

*'A child is a joy to all
the world'*

(Unaccompanied Minor Mother)

**The Experience of Unaccompanied Minor
Mothers in Ireland: Supports, Stressors,
Services.**

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*A joint study between
The Social Work Team for Separated Children Seeking Asylum, East Coast Area Health Board;
The Psychology Service for Refugees and Asylum Seekers, Northern Area Health Board,
and
Twenty-three inspiring Unaccompanied Minor Mothers.*

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Definitions of terms

Definition of Unaccompanied Minor

The following definition of unaccompanied minor is used by organisations such as the United Nations High Commissioner for Refugees (UNHCR) and UNICEF: *a person who is under the age of 18 or the legal age of majority, is separated from both parents, and is not with and being cared for by a guardian or other adult who, by law or custom, is responsible for him or her* (Separated Children In Europe Program, 2000). It should be noted that the term unaccompanied minor and separated child are often used interchangeably.

The role of the Health Board

Section 8 (5) of the Refugee Act, 1996 (Amended, 1999) states that where it appears to an immigration official or an authorised officer that a person who has arrived to the State is under the age of 18 years, that child must be referred to the relevant Health Board. The minor will be looked after according to provisions set out in the Child Care Act (1991) and the Health Board will make a decision whether to apply for asylum on the minor's behalf.

Definition of an Asylum Seeker

An asylum seeker is a person who seeks to be recognised as a refugee in accordance with the terms of the 1951 Geneva Convention.

Definition of a Refugee

In Irish law a refugee is defined as: *'a person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his or her nationality and is unable, or owing to such fear is unwilling to avail himself or herself of the protection of that country; or who, not having a nationality and being outside the country of his or her former habitual residence, is unable or, owing to such fear, is unwilling to return to it'* (Refugee Act, 1996).

The asylum process

An initial application for asylum is made with the Office of Refugee Applications Commissioner (ORAC), Department of Justice, Equality and Law Reform. Following this application a substantive interview is held (S.11 interview) with ORAC to determine eligibility for refugee status. If status is not granted at this stage, an applicant may appeal to the Refugee Appeals Tribunal (RAT). If the RAT upholds the decision not to grant refugee status, an application for Temporary Leave to Remain (TLR) can be made to the Minister of Justice.

Glossary

SCSA – Separated Children Seeking Asylum

UM – Unaccompanied Minor

UMM – Unaccompanied Minor Mother

SWSCSA – Social Work Team for Separated Children Seeking Asylum

ECAHB – East Coast Area Health Board

PSRAS – Psychology Service for Refugees and Asylum Seekers

NAHB – Northern Area Health Board

SW – Social Worker

PW – Project Worker

ORAC – Office of the Refugee Applications Commissioner (Department of Justice, Equality and Law Reform)

RAT – Refugee Appeals Tribunal

RIA – Reception and Integration Agency (Department of Justice, Equality and Law Reform)

TLR - Temporary Leave to Remain in Ireland on Humanitarian grounds.

CWO – Community Welfare Officer

VEC – Vocational Education Committee

IBC – Irish Born Child

DP – Direct Provision – policy including full board accommodation provided by RIA

EXECUTIVE SUMMARY

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Above all, practice and service development can be informed as a result of this research if credibility and due respect is afforded to the voices of the young women who participated. This is the ultimate acknowledgement of the value and depth of their experiences that they so generously shared.

EXECUTIVE SUMMARY

Background

The following definition of unaccompanied minor is used by organisations such as the United Nations High Commissioner for Refugees (UNHCR) and UNICEF: *a person who is under the age of 18 or the legal age of majority, is separated from both parents, and is not with and being cared for by a guardian or other adult who, by law or custom, is responsible for him or her* (Separated Children in Europe Program, 2000).

This study explores the context, characteristics and experiences of 23 unaccompanied minor mothers (UMM) during 2003. The aim of the study was to inform both service design and service development for this population. The study was designed as a partnership between the East Coast Area Health Board, Social Work Team for Separated Children Seeking Asylum (SWSCSA, ECAHB); the Psychology Service for Refugees and Asylum Seekers, Northern Area Health Board (PSRAS, NAHB), and the client group. Ethical approval was sought and obtained from both the ECAHB and the NAHB. A number of key agencies and individuals were consulted in the development of aspects of the research.

In 2003 there were a total of 789 referrals of unaccompanied minors (UM) to the social work team with 277 (35%) of these remaining in the care of the ECAHB. In March 2003, at the time of the initiation of the study, there were 146 female UM in care. Of this population there were 25 (17%) who were mothers and approximately a further 30 (20%) were pregnant. A total of 23 (88%) of the unaccompanied minor mothers participated in this study.

In terms of specific service provision within the Health Board, a dedicated social work team based in ECAHB provides the service for separated children on behalf of the three health boards in the Eastern Region. Referrals are received from immigration officials at points of entry, and from the Office of the Refugee Applications Commissioner (ORAC).

The ECAHB is responsible for the total care needs of these children, including appropriate care placements (hostel, residential or family), social needs, referral to medical and psychology services when necessary, liaison with educational and youth services as well as the tracing of their immediate or extended families, family assessment and reunification where it is safe and possible to do so.

A psychology service is provided by a full time senior clinical psychologist based in the Psychology Service for Refugee and Asylum Seekers, NAHB. A medical screening service in the ECAHB, provided by an Area Medical Officer, provides screening for all minors under the age of 16 and those older wishing to avail of it.

The ECAHB is also responsible for the decision to make application for asylum, if this is considered to be in the child's best interests, and to support the child through the asylum process.

These responsibilities, and the standards for the provision of these services, are outlined in the Child Care Act (1991), the Refugee Act (1996), the UN Convention on the Rights of the Child (1989) and the Statement of Good Practice (Separated Children in Europe Programme, 2000).

The impetus for this study stemmed from the significant increase in the numbers of unaccompanied minor mothers in the unaccompanied minor social work service, and consideration of their particular needs and concerns. There is sufficient evidence within the broader research literature of the U.S and the U.K. and clinical practice in industrialised countries to suggest that teenage parenthood can be associated with an increased level of health, social, cognitive and behavioural problems for both mothers and children (Maughan & Lindelow, 1997; Nagin, Pogarasky, & Farrington, 1997). A review of the literature indicated that there is a paucity of information or research regarding asylum seeking teenage mothers who are parenting outside their country of origin. This research has in part begun to address this gap. The results of this study together with evidence from the literature have informed the recommendations made.

Policy context

Since the completion of data collection in 2003 a number of changes of direct relevance to this population have occurred within the legislative and policy context. These include a Supreme Court ruling handed down on the 23rd January 2003 which stated that parents of an Irish Born Child (IBC) do not automatically have the right to reside in the State. (Prior to this decision a number of asylum applications of UM had been withdrawn and instead an application made for residency in Ireland following the birth of their Irish Born Child). Other changes relate to social welfare entitlements for asylum seekers since 1st May 2004, specifically: not being eligible to apply for child benefit allowance; the end of entitlement to rent assistance for asylum seekers, and the moving of UMs, including young mothers, at age 18, to Direct Provision (DP) accommodation provided by the Reception Integration Agency (RIA).

Conceptual framework

The conceptual frameworks that were considered most appropriate for this study are the Socio Ecological perspective (Bronfenbrenner, 1979) in conjunction with the Life Model (Germain & Gitterman, 1980). The foundation of Bronfenbrenner's (1979) socio ecological perspective is that the individual and the environment are interrelated and affect each other on many levels. Bronfenbrenner proposes that there are four levels of influence on the individual – the micro (individual), meso (proximal/social context), macro (cultural and socioeconomic)

and the exo (external contexts with indirect effects). Each level is simultaneously affected by and affects the other levels. For this study three of the four levels were considered i.e the micro, meso & macro.

Within the Life Model, Germain & Gitterman (1980) present the three main areas from which stress can arise and cause difficulties for the individual and the environment in which they are functioning- (1) life transitions; (2) environmental pressures and (3) interpersonal processes.

Definition of key constructs

Ardenne and Mahtani (1999:3) in their definition of **culture** state that ‘culture means the shared history, practices, beliefs and values of a racial, regional or religious group of people’. This is the definition that informs this study.

A further informing construct is that of **acculturation**. Berry (1995) defines acculturation as ‘the psychological adaptations that individuals make when they move between cultures’ (in Goldberger and Veroff, 1995: 457).

Support can be defined as that which acts to ameliorate the negative effects of stressors. It is useful to categorise supports into (1) information support, (2) emotional support, (3) advice and guidance (Schaefer, Coyne & Lazarus, 1981, in Rea, 2000).

Stressor can be defined as any external or internal factor that interferes with an individual’s normal adaptive processes and which thus places pressure on him/her maintaining psychological equilibrium in relation to the environment (Pearlin, 1993)

Literature review

The available research literature in relation to teenage pregnancy is predominantly from the US and the UK, so some caution needs to be exercised in direct extrapolation from these results to the population of unaccompanied minor mothers seeking asylum, which by definition represents a wide variety of cultural backgrounds. However at present this literature provides the only available reference point, and therefore can usefully serve to orient this review.

In the interests of focus, the selective review of the literature was limited to the topics pertinent to the study – (1) culture, (2) support and (3) stressors, together with consideration of some background information on the current extent of this issue and a number of observations in relation to the pathways and consequences of teenage pregnancy.

People are not just a story - they are people... they are very good at doing something... but because of the kind of life we've had we just feel lost... like the government does not allow us to do what we want to do...but I don't want to remain like that...I want to do my jobs ...I just want encouragement...this is what you do...and go for school or go for further training...(UMM)

Research design

An integrated or mixed-method design was used to examine the experiences of unaccompanied minor mothers and included both qualitative and quantitative methods. Qualitative data included text answers from the Unaccompanied Minor Mother's Questionnaire (UMMQ, Robins and Rylands, 2003) and material from a focus group with six young mothers who self-selected from the total sample of twenty-three.

Quantitative data was derived from the following measures: (1) The Parenting Stress Index - Short Form (PSI-SF, Abidin, 1983); (2) The General Health Questionnaire – 12 (GHQ-12, Goldberg and Williams, 1988); (3) The Harvard Trauma Scale (HTQ, Mollica, 1992); and (4) The Unaccompanied Minor Mother's Questionnaire (UMMQ, Robins & Rylands 2003).

Figure 1 presents the conceptual and analytical process that was undertaken in order to explore the research question.

