

**IRISH FAMILIES UNDER STRESS**

**FIFTY YEARS OF IRISH CHILD PSYCHIATRY**

**VOLUME SEVEN**

**EDITOR: MICHAEL FITZGERALD**

**SOUTH WESTERN AREA HEALTH BOARD**

## PREVIOUS BOOKS IN THE SERIES

Pathways to Child Hospitalization  
H. McGee and M. Fitzgerald (1991)  
ISBN 0948 562 072

Irish Families Under Stress – Volume 1.  
Edited by M. Fitzgerald (1991)  
ISBN 0948 562 048

Irish Families Under Stress – Volume 2.  
Edited by A. Jeffers and M. Fitzgerald (1991)  
ISBN 0948 562 056

Irish Families Under Stress – Volume 3.  
Edited by M. Fitzgerald (1991)  
ISBN 0948 562 064

Irish Families Under Stress – Volume 4.  
Edited by M. Fitzgerald (1995)  
ISBN 0948 562 099

Irish Families Under Stress – Volume 5.  
Edited by M. Fitzgerald (1996)  
ISBN 0948 562 897

Irish Families Under Stress – Volume 6.  
Edited by M. Fitzgerald (1996)  
ISBN 0948 562 34X

Irish Families Under Stress – Volume 7.  
Edited by M. Fitzgerald (2003)  
ISBN 0948 562 706

# **IRISH FAMILIES UNDER STRESS**

**FIFTY YEARS OF IRISH CHILD PSYCHIATRY**

**VOLUME SEVEN**

**EDITOR:**

**MICHAEL FITZGERALD**

**SOUTH WESTERN AREA HEALTH BOARD  
2003**

**ISBN 0948 562 706**

## Preface

### Irish Families Under Stress, Volume VII

It is a great honour to write the Preface of this the final volume of Irish Families Under Stress. Prof. Fitzgerald and his colleagues have again created a remarkable resource for all those who work with Children and Families in a time of need.

This volume plots the history and development of Child Psychiatry services in the Eastern Region and chronicles our increasing understanding of mental health issues within Families. It brings into clear focus the contemporary concerns and the expert responses of service providers today.

I am pleased to note that many of the contributors to this volume have had a significant role in advancing our understanding of conditions including Asperger's syndrome, Autism, and Attention Deficit Hyperactivity Disorder. Our knowledge of these conditions has grown enormously since the Irish Families Under Stress series began 20 years ago.

Irish society has changed radically in the past decade and while much has improved in terms of economic success, increasing demands, urgency and new stresses have been visited upon many Irish Families. Irish Families Under Stress affords a comprehensive view of the pertinent issues and succeeds in providing an insight into the most important challenges facing Irish Families and Healthcare Professionals today.

This volume maintains the important balance between in-depth knowledge and accessibility, it is written in an open an inviting style without losing any of its academic credibility. I would like to take this opportunity to congratulate all the contributors for their work and to thank Prof. Fitzgerald for bringing this extraordinary collection together in one final volume.

Hugh Kane,  
Assistant Chief Executive Officer  
South Western Area Health Board  
January 2003.

## Acknowledgements

A very large number of people supported me in Child Psychiatric Research over many years. The work could not have been done without them and their support. I would particularly like to thank Eric Fombonne, Ross Skelton, Mary Smith, Nessa Childers, Frances Fitzgerald, Owen Fitzgerald, Robert Fitzgerald, Mark Fitzgerald, Lord John Alderdice, Sir Michael Rutter FRS, Des McKiernan, Anne Jeffers, Melanie Gallagher, Brian Lawlor, Ian Robertson, Tom Moran, Brendan Doody, Malcolm MacLachlan, Michael Walsh, James Hayes, Maria Lawlor, Alan Carr, Michael Mulcahy, Gerhard Beck, Sherry Doyle, Viktoria Lyons, Vivienne Foley, John Connolly, Paula Dillon, Nuala Matthews, Colm O'Morain, John O'Leary, Orla Sheils, Ziarh Hissan Hawi, Eilish McAuliffe, Frances Brennan, John Hillery, Augusta McCabe, Eric Taylor, Lionel Hersov, Michael Buckley, Ewen McEwen, Pauline Mahon, Gertie Doonan, Ian Daly, Ann Cleary, Ruth Barrington, Gerard Harper, Fiona McNicholas, Hugh Kane, Ann Pritchard, Lisa Brennan, Jean Quigley, Thelma Pope, Virginia McLoughlin, Librarians from T.C.D., Colette Halpin, Rita Jordan, Paul Shattock, Philip Graham, Aiden Corvin, Muhammad Arshad, Aoife Brinkley, and Margaret Curley. I would like to thank all the parents and families for their critical support in this research over many years.

Permission was received from the following Journals to publish papers:

- (1) Ken Brown, Editor, Irish Journal of Psychology permission to publish Alan Carr's paper on A National Survey of Clinical Psychologists in Ireland.
- (2) Editor, The Irish Journal of Psychological Medicine for permission to publish Services for Autism in Ireland.
- (3) Editor, Advances in Psychiatric Treatment for permission to publish the Diagnosis and Differential Diagnosis of Asperger's syndrome.
- (4) Editor, The Irish Journal of Psychological Medicine for permission to publish The Psychopharmacological Treatment of Adolescent and Adult Attention Deficit Hyperactivity Disorder.
- (5) Editor, Child Psychology Psychiatry Review for permission to publish Evaluation of a Child and Family Centre.
- (6) Eoin McVey, Irish Times for permission to publish article on John McKenna.

I would like to make special mention of Michael Gill, Hannah McGee, Myra Regan, Tony Kinsella, Brian O'Shea, Hilary Hoey, David Berman, Pat Matthews, Aiveen Kirley, Louise Gallagher, Paul McCarthy, and Benny Hollywood. I would like to thank Ms. Ellen Cranley for her secretarial support in bringing this volume and all the other volumes to fruition. It would have been impossible to produce this volume without her.

## *Contents*

### *Irish Families Under Stress Volume VII*

		Page No.
<b>Acknowledgements</b>		i
<b>Preface</b>	Mr. Hugh Kane.	ii
<b>Chapter 1</b>	<i>Augusta McCabe: A Brief History of the Early Development of Social Work in Child Psychiatry in Ireland.</i>	1
<b>Chapter 2</b>	<i>Maria Lawlor, Deirdre MacIntyre: The Stay Safe Programme: Mental Health Initiative for Irish Children.</i>	18
<b>Chapter 3</b>	<i>Vivienne Foley: The History of Speech and Language Therapy in Ireland.</i>	30
<b>Chapter 4</b>	<i>Michael Nolan: Professor John McKenna, Founder of Irish Clinic Psychology.</i>	33
<b>Chapter 5</b>	<i>John Stack: The History of Child Psychiatry in Ireland.</i>	35
<b>Chapter 6</b>	<i>Orla Higgins: Child Care Workers in Child Psychiatry.</i>	37
<b>Chapter 7</b>	<i>Alan Carr: A National Survey of Clinical Psychologists</i>	

In Ireland. 39

**Chapter 8** *Bernadette Mackey, Michael Fitzgerald, Hilary Hoey:*  
A Psychosocial Study of a Population of Children and  
Adolescents with Diabetes Mellitus. 57

**Chapter 9** *Aoife Brinkley, Paul McArdle, Michael Fitzgerald:*  
Applying Risk and Protective Factor Approach to  
Substance Use Among an Irish Adolescent Population. 63

- 2 -

Page No.

**Chapter 10** *Michael Fitzgerald, Aiden Corvin:* Diagnosis and  
Differential Diagnosis of Asperger's syndrome. 82

**Chapter 11** *Barbara Coughlan, Alan Carr, Michael Fitzgerald:*  
Factors Related to the Adjustment of Siblings following  
Sudden Infant Death. 97

**Chapter 12** *Karin Grieve:* Musing and Meanderings. 111

**Chapter 13** *Michael Fitzgerald:* Psychoanalytic Psychotherapy in  
Ireland. 115

**Chapter 14** *Sheena Leeson, Alan Carr, Michael Fitzgerald, and  
Sami Moukaddem:* Recovery and Relapse in  
Multiproblem Families following Community-based  
Multidisciplinary Treatment. 120

**Chapter 15** *Catherine McDonough, S. Fahy, and Michael Fitzgerald:*  
Self Reported Depressive Symptoms, Problems and  
Personality Characteristics in Adolescence. 135

**Chapter 16** *Karen Doherty, Michael Fitzgerald, Pat Matthews:*  
Services for Autism in Ireland. 148

**Chapter 17** *Aoife Brinkley, Michael Fitzgerald, Sheila Greene,  
Paul McArdle:* Substance Use in Early Adolescents:  
A Study of the Rates and Patterns of Substance Use

	Amongst Pupils in Dublin.	165
<b>Chapter 18</b>	<i>Michael Fitzgerald: The Psychopharmacological Treatment of Adolescent and Adult Attention Deficit Hyperactivity Disorder.</i>	225
<b>Chapter 19</b>	<i>Ann Scully, Michael Fitzgerald, Anthony Kinsella, Aiveen Higgins: The Relationship Between Excess Fears in Irish Children and Maternal Anxiety.</i>	239

- 3 -

		Page No.
<b>Chapter 20</b>	<i>Gerry French, Michael Fitzgerald, Clare Collins: The Suitability of Psychoanalytic Psychotherapy For Women Living in a Socially Disadvantaged Area.</i>	246
<b>Chapter 21</b>	<i>Clare Gormley: Connections – Family Therapy in the West.</i>	254
<b>Chapter 22</b>	<i>Michael Fitzgerald: Genius, Creativity and Savantism.</i>	258
<b>Chapter 23</b>	<i>Michael Fitzgerald: Child Psychiatry 2003.</i>	262
	<b>Irish Child Psychiatric Research: Summary.</b>	266
	<b>Publications and Published Abstracts by Irish Child Psychiatrists in the SWAHB / TCD.</b>	275
	<b>Publications and Published Abstracts by other Irish Child Psychiatrists excluding the SWAHB / TCD.</b>	300
	<b>Roster of Irish Child Psychiatrists.</b>	307

## CHAPTER ONE

### *A BRIEF HISTORY OF THE EARLY DEVELOPMENT OF SOCIAL WORK IN CHILD PSYCHIATRY IN IRELAND*

*Augusta McCabe M. Soc. Sc., CQSW.*

The following history has been compiled with the help of a number of people who are, or who have been, linked to the development of the Child Psychiatric Service in Ireland. I am most grateful for the interest they showed when I approached them for information and the time they gave to setting down their recollections of the early days of child guidance, as it was then called.

The focus of this chapter is on the early days of the Child Psychiatric Service in Ireland and does not take into account the significant developments which took place from the early 1990s by which time all the health boards had established specialist Departments of Child and Family Psychiatry. For that reason, the chapter makes only a brief reference to the developments which took place after 1990.

#### *Introduction*

Social work as a profession emerged primarily from voluntary philanthropic practices, carried out mainly by women, in the late 19<sup>th</sup> century. In understanding the history of social work, the issue of gender is a factor to be taken into account; social work has been seen as woman's work and a natural extension of appropriate feminine domestic duties into the public sphere. Psychiatry, on the other hand, allied to the field of medicine, has been regarded as a masculine pursuit based on science. The male claim to this professional territory was reflected in the pronouncement made, in 1915, by Dr. Abraham Flexner in an address delivered to the National Conference of Charities and Correction when he voiced the opinion that "A profession is a brotherhood" (Lunbeck 1994:26).

The initial relationship between psychiatrists and social workers was not an easy one. In the early 1900s as college educated social workers, exclusively women, began to voice their professional aspirations they were seen as challenging the 'status quo' that is, the male dominated order of things in the professional world. However, over time, their qualifications, skills and their focus on problems rooted in the social environment, became essential to the practice of psychiatry. It was Dr. Elmer Ernest Southard, first Director of the Boston Psychopathic Hospital, who signaled a break with his profession's past when he argued that the causes of mental illness could not be attributed solely to the nervous system but might be located elsewhere in the body, even "conceivably in the environment at large" (Southard 1913:1-26)

Consistent with this view, Southard, as Director of the Boston Psychopathic Hospital, appointed a social worker "of proven mettle" Mary C. Jarrett (1876-1961) to head up the hospital's first social service department. In 1914, with Southard's blessing, she organized a six-month apprenticeship programme at the hospital to train students. Some years later this course provided the foundation for the The Smith College Training School for Social Work of which Mary Jarrett became the first associate director (Lunbeck 1994:35-45).

In contrast with the world of adult psychiatry, the place of social work in child psychiatry was more immediately recognised. In the United States, the realization that juvenile delinquency was a serious threat to society led to significant psychiatric attention being paid to children. In 1909, William H. Healy, a psychiatrist, established a court-affiliated clinic in Chicago for juvenile delinquents and included social workers, right from the start, as members of the professional team in the study of cases and the treatment of families. Thus, social and cultural factors were given a prominence in the study of delinquency that would have been unthinkable at the turn of the century (Rie, 1971).

In these circumstances, the importance of the contribution made by the social worker to child psychiatry was much more readily understood and accepted. From the very early days of the child psychiatric service, the psychiatrist, the psychologist and the social worker comprised the core members of the clinical team.

Skehill (1999) has outlined how social work has developed in Ireland. While, as she points out, Irish developments have been influenced by the traditions and aspirations of social work elsewhere, it has also been shaped by the particular nature of Irish society itself and by the key political processes within it. It is of interest to note how closely the early days of social work in child psychiatry mirrored that of the early days in social work in general, as described by Skehill in her study (1999) i.e., the influence of religion, the preponderance of women – both as providers and recipients of the service - and the frequent focus for social workers on the social problems created by poverty, poor health and lack of education.

During the course of researching this chapter an interesting letter came to hand which highlighted one of the reasons for the focus on women. In response to a published paper on running a therapeutic group, the late Professor John McKenna, Director of Psychology in the Hospitaller Order of St. John of God Child Guidance Clinic, Dublin, wrote to Dr. Ann Lavan, now of UCD, referring to her point that "fathers were not included as the groups met during working hours". The letter is appended, with permission, at Appendix A.

## *Social Work and Child Psychiatry in Ireland*

In 1966 the Department of Health published the findings of the Commission of Inquiry on Mental Illness. The Commission, Chaired by Mr. Justice Henchy, was set up in 1961 and while it was mainly concerned with adult psychiatry, significant recommendations were made relating to child psychiatry. The members of the Commission were drawn primarily from the medical profession. There was no representative from the social work profession on the Commission but a submission was received from a group called the Southern Members / Irish Region of the British Association of Psychiatric Social Workers.

The recommendations contained in the Commission's report were far seeing for the time and if even half the recommendations made had been implemented, many of the current problems facing the child care services might have been avoided. Of particular significance was the reference made to the need for a school psychological service (Commission Report: 68). It was to be sometime, 1998 in fact, before such a service was adequately established.

The main recommendations relevant to psychiatric social work and children put forward by the Commission Report included a) the need to increase the number of social workers being trained in the country, b) the provision of a psychiatric and psychological service for children in the industrial schools, c) the request that specialist staff in the psychiatric services should provide advice and guidance for those concerned with the counseling of adolescents, and d) should provide a direct service where the problem was of sufficient gravity, particularly for adolescents who appeared before the courts.

Specifically, the Commission made two recommendations in respect of social workers and children:-

- i) The need to develop specialized training facilities for psychiatric social workers in Ireland (Commission Report: 122).

*And*

- ii) The Commission recommended that regional child psychiatric clinics should be developed. It recommended that the staffing of the regional clinics should be based on a child psychiatrist, a psychologist and a psychiatric social worker, but provision would be necessary for consultation with other specialists, such as paediatricians, and a wide range of ancillary staff such as speech therapists. (Commission Report: 69).

- i) *The need to develop specialized training facilities for psychiatric social workers in Ireland (commission Report: 122)*

Up to 1966, post-graduate training for social workers had to be undertaken abroad, mainly in the UK and the USA. While the two universities, University College, Dublin, and Trinity College, Dublin, already provided the basic Bachelor of Social Science degree (Social Work) it was recommended that “ with the expanding services for the mentally handicapped and the mentally ill, there will be increased demand for the services of psychiatric social workers” (Commission Report: 122). The contribution of the psychiatric social worker was

described as “being of immense assistance and with his or her help many patients, who would otherwise require residential care, can remain in or return to the community. In addition to providing direct assistance to the patient, the social worker can obtain full information regarding the patient’s background; this considerably helps the psychiatrist to understand the patient’s problems and to arrange an appropriate course of treatment... Another important function of the social worker is to help and advise the relatives or friends with whom the patient is living” (Commission Report: 58).

The Commission, in elaborating on the role and function of the social worker, commented on what was, at that time, a sensitive aspect of the newly emerging social work profession in Ireland. The statement read “The Commission wishes to stress that nurses cannot be substituted for social workers in any organized scheme of psychiatric services, as they have not acquired the special skills necessary to undertake case work, which is an essential feature of the social worker’s role. They do, however, play a complementary role in community care, and both nurses and social workers should be aware of this fact” (Commission Report: 59).

It was acknowledged by the members of the Commission that statistics for the number of children in need of psychiatric care were not available at that time. Reference was made to the fact that in Ireland about ten years earlier, there was only one complete Child Guidance Team, which was located with the St. John of God Brothers service in Orwell Road, Dublin. By 1966 that had increased to six teams and all had indicated that they had waiting lists. The Commission recommended that the aim, initially, “should be to develop the equivalent of at least one Child Guidance team per 100,00 of the total population of all ages”. (Commission Report: 67).

ii) *The Commission recommended that regional child psychiatric clinics should be developed. It recommended that the staffing of the regional clinics should be comprised of a child psychiatrist, a psychologist and a psychiatric social worker, but provisions should allow for consultation with other specialists, such as paediatricians, and a wide range of ancillary staff such as speech therapists etc. (Commission Report: 69).*

The Commission noted that the Child Guidance Clinic, Rathgar, operated by the Hospitaller Order of St. John of God and the Child Guidance Clinic operated by the Sisters of Mercy at the Mater Hospital, Dublin, already provided most of the facilities the Commission had in mind and recommended that their services be enabled to act as regional clinics. Further, it was recommended that three additional regional clinics should be established to be located in Cork, Limerick and Galway (Commission Report: 69).

What follows is an outline of the development of the Regional Child Guidance Clinics up to the 1990’s and the social workers who participated in that development. That each clinic developed in its own individual way will be evident as the story unfolds.

## **THE CHILD PSYCHIATRIC SERVICE IN THE EASTERN REGION**

*Hospitaller Order of St. John of God – Orwell Road, Rathgar, Dublin*

The first Child Guidance Clinic to open in Ireland was that established by the St. John of God Brothers in Orwell Road, Rathgar, in Dublin and the clinic opened its door to the first client in 1955. It was started under the administration of Brother Fedelis Devlin OH, who was the Prior in Orwell Road from 1953 to 1959. In an interview with him for the purpose of this history, he indicated that the development was promoted by the Department of Health following discussions with the World Health Organisation. The Department approached the Order of the St. John of God Brothers and agreement was reached on the setting up of the Clinic in Orwell Road between 1953 and 1954. Time was needed to prepare for this initiative which included the appointment of staff with specialist training, which, at that time, could only be acquired abroad. The core team members appointed were available to take up their new posts at the end of 1955.

Dr. John Stack was the first Medical Director appointed in September 1955, Dr. John McKenna (later Professor) was appointed clinical psychologist in October 1955. The first social worker was Ms. Irene Mulaney, who, having trained abroad as a psychiatric social worker, joined the team in December 1955.

Always referred to as Ms. Mulaney, even to this day, she became a legend in her own time. Bro. Fedelis spoke warmly of Ms. Mulaney and her dedication and professional approach to the work of the Clinic. He spoke in particular of the group work she pioneered with the parents of autistic children who attended the Clinic. It is now well recognized that work with the parents of children on the autistic spectrum is a critical part of any support programme. It is worth noting that Ms. Mulaney understood this important dimension as far back as the late 1950's.

Following Irene Mulaney's retirement in 1977, Maura Wall Murphy was appointed Senior Social Worker in 1979. She was head of the social work team until 1986 when her interest in, and development of Family Mediation during this time led her to move to the Department of Justice to start up the National Family Mediation Service. Mary Fennessy, returning from the child psychiatric service in the Maudsley Hospital, London, was appointed to the post of Senior Social Worker in Orwell Road in 1987.

The service, which has now greatly expanded, is run under the title of the Lucena Clinics and provides a service from clinics located in Rathgar, Tallaght, Dun Laoghaire, and Bray/East Wicklow.

### ***Sisters of Mercy, Mater Hospital Department of Child and Family Psychiatry, Dublin***

The Mater Hospital Child Guidance Clinic (later to become the Department of Child and Family Psychiatry) was opened in 1962. The first Medical Director was Dr. Sean Malone and the first clinical psychologist was Pia Kasteel. Sr. Margherita Rock was appointed social worker in 1963, even though, as she said herself with a smile, she had not quite finished her post-graduate training, she "had had the benefit of a lengthy placement in the Notre Dame Child Guidance Clinic in Glasgow for which I have always been grateful". She remembered being there on the very first day and taking the first fourteen social histories.

Anita Owens (nee Thompson), a psychiatric social worker, was appointed to the team in early 1963, while Sr. Margherita was completing her Masters studies in the Catholic University of America, Washington. Sr. Margherita was appointed Senior Psychiatric Social Worker in the

Mater Hospital Child Guidance Clinic in 1965. She remained in that post until 1972 when left to take up a Congregational appointment within the Mercy Order. Up to that time, they were the only two social workers attached to the Clinic. Another quote from Sr. Margherita concerning caseloads gives an interesting insight to the times that were in it – “I would prefer not to say what our individual caseloads were at that time – all I will say is that there were approximately 900 open files in the department”.

Dr. Paul McQuaid became the Medical Director of the department at the end of 1964. About the same time, Therese Brady, clinical psychologist, and Sr. Jo Kennedy, Speech Therapist, joined the team. This core group constituted the founding members of what was to become a very busy and much sought after service and training facility. As Sr. Margherita described it “an innovative spirit pervaded the clinic and we were all encouraged and supported in whatever initiative we wished to progress”. This spirit of innovation was a noted feature of the child guidance movement in general and all those who have ever had the opportunity to work in child guidance would, no doubt, voice the same opinion.

The Mater Hospital extended the child psychiatric service to Ballymun in conjunction with the then EHB and opened a new unit in the Ballymun shopping center in 1974. Imelda McCarthy was the first full time social worker appointed to this new team.

### ***The Children’s Hospital in Temple Street, Dublin***

#### ***St. Francis Child Guidance Clinic***

The child guidance clinic in Temple St. Children’s Hospital operated for the first three years of its existence (1962 – 1965) in the Out Patients Department of the hospital prior to the opening of the special unit to be called St. Francis Clinic in 1965.

The pioneer of this clinic was St. Marie de Montfort who originally planned the development for the training of speech and language therapists but saw it turn into a child guidance clinic instead. The first social workers attached to St. Francis Clinic were Sr. Frances Ignatius, Nuala Harmey (nee O’Brien) and Venora O’Brien. Dorothy Staunton joined the social work team in the late 1960’s and is currently the Principal Social Worker in the Department of Child and Family Psychiatry.

### ***The Eastern Health Board***

In the mid-1960’s, Noreen Kearney was appointed Senior Psychiatric Social Worker (PSW) for the Dublin Health Authority (DHA) which, following the Health Act 1970, was to become the Eastern Health Board (EHB). As she recalls, the need for social workers to be trained for the psychiatric service was evident and had been recommended in the Commission on Mental Health of 1966. Together with Veronica Webb, the other PSW employed at that time by the DHA, she submitted a proposal for a trainee scheme to the Personnel section of the DHA. This proposal was strongly supported by Dr. Ivor Browne, who was at that time the Chief Psychiatrist. The proposal was approved and one of the most innovative training schemes for social workers got under way.

### ***The Eastern Health Board (EHB) Trainee Scheme***

The EHB trainee scheme was confined to the psychiatric service and included the service for both adults and children. The scheme was advertised in the press and candidates were selected by interview. The scheme offered a one year apprenticeship to new B. Soc. Sc. graduates, who had taken the social work option in their degree. They were apprenticed, for one year, to an experienced PSW who supervised their caseload. They were paid a nominal salary (in 1972 this was approximately £1,000 per annum) and were expected to move on to a post-graduate training course at the end of the year. It was up to the trainee to find themselves a place on a post graduate course (at that time the professional qualification was the award of the Certificate of Qualification in Social Work: CQSW). The contract was that the newly qualified social worker would return to work in the psychiatric service of the DHA/EHB, with adults or children, for a period of not less than two years on the successful completion of their training.

Noreen Kearney did a trawl through her papers for the purpose of this chapter and came up with the following list of some of the social workers who had participated in the trainee scheme between the years 1968 to its conclusion in 1974. The list, while not complete, included Brid Clarke (nee Thornhill), Jean Forbes, Leone Lunny (nee McCormack), Marie Hill, Hilary Hutch, Mary Higgins, George Jones, Margaret Kirby, Augusta McCabe, Clarie McGrath (nee Leonard), Irene McMahan (nee Farren), Emer McManus, Nora McPartland (nee Lennox), Mary Millar, Vicki Somers, and Fred Roantree.

The first two trainees were Leone Lunny and Emer McManus. Having obtained their Certificate of Qualification in Social Work (CQSW) they returned to Dublin 1968. Leone Lunny joined Noreen Kearney in St. Loman's Hospital while Emer McManus joined Veronica Webb in St. Brendan's Hospital.

### ***The Eastern Health Board Child Psychiatric Service***

Prior to the trainee scheme, in 1962/3, Ursula Hurley, social worker, was attached to the Children's Unit in St. Loman's Hospital. This Unit was primarily geared to the needs of autistic children but the special school attached to the Unit catered for children presenting with a variety of disorders. Dr. Paul McCarthy, returning from Canada, joined the Eastern Health Board (EHB) as Clinical Director of the Child Psychiatric service in 1968. Leone Lunny, fresh from the London School of Economics with her CQSW was the first psychiatric social worker to be attached to his team.

Her brief covered the newly established child guidance service launched by Paul McCarthy and located initially in St. Loman's hospital, and the two day centres, Garden Hill located in the grounds of St. James Hospital, and the clinic in Ballyfermot located at Claddagh Green.

The social workers associated with the establishment of the EHB child psychiatric service are listed at Appendix B.

## **THE CHILD PSYCHIATRIC SERVICE IN THE WEST OF IRELAND**

### ***The Western Health Board: Galway, Mayo and Roscommon***

Dr. Anthony Carroll took up his appointment as Clinical Director of the Child Psychiatric Service in the Western Health Board on the 1<sup>st</sup> April 1975. The team was first located in the unopened General Psychiatric Unit in the Regional Hospital, Galway, and the service was intended to cover the three counties of the Western Health Board, Galway, Mayo and Roscommon. The first few years involved a lot of travel to outpatient clinics in Castlebar, Ballina, Roscommon and Ballinasloe, as well as providing the service for Galway city.

As he wrote in a letter to the author, referring to the development of child guidance in the West “in establishing the service I had a community focus and a multi-disciplinary team in mind”. With an agenda like that he set about acquiring a secretary, a clinical psychologist and a social worker as quickly as possible. By September of 1975 he had appointed Jim Byrne as social worker. Jim Byrne had a background in psychiatric nursing and speech therapy and had also trained in social worker. The following year, 1976, the child guidance service was re-located to Salthill to a house called Lyradoon and Mike Grieve was appointed Senior Social Worker. The other social workers to join the team in the early days of the service included; Kate Feeley (1977); Karen Grieve (1979); Bridget O’Leary (1979) and Anne Marie Naughton (1980).

In 1978 the expanding service moved to St. Anne’s children’s home, in Taylors Hill, which had just been vacated by the Sisters of Mercy. St. Anne’s became the headquarters for the new service while Lyradoon remained as the center for family focused work. St. Anne’s was developed into a children’s center functioning as an adolescent and child residential and day assessment Unit coupled with a treatment centre with its own special school. In 1982 the Child Guidance Clinic was opened in University College Hospital, Galway.

Initially, as Tony Carroll recalls, “we had a somewhat traditional Child Guidance Team approach, but we quickly adopted Family Therapy as the most useful approach in our peripheral clinics”. While being a strong advocate of Family Therapy, Tony Carroll largely attributes the practicalities of this development within his own child guidance service to the members of his social work team, particularly Mike and Karen Grieve, who will long be remembered as the organizers of the now famous family therapy workshops on Inishbofin in June of 1980. Family Therapy enthusiasts came from all over the country for the two workshops, each workshop lasting five days, which were led by Ingegerd Wirtberg (Sweden) and Bill Petitt (UK). For the influence of social work on the development of Family Therapy in Ireland see later section in this chapter.

Tony Carroll is unstinting in his appreciation of the contribution of the social worker to the child psychiatric service. He has long been an advocate for social work and refers to the social worker as a crucial member of the child guidance team.

### **THE CHILD PSYCHIATRIC SERVICE IN THE OTHER HEALTH BOARDS**

Following the development of the services in the Eastern Health Board and the Western Health Board, a designated child psychiatric service was slow to take off in the rest of the country. Up to the early 1990s the child psychiatric service was provided in a number of different ways. Some boards contracted with the voluntary agencies already providing services to children with mental disabilities to provide a child guidance service; other boards

shared a service with professional staff providing sessions across health board boundaries; some boards used the adult psychiatric service when necessary and many of the boards sent children to the Dublin clinics for assessment when a second opinion was required.

The following is a brief sketch of the establishment of the child psychiatric service and the social workers involved in the remaining health boards up to the early 1990s.

### ***The Southern Health Board: Cork and Kerry***

The child psychiatric service in Cork grew out of the service provided by the Brothers of Charity in Lota for mentally handicapped boys as far back as 1936. In 1955 the Department of Education recognised Lota as a special school, one of three in the country, with a residential center for boys.

Betty O'Connor started her social work career as the Medical Social Worker in Barringtons Hospital, Limerick in 1945. She subsequently joined the residential center in Lota, Cork (1962-87). She recalls that the child guidance service gradually developed out of the mental handicap service as more and more children were presented who needed psychiatric attention.

Throughout the 1970's and 80's as the demand for child guidance increased, the service was moved out of Lota but continued under the aegis of the Brothers of Charity. It was located in different places in Cork at various stages in e.g., in Fitten Street, then Victoria Road, and finally moving to a purpose build center at Mahon, Cork. A range of services was offered including assessment, diagnosis, child, adolescent and family guidance services. Dr. Paddy Murray was the consultant child psychiatrist during this time and the names of the social workers associated with the developing service included: Patricia Slevin, Vanessa Curtis, Madaline Johnson, Maree Keenan and Delia Gaffney

The Southern Health established a child psychiatric service in 1994 and the first Clinical Director of Child Psychiatry, Dr. Finbar O'Leary was appointed that year. The unit was located in St. Finbarr's Hospital, Cork. The first social workers who joined the child psychiatric team were Elizabeth O'Riordan, Senior Social Worker, appointed in September 1996, with Mary Healy following a month later in October 1996.

### ***The Mid-Western Health Board: Limerick and Clare and Tipperary North Riding***

The health board service was established in November 1993 in the grounds of the Regional General Hospital, Limerick by Dr. Neil Adamson, Consultant Child Psychiatrist. Prior to this development, the Brothers of Charity in Bawnmore (under the directorship of Dr. Jim Ledwith, Consultant Psychiatrist) assessed children and adolescents in crisis on request. This was in addition to the mainstream work of the service of the Brothers of Charity which provided for people with learning disabilities.

Under Dr. Adamson, as Clinical Director of the new Department of Child, Adolescent and Family Psychiatry, the service was moved to its present location in O'Connell Street in the heart of Limerick city, in August of 1995. The service is provided by a multi-disciplinary team. The new service maintained its connection with the Brothers of Charity service in

Bawnmore, its links with the Paediatric service in the Regional General Hospital and the Community Care service, thus providing accessibility to the other relevant services.

The first Social Worker to be appointed to the service was An na Cava, who joined the service in early 1994. Dave Rush joined the team in 1995, and Kevin O'Farrell was appointed Senior Social Worker in 1996. The current Senior Social Worker, Kay O'Keeffe, was appointed to the post in 1998.

#### ***The North Western Health Board: Donegal; Sligo; Leitrim and west Cavan***

In the NW health board, up to 1992, a psychiatric service was provided for children by the adult psychiatric service, or, if warranted, the child could be sent to a clinic in Dublin for assessment. In 1992, Dr. Don McDwyer was appointed as Consultant Child Psychiatrist. A social worker, Ann Shields, was appointed in 1993 and the present Senior Social Worker, Maire Magenis was appointed to the team in 1995.

#### ***The Midland Health Board: Laoise, Offaly, Longford and Westmeath***

The history of the child guidance service in the Midland Health Board is an interesting one. A specific child guidance service was provided by the board as far back as the early 1970's (if not earlier) when Dr. Ellen Cody, based in St. Loman's Adult Psychiatric Hospital in Mullingar, practiced child psychiatry. Bridget Gallagher was attached to the service and continued when Dr. Una Batt took over from Dr. Cody about 1978. Their brief seemed to cover the whole of the Midland Health Board region and, by arrangement, extended to part of the North Eastern Health Board region where they provided sessions in Navan to cover children in Co. Meath.

The social work members of the child guidance service worked on secondment from the Community Care team on a sessional basis. This worked out at about two or three days a week in child psychiatry and the remainder of the week with the Community Care team. The pioneers in the Midland Health Board were Carmel Dolan from 1977, covering Athlone, with Siobhan Keogh and Rosin Doherty from the early 1980's covering Mullingar and Longford, respectively.

Dr. Antoinette Dalton is the current Consultant Child Psychiatrist for the Midland Health Board region and Carmel Dolan is the Senior Social Worker in the service which is based in the Hospital in Mullingar.

#### ***The North Eastern Health Board: Meath, Louth and Cavan***

The North Eastern Health Board had an arrangement with its neighbouring board, the Midland, and the psychiatric service based in St. Loman's Hospital, Mullingar, provided a service, on a sessional basis for many years until such time as the regional child psychiatric service was established in the early 1990s. Dr. Una Batt was the child psychiatrist who covered this area in the early years with Bridget Gallagher as the social worker from the Mullingar center. This provision appears to have covered Meath only at that time. A social work service was also provided from the Lourdes Hospital in Drogheda where the social worker was Maura Matthews. When the regional service was introduced by the NEHB it was

lead by Dr. Maria Lawlor, Consultant Child Psychiatrist. Bernie Henry is currently the Senior Social Worker in the child psychiatric service.

### ***The South Eastern Health Board***

Prior to the establishment of the regional health board child psychiatric service in the mid 1990s, the child guidance service was largely provided by the Brothers of Charity in Waterford together with a number of sessions provided by some of the Dublin child psychiatric clinics. The Department of Child and Family Psychiatry is located in the Regional Hospital, Waterford and the present Senior Social Worker is Noreen Dunne.

### ***The Role of the Social Worker in the Early Days of the Child Psychiatric Service***

The important contribution of the social worker to the child psychiatric team lies in the very nature of social work itself. The holistic approach which came to be recognised as the hallmark of the profession emerged over the years. While the person-situation construct has governed all of social work practice since the publication of *Social Diagnosis* by Mary Richmond in 1917, the emphasis in the early years was on direct case-work with individuals. By the 1940's group-work had become a standard part of the practice curricula in schools of social work and by the mid-1950's, social workers, along with other professionals in other disciplines, became interested in the practice of family treatment. By the 1960's a systems framework had developed which directed the social worker's attention to the functions of linkage and networking. Family treatment was integrated into social work practice by Ackerman (1961) and Minuchin (1974). The 1980's saw the emergence of a structural framework which demanded a perspective which took account not just the individual and their family but also their environment and the influence of the community.

For the purpose of this history, Ruth Torode, now Lecturer in Social Work and Director of the Bachelor in Social Studies Programme in Trinity College Dublin, plundered her personal archives and came up with a list of the tasks she performed as part of her job in Garden Hill in the 1970's. Reading the list now it is possible to see all the elements of social work, as outlined above, called into play i.e., casework, group-work and family treatment with a measure of community involvement and advocacy. What follows reflects to a great extent what most social workers in child psychiatry would have been doing during those early years.

The tasks as listed included:-

- Prioritizing referrals.
- Carrying out pre-assessment home visits to compile the family social history.
- Cataloguing the child's developmental milestone.
- Preparing and writing up the pre-assessment reports.
- Participating in the psychiatric assessment and meeting parents whilst the psychiatrist saw the child.
- Planning appropriate intervention with the psychiatrist.
- Working with parents and occasionally with the child. Work with some families was long term and often continued after the psychiatrist had ceased to see the child.

- Liaising with other team members as appropriate: psychologist, speech therapist, play therapist, etc.
- Following up on families who did not respond to appointments.
- Accessing resources, advocating on behalf of clients with welfare services, liaising with schools and community services etc.
- Presenting cases at team meetings and contributing to the discussion of other case presentations as well as attending the regular journal club.

In addition to the above, she added, on a personal note, that she also was involved in several related activities which included:

- Running a support group for mothers, while children attended a concurrent play group, on two afternoons a week for a number of years. The group was based in the Fatima Mansions Parish Centre, which was run by Sr. Claude. Most of the mothers in the group were from the locality and were socially isolated and issues addressed, at the behest of the participants, included parenting, sexuality, marital conflict, finding time for themselves etc.
- Student training. Providing supervised student placements for the Universities, on a twice yearly basis.
- Participation in a Practice Teachers training and support group.
- Weekly meetings of the EHB Psychiatric Social Workers held in St. Brendan's Hospital and organized and chaired by Noreen Kearney. This was a support group and very valuable, given that there was no formal supervision for the PSW's elsewhere in the service.
- Monthly meetings with social work and community workers in the Crumlin social service centre.
- Active participation in the Irish Association of Social Workers (IASW) and contribution to the work of particular special interests groups, attending the monthly IASW Eastern Regional presentations, involvement with the Women's movement and the Local Government and Public Service Union (later to become IMPACT).

The extent of the remit as outlined above is due in great measure to the interest and dedication of the individual social worker. Coupled with that is the fact that prior to the development of the Community Care social work teams, many children were referred to the child guidance clinics who, to-day, would be seen, more appropriately, by the Community Care service.

It is worth noting that in the early years of social work in the child psychiatric service there were a number of short-comings in terms of supervision and service co-ordination. For example, a) there was no formal supervision of the work and while there was a lot of peer support and consultation, there was no real direction or accountability on the job; b) there was an apparent lack of integration within the service i.e., different clinics in the service did not co-ordinate their work or co-operate on joint projects, and c) there seemed to be an absence of strategic planning or policy development for the service which involved the views or contribution of team members. However, in spite of these gaps, the work was satisfying and rewarding and the autonomy enjoyed by social workers appeared to act as an incentive to give of themselves, over and above the call of duty. Quite a lot of activity took place outside the nine to five of the working day so that work and social life with colleagues frequently overlapped. It would probably be true to say, of that time, that social work was still regarded

as having a vocational dimension and the commitment to the client was more than just part of the job.

An important aspect of the work was the nature of the cases which were presented to the child psychiatric service in those early years e.g. many of the cases involved multi-problem families with a history of poverty, poor housing or crowded living conditions (some women revealed having had up to twenty pregnancies), domestic violence, child abuse and neglect, chronic ill-health, alcohol abuse, depression, school phobia or agoraphobia, learning difficulties and/or significant psychiatric problems. Many of these cases became long-term and open-ended when a more goal-focused and time-limited approach might have been more effective. Two factors may have contributed to this weakness in the system, i.e., a) the lack of formal supervision for professional staff, as mentioned above, and b) the lack of a developed Community Care social work service. It was only after 1974, when the social work service was established in the Health Boards, that many of the cases which were seen, particularly in the Health Board child guidance clinics, were more appropriately referred to the social work teams in Community Care. Prior to that, child guidance clinics dealt with many cases which would later be referred to the social work departments in the community care areas.

With regard to the question of child abuse, it was unclear where responsibility rested during the early years of the child guidance service and child sexual abuse went largely unrecognized. The first Department of Health guidelines on physical child abuse (Non Accidental Injury, as it was then called) were issued in 1978 while the first Department of Health guidelines which referred to child sexual abuse appeared in 1982. It was only when training became available in the 1980's that many a professional in the child guidance service became aware, retrospectively, and with some distress, of child sexual abuse cases they might have missed in the course of their work.

Given the range and the complexity of family problems which presented to the child psychiatric service, the opportunity to learn from the experience of working with a multi-disciplinary team was exceptional. The feed-back from case presentations and discussions which took place at the regular meetings of journal clubs were regarded as an integral part of the learning environment in the child guidance service. It is small wonder that social workers who had work experience in this service developed a wealth of expertise to draw on whatever road they subsequently traveled.

### ***Family Therapy, Social Work and the Child Psychiatric Service in Ireland***

In early 1975 the Eastern Region Committee of the Irish Association of Social Workers (IASW) decided to focus on "The Family" as its theme for that year and to that group must go the credit for hosting the first workshop on Family Therapy in Ireland. Ruth Torode (attached to Garden Hill CGC at that time) confirmed from her diary that Saturday, 3<sup>rd</sup> May 1975 was the inaugural meeting facilitated by Pat Pegg from the United States and David Wilmot, Family Service Unit project leader in North London. Philip Kearney (attached to the Mater Hospital CGC at that time), Barbara Kohnstamm, Josephine Glynn and Katie McGing, all social workers, were the key organizers of the event.

Throughout the year 1975 – 1976 the group sponsored lectures, seminars and meetings on the topic of the family and out of that focus emerged the Family Therapy Network of Ireland (FTNI). In May 1976 a small group, which became known as the 'Core Group' of the FTNI

and with the support, financial and moral, of the IASW the group developed. The people most closely associated with this development were Katie McGing, Phil Kearney, Josephine Glynn and Barbara Kohnstanm. From its inception, the aim of the Network was to become a body which would bring together the talents of the relevant professions in promoting family therapy training in Ireland.

By 1978, the FTN had established itself as an ongoing entity and Family Therapy experts who were invited from abroad had generated an excitement and a keen interest within the Irish scene in learning and developing skills in this approach. Such experts included Virginia Satir and Fred La Belle (who had trained under Satir) from the Centre for Social Services of Metropolitan Montreal. Therapists from the Ackermann Institute in New York came to Dublin and ran highly successful workshops. One such therapist was Phoebe Prosky, who together with Imelda McCarthy representing the FTNI, was interviewed about her work on the Late Late Show. Other famous practitioners from abroad who provided learning opportunities up to 1980 included Sue Waldron-Skinner from the UK, Jean Sternberg from California, and Salvador Minuchin. Later in the 1980's members of the Milan team, Lynn Hoffman, Monica McGoldrick and others were regular visitors to Ireland.

In 1980, the FTNI set about organizing home grown training groups to meet the growing demand for ongoing training. Two different courses were offered that year:

- i) A nineteen week clinical supervision group co-run by Dr. Nollaig Byrne, consultant child psychiatrist at the Department of Child Psychiatry in the Mater Hospital, and
- ii) An introductory theoretical course for beginning family therapists run by Imelda McCarthy, who was, at the time, pursuing a Masters degree in Social work at UCD.

In the Autumn of 1980 the members of the FTNI (which had been independent of the IASW since 1976) met to decide on the future development of the network. It was decided, overwhelmingly, to continue with the work under way and a new Steering Committee was elected. The membership reflected the aspiration for a multi-disciplinary group and comprised: Katie McGing (social worker), Imelda McCarthy (social worker), Paddy King (psychologist/Sligo), John Phelan (General Practitioner/Waterford), Marian Murphy (social worker/Cork).

The Family Therapy Network of Ireland had gone from strength to strength in the intervening years and the two year Clinical Diploma in Family Therapy was established by the Mater Hospital in 1991 by Dr. Nollaig Byrne, Philip Kearney and Imelda McCarthy. The course is now formally linked to a Masters programme in University College, Dublin. This course is now one of the most sought after post-graduate training courses of its kind in the country with the original team gaining a widespread international reputation for their work. Dr. Jim Sheehan, who was Principal social worker in the Mater Hospital Dept. of Child and Family Psychiatry, is now the full time Director of this Family Therapy programme.

During the mid 1990's FTNI changed its name to the Family Therapy Association of Ireland (FTAI) as the organization became more professionally streamlined.

### ***The Broad Perspective***

Looking back on the early development of the child psychiatric service in Ireland; the challenges and the innovation which followed, and it is hardly surprising that social workers who had the opportunity to work in child psychiatry in those early years, should have developed a range of skills and an expertise which had a much wider application than the child guidance service itself.

A glance at the early records of the Irish Association of Social Workers and the Local Government and Public Services Union (now IMPACT) will show that many of the social workers employed in psychiatric social work and medical social work were heavily involved in the work of these organizations. The outcome of such commitment was the development of significant dimensions of the profession e.g., the contribution made by Irish social workers to the international scene through the International Federation of Social Workers and, on the home front, the initiatives brought about by the Social Workers Vocational Group within the Union.

It is also worth mentioning the diverse paths taken by some individual social workers who left child psychiatry for “fresh woods and pastures new”. Their early experience in family and child psychiatry no doubt served them well whether it was in the field of private practice, organizational development, management, public or political life. While a number of social workers moved into the world of academia, many of those who are currently in child psychiatry have pursued research options and proceeded to the level of Ph.D.

Social Work in Ireland is a relatively new profession. It has made a contribution not only through practice, but also through the administration and management of social services. Social Workers in the child psychiatric service, which was the subject of this chapter, have clearly made their own special contribution to this development and enhanced service provision for the benefit of all.

Social Workers associated with the early days of the Child Psychiatric Service of the Eastern Health Board included:-

- *Leone Lunny* **1968 – 1970** St. the Children's Unit in Loman's Hospital, Garden Hill and the Ballyfermot Clinic at Claddagh Green.
- *Sr. Vincent (later Sr. Meave O'Sullivan)* **1971-1977** Children's Unit in St. Loman's Hospital where she supervised Brid Clarke during her trainee year. She moved to the Ballyfermot Clinic at Claddagh Green. Consultant child psychiatrist at that time was Dr. Gerry O'Neill.
- *Brid Clarke* **1971 – 1972** (St. Loman's children's unit as a trainee). Adult psychiatry from 1973 to 1978 and returned to the Department of Child Psychiatry in St. James's Hospital from 1978 –1989.
- *Ruth Torode* **1972 – 1975** based in Garden Hill initially and moved to Ballyfermot clinic from 1973 to 1974. She returned to Garden Hill then under the consultants Dr. Una O'Donnell and Dr. Marianne Smith.

*Niels Veirup, a trainee social worker from Denmark, was attached to Garden Hill under the supervision of Ruth Torode in 1974.*

- *Jean Forbes* **1972 – 1972** based in the center in Garden Hill, St. James's Hospital.
- *Clare Leonard (nee McGrath)* **1972 – 1977** Castleknock Child Guidance Clinic. Consultant child psychiatrist at that time was Dr. Donal Cotter.
- *Augusta McCabe* **1973 – 1979** first located in St. Loman's Hospital, Children's Unit, and moved to the new, purpose built, Department of Child Psychiatry in the grounds of St. James's Hospital when it opened in 1975. Consultant child psychiatrist at the new clinic was Dr. Una O'Donnell.
- *Caroline Cantan* **1975 – 1978**. Worked in Phoenix Park Special School for children with emotional problems which was attached to the Castleknock Clinic. Undertook part-time locum work in St. James's Department of Child Psychiatry from 1983 – 86 while Brid Clarke was on leave of absence during her term as President of the Local Government & Public Services Union (later IMPACT).

## Bibliography

Curry, J. (1980) *Irish Social Services*. Dublin ,IPC.

Ferguson, H., Kenny, P. (Ed.) (1995) *On Behalf of the Child*. Dublin, A.A.Farmar.

Ferguson, H., Gilligan, R., and Torode, R., (Ed.) (1993) *Surviving Childhood Adversity, Issues for Policy and Practice*. Dublin. Social Studies Press, TCD.

Gilligan, R. (1991) *Irish Child Care Services, Policy, Practice and Provision*. Dublin IPC.

Lavan, A. (1970) "Simultaneous Groups as a Means of Treatment in a Child Guidance Clinic" . *Social Work Today*. October 1970. BASW. Birmingham. Pp 5-11.

Lunbeck, E. (1994) *The Psychiatric Persuasion: Knowledge, Gender and Power in Modern America*. New Jersey, Princeton University Press.

McCarthy I. (1980) *Irish Social Work Journal on Special Edition on Family Therapy - Ireland, Nov/Dec 1980 Vol. 1. No.5*. Dublin: The Irish Association of Social Workers.

Rie, H.E. (1971)' Historical Perspective of Concepts of Child Psychopathology' in H.E. Rie (Ed.), (1971) *Perspectives in Child Psychopathology*. Chicago: Aldine-Atherton.

Skehill, C. (1999) *The Nature of Social Work in Ireland. A Historical Perspective*. Lampeter, Wales. The Edwin Mellen Press.

Southard E.E. (1913) "Contributions from the Psychopathic Hospital, Boston, Massachusetts: Introductory Note" in *Boston Psychopathic Hospital, Collected Contributions, No.1*. Boston. Pp 1-26.

## CHAPTER TWO

### *THE STAY SAFE PROGRAMME: A MENTAL HEALTH INITIATIVE FOR IRISH CHILDREN*

*Maria Lawlor,  
Deirdre MacIntyre.*

#### 1.0 Background

The *Stay Safe* programme is a comprehensive school based **Child Sexual Abuse Prevention Programme** that was developed in the late 1980s in Ireland as a result of therapeutic contact with a number of sexually abused children and their families in a residential psychiatric treatment centre. These children had been referred because of persistent suicidal behaviour, depression, refractory psychosomatic problems, severe behaviour and emotional problems and, in one or two cases, because of sexually abusive behaviour to smaller children. The children were experiencing many of the now well documented effects of child sexual abuse (Beichtman, 1991; Finkelhor, 1984). At the time, the medium and long-term effects of child sexual abuse (CSA) were being increasingly reported by victims and recognised by professionals (Beichtman, 1992). A number of significant attitudes, behaviours and beliefs were identified in the *children and families* undergoing treatment:

- 1) Sexual abuse was maintained by secrecy and threats,
- 2) Victims felt they were to blame,
- 3) Children did not have a language to communicate their abuse experiences, and
- 4) Adults found difficulty talking about their own abusive childhood experiences.

Interactions with the children's parents, their extended families and teachers revealed equally significant attitudes, behaviours and beliefs:

- 5) *A majority of adults were reluctant to believe that adults they knew, sometimes loved and respected would and could sexually abuse children,*
- 6) A minority of adults believed that children themselves must be responsible for the sexual abuse,
- 7) Both parents and professionals involved with children had varying difficulties recognising indications from children about sexually abusive experiences,
- 8) Concerned adults did not know how to respond appropriately and supportively to the children even if they believed child sexual abuse could possibly have occurred, e.g. what to do next in the child's best interest to help them? Where to go? Who to approach for appropriate help.

Many victims, families and many professionals viewed the whole area of child sexual abuse as riddled with difficulties, ignorance, uncertainty and fear.

## 2.0 Assessing intervention strategies

The numbers of cases of CSA being brought to the attention of mental health professionals were increasing rapidly and treatment resources were limited. Serious consideration was given to the development of primary and secondary preventive approaches. A review of the extant literature and clinical practices indicated that the key issue to consider was the delivery of the interventions. It was decided at an early stage that in terms of effective implementation, monitoring and quality control a school based system endorsed by the parental communities might be the most effective strategy.

Apart from time with their families, children aged between 4 and 12 years spend most of their time at school. Teachers are trained to listen to children, and with some extension they could act as children's 'confidantes' about problems, including problems about abuse. Both parents and teachers could act as resources to children only if both groups knew more about the signs and symptoms of child sexual abuse. In addition, they needed to know how to respond appropriately and supportively to a child's disclosure, and how to access appropriate advice and help. Teachers needed to know *how*, *where* and *who* to contact in social services if a child disclosed sexual abuse to them, or if they had a suspicion or concern about child abuse. Teachers also needed to know what the outcome of their contact with the social services was likely to be.

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

It was decided that in order to have a noticeable primary and secondary preventive impact, a comprehensive approach would have to be taken. This approach would include teacher training, liaison between schools and social services, parent education, and only then the teaching of personal safety skills to children.

## 3.0 Review of Programmes and methods

A review of available programmes at the time revealed several short interventions (Nibert, 1989; Garbarino, 1987), a lesser number targeted children only (Garbarino, 1987). Other limitations were directly related to resources. For instance, the implementation of the UK's *Kidscape* programme (Elliott, 1986) involved having additional adults in the classroom with the children's teacher. These additional school staff were not available in Irish primary schools. More significantly, *few* programmes took children's cognitive developmental levels into account (Conte, 1985). A literature review at the time seemed to indicate that comprehensive programmes targeting children, families and schools were particularly effective. (Kolko *et al.*, 1987; Binder and McNeil, 1987). Programmes teaching children to avoid abduction by strangers involved group training and behavioural training (Fryer,

1987a,b) or video training and behavioural training (Poche, 1988). These clearly indicated active teaching methods, which included modelling and role-play, were likely to be more effective in teaching children personal safety skills. A follow up study by Finkelhor (1995) of two thousand 10-16 year olds, indicated that young people who had been taught more comprehensive programmes found those programmes more helpful, had greater knowledge of child sexual abuse. Importantly all were more likely to have used the skills taught to deal with threats and assaults, and were more likely to disclose than those who participated in brief programmes. Programmes with the most durable effects are those that include behavioural rehearsal, repeated presentations, standardised materials, trained instructors and *involve parents* (Conte, 1985; Briggs and Hawkins, 1994; Wurtele *et al.*, 1992b).

Most interventions were not suited to the Irish educational context and culture. The *Stay Safe* programme was mindful of the prevailing educational ideology (and religious ethos) which was reticent to endorse novel 'moral welfare' initiatives directed towards children. A wide ranging consultation involving all relevant educational bodies and recognised vested interest groups, resulted in an implementation model that was multidisciplinary, multilateral and both school and community based. This approach was eventually recognised as inclusive, non-threatening, and ensured acceptability of the programme materials by all parties. The multidisciplinary team consisted of professionals drawn from child psychiatry and psychology, and the teaching profession.

#### 4.0 High level goals of the Stay Safe programme

The quality of the teaching materials would clearly have an impact on the efficacy of the overall delivery of the programme. To maximise the impact of *Stay Safe* (a *school* based child abuse prevention programme), it was essential that the teaching materials reflect the suitability of the programme for the:

- ❑ Irish educational context and culture.
- ❑ Cognitive development of the child.
- ❑ Learning strategies involved (e.g. modelling, role play, and multi media presentations).
- ❑ Pro social element to be incorporated.
- ❑ Maximisation of the mental health implications of the programme by increasing children's self esteem and their knowledge about self protective strategies, and expanding their awareness of having a support structure and how to use it.

A central aim of *Stay Safe* was that children would tell adults about problems that they have and that they should continue reporting until someone helps them. The purpose of this was to remove any stigma associated with 'having a problem' and 'telling tales' about being hurt or upset. One could reasonably accept that when children realise that teachers are concerned about them feeling unsafe, afraid or upset, that they may more readily see the teacher as a resource to whom they can turn when in difficulties.

Other issues in optimising impact on children were that the programme be as *relevant* as possible by using information from research on sex offenders and about how they gain and maintain the cooperation of child victims (Conte, 1989) And that the children would enjoy learning the programme and teachers would enjoy teaching it.

The children are also taught how to assert themselves in a number of situations and this may be protective for children in the short and long term. They become aware that this mode of response is possible, they will have practised it in the school setting and may use it when a

physically, sexually or verbally abusive situation arises and thus reduce victimisation on that occasion and subsequently.

Another mental health related aim of this programme was to increase the children's self esteem and thereby reducing vulnerability. This was to be done by teachers helping children to feel better about themselves by getting them to focus on the good and safe aspects of themselves and their lives as well as helping them to develop problem solving strategies.

Bullying is a common problem and this is dealt with in some detail in the lesson plans. Children are encouraged to prevent victimisation by avoiding isolation as much as possible as well as being taught strategies to deal directly with bullying. Children are told that it is not right for others to bully them or make them feel unsafe. They are also taught the unacceptability of bullying others or making them feel unsafe.

#### 4.1 The *Stay Safe* packages

A charity the *Child Abuse Prevention Programme* (CAPP) was established to fund the development and production of the early packages. CAPP was involved in the fundraising and production of materials for the different programme components. These included teacher training, parent education, liaison between social services and school and teaching a two-tiered personal safety curriculum for the upper and lower age groups in primary schools.

The following six material packages were developed:

- i. A User's Handbook for teachers
- ii. Senior lesson plans book for senior cycle with 10 lessons and Junior lesson plans book for junior cycle with 12 lessons.
- iii. Video for children called 'Pajo says Take Care of Yourself'.
- iv. Cassette tape with 'Stay safe' song.
- v. Templates for senior and junior children's workbooks.
- vi. Template of Parent's Booklet.

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

***Every page of the children's workbook has a section for the parents signature. The aim of this was to involve the parents in each lesson. The intention was that parents would discuss the lesson content with their child and give the child an opportunity to confide in them as well as letting the children know that as parents that they are prepared to talk about such topics as touching, bullying and being upset and are prepared to listen and help. This is important as often parents may not be aware if their children are feeling bad if the children do not externalise their distress.***

Also the parental involvement in the programme gives the parent an opportunity to find out exactly how much or how little their child knows about how to look after him\herself and may then take the opportunity to advise them accordingly.

From a therapeutic point of view for victims of abuse it was considered useful to include the following:

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

- Teaching them that they should not be involved in hurting others

## **5.0 Evaluation of the *Stay Safe* Programme**

*It was important to devise a thorough, implementable evaluation strategy given the complexity of the variables involved, the difficulty in evaluating preventive interventions, and the uncertain attitudes of teachers and society in general in the late 1980s in Ireland towards CSA. For instance, sex education programmes were not available in primary level schools in Ireland. Schools, teachers and parents were ill at ease with child sexual abuse. In pioneering fashion both the Irish National Teachers Organisation and the National Parents Council were remarkably supportive. Initially, the clerically dominated school managerial associations lent equivocal support to an evaluation of the programme. However once explanations of its rationale were made plain to schools' Boards of Management, Principals, teachers and parents, all parties saw and understood the non threatening content of the teaching materials and representative sample of schools agreed to become involved in the evaluation of the programme.*

### **5.1 Design and Methodology of Evaluation**

Given the complexity of the problem being tackled and the enormous amounts of data for processing, the programme was evaluated using two different strategies. One involved evaluating the effect on children's behaviour of different levels of intervention. Teacher training, parental education and teaching the programme to children was compared with teacher training alone which was compared with a no intervention group. The other strategy involved evaluating each individual component (*Teacher training, Parent education and Teaching the programme to the Children*) separately. This was completed using knowledge/attitude questionnaires with teachers, parents and children on a pre and post test basis. This is reported in detail elsewhere by Lawlor, 1994.

In all 44 teachers, 637 parents and 1,558 children were involved. The children were from second and fifth classes. The second class children had an average age of 8 and the fifth class had an average age of 11 years. Consent was requested of parents for their children's involvement in the programme and granted in 98% of cases. Teacher training, parents meeting and teaching the children the programme (5 schools, 23 teachers, 823 children and 637 parents) was compared with teacher training only (2 schools, 11 teachers, 385 children) and with a no intervention control group (3 schools, 10 teachers, 350 children).

### **5.2 Measures**

Forty teachers of second and fifth classes were asked to complete incident and concern record forms over one school year. The incident forms were to be filled out any time the teacher was approached by a child in his class about a personal problem. Teachers were also asked to record any time they were concerned about verbal, emotional, physical or sexual abuse of a child in their class and what action they took about it on the Teacher Concern forms.

### 5.3 Results

Children whose parents and teachers were involved in the programme approached their teachers with problems significantly more often than either of the other two groups. Children with *greater involvement* in the programme made *significantly more approaches* to teachers about problems than did those where teacher training only had occurred (chi-square = 5.138, d.f. =1, p<.02). There were significantly more approaches by children who were taught the programme than in the no intervention group (chi-square = 9.374, d.f. = 1, p<.002). There were more approaches to teachers in the teacher training only group than in the no intervention group but this did not reach statistical significance. See Table 1 below.

**Table 1: No. of Approaches by treatment condition**

	Train & Teach	Train only	No intervention	Total
No. of children	823	385	350	1,558
No. of Approaches	85	24	15	124
% Approach per group	10.3	6.2	4	8
No. of Teachers	23	11	10	44
No. of Approaches per Teacher	3.7	2.2	1.5	

As one might expect most of the approaches were about bullying and a small number were about sexual abuse. See Table 2 below. These results indicated that the programme was useful at a secondary preventive level.

**Table 2: Reasons for Approaches**

Reason for Approach	Train and Teach Chn	Train only	No intervention
Bullying	58	20	11
Being lost	13	4	0
Touched	5	0	0
Upset	7	0	3
Stranger	2	0	1
Total	85	24	15

Boys approached teachers about bullying significantly more than girls did (chi-square = 6.2016, d.f. = 1, p<.02) and girls approached teachers about being touched significantly more than boys did (chi-square = 8.7195, d.f. = 1, p<.01). See Table 3 below. Surprisingly boys made three times as many approaches as girls and the majority of these were about bullying.

Although bullying was the main reason for girls to approach teachers, significantly more girls than boys approached teachers about being upset, touched, and approached by strangers (chi-square = 6.2016, d.f. = 1,  $p < .02$ ).

**Table 3: Reasons for approaches by Boys and Girls**

Reason for Approach	Total No. of Approaches N = 124	No. of Approaches by Boys N = 93	No. of Approaches By Girls N = 31
Being Bullied	89	72	17
Being Lost	17	14	3
Being Upset	10	5	5
Being Touched	5	1	4
Approach by Stranger	3	1	2

There were no significant differences in the number of approaches made by the second and fifth class groups although the younger group made more approaches. Interestingly all the approaches made about being touched were by children in the fifth class. The younger children had more incidents of being lost. Bullying was the cause of 74% of the second class and 68% of the fifth class children's reasons for approaching the teacher.

Teachers were asked to record any concerns they had over a school year about physical, sexual, emotional abuse or neglect of any child in their class. Average size of class was 35 pupils. In schools where children, parents and teachers were involved in the programme the teachers recorded more concerns about the children in their classes about a range of issues than where only teacher training or no intervention occurred. See Table 4 below

**Table 4: Teachers concerns by treatment condition**

Train and Teach Chn	Teacher Training only	No intervention
10	0	3

There were four concerns about physical abuse, three about neglect, three about emotional abuse and three about sexual abuse.

The evaluation of the individual components of the programme study is reported elsewhere (Lawlor, 1994) and showed that children, parents and teachers made significant gains in knowledge and attitudes. The gains made in children's skills and knowledge were substantial and significant. These gains were sustained at three month follow up by the children. Younger children made greater gains than older children and all showed similar levels of knowledge at follow up.

Among a number of other outcomes was that 95% of teachers who taught the programme to the children in their classes reported that they had better relationships with the children and that teaching the programme had opened up improved channels of communication between the children and themselves. 42% of teachers reported that the children applied the safety

strategies. 95% of teachers reported that they thought that all children should be taught the programme. All the teachers reported that both they and the children enjoyed the programme. 10% of teachers reported negative effects of the programme. 16% reported that the programme made children anxious about people they knew and 10% reported that some children had become too assertive.

## 6.0 Discussion of evaluation

The evaluation study of the Stay Safe programme showed that it clearly influenced children who were taught the programme to approach their teachers about problems. This is an important finding and it indicates the effectiveness of the programme to impact on children's behaviour at a secondary preventive level. Teacher training alone is of limited benefit as it had significantly less impact on children's behaviour and teachers levels of concern. It seems likely that children only see teachers as approachable about problems if they experience the teachers talking to them about the topics covered in the programme and encourage the children to approach them about problems.

Although there were only five approaches about touches these were all from children who had been taught the programme with none from either of the other treatment conditions. This indicated that some children who had experienced sexual abuse were able to approach their teachers about it after being taught the programme.

*As most approaches by both boys and girls to teachers were about bullying the programme highlighted the extent of the problem of bullying and to a greater extent for boys. This is not surprising given the reported rates of bullying in Irish primary schools (O'Moore & Brendan, 1989). Bullying can go on for years, (Besag, 1989) and is known to have serious and long term negative effects on mental health and self esteem (Kaltiala-Heino, 2000; Salmon, 1996; Rigby, 1998). It can only have been in the children's interests to disclose to the teacher about their experiences of bullying if they have the expectation that the teacher would act to remedy the situation. They are only likely to disclose again if they get a helpful response. The findings of this programme clearly indicate that bullying is a substantial problem and that more needs to be done in schools to address and prevent it. Changes are necessary particularly in the area of school policy development and in the development of strategies to deal with the problem at a primary and secondary preventive level.*

Finkelhor (1995) in his nationwide survey in U.S.A. found that children who had been taught comprehensive programmes were more likely to have used the skills learned in those comprehensive programmes, felt better able to cope with to deal with assaults and threats and were more likely to disclose abuse than those who had been taught briefer programmes. These findings clearly indicate the positive mental health implications of being taught a comprehensive prevention programme. Other researchers (Conte, 1985; Briggs and Hawkins, 1994; Wurtele et al., 1992b) have identified prevention programme features that are associated with more durable effects of child abuse prevention programmes. These features were all included in the original design of the *Stay Safe* programme

The children's knowledge about safety skills was greatly increased as a result of the programme. The implications of this are confirmed by the findings of Finkelhor and Dziuba Leatherman (1995) and Finkelhor *et al.*, 1995. They found that children who learn these

skills are empowered to resist future sexual advances. These findings highlight the likely primary preventive impact of the *Stay Safe* programme.

It was interesting that teachers and children all reported enjoying the programme. This indicated that they clearly found it acceptable. Finding that *Stay Safe* was enjoyable for all parties indicated that it was more likely that it could be implemented on a wider basis.

There needs to be repetition of the programme through the primary school years, as children may forget what they have learned without revision and reinforcement. In addition teachers need ongoing support for their roles within the programme particularly in the absence of mandatory reporting. Since 1990 many teachers and parents have used the Child Abuse Prevention Programme as a support and a resource.

## 7.0 Progress of *Stay Safe* since 1990: National Implementation and Further Development of Materials

***In 1991 three teams of six staff comprising three national school teachers and three social workers were seconded to the Child Abuse Prevention Programme CAPP to implement the programme in the eastern region of the country. This was the first time in Ireland that multidisciplinary training of teachers had occurred in a systematic way. In 1993 fourteen more staff were recruited to ensure there was a multi disciplinary team of a teacher and social worker in place in all of the health board areas in the country providing teacher training courses, liaison between schools and local social services and parent education meetings in all primary schools.***

The Child Abuse Prevention Programme (CAPP) provides parent education on demand to schools and in 2001 has a team of forty part time teachers around the country. CAPP also provides ongoing teacher training to teachers who have qualified since the early 1990s and has also provided a co-teaching service to those teachers who did not feel able to teach the curriculum to the children on their own. This has helped increase the uptake in areas of greater resistance.

Uptake of parents meeting has increased steadily over the years and the latest figures on national implementation in 2001 are that 98.6% of all primary school teachers (in 3,269 schools) have been trained, 86.2 % of all schools (2,857 schools) have held parents meeting and 75 % of all schools (2,460 schools) teach the *Stay Safe* programme. This level of national uptake is very heartening. There are a number of areas in the country where uptake is lower than in others but every year in these areas the uptake has been gradually increasing. The challenge at this stage is to ensure that schools keep on implementing the programme and that it is repeated in schools for the same children at different ages. The introduction of Social, Personal and Health Education (SPHE) to the national school curriculum should facilitate the continuation of the teaching of *Stay Safe* to the children.

The Stay Safe programme materials have also developed over the years and there is now a four tier curriculum for primary schools with an upgraded new video. There is an Irish version of the programme for the Irish speaking schools (Gaelscoileanna). Lesson plans have also been developed for special schools. These include specific adaptations and teaching materials for mentally handicapped children, deaf children and blind children. (MacIntyre, Lawlor & Cullen, 1986). Given that children with intellectual and physical disabilities are even more vulnerable than other children (Briggs and Hawkins, 1997) these developments are an important addition to the *Stay Safe* programme. The programme materials are available free to all national schools from the Child Abuse Prevention Programme.

## 8.0 Conclusions

Since 1993, we estimate, over two million Irish children have been taught the *Stay Safe* programme. By international standards, this is a child abuse prevention programme on a substantial scale.

In addition, the effectiveness and social acceptance of the *Stay Safe* programme has created a receptive climate to the implementation of other programmes addressing children's mental health. Furthermore, the programme has raised awareness in the community about the signs of sexual abuse, and the mechanisms employed by abusers to hide their activities.

Overall the impact of *Stay Safe* is a strong argument in favour of child psychiatric services being involved in the development of mental health initiatives. It also underlines the role that child psychiatrists can play not only in treating individual patients and their families, but also in developing preventive mental health programmes designed to address some of the causes of childhood psychopathology. The commitment of the Irish government to the adoption and implementation of a national policy of child abuse prevention is to its credit, and will have long term benefits for its citizens, especially the more vulnerable ones.

Acknowledgements: The authors wish to acknowledge the contribution of Michael Flattery to the evaluation of the programme and as Co-ordinator of the Child Abuse Prevention Programme Charity.

## References

- Beichtman, J.H., Zucker, K.J., Hood, J.E., daCosta, G.A., Ackman, D. (1991). A review of the short term effects of child sexual abuse. *Child Abuse and Neglect*, 15, 537-556.
- Beichtman, J.H., Zucker, K.J., Hood, J.E., daCosta, G.A., Ackman, D. & Cassavia, E. (1992). A review of the long term effects of child sexual abuse. *Child Abuse and Neglect*, 16, 101-118.
- Besag, V. (1989). *Bullies and Victims in schools*, Milton Keynes: Open University Press, 13.

- Binder, R.L., McNeil, D.E. (1987). Evaluation of a school based sexual abuse prevention programme: cognitive and emotional effects. *Child Abuse and Neglect*, 11, 497-506.
- Briggs, F. Hawkins, R.M. (1994). Follow up study of children aged 5-8 years using child protection programmes in Australia and New Zealand. *Early Child Development and Care*. 100: 111-117.
- Briggs, F. Hawkins, R.M. (1997). *Child Protection. A Guide for Teachers and Child Care Professionals*. Allen and Unwin: St. Leonards, NSW.
- Conte, J., Wolfe, S. Smith, T. (1989). What sexual offenders tell us about prevention strategies. *Child Abuse and Neglect* 13: 293-201.
- Finkelhor, D. (1984). *Child Sexual Abuse: New Theory and Research*. Free Press: New York.
- Elliott, M. (1986). *Kidscape, 1986 Programme for Prevention of Sexual Abuse of Children*. Kidscape: London.
- Finkelhor, D. & Djuba-Leatherman, J. (1995). Victimization Prevention Programs: A national survey of children's exposures and reactions. *Child Abuse and Neglect* 19, 129-140.
- Finkelhor, D., Asdigian, N., Djuba-Leatherman, J. (1995). The effectiveness of victimisation prevention instruction: an evaluation of children's responses to actual threats and assaults. *Child Abuse and Neglect* 19, 141-153.
- Fryer, G.E., Kraizer, S.K., Miyoshi, T. (1987a). Measuring actual reduction of risk to child abuse; a new approach. *Child Abuse and Neglect*, 11, 173-179.
- Fryer, G.E., Kraizer, S.K., Miyoshi, T. (1987b). Measuring children's retention of skills to resist stranger abduction: use of the simulation technique. *Child Abuse and Neglect*, 11, 181-185.
- Kaltiala-Heino, R. Rimpela, M., Rantanen, P. & Rimpela, A. (2000). Bullying at school an indicator of adolescents at risk for mental disorders. *Journal of Adolescence*, 23, 661-674.
- Kolko, D., Moser, J. Litz, J. Hughes, J. (1987). Promoting awareness and prevention of child sexual victimisation using the RedFlag\Green Flag Programme: an evaluation with follow up. *Journal of Family Violence* 2: 11-35.
- Kraizer, S.K. (1986). *Children need to know personal safety programme. In the Educator's guide to preventing Child Sexual Abuse, Nelson, M., Clark, K. (eds) Network Publications: Santa Cruz, CA.***
- Lawlor, M. (1994). *Child Sexual Abuse Prevention Programme: An Evaluation Study*. Unpublished M.D. thesis. Trinity College Dublin.

MacIntyre, D. Lawlor, M. & Cullen, R. (1996). *Personal Safety Skills for Children with Learning Difficulties Based on the Stay Safe Programme*. Dept. of Health, Child Abuse Prevention Programme: Dublin.

- Nibert, D., Cooper, S., Ford, J., Fitch, L.K., Robinson, J. (1989). The ability of young children to learn abuse prevention. *Response* 12:14-20.
- O'Moore M. and Brendan, H (1989). Bullying in Dublin Schools. *Irish Journal of Psychology*, 10, 426-421.
- Poche,C. Yoder, P., Miltenberger, R. (1988). Teaching self protection to young children using television techniques. *Journal of Applied Behavioural Analysis* 21; 253-261.
- Rigby, K. (1998). The relationship between reported health and involvement in bully victim problems at school among schoolchildren. *Journal of Health Psychology*, 3, 465-476.
- Salmon, G. James, A. & Smith, D.M. (1996). Bullying in schools: self reported anxiety, depression and self esteem in secondary school children. *British Medical Journal*, 317, 924-925.
- Wurtele,S. Kast, L.C. Melzer, A.M. (1992b). Sexual abuse prevention education for young children: a comparison of teachers and parents as instructors. *Child Abuse and Neglect*, 16: 865-876.

## **CHAPTER THREE**

### **THE HISTORY OF SPEECH AND LANGUAGE THERAPY IN IRELAND**

*Vivienne Foley.*

A relatively 'young' profession with a short history, speech and language therapy in Ireland has shown tremendous growth since its inception 30 years ago.

In the early part of the 20<sup>th</sup> century, the emergence of the speech and language therapy profession as a separate entity began with developments in the U.K., Austria, Germany and Denmark. Many of the earlier references to communication disorders reflected medical advances in terms of client groups and areas of specialism.

Prior to the arrival of qualified personnel, Father O'Flynn's work with stammers in 1920's Cork was legendary. Following the introduction of a U.K. qualified speech and language therapist to several of the Dublin voluntary institutions in the 1950's many of the hospital consultants recommended an increase in staffing levels and the establishment of speech and language therapy services in their hospital. As a result, several individuals – many of whom

were religious – travelled to the U.K. to receive professional training. In the 1960's and early 1970's, a few U.K. therapists came to work in Ireland.

By the year 1971, there were 20 therapists working in the Republic, 17 in Dublin, one each in Limerick, Kilkenny, and in Clare / Kerry.

In 1968, almost 10 years after the initial proposal to establish a speech training programme, the Dublin College of Speech and Language therapy (DCST) was born, housed at St. Vincent's Hospital (SVH), Elm Park. This programme was under the Department of Health and administered by the National Rehabilitation Board. A three year course leading to the Licentiate of the College of Speech Therapists (LCST) – later amended to the DipCST – was accredited by the professional body in the U.K.

Following the U.K. precedent of awarding the course degree status, the College of Speech Therapy moved to Trinity College, Dublin in 1979 changing its name to the School of Remedial Linguistics. It was initially assigned to the Faculty of Arts but transferred to the Faculty of Health Sciences in 1985. This necessitated another and final name change to 'the School of Clinical Speech and Language Studies' (SCSLs) – which following a 4 year course awards a B-Sc (Clin Lang.) degree.

#### Association with Child Psychiatry in Ireland

The bi-directional effect of communication and behavioural difficulties is well documented in the literature. Cohen et al. (1993) found 27.8% of a sample of child psychiatric outpatients had previously identified language problems but a further 34.4% had difficulties which had not previously been detected. Those with unsuspected language deficits were more likely to have externalising behaviour such as hyperactivity and aggression.

The nature of the 'unsuspected language deficits' has been explored in the literature. These children are often detected when learning to read and their primary underlying difficulty is identified as 'a verbal processing deficit'. This is seen as a continuum disorder, which can exist in various degrees of severity. Dyslexia / literacy delays is now considered a part of this verbal processing deficit continuum.

Bishop and Adam's (1990) critical age hypothesis has been confirmed by comparative studies on speech and language performance. Findings have indicated that if a language problem has resolved in the pre-school years, literacy development progressed normally. However, if the language problem persisted beyond the age of 5½ years then literacy difficulties developed. Articulatory skills were not found to be a strong predictor of later literacy problems.

Recent research has demonstrated a strong link between early reading failure and later social adjustment problems at least into the adolescent years (Maughton 1994, 1995). This supports Sue Spence's (1992) claim that peer popularity and communicative competence are inextricably linked. The corollary is also found to be true with those presenting with verbal vulnerability being more at risk from bullying. The implication of this data is clearly for early intervention and multidisciplinary assessments.

The Speech and Language Therapists in Child Psychiatry have observed changes in referral patterns in recent years. There has been a steady increase in the numbers of older children

being referred to Child Guidance Clinics presenting with language / literacy difficulties and a 23 fold increase in referrals to the autism service at Beechpark Special Schools, Stillorgan, Co. Dublin has been observed over a 3 year period between 1995 – 1998.

This has resulted in the creation of Northside and Southside Clinical Outreach Teams which provide a bridge between clinical and educational roles.

In addition to an increase in referral patterns, the role of the Speech and Language Therapist in Child Psychiatry is expanding. There is a shift towards a consultative model of intervention necessitating:

- Staff training
- Provision of parent workshops
- Sibling support
- Social skills training
- Disseminating professional information to community groups.

The Speech and Language Therapy service provided to Child Psychiatry has its genesis in the Community Services. Despite the differing needs of our service, half of the Speech and Language Therapists working within the Child Psychiatric service still carry community care caseloads. The Speech and Language Therapists working in Child Psychiatry support a report from the Child & Adolescent Psychiatry (CAP) section of the Irish Division of the Royal College of Psychiatrists (June 1997) which states: “This organisational variation has not been in the best interest of the development of the Child and Adolescent Psychiatry services and the population they serve”. Proposals for the provision of a specialist full time service for child psychiatry – based on client need – were submitted in May 1998 (Foley 1998).

Speech and Language Therapists in Child Psychiatry will continue to strive for a fully meet client needs as the new millennium approaches.

## **CHAPTER FOUR**

### ***PROFESSOR JOHN MCKENNA***

#### ***Michael Nolan.***

John McKenna, who died recently, was the founder and doyen of Irish Clinic Psychology. Born in Glasgow of Enniskillen parents, he was a unique mixture of Scottish and Irish: of Scottish in his speech and mode of address, of Irish in his feelings that in coming to Ireland he was coming to his own country.

After being awarded an honours degree in History at Glasgow University followed by a postgraduate degree in Psychology, he went to L'Université de Montreal where he was

awarded a doctorate summa cum laude. His clinical training in Montreal was under the great Father Noel Mailloux OP, one of a group of French-Canadian Dominicans who were Thomist in Philosophy and Freudian in their clinical understanding. John brought this powerful if unusual combination to Dublin when he became Clinical Psychologist to the new St. John of God Child Guidance Clinic at Rathgar in 1955. with his colleagues John Stack, Child Psychiatrist at Rathgar, and Desmond McGrath, Psychiatrist at the St. John of God Hospital in Stillorgan, he was a leader in the reconstitution of their services which the St. John of God Brothers had undertaken under their Provincial, Eugene Quilligan. To these men, and to Irene Mullaney, the Psychiatric Social Worker, Ireland owes an immense debt.

The availability for teaching of these professionals enabled E. F. O'Doherty, Professor of Logic and Psychology at University College Dublin, to undertake a project he long had in mind: the establishing of a University course in professional Psychology. The postgraduate Diploma in Psychology began in 1958 with a carefully chosen group of mature students who already held a University qualification and had worked in teaching, in medicine, in industry. It was an especial joy to John that among these founding students was his wife Anne, herself born in Scotland of Donegal parents. John and Anne had some 50 year of exceptionally happy married life, which was a partnership of work as well as of family.

John was a member of the Commission on Mental Handicap which laid the foundations for the services to mentally handicapped children of which Ireland can today be proud. One must mention here Jack Darby, Secretary to the Commission and as dedicated a Civil Servant as ever existed, and indeed the Civil Servants in the Department of Health generally, who took the enlightened decision to encourage voluntary as well as public services to the mentally handicapped.

John was a Clinical Psychologist of international standing and he was frequently engaged as Consultant by the World Health Organisation and UNESCO. He began to teach in the College of Surgeons and was appointed to the foundation Professorship of Psychology in that College. The appreciation of his expertise by his Medical colleagues was shown in his frequent appearances as expert witness in the High Court, where his manifest professionalism made a marked impact.

In private life he painted and wrote poetry. He developed an enthusiasm for racing and loved to go to the Curragh, dressed and equipped as a visit to the Curragh requires, and afterwards to entertain his friends to a meal prepared and presided over by his beloved wife.

Nothing pleased him more than that his only, Peter, chose a career in Medicine and was appointed to the Mater Hospital. He was especially proud when Peter became Master of the Rotunda Hospital, an institution whose long history he appreciated.

John was unswerving in his religious and political beliefs and in loyalty to his friends. His patients, clients and students who had the benefit of experiencing his wisdom, judgement and good counsel will long remember him with affection and gratitude.

John and Anne lived side-by-side with Peter and his wife Viv, where he enjoyed their company and that of his four grandchildren for the last twelve years. To his wife Anne, to Peter and Viv and to the grandchildren we offer our sympathy. May he rest in peace.

Michael Nolan,  
The Irish Times,  
Wednesday May 27<sup>th</sup> 1998.

## CHAPTER FIVE

### *HISTORY OF CHILD PSYCHIATRY IN IRELAND*

*John Stack.*

In the Chair on that particular day was Dr. Corboy. At the start of his lecture he said he was going to give a discourse on the development of Child Psychiatry in Ireland from the “cradle to the grave”. He had been in Child Psychiatry for 34 years. He said he first became aware

of Child Psychiatry in 1952 when he saw an add in the newspaper by the St. John of God Brothers for a Consultant in Child Psychiatry. This service that they had advertised was in 1952 when the WHO through the Irish Department of Health approach the St. John of God Brothers for the development of what was called then Child Guidance Services. At this time Dr. John Stack was a Senior Registrar in Psychiatry at the Crichton Royal Hospital in Dumfries in Scotland. He was working with Professor Mayer Gross and Professor Martin Roth. Dr. Stack had training in paediatrics and mental handicap. In the Crichton Royal he found himself in charge of a residential unit for children. When he applied to St. John of God's the three selected candidates were invited to the Gresham Hotel quite early in the morning. On the interview board was an American Psychoanalyst who told them that each of the candidates were going to have a psychological assessment. They were each given the Rorschach and in the afternoon he faced an interview board of about 30 members. Another member of the interview board was Dr. Jack Fitzgerald who had been Medical Superintendent in Mullingar and later went to the mental handicap service. Dr. Stack was successful in the interview and was sent off for further training in Child Psychiatry to Cincinnati in the United States. The orientation was psychoanalytic. The supervisors there could be a social worker, psychologist or staff psychoanalyst. One of his supervisors was the famous psychoanalyst Dr. Adelaide Johnson who did pioneering work on school refusal. He also admired Dr. Morris Levine there. Dr. Stack spent two years in Cincinnati. When he returned he found that there was an outpatient Child Psychiatric Clinic in Temple Street run by Dr. Mulvany. At the same time there was an outpatient Child Psychiatry Clinic in the National Children's Hospital in Harcourt Street run by Dr. Maureen Walsh. Dr. Maureen Walsh had been on the staff of the National Children's Hospital in Harcourt Street since 1951. At this time Professor John McKenna also arrived to Orwell Road from McGill in Montreal where he had done his PhD. Professor McKenna was a psychologist. The service had been running a couple of months before they considered appointing a social worker. This was late 1955 – early 1956. Even Our Lady's Hospital for Sick Children didn't have a social worker at the beginning and after opening a few months they appointed a lady Almoner. Some members of the Child Health Services at the time told Dr. Stack that "he was wasting his time and there was no need for these new fangled Child Guidance Services" as there was only the occasionally disturbed child. Nevertheless very soon the Child Health Services became a great source of referral to the Child Guidance Services and attitudes changed very rapidly. When Dr. Stack introduced himself as a Consultant in Child Psychiatry the Professor of Adult Psychiatry told him that he was Professor of Adult and Child Psychiatry. When Dr. Stack would set an exam for example in the Diploma of Child Health the Professor of Adult Psychiatry's name would appear on the paper. A Professor of Paediatrics at the time also felt that Child Psychiatry didn't have a place and that there was the occasional case of Downs syndrome or enuresis. A person at the Royal Academy of Medicine Psychiatric Section Meeting said "he didn't believe in psychology but that he did believe in smackology". The Irish National Teachers Organisation supported the Child Guidance movement. They were a great ally in the development of the service. Dr. Stack was often invited to Glenmaroon Special School. There was no knowledge of infantile autism at that stage. After the first year that we were appointed Professor John McKenna and myself were invited to address the INTO at the Annual Conference. I was then asked with Dr. McKenna to give talks in all the major towns throughout Ireland on Child Mental Health and Child Guidance. I remember the Limerick meeting they had the Bishop of Limerick in the Chair. In addition to the RMS of the local psychiatric hospital and the County Medical Officer being on the panel there was also the local schools inspector. I noticed then that each area we spoke on they set up child mental health committees. These local people then began to send to me referrals first of an organic nature and later the usual run of child psychiatric

problems. I began to work in Crumlin which is a University based teaching hospital. This led to me getting involved in teaching of undergraduates and postgraduates. When I went to Crumlin the visiting hours were 3 – 4 Monday, Wednesday and Friday. Professor Conor Ward and myself started a campaign against considerable resistance to alter these visiting hours. I did succeed in making the hospital more parent centred. I gave a talk at the prize giving in the Children's Hospital Temple Street on the needs of children with the Archbishop of Dublin in the chair. In 1961 he was joined by Dr. Corboy. Dr. Jerry O'Neill also joined. There was three child guidance teams functioning in 1961. As well as a day school for disturbed children and some pre-school facilities. There were also at this point speech therapist on the staff. I was also providing a consultation service to St. Loman's Hospital and Garden Hill centre. This was before they got a Consultant in Child Psychiatry in the Eastern health Board. Ivor Brown was involved in St. Loman's Hospital also at that time. I was on the Commission for Mental Illness that was set up in 1964. I remember in Athy what when I visited a county home there was a bylaw that no patient could be admitted two weeks before Punchestown races. The Commission recommended the development of one fully developed team of Child and Adolescent Psychiatry for each Health Board. This was approximately 1966. It also recommended small regional residential units for children. It also recommended that the paediatric hospitals should have about 10 places available for the psychosomatic type of child. Dr. Corboy joined Cluain Mhuire in 1971 and Dr. Brennan in 1974. Dr. Paul McCarthy joined the Eastern Health Board in 1968. Gradually services developed in Ballyfermot and Castleknock and used for the first time a catchment area type approach. I think the Mater service got off the ground around 1962. Dr. Paul McQuaid was the Director from 1965. The initial approach was psychodynamic psychotherapy with behaviour therapy being added in at a later stage and finally family therapy. Dr. Paddy Murray set up the Child Psychiatric Service in the Southern Health Board. He set up three teams in the Southern Health Board area. Dr. Tony Carroll set up the Galway service in 1975. There is one Consultant in the Midland Health Board. There is no development in 6 or 7 of the Health Boards. It was a mistake for some of us to do clinics in Health Boards that didn't have their own Child Psychiatrist. I did Wexford, Kilkenny and Carlow. Portlaoise these visitations would take place once per month. There are about 16 to 18 Consultants now. There is a need to double the numbers. Dr. Tom Brennan will have a new national unit for adolescents in the near future. As I plan to bow out now after 30 years I hope that at the next meeting in 30 years time that the other half of the service will be developed. Dr. Corboy replied that she hoped that Dr. Stack now would have more free time and she described how they were also

*(Recorded by M. Fitzgerald in the mid 1980's).*

## CHAPTER SIX

## CHILD CARE WORKERS IN CHILD PSYCHIATRY IN IRELAND

Orla Higgins.

The Child Care Worker in a Clinic, Residential Unit or Special School setting within Child Psychiatry has a specialised role, the goal of which is to ensure that each child/adolescent is provided with treatment and care of the highest standard in response to their identified needs.

Thankfully, today, students completing the National Diploma/Bachelor of Arts degree in Applied Social Studies in Social Care, are equipped to make an effective contribution in many areas of social care.

Looking back at the history of training compiled by members of the Irish Association of Care Workers, we learn that in the early sixties, there were only two trained Care Workers in Ireland, both of whom trained in Britain. It soon became apparent that specialised professional training courses were needed.

The first Child Care Course to start up with the recognition from the National Council for Educational Awards (N.C.E.A.) was at Cathal Brugha Street in 1974. The Regional Technical College (now I.T. Sligo), first made its application for accreditation in 1979. This was for a course in the area of residential childcare.

Subsequent course developments reflected changes in provision of care for young people, in particular, the move away from the model of large childrens' homes and correctional facilities, towards smaller units, and a shift towards community based responses to young people in need of support. There now exists a number of courses within the field of social care in the Institute of Technology around Ireland – National Certificate, National Diploma and B.A. Degree.

Child Care Workers or professional Social Care Workers have been present in Child Psychiatry since the early seventies. The role of the Child Care Worker in the Child and Family Centres, has developed significantly since their introduction over twenty years ago. He/she works in conjunction with other members of the multidisciplinary team, to facilitate the assessment, diagnosis and treatment of clients.

Therapeutic preschool intervention and group intervention, have remained the principal features of the role of the Child Care Worker. Working in collaboration with the Nurse Practitioner, the Child Care Worker facilitates the therapeutic preschool/early childhood intervention programme, which caters for children under 5 years, presenting with emotional and behavioural difficulties. This programme provides two main dimensions, comprehensive assessment and therapeutic interventions for the child and the family, if required. The focus of interventions is facilitated through play. A variety of approaches may be used, including play therapy, behaviour modification and techniques, individual parent-child work, cognitive interventions, speech therapy, and parental support and education. Involvement with parents is an integral part of the workers daily duties.

The Child Care Workers task extends also to the development and implementation of a range of therapeutic programmes to be used in a group setting. Responding to the specific needs of the children (these may include areas such as socialisation, self-esteem, anger management, bullying, bereavement, separation/divorce).

To meet the needs of young people at risk of early school leaving and anti-social behaviour, the Child Care Worker is often involved in community based inter agency projects, participating with, and offering support and advice to other services in the local area.

The Child Care Worker within the Child and Family Centre strives to maintain a good standard of education and information within the field of Child Psychiatry, to enable him/her to continue to recognise and respond to the needs of their clients.

