



**Growing Up
in Ireland**
National Longitudinal
Study of Children



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Growing Up in Ireland

National Longitudinal Study of Children

COHORT '08 (Infant Cohort)

**Report on the Pilot for Wave Five of the
Cohort '08 Survey (at 9 Years of Age)**



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REPORT ON THE PILOT FOR WAVE FIVE OF THE COHORT '08 SURVEY (AT 9 YEARS OF AGE)

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The views expressed in this report are those of the authors and do not necessarily reflect the views of the funders or of either of the two institutions involved in preparing the report.



An Roinn Leanaí
agus Gnóthai Óige
Department of Children
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TABLE OF CONTENTS

LIST OF APPENDICES	9
ACKNOWLEDGEMENTS	10
SUMMARY	11
CHAPTER 1: BACKGROUND TO PILOT PHASE	16
1.1 Introduction	17
1.2 Summary of the Conceptual Framework	17
1.3 Issues and Principles in Developing Instruments and Field Procedures	18
1.3.1 Longitudinal consistency	18
1.3.2 Changing social contexts	19
1.3.3 Implications of the design of the Cohort '98 and Cohort '08 samples	19
1.3.3.1 Cohort '98 at 9 years	19
1.3.3.2 Cohort '08 at 9 years	19
1.4 The Consultation Process	20
1.4.1 The Study Team and Study Team Management Group (STMG)	20
1.4.2 The Scientific Advisory Group (SAG)	21
1.4.3 The Children's Consultative Process	21
1.4.4 The Steering Group/Project Team and Research Ethics Committee (REC)	21
1.5 Overview of Themes Addressed in the Pilot Instrumentation	22
1.5.1 Physical health and development	22
1.5.2 Social, emotional and behavioural well-being	22
1.5.3 Educational achievement and intellectual capacity	22
1.5.4 The contexts in which 9-year-olds are growing up	23
1.6 Structure of this Report	23
CHAPTER 2: DESIGN, INFORMANTS, QUESTIONNAIRES AND INTERVIEWER TRAINING	24
2.1 Introduction	25
2.2 Design Overview and Questionnaires	25
2.2.1 Informants and questionnaires	25
2.2.2 Administering the surveys and questionnaire timings	26
2.2.3 Decisions on broad design of main phase of fieldwork	27
2.3 Interviewer Training and Debriefing	28
2.3.1 Decisions on interviewer training for main phase of fieldwork	29
2.4 Data Capture and Transfer	29
2.4.1 Decisions on data capture and transfer main phase of fieldwork	30
2.5 Testing the Feasibility of Computer Tablets for Child Self-Complete (Sensitive) Questionnaire	30
2.5.1 Decision on use of computer tablets in main phase of fieldwork	31
CHAPTER 3: RECRUITING THE FAMILIES AND INFORMED CONSENT	32
3.1 Introduction	33
3.2 Approaching the Families – Informed Consent	33
3.2.1 Decisions on approaching the family in main phase of fieldwork	34
CHAPTER 4: THE PILOT SAMPLE AND RESPONSE RATES	35
4.1 Introduction	36
4.2 The Sample	36
4.2.1 Intervening waves	36
4.2.2 Inclusion of the 'dress rehearsal' sample	36
4.2.3 Response rates for Wave 5 (age 9 years) pilot	37



CHAPTER 5: CHILD MAIN QUESTIONNAIRE	38
5.1 Child Main Questionnaire	39
5.1.1 Section A	39
5.1.1.1 Summary of changes for main phase at 9 years	39
5.1.2 Section B	40
5.1.2.1 Summary of changes for main phase at 9 years	41
CHAPTER 6: CHILD SELF-COMPLETE (SENSITIVE) QUESTIONNAIRE	42
6.1 Core Self-Complete (Sensitive) Questionnaire	43
6.1.1 Section A	43
6.1.1.1 Summary of changes for main phase at 9 years	43
6.1.2 Section B	43
6.1.2.1 Summary of changes for main phase at 9 years	44
6.1.3 Section C	44
6.1.3.1 Summary of changes for main phase at 9 years	45
6.2 Parenting Style Inventory	45
6.2.1 Performance in the pilot study	45
6.2.1.1 Summary of changes for main phase at 9 years	46
6.3 Piers-Harris Self-Concept Scale	46
6.3.1 Psychometric information	47
6.3.2 Reducing the Piers-Harris self-concept scale	47
6.3.3 Performance in the pilot study	48
6.3.3.1 Summary of changes for main phase at 9 years	49
6.4 Mode Effects in the Core Sensitive and Supplemental Questionnaires	49
6.4.1 Mode effects in the Study Child's perception of neighbourhood, school, teachers and experience of bullying	49
6.4.2 Mode effects in the Parenting Style Inventory	51
6.4.3 Mode effects in the Piers-Harris self-concept scale	51
6.4.4 Summary assessment of mode effects	52
6.4.4.1 Summary of changes for main phase at 9 years	53
6.5 Additional Modelling of Mode Effects for the Strengths and Difficulties Questionnaire	53
CHAPTER 7: CHILD'S COGNITIVE TESTS AND MEASUREMENTS	55
7.1 Introduction	56
7.2 Drumcondra Reading Test	56
7.2.1 Descriptive results	56
7.2.2 Relationships with other measures	57
7.2.2.1 Primary Caregiver's education	57
7.2.2.2 Other indicators of academic ability	57
7.2.2.3 Measures of socio-emotional and behavioural difficulties	57
7.2.3 Decision on Drumcondra Test for main fieldwork	58
7.3 Selective Attention Test	58
7.3.1 Descriptive results	58
7.3.2 Relationships with other measures	59
7.3.3 Decision on the Selective Attention test in main phase of the study	60
7.4 Blood Pressure	61
7.4.1 Descriptive statistics and comparison with norms	61
7.4.2 Feedback from interviewers	62
7.4.2.1 Summary of changes for main phase at 9 years	62
7.5 Study Child Height and Weight	62
7.5.1 Height	62
7.5.2 Weight	62
7.5.3 BMI	63
7.5.3.1 Summary of changes for main phase of fieldwork	63



CHAPTER 8: THE PRIMARY CAREGIVER'S MAIN QUESTIONNAIRE	64
8.1 Introduction	65
8.2 Overall Structure of PCG Main Questionnaire	65
8.2.1 Section A: Household composition	65
8.2.1.1 Commentary	65
8.2.2 Section B: Child's relationships	66
8.2.2.1 Commentary	66
8.2.2.2 Decisions and changes for the main phase	66
8.2.3 Section C: Child's physical health and development	66
8.2.3.1 Commentary	68
8.2.3.2 Summary of changes for the main phase	68
8.2.4 Section D: Child's diet and exercise	69
8.2.4.1 Commentary	69
8.2.4.2 Summary of changes for the main phase	69
8.2.5 Section E: Parental health	69
8.2.5.1 Commentary	70
8.2.5.2 Decisions and summary of changes for the main phase	70
8.2.6 Section F: Child's play and activities	71
8.2.6.1 Commentary	71
8.2.6.2 Summary of changes for main phase	71
8.2.7 Section G: Screen-time and internet use	72
8.2.7.1 Commentary	72
8.2.7.2 Summary of changes for main phase	73
8.2.8 Section H: Child's emotional health and well-being	73
8.2.8.1 Commentary and decisions for main phase	73
8.2.9 Section I: Parenting and family context	73
8.2.9.1 Commentary	74
8.2.9.2 Summary of changes for the main phase	75
8.2.10 Section J: Child's education	75
8.2.10.1 Commentary	75
8.2.10.2 Summary of changes for the main phase	77
8.2.11 Section K: Peer relationships and bullying	77
8.2.11.1 Commentary and decision regarding main phase of fieldwork	77
8.2.12 Section L: Socio-demographic information	77
8.2.12.1 Commentary	78
8.2.12.2 Summary of changes for the main phase	80
8.2.13 Section M: About you	81
8.2.13.1 Commentary	81
8.2.14 Section N: Neighbourhood/Community	81
8.2.14.1 Commentary	82
8.2.14.2 Summary of changes for the main phase	82
CHAPTER 9: SECONDARY CAREGIVER'S MAIN QUESTIONNAIRE	83
9.1 Introduction	84
9.2 Overall Structure and Performance of the SCG Main Questionnaire	84
9.2.1 Section A: Child's relationships	85
9.2.2 Section B: Parental health	85
9.2.3 Section C: Child's play and activity	85
9.2.4 Section E: Parenting and family context	85
9.2.5 Section F: Socio-demographics	86
9.2.5.1 Summary of Changes for Main Phase of Interviewing	86



CHAPTER 10: THE PRIMARY AND SECONDARY CAREGIVER SELF-COMPLETE (SENSITIVE) QUESTIONNAIRE	87
10.1 Primary and Secondary Caregiver Sensitive Sections	88
10.1.1 Relationship to the Study Child	89
10.1.1.1 Change for main phase	89
10.1.2 Quality of partner relationship, co-parenting scale and parental stress	89
10.1.3 Consumption of alcohol, smoking and illicit drugs	89
10.1.4 Parental anxiety and depression	90
10.1.5 Distribution of household and child-rearing activities in the home	90
10.1.6 Insertion of questions previously asked on main parental questionnaire	90
10.1.7 Details on Study Child's non-resident parent	90
10.1.8 Parents' recollections of relationship with own parents when they were 9 years old	90
10.1.9 Addition of parenting style measures	91
10.1.9.1 Summary of changes for main phase of fieldwork	91
CHAPTER 11: MAIN SCALES USED IN THE PARENTAL QUESTIONNAIRES	92
11.1 Introduction	93
11.2 Strengths and Difficulties Questionnaire	93
11.2.1 Instrument description	93
11.2.2 Performance in the pilot	93
11.2.2.1 Summary of changes for main fieldwork	94
11.3 Pianta Parent–Child Relationship Scale	94
11.3.1 Instrument description	94
11.3.2 Performance in the pilot	94
11.3.2.1 Summary of changes for main fieldwork	95
11.4 Social Skills Improvement System Rating Scales (SSIS)	95
11.4.1 Instrument description	95
11.4.2 Psychometric information	95
11.4.3 Performance in the pilot	95
11.4.3.1 Summary of changes for main fieldwork	96
11.5 The Everyday Discrimination Scale – EDS (short version)	96
11.5.1 Instrument description	96
11.5.2 Psychometric information	96
11.5.3 Performance in the pilot	96
11.5.3.1 Summary of changes for main fieldwork	96
11.6 Dyadic Adjustment Scale	97
11.6.1 Instrument description	97
11.6.2 Psychometric Information	97
11.6.3 Performance in the pilot	97
11.6.3.1 Decisions for main fieldwork	98
11.7 Co-parenting Relationship Scale (CRS)	98
11.7.1 Instrument description	98
11.7.2 Psychometric information	98
11.7.3 Performance in the pilot	98
11.7.3.1 Summary of changes for main fieldwork	99
11.8 Depression Status (CES-D scores)	100
11.8.1 Instrument description	100
11.8.2 Psychometric information	100
11.8.3 Performance in the pilot	100
11.8.3.1 Decisions for main fieldwork	100



11.9	Fast Alcohol Screening Test (FAST)	101
11.9.1	Instrument description	101
11.9.2	Psychometric information	101
11.9.3	Performance in the pilot	101
11.9.3.1	Decisions for main fieldwork	101
11.10	Parental Stress (Parental Stressors Subscale)	101
11.10.1	Instrument description	101
11.10.2	Performance in the pilot	101
11.10.2.1	Decisions for main fieldwork	101
CHAPTER 12: SCHOOL PILOT PHASE		102
12.1	Overview of Procedures for School Component	103
12.1.1	Response rates	103
12.2	Instrumentation	103
12.2.1	Teacher-on-Pupil Questionnaire	103
12.2.1.1	Summary of changes for main phase	105
12.2.2	Teacher-on-Self Questionnaire	105
12.2.2.1	Decision regarding main phase	106
12.2.3	Principal Questionnaire	106
12.2.3.1	Summary of changes for the main fieldwork phase	110
12.3	Overview of School-based Pilot	110
CHAPTER 13: CONCLUSION ON PILOT AND DECISIONS FOR MAIN PHASE		111
13.1	Overview	112
13.2	Criteria for Selecting Items for Inclusion/Exclusion Post-Pilot	113
13.3	Summary of Major Changes to the Home-Based Pilot for Main Phase	113
13.4	Decisions on the School-Based Data for the Main Phase	114
	References	115



LIST OF APPENDICES

Appendix A: Information Sheets and Consent Forms Used in Pilot Phase of the 9-year Cohort '08 Survey

- A1 Information sheet for Study Child
- A2 Information sheet for Parent(s)
- A3 General consent booklet:
 - Primary Caregiver's General Consent Form
 - Study Child's Assent Form
- A4 School Consent
 - Primary Caregiver's consent to approach Teacher for Teacher-on-Child questionnaire
 - Primary Caregiver's consent to approach school for Drumcondra vocabulary and Maths test scores
- A5 Information sheet for parent living elsewhere
- A6 Information sheet for parents and teachers

Appendices B/C: Questionnaires Used in Pilot Phase of the 9-year Cohort '08 Survey

The Study Child:

- B1 Child Main Questionnaire
- B2 Child Self-Complete (Sensitive) Questionnaire
- B3 Parenting Style Inventory [in respect of Mum, Dad, Mum's Partner, Dad's Partner (as relevant to family structure)]
- B4 Piers-Harris scale
- B5 Drumcondra Reading Test
 - Level 2
 - Level 3
 - Level 4
- B6 Selective Attention Test
- B7 One-day time-use drop off

The Primary Caregiver:

- B8 Primary Caregiver Main Questionnaire
- B9 Primary Caregiver Self-Complete (Sensitive) Questionnaire

The Secondary Caregiver:

- B10 Secondary Caregiver Main Questionnaire
- B11 Secondary Caregiver Self-Complete (Sensitive) Questionnaire
- B12 Parent living elsewhere

Schools:

- C1 Teacher-on-Pupil Questionnaire
- C2 Teacher-on-Self Questionnaire
- C3 Principal Questionnaire



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SUMMARY

ABOUT THIS REPORT

- This report summarises the experience of the pilot fieldwork with the *Growing Up in Ireland* Cohort '08 (formerly the Infant Cohort) at 9 years of age. This wave represents the fifth survey for this cohort who were first interviewed at age 9 months – and subsequently surveyed at 3, 5 and 7/8 years. It is also the first time that the younger cohort has reached an age where there was also data collection for Cohort '98 (formerly the Child Cohort). The report is intended to inform data-users of the role played by the pilot process in informing the final instrumentation and procedures for the main phase of data collection.
- A set of appendices is included with the report, which contains the information sheets and questionnaires used in the pilot phase. The report should be read in conjunction with the appendices. Question numbers refer to those used in the pilot unless otherwise stated. The questionnaires that were ultimately used in the main phase of fieldwork are available on the study's website, growingup.ie.

FIELDWORK SCHEDULING

- Fieldwork for the pilot phase of the Cohort '08 at 9 years of age was carried out between September and November 2016. This report deals principally with the experience of the pilot in the home, although there was also a schools pilot phase after the completion of the home-based pilot, which is reported in a stand-alone chapter.

QUESTIONNAIRE DEVELOPMENT AND CONSULTATION

- A broad consultative process was carried out in developing the questionnaires used in this pilot exercise. These included inputs from: literature reviews; the results of interviews with the 9-year-olds from Cohort '98; the Study Team Management Group; the Scientific Advisory Group (SAG); the Children's Consultative process (involving 9-year-olds themselves); the Project Team and Steering Group, and the project's Research Ethics Committee (REC). Ethical approval was secured for all procedures, questionnaires, tests and measurements carried out as part of this pilot process.

THE PILOT SAMPLE AND RESPONSE RATES

- The sample used in this pilot contained two components. The first was a longitudinal sample of 180 families who had participated in the pilot up to this stage with this cohort. This is referred to as Sample A. Of these families, 160 had participated at 5 years of age (the last face-to-face interview, but there was a postal survey only at 7/8 years). The second component, referred to as Sample B, was a sample of 168 additional families who had participated in a 'dress rehearsal' sample last used when the children in the cohort were 3 years of age. This gave a total target sample of 348 children.
- The overall response rate in Sample A of children who had participated when they were 5 years of age was 82.5%. Response rates among the 20 children in Sample A who had not participated at 5 years of age were considerably lower (circa 20% depending on whether last participation was at 9 months or 3 years). The response rate of children who had participated in Sample B (the Dress Rehearsal sample from 3 years of age) was 79.8%. The Study Team anticipated that the response rate in the main phase would be a few percentage points higher than the 82.5% achieved among the Sample A families who had participated at 5 years, given the longer fieldwork period available in the Main Study to return to families who were unavailable at the first attempt.
- Despite the low response rates among those families who had not participated at 5 years of age, it was decided to include former non-respondents in the target sample for the main fieldwork at 9 years of age. The response rate among this group was expected to be low, but the inclusion of previous non-participants in subsequent rounds of the study is in line with best international practice in this area.



- A major issue in the pilot was testing the feasibility of moving from a paper-and-pencil approach to administering the self-completion Child Sensitive Questionnaires to a computer-based approach (using a laptop or tablet). The possible mode effects of different forms of completion were a key consideration, as comparisons between the two cohorts at age 9 years was likely to be a key avenue for research.

APPROACHING THE FAMILIES AND SECURING INFORMED CONSENT

- An introductory letter with separate information sheets for the parents/guardians and Study Children was posted to the families. This was followed up with a personal visit from an interviewer. Signed consent was secured from the parent/guardian – and signed assent from the Study Child – before interviewing took place. This process worked well in the pilot.
- A major point to emerge from the pilot, however, was the need to reduce the complexity of the consent process. Both the consent and assent forms adopted for the main phase of fieldwork were revised and simplified.

SURVEY ADMINISTRATION

- Two laptops were used to administer the fieldwork in the home: one for the interviews with the Primary and Secondary Caregivers, the other for the interviews with the Study Child. This allowed some modules to be completed in parallel, thus reducing the overall contact time in the home.
- A split-sample between laptop, tablet and paper-and-pencil self-completion of the Child's Sensitive Questionnaire was incorporated into the pilot (see below).
- Two paper-based cognitive tests were administered to the Study Child.

INFORMANTS, QUESTIONNAIRES AND OTHER INSTRUMENTS IN THE PILOT

- The household informants in the pilot (and subsequently main) fieldwork for the 9-year phase of the Cohort '08 were:
 - the Study Child
 - the Primary Caregiver
 - the Secondary Caregiver
- A further phase of pilot fieldwork involved a postal survey of the schools attended by the Study Children. The informants there were the child's teacher and school principal.

THE PILOT TEST OF THE STUDY CHILD'S QUESTIONNAIRES (APPENDIX B1 AND B2)

- **Child Main Questionnaire (B1):** This worked well in the pilot. Some reductions were implemented for the Main Study, with a view to simplifying it and reducing administration time.
- **Child Core Sensitive (B2):** This worked well. Given the need to reduce the response burden for the child, however, there were significant reductions in the parenting-style questions and the Piers-Harris components. These much-reduced booklets were then merged with the rest of the child Self-Complete Questionnaire to form a single booklet.
- **Parenting Style Inventory (B3)** (in respect to mum, dad, mum's partner and dad's partner as appropriate) was removed in favour of continuing the parent-report measure longitudinally. Just two questions from this original booklet were carried through to the main phase.



- **Piers-Harris self-concept scale (B4):** This has been a very useful scale in the study to date but had a lot of items (60). Following extensive psychometric evaluation and negotiations with the test publisher, it was reduced to 32 items. Note that actual test items have been redacted from the appendices.
- **Drumcondra Reading Test (B5):** This worked well. The interviewer was subsequently instructed to allow up to 20 minutes to complete this test (as per the developer's recommendations) but advised that the interviewer and child might move on from the test after 15 minutes if the child had finished it. Note that actual test items have been redacted from the appendices.
- **Selective Attention Test (B6):** The Study Team had some reservations about this test, given modest relationships with other indicators related to attention in the pilot, but as it potentially measures a skill not otherwise covered, and was well received by the pilot children, it was continued for the main phase. Note that the actual test item has been redacted from the appendices.
- **Height and weight:** These posed no problems in the course of the pilot and were continued in the main phase of interviewing.
- **Blood pressure:** Two readings of the child's blood pressure were recorded in the pilot with the 9-year-olds. These posed some logistical problems and did not operate as smoothly as the measurements with the 17/18-year-olds of Cohort '98. Ultimately, it was decided to discontinue blood pressure measurement for the main phase.

THE PILOT TEST OF THE PRIMARY CAREGIVER'S MAIN QUESTIONNAIRE (APPENDIX B8)

In broad terms, this questionnaire did not pose any major issues or problems, except length. The revised drafts attempted to reduce the length, to relieve the respondent burden as much as possible. Only the summary main points are mentioned below.

- The pilot question on whether it can be justified to 'smack a child' (question B7, p.5) was moved to the PCG Self-Complete Questionnaire.
- Dosage of medication was not recorded (C9, p.7).
- A few questions on the child's dental health were deleted (C60, p.10).
- The lengthy food frequency question (D1, pp.11-12) was moved to the postal drop-off. A much shorter question on the Study Child's food intake (which was used in the 9-year Cohort '98) was inserted in its place for the Main Study.
- The questions on discrimination were moved to the Self-Complete Questionnaire (questions E17-E18, p.15 of pilot questionnaire).
- The question on child's screen-time was simplified (G1-G4, p.17, pilot questionnaire).
- Detailed questions on family-friendly workplace practices in the PCG's job were dropped (L16, p.26, pilot questionnaire).
- The details on social welfare payments were dropped, which was a major change. These questions required a lot of time to complete by the respondent and such detailed information is potentially available from other sources. It was decided to retain the question on household income (L40-L44, pp.29-30) and the question on social welfare dependency (L50, p.31).
- Some questions which serve as deprivation indicators – Qs L59–L62 (p.32) – were dropped. These had not previously been included in the study, and were added only in the pilot phase. Several were reported by the interviewers to be found repetitive by respondents. The 11 indicators for the Irish National Measure of Basic Deprivation were retained.
- Some of the items on perceptions of neighbourhood (N2, N4, N9 pp.35-36) were dropped. These were felt by respondents to be very repetitive of similar questions asked earlier in the questionnaire.



THE PILOT TEST OF THE SECONDARY CAREGIVER'S MAIN QUESTIONNAIRE (APPENDIX B10)

- Overall, this questionnaire worked well in the pilot. It was a substantially abbreviated version of the Primary Caregiver Main Questionnaire. All decisions on changes to the PCG questionnaire were followed through (where relevant) to the SCG Main Questionnaire

THE PILOT TEST OF THE PRIMARY AND SECONDARY CAREGIVER'S SELF-COMPLETE QUESTIONNAIRES (APPENDICES B9 AND B11)

- Overall, this questionnaire worked well in the pilot. Some of the main decisions on changes for the main phase of fieldwork were as follows:
 - Some questions on the detail of adoptive parenting or fostering were dropped (S2-S6, p.1 and S9-S11, p.2).
 - Only the 'conflict' subscale of the co-parenting scale (which was used for the first time in the pilot) were retained.
 - Questions S38-S39 were replaced with one question tapping into satisfaction with combined domestic and child-rearing duties.
 - A question on the child's reaction to switching accommodation in shared parenting situations was dropped as without context it yielded little information (S50, p.6).
 - The parenting style measure previously used with this cohort at 3 and 5 years was added to both the PCG and SCG self-complete questionnaires. This was to replace the parenting style inventory that was dropped from the child self-completion module and to retain longitudinal consistency with previous waves.

PILOT TEST OF COMPLETING THE QUESTIONNAIRES AND QUESTIONNAIRE TIMINGS

- The parental questionnaires were interviewer-administered or self-completed by respondents in the same modes as adopted in Cohort '98 at 9 years of age.
- Some of these elements (for example, the two cognitive tests and the parental self-complete questionnaires) can potentially be administered in parallel with other components. A major effort in revising the questionnaires and instruments was to bring about a large reduction in the contact time with and related response burden for the family.
- The administration time for the questionnaires used in the pilot is summarised below.

	Average Minutes		Average Minutes
Study Child		Primary Caregiver	
Main Questionnaire	25.0	Main Questionnaire	80.0
Core Self-Complete Questionnaire	11.0	Self-Complete Questionnaire	33.0
Parenting Style Inventory	9.0		
Selective Attention Test (SAT)	5.0	Secondary Caregiver	
Drumcondra Reading Test	25.0	Main Questionnaire	22.0
Blood Pressure (1 and 2)	9.5	Self-Complete Questionnaire	22.0
Height and Weight	4.0	Measurements	4.0
		TOTAL above	249.5



- In the pilot, a three-way split sample was used to test for mode effects in the child's self-completion of the Sensitive Questionnaires on (a) paper, (b) laptop and (c) tablet. Based on details from (i) analysis of the data from the split sample, (ii) interviewer debriefing, and (iii) a focus group of 9-year-olds in the Study Team's offices, it was decided that the Study Child should self-complete the Sensitive Questionnaires on a pencil-and-paper basis to avoid confounding inter-cohort comparisons with possible mode effects.
- Data were transferred between the Study Team's office and the field interviewers using a new IT infrastructure, based on a secure VPN. This protocol was developed and tested for the pilot with the 9-year Cohort '08. No issues were identified in this new infrastructure in the course of the pilot and it worked without any problems.

PILOTING OF SCHOOL PHASE

- A second phase of fieldwork was completed by the Study Team after the home-based pilot, in which questionnaires were sent to the schools attended by the children. These were returned by post. Questionnaires in respect of 233 children were received.
- The principal of each school completed one questionnaire that recorded mostly school-level information. However, it also included a pilot on the feasibility of collecting child-level data on test results already administered by the school.
- Teachers of participating children were asked to complete two categories of questionnaire. Each teacher completed a single Teacher-on-Self questionnaire that recorded data on their teaching methods, personal characteristics and the classroom characteristics. For each **Growing Up in Ireland** child in their class, the teacher was asked to complete a Teacher-on-Pupil questionnaire that recorded information on the child's academic progress, challenges, and relationship with the teacher.
- There was little change to the school instrumentation following the pilot. However, it was decided not to proceed with collecting information on the child's test results from the school, given the variety in the tests used. Instead, the same Drumcondra Reading Test (adjusted for class level) would be administered to all children in their home by the interviewer.



Chapter 1

Background to Pilot Phase





1.1 INTRODUCTION

Growing Up in Ireland is the national longitudinal study of children and young people in Ireland. It is funded by the Department of Children and Youth Affairs (DCYA), with a contribution from The Atlantic Philanthropies in Phase 2. It is managed and overseen by the DCYA in conjunction with the Central Statistics Office. The study is carried out by an independent team of researchers, led by the Economic and Social Research Institute (ESRI) and Trinity College Dublin (TCD).

This report summarises the Pilot Phase of the Cohort '08¹ survey of the *Growing Up in Ireland* study at 9 years of age. This represents the fifth wave² of interviewing with Cohort '08, which was recruited into the project as a random sample from the Child Benefit Register in 2008. It was also the first time this younger cohort 'caught up', age-wise, with the first wave of Cohort '98, who were also 9 years old at their initial interview in 2007.

The pilot phase with Cohort '08 at age 9 years included two components. In the first instance, the Study Children and their main caregivers were interviewed in the home face-to-face by a survey interviewer. In the course of that interview, details were recorded on the school currently attended by the Study Child. The second component involved follow-up with relevant schools to complete school-based questionnaires with the principal and Study Child's teacher. This report presents details on both aspects of the pilot, but with greater coverage of the home phase where the greater proportion of data was collected. Home-based fieldwork for this round of the project was carried out between 11 September and 4 November 2016, with school-based work following immediately afterwards. An account of the school phase is given in Chapter 13.

A set of appendices is included with this report. It contains the information sheets, consent forms and questionnaires used in the pilot phase. The report should be read in conjunction with these appendices.

1.2 SUMMARY OF THE CONCEPTUAL FRAMEWORK

Information was collected from the 9-year-olds and their main caregivers on the following areas of the children's development:

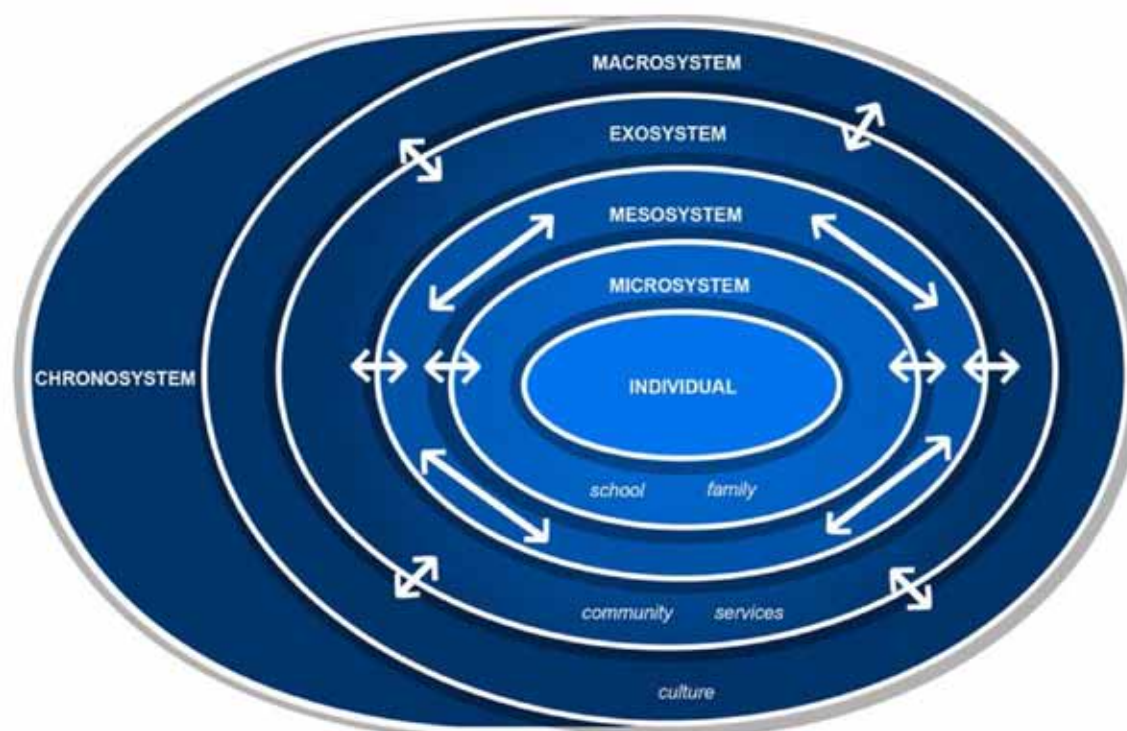
- **Physical health and development**
- **Social, emotional and behavioural well-being**
- **Educational achievement and intellectual capacity**

These are the key domains that have been explored by the study since it began in 2007 within a broadly-based bio-ecological model. This has been the lynchpin of the conceptual framework underlying the study since its inception. This framework draws heavily from the work of Bronfenbrenner (1979, 1993), whereby the ecological context of the child's development is conceptualised as a multi-layered set of systems, all of which influence the child, with varying degrees of directness (Greene et al., 2010a). Starting with the child's own attributes such as gender, health status and temperament, their development is thought to be influenced not just by their immediate environment (the 'microsystem') – typically family and school at 9 years of age – but also by the wider community and circumstances ('exosystem' and 'macrosystem'). These more distant systems may affect them either directly – such as the setting of school curricula at the national level – or indirectly through effects on the microsystem (such interactions being termed the 'mesosystem'). Changes over time, both cohort and period effects, are captured in the model by the 'chronosystem'. The model is broadly illustrated in Figure 1.1.