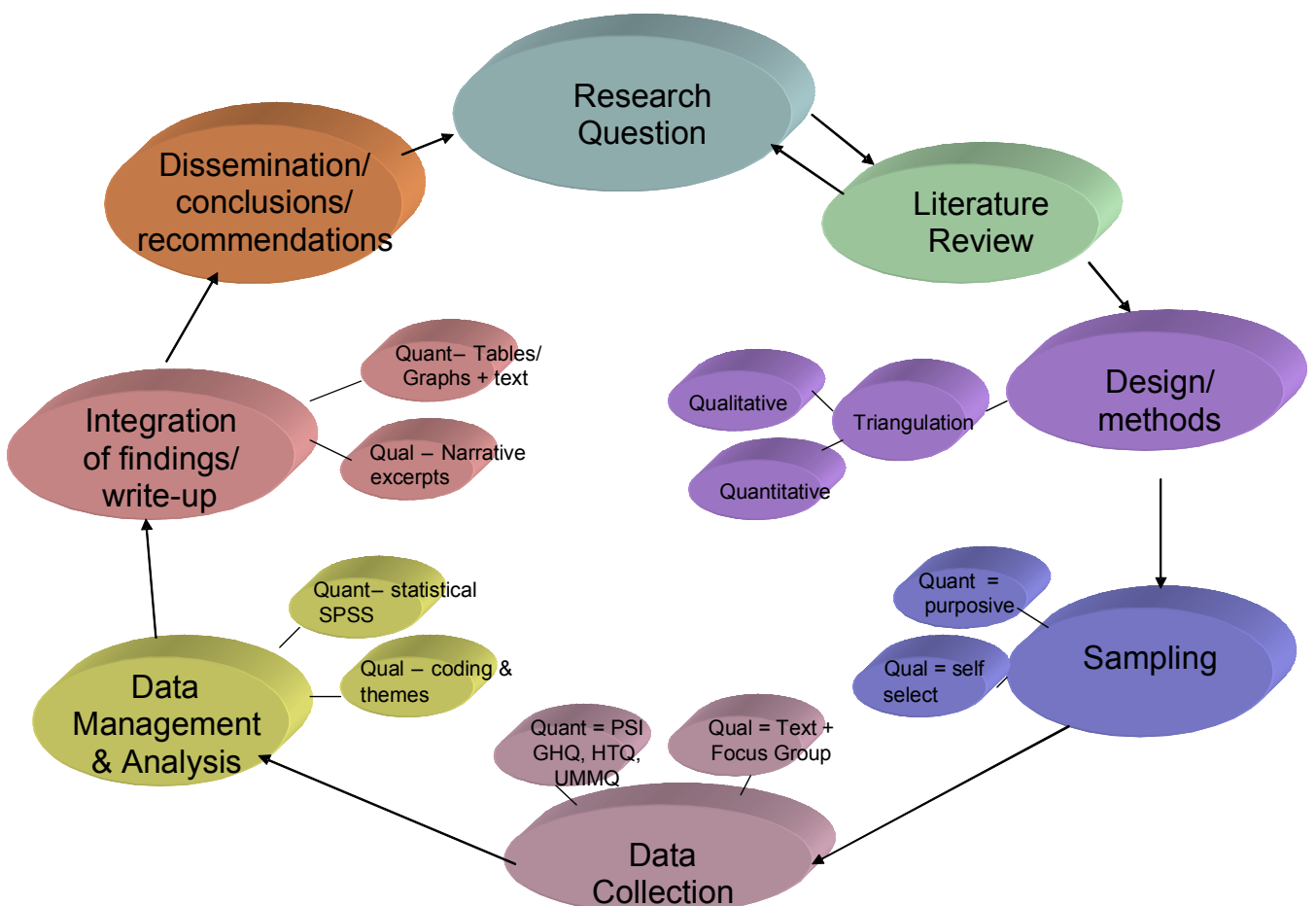


Figure 1 - Research Design

Data Analysis

The following figure presents the conceptual process underlying data management and analysis (Figure 2). Culture was examined as a primary category which permeated all levels. Following Bronfenbrenner's model outlined in the conceptual framework for this study, the results were analysed and discussed within three of the four systemic levels – the macro, the meso and the micro (Corcoran, Franklin, & Bennett P., 2000).

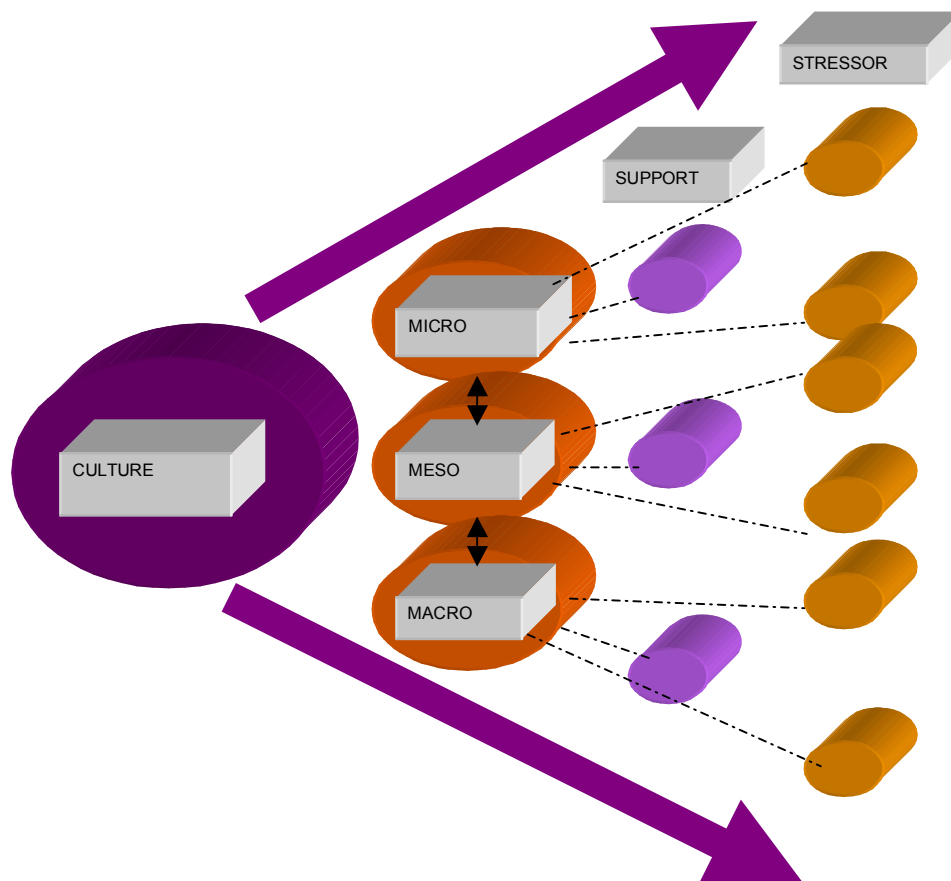


Figure 2 - Conceptual Map

Demographic information

The following table provides a summary of the demographic characteristics of the participants in the study in order to provide a contextual picture for the reader.

DEMOGRAPHIC INFORMATION			
1. Age	Min = 16 yrs	Max = 20 yrs* [two over 18]	Average = 17.5 yrs
2. Country of Origin	Africa = 21	Eastern Europe = 2	Total = 23
3. Gender of child	Male = 12 (52.2%)	Female = 11 (47.8%)	Total = 23
4. Age of child	Min = 3 months	Max = 60 months	Average = 12.5 months
5. Number of children	One child = 22	Two children = 1 (only one child in Ireland)	Total = 24
6. Country of birth of child	Ireland = 20 (87.0%)	Nigeria = 2 (8.7%) Lesotho = 1(4.3%)	Total = 23
7. Accommodation	Hostel = 13	Private rented, alone = 10	Private rented, with partner = 5
8. Income (child benefit universal)	Supplementary Welfare Allowance = 17	Unemployment Assistance = 5	Full-time work = 1
9. First language	English = 3	Other = 19 (missing data = 1)	Number of other languages = 16
10. Spoken English	Yes = 23	No = 0	Level = varies
11. Literacy	Read & write in English = 14	Read & write in own language = 12	Level = adequate – well
12. Completed Second Level School exams	Yes = 6 (26.1%)	No = 17 (73.9%)	Total = 23
13. Currently in any Education	No = 16 (69.6%)	Yes = 7 (30.4%)	Total = 23
14. Work	No = 20 (87.0%)	Voluntary = 2 (8.7%)	Full –time work =1 (4.3%)
15. Legal Status	Refugee Status = 6	Awaiting decision = 17, as in box to the right:	(Includes S.11 interviews; Appeal hearings; TLR applications; IBC applications.)

* Indicates two mothers over the age of 18 years who due to a high level of vulnerability remained clients of the service.

Table 1- Demographic Information

Summary of Results

Culture

The information in relation to culture was drawn primarily from the results of the focus group.

Attitudes in country of origin were noted in relation to pregnancy; to “single mums”, and to abortion.

The high level of support given to the new mother in the first three months was described, as were a number of traditional practices with both the mother and baby following the birth.

Issues relating to childrearing and discipline were also discussed and the differences between Ireland and country of origin were noted in relation to discipline, practices, the level of support available and also religion.

Belief systems in relation to health, in particular causal attribution of illness and ill health were also discussed.

It is the best period of the woman...like she has the mum...all she has to do is feed the baby and then give the baby back to the mum...you know and goes to rest...the mum is there to make the dinner and take care of other work and then wash the baby ...and even give her a bath, and give her a massage, (the mother)(UMM).

Micro Level

The micro level as defined by Bronfenbrenner (1979) includes the roles and characteristics of the individual. This section of the results described some of the psychological characteristics of the participants together with their narrated experiences of their parenting role and health issues. Particular attention was drawn to what they articulated or presented as either stressor or support.

The issue of gender specific trauma was also reported in relation to the results of the HTQ-a.

The results were drawn from the following instruments:

- Parenting Stress Index – Short Form (PSI-SF) (Abidin,1983)
- General Health Questionnaire –12 (GHQ-12) (Goldberg & Williams, 1988)
- Harvard Trauma Questionnaire (adapted) (HTQ - a) (Mollica,1992)

together with Focus Group transcripts (FG) and Unaccompanied Minor Mothers Questionnaire (UMMQ) (Robins & Rylands, 2003)

And then it was really really miserable, and then I missed home very very much and I missed my mum. That was a particular time in my life that I know that I needed my mum - more than anything in my life (UMM)

Meso Level

In line with the ‘conceptual map’ (Figure 2) this section presents the data from the study pertaining to the Meso level, focusing on the supportive and stressful functions of each area. To begin this presentation, the construct of ‘support’ is operationalised. This has been done in two ways. The first way is through an analysis of the results in the UMMQ where the young mothers identified the presence or absence of support in four key areas: practical support; support in care for the baby; emotional support; childcare, and also noted the source of these supports (e.g. friend, professional etc). The second part of the data presented is drawn from the young mothers' narrative from the focus group in terms of their experiences regarding support and stressors. In this instance ‘support’ includes: friends; professionals; a number of specific services; income, when considered sufficient; and ‘stressor’ includes: isolation; insufficient income; some unhelpful professionals; difficulties in getting information on and access to relevant services; unsuitable accommodation and lack of access to both education and childcare. This section concludes with what the young mothers considered to be the most important areas of support that they needed in caring for their baby.

I know that's stress...not knowing that maybe tomorrow they might just come, 'ok take your bag and carry your child and go'...

