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**THE PLANNING AND USE OF SPACE IN
IRISH HOUSES 1730 to 1830**

VOLUME 2 OF TWO VOLUMES

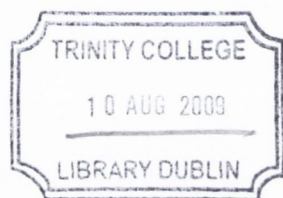
ILLUSTRATIONS

**A thesis submitted to the University of Dublin
for the Degree of Doctor of Philosophy**

PATRICIA A. McCARTHY

**UNIVERSITY OF DUBLIN, TRINITY COLLEGE
Department of the History of Art and Architecture**

2009



THESIS

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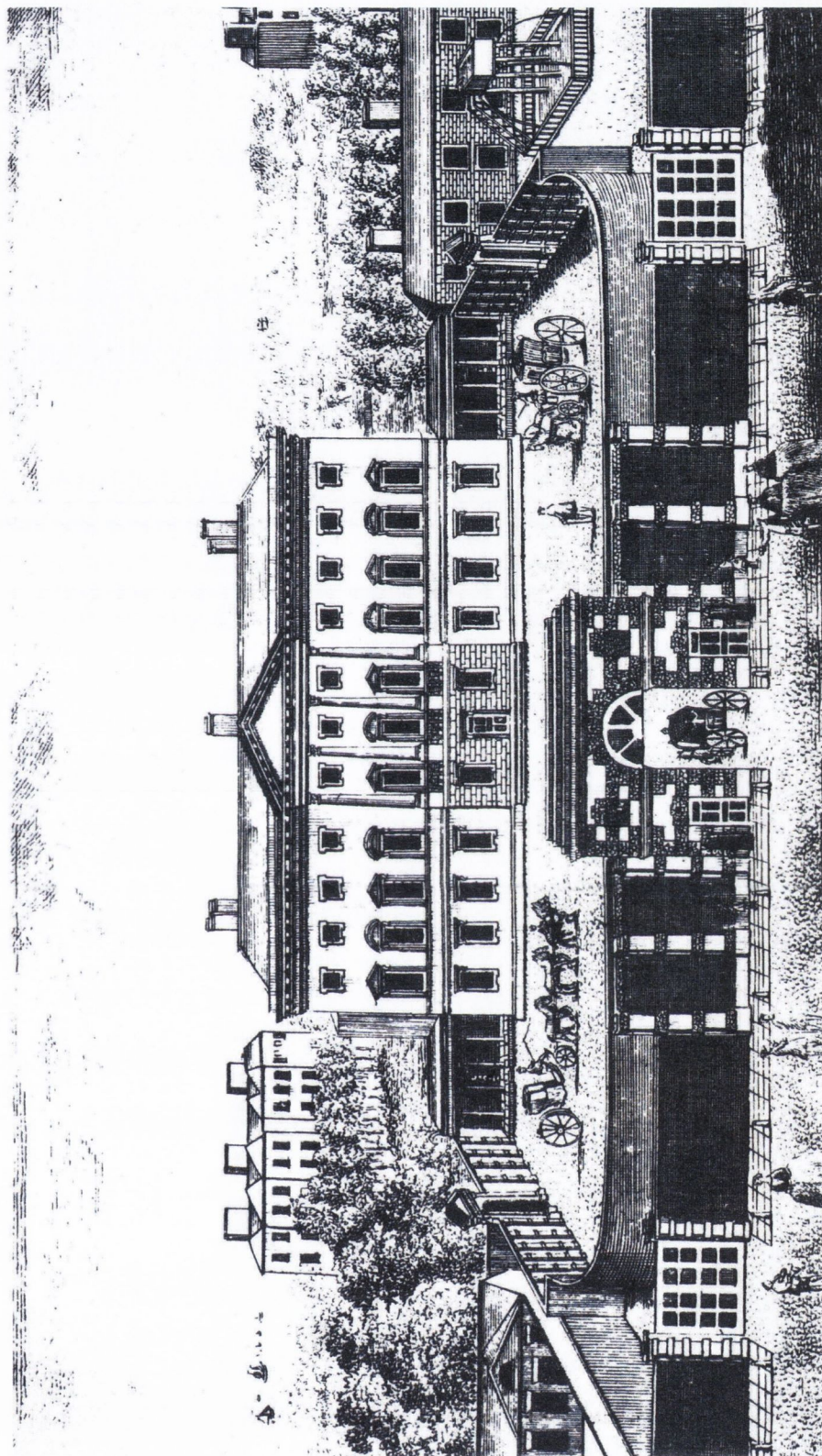


Fig. 1.1

A vignette from John Rocque, *A Survey of the City, Harbour, Bay and Environs of Dublin* (Dublin 1757) shows the forecourt of Kildare (later Leinster) House.



Fig. 1.2 George Cuitt, *Molesworth Street from the Hibernian Hotel 1820*. Kildare (Leinster) House and its monumental gateway terminate the view up the street.



Fig. 1.3 James Malton, *View of the Provost's House and Trinity College, Grafton Street, 1796*.



Fig. 1.4 Aldborough House, Dublin, engraving by William Skelton, 1796.

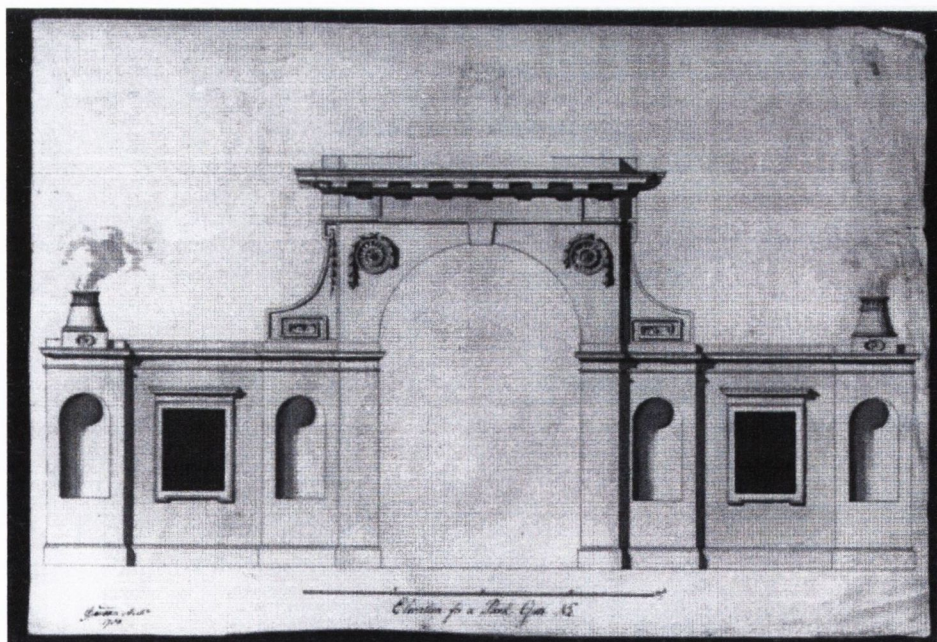


Fig. 1.5 Emo Court, county Laois, design by James Gandon 1780, for entrance gates.

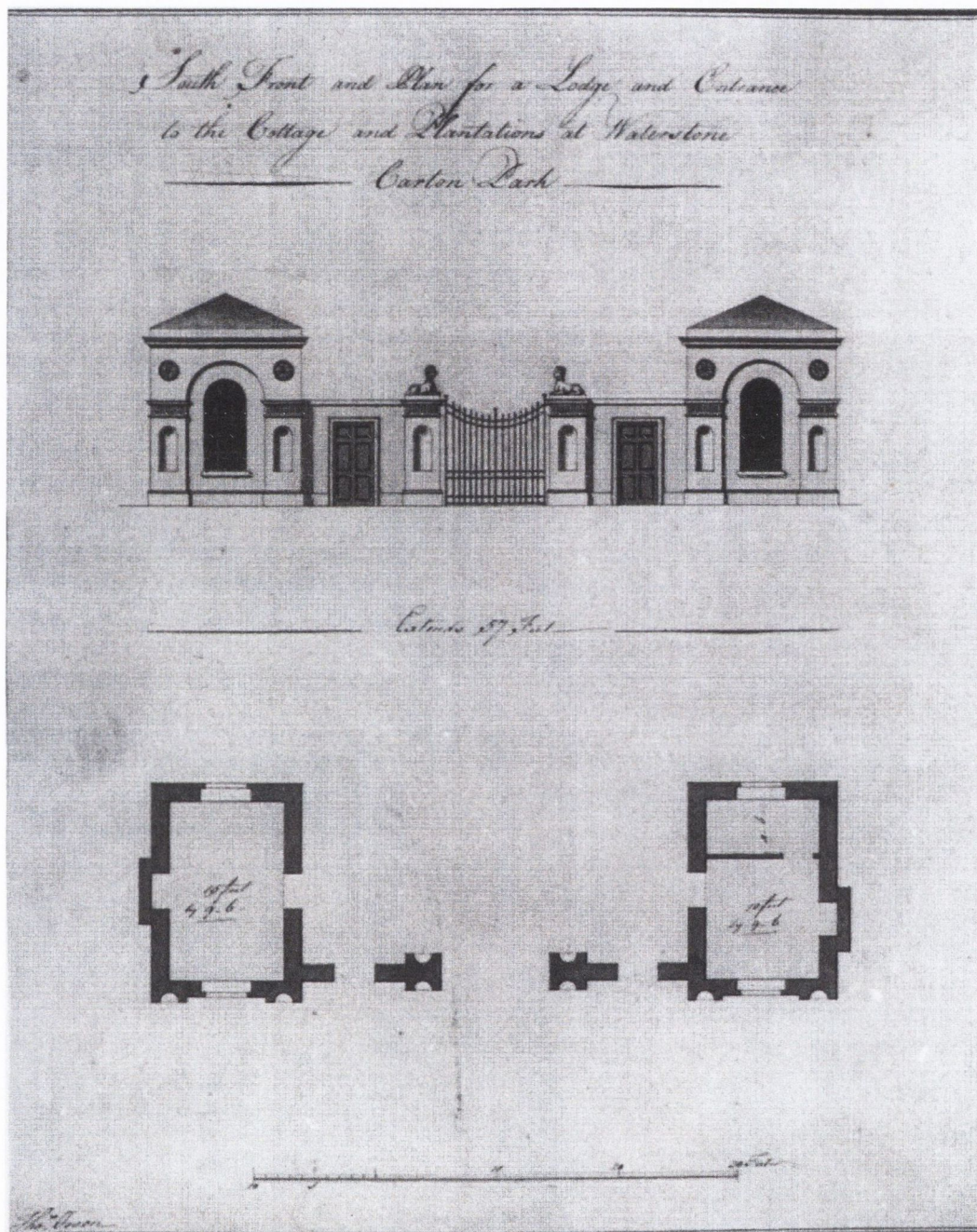


Fig. 1.6

Carton, county Kildare, 'South Front and Plan for a Lodge and Entrance to the Cottage and Plantations at Waterstone', (built as Maynooth Gate). Design by Thomas Owen.

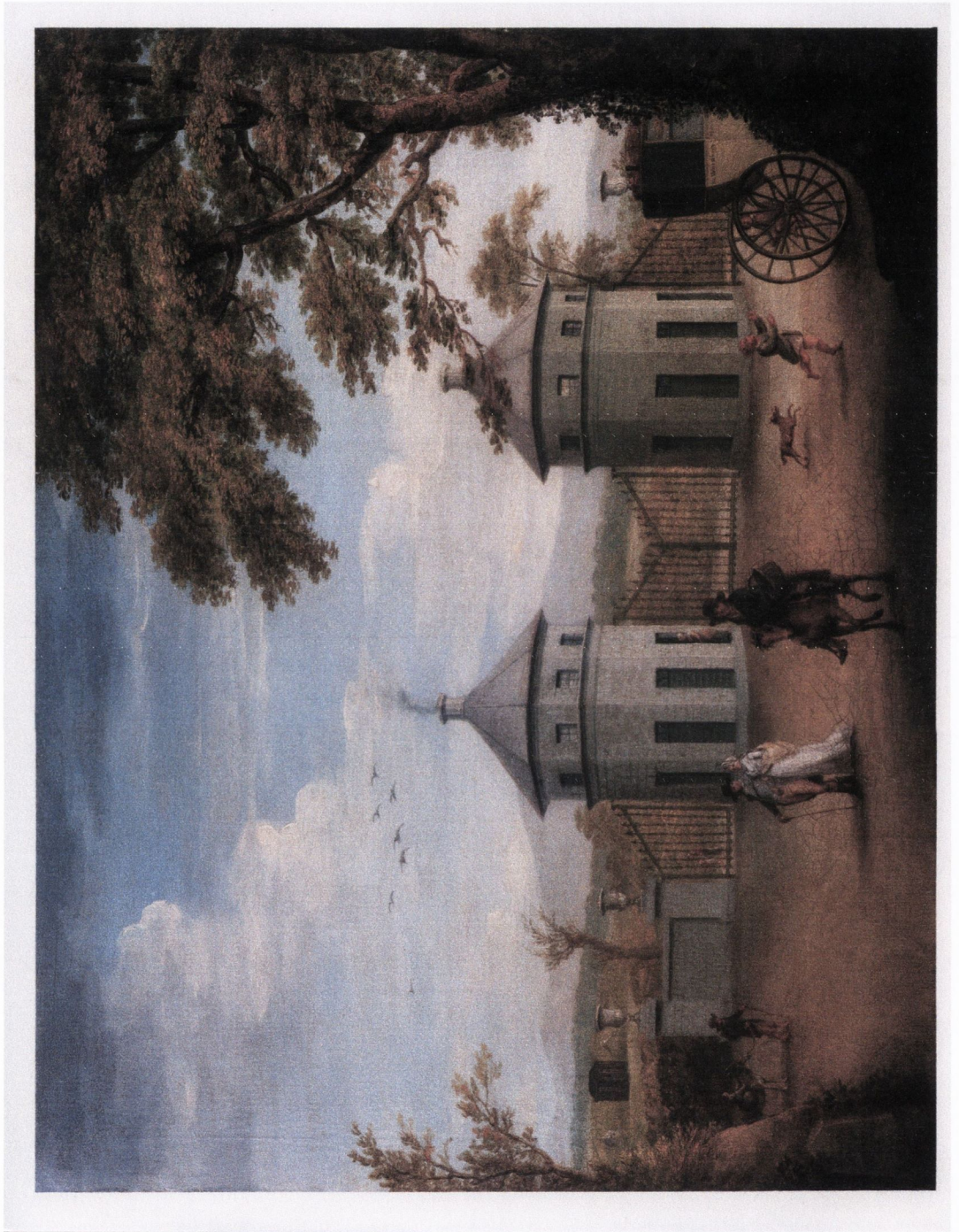


Fig. 1.7

Robert Woodburn, *The gates of Belline, Piltown, County Kilkenny*
(1800)



Fig. 1.8a Anon., *View of Stradbally House and garden, c. 1740.*



Fig. 1.8b Detail of above.

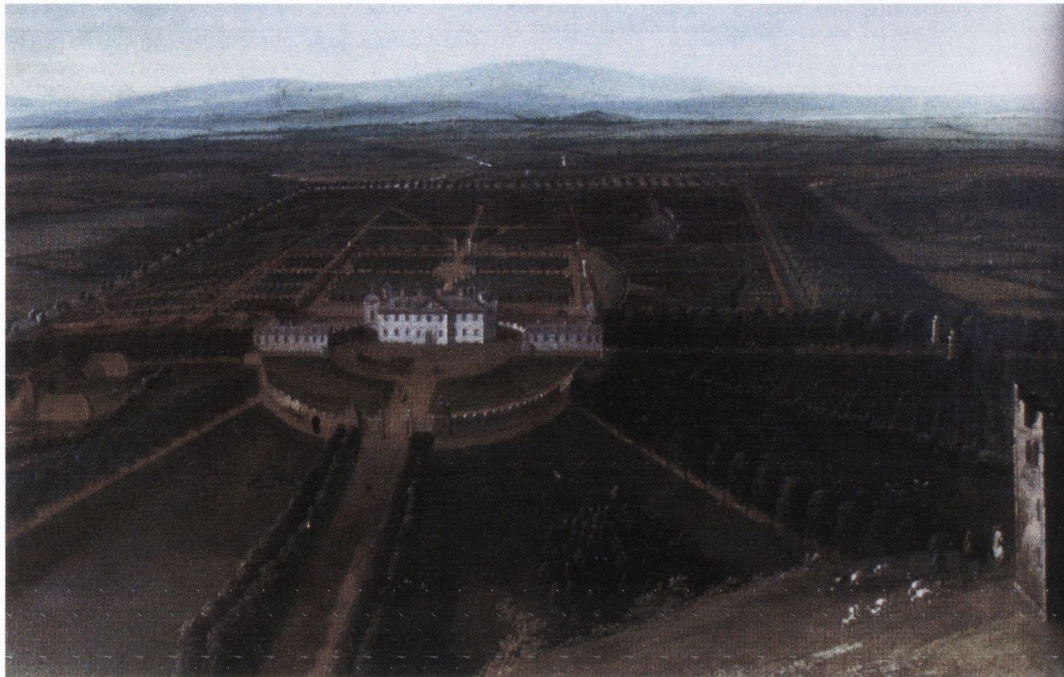


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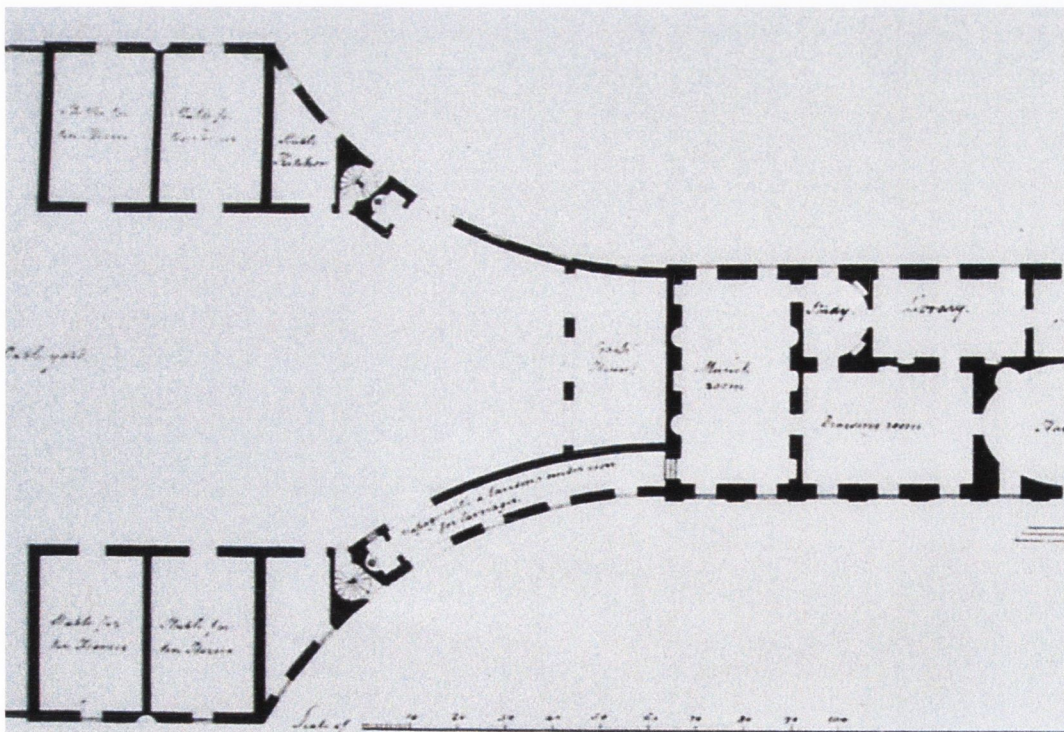


Fig. 1.10 Charleville Forest, county Offaly, proposed ground floor plan by James Byres, 1789, detail showing entry from forecourt to stable yard.

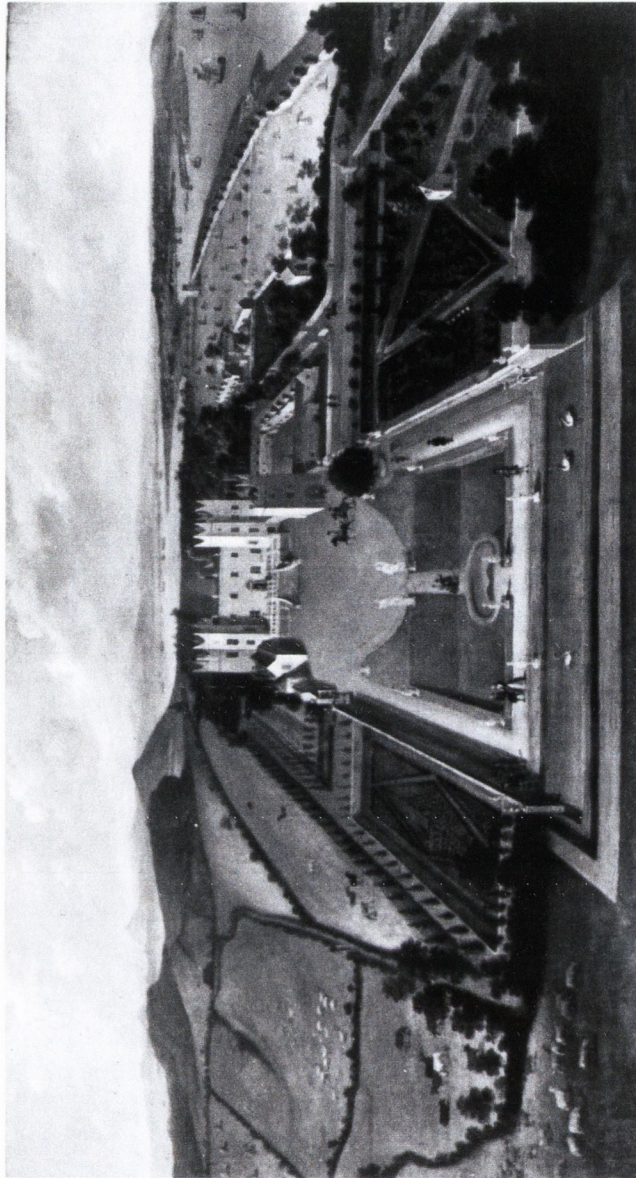


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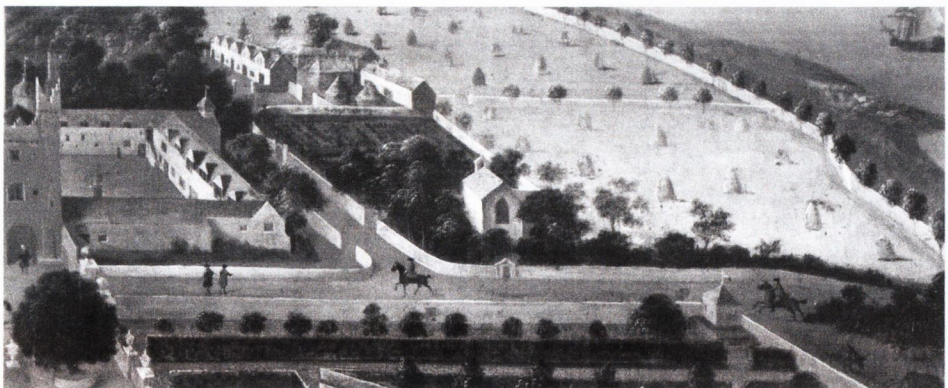


Fig. 1.12 Detail of *Howth Castle*

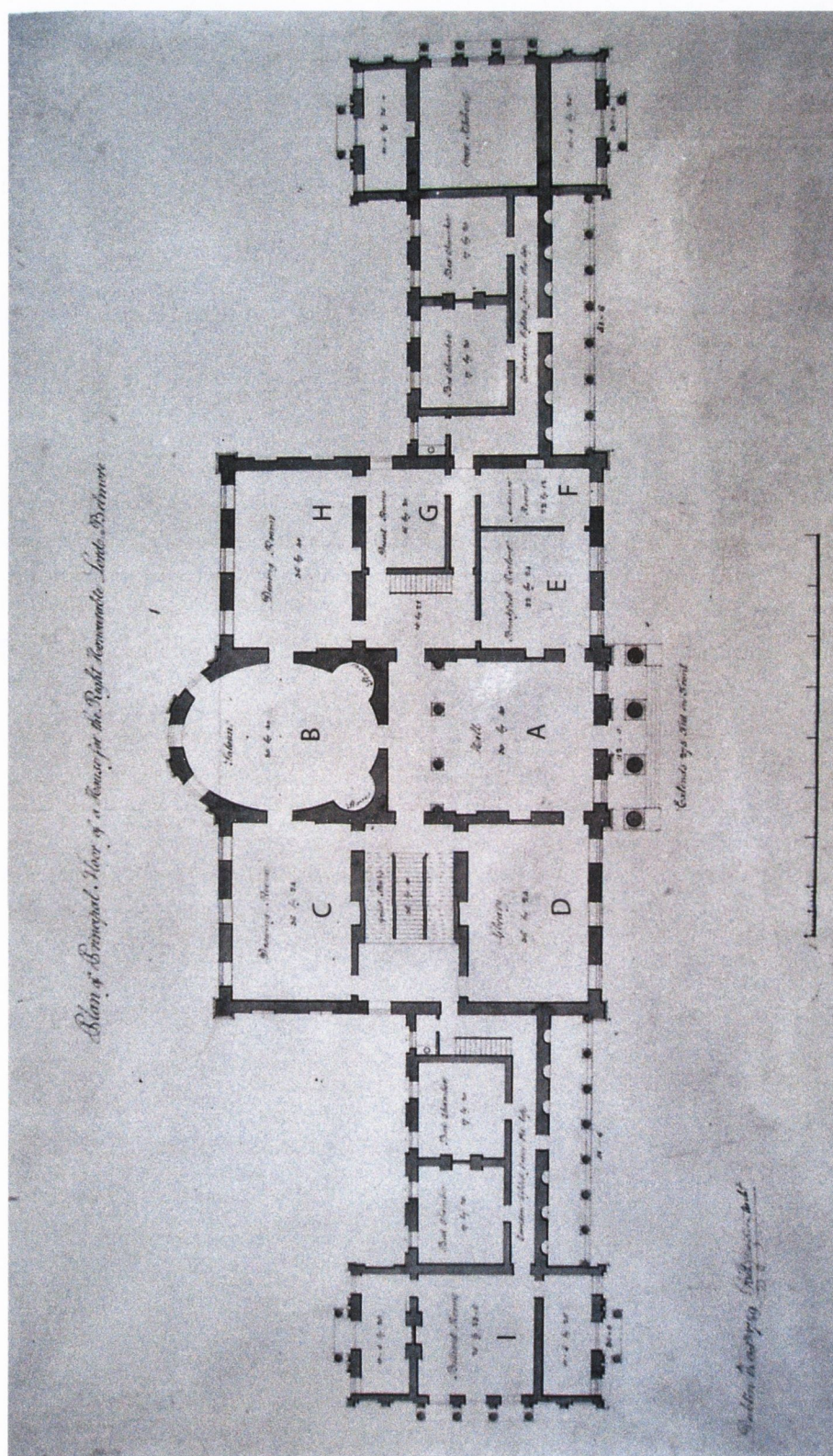


Fig. 1.13 Castle Coole, Plan of Principal Floor of a House for the Right Honorable Lord Belmore by Richard Johnston, 1789.

Key: A. Hall, B. Saloon, C. Drawing room, D. Library, E. Breakfast parlour, F. Audience room, G. Dessert room, H. Dining room, I. Billiards room.

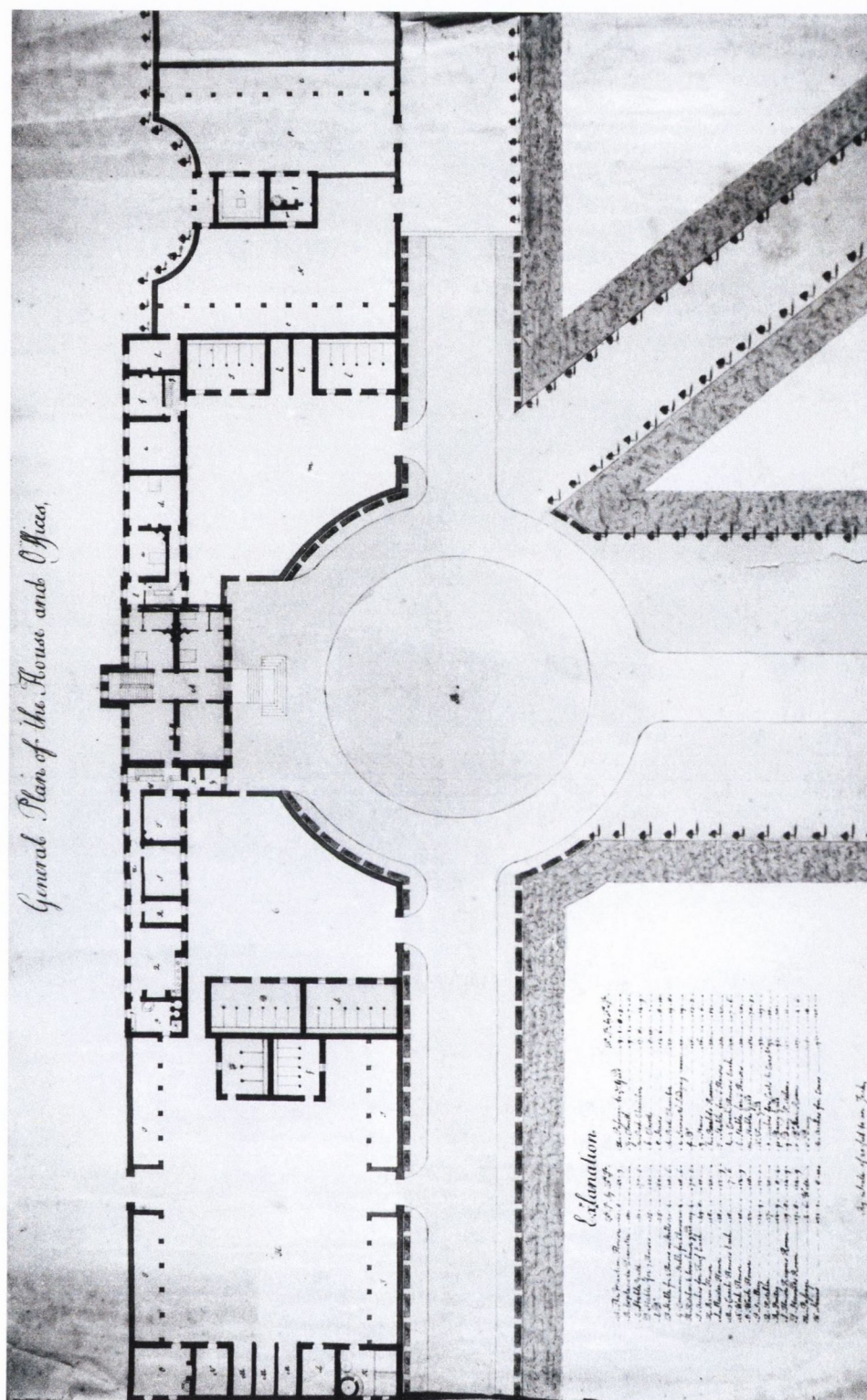


Fig. 1.15

Castle Coole, General Plan of the House and Offices, by Richard Castle, after 1730.

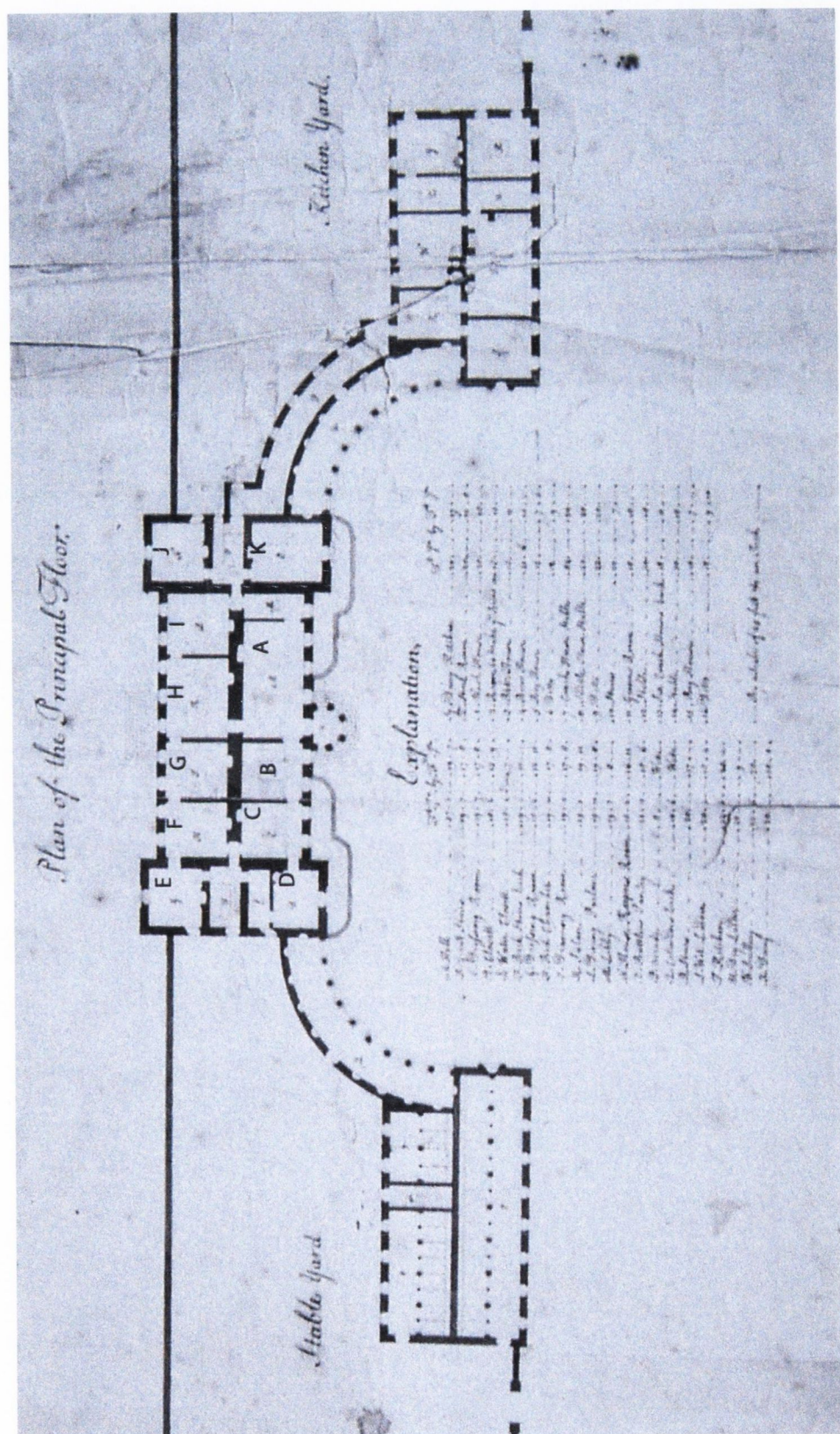


Fig. 1.16 Carton, Plan of the Principal Floor, by Richard Castle, c. 1739.

