AND PERHAPS A MEASURE OF INCREASING SOCIETAL AWARENESS AND LIBERAL-MINDEDNESS. NOTE SHOULD BE TAKEN, HOWEVER, THAT ONLY 50% OF RESPONDENTS HELD THIS VIEW IN FIRST YEAR, ON ADMISSION TO THE COURSE. IT IS SURPRISING THAT ONLY 62.5% OF THIRD YEAR RESPONDENTS THOUGHT THAT LABELLING THE MENTALLY ILL HAS THE EFFECT OF STIGMATISING THEM IN THEIR COMMUNITY, COMPARED WITH 100% WHO HELD THIS VIEW IN FIRST YEAR. PERHAPS THIS MAY BE BECAUSE, AS NURSES BECOME ACCUSTOMED TO THE NORM OF LABELLING, THEY BEGIN TO FEEL COMFORTABLE AND SECURE WITH THIS SYSTEM, AND ASSUME THAT SOCIETY AT LARGE FEELS THE SAME. THIS POINT WAS CRYSTALIZED FOR ONE OF THE AUTHORS (P.O'B.) IN A RECENT CLASS DISCUSSION WITH A GROUP OF SENIOR THIRD YEAR STUDENTS, IN A SOCIOLOGICAL DEBATE ON THE SIGNIFICANCE OF LABELLING IN PSYCHIATRIC PRACTICE. OUT OF A CLASS OF FIFTEEN, APPROXIMATELY ONE THIRD DID NOT FEEL THAT IT WAS THE LABEL PER SE, SUCH AS "SCHIZOPHRENIC," "PSYCHOTIC," "MANIC" AND SO FORTH, WHICH WAS INSTRUMENTAL IN STIGMATISING THE INDIVIDUAL; OTHER FACTORS, THEY FELT, SUCH AS ADMISSION TO A MENTAL HOSPITAL OR PARENTS' EXPRESSED ATTITUDES IN THE



PRESENCE OF THEIR CHILDREN, WERE MORE IMPORTANT - THIS IS OPEN TO DEBATE AND PERHAPS FURTHER SCIENTIFIC STUDY.

WITH REGARD TO THE STUDY AS A WHOLE, THE POINT HAS ALREADY BEEN MADE THAT ATTITUDES EXPRESSED TOWARDS PSYCHIATRY WERE RELATIVELY POSITIVE. OF COURSE, ONE HAS TO BEAR IN MIND THAT THE MAGNITUDE OF THIS COULD BE INFLUENCED BY THE FACT THAT THE PARTICIPANTS WERE EXPRESSING VIEWS/ATTITUDES TOWARDS THEIR OWN CHOSEN CAREER AREA, AND NEGATIVE ASSOCIATIONS INVOLVING CONFLICTING COGNITIONS MAY RESULT IN VARYING DEGREES OF COGNITIVE DISSONANCE, (FESTINGER, 1957).

ANOTHER INTERESTING DIMENSION TO THE FINDINGS OF THIS STUDY (AS TO OTHERS) IS THE QUESTION OF CONSISTENCY IN THE EXPRESSED ATTITUDES OVER A LONG TIME SPAN. THIS SURVEY, IN COMMON WITH MOST OFTEN PUBLISHED STUDIES IN THIS AREA, SHOWS A POSITIVE SHIFT IN ATTITUDE OVER A SHORT TIME SPAN, BUT FURTHER LONGITUDINAL STUDIES ARE NEEDED TO TEST THE LONG TERM STABILITY OF THE VIEWS EXPRESSED.

THE AUTHORS REALISE A MAJOR LIMITATION OF THE CURRENT STUDY IS IN TERMS OF ITS SMALL SIZE - A LARGER COHORT WOULD AFFORD THE CONDITIONS FOR SUBJECTING THE FINDINGS TO STATISTICAL ANALYSIS WHICH WOULD PROVIDE THE TYPE OF DETAILED RELIABLE AND STATISTICALLY SIGNIFICANT DATA NECESSARY TO DRAW VALID CONCLUSIONS. IT WOULD BE DESIRABLE, THEREFORE, TO DO A FOLLOW-UP MAIN STUDY INVOLVING A LARGE NUMBER OF NURSING STUDENTS WHICH WOULD TEST THE VALIDITY AND RELIABILITY OF SOME BROAD GENERAL TRENDS OUTLINED DESCRIPTIVELY IN THIS SHORT PAPER. THE AUTHORS INTEND TO CONDUCT SUCH A STUDY IN THE NEAR FUTURE.

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# A STUDY OF DIFFICULTIES OF STUDENTS OF PSYCHOTHERAPY

KARIN GRIEVE; MICHAEL FITZGERALD.

## INTRODUCTION

THE SUBJECT OF THIS PAPER IS THE DIFFICULTIES A GROUP OF STUDENTS OF PSYCHOTHERAPY EXPERIENCED FACE-TO-FACE WITH THEIR PATIENTS. THE THEORETICAL ORIENTATION OF THE COURSE WAS PSYCHOANALYTICAL PSYCHOTHERAPY.

THESE DIFFICULTIES WERE DISCUSSED IN INDIVIDUAL SUPERVISION, AT TIMES IN THE STUDENTS' OWN PERSONAL PSYCHOTHERAPY, BUT ALSO IN SMALL GROUPS. AT THE BEGINNING OF THE COURSE, BEFORE THE STUDENTS HAD GOT TO KNOW ONE ANOTHER, THE DIFFICULTIES WERE OFTEN DISCUSSED FROM A TECHNICAL POINT OF VIEW, E.G., "HAS ANYBODY GOT A HELPFUL TECHNIQUE TO USE WITH A SILENT PATIENT?" AS THE TRAINING PROGRESSED AND TRUST BUILT UP, THE STUDENTS WERE MORE PREPARED TO EXPOSE THEMSELVES. IN THE SMALL GROUPS, AS WELL AS IN INFORMAL DISCUSSIONS, THE ISSUE BECAME MORE PERSONAL, DIRECTED TOWARDS THE THERAPIST AND HIS/HER EXPERIENCE OF THE DIFFICULTY: WHAT HAPPENED TO THE THERAPIST DURING A SILENT INTERLUDE WITH THE PATIENT? HOW DID THE THERAPIST FEEL, WHERE WERE THE FEELINGS COMING FROM, AND TO WHOM DID THE FEELINGS REALLY BELONG?"

CONCERNING EMPIRICAL STUDIES OF THERAPISTS' EXPERIENCES AND DIFFICULTIES OF PSYCHOTHERAPY, FEW HAVE BEEN MADE. ORLINSKY AND HOWARD (1977) USED A 152-ITEM

STRUCTURED RESPONSE QUESTIONNAIRE TO GET INFORMATION ABOUT THE MULTIFACETED EXPERIENCES OF THERAPISTS. THEY IDENTIFIED A NUMBER OF CLINICALLY MEANINGFUL DIMENSIONS OF THERAPISTS' PERCEPTIONS AND EXPERIENCE. THEY DID NOT, HOWEVER, DIRECTLY EXPLORE THE WAYS IN WHICH THE THERAPIST ACTUALLY EXPERIENCED THE SESSION. THIS IS THE AREA, ON THE OTHER HAND, THAT INTERESTED JOHN D. DAVIS ET AL., (1987). THEY DEVELOPED A TAXONOMY TO BE USED AS A TOOL FOR INVESTIGATING THIS AREA. THEY CONSTRUCTED A CONSENSUAL SET OF EXPERIENTIAL CATEGORIES THAT COULD BE APPLIED TO DESCRIBE THE DIFFICULTIES EXPERIENCED BY THERAPISTS AT TIME.

## PURPOSE OF THE STUDY

> "IT IS NOT HELPFUL FOR THERAPISTS TO BE INCAPACITATED BY THEIR DIFFICULTIES; IT IS HELPFUL FOR THERAPISTS TO DISTINGUISH THEIR OWN AND THEIR PATIENTS' CONTRIBUTIONS TO THE DIFFICULTIES THEY EXPERIENCE."
>
> (JOHN D. DAVIS ET AL, 1987)

A NATURAL RETICENCE TO EXPOSE ONESELF BECOMES APPARENT WHEN SEARCHING FOR PAPERS DEALING WITH A THERAPIST'S SUBJECTIVE EXPERIENCE OF A DIFFICULT SESSION OR RELATIONSHIP. FREUD (1905) WAS POSSIBLY THE FIRST TO GIVE AN HONEST WRITE-UP OF A CASE HE FOUND DIFFICULT, HIS CASE HISTORY OF DORA, BUT THE DIFFICULTIES DESCRIBED ARE IN TERMS OF TECHNIQUE. WHAT FREUD ACTUALLY EXPERIENCED HIMSELF DURING THIS "FRAGMENT OF AN ANALYSIS" CAN ONLY BE GUESSED AT, READING BETWEEN THE LINES.



A FRANK AND OPEN PAPER ABOUT THE RELATIONSHIP BETWEEN A BLACK PARANOID SCHIZOPHRENIC AND HER WHITE THERAPIST, AND THEIR FEELINGS ABOUT EACH OTHER, WAS WRITTEN BY THE LATE GERALD W. WOHLBERG (1975).

IN AN ARTICLE ABOUT "TRYING HARD," WINSLOW R. HUNT (1978) DISCUSSED "HARD" PATIENTS AND HOW THE "TRYING HARD" IS ASSOCIATED WITH FEELINGS OF FUTILITY, IRRITATION, GUILT OR BOREDOM. "THE ANALYST DOES NOT, AT LEAST AT FIRST, LOCATE THE CHALLENGE AS BEING IN THE PATIENT. HE IS, ON THE CONTRARY, INCLINED TOWARDS SELF-REPROACH AND THINKS, "I'VE GOT TO TRY HARDER," AND THE TOTAL EXPERIENCE THREATENS HIS SELF-ESTEEM."

### RESEARCH QUESTIONS

THE QUESTIONS THIS STUDY AIMS AT ANSWERING ARE:

1 IS IS POSSIBLE TO FIT THE STUDENT'S REPORTED DIFFICULTIES INTO THE TAXONOMY, I.E., DOES THE TAXONOMY COVER THEM?

2 WHAT KIND OF RELIABILITY, AS TO THE DIFFERENT CATEGORIES AND THE PREDOMINANT ONE, DO THREE RATERS GET, TWO OF WHOM ARE BLIND RATERS?

3 BEING STUDENTS WHO ARE STUDIED, WILL THERE BE CATEGORIES WHICH HAVE A SIGNIFICANTLY HIGHER PREDOMINANCE THAN OTHERS, E.G., THERAPIST-INCOMPETENT?

## METHODOLOGY

THE TWELVE STUDENTS, FIVE MALES AND SEVEN FEMALES, EACH FILLED IN A QUESTIONNAIRE AFTER A SESSION WHICH HAD

BEEN EXPERIENCED AS DIFFICULT. ON THE QUESTIONNAIRE THE STUDENT GAVE A SHORT DESCRIPTION OF THE SITUATION FOUND DIFFICULT, AND A STATEMENT OF WHAT THE STUDENT EXPERIENCED IN THE SITUATION. THE STUDENT ALSO GRADED THE DIFFICULTY, GIVING A SUBJECTIVE RATING OF THE SEVERITY ON THE FOLLOWING SCALE:

1 = SLIGHTLY DIFFICULT;

2 = MODERATELY DIFFICULT;

3 = VERY DIFFICULT;

4 = EXTREMELY DIFFICULT;

BETWEEN THEM THE STUDENTS SUPPLIED THIRTY-THREE ACCOUNTS OF DIFFICULTIES.

RATING PROCEDURE:

THE QUESTIONNAIRES WERE RATED BY THREE RATERS (ALL FEMALE). EACH RATER INDEPENDENTLY RATED THE THIRTY-THREE ACCOUNTS OF DIFFICULTY. FOR EVERY ITEM, THE RATERS MADE A PRESENCE-ABSENCE RATING FOR EACH OF THE NINE CATEGORIES OF THERAPIST DIFFICULTY ON THE FOLLOWING SCALE:

0 = DEFINITELY ABSENT;

2 = PROBABLY ABSENT;

2 = PROBABLY PRESENT;

3 = DEFINITELY PRESENT.



FINALLY, THE RATERS IDENTIFIED ONE OF THE NINE CATEGORIES AS THE PREDOMINANT DIFFICULTY IN EACH ACCOUNT.

## CATEGORIES OF TAXONOMY (JOHN D. DAVIS ET AL., 1987)

THE NINE CATEGORIES OF DIFFICULTY ARE DEFINED BELOW, AND A RELATIVELY PURE INSTANCE OF EACH DIFFICULTY IS PROVIDED AS ILLUSTRATION:-

(1) **T-INCOMPETENT.** THE THERAPIST QUESTIONS OR NEGATIVELY EVALUATES HIS OR HER SKILLS/ PERFORMANCE/ ADEQUACY AS A THERAPIST. THE THERAPIST'S EXPRESSED CONCERN IS NOT WITH THE CONSEQUENCES OF THIS DEFICIENCY FOR THE PATIENT, BUT WITH HIS OR HER OWN NARCISSISTIC INJURY. THE THERAPIST'S CONFIDENCE IN SELF IS UNDERMINED. (IF T ALSO FEELS GUILTY, ALSO RATE AS CATEGORY 2.)

EXAMPLE: "THE PATIENT IS AFRAID OF WHAT THERAPY WILL ENTAIL AND HOVERS AROUND HER AMBIVALENCE, THEN DECIDES AGAINST THE RISK. I FEEL USELESS - IF I WERE WORTH MY SALT AS A THERAPIST, I WOULD HAVE BEEN ABLE TO FOSTER A STRONGER ALLIANCE, ELICIT GREATER TRUST. PERHAPS I SHOULD DO SOMETHING ELSE FOR A LIVING."

(2) **T-DAMAGING.** THE THERAPIST FEELS THAT HE OR SHE MAY HAVE HARMED OR FAILED THE PATIENT IN SOME WAY (OR MAY BE IN DANGER OF DOING SO). THE FOCUS OF THE THERAPIST'S CONCERN IS ON THE CONSEQUENCES OF THESE ACTIONS FOR THE PATIENT, AND ON THE THERAPIST'S RESPONSIBILITY FOR PRODUCING THESE CONSEQUENCES. THE

THERAPIST FEELS GUILTY. (IF T ALSO QUESTIONS HIS OR HER THERAPEUTIC SKILLS, ALSO RATE AS CATEGORY 1.)

EXAMPLE: "THE PATIENT IS TERRIFIED OF RESURRECTING UNBEARABLE FEELINGS FROM THE PAST, AND ASKS WHETHER SHE CAN ACHIEVE THE GOALS OF THERAPY WITHOUT DOING SO. I THINK NOT, BUT FEEL GUILTY AND SADISTIC IN SUGGESTING IT MAY BE NECESSARY TO GET IN TOUCH WITH THEM."

(3) **T-PUZZLED (TECHNICAL PERPLEXITY).** THE THERAPIST IS PUZZLED AS TO HOW BEST TO PROCEED IN THE THERAPY, BECAUSE OF DIFFICULTY IN UNDERSTANDING THE PATIENT OR THE ONGOING THERAPEUTIC TRANSACTIONS, OR BECAUSE OF INABILITY TO SEE HOW TO CIRCUMVENT AN OBSTACLE, OR BECAUSE OF INABILITY TO DECIDE BETWEEN ALTERNATIVE STRATEGIES. THE THERAPIST FEELS EITHER PUZZLED OR IN TWO MINDS ABOUT WHAT TO DO. (IF T ALSO FEELS DEFEATED OR STUCK, ALSO RATE AS CATEGORY 8.)

EXAMPLE: "THE PATIENT HAS MULTIPLE PERSONALITIES AND ONE OF THEM ASKS ME TO KEEP DISCLOSURES SECRET FROM ANOTHER. I EXPERIENCE A DILEMMA, AND CANNOT DECIDE HOW TO RESPOND; I AM NOT HAPPY ABOUT MEETING THIS REQUEST, BUT I DO NOT WANT TO WEAKEN MY ALLIANCE WITH THIS PERSONALITY."

(4) **T-THREATENED.** THE THERAPIST FEELS A NEED TO PROTECT SELF AGAINST THE PATIENT. THE THERAPIST FEELS THREATENED BY SOMETHING ABOUT THE PATIENT, OR WHAT THE PATIENT DOES, INCLUDING FEELING PERSECUTED, INTRUDED UPON, CONTROLLED, MADE TO FEEL CRAZY, OR EMOTIONALLY OR PHYSICALLY THREATENED. THE THERAPIST FEELS VULNERABLE TO THE PATIENT AND MAY REACT WITH ANXIETY OR ANGER.



EXAMPLE: "THE PATIENT IS GETTING MORE AND MORE HOSTILE TOWARDS THERAPY AND TOWARDS ME. I SUSPECT THAT THE PATIENT MAY BE ABOUT TO EXPRESS HIS FEELINGS BEHAVIOURALLY RATHER THAN VERBALLY. I FEEL ANXIOUS AND THREATENED."

(5) **T-OUT OF RAPPORT.** THE THERAPIST FEELS THAT THERE IS LITTLE PROSPECT OF BEING ABLE TO RELATE TO THE PATIENT, TO GET ON THE SAME WAVELENGTH, TO FIND A COMMON LANGUAGE, TO EXPERIENCE WARMTH TOWARDS OR LIKING FOR THE PATIENT, OR TO DEVELOP ANY ALLIANCE. THE THERAPIST FEELS GENERALLY DISTANT, OUT OF TOUCH OR ALIENATED FROM THE PATIENT.

EXAMPLE: "I AM PUT OFF BY THE PATIENT'S SELF-CENTRED ABSORPTION AND INABILITY TO SHOW WARM OR CARING FEELINGS FOR ANYBODY. I CANNOT WARM TO HIM OR REALLY GET INVOLVED IN TRYING TO HELP HIM, THOUGH I KNOW HE MIGHT BENEFIT FROM A CARING EXPERIENCE. I FEEL A MILLION MILES AWAY FROM HIM.

(6) **T'S PERSONAL ISSUES.** THE THERAPIST IS AWARE OF TRANSITORY OR ENDURING PERSONAL FEELINGS, CONFLICTS, BELIEFS OR VALUES THAT ARE UNRELATED TO THE THERAPY. HOWEVER, THEY ARE EXPERIENCED AS INTERFERING WITH THE THERAPY, OR AS THREATENING TO DO SO.

EXAMPLE: "THE PATIENT HAS BEEN PROPOUNDING SEXIST VALUES WHICH CLASH WITH MINE AND WHICH I FIND OFFENSIVE. I FIND MYSELF DRAWN INTO INTELLECTUAL DEBATES IN AN EFFORT TO CONVERT HIM, IN SPITE OF MY OWN BETTER JUDGEMENT."

(7) **Painful Reality/T's Ethical Dilemma.** This category combines two subcategories. (The wording that follows has been modified to convey more accurately the tacit conceptions that informed our ratings. The decision not to rate the subcategories separately, despite their conceptual distinction, was based on our expectation that they would occur with low frequency.)

(a) Painful Reality. The therapist is confronted with or anticipates a difficult factual situation which must be accepted for what it is. The therapist finds it painful to endure or to contemplate the situation, and to accept the way things are or may turn out to be, but experiences no difficulty in seeing how the therapy should be conducted. The therapist may feel sad or angry that the world can or could order things so, and that he or she is powerless to order them otherwise.

Example: "My patient is terminally ill but does not want to die. I share her sense of injustice and find it sadly ironic that "outcome" will depend on the quality of death."

(b) T's Ethical Dilemma. The therapist cannot decide where his or her duty lies, or what course of action is most ethical. The therapist may feel that obligations to the patient are in conflict with obligations to other persons. The therapist feels conflicted and morally troubled.

Example: "The patient wants help with bed-wetting, but I have learned that her diabetes is out of control and she will soon face serious consequences (e.g., going blind). She refuses to see her medical consultant and does not want to discuss her diabetes. I feel very torn - can it be right for me to collude in ignoring



the damage she is doing to herself, yet does she not have the right to specify what problems she wants help with?"

(8) **T-Stuck.** The therapist feels that the therapy has reached an impasse, seeing no way forward and feeling that there is no escape from the situation. Not only does the therapy feel stuck, but the therapist also feels stuck with the patient. The therapist feels trapped, hopeless, demoralised.

Example: "We are going round and round in circles getting nowhere and I am beginning to feel despondent about our prospects, yet I do not feel able to terminate because the patient's lifelong experience is of people losing patience and walking out. I feel trapped; we could flounder in this mire for ever."

(9) **T-Thwarted.** The therapist experiences the patient as actively impeding or rendering more difficult his or her efforts to pursue therapeutic objectives. The therapist feels frustrated, impatient, irritated or angry at the way these efforts are being blocked.

Example: "My patient complains unremittingly, but in spite of all my efforts to help her look at her problems she shows no inclination to do so. I feel impatient and cross that my time is being wasted."

## Difficulties - a Help or a Hindrance

John D. Davis et al. describe

> "two fundamentally different stances one can adopt towards therapists' experiences of difficulty in their work with patients. First, one can regard them purely as obstacles to therapeutic effectiveness which ideally would be avoided altogether. From this vantage point, for therapists in training, difficulties would indicate those areas where further learning should be concentrated, whereas for seasoned therapists their troublesome experiences would point to personal 'blind spots' or incomplete skills. Alternatively, one can regard difficulties as an inevitable and valuable part of the therapeutic process, on the understanding that patients are bound to recreate in the interaction with their therapists precisely those difficulties (their own and the other party's) which give rise to problems in their relationships. From this vantage point, therapist difficulties would be regarded as a rich source of therapeutic material and would need to be resolved or struggled with in the therapy, rather than trained out of existence."

John D. Davis also adopted

> "an integrating stance between these points of view in which we see the value of training and experience as consisting in the strengthening of a therapist's coping resources rather than in the elimination of difficulties."



The former of these two stances mentioned could easily be seen as a foolproof recipe for early burn-out as a therapist, a truly Promethean struggle. The second stance appears more congruent with the whole therapeutic process of which learning and discovery and integrated parts. While many students possibly start off their training under the misapprehension that there is a "right" way to conduct therapy, and that any experience of difficulty is seen as a failure on the part of the student, the hallmark of good training and supervision would be for the student to accept difficulties as something worthwhile, to be struggled with, and accept them as part of the therapeutic process.

## The Process of Change

The process of change within psychoanalytic psychotherapy comes about through the relationship of therapist and patient. Analytic psychotherapy is intensely relational and the primary emphasis is on the interaction between therapist and patient. This interaction stirs up feelings in both therapist and patient, and the difficulties the therapist encounters are manifested in the feelings categorised by Davis et al., as Incompetent, Damaging, Puzzled, Threatened, Out-of-Rapport, T's Personal Issues, Painful Reality/Ethical Dilemma, Stuck and Thwarted. As mentioned already, both therapist and patient feel things in the interaction but, for the purpose of this study, the therapist will be concentrated on.

There are three analytic concepts, in particular, which are all interactional descriptions and can be used to address specifically the interaction between

THE THERAPIST AND THE PATIENT. THEY ARE TRANSFERENCE, COUNTERTRANSFERENCE, AND PROJECTIVE IDENTIFICATION.

## TRANSFERENCE

THE PHENOMENON OF TRANSFERENCE WAS FIRST DESCRIBED AND DISCUSSED BY FREUD IN "STUDIES OF HYSTERIA" (1893 - 1895).

ZETZEL (1956) DEFINES TRANSFERENCE AS "THE DISPLACEMENT ON TO THE ANALYST OF REPRESSED WISHES AND FANTASIES DERIVED FROM EARLY CHILDHOOD."

GREENSON (1967A) MORE DESCRIPTIVELY DEFINES IT AS

> "THE EXPERIENCE OF FEELING DRIVES, ATTITUDES, FANTASIES AND DEFENCES TOWARDS A PERSON IN THE PRESENT, WHICH DO NOT BEFIT THAT PERSON, BUT ARE REPETITIONS OF REACTIONS, ORIGINATING IN REGARD TO SIGNIFICANT PERSONS OF EARLY CHILDHOOD, UNCONSCIOUSLY DISPLACED ONTO FIGURES IN THE PRESENT."

INTENSE EMOTIONAL REACTIONS TO THE THERAPIST, AS WELL AS THE ABSENCE OF ANY REACTIONS, ARE USUALLY A SIGN OF TRANSFERENCE.

GREENSON (1967B) ANSWERS THE QUESTION OF WHEN TO INTERVENE IN THE TRANSFERENCE SITUATION WITH:



> "WE INTERVENE WHEN THE TRANSFERENCE IS PRODUCING A RESISTANCE; WE TRY FIRST TO MAKE SURE THAT A REASONABLE EGO AND A WORKING ALLIANCE ARE PRESENT AND THEN ANALYSE THE RESISTANCE. IT DOES NOT MATTER WHAT QUALITY (POSITIVE OR NEGATIVE) OR QUANTITY OF TRANSFERENCE IS INVOLVED: WE INTERVENE WHEN WE SEE SIGNS OF SIGNIFICANT RESISTANCE WHEN THE ANALYTIC WORK IS UNPRODUCTIVE, STALE-MATED, OR EMOTIONALLY THIN."

ONE OF THE MANY DIFFICULTIES SOMETIMES ENCOUNTERED BY STUDENTS OF PSYCHOTHERAPY, WHEN TRYING TO FAMILIARISE THEMSELVES AND RECOGNISE A TRANSFERENCE REACTION, IS TO DISTINGUISH BETWEEN TRANSFERENCE AND THE REAL RELATIONSHIP. R. DICKES (1976) QUOTES FREUD (1937), WHO WROTE "THAT FRIENDLY INTERACTIONS BETWEEN THE TWO PARTICIPANTS WERE NOT NECESSARILY DUE TO TRANSFERENCE, BUT COULD BE BASED ON REALITY, FROM A COMMUNITY OF INTERESTS OR OTHER REAL FACTORS." ONE NON-RATIONAL REAL FACTOR IS THE SPONTANEOUS REACTION TWO PEOPLE HAVE TO EACH OTHER, FOR INSTANCE, THE VARYING POWER OF THE SEXUAL ATTRACTION BETWEEN TWO PEOPLE.

## COUNTERTRANSFERENCE

COUNTERTRANSFERENCE CAN SIMPLY BE DESCRIBED AS THOSE FEELINGS WHICH ARE STIRRED UP IN THE THERAPIST DURING THE PROCESS OF THERAPY AND WHICH, IN TURN, BECOME PART OF THE EMOTIONAL INTERACTION OF THE THERAPY. THESE FEELINGS MIGHT BE THE KIND WHICH THE THERAPIST BRINGS

TO THE THERAPY FROM HIS OR HER OWN LIFE, WHICH BECOME TRIGGERED IN THE COURSE OF THERAPY. ALTERNATIVELY, THEY MIGHT BE THOSE FELT BY THE PATIENT WHICH THE THERAPIST ALSO BEGINS TO FEEL.

HEIMANN (1950) DEALS WITH COUNTERTRANSFERENCE AS A TOOL FOR UNDERSTANDING THE PATIENT, THE BASIC ASSUMPTION BEING THAT THE ANALYST'S UNCONSCIOUS UNDERSTANDS THAT OF HER PATIENT. THIS UNDERSTANDING, ON THE DEEP LEVEL, COMES TO THE SURFACE IN THE FORM OF FEELINGS NOTICED BY THE ANALYST IN RESPONSE TO HER PATIENT.

FOR THE STUDENT, IN PARTICULAR, THE PROBLEM IS USUALLY IN THE AREA OF TRUSTING THE COUNTERTRANSFERENCE FEELINGS BEING PICKED UP, AND DARING TO USE THEM.

RACKER (1953) WRITES,

"THE ANALYST'S OBJECTIVITY CONSISTS MAINLY IN A CERTAIN ATTITUDE TOWARDS HIS OWN SUBJECTIVITY AND COUNTERTRANSFERENCE. THE NEUROTIC (OBSESSIVE) IDEAL OF OBJECTIVITY LEADS TO REPRESSION AND BLOCKING OF SUBJECTIVITY AND SO TO THE APPARENT FULFILMENT OF THE MYTH OF THE 'ANALYST WITHOUT ANXIETY OR ANGER.' THE OTHER NEUROTIC EXTREME IS THAT OF 'DROWNING' IN THE COUNTERTRANSFERENCE. TRUE OBJECTIVITY IS BASED UPON A FORM OF INTERNAL DIVISION THAT ENABLES THE ANALYST TO MAKE HIMSELF (HIS OWN COUNTERTRANSFERENCE AND SUBJECTIVITY) THE OBJECT OF HIS CONTINUOUS OBSERVATION AND ANALYSIS. THIS POSITION ALSO ENABLES HIM TO BE RELATIVELY 'OBJECTIVE' TOWARDS THE ANALYSAND."



## PROJECTIVE IDENTIFICATION

A. MALIN AND J. GROTSTEIN( 1966) WRITE THAT "THE TERM 'PROJECTIVE IDENTIFICATION' WAS FIRST USED BY MELANIE KLEIN (1946) AND WAS MEANT TO INDICATE A PROCESS IN WHICH PARTS OF THE SELF ARE SPLIT OFF AND PROJECTED INTO AN EXTERNAL OBJECT OR PART OBJECT."

THE IDENTIFICATION COMES IN WHERE THE SELF REINTROJECTS THE EXTERNAL OBJECT WITH ITS PROJECTED PART.

H. ROSENFELD (1978), IN PARTICULAR, HAS USED THE CONCEPT IN UNDERSTANDING AND TREATING THE PSYCHOTIC PATIENT. WHEN A PATIENT SPLITS OFF A PART OF HIMSELF AND PROJECTS IT INTO THE ANALYST, HE HAS A FEELING OF RELATEDNESS TO THE ANALYST, BUT ALSO FEELS HE HAS LOST SOMETHING. THE PATIENT OFTEN FEELS THAT THE SPLIT-OFF PART, NOW PART OF THE ANALYST, IS A PERSECUTOR.

THESE SPLIT-OFF PARTS CAN BE FEELINGS THAT ARE TOO PAINFUL OR UNACCEPTABLE TO THE PATIENT, SO THEY ARE PROJECTED INTO THE THERAPIST, WHO TAKES THEM ON BOARD AND EXPERIENCES THEM AS IF THEY ARE HIS OWN, AT LEAST INITIALLY. THIS ALL HAPPENS UNCONSCIOUSLY.

FOR THE STUDENT, IT CAN BE HARD TO DISTINGUISH BETWEEN THE FEELINGS WHICH REALLY COME FROM THE THERAPIST, BUT ARE TRIGGERED OFF IN THERAPY, AND THE FEELINGS THAT THE THERAPIST HAS TAKEN ON BOARD FROM THE PATIENT.

## The Group of Students

The professional background of the mature students who filled in the questionnaires was as follows:-

| | |
|---|---|
| Social Workers | 3 |
| Psychiatrists | 3 |
| Psychologists | 2 |
| Priest | 1 |
| Psychotherapists in Private Practice | 3 |
| | 12 |

The request to fill in the questionnaires was made at the beginning of the two year course, after about four months. The initial reluctance to fill them in had to do with anxieties as to who would be reading and rating the questionnaires. The students were told they could remain anonymous, if they so wished, but only three students availed of this; the remaining nine gave their names on the accounts.

## The Three Raters

The professional backgrounds of the raters were:

Social Worker and Student on the Course (KHG)
Psychiatrist in Private Practice (RL)
Social Worker/Family Therapist (FF)



## Results

Table 1.

RATINGS OF PRESENCE-ABSENCE OF THERAPY DIFFICULTY,
SHOWING RELIABILITIES BETWEEN THE THREE RATERS

| | CATEGORY: | Rating Pair: | KHG & RL | KHG & FF | RL & FF |
|---|---|---|---|---|---|
| 1: | T-Incompetent | | 0.64 | 0.39 | 0.19 |
| 2: | T-Damaging | | 0.22 | 0 | 0.08 |
| 3: | T-Puzzled | | 0.61 | 0.44 | 0.37 |
| 4: | T-Threatened | | 0.56 | 0.50 | 0.68 |
| 5: | T-Out of Rapport | | 0.60 | 0.18 | 0.40 |
| 6: | T's Personal Issues | | 0.38 | 0.43 | 0.24 |
| 7: | Painful Reality/Ethical Dilemma | | 0.83 | 0.38 | 0.26 |
| 8: | T-Stuck | | 0.11 | -0.10 | 0.20 |
| 9: | T-Thwarted | | 0.52 | 0.52 | 0.46 |

The generally weak correlations as to presence/absence of therapist difficulty would indicate that samples given by a taxonomy-naive group and rated by three raters, two of whom were blind raters, do not give a high reliability. Of the three pairs, KHG and RL have the highest reliability.

Table 2.

STRENGTH OF CORRELATIONS SHOWN IN TABLE 1

| Rating Pair: | KGH & RL | KGH & FF | RL & FF |
|---|---|---|---|
| Strong correlation (< 0.8) | 1 | 0 | 0 |
| Moderate correlation (0.5 - 0.8) | 5 | 2 | 1 |
| Weak correlation (> 0.5) | 3 | 7 | 8 |
| | — | — | — |
| | 9 | 9 | 9 |

THERE WAS ONLY ONE STRONG CORRELATION, WHICH CAME FROM CATEGORY 7, BY THE RATING PAIR KHG AND RL. THE MAJORITY OF THE CORRELATIONS WERE WEAK, 18 OF THEM, WHILE THE REMAINING 8 CORRELATIONS WERE OF MODERATE STRENGTH.



Table 3.

SHOWING THE RATERS' PREDOMINANCE RATINGS OF THE THIRTY-THREE ACCOUNTS OF DIFFICULTY

Numbers in grids refer to categories = 1: T-Incompetent 4: T-Threatened 7: Painful Reality/Ethical Dilemma
2: T-Damaging 5: T-Out of Rapport 8: T-Stuck
3: T-Puzzled 6: T's Personal Issues 9: T-Thwarted

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | X | | | X | | | X | | | X | | | | | | | | | | | | | | | | | | | | |
| KHG | 4 | 9 | 4 | 4 | 9 | 8 | 9 | 1 | 4 | 6 | 9 | 3 | 9 | 1 | 7 | 7 | 2 | 5 | 1 | 4 | 9 | 1 | 1 | 1 | 2 | 3 | 2 | 3 | 1 | 1 | | | |
| RL | 4 | 9 | 4 | 4 | 9 | 3 | 9 | 1 | 4 | 6 | 3 | 3 | 9 | 1 | 7 | 7 | 7 | 1 | 1 | 4 | 9 | 3 | 4 | 7 | 1 | 1 | 4 | 7 | 3 | 3 | 3 | 1 | 1 |
| FF | 1 | 9 | 4 | 4 | 9 | 9 | 8 | 1 | 4 | 6 | 3 | 3 | 9 | 1 | 2 | 8 | 2 | 1 | 1 | 4 | 9 | 9 | 9 | 9 | 7 | 5 | 1 | 1 | 3 | 3 | 1 | 3 | 4 | 1 |
| | | | | * | | | * | | | * | | | * | | | | | | | | | | | | | | | | | | | | |

X = Predominant category agreed by the three raters.

* = Categories 1, 4 or 9 (1: T-Incompetent; 4: T-Threatened; and 9: T-Thwarted).

Of the thirty-three accounts of difficulty, the raters agreed as to predominance on seventeen accounts (51.5%).
Of the seventeen agreed, thirteen (76.5%) come from categories 1, 4 or 9. Of the ninety-nine predominance
ratings, the categories 1, 4 or 9 are chosen sixty-three times.

Table 4.

SHOWING PREVALENCE OF THE PREDOMINANT CATEGORY FOR THE SINGLE RATERS

| | CATEGORY | RATER: KHG | RL | FF | TOTAL |
|---|---|---|---|---|---|
| 1: | T-Incompetent | 9 | 8 | 9 | 26 |
| 2: | T-Damaging | 3 | - | 2 | 5 |
| 3: | T-Puzzled | 3 | 7 | 5 | 15 |
| 4: | T-Threatened | 7 | 7 | 5 | 19 |
| 5: | T-Out of Rapport | 1 | - | 1 | 2 |
| 6: | T's Personal Issues | 1 | 1 | 1 | 3 |
| 7: | Painful Reality/Ethical Dilemma | 2 | 5 | 1 | 8 |
| 8: | T-Stuck | 1 | - | 2 | 3 |
| 9: | T-Thwarted | 6 | 5 | 7 | 18 |
| | | 33 | 33 | 33 | 99 |

THE GREATEST DIFFERENCE BETWEEN THE RATERS SHOWS IN CATEGORY 7 (PAINFUL REALITY/ETHICAL DILEMMA) WHERE RL HAS CHOSEN THIS CATEGORY FIVE TIMES AS THE PREDOMINANT CATEGORY. KHG AND FF CHOSE IT TWICE AND ONCE RESPECTIVELY. THIS MIGHT BE EXPLAINED BY THE FACT THAT



RL HAS SPENT THE LAST FIVE YEARS DOING A LOT OF WORK IN THE AREA OF DYING AND BEREAVEMENT. RL IS ALSO THE RATER WHO HAS ONLY USED SIX OF THE NINE CATEGORIES.

Table 5.

SHOWING SEVERITY OF DIFFICULTY - SUBJECTIVE RATINGS BY THE STUDENTS

| | |
|---|---|
| Extremely difficult | 1 |
| Very difficult | 11 |
| Moderately difficult | 15 |
| Slightly difficult | 6 |
| | 33 |

THERE WAS OBVIOUSLY A SELF-SELECTION BY THE STUDENTS AS TO WHAT CASES THEY FELT COMFORTABLE TO GIVE AN ACCOUNT OF. ONE MIGHT SPECULATE OVER WHETHER THE EXTREMELY DIFFICULT SESSIONS WERE SESSIONS THE STUDENTS DID NOT FEEL ABLE TO GIVE AN ACCOUNT OF, THIS BEING TOO THREATENING.

## Discussion

The only information about the taxonomy the students had was as described in **Categories of Taxonomy** earlier. Of the raters, one (KHG), was familiar with the taxonomy. The two blind raters were given the full definitions of the nine categories and the scale they were to use for the ratings. This gave a low reliability for the presence-absence ratings. No discussion took place between the raters until the ratings were done. Then it became clear that the raters often had understood differently the accounts, given by the students, as far as the absence-presence ratings were concerned.

## Predominance Ratings

When it came to choosing one predominant category, however, there was considerably more agreement. An unexpected finding was the high proportion of categories 1 T-Incompetent, 4 T-Threatened and 9 T-Thwarted. Of the 99 ratings, one of categories 1, 4 or 9 was chosen 63 times. Studying the full definitions of the nine categories, what 1, 4 and 9 seem to have in common is a threat, a threat to the coreconstruct of the therapist. Category 6, T's Personal Issues, would also fit into the same group, but it appears to be so specific that as far as the predominance ratings go, it was chosen once by each rater, and chosen for the same account, giving a 100% agreement.



### Possible Reasons for the High Numbers of Categories 1, 4 and 9:

Was it that the raters were particularly tuned in to areas of threat and insecurity, or has the high proportion of categories 1, 4 and 9 to do with what cases the students chose to report? Was it seen as permissible to feel threatened and insecure because, firstly, this could be seen as "being sensitive and in touch with yourself and your feelings" and, secondly, it only involved one person, the student? Was it less admissible to report having had an experience of having failed or harmed the patient, being out of rapport, puzzled or stuck, these being more related to the professional part of the student and involving the patient to a greater extent?

As was already mentioned, as the course progressed the students felt more comfortable about exposing themselves and their difficulties. This process was greatly helped on the way by the psychiatrist-psychotherapist who, each week, presented and interviewed a patient in front of the group. After the patient had left, this doctor freely discussed what she had felt and experienced during her interview. This set the tone for the group, a kind of official permission to feel all sorts of things and to talk about it.

Another train of thought regarding the high prevalence of categories 1, 4 and 9 is that the cases reflect the anxiety the student was going through in real life, moving from one professional role into another and, in the process, a great deal of anxiety was generated. The students had many years of

PROFESSIONAL LIFE BEHIND THEM WHEN THEY CAME ON THE COURSE, SO WERE WELL IDENTIFIED WITH THEIR ORIGINAL PROFESSIONS. MOVING INTO A DIFFERENT ROLE CREATED INSECURITIES, AND IT APPEARS TO HAVE BEEN THE CASES THAT CONFRONTED THE STUDENTS WITH THE DIFFERENTNESS OF THEIR NEW ROLE THAT CAUSED MOST OF THE PROBLEMS. FOR THE SOCIAL WORKERS IT MEANT, SIMPLISTICALLY, THAT THEY HAD TO HARNESS THEIR URGE TO BE DOING THINGS FOR THE PATIENTS AND INSTEAD CONCENTRATE ON "BEING" WITH THEM, AND FOR THE PSYCHIATRISTS TO RELATE MORE TO THE PERSON THAN TO THE PSYCHIATRIC LABEL OR DIAGNOSIS.

## TRYING HARD

LIKE A THREAT THROUGH THE THIRTY-THREE ACCOUNTS OF DIFFICULTIES RAN THE SENSE OF TRYING HARD: TRYING HARD TO BE WHAT THE STUDENT IMAGINED A PSYCHOTHERAPIST WAS LIKE, OR TRYING HARD TO DO WHAT THE STUDENT THOUGHT A PSYCHOTHERAPIST DID; TRYING HARD TO PLEASE THE SUPERVISOR, WORRYING ABOUT WHAT THE SUPERVISOR WOULD SAY; TRYING HARD TO GET THE SESSIONS TO RUN IN A WAY THAT, THE NOTION WAS, SESSIONS OUGHT TO RUN.

> "TRYING HARD IS A COMPLEX ACT AND IS CERTAINLY NOT THE SAME THING AS WORKING HARD, ALTHOUGH THE TWO THINGS CAN OCCUR TOGETHER . . . A FEELING OF TRYING HARD MAY REFLECT A SENSE OF GUILT, ESPECIALLY GUILT OVER FAILURE TO REALLY ACCOMPLISH OR TO REALLY GIVE."
>
> (WINSLOW R. HUNT, 1978).



TRYING HARD COMES FROM NOT FEELING AT EASE WITH THE PATIENT AND/OR THE TASK. THE MORE THE PATIENT PICKS UP OF THIS, THE MORE RESISTANT THE PATIENT WILL BE, AND THE HARDER THE THERAPIST WILL TRY. THIS VICIOUS CIRCLE HAS SIMILARITIES WITH CHILD-REARING, IN THE SITUATION WHERE THE PARENT ASKS THE CHILD TO DO SOMETHING AND WHEN THE CHILD DOES NOT JUMP TO IT, THE PARENT REPEATS THE REQUEST IN A LOUDER AND LOUDER VOICE. DOING MORE IN THERAPY OF SOMETHING THAT DOES NOT WORK HAS NO EFFECT, EITHER; CHANGING THE APPROACH HAS, AS EVERY PARENT KNOWS WHO HAS LEARNT TO HELP THE CHILD TO HIS FEET, RATHER THAN KEEP SHOUTING.

IF, IN EXAMPLE 9, INSTEAD OF FLOODING THE PATIENT WITH INTERPRETATIONS (WHICH THE PATIENT POLITELY LISTENED TO AND AGREED WITH, ONLY THEN TO REVERT BACK TO TALKING ABOUT WHAT SHE WAS ABLE TO TALK ABOUT AT THE TIME, NAMELY HER SOMATIC COMPLAINTS) THE THERAPIST HAD STOPPED IN HER TRACKS AND STAYED WITH THE PATIENT, THE SESSION WOULD HAVE CHANGED. THE PATIENT WOULD BE MORE LIKELY TO FEEL THE THERAPIST WAS REALLY LISTENING AT LAST, WHICH WOULD HAVE IMPROVED THE WEAK WORKING ALLIANCE.

THE THERAPIST MIGHT HAVE IMITATED HER OWN ANALYST OR GENUINELY BELIEVED THAT WHAT WAS GOING WRONG WITH THE SESSION WAS THAT HER INTERPRETATIONS WERE NOT CLEAR OR DEEP ENOUGH, SO SHE KEPT TRYING.

## INNER FREEDOM

ANOTHER THREAD THAT WEAVES ITSELF THROUGH THE ACCOUNTS OF DIFFICULTIES IS THE NOTION OF INNER FREEDOM, OR RATHER, THE LACK OF IT.

"After all the soul of analytic technique is to free analyst and patient from the normal social constraints and so favour development of the inner world. The problem is when 'classical technique' becomes the agent of a new social constraint." (N. Symington, 1983).

In many of the therapists' experience the technique has become a constraint, because of mis-interpretation, or lack of understanding, on the part of the therapist. This led to difficulties for the therapists to be ordinarily human and flexible in their eagerness to embrace the analytic technique as they understood it. Regarding the "inner act of freedom," N. Symington (1983) defines it as such:

"My contention is that the inner act of freedom in the analyst caused a therapeutic shift in the patient and new insight, learning and development in the analyst. The inter-pretation is essential in that it gives **expression** to the shift that has already occurred and makes it available to consciousness. The point though is that the essential agent of change is the inner act of the analyst and that this inner act is perceived by the patient and causes change."

## Age Gap between Therapist and Patient

This issue came up as a problem a few times during the course, mostly from a position of young therapist - elderly patient. At the start of the course it was a



particular problem for the students, who had only recently begun their own personal therapy, and had thus not done much work themselves regarding their own parents. Countertransference problems were inevitable when "she was just like my mother, and how can you treat your own mother?"

Martin and Prosen (1976) describe a few different ways in which therapists endeavour to cope with big age gaps:

1 The young therapist who acts old and lectures the patient condescendingly;

2 The therapist who assumes that the patient must really be talking about infantile problems. "When problems are promptly traced to their childhood antecedents, the therapist can find comfort in having grown beyond that level and thus feel qualified to help the patient master the problem."

3 The older therapist who feels what all patients need is a warm and wise parent.

4 The therapist who, in changing his or her own identity, sees all patients' conflicts as having to do with self-definition.

5 The therapist who tries to be a "pal" of the adolescent patient, pretending not really to be like one of "those adults."

For the therapist who has not yet reached middle age and who is busy training and planning for the

FUTURE, IT CAN BE AN UNWELCOME EXPOSURE TO REALITY LISTENING TO AN OLDER PATIENT. BEING CONFRONTED WITH A PATIENT WHO PLANS FOR THE YEARS LEFT TO LIVE, WHILE LOOKING BACK, ADDING UP THE DEBITS AND CREDITS OF HIS LIFE, CAN BE AN ANXIETY-PROVOKING EXPERIENCE FOR THE THERAPIST, WHO STILL SEES TIME AS INFINITE AND THE TERM MORTALITY AS SOMETHING BELONGING TO STATISTICS.

## CONCLUSIONS

### The Use of the Taxonomy

USING THE TAXONOMY ON A TAXONOMY-NAIVE GROUP, AND WITH ONLY THREE RATERS, TWO OF WHOM WERE BLIND RATERS, DID NOT GIVE HIGH RELIABILITIES FOR THE PRESENCE-ABSENCE RATINGS, I.E., MOST OF THE CORRELATIONS WERE WEAK CORRELATIONS, LESS THAN 0.5.

COMPARING THE THREE RATING PAIRS, KHG AND RL SHOWED HIGHER RELIABILITY, I.E., ONE STRONG CORRELATION (0.8), FIVE MODERATELY STRONG CORRELATIONS (0.6 - 0.8) AND THREE WEAK CORRELATIONS (0.5).

REGARDING THE CHOICE OF A PREDOMINANT CATEGORY, THE INTERESTING FINDING WAS THAT, OUT OF SEVENTEEN AGREED CATEGORIES, THIRTEEN BELONGED TO A GROUP OF THREE CATEGORIES, T-INCOMPETENT, T-THREATENED AND T-THWARTED. THESE THREE CATEGORIES, COMPARED WITH THE OTHER CATEGORIES (WITH THE EXCEPTION OF CATEGORY 6, T'S PERSONAL ISSUES) ALL INVOLVE A THREAT, OF A PERSONAL NATURE, TO THE THERAPIST.

SINGLING OUT THE RATING PAIR KHG AND RL, THEY AGREED ON TWENTY-FOUR ACCOUNTS AS TO PREDOMINANCE, OF



WHICH EIGHTEEN BELONGED TO THE ABOVE MENTIONED GROUP OF THREE CATEGORIES.

CONSIDERING THE FACT THAT THE SAMPLE WAS SMALL, ONLY THIRTY-THREE ACCOUNTS, AND THAT THE ACCOUNTS OF DIFFICULTIES WERE GIVEN AT THE BEGINNING OF THE COURSE, IT IS NOT SURPRISING THAT THE FEELING OF THREAT WAS SO PREVALENT IN THE ACCOUNTS.

IN CONTRAST TO THE INITIAL STUDY, THE THREE RATERS DID NOT HAVE A PERIOD OF TIME TOGETHER DISCUSSING THE DIFFERENT CATEGORIES. IF THEY HAD, THE NUMBER OF AGREED PREDOMINANCE RATINGS WOULD POSSIBLY HAVE BEEN HIGHER.

REGARDING RESEARCH QUESTION 1, (DOES THE TAXONOMY COVER THE REPORTED DIFFICULTIES?), THE ANSWER IS "YES," IN THE SENSE THAT THE RATERS HAD NO DIFFICULTY IN FINDING CATEGORIES FOR THE DIFFICULTIES. THE PROBLEM WAS, FOR THE PREDOMINANCE RATINGS, TO CHOOSE WHICH ONE, SINCE THE RATERS APPEAR TO HAVE EMPHASISED DIFFERENT PARTS OF THE DESCRIPTIONS GIVEN BY THE STUDENTS. IN FOUR CASES, THE RATERS HAVE ACTUALLY EACH CHOSEN A DIFFERENT CATEGORY.

IT WOULD HAVE BEEN INTERESTING TO HAVE REPEATED THE STUDY TOWARDS THE END OF THE COURSE, TO SEE WHETHER THE GROUP OF THE THREE CATEGORIES INVOLVING THREAT WOULD HAVE FEATURED AS PREDOMINANTLY. WITH MORE CONFIDENCE, IT IS POSSIBLE THAT THE CATEGORIES THAT INVOLVED QUESTIONS OF TECHNIQUE WOULD HAVE MOVED TO THE FOREFRONT.

## The Taxonomy as a Training Tool

Since it appears that experienced difficulties can be fitted into the categories of taxonomy, the taxonomy could usefully be employed as a road sign, showing the direction in which the therapist's difficulties lie. However, both supervisor and student would have to spend some time initially to become familiar with the different categories.

The taxonomy does not, according to this study, lend itself to being used blind. It will take an initial training period before it will become useful.

## Areas of Reported Difficulties

The students' reported difficulties lie in the areas of:-

1 Trying hard, too hard, and keeping on trying the same thing, instead of trying something different.

Connected with trying hard is the students' difficulties with "being in uncertainties, mysteries, doubts . . . " (Keats, 1817).

2 Lack of inner freedom, freedom to choose and to be flexible as a therapist. Inner freedom has a lot to do with confidence. This will only grow out of experience and supervision, where mistakes and difficulties are seen as Stop Signs (to halt at and reflect, before proceeding) rather than as cul-de-sacs and, finally and most important, the students' own analyses.



3 Differentness. As described earlier, the issue was one of age gap, but it can also be applied to situations where the therapist and patient differ as to race, sexual identify, religious persuasion, social class and personal values.

Finally, it seems that for the student to reach a degree of inner freedom and flexibility as to his or her practice, the student needs to go from the extreme of knowing very little to the extreme of wholeheartedly embracing the chosen theoretical framework, before being able to choose and discard what does not suit him or her as a person, and as a therapist.

This process is known to the student already, of course, since it replicates the development of a human being, from infant to mature adult. The infant learns and later accepts the values of the parents only, as an adolescent, to discard those values that do not fit before entering true adulthood.

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# CONTRIBUTIONS OF PSYCHOANALYSIS TO PSYCHIATRY

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THE KEY DEFINING CONCEPTS OF PSYCHOANALYSIS - CONCEPTS WHICH WILL UNDERLIE THIS PAPER - WILL FIRST BE OUTLINED, AND THEN FREUD'S VIEWS ON THE CONTRIBUTION OF PSYCHOANALYSIS TO PSYCHIATRY WILL BE DISCUSSED.

THE FOLLOWING ARE THE KEY DEFINING CONCEPTS OF PSYCHOANALYSIS:

1 THE UNCONSCIOUS - THE IDEA THAT THERE IS AN AREA OF MENTAL LIFE UNKNOWN TO A PERSON WHICH EXERTS A DYNAMIC EFFECT ON HIS BEHAVIOUR.

2 RESISTANCE AND DEFENCE - THE IDEA THAT CONSCIOUSNESS RESISTS THE EMERGENCE OF UNCONSCIOUS TENDENCIES INTO CONSCIOUSNESS.

3 TRANSFERENCE - THE IDEA THAT A PERSON TRANSFERS FEELINGS, ETC., THAT HE HAD TOWARDS PEOPLE IN HIS EARLY LIFE TO THE PSYCHIATRIST, PSYCHOLOGIST, SOCIAL WORKER, COUNSELLOR, NURSE AND SO ON, IN THE PRESENT.

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4 FREE ASSOCIATION OF IDEAS - THE FUNDAMENTAL RULE OF PSYCHOANALYTICAL TREATMENT.

5 INTERPRETATION - AIMED AT MAKING UNCONSCIOUS CONSCIOUS.

THE PHENOMENON OF PSYCHIC REALITY IS THE MOST SIGNIFICANT HUMAN EXPERIENCE AND, INDEED, IS UNIQUE TO HUMAN BEINGS. PSYCHOANALYSIS HAS A COMMITMENT TO PSYCHIC REALITY, WHICH CANNOT BE DIRECTLY PERCEIVED THROUGH THE PHYSICAL SENSES, IS ONLY DIRECTLY EXPERIENCED IN THE SELF, BUT CAN BE COMMUNICATED BY LANGUAGE - AND CAN BE INFERRED FROM OBSERVATION. PSYCHOANALYSIS IS COMMITTED TO MEANING AND TRUTH IN SO FAR AS IT IS POSSIBLE TO KNOW THEM.

FREUD TOOK A CONSIDERABLE INTEREST IN THE TOPIC OF PSYCHOANALYSIS AND ITS CONTRIBUTION TO PSYCHIATRY, AND WROTE ABOUT IT ON NO FEWER THAN THIRTEEN OCCASIONS BETWEEN 1916 AND 1933. IN 1916 HE URGED PSYCHIATRISTS TO PAY ATTENTION TO WHAT MENTALLY ILL PATIENTS SAID AND, INDEED, ONE OF FREUD'S GREAT CONTRIBUTIONS WAS TO TAKE WHAT PATIENTS SAID SERIOUSLY, AND TO ESTABLISH THE MEANING OF THEIR COMMUNICATION.

HE THEN COMPARED THE PSYCHIATRIC AND PSYCHO-ANALYTIC ASSESSMENT OF A FIFTY-THREE YEAR OLD WOMAN WITH A DELUSION OF JEALOUSY, IN 1916. HE SAID THAT FROM A PSYCHIATRIC POINT OF VIEW SHE WOULD BE SEEN AS A WOMAN WHO DEVELOPED A DELUSION AND WHO HAD BEEN PREDISPOSED TO IT BY HEREDITARY TRANSMISSION.

FREUD CARRIED OUT A PSYCHOANALYTICAL ASSESSMENT AND ESTABLISHED THAT THE PATIENT HAD TOLD A MALICIOUS HOUSEMAID ABOUT HOW AWFUL IT WOULD BE IF HER HUSBAND HAD AN AFFAIR. NOT SURPRISINGLY, THE PATIENT RECEIVED



AN ANONYMOUS LETTER ONE WEEK LATER ACCUSING HER HUSBAND OF HAVING AN AFFAIR.

IT FURTHER EMERGED THAT THE PATIENT HERSELF WAS IN LOVE WITH A YOUNG MAN, SOMETHING THAT WAS TOTALLY UNACCEPTABLE IN HER SOCIAL GROUPING. IT WAS CLEAR THAT THE WOMAN HAD USED THE DEFENCE MECHANISM OF DISPLACEMENT AND ACCUSED HER HUSBAND INSTEAD.

FREUD WENT ON IN THIS PAPER TO COMMENT THAT PSYCHOANALYSIS WAS RELATED TO PSYCHIATRY, APPROXIMATELY AS HISTOLOGY WAS TO ANATOMY.

SLATER AND ROTH (1970), IN THEIR "TEXTBOOK OF PSYCHIATRY," STATED THAT FREUD'S ELABORATION OF UNCONSCIOUS MENTAL LIFE AND PSYCHOLOGICAL INFLUENCES ON THE DEVELOPMENT OF MENTAL ILLNESS WERE REVOLUTIONARY ADVANCES FOR PSYCHIATRY. THEY ALSO POINTED OUT THAT PSYCHIATRISTS WERE MAINLY INTERESTED IN THE NATURAL HISTORY OF PSYCHIATRIC DISORDER UP TO THAT POINT, UNDER THE INFLUENCE OF KRAEPLIN, THE FATHER OF MODERN DESCRIPTIVE PSYCHIATRY. AT THAT TIME KRAEPLIN WAS OFFERING CLASSIFICATION AND FREUD WAS OFFERING UNDERSTANDING AND TREATMENT. KRAEPLIN'S VIEWS AND FREUD'S VIEWS ARE COMPLEMENTARY. SOME THERAPISTS EXPERIENCE CONSIDERABLE INTERNAL CONFLICT IN TRYING TO INTEGRATE THE TWO VIEWS OF PSYCHIATRY, BUT THEY HAVE TO BE INTEGRATED. IT IS MUCH LESS CONFLICTUAL FOR A THERAPIST TO HAVE ONLY ONE VIEW.

BEFORE DISCUSSING THE WORK OF THE PSYCHOANALYST DR. E. ZETZEL (1979), WHO INTEGRATED THESE TWO VIEWS, I WOULD LIKE TO QUOTE FREUD'S LAST REFERENCE TO PSYCHIATRY AND PSYCHOANALYSIS, IN 1933.

FREUD WROTE THAT

"THERE IS NO THEORETICAL INCONSISTENCY IN A DOCTOR WHO LIKES TO CALL HIMSELF A PSYCHO-THERAPIST USING ANALYSIS ON HIS PATIENTS ALONGSIDE ANY OTHER METHOD OF TREATMENT, ACCORDING TO THE PECULIARITIES OF THE CASE."

UNFORTUNATELY, NOT ALL PSYCHOANALYSTS WHO FOLLOWED FREUD HAD THE GOOD SENSE OF THE MASTER.

DR. ELIZABETH ZETZEL QUALIFIED AS A PSYCHOANALYST IN LONDON BEFORE THE WAR AND WENT TO WORK WITH AUBREY LEWIS AT THE MAUDSLEY. ZETZEL WAS IMMEDIATELY STRUCK BY THE CONTRIBUTION OF PSYCHIATRY TO PSYCHOANALYTIC WORK. EVEN TODAY THE CONTRIBUTION BY PSYCHIATRISTS TO PSYCHOANALYTIC WORK IS NOT FULLY ACKNOWLEDGED. A PSYCHIATRIC ASSESSMENT SHOULD BE AN INTEGRAL PART OF A PSYCHOANALYTIC ASSESSMENT.

ZETZEL, DURING HER YEARS WITH LEWIS, CONFIRMED HER CONVICTION REGARDING THE VALUE OF PSYCHOANALYTIC THEORY AS A BASIS FOR UNDERSTANDING MANY PSYCHIATRIC PROBLEMS. INDEED, ONE COULD SAY THAT PSYCHOANALYTIC THEORY AND CONCEPTS LIKE TRANSFERENCE, ACTING OUT, ETC., NEARLY ALWAYS OFFER AN UNDERSTANDING OF A PATIENT, BUT PSYCHOANALYSIS IS NOT ALWAYS THE TREATMENT OF CHOICE.

INDEED, IN THIS REGARD, AFTER THE SECOND WORLD WAR MANY PSYCHIATRISTS IN THE UNITED STATES BELIEVED IN THE TOTAL APPLICABILITY OF PSYCHOANALYSIS TO PSYCHIATRY. THIS THREATENED TO DESTROY THE INTEGRITY OF PSYCHOANALYSIS AND PSYCHIATRY IN THE UNITED STATES. PSYCHIATRISTS AND PSYCHOANALYSTS WERE UNWILLING AT THAT TIME TO UNDERTAKE THE LONG AND DIFFICULT TASK INVOLVED IN THE SEARCH FOR AREAS OF GENUINE COMMUNICATION.



IT IS INTERESTING TO NOTE THAT CONCEPTS NOW REGARDED AS OF IMPORTANCE TO PSYCHIATRISTS AND PSYCHOANALYSTS, THOSE OF TRANSFERENCE AND COUNTER-TRANSFERENCE, WERE ORIGINALLY REGARDED AS OBSTACLES TO TREATMENT. THE INTERPRETATION OF TRANSFERENCE, THAT IS, THE EMERGENCE OF INFANTILE FEELINGS IN RELATION TO THE PSYCHIATRIST, IS NOW THE MAJOR TOOL OF PSYCHOANALYTIC TECHNIQUE, AND TRANSFERENCE INTERPRET-ATIONS ARE REGARDED AS THE MOST MUTATIVE.

A DIFFICULT FORM OF TRANSFERENCE TO HANDLE, ONE WHICH IS OFTEN SEEN IN A PSYCHIATRIC HOSPITAL, IS THE EROTIC TRANSFERENCE. HERE THE PATIENT IS CONCEALING HER WISH TO BE MOTHERED BY TALKING ABOUT HER SEXUAL DESIRES FOR THE STAFF MEMBERS. OF COURSE, SHE MAY ALSO CONCEAL THESE SEXUAL DESIRES. WHAT ONE INTERPRETS HERE IS THE MATERNAL DEPRIVATION.

BEFORE AND IMMEDIATELY AFTER THE WAR, IF A DOCTOR EXPERIENCED COUNTERTRANSFERENCE FEELINGS FOR A PATIENT, HE WAS REGARDED AS BEING UNANALYSED. NOWADAYS, COUNTERTRANSFERENCE FEELINGS ARE MUCH USED IN FORMULATING INTERPRETATIONS, AND HAVE ADDED VERY CONSIDERABLY TO PSYCHOANALYTIC TECHNIQUE. FOR EXAMPLE, A YOUNG WOMAN PATIENT WAS TRYING TO FREE HERSELF FROM A DESTRUCTIVELY CRITICAL AND POSSESSIVE MOTHER. THE FEMALE PSYCHIATRIST TREATING THE PATIENT FOUND HERSELF BEING DRAWN INTO BEING CRITICAL AND CONTROLLING OF THE PATIENT. THIS WAS INTERPRETED BY THE PSYCHIATRIST TO THE PATIENT, AND THE PATIENT BECAME AWARE OF HOW SHE REPEATEDLY DREW WOMEN INTO RELATIONSHIPS OF THIS SORT.

SIR DENIS HILL (1956) HAS BEEN QUOTED AS SAYING THAT FEELINGS OF IRRITATION IN A PSYCHIATRIST SUGGEST A PRESUMPTIVE DIAGNOSIS OF HYSTERIA.

Now I would like to examine at the various levels at which psychotherapy can take place in a psychiatric hospital. Professor Cawley (1977) has provided a helpful grouping of these levels into three types. He classified support and counselling as Type 1. The characteristics of Type 1 are:

1 Unburdening of problems to a sympathetic listener. Of course, this can occur informally as well, for example, in a pub, to a neighbour over a garden fence or in an A.A. group.

2 Ventilation of feelings within a supportive relationship.

3 Discussion of current problems with a non-judgmental listener.

This type of psychotherapy is carried out by psychiatrists with chronic schizophrenics and extreme personality disorders. Judicious advice and reassurance are offered in this type of psychotherapy. Marriage Guidance Counsellors also use Type 1 psychotherapy.

Type 2 consists of intermediate forms of psychotherapy. The characteristics of Type 2 are:

4 Clarification of problems, their nature and origins, within a developing relationship.

5 Confrontation of defences.



The psychiatrist, social worker or psychologist working at this level has learned to evaluate his countertransference, and will make trial interpretations of transference phenomena, and cautious confrontation of defences.

Type 3 consists of the deepest levels of psychotherapy and psychoanalysis, and is characterised by:

6 Interpretations of unconscious motives and transference phenomena.

7 Repetition, remembering and reconstruction of the past.

8 Regression to less adult and less rational functioning.

9 Resolution of conflicts by re-experiencing and working them through. The aim of Type 3 is personality change.

The following shows the similarities and differences between supportive and exploratory psychotherapy.

The similarities are:

Unburdening of problems, ventilation of feelings, discussion of problems, support with the working alliance and reliability of time and place.

THE DIFFERENCES ARE AS FOLLOWS:

| DIFFERENCES | SUPPORTIVE | EXPLORATORY |
|---|---|---|
| | (TYPE 1) | (TYPE 3) |
| DEFENCES | SUPPORTED | CONFRONTED AND MODIFIED |
| ANXIETY | KEPT AT A MINIMUM | OPTIMAL LEVEL SOUGHT |
| TRANSFERENCE | MINIMISED AND ACCEPTED | FOSTERED, REVEALED AND ANALYSED |
| REGRESSION | DISCOURAGED | ALLOWED WITHIN SESSION |
| DREAMS | NOT ENCOURAGED | WELCOMED |
| ADVICE | OFFERED | WITHHELD |

NOW I WOULD LIKE TO EXAMINE BRIEFLY THE CONTRIBUTION OF PSYCHOANALYSIS TO GROUP THERAPY AND THE THERAPEUTIC COMMUNITY.

FREUD MADE HIS CONTRIBUTION IN 1921, WITH HIS PAPER ON GROUP PSYCHOLOGY. IT IS AGAIN INTERESTING TO NOTE THAT THREE PSYCHOANALYSTS, BION, FOULKES AND MAIN, ALL WORKING AT THE NORTHFIELD MILITARY HOSPITAL IN BIRMINGHAM DURING WORLD WAR TWO, MADE MAJOR CONTRIBUTIONS TO THESE AREAS. DR. TOM MAIN WAS THE FIRST TO USE THE TERM "THERAPEUTIC COMMUNITY," IN 1946,



AND HE SET UP AN INFLUENTIAL EXAMPLE AT THE CASSELL HOSPITAL. THE THERAPEUTIC COMMUNITY CONCEPT HAS FORGED A LINK BETWEEN PSYCHOANALYSIS AND THE SOCIAL SYSTEM, AND MANY OF THE ISSUES ARE THE SAME, FOR EXAMPLE, DEPENDENCY, AUTONOMY, AUTHORITY AND COMMUNICATION.

FOULKES ET AL (1975) INITIALLY WORKED IN GERMANY AND THEN CAME TO THE UNITED KINGDOM AND FOUNDED THE INSTITUTE OF GROUP ANALYSIS, WHICH CONTINUES TO ATTRACT MANY PSYCHIATRISTS, PSYCHOLOGISTS AND SOCIAL WORKERS, ETC. FOULKES NOTED DURING THE WAR THAT GROUP THERAPY COULD PROMOTE CONFIDENCE AND RESPONSIBILITY IN PREVIOUSLY DEMORALISED AND PASSIVELY RESENTFUL PATIENTS. HE SAW GROUPS AS FUNCTIONING AT A NUMBER OF LEVELS:

1 CURRENT ADULT RELATIONSHIPS.

2 INDIVIDUAL TRANSFERENCE RELATIONSHIPS.

3 A LEVEL OF SHARED FEELINGS AND FANTASIES.

BION (1952), WHO AS WELL AS BEING A PSYCHOANALYST WAS ALSO A VERY SUCCESSFUL TANK COMMANDER IN THE FIRST WORLD WAR, CONTRIBUTED THE IDEA OF BASIC ASSUMPTIONS OR PRIMITIVE STATES OF MIND, WHICH ARE GENERATED AUTOMATICALLY WHEN PEOPLE COME TOGETHER IN A GROUP.

1 THE DEPENDENCY - WHERE PEOPLE HAVE THE EXPECTATION OF SOLUTIONS BEING PROVIDED BY THE THERAPIST.

2 FIGHT-FLIGHT, THAT IS, FLEEING FROM OR ENGAGING IN BATTLE WITH ADVERSARIES.

3 PAIRING-COUPLING OF INDIVIDUALS WITH THE HOPE THAT IT COULD LEAD TO AN IDEA THAT WOULD PROVIDE SALVATION.

SINCE THE 1950'S THERE HAS BEEN AN INCREASING INTEREST IN THE PSYCHOANALYSIS OF ORGANISATIONS LIKE HOSPITALS. PROFESSOR ELLIOT JACQUES, A PSYCHOANALYST, PUBLISHED A SEMINAL PAPER IN 1955 ON SOCIAL SYSTEMS, AS A DEFENCE AGAINST PERSECUTORY AND DEPRESSIVE ANXIETY.

JACQUES POSTULATED THAT WITHIN THE LIFE OF ANY ORGANISATION, THE DEFENCE AGAINST ANXIETY IS ONE OF THE PRIMARY ELEMENTS THAT BIND INDIVIDUALS TOGETHER. HE SUGGESTS THAT INDIVIDUAL MEMBERS OF ORGANISATIONS PROJECT OUT THOSE IMPULSES AND INTERNAL OBJECTS THAT WOULD BE OTHERWISE UPSETTING TO THEM, FOR EXAMPLE, THE STAFF MAY CHOOSE A CONSULTANT, NURSING OFFICER OR ADMINISTRATOR AS THE PERSON ON WHOM THEY WILL PROJECT ALL THEIR UNWANTED IMPULSES, FEELINGS OF INADEQUACY, FEELINGS OF INCOMPETENCE, AND SO ON. INDEED, THE ONLY THING THE STAFF SOMETIMES AGREE ON IS WHO IS RESPONSIBLE FOR ALL THEIR PROBLEMS. IT RELIEVES THE STAFF OF ANY FEELING OF RESPONSIBILITY AND ALLOWS THEM TO FEEL GOOD. ONE OTHER POINT THAT JACQUES MAKES IS THAT THERE IS OFTEN UNCONSCIOUS COLLUSION BETWEEN THE PERSON WHO IS SELECTED IN THE WAY DESCRIBED AND THE STAFF WHO SELECT HIM AS RESPONSIBLE FOR ALL THEIR PROBLEMS. ON A WIDER SCALE, THE RELATIONSHIP BETWEEN THE NAZIS AND THE JEWS IN GERMANY IS A MORE EXTREME EXAMPLE OF THIS, ACCORDING TO JACQUES.

BETWEEN THE WARS THE INFLUENCE OF PSYCHOANALYSIS ON CHILD PSYCHIATRY WAS FAR GREATER THAN ON ADULT PSYCHIATRY. THE FIRST CHILD ANALYSIS WAS CARRIED OUT INDIRECTLY BY FREUD IN 1909, AND THE FIRST CHILD



GUIDANCE CLINIC IN THE WORLD WAS OPENED BY THOM IN BOSTON IN 1921, AND WAS PSYCHOANALYTICALLY ORIENTED. ANNA FREUD AND MELANIE KLEIN DEVELOPED CHILD ANALYSIS AND CHILD PSYCHOTHERAPY BETWEEN 1920 AND 1930. MELANIE KLEIN (1932) DEVELOPED A PLAY TECHNIQUE AS A SUBSTITUTE FOR FREE ASSOCIATION OF IDEAS IN ADULTS. MELANIE KLEIN CAME TO LONDON IN 1925 AND DEVELOPED THE KLEINIAN FORM OF CHILD PSYCHOTHERAPY AT THE TAVISTOCK CLINIC. ANNA FREUD ARRIVED IN 1939 AND DEVELOPED FREUDIAN CHILD PSYCHOTHERAPY AT THE HAMPSTEAD CLINIC. ALL CHILD GUIDANCE CLINICS AND DEPARTMENTS OF CHILD PSYCHIATRY IN LONDON HAVE CHILD PSYCHOTHERAPISTS WHO MAKE A MAJOR CONTRIBUTION TO THE CLINICS IN TERMS OF TREATMENT AND UNDERSTANDING OF CHILDREN'S PROBLEMS.