Macro Level:

The macro level of analysis examines factors in the environment that are common to the group living in it, and involves the physical, social, economic and political structures of the larger society that the individuals live in. The results of this study highlighted a number of laws, regulations and government policy that was perceived by the respondents for the most part as significant stressors. It is without debate that being an asylum seeker can be viewed as a ‘stressful’ experience. Key causal factors of stress as highlighted in this research include: level of income (social welfare payments); Direct Provision policy; not being entitled to work (post 2000); impact of Irish Born Child decision; lack of access to childcare, education and training. It was inferred that ‘support’ on this level included attaining Refugee Status and the economic, social and educational entitlements associated with this status. A further, albeit limited level of macro support was the fact that all unaccompanied minors under the age of 18 years remain in the care of the Health Board and legally are afforded the care and protection of the state as children first, and asylum seekers second. The laws of the state entitle unaccompanied minors to secondary education and to be treated as a minor in the asylum process, thus enabling them to have legal advice and the support of a worker from the Health Board to be present at all interviews through the asylum process. The absence of such support once the minor attains the age of 18 years and is moved into the adult Direct Provision system is viewed as a significant stressor for the participants in this research.

Its not that people are being lazy or don't want to do something. I want to be provided for some training for a job - I want to pay tax (UMM)

Supports and stressors

Figure 3 provides a summary of the results in relation to the supports and stressors experienced by the young mothers. The main **supports** are as follows: religion and place of worship; government financial support and accommodation; professional support; peer group, friends and other mothers; health and social services; partner; relationship with their baby. The main **stressors** are as follows: acculturation; lack of access to childcare; lack of support in the first three months post birth; lack of access to education; historic trauma; legal status/asylum process; prospect of move to Direct Provision accommodation; isolation; professional individuals and services; illness of mother or child; absence of family; barriers to participation which results in social exclusion; lack of access to culture of origin; lack of access to information about relevant services, entitlements, local bureaucracy.

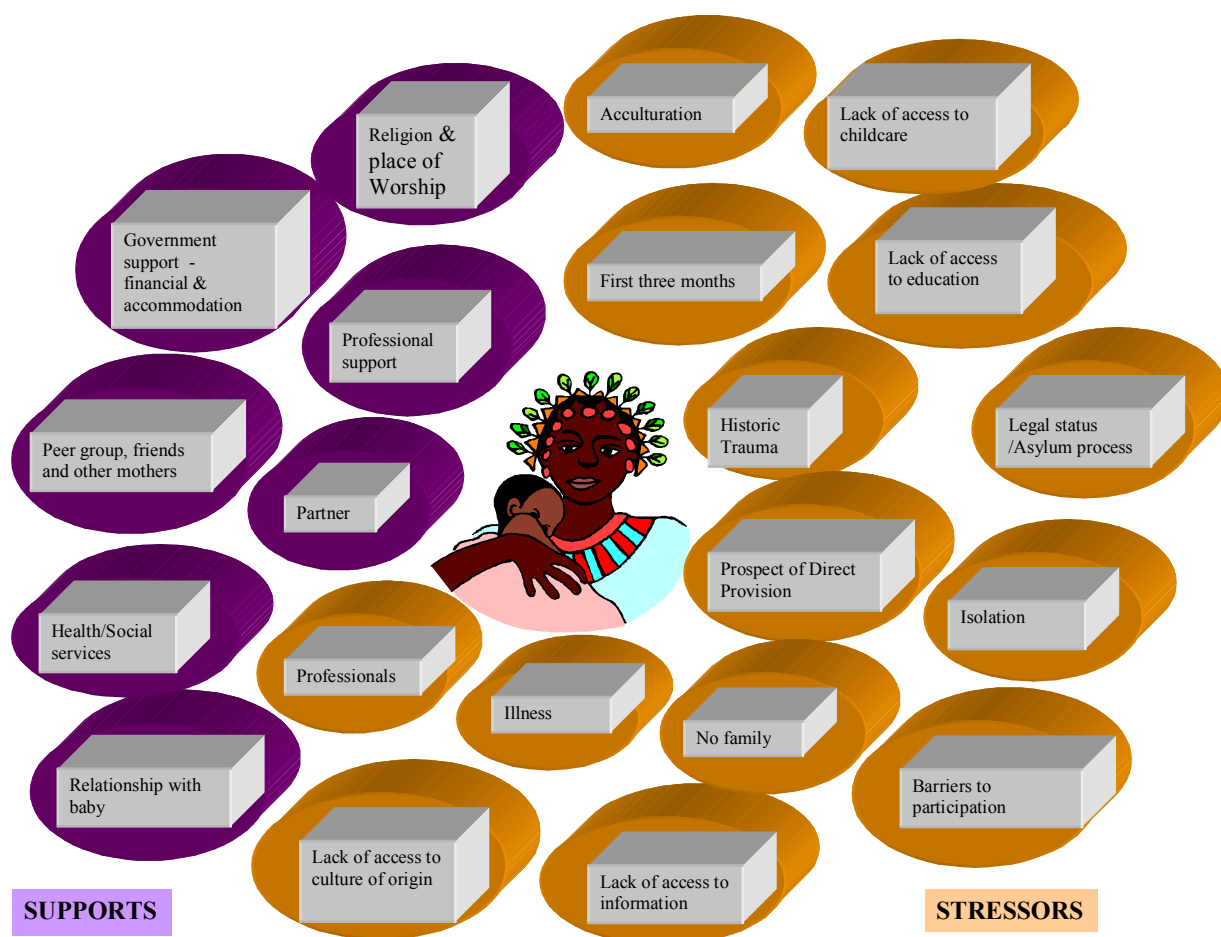


Figure 3 - Summary of Results

Discussion

The initial analysis of the results provides a wealth of information concerning the culture, the context and the experiences of this group of unaccompanied mothers. This information viewed through the lenses of stressors and supports facilitates a more focussed analysis on the areas and issues that need to be addressed – in terms of stressors that need to be minimised and supports that need to be maximised. The extent and range of sources of stress in particular, requires considerable unravelling. By ‘superimposing’ the ecological framework of micro, meso and macro levels (Bronfenbrenner, 1979) for further analysis, direction is provided in relation to where (or at what level) the stressor or support is located and therefore at what level intervention or attention is required.

The findings of this study underline the centrality of the role of culture including the process of adaptation and acculturation for the young mother. The wide range of stressors experienced by the young mothers in comparison to the paucity of support is demonstrated in Figure 3.

Absence of family and insecure legal status together with the associated limitations emerged as clearly the most significant stressors. The first three months of parenting represented a particularly stressful time within which absence of family and access to cultural practices was keenly felt. Social isolation was a marked feature of their daily life in Ireland. The experience of historic trauma was a significant characteristic of each mother’s profile. However despite this historic experience and the contemporary stressors experienced, the psychological profile of the young mothers demonstrated considerable resilience. Furthermore, despite the challenges associated with parenting as a young mother in another culture, the overwhelming positive nature of the parent child relationship was evident.

Further, what emerged very clearly from the voices of the young mothers was their desire to participate in education and employment thus ultimately play an active role in Irish society. The lack of access to any childcare provision cannot be underestimated as a barrier to participation in education, training and employment. A considerable future stressor for those young mothers still within the asylum process was the pending move to adult Direct Provision accommodation at the age of 18yrs. Of particular concern is the risk of exploitation of this vulnerable group of young women in light of this policy and practice, the consequence of which for most is a significant reduction in income and the end of support from the ECAHB, SWSCSA team.

An uplifting note as part of the conclusion in this research is that despite the simultaneous challenges and multiple demands faced by these young mothers, the resourcefulness and capacity of the young women is evident in their words. Their commitment to achieve, their high hopes for the future of their children, their desire to contribute and to achieve their life-goals is evident in their voices. The challenge to all involved in policy or service provision to these young mothers is to make the necessary changes and adaptations to support their intrinsic capacities to achieve their goals and dreams.

Recommendations

The following recommendations have been derived from the analysis of the results of this study. In order to ensure that the needs of this population are addressed in a comprehensive manner, it is essential that a multi-agency approach is undertaken to address these needs. It is envisioned that interagency interest groups and working parties be developed to pool knowledge, practice wisdom and resources at all levels in relation to services and policy regarding unaccompanied minor mothers.

Above all, practice and service development can be informed as a result of this research if credibility and due respect is afforded to the voices of the young women who participated. This is the ultimate acknowledgement of the value and depth of their experiences that they so generously shared.

No.	WHAT?	LEVEL	RECOMMENDATION	HOW?
1	PARTICIPATION	Meso	Support for active participation in decision – making , including within interagency working parties	Involve UMM as members of groups and forums where decision making takes place
2.	CULTURE	Meso	Facilitate contact with own ethnic group (cautionary note – some may not be positive about this...)	Link with ethnic groups/ individuals/ organisations in the community
3.		Meso	Facilitate access to support for (legal) cultural practices eg. bathing	Identify and link with appropriate individuals & groups
4.		Macro	Enhance cultural competency skills for staff within services	Training and development of skills
5.		Macro	Develop good practice guidelines in relation to the provision of a culturally sensitive service	Development of guidelines in each service to be informed by ethnic minority representatives
6.		Macro	Actively promote cultural diversity within staffing/volunteers of agencies and groups	Encourage application/involvement from diverse cultural backgrounds
7.	EDUCATION	Meso	Identify educational needs, including literacy level and any possible learning difficulties	Ensure individual educational needs profile for all UMM
8.		Meso	Facilitate appropriate education and/or training, directed toward economic self-sufficiency – (whether in Ireland or in county of origin)	Identify and develop appropriate education and training opportunities

9.		Meso	Provide career guidance for those who are entitled to work having been granted Refugee Status	Provide appropriate career guidance
10.	CHILDCARE	Macro	Facilitate access to childcare	Access to childcare for all mothers
11.		Macro	Consideration of support in education until age 21 (in line with the Child Care Act) for those who have obtained Refugee Status, whilst in the care of the Board	Provide financial or other support in an 'after care' framework for those leaving care, who wish to continue their education
12	SUPPORT	Meso	Facilitate access to more experienced mothers – either Irish or from C.O.O - particularly in the first three months	Through using existing programmes such as Community Mothers Programme; Teenage Parent Support Initiative; Homestart; ECAHB Befriending Project etc.
13.		Meso	Development of culturally appropriate parenting courses	Appropriate adaptation of existing courses to be informed by relevant ethnic minority representation
14.		Meso	Encourage the development of peer support networks	Establish peer support groups
15.		Meso	Facilitate access to place of worship	Provide information and facilitate as appropriate
16.		Macro	Development of an easily accessible (visual) information pack regarding services, legal rights and financial entitlements for UMMs	Adaptation of current information and resources to include needs of UMMs
17.		Macro	Support and information in transition to adult services and Direct Provision accommodation once over the age of 18 years	Establish post/s to co-ordinate the transition process
18.	HEALTH	Macro	Access to appropriate services to address historic trauma, where necessary	Identify and liaise with appropriate services for e.g. Psychology service (PSRAS)

19.		Macro	Development of health education program to include sexual and reproductive health	Ensure all UMs have access to appropriate health education program
20.	STRUCTURAL	Macro	Ensure an allocated social worker for each UMM	Increase funding to create additional posts in the social work service
21		Macro	Establish a policy forum for key interagency players in service development & delivery to UMMs	Establish forum with key players, to be hosted by the ECAHB
22.		Macro	Develop interagency policies and guidelines in relation to UMMs	Develop policy document
23.		Macro	Establish a specialist practice sub-group within the ECAHB SWSCSA, to act as resource within team and wider interagency context	Establish sub group to include Team Leader, Project Worker, Social Worker, Clinical Psychologist

Table 2 - Recommendations

And finally, some words of encouragement to her peers – whilst acknowledging the difficulties - from one of the unaccompanied minor mothers to who participated in the focus group:

So what I'm going to say is just keep going... keep going... never say no, never give up...you just keep going, always think positive...do of your best... give all your energy to anything...commit yourself in anything and you will see...you will be the winner... that's all I can tell you... that's all... because its really tough to be a mother in a foreign country. (UMM)

CHAPTER 1

INTRODUCTION

The needs of this population present a number of challenges to existing services in terms of the necessary adaptations required to provide culturally competent services.

