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EDITORIAL

SOCIAL WORK INTO THE FUTURE

Hilda Loughran

The Social Work profession faces many challenges today. Some of these are born of it's own success. We can proudly review at least a decade in which the value, effectiveness and versatility of our profession have been acknowledged. The recognition of the role of social work has become more widespread both among other professions and within government policy and planning. Partly as a result of this very success social work finds itself under resourced. One element of the resource deficit is manifested in the shortfall of available qualified people to fill current requirement s and to staff further developments.

In addition to the shortfall of personnel other issues regarding employment have been emerging. The issue is not simply a recruitment one but more broadly embraces the question of retention of staff. A study published in the Irish Social Worker in 1998 offered a forecast that newly qualified social workers were becoming more selective about the positions they regarded as suitable for long term employment (Loughran and Walsh 1998). In the present situation, where there are more posts than people to fill them, social workers are experiencing a new form of professional mobility. Of serious concern, with this increased mobility, is the future for some sectors of social work services. It would be regrettable if social workers abandoned social work posts that were considered to be undervalued and under pressure. This is of course a concern that has been raised in relation to child protection work in the past. It would be paradoxical if an area of social work practice that demands the highest standards of professional expertise were relegated to a post of last resort.

Social workers in their growing discernment and selectivity seem to value professional support, well managed structures, and employment in which their professionalism is valued and nurtured. The government is attempting to address some of these issues. Steps such as the proposed registration system have met with mixed responses. Other moves including expansion of social work education programmes and the development of internal structures to support placements have been more widely welcomed. In an era of challenge and opportunity it is crucial that social workers pull together to shape the future of our profession. In the past social workers, as a group, have been slow to invest in the development of a strong professional image. The old debate about whether or not social work is in fact a profession may have contributed to this dilution of our position. Other factors such as the lack of financial support to encourage full time representatives within the Irish Association of Social Workers has also posed problems. Whatever the reasons recent figures regarding the number of social work posts countrywide relative to the membership of the IASW are disappointing. Social workers who strive to act as advocates for their clients need to recognise the need to act as advocates for themselves. If we are to emerge from the current challenges and opportunities as a strong and unified profession, worthy of our role in working with our clients, we must all play our part. Whatever form involvement takes, through unions, professional organisations, practice teaching and special interest groups, it is essential that it is social workers themselves who spearhead changes and shape the future of social work.

The current edition of the Irish Social Work Research Journal offers a forum for the presentation of best practice in research and service delivery. The first four articles by Quin, Wilson, Manktelow and Browne, Taylor and Moloney are all examples of an increasingly reflective social work profession where evaluation and critical review are valued and encouraged. This journal is pleased to be in a position to assist in the publication and dissemination of such worthy examples of social work research. The addition of the Practice Review section will hopefully encourage practitioners to contribute to the debate on what is good practice and explore how such practice can be evaluated and expanded. We are pleased to present O'Reilly's work as the first practice review. Hopefully this journal will contribute not just to the debate about the future of social work but also offer support and encouragement to the growing numbers of social workers engaged in research either directly or indirectly connected with practice.

Reference:

Loughran, H. & Walsh, P. (1998) "Newly Qualified Irish Social Workers: What work worlds are they entering", *Irish Social Worker*, Vol. 16, No.1, pp.4-7.

Hilda Loughran is Joint Editor of the Irish Journal of Social Work Research.

CHILDREN WHO SURVIVE CANCER

by Suzanne Quin*

Key Words: Children, oncology, families.

Abstract

More than two thirds of all children who develop cancer will now survive. Therefore, increasing emphasis in research is being directed at the long term, but mainly physical effects of treatment. The aim of this study was to examine the long-term psychosocial effects of cancer on children and their families and to ascertain if there were unmet needs which should be addressed.

From a total of one hundred families approached, seventy-seven agreed to participate in the study. Respondents included the patients, their parents, siblings and where possible, extended family members. The age range of patients was three to twenty-one years at the time of the study (mean twelve years) and all were at least two years off treatment. Qualitative and quantitative analysis were performed using in-depth interviews, COPE, Offer Self Image Questionnaire, Children's Scale L, Social Skills rating Scale and the General Health Questionnaire.

Qualitative and quantitative data were found to be compatible and indicated that most children do not have any significant residual problems in relation to their behaviour, academic progress and social and family relationships. Fathers were less likely to avail of coping mechanisms, both internal and external, than were mothers. Many parents were found to still worry about their child's continued well-being. Overall, most parents and their children readjust to ordinary family life following completion of treatment. Some of the children, particularly those who are diagnosed and treated as infants or very young children, will have needs in relation to age-appropriate information as they mature. A small but very important minority would benefit from monitoring and support to help them cope with the experience and its aftermath. The study findings have clear implications for social work practice with the children and their families.

INTRODUCTION

This study was concerned with the long-term psychosocial effects of cancer diagnosis and treatment on children and on their families. With over two-thirds now achieving disease free survival, the emphasis is shifting from preoccupation with treatment and palliative care to survival and coping with the aftermath of the disease and its treatment. The focus of the study discussed in this article was the psychosocial effects of the disease and its treatment on the children, on other family members and on the family as a whole. Imputes for the study came from the social workers in oncology based in Our Lady's Hospital for Sick Children, Crumlin. They were concerned with the ongoing effects of the diagnosis and treatment on the children and their families in this context of increasing numbers of children surviving indefinitely. Given their own finite resources, the social workers were aware that their time and energies were largely taken up with children at the diagnosis and treatment stage. This left concerns but little time for long-term follow-up of those who survived. What, if any, services and, specifically, social work services should be ideally in place for this group was a key question. It was with this in mind that the social workers approached the Department of Social Policy and Social Work in UCD to set up a research project. Financial resources were available, what was needed from the practitioner's viewpoint was the creation of a research project that would answer the questions raised by practice, and, in turn, inform future practice. The research undertaken, therefore, is an example of the value of partnership between researchers and practitioners in the development of a knowledge base to inform both further research and practice.

RESEARCH PARTICIPANTS

Figures from the National Cancer Registry in Ireland have only been available since 1994. They show an average of 125 cancer patients per annum for children up to fourteen years of age. This highlights the small population that was being targeted for the research. Using a stratified random sampling technique, a nation wide sample of 100 families was selected from a total population of 249 children from the medical records in the paediatric oncology unit of Our Lady's Hospital for Sick Children, Crumlin, Dublin. This total sample had the following three criteria: they were children who had survived cancer, they had attended the Oncology Unit since 1992 and they were at least two years post treatment. Out of the sample of 100, a total of 77 families took part in the research. Of the remaining 23 families, 19 were not contractible being away at the time of the study or had moved with no forwarding address and 4 families refused to participate. The ages of the children ranged from 3 years to 21 years at the time of the study (mean age 12 years). The children's parents, their siblings living at home and extended family members (grandparents, aunts/uncles) who had close ongoing contact with the family during the illness were invited to participate in the research.

METHODS

The methodology included both qualitative and quantitative elements. The research instruments were chosen to incorporate a broad spectrum of data on the psychosocial effects of cancer diagnosis and treatment on children and their families. The results discussed below give an overview of the general findings with particular emphasis on the qualitative element of the study.

Quantitative Methods

The study used a range of standardised tests with the children who had cancer, the parents' assessment of their children and the parents' own coping strategies. The tests used with the children were: Culture Free Self Esteem Inventory (Battle, 1982); Children's Loneliness Questionnaire (Asher, 1985) for the younger children and the Offer Self Image Questionnaire Revised (Offer, 1992) for the adolescents.

For the parents' assessment of the children, the Social Skills Questionnaire – Elementary and Second Level (Gresham & Elliott, 1990) was used and the COPE (Carver et al 1989) and General Health Questionnaire (Goldberg, 1981) for parents themselves to identify their coping strategies and their self-perceived health status.

Qualitative Methods - General Interview Guide

This method was used for the qualitative element of the study. The children who had sufficient language skills to participate and all available family members were asked to undertake an in-depth interview. The interview themes were drawn from the literature review, observations on the ward and out patients, interviews with staff on the Oncology Unit and interviews with non participating families whose children were less than two years post treatment. For younger children and their siblings, simple drawings of hospital scenes were used to stimulate discussion. In addition, the children and their siblings were asked what would be their three wishes. The purpose of this was to gain some measure of the immediacy of health in relation to other aspects of their lives at the time of the study.

RESULTS – STANDARDISED QUESTIONNAIRES

Children who had Cancer

The Culture-Free Self Esteem Inventory was used with 53 younger children in the sample. In all there are 60 component items which assess general, social/peer related, academic/school related, parental/home related self-esteem. The results indicate that the children have a self-view which is positive and higher than average. When the results were further analysed, no differences were found in relation to socio-economic status but interesting gender differences did emerge. While there was no gender difference between the classification level ranges, for all but one scale, that of academic self-esteem, males scored markedly higher than did females on the other three subscales.

The Children's Loneliness Questionnaire was used to measure levels of loneliness/isolation in the younger children. In all, 38 children completed this test which comprises a twenty-four item questionnaire. The individual items are clustered to give a positive and/or negative rating to the areas of friends/social interaction, interests/activities, school/education and isolation/loneliness. The findings indicate that the children in this sample population do not generally experience loneliness and have an overall positive experience in their daily lives and activities. No significant differences were found in relation to socio-economic differences, gender or diagnosis.

The Offer Self Image Questionnaire Revised was completed by a total of 11 children aged from 13 to 18. The questionnaire contains items that are divided into component scales providing multiple indicators of self-image. These results indicate that the children are firmly within the norm range for their age. There are no anomalies within the component scales. Therefore, the sample could be regarded as well adjusted teenagers at the time of testing.

Children's Social Skills as Assessed by their Parents

The Social Skills Rating System (SSRS) has two component measures; social skills and problem behaviours. The findings showed that mothers consistently scored their children as having better social skills than did fathers. In particular, mothers of male subjects rated their children higher than did mothers of female subjects or fathers of either male or female subjects. The problem behaviour scale has three components: externalising problems; internalising problems and hyperactivity. Analysis by gender showed that mothers tended to score their sons as having higher rates of problem behaviours than did their daughters and than the fathers' scorings of either their sons or daughters. Only on two sub-scales were the children perceived to be other than average. The first is that mothers (but not fathers) of secondary level boys perceived their sons as having lower than average levels of responsibility. The second was fathers (but not mothers) of elementary boys rated them as having a higher than average levels of problem behaviours in the externalising sub-scale only. In all other respects the results indicate that the parents regarded their children as having average in terms of both their social skills and problem behaviours.

Parents Themselves

COPE is a measure to assess both levels of coping and methods of coping of adults. In this study the COPE Scale was used to assess how well the parents coped in relation to the population in general. The Scale, which is self-administered, addresses both the thought process and the actions in relation to coping. Overall, the results showed that parents in the study have average levels of coping in relation to the norm levels. A clear exception to this was the greater use of alcohol/drugs as a coping mechanism. However, cultural differences in general alcohol use needs to be taken into account. In terms of gender differences, mothers made greater use of many coping strategies, internal and external than did fathers. Analysis of the data in relation to socio-economic status and marital status of the participants did not yield any statistically significant differences.

The GHQ is a 28 item self-administered questionnaire divided into four scales that assess different elements of general health which are general level of health, sleep problems, sense of control and feelings of self worth. The results showed the parents did not regard their current state of health as any different than it had been in the past.

RESULTS – QUALITATIVE INTERVIEWS

The results of the qualitative interviews were compatible with the quantitative measures described above. The interviews provided a sense of the experience from the viewpoint of the patients and their parents. The results are presented in summary form highlighting the main points raised by each set of participants.

Interviews with Children who had Cancer

A total of forty-two children were interviewed. Their average age was 12 years with a mean duration of 5 years since diagnosis. Almost half could not recall any memories of being in hospital. Of those who did, the strongest memories were about being told what was the matter with them, aspects of treatment such as injections, magic cream, broviac, pain, the staff and the playroom. Having things explained clearly to them was considered important and, in this respect, there were twice as many positive comments than negative about the information given.

> "....the doctor explained everything.... Like what's wrong with me and all that. That's what made it easier for me. You know, that I knew what was going on."

The top four items identified as being the worst part(s) of the treatment stage were chemotherapy, losing one's hair, needles and being sick. However, there were also positive memories in that one-third of those with memories of this period regarded their experiences in treatment as being 'not too bad' and as not having had 'a hard time'. Most recalled some happy memories also associated with this time such as visits, outings, receiving presents, making new friends and meeting famous people.

Although parents are advised by staff to get their child back to school as soon as possible, a higher number than expected missed a lot of school. Almost one-third saw themselves as having initial difficulties on returning to school. However, overall there were twice as many positive comments about their re-entry to school. Almost one-fifth made special mention of their teacher as being nice and making a special effort to ensure that they did not fall behind in schoolwork. However, it was being with their friends again that was by far the most important aspect of returning to school.

Just under a quarter of the patients discussed how they had coped with the experience of having cancer. Coping strategies ranged from not thinking about it, talking to others, struggling through it and just getting on with it. This last strategy was particularly evident in the older, teenagers who conveyed a sense of urgency of getting through it, over it and back to normal. Two-fifths commented on how their parents coped. What was conveyed in the responses was the level of awareness of children in relation to their parent's feelings. Most saw their parents as being worried and upset while, at the same time, trying to hide their feelings from them.

> 'My mam was upset, my dad was upset as well but he didn't show it.'
>
> 'They (parents) were worried, you could hear their voices….'

Almost all of the children had views on the effect of having had cancer on them as individuals. More than one-third felt it had not changed them in any way. Of the two-thirds who considered it had changed them in some way, one-quarter raised physical changes such as hair colour and texture, height and weight and lower energy levels. In addition, one-third mentioned differences in thinking/coping. These varied from positive changes such as appreciating life more, being more relaxed and mature and having a greater understanding of illness to negative ones such as feeling angry, curtailed and tougher. Regarding how they saw the experience as affecting their family as a whole, two-thirds felt it had made no difference at this stage, while the remainder divided into those who held no view and those who felt it had brought the family closer.

When asked about their future, none of the children expressed concern about the possibility of the illness returning. Some did not think about the future, others thought about it in very general terms and the remainder had detailed ideas about travel, jobs and lifestyles.

> "I'm going to have two children, a boy and a girl and I'm going to be a maternity nurse."
>
> "I'd like to live in Australia."

This sense of normality was also reflected in the responses the children made when asked what they would like if they could have three wishes. The dominant choices related to wealth, having nice things, holidays, meeting famous people rather than to be well/never to be ill again. The fact that these responses were given in the context of an interview about the experience of cancer and its treatment shows that children can move on to lead a life not permeated with thoughts of illness.

Interviews with Siblings

A total of thirty-eight siblings were interviewed. The mean age was fourteen years and the average age at the time of the patients' diagnoses was nine years. Memories of the time of diagnosis were limited and centred on feelings of upset, fear, isolation, worry and not understanding what was wrong. Two-fifths considered that they were not given sufficient information while the remaining three-fifths were satisfied with the information they received. Visiting the hospital to see first hand what was happening was singled out as particularly important in helping them to feel included. The overwhelming memory of the time of diagnosis and treatment was missing their parent/s and their brother/sister and of feeling alone.

> "The worst part was when she came home and she was vomiting all of the time. She was keeping me awake. I was scared because I don't like the sound of vomiting. Mam would be looking after her all of the time and she stayed in the room all of the time and she'd hardly do anything with us."
>
> "It was horrible for us because we never had anyone really here."

Although not everyone could think of any happy memories, some mentioned some positive aspects such as staying with friends or relatives, missing school and getting treats or presents. Friends were identified as the most important source of support followed by parents and relatives. Most were not aware of how they coped specifically, conveying the sense of being caught up in a series of events outside their control. Three-fifths saw themselves as treated differently to their ill sibling. Of those who elaborated on this, it was in terms of their brother/sister getting away with more and/or getting more presents/attention.

> "Oh yes, always special treatment from everybody."
>
> "….he's the pet in the house now."

A minority of siblings noted some positive outcomes. The principal one being the sense of the family becoming closer. Only one-fifth felt the experience had had no effect on the family. This was in contrast to the much larger proportion of the children with cancer who held this view. The majority of siblings had very negative memories of the treatment phrase but saw things now as having returned to normal. However, two-thirds still had fears about their brother's/sister's health and sometimes about their own.

> "Even for us, every time we get sick we are afraid something is going to happen. It started off so simple, just a little cold or whatever."
>
> "I'd be afraid she would get it back again."

When asked about their three wishes, many of the siblings' echoed the patients' responses with wealth, material objects and holidays being the most popular choices. However, wishes in relation to avoidance of illness featured more in the siblings' lists than in the patients' as will be seen in Table 1 (over).

Table 1: Percentage of wishes relating to the avoidance of illness

	Patients	Siblings
1st Wish	15%	13%
2nd Wish	7%	32%
3rd Wish	13%	13%

Two-thirds of siblings had specific ideas about what would be helpful for others in their situation. These were to seek information, explanation, and reassurance and to share feelings of fear, isolation and anxiety.

> "....if someone could just be there...just someone that you could talk to."

Interviews with Parents

A total of seventy-four mothers and forty-six fathers took part in the qualitative interviews. They had vivid memories of the time of diagnosis. Feelings of shock, despair and fear predominated but a minority also recalled some sense of relief that

A diagnosis had been made and treatment could commence. Almost all had considered the possibility that their child might die, the word 'cancer' being equated to a death sentence for some.

> "I thought she was dying, no I thought she was dead actually. I was thinking of her coffin at that stage. Once she (the doctor) said 'cancer' that was it. As far as I was concerned she was finished, gone."

Just under one-half of the parents felt they had been given adequate information during their child's illness. The remainder was dissatisfied, largely in relation to the quantity of information received and the lack of opportunity to ask questions and get answers that were intelligible to them. Not surprisingly, the parents had graphic memories of the treatment phase and its effects on the child. They also recalled their own feelings of worry, depression and a sense of being in a constant state of disarray. Some also mentioned the negative effects on their other children

> "I think that the splitting up of the family was an awful part of it."

In hindsight, one-third of the parents regarded the experience as having had an overall positive effect on family relationships in the sense of becoming closer, living in the present and being less preoccupied with material things.

> "We go out and about and do things, not put them off."

A slightly lower proportion saw the experience as having had a negative effect.

> "I don't know if we will ever be the same again."

> "....you're not as secure in your life. You realise that things can go very wrong."

The remainder considered the illness as having no long-term effects on the family.

> "....our everyday life is the same as any other normal family. If there is a normal family, if there is such a thing."

Almost all of the parents believed that their child had changed in some way as a result of the illness. The perceived changes varied widely and ranged fairly evenly from very positive to very negative. Withdrawn, introverted, difficult, disinterested were some of the terms used to describe the negative effects while others were viewed as having become more outgoing, caring, mature and confident. The few parents who saw no changes attributed this to the very young age at which the child's cancer was diagnosed and treated.

> "He had one of the best defences of the lot, lack of knowing."