A. Hall, B. Great stairs, C. & E. Dressing rooms, D. Closet, F. Bedroom, G. Drawing room, H. Saloon, I. Dining parlour, J. Housekeeper's room, K. Butler's Pantry.

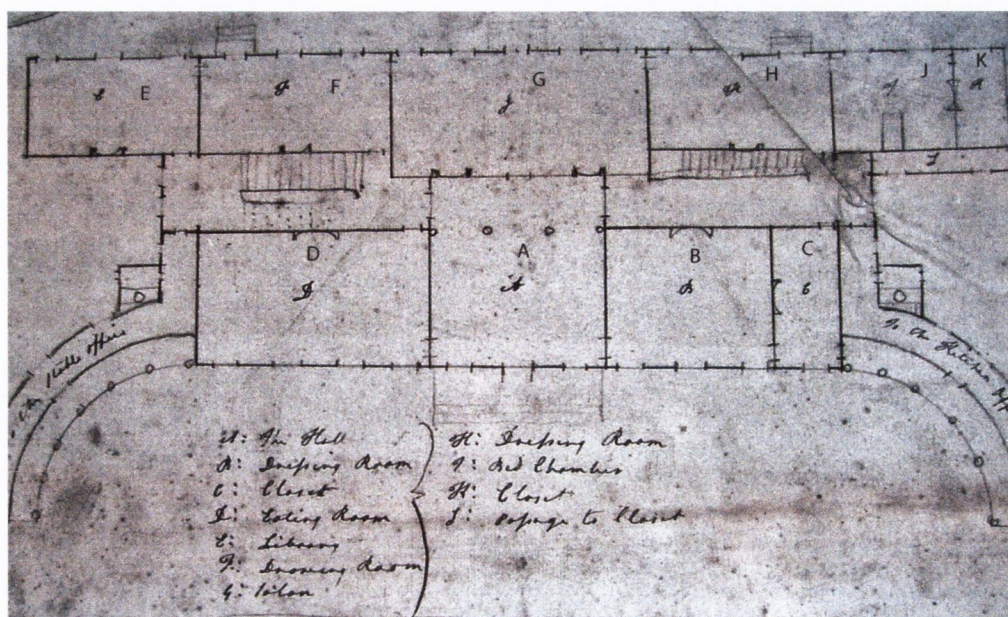


Fig. 1.17 Carton, ground-floor plan said to be by the marquis of Kildare (1762).

A. Hall, B. Dressing room, C. Closet, D. Eating room, E. Library, F. Drawing room, G. Salon, H. Dressing room, J. Bed chamber, K. Closet

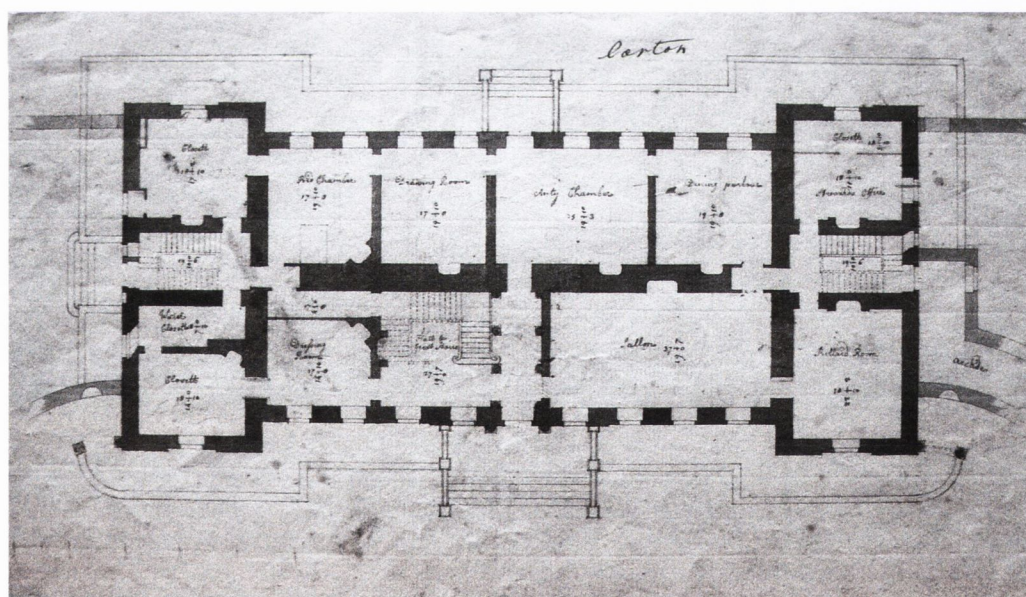


Fig. 1.18 Carton, proposed ground floor plan by Richard Castle, c. 1739.

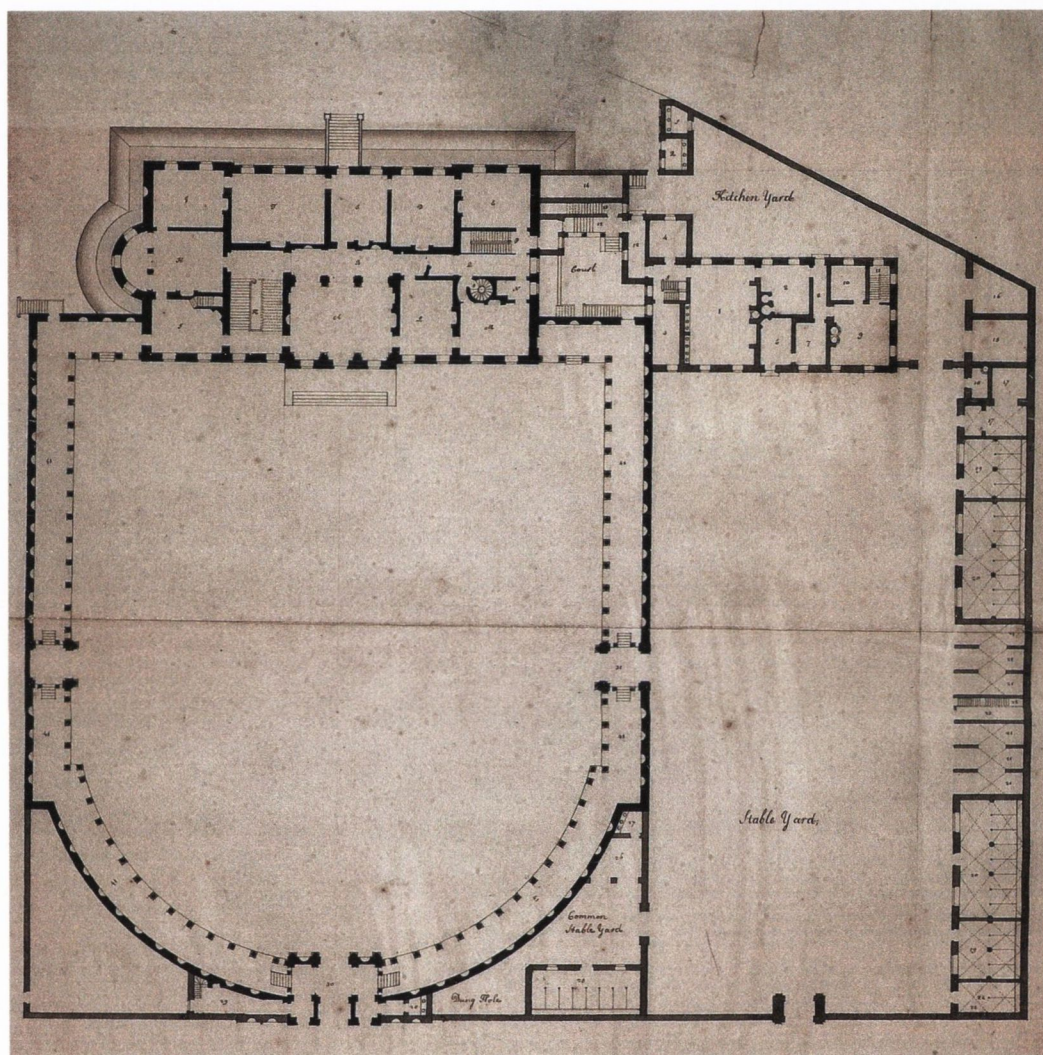


Fig. 1.19 Kildare House, Dublin, plan of the ground floor of the house and offices by Richard Castle, c. 1745.

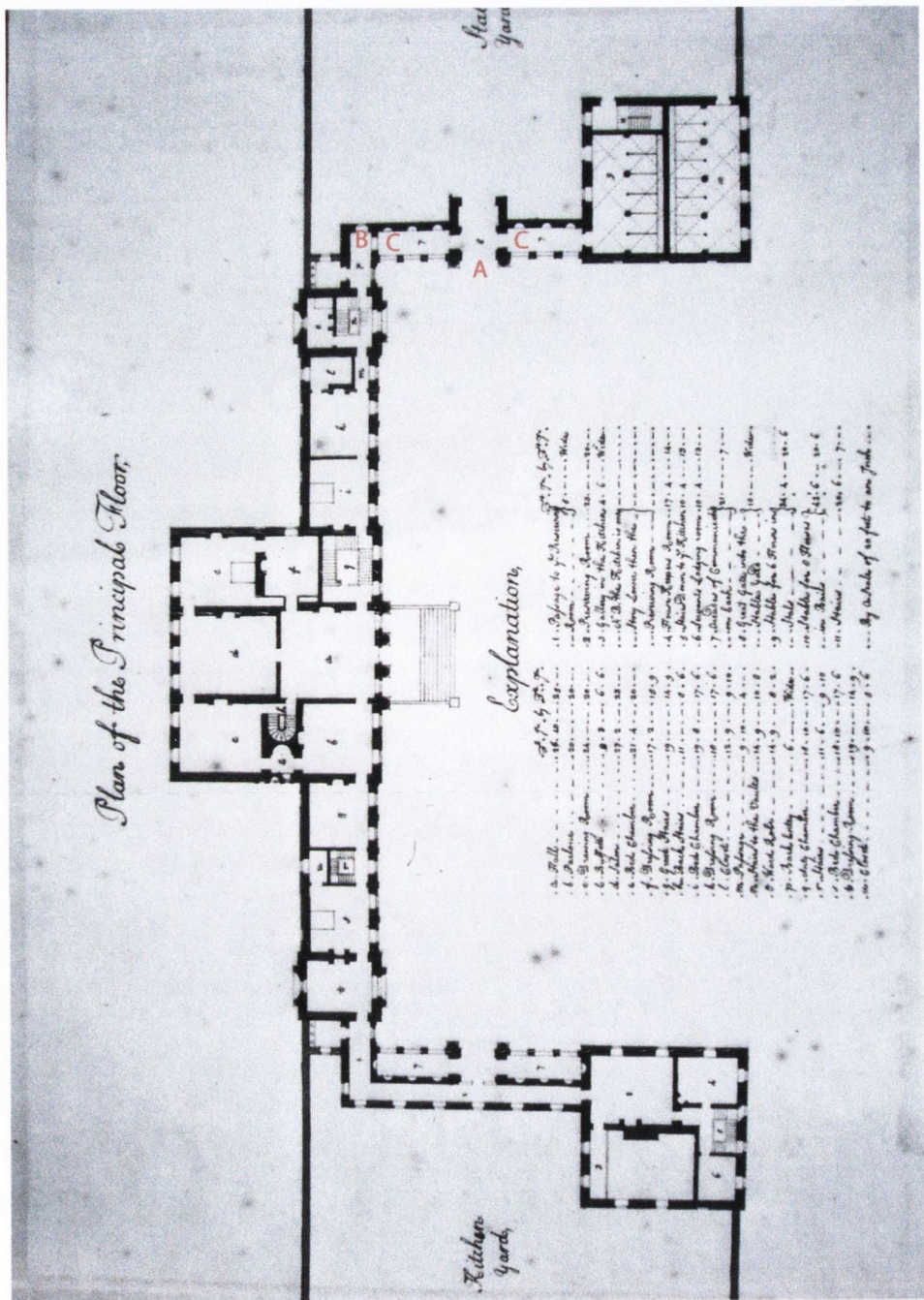


Fig. 1.20

Headfort, county Meath, Plan of the Principal Floor by Richard Castle, c. 1750.

A. Great Gate into stable yard, **B.** Back entry, **C.** Arcade of Communication.

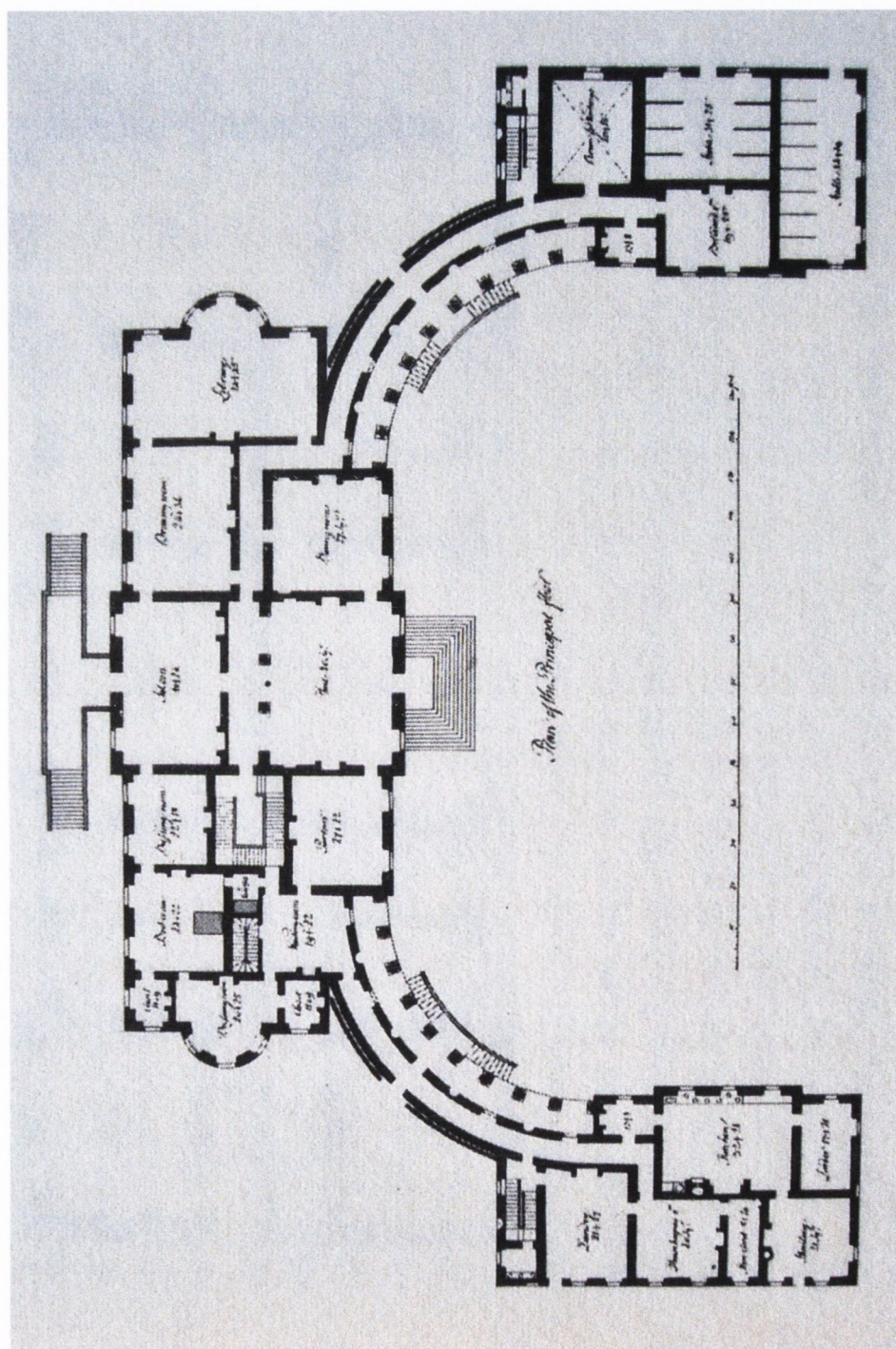


Fig. 1.21 Headfort, county Meath, Plan of the Principal floor by Sir William Chambers, 1765.

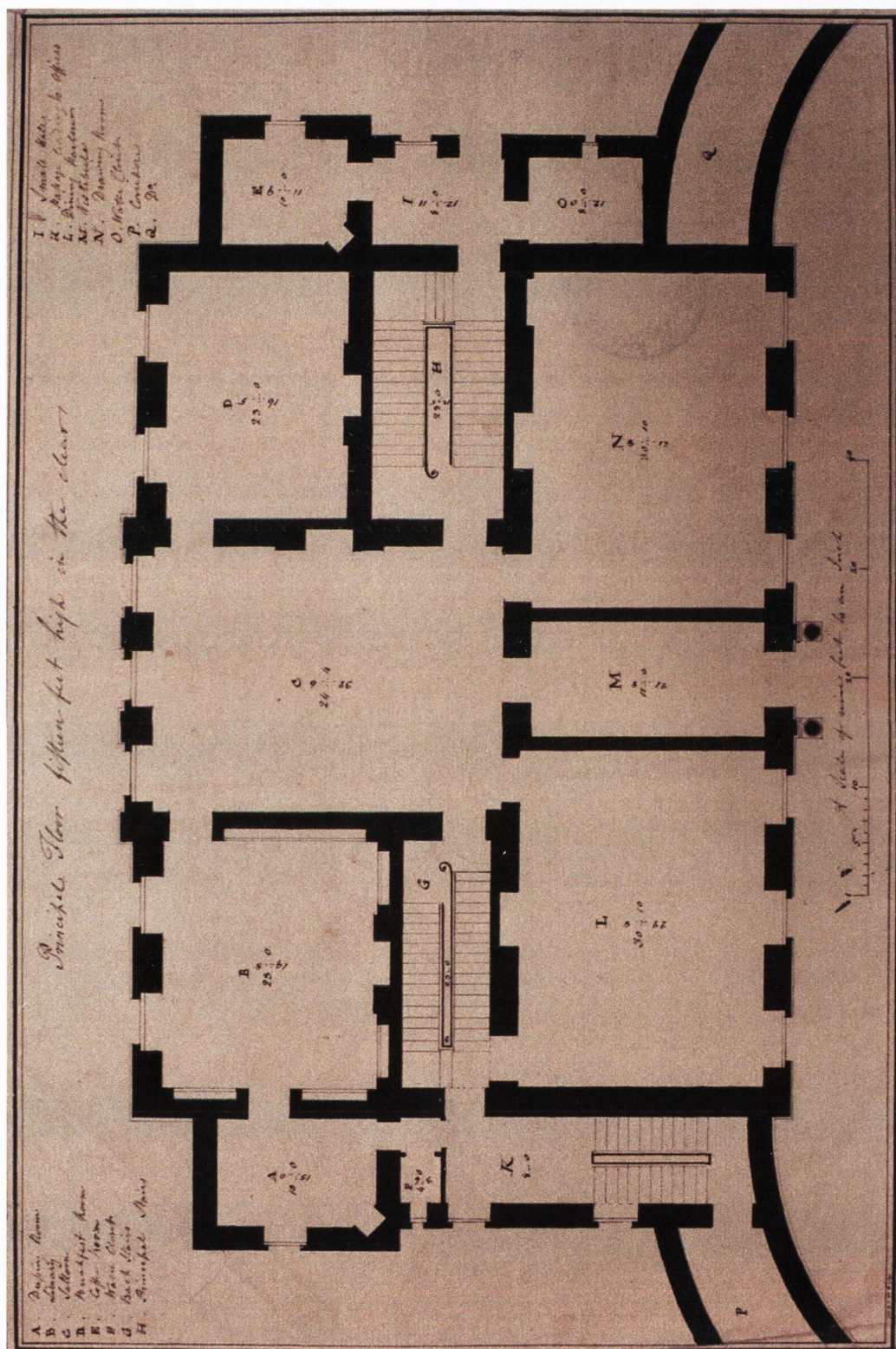


Fig. 1.22

Ardbraccan House, county Meath, plan of principal floor as executed.

A. Present story is proposed under "The New way", in which article in the Mercury Kitchen Affairs is in the Principal story of the Home news.

12) Get Lytle about a Mercury in the New way related the Principal & Chamber Kings in Civil war in the General History Review.

13) Proposed to place Lady Fort's apartment & the New way in the New way in the level of the Chamber story.

than in this plan endeavored to remedy as far as was in my power the defect in the original plan, and I believe I have succeeded in removing some of the most objectionable of them. — The approval of the Executive from and their communications are now as proposed in the plan submitted; the great retention of this plan is however a great objection to it, as well as several of the amendments as being connected with the satisfaction of the Legislature. — The Army is not of all in favor of the plan, what with their great opposition the idea of those have united rather than of our harmonious whole.

18. 10.

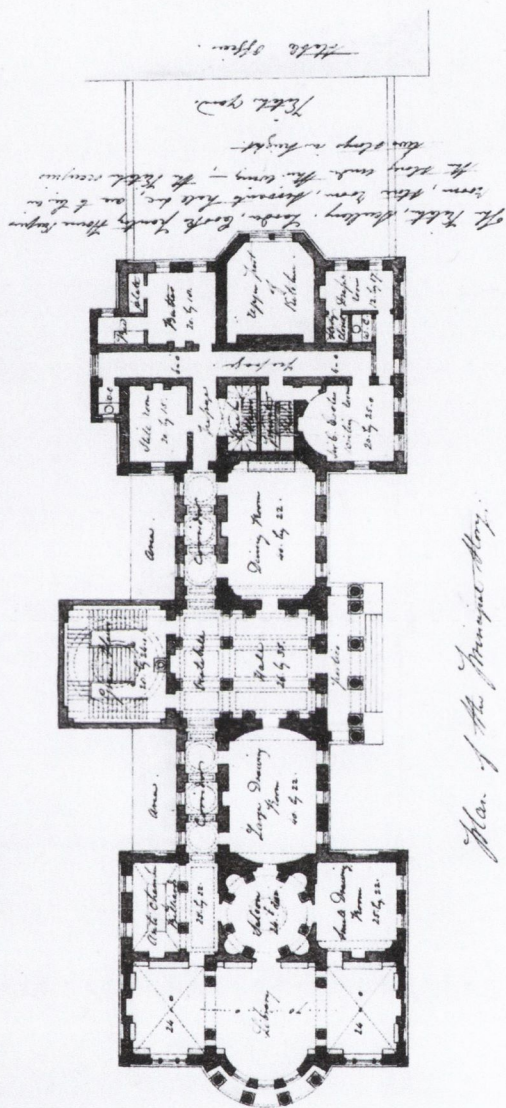


Fig. 2.1

Ballyfin, county Laois, early plan of the ground floor by Richard and William Vitruvius Morrison, *c.* 1822.

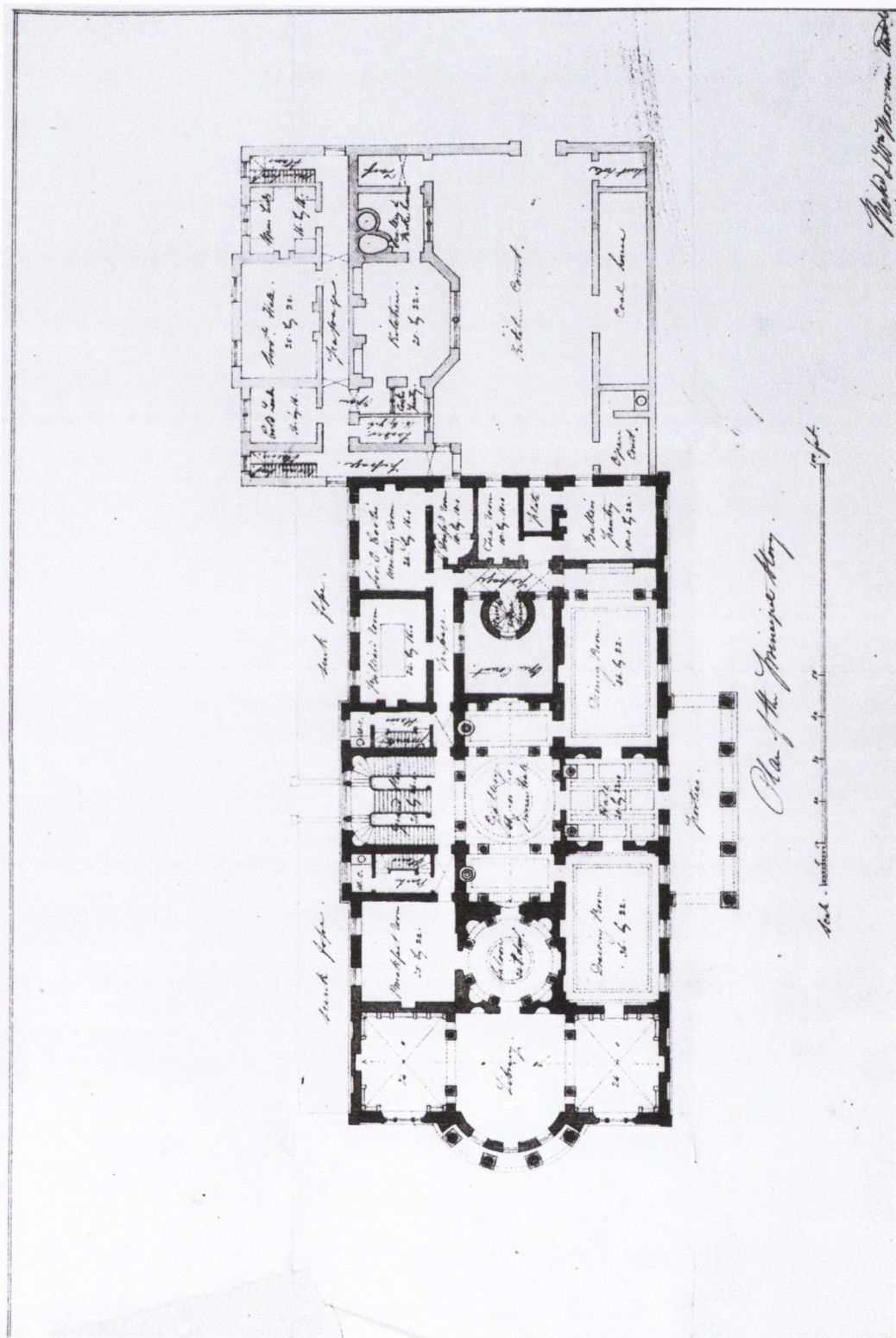


Fig. 2.2

Ballyfin, county Laois, plan of the ground floor by Richard and Willam Vitruvius Morrison, c. 1822.

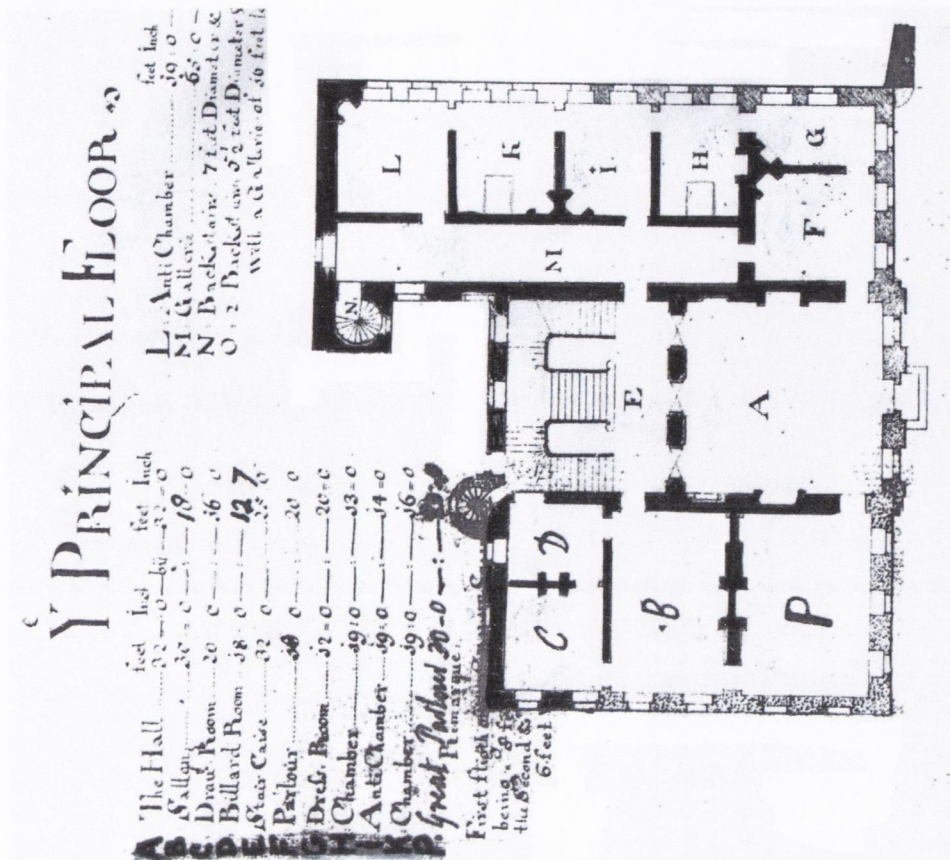


Fig. 2.4 Dromoland House, county Clare, plan of ground floor by John Aheron, 1740s.

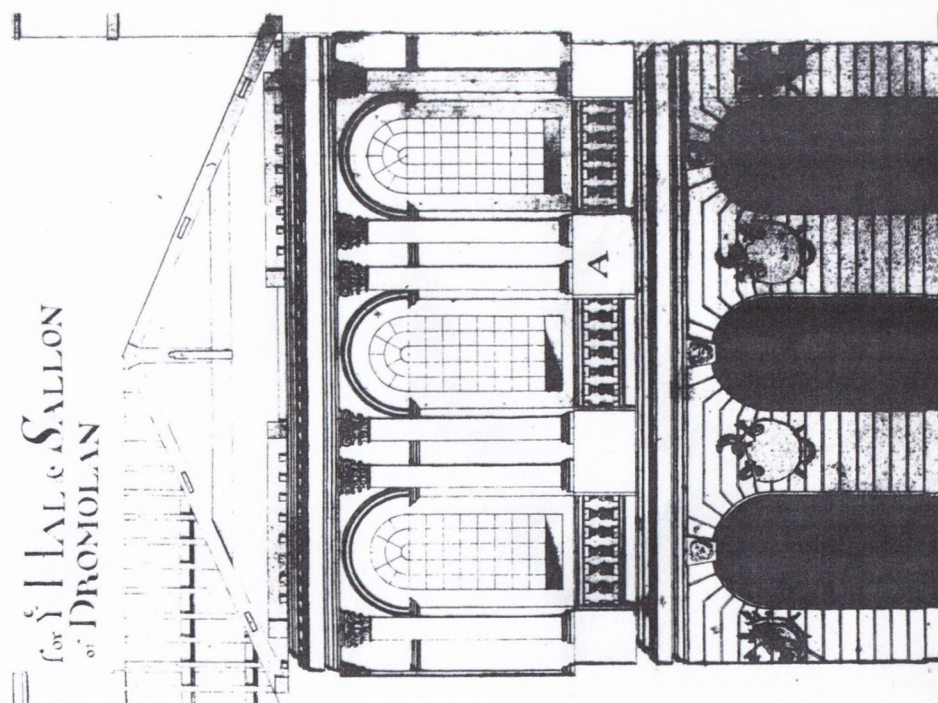


Fig. 2.5 Dromoland House, county Clare, section of two-storey hall by John Aheron, 1740s.



Fig. 2.6 Roundwood, county Laois, staircase hall.

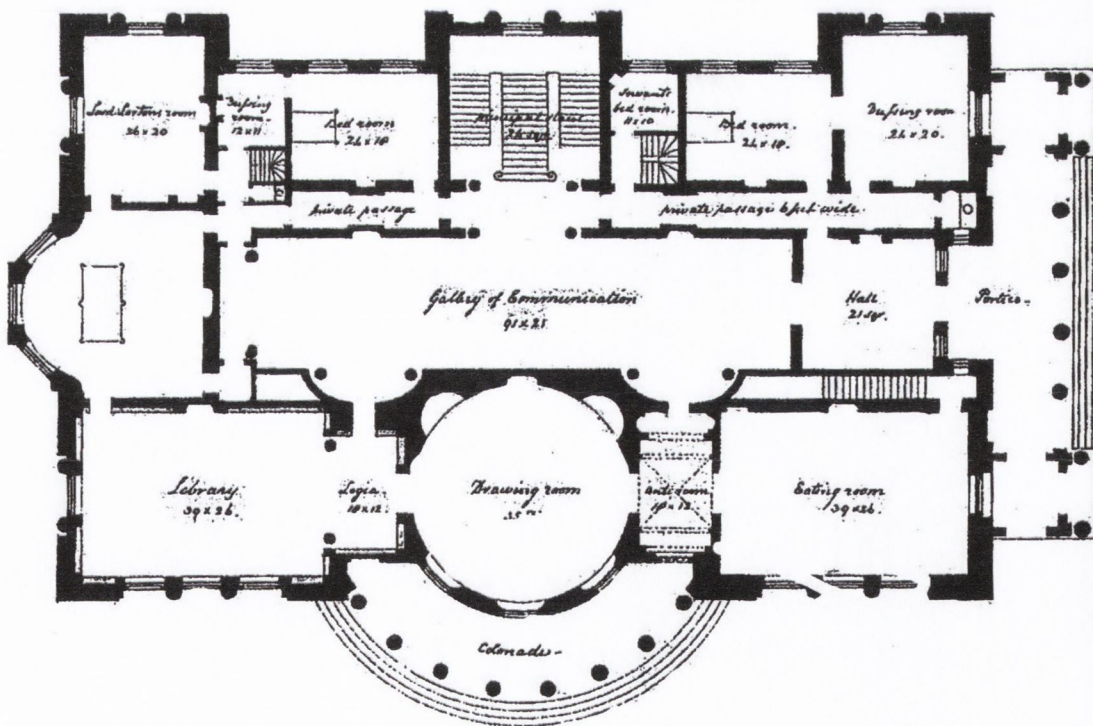


Fig. 2.7 Rockingham, county Roscommon, plan of ground floor by John Nash, 1809.