INTRODUCTION

1. 1 Introduction

This study describes the context, the characteristics and the circumstances of unaccompanied minor mothers (UMM) in Dublin, Ireland. The results of the study and relevant literature inform a number of recommendations in relation to this population.

The following definition of unaccompanied minor (UM) is used by organisations such as the United Nations High Commissioner for Refugees (UNHCR) and UNICEF: *a person who is under the age of 18 or the legal age of majority, is separated from both parents, and is not with and being cared for by a guardian or other adult who, by law or custom, is responsible for him or her.*

From January 2000 to October 2004, a total of 3632 Unaccompanied Minors have been referred to the Social Work Team for Separated Children Seeking Asylum in the East Coast Area Health Board (SWSCSA, ECAHB). In 2003 there were a total of 789 referrals of UM to the SWSCSA, of whom 277 (35%) remained in the care of the Health Board. 439 (56%) were reunited with family members in Ireland. From January to October 2004, out of 375 referrals approximately 35% of UM remained in the care of the ECAHB with the remaining 65% being reunited. For gender, age and country of origin information in 2003 and 2004 see Appendices XI, XII.

In terms of specific service provision within the Health Board, a dedicated social work team based in ECAHB provides a service for unaccompanied minors on behalf of the three health boards in the Eastern Region. This service is for children under the age of 18 years who are identified as being unaccompanied by their parents/guardians or customary caregivers when they arrive to seek asylum. Referrals are received from immigration officials at points of entry into Ireland, and from the Office of the Refugee Applications Commissioner (ORAC), Dept of Justice Equality and Law Reform.

The ECAHB is responsible for the total care needs of these children, involving immediate and ongoing social care placements, referral to medical and psychological services as appropriate, liaison with educational and youth services as well as family tracing, assessment and reunification where it is safe and possible to do so.

The psychology service is provided by a full time Senior Clinical Psychologist based in the Psychology Service for Refugee and Asylum Seekers, Northern Area Health Board (PSRAS, NAHB). The medical screening service is provided for all minors under the age of 16 and those aged 16 to 18 who choose to avail of it, by an Area Medical Officer on a halftime basis (ECAHB).

The ECAHB is also responsible for the decision to make application for asylum if this is considered to be in the child's best interests, and to support the child through the asylum process.

These responsibilities, and the standards for the provision of these services, are laid down in the Child Care Act (1991), the Refugee Act (1996), the UN Convention on the Rights of the Child (1989) and the Statement of Good Practice, Separated Children in Europe Programme (2000).

1.2 Scope of the issue

At the time that the study was initiated (March, 2003) there were 25 unaccompanied minor mothers, who were within the care of the East Coast Area Health Board, with approximately another 30 UM girls who were pregnant. The following table presents the statistics for March 2003 and September 2004.

	MARCH 2003	SEPTEMBER 2004
Total number of UM girls in care	146	149
Total number of mothers	25 (17%)	21 (14%)
Total number pregnant	30 (20%)	11 (7%)

Table 1.1 - Unaccompanied Minor Mothers and Pregnancies, March 2003 and Sept. 2004

It is extremely difficult to definitively ascertain the percentage of pregnancies that occur either before or after arrival to Ireland. Estimates provided by the social work team indicate that approximately 25% of these pregnancies occur prior to arrival, and the other 75% occurring after arrival.

Informal enquiries made by through an ORAC discussion forum with countries worldwide, including those in the EU, suggest that the numbers of unaccompanied minor mothers is higher in Ireland than other countries contacted.

1.3 Irish context

In relation to the indigenous Irish population, statistics from the Central Statistics Office (CSO, 2002) indicate that in 2001 a total of 3,096 children were born to women under 20 years old.

A number of reports in recent years in Ireland have directly pointed to the particular needs of Irish teenage parents e.g. *Teenage Parenting - Contemporary Issues*, Joint Committee on Social, Community and Family Affairs (2001), *Strengthening Families for Life*, Commission on the Family (1998), *Lone Parents, Report No. 20*, National Economic and Social Forum (2001). All have underlined the particular needs of this population for a wide variety of supports.

In acknowledgement of the needs of Irish teenage parents (lone or with a partner) a limited number of services have been developed, particularly in the non-statutory sector. These services include supported accommodation such as that provided for mothers at Northbrook House Dublin, Young Mothers in Education Project, Galway (Galway City Partnership and Western Health Board, Galway), and the Leonardo project for school aged mothers, Cork. A more recent, nationwide project was the Teen Parents Support Initiative, initially piloted in four areas in 1999, which aims to provide services to enhance and support the wellbeing of young parents and their children (Riordan, 2002).

It is widely acknowledged within this sector that the demand for services for teenage parents outweighs the resources that the services are able to offer (Riordan, 2002).

1.4 Purpose of the study

The purpose of this study was to explore the experiences and needs of unaccompanied minor mothers who are clients of the designated social service, ECAHB. In doing so, this research was able to identify the unique care needs; support needs; accommodation needs; education needs, cultural parenting issues and stressors specific to this population.

By definition the circumstance of the unaccompanied minor mothers is different to the indigenous population of teenage parents by virtue of a number of key characteristics including: (1) cultural background, (2) absence of family members in Ireland, (3) environmental context, (4) participation in the asylum process and (5) unfamiliarity with Irish structures and systems.

This study articulates the key issues in relation to unaccompanied minor mothers seeking asylum, in order to inform effective service delivery. It aims to fill some of the gaps in knowledge about this population by:

- 1) describing their characteristics and circumstances
- 2) identifying issues that need to be addressed and
- 3) making recommendations in relation to these issues.

1.5 Process of the study

An interagency working group was established in 2002 which comprised the team leader and members of the Social Work team for Separated Children Seeking Asylum (SWSCSA, ECAHB), the designated clinical psychologist (PSRAS, NAHB) and the separated children's co-ordinator from the City of Dublin Vocational Education Committee. It was proposed within this group that research be undertaken to better inform practice and service delivery to this population of clients. Ethical approval was sought and obtained from both the ECAHB and the NAHB. A number of key agencies and individuals were consulted in the development of aspects of the research (Appendix I, II).

Data collection was conducted in 2003 and 2004. Members of the SWSCSA agreed to inform and invite the UMM's to participate, and then completed the questionnaires with them. Training on the appropriate use of the questionnaires was provided by the researchers. The focus group was led by the researchers. Data analysis was done by the researchers with the support of Dr Hevey, Dept of Psychology, Trinity College Dublin. The final write up of the report was done conjointly by the researchers.

1.6 Policy context

Since the completion of data collection in 2003 a number of changes of direct relevance to this population have occurred within the policy and legislative context. These include a Supreme Court ruling handed down on the 23rd January 2003 which stated that parents of an Irish Born Child (IBC) do not automatically have the right to reside in the State. (Prior to this decision a number of asylum applications of UM had been withdrawn and instead an application made for residency in Ireland following the birth of their Irish Born Child). Other changes relate to social welfare entitlements for asylum seekers from May 1st 2004, specifically: not being eligible to apply for child benefit allowance; the end of entitlement to rent assistance for asylum seekers, and the moving of UM's, including young mothers, at age 18, to Direct Provision accommodation.

1.7 Relevant policy, legislation and guiding documents

The following documents inform the context in which practice and policy in relation to UM operates: The UN Convention on the Rights of the Child (1989); The Child Care Act (1991); Refugee Act (1996); Children First Guidelines(2001); The National Standards for Children's Residential Centres (2001); Statement of Good Practice, Separated Children in Europe Programme (2002).

CHAPTER 2

CONCEPTUAL FRAMEWORK

The message of this research to the participants was that they are viewed as knowledgeable, as potential partners, as keepers or guardians of treasured cultural and personal information and as worthy advisors to research projects (Gibbs, 2001).

2. CONCEPTUAL FRAMEWORK

2.1 Introduction

The conceptual framework provides a congruent framework in which to analyse and discuss the findings of the research. The Socio Ecological perspective (Bronfenbrenner, 1979) in conjunction with the Life Model (Germain & Gitterman, 1980) provided the conceptual frameworks that inform this study. This is due to their ability to account for both the psycho-social, systemic and environmental influences on the young mother, and the attribution of meaning to these influences. The conceptual framework commences with a discussion on the construct of ‘Culture’ and how this construct was utilised within the research.

Following is a brief description of these perspectives and the roles they play in the analysis of the phenomenon under investigation.

2.2 Culture

The following descriptions and definitions of culture provide the reader with some of the basic tenets of the construct ‘culture’.

Geertz (1973:44 in Crotty, 1998:53) notes that culture has previously been defined as ‘complexes of concrete behaviour patterns – customs, usages, traditions, habit clusters’, however he argues that culture is best seen as the source rather than the result of human thought and behaviour. He describes culture as a ‘system of significant symbols’ and presents the meaningful symbols that constitute culture as an indispensable guide to human behaviour. He further draws the link between culture and human functioning, suggesting that without culture we could not function as humans. He proposes that as a direct consequence of the way in which we have evolved, humans depend on culture to direct behaviour and organise our experience and suggests that culture is a set of control mechanisms – plans, recipes, rules, instructions – for the governing of behaviour.

Ardenne and Mahtani (1999:3) use the following definition of culture for the basis of discussion in their book regarding ‘transcultural counselling’. They state that ‘culture means the shared history, practices, beliefs and values of a racial, regional or religious group of people’.

In the context of this research consideration also needs to be given to the process of acculturation following migration, forced or otherwise. Immigration and the process of resettling are acknowledged as disequilibrating and stress provoking, by a number of authors (Berry, 1995; Frakman, 1998).

2.3 Socio Ecological Perspective

The foundation of Bronfenbrenner's (1979) socio ecological perspective is that the individual and the environment are interrelated and affect each other on many levels. The levels that are involved are the micro, meso, macro and exo levels, with each level simultaneously affecting and being affected by the others (Bronfenbrenner 1979, in Compton and Galaway, 1993: 139).

The micro level includes the individual's experiences, and for the most part is unique to the individual due to the fact that no other person experiences the environment in the same way (Compton & Galaway, 1993). The meso system includes relationships between major groups, organisations and institutions that the individual is in contact with in their daily life. The macro level involves social, cultural and economic structures, and includes language, customs and religions (Compton & Galaway, 1993). The exo system is defined as 'the settings with which the individual does not interact directly but that nonetheless have an effect on the individual's development' (Corcoran, Franklin, Bennet 2000:29).

Because of the large number of variables dealt with in this study, only the micro, meso, and macro systems were utilised in the analysis of the results. So therefore settings and contexts such as the legal and political arenas which may at times be considered within the exo system will be discussed within the macro system.