Parents were equally conscious of the effects of the illness on their other children. Again, there was a mixed response in terms of positive and negative effects although, in this respect, the negatives outweighed the positives. Changes reported included fear, resentment, attention-seeking, guilt, worry, independence and ongoing protectiveness in relation to the ill sibling. In some respects, the parents felt that the siblings had suffered more than the child with cancer.

> "She (sister) was actually worse and I think she suffered worse. She's more insecure....probably she had to learn a hard lesson."

> "It was only last year that he said he was worrying and asked 'Was it me that caused the cancer? I knocked him'."

Parents were very aware of whether or not they treated the child with cancer differently from their other children. There was an equal division between those who had made a conscious effort not to give any sort of preferential treatment and those who felt that a child who had had cancer needed extra attention and care.

Only one-third of parents considered the cancer to have had no lasting effect on their relationship. For the rest, the effects remained although diminished in intensity as the diagnostic and treatment stage became more remote in time. Almost three-quarters regarded the experience as having had the positive effect of bringing them closer as a couple. The remaining quarter found the strain on their marriage as intense, leading to breakdown and near breakdown in a few instances.

Most of the fathers interviewed saw themselves as either coping well enough or coping well with the experience of their child being diagnosed and treated for cancer. Trying to forget what was happening, trying to get on with other aspects of their lives such as work and taking each day at a time were their preferred ways of coping. The mothers interviewed also described themselves as having coped well. Talking to others, getting detailed information from hospital staff and seeking consolation in religion were very important to the mothers with over half specifically identifying their religious beliefs as having been of major importance. However, a substantial minority found little comfort in religion, feeling bitter and angry with God for having inflicted this on their child.

The extended family was the main source of support with grandparents, uncles and aunts playing a major role in providing both emotional support and practical help. Other parents of children with cancer were also cited as well as professional staff, friends, neighbours, employers and work colleagues.

Regarding the patients' current health, three-quarters reported their child as having no major limitations. In relation to their perceptions of the child and their own feelings, over two-thirds of the parents felt positive while the remainder expressed worries about some or all aspects of their child's health.

> "You see - it's over but it's not over. That's the worst of it now. I think that's the hardest. I know cancer can reoccur."

Searching for a cause, self-blame, anger and guilt were ongoing preoccupations for around one-third of the parents. Concern for the child's future was also expressed in relation to survival and to the effects on the development of personal relationships, education and employment

DISCUSSION

The use of qualitative and quantitative methods provided a rounded picture of the children and their families after a substantial time lapse since completing treatment. The fundamental question was whether the diagnosis and treatment of cancer had had serious long-term effects on the children's psychosocial development. In itself, survival does not ensure quality of life. Along with increased survival rates, therefore, has been "growing concern about the biological and psychological late effects of childhood cancer and its treatment" (Friedman and Mulhern, 1991). Studies of survivors have shown varying results in terms of psychological effects. Lozowski (1992) reported that survivors of childhood cancer saw themselves as more positive than their peers. Butler et al (1995) found that conditions such as Post Traumatic Stress Disorder do not appear to occur at an increased incidence in survivors of cancer. Less encouraging was an earlier study by Mulhern et al (1989) that found school problems and somatic complaints of undetermined origin among a sample of childhood cancer survivors. Their study found that more than half of the children to have scores suggestive of excessive behavioural problems, and nearly as many with deficits in areas of social competence. Children in single parent families were found to be at particular risk in these respects. Novakovia et al (1996) found childhood survivors reporting both positive and negative

experiences of cancer. Overall, the patients in their study indicated that, while there were negative experiences of pain, disruption of family, social and school life, there are also experiences which can result in improved self-concept and the acquisition of values that are likely to change life for the better.

The results of this study clearly indicated that most of the children were well adapted and coping effectively with all aspects of their lives. Further, in recollecting the period of diagnosis and treatment, the children's memories were by no means only negative. Parents for the most part were able to put the experience in the past in spite of some ongoing concerns about future implications for the child of having had cancer. Parents too were able to identify some positive effects on themselves and on their family as a whole in the sense of changing priorities and bringing the family closer together. Such findings are most encouraging for children currently undergoing treatment or recently post-treatment.

However, within these very positive findings, there is evidence of a small number of children and their families who have ongoing difficulties. Analysis by diagnostic group, socio-economic circumstances, family composition and gender did not show any significant differences. The only factor seemed to be one of age indicating that those approaching or having reached adolescence may benefit from psychosocial follow-up. This finding echoes a study of twenty-one adolescent survivors by Schroff-Pendley et al (1997) indicating that children diagnosed during middle childhood or adolescence are more at risk of psychological difficulties than those diagnosed in their infancy. Roberts et al (1998:16) argue that adolescent cancer patients are "uniquely challenged by cancer treatments as they must confront their own mortality and worry about their health while their peers are typically ignoring or denying these realities".

The importance of the family in the coping process of childhood survivors of cancer cannot be underestimated. A study by Kupst et al (1995) found that the most significant predictor of the child's coping and adjustment was the coping ability of its mother. Knowledge about the father's role in coping is less documented on account of their lower participation rates in studies relative to mothers (Janus & Goldberg, 1997). Pelcovitz et al (1996) suggest that the tendency of fathers to use avoidance as a coping strategy to deal with chronic illness in their child may put them at significant risk of developing Post Traumatic Stress Disorder. Findings by Dalquist et al (1996) indicate that fathers tend to rely on their spouses as their sole means of support whereas mothers have broader social support networks to turn to when their child develops a serious illness. This concurs with findings in an earlier study by Leventhal-Belfer et al (1993) that mothers often share such concerns more with friends than with their spouses while fathers did the opposite.

A particular feature of our study was the relatively high participation rate of fathers. Our findings on the coping strategies of mothers and fathers were similar to the studies cited above. The results of the COPE Scale and qualitative interviews showed that fathers typically used the coping strategies of avoidance and dependence on their spouses as their sole means of emotional support. Knowledge of such differences is important for understanding how each cope with stressful situations and indicates how professionals can use this knowledge to involve both parents meaningfully in the treatment process. Elliott Brown & Barbarin (1996), in their study of gender differences in parental coping with childhood cancer, suggest that fathers may need 'permission' to articulate their emotional responses to their child's illness. At the same time, social workers need to take account of the importance for fathers of having a sense of control in such a situation of intense stress.

Only a small number of grandparents took part in the study. Those who did participate saw their role as being supportive to their own child, the parent of the child in treatment. However, the grandparents indicated a very negative view of cancer, regarding it as a death sentence. If they can be helped in their role as providing appropriate emotional and practical support, it would be important that they be provided with up to date information on improved treatment outcomes.

Heffernan and Zanelli (1997) highlight the tendency to limit research on coping strategies to parents (particularly the mother) and the child with cancer while all but ignoring the siblings in the family. It is only recently, they point out, that research has begun to incorporate siblings in studies of children who survive cancer. Their study found siblings as experiencing major stressors where cancer occurs, resulting in feelings of anger, guilt, fear, anxiety, embarrassment and frustration. This supports an earlier view put forward by Rollins (1990) who referred to siblings as "the forgotton ones". Cincotta (1993) suggests that siblings may be at greater risk of psychosocial difficulties than their ill brothers or sisters, a view supported by other studies such as Adams and Deveau (1998), Martinson et al (1990), Eiser and Havermans (1992) and Chesler (1992).

Such findings were also reflected in our qualitative interviews of siblings. Indeed, of greatest concern within the study findings was the impact of the illness on the siblings. The negative effects during the diagnosis and treatment stages were clearly articulated by the siblings who participated in the qualitative interviews. Parents were aware of the problems for siblings but were often unable to deal with their needs effectively on account of the physical and emotional demands of having a child with cancer. A study by Shields et al (1995) of family needs when a child has cancer indicates that parents are likely to need assistance in helping them to discuss the situation with other children in the family.

Furthermore, it was evident that feelings of neglect and of being of lesser importance do not necessarily diminish when the treatment has ended successfully. Such findings indicate the need for siblings to be included as much as possible at the treatment stage and that parents are helped, in terms of information, support and practical help, to respond to the needs of siblings in these circumstances. Support services for siblings, both at the time of treatment and subsequently, could offer help to this subset of the family who would seem to be particularly vulnerable. Within this group, Hamama et al's recent study (2000) indicates that siblings who are young at the time of diagnosis and treatment may be at greater risk of ongoing stress than older children. The latter, they suggest, may have the relative advantage of being able to understand better what is happening during the illness and have more developed emotional and social skills as well as peer support to help them cope.

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The research team was: **Dr F. Breatnach** (consultant Oncologist), **Dr A. O'Meara** (Consultant Oncologist), **Mr Eddie O'Neill** (Social Worker in Oncology), **Dr Suzanne Quin** (Lecturer in Social Policy and Social Work who was the Project Director) and **Ms P. White** (Psychologist who was the Project Researcher). The study was funded by the Children's Research Centre, Our Lady's Hospital for Sick Children, Crumlin, Dublin.

PARENTING FOR A MULTICULTURAL SOCIETY

by Mary Wilson

Key Words: Adoption, multicultural, Ireland.

INTRODUCTION

The numbers of couples and families interested in adopting children from abroad has been on the increase over the past ten years. There are many factors which account for this change, notably the decrease in the numbers of children from domestic sources and the increased awareness of and access to children from abroad whose political and social circumstances make them "eligible" for adoption. (Mallows in Mullender 1991:82-83)

Consequently there has been a need and a demand from both seekers and agencies to streamline, some might even say speed up, the assessment process for those wishing to adopt from abroad. The process of assessment for foreign adoption has been refined and accelerated in recent months by the Minister in the light of research undertaken into practice and procedures (O'Brien, 1999). Parents as partners in their own assessment is one of the key features of this new approach. It is still too early to state, in the absence of empirical research, how successful this will be. But one outcome which is certain is that increasing numbers of children who have been adopted from abroad are now being reared in families in Ireland. What are the needs of families who have been formed or reformed in this way? How can these needs be best addressed? As a means of identifying and addressing these issues a pilot Foreign Post-Adoption Parenting Support Programme was developed which ran for a six week period from February to April 2000.

PROFILES OF PARTICIPANTS

Intercountry adoption is usually, although not always transracial. While there are still many infants placed for adoption, increasingly many children are a year old and older when placed and many may have been in institutions in this interim period (Triseliotis et al 1997). The stereotype of those who apply to an overseas country to adopt "tends to be that of a childless couple neither of whom share the child's experience of living in the country, or the heritage itself and have little experience of adoption" (Catholic Children's Society, Project 16-18. 1999:4).

However, the impression and the experience of the group which is under discussion here would suggest that there was more diversity in both the adopting family and the children whom they had adopted. Thirty four people, the majority of whom were couples undertook the programme and twenty six people completed it. The "drop outs" were partners of those who had commenced the course. In every case at least one member from each family completed the programme. This constitutes a very high level of attendance and reflects the findings from practice wisdom that adoptive parents are highly motivated and committed to the children whom they adopt. (Gibbons 2000).

The profile of participants comprised at least three sets of older parents who already had teenage children and thus were engaged and motivated to parent "older" preteen children from abroad. In addition, there were two other couples representing the age group of the mid forties to the early fifties who were approaching parenting for the first time. The bulk of the parents fell into the 'thirtysomething' age range and had one adopted child. One couple had just completed their assessment and were hoping to realise their parenting dream in the near future. Similarly, in relation to country of origin, children came from many diverse ethnic backgrounds such as the Far East, Latin and Central America, Africa and Europe. The majority of the children however, appeared to be from China, Guatemala, Romania and Russia. In relation to age, children whose parents were represented on the programme ranged from 1 to 12 years, with the bulk of the children falling into preschool and early school going cohorts.

RATIONALE

The idea to plan and present a parenting support programme for parents who had adopted children from abroad was taken by the group known as Cabhru (Self-Help) who have been meeting in Bessborough, Cork for a number of years. Cabhru consists of seven adoptive parents and the author. The focus of this group has been to offer parenting support to members and to act as a resource to the wider community in relation to issues concerning domestic and foreign adoption. This group, operates from an empowerment perspective. According to Thompson (1997), empowerment is defined as "seeking to maximise the power of [clients] service users and give them as much control as possible over their circumstances" (Thompson, 1997:83). Empowerment is not "done" to people, it is not a technique. Rather it is a goal of intervention as well as the process by which that goal may be achieved. Empowerment is concerned with power balances in the articulation of need. It aims to challenge and change the role of professionals from expert definers of need or resources and services towards more democratic forms of meaning and method. Participation in the creation and delivery of services can offer real and empowering experiences for adoptive parents. Through the process of empowerment they become resources for themselves and others with whom they become involved. This framework also coheres with a strengths' based approach to intervention which views the community within which service users operate as "an oasis of potential resources" (Coulshed & Orme 1998:66). Cabhru believed that their own experiences of parenting children adopted transracially and the support network which they had developed had a wider application. Their decision to share their experiences and skills was made in the context of the increased public concern and often contentious opinions generated on the challenges which multiculturalism is posing for Irish society.

The Programme which the Cabhru group formulated sought to incorporate their considerable experiences of the issues arising from the adoption process through all its stages. A flavour of their particular expertise could be summarised as follows. Three of the group are rearing families of transracially adopted children; the numbers of children in all families vary from one to six; the age of the young people in these families ranges from 8 years to 33 years. One family has yet to experience the vicissitudes of the preteen and teenage cycle which is currently "full blown" for most of the others. One family have become grandparents and revisit the issues of identity for themselves as a result. This chronological component of the group's membership was a particular strength in their approach, covering as it did over a 30 year period from initial adoption up to and including experiences of tracing and reunion. Therefore Cabhru were and are able to articulate learning's and experiences of the unfolding adoption story in unique and accessible ways which are commensurate with the requirements of good practice.

The Cabhru group of parents, decided that the time had come to publicly address the issues raised for parenting in a multicultural society, both as a means of developing awareness of the complexity involved and to offer support to others with this task. "Adoptive families are more likely to find a family association to join, which will give them support as an adoptive family." (Overseas Adoption Helpline U.K.1999)

A MODEL OF PARTNERSHIP

In addition to Cabhru, the other partners involved in this programme included, Bessborough Family Support Services and the Southern Health Board. Discussions were initiated with representatives from these groups in order to elicit support for the operation of the programme on a pilot basis. The "division of labour" which emerged subsequently represented an amalgam of the skills and inputs of each partner. Cabhru would deliver the programme. Bessborough would provide the administrative support and the venue. The Southern Health

Board would provide the funding. Interventions which link the skills and abilities of one group with the needs and demands of another, which are facilitated and resourced by other partners are representative of the approach undertaken to develop and implement this programme (Mullender & Ward 1991). Using groupwork methods this partnership sought to increase the level of provision from service providers and extend the networks available to service users.

In order to maximise the benefits which would accrue to participants in the longer term, it is important to state the type and character of the groups which are being promoted. The group which was facilitated by Cabhru was an educational group. The purpose of this type of group is to orientate and prepare members for life stages, new experiences and challenges (Preston-Shoot,1987). Facilitation and self direction are the components most uniquely embedded in this type of groupwork intervention.

Facilitation can be defined as "a developmental educational method which encourages people to share ideas, resources, opinions and to think critically in order to identify needs and find effective ways of satisfying those needs" (Prendiville, 1995:4). Groups which are self-directed have a "distinctive collaborative commitment to achieving social change on issues identified and owned by the group members themselves." (Mullender and Ward 1991:161). Parents as partners in this process are central to successful outcomes. By encouraging people to self select and participate voluntarily, such groups enhance motivation and commitment. In addition their focus is to help participants generalise from their particular situations to wider social processes. Many parents who have been assessed as suitable for adoption have by definition been given a 'certificate of excellence' regarding their parenting skills. But this can give rise to concerns about whether to seek help with the everyday problems that arise in parenting children regardless of their origins. Non-adopting parents do not have this 'quality assurance' rating and are more likely to seek and be able to access support for their parenting at certain key times. Requiring support with parenting may be perceived negatively by adoptive parents particularly by those who wish to make a second or subsequent application to adopt. It is both unrealistic and unfair to place adopters in this double bind where they are not facilitated to parent their children through the lack of adequate family support services without incurring further sanction. Preventative responses which are developmental in orientation are required to take account of the staged movement which occurs for parents from the assessment phase to the action phase of their parenting. By promoting groups which are based on principles of self direction and self selection, new partnerships can be established between Statutory and Voluntary sectors which can enhance the delivery of family support services.

PARENTING FOR A MULTICULTURAL SOCIETY

The programme which was entitled Parenting for a Multicultural Society examined issues central to the parenting of children who have been adopted from abroad. As views about the advisability of making transracial placements continue to divide opinion, it is imperative to be aware of the findings from research which have followed samples of young people over a long period of time. Rushton and Minnis (1997), have recently reviewed the available evidence from studies in the UK and the USA. Citing from the UK, Bagley, 1993 ; Charles et al, 1992; and from the USA, Simon and Altstein, 1987; Barth and Berry, 1988; they concluded that breakdown rates appear to be determined by age rather than type of placement. They concur with the general consensus, from the studies mentioned above, concerning favourable developmental outcomes for transracially placed children. These appear to be good for the majority in terms of educational attainment, peer relations and behaviour.

The most recent study is a longitudinal one carried out by Brooks and Barth(1999) in the United States. One of the aims of this study was to extend the assessment of outcome beyond the use of limited checklists of psycho-social adjustment to concepts like the strength of ethno-cultural identity. The assessment of this factor, undertaken solely with the parents of the children, found that subjects had either a secure or a strong racial identity. Many factors may influence the parents' perception, including how the young people presented their feelings to their adopted parents. But in deference to the parents' perceptions they are more likely to be grounded in a sensitivity to their adopted childrens' experiences of racism and discrimination when compared with, for example, white parents of white children. Thus while the authors' conclude that this outcome does not represent a perfect measure, it is a rare attempt to operationalise the problematic concept of identity which is much used in the post placement debate.

The Cabhru group of parents have much experience of the challenges inherent in operationalising the identity concept. They believe that one of the main variables influencing positive outcomes is the quality of the relationships within the adoptive family. Positive post placement experiences have been associated with parents who are warm, fair, accepting, encouraging, and who hold realistic expectations for their child. The family which is mutually supportive, consistent in behaviour, with open and expressive communication, who receive emotional support from extended family and local community and who enjoy contact with birth relatives and post adoption services, appears to have the best chance of providing the optimum social environment in which a positive outcome from adoption can be achieved (Howe 1998).

Therefore identity building becomes the central task for the adopted person and their parents. The possibilities and challenges of this undertaking were examined throughout the series by exploring issues of culture, race, diversity and dealing with difference. The experiences of parents and their own expertise and strategies were central to content and process . However, some sessions also included presentations made by the professionals who had been invited by the Cabhru Group to share their expertise. Issues which may delay identity building such as institutionalisation were addressed by a psychologist; coping with bullying was reviewed by a teacher and strategies for dealing with the problem identified and shared; the issues and possibilities which arise in searching and tracing were addressed by an adoptive parent and social worker respectively. The programme was structured to facilitate sharing by parents and experts in order to construct and validate parental responses as strength's focussed and empowering. An outline of the full programme appears in Appendix One.