## CHAPTER SEVEN

### *A NATIONAL SURVEY OF CLINICAL PSYCHOLOGISTS IN IRELAND*

*Alan Carr.*

#### SUMMARY

The results of a 1993 survey of 111 clinical psychologists practising in Ireland are presented in this paper. 55% of respondents were female and 45 percent were male with a mean age of 39 years and 7 months. A third of the group had a two year masters degree in clinical psychology; a third had on-the-job training; and a third had a diploma, doctorate or one-year masters degree in clinical psychology. Respondents had a mean of 13 years clinical experience and an average of 3 previous jobs in clinical psychology. Half the sample were employed in voluntary organizations and just over a quarter were employed by health boards in the special hospitals or community care programmes. 31% worked in child and family specialty, 30% in mental handicap and 23% in adult mental health. 41% were senior grade, 23% were basic grade and 19% identified themselves as service directors or consultants. 87% worked full-time and adopted complex roles involving up to 11 different activities including treatment (27%), assessment (20%), staff training (8%), research (6%), service planning (5%) and preventative education (3%). The median case load was 51; the average waiting list was three months; and it contained 22 cases. Cognitive behavioural (55%) and family systems (29%) were the most common theoretical models. Two thirds (366/527) of the research projects conducted were completed by 32 of the 111 psychologists surveyed. 61 of the 111 respondents conducted some private practice but only 6 were in full time private practice. Two thirds reported high levels of job satisfaction. All were involved in one or more of 11 continuing professional development activities to which employers contributed less than 50% of the costs. The results are discussed in the light of similar surveys conducted in the US and the UK. Implications for the profession are also considered.

#### INTRODUCTION

Surveys of clinical psychologists have been conducted in the US and the UK to document the development of the profession in these countries. In recent years the most notable of these have been carried out by John Norcross and his colleagues (Norcross, Dryden & Brust, 1992; Norcross, Brust & Dryden, 1992; Norcross, Prochaska & Gallagher, 1989a, 1989b; Norcross & Prochaska, 1982a, 1982b). To date, in Ireland, similar surveys have not been conducted either to document the development of the profession or to compare the development of clinical psychology in Ireland with its development in other countries. The present survey aimed to fill this particular gap in our knowledge. More specifically, this survey aimed to draw an accurate profile of the practice of clinical psychology in the Republic of Ireland in the early 1990's with particular reference to seven areas:

1. Demographic characteristics, qualifications and professional affiliations.
2. Employment patterns including career course, work setting, employers, specialty and grading.
3. Workload, professional activities, approach to practice and theoretical orientation.
4. Research and publications.
5. Private practice.
6. Job satisfaction.
7. Continuing professional development.

A subsidiary aim of the survey was to compare the status of Irish clinical psychologists with that of their US and UK counterparts.

## METHOD

### Participants.

The population under investigation included all clinical psychologists in the Republic of Ireland. Unfortunately, identifying this total population was not possible since, in the Republic of Ireland, registration for clinical practice is not mandatory and so no national register exists. The Psychological Society of Ireland's (PsSI) Directory of Psychologists (1993) is the closest available approximation to a comprehensive national register and so this source was used to identify participants for the survey. The PsSI Directory lists the name and address of all PsSI members along with information about their qualifications and appointments. PsSI members were included in the survey if they were either employed or qualified as clinical psychologists. There were 234 such cases. Those involved in work germane to clinical psychology including rehabilitation and mental handicap; psychotherapy; individual, couples and family counselling and therapy; behavioural analysis; neuropsychology; addiction services; health psychology and clinical forensic psychology were also included. There were 90 such cases. Members of PsSI were excluded if they identified themselves as organizational psychologists; experimental psychologists; educational psychologists without clinical responsibilities; educational and vocational guidance counsellors and PsSI members practising outside the Republic of Ireland (although inadvertently a number of such cases were surveyed and later discarded). A total of 324 PsSI members were identified using these inclusion and exclusion criteria.

### Instruments

A questionnaire was compiled with items covering the seven areas listed above in the introduction. The items were based on consultation with a group of clinical psychologists in practice throughout the country in a range of clinical contexts. Items were also selected so that comparisons could be made between Irish data and the results of similar surveys conducted in the US and UK by John Norcross and his colleagues (Norcross, Dryden & Brust, 1992; Norcross, Brust and Dryden, 1992; Norcross, Prochaska & Gallagher, 1989a, 1989b; Norcross & Prochaska, 1982a, 1982b). The six page questionnaire contained 55 items. A pilot study showed that the questionnaire required about 20 minutes for completion. A copy of the questionnaire is contained in an appendix to this paper.

## **Procedure**

Questionnaires were mailed to participants with a covering letter and SAE in the Irish Psychologist in the summer of 1993. The newsletter contained a notice describing the aims of the survey and asking members to complete and return questionnaires promptly. The following instructions were given in the letter:

Dear Colleague. I am writing to ask for your help. If you are currently involved in the practice, research or teaching of clinical psychology or a closely related field, please complete and return the enclosed questionnaire. A stamped addressed envelope is enclosed for your convenience. May I ask you to take particular care not to put your name or any identifying information on the questionnaire and also to be as frank as possible in answering the questions. Please return the questionnaire to me here at UCD as soon as possible. Many thanks for your help.

## **RESULTS**

### **Response Rate.**

Of 324 questionnaires, 142 were returned. This represents an overall response rate of 44%. Requests to return questionnaires were not sent to non-responders since this would have violated the guarantee of anonymity given to all participants.

111 respondents were qualified clinical psychologists or were working as clinical psychologists. The data presented below are based on the responses of this group.

Of the remaining 31 cases, 20 respondents clearly identified themselves as counselling psychologists. They had a primary degree in psychology and a graduate degree or professional diploma in counselling. These are excluded from the analyses below because counselling psychology is currently evolving as a separate professional discipline within psychology. Nine of the remaining respondents were academic psychologists with clinical research interests; psychologists involved in administrative or research work relevant to clinical psychology or psychologists practising outside the Republic of Ireland. Two questionnaires were excluded because they were largely incomplete.

### **Data management**

Data from the questionnaires were analysed using SPSS (Norusis, 1990). On no item were there more than 10% missing data. Three main sets of analyses were conducted. First, descriptive statistics for the group of 111 clinical psychologists were computed. These included percentages for categorical variables and means and standard deviations for interval scale variables. Throughout this paper percentages have been rounded up to the nearest whole number to simplify presentation.

In the second set of analyses three groups of psychologists, each at different *grade levels*, were compared on all remaining variables. The first group contained 26 basic grade psychologists. The second group contained 45 senior grade psychologists and there were 20 in the third group who were service directors or at consultant grade. It is worth mentioning

that those assigned to the third group had job titles that included the term *service director* or *consultant*, although some of these may actually have been on a senior grade salary. Respondents who could not be classified within the threefold scheme worked in universities, private practice or other agencies. These cases were omitted from the analyses by grade since they could not be classified into homogenous groups of sufficient size to permit reliable statistical analyses to be conducted.

In the third set of analyses, three groups of psychologists, each in different *specialties*, were compared on all remaining variables.

There were 33 in services for the mentally handicapped, 34 in child and family services and 26 in adult mental health services. The remaining participants, who were omitted from the third set of analyses, worked in other specialties such as neuropsychology, health psychology or behaviour analysis. These cases were omitted from the analyses by specialty since they could not be classified into homogenous groups of sufficient size to permit reliable statistical analyses to be conducted.

For the analyses by grade and specialty one-way ANOVAs and Student Newman-Keuls tests were used for all intergroup comparisons on interval scale variables. On categorical variables Chi Square tests were conducted with Yates correction for continuity where cell frequencies were less than 5. Only intergroup differences that were of professional interest and statistically significant at  $p < .05$  are reported.

In the next seven sections descriptive statistics for the sample as a whole are presented first. Thereafter, statistically significant results of professional interest are presented from the analyses based on grade and specialty.

### **Demographic characteristics, qualifications and affiliations.**

Demographic characteristics are given in Table 2.1. Ages of the group ranged from 26 to 64 years with a mean age of 39 years and 7 months. 55% were female and 45% were male. Almost three quarters were married (73%) and 22% were single.

With respect to qualifications, the sample was split three ways. About a third had a two year professional masters degree in clinical psychology (34%). About a third had on-the-job training (36%). The remainder had either a one year masters degree in clinical psychology (18%), a diploma in clinical psychology (6%) or a doctorate in clinical psychology (5%).

Diplomas in psychotherapy (5%), diplomas in counselling (5%), masters degrees in counselling (3%) and masters degrees in psychotherapy (1%) were rare among the group surveyed.

**Table 2.1. Demographic characteristics**

<b>Variable</b>	<b>Category</b>	<b>%</b>
<b>Age</b>	Mean = 39y 7 m Range = 26y - 64y	
<b>Gender</b>	Female Male	55 45
<b>Marital status</b>	Married Single Other	73 22 5
<b>Clinical psychology qualifications</b>	On the job training Accredited masters in clinical psychology Masters in clinical (1y) Diploma in Clinical Psychology Doctorate in Clinical Psychology	36 34 18 6 5
<b>Psychotherapy and counselling qualifications</b>	Diploma in psychotherapy Diploma in counselling Masters in counselling Masters in psychotherapy	5 5 3 1
<b>PsSI</b>	Registered psychologist Graduate member AFPsSI FPsSI	72 41 52 5
<b>BPsS</b>	Chartered psychologist Graduate member AFBPsS FBPsS	20 21 19 0
<b>Union membership</b>	IMPACT MSF SIPTU None	48 18 2 32
<b>Insurance</b>	BPsS Scheme PPS Scheme Other None	20 15 6 59
<b>Main specialty</b>	Child and family Learning difficulties Adult Mental Health Psychotherapy Physical disability Family therapy Older adult mental health Health psychology Behavioural analysis Other	31 30 23 5 3 2 2 1 1 1

**Table 2.1. Demographic characteristics**

Variable	Category	%
<b>Grade</b>	Senior	41
	Basic	23
	Consultant/Director	19
	Consultant in private practice	5
	Principal	2
	Lecturer	2
	Senior Lecturer	2
	Other	6
<b>Employer</b>	Voluntary organization	50
	HB special Hospital	16
	HB Community Care	13
	Private practice	8
	University	5
	Private hospital	4
	Private Institute	1
	Other	3
<b>Work setting</b>	Health centre/Outpatients	25
	Residential care centre	11
	Private institute	10
	Public psychiatric hospital	9
	Private practice	6
	University	5
	Children's hospital	4
	Private psychiatric hospital	3
	General hospital	3
	Other	24

**Note:** N=111.

About three quarters of the sample (72%) were Registered Psychologists with the Psychological Society of Ireland (PsSI). Only a fifth (20%) were Chartered Psychologists with the British Psychological Society (BPsS). Just over half (52%) were Associate Fellows of PsSI and about a fifth (21%) were Associate Fellows of the BPS. 41% were graduate member of PsSI and 21% were graduate members of the BPS. Only 5% were Fellows of PsSI and none were Fellows of the BPS.

Over half of the sample (59%) had no professional indemnity insurance. Those that had such insurance obtained their policies through either the Professional Psychologists Society (15%) or through the BPsS scheme (20%) or some other body (6%).

Almost a third of psychologists (32%) were not affiliated to any union. About half (48%) were in IMPACT (the Irish Municipal Public and Civil Trade Union) and about a fifth (18%) were in MSF (the Manufacturing, Science and Financial trade union) with only 2% in SIPTU (the Services, Industrial and Professional Trade Union).

### **Employment patterns: career course, work setting, employers, specialty and grading**

Within the sample the number of years of clinical experience ranged from 1-30 with a mean

of 13. The mean number of jobs held was 3 with a range from 1-9. 69 (62%) psychologists had at some stage worked with the health boards and the mean number of years for which they worked was 8 with a range from 1 to 26. 39 (35%) of the psychologists surveyed had worked abroad for an average period of 3 years with a range from between 1 and 13 years.

**Table 2.2. Employers of clinical psychologists in each speciality**

Specialty	Employer				
	Voluntary organization	Health board community care	Health board special hospital	Other	
Child mental health	% f	47% 16	24% 8	9% 3	21% 7
Adult mental health	% f	19% 5	12% 3	50% 13	19% 5
Intellectual Disability	% f	94% 31	3% 1	0% 0	3% 1

Note: Chi square = 48.49,  $p < .0001$ ,  $df = 6$ ,  $N = 93$ .

**Table 2.3. Factors associated with the grading of clinical psychologists**

Variable	Grade			X <sup>2</sup> or F	
	Basic Grade (N=26)	Senior Grade (N=45)	Director Consultant (N=20)		
Male	% f	27% <sup>b</sup> 7	44% <sup>b</sup> 20	75% <sup>a</sup> 15	10.62*
AFPSI or FPSI	% f	15% <sup>b</sup> 4	62% <sup>a</sup> 28	75% <sup>a</sup> 15	22.94**
Reg Psychol PSsI	% f	35% <sup>b</sup> 9	76% <sup>a</sup> 34	90% <sup>a</sup> 18	19.43**
PhD	% f	0% <sup>b</sup> 0	7% <sup>b</sup> 3	30% <sup>a</sup> 6	12.40*
Union Member	% f	84% <sup>a</sup> 22	73% <sup>a</sup> 32	47% <sup>b</sup> 9	8.81*
Years of experience	M SD	7.11 <sup>c</sup> 6.08	13.69 <sup>b</sup> 5.27	16.85 <sup>a</sup> 6.54	17.76**

<b>Number of research projects</b>	M	2.24 <sup>b</sup>	3.06 <sup>b</sup>	6.36 <sup>a</sup>	7.45 <sup>**</sup>
	SD	1.53	2.38	6.92	
<b>Number of presentations</b>	M	1.33 <sup>b</sup>	3.86 <sup>b</sup>	14.55 <sup>a</sup>	11.02 <sup>**</sup>
	SD	1.92	4.41	19.68	
<b>Number of publications</b>	M	0.70 <sup>a</sup>	3.30 <sup>a</sup>	9.55 <sup>b</sup>	5.86 <sup>*</sup>
	SD	1.33	8.78	12.29	
<b>Mean % time spent in consultation</b>	M	3.00 <sup>a</sup>	4.77 <sup>a</sup>	11.68 <sup>b</sup>	8.43 <sup>**</sup>
	SD	4.00	5.78	11.93	

**Note.** For categorical variables, frequencies are in parentheses and an overall chi square value with  $df = 2$  and  $N = 91$  is given in the right hand column. For interval scale variables, values in parentheses are standard deviations and in the right hand column an F value with  $df = 2, 88$  is given. For overall chi squares and F values, \* =  $p < .01$  and \*\* =  $p < .001$ . In each row, values with different superscripts differ from each other at  $p < .05$ , with  $a > b > c$ .

A quarter of the sample worked in outpatient clinics or health centres with the rest being distributed across a range of work settings including residential care (11%), private institutes (11%), public psychiatric hospitals (9%), private practice (6%), universities or colleges (5%), children's hospitals (4%), and private psychiatric hospitals (3%).

Half of the sample were employed in voluntary organizations. Just over a quarter (29%) were employed by the health boards in special hospital or community care programmes. The remainder were employed in private practice (8%), a university or college (5%), a private hospital (4%) or a private institute (1%). The bulk of the sample worked in three specialties: Child & family psychology (31%), mental handicap (30%) and adult mental health (23%). The remaining 15% of the sample were in numerically smaller specialties. These included psychotherapy (5%), physical disability (3%), family therapy (2%), the elderly (2%), health psychology (1%), and behavioural analysis (1%).

From Table 2.2 it may be seen that there was a statistically significant relationship between clinical psychologists' specialty and the context within which they were employed. Mental handicap psychologists were employed largely in voluntary organizations. About half of child and family psychologists were employed with voluntary organizations and about a quarter with the health boards community care programmes. For psychologists working in the adult mental health specialty, the major employer was the health boards special hospital programme, with 50% of them working in it.

The majority of those surveyed were working at one of three grade levels: senior grade (41%), basic grade (23%), or consultant/director grade (18%). The remaining 18% were either consultants in private practice (5%); at a principal grade in a voluntary organization (2%); at lecturer (2%) or senior lecturer (2%) grade in a university or at some other grade designation (7%).

From Table 2.3 it can be seen that directors and basic grades have clearly different profiles. The Director or Consultant grade is associated with the following characteristics:

- Being Male.
- Being an Associate Fellow or Fellow of the PsSI.
- Being Registered with the PsSI.
- Having a PhD.

- Not being a union member.
- Having about 17 years of experience.
- Having a research track record.
- Being involved in consultancy.

The basic grade, on the other hand is typified by the following attributes:

- Being female.
- Not being an Associate Fellow or Fellow of the PsSI.
- Not being Registered with the PsSI.
- Not having a PhD.
- Being a union member.
- Having about 7 years of experience.
- Not having a research track record.
- Having minimal involvement in consultancy.

### **Workload, professional activities, approach to practice and theoretical orientation**

More than four fifths (87%) of the sample were employed full time and for the sample as a whole the average working week was 37 hours with a range from 5-60 hours. The median case load was 51 with a range from 0-2400. The median rather than the mean offers a better reflection of the central tendency of this distribution because it was positively skewed by two extreme cases where caseloads of 1,500 and 2,400 were reported. These extreme values inflated the mean to 111. The average number of cases on a waiting list was 22 with a range from 0-240. The average duration of a waiting list was 3 months with a range from 0-24 months.

Psychologists were involved in 11 different professional activities. When activities were rank-ordered according to the mean percentage of time devoted to each the top three were direct treatment (27%), assessment and diagnosis, (20%) and routine administration (11%). Together treatment, diagnosis and administration for an average psychologist within the sample were taking up about three days a week. The next three activities to which psychologists devoted a substantial amount of time was indirect treatment (10%), staff training (8%) and research (6%). For an average psychologist within the sample a little over a day a week was devoted to these three activities. Service planning (5%), consultation (5%), management (4%), public education (3%) and receiving supervision (1%) together on average were allocated just under a day a week.

**Table 2.4. Mean percentage of assessment time spent on different procedures in each specialty**

---

Specialty

---

		<b>Child Mental Health (N=34)</b>	<b>Adult Mental Health (N=26)</b>	<b>Intellectual Disability (N=33)</b>	<b>F</b>
<b>Behavioural observation</b>	M SD	4.76 <sup>b</sup> 8.58	8.08 <sup>b</sup> 19.91	17.81 <sup>a</sup> 17.00	6.13*
<b>Intellectual testing</b>	M SD	17.67 <sup>b</sup> 17.33	7.52 <sup>c</sup> 7.81	36.13 <sup>a</sup> 24.1	17.78**
<b>Family Interview</b>	M SD	18.76 <sup>a</sup> 21.94	3.16 <sup>b</sup> 5.33	12.16 <sup>a</sup> 12.50	7.17**
<b>Neuro- psychological testing</b>	M SD	1.90 <sup>b</sup> 3.47	11.08 <sup>a</sup> 15.34	1.55 <sup>b</sup> 3.40	10.67**
<b>Individual interview</b>	M SD	37.41 <sup>b</sup> 27.26	54.00 <sup>a</sup> 33.51	15.48 <sup>c</sup> 22.33	13.75**

**Note.** For each row, in the right hand column an F value with df = 2, 90 is given. \* = p<.01, \*\* = p<.001. In each row means with different superscripts differ from each other at p<.05, with a>b>c.

**Table 2.5. Theoretical models used by clinical psychologists in each speciality**

		Speciality			$\chi^2$
		Child Mental Health (N=34)	Adult Mental Health (N=26)	Intellectual Disability (N=33)	
<b>Cognitive behavioural</b>	% f	38% <sup>b</sup> 13	69% <sup>a</sup> 18	73% <sup>a</sup> 24	9.76*
<b>Family systems</b>	% f	50% <sup>a</sup> 17	12% <sup>b</sup> 3	12% <sup>b</sup> 4	16.38**

**Note.** For each row, in the right hand column a chi square value with  $df = 2$  and  $N = 93$  is given. \* =  $p < .01$ , \*\* =  $p < .001$ . In each row, means with different superscripts differ from each other at  $p < .05$ , with  $a > b$ .

When assessment procedures were rank-ordered according to the mean percentage of time the sample devoted to them, the individual clinical interview (35%) was the most common procedure with intellectual testing (20%), family interviewing (11%), behavioural observation and analysis (10%), neuropsychological testing (5%) and personality testing (5%) being less widely used. For all procedures, the range for the sample varied between 1% and 100% of psychologists' assessment time.

From Table 2.4 it can be seen that in the mental handicap specialty behavioural observation and intellectual testing were more commonly used than in the other specialties. The family interview was more widely used in the child and family and mental handicap specialties than in the adult mental health specialty. Neuropsychological testing was almost exclusively associated with the adult mental health specialty. The individual interview was used more commonly by psychologists in adult mental health than in the other two specialties and this procedure was used least by those in the mental handicap specialty.

When treatment formats were rank-ordered according to the mean percentage of time the sample devoted to them, individual therapy (50%) was the most widely used, with family therapy (11%), couples therapy (7%) and group therapy (6%) being used less commonly. However for all four treatment formats the range for the sample was between 1 and 100% of treatment time devoted

Cognitive behavioural (55%) and family systems (29%) approaches were the two most commonly used non-eclectic theoretical frameworks. Humanistic/existential (13%) and psychodynamic (12%) approaches together were used by a quarter of the sample. 33% of the sample indicated that they used an eclectic approach and 42% of the sample used more than one model. From Table 2.5 it can be seen that a cognitive behavioural model was widely used by psychologists working in the mental handicap and adult mental health specialties. A family systems orientation was used more commonly by psychologists working in the child and family specialty when compared with the other two specialisms.

## **Research, presentations and publications**

The median number of research projects carried out was 3. The median number of conference presentations was 2 and the median number of academic articles was 1. Median values are given because, for all three variables, the distribution was extremely positively skewed, and so means would give an inflated impression of the central tendencies within these distributions.

Most of the research projects were done by a few industrious psychologists. In all 527 projects were carried out. 2/3 of the projects (366/527) were completed by 32 psychologists (29% of respondents). Most of the conference presentations were made by a few highly prolific individuals. In all 632 presentations were made. 69% (434/632) or just over 2/3 were made by 20 psychologists (or 18% of respondents). Most of the articles were produced by a few highly prolific psychologists. In all 471 articles were written. 2/3 of the articles (308/471) were written by 13 (12%) of the 111 psychologists surveyed. 43 (39%) wrote none. 19 books were written by 10 (9%) of the psychologists surveyed and one prolific writer wrote 6 of these.

Only a minority of clinical psychologists were uninvolved in research and publication. 14% of the sample had conducted no research projects. 27% had made no presentations and 39% had no publications.

### **Private practice**

61 of 111 respondents (55%) were in private practice and all percentages in this section are based on N=61. Almost three quarters of this group (71%) were only in occasional private practice. 10% were full time and 14% were part time. 42% used consulting rooms, a quarter worked from home and about a quarter (26%) used the office at their main place of employment for private consultations. 7% worked at a private institute. For most psychologists, private practice was a solitary activity. About two thirds (69%) practiced alone. 20% practiced with other professionals and only 11% with other psychologists. On average 59% of the group's time was devoted to therapy and 31% to assessment. Hourly fees ranged from IR£20 to IR£60 with almost two thirds of the group (64%) using a sliding fee scale. IR£20-IR£30 was the fee range used by 43% of the group. The fees of 44% of the group fell in the IR£30-IR£40 bracket. For 11% of the group a fee of IR£40-IR£50 was used. Only 2% of the group charged between IR£50 and IR£60.

**Table 2.6. Factors contributing to clinical psychologists' job satisfaction**

Factor	%
--------	---

---

Psychological intervention	67%
Variety of Tasks that make up job	49%
Teaching & Training	37%
Multidisciplinary team work	26%
Psychological Assessment	21%
Service Planning	16%
Indirect Assessment & Treatment via relatives & staff	17%
Research	14%
Relationships with other Psychologists	11%
Consultation	11%
Pay	7%
Management of Junior Staff	5%
Receiving Supervision	4%
Relationships with Social Workers	4%
Office facilities	4%
Relationships with psychiatrists	2%
Routine Administration	2%
Relationships with GPs	2%
Administrative resources	1%
Relationships with Management	1%
Relationships with Physicians & Surgeons	1%
Relationships with Nurses	0%
Work Load	0%

---

**Note:** N=111.

### **Job satisfaction**

Two thirds of the sample were very satisfied (22%) or quite satisfied (43%) with their job. 9% were slightly satisfied. The remainder were slightly dissatisfied (12%), quite dissatisfied (10%) or very dissatisfied (5%). Over half (56%) said that if they could choose their career again they would choose clinical psychology. The remainder said that if they could choose their career again they would choose another field of psychology (8%), law (6%), business (6%), medicine (5%) or some other field (19%).

From a list of 24 factors, respondents were asked to indicate the top three contributing to job satisfaction and job dissatisfaction. From Table 2.6 it may be seen that for job satisfaction, the top 5 factors identified by the sample were direct psychological treatment, the variety of tasks that make up the job, teaching and training, multidisciplinary team work and psychological assessment. For job dissatisfaction, as can be seen from Table 2.7 the top five factors were work load, pay, routine administration, lack of administrative resources, relationship with management.

**Table 2.7. Factors contributing to clinical psychologists' job dissatisfaction**

---

<b>Factor</b>	<b>%</b>
---------------	----------

---

---

Work Load	50%
Pay	37%
Routine Administration	33%
Lack of administrative resources	27%
Relationships with Management	26%
Relationships with psychiatrists	15%
Office facilities	14%
Service Planning	13%
Teaching & Training	6%
Direct Psychological Treatment	6%
Research	5%
Receiving Supervision	5%
Variety of Tasks that make up job	5%
Relationship with Physicians & Surgeons	5%
Multidisciplinary team work	5%
Management of Junior Staff	4%
Psychological Assessment	3%
Indirect Assessment & Treatment via relatives & staff	3%
Relationships with Social Workers	2%
Relationship with Nurses	2%
Relationships with other Psychologists	2%
Consultation	1%
Relationships with GPs	0%

---

**Note:** N=111.

### **Continuing professional development**

The psychologists surveyed all engaged in some continuing professional development (CPD) activities. In analysing the data, these CPD activities have been rank ordered in terms of the percentage of psychologists engaging in each activity. From Table 2.8 it is clear that the top three CPD activities in which the majority of psychologists engaged were reading professional literature, conference attendance, and attending 1-2 day training workshops. Staff development workshops and journal clubs or case presentations (both team based in-house CPD activities) were engaged in by about two fifths of those surveyed. Just over a quarter of respondents were engaged in personal psychotherapy as a CPD activity. A tenth or less were completing various part-time courses and extramural psychotherapy.

**Table 2.8. Clinical Psychologists' participation in continuing professional development**

---

<b>Activity</b>	<b>%</b>
-----------------	----------

---

Reading Professional Literature	91%
Conference Attendance	85%
1-2 day Skills Training Workshop	66%
Staff Development Workshop	42%
Journal Club or Case Presentations	40%
Personal Psychotherapy	27%
Part-time Certificate Course	10%
Extramural Psychotherapy Supervision	9%
Part-time Degree Course	9%
Part-time Diploma Course	5%
Distance Learning Programme	3%

**Note:** N=111.

When psychologists were asked what activities they would find most valuable in fostering their continuing professional development, as can be seen from Table 2.9, the majority put 1-2 day skills training workshops at the top of their list. Reading professional literature and attending staff development workshops were identified as desired CPD activities by about two fifths of the surveyed group. About a third valued conference attendance and personal psychotherapy as desired CPD activities. Extramural psychotherapy supervision on the one hand and in-house journal clubs or case presentations on the other were the next most prominently identified CPD needs. About a quarter of clinical psychologists wanted to engage in these CPD activities. Formal courses were the least commonly desired CPD activities.

**Table 2.9. Continuing professional development activities that clinical psychologists would find most useful**

Activity	%
Reading Professional Literature	43%
Staff Development Workshop	39%
Conference Attendance	33%
Personal Psychotherapy	32%
Extramural Psychotherapy Supervision	26%
Journal Club or Case Presentations	5%
Part-time Degree Course	16%
Distance Learning Programme	10%
Part-time Diploma Course	9%
Part-time Certificate Course	8%

**Note:** N=111.

The majority of clinical psychologists surveyed thought that personal growth work was *essential* in the initial training (54%) of clinical psychologists and also in their ongoing continuing professional development (51%). Over a third thought that it was desirable for personal growth work to be part of initial training (35%) and ongoing CPD (40%). Only

about a tenth viewed personal growth work as an optional part of training (11%) and CPD (9%). From Table 2.10 it can be seen that significantly more psychologists at director or consultant grade viewed personal growth work as essential for initial training when compared with senior or basic grade psychologists. There was also a trend ( $P<.07$ ) for directors to view personal growth work as essential for CPD in comparison with those from other grades.

Just over half of those surveyed (54%) believed that PSI should recommend certain levels of CPD activity. About a third (32%) believed that PSI should require certain levels of CPD activity in order for psychologists to be issued with practising certificates.

On average each clinical psychologist allocated 12 days of their own time to CPD each year (with a range of 0-52) while their employers only allocated 8 days to each psychologist per annum (with a range from 0-56). On average each clinical psychologist allocated IR£497 of their own funds to CPD (with a range for (IR£0-IR£2,500).

**Table 2.10. Clinical psychologists who believe that personal growth work is *essential* for their initial training and continuing professional development**

Variable		Grade			$\chi^2$
		Basic Grade (N=26)	Senior Grade (N=45)	Director Consultant (N=20)	
Personal growth work essential in initial training	% f	42% <sup>b</sup> 11	56% <sup>b</sup> 25	80% <sup>a</sup> 16	6.65*
Personal growth work essential in continuing professional development	% f	54% <sup>b</sup> 14	44% <sup>b</sup> 20	75% <sup>a</sup> 15	5.20†

**Note.** For each row in the right hand column a chi square value with  $df = 2$  and  $N = 93$  is given. \* =  $p<.05$ , † =  $p=.07$ . In each row, means with different superscripts differ from each other at  $p<.05$ , with  $a>b$ .

For employers the amount allocated to each clinical psychologist's CPD was IR£375 per year. The range was IR£0-IR£4,000. These same data may be expressed in aggregate form. Altogether 77 psychologists devoted 990 days of personal time to CPD while the employers of 72 psychologists allocated only 742. In all 68 clinical psychologists allocated IR£40,765 to CPD while the employers of 57 psychologists allocated only IR£31,915. For almost half of the group surveyed (49%), employers allocated no finance for CPD and in about a third (35%) of cases employers allocated no time for CPD. Only about a third of psychologists devoted no personal finance (39%) or personal time (31%) to CPD.

## DISCUSSION

Before addressing a number of substantive issues raised by the survey, the methodological issue of sample representativeness deserves discussion. The near equal male/female ratio of respondents and the fact that 68% of the group to whom questionnaires were sent were female suggests that females may have been under-represented in the sample. The omission of non-PsSI member from the sample also compromised its representativeness. The sample was therefore biased in favour of male PsSI clinicians. While differences and similarities between PsSI members and non-members are unknown, the data suggest that there is an association between gender and professional seniority. The profile of clinical psychology reflected in the results of the survey may be coloured by the over-representation of senior clinicians. With this in mind, let us turn to a discussion of a number of substantive issues raised by the overall pattern of results and to a comparison of these and the results of similar US and UK surveys. Unless otherwise indicated, all comparisons with US and UK data are based on John Norcross' recent studies (Norcross, Dryden & Brust, 1992; Norcross, Brust and Dryden, 1992; Norcross, Prochaska & Gallagher, 1989a, 1989b). To avoid unnecessary repetition, further citations of Norcross' surveys will not be made when making comparisons between US, UK and Irish data.

Demographically there marked similarities between Irish and UK clinical psychologists and substantial differences between both of these groups and their US counterparts. The gender ratio of respondents to this survey was identical to the gender ratio found in the UK but differed substantially from that reported in the US where the male/female ratio among clinical psychologists was 3:1. The mean age of clinical psychologists in this study was similar to that found in the UK but was eight years lower than the mean for US clinical psychologists.

The Irish clinical psychologists in the present survey were considerably less well qualified than their British or North American counterparts. While in Ireland only a third had masters and 5% had doctorates in clinical psychology, in the UK half had masters degrees and a quarter had doctorates. In the US almost all clinical psychologists had doctorates. While just under three quarters of Irish psychologists had PSI Registered status, over 90% of British psychologists had BPS Chartered status.

With a mean of 13 years post-qualification experience, Irish psychologists fell between their UK and US counterparts who had 11 and 17 years post-qualification experience respectively. While outpatient clinics and health centres were the most commonly reported work settings for Irish psychologists, in the UK, psychiatric hospitals (23%) or general hospitals (22%) were the most common work sites. In the US, private practice was the most common working environment with over a third (35%) of clinical psychologists working in such a setting.

The present survey underlines clinical psychologists' flexibility in being able to fulfil complex roles in diverse organizational contexts. The group surveyed worked in many contexts, changed work contexts relatively frequently and indeed worked abroad before returning to import new expertise into Ireland. The results of US and UK surveys show that the complex professional role adopted by clinical psychologists in Ireland is very similar to that of British and North American clinical psychologists.

The survey paints a picture of clinical psychologists in Ireland as a small but highly trained group of professionals who share certain core clinical, research and organizational skills but

who also are segmented into three definitive specialties. However, the working structure for psychologists in Ireland appears to have evolved so as to maximize professional isolation. Specialists are attached to organizations that provide a service in their specialty. Specialists are not members of unitary psychology departments as in the UK (MAS, 1989; MPAG, 1990). In a profession as small as clinical psychology the current structures may be one factor compromising the impact of the profession in Ireland. The profession as a whole (in conjunction with other psychologists who provide health related services) needs to consider if the professional isolation that is currently the norm should be challenged through advocating and promoting the development of more cohesive organizational structures within which to practice. The development of unified psychology departments of which specialists from all fields are members is one organizational structure that would greatly reduce professional isolation. To be consistent with current plans for the development of mental health services generally, ideally such departments would be community based and each department would serve a specific geographic sector (Department of Health, 1992, 1994).

In the US, the UK and Ireland clinical interviewing is the most commonly used assessment procedure and eclectic and integrative models of treatment were adopted by between a quarter and a third of all surveyed in all three countries. However, there are clear differences between the amount of time Irish, US and UK psychologists devote to specific assessment procedures and their allegiance to particular treatment models. US psychologists devote a third of their assessment time to objective and projective personality testing while Irish (5%) and British (3%) psychologists rarely use such procedures. Of the theoretically pure models, cognitive and behavioural theoretical orientations were by far the most common in Ireland (55%), the UK (49%) and the US (29%). While family-systems models were second in popularity in Ireland, psychodynamic models filled this slot in the US and the UK.

The pattern of research productivity found in this survey of Irish psychologists is remarkably similar to that found in US and UK surveys. In both countries a small proportion of the samples surveyed produced the majority of the publications and between a quarter and a third produced none. The median number of academic publications was highest for the US (6), next highest for the UK (2) and lowest for Ireland (1).

Irish psychologists fell between their UK and US counterparts in terms of their overall career satisfaction. While 67% of Irish psychologists said that they were quite satisfied or very satisfied with their career, 56% of UK and 89% of US psychologists expressed these levels of career satisfaction. However, comparable numbers of Irish (56%), British (50%) and North American (58%) clinical psychologists would choose clinical psychology if they could make their career choice again.

Clinical psychologists in Ireland take CPD seriously. Without guidance from PsSI or support from their employers, most psychologists engage in CPD. There is a clear need to establish a system for informing clinical psychologists and their employers about CPD opportunities and standards and facilitating its occurrence. In the US, the UK and Canada, professional bodies have drawn up clear criteria for the accreditation and recommendation of CPD courses and clear guidelines exist to help both psychologists and their employers to make decisions about the allocation of time and resources to CPD (BPsS, 1990; CPA, 1989, 1990; Hellkanp, Imm & Moll, 1989; VandeCreek & Brace, 1991). In Australia the process is less well developed (APS, 1993).

Personal growth work, personal psychotherapy and psychotherapy supervision were

recognized by the sample surveyed as significant aspects of CPD. This is consistent with Rothery's (1992) finding that 50% of clinical psychology trainees believed that personal growth work was an essential part of their initial training. Some good examples of how personal growth work may be incorporated into initial training have recently been published (e.g., Eayrs, Appleton & Lewis, 1992). The fact that there is a lack of unanimity among Irish clinical psychologists about the desirability of mandatory CPD, mirrors the situation in other countries. For example, in the US, the controversy over mandatory CPD is an ongoing debate with some states requiring CPD for relicensure and others not (Hellkanp, Imm & Moll, 1989; VandeCreek & Brace, 1991). Mandatory CPD has not been established in the UK, Canada or Australia.

An important question raised by this survey is how clinical psychologists as a highly trained yet numerically small group of professionals can be most usefully deployed within the health service. In the UK, two major recent reviews of clinical psychology services have concluded that the most efficient model for service delivery is through a *shared care* approach and the adoption of a *consultant role* by clinical psychologists (MAS, 1989; MPAG, 1990). Clinical psychology would become a consultant led service with a remit to meet population health needs across the board rather than being confined to the areas of mental health and mental handicap. Such a psychology service would aim to promote and monitor healthier lifestyles through preventative programmes and ongoing evaluative research. There would be a greater emphasis on psychologists developing treatment programmes and training other professionals in their implementation. Psychologists would also offer direct psychological services to compliment medical strategies in a partnership with colleagues from medicine and other disciplines. This shared-care/consultant-role model for clinical psychology services fits particularly well with current national plans for the development of the health service (Department of Health, 1994). Furthermore, this broader role for clinical psychology and indeed for other psychologists in the health services has been highlighted in a PsSI occasional paper which discussed the application of psychology in health education, prevention, community based services, general medicine and services for the elderly (PSI, 1990).

Funding limitations precluded extending the survey described here beyond the Republic of Ireland to include Northern Ireland. For the results of such a survey to be meaningful, data sets from the Republic of Ireland and from Northern Ireland would require separate analyses or a comparative analysis since clinical psychologists in each of these contexts work within differing administrative structures. For such a survey, clinical psychologists in Northern Ireland could be identified through the BPsS Directory of Chartered Psychologists (BPsS, 1994). This is one potentially useful avenue for future work in this area. A second important future project arising from the present study is the replication of the survey in five years to track changes in the profession over time. Such replications have been fruitfully conducted in the US (Norcross, Prochaska & Gallagher, 1989a, 1989b; Norcross & Prochaska, 1982a, 1982b).

## REFERENCES

Australian Psychological Society (1993). *Personal Communication*. National Science Centre,

191 Royal Parade, Parkville, Victoria, Australia 3052.

British Psychological Society Membership Qualifications Board (1990). *Criteria for the assessment of post-qualification courses for Chartered Psychologists: The Society's accreditation of major courses and recommendation of minor ones*. Leicester. BPS.

British Psychological Society (1994). *Directory of Chartered Psychologists*. Leicester. BPS.

Canadian Psychological Association (1989). *Practice Guidelines for providers of psychological services*. Chemin Vincent Road, Old Chelsea, Quebec, JOX 2N0. CPA.

Canadian Psychological Association (1990). *Criteria Standards and Procedures: Approval of sponsors of continuing education for Canadian psychologists*. Chemin Vincent Road, Old Chelsea, Quebec, JOX 2N0. CPA.

Department of Health (1992). *Green Paper on Mental Health*. Dublin. Stationary Office.

Department of Health (1994). *Shaping a Healthier Future. A strategy for effective healthcare in the 1990s*. Dublin. Stationary Office.

Eayrs, C., Appleton, P. & Lewis, P. (1992). Personal development counselling for clinical psychology trainees: a pilot scheme in the North Wales In-service training scheme. *Clinical Psychology Forum*, **40**, 11-14.

Hellkanp, D., Imm, P., & Moll, D. (1989). Mandatory continuing education: Desirable or undesirable. *Journal of Training and Practice in Professional Psychology*, **3**(2), 33-46.

MAS (1989). *Review of Clinical Psychology Services*. London. Mowbray.

MPAG (1990). *Clinical Psychology Project: Full Report*. London. Department of Health.

Norcross, J., Brust, A. & Dryden, W. (1992). British Clinical Psychologists: Survey findings and American comparisons. *Clinical Psychology Forum*, **40**, 24-28.

Norcross, J., Dryden, W. & Brust, A. (1992). British Clinical Psychologists: A National survey of the BPS Clinical Division. *Clinical Psychology Forum*, **40**, 18-23.

Norcross, J. & Prochaska, J. (1982a). A national survey of clinical psychologists: Characteristics and activities. *The Clinical Psychologist*, **35** (2), 1-8.

Norcross, J. & Prochaska, J. (1982b). A national survey of clinical psychologists: Affiliations and orientations. *The Clinical Psychologist*, **35** (3), 1-6.

Norcross, J., Prochaska, J. & Gallagher, K. (1989a). Clinical psychologists in the 80s: I. Demographics affiliations and satisfactions. *The Clinical Psychologist*, **42** (2), 29-39.

Norcross, J., Prochaska, J. & Gallagher, K. (1989b). Clinical psychologists in the 80s: II. Theory, research and practice. *The Clinical Psychologist*, **42** (3), 45-53.

- Norusis, M. (1990). *SPSS Base System User's Guide*. Chicago, Ill: SPSS Inc.
- Psychological Society of Ireland (1993). *Directory of Psychologists in Ireland*. 13 Adelaide Road Dublin 2. PsSI.
- Psychological Society of Ireland (1990). *Improving Health: What can Psychology Contribute*. 13 Adelaide Road Dublin 2. PsSI.
- Rothery, N. (1992). Personal growth work in the training of counselling and clinical psychologists in Ireland. *Irish Journal of Psychology*, **13**, 168-175.
- VandeCreek, L. & Brace, K. (1991). Mandatory Continuing education. *Journal of Training and Practice in Professional Psychology*, **5** (1), 23-36.

### ACKNOWLEDGEMENTS

This research was supported by a grant from the Faculty of Arts, University College Dublin. Earlier drafts of the paper were presented at the 1994 AGM of the PsSI Division of Clinical Psychology in Dublin and the 1994 annual PsSI conference in Blarney. Thanks to all who gave feedback at these meetings particularly Richard Booth and Paula Long. Thanks to Mary Boyle, Chris Linehan and Michael Drumm for assistance with data management and to Professor Ciarán Benson and Therèse Brady for their support and encouragement throughout the project. Thanks to the Editors of *The Irish Journal of Psychology* and *Clinical Psychology Forum* for permission to reproduce parts of the following papers in this chapter.

- Carr, A. (1995). Clinical Psychology in Ireland: A national survey. *Irish Journal of Psychology*. 16,1-20.
- Carr, A. (1996). A survey of clinical psychologists in Ireland: 1. Demographic characteristics, qualifications, employment patterns, workload and approach to practice. *Clinical Psychology Forum*, No 94, 7-14.
- Carr, A. (1996). A survey of clinical psychologists in Ireland: 2. Research, Job satisfaction, continuing professional development, and private practice. *Clinical Psychology Forum*, No 96, 24-30

## CHAPTER EIGHT

### A PSYCHOSOCIAL STUDY OF A POPULATION OF CHILDREN AND ADOLESCENTS WITH DIABETES MELLITUS

Bernadette Mackey, Michael Fitzgerald, Hilary Hoey.

#### Summary

Thirty-four children and adolescents and their families, all attending the Diabetic Outpatient Clinic of a Dublin Paediatric Hospital were studied. The impact of psychosocial factors was assessed by means of Questionnaires, and biochemical control was reviewed over a two year period. Results indicate an overall healthy patient group but suggest important relationships between the children's diabetic control and degree of maternal stress. A relationship was

found between poor diabetic control and (1) Moderate to severe levels of maternal stress on the General Health Questionnaire, (2) Increased reporting of behavioural problems on the Child Behaviour Inventory. Implications of these findings for future intervention are discussed.

## Introduction

Diabetes mellitus is the most common endocrine disease found in children and its reported incidence is increasing.<sup>1</sup> It is estimated that between two percent and six percent of the general population suffer from the condition.<sup>2</sup> Most children and adolescents cope reasonably well with diabetes<sup>3</sup>, however the literature suggests that a third to one-quarter of children with insulin-dependent diabetes mellitus have appreciable emotional and behavioural problems.<sup>4</sup> Children in poor health and from dysfunctional families appear to have more emotional and behavioural difficulties.<sup>3</sup> Children with diabetes, though a distinct group, share many similar issues faced by chronically ill children and their families. They require specialised care at the time of diagnosis and thereafter.<sup>5</sup> However, children and adolescents with diabetes have very specific treatment needs. Diabetes is not a static disease and childhood is inherently a developmental phenomenon.<sup>3</sup> Thus children and adolescents at different stages of development will have specific treatment needs. Children with diabetes are now viewed as a heterogeneous group and functioning within a social context.<sup>3</sup> Thus they cannot be managed in isolation as they are part of their family and wider community system.

Most current psychosocial research attempts to identify how patient and environmental variables converge to influence patient health status.<sup>3</sup> However, the literature addressing such variables is limited.<sup>3</sup> Several research studies have focussed on the impact of the child's illness on the family and conversely the influence of family factors on the child's physical and mental health. Other important influences on children are those of peer relationships and school environment, but such factors are less well studied.<sup>3</sup>

Within childhood diabetic populations, poor health status has been associated with poorer patient adjustment and a more dysfunctional family environment.<sup>3</sup> Other studies show correlations between improved diabetic control and decreased anxiety, depression and problems in living.<sup>2</sup> However, here the research findings are conflicting. Some studies have shown an association between children's level of glucose control and family stress, i.e. diabetic children in families characterised by good parental communication, marital harmony, and low levels of conflict tend to have better glucose control.<sup>5</sup> But a recent study suggests an association between low levels of parental stress and poor metabolic control in other children.<sup>5</sup> Parents of preschool children with diabetes tend to view them as more demanding and expressing more negative type behaviours, although there was no association of these findings with biochemical control.<sup>5</sup> These findings have implications in terms of professional involvement and support for parents. These latter findings have been supported by other studies which suggest that mothers of diabetic children from lower socio-economic groups report higher levels of psychosocial stress and view their children as having higher levels of behavioural problems.<sup>6</sup> To complicate the picture further, some studies suggest that better biochemical control may be associated with poorer adjustment and increased rates of disturbed behaviour.<sup>6</sup> These conflicting findings certainly highlight the need to unravel the

effects of diabetes on psychosocial factors from the effects of psychosocial factors on diabetes.<sup>7</sup>

This study examines psychosocial factors in a clinic population of children and adolescents with insulin-dependent diabetes mellitus in order to assess their impact on diabetic control.

## Subjects and Methods

The clinic population studied all attended the outpatient diabetic department of a busy Paediatric Dublin Hospital. The study was carried out during the period January 1990 to December 1991 and the total clinic population at the time was 36 children. Thirty-four children and adolescents (age range 3.4 – 16.8 years) and 33 mothers participated in the study. This represents 94.5% of the children and 91.6% of the mothers respectively. Two families refused to participate in the study. In the case of another family the parents refused to participate but allowed their child to do so. Contact was made initially at outpatients, but in most cases followed up by home visits. The subject group resided in various counties of the Eastern region of the country.

The children completed the Birelson Inventory for Depression and the Coopersmith Self Esteem Questionnaire, in addition to a Questionnaire devised by the researchers assessing the children's knowledge of and attitudes towards their illness. The mothers completed the following Questionnaires: Child Behaviour Inventory (Eyberg), Social Questionnaire, Stress Parenting Index, General Health Questionnaire (30 item).

Sociodemographic details were obtained by review of individual files. Strict biochemical indices of diabetic control as determined by the percentage of HBA1c over the preceding two year period were used. Reference values used for this study were HBA1c range of 4.5% - 9% with a mean of 5.8%. Mean values were calculated for each child and for the group. Thus biochemical control indices used were as follows:

Good Control = Mean + 1 SD (< 7.75%)  
Moderate Control = Mean +3-5 SD (7.75% - 9%)  
Poor Control = Mean + >5 SD (< 9%)

## Procedures

The Birelson Questionnaire<sup>8</sup> is a self-administered instrument assessing depressive symptomatology, with a cut-off value of 12 or more scoring positive for depression.

The Coopersmith Self Esteem Questionnaire<sup>9</sup> is a questionnaire measuring self esteem.

The Eyberg Child Behaviour Inventory is a 36 item questionnaire which shares the quantifiability of objective instruments and in addition is an easily administered and easily scored scale. It is a behaviourally specific rating scale designed to assess parental perception of behaviour problems in their children. It is applicable to children aged 2 to 16 and is completed by the child's parent.<sup>10</sup>

The Social Questionnaire<sup>11</sup> is a 33 item instrument (self administered).

The Parenting Stress Index<sup>12</sup> is a screening and diagnostic assessment technique designed to yield a measure of the relative magnitude of stress in the parent-child system. It is completed by the child's mother.

The General Health Questionnaire<sup>13</sup> (30 item) is a self-administered instrument assessing general health.

## Results

The sociodemographic profile: The findings of nearly 75% of families in upper and middle socio-economic groups suggests a rather well-resourced group. However, this does not reflect the overall clinic catchment area which is a mixed area with pockets of inner city deprivation. Nearly 80% of the children attained moderate to good control, i.e. HBA1c levels of 9% or lower.

The results of the Children's Questionnaires reveal an overall healthy group. Only one child scored positive for depressive symptomatology, i.e. score greater than 12 on the Birelson Rating Scale. While the group as a whole exhibited healthy self-esteem levels, a surprising finding was that of higher total scores in the moderately controlled group consistent throughout the sub-scores of the Coopersmith Questionnaire. Non-parametric testing i.e. Kruscher-Wallace, was used to obtain mean rank values.

We noted some very striking results in the Questionnaires completed by the mothers.

We found a relationship between increased scores on the Child Behaviour Inventory (CBI) and poor diabetic control. This was evident both in the scores rating number and intensity of behavioural problems. Non-parametric testing, i.e. Mann-Whitney, was used to assess mean rank values here. We also found a relationship between increased scores on the CBI and "cases" on the GHQ, i.e. increased reporting of child behavioural problems by mothers who reported moderate to high levels of stress on the GHQ (non-parametric testing, i.e. Mann-Whitney, used to obtain mean rank values).

The Social Questionnaire revealed increased reporting of social problems among mothers of those children with poorly controlled diabetes, with a trend towards more marital problems. Mothers of the poorly controlled group also showed increased reporting of relationship problems with their spouses.

The results of the Parenting Stress Index revealed some conflicting findings among the sub-scores, but mothers of the good control group clearly showed total lower mean rank values for stress. Nearly 25% of mothers reported moderate to high levels of stress on the General Health Questionnaire (8 out of 33). Moderate to high levels of stress on the GHQ correlates with a score of >5 which is described as a "case". As mentioned previously, a relationship was found between "cases" on the GHQ and increased scores on the CBI. There was also a relationship noted between GHQ scores of the mothers and children's diabetic control in that there was a higher percentage of poorly controlled among "cases" on the GHQ.

## Discussion

This study presents research findings in a clinic population of children and adolescents with diabetes mellitus. The group studied is small and heterogeneous and there are large variations between age range and duration of illness. However, our findings do present evidence to support a relationship between psychosocial stressors and diabetic control. As previously mentioned, the literature addressing the impact of psychosocial variables on diabetic control is small. However, there is research evidence available to support this association.

Our findings do not support other studies suggesting an association between lowered self-esteem and depressive feelings with poor diabetic control. Our group, while small in numbers, presents as an overall healthy group in terms of mental state and self esteem. Factors influencing these findings could be temperament, intellectual ability, family relationships and socio-economic factors. As mentioned earlier, the families studied as a whole suggest a bias towards the higher socio-economic groups, which may result in these families providing more effective supports and resources for their children. Our findings of high self esteem values among the moderately controlled group may support other studies which suggest that too strict biochemical control may be associated with poorer adjustment and increased rates of disturbed behaviour.<sup>4</sup>

The results of the Questionnaires completed by the mothers yield some very interesting and important results. Our findings of an association between poor diabetic control and increased reporting of social and marital problems by mothers support other studies.<sup>5</sup> The relationship between diabetic control and GHQ findings in our study again highlights the interplay between child and parent functioning, i.e. a higher percentage of poor controls among “cases” on the GHQ, and again supports other studies.<sup>5</sup> Finally our study shows a relationship between moderate to high levels of stress on the GHQ and increased CBI scores, again supporting previous studies.<sup>6</sup>

Given the above results, how can professionals intervene to prevent these effects? One possible intervention could be to provide intensive support to the poorly controlled group and their families, as this group have reported more social problems and stress. Our results would indicate that the parents are more in need of professional support than their children. Such support could be provided by a joint approach by the diabetic team and Child Psychiatrists / Psychologists, in terms of individual and / or group work with vulnerable families. This approach is currently being examined by the professionals involved in this study.

However, what is also clearly needed is more long-term prospective studies of this clinic group in order to clarify further the effects of psychosocial factors on their illness and to identify specific forms of intervention.<sup>7, 14, 15</sup>

## References

1. Burden A. C. et al. Childhood diabetes mellitus: An increasing incidence. *Diabetic Medicine*, 1989, 6 (4): 334-336.
2. Wilkinson D. G. Psychiatric aspects of diabetes mellitus. *British Journal of Psychiatry*, 1981, 138: 1-9.
3. Bennett Johnson S. Psychological aspects of childhood diabetes. *Journal of Child Psychology and Psychiatry*, 1988, 29: 729-738.
4. Fonagy P., et al. Psychological adjustment and diabetic control. *Archives of Disease in Childhood*, 1987, 62: 1009-1013.
5. Hauenstein E. J., et al. Stress in parents of children with diabetes mellitus. *Diabetes Care*, 1989; 12 (1).
6. Wysocki T., et al. Adjustment to diabetes mellitus in preschoolers and their mothers. *Diabetes Care*, 1989, 12 (8).
7. Helz J. W., Templeton B. Evidence of the role of psychosocial factors in diabetes mellitus: A review. *American Journal of Psychiatry*, 1990, 147: 10.
8. Birelson Self-Rating Scale, 1981. *Irish Child Psychology*
9. Coopersmith Self Esteem Inventory Manual. Palo Alto, California: Consulting Psychologists Press, 1986.
10. Eyberg S., et al. Child Behaviour Inventory. University of Oregon Health Services Centre.
11. Corney R. Social Questionnaire. London: Institute of Psychiatry.
12. Abidin R. R. Parenting Stress Index Manual. Charlottesville, VA: Paediatric Psychology, 1983.
13. General Health Questionnaire. General Practice Research Unit, 1978. Institute of Psychiatry.
14. Steptoe A., Wardle J. *Psychosocial Process and Health*. Cambridge University Press, 1994.
15. Roberts M. L., Koocher G.P., Routh D. K., Willis D. J. (Eds). *Readings in Paediatric Psychology*. New York: Plenum Press, 1993.

## **CHAPTER NINE**

### **APPLYING A RISK AND PROTECTIVE FACTOR APPROACH TO SUBSTANCE USE AMONG AN IRISH ADOLESCENT POPULATION**

## **Introduction**

The use and abuse of both legal and illegal substances has become recognised as a major international problem that affects all nations and all segments of society. Substance use is a multi-dimensional phenomena and the type or pattern of use can vary according to type of substance, place along the use-misuse-dependence continuum and characteristics and circumstance of the user. Each of the patterns and types of use may also be the result of multiple factors, which operate in a number of contexts. A theory which accurately reflects the heterogeneity of substance use and which can be of use in the design of intervention and prevention programmes needs to recognise that “individuals may be influenced by radically different situations, producing different effects on their behaviour” and that “the same behaviour may have totally different causes in different people” (Gorusch, 1983, p. 19).

Several authors have proposed the risk and protective factor approach to understanding teenage drug use (Newcomb, Maddahian, Skager & Bentler, 1987; Bry, McKeon & Pandina, 1982). It is argued that this approach allows for the fact that there is no single etiological cause of substance use and that the variety of substance use behaviours are reached by numerous pathways. Any one factor, deviant attitudes for example, is not considered the definitive etiological cause of drug use, but rather is considered as “one factor in a cumulative ecology of influences that are associated with increased drug involvement” (Newcomb et al., 1987, p. 428). The risk and protective factor approach can be seen as an ecological or systems model in that it examines influences from different systems, allow for the interaction between these systems, and place these in the context of development. This approach allows for the possibility that different factors may play different roles at various stages of drug involvement and in different populations or subgroups. Thus it represents a more ecological, multi-dimensional and dynamic approach.

The study of risk and protective factors associated with drug abuse has received considerable interest in the last decade. Research on developmental psychopathology has indicated that the course of adolescent drug abuse is a progression from problems that were exhibited long before adolescence (Palmer & Liddle, 1996). Thus research has increasingly turned to the study of the factors that put children at increased risk of substance abuse. Clayton (1992) defines a risk factor as “an individual attribute, individual characteristic, situational condition, or environmental context that increases the probability of drug use or abuse or a transition in level of involvement with drugs” (p. 19).

Risk factors have been extensively researched in the US and available evidence indicates that adolescent substance abuse is the result of multiple factors that are social, intrapersonal, and developmental in nature. Several longitudinal studies have been carried out to examine potential risk factors associated with adolescent substance use and a number of factors have been identified. Table 1 presents a summary of the factors identified in major studies conducted in this area (see Hawkins and Catalano, 1992 for a review of research in this area). As can be seen from the table, the factors include a number of domains of influence – individual, familial, contextual and environmental.

Table 1: Factors identified as associated with substance use in adolescence

- Low commitment to school
- Cognitive impairment
- Intelligence
- Academic failure
- Low religious involvement
- Early persistent problem behaviours
- Low self esteem
- Poor, inconsistent family management practices
- Family conflict
- Low bonding to family
- Alienation / rebellion
- Family drug behaviour
- Attitudes favourable to drug use
- Sensation seeking
- Attention deficit / hyperactivity
- Low autonomic and central nervous system arousal
- Hormonal factors
- Peer rejection in elementary school
- Association with drug using peers
- Laws / norms
- Availability
- Extreme economic deprivation
- Neighbourhood disorganisation

Adapted from Newcomb, Maddahian and Bentler (1986) and Hawkins and Catalano (1992)

More recent research has begun to look at the combined influence of risk factors through the use of risk factor indexes. Bry (1983) and Bry, McKeon & Pandina (1983) found a significant linear relationship between substance use and the number of risk factors. This demonstrated that the number of risk factors a person experiences is a more important predictor of adolescent drug use than any risk factor. This finding has been replicated in other studies. Newcomb, Maddahian & Bentler (1986) found that only 1% of students with no risk factors reported daily use of marijuana, compared with 56% of those with seven or more risk factors. Thus vulnerability increases with an increasing number of risk factors, such that individuals with greater vulnerability are more likely to engage in drug use.

A risk factor index has also been used to examine differences in exposure to and impact of risk factors according to demographic characteristics. Newcomb et al. (1987) conducted a study which examined the influence of sex, age, ethnicity and type of schooling on risk factors. Results indicated that the number of risk factors increased significantly by age; that certain ethnic groups were exposed to significantly greater number of risk factors, and that students in continuation school (students removed from regular classes due to adjustment problems in the standard curriculum) had a significantly higher number of risk factors than those attending regular school.

While knowledge about risk factors is helpful for the identification of children who are vulnerable they do not serve as a predictor for any individual child. The use of risk factors to label children also poses its own risk. Thus, increasing attention is being turned to identifying those factors that protect children from developing substance use problems.

Recent research in many areas of developmental psychology, has shifted from a focus on risk factors to an examination of the role of protective factors that moderate the effects of exposure to risk and the identification of factors that contribute to an individual's resiliency. Resilience, according to Rutter (1992), is concerned with individual variations in response to risk factors and protective factors and operates by modifying a person's response to a risk

situation. Applied to drug use, a focus on resilience would involve identifying the factors that differentiate between early drug users who go on to abuse drugs and those who do not make this transition. It is important that we strive to understand why some people respond to the combination of social and familial and individual risk factors in a more adaptive way than others. In relation to substance abuse, protective factors have been defined as “an individual attribute, individual characteristic, situational condition, or environmental context that inhibits, reduces, or buffers the probability of drug use or abuse or a transition in level of involvement with drugs” (Clayton, 1992, p. 20).

Since the literature on protection and adolescent substance use is only recently developed it is less extensive than the literature on risk factors. Newcomb (1992) looked at the influence of both risk and protective factors on substance use and abuse. He proposed that each psychosocial factor that is associated with drug involvement can be seen as bipolar. Based on this assumption a risk factor index and a protective factor index were constructed, which were composed of mutually exclusive factors that used only one end-point of influence. A factor was assigned to either the risk or protective index, on the basis of which of its extremes was more strongly related to levels of drug involvement. Results showed that both risk and protective factors were associated with inhibiting or accelerating the transition from substance use to substance abuse.

A more recent study, which examined substance use among a group of youths in late adolescence and again in early adulthood, tested a combined risk and protective factor model of adolescent substance use (Newcomb & Felix-Ortiz, 1992). Results highlighted that vulnerability, as measured by a risk factor index, a protective factor index and their interaction, was highly associated with substance use in adolescence. Vulnerability was also found to be moderately associated with certain types of substance use in young adulthood and strongly associated with heightened drug problems in adulthood. The authors argue that “protection may function in a manner similar to risk and should be operationalised as a multiple factor index” (p. 281).

The influence of protective factors is not merely defined by absence of risk, as protective factors have been found to make a unique contribution to explaining substance use, independent of the effects of risk factors. DeWit, Silverman, Goodstadt & Studota (1995) applied the risk and protective factor model to a Canadian sample. They examined the interaction between risk and protection and found a significant effect for two of the five substance use measures. This finding may indicate that the effect of protection is to dampen or moderate the influence of risk at higher levels, whereas it may have little or no effect when risk is low or absent.

The vast majority of the research in this area has been conducted using American samples. It cannot be assumed that the risk and protective factors identified in these studies are also associated with substance use in adolescent populations in other countries. In an Irish context, Grube and Morgan (1990) have pointed out that drug use may have very different meanings in Ireland than in North America. Cultural differences, differential social acceptability, differences in the prevalence of use and in the availability of substances to young people might affect the relationships between risk and protective factors and substance use. The present study aims to apply the risk and protective factor approach, in order to assess the association between risk and protective factors and substance use among an Irish adolescent population. The study also aims to test the hypothesis that extent of substance use is a function of number of risk factors.

## Method

### Sample

The sample consisted of 983 second year students in 16 schools in the Dublin metropolitan area. The schools were selected using a stratified random sampling technique. School stratified according to school type and socio-economic disadvantage, into four groups: vocational, secondary in disadvantaged area, secondary in non-disadvantaged area and private school. Approximately 1 in 6 schools were included in the sample. One special school, a school for travellers, was included in the sample. A balance of gender was aimed for although the final sample consisted of a higher proportion of girls than boys (58% and 42% of sample). The mean age of students was 14.38 years and the majority ( ) of students were 14 and 15 years of age at the time of the study.

### Response rates

Overall willingness to participate was high. Of the initial 17 schools approached only 3 schools deciding not to participate in the survey. Reasons given for non-participation included: concerns about negative publicity and the effect on school reputation, participation in previous research on substance use, and concern that it would make drug taking or anti-social behaviour more acceptable to students. In each case a refusing school was replaced from the original sampling list by a school matched on the stratification characteristics. Of the 3 replacement schools, one school decided not to participate, giving an overall response rate of 84%.

### Research Instrument

The research instrument used was a self-report questionnaire, a format commonly used in studies of adolescent substance use. The questionnaire was derived from three earlier questionnaires:

- (i) ESPAD in its British version (Hibell et al., 1997) – including the Youth Self Report (Achenbach, 1991).
- (ii) WHO ‘Health of the Youth’ questionnaire in a Lausanne version (Harkin et al., 1997) and
- (iii) A Youth Drug Use questionnaire previously piloted in Groningen.

Two items were also included from the questionnaire used in the ESRI surveys conducted in the 1980’s (Grube and Morgan, 1986, 1990).

The questionnaire covered a range of themes and included items on attitudes to and use of legal and illegal substances, anti-social behaviour, risk-taking behaviour, peer-affiliation, free-time activities, family structure, emotional and behavioural problems and adaptation to school.

## **Substance use variables**

This study includes 6 dependent variables: cigarette use, alcohol use, cannabis use, inhalant use, use of other illicit substances and a composite substance use score.

Frequency of use data was obtained for smoking, alcohol, and illegal substances. From this data three user groups were defined for five different substances or substance groups: cigarettes, alcohol, cannabis, inhalants, and all other illicit drugs. The category 'other illicit drugs' was composed of five listed substance (tranquillisers, ecstasy, amphetamines, LSD, Magic Mushrooms) and the 'other' category. These substances were grouped together as less than 5% of the sample reported use of any of them. Inhalant use was included as a separate substance use scale as use was reported by a larger proportion than the 'other illicit drugs' but a smaller proportion than cannabis. The way in which the three user groups were defined can be seen from Table 2.

It is important to distinguish between drugs since there are major differences due to pharmacological action, various social-psychological statuses, values, and expectations attached to drugs. However increasingly polydrug use has become more the norm than the exception with young people adopting a 'pick and mix' attitude, using different drugs depending on effect, occasion, and availability. A focus on specific drugs ignores the associations with other drugs. Because of this a composite substance use score was formed by summing the five drug use frequencies.

**Table 2 Definition of substance use groups**

Cigarettes (from single item have you ever smoked?)	
Group 1:	‘never’ or ‘once or twice’
Group 2:	‘now and again’ or ‘used to but have stopped’
Group 3:	‘daily’
Alcohol (from single item “How often do you drink the following alcoholic drink?”)	
Group 1:	‘never’ or ‘less than once a month’
Group 2:	‘once a month’
Group 3:	‘weekly’ or ‘daily’
Cannabis use (from item “Please fill in if you have taken these substance?” which included cannabis as one of seven listed substances)	
Group 1:	‘never’
Group 2:	‘last year’
Group 3:	‘last month’
Inhalant use (from item “Please fill in if you have taken these substance?” which included inhalants as one of seven listed substances)	
Group 1:	‘never’
Group 2:	‘last year’
Group 3:	‘last month’
Other drug use (from item “Please fill in if you have taken these substances?” combines responses regarding tranquillisers, ecstasy, amphetamines, LSD, and magic mushrooms)	
Group 1:	‘never’
Group 2:	‘last year’
Group 3:	‘last month’

## ***Risk and Protective Factors***

Twenty two risk and protective factors were chosen for which there was clear evidence in the literature of a predictive influence on drug use. While some factors may possibly be both predictors and consequences of drug use, it was thought that given the young age of the sample they were more likely to play a predictive role.

Risk and protective factors were divided into two domains for conceptual clarity and order: individual and interpersonal factors and contextual factors.

***Individual and Interpersonal Factors*** included: antisocial behaviour, attitudes, school-related factors, peer substance use, social inclusion, religion, social support, leisure activities and parental supervision.

***Contextual Factors*** included: availability, financial availability, parental employment and education, family structure and social class.

The way in which each factor was measured is described below.

### **Anti-social behaviour**

***Number of anti-social behaviours:*** A 14 item scale with yes / no response categories examines engagement in anti-social behaviour (the 14 behaviours listed ranged from not paying on a bus to hitting someone so that they needed medical treatment).

***Involvement with the police:*** A single item with yes / no response categories asked whether respondents had ever been caught or arrested by the police.

***Bullying:*** A single item measured frequency of having bullied other students during the last school year, with five response categories ranging from ‘never’ to ‘several times a week’.

### **Attitudes toward substance use**

Two measures of attitudes toward substance use were included: a perceived danger of drug use score and a ‘consequences of alcohol use’ score.

***Total perceived risk of drug use:*** Perceived danger of alcohol, tobacco, cannabis, ecstasy and heroin use was measured using a five-item scale with three response categories ranging from ‘not dangerous at all’ to ‘very dangerous’ (those answering ‘don’t know’ were excluded from analysis).

***Consequences of alcohol use:*** An eleven-item scale, with five response categories ranging from ‘very likely’ to ‘very unlikely’, looked at positive and negative consequences of alcohol use (e.g. “How likely is it that each of the following would happen to you personally if you drank alcohol – free more friendly and outgoing”).

## **School related factors**

*School enjoyment:* Whether respondents enjoyed school was measured using a single item with four response categories ranging from ‘never’ to ‘always’.

*School attendance:* A single item measuring number of whole school days missed during the past month due to truancy, with four response categories ranging from ‘none’ to ‘more than five days’.

*School performance:* A single item measured respondents perception of their academic ability with five response categories ranging from ‘well above average’ to ‘well below average’.

*Academic aspirations:* A single item measured respondents expected activity at age of 17, with five response categories ranging from ‘at school (general education)’ to ‘unemployed’.

## **Peer substance use**

*Peer substance use:* An eight-item scale measuring number of close friends using alcohol weekly, smoking daily or using tranquillisers, cannabis, cocaine, ecstasy, amphetamines or other drugs. Three response categories were given ranging from ‘no-one’ to ‘a few’.

## **Social Inclusion**

*Number of friendships:* A five-item question examining presence of types of friendships, including best friend, boy / girlfriend, with yes / no response categories.

*Romantic relationships:* A single item measuring whether respondent had a boy or girl friend.

## **Religion**

*Religious salience:* A single item measured the importance of religion in respondents everyday life with five response categories ranging from ‘very important’ to ‘very unimportant’.

## **Leisure activities**

*Involvement in sport:* A single item measured respondents type of involvement in sports, with 3 response categories ranging from ‘no’ to ‘yes, in a club’.

*Club membership:* A single item measured club membership with yes / no response categories.

**Boredom:** A single item measured frequency with which respondents experienced boredom, with 4 response categories ranging from ‘never’ to ‘very often’.

### **Parental supervision**

**Parental supervision:** A four-item scale measured parental supervision by asking if parents said anything in four different disciplinary situations, with three response categories ranging from ‘yes, often’ to ‘no, never’ (e.g. “Do your father and mother ever say anything when you stay up late at night?”).

### **Social support**

**Social support:** A single item asked who respondents could talk to if something was troubling them. A score, ranging from zero to seven, indicated the number of people respondents could go to for social support.

### **Availability**

**Number of drug offers:** A nine item scale measured the types of drugs that had been offered to respondents. The eight response categories which examined where the drug offer had taken place were collapsed into two response categories – ‘never offered’ and ‘have been offered’.

**Physical availability of cannabis:** A single item measured respondents knowledge about where to obtain cannabis with four response categories ranging from ‘yes, without a problem’ to ‘no, not very easily’.

**Financial availability:** A single item measured amount of money available to respondents per week.

### **Parental employment and education**

**Parental employment:** A single item asked about occupational status of mother and father. From this item a three-point scale was constructed which ranged from ‘2 parents working’ to ‘no parents working’.

**Parental education:** A single item asked about the highest level of schooling achieved by respondents’ father and mother.

### **Family structure**

**Family structure:** A single item asked respondents to list the people who lived at home with them. Responses were categorised as ‘intact families’, defined as having two parents living in the home, and ‘non-intact families’, defined as all other family structures.

## Social class

**Social class:** Based on the sampling method, schools were divided into three socio-economic groups. Socio-economic group 1 consisted of vocational schools and secondary schools in disadvantaged areas. Socio-economic group 2 consisted of secondary schools in non-disadvantaged areas. Socio-economic group 3 consisted of private schools.

## Procedure

A letter was sent to parents of all second year students in each participating school. The parent letter gave a brief outline of the study, described the questionnaire and gave parents the option of refusing permission for their child to take part in the study (by returning a slip to the school).

A trained researcher administered the questionnaires either during regular classroom periods or in year group assemblies. Before completing the questionnaire the researcher explained the purpose of the study and reassured students as to the anonymity and confidentiality of their responses. Students were asked to fill in the questionnaires on their own and it was emphasised that for the study to be worthwhile it was important that they give honest answers. It was also emphasised that this was an opportunity to express their own opinions and students were asked to put any comments in the allotted space at the end of the questionnaire. They were asked not to put their names on the questionnaire. These points were reiterated in the written instruction at the start of the questionnaire and an extra note regarding the anonymity of students answers was put at the start. The aims and nature of the survey were explained to students and the fact that the survey was voluntary, confidential and anonymous was emphasised. In most cases teachers were not present during the time it took students to complete the questionnaire (9 out of 16 schools). This was not possible in every school due to disciplinary concerns. Students were usually given between 60 and 80 to complete the questionnaire.

There was a very positive response to the questionnaire by students in all sixteen participating schools. Excluding absentees and questionnaires excluded from analysis because of inconsistencies or other defects (8 questionnaires), 983 students completed the survey.

## Results

The 22 risk and protective factors examined in the questionnaire were used to create risk and protective factor indices adapting a procedure outlined by Newcomb and Felix-Ortiz (1992). This procedure involved several steps. The first step involved performing a series of univariate analyses, which identified 18 of the 22 factors, as having a significant association with at least one of the substance use variables. The next step involved a series of multidiscriminant analyses and a multiple regression analysis in order to determine whether each risk and protective factor contributed a unique portion of variance to understanding substance use. Five separate multidiscriminant analyses were performed using the substance use variables (cigarette, alcohol, cannabis, inhalant and other drug use) as criteria and the risk and protective factors as predictors. A multiple regression analysis was also run using the 18

risk and protective factors as independent variables and the composite substance use score as dependent variable. Eleven of the risk and protective factors were thus found to contribute significant and unique variance in predicting at least one of the six substances use variables. These factors were: number of anti-social behaviours, police involvement, having bullied others, perceived risk of substance use, school attendance, peer substance use, having a boyfriend or girlfriend, number of drug offers, availability of cannabis, available money, and religious salience. Some of these factors were better predictors than others, in that they accounted for a larger portion of variance, or were found to act as predictors for more than one of the substance use variables. Peer drug use accounted for the largest portion of the variance for cigarette and alcohol use. Number of antisocial behaviours accounted for the largest portion of variance for the measure of cannabis use and the composite drug use score. Number of drug offers accounted for the largest portion of variance for both inhalant use and other drug use.

In step three of the procedure, in order to construct the indices, cut-points were imposed on the top and bottom 20 – 30% of the distributions of scores for each of the eleven factors identified in step two. Cut-points were used to create a pair of hypothesised “risk” and “protective” dummy variables (RDV and PDV) for each factor. For example, looking at ‘number of drug offers’ as an index of scores, the top 20% to 30% (those reporting a high number of drug offers) were given a score of “1” on the dummy risk variable and all else scored zero. Likewise, the bottom 20 – 30% (those who reported low number of drug offers) were given a score of “1” on the dummy protective variable and all else were given a score of zero. A summary of each risk / protective factor, its range, cut off point and the percentage of sample scoring 1 on the RDV and PDV is given in Table 3. The dummy risk and protective variables were correlated with the composite substance use score (CSUS) in order to determine which end of influence was the strongest (Table 4). Thus, for each factor, if the correlation between the dummy risk variable and the CSUS was greater than the correlation between the dummy protective variable and the CSUS, the variable was assigned to the risk factor index. In the same way, if the correlation between the dummy protective variable and the CSUS was greater than the correlation between the dummy risk variable and the CSUS, the variable was assigned to the protective factor index.

**Table 3. Risk / Protective factors, identified as significant predictors of substance use, and cut-points used to create a pair of hypothesised dummy risk and protective variables.**

Risk / Protective Factors	Range	Cut-point	% receiving score of 1 on DRV and DPV
<i>Number of delinquent behaviours</i>	<i>0-11</i>	$\geq 5$ <b>0</b>	<b>28.7 (DRV)</b> <b>18.9 (DPV)</b>
Involved with police	0-1	1	23.4 (DRV)
Bullying	0-4	$\geq 1$	28.0 (DRV)
Perceived risk of substance use	1-3	$\leq 2.33$ <b><math>\geq 2.8</math></b>	22.5 (DRV) <b>30.4 (DPV)</b>
School attendance	0-3	$\geq 1$	24.8 (DRV)
Peer substance use	0-16	$\geq 5$ <b>0</b>	23.1 (DRV) <b>21.3 (DPV)</b>
Boy / girlfriend	0-1	1	26.4 (DRV)
Religious salience	0-4	$\leq 1$ <b><math>\geq 4</math></b>	31.6 (DRV) <b>33.7 (DPV)</b>
Number of drug offers	0-33	$\geq 3$	28.8 (DRV)
Availability of cannabis	0-3	$\geq 3$ <b><math>\leq 1</math></b>	45.1 (DRV) <b>28.7 (DRV)</b>
Financial availability	0-300	$\geq 15$ <b><math>\leq 5</math></b>	33.2 (DRV) <b>28.3 (DPV)</b>

Note: DRV = dummy risk variable, DPV = dummy protective variable

Table 4. Correlations between the dummy risk and protective variables and the composite substance use score

Risk and Protective Factor	Dummy Risk or Protective Variable	r with composite substance use score
Number of crimes	DRV	.497*
	DPV	-.345*
Involvement with police	DRV	.416*
Bullying others	DRV	.226*
Perceived risk of drug use	DRV	.387*
	DPV	-.344*
School attendance	DRV	.438*
Peer substance use	DRV	.5089*
	DPV	-.4877*
Boy / Girlfriend	DRV	.295*
Religious Saliency	DRV	.172*
	DPV	-.139*
Number of Drug Offers	DRV	.501*
Availability of Cannabis	DRV	.488*
	DPV	-.365*
Available money	DRV	.231*
	DPV	-.195*

Note: DRV = dummy risk variable, DPV = dummy protective variable,  $p \leq .01$  (2 tailed)

*Since all of correlations with composite substance use score were higher on the dummy risk variable than for the dummy protective variable, all factors were assigned to the risk factor index. A risk factor score was created by summing each of the risk factors. The index ranged from zero to 11, with zero indicating no risk factors and 11 indicating 11 risk factors. However, only a small proportion of students scored nine or above. As a result those who scored nine or above were grouped together in order to create a smooth decreasing distribution of risk factors.*

Table 5. Differences in number of risk factors by gender

Number of risk factors	GENDER				TOTAL	
	Male		Female			
	<i>(N = 570)</i>		<i>(N = 409)</i>		<i>(N = 979)</i>	
	N	%	N	%	N	%
0	52	12.7	114	20.0	166	17.0
1	63	15.4	117	20.5	180	18.4
2	55	13.4	96	16.8	151	15.4
3	54	13.2	75	13.2	129	13.2
4	51	12.5	50	8.8	101	10.3
5	35	8.6	42	7.4	77	7.9
6	26	6.4	27	4.7	53	5.4
7	27	6.6	13	2.3	40	4.1
8	24	5.9	17	3.0	41	4.2
9 or more	22	5.3	19	3.3	42	4.2

***Table 5 provides the number and percentage of subjects scoring zero to nine on the risk factor index for the total sample and separately by gender. The modal number of risk factors was one.***

Some gender differences emerged in the number of risk factors, with a higher percentage of females (57.8%) than of males (41.5) having two or less risk factors and a higher percentage of males (24.2%) than females (13.3%) having six or more risk factors (Table 5). The mean number of risk factors among male students (3.54) was higher than the mean among female students (2.64) and a t-test confirmed that these differences were significant ( $t = -5.54, p < .001$ ) (Table 6).

In order to assess whether risk factors were related to socio-economic factors and school type, differences in the mean number of risk factors were examined between three socio-economic school groups and between the five school types. Significant differences were found between socio-economic school groups in the mean number of risk factors  $F(2,970) = 3.79, p < .05$  (Table 6). Follow-up testing using the Scheffe method indicated that the mean number of risk factors among students in the lower socio-economic group (3.28) was significantly higher than the mean number reported by students in the higher socio-economic group (2.68). Significant differences were also found between the five school types in mean number of risk factors,  $F(4,978) = 4.38, p < .01$  (Table 6). Follow-up testing revealed that the mean number of risk factors among students in the vocational schools (3.72) was significantly higher than the mean number reported by students in both voluntary schools in non-disadvantaged areas (2.95) and private schools (2.68).

In order to assess how the number of risk factors is related to each of the substance use variables, a one way analysis of variance was conducted comparing the mean scores on the risk factor index between user groups on the five substance use variables. As expected, significant group mean differences were found for all five substance use variables, with a higher number of risk factor associated with a higher level of involvement in substance use (see Table 7).

A strong correlation was found between the composite substance use score and the risk factor index (Pearson Correlation = .716,  $p < .001$ ).

Table 6. Differences in mean number of risk factor by gender, socio-economic school group, and school type.

Demographic characteristics	Risk Factor Index
<i>Gender:</i>	
Male	3.54
Female	2.64
t	-5.540**
<i>Socio-economic school group:</i>	
Group 1 (lower)	3.28c
Group 2 (middle)	2.95
Group 3 (higher)	2.68a
F	3.79*
<i>School type:</i>	
Vocational	3.72cd
Voluntary disadvantaged	3.01
Voluntary non-disadvantaged	2.95a
Private	2.68a
Special	1.80
F	4.38**

Note: \*  $p < 0.05$  \*\*  $p < 0.01$

Table 7. Correlations between the risk index score and substance use variables

USER GROUPS	TYPE OF SUBSTANCE				
	Smoking	Alcohol	Cannabis	Inhalants	Other drugs
Group 1	2.04 <sup>bc</sup>	1.99 <sup>bc</sup>	2.10 <sup>bc</sup>	2.63 <sup>bc</sup>	2.60 <sup>bc</sup>
Group 2	3.51 <sup>ac</sup>	3.31 <sup>ac</sup>	4.89 <sup>ac</sup>	4.85 <sup>ac</sup>	6.72 <sup>a</sup>
Group 3	5.56 <sup>ab</sup>	5.64 <sup>ab</sup>	6.14 <sup>ab</sup>	6.51 <sup>ab</sup>	7.12 <sup>a</sup>
F	162.56***	219.16***	288.76***	99.50***	164.67***

Note: \*\*\*  $p < 0.001$

## Discussion

The findings indicate that a number of risk factors, which operate in different domains, are significantly associated with levels of substance use among adolescents in Dublin and that the number of risk factors a person experiences is an important predictor of the level of substance use they engage in.

Some of the findings are in keeping with the results of previous studies which utilised a multivariate analysis of risk and protective factors. Looking at the relative influence of factors in the different domains the finding that peer related variables were stronger predictors than family and school related factors is similar to the results reported by DeWit et al. (1995) and by Newcomb, Maddahian, Skager and Bentler (1987). Previous research has found that peers are more important for initiation of drinking behaviour but parents are more important for establishing the setting, frequency and pattern of drinking (Swadi & Zeitlin, 1988). Thus it is possible that, if other aspects of substance use were examined, parent related variables such as parent supervision may have been found to be more influential than peer related variables. Perceived risk was found to account for a unique portion of the variance for four of the six substance use variables. This is a wider breadth of influence than was found by DeWit et al., who reported that a similar variable acted as a predictor of frequency of illegal drug use but not of the other substance use variables included in their study. Demographic and socio-economic factors were not found to be significant predictors of any measure of adolescent drug use, which is in keeping with previous findings (e.g. DeWit et al., 1995).

It is interesting that availability emerged as the most influential factor for both inhalant use and use of other illicit drugs. This factor is sometimes excluded from studies of risk factors (e.g. DeWit et al., 1995; Newcomb et al., 1987) which, given the results of the present study

would appear to be a major shortcoming. Financial availability, or the amount of money at a young person's disposal, also emerged as an important factor in the present study. This factor was not found to contribute to variance in substance use in previous studies (DeWit et al., 1995). It is possible that factors associated with availability (both drug offers and amount of weekly spending money) are particularly influential in an Irish context.

It is also clear from the results that behavioural variables and specifically those behaviours which have been described as problem behaviours – anti-social behaviours, involvement with the police and truancy – account for a significant portion of the variance for all of the substance use variables. This finding lends support to the problem behaviour theory which proposes that adolescents' smoking, drinking, drug use and other problem behaviours form a single dimension that reflects a more general underlying tendency to non-conformity or deviance (Jessor & Jessor, 1978). Previous research has found that a single dimension of general deviance accounts for the majority of the covariance among specific problem behaviours and that this factor is predictive of involvement in these behaviours at a later point in time (Osgood, Johnston, O'Malley & Bachman, 1988; Newcomb & Bentler, 1988). However, previous research that applied the problem behaviour theory to an Irish setting concluded that substance use among Irish adolescents was relatively independent of a general tendency towards deviance (Grube & Morgan, 1990b). Taking into account the fact that the previous study was based on data collected during the 1980s, it is possible that the stronger relation with problem behaviours found in the present study is due to the fact that substance use has now become more common among young people. The present results may reflect the fact that substance use is no longer seen as an extreme form of deviance any more and thus is more strongly associated with other problem behaviours commonly seen in adolescence.

The results indicate that the factors associated with substance use in adolescence can vary depending on the type of substance use under study. This justifies the use of separate substance use variables in addition to a composite substance use score in selecting factors to be included in a risk factor index. For example, using the composite substance use score alone would not have revealed the predictive value of having a boyfriend or girlfriend for the use of drugs other than cannabis and inhalants. The results indicate differences in the pattern of influence on licit and illicit substance use, with peer related factors having a stronger influence on licit substance use (smoking cigarettes and drinking alcohol) and availability having a stronger influence on illicit substance use.

***The results of the present study replicate the findings of previous research using a risk factor index (DeWit, 1995); Newcomb & Felix-Ortiz, 1992; Bry et al., 1982). This suggests that there are multiple pathways to the misuse of substances and the number of factors of person experiences is more important than the nature of any individual factor. Each factor can be reviewed as "one factor in a cumulative ecology of influences that are associated with increased drug involvement" (Newcomb et al., 1987, p. 428).***

While all measures of substance use were significantly correlated with the risk factor index, differences were found in the effectiveness of the risk factor index at accounting for different types of substance use. The substance use variables which had the strongest correlation with the risk factor index was cannabis use, followed by alcohol use, use of other illicit substances and smoking cigarettes. Inhalant use had the weakest correlation. This is in keeping with the findings of previous studies. Newcomb et al. (1987) found that the risk factor index was most strongly related to alcohol and cannabis use, but least strongly related to cocaine use and hard drug use. They suggest that risk factors are most closely related to beginning drug

use (cigarettes, alcohol and cannabis) and that other processes become important with increased drug involvement with the harder drugs. In relation to inhalant use, the present findings suggest that a different range of factors are associated with levels of use of inhalants or that there are different pattern of influence, as compared to the use of other substances.

Differences were also found in terms of exposure to risk factors between boys and girls and between students attending different types of school. Boys were found to experience significantly more risk factors than girls, suggesting that boys are at higher risk of substance use than girls. Differences between school types revealed that students in vocational schools experienced significantly more risk factors than students in both private and voluntary schools in non-disadvantaged areas. The findings are somewhat in keeping with the findings of previous research. Newcomb et al. (1987) looked at associations between risk factors and sex and type of school. While no gender differences were reported, students attending continuation schools (roughly equivalent to vocational schools in that both school types cater for students who have problems with the general curriculum reported more risk factors than students in regular schools.

An attempt was made to extrapolate from the multiple risk factor model and to create a multiple protective factor index. For all of the factors examined however the end of influence associated with risk was found to be stronger than end associated with protection. This lack of significant protective effects may be indicative of developmental functions. Scheier et al. (1994) found that protective influences appear to have their greatest period of activity for students in the seventh grade (aged 12 – 13 years) and more limited although present, influences for ninth and eleventh graders (aged 14 – 15 years and 16 – 17 respectively). Thus a younger age group than the present sample may have yielded some significant protective factors. Scheier et al. also highlight the fact that late adolescence involves an increasingly complex social psychological milieu which may result in greater opportunity to utilise and be affected by the influence of protective factors. This suggests that protective factors may also play a more influential role among an older adolescent sample.

The finding that the more risk factors an individual experiences the more likely they are to engage in substance use has obvious implications for prevention. It allows for the possibility of identifying those children who are most at risk of substance misuse and designing programmes that aim to maximise their resilience and minimise the risk. Many researchers in the area have pointed to such an approach as the most effective for future prevention work (e.g. Emshoff, 1989; Meyer, 1994).

The results also reveal a strong association between substance use and other types of problem behaviours, including truancy and anti-social behaviour. This would suggest that programmes which influence one type of behaviour will influence the others. Indeed some researchers are beginning to advocate a more systemic approach to prevention, instead of the traditional approach of developing separate prevention programmes to combat these issues. High quality, comprehensive competence-promoting programmes that are designed to influence both the children and their immediate environments are the new wave for addressing these complex problems (Weissberg, Caplan, and Harwood, 1991).

The implications of this type of study for prevention measures are huge. A clearer understanding of the factors leading to abuse and the interactions between factors would allow prevention measures to be tailored to target the behaviours or characteristics that are

commonly associated with substance abuse. According to Hawkins et al. (1992) “the most promising route to effective strategies for the prevention of adolescent alcohol and other drug problems is through a risk focussed approach” (p. 64).

The study provides evidence that factors from several environmental domains (e.g. individual, peer group, family, community) influencing substance use. To date, prevention programmes have focussed on single domains of influence; such as programmes that aim to increase individual decision making skills and self esteem. The results suggest that what is needed are comprehensive programmes which attempt to effect change within different environmental contexts, e.g. combining community based programmes which attempt to address negative peer influence and attitudes towards perceived risk.

## CHAPTER TEN

### ***DIAGNOSIS AND DIFFERENTIAL DIAGNOSIS OF ASPERGER'S SYNDROME/DISORDER***

Michael Fitzgerald and Aiden Corvin.

#### **Introduction**

*Hans Asperger (1944) described a condition he called autistic psychopathy, characterised by problems in social integration, non-verbal communication, idiosyncratic verbal communication and an egocentric preoccupation with unusual and circumscribed interests. Patients with this condition had problems with empathy, intuition, and a tendency to intellectualisation. They were also clumsy (50-90% having motor co-ordination problems), had difficulty taking part in team sports, and exhibited behavioural difficulties including aggression and as victims of bullying. Asperger and others have described these patients as producing “fantastic” stories a trait that can lead to difficulties in reality testing and confusion with schizophrenia.*

*Lorna Wing (1981) renewed interest in the condition, which she renamed Asperger's syndrome and Christopher Gillberg (1991) set out six clinical criteria for its diagnosis:- (1) Social impairments, (2) Narrow interests, (3) Repetitive routines, (4) Speech and language peculiarities, (5) Non-verbal communication problems, (6) Motor clumsiness. Inclusion of the syndrome in both ICD-10 (WHO 1982) and DSM-IV (APA 1994) classification systems has resulted in broad clinical recognition of the diagnosis. The American Psychiatric Association (APA, 1994) termed the condition Asperger's disorder and based diagnosis on impairment in social interaction and the presence of stereotypic or repetitive behaviours (see Box 1). Diagnosis requires that the impairment is clinically significant, occurs before age 3, and excludes clinically significant delay in language, cognition or other skills. The ICD-10 research criteria (WHO 1993) are virtually identical.*

The DSM-IV (APA, 1994) criteria are quite different from criteria proposed by either Wing (1981) or Gillberg (1991). Wing (23) recognised the following difficulties in the first two years of life of patient's with Asperger's syndrome:-

- a. A lack of normal interest and pleasure in people around them.
- b. A reduction in the quality and quantity of babbling.

- c. A significant reduction in shared interests.
- d. A significant reduction in the wish to communicate verbally or non-verbally.
- e. A delay in speech acquisition and impoverishment of content.
- f. No imaginative play or if it does occur it is confined to one or two rigid patterns.

Clearly Asperger's syndrome as defined by Wing or Gillberg, differs from Asperger's disorder (APA, 1994) in including speech and language difficulties in their criteria. As the vast majority of persons with Asperger's disorder do have speech and language abnormalities it is hoped that future text revisions of DSM-IV may correct this anomaly. This paper examines the differential diagnosis of Asperger's syndrome (Wing, 1981) and disorder (APA, 1994): we begin with the more common and finish with the less common causes of diagnostic confusion.