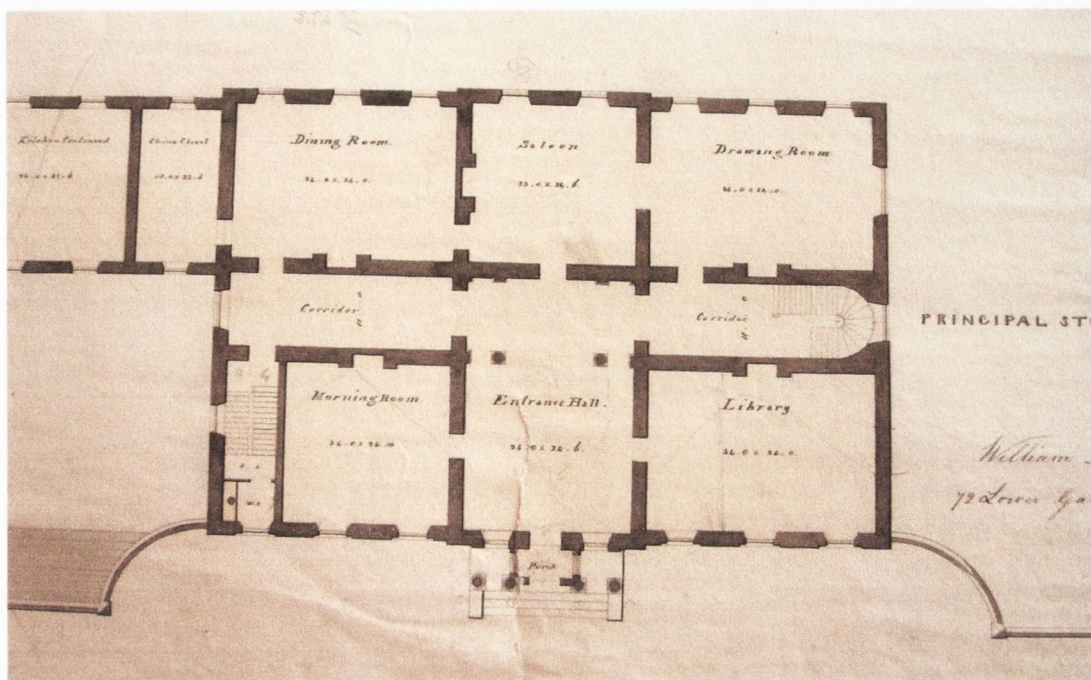


Fig. 2.8 Castle Dillon, county Armagh, plan of ground floor by William Murray, 1842.

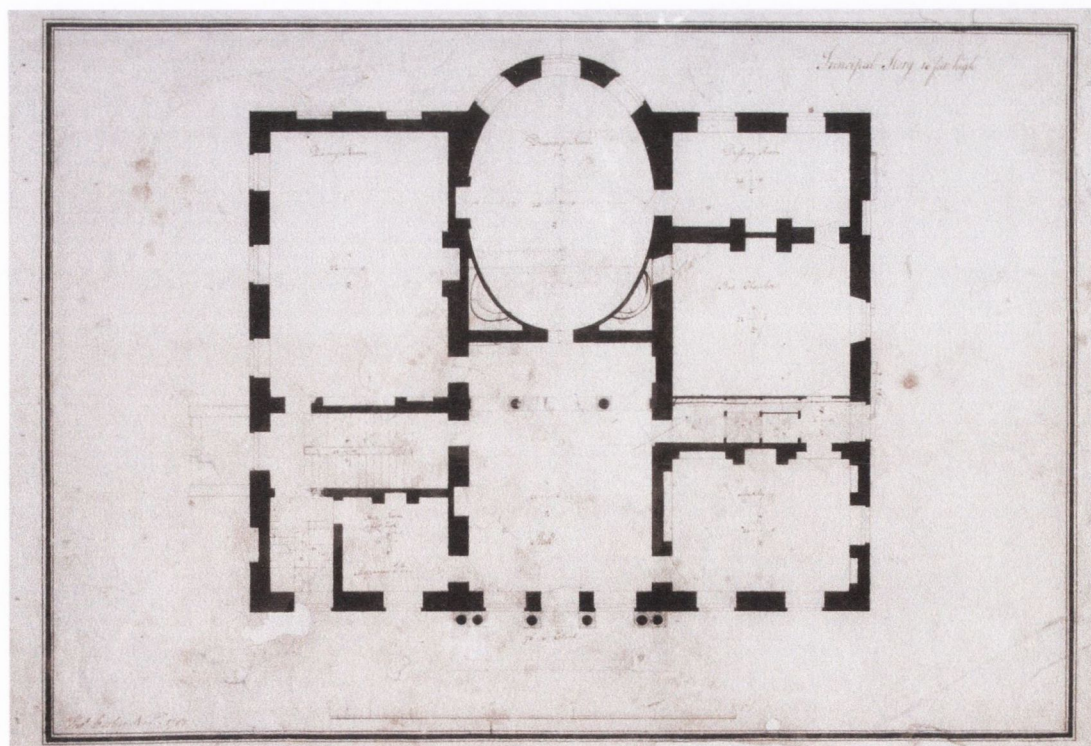


Fig. 2.9 Mount Kennedy, county Wicklow, plan of ground floor, drawn by Thomas Cooley, 1781.

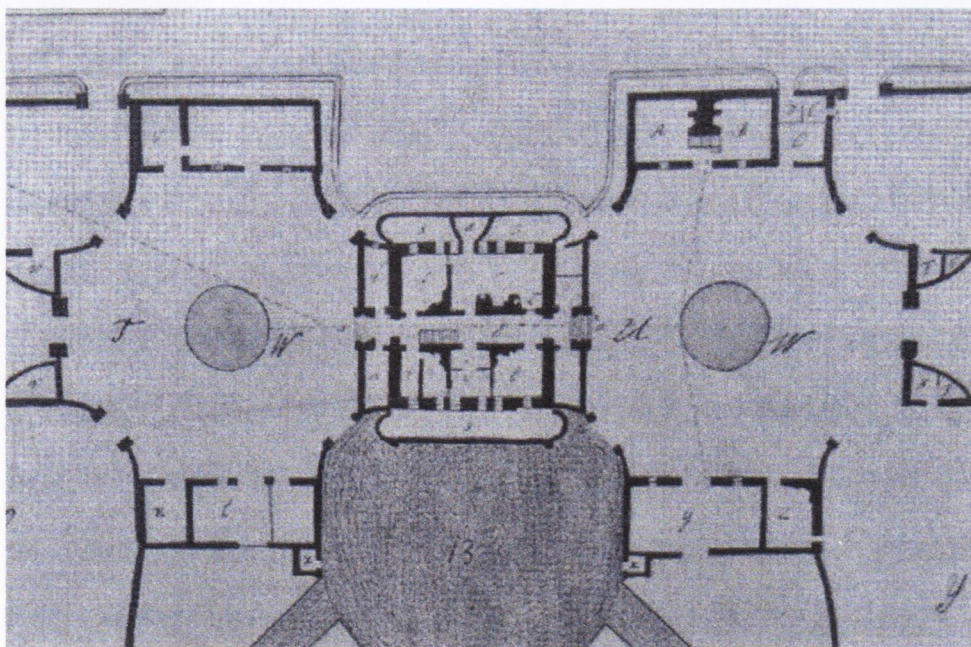


Fig. 2.10 Barbavilla, county Westmeath (c. 1730), detail of plan showing spinal corridor.

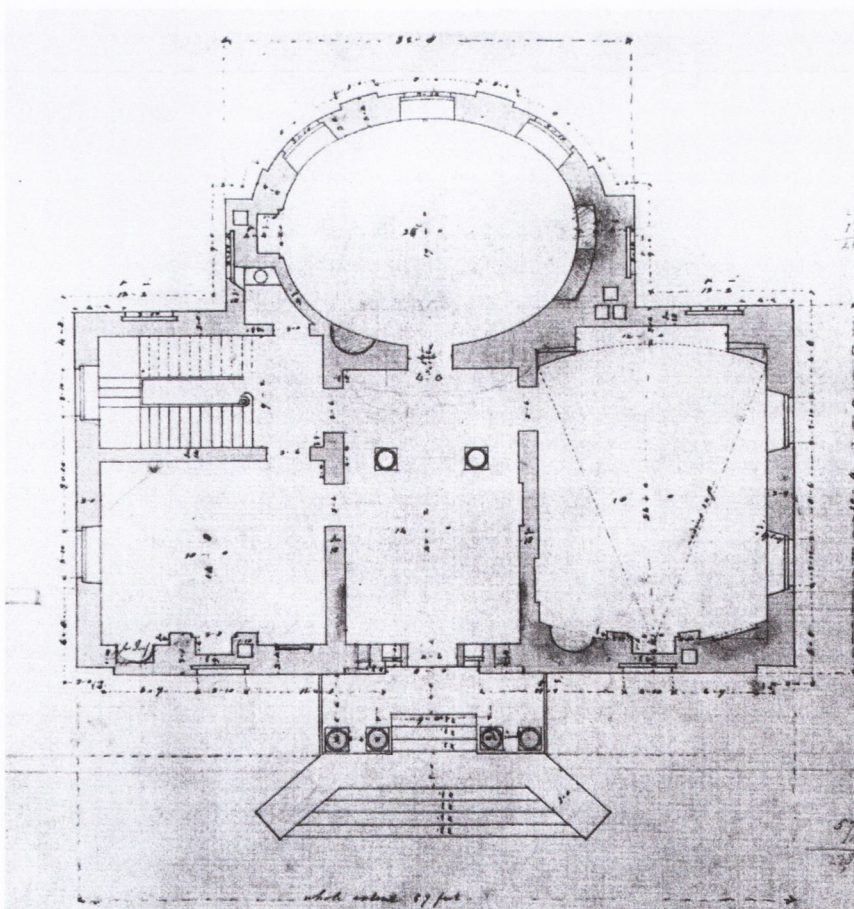


Fig. 2.11 Carriglas, county Longford, plan of ground floor by James Gandon, c. 1795. Note there is no service staircase.

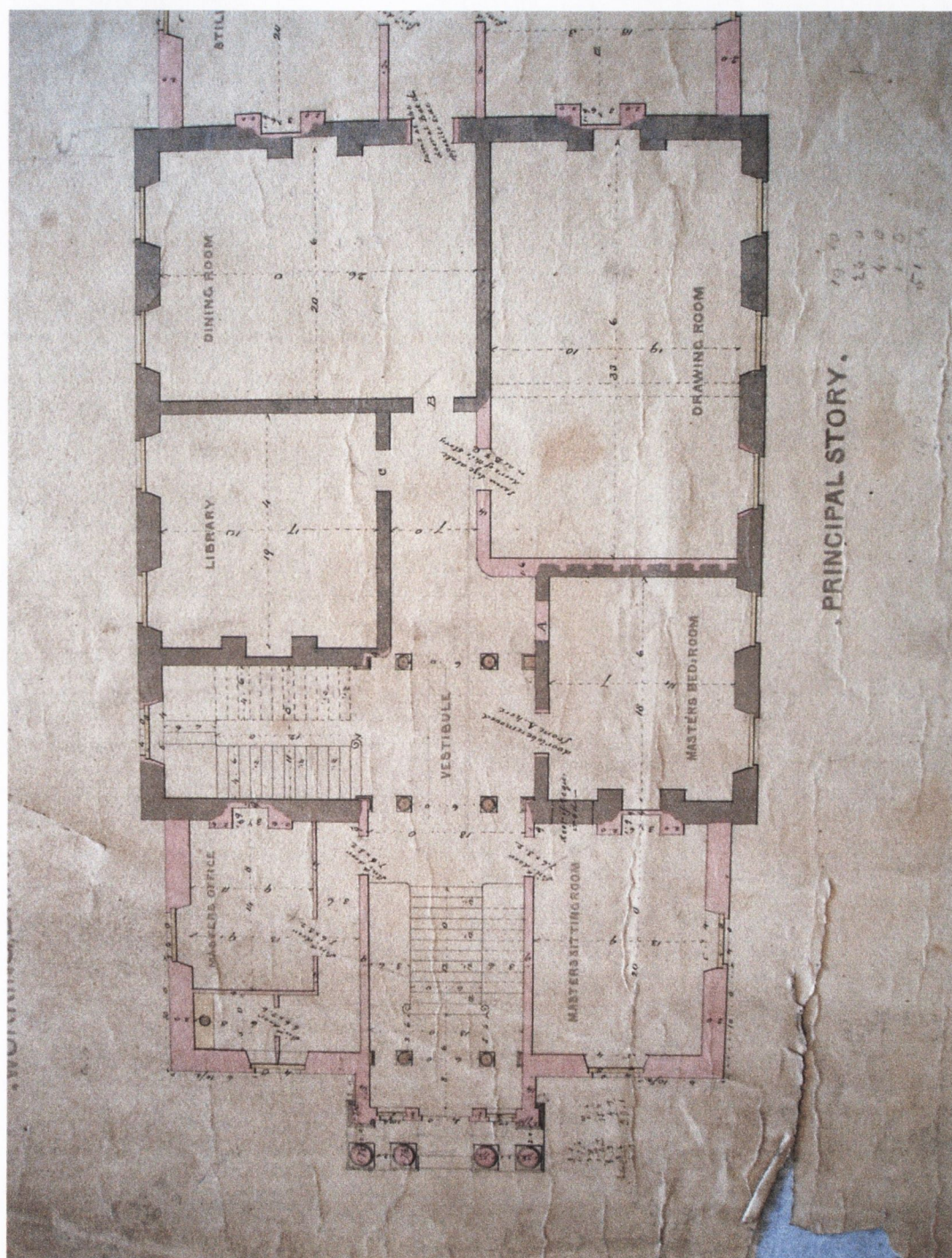


Fig. 2.12 Roxborough Castle, county Tyrone, working drawing of ground floor by William Murray, 1841.

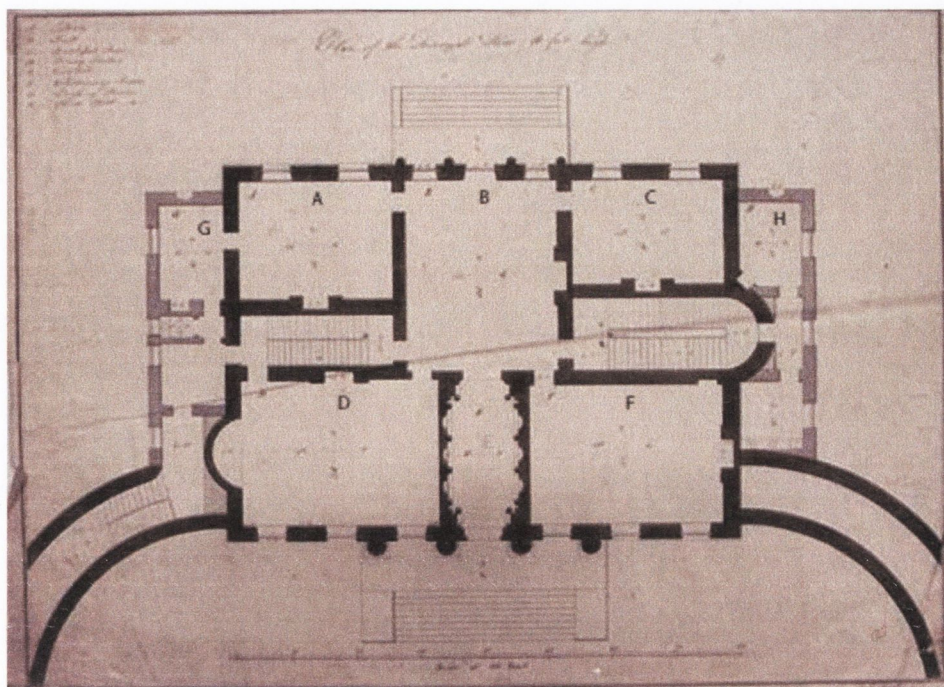


Fig. 2.13 Ardbraccan, county Meath, plan of ground floor by Daniel Augustus Beaufort, 1774.

Key: **A.** Library, **B.** Hall, **C.** Breakfast room, **D.** Dining parlour, **E.** Vestibule, **F.** Withdrawing room, **G.** Dressing room, **H.** China closet

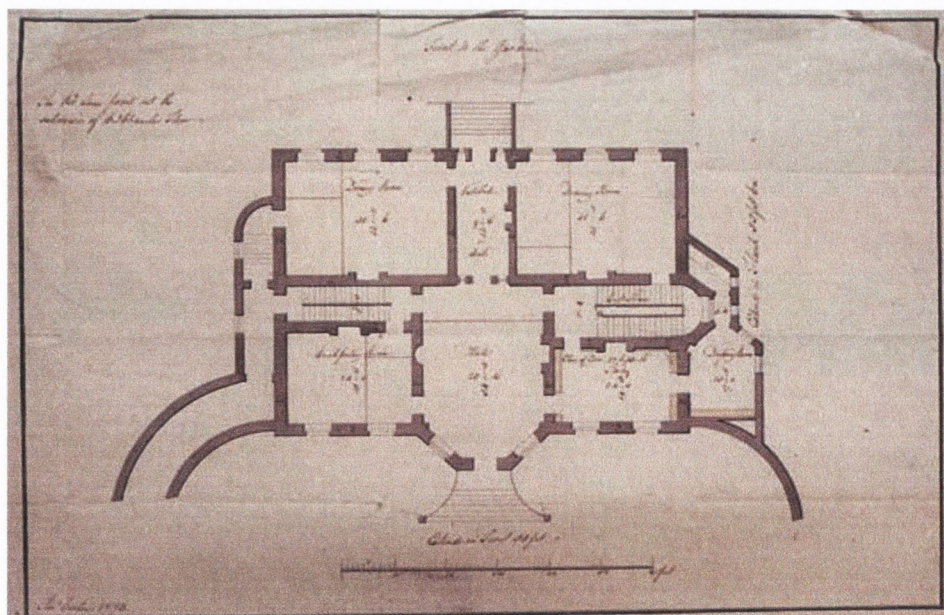


Fig. 2.14 Ardbraccan, plan of ground floor by Thomas Cooley, 1773.

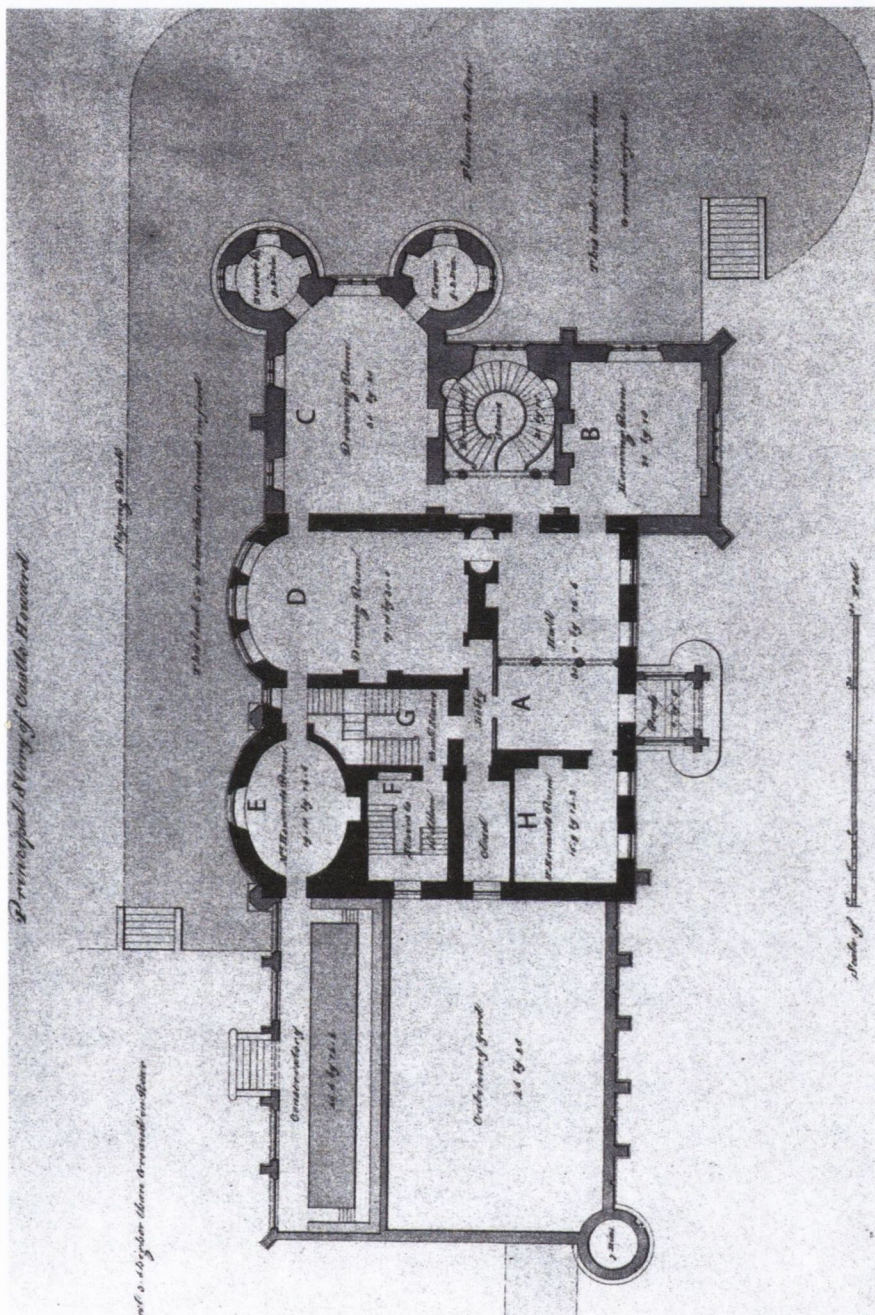
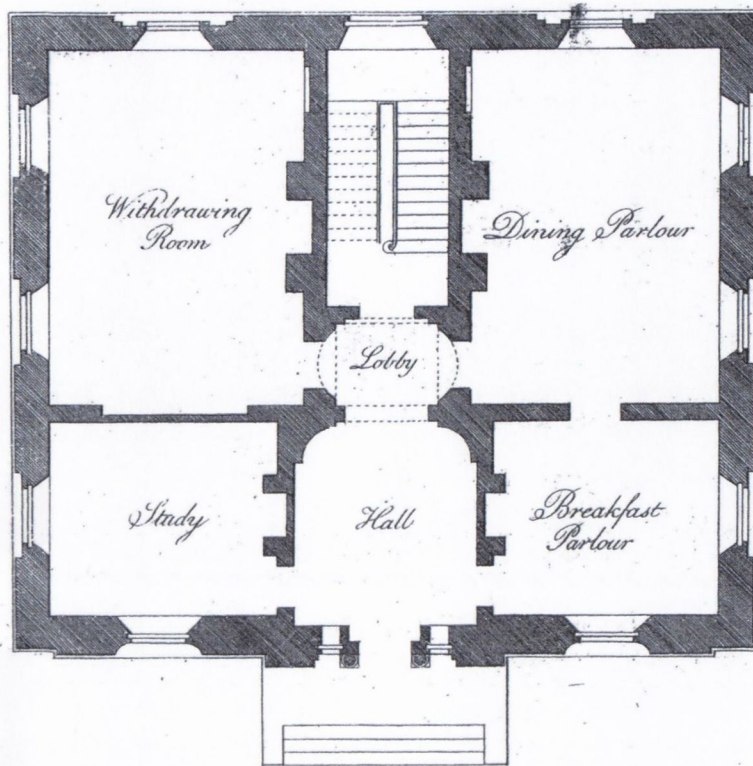


Fig. 2.15 Castle Howard, county Wicklow, design by Richard Morrison, c. 1811.

Key: **A.** Hall, **B.** Morning room, **C.** Drawing room, **D.** Dining room, **E.** Mrs Howard's room, **F.** Stairs to kitchen, **G.** Back stairs, **H.** Mr Howard's room



Figs. 2.17 Plan by Richard Morrison from his book, *Useful and ornamental designs in architecture* (Dublin 1793)

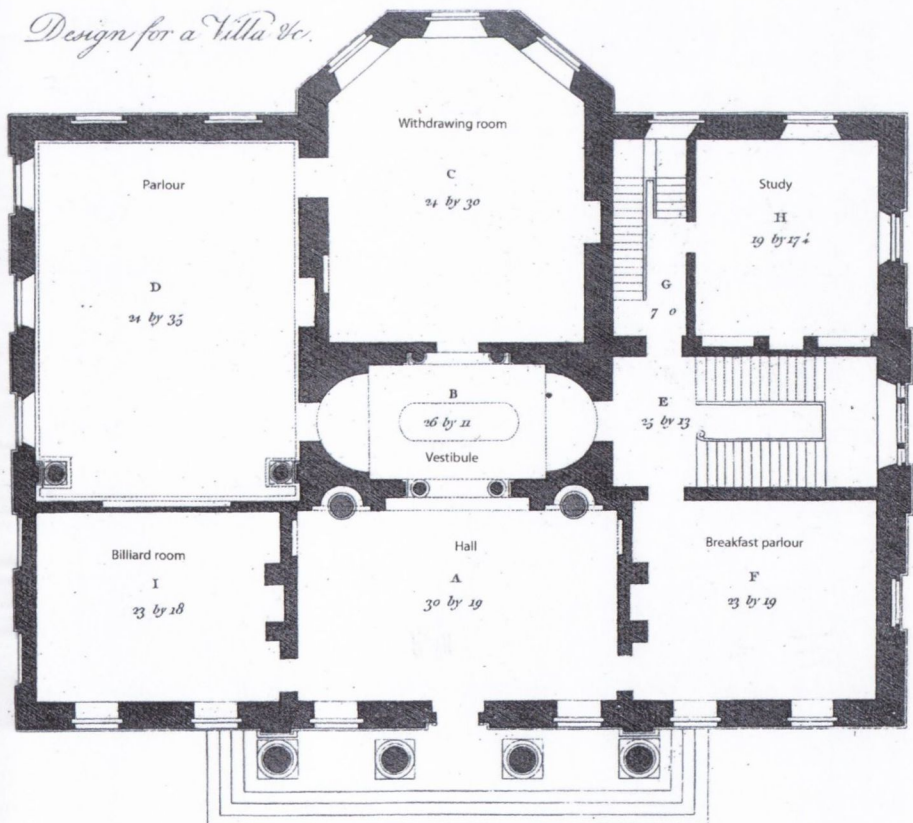


Fig. 218 Plan by Richard Morrison from his book, *Useful and ornamental designs in architecture* (Dublin 1793).

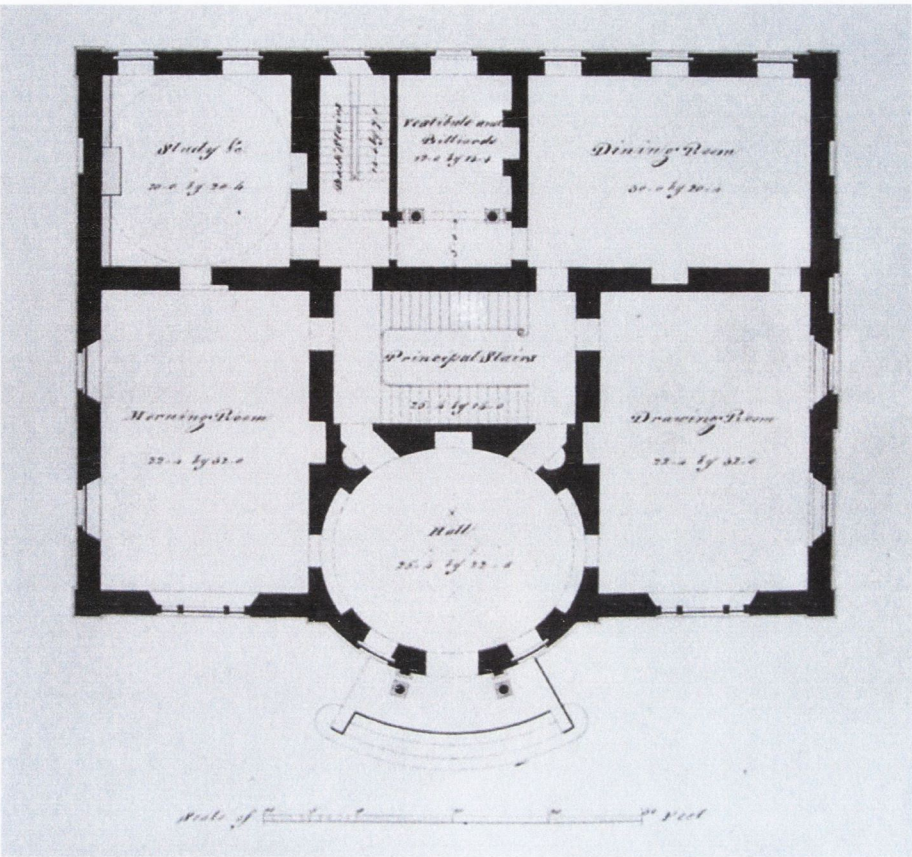


Fig. 2.19 Castlegar, county Galway, plan of ground floor by Richard Morrison, 1801.

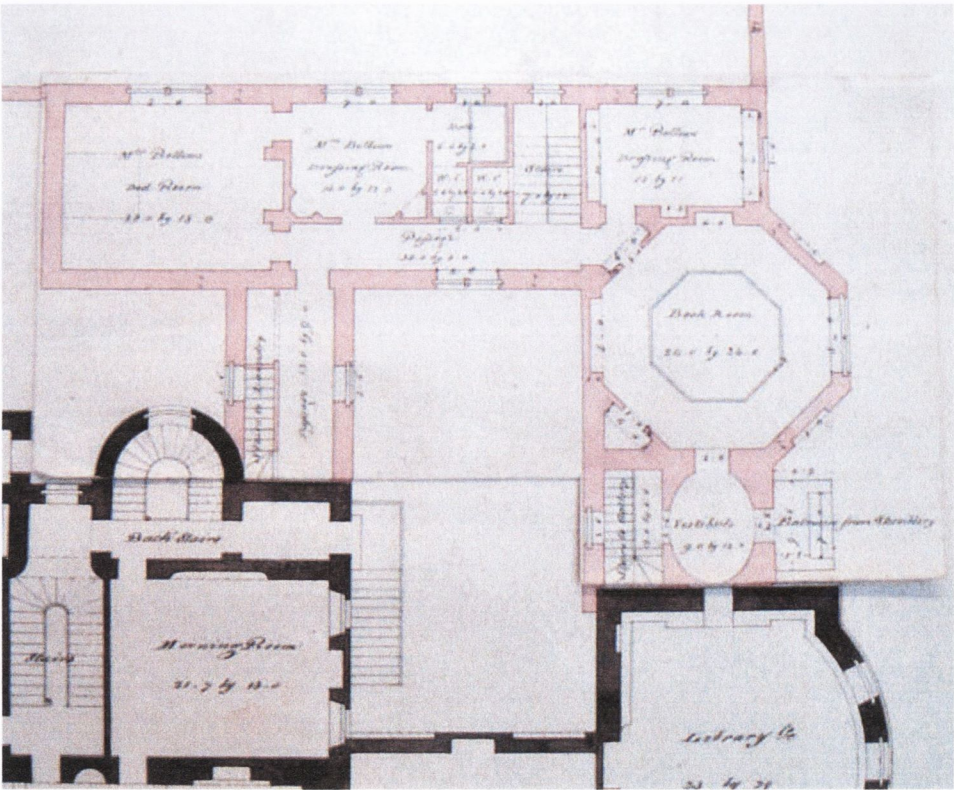


Fig. 2.20 Mount Bellew, county Galway, showing Richard Morrison's proposal for an octagonal book room, approached from the library through an oval vestibule, c. 1817.

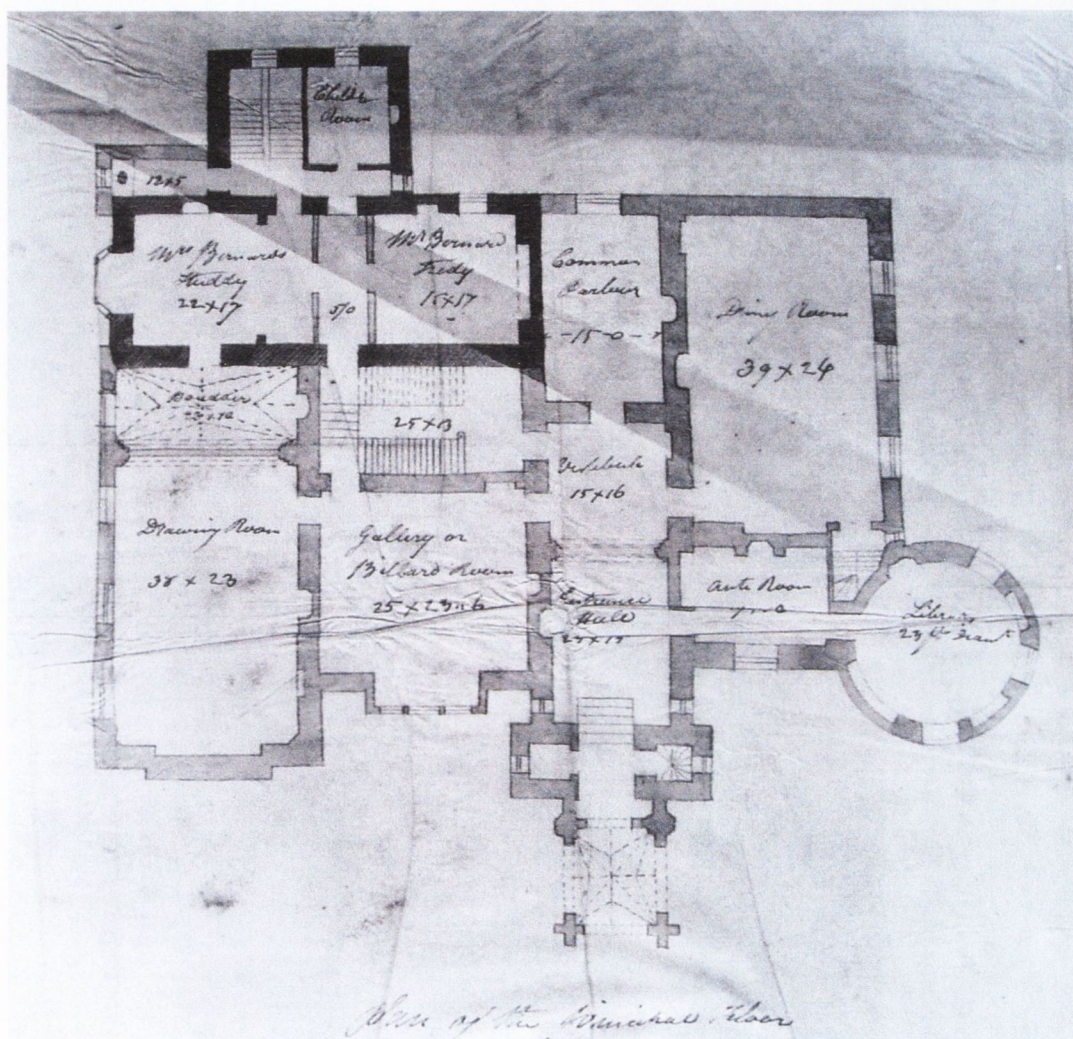


Fig. 2.21 Castle Bernard, plan of ground floor plan by G R Pain, 1833.