ISSUES WHICH WERE ADDRESSED ON PROGRAMME

Validation of Adoption

The programme began by validating adoption as a method of childcare and acknowledging the value of diversity and its contribution to Irish Society. Attitudes to race, culture and ethnicity were examined and related to the development of individual and social identity. 'Contexts' which foster social inclusion were reviewed and validated. The focus was on enabling participants to locate their experiences of parenting adopted children and validating adoption as a family form. It was this acceptance and support for adoption which was very powerful in helping participants feel safe about identifying and discussing problems which can or have arisen.

An important point of note here is that this group like all adopters before them, need to be given permission to acknowledge that they have "difficulties" in the parenting of their children.

The issues which were identified as problematic in the early stages of post adoption parenting concerned boundaries and confidentiality. Comments made to parents by family friends or neighbours, whether complimentary or derogatory, placed parents in positions which they found uncomfortable and intrusive. Practice wisdom suggests that transracial families become objects of public interest which their children may perceive negatively (Overseas Adoption Helpline,1999).

Many parents had experiences of the boundaries of curiosity about the child's origins being pushed beyond acceptable limits which could compromise the child's right to information and confidentiality. In relation to developing a healthy sense of identity in the child, the parents began to realise that this task could be seriously undermined as a result of divulging information without reference to the child, her/his needs and stage of development. They also realised that they had to find ways of dealing with such intrusive behaviour assertively. One response from the group came from a woman whose neighbours all knew she had adopted a child. One of them said that she could not imagine how someone could rear another man's child. This woman's answer was quick and swift. She replied "there's many a family rearing children like that but they just don't know it"!! The group were clearly delighted with this feisty response and relaxed quite considerably in its wake. It underlined the need to address issues directly and to move the situation along. Most "decent people" will realise that they have made a gaffe and possibly become more sensitised as a result.

From the child's point of view s/he understands that the parent is totally on her/his side and that the only person with a right to information about the child is the child herself, the family and those whom the child chooses to tell.

Many parents were fearful of returning to the assessment agencies with these issues as they believed that their need for parental and family support could be perceived as inadequacy and used against them if they decided to make a subsequent application to adopt.

In this regard, an alternative forum for family support must be made available which is independent of the assessment agency. This was a particular feature and strength of this programme and the group engaged in delivering it.

Dealing with Difference

Multicultural issues such as diversity and difference and their impact on experiences of social inclusion or exclusion, were identified and debated as they operate in education (school), community, recreation and leisure. Difference is one of the issues which attracts bullying behaviour and may facilitate a reaction which then makes the person vulnerable to its continuance. The Cabhru parents felt it was important to include this issue in the programme as it reflected their experiences of the racism and discrimination experienced by their children in school and at leisure. It also resonated with participants, one of whom movingly shared her own experience of being bullied.

The challenges for parents were discussed and options were shared. Tackling the bully and the bully's parents were considered. School policies and procedures were reviewed. The situation was well summarised by one participant who recounted his three and a half year old child's experience of an older child making reference to her "black face" "I'm from Guatemala she proudly proclaimed in a tone that indicated, silly you, not knowing about Guatemala". This parent insisted that it was the positive value which the child had attached to her identify which had enabled her to cope so well with this potentially difficult situation. Other parents agreed with this approach, which has been validated by research (Tizard and Phoenix 1993), and said that it was an important message to give to their children. Parents own experiences of adoption were central to the approach taken by this programme. The sharing of strategies such as outlined above, foster resilience and develop parenting skills.

It was the facilitated sharing of the experiences of the parents themselves, which was the factor most positively and repeatedly highlighted in participants' evaluations of the programme.

The Unfolding Adoption Story

Identity and the ongoing story of adoption with examples of why and how it needs to be updated were reviewed and discussed. Participants on the programme appeared to be unaware of the importance of the adoption story and the need to update it to keep pace with the child's comprehension and stage of development. The research suggests (McWinnie, 1967; Brodzinsky 1987) that children have to come to an understanding about the loss of their first parents. In achieving this insight they also acknowledge the potential loss of their adoptive parents. According to Brodzinsky (1990), some of the psycho-social difficulties experienced by adopted children are related to their developmental age and stage and associated with a process known as adaptive grieving. Many of the parents felt unprepared for this task and were avid for strategies which would facilitate information giving or cope with the absence of information on their child's origins.

This may have implications for the assessment phase of the adoption process. Parents may require pre-parenting interventions which will raise their awareness of the importance of the ongoing story of adoption and develop their skills in delivering this information to their children.

There is also a need to focus support on this pivotal role played by adoptive parents in helping their children cope with and adjust to their loss. Group interventions in the post-adoption era appear to offer an effective means of providing such support.

Constructing Identity

A central issue underpinning the process of becoming a person rests upon the development of a healthy identity. This is a basic task of all parenting, but is central to all adoptive parenting practice. Issues which may delay or hinder identity building were signposted. However, they were not problematised. Rather a process of normalisation was encouraged by their location in the context of the normal cycle of growth and development. The research on adoption in multicultural contexts shows many examples of a problem focussed rather than a strengths' focussed approach to parenting (Bagley 1993; Brodzinsky 1987 & 1990). The issues which these parents presented as problematic, concerned delayed language development, behavioural difficulties and institutionalisation. Some research findings suggest that children who experience such difficulties were not specific to a particular country, but "spring from early institutional rearing, whatever the orphanage" (Ames 1997). However, not all research findings agree that children are likely to find difficulty in, for example, acquiring the language of their adoptive country (Catholic Children's Society, Project 16-18. 1999:6). Many parents on this programme would concur with these findings. They reported that their children appeared to accomplish this task with ease and equally easily turn away from or suppress their original language.

The implications for the helping agencies concern the recognition of these children as being "special needs adoptions" which call for extra commitments of parents' time and energy.

There is an additional implication for agencies concerning their willingness to work with families in providing primary prevention interventions which focus on family support.

Building on Strengths

With the empowerment and strength's based approach adopted by this programme, parents were facilitated to understand and take ownership of their own particular skills in dealing with their child. By focussing and reflecting upon the normal interactions, which occur daily between parents and children, parents were encouraged in the discovery that it is in their resolution that the path to empowerment lies. Parenting strategies for identifying these issues and discovering how they are dealt with by others were central to the approach adopted. Using small groups for discussion and through facilitated exercises, parents were enabled to discuss their own approaches and develop links with others for longer term networking and support. Many examples were offered of parental and childhood resilience and the capacity of humanity to thrive and survive given the opportunity

This sharing was a particular feature of the programme which was evaluated consistently highly by participants and has implications for models of intervention which promote and foster family support.

Search and Reunion

Searching and tracing may loom fatefully in the future of many families formed by adoption. The inevitability of tracing and the issues which arise were addressed from the perspective of one adoptive parent using her own and her family's experiences of this process. The purpose was to signpost the possible future for the adopted person and their family through a review of what happens, how it is managed and possible outcomes. The focus here was to offer a glimpse of a future which does not have to be fearful, but must be prepared for. The special issues which arise in the area of foreign adoptions were identified and discussed. These included the need to seek or visit the country of origin. This may arise for different reasons and vary according to age and other factors. Birth information and records may not be reliable and adoption records may be unavailable or destroyed. The implications and consequent effects on parenting in the present and future were reviewed. Parents were mainly concerned with accessing and sharing means by which the appropriate information could be delivered in ways that are culturally sensitive as well as age appropriate. A recent study carried out by the Children's Society into searching, reunion and transracial adoptions shows the importance of adopters being able to help their children cope effectively with the challenges arising from issues of ethnic identity and experiences of racism. This entails valuing difference and embracing the child's 'race' and country of origin by building and maintaining strong links with multiracial networks (Kirton, Feast and Howe, 2000). The focus of discussion was to confirm that the sense of belonging is a complex concept that is likely to change over time and may become particularly significant in adolescence.

Multiculturalism needs to be viewed as a positive factor in parenting. Parents require validation that their adopted children will become people who will have rich and diverse strands to their identity which can give them links to more than one country.

Groupwork: an empowering paradigm

The programme was structured to facilitate the maximum sharing by parents in order to construct parental responses which were person centered and empowering. To achieve this end, small group discussion was the main method used. Facilitation was provided by Cabhru members leading to the creation of an informal relaxed atmosphere. This helped to build the group and foster a positive environment in which sharing and learning could be undertaken. In leading such groups it is important to understand how people learn. Effective learning for adults is more likely to come from participants' willingness to become engaged in shared learning to resolve difficulties felt by them to be real "It is more likely to follow from a willingness to participate in a process of discovery and enquiry in which members contribute their own experiences, offer their ideas to a shared learning process, acquire support from the group and through discussion or simulation exercises consider how to approach the situation which they are facing" (Preston-Shoot, 1987:14-15).

Groups that bring together members of the adoption community to facilitate sharing and learning from one another can enhance their adoption experience and enrich their understanding of the common experiences in adoption.

RESUME OF PROGRAMME EVALUATION

Participants were requested to complete an evaluation form which was distributed on the final night of the programme. Fifteen forms were returned in the post course period. This represented a response rate of 75%. The evaluation reviewed the programme under the following headings. A series of comments will be presented to provide a flavour of the feedback which was received.

Content: aspects that were particularly helpful and relevant

All evaluations were fullsome in their response to the first session. The following comments summarise the generality of responses;

> "Norah Gibbons presentation was particularly good for first session."
>
> "Meeting with others in same situations gives encouragement."

Presentations by Speakers : style and/or methods of delivery that were particularly helpful and relevant

The style of the presentation was mentioned by 75% of participants as worthy of note. Comments such as "Relaxed approach helps to open up discussion and "Presentations excellent, needed more time" typified the responses that were made.

The remainder of respondents additionally pointed to the need for some handouts which could be taken from each session for reflection at a later stage. Here comments such as "All speakers excellent, but would like handouts for later" reflected the views of participants.

Structure of Programme : lecture or small group discussion?

There was an 100% agreement in responses to this question. All respondents evaluated the small group discussion and sharing as one of the most valuable aspects of the programme.

Comments such as, "Small group discussion most helpful and useful in facilitating discussion" and "Small groups most helpful to allow people to talk and to be listened to" were indicative of the observations which were made by **all** participants.

In what ways could the content of this programme be improved? : aspects that should be revised or reviewed

This elicited a number of interesting responses. In addition to those who indicated a desire for more small group activity, there were others which suggested interesting additions for inclusion in future programmes. These included "Individual cultures to be presented on different nights with a national of that country giving a talk on attitudes and background" and "Racism and cultural issues need to be debated in more depth"

"More on areas such as telling the child and dealing with questions and problems later on"

In what ways could the structure of this programme be improved?: suggestions relating to methods used

This question produced a list of innovative ways in which future programmes might be developed. "Increased use of books and artwork", "Using issues raised in TV programmes and newspaper articles for discussion", referred to the methods which might be used in future programmes. Whereas the process in which participants engaged and which they considered most useful, was again referred to in comments such as "More time for open floor discussion with parents" and or "More small group and plenary work".

What advantages were there for you in coming to this programme?
In this section of the evaluation **all** participants referred to reduction in the isolation which they had felt as a singular advantage of the programme. "Reducing isolation…questions are healthy and I am not failing my child" would summarise the responses which were made. The support and encouragement which many parents gained from others on the programme also received significant mention. Looking to the future with confidence was another theme which emerged from the participants, "Feeling more prepared for challenges ahead" would be indicative of the comments that were made.

What disadvantages were there for you in coming to this programme?
There was an 80% response rate which listed "None" as the reply to this question. The remaining two respondents comments are included to demonstrate how participants rated the programme, "Transport, travelling home alone at night" and "None, except that I have a lot to learn" suggest overwhelmingly that respondents perceived no disadvantages in participating on the programme.

Did you have an opportunity to participate in discussion?
Programmes which operate using more didactic approaches or who do not use participants' skills and resources often fail to engage members meangingfully in the learning process. Because of the structure of this programme and the empowerment philosophy underpinning it, participants were enabled to make a 100% "Yes!" affirmation to this question.

Do you think future courses should facilitate more or less participation?: in what ways?
In relation to this question, the emphasis remained on the value and continued need for small group discussion and participation. The role of facilitation was seen as crucial to the success of the approach. One respondent summed this up by stating " Facilitated small group discussion vital for direct feedback to larger group"

Would you be interested in further courses on the subject of Adoption?
"Yes", "Definitely" and "Absolutely"!!! constituted the responses of **all** participants to this section of the evaluation. That there is a felt need among parents for post-adoption support is reflected in these responses. Additionally, it must be reviewed as valedictory for programme organisers to be given such a positive evaluation of their efforts. This has implications for the methodology and methods of future programme delivery.

Have you suggestions about how you would like this to proceed?
50% of respondents who operated from the perspective of more of the same, responded to this question with "Have more meetings" and "Similar format".

The other 50% of respondents appeared to be more creative and reflective in their responses. Suggestions here included, "An annual mini conference on adoption with (a) opportunities for children to socialise, (b) opportunities for parents to network and (c) a menu of thematic workshops". In the same vein some participants suggested the provision of "Opportunities to keep up contact with other parents in a structured way to progress parent learning"

Any other comments or suggestions?
Many respondents indicated that they enjoyed the programme and would miss the interaction with other parents which it offered. Sharing experiences were significantly rated by 70% of participants under this heading and appear to be an important outcome from the evaluation. More opportunities to do this are required by parents. The implications of this sharing process was summed up for this group as comprising elements which "reduced isolation and offered support, validation, help with problems."

Not withstanding the self selected nature of the group, the evaluation identified a number of factors which it would appear significantly influence motivation and outcomes. In relation to motivation, these include:

- Small group discussion
- Opportunities for participation
- Sharing experiences

In relation to outcomes the following were identified:

- Reducing isolation
- Receiving support
- Feeling prepared for future challenges

LOOKING BACK: SOME REFLECTIONS ON THE PROCESS

In September 2000, the Cabhru group came together to review the evaluations and to plan for the future. There was agreement that there is a need to "grow" new groups of parents who will be able to reach out and develop future services. These parents are in the vanguard of foreign adoption practice in Ireland. They and their children will have a major contribution to make to the quality of the life which we are striving to achieve in the new multicultural Ireland of the 21st century. A number of issues arose for the author and the group which require signposting at this stage as they are likely to have an impact on future programmes which may be envisaged. At time of writing Cabhru have had one meeting with the childcare manager for adoption services of the Southern Health Board to progress the debate with reference to these issues.

To deliver a comprehensive education programme which aims to provide knowledge to participants while ensuring that they have a good experience is a time consuming process. Groupwork by its nature requires time. It was this time which the author and other Cabhru members offered to the foreign adopters and the other agencies. In addition to their normal meetings Cabhru undertook a heavy schedule of additional work concerned with planning the content and facilitation of each session and providing support for those members who would undertake it. In addition there was wind-down and review after sessions had taken place. Had this work been undertaken by professionals, it would have been factored into their normal working day. Instead this group added on this additional work to already heavy workloads in the public and private sphere.

The "value added" nature of the commitment which such groups offer to partnership needs to be recognised and costed in real terms in future programmes.

There is a need to appraise childcare professionals of the kinds of issues and skills which parents bring with them to foreign adoption. The inputs by some of the professionals who participated, demonstrated a significantly different approach to working with families than that being pursued on the programme. While many statutory childcare services are crisis driven and problem focussed the approach of some professionals indicated a total problem focus on the issue of foreign adoption, in spite of the professional's own research findings which suggested beneficial outcomes. Some professionals did not appear to be aware that the parents who chose to attend this programme were the 'real' experts in meeting their children's needs. Consequently, but perhaps inadvertently, they undermined parents' efforts and morale in this regard.

There are learning's for childcare professionals arising from this programme. Parents as 'expert' providers for their children's needs require validation and support from childcare agencies to fulfil this role. The new partnerships which are needed and necessary will require new responses from agencies and professionals to sustain them.

The informal and small group format for presentations was most successful in enabling participants to share and learn from each other. Where the focus remained on the person and their parenting experiences and expertise, participants engaged and built on that engagement through the development of linkages and networks outside the group.

Recognising and building on strengths, opens possibilities for mutual aid and networking which replenishes social capital and fosters more humanistic approaches to social living.

The participants made suggestions in their evaluation which could usefully inform their future contributions to this area. The convening of an annual mini conference on adoption would provide an opportunity to keep up contact with others in a structured way to progress parent learning. Social gatherings or parties for families and children to socialise together would promote greater opportunities for all adoptive parents to network. That future programmes should seek to access the people and the culture of the countries from which children are adopted is both desirable and pragmatic to support the efforts of parents in this respect.

Such initiatives would give greater visibility for the positive role which multiculturalism can play in Irish society.

IMPLICATIONS FOR POLICY AND PRACTICE

For the participants who made the decision to take part in this programme there were a number of significant benefits noted in their evaluation. At a personal level for the families under discussion there was and continues to be a demand for post adoption support programmes to meet their needs. Additionally, parenting support must be considered vital and necessary to provide safeguards for the rights of children in this situation.

For Cabhru who delivered the programme there was the opportunity to share experiences, skills and strategies on parenting foreign adopted children. While there is undoubtedly much personal satisfaction to be gained from this approach, it is important to view their contribution in the context of a family focussed approach to intervention. Such models are indicative of primary prevention interventions and require resourcing in terms of development and facilitation. The Cabhru group did not happen without facilitation. Similarly, new groups which are self directed and responsive to ongoing needs will also require facilitation. There are implications for the allocation of resources to facilitate such groups to grow and continue to develop as part of the continuum of intervention and support which is required by all families at various stages of their life cycle.

Assessment and support while not mutually exclusive, are not compatible when delivered from the same source. A multi-sectoral approach to service provision of the kind represented by this programme offers one strategy of intervention. While desirable and much in demand, any such programme must be located as part of an overall strategy in foreign and domestic adoption practice in keeping with the requirements for the provision of post-adoption services under the Hague Convention. Thus there are policy implications for the development of co-operative relationships which operate from a partnership approach to service delivery.

CONCLUSION

This programme set out to deliver a pilot Foreign Post-Adoption Support Programme to the participating families. The subsequent review and evaluation suggests that the needs of parents were addressed through attendance at the programme. The overwhelming demand for more rather than less post-adoption support is indicative of the challenges and the complexity which foreign adoption parenting is signaling.

The views of participants that sharing experiences and expertise was a most useful outcome which they would like to see replicated in future interventions is significant. It points to the efficacy of the model which was used to deliver the programme. Through the use of an empowerment model, participants were facilitated to recognise and take ownership of their own strengths and strategies in parenting their adopted children.

The use of a partnership approach between voluntary and statutory agencies to provide post-adoption family support intervention has been successfully accomplished in this pilot programme. For service providers there is a real opportunity to respond pro-actively to needs by empowering through support rather than disempowering through isolation. Agencies and parents as partners can be net beneficiaries in their ownership of a process which fosters multiculturalism and social inclusion.