2.4 The Life Model

The Life Model, as proposed by Germain and Gitterman (1980), is derived from the socio ecological perspective and incorporates the view that human beings are in constant interchanges with their environment. Individuals are changed by their physical and social environments, which in turn change them through a process of continual adaptation (Payne, 1991). When these changes occur and are supported by the environment, reciprocal adaptation results. However, when social problems such as stigma or poverty enter the environmental arena, such factors reduce the possibility of reciprocal adaptation occurring, thus resulting in stress (Payne, 1991). Within these often complex interchanges, disturbances emerge in the adaptive balance between, on the one hand, the needs and capacities of the individual and, on the other, the environmental qualities and resources needed to maintain and develop as individuals (Gitterman, 1980). When the balance is disrupted, stress results which in turn creates difficulties between the individuals needs and the capacities of the environment (or supports).

The authors of this study want to note the limitation of the word 'adaptation', and caution that it can sometimes infer that the locus of control and responsibility for adaptation is based within the individual, and thus as an inference, discount the role of the environment or wider systems in this exchange.

However, the Life Model, with its inherent concept of reciprocal adaptation, explicitly focuses on the individual's strengths rather than weaknesses in life transitions and simultaneously emphasises the role of the environment within the process.

Germain & Gitterman discuss the three main arenas from which stress can arise and cause difficulties for the individual and the environment in which they are functioning. They are (1) Life transitions; (2) Environmental pressures and (3) Interpersonal processes,

2.4.1 Life transitions

Life transitions include changes and events that occur throughout the lifespan. They create new demands on a person and their environment, thus requiring new responses or adaptation (Gitterman, 1980:7). Examples of life transition events provided by Gitterman include developmental changes such as adolescence, changes in role or status, restructuring of life space brought about by moving (either voluntarily or involuntarily), and changes brought about by crisis, such as the loss of a family member. These life transitions require the individual to create changes in the way they view the world and use the environmental resources available to them. Gitterman highlights that the environment can either support or interfere with the reconciliation of life transitions, and in itself can be a source of stress. Further, other considerations such as age, sex, race, class and culture can interfere with or support the adaptation to life events.

2.4.2 Environmental pressures

The second arena in the 'Life Model', as proposed by Gitterman (1980), is the environment. The concept of reciprocity between the environment and the individual is inherent in this model, and as such proposes that it is essential to analyse the significance of environmental pressures on the individual. Gitterman infers that the environment can either assist or become detrimental in the achievement of life transitions for the individual. Difficulties can arise when an individual encounters unequal opportunities in relation to access to certain structures within society due to differences in class, race, gender, culture or status (Gitterman, 1980). As a result the individual may find it difficult to access services such as welfare organisations, education or childcare because of organisational boundaries, policies and procedures which, either overtly or covertly, inhibit such access.

2.4.3 Interpersonal processes

The third arena of the 'Life Model' concerns an individual's interpersonal relationships and communication patterns within the family and other primary groups (Gitterman, 1980:13). This part of the model encompasses an individual's expectations of themselves and others in terms of their relationship and communication style, including the way feelings and needs are expressed and recognised. When stressors occur for the individual stemming from life transitions or environmental pressures, Gitterman suggests that an individual needs to adapt their interpersonal process to account for new and creative ways of exploring communication with others (Gitterman, 1980).

2.5 Summary

The conceptual framework outlined above is useful in order to locate the experiences – in particular stressors and supports - in terms of the micro, meso and macro spheres of the environment. It is similarly useful due to its ability to clarify and identify systems that can be influenced on each level and can thus inform the way recommendations are proposed.

The message of this research to the participants was that they are viewed as knowledgeable, as potential partners, as keepers or guardians of treasured cultural and personal information and as worthy advisors to research projects (Gibbs, 2001:30).

CHAPTER 3

LITERATURE REVIEW

Berry (1995) notes that ' the probability of experiencing 'acculturation stress' can be much reduced if both participation in the larger society and maintenance of one's cultural heritage are welcomed by policy and practice in the larger acculturative arena.'

3. LITERATURE REVIEW

3.1 Introduction

The available research literature in relation to teenage pregnancy is predominantly from the U.S. and the U.K. So, some caution needs to be exercised in directly extrapolating from these results to the population of interest in this study i.e. unaccompanied minor mothers seeking asylum in Ireland - who by definition represent a wide variety of cultural backgrounds. However at present this literature provides the only available reference point, and therefore can usefully serve to orient this review.

As Corcoran, Franklin and Bennet (2000) point out, a summary of the relevant literature is less than easy since there are at this stage many hundreds of studies in the area from within a range of disciplines such as child development, psychology, social work and medicine.

In the interests of focus this selective review of the literature has been limited to the topics that are central to this study – (1) culture, (2) support, and (3) stressors. The current extent of this issue will be considered initially and a number of observations made in relation to the pathways and consequences of teenage pregnancy.

3.2 Adolescent birth rate

While substantial variation exists, there has been an overall decline over the past 25 years in the **adolescent birth rate** in the industrialised countries (Singh & Darroch, 2000). They suggest a number of reasons for this trend, including the increasing importance of education while at the same time goals of motherhood and family formation are becoming less central for young women.

Maynard (1997) in his discussion of teenage parents in the US, points to one of the implications of this decline which is that ‘today’s’ teen mothers fare worse than ‘yesterday’s’ in terms of education, participation in society and antisocial behaviour. He also suggests that as teenage motherhood becomes less common, the consequences for those who do become a mother in adolescence become increasingly severe as this group becomes more marginalized.

Of particular relevance to this study is the role of culture in influencing and determining the age at which women normally become mothers in their country of origin. Rhode (1993) (in Macleod and Durrheim, 2002) point to the central place of **culture in relation to parental age** and suggests that the appropriate age for sexual relations and parenthood is culturally defined in the context of socio-historical conditions.

In the US and the UK, belonging to a minority culture has been associated with higher rates of teenage pregnancy, however a number of authors point out that closer consideration of the data suggests that this is more a function of low

socio-economic status and its consequences, rather than race per se. (Bingham et al, 1990; Furstenberg et al, 1987 in Corcoran et al, 2000). The role of low socioeconomic status in teenage pregnancy is noted in the following section.

3.3 Pathways into and negative consequences of teenage parenthood

In relation to **pathways into teenage parenthood in UK and US**, a wide range of variables have been considered. Corcoran et al, 2000, in a review of some of the literature, note that researchers and clinicians have considered a variety of factors at the micro, meso and macro system levels (Bronfenbrenner, 1979) such as: low socio-economic status and its challenges (Abrahamse et al, 1988; Barnett et al, 1991 in Corcoran et al, 2000); negative relationship with school and low educational attainment (Santelli & Beilensen, 1992 in Corcoran et al, 2000); low level of parental control (with higher levels of monitoring likely to have a protective effect, according to a study by Hanson et al, 1987 in Corcoran et al, 2000); aspects of peer influence on the age of initiation into sexual activity (Evans, 1987; Yamaguchi & Kendal, 1987 in Corcoran et al, 2000) and the risks of alcohol and drug use as contributing factors (Yamaguchi & Kandel, 1987 in Corcoran et al, 2000).

There is limited research on the psychological variables that may precursor teenage pregnancy. One study by Morgan et al, 1995 (in Corcoran et al, 2000) considered the role of psychosocial variables and noted that pregnancy could not be predicted on the basis of the number of stressful events. In relation to low self-esteem as a possible precursor, results although somewhat mixed, generally indicate that it is not a significant predictor of teenage pregnancy. In considering the role of depression as a possible precursor, Abrahamse et al, 1988 (in Corcoran et al, 2000) found evidence that parenting outside marriage was more likely for respondents who had experienced a number of episodes of depression.

A well-established body of literature has discussed the wide variety of risks and negative consequences to both parent (usually mother) and child, in the context of teenage parenthood in the U.K. and the U.S. (Maughan & Lindelow, 1997; Nagin, Pogarasky, & Farrington, 1997). Furstenberg et al (1989) outline a range of adverse social consequences related to teenage motherhood and Frasel et al (1995) describe the negative health outcomes for both mother and child. Poverty or inadequate income, generally associated with lower socioeconomic status, has been posited as having a central role both a precursor because of the restrictions it places on life choices and as a consequence because of the possible limiting impact of teenage parenting on continuing education and employment (Flanagan, 1998).

Because of the extremely large number of studies in this area a full review of the literature on this area is beyond the scope of this study. For those interested in a more extensive review see Corcoran, (1998).

The dominant themes in the research literature in the US and UK on **the precursors and consequences** are those of “risk” and “problem”, for child, mother and society. However some researchers point out that a negative trajectory is

not necessarily a definitive outcome. Furstenberg, Brooks, Gann & Morgan (1987) (in Manlove, 1997) reject a deterministic type model that maps only negative consequences and point out that each teenage mother has her own unique circumstances, experiences and range of motivations which will have influenced an early age for parenthood. Similarly Flanagan (1998) rejects an overwhelming and generalised negative picture, noting that there are many complex reasons why an individual adolescent becomes a mother and the choices she makes in relation to giving birth and raising her child. However she does acknowledge that teenage mothers by virtue of their young age and limited life experience often require extra supports and resources.

3.4 Unaccompanied minor mothers

While there is a considerable body of literature which addresses the needs, precursors and consequences of teenage motherhood in the U.K. and the U.S., there is little or no information available about teenage mothers who are also unaccompanied minors seeking asylum in either of these countries. An extensive literature search failed to locate a single study, either within the professional disciplines of psychology or social work, which focused on this particular population. An exploration of the available **statistics and policies** in relation to unaccompanied minor mothers in other European countries resulted in limited information. The countries who responded noted that this issue was either non-existent or negligible in terms of its size.

It is worth reiterating at this point the opinion of Rhode (1993) (in Macleod and Durrheim, 2002) who underlines the role of **culture in terms of parental age**, noting that the appropriate age for sexual relations and parenthood are culturally defined.

Therefore the literature on the precursors and reasons for teenage pregnancy may be of limited relevance in considering the UMMs in this study. However given that they are now teenage mothers in Ireland the literature on the consequences is likely to be relevant and as such requires serious attention.

As Flanagan (1998) points out “adolescent mothers are adolescents and mothers” – and as such have “unique developmental needs”. Unaccompanied minor mothers are adolescents, mothers, and are also by definition immigrants and without their family – these additional characteristics add further complexity to their needs.

3.5 Culture

Culture is a central focus in this study. There are many and varied definitions of the term ‘culture’, however for the purposes of this study the following definition is considered the most useful: ‘culture means the shared history, practices, beliefs and values of a racial, regional or religious group of people’(d’Ardenne and Mahtani, 1999:3). Cultures are defined by their world view, their values and their belief-systems and are often most apparent in the roles, customs and rituals of that culture (Goldberger and Verhoff, 1995).

In terms of **health and social service provision** in a multi-cultural context, Fernando (1995) asserts that ‘fundamental changes are necessary in professional practice if service provision is to be relevant, appropriate and just in a multi-ethnic society’ and recommends that cultural competency in staff must be developed in order to provide both equality of access and equality of care in health services for ethnic minorities. Papadopoulos et al (1998) has proposed a useful model for developing **culturally competent health practitioners**. The model includes four components – cultural awareness, cultural knowledge, cultural sensitivity and cultural competence.