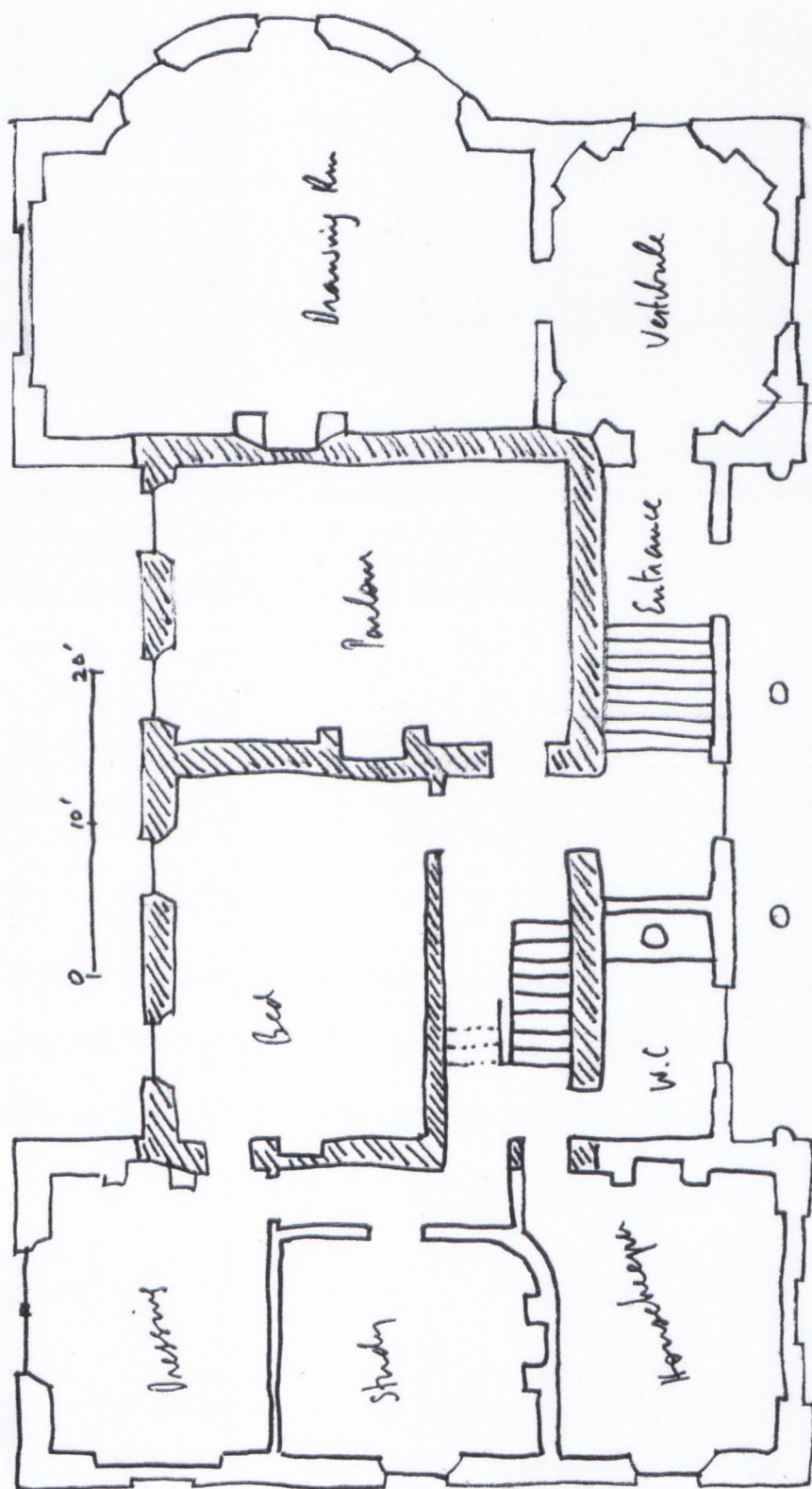


Fig. 2.22

[Old] Townley Hall, sketch plan of ground floor, drawn by Edward McParland.

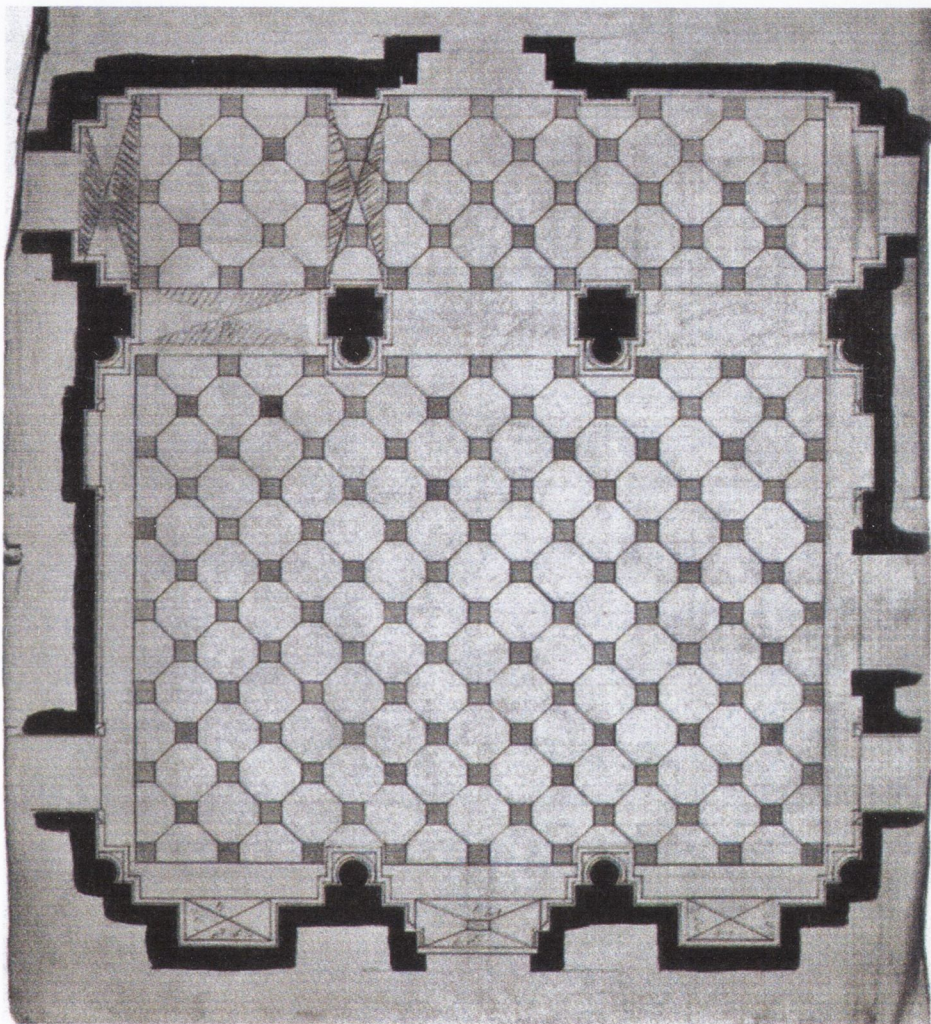


Fig. 2.23 Design for the floor of the entrance hall by Richard Castle, *c.* 1750.

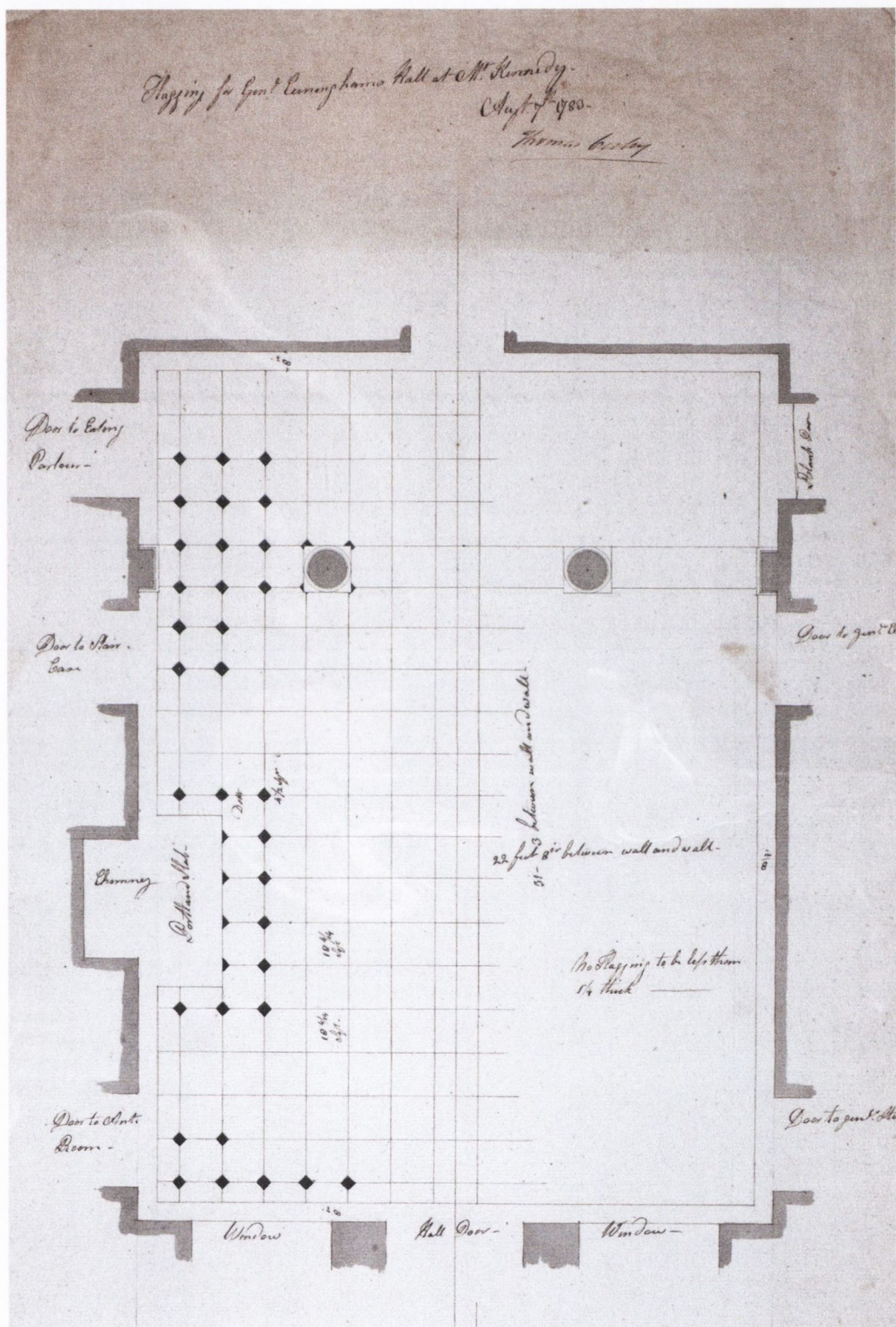


Fig. 2.24 'Flagging for Genl Cunningham's floor at Mt Kennedy, August 1783' signed by Thomas Cooley.

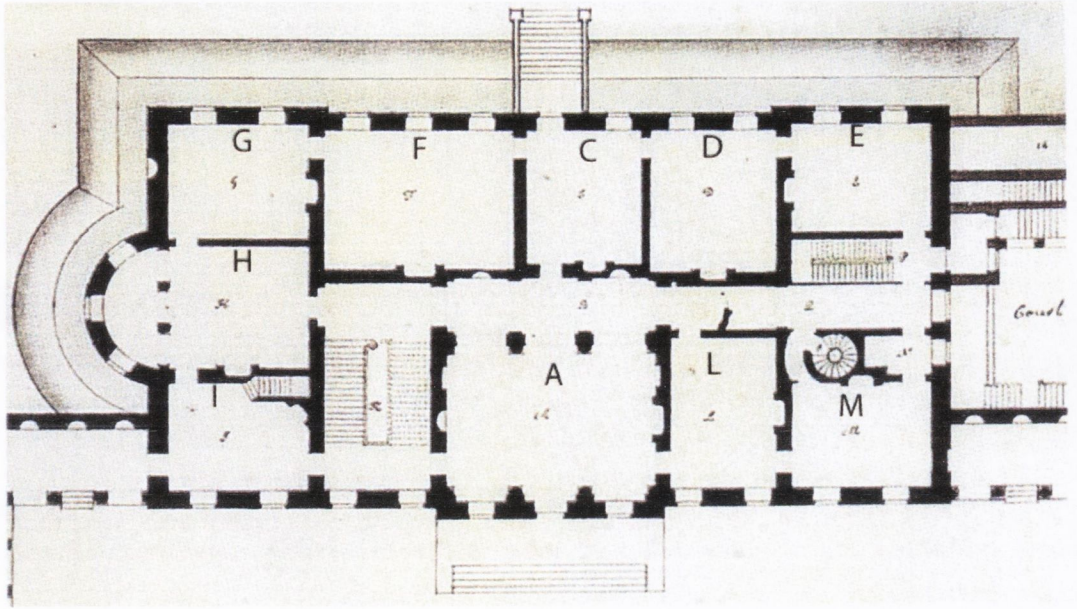


Fig. 3.1 Kildare House, plan of ground floor by Richard Castle, c. 1745.
 A. hall, C. anty room, D. drawing room, E. common eating parlour, F. great dining room, G. parlour, H. dressing room, I. servants waiting room, L. parlour, M. dressing room.

Plan of the Parlour Floor

Explanation,

	<i>S. F. by S. F.</i>
A. Hall	23 - 12
B. Dining Room	30 - 20
C. Parlour	20 - 18 4
D. Bed Chamber	12 - 11
E. G ^o	12 4 - 8 7
F. Hairs	20 - 7 6
G. Dressing Room	14 4 - 12
H. Closett	14 4 - 7 3
I. Bed Chamber	14 4 - 12
K. G ^o	14 4 - 7 3
Front	59 4
Depth	50 6
By a scale of 10 feet to $\frac{1}{2}$ of an inch,	

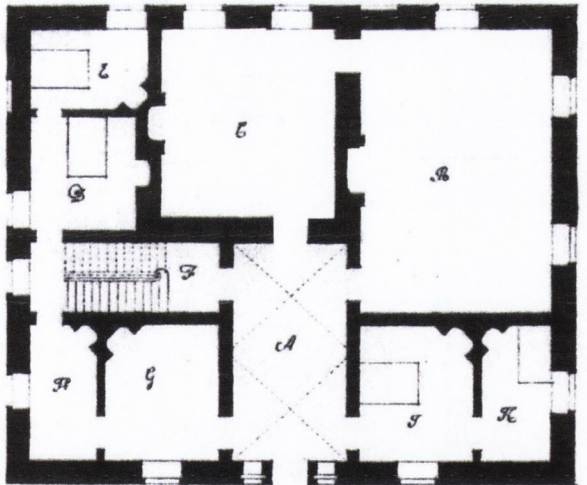


Fig. 3.2 Castle Coole, 'Plan of the Parlour Floor' by Richard Castle, c. 1730.

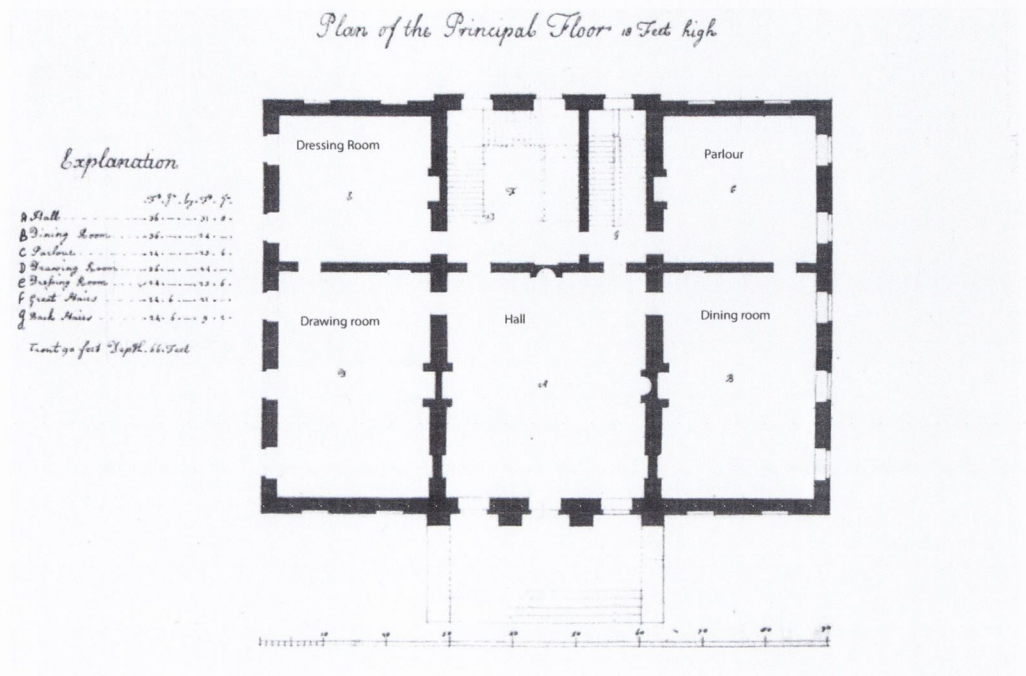


Fig. 3.3 'Plan of the Principal Floor' of a country house by Richard Castle, 1730s-1740s.

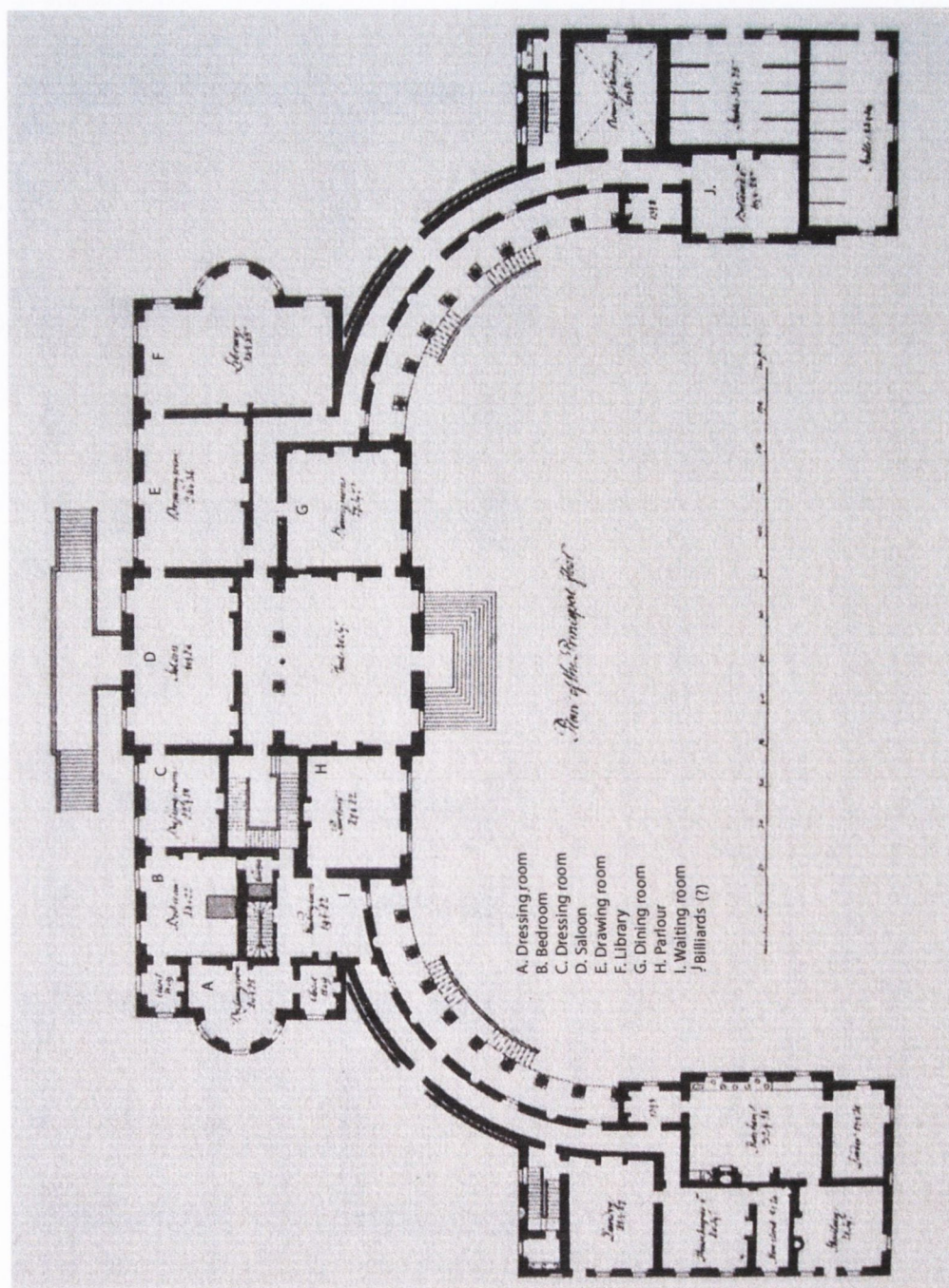


Fig. 3.4 Headfort, plan of ground floor by Sir William Chambers, 1765, with key.

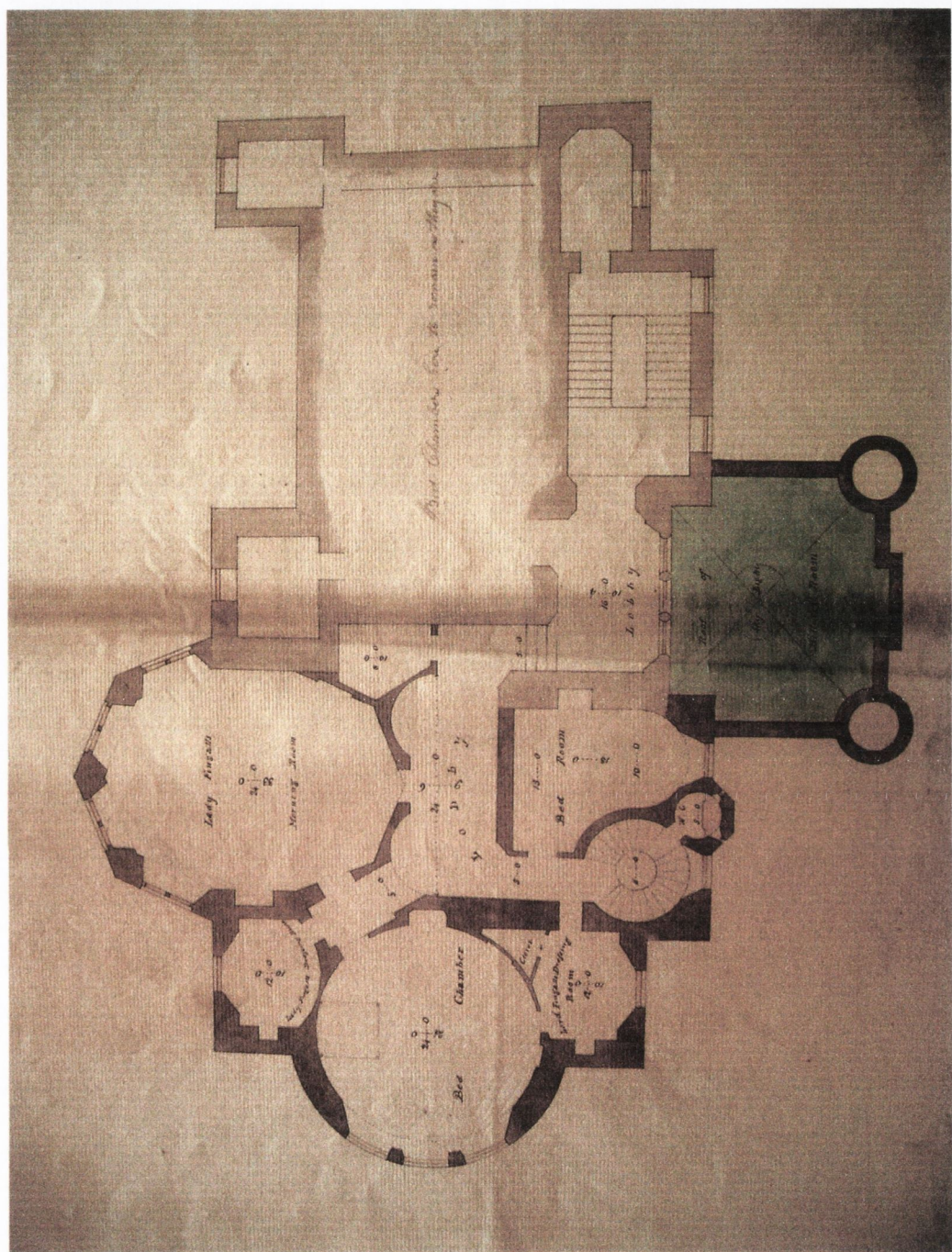
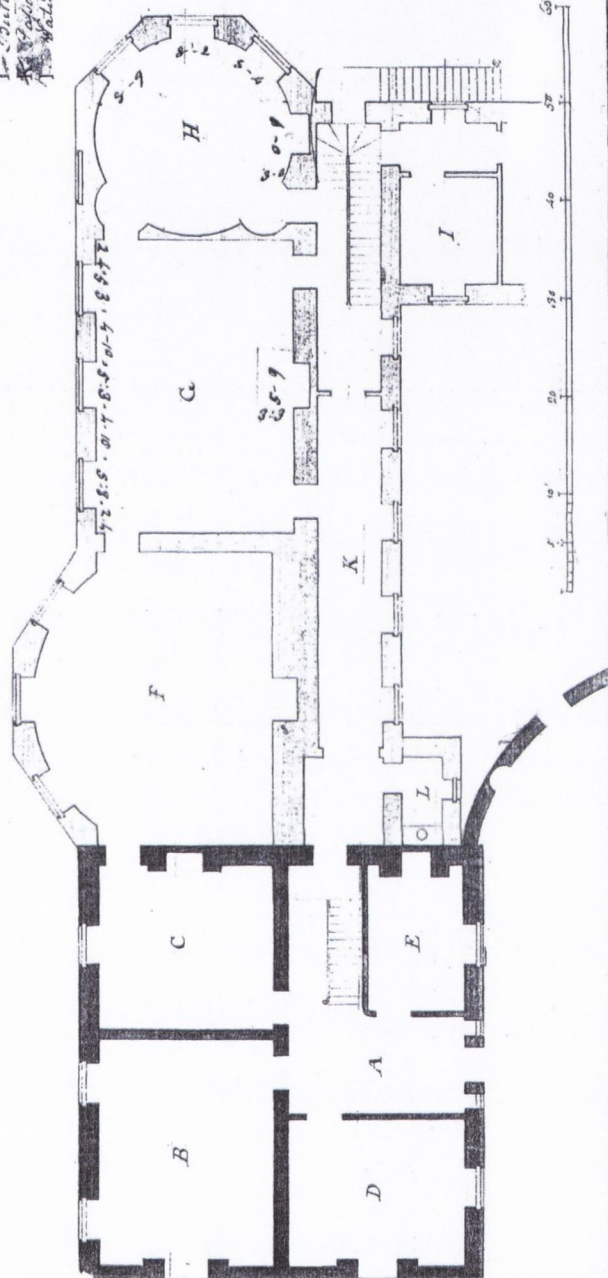


Fig. 3.5 Killeen Castle, county Meath, plan of second bedchamber floor by Francis Johnston, 1803.

A. 3. Andy.
 B. Antoon.
 C. Bed. Charle.
 D. Dreyfus. R.
 E. Withdrawing.
 F. Gating Park.
 G. Breakfast.
 H. Butter 2.
 I. Bed.
 J. Water. (Novel)



Woodville, county Dublin, plan of ground floor with proposed extension by Thomas Penrose, 1779.

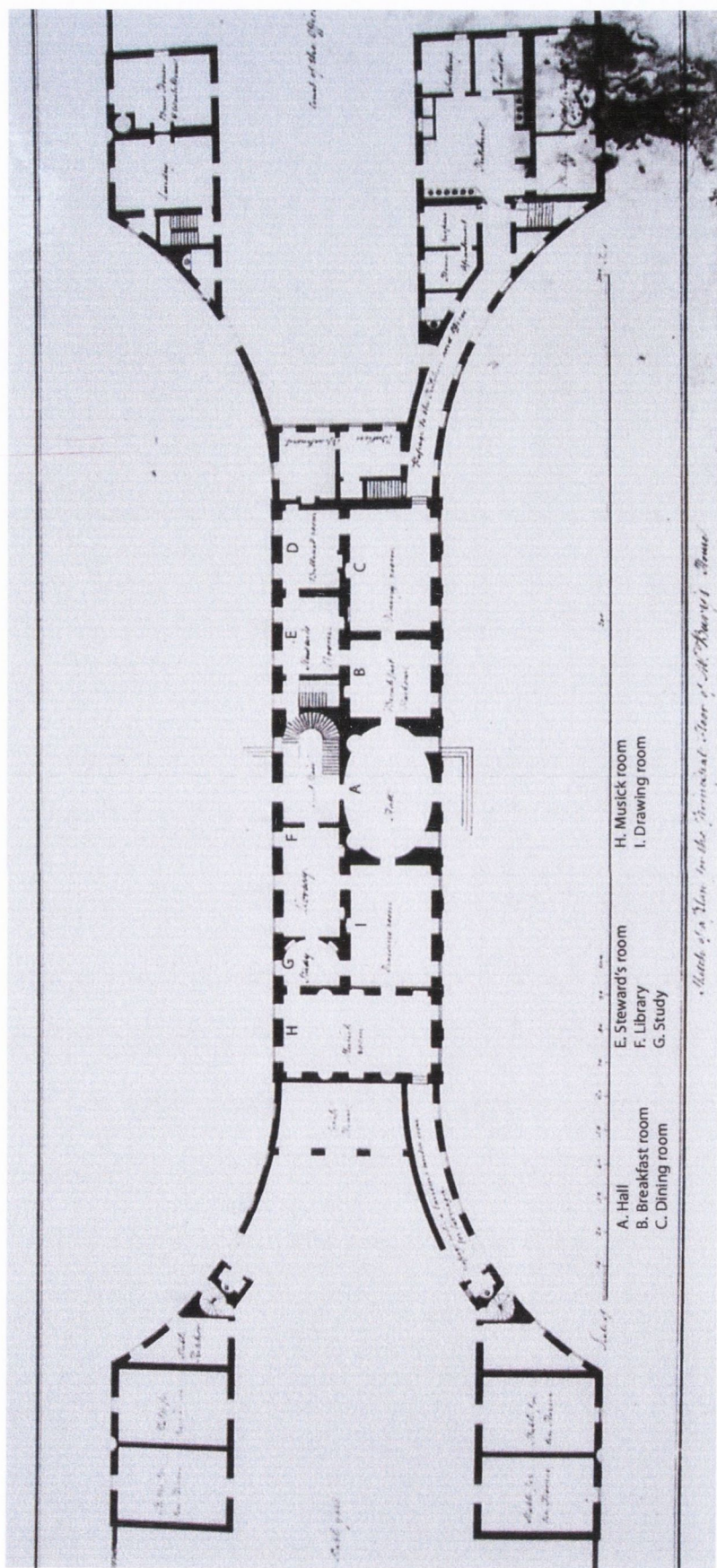


Fig. 3.7

Charleville Forest, proposal for ground floor by James Byres, 1789, with key.

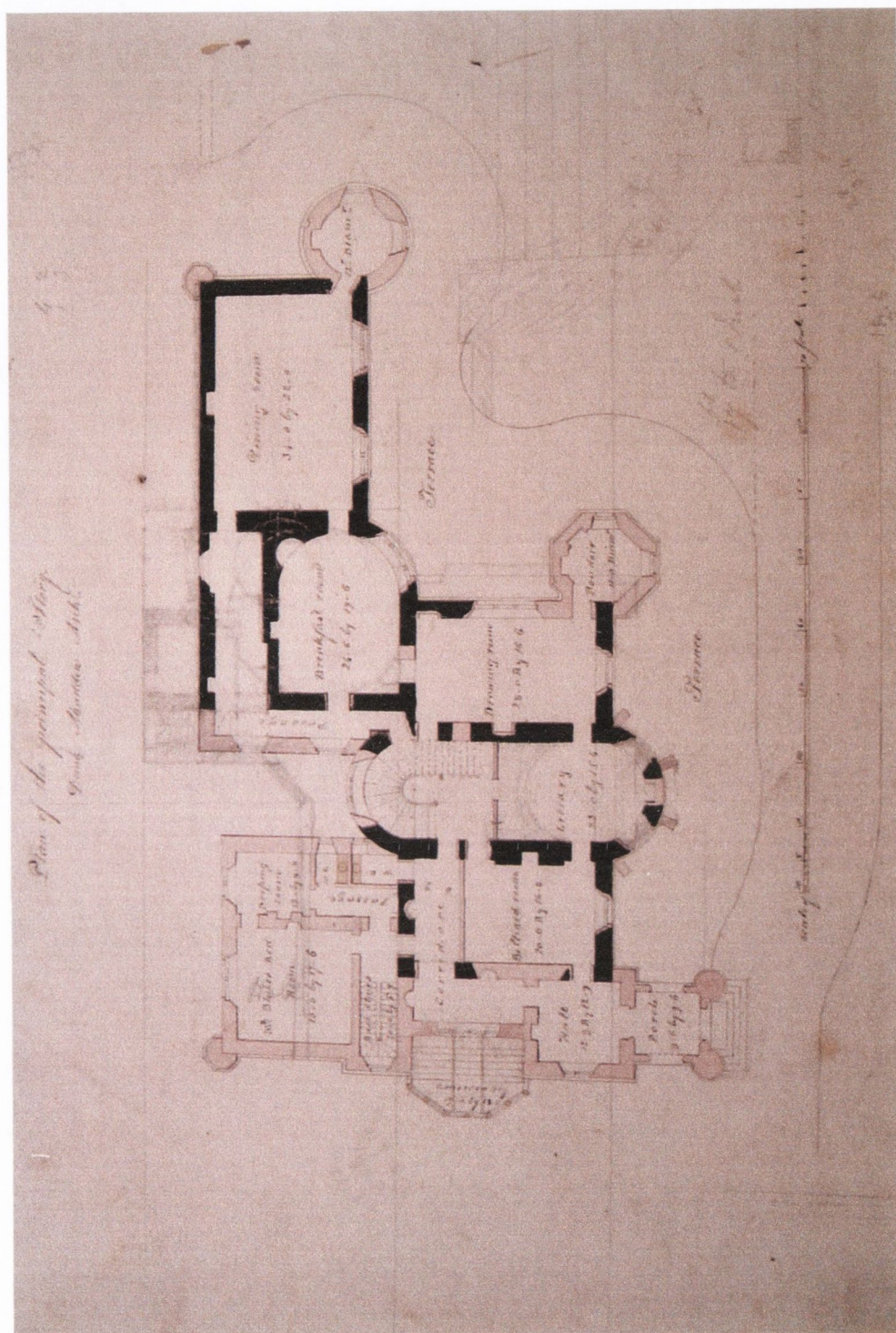


Fig. 3.8

Brook Lodge, county Galway, proposed alterations by Dominick Madden, 1826-29.