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APPENDIX ONE

Parenting for a Multicultural Society: Post Adoption Parenting Programme.

Population:	Parents who have adopted children from abroad
Referrals:	Self- referrals Bessborough Family Support Services, Blackrock, Cork. Southern Health Board.
Programme Duration:	6 x 2 hour sessions from February 2000.

SESSION ONE 8-2-00

Culture and Race: Valuing Diversity in Adoption.
Input to provide material to validate and locate their experiences of parenting adopted children.

Purpose: To provide a context for future discussion, reflection, action and evaluation.

Facilitation: Norah Gibbons, Barnardos, Dublin.

SESSION TWO 22-2-00

Bullying: Multicultural Issues in Education, Recreation & Leisure.

Purpose: To explore the experiences of bullying in school, sport and neighbourhood and to develop strategies for parents, teachers and the community.

Facilitation: Dr Brendan Byrne, Department of Education, Dublin.

SESSION THREE 7-3-00

Establishing Links & Making Connections.
Using participants' own resources to locate and share their experiences of parenting.

Purpose: To raise issues relevant to people's experiences of being adoptive parents. Commonalites and Differences. We expect that this will facilitate the emergence of themes which can be developed throughout the programme.

Facilitation: Cabhru Group Members.

SESSION FOUR 21-3-00

Identity and Adoption
Central Issues in the process of becoming a person.

Purpose: To discuss and identify the common developments in growing up.

Panel discussion with question and answer session. Panel will include adoptive parents and child psychologist.

Facilitation: Mike Van Aswegen, Psychologist, Southern Health Board.

SESSION FIVE 28-3-00

Rainbows: Sunshine & Showers
Challenges to Identity Building.

Purpose: Review and reflection upon issues which arise daily in the parenting process and sharing strategies for overcoming difficulties.

Facilitation: Cabhru Group Members.

SESSION SIX 4-4-00

The Future of Adoption: Searching & Tracing. Stories from this time, messages for the future

Purpose: To signpost the possible future for the adopted person and their family through a review of what happens, how it is managed, possibilities and outcomes.

Facilitation: Ann O Sullivan, Social Worker & Bernie White, Cabhru Group.

Proposed Dates: Commencing on Tuesday 8 February, 2000. Every two weeks until Tuesday 4 April, 2000.

IRISH FOSTER PARENTS' PERCEPTION OF SERVICES REQUIRED TO IMPROVE FOSTERING PRACTICES: A QUALITATIVE ANALYSIS

by Dr. Deborah Browne,
Prof. Max Taylor and
Ms. Ann Moloney

Key Words: Foster parents, fostering services, Ireland.

Abstract

Despite growing numbers of children being placed in foster care in Ireland, Irish foster parents remain inadequately prepared to deal with the problems inherent in this form of care. In an attempt to examine the services foster parents themselves feel they need to improve the care they provide, this study asked a sample of Cork foster parents to describe what could be done to help them. Foster parents involved in 104 specific placements completed the questions. A qualitative analysis of the replies revealed that foster parents were able to make suggestions for improvements on a number of fronts, including permanency and accessibility of social workers and more preparation and training. It also emerged that those foster parents who experienced more difficulties were more inclined to make suggestions than those who did not. The importance of increasing resources to health boards to provide enhanced services is discussed.

Introduction

Statistics clearly show that growing numbers of children are placed in foster care in many Western countries (Dept. of Health (UK), 1999; Zlotnick, Kronstadt and Klee, 1999). Ireland is no exception to this trend. In 1991 the official figures for children in community care were 2,944 (Dept. Of Health, 1993) and this had risen to 3,668 by 1996 (Dept. Of Health and Children, 1998). Health boards are frantically trying to find foster parents suitable to care for these children in substitute families, despite poor resources and the consistently heavy caseloads of social workers (e.g. see O'Kelly, 1995). Resources vary across health boards, and criticism has been levied at the lack of a national policy on training and support for all child-care specialists (McElwee, 1998).

If such a policy were to be implemented with regard to foster care, what should it consist of? McGinely pointed out that *"further research may be needed to determine the most appropriate role of health boards in their work of supporting foster parents"* (1995:155) and indeed, in Ireland such studies are scarce. More international studies advocating specialised services are wide and varied, and the next section will look at some of these. The main purpose of this paper, however, is to highlight what Irish foster parents themselves feel they need in order to satisfy their needs as carers of these children. They are, after all, the adults who have most contact with, and have the most difficult dealings with, children in care. This paper will describe a study that asked Cork foster parents what services they felt should be offered to them.

The need for exceptional services to assist fostering

Unfortunately the quality of services offered to foster parents is often less than adequate. Over the years various studies (Chamberlain et al, 1992; Rosenfeld et al, 1997; Steinhauer et al, 1988; Testa and Rolock, 1999; Triseliotis, 1989), mostly in the UK and North America, have indicated that particular services are especially needed to help foster parents successfully care for the children they are responsible for. The type of services that other studies have found to be important shall be described in this section, before the services that foster parents in the current study suggested are illustrated.

Training

Even basic training is not as common as logic might dictate, despite the numerous studies that have highlighted its importance (Dawson, 1989; Titterington, 1990). Sellick (1992) questioned foster carers who commented that training was not provided frequently enough by local authorities, and nor was it made accessible when it was offered. One parent commented, *"a lot of people can't get to them. It isn't made a condition which it should be. They don't pay people for being trained"* (Sellick, 1992:78). Many foster parents may resist attempts to modify their parenting through training, however, maintaining that they are volunteering their services for a good cause and feel they are capable of bringing up children adequately (Kufeldt and Allison, 1990). As Hughes (1997:86) pointed out, parenting that may have been "good enough" with their own children may not be adequate or may need to be adjusted for their foster child.

Training of foster parents in Ireland is a somewhat recent phenomenon. Although small-scale projects have been run since the eighties, more extensive training has only been offered in recent years. The Fostering Resource Unit, which offers training to new foster parents in the Southern Health Board, for instance, was only set up in 1994. As in other health boards, however, many families who have been fostering for several years have never received any training. This is despite the fact that some of these parents may be fostering very disturbed children with histories of neglect, dysfunctional families, inconsistent parenting and of course, child abuse (Browne, 1998a; Woods, 1995). The Kilkenny Incest report emphasised the importance of trained child-care professionals, and the recommendations state *"we recommend that the health boards provide a systematic training programme for all professionals working in the area of child abuse"* (McGuinness, 1993:113). Besides the psychologists and social workers working with these children, their foster parents should also receive this intensive training. More frequently calls are made for foster parents to be treated as professional child carers (Baker, 1989; Testa and Rolock, 1999). If they are to be viewed as such, it is highly appropriate that they should receive training for this role; after all, the child is in their care for most of the recuperating period.

Support Groups

Because foster parenting can bring with it stresses and difficulties not normally experienced by parents (Johnson, 1999; Pithers, Gray, Busconi and Houches, 1998), many foster parents find it helpful when they can meet with other parents experiencing similar situations for support and advice. Research in this area indicates that well organised support groups can improve the chances of successful outcomes (Chamberlain, Moreland and Reid, 1992; Steinhauer et al, 1988; Steinhauer et al, 1989). Like training, support groups have not been offered widely by Irish health boards. Although some successful groups have been established, more frequently groups tend to spring in different areas for a few years before disappearing again.

Financial Support

Financial compensation is also an important factor, although many foster parents are reluctant to bring it up because they view their motivation as basically altruistic (Gilligan, 1996). Sellick (1992) reported that foster carers in his study felt that not only were fostering allowances inadequate but that the systems of payment and the attitude of fostering agency staff in this regard led to feelings of anger and hopelessness. One of his foster parents commented, *"it's really diabolical the amount we get paid especially compared to child minders who have children without problems"* (Sellick, 1992:87). Sellick also found that local authorities were slow to reimburse foster carers for costs, which led to loss of respect and loyalty from carers (1992:89). Because most foster parents are not viewed as professionals but as volunteers it may be considered that they are more concerned with altruistic rather then financial reward. Studies such as Chamberlain et al (1992), however, indicate that foster parents are more satisfied with services when financial compensation is adequate.

Fostering Agency Support

Inadequate social worker intervention may lessen the success rates of foster care (Baxter, 1989; Palmer, 1990). Many researchers (Meadowcroft, 1989; Molin, 1990; Palmer, 1990) have attributed high failure rate to the fact that social workers to not respond in time to a developing crisis. Moreover, Urquhart (1989) found that foster parents who did not feel they were adequately supported in these situations were more likely to drop from fostering programs. This is not helped by the fact that foster care caseloads appear to be continually increasing in Ireland and world-wide (Albert (1994:221) cited a dramatic rise of 85% for Californian caseloads; Gilligan (1990) noted an increase of 62.5% of children coming into care in Ireland, and Ferguson (1995) also noted a similar trend in Ireland. High and demanding caseloads neither allow for sufficient supervision of cases, nor for effective decisions when social workers themselves are not properly supervised. O' Kelly, as a senior social worker in the North Western Health Board, noted that she had a staff of nineteen social workers and that *"such numbers do not lend themselves to adequate supervision"* (1995:214).

Besides needing more support from the fostering agency and their social workers, many foster parents would like to feel that they play a more active role in the entire process. Sanchirico, Lau, Kary and Russell (1998) found that involvement in service planning increased the job satisfaction of foster parents.

The perspective of the foster parent

Gilligan (1996) conducted a postal survey on a group of foster parents in an Irish health board. While these foster parents seemed to report a high level of overall job satisfaction, many parents reported dissatisfaction with a number of issues related to the support they received from the health board. These included the assessment and preparation procedures, financial issues and the uncertainty of support being there when needed. On the other hand, however, the majority of Gilligan's parents found their social worker's advice to be helpful (Gilligan, 1996:91).

It has already been described how one of Sellick's (1992) foster parents pointed out that they do not get paid as much as child-minders who do not have difficult children. This is an important point: fostering is not the same as parenting birth related children. Prospective foster carers need to be prepared for all of the problems that have been associated with this type of care, such as dealing with emotional and behavioural problems of the children, or even problems with parental visiting (Dawson, 1989; O' Higgins, 1993; Tennyson, 1998; Thompson et al, 1994; Zimmerman, 1988). Foster parents need also to be aware of the difficulties it causes for the children themselves (Browne, 1998b; Cooke Parker and Forrest, 1993; Hughes, 1997; Trasler, 1960). Because fostering is generally an altruistic act (Gilligan, 1996), some parents may not realise that *"good fostering is more than kind-hearted volunteerism"* (Kufeldt and Allison, 1990:9). From the perspective foster parents who view the situation in this manner, the fostering agency and its social workers may be viewed as little more than a nuisance and a hindrance. For example, one of the parents in Gilligan's study commented, *"the social worker should leave the rearing of the child to the foster parents with little interference – after all it is our home and rules"* (1996:93). In these cases it is very often not until the fostering situation becomes difficult that they realise the critical need for training and support.

In an attempt to examine further the services Irish foster parents require to carry out their role more effectively, the current study specifically asked foster parents to describe how they felt the services that were provided to them could be improved. This paper will now describe what the analysis revealed.

METHODOLOGY

Participants

The families involved in this study were drawn from two (mostly urban or suburban) community care areas of the Southern Health Board. All foster parents who had fostered over a specific three-year period were sent very detailed questionnaires on the progress of children who had been in their care during that period. These included placements that had since ceased, as well as a small number of families who were no longer fostering. Questionnaires were eventually completed by 74 foster families for 127 foster placements (almost 50% response rate). A very small number (5) of these families had at least one parent who had been trained by the health board for a special project with teenagers, and a further 16 had attended a general parenting skills course. While new parents have since been offered training by the health board, most of the foster parents involved in the current study had not received any preparation.

Materials

The comprehensive questionnaire was designed to examine various aspects of the family's fostering experience, including family structure, pre-placement preparation, day to day routine, problems that were encountered, contact with the health board etc. The questions that were pertinent to the current paper were as follows:

> *What do you feel could be done to help you cope better with problems that arise, or might arise, with this child?*
>
> *How do you think the fostering agency and your social worker could help you further in your role as a foster parent?*

Not all questions were answered for each placement, however, and those questions that concerned recommendations for improvement to services were answered in relation to104 foster placements (although it was hoped that parents would give an answer that was specific to each individual placement, some parents indicated that they had answered the question already for another child. This accounts for the shortfall in numbers).

Procedure and Design

As already described, foster parents were sent questionnaires in regards to specific children they had cared for or were currently caring for. They also received letters from both the health board and from the researcher explaining the purpose of the study.

When the completed questionnaires were returned the answers were qualitatively analysed. It was decided to combine the experience-orientated feminist approach that is usually used with this type of personal account data with Miles and Hubberman's (1994) data management techniques. This model "stresses variables and causal links between variables" (Denzin and Lincoln, 1994:357), which makes it easier to look at relationships between the variables generated from the analysis and placement outcome.

Answers were divided into meaningful phrases and sentences, and categories were generated based on the content of these units. Table 1, which is based on the format recommended by Miles and Hubberman (1994), describes the categories that emerged from the analysis, and gives examples of the phrases that were included under each category heading. A content analysis was then obtained by going back over each questionnaire and ticking the appropriate box of a record sheet for each foster placement where the item was discussed. The results of this are described in the next section.

Suggested Improvements to Services

The categories that describe the improvements that foster parents perceived were necessary are generally self-explanatory, as outlined in Table 1: Outline of Categories of Suggested Improvements. The first category on this table, *Permanent and Accessible Social Worker,* indicates the need that many foster parents had for a social worker that they knew well and could contact easily. Unfortunately staff turnover in the health board at this time was quite high, and foster parents regularly found that their social workers changed with little notice. Additionally, as became manifest as the category *Link Social Worker,* some parents felt that it was not adequate to have one shared social worker for both themselves and the foster child. This might affect the social worker's relationship with one party or the other, if it was felt that the social worker in question was "taking sides", as one parent in the illustrations offered in Table 1 suggested. The next two categories describe the perceived need for more preparation and training. The difference between these two categories is that *Pre-placement Preparation and Assessment* refers more to procedures before the start of a placement, while the latter refers to both prior and ongoing training needs. *Ongoing Support Group* indicates suggestions for just that, and the categories *Counselling Services* and *More Financial Support* are equally self-explanatory. *Respite Services* are often more needed when parents are fostering children with special needs, although this paper does not examine whether this is the case here. *Some parents perceived Emergency Back-up* as a much-needed improvement, and this refers to the lack (at the time of the study) of any way of contacting the health board outside normal office hours.

TABLE 1: Outline of Categories of Suggested Improvements

Suggested Improvement	*Illustration*
Permanent and Accessible Social Worker	"...had many social workers - he doesn't like the idea of them changing so often. He just gets to know one - builds up trust in them and then they are changed again. I feel the same - I prefer to deal with one person." "I suppose if we had more visits from Social Workers, but their work load is very heavy, you know." "A more permanent social worker to be assigned to the case."
Link Social Worker	"A separate social worker for me and my family, someone neutral to listen to our points of view." "One social worker for the "Host Family" and the foster child to have its own S.W." "Separate social workers would be a big advantage. I could see at times the social worker being put in a position of 'taking sides' which was unhelpful"
Pre-placement Preparation and Assessment	"Proper background information would have helped. I know it was a spur of the moment placement, but 'a mild epileptic' was not a good description" (foster parent with special needs child). "Nothing prepared us for living together, it was a shock for the first 6 mths, having another adult in the house" (special teen foster parent). "Better information about the child so that we would know what we are getting into."
Adequate Training	"Some training for me to help me to understand his moods and maybe get through to him a little better than I can now." "More training." "Videos of real situations."
Ongoing support group	"Continuing support group." "Support group available from day one."

TABLE 1 *continued*

Suggested Improvement	*Illustration*
Respite Services	"Respite opportunities and short holidays." "Respite care."
Emergency back-up	"S.W. support is there from 9-5 Monday - Friday only - there are a lot of hours left in the week in which we have to cope on our own." "24 hour service." "I often rang on a Friday evening to be told that my social worker had gone home for the weekend."
Counselling Services	"We feel we could cope better if we had contact with her counsellor." "After she left neither her sister or anybody in this family got any support or counselling" (foster parent after experiencing breakdown).
More Financial Support	"More financial support to get him involved in other activities which would help his personal development." "Funds available for extra-curricular activities." "Given an adequate allowance."
More Communication and Review Work	"It is important the that the social worker/ foster parent/ foster child discuss worries, anxieties, problems together...(social worker) failed to do this, letting us feel alienated." "Better use made of the review system." "We feel the way to cope with foster children who may have problems is if you have good communication with your social worker."
More Authority for Foster Parents	"The social worker could have treated us as intelligent adults, who were quite willing to accept advice/ practical tips." "I did not feel I had an equal voice and I did not feel like the 'co-worker' I was supposed to be."
Happy with Service as is	"The social worker is always there with advice and help whenever there is a problem."

As can be seen, categories do not merely describe services that might make things easier for the foster parent (e.g. *More Financial Support, Respite Services* or *Counselling Services*) but also services that would enable foster parents to help their foster children more professionally and more effectively (e.g. *Pre-placement Preparation and Assessment, Adequate Training* and *More Communication and Review Work*). Some of the statements that make up these later categories reflect a commitment to helping the child; one example that is given in Table 1 is *"some training for me to help me to understand his moods and maybe get through to him a little better than I can now."* Some foster parents seemed to concentrate more on these "foster parent-orientated" items than the "child-orientated" items. One foster parent with a difficult teenager, for instance, made only one suggested improvement; *"an adequate allowance to enable me to get support for myself as required, i.e. counselling or just being able to take a break"*, while another in similar - albeit not as demanding - circumstances detailed a list incorporating nearly all of the categories that later emerged.

Placement Outcome

This study was originally designed to look at certain differences between placements that were successful at the time of the study and others. To this end all placements were divided into one of three 'outcome' groups (these can, and have, been referred to as 'status' groups (Browne et al, 1999). For the purposes of the present paper it is, however, more appropriate to view the categories as the placement outcome at the time of the study. Briefly these can be described as follows:

Successful placements:	Those placements where foster parents and social workers were all satisfied with the progress of the placement.
Ambiguous placements:	Those placements where there were one or two specific reservations about the progress of the placement or about expected problems.
Crisis placements:	Those placements where there were three or more specific reservations about the progress of the placement, where a break down was considered imminent, or where it had already broken down.

RESULTS AND DISCUSSION

Suggested Improvements to Services

The suggestions that foster parents perceived were necessary to improve services have already been described in Table 1. As indicated, the suggestions made were broad and generally quite child-orientated. Some parents made many recommendations and others only detailed one or two specific suggestions. To further evaluate the categories generated from the qualitative data, Table 2: Content Analysis Summary Table on Foster Parent's Suggested Improvements illustrates a content analysis of the data. As can be seen, the largest percentage of reported cases for the categories can be seen in the more child-orientated items. A much smaller percentage of foster parents indicate that they would like *More Financial Support* and *Respite Services*.