- 1 This cohort was originally named the 'Infant Cohort', and the older cohort the 'Child Cohort', but the nomenclature has recently changed to 'Cohort '08' and 'Cohort '98', reflecting the main year of birth of the cohort members as they get older and are no longer 'infants' and 'children'.
- 2 Data were collected on a face-to-face basis when the Study Child was aged 9 months, 3 years, 5 years, and, on a postal basis from the Primary Caregiver (mostly the child's mother), when the Study Child was 7 years old.



Figure 1.1: Bronfenbrenner's Ecological Perspective on Child Development



Source: Adapted from Garbarino (1982)

The objective of the conceptual framework set out in the pilot phase with the cohort at 9 years of age was to guide the development of procedures, questionnaires and other instruments, and facilitate subsequent analysis. A basic requirement of such procedures was that they can be feasibly implemented in the homes of approximately 9,000 families included in the Main Study in a manner that is (a) acceptable to participants, (b) ethically and scientifically rigorous, and (c) able to provide the quantitative data necessary for the varied analytical frameworks underlying the research now emerging from the study.

1.3 ISSUES AND PRINCIPLES IN DEVELOPING INSTRUMENTS AND FIELD PROCEDURES

1.3.1 LONGITUDINAL CONSISTENCY

Longitudinal consistency in measurement from one round of a panel study to the next is clearly a key consideration in the development of questionnaires, measures and procedures. Only by ensuring age-appropriate longitudinal consistency can one meaningfully investigate developmental trajectories and change over time. Changes to scales, question wording or the way in which questionnaires are administered will likely affect subsequent validity of comparisons over time. Conversely, however, the appropriateness of particular content also evolves over time. Thus, a difficult balancing act can be necessary between longitudinal consistency and contemporary optimisation. For the most part, in developing the questionnaires and related instruments for the pilot phase, the Study Team attempted to maximise consistency with interviews when the children were 9 months, 3 years, 5 years and 7 years of age (as recorded in the inter-wave postal survey).

The Study Team was also sensitive to the 'between-cohort' consistency with the questionnaires completed by the 9-year-olds of Cohort '98, when those children were first interviewed in 2007/08. Interviewing at that round of the study was carried out just before the international financial crisis of 2007/2008 and before



Ireland experienced one of its worst-ever recessions. The 9-year-olds in Cohort '98, most of whom were born in 1998, were very much children of the economic boom. In contrast, the lives of the children in Cohort '08 have been characterised by severe economic recession. A particularly interesting aspect of the two-cohort design adopted in *Growing Up in Ireland* is the extent to which it will allow researchers to investigate the effects of changing macro contexts over time on the outcomes and development of children.

1.3.2 CHANGING SOCIAL CONTEXTS

Given the changing social contexts over the decade since the children of Cohort '98 were first interviewed in 2007/08, it was not feasible to maintain inter-cohort consistency in all aspects of the current wave.

The clearest example of this is in relation to digital media for 9-year-olds. For example, questions to Cohort '98 in 2007 included whether there was a computer in the Study Child's bedroom. Details on screen-time were centred on the amount of time spent watching TV, videos and DVDs. The definition of a 'computer' and both the range and accessibility of screen-based media have changed so completely over the decade that strict longitudinal consistency with the questions used in 2007 is not possible. Smartphones and computer tablets have so revolutionised this area that a new set of questions had to be developed.

The most appropriate mode in which children would self-complete the 'sensitive' questionnaires was a key issue for this pilot. These components were self-completed on paper by the 9-year-olds in Cohort '98. In developing the procedures for the surveys with the 9-year-olds in Cohort '08, the possibility of self-completing these questionnaires on a computer laptop or tablet was raised, and this was tested in the pilot. This will be discussed in detail in Chapter 6.

1.3.3 IMPLICATIONS OF THE DESIGN OF THE COHORT '98 AND COHORT '08 SAMPLES

There were significant differences in the sample design used for Cohort '98 and Cohort '08, which have major implications for data collection and response burden. In short, because the children of Cohort '98 were recruited in school-based clusters, some of the data collection – primarily the Reading and Maths tests – could be undertaken in a group setting within the classroom. The sample design is described in more detail in the following paragraphs.

1.3.3.1 Cohort '98 at 9 years

A two-stage clustered sample design was used in generating the sample for Wave 1 of the Cohort '98 survey at 9 years of age. The primary school system was used as the primary sampling unit (PSU). A sample of 910 primary schools was first recruited into the study at the first stage of sample selection. A random sample of 9-year-olds was then selected from participating schools. Home-based interviews followed the school-based component of the study in the first round of the Cohort '98 survey fieldwork.

Using the school as the PSU had several logistical, analytic and statistical advantages. Not least among these was that it allowed direct access to the principal and teachers (who are key study informants) and thus facilitated the completion of the principal and teacher questionnaires. Perhaps even more importantly, it facilitated the completion by the children of the Drumcondra tests in English and Maths, as well as the Piers-Harris self-concept scale in a group self-completion setting within the school. The self-completion of these tests and scales in the school setting substantially reduced respondent burden and contact time in the home, especially the response burden for the children.

1.3.3.2 Cohort '08 at 9 years

In contrast to the sampling approach adopted with Cohort '98, Cohort '08 was selected as a simple random sample from the Child Benefit Register. There was no school-based or other clustering involved in the sample design. The children in Cohort '08 at 9 years of age were dispersed throughout almost all of the approximately 3,400 primary schools in the country. Interviews had to take place in the home, in the first instance. Only in the course of that interview would the Study Team be able to identify which school the Study Child was attending. The Study Team then followed up in the school to complete the principal and teacher questionnaires after the home-based interviews had been completed. It did not have any contact with the children in the school.



Accordingly, all interviews and measurements with the 9-year-olds in Cohort '08 (including the Drumcondra school performance test(s) and Piers-Harris self-concept scale – which were completed in the schools by the 9-year-olds in Cohort '98) – had to be completed in the home in the Cohort '08 survey. One of the key issues investigated in the course of the pilot was the feasibility and related response burden of carrying out all data collection with the Study Children and their families in the home.

1.4 THE CONSULTATION PROCESS

The nature and content of the information that was recorded in the pilot was informed by inputs from several sources, which principally included:

- a. the study's 9-year literature review (Greene et al., 2010b)
- b. findings from the Cohort '98 survey at 9 years of age (e.g. Williams et al., 2009) and the numerous papers and reports based on Cohort '98 at 9 years of age (see: <http://www.esri.ie/growing-up-in-ireland/growing-up-in-ireland-publications/>)
- c. the Study Team and the Study Team Management Group
- d. the Scientific Advisory Group (SAG)
- e. the Children's Consultative processes which were undertaken with 9-year-olds in preparation for this phase of the study
- f. the project Steering Group and Project Team
- g. the study's Research Ethics Committee (REC)

1.4.1 THE STUDY TEAM AND STUDY TEAM MANAGEMENT GROUP (STMG)

A first draft of questionnaires and instruments was developed by the Study Team and Study Team Management Group, based on the literature review of issues arising in the lives of 9-year-olds, a review of previous findings from the 9-year-olds in Cohort '98 and studies undertaken elsewhere. In preparing these first draft questionnaires, longitudinal consistency was a key consideration, as discussed in Section 1.2.1 above. In addition, when including specific questions, the following criteria were considered, as they have been in the development of questionnaires in all rounds of *Growing Up in Ireland*:

- **Importance:** are there scientific grounds for believing that the measured concept in question exerts a substantial influence and/or outcome on one or more of the dimensions of the development or well-being of the 9-year-old?
- **Measurability:** can the characteristic be validly, reliably and ethically measured using the methods of large-scale survey research adopted in Growing Up in Ireland, in a manner which will be acceptable to respondents and not adversely impact upon response rates in the current wave or attrition rates in subsequent waves of the study?
- **Longitudinal relevance and consistency:** does the instrument have a longitudinal or dynamic character which can be consistently measured over time, in the context of the comments above on both inter- and intra-cohort consistency?
- **Policy relevance:** is the measure susceptible to or actionable through public policy? Is it policy-malleable?
- **Prevalence and variance:** is the construct sufficiently prevalent in the population as to yield an analysable level of variance in the available population samples?
- **Added value:** does the measure relate to influences on the well-being of the 9-year-old that are inadequately covered by other research?
- **Robustness:** is there a measure of the construct/variable of interest which is proven to be valid and reliable?



- **Time efficiency:** does the measure take as little interview time as possible, taking account of its relative importance and requirement for robust measurement?
- **International use:** has the measure been successfully used in research in other countries, particularly in comparable studies such as the UK Millennium Cohort Study and the Longitudinal Study of Australian Children?
- **Use in Ireland:** has the measure been successfully used in previous research in Ireland?

On this basis a preliminary set of draft questionnaires was developed by the Study Team and Study Team Management Group. These were then used as input to the consultative process with the Scientific Advisory Group (SAG).

1.4.2 THE SCIENTIFIC ADVISORY GROUP (SAG)

The Scientific Advisory Group (SAG) was made up of around 50 experts from a wide range of fields, principally drawn from third-level institutions and universities in Ireland. A first stage in consulting with the Scientific Advisory Group involved the circulation of the draft questionnaires along with a background briefing document to members. These were subsequently used as the basis for discussion at the SAG meetings.

The SAG meetings were organised along four main thematic lines, as follows:

- **Health and physical development**
- **Socio-emotional development and behaviour**
- **Educational/cognitive development**
- **Socio-demographic and family circumstances**

The meetings were chaired by members of the STMG and Study Team. SAG members were invited to contribute input, before, during, and after the meetings, to the content of the questionnaires, instruments and procedures for the pilot phase. They provided substantive advice both in the course of the meetings and in subsequent email exchanges with the Study Team. In addition, an online survey was set up so that SAG members who had been unable to attend the meetings could, at minimum, input their views on the main priorities to be addressed by the study.

1.4.3 THE CHILDREN'S CONSULTATIVE PROCESS

There were two components to the consultative process with 9-year-olds in preparation for this pilot phase of the project. The first related to the substantive issues included in the questionnaires. The second focused on the best way in which to complete the child Self-Complete Questionnaires.

The first component in the Children's Consultative Process on the substantive content of the questionnaires took place in four schools, with 35 children in total. The schools differed in terms of their size and socio-demographic composition; two were based in Dublin and the other two in rural areas. The consultation with the children focused on issues of relevance to 9-year-olds in Ireland today, with a special emphasis on their understanding and use of digital technology.

The second part of the Child Consultative Process explored the best ways for children to self-complete the Child Self-Complete Questionnaires. This involved asking a group of 11 children to complete sections of the Child Self-Complete Questionnaires on paper, on a computer laptop and on a computer tablet. Members of the Study Team observed their interactions with each format and asked them which they had preferred. When the 9-year-olds in Cohort '98 were interviewed, they completed their Self-Complete Questionnaires on a paper-and-pencil basis.

The Child Consultative Process was reviewed by the study's Research Ethics Committee in advance. Signed parental consent and child assent were secured prior to the children's participation.

1.4.4 THE STEERING GROUP/PROJECT TEAM AND RESEARCH ETHICS COMMITTEE (REC)

Very detailed comments were received from the project's Steering Group/Project Team (SGPT) at all stages



of developing this round of the project, particularly in response to the Study Team's original proposals for the pilot phase. The Steering Group/Project Team's comments covered all aspects of the study – substantive, technical, procedural and ethical.

The study's Research Ethics Committee (REC) also provided a very detailed review of all aspects of the Study Team's proposals for this pilot phase on ethical and related issues of fieldwork. All ethical issues raised by the REC were addressed and incorporated into the design and subsequent implementation of the pilot phase of the project.

1.5 OVERVIEW OF THEMES ADDRESSED IN THE PILOT INSTRUMENTATION

The topics covered by the various questionnaires used in the pilot were those of most relevance to 9-year-olds in the three domains of health, socio-emotional development and education (mentioned earlier), as well as details on the contexts and circumstances in which the children are growing and developing. The main issues identified from each of the three domains include those outlined below.

1.5.1 PHYSICAL HEALTH AND DEVELOPMENT

In this area the main issues for investigation were:

- General health and physical well-being
- Chronic illness and disability
- Healthcare use and variations in access to healthcare
- Problems with sight, hearing, speech or mobility
- Diet and exercise
- Dental health and oral hygiene
- Height, weight and body mass index

1.5.2 SOCIAL, EMOTIONAL AND BEHAVIOURAL WELL-BEING

Issues for investigation in this area included:

- Family relationships and joint activities
- Friends and problems with peers
- Child's behaviour and emotional regulation
- Child's self-concept
- Pastimes, including screen-time and digital media
- Child's sources of support

1.5.3 EDUCATIONAL ACHIEVEMENT AND INTELLECTUAL CAPACITY

Issues for investigation in this area included:

- The child's perceptions of school, teachers and subjects
- Levels of cognitive ability, both perceived and directly assessed
- Parental expectations for the child's educational attainment, and engagement with his/her learning and schooling
- Reasons for absenteeism from school
- Bullying
- Transport to and from school



1.5.4 THE CONTEXTS IN WHICH 9-YEAR-OLDS ARE GROWING UP

To assist in furthering our understanding of children's development, detailed information was needed on the contexts and environments in which 9-year-olds were being brought up. Some of these key contexts were:

- The family and changes in its structure and composition over time
- Parental income and employment status and the extent to which these affected both the material resources available to children and dynamics in family relationships
- The implications for children of parents working outside the home and related issues of childcare and work-life balance
- Neighbourhood characteristics, both parents' and children's views
- The school environment
- Religious and cultural contexts of the home, community and neighbourhood
- Formal and informal support structures
- Ethnic background or minority status of the child or family
- Disability or special educational needs (SEN) status

1.6 STRUCTURE OF THIS REPORT

The purpose of this report is to outline the process and instruments used in the pilot phase for Cohort '08 at 9 years, and to summarise the changes arising therefrom that informed the final design of the main phase for that wave.

The report is divided into seven subsequent chapters, as follows:

Chapter Two provides details on the design of the pilot phase, outlining the informants involved and the questionnaires and other instruments they were asked to complete. This includes a consideration of the length of time in the home. It also discusses interviewer training and debriefing, data capture and transfer, and an introductory discussion of a test of mode effect involved in a potential move from a paper-and-pencil approach to completing the Child Self-Complete Questionnaires to one based on computer laptops or tablets.

Chapter Three looks at respondent recruitment and issues around informed consent/assent.

Chapter Four considers the composition and size of the sample used in the pilot, as well as the response rates achieved.

Chapters Five, Six and Seven discuss the detail of the questionnaires, cognitive tests and measurements used with the Study Children in the pilot phase, along with decisions for change in the main phase of interviewing. The content of the questionnaires, along with the feasibility of having them all completed in the home and the potential effects of a change in mode of completion for the Child Self-Complete Questionnaires, are considered.

Chapters Eight, Nine and Ten address the content and issues arising from the Primary and Secondary Main and Self-Complete Questionnaires used in the pilot, along with decisions on the main phase of interviewing.

Chapter Eleven focuses on the scaled items used in the Primary and Secondary Caregiver questionnaires, especially on the reliability and validity of the scales in question.

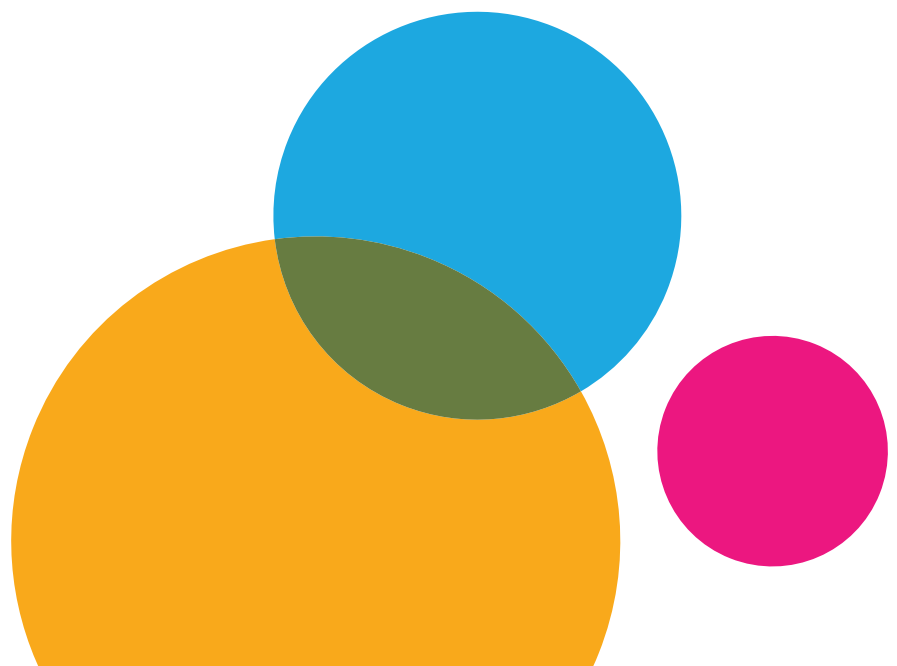
Chapter Twelve considers the pilot school-based data collection and its implications for the main survey.

Chapter Thirteen summarises the implications of the pilot for the design of the main survey instrumentation and protocols.



Chapter 2

Design, Informants, Questionnaires and
Interviewer Training





2.1 INTRODUCTION

This chapter provides an overview of the design adopted for the pilot. It begins with a summary overview of procedures, including the informants who participated, and the questionnaires administered in the home. This section also considers the timing of the various questionnaires for the pilot phase, discusses interviewer training for the pilot, and outlines details on how the data were transferred from the Study Team to field interviewers and vice versa.³

2.2 DESIGN OVERVIEW AND QUESTIONNAIRES

2.2.1 INFORMANTS AND QUESTIONNAIRES

As noted in Chapter 1, the pilot involved conducting interviews in the first instance in the Study Child's home, which were followed by postal questionnaires to the school s/he was attending.

The main respondents in the home were:

- The Study Child
- The Study Child's Primary Caregiver (PCG)
- The Study Child's Secondary Caregiver (SCG)

As in previous rounds of the study, the child's Primary Caregiver (PCG) was defined as the person who provided most care to the Study Child, knew most about him/her and was in the best position to provide detailed factual and other information about the child. As with other rounds of the study, the PCG was the child's mother in a very large majority of cases (almost 99% in the pilot). The Secondary Caregiver (SCG) was defined as the PCG's resident spouse or partner. Not all households had an SCG.

Between them, these three informants were asked to complete the following questionnaires, tests and measurements (either administered by interviewers or self-completed) in the course of the interviewer's visit to the home:

(i) *Study Child's Questionnaires:*

- Child Main Questionnaire (copy in Appendix B1)
- Child Core Self-Complete Questionnaire – self-completion (copy in Appendix B2)
- Parenting Style Inventory in respect of Study Child's mum, dad, mum's partner, dad's partner, as appropriate to the child's family structure (copies in Appendix B3)
- Piers-Harris – self-completion CASI (Appendix B4 – redacted due to copyright restrictions)
- Drumcondra Reading Test – self-completed by the child, following instruction by the interviewer (Appendix B5 – redacted due to copyright restrictions)
- Selective Attention Test (Appendix B6 – redacted due to copyright restrictions)
- One-day time-use diary, drop-off and postal return (copy in Appendix B7)

The height and weight of the Study Children were recorded by the interviewer on medically approved weighing scales and stadiometers. The Study Child's blood pressure and heart rate were also recorded, using a portable blood pressure monitor.

(ii) *Primary Caregiver (PCG) Questionnaires:*

- PCG Main (copy in Appendix B8)
- PCG Sensitive (copy in Appendix B9)
- PCG on non-singleton – for cases in which the Study Child was a non-singleton

³ Some data (such as household composition) was forward-fed from the previous survey to interviewer laptops, while the completed interview data was transferred from the interviewer laptops and tablets to a secure server at the ESRI.



(iii) Secondary Caregiver (SCG) Questionnaires:

- SCG Main (copy in Appendix B10)
- SCG Sensitive (copy in Appendix B11)
- SCG on non-singleton – for cases in which the Study Child was a non-singleton

The height (where not available from previous rounds of the study) and weight of the Study Child's Primary and Secondary Caregivers were also recorded by the interviewer, on the same medically approved weighing scales and stadiometers.

The name and address of the school attended by the Study Child was recorded from the PCG in the course of his/her interview, with a view to later completing the school principal and teacher questionnaires.

Where relevant, contact details for administering a non-resident parent questionnaire (on a postal basis) were also collected in the course of the Primary Caregiver interview.

2.2.2 ADMINISTERING THE SURVEYS AND QUESTIONNAIRE TIMINGS

The surveys were either administered by the interviewer (the main questionnaires) or self-completed by the respondent (the self-complete 'sensitive' questionnaires). Both the interviewer-administered and self-complete questionnaires with the PCG and SCG were completed on a laptop. The interviewer administered the Child Main Questionnaire on a computer laptop or tablet to the child. The sample of Study Children was split three ways to test mode effects in implementing the self-completion questionnaires by the Study Child. One sub-sample self-completed on a paper-and-pencil basis (as did all the 9-year-olds in Cohort '98); the second sub-sample self-completed on a computer tablet and the third self-completed on a laptop. (The results of the split sample design are discussed in detail in Chapter Six).

Table 2.1 provides a summary of the timings for each questionnaire component in the home with the three informants. Most of these timings came from the electronic questionnaires completed on laptop or tablet. Others (such as the timings of the Selective Attention Test) were taken from the interviewer administrative records and/or worksheet used for each household.

Some of the elements in Table 2.1 were carried out in parallel. For instance, the Drumcondra Reading Test and the Selective Attention Test were completed by the Study Child, while the SCG and PCG self-completed their respective self-complete questionnaires. Taking account of the paralleling of questionnaires leaves an administration time of approximately 3.5 hours in a two-parent family where both parents participated (along with the Study Child). This clearly represents a heavy burden on the family (especially for the Study Child).



Table 2.1: Average time taken for each questionnaire, tests and measurements in the pilot phase of Wave 5 of Cohort '08 (9 years of age)

	Average Minutes
Study Child	
Main Questionnaire	25.0
Core Self-Complete Questionnaire	11.0
Parenting Style Inventory	9.0
Selective Attention Test (SAT)	5.0
Drumcondra Reading Test	25.0
Blood Pressure (1 and 2)	9.5
Height and Weight	4.0
Primary Caregiver	
Main Questionnaire	80.0
Self-Complete Questionnaire	33.0
Secondary Caregiver	
Main Questionnaire	22.0
Self-Complete Questionnaire	22.0
Measurements	4.0
TOTAL ABOVE	249.5

2.2.3 DECISIONS ON BROAD DESIGN OF MAIN PHASE OF FIELDWORK

Overall, the broad design and implementation of this phase of the study worked well in the home. A main consideration was questionnaire length. The Study Team felt it was important to reduce the contact time with the family and the respondent burden, especially on the children. It was notable from the interviewer debriefing, and the quality assurance questionnaire issued to all participating families, that families were generally happy with their experience in the study, except for the time taken to complete the questionnaires. This was even more important given the longitudinal nature of the study, where length of contact could adversely affect response in subsequent rounds of the study. Decisions on amendments (reductions) to the questionnaires are presented in each of the relevant chapters.



2.3 INTERVIEWER TRAINING AND DEBRIEFING

Thirty interviewers were employed on the pilot study. All interviewers working on the pilot (as on all phases of the project) were required to:

- be vetted by An Garda Síochána (including providing proof of identity – usually passport and/or driving licence)
- be appointed an Officer of Statistics by the Central Statistics Office
- provide two recent references, which were verbally checked on the phone
- provide a self-declaration of appropriate physical and mental health and fitness
- provide confirmation of Class 2 car insurance on their motor policy
- provide a copy of a current valid driving licence

All pilot interviewers had previous experience of *Growing Up in Ireland* surveys and underwent five days of training on field procedures and the content of the questionnaires and other instruments. Where feasible, continuity of individual interviewers to families was maintained. Training took place in the Study Team's offices in Dublin and included the following modules:

1. Background and Objectives of the Project
2. The Role of the Interviewer
3. HR and Employment Issues
4. The Pilot Sample
5. The Interviewer's Worksheet
6. Interviewing on the Laptop and Tablet
7. Types of questions in CAPI
8. PCG Main Questionnaire
9. PCG Self-Complete Questionnaire
10. SCG Main and Self-Complete Questionnaires
11. Child's Main Questionnaire
12. Physical Measurements
13. Child Self-Complete Questionnaires (Core, PSI, Piers-Harris) – Overview
14. Child Self-Complete Questionnaire Using a Laptop or Tablet
15. Piers-Harris
16. Child Welfare and Protection
17. Drumcondra Reading Test
18. Selective Attention Test
19. Data Transfer
20. E-diary, Mileage and Supplies
21. Approaching the Family
22. Conduct in Interviews
23. Work Sheets, Consents and Administration
24. Assessment
25. Q+A



The assessment at the end of the training session included a competency test on the laptop/tablet as well as completing the administrative paperwork associated with the study. Only interviewers who were assessed at the end of training to have met an acceptable standard were assigned work on the pilot. The assessment criteria used were:

1. Understanding of the interview process and procedure
2. Competence and accuracy with the laptop/tablet
3. Communications and interpersonal skills
4. Attendance at training

On completion of fieldwork, all interviewers who had worked on the pilot were asked to complete a web-based survey on their experience of the fieldwork. This recorded any issues arising on the content of the questionnaires, tests and procedures in the home. Interviewers were also asked to rate their experience of training, support and the wireless data transfer. They subsequently attended a group debriefing session in the Study Team's offices on the 15th of November 2019 to further discuss issues that were identified from the online survey.

Each of these topics was subsequently discussed at the interviewers' debriefing session.

2.3.1 DECISIONS ON INTERVIEWER TRAINING FOR MAIN PHASE OF FIELDWORK

It was decided that interviewer training should continue into the main phase with generally the same content and format as the pilot. Feedback from interviewers on their debriefing form indicated that they felt well prepared for fieldwork after training. The training sessions were structured with multi-mode instruction via PowerPoint presentations, role play, videos, questionnaires and measurements (mostly involving aspects of working with a 9-year-old). Substantive topics on the questionnaires, technical issues on use of the laptops and data transfer, and administrative issues were also to be included in the training sessions. Interviewer assessment procedures continued as they were for the pilot phase.

2.4 DATA CAPTURE AND TRANSFER

All questionnaires were completed using a computer assisted interviewing system called Blaise (Westat, 2018). Questionnaires were identified on the computer/tablet only by an anonymised numeric code. No contact details or surnames appeared on completed questionnaires.⁴ The Blaise programs for each questionnaire were developed in such a way that they were 'locked down' on completion. Once a questionnaire was 'locked down', neither the interviewer nor any third party was able to access it in the field. This was especially important in a situation in which the laptop was used to complete both CAPI and CASI (self-completion) interviews by other respondents.

All laptops/tablets used in this process were encrypted, had password-protected boot-up and needed username and password credentials to log on.

Laptops/tablets were configured to run only: (i) the Blaise applications for the various questionnaires and (ii) the upload and download questionnaire data. Field interviewers were not able to use the devices for any other application; for example, they could not use them to access or browse the internet, or for email, word processing or other applications. All external media connections (e.g. USB storage) were disabled so that interviewers could not load software or change their configuration in any way.

⁴ First names appeared on the questionnaires, especially in the household register section. These were used in subsequent sections of the questionnaire when referring to the child or young person at the centre of the study, to ensure the integrity of the data being recorded, i.e. that the respondent was providing information in respect of the correct person in the household. This was particularly important when recording details on intra-household relationships.



The Growing Up in Ireland IT communications network was used to download and upload electronic data to and from field interviewers' laptops and tablets. The main type of information downloaded from the ESRI's offices included forward-fed information recorded in previous rounds of the study and which was used throughout the interviews. This included, for example, the information recorded in the household register in the previous interview. This was verified and updated in the course of the pilot interview as necessary, to reflect changes in household composition since the interviewer's last visit to the respondent's home. The main form of data uploaded from the field was the completed questionnaire interviews. Administrative details on ongoing progress in the fieldwork and an e-diary containing outcome codes were also uploaded on a regular basis by field interviewers.

All data that were uploaded or downloaded were in encrypted ASCII format. The files did not have any structure or layout map (though the data are themselves are structured). The structure of the data was built when the data reached either the interviewer's laptop/tablet or the dedicated server in the ESRI's offices for return of completed questionnaires. This means that, even if an encrypted ASCII file had been intercepted in transport (which was highly unlikely), its content would not have been interpretable. The content could be interpreted only after it was read into the appropriate application on either the interviewer's laptop/device or on the dedicated *Growing Up in Ireland* server located in the ESRI.

The IT communications infrastructure used in the pilot phase with Cohort '08 at 9 years of age was a newly installed system based on a secure virtual private network (VPN) using the internet. This was a new IT communications system set up for *Growing Up in Ireland*. It replaced the data transfer system based on ISDN phone lines that had been used in earlier waves. Although the old system worked very well and securely, it was technologically outdated and had to be upgraded to reflect advances in IT communications technology of the last 10 years.

2.4.1 DECISIONS ON DATA CAPTURE AND TRANSFER MAIN PHASE OF FIELDWORK

It was decided to use the same data capture and transfer system in the main phase of the project as was used in the pilot. Blaise software, developed and distributed by the Central Bureau of Statistics (CBS) in the Netherlands, provided a state-of-the-art CAPI/CASI system. The preparation and use of forward-fed data worked effectively in the pilot and was continued into the main phase of this round of the project. The new IT communications system worked well and allowed the upload and download of data to and from the field in a secure environment.

2.5 TESTING THE FEASIBILITY OF COMPUTER TABLETS FOR CHILD SELF-COMplete QUESTIONNAIRE

Up to this phase in *Growing Up in Ireland*, interviewers had used laptop computers to complete the questionnaires, on an administered or self-completion basis. In the 13-year and 17-year phases of fieldwork with Cohort '98, interviewers were each supplied with two laptops in the home – one for administering the parent questionnaires, the other for administering the child/young person questionnaires. Having two laptops allowed the interviewer to parallel the interviewer-administered and self-completed questionnaires with different informants, so as to minimise the overall contact time in the home and hence reduce respondent burden.