NOT SURPRISINGLY, MANY OF THE MAJOR DEVELOPMENTS IN PSYCHOANALYSIS AFTER WORLD WAR TWO TOOK PLACE IN LONDON. THE PSYCHOANALYST JOHN BOWLBY (1952) DEVELOPED ATTACHMENT THEORY; THE PSYCHOANALYST ROBERTSON (1958) CARRIED OUT HIS WORK ON THE EFFECT OF HOSPITALISATION ON CHILDREN; AND WINNICOTT (1979) HAD A MAJOR INFLUENCE ON CHILD AND ADULT PSYCHIATRISTS, AS WELL AS SOCIAL WORKERS, IN HIS WORK ON EARLY MOTHER/CHILD RELATIONSHIPS, WITH CONCEPTS LIKE GOOD ENOUGH MOTHERING, TRANSITIONAL OBJECTS AND PRIMARY MATERNAL PREOCCUPATION. HIS CONCEPT OF FALSE SELF HAS BEEN FOUND TO BE VERY USEFUL IN WORKING WITH PERSONALITY DISORDERS.

PSYCHOANALYSIS MADE A SIGNIFICANT CONTRIBUTION TO CHILD CARE LAW. ANNA FREUD (1973) HAS CO-AUTHORED WITH A LAWYER CALLED GOLDSTEIN A COUPLE OF VERY INFLUENTIAL BOOKS ON CHILD CARE AND LAW. THESE ARE CALLED "BEFORE THE BEST INTERESTS OF THE CHILD" AND "BEYOND THE BEST INTERESTS OF THE CHILD" AND EMPHASISE THE NOTION OF PSYCHOLOGICAL PARENTS, AND THE TWO FUNDAMENTAL PRECEPTS

OF MINIMUM INTERVENTION AND THAT THE CHILD'S NEEDS MUST BE DETERMINATE. THE FIRST BOOK HAD A MAJOR INFLUENCE ON THE CHILDREN'S ACT 1975 IN BRITAIN. THE SECOND BOOK HAD AN INFLUENCE ON THE TASK FORCE REPORT ON CHILD CARE SERVICES IN IRELAND. THIS WORK IS MAINLY OF INTEREST TO CHILD PSYCHIATRISTS AND SOCIAL WORKERS.

TODAY, FAMILY THERAPY IS A MEETING GROUND FOR PSYCHOANALYSIS AND THE MORE DIRECTIVE ACTION ORIENTATED TECHNIQUES.

THE FATHER OF FAMILY THERAPY WAS THE PSYCHOANALYST ACKERMAN (1966), WHO BEGAN TO WORK WITH FAMILIES IN THE 1940'S AND PUBLISHED A VERY SEMINAL BOOK CALLED "THE PSYCHODYNAMICS OF FAMILY LIFE."

WHEN A PSYCHOANALYTICALLY ORIENTATED FAMILY THERAPIST SEES A FAMILY, HE EXPLORES WITH THEM THE MAJOR AREA OF CONFLICT OR ANXIETY. HE WILL FOCUS ON THE DOMINANT ANXIETY FOR ABOUT 80% OF THE SESSION, AND WILL INTERPRET THE MEANING OF THE ANXIETY. THEN, IN THE LAST PART OF THE SESSION, HE WILL SUGGEST A TASK FOR THE FAMILY BASED ON THIS UNDERSTANDING, FOR EXAMPLE, SETTING LIMITS, FATHER AND SON DOING SOME TASK TOGETHER, AND SO ON.

FREUD'S MAJOR CONTRIBUTION TO THE UNDERSTANDING PSYCHOSIS WAS IN THE ANALYSIS OF A JOURNAL EVERY PSYCHIATRIST READS - "THE SCHREBER CASE." FREUD ANALYSED IT IN 1911, ALTHOUGH IT HAD BEEN WIDELY DISCUSSED IN PSYCHIATRIC CIRCLES SINCE ITS PUBLICATION IN 1903. HE CLASSIFIED THE PSYCHOSIS AS NARCISSISTIC NEUROSIS, AND FELT THEY WERE INCAPABLE OF FORMING A TRANSFERENCE BECAUSE OF THE WITHDRAWAL OF THE LIBIDO FROM THE OUTSIDE WORLD. THIS, OF COURSE, IS NO LONGER



ACCEPTED, AS PSYCHOTIC FORMS OF TRANSFERENCE HAVE BEEN IDENTIFIED FOR SOME TIME NOW.

KARL ABRAHAM (1927) WAS THE FIRST PSYCHOANALYST TO MAKE A SERIOUS EFFORT TO APPROACH THE WIDE SPECTRUM OF MENTAL ILLNESS MET WITH IN A PSYCHIATRIC HOSPITAL IN A PSYCHOANALYTIC WAY. INDEED, IT IS INTERESTING TO NOTE THAT AT ONE TIME EUGENE BLEULER, KARL JUNG AND KARL ABRAHAM ALL WORKED IN THE SAME HOSPITAL IN ZURICH. EVEN TODAY, ANY PSYCHIATRIST WOULD FIND GREAT PLEASURE IN READING ABRAHAM'S PAPERS ON SCHIZOPHRENIA, MANIC DEPRESSIVE PSYCHOSIS, ALCOHOLISM AND SO ON. ABRAHAM FOCUSED ON DEVELOPMENT IN THE FIRST TWO YEARS OF LIFE. HE WAS MELANIE KLEIN'S TRAINING ANALYST IN BERLIN, AND HER IDEAS ON CHILD DEVELOPMENT ARE BASED ON ABRAHAM'S. MELANIE KLEIN'S IDEAS ON PSYCHOSIS HAVE SIGNIFICANTLY INCREASED OUR ABILITY TO UNDERSTAND THE PSYCHOSIS. THE SAME IDEAS HAVE INCREASED OUR ABILITY TO TREAT THE PSYCHOSIS WITH PSYCHOANALYTIC PSYCHOTHERAPY. THIS TREATMENT IS NORMALLY CARRIED OUT IN CONJUNCTION WITH PHENOTHIAZINE TREATMENT, AND IT ALLOWS THE PATIENT TO MAKE USE OF HIS ILLNESS, TO DEVELOP AN UNDERSTANDING OF IT AND TO SEE IT AS HAVING A MEANING. MELANIE KLEIN EMPHASISED PATHOLOGICAL PROJECTIVE IDENTIFICATION, IN WHICH THE PSYCHOTIC PATIENT DISINTEGRATES PARTS OF HIMSELF AND PROJECTS THEM INTO PEOPLE AROUND HIM. THIS CAN LEAD HIM THEN TO HAVE THE FEELING OF BEING PERSECUTED, TO BEING UNABLE TO DIFFERENTIATE HIMSELF FROM THOSE AROUND HIM. IT CAN ALSO LEAD TO CONFUSION, LOSS OF IDENTIFY AND A FEELING OF EMPTINESS. THIS PATHOLOGICAL PROJECTIVE IDENTIFICATION IS SET IN MOTION BY EXTREME ANXIETY, HOSTILITY OR ENVY. THE OTHER MECHANISMS SHE EMPHASISED IN THE PSYCHOSIS WERE THOSE OF PRIMITIVE SPLITTING AND EXTREME IDEALISATION.

A CASE OF A SCHIZOPHRENIC WITH A NUMBER OF FIRST RANK SYMPTOMS OF SCHIZOPHRENIA WAS RECENTLY PUBLISHED IN THE INTERNATIONAL JOURNAL OF PSYCHOANALYSIS. THE PATIENT WAS TREATED IN THE MAUDSLEY HOSPITAL, USING PSYCHOANALYTIC PSYCHOTHERAPY TWICE WEEKLY FOR TEN MONTHS. THE PATIENT WAS IN FULL EMPLOYMENT AND DOING WELL AT TWO YEARS FOLLOW-UP. THE TREATMENT WENT THROUGH A NUMBER OF PHASES. IN THE FIRST PHASE THE PATIENT WAS IN A STATE OF DISINTEGRATION AND UNINTEGRATION. THEN FOLLOWED A PHASE OF DEPRESSION FOR SIX WEEKS. THIS WAS FOLLOWED BY A PHASE OF MULTIPLE FEELINGS FOR FOURTEEN WEEKS, AND AT THIS STAGE THE TREATMENT WAS MORE LIKE THE TREATMENT OF A NEUROTIC PATIENT. FINALLY, HE WENT INTO A PHASE OF SELF-SUSTAINED DEVELOPMENT THAT WAS MAINTAINED AT FOLLOW-UP.

WHEN BLEULER WAS ASKED ABOUT THE PSYCHOANALYTIC TREATMENT OF SCHIZOPHRENIA, HE SAID THAT PSYCHOANALYSIS WAS THE TREATMENT OF CHOICE IF THEY ALL COULD BE TREATED BY FREDA FROMM-REICHMANN (1948). ONE WOULD NOT DISAGREE THAT FREDA FROMM-REICHMANN WAS VERY GOOD AT TREATING SCHIZOPHRENIA, BUT MOST PSYCHOANALYSTS WOULD NOT AGREE THAT SHE WAS THE ONLY ONE. OF COURSE, ONLY A RELATIVELY SMALL NUMBER OF PSYCHOANALYSTS ARE WILLING TO TOLERATE SCHIZOPHRENIA IN ANALYSIS, AS THE DEMANDS ARE EXTREMELY GREAT. IT IS SAID THAT PSYCHOANALYSTS WHO ARE MORE IN TOUCH WITH A PSYCHOTIC LAYER OF THEMSELVES ARE BETTER ABLE TO CARRY OUT THIS KIND OF WORK. NEVERTHELESS, IT IS CLEAR THAT PSYCHOANALYSIS WILL NOT HAVE ANY EFFECT ON THE SIZE OF DILATED VENTRICLES IN THE BRAIN.

THE MOST SIGNIFICANT CONTRIBUTION OF PSYCHO-ANALYSIS TO PSYCHIATRY HAS BEEN IN THE AREA OF BRIEF PSYCHOTHERAPY.



SOME OF FREUD'S EARLY WORK COULD CERTAINLY BE CLASSIFIED AS BRIEF PSYCHOTHERAPY, SAY THAT AROUND 1900.

THE FIVE TO SIX TIMES PER WEEK CLASSICAL ANALYSIS DEVELOPED IN THE DECADE FOLLOWING 1900.

AFTER THE FIRST WORLD WAR THERE WAS A GREAT DEMAND FOR PSYCHOANALYSIS, BUT FEW PSYCHOANALYSTS AVAILABLE. FERENZI (1926) TRIED TO SPEED UP THE PROCESS OF PSYCHOANALYSIS SO IT WOULD BE MORE WIDELY AVAILABLE. HE EXPERIMENTED WITH RELAXATION TECHNIQUES, AND WITH THE ANALYST ADOPTING DEFINITE ROLES AND ATTITUDES. NO PSYCHOANALYTICALLY ORIENTATED BRIEF PSYCHOTHERAPIST WOULD OPERATE IN THAT WAY TODAY.

ONE OF THE FIRST SIGNIFICANT BOOKS ON PSYCHOTHERAPY WAS "PSYCHOANALYTIC PSYCHOTHERAPY," BY ALEXANDER AND FRENCH, PUBLISHED IN 1946. THIS RECEIVED A RATHER HOSTILE RECEPTION FROM THE PSYCHOANALYTIC ESTABLISHMENT, BECAUSE IT WAS "ALLOYING THE PURE GOLD OF PSYCHOANALYSIS WITH THE COPPER OF DIRECT SUGGESTION." AT THE TIME IT WAS SEEN AS AN ATTACK ON ORTHODOX PSYCHOANALYTIC TECHNIQUE.

BALINT (1972) INTRODUCED THE TERM "FOCAL PSYCHOTHERAPY," AND WAS THE FIRST PSYCHOANALYST IN BRITAIN TO STUDY BRIEF PSYCHOTHERAPY. HIS BEST PUPIL, DAVID MALAN (1963), HAS CARRIED OUT VERY SIGNIFICANT RESEARCH ON BRIEF PSYCHOTHERAPY AT THE TAVISTOCK OVER THE PAST TWENTY YEARS.

BEFORE BALINT AND MALAN BEGAN THEIR WORK IT WAS FELT THAT THE RESULTS OF BRIEF PSYCHOTHERAPY WERE MERELY PALLIATIVE AND TEMPORARY, THAT ONLY PATIENTS WITH ACUTE PROBLEMS COULD BE HELPED, AND THAT ONLY A

SUPERFICIAL FOCUS COULD BE DEALT WITH AND, FINALLY, THE TRANSFERENCE INTERPRETATION SHOULD NOT BE MADE.

MALAN SET OUT TO TEST THE VALIDITY OF THE IDEAS WHICH I HAVE JUST DESCRIBED. HE ASSESSED PATIENTS FOR PSYCHOTHERAPY BY USING A CLINICAL INTERVIEW BY A PSYCHOANALYST AND PROJECTIVE TESTING BY A PSYCHOLOGIST. THIS MATERIAL WAS PRESENTED TO THE RESEARCH TEAM, WHO THEN DEFINED THE BASIC NEUROTIC CONFLICT THAT LAY AT THE HEART OF THE PATIENT'S DIFFICULTIES. THIS WAS CALLED THE PSYCHODYNAMIC HYPOTHESIS, WHICH DEFINED BY IMPLICATION THE SPECIFIC KIND OF STRESS TO WHICH THE PATIENT WAS VULNERABLE, AND WHICH HE HAD TO BE ABLE TO FACE WITHOUT DISTRESS OR THE APPEARANCE OF NEW SYMPTOMS, IF THE TREATMENT WAS TO BE REGARDED AS SUCCESSFUL.

THE CRITERIA FOR ACCEPTANCE WERE AS FOLLOWS:

1 SOME CONTACT HAD TO BE MADE WITH PATIENT DURING THE ASSESSMENT, AND THERE HAD TO BE SOME RESPONSE TO INTERPRETATION.

2 FOCUS HAD TO BE FOUND.

3 THERE HAD TO BE SOME EVIDENCE OF A CAPACITY TO TOLERATE SOME ANXIETY AND DEPRESSION.

THE CRITERIA FOR REJECTION WERE AS FOLLOWS:

1 DRUG ADDICTION.

2 SERIOUS SUICIDAL ATTEMPTS.



3 LONG-TERM HOSPITALISATION.

4 MORE THAN ONE COURSE OF E.C.T.

5 CHRONIC ALCOHOLISM.

6 INABILITY TO FIND A FOCUS.

7 INABILITY TO MAKE CONTACT WITH PATIENT AT INTERVIEW.

8 GROSS EARLY DEPRIVATION, WHICH COULD LEAD TO SEVERELY DEPENDENT, UNRESOLVEABLE TRANSFERENCE.

IT IS WORTH LOOKING AT ONE OF MALAN'S CASES. THE PATIENT WAS A MARRIED MAN OF THIRTY-ONE YEARS, WHO WAS REFERRED AFTER AN OUTBURST OF UNCONTROLLABLE RAGE AGAINST HIS WIFE.

IT EMERGED DURING THE ASSESSMENT THAT HE HAD BEEN COMPLAINING OF LOSS OF ENERGY FOR A FEW MONTHS. HE WENT TO HIS G.P. AND WHEN HE RETURNED HIS WIFE SUGGESTED TO HIM THAT HE MIGHT TAKE THE DAY OFF. DESPITE HER REMARK, HE GOT READY TO GO TO WORK, AND SHE SAID THAT IN THAT CASE SHE WOULD GET ON WITH TREATING THE HOUSE FOR WOODWORM. AS THE PATIENT HAD BEEN MAKING A POOR JOB OF THIS FOR THE PREVIOUS YEAR, THE REMARK ENRAGED HIM. HE POURED A GALLON OF ANTI-WOODWORM SOLUTION DOWN THE SINK, HIT HIS WIFE AND CRIED FOR THREE HOURS.

THE PATIENT HAD A RATHER ANXIOUS, PERFECTIONISTIC PERSONALITY, AND COULD NOT RELAX. HE HAD ALWAYS SUFFERED FROM PREMATURE EJACULATION. HE REMEMBERED HIS

FATHER AS BEING A SELF-MADE MAN AND ALWAYS BEING AWAY FROM HOME WORKING.

THE FOLLOWING PSYCHODYNAMIC HYPOTHESIS WAS MADE BY THE RESEARCH TEAM. THEY FELT THAT HE HAD BEEN CONTINUALLY APPEASING A SENSE OF GUILT, WHICH WAS PRESUMABLY ABOUT SEXUAL AND AGGRESSIVE IMPULSES. THIS DEFENCE MADE HIM COMPULSIVELY PREOCCUPIED WITH WORK, AND ONLY INCREASED HIS GUILT TOWARDS HIS WIFE, WHOM HE DID NOT SATISFY.

THE FOLLOWING CRITERIA WOULD HAVE TO BE MET IF TREATMENT WAS TO BE REGARDED AS A SUCCESS. THESE CRITERIA WERE SET DOWN BEFORE TREATMENT BEGAN:

1 HE SHOULD BE ABLE TO WORK WITHOUT FATIGUE.

2 HE SHOULD BE ABLE TO TOLERATE IMPERFECTIONS IN WORK WITHOUT ANXIETY.

3 HE SHOULD BE ABLE TO TOLERATE CRITICISM AND STAND UP FOR HIMSELF.

4 HE SHOULD ENJOY SEXUAL INTERCOURSE WITH HIS WIFE.

5 HE SHOULD ENJOY HOME LIFE.

6 THERE SHOULD BE MORE WARMTH AND COMPANIONSHIP BETWEEN HIMSELF AND HIS WIFE.

I WILL PRESENT A VERY BRIEF SUMMARY OF THE COURSE OF TREATMENT. THE PATIENT WAS VERY AMBIVALENT ABOUT



TREATMENT AND, EVEN AT THE BEGINNING, WAS CONSIDERING REARRANGING HIS LIFE INSTEAD.

IN THE EARLY PHASE OF TREATMENT THE PATIENT THOUGHT HIS OUTBURST HAD TO DO WITH CRITICISM HE HAD BEEN GETTING FROM HIS BOSS FOR BEING SLOW. THE THERAPIST THEN MADE THE LINK BETWEEN THE IMPOSSIBILITY OF BEING ANGRY WITH THE BOSS AND BEING ANGRY WITH HIS FATHER AS A CHILD. HE WAS WORKING IN THE SAME WAY HIS FATHER HAD WORKED, AND THIS LED TO HIS WIFE CRITICISING HIM. IN THE THIRD SESSION, HE CLAIMED TO BE CURED. THE THERAPIST INTERPRETED THAT HE HAD BASED HIS LIFE ON THE CONTROL OF AGGRESSIVE FEELINGS, AND WAS NOW CLAMPING THEM DOWN EVEN TIGHTER.

DURING THE FOLLOWING SESSION THE PATIENT WAS VERY PASSIVE. THE THERAPIST INTERPRETED THIS IN TERMS OF A FEAR OF BEING LEFT UNSUPPORTED AND, AS A DEFENCE AGAINST DEFIANCE, A REPETITION OF HIS BEHAVIOUR WITH HIS FATHER. THE PATIENT EXPERIENCED THESE INTERPRETATIONS AS CRITICISM AND THE THERAPIST AS LIKE HIS CHILDHOOD, WHEN HE WAS EXPECTED TO SUPPRESS HIS FEELINGS AND GROW UP. HE DENIED HIS DESPAIR AND RAGE AT BEING UNLOVED BY HIS FATHER, AND MADE GREAT EFFORTS TO CONTROL HIS RAGE BY BEING OVER CONSCIENTIOUS AT WORK, SO IT WAS THE LAST STRAW WHEN HE WAS CRITICISED THERE AS WELL. IN SESSION 15 HE SAID THAT HE WANTED TO CONTINUE ON HIS OWN AND THE THERAPIST HAD NO CHOICE BUT TO ALLOW HIM. THERE WAS NO WORK ON TERMINATION.

THE PATIENT WAS FOLLOWED UP THREE YEARS AND TEN MONTHS LATER. HE WAS DOING VERY WELL AT WORK, EARNING MUCH MORE MONEY, ABLE TO BE ANGRY WITH HIS BOSS AND, INDEED, HAD FULFILLED ALL THE CRITERIA IN RELATION TO WORK THAT WERE SET DOWN INITIALLY.

IN THE FIRST TWO YEARS AFTER THE TREATMENT, THE SEXUAL RELATIONSHIP WITH HIS WIFE IMPROVED, BUT THEN HIS WIFE WENT THROUGH AN EMOTIONAL CRISIS IN RELATION TO ONE OF THEIR CHILDREN AND LOST INTEREST IN SEX. BY THE TIME HER INTEREST HAD RETURNED, THE PATIENT HAD LOST INTEREST HIMSELF, AND THERE WAS STILL SOME DEGREE OF PREMATURE EJACULATION, ALTHOUGH HIS WIFE DID ACHIEVE ORGASM ON MOST OCCASIONS. HE WAS STILL NOT ENJOYING HOME LIFE AS MUCH AS HAD BEEN HOPED FOR IN THE BEGINNING. THEREFORE, HE WAS GIVEN A SCORE OF 2.5 OUT OF 4. THE FOLLOWING IS THE SCORING USED:

0 - 0.5 UNCHANGED;

0.6 - 1.8 MODERATE IMPROVEMENT;

2.0 - 2.75 IMPROVED;

2.8 - 3.3 MUCH IMPROVED;

3.5 - 4.0 RECOVERED.

IN SUMMARY, MALAN SHOWED THAT:

1 MANY CHRONIC CASES ACHIEVED CONSIDERABLE PERSONALITY CHANGE WITH BRIEF PSYCHOTHERAPY:

2 DEEP CONFLICT COULD BE DEALT WITH IN BRIEF PSYCHOTHERAPY.

3 THE BEST RESULTS WERE OBTAINED WHERE TRANSFERENCE INTERPRETATIONS, AS WELL AS DEEP INTERPRETATIONS AND THE LINK WITH CHILDHOOD,



WERE MADE. THIS SHOWED THAT IT WAS THE SPECIFICITY OF PSYCHOANALYTIC TECHNIQUE THAT LED TO THE IMPROVEMENT.

4 THE PROGNOSIS WAS BEST WHERE THERE WAS A WILLINGNESS ON THE PART OF THE PATIENT AND THERAPIST TO BECOME DEEPLY INVOLVED, AND TO BEAR THE TENSION THAT INEVITABLY ENSUED.

MALAN ALSO NOTED TOM MAIN'S (1946) EXPERIENCE USING A PARTIAL FOCUS, OR DOING A LITTLE WITH A BAD PATIENT. TOM MAIN PUT IT TO A NUMBER OF SEVERELY DISTURBED HYSTERICS THAT HE COULDN'T HELP THEM. THEN HE WORKED THROUGH THEIR ANGER, THREATS OF SUICIDE, ETC., OVER A FEW MONTHS. AT FOLLOW-UP A FEW YEARS LATER MOST OF THEM WERE DOING WELL. INDEED, TOM MAIN'S APPROACH HAD BEEN THE FIRST HONEST APPROACH ANYONE HAD MADE TO THEM. ALL THE PREVIOUS THERAPISTS HAD, EITHER IN A SPOKEN OR UNSPOKEN WAY, PROMISED THEM MUCH MORE THAN THEY COULD DELIVER, AND WHAT THESE PATIENTS REALLY WANTED WAS FOR THEIR CHILDHOOD DEPRIVATION TO BE MADE UP TO THEM, SOMETHING WHICH WAS, OF COURSE, IMPOSSIBLE.

JAMES MANN (1973), FROM BOSTON, SET OUT THE ADVANTAGES OF BRIEF PSYCHOTHERAPY AS FOLLOWS:

1 MORE PATIENTS CAN BE SEEN.

2 THE PSYCHOTHERAPY IS MORE FOCUSED.

3 THERE IS LESS PROBLEM WITH DEPENDENCY AND REGRESSION.

4 It makes the therapist more aware of the strength of the patient.

5 It encourages the patient to face his conflicts more quickly.

6 It reduces the number of drop-outs.

7 It is useful for registrars on short rotation.

Mann offers patients a fixed number of sessions - twelve. He emphasises that the time limit embodies the reality principle. Mann has identified a number of universal conflicts dealt with in psychotherapy:

1 Independence versus dependence.

2 Activity versus passivity.

3 Adequate self-esteem versus diminished self-esteem.

4 Unresolved and delayed grief.

Mann put considerable emphasis on dealing with separation issues in the last three sessions. He has taught brief psychotherapy to registrars in Boston for many years, using a one-way screen and a video. He feels that even an inexperienced registrar can carry out brief psychotherapy satisfactorily, if he is closely supervised on each session each week.



The mistakes that beginners usually make are:

1 Ignoring the transference.

2 Ignoring the focus.

3 Ignoring termination, and

4 Not making the contract explicit.

Mann feels that the best training for brief psychotherapy is long term psychotherapy or psychoanalytic practice, and he feels that a personal analysis would be very useful, as this kind of work requires a very high degree of self-knowledge. Brief psychotherapy is in some ways more difficult than long term psychotherapy, because you have to pick up the clues more quickly and interpret more quickly. The following criticisms are sometimes made of brief psychotherapy, and given as reasons why a patient should have full psychoanalysis:-

1 That the therapist is too active, and takes too many chances with interpretations.

2 That because of the focality, it is not pure free association of ideas.

3 That unconscious time is limitless, but brief psychotherapy is very much limited.

4 That it does not deal with symptom over-determination, and problems are not fully worked through.

5 That there is not enough time for the full development and resolution of transference.

6 That work with the unconscious is slow, and psychic change is a slow process.

It is probably worthwhile examining the need for psychoanalysts and psychotherapists in the psychiatric service in Ireland. I am uncertain whether or not these needs have ever been assessed formally.

It is worth looking at Professor Wing's operational study of the need for psychotherapy in the National Health Service in England, carried out at The Maudsley.

He first established that 41 patients out of 175,000 in the Camberwell area were receiving specialised psychotherapy, that is, they were being seen either once or twice weekly, for at least six months, either by a trained analyst or by a psychoanalytically orientated psychiatrist who devoted himself mainly to psychotherapy.

This worked out at five sessions of specialised treatment per 200,000 of the population. This was only treatment time, and did not take into account a psychoanalyst or psychotherapist's other duties. If these duties were added in, then the need would be one psychoanalyst or psychotherapist per 200,000 of the



population. For a population of three million, the need would then be 15.

In the second part of Wing's study, he examined all the case notes of the Camberwell patients attending Outpatients' in 1967, and estimated that four times more patients might have been referred for specialised psychotherapy had the facilities been available. If this figure were taken, then the psychoanalysts or psychotherapists needed for a population of three million would be 75.

A start could be made in Ireland by setting up Departments of Psychoanalytic Psychotherapy with registrar, senior registrar and consultant posts, as happens in U.K. hospitals like The Maudsley, St. George's, and so on. The job description for a consultant psychotherapist would be as follows:-

1 Personal Clinical Practice:

(a) Psychoanalysis

(b) Dynamic Psychotherapy

(c) General Clinical Psychiatry.

2 Teaching:

(a) Other trainee psychotherapists

(b) Trainee psychiatrists

(C) TRAINEES IN RELATED PROFESSIONS, E.G., NURSES, SOCIAL WORKERS, CLINICAL PSYCHOLOGISTS, OCCUPATIONAL THERAPISTS

(D) TRAINEE GENERAL PRACTITIONERS

(E) MEDICAL STUDENTS

(F) OTHER UNDERGRADUATES

(G) VOLUNTEERS

(H) THE PUBLIC

3 RESEARCH

4 ADMINISTRATION

PSYCHOANALYSIS HAS ALWAYS TAKEN AN INTEREST IN GREAT LITERARY AND ARTISTIC FIGURES. I FELT I COULD NOT COME TO SWIFT'S HOSPITAL WITHOUT MENTIONING A PSYCHOANALYTIC STUDY OF JONATHAN SWIFT WHICH WAS CARRIED OUT IN THE MID 1950'S BY PHYLLIS GREENACRE (1955), WHO IS A NEW YORK PSYCHOANALYST STILL WORKING THERE AND IN HER EIGHTIES NOW.

AS YOU ALL KNOW, JONATHAN SWIFT HAD AN UNSETTLED EARLY LIFE, HIS FATHER DYING SHORTLY AFTER HE WAS CONCEIVED. HE SUFFERED FROM RELATIVE PERSONAL ISOLATION AND THERE WAS NO SECURITY WITH REGARD TO PEOPLE OR PLACES IN HIS EARLY LIFE.



IT APPEARS THAT THE ANAL STAMP WAS PUT ON HIS CHARACTER BY THE NURSE WHO LOOKED AFTER HIM DURING THE ANAL PHASE OF DEVELOPMENT. THE ANAL QUALITY OF HIS CHARACTER WAS SHOWN IN HIS GREAT PERSONAL IMMACULATENESS, HIS SECRETIVENESS, HIS INTENSE AMBITION AND HIS STUBBORN VENGEFULNESS IN RIGHTEOUS CAUSES.

IT APPEARS THAT HE SUFFERED FROM HYPOCHONDRIASIS, PARTICULARLY RELATED TO THE GASTRO-INTESTINAL TRACT, STOMACH ACHE, ETC. HE WAS PREOCCUPIED WITH THE AFFAIRS OF THE LOWER BOWEL.

IN "GULLIVER'S TRAVELS," GULLIVER RECOUNTS THE TIME, CONDITION AND UTILISATION OF HIS TOILET FUNCTIONS, ESPECIALLY HIS DEFAECATION, WITH A FIDELITY WORTHY OF A YOUNG CHILD ON A TRIP.

SWIFT'S RELATIONSHIPS WITH WOMEN ARE INTERESTING. IT APPEARS HE RETREATED FROM GENITAL SEXUALITY AND NEVER SEEMED WILLING TO CONSIDER MARRIAGE AGAIN AFTER JANE WARING. HIS GENITAL DRIVES WERE PROBABLY PARTLY SUBLIMATED THROUGH HIS CREATIVE WRITING. IN SOME OF SWIFT'S POEMS HE WAS PARTICULARLY OUTSPOKEN CONCERNING THE FILTHINESS OF THE FEMALE BODY. INDEED, ON ONE OCCASION IN A LETTER HE DESCRIBES STELLA AS A "YAHOO."

HIS ATTACHMENT TO TWO OF THE MOST IMPORTANT WOMEN IN HIS LIFE, STELLA AND VANESSA, CONTAINED A LARGE DEGREE OF IDENTIFICATION, AS IS SHOWN BY HIS WISH TO MAKE BOYS OUT OF THEM BOTH, THAT IS, REPLICAS OF HIMSELF. HE PLAYED TEACHER/NURSE WITH THEM, TEACHING THEM HOW TO READ AND WRITE AND KEEP THEIR BODIES CLEAN. STELLA WAS THE FAITHFUL, DEPENDABLE, UNCHANGING BI-SEXUALISED OBJECT, A CORNER-STONE FOR HIS LIFE. WITH HER DEATH HE BEGAN TO GO TO PIECES.

THE SUCCESSFUL PSYCHIATRIST WILL BE ABLE TO INTEGRATE THE BIOLOGICAL, PSYCHOANALYTIC AND SOCIAL ASPECTS OF PSYCHIATRY.

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# APPLIED PSYCHOANALYSIS AND CHILD PSYCHIATRY

MICHAEL FITZGERALD.

**IN THE APPLIED** FIELD, PSYCHOANALYSTS HAVE WORKED WITH PAEDIATRICIANS AND INTER-DISCIPLINARY HOSPITAL PERSONNEL. THESE WILL BE DEALT WITH LATER IN THE PAPER. ANNA FREUD, A CHILD PSYCHOANALYST, HAS WORKED WITH THE YALE LAW SCHOOL, AND THIS HAS LED TO IMPORTANT BOOKS CALLED "BEYOND THE BEST INTERESTS OF THE CHILD" AND "BEFORE THE BEST INTERESTS OF THE CHILD."

ANNA FREUD AIMED TO APPLY PSYCHOANALYTIC THERAPY TO DISTURBED CHILDREN OF ALL AGES, TO APPLY PSYCHOANALYTIC THINKING TO THE UPBRINGING OF NORMAL AND HANDICAPPED CHILDREN, AND ALSO TO INCREASE THE BODY OF KNOWLEDGE KNOWN AS "PSYCHOANALYTIC CHILD PSYCHOLOGY."

A CONSIDERABLE BODY OF ANALYTICAL KNOWLEDGE HAS BEEN ACQUIRED FROM THE OBSERVATION OF CHILDREN OUTSIDE A PURELY ANALYTIC SETTING. MANY OF THESE EARLY OBSERVATIONS WERE CARRIED OUT BY PROFESSIONALLY TRAINED PEOPLE, FOR EXAMPLE, TEACHERS, NURSERY SCHOOL WORKERS, ETC., WHO THEMSELVES HAD PERSONAL ANALYSIS AND WERE, THEREFORE, IN A BETTER POSITION TO TAKE ADVANTAGE OF

Lecture to the Association of Child Psychology and Psychiatry, University College Galway, 6th April, 1984.

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MORE EMOTIONAL DETACHMENT THAN PARENTS CAN MUSTER WHEN CONFRONTED WITH THE BEHAVIOUR OF THEIR OWN CHILDREN. I AM NOT CONCERNED WITH THE USE OF THE MICROSCOPE ON THE PSYCHOANALYTIC TECHNIQUE, BUT WITH WHAT CAN BE DISCOVERED FROM THE USE OF THE MACROSCOPE OR NAKED EYE ABOUT THE HAPPENINGS IN THE DEEPER LAYERS OF THE CHILD'S MIND, AS REFLECTED IN BEHAVIOUR DESCRIBED IN THIS PAPER.

## An Example of the Application of Psychoanalytic Knowledge to a Paediatric Intensive Care Unit

Albert Solnit (1975) showed how he was able to function effectively as a psychoanalyst in this case. Chrissie was a three-and-a-half year old girl who was run down by a car as she darted joyously across the road to greet close friends. She suffered multiple comminuted fractures of the skull, fracture of the upper extremity, etc., and this necessitated many operations and placement in a paediatric intensive care unit. One of the parents stayed with her throughout her time in hospital, on the advice and with the support of the paediatrician and his psychoanalytic collaborator. One of the aims of the psychoanalyst was to try to reduce the dehumanising effect of the unit on the care of the patient. Psychoanalytic theory suggested that care and recovery would be facilitated by the active participation of the parents. The seriously injured child needed an auxiliary ego constantly available to help her monitor the massive manipulations of her body and to preserve the continuity of the affectionate bonds between herself and her parents. The parents also had needs to help out, to be active in trying to overcome the physical trauma to Chrissie and the psychological trauma to Chrissie and themselves. The



presence of the parents facilitated non-verbal communication that enabled Chrissie to know, as she entered the world of living in full consciousness, that there was a safe and reassuring continuity between the crevice of the sudden disruption of her life and the resumption of it.

What led to a successful physical recovery, in large part, might also have been accompanied by a severe psychological trauma, which the psychoanalyst's study of the child suggested would have included a severe speech and learning problem. There is a good deal of evidence, according to Solnit, that the presence of the mother and father, their availability to counselling by the paediatrician and child psychoanalyst, and their guidance of Chrissie, were critical factors in her complete rehabilitation. For example, it appeared that Chrissie's brain damage and her extreme apprehensiveness were involved in her inability to verbalise. It may never be possible, in reconstructing her psychoneurophysiological difficulty, to say how much Chrissie recovered her speech and how much she started to speak after she overcame her fear that speaking would lead to catastrophic consequences. This speculative inference was derived from the observation that she had rushed across the street joyously and was struck by the automobile just as she was greeting her friends warmly. It is not crucial to know how important were the cortical brain factors and how important the psychological factors in this impairment of function. Both were involved and required attention in the slow, at times arduous, but full recovery of speech. Part of the guiding principles was to assist and support her parents in helping Chrissie to understand what had happened and what was happening. Chrissie's mother stated that they

WERE ADVISED AND ENCOURAGED TO DO ALL THEY COULD TO VERBALISE EXPLANATIONS TO CHRISSIE - STARTING LONG BEFORE SHE FULLY RECOVERED CONSCIOUSNESS - AS TO WHAT WAS HAPPENING TO HER, WHY THE BANDAGE, WHY THE CAST, WHY THE HELMET, ETC., AND TO EXPLAIN, AT FIRST SIMPLY BUT SOON IN QUITE PRECISE DETAILS, THE STORY OF THE ACCIDENT. THIS ADVICE WAS BASED ON THE THEORY OF UNDOING REPRESSIONS IN OVERCOMING A SUDDEN TRAUMA. IT WAS ALSO BASED ON THE ASSUMPTION THAT AMNESIA CAUSED BY PHYSICAL TRAUMA MAY CONTRIBUTE TO THE CHILD'S FEELING OF HELPLESSNESS AND ANXIETY. AT THE FOLLOW-UP, CHRISSIE CONSISTENTLY SHOWED THE ABILITY TO HANDLE QUITE MATTER-OF-FACTLY QUESTIONS FROM CHILDREN AND OTHERS ABOUT WHY SHE WORE A HELMET, HAD RESTRICTIONS ON HER ACTIVITIES AND HOW THE ACCIDENT HAPPENED. SHE WAS NOT AFRAID OF CROSSING THE ROAD.

AS CHRISSIE BECAME CONSCIOUS SHE SEEMED TO UNDERSTAND, BUT WAS UNABLE TO UNWILLING TO SPEAK. MOTHER FELT IT RELATED TO THOSE FIRST FEW FRIGHTENING DAYS WHEN SHE WAS FULLY CONSCIOUS BUT LITERALLY COULD NOT SPEAK BECAUSE OF THE TRACHEOTOMY - SHE TRIED TO MAKE NOISES A COUPLE OF TIMES, LOOKED QUITE BEWILDERED WHEN NOTHING CAME OUT AND THEN STOPPED TRYING. SHE LEARNED TO COMMUNICATE WITH SIGN LANGUAGE, AND HER FIRST WORDS CAME AFTER FOUR-AND-A-HALF WEEKS, IN THE MIDDLE OF THE NIGHT WHEN HER GESTURES COULDN'T BE SEEN, AS SHE SAID, "MUMMY, I WANT WATER."

THE PARENTS WERE HELPED TO DEVELOP A GOOD RELATIONSHIP WITH THE HOSPITAL MILIEU, TO DEVELOP A RELATIVE EASE IN THE HOSPITAL SETTING AND TO OVERCOME THE INITIAL FEELINGS OF BEWILDERMENT, FEAR AND HELPLESSNESS. THEY WERE ABLE TO ASK AND WERE ENCOURAGED TO ASK QUITE FIRMLY OF OTHERS, E.G., THE EIGHT DOCTORS INVOLVED WITH THEIR DAUGHTER AT ONE TIME,



WHAT WAS GOING ON, AND WHY IT WAS GOING ON, AND WHAT WAS GOING ON IN THE DOCTOR'S MIND. THIS DOESN'T OFTEN HAPPEN BECAUSE PARENTS ARE TOO TIMID, BUT IT HELPED THE PARENTS IN THIS CASE TO ESTABLISH A RELATIONSHIP OF TRUST AND CO-OPERATION WITH THE DOCTORS AND STAFF.

THE PARENTS WERE ALSO ENCOURAGED TO BE ACTIVE IN HELPING CHRISSIE'S RECOVERY WHICH WAS, OF COURSE, ALSO VERY THERAPEUTIC FOR THEM. THEY WERE ABLE TO SUPPLEMENT PRACTICAL SHORTAGES IN NURSING CARE AND TO PROVIDE THE PSYCHOLOGICAL ELEMENTS THAT ONLY THE FAMILY COULD PROVIDE. AS AN ASIDE, NURSES ARE OFTEN JEALOUS OF PARENTS WHEN THIS HAPPENS, BECAUSE THEY FEEL THEY SHOULD BE ABLE TO PROVIDE EVERYTHING.

IT HAS BEEN SAID THAT PSYCHOANALYSIS HAS DISCOVERED THE CHILD WITHIN THE ADULT, AND THAT CHILD PSYCHOANALYSIS DISCOVERED THE BABY WITHIN THE CHILD. WITH THE PSYCHOANALYTIC STUDY OF INFANT OBSERVATION, THE WHEEL BEGAN TO TURN FULL CIRCLE AS THE LITTLE ADULT WITHIN THE BABY CAME MORE CLEARLY INTO VIEW. OF COURSE, THERE IS ALSO HARD EVIDENCE IN RECENT YEARS THAT BABIES, IN CONTRAST TO THEIR PHYSICAL IMMATURITY, ARE IN A SENSE HIGHLY PRECOCIOUS SOCIALLY, FOR EXAMPLE, TAKING AN INTEREST IN PEOPLE BEFORE OBJECTS, ETC.

## NEONATAL INTENSIVE CARE

IN RECENT YEARS, CHILD PSYCHOTHERAPISTS HAVE GOT INVOLVED IN NEONATAL INTENSIVE CARE UNITS. THEIR AIM WAS TO THINK OF WAYS OF COMPLEMENTING THE TECHNOLOGY WITH MORE HUMAN INSTRUMENTS OF CARE. FOR EXAMPLE, ROLENE SZUR (1981) NOTED HOW, WHEN SHE WAS OBSERVING MOTHERS AND INFANTS AT HOME, MOTHERS OFTEN EXPERIENCED THIS REGULAR CONTACT AS SOMETHING HELPFUL AND

SUPPORTIVE IN ITSELF. SHE FELT THAT MAYBE THE PRESENCE AND ATTENTION OF AN OBSERVER HELPS A MOTHER TO BEGIN TO FIND HERSELF PAYING ATTENTION IN A NEW WAY TO THE BABY'S CHANGES OF MOOD AND EXPRESSION, AND SO BECOMING MORE AWARE OF HER OWN INNATE CAPACITY TO BE IN TOUCH WITH THE CHILD, THUS ENHANCING THE RELATIONSHIP. SZUR FELT THAT THIS MIGHT ALSO BE A USEFUL WAY OF INTRODUCING HERSELF INTO A NEONATAL INTENSIVE CARE UNIT AND, INDEED, THIS HAPPENED. HER PRESENCE ON THE WARD, HER BEHAVIOUR TOWARDS THE CHILDREN, AND HER COMMENTS ABOUT THE INFANTS BEGAN ALSO TO TUNE IN THE NURSES AND PARENTS WHO WERE VISITING TO THE CHILDREN, AND IN THAT WAY TO REDUCE THE DEHUMANISATION OF THE ENVIRONMENT. SHE WAS ABLE TO TUNE IN TO THE INFANTS AND UNDERSTAND THEM AND, OF COURSE, BEING UNDERSTOOD BRINGS RELIEF.

SZUR GAVE AS AN EXAMPLE A BABY, JONATHAN, BORN SEVEN WEEKS PREMATURELY IN A MILITARY HOSPITAL ABROAD AND FLOWN HOME WITHOUT HIS MOTHER, BECAUSE SHE WAS TOO ILL TO TRAVEL. ONE DAY, WHEN HE WAS FOURTEEN WEEKS OLD, THE NURSE HAD FED HIM AND SPOKEN TO HIM IN WARM AND FRIENDLY TONES AS SHE TUCKED HIM UP, AND HE SEEMED HAPPY. SOME TIME LATER HE BEGAN TO CRY LOUDLY, AND AS THIS WAS UNUSUAL SZUR WENT TO SEE WHAT WAS GOING ON. SHE NOTICED THAT THE NURSE WAS FEEDING LITTLE ROBERT ON THE OTHER SIDE OF THE WARD AND, WATCHED BY THE TEARFUL INFANT, SHE TRIED TO COMFORT HIM. AT FIRST HE WOULD NOT BE CONSOLED, BUT AFTER A WHILE HE BECAME MORE READY TO TAKE HER IN, WATCHED HER FACE AND EVENTUALLY MADE WARM LITTLE VOCAL SOUNDS. THE NURSE WHO WAS FEEDING ROBERT ALSO NOTICED WHAT WAS HAPPENING AND CAME ACROSS, CARRYING ROBERT TUCKED UNDER HER ARM. AT THIS JONATHAN STARTED COMPLAINING AGAIN, AND THE NURSE ANSWERED IN A PLAYFUL, AFFECTIONATE WAY, TELLING HIM THAT HE WAS JEALOUS. SHE CONTINUED CHATTING AND SOON JONATHAN WAS ABLE TO ENJOY THE SOCIAL OCCASION AND HIS NURSE'S



PRESENCE, MAKING NO PROTEST AS SZUR TOOK HER LEAVE. BEING UNDERSTOOD HAD BROUGHT JONATHAN A SPECIAL COMFORT IN COMPANY, AND OFFERED PERHAPS A SMALL STEP TOWARDS BEING ABLE TO FEEL LESS LONELY AND FRIGHTENED WHEN HE WAS ON HIS OWN LATER ON. THE KIND OF CARING OFFERED BY THIS NURSE IS A PART OF EVERY INFANT'S BASIC NEEDS, AND A LACK OF IT MAY BE THOUGHT OF AS A FORM OF EMOTIONAL NUTRITION. THIS LITTLE INFANT SHOWS THAT THE CAPACITY FOR FORMING AN INDIVIDUAL RELATIONSHIP CAN BE NURTURED AT AN EARLY STAGE, EVEN IN THE ABSENCE OF MOTHER WHEN THIS MAY BE UNAVOIDABLE.

THIS WORK WITH MOTHERS AND CHILDREN AND NURSES IN NEONATAL INTENSIVE CARE UNITS IS PROBABLY EXTREMELY IMPORTANT, CONSIDERING THE STRIKING LINKS BETWEEN EARLY HOSPITALISATION AND LATER PSYCHOLOGICAL DIFFICULTIES. IDEALLY, THE MOTHER AND FATHER SHOULD TAKE OVER A GREAT PART OF EVEN A VERY SICK CHILD'S CARE ON THE WARD. WHEN THIS ISN'T POSSIBLE, THE PERSONAL RELATIONSHIP BETWEEN A BABY AND A STAFF MEMBER CAN PLAY A VALUABLE PART IN PROVIDING AN INTERMEDIARY ATTACHMENT AND THREAD OF CONTINUITY TO SUSTAIN THE BABY THROUGH THE TIME OF WAITING. SZUR (1981) ALSO POINTS OUT THAT IT IS IMPORTANT NOT TO UNDERVALUE AND UNDERMINE THE ESSENTIAL NURTURING ASPECTS OF NURSING CARE AND WARD STRUCTURE. TO UNDERVALUE THE PHYSICAL SIDE OF MEDICAL CARE WOULD BE JUST AS DAMAGING AS UNDERMINING OR UNDERVALUING THE PSYCHOLOGICAL CARE.

### To be in Touch - Ernest Freud (1981)

THE MEDICAL PROFESSION IS BEGINNING TO REALISE THAT, WHILE TECHNOLOGY IN NEONATAL INTENSIVE CARE UNITS HAS MADE SPECTACULAR ADVANCEMENTS, PSYCHOLOGICAL CONSIDERATIONS HAVE OFTEN BEEN LEFT BEHIND, AND THERE IS NOW

TIME TO PAUSE AND TAKE STOCK. GRADUALLY, COMPETITION FOR WHO OWNS THE PATIENT IS BEING REPLACED BY CONSIDERATIONS OF HOW HOSPITAL AND FAMILY CAN BEST COMPLEMENT EACH OTHER TO HELP THE PATIENT TO HELP HIMSELF.

ON A SUPERFICIAL LEVEL, IT IS NOW AGREED THAT MOTHER SHOULD LOOK AFTER THE BABY AS MUCH AS POSSIBLE WHILE HE IS IN THE NEONATAL INTENSIVE CARE UNIT, AND THAT MOTHER AND INFANT SHOULD THRIVE SO THAT THEY CAN GO HOME TOGETHER AS SOON AS POSSIBLE.

ON A DEEPER LEVEL, WE OFTEN FIND THE OPPOSITE HAPPENING IN THESE UNITS. ACCORDING TO FREUD (1981), STAFF ARE OFTEN VERY POSSESSIVE OF THE PATIENTS AND DON'T WANT TO SHARE THEM WITH THEIR FAMILIES, AND OFTEN FEEL THAT THEIR AUTHORITY IS ALSO THREATENED BY THE NEW DEVELOPMENTS. SIMILARLY, MOTHERS ON A DEEPER LEVEL DO NOT WANT TO BE REMINDED OF THEIR FEELINGS OF GUILT, FAILURE AND INCOMPETENCE, AND TRY AS BEST AS THEY CAN TO DISTANCE THEMSELVES FROM THE INFANTS. THE PATHOLOGICAL COPING METHODS USED IN THESE SITUATIONS ARE DENIAL, AVOIDANCE, POSTPONEMENT AND DISPLACEMENT. MOTHER AND STAFF MAY OFTEN UNCONSCIOUSLY COLLUDE IN THE USE OF SUCH DISTANCING DEVICES. HERE I AM USING "MOTHER" AS A KIND OF SHORTHAND - I AM REALLY REFERRING TO MOTHER AND FATHER. FREUD GIVES THE FOLLOWING EXAMPLE.

THE MOTHER OF A BABY BORN WITH A HARE LIP AND CLEFT PALATE COULD HARDLY WAIT FOR THE DAY SHE WOULD BE ALLOWED TO TAKE HER BABY HOME. WHEN SHE WAS FINALLY TOLD THAT THE BABY WAS WELL ENOUGH TO BE DISCHARGED, SHE WAS OVERJOYED. THEN SHE HAD SECOND THOUGHTS AND WAS OVERCOME BY DOUBT ABOUT HER ABILITY TO LOOK AFTER THE BABY WITHOUT THE BACKING OF THE NURSING STAFF. THE



LATENT ANXIETY GOT THE UPPER HAND, AND SHE ASKED THE UNIT TO KEEP THE BABY FOR ANOTHER DAY. THE REQUEST WAS READILY GRANTED.

ON THE SURFACE, THE HOSPITAL STAFF FAVOUR KEEPING AT-RISK BABIES NO LONGER IN THE UNIT THAN ABSOLUTELY NECESSARY, YET UNDERNEATH THEY FEEL EQUALLY STRONGLY THAT THEY ARE THE ONLY TRULY COMPETENT CARE TAKERS. BY HER REQUEST, THE MOTHER OF THE HARE LIP BABY HAD DISTANCED HERSELF, AT LEAST TEMPORARILY, FROM HER ANXIETIES WHILE THE STAFF COULD DISTANCE THESELVES FROM THEIR DISINCLINATION TO LET THE BABY GO. IN SHORT, THE STAFF COULD REMAIN POSSESSIVE OF THE INFANT AND MOTHER COULD DISTANCE HERSELF FROM THE INFANT. THE COMPROMISE OF EXTENDING THE BABY'S STAY IN THE UNIT SEEMED TO REFLECT THE MECHANISM, A COPING MECHANISM OF POSTPONEMENT.

FREUD GIVES ANOTHER EXAMPLE, OF A THIRTEEN YEAR OLD MEXICAN MOTHER WHO WAS SUFFERING FROM POSTPARTUM DEPRESSION AND WAS HESITANT TO MAKE CONTACT WITH HER PREMATURE BABY GIRL, WHO HAD BEEN DELIVERED BY CAESARIAN SECTION. ENCOURAGED TO COME TO THE UNIT, SHE STOOD RIGIDLY AND STARED INTO THE INCUBATOR. FINALLY, SHE PUT HER HAND THROUGH A PORTHOLE TO TOUCH THE BABY'S EXTREMITIES. SLOWLY HER FACE LIT UP AND ONE COULD SEE HOW THE PROCESS OF GETTING IN TOUCH WITH HER BABY WAS AFFECTING HER. UNFORTUNATELY, AFTER A FEW MINUTES A TECHNICIAN APPEARED, WHEELING A GIANT X-RAY MACHINE, AND THE YOUNG MOTHER WAS ASKED TO MAKE ROOM FOR IT. SHE AGAIN BECAME WITHDRAWN AND EXPRESSIONLESS. WITHOUT A WORD, SHE SLOWLY TURNED AROUND AND MADE HER WAY TO THE DOOR AND DISAPPEARED IN THE DIRECTION OF THE POST-NATAL WARD. STAFF AND MOTHER WERE IN AGREEMENT, BOTH CONSCIOUSLY AND UNCONSCIOUSLY, THAT THE X-RAY MACHINE HAD PRIORITY. IT COULD BE ARGUED THAT THE

ESTABLISHMENT OF CLOSE PHYSICAL CONTACT BETWEEN THIS MOTHER AND HER BABY WAS OF OVER-RIDING IMPORTANCE AT THAT TIME, AND THAT THE X-RAY COULD HAVE WAITED. THE EXAMPLE ILLUSTRATES HOW EASILY ESTABLISHED MEDICAL PROCEDURES CAN TAKE UNQUESTIONED PRECEDENCE OVER PSYCHOLOGICAL CONSIDERATIONS, THEREBY JEOPARDISING FULFILMENT OF EQUALLY VITAL PSYCHOLOGICAL NEEDS.

HELEN BENDER (1981), A CHILD PSYCHOTHERAPIST, WAS INVITED BY A DEPARTMENT OF PAEDIATRICS IN A LONDON HOSPITAL TO GET INVOLVED WITH THEIR UNIT. SHE SET UP A STAFF GROUP, WHICH WAS INITIALLY GREETED WITH GREAT ENTHUSIASM, BUT THEN PROCEEDED WITH DIFFICULTY. THERE WAS LOW MORALE IN THE UNIT, AND ABSENTEEISM AND SICKNESS MEANT THAT THERE WAS A CONSTANT SHORTAGE OF STAFF. THE NURSES COMPLAINED THAT THERE WERE TOO MANY BABIES TO THE NUMBER OF STAFF TO SPEND TIME TALKING ABOUT THE BABIES AND THE STAFF. THE STAFF BEGAN TO SEE THE GROUP AS AN ADDITIONAL DEMAND AND THIS WAS, IN A WAY, TRUE AS THEY WERE EXPECTED TO THINK ABOUT ISSUES WHICH HAD PREVIOUSLY BEEN DEALT WITH BY THE DEFENCE MECHANISM OF DENIAL. RESISTANCE TO THE GROUP COULD ALSO BE UNDERSTOOD BECAUSE OF NURSES' FEARS OF FACING FUNDAMENTAL ISSUES, AND PERHAPS EXPOSING ANXIETIES AND DOUBTS ABOUT THE VERY NATURE AND VALUE OF INTENSIVE CARE NURSING WITH PRE-TERM INFANTS AND FRAGILE NEONATES. HELEN BENDER (1981), AS LEADER, OFTEN FOUND HERSELF IN A ROOM ALONE WHEN NONE OF THE STAFF TURNED UP, AND HAD FEELINGS OF HOPELESSNESS, APATHY, ISOLATION AND REJECTION. THESE COUNTERTRANSFERENCE FEELINGS WERE VERY IMPORTANT IN HELPING HER TO UNDERSTAND HOW THE STAFF OF THE UNIT FELT.

INITIALLY, HELEN BENDER (1981) FELT IT WAS VERY IMPORTANT TO CONFIRM THAT THE NURSES' INTUITIONS ABOUT PARENTS AND BABIES WERE EXTREMELY VALUABLE TOOLS, AND



COULD BE AS IMPORTANT AS THEIR TECHNICAL SKILLS, BECAUSE THE INFANT'S HEALTH MIGHT BE AFFECTED BY HIS EARLY INTERACTIONS WITH THE DOCTORS AND NURSES. THE SHARING OF INFORMATION BETWEEN GROUP MEMBERS WAS CLEARLY SHOWN BY THE FOLLOWING INCIDENT: THE NURSES BECAME CONCERNED THAT A MOTHER WAS RELUCTANT TO HANDLE HER BABY, WHO WAS THIRTY WEEKS' GESTATION. IT EMERGED THAT THE SAME MOTHER HAD HAD A NEONATAL DEATH A YEAR EARLIER. THE PARENTS WERE ANGRY THAT AT THAT TIME NOBODY TALKED TO THEM ABOUT THE DEATH. MOTHER CONCEIVED AGAIN, AND THE PRESENT BABY WAS BORN IN THE SAME HOSPITAL WHERE THE FIRST BABY DIED, BUT HAD TO BE TRANSFERRED IMMEDIATELY. MOTHER WANTED TO HOLD THE BABY, BUT HER OWN MOTHER HAD WARNED HER OF THE DANGERS OF INFECTING SUCH A TINY BABY AND THEREFORE STIFLED HER LONGINGS. MOTHER MADE TWO REQUESTS. ONE, THAT SHE WOULD BE ALLOWED TO KEEP THE BABY ON THE PRESENT UNIT EVEN IF IT IMPROVED, AND TWO, THAT SHE MIGHT BE ALLOWED HOLD THE TUBE AT FEEDING TIME BECAUSE, IN HER WORDS, IT IS DIFFICULT TO FEEL LIKE A MOTHER WHEN YOU CANNOT SEE THE BABY TAKING IT IN; YOU FEEL UNCONNECTED. AFTER THE INTERVIEW HELEN BENDER (1981) VISITED THE BABY WITH THE PARENTS, AND NOTICED SOME QUITE VIGOROUS SUCKING MOVEMENTS WHICH SHE MENTIONED TO THE PARENTS. AT THE STAFF MEETING LATER ON SHE RELAYED BACK THE WHOLE INTERVIEW TO THE NURSES. THE FOLLOWING WEEK, WHEN HELEN BENDER ARRIVED ON THE UNIT, SHE FOUND MOTHER HOLDING AND CUDDLING THE BABY. APPARENTLY, MOTHER HAD BEEN SITTING BY THE INCUBATOR WATCHING THE BABY, WHEN SHE NOTICED HER SUCKING THE CORNER OF THE COT SHEET. SHE CALLED OVER ONE OF THE NURSES, WHO CONFIRMED TO THE MOTHER THE VIGOUR OF THE ACTION AND QUITE SIMPLY SUGGESTED PUTTING THE BABY TO THE BREAST. ENCOURAGED AND SUPPORTED BY THE NURSE, MOTHER DID SO, AND THE BABY GAINED THE DISTINCTION OF BEING THE YOUNGEST BABY ON THE UNIT TO BE BREAST-FED. THIS WAS INTERESTING, AS IT

HAPPENED THAT THERE WAS A DISCUSSION GOING ON IN THE UNIT REGARDING THE EARLIEST STAGE AT WHICH ONE MIGHT ATTEMPT TO BREAST FEED WITH A PRE-TERM INFANT, AND THEY HAD FELT THAT IT WOULD BE THIRTY-TWO WEEKS.

OTHER THEMES THAT AROSE IN THE STAFF MEETING INCLUDED FEELINGS OF RIVALRY, ANGER AND HOSTILITY THAT THE NURSES FELT THAT IN A SIMILAR SITUATION THEY WOULD BE BETTER MOTHERS AND VISIT UNFAILINGLY. THE NURSES ALSO CRITICISED THE MOTHERS FOR NOT MASTERING METRIC UNITS, AND THIS COULD BE UNDERSTOOD IN TERMS OF THE STAFF PROJECTING THEIR OWN FEELINGS OF INADEQUACY INTO THE PARENTS. THE NURSES FOUND IT DIFFICULT TO BE IN TOUCH WITH THE PARENTS' ENVY OF THEM AS COPING, CAPABLE, SURROGATE MOTHERS WHEN AT TIMES THEY FELT SO HELPLESS THEMSELVES. THE ISSUE OF NURSING VERY SICK BABIES AND THE CONSTANT REALITY OF BABIES DYING ON THE UNIT HAD MADE DEATH, AND THE FEELINGS OF GUILT AND DEPRESSION IT AROUSED, THE MOST DIFFICULT OF ALL TO DEAL WITH. MANY OF THE WAYS IN WHICH STAFF RESPONDED TO THE GROUP PARALLELLED THE WAYS IN WHICH THEY RESPONDED TO DIFFICULTIES EXPERIENCED WITH INFANTS:-

1 BY AVOIDANCE OF THE SITUATION, I.E., NOT ATTENDING STAFF MEETINGS, AND SOME STAFF ADMITTED THAT THIS WAS THE ONLY WAY THEY COULD DEAL WITH THEIR ANXIETY WHEN THE PARENTS OF A DYING BABY ARRIVED TO VISIT.

2 BY DENIAL, FOR EXAMPLE, THE NURSES WERE ADAMANT THAT, UNLIKE WITH ADULT INTENSIVE CARE NURSING, ONE COULD NOT GET INVOLVED WITH BABIES.



3 BY WITHDRAWAL OF EMOTIONAL INVESTMENT; NURSES OFTEN REPORTED LOSING INTEREST IN A VERY SICK BABY WHO MIGHT DIE, OR REPORTED A FEELING OF ANGER TOWARDS THAT BABY. SOMETIMES THEY REQUESTED TO BE MOVED INTO A DIFFERENT UNIT.

4 BY MANIC REPARATION; SUCH WAS THE CASE OF ONE NURSE WHO, FOLLOWING A BABY'S DEATH, CONSOLED HERSELF WITH THE THOUGHT THAT THE MOTHER WOULD BE PREGNANT AGAIN.

MANY OF THE ANXIETIES AND TENSIONS EXPRESSED DID NOT NECESSARILY REPRESENT THE PERSONAL PATHOLOGY OF CIRCUMSTANCES, I.E., THAT THERE WERE CERTAIN CONFLICTS INHERENT IN THE NATURE OF THE WORK IN THIS SETTING. THIS UNDERSTANDING WAS PARTICULARLY IMPORTANT IN HELPING STAFF TO BE MORE TOLERANT OF PARENTS WHOM THEY EXPERIENCED AS DIFFICULT. AT OTHER TIMES IT SEEMS THAT THE WARD IN SOME SENSE BECOME A FAMILY, WHO MIGHT HELP ONE ANOTHER SHOW GRIEF, AND THIS WAS PERMISSIBLE AND DESIRABLE. THE GROUP SUCCEEDED IN PROVIDING:

1 A FORUM FOR THE EXPRESSION OF CONFLICTS AND ANXIETIES;

2 THE IDENTIFICATION AND RESOLUTION IN SOME AREAS OF CONFLICT, PARTICULARLY OVER ATTACHMENT, BEREAVEMENT AND MOURNING;

3 A FULLER APPRECIATION OF THE BABY'S PSYCHOLOGICAL AND EMOTIONAL NEEDS, AS ILLUSTRATED BY THE INTRODUCTION OF VISUAL STIMULATION, I.E., SMILING FACE CUT-OUTS FOR BABIES IN INCUBATORS.

## A Psychoanalytic Contribution to Paediatrics

Anna Freud (Gordon, B., Freud, A., 1961) wrote about the relationship between psychoanalysis and paediatrics developing rather late. Initially, psychoanalytic child psychology was interested mainly in understanding the child's emotional relationships within the family, and only at a later stage became interested in the child's behaviour in the nursery school, hospital, etc. In these early days there was hardly any communication between the physical aspect of a child's treatment and the psychological aspect.

This must seem surprising now, since any mental experience such as anxiety or distress could be discharged in the form of physical upset in the child, disturbance of sleep, food intake, etc., while any bodily discomforts or pain could cause emotional upheaval in the form of unhappiness, distress or anxiety. In short, psychosomatic reactions were the order of the day, but the links between physical and mental processes were given very little attention in hospitals.

For psychoanalysts, the breakthrough came when there was an empathic description of separation anxiety in hospitalised infants, which succeeded finally in convincing a number of doctors and nurses that, to be therapeutically effective, the care for a child's ill body needed to be complemented by concern for, and attention to, his psychological needs. The general public's readiness to acknowledge the importance of separation anxiety threatened, for a while, to overshadow the equally important fact of the illnesses themselves.



Anna Freud hoped that future programmes in paediatrics and nursing would equip all hospital staff with sufficient knowledge of emotional factors to ensure enlightened management of their child patients. She also pointed out that in maternity wards and infant clinics the opportunities for preventive work were considerable. The formation of the Paediatric Obstetric Psychiatric Association in Ireland aimed at fostering links between paediatricians, obstetricians and psychoanalytically-orientated psychiatrists, with the hope that they will increase the amount of preventive work done. What is extremely important is that each discipline should learn from the other and respect each other.

It is extremely important that obstetricians and paediatricians take an interest in what the psychotherapist is trying to do in the hospital or clinic, as junior staff are much more likely to value analytic insights if they see the various consultants also taking an interest in them. It is also reassuring to the parents that the whole child and family is being looked into, not just the physical problem alone or, indeed, the psychological problem alone.

The psychoanalytically orientated worker doesn't try to turn paediatricians into child psychiatrists, social workers into pure psychotherapists, but attempts to train them to observe in a different kind of way, to tune in to their patients in a different way, to pick up non-verbal communication more accurately, and to pay attention to their own subjective feelings and attitudes. The aim is not to change their roles, but to add new areas and new skills. The psycho-analytically orientated worker can often be most effective in joint interviews with other hospital

personnel. Conflicts often remain latent until the birth of the baby, and tend to be revived by the birth and lived out in the parent/infant relationship, especially in the feeding situation. The mother's inability to gratify her child's needs stems more often than not from the fact that she did not enjoy a satisfying relationship with her mother. Her attitudes have been shaped by her whole life; in fact, the problem is one which extends over past generations.

It is important in this situation for therapists not to undermine parents further with demonstrations of superior and esoteric knowledge. The aim in this kind of work is more to mobilise the parents' resources and to support their self esteem. Those who benefit more seem to be those who have problems during the first weeks or months of their children's lives. Short interventions at those critical periods can lead to major transformation in the mother-child and child-mother relationship.

## Psychoanalysis and the Law

In 1962 the Yale Law School approached Anna Freud at the Hampstead Clinic, suggesting collaboration on decisions involving the disposition of children in a wide variety of legal and emotional settings which demanded the exploration of the relevance of psychoanalytic insights. It was felt that the law and psychoanalysis shared a value objective, i.e., the best interests of the child, and that there was enormous potential for psychoanalysis to meaningfully transmit knowledge about the growth and development of children to lawyers, judges and other students of the law. The aim was to develop procedures which at least might



reduce the extent of injury to the emotional growth and development of children who became the subject of legal decisions. It was also felt extremely important to establish the limit of the contribution to which psychoanalysis could make to the law. Some years ago, in the United States, psychoanalysis was over-used for a period. It was unfortunately idealised during this period, and this was in nobody's best interests. This collaboration between the psychoanalysts and lawyers had major impact on legal education throughout the United States. One of the unfortunate outcomes was that much of the knowledge developed by these discussions between Yale and London was not put into practice by social workers or psychiatrists who were in the front line.

The first book that came from this group was called "Beyond the Best Interests of the Child." It examined the various procedures concerned with determining who is, or should be, assigned the opportunity and task of being the parent to a child. The parent was defined as an adult with primary responsibility for the continuous care of the child. Goldstein et al. (1973) illustrated the tension in the law between the rights of a child and the rights of competing adult claimants. The case in question happened in England from 1968 onwards, when a biological mother was challenging the adoption of her son.

The case began in 1968 when an expectant mother arranged with her local authority for the adoption of her child at birth. The child at birth was placed with "temporary" foster parents. The foster parents began adoption proceedings some months later, but in 1969 the biological mother asserted her legal right to withdraw

HER CONSENT. THE ADOPTION ACT ALLOWED CONSENT TO BE DISPENSED WITH IF THE BIOLOGICAL PARENT, USUALLY THE MOTHER, HAD ABANDONED, NEGLECTED OR ILL-TREATED THE CHILD, OR WAS WITHHOLDING CONSENT UNREASONABLY. WHAT IS INTERESTING IN THIS CASE IS THAT THE LOCAL COUNTY COURT JUDGE WAS ABLE TO CHANGE THE SPIRIT AND REVERSE THE PRIORITIES OF THIS ACT BY ASKING WHETHER CONSENT WAS BEING UNREASONABLY WITHHELD BY THE BIOLOGICAL MOTHER, BECAUSE OF HER FAILURE TO TAKE INTO ACCOUNT THE CHILD'S WELFARE. THE JUDGE SAID THAT THE CHANGE IN "PARENTS" AT THIS TIME WOULD UPSET THE CHILD. A YEAR LATER THE APPEAL COURTS REVERSED THIS DECISION. A FURTHER YEAR LATER THE HOUSE OF LORDS REINSTATED THE ADOPTION ORDER, AND LORD HAILSHAM SUPPORTED THE FIRST JUDGE'S OPINION THAT UPROOTING THE CHILD FROM THIS STABLE, HAPPY, FAMILY ATMOSPHERE AND PLUNGING IT INTO THE UNCERTAINTIES OF LIFE WITH THE BIOLOGICAL MOTHER WAS UNSATISFACTORY. THE HOUSE OF LORDS' DECISION HAD BEEN AFFECTED BY PSYCHOANALYTIC VIEWS. THE TIDE WAS TURNING FROM PURELY BIOLOGICAL RIGHTS OF PARENTS TO THE WELFARE OF CHILDREN. THE PSYCHOANALYSTS WERE ALSO POINTING OUT THE HEIGHTENED SIGNIFICANCE OF THIS EARLY TIME IN THE LIFE OF THE CHILD, AND THAT THE CHILD SHOULD STAY WITH THE PSYCHOLOGICAL PARENT WHILE LEGAL PROCEEDINGS WERE GOING ON, UNLESS THERE WERE GRAVE REASONS WHY THIS SHOULD NOT HAPPEN.

IN THEIR BOOK, "BEYOND THE BEST INTERESTS OF THE CHILD," THE AUTHORS EMPHASISED THAT WHAT SHOULD BE AIMED AT WAS THE LEAST DETRIMENTAL AMONG AVAILABLE ALTERNATIVES FOR THE CHILD WHICH WOULD BE IN THE BEST INTERESTS OF THE CHILD. IT WAS FELT THAT THIS WOULD MAKE COURTS MORE LIKELY TO CONFRONT THE DETRIMENT INHERENT IN EACH CHILD PLACEMENT. THE WORD "BEST" HAS A MAGIC ASSOCIATED WITH IT WHICH OFTEN LED DECISION



MAKERS INTO BELIEVING THAT THEY HAD A GREATER CAPACITY THAN THEY HAD FOR DOING GOOD BY WHAT THEY DECIDED.

THE BOOK INTRODUCED THE IDEA OF AVAILABLE ALTERNATIVES, TO FORCE INTO FOCUS THE CHILD'S VANTAGE POINT, AND TO MAKE THE DECISION MAKERS MORE AWARE OF THE ADVANTAGES AND DISADVANTAGES OF EACH OPTION, AND ANYTHING THAT WOULD PRECLUDE THE CHANGES OF THE CHILD BECOMING WANTED.

WHAT COMES UP THEN IS THE NOTION OF COMMON LAW PARENTHOOD OR COMMON LAW ADOPTION, WHICH IS NOT UNLIKE COMMON LAW MARRIAGE.

THEY ALSO POINTED OUT THAT THE TIE OF ADOPTION WAS NO MORE OR LESS SIGNIFICANT THAN THE BIOLOGICAL TIE. IT WAS THE REAL TIE, THE REALITY OF AN ONGOING RELATIONSHIP, THAT WAS CRUCIAL AND THAT DEMANDED THE PROTECTION OF THE STATE THROUGH LAW.

THE FIRST BOOK, "BEYOND THE BEST INTERESTS OF THE CHILD," FOCUSED ALMOST EXCLUSIVELY ON THE PROBLEMS OF CHILDREN ALREADY CAUGHT UP IN THE LEGAL SYSTEM. THE GUIDELINES DEVELOPED IN THIS BOOK RESTED ON TWO CONVICTIONS: (I) THE CHILD'S NEED FOR CONTINUITY OF CARE BY AUTONOMOUS PARENTS REQUIRED ACKNOWLEDGING THAT PARENTS SHOULD GENERALLY BE ENTITLED TO RAISE THEIR CHILDREN AS THEY THINK BEST, FREE OF STATE INTERFERENCE. THEY EMPHASISED MINIMUM INTERVENTION; (II) THEY EMPHASISED THAT THE CHILD'S WELL-BEING MUST BE PARAMOUNT, NOT THE PARENTS' OR THE FAMILIES'. THE GOAL OF INTERVENTION WAS TO CREATE OR RECREATE A FAMILY FOR THE CHILD AS QUICKLY AS POSSIBLE. THEY EMPHASISED THAT THE CHILD'S INTERESTS MUST BE PARAMOUNT, ONCE HIS CARE HAD BECOME A LEGITIMATE MATTER FOR THE STATE TO DECIDE. THE AIM WAS TO ASSURE, FOR EACH CHILD,

MEMBERSHIP IN A FAMILY WITH AT LEAST ONE PARENT WHO WANTED HIM.