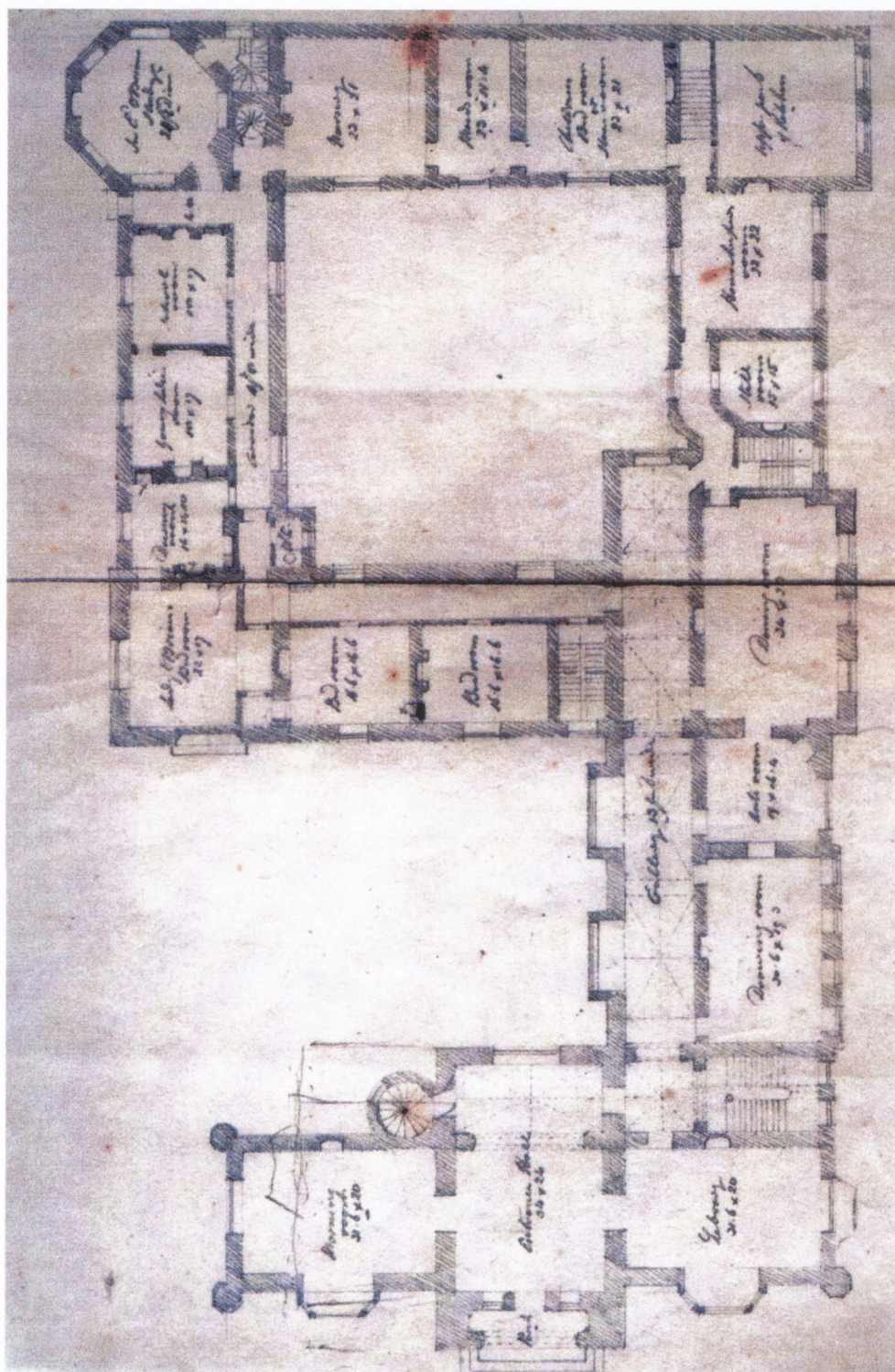


Fig. 3.9 Dromoland Castle, county Clare. Plan attributed to J & G R Pain, c. 1826.

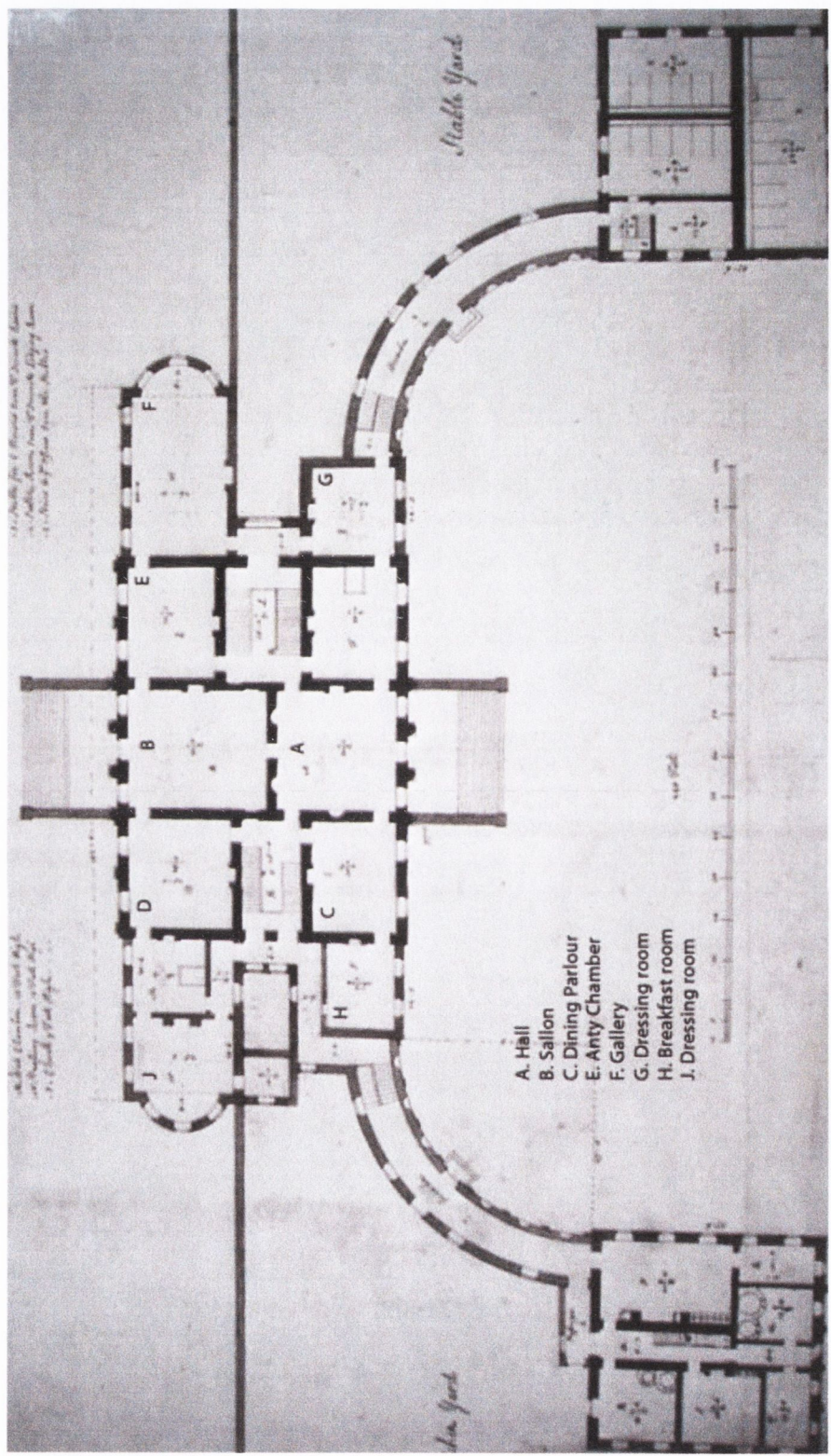


Fig. 3.10 Headfort, county Meath. Plan of ground floor (with key), attributed to John Ensor, but possibly by Richard Castle, c. 1750.

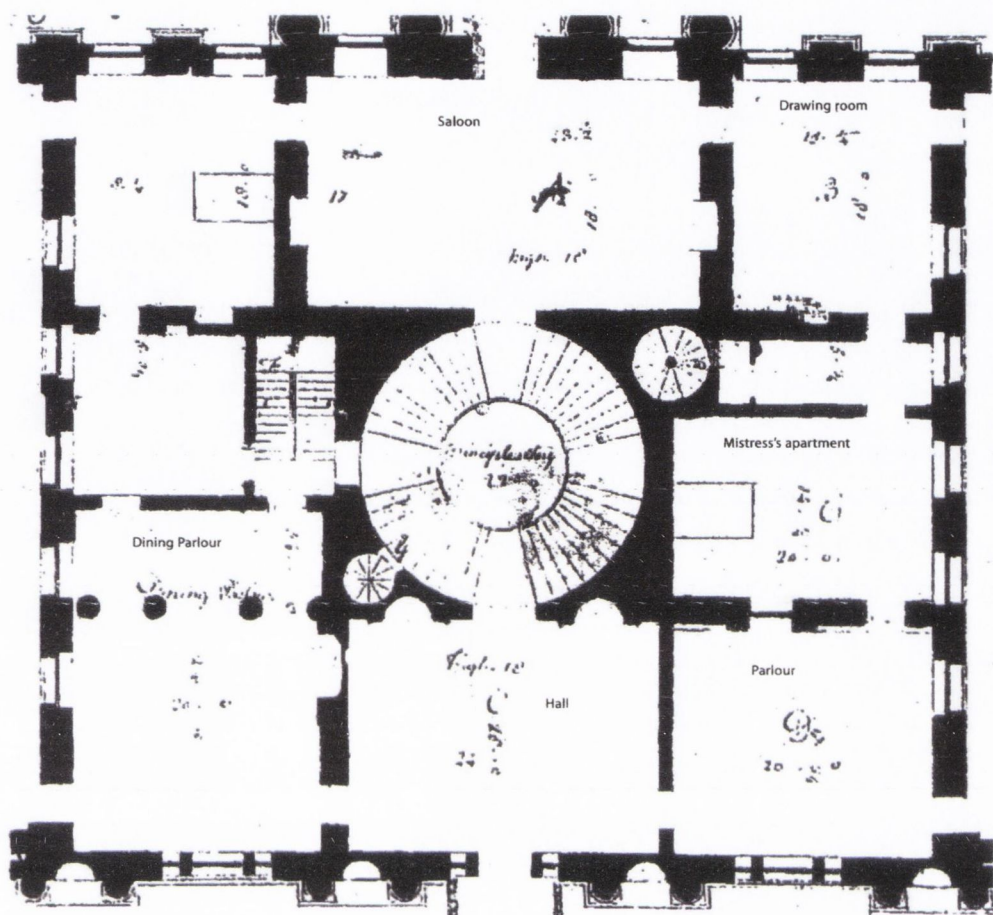


Fig. 3.12 Plan of ground floor of house by Samuel Chearnley, 1745-46.

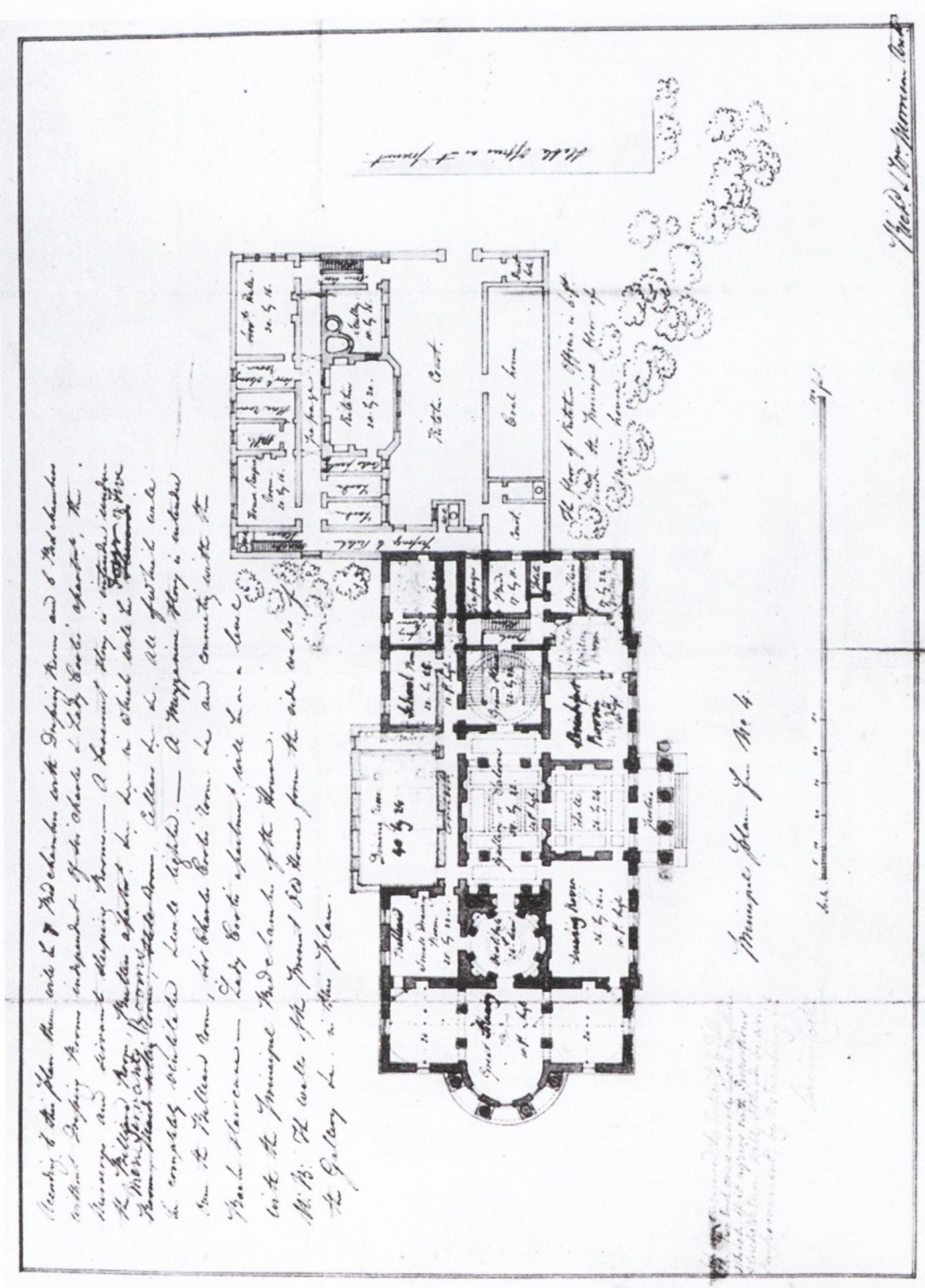


Fig. 4.1 Ballyfin, county Laois, ground floor plan by Richard & William Morrison, c. 1822.

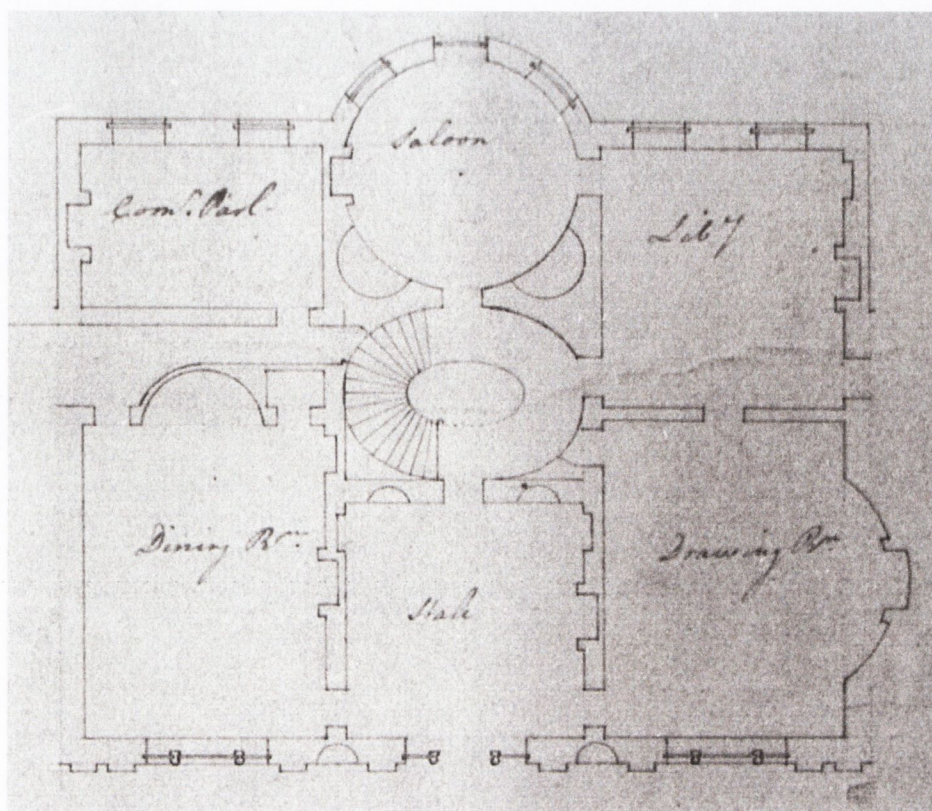


Fig. 4.2 Ardbraccan, county Meath, ground floor plan (n.s., n.d.).

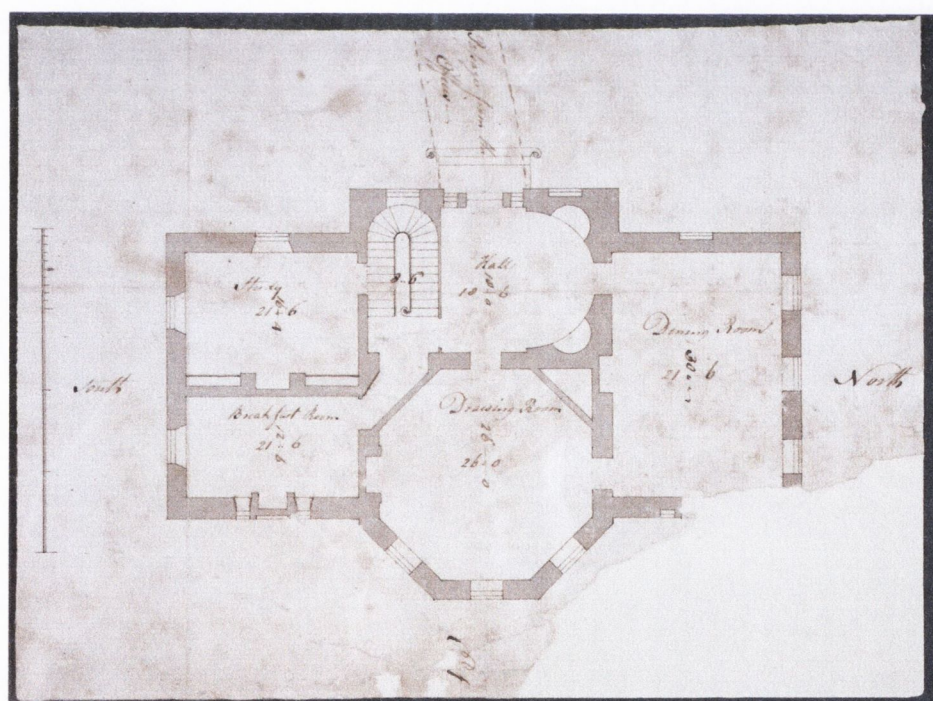


Fig. 4.3 Mount Kennedy Drawings, ground floor proposal for a house.

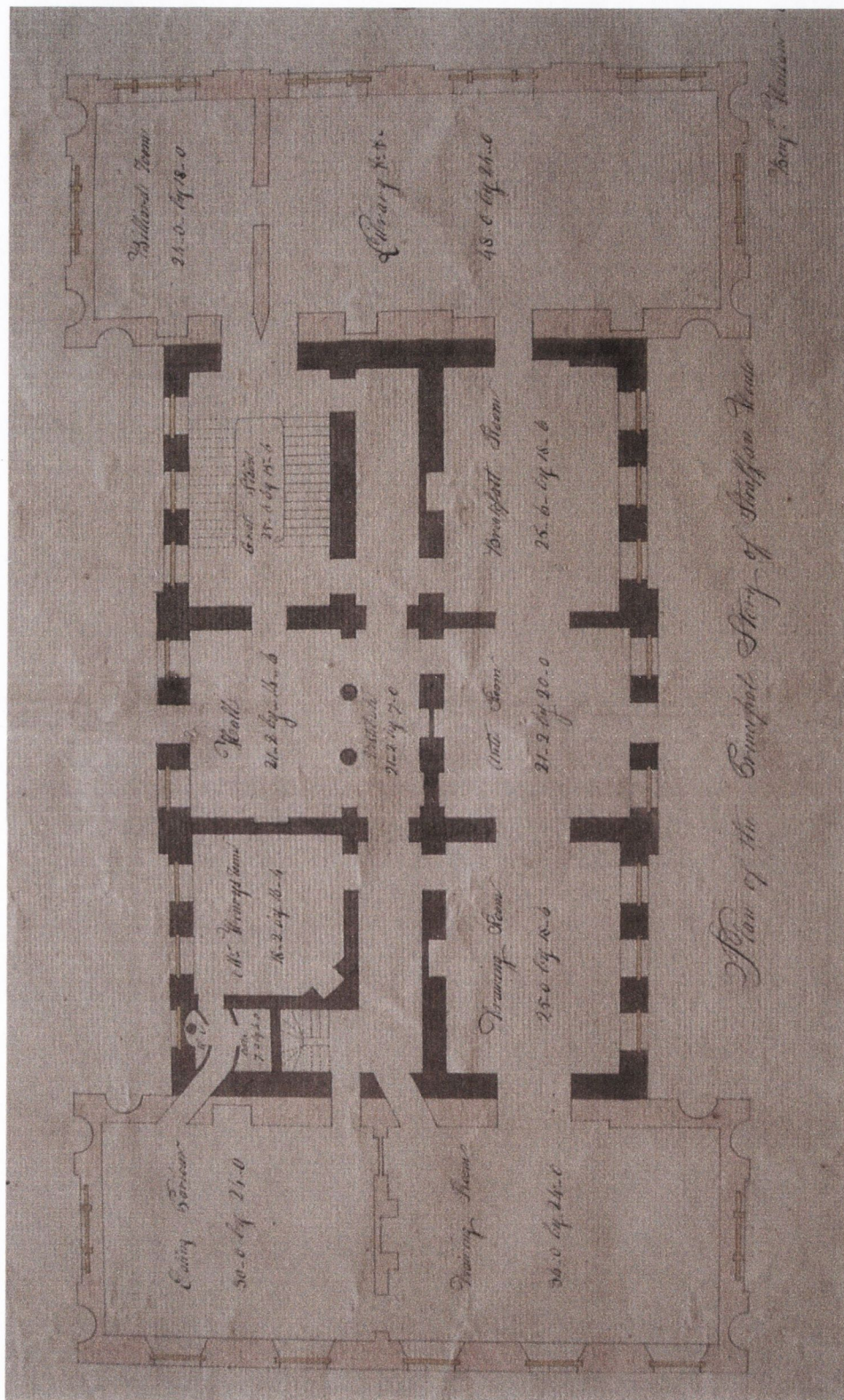


Fig. 4.4

Straffan House, county Kildare, ground floor plan with proposed new wings by Benjamin Hallam, 1808.

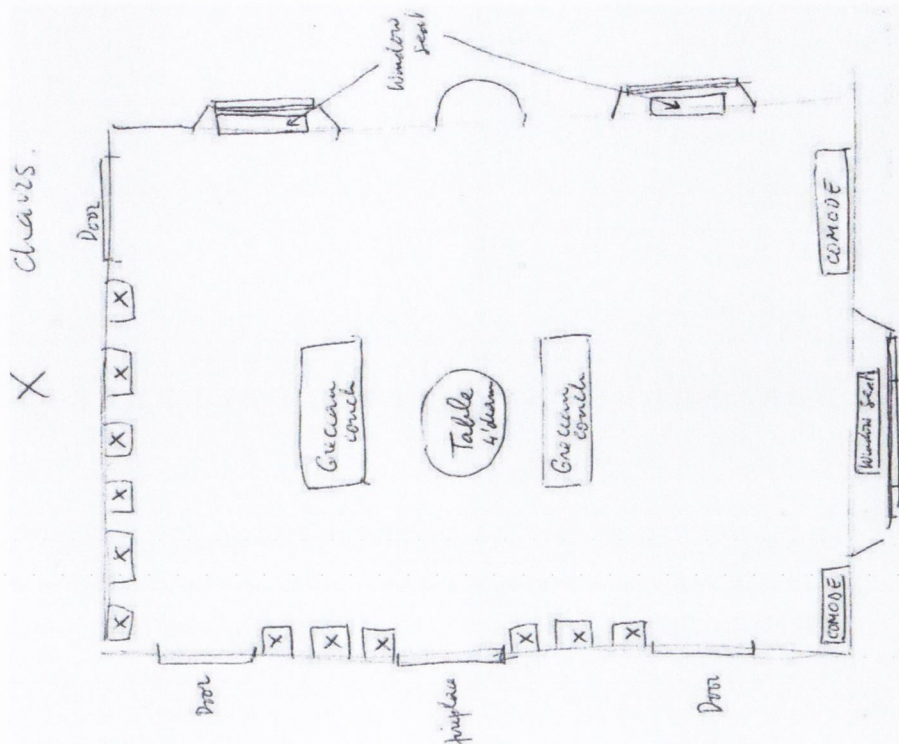


Fig. 4.5

Castlegar, county Galway. Plan by Morgan's for furnishing drawing room, sketched by Edward McParland, c. 1790s?.

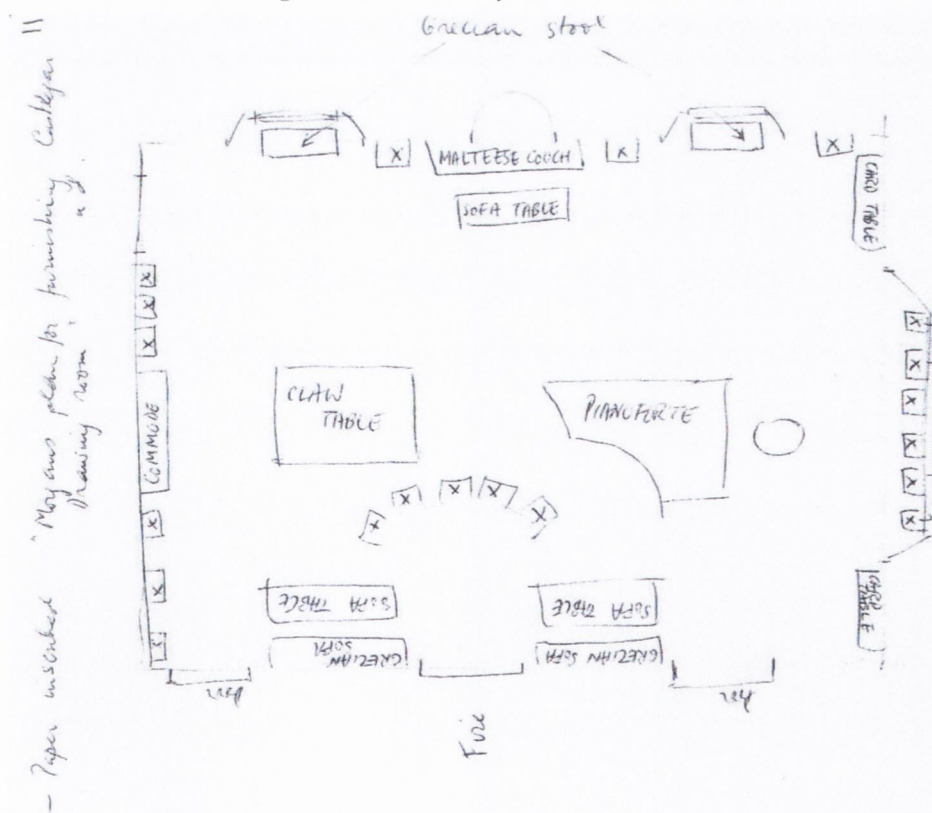


Fig. 4.6

Castlegar, county Galway. 'Morgans plan for furnishing Castlegar Drawing room', sketched by Edward McParland, c. 1790s?.

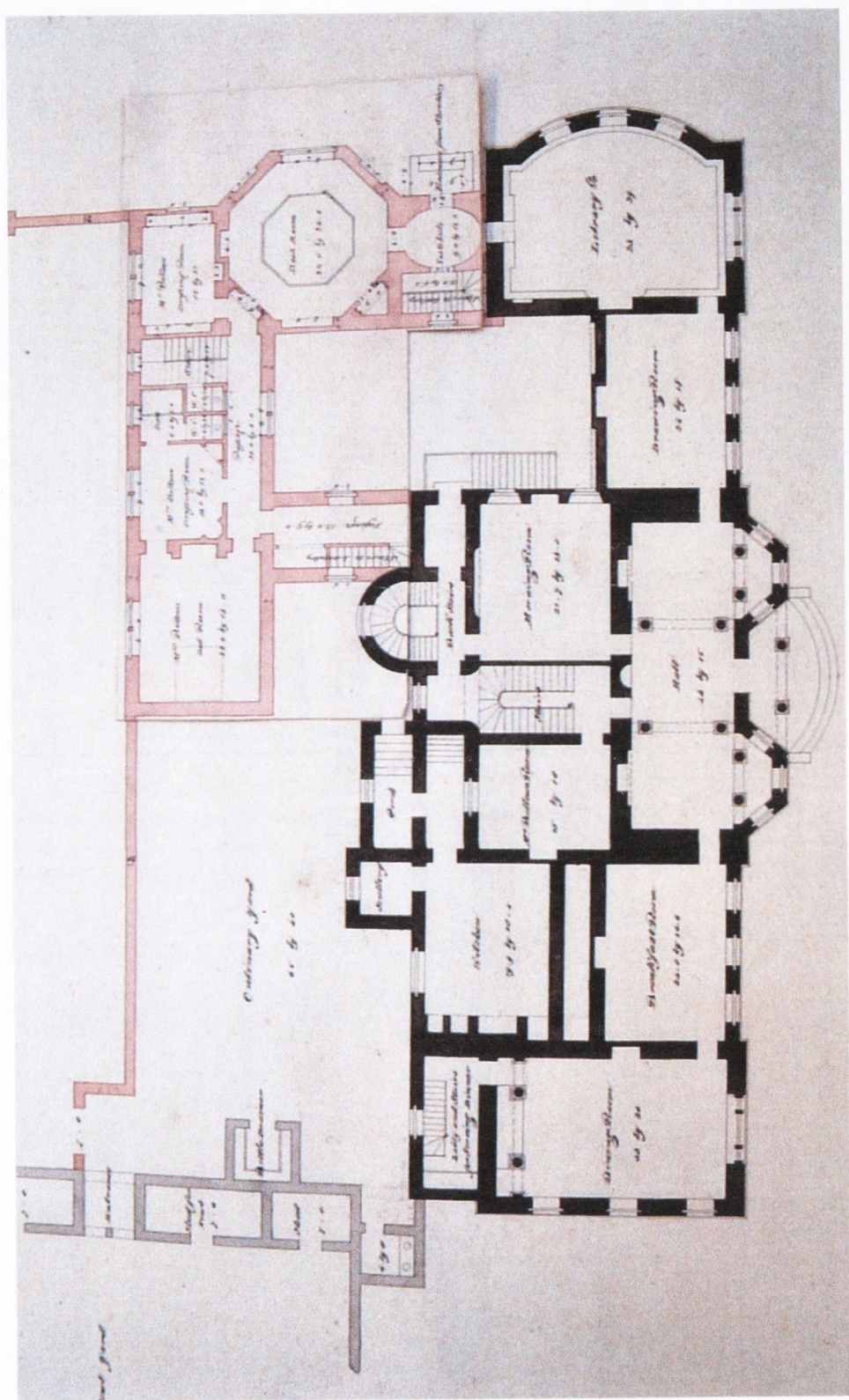


Fig. 4.7

Mount Bellew, county Galway, proposal by Richard Morrison for an octagonal book room, c. 1817.

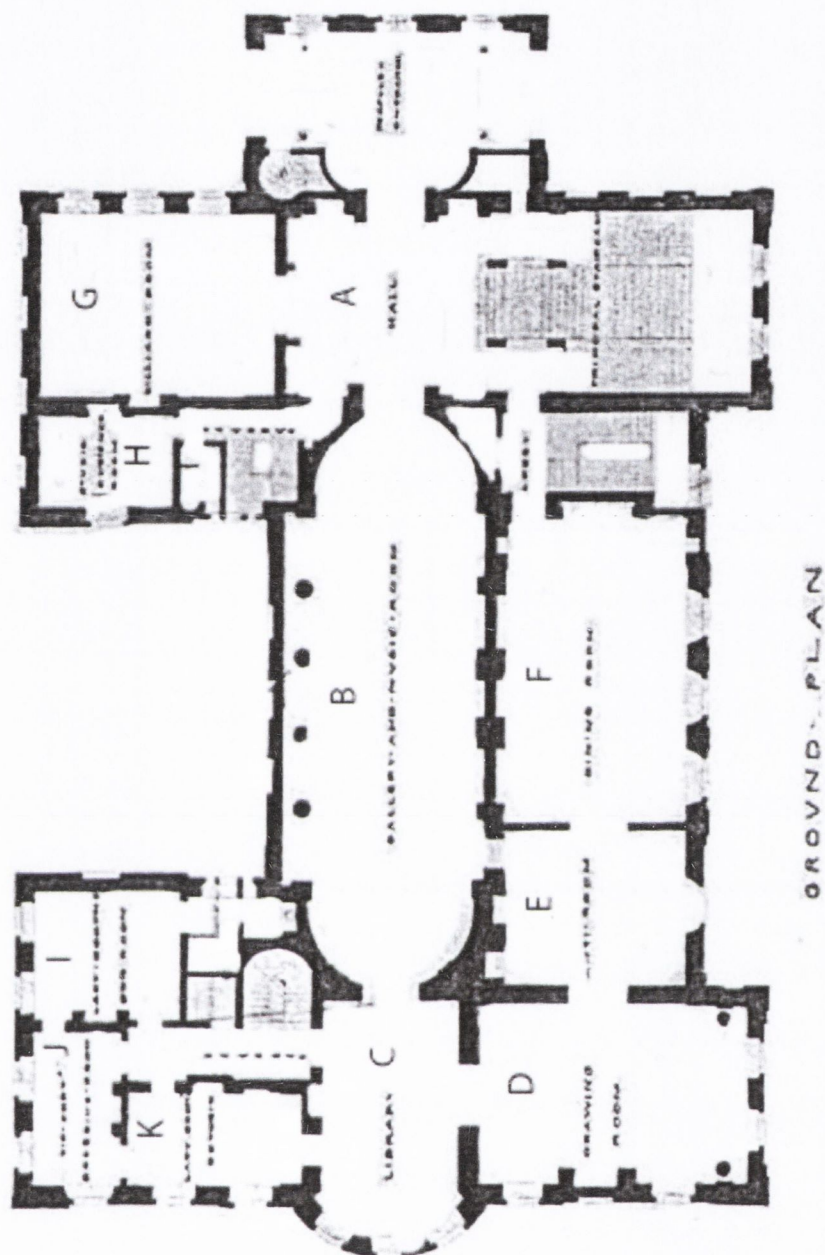


Fig. 4.9

Lissadell, county Sligo, plan of ground floor by Francis Goodwin, 1833.