The 9-year-olds in Cohort '98 completed their Self-Complete Questionnaires on paper. Following their administered main questionnaire, the interviewer explained that s/he would like the child to complete a 'sensitive' questionnaire, seal the completed form in an envelope provided by the interviewer and give the sealed envelope to the interviewer for return (unopened) to the Study Team.

In the course of the consultative process in developing the design and instrumentation for the Cohort '08 survey at 9 years of age, the issue of how the Self-Complete Questionnaires should be administered with the Study Children was raised. Given the expected high levels of computer literacy among 9-year-olds, it was proposed to test the feasibility of moving from a paper-based to a computer-based approach for completing the sensitive components of the study.



In advance of fieldwork on the pilot phase, some in-depth testing was carried out in the Study Team's offices with 12 children aged around 9 years. This exercise suggested that, while children were generally familiar with how laptops and tablets worked, the concept of using them to fill out answers to questionnaires was novel. Children may be more used to answering questions using a pen-and-paper format when completing school worksheets and tests, for example. Conversely, technology is more often used for browsing, viewing or playing games. In addition, some commonly used techniques with tablets such as 'swiping' to bring up the next question/turn the page on the tablet devices did not correspond well with the actual survey software. Nonetheless, the children were quite positive about the experience of using the electronic devices, and the survey questions generally. A further lesson learned from this practical session was that the in-ear headphones (provided for the audio assist) did not suit all children. Thus, for the pilot (and subsequently the main phase), over-head earphones with disposable, hygienic nets were supplied for the 9-year-olds to use. These headphones also had their own, easy-to-use volume adjuster.

Three modes for completion were tested in the pilot: laptop, computer tablet and paper. Some reviewers recommended tablets on the basis that these are widely used by children at this age. Laptops (with a built-in keyboard) were also suggested. Mode effects in answering patterns and longitudinal consistency in mode of administration between the 9-year surveys for Cohort '98 and Cohort '08 were also issues to be considered. If the mode of implementation for the Child Self-Complete Questionnaire had been changed for 9-year-olds between the Cohort '98 survey and the Cohort '08 survey, it could raise questions regarding the extent to which changes in estimates between the cohorts reflected real change in outcomes or simply mode effects.

In principle, the benefits of moving from paper-and-pencil to electronic completion for this part of the child interview would include a more efficient turnaround time for accessing the data for checking and other purposes, the elimination of the need for data entry and validation, and an easier way to provide an audio assist function. The issue of mode effects, however, was not a trivial one.

2.5.1 DECISION ON USE OF COMPUTER TABLETS IN MAIN PHASE OF FIELDWORK

Since the completed sub-samples for each of the three modes were small, it was difficult to identify strong mode effects in the pilot data. Some differences between those completed on paper and those completed either on tablet or laptop were identified. As this was the case, the Study Team felt that, with a view to maximising inter-cohort comparability and minimising any issues arising in the interpretation of changes in estimates between Cohort '98 to Cohort '08 at 9 years of age, it would be prudent to continue administering the self-complete part of the child's interview on paper. This is discussed in much more detail in Chapter Six.



Chapter 3

Recruiting the Families and Informed Consent





3.1 INTRODUCTION

This chapter provides an overview of the recruitment of families into the pilot, including issues around informed consent and assent for the Study Children themselves.

3.2 APPROACHING THE FAMILIES – INFORMED CONSENT

The families included in the pilot received an initial letter from the Study Team, containing two Information Sheets: one for the parent/guardian and one for the Study Child. The letter was addressed to the Study Child's Primary Caregiver (PCG) when the child last participated in the survey. As is discussed more fully below, this could have been at 3 years of age (in the Dress Rehearsal sample at that time); at 5 years of age in the 5-year pilot of this cohort, or at 7/8 years of age in the pilot sample for the postal inter-wave sweep with this cohort at 7/8 years of age. The Information Sheets used in the pilot for both the Study Child and PCG are included in Pilot Appendices A1 and A2 (respectively) of this report.

The introductory letter to families was followed by a personal visit from an interviewer, who explained the study and what participation involved for both parent(s) and the Study Child.

The interviewer paid an initial visit to the family home, followed – if contact had not been made at the earlier visits – by three call-backs at different times of the day and days of the week. Four visits were made to the home before a non-contact outcome was assigned to the family.

The interviewer secured signed consent from the PCG and assent from the 9-year-old before interviewing began.⁵ When the interviewer called to the family's home, s/he went through the relevant Information Sheets with both the PCG and the Study Child. The Information Sheets covered the following:

- a reminder of the previous visit and the purpose of the study
- the funders of the study
- why the family should take part in the study
- who is involved in running and implementing the study
- what participation in the study involved
- issues around confidentiality of the information recorded
- the types of questions asked
- the possibility of following up when the Study Child is 13 years of age
- who the interviewers are and how the family can verify an interviewer's identity
- contact details for the project

This information was reflected in the draft Consent/Assent Forms used in the pilot (shown in Pilot Appendix A3). The Primary Caregiver's consent form recorded general consent for the family's participation in the study. In addition, the Primary Caregiver was asked to sign a consent form to allow the Study Team to approach the Study Child's teacher to complete a questionnaire on the child.

Following their interview, a postal quality assurance follow-up questionnaire was issued to all families who had participated in the pilot. These 'back-check forms' asked the respondents to confirm that the interviewer had been courteous and professional, administered all elements of the home visit and provided a space for additional comments. This was issued directly by Head Office and did not go through the interviewer who had administered the survey in the home.

⁵ Assent is the agreement of someone not able (in law) to give legal consent to participate in the activity (such as a minor). Research with children requires the consent of the parent or legal guardian and the assent of the child.



A consistent theme in the interviewer debriefing was the time-consuming nature of the consent and assent process. In conjunction with the Steering Group, Research Ethics Committee and the National Adult Literacy Agency, the Study Team simplified both the Consent/Assent Forms and Information Sheets for the main phase.

The main amendments to the content of the PCG Consent Form were:

1. **Main Consent Form** – simplification of layout and language to achieve the National Adult Literacy Agency's plain language standard
2. **Follow-up/Tracing information** – this was reduced to a request for just one additional contact outside of the home (instead of two). The details were to be filled in by the interviewer on the work assignment sheet for the main phase, rather than by the PCG on the Consent Form.
3. **Nested Study Consent Form** – this form was discontinued. Families at previous waves had already indicated their willingness to be contacted about any new nested study protocols.
4. **Permission to record Study Child's blood pressure** – this form was discontinued as measurement of blood pressure in children did not proceed to the main phase.
5. **Permission to record information from the Study Child's Teacher** on Study Child – this process was continued for the main phase with some simplification. This portion of the Consent Form was also extracted on to a separate sheet to facilitate presenting it to schools as evidence that consent had been obtained.

3.2.1 DECISIONS ON APPROACHING THE FAMILY IN MAIN PHASE OF FIELDWORK

It was decided that the general approach to the family in the main phase of fieldwork would be largely as had been adopted in the pilot phase in terms of an Introductory Letter with Information Sheets for parent/guardian and Study Child, followed by a personal visit by the interviewer. An initial visit plus three call-backs, at different times of the day and days of the week, would be attempted before a non-contact outcome was assigned. Details on response rates are provided in the following chapter.

There were substantial revisions to the consent process prior to the main phase, mainly involving a simplification of the forms, as detailed in Section 3.2 above.



Chapter 4

The Pilot Sample and Response Rates





4.1 INTRODUCTION

This chapter looks at the sample used, and response rates achieved in the pilot phase of fieldwork.

4.2 THE SAMPLE

The sample used in the pilot phase with the 9-year-olds was comprised of two main components. The first component was the longitudinal pilot sample which had been recruited and first interviewed when the children were 9 months of age. This target sample at 9 months of age was made up of 292 families, 209 (71.6% of whom completed an interview). The second component added 168 families from the discontinued 'dress rehearsal' phase who had last participated when their child was 3 years of age.

4.2.1 INTERVENING WAVES

All 209 respondents who had participated at 9 months were included in the target sample for Wave 2 of the pilot, when the children were 3 years of age. At the Wave 2 pilot, 179 families completed an interview – a response rate of 88.2%, net of a small number of families who had emigrated.

The target sample for the initial pilot phase at Wave 3 (5 years of age) was made up of the 179 respondents of Wave 2 along with most of the non-respondents at that wave. The small number of families who had been identified as having moved in Wave 2 and for whom there was no forwarding address, or had emigrated, were not included in the Wave 3 target sample. A total of 158 of the 179 families who completed the questionnaires at Wave 2 also participated at Wave 3 (a response rate of 90.8%). As expected, response rates were much lower among families who had not participated at the previous wave, although a small number did complete interviews – indicating the value of approaching families who had missed a wave. A family's non-participation at a given round may have been simply because it was not convenient for them at the time, but would be happy to participate at subsequent waves.

The main advantages of including previous non-respondents in subsequent waves of the project are that it increases the completed sample size for analysis in the later waves and does not systematically exclude families who, for example, experienced a bereavement or family illness around the time of a particular wave. Not all analyses of longitudinal data will be confined to participants who have taken part in every wave of the study. If the focus of analysis is change in outcomes between 9 months and 9 years, for example, it is clearly preferable to maximise sample size at both observations, regardless of the response histories of participants at intervening points.

Accordingly, on the above basis the pilot sample at Wave 5 (age 9 years, subjects of the current report) was made up of 180 respondents, 157 of whom had participated at each previous home-interview phase. Note these calculations do not include participation in the postal survey conducted when the children were age 7/8 years (Wave 4).

4.2.2 INCLUSION OF THE 'DRESS REHEARSAL' SAMPLE

The first two rounds of *Growing Up in Ireland* included two phases in the piloting process; the first was referred to as the 'pilot' phase, the second as the 'dress rehearsal' phase. Due to resource constraints, and the fact that the first pilot phase at each round of the study included a full piloting of all questions and procedures, it was decided to discontinue the dress-rehearsal phase after Wave 2 of the Cohort '08 survey. Accordingly, the dress-rehearsal sample was interviewed when the children were 9 months and 3 years of age, but not at 5 years of age.

As is discussed in Chapter Three (and in greater detail in Chapter Six), an important aspect of the pilot phase at 9 years of age was to test the feasibility of moving the Study Child's Self-Completed 'Sensitive' Questionnaire from a paper-and-pencil format – as was used with the Study Children in Cohort '98 when they were 9 years of age – to a computer-based approach, and to consider any identifiable mode effects on response patterns. To examine this issue, the Study Team adopted a three-way split sample design for the self-completion of this module, with Study Children randomly designated to complete the 'sensitive' questionnaire in one of three ways: on paper, on a computer laptop, on a computer tablet.



To make this split-sample design as efficient as possible, it was decided to maximise the completed sample of 9-year-olds in the three splits by including 168 of the families from the dress-rehearsal phase at age 3 (the second wave). These families had most recently participated in the study when the children were 3 years old. The Study Team anticipated that the response rate among this group would be somewhat lower than among the 'pilot' sample who had participated at 5 years of age, simply because it had been much longer since they were contacted by the project. Nonetheless, their inclusion in the pilot at 9 years of age would boost the number of participants in each of the three split samples for analysis and assessment of the feasibility and impact of a move from paper and pencil to tablets or laptops.

In summary, therefore, the pilot sample used at this phase of the study included two main components: (a) the longitudinal pilot which had been included in the Cohort '08 survey since the project began (discussed in the preceding sections), and (b) the families who had last participated at 3 years of age in the dress-rehearsal sample.

4.2.3 RESPONSE RATES FOR WAVE 5 (AGE 9 YEARS) PILOT

A total of 180 9-year-olds from the original core pilot sample were included in the Cohort '08 target sample at 9 years of age; 160 of these families had participated in the pilot at 5 years of age – 132 of whom (82.5%) participated in the 9-year pilot. As expected, a considerably lower percentage of families who had most recently participated in the longitudinal pilot at 9 months or at 3 years of age re-engaged with the project and participated at 9 years of age, although some were successfully interviewed. Overall, this corresponds to a response rate of 75.6 % for all pilot families approached (including those who had not participated at age 5). A further 134 families from the 168 in the 'dress rehearsal' sample also participated in the pilot at 9 years. This gives a response rate of 79.8% among that group of families who had last participated when the Study Child was aged 3 years. The key feature of the inclusion of the dress-rehearsal sample, however, was that it provided a considerable increase in the absolute number of families participating at 9 years of age; thus affording the opportunity of a more precise analysis of mode effects on the Study Child's Self-Completion 'Sensitive' Questionnaires. In total, 270 families participated in the pilot for Cohort '08 at age 9 years.

It was expected that the response rate of 82.5% among families of the pilot sample who had taken part in the age 5 interview would be closest to that achieved in the main phase of fieldwork with this cohort. In general, one finds that the response rates in the main phases of fieldwork are a few percentage points above those in pilots. This is because the main phase of fieldwork takes place over a longer period, facilitating more flexibility in arranging appointments and a later refusal conversion exercise.



Chapter 5

Child Main Questionnaire





5.1 CHILD MAIN QUESTIONNAIRE

The main part of the child’s questionnaire was administered on a CAPI basis by the interviewer. It consisted of three sections:

- Child’s view of school and family economic status
- Child’s activities including computer/technology use
- Child’s likes and dislikes

Each of the sections in the Child Main Questionnaire is outlined below. The main considerations for continuing individual items into the main phase were their performance in the pilot and maintaining consistency with the questionnaire used with children in Cohort '98 at 9 years and/or topics covered with Cohort '08 at 5 years (in which only parents had been interviewed).

5.1.1 SECTION A

The questions in this section were about the Study Child’s feelings about school and schoolwork as well as their perception of the family’s socioeconomic status.

SECTION A	Construct	Questions	Included in Cohort '98 at 9 years
Child’s view of school and family economic status	Attitudes to school and schoolwork	1-3	✓
	Homework frequency	4	✓
	Relative economic position of family	5a-5c	✓

These questions appeared to work well with, in general, good variance in the response categories. There was no adverse feedback from families or interviewers on them except in respect of Question 5: Do you think your family is better off (has a bigger house, better car, more expensive clothes) than: *most of your classmates; most of your neighbours; other families in Ireland*. Interviewers noted that this question precipitated a negative response from a small number of families. It was used at 9 years of age with Cohort '98 with no adverse reactions from participants. Recent work (Murray & Williams, 2016) has begun to investigate how the child’s perception of their relative position is linked to their family’s actual financial position and other indicators of deprivation, using data from the Cohort '98 study; however, this needs to be balanced with possible negative reaction of participants.

5.1.1.1 Summary of changes for main phase at 9 years

- The questions on perceptions of material well-being were removed following some negative feedback from families in the pilot.
- Other parts of Section A were retained for the Main Study.



5.1.2 SECTION B

The questions in this section were about the Study Child's activities, including activities with their family, ICT usage, hobbies and pastimes, sport and exercise, weight perception, reading for fun, and self-care and chores.

SECTION B	Construct	Questions	Included in Cohort '98 at 9 years
Child's activities	Activities with parents	6a-6i	✓
	ICT usage ^a	7-27	✓
	Hobbies and pastimes	28-29	✓
	Friendship networks	30-34	
	Sport and exercise	35-37;43	✓
	Weight perception	38	✓
	Reading for fun	39-40	✓
	Self-care and chores	41-42	✓
	Likes and dislikes	44	
	Family pets	45-48	

Notes: a. Questions significantly updated from the Cohort '98 survey at 9 years

There were no problems with the questions on activities with parents, but there was significant overlap with similar questions asked of parents in the main PCG questionnaire. Hence it was decided to delete items 6a-l to reduce the child's response burden.

In terms of online activities, these generally worked well, but some children found difficulty with the four-fold response classification used in Questions 8b to 22b (on frequency of usage of the types of computer devices). This was based on answer options of: *a few times every day; once a day; 2-3 times a week; less often*. A simpler question on a list of online activities was to be adopted for the Main Study: the child was just asked which activities they had done in the last week (yes/no). Additionally, for the main phase, it was decided to create a 'Section B' of the child's questionnaire that mentioned just computer and online activities, with the remaining activities labelled as 'Section C'.

Question 28 required the child to rank their three favourite activities (1st, 2nd and 3rd) from a list of 13 items. This posed some problems for children and appeared to take them a relatively long time to complete. To simplify and to reduce the response burden for the children, this ranking question was replaced in the main phase with an open-ended question asking the children to specify the three things they liked to do most in their free time.

Again, with a view to reducing response burden, it was decided to streamline questions on friends by deleting Questions 31-33 on proximity to friends, their gender breakdown, and frequency of arguing with their friends. The questions on number of friends and meeting friends outside school were retained. As this set of questions on friends was new to this wave, there would be no loss of longitudinal or inter-cohort consistency.

There was some reorganisation of questions on sports and exercise. Question 37 on frequency of exercising and Question 43, a wordy question on frequency of moderate to vigorous activity, were replaced with a simpler question on amount of physical activity at the main phase. Questions 35 and 36 on playing sport were retained but the latter was simplified by asking the child to list up to three sports that they played, without the instruction to rank them in order of how often they played them. An open-ended question to specify their favourite sport was added in place of the ranking.



Question 38 on self-perception was commented on by a small number of parents as being insensitive for children with recognised weight issues. These concerns need to be balanced against the importance of body image and self-perception for understanding obesity and its consequences, however. It was decided to move this item to the Self-Complete Questionnaire to minimise embarrassment for the child, albeit with the possibility of some implications for inter-cohort comparisons.

With a view to reducing the overall length of the questionnaire, it was decided to delete Question 41 on personal care but to retain the subsequent question on household chores (Question 42). Although this did represent a loss of inter-cohort consistency, these questions for Cohort '98 have been little used by external researchers to date.

Among children who had pets, virtually all said they liked their pet(s) at Questions 47-48. Given the lack of variance on the 'liking' question, it was decided to reduce the pet questions to just presence and type of pet(s).

5.1.2.1 Summary of changes for main phase at 9 years

- Removal of Question 6 due to overlap with questions on the PCG Main Questionnaire.
- Simplification of questions on frequency of online activities to a list of 'what activities in the past week'.
- Separation of pastime-related questions into two separate sections: B (computer/online) and C (other likes/dislikes).
- Question 28 – favourite things to do in free time – was restructured to allow the children to record their three most favoured free-time activities, on an open-ended basis.
- Question 30 – on size of the friendship network – was retained but the following questions were removed: whether they live in the same area as Study Child (Q.31); gender mix of friends (Q.32); frequency of arguing with friends (Q.33).
- The questions on sport and frequency of exercise (Q.35-37 and Q.43) were simplified as described above.
- The question on self-perception of weight (Q.38) was moved to the child's Self-Complete Questionnaire to minimise embarrassment to some children.
- The personal care items at Question 41 were deleted to reduce response burden.
- Questions 45-48, on pets, were simplified to asking whether the family had pets and what type.



Chapter 6

Child Self-Complete (Sensitive) Questionnaire





CHILD SELF-COMPLETE QUESTIONNAIRE

The Self-Complete Questionnaire was made up of several components:

- the core Self-Complete Questionnaire
- the Parenting Style Inventory in respect of (respectively) mum, dad, mum's partner and dad's partner
- the Piers-Harris self-concept scale

These three components of the more sensitive questions for the children were self-completed through one of three methods: (i) CASI using a laptop, (ii) CASI using a computer tablet, or (iii) paper and pencil.

The next section discusses the core Self-Complete Questionnaire. This is followed by a discussion of the Parenting Style Inventory and the Piers-Harris self-concept scale. How well the items worked in the pilot was examined and decisions on the main phase of the study are presented. Section 6.4 considers issues around the mode effects on responses.

6.1 CORE SELF-COMPLETE QUESTIONNAIRE

6.1.1 SECTION A

The 15 questions in this section recorded details on the Study Child's view of different aspects of the local area in which they lived.

SECTION A	Construct	Questions	Included in Cohort '98 at 9 years
Child's view of local area	Child's perception of their local area	1-15	√

The questions on local area were used with Cohort '98 at age 9, worked well in the current pilot and were well-differentiated in terms of response categories. In the interests of streamlining the overall child self-complete module, the Study Team removed some of the items from this section that had some overlap with existing questions on either this questionnaire or with the parent components. The items removed were 4, 5, 7, 10 and 15 (traffic, green areas, youth clubs, public transport and whether adults were generally nice). There was no interview with the child at age 5, so there would not have been consistency issues with the child questionnaire in earlier years. This change left 10 remaining items that are common between Cohorts '08 and '98 at age 9, allowing for cross-cohort comparability.

6.1.1.1 Summary of changes for main phase at 9 years

- The removal of some overlapping items about the area where the child lived (items 4, 5, 7, 10 and 15) to reduce the overall length of the questionnaire.

6.1.2 SECTION B

The questions in this section related to the Study Child's view of school and peer relationships (bullying, as a victim and a perpetrator).

The questions on school and teacher seemed to work well in the pilot and elicited no negative response from parents or children. On debriefing, interviewers noted that these questions had caused no problems in the administration of the surveys.

The questions on bullying – as a victim and a perpetrator – also worked well in general. One question, however, asked victims of bullying 'If you were picked on, did it upset you? A lot; A little; Not at all'. This question received a small amount of negative feedback from parents. The Study Team decided to remove that item for the main phase to ensure children were not negatively affected.



SECTION B	Construct	Questions	Included in Cohort '98 at 9 years
Child's view of school and emotional well-being	Liking of school and teacher	16-17	√
	Interactions with teacher	18-19	√
	Bullying	20-26	√

6.1.2.1 Summary of changes for main phase at 9 years

- Question 22 on whether the bullying upset the Study Child was removed following some negative feedback.
- Remaining items in Section B were retained for the main phase.

6.1.3 SECTION C

The questions in this section focused on the Study Child's view of their family.

SECTION C	Construct	Questions	Included in Cohort '98 at 9 years
Child's view of family	Having and getting on with siblings	27-28	√
	People to talk to with a problem	29	√
	Coping strategies	30	
	Child agency within family	31	√

No issues were reported for the questions on getting on with siblings, but the Study Team felt that they were less useful than other items. Presence of siblings was recorded elsewhere in the questionnaire. Furthermore, a child may get on with some siblings but not others, and this situation was not captured by the existing questions. These questions at 27 and 28 were subsequently deleted for the main phase.

Interviewers reported a minor issue with Question 29 on whom children would talk to if they had a problem. Answer options of 'mum's partner' and 'dad's partner' were included to reflect variations in family structure, but tended to cause some confusion in other families: for example, children were overheard to ask mothers who 'mum's partner' was, and on being told 'dad', effectively duplicated the answer already given for the 'dad' option. As the questionnaire was intended to be self-completed by the child, the Study Team felt that on balance it was better to remove these options from the list. In addition, the 'grandparent' option was reworded as 'grandmother/grandfather'.

The question on coping strategies was a new follow-on question to the item on talking to others about a problem. It was not included on the questionnaire for Cohort '98 at 9 years but was included on the pilot questionnaire for the Cohort '08 survey at this age, following input during the consultative process. The list covered a selection of activities as well as an open-ended option and 'nothing'. The question worked well, giving good differentiation across categories. The most popular strategies used by 9-year-olds to cope with stress were 'spending time with family and friends' (54%), 'play sports or exercise' (42%), 'read' (37%), 'watch TV' (29%) and various forms of play. Subsequently, however, the need to reduce the time burden on child respondents – and the absence of either longitudinal or inter-cohort consistency – led to a decision to remove this item from the questionnaire.



In addition, Question 31 on child agency within the family and input to family decisions was removed in response to the pressing need to reduce the time burden on the child. The majority of children in the pilot (78%) said they 'sometimes' had a say in family decisions, with the distribution being very similar to that recorded for Cohort '98 at their main 9-year phase (74% 'sometimes', 19% 'always' and 6% 'never').

6.1.3.1 Summary of changes for main phase at 9 years

- Question 22 on whether the bullying victim had been upset by the experience was deleted on the grounds that this question met with some negative response from parents.
- Questions on siblings were removed as some of this information was captured elsewhere (Q.27-28).
- The options of 'mum's partner' and 'dad's partner' on Question 29 were removed as they caused confusion for several children in the pilot.
- The new questions on coping strategies were removed to reduce the burden on 9-year-olds.
- Question 31 on child agency was also removed to reduce the time burden on the child.

6.2 PARENTING STYLE INVENTORY

The core Self-Complete Questionnaire was followed by questions on the child's relationship with his/her parent(s) and included a couple of general questions as well as a Parenting Style Inventory.

	Construct	Questions	Included in Cohort '98 at 9 years
Child's relationship with parent	Parent encourages child at school	1	√
	How well get on with parent	2	√
	Parenting Style Inventory	3a-j	√
	Parent discipline strategies	4a-i	√

Question 1 asked how much encouragement the child received about school. Question 2 was a general question on how the child got on with the parent. The questions on the child's view of their relationship with parents contain an adapted scale measure that was previously used with Cohort '98 at 9 years (Q.3a-j). The Parenting Style Inventory II (Darling & Toyokawa, 1997) comprises two subscales of 'demandingness' and 'responsiveness' (excluding the third 'autonomy' subscale), with simpler answer categories and phrasing than the original (which had been developed for adolescents). Question 4 asked the child about how s/he was disciplined by their parents. The same child-parent relationship questions were asked in respect of all applicable parental figures (mum/dad/mum's partner/dad's partner).

6.2.1 PERFORMANCE IN THE PILOT STUDY

The internal consistency reliabilities of ($\alpha = .54$) for Responsiveness and ($\alpha = .39$) for Demandingness for the child report of mother's parenting style were somewhat lower than anticipated.

The responsiveness aspect of the parenting style measure was compared with the child's self-concept scores (measured by the self-report, Piers-Harris scale; Piers and Herzberg, 2007). Previous research has indicated that parenting style influences socio-emotional development including self-esteem (e.g. Milevsky, Schlecter, Netter & Keehn, 2007). Children with higher *overall self-concept* ('high average' category or above) tended to have higher mean scores on the *Responsiveness* Parenting Style subscale ($F = 5.81, p < .005$). There were also statistically significant associations in terms of higher mean responsiveness scores among children who were in the 'high average' or above category for the Piers-Harris subscales of *Intellectual and School Status* ($F = 6.16, p < .005$), *Physical Appearance* ($F = 6.52, p < .005$) and *Popularity* ($F = 5.90, p < .005$). Both of these measures were self-reported by the child during the home visit. There was also a weak but significant



correlation between *Responsiveness* and the (parent-reported) Strength and Difficulties Questionnaire (SDQ; Goodman, 1997) *Prosocial behaviour* ($r = 0.17, p < .01$). No differences were found for gender.

Although the Parenting Style Inventory and the other questions on this part of the self-complete inventory worked well, the Study Team in conjunction with external reviewers made the considered decision to remove most of the questions in this section. In terms of the overall length of time required for the child's participation, severe cuts were necessary, and information on discipline strategies had already been collected from parents. The Study Team decided to retain only the general question 'how do you get on with your mum/dad?'. To fill the gap in data on parenting approaches left by the removal of this scale from the child questionnaire, and to retain longitudinal consistency with earlier waves of this cohort, the questions on parenting style previously asked of parents at 3 years and 5 years were added to the parental questionnaires.

6.2.1.1 Summary of changes for main phase at 9 years

To reduce the response burden for child participants, the majority of questions from this section were removed for the main phase. Only questions on how well the child got on with his/her parents (Q23–Q24: one item for the mother and father) were retained.

Parent-report questions on parenting style previously used with this cohort at 3 and 5 years were added to the PCG Self-Complete Questionnaire to maintain longitudinal consistency.

6.3 PIERS-HARRIS SELF-CONCEPT SCALE

This scale measures the child's self-concept. The scale consists of 60 items that express how people feel about themselves, each with yes/no answers, that form six subscales plus a total score.

	Construct	Questions	Included in Cohort '98 at 9 years
Child's Self-Concept	Piers-Harris 2	1-60	√

The subscales are:

- **Behavioural Adjustment** – a subscale of 14 items on problematic behaviours
- **Intellectual and School Status** – a subscale of 16 items reflecting the Study Child's assessment of his/her abilities with respect to intellectual and academic tasks; general satisfaction with school and perceptions of future achievements
- **Physical Appearance and Attributes** – a subscale of 11 items about perceptions of physical appearance and other attributes such as leadership and ability to express ideas
- **Freedom from Anxiety** – a subscale of 14 items exploring a variety of feelings including fear, unhappiness, nervousness, shyness and feeling left out of things
- **Popularity** – a subscale of 12 items exploring the Study Child's evaluation of his or her social functioning
- **Happiness and Satisfaction** – a subscale of 10 items reflecting feelings of happiness and satisfaction with life

The scales are scored so that a higher score indicates a more positive self-evaluation in the domain being measured. This scale was used in the Cohort '98 survey at 9 years of age on a group self-completion basis in the classroom, along with the Drumcondra tests. At 13 years of age it was completed in the home.



6.3.1 PSYCHOMETRIC INFORMATION

Piers and Herzberg (2007) report reliability and validity data for a sample of 271 13-14-year-old children. They report internal consistency reliabilities for the global measure of self-concept as well as for each of the domains: Total Self-concept ($\alpha = .91$), Behavioural Adjustment ($\alpha = .81$), Intellectual and School Status ($\alpha = .82$), Physical Appearance and Attributes ($\alpha = .77$), Freedom from Anxiety ($\alpha = .82$), Popularity ($\alpha = .79$), and Happiness and Satisfaction ($\alpha = .77$).

6.3.2 REDUCING THE PIERS-HARRIS SELF-CONCEPT SCALE

Following feedback from external reviewers on the length of the full Piers-Harris questionnaire (60 items), the Study Team undertook further analyses of the Piers-Harris measures using the data collected from Cohort '98 at 9 years of age with over 8,500 participants. These analyses are described below but, in summary, the Study Team applied for, and was granted, permission from the instrument copyright-holders to substantially reduce the overall number of items in the Piers-Harris while retaining the different domains.

The Study Team undertook an exercise to reduce the Piers-Harris 60 item scale across the six subscales using the large Cohort '98 sample at age 9 years (circa 8,500 cases). It was decided that sticking to the original six-factor structure designed by the authors and used with Cohort '98 at 9 years would be more useful to researchers than attempting to find an optimal factor structure that might result in new subscales and hence lack comparability. Therefore, the original subscales were examined for their internal consistency, and individual items were evaluated as to their likely effect on scale consistency if they were removed. Numerous subsets of items were examined by removing those items that would have least impact on the overall internal consistency of the scale.