TABLE 2:
Content Analysis Summary Table on Foster Parent's Suggested Improvements

Suggested Improvement	**No. of Cases reported:**	**% of cases reported for:**
Permanent and Accessible Social Worker	60	58%
Link Social Worker	11	11%
Pre-placement Preparation and Assessment	36	35%
Adequate Training	34	33%
Ongoing support group	39	38%
Respite Services 18 17% Emergency back-up	18	17%
Counselling Services	20	19%
More Financial Support	18	17%
More Communication and Review Work	55	53%
More Authority for Foster Parents	19	18%
Happy with Service as is	15	14%

N=104

From this table it is possible to see that these foster parents, as a group, appeared most concerned about getting a permanent and accessible social worker, and with improving communication and review work. After these issues, training and support were the next most desired items. Some items were not mentioned very often, and some of these were surprising - it was expected, for instance that there would be more demand for a link social worker. Emergency back-up was only requested in17% of cases – again this was something that it was thought would be more in demand. Notably only 14% of parents reported that they were happy with the services as they were.

It is very likely that each family's experiences in fostering shall influence the type of services they feel that they need in order to operate most effectively. In order to investigate the items that foster parents looked for in more detail it was decided to examine whether there were differences between foster parents who experienced difficulties with their placements and those who did not.

Differences in suggestions between outcome groups

Table 3: Comparative Matrix of Percentage of Cases of Suggested Improvements for Each Level of Placement Status illustrates a comparative matrix of how foster parents answering for the different placement status levels are divided. This table highlights some very interesting pieces of information. When compiling this matrix it was evident that any comparison between the percentages of responses for each group out of the total number of responses would not be sufficient. Because the groups have varying numbers, it makes more sense to compare percentages of the total number of responses per outcome group. Both frequencies are given below, with the latter highlighted to aid studying the chart.

TABLE 3:
Comparative Matrix of Percentage of Cases of Suggested Improvements for Each Level of Placement Status

	Successful			Ambiguous			Crisis			
Suggested Improvement	No. reported	% of Status Group	% of Total reported	No. reported	% of Status Group	% of Total reported	No. reported	% of Status Group	% of Total reported	Total reported
Permanent/ Accessible Social Worker	25	56%	42%	12	43%	20%	23	74%	38%	60
Link Social Worker	5	11%	45%	1	4%	10%	5	16%	45%	11
Preparation/Assessment	10	22%	28%	9	32%	27%	17	55%	47%	36
Adequate Training	12	27%	35%	10	36%	29%	12	38%	35%	34
Ongoing support group	14	31%	36%	11	39%	28%	14	45%	36%	39
Respite Services	5	11%	28%	5	18%	28%	8	26%	44%	18
Emergency back-up	6	13%	33%	4	14%	22%	8	26%	44%	18
Counselling Services	5	11%	33%	5	18%	33%	10	32%	67%	15
More Financial Support	7	16%	39%	5	18%	28%	6	19%	33%	18
Communication/ Review	20	44%	36%	14	50%	26%	21	68%	38%	55
Foster Parents Authority	5	11%	26%	9	32%	47%	5	16%	26%	19
Happy with Service as is	10	22%	67%	2	7%	13%	3	10%	20%	15

Total number of responses = 104

Successful Group: N=45 Ambiguous Group: N=28 Crisis Group: N=31

The two most frequently suggested improvements, as has already been noted, ar a 'Permanent and Accessible Social Worker' and 'Improved Communication an Review Work'. It can be seen in this table that the former was suggested in hig proportions right across the three groups. *Successful* placements reported it 55% of the time, 43% of the *Ambiguous* group mentioned it, and a staggering 75% o foster parents experiencing a *Crisis* placement suggested that a permanent an accessible social worker be assigned to each case. The second important variabl here, the need for improved communication and reviews is also scored highl across the variables, and this time in progressive order through the groups. 44% of parents from the *Successful* group point out this requirement, and this rises t 50% for the *Ambiguous* group and 68% of the *Crisis* group would like to see a improvement in communication and reviews between those involved in the fostering process. This high number of such suggestions from the *Crisis* group i reflected in the percentage of total reported cases columns; despite the discrepancy of having a smaller sample number than the *Successful* group, thi group reported the largest percentage (38%) of the total number of reporte cases (albeit marginally).

For the category of *'Link Social Worker'*, there is little difference between the percentage of foster parents from the *Success* group (11%) who answered the question and the percentage of the *Crisis* group (16%), which indicates tha experiencing a difficult placement does not seem to affect the desire for a separate social worker. It can be seen that the *Ambiguous* group score comparatively differently than the other groups, with only one foster family from this group indicating that they would like a separate social worker from their foster child. As a percentage of the total number of responses for this group, the *Success* and the *Crisis* group both score 45%, and the *Ambiguous* group only 10%. Even taking account of the fact that this is the smallest group, these differences are surprising.

Another important category for the *Crisis* group appears to be the need for improved pre-placement preparation and assessment. 55% of this group note this suggestion, as opposed to 32% of the *Ambiguous* group and only 22% of the *Successful* group. As with need for improved communication, this difference is large enough so that the *Crisis* group scores a higher percentage of the total number of reported cases of this variable. This time, however, the difference is quite large (47% as opposed to 28% for the *Successful* group and 27% for the *Ambiguous* group).

Not surprisingly, the *Crisis* group also mention the need for support group respite and emergency services more often than the other two groups. Counselling services are mentioned more often, with 67% of the total of recorded responses for this category coming from parents who are answering a questionnaire for a *Crisis* placement. None of these observations are in any way unexpected - it is perfectly logical that the parents who are describing a crisis situation should be more aware of the importance of support services such as these. These categories obey an almost perfect "steps of stairs" affect, being reported most frequently by the *Crisis* group, next by the *Ambiguous* group and reported least frequently by those parents who are describing a *Successful* placement.

There is very little difference between the three groups in the percentage of foster parents who indicated that they would like to see more *financial support.* This category is only mentioned a total of 19 times and these are spread relatively evenly among the groups. The frequency of times that it was reported is not high, ranging from 16% of the *Successful* group to 19% of the *Crisis* group.

Strangely, the *Ambiguous* group suggest allowing foster parents more authority far more than either of the other groups. The frequency that this category was mentioned for this group is twice as high as it is for the *Crisis* group, and nearly three times as high as for the *Successful* group. This differences is again large enough to be notable in the percentage of total responses for that category - the *Ambiguous* group reported 47% of the total number of recorded cases of this category, while the remaining number is divided evenly between the other groups.

The only category that a higher percentage of the *Successful* group noted more than the other groups is that which indicated that they were happy with the service as it is. This was noted for 22% of this group, as opposed to only 7% of the *Ambiguous* group, and 10% of the *Crisis* group. This finding is not surprising; it makes sense that foster parents describing a successful placement would feel happier with the service. The fact that they are not experiencing problems could also be an indication that they have not had to put the services of the health board to the test in a difficult situation. This is further backed up by such statements as *"if we are to be acting parents - let us act as parents and let us make the decisions"*. As was described in the section 'The perspective of foster parents', it is an unfortunate reality that many parents who have not experienced serious problems do not view fostering as anything more than an extended form of parenting. This means that they are not open to training and preparation even when it is offered (e.g. *"I raised my own children without any training and I don't need any now"*).

Overall parents who were experiencing *'Crisis'* placements were more likely to offer suggestions for improvements. They also made many comments that indicated dissatisfaction with the services they received. Examples of these comments included: "(we were) *hindered in every way*"; *"I'm sick of crawling to the health board for money that I am owed"*; *"social worker could have been more helpful"*. As Table 3 showed, the better the *Placement Outcome*, the more likely parents were to indicate that they were happy with the services of the health board.

CONCLUSION

The foster parents in this study were asked to make suggestions as to how they perceived fostering services could be improved. It would appear from the suggestions they offered, that many parents were well tuned in to the services that they need in order to provide the best caring environments for the children in their care. In support of findings presented by Gilligan (1996), many of the responses indicate a high level of altruism in Irish foster parents. It was noted that the categories described in Table 1 are quite 'child-orientated'.

While the sample was not very large, it was large enough to be representative of Cork foster parents in general. In reality Ireland is such as small country that differences in fostering practices vary little across the health boards, and it is very probable that foster parents would make the same suggestions nationwide. Indeed, many of the issues that foster carers were dissatisfied with, and indeed the comments they made (see Table 1) are very similar to those that the parents in Gilligan's study reported they found 'hard about fostering' (1996:91-92).

Although services have improved in most Irish health boards over the last few years, the fact remains that most foster parents do not receive all of the support they need to perform their very demanding task. As was discussed at the beginning of the paper, many parents do not realise that there are fundamental differences between fostering and parenting birth related children. The figures presented in Table 3 indicate that it is often only after experiencing problems that some foster parents realise the importance of preparation, support and training. This is an indication of the "fire-brigade" service that currently exists in Irish health boards. If these parents were taught what to expect and how best to deal with the problems that they may encounter, it is possible that many of the "Crisis" placements in this study would have had a different outcome. Adequate pre-placement preparation and training, therefore, needs to educate prospective foster parents of the inherent and necessary difficulties of the task they are about to take on, as well as methods of dealing with these difficulties.

What was most surprising to the researchers was that the category that is reported the least number of times is the need for a link social worker. This was something that seemed to be expressed often and emphatically during the course of the study on an informal basis. There are various possible reasons for this. One that seems to make most logical sense is that many of the same people who brought up a link social worker when completing the questionnaire attended the meetings (e.g. Irish Foster Care Association meetings) where this need was discussed. Many foster parents who do not attend such meetings may not be familiar with the concept of a separate social worker for the foster family and for the child. The open-ended nature of the questionnaires did not allow for the detailing of researcher-suggested improvements or changes to existing services. It is possible that wider education of such concepts would have yielded a response that corresponded more to the informal emphasis encountered by the researcher. It is very likely that foster parents may be in an even better position to offer advice as to services when they are educated and informed as to the services that are available in other health boards or in other countries.

While the main aim of this paper was to describe the perspective of foster parents, the comparisons between responses given by foster parents who had experienced different outcomes for their placement offered in Table 3 yielded some very interesting information. It is worthy of note that foster parents who experienced difficulties were more keenly aware of the services they needed; these were the foster parents for whom the services of the health board were really tested. Table 3, therefore, gives an even better indication than Table 2 of the services that foster parents feel the need for most keenly when problems develop. Table 3 indicated that parent's who were describing a *Crisis* placement were far more likely, for instance, to recommend that services would be improved with a *Permanent and Accessible Social Worker, Pre-Preparation and Assessment* and *Counselling Services.* These are important findings because they show that, of all of the recommendations foster parents made, these services were found most lacking by those that needed them most. While many families overall recommended *'Adequate Training'*, therefore, *Crisis* parents were seemed to put more emphasis on preparation before the placement even began. This would indicate that health boards should perhaps put more emphasis on preparing parents for difficult situations well in advance of the start of the placement.

The evidence presented here, in concurrence with other literature on the subject (Gilligan, 1996; Sellick, 1992), suggests that fostering agencies are not providing the best possible services to foster parents. It must be acknowledged that this is generally not through lack of commitment on the part of individual social workers, but because many fostering agencies, including (and maybe especially) Irish health boards, are under resourced in so many ways. Regardless, foster parents are themselves offering the country a valuable service, and if their back-up services were adequate this would allow for more successful fostering all around. Indeed, evidence suggests that a history of failed fostering can lead to the development of criminal behaviour (Browne, 1999; Cooke Parker and Forrest, 1994; Massinga and Perry, 1991), so putting money into improving services for these children and young people would save the state money in the long term. The foster parents who participated in this study may not all have been educated as to the potential services that could be offered to assist them, but they nonetheless readily recognised what services were *not* there when they needed them. These issues will need to be very carefully considered by those planning a national policy on child-care services.

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THE INFLUENCE OF SOCIAL FACTORS ON PSYCHIATRIC HOSPITALISATION IN NORTHERN IRELAND: A REVIEW OF THE LITERATURE; AN ANALYSIS OF OFFICIAL STATISTICS AND THE IMPLICATIONS FOR SOCIAL WORKERS

by Roger Manktelow

Key Words: Psychiatric hospitalisation, Northern Ireland, social influences

Abstract

The paper reviews the knowledge of the influence of social factors on psychiatric hospitalisation within Great Britain, Northern Ireland and the Republic of Ireland and investigates the particular features of the process in Northern Ireland. Previous research by the author in Northern Ireland has found this process to be complex, to be marked by discontinuities and to have an outcome which is almost fortuitous (Manktelow 1994). The inverse relationship between social class and mental illness has been widely documented in an international context, and has also been investigated by the author in Northern Ireland. But there are other particular factors which are important mediators of social influences on psychiatric hospitalisation within the divided society of Northern Ireland. The author identifies three sets of local factors as being of importance. These are: the urban/ rural dimension; religious affiliation; and the influence of twenty five years of civil unrest on the local population's use of psychiatric hospitalisation.

An analysis of psychiatric hospital admissions according to these sets of factors showed that higher rates of psychiatric hospitalisation are experienced in rural, Catholic areas located west of the Bann. However, these findings must be interpreted with caution. Rates of psychiatric hospitalisation tell us more about

help seeking behaviour than levels of mental illness. The consequences of poor preventative mental health services in rural areas is more frequent hospital admissions and longer periods of hospitalisation.

A breakdown of psychiatric diagnoses according to religious affiliation revealed that psychotic conditions (predominantly schizophrenia) and alcoholism continue to be more common diagnoses for Catholics than Protestants whilst depression and personality disorders are more common amongst Protestants than Catholics. Higher rates of psychiatric hospitalisation amongst Catholics can be linked to the higher levels of social deprivation experienced in Catholic communities.

The importance of social workers adopting, in their mental health social work practice, a social model of mental disorder is noted. In the planning of community alternatives to psychiatric hospitalisation, service providers must complement the cultural characteristics of local communities. Post Troubles, social workers are in a unique position to contribute to the healing process by acknowledging the impact of the Troubles and seeking to ameliorate their adverse effects on mental health.

The paper reviews the methodological difficulties in conceptualising a causal mechanism operating between social factors and mental illness and argues for the adoption of a qualitative research approach to the social process of psychiatric hospitalisation

INTRODUCTION

This paper has three objectives: to review the literature on the influence of social factors on psychiatric hospitalisation; to analyse Northern Ireland psychiatric hospital statistics in relation to rural/ urban location and religious affiliation; and to spell out some implications for social workers.

I first became interested in answering the question of how do people become psychiatric patients when, having previously worked as a generic social worker in a local housing estate welfare office in inner-city Belfast, Some twenty years ago, I became a psychiatric social worker in a Northern Ireland county mental hospital. I remember that what struck me most when meeting for the first time psychiatric patients on the hospital acute admission ward was that for the majority of patients the magnitude of their problems and the extent of their behaviour difficulties were very much on a similar level to those experienced by individuals I had previously worked with as clients in the community. However, this group of community clients had had no contact with psychiatric services and no-one had thought to perceive their difficulties as being caused by mental illness. Undoubtedly, there were hospital patients who were behaving in a bizarre or disturbed manner and who were experiencing an acute psychotic episode, but this group were in a minority. The majority of my new clients in the psychiatric ward presented very similarly to my previous community clients.

This was a real paradox for me as I sought to make sense of the nature of mental illness. It became apparent that people were in hospital not so much because they were iller than people outside hospital, as is generally assumed, but, rather, because other social forces were operating which contributed to the labelling of mental illness. However, unravelling the social process of psychiatric hospitalisation proved to be a difficult task because of the number of competing causal explanations of mental disorder and the degree of emotional commitment with which their proponents promoted their opposing theories, often in the weekly multi-disciplinary team ward round.

It was clear that there was no straightforward relationship between illness and hospitalisation and that, in order to make sense of psychiatric hospitalisation, factors other than individual pathology had to be considered. I began with a positivist sociological approach. In my social work practice my clients frequently experienced the presence of social deprivation, social isolation and poor environment alongside psychiatric hospitalisation. My first research activity concentrated on measuring the significance of these factors (Manktelow 1994).

SOCIAL DEPRIVATION AND PSYCHIATRIC HOSPITALISATION

The link between social deprivation and mental illness has long been an area of considerable research investigation. More than twenty five years ago, some twenty eight international studies had reported a concentration of mental illness in the lower social classes (Dohrenwend and Dohrenwend 1974). This relationship has been confirmed in a Republic of Ireland context (Walsh 1993).

In order to investigate social deprivation and mental illness, a problem of definition of both social deprivation and mental illness has been identified. Early epidemiological studies, principally in North America (Hollingshead and Redlich 1958; Leighton and Leighton 1959) used a single measure of socio-economic status. Now a much more complex measure of deprivation has been developed to predict the uptake in psychiatric services (Jarman, et al 1992). A review of recent research has revealed a strong association between treatment for psychiatric disorder and low social class, being female, single, being from a minority ethnic group, and living alone (Thornicroft 1991). However, within the Republic of Ireland, unemployment on its own has been found to be a powerful predictor of psychiatric hospitalisation (Kammerling and O'Connor 1993). Predictors of mild psychiatric morbidity within Northern Ireland have been identified as unemployment, large family size, and being single (Cairns and Wilson 1984).

My own study of a patient population admitted to psychiatric hospital from an outer-city catchment area in Northern Ireland produced results substantially in line with the studies reported above (Manktelow 1994). In respect of socio-demographic factors, compared to the general population, patients were more likely to be older, female, and unmarried, widowed or separated. When socio-economic factors were considered, patients were more likely to be from the lower social classes, unemployed, dependent on statutory benefit and in public housing. Finally, with reference to social integration, patients were more likely to be living alone, have moved within the last two years and be non-Church attenders.

EXPLAINING THE RELATIONSHIP BETWEEN SOCIAL DEPRIVATION AND MENTAL ILLNESS

From my research findings, it could be seen that psychiatric patients represented a socially deprived group. But how were these research findings to be interpreted? It soon became clear that whilst a number of competing explanations might be postulated none could be conclusively proven. For example, is being in Social Class Five a consequence of the disabling effects of being mentally ill as the social drift exponents would argue? (Eaton 1980) Or, are the social causation theorists right in explaining psychiatric hospitalisation as a result of the material and psychological strains of lower Social Class living? (Link, Dohrenwand and Skodol 1986)

Causative factors in working class life identified by researchers have included a more frequent experience of severe life stresses (Brown and Harris 1980), high unemployment (Eczy 1993), a higher level of social isolation (Thornicroft 1991), a lack of alternative sources of help (Cohen and Taylor 1973), a powerlessness in the face of social control (Rushing 1971), and a reluctance in seeking help until urgent hospitalisation is required (Gove and Howell 1974). It can be seen that any interpretation of the preponderance of the lower social classes in psychiatric hospital has a strong ideological component. How does one choose between these competing explanations?