GUIDELINES WERE SET OUT FOR DETERMINING THE PLACEMENT AND PROCESS OF PLACEMENT OF CHILDREN WHOSE CUSTODY HAD BECOME THE SUBJECT OF LEGAL ACTION.

1 PLACEMENT DECISIONS SHOULD SAFEGUARD THE CHILD'S NEED FOR CONTINUITY OF RELATIONSHIPS.

2 PLACEMENT DECISIONS SHOULD REFLECT THE CHILD'S, NOT THE ADULT'S, SENSE OF TIME.

3 PLACEMENT DECISIONS MUST TAKE INTO ACCOUNT THE LAW'S INCAPACITY TO SUPERVISE INTERPERSONAL RELATIONSHIPS, AND THE LIMITS OF KNOWLEDGE TO MAKE LONG RANGE PREDICTIONS.

"BEYOND THE BEST INTERESTS OF THE CHILD" EXAMINES WHAT CIRCUMSTANCES SHOULD BE PRESENT IN THE FAMILY BEFORE THE STATE SHOULD INTERVENE. THIS BOOK WAS AIMED AT PREVENTING SOCIAL WORKERS, LAWYERS, POLICEMEN, ETC., FROM PLUNGING INTO FAMILIES, BASED ON THEIR OWN PERSONAL IDEAS OF HOW A FAMILY SHOULD WORK. IT HAPPENED THAT SLIGHTLY UNSATISFACTORY FAMILY SITUATIONS WERE MADE FAR WORSE BY THE INTRUSION OF THE STATE.

A CHILD NEEDS ONGOING INTERACTIONS BETWEEN HIMSELF AND HIS PARENTS SO THAT DEVELOPMENT CAN PROCEED.

THE STATE SHOULD ONLY INTERVENE INTO FAMILY PRIVACY TO BENEFIT THE CHILD WHEN THERE IS A THREAT TO HIS WELL-BEING, TO HIS SAFETY OR, OCCASIONALLY, TO HIS LIFE. THE AVAILABLE ALTERNATIVES TO THE FAMILY HOME



OFTEN FAIL TO OFFER THE CHILD WHAT HE NEEDS FOR ON-GOING PERSONALITY DEVELOPMENT. RECOGNITION OF THESE SHORT-COMINGS SHOULD ALTER THE LAW TO ASK WHETHER THE MOVE FROM AN UNSATISFACTORY HOME IS IN EVERY CASE THE BENEFICIAL MEASURE IT PURPORTS TO BE.

THE FAMILY SHOULD NOT BE INTRUDED UPON OR INVESTIGATED UNLESS THERE IS A GOOD CAUSE. SUCH INVESTIGATIONS MAY AROUSE ANGER TOWARDS THE CHILD WHO IS THE CAUSE OF THE INTRUSIONS, AND THIS MAY BE FOLLOWED BY PUNITIVE ACTION AND INCREASING FAMILY TENSION. CHILDREN, ON THEIR PART, REACT TO EVEN A TEMPORARY INFRINGEMENT OF PARENTAL AUTONOMY WITH ANXIETY, DIMINISHING TRUST, LOOSENING OF EMOTIONAL TIES, AND AN INCREASING TENDENCY TO BE OUT OF CONTROL. THE YOUNGER THE CHILD, THE GREATER HIS OWN HELPLESSNESS AND DEPENDENCE, THE STRONGER IS HIS NEED TO EXPERIENCE HIS PARENTS AS HIS LAW GIVERS - SAFE, RELIABLE, ALL POWERFUL AND INDEPENDENT.

## GROUNDS FOR INTERVENTION

IN DEFINING THESE GROUNDS, ANNA FREUD SOUGHT:

(A) TO SATISFY THE REQUISITES OF FAIR WARNING AND POWER RESTRAINT,

(B) TO TAKE INTO ACCOUNT THE STANDARD OF LEAST DETRIMENTAL ALTERNATIVES, AND

(C) TO ABIDE BY THE PREFERENCE FOR MINIMUM STATE INTRUSION ON FAMILY INTEGRITY.

## Parental Requests to Place the Child

Often parents who want to give up their children are met with disapproval. As an example, a mother requested of a social worker that her son be placed for adoption. The social worker sent her away and the mother returned home, assaulted her son, and brought him back to the social worker saying, "I really meant it, you'll believe me now. I wanted him adopted." A parental decision to give up a child means that the child is unwanted.

## Long Time Care Takers

The request by a child's long time care taker to become his parent, or the refusal by long time care takers to relinquish him to his parents or to a state agency, should be grounds for intervention. This is intended to prevent child care agencies and long absent parents, natural or adoptive, from keeping their children in limbo or from forcing them to separate from psychologically real parents who wish to continue to care for them. No child can be put "on ice" indefinitely, until absent parents are able or wish to recover him, without putting his health and well-being in jeopardy.

When the child has a psychological parent, and his care takers have a psychological child, then the rights of the absent parents should be terminated in favour of new familial ties.

The express wish of long time care takers to continue their care on a permanent basis is sufficient to imply that they are prepared to make the commitment



to him as a wanted child. Anna Freud was also very much against the practice, in which English social workers used to engage, which was to take the child to absent biological parents. This often upset the children enormously; their sleep deteriorated, they became aggressive, their school performance deteriorated and they showed that they felt threatened at the very core of their personalities by the thought of reunion with their estranged parents. What was learned was won at too high a price for the child. These tests were regarded as constituting gross violations of the principles of least intrusive invocation, and jeopardised the child's chances of a satisfactory disposition.

They proposed as maximum intervals beyond which it would be unreasonable to presume that a child's **residual** ties with his absent parents are more significant than those that have developed between him and his long term care takers: (a) Twelve months, for a child up to the age of three years at the time of placement. (b) Twenty-four months, for a child from the age of three years at the time of placement, with one exception; these time spans, coupled with the long time care takers' wish to continue custody, are reliable indicators for granting legal recognition to the new relationships, and for terminating legal relationships between the children, parents and state agencies.

Some older children hold emotional attachments to absent parents all the more fiercely the longer the separation lasts. In such cases, the absent parents will have remained the psychological ones, in spite of their absence, and their return will be welcomed by the child, and will provide him with the least detrimental

ALTERNATIVE. TO PROTECT SUCH CHILDREN AND THEIR LEGAL PARENTS FROM UNJUSTIFIED DISPOSITION, THERE SHOULD BE A SPECIAL HEARING FOR A CHILD OVER FIVE YEARS OF AGE WHO, (A) AT THE TIME OF PLACEMENT, HAD BEEN IN THE CONTINUOUS CARE OF HIS PARENTS FOR NOT LESS THAN THE THREE PRECEDING YEARS, AND (B) WHO HAD NOT BEEN SEPARATED FROM HIS PARENTS BECAUSE THEY INFLICTED, OR ATTEMPTED TO INFLICT, SERIOUS BODILY INJURY UPON HIM, OR WERE CONVICTED OF A SEXUAL OFFENCE AGAINST HIM.

## PARENTAL FAILURE

GROSS FAILURES OF PARENTAL CARE ALSO GIVE GROUNDS FOR INTERVENTION, I.E., REFUSAL BY PARENTS TO AUTHORISE LIFE-SAVING MEDICAL CARE, OR CONVICTION - OR ACQUITTAL BY REASON OF INSANITY - FOR A SEXUAL OFFENCE AGAINST ONE'S CHILD. THERE IS LITTLE DOUBT THAT CHILDREN WHO ARE SEDUCED BY PARENTS HAVE THEIR DEVELOPMENT TOWARDS MATURE SEX THROWN INTO CONFUSION BY THE SEDUCING ADULT. INTERCOURSE WITH CHILDREN IMMATURELY AROUSES THEIR GENITAL RESPONSES, WHICH THEN CANNOT BE EASILY PUT TO REST AGAIN, AND DEMAND REPEATED DIRECT SENSUAL GRATIFICATION, AND THE SEDUCED CHILD OFTEN BECOMES EITHER A SEDUCER OR, AS A RESULT OF GUILT FEELINGS, AN INHIBITED PERSON WHO IS UNLIKELY TO ENJOY NORMAL SEXUAL ACTIVITY IN LATER LIFE. IF THE PARENT WHO HAS SEDUCED THE CHILD HAS BEEN CONVICTED, OR ACQUITTED BY REASON OF INSANITY, THIS IS A CLEAR INDICATION FOR INTERVENTION. THE CASE WHERE A CHILD HAS BEEN HARMED BY A PARENT'S NON-VIOLENT SEXUAL ABUSE IS MORE COMPLICATED, AND WE DO NOT KNOW THAT STATE INTERVENTION CAN OFFER SOMETHING THAT IS LESS DETRIMENTAL. WORKING WITH THE FAMILY IN NORMAL CHILD GUIDANCE PATTERNS MAY BE MORE EFFECTIVE, IN THIS CASE, THAN BRINGING IN THE FULL WEIGHT OF THE LAW.



CASES OF CHILD ABUSE AND NEGLECT ARE CLEARER, AND I BELIEVE ANNA FREUD HAS SAID THAT WHEN A MOTHER HAS BATTERED HER CHILD AND SERIOUSLY DAMAGED IT, THE CHILD WILL HAVE EXTREME DIFFICULTY IN EVER TRUSTING MOTHER AGAIN AND, INDEED, VERY OFTEN MAY NEVER BE ABLE TO DO SO. OFTEN THESE CASES ARE FOSTERED, AND DO WELL WITH THEIR FOSTER PARENTS, WHO GRADUALLY BECOME PSYCHOLOGICAL PARENTS. THEN, SOME YEARS LATER, THE BIOLOGICAL PARENTS MAY APPLY TO THE COURTS TO HAVE THEM BACK. THEY SHOULD BE DEALT WITH AS ALREADY DESCRIBED.

THE FOLLOWING MATERIAL FROM "BEYOND THE BEST INTERESTS OF THE CHILD" WAS PUBLISHED IN 1973. NEVERTHELESS, IT CAN STILL HAPPEN THAT ONE ATTENDS A CASE CONFERENCE ON CHILD PLACEMENT WHERE THE PARTICIPANTS SEEM UNAWARE OF THIS LITERATURE OR, IF NOT UNAWARE OF IT, IT CERTAINLY DOESN'T INFLUENCE THE DISCUSSION.

## THE BIOLOGICAL PARENT-CHILD RELATIONSHIP

THIS SO-CALLED BLOOD TIE GIVES THE PARENTS THE FIRST RIGHT TO THE POSSESSION OF THE CHILD. NORMALLY, THE PHYSICAL FACTS OF HAVING BEGOTTEN THE CHILD AND GIVEN BIRTH TO IT HAVE FAR-REACHING PSYCHOLOGICAL MEANING FOR THE PARENTS, AS CONFIRMATION OF THEIR RESPECTIVE SEXUAL IDENTITIES, THEIR POTENCY AND INTACTNESS. DERIVED FROM THIS IS THE INCLUSION OF THE NEW-BORN INFANT IN THE PARENTS' SELF LOVE. THE OVERFLOW OF THIS SELF LOVE TO THE CHILD LEADS TO THE COMMON PARENTAL OVER-VALUATION OF THEIR OFFSPRING. BIOLOGICAL PARENTS ARE CREDITED WITH AN INVARIABLE, INSTINCTIVELY-BASED, POSITIVE TIE TO THE CHILD, ALTHOUGH THIS IS FREQUENTLY BELIED BY EVIDENCE TO THE CONTRARY IN CASES OF INFANTICIDE, INFANT BATTERING, CHILD NEGLECT, ETC.

THE BIOLOGICAL PARENT RELATIONSHIP TO THE CHILD IS SERIOUSLY INTERFERED WITH IN INSTANCES WHERE THE ADULTS IN QUESTION REJECT THEIR OWN MALE OR FEMALE IDENTITY. WHEN THE NEW-BORN IS DEFECTIVE, HIS VERY EXISTENCE MAY BECOME A REASON FOR SHAME OR GUILT INSTEAD OF PRIDE AND, FOR THE FATHER, A DISCREDIT TO HIS POTENCY.

BY CONTRAST, FOR THE CHILD THE PHYSICAL REALITIES OF HIS CONCEPTION AND BIRTH ARE NOT THE DIRECT CAUSE OF HIS EMOTIONAL ATTACHMENT. THIS ATTACHMENT RESULTS FROM DAY-TO-DAY ATTENTION TO HIS NEEDS FOR PHYSICAL CARE, NOURISHMENT, COMFORT, AFFECTION AND STIMULATION. ONLY A PARENT WHO PROVIDES THESE NEEDS WILL BUILD A PSYCHOLOGICAL RELATIONSHIP TO THE CHILD ON THE BASIS OF THE BIOLOGICAL ONE, AND WILL BECOME HIS PSYCHOLOGICAL PARENT IN WHOSE CARE THE CHILD CAN FEEL VALUED AND WANTED. AN ABSENT BIOLOGICAL PARENT WILL REMAIN, OR TEND TO BECOME, A STRANGER.

## THE PSYCHOLOGICAL PARENT-CHILD RELATIONSHIP

IF THE CHILD IS LOOKED AFTER IMPERSONALLY AND WITH ROUTINE REGULARITY, AS IN INSTITUTIONS, THE INFANT MAY REMAIN INVOLVED WITH HIS OWN BODY AND NOT TAKE AN ALERT INTEREST IN HIS SURROUNDINGS. WHERE THE ADULT IN CHARGE OF THE CHILD IS PERSONALLY AND EMOTIONALLY INVOLVED, A PSYCHOLOGICAL INTER-PLAY BETWEEN THEM WILL BE SUPERIMPOSED ON THE EVENTS OF BODILY CARE. THEN THE CHILD'S LIBIDINAL INTEREST WILL BE DRAWN FOR THE FIRST TIME TO THE HUMAN BEINGS IN THE OUTSIDE WORLD. THE CHILD WILL BRING TO THE HUMAN BEINGS WHO ARE CARING FOR HIM NOT ONLY HIS BODILY NEEDS, BUT ALSO HIS EMOTIONAL NEEDS, AFFECTION, COMPANIONSHIP AND STIMULATING INTIMACY. THEN THE CHILD FORMS AN INTERNAL MENTAL IMAGE OF THE PARENTS, WHICH REMAINS AVAILABLE EVEN WHEN



THEY ARE ABSENT. THE STEP WHICH FOLLOWS IS IDENTIFICATION WITH PARENTAL ATTITUDES. THE PSYCHOLOGICAL PARENT MAY BE A BIOLOGICAL, ADOPTIVE, FOSTER, OR COMMON LAW PARENT, OR ANY OTHER PERSON.

## THE WANTED CHILD

ONLY A CHILD WHO HAS AT LEAST ONE PERSON WHOM HE CAN LOVE, AND WHO ALSO FEELS LOVED, VALUED AND WANTED BY THAT PERSON, WILL DEVELOP A HEALTHY SELF ESTEEM AND BE CONVINCED OF HIS OWN VALUE. THIS IS OBVIOUSLY MUCH LESS LIKELY TO TAKE PLACE IN AN INSTITUTION AND, OF COURSE, INFANTS BORN AS A RESULT OF UNWANTED PREGNANCIES ARE MUCH MORE AT RISK.

IT IS IMPORTANT TO REMEMBER THAT BEING WANTED CEASES TO BE BENEFICIAL IF THE ADULT'S NEED FOR THE CHILD AND VALUATION OF HIM ARE EXCESSIVE, AND IF TOO LITTLE IS DEMANDED FROM HIM IN RETURN. THESE KIND OF CHILDREN BECOME TOO EGOTISTICAL. THEY MAY ALSO BECOME INEDUCABLE IN SOCIAL RESPECTS, SINCE THEY ARE UNDER NO OBLIGATION TO EARN THEIR PARENTS' APPROVAL BY CURBING THEIR OWN PRIMITIVE IMPULSES AND WISHES.

## THE ADOPTIVE PARENT-CHILD RELATIONSHIP

ADOPTION IN THE EARLY WEEKS OF AN INFANT'S LIFE GIVES THE ADOPTIVE PARENTS THE CHANCE TO DEVELOP A PSYCHOLOGICAL PARENT-CHILD RELATIONSHIP. THIS CHANCE IS DIMINISHED IF ADOPTION OCCURS AT A LATER STAGE, AFTER THE INFANT OR YOUNG CHILD HAS HAD EARLIER PLACEMENTS OR HAS FORMED AND BROKEN EARLIER ATTACHMENTS. THE CHANCE OF DEVELOPING A PSYCHOLOGICAL PARENT-CHILD RELATIONSHIP IS DIMINISHED TO TRIAL

PERIODS, BEFORE ADOPTIONS ARE FINALISED. DUE TO THE UNCERTAINTY OF THAT SITUATION, THE PARENTS MAY HESITATE DURING THIS PERIOD TO MAKE A FULL COMMITMENT TO THE CHILD. DEVELOPMENT OF PSYCHOLOGICAL PARENTHOOD MAY BE INTERFERED WITH IF THE PARENTS JUST WANT THE CHILD TO REPLACE A DEAD CHILD, AS A COMPANION FOR ANOTHER CHILD, TO HAVE AN HEIR OR TO STABILISE A MARRIAGE. THE TIME AT WHICH CHILDREN ARE TOLD ABOUT ADOPTION IS ALSO OF IMPORTANCE.

ANNA FREUD ARGUES THAT THERE SHOULD BE A RECOGNISED COMMON LAW ADOPTION WHICH WOULD OCCUR WHEN FOSTER PARENTS HAD BECOME PSYCHOLOGICAL PARENTS.

## PLACEMENT DECISIONS SHOULD SAFEGUARD THE CHILD'S NEED FOR CONTINUITY OF RELATIONSHIPS

DISRUPTIONS OF CONTINUITY HAVE DIFFERENT CONSEQUENCES FOR DIFFERENT AGES:-

1 INFANCY. FROM BIRTH TO POSSIBLY EIGHTEEN MONTHS, ANY CHANGE IN ROUTINE LEADS TO FOOD REFUSALS, DIGESTIVE UPSETS, SLEEPING DIFFICULTIES, CRYING.

2 CHANGE OF THE CARE TAKING PERSON FOR INFANTS AND TODDLERS FURTHER AFFECTS THE COURSE OF THEIR EMOTIONAL DEVELOPMENT. IF THIS CONTINUITY IS BROKEN, THE CHILDREN'S EMOTIONAL ATTACHMENTS CAN BECOME INCREASINGLY SHALLOW AND INDISCRIMINATE. THE QUALITY OF CARE FOLLOWING THE DISRUPTION IS VERY IMPORTANT, OTHERWISE THEY CAN GROW UP AS PERSONS WHO LACK WARMTH IN THEIR CONTACTS WITH THEIR FELLOW BEINGS.



3 FOR YOUNG CHILDREN UNDER THE AGE OF FIVE YEARS, BREAKDOWN IN TOILET TRAINING CAN OCCUR, AND THEY MAY LOSE OR LESSEN THEIR ABILITY TO COMMUNICATE VERBALLY.

4 FOR SCHOOL-AGED CHILDREN, BREAKS IN CONTINUITY LEAD TO RESENTMENT TOWARDS THE ADULTS WHO HAVE DISAPPOINTED THEM IN THE PAST, AND MAKE THEM ADOPT AN ATTITUDE OF NOT CARING FOR ANYBODY, OR OF MAKING THE NEW PARENT A SCAPEGOAT FOR THE SHORTCOMINGS OF THE FORMER ONE.

5 ADOLESCENTS. IT IS IMPORTANT THAT BREAKS AND DISRUPTIONS OF ATTACHMENTS SHOULD COME EXCLUSIVELY FROM THE ADOLESCENT'S SIDE, AND NOT BE IMPOSED ON HIM IN ANY FORM OF ABANDONMENT OR REJECTION ON THE PSYCHOLOGICAL PARENT'S PART.

6 ADULTS WHO AS CHILDREN SUFFERED FROM DISRUPTION OF CONTINUITY MAY THEMSELVES, IN IDENTIFYING THEIR MANY PARENTS, TREAT THEIR CHILDREN AS THEY THEMSELVES WERE TREATED, AND THEREBY CONTINUE A CYCLE, POSSIBLY FOR THE NEW GENERATION OF CHILDREN.

## IMPLICATIONS

CHILD PLACEMENTS SHOULD BE FINAL AND UNCONDITIONAL AND, PENDING FINAL PLACEMENT, THE CHILD MUST NOT BE SHIFTED AROUND TO ACCORD WITH EACH TENTATIVE DECISION.

## Custody in Divorce and Separation (Continuity of Relationships)

The lack of finality which occurs in child placement in divorce and separation proceedings invites challenges by a disappointed party, claiming changed circumstances. This absence of finality, coupled with the concomitant increase in opportunities for appeal, is in conflict with the child's need for continuity. As in adoption, custody decrees should be final, that is, not subject to modification.

Children have difficulty in relating positively to profiting from and maintaining contact with two psychological parents who are not in positive contact with each other. Loyalty conflicts are common and normal under such conditions, and may have devastating consequences by destroying the child's positive relationships with both parents.

Once it is determined who will be the custodial parent, it is that parent and not the court who must decide under what conditions he or she wishes to raise the child. Thus, the non-custodial parent should have no legally enforceable right to visit the child, and the custodial parent should have the right to decide whether it is desirable for the child to have such visits. It is important to protect the security of an ongoing relationship between the child and the custodial parent. A visiting parent has little chance to serve as a true object of love, trust and identification, since this role is based on being available on an uninterrupted day-to-day basis.



## Child's Sense of Time

The child's sense of time is based on the urgency of his or her instinctual and emotional needs, and thus differs from the adult's sense of time, as adults are better able to anticipate the future and thus to manage delay. A child's sense of time changes as he or she develops. Intervals of separation between parents and child, which at one age would constitute important breaks in continuity, might be of reduced significance at a later age.

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# TREATMENT ASPECTS OF THE HYSTERICAL PERSONALITY

MICHAEL FITZGERALD.

**THE TREATMENT** OF THE HYSTERICAL PERSONALITY IS FULL OF PITFALLS FOR THE UNWARY, AND IT IS OFTEN NOT REALISED THAT THESE PATIENTS ARE MUCH MORE DIFFICULT TO TREAT THAN WAS ONCE BELIEVED.

THE DEFINITION OF THE HYSTERICAL PERSONALITY WHICH WILL BE USED IN THIS PAPER IS AS FOLLOWS:-

THE FIRST PART OF THE DEFINITION FOCUSES ON LONG ORDER PATTERNS AS SEEN IN INTER-PERSONAL RELATIONS. THERE WILL BE EVIDENCE OF REPETITIVE, IMPULSIVE AND STEREOTYPED INTER-PERSONAL RELATIONSHIPS, E.G.,

(A) A CHILD-LIKE ROLE IN RELATION TO A CARE-GIVER;

(B) A WAIF-LIKE ROLE IN RELATION TO AN ABANDONING OR RESCUING PERSON;

(C) A HELPLESS OR SEXUALLY EXPLOITED ROLE IN RELATION TO AN AGGRESSOR.

HYSTERICAL PERSONALITIES WILL SHOW DRIFTING BUT POSSIBLY DRAMATIC LIVES, WITH AN EXISTENTIAL SENSE THAT REALITY IS NOT REALLY REAL. THEY WILL REGULARLY FEEL THAT THEY ARE NOT IN CONTROL OF THEIR LIVES AND NOT RESPONSIBLE FOR THEIR ACTIONS. WHEN TAKING A CASE

HISTORY FROM A PATIENT, THESE LONG ORDER PATTERNS ARE DETECTED BY SCANNING THE PATIENT'S LIFE CYCLE OVER MANY YEARS.

MEDIUM ORDER PATTERNS OR PERSONALITY TRAITS COMPRISE THE SECOND PART OF THE DEFINITION. CLASSICALLY, ATTENTION SEEKING BEHAVIOURS ARE ATTRIBUTED TO HYSTERICAL PERSONALITIES. THEY MAKE DEMANDS FOR ATTENTION WITH DISPLAYS OF SEX APPEAL, CHILDLIKENESS AND CHARM. THEY ALSO SHOW FLUID CHANGES OF MOOD AND TEND TO BE EXCITABLE AND EPISODICALLY FLOODED WITH FEELING. THESE TRAITS ARE DETECTED BY SCANNING HOURS AND DAYS OF A PATIENT'S LIFE.

THE THIRD PART OF THE DEFINITION FOCUSES ON SHORT ORDER PATTERNS, OR THE PATIENT'S INFORMATION PROCESSING STYLE. THE CHOICE OF GLOBAL RATHER THAN SPECIFIC LABELS FOR EXPERIENCE IS HIGHLY CHARACTERISTIC. THESE PATIENTS FIND IT VERY DIFFICULT TO PERCEIVE DETAILS IN EVENTS THAT HAPPENED TO THEM, OR IN THE EVENTS THEY WITNESS. THEY HAVE DIFFICULTY IN TRANSLATING BODILY FEELINGS INTO WORDS. THEY TEND TO USE LANGUAGE FOR ITS DRAMATIC EFFECT RATHER THAN FOR MEANING. THE PATIENT'S INFORMATION PROCESSING STYLE IS DETECTED BY SCANNING MINUTES OR SECONDS OF THE PATIENT'S LIFE.

## SUITABILITY FOR PSYCHOANALYSIS OR INTENSIVE PSYCHOANALYTIC PSYCHOTHERAPY

ZETZEL (1968) CONSIDERED THOSE PATIENTS MOST SUITABLE WHO WERE PAST ADOLESCENCE AT PRESENTATION AND HAD COMPLETED FORMAL EDUCATION. THESE PATIENTS TENDED TO BE VIRGINS OR UNABLE TO RESPOND SEXUALLY TO THE MEN TO WHOM THEY WERE MARRIED. USUALLY SOME EVENT HAD HAPPENED IN THEIR LIVES WHICH MADE THEM REALISE THAT THEIR PROBLEMS WERE WITHIN THEMSELVES. THEY TENDED TO BE THE ELDEST OF THEIR



FAMILIES AND TO BE THEIR FATHER'S FAVOURITE CHILDREN.

THEY FULFILLED THE FOLLOWING CRITERIA FOR ANALYSABILITY:-

(A) ABILITY TO ACHIEVE AND MAINTAIN A POSITIVE THERAPEUTIC ALLIANCE;

(B) ABILITY TO WORK THROUGH THE TERMINAL PHASE. THE PATIENTS ABLE TO ACHIEVE THIS HAVE ACHIEVED SUBSTANTIAL MASTERY OF AMBIVALENCE IN EARLY MOTHER/CHILD RELATIONSHIPS. THEY HAVE HAD GOOD ENOUGH MOTHERING, AND HAVE CONSOLIDATED GENUINE ONE-TO-ONE RELATIONSHIPS WITH BOTH PARENTS BEFORE THE ONSET OF THE GENITAL OEDIPAL SITUATION;

(C) THEY HAVE THE CAPACITY TO DISTINGUISH INTERNAL AND EXTERNAL REALITY, PARTICULARLY IN RESPECT OF THE REGRESSIVE REVIVAL IN THE TRANSFERENCE NEUROSIS OF A TRIANGULAR OEDIPAL CONFLICT;

(D) THEY HAVE THE CAPACITY TO TOLERATE ANXIETY AND DEPRESSION;

(E) THEY HAVE THE CAPACITY TO RENOUNCE WITHOUT BITTERNESS OR SELF-DEVALUATION THE REALISTICALLY UNAVAILABLE, AND TO ACTIVELY APPROACH AND ATTEMPT TO ATTAIN AVAILABLE OBJECTS AND REALISTIC IDEALS.

THERE ARE MORE DIFFICULTIES WITH THE NEXT GROUP OR POTENTIALLY GOOD HYSTERICS. THIS GROUP ARE CHARACTERISED BY BEING YOUNGER AND LESS MATURE THAN THE MOST SUITABLE

GROUP. THE POTENTIALLY GOOD HYSTERICAL PERSONALITY TENDS TO BE MORE PASSIVE AND TO HAVE ACHIEVED LESS ACADEMICALLY AND PROFESSIONALLY. SOME OF THIS GROUP MAY BE TOO YOUNG TO MAKE A GENUINE COMMITMENT TO TREATMENT AND MAY RESPOND WITH A FLIGHT INTO HEALTH.

THE LAST GROUP ARE UNSUITABLE FOR INTENSIVE PSYCHOANALYTIC TREATMENT. THIS DOES NOT MEAN THAT THEY COULD NOT GET SOME BENEFIT FROM LESS INTENSIVE TREATMENT. THE UNSUITABLE CASES PRESENT AS FLORIDLY HYSTERICAL WITH A FACADE WHICH LOOKS GENITAL. THEY WILL USUALLY HAVE SEEN MANY THERAPISTS. THEY USUALLY DEVELOP INTENSE EROTIC TRANSFERENCE BECAUSE OF GROSS MATERNAL DEPRIVATION. THEY WILL HAVE DIFFICULTY IN DISTINGUISHING INTERNAL AND EXTERNAL REALITY. THEIR DREAMS WILL BE FILLED WITH VAST EMPTY SPACES, SCENES OF DESOLATION, DESTRUCTION AND IMPOVERISHMENT. THEY WILL TEND TO ACT OUT SERIOUSLY OUTSIDE THE PSYCHOANALYTIC TREATMENT WITH DRUGS, ALCOHOL AND SELF-DESTRUCTIVE BEHAVIOUR, ETC. THEIR HISTORIES WILL SHOW MORE OF THE FOLLOWING FINDINGS:-

(A) ABSENCE OR SIGNIFICANT SEPARATION FROM PARENTS DURING THE FIRST FOUR YEARS;

(B) SERIOUS PATHOLOGY IN ONE OR BOTH PARENTS, OFTEN ASSOCIATED WITH AN UNHAPPY OR BROKEN MARRIAGE;

(C) SERIOUS OR PROLONGED PHYSICAL ILLNESS IN CHILDHOOD;

(D) ABSENCE OF MEANINGFUL OR SUSTAINED OBJECT RELATIONS OF EITHER SEX.



## FURTHER TREATMENT ISSUES

HYSTERICAL PERSONALITIES ARE FRIGHTENED OF RAPID CURE, WHICH THEY EQUATE WITH LOSS OF SENSE OF SELF. HYSTERICAL SYMPTOMS SHOULD BE APPROACHED INDIRECTLY AND GENTLY. THE THERAPIST SHOULD WAIT UNTIL IDEAS ARE EMOTIONALLY ALIVE IN THE SESSION BEFORE INTERPRETING. THESE PATIENTS NEED TIME TO TRY OUT NEW WAYS OF THINKING AND BEHAVING, AND PSYCHOANALYTIC TREATMENT PROVIDES THIS KIND OF BRIDGE BETWEEN THE OLD AND NEW.

THE MOST COMMON DIFFICULTIES THAT ARISE IN THE TREATMENT OF THE HYSTERICAL PERSONALITY ARE THE MISHANDLING OF THE TRANSFERENCE, COUNTERTRANSFERENCE AND LIMITS. JOSEPH BREUER COULD NOT HANDLE THE TRANSFERENCE OF ANNA O AND TOOK FLIGHT WHEN SHE DEVELOPED A PHANTOM PREGNANCY AND ACCUSED HIM OF BEING THE FATHER, (BREUER, J., AND FREUD, S., 1893 - 1895; FREUD, S. 1893 - 1899).

THE PSYCHOTHERAPIST CAN ALSO DEVELOP AN EROTICISED COUNTERTRANSFERENCE TOWARDS THIS TYPE OF PATIENT BUT, BECAUSE OF THE PROVOCATIVE NATURE OF THESE PATIENTS, HE IS MORE LIKELY TO DEVELOP A HOSTILE COUNTERTRANSFERENCE AND TO ACT THIS OUT BY TREATING THESE PATIENTS EXCESSIVELY HARSHLY OR PUNITIVELY.

SOME THERAPISTS, BECAUSE OF THEIR OWN PSYCHOPATHOLOGY, GRATIFY THESE PATIENTS' DEMANDS, WHICH THEN BECOME ENDLESS. THESE GRATIFICATIONS INCREASE THE PATIENT'S FEELINGS OF OMNIPOTENCE. THE PATIENTS THEN BECOME FRIGHTENED OF LOSS OF CONTROL AND FEEL GUILTY. THIS LEADS TO AN END OF EFFECTIVE TREATMENT. A COMMON FORM OF RESISTANCE USED BY THESE PATIENTS IS TO TRY TO GET THE PSYCHOTHERAPIST TO REVEAL SOME OF HIS PROBLEMS OF LIVING. IT IS USUALLY BEST TO SAY TO THESE PATIENTS, "I THINK YOU WILL AGREE THAT MY LIFE DOES NOT BELONG IN YOUR

TREATMENT, BUT PERHAPS YOU ARE ANXIOUS ABOUT US BOTH KNOWING YOUR THOUGHTS." THEY WILL KEEP ON INSISTING ON THE NEED FOR THIS SO-CALLED REAL RELATIONSHIP. IT IS NECESSARY TO POINT OUT HOW DESTRUCTIVE THIS WOULD BE AND THAT THEY WOULD BE NO BETTER OFF THAN BEFORE.

HYSTERICAL PERSONALITIES AND THERAPISTS SOMETIMES GET CAUGHT UP IN CYCLES OF ACTING OUT WHICH LEAD NOWHERE. THE MEANING OF THESE ACTING OUT CYCLES MUST BE INTERPRETED REPEATEDLY TO THE PATIENT. THE PATIENT WHO IS DESCRIBED AT THE END OF THIS PAPER USED TO ASK OVER AND OVER AGAIN FOR SOMETHING NICE TO BE SAID TO HER. SHE WAS NOT GRATIFIED IN THIS WAY AND FELT REJECTED. SHE WOULD COPE WITH THESE FEELINGS OF REJECTION BY ACTING OUT, FOR EXAMPLE, BY MISSING SESSIONS, GETTING OFF THE COUCH, USING ALCOHOL, SEXUAL ACTING, ETC. SHE GOT SOME GRATIFICATION AND REVENGE FROM THESE ACTING OUT EPISODES, BUT IT ALSO UPSET HER AND GAVE HER THE FEELING THAT SHE WAS NOT IN CONTROL. SHE THEN BECAME AWARE OF HER SHAME AND GUILT FOR WHAT SHE HAD DONE, AND USED TO PUNISH HERSELF BY BECOMING DEPRESSED. SHE WOULD THEN BEHAVE AS A MODEL PATIENT AS A FORM OF REPARATION FOR WHAT SHE HAD DONE. WHEN AN ACTING OUT HYSTERICAL PERSONALITY IS REFERRED, IT IS SOMETIMES USEFUL TO SAY TO THEM AT THE BEGINNING OF THE TREATMENT, PARTICULARLY IF THEY HAVE BROKEN OFF MANY PREVIOUS TREATMENTS, THAT THEY WILL PROBABLY FEEL LIKE DOING IT AGAIN, AND WHEN THEY DO THEY SHOULD TRY TO EXPLORE THE REASON FOR IT.

DURING THE TERMINATION PHASE OF THE TREATMENT OF THE HYSTERICAL PERSONALITY, RESCUE AND ~~NURTURE~~ FANTASIES SOMETIMES TEMPORARILY OCCUR. THE PATIENT MAY HAVE FANTASIES OF HAVING A DIFFERENT KIND OF RELATIONSHIP WITH THE THERAPIST AFTER TREATMENT, WHICH NEED TO BE EXPLORED. THE PATIENT MAY ALSO WANT TO CONTINUE THE TREATMENT SO AS



TO AVOID THE RISKS OF A REAL RELATIONSHIP OUTSIDE THE THERAPEUTIC SITUATION.

## COGNITIVE CHANGE

THE EFFORTS TO CHANGE THE PATIENT'S COGNITIVE STYLE ARE VERY IMPORTANT IN THE TREATMENT OF THE HYSTERICAL PERSONALITY. THE EMPHASIS ON THIS ASPECT OF THE TREATMENT IS ON EGO OPERATIONS LIKE THINKING AND PERCEPTION, RATHER THAN ON SEXUAL OR AGGRESSIVE DRIVES. TYPICALLY, THE HYSTERICAL PERSONALITY WOULD PERCEIVE AND DESCRIBE EVENTS IN A VAGUE AND IMPRESSIONISTIC WAY. AT THE SAME TIME SHE IS VERY SENSITIVE TO ASPECTS OF RELATIONSHIPS WITH PEOPLE WHO RELATE TO HER CURRENT FEARFUL AND WISHFUL EXPECTANCIES, (HOROWITZ, 1979).

FOR EXAMPLE, SHE MIGHT SEE HERSELF AS A WAIF OR DEFECTIVE CHILD-WOMAN, AND THE OTHER PERSON AS A RESCUER. SHE WOULD INTERPRET A CHANCE ENCOUNTER WITH A MAN AS "THIS IS IT!" WHAT SHE WOULD THEN SEE GOING ON BETWEEN HERSELF AND THE OTHER PERSON WOULD DEPEND ON THIS SET OF EXPECTATIONS. SHE WOULD TEND NOT TO PAY ATTENTION TO THE OTHER PERSON, BUT TO HER OWN FANTASIES OR WISHES. THE HYSTERICAL PERSONALITY IS OFTEN NOT AWARE OF HER ACTS; FOR EXAMPLE, MOVING HER BODY IN A SEXUAL WAY OR SWINGING HER LEGS. DURING TREATMENT AN ATTEMPT IS MADE TO HELP THE HYSTERICAL PERSONALITY TO PAY ATTENTION TO THOSE EXPECTANCIES AND TO HER OWN ACTS AND MOTIVES.

THE HYSTERICAL PERSONALITY INHIBITS REPRESENTATION IN TWO MAIN WAYS. SHE PREVENTS THE REPRESENTATION OF ANY THREATENING IDEAS AS IMAGES, BODILY FEELINGS OR WORDS. THE THERAPIST HELPS THE PATIENT TO PUT THESE IDEAS, FEELINGS, ETC., INTO WORDS AND TO TALK ABOUT THEM WITHOUT BEING FRIGHTENED OF THEM. THIS LEADS TO THE PATIENT

EXPERIENCING HERSELF AS AN ACTIVE THINKER AND HAVING A SENSE OF INCREASED CONTROL. THE HYSTERICAL PERSONALITY, AS I HAVE ALREADY STATED, HAS A VERY CHARACTERISTIC THINKING STYLE, THE HALLMARK OF WHICH IS THE PHRASE "I DON'T KNOW." THE PATIENT AVOIDS FURTHER THOUGHT IN THIS WAY. SHE IS THEN VERY POOR AT ANALYSING EVENTS IN TERMS OF CAUSE AND EFFECT SEQUENCES. ONE OF THE OVERALL AIMS OF PSYCHOTHERAPY WITH THE HYSTERICAL PERSONALITY IS TO HELP THE PATIENT TO THINK CLEARLY. TO ILLUSTRATE THE INTERPRETATION OF THE COGNITIVE MANOEUVRES USED BY THE HYSTERICAL PERSONALITY, I WILL PRESENT A FULL INTERPRETIVE STATEMENT. THE PATIENT IN QUESTION WAS IN THE MIDDLE OF AN EROTIC TRANSFERENCE, AND DURING THE PSYCHOANALYTIC PSYCHOTHERAPY SESSION DEVELOPED SEXUAL FEELINGS WHICH SHE WAS TRYING TO PUSH AWAY. SHE WAS AWARE ENOUGH TO TELL THE THERAPIST ABOUT THESE FEELINGS, BUT THEIR MEANING WENT IN AND OUT OF HER AWARENESS. THE PSYCHOTHERAPIST WAS EXPLORING THESE FEELINGS WITH THE PATIENT AND THE PATIENT HAD JUST SAID, "I DON'T KNOW."

IN TABLE 1, I HAVE RECORDED THE KIND OF INTERPRETATIONS THAT THE THERAPIST WOULD GIVE, AND I WILL GO INTO THE REASONS FOR EACH INTERPRETATION.

THE PSYCHOTHERAPIST MAKES THE FIRST INTERPRETIVE PHRASE, "I DON'T KNOW," TO SPECIFY THE CURRENT CONTENT AND COGNITIVE MANOEUVRE. THE SECOND INTERPRETIVE PHRASE, "SO YOU WON'T GO ON THINKING," IS MADE TO POINT OUT TO THE PATIENT WHAT IS ACCOMPLISHED BY THE COGNITIVE MANOEUVRE. THE THIRD INTERPRETIVE PHRASE, "YOU ARE FEELING EXCITED NOW," LABELS CLEARLY THE FEELINGS BEING PUSHED AWAY. THE FOURTH INTERPRETIVE PHRASE, "IN YOUR BODY," CALLS ATTENTION TO THE MODE OF REPRESENTATION OF SEXUAL FEELINGS. THE FIFTH INTERPRETIVE PHRASE, "YOU ARE AFRAID TO KNOW THAT IN WORDS," IDENTIFIES THE COGNITIVE MANOEUVRE OF NON-TRANSLATION. THIS ALSO GIVES THE



PATIENT THE SUGGESTION THAT SHE SHOULD TRANSLATE IDEAS INTO WORDS, AND PROVIDES THE MODEL FOR DOING SO.

Table 1.

INTERPRETIVE PHRASES

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|---|---|
| 1. | You say, "I don't know." |
| 2. | "So you won't go on thinking." |
| 3. | "So you are feeling excited now." |
| 4. | "In your body." |
| 5. | "You are afraid to know in words." |
| 6. | "Because you think that it is bad and dangerous." |
| 7. | "You felt the same way towards your father." |
| 8. | "You felt that was bad and dangerous." |
| 9. | "The same things happen with your male friends." |
| 10. | "Even though you do not consciously want to think of sexual excitement with them as bad and dangerous." |

THE SIXTH INTERPRETIVE PHRASE, "BECAUSE YOU THINK IT IS BAD AND DANGEROUS," CALLS ATTENTION TO AND LABELS CLEARLY HER MOTIVES FOR PUSHING ASIDE FEELINGS. THIS IS ALSO A SUGGESTION TO CHECK TO SEE IF SHE DOES FEEL ANXIOUS AND GUILTY. THE SEVENTH INTERPRETIVE PHRASE, "YOU FELT THE SAME WAY TOWARDS YOUR FATHER," LINKS HER CURRENT FEELINGS TO CHILDHOOD EXPERIENCES. THE EIGHTH INTERPRETIVE PHRASE, "YOU FELT THAT WAS BAD AND DANGEROUS," EXPLAINS THE ORIGINAL THREAT IN CHILDHOOD, WHEN WARDING-OFF MANOEUVRES WERE DESIRABLE. THE NINTH INTERPRETIVE PHRASE, "THE SAME THING HAPPENS WITH YOUR MALE FRIENDS," LINKS THE IMMEDIATE TRANSFERENCE PATTERN

IN THE TREATMENT TO HER CURRENT LIFE EXPERIENCES. THE TENTH INTERPRETIVE PHRASE, "EVEN THOUGH YOU DO NOT CONSCIOUSLY WANT TO THINK OF SEXUAL EXCITEMENT WITH THEM AS BAD AND DANGEROUS," POINTS OUT THE INAPPROPRIATE QUALITIES OF HER OLD ATTITUDES AND INCONGRUITY WITH CURRENT VALUES.

GRADUALLY, THE PATIENT BEGINS TO BE ABLE TO THINK THE UNTHINKABLE, TO PUT HER FEELINGS INTO WORDS, TO THINK THINGS THROUGH TO THEIR CONCLUSION. THIS GIVES HER AN INCREASED FEELING OF BEING IN CONTROL, AND HER SELF-CONFIDENCE ALLOWS HER TO TAKE INCREASED RISKS WITH HER BEHAVIOUR. SHE BECOMES ABLE TO CHECK CAUSE AND EFFECT SEQUENCES AND EVENTS. IN SHORT, ONE IS TRYING TO HELP THE HYSTERICAL PERSONALITY TO CHANGE HER PERCEPTION OF HERSELF AND OTHERS. THE PSYCHOTHERAPIST COUNTERACTS PARENTAL INTROJECTS, AND THE PATIENT BEGINS TO MODEL HERSELF ON THE PSYCHOTHERAPIST'S NEUTRAL OBJECTIVE - THOUGHTFUL, RATIONAL AND NON-JUDGMENTAL OPERATIONS. THE HYSTERICAL PERSONALITY HAS TO GIVE UP THE HOPE OF FINDING HER PARENTS TRANSFORMED INTO IDEALS, TO DEVELOP A SYMPATHETIC UNDERSTANDING OF THEIR FAILURES, AND TO GIVE UP THE BELIEF THAT THEY WERE DELIBERATELY TRYING TO HARM HER.

## FUTURE RESEARCH

IT IS LIKELY THAT FUTURE PSYCHOANALYTIC RESEARCH INTO THE HYSTERICAL PERSONALITY WILL FOCUS MORE ON A CAREFUL DISSECTION OF THE PATIENT'S COGNITIVE STYLE AND INNER MODELS OF THE SELF AND OTHERS. IT MAY LEAD TO SHORTER PSYCHOANALYTIC TREATMENT AND A GREATER CAPACITY FOR PSYCHOTHERAPISTS TO DEAL WITH MORE DIFFICULT HYSTERICAL PERSONALITIES.



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# THE PSYCHODYNAMIC TREATMENT OF CHARACTER DISORDERS

MICHAEL FITZGERALD.

## INTRODUCTION

THE WORD "CHARACTER" IS DERIVED FROM THE GREEK, AND REFERS TO THE ENGRAVING INSTRUMENT AND ITS PRODUCT - THE SIGN. APPLIED TO PERSONALITY, THE TERM DENOTES THOSE FEATURES CONSIDERED TO BE INDELIBLY ENGRAVED UPON IT. CHARACTER COMPRISES THE TOTALITY OF A PERSON'S STABLE EGO-SYNTONIC FUNCTIONING. IT "IS AN INDIVIDUAL, UNIQUE, AND IDIOSYNCRATIC SYNTHESIS, MANIFESTED IN BEHAVIOUR, OF THE EGO'S WAY OF RESTRUCTURING, AND SATISFYING ITS IMPULSES AND THEIR OBJECTS, TO ACHIEVE GRATIFICATIONS AND SUBLIMATIONS AND ENSURE SELF ESTEEM." (PANEL, 1983).

REICH (1949) ACKNOWLEDGED HEREDITARY PRE-DISPOSITIONS, BUT POINTED TO CHARACTER CHANGES DUE TO ANALYSIS AS PROOF THAT THE VICISSITUDES OF PREDISPOSITIONS WERE SHAPED BY ENVIRONMENTAL FORCES. HE SAID THAT THE SPECIFIC WAYS OF WALKING AND SPEAKING WERE "CHARACTER ARMOUR," WHICH WAS DEVELOPED TO PROTECT THE PATIENT FROM THE EXTERNAL WORLD AND INSTINCTUAL DANGERS.

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Reich said that the task of character "was to master stasis anxiety (actual anxiety) caused by the energies of the compromise formations formed in attempts to accommodate conflicting demands impinging upon the person from reality, the super ego, the drives and the repetition compulsion."

He focused on resistance analysis and this corresponded to the progress of analytical therapy from symptom analysis to the analysis of the total personality. It is clearly very important to analyse how the patient talks and behaves, as well as what he says or does. The analytic psychotherapy is very impoverished if the therapist only focuses on what is said. He was correct when he said that character armour "provides an infallible and immediate avenue of approach to the central infantile conflict." He overemphasised the analysis of the negative transference early on. This could be wounding to vulnerable narcissistic patients, which could have a negative effect on treatment outcome. Of course, non-analysis of the negative transference can lead to other difficulties, and to incomplete resolution of transference. The issue of dosage and timing of interpretations is critical here. No analysis of transference is equivalent to no analysis. His first aim was to make the character trait ego dystonic or painful. He would be regarded now as being overly aggressive in analytic style.

Fenichel (1945) points out that the aim is to change the "character neurosis into a symptom neurosis, and character resistance into transference resistance." This is difficult because the character pathology defines the nature of the person and people in the outside world, and it is on the basis of character pathology that the patient's world view is defined. The patient with



paranoid character pathology defines the world in a paranoid way and will be extremely resistant to changing this world view.

The highlighting of contradictions helps to make the character pathology ego dystonic. This has the effect of making the patient more accessible to treatment. This will often annoy the patient, as he may put great value on his pathological character traits. The obsessional patient often over-values some of his traits. The patient often has the sense of being "criticised" by these interpretations. These interpretations will also stimulate negative transference, which must be analysed.

Reich's (1949) aim was for quantitative rather than qualitative changes and, clearly, he was right and his major emphasis was on orgastic potency. Fenichel's (1945) goal was to transform reactive character traits into sublimatory ones. While "core character patterns" will not change, it is possible to make the ego more adaptive and to increase super ego autonomy and the ability to love and work.

## Narcissistic Personality Disorder

The essential feature, according to Reid and Wise (1989), is a pervasive pattern of grandiosity (in fantasy or in behaviour), hypersensitivity to other's evaluations, criticism of oneself and lack of empathy. There is also often an exaggerated feeling of failure when the narcissistic patient does not live up to the expected perfection. These patients are often unable to take satisfaction from their achievements. Their self esteem is often quite fragile and needs constant attention and admiration.

COHLER (1988) POINTS OUT THAT KOHUT HAS BEEN SUCCESSFUL IN TREATING DIFFICULT OR FRAGILE PATIENTS FOR WHOM THE PERSPECTIVES OF CONFLICT AND DEFENCE APPEAR TO PROVIDE INCOMPLETE EXPLANATIONS OF ORIGIN, COURSE AND DYNAMICS OF CHANGE IN PSYCHOTHERAPY. HE POINTS OUT THAT IT IS CLEAR THAT SOME PSYCHIC CONFLICTS AND PERSONAL DISTRESS ARISE FROM SOURCES OTHER THAN PRESUMED DRIVE SATISFACTION. KOHUT'S PSYCHOLOGY OF THE SELF EMPHASISES THE DEVELOPMENT OF THE EXPERIENCES OF OTHERS AS CENTRES OF INITIATIVE LEADING TO THE CONSTRUCTION OF THE SELF.

COHLER (1988) IS CRITICAL OF THE CONCEPT OF PSYCHIC ENERGY. HE POINTS OUT THAT "THERE IS NO EVIDENCE THAT ANY QUANTITY WITH THE PROPERTIES OF PSYCHIC ENERGY CAN MEANINGFULLY BE ASSOCIATED WITH PSYCHOLOGICAL FUNCTIONING." HE ALSO POINTS OUT THAT "FREUD'S MODEL PREDICTS THAT WHEN THE SELF IS HIGHLY CATHECTED, OBJECTS ARE DECATHECTED. IN FACT, WHEN PEOPLE ARE HAPPY WITH THEMSELVES THEY ARE MOST INTERESTED IN OTHERS."

KOHUT POSTULATES A DEVELOPMENTAL LINE OF AN INTER-DEPENDENT SELF CHARACTERISED BY INCREASING STABILITY, PERMANENCES AND FLEXIBILITY IN USING OTHERS AS A PSYCHOLOGICAL RESOURCE.

FOR HEALTH, IT IS NECESSARY TO MAINTAIN A NARCISSISTIC EQUILIBRIUM THROUGHOUT LIFE. AS COHLER (1988) POINTS OUT, "THIS FUNCTION IS ALSO A FUNCTION OF THE SELF; EXPERIENTIALLY THE OTHERS WHO HELP ONE TO FORM THE FUNCTION ARE PARTS OF THE SELF." KOHUT INTRODUCED THE TERM "SELF OBJECT" TO DESCRIBE SUCH A FUNCTION.

PSYCHOPATHOLOGY IS REFLECTED IN A DESPERATE NEED FOR OTHERS IN A PRIMITIVE WAY, A FEELING OF FRAGMENTATION WHEN SEPARATED FROM OTHERS. THESE PATIENTS SHOW EXTREME SENSITIVITY TO SLIGHT FLUCTUATIONS IN THE THERAPIST'S



INTROSPECTIVE AND EMPATHIC EFFORTS TO EXPERIENCE, UNDERSTAND AND RESPOND TO THE PATIENT'S DISTRESS.

THERE ARE BASICALLY THREE GROUPS OF PATIENTS WHO SHOW INCREASED SENSITIVITY TO ISSUES OF PSYCHOTHERAPY SETTING OR ALLIANCE:-

(A) A GROUP WITH A PERVASIVE FEELING OF EMPTINESS, TRIVIALITY, MEANINGLESS AND PERSONAL DISORGANISATION;

(B) A GROUP OF PATIENTS WHO HAVE BEEN NARCISSISTICALLY WOUNDED IN CHILDHOOD AND WHO SHOW CHRONIC AND EPISODIC RAGE;

(C) A GROUP WHO ACT OUT VIA SEXUALITY, ADDICTIONS, ETC., AS A WAY OF TRYING TO RE-ESTABLISH NARCISSISTIC EQUILIBRIUM. THEY ARE TRYING TO PROTECT THEMSELVES AGAINST A FEELING OF FRAGMENTATION.

BASCH (1983) SHOWED THAT DEFENCES SUCH AS DISAVOWAL, DENIAL AND DISOWNING ASPECTS OF THE SELF ARE OFTEN OBSERVED IN DISORDERS OF THE SELF.

## FORMS OF SELF PATHOLOGY

(A) DEPLETION DISORDER: THESE PATIENTS HAVE A DEPLETION DEPRESSION AND HYPOCHONDRIASIS WITH A SENSE OF NOT HAVING BEEN CARED FOR, WHERE IDEAS OF BADNESS AND PUNISHMENT ARE LARGELY ABSENT.

(B) Rage Disorder: These are psychologically wounded people who are often in states of chronic rage and who spend their lives searching for revenge. Stoller (1975) maintains that all perversions are transformations of rage. The perverse person attempts to completely control his object and regulate his self esteem.

## Transference and Self Pathology

In the self object transference the patient is using the therapist as a self object in order to replace deficiences in the self. He is trying to get a sense of self that is stable, vigorous and cohesive. The patient constructs the therapist as a part of his own self. Cohler (1988) points out that "the therapist's effort to make sense of the patient's suffering, experienced by the patient as action of himself or herself, becomes indispensable for the patient's psychological survival." The patient protects himself from awareness of the therapist's importance because of being let down in the past, and because this would interfere with the way that the patient has found to stabilise a fragile sense of self. Of course, distress will occur when there are holiday breaks and when the therapist is not empathic enough.

The idealising transference involves the functioning of the self object as part of the ideal self. The patient experiences the therapist as being full of strength, goodness and power. This transference is often mishandled by therapists by premature confrontation of it and by interpreting it as a resistance against hostility.



## Mirror Transference

The mirror transference involves the stabilisation of the grandiose self. The patient delegates to the therapist the task of supporting and encouraging grandiose expectations of the self. The patient feels well because of the therapist's appreciative response to his grandiosity. The transference is often silent until there is some empathic failure by the therapist. In the merger transference the patient's grandiose self is supported by the idea of a single entity, therapist-patient. The alter ego transference is characterised by the fantasy that patient and therapist share a world view as twins who are well and good because they are the same.

## Countertransference

The therapist may become unsettled at being treated as part of another's self, and begin to sermonise and educate the patient. The therapist should recognise and accept the patient's need for mirroring.

Iatrogenic traumatisation is common when the antiseptic "model technique" recommended by Eissler (1953) replaces the ordinary therapeutic situation, (Stone 1981). The therapist's remaining silent can be experienced by the patient as recurring traumatisation.

## Schizoid Personality Disorder

Reid and Wise (1989) point out that the essential features are pervasive indifference to social relationships, and a restricted range of emotional experience and expression. These patients prefer to be

"LONERS" AND NEITHER DESIRE NOR ENJOY SEXUAL OR PERSONAL RELATIONSHIPS. THEY ARE GENERALLY ALOOF, ARE SOCIALLY INADEQUATE AND APPEAR SELF-ABSORBED. THEY CAN ATTAIN INTELLECTUAL OR OCCUPATIONAL ACHIEVEMENT.

FROM THE PSYCHOANALYTIC POINT OF VIEW THE SCHIZOID-PARANOID PERSONALITY SHOWS THE FOLLOWING CHARACTERISTICS: THEY ARE EXTREMELY MISTRUSTFUL OF PEOPLE, BECAUSE BASIC TRUST WAS NOT BUILT UP IN CHILDHOOD BECAUSE OF THE DEFICIENCIES IN THE PARENT/CHILD RELATIONSHIP. THEY DID NOT EXPERIENCE GOOD ENOUGH PARENTING. THEY SUFFERED SERIOUS FAILURE OF EMPATHY IN CHILDHOOD. THIS LEADS TO LOSING FAITH IN AUTHORITY, THEIR PARENTS, AND TO WITHDRAWING INTO THEMSELVES. THEY INTERNALISE "BAD" INTERNAL PARENTAL FIGURES. THROUGHOUT THE REST OF THEIR LIVES THEIR SENSE OF AUTHORITY IS THAT IT IS VERY POWERFUL AND ARBITRARY.

THIS IS BEST DESCRIBED BY KAFKA. HE HAD THE SENSE OF ALWAYS BEING IN THE WRONG IN RELATION TO HIS FATHER. HE OPENS THE BOOK "THE TRIAL" WITH THE FOLLOWING SENTENCE: "SOMEONE MUST HAVE BEEN TELLING LIES ABOUT JOSEPH K. FOR WITHOUT HAVING DONE ANYTHING WRONG HE WAS ARRESTED ONE FINE MORNING." AS STORR (1979) POINTS OUT, FOR KAFKA MISUNDERSTANDING AND LACK OF COMPREHENSION WERE INEVITABLE. KAFKA REGARDED PARENTS AS TYRANTS. HE AGREED WITH SWIFT THAT "PARENTS ARE THE LEAST OF ALL TO BE TRUSTED WITH THE EDUCATION OF THEIR CHILDREN." KAFKA'S NOVELS HAVE MAJOR SCHIZOID PREOCCUPATIONS, WHICH ARE THAT AUTHORITIES ARE SO UNPREDICTABLE THAT IT IS IMPOSSIBLE TO UNDERSTAND THEM OR WORK OUT WAYS OF DEALING WITH THEM. SCHIZOIDS HAVE MAJOR FEARS OF BEING DOMINATED AND LOSING THEIR SENSE OF AUTONOMY. IT IS NOT SURPRISING, THEREFORE, THAT THEY ARE VERY FEARFUL OF MARRIAGE AND, INDEED, THIS IS SOMETHING THAT KAFKA ONLY ACHIEVED TOWARDS THE END OF HIS LIFE. THEY ARE VERY



EASILY EXHAUSTED BY PEOPLE, BUT MANY OF THEM HAVE WELL-DEVELOPED INTELLECTS AND WILL DISCUSS INTELLECTUAL OR PHILOSOPHICAL MATTERS EASILY AND FOR LONG PERIODS. INDEED, RUSSELL POINTED OUT "MY MIND (FOR ME) MORE CERTAIN THAN THE MINDS OF OTHERS." AS STORR (1979) POINTS OUT, DESCARTES REFERRED TO THE BODY AS POSSIBLY ILLUSORY AND DISTRUSTED THE EVIDENCE OF THE SENSES (FOR HIM, "I THINK, THEREFORE I AM.") SCHIZOIDS SUBSTITUTE INTELLECTUAL ACHIEVEMENT FOR HUMAN RELATIONSHIPS. CLEARLY, THIS CANNOT SUCCEED BECAUSE, AS FAIRBAIRN POINTS OUT, THE HUMAN IS BASICALLY SEEKING EMOTIONAL CONTACT WITH OTHER HUMAN BEINGS. FOR FAIRBAIRN (1963) THIS DESIRE TO MAKE CONTACT WITH PEOPLE, WHICH HE SAW AS FUNDAMENTAL, AROSE FROM THE EGO. FOR FREUD THE EMPHASIS WAS ON THE ID. IT SEEMS MORE USEFUL TO SEE HUMAN CONTACT AS ARISING BOTH FROM THE ID AND FROM THE EGO.

WHILE THE SELF ESTEEM OF THE SCHIZOID HAS BEEN DAMAGED IN CHILDHOOD, THEY CAN NEVERTHELESS HAVE A SECRET SENSE OF SUPERIORITY, FOR EXAMPLE, IN INTELLECTUAL MATTERS. THEY OFTEN HAVE DIFFICULTY IN SHOWING THEIR WORK TO THE OUTSIDE WORLD FOR FEAR OF TESTING THIS SENSE OF SUPERIORITY AND FOR FEAR OF CRITICISM.

THEY HAVE WHAT WINNICOTT (1965) CALLED A "FALSE SELF," WHICH IS A FACADE DEVELOPED IN CHILDHOOD IN REACTION TO LACK OF SENSITIVITY ON THE PART OF PARENTS. THEY ARE TREMENDOUSLY FEARFUL OF SHOWING THEIR TRUE SELF FOR FEAR THAT IT WILL BE REJECTED AGAIN AS ADULTS. THEY CAN ALSO FEAR THEIR OWN DESTRUCTIVENESS AND SOMETIMES BLAME THEMSELVES FOR THE PARENTAL LACK OF INVOLVEMENT WITH THEM. THEY FEEL THAT IT WAS THEIR FAULT THAT THEIR PARENTS WERE EXHAUSTED AND NOT ABLE TO TUNE IN TO THEM.

THE AIM OF TREATMENT WITH THE SCHIZOID PERSONALITY IS TO HELP THEM TO TRUST AND TO HOPE AGAIN. THE

THERAPIST IS TRYING TO HELP THEM TO SEE THAT THEIR PERSECUTORY VIEW OF THE WORLD IS UNJUSTIFIED. THIS IS NOT TO SAY THAT THIS VIEW OF THE WORLD, IF YOU ARE LIVING IN IRAQ IN AUGUST 1990, IS NOT ENTIRELY SENSIBLE. THEY HAVE TO BE HELPED TO UNDERSTAND THAT THERE IS AN AVERAGE EXPECTABLE ENVIRONMENT. OF COURSE THERE ARE NASTY PEOPLE IN THE WORLD BUT, BY AND LARGE, THESE ARE VERY MUCH IN A MINORITY. THE SCHIZOID HAS TO BE HELPED TO SEE THAT THE THERAPIST AND PEOPLE GENERALLY ARE NOT OUT TO DOMINATE AND ENGULF THEM. IT IS HOPED THAT THEY WILL HAVE CORRECTIVE EMOTIONAL EXPERIENCE IN PSYCHOTHERAPY WHICH WILL BE DIFFERENT FROM THE EXPERIENCE THEY HAD BETWEEN THEMSELVES AND THEIR PARENTS IN CHILDHOOD. IT IS THEN HOPED THAT THIS WILL GENERALISE OUTSIDE THE PSYCHOTHERAPY SITUATION. THEY HAVE TO BE HELPED TO LOVE AND TO ALLOW THEMSELVES TO BE LOVED. THEY HAVE TO BE HELPED TO GET IN TOUCH WITH THEIR TRUE SELVES AND ALLOW THE SPONTANEOUS PLAYFUL ASPECTS OF THEMSELVES TO BE EXPRESSED. THEY HAVE TO BE HELPED TO MOVE FROM A POSITION OF ALIENATION TO A POSITION OF HUMAN CONTACT. THEY CAN ONLY DEAL WITH THE MEANINGLESSNESS, FUTILITY AND SCHIZOID DEPRESSION THAT THEY FEEL BY MAKING HUMAN CONTACT.

## BORDERLINE PERSONALITY DISORDER

THIS IS CHARACTERISED BY A PERVASIVE PATTERN OF INSTABILITY OF SELF IMAGE, INTERPERSONAL RELATIONSHIPS AND MOOD. THERE IS AN IDENTIFY DISTURBANCE WHICH IS PERVASIVE AND FREQUENTLY MANIFESTED BY UNCERTAINTY ABOUT SELF IMAGE, SEXUAL ORIENTATION, VALUES AND CAREER, (REID, W., WISE, M., 1989).

KERNBERG (1975) STATES THAT THE BORDERLINE PERSONALITY ORGANISATION IS CHARACTERISED BY PATHOLOGICAL INTERNAL OBJECT RELATIONS WHICH HAVE DEVELOPED VERY EARLY



IN LIFE PRIOR TO THE DEVELOPMENT OF PSYCHIC STRUCTURE, DUE TO OVERLOAD OF AGGRESSIVE IMPULSIVITY WHICH GIVES RISE TO IDENTITY DIFFUSION. THERE IS SPLITTING OF PRIMITIVE DEFENCE MECHANISMS AND PROJECTIVE IDENTIFICATION.

KERNBERG (1975) IS CORRECT IN CHARACTERISING THE BORDERLINE CONDITION AS BEING DUE TO A FAILURE IN EGO DEVELOPMENT, SUCH AS NON-SPECIFIC EGO WEAKNESS WITH IMPAIRMENT IN ANXIETY TOLERANCE, IMPULSE CONTROL AND SUBLIMATORY CAPACITIES, WITH A SHIFT TOWARDS PRIMARY PROCESS THINKING. THERE IS A VERY CONSIDERABLE SPLITTING WITH GOOD AND BAD SELF IMAGES AND OBJECT IMAGES. THERE IS A PREDOMINANCE OF "BAD" INTROJECTIONS BY THE CHILD.

THERE IS A DISTURBANCE IN THE MOTHER (PARENT)/CHILD RELATIONSHIP. AS MASTERSON (1972) POINTS OUT, THE MOTHER WITHDRAWS HER LIBIDINAL INTEREST IN THE FACE OF THE CHILD'S EFFORTS TOWARDS SEPARATION - INDIVIDUALISATION. THE MOTHER, WHO OFTEN HERSELF WAS ALSO A BORDERLINE PERSONALITY, EXPERIENCES CONSIDERABLE GRATIFICATION FROM THE CHILD DURING THE SYMBIOTIC PHASE. A CRISIS OCCURS DURING THE RAPPROACHMENT SUB-PHASE WHEN MOTHER FINDS THAT SHE IS UNABLE TO TOLERATE HER TODDLER'S AMBIVALENCE, CURIOSITY AND ASSERTIVENESS. SHE IS UNABLE TO TUNE IN TO HER CHILD'S NEEDS AT THIS TIME FOR ENCOURAGEMENT, SUPPORT AND PRAISE. THE CHILD REACTS TO THIS BY REGRESSING, AND MOTHER BECOMES LIBIDINALLY AVAILABLE AGAIN. THE CHILD REALISES THAT HE OR SHE IS NOT ALLOWED TO INDIVIDUATE, AND THEREFORE REGRESSES. THE CHILD, THEREFORE, INTROJECTS A REWARDING MOTHER AND A WITHDRAWING MOTHER. THE CHILD INTROJECTS THE REWARDING PART OBJECT MOTHER WHEN HE OR SHE REGRESSES, AND FEELS GOOD BECAUSE HE IS GRATIFIED FOR BEING COMPLIANT AND REGRESSING. WHEN THE CHILD IS ASSERTIVE HE INTROJECTS A WITHDRAWN PART OBJECT MOTHER WHO IS CRITICAL, HOSTILE, ATTACKING AND

WITHDRAWING OF LIBIDINAL INTEREST, AND THE CHILD THEREFORE FEELS INADEQUATE, "BAD," UGLY AND EMPTY. THIS SENSE OF "BADNESS" LEADS TO A SENSE OF ABANDONMENT DEPRESSION, AND THE CHILD BLAMES HIMSELF FOR THE PROBLEM THAT HE IS HAVING WITH HIS MOTHER. THE ABANDONMENT CONCEPT IMPLIES THAT THE MOTHER'S WITHDRAWAL IS EXPERIENCED AS A LOSS OF PART OF HIMSELF, SO THE CHILD DEVELOPS A POOR, DEVALUED SELF IMAGE AND IS NOT ABLE TO VALUE HIS OR HER REAL ASSETS. THE CHILD FEELS THAT HE OR SHE IS NOT GOOD ENOUGH. THE MOTHER CAN ONLY COPE WITH THE YOUNG CHILD WHEN THE CHILD IS FUSED WITH HER AND NEEDS HER TO EXIST. WHEN THE CHILD ATTEMPTS TO INDIVIDUATE, HE OR SHE EXPERIENCES AN EXISTENTIALIST DREAD WHICH PRODUCES INTOLERABLE ANXIETY CAUSED BY THE FEAR OF TOTAL ABANDONMENT BY THE MOTHER. THE CHILD THEN, AND LATER AS AN ADULT, FORMS SYMBIOTIC RELATIONSHIPS WITH OTHER PEOPLE IN WHICH HE PLUS THE OTHER PERSON EQUALS ONE, SO THAT HE CANNOT TOTALLY INDIVIDUATE AS A COMPLETE ADULT. HE FEELS THAT HE IS NOT A COMPLETE PERSON AND FEEL INADEQUATE.

IT IS CLEAR THAT THIS EARLY FRUSTRATION OF THE CHILD PRODUCES AN INCREASE OF ESPECIALLY ORAL AGGRESSION. THIS IS ASSOCIATED WITH THE DEVELOPMENT OF PRIMITIVE SUPER EGO STRUCTURES. THIS FAILURE IN THE MOTHER/CHILD RELATIONSHIP MEANS THAT THE CHILD'S MIND CANNOT FUNCTION AND DEVELOP NORMALLY, AND THE MOTHER FAILS IN HER MATERNAL FUNCTION OF INTROJECTING THE CHILD'S FEELINGS AND METABOLISING AND DETOXIFYING THEM. INSTEAD, THE CHILD RE-INTROJECTS THESE PRIMITIVE FEELINGS, WITH DAMAGING RESULTS. THE CHILD HAS A SENSE OF THE "BAD" OVERWHELMING THE GOOD. THIS LEADS, AS WELL, TO A CONFUSION OF LIBIDINAL AND AGGRESSIVE IMPULSES. THE CHILD IS OVERWHELMED BY THE INCREASE IN BAD AGGRESSIVE FEELINGS, HAS A SENSE OF RAGE, ANXIETY AND A FEAR OF DEATH. THE CHILD FEELS THAT HIS NORMAL LIVELINESS AND



CURIOSITY ARE BAD AND DESTRUCTIVE. HE IS THEN NOT ABLE TO SEPARATE OUT BAD FROM GOOD FEELINGS, AND IS IN A STATE OF CONFUSION. THERE IS, THEREFORE, A CONFUSION OF LIBIDINAL AND AGGRESSIVE IMPULSES.

## TREATMENT ISSUES

AS SARAWER-FONER (1983) POINTS OUT, THESE PATIENTS DEMAND THE PRESENCE OF THE THERAPIST IN TREATMENT. THEY WANT TO SEE, HEAR AND LOOK AT THE THE THERAPIST. THEY MUST HAVE THE THERAPIST "IN THEIR SENSES." IT IS ONLY THROUGH THE PRESENCE OF THE THERAPIST THROUGH THESE MODALITIES THAT THEY ARE SURE THAT THE ABANDONMENT THEY FEAR HAS NOT TAKEN PLACE, OR WILL NOT TAKE PLACE. THERE IS AN ADVANTAGE IN SITTING UP AND BEING SEEN BY THE THERAPIST. THESE PATIENTS WILL OFTEN WANT TO BE WITH THE THERAPIST FOR EVER, TO FUSE WITH THE THERAPIST AND TO WANT THE THERAPIST TO BE ALWAYS AVAILABLE TO THEM. THEY DO NOT WANT TO INDIVIDUATE BECAUSE THIS WAS FROWNED UPON BY MOTHER IN CHILDHOOD. THEY WILL SHOW SIGNS OF REGRESSION INTO ILLNESS IF TERMINATION IS DISCUSSED.