As well as the internal consistency of the subscales, it was important to ensure that the scale as a whole covered all six component dimensions of the Piers-Harris. Consequently, the Study Team gave preference to retaining those items used in more than one subscale, to maximise use of the retained items. The final six reduced item subscales demonstrate good internal reliability and are close to the internal consistency of the six subscales in their original format for Cohort '98 (Table 6.1 below). As some items are used in more than one subscale, as noted, the reduced scale to be used in the main phase consisted of 32 items across the six subscales: *Behavioural Adjustment*; *Intellectual and School Status*; *Physical Appearance and Attributes*; *Freedom from Anxiety*; *Popularity*; *Happiness and Satisfaction*.

As regards convergent validity, for these reduced-item Piers-Harris subscales, there was little or no difference between the magnitudes and directions of the relationships of the six reduced subscales and their original full subscales.

Turning to external validity, the relationship between the reduced Piers-Harris scale and a number of other variables in the Cohort '98 survey at 9 years was explored. For example, findings showed that correlations for the original and reduced Piers-Harris Behavioural Adjustment subscale were both negatively correlated with parent-reported scores for SDQ conduct ($r = -.22, p < .01$; $r = -.21, p < .01$) and SDQ hyperactivity ($r = -.23, p < .01$; $r = -.21, p < .01$). Similarly, the original and reduced Piers-Harris Freedom from Anxiety subscales were both negatively correlated with the SDQ emotionality subscale ($r = -.18, p < .01$; $r = -.16, p < .01$) and SDQ *total difficulties* score ($r = -.22, p < .01$; $r = -.21, p < .01$).

Correspondingly, both the full and reduced-item Piers-Harris *popularity* subscales were negatively correlated with the SDQ *peer problems* subscale ($r = -.24, p < .01$; $r = -.25, p < .01$). Furthermore, the positive correlation between the Piers-Harris *happiness* subscale and the SDQ *prosocial* subscale ($r = .09, p < .01$; $r = .07, p < .01$) was reproduced across both full and reduced versions of the subscale.



Table 6.1: Piers-Harris reliability (alphas) for full and reduced item subscales

	Behavioural Adjustment	Intellectual and School Status	Physical Appearance and Attributes	Freedom from Anxiety	Popularity	Happiness and Satisfaction
Full subscales						
No. of items	14	16	11	14	12	10
Cronbach's alpha	.74	.69	.67	.79	.67	.67
Reduced subscales						
No. of items	9	8	7	8	6	6
Cronbach's alpha	.70	.63	.68	.72	.65	.63

6.3.3 PERFORMANCE IN THE PILOT STUDY

Findings of the Cohort '08 at 9 years of age pilot study data indicate that the reduced Piers-Harris scale demonstrates good internal consistency/reliability. Cronbach's alpha was calculated for the Piers-Harris measure as a whole ($\alpha = .92$), as well as for the subscales: *Behavioural Adjustment* ($\alpha = .78$); *Intellectual and School Status* ($\alpha = .75$); *Physical Appearance and Attributes* ($\alpha = .67$); *Freedom from Anxiety* ($\alpha = .81$); *Popularity* ($\alpha = .68$), and *Happiness and Satisfaction* ($\alpha = .77$).

The Cohort '08 at 9 years of age pilot questionnaire employed the full 60-item Piers-Harris scale. As a check on the convergent validity of the reduced Piers-Harris scale items, the association between both the full and reduced Piers-Harris scale and the Strengths and Difficulties Questionnaire (SDQ) was examined.

The Piers-Harris overall self-concept score correlated with the SDQ and its subscales in a conceptually meaningful manner (using the Pearson's r statistic). Pearson's correlations are presented for both the full and reduced Piers-Harris scales in this section. It can be seen that there are only minor differences in the magnitude of correlations between the full and reduced Piers-Harris scales. The Piers-Harris overall self-concept was negatively associated with Primary Caregiver-reported SDQ total difficulties (full scale $r = -.34$, $p < .01$; reduced scale $r = -.36$, $p < .01$). The Piers-Harris overall self-concept was also negatively and significantly correlated with the deficit focused SDQ subscales *emotionality* ($r = -.26$, $p < .01$; $r = -.24$, $p < .01$); *hyperactivity* ($r = -.27$, $p < .01$; $r = -.32$, $p < .01$) and *peer problems* ($r = -.32$, $p < .01$; $r = -.28$, $p < .01$). Accordingly, overall self-concept was positively correlated with *prosocial behaviour* ($r = -.23$, $p < .01$; $r = .23$, $p < .01$).

Pearson's correlations are presented for several full and reduced Piers-Harris subscales in this section. These findings showed that the Piers-Harris *behavioural adjustment* subscale was negatively correlated with SDQ *conduct* ($r = -.21$, $p < .01$; $r = -.23$, $p < .01$); SDQ *hyperactivity* ($r = -.24$, $p < .01$; $r = -.23$, $p < .01$), and SDQ *peer problems* ($r = -.15$, $p < .05$; $r = -.13$, $p < .1$). The correlation direction and strength between the Piers-Harris *Behavioural Adjustment* and SDQ *peer problems* remains the same here but drops just below the critical value for statistical significance at the $p < .05$ level within the relatively small Cohort '08 pilot sample.

Further evidence of validity (divergent validity) was demonstrated by the negative associations between the Piers-Harris *Freedom from Anxiety* and the SDQ *emotionality* subscale ($r = -.30$, $p < .01$; $r = -.27$, $p < .01$); and between the Piers-Harris *Popularity* and SDQ *peer problems* ($r = -.32$, $p < .01$; $r = -.32$, $p < .01$). *Intellectual and School Status* was negatively associated with *hyperactivity* scores on the SDQ ($r = -.24$, $p < .01$; $r = -.23$, $p < .01$).



6.3.3.1 Summary of changes for main phase at 9 years

The measure performed well in both the current pilot study and in past waves of the study and has good psychometric properties. Given the length of the measure, however, the Study Team reduced the number of overall items while retaining the subscale structure for the main phase.

6.4 MODE EFFECTS IN THE CORE SENSITIVE AND SUPPLEMENTAL QUESTIONNAIRES

As noted in Section 2.5 above, when they were interviewed in 2007/2008 the 9-year-olds in Cohort '98 self-completed their Self-Complete Questionnaires on paper. For the current phase with the 9-year-olds of Cohort '08, it was decided that the pilot study should investigate the feasibility of electronic completion of this questionnaire by the Study Children.

The potential advantages for electronic completion included the improved efficiencies in data transfer and preparation, and the possibility that the child would find a screen-based approach more engaging. It was also easier to incorporate an audio-assist function into this administration format. Conversely, the possible disadvantages of electronic self-completion included the possibility that some children might not be familiar with using a tablet or laptop, whereas virtually all would know how to use a pencil and paper; the difficulty of redacting an individual question that might be particularly sensitive (such as recent death of a parent), and the comparative lack of scope to make the on-screen appearance of the questionnaire visually appealing to children using the established survey software. The biggest potential disadvantage of changing to electronic administration was the possibility of 'mode effects' emerging as a result; this could complicate inter-cohort comparisons between Cohort '08 and Cohort '98 at 9 years, given that Cohort '98 completed on paper.

To attempt to address this issue, the sample used in the pilot was randomly split three ways to accommodate three different modes of self-completion of the child's self-completed survey: on paper, using a computer tablet and using a computer laptop. This mode effect experiment applied to the self-completion of the Child Core Sensitive; the Parenting Style Inventory and the Piers-Harris questionnaires, with a view to subsequent analysis of the results (albeit on small subsamples) to assess whether mode effects could be identified in the completed response patterns. The Study Team recognises that the subsamples used were small – 46 were completed on paper, 112 on a computer tablet, and 101 on a laptop.⁶

Additional analyses showed that, despite the random assignment to the different modes, the three subsamples differed somewhat in terms of background characteristics, including the fact that the children completing on paper tended to come from educationally disadvantaged backgrounds (based on mother's education). Perhaps related to this, they also tended to have slightly higher scores on the Strengths and Difficulties Questionnaire (see Section 6.5). For this reason, in comparing responses across the three different modes, mother's education and other background characteristics were controlled.

6.4.1 MODE EFFECTS IN THE STUDY CHILD'S PERCEPTION OF NEIGHBOURHOOD, SCHOOL, TEACHERS AND EXPERIENCE OF BULLYING

This issue was explored in the pilot data using various analyses, including logistic regression. The relevant output is illustrated in Table 6.2. The table summarises responses to the questions in the Child Core Self-Complete Questionnaire, specifically questions 1-15 on the child's perception of their local neighbourhood; questions 16 to 19c on their views on schools and teachers, and questions 20 and 24 on experience of bullying, as a victim or perpetrator. The question number is shown in Column A and a summary description of the item is in Column B.

6 The Study Team purposely assigned a smaller number of the sample to the paper mode, as it was assumed that some of the children assigned to laptop or tablet would default to this mode by preference in the course of fieldwork – because they were not digitally literate or because the household did not own a tablet. This, in fact, happened in respect of only one child who was assigned to a tablet but opted to self-complete on paper in the course of interviewing. Because of this, the numbers completing on paper were smaller than on tablet or laptop. The allocation to the three modes was random.



Because of the small number of cases completing the questionnaire on paper, the actual percentages answering ‘yes’ are not shown. Instead, the table shows the odds ratios from the logistic regression comparing the responses on paper and tablet to those on the laptop. An odds ratio greater than 1 indicates a higher proportion of 9-year-olds answering ‘Yes’ using paper/tablet than those using the laptop, while an odds ratio between 0 and 1 indicates a lower proportion answering ‘Yes’ than on the laptop. Columns C and D in Table 6.2 present the unadjusted odds ratios of answering ‘Yes’ to each question, not controlling for any other characteristic. The figures show how much more or less likely the children who completed on paper or tablet were to answer ‘Yes’ relative to those who answered on a laptop. Columns E and F present adjusted odds ratios (controlling for mother’s education and child’s sex (in case the subgroups were not proportionally representative)).

Table 6.2 shows that there are notable differences in response patterns for some of the items in question. In general, there appears to be some evidence to suggest that the children answering on paper were slightly more negative in their views about their neighbourhood or school than those answering on tablet or laptop. For example, in rows 4, 6, 11, 13, 16, 17, 18, 20 and 24, children completing on paper recorded more negative views of: traffic in their neighbourhood; prevalence of dirty streets; activities to do after school; local adults being nice; looking forward to school; liking their teacher; perception of treatment by teacher, and of being a bully victim or perpetrator. An exception to this more negative view, held by children completing the Self-Complete Questionnaire on paper, was in respect to the question ‘Is there a playground near where you live?’ (Row 8, in Table 6.2). In this case the trend was in the opposite direction, towards a more positive view of their neighbourhood than that recorded by the children who completed their questionnaire on a laptop or tablet.

Table 6.2: Comparison of responses by mode of completion (paper, tablet and laptop) for questions in the Core Self-Complete Questionnaire

A	B	Unadjusted Odds Ratios, answering ‘YES’		Adjusted Odds Ratios ¹ answering ‘YES’	
		C	D	E	F
		Paper	Tablet	Paper	Tablet
1	Like living around here	-	1.50	0.98	1.72
2	Plenty of friends to play with	0.73	1.10	0.65	1.09
3	Good places to play	1.07	0.64	1.04	0.55
4	Too much traffic	2.37	1.56	2.01	1.52
5	Green area to play	0.87	0.68	0.84	0.68
6	Dirty streets	4.24	2.69	4.44	2.75
7	Youth clubs	1.06	1.30	0.98	1.34
8	Playground	1.82	1.17	1.70	1.12
9	A lot of graffiti	1.24	1.76	1.04	1.93
10	Public transport to school	1.15	0.82	1.09	0.81
11	Activities to do after school	0.41	0.81	0.37	0.87
12	Places for children to play safely	0.61	0.71	0.61	0.72
13	Adults living here are nice to you	0.25	1.09	0.23	1.19
14	Feel safe	0.40	0.21	1.21	0.00



		Unadjusted Odds Ratios, answering 'YES'		Adjusted Odds Ratios ¹ answering 'YES'	
A	B	C	D	E	F
		Paper	Tablet	Paper	Tablet
15	Adults living here are nice to children	0.22	1.09	0.21	1.19
16	Look forward to going to school	0.56	1.15	0.52	1.09
17	Like your teacher	0.46	1.06	0.49	1.09
18	Teacher treats everyone the same	0.48	0.81	0.64	0.96
19a	Teacher – praises	0.34	0.67	0.33	0.67
19b	Teacher – gives out	-	0.09	-	0.08
19c	Teacher – talks to you	1.70	1.10	1.20	1.10
20	Been bullied	1.44	0.90	1.27	0.77
24	Bullied someone else	2.43	0.54	2.15	0.49

1 Adjusted for mother's education, child's sex, level of household's social welfare dependency, and household's economic strain (difficulties in making ends meet).

6.4.2 MODE EFFECTS IN THE PARENTING STYLE INVENTORY

Table 6.3 summarises the average scores on the Responsiveness and Demandingness subscales of the Parenting Style Inventory (PSI) for 'mum'. From analysis of the data, the Study Team feels that there was no difference in the PSI scores by the mode of administration.

Table 6.3: Comparison of average scores by mode of completion (paper, tablet and laptop) for the Parenting Style Inventory for Study Child's 'mum'

Parenting Style Inventory	Mean score (95% CI)		
	Paper	Tablet	Laptop
Responsiveness subscale	13.28	12.97	12.94
	(12.76-13.80)	(12.71-13.23)	(12.62-13.26)
Demandingness subscale	11.81	11.85	11.70
	(11.36-12.26)	(11.58-12.13)	(11.36-12.04)

6.4.3 MODE EFFECTS IN THE PIERS-HARRIS SELF-CONCEPT SCALE

Mode effects were explored for the total score and subscale scores on the Piers-Harris self-concept scale. The results are summarised in Table 6.4.

Columns B, C and D present the average scores on the total scale and each of the subscales in the Piers-Harris. One can see that there was really no difference (significant or otherwise) between the three modes of completion.



Table 6.4: Comparison of average scores by mode of completion (paper, tablet and laptop) for the total score and subscales on the Piers-Harris self-concept scale and the percentage of children classified as being 'below average' on the scales in question

Piers-Harris Self-concept scale	Mean score (95% CI)			Unadjusted Odds Ratio of being 'Below Average'		Adjusted Odds Ratio of being 'Below Average'		
	A	B	C	D	E	F	G	H
		Paper	Tablet	Laptop	Paper	Tablet	Paper	Tablet
Total score		50.05 (47.74-52.36)	50.42 (48.77-52.08)	50.27 (48.64-51.91)	1.40	1.26	1.39	1.20
Behavioural adjustment		12.72 (12.24-13.21)	12.91 (12.6-13.2)	12.66 (12.22-13.11)	1.66	1.11	2.01	1.14
Intellectual and school status		13.46 (12.71-14.21)	13.45 (12.94-13.97)	13.42 (12.91-13.92)	1.03	1.06	1.07	1.11
Physical		8.64 (8.07-9.21)	8.26 (7.84-8.68)	8.57 (8.18-8.95)	0.75	1.35	0.88	1.54
Freedom from Anxiety		11.23 (10.44-12.01)	11.57 (11.05-12.08)	11.40 (10.86-11.93)	2.05	0.98	1.97	0.95
Popularity		9.52 (8.80-10.24)	9.34 (8.92-9.76)	9.45 (9.08-9.73)	0.94	1.48	0.90	1.51
Happiness		9.18 (8.86-9.50)	9.28 (9.01-9.55)	9.34 (9.06-9.62)	2.15*	1.24	2.24*	1.30

1 Adjusted for mother's education, child's sex, level of household's social welfare dependency, and household's economic strain (difficulties in making ends meet).

Columns E and F indicate the odds of children completing on paper or tablet (relative to those completing on laptop) falling below the developer's norm into the 'below average' range on the total scale and each of the subscales. In general, a higher percentage of children who completed on paper were classified as 'below average' on most of the subscales, the exceptions being in the *Physical* and *Popularity* subscales. For example, the children who completed on paper were twice as likely (and significantly so) to be classified as being 'below average' on *Happiness* as those who completed on a laptop. The same general pattern is seen in the adjusted figures (taking account of mother's education, child's sex, household's social welfare dependency and household's difficulty in making ends meet).

6.4.4 SUMMARY ASSESSMENT OF MODE EFFECTS

It was important to attempt to draw together the findings on mode effects outlined above and to make a final assessment of their potential importance for the main phase of fieldwork with the 9-year-olds in Cohort '08.

Some of the findings presented indicate differential results in the response to the Child Self-Complete Questionnaires according to mode of completion. The Study Team once again emphasises that the split subsamples were small and, accordingly, the results were liable to random fluctuations, possibly due to the small cell counts. However, equally one cannot be sure that the differences were not as a result of



mode effects. If this were the case, then changing mode (to CASI) at this point in time could potentially compromise the inter-cohort comparability of results between the 9-year-olds in Cohort '98 and Cohort '08. Such inter-cohort comparisons may provide some of the most interesting analyses of the current wave.

The Study Team considered the feedback from interviewers in the pilot, the analysis of the pilot data and its own observations during the small-group trial when reaching a decision on mode for the main phase. Taking all these inputs on board, the Study Team felt that it would be most prudent to retain the use of paper-and-pencil (PAPI) methods for completion of the Child Self-Complete Questionnaire. The deciding factor was the concern about the potential for inter-cohort comparisons to be distorted by mode effects.

6.4.4.1 Summary of changes for main phase at 9 years

- The Child Self-Complete Questionnaire was to be administered on paper consistent with the Cohort '98 survey when the children were 9 years of age. This was to be done in a manner that protected the child's privacy and confidentiality in providing information while simultaneously taking child protection issues into account (another adult being present with the interviewer at all times when s/he was with a child in the family's home).
- An audio-assist option in the form of questions as audio files on an MP3 player was provided to help children who would benefit from hearing the questions read aloud. Interviewers provided over-ear headphones and disposable ear-pad covers to help maintain privacy.
- The questions on neighbourhood, school and teacher were maintained largely as they were in the pilot, with limited change.
- Question 22 on how much being a victim of bullying had upset the child was removed after a small amount of negative feedback.
- Question 32 on the child's input to family decisions was removed to reduce the time burden. To the Study Team's knowledge, the item had not been used for research since it was first included in the survey for 9-year-olds in Cohort '98.
- After much consideration, the Study Team removed most of the questions that made up the Parenting Style Inventory and child's report of discipline. Two questions on how the child felt they got on with their mother and father (separately for each parent) were retained and added to the main Self-Complete Questionnaire. This decision made a significant cut to the response burden for children, while several questions on parenting and discipline were retained as part of the parental questionnaires. Questions on parenting styles, as previously used with this cohort at 3 and 5 years, were added to the PCG Self-Complete Questionnaires. Following extensive additional analysis and negotiation with the test publisher, the Piers-Harris self-concept measure was considerably shortened from 60 to 32 items while retaining the original subscale structure of 6 scales.

6.5 ADDITIONAL MODELLING OF MODE EFFECTS FOR THE STRENGTHS AND DIFFICULTIES QUESTIONNAIRE

As noted earlier, despite the random assignment of the pilot sample to the three different modes for the Child Self-Complete Questionnaire, there were some differences in characteristics between the three subsamples. Table 6.5 presents summary scores for the children on the Strengths and Difficulties Questionnaire (SDQ), for each of the three modes of completing the Child Self-Complete Questionnaire, as recorded by their Primary Caregiver. Columns B, C and D present the average scores for children completing the Self-Complete Questionnaire in each of the three groups for the SDQ total score and also each of the subscales. From Table 6.5, one can see that there are differences in the average scores on the total and subscales. The Study Children who completed their Self-Complete Questionnaires on paper had a significantly higher score on the emotionality subscale than those who completed on a laptop, but not on a tablet.



Table 6.5: Study Children’s average score on the Strengths and Difficulties Questionnaire (SDQ) as recorded by their Primary Caregiver (usually the child’s mother)

Strengths and Difficulties Questionnaire (SDQ)	Mean score (95% C.I.)			
	A	B	C	D
		Paper	Tablet	Laptop
SDQ Total Difficulties score		7.50 (6.02-8.97)	5.97 (5.04-6.90)	6.05 (5.09-7.01)
Emotionality subscale		2.30* (1.71-2.89)	1.84 (1.48-2.19)	1.24 (0.98-1.50)
Conduct subscale		0.74 (0.41-1.07)	0.93 (0.71-1.15)	1.17 (0.83-1.51)
Hyperactivity subscale		8.64 (8.07-9.21)	2.40 (1.93-2.87)	2.87 (2.37-3.37)
Peer problems subscale		3.37 (2.66-4.08)	0.81 (0.61-1.01)	0.77 (0.55-0.99)
Prosocial subscale		8.91 (8.41-9.42)	9.22 (8.98-9.45)	8.84 (8.59-9.09)

The higher average score on the *total difficulties* score is consistent with the fact that the Study Children who completed on paper tended to come from the most educationally disadvantaged backgrounds.



Chapter 7

Child's Cognitive Tests and Measurements





7.1 INTRODUCTION

This chapter covers all the direct assessments of the child carried out by interviewers. The interviewers administered two cognitive tests: an adaptation of the Drumcondra Reading Test which had previously been used with Cohort '98 at age 9 years, and a new test of selective attention (the 'map mission'). In terms of physical measurements, the interviewers took the child's height and weight, as before, but with a change to the analogue weighing scales as used with Cohort '98 at 9 years instead of the digital scales used in previous waves with Cohort '08. For the first time with younger children, the Study Team also piloted the measurement of blood pressure, which had been successfully undertaken for Cohort '98 at 17/18 years.

7.2 DRUMCONDRA READING TEST

Interviewers were instructed to administer the Drumcondra Reading Test level that corresponded to the child's last year of school; i.e. a child who had just started 3rd class in September 2016 completed the Level 2 Drumcondra test. This was because the tests are curriculum-based and so October/November 2016 would be too early to administer the Level 3 test to a child who had only started 3rd class in September. Those children who had started 3rd class the previous September (2015) were administered the Level 3 test

7.2.1 DESCRIPTIVE RESULTS

From 243 completed tests, 165 children completed Level 2 and the remaining 78 completed Level 3. Children from the original pilot sample were typically around four months older than the dress-rehearsal sample and hence were more likely to be completing the higher-level test: the former were approximately evenly divided between Level 2 and Level 3 tests, whereas the latter mostly (but not exclusively) did Level 2. There are two important differences between Levels 2 and 3: (a) Level 2 answers are ticked within the test booklet while Level 3 answers need to be entered (by the child) on a separate answer sheet; and (b) the number of items in Level 2 was just 36 compared to 40 in Level 3. Due to this latter difference, a percentage correct score was calculated to facilitate comparison. It would appear that the Level 2 test was easier than Level 3, using the percentage correct measure (84.4% versus 74.3% – Table 7.1), and this difference was statistically significant ($t = 4.48$, $df = 241$, $p < .001$). Furthermore, at Level 2 nearly a quarter of children got either all items correct or just one wrong (out of 36), suggesting that scores were approaching a ceiling effect. In contrast, this was much less common at Level 3.⁷

Table 7.1: Drumcondra raw and percentage correct test scores for Levels 2 and 3

	Mean (SD) – Raw score	Mean (SD) – Percentage correct
Level 2 (n = 165)	30.4 (5.1) out of 36	84.4 (14.3)
Level 3 (n = 78)	29.7 (8.0) out of 40	74.3 (20.0)

In general, the Drumcondra reading scores are higher for this pilot sample than they were for the main Cohort '98 sample at 9 years, but with a similar trend for Level 2 scores to be higher than Level 3. Previously, the mean percentage correct for Level 2 was 72.2, and 66.2 for Level 3 (weighted), albeit for a much bigger sample ($n = 2,820$ and $n = 4,926$ respectively).

⁷ Exact percentages have cell sizes that are too small to report.



7.2.2 RELATIONSHIPS WITH OTHER MEASURES

7.2.2.1 Primary Caregiver’s education

Both the Level 2 and 3 Drumcondra Reading Test scores were associated with level of Primary Caregiver education: children whose mothers had attained higher qualifications tended to do better on this measure; those in the ‘degree or more’ bracket had means of 86.8% and 81.2% correct on Levels 2 and 3 respectively. For Level 2, however, the F-statistic for the difference by Primary Caregiver education did not quite reach overall significance [$F(2, 155) = 2.87, p = .06$]. For Level 3, the corresponding figures were $F(2, 73) = 5.60, p < .01$.

7.2.2.2 Other indicators of academic ability

The actual test score was also associated with the Primary Caregiver’s estimate of the child’s ability in both Reading and Maths. Children who received higher parental ratings scored better in the Drumcondra Reading Test. As expected, the relationship was stronger in relation to parental estimates of Reading ability than Maths for both levels (but all were statistically significant). It should be noted, however, that the analysis was somewhat constrained by the very small numbers of parents who rated their children as below average – even when combining the ‘poor’ and ‘below average’ categories as in Table 7.2 below.

Table 7.2: Mean Drumcondra Reading percentage correct scores according to Primary Caregiver’s estimates of the child’s ability in Maths and Reading

Parental rating	Level 2		Level 3	
	Maths	Reading	Maths	Reading
Poor/below average	*	*	*	*
Average	78.4	77.5	68.7	64.0
Above average	87.2	87.5	81.0	79.7
Excellent	88.6	92.2	82.0	83.6
Significance test	F = 7.42 (3, 154), $p < .001$	F = 20.65 (3, 154), $p < .001$	F = 6.77 (3, 72), $p < .001$	F = 10.33 (3, 72), $p < .001$

* Cell sizes below 30

7.2.2.3 Measures of socio-emotional and behavioural difficulties

Both Level 2 and Level 3 Drumcondra Reading scores were negatively associated with the hyperactivity subscale, as would be expected (Table 7.3). Both levels also showed a significant negative association with the SDQ total difficulties score but only the Level 2 scores had a significant association with the prosocial subscale. However, there was no prior reason to expect a relationship with the prosocial scale.

Table 7.3: Correlations between the Drumcondra Reading percentage correct and the SDQ scales

SDQ	Emotional	Conduct	Hyperactivity	Peer problems	Prosocial	Total
Level 2	-.09	-.12	-.24	-.12	.24	-.22
(n = 158)	$p = .25$	$p = .13$	$p < .01$	$p = .14$	$p < .01$	$p < .01$
Level 3	-.17	-.22	-.35	-.03	.15	-.30
(n = 75)	$p = .15$	$p = .06$	$p < .01$	$p = .81$	$p = .19$	$p < .01$



7.2.3 DECISION ON DRUMCONDRA TEST FOR MAIN FIELDWORK

Overall, the Drumcondra Reading Test worked well in the pilot. In the interviewer debriefing, however, a number of interviewers commented on the diversity of conditions within the home as regards taking the test. Some children had 'exam conditions' whereas others had considerably less than optimal conditions in terms of space or distractions. For main fieldwork, the decision was made to have interviewers note the suitability of the 'test conditions' so that researchers might take them into account in analyses. Interviewers continued to inform parents when scheduling an interview that a quiet space would be preferable for the child to complete the tests.

Another point to emerge from the pilot was that many children finished the test well before the prescribed 20 minutes. Therefore, it was expected that the test would typically take only around 12 minutes to complete. Nevertheless, children would be allowed up to 20 minutes if they needed it. This had implications for the timing of the overall household visit and the 'paralleling' of components within the home. When discussing the use of the test in the pilot, the test developers noted that this (the shorter average completion time) could possibly be the case and that the 20 minutes allocated to the test would probably not be necessary in most cases.

7.3 SELECTIVE ATTENTION TEST

The 'map mission' subtest from the Tests of Everyday Attention for Children (TEA-Ch) was used as a measure of executive processing in this pilot. It was the first time *Growing Up in Ireland* had attempted to directly assess this aspect of cognition, but the Study Team were interested in (a) having a measure of cognitive development that was independent of the curriculum and (b) exploring whether the ability to manage distractions could be an early predictor of later success in exams and general decision-making.

The 'map mission' test requires children to search for small symbols or 'targets' (a knife and fork in this instance) on an A3-sized map. These targets compete with a lot of other information on the map such as road numbers and typical topographical indicators. There are 80 symbols to be found and circled on the map; however, as the child only has one minute to search the map, it was highly unlikely that anyone would find all of them in the time available.

The map mission is a test of selective attention whereby children must ignore the competing, distracting information on the map and focus solely on finding symbols that match the target. It was selected because it was:

- from a well-established battery of attention measures
- 'child-friendly' and age-appropriate
- largely non-verbal, apart from understanding the short instructions
- could feasibly be administered in the home by interviewers with basic training
- took very little time in the household

7.3.1 DESCRIPTIVE RESULTS

The mean score from 257 completed maps was 31.7 (out of a maximum of 80) with a standard deviation (SD) of 7.6. The lowest score was 12 and the highest was 64.

Table 7.4 compares these scores with the results of two other studies testing the psychometrics of the TEA-Ch subscales. One of these was by the original test authors on a sample of children in Australia (Manly, Andersonnet, Nimmo-Smith, Turner, Watson & Robertson, 2001) and the other on a sample of Chinese children (Chan, Wang, Jiawen, Leung & Mok, 2008). As it happens, the data from these two studies are divided by age, with one group being aged 7-9 years and the other 9-11 years, so both age groups are contrasted here. The means and standard deviations for the *Growing Up in Ireland* pilot are similar to the



other two studies, but more similar to the younger group in the Australian sample and to the older group in the Chinese sample. However, that the Irish sample was both larger and less diverse in age than the other two samples for the relevant age brackets, so some variation in scoring was to be expected.

Table 7.4: Comparison of *Growing Up in Ireland* pilot scores

	Growing Up in Ireland Pilot	Manly et al. (2001)		Chan et al. (2008)	
		9:1–9:6 years	7–9 years	9–11 years	7–9 years
	(n = 257)	(n = 56)	(n = 54)	(n = 45)	(n = 56)
Mean (SD)	31.7 (7.6)	30.0 (9.7)	42.6 (9.9)	21.3 (8.6)	28.5 (10.3)

7.3.2 RELATIONSHIPS WITH OTHER MEASURES

There is a limited number of other candidates in the data by which the measure of selective attention can be assessed. It is primarily a measure of executive functioning, and other work by Manly et al. (2001) suggests that, while the measure is correlated with IQ, it is unrelated to vocabulary. Manly et al. (2001) give the correlation with the IQ estimate from the WISC III as ($r = .25, p < .01$) but just $r = .15$ (n.s.) for vocabulary; whereas correlations with non-verbal subtests like block design and object assembly were $r = .24$ and $r = .27$ (both $p < .001$).

In the *Growing Up in Ireland* pilot, there was a modest though significant relationship between the measure of selective attention and the Drumcondra Reading Test scores for children completing the Level 2 version of the test ($r = .17, n = 155, p < .05$). There was no correlation, however, between the attention and reading measures for children who completed the Level 3 Drumcondra test ($r = .09, n = 76, p = .42$).