The ERHA Regional Health Strategy for Ethnic Minorities notes that ‘central to a culture of equality promotion within organisations is the development of cultural competence so that staff are equipped with the knowledge and skills to deliver services to a multi-ethnic society and to work in multi-cultural teams’ (2004:38). Countries like the U.S. and the U.K. who have longer histories than Ireland in terms of their multicultural composition, have attempted to directly address some of the issues involved in addressing the health needs of multicultural populations - by producing for e.g. Standards for Culturally and Linguistically Appropriate Services in the U.S. (Dept. of Health and Human Services Office of Minority Health, 2000) and in the U.K., a definition of ‘cultural competence’ in the context of health and social services (DHSS Office of Minority Health, 2000).

In relation to the parenting process Sidebotham et al (2001), in their study of parent’s perceptions, acknowledge the crucial and central role of culture and discuss the importance of cultural factors in providing the wider context within which a child develops.

It is beyond the scope of this study to examine or to explore in detail the many cultures of origin for each of the unaccompanied minor mothers in this study. However since a significant majority come from West Africa, a brief overview of the salient features of the **West African world-view**, will be considered.

Lassiter J. (1999) notes that African scholars since the early nineteen sixties have asserted that there are a range of psychological and cultural themes that are unique to Sub-Sahara Africa, although he also points out that these patterns are undergoing rapid change in an increasingly globalised world.

Makgoba (1997) (in Lassiter, 1999) describes people of African descent as sharing belief systems and values that are central to an African identity and culture. He gives as examples African hospitality, friendliness, the consensus seeking principle –‘ubuntu’ and points to the emphasis on community rather than on the individual in African society.

In relation to the parenting role there are a number of relevant features described in the literature. The role of the mother, the elders and the role of the extended family are most often described in terms of providing practical support and shared care in relation to the child/ren and also in providing advice and guidance (Nave, 1999).

These roles are of particular significance for the population of unaccompanied minor mothers in terms of their absence. The implications of this absence, at the time of becoming a mother, has not to date been considered in the literature.

Rituals and rites of passage play an important role in African social and cultural life. Rites and ceremonies accompany the transition into a different stage of life including the beginning of adulthood, marriage, birth and death.

Much has written about the place and value of ritual in society and in particular the psychological functions of ritual. Hill (1996) describes how rituals assist people in adjusting to life stage transitions and Erikson (1963) has outlined the importance of ritual for the development of identity.

Rituals and practices associated with **childbirth** and parenting are of particular relevance to this study. The naming of children is considered an important event and is usually marked by ceremony (Hill, 1996). Grimes (2002) suggests that baptism, within the Christian tradition, can be considered as a rite of passage at the time of new life.

Another practice is of a ritual first bath shortly after birth which includes a vigorous massage the baby, commonly referred to as ‘bathing’ the baby (Obola, B.)¹. Geurts (2002) in her description of this ritual in an area in Ghana noted that it was an explicitly social phenomenon, attracting many observers from the community. In her reports of discussions with participants about the meaning and importance of this event, she notes that the values of both cleanliness and physical flexibility were associated with the practice.

It must also be noted that there are cultural practices that may not be acceptable in all parts of the world – for e.g. female genital mutilation or female circumcision is widely practised in parts of Africa (and throughout the world) however is defined as ‘violence against women’ in the U.N. Declaration on Elimination of Violence Against Women (1993).

Cultural practices in relation to **child rearing** and socialisation practices are also of interest. Nyasani (1997: 129) in Lassiter (1999) declares that as a result of differences in child-rearing practices there is a ‘fundamental difference between the traditional African child and a child in the Western culture.’ Gardiner et al (1998) (in Shiraev & Lead, 2001) have noted that African parents use different strategies when they teach their children to walk and that motor skills of African infants develop earlier than white children.

A prominent feature of childcare in Africa is the practice of carrying the baby on the back. Geurts (2002: 98) reports that ‘throughout West Africa, there is a widespread practice in which women attach their small children to their backs

¹ Project Worker from Kenya with SWSCSA - personal communication

by wrapping the children in a cloth bound around their abdomen and breasts'. She notes that the practice in the Anlo speaking area of south east Ghana, is associated with balance and posture for the mother, safety and security for the baby and the development of a strong bond between mother and baby.

Finally **attitudes, beliefs and practices in relation to health and sickness** are of relevance. While increasingly there are western medical treatments available throughout Africa, physical illness, mental illness and misfortune are often considered to be the results of mystical or spiritual forces like witchcraft and sorcery, or negative influences from ancestors or others from the spirit world. If this is believed to be the case help may be sought from a traditional healer who will apply both physical and spiritual methods to resolve the problem. He/she can also offer protection from witchcraft and sorcery through the use of medications and charms (Anti, 1996). Pastors and priests may also be consulted for prayers and 'divine healing' if it is believed that the source of the illness or misfortune is 'spiritual'.

3.6 Stressors

Stressors can be perceived and defined as such in different ways by different people according to experience and temperament and therefore each individual will define for his/herself what is experienced as stressful or not. Pearlin (1982) usefully defines three types of contextual stressors; (1) normative life cycle transitions; (2) unscheduled or involuntary life events; (3) continuing stressful life experiences. He suggests that the negative effects can be both additive and cumulative.

It is helpful to apply Bronfenbrenner's ecological model (1979) – **the micro system; the meso system; the macro system and the exo system**, to consider the 'location' of the stressor (note however that the exo system is not included in the analysis within this study). The World Health Organisation also advocates a socio-ecological approach to health issues and suggests that such an approach empowers both the individual and the community. The Risk Approach Framework within the National Child Health Programme of the WHO acknowledges that there are determinants of health that are located in social structures (e.g. poverty) and as such are not within an individual's control (Hayes, 1992).

In considering the possible sources of stress for parents Abidin (1983) describes the primary **components of the parent - child system** as follows (1) the characteristics of the parent, (2) the characteristics of the child and (3) the interaction between the parent and child. These stressors **at the micro level** therefore may be associated with the parent's circumstances or experiences (for e.g. marital problems) and/or factors intrinsic to the child (for e.g. serious illness) and/or negative social interactions between parent and child.

Personal ill health, particularly if sustained, is generally considered as a significant stressor. And a child's ill-health will generally be experienced as a significant stressor by the parent. A further possible stressor associated with ill

health for immigrants, refugees and asylum seekers can be difficulties in accessing appropriate health care because of such factors as difficulties in access, lack of information and/or lack of interpreters (Olness, 1998).

Other possible sources of stress for the population of this study may be in the external systems (the meso and macro levels) – for example **at the meso level** stressors may include: less than optimal socio-economic conditions including inadequate income, living/home environment, lack of access to support structures. A study by Barth et al (1983) (in Corcoran et al, 2000), found that levels of psychological distress were better predicted by low socioeconomic status and its consequent limitations together with reduced levels of social support than by the parenting status alone.

And **at the macro level** the stressors are likely to include: legislative barriers to participation in society with the consequent risk of social exclusion and marginalization; an uncertain future and participation in a stressful legal process.

Cultural variables, including the process of acculturation can also contribute to the experience of stress (Berry, 1995).

Poverty is consistently referred to as a stressor and is often associated with low educational attainment and consequent limited occupational opportunities. In discussing the impact of societal changes including standard of living and increased living costs Hill and Tisdall (1997) note that single parents in particular are at risk of poverty and its consequences. As well as the more obvious consequences of limited income on the capacity to ‘consume’ i.e. buy goods, a further impact of poverty is **sustained exclusion from opportunity**, with negative consequences for satisfactory participation in society, physical health and well-being. (Sidebotham et al 2001). Flanagan (1998) points out that there is a higher risk of poverty for the mother if she is parenting alone, and notes that if the mother has **no formal educational or vocational qualification** that risk is even higher. Singh & Darroch (2000) note that the risk of negative consequences is further compounded when the teenage mother is **parenting without a partner** and has to rely on financial support from the government and/or her parents.

Poverty and **social exclusion** are recognised as being connected and strongly associated both as precursors and consequences of single teenage parents in particular and tend to be associated with lower levels of education (Flanagan, 1998). On the basis of their findings Corcoran et al (2000: 36) suggest that there is a need to help teenage parents ‘gain access to resources to succeed educationally and occupationally’. They argue that ‘addressing socioeconomic needs would prevent further pregnancies and would better assist teenagers in providing for their families’.

The process of **acculturation** is of interest in this study because it concerns the psychological adaptations that individuals make when they move between cultures (Berry, 1995). This process has been acknowledged as stressful

by a number of authors (Fraktman, 1998; Berry, 1995; La Fromboise et al, 1995). Ahearn, Loughry & Ager ,1999) note that both pre-migration and post migration experiences influence the acculturation process of the asylum-seeker or refugee child and adolescent to a new culture and country.

A wide range of factors determine the extent to which this acculturation process is experienced as negative or problematic (Murphy, 1965 in Berry, 1995). These factors include (following Bronfenbrenner's model, 1979) '**micro level**' factors - the personal, social and cultural qualities of the individual, the motivation for departure, their expectations and goals; '**meso level**' factors - the presence or absence of family and community support, the quality of personal relationships, the presence or absence of spiritual or religious support; and also '**macro level**' factors - relevant legislation, the social policy climate of the host country, the degree of pluralism in the host society and the extent to which structural policies include or exclude the acculturating group in relation to participation in wider society. If the process is negatively experienced, acculturation may impact negatively on psychological health (Berry, 1995).

A possible negative impact on **mental health** is noted by Beiser, Barwick, and Berry et al, 1988 (in Berry, 1995) who suggest that if a **desire to participate in wider society** is not supported there can be serious negative impact on the mental health of the person in the acculturating process. However this negative impact is less likely if there is an experience of more control over the relationship with the majority culture (La Fromboise et al, 1995). Berry (1995) points out that if the wider social policy and practice climate serve to welcome participation in the host society as well as encourage connection with one's culture of origin, then the negative impact of acculturation stress can be reduced. These observations highlight the importance of a sense of belonging and a sense of social inclusion for psychological health. Furthermore, Beiser (1987) found that refugees who came alone or were not involved with people from their home culture were more depressed one year after arrival than those who were with family or were connected to a community. Berry (1995: 486) refers to research reviewed in Beiser, Barwick, Berry et al., 1988 that indicates that '**a desire for cultural maintenance**, if thwarted, can lead to a serious decline in the mental health of acculturating individuals'.

The unaccompanied minor mothers in this study have each been in this process of acculturation for at least a number of months. Their process is compounded by a number of other factors as well as those already noted – for many if not all this move from their country of origin has not been of a voluntary nature and for those who do not have refugee status their future is fraught with uncertainty because of an insecure legal position. For those who do not have access to a cultural community, support in terms of maintaining cultural practices may not be available to them.

In the context of immigration, whether for economic reasons or because of a risk of persecution, a further potential stressor is the experience of **racism and hostility** in the host country. This issue is unfortunately a very real

experience for many who have emigrated to Ireland. (Lentin and McVeigh, 2002). Patel and Fatimilehin (1999), note the serious negative consequences for psychological health as the consequence of the experiences of racism.