IT IS IMPORTANT WITH BORDERLINE PATIENTS NOT TO PREMATURELY INTERPRET, AND TO ATTEND TO WHAT IS UNKNOWN BOTH TO THE THERAPIST AND TO THE PATIENT. IT IS IMPORTANT TO "TOLERATE THE FRUSTRATION OF DOUBT, OF CONFUSION AND OF IGNORANCE WITHOUT AN IRRITABLE REACHING AFTER FACT AND REASON." (KEATES, QUOTED BY BION, 1970). AS GROTSTEIN (1981) POINTS OUT, "UNDERSTANDING MAY BE ONE OF THE MOST SOPHISTICATED WAYS OF AVOIDING THE TRUTH WHILE AT THE SAME TIME BELIEVING THAT ONE HAS ARRIVED AT IT." IT IS IMPORTANT FOR THE THERAPIST TO ACT IN THE ROLE OF CONTAINER OF THE PATIENT'S ANXIETIES AND TO TOLERATE HIS OR HER OWN FRUSTRATION AT NOT UNDERSTANDING. IN THIS WAY, THE BORDERLINE PATIENT IS ABLE TO INTROJECT

AN OBJECT WHICH HAS MORE "NEGATIVE CAPACILITY" THAN HIMSELF, (ISSORFF, 1988).

A PROBLEM THAT CAUSES CONSIDERABLE ANXIETY IN THE TREATMENT OF BORDERLINE PERSONALITIES IS BRIEF PSYCHOTIC EPISODES WHEN THE PATIENT DEVELOPS A TRANSFERENCE PSYCHOSIS. THE BORDERLINE PATIENT TENDS TO INDUCE STRONG COUNTERTRANSFERENCE REACTIONS. THE PATIENT IS CONFUSED AND PROJECTS THIS CONFUSION INTO THE THERAPIST, AND THEREFORE THE THERAPIST FEELS CONFUSED AS WELL. OF COURSE, NOT ALL OF THE CONFUSION IS DUE TO THE PATIENT'S PROJECTIONS, AS THERAPISTS ALSO HAVE LIMITATIONS, PARTICULARLY IN DEALING WITH PATIENTS WHO ARE CONFUSED IN THEIR THINKING AND HAVE AN INABILITY FOR ABSTRACT THINKING. THE THERAPIST FEELS WHAT IT WAS LIKE FOR THE PATIENT TO BE BATTERED AND CRUSHED, AND THIS COUNTERTRANSFERENCE EXPERIENCE IS VERY VALUABLE, BECAUSE IT ALLOWED THE THERAPIST TO UNDERSTAND THE BATTERED AND CRUSHED CHILD IN THE PATIENT. THE AUTHOR OF THIS PAPER HAS FOUND THAT THE CONFUSION THAT PATIENT AND THERAPIST EXPERIENCE EARLY ON IN TREATMENT DOES RESOLVE. BECAUSE OF THE EXCESSIVE USE OF PROJECTION BY THESE PATIENTS, THEY EXPERIENCE THE WORLD AND THE THERAPIST AS BEING HOSTILE TO THEM. THEY SOMETIMES PROJECT AGGRESSION INTO PEOPLE, AND THEN FEEL THAT PEOPLE ARE GOING TO ATTACK OR KILL THEM. THEY SOMETIMES PROJECT THEIR PRIMITIVE SUPER EGO ONTO THE THERAPIST, AND THEN THEY HEAR EVERYTHING THAT THE THERAPIST SAYS AS BEING CRITICAL OF THEM, AND THIS MAKES THEM EVEN MORE ANXIOUS. THIS PRIMITIVE SUPER EGO IS ALSO ONE OF THE REASONS WHY SOME OF THESE PATIENTS DEVELOP NEGATIVE THERAPEUTIC REACTIONS.

THE HEALTHY PART OF THESE PATIENTS IS LOOKING FOR A SENSITIVE THERAPIST WHO WILL BE EMPATHIC TO THEM AND HAVE SUFFICIENT "NEGATIVE CAPACILITY." ANOTHER PART OF THESE PATIENTS WANTS TO REPEAT THE PAST, TO REMAIN



SYMBIOTICALLY ATTACHED TO THE THERAPIST AND NEVER TO SEPARATE OR INDIVIDUATE. THEY BELIEVE THAT IF THEY INDIVIDUATE, THE THERAPIST WILL WITHDRAW FROM THEM AND BECOME CRITICAL OF THEM LIKE THEIR MOTHER. THE THERAPIST HAS TO TRY TO HELP THEM TO THINK CLEARLY AND TO SEPARATE OUT LIBIDINAL AND AGGRESSIVE IMPULSES. THE THERAPIST HAS TO HELP THEM TAKE BACK AND UNDERSTAND THEIR PROJECTIONS. THE THERAPIST, THROUGH INTERPRETATIONS AND CONSISTENCY, WILL BE INTERNALISED BY THE PATIENT, AND THIS GOOD INTERNAL OBJECT WILL HAVE AN AMELIORATING EFFECT ON THE "BAD" INTERNAL OBJECTS FROM CHILDHOOD. THE THERAPIST'S MORE BENEVOLENT SUPER EGO AND STYLE OF THINKING IS ALSO INTERNALISED. THESE PATIENTS CAN MAKE PROGRESS IN PSYCHOTHERAPY, AND WALDINGER (1984) HAS SHOWN THAT THOSE PATIENTS WHO HAVE MORE EXTENSIVE TREATMENT HAVE BETTER OUTCOMES.

FINALLY, A COMMENT ABOUT KERNBERG'S THEORIES. KERNBERG'S WRITING IS UNSATISFACTORY BECAUSE AS, KRAMER (1988) POINTS OUT, IT COMBINES ORIENTATIONS WHICH ARE THEORETICALLY INCOMPATIBLE, THERAPEUTICALLY INCOMPATIBLE OR CONCEPTUALLY INCONSISTENT. OF COURSE, THERE ARE MANY EXTREMELY USEFUL IDEAS IN THESE DISPARATE SYSTEMS - KLEIN, FAIRBAIRN, WINNICOTT, ERICKSON, MAHLER AND OTHERS. CLEARLY DIFFERENT THEORETICAL SYSTEMS WILL YIELD DIFFERENT DATA AND THIS IS UNDEREMPHASISED BY KERNBERG.

## OBSESSIVE COMPULSIVE PERSONALITY DISORDER

THIS IS CHARACTERISED BY A PERVASIVE PERFECTIONISM AND INFLEXIBILITY. THE PATIENTS HAVE EXCESSIVELY STRICT AND HIGH STANDARDS AND ARE OVERLY CONCERNED WITH RULES, EFFICIENCY AND TRIVIA. THEY ARE OFTEN PREOCCUPIED WITH WORK TO THE EXCLUSION OF PLEASURE AND RELATIONSHIPS. LOGIC AND INTELLECT ARE FREQUENTLY SUBSTITUTED FOR

affective behaviour. They are very indecisive and ambivalent. They inflict harsh judgements on themselves and others, (Reid, W. H., Wise, M. G., 1989)

## Psychodynamic Aetiological Theories

Freud (1909) emphasised "constitutional causes." Salzman (1980) points out that psychodynamic theories centre around aggression and rage and a battle for autonomy between the child and mother. Identification with parents plays a major part in the development of the adult personality. As well as constitutional factors, there is clearly a role for the child identifying with obsessional parents' style of behaviour and thinking. It is possible that inflexible and rigid parents, who are unable to tune in to the emotional needs of the child and to the child's need for flexibility and doing things at the child's pace, is important here. It is possible that excessively harsh toilet training from obsessional parents could play a part in bringing about obsessional personality disorders. In the past there has been an excessive focus on the parent/child relationship in relation to toilet training. The discussion of toilet training is basically a shorthand for all the interactions between parents and child. It would appear that the parents of obsessional patients have difficulty in establishing the child's pace of development and going along with it, and have difficulty in developing the reciprocity and mutuality needed for satisfactory parent/child relations.. These parents tend to be excessively anxious and worried if the child is not fitting into what they see as the normal patterns. It would appear that they have excessively high standards for their children. It is possible that these parents also have difficulty in handling affect and tuning in to



affective elements in the child. They tend to see child development in intellectual or learning theory terms. Obsessional patients have disordered self esteem caused by the inability of these parents to tune in to and praise the child at the appropriate time. Indeed, it is likely that the parents' perfectionism has led them to being critical of, instead of praising, the child and thereby undermining the child's sense of self and sense of identity, which increases the child's sense of insecurity. The parents' inability to handle affect is then repeated in the obsessional personality disordered patient later on.

Salzman (1980) believes that issues of control and rigidity are more important to the dynamics of the disorder than issues related to aggression, anger and hostility. Nevertheless, I believe that both are important. Obsessional patients are frightened of their instincts, and this was well put in the "Ninth book of the Republic" when Socrates stated that "in all of us, even in good men, there is a lawless wild beast - nature, which appears out in sleep." Some obsessional symptoms are set up to deal with this "beast." In my own experience, obsessional symptoms are more often used to deal with aggressive impulses than sexual impulses. It has also been noted that some patients with obsessional personality have shown precocious intellectual development in childhood, and here the ego development has outstripped the libidinal development. Clearly, child-rearing practices could play a part in pushing the child to develop too rapidly for his age. The parents may have pushed the child to develop intellectual capacities excessively, and inhibited outlets for more direct instinctual gratification. The high level of obsessional personality in Ireland may be due to repressive upbringing, particularly in the past.

## Treatment Issues

In treating obsessional personalities, it is a mistake to search for ultimate causes in the form of a simple early traumatic experience. This kind of endless searching actually increases obsessional mechanisms and intellectualisation.

Salzman (1980) is right when he says that the free association process can defeat the purpose of therapy, as patients can ramble on indefinitely. He points out that the therapist must be active and energetic, and that he must intervene when the communication becomes too confusing or too filled with unrelated details. I have often noticed that these patients have much greater infantile amnesias than other patients, and this makes the search for an ultimate cause even more futile. It is more helpful to examine recent events in the patient's life and the patient's thinking processes and affects in the here and now with the therapist. In my experience, these patients respond less well to transference interpretations, as they are so involved in their own thinking processes. Nevertheless, they can be extremely defended because they are so fearful of their internal world and about what they might do.

These patients often require a multi-modal approach in treatment. Psychoanalytic psychotherapy is often not enough on its own. Salzman (1980) is correct when he points out that these patients require encouragement, support, pressure and sometimes medication.



He points out that it is important

1 to discover and elucidate the basis for the excessive feeling of insecurity that requires absolute guarantees before action is pursued, and to demonstrate by repeated interpretation and encouragement to action that such guarantees are not necessary, and

2 to show the patient that anxiety is universal and omnipresent, and can never be permanently eliminated from life.

It is clear, as well, that a combined approach, is at times required with these patients, that is, psychoanalytic psychotherapy and behaviour therapy.

The treatment must also focus on the harsh super-ego of these patients. This harsh super-ego must be interpreted and the patient assisted in the development of more guilt-free living. The therapeutic process will also allow the patient to internalise the therapist's more reasonable approach to conscience matters. The patient is helped to feel more at ease with his or her sexual and aggressive feelings, and the therapist will show the patient that he does not need to be so guilty about them. In short, the therapist is trying to help the obsessional patient to feel.

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# INDIVIDUAL PSYCHOTHERAPY IN A CUSTODIAL INSTITUTION

MARTIN DALY; MICHAEL FITZGERALD.

"FOR TO TALK NONSENSE IN YOUR OWN WAY IS A DAMN SIGHT BETTER THAN TALKING SENSE IN SOMEONE ELSE'S; IN THE FIRST CASE, YOU'RE A MAN; IN THE SECOND, YOU'RE NOTHING BUT A MAGPIE! TRUTH WON'T RUN AWAY, BUT LIFE CAN BE EASILY BOARDED UP."

(DOSTOYEVSKY: "CRIME AND PUNISHMENT")

"WE ALL, IN FACT, VERY OFTEN ACT LIKE MADMEN, WITH THE SLIGHT DIFFERENCE THAT THE PEOPLE WHO ARE 'MENTAL' ARE A LITTLE MADDER THAN WE ARE. A NORMAL PERSON, IT'S TRUE, HARDLY EXISTS AT ALL. THERE MAY BE ONE IN TEN THOUSAND OR PERHAPS ONE IN A HUNDRED THOUSAND, BUT EVEN THEN, HE IS WHAT I MIGHT CALL RATHER A FEEBLE SPECIMEN."

(DOSTOYEVSKY: "CRIME AND PUNISHMENT")

THE AUTHORS OF THIS PAPER SENSED A LACK OF AND A NEED FOR FORMAL PSYCHOTHERAPY FOR RESIDENTS OF CUSTODIAL INSTITUTIONS.

"PSYCHOTHERAPY" IS A TERM THAT IS APPLIED NOT JUST TO FORMAL METHODS OF INTERVENTION OF A PSYCHODYNAMIC KIND, BUT ALSO TO THE PROVISION OF SUPPORT AND REASSURANCE THROUGH LISTENING, ADVISING AND EXPLAINING. COMMON TO MOST DEFINITIONS IS THE EMPHASIS ON THE RELATIONSHIP BETWEEN THE THERAPIST AND THE CLIENT. IT IS A PROFESSIONAL HELPING RELATIONSHIP WHICH DIFFERS FROM OTHER RELATIONSHIPS. THE FACT THAT THE THERAPIST IS A TRAINED PERSON MUST BE EMPHASISED. WHILE IT APPEARS THAT SOME PEOPLE ARE NATURALLY MORE SUITED THAN OTHERS TO BE PSYCHOTHERAPISTS, SUITABILITY ALONE IS NOT SUFFICIENT, AND NEITHER ARE EMPATHY NOR ENTHUSIASM.

## THE WHITAKER REPORT

IN JULY 1985 THE REPORT OF THE COMMITTEE OF INQUIRY INTO THE PENAL SYSTEM, THE WHITAKER REPORT, WAS PUBLISHED. IT STATED THAT, WHILE PROGRESS HAD BEEN MADE IN THE PREVIOUS TEN YEARS IN THE PROVISION OF CARING SERVICES IN CUSTODIAL INSTITUTIONS, EACH OF THE FOUR SPECIALIST SERVICES - WORK, EDUCATION, WELFARE AND PSYCHOLOGY - RETAINED MUCH OF THE QUALITY OF BEING A USEFUL APPENDAGE TO THE CUSTODIAL SYSTEM AND BEING PERIPHERAL TO WHAT WAS SEEN AS THE REAL BUSINESS OF RUNNING CUSTODIAL UNITS - CONTAINMENT AND SECURITY.

THERE ARE FOUR PSYCHOLOGISTS ATTACHED TO CUSTODIAL ESTABLISHMENTS AND PLACES OF DETENTION. THREE ARE ENGAGED IN PROVIDING A CLINICAL SERVICE, MAINLY ASSESSMENT, TO THE ELEVEN CUSTODIAL ESTABLISHMENTS AND PLACES OF DETENTION SPREAD THROUGHOUT THE COUNTRY WHICH



ACCOMMODATE ABOUT TWO THOUSAND PEOPLE IN CUSTODIAL INSTITUTIONS IN IRELAND. THE FOURTH PSYCHOLOGIST IS ENGAGED MAINLY IN RESEARCH. PSYCHIATRIC SERVICES ARE PROVIDED ON A CONSULTANCY BASIS BY PSYCHIATRISTS FROM THE LOCAL HEALTH BOARDS.

THE WHITAKER COMMITTEE CONSIDERED THAT THE PHYSICAL AND PSYCHOLOGICAL IMPACT OF CUSTODY LIMITS WHAT CAN BE ACHIEVED IN THE PERSONAL DEVELOPMENT OF RESIDENTS. NEVERTHELESS, IT RECOMMENDED THAT A PERSONAL DEVELOPMENT PROGRAMME SHOULD BE PREPARED BY THE PROFESSIONAL SERVICES FOR EVERY LONG TERM RESIDENT, WHICH SHOULD BE DISCUSSED AND AGREED WITH HIM OR HER, AND REVIEWED PERIODICALLY BY THE PROFESSIONAL SERVICES. IT STATED THAT A RESIDENT'S PARTICIPATION MUST BE VOLUNTARY. IT CONSIDERED THAT THE EMPHASIS IN CUSTODIAL PSYCHIATRY SHOULD BE ON PROMOTING THE MENTAL HEALTH OF THE RESIDENTS, RATHER THAN THE BROADER AIM OF ATTEMPTING TO REFORM THEM. IT RECOMMENDED THE STRENGTHENING OF THE PSYCHIATRIC SERVICES.

PSYCHOTHERAPY WAS RECOMMENDED ONLY IN RELATION TO THOSE "CONVICTED OF SERIOUS SEX OFFENCES." YET, THE REPORT CONSIDERED THAT EFFECTIVE THERAPY FOR THESE RESIDENTS PRESENTS DIFFICULTIES: CONSIDERATION OF MEDICAL ETHICS; THE CUSTODIAL ENVIRONMENT ITSELF; THE ANIMOSITY OF OTHER RESIDENTS AND SOME STAFF. FOR THESE REASONS, IT RECOMMENDED THAT TREATMENT OF SEX OFFENDERS SHOULD BE UNDERTAKEN, WHERE POSSIBLE, WITHIN A SPECIAL SETTING HAVING A THERAPEUTIC BIAS.

THE WHITAKER COMMITTEE RECOMMENDED THAT A RANGE OF SERVICES BE PROVIDED FOR RESIDENTS WHICH WILL GIVE THEM AN OPPORTUNITY NOT MERELY TO SURVIVE, BUT TO RETURN TO ORDINARY LIFE BETTER EQUIPPED. IT RECOGNISED, HOWEVER, THAT NO MATTER HOW GOOD THE SERVICES, IT IS IN THE END

THE RESIDENT WHO MUST CHOOSE. THE CUSTODIAL UNIT CAN DO MUCH, BUT IT CANNOT GUARANTEE WHAT WILL HAPPEN WHEN THE RESIDENT RETURNS TO THE OUTSIDE. UNFORTUNATELY, BEHAVIOUR INSIDE A CUSTODIAL UNIT IS NOT A GOOD PREDICTOR OF BEHAVIOUR IN THE WIDER COMMUNITY. THE CUSTODIAL UNIT SHOULD ENABLE THESE RESIDENTS TO MAKE THE BEST POSSIBLE USE OF THEIR TIME BY ENCOURAGING PERSONAL DEVELOPMENT IN VARIOUS WAYS. HOWEVER, RESIDENTS MUST BE FREELY ALLOWED TO CHOOSE OR TO REJECT WHATEVER SERVICES ARE AVILABLE, SUCH AS "PSYCHOLOGICAL COUNSELLING, GROUP THERAPY AND OTHER SUCH SERVICES. THE APPROACH MUST BE FACILITATIVE, NOT COERCIVE."

## Involuntary Residents and Psychotherapy

IT BECOME CLEAR TO THE AUTHORS THAT RESIDENTS NEEDED DESPERATELY TO BE HELPED TO TALK ABOUT THEIR LIVES AND WORK THROUGH MANY UNRESOLVED CONFLICT AREAS. IF, AS MURRAY COX (1976) STATES, THE CORE DATUM OF DYNAMIC PSYCHOTHERAPY IS THE FACT THAT MOVEMENT ALWAYS OCCURS IN THE DIRECTION OF DISCLOSURE AS DEFENCES ARE GRADUALLY RELINQUISHED. WHITELY (1986) STATES THAT PSYCHOTHERAPY IS THE READJUSTMENT OF THE INTRA-PERSONAL ATTITUDES AND FEELINGS OF THE INDIVIDUAL, AND IS BASED ON A PROCESS OF RE-EXPERIENCING ATTACHMENT TO KEY FIGURES AND WORKING TOWARDS A BETTER RESOLUTION OF THE TENSIONS AND CONFLICTS INVOLVED, THEN SOME IN CUSTODIAL UNITS, AND NOT ONLY THOSE CONVICTED OF SEX-RELATED OFFENCES, WERE IN NEED OF AND CAPABLE OF THAT.

## The Environment of a Closed Institution

WHEN CONSIDERING THE POSSIBILITY OF INTRODUCING PSYCHO-THERAPY TO CUSTODIAL UNITS, IT IS IMPORTANT TO UNDER-



STAND THE ENVIRONMENT OF A PARTICULAR KIND OF CLOSED INSTITUTION. AS CLARKE AND GLATT (1885) SAY:

> "INSTITUTIONALISATION IS A PROCESS WHICH UNDERMINES SELF RESPONSIBILITY AND USE OF INITIATIVE DUE TO THE PROVISION OF THE INMATES' NEEDS AND THE LACK OF RECOGNITION OF INDIVIDUALITY. IT IS MOST LIKELY THAT THE EFFECTS OF INSTITUTIONALISATION MAY BE SEEN MOST DRAMATICALLLY IN PENAL INSTITUTIONS."

A FUNDAMENTAL ASPECT OF CUSTODY IS DEPRIVATION OF LIBERTY, WHICH NECESSARILY IMPLIES LACK OF OPPORTUNITY FOR USING RESPONSIBILITY AND INITIATIVE.

THE WHITAKER COMMITTEE (1985) STATES THAT THE PHYSICAL IMPACT OF THE STARK CONDITIONS IN CUSTODIAL UNITS IS ALWAYS SECONDARY TO ITS PSYCHOLOGICAL IMPACT. THERE IS SIMPLY NO HUMANE WAY THAT ONE HUMAN BEING CAN LOCK UP ANOTHER.

> "HUMANE INTENTIONS ARE NO GUARANTEE OF HUMANE RESULTS AND EVEN AMONG THE BEST MOTIVATED OF PROFESSIONAL STAFF, THERE IS A TENDENCY TO SEE THE INMATE AS AN INVOLUNTARY RESIDENT FIRST AND AS A PATIENT, A STUDENT, AN APPRENTICE OR A CLIENT SECOND."

IN ALL CUSTODIAL INSTITUTIONS THE POSSIBILITY OF REHABILITATION IS IMPEDED BY THE IMPOSITION OF AN ARTIFICIAL HOMOGENEITY AND BY AN ATMOSPHERE OF MISTRUST - BETWEEN RESIDENTS AND STAFF, AND BETWEEN RESIDENT AND RESIDENT. A RESIDENT IS EXPECTED TO DEVELOP A MATURE

ATTITUDE IN A SITUATION WHERE EVEN IN LETTERS AND VISITS, BECAUSE OF CENSORSHIP AND SUPERVISION, ONE CANNOT EXPRESS TRUE FEELINGS. IN MANY CUSTODIAL UNITS THE RESIDENT HAS EVERY MOVEMENT SCHEDULED AND DIRECTED, AND HAS LITTLE CONTROL OVER PERSONAL ACTIONS OR LITTLE RESPONSIBILITY FOR THEM.

> "ALL CUSTODIAL UNITS ARE STEEPED IN A CUSTODIAL CULTURE THAT ALLOWS LITTLE INDIVIDUAL RESPONSIBILITY AND YET WITHOUT SUCH RESPONSIBILITY, REHABILITATION AND PERSONAL DEVELOPMENT ARE IMPOSSIBLE."

CUSTODIAL INSTITUTIONS INCORPORATE AN INTRICATE NETWORK OF RELATIONSHIPS, WITHIN WHICH RESIDENTS CAN IMPROVE OR REGRESS. WHILE IT IS AN ENVIRONMENT WHICH IS CONDUCIVE TO INSTITUTIONALISATION AND THE FORMATION OF FEELINGS OF HELPLESSNESS, DYNAMIC PSYCHOTHERAPY, ALTHOUGH DIFFICULT, COULD CHALLENGE THE TRADITIONAL CUSTODIAL MODEL. IT COULD GIVE SOME RESIDENTS THE OPPORTUNITY TO ACHIEVE SOME PERSONAL GROWTH.

## PSYCHOTHERAPY IN A "CLOSED" VERSUS "OPEN" SITUATION

THERE ARE MANY FACTORS OPERATIVE IN A CUSTODIAL INSTITUTION WHICH ARE NOT PRESENT IN AN OPEN PSYCHOTHERAPEUTIC SITUATION. BUT EVEN WITHIN A CUSTODIAL INSTITUTION THERE ARE DIFFERENCES. AS MURRAY COX (1976) STATES, THERE ARE FUNDAMENTALLY DIFFERENT PARAMETERS OPERATING WHEN PSYCHOTHERAPY IS EMBARKED UPON WITHIN A SECURE SETTING WHERE BOTH PATIENT AND THERAPIST ARE AWARE OF AN APPROACHING DATE OF RELEASE WHICH, APART FROM LOSS OF REMISSION, DRAWS INEXORABLY



CLOSER. THIS IS BOUND TO INFLUENCE THE CONTENT OF THERAPY, IRRESPECTIVE OF WHO SETS THE LIMITS. THERE MAY BE AN INHERENT CONFLICT IN THE SITUATION WHERE A PATIENT WHO WISHES TO CONTINUE PSYCHOTHERAPY BECAUSE OF A DEVELOPING POSITIVE TRANSFERENCE TOWARDS THE THERAPIST MAY, SIMULTANEOUSLY, BE EAGERLY AWAITING HIS "DAY OF RELEASE."

THE FOLLOWING IS AN EXAMPLE OF A CUSTODIAL INSTITUTION WHERE THE CLIENTS WHO WERE IN PSYCHOTHERAPY WERE ACCOMMODATED. THE DETAILS GIVEN ARE THOSE WHICH WERE CONSIDERED (BY M.D.) RELEVANT TO THE WHOLE CONTEXT IN WHICH THE PSYCHOTHERAPY WAS CONDUCTED, AND TO THE AREAS OF TRANSFERENCE AND COUNTERTRANSFERENCE IN THE PSYCHOTHERAPY.

THE MAJORITY OF RESIDENTS' ROOMS ARE SINGLE ONES, AND MEASURE ABOUT THIRTEEN FEET BY SEVEN FEET BY NINE TO TEN FEET HIGH, WITH WINDOWS OF ABOUT 700 SQUARE INCHES. THE ROOMS OR WINGS RADIATE FROM A CENTRAL OBSERVATION POINT.

CUSTODIAL REGIMES ARE LARGELY DETERMINED BY THE GENERAL CONDITION OF THE BUILDINGS, THE LEVEL OF SECURITY, THE DAILY ROUTINE, THE EXTENT OF PROVISION OF BASIC NECESSITIES FOR PHYSICAL COMFORT, SUCH AS FOOD, CLOTHING, SLEEPING ACCOMMODATION, HEATING AND SANITATION/HYGIENE FACILITIES, THE PRESSURE ON SPACE, THE FACILITIES AVAILABLE FOR ACTIVITIES, THE EXTENT TO WHICH "OUTSIDE CONTACTS" BY WAY OF LETTERS AND VISITS ARE FACILITATED, AND FINANCIAL CONSTRAINTS.

THE DAILY ROUTINE IS AS FOLLOWS. IT IS BASED ON A TIMETABLE WHICH ALLOWS FOR WORK OR EDUCATION ACTIVITIES IN THE MORNINGS AND AFTERNOONS, AND RECREATION IN THE EVENINGS (OUT OF DOORS DURING THE SUMMER). DURING

WINTER, ONE HOUR'S OUTDOOR RECREATION EACH DAY (WEATHER PERMITTING) MUST BE GIVEN. THE MAIN FEATURES OF THE ROUTINE ARE THE LONG LOCK-UP TIME (ABOUT SIXTEEN HOURS) AND THE SHORT TIME AVAILABLE FOR WORK OR EDUCATION ACTIVITIES (ABOUT FOUR HOURS). A TYPICAL TIMETABLE IS:

| | |
|---|---|
| 08.00 - 08.15 | MORNING CALL, UNLOCK |
| 08.30 | BREAKFAST AND LOCK-UP |
| 09.30 | UNLOCK, WORK/EDUCATION |
| 12.30 | DINNER AND LOCK-UP |
| 14.14 | UNLOCK, WORK/EDUCATION |
| 16.30 | TEA AND LOCK-UP |
| 17.15 | UNLOCK AND RECREATION |
| 19.00 | SUPPER |
| 19.30 - 20.00 | LOCK-UP |

RESIDENTS MAINTAIN CONTACT WITH THEIR FAMILIES AND FRIENDS BY WAY OF VISITS AND LETTERS. THEY MAY RECEIVE ONE VISIT PER WEEK OF A HALF-HOUR'S DURATION, FROM A GROUP OF NOT MORE THAN THREE PEOPLE, BUT EXTRA VISITS ARE FREQUENTLY ALLOWED, ON APPLICATION TO THE PERSON IN CHARGE. VISITS ARE IN THE SIGHT AND HEARING OF STAFF. RESIDENTS MAY WRITE TWO LETTERS PER WEEK, AND MAY RECEIVE ALL INCOMING MAIL.



THIS CUSTODIAL UNIT HAS GOOD PURPOSE-BUILT FACILITIES FOR EDUCATION, WORK AND RECREATION.

A PART-TIME MEDICAL OFFICER IS APPOINTED TO THE CUSTODIAL UNIT. IN 1990 A FULL-TIME MEDICAL OFFICER WAS APPOINTED TO THE CUSTODIAL SERVICE. HE IS RESPONSIBLE, IN GENERAL, FOR THE MEDICAL WELFARE OF BOTH RESIDENTS AND STAFF. HE IS REQUIRED TO PAY PARTICULAR ATTENTION TO RESIDENTS WITH PSYCHIATRIC PROBLEMS. THERE ARE NO HOSPITAL FACILITIES AT THE CUSTODIAL UNIT.

THERE IS ONE FULL-TIME CATHOLIC CHAPLAIN AT THE CUSTODIAL INSTITUTION, AND CLERGYMEN OF OTHER DENOMINATIONS ATTEND THE INSTITUTION AS NECESSARY.

VERY FEW RESIDENTS SERVE UP TO THEIR RELEASE DATE, BUT THE ACTUAL LENGTH OF TIME SERVED DEPENDS ON INDIVIDUAL FACTORS. HOWEVER, CERTAIN CATEGORIES OF OFFENDERS HAVE ALWAYS RECEIVED VERY LITTLE BY WAY OF TEMPORARY RELEASE.

THE ENCLOSED ENVIRONMENT OF THE CUSTODIAL UNIT IMPOSES CONSTRAINTS ON ANY KIND OF PSYCHOTHERAPEUTIC WORK. THE SOCIAL SETTING IS ABNORMAL. IT IS AN ALL-MALE SETTING. FAMILIES ARE EXCLUDED EXCEPT ON VISITS. THERE IS NO ACCESS TO ALCOHOL. THESE FEATURES OF THE SOCIAL ENVIRONMENT MUST BE TAKEN INTO ACCOUNT IN DOING PSYCHOTHERAPY WITH RESIDENTS. ALSO, AS STATED ALREADY, THE INSTITUTION MAINTAINS A HIGH DEGREE OF INTERNAL CONTROL, WHICH MILITATES AGAINST THE DEVELOPMENT IN RESIDENTS OF INDEPENDENCE AND TAKING RESPONSIBILITY WITHIN A SOCIAL GROUP, DESPITE THEIR NEED FOR THIS.

HOWEVER, THE PURSUIT OF "NORMALISATION" IS COUNTERBALANCED BY A RECOGNITION THAT THE SEVERITY OF

THE RESIDENT PSYCHOPATHOLOGY WAS ASSOCIATED PRIOR TO ADMISSION WITH BEHAVIOUR SERIOUSLY ENDANGERING OTHERS; AND THE ENVIRONMENTAL CONTROL OF THE RESIDENT MAY HAVE AN IMPORTANT LONG TERM ROLE IN HELPING PATIENTS WHO ARE POORLY SOCIALISED, QUITE APART FROM THE ESSENTIAL REQUIREMENTS OF SAFETY. THE CUSTODIAL SETTING MAY PROVIDE A NECESSARY "HOLDING ENVIRONMENT" (Cox, 1986) AND "BREATHING SPACE" IN WHICH THE PATIENT MAY GAIN GREATER INSIGHT AND CONTROL BEFORE RETURNING TO THE STRESSES OF THE SETTING IN WHICH HIS PROBLEMS BECAME MANIFEST. EVEN WITH "LIFE" RESIDENTS, WHILE THERE IS NOT A DEFINITE RELEASE DATE, THERE IS AN EXPECTATION OF RELEASE ON LICENCE AFTER NINE OR TEN YEARS, AND THIS CAN ENCOURAGE MOTIVATION FOR GENUINE CHANGE THROUGHOUT THE RESIDENT'S STAY.

IN A CUSTODIAL INSTITUTION, RESIDENTS WERE GIVEN AN OPPORTUNITY OF TALKING TO A PROFESSIONAL PERSON ABOUT THEIR LIFE. THE CHAPLAIN IDENTIFIED RESIDENTS WHO MIGHT BE INTERESTED, AND FOUR TOOK UP THE OFFER.

IT IS IMPORTANT TO STATE AT THIS POINT THAT IT IS IMPOSSIBLE TO ISOLATE THE EFFECTS OF FORMAL PSYCHOTHERAPY SESSIONS FROM THE BROAD STREAM OF LIFE WITHIN THE CUSTODIAL INSTITUTION AS A WHOLE. THERE ARE SO MANY CONTINGENT HAPPENINGS WHICH IMPINGE UPON THE WELL-BEING AND SELF ESTEEM OF A RESIDENT THAT IT IS HIGHLY UNLIKELY THAT PSYCHOTHERAPY "PER SE" COULD CLAIM "SUCCESS" OR BE BLAMED FOR "FAILURE."

THERE ARE PROBLEMS MEASURING THE EFFECTIVENESS OF PSYCHOTHERAPY. BERGIN AND LAMBERT (LAMBERT, 1983) STATE THAT "THERE IS LONG WAY TO GO BEFORE CONSENSUS WILL BE REACHED ON THE TYPE OF YARDSTICK TO APPLY IN MEASURING THE RESULTS OF PSYCHOTHERAPY AND BEHAVIOUR-CHANGE TECHNIQUES." THE NUMBER OF CLIENTS IN THERAPY



DURING THE STUDY IN THIS PAPER WAS TOO SMALL TO WARRANT A QUANTITATIVE/STATISTICAL APPROACH, AND THERE IS VERY LITTLE REPORTED ON PSYCHOTHERAPEUTIC WORK BEING DONE IN PRISONS.

AT THE SAME TIME, REVIEWS OF CONTROLLED STUDIES WITHIN THE OUTCOMES LITERATURE SHOW THAT THE THERAPIST HIMSELF, WHILE BOTH CONDUCTING THE THERAPY AND BEING A SEEMINGLY "UNRELIABLE" OBSERVER, DOES HAVE SUCCESSFUL THERAPEUTIC OUTCOME. BUT, MORE IMPORTANTLY, THE THERAPIST'S VIEW OF THE THERAPEUTIC PROCESSES AND OUTCOME REPRESENTS A UNIQUE VIEW THAT CANNOT BE REPORTED BY ANY OTHER OBSERVER. WHEREAS THERE HAS BEEN AMPLE REASON TO QUESTION WHETHER THE VIEW OF THE THERAPIST IS AN "UNBIASED" VIEW, THE THERAPIST IS, NEVERTHELESS, A RICH SOURCE OF INFORMATION AND INSIGHT ABOUT THE FACETS THAT COMPRISE THE THERAPEUTIC EXPERIENCE AND OUTCOME. MINTZ (LAMBERT, 1983) SUGGESTS THAT THE DATA DERIVED FROM THERAPISTS MAY BE NO BETTER OR NO WORSE THAN DATA DERIVED FROM OTHER SOURCES: "EACH OBSERVER-PARTICIPANT OF THERAPY HAS A UNIQUE CONTRIBUTION TO MAKE, AND EACH IS BLESSED OR PLAGUED WITH COMPARABLE DEGREES OF RELIABILITY, OR CONVERSELY, UNRELIABILITY."

THE THERAPIST'S EVALUATION CAN REPRESENT A VALID PERSPECTIVE OF THE THERAPEUTIC PROCESSES AND OUTCOME, BUT WITH SOME POTENTIALLY IDENTIFIABLE SOURCES OF UNRELIABILITY AND BIAS.

BERGIN AND LAMBERT (LAMBERT, 1983) IN THEIR ARTICLE, CONCLUDE THAT THE THERAPIST'S OBSERVATIONS AND EVALUATIONS NOT ONLY CAN, BUT SHOULD BE, CONSIDERED AS A VALUABLE SOURCE OF DATA ABOUT THE PROCESSES AND OUTCOME OF PSYCHOTHERAPY.

As Ormrod (1975) says: "Unless the study of offenders is undertaken on an individual basis, little progress will be made." Throughout the therapy of these custodial residents by M. D., there was a level of engagement and commitment as evidenced in the accounts of the sessions. This should help counter too ready a dismissal of such cases as "untreatable" and undeserving of psychotherapeutic help.

Murray Cox (Rosen, 1979) states that the term "sex offender" covers a wide range of human activity and motivation, ranging from an almost harmless and trivial deviation from a socially acceptable norm, such as that of the "voyeur," to the extremely disturbed and disturbing homosexual killing.

There is no unitary psychopathology underlying all sex offences because of the over-determined, multi-causal nature of the offence. There is no homogeneity of dynamic patterning behind the heterogeneous offences "against the person" known as sex offences. The sex offender is not confined to any single nosological classification. He may be appropriately diagnosed as neurotic, psychotic, psychopathic, or subnormal, and all possible organic causes must be considered.

The clients seen by M. D. had a history of severe deprivation in their early upbringing; a history of delinquency and personality difficulties to which descriptive terms such as "explosive," "paranoid" and "schizoid" might be applied. From a psychodynamic point of view, many showed features of "borderline personality organisation," (Kernberg, 1975). Many of them had character disorders.



their story and to develop a capacity for caring for people, rather than "using" and "exploiting" them.

Murray Cox (Rosen, 1979) states that primitive anti-social acting out, involving assault, may be modified by psychotherapy into more acceptable styles of expression, and inner conflicts may be dealt with by increasingly differentiated and less anti-social defences.

Murray Cox (Rosen, 1979) also states that the most ubiquitous and valuable concept in understanding the sex offender is that of preservation of self. Psycho-therapy and the unfolding of life events, which can never be dissociated, can free the client from the restrictions imposed by low self esteem.

In therapy, the subject is invited to speak and the therapist is the one to whom he speaks, and to whom he speaks freely. That is what the therapist is there for.

The clients were invited to speak, to say, according to the fundamental rule of analysis, "what he thinks and feels, selecting nothing and omitting nothing from what comes to mind, even where this seems to him unpleasant to have to communicate, ridiculous, devoid of interest or irrelevant."

The clients resisted with many ploys, yet there was movement that was clear to M. D. and M. F. over time, taking it that therapy always moves in the direction of disclosure, by which is meant that the unconscious becomes conscious.

Murray Cox (1986) states that the process is: Unconscious ----- conscious-withheld ----- conscious-disclosed.

He states that the therapist's task is always that of facilitating disclosure, and that psychotherapy with a sex offender is never satisfactory if he discusses, with appropriate effect, everything except his offence. But it is equally unsatisfactory if he discusses only his offence. Murray Cox also states that, in his experience, it is possible to fail the client precisely at the point where he is most vulnerable and, indeed, welcomes further confrontation with himself.

Murray Cox (Rosen, 1979) states that genuine disclosures about a sex offence always lead back to earlier relationships (in fact or fantasy) which were unsatisfactory, and that again and again the client retraces his emotional footsteps to early life-experience.

Once the therapeutic alliance is firmly established, the clients no longer regard the therapist's incursive activity as an attack. It is gradually reconstrued as the necessary, though painful, co-operation of an "ally."

Cox (1987) states that initially a custodial resident, when talking about his offence, speaks as if the person he is "here and now" in the interview and the person who committed the offence are completely different individuals. There is a high degree of "splitting off" or of "disowning" parts of self which are too difficult to face. They say that one therapeutic task is gradually to enable the client to acknowledge and understand those aspects of himself and



his past experience that he initially disowns; that the client has to appropriate the concern about his own capacity for violence and understanding of it. Psychotherapy in an Irish custodial institution supported this view.

There was a history of rejection and insecurity in many residents' early lives. Custodial units accentuate this in that, if someone does not visit on the expected day, there is no way of knowing what has happened and the isolation heightens paranoid thoughts. There is often, as a result, a fear of relationships. There was often highly transferential material in the sessions. As Murray Cox (Rosen, 1979) states, during individual psychotherapy, as transference is established and develops, the therapist is invested with feelings which the patient had previously invested in "significant others."

The authors found that working with clients in the custodial unit made particular emotional demands on M. D. which, although present in other therapeutic alliances, there assumed heightened significance. Sometimes M. D. had nothing to say to the awfulness of what was being spoken.

The compulsion to confess is evident among some prisoners. The guilt seems to become unbearable and perhaps the isolation in the "holding" situation limits the opportunities for escapism, for "acting out."

## Discussion

A psychoanalytic dynamic formulation alone does not account for the complex interaction which constitutes a

SEX OFFENCE. IT ALWAYS INVOLVES ACTION BETWEEN TWO PEOPLE. SO THE THERAPY IS NOT SOLELY CONCERNED WITH FANTASY. THE PSYCHOPATHOLOGY OF THE SEX OFFENDER IS DIFFERENT FROM THAT OF THE LAW-ABIDING CITIZEN, WHOSE "SEX OFFENCES" MOSTLY REMAIN SAFELY WITHIN HIS FANTASY WORLD.

IN RELATION TO THE OFFENCE ITSELF, PSYCHOANALYTIC FACTORS NEVER OPERATE ON THEIR OWN. THERE IS ALWAYS A SOCIAL SETTING IN WHICH THE OFFENCE ACTUALLY TAKES PLACE, ALTHOUGH IT MAY HAVE TAKEN PLACE IN THE CLIENT'S FANTASY ON MANY OCCASIONS IN OTHER SETTINGS. EXACTLY WHY THE OFFENCE WAS COMMITTED IN THIS PLACE, AT THIS TIME, WITH THIS VICTIM, WAS ACHIEVED WITH THE PATIENTS TREATED.

AT THE SAME TIME, WE CONSIDER THAT THERE WAS VERY DEFINITE MOVEMENT DURING THE TIME THE THERAPIST WAS MEETING WITH THE PATIENTS. THE PSYCHOTHERAPY HELPED THEM TO UNDERSTAND AND MODIFY THEIR INNER WORLD OF FANTASY AND THEIR CONSTRUCTION OF REALITY WHICH HAD LED TO AN INCIDENT THAT DESIGNATED THEM AS A SEX OFFENDER.

MURRAY COX (ROSEN, 1979) STATES THAT THE THERAPIST IS NOT "WHOLLY OTHER." CLIENTS CONFRONT HIM WITH PART OF HIMSELF WHICH IS USUALLY HIDDEN. THE THERAPIST NEEDS TO BE RUTHLESSLY RIGOROUS IN DIAGNOSTIC APPRAISAL, ALERT FOR ANY DISCLOSURES, AND AWARE OF THE RISKS OF ACTING OUT. YET, AT THE SAME TIME, HE NEEDS TO RETAIN WARMTH AND A SENSE OF BEING AT EASE WITH HIMSELF. IT WAS OF CONSIDERABLE HELP TO M. D. TO HAVE FORMERLY WORKED IN A CUSTODIAL SETTING FOR SIX YEARS AS A CHAPLAIN. M. D. DID NOT THINK IT WOULD HAVE BEEN POSSIBLE FOR HIM TO CARRY THROUGH THE WORK, IF HE HAD NOT BEEN SUPERVISED WHILE DOING IT BY M. F.



THE SETTING IN WHICH M.D. MET CLIENTS FOR THERAPY WAS DEFINITELY "SECURE," SO THAT THE THERAPEUTIC SPACE TOOK ON A LITERAL "CONCRETE" QUALITY, READILY DISCERNIBLE IN THE FORM OF BARS AT THE WINDOWS AND LOCKS ON GATES AND ON MOST DOORS. THESE WERE CONSTANT REMINDERS THAT THE THERAPEUTIC SPACE HAD UNDENIABLE BOUNDARIES. THE EXPERIENCE OF WORKING BOTH IN "OPEN" AND "CLOSED" SITUATIONS SHOWS THAT SUCH CUSTODIAL EMBLEMS AS BARS AND KEYS INTENSIFY RATHER THAN DIMINISH THE EFFECTIVE FLOW OF THE THERAPEUTIC ENCOUNTER. THERE IS THE SYMBOLIC THERAPEUTIC SPACE, BUT THIS IS ALSO THERE IN A PHYSICAL SPACE, CONFINED BY A SECURE PERIMETER, WHICH IS ALSO THERAPEUTIC. THIS SEEMS TO INTENSIFY TRANSFERENCE PHENOMENA AND SO HELPS THE THERAPY. IT IS "SECURE" IN A DOUBLE SENSE. THE PSYCHOTHERAPEUTIC PROCESSES, HOWEVER, WERE NO DIFFERENT FROM THOSE IN THE "OPEN" SITUATION. IT WAS "NORMAL" PSYCHOTHERAPY IN AN ABNORMAL SITUATION. IT IS FOR THIS REASON THAT WE ARGUE FOR THE PRESENCE OF THE OPPORTUNITY FOR PSYCHOTHERAPY IN CUSTODIAL INSTITUTIONS. ALSO, WE DO NOT THINK THAT PSYCHOTHERAPY WITH "SEX OFFENDERS" NEEDS TO TAKE PLACE IN A "SPECIAL SETTING," AS THE WHITAKER REPORT RECOMMENDS.

THERE IS A GREAT DANGER IN EXTRAPOLATING FROM A FEW CASES THE ASSUMPTION THAT THERAPY WOULD BE SUITABLE FOR ALL IN CUSTODY. AS WAS EVIDENCED TO US BY A CLIENT WHO STOPPED ATTENDING AFTER TWELVE SESSIONS, THAT WAS NOT SO.

DEFINITE MOVEMENT OCCURRED WITH ALL FOUR CLIENTS OVER THE TIME M. D. WORKED WITH THEM. HOWEVER, AS ONLY ONE CLIENT FINISHED HIS SENTENCE WHILE M. D. WAS WITH HIM, IT WAS ONLY IN THIS CASE WE COULD OBSERVE HOW THE CUSTODIAL CONTEXT CAN INTERFERE WITH THE WORK OF THE

THERAPY. THERE CAN BE A FOCUS ON "GETTING OUT" RATHER THAN WORKING THROUGH.

LASTLY, IN OUR EXPERIENCE IT IS IMPORTANT, AND PROBABLY ESSENTIAL, THAT THE THERAPIST BE "NEUTRAL" IN THE CUSTODIAL SYSTEM, WITHOUT ANY POWER TO PUT IN THE "GOOD WORD," TO RECOMMEND A "DAY OUT," OR "EARLY RELEASE" OR WHATEVER.

PSYCHOANALYTIC PSYCHOTHERAPY IS A SLOW PROCESS, BUT WE CONSIDER IT SHOULD BE AVAILABLE FOR THOSE IN CUSTODIAL INSTITUTIONS WHO MIGHT BENEFIT FROM IT.



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# PSYCHOANALYSIS, BEHAVIOUR THERAPY AND PHARMACOTHERAPY

MICHAEL FITZGERALD.

**IT IS SOBERING** TO REFLECT THAT IT IS ABOUT SIXTY YEARS SINCE THOMAS FRENCH (1933) PUBLISHED HIS ARTICLE ON THE INTER-RELATIONS BETWEEN PSYCHOANALYSIS AND THE EXPERIMENTAL WORK OF PAVLOV. IN HIS PAPER, FRENCH CLEARLY DELINEATED THE MANNER AND DIRECTIONS IN WHICH THE THEORIES OF CONDITIONING MIGHT ENRICH ONE ANOTHER. REGRETTABLY, HIS OPENNESS TO NEW IDEAS HAS NOT BEEN CHARACTERISTIC OF MOST SCHOOLS OF PSYCHIATRIC THOUGHT, WHICH HAVE TENDED INSTEAD TO DEVLEOP AN UNFORTUNATE DEGREE OF INSULARITY. THIS HAS OCCURRED DESPITE THE OBVIOUS REALITY THAT THE BIOSOCIAL-PSYCHOLOGICAL NATURE OF MAN IS SUCH THAT NO ONE THEORY OR DISCIPLINE IS LIKELY, IN THE FORESEEABLE FUTURE, TO EXPLAIN, MUCH LESS PREDICT, ALL OF THE COMPLEXITIES OF HUMAN BEHAVIOUR. ALL TOO OFTEN DISPUTING THEORETICIANS, LIKE DISABLED, BLIND MEN DESCRIBING THE ELEPHANT, ASSUME THAT THE WHOLE IS JUST A GIGANTIC MAGNIFICATION OF THE PARTS WITH WHICH THEY ARE IN CONTACT. WHEN TREATMENT STRATEGIES ARE EXTRAPOLATED FROM SUCH NARROW VIEWS, MORE OFTEN THAN NOT THEY FAIL TO ACHIEVE THE PARSIMONY OF EFFORT, THE BREADTH OF APPLICATION, AND THE MAXIMUM OF EFFICIENCY THAT ONE WOULD HOPE FOR.

Based on lecture to Association of Child Psychology and Psychiatry at Lota, Glanmire, Co. Cork, 26th April, 1985.

It is impossible adequately to conceptualise personality development, symptom formation, or responses to psychotherapy, without taking into consideration theories of conflict as well as those of learning. Similarly, the processes of adaptation and maturation, whether viewed from the perspective of coping with internal or external stimuli, cannot be adequately understood without taking into consideration the manner by which previous learning and conflict resolution have shaped the perception and responses to current circumstances.

Psychodynamic therapies conceptualise human behaviour as influenced by unconscious and dynamically active forces and conflicts that are derived from developmentally important antecedent experiences, and that distort the way one perceives and responds to current transaction. Viewed in this fashion, behavioural obstinacy in the face of authority, for example, is seen not merely as a learned response to the stimulus of authority, but as a psychologically essential process dealing with potentially disruptive feelings and anxieties that are associated with unresolved conflicts with significant authority figures in one's past. These distorted ways of dealing with authority, however, often become so strongly learned and reinforced that they may develop an autonomy which can result in the persistence of all the behaviour, even after the dynamic aetiological factors have been resolved. Moreover, not all maladaptive behaviour is necessarily due to persistent unconscious conflict. Some faulty behaviour may be extinguished either naturally or by rather simple behavioural interventions or social learning.



These facts have significance both diagnostically and therapeutically. Thus, a simple diagnostic label such as a phobia tells us very little in itself about the nature of the clinical task to be accomplished if the patient is to be freed from the debilitating symptom. An acute driving phobia following a traumatic car accident is usually quite different from an insidious agoraphobia that over time has invaded every aspect of the patient's life.

Thus, symptoms can result from relatively uncomplicated conditioned learning or from complex psychodynamic factors, or both. Thus, it makes sense to organise the treatment of a condition around the relative importance of the aetiological factors involved. Appropriate treatment planning is not determined by the mere assignment of a correct diagnostic label, but rather through an accurate assessment of the relative importance of psychic conflict, unconscious mental processes, conditioned learning, and situational factors contributing to reinforcement or extinction of symptoms. It is clearly just as insufficient for the dynamic psychotherapist to ignore the rich literature on behavioural learning, as for the behavioural therapist to ignore the manner by which unconscious processes and conflicts shape such learning. There is little doubt that a significant number of failures in behavioural therapy are the result of neglecting to recognise and deal with the unconscious dynamics and transference reactions that have been mobilised in the treatment situation.

It is clear, as well, that adherents of the psychodynamic and behavioural approaches sometimes use different terminology to describe similar concepts. For example, the analytic concept of secondary gain and

THE BEHAVIOURAL CONCEPT OF REINFORCEMENT REFLECT DIFFERENT WAYS OF DESCRIBING ESSENTIALLY SIMILAR PROCESSES THAT ARE INVOLVED IN THE RESISTANCE TO THERAPEUTIC CHANGE. SIMILARLY, THE CONCEPTS OF TRANSFERENCE AND OF CONDITIONED LEARNING BOTH REPRESENT EFFORTS TO DEAL WITH THE PERSISTENCE OF A STEREOTYPED RESPONSE TO INTER-PERSONAL STIMULI, ALTHOUGH IN VERY DIFFERENT TERMS. THIS IS NOT TO IMPLY THAT THERE ARE NO IMPORTANT DIFFERENCES BETWEEN PSYCHODYNAMIC THEORY AND BEHAVIOURAL THEORY, OR IN THE BASIC PSYCHO-THERAPEUTIC STANCES THAT ARE DERIVED FROM THESE THEORETICAL DIFFERENCES. DESPITE THESE DIFFERENCES, HOWEVER, THERE IS EVIDENCE THAT IN A WIDE VARIETY OF CLINICAL SITUATIONS THE PSYCHODYNAMIC AND BEHAVIOURAL APPROACHES ARE NEITHER CONTRADICTORY NOR ANTITHETICAL BUT, RATHER, ARE COMPLEMENTARY. FOR THIS REASON THERE ARE OFTEN SITUATIONS WHERE AN INTEGRATION OF THESE TWO APPROACHES TENDS TO ENHANCE THE CLINICAL EFFECTIVENESS OF EITHER APPROACH USED ALONE. FOR EXAMPLE, SYMPTOM REMOVAL DOES NOT NECESSARILY LEAD TO SYMPTOM SUBSTITUTION. OFTEN IT MAY BRING INTO AWARENESS PREVIOUSLY REPRESSED MATERIAL, AND THUS MAKE UNDERLYING CONFLICTS MORE ACCESSIBLE TO DYNAMIC INTERVENTION. THUS, INSIGHT MAY FOLLOW RATHER THAN PRECEDE THE RESOLUTION OF SYMPTOMS, AND THIS IN TURN MAY FACILITATE DYNAMIC PSYCHOTHERAPY. IT ALSO APPEARS NOW THAT THE WIDELY FEARED CONSEQUENCES OF SPLIT TRANSFERENCE OR DISRUPTIVE ACTING OUT DID NOT BECOME UNMANAGEABLE IN MOST CASES WHEN DIFFERENT THERAPISTS HAVE BEEN USED. THERE IS ALSO SOME EVIDENCE THAT A COMBINED PSYCHODYNAMIC AND BEHAVIOURAL APPROACH IN THE TREATMENT OF COUPLES AND IN GROUP THERAPY HAS BEEN HELPFUL. THE UTILISATION OF SUCH A COMBINED APPROACH HAS PROBABLY ACHIEVED ITS WIDEST ACCEPTANCE IN THE AREA OF THE TREATMENT OF SEXUAL DYSFUNCTION, THAT IS, IN SEX THERAPY. IT IS USUALLY INFLEXIBILITY IN THE



PRACTITIONER, RATHER THAN ANY INHERENT INFLEXIBILITY IN THEORY, WHICH EXPLAINS RESISTANCE TO THE EVOLUTION OF NEW CLINICAL TECHNIQUES. NOWHERE IS THIS MORE APPARENT THAN IN THE AREAS OF PSYCHODYNAMIC AND BEHAVIOURAL THEORY, WHICH ARE NOT MERELY OPEN SYSTEMS, BUT SIGNIFICANT AND COMPLEMENTARY APPROACHES TO THE COMPLEX PROBLEMS OF PERSONALITY DEVELOPMENT AND ADAPTATION.

IN THE COURSE OF PSYCHIATRIC, PSYCHOLOGICAL AND SOCIAL WORK TRAINING AND PRACTICE, OUR PROFESSIONAL IDENTITIES BECOME SO INTIMATELY LINKED TO WHAT WE HAVE LEARNED AND HOW WE PRACTISE THAT WE ARE PRONE TO EXTOL UNCRITICALLY THE VIRTUES OF OUR OWN TECHNIQUES, AND TO DEPRECIATE THOSE TECHNIQUES THAT ARE DIFFERENT. THE DIALOGUE THAT HAS GONE ON BETWEEN MOST BEHAVIOUR THERAPISTS AND DYNAMIC PSYCHOTHERAPISTS HAS BEEN MARRED BY THIS KIND OF BIAS, AND CLAIMS AS WELL AS ATTACKS HAVE BEEN MADE ON BOTH SIDES THAT ARE EXAGGERATED AND UNTENABLE. SCIENCE IS NOT SERVED BY SUCH EMOTIONAL POLEMICS, BUT RATHER BY OBJECTIVE EFFORTS TO EVALUATE AND EXTEND OUR KNOWLEDGE, (MARMOR, 1971).

PART OF THE CONFUSION THAT EXISTS IN DISCUSSING THESE TWO BASIC APPROACHES TO THERAPY IS THAT THEY ARE OFTEN DEALT WITH AS THOUGH EACH GROUP REPRESENTS A DISTINCT ENTITY WHEN, IN FACT, THEY ARE ANYTHING BUT MONOLITHIC.

AT ONE END OF EACH SPECTRUM THE THEORIES OF BEHAVIOURAL AND DYNAMIC PSYCHOTHERAPISTS TEND TO CONVERGE, WHILE AT THE OTHER END THEIR DIVERGENCE IS VERY GREAT. IT IS BECAUSE ADHERENTS OF THESE TWO APPROACHES TEND TO DEFINE EACH OTHER STEREOTYPICALLY IN TERMS OF THEIR EXTREMES, THAT SO MUCH MISUNDERSTANDING AND HEAT IS OFTEN GENERATED BETWEEN THEM.

It is of interest that Masters and Johnson (1965) were acutely aware of psychodynamic factors in the sexual behaviour of their couples. In their preliminary interviews, they carefully assessed and evaluated the importance of these factors, and if they considered the neurotic components or inter-personal difficulties to be too great, they would refuse to proceed with their method and refer the couples back to their physicians for individual or marital therapy.

The fact also that Masters and Johnson (1965) insist that the therapeutic team consist of a man and a woman reveals their sensitivity to the transference implications of their relationship to their couples. They function as a sexually permissive and empathic mother surrogate and father surrogate, who offer not only valuable technical advice and suggestions concerning sexual behaviour, but also a compassion and understanding that constitute a corrective emotional experience for their patients.

Marks and Gelder (1966), among others, have demonstrated that the use of both behaviour therapy and dynamic therapy in the same patient, either concurrently or in sequence, often brings about better therapeutic results than the standard use of either approach alone. Indeed, many dynamic psychotherapists have for years been unwittingly using such a combination of approaches when they prescribe drugs for the direct control of certain symptoms, while concurrently pursuing a psychotherapeutic approach. For example, I have observed a patient decide that he needed psychoanalysis following being successfully treated with behaviour therapy.



The behaviour therapies and dynamic psychotherapies, far from being irreconcilable, are complementary psychotherapeutic approaches. The line of demarcation between them is by no means a sharp one. Behaviour therapists do many things in the course of their conditioning procedures that duplicate the activities of dynamic psychotherapists. There is an overlap between dynamic psychotherapy and behaviour therapy in terms of:-

1 Discussions with a non-judgmental listener, and the development of an understanding of the patient's personality and background;

2 Explanation of techniques and of the unadaptiveness of anxieties and symptoms;

3 Situational factors;

4 Secondary gain, reinforcement and resistance;

5 Empathic concern of therapist;

6 Respect for patient;

7 Realistic hopefulness of therapist;

8 Reliability of therapist;

9 Strength (not rigidity) of therapist;

10 Relaxation;

11 Treatment alliance;

12 Working through;

13 Provision of a secure base and trusting relationship;

14 Confrontation of anxiety, for example, phobia;

15 Corrective emotional experience;

16 Negative therapeutic reaction, for example, patient not getting better because symptoms are absorbing unconscious guilt;

17 Transference - interpreted in analytic psychotherapy. Not interpreted in behaviour therapy;

18 Countertransference - therapist's neurotic features which interfere with professional attitude and treatment process;

19 Fear of change in the patient;

20 Acting out of earlier infantile states and impulses;

21 Repeatedly working through and unlearning of a neurotic solution.

The process in both approaches is best explicated in terms of current theories of learning which go beyond simple conditioning explanations and encompass central cognitive processes also. The fact that in some disorders one or other approach may be more



effective is no surprise, and presents no contradiction. Just as there is no single best way of teaching all pupils all subjects, there is no single psychotherapeutic technique that is optimum for all patients and all psychiatric disorders.

It was noted even in 1969 that behaviour therapists were beginning to treat a broader spectrum of more difficult patients, for example, complex psychoneurotic problems, character neuroses, and borderline psychotic problems, with the result that their treatment procedures were becoming longer and more complicated, with concomitant lowering of success rates.

It is also interesting to realise that many of the earlier behaviour therapists, in America particularly, had considerable knowledge of the psychoanalytic principles and techniques before they got involved in strictly behaviour therapy. They continued to use their earlier knowledge, often unconsciously. One could see this in the way they selected patients' relevant hierarchies. One could also see how Wolpe (1958) and his associates made very effective use of the patient/therapist relationship to establish the context in which the specific behavioural techniques could be used most effectively. Although the behaviour therapists did not wish to ascribe their results to any dynamic theories they had learned in the past, it was clear that many of the clinical decisions and treatments were based on an understanding of some functional organisation of behaviour, and an appreciation of the power of the relationship. It is clear, as well, that patient factors far outweigh therapist and technical factors in terms of effectiveness. The danger for new training programmes at this

TIME IS THAT THE TRAINEES WILL BE EXPOSED ONLY TO LEARNING THEORY AND BEHAVIOURAL TECHNIQUES, WITHOUT HAVING BEEN TRAINED IN OTHER AREAS OF PSYCHOLOGY. THIS COULD HAVE LED, AND I THINK MAY LEAD, TO SOME TRAININGS BECOMING ONESIDED. I THINK THIS IS WHAT HAS HAPPENED, UNFORTUNATELY, IN SOME DEPARTMENTS OF PSYCHOLOGY IN THIS COUNTRY.

THE COMBINED APPROACH TO PSYCHOTHERAPY OCCURS WHEN THE BEHAVIOUR THERAPIST AND THE PSYCHOANALYST COLLABORATE IN TREATMENT. THE INTEGRATED APPROACH TO PSYCHOTHERAPY TAKES PLACE WHEN A SINGLE THERAPIST INTEGRATES WITHIN HIS OWN CLINICAL APPROACH BEHAVIOURAL AND PSYCHOANALYTIC PRINCIPLES. THE THERAPIST ATTEMPTS TO DIRECT THE COGNITIVE CONTEXT OF WHAT HE SAYS TOWARDS INSIGHT, WHILE SIMULTANEOUSLY MANAGING TO KEEP THE BEHAVIOUR VALENCE (REINFORCEMENT) AND TIMING (CONTINGENCIES) OF HIS THERAPEUTIC INTERACTIONS CONSONANT WITH THE PLANNED BEHAVIOURAL ANALYSIS, AND HE CAN THEREFORE EFFECT BEHAVIOURAL CHANGE AND FUNCTION SIMULTANEOUSLY AS A BEHAVIOUR THERAPIST AND AN ANALYTIC THERAPIST, (BIRK, L., BRINKLEY-BIRK, A. M. 1974).

AS FAR AS COMBINED TREATMENT IS CONCERNED, SOME THERAPISTS HAVE FOUND THIS TO BE SYNERGISTIC, WITH BEHAVIOUR THERAPY INITIATING CHANGE AND ANALYTIC PSYCHOTHERAPY FUNCTIONING TO MAKE IT MORE PERMANENT. THERE IS ALSO SOME EVIDENCE FOR BEHAVIOUR THERAPY FOR A SPECIFIC SYMPTOM FACILITATING THE DEVELOPMENT OF TRANSFERENCE REACTIONS AND INSIGHTS TO MATERIAL PREVIOUSLY BOUND BY THE SYMPTOM, (SEAGRAVE, 1976). IN COMBINED TREATMENT ATTENTION MUST BE PAID TO COMPETITION BETWEEN THERAPISTS.

IN THE 1980'S THERE HAS BEEN, INCREASINGLY, INTEREST IN THE USE OF DRUGS AND PSYCHOTHERAPY. THE



GAP BETWEEN THE TWO MODALITIES HAS BEEN SLOWLY CLOSING IN RECENT YEARS. IT IS BEING INCREASINGLY SUGGESTED THAT, IN THE BEST OF ALL PSYCHOPHARMACOTHERAPY WORLDS, PSYCHOTHERAPY AND PHARMACOTHERAPY WOULD HAVE A CO-OPERATIVE RATHER THAN A COMPETITIVE OR AN INCONSEQUENTIAL INTERACTION, AN ADDITIVE OR EVEN MUTUALLY POTENTIATING RELATION. IDEALLY, THEN, PSYCHOTHERAPY AND PHARMACOTHERAPY WOULD WORK BOTH SEPARATELY AND SEQUENTIALLY IN A TOTAL THERAPEUTIC REGIME.

EACH WOULD HAVE DIFFERENTIAL EFFECTS OR LOCI OF OUTCOME - DRUGS HAVE THEIR MAJOR EFFECTS ON SYMPTOM FORMATION AND AFFECTIVE DISTRESS, WHEREAS PSYCHOTHERAPY MORE DIRECTLY INFLUENCES INTER-PERSONAL RELATIONS AND SOCIAL ADJUSTMENT.

EACH IS ACTIVATED AND SUSTAINED ON A DIFFERENT TIME SCHEDULE: DRUGS MAY TAKE EFFECT SOONER, BE OF SHORTER DURATION, AND BE USED PROPHYLACTICALLY; PSYCHOTHERAPY RESULTS MAY NOT REVEAL THEMSELVES UNTIL LATER, BUT THEY LAST LONGER, AS IS SHOWN FROM SOME OF THE RESEARCH.

THUS, FOR EXAMPLE, IN CLINICAL PRACTICE SYMPTOM REMOVAL OR RELIEF, BY THUS LAYING THE GROUNDWORK FOR THE FACILITATION OF INTER-PERSONAL ACCESSIBILITY, DRUGS CAN SERVE BOTH AS A PREREQUISITE AND A CONTINUING CONDITION FOR THE ESTABLISHMENT OF A THERAPEUTIC RELATIONSHIP AND, THEREAFTER, FOR ONGOING PSYCHOTHERAPEUTIC INTERVENTIONS. ANNA FREUD HAS SAID THAT SHE COULD NOT HAVE TREATED CERTAIN PATIENTS WITHOUT THE HELP OF DRUGS PRESCRIBED BY A PSYCHIATRIST. IN SOME SITUATIONS THERE ARE ALTERNATIVE TREATMENTS AVAILABLE, AND IT IS IMPORTANT TO DISCUSS THESE WITH PATIENTS AND FAMILIES, WHETHER ANALYTIC PSYCHOTHERAPY, BEHAVIOUR

THERAPY OR PHARMACOTHERAPY. IF THE TREATMENT MODE IS ACCEPTABLE TO THEM, IT IS MORE LIKELY TO BE EFFECTIVE.

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# THE EFFECTIVENESS OF PSYCHOANALYTICAL PSYCHOTHERAPY: COMPARISON OF GROUP AND INDIVIDUAL TREATMENTS.

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## SUMMARY


THE EFFECTIVENESS OF PSYCHOTHERAPY IS A MUCH DEBATED AND CONTROVERSIAL ISSUE. STUDIES ARE BESET WITH METHODOLOGICAL PROBLEMS AND OUTCOME CRITERIA ILL-DEFINED. USING THE GENERAL HEALTH QUESTIONNAIRE-30 (GOLDBERG), A SELF-REPORT QUESTIONNAIRE, WE FOUND THAT PSYCHOANALYTICAL PSYCHOTHERAPY AS CONDUCTED BY TRAINEES WAS EFFECTIVE ($p = 0.009$) BUT THAT NO DIFFERENCE WAS FOUND BETWEEN INDIVIDUAL AND GROUP TREATMENTS IN TERMS OF DEGREE OF IMPROVEMENT.

THE OVERALL EFFECT SIZE WAS 1.29 (I 1.52) STANDARD DEVIATION UNITS. THOSE IN INDIVIDUAL THERAPY TENDED TO HAVE INTRAPERSONAL GOALS, WHEREAS THE PATIENTS IN GROUP THERAPY HAD INTERPERSONAL GOALS AS THEIR PRIORITY, AS MEASURED BY THE SELF-DEVELOPMENT PROJECT LIST-90, A NEW INSTRUMENT DEVISED IN NORWAY TO MEASURE INDIVIDUALISED OUTCOMES. THERAPISTS' RATINGS CORRELATED MODERATELY WELL WITH THE PATIENTS' SELF-RATINGS.


## INTRODUCTION

SINCE EYSENCK'S FAMOUS CHARGE IN 1952 THAT PSYCHOANALYTICAL PSYCHOTHERAPY HAD NO VALUE,

RESEARCHERS IN PSYCHOTHERAPY HAVE RALLIED TO REFUTE HIS CLAIM. NUMEROUS STUDIES, BOTH OF OUTCOME AND PROCESS, HAVE BEEN CONDUCTED. HOWEVER, WITH SUCH DIVERSE SCHOOLS OF PSYCHOTHERAPY, RANGING FROM ANALYTICAL TO COGNITIVE TO BEHAVIOURAL, COMPARABILITY OF STUDIES HAS BEEN A MAJOR PROBLEM. DUE TO THE COMPLEXITY OF THE HUMAN INDIVIDUAL, OUTCOME CRITERIA HAVE BEEN ILL-DEFINED AND STUDIES ARE BESET WITH METHODOLOGICAL PROBLEMS. THE ADVENT OF META-ANALYSIS, A STATISTICAL TECHNIQUE TO ASSESS COMBINED RESULTS OF LARGE NUMBERS OF STUDIES, HAS MOVED FORWARD THE FRONTIER OF RESEARCH. MANY QUESTIONS, THOUGH, REMAIN UNANSWERED. THE PURPOSE OF THIS STUDY WAS TO DISCOVER IF PSYCHOANALYTICAL PSYCHOTHERAPY WAS EFFECTIVE AND, IF SO, WHETHER INDIVIDUAL THERAPY WAS BETTER THAN GROUP THERAPY. WE ALSO COMPARED CLIENT OUTCOME RATINGS WITH THERAPIST RATINGS, AND EVALUATED THEIR CONCURRENCE. WE DID NOT ATTEMPT TO PRODUCE A RANDOMISED, CONTROLLED STUDY OF HOMOGENEOUS CLIENTS, WITH IDENTICAL CONDITIONS, UNDERGOING IDENTICAL TREATMENTS, AS THIS SITUATION DOES NOT PERTAIN IN CLINICAL PRACTICE.

INSTEAD, NOTING ALL THE SHORTCOMINGS IN OUR HEALTH-CARE SERVICE, WE HAVE TRIED TO EVALUATE WHAT ACTUALLY HAPPENS TO THE PATIENTS TREATED BY US WITH PSYCHOANALYTICAL PSYCHOTHERAPY.

## METHODS

### THE THERAPISTS AND THEIR SUPERVISION

ALL OF THE THERAPISTS IN THE STUDY WERE TRAINEES ATTENDING A TWO YEAR MASTERS COURSE IN PSYCHOTHERAPY. FIVE TRAINEES IN INDIVIDUAL AND ONE TRAINEE IN GROUP



PSYCHOANALYTICAL PSYCHOTHERAPY PARTICIPATED IN THE STUDY. DEMOGRAPHIC DATA WAS COLLECTED, INCLUDING AGE, SEX, QUALIFICATIONS, PREVIOUS PERSONAL PSYCHOTHERAPY AND PREVIOUS SUPERVISION, FROM EACH TRAINEE. OF THE FIVE TRAINEES IN INDIVIDUAL PSYCHOTHERAPY, TWO WERE DOCTORS, TWO WERE SOCIAL WORKERS AND ONE WAS A PRIEST WITH A MA DEGREE. THE MEAN AGE WAS 38 YEARS (RANGE 30 - 47). THE PRIEST AND ONE OF THE DOCTORS WERE MALE AND THE OTHER THREE TRAINEES FEMALE. FOUR HAD NO PREVIOUS EXPERIENCE OF PSYCHOTHERAPY, BUT ONE HAD BEEN IN PSYCHOTHERAPY FOR THREE YEARS AND HAD BEEN SUPERVISED OVER THE SAME PERIOD OF TIME. PARTICIPATION IN THE COURSE NECESSITATED EACH TRAINEE TAKING ON SEVERAL CLIENTS FOR INDIVIDUAL PSYCHOANALYTICAL PSYCHOTHERAPY. THE TRAINEE HAD TO UNDERGO A PERSONAL PSYCHOTHERAPY ALSO, AND HAD TO MEET HIS SUPERVISOR ON A WEEKLY BASIS.