### ***Differential Diagnosis***

#### **(1) OTHER PERVASIVE DEVELOPMENTAL DISORDERS (PDD)**

##### **a) Autism/ Autism Spectrum Disorders (ASD's) (APA, 1994)**

Autism shares the same criteria for abnormal social interaction and behaviour as Asperger's disorder, but requires additional impairments in communication (see box 2). DSM-IV requires a delay or abnormal functioning in social, communication and behavioural domains before age three. In this classification, if both diagnoses can be made Autism takes preference. In practise diagnostic systems which separate Asperger's syndrome from the autistic spectrum disorders (ASD's) have not been satisfactory. Both disorders segregate within the same families, and share the same co-morbidity. Several authors have suggested that patients with Asperger's syndrome have higher verbal than performance IQ, and that the reverse discrepancy is found in high functioning autism. Language abnormalities can be a feature of Asperger's syndrome and current research data does not support their separation into different classifications (Prior and Ozonoff 1998). If autism and Asperger's syndrome differ at all it is in the degree of impairment rather than in having discrete, specific and independent features. Combining both into an Autistic Spectrum (Wing, 1996) is a better way forward.

The epidemiological characteristics of these disorders (ASD's) are unclear but an international prevalence of 5-22 per 10,000 is suggested. These disorders are approximately 8-10 times more common in boys than in girls.

##### **b) Pervasive Developmental Disorder Not Otherwise Specified (PDDNOS) (APA, 1994)**

***Another diagnosis of relevance is PDDNOS which is characterised by "a severe and pervasive impairment in the development of reciprocal social interaction or verbal and non-verbal communication skills or when stereotyped behaviour, interests and activities are present". This category in DSM-IV needs to be revised as the inclusion of two "or's" greatly dilutes the meaning of the category and grossly widens it as a category (Fitzgerald, 1999). It would be quite useful if it included at least two out of the major criteria of autism from autistic disorder criteria DSM-IV as described above. Indeed this is how many***

*careful clinicians make the diagnosis. In the past particularly in the United States PDDNOS was used as a synonym for Asperger's syndrome, though for parents this title is unhelpful and confusing.*

c) Rett's disorder

*Rett's disorder is characterised by apparently normal development in the first five months of life and subsequent deceleration of head growth, loss of previously acquired hand skills, loss of social engagement, poorly co-ordinated gait and language problems. The disorder is not part of the autistic spectrum and is unlikely to be of major relevance to most adult psychiatrists.*

d) Childhood disintegrative disorder

*This disorder presents following a two-year history of normal development with loss of skills e.g. language, bowel and bladder control as well as motor skills. There are also problems in social interaction, communication and stereotypical patterns of behaviour. Obviously a detailed and accurate developmental history is vital for making the diagnosis.*

## **(2) SCHIZOPHRENIA SPECTRUM DISORDERS**

a) *Schizophrenia* (APA, 1994)

Anecdotal evidence would suggest that in the past many patients with Asperger's syndrome were diagnosed as schizophrenic, often of the simple or latent subtypes. In describing simple schizophrenia, Bleuler (1911) described social withdrawal and affective flattening; he also pointed out the "oddness" and "eccentricity" of latent schizophrenics. Kraepelin (1919) described a similar subgroup of his schizophrenia patients as being timid, with a narrow circle of interests, cold relations to companions and lacking sympathy or attachment. These descriptions and Bleuler's 4A's apply more closely to the autistic spectrum disorders than to schizophrenia. Simple schizophrenia has been described as a "diagnostic wastebasket" (Lewis, 1936) with vague or contradictory criteria, it has been removed from DSM-IV, though it is retained in ICD-10. Most of these patients would now be classified as having ASD, and with an accurate developmental history such diagnostic confusion should be avoided. A recent paper by Kendler et al. (1994) highlights the problem. In describing case vignettes of schizophrenic patients three cases include characteristics such as "shy", "avoiding eye contact", "no social contacts", "odd", "slow monotonous voice", and "awkwardness when meeting people". One cannot make a definitive diagnosis from a brief case vignette but these features do suggest Asperger's syndrome.

*Despite the difficulties that Asperger's syndrome patients have with understanding the subtleties of social behaviour, the similarities with schizophrenia are more apparent than real. Attwood (1998) describes how this misdiagnosis can occur - "when a psychiatrist asks (a person with Asperger's syndrome) - Do you hear voices? - the response is likely to be yes. This is due to a literal interpretation of the question... A subsequent question may be - Do you hear voices of people who aren't there? This can also receive the reply yes. Further questioning reveals the answer is based on hearing people talking from an*

*adjacent room". In addition to concrete thinking, by being deficient in understanding how other minds think, patients with Asperger's syndrome can misinterpret what is said, and themselves be labelled paranoid. Misinterpreting social contacts can also lead to inappropriate emotional responses and contribute to the impression of affective flattening (Wing, 1997). Persons with Asperger's syndrome sometimes speak their thoughts out loud, which again can be misinterpreted by a psychiatrist. Language abnormalities include substitutions, literalness, problems with prosody, staccato speech, and monotonous speech that is excessively pedantic and focussed on details or obsessive questions. A tendency to direct the conversation towards obsessions could easily be mistaken for showing evidence of associative loosening. Ramsey et al. (1986) in their study of thought disorder and affective flattening in autistic and schizophrenic patients found that they did not differ in terms of affective flattening but that adults with autism showed significantly less derailment and illogicality. Adults with autism did show a high degree of poverty of speech, poverty of content, as well as perseveration. While schizophrenia and autism spectrum disorders differ in age at onset, developmental history, and mental state examination, diagnosing psychosis in individuals with ASD is obviously difficult. Nevertheless, Volkmar and Cohen (1991) conclude that the frequency of schizophrenia in individuals with autism is 0.6 % (comparable to the general population).*

**b) Schizoid Personality in Childhood (Wolff and Chick, 1980)**

*The core features of Schizoid Personality of Childhood (Wolff and Chick, 1980) include solitariness, lack of empathy, emotional detachment, increased sensitivity, at times paranoid ideation, and single-minded pursuit of special interests. All these features are seen in Asperger's syndrome and there is overlap between schizoid personality in childhood and Asperger's syndrome. Co-morbid issues are likewise similar for both conditions i.e. depression or behaviour problems in particular. Indeed Tsai (1992) points out that schizoid disorder is "defined so loosely that it could include the more high functioning but withdrawn autistic people". In Sula Wolff's most recent writing (1998) on schizoid personality in childhood, the present authors concluded on the basis of the evidence presented that there was significant overlap between Asperger's syndrome and schizoid personality of childhood.*

**c) Schizotypal Personality Disorder (APA, 1994)**

*The core features of Schizotypal Personality Disorder (APA, 1994) include odd beliefs or magical thinking, bizarre fantasies or preoccupations, odd thinking and speech, odd eccentric or peculiar behaviour and appearance, as well as lack of close friends and social anxiety. There are similarities between this condition and Asperger's syndrome and indeed Wing (1997) points out that all these criteria can also occur in Asperger's syndrome. In addition Szatmari (1998) points out that Wolff (1995) regards "Asperger's syndrome and schizoid / schizotypal disorders as interchangeable terms that identify roughly the same group of children". Meijer and Treffers (1991) note that it may be quite difficult in children to separate schizotypal personality disorder from atypical PDD. In the same vein Volkmar (1988) points out the difficulty of differentiating schizotypal personality disorder from insidious early onset schizophrenia in children with a life long personality abnormality. The conditions do differ in a number of respects. Some persons with schizotypal personality disorder have "a developmental history free of impairments in*

*reciprocal social interaction and communication” (Szatmari, 1998). There appears to be an increased rate of the development of schizophrenia in schizotypal personality disorder, and these disorders are genetically related at least in adults. As previously mentioned the rate of development of schizophrenia in ASD is no greater than would be expected by chance.*

### **(3) ATTENTION DEFICIT HYPERACTIVITY DISORDER (APA, 1994)**

*The core features of Attention Deficit Hyperactivity Disorder (ADHD) are inattention, distractibility, fidgetiness, impulsivity and hyperactivity. Persons with high functioning autism spectrum disorders may be hyperactive, impulsive, have a short attention span, and also executive function deficits like patients with ADHD. The conditions differ in that ADHD patients lack the classic impairment in reciprocal social interaction, narrow interests, repetitive routines and non-verbal problems of persons with Asperger’s syndrome. There is a hierarchical rule in DSM-IV (APA, 1994) in that if a person meets the criteria for a Pervasive Developmental Disorder they cannot be diagnosed as having ADHD but this does not apply in ICD10 (WHO, 1992) where a dual diagnosis of Asperger’s syndrome and ADHD is possible.*

*Gillberg and Ehlers (1998) point out that children who meet criteria for ADHD – “sometimes meet full criteria for Asperger’s syndrome”. These authors go on to state that “in one study, 21% of children with a severe problem of this kind met full criteria for Asperger’s syndrome (Gillberg 1989, and Gillberg et al. 1989) and a further 36% had some autistic traits” (Gillberg, 1983). A developmental history is usually sufficient to separate ADHD from Asperger’s syndrome, but ADHD can present as soon as the child can walk, and it is important to consider that impulsivity can interfere with social relationships, making children appear unempathic (Whelan and Henken, 1992). Indeed ADHD children can be so distractible that they appear in “a world of their own” and therefore appear socially disconnected (Towbin, 1997). It is not surprising therefore that children with Asperger’s syndrome are not uncommonly misdiagnosed as having ADHD when in clinical practice it is the attention and hyperactive problems that parents often first observe as problems.*

### **(4) OBSESSIVE COMPULSIVE DISORDERS (APA, 1994)**

*The core features of obsessive compulsive disorder are recurrent and persistent thoughts, impulses, or images that are experienced at sometime during the disturbance as intrusive and inappropriate and that cause marked anxiety or distress. A person recognises that the obsessional thoughts, impulses or images are a product of their own mind. Compulsions involve repetitive behaviours or mental acts that the person feels driven to perform. The behaviour or mental acts are aimed at preventing or reducing the stress or preventing some dreaded event or situation. In adulthood a person recognises that they are excessive or unreasonable but this does not apply to children (APA, 1994). Wing (1997) notes that OCD phenomena including the urge to count and manipulate numbers, to repeat the same action over and over again are similar to the repetitive routines of persons with Asperger’s syndrome. Persons with both conditions can also display ritualistic behaviour and resistance to change. Where they differ is that persons with Asperger’s syndrome have “obsessive” interests which are not experienced as ego-dystonic and indeed are often*

*enjoyed (Szatmari, 1998). Compulsions and obsessions are less elaborate in Asperger's syndrome and tend to be more concrete and stereotypic (McDougal et al., 1995). OCD generally has a much later onset and lacks the poor social-emotional reciprocity, empathy problems and social skills difficulties of persons with Asperger's syndrome (Szatmari, 1998). Baron-Cohen (1989) was critical of the use of the term obsession in persons with autism because the subjective phenomena of resistance to repetitive activities could not be discerned in autism and he suggested instead the phrase "repetitive activities" for this phenomenon. In terms of co-morbidity depression and anxiety would be quite common in both conditions. Once again the early developmental history is key to making a differential diagnosis.*

## **(5) AFFECTIVE DISORDERS**

*Despite some overlap in symptomatology (including social withdrawal, lack of emotional response, and loss of interest in relationships) affective disorders differ in representing a distinct change from premorbid functioning, and typically are associated with an onset in adulthood. Epidemiological studies of psychiatric co-morbidity are lacking in individuals with autistic spectrum disorders but depression, anxiety disorders and bipolar disorder occur more commonly than in the general population and represent substantial morbidity (for review see Howlin, 2000).*

## **(6) OVERLAPPING DIAGNOSTIC CATEGORIES**

### **a) Semantic Pragmatic Disorder (Rapin and Allen, 1983)**

*This is probably not an uncommon cause of misdiagnosis. Children with autistic spectrum disorders often have some language difficulties and therefore will attend a speech therapist in the first incidence and receive a diagnosis of Semantic Pragmatic Disorder. Semantic Pragmatic Disorder is characterised by "near-normal vocabulary, grammar, and phonology, but language use is abnormal in content and function and comprehension is also impaired. There are considerable difficulties in initiating or sustaining a conversation, making cohesive links in conversation from topic to topic, and words are used out of context" (Szatmari, 1998). This is an exact description of the language problems of Asperger's syndrome.*

The differences of course are that there is no reference in this definition to reciprocal social and emotional interactional problems and no reference to repetitive and stereotyped patterns of behaviour. The existence of Semantic Pragmatic Disorder as a separate entity is highly uncertain. Indeed Allen and Rapin (1992) now believe that there is a high degree of co-morbidity between these conditions. Indeed when one examines Lorna Wing's (1981) paper on Asperger's syndrome from the language point of view (Foley, 1999) it is clear that there is a great deal of pragmatic language difficulties in many of her criteria. For example, the criterion for a reduction in quality and quantity of babbling refers to expressive language difficulties. A delay in speech acquisition and impoverishment of content refers to receptive-expressive language problems and receptive-pragmatic language difficulties are represented by defective imaginative play. The clinical validity of the Semantic Pragmatic Disorder diagnosis is questionable.

**b) Deficits in Attention, Motor Control and Perception (DAMP) (Gillberg et al., 1982)**

*The core features of DAMP include a disturbance of attention which is cross-situational, gross motor dysfunction or fine motor dysfunction or perceptual dysfunctions which are not accounted for by associated mental retardation or cerebral palsy. DAMP and Asperger's syndrome are similar and Gillberg (1985) points out that both can occur together. Overlapping features include: the condition being more common in boys, the perceptual problems, a failure to adjust volume and pitch of voice, and motor clumsiness (though the latter is not recognised in the Asperger's disorder criteria. It appears that from a clinical perspective the clumsiness is often absent from very high functioning individuals with Asperger's syndrome. In terms of differences it should be noted that attention difficulties are not part of the definition of Asperger's syndrome and in Asperger's disorder (APA, 1994) there can be no clinically significant general delay in language or delay in cognitive development (APA, 1994). DAMP can have significant speech and language problems e.g. articulation problems, hypotonia of the mouth, and certain variants of stuttering (Gillberg, 1995). Heredity appears to play a much lesser role in DAMP than in Asperger's syndrome (Gillberg, 1995). It would appear that criminal difficulties are more common at follow up in persons with DAMP than in persons with Asperger's syndrome because in adult life about half of the persons with DAMP had significant and persistent problems which included criminal offences (Gillberg, 1995).*

**c) Multidimensionally Impaired Disorder (MDI) (McKenna et al., 1994; Kumra et al., 1998)**

*The core features of this disorder include a poor ability to distinguish fantasy from reality, impairment in interpersonal skills and multiple deficits in processing information. While these features can be seen in Asperger's syndrome, according to Kumra et al. (1998) the MDI children lacked the severe impairments in social interaction, stereotyped behaviours and interests, inability to engage in make-believe play with a characteristic profile of intellectual performance; or deviant language development commonly seen in children with pervasive developmental disorders.*

Fitzgerald (1998) has argued that MDI should be categorised with autism or Asperger's syndrome because of the impaired interpersonal skills despite a desire to initiate social interaction with peers, and cognitive deficits which were indicated by multiple deficits in information processing. He suggested that McKenna et al. (1994) and Kumra et al. (1998) were correct when they described the MDI syndrome as an "artificial grouping of severely impaired children". Kumra (1998) admits that there remains considerable confusion in the field about whether MDI should be linked with schizophrenia, bipolar disorder or autism. He was aware that PDDNOS or Asperger's disorder might present with psychotic symptoms and therefore excluded these from their study (McKenna et al., 1994). To demonstrate the validity of MDI as a discrete category Kumra et al (1998) have investigated whether this group of children have a different outcome, family history, neurobiological characteristics, and treatment compared with children who have other psychiatric disorders (Kumra et al., 1998 (unpublished); Robins and Guze, 1970). Thus far, they have demonstrated that both MDI and childhood onset schizophrenia (COS) children share a similar pattern of cytogenetic abnormalities, neuropsychological deficits, structural brain abnormalities, smooth-pursuit eye-tracking abnormalities, premorbid history, and elevated rates of schizophrenia spectrum

disorder in first degree relatives (Kumra et al., unpublished, 1998). In contrast to patients with COS, the MDI cohort had an overrepresentation of male subjects, earlier cognitive and behaviour difficulties, earlier age at onset of psychotic symptoms, a more striking depression in Freedom From Distractibility scores, and a less severe deficit in verbal learning. They speculate that the MDI syndrome might represent an atypical variant of COS (Kumra et al., 1998).

In terms of clinical utility the Asperger's syndrome diagnosis will be of far greater benefit to families than MDI. The Asperger's syndrome diagnosis will allow parents to engage with educational, psychological, and psychiatric services appropriate to their condition (Fitzgerald, 1998).

**d) *Multiple Complex Developmental Disorder (MCDD)*** (Cohen et al., 1987)

*The core features of this condition are (1) Affective regulation problems, (2) Impaired capacity for relating, (3) Impaired cognitive processing in children, (4) Disorganisation precipitated by changes in routine, (5) Impairment in empathy, and (6) Co-morbid anxiety or depression. In support of the condition Van der Gaag and colleagues (1995) found that both thought disorder and affective dysregulation were more characteristic of MCDD subjects, whereas problems in social interaction, communication, and behavioural adjustment were more typical of subjects with autistic disorder. Once again this description of MCDD reads like autism. It has an uncertain nosological status. The core features can occur in Asperger's syndrome.*

**e) *Cerebellar Affective Syndrome*** (Schmahmann et al., 1998)

The core features of this syndrome are an impairment of executive functions such as planning, set shifting, abstract reasoning, and working memory. It also includes difficulties with spatial cognition including visuo-spatial organisation with disinhibited or inappropriate behaviour. The differences from Asperger's syndrome are that it is a late onset condition and in the persons so far studied with this condition range in age from 23 to 74 years. They presented with post infectious cerebellitis, cerebellar tumours and strokes. Differential diagnosis is easily made on history taking. It is a differential diagnosis that will have to be considered in the future in older patients.

**f) *Dyslogia*** (Jordan, 1972)

*The similarities between Dyslogia and Asperger's syndrome are complete. Dyslogic syndrome has been described by Jordan (1972) as the "the inability to employ logic, common sense in making a decision". Jordan goes on to point out that this pattern is often "misidentified as paranoia or even schizophrenia in adolescence". Dyslogic students have difficulty in integrating all data into a working whole and make decisions based on partial facts. These students tend to have temper tantrums and to be rather active, impatient, and impulsive. They have difficulty seeing that their decision making is skewed and do not take the interests of fellow students into account. These students have difficulty in seeing the "forest for the trees, nor does he see all the trees" (Jordan, 1972). They tend to make mistakes in maths computation because of not noticing the signs. Jordan goes on to point*

*out that “the dyslogic person is usually an aggressive, basically happy individual who just can't wait for all the pieces to be assembled”. He adds that “dating and courtship are precarious because few people with normal personalities can tolerate the abrasive force of being closely involved with a dyslogic friend”. He also adds that these students are often unpopular and form social bonds with other students with similar difficulties. He also mentions that these persons can have difficulties with the law. The main problem is an inability to use long term common sense to an effective degree. They tend to be unrealistic in life goals and tend to be dreamers about the future and have unrealistic expectations about the future. These persons are especially vulnerable to manipulative and exploitative persons.*

**g) Developmental Learning Disability of the Right Hemisphere (or Social-Emotional Learning Disorder) (Denckla et al., 1983, Wentraub et al., 1983)**

*This disorder could be seen as a lack of communication between neurologists and psychiatrists since there is such an overlap between this condition and Asperger's syndrome. The condition described is on where children have difficulty understanding social and emotional information.*

**h) Non-verbal Learning Disability (Myklebust et al., 1975)**

This is a disability characterised by deficits in perception, co-ordination, socialisation, non-verbal problem solving, and understanding of humour but with well developed rote memory (Rourke et al., 1989). As many persons with Asperger's syndrome have this disability, the diagnosis of Asperger's syndrome is often preferred as the primary diagnosis, and is certainly the most clinically useful. This is an example of excessive diagnostic “splitting”, though non-verbal learning disability can occur with other disorders.

## **Discussion**

Asperger's syndrome can be misdiagnosed as a variety of conditions requiring contradictory treatments and having a range of outcomes. Misdiagnosis as schizophrenia leads to the prescribing of neuroleptics and an unnecessary risk of tardive dyskinesia; misdiagnosis as ADHD to the prescription of psychostimulants like methylphenidate which can cause deterioration in behaviour in persons with Asperger's syndrome. Treatment resistant mental illness in adult psychiatry is sometimes due to Asperger's syndrome (Ryan, 1992). Diagnostic confusion increases individual and family burden, and causes families to seek unhelpful therapies or join the wrong support groups. The confusion with other disorders arises because many disorders have similar symptoms e.g. (1) ‘Autistic Behaviour’ in schizophrenia and autism, (2) Hyperactivity in ADHD and autism. The problem is compounded by partial diagnostic assessments or the use of outdated diagnostic categorisations i.e. putting all ‘autistic type behaviours’ into a psychotic category or being unaware of the existence of Asperger's syndrome because old classification systems are being used i.e. ICD-9 (WHO, 1978) or DSM-III (APA, 1980).

Clearly the differentiation of Asperger's disorder from other conditions is complex because of the many possibilities for misdiagnosis described in this paper. The key to this task is a clear early developmental history with a systematic discussion of all the criteria set out for Asperger's syndrome (Wing, 1981; Gillberg, 1991) or Asperger's disorder (APA, 1994). The multidisciplinary team approach is critical and the diagnosis from a solely neurological, speech and language or educational point of view must cease if families are to be spared confused partial diagnoses.

## *References*

- Allen D. A., Rapin I. (1992). Autistic children are also dysphasic. In Naruse H., Ornitz E. M. (Eds). *Neurobiology of infantile autism*. Amersdam: Excerpta Medica.
- American Psychiatric Association (1987). *Diagnostic and Statistical Manual of Mental Disorders*. 3<sup>rd</sup> Edition, DSM-III-R. Washington DC: APA.
- American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders*. 4<sup>th</sup> Edition, DSM-IV. Washington DC: APA.
- Asperger H. (1944). Die "Autistischen Psychopathen" im Kindesalter. *Archives fur Psychiatrie und Nervenkrankheiten*, 117, 76 – 136.
- Attwood T. (1988). *Asperger's syndrome*. London: Jessica Kingsley.
- Baron-Cohen S. (1989). Do autistic children have obsessions and compulsions? *British Journal of Clinical Psychology*, 28, 193 – 200.
- Bleuler E. (1911). *Dementia Praecox or the group of Schizophrenias*. Translated by Zinkin G. New York, International University Press, 1950.
- Cohen D., Paul R., Volkmar F. (1987). Issues in classification of pervasive developmental disorders and associated conditions. In Cohen D. J., Donnellan A. M., Paul R. (Eds). *Handbook of Autism and Pervasive Developmental Disorders*. New York: Wiley.
- Denckla M.B. (1983). The neuropsychology of social-emotional learning disabilities. *Archives of Neurology*, 40, 461 – 462.
- Fitzgerald M. (1998). Multidimensionally impaired disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37, 11, 1125.
- Foley V. (1999). *Asperger's syndrome from a language point of view*. Personal Communication.
- Gillberg C. (1983). Psychotic behaviour in children and young adults in a mental handicap hostel. *Acta Psychiatrica Scandinavia*, 68, 351 – 358.
- Gillberg C. (1985). *Clinical child neuropsychiatry*. Cambridge: Cambridge University Press.

- Gillberg C. (1989). Asperger's syndrome in 23 Swedish children. *Developmental Medicine and Child Neurology*, 31, 520 – 531.
- Gillberg C. (1991). Clinical and neurobiological aspects of Asperger's syndrome in six families studied. In U. Frith (Ed.) *Autism and Asperger's syndrome*. Cambridge: Cambridge University Press.
- Gillberg C. (1998). Asperger's syndrome and high functioning autism. *British Journal of Psychiatry*, 172, 200 – 209.
- Gillberg C., Ehlers S. (1998). High functioning people with autism and Asperger's syndrome. In Schopler E., Mesibov G., Kuncie L. J. *Asperger's syndrome or High – Functioning Autism*. Plenum: New York.
- Gillberg C., Rasmussen T., Carlstrom G., Svenson B., Waldenstrom E. (1982). Perceptual, motor and attentional deficits in 6 year old children. Epidemiological aspects. *Journal of Child Psychology and Psychiatry*, 23, 131 – 144.
- Gillberg I. C., Gillberg C. (1989). Asperger's syndrome – some epidemiological considerations: A research note. *Journal of Child Psychology and Psychiatry*, 30, 631 – 638.
- Howlin P. (2000). Outcome in adult life for more able individuals with autism or Asperger's syndrome. *Autism*, 4, 63 – 84.
- Jordan (1972). *Dyslexia in the classroom*. Columbus Ohio: Merrill.
- Kendler K. S., McGuire M., Gruender G. A., Walsh D. (1994). An epidemiologic, clinical and family study of simple schizophrenia in Co. Roscommon, Ireland. *American Journal of Psychiatry*, 151, 27 – 34.
- Klin A., Volkmar S. R., Sparrow S. S., Cicchetti D. V., Rourke B. P. (1995). Validity and neuro-psychological characterisation of Asperger's syndrome: Convergence with non-verbal learning disability syndrome. *Journal of Child Psychology and Psychiatry*, 36, 1127 – 1140.
- Kraepelin E. (1919). *Dementia Praecox and Paraphrenia*. In: *Textbook of Psychiatry*, 8<sup>th</sup> Edition, 176 – 177. Edinburgh: ES Livingstone.
- Kumra S. (1998). Multidimensionally impaired disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37, 11, 1125 – 1126.
- Kumra S., Jacobsen L. K., Lenane M., Zahn T. P., Wiggs E., Alghband-Rad J., Castellanos F. X., Frazier J. A., McKenna K., Gordon C. T., Smith A., Hamburger S., Rapoport J. L. (1998). Multidimensionally impaired disorder: Is it a variant of very early - onset schizophrenia? *Journal of the American Academy of Child and Adolescent Psychiatry*, 37, 1, 91 – 99.
- Lewis N. D. C. (1936). *Research in dementia praecox (Past attainments, present trends, and future possibilities)*. New York: Committee on Mental Hygiene, 1936.
- McDougal C. J., Kresch L. E., Goodman W. K., Naylor S. T., Volkmar F. R., Cohen D. J., Price L. H. (1995). A case - controlled study of repetitive thoughts and behaviour in

- adults with autistic disorder and obsessive compulsive disorder. *American Journal of Psychiatry*, 152, 5, 772 – 777.
- McKenna K., Gordon C., Lenane M., Kaysen D., Fahey K., Rapoport J. (1994). Looking for childhood onset schizophrenia: the first 71 cases screened. *Journal of the American Academy of Child and Adolescent Psychiatry*, 33, 636 – 644.
- Meijers M., Treffers P. D. A. (1991). Borderline and schizotypal disorders in children and adolescents. *British Journal of Psychiatry*, 158, 205 – 212.
- Myklebust H.R. Non-verbal learning disabilities: Assessment and intervention. In Myklebust H.R. (Ed). *Progress in Learning Disabilities*. New York, N.Y.: Grune and Stratton 1975.
- Prior M., Ozonoff S. (1998). Psychological factors in autism. In Volkmar F. *Autism and pervasive developmental disorders*. Cambridge: Cambridge University Press.
- Ramsey J. M., Andresen N. C., Rapoport J. L. (1986). Thought, language, communication, and affective flattening in autistic adults. *Archives of General Psychiatry*, 43, 741 – 777.
- Rapin I., Allen D. (1983). Developmental language disorders: Nosological considerations. In: U. Kirk (Ed), *Neuropsychology of Language, Reading, and Spelling*. New York: Academic Press.
- Robins E., Guze S. (1970). Establishment of diagnostic validity in psychiatric illness: its application to schizophrenia. *American Journal of Psychiatry*, 126, 107 – 111.
- Rourke B. P., Young G. C., Leenaar A. A. (1989). A childhood learning disability that predisposes those afflicted to adolescent and adult depression and suicide risk. *Journal of Learning Disabilities*, 22, 169 – 175.
- Ryan R. M. (1992). Treatment resistant chronic mental illness: Is it Asperger's syndrome? *Hospital and Community Psychiatry*, 43, 8, 807 – 811.
- Schmahmann J. D., Sherman J. C. (1998). The cerebellar cognitive affective syndrome. *Brain*, 121, 561 – 579.
- Szatmari P. (1998). Differential diagnosis of Asperger's disorder. In: Schopler E., Mesibov G., Kunc L. (1998). *Asperger's syndrome or high functioning autism?* New York: Plenum.
- Towbin K. (1997). Pervasive developmental disorders not otherwise specified. In: Cohen D. J., Volkmar S. R. *Handbook of Autism and Pervasive Developmental Disorders*. New York: Wiley.
- Tsai L. Y. (1992). Diagnostic issues in high functioning autism. In Schopler E. and Mesibov G. (Eds). *High functioning individuals with autism*. New York: Plenum Press.
- Van der Gaag R. J., Buitelaar J., Ban E. V. D., Bezemer M., Njio L., Engeland H. V. (1995). A controlled multivariate chart review of multiple complex developmental disorder.

- Journal of the American Academy of Child and Adolescent Psychiatry, 34, 1096 – 1106.
- Voeller K. K. S. (1986). Right-hemisphere deficit syndrome in children. *American Journal of Psychiatry*, 143, 1004 – 1009.
- Volkmar F. R., Cohen D. J., Hoshino Y., Paul R. (1988). Phenomenology and classification of childhood psychosis. *Psychological Medicine*, 18, 1, 191 – 201.
- Weintraub S., Mesulam M. M. (1983). Developmental learning disabilities of the right hemisphere: Emotional, interpersonal, and cognitive components. *Archives of Neurology*, 40, 463 – 468.
- Whalen C. K., Henkler B. (1992). The social profiles of attention deficit hyperactivity disorder: five fundamental facets. *Child and Adolescent Psychiatric Clinics of North America*, 1, 395 – 410.
- Wing L. (1981). Asperger's syndrome: A clinical account. *Psychological Medicine*, 11, 115 – 130.
- Wing L. (1996). *The autistic spectrum*. London: Constable.
- Wing L. (1997). Diagnosis and classification. In: Cohen D. J., Volkmar F. R. (1997). *Handbook of autism and pervasive developmental disorders*. New York: Wiley.
- Wing L. (1998). The history of Asperger's syndrome. In: Schopler E., Mesibov G., Kuncle L. *Asperger's syndrome or high functioning autism?* Plenum: New York.
- Wolff S. (1995). *Loners: the life path of unusual children*. London: Routledge.
- Wolff S. (1998). Schizoid personality in childhood: the links with Asperger's syndrome, schizophrenia spectrum disorders, and elective mutism. In: Schopler E., Mesibov G., Kuncle L. (1998). *Asperger's syndrome or high functioning autism*. New York: Plenum.
- Wolff S., Chick J. (1980). Schizoid personality in childhood: A controlled follow up study. *Psychological Medicine*, 10, 85 – 100.
- World Health Organisation (1978). *International Classification of Diseases (9<sup>th</sup> Edition)*. Geneva: WHO.
- World Health Organisation facets. (1979). *An International Follow-up study of schizophrenia*. New York: Wiley.
- World Health Organisation (1992). *International Classification of Diseases (10<sup>th</sup> Ed) Clinical description and diagnostic guidelines*. Geneva: W.H.O.

Box 1 DSM-IV criteria for the diagnosis of Asperger's Disorder

- A. Quantitative impairment in social interaction, as manifest by at least two of the following:
- (1) Marked impairment in the use of multiple non-verbal behaviours such as eye-to-eye gaze, facial expression, body posture, and gestures to regulate social interaction
  - (2) Failure to develop peer relationships appropriate to developmental level
  - (3) A lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest to other people)
  - (4) Lack of social and emotional reciprocity
- B. Restricted repetitive and stereotyped patterns of behaviour, interests, and activities, as manifest by at least one of the following:
- (1) An encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
  - (2) Apparently inflexible adherence to specific, non-functional routines or rituals
  - (3) Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
  - (4) Persistent preoccupation with parts of objects.

***This disturbance must be clinically significant, but without clinically significant language delay or delay in cognitive development or other skills.***

Box 2 Additional DSM-IV criteria for Autism

Must meet criteria A. and B. in Box 1, but in addition:

- A. Quantitative impairments in communication as manifested by at least one of the following:
- (1) Delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication).
  - (2) In individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others stereotyped and repetitive use of language or idiosyncratic language.
  - (3) Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level

*Box 3 Differential diagnosis of Asperger's syndrome*

1. Other Pervasive Developmental Disorders (PDD):
  - a) *Autism*
  - b) *Pervasive Developmental Disorder Not Otherwise Specified (PDDNOS)*
  - c) *Childhood Disintegrative Disorder*
  - d) *Rett's Disorder*
  
2. Schizophrenia spectrum disorders:
  - a) *Schizophrenia*
  - b) *Schizotypal Disorder*
  - c) *Schizoid Personality Disorder*
  
3. Adult Attention Deficit Hyperactivity Disorder (ADHD)
  
4. Obsessive Compulsive Disorder
  
5. Depression
  
6. Diagnostic categories overlapping with PDD:
  - a) *Semantic Pragmatic Disorder*
  - b) *Deficits in Attention, Motor Control and Perception (DAMP)*
  - c) *Multidimensionally impaired disorder (MDI)*
  - d) *Multiple complex developmental disorder (MCDD)*
  - e) *Developmental Learning Disability of the Right Hemisphere or Social-Emotional Learning Disorder*
  - f) *Non-verbal Learning Disability*

## CHAPTER ELEVEN

### *FACTORS RELATED TO THE ADJUSTMENT OF SIBLINGS FOLLOWING SUDDEN INFANT DEATH*

Barbara Coughlan, Alan Carr & Michael Fitzgerald.

#### INTRODUCTION

Sudden Infant Death Syndrome (SIDS) commonly known as Cot Death or Crib Death refers to “the sudden death of an infant or young child which is unexpected by history and in which a thorough post-mortem examination fails to demonstrate an adequate cause of death” (SIDS Global Strategy, 1994). SIDS is a major public health problem in Ireland and elsewhere (Radic, Griffin & Cahalane, 1983; Arneil, Gibson, McIntosh et al, 1985). Four in every ten infant deaths in Ireland are due to SIDS and the SIDS mortality rate in 1993 was 0.7 per 1000 live births (ISIDA, 1993).

References to sudden and unexpected infant death occur in the Old Testament and Roman records, and in medical and legal literature of the 12<sup>th</sup> and 13<sup>th</sup> centuries (Guntheroth, 1989). Modern medical interest in the problem began in the late 19<sup>th</sup> century and since the 1950's research in the fields of pathology, physiology and epidemiology has attempted to generate hypotheses about potential vulnerability factors with a view to prevention (Limerick 1992). Until etiological research can insure prevention, the problem of understanding and dealing with the aftermath of SIDS deserves attention.

Only a handful of studies have addressed the psychological sequelae of SIDS for parents (e.g, Blueglass, 1981; Dyregrov & Mattiesen, 1987; Feeley & Gottlieb, 1988-1989; Price, Carter, Sheldon & Bendell, 1985; Ostfeld, Ryan, Hiatt & Hegyi, 1993; Williams & Nikolaisen, 1982; Mandell, McAnulty & Reece, 1980) and siblings (e.g., Cornwell, Nurcombe & Stevens, 1977; Defrain & Ernst, 1978; Hutton & Bradley, 1994; Mandell, McClain, & Reece, 1988; Powell, 1991).

These studies have consistently found that SIDS has severe and prolonged psychological effects on parents and siblings. For parents it leads to alterations in mood, cognition and behaviour associated with grief processes. These include sadness, guilt, anger, anxiety, hallucinations of the deceased child, concentration problems and difficulties maintaining usual routines at work and at home. For example, Dyregrov and Mattiesen (1987) investigated grief reactions in parents relating to three kinds of infant death (stillbirth, neonatal death and SIDS) between one and four years after the death. They found higher

levels of disturbance, especially anxiety and intrusive thoughts and prolonged disturbance in the parents of babies dying from SIDS than in parents from the other two groups. Cases of parental psychiatric morbidity following SIDS have also been reported (Blueglass, 1981).

Both internalizing and externalizing behavioural problems have been found in siblings following SIDS. Depression, separation anxiety, clinging, bedwetting, nightmares, somatic complaints, school problems, and destructiveness are among the more commonly reported difficulties (Cornwell, Nurcombe & Stevens, 1977; Defrain & Ernst, 1978; Hutton & Bradley, 1994; Mandell, McClain, & Reece, 1988; Powell, 1991).

Results from a number of studies suggest that marital, parent-child and peer relationships may deteriorate following SIDS. For example, Powell (1991) found that over 50% of the families in her study showed marital strain and Hutton and Bradley (1994) reported that compared with matched controls, SIDS-siblings family and peer relationships were characterized by more aggression and social withdrawal.

Results of available studies suggest that there is considerable variability in the rate and pattern of recovery for parents and siblings following SIDS. The overall trend is for the initial crisis to be associated with serious disruption and difficulties and that over a period this subsides. Improvement rarely follows a smooth and predictable course. Lapses into profound grief on both predictable occasions (such as anniversaries) and unpredictable occasions are common. Defrain and Ernst (1978) found that families required an average of 8.3 months to regain the level of family organization present before the death. Price, Carter, Sheldon and Bendell (1985) reported in their study of 73 SIDS-bereaved mothers, that grief symptoms persisted in the majority of mothers interviewed for at least three years after the death of a baby. Powell (1991) in a retrospective study of parents' perceptions of their surviving children's responses to SIDS found a combination of symptoms such as seeking parental affection, separation anxiety, fear of being alone and incessant curiosity about death for up to 3 years in siblings.

A ubiquitous finding is the variability in siblings' responses to SIDS. While it appears that many SIDS-siblings, develop severe and prolonged behavioural difficulties and relationship problems, some do not. The overall objective of the present study was to identify psychosocial factors associated with adjustment of siblings to Sudden Infant Death Syndrome. The wider literature on grief in children suggests that variability in children's grief reactions to losses of any type is due to variability in personal characteristics, parental characteristics and features of the child's family and social network (Corr & Balk, 1996; Walsh & McGoldrick, 1991; Smith & Pennell, 1996). Thus, the specific aim of this study was to pinpoint those psychological characteristics of siblings and parents and those psychosocial characteristics of families and their wider social networks which contribute significantly to the adjustment of siblings to SIDS. The identification of these factors may suggest hypotheses which explain why some siblings adjust to SIDS while others do not.

The five published studies on siblings' adjustment to sudden infant death identified in a literature search (Cornwell, Nurcombe & Stevens, 1977; Defrain & Ernst, 1978; Hutton & Bradley, 1994; Mandell, McClain & Reece, 1988; Powell, 1991) have all been small scale projects with the largest sample of SIDS-siblings being 38 (Hutton & Bradley, 1994). With one exception in which the Child Behaviour Checklist was used (Hutton & Bradley, 1994) none have employed standardized assessment instruments. It was intended that the present study would overcome these methodological weaknesses.

## **METHOD**

### **Participants**

Seventy mothers and 53 fathers of 119 children participated in this study. Participants came from 72 families in which one child had died of sudden infant death. The Irish Sudden Infant Death Association (ISIDA) issued invitations to all 800 families from the Republic of Ireland on their confidential mailing list in which a sudden infant death had occurred prior to 1993. It was estimated from data presented in the National Sudden Infant Death Register 1993 Report that 568 of the 800 invited families had children alive at the time of the sudden infant death. Of these 568 potential respondents, 139 families agreed to participate in the study. Families were included in the study if they contained children aged between 4 and 16 years at the time of the study and if these children had been alive at the time of the sudden infant death. Of the 139 families who agreed to participate in the study, 72 families met the criteria and completed data collection procedures for at least one child and one parent. This group of 72 families represented 12.6% of the total pool of 568 potential cases. Demographic characteristics of these families are given in Table 1.

The distribution of participants across socio-economic groups in this study, with only 38% of cases coming from classes 4, 5 and 6, differs from that in the National Sudden Infant Death Register (ISIDA, 1993). In 1993, 57% of SIDS cases occurred in Class 4, 5, and 6. Thus, the results of this study may not be validly generalized to all families in which sudden infant death has occurred, but only to cases which meet the demographic profile set out in Table 1. From the table it is apparent that the average participant was an 11 year old boy or girl from a middle or upper-middle class intact family whose sibling had died a sudden death about 7 years before the study. Mothers who participated were in their late 30s and fathers were in the early 50s, with a third of families being rurally based and the rest living in urban settings.

**Table 1. Demographic characteristics.**

<b>Variable</b>	<b>Categories</b>	<b>Sample Statistics</b>	<b>Population Statistics</b>
Number of participants	Mothers	70	
	Fathers	53	
	Sibling	119	
Sibling's gender	Male	55%	
	Female	45%	
Sibling's age at interview	Mean	10.9 years	
	SD	3.2 years	
	Range	4-16 years	

Sibling's age at time of SIDS	Mean	4.4 years	
	SD	2.6 years	
	Range	1-13 years	
Time since SIDS	Mean	7.0 years	
	SD	3.3 years	
	<5	50.7%	
	>5	49.3%	
Mothers' ages	Mean	37.9 years	
	SD	5.1 years	
	Range	20-49 years	
Fathers' ages	Mean	50.5 years	
	SD	6.4 years	
	Range	28-58 years	
Family structure	Intact nuclear	90%	
	Single parent, reconstituted or other	10%	
Geographical region	Urban	31%	35.5%
	Rural	69%	65.5%
SES	Class 1. Higher professional, farmer 200 acres	12.6%	9.9%
	Class 2. Lower professional 100-199 acres	25.3%	14.1%
	Class 3. Non-manual, farmer 50-99 acres	23.9%	15.5%
	Class 4. Skilled manual, farmer 30-49 acres	28.2%	22.8%
	Class 5. Semi-skilled, farmer 30 acres	5.6%	15.4%
	Class 6. Unskilled	4.2%	10.2%

**Note:** Population statistics are taken from CSO (1986). Census 86: Summary Population Report Second Series. Dublin: CSO.

## Instruments

Siblings' adjustment was assessed with Achenbach's (1991) Child Behaviour Checklist (CBCL) and Kovacs' (1992) Children's Depression Inventory (CDI). Siblings' psychological characteristics were assessed with Form A of Battle's (1992) Culture Free Self-Esteem Inventory and Nowicki-Strickland's (1973) Locus of Control Scale. Psychological characteristics of parents were assessed with the 28 item version of the General Health Questionnaire (GHQ-28, Goldberg & Williams, 1988); the general scale of Form AD of Battle's (1992) Culture Free Self-esteem Inventory; and Lumpkin's (1985) Brief Locus of Control scale. Parental perceptions of aspects of family functioning and the family's social network were assessed with the McMaster Family Assessment Device (FAD, Kabacoff, Miller, Bishop, Epstein & Keitner, 1990); Schumm et al's (1986) Kansas Marital Satisfaction Scale (KMS) and Dahlem, Zimet & Walker's (1991) Multidimensional Scale of Perceived Social Support Scale. The reliability and validity of all these instruments have been well established. A brief description of each instrument follows.

## Sibling Adjustment

**The Child Behaviour Checklist (CBCL).** This is a 113 item inventory completed by parents (Achenbach, 1991). Items describe problem behaviours that children in the 4-16 year age bracket may exhibit. A three point response format is used for each item. For this study, T-scores for the total problem behaviour scale and both internalizing and externalizing behaviour problem scales were derived from parental responses to the checklist and included in statistical analyses. Cases obtaining T-scores above 63 on the total problem scale of the CBCL qualify for a DSM diagnosis in about 79% of cases usually of either an emotional disorder or a conduct disorder (Kasius, Ferdinand, van den Berg & Verhulst, 1997). On the CBCL, higher scores indicate greater symptomatology.

**Children's Depression Inventory (CDI).** The CDI is a 27-item self-rated symptom oriented scale, suitable for school age children and adolescents (Kovacs, 1992). The instrument quantifies a range of depressive symptoms including disturbed mood, hedonic capacity, vegetative functions, self-evaluation and interpersonal behaviours. Several items concern the consequences of depression in the contexts that are specifically relevant to children. Each CDI item consists of three choices, keyed 0, 1, 2, with higher scores indicating greater symptomatology. The child uses the options to rate the degree to which each statement describes him or her for the past two weeks. The CDI has internal consistency and test-retest reliabilities above .8 (Smucker, Craighead, Craighead & Green, 1986). The total depression score on the CDI has been shown to discriminate between youngsters with major depressive disorders and non-affective psychiatric controls and cases falling above a cut-off score of 63 on the scale typically qualify for a DSM diagnosis of major depression (Kovacs, 1992).

### **Siblings' psychological characteristics**

**Culture Free Self-Esteem Inventory (CFSEI).** Form A of this instrument is a 30 item self-report inventory, with two response categories per item. The instrument yields a total score and scores on five subscales which assess general, social, academic and parental self-esteem and social desirability or response set. In the present study, only the total self-esteem score, for which there is reasonable reliability and validity data (Battle, 1992), was included in the statistical analyses. Higher scores indicated greater self-esteem.

**Nowicki-Strickland Locus of Control Scale.** This widely used and well validated scale was constructed as a children's version of Rotter's (1966) adult locus of control scale. The short form, used in the present study comprised 23 items describing reinforcement situations across interpersonal and motivational areas such as, affiliation, achievement and dependency (Nowicki-Strickland's, 1973). There were two response categories for each item. The higher scores were associated with an external orientation.

### **Parental characteristics**

**General Health Questionnaire (GHQ-28).** For both mothers and fathers, psychological adjustment was evaluated using the 28 item version of the GHQ which yields an overall score and subscale scores for somatic symptoms, anxiety, social dysfunction and depression (Goldberg & Williams, 1988). For each item, four-point response formats were used and the 0,0,1,1 scoring method was employed to obtain total and subscale scores. Cases receiving

scores of 5 or more following psychiatric interview typically receive a psychiatric diagnosis (Goldberg & Williams, 1988).

**Culture Free Self-Esteem Inventory (CFSEI).** For mothers and fathers self-esteem was assessed using the 15 item general self-esteem (SE) subscale from the AD form of the Battle Culture Free Self-esteem Inventory (Battle, 1992). True/False response formats were used for all items and raw scores were converted to T-scores using the adult norms in Battle's 1992 manual. Higher scores indicate greater self-esteem.

**Brief Locus of Control Scale (BLCS).** Parents' locus of control was evaluated with Lumpkin's (1985) Brief Locus of Control scale which contains six items from Rotter's original (1966) instrument. Three items relate to internal control, and three to external control. Five-point Likert response formats were used for each item. A higher score on the scale indicates a more internal locus of control. Lumpkin (1985) has shown that the scale has construct validity.

### **Parental perceptions of the family and social network**

**McMaster Family Assessment Device (FAD).** Mothers' and fathers' perception of family functioning was evaluated using this 60 item inventory (Kabacoff, Miller, Bishop, Epstein & Keitner, 1990). It yields scores on the following seven subscales: problem-solving, communication, roles, affective responsiveness, affective involvement, behaviour control and general functioning. A four point Likert response format is used for responding to each item with responses ranging from strongly agree to strongly disagree. Subscale scores are based on subscale item totals divided by the number of items to which responses were given with higher scores indicating greater pathology. The FAD has been shown to discriminate between clinical and non-clinical families and clinically a cut-off score of 2 on the general functioning scale may be used to identify families with significant adjustment difficulties.

**Kansas Marital Satisfaction Scale (KMS).** This three item scale was used to assess parents' perceptions of the quality of their marital relationship. The items assess satisfaction with the spouse, marriage and relationship and the scale as a whole, despite its brevity has been shown to correlate highly with other more extensive measures of marital satisfaction (Schumm, Paff-Bergen, Hatch et al, 1986).

**Multidimensional Scale of Perceived Social Support (MSPSS).** Perceived social support available to parents was evaluated with this 12 item inventory which assesses perceived social support from family, friends and significant others (Dahlem, Zimet & Walker, 1991). Responses to each item are given on seven point Likert scales and the instrument is scored so that higher scores indicate greater support.

### **Procedure**

Participants were contacted by telephone or letter if no telephone contact number was available and an appointment was made for one of us (BC) to visit the family and collect data in a single session. In some instances participants were sent questionnaires by mail to complete prior to the researcher's visit and the data collection session was used to check for completeness and accuracy and to clarify ambiguous items. In other instances all data were collected in a structured interview format. In each family, each child over the age of 4

completed the CDI, Form A of the CFSEI, and the Nowicki-Strickland Locus of Control Scale. In each family one parent (usually the mother) completed the CBCL and a demographic questionnaire. Mothers and fathers each completed the GHQ-2; the general scale of the AD form of the CFSEI; the Brief Locus of Control Scale; the FAD; the KMS; and the MSPSS.

## **RESULTS**

In presenting the results, descriptive statistics on the status of siblings and parents on psychological and psychosocial variables will first be presented. The results of two distinct but complementary sets of analyses will then be given which throw light on the correlates of adjustment of siblings to sudden infant death. The first set of results are from t-tests conducted to identify significant differences between siblings who scored above and below the clinical cut-off of the total problem scale of the CBCL on personal, parental and family characteristics. The second set of results are from a series of stepwise multiple regression analyses in which personal, parental and family characteristics which predict sibling adjustment following sudden infant death were identified.

### **Siblings' adjustment and characteristics**

In Table 2, descriptive statistics for variables which are indices of siblings' psychological adjustment are presented along with those for variables which reflect broader psychological characteristics, specifically self-esteem and locus of control. Mean scores for the group of 119 siblings on the CBCL internalizing, externalizing and total problem behaviour scales; the CDI depression scale; and the CFSEI self-esteem scale were within the normal range. Normative data for the locus of control scale were unavailable.

**Table 2. Descriptive statistics for indices of siblings' adjustment and siblings' psychological characteristics.**

<b>Domain</b>	<b>Variable</b>	<b>Mean</b>	<b>SD</b>	<b>% in clinical range</b>
<b>Indices of adjustment</b>	CBCL total behaviour problems	52.6	11.9	18%
	CBCL internalizing behaviour problems	54.3	11.8	
	CBCL externalizing behaviour problems	50.8	10.5	
	CDI depression	46.3	9.9	9%
<b>Psychological characteristics</b>	Self-esteem	54.7	10.4	
	Locus of control	9.0	3.5	

**Note:** CBCL=Child Behaviour Checklist. CDI= Childhood depression inventory. N=119. Clinical-cut-off t-score of 63 which falls at the 91st percentile was used to determine % in clinical range.

On the total behaviour problem scale of the CBCL 18% of cases obtained scores which fell above the cut-off T-score of 63. This cut-off score of 63 falls at the 91<sup>st</sup> percentile, so in the general population, it would be expected that only 9% of cases would fall above this cut-off score. Thus, compared with children from the general population, twice as many of the SIDS-siblings in this study had significant behavioural problems.

On the CDI depression scale, 9% of cases fell above the cut-off T-score of 63. This cut-off score of 63 fell at the 91<sup>st</sup> percentile, so in the general population, it would be expected that exactly 9% of cases would fall above this cut-off score. Thus, there was no difference in depression levels, as assessed by the CDI, between children from the general population and the SIDS-siblings in this study.

### Parental characteristics and perception of the family and social network

In Table 3, characteristics of 70 mothers and 53 fathers and their perceptions of family and social network characteristics are presented. Mean scores for mothers and fathers on the GHQ-28 and the CFSEI general self-esteem scale were within the normal range. Normative data for the locus of control scale were unavailable. For both self-esteem and locus of control, fathers obtained significantly higher scores than mothers. 21% of fathers' and 30% of mothers' scores on the GHQ-28 fell above the cut-off score of 5. These rates did not differ significantly (Chi Square = 16.5, df=1, N=123), nor were they higher than those found in community studies (Cox, Blaxter, Buckle et al, 1987). On the general functioning scale of the FAD, mean scores for mothers and fathers were below 2 and therefore within the normal range. Mothers and fathers differed in their perception of the adequacy of family communication with fathers seeing it as more problematic compared with mothers.

*Normative data for the KMS index of marital satisfaction and the MSPSS index of social support were unavailable, so conclusions about the status of the group studied with respect to the general population were not drawn. When mothers and fathers were compared on these variable, it was found that fathers reported greater marital satisfaction in comparison with mothers.*

**Table 3. Mothers' and fathers' psychological characteristics and perception of the family and social network.**

Domain	Variable		Mothers (n=70)	Fathers (N=53)	t
<b>Psychological characteristics</b>	GHQ	M	3.7	2.4	1.57
		SD	4.3	3.6	
	Self-esteem	M	43.8	47.4	2.78 **
		SD	8.7	6.9	
Locus of control	M	3.1	3.5	3.45 ***	
	SD	3.7	0.5		
<b>Perceived family functioning</b>	FAD problem solving	M	1.9	2.0	1.15
		SD	0.4	0.3	
	FAD communication	M	2.1	2.2	2.11 *
		SD	0.4	0.2	
	FAD roles	M	2.4	2.3	1.45
		SD	0.4	0.3	

	FAD affective responsiveness	M	1.9	2.1	1.80	
		SD	0.5	0.3		
	FAD affective involvement	M	2.1	2.0	0.70	
		SD	0.5	0.3		
	FAD behaviour control	M	1.9	1.8	0.03	
		SD	0.5	0.4		
	FAD general functioning	M	1.9	1.9	0.19	
		SD	0.4	0.2		
<b>Marital satisfaction</b>	KMS score	M	16.5	18.8	2.68	***
		SD	5.1	3.7		
<b>Perceived social support</b>	MSPSS total score	M	5.7	5.4	1.23	
		SD	1.2	1.1		

**Note:** M=mean. SD=standard deviation. GHQ=General Health Questionnaire. FAD=Family Assessment Device. KMS=Kansas Marital Satisfaction scale. MSPSS= Multidimensional Scale of Perceived Social Support. \* p< .05. \*\* p< .01. \*\*\*p<.001.

### Clinical vs non-clinical cases

It was noted above that fifteen SIDS-siblings (18% of the group of 119) obtained CBCL total problem scale T- scores above the clinical cut-off point of 63. To identify differences between these clinical cases and the remaining siblings who participated in the study the means of the two groups, for all variables, were compared using t-tests. Significant results from these analyses are presented in Table 4, where it may be seen that clinical cases had lower self-esteem and a more external locus of control. Their fathers and mothers also had lower self-esteem. Their mothers reported significantly worse psychological adjustment and the mean GHQ-28 score for the mothers of the clinical group (mean = 7.1) was above the GHQ-28 clinical cut-off of 5. Compared with the non-clinical group, both mothers and fathers in the clinical group perceived family roles to be problematic. In addition mothers in this group perceived greater problems with family problem-solving, general family functioning, and marital satisfaction.

**Table 4. Differences between clinical and non-clinical cases on personal, parental and family characteristics.**

Domain	Variable		Clinical Group	Non-clinical Group	t	
<b>Personal characteristics</b>	Self-esteem	M	46.7	56.4	3.8	**
		SD	12.5	9.3		*
	Locus of control	M	11.4	8.3	2.9	**
		SD	4.3	3.1		
<b>Parental characteristics</b>	Mothers' self-esteem	M	37.8	45.6	3.1	**
		SD	9.1	8.4		
	Fathers' self-esteem	M	44.0	48.4	2.0	*
		SD	7.5	6.6		
	Mothers' GHQ	M	7.1	2.8	2.9	**
		SD	5.4	3.3		
<b>Family characteristics</b>	Mothers' perceived family roles	M	2.6	2.4	1.9	*
		SD	0.4	0.4		

Fathers' perceived family roles	M	2.7	2.4	2.9 *
	SD	0.4	0.4	
Mothers' perceived general family functioning	M	2.2	1.8	3.4 **
	SD	0.4	0.4	*
Mothers' perceived family problem solving	M	2.1	1.8	2.3 *
	SD	0.4	0.4	
Mothers' marital satisfaction	M	12.9	17.4	3.1 **
	SD	5.5	4.6	

**Note:** M=mean. SD=standard deviation. GHQ=General Health Questionnaire. \* p< .05. \*\* p< .01. \*\*\*p<.001.

### Predictors of sibling adjustment

To identify the most parsimonious set of variables predictive of sibling adjustment following sudden infant death, variables reflecting personal, parental and family characteristics were entered as potential predictors into a series of four stepwise multiple regression analyses. One such analysis was conducted for each of the following dependent variables: the CBCL internalizing scale; the CBCL externalizing scale; the CBCL total problem behaviour scale; and the CDI depression scale. In each of these analyses the following 14 independent or predictor variables were included: siblings' self-esteem, siblings' locus of control, mothers' GHQ, mothers' self-esteem, mothers' locus of control, mothers' FAD total score, mothers' marital satisfaction, mothers' perceived social support, fathers' GHQ, fathers' self-esteem, fathers' locus of control, fathers' FAD total score, fathers' marital satisfaction, and fathers' perceived social support.

Prior to conducting these regression analyses, all dependent and independent variables were examined through SPSS frequencies programme for accuracy of data entry, missing values and fit between their distribution and the assumptions of regression analysis. Missing data were accounted for in the regression analyses by inserting the group means for the missing values. This was accomplished through the mean substitution option in the SPSS<sup>X</sup> Programme. This procedure was chosen as it was a less conservative method than adding an overall mean and not as liberal as using prior knowledge (Tabachnick & Fidell, 1989). To reduce skewness in the distribution and improve normality and homoscedasticity of the residuals logarithmic transformations were used on a number of the dependent and independent variables. In these analyses there was a ratio of 8.5 cases for every independent variable, a ratio close to that of 1:10 recommended for multivariate analyses (Hair, Anderson, Tatham & Black, 1992).

Table 5. Predictors of siblings' adjustment following SIDS: Results of stepwise multiple regression analyses.

Dependent adjustment variables	No. steps	Independent predictor variables	b	Multiple R	R <sup>2</sup>	Adjust R <sup>2</sup>	F	df
--------------------------------	-----------	---------------------------------	---	------------	----------------	-----------------------	---	----

CBCL total problem score	3	Siblings' self-esteem	-.28	.40	.14	.13	19.4*	3, 115
		Mothers' GHQ	.33	.51	.26	.25	20.4*	
		Siblings' locus of control	.19	.54	.29	.27	15.8*	
CBCL externalizing behaviour	2	Siblings' self-esteem	.33	.33	.11	.10	14.7*	2, 116
		Mothers' GHQ	-.27	.43	.18	.20	13.1*	
CBCL internalizing behaviour	3	Siblings' self-esteem	-.26	.34	.12	.11	15.3*	3, 117
		Mothers' GHQ	.3	.46	.21	.20	15.9*	
		Siblings' locus of control	.18	.49	.24	.22	12.3*	
CDI depression	1	Siblings' self-esteem	-.70	.70	.5	.49	115.5*	1, 117

**Note:** CBCL=Child Behaviour Checklist. CDI=Child Depression Inventory. GHQ=General Health Questionnaire. \*p<.001.

From Table 5 it may be seen that 3 of the 14 independent variables were identified as significant predictors of sibling adjustment in the multiple regression analyses. These were: siblings' self-esteem; siblings' locus of control; and mothers' GHQ. The following conclusions may be drawn from the results set out in Table 5, about the amount of variance accounted for by predictor variables in each of the four analyses. 27% of the variance in CBCL total problem behaviour scores was accounted for by three predictor variables: siblings' self-esteem (13%), mothers' GHQ (12%) and siblings' locus of control (2%). 20% of the variance in CBCL internalizing behaviour problem scores was accounted for by two predictor variables: siblings' self-esteem (10%) and mothers' GHQ (10%). 22% of the variance in CBCL internalizing behaviour problem scores was accounted for by three predictor variables: siblings' self-esteem (11%), mothers' GHQ (10%) and siblings' locus of control (2%). 49% of the variance in CDI depression scores was accounted for by siblings' self-esteem scores. No other significant predictor variables were identified in this analysis.

The importance of the predictor variables identified in these four analyses may be assessed by noting the number of analyses in which they were identified as significant predictors and the amount of variance they accounted for in these analyses. The siblings' self-esteem score was entered as the first predictor variable in all four analyses and accounted for between 10-13% of the variance for the three CBCL scales and 49% of the variance for the CDI depression scale. This is clearly the most important predictor of sibling adjustment. Mothers' GHQ score was entered as the second predictor variable in the three regression analyses involving CBCL scales. Across the three analyses the mothers' score on the GHQ accounted for 9-12% of the variance. This is the second most important predictor of sibling adjustment. Locus of control was entered as the third predictor variable in the regression analyses in which the CBCL total problem scale and CBCL internalizing behaviour problem scale were the dependent variables. In each of these analyses siblings' locus of control accounted for only 2% of the variance. Thus, siblings locus of control was the third most important predictor of sibling adjustment.

## **DISCUSSION**

Before discussing the substantive findings of this study, some comments on the methodological limitations which constrain the generalizability of its findings are in order. This was a study of a non-representative self-selected group of siblings and parents from families in which SIDS had occurred. Cases from higher socio-economic groups were over-represented. Thus, results from this study may not validly be generalized to siblings in families from lower socio-economic groups. Participants in this study were 11 year old boys or girls from intact families whose siblings had died a sudden death about 7 years before the study. Mothers who participated were in their late 30s and fathers were in the early 50s, with a third of families being rurally based and the rest living in urban settings. The results from the study cannot validly be generalized beyond that sector of the population of families in which SIDS has occurred which shares this demographic profile. With these caveats in mind, the substantive findings will be considered.

The specific aim of this study was to pinpoint those psychological characteristics of siblings and parents and those psychosocial characteristics of families and their wider social networks which contribute significantly to the adjustment of siblings to SIDS. Twice as many of the SIDS-siblings in this study (18%), compared with the Child Behaviour Checklist standardization sample, had significant behavioural problems. In terms of personal characteristics, these poorly adjusted SIDS-siblings had lower self-esteem and a more external locus of control compared with the rest of the group. In terms of parental characteristics, their fathers and mothers also had lower self-esteem and their mother's had poorer psychological adjustment. In terms of family functioning, fathers and mothers of poorly adjusted SIDS-siblings perceived marked problems in family organization. Both mothers and fathers in the clinical group perceived family roles to be problematic. There was a lack of clarity about roles and a lack of clear boundaries between roles. In addition mothers of poorly adjusted SIDS-siblings perceived greater problems with general family functioning and more specifically with family problem-solving routines and marital satisfaction.

Of all of these personal, parental and family factors three were of particular significance for sibling adjustment: siblings' self-esteem, maternal mental health, and siblings' locus of control. Thus, the more SIDS-siblings evaluated themselves positively; the more they believed that they had control over important sources of reinforcement; and the better their mothers' mental health, the more likely they were to be well adjusted. That is, the more likely they were to have lower levels of behaviour problems and depression.

These results suggest a number of hypotheses which explain why some siblings adjust to SIDS while others do not. The first is that siblings who adjust to SIDS may reside in families where their mothers work through their grief sufficiently to avoid mental health problems which could otherwise compromise their capacity to offer a *good-enough* parenting environment for siblings to develop positive self-esteem and an internal locus of control. The second hypothesis suggested by the results of this study is that this positive outcome is less likely to happen in families where both parents have low self-esteem, where there is a lack of clarity about roles, and in which wives or mothers experience low marital satisfaction and a lack of effectiveness in family problem-solving routines. A longitudinal study would be necessary to test the validity of these hypotheses, since there are a number of alternative explanations. For example, parental self-esteem and family role clarity may not be predisposing factors as suggested, but rather be a consequence of sibling's adjustment difficulties and maternal mental health problems.

The results of the present study are consistent with those of the five published studies on siblings' adjustment to sudden infant death insofar as they show that behavioural difficulties are over-represented in SIDS-siblings (Cornwell, Nurcombe & Stevens, 1977; Defrain & Ernst, 1978; Hutton & Bradley, 1994; Mandell, McClain & Reece, 1988; Powell, 1991). This sub-group clearly require health service input to help them deal with the psychological sequelae of SIDS. Given the factors associated with poor adjustment in SIDS-siblings, probably a family therapy based service would be most appropriate.

However, it is important to highlight that the vast majority of children (82%) did not display clinically significant levels of behavioural problems on the CBCL and 92% did not show clinically significant levels of depressive symptomatology on the CDI.

With respect to the parents who participated in this study, 79% of fathers and 70% of mothers reported no clinically significant mental health difficulties on the GHQ-28. These results are comparable to the finding in a major UK community survey of over 6000 people in which 68% of respondents fell below the clinical cut-off score and in the healthy range on the GHQ-30 (Cox et al, 1987). While Cox et al's (1987) study employed the GHQ-30 rather than the GHQ-28, both instruments have been shown to yield similar results when used for screening, therefore it is valid to compare these results with those of the present study. Our findings suggest that 7 years after the loss of a child, most parents find some way to cope with the loss sufficiently to avoid clinically significant mental health problems. This demonstrates the remarkable resilience of families in dealing with SIDS.

The relative psychological health of the majority of siblings and parents in families where SIDS has occurred suggest that services for most families with SIDS, with similar profiles to those who participated in this study, should be made available in the immediate aftermath of the bereavement and that in the longer term far less intensive service provision will be required.

## **SUMMARY**

Participants in this study were 119 siblings of children who had died from sudden infant death and their parents. This non-representative self-selected group, were profiled as 11 year old boys or girls from middle or upper-middle class intact families whose siblings had died a sudden death about 7 years before the study. Mothers who participated were in their late 30s and fathers were in the early 50s, with a third of families being rurally based and the rest living in urban settings. 18% obtained T-scores above the cut-off of 63 on the total problem scale or the Child Behaviour Checklist. These clinical cases had lower self-esteem and a more external locus of control compared with the rest of the group. Their fathers and mothers also had lower self-esteem and their mothers were more poorly psychologically adjusted. Compared with the non-clinical group, both mothers and fathers in the clinical group perceived marked problems in family functioning. From a wide range of measures of personal, parental and family characteristics, siblings' self-esteem, maternal mental health and sibling' locus of control were identified in a series of stepwise multiple regression analyses as the most significant predictors of siblings' adjustment.

## **ACKNOWLEDGEMENTS**

The research reported in this paper was funded in part by a grant from ISIDA, in part by the EHB, and in part by a Faculty of Arts grant from UCD. However, the views expressed in this article are those of the authors and do not reflect the views or policies of the ISIDA, the EHB or UCD. Thanks to the editor of the Irish Journal of Psychology for permission to reprint this paper which previously appeared as Coughlan, B., Carr, A., & Fitzgerald, M. (1998). Factors related to the adjustment of siblings following sudden infant death. *Irish Journal of Psychology*, 19, 295-312.

## **REFERENCES**

- Achenbach, T. (1991). *Manual for the child behaviour checklist. 4-18 and 1991 profile.* Burlington, VT: University of Vermont Department of Psychiatry.
- Arneil, G., Gibson, A., McIntosh, H., Brooks., Harvie, A. & Patrick, W. (1985). National post perinatal infant mortality and cot death study. *The Lancet*, 30, 740-743.
- Battle, J. (1992). *Culture free self-esteem inventories (Second Edition).* Austin, Tx: PRO-ED.
- Blueglass, K. (1981). Annotation: Psychosocial aspects of the Sudden Infant Death Syndrome ("The Cot Death"). *Journal of Child Psychology & Psychiatry*, 22, 411-421.
- Cornwell, J. Nurcombe, B. & Stevens, L. (1977). Family responses to the loss of a child by sudden infant death syndrome. *Medical Journal of Australia.*, 135, 656-658.
- Corr, C. & Balk, D. (1996). *Handbook of adolescent death and bereavement.* New York: Springer.
- Cox, B., Blaxter, M., Buckle, A., Morrison, J. & May, R. (1987). *The health and lifestyle survey.* Cambridge: Health Promotion Research Trust.
- CSO (1986). *Census 86. Summary population report-second series.* Dublin: CSO.
- Dahlem, N, Zimet, G. & Walker, R. (1991). A multidimensional scale of Perceived social support. *Journal of Clinical Psychology*, 47, 756-761.
- Defrain, J. & Ernst, L. (1978). The psychological effects of sudden infant death syndrome on surviving family members. *Journal of Family Practice*, 6, 985-989.
- Dyregrov, A. & Mattiesen, S. B. (1987). Stillbirth, neonatal death and sudden infant death (SIDS): parental reactions. *Scandinavian Journal of Psychology*, 28, 104-114.
- Feeley, N. & Gottlieb, N. (1988-89). Parents' coping and communication following their infant's death. *Omega Journal of Death and Dying*, 19, 51-57.

- Goldberg, D. & Williams, P. (1988). *A users guide to the GHQ*. Windsor, UK: NFER-Nelson.
- Guntheroth, W.G. (1989). *Crib death: The sudden infant syndrome*. London: Futura Publishing.
- Hair, I.F., Anderson, R. E., Tatham, R.L. & Black, N. C. (1992). *Multivariate data analysis with readings*. (Third Edition). New Jersey: Prentice Hall Inc.
- Hutton, C.J. & Bradley B.S. (1994). Effects of sudden infant death on bereaved siblings: a comparative study. *Journal of Child Psychology & Psychiatry*, 35, 723-732.
- ISIDA (1993) Part one national sudden infant death register. Dublin: ISIDA
- Kabacoff, R. Miller, I., Bishop, D., Epstein, N. & Keitner, G. (1990). A psychometric study of the McMaster Family Assessment Device. *Journal of Family Psychology*, 3, 431-439.
- Kasius, M., Ferdinand, R., van den Berg, H. & Verhulst, F. (1997). Associations between different diagnostic approaches for child and adolescent psychopathology. *Journal of Child Psychology and Psychiatry*, 38, 625-632.
- Kovacs, M. (1992). *The Children's Depression Inventory*. New York: Multi-Health Systems.
- Limerick, S. R. (1992). Sudden infant death in historical perspective. *Journal Clinical Pathology*, 45, (Supplement), 3-6.
- Lumpkin, J.R. (1985). Validity of a brief locus of control scale for survey research. *Psychological Reports*, 57, 655-659.
- Mandell, F. Mc Anulty, E. & Reece, R. (1980). Observations of Paternal Response to Sudden Unanticipated Infant Death. *Pediatrics*, 65, 2, 221-225.
- Mandell, F., Mc Clain, M. & Reece, R. (1988). The sudden infant death syndrome: siblings and their place in the family. *Annals of the New York Academy of Sciences*, 533, 129-131.
- Nowicki, S & Strickland, B. (1973). A locus of control scale for children. *Journal of Consulting and Clinical Psychology*, 40, 148-154.
- Ostfeld, B.M., Ryan, T., Hiatt, M. & Hegyi, T. (1993). Maternal Grief after Sudden Infant Death Syndrome. *Developmental and Behavioural Pediatrics*, 14, 156-162.
- Powell, M. (1991). The psychosocial impact of sudden infant death syndrome on siblings. *Irish Journal of Psychology*, 12, 235-237.
- Price, M., Carter, B.D., Sheldon, T.L. & Bendell, R.D. (1985). Maternal Perceptions of sudden infant death syndrome. *Children's Health Care*, 14, 22-31.

- Radic, A., Griffin, M. & Cahalane, S. (1983). Post neonatal mortality in Dublin with special consideration of SIDS Irish Medical Journal 76, 340-343.
- Rotter, J.B. (1966). Generalized expectancies for internal versus external control of reinforcement. Psych. Monographs, 80, (Whole No. 609).
- Schumm, W., Paff-Bergen L., Hatch, R., Obiorah, F., Copeland, J., Meens, L., & Bugaighis, M. (1986). Concurrent and discriminant validity of the Kansas Marital Satisfaction Scale. Journal of Marriage and the Family, 48, 381-387.
- SIDS Global Strategy (1994). Third SIDS International Conference, Norway.
- Smith, S. & Pennell, M. (1996). Interventions with bereaved children. London: Kingsley.
- Smucker, M. R., Craighead, W.E., Craighead, L.W. & Green, B.J. (1986). Normativity and reliability data for the Children's Depression Inventory. Journal of Abnormal Child psychology, 14, 25-40.
- Tabachnick, B. G. & Fidell, L. S. (1989). Using multivariate statistics. New York: Harper Collins Publishers.
- Walsh, F. & McGoldrick, M. (1991). Living beyond loss: death in the family. New York: Norton.
- Williams, A. & Nikolaisen, S. M. (1982). Sudden Infant Death Syndrome: Parents Perceptions and Responses to the loss of their infants. Research in Nursing and Health, 5, 55-61.

## CHAPTER TWELVE

### *MUSINGS AND MEANDERINGS*

*Karin Grieve.*

In the last few years there have been visitors to our service from other parts of the country and from abroad. It has always caused consternation when we have told them that roughly a third of the clinical and residential staff have worked in the service for 20 years plus. After the consternation the visitors have always wanted to know what it has been like and what it is like now. I am not proposing to do all that today. I will however give you a few thoughts and memories about it on this particular day, being the first day of retirement for Dr. Carroll.

It seems to me that the Service has now gone through its first life cycle. Tony is the first person out of the original group, still in the Service, to retire.

At the birth of the Service we were all young or at least full of energy. We thought nothing of heading off in the evenings out to small Health Centres in Co. Galway, Mayo or Roscommon to let people know that our service existed and what we had to offer. The gap between what we wanted to offer, the most important part in our minds being family therapy, and what our audience wanted, was huge. They wanted to know if we could get houses for people or if we would come and give a talk about hygiene in the local school. After the talk we always got a cup of tea and apple pie and we crowded with the rest over the electric fire with one bar. There never was any heating at night in those Health Centres, if at all.

We were all passionate about family therapy in particular in those days. Tony declared Wednesday afternoons training afternoons. Whoever had been away on a course or workshop would present what they had learnt and then we all, including Tony, who luckily was secure enough in himself not to have to pretend that he knew everything, although he did know most things actually, but he happily joined in as one of the group practising circular questioning, working with genograms or how to do a family sculpt or whoever had a difficult family therapy case would present this.

As professionals we were rather undifferentiated in those days. I am not talking about Tony, but the rest of us. The psychologists did not want to test people, the social workers saw no point in taking social histories in isolation and the young doctors did not believe in medicating young children. What we all wanted to do was to practice family therapy or individual therapy if we couldn't get the family to agree to come. We were like a group of adolescents all wearing black, if you had seen one of us performing professionally you had seen us all, irrespective of our background degrees. The residential side of the Service mirrored at that time this undifferentiation, nurses and child care workers both provided milieu therapy for the children in St. Anne's.

Outside work we were also roughly going through the same life stages. We were out and about, Galway was still small in those days, some found partners, and others stayed on their own. There were a few years when the lunch time topic of conversation never went beyond soakaways and septic tanks, in detail, in the middle of the bacon and cabbage. Then people started to produce children and I remember being pregnant and walking in to the coffee room where there was a heated discussion about Peadouce nappies versus Pampers. I remember wondering was this what I was going to be reduced to once my baby was born.

From my memory it was about this time that we professionally started to individuate and take off in different directions, often meeting resistance for a while from the rest of the group. In many ways it was a confusing time. A lot of us came from somewhere else than the West of Ireland, and had little or no access to extended family for support when it came to family life and child rearing. It was not a case of everybody mixing outside work as well, some did and others did not, but there was a family atmosphere at work. So while professionally we had reached the point of wanting to do our own thing more, risking the disapproval of the group around us in so doing, at the same time we were increasingly dependent on each other for support when it came to our own children and when it came to facing crisis' in our own lives. We compared notes and looked for support and advice from each other, especially since we knew the way we dealt with personal issues would reflect in our work with patients. It was such a supportive place to come in to in the morning if you had had a night when you had been up a lot with a crying baby or if your toddler had been hanging on to your leg crying "don't go mummy" when you left him at the childminder's and you walked away upset wondering about your choices, or lack of them, in life. There was always someone who noticed and who made you a cup of coffee and listened to your woes.

The years have passed. If we started off as adolescents then individuated and took on adult roles and responsibilities, the original group, still a third of the service, are now truly middle aged and a bit! A lot of things have happened to people in the Service, good things but also a lot of tragedy. St. Anne's has got bigger with more staff that has helped to revitalise the Service while the core group are there as culture carriers or grandparents, who can explain to new staff about Tony's yearly star performance as Santa for example. Tony has worked so very hard through the years trying to get us away from being institutionalised and we have been so very happy to be institutionalised when it came to the Peter Kindle party in the library of St. Anne's. We all drew a name out of a hat and then you had to buy a present for that person. When Ton put on his Santa hat and started to give out the presents all the strife and disagreements of the year disappeared and we managed like any other family to keep it together for a few hours. The most memorable Christmas present in my mind is the one of the years when we were all supposed to move up to Merlin Park. No one really knew what was happening as usual. The present was a peaked cap with two peaks pointing in different directions, the caption above the peaks read: I'm their leader, which way did they go?

Today if you walk in to the coffee room and the older group are there a lot of the talk has to do with pension plans and physical ailments, the old core group have reached what someone kindly called the heavy maintenance phase. However the younger half of the Service are now coming up behind us full of enthusiasm and energy to try new things and at the moment there is a happy marriage between the old and the new with appreciation from both sides for what the other has to offer. Now this was just a very sketchy picture of the process and of the people in the Service that Tony started 27 years ago.

Coming back to the day that is in it I also want to say something about working with Tony.

A few weeks ago I went with Tony and another doctor to do our last clinic together in Ballinasloe. While we packed the box of files into the car I remarked that we had done this journey every month for 23 and a half years. I was feeling nostalgic and a bit emotional at the prospect of the end of an era. Tony, who doesn't like anyone being maudlin, turned around and remarked that the amount of years was irrelevant really and that once a routine was established it really did not matter whether it was five years or 23 and a half years. This is a typical Tony remark. Our trips to Ballinasloe had become a routine however. I usually drove, in fact I can only remember Tony driving once. This was many years ago when I was a cancan dancer in *The Merry Widow* for seven nights running. Tony kindly suggested he drove and I could sleep in the back.

We would set off from St. Anne's around 9.45 a.m. Tony shuffled post and papers up to about Headford roundabout. Then just before the dual carriageway he opened the *Irish Times* and we would drive on in companionable silence.

Somewhere between Craughwell and Loughrea Tony put down his paper and started to converse. This was always a most enjoyable part of the day. It was a good time to bring up any difficulties I had with a current case for example and Tony always took his time to give me his thoughts on the matter. But it was also a time when Tony showed his vast knowledge and great interest in everything. He showed us the exact fields under which hundreds of soldiers were buried, when we were passing through Aughrim, other times he described the old horse fair in Caherme, Co. Tipperary, where Napoleon brought his horses for his army and, as legend has it, his own favourite horse Marengo. Or he would reflect on an Irish word looking for its origin.

The conversation could then move on to books or films, the special functions of the various saints as well as discussing whether it was better to chance number 8 coming up again on the Lotto or whether to go for 33 that had not come up for a long time. I had better hasten to say I would bring that up, not Tony. But he would graciously consider it. At certain times of the year like the time of the Galway Races or of Cheltenham we would discuss the horses and different ways of betting. He often won and I still can't work out how he chooses his horses. I am not suggesting he is a gambler. I am only giving examples of his vast repertoire when it comes to enjoyable conversations and his genuine interest in everything.

This genuine interest was very apparent to the patients that we saw when we reached Ballinasloe. I have shared many family sessions with Tony through the years and have learnt from him how to genuinely trust that parents are doing the best they know how for their children. This sounds very simple and obvious but to me this represents the corner stone of a child guidance clinic. If you genuinely believe this you work in partnership with the parents, both of you looking at the jigsaw pieces of the child's life and symptoms rather like a modern detective.

Starting off a session, Tony often asked about the origin of the names in the family or about any Irish word in their address. The family relaxed in their chairs and we would get bits of family history that might be highly significant when it came to diagnosing their difficulties or it might be purely anecdotal. Whichever, it certainly made for a so called positive treatment alliance.

This positive alliance was really needed sometimes when Tony came up with his more ingenious but totally unexpected suggestions. Years ago a very young lad with a gambling problem and his parents were astounded when Tony praised the lad for his generosity, the lad obviously realising that the owner of the slot machines really needed his money and suggested the lad sent his money to the owner in an envelop every week. This would free up the time for the lad to pursue his other interests that were getting neglected because of the gambling. We don't know what the lad thought but the parents reported later that he was cured and had returned to playing football with his friends instead.

Sometimes the families provided the ingenious and unexpected solutions themselves like the family where the children were allergic to the pets and the solution was to send the children to boarding school and keep the pets. The family reassured us that this was a family decision.

After 23 years in the prefab that constituted Ballinasloe Health Centre the team had the pleasure of moving into the new, impressive Health Centre before Tony left. Instead we saw families in the social workers interview room when they did not need it or in the psychologists office if they were both out of in the eye room, which was next door to the social welfare man and the walls so thin we had to try to talk when they were talking next door and be silent when they were silent. All through the years of this state of affairs Tony was truly professional. The rest of us moaned while he concentrated on the job that had to be done. Only once did I hear him make a spontaneous exclamation. That was when we brought a family down to the social workers interview room and when Tony opened the door one of the walls of the room had disappeared leaving a gaping hole where the fourth wall used to be.

Returning to Galway the routine continued. Tony dictated all the notes and letters from the clinic while I drove and in between we discussed our different impressions of the patients we had seen.

On the way back we sometimes made stops. Once we stopped off in Loughrea and visited a nun who was a nurse in our service at one stage who was then Sister C. She then became Sister M.B. when she joined the Carmelite convent in Loughrea which is a closed order. The rumour had it however that she was going to Nigeria to be closed in there. Tony found a book at home about Nigeria and decided this was just what Sister M.B. needed so we called on her. We got keys in the front of the building and were told to go to the back and let ourselves in. This we did and ended up in a freezing room with a wall with a big grid on it with curtains closed. We heard a noise, the curtains were opened and there was Sister M.B. smiling broadly and warmly which was just as well since the electric heater with one bar wasn't doing much heat wise. She was very touched to get the book and explained to us that a local Moslem chief in Nigeria was offering to build a convent if the nuns would come and offer health care to the area. She was leaving shortly and told us happily that she expected to live rough until the building was erected and she would be closed in again. We were very quiet on the way back.

Finally our routine trip brought us back up the avenue in front of St. Anne's.

So now Tony, you are moving on to a different phase. Instead of being maudlin and emotional I was going to play for you a short bit of Swedish music, Abba singing "Thank you for the memories" but I discovered they actually sing "Thank you for the music" so I decided

instead to say something in Irish that would be very appropriate to anyone retiring in the West of Ireland: Solas na greine ort i gnonai. Go raibh maith agh, Tony.

## CHAPTER THIRTEEN

### *PSYCHOANALYTIC PSYCHOTHERAPY IN IRELAND - A PERSONAL VIEW*

*Michael Fitzgerald.*

There has been an ‘explosion’ of interest in psychoanalytic psychotherapy in Ireland in the past 13 years. This growth has been due to professional developments and consumer demands. It is of interest that in an interview that Adam Limentani (1994) pointed out that Freud was interested in this ‘explosion’ and told his followers in 1923 “you must do something about this ‘explosion’ of demands for psychotherapy that is about to happen! You will see what is going to happen”. Limentani went on to state that Freud was right. Clearly this ‘explosion’ was much delayed in Ireland partly because Ireland is an island at the periphery of Europe and also because no member of the medical profession, the dominant profession in this area was willing to take a lead. In addition there has been dissatisfaction by patients with the lack of psychotherapy services being provided by the medical and psychiatric profession. The medical profession particularly in the past have been trained using the medical biological model which has been the dominant paradigm. The advisers to government are drawn from doctors with this paradigm as indeed have ministers for health on at least two occasions in recent years. This has led to a lack of understanding of non medical approaches to treatment. In addition the development of psychotherapy has also been inhibited by the lack of support for Senior Registrar posts in psychotherapy and Consultant Psychotherapist posts within the Health Service. In addition an interest in psychotherapy will not advance medical doctors careers.

In 1993 it was estimated that there are about 300 psychotherapists in Ireland of which 10% were medically qualified. These included psychoanalytic psychotherapists; cognitive and behavioural; family and marital; constructivist and humanistic. There were well over 1,000 counsellors, many of these were guidance counsellors and a small group of practitioners who called themselves counsellors indistinguishable from psychotherapists. In the middle of the 20<sup>th</sup> century psychoanalytic ideas in Ireland were largely discussed by a group in Monkstown Co. Dublin.

In 1981 on my return to Ireland I began to realise that there was an interest in the psychotherapeutic aspects of general practice by some General Practitioners. This interest led me to conduct a Balint Group for General Practitioners in the West of Dublin. This was a particularly rewarding experience and led me to found The Irish Balint Society which focused on the application of psychoanalysis to general practice. I then considered that other medical specialities would be also interested in the application of psychoanalysis. I therefore founded the Irish Paediatric Obstetric Psychiatric Society in 1982. This society held annual meetings at the National Maternity Hospital, Coombe Hospital, etc., with enormous interest from Paediatricians, Obstetricians, Nurses, Social Workers.

As a Psychoanalyst and a Consultant Child Psychiatrist working with disturbed families it came to my notice that there was an excessive emphasis on Family Therapy and on systems approaches with a relative neglect of the intrapsychic processes in disturbed children. This led me in 1982 to initiate the Child Psychoanalytic Psychotherapy Group which became in 1986 The Irish Forum for Child Psychotherapy. At this point I felt that discussions about child psychoanalytic psychotherapy while laudable in themselves were insufficient. I felt that there was a need for a training course in child psychoanalytic psychotherapy and I was ably supported by Dr. Mary Smith and Dr. Louise Tansey in the development of the first Child and Adolescent Psychotherapy Diploma course which commenced in October 1990. About this time I was travelling regularly to Europe having been invited to represent the Irish view point and to found a European Association of Psychotherapy. During these discussions I began to realise that academic attachments would play a large role in most future courses. The diploma in Child Psychotherapy was converted to a Masters at T.C.D. in 1993.

Since I also have an interest in adult psychoanalytic psychotherapy I set in train a similar process and founded the Irish Association for Psychoanalytic Psychotherapy in 1982 with Lord John Alderdice as the first Treasurer and Dr. C. P. Noone as the first Chairperson. This association held meetings to discuss topics related to adult psychoanalytic psychotherapy. Then around the time of The New Ireland Forum Lord Alderdice suggested that the Forum would be a good word to have in the title of an Irish organisation which I agreed and this led to the formation of the Irish Forum for Psychoanalytic Psychotherapy. Lord J. Alderdice was the first Secretary, Mary Pyle as the first Treasurer in 1985, and myself as the first Chairperson in 1985.

The IFPP then began to concern itself after a period of continuing discussions on psychoanalytic psychotherapy with accreditation issues. The criteria for membership of the IFPP began to be gradually harmonised with Europe. A grandparent clause allowed professionals with different trainings in the past and experience of working in the area of psychoanalytic psychotherapy to also become members. The IFPP became recognised as the major place for discussions on theoretical, clinical and professional issues in relation to psychoanalytic psychotherapy in Ireland. Another activity associated with the IFPP was the founding of the Journal. I saw a need for this as a way of giving members an opportunity to

express themselves creatively in print and founded the Journal in 1986 with Lord John Alderdice. Then the IFPP began discussions about setting up psychoanalytic psychotherapy training. A training institute was set up in 1993 called The Irish Institute of Psychoanalytic Psychotherapy of whom the founding members were Felicity Casserly (Treasurer), Nessa Childers, Michael Fitzgerald (Co-chairperson), Rita McCarthy, Ann Murphy (Co-chairperson), Ellen O'Malley Dunlop, Mary Pyle (Co-ordinator of Training Course), Ross Skelton (Examinations Secretary) and Patricia Skar (Secretary). This course has its first intake of 15 students in October 1993. The course is basically an integrative/integrated dynamic psychotherapy course with all the major psychoanalytic and analytic thinkers emphasised. It had in addition a group psychotherapy training experience as well as an infant observation experience something which has become essential for anybody becoming a psychotherapist since the 1990's. It was converted into an MSc (T.C.D.) later in the 1990's.

On my return to Ireland in 1981 I was contacted by Cormac Gallagher who was at that time working in the Department of Psychiatry, St. Vincent's Hospital, Elm Park as a psychologist. During the course of meetings continuing on to 1982 I suggested to him a psychoanalytic psychotherapy training course and put a model of such a course on paper for the first time. He then discussed it with Professor Noel Walshe who expressed an interest in it. Following on this Professor Ivor Browne and Vincent Kenny also became interested in setting up a parallel course in constructivist psychotherapy. A meeting took place on the 13<sup>th</sup> of May 1983 with Noel Walshe, Cormac Gallagher, Vincent Kenny, Mary Darby and myself to discuss proposals for courses in psychotherapy. There followed then many meetings through 1984 and early 1985 and the first course in adult psychoanalytic psychotherapy with a Master's Degree associated from U.C.D. began on the 15<sup>th</sup> of October 1985. There were at least 17 meetings leading up to the commencement of the course. In addition for many years I have had the opportunity to supervise trainee psychiatrists and others in psychotherapy in most Eastern Health Board areas e.g. Kildare and West Dublin at St. Loman's Hospital, North County Dublin at Artane Day Centre, North West Dublin at St. Lawrences Road, South Dublin at Vergemount Hospital and St. James's Hospital.

The training course under direction of the Institute of Group Analysis in London has been another very successful initiative here in Dublin. The original Irish organising committee were Mary Darby, Therese Brady, Cormac Gallagher, Noel Walshe, Michael Fitzgerald, James Kelly and Conall Larkin.

Another welcome development was the M.Phil in psychoanalytic studies initiated by Ross Skelton and David Berman and the development at LSB in Balfe Street Dublin where degree courses are now offered.

### **The Northern Ireland situation:**

In 1981 I was invited to a meeting with Professor George Fenton Professor of Psychiatry Queen's University Belfast and Professor Joe Meehan Professor of Psychiatry Trinity College Dublin about the issue of psychotherapy training within the Department of Psychiatry in Belfast. This led to my appointment as a tutor in psychotherapy in the Department of Psychiatry, Belfast City Hospital. Since that appointment I have supervised Senior Registrars in Psychiatry initially and later Senior Registrars in psychotherapy on a regular basis. They have travelled down from Belfast for the supervisory sessions. From these small beginnings evolved a dynamic Department of Psychotherapy. I took part in a

number of discussions with Lord Alderdice and Dr. Clare Adams during the period of development of the Master's Degree in Psychotherapy at Queen's University Belfast. Unlike the situation in the Republic of Ireland where developments in psychotherapy in the Public Health Service are very few and far between, Lord John Alderdice supported by Dr. C. Adams has made been great strides in the Public Health Service in the delivery of psychotherapy services to disadvantaged patients who otherwise would not be able to avail of psychotherapy. The combined output of graduates for all the Irish courses (Masters or equivalent) was well over 100 in 1993.

A major development in Northern Ireland occurred in 1991 when Lord John Alderdice, Dr. Clare Adams and others founded the Northern Ireland Institute of Human Relations. Its aim was to integrate efforts to develop psychoanalytically informed activities and to act as a focus for those who were working in this field in Northern Ireland.

I founded The Irish Standing Conference on Psychotherapy in 1990 which embraces all the major psychotherapy organisation in Ireland. I found a full and immediate support for this conference from all the major psychotherapy training organisations e.g. family therapy, psychoanalytic psychotherapy, constructivist psychotherapy, humanistic and integrative psychotherapy, and behaviour and cognitive psychotherapy. The first meeting was attended by Ger Murphy a Humanistic Psychotherapist, Ruth O'Donnell a Family Therapist and Ed McHale a Family and Marital Therapist. At the following Dorothy Gunne represented the constructivist psychotherapists and Aidan Lawlor the behaviourists.

I had one meeting with representatives of the Irish Association of Counselling to discuss the possibility of a counselling section of the I.C.P. in the National Children's Hospital but this did not progress.

In recent years the Department of Health has consulted the Irish Standing Conference on Psychotherapy on major mental health issues. The Irish Standing Conference on Psychotherapy has links with the European Association of Psychotherapy. On the 3<sup>rd</sup> of July 1992 the European Association for Psychotherapy was incorporated in Brussels and I was one of the 15 signatories to the document of incorporation. The EAP is basically an umbrella organisation of national umbrella organisations within each country within the Ec. At about the same time I was invited to attend the first meeting of the European Federation for Psychoanalytic Psychotherapy which was playing a similar role with a narrower focus on psychoanalytic psychotherapy in London in 1991. The EFPP criteria are now being used by the Irish Institute for Psychoanalytic Psychotherapy and the Child and Adolescent Psychotherapy Training Programme T.C.D..