A. Hall, B. Gallery & Music room, C. Library, D. Drawing room, E. Anti-room, F. Dining room, G. Billiard room, H. Studio Audience room, I. Lady Booth's bedroom, J. Sir Robert's dressing room, K. Lady Booth's boudoir.

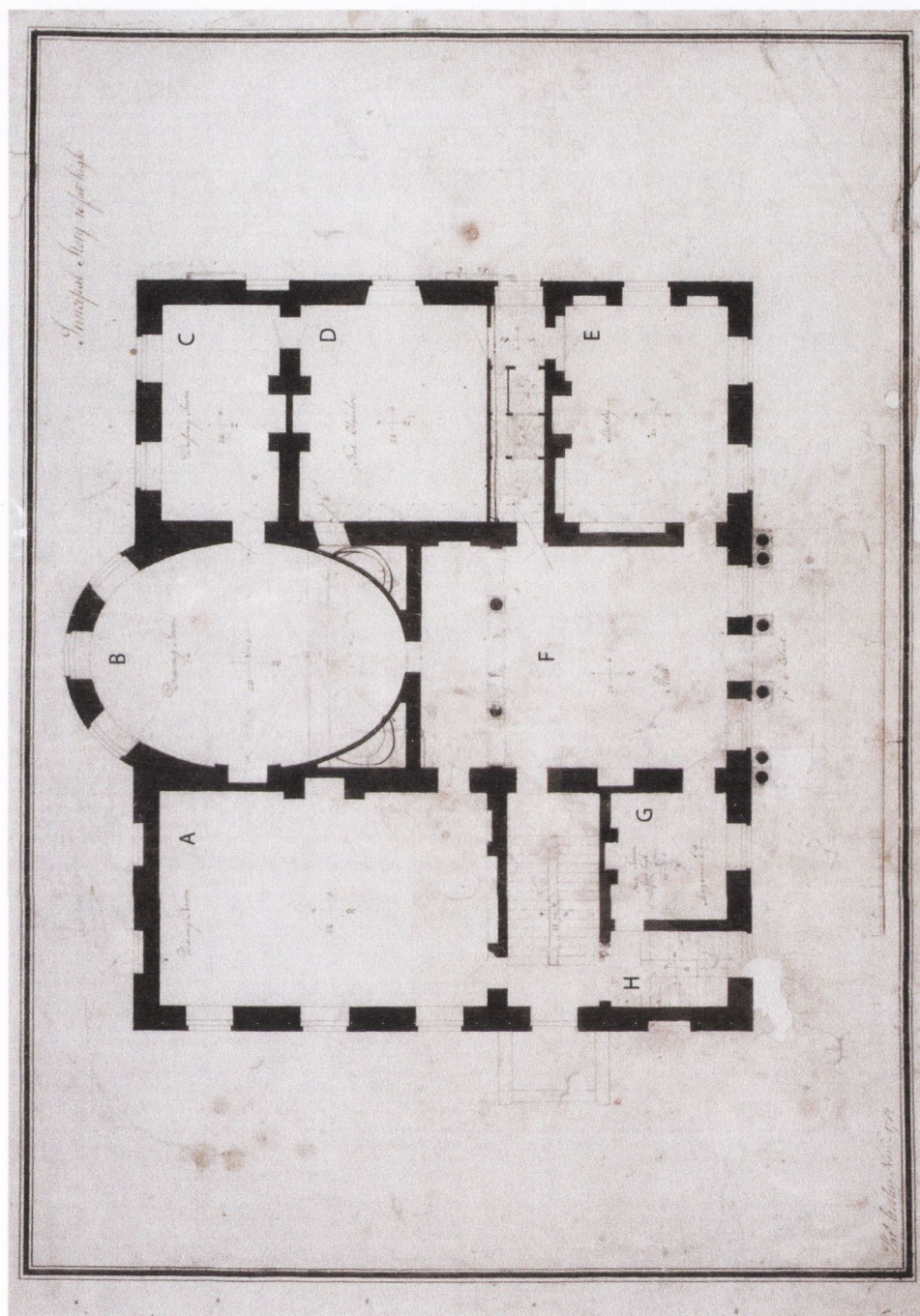


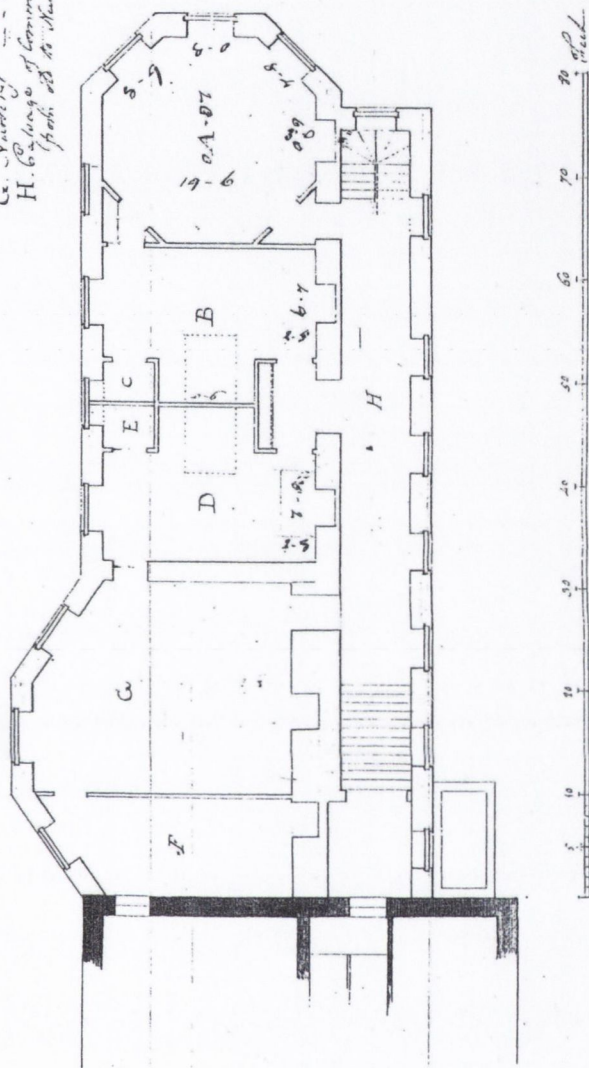
Fig. 4.10

Mount Kennedy, county Wicklow

A. Dining room, B. Drawing room, C. Dressing room,
D. Bedchamber, E. Study, F. Hall, G. Anty room, H. Backstairs.

Bed Chamber Story at Woodville

- Reference*
- A. 1st Chamber Dining Room 20-22
 - B. 2nd Chamber 15-0 1/2
 - C. Light Closet to D 4-0 1/2
 - D. 3rd Chamber 14-9 1/2
 - E. Light Closet to D 4-0 1/2
 - F. 4th Chamber 10-8
 - G. Nursery 20-0 1/2
 - H. Passage of Communication from D to New Staircase 6-6 1/2



Thomas Penrose Architect

Fig. 4.12

Woodville, county Dublin, 'Bed Chamber Story at Woodville' by Thomas Penrose, 1779.

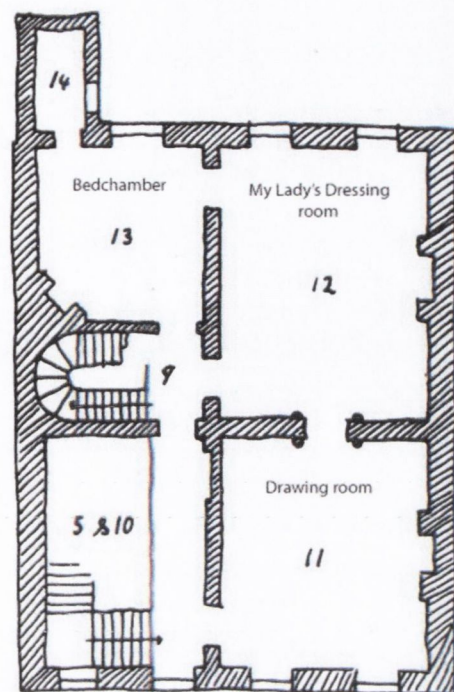


Fig. 4.13 45 Kildare Street, plan of first floor, reconstructed by David Griffin.

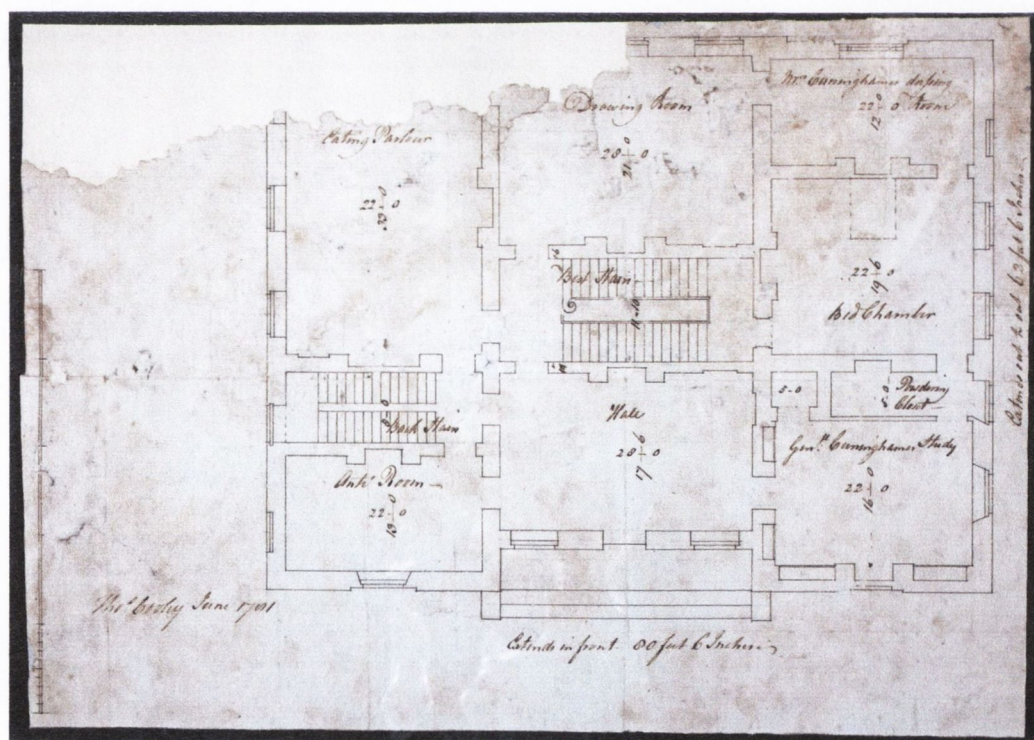


Fig. 4.14 Mount Kennedy, proposal for ground floor, drawn by Thomas Cooley, 1781.

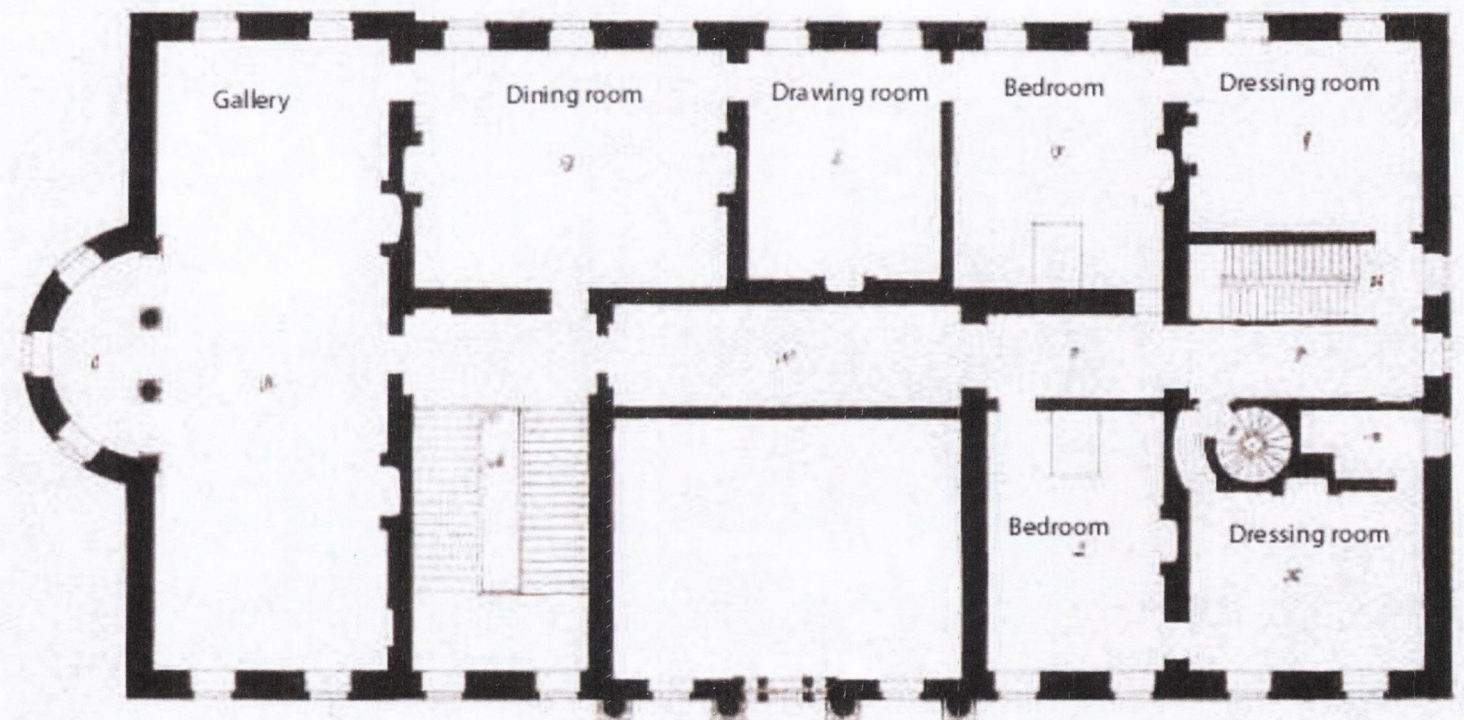


Fig. 4.15

Kildare House, plan of first floor by Richard Castle c. 1745.

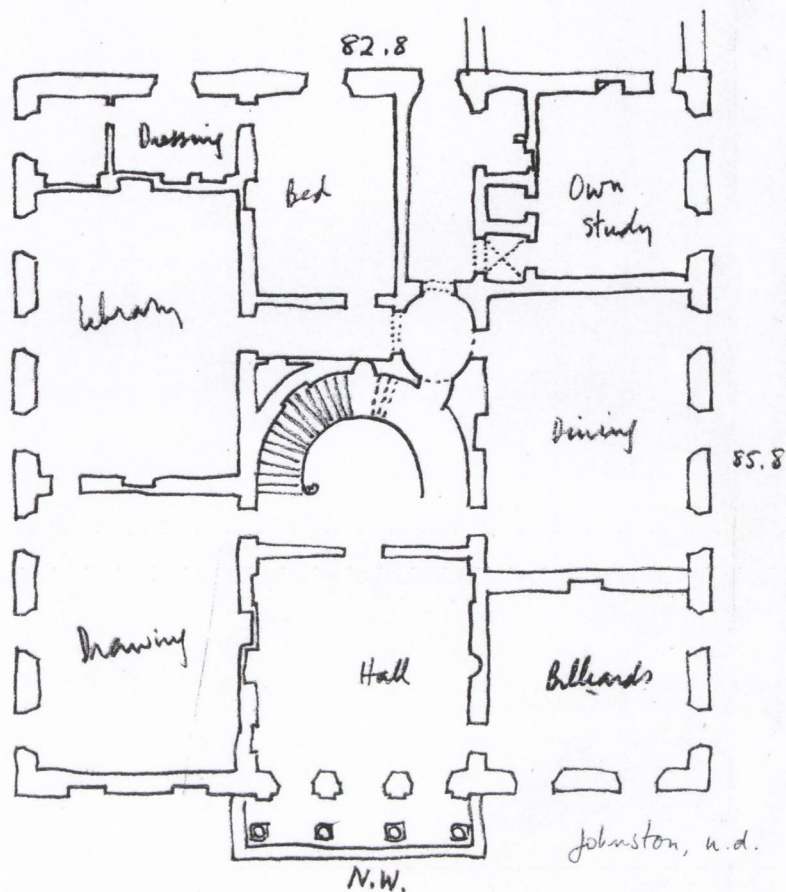


Fig. 4.16 Townley Hall, county Louth, sketch plan of Francis Johnston's proposal for the ground floor.

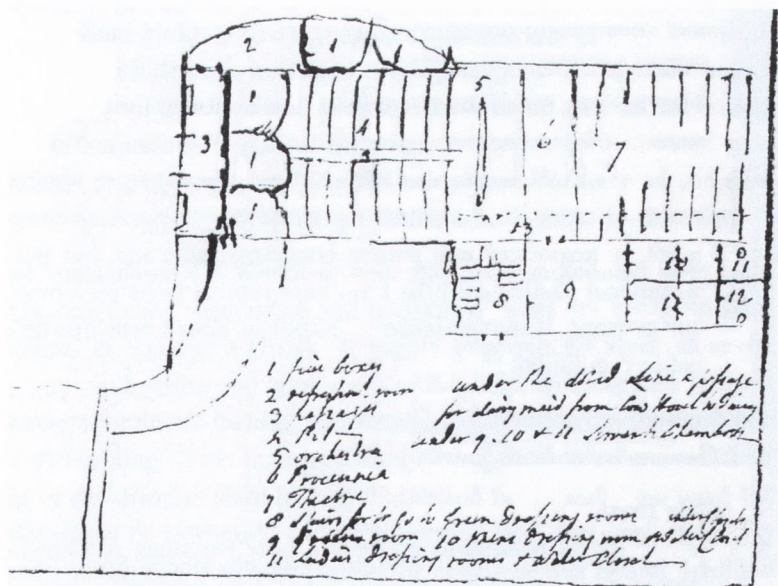
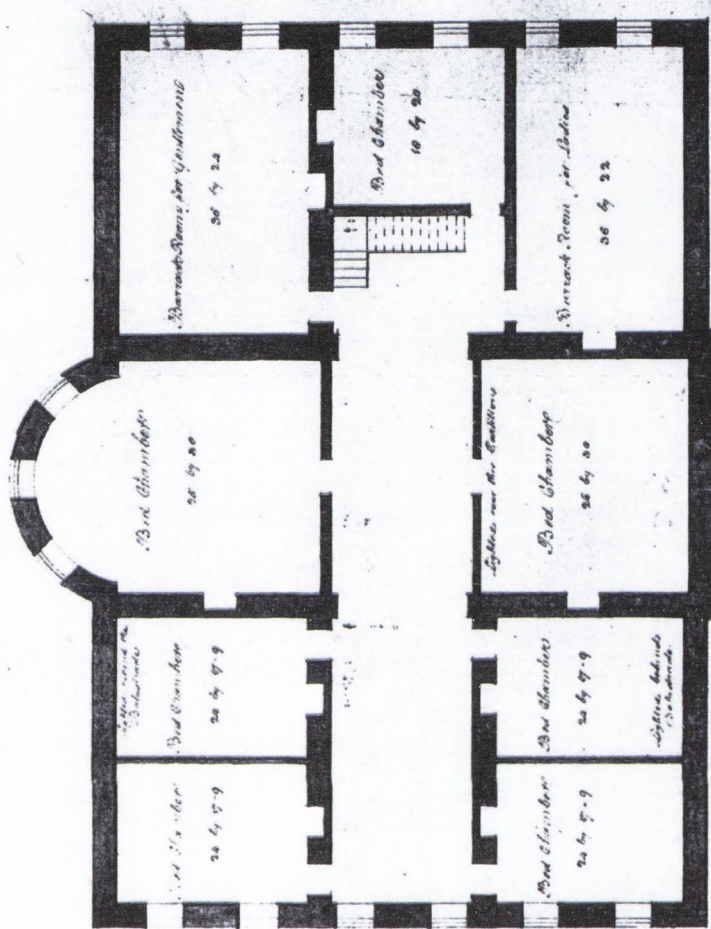


Fig. 4.17 Aldborough House, sketch design for theatre wing, attributed to Lord Aldborough. Key: (1) five boxes; (2) refreshment room; (4) pit; (5) orchestra; (6) proscenium; (7) Theatre; (8) stairs [from basement] to Green dressing room; (9) Green room; (10, 11) men's and ladies dressing rooms with WCs.

Plan of 'Attic' Story.



11. 13 Oct 1789. R. Johnston Archt.

Fig. 5.1 Castle Coole, county Fermanagh, plan of attic storey by Richard Johnston, 1789, showing barrack rooms for ladies and gentlemen.

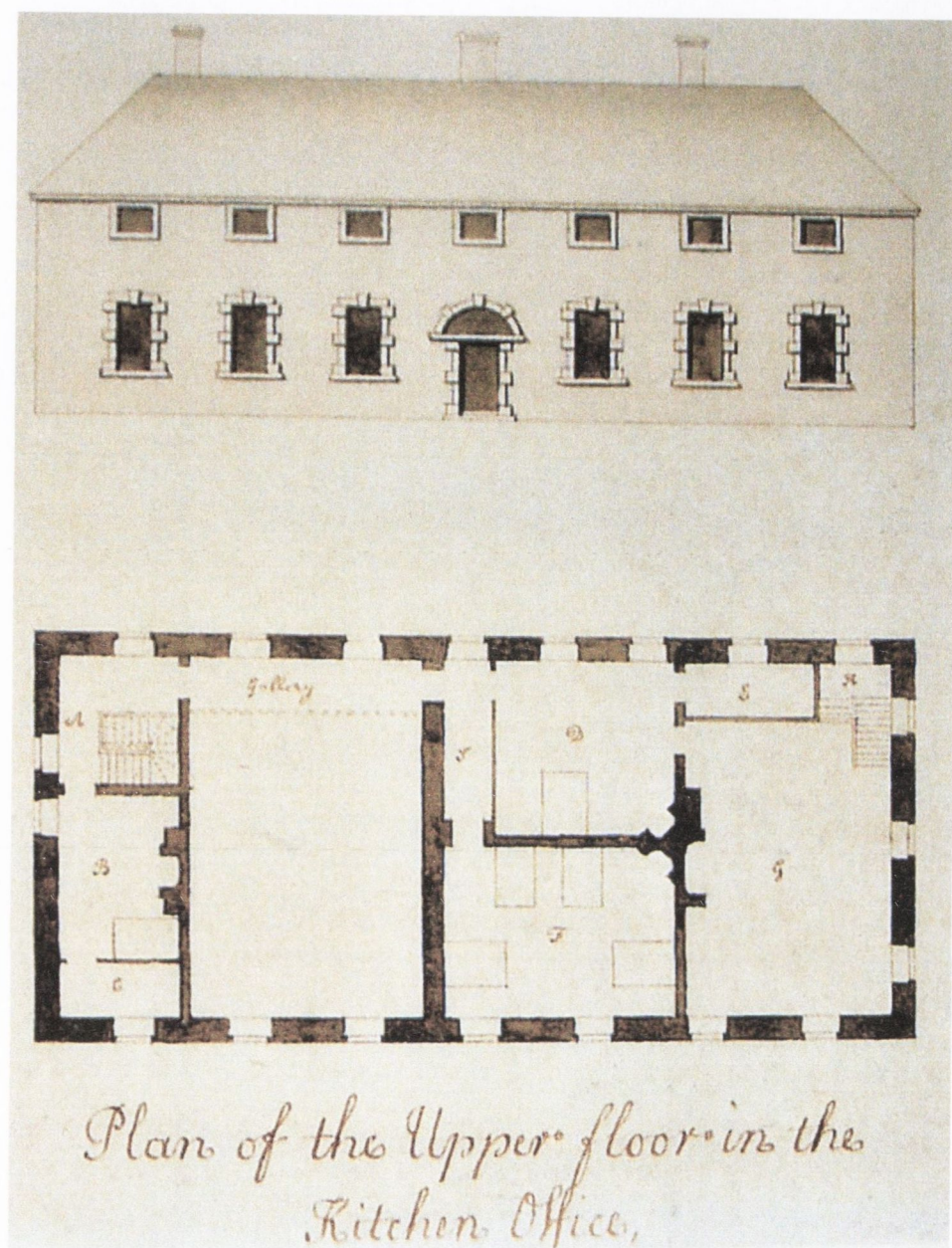


Fig. 5.2 Kildare House, elevation and first floor plan of kitchen and laundry block by Richard Castle, c. 1745.

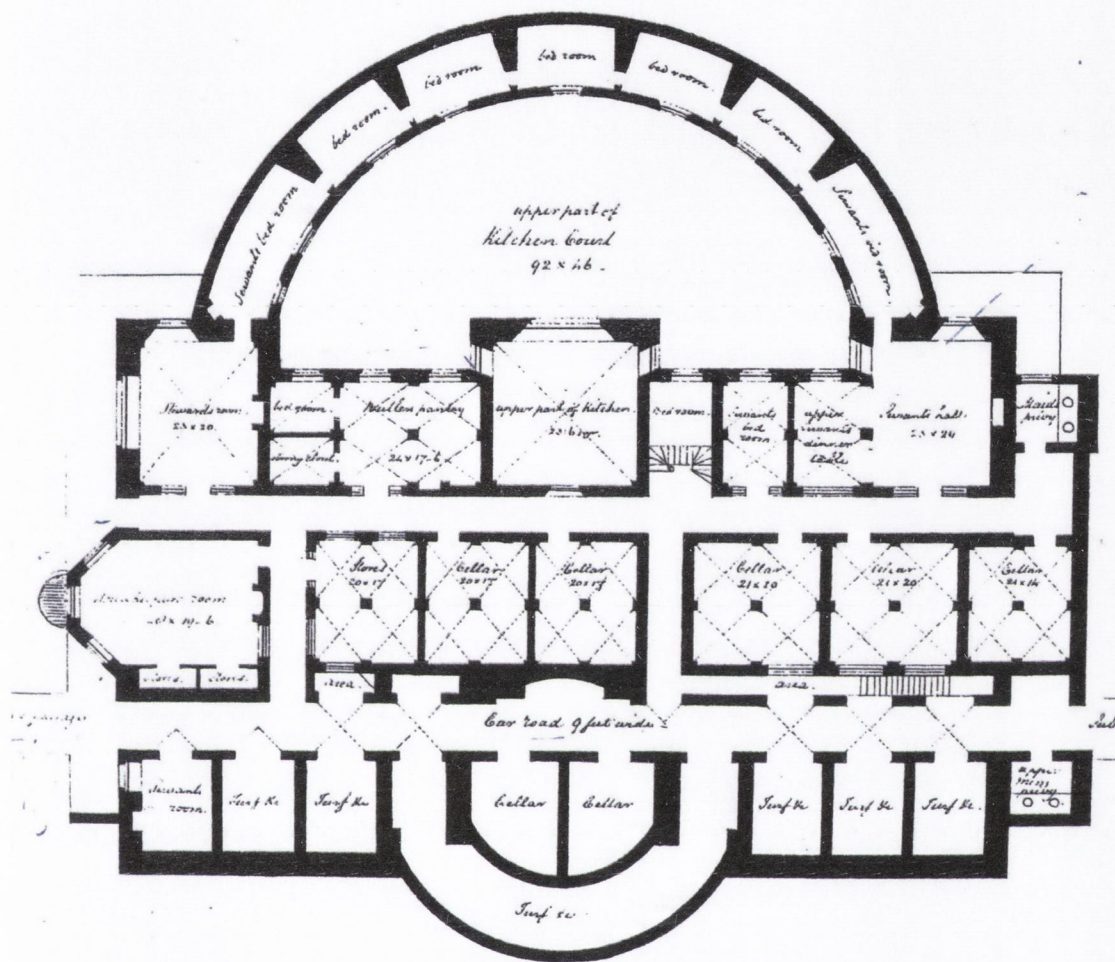


Fig. 5.3 Rockingham, county Roscommon, proposed plan of the upper basement floor by John Nash, 1809.

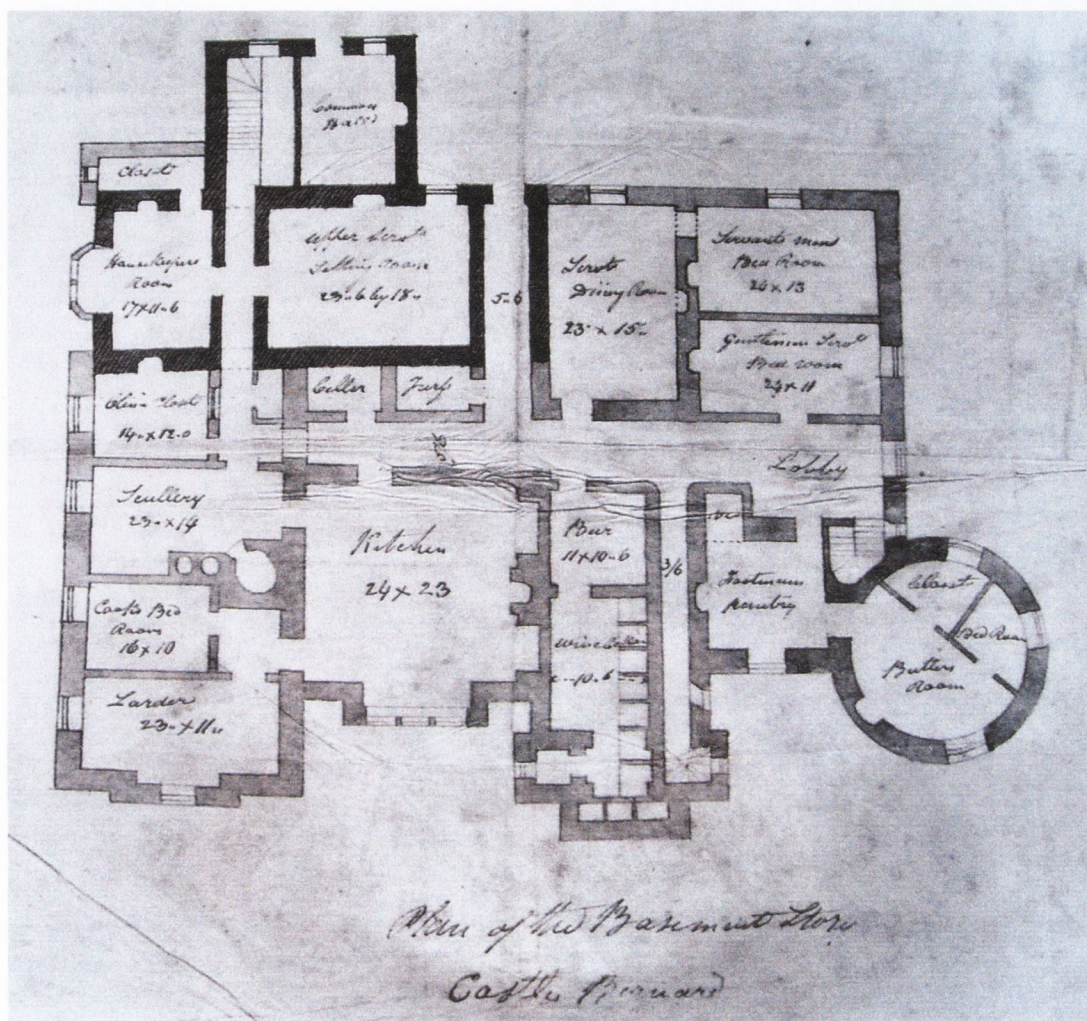


Fig. 5.4 Castle Bernard, county Offaly, plan of basement storey by G R Pain, 1833.

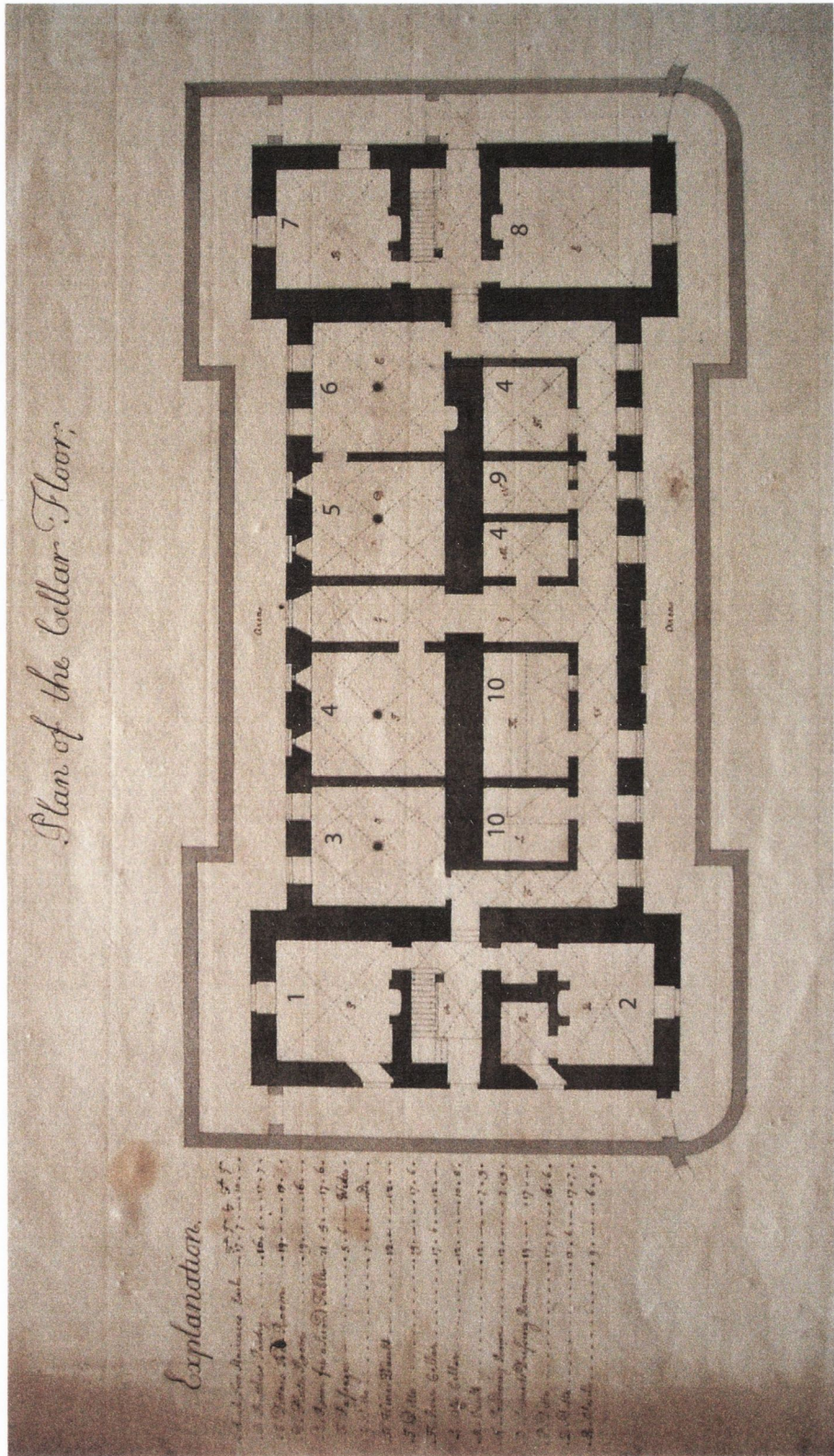


Fig. 5.5 Carton, county Kildare, plan of the basement storey (c. 1739).