THE COURSE WAS BROAD-BASED, AND INCLUDED BOTH THEORETICAL AND CLINICAL INPUT. FREUDIAN AND KLEINIAN THEORIES WERE GIVEN SPECIAL PROMINENCE. THE TRAINEE IN THE GROUP PSYCHOANALYTICAL PSYCHOTHERAPY COURSE WAS A MALE DOCTOR, AGED 32, WITH NO PREVIOUS TRAINING OR SUPERVISION IN PSYCHOTHERAPY. HE DID NOT UNDERGO PERSONAL PSYCHOTHERAPY. THE GROUP PSYCHOANALYTICAL PSYCHOTHERAPY COURSE IS A FIVE YEAR COURSE HELD OVER WEEKENDS DURING THE ACADEMIC YEAR. THE TRAINEE WAS IN HIS FIRST YEAR, AND HAD REGULAR SUPERVISION BY A FULLY QUALIFIED GROUP PSYCHOANALYST.

### THE PATIENTS' CHARACTERISTICS

SIXTEEN PATIENTS PARTICIPATED IN THE STUDY, TEN IN THE GROUP AND SIX IN INDIVIDUAL THERAPY. ALL WERE OUT-PATIENTS. ALL OF THE PATIENTS IN INDIVIDUAL THERAPY WERE REFERRED FOR PSYCHOANALYTICAL PSYCHOTHERAPY BY A

CONSULTANT PSYCHIATRIST ATTACHED TO THE DEPARTMENT OF PSYCHIATRY IN A GENERAL HOSPITAL. ALL OF THE PATIENTS IN THE GROUP WERE REFERRED BY EITHER A CONSULTANT PSYCHIATRIST OR BY A REGISTRAR IN PSYCHIATRY. THE PATIENTS WERE ATTENDING A COMMUNITY-BASED PSYCHIATRIC SERVICE WHICH HAS APPROXIMATELY THE SAME CATCHMENT AREA AS THE GENERAL HOSPITAL. ALL TEN PATIENTS WERE PUBLIC PATIENTS. EACH WAS INTERVIEWED BY THE TRAINEE IN GROUP PSYCHOTHERAPY TO ENSURE THEIR SUITABILITY FOR THE GROUP. DEMOGRAPHIC DATA, INCLUDING AGE, SEX, MARITAL STATUS, EDUCATION, OCCUPATION, DURATION OF PRESENTING COMPLAINT, PAST PSYCHIATRIC HISTORY AND MEDICATION, WERE RECORDED. DIAGNOSIS AS MADE BY THE REFERRING CONSULTANT OR REGISTRAR WAS BASED ON THE INTERNATIONAL CLASSIFICATION OF DISEASES-9 (ICD-9) CRITERIA (1978). REGARDING THE SIX PATIENTS TREATED INDIVIDUALLY, THE MEAN AGE WAS 29.8 YEARS (RANGE 16 - 41). THREE (50%) WERE MALE AND 3 (50%) WERE FEMALE; 5 (83%) WERE SINGLE AND 1 (17%) MARRIED.

EDUCATION AND OCCUPATION ARE SHOWN ON TABLE 1. THREE PATIENTS (50%) COMPLETED SECONDARY EDUCATION AND THREE PATIENTS (33.3%) COMPLETED UNIVERSITY EDUCATION. THREE (50%) WERE EMPLOYED, 2 (33.3%) WERE UNEMPLOYED AND 1 (16.7%) WAS A STUDENT. THE MEAN DURATION OF PRESENTING COMPLAINT WAS 6.3 YEARS (RANGE 9 MONTHS TO 20 YEARS) INDICATING THE CHRONIC NATURE OF THEIR ILLNESSES. FOUR (66.7%) ACKNOWLEDGED A PAST PSYCHIATRIC HISTORY AND 2 (33.3%) WERE ON PSYCHOTROPHIC MEDICATION. DIAGNOSES ARE SHOWN IN TABLE 2.



Table 1.

EDUCATIONAL STATUS AND OCCUPATION/EMPLOYMENT

EDUCATION

| | No Formal | Primary | Intermediate | Leaving | Third Level |
|---|---|---|---|---|---|
| Individual (n = 6) | | 1 | 2 | 1 | 2 |
| Group (n = 10) | 1 | 2 | 1 | 3 | 3 |

OCCUPATION/EMPLOYMENT

| | Employed | Unemployed | Housewife | Student |
|---|---|---|---|---|
| Individual (n = 6) | 3 | 2 | 0 | 1 |
| Group (n = 10) | 6 | 3 | 1 | |

Table 2.

DIAGNOSES: ICD-9 (+ Borderline Personality Disorder)

| | | |
|---|---|---|
| INDIVIDUAL: (n = 6) | Subject 1 | Neurotic Depression |
| | 2 | Neurotic Depression and Childhood Sexual Abuse |
| | 3 | Alcohol Dependency |
| | 4 | Adjustment Reaction |
| | 5 | Neurotic Depression and Obsessional Personality Disorder |
| | 6 | Depressive Personality Disorder |
| GROUP: (n = 10) | Subject 1 | Neurotic Depression |
| | 2 | Neurasthenia |
| | 3 | Schizophrenia |
| | 4 | Neurotic Depression |
| | 5 | Anxiety Neurosis |
| | 6 | Neurotic Depression |
| | 7 | Neurotic Depression |
| | 8 | Hysterical Personality Disorder |
| | 9 | Neurotic Depression |
| | 10 | Borderline Personality Disorder |



Regarding the ten patients in the group, the mean age was 36.4 years (range 24 - 48). Four (40%) were male, and six (50%) were female. Five (50%) were married and five (50%) single. The education and occupation profiles are also shown on Table 1. Six (60%) completed secondary education and three (30%) completed university education. Six (60%) were employed and three (30%) unemployed. One (10%) was a housewife. The mean duration of complaint was 7.48 years (range 2 months to 16 years), again indicating the chronicity of their complaints. Eight (80%) had a past psychiatric history and eight (80%) were on psychotrophic medication. A list of diagnoses based on ICD-9 is on Table 2.

## The Therapeutic Method

The therapeutic method employed by the trainees was psychoanalytical psychotherapy. In the individual cases, the therapists adopted the classical stance of evenly-suspended attention, maintaining an opaque facade. The golden rule of "Free Association" was adhered to (Freud 1916, 1933) and emphasis was placed on interpreting the resistance and the transference. Dream interpretation (Freud 1900), the "Royal Road to the Unconscious" and parapraxes were highlighted, and the overall goal was to make the unconscious conscious. Sessions lasted for 50 minutes and occurred on a weekly basis, at the same time and at the same place. The same principles applied to the group setting, although the sessions were longer, lasting 90 minutes each. In order to validate the treatment and to ensure its integrity, a transcript was made by each trainee of a session with a client. A tape recording was also made of a group session and a supervisor (M. F.) assessed

BOTH THE TRANSCRIPTS AND THE RECORDING. THE FACT THAT ALL THE THERAPISTS WERE TRAINEES, ATTENDING THEIR SUPERVISORS REGULARLY, ALSO ENSURED THE INTEGRITY OF THE TREATMENT.

THE GROUP WAS HELD ON A WEEKLY BASIS OVER A SIX MONTH PERIOD. EACH PATIENT WAS INFORMED OF THE DURATION OF THE GROUP BEFORE THEY STARTED, AND THE METHOD OF PSYCHOANALYTICAL PSYCHOTHERAPY WAS EXPLAINED TO THEM. THE PATIENTS IN INDIVIDUAL THERAPY WERE TOLD, EITHER BEFORE THEY STARTED TREATMENT OR JUST AFTER STARTING, ABOUT THE STUDY. THEY WERE TOLD THAT AN ASSESSMENT WOULD BE PERFORMED AFTER THREE AND SIX MONTHS' THERAPY. THE DURATION OF THEIR THERAPY WAS AN ISSUE, HOWEVER, BETWEEN THEMSELVES AND THEIR THERAPIST, AND IT DID NOT HAVE TO TERMINATE AFTER THE SIX-MONTH ASSESSMENT.

## THE HYPOTHESIS

WORKING IN THE CLINICAL SPHERE, WITH THE CONSTRAINTS OF SMALL NUMBERS, DEPENDENCY ON OTHERS FOR REFERRALS, AND THE INHERENT COMPLEXITY OF THE PROBLEMS BROUGHT BY PATIENTS TO THERAPISTS, WE WERE NOT ABLE TO ADHERE TO THE CLASSICAL RESEARCH DESIGN OF STANDARD CLINICAL TRIALS. INSTEAD, WE PROPOSED TO INVESTIGATE WHETHER THE ACTUAL PATIENTS WE WERE REFERRED AND WHOM WE WERE TREATING WITH PSYCHOANALYTICAL PSYCHOTHERAPY IMPROVED OR NOT. MINDFUL OF THE OBVIOUS DEFICIENCIES IN OUR APPROACH, WE DECIDED TO ASSESS PATIENTS AFTER OBTAINING THEIR CONSENT, EITHER BEFORE TREATMENT OR JUST AFTER IT HAD COMMENCED, AT THREE MONTHS AND AT SIX MONTHS. EVEN IF A PATIENT DROPPED OUT, HE WAS ASKED TO COMPLETE THE ASSESSMENTS. DUE TO THE FACT THAT THE PATIENTS WERE COMPLETING SERIAL QUESTIONNAIRES, WE FELT THAT THEY



WERE FUNCTIONING AS THEIR OWN CONTROL GROUP AND NO SPECIFIC NON-TREATMENT GROUP WAS INCLUDED. WE ALSO WISHED TO DISCOVER WHETHER ANY DIFFERENCES WOULD EMERGE BETWEEN THE OUTCOMES OF THOSE TREATED INDIVIDUALLY AND THOSE TREATED IN A GROUP. STANDARD STATISTICAL METHODS WERE EMPLOYED AFTER THE DATA WERE COLLECTED.

## INSTRUMENTS

IN ORDER TO EVALUATE OUTCOME, WE DECIDED TO USE TWO DIFFERENT INSTRUMENTS. TO MEASURE THE PATIENTS' SYMPTOMS OR PSYCHOPATHOLOGY, WE DECIDED TO USE THE GENERAL HEALTH QUESTIONNAIRE-30 (GOLDBERG, 1972). TO ASSESS POSITIVE GOAL ATTAINMENT, WE USED A NEW INSTRUMENT, THE SELF-DEVELOPMENT PROJECT LIST-90, DEVISED BY PROFESSOR LEIF J. BRAATEN IN OSLO, NORWAY.

THE GHQ-30 WAS DEVISED BY PROFESSOR GOLDBERG IN 1972, AND IS NOW THE INSTRUMENT OF CHOICE FOR SCREENING PSYCHIATRIC DISORDER IN PATIENT AND COMMUNITY SAMPLES, (HUPPERT, 1989). IT HAS BEEN USED EXTENSIVELY BOTH IN VARIOUS CULTURES AND DIFFERENT LINGUISTIC GROUPS (CHAN AND CHAN, 1983; HODIAMONT, 1986). IT IS A SELF-REPORT QUESTIONNAIRE, AND THERE ARE 60, 30, 28 AND 20-ITEM VERSIONS. IN THE 30-ITEM VERSION, A PATIENT CAN SCORE BETWEEN 0 AND 30, WITH A SCORE GREATER THAN 5 INDICATING SIGNIFICANT PSYCHOPATHOLOGY. IN HIS ORIGINAL WORK, GOLDBERG FOUND THAT THE TEST-RETEST RELIABILITY OF THE GHQ WAS +0.95. ITS VALIDITY HAS BEEN ESTABLISHED BY NUMEROUS STUDIES (TARNOPOLSKY ET AL., 1979) AND ITS CORRELATIONS WITH CLINICAL ASSESSMENT RANGES FROM +0.71 TO +0.88. FOR THE 30-ITEM VERSION, THE SENSITIVITY AND SPECIFICITY RANGE FROM 75 - 85%, DEPENDING ON THE STUDY. THE QUESTIONNAIRE COVERS SYMPTOMS SUCH AS ANXIETY, DEPRESSION, FEELINGS

OF INCOMPETENCE, DIFFICULTY IN COPING AND SOCIAL DYSFUNCTION.

THE SELF-DEVELOPMENT PROJECT LIST-90 IS THE FRUIT OF TEN YEARS' WORK BY PROFESSOR LEIF J. BRAATEN IN OSLO. RECOGNISING THE NEED FOR AN INSTRUMENT WHICH MEASURED POSITIVE GOAL ATTAINMENT, RATHER THAN PSYCHOPATHOLOGY, HE COLLECTED DATA FROM CLIENTS, AND NOTICED HOW THEY HIGHLIGHTED AREAS OF IMPORTANCE TO THEM, SUCH AS INTIMACY, DEPENDENCY AND ASSERTIVENESS. USING THE SYMPTOM CHECK LIST-90 OF DEROGATIS (1977) AS A MODEL, HE DEVELOPED AN INSTRUMENT CAPABLE OF DETECTING INDIVIDUALISED TARGET GOALS. HIS CONTENTION WAS THAT A PERSON STARTING PSYCHOTHERAPY HAD SEVERAL PRIORITIES OR GOALS. AS THE THERAPY PROGRESSED THE PROBLEMS WERE WORKED THROUGH, AND HENCE THE GOALS CHANGED. WHAT WAS A PRIORITY NO LONGER REMAINED SO. THE SCORING OF HIS INSTRUMENT REFLECTS THIS CHANGE. THE CLIENT CAN GIVE A VALUE BETWEEN 0 AND 4 TO A SPECIFIC GOAL, WITH 0 REPRESENTING NO IMPORTANCE AND 4 EXTREME IMPORTANCE TO HIM. ALTOGETHER, 90 GOALS ARE IDENTIFIED, WHICH AFTER FACTOR ANALYSIS ARE DIVIDED INTO 5 FACTORS, 3 INTERPERSONAL AND 2 INTRAPERSONAL. THE INTERPERSONAL ONES ARE DEPENDENCY, INTIMACY AND SOCIAL ASSERTIVENESS. THE INTRAPERSONAL ONES ARE SELF-INDIVIDUATION AND SELF-ACCEPTANCE.

BY COMPLETING SERIAL ASSESSMENTS, ONE CAN FOLLOW THE CHANGING GOALS OF AN INDIVIDUAL DURING THE COURSE OF THERAPY.

THE RELIABILITY OF THE INSTRUMENT WAS FOUND TO BE + 0.90 IN PROFESSOR BRAATEN'S ORIGINAL WORK. AS THIS IS THE FIRST OCCASION IT HAS BEEN USED IN IRELAND, AND AS IT HAS NOT BEEN WIDELY USED IN THE ENGLISH SPEAKING WORLD, VALIDATION STUDIES HAVE YET TO BE PERFORMED



OUTSIDE NORWAY. THE PROBLEM OF COMPARABILITY EXISTS ALSO, AS THE INSTRUMENT IS INDIVIDUALISED AND, HENCE, STATISTICAL ANALYSIS IS DIFFICULT. DUE TO THE SMALL NUMBERS IN OUR STUDY, WE DID NOT THINK IT APPROPRIATE TO TRY TO STATISTICALLY ANALYSE OUR RESULTS. RATHER, WE HAVE TAKEN EACH CASE IN ITS OWN RIGHT, AND ANALYSED IT SEPARATELY.

THE EFFECTIVENESS OF PSYCHOTHERAPY WAS DETERMINED BY THE STATISTICAL ANALYSIS OF THE CHANGE IN GHQ MEAN SCORES OVER TIME. AS ALREADY DESCRIBED, BOTH THE GHQ AND THE STPL-90 WERE ADMINISTERED TO EACH PATIENT PRE-THERAPY, OR JUST AFTER STARTING THERAPY, AT THREE MONTHS AND AT SIX MONTHS. TWO OF THE PARTICIPANTS IN THE GROUP THERAPY DID NOT COMPLETE THE QUESTIONNAIRE AT THREE MONTHS. ONE HAD DROPPED OUT AT SEVEN WEEKS AND THE OTHER HAD CHANGED ADDRESSES. THE LADY WHO DROPPED OUT AT SEVEN WEEKS WAS NOT INCLUDED FOR STATISTICAL PURPOSES WHEN ASSESSING EFFECTIVENESS OF TREATMENT, AS IT WAS FELT THAT SHE HAD SPENT TOO LITTLE TIME IN THE GROUP FOR ANY MEANINGFUL CONCLUSIONS TO BE DRAWN. BOTH COMPLETED THE ASSESSMENT AT SIX MONTHS, THOUGH. THE ATTRITION RATE WAS RECORDED FOR ALL PATIENTS AND, IN FACT, 50% OF PATIENTS BOTH IN THE GROUP AND IN INDIVIDUAL THERAPY DID NOT COMPLETE SIX MONTHS. FOR STATISTICAL ANALYSIS, THEREFORE, WE DIVIDED OUR SAMPLES INTO THOSE WHO COMPLETED SIX MONTHS AND THOSE WHO DID NOT COMPLETE SIX MONTHS. WE CALCULATED MEAN GHQ SCORES PRE-THERAPY, AT THREE MONTHS AND AT SIX MONTHS, FOR THE TEN PATIENTS IN GROUP THERAPY AND THE SIX PATIENTS IN INDIVIDUAL THERAPY. DIVIDING THE TEN PATIENTS IN GROUP THERAPY INTO THOSE WHO COMPLETED SIX MONTHS AND THOSE WHO DID NOT, WE AGAIN CALCULATED THE MEAN GHQ SCORES PRE-TREATMENT, AT THREE MONTHS AND AT SIX MONTHS. LIKEWISE, FOR THE SIX IN INDIVIDUAL THERAPY, WE SUB-DIVIDED THESE INTO COMPLETED AND UNCOMPLETED SUB-

GROUPS, AND CALCULATED THE MEAN GHQ VALUES AGAIN PRE-THERAPY, AT THREE MONTHS AND AT SIX MONTHS, SEE TABLE 3, BELOW.

Table 3.

GHQ MEAN SCORES (+/- STANDARD DEVIATION)

Pre-therapy, Mid-therapy (3 months), and Post-therapy (6 months)

| | Pre | Mid | Post |
|---|---|---|---|
| Individuals (n = 6) | 12.5 (+/- 4.9) | 5.7 (+/- 6.1) | 5.3 (+/- 4.9) |
| Group (n = 10) | 18.8 (+/- 7.6) | 6.0 (+/- 7.3) | 12.2 (+/- 10.6) |

GHQ MEAN SCORES

Divided into those who completed 6 months and those who terminated prematurely.

| | Completed 6 months | Pre | Mid | Post |
|---|---|---|---|---|
| Individuals (n = 6) | Yes | 10.7 | 9.3 | 4.7 |
| | No | 14.3 | 2.0 | 6.0 |
| Group (n = 10) | Yes | 15.4 | 6.3 | 11.2 |
| | No | 22.2 | 5.8 | 13.2 |



HOWEVER, BECAUSE OF THE ATTRITION RATE, THE SIX-MONTH GHQ VALUES WERE NOT THE END OF TREATMENT SCORES IN 50% OF OUR POPULATION. WE THEREFORE TOOK THE THREE-MONTH SCORE FOR THOSE WHO DROPPED OUT. THE MEAN NUMBER OF WEEKS COMPLETED IN THERAPY FOR THOSE WHO DROPPED OUT WAS 17 (RANGE 14 - 19).

WE USED THE REPEATED MEASURES ANALYSIS OF VARIANCE TO DETERMINE THE EFFICACY OF TREATMENT BASED ON THE MEAN GHQ SCORES. OTHER STATISTICAL METHODS, INCLUDING FISHER'S EXACT TEST, THE CHI-SQUARED TEST, THE T-TEST AND THE MEDIAN TEST, WERE EMPLOYED TO ANALYSE THE DEMOGRAPHIC DATA. WE ALSO CALCULATED THE EFFECT SIZE FOR THE INDIVIDUAL AND GROUP SAMPLES BOTH SEPARATELY AND TOGETHER. THE EFFECT SIZE IS A REFLECTION OF THE MAGNITUDE OF EFFECT OF THERAPY. THE AVERAGE EFFECT SIZE IS 1 STANDARD DEVIATION UNIT, WHICH MEANS THAT AT THE END OF TREATMENT THE AVERAGE TREATED PERSON IS BETTER OFF THAN 80% OF THE UNTREATED SAMPLE, (SMITH AND GLASS, 1977).

BOTH THE GHQ AND SDPL-90 ARE PATIENT RATING ASSESSMENTS, I.E., CONDUCTED BY THE PATIENTS THEMSELVES USING SELF-REPORT QUESTIONNAIRES. WE THOUGHT IT WOULD BE APPROPRIATE TO INCLUDE A THERAPIST'S RATING OF THE PATIENT'S PROGRESS. USING AN ANALOGUE SCALE WITH THE SCORE FROM 0 - 10, WITH 0 AS NO IMPROVEMENT OR A DISIMPROVEMENT AND 10 BACK TO NORMAL, WE ASKED THE THERAPISTS TO RATE THEIR CLIENTS IN TERMS OF SYMPTOM RELIEF, RELATIONSHIPS AND WORK. WE COMPARED THE THERAPIST'S ASSESSMENT WITH THE PATIENT'S OWN GHQ AND SDPL-90 SCORES.

## Results

### Comparability of Two Population Samples

The patients in group therapy and those in individual therapy were not matched before therapy commenced. Each had been referred by psychiatrists for psychoanalytical psychotherapy. On close examination, though, we found that the two samples were, in fact, well matched.

The mean age (+/- SD) of patients in group therapy was 36.4 years (+/- 8.1), and for those in individual therapy was 29.8 (+/- 8.9). Using the t-test, no significant difference was found between the means (p = 1.000).

Using Fisher's Exact Test, because of the small numbers in the study no significant difference was found in the sex distribution (p = 1.000). The ratio of male to female in individual therapy was 1 to 1, whereas in group therapy it was 2 to 3.

Regarding marital status, 5 of the patients in individual therapy were single and 1 was married. Five patients were also single in group therapy, and the remaining 5 were married. No significant difference was found (p = 0.30) using Fisher's Exact Test. Educational Level was divided into 5 sub-divisions, ranging from no formal education to third level.

The results are shown in Table 1. There were too many categories with too few numbers to test for significance. Statistically, the cells with expected frequencies of less than 5 were 87.5%, hence the chi-



squared test was unreliable. Macroscopically, though, one can see that the two samples are very similar. Fifty per cent of the patients in individual therapy had Leaving Certificate or third level education, as opposed to 60% of those in group therapy.

Occupation is recorded on Table 1 also. As with educational level, there were too many categories to test for significance. However, the two samples do appear to be matched, as 50% of the people in individual therapy and 60% of those in group therapy were employed.

There was no statistically significant difference between the two samples concerning psychotrophic medication (p = 0.12). However, more of the group patients were taking medication, which included tricyclic anti-depressents, MAOI's and benzodiazepine. The patient who dropped out of the group after seven weeks was taking both oral and depot phenothiazies and a tricyclic anti-depressent.

The duration of presenting complaint was not normally distributed, and therefore a Median Test was performed. No statistically significant difference was found (p = 0.61). The mean (+/- SD) duration of presenting complaint in the patients receiving individual therapy was 6.29 (+/- 7.4) years and in the group 7.48 (+/- 5.8) years.

Four patients out of the six in individual therapy had a past history of psychiatric illness, whereas the corresponding figure in the group was 8 out of 10. A p value of 0.60 was obtained, using Fisher's Exact Test, thus indicating no significant difference between the samples.

STATISTICALLY, THERE WAS NO DIFFERENCE BETWEEN THE PATIENTS TREATED INDIVIDUALLY AND THOSE TREATED IN THE GROUP CONCERNING AGE, SEX, MARITAL STATUS, MEDICATION, DURATION OF PRESENTING COMPLAINT, OR PRESENCE OF A PAST PSYCHIATRIC HISTORY. STATISTICAL METHODS COULD NOT BE EMPLOYED FOR EDUCATION AND OCCUPATION, DUE TO THE NUMBER OF CATEGORIES AND SMALL NUMBER OF PATIENTS, BUT THE TWO SAMPLES APPEARED TO BE WELL MATCHED.

## ATTRITION RATES

FIGURE 1 DISPLAYS THE ATTRITION RATES FOR BOTH PATIENTS IN INDIVIDUAL AND IN GROUP THERAPY. IN BOTH INSTANCES, 50% OF PATIENTS DROPPED OUT BEFORE THE SIX-MONTH PERIOD EXPIRED. OF THE THREE PEOPLE IN INDIVIDUAL THERAPY WHO DROPPED OUT, TWO DID SO BECAUSE THEY WERE DISSATISFIED WITH THEIR TREATMENT AND ONE BECAUSE SHE FELT BETTER. THE PATIENT WHO FELT BETTER WAS A SIXTEEN-YEAR OLD STUDENT WITH AN ADJUSTMENT REACTION. SHE HAD THE SHORTEST DURATION OF COMPLAINT OF ALL SIX PEOPLE RECEIVING INDIVIDUAL THERAPY. FIVE PATIENTS OUT OF TEN DID NOT COMPLETE THE SIX MONTHS IN THE GROUP THERAPY. TWO LEFT BECAUSE THEY WERE DISSATISFIED, ONE PATIENT GOT A JOB, AND ANOTHER GOT A PLACE ON A NIGHT COURSE WHICH WAS HELD ON THE SAME EVENING AS THE GROUP. THE FIFTH PERSON WAS REFERRED TO A DAY HOSPITAL, AND OF HIS OWN VOLITION STOPPED ATTENDING THE GROUP.

## GHQ RESULTS

AS OUTLINED IN THE SECTION ON METHODS, GHQ SCORES WERE RECORDED PRE-THERAPY, MID AND POST-THERAPY, I.E. AT, OR JUST AFTER THE START OF THERAPY, AT THREE MONTHS AND AT SIX MONTHS. THE MEANS OF THE GHQ SCORES FOR THE



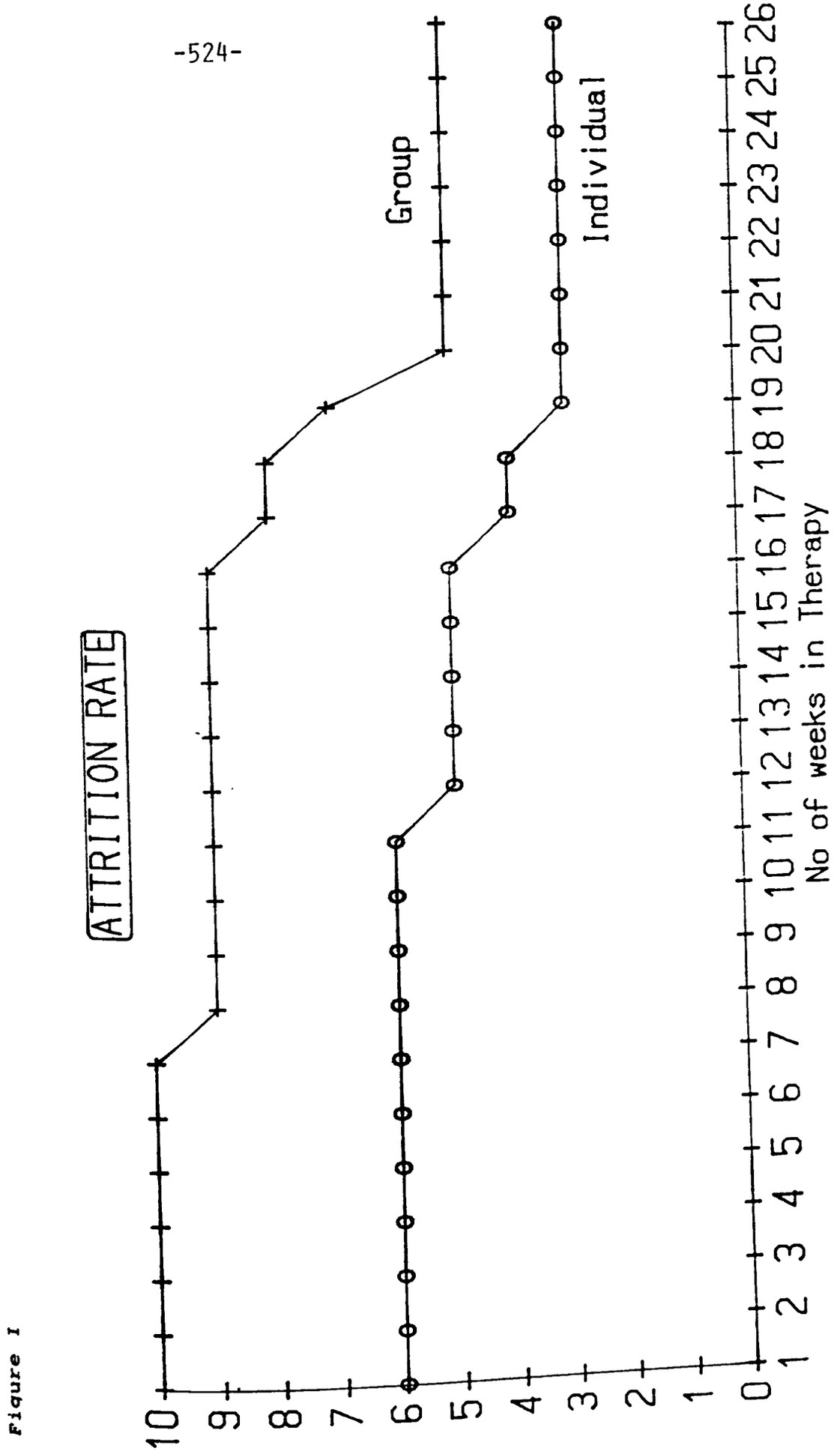



Figure 1

PATIENTS IN INDIVIDUAL AND GROUP THERAPY ARE RECORDED IN TABLE 3. HOWEVER, THERE WAS A 50% ATTRITION RATE. THEREFORE, THE INDIVIDUAL AND GROUP PATIENTS WERE DIVIDED INTO THOSE WHO COMPLETED SIX MONTHS AND THOSE WHO DID NOT. THE MEAN GHQ SCORES FOR THESE ARE ALSO SEEN IN TABLE 3.

FOR THOSE WHO COMPLETED SIX MONTHS' THERAPY, WE TOOK THE POST-TREATMENT GHQ SCORE AS THEIR END OF TREATMENT SCORE. FOR THOSE WHO DID NOT COMPLETE SIX MONTHS, WE TOOK THEIR MID-TREATMENT GHQ SCORE AS THEIR END OF TREATMENT SCORE. IN THIS WAY, WE CALCULATED THE PRE AND END GHQ MEANS FOR THE PATIENTS IN INDIVIDUAL THERAPY AND THOSE IN GROUP THERAPY.

Table 4.

GHQ MEAN SCORES (+/- SD)

Pre and End of Therapy

| | Pre | End | Change |
|---|---|---|---|
| Individual | 12.5 (+/- 4.9) | 3.3 (+/- 4.9) | 9.2 |
| Group | 18.6 (+/- 8.0) | 8.8 (+/- 9.0) | 9.8 |

SUBJECTING THIS DATA TO STATISTICAL ANALYSIS (REPEATED MEASURES ANALYSIS OF VARIANCE), TWO MAIN EFFECTS OF THERAPY EMERGE. FIRSTLY, PATIENTS IMPROVE



WITH PSYCHOTHERAPY AND THE IMPROVEMENT IS STATISTICALLY SIGNIFICANT ($F = 9.44$, $df = 1$, $p = 9.009$).

SECONDLY, PATIENTS IMPROVE REGARDLESS OF THE TYPE OF THERAPY. THE CHANGE IN GHQ MEAN SCORES BETWEEN PRE AND END THERAPY LEVELS ARE VIRTUALLY IDENTICAL FOR PATIENTS IN INDIVIDUAL THERAPY (9.2) AND THOSE IN GROUP THERAPY (9.8). THE DIFFERENCES BETWEEN THERAPIES IS, THEREFORE, NOT STATISTICALLY SIGNIFICANT ($p = 0.923$).

ANOTHER FACT EMERGES FROM OUR DATA. THOSE IN INDIVIDUAL THERAPY CONSISTENTLY SCORED LOWER ON THE GHQ THAN THOSE IN GROUP THERAPY. THIS REACHED STATISTICAL SIGNIFICANCE ($F = 5.82$, $df = 1$, $p = 0.031$). IT AFFIRMS THAT THOSE IN INDIVIDUAL THERAPY HAD LESS PSYCHOPATHOLOGY, BOTH AT THE BEGINNING AND AT THE END OF THE TREATMENT, THAN THOSE IN THE GROUP THERAPY.

THE SDPL-90 ALLOWS INDIVIDUALISED OUTCOME MEASURES TO BE EMPLOYED AND OBSERVED. WE DID NOT SUBJECT ITS RESULTS TO STATISTICAL ANALYSIS, AS WE FELT THAT IT WAS ONLY MEANINGFUL WHEN CONSIDERING THE RESULTS IN THE CONTEXT OF THE SPECIFIC PATIENT INVOLVED. HOWEVER, SOME FACTS DID EMERGE. GIVEN THE THEORY THAT A PATIENT'S PRIORITIES OR GOALS CHANGE DURING PSYCHOTHERAPY AS PROBLEMS ARE WORKED THROUGH, WE LOOKED AT THE PERCENTAGE OF PATIENTS IN INDIVIDUAL THERAPY WHO CHANGED THEIR MAIN GOAL DURING THERAPY, COMPARED WITH THOSE IN GROUP THERAPY. TWO PATIENTS OUT OF SIX (33.3%) IN INDIVIDUAL THERAPY CHANGED THEIR MAIN PRIORITY BETWEEN THE START AND END OF TREATMENT. FOUR OUT OF NINE PATIENTS IN GROUP THERAPY (44.4%) CHANGED THEIR NUMBER 1 PRIORITY OVER THE SAME TIME. THE MOST COMMON PRIORITY OF THE PATIENTS IN INDIVIDUAL THERAPY WAS SELF-ACCEPTANCE (3 OUT OF 6) AND THE LEAST COMMON PRIORITY WAS DEPENDENCY (4 OUT OF 6). REGARDING THE

GROUP, THE MOST COMMON MAIN PRIORITY WAS ASSERTIVENESS (6 OUT OF 10) AND THE LEAST COMMON PRIORITY WAS SELF-ACCEPTANCE (6 OUT OF 10). THE SERIES OF GRAPHS (1 TO 16) DEPICT THE CHANGING SDPL-90 SCORES OVER THE SIX MONTH PERIOD FOR ALL 16 PATIENTS IN THE STUDY.

THE THERAPISTS' RATINGS OF THE PATIENTS' OUTCOMES CONCERNING SYMPTOMATIC IMPROVEMENT, RELATIONSHIPS AND WORK ARE SHOWN IN TABLE 5. COMPARISON OF THESE FIGURES AND THE PATIENTS' RATINGS WILL TAKE PLACE IN THE **DISCUSSION.**

FINALLY, TO MEASURE THE EXTENT OF CHANGE OR THE MAGNITUDE OF THE EFFECT OF TREATMENT, THE EFFECT SIZES WERE CALCULATED. WE CALCULATED THE EFFECT SIZE FOR ALL THE PATIENTS TOGETHER, AND THEN SEPARATELY FOR THOSE IN INDIVIDUAL AND IN GROUP THERAPY. THE OVERALL EFFECT SIZE (+/- SD) WAS 1.29 (+/- 1.52) STANDARD DEVIATION UNITS WITH A RANGE OF - 2.4 TO 2.8. IN FACT, TWELVE OUT OF THE FIFTEEN PATIENTS HAD EFFECT SIZE GREATER THAN 0.5 STANDARD DEVIATION UNITS. THE REMAINING THREE PATIENTS DISIMPROVED WITH THERAPY, AND THEIR EFFECT SIZE WAS LESS THAN 0.5 STANDARD DEVIATION UNITS. FOR THOSE IN INDIVIDUAL THERAPY, THE OVERALL EFFECT SIZE WAS 1.24 STANDARD DEVIATION UNITS, AND FOR THOSE IN GROUP THERAPY IT WAS 1.32 STANDARD DEVIATION UNITS. THERE WAS NO STATISTICALLY SIGNIFICANT DIFFERENCE BETWEEN THEM ($T = 0.1$, $DF = 13$, $P = 9.92$).

## DISCUSSION

HERINK, IN 1980, IDENTIFIED APPROXIMATELY 250 DIFFERENT FORMS OF PSYCHOTHERAPY. WITH SUCH AN ARRAY OF THERAPIES, MORE AND MORE PEOPLE ARE ASKING THE PERTINENT QUESTION ABOUT EFFICACY. THE IMPORTANCE OF



RESEARCH IS THEREFORE UNDERLINED, BUT THE PROBLEMS IN PSYCHOTHERAPY RESEARCH ARE COMPLEX AND DEFINITIVE ANSWERS DIFFICULT TO DISTIL. A FUNDAMENTAL QUESTION CONCERNS THE GOALS OF PSYCHOANALYTICAL PSYCHOTHERAPY. IS IT TO MAKE UNCONSCIOUS PHENOMENA CONSCIOUS AND, IF SO, HOW IS ONE TO MEASURE THAT? IS IT TO PRODUCE SYMPTOM RELIEF AND PERSONALITY CHANGE? HOW SHOULD THAT BE MEASURED? THE INSTRUMENTS AVAILABLE TO US TO MEASURE OUTCOME ARE MANY AND VARIED. BUT THE COMPLEXITY OF THE HUMAN INDIVIDUAL, THE SUBJECT OF OUR RESEARCHES, AND THE DIVERSITY OF CLINICAL SITUATION PRESENTED TO US, CAN BOTH BE DIFFICULT TO ENCAPSULATE, EVEN WITH THE BEST OF INSTRUMENTS.

WE PROPOSE TO FIRST EXAMINE THE RESULTS OF OUR STUDY AND THEN TO TAKE AN OVERVIEW OF THE PROBLEMS ENCOUNTERED IN RESEARCH IN PSYCHOANALYTICAL PSYCHOTHERAPY.

AT THE VERY START OF THIS STUDY, TWO QUESTIONS WERE POSED: WAS PSYCHOTHERAPY EFFECTIVE AND, IF SO, WAS INDIVIDUAL THERAPY BETTER THAN GROUP THERAPY? THE RESULTS OF THIS STUDY SHOW THAT PSYCHOTHERAPY, AS MEASURED BY GHQ MEAN SCORES, **IS** EFFECTIVE IN THE PATIENTS BEING TREATED THERE. THE DIFFERENCE BETWEEN MEAN PRE TREATMENT AND END OF TREATMENT GHQ SCORES REACHED STATISTICAL SIGNIFICANCE ($P = 0.09$). THIS WAS CONFIRMED BY THE FINDING THAT THE EFFECT SIZE WAS 1.29 (+/- 1.52) STANDARD DEVIATION UNITS. SMITH ET AL. (1980) FOUND AN AVERAGE EFFECT SIZE OF 0.85 STANDARD DEVIATION UNITS OVER 475 STUDIES COMPARING TREATED AND UNTREATED GROUPS, WHICH MEANT THAT THE AVERAGE TREATED PERSON WAS BETTER OFF THAN 80% OF THE UNTREATED SAMPLE. THE EFFECT SIZE OF 1.29 IN OUR STUDY COMPARES VERY FAVOURABLY WITH THE AVERAGE EFFECT SIZE OF 0.85 STANDARD DEVIATION UNITS.

Table 5.

THERAPISTS' RATINGS

| | Symptom Improvement | Relationship | Work |
|---|---|---|---|
| INDIVIDUALS: (n = 6) | | | |
| Subject 1 | 6 | 5 | 6 |
| 2 | 8 | 3 | 8 |
| 3 | 4 | 3 | 4 |
| 4 | 5 | 5 | 5 |
| 5 | 6 | 4 | 2 |
| 6 | 1 | 0.5 | 0.5 |
| GROUP: (n = 10) | | | |
| Subject 1 | 3 | 3 | 3 |
| 2 | 8 | 5 | 0 |
| 3 | 0 | 0 | 0 |
| 4 | 4 | 3 | 8 |
| 5 | 0 | 0 | 0 |
| 6 | 7 | 5 | 8 |
| 7 | 0 | 4 | 3 |
| 8 | 8 | 8 | 8 |
| 9 | 5 | 6 | 0 |
| 10 | 0 | 0 | 0 |

Analogue Scale 0 - 10. 0 = No improvement or disimprovement. 10 = Normal.



Did the patients in individual therapy fare better than those in group therapy? From our results, no real difference was found between the effectiveness of either method. Both sets of patients improved and both improved to the same degree, as measured by GHQ mean scores ($p = 0.923$). The effect size results confirmed these findings ($p = 0.92$). This raises the question about differences in therapy and whether all treatments are equally effective. Smith et al. (1980) contend that differences between therapies are slight or nonexistent. Different treatments produce similar outcomes (Sloane et al., 1975). Luborsky's famous "Dodo Bird Verdict" (1975) that "Everyone has won and all must have prizes," seems to be borne out by our results. The psychotherapy was effective but the type of therapy, whether individual or group, was immaterial. Freud (1916) stressed the point that the important ingredients in therapy were from "Strict and Untendentious Psychoanalysis," but Storr (1979) has challenged this contention, and questioned "the pure gold of analysis." He felt that common factors in all psychotherapies were operating to produce a successful outcome and that, with further process research, these factors would be illuminated. Jerome Frank (1961, 1973, 1982) addressed himself to these "common factors." He suggested that therapies produce their effects because they provide:

1 An emotionally charged and confiding relationship;

2 A setting in which patient's expectancies for help, and confidence in the therapist's role as a healer, are strengthened;

3 A RATIONALE OR CONCEPTUAL SCHEME THAT PLAUSIBLY EXPLAINS THE SYMPTOMS AND PRESCRIBES A PROCEDURE FOR THIS RESOLUTION;

4 A SET OF PROCEDURES IN WHICH BOTH PATIENT AND THERAPIST ENGAGE, AND WHICH THEY BELIEVE TO BE A MEANS OF RESTORING THE PATIENT.

THESE "COMMON FACTORS" ARE AT THE CORE OF THE TREATMENT, REGARDLESS OF THE SPECIFIC SCHOOL TO WHICH THE THERAPIST BELONGS. THEY ARE NOT THE ONLY COMMON FACTORS IDENTIFIED, EITHER. THE CLIENT-CENTRED SCHOOL EMPHASISE "ACCURATE EMPATHY, POSITIVE REGARD, NON-POSSESSIVE WARMTH AND GENUINENESS" AS THE IMPORTANT COMMON FACTORS IN PSYCHOTHERAPY, FACTORS WHICH, OF COURSE, ARE OF FUNDAMENTAL IMPORTANCE IN THE FORMATION OF A THERAPEUTIC ALLIANCE. SUFFICE IT TO SAY, AT PRESENT, THAT THE PSYCHOANALYTICAL PSYCHOTHERAPY AS PRACTISED IN THIS STUDY IS EFFECTIVE, BUT THAT WHETHER THIS IS DUE TO THE RESOLUTION OF THE TRANSFERENCE, THE MAKING CONSCIOUS OF UNCONSCIOUS PHENOMENA, OR TO "COMMON FACTORS" IS STILL OPEN TO QUESTION, AND ANY ATTEMPTED ANSWER TO EXPLAIN IMPROVEMENTS IN CLIENTS CAN ONLY BE SPECULATIVE.

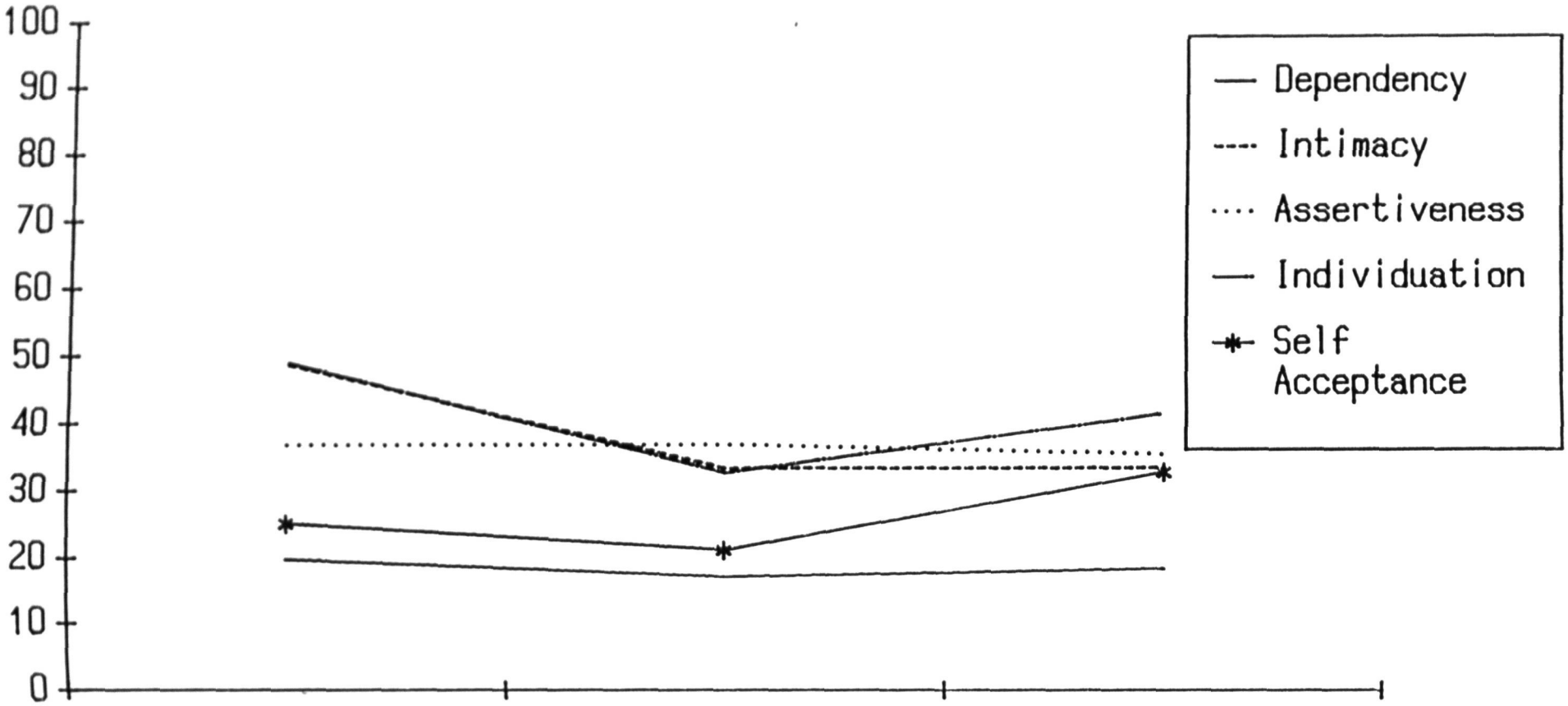
MOVING TO THE QUESTION OF THERAPISTS' RATINGS AND THEIR CONCORDANCE WITH PATIENTS' SELF-RATINGS, A NUMBER OF FACTS EMERGE. MINTZ ET AL. (1973) SHOWED THAT THERE WAS ONLY A MODERATE CORRELATION AT BEST, AND MARTIN AND STERNE (1976) HIGHLIGHTED THE FACT THAT THERAPISTS' RATINGS WERE AFFECTED BY THE DEGREE TO WHICH THEY LIKED THEIR PATIENTS. IF WE CONSIDER THE PATIENTS IN THE GROUP FIRST, AND DIVIDE THEM INTO THOSE WHO COMPLETED THE SIX MONTHS AND THOSE WHO TERMINATED PREMATURELY, WE SEE THAT THREE PATIENTS WHO LEFT THE GROUP EARLY WERE



GIVEN 0 RATING BY THE THERAPISTS IN TERMS OF SYMPTOM IMPROVEMENT, RELATIONSHIPS AND WORK. TWO WERE PATIENTS WHO LEFT THE GROUP BECAUSE THEY WERE DISSATISFIED, AND THE THIRD WAS THE PATIENT WHO WAS REFERRED TO A DAY HOSPITAL. HE HAD COMPLETED 16 WEEKS IN THE GROUP AND HIS GHQ SCORE HAD DROPPED FROM 25 TO 5. OBJECTIVELY, HE HAD MADE PROGRESS IN TERMS OF SYMPTOM RELIEF. IT APPEARS, THEREFORE, THAT THE THERAPIST UNDERESTIMATED HIS IMPROVEMENT, AND SUBJECTIVE FACTORS MAY HAVE INTRODUCED BIAS INTO THEIR SCORING. TURNING TO THOSE WHO COMPLETED SIX MONTHS IN THE GROUP, TWO PATIENTS (SUBJECT 6 AND 9) WHO WERE MUCH IMPROVED ON GHQ SCORES, DROPPING FROM 18 TO 1 AND 22 TO 1 RESPECTIVELY DURING THERAPY, WERE GIVEN SCORES OF 7 AND 5 OUT OF 10 IN TERMS OF SYMPTOMATIC IMPROVEMENT BY THE THERAPISTS, AGAIN ILLUSTRATING AN UNDERESTIMATE OF IMPROVEMENT, ALTHOUGH CORRECTLY IDENTIFYING THE TREND. ONE PATIENT (SUBJECT 7) WHO DISIMPROVED WITH TREATMENT, THE GHQ RISING FROM 9 TO 27, WAS CORRECTLY IDENTIFIED BY THE THERAPISTS AND GIVEN A SYMPTOM IMPROVEMENT SCORE OF 0, INDICATING NO IMPROVEMENT OR A DISIMPROVEMENT.

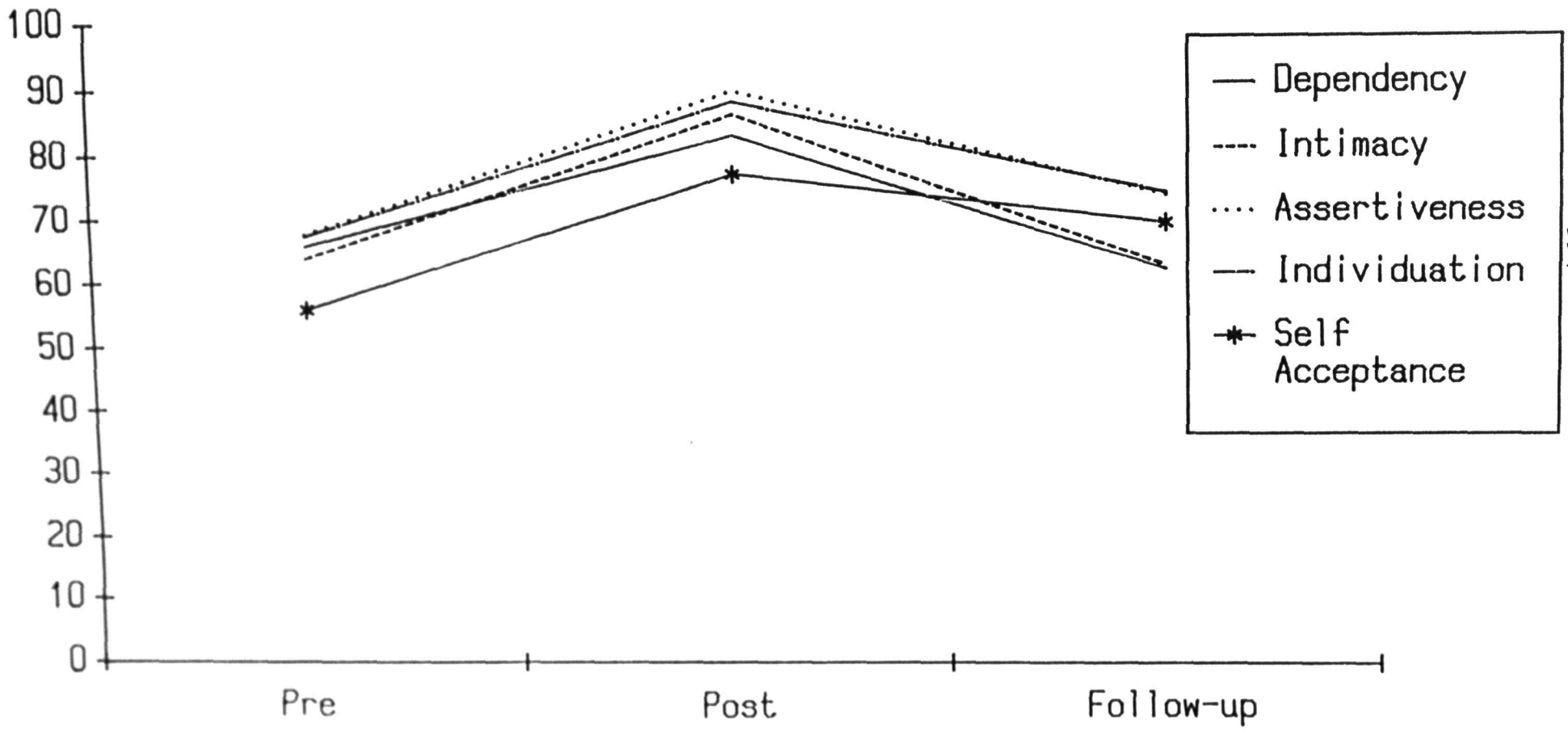
SIMILAR PATTERNS EMERGED IN THE THERAPIST RATINGS OF THOSE IN INDIVIDUAL THERAPY. IMPROVEMENT TRENDS, AS MEASURED BY GHQ SCORES, WERE CORRECTLY IDENTIFIED BY THE THERAPISTS' VALUATIONS. SUBJECT 2, WHOSE GHQ SCORE FELL FROM 14 TO 0 DURING THE SIX-MONTH ASSESSMENT, WAS GIVEN A RATING OF 8 BY HER THERAPIST IN TERMS OF SYMPTOMATIC IMPROVEMENT. THE ONE PATIENT WHO GOT WORSE (SUBJECT 6), WITH THE GHQ RISING FROM 5 TO 13, WAS GIVEN THE SCORE OF 1 IN TERMS OF SYMPTOMATIC IMPROVEMENT, AND 0.5 FOR BOTH RELATIONSHIPS AND WORK. THE THERAPIST HAD CORRECTLY ASCERTAINED THE MAGNITUDE OF THE PATIENT'S DIFFICULTIES.