The current situation is relatively healthy with regard to psychotherapy but more needs to be done to establish psychotherapy as a profession in its own right, and in getting reimbursement for psychotherapy and counselling provided by psychotherapists and counsellors. I have had a meeting with the Voluntary Health Insurance to discuss this matter. I put to them that psychotherapy could be argued for purely on economic grounds, i.e. that it reduces general medical service demands by 20% and reduces inpatient hospital stays. (Taller et al., 1994; Anchor 1989). The research is also very clear that it is more effective than placebo and more effective than no treatment. (Fitzgerald 1987; Malan 1973). In addition it speeds up the rate of recovery of patients with many psychological problems. There is also evidence that some patients with serious psychological problems gain a benefit which is additive from a combination of pharmacological and psychotherapeutic interventions. The additive effect is

due to differential effects of the two treatments. A psychotherapy post was recognised by the Department of Health in the 1990's something which will open the door for further state developments.

The trend now is for psychiatrists to become neuropsychiatrists and focus on the brain while the 'mind' or the humanistic elements of personal stress are treated by psychotherapists and counsellors. This gives non-medical practitioners a huge importance in the alleviation of human suffering. This places enormous importance on close working relationships between counsellors / psychotherapists and G.P.'s / psychotherapists if persons in distress are to get the best availability of care.

#### REFERENCES:

- Anchor K. (1989). *The handbook of Medical Psychotherapy; Cost - effectiveness strategies in Mental Health.* Hogrese & Humberbern.
- Di Mascio A., Weissman M., Prusoff B. A., Neu C., Zwillling M., Klerman G. (1979). Differential symptom reduction by drug and psychotherapy in acute depression. *Arch. Gen. Psych.*, 36, 1450 - 1458.
- Fitzgerald M. (1987). The effectiveness of psychotherapy. *The Journal of the Irish Forum for Psychoanalytic Psychotherapy.* 1, 1, 29 - 35.
- Karasu T. (1982). Psychotherapy and Pharmacotherapy; towards an integrative model. *Amer. J. Psych.* 139, 9, 1102 - 1113.
- Malan D. H. (1973). The outcome problem in psychotherapy research. *Arch. Gen. Psych.* 29; 719 - 729.
- Talley P. F., Strupp H. H., Butler S. S. (1994). *Psychotherapy research and practice.* Harper Collins: London.

## CHAPTER FOURTEEN

### ***RECOVERY AND RELAPSE IN MULTIPROBLEM FAMILIES FOLLOWING COMMUNITY-BASED MULTIDISCIPLINARY TREATMENT***

*Sheena Leeson, Alan Carr, Michael Fitzgerald & Sami Moukaddem.*

#### INTRODUCTION

There is a substantial literature on the effectiveness of psychological treatments for children's problems (Campbell & Patterson, 1995; Estrada & Pinsof, 1995; Kazdin, 1988; Kazdin, 1994; Shadish, Montgomery, Wilson, Wilson, Bright & Okwumabua, 1993; Target & Fonagy, 1996; Weisz & Weiss, 1993). The majority of studies have examined the effectiveness of a specific unimodal treatment, offered by unidisciplinary treatment teams, to analogue populations with focal problems. Such treatment has typically been conducted in

university treatment centres using a group therapy format informed by a cognitive behavioural model that minimizes parental involvement. Unfortunately making valid generalizations about the effectiveness of psychological interventions with children in routine community-based clinics on the basis of this literature is problematic. This is because within such community settings clinical psychologists are usually required to offer therapy within the context of a multimodal package, as a member of a multidisciplinary team, to referred cases, with complex problems. Typically such therapy is eclectic and entails parental involvement (Kazdin, Siegel & Bass, 1990). Only a handful of comparative studies have examined the effectiveness of routine outpatient multidisciplinary community-based treatment programmes in helping multiproblem families referred for children's psychological problems (Weisz & Weiss, 1993). It is to this question that the present study is addressed.

The results of analogue studies conducted in university-based treatment settings are predominantly positive and reported effect sizes from meta-analyses range from .6 to .7, indicating that the average treated case is better off following treatment than between 73 and 76% of untreated cases (Target & Fonagy, 1996). Results from community-based studies with complex cases referred for treatment are less positive (Weisz & Weiss, 1993). Before reviewing the results of these studies, their methodological shortcomings deserve consideration.

Ethical constraints compromise the methodological rigour with which community-based treatment outcome studies may be conducted. A central difficulty is randomly assigning cases to treatment and control groups, since withholding treatment from children and families facing serious psychological difficulties and who wish to engage in treatment may be construed as unethical. A variety of strategies have been used to deal with this problem and control groups have been formed from non-referred matched cases; matched cases who drop-out of treatment early; or waiting list control cases. The validity of conclusions drawn from studies in which matched non-referred controls have been used is compromised by the fact that members of the control group may have very different expectations than those of the treatment group. They may either view their problems as trivial and therefore not requiring treatment or they may view them as very serious and be demoralized by the unavailability of treatment. The validity of conclusions from studies employing a drop-out control group may be compromised also by a difference in expectations of treatment and control groups. Controls may either view their limited contact as sufficient to resolve their problems and make a *flight into health*, or they may have become disenchanted with treatment and deteriorate. In studies employing waiting list controls, groups probably have similar expectations with respect to treatment. However, there is the risk that they may receive a substantial amount of crisis intervention while on the waiting list and so not represent an untreated group. With these methodological concerns in mind, let us turn to a review of community clinic-based treatment outcome studies.

Shepard, Oppenheim and Mitchell (1966) compared the outcome for 50 children referred for treatment to a clinic in Buckinghamshire in the UK with a non-referred control group of 50 children matched for age, gender and problem type and severity. Two years after pre-treatment assessment, blind judges using structured parent interviews found that 63% of treatment cases and 61% of control cases were improved. The main problem with this study was the fact that pretreatment assessments revealed that parents in the control group were less distressed by their children's psychological problems than those in the treatment group and had expectations that their children's problems were transient. These differences in expectations may have accounted for the positive outcome of the control group.

Levitt, Beiser and Robertson (1959) conducted a study of predominantly parent or parent-child-based treatment of preadolescent conduct disordered boys at the Institute for Juvenile Research in the USA. They compared the outcome of 237 treated cases who received an average of 18 hours of therapy with that of 93 drop-out controls. At five year follow-up, no differences were found between treated cases and controls on 26 outcome variables which included child self-report instruments, parent report instruments and therapist ratings.

Ashcraft (1971) studied two groups of predominantly preadolescent emotionally disturbed boys with significant learning problems. At five year follow-up there were no differences between the 40 treated cases and 43 drop-out controls on standardised achievement tests. While the scores of the control group remained consistently low at each annual re-assessment during the five year follow-up period, those of the treatment group showed a pattern of improvement for the first two years following therapy and a decline thereafter.

In a more recent study, Weisz and Weiss (1989) recruited participants from nine US outpatient mental health clinics. They were predominantly preadolescent boys who received an average of 12 sessions of therapy. The status of 93 treated cases was compared with that of 60 drop-out controls six months and one year following treatment. At both follow-up points no intergroup differences were found on the Child Behaviour Checklist (Achenbach, 1991), the Teacher Report Form (Achenbach, 1991), or ratings of improvement on three case-specific target problems.

DeFries, Jenkins and Williams (1964) in a study at Westchester County New York, randomly assigned members of 27 matched pairs of 6-15 year old children in foster care to treatment or control groups. Treated cases received three years of regular child-focused therapy coupled with foster parent support services, while untreated cases received routine monitoring. Following treatment, the groups did not differ on ratings of clinical improvement made by blind judges and the treated group showed a marginally greater rate of institutionalization, an outcome the treatment programme was designed to prevent.

In contrast to the negative results of the five studies just reviewed Lehrman, Sirluck, Black and Glick (1949) found that treated cases fared better following therapy than drop-out controls. They compared the outcome of 196 psychoanalytically treated cases with 110 drop-out controls at the New York-based Jewish Board of Guardians Child Guidance Clinics. Cases were predominantly preadolescent boys referred for treatment of conduct or neurotic problems and the majority of treated cases received 30 sessions of therapy. One year after the cases were closed 51% of treated cases and 32% of controls were classified by a panel of judges on the basis of case notes to have made clinically significant improvement. A problem with the study, over and above the inherent difficulties of using drop-outs as control, was that there was a preponderance of conduct disordered cases in the control group, and more neurotic cases in the treatment group. Because the former have a poorer prognosis than the latter, the differences in proportions of cases in each diagnostic group may have accounted for the apparent success of treatment.

This brief review suggests that, unlike laboratory-based treatment offered to solicited cases with focal problems, treatment offered in community-based clinics is probably not effective in treating the complex conduct and emotional problems of referred cases. However, this conclusion rests on the results of a set of methodologically imperfect studies. Of the six studies reviewed, only one included waiting list controls. The remainder used non-referred or

drop-out controls. The generalizability of the results of the five older studies (conducted between 1949 and 1971) to the treatment of children in the 1990s is also questionable.

The aim of this study was to evaluate the impact of routine outpatient treatment offered by a multidisciplinary child and family mental health services team in the 1990s on the adjustment of a group of multi problem families using a waiting list control design.

## METHOD

### Participants

Participants in this study were 94 consecutive routine referrals to a community-based Child and Family Psychiatry Centre in a west Dublin suburb (the Ballyfermot Child and Family Clinic) and a Child and Family Psychiatry Centre attached to a large hospital in central Dublin (St. James's Hospital).

**Table 1. Demographic characteristics**

Variable		Treatment Group (N=47)	Control Group (N=47)
Child's gender	Male	36%	23%
	Female	64%	77%
Child's age	Mean	9.7 years	10.0 years
	Range	4-15 years	5-15 years
Mother's age	Mean	37.8 years	35.4 years
	Range	25-49 years	23-52 years
Father's age	Mean	39.2 years	36.6 years
	Range	28-50 years	26-55 years
Child lives with	Two parents	60%	57%
	One parent	23%	26 %
	Mother and others	17%	17%
Weekly household income	Mean	£197	£174
	Range	£85-£400	£80-£371
Father's occupational status	Employed part or full time	64%	62%
Mother's occupational status	Employed part or full time	34%	32%

The first 47 of these referrals were assigned to the treatment group and the remaining 47 were assigned to a waiting list control group. From Table 1 it may be seen that the two groups were demographically similar. With respect to the referred children, there were approximately twice as many boys as girls, with an average age of about 10 years. Parents in these families were in their mid- to late- 30s and over in a third of families, the parents were separated. Approximately two thirds of fathers and one third of the mothers were employed outside the home. The average weekly income in these families was low and all families were from SES category 6 (O'Hare, Whelan & Cummins, 1991). All families had three or more clinically significant problems and so are classifiable as multiproblem families.

## **Instruments**

The Child Behaviour Checklist (CBCL, Achenbach, 1991) and the 28 item version of the General Health Questionnaire (GHQ-28, Goldberg & Williams, 1988) were the principal instruments used to assess symptomatic change for children and mothers respectively.

**The Child Behaviour Checklist (CBCL).** This is a 113 item inventory completed by parents (Achenbach, 1991). Items describe problem behaviours that children in the 4-16 year age bracket may exhibit. A three point response format is used for each item. For this study, T-scores for the total problem behaviour scale, the internalizing and externalizing behaviour problem scales and eight subscales were derived from parental responses to the checklist and included in statistical analyses. The subscales were: withdrawn; somatic complaints; anxious/depressed; social problems; thought problems; attention problems; delinquent behaviour; and aggressive behaviour. Cases obtaining T-scores above 63 on the total problem scale of the CBCL qualify for a DSM diagnosis in about 79% of cases usually of either an emotional disorder or a conduct disorder (Kasius, Ferdinand, van den Berg & Verhulst, 1997). This cut-off point of 63 was used in the present study to analyse frequencies of cases showing clinically significant change.

**General Health Questionnaire (GHQ-28).** For both mothers and fathers, psychological adjustment was evaluated using the 28 item version of the GHQ which yields an overall score and subscale scores for somatic symptoms, anxiety, social dysfunction and depression (Goldberg & Williams, 1988). For each item, four-point response formats were used and the 0,0,1,1 scoring method was employed to obtain total and subscale scores. Cases receiving scores of 5 or more following psychiatric interview typically receive a psychiatric diagnosis and this cut-off point was used in the present study to analyse frequencies of cases showing clinically significant change (Goldberg & Williams, 1988).

**Consumer Response Questionnaire (CRQ).** This 26 item questionnaire contained items that inquired about parents' views on the service they received while attending the clinics (Nicol, Stretch & Fundudis, 1993).

## **Procedure**

Participants in both treatment and control groups were assessed at the outset of the study (Time 1) and three months later (Time 2). In addition the treatment group was assessed nine months after the beginning of the study (Time 3). All assessments were conducted in participants' homes and in all cases the mother was the principal informant. Members of the treatment group received routine non-manualized outpatient treatment from multidisciplinary child and family psychiatry teams. Members of these teams came from the following disciplines: psychiatry, clinical psychology, social work, child care and community psychiatric nursing. Input to cases ranged from a single session to 20 sessions over three months, with the average input being 7 sessions. Assessment and treatment programmes were individually tailored to meet the needs of each case. All programmes included preliminary assessment interviews with parents and children. Treatment programmes included support and advice on behavioural child management for parents and individual supportive work with children. Where appropriate, speech therapy was provided. Cases were approximately equally divided between those that completed treatment and those that dropped out.

## RESULTS

Complete data on all cases were obtained at Time 1. At Time 2 one case was lost from the treatment group and one from the control group. At Time 3, we were unable to trace 16 cases in the treatment group. These 16 cases did not differ from the remain 31 on demographic or clinical variables.

In presenting the results, changes in group mean scores on the CBCL and the GHQ-28 will first be addressed. Analyses of frequencies of cases showing clinically significant change will then be outlined. Finally, consumer response data will be considered.

### **Analysis of changes in group means**

For the 11 CBCL scales and the 5 GHQ-28 scales a series of analyses was conducted to examine statistically significant change in group means. To examine statistically significant change from Time 1 to Time 2 for both groups, each dependent variable was analysed using a 2X2, one-between one-within mixed model ANOVA. To examine statistically significant change from Time 1, to Time 2, to Time 3 within the treatment group, each dependent variable was analysed using a repeated measures ANOVA. Where main effects or interactions were found, Bonferroni t-tests were used to examine differences between pairs of means.

It was expected that in all mixed model ANOVAs a statistically significant Group X Time interaction would occur and that comparison of pairs of means would show a significant reduction in symptoms from Time 1 to Time 2 for the treatment group only. It was also expected that in all repeated measures ANOVAs a significant Time effect would occur and that comparison of pairs of means would show a significant reduction in symptoms from Time 1 to Time 2 but not significant change from Time 2 to Time 3. In presenting the results, the main focus in the text will be on these sets of effects although all effects are presented in the Tables 2 and 3.

Because control group means differed from those of the treatment group for a number of variables at Time 1, a set of alternative analyses was conducted in which the significance of differences between the two groups at Time 2 was tested with ANCOVAs using Time 1 scores as covariates. Results of ANCOVAs for the 11 CBCL scales and the 5 GHQ-28 scales were similar to the results of the ANOVAs and are not reported in this paper.

**Child Behaviour Checklist.** Means, standard deviations and results of the ANOVAs for the 11 child behaviour scales are presented in Table 2. For the mixed model ANOVAs significant Group X Time effects were observed as expected for the total, internalising and externalising scales and four subscales (withdrawn, thought problems, attention problems and delinquent behaviour) of the CBCL. In each instance, means at Time 2 were significantly lower than those at Time 1 for the treatment group but not the control group. For the CBCL total score, the effect size, based on means for the treatment and control group at Time 2 and correcting for differences in group means at Time 1 was .79. This indicates that the average treated case was functioning better than 78% of untreated cases at Time 2.

For the repeated measures ANOVAs, significant Time effects were observed as expected for all 11 CBCL scales. However contrary to expectation in all instances scores at Time 3 were significantly higher than at Time 2 and in four instances (total problem score, externalizing, delinquent behaviour and aggressive behaviour scales) scores at Time 3 were greater than those at Time 1.

**General Health Questionnaire-28.** Means, standard deviations and results of the ANOVAs for the 5 GHQ-28 scales are presented in Table 3. For the mixed model ANOVAs, significant Group X Time effects were observed as expected for the GHQ-28 total scale and the somatic symptoms subscale. For the GHQ-28 total score, the effect size, based on means for the treatment and control group at Time 2 and correcting for differences in group means at Time 1 was .34. This indicates that the average treated case was functioning better than 64% of untreated cases at Time 2.

For the total scale and three of the four subscales (somatic symptoms, anxiety and insomnia, and social dysfunction), means at Time 2 were significantly smaller than those at Time 1 for the treatment group but not the control group. Mean scores on the severe depression subscale were not significantly lower at Time 2, compared with Time 1, for either the treatment group or the control group.

For the repeated measures ANOVA significant Time effects were observed as expected for the total scale and two subscales (somatic symptoms and anxiety and insomnia). However contrary to expectations in all instances scores at Time 3 were greater than at Time 2 and in one instance, for the severe depression subscale, scores at Time 3 were significantly greater than those at Time 1.

**Table 2. Results of ANOVAs for CBCL scales**

Variable		Group					ANOVA Effects				<i>Differences between means</i>	
		Treatment Group			Control Group		Group Effect	Time Effect	Group By Time Interaction	Time Effect for Treatment Group	Between treatment & Control Groups	Within Treatment Group & within Control Group
		Time 1	Time 2	Time 3	Time 1	Time 2	F	F	F	F		
<b>Total</b>	<b>M</b> <b>SD</b>	61.52 14.12	52.65 11.81	65.58 10.94	73.67 06.68	72.04 09.15	76.96***	38.76***	19.89***	46.07***	TGT <sub>1</sub> < CGT <sub>1</sub> TGT <sub>2</sub> < CGT <sub>2</sub>	TGT <sub>3</sub> > TGT <sub>1</sub> > TGT <sub>2</sub> CGT <sub>1</sub> = CGT <sub>2</sub>
<b>Internalising</b>	<b>M</b> <b>SD</b>	62.07 10.91	53.58 11.59	64.36 11.97	72.63 08.86	69.87 11.18	55.01***	38.30***	12.05***	31.59***	TGT <sub>1</sub> < CGT <sub>1</sub> TGT <sub>2</sub> < CGT <sub>2</sub>	TGT <sub>1</sub> = TGT <sub>3</sub> > TGT <sub>2</sub> CGT <sub>1</sub> = CGT <sub>2</sub>
<b>Externalising</b>	<b>M</b> <b>SD</b>	58.39 12.13	51.32 11.28	63.71 12.53	72.59 09.95	70.85 12.15	71.98***	33.25***	11.24***	30.86***	TGT <sub>1</sub> < CGT <sub>1</sub> TGT <sub>2</sub> < CGT <sub>2</sub>	TGT <sub>3</sub> > TGT <sub>1</sub> > TGT <sub>2</sub> CGT <sub>1</sub> = CGT <sub>2</sub>
<b>Withdrawn</b>	<b>M</b> <b>SD</b>	64.61 10.76	57.45 10.45	67.94 13.47	74.09 10.88	72.15 12.55	36.33***	26.42***	10.13**	26.81***	TGT <sub>1</sub> < CGT <sub>1</sub> TGT <sub>2</sub> < CGT <sub>2</sub>	TGT <sub>1</sub> = TGT <sub>3</sub> > TGT <sub>2</sub> CGT <sub>1</sub> = CGT <sub>2</sub>
<b>Somatic complaints</b>	<b>M</b> <b>SD</b>	56.61 08.68	53.61 07.12	58.90 10.31	64.13 12.31	60.98 11.98	14.86***	11.65***	00.13	04.33*	TGT <sub>1</sub> < CGT <sub>1</sub> TGT <sub>2</sub> < CGT <sub>2</sub>	TGT <sub>1</sub> = TGT <sub>3</sub> > TGT <sub>2</sub> CGT <sub>1</sub> > CGT <sub>2</sub>
<b>Anxious depressed</b>	<b>M</b> <b>SD</b>	63.07 08.36	56.81 07.88	64.65 11.26	72.70 10.92	69.09 11.95	41.35***	44.60***	03.36	21.39***	TGT <sub>1</sub> < CGT <sub>1</sub> TGT <sub>2</sub> < CGT <sub>2</sub>	TGT <sub>1</sub> = TGT <sub>3</sub> > TGT <sub>2</sub> CGT <sub>1</sub> > CGT <sub>2</sub>
<b>Social problems</b>	<b>M</b> <b>SD</b>	59.94 10.48	56.97 08.67	62.58 11.17	64.94 11.82	63.87 10.78	10.54**	09.82**	03.01	05.55**	TGT <sub>1</sub> < CGT <sub>1</sub> TGT <sub>2</sub> < CGT <sub>2</sub>	TGT <sub>1</sub> = TGT <sub>3</sub> > TGT <sub>2</sub> CGT <sub>1</sub> = CGT <sub>2</sub>
<b>Thought problems</b>	<b>M</b> <b>SD</b>	59.48 09.82	54.74 07.49	58.58 11.31	65.28 09.80	65.11 10.31	24.19***	09.99**	08.64**	10.57***	TGT <sub>1</sub> < CGT <sub>1</sub> TGT <sub>2</sub> < CGT <sub>2</sub>	TGT <sub>1</sub> = TGT <sub>3</sub> > TGT <sub>2</sub> CGT <sub>1</sub> = CGT <sub>2</sub>
<b>Attention problems</b>	<b>M</b> <b>SD</b>	64.42 11.68	58.26 09.78	66.77 12.69	70.65 11.08	70.30 12.40	20.00***	15.04***	12.05***	15.97***	TGT <sub>1</sub> < CGT <sub>1</sub> TGT <sub>2</sub> < CGT <sub>2</sub>	TGT <sub>1</sub> = TGT <sub>3</sub> > TGT <sub>2</sub> CGT <sub>1</sub> = CGT <sub>2</sub>
<b>Delinquent behaviour</b>	<b>M</b> <b>SD</b>	59.48 08.20	54.74 06.68	63.07 10.88	71.44 11.89	71.33 12.41	61.32***	08.45**	07.59**	11.78***	TGT <sub>1</sub> < CGT <sub>1</sub> TGT <sub>2</sub> < CGT <sub>2</sub>	TGT <sub>3</sub> > TGT <sub>1</sub> > TGT <sub>2</sub> CGT <sub>1</sub> = CGT <sub>2</sub>
<b>Aggressive behaviour</b>	<b>M</b> <b>SD</b>	60.97 10.84	55.71 07.81	65.52 12.09	73.41 13.30	71.48 14.58	47.82***	12.57***	01.85	17.00***	TGT <sub>1</sub> < CGT <sub>1</sub> TGT <sub>2</sub> < CGT <sub>2</sub>	TGT <sub>3</sub> > TGT <sub>1</sub> > TGT <sub>2</sub> CGT <sub>1</sub> = CGT <sub>2</sub>

**Notes:** M =Mean. SD=Standard Deviation. ANOVA effects are from a 2 X 2, Groups X Time ANOVA and a repeated Measures ANOVA for Time 1, Time 2 & Time 3 on the Treatment Group only. TGT1 = Mean Of Treatment Group at Time 1, N = 47. TGT2 = Mean Of Treatment Group at Time 2, N = 46. TGT3 = Mean Of Treatment Group at Time 3, N = 31. CGT1 = Mean Of Control Group at Time 1, N = 47. CGT2 = Mean Of Control Group at Time 2, N = 46. \* p < .05, \*\* p < .01, \*\*\* p < .001



**Table 3. Results of ANOVAs for mothers' GHQ-28 scales**

Variable	Group						ANOVA Effects				<i>Differences between means</i>	
	Treatment Group			Control Group			Group Effect	Time Effect	Group ByTime Interaction	Time Effect for Treatment Group	Between treatment & Control Groups	Within Treatment Group & within Control Group
	Time 1	Time 2	Time 3	Time 1	Time 2	F	F	F	F			
<b>Total</b>	<b>M</b>	7.84	4.65	9.23	10.94	10.07	14.02***	11.44***	4.24*	8.24***	TGT <sub>1</sub> < CGT <sub>1</sub>	TGT <sub>1</sub> = TGT <sub>3</sub> > TGT <sub>2</sub>
	<b>SD</b>	6.71	7.03	8.35	07.25	08.56					TGT <sub>2</sub> < CGT <sub>2</sub>	CGT <sub>1</sub> = CGT <sub>2</sub>
<b>Somatic symptoms</b>	<b>M</b>	2.77	1.68	2.71	3.09	3.04	07.55**	05.76*	4.94*	4.64*	TGT <sub>1</sub> = CGT <sub>1</sub>	TGT <sub>1</sub> = TGT <sub>3</sub> > TGT <sub>2</sub>
	<b>SD</b>	2.22	2.34	2.49	2.32	2.33					TGT <sub>2</sub> < CGT <sub>2</sub>	CGT <sub>1</sub> = CGT <sub>2</sub>
<b>Anxiety insomnia</b>	<b>M</b>	2.94	1.36	3.16	3.76	3.22	14.62***	15.80***	3.67	8.61***	TGT <sub>1</sub> < CGT <sub>1</sub>	TGT <sub>1</sub> = TGT <sub>3</sub> > TGT <sub>2</sub>
	<b>SD</b>	2.73	2.18	2.92	2.32	2.69					TGT <sub>2</sub> < CGT <sub>2</sub>	CGT <sub>1</sub> = CGT <sub>2</sub>
<b>Social dysfunction</b>	<b>M</b>	1.32	0.84	1.61	1.80	1.74	05.80*	02.89	1.84	3.53*	TGT <sub>1</sub> = CGT <sub>1</sub>	TGT <sub>1</sub> = TGT <sub>3</sub> > TGT <sub>2</sub>
	<b>SD</b>	1.83	1.85	2.09	2.12	2.40					TGT <sub>2</sub> < CGT <sub>2</sub>	CGT <sub>1</sub> = CGT <sub>2</sub>
<b>Depression</b>	<b>M</b>	0.81	0.77	1.74	2.26	1.98	13.58***	02.00	0.00	4.89*	TGT <sub>1</sub> < CGT <sub>1</sub>	TGT <sub>1</sub> = TGT <sub>2</sub> < TGT <sub>3</sub>
	<b>SD</b>	1.64	1.88	2.16	2.28	2.63					TGT <sub>2</sub> < CGT <sub>2</sub>	CGT <sub>1</sub> = CGT <sub>2</sub>

a  
d  
j  
u  
st  
ri  
g  
h  
t

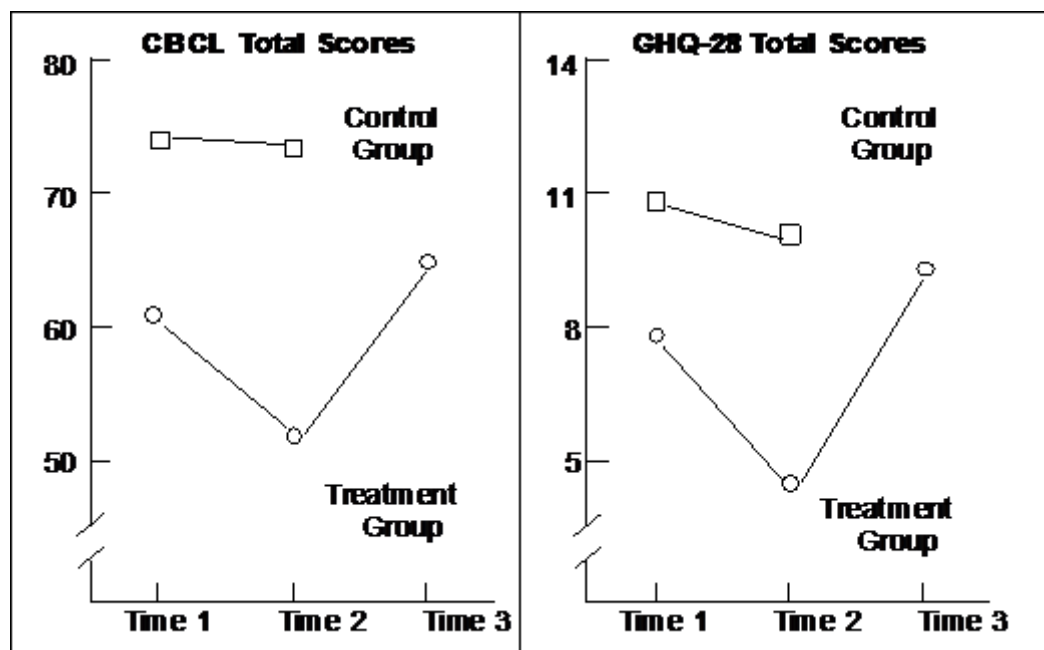
**Notes:** M =Mean. SD=Standard Deviation. ANOVA effects are from a 2 X 2, Groups X Time ANOVA and a repeated Measures ANOVA for Time 1, Time 2 & Time 3 on the Treatment Group only. TGT1 = Mean Of Treatment Group at Time 1, N = 47. TGT2 = Mean Of Treatment Group at Time 2, N = 46. TGT3 = Mean Of Treatment Group at Time 3, N = 31. CGT1 = Mean Of Control Group at Time 1, N = 47. CGT2 = Mean Of Control Group at Time 2, N = 46.

\* p < .05. \*\* p < .01, \*\*\* p < .001



**Conclusion concerning changes in group means.** Graphs of mean scores for children on the total problem score of the CBCL and for mothers on the total score of the GHQ-28 are presented in Figure 1.1. These two graphs illustrate the principal conclusion that may be drawn from the statistical analyses reported in this section. That is, the treatment group showed a significant recovery from Time 1 to Time 2 and a significant relapse from Time 2 to Time 3. In contrast, the comparison group showed no significant change from Time 1 to Time 2.

*Figure 1.1. Child Behaviour Checklist and General Health Questionnaire mean total scores*



### **Analysis of clinically significant change**

Cases were classified as improved, deteriorated or showing no change with reference to clinical cut-off scores of 63 for the total problem scale of the CBCL and 5 for the GHQ-28 total scale. Cases classified as improved, were those whose scores changed from above to below the clinical cut-off from one assessment time to the next. Deterioration from one assessment occasion to another was deemed to have occurred where scores moved from the non-clinical to the clinical range with respect to the cut-off score. Cases were classified as showing no change where their status with respect to the clinical cut-off score did not change from one assessment time to the next.

A set of analyses was conducted to examine frequencies of cases showing clinically significant improvement or deterioration in the treatment and control groups. The number of cases showing clinically significant change from Time 1 to Time 2 was determined for both groups. For the treatment group, the numbers of cases showing clinically significant change from Time 2 to Time 3, and from Time 1 to Time 3 were also identified.

Chi square tests were used to examine differences between the treatment and control groups in the distribution of cases which had improved, showed no change, or deteriorated from Time 1 to Time 2. For the treatment group, Chi square tests were conducted to investigate

changes in the frequencies of cases which had improved, demonstrated no change, or deteriorated from Time 2 to Time 3, and from Time 1 to Time 3. In these latter two analyses, the expected distribution of cases in each clinical change category was that observed for Time 1 to Time 2. Where significant Chi Square values were found, the standardised residual (Hinkle, Wiersma & Jurs, 1994) was computed for each category to determine which of the categories were major contributors to the statistical significance.

An alternative set of analyses, in which the Reliable Change Index (RCI, Jacobson, Follette & Revenstorf, 1984; Hageman, & Arrindell, 1993) was used to examine rates of clinically significant change, was also conducted. Rates of change, based on the RCI are more conservative than those based on status with respect to clinical cut-off scores. It was therefore not surprising that the results of these analyses were in the same direction, but less statistically significant than the analyses based on cut-off scores. Only the results of the analyses based on cut-off scores are reported below.

**Table 4. Rates of clinically significant change for children on the CBCL**

Group	Time Period	Symptomatic status			Comparison	$\chi^2$	P
		Deteriorated	No Change	Improved			
Control	T1 – T2	02.2% (01)	84.8% (39)	13.0% (06)			
Treatment	T1 – T2	00.0% (00)*	59.1% (26)	40.9% (18)**	TG. T1-T2 vs CG. T1-T2	9.56	.01
Treatment	T2 – T3	45.2% (14)**	54.8% (17)	00.0% (00)*	TG. T2-T3 vs TG. T1-T2	32.61	.01
Treatment	T1 – T3	06.5% (02)	90.3% (28)	03.2% (01)*	TG.T1-T3 vs TG.TI-T2	15.50	.01

**Notes:** A cut-off point of 63 for the CBCL total was used. For all analyses 2X3 chi square tests with df=2 were calculated. A significance level of .01 was assumed. Major contributors to the significant chi square value (as determined by standardised residuals) are indicated by: \*\* = More cases improved / deteriorated than expected, \* = Less cases improved / deteriorated than expected. Due to rounding cells may not sum to 100%.

**Child Behaviour Checklist.** Frequencies of cases classified with respect to the clinical cut-off score of the CBCL total scale, as improved, deteriorated or showing no change from one assessment period to another are presented in Table 4 along with the results of chi square analyses.

Compared with the control group, significantly more cases in the treatment group improved from Time 1 to Time 2. Only 13% of cases in the control group improved over this three month period, whereas 40.9% of cases in the treatment group improved.

In the treatment group, significantly more cases deteriorated from Time 2 to Time 3 compared with the number that deteriorated from Time 1 to Time 2. While no cases

deteriorated from Time 1 to Time 2, 45.2% of cases deteriorated from Time 2 to Time 3. Significantly fewer cases improved from Time 2 to Time 3 compared with the number that improved from Time 1 to Time 2. While 40.9% of cases improved from Time 1 to Time 2, not a single case improved from Time 2 to Time 3.

In the treatment group, significantly fewer cases improved from Time 1 to Time 3 compared with the number that improved from Time 1 to Time 2. While 40.9% of cases improved from Time 1 to Time 2, only 3.2% of cases improved from Time 1 to Time 3.

**Table 5. Rates of clinically significant change for mothers on the GHQ-28**

Group	Time period	Symptomatic status			Comparison	P	
		Deteriorated	No Change	Improved		$\chi^2$	
Control	T1 - T2	04.4% (02)	71.7% (33)	23.9% (11)			
Treatment	T1 - T2	04.4% (02)	60.0% (27)	35.6% (16)	TG. T1-T2 vs CG. T1-T2	—	NS
Treatment	T2 - T3	32.3% (10)**	64.5% (20)	03.2% (01)*	TG. T2-T3 vs TG. T1-T2	17.36	.01
Treatment	T1 - T3	12.9% (04)	67.7% (21)	19.4% (06)	TG.T1-T3 vs TG.T1-T2	—	NS

**Notes:** A cut-off point of 5 for the GHQ-28 total was used. For all analyses 2X3 chi square tests with df=2 were calculated. A significance level of .01 was assumed. Major contributors to the significant chi square value (as determined by standardised residuals) are indicated by: \*\* = More cases improved / deteriorated than expected, \* = Less cases improved / deteriorated than expected. Due to rounding cells may not sum to 100%.

**General Health Questionnaire-28.** Frequencies of cases classified with respect to the clinical cut-off score of the GHQ-28 total scale, as improved, deteriorated or showing no change from one assessment period to another are presented in Table 5 along with the results of statistically significant chi square analyses.

From Time 1 to Time 2, differences in rates of improvement for the treatment and control group did not differ significantly. 35.6% of mothers in the treatment group and 23.9% of mothers in the control group improved from Time 1 to Time 2.

In the treatment group, significantly more cases deteriorated from Time 2 to Time 3 compared with the number that deteriorated from Time 1 to Time 2. While only 4.4% of cases deteriorated from Time 1 to Time 2, 32.3% of cases deteriorated from Time 2 to Time 3. Significantly fewer cases improved from Time 2 to Time 3 compared with the number that improved from Time 1 to Time 2. While 35.6% of cases improved from Time 1 to Time 2, only 3.2% of cases improved from Time 2 to Time 3.

In the treatment group, differences in rates of improvement from Time 1 to Time 2 and Time 1 to Time 3 did not differ significantly.

**Conclusions concerning clinically significant change.** In round numbers, from Time 1 to Time 2, 41% of treated children showed clinically significant improvement (a significantly greater number than in the control group) and from Time 2 to Time 3, 45% of treated cases relapsed. From Time 1 to Time 2, 36% of mothers in the treatment group showed clinically significant improvement (but this was no different than the rate of improvement in the control group) and from Time 2 to Time 3, 32% of mothers relapsed.

### Consumer Response Questionnaire

Percentages of mothers who endorsed items on the consumer response questionnaire at Time 2 are presented in Table 6. More than two thirds of cases reported finding it easy to talk to multidisciplinary team members, found the conversations helpful, and found it useful to see that others had similar problems. Between a half and two thirds of respondents found that treatment helped them to cope better with their children; cope better with their children's sleeping, eating and behaviour problems; and understand themselves, their reactions and their children better. Between a quarter and a half of mothers believed that the family meetings were useful and helped them understand their child and family better.

However, between a quarter and a half of cases also would have liked more frequent meetings in which more advice was given, particularly advice on child management. Less than a quarter of cases worried about issues discussed in treatment; felt upset after sessions; felt that too many questions were asked; believed that other family members should have been included; or believed the sessions were of little use because they were *just talk* or were apparently irrelevant to solving the problem. Less than a tenth of mothers reported that too many sessions were offered or that the sessions were inconvenient.

**Table 6. Consumer Response Questionnaire results for the treatment group at Time 2**

Variable	%
1. It was very easy to talk to the worker.	87
2. It helped to have someone to talk to.	76
3. I found it helpful on the whole.	75
4. The meetings were useful to me in seeing that other people may have similar difficulties to me.	67
5. It helped me think out ways of coping with my child.	62
6. It helped me to understand my child more.	60
7. It helped me understand myself more than before.	59
8. It helped me to think of ways to cope with behaviour difficulties in my child.	57
9. It helped me to understand my own reactions to things better.	52
10. It helped me to think of ways to cope with my child's sleep or eating problem.	50
11. It helped me to understand things about the whole family.	47
12. I would have liked more advice.	42
13. I would like to have been told more about handling my children.	41
14. It helped me to understand my child better.	39
15. The meetings were useful to us as a family group.	36

16. The visits would have been more useful if they had been more frequent.	32
17. I worried over what had been discussed.	24
18. There were not enough visits to be really useful.	23
19. It was just talk and not really useful.	23
20. I sometimes felt upset after the discussions.	20
21. Other family members should have had a chance to join in the discussions.	20
22. It was difficult to see the point of some of the things brought up.	19
23. Too many questions were asked.	18
24. Discussions like that are just a waste of time.	13
25. I found the visits inconvenient.	10
26. Fewer visits would have been better.	5

---

**Note:** N=47. Percentages sum to more than 100 because all respondents could endorse all items.

**Conclusion from the consumer response questionnaire.** Predominantly positive comments were made by the majority of mothers about the service, and predominantly negative comments were made by under a quarter of respondents.

## DISCUSSION

The expectation that treatment would lead to significant improvement in mothers' and children's symptoms was borne out by the present study. The expectation that gains made over the course of treatment would be sustained at 9 month follow-up was not met. Mean levels of symptoms for mothers and children at follow-up were not significantly lower than at intake and the majority of cases that improved from Time 1 to Time 2 had relapsed by Time 3. However, at Time 2 the majority of mothers viewed the service in a positive light and only a minority made predominantly negative comments about it.

Considerable confidence may be placed in these results for a number of reasons. First, cases were assigned to the treatment and control groups in a way that did not introduce bias in terms of clients' motivation to benefit from therapy. That is, participants were two cohorts of consecutive referral. These two cohorts were demographically similar. Also, because the treatment group scored lower than the control group on both the CBCL and GHQ at T1, if anything this situation would have introduced a bias in favour of the treatment group showing a more positive response to treatment. Second, the two cohorts were representative of typical referrals to the centres involved in the study both because they contained consecutive referrals and because they were relatively large (n=47). Third, well validated, reliable instruments were used to assess children's and parents' symptomatology. Fourth, independent researchers (SL and SM) gathered the data and these researchers were not part of the treatment team staff. Fifth, the quality of treatment in both settings was of the highest standard. Members of the teams at Ballyfermot Child and Family Centre and St. James's Hospital were all experienced clinicians committed to the highest standards of multidisciplinary care. Treatment, in this study, was not offered by novice clinicians, as is often the case in studies of treatment effectiveness. A sixth reason for having confidence in the results is the duration of the follow-up period. The final round of data collection occurred 9 months following the baseline assessment period. Thus the pattern of changes in symptomatology probably reflected enduring changes rather than short term fluctuations.

The pattern of recovery and relapse observed in this study requires explanation. Our hypothesis is that the services provided led not only to improvements in parenting skills, parent-child co-operation, and mood regulation for parents and children, but also provided ongoing social support and a social context within which these gains could be maintained. However, when treatment ended, this social support was withdrawn. This in turn probably led to the recurrence of mood regulation problems for parents and children. These difficulties in turn probably eroded patterns of parent-child co-operation and parenting skills which had developed during treatment.

The results of the study reported in this paper are consistent with the results of five of the six community-based treatment outcome studies reviewed in the introduction section of this paper (Ashcraft, 1971; DeFries, Jenkins & Williams, 1964; Levitt, Beiser & Robertson, 1959; Shepard, Oppenheim & Mitchell, 1966; Weisz & Weiss, 1989), but are inconsistent with the voluminous literature describing university-based treatment studies with analogue populations (Weisz & Weiss, 1993).

At a methodological level, this study underlines the importance of conducting community-based treatment outcome studies on service using populations rather than university-based studies with analogue populations such as clients solicited through press advertisements. At a service development level, the results of this study point to the importance of developing a chronic care rather than acute care approach to service provision for multiproblem families. There can be little doubt that sustained regular, albeit less frequent contact with treatment services would have led to the maintenance of treatment gains. That is, there is a strong argument here for the long term provision of *booster sessions* for multiproblem families (Estrada & Pinosof, 1995).

Future research in this area should examine the processes that underpin the pattern of recovery and relapse identified in this study and should examine the impact of the long term provision of "booster session" on these processes.

## SUMMARY

In a comparative group outcome study of 47 multiproblem families which received treatment from multidisciplinary child and family mental health services teams and 47 waiting list controls, it was found that treated cases showed significant improvement over the course of three months during which they attended the service. Improvement occurred in children's behavioural adjustment and maternal psychological health. Waiting list controls did not improve significantly on either of these variables during the three month treatment period. However, mean scores of the treatment group at nine months follow-up were not significantly better than pretreatment scores, indicating that gains made during treatment were lost at follow-up. An analysis of the clinical significance of changes in children's adjustment showed that while 41% of children moved from the clinical to the normal range during the course of treatment, all had relapsed at six-month follow up. These results point to the importance of developing a chronic care rather than an acute care approach to service provision for multiproblem families.

## ACKNOWLEDGEMENTS

The research reported in this paper was funded in part by a grant from the EHB, and in part by a Faculty of Arts grant from UCD. However, the views expressed in this article are those of the authors and do not reflect the views or policies of the EHB or UCD. Thanks to the editor of the Irish Journal of Psychology for permission to reprint this paper which previously appeared as Leeson, S., Carr, A, Fitzgerald, M. & Moukaddem, S. (1999). Recovery and relapse in multiproblem families following community based multidisciplinary treatment. *Irish Journal of Psychology*, 20 (1), 69-88.

## REFERENCES

- Achenbach, T. (1991). Integrative guide for the 1991 CBCL/4-18, YSR, and TRF profiles. Burlington, VT: University of Vermont.
- Ashcraft, C. (1971). The later school adjustment of treated and untreated emotionally handicapped children. *Journal of School Psychology*, 9, 338-342.
- Campbell, T. & Patterson, J. (1995). The effectiveness of family interventions in the treatment of physical illness. *Journal of Marital and Family Therapy*, 21, 545-583.
- DeFries, Z., Jenkins, S. & Williams, E. (1964). Treatment of disturbed children in foster care. *American Journal of Orthopsychiatry*, 34, 615-624.
- Estrada, A. & Pinsof, W. (1995). The effectiveness of family therapies for selected behavioural disorders of childhood. *Journal of Marital and Family Therapy*, 21, 403-440.
- Goldberg, D. & Williams, P. (1988). A user's guide to the General Health Questionnaire. Windsor : NFER-Nelson.
- Hageman, W. & Arrindell, W. (1993). A further refinement of the reliable change (RC) index by improving the pre-post difference score: Introducing RC-ID. *Behaviour Research and Therapy*, 31, 693-700.
- Hinkle, D., Wiersma, W. & Jurs, S. (1994). *Applied Statistics for the Behavioural Sciences*. Third Edition. Boston, Houghton Mifflin.
- Jacobson, N., Follette, W. & Revenstorff, D. (1984). Psychotherapy outcome research: Methods for reporting variability and evaluating clinical significance. *Behaviour Therapy*, 15, 336-352.
- Kasius, M., Ferdinand, R., van den Berg, H. & Verhulst, F. (1997). Associations between different diagnostic approaches for child and adolescent psychopathology. *Journal of Child Psychology and Psychiatry*, 38, 625-632.
- Kazdin, A. (1988). *Child psychotherapy: developing and identifying effective treatments*. New York: Pergamon.
- Kazdin, A. (1994). Psychotherapy for children and adolescents. In S. Bergin & S. Garfield (eds.), *Handbook of psychotherapy and behaviour change* (Fourth edition, pp. 543-594). New York: Wiley. A definitive review, but out of date.
- Kazdin, A., Siegel, T. & Bass, D. (1990). Drawing on clinic practice to inform research on child and adolescent psychotherapy: Survey of practitioners. *Professional Psychology: Research and Practice*, 21, 189-198.
- Lehrman, L., Sirluck, H., Black, B. & Glick, S. (1949). Success and failure of treatment of children in the child guidance clinics of the Jewish Board of Guardians. (Jewish Board of Guardians Research Monographs No. 1.) New York: Jewish Board of Guardians

- Levitt, E., Beiser, H. & Robertson, R. (1959). A follow-up evaluation of cases treated at a community child guidance clinic. *American Journal of Orthopsychiatry*, 29, 337-347.
- Nicol, R., Stretch, D. & Fundudis, T. (1993). *Preschool children in troubled families*. Chichester: Wiley.
- O'Hare, A. Whelan, C. & Cummins, P. (1991). Development of Irish census based social class scale. *The Economic and Social Review*, 22 (2), 135-156.
- Shadish, W., Montgomery, L., Wilson, P., Wilson, M., Bright, I. & Okwumabua, T. (1993). The effects of family and marital psychotherapies: A meta-analysis. *Journal of Consulting and Clinical Psychology*, 61, 992-1002.
- Shepard, M., Oppenheim, A. & Mitchell, S. (1966). Childhood behaviour disorders and the child guidance clinic: An epidemiological study. *Journal of Child Psychology and Psychiatry*, 7, 39-52.
- Target, M. & Fonagy, P. (1996). The psychological treatment of child and adolescent psychological disorders. In Roth, A. & Fonagy, P. (eds.), *What works for whom. A critical review of psychotherapy research*. New York: Guilford.
- Weisz, J. & Weiss, B. (1989). Assessing the effects of clinic-based psychotherapy with children and adolescents. *Journal of Consulting and Clinical Psychology*, 57, 741-746.
- Weisz, J. & Weiss, B. (1993) *Effects of psychotherapy with children and adolescents*. London: Sage.

## CHAPTER FIFTEEN

### *SELF REPORTED DEPRESSIVE SYMPTOMS, PROBLEMS AND PERSONALITY CHARACTERISTICS IN ADOLESCENCE*

*C. M. McDonough, S. T. Fahy, M. Fitzgerald.*

#### *Key Words*

Adolescents, depression, personality, Youth Self Report (YSR), Birleson (DSRS) Depression Self-Rating Scale, Jesness Personality Inventory.

#### *Summary*

This study set out to look at self reported depressive symptoms, competencies and personality characteristics in a group of 165 adolescents. The instruments used were the Birleson Self-Rating Scale (DSRS), Youth Self Report and the Jesness Personality Inventory.

Thirteen percent of the group ( $n = 20$ ) scored above the cut-off on the DSRS. The adolescents who scored in the depressed range ranked themselves as competent as those in the non-depressed range. Statistically significant differences were found in levels of suicidal ideation and personality characteristics between the group above the cut-off on the DSRS and those below.

#### *Introduction*

It has been shown that depression in youth is a valid clinical phenomenon with substantial risk of recurrence (McCauley, 1993). Two-thirds of those with dysthymic states which do not reach the full criteria for a depressive illness in middle childhood and adolescence, will develop a major depressive disorder within 5 years (Kovacs, 1984). A review by Pataki (1995) suggested that depression in children and adolescents is associated with long-term morbidity and risk of suicide.

In this age group it has been said that problems at school or at home may be markers for depression (Sturtz, 1991) and that this may be associated with lower levels of self-esteem (Avison, 1992). In a study by Bloch (1991) which looked at personality and depressive symptomatology, females with characteristics of concern over self-adequacy were more likely to become depressed.

This study set out firstly to measure the **levels of depressive symptomatology in a non-clinical group of adolescents**. Secondly two questions were posed: one, was there any relationship between the **level of these symptoms and self-perceived competencies** in areas of activity and performance and two, between **personality characteristics and depressive symptomatology**. The hypothesis was that adolescents who scored above the cut-off on the depression self-rating scale would rate themselves as being less competent, less socially well adjusted and with lower levels of self-esteem.

## ***Methods***

Two secondary schools, one female and one male in the catchment area of the Child and Adolescent Psychiatric Services of the Eastern Health Board, Dublin, Ireland were asked to participate in this study. An explanatory note was sent to all parents requesting permission for their child to take part in the study. All students in first year classes (age range 11-14) were given two self-rated questionnaires to complete during class time (n = 165). A researcher was available to explain the content of the questionnaires and to clarify any queries. Names were not recorded in order to preserve confidentiality.

## ***Questionnaires***

Data was collected on the Depression Self-Rating Scale (Birleson, 1981), the Youth Self Report (Achenbach & Edelbrock, 1987) and the Jesness Personality Inventory (Jesness, 1962, 1966).

### ***Depression Self-Rating Scale (DSRS)***

The DSRS is an 18 item questionnaire developed by Birleson in 1981 to screen for depressive illness in children. Each item is a statement which the child is asked to rate in terms of how it applies to them i.e. never, sometimes, often. The answers are scored 0, 1 or 2 on an ordinal scale depending on their negative or positive effect. A score of greater than 13 was used as a cut-off for the depressed group (i.e. scores above the 90<sup>th</sup> percentile). Subsequent authors (Firth & Chaplin, 1987; Fundudis, 1991) have confirmed its usefulness as a screening instrument. Ivarsson (1997) described the DSRS as a reliable and valid measure of depression.

### ***Youth Self Report (YSR)***

The YSR was adapted from the Child Behaviour Checklist and was devised by Achenbach & Edelbrock in 1981. It is a self-rating questionnaire which records in a standardised format the competencies and behaviour problems of children aged 11-18 years. It also allows collection of epidemiological data such as age, sex, and parent's occupation. There have been several updates to the original version. The 1986 version was used in this study. The YSR shows test-retest correlation of  $r = 0.81$  for both sexes (Achenbach & Edelbrock, 1987).

The Total Competence Score can be calculated by summing the scores of the Activities and Social Scales and the mean performance in academic subjects. The Social Scale allows students to rate their involvement in social activities such as involvement in clubs or organisations, number of friends, contact with friends, etc. The Activities Scale allows self-rating of involvement in sporting activities, hobbies and chores. Competence scores may be useful in describing particular strengths and weaknesses acknowledged by individual adolescents.

There are 112 items, which aim to identify psychological and behavioural problems. A Total Problem Score is the sum of the scores circled on problem items by each child. This section looks at symptom subscales that can be categorised as somatic, depressed, unpopular, thought disordered, aggressive, and delinquent.

Raw scores on each of the scales can be converted to T scores, which is approximate to particular percentiles across all scales. Low scores ( $T < 30$ ) on the competence scales are considered deviant whereas high scores on the problem scales are considered deviant. The specific Total Problem Score for the clinical range is 68 for males and 70 for females ( $T > 62$ ).

A comparative study carried out between the YSR and the MMPI (Berlter and Foster, 1996) supports the validity of the YSR as a self-report measure with a heterogeneous clinical sample of adolescents.

### *Jesness Inventory*

The Jesness Inventory is a 155 item true-false personality measure. Since it was devised in 1966 it has been revised and modified so that it is now considered suitable for assessment and classification of personality in non-delinquent adolescents (Martin, 1981). The instrument provides scores on 11 personality characteristics / scales. These scales include Social Maladjustment (SM) which refers to inadequate or disturbed socialisation, Value Orientation (VO) which implies a tendency to share attitudes and opinions of persons in a lower socio-economic group, Immaturity (IMM) reflects the tendency to have opinions and attitudes that reflect a younger age group, Autism (AU) reflects a tendency to distort reality to suit one's own needs, Alienation (AI) refers to distrust especially towards those in authority, Manifest Aggression (MA) indicates awareness of feelings of anger and frustration and a difficulty in controlling such feelings, Withdrawal-Depression (Wd) indicates a tendency towards isolation and a dissatisfaction with self and others, Social Anxiety (SA) refers to conscious emotional discomfort towards interpersonal relationships, Regression (REP) indicates the exclusion of certain feelings and emotions from conscious experience and Denial (DEN) indicates an unwillingness to acknowledge unpleasant events that occur in daily life. Also there is an index which refers to a tendency to resolve social or personal problems in ways that show disregard for social norms or rules (Jesness, 1983).

Raw scores are obtained by totalling the number of marked responses for each scale and T score equivalents can be obtained using a table matching the subject's age and sex. The asocial index can then be obtained using the table and computation box provided.

### *Analyses*

The DSRS was used to divide the students into two groups, those above the cut-off of 13, the "**DSRS positive**" ("depressed") group and those below this score, the "**DSRS negative**" ("non-depressed") group. The two groups were then compared using the YSR and the Jesness scales in order to see if any differences were evident.

In particular two questions on the YSR and one question on the DSRS were examined to identify differences, if any one scores on self-harm or suicidal ideation. These were "I deliberately try to hurt or kill myself" and "I think about killing myself" from the problem statements on the YSR and "I think life isn't worth living" from DSRS. Scores ranged from 0 (never) to 1 or 2 (somewhat or often true) for these questions. The question from the DSRS has been previously used as an indicator of moderate or severe degrees of suicidal ideation and was found to have a significant correlation with depressive symptomatology (Ivarsson & Gillberg, 1997).

## Statistical Analysis

The data collected was entered on an Excel database and analysed using Statistical Package for the Social Sciences (SPSS) where applicable.

Differences tests, namely t-tests and chi-square tests were used to investigate if the “DSRS positive” and “DSRS negative” groups differed on any of the measures employed.

## Results

In this study of 165 students, ten children, all of whom were male, incompletely filled out the DSRS so these were excluded from the analysis leaving a total study cohort of 155. The gender breakdown was 67 females (41%) and 98 males (59%). No parents refused to allow their child to partake but some children were missing from school on the day of the study.

Twenty children scored above the cut off on the DSRS (13%; CI 7.6-18.2). There was a statistically significant difference found between the sexes, more females (16) than males (4) scored above the cut-off on the DSRS (24% vs 4.5%). The distribution of DSRS results according to gender is provided in Table 1. Females had a higher mean score (9.7 vs 7.3;  $t = -3.33$ ;  $df = 153$ ;  $p < 0.05$ ). Neither of these means was above the cut-off of 13 but looking at the mode (most commonly recorded score) this was two points above this cut-off for females (females = 15, males = 6). There was also a greater range of scores amongst females than males (0 to 26 vs 0 to 15). No statistical differences were noted between the two groups in terms of socio-economic group ( $\chi^2 = 0.177$ ;  $df = 2$ ;  $p > 0.05$ ). No additional analysis was done on gender differences between the two groups due to the small number of males in the “DSRS positive” group.

**Table 1: Depressive symptoms, problems and personality in adolescents; breakdown of DSRS scores by sex**

	Males (n = 88)	Females (n = 67)
DSRS Score		
No. of above cut-off	4	16
Mean score	7.3	9.7
Median	7	9
Mode	6	15
Maximum	15	26
Minimum	0	0

### **Comparison of “DSRS positive” and “DSRS negative” groups on the YSR**

The YSR allows values to be computed for the Total Competence Score and the Total Problem Score. A T-score less than thirty on the Total Competence Score is deemed to be deviant. Results on this sub-scale can be seen on Table 2. Using chi-square analysis with a Yates continuity correction, no statistically significant difference was found between the numbers in the “DSRS positive” and “DSRS negative” groups who scored outside the normal

range, indicating that one group did not perceive themselves to have more weaknesses and less strengths than the other (10% vs 2%; chi-square = 1.971; df = 1; p = 0.16). This Total Competence Score is computed using scores in Social, Activities and general academic areas. Few differences were noted on these scales, with all the participants scoring in the abnormal range on the Social Scale. Due to small numbers no further analysis was conducted.

**Table 2. Depressive symptoms, problems and personality in adolescents; distribution of abnormal Total Competence Scores by DSRS status**

	“DSRS positive” (n = 20)		“DSRS negative” (n = 126)	
	N	%	N	%
Abnormal Total Competence Score (T < 30)	2	10	2	2
Normal Total Competence Score (T >/ = 30)	18	90	124	98

(Chi-square = 1.971; df = 1; p > 0.05)

On the Total Problem Score a T-score of greater than 62 is taken as the cut-off for deviancy. Again chi-square analysis with a Yates continuity correction was employed to investigate if any differences in the numbers of “DSRS positive” and “DSRS negative” adolescents who fell into the deviant group. The pattern of results is shown on Table 3. No statistically significant result was found, nether group reported more self-perceived problem areas (33.3% vs 13.5%; chi-square = 3.260; df = 1; p 0.071).

**Table 3. Depressive symptoms, problems and personality in adolescents; Distribution of abnormal Total Problem Scores by DSRS status**

	“DSRS positive” (n = 18 <sup>1</sup> )	“DSRS negative” (n = 126)

<sup>1</sup> Due to missing data on the YSR the total number in the “DSRS positive” group was 18.

	N	%	N	%
Abnormal Total Problem Score (T < 62)	6	33	17	14
Normal Total Problem Score (T ≤ 62)	12	67	109	86

(chi-square = 3.26; df = 1; p > 0.05)

***Comparison of “DSRS positive” group and “DSRS negative” group on the Jesness Inventory***

On the Jesness Personality Inventory ten scales were investigated as outlined in the methods section. T-test analysis was used to investigate if there were any group differences. The two groups differed greatly in size (20 vs 135), so in order not to violate one of the parameters of conducting a t-test, i.e. equal numbers in each group, a random sample of twenty was chosen from the “DSRS negative” group (using the sample procedure on SPSS).

There was statistically significant differences found for nine of the characteristics (82%), with the “DSRS positive” group scoring higher in each case (see Table 4). The findings were most marked for denial (p < 0.001), withdrawal (p < 0.001), social maladjustment (p < 0.005) and value orientation (p < 0.005).

**Table 4. Depressive symptoms, problems and personality in adolescents; Distribution of mean scores on Jesness Personality Inventory by DSRS status**

	Mean T Scores		Significance Levels
	“DSRS positive” (n = 18)	“DSRS negative” (n = 16) <sup>2</sup>	
Social Maladjustment	72.8	57.2	p < 0.005
Value Orientation	63.8	52.1	p < 0.005
Immaturity	54.2	56.1	NS
Autism	62.1	54.9	P < 0.05
Alienation	63.2	55.8	p < 0.01
Manifest Aggression	58.9	50.4	p < 0.01
Withdrawal	56.7	47.6	p < 0.001
Social Anxiety	54.1	45.5	p < 0.05
Repression	51.7	52.5	NS
Denial	38.7	48.3	p < 0.001

***Comparison of “DSRS positive” group and “DSRS negative” group on suicidality***

Responses of the “DSRS positive” and “DSRS negative” groups were also compared on answers given to three specific questions. The two questions on the Youth Self-Report were “I deliberately try to hurt or kill myself” and “I think about killing myself”. One question from the DSRS, “I think life isn’t worth living” was also examined. Overall sixteen students (10%) answered “somewhat or often true” to the question “I deliberately try to hurt or kill myself”, with twenty-eight (17%) reporting that it was “somewhat or often true” that “I think about killing myself”. More than a quarter (28%) had sometimes or often felt, in the week previous to answering, that “I think life isn’t worth living”.

Comparisons were then made between the “DSRS positive” and “DSRS negative” for these questions using chi-square tests (Table 5). Those scoring zero were compared with the group scoring one or two. The “DSRS positive” group were statistically more likely to admit to thinking that life is not worth living” chi-square = 48.09; df = 1; p = 0.00000) and to think about killing themselves (chi-square = 14.44; df = 1; p = 0.00014).

<sup>2</sup> Due to missing data on the Jesness Inventory eighteen “DSRS positive” adolescents were compared with sixteen “DSRS negative” adolescents.

**Table 5. Depressive symptoms, problems and personality in adolescents; Distribution scores on suicidal ideation by DSRS status**

	“DSRS positive” (n = 20)		“DSRS negative” (n = 135 <sup>3</sup> )		Significance levels		
	n	(%)	n	(%)	Chi-square	df	p
YSR Q 18 <sup>a</sup>							
0	15	(75)	124	(92)	3.68	1	0.055
1 OR 2	5	(15)	11	(8)			
YSR Q 91 <sup>b</sup>							
0	10	(50)	118	(87)	14.44	1	0.00014
1 OR 2	10	(50)	17	(13)			
BIRL Q 10 <sup>c</sup>							
0	1	(5)	108	(81)	44.5	1	0.000005
1 OR 2	19	(95)	26	(19)			

<sup>a</sup> “I deliberately try to hurt or kill myself”

<sup>b</sup> “I think about killing myself”

<sup>c</sup> “I think life isn’t worth living”

### **Discussion**

Overall, 13% of adolescents in this study scored in the depressed range on the DSRS, with a greater proportion of females than males in this group (24% vs 4.5%). Those who scored in the “DSRS positive” group reported themselves to be as competent as those who did not score in the depressed range. However different personality characteristics were evident between the two groups. Thoughts of self-harm were found in 18.5% of the adolescents surveyed. Adolescents in the “DSRS positive” group were more likely to admit to thinking about killing themselves (50% vs 13%).

Ivarsson (1997) in his study of a non-clinical group of adolescents using the DSRS found an incidence of depression of 9%. There has been a wide variation in findings in other studies depending on the definitions used and groups studied. In a study by Kashani (1979) in a

<sup>3</sup> Due to missing data on the YSR the total number in the “DSRS negative” group for question 10 was 134.

family practice setting using DSM-III criteria the incidence was only 1.9%. Work carried out in child psychiatric population has varied from 1.4% to 36% (Kolvin, 1991; Leader, 1984; Pearce, 1978; Kovacs, 1977; Rutter, 1976). In both this study and Ivarsson's (1997) work females attained higher scores than males on the DSRS questionnaire. In keeping with our findings a shift in the sex ratio of depressed children and adolescents has been evident from a male preponderance before puberty to a female preponderance after puberty (Rutter, 1985; Kolvin, 1991). One explanation given for the increased rate of depressive symptomatology in female adolescents is lower levels of self-esteem than in males of similar ages (Avison, 1992).

The YSR has been used in a number of previous studies in non-clinical groups to measure self-perceived competencies and problems. In a study by Brown (1990), carried out in a girls school, findings were similar to this study. No one scored in the abnormal range on the social or competency scales and 15.4% had a Total Problem Score in the clinical range as compared with 16% in this study.

Verhulst (1989) looked at a population of adolescents gathered from birth registers and compared them with adolescents referred to psychiatric outpatient services. He found that referral status accounted for 34% of the variance between score on the Total Problem Scale. Competence scores however, showed much weaker discrimination between the referred and non-referred groups. In the follow-up (Verhulst et al., 1993) they found that self-reported Total Problem Scores did not change significantly over the two years.

The use of the YSR to measure self-perceived competencies and problem areas is in keeping with the trend for modern clinicians to look for certain problems that may be associated with lowered mood in adolescents (Renouf, 1997). Problems at school, at home, in relationships or health problems may be markers of depression (Sturtz, 1991). The adolescents who scored in the depressed range in our study ranked themselves as competent socially, academically and in their activities as those in the non-depressed range. Findings in other studies have shown a high correlation between self-worth and depressed mood (Renouf & Harter, 1990). Two groups of features have been shown to be related, firstly a sense of competency in physical appearance, peer likeability and athletics and secondly scholastic competence and behavioural conduct (McCauley, 1993).

There were statistically significant differences between scores on all the Jesness characteristics except immaturity and repression between "DSRS negative" and "DSRS positive" groups. The findings in this study showed that these differences were especially marked for social maladjustment, withdrawal, value orientation and denial. Social maladjustment in this inventory is characterised by inadequate or disturbed socialisation, withdrawal by a tendency towards isolation and a dissatisfaction with self and others, value orientation by a tendency to share attitudes and opinions of persons in a lower socio-economic group and denial by an unwillingness to acknowledge unpleasant events that occur in everyday life. This is at variance to the YSR results where this group denied problems in the areas of competency and socialisation but these findings are more in keeping with other studies linking personality with depression.

The Newcastle Depression Project (Berney, 1991) which looked at pre-morbid personality traits preceding childhood depression compared with other psychiatric diagnoses in 9 to 16 year olds. Berney found that the depressed group had higher obsessional scores but lower anxious and hysterical personality pattern scores than adolescents with other psychiatric diagnoses. They were more likely to score higher on obstinacy, impulsiveness, attention seeking behaviour, and dependence. Hirschfield (1989) looked at personality characteristics

in first degree relatives and spouses of depressed patients. The personality traits found in those later becoming depressed were less emotional strength, more introspection and increased emotional arousal, and a greater need for attention. He found that in the age group 17 to 30 no differences in personality could be found between those becoming depressed and those never depressed. In a prospective study by Bloch et al. (1991) personality and cognitive development were assessed pre-morbidly between 3 and 18 and depressive symptomatology measured at age 18. Girls with the greatest tendency towards depression were more likely to have characteristics of concern over self-adequacy, increased vulnerability and anxiety and a tendency to self-ruminate. Boys however were more likely to show traits of negativism, sensitivity to criticism and lack of trust. He felt that problems with accomplishment and hostility for boys and with self-esteem for girls were related to later depression.

In this study a disturbingly high number of the respondents admitted to feelings that life was not worth living. The figure of six percent in this study who said they felt like this “most of the time” is slightly higher than in Ivarsson’s study (1997) which found an incidence of 4% suicidal ideation in a non-clinical sample. It is in keeping with the figure of 7% found in another Irish non-clinical group of female adolescents (Brown, 1990).

Ivarsson showed strong correlations between suicidal ideation as measured by this question and depressive symptomatology, similarly this study showed that those in the “DSRS positive” group were more likely to report suicidal ideation. Harrington (1990) found that suicidal features were one of four symptoms which best discriminated between depressed and non-depressed children. Suicidal thinking has been shown to be related to depression, loneliness, pessimism and with less self-esteem in adolescents (Roberts, 1998).

This study is limited by a number of factors. The study was carried out in two schools who agreed to partake in the catchment area in which the author was working and so may not be representative of all Irish adolescents. Numbers not attending school on the day the questionnaires were distributed were not recorded for each group. Analysis on gender differences between groups was not carried out due to the large difference in numbers of males and females who scored in the depressed range. It would be beneficial to repeat this work using a larger cohort of males in order to allow for meaningful statistical analysis.

The DSRS is a screening instrument not a diagnostic test, so only depressive symptomatology could be measured not depressive disorder. Much of the work carried out using the Jesness Inventory has been in delinquent groups but it has been found to differentiate between delinquents and non-delinquents (Martin, 1981). Its advantage is user friendliness in comparison to other methods of assessing personality characteristics in the age group. However it must be remembered that depressive symptomatology can lead to contamination of scores on personality inventories and so interpretation of results should be made with caution.

In this study, self reported competencies and problems did not discriminate between “DSRS negative” and “DSRS positive” adolescents but this needs to be further investigated using a larger study group and standardised diagnostic criteria for depressive disorders. However findings on the personality inventory were more in keeping with previous research showing links between certain personality characteristics, low self-esteem and depressive symptomatology. These differences in personality characteristics may be influential in identifying “at risk” adolescents or in designing specific intervention strategies.

Further work in this area using larger samples and longitudinal follow-up of depressive symptoms and personality characteristics may help to elucidate prognostic indicators.

## *References*

- Achenbach T. M., Edelbrock C. S. (1987). *Manual for the Youth Self-Report and Profile*. Burlington V. T. Department of Psychiatry, University of Vermont.
- Achenbach T. M., Edelbrock C. S. (1981). Behavioural problems and competencies reported by parents of normal and disturbed children aged four to sixteen. *Monographs Soc Res Child Development*, 46, Serial No. 188.
- American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders*, 4<sup>th</sup> Edition. Washington DC: APA.
- Avison W R., McAlpine D. D. (1992). Gender differences in symptoms of depression among adolescents. *Journal of Health and Social Behaviour*, 33 (2), 77 – 96.
- Berney T. P., Bhate S R., Kolvin I., Famuyima O. O., Barrett M. L., Fundudis T., Tryer S. P. (1991). The Context of Childhood Depression, The Newcastle Childhood Depression Project. *British Journal of Psychiatry*, 159 (11), 28 – 35.
- Bertler R. W., Foster K. Y., Imm P. S. (1996). Convergent validity of select scales of the MMPI and the Achenbach Child Behaviour Checklist-Youth Self-Report. *Psychological Reports*, 79 (3), 1091 – 1100.
- Birleson P. (1981). The Validity of Depressive Disorders in Childhood and the Development of a Self-Rating Scale. *Journal of Psychology and Psychiatry*, 22, 73 – 88.
- Birleson P., Hudson I., Buchanan D., Woffe, S. (1987). Clinical Evaluation of a Self-Rating Scale for Depressive Disorder in Childhood. *Journal of Child Psychology and Psychiatry*, 28 (28), 43 – 60.
- Bloch J., Gjerde P. F., Block J. H. (1991). Personality antecedents of depressive tendencies in 18 year olds: A prospective study. *Journal of Personality and Social Psychology*, 60, 726 – 738.
- Brown K., Fitzgerald M., Kinsella A. (1990). Prevalence of Psychological distress in Irish female adolescents. *Journal of Adolescence*, 13, 341 – 350.
- Firth M. A., Chaplin L. (1987). Research note: The use of the Birleson Depression Scale with a non-clinical sample of boys. *Journal of Child Psychology and Psychiatry*, 128 (1), 79 – 85.
- Fundudis T., Berney T. P., Kolvin I., Famuyima O. O., Barrett L., Bhate S. R., Tryer S. P. (1991). Reliability and Validity of two Self-Rating Scales in the Assessment of Childhood Depression. *British Journal of Psychiatry*, 159 (11), 36 – 40.
- Jesness C. F. (1962). *The Jesness Inventory: Development and Validation*. Research Report No. 29. Sacramento: California Youth Authority.

- Jesness C. F. (1966). *Manual of the Jesness Inventory*. Palo Alto: Consulting Psychologists Press.
- Harrington R. C., Fudge H., Rutter M., Pickles A., Hill J. (1990). Adult outcomes of childhood and adolescent depression: 1. Psychiatric status. *Archives of General Psychiatry*, 47, 465 – 473.
- Hirschfield R. M. A., Klerman G. L., Lavori P. (1989). Premorbid personality assessments of first onset of major depression. *Archives of General psychiatry*, 46, 345 – 350.
- Ivarsson T., Gillberg C. (1997). Depressive symptoms in Swedish adolescents: Normative data using the Birleson Self-Rating Scale (DSRS). *Journal of Affective Disorders*, 42, 59 – 68.
- Kashani J., Simonds J. F. (1979). The incidence of Depression in Children. *American Journal of psychiatry*, 136 (9), 1203 – 1205.
- Kolvin I., Barrett M. L., Bhate S. R., Berney T. P., Famuyima O. O., Fundudis T., Tryer S. (1991). The Newcastle Child Depression Project, Diagnosis and Classification of Depression. *British Journal of Psychiatry*, 159 (11), 9 – 21.
- Kovacs M., Feinberg T. L., Crouse-Novak M. A., Paulauskas L., Finkelstein R. (1984). Depressive Disorders in Childhood, A Longitudinal Prospective Study of Characteristics and Recovery. *Archives of General Psychiatry*, 41, 229 – 237.
- Kovacs M., Beck A. T. (1977). An empirical-clinical approach towards a definition of child depression. In *Depression in Childhood: Diagnosis, Research and Conceptual Models*, (Eds J. G. Schulterbrandt and A. Raskin). New York: Raven Press, 1 – 25.
- Leader H., Fitzgerald M., Kinsella A. (1984). The incidence of major depressive disorder in children attending a Child Guidance Clinic. *British Journal of Clinical and Social Psychiatry*, 6 (4), 117 – 119.
- Martin R. D. (1981). Cross-validation of the Jesness Inventory with delinquents and non-delinquents. *Journal of Consulting and Clinical Psychology*, 49, 10 – 14.
- McCauley E., Myers K., Mitchell J., Calderon R., Schloredt K., Treder R. (1993). Depression in young people: initial presentation and clinical course. *Journal of the American Academy of Child and Adolescent Psychiatry*, 32 (4), 714 – 722.
- Pataki C. S., Carlson G. A. (1995). Childhood and adolescent depression: A review. *Harvard Review of Psychiatry*, 3 (3), 140 – 151.
- Pearce J. B. (1978). The recognition of depressive disorder in children. *Journal of the Royal Society of Medicine*, 71, 494 – 500.
- Renouf A G., Harter S. (1990). Low self-worth and anger as components of the depressive experience in young adolescents. *Development and Psychopathology*, 2, 293 – 310.
- Renouf A. G., Kovacs M., Mukerij P. (1997). Relationship of depressive, conduct and comorbid disorders and social functioning in childhood. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36 (7), 998 – 1004.

- Roberts R. E., Roberts C. R., Chen Y. R. (1998). Suicidal thinking among adolescents with a history of attempted suicide. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36 (7), 998 – 1004.
- Rutter M. (1976). Research Report, Isle of Wight Studies 1964 to 1974. *Psychological Medicine*, 6, 313 – 332.
- Rutter M. (1985). Epidemiology of child psychiatric disorder: Methodological issues and some substantive findings. *Child Psychiatry Human Development*, 15 (4), 209 – 233.
- Sturtz G. S. (1991). Depression and chronic fatigue in children. A masquerade ball. *Primary Care*, 18 (2), 247 – 257.
- Verhulst F. C., Prince J., Vervuurt-Poot C., de Long J. (1989). Mental health in Dutch adolescents: Self-reported competencies and problems for ages 11 – 18. *Acta Psychiatrica Scandinavica*, 356 (80), 1 – 38.
- Verhulst F. C., Van Wattum P. J. (1993). Two year stability of self-reported problems in an epidemiological sample of adolescents. *Acta Psychiatrica Scandinavica*, 87, 322 – 328.
- Welner Z. (1978). Childhood depression: An overview. *Journal of Nervous and Mental Disorders*, 166 (8), 588 – 593.
- World Health Organisation (1987). *International Classification of Diseases, 10<sup>th</sup> Revision*. Geneva, Switzerland: WHO.

## CHAPTER SIXTEEN

### *SERVICES FOR AUTISM IN IRELAND*

*Karen Doherty<sup>1</sup>, Michael Fitzgerald<sup>1</sup>, Pat Matthews<sup>2</sup>.*

Trinity College Dublin<sup>1</sup>, Irish Society for Autism<sup>2</sup>.

The present study involved 85 individuals with autism and their families. Participants with autism ranged in age from 8 – 33 years (mean 20.32 years, SD = 6.33). The primary caregiver of each of the 85 participants was administered a questionnaire concerned with service satisfaction and support. The keyworker of each participant was administered the Autistic Disorders Diagnostic Checklist and a questionnaire pertaining to the client's service. The study found that over one-third of the keyworkers interviewed had received no training in the area of autism. Older clients were significantly less likely than younger clients to have an Individual Educational Plan in place. Overall service satisfaction was good but caregivers wanted to see more parental involvement in service provision and to have an assurance of ongoing care for the individual with autism. The study's findings suggest a need for more partnership between parents and staff in the care and education of individuals with autism.

Education has been by far the most powerful source of improvement for individuals with autism since the condition was officially recognised (Rutter, 1985). Persons with autism now spend more years in education than ever before and the importance of quality service provision cannot be overstated. Paul (1987) in her review of the course of autism noted that outcomes for people with autism have been affected in the past by limited opportunities for schooling and the lack of appropriate residential care. Paul concluded that: "The improvements in education for autistic children and in adult community service that have recently been developed and are continuing to evolve may change the long-term outlook" (Paul, 1987).

The principles of service provision in Ireland outlined by the Department of Health Report on Services for Persons with Autism (1994) specify that services should:

- (1) Be specific to the triad of impairments characterising autism.
- (2) Have an approach that is tailored to individual needs.
- (3) Involve parents as partners.

(4) Be localised.

The Department of Health Report (1994) also advocates that staff working with individuals with autism are trained and knowledgeable about autism. Staff should be supported by multidisciplinary teams representing all areas of knowledge including Psychiatry, Psychology, Speech and Language Therapy, and Social Work. The Report recommends that an Individual Education Plan (IEP) based on multidisciplinary assessment should be drawn up for each client immediately after diagnosis. It suggests that services for people with autism should be wide-ranging enough to encompass all developmental levels from infancy to adulthood and all levels of disability from mild to severe. The Report goes on to stress that support for the family should be an integral part of any treatment plan and that parents should be involved in treatment from the start. Regular respite care and home support are advocated in order to alleviate the burden of care on families. Finally, the Report recommends special attention for adolescents with autism including family support and forward planning to ensure that the transition from school to adult services proceeds smoothly.

### *Services and Families*

Very few studies have asked parents of individuals with autism for their opinions on the services available to their children. Smith, Chung, and Vostanis (1994) surveyed members of the West Midlands autistic Society in England who were parents of children/adolescents with autism aged from one to 19 years. They found that the majority of parents (apart from those whose children were in services specifically for autism) did not feel that their children were receiving an appropriate special education programme. When asked to comment on their child's present service provision, less than one-third had anything positive to say. These difficulties were experienced to much the same degree by parents of younger and older children. Lloyd-Bostock (1976) found that many parents felt that they had become the experts on their children and that service providers were not sufficiently well informed.

Bristol and Schopler (1983) looked at families of children with autism and found that 70% of families reporting high levels of stress were receiving service provision without attendant parent support services. O'Moore's (1978) findings also highlight the role of professional support. A total of 68% of mothers in O'Moore's Irish study reported worries about how they were managing their child with autism and some of these mothers cited the lack of information and guidance from specialists as the cause of their difficulties in child management (no exact figures were given by O'Moore).

Pfeiffer and Nelson (1992) asked a select group of professionals in the field of autism to give their views on "the cutting edge of services for people with autism". The professionals surveyed considered advances in family treatment to include parent education, family advocacy and support services, and active participation of the family in treatment of individuals with autism. Kyne (1980) pointed out that parents have become more aware of their rights as participants in their child's education and are increasingly being valued by professionals for their unique role in the struggle to understand and treat individuals with autism.

### *Social Support*

The mediating effect of social support on an individual's response to stressful life-events is well established. The dimensions of social support include instrumental assistance,

information provision, emotional empathy and understanding, all of which can be provided on a number of ecological levels, including intimate relationships, extended family, and services. Gill (1990) compared mothers of children with autism, mothers of learning disabled children, and mothers of normally developing children and found social support to be an effective buffer of stress for these women. Wolf, Noh, Fisman and Speechley (1989) confirmed the stress-buffering effects of perceived social support for mothers of children with autism. Holmes and Carr (1991) confirmed previous findings (Ayer and Alaszewski, 1984; Grant, 1986; Wilkin, 1979) revealing the lack of support offered by the extended family, friends and neighbours with the daily care of an individual with autism. The same authors point out, however, that there was perceived support from the majority of friends and neighbours although practical offers of help were infrequent. Despite the fact that over three-thirds of parents in the Holmes and Carr study reported problems in caring, less than half wanted help. Wilkin (1979) reported a similar finding. Bristol (1984) reported that, in a group of 40 mothers of children with autism, the highest stress group and the lowest stress group differed with reference to support networks and availability of services. The lowest stress others reported greater perceived support from partner, family, friends, and other parents of learning disabled children.

### *Life Long Services*

Autism is a lifelong condition and the vast majority of individuals with autism will require lifelong care. Several researchers have looked at the effects on families of individuals with autism through adolescence and adulthood (Bristol, 1984; DeMyer, 1979; DeMyer & Goldberg, 1983; Holroyd & McArthur, 1976). Holmes and Carr concluded that parents found it more difficult to cope as their son or daughter with autism grew older, the same finding reported by Bristol and Schopler (1983).

With the young autistic child, the unrelenting care-giving demands constitute the main source of stress for parents. Later on, behaviour management, self-help skills training, and appropriate school placement emerge as potent stressors. As the individual with autism reaches adolescence and adulthood, behavioural problems are often exacerbated as the person increases in size and strength and the discrepancy between sexual maturity and social immaturity becomes apparent (Bristol, 1984; DeMyer, 1979). Stigma attached to the individual with autism may become more pronounced. A fully-grown adult who displays the behavioural anomalies typical of autism will be seen as far less acceptable by society than a young child showing the same problems. Cumulative stress effects may lead to psychological 'burnout' for some parents. This can be compounded by a growing sense of resignation as parents come to realize that their adult son or daughter has progressed as far as potential allows. According to Suelze and Keenan (1981), parents of older learning disabled children have less support, are more isolated, and have greater need for expanded services than parents with younger children.

The chronic difficulties inherent in being a 'perpetual parent' lead most to opt for professional help in caring for their child. An adaptable service responding to the changing needs of the individual with autism and the family can make the difference between coping and not coping with these difficulties. DeMyer (1979) estimates that 75% of autistic adults will eventually need full time residential care. Accepting this can be a cause of great distress to many parents who may struggle with feelings of failure and guilt. Bristol and Schopler (1983) found that two-thirds of the parents in their study reported worries about what would happen when they could no longer take care of their son or daughter. Hirst (1985) found a commonly expressed concern of parents related to fears about the future care and provision

for their child. Card (1983) examined this concern finding that, although all parents were concerned about future provision and all were in favour of training in independent living for learning disabled adults, most expressed a strong desire to keep their son or daughter at home for as long as possible. DeMyer (1979) advocates locating residential units as near as possible to the family home enabling parents to remain an active part of their son's or daughter's life.

### ***Specialised or Integrated?***

Janicki, Lubin and Friedman (1983) in a study of service needs of individuals with autism point out that the needs of this group differ significantly from those of other developmental disabled persons. They propose the necessity for services that specifically address the unique needs of individuals with autism. Mesibov (1990) has suggested that the ideals inherent in Wolfensberger's (1972) concept of normalisation and the highly specialised care requirements of the individual with autism cannot be reconciled. This reflects a legitimate concern of parents who may question whether their son's or daughter's needs can be appropriately addressed in a heterogeneous school setting. Individualised specialist education provision for children with autism is now being provided in mainstream schools and demonstrates that specialised and integrated schooling are not necessarily opposing terms. The provision of specialist education within the context of an integrated setting may, in the long term, prove to be a valuable step forward in the education of individuals with autism.

The aim of the present study is to look at service provision and support available to 85 children, adolescents and young adults with autism and their families in the Eastern Health Board area of Ireland. This paper proposes to look at each participant's current placement and to present caregivers' views on the services and support available to persons with autism and their families.

## ***Method***

### ***Selection of Participants***

In 1990, a study identified 272 clients with autism attending services in the Eastern Health Board area of Ireland. Staff were contacted at all EHB services dealing with special needs clients and asked to identify any clients under the age of 25 years with "autistic tendencies". 309 clients were considered to have autistic tendencies by staff at their service. Keyworkers for each of the 309 clients completed the Autistic Disorders Diagnostic Checklist (Wing, 1987) based on DSM-III-R criteria (APA, 1987). 272 of those clients originally identified by staff as having "autistic tendencies" fulfilled the AD/DC criteria for autism.

In 1991, 100 of these 272 individuals were selected on the basis of geographical proximity (i.e. all resided in Dublin or Kildare) to participate in a study of the psychosocial effects on the families of persons with autism. The study was published as "Planning for the future of autistic persons: A prevalence and psychosocial study" (Fitzgerald, Matthews, Birkbeck and O'Connor, 1997). The present study followed up 85 of the 100 participants involved in the Fitzgerald et al. (1997) study. Three of the clients had since died and the parents of a further two clients had died. Ten families chose not to partake in the research. The longitudinal findings of the follow-up are discussed elsewhere (Doherty, 1999).

### ***Descriptive Characteristics of Participants***

The 85 participants ranged in age from 8 to 33 years (mean 20.32 years, median 19 years, SD 6.33). Sixty-six participants were male (78%) and 19 were female (22%). All participants had been identified in the original study as having “autistic tendencies” and all had fulfilled the Autistic Disorders Diagnostic Checklist (Wing, 1987) criteria for autism. In the present study, all but two of the participants met the ADDC criteria for the second time. These two individuals were still included in the analyses as one had been diagnosed with autism by a psychiatrist and the other was considered to have autism by his family and by staff at his service.

## ***Instruments***

### ***Autistic Disorders Diagnostic Checklist***

The ADDC was developed by Lorna Wing to provide a basis for the revision of the diagnostic criteria for autism used in the DSM-III (APA, 1980). The goal of the checklist is to identify the expression of autistic behaviours in clients from earliest infancy to young adulthood. The ADDC defines three areas of impairment:

Section A: Impairment of Reciprocal Social Interaction

Section B: Impairment in Communication, Language and Symbolic Development

Section C: Restricted Repertoire of Repetitive Behaviours.

The ‘triad of impairments’ is currently considered to represent the central defining features of autism (DSM IV, APA, 1994). The ADDC is administered to the staff members / keyworker who knows the client best. For each of the three sections, a general description of the client’s behaviour is sought and, within that framework, the presence or absence of the appropriate specific behaviours on the checklist is established. To fulfil the criteria for a diagnosis of autism, the client must exhibit three behaviours from Section A, three behaviours from Section B, and, at least one behaviour from Section C. Individuals who are positively diagnosed using the ADDC also meet all of Rutter’s (1978) criteria for autism with the exception of the requirement of diagnosis before the age of three years. An inter-rater reliability study of the ADDC conducted by Fitzgerald et al. (1997) yielded levels of agreement ranging from 95% to 100% with Kappa coefficients ranging from 0.47 to 1.00 on each of the checklist’s 83 items. The ADDC was published with minor alterations in 1996 as the Wing Autistic Disorder Interview Checklist (WADIC) (Wing, 1996).

### ***Services and Support Questionnaire***

This is a 33 item questionnaire for primary caregivers devised for the present study. It looks at caregivers’ satisfaction with the current service attended by their son/daughter with autism as well as the level of support from friends, family, and services in the care of the individual with autism. Ratings are made on a four-point Likert scale ranging from ‘Very Satisfied’ to ‘Very Dissatisfied’ or on a bimodal YES/ NO response scale. An inter-rater reliability study was conducted yielding Kappa coefficients ranging from 0.63 to 1.00 on each of the 33 items in the questionnaire.

### ***Placement Questionnaire***

The Placement Questionnaire (devised for the present study) is a 10 item questionnaire administered to the client's keyworker. It looks at the following aspects of the client's current placement and service:

- (1) Staff Training.
- (2) Individualised Education Plan.
- (3) Daily Programme.
- (4) Staff-Client Ratios.
- (5) Professionals available to Client.
- (6) Long Term Service Plan.

An inter-rater reliability study was conducted yielding Kappa coefficients ranging from 0.89 to 1.00 on each of the questionnaire's 10 items.

### ***Procedure***

The 100 families involved in the original Fitzgerald et al. (1997) study were contacted with a letter explaining the nature of the present study and requesting their participation. The 85 caregivers (81 mothers and 4 fathers) who agreed to take part in the study were interviewed in their own homes in almost all cases. Because of difficulties in travelling to some homes, two mothers were interviewed in the private offices of the Irish Society for Autism and two mothers were interviewed by telephone. Permission was obtained from the caregivers and from the services of each of the 85 participants to interview a keyworker or staff member familiar with each participant. Each keyworker was visited at the service and administered the Autistic Disorders Diagnostic Checklist in order to confirm the client's diagnosis of autism. The Placement Questionnaire looking at the client's current service was also administered. The first author (KD) conducted all interviews with staff and caregivers.

## ***Results***

### ***Autistic Disorders Diagnostic Checklist***

All of the individuals with autism fulfilled the ADDC criteria for autism in the original study eight years ago and all but two fulfilled the same criteria in the present study. Scores on the ADDC ranged from 7 to 34 with a mean score of 18.88 (SD = 6.83).

### ***Social Impairment***

The majority of individuals with autism (78%) were described as having 'no peer friendships despite ample opportunities' and most preferred solitary activities (73%). Over half displayed a poor appreciation of social norms as manifested by a 'lack of awareness of correct behaviour in public'.

## *Language and Communication*

Language abilities were notably impaired. Almost one third of participants (29%) had no spoken language (and failure to compensate with gesture or mime). One third of participants had some speech but did not initiate or sustain conversation, and a further one third displayed repetitive, one-sided speech without appropriate conversational turn taking. Stereotyped speech and echolalia was evident in 40% of cases. This reflects the findings of previous outcome studies (e.g. Rutter, 1970).

## *Behaviour*

All participants demonstrated the restricted, repetitive behaviour patterns that complete the triad of impairments. Most individuals displayed simple repetitive bodily movements such as rocking (57%). Almost one third showed sensory preoccupations and a further one third were preoccupied with repetitive behaviours involving objects, such as spinning. This reflects the findings of Rutter (1970) who noted that repetitive behaviours and preoccupations often persist into adolescence and adulthood even when general behaviour improves. Worryingly, one third of participants displayed repetitive self-injury although this had not increased over time as reported by some investigators (Gillberg & Steffenberg, 1987).

## *Diagnoses*

Almost all of the participants (92%) had been given a clinical diagnosis, in most cases by a psychiatrist. Of the 8% of participants with no official diagnosis, two families (2%) had been told informally by staff at their service that the client had autism and one family “gradually realised it was autism”. Most participants (65%) had a diagnosis of autism or autistic tendencies/features. One participant (1%) had Asperger’s syndrome (although in several more cases AS was suspected but not confirmed), two (2%) had fragile X syndrome, and nine clients (11%) had a diagnosis of Down’s syndrome. In the case of one client with Down’s, a secondary diagnosis of autism was not officially given as the diagnosing clinician felt that this diagnosis would limit the child’s placement options. Eleven percent of participants were diagnosed with mild, moderate, and severe mental handicaps and 1% were diagnosed with “brain damage”. Eleven percent of clients (those with Down’s) were diagnosed at birth. The age at time of diagnosis ranged from 0 to 25 years (mean 54.58 months, SD 55.16). Almost half of the participants (47%) were diagnosed at or before the age of 36 months. The remaining 53% received their diagnosis after the age of 36 months.