Growing Up in Ireland did not administer a Maths test at this wave due to the response burden on the child. Parents were asked, however, to rate the child’s Maths ability on a five-point scale from ‘poor’ to ‘excellent’. This measure showed a slight trend for children who were rated as better on Maths to also do better on the attention measure (Table 7.5) but the differences were only marginally significant. There did not appear to be any clear relationship between parental ratings of the child’s reading ability and his/her attention scores (also Table 7.5).

Table 7.5: Selective attention test (mean) scores by parental ratings of child’s academic ability

Parental rating	Maths	Reading
Poor/below average	29.4	30.3
Average	30.9	31.0
Above average	31.6	32.8
Excellent	33.9	31.6

Children of Primary Caregivers with higher levels of education tended to do better on the measure of selective attention. The mean score for children of Primary Caregivers with degree-level education or above was 33.3, compared to 31.0 at diploma/certificate level and 29.8 for Leaving Certificate or less: the difference between degree-level and Leaving Certificate was statistically significant in a Bonferroni post-hoc test.

The Selective Attention measure was also compared with the subscales of the Strengths and Difficulties Questionnaire (SDQ). Although the hypothesis for an association was weak, it was reasonable to investigate



the possibility that a well-developed capacity for executive processing may be reflected in the ability to control one’s behaviour. As Table 7.6 shows, there were modest but significant associations between the Selective Attention test score and the *emotionality* ($r = -.14, p < .05$) and *peer problems* ($r = -.14, p < .05$) subscales of the SDQ – suggesting that children with better selective attention had fewer emotional and peer problems. There was also a negative correlation with the total SDQ score and a trend towards a positive association between attention and the prosocial subscale, although the latter did not quite reach statistical significance ($r = .12, p = .06$). In separate analyses (not shown here), the measure of attention was also compared with the self-control subscale of the SSIS-RS but the relationship was not significant ($r = .05, n = 247, p = .40$).

Table 7.6: Correlations between scores on Selective Attention measure and the parent-reported SDQ subscales (and total)

SDQ	Emotional	Conduct	Hyperactivity	Peer problems	Prosocial	Total difficulties
Selective attention (n = 248)	-.14 $p < .05$	-.08 $p = .24$	-.10 $p = .12$	-.14 $p < .05$.12 $p = .06$	-.15 $p < .05$

7.3.3 DECISION ON THE SELECTIVE ATTENTION TEST IN MAIN PHASE OF THE STUDY

The Selective Attention test performed as expected in terms of previous research and showed good variability. Its relationship to other measures was weaker than expected, although this may have been largely due to the dearth of similar measures in the data. Given that the Selective Attention test was intended as a measure of a cognitive outcome not otherwise captured in the study, the weak relationship with other measures could be viewed as a positive attribute.

Although the ultimate value of this measure was less certain than the tried-and-tested vocabulary-type measure (Drumcondra Reading Test), it had high ‘potential’. This test could be a useful alternative view of a child’s cognitive ability for individuals where a vocabulary measure may be an under-estimate. For example, some less confident children may be put off by the very formal test procedure for the Drumcondra Reading Test and do less well than they might in less formal conditions. From the interviewers’ reports, the test was well received by the children as it seemed somewhat like a game and acted as an excellent ‘ice-breaker’ before the more school-like reading test. The Selective Attention test measures a different, more ‘fluid’ aspect of cognitive ability – given that it does not rely on learned knowledge in the same way as a vocabulary test – and might be a useful indicator as children get older of the ability to ‘filter out’ distractions that are an impediment to academic learning.

The Study Team initially advocated that the Selective Attention test be discontinued for the main phase given the somewhat disappointing correlations with the limited other indicators of attention collected in the pilot. The international reviewers were, however, more enthusiastic about it and keen to include a non-verbal measure of cognitive development. On balance, the Study Team therefore accepted the reviewers’ recommendation to proceed with the ‘map mission’ test for the main phase. There were no changes to procedure from those used in the pilot. Permission was sought, and received, from the test publishers to reproduce individual copies of the maps so that the interviewers’ scoring of the test could be checked by field staff.



7.4 BLOOD PRESSURE

Following from the successful implementation of blood pressure measurement with Cohort '98 at age 17/18 years, the Study Team piloted the possibility of measuring blood pressure among 9-year-olds in Cohort '08. Although blood pressure is not routinely checked in children, and high readings would be relatively rare, some clinicians advocate regular measurements from the age of 3 years. Given the high rates of overweight and obesity already identified in this cohort from a young age, and the relative dearth of population statistics on blood pressure for this age group, the Study Team were hopeful that this type of data – if feasible to collect – would be a useful addition to child health researchers.

For this *Growing Up in Ireland* pilot, interviewers took two blood pressure readings from the children using an automated Omron monitor (the same as used for Cohort '98 at 17) and a special child-sized cuff. Each reading gave values for systolic and diastolic pressure, and heart rate. The upper part of Table 7.7 below provides the descriptive statistics for each reading collected in the *Growing Up in Ireland* pilot; the lower part (left-side) gives the percentiles expected for a child aged 9 years of average height.⁸ Ostchega, Porter, Hughes, Dillon & Nwanko (2011) provide reference data on pulse rates by age group for healthy adults and children, collected between 1999 and 2008 in the United States.⁹ They report a mean resting pulse rate of 83 beats per minute for children aged 9-11 years (SE = 0.4, N = 2,366). Paediatric medical guidelines for heart rate published in the USA (Novak & Gill, 2018) indicate a 'normal' range of 75-118 beats per minute for children aged 6 – 11 years. Figures for normal blood pressure (for 6 – 9 year-olds) from the same source suggest 97 – 115 (mm Hg) as the range for systolic measurement and 57 – 76 for diastolic.

7.4.1 DESCRIPTIVE STATISTICS AND COMPARISON WITH NORMS

In general, the values from the pilot were as expected. Looking at Table 7.7, for example, the mean first systolic measurement in the pilot was 103.6, which compares to an expected value of 100 from the population tables (assuming average height). Likewise, the first mean diastolic measurement for *Growing Up in Ireland* was 67 compared to an expected mean of 60. Both measures are within the suggested 'normal' range outlined above.

In relation to heart rate, the mean values at both measurements (78.7 and 77.3 beats per minute) were within the expected range of 75 – 118.

Table 7.7: Systolic, diastolic and heart rate measurements in the *Growing Up in Ireland* (GUI) pilot for Cohort '08 at 9 years, and expected measurements based on US tables

		Systolic #1	Diastolic #1	Heart rate #1	Systolic #2	Diastolic #2	Heart rate #2
GUI measurements	N	256	256	256	248	248	248
	Mean	103.6	67.0	78.7	103.5	67.7	77.3
	Std. Dev.	12.2	11.2	12.7	14.8	13.7	12.8
Guidelines from BP tables (percentiles)	50th	100	60				
	90th	114	75				
	95th	118	79				
	99th	125	87				

Note: The BP percentiles from tables are for 9-year-old children at the 50th percentile of height.

⁸ US National Library of Medicine, Medline Encyclopaedia. <https://medlineplus.gov/ency/article/003399.htm>

⁹ This was those who did not have a current medical condition or use a medication that would affect the resting pulse rate.



The highest systolic cut-offs from the population tables were used to categorise the child’s blood pressure, i.e. those for a 9-year-old child in the 95th percentile for height. The 95th percentile for systolic pressure was considered ‘high’. Table 7.8 categorises the children by percentile blood pressure for each reading. This shows that around 10% were in the high range for individual measurements, although considerably fewer would have consistently high measurements for the systolic reading if adopting a best-of-two approach.

Table 7.8: Percentage of children at each percentile threshold separately for all four blood pressure measurements

	Systolic #1 %	Systolic #2 %	Diastolic #1 %	Diastolic #2 %
50th percentile or below	55.1	60.1	34.4	40.3
50th–90th percentile	34.4	27.8	53.5	44.0
Over 90th percentile	10.5	12.1	12.1	15.7

Note: The thresholds used are the most generous (i.e. those for 9-year-old children at 95th height percentile).

7.4.2 FEEDBACK FROM INTERVIEWERS

Although most interviewers did eventually secure two blood pressure readings, many reported at the debriefing that in practice it was much more difficult than for 17/18-year-olds. While just a small number of children were said to be afraid of the procedure, the most common problems were: (a) getting the child to stay still while the measurement was being taken – some said it tickled when the cuff inflated, for example, and (b) the machine failing to record a measurement. This latter problem was most likely due to difficulties in getting a snug fit of the cuff on the child’s arm; either some children were too small for even the paediatric cuff or the interviewer had difficulty in judging the appropriate tightness.

7.4.2.1 Summary of changes for main phase at 9 years

The experience of the pilot showed that taking blood pressure measurements from 9-year-olds was feasible but technically more challenging than the experience with young adults. The Study Team was concerned that the difficulty in securing a reading from young children might lead to a greater number of unreliable measurements and raised questions about its subsequent usefulness. Additionally, while only a small number of children were reported to find the measurement uncomfortable or scary, it did seem to be more of an issue for this age group than for the young adults.

Taking account of these factors, it was decided that the measurement of blood pressure in 9-year-olds be discontinued for the Main Study, with a view to revisiting it at a later wave.

7.5 STUDY CHILD HEIGHT AND WEIGHT

7.5.1 HEIGHT

The Study Child’s height was measured by the same height stick as used in all previous waves of *Growing Up in Ireland*. The mean height was 135.9cm (SD = 6.0), ranged between 113 and 156cm and was approximately consistent with the expected height of around 133cm according to height charts, and with the measurement for the 9-year-olds in Cohort ‘98 at just over 136cm. Measurements for some apparent outliers were confirmed through contact with the relevant interviewers.

7.5.2 WEIGHT

The Study Child’s weight was recorded using the analogue (mechanical) weighing scale previously used with Cohort ‘98 at age 9 years. In previous waves of the Cohort ‘08 survey, however, a special paediatric weighing scale with a digital display had been used. The mechanical weighing scale was used this time (a) to facilitate a comparison with readings from Cohort ‘98 and (b) because some children may exceed the upper weight limit on the digital weighing scale by this age. A disadvantage of the analogue weighing



scale was that it only allows measurements within about half a kilogram, which is not as precise as the digital weighing scale.

The mean weight was 31.7kg (SD = 6.4), with a minimum of 19kg and a maximum of 60kg. This was somewhat heavier than the expected mean value of around 27kg from the population growth charts but also slightly less than the 34kg recorded for the main Cohort '98 survey at age 9.

7.5.3 BMI

Body Mass Index (BMI) is an approximate measure of overweight and obesity calculated on the basis of the ratio between height and weight. In the *Growing Up in Ireland* pilot at 9 years, the mean BMI was 17.0 (SD = 2.6) and ranged from 12.3 to 27.8. A healthy BMI for a 9-year-old is roughly between 14 and 18.

Using the same cut-off as used for Cohort '98 at 9 years, 83% of the pilot children were not overweight, while the remaining 17% were overweight or obese. These figures are somewhat better than those found for Cohort '98 at the same age when 25% were overweight or obese. The reader should remember the small cell sizes involved in the pilot sample, however.

7.5.3.1 Summary of changes for main phase of fieldwork

There were no problems reported by interviewers in taking height and weight measurements. It was decided to proceed with the measurement of height and weight for the main phase, as conducted in the pilot.



Chapter 8

The Primary Caregiver's Main Questionnaire





8.1 INTRODUCTION

This chapter outlines the topics covered in the Primary Caregiver Questionnaire (Main) as used in the Pilot Phase of the Cohort '08 (9-year) study. The full text of this pilot questionnaire is given in Pilot Appendix B8; it is intended that the current chapter be read in conjunction with that appendix. Note that question numbers refer to the questionnaire used in the pilot and not that adopted for the Main Study. The principal instrument to be administered in the home was the Primary Caregiver (PCG) Questionnaire. The PCG was usually the mother.

Each questionnaire section is tabulated to summarise the content, and to indicate where measures and/or topics were also included in the 3-year or 5-year waves of the Cohort '08 survey, or at the 9-year wave of the Cohort '98 survey. The discussion focuses on new questions (not used before with either cohort) and those for which issues arose during the pilot. Each section notes any decisions regarding changes to the instrumentation for the main survey.

8.2 OVERALL STRUCTURE OF PCG MAIN QUESTIONNAIRE

The Primary Caregiver Main Questionnaire has 11 broad sections:

Section A:	Household composition
Section B:	Child's relationships
Section C:	Child's physical health and development
Section D:	Child's diet and exercise
Section E:	Parental health
Section F:	Child's play and activities
Section G:	Screen and internet use
Section H:	Child's emotional health and well-being
Section I:	Parenting and family context
Section J:	Child's education
Section K:	Peer relationships and bullying
Section L:	Socio-demographics
Section M:	About you (the PCG)
Section N:	Neighbourhood/Community

8.2.1 SECTION A: HOUSEHOLD COMPOSITION

This section captured demographic details such as the name, gender, date of birth, economic status and relationship to the Primary Caregiver and Study Child of each person resident in the household. This section was also used to record those who had entered or left the household since the last interview.

Section A	Construct	Questions	Included at age 3	Included at age 5	Included at age 9 (Cohort '98)
Household composition	Household composition & family structure (including family changes)	A1–A8	✓	✓	✓
	Siblings living outside the household	A9	✓	✓	✓



8.2.1.1 Commentary

Household composition

These variables were essential for examining family structure and relationship issues that affect the child (e.g. lone versus dual-parent families). They are also necessary for deriving key measures such as family size and equivalised income. These questions were administered in the same way as in all other follow-up waves of *Growing Up in Ireland* so far and no problems were reported.

8.2.2 SECTION B: CHILD'S RELATIONSHIPS

Section B collected information on sleep and discipline as well as two standard scales: the Pianta Scale on parent-child relationship (Pianta, 1992) and the Social Skills Improvement System (SSIS) Rating Scales (Gresham & Elliott, 1990) on the child's social development.

Section B	Construct	Questions	Included at age 3	Included at age 5	Included at age 9 (Cohort '98)
Child's sleep patterns and relationships	Child's sleeping patterns	B1–B2	✓	✓	
	Parent-Child relationship (Pianta scale)	B4	✓	✓	✓
	Disciplining the child	B5	✓	✓	✓
	Social skills measure (SSIS-RS)	B6		✓	
	Attitude to smacking	B7			

8.2.2.1 Commentary

The two scaled measures (Pianta and SSIS-RS), discussed in detail in Chapter 11, both appeared to function as expected.

Since there were no problems with the other questions on sleeping patterns and discipline, it was decided that they be retained for the main phase of fieldwork. Amendments to the Children First Bill passed in the Dáil (Irish Parliament) since November 2015 removed from Irish law the provision for 'reasonable chastisement', which allowed parents, teachers and carers to punish children physically in certain circumstances (DCYA, 2017). Essentially, this meant that smacking children became illegal. To ask parents directly about their behaviour would be difficult from an ethical perspective, and, practically, could result in an unhelpful underestimate of prevalence given the publicity surrounding the change in the law at the time. In the pilot, parents were not asked directly whether they smacked their child but instead were asked what they thought about smacking a child when he/she misbehaved (B7); 54% said it was 'never justified', 14% 'sometimes', 30% 'depends on the circumstances' and the remainder said they didn't know. While the question worked well, the Study Team felt that recent media coverage of the issue made self-completion of this question advisable in order to minimise social desirability bias.

8.2.2.2 Decisions and changes for the main phase

It was decided that the B7 question on attitudes to smacking be moved to the PCG (and SCG) Self-Complete Questionnaires. After further discussion with the Steering Group and reviewers on the need to reduce the overall respondent burden, it was decided to also remove the SSIS-RS scale. This represents some loss of longitudinal consistency but not inter-cohort comparison, as the scale was never used with Cohort '98.

8.2.3 SECTION C: CHILD'S PHYSICAL HEALTH AND DEVELOPMENT

Section C collected information on the current health of the Study Child, including general health, ongoing chronic illness(es), healthcare use, antibiotic use, nights spent in hospital, nature of any accidents (and nature of most serious accident if relevant), sight/hearing problems, reasons for not getting treatment, concerns about speech, oral health/dental care, mobility and supports.



Section C	Construct	Questions	Included at age 3	Included at age 5	Included at age 9 (Cohort '98)
Child's physical health and development	Current health	C1	✓	✓	✓
	Chronic, longstanding illnesses, conditions, disability, and diagnosis	C2-C7	✓	✓	✓
	Food allergies	C8	✓	✓	
	Current medication for longstanding illness, condition or disability	C9			
	Sight problem requiring correction, diagnosis, nature and duration of problem, and extent to which hampered	C10-C15	✓	✓	✓
	Hearing problem requiring correction, diagnosis, nature and duration of problem, and extent to which hampered; treatment	C16-C23	✓	✓	✓
	Mobility and supports	C24-C26			✓
	Wheezing and asthma	C27-C29	✓	✓	
	Healthcare use	C30	✓	✓	✓
	Antibiotic use	C31-C32	✓	✓	
	Nights spent in hospital	C33	✓	✓	✓
	Accidents	C34-C40		✓	✓
	Constraints in accessing healthcare	C41-C43	✓	✓	✓
	Concerns re child's speech development	C44-C50	✓	✓	✓
	Specific learning difficulty, communication or coordination disorder	C51-C56			✓
	Oral health/Dental care	C57-C63	✓	✓	✓
Constraints in accessing dental care	C64			✓	



8.2.3.1 Commentary

Date of diagnosis

Overall, these questions worked well. The interviewers had some general feedback that parents found it difficult to recall the exact month of, for example, diagnosis of a sight problem (C14). Therefore, it was decided that only the year of diagnosis would be requested, unless that was in the current year when month would be asked too.

Medications

The principal discussion for this section related to a new set of questions collecting details on the child's medications (C9). Parents were asked to provide the name, dosage and month/year of starting each medication (up to a maximum of five). Interviewers were instructed to ask to view the actual medication label so as to record details accurately. While this question seemed to provide sensible information, a quarter of medications were recorded without reference to the label. At the debriefing, interviewers said that parents had either already disposed of the packaging or were disinclined to search for it – and where they did, this took up several minutes. It was therefore decided that medication name details be recorded by interviewers based on parental report, but they would not ask to see the labelling or record the dosage. This would still yield information on the types of medications prescribed for the 9-year-olds, though the reliance on parent-recollection was likely to be more error-prone than recording the details from the packaging.

Using out-of-hours services and private emergency clinics

Two new categories were included in the list of medical-care providers at C30. These were an 'out of hours GP service' (C30b) and 'a private walk-in clinic or medical centre e.g. Swiftcare' (C30h). While 17% had used the out-of-hours service, just a small percentage had used the latter private centre – perhaps not unusual given that this was mainly for emergencies and only in large urban centres. It was decided to keep these new categories to reflect the changing profile of medical-care provision, with the expectation that the absolute number of families using private medical centres would be much greater in the larger sample for the main phase.

Dental health

The section on dental health was considerably expanded compared to previous waves (starting at C57). There were no problems with these questions. However, given the pressing need to reduce the overall length of the PCG Main Questionnaire, the decision was made to streamline the section and reduce the number of these questions.

8.2.3.2 Summary of changes for the main phase

- C2-C7 – Only year of diagnosis was to be collected for chronic conditions, unless it was in the current year when month would also be recorded.
- C9 – Details on the names of medications were to be collected but without details on dosage or the request for the interviewer to read the label.
- C30 – Retention of additional options for healthcare provided by out-of-hours services and private walk-in clinics
- C57 – Reduction in questions on dental health; specifically, removal of questions on experience of dental pain/infection (C60b), antibiotic use for dental infections (C60c), and satisfaction with the alignment of the child's teeth (C62)



8.2.4 SECTION D: CHILD'S DIET AND EXERCISE

Section D covered the child's diet, parent perception of the child's weight, amount of exercise (both light and hard), and distance to school, means of travel, and time getting there.

Section D	Construct	Questions	Included at age 3	Included at age 5	Included at age 9 (Cohort '98)
Child's diet and exercise	Child's dietary profile – inventory of food intake*	D1	✓	✓	✓
	Eating before going to school	D2		✓	✓
	PCG's perception of child's weight	D3	✓	✓	✓
	Hard and light exercise	D4–D5			✓
	Distance to school, means of transport, and time spent on travel	D6–D8			✓

* The long Food Frequency Questionnaire (FFQ) was previously used at 5 years but at all other waves a different measure that was much shorter – and less detailed – was used.

8.2.4.1 Commentary

Food Frequency Questionnaire (FFQ)

Interviewers working on the pilot consistently commented on the response burden associated with the detailed Food Frequency Questionnaire. In addition to the length of the measure, it was also perceived as repetitive and something that would be easier to self-complete on paper rather than being read out. In contrast to when this set of items had been used at age 5 years, interviewers reported more 'commentary' from parents around individual diet items – perhaps indicating a greater awareness of what the child should have been eating (in contrast, perhaps, to what they actually did eat).

Based on the interviewers' feedback and the time taken by this measure as recorded automatically by the CAPI program (a mean of 6.5 minutes, ranging between 2 and 15 minutes – and excluding a small number of outliers in excess of that), the Study Team initially recommended moving this very long scale to the drop-off booklet with the time-use diary. The much shorter inventory used in the 7/8-year postal survey (and previously used with Cohort '98 at age 9) was moved into the main interview to capture at least basic dietary information for all children.

There were no other suggestions for changes in Section D.

8.2.4.2 Summary of changes for the main phase

The Study Team had recommended that the long FFQ be moved to the self-complete leave-behind (with the time-use diary), while the previously used shorter inventory was added into the PCG Main Questionnaire in its place. After further discussion with the Steering Group and reviewers, however, it was decided to discontinue the long FFQ entirely in the interests of limiting the burden for participants. This approach maintained consistency with Cohort '08 at ages 3 and 7/8 years, and with Cohort '98 at 9 years, allowing for both longitudinal and cross-cohort comparisons.

8.2.5 SECTION E: PARENTAL HEALTH

This section asked about parental health, including chronic conditions, exercise and weight perception. It also asked about the family's and child's medical insurance cover, and whether the parent was a carer for anyone. It included the Everyday Discrimination Scale.



Section E	Construct	Questions	Included at age 3	Included at age 5	Included at age 9 (Cohort '98)
Parental health	PCG current health	E1	✓	✓	✓
	PCG chronic, longstanding conditions	E2–E5	✓	✓	✓
	Family and child medical cover – none, full cover, or GP only	E6–E8	✓	✓	✓
	Caring for someone with illness or special needs; where, time spent and related pressure on family life	E9–E14			
	Physically active	E15	✓	✓	✓
	Perception of own weight	E16	✓	✓	✓
	Perceived discrimination	E17			

8.2.5.1 Commentary

Parental health (E1–E6 and E15–E16)

These questions worked well. As in earlier sections, the decision was made to ask ‘month’ of onset of a chronic condition only if the condition had started in the current year. Feedback from experienced interviewers who had worked on multiple waves of the study indicated that participants often had difficulty remembering the month of onset if the diagnosis wasn’t recent. A question was added to this subsection for the main survey on whether any long-standing conditions had been diagnosed by a doctor.

Health insurance/Medical card coverage

There were no issues reported in relation to these questions (E6–E8) and no changes were suggested.

Parent as carer

These questions at E9–E14 were new to *Growing Up in Ireland* and were intended to pick up the parent’s other caring responsibilities and how they might affect the main parenting role or family dynamic. Just under 15% of Primary Caregivers reported ‘looking after anyone who needs special help or care’.

Everyday Discrimination Scale

This scale is discussed in detail in Chapter 11. The scale had previously been used with the young people in Cohort ‘98 at age 17/18 years but this was its first use with the Primary Caregiver. Psychometrically, the scale worked well but for a number of respondents their experience of harassment related specifically to their occupation (e.g. being a garda or teacher). This was not the type of discrimination the Study Team had in mind when including the scale initially, although the problem of occupation-related harassment seems to be a major issue for some parents. This issue and related suggestions are detailed further in Chapter 11.

8.2.5.2 Decisions and summary of changes for the main phase

- The ‘month’ part of E4 on timing of diagnosis was to be asked only if diagnosis was in the current year.
- A question on whether a long-standing condition had been diagnosed by a medical professional was added.
- The Everyday Discrimination Scale was moved to the self-complete section and an additional ‘reason’ for discrimination as ‘being related to parental occupation’ was included for clarity.



8.2.6 SECTION F: CHILD'S PLAY AND ACTIVITIES

This section asked questions about activities shared with the child, time spent reading for pleasure, development and maintenance of the child's cultural identity, and pocket money.

8.2.6.1 Commentary

Activities done with the child and reading for pleasure by child

The items included in the lists at F1 and F2 worked well and only some minor changes were suggested. These were to (a) delete F1c 'visited the library' with the Primary Caregiver as it was largely duplicated by F2e (visiting a library with any family member), and (b) delete F2h 'going for a picnic or camping' as this was likely to be seasonal and weather-dependent. Instead, it was decided to extend F2g 'going for a walk or cycle' to include 'a hike' to capture a longer activity/outing. There were no issues on questions about time spent reading (F3/F4) and no changes were suggested.

Section F	Construct	Questions	Included at age 3	Included at age 5	Included at age 9 (Cohort '98)
Child's play, activities & temperament	Activities done with the child	F1–F2	✓	✓	
	Time spent reading for pleasure	F3–F4			✓
	Development and maintenance of child's cultural identity	F5–F6			
	Pocket money	F7			✓

Specific cultural activities

A completely new question was introduced in this pilot about the child's activities where the parents had a specific aim to develop or maintain his/her 'cultural or national identity' (F5/F6). Over a third of parents (36%) answered in the affirmative. Details of the activity were collected in an open-ended question that was asked of everyone regardless of ethnicity or citizenship. Many of the text responses referred to Gaelic Athletic Association sporting activities (such as hurling and camogie) or generic answers that didn't specify which culture/identity was being fostered (e.g. 'attending cultural events'). The Study Team suggested, therefore, that an additional question be inserted before the open-ended description to specify whether the activity refers to Irish or another culture. The latter could be important to migrants retaining a sense of their cultural identity as well as to broadening the awareness of other cultures among Irish children.

Pocket money

There were no problems reported with this question at F7, although there was some speculation as to whether the term 'pocket money' should refer only to money the child was free to spend as they wanted. Some parents may give the child money to cover the costs of pre-agreed activities such as a weekly dance lesson, which could lead to some confusion. In the pilot, over half of children (55%) got no pocket money, 12% got €2 and 16% got €5 (per week). Given the need to reduce some of the response burden on the PCG questionnaire and the possibility for ambiguity about the question, the Study Team decided to remove this question for the main phase.

8.2.6.2 Summary of changes for main phase

- F1c (visiting the library) was deleted due to duplication with F2e.
- F2h (going on a picnic or camping) was deleted due to weather/seasonal variations but 'a hike' was added to F2g.
- A new question was added to identify whether activities to maintain cultural identity related to Irish or other cultural/national identity at question F5/F6.
- Question F7 on pocket money was removed.



8.2.7 SECTION G: SCREEN-TIME AND INTERNET USE

This section collected a lot of detailed information on the nature of screen-time and internet use. While such information had been collected from Cohort '98 at age 9 years, the questions were updated and expanded to reflect technological changes in the last decade.

Section G	Construct	Questions	Included at age 3	Included at age 5	Included at age 9 (Cohort '98)
Screen-time and internet use	Use of electronic devices; home access; internet access; hours of use weekdays/weekends	G1–G4			√
	What 'screen-time' is used for	G5			√
	How television/ films are accessed	G6			
	Type of internet access in the home	G7			
	Internet supervision/ monitoring	G8–G10			√
	(Child) Online profile (social media etc)	G11			

8.2.7.1 Commentary

Screen-time and devices

This section, particularly the breakdown of time spent on each device in questions G1–G4, was reported by the interviewers to be time-consuming and quite repetitive, with parents finding it difficult to be specific on the time spent on each individual device. The Study Team therefore suggested reducing the detail in this table, primarily by asking the Primary Caregiver for just the time spent watching television and, separately, for an estimate of other screen-time. These activities would continue to be asked as 'time per day', with separate estimates for a weekday and weekend day. In this pilot, for example, fewer than 10% of children watched 2 hours or more of television on a weekday but this rose to nearly half of all children on a weekend day.

The Primary Caregiver was asked to indicate which devices the children used for their other screen-time in the pilot but, for the main phase, respondents selected all applicable devices from a list. In terms of popular devices in the pilot, 79% of 9-year-olds had access to a tablet such as an iPad at home, 66% a games console, 45% a laptop, 40% a smartphone and 44% some other kind of handheld device. Only 26% had access to a desktop computer and just 11% to an e-book reader such as a Kindle. In the main phase, in order to simplify this section, the Primary Caregiver was not asked to specify whether each of these devices was connected to the internet (G2a-i). These changes were intended to substantially reduce the time taken to complete this section without overly compromising on useful data on the nature of the 9-year-old's use of screen-based devices.

Details on types of screen-time activities and access to the internet

The questions on what the child did while using screen-based media, the source of television content and type of internet access were new questions largely devised by the Study Team, and seemed to work well. In relation to the source of television content (a 'tick all that apply' question), 60% watched regular scheduled programming, 20% regular programming that had been recorded, 24% on-demand services like Netflix, 21% YouTube or similar websites, and 10% DVDs.



In terms of type of internet connection in the home, the most common was broadband with wi-fi (87%). When it came to supervised activity online, 60% of Primary Caregivers said the child was always supervised by an adult when accessing the internet, and just 44% had installed monitoring/child safety software like Net Nanny. The most popular strategies used to restrict screen-time (either content or time) were rules about total time spent on screen-time (74%), rules about content (66%), rules about the time of day devices can be used (56%), and engaging the child in alternative activities (52%). Forty-three per cent of parents used PIN numbers or passwords to restrict devices, 36% used 'child-safe' settings and just 10% said they used a strategy of locking away devices or modems.

At the debriefing, some interviewers felt that parents lacked knowledge about how a child might use the internet, in particular the possibility of engaging with strangers online via computer games that connect to the internet (even from a console). In relation to the specific question about online profiles asked at G11 in the survey, 15% of Primary Caregivers said the child had a social media or computer game profile (or both).

It was decided to retain questions G5-G11 as used for the pilot.

8.2.7.2 Summary of changes for main phase

- The per-device detail on time spent (in G3-4) was replaced with just a television-time and another 'other screen-time' estimate, while maintaining the separation between weekday and weekend time.
- The questions at G2 on whether each specific device could connect to the internet were removed.

8.2.8 SECTION H: CHILD'S EMOTIONAL HEALTH AND WELL-BEING

This section included the Strengths and Difficulties Questionnaire (including the 'impact' module) and experience of adverse life events since the child was aged 5 years.

Section H	Construct	Questions	Included at age 3	Included at age 5	Included at age 9 (Cohort '98)
Child's emotional health and well-being	Life events	H1	√	√	√
	Strengths and Difficulties Questionnaire (SDQ)	H2	√	√	√
	Parent perception of difficulties and impact of these	H3-H7		√	

8.2.8.1 Commentary and decisions for main phase

There were no issues reported with this section, but, given the need to reduce the overall length of the questionnaire, it was decided to exclude the additional 'impact module' of the Strengths and Difficulties Questionnaire (SDQ). Although this module was used once before in *Growing Up in Ireland*, excluding it would not compromise the inter-cohort consistency with the 9-year wave of Cohort '98. This change would leave the main SDQ measure unaffected. The SDQ is discussed in detail in Chapter 11.