SUBJECT 1 - Group Therapy

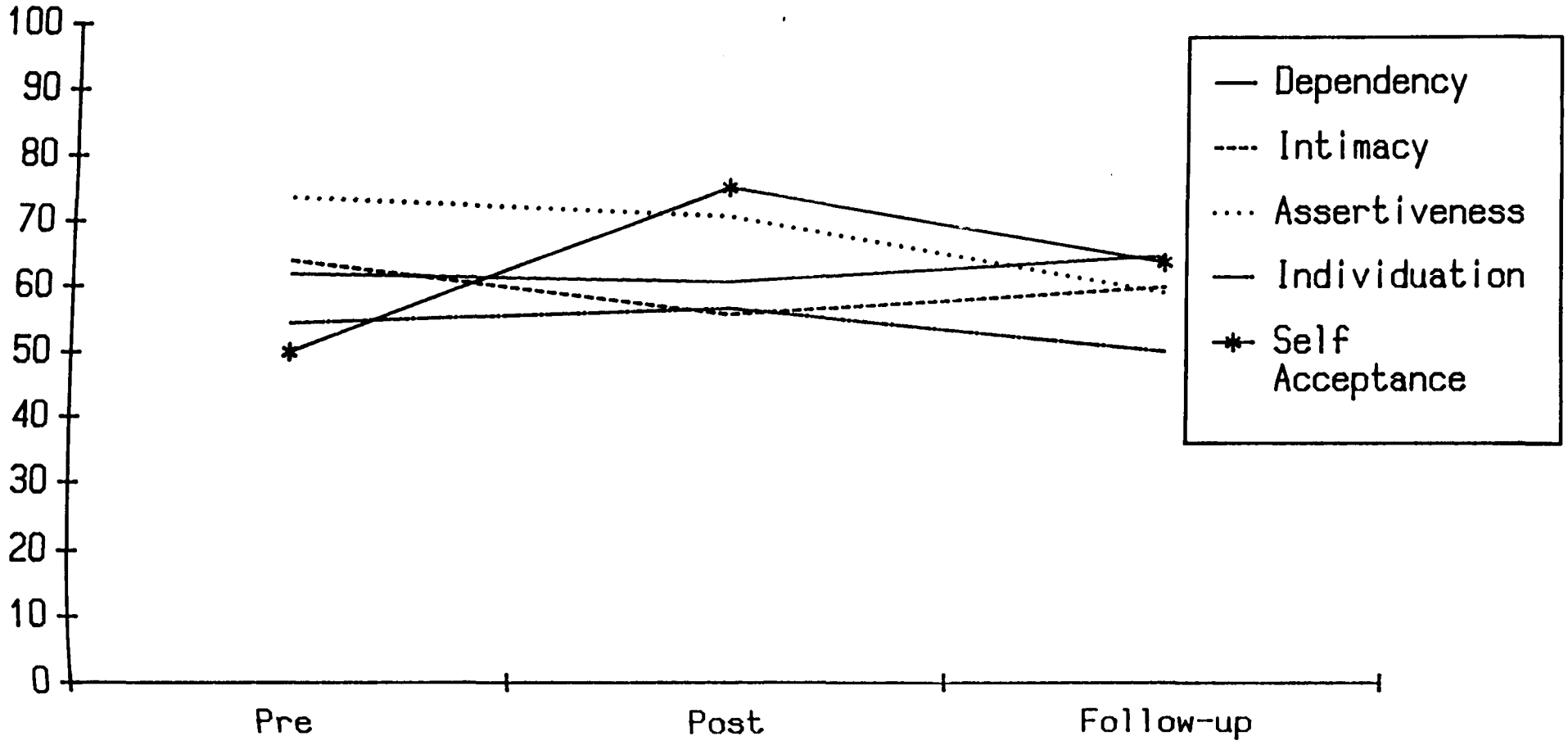




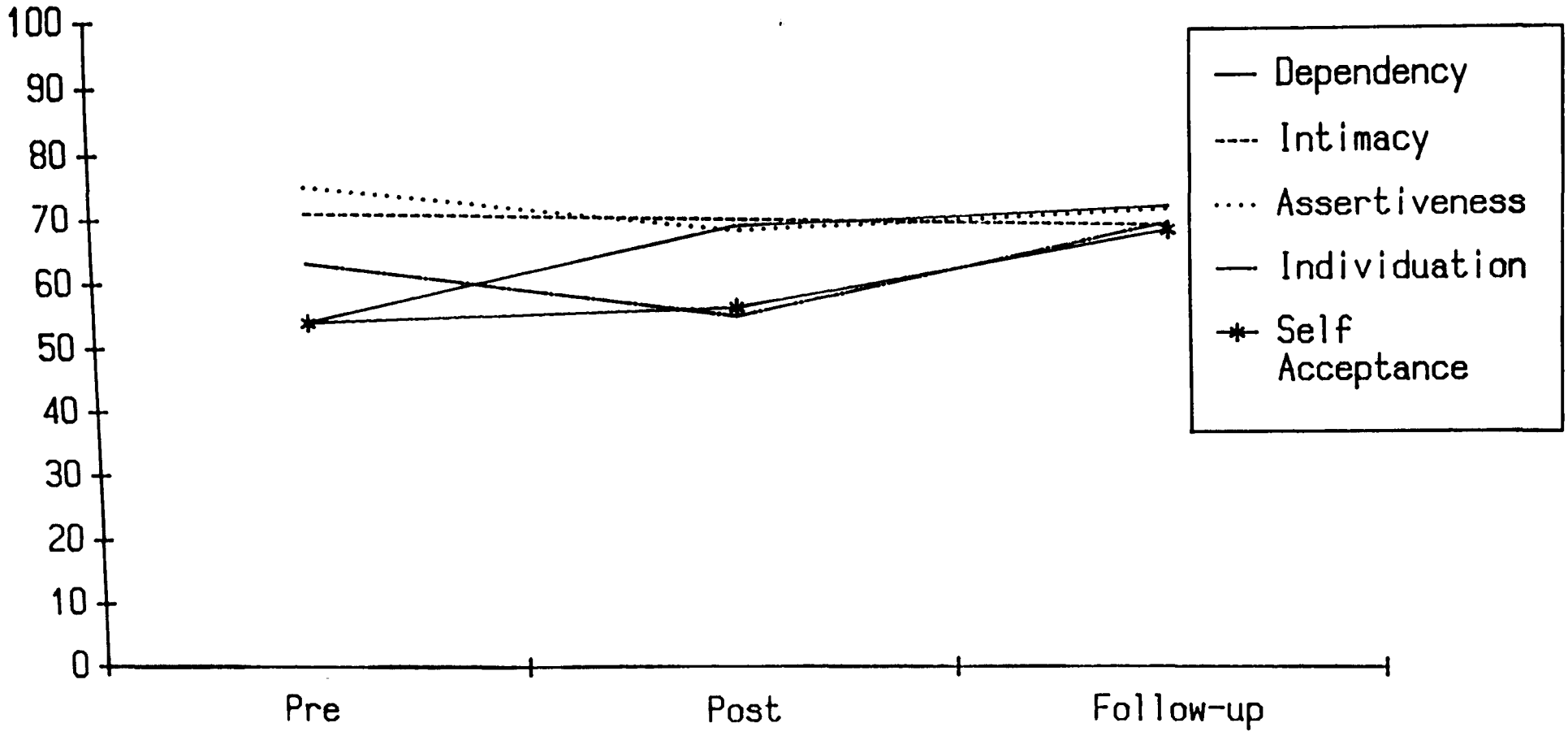

SUBJECT 2 - Group Therapy



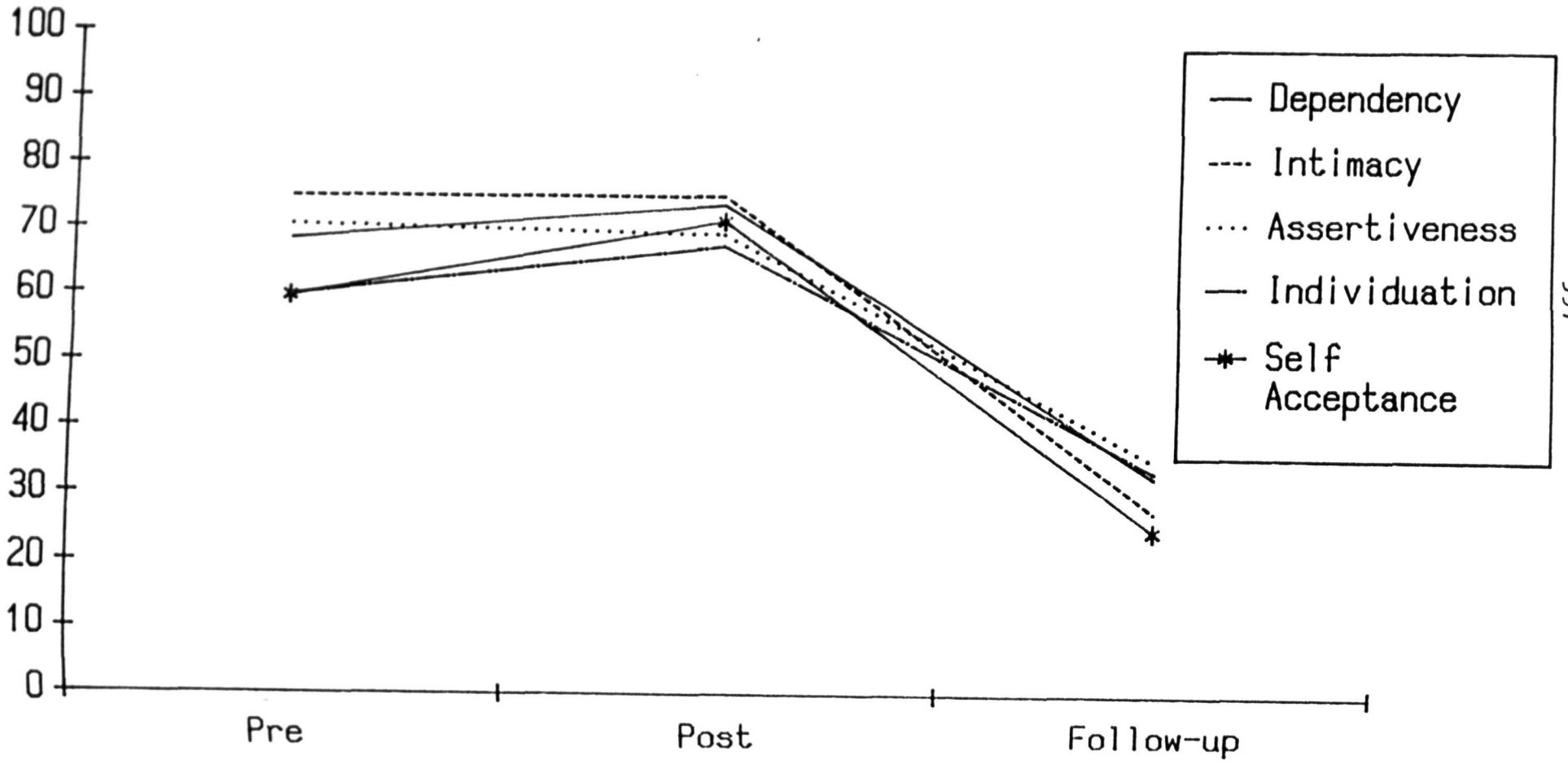
SUBJECT 3 - Group Therapy




SUBJECT 4 - Group Therapy

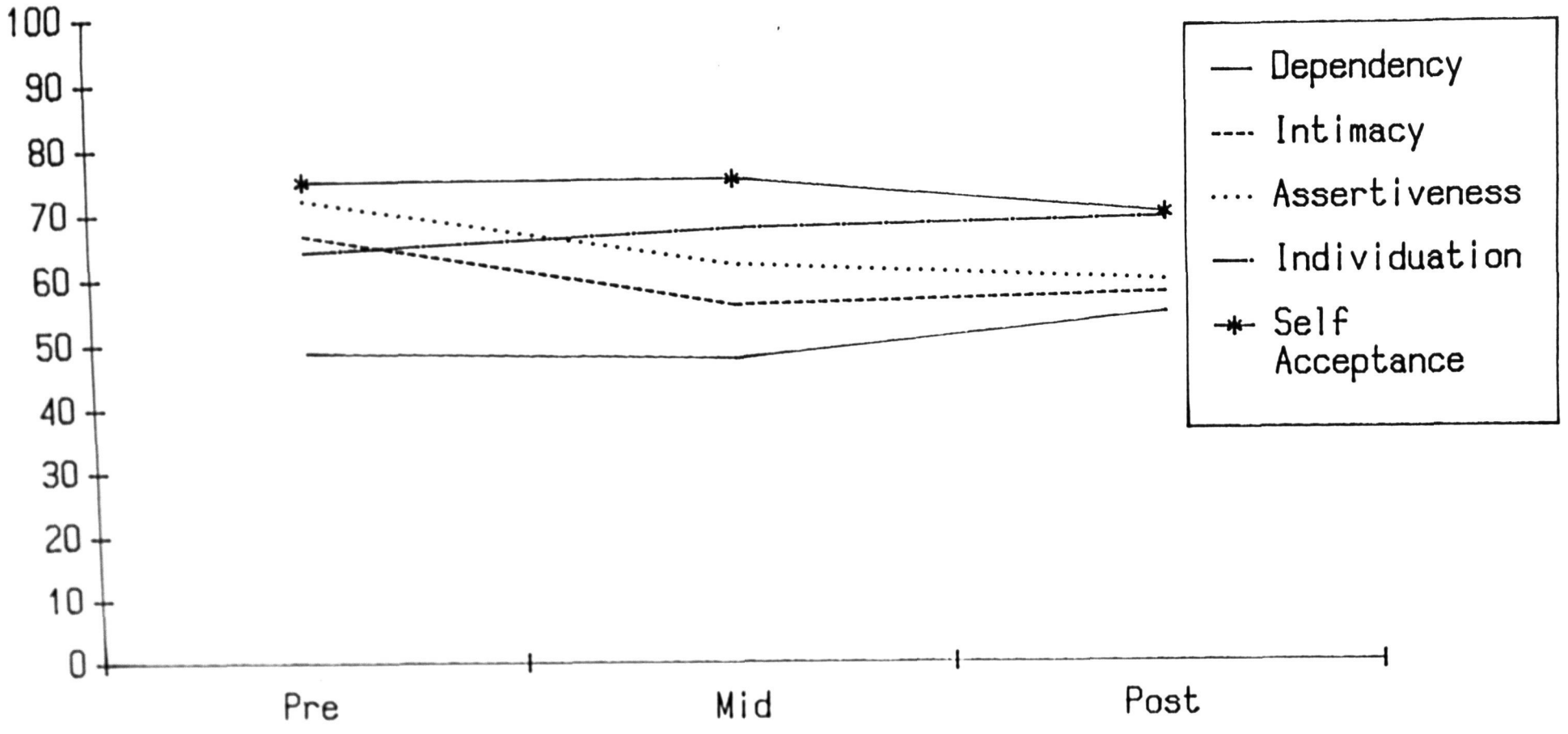


SUBJECT 5 - Group Therapy

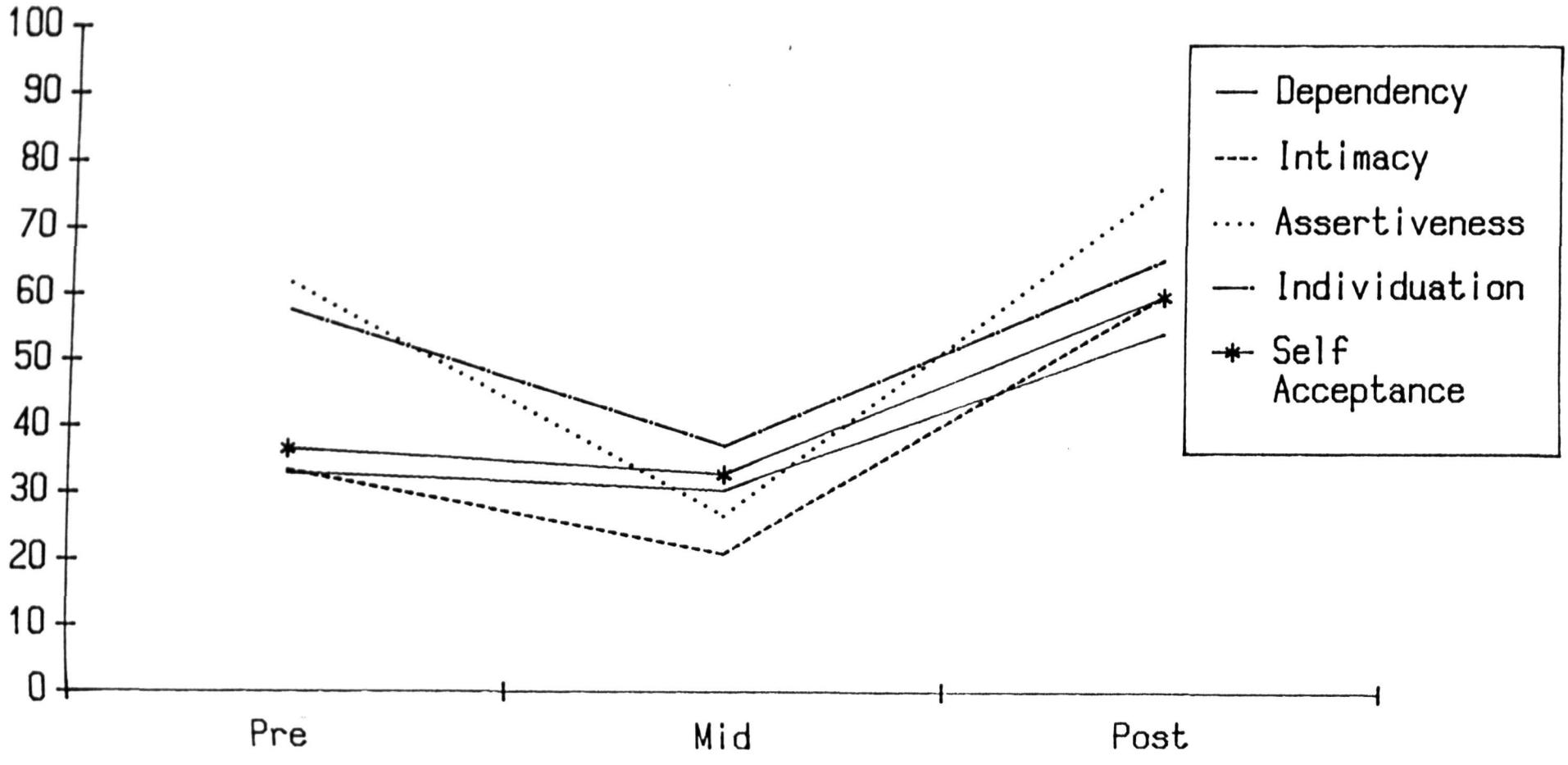




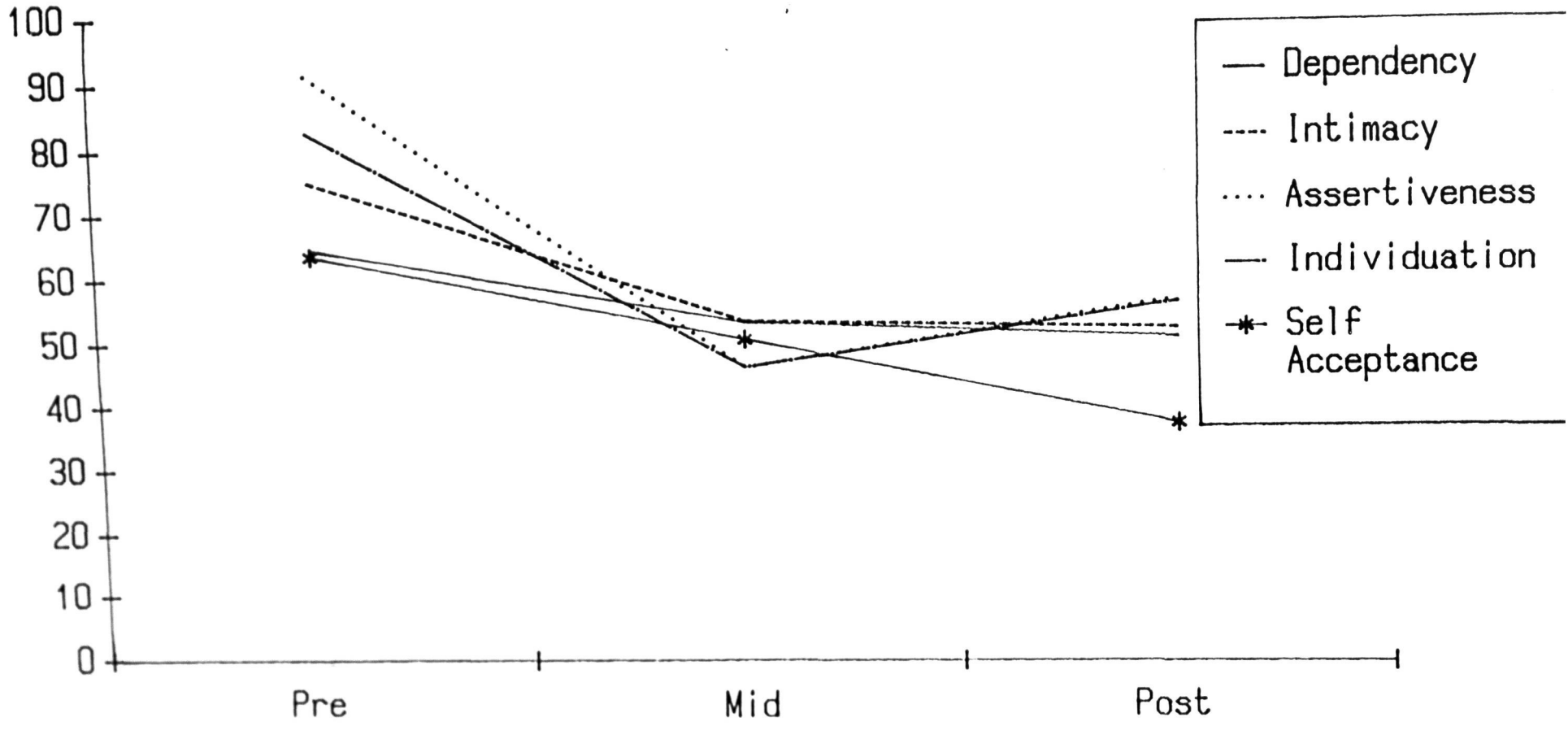

SUBJECT 6 - Group Therapy



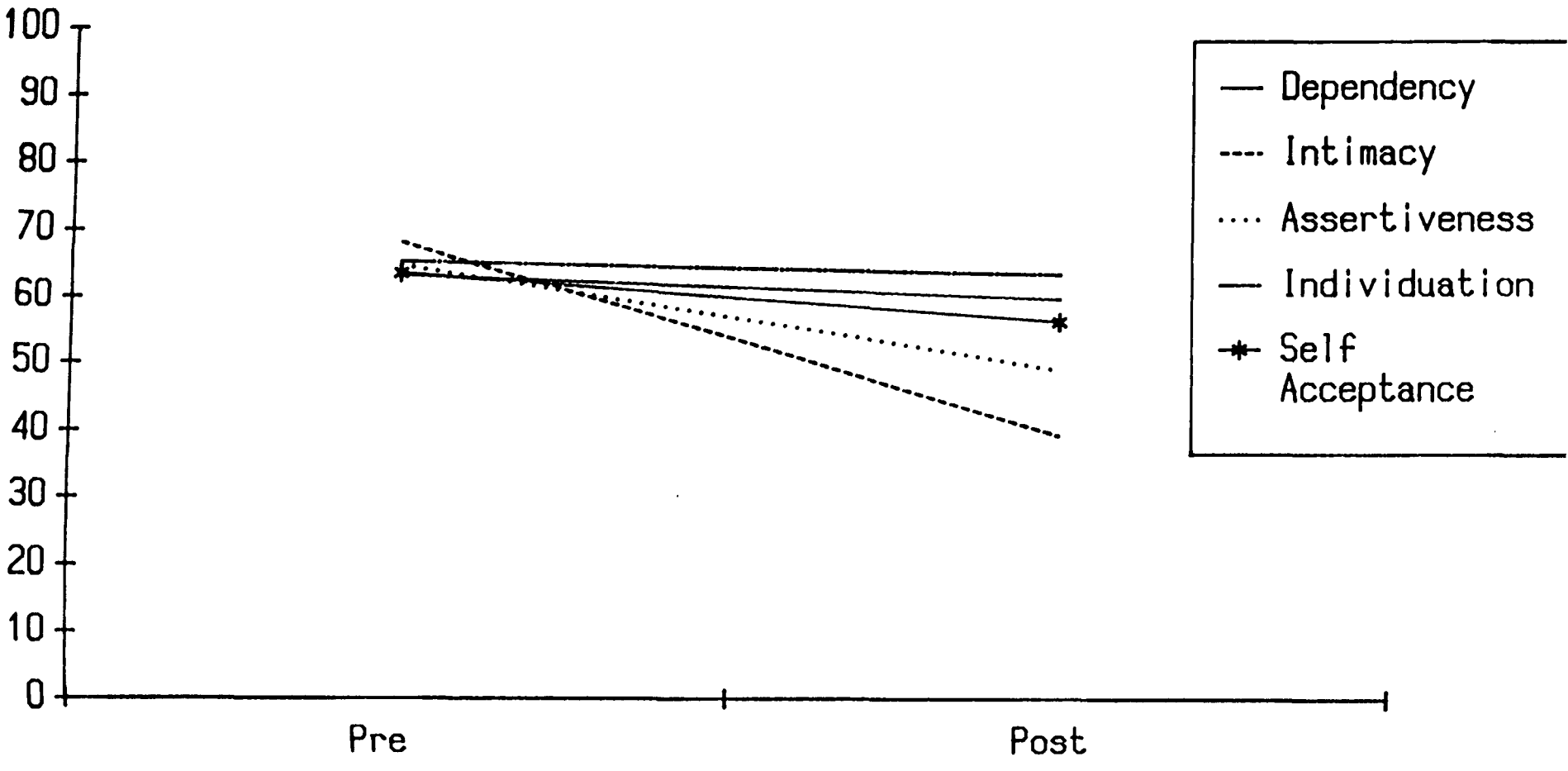
SUBJECT 7 - Group Therapy



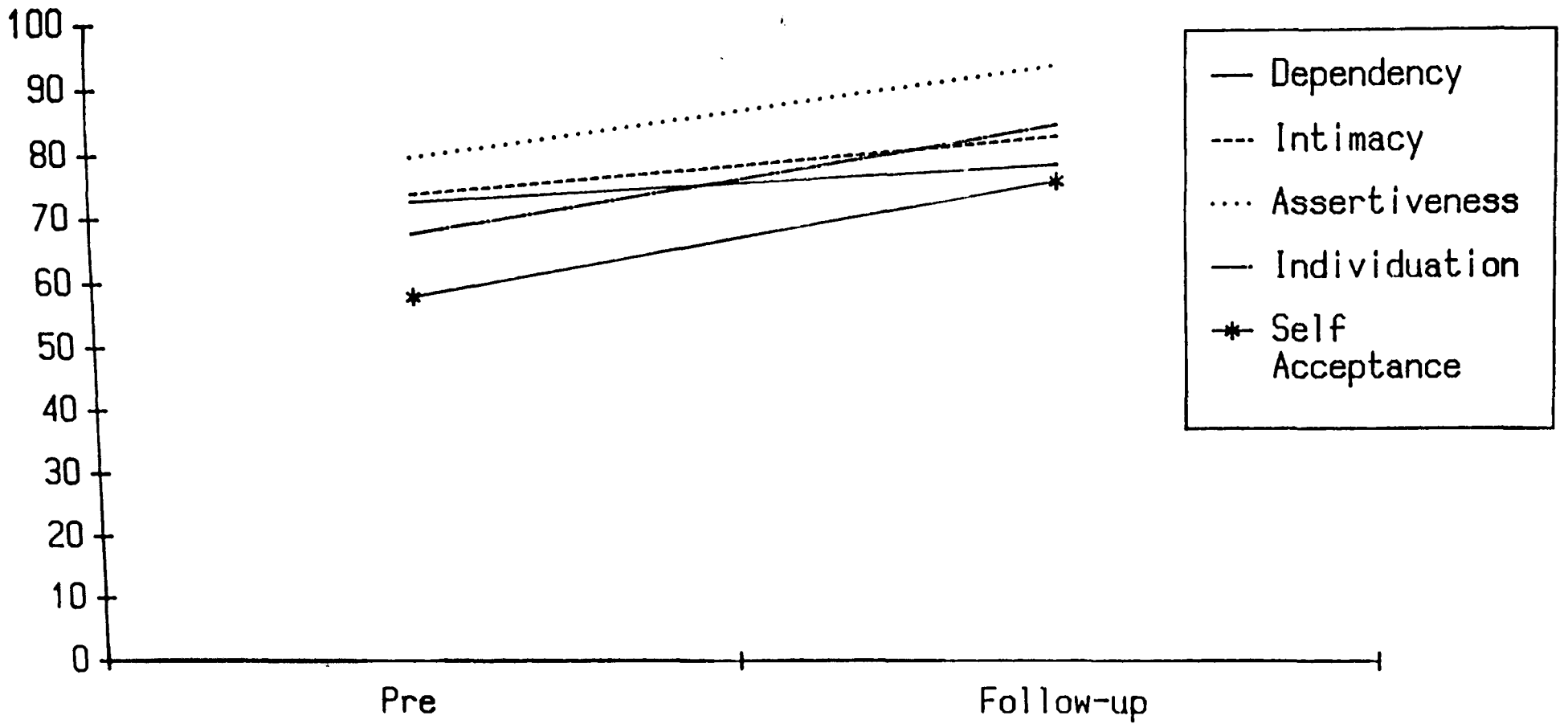

SUBJECT 8 - Group Therapy



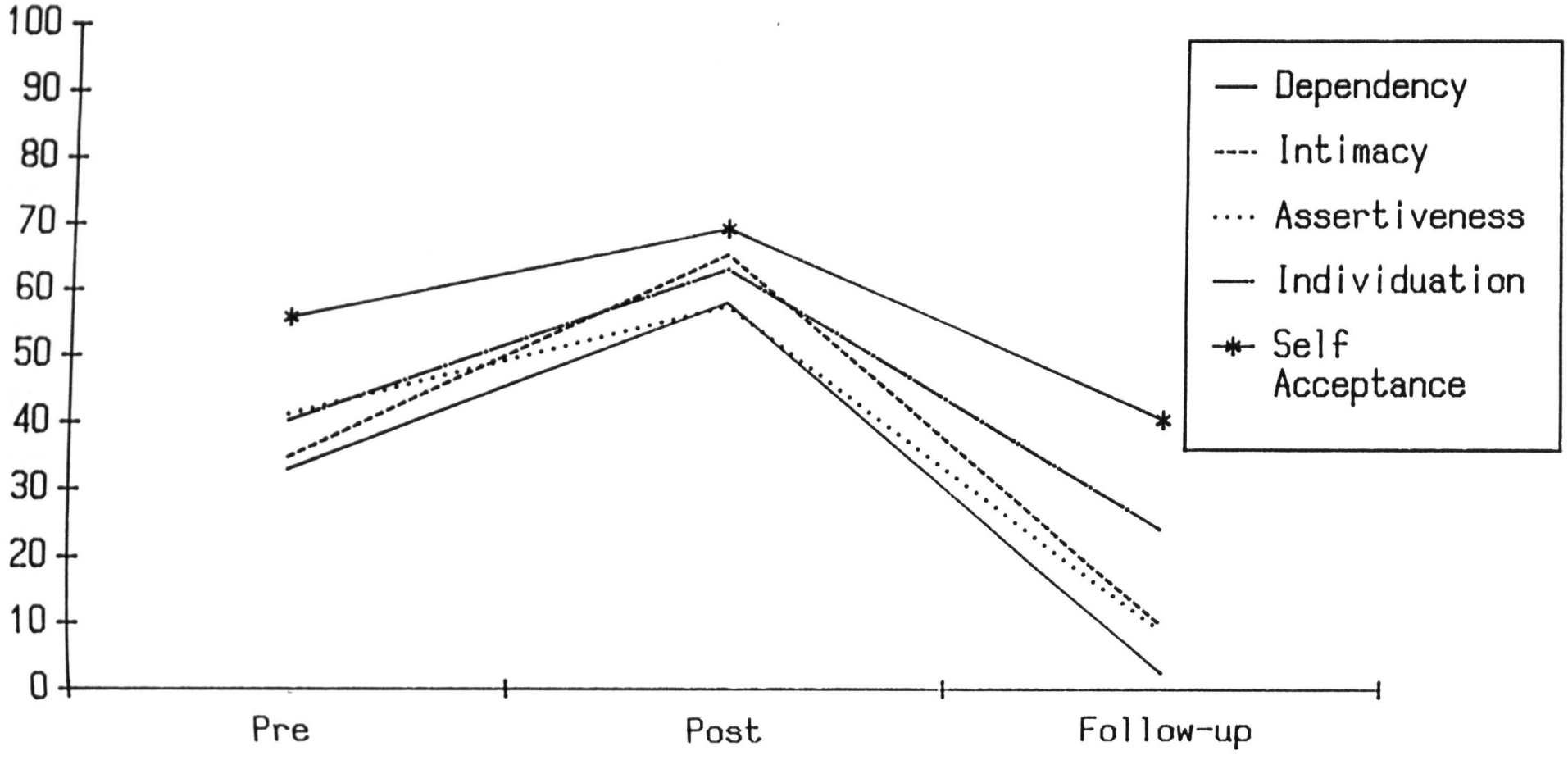
SUBJECT 9 - Group Therapy



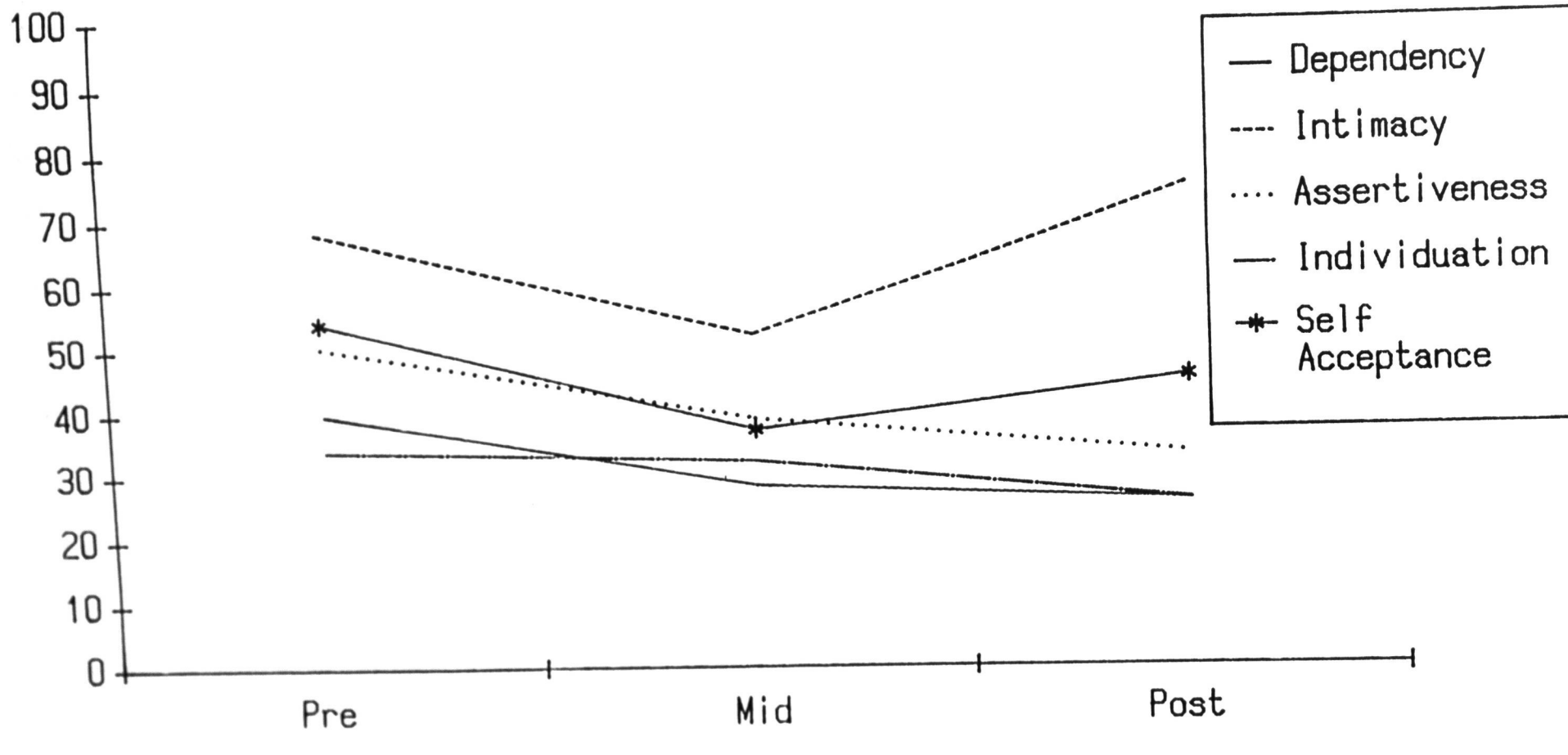

Subject 10 - Group Therapy



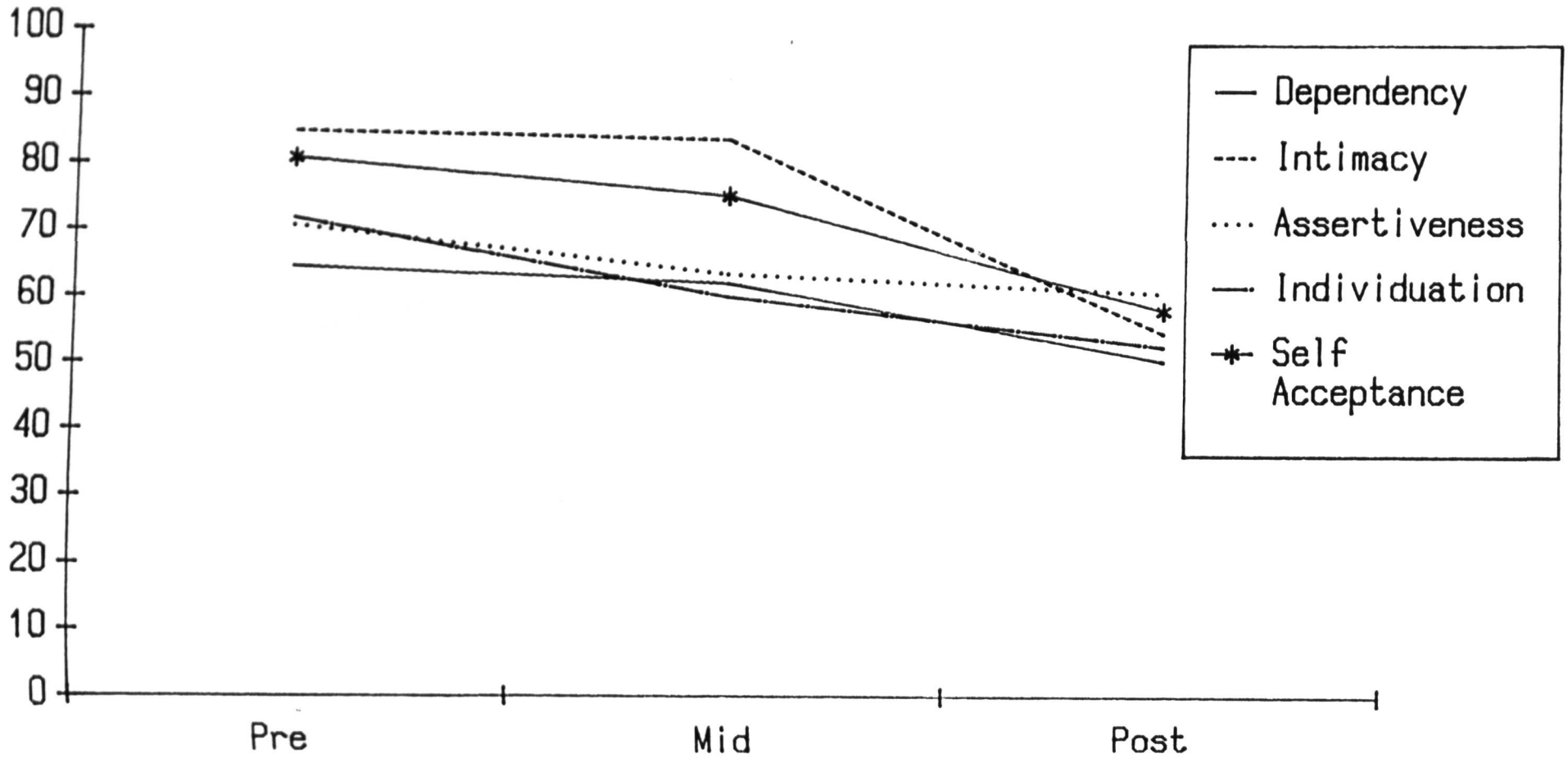
SUBJECT 1 - Individual Therapy



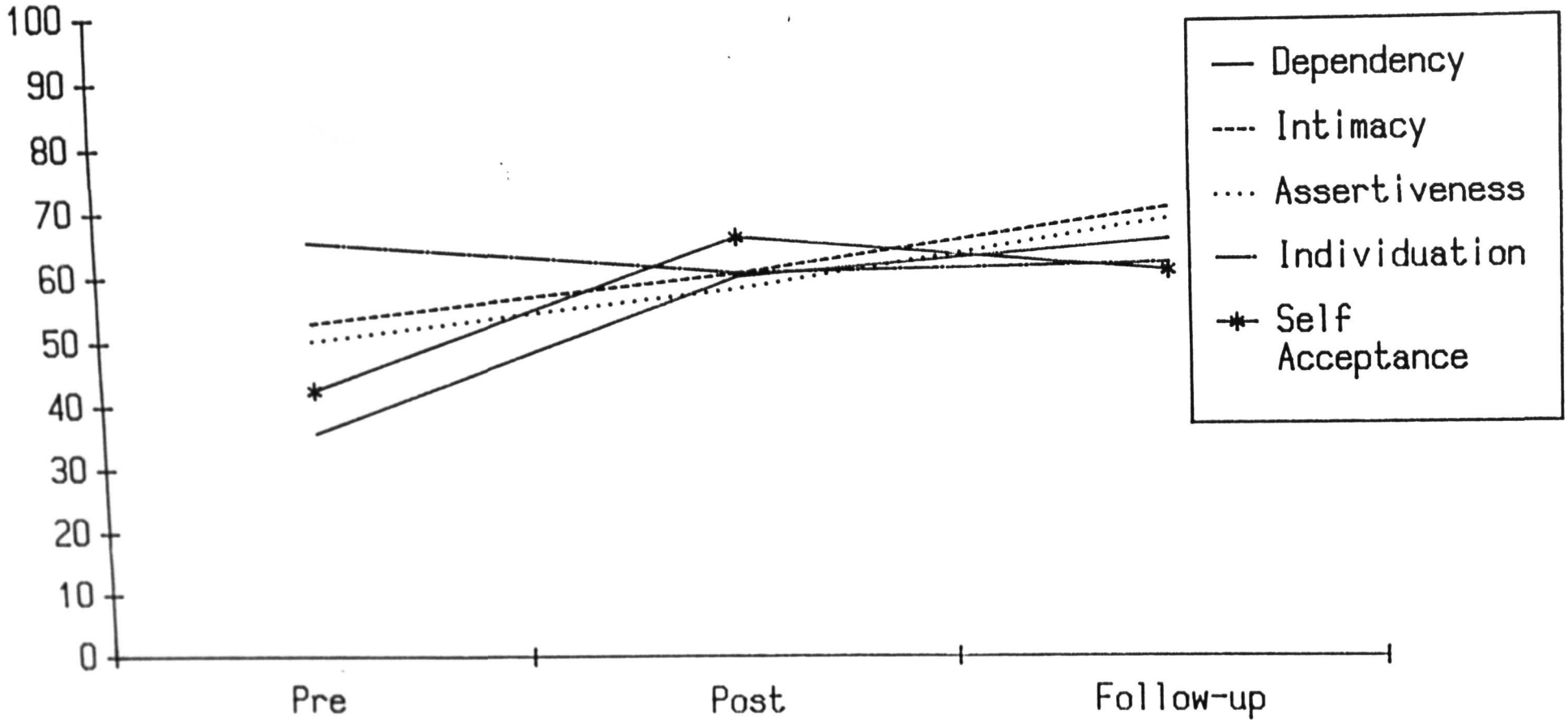

SUBJECT 2 - Individual Therapy



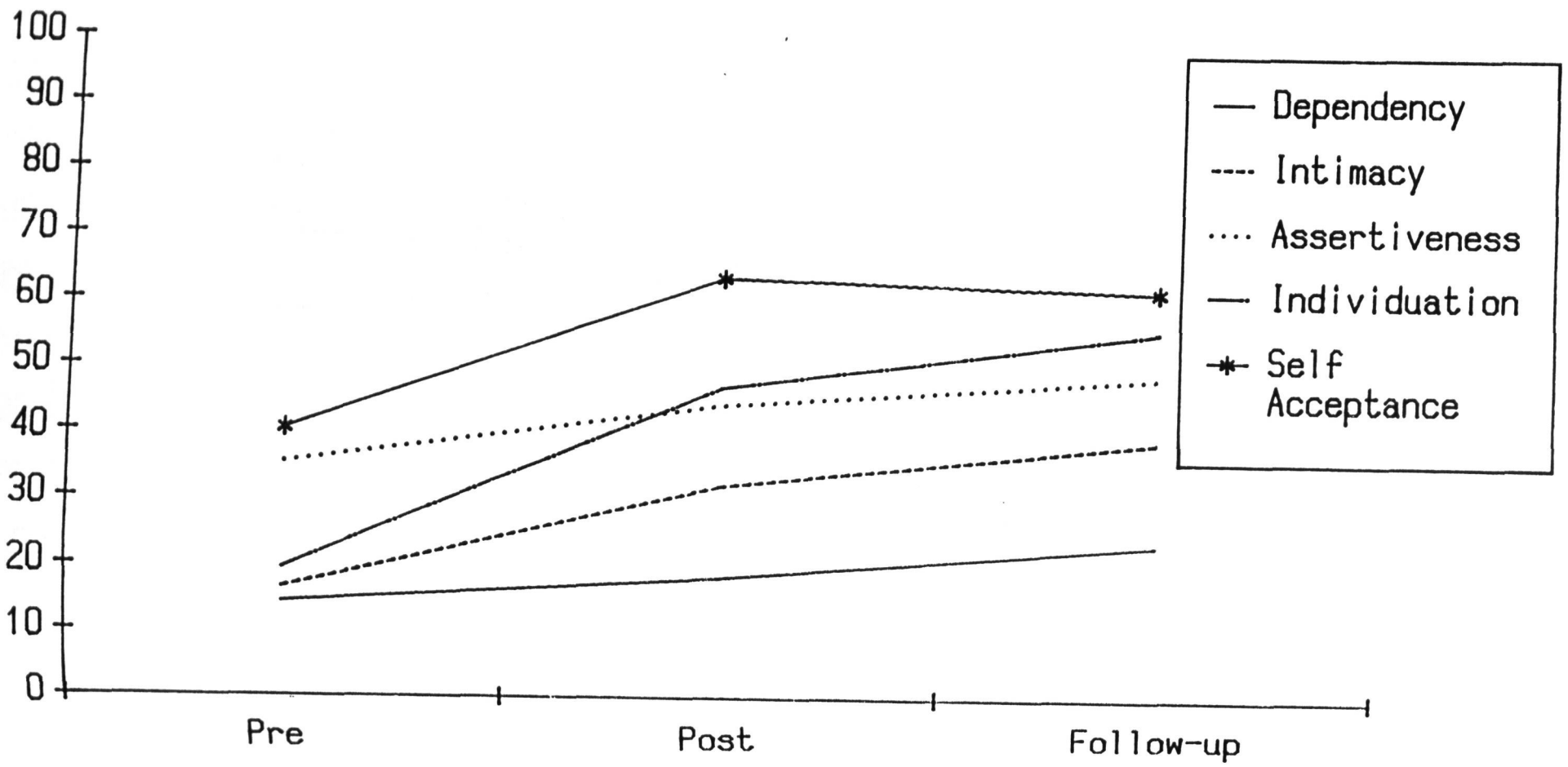
SUBJECT 3 - Individual Therapy



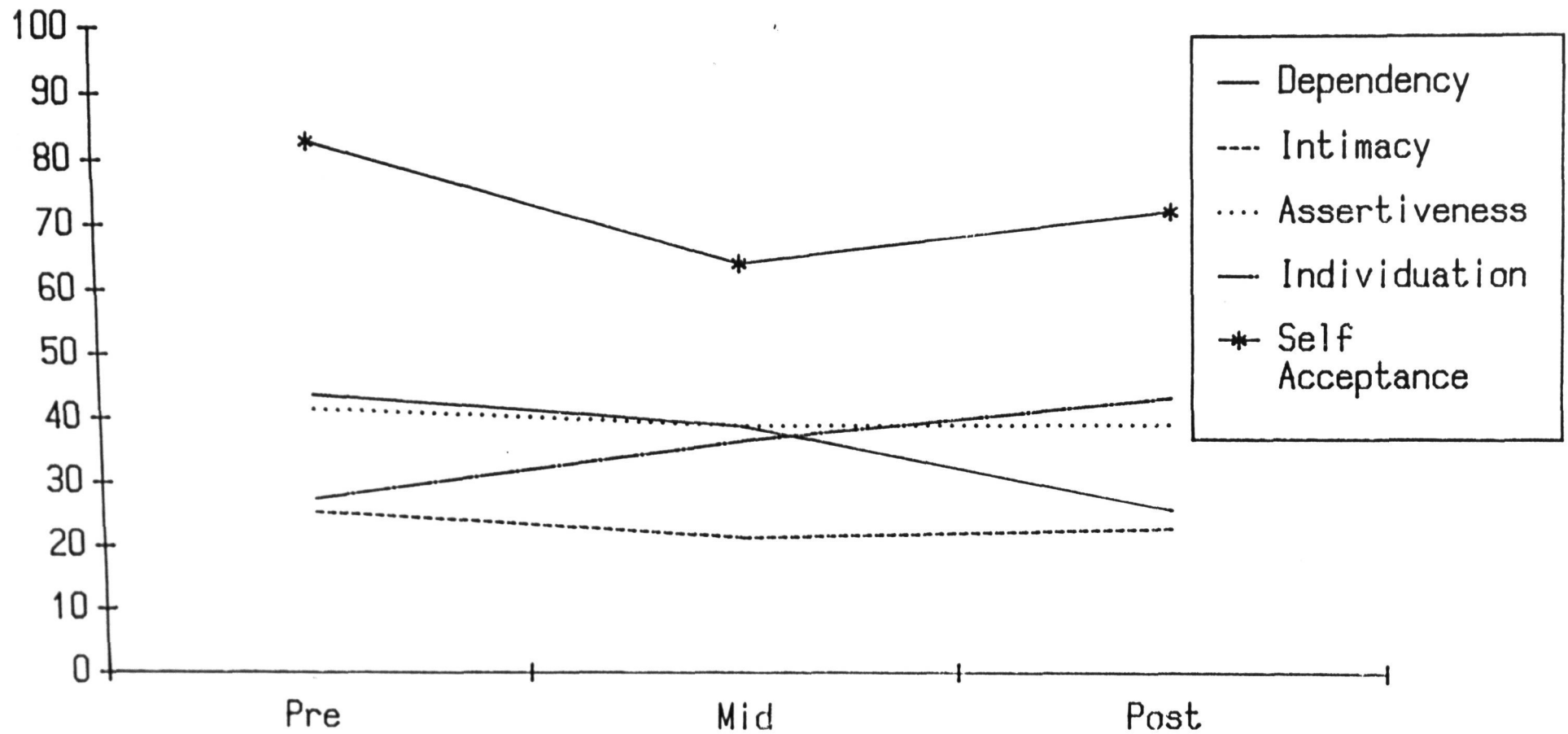

SUBJECT 4 - Individual Therapy



SUBJECT 5 - Individual Therapy




SUBJECT 6 - Individual Therapy



Psychotherapists recognise that change in patients is multidimensional, and that individualised outcome measures are desirable, although difficult to use. The SDPL-90 appears to be a useful instrument in measuring changing goals or priorities in psychotherapy, covering important areas such as intimacy, self-acceptance and assertiveness. However, comparability of results is problematic. Lewin (1947) suggested that greater improvements in sociability occur in patients in group therapy. Sociability relates to interpersonal factors such as dependency, intimacy and social assertiveness. Individual therapy may be more beneficial for intrapersonal difficulties such as self-individuation and self-acceptance. It is interesting to note that the main priority amongst patients in group therapy was social assertiveness, which is related to sociability, and the least important goal was self-acceptance. Among the patients in individual therapy the main priority was self-acceptance, an intrapersonal factor, and the least priority was dependency, an interpersonal factor. It is speculative to wonder if the psychiatrists referring the patients for therapy had unconsciously identified the greater needs of their clients, so that those with interpersonal factors as priority ended up in group therapy, and those with intrapersonal factors a priority in individual therapy.

The SDPL-90 graph of subject 1 in individual therapy and subject 5 in group therapy deserve special mention. Both terminated their therapy prematurely, subject 1 because he had changed to a local group therapy and subject 5 because she was dissatisfied with her treatment. Both were sent the six-month GHQ and SDPL-90 by post for completion, and both delayed in returning the completed questionnaires. The GHQ scores at six months had disimproved on the three-month



figures, and the SDPL-90 scores were all very much lower than the pre-treatment and three-month scores. It is suggested that the SDPL-90 scores at six months are indicative of a negative therapeutic reaction, and the very low marks are an acting out of their dissatisfaction with the therapy.

The attrition rate was 50%, both for those in individual therapy and those in group therapy. This is a high figure. However, the mean duration of complaint for the entire 16 patients was 6.8 years. Of those who did not complete six months in therapy, the mean duration of complaint was 6.1 years. Hence, both those who completed the full six months and those who did not were chronic patients with chronic disabilities. It may suggest that those who dropped out required a more supportive therapy, but attrition is not a function of chronicity of complaint in our study. Frank (1957) outlined several factors associated with high drop-out rates which included lower social class, the less educated, the less integrated into society and the less ready to talk about their feelings. In those who dropped out of our study, there was a wide educational spread. One had no formal education; two had primary education; two had secondary education; and two had third level education. From the educational standpoint, this does not concur with Frank's results.

Strupp, Hadley, and Gomes-Schwartz (1977), in their book "Psychotherapy for Better or Worse," brought to our attention the fact that psychotherapy could be harmful for some people. They used the term "negative effect" to describe a deterioration in the patient's condition during therapy. Three of the patients in our study had an effect size of less than 0.5 Standard Deviation Units, indicating a disimprovement. It is

IMPOSSIBLE TO SAY IF THIS CHANGE IS ENTIRELY DUE TO THERAPY, AS THERE ARE SO MANY VARIABLES WHICH COULD EXPLAIN THE NEGATIVE EFFECT. GARFIELD AND BERGIN (1986), IN A REVIEW OF THE LITERATURE, STATE THAT PSYCHOTHERAPY CAN AND DOES CAUSE HARM TO A PERCENTAGE OF PATIENTS IT IS INTENDED TO HELP. CLIENT, THERAPIST AND OTHER VARIABLES ARE ALL IMPLICATED. THE MORE SEVERELY DISTURBED PATIENT HAS A POOR OUTCOME, AND HORWITZ'S EXAMPLE OF THE BORDERLINE PATIENT (1974) WAS BORNE OUT IN OUR STUDY. SUBJECT 10 IN THE GROUP, WITH A DIAGNOSIS OF BORDERLINE PERSONALITY DISORDER, LASTED ONLY SEVEN WEEKS IN THERAPY. AN IMPATIENT, AUTHORITARIAN LEADER IN A GROUP IS ALSO ASSOCIATED WITH A POOR OUTCOME (YALOM AND LIEBERMAN, 1971). SLOANE ET AL. (1975) SUGGESTED THAT, WHEN THERAPISTS ARE CAREFULLY CHOSEN, THE NEGATIVE EFFECTS VIRTUALLY DISAPPEAR. OVERALL, THE AREA REMAINS CONTROVERSIAL AND IT IS DIFFICULT TO BE DEFINITIVE ABOUT NEGATIVE OUTCOMES.

RESEARCH IN PSYCHOTHERAPY POSES SEVERAL UNIQUE PROBLEMS, AND A VAST LITERATURE HAS BUILT UP OVER SPECIFIC METHODOLOGICAL ISSUES. CLARE (1988) REVIEWED THE PROBLEMS IN PSYCHOTHERAPY RESEARCH AND, INDEED, AN ENTIRE THESIS COULD BE CONDUCTED ON THAT ISSUE ALONE. OF PARTICULAR RELEVANCE TO THIS STUDY IS THE FINDING THAT NO SIGNIFICANT DIFFERENCE IN OUTCOME WAS FOUND BETWEEN PATIENTS TREATED BY EXPERIENCED ANALYSTS AND THOSE TREATED BY PSYCHIATRIC RESIDENTS IN TRAINING, (STRUPP ET AL., 1969). ALL OF THE THERAPISTS IN OUR STUDY WERE TRAINEES, ALBEIT HAVING WEEKLY SUPERVISION. ANOTHER CONTENTIOUS TOPIC IS THE QUESTION OF OUTCOME CRITERIA. MALAN ET AL. (1968) CONTEND THAT OUTCOME SHOULD BE ASSESSED DYNAMICALLY, AS WELL AS SYMPTOMATICALLY, INCORPORATING FORMULATIONS OF DYNAMICALLY BASED MEASURES. THIS REMAINS A CONTENTIOUS



AREA, AND THERE ARE NO AGREED OUTCOME CRITERIA IN GENERAL USE.

IN CONCLUSION, IT IS FELT THAT RESEARCH IN PSYCHOTHERAPY PRESENTS A CHALLENGING AND WORTHWHILE EXERCISE FOR ALL OF US ENGAGED IN PSYCHOTHERAPY. IT IS OF FUNDAMENTAL IMPORTANCE, AS IT MAKES US PLACE OUR SKILLS ON THE LINE, AND CAN ONLY HELP US TO FIND THE RIGHT PLACE FOR PSYCHOTHERAPY. PSYCHOANALYTICALLY ORIENTED PSYCHOTHERAPY IS NOT A PANACEA, BUT RATHER A MOST IMPORTANT WEAPON IN THE BATTLE AGAINST WHAT FREUD TERMED "HUMAN MISERY." THE QUESTION SHOULD BE - WHAT IS THE RIGHT TYPE OF PSYCHOTHERAPY FOR THIS PARTICULAR PATIENT, IN THESE PARTICULAR CIRCUMSTANCES? IN THIS STUDY WE HAVE SHOWN THAT PSYCHOANALYTICAL PSYCHOTHERAPY, AS PRACTISED IN THIS STUDY, IS EFFECTIVE, BUT THAT THE EFFECT, AS MEASURED BY GHQ SCORES, IS THE SAME WHETHER THE PATIENT IS IN INDIVIDUAL OR GROUP THERAPY. THE PRIORITIES OF THE PATIENTS IN INDIVIDUAL AND GROUP THERAPY ARE DIFFERENT, AND IT IS FELT THAT THIS INDICATES THE NEED FOR BOTH INDIVIDUAL AND GROUP FORMS OF PSYCHOTHERAPY. OUR SKILLS IN THE FUTURE WILL HAVE TO INCLUDE THE ACCURATE IDENTIFICATION OF THOSE PATIENTS WHO WILL BEST RESPOND TO EITHER INDIVIDUAL OR GROUP SETTINGS.

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# EXISTENTIALISM, PSYCHIATRY AND PSYCHOANALYSIS

MICHAEL FITZGERALD.

**THE UNDERLYING** CARTESIAN ASSUMPTION HAS BEEN THAT THERE IS A DIVORCE BETWEEN MAN AND THE WORLD. THIS SPLIT IS DEEPLY ROOTED IN WESTERN THOUGHT AND PERVADES ALL OUR THINKING. THE EXISTENTIALIST ENDEAVOUR HAS BEEN TO REPAIR THIS SPLIT BETWEEN MAN AND THE WORLD, AND TO SEE THEM NOT AS SEPARATE ENTITIES BUT AS A SINGLE REALITY, MAN IN THE WORLD.

DREYFUS (1987), IN AN EXCELLENT INTRODUCTION TO HEIDEGGER, POINTS OUT THAT IN "BEING AND TIME" HEIDEGGER DISCUSSED HIS FAVOURITE EXISTENTIALIST THEMES SUCH AS GUILT, DEATH, FALLING AND LEVELLING. GUILT AND DEATH TURN OUT TO BE VERSIONS OF ANXIETY. DASEIN, ACCORDING TO HEIDEGGER, IS ALWAYS DIMLY AWARE THAT THE WAY THE WORLD IS, IS UNGROUNDED, I.E., THERE IS NO REASON ONE HAS TO DO THINGS THE WAY ONE DOES. HUMAN NATURE DOES NOT REQUIRE IT.

HEIDEGGER EXPRESSES THIS EXISTENTIALIST VIEW BY SAYING THAT THE ESSENCE OF DASEIN IS ITS EXISTENCE. THIS MEANS THERE IS NO HUMAN NATURE, WE ARE WHAT WE TAKE OURSELVES TO BE - HOW WE INTERPRET OURSELVES IN

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OUR PRACTICES. THIS IS RATHER UNSETTLING, ACCORDING TO HIM. "NOT BEING AT HOME" IS HIS PRECISE PHRASE FOR IT. ANXIETY IS OUR RESPONSE TO THE FUNDAMENTALLY UNSETTLING CHARACTER OF BEING THERE, AND THE QUESTION IS "WHAT DO WE DO ABOUT IT?"

WE CAN FLEE ANXIETY, IN WHICH CASE WE GO BACK TO THE KIND OF CONFORMITY WHICH IS REQUIRED OF EVERYONE IF THEY ARE TO BE INTELLIGIBLE. WE DO WHAT ONE DOES AND TALK AS ONE TALKS, BUT WE USE THE NORMS TO FLEE UNSETTLEDNESS. WE BECOME CONFORMISTS. DREYFUS (1987) GOES ON TO STATE THAT WE TRY DESPERATELY TO SHAPE UP TO THE NORMS, TO PRONOUNCE THINGS THE RIGHT WAY, TO DRESS IN THE RIGHT WAY, ETC. THAT IS HOW ONE FLEES INTO INAUTHENTICITY, WHAT WINNICOTT (1965) CALLED THE "FALSE SELF." THAT WOULD BE, IN EFFECT, DISOWNING WHAT IS TO BE DASEIN.

FOR HEIDEGGER, TO OWN UP MEANS TO HOLD ON TO ANXIETY RATHER THAN TO FLEE IT. IF YOU CHOOSE TO DO THAT - AND, IN ANXIETY, YOUR NORMAL UNREFLECTIVE PRESSING INTO POSSIBILITIES HAS BROKEN DOWN, SO YOU HAVE TO MAKE A REFLECTIVE CHOICE - YOU WILL BE THROWN INTO AN ENTIRELY DIFFERENT WAY OF BEING HUMAN. A PERSON DOES NOT NECESSARILY CHANGE WHAT HE IS DOING, BUT WHAT HE REALISES IS THAT THERE IS NO FINAL MEANING OUT OF LIFE, NOR CAN HE FIND ANY RATIONAL GROUNDING FOR ANYTHING.

IN THIS AUTHENTIC ACTIVITY, HEIDEGGER SAYS, YOU NO LONGER RESPOND TO WHAT HE CALLS "THE GENERAL SITUATION." YOU RESPOND TO THE UNIQUE SITUATION. FOR EXAMPLE, DREYFUS SAYS THAT AT LUNCH TIME A CARPENTER COULD PUT DOWN HIS HAMMER AND EAT HIS SAUSAGES, BUT IF THERE WERE BEAUTIFUL FLOWERS BLOOMING OUTSIDE, AND IF HE WERE AUTHENTIC HE WOULDN'T HAVE TO SIT AND EAT HIS



SAUSAGES, BUT COULD SKIP LUNCH AND WANDER AMONG THE FLOWERS. HE SAYS THAT HE CAN ONLY DO WHAT ONE DOES. HE CAN'T TAKE OFF HIS CLOTHES AND ROLL IN THE FLOWERS. ONE DOESN'T DO THAT BECAUSE THERE IS STILL SPACE FOR AUTHENTICITY, NAMELY, DOING THE SORT OF THING THAT ONE DOES IN A WAY THAT ALLOWS A RESPONSE TO THE UNIQUE SITUATION WITHOUT CONCERN FOR RESPECTABILITY AND CONFORMITY. THAT KIND OF LIFE, NOT TRYING TO GET ABSOLUTE MEANING AND RESPONDING TO THE CURRENT SITUATION, MAKES YOU AN INDIVIDUAL AND NO LONGER ZOMBIE LIKE. HEIDEGGER SAYS IT MAKES YOU FLEXIBLE, ALIVE, JOYOUS; THAT IS HIS IDEA ABOUT HOW ONE SHOULD LIVE. THIS IS INTERESTING BECAUSE I THINK MOST PSYCHOTHERAPISTS WOULD AGREE WITH THIS. MANY OF THE PATIENTS WHO COME FOR TREATMENT TODAY HAVE MAJOR PROBLEMS WITH AUTHENTICITY AND BEING REAL. THEY ARE OUT OF TOUCH WITH THEIR REAL SELVES. THEY HAVE VERY HIGHLY DEVELOPED FALSE SELVES. PSYCHOANALYSIS IS ALSO AIMING TO MAKE PEOPLE REFLECTIVE, AS HEIDEGGER WANTS THEM TO BE.

DASEIN WAS AN EXTREMELY IMPORTANT CONCEPT FOR HEIDEGGER, AND HE STATED THAT IT WAS ORIENTED TOWARDS THE FUTURE, DOING SOMETHING NOW IN ORDER TO BE IN A POSITION TO DO SOMETHING ELSE LATER ON, AND ALL THIS MAKES SENSE AS ORIENTED TOWARDS SOMETHING WHICH THAT PERSON IS FINALLY UP TO BUT NEED NOT HAVE, AND PROBABLY CANNOT HAVE IN MIND. WE BECOME DASEIN, OR GET DASEIN IN US, ONLY WHEN WE GET SOCIALISED INTO THE SHARED COPING SKILLS, MOODS, POSSIBILITIES AND SO ON. DASEIN IS ALWAYS ALREADY BEING WITH. MOREOVER, SINCE THESE SKILLS ARE SOCIAL, DASEIN GENERALLY DOES WHAT ANYONE IN THE SOCIETY DOES.

THE CARTESIAN TRADITION THINKS OF MAN'S RELATIONSHIP TO THE WORLD IN TERMS OF SUBJECTS KNOWING

objects. Heidegger realised that it wasn't always simply subjects relating to objects. He noticed that awareness and conscientiousness did not play a necessary role at all. He gave the example of a carpenter hammering a nail. When things are going well, the hammer becomes transparent for him, and he is then not a subject directed towards the object - the hammer. He does not have to think about it at all. This would be happening in what Freud would call pre-conscious. He pointed out that when we look at this "ready to hand" way of being with things, we just do not find conscious subjects directed towards independent objects at all. Again, I think the emphasis here must be on the pre-conscious, and not in the deep unconscious as described by Freud. According to Heidegger, we are not detached from some external reality which is out there, trying to gain knowledge of it as something categorically different from ourselves, and trying to relate to it. On the contrary, we are a part and parcel of it all, and from the very beginning we are in amongst it all, being in it, coping with it. In consequence, we are not in any primary sense observing subjects or knowing beings in the way traditional philosophers have regarded us. What we are, characteristically, are coping beings - or even, one might feel tempted to say, being beings, according to Dreyfus.

The later Heidegger no longer takes anxiety to be a universal structure, which is clearly wrong, as anxiety is universal. Heidegger claims that the Greeks didn't experience anxiety in the face of meaninglessness, nor did the Christians either. Well, maybe they didn't feel anxiety about certain issues, but no doubt they had great reason to feel anxiety about other matters. The later Heidegger thinks our



modern experience of anxiety results from what he sees as a ruthless, nihilistic, technological understanding of being. He is probably right about this, but then, Durkheim pointed out similar issues towards the end of the nineteenth century in France.

Heidegger was keen on nihilism, by which he meant there were no meaningful differences any more. He thought that we might be stuck in the darkest night for the rest of human history. Dreyfus pointed out that he was not totally pessimistic, since he thought that the very lack of local concerns and meaningful differences might make us appreciate non-efficient practices - what he called the saving power of insignificant things. Here he meant friendship, back-packing into the wilderness, etc. In our society he feels efficiency is everything, and nothing else matters, and it is only those marginal practices like drinking wine in a wine bar that are marginal and non-efficient. Overcoming nihilism is a possibility for Heidegger, because it means getting over our technological understanding of being, not of technology. I think Heidegger is right about nihilism and efficiency and the lack of meaningful differences in our world. Heidegger repudiates the idea that most of our activities are directed by conscious choice or decision. Of course, Freud has said this also, in the nineteenth century.

Heidegger offers a phenomenological analysis of everyday practical know-how that dispenses altogether with the need for mental states like desiring, believing, following a rule and so on, and thus with their intentional content. I think it is important here to realise that Heidegger is talking about very superficial phenomena.

Dreyfus points out that what Heidegger is saying is that we direct our full conscious attention at matters only when things go wrong, when a specific problem arises. Most of the time we are borne along in a light medium which we take for granted, and are not conscious of, and don't direct our attention to.

So what is of value in existentialism for psychiatry? Psychoanalysts would agree that when things are going well we are not aware of much of what is going on in our own conscious, and that it is only when some problem or conflict arises that we become aware of what is going on. Indeed, psychoanalysis is about making a patient aware, making the patient reflective, making the unconscious conscious and bringing forward unconscious events, memories and childhood experiences which are normally unconscious. In a way psychoanalysis is creating the self-objects split by making the patient aware of these matters. My own belief is that in parts of the analytic session, the existential position is relevant where the patient sucks in the analyst in the transference or the analyst allows the patient to be sucked into him in the countertransference and then, when the analyst makes an interpretation, it is based on this existential data while the interpretation is made from a Cartesian position where the analyst is separate from the patient. Symington (1986) notes that knowledge that is arrived at in psychoanalysis through insight occurs through a new kind of being in the world for analyst and patient together. The insight comes from this special, existential interaction where there is a kind of "mix-up" between the patient and the analyst; the interpretation is then based partly on the outcome of this "mix-up" experience. The Cartesian and



existential positions are, therefore, relevant for psychoanalysis.

Heidegger is right when he talks about our modern experience of anxiety as resulting from what he sees as the ruthless, nihilistic, technological understanding of being. He is also right when he says that people can't stand distance from the norm and that they get anxious if they feel at a distance from the norm. I think that he is right when he says that anxiety is our response to the fundamentally unsettling character of being there or feeling that the world is more ungrounded now than in the past. He also seems to be suggesting that we should be more spontaneous, and that we have more choices than we realise. Most psychotherapists would agree with this.

The following summary of what the existentialists state does provide a background in which psychoanalytic psychotherapy takes place. They point out that:-

(a) We are born into the world alone;

(b) We live in loneliness;

(c) We go out of the world alone;

(d) Death is sure and nothingness beyond it arouses dread;

(e) Guilt is a condition of our existence;

(f) We are separated from one another by the tradition and ways of our present culture and times.

There are also a number of serious problems with existentialism. Existentialist psychiatry denies the whole concept of mental illness, the biological basis of certain mental illnesses, as well as genetic factors. This extreme position is unhelpful and inaccurate. Rollo May (1958), an existential psychiatrist, scrapped the entire understanding of mankind that had been so carefully pieced together by Freud in psychoanalysis, and attempted to replace it with an existential philosophy which tried to describe psychological reality in terms of philosophical generalities.

Unlike Freud in psychoanalysis, existential psychiatry establishes a dependent relationship that gratifies and cannot be broken because it is never brought to analysis. Existentialism, by ignoring the transference, preserves the childhood constellation. It is likely that Heidegger is wrong when he said that before Plato, the Greeks felt rooted and weren't unsettled or anxious. Heidegger is far too pessimistic when he says you can no longer expect to get any final meaning out of life or find any rational grounding for anything. Existential liberation philosophy is wrong when it says that sexual drives cannot be liberated. According to these philosophers, liberation comes from realising that there is no deep truth in the individual subject. There is no meaning in Dasein after all. This, of course, means that meaninglessness is all there is. The existentialists would seem to be saying that accepting this meaninglessness is what is liberating. Clinical experience of working with patients over many years shows that precisely the opposite is true, that many of their feelings, sexual and aggressive drives are repressed and that their general behaviour, feelings and thinking are full of



meaning. Albert Camus over-simplifies the situation when he says, "There is but one serious philosophic problem and that is suicide."

When one examines the western world in the 1990's, there are signs of hope that the world is not in the final stages of a long decline into industrial nihilism, as Heidegger believed. Indeed, western ideas have never been so powerful throughout the world.

Finally, it is impossible to discuss Heidegger without discussing the man and his behaviour. Professor Zimmerman (1989) pointed out, in reviewing a book by Hugo Ott (1989) on Martin Heidegger, that Heidegger's commitment to Nazism was neither accidental nor unrelated to his philosophy, but rather was profound and enduring because he himself believed his philosophy was a spiritual core of the Nazi movement. Henceforth, readers of Heidegger's works must acknowledge that his thinking was inextricably embedded in a reactionary world view consistent in many ways with Nazism. Certainly, his thinking is too profound and original to be described as merely an exercise in Nazi apologetics, yet those who admire it must also reckon with its indisputable and deeply troubling political dimension. In 1933 he became the first Nazi Rektor of Freiburg University, and Heidegger maintained that only his philosophy could provide the proper spiritual leadership for Hitler's revolution. He denied his guilt during 1945, after the French occupied Freiburg, and finally had a nervous breakdown in the spring of 1946. Karl Jaspers insisted he come to terms with his guilt. Ott (1989) claimed that Heidegger had delusions of grandeur. It isn't clear whether Ott was speaking in a general lay sense, or in a psychiatric sense. Ott was referring to Heidegger's conviction

ABOUT HIS FATED ROLE AS GERMANY'S SPIRITUAL LEADER, WHICH LED HIM TO ABSOLVE HIMSELF OF MORAL GUILT FOR HIS ACTIONS AND TO MAKE SCAPEGOATS OF OTHERS.

I THINK MYSELF THAT HEIDEGGER MAY NOT HAVE HAD DELUSIONS OF GRANDEUR, BUT THAT THERE MAY HAVE BEEN GRANDIOSE ELEMENTS TO HIS PERSONALITY, AND THAT HIS PHILOSOPHY REFLECTED THIS GRANDIOSITY. AS PSYCHIATRISTS WE ARE OFTEN LEFT TO EXPLAIN HOW A MAN CAN PRODUCE SO MANY USEFUL IDEAS, AND BE ONE OF THE GREATEST PHILOSOPHERS OF THE TWENTIETH CENTURY, YET AT THE SAME TIME BE A COMMITTED NAZI. THIS IS NOT STRANGE TO US, BECAUSE EVERY DAY WHEN WE WORK WITH OUR PATIENTS WE SEE SO MANY CONTRADICTIONS IN THEIR LIVES.

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# PSYCHOANALYSIS AND LITERATURE

MICHAEL FITZGERALD.

**MARGO WADDELL** HAS ASKED AN INTERESTING QUESTION ABOUT PSYCHOANALYSIS AND LITERATURE WHICH SOME OF YOU MIGHT LIKE TO ANSWER. SHE PUT IT AS FOLLOWS: "DOES PSYCHOANALYSIS ACT AS AN INTERPRETER/EXPLAINER OF LITERATURE, OR RATHER, IS PSYCHOANALYSIS THE TRUE CHILD OF LITERATURE?" I THINK THE ISSUE IS MUCH BROADER. AS PSYCHOANALYSTS, LITERATURE IS VERY HELPFUL TO US, AS WE SHARE MANY OF THE SAME CONCERNS; POETS AND PSYCHOTHERAPISTS HAVE BEEN DESCRIBED AS BLOOD BROTHERS.

WHAT ONE SEES OVER AND OVER AGAIN WHEN READING NOVELS IS THAT THEY HAVE THE WORDS THAT RESONATE, THE WORDS THAT SAY WHAT WE FEEL, AND WE HAVE TO BE GUIDED BY THEM IN THE WORDS WE USE IN OUR INTERPRETATIONS. OUR TECHNICAL WORDS HAVE LITTLE RING TO THEM OUTSIDE A PSYCHOANALYTIC SEMINAR.

NEVERTHELESS, I DON'T AGREE WITH BECKETT WHEN HE SAYS, "WORDS ARE ALL WE HAVE." THIS SEEMS TOO INTELLECTUAL.

Based on lecture to Northern Ireland Association for the study of Psychoanalysis, Muckamore, 20th January, 1990.

After one performance of Beckett's "End Game" the critics were harsh, and somebody said to Beckett that they didn't understand the play. Beckett's wife replied, "I should certainly hope not." It appears to me that some psychoanalytic writers' main aim is to obscure, as Beckett's wife hoped he would, rather than to clarify. One author has said that if you understand anything, then you have misunderstood it, and this seems to suggest that there is no possibility of knowing, no possibility of understanding. While I would accept the notion that absolute truth is unattainable, nevertheless we can acquire approximate truth, which can be enormously helpful to patients.

George Bernard Shaw's view of the Irishman was helpful. He said,

> "An Irishman's imagination never lets him alone, never convinces him, never satisfies him; but it makes him that he can't face reality nor deal with it nor handle it nor conquer it; he can only sneer at them that do, and imagination is such a torture that he can't bear it without whiskey, and all the while there goes on a horrible, senseless, mischievous laughter."

Thinking about borderline or psychotic patients, nobody has put it better than Yeats when he said, "Things fall apart, the centre cannot hold."

When I think of many modern writers - Ibsen, Kafka, Conrad or Beckett - I think of alienation, and it is possible that people are more alienated today



than they were a hundred and fifty years ago. Then, people lived much closer together, were much more involved with one another in cities and, indeed, in the country. I think psychoanalysts and novelists are ploughing the same furrow in dealing with alienation and in helping other people to deal with it, to be less paranoid and to link with other human beings.

Ibsen takes up the theme of alienation when he says, "Everything must be borne alone - despair, resistance and defeat."

Certainly, Nietzsche was partly right when he said that modern men were the children of a fragmented, pluralistic, sick and weird period. Similar themes to Nietzsche's are taken up in T. S. Eliot's poem, "The Wasteland," with its vision of cultural collapse and universal fragmentation. While there is undoubtedly reality in what these authors are saying, there is also some element of projection of their own internal worlds onto the external world.

I feel George Steiner is also right when he points out that one of the problems of the western intellect is a drive towards objective contemplation, logical analysis and scientific classification which cuts people off from their true sense of being. In psychotherapy and in psychoanalysis we are trying to reverse these processes.

The writers Beckett and Freud put emphasis on self-reliance, and Ibsen does likewise when he has Nora say in "A Doll's House," "I have to educate myself first, you can't do that for me - I have another duty, equally sacred, my duty of myself." The word "education" is an interesting one here, and it has

SOMETIMES BEEN FROWNED UPON IN PSYCHOANALYSIS. NEVERTHELESS, THERE IS SCIENTIFIC EVIDENCE NOW THAT PATIENTS WHO HAVE A CLEAR UNDERSTANDING OF WHAT THE TREATMENT IS ABOUT HAVE BETTER OUTCOMES THAN OTHERS. ANNA FREUD'S TECHNIQUE OF CHILD PSYCHOTHERAPY USED TO HAVE AN EDUCATIVE ELEMENT IN THE EARLY STAGES OF TREATMENT.

IN PSYCHOANALYSIS WE ARE INTERESTED IN DEEP DOWN THINGS; AS GERALD MANLEY HOPKINS PUT IT, "THERE LIVES THE DEAREST FRESHNESS DEEP DOWN THINGS," AND PATIENTS COME TO LIFE, BECOME MORE WHOLE, WHEN THEY ACHIEVE CONTACT WITH THESE "DEEP DOWN THINGS."

PLATO SAID, "WE ARE TRYING TO CALL SOMETHING INTO EXISTENCE THAT WAS NOT THERE BEFORE." PROUST WOULD SAY THAT WE ARE TRYING TO "REMEMBER TIMES PAST." I PREFER THE FRENCH TITLE, "RECHERCHE DU TEMPS PERDU," WHICH BRINGS FORTH THE NOTION OF RESEARCHING THE PAST.

WE IN PSYCHOANALYSIS ARE HELPING THE PATIENTS TO ENGAGE WITH THEIR EVOLVING STORIES. IF A PATIENT TELLS PART OF HIS STORY TOO EASILY, THIS USUALLY SIGNIFIES THAT THIS IS NOT THE PART OF HIS STORY WHICH NEEDS TO BE TOLD. ROBERT GRAVES PUT IT CORRECTLY WHEN HE SAID "THERE IS ONLY ONE STORY AND ONE STORY THAT WILL PROVE WORTH YOUR TELLING."

FREUD, IBSEN AND VIRGINIA WOOLF ALL TALK ABOUT THE DIFFICULTY OF FACING REALITY. IT'S CLEAR FROM DOING PSYCHOTHERAPY AND PSYCHOANALYSIS THAT PEOPLE TAKE IN AS LITTLE OF REALITY AS THEY CAN. VIRGINIA WOOLFE PUT IT AS FOLLOWS: "I HAVE TO PREPARE MYSELF FOR THE SIGHT OF MYSELF." BEFORE A SESSION IBSEN TALKS ABOUT ALL SORTS OF DEAD IDEAS AND ALL SORTS OF OLD AND OBSOLETE BELIEFS. HE SAYS "THEY ARE NOT IN US BUT THEY ARE



GRIEF AND LOSS AND WE CAN NEVER FREE OURSELVES FROM THEM. AND THEN WE ARE, ONE AND ALL, SO PITIFULLY AFRAID OF LIGHT."

METAPHOR IS MUCH USED BY NOVELISTS AND IS ALSO VERY IMPORTANT IN PSYCHOANALYSIS, AS IT ALLOWS MUTATIVE CHANGES TO OCCUR WHICH MIGHT BE DIFFICULT OTHERWISE. METAPHOR ALLOWS THE PATIENT THE POSSIBILITY OF ENGAGEMENT WITH PRIMORDIAL THEMES TO WHICH ALL OUR EXPERIENCE GRAVITATES, AND WHICH TECHNICAL TERMS DO NOT, AS "A BROKEN HEART" AFTER THE DEATH OF SOMEBODY CLOSE HAS A MUCH DEEPER RING TO IT THAN, SAY, "AN UNRESOLVED GRIEF REACTION."

I AM INTERESTED BY SOMETHING BECKETT SAID WHICH I THINK THROWS LIGHT ON OUR PROBLEMS WITH INTERPRETATIONS, IN A SENSE THAT I'VE OFTEN HAD OF THE DIFFICULTY OF REALLY GETTING AN INTERPRETATION RIGHT, OF REALLY GETTING THE WORDS RIGHT, OF USING THE RIGHT WORDS AND THE RIGHT TONE, AND NOT SAYING TOO MUCH OR NOT BEING TOO BRIEF; IN THE SENSE OF NOT GIVING THE PATIENT SUFFICIENT ELABORATION TO ALLOW HIM TO UNDERSTAND THE INTERPRETATION. BECKETT SAID, "WHATEVER SAID, IT WAS NEVER ENOUGH . . . AND ALWAYS TOO MUCH."

IT IS WORTH NOTING THAT THE WORDS "METAPHOR" AND "TRANSFERENCE" CARRY DIFFERENT CONNOTATIONAL LOADINGS, ESPECIALLY FOR THE PSYCHOTHERAPIST, AND IT IS IMPORTANT TO REMEMBER THAT THEY ACTUALLY HAVE IDENTICAL MEANINGS. (PEDDER, 1979). BOTH MEAN "TO CARRY ACROSS," FROM THE GREEK AND LATIN RESPECTIVELY. CULTURE AND LANGUAGE ARE PERVADED BY METAPHORS, WHICH ARE FOUND IN CONFUSION IN THE EXPRESSIVE LANGUAGE OF PSYCHOTHERAPY. BY COMMON DEFINITION, AND BY ETYMOLOGY, A METAPHOR IS A TRANSFER OF MEANING, BOTH IN INTENTION AND EXTENSION, (BEARDSLEY, 1967).

In exploring the mutative capacity of metaphor, Cox and Theilgaard (1987) state:

> "We have given many examples of the way in which metaphor can serve as a container for feelings which are too overwhelming to be tolerated. We have also shown how it can prove to be a vehicle for carrying, mobilising, expressing and integrating effect and cognition in furthering the therapeutic process. Metaphor exerts its mutative effect by energising an alternative perspectival aspect of experience. This means that materials which the patient has endeavoured to relinquish, avoid, or deny so that it is safely classified, categorised and filed away, appears again in the pending action file. This inevitably has a startling effect upon the patient. This may take the form of surprised relief because the presumed intolerable was found to be acceptable. On the other hand, the discovery that there is still fire, in affect, embers can indicate that material, previously regarded as defused and safe, has once again become disconcertingly insistent."

Metaphor, according to Abse (1971), usually already denotes something else. Stanford (1936) has pointed out that metaphor cannot exist until some meanings of words are already stereotyped. Where there is no current sense of the word, there can be no metaphor. The essence of the meaning of metaphor implies, according to Stanford (1936), the sense of



transference, the process of transferring a word from one object to refer to another.

The novelist John Banville has stated that his novels are always as much about what is not there as what is, about the absences that surround his characters. (O'Toole, 1989). This to me has echoes of the third ear of psychoanalysis. Banville says, "All my books are about people who can't live fully. All the weight is on what is not there." I find this interesting, as well, because I think many of the patients who come to see us nowadays come for this reason. I think if we were talking about this we would say patients come because of problems of living. Nevertheless, I feel Banville's phrase about not being able to live fully is excellent and accurate.

In writing his novels Banville wants, like the narrator of "Mephisto," to let in more of the chaos, more of the spontanaeity of life. This again seems to me a good description of the analytical psychotherapist's position and of psychoanalytic regression.

Again, I think Beckett says something about the psychoanalytic position and, indeed, the position that I think Freud took up when he said "I have never in my life been on my way anywhere, but simply on my way." This suggests to me analysing and making sense of what the patient is saying, but not forcing him into any way of life or way of behaving that we might value ourselves, not that I don't regard psychoanalysis as value free. I think that the analyst's values are enormously important and are evident to the patient, if not verbally, at least non-verbally and unconsciously. I believe that the patient internalises the analyst's

VALUES UNCONSCIOUSLY AND IDENTIFIES WITH THESE VALUES WHETHER HE LIKES IT OR NOT. I BELIEVE THAT RIGHT FROM THE BEGINNING THE PATIENT'S UNCONSCIOUS AND THE ANALYST'S UNCONSCIOUS ARE IN COMMUNICATION AND THAT THERE IS A TRANSFER OF IDEAS, FEELINGS, ETC., BACK AND FORTH THROUGHOUT THE TREATMENT.

I THINK THAT THIS MIX-UP OF THE TWO UNCONSCIOUSES IS WHAT GIVES THE ANALYST HIS COUNTERTRANSFERENCE FEELINGS AND, PARTIALLY AT LEAST, ALLOWS HIM TO MAKE INTERPRETATIONS BASED ON THESE FEELINGS WHICH HELP TO RESOLVE UNCONSCIOUS CONFLICT. THIS, OF COURSE, PUTS THE KIND OF PERSON THE ANALYST IS, HOW HE REALLY IS, AS SOMETHING VERY CENTRAL.

SEAMUS HEANEY'S POETRY SHOWS US, IN A WAY, WHAT THE ESSENCE OF PSYCHOTHERAPY IS, AND HOW POETRY PROVIDES A BRIDGE FOR PSYCHOANALYSIS. JOHN CAREY, THE CRITIC, POINTED OUT THAT ONE OF THE REASONS HEANEY IS SUCCESSFUL IS THAT HE HAS AVOIDED THE OBSCURITY WHICH HAS BECOME ENDEMIC IN MODERN POETRY SINCE THE DAYS OF ELIOT, AN OBSCURITY WHICH WAS DESIGNED TO KEEP THE CULTURE ALOOF FROM THE PHILISTINE MASSES. HE POINTS OUT THAT SEAMUS HEANEY DOES NOT WISH TO PERPLEX PEOPLE, OR TO MAKE THEM FEEL INFERIOR. UNFORTUNATELY, SOME PSYCHOANALYTIC THEORISTS TODAY ARE VERY INTERESTED IN PERPLEXING PEOPLE AND MAKING THEM FEEL INFERIOR, WITH THEIR OBSCURE AND UNVALIDATED THEORIES. HEANEY WAS CONCERNED ABOUT THE IMPERIALISM OF LANGUAGE - THE GREED WITH WHICH IT STEALS FROM LIFE AND FROM THE SOLIDITY OF THINGS, AS IT SEEMS TO ME SOME PSYCHOANALYTIC THEORIES DO TODAY.

SEAMUS HEANEY IS SUCCESSFUL BECAUSE HE REALISES THAT THERE IS MORE TO LIFE THAN BOOKISHNESS AND INTELLECTUALISING. HE ADMIRES BASIC SKILLS LIKE



THATCHING, BUTTER-CHURNING AND FORGING, WHERE CREATIVITY RETREATS FROM WORDS INTO SILENT TRADITIONAL OPERATIONS. THERE IS SOMETHING HERE, AS WELL, FOR TODAY'S PSYCHOTHERAPISTS, WHO SOMETIMES OVER-EMPHASISE WORDS AND DO NOT PAY SUFFICIENT ATTENTION TO NON-VERBAL BEHAVIOUR.