## *Caregivers*

Caregivers ranged in age from 34 to 72 years (mean 51.3, SD 9.2). 78% of the primary caregivers were married women, 6% were separated women, 1% was a separated man, 11% were widows, 2% were widowers, 1% was single, and 1% was divorced. In all, 22% of caregivers were looking after their disabled son/daughter without a partner. 54% of mothers were working fulltime in the home. Of those employed outside the home, 8% were nurses, 7% were teachers, 5% were secretaries, and 6% were domestics. Close to one third of families (32%) were living on social welfare, state pensions, or work pensions. A further 18% of families had an income of £10-14 K per annum and 16% of families had an income exceeding £25 K per annum.

**Table 1:** Demographic information on primary caregivers of individuals with Autism

---

<b>Age</b>	<b>Mean</b> 51.3 years (SD 9.2)	<b>Range</b> 34-72 years	
<b>Occupation</b>	<b>Homemaker</b> 54%	<b>Employed Outside Home</b> 46%	
<b>Marital Status</b>	<b>Single</b> <b>Married</b> <b>Widowed</b> <b>Separated / Divorced</b>	1% 78% 13% 8%	
<b>Socio-economic Status</b>	<b>Class I</b> 17%	<b>Class II</b> 10%	<b>Class III</b> 14%
	<b>Class IV</b> 20%	<b>Class V</b> 15%	<b>Class VI</b> 13%
	<b>Class VII</b> 6%	<b>Class VIII</b> 5%	

---

***Features of Services***

Participants attended a total of 25 different services in the Eastern Health Board area. Time spent at the current service ranged from 9 months to 26 and a half years (mean 103.9 months, SD 73.97). Forty six percent of the services catered for autism only. Exactly half of the services (50%) catered for learning disabilities. Forty two percent of participants were resident with one or both parents, 32% of participants were living in residential care for persons with autism, and 22% were living in residential care for persons with a learning disability. Two individuals (2%) were residing in a psychiatric hospital and one individual (1%) was at a residential unit for the blind. In all, 58% of participants were in residential care.

---

**Table 2:** Demographic information on 85 participants with autism

---

<b>Gender</b>	<b>%</b>	<b>N</b>
<b>Male</b>	78	66
<b>Female</b>	22	19
<b>Age</b>	<b>Mean</b>	
	20.32 years (SD 6.33)	
	<b>Range</b>	
	8-33 years	
<b>Residential Status</b>	<b>At Home</b>	
	<b>%</b>	<b>N</b>
	42	36
	<b>Residential Care</b>	
	<b>%</b>	<b>N</b>
	58	49

---

Most services (60%) provided respite care but only 52% of the families availed of a respite service. The majority of caregivers (67%) did not want more respite. Only one third of caregivers did want more respite care made available. It is worth noting, however, that most participants were already living in residential care.

Staff interviews revealed that Individual Education Plans (IEPs) were in place for 70% of clients with autism but almost one third (30%) of clients had no formal IEP. Less than half of caregivers (46%) were involved in formulating IEPs. Reviews of IEPs by multidisciplinary team took place once a year in one third of cases, 15% of IEPs were reviewed twice a year, 15% were reviewed three times a year, and a further 15% were reviewed “as needed”. Worryingly, 5% of IEPs were never reviewed according to staff and another 5% of staff did not know if how often the IEP was reviewed. Most clients (84%) under the median age of 19 years had an IEP in place compared to just over half of clients over the age of 19 years (54%). Independent samples t-test confirmed this as a highly significant difference between the younger and older age groups ( $t = 4.25$ ,  $df = 38$ ,  $p < .0005$ ).

Most of the keyworkers interviewed (64%) had received training, usually in-service, about autism, but more than a third (36%) had received no training in the area of autism. Keyworkers reported that during the clients’ daily programmes, staff-client ratios ranged from 1:1 (10% of cases) to 1:18 (3% of cases). The most common staff-client ratio was 1:3 (28% of cases). The vast majority of clients (95%) did receive 1:1 instruction and support at some point during their daily programme. Class sizes ranged from the client alone (2%) to 30 pupils including the client (1%). Keyworkers outlined the areas of learning focused on in the client’s daily programme. All clients spent time on leisure and recreation skills and almost all (96%) engaged in sporting activities. Most clients were receiving social skills training (93%) and learning to use community facilities such as shops and restaurants (93%). Self-help and independent living skills were being taught to the majority of clients (93%) as part of their daily programme.

Keyworkers were asked about each client's access to members of a multidisciplinary team. Most clients attended a psychiatrist (84%) but only three of these had regular structured meetings, the rest attended 'as needed'. Almost two-thirds (65%) attended a psychologist but only one individual had regular (in this case, weekly) meetings. The majority of clients (87%) had no access to a physiotherapy service although staff members added that this was not necessary for most clients. More than half of the clients (56%) had access to a social worker but only one client had regular meetings. Just over one quarter of the clients (27%) had access to a speech therapist but none had regular meetings. Less than one fifth (18%) had access to an occupational therapy service.

According to keyworkers, most services (68%) had a long-term service plan in place to ensure the future treatment and care of clients in adolescence and adulthood. However, close to one third of services (31%) had no future service plan arranged for clients. One keyworker (1%) did not know if a long-term plan for the client was in place or not.

### ***Service Satisfaction***

The study found service satisfaction to be high among the caregivers interviewed. The vast majority of caregivers (94%) were fairly satisfied or very satisfied (63%) with the support they were getting from their service. The same number (94%) felt that the current service was suitable in meeting their son's or daughter's needs. Only five caregivers (6%) were not satisfied or very dissatisfied with the support from their service. Most caregivers (81%) felt involved enough and 6% felt excluded from the service. When asked how often they met with staff to discuss the client, 1% of caregivers said they met staff daily. 7% met staff weekly, 14% met monthly, and 19% met every term (approximately three months). Twenty eight percent only met staff once a year. Another 28% met staff "as needed" and 2% of caregivers said they never met with staff. Close to half of caregivers (45%) had received no information about autism from their current service and 16% had received "hardly any" or "some but not enough". Only 39% of caregivers felt they had received "enough" information about autism from their service.

### ***Service Strengths and Weaknesses***

When caregivers were asked about the aspects of their son's or daughter's service that they were most satisfied with, 80% of caregivers said "the staff". Over one third (34%) of caregivers were satisfied with the location and setting of their service and 18% mentioned the facilities and activities provided by the service. 11% were satisfied with the "homeliness" of the service where residential care was being provided. 9% were most satisfied with the fact that they had received an assurance from their service of lifelong care for their son or daughter with autism.

Caregivers were also asked about the aspects of their service that they felt could be improved. Almost a quarter (24%) wanted to be more involved in the service, suggesting more scheduled parent-staff meetings and the need for a social worker to liaise between home and service. 11% of caregivers felt that more funding and resources were necessary for their service and a further 11% suggested more staff training in autism. One fifth of caregivers felt that their service could be improved by providing an assurance of ongoing care for their son or daughter.

### *Future Services*

When asked about future service needs, 40% of caregivers said that their son/daughter would need another day service in the future. Of these, most caregivers (68%) did not feel confident that a place would be available. Over half of the caregivers interviewed (53%) said that their son/daughter would need a residential service in the future but only 35% of these were confident that a place would be available. Most caregivers (65%) needing future residential care for their son/daughter were not confident that a place would be available. As can be seen from Table 3, the percentage of clients with autism in residential care moves from 20% in the 8-12 years age group to 94% in the 28-33 years age group. Chi square analysis revealed highly significant differences between the age groups on this measure (20.99, df = 4,  $p < .0005$ ).

---

**Table 3:** Percentage of clients from each age group in Day Service and Residential Service

---

<b>Age</b>	<b>Day Service %</b>	<b>Residential %</b>	<b>Total N</b>
8-12	80%	20%	5
13-17	67%	33%	30
18-22	35%	65%	20
23-27	33%	67%	12
28-33	6%	94%	18
<b>Total</b>	42%	58%	85

---

### *Effects on Families*

#### *Impact on Mothers and Fathers*

Only 26% of primary caregivers reported satisfaction with their opportunities for leisure. One third of caregivers reported minor difficulties and 43% had marked or severe difficulties in finding opportunities for leisure. Just over half of caregivers (51%) felt that the extent of their social contact was adequate, with 19% reporting minor difficulties and almost one third (31%) reporting that the extent of their social contacts was markedly or severely inadequate.

A number of caregivers volunteered information about their psychological health in the course of the interview. Three of the mothers in the study (4%) had received counselling for recurrent panic attacks. One mother was being treated for depression with medication and another mother had been hospitalised for alcoholism and depression. Three of the fathers had suffered with depression after the diagnosis of autism was received; two of these had seen a mental health professional.

### ***Impact on Siblings***

Most caregivers felt that the participant's disability had had a severe effect (28%) or a moderate impact (30%) on siblings. Almost a quarter (24%) reported a slight impact on siblings while only 12% of caregivers felt that the participant's disability had had no effect on siblings. A small number of caregivers noted psychological and behavioural difficulties in their other children that they believed were related to the experience of having a sibling with autism. These included one younger brother being hospitalised because of depression and another younger brother displaying elective mutism for 12 months.

### ***Social Support***

Many caregivers (40%) felt no support or 'hardly any' support from their family in the care of their disabled son/daughter. One third felt some support and another one third felt 'very supported' by their family. A similar number of caregivers (41%) felt no support or 'hardly any' support from friends in caring for their son/daughter, 39% felt some support and only 20% felt very supported by friends. With regard to practical help, the majority of caregivers (61%) reported that family members never or rarely looked after the person with autism to give them a break. 23% reported that family members occasionally looked after the participant and only 15% said that family members often looked after the participant.

An even larger number of caregivers (77%) reported that friends never looked after the participant with autism, 9% of friends rarely looked after the participant, 13% occasionally did, and only 1% of caregivers had a friend who regularly took care of their son or daughter with autism. It is worth noting that many caregivers did mention that they would not expect friends to look after their autistic son or daughter because, in the words of one parent, "they wouldn't be able to cope with him". Most caregivers (79%) did not attend any support group. Over one third of these (37%) said they would like to attend a support group while the remaining 63% did not wish to attend a support group. Almost none of the siblings attended a support group (only 2%). According to their parents, most siblings (76%) did not want to attend a support group. Parents of 14% of families reported that siblings did wish to attend a support group. Nine percent of parents did not know the siblings' feelings on this matter.

## ***Discussion***

### ***Features of Services***

Examining the features of service provision in the light of the 1994 Department of Health Report, the study found that over one third of staff interviewed (all of whom were selected by the service as the staff member who knew the client best) had received no training in the area of autism. All staff at services specifically for autism had received training but most of the staff at the heterogeneous services had not been trained in the area of autism. No other significant differences between specialised and heterogeneous services were found. Individualised Education Plans (IEPs) were found to be in place for most clients. However, one third of clients had no IEP in place and older clients (over 19 years old) were significantly less likely to have an IEP. Only a little over half of the clients in this age group had a written IEP according to staff. Even when IEPs were in place, parental involvement in the formulation and review of the IEP occurred in less than half of all cases.

Most clients had access to multidisciplinary professionals such as psychiatrists and psychologists but regular structured meetings were rare. Less than one third of clients had access to a speech therapist and no one was receiving regular speech therapy. Future provision for the individual with autism was a concern for many parents and most services did have a future service plan for all clients. One third of services did not, however, have any future provision arranged for clients. With regard to diagnosis, over half of the participants had not received an official diagnosis until after the age of 36 months. One participant had only received the correct diagnosis at the age of 25 years and 8% of participants still had no clinical diagnosis. This clearly needs to be addressed, as an essential prerequisite of adequate service provision is a definite diagnosis, which delineates the child's unique abilities, disabilities and specific service needs.

### *Service Satisfaction*

The study found that the vast majority of caregivers (94%) were satisfied with the service provision for their son/daughter with autism. A high degree of consensus emerged when caregivers were asked about the strengths and weaknesses of services. Most caregivers were particularly happy with the staff at the service although one tenth did feel that more staff training in the area of autism was needed. Almost one quarter of caregivers recommended more parent-staff meetings and the need for a social worker to liaise between service and home. As reported by Hirst (1985), a major area of concern expressed by caregivers was the uncertainty about the future care and treatment of the individual with autism. One fifth of caregivers wanted an assurance of ongoing care for their son/daughter and two thirds of caregivers requiring future day or residential care were not confident that this would be available.

There are clear implications for future service provision inherent in these findings. The Department of Health (1994) recommendations need to be consistently implemented with standardised individual assessment and planning provided for all clients, regardless of age. A standardised education programme for autism is needed to ensure that the wide-ranging needs of these individuals are consistently met. The consensus in the views expressed by caregivers provides some valuable pointers on the road to improvement. Although great progress has taken place in the relationship between parents and professionals, the commonly expressed desire for more parental involvement indicates that more work is needed in this area. Improved staff training and education, particularly in heterogeneous services, is essential if the unique needs of individuals with autism are met. Parents' worries about continuity of service provision and future care for their son/daughter with autism need to be addressed with a recognition from service providers that adequate service provision is a life-long need for most individuals with autism and one that must be tackled early on in the individual's life.

### *Support*

A large number of caregivers reported that they had no support or hardly any support from family (40%) and friends (41%) in caring for the person with autism. Most caregivers (79%) had no involvement in a support group although more than one third did want to attend a support group. Only a tiny minority of siblings (2%) were attending a sibling support group. Although parents reported that most siblings were teenagers or adults and did not have "the time or the interest" to attend a support group, it is worth noting that 88% of siblings were judged to have been affected by the presence of the person with autism, and a small number displayed psychological problems. This finding warrants future research. Is the tiny number

of siblings attending support groups attributable to the lack of sibling support groups provided by services or is there an unwillingness on the part of parents to 'pathologise' normally developing siblings by encouraging attendance at a support group? Knowledge of the siblings' own views about support groups would provide some guidance here. The majority of parents were not attending a support group themselves so perhaps a fruitful area of further enquiry would be parental and sibling attitudes towards support groups.

Although the majority of participants in the study required fulltime care, most caregivers (61%) reported that family members rarely or never look after the individual with autism to give them a break and that friends were even less likely to do so. This confirms the findings of previous research revealing the lack of support offered by family and friends of previous research revealing the lack of support offered by family and friends with the care of an individual with autism (Ayer and Alaszewski, 1984; Grant, 1986; Holmes and Carr, 1991; Wilkin, 1979). Many caregivers pointed out that they would not ask for help in caring for their son/daughter, comments included: "it's not their job, it's mine" and "they wouldn't know how to handle him". Similarly, although two thirds of services provided respite care to clients only half of caregivers availed of this. Most caregivers did not express a need for more respite care. When asked about leisure time, however, only one quarter of caregivers reported satisfaction with their opportunities for leisure. This reflects the unwillingness of some caregivers to accept help even when help is warranted, a finding also reported by Holmes and Carr (1991).

The suggested move towards a partnership of parents and staff in the care and education of individuals with autism may encourage parents to share the responsibilities they currently feel are theirs to shoulder alone. Schopler and Mesibov (1984) have emphasised the value of parents as co-therapists. This allows for an interchange of resources, knowledge and skills between staff and parents as well as ensuring a continuum in the care and education of the individual with autism. In light of the desire expressed by caregivers in the present study for more parental involvement in service provision, a move towards parents-as-parents is clearly desirable.

The present study highlights the potential value of Individualised Family Service Plans (IFSPs) co-developed by caregivers and staff. The IFSP should contain: a statement of the child's current level of development, based on objective assessment, a statement of the family's resources, priorities, and concerns for enhancing the child's development, a statement of the major outcomes expected to be achieved for the child and family, and a statement of the steps to be taken to support the transition of the child from home to school and onwards to adult services. It is recommended that IFSPs come to play a valuable role in the future development of services for individuals with autism and their families.

### ***Methodological Considerations and Recommendations for Future Research***

It should be noted that the two individuals who did not fulfil the ADDC criteria in this study did, in fact, fulfil the criteria for Section A and Section C of the checklist but did not fulfil the criteria for Section B – impairment of language, communication and symbolic development. The revised ADDC, published in 1996 as the Wing Autistic Disorder Interview Checklist (WADIC) contains an extended version of Section B. The present study therefore recommends the use of the WADIC in future research (Wing, 1996).

The authors of the present study recommend the need for future research to attempt to assess the unmet needs of individuals with autism by asking not just the caregivers but also the

individuals themselves. The general level of low functioning of some of the participants in the present study precluded this and information was sought from caregivers and staff. Wherever possible, however, it would be ethically preferable to obtain the consent of adult individuals themselves and to rely on their own reports as well as those of caregivers and staff in gathering information.

In conclusion, the findings of this study indicate that although service satisfaction is high among caregivers, services in Ireland still have some way to go in meeting the principles of services provision for persons with autism outlined by the Department of Health Report (1994).

### ***References***

- American Psychiatric Association (1980). *Diagnostic and Statistical Manual of Mental Disorders*. (3<sup>rd</sup> Edition). Washington DC: APA.
- American Psychiatric Association (1987). *Diagnostic and Statistical Manual of Mental Disorders*. (3<sup>rd</sup> Edition-Revised). Washington DC: APA.
- American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders*. (4<sup>th</sup> Edition). Washington DC: APA.
- Ayer, S. & Alaszewski A. (1984). *Community Care and the Mentally Handicapped*. London: Croom Helm.
- Bristol, M. M. (1984). Family resources and successful adaptation to autistic children. In E. Schopler & G. B. Mesibov (Eds.), *The effects of autism on the family*. New York: Plenum Press.
- Card, H. (1983). What will happen when we've gone? *Community Care*, July 28<sup>th</sup>.
- Department of Health (1994). *Services for persons with autism*. Dublin: Department of Health.
- DeMyer, M. K. (1979). *Parents and children in autism*. Washington DC: Winston.
- DeMyer, M. K. & Goldberg, J. (1983). Family needs of the autistic adolescent. In E. Schopler and G. B. Mesibov (Eds.), *Autism in adults and adolescents*. New York: Plenum Press.
- Doherty, K. (1999). *Autism and the family: A longitudinal study*. Unpublished M.Sc. dissertation. Trinity College, Dublin.
- Fitzgerald, M., Matthews, P., Birkbeck, G. & O'Connor, J. (1997). Planning for the future of autistic persons: A prevalence and psychosocial study in the Eastern Health Board area of Dublin. *Irish Families Under Stress*, Vol. 6.
- Gill, M. J. (1990). *The assessment of social support and individual characteristics as buffers against stress in mothers of handicapped and non-handicapped children*. Unpublished doctoral dissertation. Rutgers, The State University of New Jersey.

- Gillberg, C. & Steffenberg, S. (1987). Outcome and prognostic factors in infantile autism and similar conditions: A population based study of 46 cases followed through puberty. *Journal of Autism and Developmental Disorders*, 17, 272-288.
- Grant, G. (1986). The structure of care networks in families with mentally handicapped adult dependants. (Working paper No. 41) Centre for Social Policy Research and Development, Department of Social Theory and Institutions, University of North Wales, Bangor.
- Hirst, M. (1985). Dependency on family care of young adults with disabilities. *Child: Care, Health and Development*, 11, 241-257.
- Holmes, N. & Carr, J. (1991). The pattern of care in families with adults with mental handicap: A comparison between families of autistic adults and Down's syndrome adults. *Journal of autism and Developmental Disorders*, 21, 2, 161-176.
- Holroyd, J. & McArthur, D. (1976). Mental retardation and stress on the parents: A contrast between Down's syndrome and childhood autism. *American Journal of Mental Deficiency*, 80, 431-436.
- Janicki, M. P., Lubin, R. A. & Friedman, E. (1983). Variations in characteristics and service needs of persons with autism. *Journal of Autism and Developmental Disorders*, 13, 73-85.
- Kyne, J. (1980). The evolving parent-professional relationship. In B. Wilcox & A. Thompson (Eds.), *Critical issues in educating autistic children and youth*. Washington, DC: U.S. Department of Education.
- Lloyd-Bostock, S. (1976). Parents' experiences of official help and guidance in caring for a mentally handicapped child. *Child: Care, Health and Development*, 2, 325-338.
- Mesibov, G. B. (1990). Normalisation and its relevance today. *Journal of Autism and Developmental Disorders*, 20, 379-390.
- O'Moore, M. (1978). Living with autism. *The Irish Journal of Psychology*, 4, 33-52.
- Paul, R. (1987). Natural history. In D. J. Cohen & A. M. Donnellan (Eds.), *Handbook of Autism and Developmental Disorders*, New York: Wiley and Sons.
- Pfeiffer, S. I. & Nelson, D. D. (1992). The cutting edge in services for people with autism. *Journal of Autism and Developmental Disorders*, 22, 95-105.
- Rutter, M. (1970). Autistic children: Infancy to adulthood. *Seminars in Psychiatry*, 2, 435-450.
- Rutter, M. (1978). Diagnosis and definition. In M. Rutter, & E. Schopler (Eds.), *Autism: A reappraisal of concepts and treatments*. New York: Plenum Press.
- Rutter, M. (1985). The treatment of autistic children. *Journal of Child Psychology and Child Psychiatry*, 26, 193-214.

- Schopler, E. & Mesibov, G. B. (1984). *The effects of autism on the family*. New York: Plenum Press.
- Smith, B., Chung, M. C. & Vostanis, P. (1994). The path to care in autism: Is it better now? *Journal of Autism and Developmental Disorders*, 19, 551-563.
- Suelze, M. & Keenan, V. (1981). Changes in family support networks over the life cycle of mentally retarded persons. *American Journal of Mental Deficiency*, 86, 267-274.
- Wilkin, D. (1979). *Caring for the mentally handicapped child*. London: Croom Helm.
- Wing, L. (1987). *Autistic Disorders Diagnostic Checklist*. Personal Communication to Michael Fitzgerald. Revised version published 1996.
- Wing, L. (1996). *Wing Autistic Disorder Interview Checklist – WADIC*. In I. Rapin (Ed.), *Preschool children with inadequate communication*. London: Mackeith Press.
- Wolf, L. C., Noh, S., Fisman, S. N. & Speechley, M. (1989). Brief Report: Psychological effects of parenting stress on parents of autistic children. *Journal of Autism and Developmental Disorders*, 19, 157-166.
- Wolfensberger, W. (1972). *The principle of normalisation in human services*. Toronto: National Institute on Mental Retardation.

## CHAPTER SEVENTEEN

### *SUBSTANCE USE IN EARLY ADOLESCENCE: A STUDY OF THE RATES AND PATTERNS OF SUBSTANCE USE AMONG PUPILS IN DUBLIN*

*Aoife Brinkley, Michael Fitzgerald,  
Sheila Greene, Paul McArdle.*

#### INTRODUCTION

In the last decade the use and abuse of substances has become recognised as a major national and international problem. The prevalence of substance use among young people has received considerable attention. While there is no shortage of anecdotal evidence regarding the use of substances among adolescents, it is only recently that research has been conducted in this area in Ireland. The present study aims to update information on trends and patterns of substance use among adolescents in Dublin and to gain information on the differences in rates and patterns of substance use between five European cities.

#### **1.1 Definitions of Adolescent Substance Use**

While there seems to be a consensus that the use and abuse of drugs, particularly among adolescents, is a growing problem and one which has important consequences for our society, there is no general agreement about how this problem can be defined and described. Medical

conceptualisations of addiction and substance dependency differentiate between non-problematic use of substances and misuse or problematic use. Traditionally this distinction has not been applied to adolescent drug use. This is because there was, and to a certain extent still is, an underlying assumption that all adolescent drug use is deviant and problematic and therefore can be described as drug abuse.

The assumption that all adolescent drug use is problematic is based on both the medical model and the criminal status of drug use. The former defines drugs as physically and psychologically harmful and people who use drugs as 'sick'. The latter defines adolescent use of alcohol and cigarettes and all use of other substances as illegal and therefore deviant. Research generally ignores the more positive reasons for and aspects of drug taking and adopts a problem perspective. This view does not allow for the fact that there are large differences in behavioural outcomes of illicit drug use. Gutierrez et al. (1994) has found that infrequent or experimental users actually share more similarities with abstainers than with frequent substance users. The belief that all substance use is dysfunctional may serve to distract us from focusing on the antecedents to more serious teen substance use and the concurrent problems that accompany the misuse. It also ignores the reality of the user, and their experiences. Adolescents themselves have a more sophisticated view of their own drug use and that of their peers. They recognise that not all drug use is problematic, distinguish between different types of use and often recognise a hierarchy of drugs (e.g. hard and soft drugs). Adolescents may use drugs to substantive ends, for example to increase sociability and to expressive ends (Glassner & Loughlin, 1987). The danger of relaying the message that all drugs are bad through prevention programmes and drug education is that it does not take into account the reality of those it is trying to target. This may result in adolescents rejecting the message of prevention/education.

It is useful to make a distinction between use and misuse of substances as it reflects a more realistic view of adolescent substance use. It also allows for the identification of factors that differentiate between those whose use is problematic and those who use substances in a more positive way.

The assertion that there is such a thing as non-problematic adolescent drug use is a contentious one. It questions the assumption underlying the vast majority of drug research and drug related policy - that all drugs are bad. There is a marked dissonance between policy on the one hand and services on the other. While the emphasis is on repression and abstinence at policy level, many services adopt a harm reduction approach and a goal of non-problematic or controlled use rather than abuse. Recent government documents have shown some recognition of the variety of patterns of drug use and the possibility that all use is not misuse (e.g. Department of the Taoiseach, 1997). Policies, prevention programmes and media campaigns however continue to stress abstinence and seek to prevent *all* drug use. The 'Just Say No' campaign in America demonstrates the flaws in this type of approach - an approach which stems from the belief that there is no such thing as responsible use of substances and that children can be taught never to drink or smoke.

According to Newcomb and Bentler (1988) "as scientists, we must challenge the rather uncritical and unscientific assumption that drug use, in and of itself, is bad and should be prevented, understood or treated" (p.14). Research has consistently shown that a large proportion of adolescents regularly use alcohol and cigarettes, and that a growing proportion are regular users of illicit substances. Dryfoos (1990) argues that "experimentation with substances must be viewed as one of the developmental task of early adolescents" (p. 45). Only a small number will experience problems associated with their use, or will go on to

develop a dependence. Experimentation and a variable pattern of use and cessation have been found to be much more common than heavy or problematic use (Howard, 1997).

While recognising the naivety of the assertion that all drugs are bad it is important not to lose sight of the fact that many adolescents do experience problems associated with dependence on drugs (e.g. increase in tolerance, withdrawal symptoms, and attempts to curtail use). We must be very careful about using terms like 'normal' and 'healthy' in relation to adolescent substance use, as this implies condonement. The health risk from regular smoking and drinking has been well documented, and even infrequent use of substances can have serious consequences for the physical and emotional well being of an individual. Regular use of substances during adolescence has been found to result in delays in achieving developmental goals, and a pseudo-maturity which ill prepares the individual for the real difficulties of adult life (Newcomb & Bentler, 1988).

What is needed in defining adolescent substance use is a recognition that there are different levels of drug involvement, even in adolescence. The ways in which the concept of adolescent substance use was defined twenty years ago is no longer relevant, as such behaviour has increasingly become part of the normal repertoire of adolescent behaviours. The way in which substance use and abuse is defined is also subject to cultural differences. It depends on a particular society's norms with respect to the acceptability of recreational use of substances, its definitions of heavy use and its tolerance for substance related problem behaviour. This illustrates the need to regularly update the way in which use and abuse, experimental and regular use etc. are defined and to clarify what is meant by these terms.

## **1.2 Research on Adolescent Substance Use in Ireland**

Up until relatively recently there was a distinct lack of research in this area in Ireland. The first studies of adolescent illicit drug use in Ireland were conducted in the 1970's and these studies showed low rates of lifetime use of illegal substances among Irish pupils (1.3% of pupils aged under 16 and 4.9% of pupils over 16 years of age) (Nevin et al., 1971). The same type of survey was conducted a decade later and results showed a marked increase when compared to the earlier study (9.0% of those under 16 years and 20.0% of those over 16 years had taken drugs) (Shelley et al., 1982).

Grube and Morgan (1986, 1990) conducted a series of studies in the mid to late 80's in order to estimate the prevalence of smoking, drinking and use of drugs. In a nation-wide sample of pupils aged between 13 and 17 years the authors found that a quarter of pupils were regular smokers and over a third were regular drinkers. It was found that just over one fifth of the sample had tried drugs other than tobacco and alcohol, with marijuana and glue or other inhalants being the most popular.

The results of the ESRI surveys showed that Irish teenagers had low rates of drug use when compared with teenagers in other countries, with the exception of solvent and inhalant use which was high by international standards (Morgan & Grube, 1989).

Recently there has been a move to large scale surveys which compare data gathered in a similar way in different countries. This has illustrated the differences that exist between countries - in both the drugs that are available to young people and in rates and patterns of use. The European School Survey Project on Alcohol and other Drugs, or ESPAD (Hibell et al., 1997) is one such study. Surveys were conducted in 26 countries, including Ireland, where a national sample of 1849 fifth year pupils participated in the survey.

74% of pupils had tried smoking cigarettes at least once, while 37% were regular smokers<sup>4</sup>. Both figures are higher than the average proportion for all countries. The proportion of students who reported drinking alcohol during the last 12 months was 87% - somewhat higher than average for all the countries. Binge drinking (drinking 5 drinks or more in a row) was reported by 23% of Irish students - the highest rate amongst participating countries.

Use of illegal drugs was found to be very common among Irish students: 37% indicated use of cannabis and 16% had used an illicit drug other than cannabis. Again these rates are considerably higher than the average for all participating countries. The most commonly used illegal drugs after cannabis were LSD or other hallucinogens, and ecstasy. 1% of students had used drugs by injection. Looking at frequency of use, 10% of students reported having used cannabis 20 times or more while 19% had used cannabis in the last thirty days.

The age at which pupils had first used substances was examined. Approximately a fifth of pupils reported having started daily smoking by age 13 or younger and the same proportion reported having been drunk at that age. 9% of Irish students had used inhalants at age 13 or less and 7% had used cannabis at this age.

The ESPAD study (Hibell et al., 1997) found that a higher proportion of girls than boys smoked, while boys had higher rates than girls on all measures of alcohol use and drunkenness. A higher proportion of boys than girls had also tried cannabis and any other illicit drug. More boys than girls also reported early onset of use of illicit drugs (13 years or younger). However, when compared to data from the studies conducted in the 1980's, the findings suggest a slight convergence in rates of alcohol and illegal drug use between the sexes.

A 1996 survey which examined use of illicit substances among fourth and fifth year pupils (15-17 year olds) in North Dublin (Murphy, 1996) found that lifetime prevalence of any of four drugs (cannabis, amphetamines, LSD, Ecstasy) was 62.5%. Boys reported a higher rate of drug use compared to girls.

Data from these surveys show a marked increase in the use of substances, both legal and illegal, among the Irish school population. While a similar trend has been observed in other countries, the increase seems to be particularly marked in Ireland. While surveys conducted in the 1980's found that substance use among Irish adolescents was low by international standards, more recent surveys have revealed a change. The ESPAD (Hibell et al., 1997) study found higher rates of use for all substances among Irish pupils when compared to the 25 other European countries that took part in the survey. This was particularly true of illicit drug use.

There are several possible explanations for the increase and the current high rates.

*Literature on substance use suggests that an increase in rates of use may be associated with increased consumerism (Parker, 1997), economic growth (Osterburg, 1986), changes in parenting patterns, or a decrease in the importance of religion and the opportunities for occupational achievement (Silbereisen, 1995).*

Previous studies have found that prevalence of adolescent substance use is significantly higher in Dublin compared to rural areas. While national surveys such as the ESPAD are

---

<sup>4</sup>lifetime use of 40 times or more

useful for cross-national comparisons, it is also important to gather localised data. This will increase knowledge of regional differences and allow prevention strategies to be designed to address local needs.

Recent studies of substance use among school populations have investigated use among post Junior Certificate pupils. If we are to gain an understanding of the nature of problematic substance use it is essential that we also look at a younger adolescent population. Research points to the fact that children who use alcohol and other drugs before the age of 15 have a greater likelihood of becoming problem alcohol and drug users. The early use of substances has also been found to be associated with worst outcome in terms of both likelihood of dependence and its persistence (Robins, 1992). The use and abuse of substances may be defined differently and be associated in distinct ways depending on the specific age group being studied (Newcomb, 1992). Surveying younger teenagers will tell us whether the normalisation of substance use is confined to older adolescents or whether it has filtered down to a younger age group. It will also discover whether the pattern of poly-drug use and use of the so-called dance drugs (ecstasy, amphetamines and LSD) is to be found among the younger population.

### **1.3 Theories on Adolescent Drug Use**

A large number of theories have been developed since the early 70's in an attempt to better understand drug use and misuse. These theories draw from a variety of disciplines and emphasise different aspects and patterns of drug use. Social learning theory sees the use of substances as a learned behaviour. According to problem behaviour theory substance use in adolescence is an aspect of a general anti-establishment unconventional behaviour. Strain theory sees substance use as resulting from frustrated needs or wants while social control theory links it with weak internalised social controls. One of the shortcomings of the above theories is that they focus on one dimension of drug abuse. Each theory can be said to relate to and have explanatory power for one type or pattern of substance use, but they do not take into account the fact that the non-medical use of substances is a multi-dimensional phenomenon. There are many different types and patterns of drug use which vary for type of drug, place along the use-misuse-dependence continuum and characteristics and circumstance of the user. Each of the patterns and types of use may also be the result of multiple factors, which operate in a number of contexts.

What is needed is a theoretical approach which recognises that "individuals may be influenced by radically different situations, producing different effects on their behaviour" and the fact that "the same behaviour may have totally different causes in different people" (Gorusch, 1983, p. 19). A theory which accurately reflects the heterogeneity of drug use and which can be of use in the design of intervention and prevention programmes needs to take into account the different stages of drug involvement. It cannot be assumed that experimentation and frequent use or initial drug use and drug addiction are subject to the same etiological factors and this is one of the limitations of many models of drug abuse. There is also a need to include socio-cultural factors in any model or theory of drug use. Explanations that emphasise individual characteristics or attributes of personality overlook situational variables such as availability, social norms and laws. These obviously have an important impact on how, and which drugs are used and by whom. What is needed is a ecological or social situational model.

Several authors have proposed a risk-factor approach to understanding teenage drug use (Newcomb et al., 1987; Bry, 1983). It is argued that this approach allows for the fact that

there are numerous pathways to substance use that are not captured by a single etiological cause. Any one factor, deviant attitudes for example, is not considered the definitive etiological cause of drug use, but is considered “one factor in a cumulative ecology of influences that are associated with increased drug involvement”. This approach also allows for the fact that different factors may play different roles at various stages of drug involvement and in different populations or subgroups.

#### **1.4 Risk and Protective Factors**

Clayton (1992) defines a risk factor as “an individual attribute, individual characteristic, situational condition, or environmental context that increases the probability of drug use or abuse or a transition in level of involvement with drugs”.

Risk factors have been well researched in the United States and available evidence indicates that adolescent substance abuse is the result of multiple factors that are social, intrapersonal, and developmental in nature. Recent studies have divided risk factors into contextual factors and individual/interpersonal factors (e.g. Hawkins and Catalano 1992) This approach expands on the former focus on individual characteristics thus representing a more ecological, multi-dimensional and dynamic approach. Attempts have also been made to distinguish between risk factors associated with different levels of use (Gutierrez et al. 1994, Sheier & Newcomb 1991) and to investigate the impact of social and demographic differences on risk factors (Newcomb 1987). In line with the multi-causal approach, research has demonstrated that several risk or protective factors can have an impact on a single outcome and that the influence is cumulative (Bry 1992, 1993; Newcomb, 1986).

Among the risk factors identified for adolescent drug use are:

- Low commitment to school
- Cognitive impairment
- Academic failure
- Low religious involvement
- Early persistent problems behaviours
- Poor, inconsistent family management practices
- Family conflict
- Low bonding to family
- Alienation/rebellion
- Family drug behaviour
- Attitudes favourable to drug use
- Sensation seeking
- Attention deficit/hyperactivity
- Low autonomic and central nervous system arousal
- Hormonal factors
- Peer rejection in elementary school
- Association with drug using peers
- Laws and norms
- Availability
- Extreme economic deprivation
- Neighbourhood disorganisation (From Hawkins, Catalano & Miller, 1992)

Recent developmental research has shifted from a focus on risk factors to examine the role of protective factors that moderate the effects of exposure to risk and the identification of factors

that contribute to an individual's resiliency. Resilience, according to Rutter (1992), is concerned with individual variations in response to risk factors and protective factors operate by modifying a person's response to a risk situation. Applied to drug use, a focus on resilience would involve identifying the factors that differentiate between early drug users who go on to abuse drugs and those who do not make this transition.

There is a growing body of research which examines the role of protective influences on adolescent substance use (e.g. Scheier et al. 1994, Newcomb 1992, Newcomb & Felix-Ortiz 1992). In relation to substance abuse Clayton (1992) defines protective factor as "an individual attribute, individual characteristic, situational condition, or environmental context that inhibits, reduces, or buffers the probability of drug use or abuse or a transition in level of involvement with drugs". This is a promising area as may help us to understand why some people respond to the combination of social and familial risk factors in a more adaptive way than others.

## **1.5 Aims of Research**

The study aims, within an Irish context, to:

- Examine prevalence and patterns of use of legal and illegal substances among young adolescents.
- Examine gender and socio-economic differences in rates and patterns of substance use.
- Refine the understanding of risk and protective factors associated with drug use and other risky behaviours.
- Examine factors that differentiate between abstainers (both vulnerable and resistant), experimental and repeated users.
- Expand the way in which substance use in adolescence has been defined.
- Strengthen research on drugs in Ireland.

The study was conducted as part of a European collaborative project. The project, called Drug Dependence: Risk and Monitoring (DDRAM), was conducted in five cities: Newcastle upon Tyne, Dublin, Groningen, Rome and Bremen. The DDRAM project aims to:

- Monitor trends in the use of legal and illegal substances and examine associated factors among young people (aged 14 and 15 years) in their second year of secondary education in the five cities.
- To gain comparative information on the rates and patterns of substance use among young people in the five cities.
- To establish a data base concerning 10 to 12 year olds as the initial stage of a planned longitudinal study of risk and protective factors associated with risk taking behaviour and - to refine the understanding of antecedents of risk behaviours and the identification of young people at risk.
- To strengthen research on drugs in Europe.

## **METHOD**

### **2.1 Sample**

The sample consisted of 983 second year pupils in 16 schools in the Dublin metropolitan area. The schools were selected using a stratified random sampling technique, with a definite balance being maintained by school type - vocational, secondary in disadvantaged area, secondary in non-disadvantaged area and private school. One special school, a school for travellers, was included in the sample. A balance of gender was also aimed for.

### **2.2 Response rates**

Overall the response from schools was very positive, with only 3 schools deciding not to participate in the survey. Reasons given for non-participation included: concerns about negative publicity and the effect on school reputation, participation in previous research on substance use, and concern that it would make drug taking or delinquent behaviour more acceptable to pupils. In each case a refusing school was replaced from the original sampling list by a school matched on the stratification characteristics.

### **2.3 Research Instrument**

The research instrument used was a self-report questionnaire, a format used in many previous studies of drug-taking. The questionnaire included questions on trends and patterns of substance use, delinquency, risk-taking behaviour, peer-affiliation, free-time activities, family structure, emotional and behavioural problems and adaptation to school.

### **2.4 Procedure**

A letter was sent to parents of all second year pupils in each participating school. The parent letter gave a brief outline of the study, described the questionnaire and gave parents the option of refusing permission for their child to take part in the study (by returning a slip to the school).

The researcher then visited the school and distributed the questionnaires, remaining with the pupils throughout to answer any questions etc. The aims and nature of the survey were explained to pupils and the fact that the survey was voluntary, confidential and anonymous was emphasised. In most cases teachers were not present during the time it took pupils to complete the questionnaire (9 out of 16 schools). This was not possible in every school due to disciplinary concerns. Pupils were usually given between 60 and 80 to complete the questionnaire.

There was a very positive response to the questionnaire by pupils in all sixteen participating schools. Excluding absentees and questionnaires excluded from analysis because of inconsistencies or other defects (8 questionnaires), 983 students completed the survey.

## RESULTS

### 3.1 The Sample

The sample of 983 questionnaires had a higher proportion of girls than boys, with 570 girls (58% of sample) and 409 boys (42% of sample). The age breakdown of participating pupils can be seen in Table 1.1. The majority of pupils were born in 1982 or 1983, and so were 14 and 15 years of age at the time of the study. The mean age was 14.38.

**Table 1.1** Respondents year of birth by gender - percentages

<i>YEAR</i>	<i>GENDER</i>		
	<i>Female</i>	<i>Male</i>	<i>Total</i>
1981	2 (12)	2 (10)	2 (22)
1982	43 (242)	31 (124)	38 (366)
1983	54 (307)	54 (218)	54 (525)
1984	1 (5)	13 (51)	6 (56)
TOTAL	100 (566)	100 (403)	100 (969)

Note: Valid Cases = 969, Missing cases = 14. Ns in parentheses.

The family structure of participating pupils can be seen in Table 1.2. The majority of pupils (80%) lived in an 'intact family', which was defined as a family with both natural parents living in the home. 14% lived in a single-parent family and 2% lived in a step-family, which was defined as a family with the mother and the mother's partner, or the father and the father's partner living in the home.

**Table 1.2** Respondents family structure

<i>FAMILY STRUCTURE</i>	<i>%</i>	<i>N</i>
Intact family	80	(787)
Step-family	2	(20)
Single-parent family	14	(137)
Other	4	(39)
TOTAL	100	(983)

Note: Valid Cases = 983, Missing cases = 0. Ns in parentheses.

Parental employment can be seen in Table 1.3. Just under a third of the sample (32%) had a father in employment and a mother who did not work outside the home. Just over a quarter (27%) had two parents in full-time employment and just under a quarter (24%) had one parent in full-time employment and one parent in part-time employment.

**Table 1.3** Respondents parents employment

<i>PARENTAL EMPLOYMENT</i>	<i>%</i>	<i>N</i>
Both work full-time	27	(255)
One full-time, one part-time	24	(225)
Both work part-time	3	(26)
Father works, mother doesn't	32	(300)
Mother works, father doesn't	10	(95)
Both unemployed	4	(42)
TOTAL	100	(943)

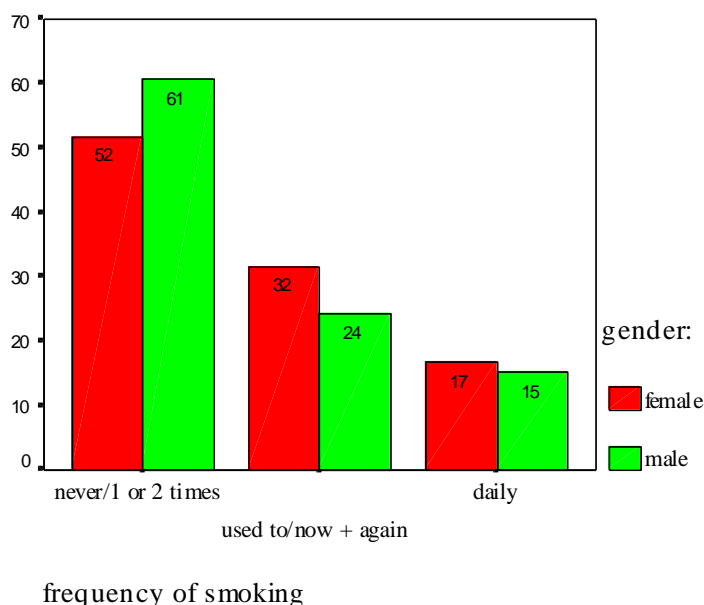
Note: Valid cases = 943, Missing cases = 40. Ns in parentheses.

## Substance Use

### **3.2 Tobacco**

Pupils were asked whether they had ever smoked. A third of the total sample had never smoked cigarettes, 22% had smoked once or twice, 15% used to smoke but had stopped, 9% smoked now and again and 16% smoked cigarettes daily. Respondents were divided into three categories depending on frequency of use of cigarettes: those who never smoked or who had smoked once or twice, those who used to smoke or who smoke now and again and those who smoke daily. Figure 2.1 presents the percentage of responses for each of the three tobacco use categories. There was a significant difference between the proportion of girls and boys who reported that they smoked ( $\chi^2(4) = 19.124, p < .001$ ). As can be seen from the chart more girls than boys reported that they smoke daily and that they used to smoke or smoke now and again.

**Figure 2.1** Reported use of tobacco by gender - percentages.



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

Pupils who smoked were also asked to indicate how many cigarettes they smoked on average each day. The mean number of cigarettes smoked was 4.2 (SD = 5.7). Although a higher proportion of girls reported smoking than boys, boys smoke more cigarettes on average than girls. The mean number of cigarettes reported by boys was 4.7 compared to a mean of 3.9 cigarettes reported by girls. This difference was not found to be significant,  $t(405) = -1.63$ ,  $p > 0.10$ . Table 2.1 shows the numbers of cigarettes smoked each day, by category. The differences between girls and boys was found to be significant,  $\chi^2(3) = 9.5$ ,  $p < .05$ . As can be seen from the table a much higher proportion of boys than girls reported that they smoke more than 10 cigarettes a day.

**Table 2.1** Average number of cigarettes smoked each day among pupils who smoke by gender – percentages

NUMBER OF CIGARETTES	GENDER		
	Girls	Boys	Total
1-2 cigarettes	34 (76)	27 (39)	31 (115)
3-5 cigarettes	27 (59)	27 (40)	27 (99)
6-10 cigarettes	31 (69)	29 (42)	30 (111)
11 + cigarettes	8 (17)	18 (26)	12 (43)
TOTAL	100 (221)	101 (147)	100 (368)

Note: Ns in parentheses, non smokers = 321, Missing cases = 96

Pupils were asked, if they had ever smoked, to indicate their reasons for smoking. Pupils who had never smoked were asked to indicate their reasons for not smoking. Reasons given for smoking can be seen in Table 2.2, while Table 2.3 shows the reasons given for not smoking.

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

Looking at the reasons given for not smoking, the majority of pupils (79%) who did not smoke said it was because 'its bad for the health'. Approximately a third of pupils said it was because they practise a sport (34%) or because their parents forbid it or advise against it (30%). Again some significant gender differences emerged. A higher proportion of boys than girls said they did not smoke because it is bad for the health ( $\chi^2(1) = 3.9, p > .05$ ) or because they practise a sport ( $\chi^2(1) = 36.9, p > .001$ ), while a higher proportion of girls than boys said they didn't like the taste ( $\chi^2(1) = 9.7, p > .01$ ).

**Table 2.2** Reasons for smoking by gender - percentages of those who have smoked

REASONS FOR SMOKING	GENDER		
	Girls	Boys	Total
My friends smoke	35 (139)	*43 (104)	38 (243)
Wanted to try	***85 (336)	68 (171)	78 (507)
It relaxes me	19 (77)	**29 (72)	23 (149)
I can't quit	17 (68)	12 (30)	15 (98)
People smoke in the places I usually go	20 (78)	17 (44)	19 (122)

Notes: Valid cases = 650, Missing cases = 336 of which 321 were non-smokers. Ns in parentheses. Total % exceeds 100 since respondents could tick up to three reasons.

\*  $p < .05$     \*\*  $p < .01$     \*\*\*  $p < .001$

**Table 2.3** Reasons for not smoking by gender - percentages of those who have not smoked

REASONS FOR NOT SMOKING	GENDER		
	Girls	Boys	Total
Its bad for the health	77 (309)	*83 (234)	79 (543)
I don't like the taste	**31 (126)	21 (58)	27 (184)
My parents advise me not to or forbid me to	29 (115)	33 (92)	30 (207)
I practise a sport	25 (101)	***47 (134)	34 (235)
I'm too young	21 (86)	17 (48)	20 (134)
Its too expensive	30 (122)	25 (70)	28 (192)

Notes: Valid cases = 689, Missing cases = 294 of which 201 are smokers. Ns in parentheses. Total % exceeds 100 since respondents could tick up to three reasons.

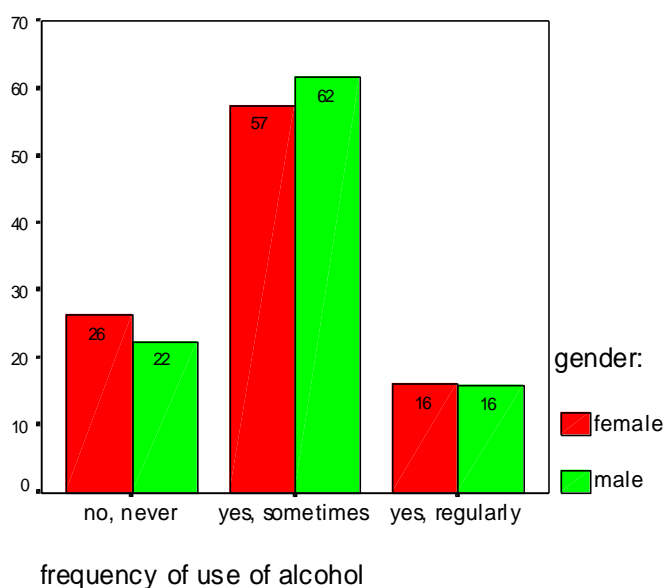
\* p < .05    \*\* p < .01    \*\*\* p < .001

When the pupils who smoked were asked what their parents thought about them smoking, 55% said that their parents did not know that they smoked and 40% said that their parents advise against them smoking.

### 3.3 Alcohol

25% of pupils reported that they never drink alcohol, 59% reported that they sometimes drink and 16% said that they drink regularly. Figure 3.1 shows that a slightly lower proportion of males than females reported that they never drink and a slightly higher proportion of males reported that they drink sometimes. These differences were not significant ( $\chi^2(2) = 2.1, p > 0.1$ ). There were no gender differences in the proportion reporting that they drink regularly.

**Figure 3.1** Reported use of alcohol by gender - percentages



Pupils were asked to specify how often they had drunk any of a list of 6 alcoholic drinks. Table 3.1 shows the proportion of pupils who drink the different types of alcoholic drink. The type of drink that pupils drank the most often was alcoholic soft-drinks (75% of those who drink alcohol) and larger, stout or cider (72% of those who drink alcohol). The least common

types of alcohol used by pupils were spirits, spirits with mixers and wine. Significant gender differences were found for two of the types of drink listed. A higher proportion of boys than girls reported that they drank larger, stout or cider ( $\chi^2(4) = 13.9, p < .01$ ) and a higher proportion of girls than boys drank alcoholic soft-drinks ( $\chi^2(4) = 19.4, p < .001$ ).

**Table 3.1** Frequency of use of different types of alcohol - percentages of those who use alcohol

TYPE OF ALCOHOL USED	FREQUENCY OF USE			
	Less than once a month	Once a month	At least once a week	Daily
Low alcohol beer	31 (181)	18 (105)	7 (40)	1 (5)
Larger, stout, cider	32 (187)	22 (130)	17 (120)	1 (5)
Wine	30 (163)	11 (61)	4 (22)	1 (4)
Alcoholic soft-drinks	36 (210)	26 (153)	12 (71)	1 (7)
Spirits with mixers	22 (122)	13 (70)	7 (37)	2 (10)
Spirits	17 (95)	11 (61)	6 (35)	2 (11)
Other	13 (41)	7 (21)	6 (20)	1 (4)

Notes: Valid cases = 588, Missing cases = 395, of which 236 = non-drinkers. Ns in parentheses.

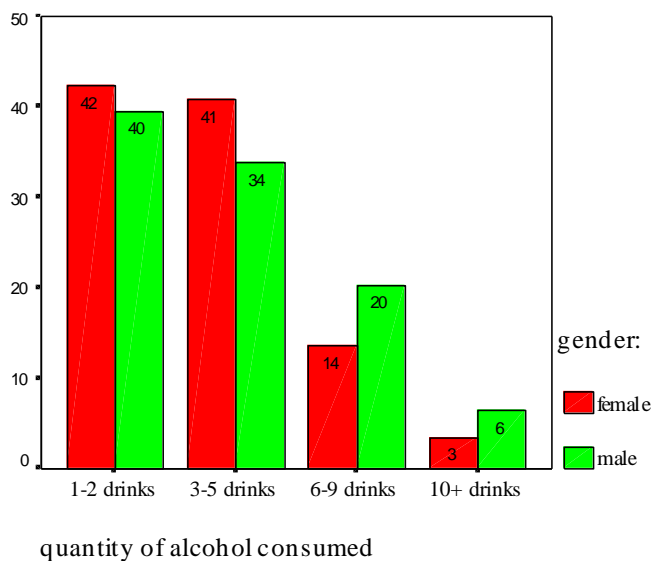
Frequency of pupils alcohol use was investigated<sup>5</sup>. 3% of pupils who drink (2% of total sample) reported daily use of alcohol, 27% (18% of total) reported weekly use, 33% (22% of total) reported monthly use and 37% (25% of total) reported using alcohol less than once a month.

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

The mean amount of alcohol consumed on an average occasion was 3.6 units (SD = 2.7). Boys reported drinking significantly more on average than girls (mean for boys was 4.0 compared to a mean of 3.4 among girls;  $t(588) = -2.9, p < .01$ ). 26% of boys reported that when they drink they consume 6 or more units, compared to 17% of girls (see Figure 3.2).

<sup>5</sup> Valid cases = 919, Missing cases = 64.

**Figure 3.2** Quantity of alcohol usually consumed by gender



Pupils who had used alcohol were asked to indicate their reasons for drinking, while pupils who had not used alcohol were asked to indicate their reasons for not drinking. Results can be seen in Table 3.2 and Table 3.3. The most common reason given for drinking was ‘wanted to try’ (61% of pupils who drink alcohol). Half of pupils who drink said that they did so because they like to drink on special occasions while just under half (46%) said it was because they like the taste. A significantly higher proportion of girls than boys cited curiosity as their reason for drinking, ( $\chi^2(1) = 25.4, p < .001$ ).

**Table 3.2** Reasons given for drinking alcohol by gender - percentages of those who use alcohol

REASONS FOR DRINKING	GENDER		
	Girls	Boys	Total
My friends drink	26 (107)	27 (80)	26 (187)
I wanted to try	*69 (281)	50 (151)	61 (432)
I like the taste	48 (195)	44 (132)	46 (327)
I like the effects	36 (147)	37 (110)	36 (257)
I feel better when I drink	13 (52)	16 (47)	14 (99)
I like to drink alcohol on special occasions	48 (196)	52 (154)	50 (350)
There is alcohol in the places I usually go out	13 (51)	8 (24)	11 (75)

Notes: Valid cases = 709, Missing cases = 274, of which 236 = non-drinkers. *N*s in parentheses. \*  $p < .001$

The most commonly cited reason for not drinking was the fact that it is bad for the health (45% of pupils who do not drink). Approximately a third of pupils who do not drink gave as reasons that their parents are against it or forbid it (36%), that they are too young (35%) and that they don’t want to be drunk (30%). Looking at gender differences, a significantly higher proportion of girls than boys gave as reasons that they didn’t like the taste ( $\chi^2(1) =$

9.1,  $p < .01$ ) while a significantly higher proportion of boys than girls cited the fact that their parents advised against it or forbade it ( $\chi^2(1) = 10.7, p < .001$ ).

**Table 3.3** Reasons given for not drinking alcohol by gender - percentages of those who do not use alcohol

<i>REASONS GIVEN FOR NOT DRINKING</i>	<i>GENDER</i>		
	<i>Girls</i>	<i>Boys</i>	<i>Total</i>
Its bad for the health	42 (127)	51 (99)	45 (226)
I don't like the taste	*31 (94)	19 (37)	26 (131)
My parents advise me not to or forbid me to	30 (91)	**44 (87)	36 (178)
Its forbidden	11 (33)	11 (21)	11 (54)
I don't want to be drunk	32 (98)	27 (52)	30 (150)
I'm too young	32 (98)	38 (75)	35 (173)
It could change my mood	13 (38)	9 (18)	11 (56)
Its too expensive	28 (81)	20 (40)	24 (121)

Notes: Valid cases = 499, Missing cases = 484. *Ns* in parentheses. \*  $p < .01$  \*\* $p < .001$

In order to examine the context in which pupils drink alcohol, pupils who used alcohol were asked to indicate where they usually were when they drank. As can be seen from Table 3.4 the most common location for drinking is outside - on the street, in a park, on the beach or other open area (61% of those who drink). The next most common location is in someone else's home, which was reported by over half of pupils who drink alcohol (56%). Approximately a third of those who drink said that they drink in their own home (33%) or at a disco or club (30%). Looking at gender differences, significantly more girls than boys reported that they drank at someone else's home ( $\chi^2(1) = 6.2, p < .01$ ) and in pubs ( $\chi^2(1) = 7.1, p < .01$ ).

**Table 3.4** Usual location of drinking by gender - percentages of those who use alcohol

<i>LOCATION OF DRINKING</i>	<i>GENDER</i>		
	<i>Girls</i>	<i>Boys</i>	<i>Total</i>
At home	32 (131)	34 (104)	33 (235)
At someone else's home	*60 (242)	50 (152)	56 (394)
On street, park, beach	62 (250)	60 (182)	61 (432)
In the pub	*15 (62)	9 (26)	12 (88)
At a disco or club	32 (128)	28 (84)	30 (212)
Restaurant	8 (32)	5 (14)	7 (46)
Other	11 (46)	13 (38)	12 (84)

Notes: Valid cases = 711, Missing cases = 272, of which 236 = non-drinkers. *Ns* in parentheses. \*  $p < .01$   
Pupils who use alcohol were asked what their parents thought about them drinking alcohol. 57% of those who drink<sup>6</sup> said that their parents did not know that they drink, while a quarter of the sample said that their parents advise against them drinking. Just under a tenth of pupils

<sup>6</sup> Valid cases = 690, Missing cases = 293 of which 236 are non-drinkers.

(9%) said that their parents think it's all right and the same proportion said their parents say nothing about it.

### 3.4 Illicit Substances

Respondents were asked whether or not they had used any of eight drugs listed, and those who had used the drug were asked to indicate whether they had used it in the past year or in the past four weeks. Just under a third of the sample (32%) reported use of at least one illicit substance. 17% of the sample had used an illicit substance in the last month and 15% had used an illicit substance in the past year. A significant gender difference was found in rates of use of any illicit substance (27% girls, 38% boys;  $\chi^2(1) = 12.3, p < .001$ ) and for past month use of any illicit substance (14% girls, 22% boys;  $\chi^2(1) = 9.5, p < .01$ ).

Figure 4.1 shows reported use for each of the listed drugs. Cannabis was the most commonly used illicit drug, with 29% of pupils having used it either in the last year or in the last month (14% last year, 15% last month). The next most commonly used drug were the solvents (glue, aerosols, butane gas, petrol etc.) which had been used by 14% of pupils (8% last year, 7% last month). All other illicit drugs had been used by 5% or less of the sample. In total 18% of the sample had used an illicit substance other than cannabis, and a significantly higher proportion of boys than girls had done so (22% of boys compared to 16% of girls,  $\chi^2(1) = 5.0, p < .05$ ).

**Figure 4.1** Any use of illicit drugs - percentage of pupils who had used the listed illicit substances

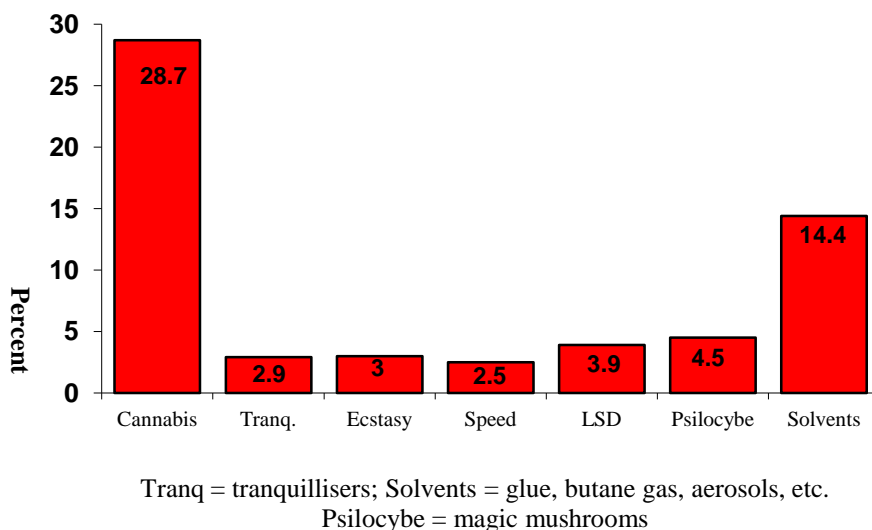
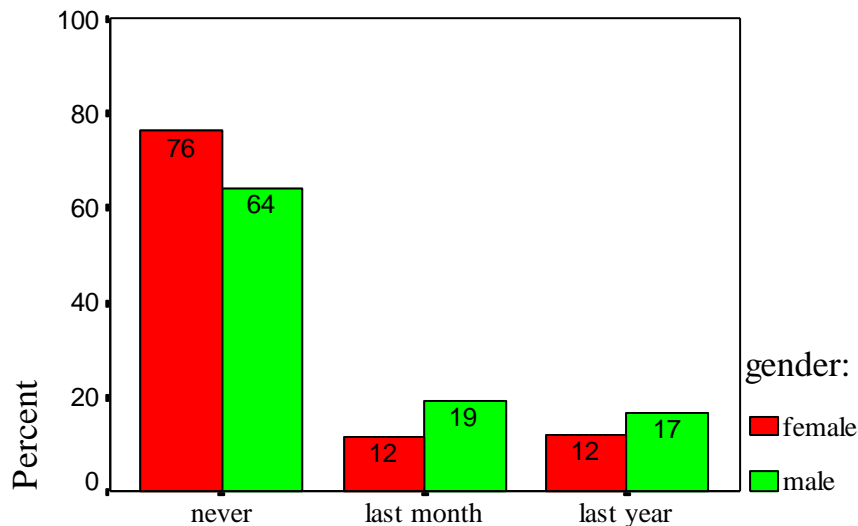
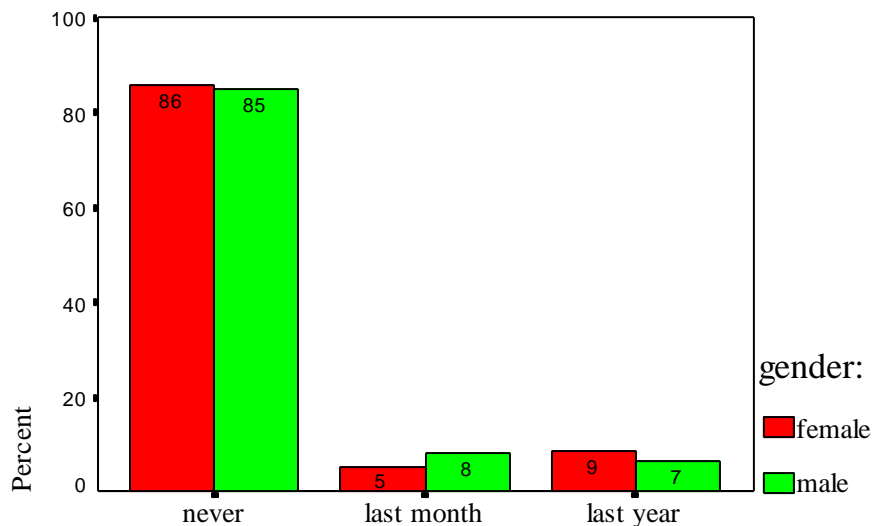


Figure 4.2 shows the proportion of boys and girls who reported having used cannabis in the last four weeks and in the last year. A higher proportion of boys than girls had used cannabis both in the last year and in the last month and this difference was significant ( $\chi^2(2) = 16.5, p < .001$ ). The prevalence of last month and last year use of solvents among boys and girls can be seen in Figure 4.3. These differences were not significant.

**Figure 4.2** Use of cannabis in last month and last year by gender – percentages



**Figure 4.3** Use of inhalants in last month and last year, by gender - percentages.



Looking at gender differences in the use of other illicit substances, significant differences were found in the use of amphetamines (4% of boys had used either within last month or year compared to 1% of girls,  $\chi^2(2) = 17.7$ ,  $p < .001$ ), LSD (boys 7%, girls 2%;  $\chi^2(2) = 16.2$ ,  $p < .001$ ), and magic mushrooms (boys 8%, girls 2%;  $\chi^2(2) = 17.7$ ,  $p < .001$ ).

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

Pupils who had used illicit drugs were asked to indicate the reasons why. As can be seen from Table 4.1, the majority of pupils who had used drugs (80%) reported that they had taken drugs because they wanted to try. This was the reason most commonly given, followed by 'I

like the effects' (44%) and 'my friends take drugs (30%).' 'I feel better when I take drugs' and 'there are drugs in the places I go' were both given as reasons by just under a quarter of those pupils who had used drugs (23% each). 17% of pupils who had used drugs gave as a reason that drug taking is a tradition among young people. A significantly higher proportion of girls than boys said that they had used drugs because 'I wanted to try' ( $\chi^2(1) = 6.1, p < .05$ ).

Pupils who had never used illicit substances were also asked to indicate the reasons (see Table 4.2). The most commonly cited reason for not taking drugs was the fact that it is bad for the health (79%). Over a half (56%) of those who have not used drugs gave 'risk of dependency' as a reason while 'I don't like the effects' and 'my parents advise me not to or forbid it' were given as reasons by 40% and 39%. Significant gender differences were found for six of the reasons given. A higher proportion of boys than girls said that they did not use drugs because of the effect on health ( $\chi^2(1) = 12.7, p < .001$ ), parental advice ( $\chi^2(1) = 9.8, p < .01$ ) and its illegal status ( $\chi^2(1) = 6.0, p < .05$ ). A higher proportion of girls than boys said that they did not use drugs because of the risk of dependency ( $\chi^2(1) = 11.9, p < .001$ ), the effects ( $\chi^2(1) = 5.1, p < .05$ ) and the cost ( $\chi^2(1) = 5.0, p < .05$ ).

**Table 4.1** Reasons given for taking drugs by gender - percentages of those who use drugs

REASONS GIVEN FOR TAKING DRUGS	GENDER		
	Girls	Boys	Total
I wanted to try	*86 (123)	75 (111)	80 (234)
I like the effects	39 (56)	48 (71)	44 (127)
My friends take drugs	25 (36)	35 (52)	30 (88)
I feel better when I take drugs	25 (36)	22 (32)	23 (68)
There are drugs in the places I usually go out	23 (33)	23 (34)	23 (67)
Its a tradition among young people	17 (24)	17 (25)	17 (49)

Notes: Valid cases = 293, Missing cases = 690, of which 527 = non-drug users. *N*s in parentheses.

\*  $p < .05$

**Table 4.2** Reasons given for not taking drugs by gender - percentages of those who do not use drugs

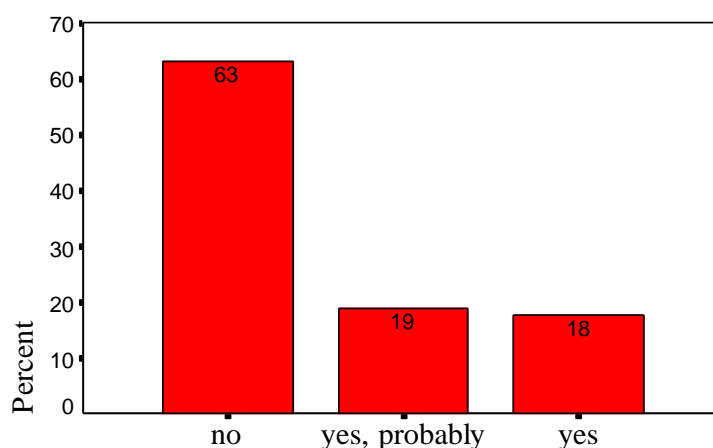
REASONS GIVEN FOR NOT TAKING DRUGS	GENDER		
	Girls	Boys	Total
Its bad for the health	75 (345)	***88 (265)	79 (610)
Risk of dependency	***61 (282)	49 (151)	56 (433)
I don't like the effects	*43 (198)	35 (108)	40 (306)
My parents advise me not to or forbid me to	34 (158)	**46 (141)	39 (299)
Its against the law	29 (131)	*37 (114)	32 (245)
Its too expensive	*21 (96)	15 (45)	18 (141)
It could change my mood	16 (72)	14 (43)	15 (115)
My friends don't take drugs	10 (46)	12 (38)	11 (84)

Notes: Valid cases = 771, Missing cases = 212. *N*s in parentheses.

\* p< .05    \*\* p <.01    \*\*\*p<.001

In order to examine vulnerability to illicit drug use pupils were asked if they would accept three listed substances if they were offered to them. When asked if they would accept a joint, if offered, well over half of the sample (63%) answered ‘no’, 19% answered ‘yes, probably’ and 18% answered ‘yes’.

**Figure 4.5** Vulnerability to cannabis use - ‘If someone offered you a joint would you accept?’ - percentages



Pupils were also asked if they would accept ecstasy if offered. The majority (94%) of pupils answered ‘no’, 2% answered ‘yes maybe’ and 4% answered ‘yes, probably’. In relation to cocaine, 95% said that they would not accept it, 2% answered ‘yes, maybe’ and 3% answered ‘yes, probably’. Significant gender differences were found for both cannabis and cocaine, with more boys than girls saying that they would accept the substances, if offered (cannabis:  $\chi^2(2) = 7.6, p <.05$ , cocaine:  $\chi^2(2) = 6.2, p <.05$ ).

In order to identify pupils who had not used any illegal substances but who were vulnerable to such use, the proportion of pupils who had never used an illicit substance but said that they would accept a substance if offered was examined. 10% of the sample could be described as vulnerable non-users, that is they had never used an illicit substance but said that they would accept either a joint, ecstasy or cocaine if offered. This group represents 15% of pupils who had never used an illicit substance. Of those who reported that they had never used cannabis, 16% said that they would accept a joint if offered (13% ‘yes, probably’ and 3% ‘yes’). This group represents 11% of the total sample.

### 3.5 Availability and Accessibility

Pupils who smoked were asked to indicate how they usually obtained cigarettes. Of pupils who smoked<sup>7</sup>, 61% said that they bought their cigarettes and 60% said that they obtained them from a friend. 43% said that cigarettes were shared around a group of friends, 18% said

<sup>7</sup> Valid cases = 485, missing cases = 498 of which 247 were non-smokers

that they took them from home without their parents permission and 18% said that they obtained them from a brother or sister.

Pupils were asked, if they drank, to indicate how they usually obtained alcohol. The majority of those who use alcohol indicated that they obtained it from a friend (60%)<sup>8</sup>. Just under a half of pupils (47%) said that they bought it, while 38% said that it was shared around a group of friends. 31% of pupils said that they took it from home, 22% said that they obtained it from a brother or sister, and 17% said they got it from one or both parents.

The availability of illicit substances was examined. Pupils were asked if they had ever been offered any of a list of illicit drugs. 60% of the total sample had been offered at least one illicit drug. A higher proportion of boys than girls had been offered an illicit substance (66% compared to 56%,  $\chi^2(1) = 10.2, p < .01$ ). Cannabis was the most accessible drug, with over half of the respondents having been offered it (54%), followed by ecstasy (30%), solvents (21%), LSD (20%), amphetamines (18%) and magic mushrooms (13%). Tranquillisers had been offered to 10% of the sample, while 9% reported having been offered substances other than those listed (other substances names by respondents included petrol, tobacco, benzodiazepines (*Roche*) and amyl nitrate (*poppers*)).

The most common places in which pupils were offered drugs were on the street, at a rave or disco and at a friend's home (see Table 4.3). While for each of the substances 'on the street' was the place where the most pupils had been offered, there were some differences between substances. Cannabis and solvents had been offered to some pupils at a friend's home or at school. For the three party drugs - LSD, amphetamines and ecstasy - the proportion of pupils who were offered them 'at a rave or disco' was similar to the proportion who had been offered them 'on the street'.

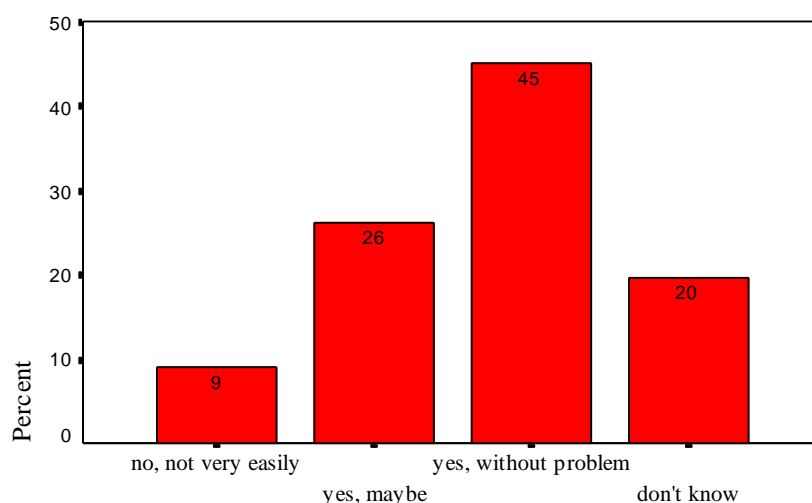
**Table 4.3** Exposure to illicit drugs - 'Have you ever been offered any of the following substances? If so, where?' - percentages of positive responses

TYPE OF DRUG OFFERED	PLACE WHERE DRUG WAS OFFERED						
	At home	At friends home	Bar or pub	On the street	At school	At a rave or disco	Other
Cannabis	5	15	3	37	6	16	5
Tranquillisers	0	2	1	5	0	3	0
Ecstasy	2	2	2	16	2	16	2
Amphetamines	1	2	1	9	1	7	1
LSD	2	3	1	11	1	7	1
Magic Mushrooms	2	3	1	6	2	4	1
Glue/Solvents	3	7	1	9	6	3	1
Other	1	2	0	3	1	1	1

Since school surveys show that cannabis is the illicit substance most commonly used among young people, availability of this drug was examined. Pupils were asked if they would know where to obtain a joint. As can be seen from Figure 4.4 the majority (71%) of respondents reported that they would know where to obtain cannabis. Almost half of the total sample (45%) answered 'yes, without any problems' and just over a quarter answered 'yes, maybe'. One fifth of pupils said that they didn't know and less than a tenth of pupils said that they would not be able to obtain cannabis very easily.

<sup>8</sup> Valid cases = 630, Missing cases = 353, of which 157 are non-drinkers.

**Figure 4.4** Perceived availability of cannabis - ‘would you know where to obtain a joint?’ – percentages



Pupils who had used cannabis and ecstasy were asked to indicate how they usually obtained the substances (see Table 4.4) and some differences emerged in how the two substances are obtained. In relation to cannabis the most common sources were ‘from a friend’ (64% of pupils who had used cannabis) and ‘shared around a group of friends’ (62%). 38% said that they usually buy it and a quarter said that they usually got it from a stranger. 15% said that they usually got it from a brother or sister and 6% said they took it from home without their parents’ permission. In relation to ecstasy, friends were again the most common source (59% of pupils who used had obtained ‘from a friend’ and 15% ‘shared around a group of friends’). In comparison to cannabis, a slightly higher proportion of pupils who had used ecstasy reported that they obtained ecstasy from a stranger (39%) or bought it (31%). 10% of ecstasy users said they took it from home without their parents’ permission and 8% of users obtained ecstasy from a brother or sister.

**Table 4.4** How substances are obtained by type of drug - percentages

<i>HOW SUBSTANCE WAS OBTAINED</i>	<i>DRUG</i>			
	<i>Cannabis</i>		<i>Ecstasy</i>	
From a brother or sister	15	(4)	8	(0.3)
From a friend	64	(18)	59	(2.3)
From a stranger	25	(7)	39	(1.5)
It is passed or shared around a group of friends	62	(18)	15	(0.6)
I buy it	38	(11)	31	(1.2)
From (one of) my parents	2	(1)	5	(0.2)
I take it from home without my parents permission	6	(2)	10	(0.4)
Other	3	(1)	3	(0.1)

Note: Percentages exclude those who have never used the substance, while percentages in bracket refer to total sample

### 3.6 Attitudes to Substance Use

Pupils were asked to indicate on a five-point scale whether they thought a list of events were likely to occur to them if they drank alcohol. As can be seen from Table 3.5 pupils think that they are more likely to experience positive events after drinking alcohol than negative events. The most common expected outcomes are that an individual would have a lot of fun (83% of sample reported it was likely or very likely) and would feel happy (80% of sample). Almost two thirds of the sample said that it was likely or very likely that they would feel relaxed (65%) and over a half said that it was likely or very likely that they would forget their problems (56%).

*Looking at negative outcomes ‘do something I would regret’ and ‘have a hangover’ were seen as likely or very likely outcomes by 47% and 44% of the sample respectively. ‘Harm to health’ and ‘feel sick’ were seen as likely or very likely by over a third of the sample (39% and 33%). It should be noted, however, that for each of these negative outcomes, with the exception of ‘do something I would regret’ a similar or higher proportion of the sample saw them as unlikely or very unlikely outcomes. Pupils see dependency as the least likely outcome (71% said they thought it was unlikely or very unlikely), followed by getting into trouble with the police (55% said they thought it was unlikely or very unlikely).*

**Table 3.5** Likely events after alcohol - percentages of likely/very likely and unlikely/very unlikely

<i>EVENTS AFTER ALCOHOL</i>	<i>very unlikely or unlikely</i>	<i>likely or very likely</i>
Feel relaxed	16 (109)	65 (432)
Trouble with police	55 (374)	33 (219)
Harm my health	37 (242)	39 (258)
Feel happy	9 (63)	80 (541)
Forget my problems	29 (196)	56 (373)
Cant stop drinking	71 (467)	17 (109)
Have a hangover	43 (287)	44 (293)
Act more friendly/outgoing	12 (78)	74 (494)
Do something I would regret	32 (212)	47 (316)
Have a lot of fun	7 (48)	83 (570)
Feel sick	44 (195)	38 (158)

Notes: Valid cases = 673, Missing cases = 310. Ns in parentheses.

Some gender differences were found in expected outcomes. Getting in trouble with the police was seen as more likely by boys and more unlikely by girls ( $\chi^2(4) = 14.1, p < .01$ ), while feeling more friendly and outgoing was seen as more likely by girls and more unlikely by boys ( $\chi^2(4) = 19.3, p < .001$ ). More boys than girls reported feeling sick as a likely outcome ( $\chi^2(4) = 12.4, p < .01$ ).

Pupils were asked what in their opinion were the effects of a list of substances. The results can be seen in Table 4.5. The most commonly cited effects of cannabis, alcohol and tobacco were relaxation and pleasure. While a high proportion of pupils did not know the effects of ecstasy, cocaine or heroin, among those who did dependency was cited most commonly as

the effect of heroin and cocaine, while hallucination and pleasure were the most commonly cited effects of ecstasy.

In order to examine the proportions citing positive and negative effects, pleasure and relaxation were combined as positive effects and pain and dependency were combined as negative effects (see Table 4.6). For alcohol, cannabis and tobacco the positive effects were cited by a higher proportion of pupils than the negative effects. Alcohol was seen in the most favourable light followed closely by cannabis and tobacco. Pupils seemed to have a somewhat neutral attitude toward ecstasy with an equal proportion of pupils citing the negative and the positive effects. For both heroin and cocaine the negative effects were cited more often than the positive effects, with heroin being perceived in a more negative way than cocaine.

**Table 4.5** Perceived effects of six substances - percentages

<i>EFFECT</i>	<i>TYPE OF SUBSTANCE</i>					
	<i>Joint</i>	<i>Alcohol</i>	<i>Heroin</i>	<i>Cocaine</i>	<i>Tobacco</i>	<i>Ecstasy</i>
Pleasure	50 (37)	60 (55)	28 (14)	31 (15)	32 (26)	40 (24)
Pain	4 (3)	4 (3)	38 (20)	28 (13)	5 (5)	27 (16)
Relaxation	60 (44)	41 (37)	20 (20)	19 (9)	49 (41)	14 (9)
Dependency	12 (9)	13 (12)	43 (23)	40 (19)	24 (20)	24 (15)
Modification of mood	22 (16)	31 (28)	33 (17)	35 (17)	7 (6)	39 (23)
Hallucination	11 (8)	5 (5)	33 (17)	31 (15)	1 (1)	51 (30)
No effect	2 (2)	4 (3)	1 (.3)	1 (.2)	19 (16)	1 (.3)
Don't know	26	8	48	52	17	41

Note: The first percentage refers to the number of responses as a proportion of students who gave an answer regarding effects of the substance (i.e. excluding missing cases and those who answered 'don't know'). The percentage in brackets refers to the number of responses as a proportion of the total sample.

**Table 4.6** Perceived positive and negative effects of six substances – percentages

<i>EFFECT</i>	<i>SUBSTANCE</i>					
	<i>Joint</i>	<i>Alcohol</i>	<i>Heroin</i>	<i>Cocaine</i>	<i>Tobacco</i>	<i>Ecstasy</i>
Positive	59	70	17	16	52	24
Negative	11	14	32	26	23	24

Note: Percentages refer to total sample. Positive effects are pleasure and relaxation while negative effects are dependency and pain.

Looking at gender differences there were significant differences between the proportion of girls and boys citing positive and negative effects for several of the substances. More girls than boys cited the positive effects of alcohol (74% of girls compared to 64% of boys,  $\chi^2(1) = 10.3$ ,  $p < .01$ ), tobacco (54% of girls compared to 48% of boys,  $\chi^2(1) = 4.0$ ,  $p < .05$ ), and ecstasy (27% of girls compared to 19% of boys,  $\chi^2(1) = 8.8$ ,  $p < .01$ ). The only significant gender difference in the proportions citing negative effects was in relation to tobacco. More girls than boys cited the negative effects of tobacco (26% compared to 18%,  $\chi^2(1) = 7.2$ ,  $p < .01$ ).

In relation to the effects of cannabis, significant differences were found between the pupils who had used and pupils who had never used cannabis. A higher proportion of users of cannabis cited the positive effects compared to those who had not used cannabis (85% of users compared to 48% of non-users,  $\chi^2(1) = 108.6$ ,  $p < .001$ ). There was also a significant difference in relation to the negative effects of cannabis, with a lower proportion of users citing the negative effects compared to those who had not used cannabis (5% of users compared 14% of non-users,  $\chi^2(1) = 16.4$ ,  $p < .001$ ).

Looking at the reported effects of alcohol, there was a significant difference between the proportion of abstainers, occasional drinkers and regular drinkers who reported positive effects of alcohol. The lowest proportion of positive effects was reported by those who did

not drink while those who drank regularly the highest (abstainers - 47%, occasional drinkers - 75%, frequent drinkers - 88%;  $\chi^2(2) = 86.6, p < .0001$ ).

Significant differences were found between pupils who had used an illicit substance and pupils who had never used an illicit substance in the proportion reporting negative effects of ecstasy, cocaine and heroin. 35.5% of pupils who had never used illicit substances reported the negative effects of heroin compared to 25.7% of pupils who had used an illicit substance ( $\chi^2(1) = 9.3, p < .01$ ). The proportion reporting negative effects of ecstasy was also higher amongst those who had never used an illicit substance compared with those who had used an illicit substance (28% compared to 17%;  $\chi^2(1) = 15.7, p < .001$ ). The same pattern was found for the negative effects of cocaine, with 28% of pupils who had never used an illicit substance reporting the negative effects compared to 21% of pupils who had used an illicit substance ( $\chi^2(1) = 4.8, p < .05$ ).

Looking at reported effects of tobacco, a significant difference was found between the different categories of smokers. The highest proportion of reported positive effects was found among those who smoke 'now and again' while the lowest proportion was among those who had never smoked (never smoked - 41%, once or twice - 48%, used to smoke but have stopped - 57%, smoke now and again - 66% and daily smokers - 63%;  $\chi^2(4) = 38.6, p < .0001$ ).

### **3.7 Delinquency**

Pupils were asked if they had committed any of a list of 14 delinquent behaviours, ranging from using public transport without paying, to fighting in public. As can be seen in Table 5.1 the most common delinquent behaviours were graffiti (52%), fighting in public (47%) and fare dodging (40%). Just over a third of the sample admitted to shoplifting (36%) and having bothered or threatened someone (36%).

Looking at gender differences, highly significant differences were found for all but two of the behaviours (running away and graffiti, being the exception), with a higher proportion of boys than girls having engaged in the behaviour.

**Table 5.1** Delinquent behaviour by gender - percentages

<i>DELINQUENT BEHAVIOUR</i>	<i>GENDER</i>		
	<i>Girls</i>	<i>Boys</i>	<i>Total</i>
Running away	6 (35)	8 (30)	7 (65)
Fare dodging	***32 (178)	50 (193)	40 (371)
Shoplifting	***29 (160)	45 (172)	36 (332)
Vandalism	***30 (166)	50 (193)	3 (359)
Graffiti	52 (288)	52 (202)	52 (490)
Bothering or threatening someone	***30 (168)	45 (172)	36 (340)
Hitting someone	***8 (46)	20 (77)	13 (123)
Starting a fire	***8 (40)	25 (89)	14 (129)
Breaking and entering	***10 (56)	25 (92)	16 (148)
Stolen money from vending machine/telephone box	***9 (47)	17 (64)	12 (111)
Stolen from fellow pupil	**13 (68)	21 (77)	16 (145)
Fighting in public	***41 (226)	57 (219)	47 (445)
Carrying weapon	***10 (54)	39 (148)	22 (202)
Throwing stones	***16 (89)	40 (152)	26 (241)

*Notes:* Number of valid cases varies from 895 to 943. Number of missing cases varies from 40 to 88. *Ns* in parentheses.

\*  $p < .05$  \*\*  $p < .01$  \*\*\* $p < .001$

The mean number of delinquent behaviours committed by each pupil was 3.2 (SD = 2.81, range = 0 to 11). The mean for boys was significantly higher than the mean for girls (4.1 compared to 2.6,  $t(765) = -8.2$ ,  $p < .001$ ). A break down of the number of crimes committed can be seen in Table 5.2. The proportion of girls who had not committed any offences was more than double the proportion of boys, while the proportion of boys who had committed 5 or more offences was almost double the proportion of girls.

**Table 5.2** Number of delinquent behaviours according to gender - percentages

<i>NUMBER OF DELINQUENT BEHAVIOURS</i>	<i>GENDER</i>		
	<i>Girls</i>	<i>Boys</i>	<i>Total</i>
None	25 (141)	11 (43)	19 (184)
1-2	33 (187)	25 (101)	30 (288)
3-4	21 (121)	24 (97)	22 (218)
5 or more	21 (118)	40 (159)	29 (277)
TOTAL	100 (567)	100 (400)	100 (967)

*Notes:* Valid cases = 967, Missing cases = 484. *Ns* in parentheses.

Pupils were asked if they had ever been caught or arrested by the police<sup>9</sup>. 23% of the sample said that they had and again there was a significant gender difference, with a higher

<sup>9</sup> Number of valid cases = 956, number of missing cases = 27

proportion of boys than girls reporting having been caught (32% compared to 17%,  $\chi^2(1) = 30.9, p < .001$ ).

Pupils were also asked what they thought of five different offences (see Table 5.3). Harassment of a girl was the offence most strongly disapproved of and shoplifting was seen as the most acceptable offence by both genders. Significant gender differences were found, however, with a higher proportion of girls than boys disapproving of shoplifting, harassment of a girl, selling drugs or selling stolen goods.

**Table 5.3** Opinion of offences by gender - percentages

TYPE OF OFFENCE	APPROVAL/ DISAPPROVAL	GENDER		
		Girls	Boys	Total
Shoplifting	its ok/don't care	43	58	58
	disapprove	***57	42	42
Harassing a girl	its ok/don't care	6	10	7
	disapprove	*94	90	93
Selling drugs	its ok/don't care	18	31	23
	disapprove	***82	69	77
Damaging a phone box, bicycle etc.	its ok/don't care	41	47	43
	disapprove	59	53	57
Selling stolen Goods	its ok/don't care	33	46	39
	disapprove	***67	54	61

Notes: Percentages given are a proportion of pupils excluding those who answered 'don't know' (7% of total sample on average) and those who did not answer the question (1% of total sample on average). Disapprove includes those who answered 'disapprove' or 'strongly disapprove'

\* p < .05    \*\* p < .01    \*\*\* p < .001

### 3.8 Association between Problem Behaviours

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

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

Table 6.2 and 6.3 shows the percentage of pupils who had engaged in delinquent behaviour according to alcohol and cannabis use. The differences in number of delinquent behaviour according to frequency of alcohol consumption were found to be significant,  $\chi^2(6) = 207.8, p < .001$ . 28% of those who abstained from alcohol had committed none of the listed delinquent behaviours compared to 13% of infrequent drinkers and 3.5% of frequent drinkers. 65% of pupils who used alcohol on a weekly or daily basis had committed 5 or more of the listed behaviours. The same pattern emerged for cannabis use, with a quarter of non-users having committed none of the listed behaviours compared to 4% of those who had used

cannabis. 64% of last month users had committed 5 or more of the listed behaviours. Again these difference were found to be significant,  $\chi^2(6) = 214.2, p < .001$ .

**Table 6.2** Number of delinquent behaviours by level of alcohol use – percentages

NUMBER OF DELINQUENT BEHAVIOURS	FREQUENCY OF ALCOHOL USE					
	Never / less than once a month		Monthly use		Weekly or daily use	
None	28	(136)	13	(29)	3	(7)
1-2	37	(182)	28	(61)	11	(23)
3-4	21	(104)	28	(60)	21	(41)
5+	14	(69)	31	(68)	65	(129)
TOTAL	100	(491)	100	(218)	100	(200)

Notes: Valid cases = 909, Missing cases = 74. Ns in parentheses.

**Table 6.3** Number of delinquent behaviours by level of cannabis use - percentages

NUMBER OF DELINQUENT BEHAVIOURS	FREQUENCY OF CANNABIS USE					
	Never		Last year		Last month	
None	25	(174)	4	(5)	4	(5)
1-2	36	(255)	14	(18)	12	(16)
3-4	23	(162)	23	(29)	20	(28)
5+	16	(116)	59	(76)	64	(87)
TOTAL	100	(707)	100	(128)	100	(136)

Notes: Valid cases = 971, Missing cases = 12. Ns in parentheses.

### 3.9 School Related Variables

The questionnaire examined several school-related issues. Pupils were asked about how many days of school they had missed in the past month due to illness, truancy or family holiday. Looking at days missed due to illness over one quarter of the sample had not missed any days due to illness (27%), almost a third had missed one to two days and one fifth had missed three to five days and over five days (see Table 7.1).

Compared to the proportion of pupils who missed school due to illness, a smaller proportion of pupils had missed schools due to truancy. Three quarters of the sample had not missed any days due to truancy. 15% had missed one to two days, 4% had missed 3 to 5 days and 6% had missed more than five days (see Table 7.2). A smaller proportion of pupils again had missed school due to family holiday. The vast majority of pupils (81%) had not missed any days of school, 11% had missed one or two days, 3% had missed 3 to 5 days and 5% had missed more than 5 days.

Looking at gender differences significant differences were found in relation to days missed due to illness and days missed due to truancy. A higher proportion of girls had missed school

due to illness ( $\chi^2(3) = 9.9, p < .05$ ). For example 24% of girls had missed more than five days compared to 16% of boys (see Table 7.1). On the other hand a higher proportion of boys than girls had missed days of school due to truancy ( $\chi^2(3) = 9.4, p < .05$ ). 8% of boys had missed five or more days of school due to truancy compared to 4% of girls (see Table 7.2).

**Table 7.1** Days of school missed due to illness by gender – percentages

NUMBER OF DAYS MISSED	GENDER				
	Girls		Boys		Total
None	27	(137)	28	(100)	27 (237)
1-2 days	29	(149)	35	(125)	32 (274)
3-5 days	20	(100)	21	(73)	20 (173)
More than 5 days	24	(123)	16	(56)	21 (179)
TOTAL	100	(509)	100	(354)	100 (863)

Notes: Valid cases = 863, Missing cases = 109. Ns in parentheses.