A qualitative research approach offers an alternative which focuses on the ways in which the concept of mental illness is employed (Blum 1970). By investigating individual experiences of becoming a psychiatric patient, it is possible to deconstruct the social process of psychiatric hospitalisation. It is this process of definition which requires investigation so that the ways in which people come to choose a mental illness explanation from various methods of understanding is explained. Such an approach avoids the problem of what constitutes mental illness which has bedevilled psychiatric epidemiology as researchers have struggled to discover the `real' rate of mental illness. As Taylor and Chave (1964) state `the size of the mesh of the net determines the size of the catch'. Psychiatric hospital surveys produce the lowest level of mental illness, surveys of primary health care produce a higher level, whilst community surveys produce the highest rate.

THE CASE OF NORTHERN IRELAND

Since the mid-eighties, in Northern Ireland as in all other countries, there has been a substantial reduction in the number of psychiatric hospitals beds. Government policy has required a further 30% reduction over the period 1997-2002 (DHSS 1996). However, per capita levels of acute hospital care provision are higher in Northern Ireland and Northern Ireland people continue to be admitted for acute hospital treatment more frequently than in Great Britain (Campbell and Stevenson 1993). Within the broad framework of community care for people with mental illness, there has developed an interest in the possibility of alternatives to hospital to reduce the number and length of hospital admissions (DHSS 1989). If such new services are to offer real alternatives, then they must meet those needs which are presently being met, albeit inappropiately in the government's eyes, by psychiatric hospital admission. When such community services are being developed, the specific cultural characteristics of individual communities must be considered so that formal services complement and facilitate informal networks of support.

We know a great deal about certain individual geographical locations which have been extensively researched such as the inner city area of Camberwell, South London (Brown and Harris 1980). In that seminal study, the researchers identified the mechanisms which explained the link between being a working class woman and suffering from depression. Briefly two sets of factors were described. The first were termed vulnerability factors which resulted in low personal self-esteem. Four adverse conditions of working class life were identified: three or more children under the age of fourteen; loss of own mother before age of eleven; no outside employment; and an absence of an intimate, confiding relationship. If all these factors were present, then the individual woman was vulnerable to the onset of depression. What triggered the depressive episode was a provoking agent which was one of a set of negative life events. These stressful events were also more frequently experienced by working class women than others. Essentially working class women in South London had more to cope with and fewer resources - both material and emotional - to do so.

It is clear that the broad thrust of the findings of the Camberwell study apply across urban communities in general including those in Northern Ireland. But, what also requires investigation are the specific conditions which might operate in individual geographical settings within Northern Ireland. It is proposed that three sets of factors are key influences in the relationship between social deprivation and psychiatric hospitalisation within Northern Ireland. These are the rural/urban location, religious affiliation and the effects of the Troubles.

In order to help orientate the reader, the following map of Northern Ireland shows the District Council boundaries, their majority religious composition and the natural dividing line of the River Bann.

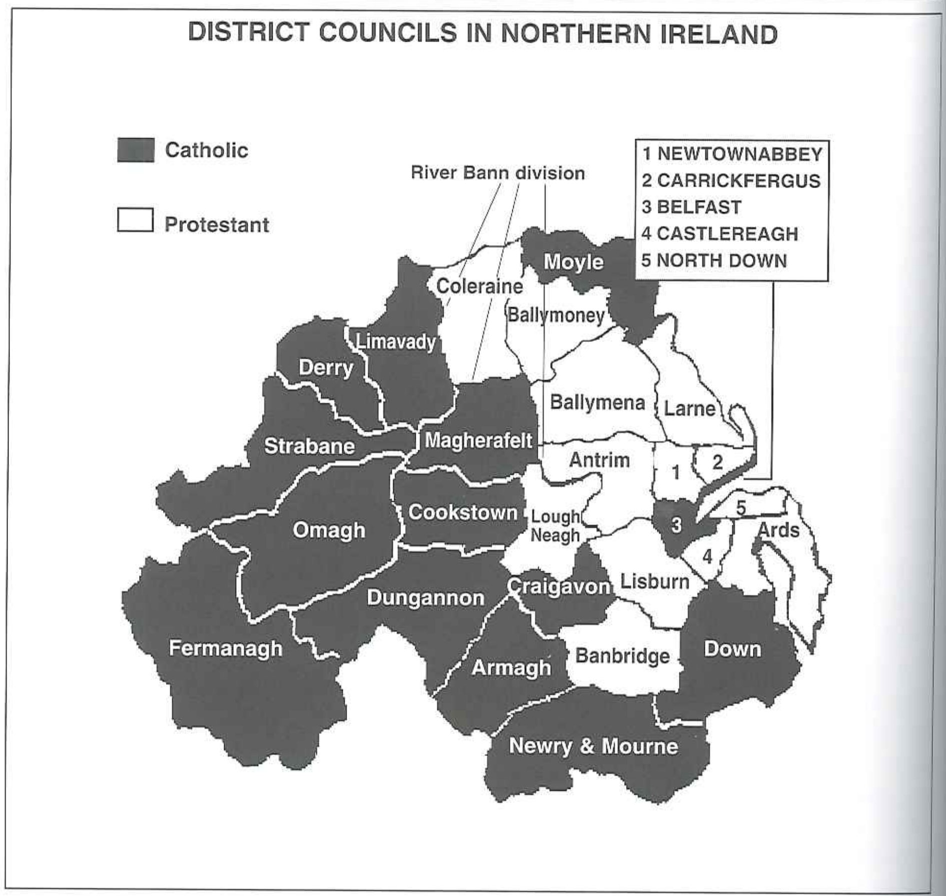

Figure 1

The division of Northern Ireland into twenty three local District Councils and their predominant religious composition is shown in Figure 1. There is a clear division between east and west of the Bann. In the east of the province, the District Councils are predominantly Protestant, industrialised, wealthy, heavily populated with a high level of service development. In contrast, west of the Bann is Catholic, rural, poorer, with fewer services and more sparsely populated with the exception of Derry city. Three quarters of the total Northern Ireland population of one and a half million live in the eastern half of the province within twenty miles of Belfast (Breen, Devine and Dowds 1996). However, there remains a substantial rural population located primarily in the western half of Northern Ireland and it has been suggested that the River Bann provides a natural dividing line between the urban East and the rural West of the Province (Murphy and Vega 1982).

The experience of the `Troubles' is influenced by location, although the River Bann does not act as an identifiable boundary in this respect. When discussing the 'Troubles', it is important to recognise how the violence has changed in its intensity, its nature and its location since its beginning in 1969 (Fay et al 1999). Parts of Northern Ireland have been left largely untouched, whereas in other areas the 'Troubles' have been directly and continuously experienced by the local population with consequent long-term adverse effects on individual mental health. Similarly, certain occupations have a high level of experience of violence and, as a result, are more vulnerable to poor mental health.

THE URBAN/RURAL DIMENSION AND PSYCHIATRIC HOSPITALISATION

The importance of urbanisation as an influence on the distribution of mental illness has been attributed to the concentration of problems of deprivation and isolation in inner city areas resulting in higher admission rates to hospital (Cotterill and Thomas 1993). In contrast, features of rural life, such as a quiet stress-free life style and the presence of extended family support, are applauded for contributing to positive mental health. However the picture is not nearly so clear-cut and this is illustrated when one compares rural and urban hospital admission rates.

Internationally, the distribution of psychiatric diagnoses between urban and rural areas is one of schizophrenia, neuroses and personality disorders being urban diagnoses while depression is more common in rural areas (Dohrenwend and Dohrenwend 1974). However, within the Republic of Ireland, there is a skewed picture with schizophrenia being predominantly a rural diagnosis, especially amongst middle-aged bachelor men in the West (Walsh 1993). Social factors have been increasingly emphasised as explanations. Certainly, one important influence has been the legacy of Victorian institutional provision which has bequeathed to the Republic of Ireland one of the highest rates of psychiatric bed provision per head of population in the world. On a family level, both maternal attitudes and the double binds of family life have been blamed for contributing to mental illness in the West of Ireland (Scheper-Hughes 1979).

The lack of opportunities and the absence of therapeutic alternatives to psychiatric hospitalisation in rural areas have been identified in recent research as contributory factors to the high rates of hospital admissions. (Keatinge 1989). The reported rural excess of schizophrenia in the West of Ireland is blamed on the 'after-care syndrome', when individuals, with few economic possibilities and tied to their family of origin, are admitted to hospital for the first time in middle life but then require frequent and prolonged periods in hospital. A similar picture has been described west of the Bann in Northern Ireland where Catholic, rural bachelor men have high rates of psychiatric hospital admission (Murphy 1975).

In contrast, research studies have revealed that urban areas in both the North and South of Ireland are similar to urban areas outside Ireland. High rates of admission for alcoholism and neuroses are reported in Dublin (Ni Nuallain, O'Hare and Walsh 1987) and problem drinking has been found to be most prevalent in urban eastern areas of Northern Ireland (Blaney and MacKenzie 1980). The predominantly Protestant and urbanised area, east of the Bann, has a picture of psychiatric hospitalisation similar to Britain (Murphy and Vega 1982).

Table 1 (opposite) presents an analysis of discharges from psychiatric hospital according to District Council of origin. District Councils are categorised rural (less than 100 people per square kilometre) or urban (more than 100 people per square kilometre). Population figures are taken from the 1991 Census for Northern Ireland. In order to make a contemporaneous comparison, psychiatric hospitalisation rates are based on returns for 1993/4 from the Mental Health Inpatient System (MHIS) administered by the DHSS(NI) with a coverage of 95%, using discharge data (it is possible for an individual to be discharged more than once in a year). In Table I, District Councils are ranked according to their psychiatric hospital admission rate per 10,000 population.

When psychiatric hospital admissions are broken down according to District Councils as shown , it can be seen that the social geography of Northern Ireland is of great importance The eight District Councils with the highest rates of psychiatric hospitalisation are predominantly Catholic, west of the Bann and rural. There are two urban exceptions to this rural picture. Derry city is overwhelmingly Catholic with problems of long-tern unemployment due to past neglect and discrimination. The city has a high rate of hospitalisation. The other urban area with high rate of hospitalisation, Craigavon, is something of a special case. Designated a new town, it was heavily overbuilt in the seventies and has now become something of an area of social exclusion particularly for ethnic minorities.

It has been seen that there is a strong established link between material deprivation and ill-health in Northern Ireland (Stringer 1992). The following indicators of physical ill-health have been found to be excessive in poor Northern Ireland communities: stillbirths and prenatal mortality: low birth weight; excessive alcohol consumption; and the proportion of young smokers (Moore, Harrisson, Mason and Orr, 1996). It has also been found that the suicide rate west of the Bann is the highest in Northern Ireland with particularly high rates for young males (McAllister 2000).

Because of their higher levels of unemployment, Catholics experience greater material deprivation and consequently lower levels of health. Outside of North and West Belfast it has been found that there is a concentration of deprivation in the northwestern districts of Strabane, Derry and Limavady (Stringer, 1990). In contrast, the eight District Council areas with the lowest rates of psychiatric hospitalisation are all east of the Bann and Protestant (with one Catholic exception) and where deprivation is strikingly absent in the three districts immediately to the south and east of Belfast in Lisburn, Castlereagh and north Down.

TABLE 1:
N.I. Psychiatric Hospital Discharges 1993/94 by District Council

District Council	Hospital Discharges	Population Density	Religion	Location
1. Omagh	93.8	Rural	Catholic	West
2. Derry	71.2	Urban	Catholic	West
3. Dungannon	69.3	Rural	Catholic	West
4. Craigavon	68.7	Urban	Catholic	West
5. Fermanagh	66.4	Rural	Catholic	West
6. Cookstown	65.5	Rural	Catholic	West
7. Strabane	58.8	Rural	Catholic	West
8. Armagh	55.8	Rural	Catholic	West
9. Newtownabbey	55.6	Urban	Protestant	East
10. Ballymena	54.6	Rural	Protestant	East
11. Belfast	51.4	Urban	Protestant	East
12. Antrim	50.1	Urban	Protestant	East
13. Carrickfergus	47.6	Urban	Protestant	East
14. Lisburn	47.3	Urban	Protestant	East
15. Down	43.9	Rural	Protestant	East
16. Magherafelt	43.4	Rural	Catholic	East
17. Limavady	42.2	Rural	Protestant	West
18. Castlereagh	40.7	Urban	Protestant	East
19. Banbridge	40.4	Rural	Protestant	East
20. North Down	39.2	Urban	Protestant	East
21. Moyle	36.1	Rural	Catholic	East
22. Larne	35.5	Rural	Protestant	East
23. Ards	30.7	Urban	Protestant	East
24. Ballymoney	22.0	Rural	Protestant	East

RELIGIOUS AFFILIATION AND PSYCHIATRIC HOSPITALISATION

There are three ways in which religion may influence mental illness. Firstly, an association between psychiatric diagnosis and religious grouping has been revealed by a study of hospital admission statistics in Mid-western America

(McDonald and Luckett 1983). Relationships were reported between mainline Protestant and the diagnosis of personality disorder, non-mainline Protestant and depression, and Catholics and obsessional behaviour. A second influence of religious affiliation is likely to be on the content of psychiatric symptomatology and there is general agreement that heightened religious concern and conflict characterise patients in psychiatric hospitals (Anderson and Yong 1988; Lowe and Braaten 1975). Finally, religious belief and church attendance are important indicators of social integration. Their importance was first identified by Durkheim (1951) in his linking of rising social anomie, as indicated by falling church attendances amongst other variables, with an increased rate of suicide.

Within Northern Ireland, where 60% of the population are weekly Church attenders, religious affiliation determines ethnic identity. Church non-attendance remains a meaningful indicator of social disintegration But, being Catholic or Protestant is not just a matter of church membership, it is an influence on a whole range of social variables (O'Connor 1994). These are likely to include cultural identity, political loyalty, area of residence, place of education, employment possibilities, experience of the 'Troubles', help seeking behaviour, use of statutory services and, perhaps, psychiatric hospitalisation. Religious identity has therefore taken on a particular significance over the twenty five years of civil unrest.

Within Northern Ireland, an analysis of psychiatric admission rates found that Catholics were twice as likely to be admitted for schizophrenia and alcoholism as Protestants (Murphy 1975). My own study in Greater Belfast found generally low levels of church attendance amongst the patient sample and that this was particularly pronounced for members of the Church of Ireland (Manktelow 1994).

Table 2 presents an analysis of psychiatric diagnoses according to religious affiliation. Rates are per 10,000 head of population for each community group. The Protestant group includes all religious groups except Roman Catholic, not known, none or not coded. As with any body of official statistics care must be taken with their interpretation, and this is particularly true in Northern Ireland where official surveys such as the population census take on a major political significance. Census figures in Northern Ireland are bedevilled with a high non-return rate for religious affiliation and it is the same case for hospital statistics.

Overall, the psychiatric hospital usage rate is higher amongst Catholics than Protestants but this may not simply be caused by higher levels of disorder. Rather, it may reflect a lack of alternatives to hospital, a greater readiness to seek help and a consequence of the greater relative social deprivation experienced by Catholics (Compton 1995).

It can be seen from Table 2 that psychotic conditions (predominantly schizophrenia) and alcoholism continue to be more common diagnoses for Catholics than Protestants whilst depression and personality disorders are more common amongst Protestants than Catholics. The widest differential is in respect to alcoholism where the Catholic hospital discharge rate is twice that of the Protestant. These findings are similar to those revealed by an analysis of hospital admissions of nearly thirty years ago for 1966/7 (Murphy and Vega 1982). It is surprising how little has changed in respect of psychiatric hospital usage and religious affiliation despite all the upheavals of the Troubles.

TABLE 2:
Psychiatric hospital discharges 1993/94
Diagnosis and religious affiliation (per 10,000 of the population)

Diagnosis	Protestants	Catholics	None/ Not known	Total
Psychotic Condition	12.84	14.46	12.98	16.15
Depression	11.2	10.88	10.97	12.17
Neurosis	6.21	6.49	5.86	6.99
Personality Disorders	3.14	2.56	4.14	3.33
Alcoholism	6.28	11.38	4.94	8.52
Drug Abuse	1.33	1.88	1.78	1.68
Other	5.3	5.28	7.18	6.08
TOTAL	**46.31**	**52.94**	**47.86**	**54.9**

The higher rates of hospitalisation relate to Catholics whom, it has been seen, are more likely to be diagnosed as suffering from schizophrenia or alcoholism. However, this does not necessarily mean that these disorders are more common in the community amongst Catholics than Protestants. The higher rates are in rural District Councils. These higher levels of hospitalisation west of the Bann may be caused, rather, by the fact that traditionally in rural areas there is little investment in services which act as alternatives to hospital. In the absence of preventative services, hospitalisation, rather than the last resort, becomes the only resort and for that reason admission may be delayed for as long as possible but once used, readmission is frequent.

MENTAL HEALTH AND THE 'TROUBLES'

The 'Troubles' have added a further dimension to the operation of religious affiliation in the process of psychiatric hospitalisation. It is impossible to ignore the long term stressful effects of the 'Troubles' on the mental health of the local population. What has been discovered about this relationship is now reviewed.

The early years of the civil unrest were characterised by street rioting and intimidation resulting in the segregation of communities along religious lines in the biggest population movement in Europe since the Second World War. Two Belfast psychiatrists produced a number of studies which argued that mental health had remained unaffected. This surprising finding was based on the fact that no increased take-up in psychiatric services had been recorded (Lyons 1971; Fraser 1971). In fact, it was even suggested that the 'Troubles' may have had positive mental health effects in externalising aggression and allowing a recognised outlet for psychopathic individuals (Lyons 1972). Nobody who has experienced working in the caring professions in Northern Ireland could support such an explanation.

What these early studies failed to consider was how the violence had discouraged people from travelling outside their respective safe areas and had restricted them from seeking help from the psychiatric services. When contact with General Practitioners, largely based in local areas, was investigated a significant increased uptake in mental health referrals was reported (Lyons 1979). These increased numbers were related to people suffering from anxiety symptoms which were described at the time as largely transitory. When prescribing trends for psychotropic drugs used in the treatment of mental illness were analysed, a greater increase in minor tranquilliser use was reported in Northern Ireland than in Britain (King et al 1982). Finally, studies of the victims of violence have reported a diagnosis of post-traumatic stress disorder in one fifth of cases (Loughrey et al 1982; Curran 1988).

All this evidence suggests that there are adverse mental health consequences of the 'Troubles' which are seen in an increase in mild psychiatric morbidity rather than major mental illness. Other evidence, such as the high rate of heart disease in Northern Ireland, the high rate of absenteeism from work, and the high rates of general hospitalisation are other indicators of the adverse effect on general health of living under the 'Troubles' (Campbell and Stevenson 1993).

How people have preserved their mental health in this period of civil violence is a question of considerable interest. Social psychologists have identified two personal mechanisms - denial and habituation. A study of two towns with differing levels of local violence found that those reporting as more healthy had resorted to denial of, and distancing from the violence in order to preserve their general well-being (Cairns and Wilson 1984). Secondly, it has been argued that people in Northern Ireland have become habituated to a normal or acceptable level of violence which has become a back-drop to everyday life (McWhirter 1986).