Key: 1, 2 & 3. Servants' dressing rooms, 4. Wine vault, 5. Plate room, 6. Butler's bedroom, 7. Butler's pantry, 8. Room for a second table, 9. Powdering room, 10. Ale & beer cellars.

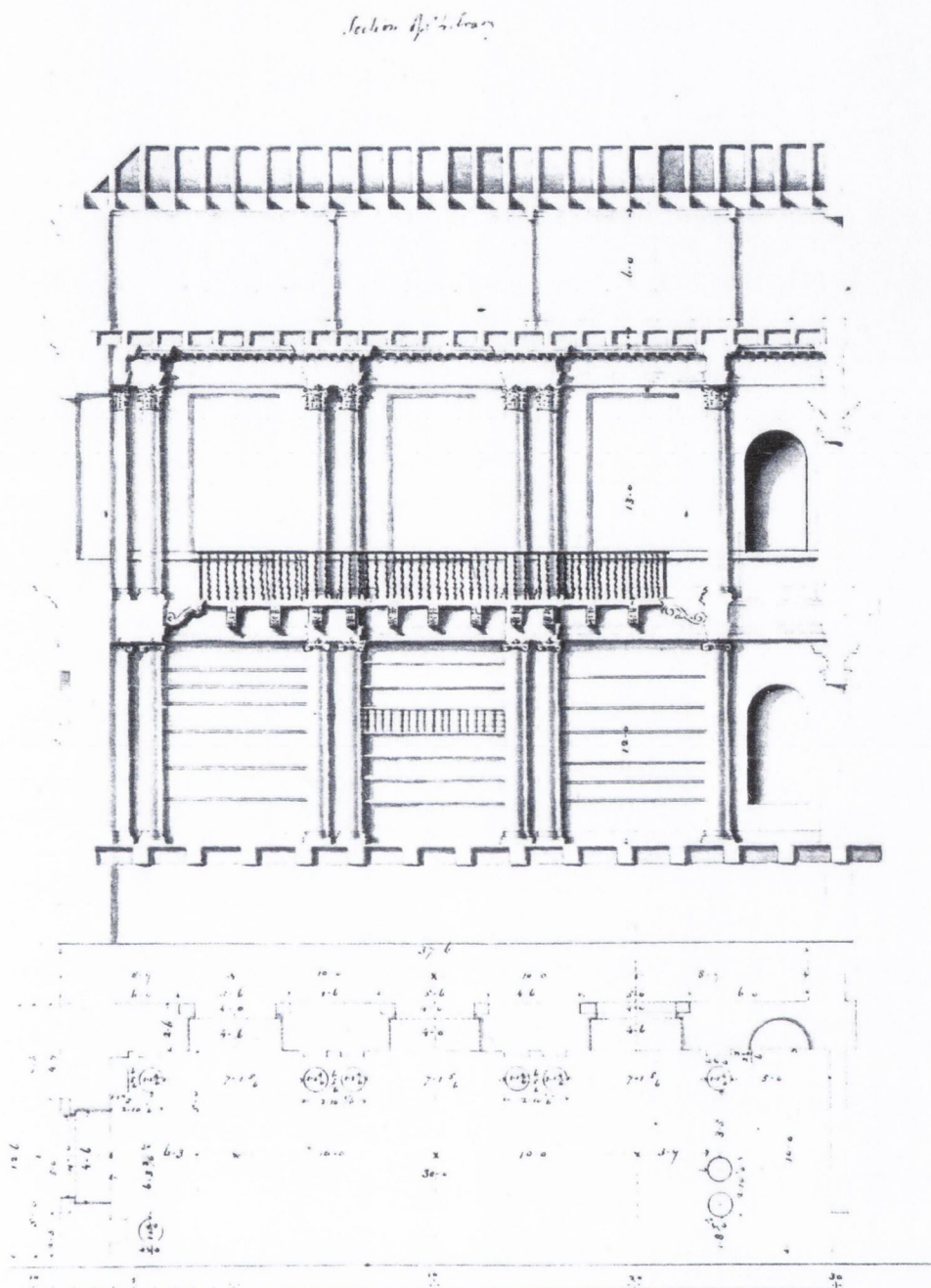


Fig. 5.8 'Section through the Library Wing of Stillorgan House as intended by Pearce.'

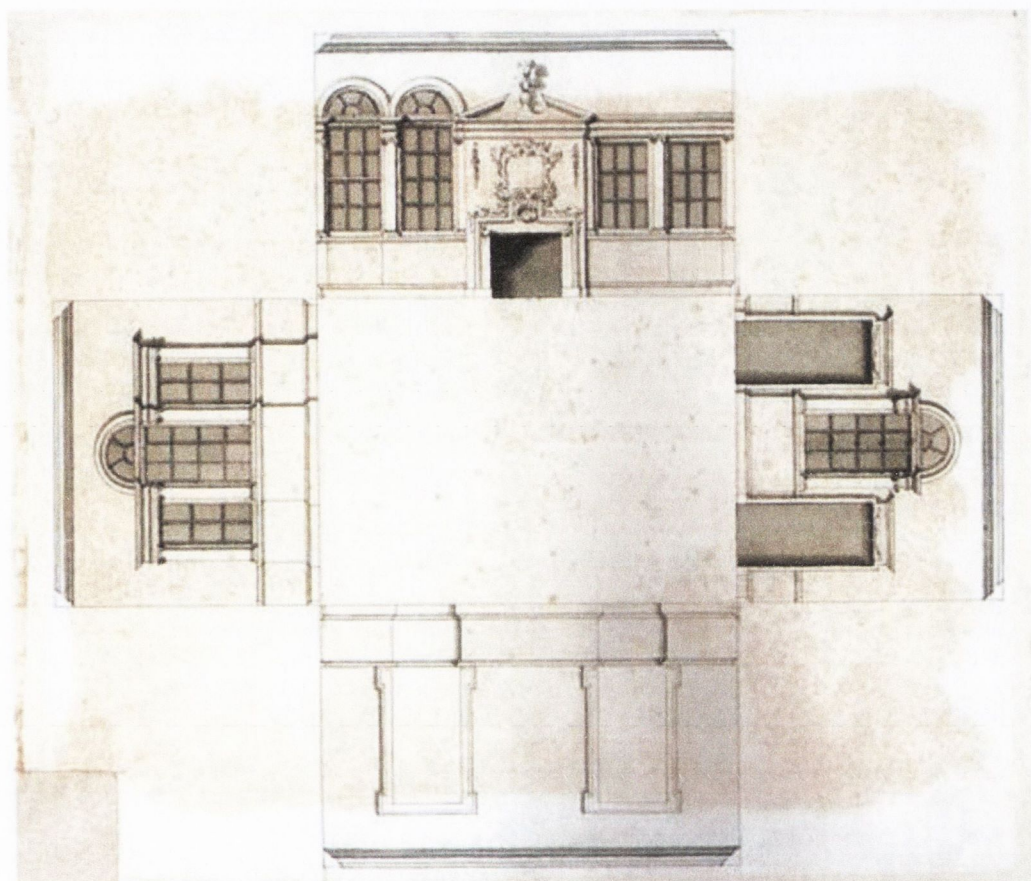


Fig. 5.9

Kildare House, design for earl of Kildare's library by Richard Castle, *c.* 1745.

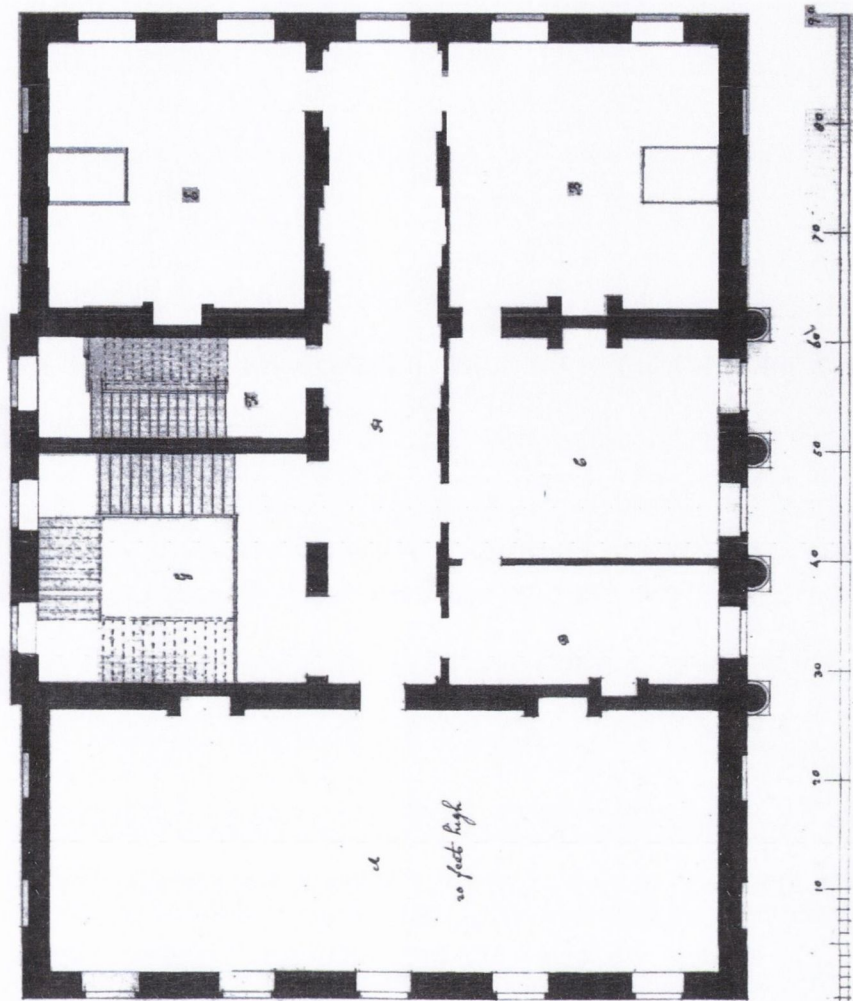


Fig. 5.10 First-floor plan of house attributed to Richard Castle.

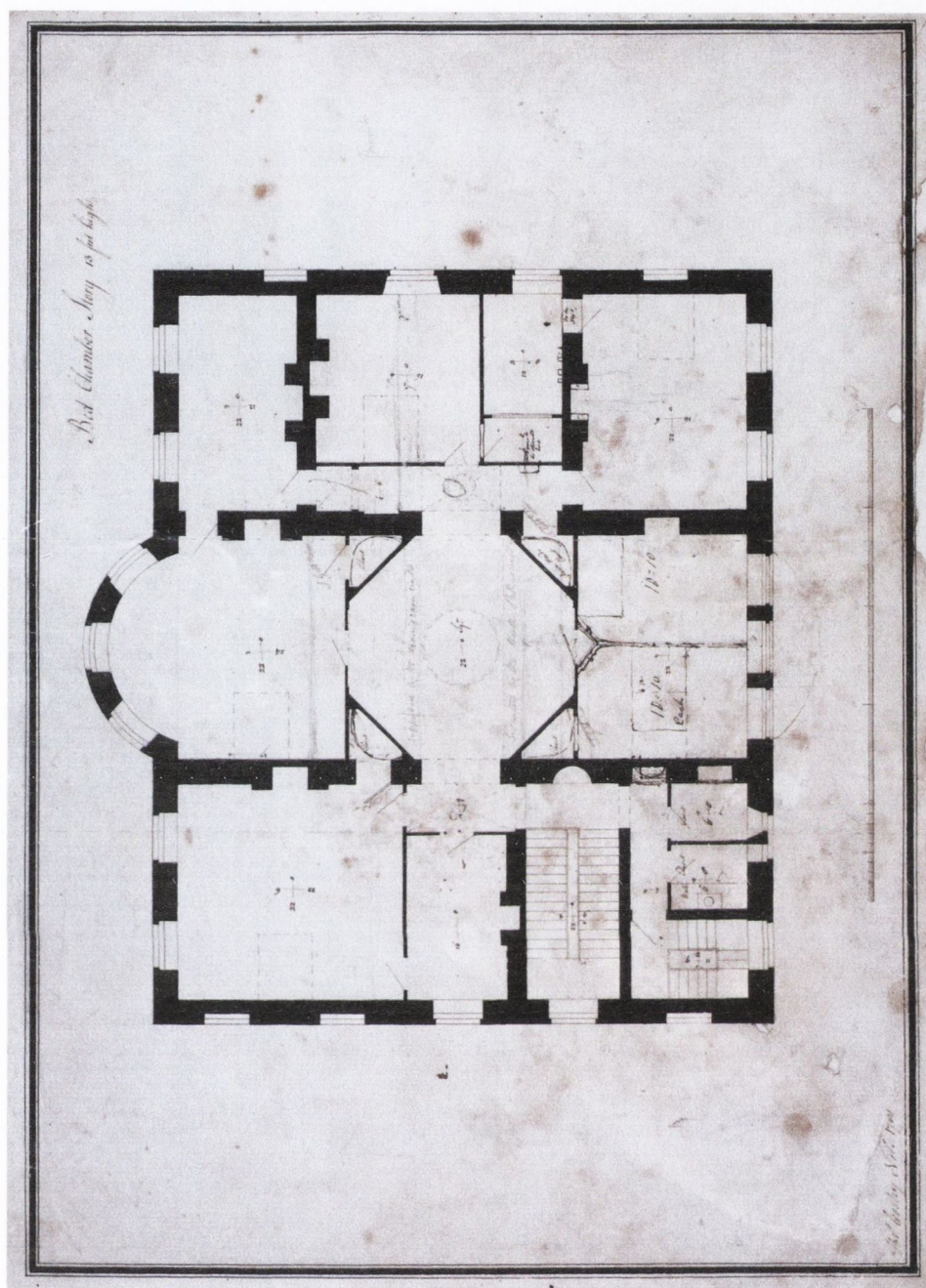


Fig. 5.11 Mount Kennedy, plan of bedchamber floor showing octagonal lobby.

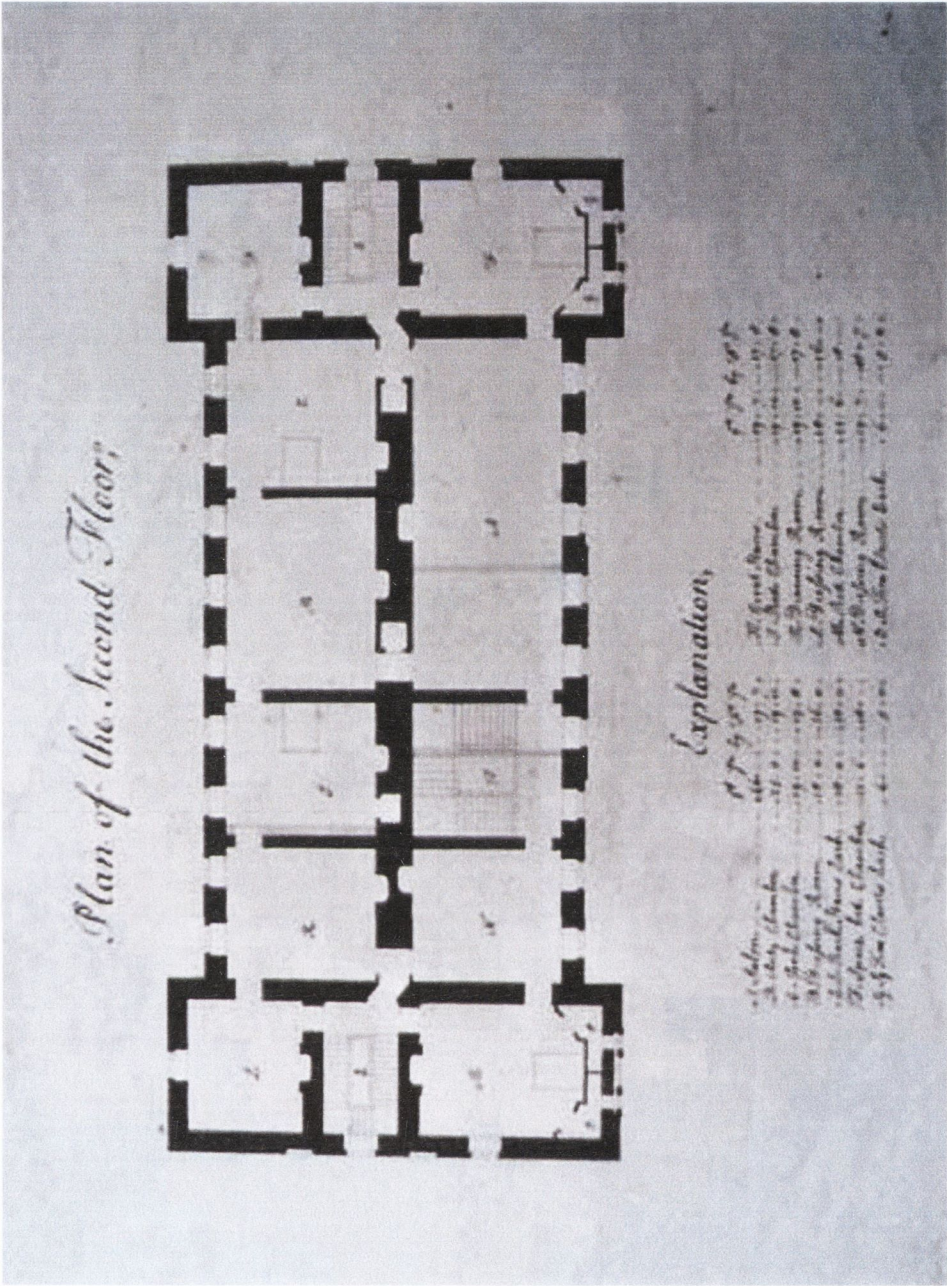


Fig. 5.12 Carton, 'Plan of the Second Floor' by Richard Castle, c. 1739.

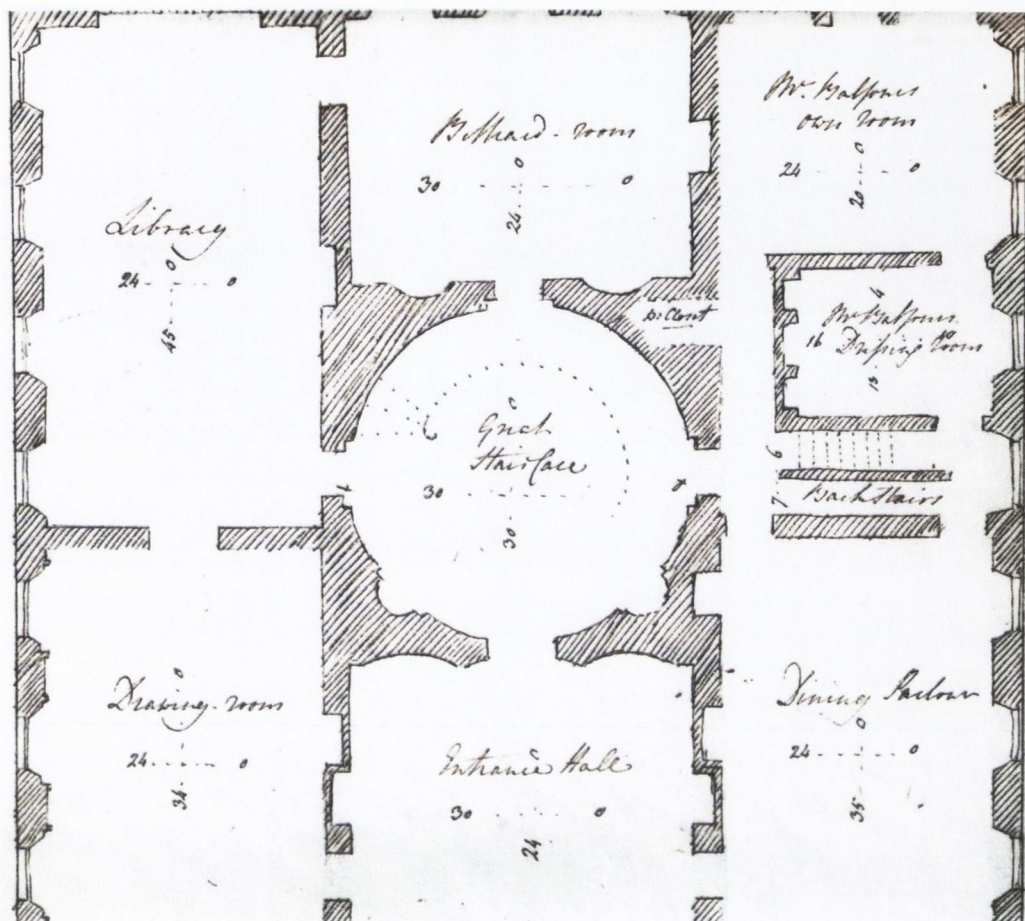


Fig. 5.14 Townley Hall, ground floor.
(Cropped photograph supplied by NLI)

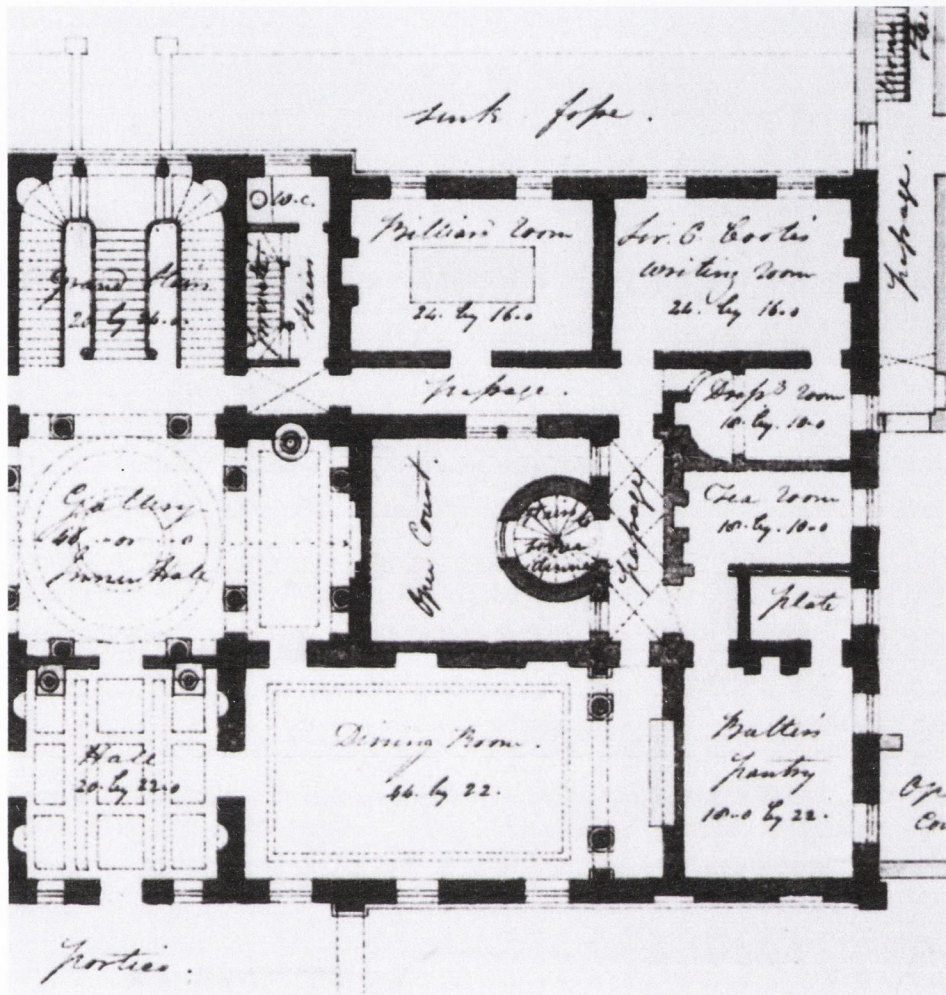


Fig. 5.17 Ballyfin, detail of 'Plan of the Principal Story', c. 1822, showing Sir Charles Coote's private rooms.

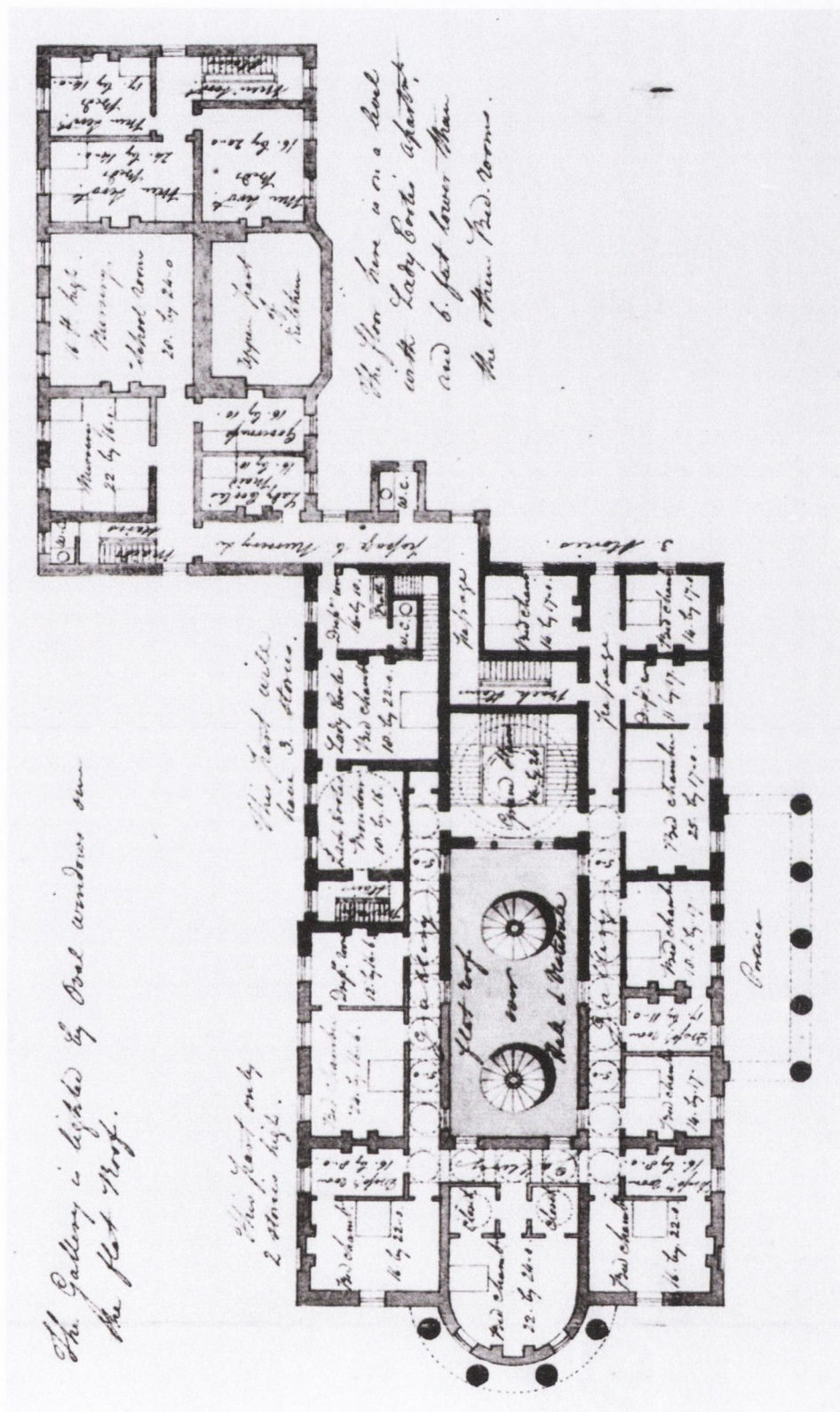


Fig. 5.18

Ballyfin, detail of 'Chamber Plan No. 1', bedchamber storey, c. 1822, showing Lady Coote's suite and its relation to children's and servants' accommodation in wing.

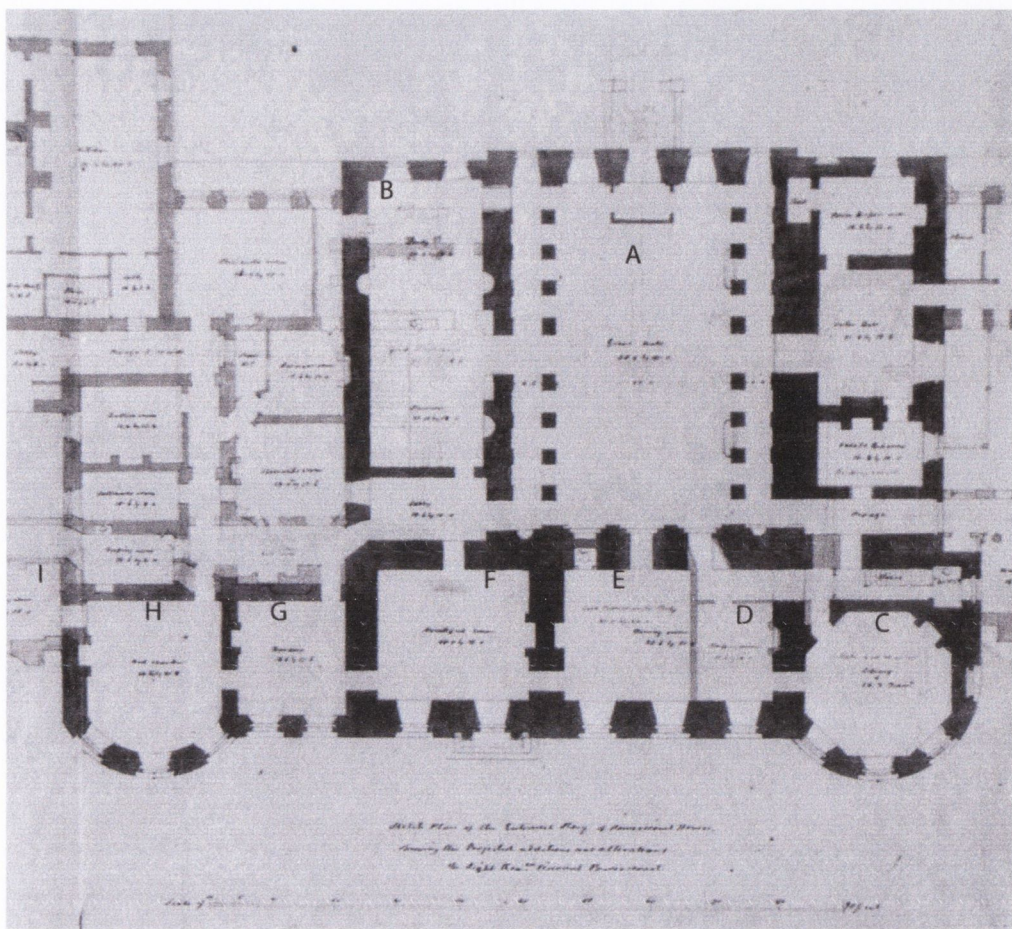


Fig. 5.20 Powerscourt, county Wicklow. Ground floor plan by Daniel Robertson, 1843

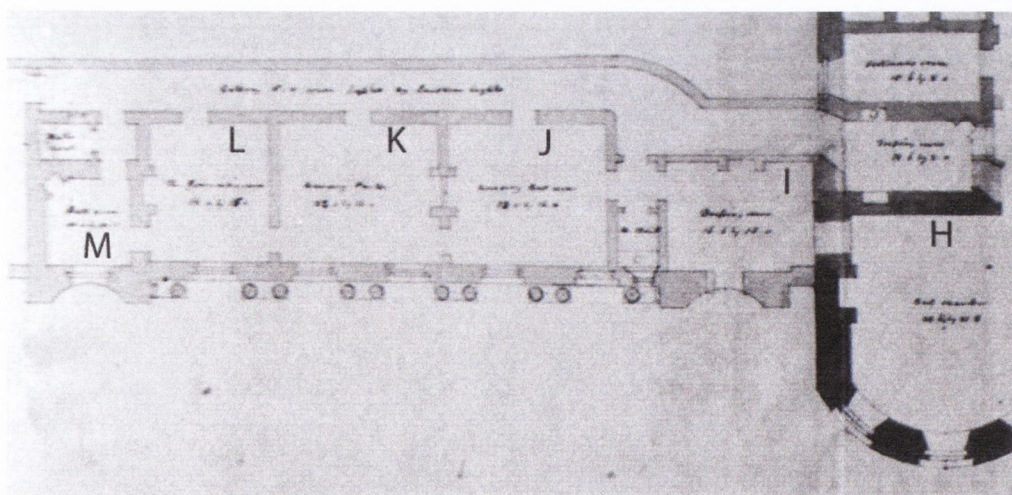


Fig. 5.21 Powerscourt, proposed alterations to garden wing.

Key to both images: A. Great Hall, B. Waiting room, C. Library, D. Dressing room, E. Lord Powerscourt's study, F. Breakfast room, G. Boudoir, H. Bedroom, I. Dressing room, J. Nursery bed room, K. Nursery parlour, L. Governess's room, M. Bathroom.