The most commonly experienced adverse event was the death of a close family member (40%), typically a (great) grandparent but also some aunts and uncles. Serious illness/injury of a family member was the next most common (16%), followed by 'conflict between parents' (14%).

8.2.9 SECTION I: PARENTING AND FAMILY CONTEXT

This section covered a range of topics relating to the family context such as work-life balance, family activities and religiosity. It concluded with some items on serious misbehaviours used originally in Cohort '98 at 9 years and that originally came from a set of items relating to the diagnosis of conduct disorder. They were placed so as to avoid being asked directly after some related items that formed part of the Strengths and Difficulties Questionnaire in Section H.



Section I	Construct	Questions	Included at age 3	Included at age 5	Included at age 9 (Cohort '98)
Parenting and family context	Job security and work-life balance	I1	✓	✓	✓
	Time spent together as a family	I2	✓		✓
	Sibling relationships*	I3–I4	✓	✓	✓
	Regular contact with grandparents, how many still alive, closeness of relationship with child; other relations	I5–I9	✓	✓	✓
	Satisfaction with amount of support from family and friends	I10	✓	✓	
	Child's religion and attendance at religious services	I11–I13			✓
	PCG's religiosity and spirituality	I14–I15			
	PCG's religion	I16–I17	✓	✓	✓
	Child's conduct disorder	I18			✓

*Sibling relationships included in child questionnaire at 9 years (Cohort '98).

8.2.9.1 Commentary

Work-life balance

The questions at I1a and b were new questions relating to job security. Some interviewers felt that these were potentially sensitive and so the decision was made to move I1a (agree/disagree that 'my job is secure') to the Self-Complete Questionnaire, and to delete I1b as it was largely a duplication of I1a. Fewer than 10% of Primary Caregivers disagreed that their jobs were secure but a third said it was 'not applicable' to them.

The remaining questions at I1c-f have been used in all previous waves and did not raise any issues in the pilot: no changes were suggested for the main phase.

Family activities and extended family

In general, there were no problems reported with any of the questions from I2 to I10 which covered family activities, getting on with siblings, contact with grandparents and extended family, and perceived support from family and friends. The only issue that arose for a small number of interviewers were families who had more than four 'grandparents' because of the repartnering of grandparents. No changes were made to this question for the main phase, but an instruction was to be included for interviewers that, should it arise, the questions should focus on the four grandparental figures closest to the child.

Religion and spirituality

Questions I11 and I13 asked about the religious denomination and observance (in terms of attendance) of the Study Child. Questions I14 to I16 asked about the Primary Caregiver's own religion, which would most likely, but not necessarily, be the same as the child's. Although no issues were reported, the Study Team felt that the questions on being religious or spiritual might be more logical after, rather than before, the question on parental denomination. Nearly 20% of respondents said they were 'not at all' religious. More



people described themselves as 'very much (a spiritual person)' (24%) than 'very much (a religious person)' (14%). A follow-up question on the frequency of the Primary Caregiver's own attendance at religious services was added after the question on denomination.

Serious misbehaviour

As anticipated, very few children were described as having engaged in the more serious misbehaviours listed at I18. These questions were potentially important predictors of current and future behavioural problems but, conversely, the prevalence on most of the items was low and there was overlap with some of the SDQ subscales/items. Therefore, considering the need to reduce the response burden for parents, it was decided that these questions be removed from the main phase of the survey.

8.2.9.2 Summary of changes for the main phase

- Question I1b was dropped due to duplication with I1a and that question ('my job is secure') was moved to the self-complete section as it was potentially sensitive.
- The sequencing of questions I14-I17 on religion/spirituality of the Primary Caregiver was changed so that questions about being religious or spiritual came after the question about denomination. A question on frequency of PCG's religious attendance was added.
- The serious misbehaviour items at I18 were removed due to low frequencies and some overlap with SDQ items.

8.2.10 SECTION J: CHILD'S EDUCATION

This section collected information on childcare, involvement in clubs, attendance at parent-teacher meetings, absenteeism, homework, school performance, peers, and aspirations for child.

8.2.10.1 Commentary

Childcare

Questions J1 to J5 on current arrangements for out-of-school care did not seem to pose any problems so the decision was to maintain them as used in the pilot. The pilot data indicated that 37% of 9-year-olds had regular childcare by someone other than their resident parents.

Extra-curricular activities

Question J6 asked about the child's organised extra-curricular activities. There were additional questions on whether an activity took place in the school (or elsewhere or both) and if it had to be paid for. They were very similar to questions asked of Cohort '98 at age 9 years except that the categories of activities were more disaggregated than previously (e.g. 'sports/fitness clubs' was separated into 'team sports' and 'individual sports'). This was intended to gather additional detail on whether the activities were likely to have a strong social element (e.g. team-based sports). In addition, the 'location' questions in the pilot were new to this wave.



Section J	Construct	Questions	Included at age 3	Included at age 5	Included at age 9 (Cohort '98)
Child's education	Details of child's current school and class	J0		√	
	Childcare arrangements/time spent/costs	J1–J5	√	√	√
	Child participation in clubs/organisations, where, whether paid for	J6			√
	Attend parent-teacher meeting	J7			√
	Absenteeism	J8–J9			√
	Homework – frequency of and time spent on and help with	J10–J12			√
	Perception of child's performance in school	J13–J14			√
	Number of children's books in the home; use of public library	J15–J16	√	√	√
	Voluntary contributions to school – asked for, paid, amount	J17			
	Future educational aspirations for child	J18			√
	Child's name down for secondary school	J19			

The main issue arising from the pilot was the large number of answers in the 'other, please specify' category (23%). Many of these were individual sports such as swimming and gymnastics, and while it was not clear from the recorded responses why they were not included in the existing categories, it was decided to clarify the terms 'individual' and 'team' sports – in case there was confusion surrounding participation, for example, as part of a gymnastics team. For the Main Study, 'individual' sports were defined as 'sports where the child participates individually not as part of a team e.g. judo, running, swimming etc' and 'team' sports as those 'where the child participates as part of a team, e.g. football, rugby, hockey etc'.

Some parents also mentioned language classes as an 'other, specify' extra-curricular activity, which would not fit into any of the existing categories. Therefore, it was decided to include an additional category of 'language classes'. Furthermore, the introduction to the question would be modified slightly to read '... does child participate in any club, organization or class outside of school hours...?' In order to facilitate the extra time needed for these modifications, and because there may be confusion as to whether activities are organised by the school or just take place in school facilities, it was decided to delete the questions asking about the location of the activity (school/elsewhere/both). As this element of the question was not included in the Cohort '98 survey at 9 years, there was no loss of inter-cohort comparability with its removal.



School and education

Questions J7-J16, J18 and J19 related to school and education, including homework, books in the home and the Primary Caregiver’s estimates of the child’s ability and likely level of educational attainment. There were no problems with these questions, and most had been previously used with Cohort ‘98 at 9 years.

Questions J17a-c were new questions relating to ‘voluntary’ monetary contributions to schools: 72% of respondents said the child’s school requested a voluntary contribution and over 91% of those parents had paid it. The modal amounts were €50 and €100 but with considerable variation between €10 and €50. There was a small number of higher amounts, but these were possibly errors or referred to a number of children from the same family. Interviewers had been instructed to work out an amount-per-child if the contribution covered a number of children, but a rewording of this question was deemed necessary for the main phase.

8.2.10.2 Summary of changes for the main phase

- For J6 (extra-curricular activities), the detail on whether activity takes place in school was removed, clarifications on individual and team sports were included, and language classes were added as a distinct answer category, as outlined in detail above.
- The question at J17c – amount asked for by school (as a voluntary contribution) – was redrafted so that parents stated the total amount paid and the number of children covered (rather than asking them to do a calculation).

8.2.11 SECTION K: PEER RELATIONSHIPS AND BULLYING

This was a short section with the main focus on parental knowledge of the child being bullied and the reasons for it.

Section K	Construct	Questions	Included at age 3	Included at age 5	Included at age 9 (Cohort ‘98)
Peer relationships and bullying	Number of, and time spent with, peers	K1–K2			√
	Knowledge of child being bullied, type and reason for bullying	K3–K5			√

8.2.11.1 Commentary and decision regarding main phase of fieldwork

There were no problems reported regarding any of the questions in this section. In relation to bullying, 17% of Primary Caregivers said the child had been bullied in the last year. The comparable figure for Cohort ‘98 at 9 years had been 24%. In terms of reasons for the bullying, there was quite a high rate of ‘other, please specify’ responses but there was not enough consistency in the open text responses to suggest an additional category for the main questionnaire.

It was decided to keep this section as was for the Main Study.

8.2.12 SECTION L: SOCIO-DEMOGRAPHIC INFORMATION

Section L was a long and wide-ranging module covering a variety of socio-demographic and contextual information relating to accommodation, work, social welfare receipt, income, deprivation and historic grandparental status.



Section L	Construct	Questions	Included at age 3	Included at age 5	Included at age 9 (Cohort '98)
Socio-Demographic Information	Nature of accommodation	L1–L3	✓	✓	✓
	Nature of tenure	L4	✓	✓	✓
	Number of bedrooms/children sharing bedroom	L5–L7			
	Suitability of accommodation for family	L8–L9	✓	✓	✓
	Principal economic status/ family social class/nature of occupation & employment/ reasons not working	L10–L33	✓	✓	✓
	Partner's occupation	L34–L37	✓	✓	✓
	Engagement in paid work over the past 4 years; activity when not working	L38–L39			
	Family income	L40–L44	✓	✓	✓
	Social welfare payments	L45–L50	✓	✓	✓
	Family 'basic' deprivation indicators	L51–L57; L62	✓	✓	✓
	Debt and debt burden	L58–L61; L63			
	Perceived change in financial circumstances over past 4 years	L64–L65			
	Grandparental work status	L66–L73			

8.2.12.1 Commentary

Accommodation

Questions L1- L10 dealt with accommodation and nature of tenure. Most of the questions had been previously used without difficulty in other phases of *Growing Up in Ireland*. No problems were reported in this pilot. An additional answer category of 'emergency accommodation' had been included in the nature of occupancy question at L4 but no-one in the pilot selected it. Just over 10% of parents said their current accommodation was not suitable for the family's needs.

Principal Economic Status

Unsocial hours

Questions L10-L39 collected information on the principal economic status of the Primary Caregiver and details of his/her employment, with some questions on the Secondary Caregiver's employment. Nearly all the questions have been routinely used in many waves of the study, but some new questions were included on shift work, overtime and weekend work (L13-L14). Over half of those respondents in employment had to



work evenings or nights at least occasionally. Nearly 40% had to work overtime at short notice on occasion. Over a quarter had to work during the weekend once a month or more often.

Family-friendly workplaces

The list of items at question L16 relates to family-friendly workplace provisions. As it was originally used at the first wave of the Cohort '08 survey, the Study Team felt that some of the items were now less relevant to the children at age 9 years and could be streamlined. Ultimately it was decided to ask the single rating question on how good the respondent's employer was in terms of allowing 'family friendly' working (originally L17).

Secondary Caregiver's employment

There was some negative feedback from interviewers in relation to the respondents' reactions to being asked several detailed questions about their partner's employment (i.e. Primary Caregivers giving details on the Secondary Caregiver's occupation). While *Growing Up in Ireland* has always asked the Primary Caregiver to give the nature of their partner's occupation (i.e. an open-ended question on what they do for a living), the questions had been expanded for this pilot (L34-L37).

It sometimes occurs that a Secondary Caregiver does not complete his/her own interview and hence the Primary Caregiver's report was necessary to formulate a household-level social class (an important variable for analysis). Asking additional questions about the Secondary Caregiver's number of employees, etc, was intended to improve this proxy-classification where needed, but some of the interviewers reported frustration from families that, in many cases, these detailed questions would be asked twice. In addition, a Primary Caregiver would sometimes have to ask the Secondary Caregiver for the relevant details on number of staff supervised, etc. Therefore, it was decided to revert to just asking the Primary Caregiver about the nature of their partner's occupation (e.g. store manager, barber, etc) and whether he/she was self-employed, an employee or not employed/other.

Employment history

Another new set of questions relating to the Primary Caregiver's employment were those asking about work history in the last four years (i.e. 48 months, since the age 5 years interview approximately). The questions at L38 and L39 asked for number of months in paid employment, and, if less than 48, how many months were spent (a) looking after family, (b) unemployed and looking for work or (c) something else. About half of Primary Caregivers had spent at least some of the 48 months outside of paid employment – mostly looking after family – while 22% had spent the entire 48 months doing so. As responses to this question took some time to work out to the level of detail asked in the pilot, it was decided that the respondent simply be asked how many of the previous 48 months had been spent in employment, without the breakdown of the non-working months.

Household income and social welfare receipt

Questions on household income (L40 to L44) were as used previously and posed no undue difficulties. It was decided to retain the income questions in this format.

It was decided, however, to make a major change to questions about social welfare receipt, other than Child Benefit (L46). To capture all social welfare payments to the household requires presenting a long and detailed list to participants, which was time-consuming and difficult to read. For the pilot, the Study Team had in fact broken question L46 into a series of seven separate questions to make the chunks of payment types more manageable. While making the questions easier to administer, this added considerably to the time taken. Even though this detailed information has been collected at each wave, it has been under-used by researchers accessing the GUI data. Therefore, it was decided to drop the detailed list of social welfare payments, reducing the social welfare questions to (a) receipt of a social welfare payment (yes/no), and (b) percentage of total income that comes from social welfare payments of any kind, including Child Benefit (L50).



Deprivation indicators

There were several new questions relating to deprivation and household debt added to this section in the pilot. These included L58a-c (unable to pay rent/mortgage, utility bills, loans – fewer than 10% each); L59 (total burden of housing costs – 25% 'heavy burden'); L60 (debt to meet ordinary living expenses – 17%); L61 (family can afford to save – 55% yes) and L62 (paid family holiday away from home – 75% yes). While there were no problems per se with these questions, the Study Team were cognisant of the total volume of questions relating to deprivation in this section when combined with previously used indicators at L51a-i, L52, L53, L54, L55, L56 and L57. It was therefore decided to remove almost all of the 'new' deprivation indicators in favour of retaining the original set for comparison purposes (both within this cohort and with Cohort '98). Question L58a – unable to pay rent or mortgage – would remain.

While previously for Cohort 08, the questionnaire had asked about the effect of the recession, for this pilot the question was reworded slightly to allow respondents to indicate that they were now better off or worse off since the 5-year interview (L64). Although the question asked at age 5 was different, it would not make sense to ask about the effects of the recession at the 9-year interview as the economy was recovering.¹⁰ Ten per cent of respondents said they were 'much better off now', 28% were 'somewhat better off', 34% were 'no change', 28% were 'somewhat' or 'much worse off'. L65 was an open-ended question on the reason for the change (good or bad). Most of the reasons for improvement related to getting employment or an improvement in payment for work; and conversely many of the reasons for a worsening situation were either the loss of employment/wages or an increase in living costs without an increase in income. It was decided to retain this question as used in the pilot.

Historic questions on grandparental employment and income level

There were some new questions for this cohort about their own family context when they themselves had been 16 years old. The question on whether their own parents had had difficulty making ends meet (L63) was also asked of the parents of Cohort '98 at the same age. The parents in Cohort '98 were asked about the occupations of their own parents (i.e. the child's grandparents) at the age 17/18-year interviews and these questions were included in this pilot for the Cohort '08 survey (L66-L71). Most of the feedback from the pilot related to the difficulty in assigning grandparents to the social class categories at L69/73. Although an interesting topic, it was recognised that such historical questions were not as pertinent as others to this stage of the child's life. It was therefore decided to reduce this set to the item on difficulty in making ends meet when the parent was 16 (L63) and whether both grandparents were still alive at that time (L66/L70).

8.2.12.2 Summary of changes for the main phase

- The detailed list of family-friendly policies at L16 was deleted in favour of retaining the single rating of the employer as family-friendly.
- The questions on the Secondary Caregiver's occupation were streamlined back to those on nature of occupation and status as employee/self-employed/unemployed.
- There was a substantial reduction in detail in the questions on social welfare payment at L46 and L48.
- The 'new' deprivation and debt indicators at L58b, c and L59-L62 were removed in favour of keeping continuity with the 'old' measures used in all previous waves of Growing Up in Ireland with both cohorts.
- Questions on grandparental employment (L67-69/L70-73) were deleted as they were less focused on the Study Child than other questions in the survey and could be collected at another wave.

¹⁰ At the time of the Cohort '98 9-year interviews, the recession had not yet begun.



8.2.13 SECTION M: ABOUT YOU

This section collects data on parent’s education; child’s first language; parent’s reading and numeracy; religion; citizenship, and ethnicity. Many of the items in this section are only asked of the very small number of new respondents, that is, where there was a change in Primary Caregiver.

Section M	Construct	Questions	Included at age 3	Included at age 5	Included at age 9 (Cohort '98)
About You (the respondent)	PCG education	M1–M4	✓	✓	✓
	Child’s first language and main language used in the home	M5–M6	✓	✓	✓
	PCG’s competence in English	M7–M9	✓	✓	✓
	PCG’s numeracy	M10	✓	✓	✓
	PCG citizenship and country of birth	M11–M15	✓	✓	✓
	Child’s citizenship	M16–M17			
	PCG’s ethnicity	M18	✓	✓	✓

8.2.13.1 Commentary

There were no suggestions for edits to this section, and no issues arose during piloting. The only change between the pilot and main phases was that the level of education recorded at previous waves was ‘forward-fed’ for returning respondents. This means that respondents were asked to confirm their previous level of education and could update or correct it if necessary, rather than being asked the question afresh. New respondents were asked to choose their educational level from the entire list. The ‘forward-feed’ measure for returning respondents would result in a small reduction in interview time and helped to limit the introduction of longitudinal inconsistencies.

8.2.14 SECTION N: NEIGHBOURHOOD/COMMUNITY

Questions in this section included perception of local area, family in the area, time spent living in the area, and perception of neighbourliness.

Section N	Construct	Questions	Included at age 3	Included at age 5	Included at age 9 (Cohort '98)
Neighbourhood/Community	Length of time living in area	N1	✓	✓	✓
	Perceived safety and quality of local neighbourhood	N2, N5, N6	✓	✓	✓
	Community participation	N3–N4			✓
	Local services	N7		✓	✓
	Family living in local area	N8			✓
	Neighbourliness	N9–N10		✓	
	Urban/rural situation of house	N11		✓	✓



8.2.14.1 Commentary

Most of the feedback from interviewers on this section concerned the amount of repetition from similar questions. It was therefore decided to streamline this section by reverting mostly to community questions that have been routinely asked in other waves of *Growing Up in Ireland* such as N5a-d, N6a-c and N7a-j. Most of the 13 items at N2 were removed apart from N2g (traffic), N2i (helpful neighbours), N2j (trust neighbours) and N2m (neighbourhood identity). These were added on to the end of N6 given the common theme and shared answer categories. In addition, N4 (community service activity) and N9 were removed given their similarity to other items.

8.2.14.2 Summary of changes for the main phase

- Most of the N2 items on local area/neighbours were deleted due to repetition, except items g, i, j and m, which were combined with items at N6.
- N4 (community service) was removed because of too much overlap with N3 (voluntary activity).
- N9 was removed due to a surfeit of questions on neighbours.



Chapter 9

Secondary Caregiver's Main Questionnaire





9.1 INTRODUCTION

This chapter outlines the topics covered in the Secondary Caregiver’s Main Questionnaire, 200 of which were completed by participants in this pilot. This contains a subset of the questions included in the Primary Caregiver’s Main Questionnaire. The questions on the Secondary Caregiver’s questionnaire are largely those that record information on the Secondary Caregiver him/herself and his/her relationship with the Study Child. They do not include factual information on the Study Child.

9.2 OVERALL STRUCTURE AND PERFORMANCE OF THE SCG MAIN QUESTIONNAIRE

The SCG Main Questionnaire used in the pilot had six broad sections:

Section	Construct	Questions	Included at age 3	Included at age 5	Included at age 9 (Cohort '98)
A Child's relationships	Parent-Child relationship (Pianta scale)	A1		✓	✓
	Discipline strategies	A2			✓
	SCG's attitudes on smacking a child	A3			
	SCG's perception of child's weight	A4	✓	✓	✓
B Parental Health	SCG current health	B1	✓	✓	✓
	SCG chronic, longstanding conditions	B2-B5	✓	✓	✓
	Caring duties	B6-B11			
	Self-recorded physical activity and perception of weight	B12-B13	✓	✓	✓
	Experience of discrimination	B14-B15			
C Child's play and activities	Activities undertaken with the Study Child by the SCG	C1-C2	✓	✓	✓
E Parenting and family	Work-life balance and job security	E1	✓	✓	✓
	Doing things together as a family	E2	✓	✓	✓
	Support from family and friends	E3	✓	✓	✓
	Religiosity and spirituality	E4-E5	✓	✓	✓
	Religious denomination	E6-E7	✓	✓	✓



Section	Construct	Questions	Included at age 3	Included at age 5	Included at age 9 (Cohort '98)
F Socio-demographics	Economic status and related circumstances		✓	✓	✓
	Parenting style	F1-F24	✓	✓	
	Work activity, or other over last 4 years	F25-F26			
	Family circumstances when SCG was 16	F27-F33			
G About you	Level of educational attainment	G1-G4	✓	✓	✓
	Literacy, numeracy, proficiency in English, religion, citizenship, country of birth and ethnicity	G5-G14	✓	✓	✓
	Involvement in local voluntary organisations/participation in ongoing community service	G15-G16	✓	✓	✓

9.2.1 SECTION A: CHILD'S RELATIONSHIPS

The Pianta scale is discussed in detail in Chapter 11. It appeared to work as expected in the pilot. Question A3 on the respondent's view of the justification of 'ever smacking a child' worked in the pilot, but (as for the PCG questionnaire) was moved to the Self-Complete Questionnaire for reasons outlined in Chapter 11. Note that, for the main phase, sections on the SCG Main Questionnaire were relabelled to correspond with the equivalent sections on the PCG Main Questionnaire; thus, in the main phase this section on the child's relationships was Section B rather than Section A.

9.2.2 SECTION B: PARENTAL HEALTH

Most of the questions in this section had been used in almost all rounds of the project up to this point and posed no issues in the course of the pilot. A question on whether the SCG's long-standing health condition had been diagnosed by a doctor was added to that sub-section (QE4a in the main phase).

As per the PCG Main Questionnaire, the everyday discrimination scale was moved to the self-complete module and an answer category was added for occupation-related discrimination. Section B was renamed Section E for the main phase.

9.2.3 SECTION C: CHILD'S PLAY AND ACTIVITY

These questions recorded details on the amount of time spent in family activities and organised family time. They performed largely as expected in the pilot study. It was decided to add one additional item to C2 – item *g. Going for a walk, a cycle, a hike etc.* – in line with changes to the PCG Main Questionnaire.

Section C was renamed Section F for the main phase.

9.2.4 SECTION E: PARENTING AND FAMILY CONTEXT

Most of these questions have been used in previous rounds of the study and there were no surprises in the pilot. Questions E1a and E1b on perception of job security were the only two new items in this round of the study. In keeping with the decision on changes for the equivalent questions on the PCG Main Questionnaire, E1a (on how secure the respondent's job was) was moved to the Self-Complete Questionnaire and E1b was deleted.



A question on the SCG's own religious denomination and frequency of attendance was added to this section for the main phase. In the pilot, denomination was only asked of PCGs.

Section E was renamed Section I for the main phase.

9.2.5 SECTION F: SOCIO-DEMOGRAPHICS

Most of the questions in this section have been used in previous rounds of the study and there were no issues arising in this pilot. As was discussed above in relation to the comparable question (L16) in the Primary Caregiver Main Questionnaire, questions on family-friendly facilities in the workplace were reduced substantially by deleting F7. This left just F8, the single question rating the employer from very good to very poor in terms of family-friendly working.

The other changes in this section also reflected amendments to the equivalent questions on the main PCG questionnaire. These were: the reduction of the detail on economic status for the past 48 months (F25-26) to just number of months in employment; the deletion of the questions on (grand)parent social class (F31-33 and F35-37); and question F27 on historical difficulty making ends meet was moved to come after the question on current difficulties.

Section F was renamed Section L in the main phase.

9.2.5.1 Summary of Changes for Main Phase of Interviewing

- Question A3 on perception of 'smacking' a child was moved to the SCG Self-Complete Questionnaire.
- A new question on whether a long-standing condition had been diagnosed by a medical professional was added to the section on parental health.
- The Everyday Discrimination Scale was moved to the Self-Complete Questionnaire and a response category was added to reason for discrimination – *my job/occupation*.
- One item was added to C2 – *g. Going for a walk, a cycle, a hike etc* – as per the PCG Main Questionnaire.
- Question E1b on job security was deleted and the similar question at E1a moved to the Self-Complete Questionnaire.
- Questions on the SCG's religious beliefs and frequency of attendance were added.
- Question F7 on detailed family-friendly policies was deleted.
- The question on economic status in the past 48 months at F25/26 was simplified to just number of months in employment.
- Questions on (grand) parental social class were deleted (F31-33 and F35-37).
- All sections of the SCG questionnaire in the main phase were relabelled to correspond with the corresponding section letters of the main PCG questionnaire. For example, the section on socio-demographics would be 'section L' for both respondents, even though the SCG questionnaire has no section J or K.



Chapter 10

The Primary and Secondary Caregiver
Self-Complete (Sensitive) Questionnaire





10.1 PRIMARY AND SECONDARY CAREGIVER SENSITIVE SECTIONS

The supplementary or sensitive section of the questionnaire recorded some potentially more sensitive information from the respondent and was completed on a computer-assisted self-completion (CASI) basis. The same questionnaire was used for both Primary and Secondary Caregivers, and taps into the issues shown in the table below. In addition, Primary Caregivers (PCGs) reported the 'reasons for leaving' for people who were no longer living in the household. In this pilot, 265 PCGs and 200 SCGs self-completed this module.

Construct	Questions	Included at age 3	Included at age 5	Included at age 9 (Cohort '98)
Details on persons who have left family since Wave 1 (PCG only)	AS1–AS3	✓	✓	
Relationship to Study Child – biological, adoptive, foster	S1–S11	✓	✓	✓
Marital status	S12–S16	✓	✓	✓
Quality of couple relationship	S17–S20	✓	✓	✓
Co-parenting	S21–S22			
Parental stress	S23	✓	✓	✓
Parental efficacy	S24	✓	✓	✓
Currently pregnant? Only asked if female	S25	✓	✓	✓
Current alcohol consumption	S26–28e	✓	✓	✓
Current smoking	S29–S31	✓	✓	✓
Current drug taking	S32	✓	✓	✓
Depression & anxiety	S33–S35	✓	✓	✓
Contact with An Garda Síochána / Criminal Justice System (CJS)	S36–S37	✓	✓	✓
Sharing of family chores	S38	✓	✓	✓
Sharing of child-rearing tasks	S39	✓	✓	
Only where there was a non-resident parent				
Nature of previous relationship with child's non-resident parent	S40–S42	✓	✓	✓
Custody arrangements	S43–S46	✓	✓	✓
Non-resident parent's (NRP) contact with Study Child	S47–S49	✓	✓	✓
Child's adjustment on moving from one parent to another	S50–S51			
Maintenance arrangements	S52	✓	✓	✓
Involvement of NRP in child rearing	S53–S57			
Current relationship with NRP	S58	✓	✓	✓
Other children living with NRP	S59–S60			
All caregivers				
Relationship with own parents at 9 years old	S62–S63			



The Self-Complete Questionnaire was largely unchanged from the third round of the Cohort '08 survey (at 5 years) apart from the inclusion of the new co-parenting scales and questions on how parents had got on with their own parents when they were younger. It worked well in the pilot and frequency distributions were in line with expectations.

10.1.1 RELATIONSHIP TO THE STUDY CHILD

Questions AS1 to S11 recorded details on the caregiver's relationship to the Study Child. S2 recorded details on whether or not the caregiver was an adoptive parent of the Study Child. In cases where the caregiver was an adoptive parent, s/he was asked for details (at S3 to S6) on whether or not it was an inter-country or domestic adoption or an inter or intra family adoption, and the age of child on adoption. Equally, S7 recorded whether the caregiver was a foster parent. If s/he was, details on the nature of the fostering were recorded (at questions S9 to S11). The number of adoptive and fostered children in the pilot was too small to carry out an analysis. Accordingly, it was decided that some of the detailed information on nature of adoption and fostering should be removed, as it would apply to only a small minority of respondents. For most adopted children, and those in long-term foster placements, this information would have been recorded in earlier waves.

10.1.1.1 Change for main phase

It was decided to remove questions S3-S6 (adoption details) and S9-S11 (fostering details).

10.1.2 QUALITY OF PARTNER RELATIONSHIP, CO-PARENTING SCALE AND PARENTAL STRESS

Questions S12-S20 recorded details on the caregiver's marital status, followed by the Dyadic Adjustment Scale (DAS-4) on the quality of their relationship (Sabourin, Valois & Lussier, 2005). This scale has been used in most waves of the project to date. This scale performed well in the pilot and, along with other scales used, is described in Chapter 11 below.

Co-parenting refers to how two individuals work together in their parenting roles and the support they provide for one another in raising children for whom they share responsibility (Feinberg, 2003). This is conceptually distinct from the inter-parental relationship, instead reflecting a triadic relationship system, incorporating the child and both parents (Feinberg, 2003; Van Egeren & Hawkins, 2004). Evidence has suggested that co-parenting has a stronger influence on parent-child relationships and child outcomes than the inter-parental relationship/marital quality, because it is more proximally related to parenting (McHale, 2007). Three subscales of co-parenting (support, undermining and conflict) were included in the pilot questionnaire. The psychometrics for each of the three subscales were good. The measure and its subscales are discussed in more detail in Chapter 11.

Even though the three subscales performed well in the pilot, a number of respondents in the pilot felt that some of the information recorded was repetitive. As discussed in more detail in Chapter 11, there was, for example, a substantial overlap with the DAS-4 scale. With a view to reducing respondent burden and taking on board the strong relationship between the co-parenting scale and the DAS-4 (which will be recorded in the main phase of interviewing), it seemed difficult to justify inclusion of all three subscales used in the pilot. Accordingly, it was decided to retain only the conflict subscale for the main phase.

Questions S23 and S24 respectively recorded details on parental stress and self-efficacy in the parenting role (for the latter see Coleman and Karraker, 2003). These measures have been used previously in the project and performed well in the pilot. Chapter 11 contains more detailed discussion of the psychometric properties of the parental stressor subscale.