HEANEY EMPHASISES THE FEEL OF THINGS AND, UNFORTUNATELY, WITH SOME PSYCHOTHERAPIES TODAY FEELINGS ARE DOWN-GRADED. I WILL QUOTE JOHN CAREY AGAIN, WHO SAYS THAT HEANEY'S "FEEL OF THINGS COMES SO VIVIDLY INTO HIS POEMS THAT THEY SEEM TO BE WRITTEN IN SOMETHING THICKER THAN LANGUAGE - SOMETHING LIKE MUD, FOR EXAMPLE, WHICH HE HAS, IN FACT, WRITTEN ABOUT A GOOD DEAL, AND WHICH SPREADS ITS DARKLY GLUTINOUS TEXTURE THROUGH THE POETRY OF HIS MIDDLE YEARS." HEANEY REMEMBERS THAT, AS A CHILD, HE LOVED "PADDLING THROUGH MUCK IN A DEEP TRAIN AND FINGERING SLIME." HE INSISTS THAT WRITING POETRY AS AN ADULT SATISFIES THE SAME URGES AS THESE EARLY MUD DELVINGS. THE MUD WAS HIS OWN SUBCONSCIOUS, INTO WHICH POETRY SANK A SHAFT.

IN A WAY, THAT'S WHERE PSYCHOTHERAPISTS AND PATIENTS MUST VENTURE AS WELL - INTO THE MUD, INTO THE UPSET, ANGER, AND HATE OF THE UNCONSCIOUS AND OF THE PAST.

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# IRISH PSYCHIATRY - THE WAY FORWARD TO THE YEAR 2000

MICHAEL FITZGERALD.

**PREDICTING** WHAT WILL DEVELOP IN PSYCHIATRY IN THE NEXT TEN YEARS IS AN UNCERTAIN ENTERPRISE, WHICH INVOLVES THE HOPES AND WISHES OF THE AUTHOR OF SUCH PREDICTIONS. IT IS CLEARLY IMPOSSIBLE TO PREDICT ACCURATELY, BUT THE EXERCISE IS VALUABLE IN THAT IT RAISES ISSUES FOR DEBATE AND RESEARCH. WHAT FOLLOWS IS WHAT I THINK MIGHT OR SHOULD HAPPEN IN THE NEXT TEN YEARS.

IT SEEMS LOGICAL TO START WITH PREVENTIVE PSYCHIATRY, AND IT IS LIKELY THAT THIS WILL HAVE A MUCH HIGHER PROFILE IN THE COMING YEARS. THIS IS AN AREA IN NEED OF A GREATLY INCREASED RESEARCH EFFORT. IT IS ALSO AN AREA OF CLAIMS, AND HOPES OF THE PAST HAVE NOT BEEN FULFILLED. THERE WILL CLEARLY HAVE TO BE A SHIFT OF FUNDING FROM THE TREATMENT OF PSYCHIATRIC ILLNESS TO THE PREVENTIVE AREA. THIS IS GOING TO BE EXTREMELY DIFFICULT TO ACHIEVE, AS THE PREVENTIVE PSYCHIATRY LOBBY IS VERY WEAK. DESPITE THE CONTROVERSY ABOUT THE EFFECTIVENESS OF PREVENTION, THERE ARE WORTHWHILE WAYS FORWARD. THERE IS A NEED FOR EXPANSION OF THE EASTERN HEALTH BOARD COMMUNITY MOTHERS' SCHEME AND OF SCHEMES OF HIGH QUALITY PRE-SCHOOL EDUCATION, WITH TRAINING IN PARENTING SKILLS FOR PARENTS AND CHILDREN AT RISK WHO ARE SHOWING SIGNS OF BEHAVIOURAL DEVIANCE. THERE IS CLEARLY A NEED FOR NEW PARENT TRAINING TECHNIQUES TO BE DEVELOPED AND EVALUATED IN TERMS OF PREVENTIVE

POTENTIAL. IMPROVED PSYCHOLOGICAL MANAGEMENT OF CHILDREN WITH CHRONIC PHYSICAL DISORDERS, AS WELL AS CHILDREN IN HOSPITAL FOR LONG PERIODS, MAY ALSO HAVE PREVENTIVE POTENTIAL. STUDIES OF CHILDREN HOSPITALISED FOR GASTROENTERITIS SUGGEST THAT IMPROVING SOCIAL SUPPORT FOR MOTHERS AND ISOLATED FAMILIES MAY IMPROVE THEIR COPING ABILITY AND HAVE PREVENTIVE POTENTIAL, (MCGEE AND FITZGERALD, 1988). EARLY AND EFFECTIVE TREATMENT OF PARENTAL MENTAL ILLNESS, ESPECIALLY PUERPERAL MENTAL ILLNESS, MAY ALSO HAVE PREVENTIVE POTENTIAL BECAUSE OF THE CLOSE LINK BETWEEN PARENTAL MENTAL ILLNESS AND CHILD PSYCHIATRIC ILLNESS.

IN THE CHILD PSYCHIATRY DOMAIN IT IS HOPED THAT ADULT PSYCHIATRISTS WILL INCREASINGLY TAKE AN INTEREST IN FAMILY PSYCHIATRY AND IN DISTURBED CHILDREN, WITH REALISATION OF THE VERY SERIOUS NEGATIVE EFFECTS OF ADULT MENTAL ILLNESS ON CHILDREN. ALL REGISTRARS IN PSYCHIATRY SHOULD HAVE MEANINGFUL EXPERIENCE IN CHILD PSYCHIATRY, CHILD PSYCHOTHERAPY AND FAMILY THERAPY. THERE SHOULD BE MUCH CLOSER LIAISON BETWEEN ADULT PSYCHIATRISTS AND CHILD PSYCHIATRISTS. THE SHARP DIVISION BETWEEN ADULT PSYCHIATRY AND CHILD PSYCHIATRY WHICH WE HAVE AT PRESENT DOES NOT MAKE MUCH CLINICAL SENSE.

IDEALLY, A PSYCHIATRIST SHOULD BE ABLE TO TREAT THE PSYCHIATRIC PROBLEMS OF THE FAMILY MEMBERS WITH WHOM HE IS CONFRONTED. IT IS NOT ENOUGH JUST TO SINGLE OUT ONE MEMBER OF A FAMILY FOR TREATMENT, WHEN A NUMBER OF FAMILY MEMBERS ARE DISTURBED. ADULT PSYCHIATRISTS SHOULD PAY MORE ATTENTION TO SYSTEMS CONCEPTS. CLEARLY, A BIO-PSYCHOSOCIAL MODEL OF PSYCHIATRY IS THE ONLY WAY FORWARD. PSYCHIATRY HAS SUFFERED CONSIDERABLY IN THE PAST FROM AN EXCESSIVE EMPHASIS ON BIOLOGICAL, PSYCHOLOGICAL OR SOCIAL ASPECTS OF PSYCHIATRY



INDIVIDUALLY, WITH EACH GROUP NEGLECTING THE CONTRIBUTIONS OF THE OTHER TWO.

CONDUCT DISORDERED CHILDREN ARE VERY COMMON IN CHILD PSYCHIATRY, BUT PARTICULARLY THE SEVERER FORMS HAVE PROVED VERY DIFFICULT TO AMELIORATE. THERE IS A GREAT NEED TO INCREASE OUR UNDERSTANDING AND TREATMENT METHODS OF THIS CONDITION. IT WOULD BE INTERESTING TO SEE IF CHILDREN COULD BE GIVEN STRATEGIES AIMED AT PROTECTING THEM FROM THE EFFECTS OF PARENTAL MENTAL ILLNESS. THERE SHOULD BE A CAUTIOUS INCREASE IN THE USAGE OF DRUGS IN CHILD PSYCHIATRY, AS IT APPEARS THAT THEY ARE SOMEWHAT UNDER-UTILISED AT THE MOMENT, WITH THE FASHION FOR FAMILY THERAPY. THEY CAN HAVE A PLACE, FOR EXAMPLE, IN THE HYPERKINETIC DISORDER, AND THIS BENEFIT MAY AUGMENT FAMILY AND BEHAVIOURAL INTERVENTION. NO EFFORT MUST BE SPARED IN EVALUATING THE EFFECTIVENESS OF ALL THERAPEUTIC APPROACHES. IT IS HOPED THAT THE MATCHING OF PATIENT AND TREATMENT WILL HAVE IMPROVED, AND THAT THERE WILL BE AN INCREASED USAGE OF HOME-BASED TREATMENTS, PARTICULARLY WITH MULTI-PROBLEM FAMILIES. AS CHILD PSYCHIATRIC PROBLEMS ARE NOT UNCOMMONLY MULTI-FACTORIAL IN ORIGIN, NON-INVASIVE BRAIN-IMAGING TECHNIQUES ARE LIKELY TO MAKE SMALL BUT IMPORTANT CONTRIBUTIONS TO CHILD PSYCHIATRY. IT IS LIKELY THAT THERE WILL BE MANDATORY REPORTING OF CHILD SEXUAL ABUSE, AND THAT WITHIN THE NEXT TEN YEARS CHILDREN IN COURT WILL BE INTERVIEWED BEHIND A ONE-WAY SCREEN OR ON CLOSED CIRCUIT TELEVISION. IT WILL BECOME INCREASINGLY REALISED THAT CHILDREN ARE AS ACCURATE AS ADULTS IN THEIR REPORTING OF WHAT HAPPENS TO THEM. IN THE NEXT TEN YEARS CHILD PSYCHOTHERAPY WILL HAVE REGAINED ITS PROPER PLACE IN CHILD PSYCHIATRY. THERE WILL BE INCREASED EMPHASIS ON THE INDIVIDUAL DISTURBED CHILD IN ADDITION TO THE FAMILY AND WIDER SOCIAL FACTORS. THE IMPORTANCE OF SCHOOL PROCESSES ON

CHILDREN WILL BE INCREASINGLY RECOGNISED, AND MALFUNCTIONING SCHOOLS WITH A POOR ETHOS WILL RECEIVE SPECIAL HELP. THE DEVELOPMENT OF PLANNING SKILLS AND THE PROVISION OF SUCCESS EXPERIENCES WILL BE INCREASINGLY EMPHASISED IN SCHOOLS. THERE WILL BE TWO CHILD PSYCHIATRISTS PER 200,000 OF THE POPULATION THROUGHOUT THE COUNTRY. CHILD PSYCHIATRISTS WILL BE CARRYING OUT SESSIONS IN GROUP GENERAL PRACTICES. CHILD PSYCHIATRISTS WILL ALSO BE ATTACHED TO COMMUNITY CARE SOCIAL WORK DEPARTMENTS. SERVICES FOR THE DISTURBED MENTALLY HANDICAPPED WILL BE INCREASINGLY DEVELOPED BY CONSULTANT CHILD PSYCHIATRISTS WITH SPECIAL INTEREST IN MENTAL HANDICAP. THERE WILL BE TWO ACADEMIC DEPARTMENTS OF CHILD PSYCHIATRY IN IRELAND.

AFTER MANY YEARS OF DISAPPOINTING PROGRESS IN PSYCHOPHARMACOLOGY, NEW DRUGS WILL BE INTRODUCED WHICH WILL HAVE REAL BENEFITS FOR PATIENTS. PSYCHIATRY WILL NOT HAVE "LOST THE MIND," AS ONCE FEARED. THE RIVALRY AND COMPETITIVENESS BETWEEN MENTAL HEALTH PROFESSIONALS WILL HAVE REDUCED, AND THERE WILL BE INCREASING RESPECT AND ACKNOWLEDGEMENT FOR THE CONTRIBUTIONS OF OTHER DISCIPLINES. THE SEVERITY AND PROBLEMS OF THE SERIOUSLY MENTALLY ILL WILL FINALLY BE RECOGNISED BY PRACTITIONERS WORKING OUTSIDE HOSPITAL ENVIRONMENTS. INCREASINGLY, THE DAMAGING EFFECTS OF SOCIAL ISOLATION WILL BE RECOGNISED AND VOLUNTARY AND STATUTORY ORGANISATIONS WILL BE ORGANISED TO SUPPORT THE SOCIALLY ISOLATED. RETIRED PEOPLE, THE CLERGY AND OTHERS WILL BE MAKING A CONTRIBUTION HERE. ADULT PSYCHIATRISTS WILL BE INCREASINGLY CARRYING OUT SESSIONS IN GROUP GENERAL PRACTICES AND THERE WILL BE MORE SENIOR REGISTRAR POSTS IN GENERAL PSYCHIATRY. OVERALL, THERE WILL BE A REDUCED PRESCRIBING OF PSYCHOACTIVE DRUGS, WITH A GREATER RECOGNITION OF PSYCHOSOCIAL FACTORS IN ADULT PSYCHIATRY. IT IS LIKELY THAT MORE AND MORE



SOPHISTICATED EPIDEMIOLOGICAL DATA WILL BE AVAILABLE TO EACH HOSPITAL AND HEALTH BOARD AREA, WHICH WILL ASSIST PLANNING SERVICES. THE CLINICAL EFFECTIVENESS AND COST EFFECTIVENESS OF ALL PSYCHIATRIC PROGRAMMES WILL BE CONTINUALLY MONITORED. THE EFFECT OF PSYCHIATRIC TREATMENT ON QUALITY OF LIFE WILL BECOME INCREASINGLY IMPORTANT.

GERIATRIC PATIENTS WILL BE LOOKED AFTER BY GERIATRICIANS IN GERIATRIC RESIDENTIAL ACCOMMODATION, AND NOT BY PSYCHIATRISTS. OLD-AGE PSYCHIATRY WILL HAVE SPECIALIST CONSULTANT COVER OF ONE SESSION FOR EVERY 2,000 ELDERLY PEOPLE. DOMICILIARY ASSESSMENT WILL BE REGARDED AS VERY IMPORTANT IN OLD-AGE PSYCHIATRY.

AS MALLET (1990) POINTS OUT, MOLECULAR GENETICS WILL INCREASE OUR KNOWLEDGE OF SOME SEVERE MENTAL DISORDERS IN THE NEXT DECADE, THROUGH THE IDENTIFICATION OF GENETIC MARKERS "THAT SEGREGATE WITH THE DISEASES IN LARGE REFERENCE FAMILIES WHERE HOMOGENEITY AND HIGH PENETRANCE OF THE TRAIT HAS BEEN CAREFULLY ESTABLISHED." HOPEFULLY THIS SHOULD LEAD TO IMPROVED TREATMENT, WHETHER OF DRUG TYPE OR OF A PSYCHOSOCIAL TYPE. IT WOULD BE REASONABLE TO FOCUS MAJOR EFFORT ON ESTABLISHING A LINKAGE MAP, PARTICULARLY FOR SCHIZOPHRENIA AND AFFECTIVE DISORDERS. MALLET (1990) POINTS OUT THAT THIS WOULD ENABLE THE NUMBER OF GENES, THE MODE OF INHERITANCE AND THE PRECISE DNA DEFECTS TO BE DETERMINED. IT WOULD BE INTERESTING THEN TO STUDY THE INTERACTION BETWEEN ENVIRONMENTAL AND GENETIC FACTORS IN "HIGH RISK" FAMILIES. THE FACT THAT NEW DNA MARKERS ARE AVAILABLE WILL HAVE A MAJOR IMPACT ON RESEARCH. THE EXISTENCE OF HIGHLY POLYMORPHIC RESTRICTION FRAGMENT MARKERS (RFLP) SPANNING THE GENOME AT VERY CLOSE INTERVALS HAS GREATLY INCREASED OUR KNOWLEDGE OF THE NEURO-MOLECULAR LEVEL OF

MENTAL ILLNESS. IT IS NECESSARY TO STUDY LARGE MULTIPLY-AFFECTED FAMILIES THROUGH LINKAGE ANALYSIS. THE WHOLE GENOME MUST BE SCREENED.

PSYCHOTHERAPY WILL CONTINUE TO BE SEEN AS A PRIMARY TREATMENT METHOD, AND IT WILL ALSO BE USED IN CONJUNCTION WITH OTHER TREATMENT METHODS. IT WILL BE SEEN AS HAVING WIDE APPLICATION, AND BE OF PARTICULAR IMPORTANCE IN THE TREATMENT OF ADJUSTMENT REACTIONS AND UNRESOLVED GRIEF; IN TREATING SELECTED PATIENTS WITH PSYCHOSOMATIC DISORDERS AND POST-TRAUMATIC CONDITIONS, INCLUDING THE SEQUELAE OF ACCIDENTS, RAPE AND SEXUAL ABUSE. PHYSICIANS AND SURGEONS WILL INCREASINGLY APPRECIATE THE IMPACT OF PSYCHOLOGICAL FACTORS, PARTICULARLY WITH THE INCREASED TRAINING IN PSYCHIATRY AT MEDICAL STUDENT LEVEL, AND THROUGH PUBLIC DEMAND THAT THESE FACTORS BE ACKNOWLEDGED. PSYCHOTHERAPY WILL BE SEEN AS VALUABLE IN THE MANAGEMENT OF PHYSICAL ILLNESSES WHERE PATIENTS HAVE DIFFICULTY IN ADJUSTING OR ACCEPTING IRREMEDIAL HANDICAPS OR DISTRESSING SYMPTOMS. PSYCHIATRISTS WITH A SPECIAL INTEREST IN PSYCHOTHERAPY HAVE EMPHASISED THE IMPORTANCE OF INTERPERSONAL FACTORS IN HOSPITAL, MEDICAL AND GENERAL PRACTICE. PSYCHOTHERAPY WILL HAVE BECOME ONE OF THE IMPORTANT SUB-SPECIALTIES. THIS SUB-SPECIALISATION IN PSYCHOTHERAPY WILL ELEVATE THE LEVEL OF PSYCHIATRIC CARE RECEIVED BY MANY PATIENTS. THERE WILL BE INCREASED USE BY GENERAL PSYCHIATRISTS OF PSYCHOTHERAPY CONSULTATION. THE CONSULTATION PROCESS WILL ASSURE A BETTER QUALITY AS WELL AS AN ONGOING EDUCATION OF GENERALISTS.

THIS WILL COUNTER THE TENDENCY OF SOME PSYCHIATRISTS AS QUALIFIED TO TREAT ANY PATIENT WITH AN ECLECTIC AMALGAM OF GENERIC PSYCHOTHERAPY AND NON-SPECIFIC PSYCHOPHARMACOLOGY. IT WILL BE SEEN AS



IMPORTANT FOR PSYCHOTHERAPISTS TO MAINTAIN THEIR INTEREST IN GENERAL OR CHILD PSYCHIATRY, SO THAT THEY CAN CONTINUE TO BUILD BRIDGES AND APPRECIATE WHAT GENERAL PSYCHIATRY HAS TO OFFER. ALL REGISTRARS IN TRAINING SHOULD SPEND AT LEAST A YEAR IN PSYCHOTHERAPY TRAINING, AND ACQUIRE ADVANCED TRAINING IN ONE BRANCH OF PSYCHOTHERAPY. THERE WILL BE MUCH INCREASED USAGE OF PSYCHOTHERAPY BY GENERAL PRACTITIONERS. PSYCHIATRY WILL PAY INCREASED ATTENTION TO THE SUFFERING OF THE YOUNG, THE PATIENTS WITH NEUROTIC PROBLEMS AND THE PATIENTS WITH RELATIONSHIP PROBLEMS AND PROBLEMS OF LIVING. AS THE DEPARTMENT OF HEALTH DOCUMENT "PLANNING FOR THE FUTURE" POINTED OUT, THERE NEEDS TO BE INCREASED USE OF A VARIETY OF FORMS OF PSYCHOTHERAPY IN OUT-PATIENT CLINICS, DAY HOSPITALS AND IN-PATIENT UNITS. IT IS LIKELY THAT PSYCHOTHERAPY WILL BE REGULATED THROUGH A STATUTORY BODY. THERE WILL BE AT LEAST ONE ACADEMIC DEPARTMENT OF PSYCHOTHERAPY IN THE COUNTRY.

THE NEW MENTAL HEALTH ACT WILL BE IN PLACE, WITH ITS GREATER EMPHASIS ON COMMUNITY CARE. THE STIGMA OF MENTAL ILLNESS WILL CONTINUE TO FALL. THIS WILL BE ASSISTED BY FORMER PATIENTS TALKING ABOUT THEIR PSYCHIATRIC ILLNESSES. IT IS LIKELY THAT THERE WILL BE A NUMBER OF REGIONAL SECURE UNITS IN THE COUNTRY. A PSYCHIATRIC DEFENCE MAY BE INTRODUCED WHICH WILL ALLOW MURDER CHARGES TO BE REDUCED TO MANSLAUGHTER. THE JUDGE WILL THEN DECIDE WHAT THE BEST RESPONSE WILL BE. ANOTHER POSSIBILITY IS THAT HOSPITAL ORDERS WILL HAVE BEEN INTRODUCED WHICH WILL ALLOW JUDGES TO COMMIT PATIENTS TO ANY PSYCHIATRIC HOSPITAL, WITH THE AGREEMENT OF THE HOSPITAL DOCTORS. YET ANOTHER POSSIBILITY IS THAT A PSYCHIATRIC REVIEW TRIBUNAL WILL BE SET UP TO EXAMINE PATIENTS UNDER PSYCHIATRIC DETENTION IN THE CENTRAL MENTAL HOSPITAL, AND TO CARRY

OUT SIX-MONTHLY REVIEWS, (A. O'CONNOR, 1990). IT IS ALSO POSSIBLE THAT ALCOHOL AND DRUG ABUSE WILL NO LONGER BE CERTIFIABLE ILLNESS, (SMITH, 1990). IT IS LIKELY THAT THE VOLUNTARY FORM OF ADMITTING PATIENTS TO PSYCHIATRIC HOSPITALS WILL BE ABOLISHED. IT IS ALSO LIKELY THAT PATIENTS DETAINED UNDER THE MENTAL HEALTH ACT WILL BE REVIEWED BY A MEDICAL REVIEW COMMITTEE AT ONE WEEK AND AT ONE MONTH.

BY THE YEAR 2000 THE PROCESS OF REHABILITATION AND THE PLACEMENT OF PLACEABLE PATIENTS FROM LARGER PSYCHIATRIC HOSPITALS IN THE COMMUNITY WILL BE COMPLETE THROUGHOUT THE COUNTRY. THE QUESTION THEN WILL BE, WHAT WILL HAPPEN IN THIS POST-COMMUNITY CARE ERA? COMMUNITY CARE HAS ABSORBED AN ENORMOUS AMOUNT OF ADMINISTRATIVE AND MENTAL HEALTH PROFESSIONAL ENERGY OVER THE YEARS, AND I HOPE THAT IN THE POST-COMMUNITY CARE ERA THIS ENERGY WILL BECOME AVAILABLE FOR INCREASING PSYCHOTHERAPY AND SUPPORT SERVICES FOR ISOLATED FAMILIES.

IT IS IMPORTANT THAT ALL PSYCHIATRISTS CRITICALLY EVALUATE ALL ASPECTS OF THEIR PSYCHIATRIC PRACTICES. THE ALTERNATIVE IS STAGNATION, WITH EXCESSIVE EMPHASIS BEING GIVEN TO INSTITUTIONALISED RITUALS WHICH ARE CARRIED OUT IN A REFLEXIVE WAY. PSYCHIATRY HAS TO CONTINUALLY CHANGE TO STAY ALIVE. INEVITABLY, CHANGE INVOLVES SOME RISK, BUT THIS CAN BE MINIMISED IF THE CHANGES ARE SCIENTIFICALLY EVALUATED FROM AN EARLY STAGE.



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# BOOK REVIEWS

BY MICHAEL FITZGERALD

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**THE VISIBLE AND INVISIBLE GROUP.** AGAZARIAN, Y., AND PETERS, R. (1989). TAVISTOCK-ROUTLEDGE.

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THIS IS AN EXCELLENT TEXTBOOK ON THE TECHNIQUE OF GROUP PSYCHOTHERAPY. IT IS DIVIDED INTO THREE PARTS. THE FIRST PART DEALS WITH THEORETICAL CONCEPTS AND THE SECOND WITH PATIENT SELECTION AND GROUP DEVELOPMENTAL PHASES. THE FINAL PART FOCUSES ON QUESTIONS OF CO-THERAPY, TRANSFERENCE AND COUNTERTRANSFERENCE.

THE AUTHORS POINT OUT THAT THE INVISIBLE GROUP IS THAT WHICH ONLY EXISTS THROUGH THEORETICAL EYES. THE THEORY USED IS PSYCHOANALYTIC, AND THE AUTHORS STATE: "WE HAVE NOT FOUND ANY OTHER THEORY THAT EXPLAINS PERSONALITY DYNAMICS BETTER OR WITH MORE COMPREHENSIVE-NESS." THERE IS ALSO HAS A HIGH QUALITY REFERENCE SECTION WHICH GIVES SOME INDICATION OF WHAT THE BOOK IS ABOUT, AS WELL AS A GLOSSARY. THE AUTHORS ARE VERY KEEN ON CO-THERAPY, BECAUSE THEY STATE THAT "WIDER RANGE OF SKILLS IN DIAGNOSIS OF SITUATIONS AND INTERVENTION IS AVAILABLE AND A FAR MORE EFFECTIVE CHECK AGAINST COUNTERTRANSFERENCE BEHAVIOUR IS PROVIDED." THIS IS UNDOUBTEDLY TRUE BUT, WITH THE HUGE NUMBERS OF PATIENTS REQUIRING PSYCHOTHERAPY, IT IS DOUBTFUL IN THE CURRENT ECONOMIC CLIMATE IF TWO THERAPISTS ARE GOING TO BE AVAILABLE TO CONDUCT ALL GROUPS. IT IS MORE LIKELY THAT CO-THERAPY WILL BE AVAILABLE AS A TRAINING TECHNIQUE.

THIS BOOK CAN BE RECOMMENDED TO ALL PROFESSIONALS WORKING WITH GROUPS.

**Childhood Bereavement and its Aftermath.**
Altschul, S. and Pollock, G. H. (Eds). International Universities Press (1988).

This book attempted to present the findings of the research on childhood bereavement from the Institute for Psychoanalysis of Chicago. This work started in the 1950's as a study of adult psychoanalytic patients who had while in childhood suffered the loss of a parent by death, and was later enlarged by the addition of a study of bereaved children close to the time of parental death.

It was noted that there was a resistance to the awareness of the transference in adult patients who had suffered bereavement. These patients appear to avoid getting involved with the analyst as a way of preserving the relationship with the dead parent. These patients often came into treatment when they were involved in some life event, for example, marriage and they showed little or no reaction to the parental bereavement in childhood, and had little memory of grief at that time. Altschul speculated initially that these patients denied the significance of the parental loss and avoided mourning, which in turn led to an incomplete and prolonged mourning and an arrest in ego development at the level achieved at the time of the loss. He then aimed, with these patients, to get them involved with him so that the mourning process could be resumed, or advanced.

The follow-up study of children recently bereaved showed that all were symptomatic during the first year of the bereavement. Pre-school children showed, rather than overt depression, evidence of regressive



behaviour, phobic or fearful reactions, and a facade of playful or happy feelings; "some of these younger children were striking, nonetheless, in the expression of plaintive, sad, mournful feelings." The latency boys, who had suffered the loss of father, showed evidence of sadness, despite otherwise functioning well. Some of them also showed learning difficulties. In addition, phobic symptoms and intense longings, and wishes for a re-union with the deceased parent, pseudo maturity, vulnerability or uncertainty about their personal adequacy in situations of separation were the more common symptomatic features of this group of otherwise healthy children. A small group of latency boys denied the impact of the death on their lives. The authors also point out that the fact that the working through is incomplete does not by itself imply pathology, since the child can deal with some of these unfinished issues at a later date, when a more opportune time ensues, and then the mourning process can be reactivated and a more comprehensive working through carried out. They also make another important point, that "mourning in the sense of decathexis of the lost object is never complete, even in the adult, nor would such a state be desirable." One of the key elements as far as childhood bereavement is concerned is the support of the surviving parent to negotiate the painful, difficult process of mourning.

It is important to note that only 25% of the surviving parents were capable of tolerating their own as well as the child's grief, so that they could support and facilitate the child's mourning process. The other 75% of parents were regarded as requiring some support to help their children carry out this process. This is clearly a matter of great importance for adult psychiatrists, and an example of preventive

PSYCHIATRY. IT WAS ALSO FELT IMPORTANT IN THE TREATMENT OF THE CHILD THAT THE CHILD SHOULD GAIN A MORE COMPREHENSIVE AND STABLE IMAGE OF THE LOSS OF THE PARENT. THIS WAS AN EFFORT TO PREVENT THE CHILD'S MEMORIES BECOMING STEREOTYPIC, AND THE PARENT REMAINING STATIC IN THE CHILD'S MIND.

POLLOCK POINTS OUT THAT GRIEF CAN BE CREATIVE AND NOTES HOW JAMES BARRIE, IN AN EFFORT TO HELP HIS BEREAVED MOTHER, BEGAN TO WRITE STORIES FOR HER AMUSEMENT. THIS BOOK IS BASICALLY A PSYCHOANALYTIC APPROACH TO BEREAVEMENT AND ITS AFTERMATH. READING IT REMINDED ME THAT ROBERT FURMAN STATED THE FOLLOWING SOME YEARS AGO: "I HAVE FELT THAT A CHILD USUALLY HAS THE CAPACITY FOR MOURNING, UNDER PROPER CIRCUMSTANCES, FROM SOMEWHERE AROUND AGE FOUR, WHEREAS WOLFENSTEIN NAGERA FELT THAT A CHILD CANNOT MOURN UNTIL THE TERMINATION OF ADOLESCENCE. THIS WOULD MEAN, TO ME, UNTIL YOUNG ADULTHOOD IS REACHED. IN OTHER WORDS, I BELIEVE A CHILD, FROM AGE FOUR ON, HAS THE CAPACITY FOR COMPLETING THE REQUIREMENTS OF THE MOURNING TASK; AND THEY BELIEVE, IF I UNDERSTAND THEM CORRECTLY, THAT NO CHILD CAN COMPLETE THIS TASK."

THE CRITERIA FOR MOURNING INCLUDE EGO MATURITY AND STRENGTH, AS WELL AS THE ACHIEVEMENT OF OBJECT CONSTANCY. THERE IS A NEED FOR GOOD REALITY TESTING AND A BASIC ACCEPTANCE OF THE REALITY PRINCIPLE AND IMPULSE CONTROL, AS WELL AS A CAPACITY FOR VERBALISATION AND IDENTIFICATION OF FEELINGS, ADEQUATE MEMORY, PERCEPTION, UNDERSTANDING OF TIME CONCEPTS, AND THE ABILITY TO DISTINGUISH BETWEEN LIVING AND NON-LIVING, INCLUDING THE ACHIEVEMENT OF CASUAL THINKING.



**THE CHILD AND HIS FAMILY - PERILOUS DEVELOPMENTS: CHILD-REARING AND IDENTITY FORMATION AND DISTRESS.**
ANTHONY, E. J. AND CHILAND, C. (1988). WILEY.

THIS BOOK EXPLORES THE CHILD'S DEVELOPMENT OF SELF IMAGE AND SELF CONCEPTS UNDER STRESSFUL CONDITIONS OF VARYING TYPES. IT HAS SECTIONS ON IDENTITY FORMATION UNDER STRESS, STRESSFUL PARENTHOOD, STRESSFUL INFANCY, DISTRESS OF CHRONIC ILLNESS ON CHILDREN AND ADOLESCENCE, AS WELL AS THE REACTIONS OF CHILDREN AND THEIR PARENTS TO DISASTROUS AND VIOLENT CIRCUMSTANCES. ANTHONY NOTES THAT WESTERN TYPE INDUSTRIALISED SOCIETIES ARE PARTICULARLY DEMANDING AND STRESSFUL. THIS, OF COURSE, CAN ALSO BE SEEN IN IRELAND, WHERE THE RATES OF CHILD PSYCHIATRIC DISTURBANCE ARE MUCH GREATER IN URBAN AS OPPOSED TO RURAL AREAS. HE POINTS OUT THAT, IN MOST STRESS RESEARCH, THE DEVELOPMENTAL POINT OF VIEW IS NOT INCLUDED, AND THIS IS A SIGNIFICANT DEFICIT. HE QUOTES TERR AS STATING THAT OVERWHELMING ANXIETY IS NOT A POTENTIALLY TOUGHENING EXPERIENCE, BUT RATHER POSES A SIGNIFICANT PERSISTENT BURDEN ON THE CHILD'S PERSONALITY DEVELOPMENT. IT IS NOT YET KNOWN WHETHER A HARD LIFE STEELS A CHILD, AS SUGGESTED BY BLEULER, OR SENSITISES HIM TO ADVERTISITY.

THE BOOK BASICALLY LOOKS AT RECENT RESEARCH IN CHILD PSYCHIATRY, AND IS THEREFORE A BOOK TO BE "DIPPED INTO" RATHER THAN READ FROM BEGINNING TO END. IT IS BASICALLY A COLLECTION OF PAPERS, AND MOST PROFESSIONALS WORKING IN THE FIELD OF CHILD PSYCHIATRY WOULD FIND ONE OR TWO PAPERS OF INTEREST TO THEM. IT IS A BOOK FOR THE INSTITUTIONAL RATHER THAN THE PRIVATE LIBRARY.

**THE INQUIRING MAN: THE PSYCHOLOGY OF PERSONAL CONSTRUCTS.** BANNISTER, D. AND FRANSELLA, F. (1986). CROOM HELM, LONDON.

PERSONAL CONSTRUCT THEORY, DEVELOPED BY G. A. KELLY THIRTY YEARS AGO, STATES THAT EACH INDIVIDUAL, AS A RESULT OF HIS EXPERIENCE, DEVELOPS A PERSONAL REPERTOIRE OF CONCEPTS OR CONSTRUCTS, AND OF THE RELATIONSHIP BETWEEN THESE CONCEPTS, BY MEANS OF WHICH HE CONSTRUES HIS ENVIRONMENT IN GENERAL, AND THE NEW SITUATIONS IN PARTICULAR. THERE IS AN ASSOCIATED TECHNIQUE, THE REPERTORY GRID TECHNIQUE FAMILIAR TO PSYCHIATRISTS, WHICH DESERVES TO BE USED MUCH MORE.

THE AUTHORS EMPHASISE THAT THIS THEORY SEES MAN "NOT AS AN INFANTILE SAVAGE, NOR AS A JUST-CLEVERER-THAN-THE-AVERAGE-RAT, NOR AS THE VICTIM OF HIS BIOGRAPHY, BUT AS AN INVETERATE INQUIRER, SELF-INVENTED AND SHAPED, SOMETIMES WONDERFULLY AND SOMETIMES DISASTROUSLY, BY THE DIRECTION OF HIS INQUIRIES." CLINICIANS HAVE FOUND THE UNDERSTANDING OF THE MOTIVATIONAL ASPECT OF MAN IMPORTANT, AND WOULD FIND IT DIFFICULT TO ACCEPT KELLY'S REJECTION OF THE IMPORTANCE OF THESE ASPECTS. MANY PATIENTS FIND THE CLARIFICATION OF THEIR MOTIVES VALUABLE IN UNDERSTANDING THEMSELVES AND ENLARGING THEIR AREA OF CONSCIOUSNESS. IT IS CLEAR THAT THE AUTHORS' UNDERSTANDING OF PSYCHOANALYSIS AND RECENT DEVELOPMENTS IN PSYCHOANALYSIS IS VERY LIMITED.

CLINICIANS HAVE FOUND IT USEFUL TO EXAMINE THE PATIENTS' BIOLOGICAL MAKE-UP, THE EFFECTS OF FAMILY ENVIRONMENT IN CHILDHOOD AND OTHER LIFE EXPERIENCES AS THE PATIENT DEVELOPS, AND WOULD NOT SEE IT AS SUFFICIENT TO FOCUS ON HOW PATIENTS CONSTRUE THE WORLD.



THERE APPEARS TO BE CONSIDERABLE OVERLAP BETWEEN PERSONAL CONSTRUCT PSYCHOLOGY AND OTHER PSYCHOLOGIES, FOR EXAMPLE, IN "LIBERATION THROUGH UNDERSTANDING." PERSONAL CONSTRUCT PSYCHOLOGY SEES THE RELATIONSHIP BETWEEN THE PSYCHOTHERAPIST AND CLIENT AS THAT OF CO-EXPERIMENTERS, AND MANY PSYCHOANALYTICALLY ORIENTED PSYCHOTHERAPISTS WOULD ALSO SEE THEMSELVES AS CO-EXPERIMENTERS WITH PATIENTS, AND WOULD SEE THEMSELVES AS PUTTING FORWARD HYPOTHESES WHICH WOULD THEN BE EXPLORED AND TESTED IN THE SESSIONS. DESPITE THE AUTHORS' CRITICISM OF OTHER PSYCHOLOGIES IN THE EARLY PART OF THE BOOK, THEY DO SEEM TO BE EXPRESSING AN ECLECTIC PSYCHOTHERAPEUTIC APPROACH WHEN THEY STATE: "THUS A PERSONAL CONSTRUCT PSYCHOTHERAPY MIGHT WELL INCLUDE BEHAVIOUR THERAPY METHODS IF, FOR INSTANCE, THE CLIENT WAS HAVING DIFFICULTY IN TIGHTENING CONSTRUING IN A GIVEN AREA. IT MIGHT INCLUDE PSYCHOANALYTIC TYPE OF FREE ASSOCIATION IF THE PATIENT HAD DIFFICULTY IN LOOSENING CONSTRUCTS." THE LABELLING BY THE PERSONAL CONSTRUCT PSYCHOTHERAPIST OF "ELUSIVE THOUGHTS IS, AT THE PROPER TIME, CRUCIAL TO MAKING FURTHER ENQUIRIES TO THE EXPERIMENTAL TESTING OF HYPOTHESIS," IS SIMILAR TO THE PSYCHOANALYTIC APPROACH, AS IS THE STATEMENT THAT PERSONAL CONSTRUCT PSYCHOTHERAPY FOCUSES "ON TRYING TO UNDERSTAND THE METAPHORS AND MYTHS THAT ARE AN INTEGRAL PART OF ANY PERSONAL LANGUAGE SYSTEM."

THE BOOK ALSO CONTAINS A VERY INTERESTING DISCUSSION OF THE ROLE OF SCIENCE IN PSYCHOLOGY AND PSYCHIATRY. OVERALL, IT IS AN EXCELLENT BOOK ON PERSONAL CONSTRUCT PSYCHOLOGY, AND CONSULTANT PSYCHIATRISTS AND PSYCHIATRISTS IN TRAINING WILL FIND IT VERY INTERESTING AND STIMULATING, AND WELL WORTH INVESTING IN.

**Suicide.** Barraclough, B. (1987). Croom and Helm.

This book, by a leading figure in the study of suicide, summarises research into this area by Dr. Baraclough and co-workers over almost twenty years. It describes a follow-up of 100 suicides of the medium term outcome for an unselected group of spouses and children bereaved by suicide. It also contains a study of a consecutive series of 100 suicides which is well known to psychiatrists.

The book considers the importance of physical disease in contributing to suicide, and points out that it is modest in comparison to that of mental disease. The author notes that epilepsy is associated with a high suicide rate. In disussing the occurrence of increased life events among more suicides than controls, he points out that illness behaviour, or conduct arising from an abnormal personality, may result in events which change the social environment unfavourably, worsening the outlook or the illness, inducing depressed moods and enhancing the risk of suicide. He also points out that "there are large differences between national suicide rates. Ascertainment procedures cannot explain more than a small part of these differences, at least for those states considered here. Genuine international differences in suicide incidences therefore appear to exist." Baraclough makes an additional comment on suicide statistics: "Criticism of the accuracy of official suicide statistics, much of it destructive and sometimes going so far as to dismiss statistics as useless, became frequent during the 1960's.

He notes that since 1971 the suicide rate has been



rising again, despite improvements in the care of the mentally ill. He points out that improvements in medical practice have not been shown to bear a relationship to trends in the suicide rate.

He did not mention studies of suicide prevention by Miller in the United States, which suggested that intensive suicide prevention programmes had some success in reducing female suicides. This is an excellent and clear book that can be fully recommended to psychiatrists in training, as well as to consultant psychiatrists.

**Mind Waves.** Edited by Blackmore and Greenfield. (1989)

Some of the oldest philosophical questions surround the "mind-brain" problem and a recent book, called "Mind Waves," edited by Blackmore and Greenfield, brings together philosophers, psychiatrists, psychoanalysts and other scientists to carry out an examination of this problem in a series of fascinating papers.

There is a discussion about how behaviourism came to a halt because the humble laboratory rat proved too resourceful, too thoughtful, too rich in insight to be treated as if it were a mindless machine. The authors point out that most behaviourists had denied the necessity of postulating mental states, but the need to see behaviour in terms of intentions kept intruding.

The psychology of behaviour then returned to its nineteenth-century roots in the current fashion for "cognitive" explanations of the actions of animals, as well as people. Brain researchers of all sorts have

BEEN FORCED TO TAKE SERIOUSLY MENTALISTIC EXPLANATIONS OF BEHAVIOUR, AND MOST OF THEM SEE PERCEPTION, INTENTION, THOUGHT, AND WILL TO BE LEGITIMATE SUBJECTS OF INTEREST FOR THE RAPIDLY GROWING SUBJECT OF NEUROSCIENCE.

THE EDITORS, IN THE PREFACE, MAKE THE COMMON MISTAKE OF DISCUSSING THE DUALISM OF DESCARTES. IF THEY HAD RE-READ DESCARTES, THEY WOULD HAVE SEEN THAT HE DISCUSSED REPEATEDLY THE RELATIONSHIP BETWEEN MIND AND BODY. DESCARTES HAS BEEN SCAPE-GOATED BY WORKERS IN THE PSYCHOSOMATIC FIELD, BY THEIR INSISTENCE ON CONTINUALLY BLAMING HIM FOR THE SPLIT BETWEEN MIND AND BODY.

SOME OF THE PROBLEMS IN PSYCHIATRY HAVE BEEN CAUSED BY THE ISOLATION OF ONE GROUP OF RESEARCH WORKERS FROM ANOTHER. THE PSYCHOANALYSTS TEND TO WORK IN THEIR AREA, ISOLATED FROM THE BIOLOGICAL RESEARCHERS AND THE PHILOSOPHERS.

MANY UNSATISFACTORY LINES OF RESEARCH WOULD NOT HAVE COMMENCED IF THE VARIOUS GROUPS RELATED MORE CLOSELY TO ONE ANOTHER. AN EXAMPLE OF THIS WOULD BE THE "LAINGIAN EXPLANATIONS OF MADNESS IN TERMS OF ERRORS IN SOCIETY." THESE ERRORS WOULD NOT HAVE BEEN MADE IF LAING HAD BEEN AWARE OF THE GROWING EVIDENCE FOR PHYSIOLOGICAL DISTURBANCES IN BRAIN FUNCTION IN SCHIZOPHRENIA. NEVERTHELESS, GORDON CLARIDGE IS CRITICAL OF THIS NEW "ORGANIC" PHASE IN SCHIZOPHRENIA, BECAUSE HE CLAIMS THAT THOSE WORKING IN THE FIELD HAVE RARELY MATCHED THEIR CONCEPTUALISATIONS AND EXPLANATIONS OF SCHIZOPHRENIA TO THE COMPLEXITY OF THE CONDITION.



IN A CHAPTER ON PSYCHOANALYSIS AND SCIENCE, ANTHONY STORR FEELS THAT ADOPTING AN OBJECTIVE, MECHANISTIC STANCE TOWARDS HUMAN BEINGS ACTUALLY DEPRIVES THE OBSERVER OF AN IMPORTANT SOURCE OF UNDERSTANDING. HE FAILS TO SEE THAT THE PSYCHOANALYST USES INTUITION AND EMPATHY DURING AN ANALYTIC SESSION, WHEN HE IS COLLECTING DATA TO MAKE AN INTERPRETATION.

ONCE THE DATA ARE COLLECTED, THE ANALYST BECOMES OBJECTIVE AND FORMULATES AN INTERPRETATION INITIALLY IN TERMS OF HYPOTHESIS, WHICH IS THEN EXAMINED WITH THE PATIENT. AT THE END OF THIS PROCESS, INTERPRETATION WILL BE ACCEPTED OR REJECTED ON THE BASIS OF THE WEIGHING-UP OF EVIDENCE BY ANALYST AND PATIENT.

BRIAN FARRELL HAS AN INTERESTING CHAPTER ON PSYCHOANALYTIC EXPLANATION, WITH SPECIAL REFERENCE TO HISTORICAL MATERIAL, AND HE POINTS OUT THAT WHEN PSYCHOANALYSIS IS USED WITH CARE, IT "CAN NEVERTHELESS OFTEN HELP TO EXPLAIN WHAT IS PUZZLING, AND HELPS US TO SEE THINGS IN NEW AND INTERESTING WAYS." HE ALSO POINTS OUT THAT IT IS BEST TO USE IT WITH BIOGRAPHICAL WORK, WHERE SUFFICIENT MATERIAL IS AVAILABLE FOR ANALYSIS.

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**ERNEST JONES: FREUD'S ALTER EGO.** VINCENT BROME. (1982). CALIBAN BOOKS.

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VINCENT BROME'S BOOK IS A DILIGENTLY RESEARCHED BIOGRAPHY OF JONES, IN THE MOULD OF S. J. SULLOWAY'S RECENT CRITICAL BIOGRAPHY OF FREUD. BROME HAS WRITTEN A NUMBER OF BIOGRAPHICAL BOOKS OVER THE PAST FIFTEEN YEARS ON VARIOUS EMINENT PSYCHOANALYSTS. NEVERTHELESS, HE WRITES AS AN OUTSIDER, WHICH HAS THE ADVANTAGE OF

INCREASING OBJECTIVITY, BUT THIS IS OFFSET AT TIMES BY A LACK OF FEELING FOR PSYCHOANALYSIS WHICH COMES ACROSS IN THE BOOK. THIS BOOK ALSO DEALS WITH THE PERSONALITIES OF OTHER EARLY PSYCHOANALYSTS AND, IN THAT SENSE, IT WOULD BE OF INTEREST TO THE AVERAGE READER AS THE DUST JACKET CLAIMS. NEVERTHELESS, I BELIEVE THE BOOK DOES PRESUPPOSE SOME KNOWLEDGE OF PSYCHOANALYTIC IDEAS.

ERNEST JONES, THE FIRST BRITISH DOCTOR TO BECOME INTERESTED IN PSYCHOANALYSIS (ABOUT 1905), CONTRIBUTED AN ENORMOUS AMOUNT TO THE ORGANISATION AND SPREAD OF PSYCHOANALYSIS THROUGHOUT THE WORLD. JONES' BIOGRAPHY OF SIGMUND FREUD, THE FOUNDER OF PSYCHOANALYSIS, WAS ONE OF THE OUTSTANDING BIOGRAPHIES OF THE AGE, AND A MONUMENT TO ONE OF THE MOST ORIGINAL THINKERS OF THE TWENTIETH CENTURY. ALTHOUGH JONES WAS UNDOUBTEDLY A BRILLIANT MAN, WHO WAS CALLED BY FREUD "AN INDOMITABLE WRITER," HE WAS HIMSELF AWARE THAT HE WAS NOT AS CREATIVE AS FREUD, AND PUT IT WELL WHEN HE WROTE OF HIMSELF, "THE ORIGINALITY COMPLEX IS NOT STRONG IN ME, MY AMBITION IS RATHER TO KNOW, TO BE 'BEHIND THE SCENES,' 'IN THE KNOW,' RATHER THAN TO FIND OUT." INDEED, HE COMPARED HIS RELATIONS WITH FREUD TO THOSE OF HUXLEY WITH DARWIN.

FREUD WAS A MAN WHO APPROACHED THE MIND SCIENTIFICALLY, A METHOD WHICH HAD ALREADY OCCURRED TO JONES, AND TREATED THOUGHTS AS MENTAL EVENTS CAPABLE OF SCRUTINY LIKE ATOMS OF MOLECULES. LIKE FREUD, JONES GAVE UP HYPNOSIS FOR THE PSYCHOANALYTIC TECHNIQUE OF FREE ASSOCIATION OF IDEAS. FREUD'S GENIUS WAS TO EXAMINE EVERY WORD THE PATIENT SAID, TO TRACE THE UNCONSCIOUS CONFLICT AND TO FREE THE PATIENT FROM HIS SYMPTOMS AND INHIBITIONS. JONES CAME TO SEE THAT, AS FREUD POINTED OUT, SEXUAL CONFLICT COULD BE SHOWN TO BE PRESENT IN PATIENTS WITH HYSTERICAL SYMPTOMS. THE



IMPORTANCE OF INFANTILE SEXUALITY WAS MUCH NEGLECTED AT THIS TIME.

JONES WAS BORN IN WALES, AND WAS INFLUENCED TO STUDY MEDICINE BY A DOCTOR WHO TRAINED IN DUBLIN. JONES HIMSELF TRAINED IN LONDON AT THE END OF THE NINETEENTH CENTURY AND WAS A BRILLIANT MEDICAL STUDENT. HE WAS A DECISIVE MAN, AND PROPOSED TO HIS WIFE THREE DAYS AFTER MEETING HER, LIVING WITH HER HAPPILY FOR THIRTY-SIX YEARS. AT THE SAME TIME, HE HAD ONLY LIMITED TIME FOR FAMILY LIFE, SOMETHING WHICH PROBABLY CHARACTERISES MOST GREAT MEN.

JONES WAS INVOLVED WITH MANY OF THE GREAT FIGURES OF THE AGE, FOR EXAMPLE, WELLS AND SHAW. WILLIAM JAMES SAID TO HIM, "YOURS IS THE PSYCHOLOGY OF THE FUTURE." HE TREATED THE WIFE OF D. H. LAWRENCE, AND ONE NIGHT SHE BROKE INTO HIS FLAT BEGGING FOR REFUGE, SINCE HER HUSBAND WAS ABOUT TO MURDER HER. WHAT JONES SAID TO HER HAS INTRIGUED LAWRENCE SCHOLARS EVER SINCE.

IT WAS A PITY THAT BROME DID NOT DISCUSS A PAPER JONES WROTE IN 1922, CALLED "THE ISLAND OF IRELAND, A PSYCHOANALYTICAL CONTRIBUTION TO POLITICAL PSYCHOLOGY." HERE JONES EXAMINED, ALONG PSYCHOANALYTICAL LINES, ONE OF THE REASONS FOR THE LONG-TERM, CONFLICTING RELATIONSHIP BETWEEN IRELAND AND ENGLAND IN CONTRAST TO THE ACCOMMODATION REACHED WITH SCOTLAND AND WALES. HE NOTED THAT THE RELATIONSHIP BETWEEN ENGLAND AND SCOTLAND WAS TYPICAL OF THAT SUBSISTING BETWEEN TWO STRONG AND WELL-MATCHED MEN WHO, AFTER A PERIOD OF FIGHTING, AGREED TO BE RECONCILED. HE SAW THE RELATIONS BETWEEN ENGLAND AND WALES AS RESEMBLING THAT BETWEEN TWO BROTHERS OF ABOUT EQUAL SIZE, WITH GOOD HUMOUR AND TOLERANCE ON THE ONE SIDE, AND A COMBINATION OF PETULANCE AND ADMIRATION ON THE OTHER. HE FELT THAT

THE PSYCHOLOGY OF ISLANDERS WAS IMPORTANT IN UNDERSTANDING THE LONG CONFLICT BETWEEN IRELAND AND ENGLAND - THE TENDENCY OF THE GEOGRAPHICAL INSULARITY TO BECOME UNCONSCIOUSLY ASSOCIATED WITH PARTICULAR COMPLEXES. HE POINTED OUT THAT THE COMPLEXES TO WHICH THE IDEA OF AN ISLAND HOME BECAME ATTACHED ARE THOSE RELATING TO THE IDEAS OF WOMAN, VIRGIN MOTHER AND WOMB. HE NOTED THAT NO COUNTRY HAD SUCH A VARIETY OF FEMININE NAMES (OF WHICH HE GAVE TEN EXAMPLES, RANGING FROM "IIVERNIA" TO "DARK ROSALEEN"), AND THAT THE CONCEPT OF MOTHER COUNTRY HAD GREATER SIGNIFICANCE IN IRELAND THAN IN OTHER COUNTRIES. HE POINTED OUT THAT IT WAS ALMOST IMPOSSIBLE FOR IRISH MEN TO EXPRESS THEIR FEELINGS ON POLITICAL SUBJECTS WITHOUT USING SUCH IMAGERY. FOR EXAMPLE, DE VALERA SAID OF THE FREE STATERS IN 1922, "THEY WANTED TO COME AND HOLD IRELAND WHILE THE SHACKLES WERE BEING PUT ON HER." IN A SIMILAR VEIN HE COMMENTED ON W. B. YEATS' PLAY, "KATHLEEN NI HOULIHAN," WHERE THE SPIRIT OF IRELAND IS DEPICTED AS A POOR WANDERING OLD WOMAN WHOSE SORROWS IMPEL THE YOUNG MEN TO FORSAKE ALL ELSE, EVEN THEIR BRIDES ON THEIR WEDDING DAY, TO FOLLOW HER CALL. FINALLY, HE NOTED THAT IT WAS A CITIZEN OF ANOTHER CELTIC LAND WHO WAS THE FIRST TO WOO IRELAND WITH AN OFFERING OF AN HONOURABLE SETTLEMENT. HE SAW THE ENGLISH IN PREVIOUS CENTURIES AS "RAVISHING A VIRGIN ISLAND AS THOUGH SHE WAS A HARLOT" AND "THE SETTLEMENT OF ULSTER AS AN ABIDING RAPE."

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**EARLY PREDICTION AND PREVENTION OF CHILD ABUSE.** (EDS). BROWNE, K., DAVIES, C. AND STRATTON, P. (1988). WILEY.

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THIS BOOK AROSE OUT OF A CONFERENCE WHICH AIMED AT PREDICTING AND PREVENTING THE ABUSE AND NEGLECT OF YOUNG CHILDREN. THERE ARE CONTRIBUTIONS FROM THE MAJOR



FIGURES IN THE FIELD, BOTH IN BRITAIN AND NORTH AMERICA. THE AUTHORS DISCUSS THE CAUSES AND CONSEQUENCES OF ALL FORMS OF MALTREATMENT, AND NOTE THE LACK OF CONSENSUS CONCERNING THE DEFINITIONS OF VARIOUS FORMS OF ABUSE.

THERE IS A DISCUSSION OF THE CHARACTERISTICS OF CHILDREN AND PARENTS WHICH MAKE THEM VULNERABLE FOR CHILD ABUSE AND NEGLECT. THERE IS ALSO A DISCUSSION OF TELEPHONE HELP-LINES AND A STATEMENT THAT "THE INFLUENCE OF TELEPHONE HELP-LINES ON SECONDARY AND TERTIARY PREVENTION OF CHILD ABUSE AND NEGLECT IS MINIMAL." THEY POINT OUT THAT "ONLY 6% OF THE CALLS WERE FROM CHILDREN UNDER THE AGE OF TEN YEARS, THE AGE GROUP MOST AT RISK OF CHILD MALTREATMENT." THEY QUESTION WHETHER TELEPHONE HELP-LINES SUCH AS "CHILDLINE" SAVE CHILDREN'S LIVES. INDEED, THEY POINT OUT THAT "SOME PROFESSIONALS CONSIDER THAT CHILDREN AND ADOLESCENTS WHO BEGIN TO TALK ABOUT THEIR ABUSIVE EXPERIENCES, WITHOUT STATUTORY HELP AND SUPPORT, MAY BE PUTTING THEIR LIVES AT FURTHER RISK."

THERE IS ALSO A CHAPTER ON SCREENING FOR CHILD ABUSE AND NEGLECT. THE GREAT PROBLEM WITH THIS IS THE FALSE ALARMS, AND IN ONE STUDY THERE WERE 1,195 FALSE ALARMS OR FALSE POSITIVES. THE BOOK ALSO CONTAINS A VALUABLE SECTION ON THE TREATMENT OF CHILD ABUSE IN THE HOME ENVIRONMENT, ON HELPING EMOTIONALLY ABUSED CHILDREN WHO FAIL TO THRIVE, AND A CHAPTER ON CHILD MALTREATMENT AND THE EMERGENT FAMILY SYSTEM BY JAY BELSKY, A MAJOR AND CREATIVE RESEARCHER IN THIS AREA. THIS BOOK IS ESSENTIAL READING FOR ALL PROFESSIONALS HAVING CONTACT WITH FAMILIES WHERE A CHILD IS AT RISK OF BEING ABUSED.

**Mutative Metaphors in Psychotherapy (The Aeolian Mode).** Cox, M. and Theilgaard, A. (1987). London: Tavistock.

"But the image has touched the depths before it stirs the surface."

The story of the Aeolian harp is based on the myth of Orpheus, upon whose harp the wind played after he had been lynched by the maids of Lesbos. In the Foreword to the book Philip Brockbank, Director of the Shakespeare Institute, discusses the history of the Aeolian harp as metaphor. He points out that it served the purposes of a transcendental and a mechanical understanding of spiritual and psychological processes, and that "the instrument thus offered the eighteenth-century optimist the expression of a divine aesthetic order beyond the turbulence of ordinary life."

Malcolm Pines, in the Introduction to the book, describes the various psychoanalytic maps available now. He notes that a psychoanalytic map issued in London gives much more of the area of mind over the primitive world. He states that "continental (psychoanalytical) maps are almost unusable by Anglo-Saxon navigators. The French maps require months of arguments and explanation before it becomes clear how they are to be used, for the meaning of each word is controversial and has to be defined." He points out that "psychotherapists are rediscovering that psychotherapy is not primarily a precise technology of accurately used words. The depths of the mind are reached and touched by simple words that speak in images and metaphors, speak in a universal, timeless language predating contemporary ideas. A language that



touches the heart, the ancient seat of the emotions, that speaks to the soul, that aspect of the human being that nineteenth-century science thought to have eliminated."

He notes that the classical metaphor for the mind was that it was a mirror reflecting nature. He also points out that the Aeolian harp then became another less well known metaphor for the poet's mind. In the prologue the author points out that the Aeolian mode of psychotherapy depends on the therapist's capacity to pick up the "music in the wind." Transference interpretation is regarded as a specific form of metaphoric mutation where a link is made between childhood relationships and the ongoing psycho-therapeutic one. This has a bridging effect of linking the here and now with childhood experience. The author emphasises the importance of surprise, and clearly effective interpretations are often experienced by patients as a surprise. Indeed, this is a kind of validation of an interpretation.

This form of psychotherapy aims to heal the split between the arts and medical faculties, and also between psychoanalysis and literature. Psycho-therapists often work with metaphor, because it is all they have available at times but, at the same time, it is not inconsiderable because of its ability to plunge the depths. As the authors point out, "much of the book is the psychotherapist task of enabling the patient to engage with his own evolving story."

Aeolian mode involves a search during psycho-therapy for "the pattern which connects;" this of course is true, as much psychotherapy is about helping the patient to see the main themes in his life and to

SEE REPEATING PATTERNS OF WHICH HE MAY NOT BE AWARE. IN A WAY, THE PROCESS OF PSYCHOTHERAPY IS LIKE KNITTING A PATTERNED SWEATER. THE AUTHORS QUOTE MALAN, WHO STATES THAT THE AIM OF EVERY MOMENT OF EVERY SESSION IS TO PUT THE PATIENT IN TOUCH WITH AS MUCH OF HIS TRUE FEELINGS AS HE CAN BEAR. THIS IS NEVER EASY; IT REQUIRES COURAGE TO ENTER ONE'S OWN STORY, AND THE AEOLIAN MODE FACILITATES THIS DIFFICULT TASK BECAUSE IT INTENSIFIES EMPATHIC PRECISION. THEY POINT OUT THAT THE AEOLIAN MODE SOMETIMES ENABLED THEM TO REACH PATIENTS WHO MIGHT OTHERWISE BE DYNAMICALLY INACCESSIBLE AND IMPERVIOUS TO EVERY ATTEMPT AT EMPATHY.

THEY LAY CONSIDERABLE EMPHASIS ON POIESIS, WHICH IS "CALLING SOMETHING INTO EXISTENCE THAT WAS NOT THERE BEFORE." THE THERAPIST IS TRYING TO DETECT WHAT THE PATIENT IS TRYING TO BRING INTO EXISTENCE FOR THE FIRST TIME. IT IS CLEAR FROM THE BOOK THAT A THERAPIST NEEDS TO HAVE A HIGHLY DEVELOPED AESTHETIC SENSE. TO BE ABLE TO HAVE A CONSIDERABLE ASSOCIATIVE RESERVOIR, A THERAPIST NEEDS CONSIDERABLE KNOWLEDGE AND EXPERIENCE OF LIFE. THIS MAY POSE DIFFICULTIES FOR VERY YOUNG PSYCHOTHERAPISTS. THE IMPORTANT THING FOR A THERAPIST IS TO FIND THE WORDS TO SAY SOMETHING THAT PAYS ATTENTION TO THE DEPTH OF WHAT THE PATIENT IS SAYING, AND TO PUT IT BEFORE A PATIENT IN AN ACCEPTABLE MANNER WHICH THE PATIENT WILL FIND HELPFUL, AND IT IS HERE THAT A METAPHOR CAN BE VERY IMPORTANT. THE THERAPIST CANNOT SUMMON THESE METAPHORS BUT, IF HE PAYS ATTENTION TO HIS ASSOCIATIONS, THEY WILL COME TO HIM. HE HAS TO EXAMINE HIS COUNTERTRANSFERENCE TO SEE IF THESE METAPHORS RELATE TO HIMSELF OR TO HIS PATIENT. AT CERTAIN POINTS THE PATIENT IS SOMEWHAT UNSETTLED AND PARTICULARLY RECEPTIVE TO A THERAPIST'S INTERPRET-



ATIONS, AND IT IS AT THESE POINTS THAT MUTATIVE METAPHORS WILL BE PARTICULARLY EFFECTIVE.

THE AUTHORS QUOTE OSCAR WILDE AS FOLLOWS:- "ALL TRIALS ARE TRIALS FOR ONE'S LIFE."

INDEED, IN A WAY, PATIENT AND THERAPIST ARE ON TRIAL AT EACH SESSION, BUT PARTICULARLY AT THE FIRST SESSION, WHEN THEY ARE TRYING TO ESTABLISH WHETHER THEY CAN WORK TOGETHER AND WHETHER THERE IS AN ADEQUATE "FIT" BETWEEN THEM.

THIS IS AN ENJOYABLE BOOK, STIMULATING, A "GOOD READ," AND IT IS DIFFICULT TO PUT IT DOWN ONCE ONE STARTS READING IT, SOMETHING THAT IS RARE WITH PSYCHOTHERAPY BOOKS. IT IS VERY INFORMATIVE AND CAN BE RECOMMENDED TO ALL WHO PRACTISE PSYCHOTHERAPY. IT WILL RE-AWAKEN IN THE READER MEMORIES OF HIS OR HER OWN EARLY LIFE. THE BEST COMMENT ONE CAN MAKE ABOUT THE BOOK IS THAT THE EXPERIENCED PSYCHOTHERAPIST WILL ALREADY HAVE "KNOWN" MUCH OF WHAT IT IS ABOUT.

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**CARING FOR THE SUICIDAL.** ELDRID, J. (1988). CONSTABLE.

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THIS BOOK IS DESCRIBED AS A HANDBOOK FOR HELPING THE SUICIDAL. IT HAS CHAPTERS ON PARASUICIDE, FAILED SUICIDES AND REPEATERS, AND ALSO A CHAPTER WHICH FOCUSES ON THE SOCIOLOGICAL, PSYCHOLOGICAL AND PSYCHO-ANALYTICAL APPROACHES TO SUICIDAL PATIENTS. THE FINAL CHAPTER IS ON CARING FOR THOSE BEREAVED BY SUICIDE. THE BOOK ALSO HAS A CONSIDERABLE AMOUNT OF USEFUL INFORMATION ON SUICIDE. THE AUTHOR NOTES THAT THE TOTAL RATE OF ATTEMPTED SUICIDES COMING INTO CONTACT

WITH A MEDICAL AGENCY IN THE EEC HAS BEEN ESTIMATED BY DIEKSTRA TO BE 215, WITH A RANGE OF 54 TO 440 PER 100,000 PERSONS AGED 15 YEARS AND OVER. HE ALSO NOTES THAT THIS FIGURE IS MOST LIKELY AN UNDER-ESTIMATE, AS MANY ATTEMPTED SUICIDES DO NOT COME INTO CONTACT WITH MEDICAL AGENCIES. HE ALSO ESTIMATES THAT OVER 381,000 ANNUALLY CONTACT THE SAMARITANS FOR THE FIRST TIME, AND THAT 22% OF THESE INDICATE THEY HAD SUICIDAL FEELINGS AND THOUGHTS. HE QUOTES KREITMAN, WHO STATES THAT A UK GENERAL PRACTITIONER, WITH A LIST OF 2,500 PATIENTS, COULD EXPECT TO ENCOUNTER A SUICIDE EVERY THREE OR FOUR YEARS, AND THAT THE SAME GENERAL PRACTITIONER HAS SIX OR SEVEN PEOPLE ON HIS LIST EACH YEAR WHO BECOME PARASUICIDES.

IN DISCUSSING SUICIDE PREVENTION CENTRES, ELDRID IS QUITE RIGHT TO POINT OUT THAT "IT IS EXTREMELY DIFFICULT TO EVALUATE THE EFFECTIVENESS OF THESE AGENCIES WITH PROVEN FACTS." HE QUITE RIGHTLY ATTACHES GREAT IMPORTANCE TO "CO-OPERATION BETWEEN VOLUNTEERS AND PROFESSIONALS" IN THIS AREA. THE WRITER HAS A VERY GOOD "FEEL" FOR THE SUICIDAL PERSON. HE DISCUSSES DURKHEIM'S WORK ON SUICIDE WRITTEN IN THE NINETEENTH CENTURY BUT, TO DURKHEIM'S CREDIT, STILL MUCH QUOTED TODAY. HE QUOTES BILLER, WHO POINTED OUT "IN THE WEEK THAT PRESIDENT KENNEDY WAS ASSASSINATED, THERE WERE NO SUICIDES IN THE TWENTY-NINE AMERICAN CITIES STUDIED, COMPARED WITH AN AVERAGE OF 4.35 FOR THE SAME WEEK, 1956 - 1972. THIS WOULD APPEAR TO CONFIRM DURKHEIM'S HYPOTHESIS THAT NATIONAL EMERGENCIES CAN HAVE THE EFFECT OF LOWERING THE SUICIDE RATE." HE QUOTES ALBERT CAMUS AS STATING, "THERE IS BUT ONE SERIOUS PHILOSOPHIC PROBLEM, AND THAT IS SUICIDE."

ELDRID STATES THAT MEDICINE HAS HAD GREAT SUCCESS IN PROLONGING LIFE BUT, ON THE OTHER HAND, COUNTRIES



HAVE BEEN DEVELOPING WEAPONS CAPABLE OF TOTAL ANNIHILATION. I AM QUITE UNCERTAIN WHETHER THE NUCLEAR THREAT IS A MAJOR ISSUE FOR SUICIDAL ADOLESCENTS IN THIS COUNTRY, BUT HE CLAIMS THAT SUICIDE NOTES IN OTHER COUNTRIES FREQUENTLY REFER TO IT. AS A PRACTICAL HANDBOOK, THIS BOOK CAN BE RECOMMENDED.

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**REBEL WITHOUT A CAUSE.** EYSENCK, H. (1990). W. H. ALLEN.

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EYSENCK IS A VERY FAMOUS PSYCHOLOGIST, AND HE TELLS US IN THIS BOOK HOW FAMOUS HE IS, WHEN HE POINTS OUT THAT IN 1978 HE WAS THE FIFTH MOST CITED PSYCHOLOGIST AFTER FREUD, PIAGET, WINER AND BANDURA. CLIFFORD YORKE STATED RECENTLY THAT "BIOGRAPHY SHOULD BE ADDED TO FREUD'S LIST OF IMPOSSIBLE PROFESSIONS - POLITICS, PARENTHOOD AND PSYCHOANALYSIS ITSELF." AUTOBIOGRAPHY IS EVEN MORE DIFFICULT. WHY DID EYSENCK WRITE THIS BOOK? MARY WARNOCK PUT IT AS FOLLOWS: "THE SUSPICION THAT EYSENCK IS LESS INTERESTED IN SCIENCE THAN IN SHOWING OFF HIS FEARLESS UNORTHODOXY IS HARD TO SUPPRESS." EYSENCK IS QUITE REVEALING ABOUT HIS CHILDHOOD WHEN HE TELLS US THAT HE GREW UP "WITH MY FATHER AND MOTHER HARDLY EVER PRESENT, I GREW UP WITHOUT THE SOCIALISING INFLUENCE OF A GOOD HOME. I DID MORE OR LESS WHAT I WANTED, WITH NO ONE AND NOTHING TO RESTRAIN ME." HIS FATHER WORKED AS AN ANCHOR MAN IN LARGE CABARETS, AND DID NOT KNOW HOW TO COMMUNICATE WITH CHILDREN.

THROUGHOUT THE BOOK EYSENCK ATTACKS MEDICINE, PSYCHIATRY AND PSYCHOANALYSIS. IN 1952 HE STATED THAT TWO-THIRDS OF NEUROTIC PATIENTS IMPROVED, WHETHER THEY WERE TREATED OR NOT. IN HIS AUTOBIOGRAPHY HE DOES NOT

mention that Kellner re-examined the literature and found a number of controlled studies of psychotherapy which Eysenck had not reviewed. Thus began what Mallan called "the process of exposing some of the oversights common to polemics." Kellner pointed out that Eysenck had accepted without criticism Wolpe's figure of 90% improvement rate, which excluded patients who broke off treatment prematurely, while, writing about psychoanalysis, he stated "as in regard to the psychoanalytic results, we have classed those who stopped treatment together with those who have not improved." This appears to be reasonable, because a patient who has failed to finish his treatment and has not improved is surely a therapeutic failure. It also reveals that Eysenck quoted negative results and ignored the positive results for psychotherapy. Kellner concluded that "on comparing Eysenck's paper with the published evidence on the efficacy of psychotherapy, I can only conclude that Eysenck's review of the literature is incomplete, that both the selection of his evidence in the presentation are biased and that his conclusions on the effectiveness of psychotherapy are misleading."

Bergin then carried out a further re-examination of Eysenck's figures. It became clear that thoughout Eysenck's review of the literature he dichotomized therapeutic results into "improved" and "unimproved." Where the author concerned had four categories of improvement, this was easy; where he had only three, Eyesenck halved the middle group, assigning one half to "improved" and one half to "unimproved." Now, it so happened that in one of the two important studies purporting to give the figures for spontaneous remissions, namely that of Landis, there were three categories. Did Eysenck divide the middle category into two, as he had done for the treated series? No,



he classed the whole of the middle category as improved, giving an inflated value of 73%. When Bergin recalculated the spontaneous improvement rate for neurotic patients, he found a rate of 30%, which has been shown in more recent studies.

It is interesting to keep in mind Eysenck's comment that "in science only one thing matters, and that is the facts," when reading his discussion on the effectiveness of psychotherapy. It is also of interest that Mary Warnock, who supports Eysenck's views on the effectiveness of psychoanalysis (although she admits to being "ignorant and prejudiced") is not convinced by Eysenck, and that she said she found little argument or explanation to be found in the book in relation to his claims. It is clear that he has failed even to convince one of his own supporters. Reading Eysenck's comments on psychotherapy one is reminded of Nietzsche, who said "convictions are more dangerous enemies of truth than lies." What was of value in Eysenck's criticisms of psychotherapy was that his criticisms led psychotherapists to scientifically study the outcome of psychotherapy. There is an excellent description in this book of Eysenck's childhood and early life experiences in Germany during the Second World War.

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**People and Change.** Flanagan, C. M. (1990) Lawrence Erlbaum.

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This book will be as valuable to stressed doctors as to their patients with problems of living. Flanagan points out that problems of living, which are exaggerations of normal behaviour and experiences, are not the same thing as mental illness. In her view, the

MENTALLY ILL PERSON BEHAVES "IN A VERY UNCHARACTERISTIC OR UNPREDICTABLE FASHION."