**Table 7.2** Days of school missed due to truancy by gender – percentages

NUMBER OF DAYS MISSED	GENDER				
	Girls		Boys		Total
None	76	(293)	74	(208)	75 (501)
1-2 days	17	(63)	12	(34)	15 (97)
3-5 days	3	(13)	6	(16)	4 (29)
More than 5 days	4	(15)	8	(23)	6 (38)
TOTAL	100	(384)	100	(281)	100 (665)

Notes. Valid cases = 665, Missing cases = 318. Ns in parentheses.

Pupils were asked if they enjoyed school (see Table 7.3). Over half of the sample (58%) said that they sometimes enjoyed school. One fifth said that they often enjoyed it and 5% said that they always enjoyed it. Just under one fifth (17%) said that they never enjoyed it. Significant gender differences were found in responses to this question, with a higher proportion of girls than boys saying that they enjoyed school ( $\chi^2(3) = 20.3, p < .001$ ). While a similar proportion said that they enjoyed school sometimes and always, a higher proportion of girls said that they often enjoyed it (23% compared to 16%) and a higher proportion of boys said that they never enjoyed it (23% compared to 13%).

**Table 7.3** “Do you enjoy school?” by gender – percentages.

FREQUENCY OF ENJOYING SCHOOL	GENDER				
	Girls		Boys		Total
Never	13	(75)	23	(92)	17 (167)
Sometimes	58	(326)	58	(234)	58 (560)
Often	24	(132)	15	(63)	20 (195)
Always	5	(30)	4	(16)	5 (46)

TOTAL	100	(563)	100	(405)	100	(968)
-------	-----	-------	-----	-------	-----	-------

Notes: Valid cases = 968, Missing cases = 15. Ns in parentheses

When asked how good they were at schoolwork compared to others the same age, over half of the sample (55%) said that they were average (see Table 7.4). Almost a third of the sample (32%) said that they were above average – 6% well above average and 25% above average. 13% of the sample said that they were below average – 5% well below average and 8% below average.

Significant gender differences were found with a higher proportion of boys than girls saying that they were above average ability (43% compared to 24%). Girls were more likely than boys to say that they were of average ability (62% compared to 46%) or below average (14% compared to 12%). These differences were significant,  $\chi^2(4) = 48.0, p < .001$ .

**Table 7.4** Academic ability by gender – percentages

PERCEIVED ACADEMIC ABILITY	GENDER					
	Girls		Boys		Total	
Well below average	4	(25)	5	(21)	5	(46)
Below average	10	(56)	7	(26)	9	(82)
Average	62	(347)	46	(182)	55	(529)
Above average	21	(118)	31	(125)	25	(243)
Well above average	3	(17)	11	(44)	6	(61)
TOTAL	100	(563)	100	(398)	100	(961)

Notes: Valid cases = 961, Missing cases = 22. Ns in parentheses.

Pupils were also asked what they thought they would be doing at the age of 17 (see Table 7.5). The majority of respondents (85%) said that they would be in school – 71% in general education and 14% in vocational education. One tenth of the sample said that they would be working while 4% said that they would be in some type of training. Less than 1% said that they would be unemployed.

Significant gender differences were found ( $\chi^2(4) = 25.8, p < .001$ ). A higher proportion of girls than boys said that they would be in general education at the age of 17, while a higher proportion of boys than girls said that they would be working, in vocational education, or training.

**Table 7.5** “What do you think you will be doing when you are 17?”  
by gender – percentages

EXPECTED ACTIVITIES AT AGE 17	GENDER					
	Girls		Boys		Total	
Unemployed	1	(3)	*0	(1)	1	(4)
Working	7	(34)	14	(44)	10	(78)
Training	3	(13)	7	(22)	4	(35)

School (vocational)	11	(52)	17	(53)	14	(105)
School (general)	78	(353)	62	(194)	71	(547)
TOTAL	100	(455)	100	(314)	100	(769)

Notes: Valid cases = 769, Missing cases = 214 of which 101 (12% of total sample) answered that they did not know what they would be doing at the age of 17. The percentages given are the percentages of responses excluding those who did not answer and those who answered 'don't know'. Ns in parentheses.

\* Less than 1%.

Two questions were asked about bullying – whether pupils had been bullied during the past school year, and whether they themselves had bullied other pupils (see Table 7.6 and Table 7.7). The majority of pupils (68%) said that they had not been bullied in the past year, while a quarter said that they had been bullied once or twice. 5% said that they had been bullied regularly, 2% said that they had been bullied once a week and 2% said they had been bullied several times a week. When asked about whether they had bullied fellow pupils, again the majority of pupils (72%) said that they had not done this in the past year. Just under a quarter (24%) said that they had bullied other pupils once or twice. 3% said that they bullied other pupils regularly while under 1% reported bullying once a week and several times a week.

Significant gender differences were found for both questions on bullying. A higher proportion of boys than girls reported having been bullied ( $\chi^2(4) = 22.8, p < .001$ ). 60% of boys had never been bullied compared to 75% of girls. The same pattern was found with regard to bullying other pupils, with a higher proportion of boys than girls saying that they had bullied other pupils in the last year ( $\chi^2(4) = 23.5, p < .001$ ). 66% of boys said that they had never bullied other pupils compared to 77% of girls.

**Table 7.6** Frequency of being bullied or teased in last school year by gender – percentages

<i>FREQUENCY OF BEING BULLIED</i>	<i>GENDER</i>					
	<i>Girls</i>		<i>Boys</i>		<i>Total</i>	
Never	74	(416)	60	(242)	68	(658)
1-2 times	20	(111)	29	(116)	23	(227)
Regularly	4	(20)	6	(23)	5	(43)
Once a week	1	(7)	2	(10)	2	(17)
Several times a week	1	(8)	3	(13)	2	(21)
TOTAL	100	(562)	100	(404)	101	(966)

Notes: Valid cases = 966, Missing cases = 17. Ns in parentheses.

**Table 7.7** Frequency of having bullied or teased others in last school year by gender – percentages

<i>FREQUENCY OF BULLYING OTHERS</i>	<i>GENDER</i>					
	<i>Girls</i>		<i>Boys</i>		<i>Total</i>	
Never	77	(430)	66	(265)	72	(695)
1-2 times	22	(122)	27	(108)	24	(230)
Regularly	1	(7)	4	(18)	3	(25)
Once a week	*0	(1)	1	(4)	*0	(5)

Several times a week	*0	(2)	2	(7)	1	(9)
TOTAL	100	(562)	100	(402)	100	(964)

Notes: Valid cases = 964, Missing cases = 19. Ns in parentheses.

\* Less than 1%.

Pupils were asked to mark which of a list of subjects they would like to be informed or better informed on in school (see Table 7.8). The subjects listed were: nutrition, road traffic accidents, tobacco, alcohol, illegal drugs, sexual relations, AIDS, cancer risks, medication, weight problems, stress, environmental health and other. The subject on which the highest proportion of pupils would like to be informed on was AIDS (73% of the sample). Over half of the sample said that they would like to be informed about sexual relation (65%) and illegal drugs (60%). Half of the sample said that they would like be informed about cancer, while just under half of the sample listed weight and stress (42% and 40%). A third of pupils said they would like to be informed about alcohol and just under a quarter said the same of tobacco (23%). Under a quarter of the sample said they would like to be informed on the other listed topics (nutrition, traffic, medication, environment and other).

Looking at gender differences, significant differences were found in the proportion of pupils who wanted to be informed on AIDS ( $\chi^2(1) = 6.9, p < .01$ ), weight ( $\chi^2(1) = 126.4, p < .001$ ), stress ( $\chi^2(1) = 13.9, p < .001$ ), cancer ( $\chi^2(1) = 11.1, p < .001$ ) and tobacco ( $\chi^2(1) = 4.1, p < .05$ ). A higher proportion of girls than boys said they would like to be informed on all these topics with the exception of tobacco which more boys than girls wanted to be informed on. The most striking gender differences was found in relation to weight, with 55% of girls wanting to be informed on it compared to 18% of boys.

**Table 7.8** Subjects on which pupils would like to be informed or better informed in school by gender- percentages

SUBJECT	GENDER					
	Girls		Boys		Total	
Tobacco	20	(114)	26	(100)	* 23	(214)
Alcohol	31	(172)	36	(139)	33	(311)
Illegal drugs	58	(327)	62	(239)	60	(566)
Sexual relations	64	(360)	65	(252)	65	(612)
AIDS	76	(429)	67	(265)	**73	(694)
Cancer	55	(308)	44	(169)	***50	(477)
Weight	55	(308)	18	(71)	***40	(379)
Stress	47	(265)	35	(386)	***42	(948)

Notes: Valid cases = 948 , Missing cases = 35. Ns in parentheses.

\*  $p < 0.05$  \*\*  $p < 0.01$  \*\*\* $p < 0.001$

The discussion of smoking, drinking, illicit drugs and AIDS in school was also addressed. Pupils were asked if these subjects had been talked about in school, and if so, whether they were discussed too much, enough or not enough (see Table 7.9).

In relation to tobacco just under half of the sample said that they had talked about it enough in school (41%) while a third of pupils said that they had talked about it but not enough. Just under one fifth (17%) said that it had never been discussed. In relation to drinking, just over one third of pupils said that they had talked about it enough and not enough (36% and 35% respectively). One fifth said that it had never been discussed in class. Almost half of the sample said that they had not discussed illicit drugs enough, while 28% said they this topic had been discussed enough and 17% said that it had never been discussed. The most striking result was in relation to the discussion of AIDS. Almost two thirds of the sample (64%) said that they had never discussed AIDS in class, while just under one third said that it had been discussed but not enough (27%).

**Table 7.9** Frequency with which smoking, drinking, illicit drugs and AIDS had been discussed in class by gender – percentages

SUBJECT	GENDER					
	Girls		Boys		Total	
<b>SMOKING</b>						
yes, too much	11	(59)	6	(20)	9	(79)
yes, enough	49	(260)	29	(105)	41	(365)
yes, but not enough	33	(174)	33	(119)	33	(298)
never	7	(36)	32	(112)	17	(148)
TOTAL	100	(529)	100	(356)	100	(890)
<b>DRINKING</b>						
yes, too much	11	(56)	5	(18)	8	(74)
yes, enough	42	(219)	27	(98)	36	(317)
yes, but not enough	36	(191)	34	(124)	35	(315)
never	11	(60)	34	(122)	21	(182)
TOTAL	100	(526)	100	(362)	100	(888)
<b>ILLICIT DRUGS</b>						
yes, too much	10	(55)	6	(22)	9	(77)
yes, enough	33	(176)	20	(76)	28	(252)
yes, but not enough	46	(249)	47	(174)	46	(423)
never	11	(57)	27	(102)	17	(159)
TOTAL	100	(526)	100	(374)	100	(911)
<b>AIDS</b>						
yes, too much	3	(15)	1	(4)	2	(19)
yes, enough	7	(38)	6	(22)	7	(60)
yes, but not enough	31	(159)	21	(73)	27	(232)
never	59	(307)	72	(250)	64	(557)
TOTAL	100	(519)	100	(349)	100	(868)

Notes: Smoking: Valid cases = 885, Missing cases = 98. Alcohol: Valid cases = 888, Missing cases = 95. Illicit drugs: Valid cases = 911, Missing cases = 72. AIDS: Valid cases = 868, Missing cases = 115. *N*s in parentheses.

Looking at gender differences, significant differences ( $p < .001$ ) were found in relation to tobacco ( $\chi^2(3) = 104.6, p < .001$ ), alcohol ( $\chi^2(3) = 73.3, p < .001$ ), illegal drugs ( $\chi^2(3) = 52.4, p < .001$ ) and to AIDS ( $\chi^2(3) = 15.6, p < .001$ ). The pattern of differences is strikingly similar for responses on smoking, drinking and illicit drugs. For all three subjects a higher proportion of boys than girls had never discussed the subject in class. A similar proportion said that the subjects had been discussed but not enough and a higher proportion of girls than boys said that the subjects had been discussed either enough or too much. The pattern of difference in relation to AIDS is slightly different, with a higher proportion of girls than boys saying it had not been discussed enough and a higher proportion of boys than girls saying it had never been discussed.

### 3.10 Differences between Schools

Differences in substance use between the 16 participating schools were examined. The schools were then divided into high, middle and low socio-economic groups, based on

catchment area and type of school. Differences between the three socio-economic groups were examined. Finally differences between single gender and mixed gender schools were examined.

Looking first at differences between individual schools, significant differences were found in relation to both legal and illegal drug use. Looking at smoking the proportion of pupils who said they smoked now and again ranged from 10% to 45% and the proportion of daily smokers ranged from 4% to 36%. Frequent use of alcohol (weekly or more frequent use) ranged from 11% of pupils to 31% of pupils, and daily use was found to be particularly high in one school. A significant difference was also found in the prevalence of binge drinking among pupils, which ranged from 18% to 55%. The proportion of pupils reporting last year use of cannabis ranged from 5% to 24% while last month or recent use ranged from 6% to 28%. Last year use of solvents and inhalants ranged from no use to 20% while last month or recent use ranged from no use to 14%. Looking at the use of illicit drugs other than cannabis and solvents, last year use ranged from no use to 15% while last month or recent use ranged from no use to 10%. Significant differences were also found between individual school on measures of availability. The proportion of pupils who had been offered an illicit substance ranged from 32% to 79%. The proportion who said that they would know where to obtain a joint ranged from 52% to 88%.

The results of individual schools show that schools can differ dramatically in the particular substances used by their pupils. In one school pupils had the highest rates of smoking and of binge drinking, but the lowest rates of solvent use. In the school that had the highest rates of solvent use, pupils reported the lowest rates of use of drugs other than cannabis and solvents. It is also interesting that schools in the same area were found to differ in the pattern of substance use among their pupils. Two schools in the same disadvantaged area participated in the study. While pupils in one school reported the highest rates of drinking and cannabis use the other school reported the lowest rates of smoking, drinking and use of drugs other than cannabis and solvents. Looking at availability, it is interesting that the school that reported the lowest rate of drug offers and the lowest proportion of pupils who would know where to obtain a joint, also reported one of the highest rates of cannabis use.

*Looking at differences between schools according to socio-economic status, significant difference were found in relation to smoking, cannabis use, solvent use and drug offers. No significant differences were found in relation to alcohol use.*

*A particular pattern emerged in relation to smoking, with pupils in the high socio-economic schools reporting high rates of infrequent use and pupils in the low socio-economic schools (or schools in disadvantaged areas) reporting high rates of frequent use. Pupils in the middle socio-economic group reported the lowest rates of smoking (see Table 8.1). These differences were found to be significant,  $\chi^2(4) = 21.1, p < .001$ .*

*Table 8.1 Frequency of smoking by socio-economic school group – percentages*

FREQUENCY OF SMOKING	SCHOOL TYPE – SOCIO-ECONOMIC GROUP					
	SEC 1 (lowest)		SEC 2 (middle)		SEC 3 (highest)	
<i>Never/1 or 2 times</i>	55	(220)	59	(231)	49	(88)
<i>Used to/now and again</i>	25	(98)	27	(108)	40	(72)
<i>Daily</i>	20	(80)	14	(56)	11	(19)

<b>TOTAL</b>	<b>100</b>	<b>(398)</b>	<b>100</b>	<b>(395)</b>	<b>100</b>	<b>(179)</b>
--------------	------------	--------------	------------	--------------	------------	--------------

*Notes: Valid cases = 972, Missing cases = 11 (special school excluded from analysis).  
Ns in parentheses.*

*Looking at cannabis use a slightly different pattern emerged (see Table 8.2). Pupils in schools assigned to lower socio-economic group had the highest rates of both last year and last month use of cannabis. Schools in the middle and high socio-economic groups had similar rates of cannabis use. These differences were found to be significant,  $\chi^2(4) = 9.4$ ,  $p < .05$ .*

*Significant differences also emerged in relation to inhalant use,  $\chi^2(4) = 10.6$ ,  $p < .05$ . Schools in the low socio-economic group had the highest reported rates of last year use of inhalants, but the highest rates of last month inhalant use were reported in schools assigned to the higher socio-economic group. Reported use was lowest in the middle socio-economic group.*

*Table 8.2 Frequency of cannabis use by socio-economic school group – percentages*

FREQUENCY OF CANNABIS USE	SCHOOL TYPE – SOCIO-ECONOMIC GROUP					
	SEC 1 (lowest)		SEC 2 (middle)		SEC 3 (highest)	
<i>Never</i>	<b>68</b>	<b>(271)</b>	<b>76</b>	<b>(300)</b>	<b>77</b>	<b>(137)</b>
<i>Last year</i>	<b>16</b>	<b>(62)</b>	<b>11</b>	<b>(42)</b>	<b>13</b>	<b>(24)</b>
<i>Last month</i>	<b>16</b>	<b>(65)</b>	<b>13</b>	<b>(53)</b>	<b>10</b>	<b>(18)</b>
<b>TOTAL</b>	<b>100</b>	<b>(398)</b>	<b>100</b>	<b>(395)</b>	<b>100</b>	<b>(179)</b>

*Notes: Valid cases = 972, Missing cases = 11 (special school excluded from analysis).  
Ns in parentheses.*

*Table 8.3 Frequency of inhalant use by socio-economic school group – percentages*

FREQUENCY OF INHALANT USE	SCHOOL TYPE – SOCIO-ECONOMIC GROUP					
	SEC 1 (lowest)		SEC 2 (middle)		SEC 3 (highest)	
<i>Never</i>	<b>86</b>	<b>(342)</b>	<b>89</b>	<b>(350)</b>	<b>83</b>	<b>(149)</b>
<i>Last year</i>	<b>9</b>	<b>(38)</b>	<b>4</b>	<b>(18)</b>	<b>9</b>	<b>(16)</b>
<i>Last month</i>	<b>5</b>	<b>(18)</b>	<b>7</b>	<b>(27)</b>	<b>8</b>	<b>(14)</b>
<b>TOTAL</b>	<b>100</b>	<b>(398)</b>	<b>100</b>	<b>(395)</b>	<b>100</b>	<b>(179)</b>

*Notes: Valid cases = 972, Missing cases = 11 (special school excluded from analysis).  
Ns in parentheses.*

*Looking at availability, the highest rate of drug offers was reported by pupils in the schools in the lowest socio-economic group (65% of pupils had been offered at least one illicit substance). Pupils in the highest socio-economic group reported the lowest rates of drug offers (54%) while pupils in the middle socio-economic group reported moderate rates of drug offers (58%). These differences were found to be significant,  $\chi^2(2) = 8.4$ ,  $p < .05$ .*

Taking gender into account, some significant differences were found between single gender and mixed gender schools. Differences were found for boys smoking behaviour, with a higher proportion of smokers in mixed schools (daily smoking - 25% of boys in mixed schools 12% of boys in single sex schools). The other differences were for female pupils

only. Girls in mixed sex schools reported higher rates of cannabis than girls in single sex schools (33% of girls in mixed schools, 21% of girls in single gender schools). Girls in mixed schools also reported a higher rate of binge drinking (47% of girls in mixed schools, 23% of girls in single sex schools).

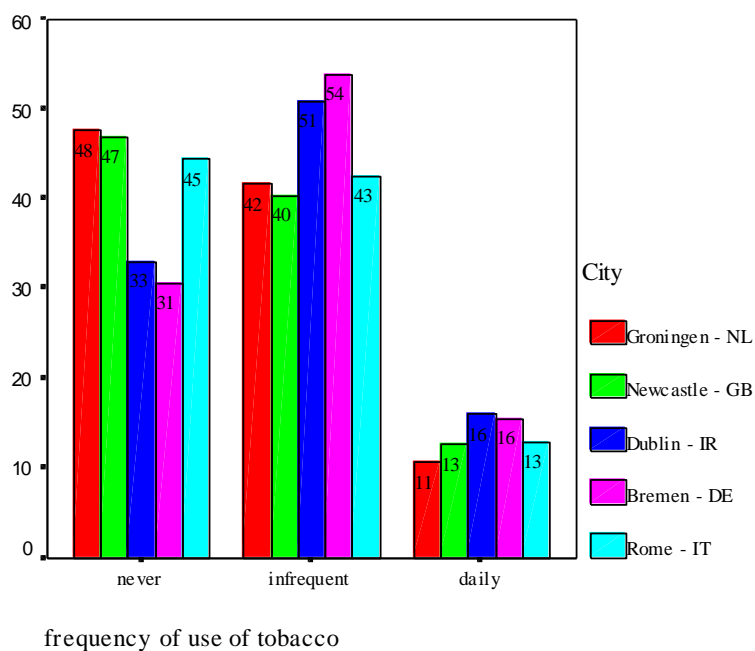
### 3.11 Differences between Cities

Five cities participated in the DDRAM study - Bremen (Germany), Groningen (the Netherlands), Newcastle (England), Rome (Italy) and Dublin. A random sample of schools was obtained in each city, giving a total sample of almost 4,000 pupils. For international comparison, analyses were confined to the 14- and 15-year old pupils.

*Smoking:*

***Smoking ('now and again' or daily) was most common in Bremen, Rome and Dublin (Figure 9.1) and least common in Newcastle and Groningen where approaching half the young people sampled had never smoked. Overall, a higher proportion of females than males reported having smoked (Table 9.1). Males, however, reported that they began smoking at a slightly younger mean age (11.5 years for males and 11.8 for females); and 18% of male smokers smoked before their tenth year, compared to 12% of female smokers. Thus, while more females than males smoked, males began at a younger age. This pattern was apparent in all five cities; the lowest age of initiation was in Dublin and the highest in Rome.***

**Figure 9.1.** Pupils use of tobacco by city – percentages



**Table 9.1** Percentage of pupils smoking cigarettes by gender and city

SMOKING	Bremen		Newcastle		Dublin		Rome		Groningen		Total	
	F	M	F	M	F	M	F	M	F	M	F	M
Never	30	32	41	52	30	38	45	44	43	52	36	44
Have tried it	36	41	34	31	35	38	23	31	37	30	33	34
Now and again	17	14	10	6	19	8	17	15	10	7	15	9
Daily	17	14	15	11	16	16	15	10	10	12	15	12

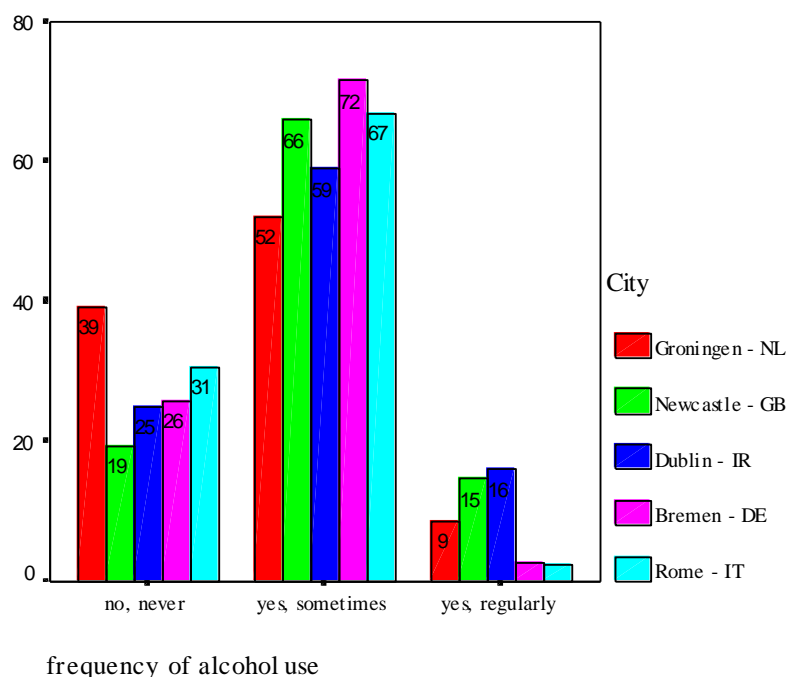
*Alcohol:*

Overall, approximately a quarter of the young people questioned had never tried alcohol (Table 9.2). Groningen youth reported comparatively low levels of alcohol consumption and Dublin and Newcastle youth reported the highest rates of regular alcohol consumption, and the lowest rates of abstinence (see Figure 9.2). Reported rates of alcohol consumption were approximately equal for males and females (see Table 9.2). The mean age of alcohol initiation was within a narrow range across the five cities: 11.1 to 12 years and marginally lower for males than females: respectively 11.4 and 11.8 years.

**Table 9.2** Consumption of alcohol (%) by gender and city

	Bremen		Newcastle		Dublin		Rome		Groningen		Total	
	f	m	f	m	f	m	f	m	f	m	f	m
Never	24	29	19	20	27	22	30	31	43	35	27	25
Now and again	73	69	67	64	57	62	67	67	51	53	64	64
Regularly	3	2	14	16	16	16	2	2	5	12	9	11

**Figure 9.2.** Frequency of alcohol use by city - percentages

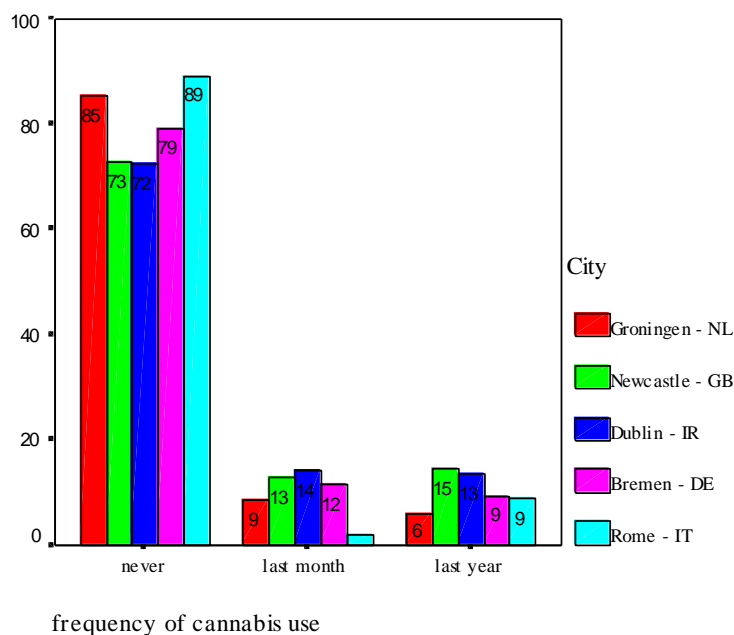


### Cannabis use:

Approximately three-quarters of the young people in the survey reported that they had never tried cannabis, 11% had used cannabis in the last year and 11% had used cannabis in the previous 4 weeks. The highest rate of use, and the lowest rate of abstinence from cannabis was reported by Dublin and Newcastle youth; while Rome and Groningen youth reported the lowest use of, and the highest rate of abstinence from cannabis (Figure 9.3).

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

**Figure 9.3.** Frequency of use of cannabis by city - percentages



*Non-cannabis illicit drug use:*

Newcastle and Dublin youth reported the highest rates of non-cannabis illicit drug use. Rome youth reported marginally raised rates of tranquilliser use; Newcastle youth, amphetamines and solvent use, and Dublin youth solvent use. With the latter exceptions, rates of non-cannabis illicit drug use were low in the five cities (Table 9.3).

**Table 9.3.** Percentage of pupils in each city reporting non-cannabis drug use

% who have used	Bremen	Newcastle	Dublin	Rome	Groningen
Tranquillisers	1	3	3	7	-
Ecstasy	3	2	3	1	3
Speed	2	7	3	1	1
LSD	1	4	4	-	-
'Magic' mushrooms	1	5	4	x	3
Glue	4	6	13	x	2
Cocaine	x	2	x	x	-
Anabolic steroids	x	1	-	x	-

-: less than 1%, x: not asked

*Availability and Drug Uptake:*

*Some striking differences emerged between the five cities in the perceived availability of illegal substances. The highest percentage of pupils who had been offered at least one illegal substance was found in Dublin, while the lowest rate of drug offers was reported by youth in Groningen and Rome (see Table 9.4).*

*Drug uptake refers to the number of pupils taking drugs as a percentage of the total number offered drugs. This measure offers a way of examining the effect of availability on*

*illicit drug use. As can be seen from Table 9.4 the highest rates of drug uptake were reported by youth in Rome, Bremen and Newcastle, where 57% and 56% of pupils. Youth in Dublin reported the lowest rate of drug uptake, with half of pupils who had been in offer situations reporting use of an illicit substance.*

**Table 9.4** Percentage of pupils who have been offered an illicit substance and rate of drug uptake by city

	<i>Bremen</i>	<i>Newcastle</i>	<i>Dublin</i>	<i>Rome</i>	<i>Groningen</i>
Drug offers	43	44	60	37	35
Drug uptake	56	56	50	57	54

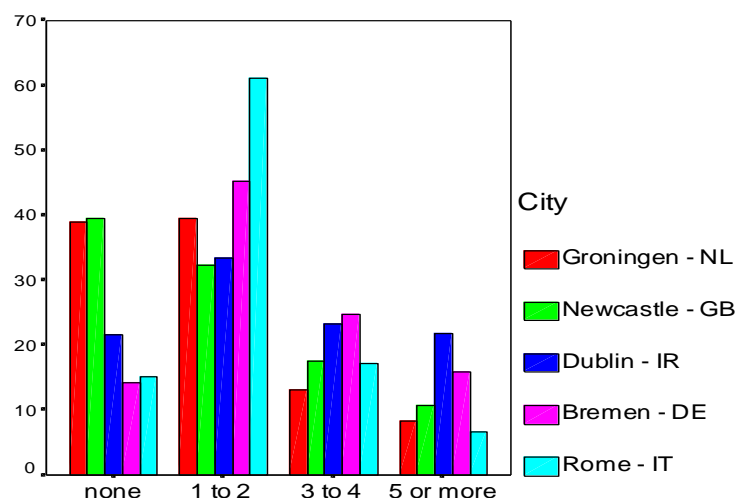
*Delinquent Behaviour:*

Approximately 80% of pupils in Bremen and Rome, compared to only 19% and 25% in Groningen and Newcastle acknowledged non-payment of fares on public transport (Table 9.4). Fare dodging aside, Dublin youth reported the highest rates of graffiti writing, vandalism, public nuisance, fighting in public and persistent criminality. Rome youths were relatively law-abiding, while reported rates in Groningen, Bremen and Newcastle were intermediate. This pattern is also found in the numbers of crimes committed by youth in each city (Figure 9.4). Youth in Groningen and Newcastle reported the highest rate of having committed none of the delinquent behaviours, youth in Rome had the highest rate of having engaged in only one of the behaviours, while youth in Dublin had the highest rate of having committed 5 or more of the behaviours.

**Table 9.5** Percentage of pupils reporting punishable offences in each city - percentages

<i>%</i>	<i>Bremen</i>	<i>Newcastle</i>	<i>Dublin</i>	<i>Rome</i>	<i>Groningen</i>
Fare dodging	81	25	39	78	19
Shoplifting	41	22	34	24	28
Vandalism	30	31	37	17	20
Graffiti	30	37	52	24	18
Public nuisance	19	11	36	13	12
Fighting in public	18	33	47	11	25
Carrying weapon	28	17	22	8	23

**Figure 9.4.** Number of delinquent behaviours by cities – percentages



number of delinquent behaviours  
*(includes fare dodging, shoplifting, vandalism, graffiti, causing a public nuisance, fighting in public and carrying a weapon)*

#### Health education:

The majority of young people reported dissatisfaction with school-based information on AIDS in all five cities, and concerning drugs in Bremen, Rome and Dublin, and alcohol and tobacco in Bremen and Rome (see Table 9.5). Groningen and Newcastle youth (with the striking exception of their experience of AIDS information) reported the least dissatisfaction.

**Table 9.6** Percentage of pupils reporting dissatisfaction with school-based information concerning substances by gender by city

% none/ Insufficient	Bremen		Newcastle		Dublin		Rome		Groningen	
	F	M	F	M	F	M	F	M	F	M
Tobacco	63	58	39	40	37	64	63	64	31	35
Alcohol	75	68	45	47	48	66	79	71	48	48
Drugs	74	67	49	51	57	73	58	61	45	48
AIDS	89	83	72	72	88	90	77	69	39	45

### 3.12 Summary of Results

#### **CIGARETTES**

- Lifetime prevalence was 77%, with 14% of pupils saying that they smoked now and again and 16% saying that they smoked daily.
- The average age at which pupils started smoking was 11 years and on average pupils smoked 4 cigarettes a day.
- There was a high proportion of heavy smokers. Amongst pupils who smoked, 30% smoked 6-10 cigarettes a day and 12% smoked more than 10 cigarettes a day.

- A higher proportion of girls smoked than boys, but on average boys began at a slightly younger age and smoked more cigarettes than girls.
- The most commonly given reason for smoking was that they wanted to try followed by 'my friends smoke'.
- The most commonly given reasons for not smoking were harm to health, followed by involvement in sport and parental disapproval.

## ***ALCOHOL***

- A quarter of pupils said that they never drink while 59% said that they sometimes drink and 16% said that they drink regularly.
- The most popular types of drink were 'alcoholic soft-drinks' and 'larger, stout or cider'.
- A quarter of pupils reported using alcohol less than once a month, a quarter reported monthly use, one fifth reported weekly use and 3% reported daily use.
- The average age at which pupils started drinking was 11.6 years and on average pupils reported drinking 3.63 units per occasion.
- Binge drinking (drinking 5 or more drinks in a row) was reported by just over one fifth of the total sample
- There were no significant gender differences for alcohol use.
- The most commonly given reasons for drinking were wanting to try, because they like to drink on special occasions and because they like the taste.
- The most commonly given reasons for not drinking were harm to health, parental disapproval and because they are too young.
- The places where pupils drink the most frequently are on a street, park or beach and in someone else's home.
- The majority of pupils who drink indicated that they usually get alcohol from a friend (60%) while just under a half said that they bought it.
- Having a lot of fun, feeling happy, acting more friendly and outgoing, and feeling relaxed were seen as the most likely consequences of drinking alcohol by the majority of pupils.
- Not being able to stop drinking and getting into trouble with police were seen as the most unlikely consequences by the majority of the sample.

## ***ILLICIT SUBSTANCES***

- Just under a third of the sample reported use of at least one illicit substance, with 15% having used in the last year and 17% in the last month.
- Cannabis was the most commonly used substance (just under a third of pupils had used it), followed by inhalants (14% of the pupils had used it).
- All other illicit drugs had been used by 5% or less of the sample, with the order of popularity being magic mushrooms, LSD, ecstasy, tranquillisers and amphetamines.
- The mean age for first use of cannabis was 12.5 years while the mean age for first use of inhalants was 12.4 years.
- Significantly more boys than girls had used any illicit substance, cannabis, amphetamines, magic mushrooms and LSD and boys had a lower mean age at first use of cannabis.
- The most commonly given reasons for using illicit drugs were wanting to try, and 'because I like the effects'.
- The most commonly given reasons for not taking drugs were harm to health and the risk of dependency.

- The most common ways in which pupils obtained illicit substances were from a friend, by it being passed around a group of friends, from a stranger or by buying it.
- 60% of the sample said that they had been offered at least one illicit substance, cannabis being the drug most commonly offered followed by ecstasy.
- The places where pupils were most commonly offered illicit substances was on the street, at a rave or disco and at a friends home.
- The most commonly cited effects of cannabis, alcohol and tobacco were relaxation and pleasure. Dependency was cited most commonly as the effect of heroin and cocaine, while hallucination and pleasure were the most commonly cited effects of ecstasy.
- For alcohol, cannabis and tobacco the positive effects were cited by a higher proportion of pupils than the negative effects. Alcohol was seen in the most favourable light followed closely by cannabis and tobacco.

### **DELINQUENT BEHAVIOUR**

- The most common delinquent behaviours were graffiti and fighting in public, both of which were reported by approximately half of the sample, while just over a third of the sample admitted to shoplifting and having bothered or threatened someone.
- Almost a quarter of the sample had been caught or arrested by the police.
- There were significant gender differences with boys having engaged in a higher number of delinquent behaviours and a higher proportion having been involved with the police.
- There was a significant relationship between substance use and delinquent behaviour, with the number of delinquent behaviours increasing with level of involvement with both alcohol and cannabis.

### **DIFFERENCES BETWEEN SCHOOLS**

- Significant differences were found in the rates of substance use between individual schools, between schools based on socio-economic grouping, and between mixed and single gender schools.

### **COMPARISON WITH OTHER CITIES**

- Of the five cities that participated in the study (Bremen, Groningen, Newcastle, Rome and Dublin) youth in Dublin had some of the highest rates of substance use and delinquent behaviour.
- Pupils in Dublin reported one of the highest rates of regular smoking, with 16% of young people reporting daily smoking compared with 16% in Bremen, 13% in both Newcastle and Rome, and 11% in Groningen.
- Pupils in Dublin reported the highest rate of regular alcohol consumption, with 16% reporting regular use of alcohol, compared with 15% in Newcastle, 9% in Groningen, 2% in both Bremen and Rome. Dublin youth reported one of the lowest rates of abstinence from alcohol, and reported drinking more on an average drinking session than young people in the other cities.
- Dublin youth reported the highest rates of cannabis use. 28% of pupils in Dublin reported having used cannabis either in the last year or the last month, compared with 27% in Newcastle, 21% in Bremen, 15% in Groningen and 11% in Rome. Dublin youth also reported the lowest age of first use of cannabis, and one of the highest rates of use of illicit

drugs other than cannabis, with use of inhalants being particularly high in comparison to the other cities.

- Compared to the other cities participating in the study, availability of illegal substance was highest in Dublin. 60% of pupils in Dublin had been offered an illicit substance, compared with 44% in Newcastle, 43% in Bremen, 37% in Rome and 35% in Groningen.

Dublin youth reported the highest rates of graffiti writing, vandalism, public nuisance, fighting in public and persistent criminality. Rates of fighting in public and causing a public nuisance were twice as high as those in the other cities.

## DISCUSSION

The study provided an accurate and up to date picture of the levels and patterns of substance use among young adolescents in Dublin. Results show that there is a high level of substance use among 14- and 15-year-old Dublin pupils. This is particularly true of legal substances, with three-quarters of the sample reporting lifetime prevalence of alcohol and tobacco. The pattern of use among approximately half of the sample was of infrequent use, while approximately one fifth reported frequent use of alcohol and tobacco. Use of illicit substances was less common, with approximately a third of the sample reporting having used at least one such substance.

### 4.1 Increasing Use of Substances in Adolescence

Previous research has pointed to a sharp increase in substance use among adolescents in the last decade and the present study confirms this conjecture. This suggests that the use of substances in adolescence is becoming increasingly common. A recent study of drug use among young people in the North-West England found that 36% of 14 to 15 year olds had used an illicit substance (Measham et al., 1994). The results led the authors to conclude that drug use was becoming 'normalised' among young people. The results of the present study show levels of use of legal substances which are as high and levels of illegal drug use which are only marginally lower than those reported by Measham and her colleagues. The high levels of use are particularly striking in relation to legal substances. For both alcohol and cigarettes the group of pupils who have abstained from use are very much in the minority.

In light of the findings, it is questionable whether the traditional view of adolescent substance use as a deviant behaviour is still relevant. Indeed the rise in rates of use has led one author to argue that, given an environment that condones and encourages experimentation, it is abstinence rather than use which can be described as deviant behaviour (Foxcroft & Lowe, 1991). Indeed some research has indicated that in certain adolescent populations, experimental users of marijuana and other illicit drugs are in better psychological health than either heavy users or abstinent nonusers (Baumrind & Moselle 1985, Shedler and Block 1990). Among the present sample experimentation rather than frequent use of substances was the most common pattern of use. It is important to make distinctions between the different patterns of use, so that the factors which contribute to frequent use or misuse can be identified.

It is useful to look at how young people themselves perceive substance use. Taking the use of cannabis as an example, the results show that young people do not see it as a dangerous activity. Indeed the use of cannabis is seen in a more favourable light than the use of cigarettes. This points to the discrepancy between the message adopted by many prevention programmes that 'all drugs are evil' and the adolescents own perception of drugs and drug

use. In light of both the level of substance use and young people's perception of such use, there is a clear need for a harm reduction element in prevention strategies.

Pupils perception of the consequences of alcohol use are particularly striking and show that young people have a very positive attitude to alcohol. This points to a possible gap in young peoples knowledge about the potential negative consequences, both short term and long term, of alcohol use. Research has found that young adults who expect alcohol to have a positive effect have heavier patterns of consumption and are more likely to abuse alcohol.

Looking at the reasons given by pupils for their use of tobacco, alcohol or illicit drugs, it is evident that curiosity is one of the main factors behind substance use. In the case of alcohol a high proportion of pupils also said that they drank because they liked to drink on special occasions and because they like the taste. This indicates an attitude to and experience of alcohol that is not unlike adults. In the case of illicit drugs, a high proportion of users said they used drugs because they liked the effects. These results indicate that young people are motivated less with peer group status and more with what Parker (1995) has described as "rational consumption as part of young peoples approach to their leisure time" (pg. 26). According to Coggans and Watson (1995) "School-based drug education has frequently failed to take into account the likelihood that many young people use drugs on a recreational basis because they wish to experiment or enjoy the pleasurable aspects of intoxication, not because they lack knowledge, the social skills to 'say no' or because they have a poor self image".

#### **4.2 Availability and Accessibility**

The results show that both legal and illegal substances are readily available to the young people surveyed. Despite the law regarding the purchase of alcohol and cigarettes, the majority of pupils who smoked said that they usually bought their cigarettes and just under a half of pupils who drank said that they usually bought the alcohol. This highlights a clear need for the implementation of laws regarding the sale of alcohol and cigarettes to young people. A new national identification card scheme aimed at combating under-age drinking is being implemented in April. Although this is being introduced on a voluntary basis it has been welcomed by the National Off-Licence Association and should go some way to reducing the sale of alcohol to young people aged under 18 years.

Other strategies such as server intervention programmes can reduce the sale of alcohol and cigarettes to young people. These programmes involve researchers, drug abuse specialists, local authorities or other concerned citizens working co-operatively with retailers to review and revise their policies and procedures and provide training for personnel. Another possible action would be to increase the minimum legal age for sale of alcohol and cigarettes. The US Food and Drug Administration recently issued new rules which prohibit the sale of tobacco to anyone under 18 years and require retailers to check photographic identification for everyone under 26. However given the differences in cultural attitudes toward adolescent smoking and drinking (Irish people are relatively complacent, while in America there is a very strong 'anti smoking' attitude) and the fact that current age limits are not being implemented, it is unlikely that increasing the legal age would have significant effects.

Looking at availability of illegal substances, the majority of pupils reported that they had been offered an illicit substance and would know where to obtain cannabis. While the street was one of the most common places where pupils had been offered illicit substances, the

majority of pupils who had used an illicit substance had obtained the substance from a friend or group of friends. This dispels the myth of young people being tempted into drug use by pushers. The reality is that while drugs are readily available on the streets, it is the young people's friends and peer group who are the most common suppliers.

Considerable efforts have been made in the last few years to curb the supply of illicit substances, through Garda campaigns such as Operation Cleanstreets. While such campaigns have been successful in identifying and prosecuting many drug dealers, it would seem that from a young person's perspective illicit substances are still readily available. A project called 'Say No and Phone' is currently being developed for primary schools by the INTO, the Gardai and the Chambers of Commerce which will encourage children to refuse drugs and give the pushers name to the Gardai. While a project of this kind might reduce the numbers of young people being offered drugs on the streets it does not take into account the fact that the majority of young people who use drugs obtain them from their friends.

There is a need for a new and innovative approach to tackling the issue of availability of illicit substances. The supply of drugs through friends is unlikely to be effected by efforts to clamp down on heroin dealers. It is efforts such as peer education which are more likely to have a positive effect. Morgan, referring to the fact that the main source of supply is friends said "For policy makers this shows clearly that prevention starts with friends and that you cant blame the supply of drugs for the drugs problem" (Irish Times, Nov 8, 1997).

The findings show that a number of young people had been offered illegal drugs at a rave or disco, at school and at a friend's home. One possible way of addressing this issue would be to ensure that there are clear and consistent policies about substance use in the places where young people meet. Schools, youth clubs and discos/clubs should develop guidelines for how to deal with finding drugs. The National Youth Council of Ireland have produced a handbook which provides possible guidelines for how to deal with a variety of drug related situations and they recognise that some reactions may further alienate the young drug user from the support offered by a youth club. This is also true of school policies, which can be detrimental to young people (e.g. in the circumstance of expulsion from school). Young people themselves might be involved in the formulation of school or club policies regarding substance use or at least be well informed as to what these policies are.

#### 4.3 *Delinquent Behaviour*

***The young people surveyed reported very high rates of delinquent behaviours and contact with police. This points to an urgent need for interventions that address delinquency. The high rates of delinquent behaviours and police contact are in line with information regarding the caseload of the Garda Juvenile Liaison scheme. The scheme is designed to divert children who get into trouble with the law from further crime, by working with the child and the child's family. The scheme dealt with 15,000 cases in 1997 and dealt with more than 40 cases a day. There have been many suggestions of how to reduce juvenile delinquency. As far back as 1970 the Kennedy report called for interventions which would help parents cope more effectively, such as improved amenities and parenting courses. In 1980 the Task Force on Child Care Services called for projects which could cope with young people barred from ordinary clubs and activities. Efforts to channel children who become involved in delinquency into more productive and socially acceptable activities promise success. One such project, Carline, gives children who have been involved in joyriding a chance to work with cars in a supervised, structured and respectful environment. The provision of child care facilities may also serve to reduce juvenile criminality.***

#### **4.4 Age of Pupils**

The results are particularly striking given the age of the pupils surveyed. While more recent surveys have looked at substance use among the older school population the present study surveyed pre Junior Certificate pupils. It is interesting to look at differences between the findings of the ESPAD study conducted in 1995 (Hibell et al., 1997) with the present findings. The ESPAD study was conducted with pupils in fifth year of post primary education while the present study surveyed second year pupils. Despite the age gap there were only marginal differences between the rates of use reported in both surveys. The older pupils reporting similar rates of use of cigarettes and alcohol and only slightly higher rates of illicit drug use. These findings show that the widespread use of alcohol and tobacco is not confined to older adolescence. Some clear differences can be identified between the two age groups in the use of illicit drugs. While there are only small differences in prevalence of cannabis use and solvent use, the use of the so called dance drugs is much more prevalent amongst the older adolescents. Lifetime use of LSD and ecstasy were reported by approximately 1 in 10 of the students participating in the ESPAD study (Hibell et al., 1997). In comparison, less than 5% of the present sample had used either of these substances. This suggests that the pattern of poly-drug use is more typical in older adolescence.

#### **4.5 Gender Differences**

The findings indicate only small differences between boys and girls in the prevalence of substance use. This shows that gender differences in the use of substances are fragmenting. Traditionally the rate of substance use among boys was almost double that among girls. The present study found that only a slightly higher number of boys had used alcohol and illegal drugs, and girls were more likely than boys to smoke. Amongst those who did use a particular substance, however, boys used a larger quantity of the substance and started using at a younger age than girls. In contrast to substance use, there were clear and striking gender differences in relation to delinquent behaviours. Boys reported much higher rates of nearly all of the delinquent behaviours, with approximately half of the male sample reporting many of the behaviours.

#### **4.6 Differences between Schools**

Significant differences were found in the rates of substance use between individual schools. That one school could have a third of their pupils smoking daily while another had only 4% daily smokers gives some indication of the extent of these differences. There are a range of factors which may be contributing to these differences: differential availability of drugs in the neighbourhoods around the schools, substance use norms within a school, school climate. The findings suggest that it is possible to measure drug exposure and drug taking by school when pupils are 13 or 14 years old and thereby produce a profile of the pupil population in respect of drug issues. This would allow for the implementation of more sophisticated and appropriately targeted preventative strategies.

Significant differences were found between schools based on socio-economic grouping. Schools in the low socio-economic group (schools in disadvantaged areas) had higher rates of frequent smoking, cannabis use and drug offers. Schools in the middle socio-economic group had low rates of smoking and inhalant use and moderate rates of drug offers. Schools in the

high socio-economic group had the highest rates of inhalant use and infrequent smoking, moderate rates of cannabis use and low rates of drug offers. Some differences were also found between mixed and single gender schools. The results show that rates of substance use are higher in mixed schools and suggest that this may be due to diminished gender differences. Compared to single gender schools, rates of smoking among boys in mixed schools were closer to those of girls and rates of cannabis and binge drinking among girls were closer to those of boys. These findings further illustrate the need to tailor prevention strategies to the needs of individual schools or school type.

#### 4.7 Differences between Cities

*Studies conducted in the 1980's showed that Irish teenagers had low rates of illegal drug use when compared with teenagers in the United States, England, Scotland, France, Spain and West Germany. The exception was found in relation to inhalant and solvent use, which was high among Irish by international standards (Morgan & Grube, 1989). The present study was conducted in five cities in Europe. A comparison of prevalence rates across the five cities shows that rates of use among Irish young people have changed in relation to other countries. While solvent and inhalant use is still higher among young people in Dublin, the use of other illicit substances and the use of alcohol are also high in comparison to the other cities. This is in keeping with the results of a comparative study conducted in 1995 (Hibell et al. 1997). The finding that adolescents in Dublin engage in higher levels of substance use than pupils in other cities is particularly interesting in light of national efforts to provide drug education and to interdict drugs, and given the more liberal policies in place in some of the comparison countries (e.g. the Netherlands). It is crucial that efforts be made to identify factors that contribute to national and regional variations in substance use prevalence.*

*There are several possible reasons why adolescent substance use has increased in Ireland in comparison to other countries. It has been suggested that substance use rates may be affected by economic factors. The decline in alcohol consumption in some European countries during the 1980's, for example, has been linked to economic recession (Osterburg, 1986). It is possible that the present economic growth in Ireland and the associated rise in disposable income may be linked to the increase in rates of substance use. Over the last decade Irish society has experienced considerable changes in relation to the structure of the family and parenting style. These factors have also been identified as having an effect on prevalence of substance use among young people.*

A more obvious factor affecting substance use is the availability and accessibility of substances. Compared to the other cities participating in the study, availability of illegal substance was highest in Dublin. It is particularly interesting that the lowest rate of offer situations was found in Groningen, where use of cannabis has been decriminalised. The uptake rates give some idea of the impact of availability of illegal substance on rates of use. The uptake rate is actually low in Dublin compared to the other cities. This suggests that if the issue of availability were addressed in an effective way, we might see a decrease in the rates of use of substances.

The rates of delinquent behaviour were higher in Dublin than in the other cities involved in the study, particularly in relation to aggressive acts (fighting in public and threatening/bothering someone) and shoplifting.

## **4.8 Postmodernism and Popular Culture**

Parker (1995) has pointed out that the use of illicit drugs has become internalised or integrated into 'official' youth culture and argues that this can be illustrated in the way youth magazines, music, fashion markets and popular language have incorporated drugs. Indeed it seems that drug culture is no longer a subculture but has been assimilated into popular culture. Advertisements are increasingly using drug-related imagery to sell their products. There was concern recently about the popularity of 'heroin chic' in the fashion world. There has also been a spate of books and movies and t.v. shows which depict the drugs lifestyle and these have been popular.

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

## **4.9 Prevention**

Various approaches have been adopted in the area of drugs education in Ireland. These have included information giving, affective education, and social and personal development.

Several media campaigns aimed at educating young people about the dangers of drug use have been implemented in the last few years. The Health Promotion Unit recently launched a series of posters displaying close up images of leg abscess and mouth ulcers in an effort to show young people some of the health risks involved in heroin use. The effectiveness of such campaigns is questionable. According to a recent publication on drug prevention 'evidence from recent surveys suggest that direct communication to young people of information about drugs, even though aimed at alerting them to the dangers, is likely to cause experimentation' (Dorn & Murji, 1992). The information used in such campaigns is often at odds with young people's direct or indirect experience of drugs, and young people are likely to reject the overall message because of this.

Looking at school based preventive activities one of the more traditional approaches is to invite ex-addicts to the school to talk to pupils about the dangers of substance use. The effectiveness of this approach has also been questioned. A report was published in 1974 by the Committee on Drugs Education which expressed a concern about one off scare tactics sessions conducted by outside speakers and concentrating on the negative effects of drugs. It recommended that drugs be incorporated into a wider context and conducted by people whose work with young people is on-going, rather than being provided as a separate activity. Despite this lots of schools are still using one off sessions with ex drug addicts who talk to pupils about the dangers of drug use. The relevance of this type of intervention to the students and to their own experiences of drug use is questionable. It can also serve to strengthen children's stereotypes about drug users, thus creating a distance between their own experience of substance use (whether it be occasional drinking or smoking cannabis) and the experience presented to them by the ex-addict. This in turn may make it more difficult for young people to recognise their own problematic use or to access services. It is likely that in implementing such interventions schools are responding to the wishes of parents. As part of the overall DDRAM study 140 interviews were conducted with parents of pupils in sixth class. Almost a third of parents interviewed said they thought schools should invite ex drug

addicts in to talk to pupils. There is a clear need to educate both parents and teachers about what does and does not work in the area of substance use prevention.

The type of approach currently endorsed by the Department of Education is the use of a lifeskills curriculum. This type of curriculum looks at a range of human behaviours, which could be broadly viewed as having health implications, and deals with alcohol and drug consumption in a way that was nondirective and relativistic. The 'On Your Own Two Feet' programme is an example of such a curriculum. Programmes which use a lifeskills approach and interactive methods have been found to be effective in delaying onset of drug use or inhibiting a move to harder drugs. The scale of success of even the most effective programmes, however, are small (Tobler & Stratton, 1997). This means that a large number of young people go through such programmes and still go on to use drugs. Whether it is realistic to expect lifeskills education, or indeed any education, to stop all young people from trying drugs is questionable.

Prevention programmes need to take into account the reality of the user. This means recognising the extent of young people's use of substances, their attitudes towards substance use and their reasons for use. The information and messages given to young people should be legitimate and relevant to their own experiences of substance use. Given the fact that most young people will have engaged in at least some form of substance use, there is a clear need for primary prevention to be complemented by secondary prevention or harm reduction approaches. The focus of prevention policy in Europe has shifted from drug prevention to addiction prevention. This reflects a growing awareness of the need to change the aim of preventative effort from abstinence to moderation or from the prevention of all substance use to the prevention of the misuse of substance. In order for any intervention to be successful it must have realistic aims. As Dorn and Murji (1992) suggest 'aims may be more realistic where they focus on reduction in levels of consumption rather than on prevention of initiation' (p.4).

Substance use prevention programmes are currently implemented on a voluntary basis in post-primary schools. Recently efforts have been made to move prevention programmes into primary schools. The minister for Education, Mr. Martin, recently announced a drug education programme which will be given to children at primary schools in areas most affected by drug misuse. The "Walk Tall" programme is graded to deal with children from infants to sixth class and has a different emphasis to suit the age of the children. The results of the present study show that many pupils had started to use substances before reaching post-primary school. This highlights the need for substance use prevention programmes in primary school. Such programmes should not be confined to certain areas, but should be implemented across the board. The results of this and other studies show that substance use occurs in all areas. It is clear that some groups of young people may be at increased risk of developing problematic use due to social and environmental factors. However the best way of tackling this issue is to combine a universal drug education programme for the wider young population with specific interventions tailored to the needs of more vulnerable young people.

Since the publication of the first and second reports of the Ministerial Task Force to Reduce the Demand for Drugs, a lot of attention has been focused on the prevention of illegal substance use. Less attention has been paid to the use of legal substances, particularly to the use of cigarettes. Looking at the results of the present study however, it is clear that the prevalence of alcohol and cigarette use is particularly high. The health implications of such widespread use are enormous. Recent studies of tobacco related deaths in the US show that they exceed the total associated with AIDS, motor accidents, homicides, alcohol, illegal drugs, suicides and fires. Despite the danger to health there is ambivalence and a certain

amount of complacency in the attitude to adolescent drinking and smoking in Ireland. There is an urgent need for prevention strategies that address the use of legal substances, rather than focusing exclusively on illegal substances.

To date the majority of preventive efforts have taken place in the school setting. The majority of substance use takes place outside of the school, however, and skills learned in the classroom may not generalise to other settings. It is important to extend the settings in which substance use prevention programmes are implemented. Interventions should also take place in the community - in youth clubs, sports clubs and community centres. Since many children are engaged in interactions outside the school system, youth and community workers are ideally placed to play an important role in drugs education. It is therefore vital that the response to the drugs issue is based in the community where generally there are a large number of agencies and organisations to co-ordinate and facilitate the work.

It is also important to adopt strategies that look at factors outside of the individual (macro as well as micro systems). A cultural or systemic approach to substance use prevention focuses on the social situation of the drug user and is based on the assumption that socio-economic factors and behaviour norms influence drug use. It is clear from the results that adolescents are growing up in a culture in which, amongst both users and non-users, substances are seen as readily available and their use is increasingly seen by young people as acceptable and normal behaviour. The systemic approach is particularly appropriate for interventions that take place in the community. Such interventions have many advantages. They can lend support to school based programmes. It has been argued that without such support and involvement from the community, it is unlikely that any school based prevention effort can be completely successful. Community involvement can also lead to a reduction in the physical and social availability of substance, thus influencing 'those aspects of the social and physical environment that impact upon an adolescents decisions regarding smoking, drinking and drug use' (Ratcliffe & Wallack, 1985). It can also promote a normative climate that is supportive of policy and social changes.

One type of community involvement which is becoming more popular is the involvement of parents in substance use prevention efforts. Parental groups can serve an educational function by increasing parental awareness of adolescent smoking, drinking and drug use, by informing parents about the early signs of drug involvement and by educating parents about successful preventive strategies. Parents can also provide support for policies and prevention activities in schools. In educating parents it is important to provide information which is geared towards helping them to understand substance use from a young persons viewpoint. Working with parents and young people together to enhance family relationships prior to the generational conflicts of adolescence could have a real impact on young peoples drug use (McClure & Wilcock, 1998).

One of the downfalls of many prevention and intervention strategies in this country is the lack of evaluation. Where evaluation evidence does exist it is often ignored. Butler (1994) has commented that

"The use of education as a means of prevention appears to have become institutionalised in Ireland, as elsewhere, so that it is carried on almost as though it were an end in itself, with little or no reference to the evidence of the outcome studies" (pg. 137).

It is essential that evaluation is built into any preventative activity or strategy, and that the results of such evaluations are used to ensure that programmes are effective.

Non-interactive programmes - affected only knowledge. Another area that is often overlooked in the development of prevention programmes is needs analysis. There is a world of difference between understanding needs and knowing how best to meet them on the one hand, and making assumptions about needs and how to meet them on the other. Drug education needs will vary in relation to a range of factors, including age, development of personal and social competencies, attitudes, beliefs and drug related behaviour. Community factors such as local norms, availability and social acceptability of substance use can also effect the needs of a particular group of young people. Before putting programmes into place it is vital that the needs of a target group are understood and the aims and objectives are clearly defined and realistic.

#### **4.10 Drug Policies**

The focus of drugs policy in Ireland over the last decade has shifted from supply reduction to demand reduction. This shift sees issues such as educational prevention programmes and research into the etiology of substance abuse coming to the fore. A recent government document recommended that “in the long term the most effective response [to the drugs crisis] might be to put proper preventive strategies in place” (First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs, October 1996). The present multi-modal response, which combines supply reduction efforts, treatment services and prevention strategies would seem to be the most effective way of addressing the problem of substance misuse.

According to Parker (1995) a different approach is adopted in relation to drug policy compared to other policies, in that if a policy is not working the reaction is to put more money into it. This points to an urgent need for continuing evaluation of the efforts being made to curb the demand and supply of drugs. There are now many initiatives in place which attempt to address the problem of drug abuse, including local and national prevention programmes, media campaigns and various treatment services. What is missing is consistent evaluations of these initiatives, and dissemination of the results of such evaluations.

There is also a need for continuing efforts in the area of treatment. While there has been some success in the establishment of community treatment centres, there has been difficulty in winning local acceptability for drug treatment centres in some areas. This may be due, in part, to pessimism regarding the efficacy of treatment in the area of addiction. However, recent studies have demonstrated the success of addiction treatment (Bryan, 1998), which supports further Government spending in this area.

#### **4.11 Treatment Services**

As well as primary and secondary preventive efforts, there is an urgent need for the development of tertiary preventive strategies, or treatment services for adolescents. Given the levels of substance use reported in this and other recent surveys, the emerging patterns of poly-drug use and the increasing sophistication of the illegal drug market, it is likely that numbers of young people experiencing addiction and other problems associated with drug use will increase. According to the 1996 National Report on Treated Drug Misuse in Ireland “clients presenting for treatment over the seven year period are getting younger” (Moran et al., 1997). In 1996 there were 223 school goers amongst all cases treated for drug misuse in

the National Drug Treatment Reporting System, 66% of which were resident in the Eastern Health Board (Moran et al., 1997).

*At present there is a paucity of services designed specifically for young drug users. Most services are geared toward older opiate users. Adolescents who are experiencing problems with drug use may be reluctant to access such services because they associate them with the image of the 'junkie'. A recent report of addiction services in the South inner city pointed to the difficulty in getting young people to access services. One service described a noticeable increase in younger drug users who were testing for HIV but were not using the rest of the services, still not realising they have a problem.*

*There is an increasing need for user friendly, age, drug and legal appropriate services. Services for adolescents need to cater for problematic use of both opiates and non-opiates. They need to take developmental factors into consideration and recognise that there are often problems other than those associated with drug misuse: child abuse, neglect or family difficulties. For example, young people presenting for treatment may be the second generation of drug users, having parents or older siblings who were involved in drug use in the early eighties. In order to increase accessibility of services outreach facilities should be provided. In creating and expanding an adolescent service, lessons can be learned from Britain, where some of the policy issues around adolescent drug use have been tackled, and from existing projects. One such project is the Crinan Youth Project, a pilot scheme for teenage heroin addicts which has been in operation for just over a year in Dublin's north inner city. The Young Persons Programmes, which have been developed at three Eastern Health Board addiction centres, are further examples of efforts which have been made to provide services geared specifically to adolescents.*

#### 4.12 Summary of Recommendations

- *Further measures should be taken to reduce the availability of legal substances to young people, such as the implementation of the national identification card scheme and enforcement of the laws regarding sale of tobacco.*
- *A new and innovative approach to tackling the issue of availability of illicit substances is needed. Suggestions include the development of set policies and procedures regarding substance use in places where young people meet and peer education.*
- *Further attention should be focused on delinquent behaviour among young people, for example expanding the work of the Juvenile Liaison scheme.*
- Prevention programmes should be developed and assessed which adopt a systemic approach and attempt to address all types of problem behaviour.
- Universal drug education for both primary and postprimary school pupils should be complemented by specific interventions tailored to the needs of more vulnerable groups.
- Drug prevention efforts should include a range of strategic educational goals ranging from primary prevention through to harm reduction.
- Preventive activities should take place in a variety of settings: in youth clubs, sports clubs, community settings as well as schools.
- Current parental substance use education programmes should be expanded, and parents should be encouraged to become involved in prevention activities.
- Needs assessment and evaluation should be built into all prevention activities to ensure effectiveness and efficiency.
- Information about which preventive methods are effective, and which are less effective, should be disseminated to teachers, youth workers and parents.
- Treatment services geared specifically for adolescent users need to be expanded.

- Regular school based surveys are needed to monitor trends in rates and patterns of substance use among adolescents.
- Further research is needed into the following areas: the effect of availability on levels of use, the relationship between substance use and other problem behaviours, and the role of factors such as school climate.
- Surveys should be conducted examining rates and patterns of substance use among those who are not reached by school surveys: absentees, early school leavers and homeless youth.
- More in-depth longitudinal studies would increase understanding of the risk and protective factors associated with substance abuse and the long-term outcomes of engaging in substance use during adolescence.

### **ACKNOWLEDGEMENTS**

The authors would like to express thanks to the Eastern Health Board staff who gave their support and time to the project: Mr. Benny Hollywood for his advice, patience and support throughout the project, Mr. Michael Walsh and Ms. Brid Clarke for their support of the project and Ms. Ellen Cranley for her cheerful and helpful secretarial assistance.

We would like to thank the staff of the Psychology Department in Trinity College Dublin for continuing advice and support.

Thanks are also due to our colleagues on the Drug Dependence Risk and Monitoring Study (DDRAM): Dr. Paul McArdle and Rob Johnson in Newcastle; Maria Blom, Auke Wiegiersma, Rik Pos and Geert De Jong in Groningen; Stephan Quensel, Ingo Ilja Michels and Brigitta Kolte in Bremen; and Ingo Stockel and Anna Picciolini in Rome.

Finally many thanks to the teachers, pupils and parents who participated in the study.

### **References**

- Baumrind, D. & Moselle, K.A. (1985). A developmental perspective on adolescent drug abuse. *Advances in Alcohol and Substance Abuse*, 4 (3-4), 31-67.
- Bry B. H., Mc Keon, P. & Pandina, R.J. (1982). Extent of drug use as a function of number of risk factors. *Journal of Abnormal Psychology*, 91 (4), 273 - 279.
- Bry, B. H. (1983) Predicting drug abuse: Review and reformulation. *International Journal of Addictions*, 18, 223 - 233.
- Bryan, C. (1998). The surprising efficacy of treatments for addictive disorders. American Psychiatric Association General Meeting. Toronto.
- Butler, S. (1994). Alcohol and drug education in Ireland: Aims, methods and difficulties. *Oideas*, 42, 125-140.
- Clayton, R. (1992). Transitions in Drug Use: Risk and Protective Factors. In M. Glantz and R. Pickens (Eds.), *Vulnerability to drug abuse* (pp.19-57), American Psychological Association, Washington DC.

- Coggans, N. & Watson, J. (1995). *Drugs education: Approaches, effectiveness and implications for delivery*, HEBS Working Paper, 1. Edinburgh: Health Education Board for Scotland.
- Department of the Taoiseach (1996). *First report of the Ministerial Task Force on measures to reduce the demand for drugs*. Dublin: Government Publications.
- Department of the Taoiseach (1997). *Second report of the Ministerial Task Force on measures to reduce the demand for drugs*. Dublin: Government Publications.
- Dorn, N. & Murji, K. (1992). *Drug prevention: A review of the English language literature*. London: ISDD.
- Dryfoos, J.G. (1990). *Adolescents at risk: Prevalence and prevention*. New York: Oxford University Press.
- Foxcroft, D.R., & Lowe, G. (1991). Adolescent drinking behaviour and family socialisation factors: a meta-analysis. *Journal of Adolescence*, 14, 255 - 273.
- Glassner, B. & Loughlin, J. (1987). *Drugs in adolescent worlds: Burnouts to straights*. New York: St. Martins Press.
- Gorusch, R. L. (1983). Interactive Models of Non-Medical Drug Use. In D.J. Lettieri, M. Sayers & H. W. Pearson (Eds.) *Theories on drug abuse*.
- Grube, J.W. & Morgan, M (1986). *Smoking, drinking and other drug use among Dublin post-primary pupils*, Dublin: ESRI.
- Grube, J.W. & Morgan, M (1990). *The development and maintenance of smoking, drinking and other drug use among Dublin post-primary pupils*. Dublin: ESRI.
- Gutierrez, S.E.; Molof, M.; Ungerleider, S. (1994). Relationship of “risk” factors to teen substance use: A comparison of abstainers, infrequent users and frequent users. *International Journal of the Addictions*, 29 (12), 1559 – 1579.
- Hawkins, D. J., Catalano, F. & Miller, Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early childhood: Implications for substance abuse prevention. *Psychological Bulletin*, 112 (1), 64 - 105.
- Hibell, B., Andersson, B., Bjarnason, T., Kokkevi, A., Morgan, M. & Narusk, A. (1997). *The 1995 ESPAD report: Alcohol and other drug use among students in 26 European countries*. Council of Europe, Pompidou Group.
- Howard, J. (1997). Psychoactive substance use and adolescence (part 1): Prevention. *Journal of Substance Misuse*, 2, 17-23.
- McClure, A. & Wilcock, J. (1998). The generation gap: Barriers to effective communication. *Druglink*, 13 (4), 12-13.
- Measham, F., Newcombe, R. & Parker, H. (1994). The normalisation of recreational drug use among teenagers in North West England. *British Journal of Sociology*, 45 (2), 287 - 312.

- Morgan, M. (1997, Nov 8). Quoted in N. Haughey, The Drugs do work and so does the Drink. Irish Times. Available: <http://www.irish-times/paper/1997/1108/hom49.html>.
- Morgan, M. & Grube, J.W. (1989). Drug use in Irish schools: A comparison with other countries. *Oideas*, 34, 21-31.
- Murphy, E. (1996). The teenage drugs explosion: Fact or fiction. Unpublished thesis, Royal College of Physicians of Ireland.
- Nevin, M., O'Rourke, A., Wilson-Davies, K. & DEan, G. (1971). Drugs - A report on a study of Dublin post-primary school children, 1970. *Journal of the Irish Medical Association*, 64 (406), 91-100.
- Newcomb, M.D. (1992). Understanding the multidimensional nature of drug use and abuse: The role of consumption, risk factors, and protective factors. In M Glantz and R Pickens (Eds.), *Vulnerability to drug abuse* (pp.255-297), Washington DC: American Psychological Association.
- Newcomb, M.D., & Bentler, P.M. (1988). *Consequences of adolescent drug use: Impact on the lives of young adults*. Newbury Park, CA: Sage.
- Newcomb, M.D. & Felix-Ortiz M. (1992). Multiple protective and risk factors for drug use and abuse: Cross-sectional and prospective findings. *Journal of Personality and Social Psychology*, 63 (2), 280-296.
- Newcomb, M.D., Maddahian E., Skager R. & Bentler P.M. (1987). Substance abuse and psychosocial risk factors among teenagers: Association with sex, age, ethnicity and type of school. *American Journal of Drug and Alcohol Abuse*, 13 (4), 413 - 433.
- Ohannessian, C. M., Stabenau, J. R. & Hesselbrock, V.M. (1995). Childhood and adulthood temperament and problem behaviours and adulthood substance use. *Addictive Behaviors*, 20 (1), 77 - 86.
- Osterburg, E. (1986). Alcohol-related problems in cross cultural perspective: Results of the ISACE-study. In T.F. Barbor (ed.) *Alcohol and Culture*, 10-20. New York: The New York Academy of Sciences.
- Palmer, R.B., & Liddle, H.A. (1996). Adolescent Drug Abuse: Contemporary Perspectives on Etiology and Treatment. In G.M. Blau, & T.D. Gullotta (Eds.) *Adolescent Dysfunctional Behaviour: Causes, Interventions and Prevention*. Ca: Sage Publications.
- Parker, H. (1997). Young people and drugs problems: Issues for future policies. Keynote address in seminar Trinity College, Saturday, November 22, organised by The Children's Research Centre in conjunction with the Course in Addiction Studies.
- Parker, H., Measham, F., & Aldridge, J. (1995). *Drug futures: Changing patterns of drug use amongst English youth*. London: ISDD Research Monograph Series 7.
- Ratcliffe, J. & Wallack, L. (1985). Primary prevention in public health: An analysis of basic assumptions. *International Quarterly of Community Health Education*, 6, 215-239.

- Robins, L. (1992). Synthesis and analysis of longitudinal research on substance abuse. A Report for the Robert Wood Johnson Foundation, US.
- Rutter, M. (1992). Psychosocial resilience and protective mechanisms. In J. E. Rolf et al. (Eds.) Risk and protective factors in the development of psychopathology. New York: Cambridge University Press.
- Scheier, L. M. & Newcomb, M.D. (1991). Differentiation of early adolescent predictors of drug use versus abuse: A developmental risk factor model. *Journal of Substance Abuse*, 3, 277 - 299.
- Scheier, L.M., Newcomb, M. & Skager, R. (1994). Risk, protection and vulnerability to adolescent drug use: Latent variable models of three age groups. *Journal of Drug Education*, 24 (1), 49-82.
- Shedler J. & Block, J. (1990). Adolescent drug use and psychological health: A longitudinal inquiry. *American Psychologist*, 45 (5), 612-630.
- Shelley, E.B., Wilson-Davis, K. & O'Rourke, F. (1982). Drugs - A study in Dublin post-primary schools. *Irish Medical Journal*, 75 (7), 254-259.
- Silbereisen, R.K., Robins, L. & Rutter, M. (1995) Secular trends in substance use: Concepts and data on the impact of social change on alcohol and drug abuse. In M. Rutter & D. J. Smith (Eds.), *Psychosocial disorders in young people: Time trends and their causes* (pp. 490-543). Chichester: Wiley and Sons.
- Tobler, N. & Stratton, H. (1997). Effectiveness of school based prevention programmes: A meta-analysis of the research. *Journal of Primary Prevention*, 18(1), 71-128.

## CHAPTER EIGHTEEN

### THE PSYCHOPHARMACOLOGICAL TREATMENT OF ADOLESCENT AND ADULT ATTENTION DEFICIT HYPERACTIVITY DISORDER

*Michael Fitzgerald.*

*Adult ADHD is becoming a rather “firm” diagnosis in adult psychiatry practice. Nevertheless it is a diagnosis that is often missed which leads to unnecessary distress to patients.*

The following are the three core clinical symptoms of Attention Deficit Hyperactivity Disorder in adults<sup>1</sup>:

- (1) The first core clinical symptoms relate to inattention and distractibility. These patients show poor concentration; are unable to complete reading or other cognitive tasks; shifting activities frequently; daydreaming frequently; are easily distracted by external stimuli or events; are distracted by internal thoughts; are forgetful; have problems organising time; pay poor attention to detail and has difficulty listening.
- (2) The second core clinical symptom relates to impulsivity and the issues here are impatience; acting without thinking; talking out of turn; has impulsive urges and temper tantrums.
- (3) The third core clinical symptom is hyperactivity and the issues here are having a restless feeling; having motor hyperactivity; having difficulty remaining seated during meetings and meals and having difficulty working quietly.

The coding note in relation to ADHD in DSM-IV<sup>2</sup> states that ‘for individuals (especially adolescents and adults) who currently have symptoms that no longer meet full criteria the code of ‘in partial remission’ should be specified’.

Kevin Murphy and Russell Barkley<sup>3</sup> point out that DSM-IV may be inappropriately worded for adults and that the diagnostic thresholds could be too stringent when applied to adults which could result in underdiagnosis of the condition even when it is present. They point out that ADHD should be diagnosed in adults ‘whenever problems with poor inhibition, sustained attention, and restlessness have persisted since childhood and have resulted in impairment’.

*Goodman and Scott<sup>4</sup> point out that ICD-10<sup>5</sup> and DSM-IV<sup>2</sup> definitions are very similar except that the terms used are Hyperkinesis and Attention Deficit Hyperactivity Disorder respectively. They require pervasiveness, chronicity and early onset. The DSM-IV<sup>2</sup> criteria playing quietly is not relevant for adults but adults do show affective lability and impulsivity.*

Gorman and Greenberg<sup>6</sup> point out that “ADHD occurs in 3 – 4% of adults. Unfortunately, some clinicians simply do not believe this. In fact, some clinicians will not treat anyone after 12 – 13 years of age, even teenagers who had ADHD as a child, and who are still having attentional problems. Persistence into adulthood has been officially recognised since 1978”. They also point out that less than half children with ADHD will “outgrow it”.

Toone and van der Linden<sup>7</sup> have suggested that approximately 0.5% - 1% of the young adult population have symptoms associated with ADHD in the U.K.

### ***Predictive Validity and Reliability:***

Spencer<sup>8</sup> points out that this has been studied in the context of psychopharmacological treatment trials. They point out that the range of response varies from 25% to 75% while with children and adolescent the response rate is a fairly uniform 70%. This could be due to different diagnostic methods, sample characteristics on dosage regimes. They conclude that “few studies of predictive validity have been done, psychopharmacological treatment findings show that being diagnosed with adult ADHD predicts a positive response with stimulants. Finally, family genetic studies suggest that adult ADHD has neurobiological and familial correlates implying a genetic link with childhood ADHD. Taken together, these findings indicate that ADHD is a valid clinical entity in adults”. They also note that follow-up data indicate that adult ADHD is associated with “psychosocial dysfunction, work failure, substance abuse and antisocial personality”.

Diagnostically ADHD has to have an onset before 7 years in DSM-IV has led some clinicians to question the reliability of retrospective reports and not consider adult ADHD. Spencer et al. point out this “unlike episodic conditions like mood disorders, ADHD is a chronic disabling disorder that is not likely to be forgotten”. They conclude from their review of studies that reliable and valid retrospective diagnosis of childhood onset ADHD can be made.

Chiarello and Cole<sup>9</sup> point out that an effort is now being made to demarcate “a group of patients who may occupy a band on the character disorder spectrum and who may represent a distinct and pharmacologically treatable syndrome”. They also point out that there is increasing evidence for the support of the “syndromal validity of adult ADD”. This is supported by the often persistence of childhood ADHD into adolescence and young adulthood. In addition they point out that “there is evidence that adult ADD runs in families” and can benefit from psychostimulants.

***Demuth<sup>10</sup> emphasises the importance of a comprehensive history as well as “securing background information in person on the partner and by questionnaire from parents” as well as other people who know the patient well. Persons with ADHD can have difficulty in giving a good history themselves. Clearly school records and employment history will be very important as persons with ADHD often seriously under perform in these areas. The issue of looking for co-morbid diagnosis is also critical because these so often occur. Demuth<sup>10</sup> points out that “adults with ADHD who possess higher IQs may simply compensate better, perform at average levels while still under achieving, or maybe overlooked due to the lack of hyperactivity”.***

Demuth<sup>10</sup> also notes in a history of never-ending piles of work at home and in place of work as well as accidents, substance abuse, difficulty completing the reading of a book, problems with sleep, extremes of temperament and attempts to treat the condition with self medication using alcohol, nicotine, caffeine or cocaine. She notes that some “ADHD adults report that

cocaine helps them to focus and concentrate more effectively and they do not appear to experience the same “high” the others may experience”.

Wilens<sup>1</sup> et al. they found that adults with ADHD reported difficulty with comprehension of written material due to poor concentration and that they have an inability to attend to and code information into short term memory. They have a low tolerance of frustration and tend to be stubborn and have chronic conflicts in relationships with peers. They have an “enduring impulsivity, lack of concentration, an inability to organise and complete tasks which typically lead to academic and career underachievement, interpersonal difficulties and intrapsychic distress”. They experience failures in many areas of their life and this can lead to low self esteem and a sense of hopelessness. Hechman<sup>11</sup> points out that they tend to be better in verbal abilities and it will be noticed that their educational work records show many changes of jobs and a drop out from further education.

In terms of occupational performance under performance occupationally is probably much more common although the occasional person with adult ADHD can do very well if they find the right niche in life.

### ***Co-morbidity and Differential Diagnosis:***

Shekim<sup>12</sup> et al. found that in the sample of 56 adults that “the majority of the sample had additional diagnosis and only 7 had ADHD diagnosis alone. 53% of the sample met the criteria for generalised anxiety disorder, 34% for alcohol abuse or dependence, 30% drug abuse, 25% dysthymic disorder, and 25% cyclothymic disorder. These findings were similar to those reported in the literature”.

Some clinicians believe that adult ADHD really doesn’t exist and that it is really a form of atypical depression. This is not true even though there is a very high rate of co-morbidity with depression. Indeed adult ADHD is Attention Deficit Hyperactivity Disorder in its more pure form.

If the clinician does not take a childhood history he / she may confuse bipolar disorder with ADHD. If they take a childhood history they will see ADHD having an onset before age 7 and then will be less likely to confuse it with bipolar disorder which tends to have a later onset. Here there are very many overlapping symptoms if one just look at symptoms. Some people have grossly over diagnosed bipolar disorder when in actual fact the persons had ADHD. Adult ADHD’s have about twice the amount of major depression i.e. about 27%. Personality disorder is also co-morbid in about 20%.

The following disorders can lead to a misdiagnosis of ADHD and these include patients who drink too much coffee, have anxiety states, have mania or hyperthyroidism, have experienced head injury, Post Traumatic Stress Disorder or chronic drug abuse most of their life.

Adult ADHD can also be confused with antisocial personality disorder, borderline personality disorder and schizophrenia.

### ***Neuropsychological Tests:***

There is no definitive neuropsychological test for ADHD. Continuous performance tests are sometimes used to assess attention.

Test of Variables of Attention<sup>13</sup> began development in the 1960s. The current version 7 was released in 1997. It takes 21 minutes to complete. It can be used for all ages from 4 to 80 years old. It measures attention during both uninteresting and stimulating tasks. It also measures impulsivity or disinhibition as well as reaction time. It also measures variability in responses as persons with ADHD tend to be more inconsistent than normal.

The T.O.V.A. has been standardised for adults. In a recent study the T.O.V.A. correctly classified 89% of attention deficit cases (and 90% of normals) with 11% false negatives and 10% false positives<sup>14</sup>. Greenberg<sup>14</sup> also uses the T.O.V.A. to indicate dosage levels as medication is adjusted.

Toone<sup>7</sup> et al. points out that neuropsychological tests like continuous performance tests are not diagnostic but “should be used in combination with other sources of information at assessment” and that they can be “useful in establishing a baseline against which the response to treatment can be monitored”.

Other neuropsychological tests include the Matching Familiar Figures test<sup>15</sup> which involves presenting an image to the subject and asking them to match the image to the identical one from a selection of variants.

The letter cancellation test<sup>16</sup> is sensitive to hyperactivity and involves the deletion of a target letter from a random sample of alphabetical letters.

### ***Genetics of ADHD:***

Attention Deficit Hyperactivity Disorder is a familial disorder with a large genetic component. As Toone<sup>7</sup> et al. points out twin and adoption studies support “a genetic, rather than an environmental, cause for the increased rate of ADHD in families”. Goodman and Stevenson<sup>16</sup> examined heritability factors in 127 monozygotic twins and 111 dizygotic twins. They showed a concordance for ADHD of 51% in monozygotic twins and 33% in dizygotic twins. Medications which inhibit Dopamine neurotransmission, such as Methylphenidate and amphetamine significantly improve behaviour in ADHD, suggesting that abnormalities in the Dopamine neurotransmitter system maybe aetiologically involved. Some authors have estimated that the genetic component is 60 – 80% of the variance in liability, but is likely to be made up of several genes each of small effect<sup>17,18</sup>. On the other hand Goodman and Stevenson<sup>16</sup> estimated that the heritability of all in of living of traits of hyperactivity and attention as being 30 – 50% with common environmental factors accounting for 0 – 30% of the variance.

The work by Dr. Michael Gill on susceptibility genes has been of great importance in furthering genetics of ADHD. Gill et al. confirmed an association between Attention Deficit Hyperactivity Disorder and a dopamine transport polymorphism<sup>19</sup>. Further studies have implicated dopamine beta hydroxise<sup>20</sup>.

### ***Unlicensed Drugs:***

***It is the Psychiatrist's duty to prescribe psychotropic medications for adults which would be beneficial to the adults and he or she should be familiar with current opinion on the***

*effectiveness of these drugs and their safety. They should be aware of the information available in the published scientific literature and in the light of their own experience they should be able to decide what drug to prescribe and what dosage to prescribe. In the United Kingdom “the Department of Health has stated that it would not expect that a health authority would seek to fetter a clinician’s freedom to prescribe by expressly directing its medical staff against prescribing unlicensed products”. The book Medicines for Children<sup>14</sup> published by the Royal College of Paediatrics and Child Health states that “even if a health authority were to direct its medical staff, the view of the Department lawyers is that a court would be reluctant to support the authority in those circumstances. We also understand the courts would not hold the prescription of a medicine in these circumstances to be a breach of the duty of care, if that treatment was supported by a respected body of medical opinion. We consider that NHS Trusts should support therapeutic practices that are advocated by a respectable, responsible body of professional opinion”<sup>21</sup>.*

*Medications for adult ADHD mainly fall into the category of unlicensed medications or off label medications. When using an unlicensed product the manufacturing company is not held liable for any misadventure arising from its use, but the Consultant or prescriber is held fully liable. While there is no obligation to obtain consent from a patient for the use of unlicensed medications and indeed many patients become worried when informed they are being given an unlicensed medication and require reassurance. It is best to tell patients that the medications are off label in my opinion.*

Healy<sup>22</sup> quotes Mr. Panting from the Medical Protection Society as stating that “broadly speaking, provided there is supportive expert opinion, then the claim will be defensible, irrespective of the wording of the drug license”.

*The consultants in each hospital region or Health Board should get together to establish a professional consensus on the treatment of ADHD using the off label drugs.*

Ritalin:

Green<sup>23</sup> points out that in relation to adolescent Attention Deficit Hyperactivity Disorder the following medications may be therapeutically indicated –

(1) Stimulants, (2) Tricyclic antidepressants, (3) Antipsychotics, (4) Clonidine, (5) Guanfacine, (6) Fluoxetine, (7) Clomipramine, (8) Monamine oxidase inhibitors, (9) Bupropion.

*Wender<sup>24</sup> et al. points out that Ritalin is still the first choice treatment and found that Methylphenidate “in doses up to 60 mgs per day was clearly superior to placebo when used in a cross over design in a group of adults with prominent ADD symptoms”. In that particular study 53% improved with Ritalin, and 8% with a tricyclic antidepressant.*

Methylphenidate has the effect of improving attention, short term memory and work accuracy. In addition they improve socialisation with parents, friends and motor effects are seen in an improvement in handwriting and fine motor control. They decrease impulsivity, distractibility, irritability, aggression, oppositional behaviour and disruptiveness.

Chiarello and Cole<sup>9</sup> point out that “these findings suggest that adult ADD may indeed be a residual form of the childhood disorder, and that adult suffering from the adult manifestation

of the condition appear to be responsive to psychostimulants”. They conclude that “if the true likelihood of “real” stimulant response lies somewhere between 26% and 57%, then some controlled studies will be statistically significant and some will not be”.

***Double blind placebo trials have shown that dosages are quite similar to dosages used in children which are prescribed for adults have been shown to be just as effective in adults as in children.***

Rosenberg<sup>25</sup> points out that the following are relative contraindications to stimulant medication:

(1) Psychosis, (2) Pregnancy, (3) History of adverse reaction to stimulants, (4) Height and growth retardation, (5) Cardiac and blood pressure anomalies, (6) Patient being currently treated with a Monamine oxidase inhibitor.

The common side effects of Ritalin include insomnia, decreased appetite, gastrointestinal pain, irritability, increased heart rate and paradoxical worsening of behaviour. The following are uncommon side effects to stimulants and they include psychosis, major depressive episodes, cognitive impairment, increased blood pressure, dizziness, lethargy and fatigue, nausea and constipation, rash and hives, hyperacusis, formication and necrotizing vasculitis.

Rosenberg<sup>25</sup> also points out that Methylphenidate inhibits the metabolism of anticoagulants, anticonvulsants as well as decreasing the hypotensive effect of Guanethidine. In combination with Imipramine it can cause confusion, mood lability, aggression, agitation and psychosis. It exaggerates the effect of ephedrine.

Stimulants are contraindicated in patients with a psychotic illness or if there is a history of a psychotic illness as it can precipitate psychosis or indeed cause deterioration in a pre-existing psychosis. There is some risk of abuse of these medications.

There was concern that the prescription of stimulants in patients with coexisting seizure disorder would lower the seizure threshold. Recent studies attest to the safety of Methylphenidate in children with epilepsy. It is interesting that there is no evidence that body weight predicts optimal dose of Methylphenidate. At every weight level there is evidence that some children will respond to low doses while others will respond to high doses. Pliska<sup>26</sup> in relation to tics and stimulants has been shown that overall, at higher doses (1 mg per kilogram per day) there was a significant increase in tics on Methylphenidate. At lower doses Methylphenidate was not different from placebo in increasing tics. Stimulants are not an absolute contraindication in Tic-Tourette’s disorders with ADHD but it is important to start with lower doses and indeed in some patients the tics may actually decrease.

While a patient is on Methylphenidate it is traditional to monitor the blood pressure and weight every three months and to do a full blood count once per year.

Spencer<sup>27</sup> et al. found that the response to Methylphenidate was independent of gender, psychiatric co-morbidity with anxiety or moderate depression, or family history of psychiatric disorders. They used 1.0 mg / kg per day of Methylphenidate hydrochloride. The maximum total dose used in the USA is about 70 mg per day.

***Spencer<sup>27</sup> et al. showed that a higher dose of 1 mg per kilogram per day had a better response. They found this higher response rate was seen with the higher dose i.e. 70%***

*compared with approximately 50%. Methylphenidate has a plasma half life of about three hours and is totally excreted within 12 hours. Clinical improvement reaches a peak in 1 to 2 hours but requires multiple doses per day. It has its greatest effect on motor activity, restlessness and inattention. Initial starting dose is 5 mgs at 8 a.m. and midday. It can be increased every two to three days if there are no side effects. In Ireland the dose range is up to 40 mgs per day and in the U.K. up to 60 mgs per day. 20 mgs is the usual maximum prescribed at any one time. The last dose is usually given around 3.30 to 4.00 p.m. as if it is given later it can cause insomnia.*

As patients often forget to take their medication he suggested a wrist watch alarm to remind them. Wender<sup>28</sup> also notes that patients responsive to stimulant drugs rarely require increased doses after they reached their benefit plateaux. Tolerance is the exception rather than the rule. He points out that most patients experience no decrease in efficacy even after years of use.

*Levin<sup>29</sup> et al. in a study of cocaine abusers with ADHD suggests that under close supervision, the combined intervention of sustained-release Methylphenidate and relapse prevention therapy may be effective in treating individuals with both adult ADHD and cocaine dependence.*

Levin<sup>30</sup> et al. found that subpopulation of cocaine abusers may be one of the most difficult to treat, particularly if the ADHD remains undetected. To provide effective treatment for cocaine abusers, clinicians may need to identify subpopulations of patients, such as those with ADHD, and target both pharmacologic and nonpharmacologic interventions for these groups. As stimulants can be abused Zametkin<sup>31</sup> points out that psychiatrists should be alert for early prescription renewals and for patients seeing multiple psychiatrists or other doctors for prescriptions.

#### **Tricyclics:**

Imipramine has shown clinical efficacy in the treatment of Attention Deficit Hyperactivity Disorders. It is used when Methylphenidate has not been effective or when there has been problems with side effects or alternatively when there is ADHD and a mood disorder.

*Spencer<sup>32</sup> et al. point out that the tricyclic antidepressants e.g. Imipramine have reported a high rate of improvement of ADHD symptoms with no change or improvement in tic disorder over extended follow-up period.*

*Wilens<sup>34</sup> and colleagues found a highly significant difference in the reduction of ADHD symptoms between adults receiving Desipramine and placebo. They found that 68% of Desipramine treated subjects and no subjects in the placebo group were considered positive responders. The response to the Desipramine was independent of dose, level of impairment, gender, or lifetime psychiatric comorbidity with anxiety or depressive disorders. They regarded Desipramine as being effective in the treatment of ADHD in adults.*

#### **Clonidine:**

A third choice drug in the treatment of ADHD is Clonidine, an anti-hypertensive drug which has been found in recent times to be effective in treating persons with ADHD. It is not

uncommonly prescribed when there is a poor response to stimulant drugs or there are tic disorders in addition to hyperactivity. It is also used when there is ADHD with Oppositional Defiant Disorder or Conduct Disorder or anxiety / hyperarousal. There is a relative contraindication to Clonidine use if there is a history of depression or cardiovascular disorders or renal or liver disease. It is usual to start with 25 micrograms at night increasing by 26 micrograms increments to 100 / 200 micrograms if tolerated in adolescents. Clonidine usually improves the behaviour for three to six hours while its sedative effects are most prominent 30 to 90 minutes after the last dose. Clonidine is usually prescribed divided in two doses at breakfast and at bedtime. Nevertheless Hunt<sup>35</sup> et al. suggests that because of Clonidine's short serum half-life, Clonidine should be administered 3-4 times daily and at bedtime. Dosage should be gradually built up over two to four weeks is usually 3 / 5 µg/kg/day. It is possible to make an evaluation of its effectiveness after six weeks on the full dose. Orthostatic hypotension and cardiac arrhythmia's are rare but potentially serious; so the doctor should monitor blood pressure, pulse and do an electrocardiograms before treatment and at higher doses of Clonidine. Contraindications include cardiac arrhythmia's and major depressions.