IMPLICATIONS FOR SOCIAL WORK

There are significant implications for social workers arising from the present analysis. Most importantly, mental health social workers need to adopt *a social model of mental disorder* which emphasises social factors and interpersonal relationships as explanations for behaviour. Such an approach offers a distinct and holistic alternative to the medical model of mental disorder which has a tendency to isolate the individual from family and environment. Unfortunately, because people with mental illness are often patients in hospitals or clinics, they are consequently divorced from their social and family backgrounds and the impact of their social contexts is all too easily ignored. The social perspective corrects this distortion of reality.

As a social worker in mental health settings in hospital and community, our search for an explanation of psychiatric breakdown takes place on the family and society level as much as on the individual. At a micro-social-interactional level, the quality of social networks, partner relationships and family life are investigated as sources of emotional distress. When families report their experience of hardship, discrimination and relationship breakdown, these are identified as the aetiological factors in the onset of mental illness.

However, it is imperative that we should not ignore the macro-societal level, where structural and environmental factors such as poverty, inadequate housing and unemployment are identified as causes of stress and disorder. The present paper has identified a number of key influences on the likelihood of psychiatric hospitalisation which operate in Northern Ireland society. Social workers must develop an awareness that location and religious affiliation increase the risk of psychiatric breakdown. Intervening variables of social deprivation and the impact of the Troubles require the development of a primary prevention strategy to promote positive mental health.

The analysis has underlined the need to take into account the particular characteristics of local communities in Northern Ireland when planning new services. In order to reduce psychiatric hospitalisation rates, community alternatives should be targeted at high risk areas and groups. Such alternatives need to complement rather than replace existing sources of informal support and take account of the cultural characteristics of local communities. They will have the advantage of avoiding the medicalisation of social difficulties and the negative label attached to being a psychiatric patient.

Since 1994, post-ceasefire, a period of relative peace has created safe, public spaces in which to debate the topic of political violence and its effects. Now we no longer need to deny the 'Troubles', will there be a flood of post-traumatic mental ill-health? A number of voluntary groups have been established with the purpose of meeting the emotional needs arising out of the 'Troubles' experience. On a statutory level, trauma teams have existed for the last decade to offer individual counselling to the victims of civil disasters and have also been involved following recent Troubles related incidents. The skills of mediation have an invaluable part to play in the resolution of past hurts and grievances both on an individual and community level. Reconciliation requires recognition of what has happened in the past, an expression of remorse and an acknowledgement of reparation. On this basis, people are healed and a positive mental wellbeing promoted. Social workers are uniquely placed to play an invaluable part in this healing process (Manktelow 1998).

CONCLUSIONS

Within the island of Ireland, political division is North/ South but there is also an important dividing line between the urban East and the rural West. Within Northern Ireland, the River Bann acts as a natural East/ West boundary separating the urban relatively well-off Protestant East with lower rates of psychiatric hospital admission from the rural poorer Catholic West with a higher rate of psychiatric hospitalisation. The data presented therefore supports the importance of two sets of mediating or intervening factors - urban/rural location and Protestant/ Catholic religious affiliation - in the relationship between social deprivation and psychiatric hospitalisation in the divided society of Northern Ireland. A similar explanatory model has been presented in other international settings (Thornicroft, Bisoffi, De Silva and Tansella 1993).

This paper has not argued that psychiatric hospitalisation rates are an indicator of levels of mental illness. Rather, such statistics tell us two things: firstly, about patterns of help seeking behaviour in the absence of community alternatives to hospital admission; and, secondly, about how high levels of social deprivation show their effects in psychiatric hospital admission.

Further research is required to illuminate the social process of psychiatric hospitalisation. Such an approach requires the collection of individual retrospective accounts of the sequence of events leading to hospital admission and people's understanding of this process. The author has previously adopted an ethnomethodological approach to describe the activities of the gatekeepers who operate along the path to psychiatric hospitalisation (Manktelow 1994). These included informal groups - self, family, friends and clergy - and formal groups - general practitioner, police, social workers and psychiatrists. How each of these groups defined and categorised behaviour through the use of 'common-sense' and a set of 'rules of thumb' was investigated and described.

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CAN APPLIED BEHAVIOUR ANALYSIS PROVIDE A SCIENTIFIC BASIS TO IRISH SOCIAL WORK PRACTICE?

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Key Words: Behavioural analysis, Social Work Practice.

Abstract

The implementation of the Child Care Act 1991 has led to the development of a broader range of services for children and families, with an emphasis on accountability and evaluation. While social work has adopted new forms of practice such as brief- and solution-focussed approaches, there is an absence of practitioner-led, empirical research. This article provides an overview of applied behaviour analysis, a form of intervention which is based on the science of behaviour. The article also reviews the polarised debate which has attended the application of scientific methods to social work practice. Finally, the article concludes that Irish social work practice would be enhanced by the inclusion of behavioural methods in its repertoire.

INTRODUCTION

The Irish social work context

The past 30 years have been a period of sustained development and change for social work, which is a relatively new profession in Ireland. Social work in Ireland has its origins in 19th-century philanthropic practices, which took place primarily under the auspices of the major religious institutions (Skehill, 2000). Skehill found that social work practice up to the mid-20th century was characterised by voluntarism and spirituality, and was often fuelled by sectarian rivalry.

The emergence of social work as a profession coincided with, and can to a large extent be attributed to, the Health Act 1970 which led to the establishment of eight health board regions, each of which was sub-divided into a number of community care areas. Within the newly organised health and social services, social work was identified as providing a generic social service to the community, which included the care and protection of children (Department of Health, 1973). These developments closely resemble the emergence of generic social work in Britain following the publication of the Seebohm Report in 1968 (Banks, 1996). Skehill (in print) has identified two factors which led to social work being given the primary statutory responsibility for child care from the time that the health boards were established; firstly, there was a lack of availability and an unwillingness to assume this responsibility among other personnel, such as public health nurses and assistance officers; secondly, the newly formed services offered social work an opportunity to adopt a primary role in relation to child care, in contrast to the auxiliary role which it occupied in medical and psychiatric services.

While social workers have been employed within a range of sectors which include the probation and welfare service, hospitals, and local authorities, as well as a wide range of voluntary organisations, the majority of those employed in the health and social services are involved in child care and child protection services (Lavan, 1998). For social workers in child care and child protection services, the enactment of the Child Care Act 1991 has major implications. This act replaced the Children's Act 1908, and broadened the definition of child welfare by focusing not only on child protection, but also on children in alternative care, and family support, and it has been viewed as "a template of social reform" (Powell, 1998: 315). The gradual implementation of the Act has led to the development of new and evolving services in the areas of child protection and family support (Gilligan, 1996). Family support services are envisaged as reducing stress on families by providing social support, particularly in areas of social deprivation (Eastern Health Board, 1996). Family intervention services have also been developed with the establishment of child guidance clinics in each health board area. These developments have been accompanied by organisational changes which erode the traditional distinction between child protection and clinical services. For example, until recently child protection services and child guidance clinics within the Eastern Health Board region, which is the most densely populated region, operated within separate administrative programmes. These separate programmes have now been amalgamated, along with family support services, into the Children and Families Programme. These legislative and organisational developments have been accompanied by an emphasis on accountability and evaluation (Eastern Health Board, 1996).

Child care, which was inextricably linked to the emergence of social work as a profession, has remained a central concern for social work. It has been noted however, that child protection is frequently equated with child care, and that services have developed according to a crisis-intervention model, rather than according to a model which would promote the welfare of children who are considered to be at risk (Kilmurray and Richardson, 1994). While the Child Care Act 1991 broadened the definition of child welfare, it was introduced in response to intense media coverage of a number of high-profile child abuse cases, and the circumstances which led to its introduction have threatened to distract attention from the preventive aspects of the act (Powell, 1998).

The broad definition of child welfare which is provided by the Child Care Act 1991, and the organisational changes to which it has led, have taken place within the context of broad social changes which have profound implications for social work practitioners:

> Social work practitioners are consequently looking at a new and uncertain landscape, constantly changing and reconstituting itself in new and more challenging forms. (Powell, 1998: 311-328)

While traditional social work methods such as task-centred, crisis intervention and problem-solving approaches are giving way to brief- and solution-focussed approaches which have been characterised as being more discursive, empowering and consumer-oriented (Skehill, 2000), there is a noticeable absence of practitioner-led, empirical research (Gilligan, 1996; Lavan, 1998).

In the context of the expansion of social work practice methods which has accompanied these legislative and organisational changes, it is imperative that social work in Ireland demonstrates a commitment to evaluation and to practice-based research. This article is intended to contribute to a theoretical discourse on effectiveness and evaluation as central issues in Irish social work practice. Firstly, it provides an overview of *applied behaviour analysis*, a type of behavioural intervention in which constant evaluation provides the basis for the development of effective treatment methods. Secondly, it reviews the polarised debate which attended the emergence of the *empirical practice movement* in the 60's. This debate centred on whether social work practice can, or indeed should be evaluated, and it has continued up to the present day.

Applied behaviour analysis

The term *behaviourism* originated in a paper which was published by J.B. Watson in 1913, entitled "Psychology as the behaviourist views it", in which he drew upon the objective tradition of psychology which had emerged in the 19th century (Baum, 1994). Watson expressed the increasing uneasiness among psychologists who espoused the objective tradition with introspection as a method of enquiry:

> If you fail to reproduce my findings... it is due to the fact that your introspection is untrained. The attack is made upon the observer and not upon the experimental setting... If you can't observe 3-9 states of clearness in attention, your introspection is poor. If on the other hand a feeling seems clear to you, your introspection is again faulty. You are seeing too much. Feelings are never clear (Watson, 1913, *cited in Baum, 1994: 9*).

The term *behaviourism* refers to the set of ideas upon which the science of behaviour is based, and it has been described as a philosophy of science, rather than the science of behaviour itself (Baum, 1994). Behaviourism is based upon the central premise that "there can be a science of behaviour" (Baum, 1994:p. 3). *Behaviour modification* refers to the assessment, evaluation and alteration of behaviour according to behavioural principles, and is conducted within a broad range of social, educational and therapeutic settings:

> The approach focuses on the treatment of clinical problems and on the development of adaptive functioning in everyday life. (Kazdin, 1994: 1)

Kazdin (1994) identifies applied behaviour analysis as a form of behaviour modification and proposes that, rather than being a single entity, behaviour modification is a collective term for a range of practices which share the following major characteristics: they focus on behaviour as the primary focus of interest; they assert that behaviour can be changed through the provision of new learning experiences; they rely on direct and active treatments; they are committed to the assessment and evaluation of treatment methods; and they recruit key personnel from the learning environment, such as teachers, parents and institutional staff, to participate in the delivery of treatment. While Kazdin (1994) contends that applied behaviour analysis is a form of behaviour modification, Walshe argues that behaviour modification is outmoded, and that it needs to be replaced by an approach which based more directly on behavioural principles:

> ... it needs to be replaced by an approach that is applied, behavioural and analytic. Such an approach entails far more than changing behaviour. It entails understanding behaviour and the complexity of the interactions between individuals and their environment, particularly their social environment (1997: 101).

Mediational and *non-mediational* concepts of learning have given rise to two distinct traditions within the field of behaviour therapy (Kazdin,1994). Mediational concepts of learning recognise the role of subjective states and cognitions (such as perceptions, plans, attributions and expectations) in processing or mediating environmental events. Mediational concepts emerged in the context of the *cognitive revolution* which took place in the 1970's, when behavioural therapists began to identify themselves as *cognitive-behavioural* (Sheldon, 1995). Kazdin identifies social learning theory, which belongs to the mediational tradition, as the dominant view within contemporary behaviour therapy because

> ...it recognizes the importance of both cognitive and environmental influences and their interaction. A broad social learning view is a useful way of considering multiple influences on behaviour and of incorporating research from different areas (1994: 24).

Non-mediational concepts of learning focus exclusively on observable behaviour and environmental variables:

> The external variables of which behaviour is a function provide for what may be called a causal or functional analysis. We undertake to predict and control the behaviour of the individual organism. This is our "dependent variable"- the effect for which we are to find the cause. Our "independent variables"- the causes of behaviour- are the external conditions of which the behaviour is a function. Relations between the two- the "cause and effect relationships" in behaviour- are the laws of a science. (Skinner, 1953: 35)

The science to which Skinner refers is *behaviour analysis*, and the philosophy on which it is based is *radical behaviourism*. Mattaini and Thyer (1996) identify a number of distinct but interrelated activities within behaviour analysis which include; the *experimental analysis of behaviour*, which involves laboratory research with humans and animals, and of which Skinner's own experimental work with pigeons and rats is an example; the *conceptual analysis of behaviour* which involves theoretical and historical explorations (for example, Baum, 1994); *cultural analysis and design*, which seeks to understand and design social systems (for example, Thyer, 1996); and *applied behaviour analysis*, (for example, O'Reilly and Dillenberger, 1997; 2000). Applied behaviour analysis has a more narrow focus than forms of behaviour therapy which are based on mediational concepts of learning and which attempt to generate broad theories of behaviour;

> ... the goal of applied behaviour analysis has not been to develop a broad theory of behaviour. The overall questions of applied behaviour analysis concern the extent to which the principles developed in laboratory research can be useful in developing effective treatment, education, and rehabilitative programmes and the extent to which human behaviour can be altered in significant ways to improve functioning in everyday life (Kazdin, 1994: 24).

In 1968, Baer, Wolf and Risley published "Some current dimensions of applied behaviour analysis" which represents a milestone in the emergence of applied behaviour analysis as a distinct discipline, and which specified that research which is based on this method should be applied, behavioural, analytic, technological, conceptually systematic, effective, and that the generalisation of treatment effects should be demonstrated.

1. ***Applied.*** This term distinguishes applied behaviour analysis from the experimental analysis of behaviour which is usually conducted in laboratory settings, and involves the examination of functional relations which may not be directly related to human problems. This criterion requires that research focuses upon behaviour which is directly relevant to the client or to society. Applied behaviour analysis has been applied to virtually all socially significant human behaviour including (to cite but a few examples which illustrate its broad range of application) smoking, littering, speeding, child-rearing, marital conflict, academic skills and child-rearing practices (Cooper, et *al* 1987).

2. ***Behavioural.*** Behaviour analytic research focuses on behaviours which have a specific *topography*, or physical shape which is distinct from the verbal report of that behaviour (Cooper, Heron, and Heward, 1987). The specific topography of a behaviour allows it to be measured in terms of one or a number of dimensions of behaviour which include; frequency, duration, latency (which refers to the length of time, or the delay, between the stimulus and the behaviour), and percentage correct or incorrect (Grant, et al 1994). Baer, et al (1968) emphasise that, while the client's target behaviour must be measured, so too must the behaviour of all people involved in a study, in order to ensure that what appears to be a change in the client's behaviour is not due to change in the behaviour of the experimenters.

3. ***Analytic.*** Behaviour analytic studies are designed to demonstrate a causal relationship between a manipulated event (the independent variable) and the target behaviour (the dependent variable). In a laboratory setting, the experimenter can demonstrate a causal relationship between the independent and dependent variables by controlling the occurrence or non-occurrence of the independent variable. In applied settings, however, ethical considerations often prevent the removal of the independent variable (e.g. the cessation of a form of therapeutic intervention), and behaviour analysts have adopted a pragmatic approach to the demonstration of experimental control:

   > The ultimate issue is believability: has the experimenter shown enough control to demonstrate a functional relation. (Cooper, et al 1987: 5)

4. ***Technological.*** Behaviour analytic studies must include explicit and comprehensive descriptions of all procedures which are used, to the extent that it should be possible to replicate them.

5. ***Conceptually systematic.*** The procedures which are used in behaviour analytic studies must be conceptually systematic, to the extent that the procedures which are applied are derived from behavioural concepts (Cooper *et al.*, 1987).

6. ***Effective.*** In order to be judged effective, an applied behavioural study must demonstrate behavioural change which is socially, rather than theoretically or statistically significant.

7. ***Concern with generalisation.*** Generalisation has been defined as the "...occurrence of relevant behaviour under different, non-training conditions (i.e., across subjects, settings, people, behaviours and/or time without the scheduling of the same events in those conditions as had been scheduled in the training conditions)" (Stokes and Baer, 1977: 350). This definition of generalisation has been characterised as being both pragmatic and relative: generality of behaviour change is accepted as having occurred if the trained behaviour occurs at other times or in other places without being re-taught completely, or if training results in the occurrence of other, related behaviours which do not require complete training (Cooper, et al. 1987). Stokes, et al (1977) contend that even if additional training is provided in order to produce change of behaviour in non-training conditions, generalisation can be deemed to have occurred as long as the cost or the extent is less than the initial intervention. The emphasis which applied behaviour analysis places on generalisation is consistent with its emphasis upon socially (rather than theoretically) significant behaviour change. Generalisation of treatment effects is an important issue because treatment is successful only when the desired change is achieved in relevant settings or in the presence of relevant persons:

   > "If the application of behavioural techniques does not produce large enough effects for practical value, then the application has failed". (Baer, et al 1968: 7).

   For example, if behavioural change is achieved in the clinic setting but does not generalise to the home setting, treatment cannot be considered complete or successful. Without due consideration of the generalisation of treatment effects, treatment becomes unnecessarily prolonged and relapse is much more likely.

These criteria for behaviour analytic research indicate that evaluation is an integral dimension of intervention, and that the criteria for research apply equally to intervention.

The exclusive focus on observable behaviour which characterises applied behaviour analysis has led to the popular misconception that the discipline dispenses with subjective experience from its analysis, and is therefore at odds with other contemporary theoretical and philosophical approaches to human behaviour (Taylor and O'Reilly, 1997). Applied behaviour analysis is, however, distinguished from *methodological behaviourism* (a version of behaviourism which predated it) which relies exclusively on objective definitions of behaviour (Baum, 1994). Methodological behaviourism involves the definition of behaviour in purely objective terms:

> Methodological behaviourists ...argued that science must confine itself to events that can be observed by two or more people; truth must be by agreement. There is a private world of feelings and states of mind, but it is out of reach of a second person and hence of science. That was not a very satisfactory position of course. How people feel is often as important as what they do (Skinner, 1989: 3, *cited in Taylor and O'Reilly, 1997: 21*)

Baum (1994) identifies the distinction between methodological and applied behaviour analysis in terms of their different philosophical foundations. Methodological behaviourism reflects a philosophical outlook termed *realism.* Realism, when applied to the study of behaviour, contends that knowledge of behaviour which is based on sensory data is imperfect, and that scientific knowledge provides a means of studying an objective reality, to which behaviour belongs. Methodological behaviourism therefore accepts the distinction between objective data which is obtained through scientific method, and subjective data. Subjective data, such as an individual's verbal explanation of why he or she is behaving in a particular fashion, is not of interest to methodological behaviourism which focuses exclusively on the mechanics of that action. Applied behaviour analysis and radical behaviourism reflect a philosophical outlook termed *pragmatism,* which is not as concerned with the question of what constitutes real behaviour, as much as it is concerned with providing a useful explanation of behaviour. A useful explanation of behaviour from a radical behaviourist perspective can include an individual's verbal explanation of why he/she is behaving in a particular fashion, but it will also include an examination of immediate and historical environmental events which influence the behaviour. The environmental events which influence behaviour do not, however, exist exclusively outside the individual, because the environment is not conceived as an objective reality:

> When we say that behaviour is a function of the environment, the term "environment" presumably means any event in the universe capable of affecting the organism. But part of the universe is enclosed within the organism's own skin...With respect to each individual, in other words, a small part of the universe is *private* (Skinner,1953: 257).