Fraktman (1998) points to a number of other potential stressors of particular relevance to this study, including the **absence of family, the absence of community**, and the **isolation** experienced by mothers at home with young children and notes that that these difficult contextual factors may at times contribute to depression.

Historic **traumatic experience**, while not specific to this population, is a further issue to be considered. By definition asylum seekers are likely to have lived in political or social chaos with the attendant issues. Though some commonalities in terms of post trauma response have been identified, the psychological impact of traumatic experience is agreed to be particular to the individual and is mediated by a number of factors such as the nature of the trauma, the post trauma environment, the pre trauma history and personality (Joseph et al, 1997). Therefore it is not possible to predict definitively the psychological consequences of a traumatic event for an individual.

A number of authors point to the importance of taking into account the cultural meaning of trauma and cultural idioms of distress (Bracken, 2002; Summerfield, 1999). They note that the definition of trauma as such will depend on the socio-cultural background of the individual, which will include the beliefs and attitudes he/she will have internalised in the process of enculturation. With reference to recovery from trauma both Bracken (2002) and Summerfield (1995, 1999) emphasise the importance of the resumption of the ordinary, everyday activities with family, community, religious and economic activity for social and psychological recovery.

The **uncertain legal status** of the unaccompanied minor mother represents a significant stressor. Westermayer (1989) observes that for asylum seeker children and their families the uncertainty about their future causes considerable stress and compounds the impact of any pre-migratory trauma that may have been experienced by them. Okitikpi and Aymer (2003) in their exploration of social work with African refugee children and their families point to the social worker's observations that their insecure legal status was often the cause of anxiety, depression, a sense of isolation and marginalization. Rae (2000) in her study on unaccompanied minors notes that a fear of being sent home was a stressor for all the study participants. Vargus (1999, in Rea, 2000) also highlights the numerous other stressors in this context: the stress of the legal process with associated anxieties; the loss of home and family; the experience of acculturation and possibly a different language; and traumatic experience. He suggests that these stressors can collectively lead to marginalisation and isolation and negatively impact on emotional, cognitive and social development and that for the adolescent the normal tasks of this developmental phase may be interrupted. The experience of uncertainty is experienced as stressful itself and also negatively impacts on a sense of belonging or connection which might otherwise serve to psychologically protect. As a result unaccompanied children and adolescents may experience higher levels of **psychological distress**.

By definition much of the experience of the unaccompanied minor is marked by absence – absence of the ordinary scaffolding that usually holds one’s life together – the absence of both extended and nuclear family, of secure legal status, the absence of familiarity, of community, of a sense of belonging.

However, while acknowledging the number of stressors associated in particular with asylum seekers and refugees, it is also worth noting that much of the literature points to the generally high levels of **psychological resilience** in these populations (Ager, 1997). In the light of both the literature and clinical experience it is clear that a balanced perspective needs to be maintained - one that acknowledges the complexity and variety of stressors but which simultaneously acknowledges the individual’s strengths, capacities and resilience.

3.7 Support

Much of the literature in relation to teenage parenting points to the central role of **social support** in terms of its absence or presence. Social support is of interest because of its suggested role as a protector against the negative impact of stress. The buffering theory of social support suggests that in the case of teenage mothers, when the level of social support is high, less stress will be experienced in the parenting role and this in turn will positively impact on parenting behaviour (Nitz et al, 1995 in Bunting and McCauley, 2004).

Schaefer, Coyne and Lazarus (1981, in Rea, 2000) make a useful distinction between the different types of support that can be provided – (1) emotional, (2) tangible and (3) information. While related, each type of support is uniquely important and has a different function.

In their review of the available literature on **family, partner and peer support** for teenage mothers (**meso level**), Bunting and McCauley (2004) concluded that these three sources of support were each significant. They noted that family support can have a positive effect on parenting skills; that support from the father or male partner can also have such an effect as well as being associated with better psychological and psychological outcomes for the mother and that the emotional support from peers was considered important by the teenage mothers themselves.

In terms of support provided by **services (meso level)** for teenage parents, Riordan (2002: 81) summarises the supports considered helpful by participants in the Teenage Parents Support Initiative (a project providing support services for single teenage parents) as follows: ‘support with parenting; provision of information on a range of issues including income supports, health services, education and training; having ‘someone to talk to’; and access to support groups, as well as, individual one-to-one supports’. Support in not only their parenting role but also their personal role as a young adult was also identified as being useful, in particular encouragement and support for participation in education together with assistance for childcare.

At the personal (**micro level**) level the role of **religious faith** has also been noted as a source of support and as having a stress-buffering function (Lowenthal, 1995).

Results from a study by Parks, Lenz and Jenkins (1992) in Coll et al, (1998) point to the importance of social support in terms of its buffering role in relation to stressors as well as directly contributing to parenting. They note that supporting parenting and reducing stress for the parent particularly in the early childhood years of will contribute to a positive social environment and thus help children in terms of achieving their maximum their potential.

Furthermore they report that research evidence suggests that the relative balance between stressors and social support both directly and indirectly determines the quality of parenting and attachment relationships and thus impacts directly on the development of the child. Facilitating positive parenting is best achieved by supporting the parent's needs – by so doing the parent becomes enabled to effectively parent and the parent-child relationship is enhanced. It is under these conditions that a healthy attachment is promoted and thus the **optimal psychological environment provided for the child.**

The evidence is overwhelming in favour of the argument that social support reduces risks and enhances positive outcomes, for the teenage mother and her child. However while acknowledging the crucial role of support it is important not to construct, either consciously or inadvertently, a passive or dependant role for the recipient. As Fraktman (1998) points out support should be empowering of the recipient, acknowledging both strengths and capacities while facilitating the development of the individual and her own support networks

CHAPTER 4

METHODOLOGY

The aim of the Research:

To explore the context, characteristics and experiences of 23 unaccompanied minor mothers in Ireland, in order to inform service design and development.

4.3 Research design

An integrated or mixed-method design was considered the most suitable approach to examine the experiences of unaccompanied minor mothers. This study therefore included both qualitative and quantitative methods. Thus the research data included both a rich description from the participants' voices of their experiences and results from the use of standardised measures together with a formally constructed questionnaire.

Triangulation forms the key methodological philosophy and practice upon which this study is based. It refers to using two or more sources to achieve a comprehensive picture of a fixed point of reference (Padgett, 1998:96), and is also widely acknowledged as a means of enhancing rigour in qualitative studies (Darlington & Stott, 2002; Crotty, 1998; Padgett, 1998). Denzin (1978, in Padgett, 1998) describes four types of triangulation:

1. *Theory Triangulation*: This relates to the use of multiple theoretical perspectives to analyse the same set of data. This study has operationalised theory triangulation through the use of theoretical perspectives drawn from psychology, sociology and social work.
2. *Methodological Triangulation*: This concept relates to the use of multiple methods to study a single phenomenon. This study has achieved methodological triangulation by incorporating both qualitative and quantitative methodology to obtain the data.
3. *Observer Triangulation*: This concept refers to using more than one observer in a study to achieve intersubjective agreement. This was accomplished by both researchers being involved in the focus group, with one as the lead facilitator and the other as observer. This was further developed in the coding stage of the data analysis with both researchers coding independently before coming together to cross reference.
4. *Data Triangulation*: This relates to using more than one source of data (e.g. interviews, observations, questionnaires). This study has achieved data triangulation by using questionnaires; psychological measures; focus group and content analysis from files as methods of data collection.

The authors of this research have also included a fifth type as noted by Janesick (1994, in Padgett 1998)

5. *Interdisciplinary Triangulation*: This speaks of utilising more than one professional discipline in a single study. This was achieved through the fact that one researcher was a Clinical Psychologist and the other a Social Worker.

4.4 Sample

A convenience sample (Leedy, 1997:204) was used for the collection of data via questionnaires. The participants were 'purposefully' chosen for the research due to the fact that they were knowledgeable and experienced in the phenomena, thus increasing the usefulness of the information obtained from the small sample (Leedy, 1997).

4.4.1 Sampling Method

The criteria for inclusion in the study were as follows:

- (1) Unaccompanied minor mothers who are clients of the SWSCSA, and
- (2) Who have children over the age of 3 months.

A total of twenty three UMMs participated in the study and were drawn from a population of twenty five UMM's who were clients of the social work service at the time of the study (two mothers from the total population did not fit the criteria for inclusion). All of those who completed the questionnaires were informed of the focus group and were invited to attend. Six UMMs, from the total sample of twenty-three, self-selected to participate.

Willingness of the participants to be involved was ensured through the participant signing an agreed consent form after a thorough written and verbal explanation was given. The information provided to the participant was translated into the participant's first language as deemed necessary.

4.5 Data collection and analysis - Quantitative

4.5.1. Instruments

(1) Unaccompanied Minor Mother's Questionnaire (UMMQ) - Appendix VI

This instrument was specifically developed for this study and stemmed from an extensive review of the literature coupled with practice wisdom and experiences of practitioners in many relevant agencies in the field. During the process of designing of the questionnaire relevant players within key services and agencies were approached for advice, input and revision (see Appendix 3). This was done in order to identify potential gaps in the instrument, as well as to facilitate transparency of process and collaboration of practice.

The UMMQ is primarily concerned with obtaining quantitative data specifically relating to the following areas: Support; Health; Accommodation; Education; Looking after your baby; Negative and Positive experiences; Differences and Similarities (Ireland and Country of Origin) and Future. A number of questions are open-ended with space being provided for the respondents to expand on answers if they chose.

(2) Harvard Trauma Questionnaire (adapted) (HTQ-a) (Mollica et al, 1992) - Appendix VII

The original Harvard Trauma Questionnaire (HTQ) is a checklist developed by the Harvard Program in Refugee Trauma at Harvard University (HPRT) (Mollica et al, 1992). It inquires about a variety of trauma events that the individual may have experienced. The HTQ checklist is part of a larger, four part instrument developed by HPRT. This scale consists of 45 trauma events which are equally weighted and there are two possible responses- 'yes' or 'no'. The amended version developed for this research included 13 extra items specifically relating to the population under investigation such as item 47: Prolonged sexual abuse/exploitation (e.g. in Rebel Camp) or item 51: Traumatic journey to Ireland. The amended version comprised therefore a total of 57 items that required a "Yes" or "No" answers

including one item where any other life threatening or traumatic situation could be described, and a final section for information on the young mother's stage in the Asylum process.

(3) The Parenting Stress Index – Short Form (PSI-SF) (Abidin, 1983) - Appendix VIII

The Parenting Stress Index (PSI) was designed to ‘identify parent-child systems that were under stress and at risk for the development of dysfunctional parenting behaviours or behaviour problems in the child’ (Abidin, 1983).

The PSI has been used with a variety of ethnic minorities in the U.S. however there is no literature available on its use with the population in this study.

The PSI - SF consists of a questionnaire (‘test form’) with instructions on how to complete a total of thirty-six questions relating to the parenting role, and includes an area for recording demographic information. If a respondent is literate and can complete the test form independently, it will usually take about ten minutes. For the full text of questions and response options see Appendix (VIII).