When Clonidine is being terminated it should be stopped slowly because of the danger of increased blood pressure.

Hunt<sup>35</sup> noted that in contrast to the stimulants, Clonidine appears to increase frustration tolerance but does not decrease distractibility. It has also been used in the treatment of sleep disturbances in adolescents diagnosed with ADHD. It is not licensed for ADHD.

### ***Combination of Drugs:***

A not unusual combination of drugs, used particularly in America, and less frequently in Europe are Methylphenidate and Clonidine. It appears that Methylphenidate particularly improves concentration and Clonidine reduces hyperactivity and impulsivity. There was concern for the safety of this combination because of the sudden deaths in three children taking Clonidine and Methylphenidate. None of these deaths could be directly linked to Clonidine. One child had no detectable Clonidine or Methylphenidate in their blood post-mortem, and "the second had extensive fibrotic scarring of the heart thought to be congenital, while the third died after an intentional overdose of Fluoxetine"<sup>37</sup>. It is important then to monitor patients on this combination for height, weight, blood pressure as well as ECG monitoring particularly early in treatment when "previously unidentified congenital abnormalities might be uncovered"<sup>37</sup>. This combination has been found useful when there is ADHD and Oppositional Defiant Disorder or Conduct Disorder is present. The other most commonly used combinations of medications in the United States would include a psychostimulant with a selective Serotonin reuptake inhibitor antidepressant with Clonidine or Buspirone or a beta blocker. If there is ADHD and panic attacks Methylphenidate plus Propranolol has been used.

If there was ADHD plus anxiety, anger, ODD or agitation Buspirone 5 mg daily increasing by 5 mg increments to a usual maintenance of 15 – 30 mg, has been used in addition to a psychostimulant.

***Spencer<sup>32</sup> et al. also suggest the following treatment for ADHD plus anxiety stimulant plus Buspirone or stimulant plus SSRI – tricyclic antidepressant. They suggest for ADHD plus multiple co-morbidity's that the prescriber should address each co-morbidity and priorities by severity. They also point out that following a sufficient period of clinical stabilisation***

*i.e. 6 to 12 months it is prudent to re-evaluate the need for continued psychopharmacological intervention. They conclude that “stimulant medications continue to be the first line drugs of choice for uncomplicated ADHD in individuals of all ages, with tricyclic antidepressants and Bupropion for non-responders or patients with concurrent psychiatric disorders. They also state that “current clinical experience suggest that multiple agents may be necessary in the successful treatment of some complex ADHD patients with partial responses or psychiatric co-morbidity”.*

#### **Bupropion:**

*Spencer<sup>32</sup> et al. point out that Bupropion is a novel antidepressant which possess’ both indirect Dopamine and Noradrenergic agonist effects. They point out that in an open label study of 19 adults treated with an average of 360 mgs of Bupropion for 6 to 8 weeks a moderate to marked response was observed in 74% of subjects and sustained improvement at 1 year in 10 subjects. The response of ADHD to Bupropion appeared to be rapid and sustained. The dose of Bupropion for ADHD was similar to that for depression with a suggested maximum dose of 450 mgs per day divided into three daily doses for adults. They conclude that “Bupropion should be limited to patients who fail to respond or cannot tolerate more conventional treatments”.*

*Wender<sup>33</sup> et al. treated 19 adults with Attention Deficit Hyperactivity Disorder with an open trial of Bupropion. These patients had received maintenance stimulant medication or monoamine oxidase inhibitors for average of 3.7 years. Fourteen of the patients experienced moderate to marked benefit from Bupropion; ten of these patients chose to continue Bupropion rather than their former medication. These results suggest Bupropion may be an alternative to stimulants in treating some adults with Attention Deficit Hyperactivity Disorder.*

*For Bupropion Wender<sup>36</sup> suggests an effective dose as being between 50 and 150 mgs three times a day. His policy is to divide the tablets and start with 37.5 mgs twice a day gradually increasing the frequency to three times a day, dosing as required and tolerated. He holds the view that Bupropion may be more effective in ADHD patients who suffer from a concurrent chronic major depression.*

*Wilens<sup>37</sup> et al. state that Bupropion SR was associated with a significant reduction in ADHD symptoms, which exceeded the placebo at the end of the six week treatment period.*

#### **Venlafaxine:**

*Spencer<sup>32</sup> et al. also point out that when using Venlafaxine, unlike the SSRIs, there is a need to monitor for potential cardiac effect, such as diastolic hypertension.*

*There is also some preliminary information on an open-label trial of Venlafaxine in adults with Attention Deficit Disorder. Twelve out of 16 patients decreased Attention Deficit Disorder ratings by almost half<sup>38</sup>. Hedges<sup>39</sup> and colleagues suggested that control trials should be conducted with Venlafaxine for ADHD.*

*Bender<sup>41</sup> points out that in an open-label trial ADD adult patients were treated with Venlafaxine showed a reduction in symptoms. Horig-Rohan<sup>40</sup> found that “improvement in both depressive and ADHD symptoms was comparable with Venlafaxine, Bupropion and the*

stimulant – antidepressant combination; while a stimulant alone appeared less effective for depressive symptoms”. Horig-Rohan<sup>40</sup> speculated that “there maybe something unique about the Venlafaxine based on its Phenylethylamine chemical structure”.

Tomoxetine:

*Spencer<sup>32</sup> et al. also point out that Tomoxetine has been used for the treatment of adults with ADHD. They used an average daily dose of 76 mgs per day. Tomoxetine was shown to be more effective than placebo (53% versus 10.5%  $p < .05$ ).*

Guanfacine:

*Spencer<sup>32</sup> et al. also point out that Guanfacine has been used with adolescents with ADHD with positive effects and had a similar side effect profile to Clonidine although less sedation has been reported.*

The findings suggest that Guanfacine may be a useful agent in the management of a number of the core features of ADHD. Further studies with a double-blinded placebo-controlled design appear indicated.

**Risperidone:**

*Risperidone, an atypical antipsychotic drug, which is licensed for use in children over age 15 for the treatment of psychosis. Nevertheless it has been found useful in younger children and for conditions like Tourette's. the dosage regime is 0.25 milligrams on day one to increase gradually to a maximum of 4 mgs daily in divided doses. Not uncommonly a low dose can be effective. It is necessary to do a baseline blood test (FBC, LFT), repeated at three monthly intervals and to monitor blood pressure and weight regularly as weight gain can be a problem with Risperidone. There is some clinical experience (but no formal studies) of the use of Methylphenidate and Risperidone in adolescents with severe ADHD / impulsive conditions where benefit has been shown, when all other possibilities have been exhausted. Clearly this requires further study.*

*Kewley<sup>42</sup> has pointed out that Risperidone may sometimes be required when there is comorbid ADHD and Oppositional Defiant Disorder and Conduct Disorder. These patients had been on Ritalin plus Clonidine and when Clonidine failed Risperidone was added in. He found that 67% of 30 children showed a very significant improvement in symptoms. There is the risk of extrapyramidal side effects.*

There is also a need for an active multimodal approach, including somatic treatment, psychotherapy, including cognitive re-mediation strategies to enhance attention, organisation, memory, and problem solving skills in patients with ADHD.

**Cholinergic Agonist:**

*Wilens<sup>43</sup> et al. found that “ABT – 418, nicotinic analogue, maybe a potentially useful agent in ADHD”.*

**Conclusion:**

***It is quite likely that adult ADHD is actually going to become one of the rather “firm” diagnosis in adult psychiatry.***

***It is not uncommon to treat the mood disorder and completely miss the ADHD. Treatment may have the effect of reducing drug addiction and imprisonment. There appears to be high rates of ADHD in prisons<sup>44</sup>. Patients treated for ADHD have less drug abuse later on not more. These adult ADHD patients often are very much under employed as adults and often are very much under functioning in terms of their intellectual capacity. Genetic factors appear relevant<sup>45,46</sup>.***

The issue of unlicensed medications in the treatment of adult ADHD has always to be kept in mind<sup>47,48</sup>.

I wish to thank Ms. Ellen Cranley for secretarial assistance.

**References:**

- (1) Wilens T. Attention Deficit Hyperactivity Disorder and co-morbid substance use disorders in adults. *Psychiatric Services* 1995; 46(8): 761-763.
- (2) American Psychiatric Association. DSM-IV American Psychiatric Association: Washington DC, 1994.
- (3) Murphy K., Barkley R. Attention Deficit Hyperactivity Disorder adults: co-morbidities and adaptive impairments. *Compr Psychiatry* 1996; 37(6): 393-401.
- (4) Goodman R., Scott S. *Child Psychiatry*. Oxford: Blackwell Science, 1997.
- (5) World Health Organisation. *The ICD10 Classification of Mental and Behavioural Disorders*. W.H.O.: Geneva, 1992.
- (6) Gorman C., Greenberg L. All you ever wanted to know about Attention Deficits but didn't know when to ask . . . Universal Attention Disorders Inc. Los Alamitos, 1997.
- (7) Toone B., Clarke M., Young S. Attention Deficit Hyperactivity Disorder in adults. *Advances in Psychiatric Treatment* 1999, 5, 111-118.
- (8) Spencer T., Biederman J., Wilens T., Faraone S. Is Attention Deficit Hyperactivity Disorder in adults a valid disorder? *Harvard Review Psychiatry* 1994; 1: 326-35.
- (9) Chiarello R., Cole J. The use of psychostimulants in general psychiatry. *Archives of General Psychiatry* 1987, 44, 286-295.
- (10) Demuth N. ADHD adult evaluation in private practice: what is sufficient and cost effective. In the ADHD Report 1996, 4, 1, 8-13.
- (11) Hechman L. American Academy of Child and Adolescent Psychiatry Meeting. Challenges and controversies in the diagnosis of adult ADHD 1999, C9018 Chicago: USA.

- (12) Shekim W., Asarnow R., Hess E., Zaucha K., Wheeler N. A clinical and demographic profile of a sample of adults with Attention Deficit Hyperactivity Disorder, residual state. *Comprehensive Psychiatry* 1990, 31, 5, 416-425.
- (13) Test of Variables of Attention. Universal Attention Disorders Inc. Los Alamitos, CA, 1997.
- (14) Greenberg L. Treating Attention Deficit disorders in children and adults. *Psychiatric Times Medicine and Behaviour*, January 1992, 18-19.
- (15) Cairns E., Cammock T. Development of a more reliable version of the Matching Familiar Figures Test. *Developmental Psychology* 1978, 14, 555-560.
- (16) Goodman R., Stevenson J. A twin study of hyperactivity. *Journal of Child Psychology and Psychiatry* 1989, 30, 671-709.
- (17) Cook E., Stein M., Krasowski M. Association of Attention Deficit Disorder and the Dopamine transporter gene. *American Journal of Medical Genetics* 1995, 56, 993-998.
- (18) Biederman J., Faraone J., Keenan K. Further evidence for family genetic risk factors in Attention Deficit Hyperactivity Disorder. *archives of General Psychiatry*, 49, 728-738.
- (19) Gill M., Fitzgerald M., Hawi Z., Heron S. Confirmation of association between Attention Deficit Disorder and a Dopamine transporter polymorphism. *Molecular Psychiatry* 1997, 2, 4, 311-313.
- (20) Daly G., Hawi Z., Fitzgerald M., Gill M. Mapping susceptibility loci in Attention Deficit Hyperactivity Disorder: preferential transmission of parental alleles at Dat1, DBH, DRD5 to affected children. *American Academy of Child and Adolescent Psychiatry, Annual Meeting. Chicago, USA, 1999, 121.*
- (21) Medicines for Children. Royal College of Paediatrics and Child Health Publications: London, 1999.
- (22) Healy R. Prescriptions, licenses and evidence: A reply. *Psychiatric Bulletin*, 1999, 23, 442-443.
- (23) Green W. H. Child and adolescent clinical psychopharmacology. Williams and Wilkins: Baltimore, 1995.
- (24) Wender P. H., Reimher R., Wood D., Ward M. The first choice treatment is still Ritalin. A control study of Methylphenidate in the treatment of Attention Deficit Disorder, residual type in adults. *American Journal of Psychiatry* 1985, 142, 547-552.
- (25) Rosenberg D., Hottum J., Ryan N., Gershon S. Pocket guide for the textbook of pharmacotherapy for child and adolescent psychiatric disorders. Taylor and Francis: Washington, 1998.
- (26) Pliska S. What's new in stimulant treatment of Attention Deficit Hyperactivity Disorder. *American Academy of Child and Adolescent Psychiatry. 44<sup>th</sup> Annual Meeting, Toronto, 1998.*

- (27) Spencer T., Wilens T., Biederman J. Double-blind crossover trial of Methylphenidate in placebo in adults with childhood onset Attention Deficit Hyperactivity Disorder. *Archives of General Psychiatry* 1995, 52, 434-443.
- (28) Wender P. *Attention Deficit Disorder in adults*. Oxford University Press: Oxford, 1995.
- (29) Levin F. R., Evans S. M., McDowell D. M., Kleber H. D. Methylphenidate treatment for cocaine abusers with adult Attention Deficit Hyperactivity Disorder: A pilot study. *Journal of Clinical Psychiatry* 1998, 59(6): 300-305.
- (30) Levin F. R., Evans S. M., Kleber H. D. Prevalence of adult Attention Deficit Hyperactivity Disorder among cocaine abusers seeing treatment. *Drug Alcohol Dependence* 1998, 52(1): 15-25.
- (31) Zimetkin A. ADHD, the DEA and you. *ADHD Report*, 1999, 7, 1, 5-6.
- (32) Spencer T., Biederman T., Wilens T. Pharmacotherapy of Attention Deficit Hyperactivity Disorder: A life span approach. *Advanced psychopharmacology: Contemporary issues in clinical care*. Institute 7, American Academy of Child and Adolescent Psychiatry Meeting, Chicago, October 1999.
- (33) Wender P. H., Reimherr F. W. Bupropion treatment of Attention Deficit Hyperactivity Disorder in adults. *American Journal of Psychiatry* 1990, 147(8): 1018-20.
- (34) Wilens T., Biederman J., Prince J. Six week double blind, placebo controlled study of Desipramine for adult ADHD. *American Journal of Psychiatry* 1996, 153, 1147-1153.
- (35) Hunt R. D., Capper L., O'Connell P. Clonidine in Child and Adolescent Psychiatry. *Adolescent Psychopharmacology* 1990, 1, 87-102.
- (36) Wender P. *Attention Deficit Hyperactivity Disorder in adults*. Oxford University Press: Oxford, 1995.
- (37) Wilens T., Spencer T. Combining Methylphenidate and Clonidine. *Journal of the American Academy of Child and Adolescent Psychiatry* 1999, 38, 5, 614-616.
- (38) Wilens T., Spender T., Biederman J. A controlled trial of Bupropion SR for Attention Deficit Hyperactivity Disorder in adults. *American Academy of Child and Adolescent Psychiatry Meeting*, Chicago, November 1999.
- (39) Hedges D., Reimherr F. W., Rogers A. An open label trial of Venlafaxine in adult patients with ADHD. *Psychopharmacology bulletin* 1995, 31, 779-783.
- (40) Horig-Rohan M., Amsterdam J. Venlafaxine versus stimulant therapy in patients with dual diagnosis of Attention Deficit Disorder and Depression. *NCDEU Annual Meeting*, June 3<sup>rd</sup> 1995: Orlando, Florida.
- (41) Bender K. A dual-action antidepressant. *Psychiatric Times Monograph*, 1997, 6-12.

- (42) Kewley G. D. Risperidone in co-morbid ADHD and Oppositional Defiant Disorder / Conduct Disorder. *Journal of the American Academy of Child and Adolescent Psychiatry* 1999, 38, 11, 1327-1328.
- (43) Wilens T., Biederman J., Spencer T., Bostig J. A cholinergic agonist for Attention Deficit Hyperactivity Disorder: A pilot controlled clinical trial of ABT – 418 in adults. *American Academy of Child and Adolescent Psychiatry Meeting, Chicago, November 1999.*
- (44) Curran S., Fitzgerald M. Attention Deficit Hyperactivity Disorder in the prison population. *American Journal of Psychiatry* 1999, 156, 10, 1664-1665.
- (45) Hawi Z., McCarron M., Fitzgerald M., Gill M. Association between ADHD and the Dopamine beta hydroxylase gene. *Molecular Psychiatry* 1999, 4, 1, 269.
- (46) Kent L., Fitzgerald M., Hawi Z., Gill M., Middle F., Craddock N. Nicotinic acetylcholine receptor Alfa 4 sub unit gene polymorphisms and Attention Deficit Hyperactivity Disorder. *Molecular Psychiatry* 1999, 4, Supplement 1, 109.
- (47) Fitzgerald M. Fundamentals of child psychopharmacology. *CNS* 1999, 2, 2, 16-18.
- (48) Fitzgerald M. Unlicensed and off label drug use for children with child psychiatric problems. *Irish Medical Journal* 1999, 92, 2, 284.

## CHAPTER NINETEEN

### *THE RELATIONSHIP BETWEEN EXCESS FEARS IN IRISH CHILDREN AND MATERNAL ANXIETY*

*Ann Scully, Michael Fitzgerald, Anthony Kinsella,  
and Aiveen Higgins.*

The study examined the fears of 50 Child and Family Clinic attenders and a control group of 20 children, as rated by their mothers. Mothers were assessed for anxiety and depression symptoms and a positive correlation was found between maternal anxiety and excessive fears in children. The study found no statistical difference in levels of excessive fear between the clinic and control group. However differences may exist between groups for type and range of feared objects. Possible explanations and implications for the maternal anxiety / excessive fears correlation are discussed.

Fear is defined as “feeling of alarm or dread that is invoked by some specific object or situation, or by an anticipation or thought of that object/situation” (Rutter, 1993, p. 161). Fears in childhood are relatively common (Jersild & Holms, 1935; MacFarland, Allen & Hoznik, 1954). Lapouse and Monk (1959) found seven or more fears or worries in a sample of children aged 6-12 years.

Children’s fears are generally age-specific and follow a developmental pattern which reflects changes in the growing child’s perspective of reality (Bauer, 1976; King, Hamilton & Ollendick, 1988; Marks, 1987). They appear to emerge when the child becomes increasingly aware of potential danger (Jones & Jones, 1928) and are normal responses to a wide variety of threatening situations or objects (Ollendick, 1979). In this sense, childhood fears possess a survival or adaptive value (Marks, 1987), as they provide a protective response to an unknown and uncontrollable situation.

While most childhood fears are mild, transitory and adaptive (Ollendick, 1979), others are excessive, persistent and may result in maladaptive avoidance behaviour, causing great distress to the child (Miller, Barrett & Hampe, 1974). In addition, childhood fears may

frequently be related to other unpleasant emotions such as anxiety (Ollendick, Yule & Ollier, 1991) and lowered self-concepts (Ollendick, 1983).

While substantial research has been conducted on the nature of feared objects and the development trend of fears (e.g. Bauer, 1976; Ollendick, 1979; 1985), surprisingly little is known about the factors that influence fear. A substantial body of research suggests that both anxiety and excessive fears tend to run in families (Lahy & Kazdin, 1988). Children of anxious parents appear to be more fearful than children of non-anxious parents (Silverman, Cerny, Nelles & Burke, 1988). However, there is continuing uncertainty about the mechanisms involved. Genetics clearly play a role in the development of anxiety (Weissman, 1993 for review). More recently, research has indicated that fear may also be genetically influenced (Abe, Oda & Hatta, 1984). However, additional psychological factors are also likely to be involved. Modelling is thought to play an important role. It has been suggested that exposure to a parent with an anxiety disorder may predispose a child to develop an anxious stance by modelling caution and fearfulness (Rosenbaum, Biederman, Gersten, Hirschfeld, Menninger, Herman, Kagan, Reznick & Snidman, 1988). Children of mothers who never display their fears have lower levels of fear than children of mothers who frequently expressed fears (Muris, Steerneman, Merckelbach & Meesters, 1996).

Previous research on Irish populations has examined anxiety and depression in children and their mothers (Murphy, Fitzgerald & Kinsella, 1989), but has not examined the relationship between maternal anxiety and excessive fears in their children. In addition, fear and anxiety in children have often been studied as one entity. While the two concepts are clearly related, childhood fears need to be studied per se not only because basic differences may exist between the two, but also so we can learn to deal with children's fears before they become excessive. This is particularly important since excessive fears in childhood may predispose a child to anxiety disorders in later life.

The purpose of the present study was to explore the relationship between levels of fear in Irish children and anxiety symptoms in their mothers. Fifty children attending a Child and Family Clinic and a control group of non-clinic attenders from a similar sociodemographic background participated in the study. Mothers of all children were interviewed. Children's levels of fear were assessed by the Louisville Fear Survey for Children (Miller, Barrett, Hampe & Noble, 1973). The Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983) was administered to assess anxiety and depressive symptoms in mothers, while the Wheatley Stress Profile (Wheatley, 1993) provided a measure of maternal stress. It was expected that high levels of excessive fear in children would correlate positively with maternal anxiety symptoms. It was also predicted that clinic attenders would have higher fear levels than the control group.

## *Method*

### *Participants*

Fifty Child and Family Clinic attenders (17 girls and 33 boys), and their mothers took part in the study. A control group of 20 children (10 girls and 10 boys: mean age 10 years) and their mothers, sharing similar sociodemographic characteristics with the clinic group (i.e. disadvantaged local authority housing areas with high unemployment) were randomly selected from the local school register. The clinic group were between six and sixteen years of age and were attending the centre for emotional, conduct and mixed disorders.

## ***Procedure***

The Louisville Fear Survey for Children (Miller et al., 1973), the Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983), and the Wheatley Stress Scale (Wheatley, 1993) were administered in that order to each mother according to the standard administration procedures for the three instruments. While the Louisville Fear Survey may be administered directly to children, ratings of each child's fears were obtained instead from mothers as research suggests that mothers provide accurate and consistent information concerning their child's fears (Bondy, Sheslow & Garcia, 1985; Silverman & Nelles, 1989). Mothers of the clinic group were interviewed either at the clinic or at home. Control group mothers were interviewed at home. Information regarding marital status, employment and clinical diagnosis were also obtained.

## ***Instruments***

### ***Louisville Fear Survey for Children (Miller et al., 1973)***

This is an 81 item inventory which covers the full range of fear behaviour for children aged 4 to 18 years. The child's level of fear of each item is rated on a 3 point scale: 'No Fear', 'Normal or Reasonable Fear', and 'Unrealistic or Excessive Fear'. Factor analyses have divided the 81 items into three main divisions, in addition to a miscellaneous factor. The three factors are physical injury (e.g. war, deep water), natural events (e.g. storms, the dark) and social stress (e.g. examinations, being criticised). Split half reliability for the instrument on the general population is 0.96.

### ***Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983)***

This is a 16 item self assessment scale. In this study the items were read aloud to each mother and scored by the researcher to avoid illiteracy difficulties.

### ***Wheatley Stress Profile (Wheatley, 1993)***

This schedule assesses the severity of stress across nine areas of life as follows:

- (1) Social Habits: Alcohol, tobacco, caffeine, and addictive drug use.
- (2) Social Relationships: Marital difficulties, relationships with others, lack of close confidante, discontent at work or unemployment.
- (3) Life Events: Health, serious illness/death, emotional events, earnings, unemployment.
- (4) Sexual Problems: Dissatisfaction, physical problems, dyspareunia, fear of pregnancy.
- (5) Sleep Disturbance: Delayed onset, early awakening.
- (6) Anxiety: Panic attacks, phobias, somatic complaints.

- (7) Depression: Suicidal behaviour, poor concentration.
- (8) Menstrual Problems: Pre-menstrual syndrome, menopausal effects.

The stress profile was administered by the researcher to each mother. Social habits were rated on a 3 point scale. All other items were rated on a 4 point scale.

### **Results**

The control group response rate was 100%. Three of the fifty clinic attenders were excluded from statistical analyses due to incomplete data. Assessment results from these three participants was included elsewhere when relevant.

#### ***Louisville Fear Survey Results***

62% of the clinic attenders (31/50 children, 18/33 boys & 13/17 girls) had an excessive level of fear of 1-42 of the items on the schedule. 45% of the control group (9/20 children, 3/10 boys & 6/10 girls) had excessive fear of 1-22 of the items. There was no statistically significant difference between the levels of excessive fears of the clinic and control group.

The most common excessive fears of the clinical and the control group (i.e. items that were rated 'excessive' by mothers with the greatest frequency) are displayed in Tables 1 and 2. As can be seen in Table 1, the most common excessive fear of the clinic attenders is that of being criticised (29%), while 55% of the control group excessively feared the death of a close family member (See Table 2).

**Table 1: Most Common Fears of Clinic Attenders**

<b>% of Children</b>	<b>Feared Object or Situation</b>
29%	Being criticised
23%	Being kidnapped
19%	Making mistakes
19%	Death of family member
19%	Being adopted
19%	Getting an injection
19%	Losing control
19%	Nightmares
19%	Faces at windows

Fears that occurred in the clinic attenders but not in the control group included being adopted, losing control (19%), the dark, class recitals, making someone angry (16%), the Devil, lifts, enclosed places, family member falling ill (13%), and people in uniforms, ugly people, exams, crowds, masks, going to sleep, and seeing someone wounded (9%). Items on the Fear Schedule that were not feared by either group include sin, toilets, strange rooms, being locked up, furry toys, old people, people of the opposite sex, members of other races, and having bowel movements.

**Table 2: Most Common Fears of Control Group**

<b>% of Children</b>	<b>Feared Object or Situation</b>
----------------------	-----------------------------------

25%	Death of family member
20%	Being kidnapped
20%	Parents divorcing
20%	Loud noises
15%	Separation from parents

***Hospital Anxiety and Depression Scale (HAD)***

Fifteen of the 50 mothers of clinic attenders (30%) had HAD-Anxiety scores greater than 10 (indicating morbidity). Twelve of these fifteen mothers had children with excessive levels of fears. 10% of the clinic group (5/50) had HAD-Depression scores indicating morbidity. Three of these five had children with excessive fears.

Seven of the control mothers (35%) had high HAD-Anxiety scores. None had high HAD-Depression scores. Six of the seven mothers with high HAD-Anxiety scores had children who had excessive levels of fear. Combining the two study groups, only one child of the 27 mothers with high anxiety had no excessive fears, indicating a positive correlation between maternal anxiety and excessive levels of fears in children.

***Wheatley Stress Scale***

The Wheatley Stress profile revealed quite high ratings of life events. 10% of the clinic group mothers scored 12 points or more out of a maximum score of 15 points.

A multiple regression model was used to investigate the influence of HAD-Anxiety, HAD-Depression, age, sex, occupation, diagnosis, marital status, group (clinic/control), and Wheatley Stress Scale scores on the excessive fear measure. Higher levels of HAD-Anxiety scores were associated with an increase in excess levels of fears. Lower levels of excess fears were associated with married, as opposed to single, marital status. There was no evidence of a difference in levels of excess fears between the clinic and the control group.

***Discussion***

The results indicate quite high fear levels for both the clinic group (62% had excessive fears) and the control group (45% had excessive fears), with no statistically significant difference between the level of excessive fears for the two groups.

The most common fears of the control group involved separation from parents or close family member (e.g. death of family member, being kidnapped, parents divorcing, separation from parents). While the clinic group also had separation fears, social fears were also in evidence (e.g. being criticised, making mistakes, losing control). Semi-structured interviews with the children themselves might reveal the more exact meanings which children attach to their fears. For example, while the Louisville Fear Survey tells us that fear of being criticised is common amongst the clinic group, it does not tell us who they fear criticism from. Similarly, do children fear kidnapping because they are afraid of the actual act or because of separation from their parents?

The two groups also differed in the range of items excessively feared. The clinic group had excessive fears of 1-42 items on the schedule, while the control group feared between 1 and 22 items.

Thus while there was no evidence of a difference in levels of excessive fear between the two groups, it would appear that differences in type and range of feared object or situation exist.

Similar to previous research (Silverman et al., 1988), the results reveal a positive correlation between anxious mothers and excess fearfulness in their children. It has been well documented that anxiety tends to run in families (Lay & Kazdin, 1988). Perhaps excessive or unrealistic fears in children provide a link between anxious parents and anxiety disorders in their children. It may be the case that anxious mothers model fearful behaviour to their children, and these children's 'normal' developmental fears become excessive, predisposing the child to anxiety problems in later life. This of course is only one tentative suggestion amongst many. The results of the study are correlational and therefore tell us only that a relationship exists, and not why maternal anxiety is linked to excess childhood fears. It may be due to modelling or an overprotective parenting style. Different types of fears (e.g. social fears, separation fears) may be gained in different ways or from different sources. On the other hand, fearful children may trigger anxiety symptoms in their mothers. Perhaps mothers are anxious and their children fearful because of a third unknown variable. It may even be the case that anxious mothers only perceive their children as more fearful than non-anxious mothers. Future studies should consider obtaining fear ratings from other sources such as teachers and children themselves as well as their mothers.

Excessive childhood fears are distressful, threaten a child's sense of security, may adversely affect schoolwork and may be related to anxiety and lowered self-concepts (Ollendick, 1983). It is important to try to establish the mechanisms which cause or affect fears so that we may teach children how to deal with them before they become excessive, unrealistic and debilitating. By doing this we may also be protecting vulnerable children against possible anxiety disorders in later life.

### ***References***

- Abe, K., Oda, N. & Hatta, H. (1984). Behavioural genetics of early childhood: Fears, restlessness, motion sickness and enuresis. *Acta Geneticae Medicae et Gemellologiae Twin Research*, 33 (2), 303-306.
- Bauer, D. (1976). An exploratory study of developmental changes in children's fears. *Journal of Child Psychology and Psychiatry*, 17, 69-74.
- Jersild, A. & Holmes, F. (1935). Children's fears. *Child Development Monograph*, 20.
- Jones, H. & Jones, M. (1928). Fear. *Childhood Education*, 5, 136-143.
- King, N., Hamilton, D. & Ollendick, T. H. (1988). Children's phobias: A behavioural perspective. Chichester: Wiley.
- Lahey, B. & Kazdin, A. (1988). *Advances in clinical child psychology*, Vol. 11. New York: Plenum.
- Lapouse, R. & Monk, M. (1959). Fears and worries in a representative sample of children. *Orthopsychiatry*, 29, 808-818.

- MacFarland, J., Allen, L. & Hoznik, M. (1954). A developmental study of the behaviour problems of normal children between 21 months and 14 years. University of California Press: Berkeley.
- Marks, I. (1987). Fears, phobias and rituals. Oxford: Oxford University Press.
- Miller, L., Barrett, C. & Hampe, E. (1974). Phobias of childhood in a prescientific era. In A. Davids (Ed), *Child Personality and Psychopathology: Current topics*. New York: Wiley.
- Miller, L., Barrett, C., Hampe, E. & Noble, H. (1973). Factor structure of childhood fears. *Journal of Consulting and Clinical Psychology*, 39, 264-268.
- Muris, P., Steerneman, P., Merckelbach, H. & Meesters, C. (1996). The role of parental fearfulness and modelling in children's fear. *Behaviour Research and Therapy*, 34 (3), 265-268.
- Murphy, M., Fitzgerald, M. & Kinsella, A. (1989). A study of emotions and behaviour in children attending a normal school in an urban area. *Irish Journal of Medical Science*, 77, 5: 129-130.
- Ollendick, T. (1979). Fear reduction techniques with children. In M. Hersen, R. M. Eisler & P. M. Miller (Eds), *Progress in Behaviour Modification*, Vol. 8, pp. 127-168. New York: Academic Press.
- Ollendick, T. (1983). Reliability and validity of the Revised Fear Survey Schedule for Children (FSSC-R). *Behaviour Research and Therapy*, 21, 685-692.
- Ollendick, T., Matson, J. & Helsel, W. (1985). Fears in children and adolescents: Normative data. *Behaviour Research and Therapy*, 23, 465-467.
- Ollendick, T., Yule W. & Ollier, K. (1991). Fears in British children and their relationship to manifest anxiety and depression. *Journal of Child Psychiatry and Psychology*, 32 (2), 321-331.
- Rosenbaum, J., Biederman, J., Gersten, M., Hirschfeld, D., Menninger, S., Herman, J., Kagan, J., Reznick, S. & Snidman, N. (1988). Behavioural inhibition in children of parents with panic disorder and agoraphobia. A controlled study. *Archives of General Psychiatry*, 45, 463-470.
- Rutter, M. & Rutter, M. (1993). *Developing Minds*. London: Penguin.
- Silverman, W., Cerny, J., Nelles, W. & Burke, A. (1988). Behaviour problems in children with anxiety disorders. *Journal of the American Academy of Child and Adolescent psychiatry*, 27, 779-784.
- Weissman, M. (1993). Family genetic studies of panic disorder. *Journal of Psychiatric Research*, 27, Suppl. 1, 69-78.
- Wheatley, D. (1993). The Wheatley Stress Profile, *Stress Medicine*, 9, 5-9.
- Zigmond & Snaith, (1983). Hospital Anxiety and Depression Scale, *Acta Psychiatrica Scandinavica*, 67, 361-370.

## CHAPTER TWENTY

### *THE SUITABILITY OF PSYCHOANALYTICAL PSYCHOTHERAPY FOR WOMEN LIVING IN A SOCIALLY DISADVANTAGED AREA*

*Gerry French, Michael Fitzgerald, Claire Collins.*

#### *Abstract*

#### *Introduction*

The purpose of this pilot study was to identify areas of stress to women from the lower socio-economic classes and to examine the suitability of these women to psychoanalytic psychotherapy.

#### *Method*

A representative sample of 53 women from a socially deprived background were studied. Three research tools were employed to obtain the required information: The Investigative Interview, The General Health Questionnaire, and The Social Problem Questionnaire.

#### *Results*

Fifteen percent of the subjects were considered to be suitable for psychoanalytic psychotherapy. There was a significant difference between those who were suitable for psychoanalytic psychotherapy and respondents who were not suitable with regard to social problems and general health scores. Contact with family and relations emerged as an important support factor.

#### *Conclusion*

Psychoanalytic psychotherapy may be useful to women from the lower socio-economic group living in socially deprived areas. The social support network in these communities is an important factor which must be integrated into any intervention system. In addition, it is important that therapists be adequately trained and equipped with the skills required to deal with individuals from such disadvantaged areas.

### ***Introduction***

Lorion and Felner<sup>1</sup> point out how Freud himself anticipated that responding to the reality of the lifestyles of the socially disadvantaged would demand a change in the way insight-oriented treatments are carried out.

One may reasonably expect that at some time or another the conscience of the community will awake and admonish it that the poor person has just as much right to help for his mind as he now has for the surgeon's means for saving his life . . . the task will then arise for us to adopt our techniques to the new conditions. I have no doubt that the validity of our psychological assumptions will impress the uneducated too, that we shall need to find the simplest and most natural expressions for our theoretical doctrines.<sup>1</sup>

Studies conducted mainly in the United States, among them Reissman<sup>2</sup>, have shown that psychotherapy in clients from lower socio-economic groups need to be less reliant on introspection and more reliant on "motoric activities".

Goldfarb<sup>3</sup> favoured procedures which make problems more immediate and concrete and therefore more involving for the person from a deprived environment. He also recommended the use of play and family therapy. A paper written by Gurin et al.<sup>4</sup> concurs, asserting that with blue-collar and lower socio-economic groups it is more practical to set direct and immediate treatment goals rather than gear treatment towards a long range personality reorganisation.

Lorion<sup>5</sup> warns that researchers must not ignore traditional approaches and suggests that they should take care not to alter primary therapeutic strategies while attempting to modify strategies to better fit the lower socio-economic groups.

On the whole, research in the field of mental health and the lower social classes has largely been neglected. Lorion and Felner<sup>1</sup> considered the decreased level of attention and effort being focussed on the mental health needs of this group during the past decade to be distressing.

The purpose of this pilot study was to assess the suitability of women living in a socially disadvantaged area in Dublin or psychoanalytic psychotherapy and to identify the factors which contribute to stress among these women.

### ***Methods***

Fifty three women from a socially deprived background were studied. The sample consisted of all women who attended the local community centre for any reason within a given

specified week. There was no reason to suggest that those who attended the community centre during the particular week chosen to conduct the interviews were in any way different than the usual clientele. The respondents lived in what is referred to as a “high rise” housing estate with 88% unemployed, 95% rented accommodation and 90% of inhabitants possessing no formal education beyond the age of 15 years.

The area from which the sample was chosen was designed to attract inner-city residents and to be a “new and closely integrated community enjoying from the beginning all the facilities of a new small town”. However, twenty years on it was described in this way:

The casual visitor to the area is immediately struck by the level of physical deprivation, especially around the flat complexes. Lifts out of order, poor lighting on stairways, vandalised flats without doors or window, litter especially around the basement – chutes, graffiti, etc. What strikes the casual visitor is a day-to-day reality for residents. The general physical malaise increases the sense, within the people of this area, that somewhere there is a lack of pride and interest in their community.<sup>6</sup>

Three research tools were employed to obtain information: The Investigative Interview; The General Health Questionnaire (GHQ), and The Social Problem Questionnaire (SPQ). The interviewer was trained and advised on the administration of the questionnaires.

### ***The Investigative Interview***

This uses a semi-structured questionnaire to assess suitability for psychotherapy of a psychoanalytic nature. The criteria include the ability (1) to uphold a positive therapeutic alliance; (2) to work through the terminal phase; (3) to distinguish internal and external reality; (4) to tolerate depression and anxiety, and (5) to discard false for realistic ideals.<sup>7</sup>

### ***The General Health Questionnaire (GHQ)***<sup>8</sup>

This was designed as a self-administered screening test aimed at detecting psychiatric disorders among respondents in community settings. It contains sixty-four questions which cover felt-psychological disturbance, unhappiness, social inadequacy and lack of identity. It is easy to administer, acceptable to respondents and takes approximately ten to twelve minutes to complete.

### ***The Social Problem Questionnaire (SPQ)***<sup>9</sup>

This is a short, self-administered questionnaire identifying social problems, difficulties and dissatisfactions. It covers housing, occupation, finance, social and leisure activities, child/parent and marital relationships together with relationships with friends, neighbours and workmates.

## ***Results***

In total 53 women were interviewed of whom 10 were in their twenties, 24 in their thirties, 13 in their forties, and 2 in their fifties. The age of four of the interviewees was unknown.

The majority of the respondents were either married or co-habiting, 7 were single, 1 was widowed, 8 were separated, and 1 was legally divorced.

The data obtained from the SPQ showed that a large percentage of those surveyed had social problems. The areas in which difficulties were most commonly experienced were: finance, relations, social contacts, housing, and children (Table 1). The problems reported were unrelated to the age or marital status of the respondents.

The data comparing respondents' GHQ scores with the problem areas identified on the SPQ revealed that more interviewees with negative health on the GHQ tended to report social problems (Table 1).

Although a higher percentage of those with a negative GHQ reported having difficulty in most areas, this was significant for housing problems alone.

Again, the age or marital status of the respondents did not appear to have an affect on the relationship between GHQ scores and reported social problems.

**Table 1: General Health and Social Problems**

<b>Problem</b>	<b>Overall %</b>	<b>Pos GHQ (&lt;5) %</b>	<b>Neg GHQ (&gt;5) %</b>
Financial	94.3	89.7	100
Relations	66.0	58.6	75
Social Contacts	58.5	55.2	63
Housing	49.0	31.0	71*
Children	45.3	37.9	54
Work	34.0	24.1	46
Other Domestic	30.2	31.0	29
Other	19.6	20.7	13
Marital	15.1	7.0	25.0
Legal	7.7	6.9	8.3
Living Alone	3.8	3.5	4.2

\* P value < 0.05

The average scores on the GHQ scale with the problem areas mentioned by respondents. Those experiencing social difficulties uniformly scored worse on the GHQ, however, the areas of housing and finance alone showed a significant correlation with GHQ score.

The data from the investigative interview found that 12 out of the 53 interviewees were suitable for some form of psychotherapy. Of these 12, 8 were suitable for formal

psychotherapy. Age and marital status were not significant factors in the determination of suitability for psychotherapy.

Tables 2 and 3 compared the GHQ levels of respondents considered to be suitable and unsuitable for psychotherapy. There was a significant difference on GHQ score between the groups. Those who were considered suitable for formal psychotherapy had a considerably higher mean rank score than those unsuitable or not in need of psychotherapy.

Almost two thirds of those considered suitable for formal psychotherapy were considered to have negative health compared to one half of those not in need of formal therapy and 41% of those not suitable for therapy. Thus, there appears to be a relationship between measured health status using the GHQ with psychotherapy classification although this does not reach the level of significance.

**Table 2: Suitability for Psychotherapy and GHQ Score (N = 53)**

	<b>n</b>	<b>Median Rank</b>
Suitable for Psychotherapy	8	40.06
Not suitable for formal Psychotherapy	4	24.00
Not in need of Psychotherapy	41	24.74
		P = 0.033

**Table 3: Suitability for Psychotherapy by GHQ Status (N = 53)**

	<b>Yes</b> %	<b>Not Formal</b> %	<b>No Therapy</b> %
Positive Health (<5)	37	50	58
Negative Health (>5)	63	50	42
			P = 0.539

### **Discussion**

A theme running through all the interviews was the high level of dependency and a sense of alienation of the interviewees. We noted the extraordinary efforts that were made by these women to stay in contact with their mothers. We feel that this may be a “reaching out” for the type of community they experienced in the close and warm Dublin inner city, an area they lived in before being moved out to this new estate. It also struck us that this is similar to the supportive environment necessary for psychoanalytic psychotherapy. This is really an extension of Fitzgerald’s idea of the necessity of a “co-therapist” for successful psychotherapy.<sup>10</sup> The high percentage experiencing problems with housing and finance is understandable when empirical reports on the poverty in Ireland are taken into consideration.

It is not a surprise that community, church and charity groupings have led a “fight back” against alienation by putting in place many support systems. The present existence of fifty organisations providing support groups, social welfare and leisure resources gives testimony to this. However, that support alone, will not be sufficient to unravel neurotic problems. The psychotherapeutic approach is probably also needed for those problems.<sup>11</sup>

In the Irish context certain factors need to be investigated if drop out from therapy is to be avoided. Clearly lower social class patients suffer from psychological stress similar to other socio-economic groups. The major difference is the increased stress which disadvantaged groups live under and the reduced resources they have as compared with those in more advantaged groups. It is unfortunate that psychotherapy is much less available to disadvantaged groups. It seems likely that not only are they under more stress but less formal psychotherapeutic resources are directed toward assisting them. Some people express what can only be described as a myth – that because people are disadvantaged they cannot benefit from formal psychotherapy. This would seem to be prejudicial.

Another factor which needs to be considered is the training and experience of the psychotherapist working with lower socio-economic patients. The language used in the interaction with these people must be appropriate to them. It is also likely that since the majority of psychotherapists are middle-class this factor must be acknowledged and taken into account. There is evidence that lower socio-economic group clients are less likely than those in the upper and middle class groups to be accepted for treatment, to be assigned to intensive psychotherapy, and that they are more likely to drop out of the therapy at an early stage. However, there does not seem to be much evidence of differences in outcome for those who remain in treatment. Parloff et al.<sup>12</sup>, go on to state that the literature has focussed on middle class values and biases of many mental health professionals. They point out that many middle class therapists prefer to work with patients like themselves who share their values and speak their language, with whom they’re comfortable and feel they can communicate, and whom they regard as “good candidates” for psychotherapy.

In this study the interviewer became increasingly aware of language and value differences. For instance, interviewees tended to use a narrative rather than a question and answer style of response.

The interviewer also noticed that the interviewees’ tendency to physically move around during interviews did not indicate resistance – sitting down in a chair was not necessarily the most comfortable position for the interviewees. Research suggests that there is a need to train therapists to use more flexible, active styles with lower socio-economic patients.<sup>13</sup> The interviewer also had to “learn” phraseology and idioms commonly used among residents of Dublin based estates.

Kandel<sup>14</sup> studied the issue of therapist and patient social class in a psychiatric setting and found that when the psychiatric resident could choose whether or not to include a patient in psychotherapy, those of lower socio-economic origins saw approximately equal proportions of each class of patients. Therapists of higher social class origins tended to include more patients of their own class.

The findings of this pilot study suggest that more research needs to be done on the relationship between a psychotherapist’s experience and drop out rate in lower socio-economic clients. Research already suggests that the more experienced psychotherapist is able to be more flexible and to use a broad spectrum of therapeutic approaches.<sup>15</sup> It has also

been suggested that there is a need to train therapists to use more flexible active styles with lower class patients.

A recent outcome study by Fitzgerald, Moukaddem, and Barry (1994)<sup>16</sup> showed the eclectic psychotherapeutic approaches used in a Child and Family Centre did reduce stress as measured by GHQ in mothers of disturbed children in a disadvantaged area.

Results from this investigation suggest a need for further study of psychotherapy in women of lower socio-economic status. It appears that churches and charities have addressed the harmful effects of economic and social deprivation in this distressed area. This is supported by the existence of fifty voluntary organisations providing support groups, social welfare and leisure resources. However, the support offered by these organisations needs to be combined with the study of therapeutic work to see if it is possible to empower women in this instance to move from a position of dependency to inter-dependency and independence and so lessen the passivity, hopelessness and fatalism brought about by the daily hassles and other social and economic deprivations which these women experience daily. The purpose of such a therapy investigation would be to help women develop autonomy, assertiveness and an internal locus of control.

### **References**

- (1) Lorion R. P., and Felner R. D. "Cognition and Learning in Traditional and Behavioural Therapy", in Sol L., Garfield and Allen E. B., *Handbook of Psychotherapy and Behaviour Change*. New York: John Wiley and Sons, 1986; 739-775.
- (2) Reissman F. *New Approaches to Mental Health: Treatment for Labour and Low Income Groups*, Report No. 2. New York: National Institute of Labour Education 1964; 4: 112-117.
- (3) Goldfarb J. *Role-Playing and the Poor*. New York: Mobilisation for Youth 1963; 4.
- (4) Gurin et al. *Americans View Their Mental Health*. New York: Basic Books, 1960.
- (5) Lorion R. P. "Socio-economic status and traditional treatment approached reconsidered". *Psychological Bulletin* 1973; 79: 263-270.
- (6) Muldowney and Mulhall. *A Block of Flats* 1975, Dublin Corporation, Dublin.
- (7) Fitzgerald M. "Assessment of a Patient for Psychotherapy". *Journal of Irish Forum for Psychoanalytic Psychotherapy* 1987; 1: 29-35.
- (8) Goldberg D. R. *Manual of the General Health Questionnaire*, Windsor: NFER. 1978.
- (9) Corney R., Clare A., and Fry J. The Development of Self Report Questionnaire to Identify Social Problems. *Psychological Medicine* 1982; 12: 903-909.
- (10) Fitzgerald M. "The Technique of Psychoanalytic Psychotherapy", *Journal of Irish Forum for Psychoanalytic Psychotherapy* 19.

- (11) Garfield S., and Bergin A. *Handbook of Psychotherapy and Behaviour Change: An Empirical Analysis*, Third Edition, Wiley; Chichester, 1986.
- (12) Parloff M., Waskow I., and Wolfe B. "Research on Therapist Variables in Relation to Process and Outcome", in Garfield S. and Bergin A. *Handbook of Psychotherapy and Behaviour Change*, Wiley: Chichester, 1978.
- (13) Howar K., Rickels K., Mock J., Lipman R., Kovey L., and Bauman N. "Therapeutic style and attrition rate for psychiatric drug treatment", *Journal of Nervous and Mental Diseases* 1970; 150: 102-110.
- (14) Kandel D. B. "Status Homophily, Social Context and Participation in Psychotherapy", *American Journal of Sociology*, 1966; 71: 640-650.
- (15) Baum O. E., Felzer S. B., D'zmura T. L., and Schumaker E. "Psychotherapy, drop outs and lower socio-economic patients". *American Journal of Orthopsychiatry*, 1966; 35: 629-635.
- (16) Fitzgerald M., Moukaddem S., and Barry M. *An Outcome Study of the Effectiveness of Intervention with Mothers and Children in a Child and Family Centre*, P.S.I. Annual Conference, Sligo, 1993.

## CHAPTER TWENTY ONE

### *CONNECTIONS – FAMILY THERAPY IN THE WEST*

*Clare Gormley.*

In first reflecting on this presentation I wanted to convey something of the unique culture of the West of Ireland, so I decided to illustrate my talk with images of the landscape and the people. Curiously, I discovered that twenty-five years ago when the then recently appointed clinical director of the Western Health Board's Child and Adolescent Psychiatry Service – Dr. Anthony Carroll, was establishing connections with general practitioners in the region, he had utilised Bord Failte slides of the same landscape. This was at a time however when the words 'children' and 'psychiatry' were rarely uttered in the same sentence.

The Western Health Board Child and Adolescent Psychiatry Service (WHBCAPS) has progressed since it's inception and is now served by more than ninety staff employed in three multidisciplinary teams and St. Anne's Children's Centre with in-patient and school facilities. Currently three further multidisciplinary teams are planned for Co. Roscommon, Co. Mayo and South Connemara.

The focus of intervention at St. Anne's Children's Centre was initially that of 'milieu therapy' whereby emphasis was placed on the environment to provide security for the child. Equally important within this framework were *all* staff members with whom the child had contact, including cooks, porters, administration staff, nurses, child-care workers and teachers. For anyone who has worked at St. Anne's the importance of ritual is also evident, from daily routines to seasonal celebrations/ sports-days and splendid Christmas festivities.

The central functions of St. Anne's have been complemented with full multidisciplinary support: occupational therapy, speech and language therapy, play therapy, psychology and psychiatry.

Dr. Carroll's initiative has also ensured that the WHBCAPS has provided a key educational role connected with National University of Ireland, Galway School of Medicine and national training programmes in psychiatry, psychology and other disciplines. The Association for Child Psychology and Psychiatry has similarly benefited from Dr. Carroll's energy in his organisation and hosting of their annual conferences in Galway.

These developments are all set against the changing culture and demographics within the region. In 1975 Galway was a distinctly rural market town. The Western Health Board population could, at that time, be divided into five community groupings, with certain differences in cultures and traditions:

1. Connemara / Gaeltacht / Coastal.
2. Inland rural.
3. Traveller.
4. Native city.
5. "Blow-ins" i.e. those from other parts of Ireland / Europe.

Today, Galway has changed to a truly cosmopolitan city (for some years it held the title of the fastest growing city in Europe). There has been increasing immigration from Europe and America, together with new communities of refugees and asylum seekers. These changes shift from the relative homogeneity of the past and, while enriching, bring challenges of adaptation for communities and the services which support them.

Added to these demographic changes, the past quarter of a century has witnessed the emergence of hitherto taboo issues that have impacted on the focus of service provision. Following acknowledgement of the realities of domestic violence, child sexual abuse has moved from a position of being viewed as a rare occurrence to the current awareness that it is all too prevalent.

In 1997 Ireland legalised divorce, which reflected the changing trends towards marriage and separation. Over the past years our service has perceived an increase in families referred in relation to separation issues. These families recognise the potential impact for children of separation and seek support with this transition. My prediction would be that the next phase could see a need to focus on the challenges for 'blended' families.

### ***Development of the Western Health Board Family Therapy Service***

Dr. Carroll commenced his new post with a clear position; "We are all family therapists". His deep interest in the field of family therapy led to a culture within the service of exploration of this relatively new way of working with clients. Fanchea Flood, Noelle O'Hanlon, Mick Mulally, Mike Grieve, Bridget O'Leary and Karin Grieve were all instrumental in developing the family therapy focus at St. Anne's and the outpatient service at Lyradoon Family Centre.

For those of us who came later there was a sense of having missed out on this formative era. Within family therapy internationally there is a concept of 'Milan' and 'Post-Milan'. For us the distinction is between 'Inishboffin' and 'Post-Inishboffin'. Apparently Dr. Carroll and staff were so willing to immerse themselves in exploring family and group dynamics that

they took off for an intensive week to Inishboffin with two facilitators from Sweden. Mary Banotti (M.E.P.) who was also a social worker at that time recounted at a recent conference how the experience of adventure on Inishboffin has remained significant for her. Those of us in the 'Post-Inishboffin' camp still wonder, "What happened at Inishboffin?" but are resigned to let the answers remain in service mythology.

In 1995 the Western Health Board Family Therapy Service (WHBFTS) was formally launched with the appointment of a Senior Social Worker (Lorraine O'Gorman) and Senior Psychologist (Clare Gormley) in Family Therapy. Together with Alan Delahunty (Senior Psychologist, part-time) we provide a service for the three counties of WHB under the auspices of CAPS.

Given the dilemmas of equity and accessibility across three counties with such a small team we have focused our direct client work primarily from Galway at Lyradoon Family Centre. Outreach to the counties is expected to improve with three new posts within the new Child Guidance Teams. In the interim we provide a consultation service to W.H.B. Child Guidance and Community Care staff throughout the region. Consultations have recently been enhanced by video-conferencing facilities.

We also connect with professionals who have an interest in sharing and developing systemic ideas through monthly 'Family Therapy Forums' held in each county. Currently we have a mailing list of approximately 150 professionals from both statutory and voluntary sectors. The format for the forums has proved successful since 1996 with a wide variety of presentations and workshops provided by the facilitators and group members. Topics have included, for example: 'What works in Therapy- Scott Millar's research'; 'Narrative Therapy and 'Solution-Focused Brief Therapy, video workshop'.

In addition to the monthly Forums we organise a monthly Family Therapy Development Group that is open to those professionals specifically practising family therapy. The group is a forum for reflection on practice and stretching of family therapy ideas.

Part of our remit also includes training. We provide a range of options ranging from one-off lectures to medical students and other staff to a one-year programme of academic and clinical practice focusing on systemic methods for Senior Registrars and C.A.P.S. staff.

To date over 400 families (1,000 individuals) have been referred to WHBFTS. Primary reasons for referral are: child behaviour difficulties; 'out of control' teenagers; marital/separation issues and violence (including domestic violence). While our primary service entails family/individual appointments, Dr. Carroll's policy of 'opportunistic service development' has enabled us to develop according to our interests / experience e.g. 'Parents Plus' groups; programmes for adolescents who have sexually abused and anger management programmes.

## Influence of Dr. Carroll

Over the years the international field of family therapy has been a dynamic rollercoaster of changing ideas and schools. In reflecting on Dr. Carroll's guidance and observing his positioning with families when co-working with him, I can trace both his breadth and depth of knowledge in this field. An early piece of his paradoxical/strategic advice to us was: "If families leave saying you're no help and they can sort it out now themselves, you've done a great job!" He promoted Reflecting Team processes and often indicated that he wished he

could join the team more often. Dr. Carroll's intuitive, personal fascination with literature and culture pre-dated the subsequent developments of Narrative and Social Constructionist thinking.

For me the key meaning of working with Dr. Carroll has been the sense of a 'secure base'. His position in relation to his team was one of fostering collegial relationships. His sense of clear boundaries effectively 'buffered' staff from bureaucracy and allowed us freedom to take risks. His clarity in relation to boundaries facilitated our analysis of referrals, as he would ask "What is the question? Who is the client? Have we a role?" Dr. Carroll utilised neutrality to manage the boundary between Clinical Director and staff, yet, in times of personal crisis/loss, he would reach out personally, indicating his support. His capacity for dialogic discussion created a respect for differing perspectives (the 'multiverse') and openness to new ideas. Truly, Dr. Carroll never 'married his hypothesis' and this was evidenced not just in relation to family therapy but also in his capacity to move seamlessly between therapeutic approaches.

## Changing Connections

Some years ago Dr. Carroll indicated that he would retire when St. Anne's centre moved to the planned purpose-built centre at Merlin Park or when there were one hundred members of staff. In life, we don't control our 'exits and our entrances'- there is possibly never a 'right' time. Dr. Carroll's retirement now brings our service into an 'organizational life-cycle' transition. What stage is this- individuation, launching or 'empty nest'?

Within the service, staff have been reflecting on how they have perceived Dr. Carroll. The metaphor of "Father" has been suggested to him, to which he replies that he has always tried to avoid this. Another description has been that of 'Captain', -this has led to the comment that, in the current climate of cutbacks, he has taken the right moment to hop into a lifeboat!

The metaphor of 'Gardener' appeals to me, as I know Dr. Carroll is an enthusiastic gardener. In planting the landscape of our service I believe he has not tried to create a formal garden, but rather one that blends with nature and follows it's own unpredictable course.

Perhaps now is an opportune time to retire, in the season of autumn - a time to relax, to hibernate before spring. As a service we have received many postcards from Dr. Carroll from abroad that reveal his humour and, indeed, his poetry. Perhaps spring will herald the emergence of a new and creative connection – Dr. A.G. Carroll, author and poet?

Clare Gormley, Senior Clinical Psychologist in Family Therapy.

### *Postcard from Tony: New Orleans, May 2001.*

Saturday Evening  
sitting by the Mississippi,  
Listening to the Jazz  
wafting down from the French Quarter,  
As the paddleboats crawl  
to the Gulf of Mexico.

Cajun food  
in a Creole restaurant.

Somehow it's hard to keep the focus  
on O.C.D. and C.B.T.,  
as I wonder if my distractibility  
is due to A.D.H.D.

*(Anthony G. Carroll.)*

## CHAPTER TWENTY TWO

### *GENIUS, CREATIVITY AND SAVANTISM*

*Michael Fitzgerald.*

Persons with High Functioning Autism or Asperger's syndrome can show considerable creativity. Indeed they have the capacity for extreme creativity in a small number of cases. Evidence of minor creativity would be more common. The features of autism / Asperger's syndrome that would enhance creativity would include intense focus on narrow interests. It is rarely possible to make major advances in science without this narrow intense focus. The lack of interest in emotional issues means that there is far more time available for intellectual mathematical, philosophical, and other scientific pursuits. Their time is not taken up with interpersonal relationships and with ordinary everyday life. They are often workaholics and their whole life is devoted to their creative pursuit. Persons with autism often have abnormal brain functioning and indeed brain structure and these deficits in some way enhance creativity. This kind of creativity has genetic underpinning of a type that has not yet been fully elucidated. Heritability factors account for about 93% of the variants in the aetiology of autism / Asperger's syndrome. The following are some examples of this creativity.

*Henry Cavendish*

Henry Cavendish (1731 – 1810) had High Functioning Autism / Asperger's syndrome. He was an enormously successful scientist. He had enormous difficulties in interpersonal relationships. He was a man of enormous routines and regularities in his conduct of his life. He was very poor at speech making. Nevertheless he could be very precise in his use of language. He lacked empathy in interpersonal relationships and Berry notes Cavendish's "striking deficiencies as a human being". Indeed "his habitual profound withdrawal lead one contemporary to characterise him as 'the coldest and most indifferent of mortals'". He had an awkward gait and there is absolutely no doubt that like Newton and Einstein he had High Functioning Autism / Asperger's syndrome.

### ***Charles Babbage***

Charles Babbage (1792 – 1871) also had High Functioning Autism / Asperger's syndrome. He was the father of the modern computer. He was an autodidact. He spent a great deal of his life trying to build calculating machines. The first one was called a 'difference engine' and the second an 'analytical engine'. According to Swade Babbage's engine 'gave new impetus to the notion of a "thinking machine" and stimulated the debate about the relationship between the mind and physical mechanism'. He had major problems in interpersonal relationships. He worked largely in isolation. He had a socially immature personality not uncommon in persons with High Functioning Autism / Asperger's syndrome. He suffered from anxiety and depression. He was an excellent mathematician. He was described as an eccentric and comic figure. He was naïve and showed a lack of commonsense.

### ***Archimedes***

Archimedes (C 287 – 212 BC) also had High Functioning Autism / Asperger's syndrome. He was an extremely eccentric individual spending as much of his life isolated in solitary. He had a good mechanical mind. He invented what is called the Archimedes screw for pumping water which is still used to this day. He was highly regarded as an engineer and inventor. He only liked to talk to mathematicians. He was the discoverer of what is called the Archimedes principal i.e. that the floating body will displace its own weight in fluid. He was an obsessive mathematician. He neglected his personal hygiene. Like Newton he left his meals untouched when he was deep in mathematics.

### ***Norbert Wiener***

Norbert Wiener (1894 – 1964) was another mathematician with High Functioning Autism / Asperger's syndrome. He was an autodidact, a linguist, and a rather absent minded professor. He was a socially immature child. He lacked empathy and was tactless with people. He was rather a lone wolf and was uncertain about how to conduct conversations. He was a very poor teacher. He was very routine bound. He was a rather clumsy child which is not uncommon with HFA / ASP and indeed like many others he suffered from anxiety and depression. He was described as being very eccentric.

### ***Nikola Tesla***

Nikola Tesla was a famous electrical inventor who had High Functioning Autism / Asperger's syndrome. He had a photographic memory. He was a linguist. He was an avid

reader. He had an obsessive compulsive personality type. He was an autodidact. He had major difficulties in social relationships, was socially immature and naïve. He was extremely controlling and spoke with a high pitched voice. He was extremely naïve in dealing with people who would finance his inventions. He was very much a loner and remained unmarried and was extremely interested in pigeons. He had no capacity to manage money. His main interest was in inventions. He was the inventor of radio among many other things.

### ***David Hilbert***

The mathematician David Hilbert (1862 – 1943) had High Functioning Autism / Asperger's syndrome. He was a great mathematician. He showed eccentric interpersonal behaviour and was socially immature. His only interest was in discussing mathematical subjects. He showed extreme self control. Routines were extremely important to him. He tended to show repetitive language. Nevertheless he was very precise in his use of words. He showed lack of empathy. He believed no scientist should marry. He suffered from anxiety and depression.

### ***G. H. Hardy***

The great English mathematician G. H. Hardy had High Functioning Autism / Asperger's syndrome. He was a very eccentric man who never married. Routine was extremely important to him. His great interest in life was mathematics. He loved cats. He was extremely honest in his behaviour. Later he suffered from depression and attempted suicide. Attempting suicide is not uncommon in persons with High Functioning Autism / Asperger's syndrome.

### ***Dimitri Mendeleev***

Dimitri Mendeleev who developed the periodic table in chemistry had High Functioning Autism / Asperger's syndrome. He had major difficulties in interpersonal relationships. He was most eccentric looking. He cut his hair once a year. He had tremendous focus on chemistry and on chemical elements and it was this intense focus that brought him success. Like so many successful people with HFA / ASP he performed poorly in school.

### ***William James Sidis***

William James Sidis the great mathematician had High Functioning Autism / Asperger's syndrome. He was born in 1898 and said his first word at 6 months of age. He was into complex mathematics at the age of 11. He was a child prodigy. When he worked in a different time zone in America he kept his watch on Eastern Time. He was relentlessly teased and humiliated by peers. He was completely unathletic. He wrote books even as a child. He was socially naïve and had huge difficulties in emotional relationships. He was extremely intelligent and extremely hard working. He was able to create imaginary worlds. He had no sense of any social nuances or social graces. Like many people with High Functioning Autism / Asperger's syndrome when he was eating he would eat vegetables first, then potatoes, and then meat etc. He had an enormous mathematical capacity. He was socially and physically awkward. He was supposed to have one of the highest IQ's in America. He was ostracised in the press for being a genius. He died in 1944 from a cerebral

haemorrhage. He had an extraordinary painful tortured life. This was because he couldn't make his way in the social world.

### ***Kurt Godel***

Kurt Godel the famous mathematician had High Functioning Autism / Asperger's syndrome. He was famous for his incompleteness paper. He was extremely eccentric and a loner with major problems in interpersonal relationships. He was a linguist. He was an autodidact. He was an exceptionally good chess player. He had major dietary problems. He suffered from anxiety and depression. He engaged in very little conversations that hadn't to do with mathematics. He was socially immature, very naïve, and had poor relationships with people. He was a hoarder.

### ***Glen Gould***

Glen Gould the famous pianist had High Functioning Autism / Asperger's syndrome. He was most unhappy at school which is typical for persons with High Functioning Autism / Asperger's syndrome. He had absolute pitch and musical ability was evident from about the age of three. He had huge problems in social relationships and was very much a loner. He was extremely controlling and showed lack of empathy. He was happiest on the telephone. He had a most eccentric playing style but produced brilliant sound. He was rather hypochondriacal about his body. He had to have complete control. He was fascinated with musical technology. He was obsessed with music. He had a rather musical / mechanical mind. He was extremely eccentric.

### ***References***

- Berry A. J. (1960). Henry Cavendish: His life and scientific work, London: Hutchinson.
- Shapin S. (1991). A scholar and a gentleman: The problematic identity of the scientific practitioner in early modern England. *History of Science*, 29, 290 – 292.
- Doron S. (2000). The cogwheel brain: Charles Babbage and the Quest to build the First Computer. London: Little Brown and Company.

## CHAPTER TWENTY THREE

CHILD PSYCHIATRY 2003

*Michael Fitzgerald.*

*Child psychiatry has now “come of age”. It has come from a position of non-existence as a speciality in its own right in the early 1900’s to a state of full recognition in the western world in the year 2002. Before the development of the speciality of Child Psychiatry children with psychiatric problems were dealt with in a rather limited way by adult psychiatrists (neuropsychiatrists) and paediatricians.*

### *Early Developments and Psychoanalysis*

Clearly the development of child psychiatry in the United Kingdom was started by the need to intervene with delinquents. The early model focussed on the social worker counselling the mother and the medical doctor intervening with the child using play therapy which was formalised by Hermine Hug Helmuth, Anna Freud and Melanie Klein into child psychotherapy. The early background was largely influenced by psychoanalysis which was

the dominant paradigm until the 1970's. Family therapy then became the dominant paradigm and child psychotherapy experienced a decline in interest. Nevertheless child psychotherapy has a more significant role to play than currently appreciated. There have been some encouraging developments in the area with the development of an MSc. in child psychotherapy at Trinity College Dublin.

### *Effectiveness of Child Psychotherapy and Psychiatry*

There is absolutely no doubt that child psychotherapy should play a larger role in child psychiatry than it does at present as there is evidence to its effectiveness (Fitzgerald, 1998; Corvin and Fitzgerald, 2000). A landmark study of child psychoanalysis of 763 cases showed that "child psychoanalysis to be particularly effective where seriously disturbed children under 12 years suffering from a variety of psychiatric disorders, particularly those which involve anxiety" (Fonagy and Target, 1996). Child psychotherapy is effective with a 68 – 78% improvement rate compared with a 25% spontaneous improvement rate. There is evidence that intensive treatment (Heinicke and Ramsey Klee, 1986) is associated with better outcome. Children with disruptive disorders treated for three years or more had as good an outcome as those with emotional disorders. While a number of meta-analytic studies (Weisz and Weiss, 1993) have shown a greater effect size for behavioural than non-behavioural treatment, Shirk and Russell (1992) have shown convincingly that it erroneous for the wider community to be under the impression that psychodynamic psychotherapy has been shown to be less effective than the newer treatments. Effect sizes are similar for child and adult psychotherapy. It is important to realise the limitations of meta-analytic studies including problems with confounding variables and unrepresentativeness of many studies.

In a "real-life" child psychiatric outpatient study where eclectic treatments were administered significant improvements in both children and parents were shown at three months follow-up (Moukaddem, Fitzgerald et al., 1998). A most disturbing feature was found at one year follow-up (Leeson, Fitzgerald et al., 1999) in that all the positive benefits were lost. There is an urgent need for replication. If it was replicated more than once it would suggest that the current eclectic mixture of interventions requires modification. A possible change would be to long term interventions with a move to a more chronic model of care. At the very least it suggests the need to consider planned booster interventions in children and adolescents referred to child psychiatric outpatients. Indeed if long term benefit outcomes are to be maintained these booster interventions might include child psychotherapy, family therapy, psychopharmacological interventions and other appropriate interventions.

### *Neurochild psychiatry*

There is little doubt that in the early part of the 21<sup>st</sup> century the biggest change in child psychiatry will be a move to increased biological especially genetic understanding in child psychiatry (Daly et al., 1999). Unfortunately in the near future child psychiatry outpatient clinics are going to resemble current adult psychiatric clinics where children will visit to have their medication reviewed having been diagnosed with ADHD, depression etc.. The medications they will be on will include Ritalin, Dexamphetamine, Clonidine, Tofranil, etc.. Indeed current research in child psychiatry very much mirrors adult psychiatric research. Child psychiatric problems will come to become conceptualised largely in biological terms even though it is likely that only 30% of the variance in relation to the aetiology of child psychopathological problems will be explained by biological factors. In the ideal world it is possible that the causes of child psychiatric problems will be one third biological, one third

individual and family, and one third wider social factors. This would lead to multimodal interventions and less “doctrinaire” child psychiatry of any form. Surprisingly, just now, biological treatments are under utilised e.g. Ritalin plus Clonidine for ADHD and Conduct Disorder. It is possible that if some of these interventions were applied the risk for later delinquency in adolescents with ADHD might be reduced. Of course some of these medications are off label e.g. Clonidine. A balanced approach is always very difficult to achieve in any form of psychiatry and child psychiatry is no exception.

### ***The Child Psychiatrist as Diagnostician: A New Identity***

A major role for the child psychiatrist in the 21<sup>st</sup> century will be as a diagnostician of the various behavioural phenotypes for example Autism Spectrum Disorders etc.. In the past many of these children were diagnosed as having emotional disorders with catastrophic consequences for the children themselves and their families. The heritability of autism is estimated at about 92%. Autism was blamed on so called “refrigerator mothers”. This is probably the greatest catastrophe in child psychiatry in the 20<sup>th</sup> century. Tragically child psychiatry misinterpreted John Bowlby’s research on attachment and also got into a “blaming mode” i.e. blaming mothers for many child psychiatric problems. Of course this has now ceased in relation to autism but is still in existence in relation to Attention Deficit Hyperactivity Disorder where there is also evidence of major heritability. The early 21<sup>st</sup> century child psychiatrist will be judged by their ability to diagnose autism, Asperger’s disorder, Rett’s syndrome, fragile X syndrome, Attention Deficit Hyperactivity Disorder, childhood disintegrative disorder, etc..

Clearly child psychiatrists have recovered their role and their identity which was almost completely lost during the “Family Therapy” era. The medical child psychiatrist is very much in demand at present. The public have recognised their value particularly in relation to the behavioural phenotypes. With the increase in depression, (Fitzgerald, 1994) attempted suicide (O’Sullivan et al., 1998) since the 2<sup>nd</sup> World War the need for child psychiatrists was never greater. One study of 2,000 ten year olds found that 16% had either emotional, conduct or a mixture of both problems (Fitzgerald, 1991). These huge numbers provide a great challenge to child psychiatrists.

### ***The Need for Balance***

In the 21<sup>st</sup> century the greatest challenge facing the child psychiatrist will be how to balance biological, individual and social factors. This balance was not achieved in the 20<sup>th</sup> century but the knowledge based in the 21<sup>st</sup> century will be greater and it should be possible to balance various etiological factors more satisfactorily than in the 20<sup>th</sup> century with the development of more focussed treatments. Child psychiatrists are likely to come under increased pressure to more rapid diagnostic assessments with the development of clear treatment objectives of a structured nature with an emphasis on briefer interventions of a pharmacological or psychotherapeutic nature (Jongsma, Peterson and McInnis, 1996). Evidence based child psychiatry will be of critical importance (Corvin and Fitzgerald, 2000). Structured protocols for diagnosis and intervention as are now being developed with Attention Deficit Hyperactivity Disorder are likely to become the norm. Unfortunately the need of many children and families won’t fit into these rigid protocols. These negative effects of the structured protocols will have to be addressed in due course. The opinion of the experienced clinician will have to remain of paramount importance.

## References

- (1) Corvin A., Fitzgerald M. (2000). Evidence based medicine: Psychoanalysis and psychotherapy. *Psychoanalytic Psychotherapy*, 1, 2, 143 – 151.
- (2) Daly G., Hawi Z., Fitzgerald M., Gill M. (1999). Mapping susceptibility loci in Attention Deficit Hyperactivity Disorder: Preferential transmission of parental alleles at DAT1, DBH, and DRD5 to affected children. *Molecular Psychiatry*, 4, 192 – 196.
- (3) **Fitzgerald M. (1998). *Child psychoanalytic psychotherapy. Advances in Psychiatric Treatment*, 4, 18 – 24.**
- (4) Fitzgerald M., Jeffers A., Kinsella A. (1994). A follow-up study of depressive illness in childhood. *British Journal of Clinical and Social Psychiatry*, 9, 12 – 15.
- (5) Fonagy P., Target M. (1994). Predictors of outcome in child psychoanalysis: A retrospective of 763 cases at the Anna Freud Centre. *Journal of the American Psychoanalytic Association*, 44, 27 – 78.
- (6) Heinicke C. M., Ramsey Klee D. M. (1986). Outcome of child psychotherapy as a function of frequency of sessions. *Journal of the American Academy of Child Psychiatry*, 25, 247 – 253.
- (7) Jeffers A., Fitzgerald M. (1991). *Irish Families Under Stress*. E.H.B.: Dublin.
- (8) **Jongsma A. E., Peterson L. M., McInnis W. (1996). *The child and adolescent psychotherapy treatment planner*. Wiley: Chichester.**
- (9) Leeson S., Fitzgerald M., Carr A. (1999). Recovery and relapse in multi problem families following community based multidisciplinary treatment. *Irish Journal of Psychology*, 20, 1, 69 – 88.
- (10) Moukaddem S., Fitzgerald M., Barry M. (1998). Evaluation of a child and family centre. *Child Psychology and Psychiatry Review*, 3, 4, 161 – 166.
- (11) O’Sullivan M., Fitzgerald M. (1998). Suicidal ideation and acts of self harm among Dublin school children, 21, 4, 427 – 444.
- (12) Shirk S. R., Russell R. C. (1992). A re-evaluation of estimates of child therapy effectiveness. *Journal of the American Academy of Child and Adolescent Psychiatry*, 31, 703 – 709.
- (13) Weisz J. R., Weiss B. (1993). *Effective psychotherapy with children and adolescents*. London: Sage.

***IRISH CHILD PSYCHIATRIC  
RESEARCH: SUMMARY***

(1) ***Preschool and Primary School***

- (a) Preschool behaviour problems 17% (215, 15, 16), sleep problems: 25% of boys and 33% of girls (236).
- (b) Primary school children behavioural problems 20% for boys and 11% of girls (N = 2029). There is a greater behavioural problem in children in disadvantaged schools (5, 37, 45, 80, 89, 171, 170, 169, 176, 187, 188, 192, 198, 236, 255, 256, 259, 271, 301, 311, 312, 313, 335, 346, 348).
- (c) Depression study in a primary school showed that 7% of the children showed evidence of depressive disorder (5). Follow-up study of depressed children in a clinic showed that 50% were still depressed 5 years later (250, 251, 172, 192, 80).

- (d) Anxiety in a urban disadvantaged school 3.5% of the children showed evidence of anxiety (15, 16).
- (e) In a study of social difficulties in a normal school 13% had difficulties with peers, 17% had difficulties with adults and 11% had general social difficulties (348).
- (f) Fire setting: 19% of children attending a Child Psychiatric Outpatients showed evidence of fire setting (180).
- (g) Children's fears: 40% of children attending a Child Psychiatric Outpatients showed evidence of excessive fears (346).
- (h) In a 2000 children study 4% of the males and 1% of females were bullied (173, 234).
- (i) There was no increase in blood lead in children attending a Child Psychiatric Outpatients (191).
- (j) Motivation: Children in an urban primary school showed high intrinsic motivation. Behaviourally disturbed children showed higher levels of independent judgement as against dependence on teacher's judgement (334).
- (k) Miserable feelings: In a study of 2026 ten year olds 2% of the males and 3% of the females were miserable (234).

(2) *Adolescents*

- (a) Female adolescents: 15% showed evidence of psychological stress in an inner city school with 11% often crying; 11% often having stomach aches; 6% often using drugs or alcohol; 6% often wishing they were the opposite sex; and 7% often having suicidal thoughts (350).
- (b) Male adolescents: Males had lower scoring on the General Health Questionnaire and had less suicidal ideation than boys (Another study found 7% of female adolescents to being depressed) (168, 167, 173, 165).
- (c) Abnormal eating habits: Female. Among 16 year old females in a normal school 11% admitted to dieting; 7% to exercising strenuously to burn off calories; 11% of avoiding foods with high carbohydrate content; 15% described eating binges with feelings of loss of control; 4% used laxatives; and 17% felt that food controlled their lives, while 18% admitted to feeling anxious in relation to eating (168).
- (d) Body shape and abnormal eating attitudes in male adolescents: 1% of boys showed evidence of abnormal eating attitudes; 3% showed abnormal concern about being fat on the Body Shape Questionnaire (206).

- (e) Attitude to authority: 84% of Irish adolescents expressed pro-authority feelings. There was also a negative correlation between level of psychological distress and positive attitude towards parents (252).
- (f) Adolescents menarche: The average age of onset of menarche in 836 Irish school girls was  $12.5 \pm 0.06$  (189).
- (g) Delinquency: A follow-up study of delinquent behaviour showed that 20% had drug problems and there was a 92% recidivist rate (237).
- (h) Drug use in young Irish adolescents: In a study of five cities, Dublin, Bremin, Groingen, Newcastle-upon-Tyne and Rome there was higher drug availability in Dublin than any of the other cities (8, 9, 10, 11, 261, 262, 263).

(3) ***Physical Health, Childhood, Adolescents, Paediatric Hospitals***

- (a) Considerable psychopathology was found in children and parents attending Paediatric Outpatients (52).
- (b) Adolescent health In a study of adolescents in a normal school 1% rated their health as poor; 25% drink alcohol at least once weekly, and 29% visited their G.P. in the previous three months; 61% had taken medicine the previous four weeks; 16% of the boys and 3% of the girls had tried glue sniffing (39). Diabetic children who had good control of their diabetes were less stressed (215, 216, 217, 218, 219, 220, 223, 224, 225, 226, 227, 228, 258).
- (c) 82% of parents were satisfied with the service they received in the Paediatric Outpatients (159).
- (d) In relation to gastroenteritis there was a significant excess of Hospital referrals for gastroenteritis by General Practitioners with prior Hospital training in an Infectious Disease Hospital. 25% of General Practitioners were still using antidiarrhoeals and antienetics in the treatment of gastroenteritis despite the general principal of fluids only for gastroenteritis. In a study of Home or Hospital Care for childhood gastroenteritis it was found that being either a young child, a child of a lone parent or a child of an anxious mother were factors which were equally likely and more likely than being moderately sick to result in referral to Hospital. Only half of the Irish Doctors interviewed believed that hospitalisation of children had negative psychological effects (293, 294, 296, 297, 298, 299, 300).
- (e) Immunisation: In a study of children who had gastroenteritis and were treated in Hospital or at Home it was found that 53% of home care children had measles immunisation which is similar to national levels at the time while only 22% of the Hospital care children had measles immunisation at the time (295).

(4) ***Attention Deficit Hyperactivity Disorder***

- (a) Approximately 2% of children in a study in a community were found to have ADHD. A number of Dopamine polymorphisms have been found to be important in ADHD (2, 236, 12, 121, 122, 132, 135, 137, 144, 138, 163, 202, 207, 208, 209, 210, 211, 212, 213, 229, 234, 238, 239, 240, 241, 265, 266, 267, 274, 280, 335).

(5) *Autism*

- (a) A study of the prevalence of childhood autism found a rate of 4.3 children with autism per 10,000 of the population in the age range 8 – 10 year olds in the former Eastern Health Board. There was considerable family burden in relation to autism, genetic factors were found to be clearly important (14, 21, 22, 23, 24, 25, 26, 27, 40, 41, 102, 107, 109, 110, 111, 112, 113, 114, 115, 118, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 140, 142, 143, 145, 146, 147, 149, 151, 152, 161, 194, 193, 195, 196, 197, 260, 269, 277).

(6) *Psychopathological Aspects of Family Life*

- (a) Mothers in Malaysia had significantly lower rates of depressive and anxiety symptoms when compared to Irish mothers (153).
- (b) Mothers of children hospitalised with gastroenteritis had significantly higher levels of psychological distress than mothers who looked after their children at home (299). There was no statistical association between maternal antenatal depression and child behaviour problems but there was a six times increased risk of behaviour problems in the child if mother was currently depressed. A study of mothers postnatally showed that 38% showed evidence of depression (304, 182).
- (c) In a General Practice Study of 70 children there was a significant relationship between maternal depressive symptoms and behavioural deviance in the children (37).
- (d) In a study of mothers of 50 consecutive attenders at a Child Psychiatric Outpatients 35 out of the 50 showed formal psychiatric disorder (301).
- (e) In a study of preschool children there was a significant relationship between depressive symptoms in mothers and behavioural deviance in children (170).
- (f) 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 it was evident that there was significantly higher levels of hopelessness found in the mothers attending the Child Psychiatric Outpatients (18).
- (g) 72% of children of psychiatric inpatient mothers were found to have social competence problems (330).

- (h) In many of the studies there was a significant relationship between marital disharmony and behavioural deviance in children (255, 301).
- (i) A study of the Family System Test found it to be a poor predictor of clinical status (242).
- (j) Unfair, harsh discipline by parents was predictive of later development of depression (328).
- (k) In a study of the lifetime prevalence of depressive disorder the total number of relatives involved was 1 for 1.7 patients (351).
- (l) A study of parental rearing practices of depressed patients showed that they were more rejecting, more over protective, and more favouring of the subject than a comparison group (328).
- (m) In a study of lone parenthood: Married versus unmarried mothers found that 60% of the married mothers and 18% of the single mothers wished to conceive at the time they became pregnant. 34% of the male partners of the lone parents did not want to know about the pregnancy. The group of lone parents living alone were under considerable stress with three quarters of them having major financial problems as opposed to 19% of those living with their parents (290).
- (n) In a study of mothers attending a Child Psychiatric Outpatients it was found that 17% of the mothers were problem drinkers and 13% were taking Benzodiazepines daily (333).
- (o) Considerable psychosocial stress was found in parents of children who had a child who suffered Sudden Infant Death (19, 20).

(7) ***Speech and Language Problems***

- (a) In a study of 50 consecutive outpatient attenders it was found (310) that 10% of the sample showed a mild phonological disorder and 5% a moderate phonological disorder. 42% showed a mild language disorder and 5% showed a moderate language disorder. 10% showed voice disorders. 5% showed a mild stammer and 5% showed a severe stammer. There was also a high rate of behaviour problems among children with language delay. Of the 22 children with language delay 59% had behaviour problems compared to 14% in the general population. Clearly Speech and Language problems should be given greater attention in routine child psychiatric assessments.

(8) ***Psychopharmacology***

- (a) 90% of Irish Child Psychiatrists prescribed psychotropic drugs (303).
- (b) The prevalence of use of medication was lowest at 8% in Denmark (341).

- (c) Psychostimulants and other medications which are off label like Clonidine are used in the treatment of Attention Deficit Hyperactivity Disorder and Oppositional Defiant Disorder (101, 121, 122, 137, 138, 141, 303).
- (d) Serotonin reuptake inhibitors like Sertraline – Fluoxetine are often used in Obsessive Compulsive Disorder (155).

(9) ***Suicidal Thoughts and Suicidal Behaviour***

- (a) In a normal primary school 15% of a sample of boys thought that life was not worth living most of the time and 18% thought that life was not worth living sometimes.
- (b) In a study of a Child Psychiatric Outpatients 60% of a sample of children who had thoughts of killing themselves knew someone who had attempted suicide (203).
- (c) In a study of suicide victims in Dublin over a year it was found that 70% were male, 35% had previously attempted suicide, and 53% saw a Doctor in the previous month. 44% experienced hopeless feelings. The Central Statistics Office at the time the study was done underestimated the suicide rate by 20% (291).
- (d) An eight year follow-up of attempted suicide found that 2 out of the 26 had died and 19% had further suicide attempts (28, 29, 31, 32, 33, 34).
- (e) A community study of parasuicide found that almost all had attended casualty (331, 332).
- (f) There was a high overprotection score rate among parents of children who attempted suicide. There were considerable rates of suicidal ideation in children in a normal school (340, 339, 338, 337, 336, 43, 44, 349).

(10) ***Personality Disorder***

- (a) A study of the personalities of 50 Child Guidance Clinic attenders found that 5 could be given a diagnosis of Personality Disorder (345).

(11) ***Audit in Child Psychiatry***

- (a) Studies of the outcome of interventions in Child Psychiatry Outpatients have found that there was good outcome at three months follow-up but that all evidence of improvement had disappeared at one year follow-up.

- (b) Another study looking at the effective booster sessions found that families who had booster sessions had better long-term outcomes.
- (c) Child Psychiatry will need to approach child psychiatric problems from a chronic care and treatment model as many are either persistent or recurrent as is the case with many problems in medicine generally.
- (d) 77% of mothers express satisfaction at the service provided by the Child and Family Centre.
- (e) 30% of children expressed anxiety and apprehension about a visit to a Child and Family Centre / Child Psychiatric Outpatients (175, 166, 306, 307).

(12) ***Burn Out in Child Psychiatric Personnel***

- (a) Personnel working Residential Child Psychiatry were more likely to be emotionally exhausted than personnel working in Outpatient Child Psychiatry (309).

(13) ***Life Events and Child Psychiatry***

- (a) There were increased numbers of life events in children referred to Child Psychiatry. Failure of a class in school and increased number of arguments between parents were associated with an increase likelihood of referral (45).

(14) ***Prosocial Behaviour and Behaviour Problems***

- (a) High trait anxiety was accompanied by lower prosocial behaviour scores and higher behavioural deviance ratings (311).

(15) ***Family Burden of a Child with Special Needs***

- (a) Parents who had a child with special needs felt more incompetent, felt lack of attachment, were more restricted in their parental role, were more socially isolated, more depressed, and had more marital stress (158).

(16) ***Self Esteem and Psychiatric Problems in Children***

- (a) School self-esteem was not reduced in children attending a day special school. Parental self-esteem and locus of control have an impact on children's self esteem scores. An inverse relationship was found between anxiety and self-perception. Disturbed preschool children were less competent at performing tasks (311, 246, 177, 15, 16).

(17) ***Psychotherapy Papers***

- (a) Relational model of psychoanalysis (82) cost effectiveness of psychotherapy, psychotherapy reduces the use of medical services. Psychotherapy is more effective than the passage of time. Child psychotherapy is effective (113, 114, 150, 306, 307, 252, 253, 254).
- (b) Supervision of Psychotherapists (57).
- (c) Technique of Psychoanalytic Psychotherapy (150, 56).
- (d) Applied Psychoanalysis (59).
- (e) Psychoanalysis behaviour therapy and pharmacology (68).
- (f) Balint groups in general practice. A psychotherapeutic approach to general practice (53).
- (g) The psychoanalytic treatment of Hysterical Personality (51).
- (h) The psychoanalytic treatment of Narcissistic Personality (77).
- (i) Training therapist difficulties (204).
- (j) Registration of Psychotherapists and Psychotherapy Services (70, 74, 150).
- (k) Psychotherapy in the prison situation (36).
- (l) Contribution of Psychoanalysis to Psychiatry (72).
- (m) Attitudes to Psychiatry and Psychotherapy Training of Doctors (85, 318).
- (n) European Psychotherapy, Counselling, and the Future of Psychiatry (84, 75, 76).
- (o) Irish Standing Conference on Psychotherapy (66).
- (p) Irish Psychiatry the Way Forward (65).
- (q) The Boundaries of Psychotherapy (71).
- (r) The Supervision of Trainee Therapists (57).
- (s) Why Psychotherapy (58).
- (t) The Effectiveness of Psychotherapy (54).
- (u) Evidence-based Medicine, Psychoanalysis and Psychotherapy (17).

(18) *Miscellaneous*

- (a) The Effects of Sudden Infant Death on Families (19, 20).
- (b) Impulsivity and Suicide (117).
- (c) A 16 year follow-up of a Child Psychiatric Inpatient Population (214).
- (d) A study of Psychosocial Health Status of Irish Traveller Mothers and Children (222).
- (e) Ireland A Changing Society, Irish Families Under Stress, Volume IV, 1995.
- (f) Leisure Activities in Adolescent School Children (165).
- (g) The Effect of Domestic Violence on Children (186).
- (h) Social Support and Behaviour Problems in Children (198).
- (i) A Psychosocial Study of a Population of Diabetic Children and Adolescents (258).
- (j) International Variations in Youth Drug Use (262, 263).
- (k) Cognitive Behavioural Intervention in a Group of Diabetic Children (287).
- (l) Psychopathology following a Road Traffic Accident (317).
- (m) Turner's syndrome (320, 321, 322, 323, 324).
- (n) The Measurement of Adolescent Adaptive Processes in Clinical Interview (350).
- (o) Delinquency in Irish Families (61).
- (p) Disconnection in Irish Families (62).
- (q) Existentialism and Psychiatry (63).

***PUBLICATIONS AND PUBLISHED ABSTRACTS ETC.  
BY IRISH CHILD PSYCHIATRISTS***

***1971 – 2003***

***South Western Area Health Board (Part of former Eastern Health Board) and Trinity College Dublin Publications and Published Abstracts, etc.***

- (1) Arshad M., Fitzgerald M. (2002). Did Nobel Prize Winner John Nash have Asperger's syndrome and Schizophrenia? *Irish Psychiatrist*, Vol. 3, Issue 3, 90 – 94.
- (2) Arshad M., Fitzgerald M. (2002). Long acting psychostimulants in ADD / ADHD. *The Irish Journal of Clinical Medicine*, 33, 1, 28 – 34.

- (3) Barrett N., Fitzgerald M. (1990). Impasse with routine psychiatric treatment: progress with analytic psychotherapy in a case of neurotic depression. *The Midland Journal of Psychotherapy*, 11, 1, 9 – 17.
- (4) Barry M., O'Brien M., Fitzgerald M. (1996). Parasuicide in E.H.B. Child Guidance Clinics. 27<sup>th</sup> Psychological Society of Ireland, Annual Conference, Waterford.
- (5) Barton Y., Fitzgerald M. (1986). A study of behavioural deviance in 10 and 11 year old Irish school girls in an urban area. *Irish Journal of Medical Science*, 155 (3), 80 – 82.
- (6) Berman D., Fitzgerald M., Hayes J. (1996). The danger of words and writings on Wittgenstein. M. O. C. Drury. Bristol: Thoemmes Press.
- (7) Bowman E. P. (1988). Asperger's syndrome and autism; the case for a connection. *British Journal of Psychiatry*, 152, 377 – 382.
- (8) Brinkley A., Fitzgerald M. (1999). Alcohol use in early adolescents – is a distinction between occasional and frequent use valid? *European Child and Adolescent Psychiatry*, 8, 2, 205.
- (9) Brinkley A., Fitzgerald M. (2001). Risky business: A risk focussed approach to adolescent substance abuse. 48<sup>th</sup> Annual American Academy of Child and Adolescent Psychiatry, Honolulu, October 23<sup>rd</sup> – 28<sup>th</sup>, 144.
- (10) Brinkley A., Fitzgerald M., McArdle P. (1999). Substance use rates and delinquent behaviour among young people in five European cities. *Proceedings of the Royal College of Psychiatrists Annual Meeting*, April 1999: Manchester.
- (11) Brinkley A., Michels I., McArdle P., Fitzgerald M. (1998). Drug dependence: Risk and monitoring. *European Drug Prevention and Drug Policy Conference*, Vienna.
- (12) Brophy K., Hawi Z., Kirley A., Fitzgerald M., Gill M. (2002). Synaptosomal associated protein 25 (SNAP-25) and Attention Deficit Hyperactivity Disorder (ADHD): Evidence of linkage and association in the Irish population. *In Press*.
- (13) Brown K., Fitzgerald M., Kinsella A. (1990). Prevalence of psychological distress in Irish female adolescents. *J. Adolescence*, 13, 4, 341 – 350.
- (14) Buxbaum J., Silverman J., Smith C., Kilifarski M., Reichert J., Zong C., Zhou G., Lawlor B., Fitzgerald M., Galvin P., Whiting K., Greenberg D., Davis K. (1999). A genome-wide linkage study in autism. *Molecular Psychiatry*, 4, Supplement 1, 13.
- (15) Cheasty M., Fitzgerald M. (1994). The social competency of psychiatrically disturbed preschool children compared to a control group. *In Proceedings of the Royal College of Psychiatrists Annual Meeting*, Cork, 67.
- (16) Cheasty M., Fitzgerald M., O'Callaghan E. (1996). The social competency of psychiatrically disturbed pre-school children compared with that of a control group. *British Journal of Clinical and Social Psychiatry*, Volume 9, No. 4, 10 – 12.
- (17) Corvin A., Fitzgerald M. (2000). Evidence-based medicine psychoanalysis and psychotherapy. *Psychoanalytic Psychotherapy*, Volume 14, No. 2, 143 – 151.