Decision for main phase of fieldwork

It was decided to remove S21 (part of the co-parenting scale) due to overlap with other items in this questionnaire; S22 on conflict in the parenting relationship between the resident caregivers was retained.

10.1.3 CONSUMPTION OF ALCOHOL, SMOKING AND ILLICIT DRUGS

Questions S26-S28e recorded details on alcohol use and consumption. S28 was the FAST alcohol screening



test for alcohol misuse (Hodgson, Alwyn, John, Thom & Smith, 2002). Questions S29-31 recorded details on smoking (including a new question on 'vaping'), while S32a recorded information on taking illicit drugs. All of these questions were used in previous rounds of the study and worked well in the pilot; the vaping question had been used for the first time with Cohort '98 at 17/18 years.

A new question was added at this round (S32b) on the use of so-called 'legal highs' or 'head shop drugs'. Although no respondents answered in the affirmative on this question, it was decided to continue the question into the main phase, given the much larger sample in the main phase. There was also a small number answering in the affirmative to S32a on other types of drugs, but again this was anticipated given the relatively small pilot sample.

10.1.4 PARENTAL ANXIETY AND DEPRESSION

Questions S33-S35 were used to record information on anxiety and depression. The last question contained the 8-item Centre for Epidemiological Studies Depression Scale (CES-D), a short screener for depression. Both sets of questions were previously used at various rounds of the study.

10.1.5 DISTRIBUTION OF HOUSEHOLD AND CHILD-REARING ACTIVITIES IN THE HOME

Questions S38 and S39 focused on perceived equity of the distribution of household and family-rearing chores in the home. Although both performed as anticipated in the pilot phase, it was decided to combine the two questions into one in order to reduce perceived repetition. Thus, the new wording refers to the sharing of '...domestic and child-rearing tasks...'

10.1.6 INSERTION OF QUESTIONS PREVIOUSLY ASKED ON MAIN PARENTAL QUESTIONNAIRE

As discussed in previous chapters, after the pilot experience it was felt that some questions would be more suitable for self-completion. These questions were inserted before the existing questions on non-resident parents. The new S43 became the single-item question on attitudes to smacking. The new S44 and S45 were the multi-item questions making up the Everyday Discrimination Scale.

10.1.7 DETAILS ON STUDY CHILD'S NON-RESIDENT PARENT

Questions S40-S61 recorded information on the characteristics of the non-resident parent (where relevant), including details on parenting arrangements, contact with the Study Child and so on. Most of these questions were included in earlier rounds of the study and performed as anticipated.

One exception to this was a question on adjustment issues that might arise for the Study Child in moving between parental households (Q.S50-51). Although answered on a self-completion basis, the questions appeared to cause confusion to some respondents and, on reflection, possibly do not provide a great deal of additional usable information for analysis. On this basis it was decided to drop the question.

Some small additional changes are summarised in the paragraph below.

Decisions

The answer options for S40 on the current status of the other biological parent were simplified by removing the 'temporarily lives elsewhere' option.

The wording of S48a – face-to-face contact with the other parent – was reworded to exclude video calling (e.g. Skype) as 'face-to-face'.

Questions S50-51 on the child's ability to settle after staying with the other parent were removed.

10.1.8 PARENTS' RECOLLECTIONS OF RELATIONSHIP WITH OWN PARENTS WHEN THEY WERE 9 YEARS OLD

Two new questions were added to the Self-Complete Questionnaire about the parent's closeness to their own mother and father when they were 9 years old (S62 and S63). These questions could, for example, give some insight into how parent-child dynamics may in some ways be transmitted inter-generationally. The frequencies for the main response categories are summarised below. Participants also had the option of



responding as 'parent deceased/not living with me' or 'cannot remember'. As there was good variation in responses, and no problems were reported, these questions were retained for the main phase of fieldwork.

Table 10.1 Frequencies of responses to Self-Complete Questionnaire about the parent's closeness to their own mother and father when they were 9 years old

		Very close	Quite close	Quite distant	Very distant
PCG	Mother	49%	37%	11%	
	Father	39%	36%	17%	
SCG	Mother	55%	36%	*	
	Father	38%	40%	*	

* Cell size under 30.

10.1.9 ADDITION OF PARENTING STYLE MEASURES

As noted in an earlier chapter, the pilot of this wave sought initially to repeat the same parenting style measures as used with Cohort '98 at 9 years. That measure had been asked of the children rather than the parents. The piloting process, however, highlighted the urgent need to reduce the burden on child respondents. It was also noted that the change at age 9 to a child-report of parenting style meant losing longitudinal consistency with previous waves of the Cohort '08 survey. Therefore, it was decided that the parenting style measure be deleted from the child questionnaire for the main phase; instead the parent-report scales previously used at ages 3 and 5 years would be introduced to the parental self-complete questionnaires. There were three subscales measuring warmth, hostility and consistency and they appeared as the new questions S18 and S19.

10.1.9.1 Summary of changes for main phase of fieldwork

- Some details on fostering and adoption were deleted due to the repetition from earlier waves and the small expected frequencies for new cases; specifically, S3-S6 and S9-S11.
- The support and undermining subscales of the co-parenting measure at S21 were removed due to repetition with some other items; leaving just the conflict subscale at (previously) S22.
- Questions S38-S39 were replaced with one question tapping into satisfaction with regard to combined domestic and child-rearing duties.
- Questions S50 and S51 on child's adjustment after moving between parents were deemed to be of lesser importance and were removed to facilitate the addition of other questions to the self-complete module.
- The question on the PCG/SCG's attitude to 'smacking a child' was moved from the interviewer-administered Main Questionnaire to the Self-Complete Questionnaire.
- The Everyday Discrimination Scale was moved from the Main Questionnaire to the Self-Complete Questionnaire.
- The parenting style subscales of warmth, hostility and consistency – used in previous waves of the Cohort '08 survey – were added to replace the measures removed from the Child Questionnaire (Qs S18-S19 in Appendix B9).
- Some small additional wording changes were made, as detailed above.



Chapter 11

Main Scales Used in the Parental Questionnaires





11.1 INTRODUCTION

This chapter considers the main instruments in the Primary (PCG) and Secondary Caregiver (SCG) questionnaires. Scales used in the child questionnaires are discussed in Chapters 5 and 6. Some scales only feature in the questionnaire for the Primary Caregiver.

11.2 STRENGTHS AND DIFFICULTIES QUESTIONNAIRE

11.2.1 INSTRUMENT DESCRIPTION

The Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997) is a 25-item measure of both prosocial and problematic behaviour that is suitable from age 3 years and through adolescence. There are different versions for parents, youths and teachers. *Growing Up in Ireland* used both of the adult forms at this wave, but just the parent-report is discussed here. The instrument is described in more detail in McCrory, Williams, Murray, Quail & Thornton (2013). In *Growing Up in Ireland*, the parent-report version has been used in the PCG questionnaire at all waves between the ages of 3 and 17/18 years.

The impact scale of the SDQ was added to the 5-year sweep to ascertain the parent’s perception of the impact on the child of any potential adverse experiences. It was piloted again in this 9-year pilot. The impact module was not used with 9-year-olds in Cohort '98.

11.2.2 PERFORMANCE IN THE PILOT

In terms of internal consistency and reliability, findings were mixed for the subscales in the current pilot. For example, alphas were moderate-to-good for the *emotionality* (= .61), *prosocial* (= .63), *conduct* (= .62) and *hyperactivity* subscales (= .79), but lower for the *peer problems* subscale (= .48). Previous investigators have also reported mixed reliabilities for the SDQ subscales (see, for example, Goodman 2001; Van Roy, Veenstra & Clench-Aas, 2008). The alpha for the *total difficulties* score was good (= .65).

Table 11.1: Summary statistics for the SDQ subscales and total score

	SDQ Emotionality	SDQ Conduct	SDQ Hyperactivity	SDQ Peer problems	SDQ Prosocial	SDQ Total difficulty
N	262	262	262	262	262	262
Mean	1.71	1.02	2.76	.88	8.99	6.36
Median	1	1	2	0	9	5
Minimum	0	0	0	0	1	0
Maximum achieved score	9	10	10	7	9	24
Maximum possible score	10	10	10	10	10	40

Overall, the scores on the total difficulties measure were relatively low for the pilot group (maximum achieved score of 24 out of a possible maximum of 40) with a mean score of 6.4, although this was probably not surprising for this age group. There was, as expected, a significant correlation between the Pianta *conflict* subscale (also parent-reported) and the SDQ *conduct* subscale ($r = .66, p < .01$) and *total difficulties* score ($r = .53, p < .01$). These findings indicate that parents who report more conflict in their relationship with the child also tend to report more behavioural problems.

An extended version of the SDQ was used in the pilot to ask whether the respondent (Primary Caregiver) thought the child had a problem, and if so, enquired further about chronicity, distress, social impairment and burden to others. The extended version potentially provides useful additional information for clinicians and researchers (Goodman & Gotlib, 1999). While almost 79% of the children were not seen to be affected



by difficulties with *emotionality, hyperactivity, conduct, or peer problems*, 21% were affected by difficulties in one or more of these areas to a greater or lesser extent. Not surprisingly, higher impact scores were associated with more difficulties as recorded by the main SDQ measure, for example for *total difficulties* ($r = .64; p < .01$). Impact scores were also significantly associated with conflict in the parent-child relationship ($r = .44; p < .01$).

11.2.2.1 Summary of changes for main fieldwork

It was decided to retain the SDQ for the Main Study to ensure longitudinal continuity with earlier waves of *Growing Up in Ireland*, and also to enable international comparisons (for example with the ALSPAC and Millennium Cohort Studies in the UK). It performed reasonably well in this pilot, as in other waves of the study.

Given the overall response burden for parents and the household, however, it was decided to remove the impact module from the SDQ at this time.

11.3 PIANTA PARENT-CHILD RELATIONSHIP SCALE

11.3.1 INSTRUMENT DESCRIPTION

The Pianta parent-child relationship scale is a parent-reported assessment of the quality of the relationship with the child (Pianta, 1992). It was completed by both the PCG and SCG. This scale measures perceived *conflict* and *closeness* in the parent-child relationship. The measure is discussed in detail in Thornton, Williams, McCrory, Murray & Quail (2013) and McCrory, Williams, Murray, Quail & Thornton (2013).

11.3.2 PERFORMANCE IN THE PILOT

The internal consistency of the *conflict* subscale (on the 15-item version) was good for both the Primary Caregiver ($\alpha = .80$) and the Secondary Caregiver ($\alpha = .74$). The internal consistency reliability of the *closeness* subscale was also good for the Secondary Caregiver ($\alpha = .71$) but somewhat lower for the Primary Caregiver ($\alpha = .55$).

Table 11.2: Scale statistics for level of closeness subscale, PCG

Mean	Variance	Std. Deviation	N of Items
33.59	4.15	2.04	7

Table 11.3: Scale Statistics for level of conflict subscale PCG

Mean	Variance	Std. Deviation	N of Items
14.60	33.80	5.81	8

The validity of the Pianta scores was supported by predicted correlations with measures of emotional and behavioural outcomes as measured by the SDQ. Findings indicated a positive association between level of *conflict* in the parent-child relationship and *emotionality* ($r = .26, p < .01$), *conduct* ($r = .66, p < .01$), *hyperactivity* ($r = .36, p < .01$), *peer problems* ($r = .28, p < .01$) and *total difficulties* scores ($r = .53, p < .01$), such that greater conflict was associated with more behavioural problems (as also reported by the parent). There was a negative association with the child's *prosocial behaviour* ($r = -.34, p < .01$), indicating less conflict where the parent also reported more positive behaviour towards others from the child. Likewise, findings indicated a negative correlation between level of *closeness* in the parent-child relationship and *emotionality* ($r = -.17, p < .01$), *conduct* ($r = -.40, p < .01$), *hyperactivity* ($r = -.21, p < .01$), *peer problems* ($r = -.15, p < .01$) and *total difficulties* ($r = -.31, p < .01$), but a positive correlation with *prosocial behaviour* ($r = .30, p < .01$).



11.3.2.1 Summary of changes for main fieldwork

The Pianta performed well in earlier waves of the study, and in this pilot. Given the importance of the measure in terms of its association with other pertinent child indicators, it was decided to adopt the 15-item version for the 9-year Main Phase of the Cohort '08 survey. The Pianta has also been used in the Millennium Cohort Study (UK) and the Longitudinal Study of Australian Children, and so will provide comparability in the international sphere.

11.4 SOCIAL SKILLS IMPROVEMENT SYSTEM RATING SCALES (SSIS)

11.4.1 INSTRUMENT DESCRIPTION

The Social Skills Improvement System Rating Scale (SSIS-RS: Gresham & Elliot, 2008) is a comprehensive rating scale designed to assess social skills, problem behaviours, and academic competence. It is suitable for children and adolescents from age 3 to age 18. Four subscales from the full SSIS have been previously used with this cohort at the 5 year and 7/8-year phases in a 'social skills' section of the questionnaire. These SSIS-RS subscales were: *assertion*, *responsibility*, *empathy* and *self-control*.

Higher scores on the SSIS-RS rating scales indicate greater competence in a given domain, and the measure as a whole can therefore be seen as 'positively framed'; i.e. it provides a measure of a child's ability rather than their problems. The SSIS-RS subscales were selected as 'positively framed' measures as they could complement the more 'problem' or 'deficit' focus of the Strengths and Difficulties Questionnaire (SDQ). Higher scores on most SDQ subscales indicate worse problems or a greater deficit in a given domain.

11.4.2 PSYCHOMETRIC INFORMATION

Internal reliability for the SSIS-RS as reported by the scale authors was moderate to high: *cooperation* ($\alpha = .85$), *assertion* ($\alpha = .78$), *responsibility* ($\alpha = .86$), *empathy* ($\alpha = .87$), *self-control* ($\alpha = .84$), and for the overall social skills (including some additional subscales not used by **Growing Up in Ireland**) measure, internal consistency was high ($\alpha = .96$).

Evidence of validity for the scores obtained from the SSIS-RS has been demonstrated by correlational studies with other widely used instruments such as the Behavioral Assessment System (2nd ed.; BASC-2; Reynolds & Kamphaus, 2004), the SSRS (Gresham & Elliott, 1990), and the Vineland Adaptive Behavior Scale (2nd ed.; Vineland II; Sparrow, Cicchetti & Balla, 2005). Overall, the SSIS-RS shows moderate to high correlations (depending on the scale and subscale) with each of these instruments (see Gresham & Elliott, 2008, for more detail).

Finally, the SSIS-RS has been shown to differentiate members of specific populations such as those with attention deficit/hyperactivity disorder, autism spectrum disorder, developmental delay, emotional/behavioural disturbance, intellectual disability, and speech/language impairment (Gresham & Elliott, 2008).

11.4.3 PERFORMANCE IN THE PILOT

The four subscales used in **Growing Up in Ireland** performed well in terms of their internal consistency. The following alphas were found for the subscales: *assertion* ($\alpha = .65$), *responsibility* ($\alpha = .77$), *empathy* ($\alpha = .83$), *self-control* ($\alpha = .77$).

The validity checks revealed expected convergent relationships with other related measures. For example, the SSIS-RS correlated with the SDQ, in that all aspects of social skills correlated negatively with the deficit-focused subscales, and the *total difficulties* score on the SDQ as follows: *assertion*: ($r = -.14$, $p < .01$); *responsibility*: ($r = -.57$, $p < .01$); *empathy*: ($r = -.31$, $p < .01$); *self-control*: ($r = -.50$, $p < .01$). The SDQ *prosocial* measure correlated positively with SSIS: *assertion*: ($r = .16$, $p < .01$); *responsibility*: ($r = .45$, $p < .01$); *empathy*: ($r = .57$, $p < .01$); *self-control*: ($r = .50$, $p < .01$).

No gender differences were found on the assertion, responsibility and self-control SSIS-RS subscales. However, there was a slight but significant difference between males and females on empathy scores, with females scoring slightly higher (15.41) compared to males (14.48).



11.4.3.1 Summary of changes for main fieldwork

Although these subscales appeared to work well in the pilot, given the additions to other areas of the PCG interview, and the strong correlations with the SDQ prosocial scale, it was decided to drop the SSIS-RS from the main phase.

11.5 THE EVERYDAY DISCRIMINATION SCALE – EDS (SHORT VERSION)

11.5.1 INSTRUMENT DESCRIPTION

The short version of the Everyday Discrimination Scale was used in the pilot study. This 5-item scale asks participants to indicate how frequently they experience various forms of interpersonal mistreatment in their day-to-day lives. It is assessed on a six-point scale (0=never, 1=less than once a year, 2=a few times a year, 3=a few times a month, 4=at least once a week, 5=almost every day). Examples of items in the scale include: 'You are treated with less courtesy than other people', 'You receive poorer service than other people at restaurants or stores' and 'People act as if they think you are not smart'. This 5-item scale was adapted from the original 9-item version of the EDS (Williams, Yu, Jackson & Anderson, 1997), which demonstrated good reliability and validity (Bernstein, Park, Shin, Cho & Park, 2011).

Follow-up questions are asked of respondents who answer 'a few times a year' or more frequently to at least one question, to ascertain what they thought was the main reason for the experience. They are presented with a list of possible reasons, adapted for the pilot to include the nine grounds of discrimination as covered by Irish legislation: gender, civil status (including marital status), family status, race (which includes skin colour, ethnic group and nationality), age, religion, sexual orientation, family status (e.g. pregnant or with children), disability and membership of the Traveller community. Respondents were also offered an option to specify 'education or income level' and 'other' reason.

11.5.2 PSYCHOMETRIC INFORMATION

This 5-item scale was adapted from the original 9-item version of the EDS (Williams, Yu, Jackson, & Anderson, 1997), which demonstrated good reliability and validity (e.g. Bernstein et al., 2011). Stucky, Gottfredson, Panter, Daye, Allen & Wightman (2011), found that a shortened version of the EDS retained strong psychometric properties. Good reliability ($\alpha = .84$) was found with an African American sample of law students (N = 589) and with a more representative sample of African Americans ($\alpha = .82$) (N = 3,570), obtained as a subsample of the National Survey of American Life (Pennell et al., 2004).

11.5.3 PERFORMANCE IN THE PILOT

The scale seemed to work well in the pilot, and reliability statistics for the EDS were moderately good at ($\alpha = .70$) for the Primary Caregiver and ($\alpha = .77$) for the Secondary Caregiver. Scores for Primary Caregivers ranged between 0 and 13 and between 0 and 18 for Secondary Caregivers, out of a maximum possible score of 25.

Just over one-third of Primary Caregivers (36%) were routed into the questions about the reasons for experiences of discrimination. Respondents could tick all of the reasons that applied. Notably, 47% of PCGs who were asked this question stated the reason as 'other (please specify)', and this was most frequently to do with their job or occupation.

Half (51%) of Secondary Caregivers were routed into the question about the main reason for these experiences. Again, the majority of relevant participants (73%) ticked the 'other (please specify)' option, and the most frequently reported reasons were again related to their job or occupation.

11.5.3.1 Summary of changes for main fieldwork

As a significant proportion of Primary and Secondary Caregivers had reported the main reason for experiences of discrimination as 'other', specifically as relating to their work or occupation, the response options were amended to reflect this as a new category. The response options adopted for the main phase



were as follows:

1. Your gender
2. Your race/skin colour/ethnic group/nationality
3. Your age
4. Your religion
5. Your sexual orientation
6. Your education or income level
7. Your marital status
8. Your family status (e.g. pregnant or with children)
9. A disability
10. Membership of the Traveller community
11. Your job or occupation*
12. Other (please specify)

* Additional response option for the Main Study

It was decided to move this scale to the parent Self-Complete Questionnaires instead of the Main Questionnaire (where it was located in the pilot). This was primarily due to a number of interviewers reporting that some parents felt uncomfortable answering these questions on an interviewer-administered basis.

11.6 DYADIC ADJUSTMENT SCALE

11.6.1 INSTRUMENT DESCRIPTION

The Dyadic Adjustment Scale (DAS-4; Sabourin et al., 2005) is a self-reported measure of the partner relationship. The shorter 4-item DAS provides an assessment of relationship satisfaction based on participants' self-report. It is used to assess the state of a marriage or partnership. Compared with the original 32-item version of the DAS, it was found to be effective in predicting couple dissolution. This version has the advantage of being extremely brief and therefore less time-consuming for the respondents. It, or the 7-item version, have been used in previous waves of *Growing Up in Ireland* and so provides a high level of longitudinal continuity in measuring quality of partner relationships.

The measure was self-completed by both the Primary and Secondary Caregivers. It was only asked of parents who reside with a spouse or partner.

11.6.2 PSYCHOMETRIC INFORMATION

Sabourin et al. (2005), found reliability for the 4-item measure to be higher than ($\alpha = .81$) at all levels of couple distress. The reliability of the DAS-4 increased up to ($\alpha = .92$) for non-distressed participants. The standardised alpha for the DAS-4 was ($\alpha = .84$), and the standardised alphas for the alternative brief versions used in previous studies were ($\alpha = .85$) for the DAS-7 (Sharpley & Rogers, 1984) and ($\alpha = .94$) for the original DAS-32. Differences among the short versions of the DAS were not found to be substantial; therefore the 4-item version preserved good internal consistency.

11.6.3 PERFORMANCE IN THE PILOT

The DAS indicated good internal reliability for both the Primary ($\alpha = .75$) and Secondary Caregivers ($\alpha = .73$). A wide range of scores were reported within the possible range of 0 to 21.



Table 11.4: Summary statistics for PCG and SCG Dynamic Adjustment Scales

Mean	DAS PCG	DAS SCG
Mean	16.39	16.79
Median	17.00	17.00
Minimum	1.00	2.00
Maximum	21.00	21.00

11.6.3.1 Decisions for main fieldwork

The 4-item DAS appeared to work well in the study and, to ensure longitudinal consistency with the 5-year wave, it was decided to retain it for the main phase at 9 years. The scale appeared in the self-complete questionnaire for both the Primary and Secondary Caregivers.

11.7 CO-PARENTING RELATIONSHIP SCALE (CRS)

11.7.1 INSTRUMENT DESCRIPTION

The CRS was designed as a comprehensive self-report measure of the quality of co-parenting in a family. It includes 35 items and seven subscales. The subscales are: *Co-parenting agreement*, *Co-parenting closeness*, *exposure to conflict*, *Co-parenting support*, *Co-parenting undermining*, *endorse partner parenting*, and *division of labour*. As it was not feasible to add all 35 items to the existing questionnaire (i.e. as used in previous waves), just three subscales of the CRS (Feinberg, Brown & Kahn, 2012) were included in the 9-year pilot survey as follows: *Co-parenting support*, *Co-parenting undermining* and *Exposure to conflict*.

11.7.2 PSYCHOMETRIC INFORMATION

The three subscales of the CRS used in the 9-year pilot have previously demonstrated good internal consistency as well as good reliability and validity (Feinberg, Brown & Kahn, 2012). In addition, parents tend to demonstrate reasonable levels of agreement on overall co-parenting relationship quality (Feinberg, Brown & Kahn, 2012).

11.7.3 PERFORMANCE IN THE PILOT

The three subscales seemed to work well in the pilot, and reliability statistics for all three were very good for both Primary and Secondary Caregivers: *Co-parenting support* ($\alpha = .88$ and $.87$, respectively), *Co-parenting undermining* ($\alpha = .75$ and $.81$) and *exposure to conflict* ($\alpha = .76$ and $.88$). There was a good range of scores on the three subscales, as shown in Table 11.5, where the possible minimum was 0 and maximum was 6. As shown in Table 11.6, ranges were similar for the three subscales for the Secondary Caregivers.

Table 11.5: Summary statistics for the three PCG co-parenting subscales used

	Support	Undermining	Exposure to Conflict
Number of items in the subscale	6	6	5
Mean	4.62	.66	.65
Median	6.00	5.33	3.20
Minimum	.83	0.00	0.00
Maximum	6.00	5.00	5.20



Table 11.6: Summary statistics for the three SCG co-parenting subscales used

	Support	Undermining	Exposure to Conflict
Number of items in subscale	6	6	5
Mean	4.73	.95	.68
Median	5.00	.67	.40
Minimum	.83	0.00	0.00
Maximum	6.00	5.00	5.20

As suggested by previous literature (Feinberg, Brown & Kahn, 2012), the consistency between Primary and Secondary Caregiver reports was good for all three subscales (Table 11.7).

Table 11.7: Correlation coefficients between PCG and SCG co-parenting subscales

		Support	Undermining	Exposure to conflict	Support	Undermining	Exposure to conflict
PCG	Support	1			.58**	-.38**	-.40**
	Undermining	-.40**	1		-.41**	.47**	.35**
	Exposure to conflict	-.41**	.42**	1	-.24**	.28**	.57**
SCG	Support				1		
	Undermining				-.43**	1	
	Exposure to conflict				-.37**	.64**	1

** Correlation was significant at the 0.01 level (2-tailed).

There were strong relationships between the individual co-parenting subscales and the Dyadic Adjustment Scale (DAS – a measure of couple relationship quality; see Table 11.8). This relationship was strongest for the Co-parenting Support subscale, but still strong for undermining and exposure to conflict.

Table 11.8: Correlation coefficients between PCG and SCG co-parenting subscales and DAS

	PCG			SCG		
	Support	Undermining	Exposure to conflict	Support	Undermining	Exposure to conflict
PCG DAS	.61**	-.53**	-.45**	-	-	-
SCG DAS	-	-	-	.69**	-.52**	-.42**

**Correlation was significant at the 0.01 level (2-tailed).

11.7.3.1 Summary of changes for main fieldwork

It was decided to retain just the conflict subscale from the CRS but not the other two for the main phase of fieldwork. This decision was made in light of some similarities between items in the subscales and other measures on the questionnaire; for example, between the self-rating of parental efficacy (S24) and S21l 'my partner makes me feel like I'm the best possible parent for our child'; and between the parental rating of how fairly domestic and child-rearing tasks are shared between the couple and item S21k 'when I'm at my wit's end as a parent, partner gives me extra support I need' (S38/9). In addition, it was decided to add



the parenting style measure previously used at ages 3 and 5 years to the self-complete module for parents – this would be completed by all Primary Caregivers and not just those living as a couple. This inclusion put additional pressure on space in the questionnaire.

11.8 DEPRESSION STATUS (CES-D SCORES)

11.8.1 INSTRUMENT DESCRIPTION

The CES-D (Melchior, Huba, Brown & Reback, 1993) is a widely used self-report measure that was developed as a screening instrument for depression in the general population as opposed to being a diagnostic tool that measures the presence of clinical depression. The short (8-item) version of the CES-D, which correlates highly with the full 20-item version, was used in the pilot. This measure has also been used in previous waves of *Growing Up in Ireland*.

11.8.2 PSYCHOMETRIC INFORMATION

The CES-D was reported to have good internal reliability consistency ($\alpha = .86$) and to correlate $r = .93$ with the original 20-item version of the instrument. Test-retest reliability was reported as $r = .83$ and $r = .87$ for assessment at 6 and 12 months later, respectively, compared to the original scores (DiClemente et al., 2005). The concurrent validity of the scale has been established through its association with other depression measures such as the Beck Depression Inventory (Melchior et al., 1993). Furthermore, it has been shown to discriminate depressive disorders from other forms of psychopathology (e.g. Roberts, Andrews, Lewinsohn & Hops, 1990).

11.8.3 PERFORMANCE IN THE PILOT

In the pilot, reliability for this measure was good for both the Primary ($\alpha = .88$) and Secondary Caregivers ($\alpha = .74$). A minority of caregivers (< 30 individuals in either group) exceeded the threshold normally used to indicate depression. Among Primary Caregivers, there was a small number of high-scoring individuals, which magnified the difference in CES-D means between Primary and Secondary Caregivers. This tends to produce skewed distribution of scores. The skewed shape of the distribution, with a small number of values at or close to the maximum achieved score, means that the average is above the median in the pilot sample. When high outliers were removed using a 95% trimmed mean, the depression scores were closer, albeit with PCGs still reporting significantly higher average depression scores than SCGs. These trends are in line with expectations around previous uses of this scale in *Growing Up in Ireland* and with results seen in previous research covered above.

Table 11.9: Summary statistics for PCG and SCG CES-D

	PCG – Total score	SCG – Total score
Mean	2.44	1.70
5% Trimmed Mean	1.90	1.40
Median	1.00	1.00
Minimum	0	0
Maximum	24	12

11.8.3.1 Decisions for main fieldwork

The CES-D measure appeared to work well in the pilot. To ensure longitudinal consistency, it was decided to include it in the Main Study unchanged.



11.9 FAST ALCOHOL SCREENING TEST (FAST)

11.9.1 INSTRUMENT DESCRIPTION

The FAST is a short version of the AUDIT questionnaire, a useful and robust screening test for problematic alcohol use. The FAST questionnaire has just 4 items and screens for hazardous drinking as well as harmful drinking and alcohol dependence. Administration is straightforward and the questionnaire can be self-completed. Average administration time is reported to be less than 20 seconds (Hodgson et al., 2002). The FAST questionnaire has been used in other waves of *Growing Up in Ireland*.

11.9.2 PSYCHOMETRIC INFORMATION

Cronbach's alpha for the inter-correlation between FAST items was reported to be ($\alpha = .77$), with one-week test-retest reliability given as $r = .81$. A check on specificity and sensitivity (see Altman & Bland, 1994), compared to the original AUDIT using 2,185 patients admitted to an accident and emergency (A&E) setting, found the sensitivity of the FAST to be 93% with 88% specificity.

11.9.3 PERFORMANCE IN THE PILOT

Almost 40% of Primary Caregivers reported *never* drinking 6 or more drinks in one go, 46% reported doing this *less than monthly*, and the remainder were either more frequent or did not consume alcohol at all. Fewer than 10% of the Primary Caregivers in the pilot sample could be classified as potentially hazardous drinkers.

A somewhat larger proportion of Secondary Caregivers could be classified as potentially hazardous drinkers, but the number of individuals was too small for further analysis in this pilot sample. Regarding the performance of the FAST in the Secondary Caregiver Self-Complete Questionnaire, 39% reported *never* drinking 6 or more drinks in one go, 45% reported doing so *less than monthly*, and the remainder were either more frequent or did not consume alcohol at all.

11.9.3.1 Decisions for main fieldwork

It was decided that these questions be used in the Main Study as they had been in the pilot, with no changes.

11.10 PARENTAL STRESS (PARENTAL STRESSORS SUBSCALE)

11.10.1 INSTRUMENT DESCRIPTION

The Parental Stress Scale (Berry & Jones, 1995) is an 18-item self-report scale designed to assess both positive and negative aspects of parenthood. It comprises four subscales: *Parental Rewards* (6 items); *Parental Stressors* (6 items); *Lack of control* (3 items), and *Parental Satisfaction* (3 items). Items are rated on a 5-point Likert-type scale ranging from 'strongly disagree' to 'strongly agree'. A total stress score is calculated as a composite of the items (ranging from 18-90), with higher scores indicating higher levels of stress.