Private events, such as a tooth-ache, are accessible to and can only be reported on by one individual. Public events, such as a storm, are accessible to and can be reported on by a range of individuals. Apart from accessibility, the distinction between public and private events is of little importance to radical behaviourism, which asserts that both are governed by the same laws of behaviour:

> We need not suppose that events which take place within an organism's skin have special properties for that reason. A private event may be distinguished by its limited accessibility, but not, so far as we know, by any special structure or nature. (Skinner, 1953: 257)

From the perspective of radical behaviourism, private events such as thoughts and feelings are governed by the same laws of behaviour as public events, and are therefore not the sole cause of behaviour. This approach to private events is a distinguishing characteristic of applied behaviour analysis:

> Our "radical" component insists that we can and should talk about private events, but in behavioural ways: at least, that will rob them of their mystical status as causes in cognitive science; and at best, it may show us how to achieve some degree of experimental control over them (Baer, 1997: ix).

While radical behaviourism is distinct from methodological behaviourism which dispensed altogether with private events, it is also distinct from a range of orientations within the behavioural sciences which focus primarily on private events in the search for the causes of behaviour (e.g. Rogers, 1975). The application of science to human behaviour stands in direct contrast to these orientations, involving as it does description, prediction and ultimately, control:

> Prevailing philosophies of human nature recognise an internal "will" which has the power of interfering with causal relationships and which makes prediction and control impossible. To suggest that we abandon this view is to threaten many cherished beliefs- to undermine what appears to be a stimulating and productive conception of human nature. (Skinner, 1953: 7)

Prediction and control of human behaviour involve determinism, which is a fundamental characteristic of science. When science is applied to human affairs it runs counter to long-standing cultural traditions which explain human behaviour in terms of free will, choice and individual responsibility (Baum, 1994).

From the perspective of radical behaviourism, the explanation of behaviour in terms of inner causes constitutes *mentalism* (Baum, 1994). Mentalism involves the explanation of behaviour by reference to inner states and feelings such as, for example, interpretations, perceptions, attitudes, thoughts, beliefs, wants and desires (Taylor and O'Reilly, 1997). From a mentalistic perespective, behaviour is not a focus of primary interest, but is indicative of an hypothesised inner entity:

> Unable to understand how or why the person we see behaves as he does, we attribute his behaviour to a person we cannot see, whose behaviour we cannot explain either but about whom we are not inclined to ask questions. (Skinner, 1971: 19)

Baum (1994) identifies two characteristics of mental fictions which limit their usefulness in providing explanations of behaviour:

1. *Mental fictions obstruct enquiry*. When behaviour is attributed to an hypothesised inner entity (e.g. "Paul's aggressive behaviour and other symptoms indicate that he is conduct disordered"), further enquiry is deflected because it is not possible to study the entity:

   > Mentalistic explanations allay curiosity and bring inquiry to a stop. It is so easy to observe feelings and states of mind at a time and in a place which makes them seem like causes that we are not inclined to inquire further (Skinner, 1974: 15-16).

2. *Mental fictions lead to circular reasoning*. The use of mental fictions to explain behaviour involves inferring a fictional entity from behaviour and then using the inferred entity as the explanation; e.g. a statement such as "Paul's aggressive behaviour and other symptoms indicate that he conduct disordered", usually leads to a statement such as "Conduct disorder in Paul causes him to be aggressive": the behaviour is considered to be evidence of an hypothesised inner entity which in turn is offered as an explanation of behaviour.

From the pragmatic perspective of applied behaviour analysis, both mentalism and realism are restrictive because they inhibit inquiry (Cooper, et al 1987). In order to pursue the study of behaviour as a primary subject of interest, applied behaviour analysis has developed a "consistent, systematic, comprehensive, natural science of behaviour" (Taylor, et al 1997: 41). Applied behaviour analysis therefore resembles other natural sciences, such as physics, biology and chemistry in its focus on a physical (as opposed to a non-physical or mental) subject matter:

> Natural scientists are consistent in attending only to physical phenomena- events that are known or at least strongly suspected to exist. Furthermore, they attempt to explain physical phenomena only in terms of other physical phenomena (Johnston, et al 1993: 4).

Social work and scientific practice

While there are different views as to whether applied behaviour analysis is a sub-category of behaviour modification or whether behaviour modification is an outmoded form of behavioural practice, both are fundamentally scientific activities; they involve the selection of intervention methods based on what research suggests is effective, and the ongoing evaluation of progress (Gambrill, 1995). A concern with evaluation is a central distinction between scientific and non-scientific activity:

> Measurement is the cornerstone of all scientific activity. The history of science is coextensive with the history of measurement of natural phenomena because without measurement, science is indistinguishable from natural philosophy (Johnston, et al 1993: 21).

Much of the controversy which has greeted the introduction of behavioural methods to social work practice relates to the essentially scientific character of these activities. The position of social work in relation to applied behaviour analysis can therefore be viewed within the broader context of the difficult introduction and accommodation of behaviour therapy (including behaviour modification) within social work, because many of the objections which apply to behaviour therapy relate to the scientific status which it shares with applied behaviour analysis.

Behaviour therapy was first introduced to social work practice in the United States in the early 1960's within the context of doctoral programmes in the schools of social work at the University of Michigan and Columbia University (Reid, 1994). It was strongly identified with the newly emerging *empirical practice movement* (EPM). EPM promoted social work practice methods which were compatible with three activities; firstly, the use of research methods in order to facilitate assessment, planning, and the evaluation of social work intervention; secondly, the use of interventions whose effectiveness has been established by research evidence; and thirdly, the building of knowledge through the dissemination of practice-based research (Reid, 1994). While EPM loudly proclaimed its scientific identity, this was by no means the first occasion when a scientific basis to social work practice had been proposed (Reid, 1994). Richmond (1917), for example, proposed that social work practice should be based on *social diagnosis*. Social diagnosis involved gathering facts to serve as the basis of an hypothesis which is then tested by obtaining relevant evidence. Similarly Hollis (1963) emphasised that psychoanalytic casework was a scientific activity in which factually-based inferences lead to diagnosis, and in which the individual is viewed within a framework which is based on knowledge. Finally, Reid (1977) introduced a model of task-centred casework which included the following elements; planned brevity, a clearly defined focus, and the use of contracts, within a clearly defined treatment structure or organisation. These early figures contributed to a tradition of social work practice which was rational and systematic. This earlier tradition of social work practice was therefore broadly compatible with some aspects of EPM; practice decisions were based on empirical evidence, environmental as well as individual factors were a focus of interest, intervention methods were tailored to individual client needs, and a constructive approach was adopted by utilising individual and environmental assets (Gambrill, 1995). Never-the-less, while the empirical nature of EPM has led to it being closely identified with behaviour therapy, it encompasses a broad range of practice methods in an eclectic fashion:

> The empirical practice movement became a distinct approach to practice, one that absorbed the measurement technology of behaviour modification without adopting all of its technology for effecting change. (Reid, 1994: 169)

The introduction of behaviour modification to social work practice derived its imperative from two important areas of controversy (Payne, 1997). Firstly, behaviourism emerged as a credible alternative to psychodynamic theory, on which much social work practice was based. From the perspective of EPM, traditional social work practice was characterised as "vague, unvalidated and haphazardly-derived" (Fischer, 1993: 19). From the perspective of the behavioural practitioner, it was "lacking clarity and purpose, possessing a vagueness of method and showing a wishy-washiness that is altogether indefensible " (Howe, 1987: 82). Furthermore, social work practice resembled a client beset by "lack of stable identity...chronic self doubt...depression punctuated by bouts of mania and self-destructiveness (Sheldon, 1995: 2). Secondly, empirical studies of social work effectiveness indicated that it was simply not effective. For example, Fischer reviewed 17 controlled studies of the effectiveness of social work practice and found that it compared unfavourably with the effectiveness of psychotherapy and counselling, corrective intervention by the criminal justice system, psychiatric hospitalisation and education- none of which emerged as convincingly effective either:

> In none of these studies was there clear evidence that professional social work services produced results superior to no treatment at all, or in any way better than the minimal services provided by non-professional workers to a contact group of clients (1978: 218).

While later reviews of studies on the effectiveness of social work practice have suggested that it is not as ineffective as Fischer (1978) concluded, they also suggest that if there are grounds for optimism about the effectiveness of social work intervention, they rest squarely on the shoulders of behavioural methods. For example, Reid and Hanrahan (1981) found that, among 18 studies of direct social work intervention which used rigorous experimental designs, and which demonstrated that social work intervention was effective, the majority involved behavioural methods, although other influences, such as task-centred and client-centred approaches were also evident. A later review, which used similar criteria to Reid, et al (1981) found further evidence of the effectiveness of social work intervention, although it acknowledged the relative scarcity of studies which were based on sound methodology:

> ...we need much more methodologically credible experimental research evaluating the effectiveness of direct practice (Rubin, 1985: 475).

Similarly, a review of 95 experimental, quasi-experimental, pre-experimental and client-opinion studies of the effectiveness of social work practice found that almost 75% showed positive results (Macdonald, Sheldon, and Gillespie, 1992) and that behavioural and cognitive-behavioural methods were most strongly correlated with positive outcomes.

It is not surprising that the implicit and explicit criticism of non-scientific social work practice which has attended the introduction of behavioural methods has provoked a generally hostile response within the discipline. Social work's resistance to scientific method in general and to behaviour therapy modification in particular has been expressed in both political and philosophical terms.

Political objections

Feminism has provided one source of political objections to the application of scientific methods to social work practice and research. For example, Davis (1985) identifies a rift between clinical social work practice which is identified as predominantly female, and academic and research activity which is identified as male. The rift is predicated upon the dichotomy between the female experience or *voice* which is characterised by connectedness with others, and the male experience or voice which is characterised by separateness from others. From this perspective EPM, which emphasises evaluation rather than engagement and which is advocated primarily by male academics, involves the "suppression of the female voice" (Davis, 1985: 111) among social work practitioners who are predominantly female, and whose work emphasises engagement with the client. Similarly, Trinder characterises EPM as a myopic search for certainty which ignores wider political issues regarding the allocation of resources within society;

> In an insecure world, with a hostile media and unruly clients, there is an attraction in a practice and research methodology based on control, measurement and certainty...The gaze of the researcher and practitioner becomes ever narrower as the search for certainty and control heightens (1996: 253).

Lorenz (1994), in a review of the historical and conceptual origins of social work in different European countries, also highlights the inherent dangers of scientific practices which ignore wider political issues. Lorenz (1994) describes how, in the 1930's, professional training had endowed social work in Germany with a degree of autonomy from religious and ideological missions as well as from state welfare. International links had been forged which should have enabled the discipline to rise above local perspectives and to identify universal concerns. Social work, in common with other disciplines, was characterised by a reliance on objective, scientific methods. Progressive, innovative methods of intervention were devised in the areas of residential care and learning disability, but the implementation of progressive methods of intervention was hampered by the limited resources of the Weimar Republic. Lorenz acknowledges that it is difficult to establish the extent of social work's complicity with the National Socialist regime, but suggests that the application of objective criteria for the inclusion and exclusion of people from programmes (even though these programmes were innovative and highly impressive on their own terms) was compatible with

> "the logic of a state which claimed an absolute, unrestrained power to grant or deny human rights at will, a logic towards which all activities of that state, carried out by myriads of officials and volunteers, were potentially directed" (1994: 63).

Lorenz concludes that, with the benefit of an historical perspective, it is possible to view social work's inability to devise a unitary model for practice as a potential advantage to the discipline:

> A model of practice that is assumed to apply universally is likely to be oppressive in the sense that it claims to derive its criteria from a level "above" the traditions of practice, personal preferences and cultural norms which prevail in specific local contexts (1994: 181).

Philosophical objections

The philosophical objections to the application of scientific methods to social work practice and research were raised within the context of an epistemological debate which took place within the discipline within the 1980's, and which was conducted in terms of *logical positivism* (or *logical empiricism*) versus other philosophies (Fischer, 1993). Slife *et al.* contrast logical positivism with realism in terms which indicate its compatibility with the pragmatic outlook which informs radical behaviourism:

> Positivism is...a more moderate position. Its proponents do not hold that scientists study things the way they really are. Rather, the purpose of science is to help scientists formulate a coherent view, or model of the world. From this position, scientists gain confidence about certain regularities on the basis of experiments, then they formulate laws and constructs that they use to explain those regularities (1995: 176).

Positivism therefore contends that the world has a reality which is measurable and independent of the views which individuals hold about it (Barber, 1996).

Prominent among the views which oppose logical positivism is that of *social constructionism.* Social constructionism provides an analysis of the social and cultural context within which theoretical knowledge (including scientific knowledge) is developed, and is based on four main assumptions; firstly, that knowledge which is derived from scientific method is not necessarily endowed with greater authority by virtue of having been sanitised of subjective experience; secondly, that knowledge of the world (including scientific knowledge) is developed in a social context which is culturally and historically determined; thirdly, that scientific knowledge has attained dominance through social factors rather than through evaluation of evidence; and fourthly, that the dominant position of scientific explanation has social and political implications (Witkin and Gottschalk, 1988; Slife, et al 1995; Barber, 1996). Social constructionism belongs to a broader philosophical perspective termed *postmodernism,* which began to influence social work in the 1990's (Payne, 1997). Postmodernism opposes itself to *modernism,* which constitutes the dominant tradition in Western philosophy since the 17th century, and which concerns itself with the metaphysical, absolute laws which determine how the world functions (Slife, et al 1995). Postmodernism therefore contends that there are no laws or principles which can be invoked to explain human behaviour, such as the unconscious mind of psychodynamic theory, the principles of learning of behaviourism, or the structures and processes of cognitive theory:

> Indeed postmodernists tend to be suspicious of structures and abstractions of any sort that can be invoked as explanation. (Slife, et al 1995: 54)

Fischer (1993) notes that, while there is some variation in the specific philosophical standpoints of those who oppose logical positivism as it applies to social work practice and research, they share a number of common priorities; an emphasis on the value of subjective experience and the social context within which research is conducted; a recognition of the biases which are inherent in all methods of data collection; and support of the use of the insights and involvement of researchers, practitioners and clients.

The philosophical debate between proponents and opponents of logical positivism has also been conducted in terms of the relative merits of *quantitative* versus *qualitative* methods in social work research (Barber, 1996; Epstein, 1986). Quantitative (or experimental) designs, such as those which are used in applied behavioural research (for example, O'Reilly and Dillenburger, 1997) test and validate hypotheses about cause-and-effect relationships, whereas qualitative (or exploratory) designs are used to arrive at descriptions of social phenomena either as primary sources of interest, or to assist in generating hypotheses for further investigation (Fischer, 1993). Quantitative studies obtain data by means of surveys, correlational and experimental designs, and standardised observational methods (Fischer, 1993) Quantitative research methods are designed to measure specific aspects of client behaviour (for example, changes in the behaviour of a client or group of clients in response to intervention). In direct contrast to these methods, qualitative studies use participant observation and investigative interviews, in order to understand the meaning of the client's world and actions (Kvale, 1996). Qualitative research methods therefore reflect the influence of postmodernism which contends that an understanding of social behaviour is achieved, not through the measurement, but through active engagement with the participants (Slife, et al 1995).

The debate about the application of scientific methods to the evaluation of social work practice has been distinguished by exchanges which are polarised (for example, Thyer, 1987; Nagel, 1988; Thyer, 1988) and, at times, personalised (for example, Witkin, 1991; Harrison, Hudson, and Thyer, 1992; Witkin, 1992). The polarity of the debate has been characterised by the use of rhetoric rather than discourse:

> The style of the debate is similar to that between politically opposed factions, in which each side does not want to hear the other. (Piele, 1988: 8)

The polarised debate has been characterised as a "divisive and destructive paradigm war" which has split the evaluation community as a whole, and which has been reproduced within social work:

> ...up to the late 1980's and early 1990's, leading proponents of constructivist philosophy and qualitative methods and champions of positivist or post-positivist philosophy and quantitative methods became locked in personal combat that deteriorated to name-calling. All together, nearly three decades have been marked by acrimony between these seemingly irreconcilable methodological persuasions (Worthen, 2000: 6).

A number of solutions to the unproductive polarity of the debate have been proposed. Piele suggests that a solution lies in the development of an all-inclusive *new paradigm research* approach which avoids absolutism, which includes both empirical and non-empirical research methods and in which "neither is seen as better than the other" (1988: 12). Similarly Sells, Smith and Sprenkle (1995) suggest a *multi-method* or an *integrated multi-methodological* approach which includes both qualitative and quantitative methods within individual studies. These solutions, however, appear to resemble "methodological relativism ...in which all propositions and findings are created equal, which in turn implies that all investigators have won, and all must have prizes" (Sheldon, 1998: 4). It seems unlikely that methodological relativism, which is in itself reminiscent of eclecticism, can withstand scrutiny from a scientific perspective which expects that the choice of social work practice methods should be based on evidence, rather than blind affiliation (Sheldon, 1995; Barber, 1996). Worthen therefore concludes that no convincing resolution to the debate is apparent:

> Unless some way is found to re-channel the dialogue about these "opposing" paradigms and methodologies into more productive avenues, the field of evaluation will still be hampered conceptually and operationally as it moves into the next century (2000: 7).

There is little evidence of practice-based social work research in Ireland which is based on quantitative methods, and post-modernism appears to be the dominant philosophical outlook (for example, Powell, 1998). It would regrettable if the introduction of empirical practice-based research were to reactivate the debate which has polarised the evaluation community in general and social work in particular.

CONCLUSION

Recent legislative and organisational changes in Ireland have led to an increased emphasis on accountability and evaluation in the area of child welfare, and have created a context for the expansion of social work practice methods. As evaluation is the cornerstone of science, this article proposes that this is an appropriate time for social work in Ireland to adopt the scientific methods of behaviourism in general and of applied behaviour analysis in particular. It is hoped that the expansion of social work practice through the inclusion of behavioural methods will lead to more effective methods of intervention.

Furthermore it is hoped that this development will lead, not to localised paradigm wars, but to the necessary respect for diversity which emerges when social work is considered in a European context:

> The diversity of social work approaches which, despite all efforts at international harmonisation has not been levelled to one standard norm, might turn out to be one of the professions greatest assets in facing up to the diversity of the newly emerging welfare scenario. (Lorenz, 1994: 181)

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   e.g.: Saleebey, D. (1992), *The Strengths Perspective in Social Work*, New York: Longmans.

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