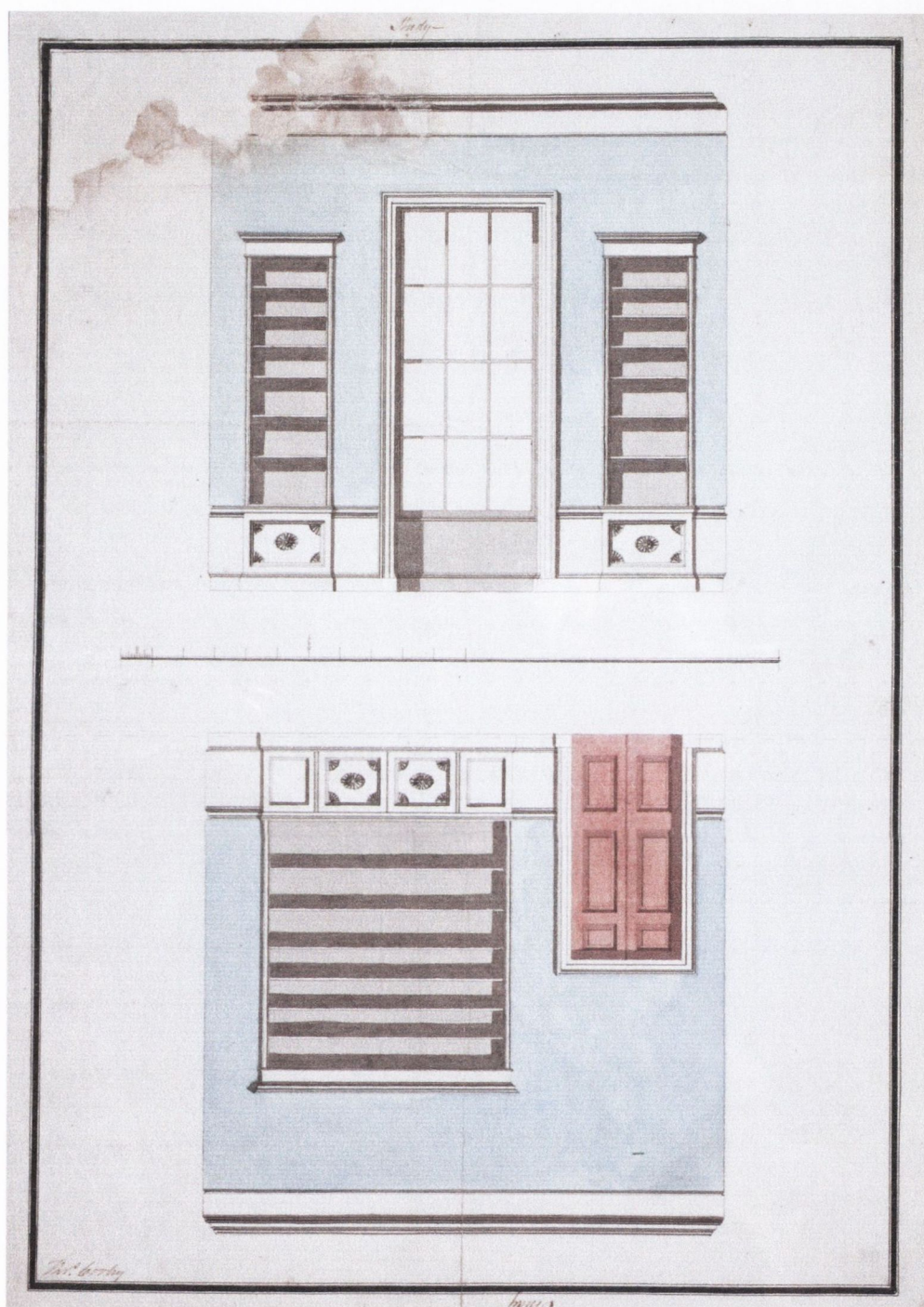


Fig. 5.22 Mount Kennedy, proposed elevations for study, drawn by Thomas Cooley.

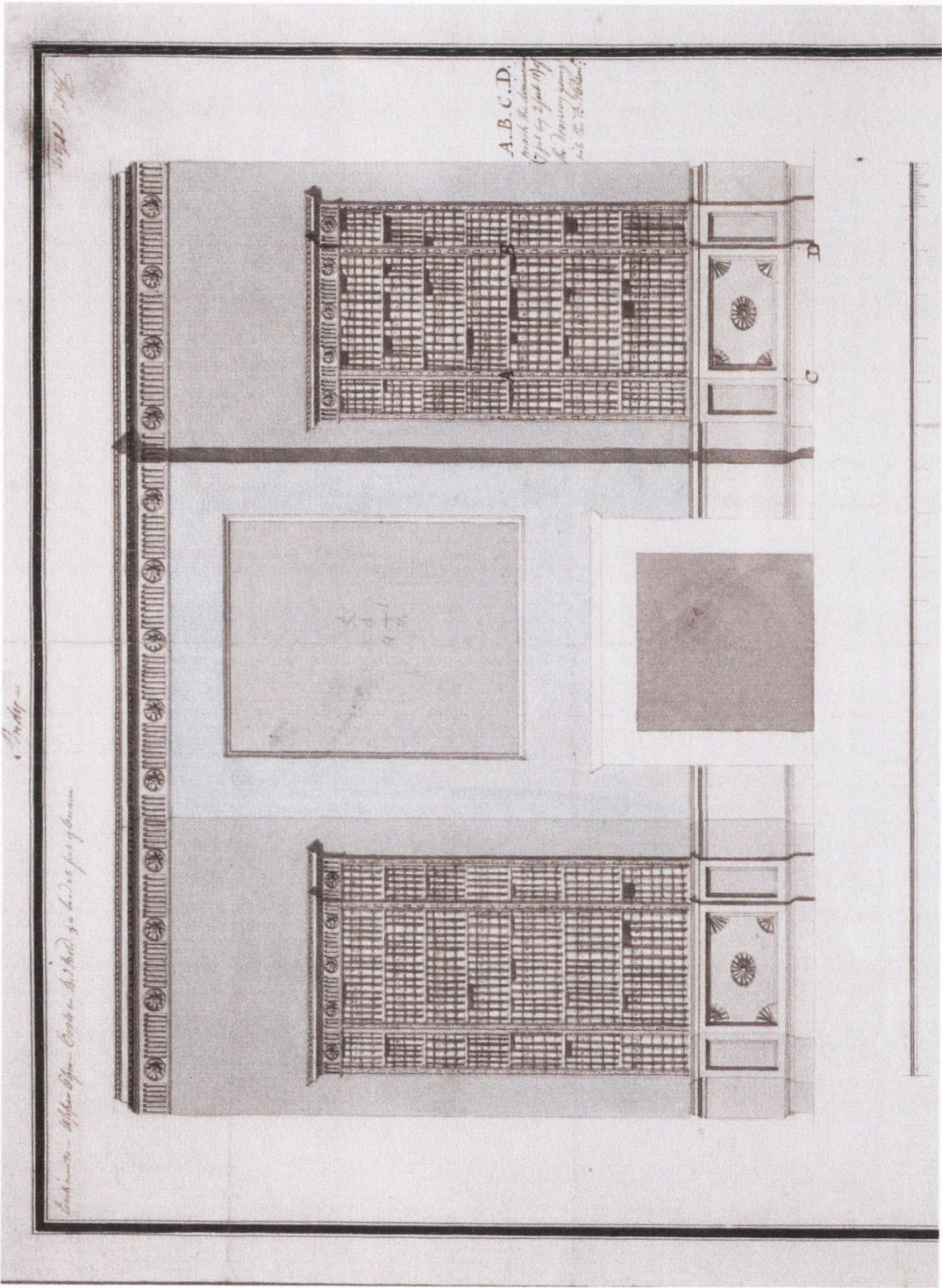


Fig. 5.23 Mount Kennedy, proposed elevation for study.

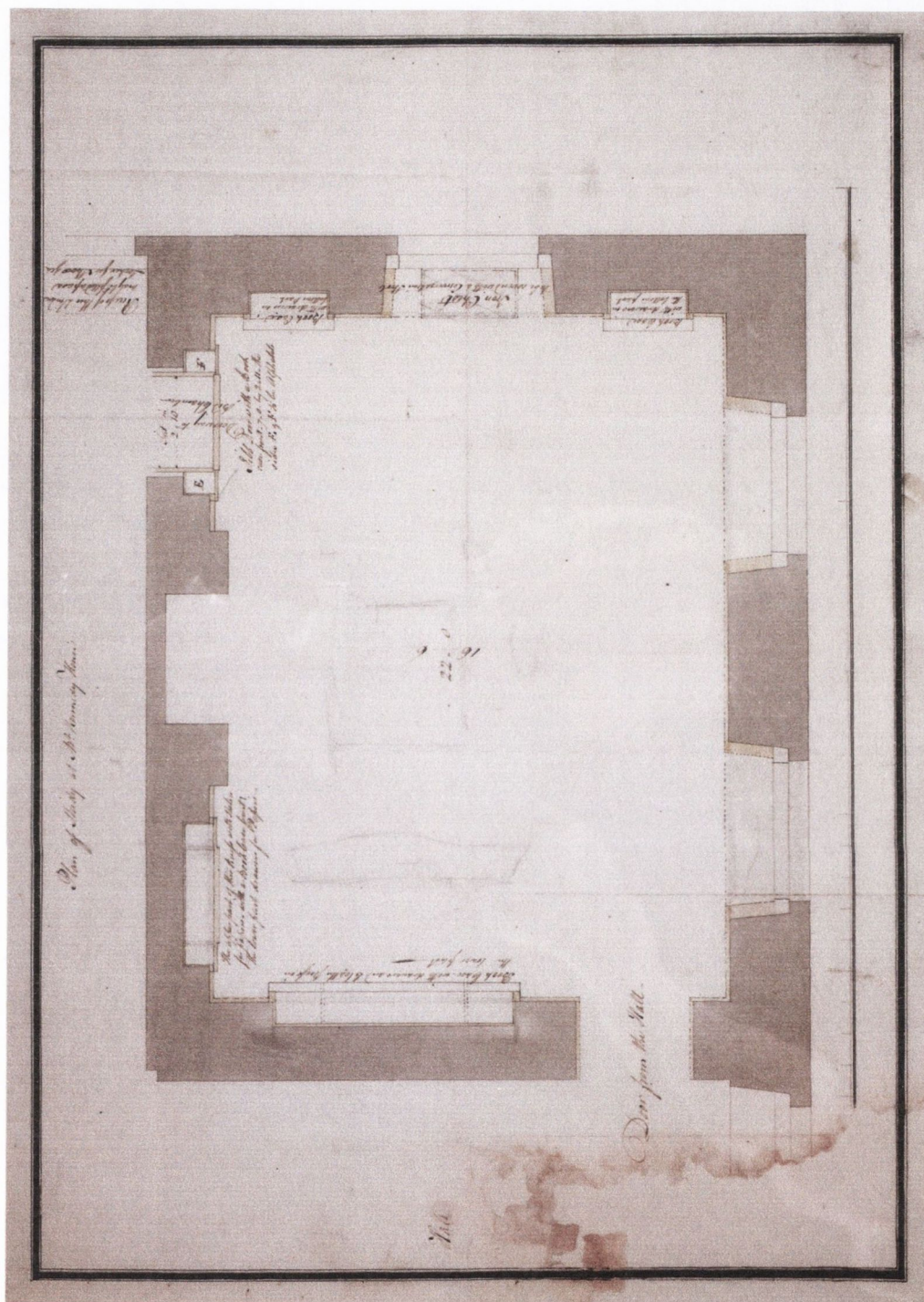


Fig. 5.24 Mount Kennedy, 'Plan of Study at Mt. Kennedy House'.

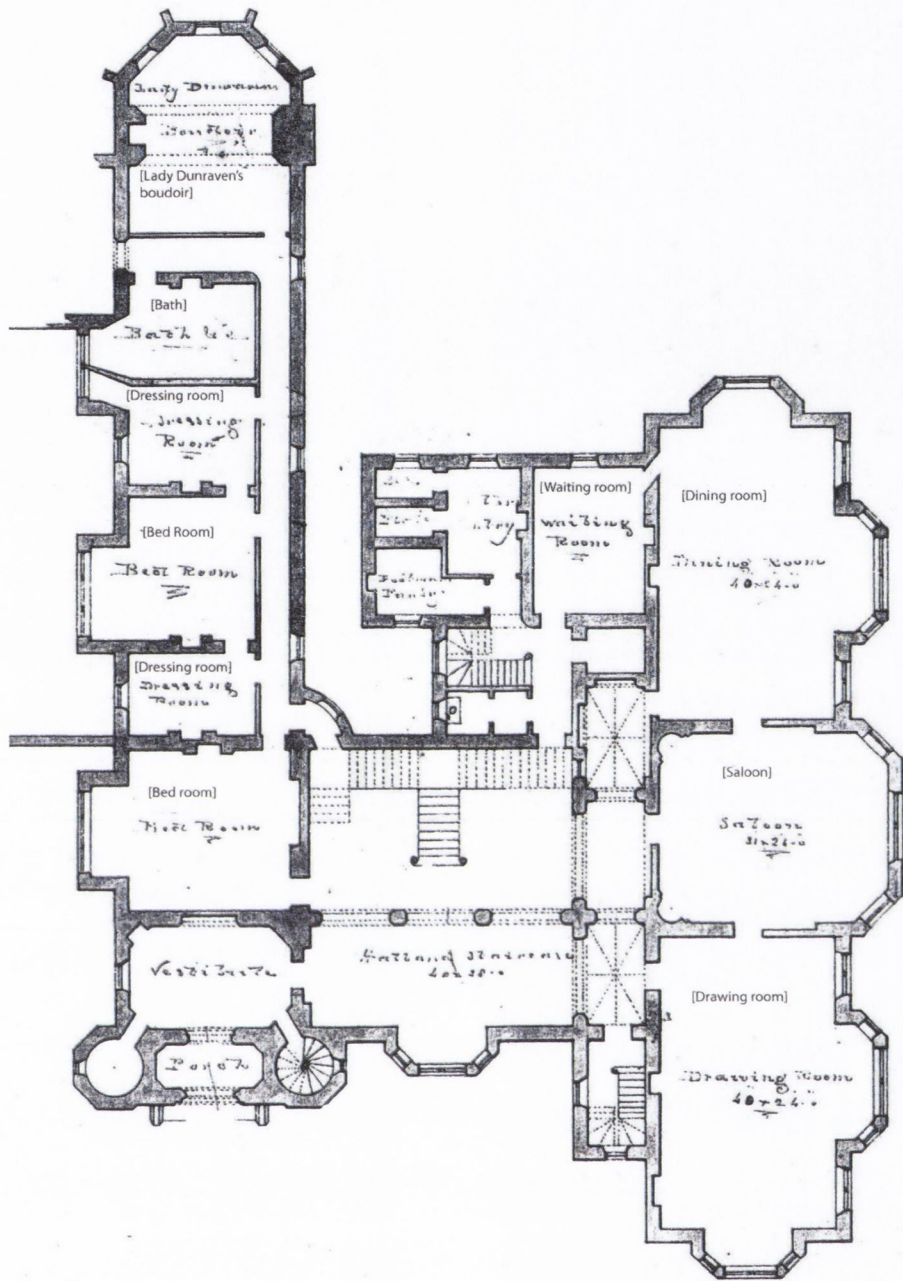


Fig. 5.25 Adare Manor, 'Plan of Principal Floor' by J & G R Pain, 1834.

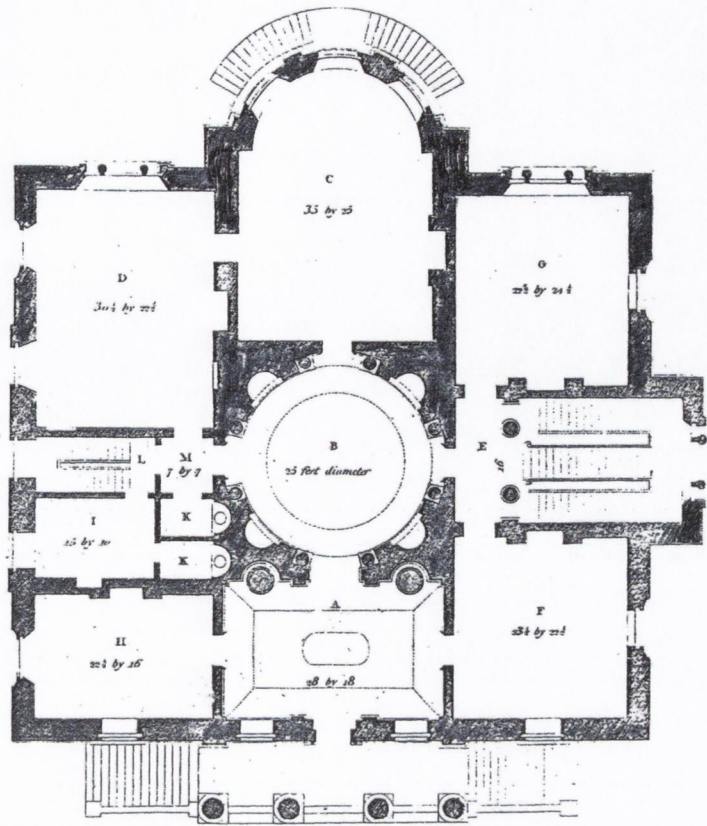


Fig. 5.26 *A design for a villa*, Richard Morrison (1793)
 A. Hall, B. Saloon, C. Withdrawing room, D. Dining room, E. Main staircase, F. Breakfast room, G. Library, H. Billiard room, I. Gentleman's dressing room, K. Water closets.

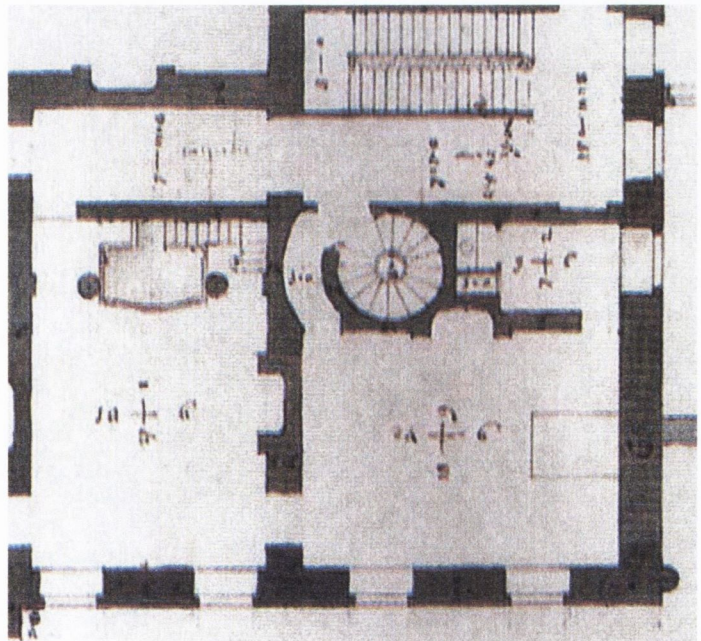


Fig. 5.27 Kildare House, detail showing ground-floor bath room and bedroom to the right of the hall.

Results Part I

Descriptive analysis of phantom and residual limb pain experiences

Of the 952 respondents, 870 (91.4%) responded to the question on phantom pain experience and nearly three quarters of those reported that they experience phantom limb pain ($n = 646$, 74.3%) (67.9% of the total sample). Eight hundred and forty people (88.24%) responded to the question regarding residual limb pain experience and over three quarters ($n = 642$, 76.4%) indicated that they experience residual limb pain (67.4% of the total sample), a further 5 people (0.60%) reported that the nature of their injuries (i.e. complete disarticulations) meant that the question was not applicable.

The frequencies and durations with which the respondents experienced phantom pain and residual limb pain during the *previous week* are detailed in Table 6.1. Forty-one per cent of those who reported phantom pain experienced phantom pain five times per week or more and 30.5% of those who affirmed the experience of residual limb pain indicated that they experienced residual limb pain at least five times per week. The duration of the typical phantom pain episode was brief for most respondents – 44.8% of the 462 respondents who rated the duration of pain episodes reported phantom pain lasting between a few seconds to half an hour. However, phantom pain of more extended durations was also reported – hours (31.2%), 24 hours (1.5%), days (2.3%), constant phantom pain (10%). In terms of residual limb pain, of the 510 respondents who reported average duration of residual limb pain episodes experienced in the past week 41.2% reported pain lasting from seconds to half an hour and 33.9% reported pain episodes lasting from hours to days while 11.8% reported constant pain in their residual limbs.

	Phantom pain (%)	Residual limb pain (%)
<i>Frequency of pain experience during the past week ^a</i>		
Constant	51 (7.9)	60 (9.3)
Daily or almost daily	71 (11.0)	90 (14.0)
Five or more times	142 (22.0)	46 (7.2)
Two or three times	16 (2.5)	
Three or four times	51 (7.9)	66 (10.3)
One or two occasions	45 (7.0)	147 (22.9)
Other descriptors	58 (13.4)	65 (13.7)
<i>Duration of pain experience during the past week ^b</i>		
Seconds	48 (10.4)	60 (11.8)
Minutes	136 (29.4)	117 (22.9)
Half an hour	23 (5.0)	33 (6.5)
Hours	144 (31.1)	143 (28.0)
24 hours	7 (1.5)	18 (3.5)
Days	11 (2.4)	12 (2.3)
Constant	46 (10.0)	60 (11.8)
Varied	35 (7.6)	38 (7.5)
Other descriptors	8 (1.7)	26 (5.1)

Table 6.1: Frequency and average duration of phantom pain and residual limb pain experiences in the past week.

^a The percentages calculated are based on the number of people experiencing the pain condition: phantom pain (n = 646) and residual limb pain (n = 642).

^b The percentages are calculated based on the number of people rating the average duration of pain: phantom pain (n = 462) and residual limb pain (n = 510).

The average intensity and extent of lifestyle interference resulting from each of phantom and residual limb pain during the past week are summarised in Table 6.2. ‘Discomforting’ was the most frequently endorsed intensity category for both phantom (47.9%) and residual limb pain (44.5%). However, almost a third of respondents who rated typical phantom pain intensity and nearly a quarter of those who rated residual limb pain intensity reported severe pain – phantom pain rating: horrible (13.8%) and excruciating (17.7%); residual limb pain rating: horrible (10.2%) and excruciating (12.6%). Of those with phantom limb pain, 31.9% indicated that such pain did not cause lifestyle interference during the past week

(“not at all”), almost a quarter indicated they had experienced “a little bit of lifestyle” interference as a consequence of phantom pain, 22.3% reported moderate interference, 12.8% quite a bit of interference, and 8.7% a lot of interference. Comparable figures for those who experienced residual limb pain were: 24.3% not at all, 21.9% a little bit, 26.2% moderate interference, 15.9% quite a bit and 11.5% a lot of lifestyle interference attributable to residual limb pain.

	Phantom pain (%)	Residual limb pain (%)
<i>Average pain intensity in the past week ^a</i>		
Mild	89 (19.8)	44 (8.2)
Discomforting	215 (47.9)	240 (44.5)
Distressing	108 (24.1)	132 (24.5)
Horrible	62 (13.8)	55 (10.2)
Excruciating	75 (17.7)	68 (12.6)
<i>Interference with normal lifestyle during the past week ^b</i>		
Not at all	179 (31.9)	131 (24.3)
A little bit	136 (24.2)	118 (21.9)
Moderate	125 (22.3)	141 (26.2)
Quite a bit	72 (12.8)	86 (15.9)
A lot	49 (8.7)	62 (11.5)

Table 6.2: Average intensity and extent of lifestyle interference resulting from phantom and residual limb pain in the past week.

^a The percentages calculated are based on the number of people who responded to the question: phantom pain (n = 549) and residual limb pain (n = 539).

^b The percentages calculated are based on the number of people who responded to the question: phantom pain (n = 561) and residual limb pain (n = 538).

In order to further investigate the experience of pain in greater detail, the sample was subdivided into four groups according to pain experience. Only the 815 individuals who responded to questions on both PLP and RLP were categorised. Just 90 people (11%) experienced no pain. Ninety-eight people (12%) experienced phantom pain only; whereas 120 people (14.7%) experienced residual limb pain only and 507 people (62.2%) experienced both phantom and residual limb pain. The association between the experience of residual limb pain and phantom limb pain was significant ($\chi^2_{(1)} = 64.053$, $p < .001$; OR .252). The relative risk of

experiencing phantom pain when having residual limb pain is about one and a half times as high compared with those not experiencing residual limb pain (RR 1.471). As shown in Figure 6.1, the intensity of respondent’s average pain episodes in the past week did not differ significantly across the two domains measured ($Z = -.056$, $p = .955$). This result was consistent amongst both the upper and lower extremity amputee groups.

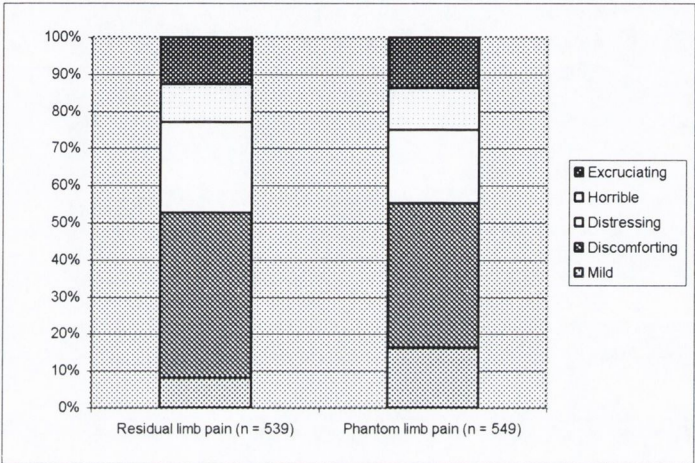


Figure 6.1: Distribution of average intensity ratings for RLP & PLP during the past week.

Similarly for both lower extremity ($Z = -2.250$, $p = .024$) and upper extremity ($Z = -.790$, $p = .43$) amputation groups respondent’s level of pain-related lifestyle interference did not differ significantly across the two domains measured ($Z = -.790$, $p = .43$) (see Figure 6.2).

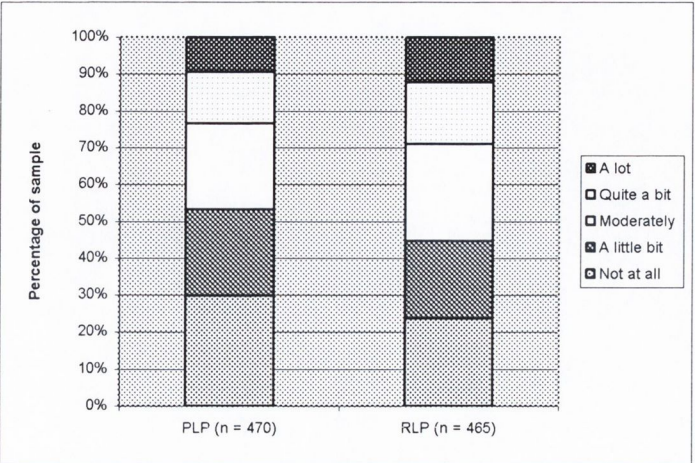


Figure 6.2: Distribution of extent of lifestyle interference resulting from RLP & PLP in the previous week.

PLP aggravating and relieving factors

When asked about their abilities to increase or decrease PLP, 358 people (61.8%) indicated they were unable to influence PLP experience, while 221 respondents (38.2%) could influence PLP experience. 195 people described their strategies for decreasing phantom limb pain, detailed in Table 6.3. The most frequently cited strategies involved taking pain medication and manipulation of the residual limb. The intensity of residual limb manipulation ranged from gentle touch and massage (n = 33) to hitting and banging the residual limb (n = 8).

Only 18 respondents detailed techniques for increasing phantom pain. Six people suggested that phantom pain could be increased by moving or attempting to move their phantom, wearing a prosthesis was implicated by five respondents, whereas 2 respondents indicated that “moving around” increased their pain. For two individuals thinking about phantom pain led to deterioration in pain intensity, however, in one of these cases the respondent indicated that concentrating on the pain to bring it to a climax sometimes led its to amelioration i.e. it ‘burnt itself out’. Decreasing weight or pressure on the stump could increase phantom pain for one respondent and finally shaking or knocking the stump, getting it cold or pressing particular areas meant worsening phantom pain for one person.

Strategy	Frequency
Taking painkillers	50
Manipulation of the residual limb	41
Distracting thought or activities	22
Wearing prosthesis	15
Apply heat	13
Adjust position	11
Remove prosthesis	10
Use TENS machine	7
Move or attempt to move the phantom	6
Wear magnetic bracelet	6
Take a warm bath	5
Apply pressure to the stump	5
Try to relax	4
Move stump/tighten stump muscles	3
Implant	3
Avoid carbonated drinks with sweeteners	2
Tell oneself it isn't there	2
Apply salve or cream to stump	2
Apply cold compress	1
Remain very still	1
Have a drink	1
Scream and shout	1
Try to increase pain until it 'burns out'	1
Sedatives	1

Table 6.3: Strategies employed to decrease phantom pain

Impact of prosthesis use on PLP

Of the 522 respondents who described the influence of prosthesis use on phantom pain, 12 (2.3%) indicated that they were unsure if prosthesis use affected their phantom pain experience, 367 people (70.3%) reported that use of a prosthesis had no impact on their phantom pain and 143 respondents (27.4%) indicated that prosthesis use was an influential factor in phantom pain experience. Of these, 25 people (17.5%) indicated that prosthesis use contributed to worsening phantom pain

while 32 respondents (22.4%) indicated that phantom pain could be ameliorated by prosthesis use, 86 people (60.1%) did not specify the direction of the relationship.

Factors associated with phantom pain and residual limb pain

Phantom pain

Age and time since amputation

For respondents with phantom pain the time since amputation was significantly shorter ($t_{(454)} = 4.118$, $p < .001$) when compared with respondents who did not experience phantom pain, see Table 6.4. However, time elapsed since amputation was not related to either intensity of PLP ($F_{(4,529)} = .608$, $p = 0.657$) or lifestyle interference resulting from PLP ($F_{(4,540)} = 1.049$, $p = 0.381$).

Phantom pain	Yes: mean (SD)	No: mean (SD)	<i>P</i>	<i>d</i>
Age (years)	73.80 (12.05)	75.12 (12.65)	0.165	< 0.20
Time since amputation (months)	506.31 (255.74)	578.77 (210.63)	< 0.001	0.30

Table 6.4: Age at follow-up and time since amputation of respondents who experienced phantom pain and who did not experience phantom pain.

As indicated in Table 6.4, respondents experiencing phantom pain did not differ significantly from those not experiencing phantom pain with respect to age at follow-up. Similarly, age was not associated with either PLP intensity ($F_{(4,539)} = 1.167$, $p = 0.324$) or interference resulting from phantom pain ($F_{(4,550)} = 1.450$, $p = 0.216$).

Amputation aetiology

The prevalence of phantom pain was significantly higher ($\chi^2_{(1)} = 22.392$, $p < .01$; OR 4.206) for the disease-related amputation group (91.3%) than for the traumatic amputation group (71.3%), see Table 6.5. Given the association between time since amputation and phantom pain and the substantial and statistically significant difference in time elapsed since amputations between the two aetiology groups time since amputation represents a potential confound. When comparison is arbitrarily limited to those whose amputation occurred within the past 15 years the relationship

between amputation aetiology and phantom pain is still significant. Three quarters (75.4%; $n = 61$) of those with trauma related amputation and 90.5% ($n = 85$) of those with amputations due to disease occurring in the past 15 years experience phantom pain ($\chi^2_{(1)} = 6.165$, $p = 0.013$; OR .391). The relative risk of experiencing phantom pain following amputation necessitated by disease is about twice as high (RR 1.8) compared with amputation necessitated by trauma.

Neither intensity ($F_{(1,534)} = 2.415$, $p = 0.121$) nor lifestyle interference resulting from phantom pain ($F_{(1,552)} = .008$, $p = 0.929$) varied according to amputation aetiology.

Site and level of amputation

Phantom pain was present in 74.3% of those with lower extremity amputations and 72.6% of those with upper limb amputations. This difference is not statistically significant ($\chi^2_{(2)} = 1.391$, $p = .499$) see Table 6.5. Similarly the incidence of phantom pain was not higher in respondents who had more than one limb amputated ($\chi^2_{(2)} = 1.269$, $p = .530$). However, both intensity of pain episodes in the previous week ($F_{(2,546)} = 6.299$, $p = .002$) and lifestyle interference resulting from phantom pain ($F_{(2,558)} = 5.028$, $p = .007$) differed in accordance to whether the amputation pertained to an upper or lower extremity. Post hoc Games-Howell analyses revealed that lower extremity amputees had more intense phantom pain (mean 2.75, SD 1.28) that resulted in more extensive lifestyle disturbance (mean 2.50, SD 1.30) than upper extremity amputees (mean intensity 2.32, SD 1.10; mean interference 2.03, SD 1.19).

Factor	(n)	Phantom pain (%)	P	OR
Traumatic amputation	Yes (732)	522 (71.3)	< .001	.252
	No (126)	115 (91.3)		
Lower extremity amputation	Yes (730)	542 (74.2)	0.733	.928
	No (125)	91 (72.8)		
Number of limbs amputated	One only (786)	579 (73.7)	0.224	1.409
	More than one (84)	67 (79.8)		
Other medical problems	Yes (524)	396 (75.6)	0.070	.731
	No (238)	165 (69.3)		
Prosthesis use	Yes (762)	556 (73.0)	0.021	1.853
	No (108)	90 (83.3)		
Duration of prosthesis use	<8 hours daily (68)	47 (69.1)	0.500	1.206
	>8 hours daily (608)	440 (72.4)		
Residual limb pain	Yes (627)	507 (80.9)	< .001	.252
	No (186)	96 (51.6)		
Amputation level ^a	Above elbow (65)	51 (78.5)	0.463	
	Through elbow (6)	4 (66.7)		
	Below elbow (47)	31 (78.7)		
	Above knee (299)	227 (75.9)		
	Through knee (12)	8 (66.7)		
	Below knee (353)	255 (72.2)		

Table 6.5: Association between phantom pain and suggested determinants. The percentages in parentheses represent the percentage of respondents exposed to a factor (or not) experiencing phantom pain. Note that not all the figures add up to a total of 870 (i.e. the number of respondents who answered the question pertaining to phantom pain occurrence) as not all respondents answered every question.

^a Respondents with more than one limb amputation were excluded from this analysis.

Level of limb amputation was unrelated to PLP occurrence ($\chi^2_{(5)} = 3.818$, $p = .576$) (see Table 6.5). However, PLP intensity ($F_{(7,520)} = 4.839$, $p < .0001$) varied according to level of amputation. Post hoc analyses using the Games-Howell test indicated that bilateral lower extremity amputees reported significantly more intense PLP in the previous week (mean 2.86, SD 1.36) than individuals with below elbow amputations (mean 2.61, SD 1.16), in addition, unilateral above knee amputees had

significantly more intense PLP (mean 3.01, SD 1.33) than either below elbow or below knee amputees (mean 2.48, SD 1.17). Comparison of average pain intensity levels reported by individuals with lower extremity amputations only revealed that those with above knee level amputations reported significantly more intense phantom pain than those with below knee amputations ($F_{(3,439)} = 5.867, p = .001$). All other comparisons were not significant. Similarly, comparison of reported pain intensities for the upper extremity amputation group revealed that those with above elbow amputations on average reported significantly more intense phantom pain than those with below elbow amputations ($F_{(1,68)} = 5.786, p = .029$). The mean and standard deviations of pain intensity ratings for those with above or below knee and above or below elbow amputations are illustrated in Table 6.6.

Amputation level	Mean intensity rating (SD)
Above knee	3.03 (1.32)
Below knee	2.51 (1.17)
Above elbow	2.60 (1.18)
Below elbow	2.00 (.866)

Table 6.6: Average phantom pain intensity ratings.

Level of amputation was also related to the extent of lifestyle interference resulting from PLP ($F_{(7, 531)} = 3.765, p = .001$). Bonferroni post hoc comparisons indicated that through knee amputees reported significantly more interference with lifestyle activities in the past week as a consequence of PLP (mean 3.75, SD 1.75) compared with below knee amputees (mean 2.30, SD 1.22) and both above (mean 2.22, SD 1.30) and below (mean 1.81, SD 1.02) elbow amputees. All other comparisons were not significant. Comparison PLP-related lifestyle interference in the lower extremity amputation group alone revealed that those with above knee amputations reported significantly ($F_{(3,457)} = 5.123, p = .002$) greater PLP-related lifestyle interference than those with below knee amputations (mean (SD) ratings 2.62 (1.27) and 2.30 (1.22), respectively). All other comparisons were not significant. When only cases of upper extremity amputation were included there was no main effect of amputation level ($p = 0.171$).