- (18) Cotter S., Fitzgerald M., Kinsella A. (1991). Hopelessness among mothers of children with behaviour problems. *Irish Journal of Psychiatry*, 12, 14 – 16.
- (19) Coughlan B., Carr A., Fitzgerald M. (1998). Factors related to the adjustment of siblings following sudden infant death. *Irish Journal of Psychology*, 19, 2 – 3, 295 – 312.
- (20) Coughlan B., Fitzgerald M., Carr A. (1995). Adjustment of siblings to sudden infant death: A national Irish study. *Royal College Psychiatrists Meeting Glasgow*, 44.
- (21) Coulthard C., Fitzgerald M. (1996). Autism – Who Cares? 5<sup>th</sup> Congress Autism – Europe Barcelona.
- (22) Coulthard P., Fitzgerald M. (1997). Friends, relations, and professionals? Social support in families who have a child with autism spectrum disorder. 5<sup>th</sup> European Congress of Psychology, Dublin.
- (23) Coulthard P., Fitzgerald M. (1997). Religious beliefs and personal ideologies as a resource when coping with a child with autism. *PSI 27<sup>th</sup> Annual Conference*. Ennis.
- (24) Coulthard P., Fitzgerald M. (1999). In God we trust? Organised religion and personal beliefs as resources and coping strategies, and their implications for health in parents with a child on the Autistic Spectrum. *Mental Health, Religion, and Culture Journal*, 2, 1, 19 – 33.
- (25) Coulthard P., Fitzgerald M. (1999). Parenting adolescents on the autistic spectrum. *European Child and Adolescent Psychiatry Journal*, 8, 2, 464.
- (26) Coulthard P., Fitzgerald M., Matthews P. (1996). Autism and a wider social support network. In *Proceedings of the 5<sup>th</sup> Congress - Autism Europe, Barcelona*, 26.
- (27) Coulthard P., Matthews P., Fitzgerald M. (1995). The impact of a child with autism on their family, with particular reference to social support. *Royal College of Psychiatrists Child and Adolescent Psychiatry Section, Annual Residential Meeting, Dublin*, 50.
- (28) Curran A., Greene V., Fitzgerald M. (1995). Parasuicide: Preliminary results of a prospective eight year follow up. In *Proceedings of the Royal College of Psychiatrists Winter Meeting, Glasgow*, 39.
- (29) Curran S., Fitzgerald M. (1998). A prospective 8½ year follow up study of parasuicides. *Royal College of Psychiatrists, Annual Meeting, Belfast, June 1998*.
- (30) Curran S., Fitzgerald M. (1999). Attention deficit hyperactivity disorder in the prison population. *American Journal of Psychiatry*, 156, 10, 1664 – 1665.
- (31) Curran S., Fitzgerald M., Green V. (1998). What becomes of the broken hearted? A prospective follow up study of parasuicides. 7<sup>th</sup> European Symposium on Suicide and Suicidal Behaviour. *Gent, Belgium, September*, 74.

- (32) Curran S., Fitzgerald M., Green V. (1999). Psychopathology 8½ years post parasuicide. *The Journal of Crisis Intervention and Suicide Prevention: Crisis*, 20, 3, 115 – 120.
- (33) Curran S., Fitzgerald M., Greene V. T. (1995). Parasuicide and parental bonding. Royal College of Psychiatrists, Child and Adolescent Psychiatry Section, Annual Residential Meeting, Dublin, 40.
- (34) Curran S., Greene V., Fitzgerald M. (1994). Attempted suicide: An eight year follow up. In the value of research for clinical practice. Eireann Public: Dublin, 36.
- (35) Daly G., Hawi Z., Fitzgerald M., Gill M. (1999). Mapping susceptibility loci in Attention Deficit Hyperactivity Disorder: Preferential transmission of parental alleles at DAT1, DBH and DRD5 to affected children. *Molecular Psychiatry*, 4: 192 – 196.
- (36) Daly M., Fitzgerald M. (1991). Psychotherapy in a custodial setting. In *Irish Families Under Stress*, Volume 3, E.H.B.: Dublin, 477 – 495.
- (37) Day-Cody D., Fitzgerald M. (1989). Childhood behavioural problems and maternal depression in general practice. *Irish Journal of Psychological Medicine*, 6, 112 – 114.
- (38) De Arce M. A., Fitzgerald M. First Irish family with fragile X chromosome. *Irish Families Under Stress*, Volume 3, E.H.B.: Dublin. 228 – 232.
- (39) Devitt P., Fitzgerald M., Kinsella A. (1991). Adolescents and their health. *Irish families Under Stress*. Volume 3, E.H.B.: Dublin.
- (40) Doherty K., Fitzgerald M. (1999). Autism and the psychosocial effects on the family. *European Child and Adolescent Psychiatry*, 8, 2, 465.
- (41) Doherty K., Fitzgerald M., Matthews P. (2000). Services for autism in Ireland. *Irish Journal of Psychology*, 21, 1 – 2, 50 – 69.
- (42) Doody B. (1995). Use of seclusion in a residential assessment and treatment unit. Royal College of Psychiatrists: Child and Adolescent Psychiatry Section Meeting, Dublin.
- (43) Doody B., Fitzgerald M. (1995). Prevalence of suicidal ideation among adolescents. Royal College of Psychiatrists Child and Adolescent Psychiatry Section, Annual Residential Meeting, Dublin, 42.
- (44) Doody B., O'Brien C. (1998). A review of 50 consecutive presentations of deliberate self harm to a child and adolescent psychiatric service. 7<sup>th</sup> European Symposium on Suicide and Suicidal Behaviour. Gent, Belgium.
- (45) Dooley E., Fitzgerald M. (1984). Life events and psychiatric referral in children: comparison with a general population. *Irish Journal of Medical Science*, 159: 9, 310 – 315.
- (46) Dowling B., McQuaid P. (1990). Childhood PDD: A 20 year follow up. Royal College of Psychiatrists, Annual Meeting, Galway.
- (47) Dowling B., Webb M., Halpin C., Sangiwa M. (1990). Fluoxetine: A comparative study with Dothiepin. *Irish Journal of Psychiatry*, 11, 1, 83 – 87.

- (48) Drumm M., Carr A., Fitzgerald M. (1998). An investigation into the relative merits of three approaches to structured family assessment. 14<sup>th</sup> International Congress of Child and Adolescent Psychiatry and Allied Professions, Stockholm, August, 213.
- (49) Drumm A., Carr A., Fitzgerald M. (1998). The Beavers, McMaster and Circumflex Clinical Rating Scales. A study of sensitivity, specificity and discriminant validity. *Journal of Family Therapy*, 221, 225 – 238.
- (50) Drumm M., Carr A., Fitzgerald M. (1998). The sensitivity and specificity of three approaches to family evaluation. Royal College of Psychiatrists, Annual Meeting, Belfast, 58.
- (51) Fitzgerald M. (1983). Treatment aspects of the hysterical personality. *Irish Journal of Psychotherapy*, 2; 2: 61 – 64.
- (52) Fitzgerald M. (1985). Behavioural deviance and maternal depressive symptoms in paediatric outpatients. *Archives Disease Childhood*, 60, 550 – 562.
- (53) Fitzgerald M. (1987). The Balint group in general practice. *Irish Journal of Psychotherapy and Psychosomatic Medicine*, 4, 1: 23 – 26.
- (54) Fitzgerald M. (1987). The effectiveness of psychotherapy. *Journal Irish Forum Psychoanalytic Psychotherapy*, 1, 1: 29 – 35.
- (55) Fitzgerald M. (1988). Editorial (integrating psychoanalytic theories). *Journal Irish Forum for Psychoanalytic Psychotherapy*, 1, 2, 1.
- (56) Fitzgerald M. (1988). The technique of analytic psychotherapy. *Journal Irish Forum Psychoanalytic Psychotherapy*, 1, 2: 34 – 44.
- (57) Fitzgerald M. (1990). Supervision of trainee therapists. *Journal Irish Journal Psychoanalytic Psychotherapy*, 1: 4: 17 – 29.
- (58) Fitzgerald M. (1990). Why Psychotherapy? *Journal Postgraduate Medical Education*, 3, 12, 324 – 326.
- (59) Fitzgerald M. (1991). Applied psychoanalysis and child psychiatry. In *Irish Families Under Stress*, Volume 3, E.H.B.: Dublin, 414 – 444.
- (60) Fitzgerald M. (1991). Children and families. In *Mental Health in Ireland*. Edited by C. Keane, Gill & McMillan / R.T.E.: Dublin.
- (61) Fitzgerald M. (1991). Delinquency in Irish Families Under Stress, Volume 3, E.H.B.: Dublin, 166 – 184.
- (62) Fitzgerald M. (1991). Disconnection in Irish Families Under Stress, Volume 3, E.H.B.: Dublin, 270 – 280.
- (63) Fitzgerald M. (1991). Existentialism and psychiatry. *Journal Irish Forum Psychoanalytic psychotherapy*, 2, 1, 27 - 35.
- (64) Fitzgerald M. (1991). *Irish Families Under Stress*, Volume 3. E.H.B.: Dublin.

- (65) Fitzgerald M. (1991). Irish Psychiatry – the way forward to the year 2000. Irish Families Under Stress, Volume 3. E.H.B.: Dublin, 576 – 584.
- (66) Fitzgerald M. (1991). Irish Standing Conference on Psychotherapy. Journal Irish Forum for Psychoanalytic Psychotherapy, 2, i.
- (67) Fitzgerald M. (1991). Levels of psychosocial stress and disturbance in Irish children. In coping with adversity. Pergamon, 26.
- (68) Fitzgerald M. (1991). Psychoanalysis, behaviour therapy and pharmacotherapy. In Irish Families Under Stress, Volume 3, E.H.B.: Dublin, 496 – 507.
- (69) Fitzgerald M. (1991). Psychological adaptation to pregnancy - psychoanalytic aspects. In Irish Families Under Stress, Volume 3, E.H.B.: Dublin, 50 – 63.
- (70) Fitzgerald M. (1991). Psychotherapy services in Ireland. Irish Families Under Stress, Volume 3, E.H.B.
- (71) Fitzgerald M. (1991). The boundaries of psychotherapy. In Irish Families Under Stress, Volume 4, E.H.B.: Dublin.
- (72) Fitzgerald M. (1991). The contribution of psychoanalysis to psychiatry paper to St. Patrick's Hospital, Dublin. In Irish Families Under Stress, Volume 3, E.H.B.: Dublin, 385 – 413.
- (73) Fitzgerald M. (1991). The middle years. Irish Families Under Stress, Volume 3, E.H.B.: Dublin, 280 – 287.
- (74) Fitzgerald M. (1991). The statutory registration of psychotherapists. In Irish Families Under Stress, Volume 3, E.H.B.: Dublin, 310 – 313.
- (75) Fitzgerald M. (1992). "The end of Psychiatry". In Psychiatry in Europe, Royal College Psychiatrists Meeting, 52 – 53.
- (76) Fitzgerald M. (1992). The future of psychotherapy. Journal Irish Forum Psychoanalytic Psychotherapy, 2, 2, 13 – 33.
- (77) Fitzgerald M. (1992). The treatment of character disorder. Journal of the Irish forum for Psychoanalytic Psychotherapy, 2, 13 – 33.
- (78) Fitzgerald M. (1993). Child Psychiatry in O'Shea B. and Falvey J. Text Book of Psychological Medicine. Dublin: E.H.B.
- (79) Fitzgerald M. (1993). Child Psychoanalysis. In Psychotherapy in Ireland. Edited by E. Boyne. Columba Press: Dublin.
- (80) Fitzgerald M. (1993). Childhood depression. Irish Bulletin of Psychiatry, 1, 1, 4.
- (81) Fitzgerald M. (1993). European psychotherapy. Journal Irish Forum for Psychoanalytic Psychotherapy, 3, 3 – 6.

- (82) Fitzgerald M. (1993). Psychoanalysis in O'Shea B. and Falvey J. Text Book of Psychological Medicine. Dublin; E.H.B.
- (83) Fitzgerald M. (1994). European psychotherapy and Counselling. Inside Out, 17, 15 – 18.
- (84) Fitzgerald M. (1994). Psychosocial state of children and mothers. In the value of research for clinical practice. Eireann Publications: Dublin, 36 – 37.
- (85) Fitzgerald M. (1994). Psychotherapy in Ireland. Royal College of Psychiatrists Annual Meeting, 89.
- (86) Fitzgerald M. (1994). The training of doctors in psychotherapy. Proceedings Royal College Psychiatrists Annual Meeting Cork.
- (87) Fitzgerald M. (1995). A ten year follow up of boys admitted to an assessment centre for juvenile offenders. Tenth International Congress. European Society for Child and Adolescent Psychiatry, Utrecht, 182.
- (88) Fitzgerald M. (1995). Developments in psychoanalytic psychotherapy in Ireland. A personal view 1981 – 1993. Irish Journal of Child and Adolescent Psychotherapy, 1, 1: 5 – 14.
- (89) Fitzgerald M. (1995). Epidemiological aspects of Irish Child Psychiatry. Royal College of Psychiatrists Child and Adolescent Psychiatry Section, Annual Residential Meeting, Dublin 26.
- (90) Fitzgerald M. (1995). Irish Psychiatry; the problem of achieving a balance. In Irish Families Under Stress, Volume 4, E.H.B.: Dublin.
- (91) Fitzgerald M. (1995). The boundaries of psychotherapy. In Irish Families Under Stress, Volume 4, E.H.B.: Dublin.
- (92) Fitzgerald M. (1996). Current research on autism in Ireland. Frontline, 26; 21 – 22.
- (93) Fitzgerald M. (1996). Does child psychiatry work? In Proceedings of the 3<sup>rd</sup> European conference, Association for Child Psychology and Psychiatry, Glasgow, 49 – 50.
- (94) Fitzgerald M. (1996). Irish Families Under Stress, Volume 5, Dublin, Eastern Health Board, 155 pages.
- (95) Fitzgerald M. (1996). Irish Families Under Stress, Volume 5. Evaluation and Audit of a Child and Family Centre, E.H.B: Dublin.
- (96) Fitzgerald M. (1996). Mental health problems among adolescents. Ulster Paediatric Society in association with British Association of Community Child Health Annual Symposium, March, Belfast Castle.
- (97) Fitzgerald M. (1997). Asperger syndrome. In: Proceedings of the Asperger's Syndrome Association Conference, Dublin 1 – 7.

- (98) Fitzgerald M. (1997). The development of counselling and psychotherapeutic skills through supervision. In Proceedings of the Association for Study of Medical Education Conference of Psychology, Vienna, 30.
- (99) Fitzgerald M. (1997). The relationship between child, adolescent and adult psychiatry. *Irish Journal of Psychological Medicine*, 14, 2, 42.
- (100) Fitzgerald M. (1998). A prevalence and psychosocial study of autism in Ireland. 14<sup>th</sup> International Congress of Child and Adolescent Psychiatry and Allied Professions, Stockholm, August, 192.
- (101) Fitzgerald M. (1998). Adult attention deficit hyperactivity disorder. *Irish Journal of Psychological Medicine*, 15, 3, 82 – 83.
- (102) Fitzgerald M. (1998). Antecedents to Asperger's syndrome. *Autism – International Journal of Research and Practice*, 2, 4, 427 – 429.
- (103) Fitzgerald M. (1998). Child psychoanalytic psychotherapy. *A Quarterly Publication for Humanistic and Integrative Psychotherapy: Inside Out*. 33, 32 – 35.
- (104) Fitzgerald M. (1998). Child psychoanalytic psychotherapy. *Advances in Psychiatric Treatment*, 4, 18 – 24.
- (105) Fitzgerald M. (1998). Counselling children who have suffered separation and loss, Éisteach: A Quarterly Journal of Counselling and Therapy, 2, 4, 25 – 27.
- (106) Fitzgerald M. (1998). Depression and psychological factors in school children. 14<sup>th</sup> International Congress of Child and Adolescent Psychiatry and Allied Professions, Stockholm, August, 218.
- (107) Fitzgerald M. (1998). Multidimensionally impaired disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37, 11, 1125.
- (108) Fitzgerald M. (1998). The prevalence and psychosocial study of autism in Ireland. 14<sup>th</sup> International Congress of Child and Adolescent Psychiatry and Allied Professions, Stockholm, August, 192.
- (109) Fitzgerald M. (1999). Alfred Kinsey: Asperger's disorder. *Journal of Autism and Developmental Disorders*, 9, 4, 225.
- (110) Fitzgerald M. (1999). Criteria for Asperger's disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38, 9, 1071.
- (111) Fitzgerald M. (1999). Cycles and epicycles of autism. *Journal of Autism and Developmental Disorders*, 29, 2, 183.
- (112) Fitzgerald M. (1999). Did “the man who loved only numbers” Paul Erdos, have Asperger's syndrome? *Nord. J. Psychiatry*, 53, 6, 1 – 2.
- (113) Fitzgerald M. (1999). Did Isaac Newton have Asperger's Disorder? *European Child and Adolescent Psychiatry Journal*, 8, 204.

- (114) Fitzgerald M. (1999). Did Ludwig Wittgenstein have Asperger's syndrome. *American Academy of Child and Adolescent Psychiatry, Annual Meeting, Chicago*, 18.
- (115) Fitzgerald M. (1999). Differential diagnosis of adolescent and adult Pervasive Developmental Disorder / Autism Spectrum Disorders. *Irish Journal of Psychological Medicine*, 16, 4, 145 – 148.
- (116) Fitzgerald M. (1999). Fundamentals of Child Psychopharmacology. *CNS*, 2, 2, 16 – 18.
- (117) Fitzgerald M. (1999). Impulsivity and suicide. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38, 8, 939 – 940.
- (118) Fitzgerald M. (1999). Pervasive Developmental Disorder – Not Otherwise Specified. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38, 3, 229.
- (119) Fitzgerald M. (1999). Psychoanalytic psychotherapy in Ireland. *A quarterly Journal of Counselling and Therapy: Eisteach*, 2, 11, 39 – 42.
- (120) Fitzgerald M. (1999). Suicidal behaviour in children. *Irish Journal of Psychological Medicine*, 16, 1, 34 – 35.
- (121) Fitzgerald M. (1999). Treatment of children with ADHD with particular emphasis on pre-school children. *CPD Bulletin, Psychiatry*, 1, 3, 93.
- (122) Fitzgerald M. (1999). Unlicensed and off label drug use for children with child psychiatric problems. *Irish Medical Journal*, 92, 2, 284.
- (123) Fitzgerald M. (2000). Did Bartok have High Functioning Autism or Asperger's syndrome? *Autism – Europe Link*, 29, 21.
- (124) Fitzgerald M. (2000). Did Field Marshal Bernard Montgomery (Montgomery of Alamein) have Asperger's syndrome? *Indian Journal of Psychiatry*, 42, 1, 73 – 76.
- (125) Fitzgerald M. (2000). Did Ludwig Wittgenstein have Asperger's syndrome? *European Child and Adolescent Psychiatry Journal*, 9, 61 – 65.
- (126) Fitzgerald M. (2000). Einstein: Brain and behaviour. *Journal of Autism and Developmental Disorders*, 620 – 621.
- (127) Fitzgerald M. (2000). Is the cognitive style of persons with Asperger's syndrome also a "mathematical style"? *Journal of Autism and Developmental Disorders*, 30, 2, 175 – 176.
- (128) Fitzgerald M. (2000). Jonathan Swift: Victim of Asperger's syndrome. *Canadian Journal of Diagnosis*, 31 – 36.
- (129) Fitzgerald M. (2000). Ludwig Wittgenstein: Autism and Philosophy. *Journal of Autism and Developmental Disorders*, 621 – 622.
- (130) Fitzgerald M. (2000). Wolfgang Amadeus Mozart: The Allegro Composer. *Canadian Journal of Diagnosis*, 2000, 17, 11, 61 – 64.

- (131) Fitzgerald M. (2001). Autistic psychopathy. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40: 8, 870.
- (132) Fitzgerald M. (2001). Borderline pathology. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40, 10, 1124.
- (133) Fitzgerald M. (2001). Checklist for autism in toddlers. *Irish Medical Journal*, Volume 94, No. 8, 254.
- (134) Fitzgerald M. (2001). Did Isaac Newton have Asperger's disorder? 48<sup>th</sup> Annual American Academy of Child and Adolescent Psychiatry, Honolulu, October 23<sup>rd</sup> – 28<sup>th</sup>, 20.
- (135) Fitzgerald M. (2001). Did Lord Byron have Attention Deficit Hyperactivity Disorder? *Journal of Medical Biography*, 9, 31 – 33.
- (136) Fitzgerald M. (2001). Did President Eamon de Valera have a developmental disorder? *Journal of Medical Biography*, 9, 31 – 33.
- (137) Fitzgerald M. (2001). Does adult Attention Deficit Hyperactivity Disorder exist? *Journal of Psychiatry and Neurosciences*, 2, 1, 114 – 116.
- (138) Fitzgerald M. (2001). Psychopharmacological treatment of adolescent and adult Attention Deficit Hyperactivity Disorder. *Irish Journal of Psychological Medicine*, 18, 3, 93 – 98.
- (139) Fitzgerald M. (2001). The development of psychotherapy in Northern Ireland. *Irish Journal of Psychological Medicine*, 18, 1, 38.
- (140) Fitzgerald M. (2001). The influence of Wittgenstein's Asperger's syndrome on Philosophy in the 20<sup>th</sup> Century. 24<sup>th</sup> International Wittgenstein Symposium, Kirchberg am Wechsel, Austria, 12<sup>th</sup> – 18<sup>th</sup> August, 5.
- (141) Fitzgerald M. (2001). Under diagnosed and controversial. *Chemistry and Industry*, 342 – 343.
- (142) Fitzgerald M. (2001). Was Spinoza autistic? *Philosophers Magazine Spring*, 15 – 16.
- (143) Fitzgerald M. (2002). Asperger's disorder and mathematicians of genius. *Journal of Autism and Developmental Disorders*, 32, 1, 59 – 60.
- (144) Fitzgerald M. (2002). *Child Psychiatry*, 349 – 369. In O'Shea B. (Ed). *A textbook of Psychological Medicine – an Irish Perspective*. Eireann Publications: Dublin.
- (145) Fitzgerald M. (2002). Did Ramanujan have Asperger's syndrome. *Journal of Medical Biography*, 10, 167 – 169.
- (146) Fitzgerald M. (2002). Did 'Stonewall' Jackson have Asperger's syndrome? *Irish Psychiatrist*, 3, 6, 223 – 224.

- (147) Fitzgerald M. (2002). Louis Wain and Asperger's syndrome. *Irish Journal of Psychological Medicine*, 19, 3, 101.
- (148) Fitzgerald M. (2002). Mind and morals. *Philosophy Now*, 38.
- (149) Fitzgerald M. (2002). Misdiagnosis of Asperger's syndrome as anancastic personality disorder. *Autism, International Journal of Research and Practice*, 6, 4, 435.
- (150) Fitzgerald M. (2002). Psychoanalysis, 73 – 39. In O'Shea B. *A Textbook of Psychological Medicine – an Irish Perspective*. 4<sup>th</sup> Edition, Eireann, Publications: Dublin.
- (151) Fitzgerald M. (2002). Wittgenstein and autism. *Times Literary Supplement*, August 2<sup>nd</sup>, 15.
- (152) Fitzgerald M. (2003). Asperger's syndrome. *The Edinburgh International Encyclopaedia of Psychoanalysis*, general Editor Ross M. Skelton.
- (153) Fitzgerald M., Balbin I., Kinsella A. (1986). A study of behavioural deviance and maternal depressive and anxiety symptoms in Malaysia and Ireland. In *new approaches to infant, child, adolescent and family mental health*. Expansion Scientifique Francaise, 551 – 552.
- (154) Fitzgerald M., Berman D. (1994). Of sound mind. *Nature*, 368, 92. Reprinted in *Portraits of Wittgenstein*. Edited by F. A. Flowers, Thoemmes Press, 1999.
- (155) Fitzgerald M., Berman D. (1996). Obsessive compulsive disorder in the 1990's. *Irish Journal of Child & Adolescent Psychotherapy*, Volume 1, No. 2, 65 – 74.
- (156) Fitzgerald M., Birkbeck G., Matthews P. (1998). A prevalence and psychosocial study of autism in Ireland. *Royal College of Psychiatrists, Annual Meeting, Belfast*, 41.
- (157) Fitzgerald M., Brinkley A. (1998). Drug use in Ireland. 10<sup>th</sup> Conference of the *European Child Psychiatry Research Group, Paris, France, October, 7*.
- (158) Fitzgerald M., Butler B., Kinsella A. (1990). The burden on a family having a child with special needs. *Irish Journal of Psychological. Medicine*, 7, 109 – 113.
- (159) Fitzgerald M., Callaghan M., McDonald M. (1995). Consumer satisfaction in a paediatric outpatients. In *Irish Families Under Stress, Volume 4, E.H.B.: Dublin*.
- (160) Fitzgerald M., Cleary A., Nixon E. (2003). "The Dublin 2000 ten year olds study". A 10 year follow up of a subsample. *Department of Social, Community and Family Affairs, Dublin*.
- (161) Fitzgerald M., Corvin A. (2001). Diagnosis and differential diagnosis of Asperger's syndrome. *Advances in Psychiatric Treatment*, 7, 310 – 318.
- (162) Fitzgerald M., Coughlan C., Carr A. (1998). Factors related to the adjustment of siblings following a sudden infant death. 14<sup>th</sup> *International Congress of Child and Adolescent Psychiatry and Allied Professions, Stockholm, August, 346*.

- (163) Fitzgerald M., Flannery W. (2002). Did Cromwell have Hyperkinetic syndrome? Annual Residential Meeting, Child and Adolescent Psychiatry Faculty: Royal College of Psychiatrists Child and Adolescent Psychiatry Faculty, Residential Meeting Proceedings, September 2002, Harrogate International Centre, 13 – 14.
- (164) Fitzgerald M., Hayes M., Joseph A. (1995). Leisure activities of adolescent school girls. In Proceedings of the Royal College of Psychiatrists Annual Meeting, Cork, 67 – 68.
- (165) Fitzgerald M., Hayes M., Regan M. (1995). Leisure activities of adolescent school children. *Journal of Adolescence*, 18, 349 – 358.
- (166) Fitzgerald M., Heffernan B., MacLachlan M., McAuliffe E. (2002). The impact of booster sessions on the treatment outcome of children and adolescents with behavioural and other problems. Annual Residential Meeting, Child and Adolescent Psychiatry Faculty: Royal College of Psychiatrists, Harrogate, September 2002, 5.
- (167) Fitzgerald M., Horgan M. (1991). Screening for psychological distress among Dublin adolescents. *Irish Journal of Psychiatry*, 12, 1, 7 – 9.
- (168) Fitzgerald M., Horgan M. (1991). Screening of abnormal eating attitudes in 16 year old Dublin school girls. *Ir. J. Med. Sc.*, 160, 6, 170 – 172.
- (169) Fitzgerald M., Jeffers A. (1990). The prevalence of behaviour problems and child psychiatric disorder in an urban area. *Psychiatric Bulletin Supplement* 3, 29.
- (170) Fitzgerald M., Jeffers A. (1992). Children and parents under stress - lessons from recent Irish studies. Royal College Psychiatrists Annual Meeting. Dublin, 64.
- (171) Fitzgerald M., Jeffers A. (1994). Psychosocial factors associated with psychological problems in Irish children and their mothers. *Economic and Social Review*, 125, 285 – 301.
- (172) Fitzgerald M., Jeffers A., Kinsella A. (1994). A follow up study of depressive illness in childhood. *British Journal Clinical and Social Psychiatry*, 9, 1, 12 – 15.
- (173) Fitzgerald M., Joseph A. (1994). The values of Irish adolescents. *Irish Journal of Psychiatry*, 15, 2, 4 – 6.
- (174) Fitzgerald M., Joseph A., O'Neill D. (1997). Parasuicide in a disadvantaged area. *Irish Journal of Psychiatry*, 16, 3, 10 – 11.
- (175) Fitzgerald M., Keenan O. (1989). A study of expectations of a Child & Family Centre. *The Journal of the Irish Forum for Psychoanalytic Psychotherapy*, 1, 3, 15 – 23.
- (176) Fitzgerald M., Kinsella A. (1987). Behavioural deviance in an Irish urban and rural town sample. *Ir. J. Med. Sc.*, 156, 219 – 221.

- (177) Fitzgerald M., Maher C. (1995). Self esteem and anxiety in children. European Society for Child and Adolescent Psychiatry, 10<sup>th</sup> Annual Congress, Utrecht, Netherlands.
- (178) Fitzgerald M., Matthews P. (1998). Increased mortality in persons with autism. *International Journal of Research and Practice: Autism*, 2, 4, 429 – 430.
- (179) Fitzgerald M., Matthews P., Birkbeck G., O'Connor J. (1997). Irish Families Under Stress, Volume 6. A prevalence on psychosocial study in the Eastern Health Board area of Dublin. Eastern Health Board: Dublin.
- (180) Fitzgerald M., McArdle P., Brinkley A. (1998). A European study of substance use in adolescents. European Child Psychiatry Research Group Meeting, Paris, October, 12.
- (181) Fitzgerald M., McCarthy R. (1995). Aspects of suicidal behavioural in children. Royal College of Psychiatrists Annual Meeting Torquay. 37.
- (182) Fitzgerald M., McDermott M. (1995). Psychosocial morbidity in a group of socially disadvantaged pregnant women. European Society for Child and Adolescent Psychiatry, 10<sup>th</sup> Annual Congress, Utrecht, Netherlands.
- (183) Fitzgerald M., McGee H. (1989). Psychosocial factors influencing childhood hospital admissions. European Medical Research Council Meeting Brussels. Abstract.
- (184) Fitzgerald M., McGee H. (1990). Psychological health status of mothers and the admission of children to hospital with gastroenteritis. *International Journal Family Practice*, 7, 2, 116 – 120.
- (185) Fitzgerald M., McGee H. (1991). Should children with minor medical problems be sent to hospital? Infant care practices in families with children hospitalised and non hospitalised for gastroenteritis. *Ulster Medical Journal* 60, 1, 53 – 57.
- (186) Fitzgerald M., Murphy E. (2001). Effects of domestic violence on children. 48<sup>th</sup> Annual American Academy of Child and Adolescent Psychiatry, Honolulu, October 23<sup>rd</sup> – 28<sup>th</sup>, 140.
- (187) Fitzgerald M., Murphy M., Kinsella A. (1991). Reading ability and behavioural deviance in child population. Association of Psychology – Psychiatry Meeting, Dublin, January.
- (188) Fitzgerald M., O'Hanlon M. (1991). The incidence of fire setting and associated psychopathology of children attending a child psychiatric outpatients. *Irish Journal of Medical Science*, 160, 5, 128 – 129.
- (189) Fitzgerald M., O'Hanlon M., Kinsella A. (1990). The onset of Menarche in an Eastern Health Board population. *Irish Journal of Psychiatry*, 11, 2, 3 – 4.
- (190) Fitzgerald M., O'Neill D., Joseph A. (1997). A community study of parasuicide in a disadvantaged area. *Irish Journal of Psychiatry*, 16, 3, 10 – 11.
- (191) Fitzgerald M., O'Rourke M., Murphy M. (1987). Blood lead levels of children attending a child guidance clinic. *Irish Journal of Psychiatry*, 8, 2, 4 – 13.

- (192) Fitzgerald M., Pritchard A., Kinsella A. (1988). A psychosocial and educational study of travellers children. *Irish Journal of Psychological Medicine*, 5 (1), 33 – 36.
- (193) Fitzgerald M., Woods M., Matthews P. (1999). Investigation of possible links between autism and coeliac disease. *Autism: International Journal of Research and Practice*, 3, 2, 193 – 195.
- (194) Gallagher L., Becker K., Kearney G., Dunlop A., Ekstrom L., Stallings R., Green A., Fitzgerald M., Gill M. (2002). A case of autism associated with del(2)(q32.1q32.2) or (q32.2q32.3). In Press.
- (195) Gallagher L., Fitzgerald M. (2002). The syndrome of autism. *The Irish Journal of Clinical Medicine*, 32, 5, 14 – 22.
- (196) Gallagher L., Hawi A., Kearney G., Fitzgerald M., Gill M. No association between allelic variants of HOXA1 / HOXB1 Autism. (Submitted).
- (197) Galvin P., Lawlor L., Fitzgerald M., Davis K., Silverman J. (1998). Family studies in autism. 14<sup>th</sup> International Congress of Child and Adolescent Psychiatry and Allied Professions, Stockholm, 82.
- (198) Gannon M., Fitzgerald M., Kinsella A. (1992). Social support and behaviour problems in children. *British Journal, Clinical & Social Psychiatry*, 8, 3, 64 – 66.
- (199) Garland M., Fitzgerald M. (1998). Social skills correlates of depressed mood in normal young adolescents. *Irish Journal of Psychological Medicine*, 15, 1, 19 – 21.
- (200) Garland M., Fitzgerald M. (1998). The relationship between social skills and depressed mood in normal young adolescents. 14<sup>th</sup> International Congress of Child and Adolescent Psychiatry and Allied Professions, Stockholm, August, 219.
- (201) Gervin M., Smyth B., Bamford L., Keenan E. (1998). Chasing the dragon: Experience in Ireland and association with Ecstasy. *Addiction*, 93, 601 – 603.
- (202) Gill M., Daly G., Hawi Z., Heron S., Fitzgerald M. (1997). Confirmation of association between attention deficit hyperactivity disorder and a dopamine transporter polymorphism. *Molecular Psychiatry*, 2, 311 – 313.
- (203) Grace M., Fitzgerald M. (1994). Suicidal behaviour in children attending a child psychiatric clinic. In *Proceedings of the Fifth European Symposium on Suicide*, Cork, 29.
- (204) Grieve K., Fitzgerald M. (1991). A study of difficulties of students of psychotherapy. In *Irish Families Under Stress*, Volume 3, E.H.B.: Dublin, 352 – 384.
- (205) Halpin C., Fitzgerald M. (1991). Response to the working party on child adolescent psychiatric services in the Eastern Health Board. IV. *Irish Families Under Stress*, Volume 3, E.H.B.: Dublin, 299 – 306.
- (206) Halpin C., Fitzgerald M. (1992). A study of abnormal eating attitudes and body shape in male adolescents. *Irish Journal of Psychiatry*, 3, 3 – 6.

- (207) Hawi Z., Brophy K., Kirley A., Fitzgerald M., Gill M. (2001). Synaptosomal-associated protein 25 (SNAP-25) and Attention Deficit Hyperactivity Disorder: evidence of linkage and association in the Irish population. *Molecular Psychiatry* (In press).
- (208) Hawi Z., Dring M., Kirley A., Foley D., Kent K., Asherson P., Curran C., Gould A., Richards S., Thapar A., Fitzgerald M., Gill M. (2002). Serotonergic system and Attention Deficit Hyperactivity Disorder (ADHD): A potential susceptibility locus at the 5-HT1B receptor gene in 270 Trios from a multi centre sample. *Neuropsychiatric Genetics*.
- (209) Hawi Z., Foley D., Kirley A., McCarron M., Fitzgerald M., Gill M. (2001). Dopa decarboxylase gene polymorphisms and Attention Deficit Hyperactivity Disorder: No evidence for association in the Irish population. *Molecular Psychiatry*, 6, 4, 420 – 424.
- (210) Hawi Z., Kirley A., Mullins C., Fitzgerald M., Gill M. (2000). No association of Serotonin transporter gene polymorphisms with Attention Deficit Hyperactivity Disorder. *American Journal of Medical Genetics*, 96, 4, 490.
- (211) Hawi Z., McCarron M., Fitzgerald M., Gill M. (1999). Association between Attention Deficit Hyperactivity Disorder and the Dopamine Beta Hydroxylase gene: Linkage disequilibrium relationship between polymorphisms. *Molecular Psychiatry*, 4, Supplement 1, 269.
- (212) Hawi Z., McCarron M., Kirley A., Daly G., Fitzgerald M., Gill M. (2000). No association of the dopamine DRD4 receptor gene polymorphism with Attention Deficit Hyperactivity Disorder in the Irish population. *American Journal of Medical Genetics*, 12, 96, 3, 268 – 272.
- (213) Hawi Z., Miller N., Daly G., Fitzgerald M., Gill M. (2000). No association between Catechol-O-methyltransferase (COMT) gene polymorphism and Attention Deficit Hyperactivity Disorder in an Irish sample. *American Journal of Medical Genetics*, 12, 96, 3, 282 – 284.
- (214) Healy E., Fitzgerald M. (2000). A sixteen year follow up of a child inpatient population. *European Child and Adolescent Psychiatry*, 9, 1, 46 – 53.
- (215) Heary C., Hennessy E., McGee H., Breathnach F., Fitzgerald M. (1999). Children's views of hospital services. Paper presented at the Psychological Society of Ireland Conference, Cork.
- (216) Heary C., Hennessy E., McGee H., Breathnach F., Fitzgerald M. (1999). Children's views of hospital services. Poster presentation at the European Health Psychology Conference, Florence.
- (217) Heary C., Hennessy E., McGee H., Breathnach F., Fitzgerald M. (2000). Assessing the quality of hospital services: What do children think is important? Paper presented at the British Psychological Society, Developmental Section Annual Conference, University of Bristol, U.K.
- (218) Heary C., Hennessy E., McGee H., Breathnach F., Fitzgerald M. (2001). A child centred evaluation of paediatric hospital services. Paper presented at the 2<sup>nd</sup> Biennial Health Services Research Conference, Cork, Ireland.

- (219) Heary C., Hennessy E., McGee H., Breathnach F., Fitzgerald M. (2001). The development of an instrument to measure children's satisfaction with paediatric hospital services. Paper presented at the European Health Psychology Conference, St. Andrew's, Scotland.
- (220) Heary C., Hennessy E., McGee H., Breathnach F., Fitzgerald M. (2002). The Children's Evaluation Questionnaire (CHEQ): Development of a child-centred evaluation of hospital services. Paper presented at the Royal College of Surgeons in Ireland, Research Day.
- (221) Heron S., Fitzgerald M., Barry J., MacLachlan M. (1998). Irish travellers: Conception of health and illness. Psychological Society of Ireland Annual Meeting, Kilkenny, 40.
- (222) Heron S., Fitzgerald M., Barry J., MacLachlan M. (2000). A study of the psychosocial health status of Irish traveller mothers and children. In: *Cultivating Pluralism*. Eds. M. MacLachlan and M. O'Connell, Oak Tree Press.
- (223) Hoey H., Fitzgerald M., McGee H. (2001). Good metabolic control is associated with better quality of life in 2,101 adolescents with type 1 diabetes. *Diabetes Care*, 24, 11, 1923 – 1931.
- (224) Hoey H., Flynn M., De Arce M., MacKay B., Connolly M., Fitzgerald M., O'Connor J., Lambe K., Brennan A., Corby A., Quinn E. (1994). Research on growth standards. Turners syndrome and diabetes. In *the Value of Research for Clinical Practice Eireann*. Public: Dublin, 33.
- (225) Hoey H., McGee H., Fitzgerald M. (1999). International quality of life instruments for assessment of children / adolescents with diabetes and their families. *Diabetes: Journal of the American Diabetes Association*, 48, 1, 397.
- (226) Hoey H., McGee H., Fitzgerald M., Mortensen H., Hougaard P. (1999). Multidimensional, international quality of life questionnaires for children and adolescents with IDDM and their families. *Diabetes Research and Clinical Practice*, ISPAD, 74.
- (227) Hoey H., Mortensen H., McGee H., Fitzgerald M. (1999). Is metabolic control related to quality of life? A study of 2,103 children and adolescents with IDDM from 17 countries. *Diabetes Research and Clinical Practice*, 44, 6.
- (228) Hoey H., Mortensen H., McGee H., Fitzgerald M., Hougaard P. (2000). Hvidore study group on childhood diabetes. Metabolic control and quality of life in 2,101 adolescents with diabetes. *Irish Journal of Medical Science*, 169, 1, Supplement 2, 14.
- (229) Holmes J., Payton A., Barrett J., Harrington R., McGuffin P., Owen M., Ollier W., Worthington J., Gill M., Kirley A., Hawi Z., Fitzgerald M., Asherson P., Curran S., Mill J., Gould A., Taylor E., Kent L., Craddock N., Thapar A. (2002). Association of DRD4 in children with Attention Deficit Hyperactivity Disorder and comorbid conduct problems. *American Journal of Medical Genetics*, 114, 150 – 153.

- (230) Houlihan B., Fitzgerald M. (1995). Attitudes of Irish adolescent to parents, authority and cultural identity: An urban rural study. European Society for Child and Adolescent Psychiatry, 10<sup>th</sup> Annual Congress, Utrecht, Netherlands, 24.
- (231) Houlihan B., Fitzgerald M., O'Regan M. (1992). Depression in Irish adolescents. Royal College Psychiatrists. Annual Meeting, Dublin, 31.
- (232) Houlihan M., Fitzgerald M., O'Regan M. (1994). A study of self esteem, hostility and general health of adolescents in an urban and a rural area. *Journal of Adolescence*, 17, 565 – 577.
- (233) Huber V., Fitzgerald M., Kachele H. (1989). Psychotherapy research in social context. Third European SPR Conference on Psychotherapy. Research Bern Switzerland, 50.
- (234) Jeffers A., Fitzgerald M. (1991). *Irish Families Under Stress, Volume 2*. Dublin: Eastern Health Board.
- (235) Jeffers A., Fitzgerald M. (1994). A study of maternal mental illness in an urban community. In *Proceedings of the Royal College of Psychiatrists Annual Meeting*, Cork, 60.
- (236) Kapoor V., O'Rourke M. H., Fitzgerald M., Breen P. (1985). The prevalence of sleep related disorders and bed wetting in children of mothers attending a public health clinic. *Irish Journal of Psychiatry*, 9, 1, 18 – 22.
- (237) Kelly M., Fitzgerald M., Mackey B. (1999). A 10 year descriptive follow-up study of 50 delinquent boys. *The British Journal of Clinical and Social Psychiatry*, 10, 1, 8 – 13.
- (238) Kent L., Middle F., Hawi Z., Fitzgerald M., Gill M., Feehan C., Craddock N. (2001). Nicotinic acetylcholine receptor Alfa 4 subunit gene polymorphisms and Attention Deficit Hyperactivity Disorder. *Psychiatric Genetics*, 11(1): 37 – 40.
- (239) Kirley A., Fitzgerald M. (2002). Adult Attention Deficit Hyperactivity Disorder: A controversial diagnosis. *Irish Journal of Psychological Medicine*, 19, 3, 86 – 91.
- (240) Kirley A., Fitzgerald M., Gill M. (2000). No association of the DRDII polymorphism in Attention Deficit Hyperactivity Disorder in an Irish population. *American Journal of Medical Genetics*, 96, 4, 488.
- (241) Kirley A., Hawi Z., Daly G., McCarron M., Mullins C., Millar N., Fitzgerald M., Gill M. (2002). Dopaminergic system genes in Attention Deficit Hyperactivity Disorder: Towards a biological hypothesis. *Neuropsychopharmacology*, 27, 607 – 619.
- (242) Lambe K., Carr A., Fitzgerald M. (1998). The family system test: An examination of its capability as a diagnostic tool in clinical and non-clinical settings. 14<sup>th</sup> International Congress of Child and Adolescent Psychiatry and Allied Professions, Stockholm, 217.
- (243) Lambe K., Fitzgerald M. (1995). A psychosocial study of diabetic control, the father's role. Tenth International Congress. European Society for Child and Adolescent Psychiatry. Utrecht, 28 – 29.

- (244) Lambe K., Fitzgerald M. (1998). Suicidal ideation and acts of self harm among west Dublin school children. *Journal of Adolescence*, 21, 4, 427 – 444.
- (245) Lambe K., Fitzgerald M., Hoey H. (1995). Does parental self esteem and locus of control have an impact on their children's ratings? Royal College of Psychiatrists Child and Adolescent Psychiatry Section, Annual Residential Meeting, Dublin, 54.
- (246) Lambe K., Fitzgerald M., Hoey H. (1996). Diabetes control and emotional adjustment in young Irish patients. In *Proceedings of the 10<sup>th</sup> European Health Psychology Society Conference*, Dublin, 10.
- (247) Lambe K., Fitzgerald M., Hoey H. (1997). Psychiatric symptoms of mothers and fathers of children with diabetes: A controlled study. In: *Proceedings of the 5<sup>th</sup> European Congress of Psychology*, Dublin, 135.
- (248) Lawlor M. (1996). Can a child abuse prevention programme affect children's behaviour. 11<sup>th</sup> ISPCAN Meeting, Dublin, 182.
- (249) Lawlor M. (1996). Child protection and the school. 11<sup>th</sup> ISPCAN Meeting, Dublin, 22.
- (250) Leader H., Fitzgerald M., Kinsella A. (1985). Behaviourally deviant pre-school children and depressed mothers. *Irish Journal of Medical Science*, 154, 3, 106 – 109.
- (251) Leader H., Fitzgerald M., Kinsella A. (1989). The incidence of major depressive disorder in children attending a child guidance clinic. *British Journal Clinical and Social Psychiatry*, 6, 4, 117 – 147.
- (252) Leeson S., Carr A., Fitzgerald M. (1998). Patterns of recovery and relapse in children and mothers attending an outpatient child and family service. 14<sup>th</sup> International Congress of Child and Adolescent Psychiatry and Allied Professions, Stockholm, August, 324.
- (253) Leeson S., Carr A., Fitzgerald M., Moukaddem S. (1999). Recovery and relapse: the West Dublin child and family service outcome study. *Irish Journal of Psychology*, 20, 1, 69 – 88.
- (254) Leeson S., Fitzgerald M., Carr A., Moukaddem S. (1995). The West Dublin Child Guidance Service Evaluation. Tenth International Congress. European Society for Child and Adolescent Psychiatry, Utrecht, 84.
- (255) Lucey C., Fitzgerald M. (1989). Marital adjustment and behaviour problems in children. *Irish Journal of Medical Science*, 158, 11, 269 – 271.
- (256) Lynch K., Fitzgerald M., Kinsella A. (1987). The prevalence of child psychiatric disorder in 10 and 1 year old boys in an urban area. *Irish Journal of Psychiatry*, 8 (2), 20 – 24.
- (257) Lowe N., Hawi Z., Fitzgerald M., Gill M. (2001). No evidence of linkage or association between the ADHD and DXS 7 locus in Irish population. *American Journal of Medical Genetics*, 8, 105, 4, 394 – 395.

- (258) Mackey B., Fitzgerald M., Hoey H. (1998). A psychosocial study of a population of diabetic children and adolescents. European Society for Child and Adolescent Psychiatry, 10<sup>th</sup> Annual Congress, Utrecht, Netherlands.
- (259) Maher C., Fitzgerald M. (1996). Relating anxiety levels and self esteem in school children. Irish Journal of Psychiatry, 16, 2, 6 – 7.
- (260) Matthews P., Woods M., Fitzgerald M. (1998). Research on possible links between autism and coeliac disease. Royal College of Psychiatrists Annual Meeting, Belfast, 42.
- (261) McArdle P., Fitzgerald M., Brinkley A. (2002). European Adolescent Substance Use. Addiction, 97, 329 – 336.
- (262) McArdle P., Gilvarry E., Fitzgerald M., Brinkley A., Wiegiersma A., Quensel S. (2000). International variations in youth drug use. European Addiction and Research, 6, 163 – 169.
- (263) McArdle P., Wiegiersma A., Gilvarry E., Kolte B., McCarthy S., Fitzgerald M., Brinkley A., Blom M., Stoeckel I., Pierolini A., Michels I., Johnson R., Quensel S. (2002). European adolescent substance use: The roles of family structure, function and gender. Society for the Study of Addiction to Alcohol and Drugs. Addiction, 97, 329 – 336.
- (264) McCarthy P. (1977). Memorandum on medical manpower by IMA Subcommittee. Journal of the Irish Medical Association, September 2<sup>nd</sup>, Volume 70, No. 13, 397 – 402.
- (265) McCarthy P. (1982). Attention and cognitive task induced cardiovascular arousal in learning disabled boys and girls with Hydergine. 10<sup>th</sup> IACPP, Dublin, 110.
- (266) McCarthy P. (1982). Hydergine, social behaviour and laboratory performance in children with learning difficulties. 10<sup>th</sup> IACPP Conference, Dublin 109.
- (267) McCarthy P. (1982). Hydergine: A role in treatment of somatic expression of stress. 10<sup>th</sup> IACPP, Dublin, 111.
- (268) McCarthy P. (1982). School behaviour attention and cardiovascular arousal in children with learning difficulties. 10<sup>th</sup> IACPP, Dublin, 110.
- (269) McCarthy P. (1985). Childhood autism: 0 - 35 years. Irish Medical Journal, 78, 7, 182 – 187.
- (270) McCarthy P. (1986). Childhood psychological response to stress. 11<sup>th</sup> IACPP Congress, Paris, 32.
- (271) McCarthy P. (1986). Prevalence of behavioural maladjustment in a social cross section of Irish urban school children. Irish Medical Journal, 79, No. 5, 125 – 129.
- (272) McCarthy P. (1993). Re-integrating the acutely hospitalised adolescent. 4<sup>th</sup> W.A.P.R. Congress, Dublin.

- (273) McCarthy P. (1994). Crisis intervention. International ACPP Meeting, San Francisco.
- (274) McCarthy P. (1995). Hyperactivity: How to manage it? Royal College of Psychiatrists: Child and Adolescent Psychiatry Section Meeting, Dublin.
- (275) McCarthy P. (1995). The rape victim report. European Child and Adolescent Psychiatrists Meeting, Utrecht, 150.
- (276) McCarthy P. (1998). EUMS Workshop: Continuing Medical Education. 14<sup>th</sup> International Congress of Child and Adolescent Psychiatry and Allied Professions, Stockholm, August, 299.
- (277) McCarthy P., Fitzgerald M., Smith M. (1984). Prevalence of childhood autism in Ireland. *Irish Medical Journal*, 77, 129 – 130.
- (278) McCarthy P., Lynch K. (1986). Emotional disorders versus conduct disorders in children: Cardiovascular response to stress. 11<sup>th</sup> IACPP, Paris, 33.
- (279) McCarthy P., McCarthy C. (1994). An adolescent short-stay secure residential unit. 13<sup>th</sup> International ACPP Meeting, San Francisco, 216.
- (280) McCarthy P., Moran T. (1981). The effect of Hydergine on child attention deficits. *British Journal of Clinical Practice*, 11<sup>th</sup> December.
- (281) McCarthy P., Moran T., Mangan B. (1982). Methodological outline of a study of Hydergine in children with learning difficulties. 10<sup>th</sup> IACPP Conference, Dublin, 109.
- (282) McDermott M. (1995). Encopresis: A heap of trouble. Royal College of Psychiatrists: Child and Adolescent Psychiatry Section Meeting, Dublin.
- (283) McDermott M. (1995). Retrospective study of admissions to a residential treatment centre for children and adolescents. Royal College of Psychiatrists: Child and Adolescent Psychiatry Section Meeting, Dublin.
- (284) McDermott M., Brennan A., Fitzgerald M., Hoey H. (1998). Cognitive behavioural intervention in a group of diabetic children versus controls. 14<sup>th</sup> International Congress of Child and Adolescent Psychiatry and Allied Professions, Stockholm, August, 349.
- (285) McDermott M., Fitzgerald M. (1994). A study of psychiatric morbidity in a group of pregnant women. Royal College Psychiatrists Annual Meeting Cork 1994, 77.
- (286) McDermott M., Fitzgerald M., Cloonan B. (1994). A study of social problems and psychiatric morbidity in a group of pregnant women from a socially disadvantaged area. In International Conference of Marcé Society, Cambridge, 27.
- (287) McDermott M., Fitzgerald M., Connolly M., Hoey H. (1995). Cognitive behavioural intervention in a group of diabetic children versus control. Tenth International Congress. European Society for Child and Adolescent Psychiatry, Utrecht, 77.

- (288) McDermott M., McCrystal P., Fitzgerald M. (2001). Assessment of Post Traumatic Stress Disorder in children and adolescents two years after the Omagh bomb. Royal College of Psychiatrists, Child and Adolescent Psychiatry Faculty, Residential Meeting, York, 3<sup>rd</sup> – 5<sup>th</sup> October, 222.
- (289) McDonagh C., Fitzgerald M. (1995). A study of depression and personality in school going children. In Proceedings of the Royal College of Psychiatrists Winter Meeting, Glasgow, 45.
- (290) McDonnell K., Fitzgerald M., Kinsella A. (1988). A community based study of unmarried and married mothers. *Irish Journal of Medical Science*, 157: 3, 70 – 82.
- (291) McGauran S., Fitzgerald M., Kinsella A. (1991). Psychosocial aspects of suicide in an Irish urban area. *Topics in Psychiatry*. Lilly: Basingstoke, 3 – 11.
- (292) McGauran S., Fitzgerald M., Lyons R. (1997). Suicide – Who are the Victims? A psychological profile of suicide victims, Dublin, 1989 – 1990. *Irish Journal of Psychiatry*, 16, 3, 2 – 6.
- (293) McGee H., Fitzgerald M. (1988). Family factors in influencing child health care decisions. *Irish Psychologist*, 15: 24.
- (294) McGee H., Fitzgerald M. (1988). Home or hospital care for childhood gastroenteritis; determining factors and recommendations for improved management. *Journal of the Irish College of Physicians and Surgeons*, 17, 3, 134.
- (295) McGee H., Fitzgerald M. (1989). Immunisation uptake - an ongoing cause for concern. *Irish Families Under Stress*. Volume 4, E.H.B.: Dublin.
- (296) McGee H., Fitzgerald M. (1990). Attitudes of urban Irish doctors to the hospitalisation of young children. *Irish Journal of Psychology*, 11, 1, 77 – 81.
- (297) McGee H., Fitzgerald M. (1990). The impact of hospital experiences during training on G.P. referral rates. *Irish Journal of Psychological Medicine*, 1990, 7, 22 – 23.
- (298) McGee H., Fitzgerald M. (1990). The influence of non-medical factors in childhood hospitalisation. *British Psychological Society, Occasional Paper 2*, Leicester.
- (299) McGee H., Fitzgerald M. (1991). Childhood hospitalisation for gastroenteritis: Psychosocial and medical factors. *International Journal of Psychiatry in Medicine*, 21, 4, 355 – 368.
- (300) McGee H., Fitzgerald M. (1991). *Pathways to Childhood Hospitalisation*. Health Promotion Unit, Department of Health, Dublin, 1988. This publication was followed by a leaflet on gastroenteritis published by the Health Promotion Unit of the Department of Health. *Pathways to Childhood Hospitalisation* was reprinted by the Department of Health and the Eastern Health Board in 1991 with a preface by Mr. C. Flood, Minister for State Department of Health.
- (301) McNestry F. B., Fitzgerald M., Kinsella A. (1988). Maternal mental health, childhood behaviour problems and social disadvantage in families of children attending a child guidance clinic. *Ir. J. Psych.*, 9, 2, 14 – 17.

- (302) Michels I., Brinkley A., Fitzgerald M. (1998). Leisure time and health and social risk behaviours among young pupils in five European cities. 2<sup>nd</sup> International Conference on Health, Precariousness, Vulnerability in Europe, Paris, France, December, 4.
- (303) Mirza K., McCarthy P., Fitzgerald M. (1994). Prescribing practices of Irish child psychiatrists. In Proceedings of the Royal College of Psychiatrists Annual Meeting, Cork, 69.
- (304) Mohan D., Fitzgerald M., Collins C. (1998). The relationship between maternal depression (antenatal and pre-school stage) and childhood behaviour problems. *Irish Journal of Psychological Medicine*, 50, 1, 10 – 13.
- (305) Moore K., Abouzakouk M., Feighery C., Fitzgerald M. (1998). The prevalence of coeliac disease in children with autistic spectrum disorders. 14<sup>th</sup> International Congress of Child and Adolescent Psychiatry and Allied Professions, Stockholm, August, 90.
- (306) Moukaddem S., Fitzgerald M. (1994). An audit of a Child & Family Centre. Royal College of Psychiatrists. Annual Meeting Cork, 14.
- (307) Moukaddem S., Fitzgerald M., Barry M. (1998). Evaluation of a child and family centre. *Child Psychology and Psychiatry Review*, 3, 4, 161 – 168.
- (308) Mulhall D., Fitzgerald M., Kinsella A. (1988). A study of the relationships between the home environment and psychiatric symptoms in children and parents. *Irish Journal of Psychiatry*, 9, 1, 13 – 18.
- (309) Murphy G., Smith E., Wynne R., Fitzgerald M., Clarkin N. Stress in child psychiatric service. In *Irish Families Under Stress*, Volume 3, E.H.B.: Dublin, 314 – 332.
- (310) Murphy M., Fitzgerald M. (1989). A study of speech/language disability and behavioural deviance in children referred to a child psychiatric outpatients. *Irish Families Under Stress*, Volume 4, E.H.B.: Dublin.
- (311) Murphy M., Fitzgerald M., Fitzpatrick L., Kinsella A. (1988). Self esteem and behavioural deviance in child populations. *Irish Journal of Psychological Medicine*, 5: 94 – 97.
- (312) Murphy M., Fitzgerald M., Kinsella A., Cullen M. (1989). A study of emotions and behaviour in children attending a normal school in an urban area. *Irish Journal of Medical Science*, 158, 4, 117 – 147.
- (313) Murphy P., Fitzgerald M. (1988). A study of temperamental characteristics in children. *Irish Journal of Psychological Medicine*, 1, 13 – 16.
- (314) Nelis S., Fitzgerald M. (1997). Epidemiology of psychological problems in adolescents: a longitudinal perspective. In: Proceedings of the 5<sup>th</sup> European Congress of Psychology, Dublin, 64.
- (315) Ni Ghallchobhair M., Fitzgerald M. (1995). Suitability for psychotherapy – a prognostic profile for children. Pilot study of a semi structured interview. Royal

- (316) Ni Ghallchobhair M., Fitzgerald M. (1996). Psychotherapy assessment for children and adolescents. A preliminary study of a semi structured interview. *Irish Journal of Child and Adolescent Psychotherapy*, 1, 2, 5 – 14.
- (317) O'Brien C., Kissane N., Fitzgerald M. (1999). Psychopathology following a road traffic accident. *European Child and Adolescent Psychiatry Journal*, 8, 2, 686.
- (318) O'Brien P., Fitzgerald M. (1991). A study of changing attitudes of nursing students to psychiatry over the course of their training. In *Irish Families Under Stress*, Volume 3, E.H.B.: Dublin, 333 – 353.
- (319) O'Connor J., Fitzgerald M. (1995). A psychosocial study of Turner's syndrome in an Irish population. *European Society for Child and Adolescent Psychiatry*, 10<sup>th</sup> International Congress, Utrecht, 182.
- (320) O'Connor J., Fitzgerald M., Hoey H. (1995). Processing the meaning and consequences of Turner's syndrome; A discussion of family and patient adaptation to a syndrome of childhood and adolescence. *Royal College of Psychiatrists Child and Adolescent Psychiatry Section, Annual Residential Meeting, Dublin 12*.
- (321) O'Connor J., Fitzgerald M., Hoey H. (1996). The consequences of the findings of social, cognitive and neuropsychological research for decisions concerning interventions with girls with Turner's Syndrome. *The 10<sup>th</sup> European Health Psychology Society Conference, Dublin, 7*.
- (322) O'Connor J., Fitzgerald M., Hoey H. (1997). Selected areas of intellectual functioning in girls with Turner's syndrome: An study of the impact of Karyotype on aspects of performance and verbal intelligence. *Royal College of Psychiatrists, Annual Meeting, Belfast, June, 42 – 43*.
- (323) O'Connor J., Fitzgerald M., Hoey H., Linehan C. (1999). Diverging attributions of sex role identity. *European Child and Adolescent Psychiatry Journal*, 8, 2, 655.
- (324) O'Connor J., Fitzgerald M., Linehan C. (1999). The psychosocial functioning of girls with Turner syndrome: An examination of selected indices. *Proceedings of the Royal College of Psychiatrists Annual Meeting, Summer 1999, Birmingham, 175*.
- (325) O'Donoghue K. (1995). Retrospective study of admissions to a residential treatment centre. *10<sup>th</sup> Congress of ESCAP, Utrecht, 83*.
- (326) O'Driscoll E., Shelley R., Fitzgerald M., Regan C. Expression of serum sialyltransferase in schizophrenic and autistic patients. Abstract.
- (327) O'Flynn M., Fitzgerald M., Simms C. (1997). Are mothers and children with conduct disorder temperamentally incompatible? *5<sup>th</sup> European Congress of Psychology, Dublin*.

- (328) O'Grady Walshe A., Fitzgerald M., Kinsella A. (1996). The role of perceived parental rearing practices in depressive illness. *British Journal of Clinical and Social Psychiatry*, 9, 4: 70 – 75.
- (329) O'Hanrahan S., Fitzgerald M., O'Regan M. (1999). Personality traits in parents of people with autism. *Irish Journal of Psychological Medicine*, 16, 2, 59 – 60.
- (330) O'Leary Z., Fitzgerald M., Naidu M. (1989). A study of behavioural deviance and social competence in children of psychiatric inpatient females. *Irish Journal of Psychiatry* 10, 2, 8 – 10.
- (331) O'Neill D., Fitzgerald M. (1998). Parasuicide in a disadvantaged area of Dublin. 7<sup>th</sup> European Symposium on Suicide and Suicidal Behaviour. Gent, Belgium, September, 5.
- (332) O'Neill D., Fitzgerald M. (1999). Are accident and emergency parasuicide data representative of community rates. *Proceedings of the Royal College of Psychiatrists Annual Meeting, Summer 1999, Birmingham*, 207.
- (333) O'Neill T., Fitzgerald M., McGee H. (1991). Consumption of alcohol and drugs in mothers of children attending a child psychiatric clinic. *Irish Journal of Psychiatry*, 12, 3 – 5.
- (334) O'Regan S., Fitzgerald M., Kinsella A. (1991). Motivation towards learning and behaviour deviance in 8 to 13 year old children attending an urban primary school. *Irish Journal of Psychological Medicine*, 8, 128 – 129.
- (335) O'Rourke M., Fitzgerald M. (1986). An epidemiological study of behavioural deviance, hyperactivity and physical abnormalities in a Dublin primary school population. *Irish Journal of Psychiatry*, 6(1), 10 – 16.
- (336) O'Rourke M., Fitzgerald M. (1995). Aspects of suicidal behaviour in children. *Royal College of Psychiatrists Child and Adolescent Psychiatry Section, Annual Residential Meeting, Dublin*, 42.
- (337) O'Rourke R., Fitzgerald M. (1998). Problems with assessing suicidal thinking in boys and girls in Ireland. 14<sup>th</sup> International Congress of Child and Adolescent Psychiatry and Allied Professions, Stockholm, August, 226.
- (338) O'Rourke R., Fitzgerald M. (1998). Suicidal thinking in boys and girls in Ireland: A controlled study, 7<sup>th</sup> European Symposium on Suicide and Suicidal Behaviour. Gent, Belgium, September, 80.
- (339) O'Rourke R., Fitzgerald M. (1999). Gender issues in suicide in Irish children. *European Child and Adolescent Psychiatry*, 8, 2, 447.
- (340) O'Sullivan M., Fitzgerald M. (1998). Suicidal ideation and acts of self harm among Dublin school children. *Journal of Adolescence*, 21, 4, 427 – 444.
- (341) Piha J., Jorgesen O. S., McQuaid P. E., Klosinski G., Fitzgerald M., Sogaard H., Sourdandre A. (1991). Child psychiatric inpatient treatment in Denmark, Finland,

Ireland, and Switzerland. 9<sup>th</sup> Congress of European Society of Child and Adolescent Psychiatry, London.

- (342) Ryan I. (1990). How I do it – A multidisciplinary team approach to child sexual abuse assessment. Royal College of Psychiatrists, Child and Adolescent Section Residential Meeting, Glasgow.
- (343) Ryan I. (1990). Parents perceptions of a validation service. 8<sup>th</sup> International Congress on Child Abuse and Neglect, Hamburg.
- (344) Ryan I. (1990). True or false - A dilemma facing Professions. Evaluating Cases of Sexual Abuse. 8<sup>th</sup> International Congress on Child Abuse and Neglect, Hamburg.
- (345) Ryan I., Fitzgerald M., Kinsella A. (1991). The personalities of child psychiatric patients. In Irish Families Under Stress, Volume 3, E.H.B.: Dublin, 185 – 191.
- (346) Scully A., Fitzgerald M. A comparison of fears in children attending a child psychiatric centre patients with fears in children attending a normal school. Submitted for publication.
- (347) Sheehan J., Fitzgerald M. (1994). Measuring progress in psychoanalytic psychotherapy. *Journal Group Analytic Psychotherapy*, 27(2): 211 – 220.
- (348) Stone D., Fitzgerald M., Kinsella A. (1990). A study of behavioural deviance and social difficulties in 11 and 12 year old school children. *Irish Journal of Psychiatry*, Spring, 12 – 14.
- (349) Stone D., Fitzgerald M., Walsh N. (1994). A study of failed suicides. Fifth European Symposium on suicide. Cork, 116.
- (350) Tansey L., Fitzgerald M., Kinsella A. (1990). The measurement of adolescent adaptive process in clinical interview. *Journal of Adolescence*, 13, 299 – 305.
- (351) Veluri R., Fitzgerald M. (1993). A study of the lifetime prevalence of depressive disorder in the first degree relatives of patients with major depressive disorder. *Irish Journal of Psychiatry*, Spring, 3 – 4.
- (352) Williams H., Fitzgerald M., Kinsella A. (1989). Psychological distress and attitude in authority in a sample of Irish adolescents. *Irish Journal of Psychological Medicine*, 5, 37 – 40.

**PUBLICATIONS AND PUBLISHED ABSTRACTS ETC.  
BY IRISH CHILD PSYCHIATRISTS**

**1971 – 2002**

***Publications and Published Abstracts etc. by Irish Child Psychiatrists excluding Trinity College Dublin / South Western Area Health Board***

- (1a) Adamson N., Killelea D. (1996). A study of general practitioner needs of a new child psychiatric service. *Irish Journal of Psychological Medicine*, 13, 1, 30 – 32.
- (2a) Agras S., Hammer L., McNicholas F., (1999). A prospective study of the influence of eating disordered mothers on their children. *International Journal of Eating Disorder*, 25, 253 – 262.
- (3a) Anglim M. (1995). Reversible autistic type regression without seizures as a manifestation of epilepsy? 10<sup>th</sup> ESCAP, Utrecht, 171.
- (4a) Bradley O., Ganter K. (1993). Suicide behaviour in a community based child and adolescent psychiatric service. *Irish Medical Journal*, 86, 5, 161 – 162.
- (5a) Bradley O., Lane O., O'Donovan A. (1990). What does the future hold for those who attend a special school for emotionally disturbed. Royal College of Psychiatrists, Annual Meeting, Galway.
- (6a) Brennan T. (1979). A community based psychiatric service for adolescents. *Journal of the Irish Medical Association*, September 28<sup>th</sup>, Volume 72, No. 9, page 371 – 376.
- (7a) Brennan T. G., O'Loidean D. S. (1983). Psychopathology in Irish adolescents. *Irish Medical Journal*, 76, 3, 142 – 145.
- (8a) Byrne N. (1992). Working with child and family adversity: Are there acceptable levels of risk and protection? Conference on Surviving Childhood Adversity, Trinity College.
- (9a) Byrne N., McCarthy I. (1986). Irish women. Conference at U.M.D.N.J., Robert Wood Johnson Medical School, September 15<sup>th</sup>.
- (10a) Byrne N., McCarthy I. (1988). Moving statues: Requesting ambivalence in ambiguous discourse. *Irish Journal of Psychology*, 9, 173 – 182.
- (11a) Carroll A. (1982). Children in distress in the West of Ireland. 10<sup>th</sup> International Conference Association of Child Psychology and Psychiatry, Dublin, 215.
- (12a) Cassidy B., Smyth B., Sheppard N. (1998). The Samaritans and parasuicide. *Irish Journal of Medical Science*, 167(5), 23 (Abstract).

- (13a) Connolly L., Sharry J., Fitzpatrick C. (1998). Evaluation of video based parent training programmes. 14<sup>th</sup> International Congress of Child and Adolescent Psychiatry and Allied Professions, Stockholm, August, 54.
- (14a) Cryan E., Byrne E. M., O'Donovan A., O'Callaghan E. (1996). Brief report: A case control study of obstetric complications and later autistic disorder. *Journal of Autism Developmental Disorders*, 26, No. 4, 453 – 460.
- (15a) Cryan E., Ganter K. (1992). Childhood hallucinations in the context of parental psychopathology. *Irish Journal of Psychological Medicine*, 9, 2, 120 – 121.
- (16a) Deehan A., Fitzpatrick C. (1993). Sexual behaviour and knowledge of normal children as perceived by their parents, 86, 4, 130 – 132.
- (17a) Doherty M. B., Madansky D., Kraft J., Carter-Ake L. L., Rosenthal P., Coughlin B. F. (1986). Cortisol dynamics and test performance of the DST in 97 psychiatrically hospitalised children aged 3 – 16 years. *Journal of American Academy of Child Psychiatry*, 25 (3): 400 – 408.
- (18a) Doherty M. B., Manderson M., Carter-Ake L. L. (1978). Time-limited psychiatric hospitalisation of children: A model and three year outcome. *Hospital and Community Psychiatry*, 38 (6): 643 – 647.
- (19a) Doherty M. B., Rosenfeld A. A. (1984). Play assessment in the differential diagnosis of autism and other causes of severe language disorder. *Journal of Developmental and Behavioural Paediatrics*, 5, 26 – 29.
- (20a) Doyle M. (1991). Sibling psychosis. Annual Research day. St. John of God's Conference.
- (21a) Doyle M. (1994). Encopresis. Royal College of Psychiatrists Annual Meeting, Trinity College Dublin.
- (22a) Fitzpatrick C. (1982). Parents understanding referral to different outpatient departments. *Irish Medical Journal*, Volume 75, No. 12, 446 – 448.
- (23a) Fitzpatrick C. (1995). Depression in adolescents. *Irish Medical Journal*, 88, 2, 42 – 45.
- (24a) Fitzpatrick C. (1998). Refusal to eat or drink in young children with anxiety disorders. *Clinical Child Psychology and Psychiatry*, 3, 1, 31 – 38.
- (25a) Fitzpatrick C., Colquhoun P. (1988). Abnormal illness behaviour. *Association for Child Psychology and Psychiatry Newsletter* 10, 9 – 13.
- (26a) Fitzpatrick C., Connolly L., Sharry J. (1998). Developing a video based parent training programme to suit cultural needs. 14<sup>th</sup> International of Child and Adolescent Psychiatry and Allied Professions, Stockholm, August, 53.
- (27a) Gringras P., McNicholas F. (1999). Developing rational protocols for paediatric psychopharmacological prescribing. *Child: Care, Health & Development*, 25, No. 3, 223 – 233.

- (28a) Gringras P., McNicholas F. (2000). Psychopharmacology: Its place in Child Psychiatry. *Prescriber*, 11: (6), 115 – 122.
- (29a) Harpur J., Lawlor M., Foley V., Fitzgerald M. (2002). Normal adolescents as drama script writers in a multimedia computer project. *Proceedings of IMFAR Conference*, November 2002. Florida USA P2 7.5 p 78.
- (30a) Healy N. Clinical note. Childhood neurotic disorders with a sexual content need not imply child sexual abuse. *32: 857 – 863*.
- (31a) Healy N. M. (1965). Gilles de la Tourette syndrome in an autistic child. *Journal of the Irish Medical Association*, 93 – 94.
- (32a) Hillary J., Halpin C. (1994). The assessment of 149 patients with dual diagnosis (mental handicap and psychiatric illness) living in a residential centre. *Royal College of Psychiatrists Annual Meeting, Cork*, 84.
- (33a) Hillary J., Mulcahy M. (1997). Self injurious behaviour in persons with a mental handicap: An epidemiological study in an Irish population. *Irish Journal of Psychological Medicine*, 14, 1, 12 – 15.
- (34a) James D., Lawlor M. (2001). Psychological problems of early school leavers. *Irish Journal of Psychological Medicine*, 18 (2), 61 – 65.
- (35a) James D., Sofroniou N., Lawlor M. (2003). Analysis of emotional response to bullying. *Irish Journal of Psychology*.
- (36a) Kelly T., McArdle P. (1997). Using the Achenbach Child Behaviour Checklist in a differential diagnosis of disruptive behaviour disorders. *Irish Journal of Psychological Medicine*, 14, 4, 136 – 138.
- (37a) Lawlor M. (1993). Assessment of the likelihood of primary school teachers believing children's disclosures of child sexual abuse. *Child Abuse Review*, Volume 2, 174 – 184.
- (38a) Lawlor M. (2001). Suicidal ideation in adolescence as a result of bullying: the importance of asking. *Modern Medicine of Ireland*, 31, 11, 43 – 46.
- (39a) Lawlor M., Flynn A., James D., Courtney P., Henry B. (2002). The cool school response to school bullying. Paper in proceedings of Irish Association of Suicidology and National Suicide Review Group Conference on Suicide and Bullying. Tralee November 2002.
- (40a) Lawlor M., Flynn A., James D., Courtney P., Henry B. (2002). Responding to bullying. First steps for teachers, 2002 Cool School Programme, NEHB Drogheda.
- (41a) Lawlor M., Flynn A., James D., Courtney P., Henry B. (2002). Investigating and resolving bullying in school. 2002 Cool School Programme, NEHB, Drogheda.
- (42a) Lawlor M., James D. (2000). Prevalence of psychological problems in Irish school going adolescents. *Irish Journal of Psychological Medicine*, 17, 4, 117 – 122.

- (43a) Lawlor M., MacIntyre D. (1991). Stay Safe Programme: A child abuse prevention programme for primary schools. Eastern Health Board and the Department of Health.
- (44a) Lawlor M., MacIntyre D. (1991). Stay Safe Programme, First Edition, published in Dublin in 1991. Contained three separate books (Teachers Handbook, Junior Lesson Plans, and Senior Lessons Plans). Senior and junior workbooks, a video, and cassette tape.
- (45a) Lawlor M., MacIntyre D. (1993). Stay Safe Programme, Second Edition, published in 1993. Contained five separate books (Teachers Handbook, Infants Lesson Plans, First and Second Class Lesson Plans, Third and Fourth Class Lesson Plans, Fifth and Sixth Class Lessons Plans). Workbooks, video and cassette tape.
- (46a) Lawlor M., MacIntyre D., Flattery M. (1989). Mind that child (Video), Dublin Veritas.
- (47a) Lawlor M., MacIntyre D., Flattery M. (1993). Bi Sabhailte Dublin: Child Abuse Prevention Programme (Irish Translation).
- (48a) Lawlor M., MacIntyre D., Flattery M. (1994). Stay Safe: A Parent's Guide, First Edition. Child Abuse Prevention Programme.
- (49a) Lawlor M., MacIntyre D., Cullen R. (1996). Stay Safe: Personal Safety Skills for Children with Disabilities. Dublin. Child Abuse Prevention Programme: Dublin.
- (50a) Lawlor M., MacIntyre D., Cullen R. (2000). Stay Safe: A Parent's Guide, Second Edition. Child Abuse Prevention Programme.
- (51a) MacIntyre D., Carr A., Lawlor M., Flattery M. (2000). Development of Stay Safe Programme. Child Abuse Review, 9, 200 – 216.
- (52a) McArdle P., O'Brien G., Kolvin I. (2002). Hyperactivity and Conduct Disorder: Exploring origins. Irish Journal of Psychological Medicine, 19 (2), 42 – 47.
- (53a) McAuley R. (1982). Training parents to modify conduct problems in their children. Journal of Child Psychology Child Psychiatry, 23: 335 – 342.
- (54a) McAuley R. (1993). Counselling parents in child behaviour therapy. In Managing Children with Psychiatric Problems. Edited by M. Garralda and published by BMJ.
- (55a) McCarthy I., Byrne N. (1988). Mistaken love: Conversations on the problem of incest in an Irish context. Family Process, 27, 181 – 199.
- (56a) McCauley R. (1982). The behaviour therapist in a child psychiatry setting. 10<sup>th</sup> IACPP, Dublin, 164.
- (57a) McCauley R. (1982). The impact of urban violence on children referred to a child guidance centre. 10<sup>th</sup> IACPP, Dublin, 106.

- (58a) McCune N. (1998). Attention deficit hyperactivity disorder and thyroid dysfunction. *Proceedings of the Faculty of Child and Adolescent Psychiatry, Annual Meeting, Bristol, September*, 50.
- (59a) McCune N., Walford G. (1991). The role of the psychiatrist in child sexual abuse. *Irish Journal of Psychological Medicine*, 8, 2, 93 – 99.
- (60a) McNicholas F. (1996). Eating psychopathology and its effect on pregnancy, infant growth and development. *Irish Journal of Psychological Medicine*, 13 (2): 67 – 69.
- (61a) McNicholas F. (1997). Attitudes of general practitioners to child psychiatric services. *Irish Journal of Psychological Medicine*, 14, 2, 43 – 45.
- (62a) McNicholas F. (1998). ‘Infancy and early childhood: The practice of clinical assessment and intervention with emotional and developmental challenges. Stanley L. Greenspan’. *British Journal of Psychiatry*, Vol. 162, 143 – 144 (Book Review).
- (63a) McNicholas F. (2000). Good practice in Attention Deficit Hyperactivity Disorder. *Irish Journal of Psychological Medicine*, 17 (2), 62 – 66.
- (64a) McNicholas F., Baird G. (2000). Early onset Bipolar Disorder and ADHD: Diagnostic confusion due to co-morbidity. *Clinical Child Psychology and Psychiatry*, Vol. 5, No. 4.
- (65a) McNicholas F., Gringras P. (2000). Guide to Attention Deficit Hyperactivity Disorder. *Prescriber*, 11: (7), 19 – 29.
- (66a) McNicholas F., Slonims V., Cass H. (2000). Exaggeration of symptoms or psychiatric Munchausen Syndrome by Proxy? *Child Psychology and Psychiatry Review*, Vol. 5 (2), 69 – 75.
- (67a) McQuaid P. (1971). The character disorder child in Ireland. *Journal of the Irish Medical Association*, 64, 407, 125 – 131.
- (68a) McQuaid P. (1974). The disadvantaged adolescent. *Journal of the Irish Medical Association*, 67, 24, 629 – 634.
- (69a) McQuaid P. (1975). Infantile autism in twins. *British Journal of Psychiatry*, 127, 530 – 534.
- (70a) McQuaid P. (1977). Learning disability / a review. *Journal of the Irish Medical Association*, September 30<sup>th</sup>, Volume 70, No. 14, 425 – 431.
- (71a) McQuaid P. (1977). Some aspects of family violence as it effects young children. *Journal of the Irish Medical Association*, December 16<sup>th</sup>, Volume 70, No. 19, 569 – 573.
- (72a) McQuaid P. (1985). Child and family psychiatry – the Irish dimension. *Irish Journal of Psychiatry*, 6, 2, 16 – 21.
- (73a) McQuaid P. E. (1978). Child criminals? *Journal of the Irish Medical Association*, October 31st, Volume 71, No. 15, 515 – 518.

- (74a) McQuaid P., Ahern D. (1991). Irish general practice in clinical psychology. *Irish Journal of Psychological Medicine*, 8, 2, 174 – 176.
- (75a) McQuaid P., Ganter K. (1982). Gilles de la Tourette Syndrome - interventions and medication. 10<sup>th</sup> IACPP, Dublin, 28.
- (76a) Michael J., O'Mahony D., Sinnanan K. (1981). Comparison of the incidence of physical disorders among acute day hospital patients and hospital inpatients. *Irish Journal of Psychiatry*, Vol. 1, No. 1.
- (77a) Munjal A., Latimer M., McCune N. (1994). Attendance at child psychiatry new patient clinic. *Irish Journal of Psychological Medicine*, 11, 4, 182 – 184.
- (78a) Murray M., Healy N. (1991). Tele therapy. 9<sup>th</sup> ESCAP, London.
- (79a) Murray M., Healy N. (1994). Prevalence of video viewing among adolescents. Royal College of Psychiatrists Annual Meeting, Cork, 69.
- (80a) Nelis S., Carr A. (1997). Expressed emotion: A psychosocial risk factor in psychological problems in adolescents. 5<sup>th</sup> European Congress of Psychology, Dublin.
- (81a) Nutt D., Baldwin D., Beaumont G., Bell C., Denny C., Knapp M., Maxwell R., McNicholas F., Wells A. (1999). Guidelines for the management of social phobia / social anxiety disorder. *Primary Care Psychiatry*, 5, 4, 147 – 155.
- (82a) O'Leary F. (1994). Climate, seasonality and adolescent psychiatric disorders. 5<sup>th</sup> European Symposium on Suicide, Cork, 117.
- (83a) O'Sullivan M. (2003). Anxiety disorders in adolescence. *Modern Medicine*, 33, 1, 23 – 27.
- (84a) O'Sullivan M., Meagher D. (1998). Assaults on psychiatrists. *Irish Journal of Psychological Medicine*, 15, 2, 54 – 57.
- (85a) Rooney S., Byrne G. (1997). Object relations theory applied to early emotional deprivation, resulting in autistic spectrum disorder. *Irish Journal of Psychological Medicine*, 14, 4, 132 – 135.
- (86a) Sharry J., Connolly L., Fitzpatrick C. (1998). Running a video based parent training programme with parents of children with behavioural problems. 14<sup>th</sup> International Congress of Child and Adolescent Psychiatry and Allied Professions, Stockholm, August, 53.
- (87a) Smyth B., Keenan E., Dorman A., O'Connor J. J. (1994). Gender differences in needle sharing behaviour patterns. *Addiction*, 89: 96.
- (88a) Smyth B., Keenan E., Dorman A., O'Connor J. J. (1995). Hepatitis C infection among injecting drug users attending the National Drug Treatment Centre. *Irish Journal of Medical Science*, 267 – 268.

- (89a) Smyth B., Keenan E., O'Connor J. J. (In Press). Bloodborne viral infection in Irish injecting drug users. *Addiction*, November 1998.
- (90a) Smyth B., Keenan E., O'Connor J. J. (In Press). Hepatitis C virus infection among recent onset injecting drug users in Dublin. *Addiction Biology*, 1998 (Abstract).
- (91a) Smyth B., McMahon J., O'Connor J. J., Ryan J. (1999). Knowledge regarding Hepatitis C among injecting drug users. Accepted by *Drugs: Education, Prevention and Policy*.
- (92a) Stack J. (1983). History of Irish child psychiatry. Annual ACPP Meeting, Cluain Mhuire, June.

## *ROSTER OF IRISH CHILD PSYCHIATRISTS*

Philip Tyndall.  
Keith Holmes.  
Maria Lawlor.  
Mandy Burke.  
Martin O'Sullivan.  
A. O'Donohue.  
Catherine McElearney.  
Fiona McNicholas.  
Brenda Dowling.  
Yvonne Begley.  
Mary Smith.  
Catherine O'Brien.  
C. Craven.  
Paul McQuaid.  
Imelda Ryan.  
Tom Brennan.  
Louise Gallagher.  
Kate Ganter.  
Louise Tansey.  
Howard Campbell.  
Gerry Byrne.  
Marie Ann Smith.  
Nollaig Byrne.  
William Nelson.  
Ann Marie Waldron.  
Mary Hayes.  
Catherine Margan.  
Don Cotter.  
Philip Dodd.  
Caroline McKenna.  
Elizabeth Dollard.  
Rachel Latey.  
A. Madan.  
Peter Gallagher.  
Elizabeth Cormack.  
Angela Kearney.  
Elma Hedderman.  
Sabina Feeney.  
M. D. McGuinness.  
Eimear Philbin Bowman.  
Richard Wilson.  
Morna Manwell.  
Mary Shortt.  
Anna McGovern.  
Brian Mangan.

Oonagh Bradley.  
Kathryn O'Donoghue.  
Carol Fitzpatrick.  
Maria Dunne.  
Bernadette Mackey.  
Gill Randell.  
Maevae Doyle.  
Dave Broderick.  
Paul McCarthy.  
Roger McAuley.  
Anthony Carroll.  
Helen Leader.  
Vivienne Whelan.  
David Leahy.  
Declan Sheerin.  
Betty Corboy.  
Ann O'Donovan.  
Jerry O'Neill.  
Melanie Gallagher.  
Neil Adamson.  
Nuala Healy.  
Mary Smith.  
Maura McDermott.  
Antoinette Dalton.  
Eithne Foley.  
Paul Siung.  
Mary Rose McCarthy.  
Betty Barnes.  
Carol Fitzpatrick.  
Caroline Noone.  
Mary Concannon Bluett.  
Tom Moran.  
Ewen McEwen.  
Ann Murray.  
Niall Falls.  
Aisling Mulligan.  
Fionnuala Lynch.  
S. Dineen.  
Maureen Doherty.  
John Hillery.  
Margaret Grace.  
Janet Wilson.  
Karen Fulton.  
Maria Migone.  
Andrew Collins.

Colette Halpin.  
Finbar O'Leary.  
A. D'Alla.  
Louise Connolly.  
Leo Mestel.  
Shauna McCarthy.  
Louise Atkin.  
Kieran Moore.  
Michael Fitzgerald.  
Georgina O'Brien.  
Brian Houlihan.  
Brendan Doodly.  
Helen Keeley.  
Ann Marie Robertson.  
Peadar O'Grady.  
Maureen Walsh (R.I.P.).  
Mairin Doherty.  
Joan Michael.  
Victor O'Loughlin.  
John Stack (R.I.P.).  
Marie Kennedy.  
Stephen Kane.  
Una Batt.  
Don McDwyer.  
Margo Anglim.  
Mary Belton.  
Una O'Donnell.  
Brenda O'Donnell (R.I.P.).  
Yvonne Begley.  
Paddy Murray (R.I.P.).  
Bernie Mangan.  
Geraldine Walford.  
Fionnuala Leddy.  
Noel McCune.  
A. Boachie.  
Naomi Kissane.  
A. Power.  
Bobby Smyth.  
Nollaig Byrne.  
Lisleen Cassidy.  
Rachel Davies.  
Sheila Rogers.  
Julie Manderson.  
Catherine Mangan.  
Sheelagh Rogan.

*Michael Fitzgerald*

He undertook his internship at the Chicago Medical School U.S.A. in 1970 and worked as a junior doctor at St. Patrick's Hospital Dublin from 1972 onwards. Then he worked at the Bethlem Royal and Maudsley Hospital London and the National Hospital for Nervous Diseases, Queen's Square, London 1975 to 1978. Then in 1979 he was a senior registrar in Psychiatry King's College Hospital London. He has been a consultant psychiatrist for the National Children's Hospital Dublin (and later incorporated into the Adelaide and Meath Hospital), Our Lady's Hospital for Sick Children Dublin, and the South Western Area Health Board in Dublin. He received an M.B. from the University College Galway and an M.D. from T.C.D. In 1996 he became the first professor of child psychiatry in Ireland – the Henry Marsh Professor of Child Psychiatry at Trinity College Dublin. He is the clinical and research consultant for the Irish Society for Autism. He became an associate member of the British Psychoanalytic Society and the International Psychoanalytic Association in 1980 and remains the only psychoanalyst recognised by the International Psychoanalytic Association in the Republic of Ireland (2003) and was the first to practice here with this recognition.

He initiated the first Masters programme in Adult Psychoanalytic Psychotherapy in the 1980's. In the 1990's he developed with Dr. Mary Smith a Masters programme in Child and Adolescent Psychoanalytic Psychotherapy at Trinity College Dublin and with Nessa Childers, Ross Skelton, Ann Murphy and others a Masters programme in Adult Psychoanalytic Psychotherapy at Trinity College Dublin. He founded the Journal the Irish Forum for Psychoanalytic Psychotherapy and the Irish Journal for Child Psychotherapy. He founded the Irish Standing Conference on Psychotherapy. He is co-chair of the Irish Institute of Psychoanalytic Psychotherapy. He has been a tutor in Psychotherapy Queens University Belfast. He has supervised staff in training in psychotherapy at St. Ita's Hospital, St. Loman's Hospital, Artane Day Centre, Vergemount Hospital and St. Patrick's Hospital Dublin.

He is on the Editorial Advisory Board of the European Child and Adolescent Psychiatry Journal, Journal of the Irish Psychiatric Association, and the Irish Journal of Psychological Medicine. He is a past chairman of the Child Psychiatry Section and Psychotherapy Section of the Irish Division Royal College of Psychiatrists and of the Association of Child Psychology and Child Psychiatry Irish Branch. He has been a member of the Royal College of Psychiatrists in London Psychotherapy Section, Psychotherapy Training (PTSAC) Committee, Learning Disability Executive and Child Psychiatry Executive of the Royal College of Psychiatrists. He was also a founding member of the European Association of Psychotherapy (EAP) in Holland. He was involved in the early stages with the development of the European Federation of Psychoanalytic Psychotherapy.

He has worked in the field of autism since 1973 and has diagnosed over 800 patients with autism and Asperger's syndrome. He is a member of the Royal College of Surgeons in England. He is a fellow of the Royal College of Psychiatrists in London. He is an honorary member of the Northern Ireland Association for the study of Psychoanalysis. He is also an honorary foundation member of the Northern Ireland Institute of Human Relations. He was appointed to the Government Commission on the Family and also the Eastern Regional Health Authority Review Group on Autism as well as the Department of Education and Science Task Force on Autism. He is a life member of the Irish Byron Society. He has been a director of the Gheel Autism Services (for persons with autism), chairperson of the Irish Association of Suicidology and Panda Foundation in Clare. He has over 300 published contributions to the literature including books, peer reviewed papers, abstracts and letters to the editor of Peer Reviewed Journals. He has edited or co-edited eight books. He has been involved in research collaborations in 18 countries. He has been chairman of the Board of Management of two Schools for children with autism Ballyowen Meadows and Setanta for over 21 years. He has contributed to the

media on over 150 occasions and presented six programmes on adolescence for RTE TV. He was a judge at the Aer Lingus Young Scientists and later the ESAT exhibition.