Due to time pressures, and for longitudinal consistency with recent waves in *Growing Up in Ireland*, only the 6-item Parental Stressors subscale was used in the current pilot study. Further information on this measure is detailed in McCrory et al. (2013).

11.10.2 PERFORMANCE IN PILOT

Internal consistency was high for the Parental Stressors subscale (PCG) in the current study ($\alpha = .75$). Higher scores indicate more stress. A total stress score was calculated by summing across the 6 items (range=6–30). Overall, the scale items showed a good spread of scores, with a minimum and maximum score achieved for all individual items. Total stress scores for the Primary Caregiver ranged from 6 to 26 (the maximum score of 30 was not achieved), with a mean of 13.65 (S.D. = 4.26). Similarly, total stress scores for the Secondary Caregiver ranged from 6 to 25, with a mean of 13.36 (S.D. = 4.34).

Higher scores on the CES-D Depression indicator were correlated with greater parental stress for both the Primary Caregiver ($r = .40$, $p < .01$) and Secondary Caregiver ($r = .29$, $p < .01$).

11.10.2.1 Decisions for main fieldwork

This subscale worked well in the pilot study and has previously featured in all earlier waves for this cohort. It was decided, therefore, that the Parental Stressors subscale be maintained for the main 9-year study.



Chapter 12

School Pilot Phase





12.1 OVERVIEW OF PROCEDURES FOR SCHOOL COMPONENT

The school phase for the pilot was completed using postal questionnaires to the schools. The instrumentation and procedures were similar to those used for the school phase with this cohort at age 5 years, while also drawing on some questions previously used with Cohort '98 at 9 years of age.

Three separate questionnaires were completed in the school, described in more detail in the following section:

- Teacher-on-Pupil (one per Study Child)
- Teacher-on-Self (one per teacher)
- Principal (one per school)

In the course of the home interview, the Primary Caregiver (PCG) was asked to provide the name of the school currently attended by the 9-year-old. The PCG was also asked to give signed consent to contact the child's teacher with regard to the teacher completing a questionnaire about the Study Child (the Teacher-on-Pupil Questionnaire). Teachers were further asked to complete a questionnaire about themselves and their classrooms, and principals were asked to fill out a questionnaire about the school. Specific consent was requested from the Primary Caregivers in relation to the teacher providing details about the Study Child. The Primary Caregivers were also informed of the intention to collect other information about the school and teacher.

A pack of questionnaires and information sheets was sent by post to each school that had a *Growing Up in Ireland* Study Child in the pilot. A member of the fieldwork team contacted each principal to guide them through the process of assigning a within-school pupil number to each Study Child and distributing the correct number of blank questionnaires to each teacher. The principal then collected the completed questionnaires from the teachers and, along with their own completed questionnaire, returned them by post to *Growing Up in Ireland*.

12.1.1 RESPONSE RATES

As anticipated, virtually all Primary Caregivers gave their consent for the Study Child's teacher to be contacted about him/her. Similarly, a very high level of co-operation was received from schools and their staff in the pilot. Out of 251 pupils, a Teacher-on-Pupil Questionnaire was completed in respect of 233 children, 215 teachers returned a Teacher-on-Self Questionnaire (in respect of 227 pupils) and 198 principals returned a Principal Questionnaire (in respect of 234 pupils).

12.2 INSTRUMENTATION

12.2.1 TEACHER-ON-PUPIL QUESTIONNAIRE

The Teacher-on-Pupil Questionnaire dealt specifically with information relating to the Study Child and there was one Teacher-on-Pupil Questionnaire for each child (see Appendix C1). This covered issues such as preparedness for school (e.g. arriving at school on time, with a packed lunch, etc), the teacher's perceptions of the child's academic ability, and parental engagement with the child's education. This questionnaire also included the Strengths and Difficulties Questionnaire and the Pianta Student-Teacher relationship scale. The Teacher-on-Pupil Questionnaire added to the data collected in the home by providing information on the Study Child from a different informant and with respect to a different context.

The following paragraphs summarise the topics covered in this questionnaire, which is largely based on the corresponding questionnaires used with this cohort at 5 years and Cohort '98 at 9 years. The topics of the questionnaires used in earlier waves with this cohort or at 9 years for the 98 cohort are indicated and any changes are highlighted.



Q1–Q4: Characteristics of the Study Child

Basic information was recorded on the child, including their gender, date of birth, current school class/grade and how long the teacher had been teaching him/her.

Q5–Q6: Child adequately prepared for/attendance at school

These questions recorded how often the Study Child was absent (Q5) or inadequately prepared for school in terms of being unsuitably dressed for weather conditions, being hungry, lacking cleanliness, etc (Q6). The set of items at Question 6 was adapted from the Early Childhood Longitudinal Study in the USA. Question 5 (absenteeism) was not collected at age 5.

Q7: Homework completion

This question recorded how often the Study Child failed to complete their homework. It included an option for 'child does not receive homework'.

Q8–Q11: Streaming

This question recorded details on within-class grouping on the basis of Reading and/or Maths ability. If relevant, it noted whether the child was in the high, middle or low streams.

Q12: Teacher's perception of child's abilities

This set of items asked the parent to rate the child's abilities in a number of areas such as speaking and listening, reading, writing, science, maths and numeracy, physical education and art. The teacher was asked to reference all other children of this age and not just relative to the child's classmates. The question was adapted from the Millennium Cohort Study Age 7 survey (teacher questionnaire).

Q13: Strengths and Difficulties Questionnaire (SDQ)

The SDQ (e.g. Goodman, 1997) was completed by the teacher to measure the Study Child's behaviours in the classroom. The SDQ produces subscale scores for hyperactivity/inattention, peer problems, conduct problems, emotionality ('difficulties') and prosocial behaviour ('strengths'). The four difficulties subscales can be summed to give a 'total difficulties' score. The SDQ was also completed by the Primary Caregiver in the course of the main home-based survey. The teacher version of the SDQ is intended to provide an assessment of the child's socio-emotional development from an additional informant. The teacher would be likely to assess the development of the 9-year-old in comparison to his or her classmates and in the school rather than the home context.

Q14, 16–17: Parental engagement

At Question 14, teachers reported on whether the Study Child's parent(s) attended parent-teacher meetings (a yes/no answer option) – this information was not collected at age 5. Teachers also gave their perceptions on how interested the parents (mothers and fathers separately) were in the child's education (Q16). Question 17 recorded details on contact between the teacher and parents in relation to behavioural issues and schoolwork, and whether the teacher perceived that the child received encouragement for their schoolwork at home. The items at Question 16 and Question 17 were asked for this cohort at 5 years, but not Cohort '98 at age 9.

Q15: Disposition and attitudes to school

This set of questions asked the teacher to describe whether the Study Child had reached certain 'milestones' in relation to their capacity for learning such as 'showing an interest in classroom activities' and 'selects resources independently'. These questions originated in the Millennium Cohort Study and were a subset of the longer list, also used with this cohort at 5 years of age (but not with Cohort '98 at age 9). Following the pilot, it was decided that the items relating to being able to dress and manage personal hygiene would not be age-appropriate for most 9-year-olds and so were excluded for the main phase of the study.

Q18: The Pianta Student-Teacher Relationship Scale (STRS, Pianta, 1992)

This set of items recorded details on both positive and negative aspects of the teacher-child relationship. Similar to the parent version of the scale described in detail earlier, the questionnaire items combine to form two subscales covering 'positive aspects' (i.e. closeness) and 'negative aspects' (i.e. conflict) of the



Study Child's relationship with their teacher. The student-teacher relationship is distinct from the child-parent relationship; the inclusion of the two measures was intended to provide a picture of the 9-year-old's relationship to adults in different contexts. As part of the pilot evaluation, it was noted that, regrettably, a formatting error had led to the repetition of some of the 'milestone' items from Question 15 as part of the Pianta table. These extraneous items were removed for the main phase version of the questionnaire. A further amendment involved a change to the order of the response categories, so as to be consistent with other uses of this scale. This scale had appeared on the questionnaire for this cohort at age 5 years, but not for Cohort '98 at age 9.

Q19–Q21: Special educational needs and supports

These items recorded whether or not the Study Child had any special educational need, including a disability (physical, sensory or learning), emotional/behavioural problem or other characteristic that limited his/her participation in school (Q19). Follow-on questions (20–21) collected information on what, if any supports, were provided to the child in the school – such as a Special Needs Assistant or support for English as a second language.

12.2.1.1 Summary of changes for main phase

It was decided to retain this questionnaire as used in the pilot. The formatting errors noted above were corrected before the main phase.

12.2.2 TEACHER-ON-SELF QUESTIONNAIRE

This questionnaire collected information on the demographic details of the teacher himself/herself, such as age, gender, and qualifications. In addition, the Teacher-on-Self Questionnaire collected data at the classroom level on topics such as curriculum, teaching methods and class composition. Again, the content of the questionnaire was largely drawn from the corresponding questionnaires from the two previous rounds of primary school surveys in *Growing Up in Ireland* (Cohort '08 at 5 and Cohort '98 at 9) – and topics were covered at both of these previous waves unless otherwise indicated. Each participating teacher completed just one of these questionnaires. The questionnaire can be viewed in Appendix C2.

Q1–Q7: Characteristics of the teacher

These items recorded the teacher's demographic details of gender and age, as well as their qualifications and years of teaching experience. Questions 6 and 7 asked whether the teacher had done any continuing professional development (CPD) in the last year, and if so, how much. These last two questions did not feature on the questionnaire for Cohort '98 at 9 years.

Q8–Q13: Classroom characteristics

At Question 8, teachers recorded the number of children in the classroom and their gender mix, and also what year groups they taught. In some schools, especially smaller ones in rural areas, one teacher may have to teach children of different ages and year groups in the one room (referred to as 'multi-grade classes'). Questions 9–13 recorded information relating to special educational needs (SEN) in the classroom: whether the children in the class had been assigned to a particular ability group, the number of children with different types of SEN, and support from Special Needs Assistants.

Q14: Subjects covered in the classroom

Question 14 was a table in which teachers indicated the different subjects they taught and approximately how much time was spent on each in a typical week.

Q15–Q17: Teaching methods and use of electronic equipment

At Question 15 and 16, teachers recorded if they used an interactive whiteboard and whether the children accessed the internet during class. Question 17 was a detailed list of different teaching methods, including aspects of interactive and passive teaching techniques. The list also included the use of computer equipment and physical play, and the teacher indicated the frequency each was used from 'never' to 'every day'.



Q18–Q19: Homework

Teachers were asked how many nights per week they gave out homework for, and how long they expected pupils to spend on it.

Q20–Q21: Pupil assessment

Question 20 was a list of methods that teachers might use to assess a pupil's progress (e.g. tests and observations) and how often each was used (from 'never/almost never' to 'weekly'). The next question asked whether the results of these assessments were used to plan teaching.

Q22: Teacher's perceived autonomy

This question recorded details about perceived control over various aspects of teaching, including selection of subjects and year group, teaching methods and discipline. Answer options ranged from 'no control' to 'a great deal of control'.

Q23: Teacher's perception of pupils in the school

This set of items captured the teacher's perception of the extent to which pupils enjoyed school, were well-behaved, respectful and rewarding to work with.

Q24–Q25: Perceived parental engagement

These questions recorded information on the level of involvement of parents in the school and their interest in their child's education as perceived by the teacher – in terms of both attendance at meetings and approaching the parent informally. The items here aim to get an impression of overall levels of engagement between parents and school and not the engagement of the individual parents of the Study Child (which were covered in the Teacher-on-Pupil Questionnaire).

Q26: Challenges for the teacher

This was an open-ended question for the teacher to describe the main challenges they faced in their job. It was a new question for *Growing Up in Ireland* at this wave.

Q27: Teacher's stress and satisfaction levels

Teachers were asked to rate (a) how stressed by and (b) how satisfied with their job as a teacher they were.

12.2.2.1 Decision regarding main phase

The decision was made to implement this questionnaire with no amendments for the main phase of fieldwork.

12.2.3 PRINCIPAL QUESTIONNAIRE

The Principal Questionnaire recorded details on the characteristics of the school principal him/herself and the resources, management, practices and ethos of the school attended by the Study Child. As with the previous questionnaires, the items were drawn primarily from the equivalent instruments for this cohort at age 5 and Cohort '98 at age 9 years. The questionnaire used in the pilot is contained in Appendix C3.

Q1–Q6: Principal's characteristics

These items captured basic descriptive information about the principal, including age, gender, length of time in the role of principal, and their qualifications. Questions 5 and 6 were on their recent continuous professional development, which were new questions at this wave.

Q7–Q12: Basic school information

These items included the DEIS status (i.e. designated as serving a disadvantaged community) of the school, whether it is a fee-paying school and the number of pupils (by gender). Questions 9–11 were new items on whether the school sought voluntary contributions from parents; and if it did, how much and how many parents pay. These were new questions for *Growing Up in Ireland*. Between the pilot and main phase, the routing of these contribution questions on type of school was eliminated to allow fee-paying schools to indicate any additional voluntary payments from parents. The question on whether the school was fee-



paying had been asked at age 5 years, but not at 9 years for Cohort '98. DEIS status and fees (regular and voluntary) are important for evaluating educational policy and for assessing proposed changes to policy.

In addition to the other items on the school characteristics, it was decided to add questions on the main language medium of the school (i.e. English or Irish) and the religious ethos of the school. This latter question included options for Educate Together (not a faith-based ethos) and 'other – please specify'. These items had not been included for this cohort at age 5.

The number of boys and girls enrolled in the school was collected at Q12.

Q13–Q16: Staff resources

This detailed section recorded information on the number and characteristics of staff in the school. Staff numbers were broken down by administrative, teaching and support categories; full and part-time, and by gender (for teaching staff). The principal was also asked if they had a teaching class assigned to them (in addition to their role as principal).

Q17–Q22: School buildings

The questions in this sub-section collected data on the physical characteristics of the school in terms of the number of classrooms and number of classes they had to accommodate; the number of prefabs (i.e. temporary structures) in use, and how many children the school was designed to accommodate. There were further questions on the year the school was built and when it had last been refurbished.

Q23: Adequacy of school facilities and resources

These questions, originally adapted from the Early Childhood Longitudinal Study (ECLS), were designed to assess the adequacy of the school's facilities and resources across 17 areas (e.g. number of teachers, administrative support, toilet facilities). The principal was asked to rate each category of resource on a 4-point scale ranging from 'poor' to 'excellent'. Seven of the original ECLS items were retained and supplemented with 10 additional items provided by the education panel of experts.

Q24: Home-School-Community Liaison Co-ordinator

This was a single item on whether the school had a Home-School-Community Liaison Co-ordinator. This is a support available to all DEIS¹¹ schools, which is targeted at pupils at risk of not reaching their educational potential. The co-ordinator works to support parents and to harness community resources, and works with the children themselves with a view to promoting retention of the students in the education system and to enhancing their achievement. This information will allow an assessment of how pupils benefit from the availability in the school of this resource.

Q25–Q28: Free school meal provision

Principals were asked if the school provided a breakfast club or free meals at lunchtime (or both), and, if yes, whether these were made available under the DEIS scheme.

Q29: Services available to parents

This question asked if any of 5 services targeted at parents were made available through the school. These ranged from an active parents' council to access to health or social service professionals on the school premises. This topic had appeared at age 5 years but not for Cohort '98 at age 9.

Q30–Q33: Computer resources in the school

Questions 30 and 31 recorded details on the total number of computers available in the school and how many were available to the pupils. Question 33 asked about the availability of a dedicated computer room, while Question 32 was a more recent question on whether children used individual devices such as tablet computers during classes.

11 The Delivering Equality of Opportunity in Irish Schools (DEIS) scheme targets additional funding towards schools serving more disadvantaged populations. At primary level, there are three types of schools: DEIS Urban Band 1 (the most disadvantaged), DEIS Urban Band 2 and Rural DEIS (in addition to non-DEIS schools).



Q34: Community access to school facilities

This was a question on whether the school buildings and facilities (e.g. playing fields) were open to the local community outside of school hours.

Q35: Extracurricular activities

This question asked principals to indicate what extracurricular activities (sports, music, etc) were provided by the school and what scheme (e.g. DEIS), if any, they were provided under.

Q36: Influences on school ethos

For this question, principals rated the importance of different influences on the school's ethos. Factors included sport, religion, social justice and the Irish language and culture among others. Each one was rated on a 3-point scale from 'not important' to 'very important', with a fourth option of 'not sure'. While this information was collected for Cohort '98 at age 9 years, it had not yet been asked of this cohort.

As already noted, an additional question was included for the Main Study on which religion (if any) influenced the school's ethos.

Q37: Pupil population composition

This set of items recorded information on the number of children in the school from different backgrounds or with additional needs, such as being from the Traveller community or having a disability. This question gave an indicator of how diverse the school-mix was.

Q38–Q39: School attendance levels

The school returns these figures to the Department of Education and Skills on an annual basis. They consist of the average daily attendance for the school year, and the proportion of pupils who had missed 20 days or more.

Q40: School catchment area

This question asked about the proportion of students who lived within a 20-minute walk from the school (i.e. from the local area). Note that, in rural areas, children may have to travel further than this to attend their nearest school.

Q41: Types of support for children with emotional/behavioural problems

Question 41 concerned the level and type of interpersonal supports in the school for children with emotional/behavioural problems. For the Main Study the list of potential supports was expanded to include services provided by NEPS (National Educational Psychology Services), CAMHS (Child and Adolescent Mental Health Services) and Tusla (the national child and family support agency).

Q42: Numbers of children with educational challenges

This question, previously used in education research by the ESRI, recorded details on the proportion of students who had such literacy, numeracy or behavioural problems as to adversely affect their educational development. The proportion of children in need of support in these areas could then be calculated relative to the total number of pupils in the school. The presence of a Home-School- Community Liaison Co-ordinator and of supports for children with emotional/behavioural problems could be examined in the light of the number of children with educational challenges.

Q43–Q47: Admission and streaming criteria

This set of questions records information on whether the school is oversubscribed, and if so, how selective were its admission criteria. Question 47 is specifically on ability-based streaming in the school. For the main phase, the answer options for this question were re-ordered slightly so that the option 'one class per year group' – which would be the case in many smaller schools – came first on the list rather than last.

Q48–Q50: Engagement with parents

Data were collected on whether the school holds a formal parent-teacher meeting at least once a year and the proportion of parents in attendance (Q48–49). Question 50 asked whether the school encouraged the involvement of parents in (a) curricular and (b) extra-curricular activities.



Q51: Pupil engagement with school

These items were related to how much pupils enjoy being at school; are well behaved, and show respect for peers and teachers – as perceived by the principal. They had been asked of this cohort at age 5, but not Cohort '98 at age 9. For the Main Study, an option of 'not applicable' was added for the item 'settle into junior infants quickly' as not all schools offer classes to the youngest pupils. The school-readiness of the pupils as they start school will have implications for the teaching strategy adopted and for the rate of progress in the curriculum in the early years at school. This item therefore adds to the information collected on overall pupil engagement with the school.

Q52–Q54: Code of behaviour (disciplinary policy) in the school

Question 52 asked whether the school had a written 'Code of Behaviour' (i.e. discipline policy). Question 53 asked to what extent teachers, parents, pupils and the board of management were involved in developing the policy. Question 54 collected information about the frequency with which various forms of discipline, such as detention, written report to parents, suspension, etc were applied in the school. The question on behaviour policy was a variation from the question asked of Cohort '98 at age 9. The change from the version used with Cohort '98 reflected a change in the terminology used by schools. The words 'Code of Behaviour (disciplinary policy)' were used rather than simply 'disciplinary policy'.

Q55: Bullying in the school

This was a single question that asked principals whether bullying was a problem in the school. There were three answer options: 'major problem', 'minor problem' and 'no problem at all'.

Q56: Perception of teachers' attitudes

This set of items was adapted from the teacher schedule used in 'Do Schools Differ?' (Smyth, 1999), and concerned the principal's general perception of teachers in the school. They were asked to indicate what proportion of teachers in the school were positive about the school, got help and support from colleagues, were open to new things, and eager to participate in professional development.

Q57-58: Being a principal

Question 57 was an open-ended question asking about the main challenges facing the respondent as principal. For the Main Study, the space allowed for this question was expanded from a line and a half to four-and-a-half lines. This was a new question for *Growing Up in Ireland*. Question 58, similar to that asked of teachers, asked the principal to rate (a) how stressed by and (b) how satisfied with their job they felt.

Q59-61: Use of standardised tests in the school

On the Principal Questionnaire, he/she was asked if the school administered standardised tests in Reading and Maths, which tests and to which year (2nd class, 3rd class or both). Question 61 was a question on whether, in principle, the school would make those test scores available to *Growing Up in Ireland*. These questions were not asked in the Main Study for the reasons outlined below. The study had not previously requested test results from the school.

Principals were further asked – on a separate school record sheet – to note whether standardised test results for English and Maths might be available for each individual child. Potentially, if complete coverage of scores from a single standardised test was available from tests already administered in the school, it would not be necessary for *Growing Up in Ireland* to administer its own tests. Omitting cognitive tests from the home visit would considerably reduce the burden on respondents should a suitable alternative be available.

Schools were generally very co-operative in making test results available (where parents had consented to child-level information being collected from the school); however, it was not possible to get complete and harmonised coverage by this method. Principals reported the existence of English test scores for 216 out of 263 children – 200 of which could be made available to *Growing Up in Ireland*. Corresponding figures were 215 and 198 respectively for Maths tests. Not all schools used the same tests, although those produced by the Education Research Centre in Drumcondra predominated among the pilot schools. A substantial minority used 'Micra T' and 'Sigma T' tests, with a smaller proportion using something different.



An additional complication, although one that could probably have been harmonised for the Main Study, was that principals supplied different types of scores for the same test (e.g. some reported the STEN, others percentile rank and so on). Ultimately, it was decided that all children in the Main Study complete the Drumcondra Reading Test in the home with the interviewer. This was to improve not just the consistency in the actual test but also the within-home context and the lapse between interview and test (i.e. none for most children). This approach also meant that 9-year-olds in both *Growing Up in Ireland* cohorts would complete the same reading test, albeit that Cohort '98 had completed the test in the classroom setting.

12.2.3.1 Summary of changes for the main fieldwork phase

The questionnaires used in the pilot were to be used in the main data collection stage with the minor changes described. The most notable changes to the principal's materials were the addition of questions on the main language of instruction and specific religious ethos, and the decision not to collect test data on individual children from schools.

12.3 OVERVIEW OF SCHOOL-BASED PILOT

This survey of schools was very similar to those previously conducted by *Growing Up in Ireland*. In contrast to Cohort '98 (but the same as Cohort '08 at 5 years of age), it was necessary to interview families in the home first to find out which school the child was currently attending. The absence of clustering by school, as was the case for Cohort '98 at age 9, also meant that proportionally more schools had to be contacted relative to the number of children. This aspect of the pilot had, however, been anticipated.

Overall, the pilot was very successful in terms of both materials, procedures and response rates. Few changes were required for the main phase. Once again, the Study Team are happy to gratefully acknowledge the participation and support of school management and staff.

A new feature of this pilot in the school was the exploration of the possibility of collecting test scores on individual children from the school. While a high level of co-operation in the exercise of collecting previously completed test scores was received from both families and schools, the Study Team found that there was insufficient consistency in the type, scoring (and timing) of school-administered tests. In the interests of maximising comparisons both within the cohort and between cohorts, it was decided that the Drumcondra Reading Test be administered to all children in the home in the main phase of fieldwork. This would take place at the same time as the home interview. Unfortunately, it was necessary to restrict the testing to just one (Reading) rather than the two used with Cohort '98 to keep the response burden for the child at a reasonable level.

The protocols and instruments used for the pilot were to be retained, largely unchanged, for the main phase. The only changes were the addition of items to the Principal Questionnaire on the main language of instruction and specific religious ethos. The decision was made not to collect test data on individual children from schools, so the questions on the types of test conducted were dropped.



Chapter 13

Conclusion on Pilot and Decisions for Main Phase





13.1 OVERVIEW

This pilot exercise was conducted with the 9-year-olds and their families in Cohort '08, the younger of the two *Growing Up in Ireland* cohorts. Cohort '98 had been interviewed at age 9 just before the start of the recession, while Cohort '08 interviews were taking place as the economy moved into a robust recovery. This offers the possibility for some very informative inter-cohort comparisons, with potential lessons about the impact on children of spending their early years in a period of recession. There were also a number of important policy changes in the period, including the development of an early childhood care and education system. The inter-cohort comparison would allow the effects of these policy changes to be examined as well.

The 9-year interview with Cohort '08 represents the fourth time these children and their families were interviewed in person (with an additional wave of data collection by post at age 7/8). The longitudinal nature of the study allowed for the consideration of changes over time in children's health, socio-emotional development and cognitive development, and also of the way these trajectories were affected by their different family and economic circumstances and other experiences.

As discussed below, the design of the instrumentation was linked to the objectives of the *Growing Up in Ireland* project, including an emphasis on appropriateness to the stage of development of the child and on policy relevance. In order to make the most of the possibilities of comparisons with Cohort '98 and with the situation of Cohort '08 in earlier waves, the design of the instrumentation was undertaken with a view to allowing both types of comparison. At the same time, there was a need to take account of important changes in the lives of children and include items to capture issues such as their use of information technology.

There were also changes to the administration of the survey arising from the sample design. Cohort '98 at 9 years old was selected as a school-based sample. This meant that the school and class of each 9-year-old was known in advance. Cognitive measurement took place in the schools separately from the home visit. This approach was not possible for Cohort '08: the sample was spread much more widely across the country and the child's school could only be identified after the home visit had been made, rather than being known in advance of the home visit. In the absence of clustering by school, the cognitive tests needed to be conducted in the home. This meant that the constraints on space in the home-based interviewing were much more stringent than had been the case for Cohort '98 at 9 years old.

The piloting exercise for this phase was largely successful. A key part was the trialling of alternative modes of self-completion for the Child's Sensitive Questionnaire, but ultimately it was decided to continue with pen-and-paper to avoid mode effects. Another new factor in the pilot was the introduction of the 'map mission', a new test of executive functioning (specifically selective attention). The scoring from this test in the pilot was in line with international norms, but the patterns of association with other measures related to attention, such as the hyperactivity subscale of the Strengths and Difficulties Questionnaire (SDQ), were much more modest than expected. However, in consultation with the international reviewers and the project's Steering Group, it was decided to continue with this new, short test given that *Growing Up in Ireland* has not previously collected any data on this area of cognitive development.

The main issue that needed to be addressed, as identified in the pilot, was the response burden for participating households. This was especially the case for child respondents since, as noted above, the participants needed to complete all components within the home visit. To a large extent, this had been anticipated by the Study Team and hence only the Reading part of the Drumcondra tests was administered in the pilot (children in Cohort '98 had done both Reading and Maths tests). Despite this change, the burden for 9-year-olds in the current pilot was still too onerous – especially as many would be participating in the evenings after a day at school. This meant that the Study Team had to make some difficult decisions in removing material from both the child and parent instruments in order to reduce the time required from participants.



13.2 CRITERIA FOR SELECTING ITEMS FOR INCLUSION/EXCLUSION POST-PILOT

In evaluating which individual items or components would be removed to reduce the burden on respondents, the Study Team was primarily guided by the criteria that had guided the initial formulation. These were:

- Importance of the measured concept for development
- Quality of the measure for the intended concept
- Policy relevance
- Longitudinal consistency
- Inter-cohort consistency
- Feasibility of the measure for a home-based survey
- Added value of the measure (i.e. presence of related measures in the instrumentation or data available from other sources)
- Time-urgency of the measure (i.e. already collected in *Growing Up in Ireland* or could be collected at another wave instead)
- Acceptability of the measure to respondents

13.3 SUMMARY OF MAJOR CHANGES TO THE HOME-BASED PILOT FOR MAIN PHASE

The changes have been detailed in the preceding chapters, and a more complete overview is presented in the executive summary at the start of this report. Below is a summary of the more significant changes/decisions for the main data collection for the Cohort '08 9-year-old wave.

Child self-completion mode: Although the Study Team actively explored the possibility of a digital self-complete mode for the Child Self-Complete Questionnaire – comparing pen-and-paper, tablet and laptop options in the pilot – the possibility of mode effects could not be safely ruled out. Hence, it was decided that the main phase would use a pen-and-paper mode to safeguard inter-cohort consistency with the Cohort '98 data at the same age.

Support for those with literacy difficulties: In order to be as inclusive as possible, an audio-recording of the paper questionnaire was prepared to help less-confident readers. The paper questionnaire also made it easier for interviewers to block out potentially upsetting questions for individuals using colourful stickers (e.g. to obscure the question on pets if the child had been upset over the recent demise of the family dog).

Parenting style measure: In the pilot, children had completed a separate questionnaire for each parental figure (mum/dad/mum's partner/dad's partner) using the same adapted Parenting Style Inventory as completed by 9-year-old participants in Cohort '98. This, however, was identified in the pilot as a time-consuming exercise for the child and family because (a) the inventory was to be completed for up to three parental figures (e.g. mum, mum's resident partner and non-resident dad); and (b) several minutes were needed with the Primary Caregiver to establish the correct configuration of forms to be presented to the child. In addition, while the use of this measure maintained inter-cohort consistency, longitudinal consistency within-cohort was lost because in previous waves a different parent-reported measure had been used. For the main phase, it was decided to revert to the parent-report measure used previously with this cohort – both to maintain longitudinal consistency and reduce the response burden on the child.

Social welfare payment details: In previous waves of *Growing Up in Ireland*, detailed information was collected on the exact nature of social welfare payments received by the household. This required the Primary Caregiver to read through a list of 40+ payments and indicate which were received by any member of the household. Given the pressing need to reduce response burden at this wave, and the fact that data on social welfare receipt by families was collected through other national surveys, it was decided to remove the question on type of payment for the main phase. The Primary Caregiver's estimate of the proportion of total household income that came from social welfare payments was retained.



Simplification of information sheets and consent forms: Following feedback from interviewers and the Steering Group, there were substantial revisions to the information sheets and consent forms for both parents and children. Before the Main Study, these documents were reviewed by the National Adult Literacy Association and subsequently awarded their 'Plain English' mark for clarity.

13.4 DECISIONS ON THE SCHOOL-BASED DATA FOR THE MAIN PHASE

Overall, the pilot was very successful in terms of protocols, instrumentation and response rates. Few changes were required for the main phase. It was decided to proceed with data collection from the school principal on him/herself and on the school in general, on the 9-year-old's teacher on him/herself, and on the 9-year-old. Since the identification of the school required prior completion of the home-based questionnaire, the school-based phase would take place after the home-based phase.

The protocols and instruments used for the pilot were to be retained with only very minor changes. The decision was made not to collect test data on individual children from schools, so the questions on the types of test conducted in the school were dropped.



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