PROBLEMS OF LIVING INCLUDE SUCH THINGS AS "ANXIETY, FEARS, DIFFICULTIES IN RELATING TO OTHER PEOPLE, OVER-INDULGENCE IN FOOD, AND TENSION HEADACHES." THE AUTHOR POINTS OUT THAT "IN ANY ONE YEAR, BETWEEN 10% AND 15% OF THE POPULATION CONSULT THEIR MEDICAL DOCTORS WITH A COMPLAINT THAT IS LARGELY, IF NOT ENTIRELY, PSYCHOLOGICAL IN NATURE. ABOUT 1 IN 15 PERSONS SPENDS TIME IN A PSYCHIATRIC HOSPITAL AT SOME STAGE IN HIS OR HER LIFE. ONE STUDY PREDICTED THAT 43% OF MEN AND 73% OF WOMEN CAN BE EXPECTED TO SUFFER FROM A PSYCHOLOGICAL DISORDER OVER A LIFETIME OF 60 YEARS. LARGE SCALE SURVEYS CARRIED OUT IN THE UNITED STATES AND CANADA SUGGEST THAT, AT ANY ONE TIME, OVER HALF THE POPULATION IS SUFFERING FROM EMOTIONAL PROBLEMS OF SOME KIND. IT IS ESTIMATED THAT 15% OF THE POPULATION OF THE UNITED STATES AND BRITAIN TAKE TRANQUILLISING DRUGS ON A REGULAR BASIS. MALCOLM LADER ESTIMATED THAT ABOUT ONE THIRD OF THE ADULT POPULATION SUFFER CONSTANTLY FROM NERVOUS COMPLAINTS, ESPECIALLY ANXIETY.

THERE ARE MANY EXTERNAL SOURCES OF STRESS FOR DOCTORS AND THEIR PATIENTS. THE AUTHOR POINTS OUT THAT "IT IS NOT THE ACTS OF GOD" BUT THE LITTLE THINGS THAT REALLY GET TO PEOPLE AND GRADUALLY ERODE HEALTH AND SELF-CONFIDENCE. IT IS WELL KNOWN THAT SOCIAL SUPPORT CAN BE A MAJOR MEDIATING FACTOR IN TIMES OF STRESS, AND THAT IT IS EQUALLY IMPORTANT FOR BOTH DOCTORS AND PATIENTS TO HAVE AT LEAST ONE QUALITY RELATIONSHIP WITH SOMEONE IN WHOM THEY CAN CONFIDE ON THE BASIS OF INTIMACY AND TRUST. AN EXAMPLE OF AN INTERNAL SOURCE



OF STRESS OR FAULTY THINKING IS NEGATIVE ATTUNEMENT, WHERE THE INDIVIDUAL ONLY FOCUSES ON THE NEGATIVE ASPECT OF ANY EVENT AND IGNORES THE POSITIVE SIDE. CLINICAL EXPERIENCE WOULD SUGGEST THAT THIS IS QUITE COMMON IN IRISH POPULATIONS. IT IS IMPORTANT FOR DOCTORS AND PATIENTS TO CHALLENGE THE "MYTH OF UNCHANGEABILITY" AND TO REALISE THAT PEOPLE CAN CHANGE THEIR LIFE STYLE AND THINKING INTO OLD AGE. NEVERTHELESS, IT IS INTERESTING THAT "20% - 80% OF PEOPLE DO NOT FOLLOW PROFESSIONAL ADVICE OR GUIDE LINES" AFTER A CONSULTATION.

THE IMPORTANCE OF A PSYCHOLOGICAL APPROACH TO CONSULTATION IS EMPHASISED BY MALCOLM LADER'S POINT "THAT OVER A THIRD OF PATIENTS WHO SEEK MEDICAL HELP ARE EXPERIENCING SYMPTOMS ARISING, NOT FROM PHYSICAL ILLNESS, BUT FROM PSYCHOLOGICAL DIFFICULTIES."

DOCTORS AND PATIENTS WILL CHANGE IF THEY ACHIEVE A COGNITIVE RESTRUCTURING, THAT IS, IDENTIFY FAULTY THINKING AND ITS NEGATIVE IMPACT AND REPLACE IT WITH MORE LOGICAL ADAPTIVE THINKING. WHEN THEY IDENTIFY THEIR MALADAPTIVE THINKING AND BELIEFS, THEY HAVE TO LEARN TO TALK TO THEMSELVES AND MODIFY THEIR MALADAPTIVE COGNITIONS. THIS BOOK COULD BE OF VALUE TO THE JUNIOR HOUSE OFFICERS "WHO WERE FOUND TO HAVE ESTIMATED PREVALENCE OF EMOTIONAL DISTURBANCE OF 50%" BY FIRTH-COZENS. THOSE WHO ARE MOST AT RISK ARE THOSE WHO ARE "MORE EMPATHETIC AND MORE SELF-CRITICAL." THE BOOK WOULD BE EQUALLY USEFUL FOR MEDICAL STUDENTS, IN WHOM FIRTH FOUND AN "ESTIMATED PREVALENCE OF EMOTIONAL DISTURBANCE OF 31.2%" IN FOURTH YEAR MEDICAL STUDENTS.

**THE PSYCHOANALYST IN PSYCHIATRY.** FREEMAN, T. (1988). KARNAC BOOKS, LONDON.

DR. T. FREEMAN IS WELL QUALIFIED TO WRITE A BOOK ON THE PSYCHOANALYST IN PSYCHIATRY, AS HE HAS WORKED FOR MANY YEARS AS A CONSULTANT PSYCHIATRIST IN ADULT PSYCHIATRIC HOSPITALS WHERE, BEING A TRAINED PSYCHOANALYST, HE HAS BROUGHT HIS PSYCHOANALYTIC EYE TO BEAR ON PROCEEDINGS. HE BELIEVES THAT PSYCHOANALYSIS HAS AN IMPORTANT PART TO PLAY IN THE UNDERSTANDING OF SEVERE PSYCHIATRIC DISTURBANCE. HE POINTS OUT THAT "DRUG THERAPY HAS BEEN SUCCESSFUL IN DISPELLING THE POSITIVE SYMPTOMS," AND GOES ON TO STATE "BUT IT HAS FAILED TO INFLUENCE THE CORE OF THE MORBID PROCESS. WITH THE AID OF PSYCHOANALYTIC CONCEPTS . . . IT IS POSSIBLE TO DISCOVER THE MEANING OF THE DELUSIONAL AND HALLUCINATORY PHENOMENA."

IN THE INTRODUCTION TO THE BOOK, PROFESSOR A. SOLNIT POINTS OUT THAT "THERE IS AN UNREALISTIC EFFORT TO POLARISE OUR THEORY AND METHODS OF DIAGNOSIS AND TREATMENT, AND AN ALL TOO FAMILIAR HUMAN WISH TO SIMPLIFY MULTI-DETERMINED PHENOMENA INTO AN EITHER/OR EXPLANATION OF THE CHARACTERISTICS, DEVELOPMENT AND TREATMENT OF PATIENTS WHO ARE MENTALLY ILL." TOM FREEMAN DEMONSTRATES IN THIS BOOK THAT COMPLEMENTARY EXPLANATIONS AND TREATMENTS OF SEVERE PSYCHIATRIC ILLNESS CAN BE MUTUALLY ILLUMINATING AND HELPFUL. PROFESSOR SOLNIT ADDS THE WARNING THAT "THE PSYCHOANALYTIC APPROACH WHEN MISUSED OR ABUSED CAN ALSO COMPLICATE OR IMPAIR THE PATIENT'S RECOVERY, JUST AS IT CAN FACILITATE CLEARING THE PATHWAY TO RECOVERY WHEN IT IS WELL USED." PROFESSOR SOLNIT MAKES AN IMPORTANT POINT WHEN HE STATES THAT THE BOOK "IS AN INVITING REMINDER THAT AS PSYCHOANALYST, IN COLLABORATING WITH BIOLOGICAL PSYCHIATRISTS, WE HAVE PROMISING OPPORTUNITIES TO ENLARGE OUR KNOWLEDGE AND TO IMPROVE THE CARE OF PATIENTS WITH MAJOR PSYCHIATRIC DISORDERS." DR. FREEMAN POINTS OUT THAT, WITH MEDICATION IN MODEST DOSE AND IN THE CONTEXT OF AN UNDERSTANDING RELATIONSHIP WITH PSYCHIATRIST OR NURSE, IT IS STILL POSSIBLE THROUGH THE PATIENT'S UTTERANCES TO OBSERVE THE GREAT VARIATION WITHIN AND BETWEEN TYPES OF PSYCHOSES THAT EXIST, AND TO FOLLOW THE DIFFERENT COURSES OF ILLNESSES.

THE AUTHOR POINTS OUT THAT TRANSITIVISM AND APPERSONATION ARE AT THE HEART OF DIFFERENT PSYCHOANALYTIC THEORIES OF PSYCHOSIS. IN RELATION TO THESE PHENOMENA HE EMPHASISES THE LOSS OF EGO BOUNDARIES, LOSS OF CAPACITY TO DISCRIMINATE BETWEEN MENTAL REPRESENTATIONS OF THE SELF AND THOSE OF OTHERS. PARTS OF THE SELF ARE CARRIED OUT (EXTERNALISED) ONTO THE EXTERNAL OBJECT WHERE THEY REMAIN (TRANSITIVISM), WHILE SOME FEATURES OF THE OBJECT REMAIN IN SELF (APPERSONATION). THE AUTHOR REMINDS US THAT FREUD'S THEORY OF PSYCHOSIS VIVIDLY ILLUSTRATES THE JACKSONIAN PRINCIPLE THAT DAMAGE TO HEALTHY MENTAL OR NERVOUS FUNCTIONS LEADS TO THE APPEARANCE OF LESS ADVANCED (AUTOMATIC) FORMS OF MENTAL OR NERVOUS ACTIVITY WHICH SUBSTITUTES FOR WHAT HAS BEEN LOST. THE EMPHASIS THROUGHOUT THE BOOK IS ON THE MEANING OF PSYCHIATRIC SYMPTOMS, WHETHER NEUROTIC OR PSYCHOTIC.

IN A CHAPTER ON A DEVELOPMENTAL THEORY OF PSYCHOSIS, DR. FREEMAN POINTS OUT THAT THE PSYCHOTIC CONFLICT CLASHES BETWEEN LOVE AND HATE, MASCULINITY AND FEMINITY, AND BETWEEN ACTIVITY AND PASSIVITY.

IN HIS CHAPTER ON THE TREATMENT OF PSYCHOSIS, HE STATES THAT THE NUCLEUS OF PSYCHOSIS MIGHT BE ORGANIC

IN ORIGIN, BUT THE RESULTING SYMPTOMS ARE PSYCHOLOGICALLY DETERMINED. HE ALSO POINTS OUT THAT PSYCHOANALYSTS PIONEERED THE GROUP AND COMMUNITY THERAPEUTIC TECHNIQUES WHICH ARE PART OF CURRENT HOSPITAL PRACTICE IN THE UK AND IRELAND. UNFORTUNATELY, THE DEBT OF PSYCHIATRY TO PSYCHOANALYSIS IS OFTEN FORGOTTEN. HE STATES THAT IT IS OF INTEREST THAT THE INTRODUCTION OF CHLORPROMAZINE IN 1952 COINCIDED WITH THE OPENING OF THE LOCKED WARDS AND THE INTRODUCTION OF PSYCHOSOCIAL MEASURES. IT IS LIKELY THAT THE PROGRESS WHICH BEGAN THEN WAS DUE TO A COMBINATION OF DRUG AND PSYCHOTHERAPEUTIC TREATMENT. DR. FREEMAN DID NOT COME DOWN ON ONE SIDE OR THE OTHER IN HIS BOOK.

THIS IS A TIMELY BOOK, WHICH IS THE RESULT OF YEARS OF WORK WITH PATIENTS ON A ONE-TO-ONE BASIS, AND IS CLEARLY THE PRODUCT OF GREAT EXPERIENCE. FINALLY, THE AUTHOR QUOTES FREUD WITH EFFECT: "IT REMAINS TRUE THAT IN SCIENTIFIC MATTERS IT IS ALWAYS EXPERIENCE, AND NEVER AUTHORITY WITHOUT EXPERIENCE, THAT GIVES THE FINAL VERDICT, WHETHER IN FAVOUR OR AGAINST."

THIS BOOK CAN BE RECOMMENDED TO ALL THE HELPING PROFESSIONS WHO WORK WITH SEVERE PSYCHIATRIC ILLNESS, BOTH WITHIN AND OUTSIDE THE PSYCHIATRIC HOSPITAL.

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**CHILD PSYCHIATRY: A DEVELOPMENTAL APPROACH.**
GRAHAM, PHILIP. (1986). OXFORD MEDICAL PUBLICATIONS.

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THIS IS A COMPREHENSIVE TEXTBOOK COVERING ALL ASPECTS OF CHILD PSYCHIATRIC DISORDER, INCLUDING METHODS OF ASSESSMENT AND TREATMENT. THE FIRST PART OF THE BOOK CONTAINS AN OVERVIEW OF THE SUBJECT AND A DISCUSSION OF



CLASSIFICATION OF THE PSYCHIATRIC DISORDERS OF CHILDHOOD. THIS IS FOLLOWED BY A DESCRIPTION OF THE DEVELOPMENT OF NORMAL AND ABNORMAL PARENTAL BEHAVIOUR, INCLUDING PHYSICAL AND SEXUAL CHILD ABUSE. IT ALSO FOCUSES ON NORMAL AND ABNORMAL PATTERNS OF CHILD DEVELOPMENT, INCLUDING FEEDING, SLEEPING AND SOCIAL RELATIONSHIPS, AS WELL AS SPEECH AND LANGUAGE DISORDER. THERE IS EMPHASIS ON PSYCHOSOCIAL ASPECTS OF DIFFERENT PHYSICAL CONDITIONS OCCURRING IN CHILDHOOD, AND THERE ARE ALSO SECTIONS ON TREATMENT AND CHILD PSYCHIATRIC SERVICES. THE CONTENTS OF THE BOOK ARE WELL LAID OUT, WHICH MAKES FOR EASE OF REFERENCE AND STUDY. THERE IS A CHAPTER ON PREVENTIVE APPROACHES WHICH IS MISSING FROM OTHER TEXTBOOKS.

THE BOOK FILLS A GAP BETWEEN THE CURRENT INTRODUCTORY TEXTBOOK OF CHILD PSYCHIATRY, WHICH CONTAINED TOO LITTLE INFORMATION, AND VERY LARGE TEXTBOOKS WHICH CONTAIN UNNECESSARY DETAILS FOR MOST PROFESSIONALS IN THE FIELD OF CHILD PSYCHIATRY, PSYCHOLOGY AND ALLIED PROFESSIONAL FIELDS.

THE AUTHOR EMPHASISES SOMETHING THAT IS VERY IMPORTANT FOR ADULT PSYCHIATRISTS, "THAT ALL TYPES OF (PARENTAL) MENTAL DISORDER ARE LINKED TO A RAISED RATE OF BEHAVIOUR AND EMOTIONAL PROBLEMS IN CHILDREN." THERE NEED TO BE CONSIDERABLE LINKS BETWEEN ADULT AND CHILD PSYCHIATRISTS IN IRELAND, AND IT IS IMPORTANT FOR ADULT PSYCHIATRISTS TO REFER DISTURBED CHILDREN OF THEIR ADULT PATIENTS TO THEIR LOCAL CHILD PSYCHIATRIC DEPARTMENT. THE SAME IS TRUE OF MARRIAGE GUIDANCE COUNSELLORS BECAUSE, AS THE AUTHOR STATES, "THE QUALITY OF PARENTAL MARRIAGE IS AN IMPORTANT FACTOR IN WHETHER A CHILD DEVELOPS AN EMOTIONAL OR BEHAVIOURAL DISORDER."

THIS BOOK IS ESSENTIAL READING FOR ALL PSYCHIATRISTS AND PAEDIATRICIANS IN TRAINING, AS WELL STUDENTS OF PSYCHOLOGY, SOCIAL WORK, PSYCHOTHERAPY AND PAEDIATRIC NURSING. IT IS AVAILABLE IN PAPERBACK, AND THE PRICE IS THEREFORE MODEST.

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**THE FAMILY: EVALUATION AND TREATMENT,** EDITED BY C. K. HOFLING AND J. M. LEWIS, BRUNNER MAZEL PUBLISHERS NEW YORK, 1980.

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THIS BOOK PROVIDES A VERY COMPREHENSIVE REVIEW OF CURRENT RESEARCH WORK INTO FAMILY PATHOLOGY, ASSESSMENT AND TREATMENT, WITH CONTRIBUTIONS FROM LEADING EXPERTS IN THE FIELD OF FAMILY RESEARCH AND THERAPY.

IN CHAPTER ONE, J. M. LEWIS PROVIDES A VERY GOOD CLASSIFICATION OF FAMILIES, DEPENDING ON LEVEL OF COMPETENCE FROM OPTIMAL TO SEVERELY DYSFUNCTIONAL. THIS CHAPTER, AND INDEED THE ENTIRE BOOK, EMPHASISES THE INTERACTION BETWEEN BIOLOGIC AND FAMILY VARIABLES IN THE PRODUCTION OF PSYCHIATRIC ILLNESS. UNFORTUNATELY, MANY FAMILY THERAPISTS TODAY TEND TO IGNORE BIOLOGIC VARIABLES.

T. LIDZ CONTRIBUTED AN EXCELLENT CHAPTER ON THE ROLE OF THE FAMILY IN THE DEVELOPMENT OF THE INDIVIDUAL, USING "TIME TESTED PSYCHOANALYTIC CONCEPTS AND DRAWING ON HIS OWN FUNDAMENTAL RESEARCH." HE ALSO PROVIDES AN EXCELLENT BIBLIOGRAPHY, WHICH INDEED WAS A FEATURE OF MOST CHAPTERS OF THIS BOOK.

A. SOLNIT, WHO HAS WORKED WITH A. FREUD FOR MANY YEARS ON THE RELATIONSHIP BETWEEN THE LAW AND CHILDREN'S EMOTIONAL HEALTH (GOLDSTEIN ET AL., 1973),



HAS WRITTEN AN INTERESTING AND LUCID CHAPTER ON "THE APPRAISAL OF THE INDIVIDUAL IN THE FAMILY: CRITERIA FOR HEALTHY PSYCHOLOGICAL DEVELOPMENT IN CHILDHOOD." HE DEFINES MENTAL HEALTH IN TERMS OF "A SENSE OF SELF," AND OUTLINES THE CHANGES SINCE 1800 IN THE LAW WITH REGARD TO CHILDREN.

THERE IS A VERY GOOD CHAPTER ON ASSESSING THE FAMILY UNIT. THE DEVELOPMENTAL, LONGITUDINAL AND PSYCHOANALYTIC VIEWS OF FAMILY DEVELOPMENT ARE CONTRASTED WITH THE BEHAVIOURAL SYSTEMS OF THE "HERE AND NOW" APPROACH. THE FAMILY DIRECTION OR FOCUS ON INTERNAL FAMILY DYNAMICS, E.G., "THE FORTRESS FAMILY," IS CONTRASTED WITH THE ENVIRONMENT DIRECTED APPROACH WHERE THE FOCUS IS ON THE SOCIAL NETWORK. THE CRISIS ORIENTATION APPROACH IS CONTRASTED WITH THE "CHARACTER ORIENTATION" APPROACH, WHICH FOCUSES ON ENDURING PATTERNS IN THE FAMILY, E.G., FAMILY RULES. THE AUTHORS OF THIS CHAPTER EMPHASISE THAT "THE CLINICIANS' THEORETICAL PERSPECTIVE DETERMINES WHAT IS LOOKED FOR IN FAMILIES AND HOW THE DATA ARE INTERPRETED." IF THERAPISTS KEPT THIS IN MIND WHEN DISCUSSING ONE ANOTHER'S WORK, IT WOULD REDUCE MUCH OF THE CONFLICT BETWEEN THOSE APPLYING DIFFERENT APPROACHES.

SAUL BROWN HAS WRITTEN A CLINICAL CHAPTER CALLED "FAMILY INTERVIEWING AS A BASIS FOR CLINICAL MANAGEMENT." HE EMPHASISES THE IMPORTANCE OF THE DIFFERENTIATION BETWEEN FAMILY INTERVIEWING AND FAMILY THERAPY. I WOULD AGREE WITH HIM, AND FEEL THAT NOWADAYS FAMILY THERAPISTS SOMETIMES RUSH INTO FAMILY THERAPY WITHOUT PROPER FAMILY ASSESSMENT. HE IS A RATHER "NON-DOCTRINAIRE" FAMILY THERAPIST, AND IS WILLING FOR MEMBERS OF THE FAMILY TO HAVE INDIVIDUAL PSYCHOTHERAPY AT THE SAME TIME, IF NECESSARY. HOWEVER, HE DOES NOT EXPLORE THE DIFFICULTIES OF HAVING A NUMBER

OF THERAPISTS INVOLVED WITH A FAMILY AT ONE TIME, WHICH CAN BE VERY CONFUSING FOR FAMILY MEMBERS.

JAMES AND JESSIE MILLER HAVE WRITTEN A VERY COMPREHENSIVE AND LUCID CHAPTER ON "THE FAMILY AS A SYSTEM." THEY BELIEVE THAT GENERAL LIVING SYSTEMS THEORY WILL PROVIDE THE PRINCIPAL CONCEPTUAL INTEGRATION FOR PSYCHIATRY. I BELIEVE THAT THIS IS AN EXCESSIVELY AMBITIOUS VIEW BUT, NEVERTHELESS, I FEEL SYSTEMS THEORY HAS A MAJOR CONTRIBUTION TO MAKE. THE MILLERS DESCRIBE NINETEEN SUB-SYSTEMS OF FAMILIES, E.G., DECODER, AND SEVEN LEVELS FOR EACH SUB-SYSTEM, FROM CELL TO SUPRANATIONAL SYSTEM. THESE SUB-SYSTEMS AND LEVELS CAN BE OF GREAT ASSISTANCE IN MAKING AN ASSESSMENT OF FAMILY PATHOLOGY AND DECIDING WHERE TO FOCUS THERAPEUTIC EFFORTS. IT IS UNFORTUNATE THAT MANY PSYCHIATRISTS, PSYCHOLOGISTS AND SOCIAL WORKERS ONLY HAVE A VERY LIMITED KNOWLEDGE OF SYSTEMS THEORY.

DAVID BARASH, A ZOOLOGIST AND PSYCHOLOGIST, HAS CONTRIBUTED A FASCINATING CHAPTER ON THE EVOLUTIONARY ASPECTS OF THE FAMILY. HIS BASIC PREMISE, AND THE PREMISE OF THE SOCIOBIOLOGISTS, "IS THAT NATURAL SELECTION WILL OPERATE UPON BEHAVIOUR SO AS TO MAXIMISE FITNESS." AN EVOLUTIONARY APPROACH TO BEHAVIOUR RELIES HEAVILY ON THE ROLE OF GENETIC INFLUENCE, AS OPPOSED TO DETERMINISM. HE PERCEIVES FAMILIES AS BEING COMPOSED OF BASICALLY SELFISH INDIVIDUALS ONLY INTERESTED IN THEMSELVES, E.G., "FAMILIES ARE COMPOSED OF INDIVIDUALISTS, EACH OF WHOM IS SELECTED TO MAXIMISE HIS OR HER FITNESS AND NOT THAT OF ANYONE ELSE." (PAGE 213). WHILE ONE MEETS FAMILIES WHO WOULD FIT THIS DESCRIPTION, IT CERTAINLY DOES NOT COVER A LARGE NUMBER OF HUMAN FAMILIES.

THE CHAPTER ON INDICATIONS AND CONTRA-INDICATIONS



FOR FAMILY THERAPY ILLUSTRATES THAT THERE ARE NO VERY CLEAR INDICATIONS OR CONTRA-INDICATIONS. SCHECHTER STATES THAT FAMILY THERAPY IS CONTRA-INDICATED IN PSYCHOTIC STATES, WHILE ALANEN STATES THAT FAMILY THERAPY IS INDICATED IN PSYCHOTIC STATES. LIEF MAKES A PLEA FOR THERAPISTS TO USE "THE TREATMENT MOST APPROPRIATE FOR PATIENTS IN A PARTICULAR SITUATION AT A GIVEN TIME." HE ILLUSTRATES WITH A CASE WHERE INDIVIDUAL PSYCHOTHERAPY, CONCURRENT MARITAL THERAPY, INTERMIXED WITH CONJOINT SESSIONS AND FAMILY THERAPY WERE USED.

ON FAMILY THERAPY, DON BLOCK CONTRIBUTED ONE OF THE BEST CHAPTERS IN THE BOOK. HE GIVES AN EXCELLENT HISTORICAL INTRODUCTION TO FAMILY THERAPY, PERCEIVING IT AS "AN ACTION THERAPY; A DO, SHOW, AND TELL TECHNIQUE." HE EMPHASISES "THE PROMOTION OF DISEQUILIBRATION" AS A FAMILY THERAPY TECHNIQUE. HE IS INTERESTED IN THE HISTORY OF THE FAMILY, AND STATES THAT STRESS OCCURS AT A DEVELOPMENTAL TRANSITION IN THE FAMILY, AND THIS IS OFTEN RELATED TO THE REACTIVATION OF SIMILAR UNRESOLVED ISSUES IN THE PARENTAL LIFE. HE POINTS OUT THAT FAMILY THERAPISTS ARE INTERESTED IN FAMILY FUNCTIONS, FAMILY TASKS, FAMILY INTERFACES WITH OTHER SYSTEMS, RATHER THAN THINKING PRIMARILY IN TERMS OF THE SUCCESS OR FAILURE OF COPING MECHANISMS OF AN INDIVIDUAL. HE DISCUSSES THE POLITICS OF FAMILY THERAPY, AND SAYS THAT IT PRODUCES "A LATERALISATION OF POWER AND REDUCES THE INFLUENCE OF THE TRADITIONALLY ORGANISED VERTICAL HIERARCHIES OF PSYCHIATRY, PSYCHOLOGY AND NURSING."

CHAPTER TEN WAS A PROCESS RECORDING OF A PANEL DISCUSSION ON FAMILY THERAPY. IT WAS INTERESTING THAT BROWN AND BLOCK STATED THAT FAMILY THERAPISTS NEEDED PERSONAL PSYCHOTHERAPY, AND "THAT IT IS DOUBTFUL THAT ONE CAN MANAGE WELL THE ENORMOUSLY COMPLEX SERIES OF

INTERNAL FEELINGS THAT A FAMILY INTERVIEWER AND THERAPIST MUST EXPERIENCE UNLESS HE OR SHE HAS HAD A LOT OF INDIVIDUAL TREATMENT." IT IS INTERESTING TO NOTE THAT MANY OF THE LEADING FAMILY THERAPISTS IN BRITAIN ARE PSYCHOANALYSTS. THEY ALSO STATE THAT FAMILY THERAPISTS WHO ARE MARRIED, AND HAVE REARED CHILDREN AND ADOLESCENTS, ARE MORE LIKELY TO BE ABLE TO EMPATHISE WITH THE PARENTS' PROBLEMS WITH THEIR OFF-SPRING. THEY ALSO NOTE THE DIFFICULTY IN LOS ANGELES OF GETTING LOWER SOCIO-ECONOMIC GROUPS TO ATTEND FOR MORE THAN THREE OR FOUR SESSIONS. THIS IS SIMILAR TO WHAT HAPPENS WITH THE SAME SOCIO-ECONOMIC GROUP IN DUBLIN. THEY FAVOUR REINFORCEMENT AND BEHAVIOUR MODIFICATION TECHNIQUES, AND EDUCATIONAL KINDS OF INTERVENTIONS WITH THIS SOCIO-ECONOMIC GROUP.

THIS BOOK CAN BE RECOMMENDED TO PSYCHIATRISTS, PSYCHOLOGISTS AND SOCIAL WORKERS WORKING WITH FAMILIES.

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Grinberg, L. (1975). **An Introduction to Work of Bion.** Clunie Press.

Goldstein, J., Freud, F. A. and Solnit, A. **Beyond the Best Interest of the Child.** Free Press, 1975.

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**TIME LIMITED PSYCHOTHERAPY.** MANN, J., GOLDMAN, R. (1987). AMERICAN PSYCHIATRIC PRESS.

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THIS IS A COMPETENT BOOK ON BRIEF PSYCHOTHERAPY, FIRST PUBLISHED IN 1982. IT HAS DETAILED PSYCHOTHERAPEUTIC CASE HISTORIES WHICH ARE PROCESS RECORDED. IT IS POSSIBLE FOR THE READER, THEREFORE, TO FOLLOW WHAT THE



PATIENT SAID AND THE INTERPRETATIONS MADE BY THE THERAPIST. THESE CASE HISTORIES GIVE THE BEGINNING THERAPIST A GOOD "FEEL" OF THE PSYCHOTHERAPEUTIC PROCESS. IN ADDITION TO REVIEWING THE BRIEF PSYCHO-THERAPY MODEL, THIS BOOK ALSO DEVOTES A CHAPTER TO DISCUSSING THE CENTRAL ISSUE OF TIME AND THE THEORY OF THERAPEUTIC CHANGE IN TIME LIMITED PSYCHOTHERAPY. THE AUTHORS POINT OUT THAT TIME LIMITED TREATMENT DOES NOT ATTEMPT TO COMPETE WITH PSYCHOANALYSIS, THE GOALS OF WHICH ARE MUCH MORE AMBITIOUS. IN ANALYSIS, THE ANALYST ATTEMPTS TO RESOLVE CONFLICT AT EVERY LEVEL IN THE CONTEXT OF UNLIMITED TIME. IN BRIEF PSYCHOTHERAPY, THE INTERPRETATIONS ARE MADE TO THE CENTRAL ISSUE OR CORE CONFLICT OR FOCUS, AND A THOROUGH REWORKING OF THE OLD CONFLICTS IS ATTEMPTED IN THE CONTEXT OF TELESCOPED TIME. I BELIEVE THAT ONE OF THE PROBLEMS WITH BRIEF PSYCHOTHERAPY IS THAT ONE NEEDS A LOT OF EXPERIENCE TO DO IT EFFECTIVELY. IN A WAY, EXPERIENCE OF LONG TERM PSYCHOTHERAPY IS THE BEST PREPARATION FOR BRIEF PSYCHOTHERAPY. NEVERTHELESS, I HAVE SEEN MANY NEOPHYTES CARRY OUT VERY SUCCESSFUL TIME LIMITED PSYCHOTHERAPY UNDER SUPERVISION. THIS BOOK WOULD BE OF USE TO TRAINEE REGISTRARS, PSYCHOLOGISTS, SOCIAL WORKERS AND NURSES.

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**RESEARCH LINKING TO SOCIAL SCIENCES AND MEDICINE - A DIRECTORY OF IRISH WORK IN THE EIGHTIES.** MEDICAL AND HEALTH GROUP, PSI. DUBLIN: P.S.I. 1988.

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HANNAH MCGEE AND HER COLLEAGUES ARE TO BE CONGRATULATED ON BRINGING OUT THIS MUCH NEEDED DIRECTORY OF IRISH RESEARCH WORK. THE DIRECTORY AIMS TO INFORM THE RESEARCH COMMUNITY OF THE WORK BEING UNDERTAKEN BY VARIOUS PROFESSIONS AND ORGANISATIONS IN IRELAND, AND

ACHIEVES THIS GOAL. IT IDENTIFIES OVER 200 RESEARCH PROJECTS UNDERTAKEN IN IRELAND IN THE 1980'S. A SUMMARY IS PROVIDED OF OVER 100 PROJECTS. THE DIRECTORY IS OF INTEREST TO PSYCHIATRISTS, PSYCHOLOGISTS, SPEECH THERAPISTS, SOCIAL WORKERS AND SOCIOLOGISTS. THE AUTHORS HOPE THAT IT WILL INCREASE COMMUNICATION AND CROSS-FERTILISATION OF IDEAS WITHIN THE VARIOUS RESEARCH COMMUNITIES.

THE CONTENTS ARE LISTED UNDER HOSPITALS, RESEARCH AGENCIES AND THIRD-LEVEL INSTITUTIONS, INCLUDING NATIONAL INSTITUTES FOR HIGHER EDUCATION AND UNIVERSITIES. THERE IS ALSO AN AUTHOR AND SUBJECT INDEX, WHICH I FOUND TO BE HELPFUL. THIS KIND OF PUBLICATION HAS BEEN AVAILABLE IN THE UK FOR MANY YEARS. IT ALLOWS A PROSPECTIVE RESEARCHER TO SEE IF THE PROJECT IS ALREADY BEING UNDERTAKEN BY SOMEBODY ELSE IN IRELAND. EVEN THOUGH IRELAND IS A VERY SMALL COUNTRY, IT CAN BE DIFFICULT WITHOUT A DIRECTORY SUCH AS THIS TO ESTABLISH WHAT RESEARCH IS GOING ON IN ANOTHER PART OF THE COUNTRY. NATURALLY, NO DIRECTORY COVERS EVERY PROJECT TAKING PLACE IN THE DESIGNATED AREA, BUT THERE ARE MORE THAN SUFFICIENT PROJECTS ENUMERATED TO MAKE THE PURCHASE OF THIS DIRECTORY WORTHWHILE.

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**THE OEDIPUS PAPERS.** POLLOCK, G. H. AND ROSS, J. M. (1988). INTERNATIONAL UNIVERSITIES PRESS.

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THIS BOOK IS DIVIDED INTO THREE SECTIONS. THE FIRST SECTION LOOKS AT INTERPRETATIONS OF THE MYTH BEFORE 1970, COMMENCING WITH FREUD'S DISCUSSION OF IT IN "THE INTERPRETATION OF DREAMS." THE SECOND SECTION OF THE BOOK COVERS INTERPRETATIONS OF THE MYTH FROM 1970 TO THE PRESENT DAY. THE LAST SECTION LOOKS AT CLINICAL,



CULTURAL AND DEVELOPMENTAL IMPLICATIONS OF THE STORY OF OEDIPUS.

IN THE INTRODUCTION, THE EDITORS DISCUSS THE EARLY FOCUS ON OEDIPAL ISSUES, WITH LATER DEVELOPMENTS IN PRE-OEDIPAL ISSUES. THEY POINT OUT THAT SCIENTIFIC THEORIES ARE OFTEN SIMPLIFICATIONS THAT DO NOT TAKE INTO ACCOUNT DIVERSITY, COMPLEXITY, AND COMPREHENSIVENESS. REIK, IN A CHAPTER ON OEDIPUS AND THE SPHINX, POINTS OUT THAT OEDIPUS, THE UNRAVELLER OF RIDDLES, AND THE SPHINX - A PICTURE SO RICH IN ASSOCIATIONS - MAY JUSTLY ADORN THE ACHIEVEMENTS OF PSYCHOANALYTIC RESEARCH; ESPECIALLY AS A CONSTANT WARNING THAT WE MUST NEVER BE CONTENT WITH WHAT HAS BEEN ATTAINED.

BELA GRUNBERGER HAS A CHAPTER ON OEDIPAL CONFLICTS OF THE ANALYST. SHE DISCUSSED "CERTAIN CURRENT TRENDS IN FRENCH PSYCHOANALYSIS," AS FOLLOWS: "THERE IS AN ANTAGONISM BETWEEN THE TWO FUNDAMENTAL AND, IN FACT, CONTRADICTORY POSITIONS: THAT OF THE ANALYST, WHOM I SHALL OEDIPAL (SINCE THE ADJECTIVE 'FREUDIAN' HAS BECOME USURPED), AND THE ANALYST FOR WHOM TREATMENT, EVEN AS AN OBJECT TO BE CATHECTED, IS NEGLIGIBLE. WHAT HE RETAINS OF ANALYSIS IS HIS INTELLECTUAL CONSTRUCTION, AND HE SHORTENS THE ANALYTIC SESSION TO BE SURE THAT NO SPECIFIC ATMOSPHERE COULD TAKE SHAPE WHICH WOULD FAVOUR THE VITAL EMOTIONAL ENGAGEMENT OF THE UNCONSCIOUS OF BOTH PATIENT AND ANALYST. HAVING PUSHED ASIDE THE EXPERIENCE THAT SHOULD BE LIVED THROUGH, ONE COULD, IN A PINCH, DO WITHOUT THE PATIENT, AND ANALYSIS COULD BECOME A PHILOSOPHY, ON A PHILOSOPHY, TO THE EXTENT IT APPLIES ITS REFLECTION TO A PHILOSOPHICO-GRAMMATICOLINGUISTIC CONSTRUCTION WHICH IS CALLED PSYCHOANALYSIS." GRUNBERGER ALSO POINTS OUT THAT PSYCHOANALYSIS "LIKE ANY OTHER DISCIPLINE

CONSIDERED IN THE STRICTLY INTELLECTUAL ANGLE - CAN BE LEARNED AS A SORT OF PIDGIN-ANALYSIS."

THERE IS ALSO A CHAPTER BY SPIRO ON THE UNIVERSALITY OF THE OEDIPUS COMPLEX. SPIRO POINTS OUT THAT THE VERY NUB OF MALINOWSKI'S CONTENTION THAT THE STRUCTURE OF THE NUCLEAR COMPLEX IS CULTURALLY VARIABLE NOT ONLY IN PRINCIPLE, BUT ALSO IN FACT, CONSISTS IN HIS CLAIM THAT ALTHOUGH THE BIOLOGICAL MOTHER IS THE PRIMARY MOTHERING FIGURE IN THE TROBRIANDS, IT IS THE SISTER WHO IS THE PRIMARY OBJECT OF THE BOY'S LIBIDINAL DESIRES. IT IS INTERESTING THAT THIS CLAIM IS REFUTED BY MALINOWSKI'S OWN EVIDENCE. THIS CLAIM HAS BEEN ACCEPTED FOR FIFTY YEARS, AND SPIRO SEES IT AS A SCIENTIFIC MYTH. THIS DOES NOT SURPRISE SPIRO, AS HE SEES THE HISTORY OF SCIENCE AS A HISTORY OF PERSISTENT REFUTATIONS OF WELL-ESTABLISHED GENERALISATIONS. THIS BOOK WOULD BE OF INTEREST TO ALL HEALTH PROFESSIONALS. IT DOES REQUIRE BACKGROUND KNOWLEDGE OF PSYCHOANALYSIS TO GET FULL BENEFIT FROM READING IT. THE EDITORS PERFORM THE USEFUL FUNCTION OF BRINGING TOGETHER ALL THE MAJOR PAPERS ON THE OEDIPUS STORY FOR ALMOST THE LAST HUNDRED YEARS.

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**NEW CONCEPTS IN PSYCHOANALYTIC PSYCHOTHERAPY.**
ROSS, J. M. AND MYERS, W. A. (1989). AMERICAN PSYCHIATRIC PRESS.

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THIS BOOK AIMS TO APPLY PSYCHOANALYTIC KNOWLEDGE TO GENERAL PSYCHIATRY, INCLUDING SCHOOLS AND GENERAL HOSPITALS. IT AIMS TO TRANSFER IT FROM THE COUCH TO COMMUNITY PSYCHIATRIC SETTINGS. THE BOOK CONTAINS SUMMARIES AND CRITIQUES OF THE THEORIES OF KERNBERG AND KOHUD. ROSS AND MYERS POINT OUT THAT THIS MODE OF



TREATMENT CAN "INTERDIGITATE WITH, ENHANCE, AND IN TURN BENEFIT FROM, MANY OF THE NEW ADVANCES, BIOLOGICAL AND OTHERWISE, HITHERTO OFTEN REGARDED AS OUTSIDE ITS SCOPE."

THE FIRST CHAPTER PROVIDES AN EXCELLENT DESCRIPTION OF NARCISSISTIC AND BORDERLINE PERSONALITY PROBLEMS BUT, LIKE THE BOOK AS A WHOLE, REQUIRES A BACKGROUND OF KNOWLEDGE IN PSYCHOANALYSIS, AND THEREFORE WOULD ONLY BE SUITABLE FOR THE MORE ADVANCED TRAINEE OR EXPERIENCED HEALTH PROFESSIONAL. DIRECT OBSERVATIONS OF FAMILIES WERE USED TO STUDY THESE PERSONALITY PROBLEMS, AND IT WAS NOTED THAT THERE WERE REPEATED AND CHARACTERISTIC EPISODES OF REGRESSION WITHIN ALL FAMILY MEMBERS, AND THAT ADOLESCENTS WERE NOT SUPPORTED BY THEIR PARENTS IN ACCOMPLISHING PHASE APPROPRIATE LIFE TASKS. THE COMBINED TREATMENTS USED WITH THESE FAMILIES INCLUDED INDIVIDUAL PSYCHOTHERAPY, FAMILY THERAPY AND MARITAL THERAPY.

THERE IS ALSO AN INTERESTING CHAPTER BY KELLY AND OLSEN ON THE REAL RELATIONSHIP IN PSYCHOANALYTIC PSYCHOTHERAPY. THEY EMPHASISE THAT THE PATIENT MUST HAVE TWO PARALLEL EXPERIENCES, ONE OF THE REAL RELATIONSHIP IN THE PRESENT, AND THE OTHER A RELIVING INTRANSFERENCE OF THE PAST. THEY ARE CRITICAL OF THE THERAPIST AS AN IMPERSONAL SCREEN AND MAINTAIN, I BELIEVE QUITE RIGHTLY, THAT AN EMOTIONALLY REAL RELATIONSHIP IN THE PRESENT FACILITATES THE DEVELOPMENT OF TRANSFERENCE THAT IS THERAPEUTICALLY USEFUL, SOMETHING THAT FACILITATES THE PATIENT'S INTERNALISATION OF ASPECTS OF THE THERAPIST'S FUNCTIONING. THERE IS AN OMISSION FROM THE REFERENCES OF KLAUBER, WHO PIONEERED DISCUSSION OF THIS ISSUE. THERE IS ALSO AN EXCELLENT CHAPTER ON MASOCHISTIC CHARACTER PATHOLOGY IN LIAISON PSYCHIATRY AND ITS

HANDLING, AND HOW THESE PATIENTS NEED TO REPEAT EARLY NEGATIVE PARENT-CHILD RELATIONSHIPS WITH DOCTORS.

THERE IS A USEFUL CHAPTER FOR CHILD PSYCHIATRISTS ON SCHOOL CONSULTATION AND THE NEED TO HELP TEACHERS UNDERSTAND THE BASIC NATURE OF THE CHILD. THERE FOLLOWS AN IMPORTANT CHAPTER BY PARENS ON PARENT EDUCATION, AND PSYCHOANALYTIC CONTRIBUTIONS TO THIS WHICH WOULD BE VERY USEFUL TO PROFESSIONALS CONDUCTING ANTE-NATAL CLASSES, AND TO CURRENTLY COMMENCING HOMESTART PROGRAMMES IN DISADVANTAGED URBAN AREAS. PARENS POINTS OUT THAT "THERE IS MUCH TEACHABLE KNOWLEDGE, TEACHABLE SKILL IN MOTHERING, IN PARENTING." BERMAN DISCUSSES THE SUPERVISOR-SUPERVISEE RELATIONSHIP, SOMETHING THAT IS MUCH NEGLECTED, AND DISCUSSES THE UNAVOIDABLE OVERLAP BETWEEN SUPERVISION AND THERAPY.

THE BOOK WOULD PROBABLY BE MOST SUITABLE IN AN INSTITUTIONAL LIBRARY, ALTHOUGH THOSE PARTICULARLY INTERESTED IN ANALYTICAL PSYCHOTHERAPY WOULD FIND IT WELL WORTH BUYING.

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**ORDINARY ECSTASY.** ROWAN, J. (1988). (HUMANISTIC PSYCHOLOGY IN ACTION). ROUTLEDGE.

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DESPITE ITS RATHER OFF-PUTTING TITLE, THIS BOOK IS OF INTEREST AND SUMMARISES FOR CORE PROFESSIONALS WHAT THEIR PATIENTS MAY VERY WELL BE READING. THE BOOK DOES FULFIL THE AUTHOR'S INTENTION OF INFORMING PEOPLE "WHO HAVE HEARD OF HUMANISTIC PSYCHOLOGY AND WANTED TO KNOW MORE ABOUT IT, OR FOR PEOPLE WHO HAVE BEEN TO AN ENCOUNTER GROUP (OR CO-COUNSELLING, OR MEDICATION, OR ANY OF THE OTHER ACTIVITIES MENTIONED IN THIS BOOK) AND



WANT TO UNDERSTAND MORE ABOUT WHAT THEY HAVE BEEN DOING." LIKE MOST PSYCHOTHERAPIES, HUMANISTIC PSYCHOLOGY IS INTERESTED IN PERSONAL GROWTH, EXISTENTIAL CHOICE, AND THE FULFILMENT OF HUMAN POTENTIAL.

THERE IS A DISCUSSION ON THE T-GROUP, WHICH IS BEING USED BY ORGANISATIONS IN THE MOVE FROM AN AUTOCRATIC TO A MORE PARTICIPATIVE STYLE OF MANAGEMENT. THERE IS ALSO A DISCUSSION OF MASLOW'S "SELF-ACTUALISATION," OR BECOMING THE SELF THAT ONE TRULY IS. THIS LEADS ON TO A DISCUSSION OF THE AIMS OF ALL PSYCHOTHERAPY, I.E. TO SEE REALITY AS IT IS, TO BECOME SPONTANEOUS AND TO ACCEPT ONSELF. INDEED, IT WAS MASLOW WHO SET UP THE MOVEMENT NOW KNOWN AS HUMANISTIC PSYCHOLOGY. ROGERS IS QUOTED AS SAYING, "THERE IS NO BEAST IN MAN." THIS SEEMS TO DENY THE AGGRESSIVE AND DESTRUCTIVE SIDES OF MAN'S NATURE. ONE CAN ONLY DISAGREE WITH THE EXISTENTIAL PSYCHIATRY WHICH DENIES THE WHOLE CONCEPT OF MENTAL ILLNESS. THIS DENIAL OF BIOLOGICAL AND GENETIC FACTORS SEEMS MORE OF A STEP BACKWARDS THAN FORWARDS.

THERE FOLLOWS A DISCUSSION OF ZEN, TAO AND TANTRA. "THE ESSENCE OF THE TANTRIC APPROACH IS ITS EXPERIMENTALISM. THERE IS LITTLE OR NO EMPHASIS ON LEARNING THE CORRECT THEORIES AND READING THE CORRECT BOOKS - THE IMPORTANT THING IS TO DO IT." THIS SEEMS TO BRING UP THE ISSUE OF RE-INVENTING THE WHEEL EACH TIME. MASLOW STATED THAT A PEAK EXPERIENCE (HIS NAME FOR ECSTASY) COULD BE THE MOST IMPORTANT EVENT IN A PERSON'S LIFE. HORNE CALLED IT "CASUAL EXTRAVERTED MYSTICISM." HUMANISTIC PSYCHOLOGY IS ABOUT THE INTEGRATION OF BODY, FEELINGS, INTELLECT AND SPIRIT. THERE IS PROBABLY TRUTH IN THE IDEA THAT MANY OF OUR ORGANISATIONS ARE DRIVING PEOPLE DOWN INTO ANOMIE AND ALIENATION, AS DURKHEIM POINTED OUT IN THE NINETEENTH

century. Self disclosure is regarded as a cure for loneliness, and an I-Thou encounter with another person is seen as a deep human need.

There is a discussion of the Encounter Group Movement and the Synanom approach which involves direct confrontation of one group by another member. The attacking members use emotion and intuition, and project their own problems onto the focal person. This seems to me to be highly dangerous, and is probably one of the reasons that encounter groups have led to a deterioration in personal functioning of some members. Co-counselling may have a place for minor psychological problems, because professionals cannot reach all those with psychological problems. Nevertheless, this activity should have more rational professional monitoring as a safeguard for participants.

Another problem is that humanistic psychology does not attach very much importance to diagnostic categories, and therefore patients who have conditions with a large biological base to them may not get the appropriate treatment. It seems reasonable that one should make a diagnosis before treatment. Szasz claims that psychiatric classification, unlike medical diagnosis, invalidates the experience of human beings. Clearly, this is not so if the appropriate treatment, whether psychotherapy or some other form of treatment, is prescribed. The fact of the matter is that problems are classified, not people.



**Attachment and the Therapeutic Process.**
Sacksteder, J., Schwartz, D., Akabane. (Eds). (1987). Madison, Connecticut: International University Press.

The book is divided into four parts: part one, theory; part two, research; part three, therapy; and part four, a series of papers of Otto Will, who was Medical Director of the Austin Riggs Centre in Massachusette, which specialised in psychoanalytic psychotherapy for psychotic and non-psychotic seriously disturbed individuals.

There is an excellent chapter by Merton Gill, who asserts that psychoanalysis must choose between a person and an energy discharge point of view, as well as between a hermeneutic and a natural science framework. My own view is that it is not necessary to choose one of these categories, but that they reflect different aspects of psychoanalysis. There is little doubt that psychoanalysis is a science of meaning but, at the same time, certain aspects of it can be statistically tested, for example, through outcome studies. The energy discharge point of view seems to be helpful in understanding obsessional neurosis, and the person point of view helpful in understanding borderline personalities. Gill feels that "the basic integrating point of view of psychoanalysis should be that of relations between people, not that of energy discharge." This relationship point of view is also emphasised by another chapter by Wynne in the book, and also by John Bowlby's chapter on "Defensive Processes in the Light of Attachment Theory."

Lyman Wynne notes the "frankly deprecatory attacks and counter-attacks" made between practitioners of

INDIVIDUAL PSYCHOTHERAPY AND FAMILY THERAPY OVER THE PAST TWENTY-FIVE YEARS. HE FEELS IT IS UNSATISFACTORY THAT PRACTITIONERS USE TECHNIQUES FROM VARIOUS PSYCHOTHERAPIES TOGETHER IN A HAPHAZARD WAY. WYNNE POINTS OUT THAT HIS "RELATEDNESS PARADIGM" CAN BE VIEWED WITHIN A SYSTEMS THEORIES' PERSPECTIVE AS SUPRA-ORDINATE TO THE PERSON PARADIGM. WYNNE FEELS THAT THE RELATEDNESS HAS ITS BEGINNINGS IN ATTACHMENTS AND CARE GIVING. HE SEES MUTUALITY WHERE THE IDENTITY OF EACH PARTICIPANT IS RECOGNISED AND POSITIVELY VALUED, WHILST PSEUDOMUTUALITY OCCURS WHEN THERE IS A PREDOMINANT ABSORPTION IN FITTING TOGETHER, AT THE EXPENSE OF THE DIFFERENTIATION OF THE IDENTITIES OF THE PERSON IN THE RELATION.

DANIEL SCHARTZ FOCUSES ON INTRA-PSYCHIC STRUCTURE AND INTERACTION, AND SUGGESTS THAT THE REASON PEOPLE DIE SOMETIMES SHORTLY AFTER RETIREMENT IS BECAUSE THERE IS A LOSS OF THE OPPORTUNITY TO EXERCISE THE INTRA-PSYCHIC FUNCTION THAT IS CRUCIAL TO SUCH VITALITY.

THERE IS A VERY INTERESTING CHAPTER ON ERRORS IN THE PRACTICE OF PSYCHOTHERAPY, AND ALSO IN CREATIVITY. THIS CHAPTER WOULD BE OF PARTICULAR USE TO THERAPISTS BEGINNING PSYCHOTHERAPY. ERRORS CAN BE VERY PRODUCTIVE, E.G., FLEMING'S DISCOVERY OF PENICILLIN AND PASTEUR'S DEVELOPMENT OF THE CONCEPT OF IMMUNISATION, WHICH CAN BE SEEN AS PARTICULAR INCIDENCES OF THE ARTICULATION OF ERROR. IT WAS PASTEUR WHO ALSO STATED THAT "CHANCE FAVOURS THE PREPARED MIND." IF THE THERAPIST UNDERSTANDS WHY HE HAS MADE AN ERROR IN INTERPRETATION, IT CAN BE QUITE USEFUL FOR HIM TO TRACE THE ORIGINS OF THIS IN HIMSELF, AND ALSO TO SEE WHAT THE PATIENT DID TO PROVOKE HIM TO MAKE THIS ERROR. IT CAN GIVE INSIGHT INTO THE PATIENT'S AND THERAPIST'S PSYCHOLOGY. IN RECENT YEARS, THE ANALYSIS OF COUNTER-



TRANSFERENCE IS SEEN AS A MAJOR ROLE IN PSYCHOTHERAPY. IT WAS PAULA HEIMAN, IN PARTICULAR, WHO EMPHASISED THE IMPORTANCE OF COUNTERTRANSFERENCE AND SHOWED HOW USEFUL IT COULD BE. PRIOR TO THAT IT HAD BEEN SEEN SIMPLY AS A SIGN OF NOT BEING PROPERLY ANALYSED, AND THEREFORE A NEGATIVE EXPERIENCE.

HILDA BRUCH WROTE A CHAPTER ON THE CHANGING PICTURE OF ANOREXIA NERVOSA WHICH RESEMBLED FAIRLY CLOSELY THE IDEAS OF KOHUT IN HIS PSYCHOLOGY OF THE SELF. THE EMPHASIS IS ON THE NECESSITY OF A FAVOURABLE ENVIRONMENT FOR THE HEALTHY DEVELOPMENT OF THE SELF, AND FOR POSITIVE RESPONSES TO A CHILD'S EXPRESSION OF NEEDS. THERE IS MUCH IN THE BOOK THAT WOULD INTEREST THE PSYCHIATRIST INTERESTED IN PSYCHOANALYSIS IN THE 1980's. MANY OF THE CURRENT ISSUES ARE DEALT WITH IN THE BOOK, AND IT WOULD ALSO INTEREST THOSE WHO WORK WITH THE MORE SEVERELY DISTURBED PATIENTS.

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**PROJECTION, IDENTIFICATION, PROJECTIVE IDENTIFICATION.**
SANDLER, J. (1987). INTERNATIONAL UNIVERSITY PRESS.
MADISON, C. T.

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THE PAPERS AND DISCUSSIONS IN THIS BOOK WERE GIVEN AT THE FIRST CONFERENCE OF THE SIGMUND FREUD CENTRE OF THE HEBREW UNIVERSITY OF JERUSALEM. THE BOOK OPENS WITH CHAPTERS BY SANDLER ON INTERNALISATION, EXTERNALISATION AND PROJECTIVE IDENTIFICATION. THESE CHAPTERS ARE FOLLOWED BY A VERY CLEAR PROJECTIVE IDENTIFICATION BY KERNBERG, AND AN EXCELLENT CLINICAL PAPER ON THE SAME TOPIC BY BETTY JOSEPH. THE CHAPTER BY MEISSNER ON PROJECTIVE IDENTIFICATION IS LESS CLEAR.

Sandler emphasises at the beginning of the book that it deals with "concepts, with theoretical constructs whose value should be considered primarily in terms of their clinical utility." This emphasis on clinical utility is extremely important because, when psychoanalytical thinkers get excessively abstract and distant from clinical material, they often become less useful and less helpful in their productions.

Sandler describes primary identification as "a state of primary identity or primary confusion, in which the infant cannot differentiate the representational aspects of his own self from those of the object. He describes secondary identification as a process where the representational boundary between self and object is not lost, but the subject embodies in the self-representation attributes of the object, real or fantasised. In this sense the term can be regarded as the vehicle for so-called secondary narcissism in which admiration, love, and esteem for the object are transferred to one's self, which is in Kleinan terms 'introjective identification'."

Projective identification is a very difficult concept for therapists to grasp when they first come across it. Sandler points out that for Klein "projective identification involved splitting, which I would understand in this context as splitting-off of parts of the self-representation or of the object representation. Projective identification involves projection in that it is an identifying of the object with the split-off parts of the self." He goes on to state that "the real object employed in the process of projective identification is not regarded as being affected - the parts of the self put into the object



are put into the fantasy object, the internal object, not the external object."

The concept of projective identification was widened in the 1950's by Paul Heiman, with work on countertransference. The countertransference reaction was seen as an important source of information about what was happening in the patient. The concept was further developed in the 1960's with what Sandler described as the "externalisation of parts of the self or of the internal object occurring directly into the external object." Bion talks about the function of the container and the putting of things into the object: "an evacuation of the bad breast takes place through a realistic projective identification. The mother, with her capacity for reverie, transforms the unpleasant sensations linked to the 'bad breast' and provides relief for the infant, who then reintrojects the mitigated and modified emotional experience." Sandler points out that these formulations can be related to Winnicott's holding function of the good mother. Sandler ends his chapter with an emphasis of the importance of differentiating between what belongs to the therapist and what is projected by the patient.

The clinical paper by Betty Joseph reflects the shift which Sandler points out, from an emphasis on instinct to an emphasis nowadays in psychoanalysis on narcissistic equilibrium and its maintenance. Sandler emphasises the need for psychoanalysis to have a double theory of motivation, one focusing on drives and the other focusing on painful feelings.

This book and the three previous books by Sandler, (1) The Analysis of Defence: the Ego and Mechanisms of Defence Revisited, (2) The Technique of Child Analysis,

and (3) The Patient and the Analyst, can be recommended to all psychiatrists, psychologists and social workers working with psychiatric patients. Nobody writing today is able to elaborate psychoanalytic ideas with greater clarity and attention to detail than Sandler. He has made an enormous contribution in elucidating difficult psychoanalytic concepts to neophytes and to more senior psychotherapeutic practitioners.

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**Autistic Barriers in Neurotic Patients,** Tustin, F. (1986). Karnac Books, London:

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This excellent book is divided into two parts. Part 1 deals with psychogenic autism, and is of particular relevance to child psychiatrists, child psychologists, child psychotherapists and nurses working with autistic children. Part 2 deals with psychogenic autism in neurotic patients, and is of considerable relevance to adult psychiatrists, psychologists and all those who work with personality disorders.

Tustin points out that patients develop an autistic immobilisation as a result of early interpersonal traumas. These patients often have a mother whose confidence was being undermined in various ways, and a father whose presence, for various reasons, was insufficiently felt. As a result of trauma, an encapsulating reaction protects the damaged part of the personality and shuts out the fear of being killed but, unfortunately, the price to be paid is that psychic functioning is frozen and immobilised. The patient then turns away from the outside world which presents such threats, in favour of a subjective sensation-dominated world which is under his direct control.



These patients are often extremely perfectionistic, and their excessively high standards for other people cause them great psychological pain. They are impoverished in their thinking and feeling, and not psychologically minded. They tend to be extremely concrete in their thinking. In discussing the aetiology of autism, Tustin points out something with which most people agree: that there is something in the nature of the child which predisposes him to autism. Here she seems to be drawing attention to her multifactorial view of the aetiology.

The second half of the book brings to the reader's mind many difficult adult personality disorders, and throws new light on them. Tustin suggests that many of these disorders have a hidden capsule of psychogenic autism. It would appear useful to think of the schizoid personalities, in particular. She points out that patients with autistic elements to their personalities have poor identities and a poor sense of self, as well as having poor capacities to empathise. She quotes W. B. Yeats on the demoralising effects of this lack of a central core to the personality:

> "Things fall apart; the centre cannot hold;
> Mere anarchy is loosed upon the world,
> The blood-dimmed tide is loosed."

Tustin makes the point that, in treatment, the therapist needs to be more firm and active than is usual in analytically-based psychotherapy. She describes treatment as going through three phases: (1) Modifying the autistic barriers, so that relationships with people can be set in train; (2) Healing the damaged psyche (psychotherapy can begin); (3) Psychoanalysis as it is ordinarily practised. The

PATIENTS HAVE TO BE HELPED TO FACE THEIR TERRORS, RATHER THAN AVOIDING THEM. THEY HAVE TO BE HELPED TO DISCOVER THE HIDDEN STRENGTHS IN THEIR PERSONALITY AND NOT BE TREATED LIKE PRECIOUS DRESDEN CHINA. THE THERAPIST NEEDS CONSIDERABLE CAPACITY FOR EMPATHY AND IMAGINATION, AS THESE HAVE NOT BEEN DEVELOPED IN THESE PATIENTS.

THE BOOK ALSO CONTAINS AN INTERESTING DISCUSSION OF SCIENCE AND PSYCHOLOGY. IN THIS BOOK SHE HAS ACHIEVED A BALANCE BETWEEN WHAT MEDAWAR CALLS "TWO VOICES, THE ONE IMAGINATIVE AND THE OTHER CRITICAL, BETWEEN CONJECTURE AND REPUTATION."

THIS BOOK HAS A "RING OF TRUTH" ABOUT IT, IS ORIGINAL, AND THROWS NEW LIGHT ON HITHERTO PUZZLING AREAS OF THE HUMAN PERSONALITY.

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**INSTINCTUAL STIMULATION OF CHILDREN. VOLUME 1: CLINICAL FINDINGS AND VOLUME 2: CLINICAL CASES.**
WEIL, J. NEW YORK: INTERNATIONAL UNIVERSITIES PRESS. (1989).

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THESE TWO EXCELLENT AND TIMELY VOLUMES FOCUS ON A WIDE VARIETY OF FORMS OF SEXUAL ABUSE OF CHILDREN, AS WELL AS EXAMINING THE EFFECTS OF CORPORAL PUNISHMENT. THERE IS A VERY LARGE AMOUNT OF EXTREMELY USEFUL CLINICAL MATERIAL. THERE IS ALSO A REVIEW OF CASES OF ABUSE PUBLISHED IN THE GENERAL LITERATURE, FROM S. FREUD'S CASE OF LITTLE HANS ONWARDS. THE AUTHOR SHOWS THAT A WIDE VARIETY OF CHILDREN'S SYMPTOMS CAN BE TRACED BACK TO EXCESSIVE INSTINCTUAL STIMULATION OF CHILDREN. THE VOLUMES MEET THE NEED FOR AN INCREASED AVAILABILITY OF IN-DEPTH CASES WHICH FOCUS UPON CHILDREN'S SYMPTOMS IN



RELATION TO THEIR HISTORY OF EXCESSIVE EROGENOUS, EROTIC AND PHYSICALLY PUNITIVE CONTACTS WITH ADULTS. THE AUTHOR ALSO ACKNOWLEDGES THE LIMITATIONS OF THE STUDY, AND QUOTES DR. BAILAR OF THE DEPARTMENT OF BIO-STATISTICS, HARVARD SCHOOL OF PUBLIC HEALTH: "ANY RESEARCH PROGRAMME THAT WILL TAKE NO RISKS WITH EXTERNALLY CONTROLLED OR EVEN UNCONTROLLED STUDIES OF POTENTIALLY IMPORTANT ADVANCES, RUNS THE RISK OF BECOMING IRRELEVANT TO THE MOST IMPORTANT CURRENT DEVELOPMENTS IN SCIENCE AND MEDICINE."

THE AUTHOR ALSO COMMENTS, IN DISCUSSING FREUD'S SEDUCTION THEORY, THAT "HE KEPT COMING BACK TO THE IMPORTANCE OF THIS THEORY." AT THE BEGINNING OF THIS CENTURY FREUD INVESTIGATED NEUROTIC SYMPTOMS AND FOUND THAT CHILDREN'S EXPOSURE TO SEXUALISED CONTACTS WITH ADULTS AND ADOLESCENTS WAS OF AETIOLOGICAL IMPORTANCE. THERE FOLLOWS A PERIOD WHEN FREUD SOMEWHAT OVERESTIMATED THE IMPORTANCE OF PHANTASY. NEVERTHE-LESS, IN THE FOLLOWING YEARS HE DID CONTINUE TO EMPHASISE THE IMPORTANCE OF HIS SEDUCTION THEORY, AND IN 1916 HE DISCUSSED IT ON FOUR OCCASIONS IN HIS "INTRODUCTORY LECTURES ON PSYCHOANALYSIS." AGAIN, TOWARDS THE END OF HIS LIFE IN 1938, IN HIS "OUTLINE OF PSYCHOANALYSIS," HE POINTED OUT THAT NEUROTIC SYMPTOMS OFTEN STEM FROM "SEXUAL ABUSE OF CHILDREN BY ADULTS." IT IS OF INTEREST THAT WEIL DID NOT MENTION MASSON'S BOOK ON THIS ISSUE, IN WHICH HE WAS CRITICAL OF FREUD. IT WOULD HAVE BEEN WORTH DISCUSSING THIS, AS IT IS WIDELY KNOWN ABOUT, AND WAS DESCRIBED BY FRANK CIOSSI IN "THE TIMES LITERARY SUPPLEMENT" OF JULY 6TH, 1984, AS BEING TENDENTIOUS AND UNRELIABLE. GEORGE STEINER ALSO DESCRIBED MASSON'S BOOK AS BEING INCREDIBLY NAIVE, AND GOES ON TO SAY THAT MASSON'S DESCRIPTION OF MOTIVES IS ABSURD. GILLESPIE, IN A REVIEW OF MASSON'S BOOK, "THE ASSAULT ON TRUTH," POINTS OUT THAT FREUD WAS NEVER

SO FOOLISH TO DENY THE OCCURRENCE OF SEDUCTION AND OTHER ABUSES OF CHILDREN. AS GILLESPIE POINTS OUT, PSYCHOANALYSIS IS QUITE CAPABLE OF COMING TO TERMS WITH THE IDEA THAT THE IMPORTANCE OF THE TRAUMATIC FACTOR HAD BEEN INSUFFICIENTLY RECOGNISED. NOBODY TODAY WOULD DISAGREE WITH FREUD'S STATEMENT (1931) THAT ACTUAL SEDUCTION WAS COMMON, AND HE SAID "WHEN SEDUCTION INTERVENES IT INVARIABLY DISTURBS THE NATURAL COURSE OF THE DEVELOPMENTAL PROCESSES, AND IT OFTEN LEAVES BEHIND EXTENSIVE AND LASTING CONSEQUENCES."

THESE TWO BOOKS BY WEIL CAN BE REGARDED AS ESSENTIAL READING FOR ALL MENTAL HEALTH PROFESSIONALS. THEY SHOULD ALSO BE IN ALL ADULT AND CHILD PSYCHIATRIC LIBRARIES AND BE AVAILABLE FOR STUDENTS WHO MAY NOT BE ABLE TO PURCHASE THEM BECAUSE OF THEIR PRICE.

FINALLY, THE BIGGEST QUESTION MENTAL HEALTH PROFESSIONALS HAVE TO ASK THEMSELVES IS WHY, UP TO RELATIVELY RECENTLY, THEY IGNORED THE IMPORTANCE OF CHILD SEXUAL ABUSE.

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**CHILDREN'S FANTASIES - THE SHAPING OF RELATIONSHIPS.**
WEININGER, O. KARNAC BOOKS.

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THE AUTHOR OF THIS BOOK IS A PROFESSOR OF APPLIED PSYCHOLOGY. HE HAS WRITTEN A PREVIOUS BOOK ON THE PSYCHOLOGY OF MELANIE KLEIN. THIS BOOK FOCUSES ON THE KLEINAN VIEW OF CHILD DEVELOPMENT, WHICH PLACES GREAT EMPHASIS ON FANTASY. MELANIE KLEIN WAS A MAJOR FIGURE IN THE DEVELOPMENT OF CHILD PSYCHOTHERAPY. SHE SHOWED HOW THE CHILD'S PLAY COULD BE USED TO UNDERSTAND THE MIND, THE MEANING OF SUBJECTIVE EXPERIENCE AND THE BEHAVIOUR OF THE CHILD. KLEINAN THEORY IS PARTICULARLY



GOOD AT UNDERSTANDING DEVELOPMENT IN THE FIRST YEAR OF LIFE, AND AT UNDERSTANDING PARANOID-SCHIZOID PHENOMENA.

THIS BOOK HAS A DETAILED CASE EXAMPLE WHICH ANYBODY PRACTISING CHILD PSYCHOTHERAPY AND USING THE SQUIGGLE TECHNIQUE OF WINNICOTT COULD FIND VERY INTERESTING. SOME OF THE INTERPRETATIONS MADE IN THE BOOK ARE EXCESSIVELY SPECULATIVE, AND GO BEYOND THE DATA PRESENTED. ON ONE OCCASION, FOR EXAMPLE, THE AUTHOR DID NOT GIVE SUFFICIENT ATTENTION TO TEMPERAMENTAL DIFFICULTIES AND THE FACT THAT THE CHILD APPEARED TO BE TEMPERAMENTALLY DIFFICULT, AND THEREFORE THE PHENOMENA PRESENTED HAD MORE A CONSTITUTIONAL THAN A PSYCHOLOGICAL ROOT.

NEVERTHELESS, THIS IS A VERY READABLE BOOK, WHICH CONTAINS A VERY CLEAR EXPOSITION OF KLEINAN THEORY AND WOULD BE WELL WORTH READING BY ANYBODY WITH AN INTEREST IN CHILD DEVELOPMENT, BOTH NORMAL AND PATHOLOGICAL.

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**DEVELOPMENTAL PSYCHOPATHOLOGY.** YORKE, C., WISEBERG, S. AND FREEMAN, T. (1989). YALE UNIVERSITY PRESS.

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THIS BOOK HAS HAD A GESTATION PERIOD OF THIRTEEN YEARS AND IT HAS BEEN WORTH WAITING FOR. IT EMPHASISES THE DEVELOPMENTAL POINT OF VIEW WHICH, OF COURSE, IS CRITICAL TO PSYCHOANALYSIS AND PSYCHIATRY. IT HAS CHAPTERS ON DEPRESSION, NEUROSIS, CHARACTER DISORDERS AND OTHER SERIOUS PSYCHIATRIC DISORDERS. IN THE PREFACE, THE AUTHORS EMPHASISE THAT "AN INFORMED PSYCHIATRY DEMANDS A PSYCHOANALYTIC PERSPECTIVE DOES NOT IMPLY THAT OTHER DISCIPLINES - GENETICS, NEUROSCIENCE, EPIDEMIOLOGY, SOCIOLOGY, TO MENTION SOME OF THE MORE OBVIOUS - SHOULD NOT BE GIVEN DUE WEIGHT. BUT IT IS

OUR INTENTION TO REAFFIRM THAT THERE IS NO PSYCHIATRY WITHOUT A COHERENT AND COMPREHENSIVE PSYCHOLOGY." THE AUTHORS ALSO POINT OUT THAT "WE DO NOT TAKE THE VIEW THAT PSYCHOANALYSIS IS A THERAPEUTIC TREATMENT OF CHOICE FOR ALL PSYCHIATRIC DISORDERS."

THE CHAPTER ON ANXIETY, SIGNAL ANXIETY AND PANIC IS PARTICULARLY HELPFUL AND TIMELY, WITH THE CURRENT ENORMOUS INTEREST IN POST-TRAUMATIC STRESS DISORDERS. IT DISCUSSES WHAT HAPPENS TO THE INDIVIDUAL WHEN THE PROTECTIVE SHIELD AGAINST EXTERNAL STIMULI IS BROKEN. THE SECOND CHAPTER HAS A VERY INTERESTING CONTRIBUTION FROM ANNA FREUD, WHERE SHE DISCUSSES DEVELOPMENTAL DISHARMONIES. AMONG OTHER THINGS, SHE GIVES WEIGHT TO CONSTITUTIONALLY DETERMINED DEVIATIONS, AND POINTS OUT THAT INTERFERENCE IN THE NORMAL DEVELOPMENT CAN OCCUR WHEN SEXUAL OR AGGRESSIVE ENDOWMENT IS DEFICIENT IN QUANTITY, OR WHEN THE SEXUAL OR AGGRESSIVE DRIVES ARE EXCESSIVE AND THE PERSONALITY FINDS IT DIFFICULT TO ACCOMMODATE THEM. OUR UNDERSTANDING OF SEVERE PSYCHOPATHOLOGY HAS BEEN MUCH INCREASED BY DR. TOM FREEMAN FROM NORTHERN IRELAND, AND THIS IS CONTINUED IN THIS BOOK. MANY READERS WILL BE FAMILIAR WITH A PREVIOUS BOOK OF HIS, "THE PSYCHOANALYST IN PSYCHIATRY."

THIS BOOK WILL BE AN INVALUABLE RESOURCE FOR TRAINEES IN PSYCHIATRY AND PSYCHOTHERAPY, AND FOR CHILD AND ADULT PSYCHIATRISTS.

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