A total of four scores relating to the parenting role are computed from the completed questionnaire. These are as follows:

1. **Total Stress score** which gives an indication of the overall level of parenting stress experienced.
2. **Parental Distress score** which determines the distress the parent experiences in their role as parent, as a function of personal factors that are directly related to parenting.
3. **Parent-Child Dysfunctional Interaction score** focuses on the parent’s perception of the parent-child relationship.
4. **Difficult Child score** focuses on the parent’s perception of the behaviour of the child.

Any scores that are at or above the 85th to 90th percentile are considered to be high and merit further investigation and/or appropriate referral.

A further score is derived from a Defensive Responding scale, which helps to detect any bias in the responses.

(4) General Health Questionnaire -12 (GHQ -12) (Goldberg & Williams, 1988) – Appendix IX

The GHQ is designed to detect psychological distress in community settings. It consists of sixty items and focuses on breaks in normal function rather than on life-long traits. The GHQ-12 is directly derived from the GHQ-60 and consists of twelve items.

It is widely used in research and has been used in a number of cross-cultural settings without loss of validity (Goldberg & Williams, 1988).

The questionnaire can be self-administered by a literate respondent and will usually take less than ten minutes to complete. For the full text of questions and response options see Appendix (IX)

Note: while neither the GHQ-12 (Goldberg & Williams, 1988) nor the PSI-SF (Abidin, 1983) have been validated for use in the cultures of this research sample, the researchers believed that the results would be worthy of examination and would provide useful information.

4.5.2 Quantitative data collection process

(1) UMMQ, PSI-SF and GHQ-12

The PSI-SF, GHQ-12, and UMMQ questionnaires were distributed to the twenty three participants. The distribution and completion of the questionnaires was facilitated by the young mother's allocated Project or Social Worker. Participation in the research was entirely voluntary following full explanation of the research purpose and process. A training and information session was conducted by the researchers with all allocated Social Workers and Project Workers in order to ensure consistency in explanation of the research process, concepts, and rating measures for the young mothers.

(2) HTQ - adapted

A further quantitative task was a content analysis of client files using an adapted version of the Harvard Trauma Questionnaire (HTQ) (Appendix VII) in order to determine the number of traumatic stressors that the young mother has experienced either before, during or after her arrival to Ireland.

4.5.3 Quantitative data management

- (1) The data from the PSI-SF; GHQ-12, and UMMQ was collated in paper format for analysis.
- (2) The HTQ-a was completed by one of the researchers via content analysis of the client files.

4.5.4 Quantitative data analysis

The data from the PSI-SF, GHQ -12, HTQ-a and the quantitative data from UMMQ were coded and entered into SPSS 12.0 (SPSS Inc.,2003) for statistical analysis.

4.6 Data collection and analysis - Qualitative

4.6.1 Methods

(1) The Focus Group

Selection for the focus groups was done on a voluntary basis with the participants self- selecting for inclusion. The questions posited in the focus group were informed by the results of the UMMQ. The purpose of the focus group was to allow the researchers to explore in depth, in a qualitative way the experiences of being a young minor mother. This allowed the researchers to acquire a more comprehensive understanding of how participants dealt with the numerous aspects associated with caring for a young child/baby whilst being in the asylum process in Ireland. Through this process the researchers were more able to understand the individual's attribution of meaning to their constructs of culture, support and stressor, and provide the researchers with examples of such.

(2) The UMMQ - 'open-ended' questions

See 4.5.1.(1) for information on the questionnaire. The following questions included space for respondents to expand on replies and/or to respond in a narrative form: Q.11; Q.12; Q.13; Q.14; Q.15; Q.16; Q.17; Q.18 and Q.19.

4.6.2 Qualitative data collection process

(1) The Focus Group

The focus group was undertaken with a self-selecting group of 6 young mothers – all of whom had completed the aforementioned questionnaires. The process consisted of non – directive questions from the researcher leading the group with accompanying probes. However the group members also introduced and were encouraged to speak about topics of their choosing. One researcher took the lead role in the facilitation of the group while the other observed and took notes regarding non-verbal communication patterns. The focus group was audio recorded. The emphasis was on exploring the meaning of the young mothers experiences in Ireland, and the supports and stressors associated with this experience. Questions included asking participants how they define constructs such as ‘support’ and ‘stressor’. Other questions included enquiring about specific cultural practices in child rearing and belief systems. The entire focus group process lasted approximately two hours however ample time was provided both at the beginning and end of the interview for further questions or clarifications to be made regarding the study. Child care was provided on site for the young mothers in order for them to fully participate.

(2) The UMMQ - open ended questions

For information on the distribution and completion of the UMMQ see 4.5.2

4.6.3 Qualitative data recording

- (1) The focus group was audio taped in order to accurately record data for analysis. This audio recording was then transcribed into paper format for coding and analysis of the themes.
- (2) The responses from the UMMQ open-ended questions were collated and recorded.

4.6.4 Qualitative data analysis

Barrit (1986) suggests that the focus of a phenomenological researcher is to ‘look for concealed themes that lie unexamined in the events of everyday life...and to find meaningful, shared themes in different people's accounts of a shared experience (cited in Leedy, 1997:162). The qualitative data analysis of this study aimed to follow this suggestion by dividing the young mother’s reported experiences into themes or ‘meaning units’. This was operationalised by the identification of six broad thematic areas from within the focus group transcripts (Appendix X). These themes were then identified within the text and colour coded individually by both researchers in order to allow for observer triangulation of the results. This process then enabled the researchers to further ‘collapse’ the identified categories and

themes into two major areas: Culture (including similarities and differences; belief systems; attitudes to women in country of origin); and Wider Systems (including accommodation; money; education; health). This data was then examined using the categories 'support' and 'stressor', and analysed at the macro and micro levels of the wider system. The responses from the UMMQ open-ended questions were categorised in a similar manner following the themes identified.

4.7 Ethical Considerations

Ethical considerations in this study centred primarily on the issues of (1.) informed consent (2.) confidentiality and (3.) the wellbeing of the participants.

(1) Informed Consent

A central consideration was the informed consent of the participants at all stages of the study. This involved both a written and verbal explanation including an explanation of the data collection and interview procedure followed by written consent. Participants were advised in writing of the complaints procedure available to them.

(2) Confidentiality

The participants were informed that they would not be identified in any of the data collected or within the procedure for audio recording of the focus group. Participants were also informed that they could request the results from their PSI-SF or GHQ-12 to be provided to themselves or their social worker if they desired. The storage and security of the data was explained, similarly that no identifying details will be recorded or documented in any report or recommendations. Whilst all care was taken to ensure confidentiality, it was pointed out that as the numbers of unaccompanied minor mothers is small, it was not possible to ensure complete confidentiality in the context of the focus group.

(3) Wellbeing of the participants:

In the event of a significant score or result from PSI –SF or GHQ -12 indicating a high level of distress or cause for concern, it was agreed that the client's social worker would be directly informed in order to follow up as appropriate and provide the necessary supports or referral. It was also established that a crisis appointment with the psychology service (PSRAS) would be available at any stage if deemed necessary by the project or social worker of the SWSCSA.

CHAPTER 5

RESULTS

‘People are not just a story - they are people... they are very good at doing something... but because of the kind of life we’ve had we just feel lost... like the government does not allow us to do what we want to do...but I don’t want to remain like that...I want to do my jobs ...I just want encouragement...this is what you do...and go for school or go for further training...’ (UMM)

5. RESULTS

5.1 Introduction

The results have been analysed on the following levels in line with the conceptual framework and methodology. The conceptual map (Figure 5.1) provides a visual representation of how they have been approached for consideration. The variables described are grouped and presented in four sections as follows:

- **Culture** is located within the macro level by Bronfenbrenner (1979) & Germain and Gitterman (1980). For the purposes of this study and analysis 'Culture', including the acculturation process, is treated and discussed as a separate variable that interacts with and surrounds all levels.
- **The Micro level** includes psychological characteristics (derived from results of GHQ-12, PSI-SF and HTQ-adapted), gender related abuse and role as mother.
- **The Meso level** includes the '**support variables**' - professionals/ formal services and place of worship, and the '**stressor variables**' - absence of family; social isolation; some professionals; barriers to education and work, and lack of access to childcare together with accommodation and income which were in both the 'support' and 'stressor' categories.
- **The Macro level** includes the '**support variables**' - financial support from Government, and the '**stressor variables**' - Government policies and legislation; uncertain future legal status and implications and the prospect of Direct Provision adult accommodation.

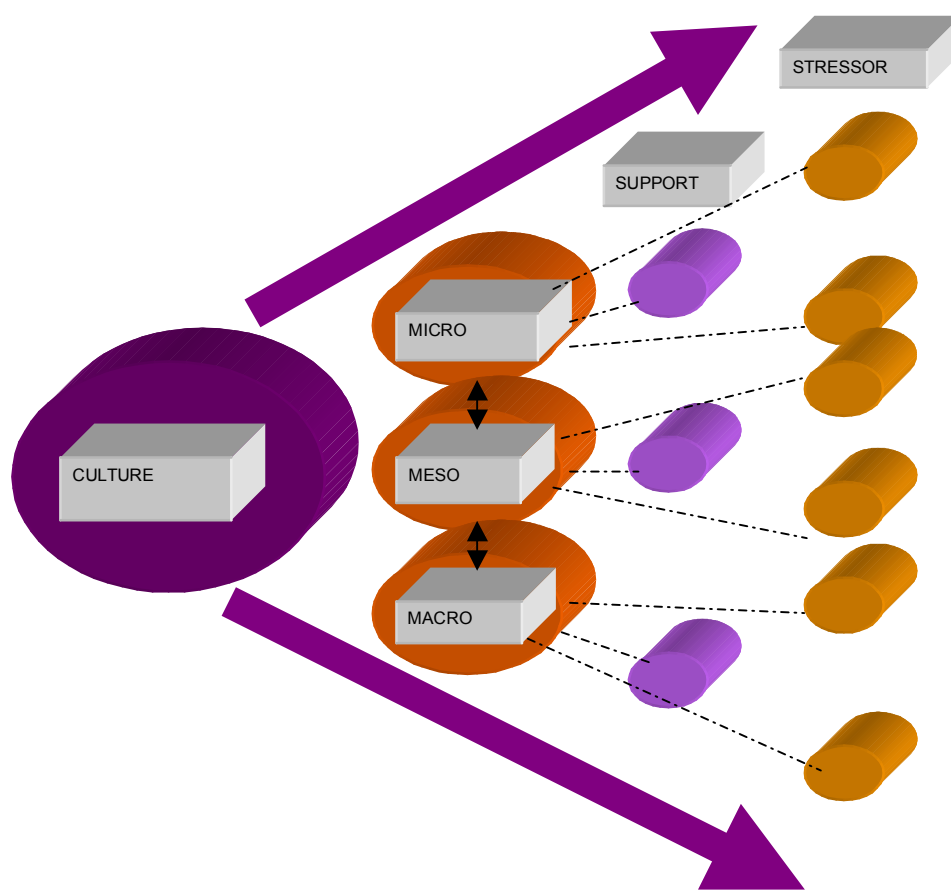


Figure 5.1 – Conceptual Map

5.2 Analysis of results

Important note for the reader

In considering the data from the **focus group transcripts and text answers in the UMMQ** for inclusion in the presentation of results, particular attention was paid to honouring the voices of the participants through accurate reproduction of their words. Therefore grammatical errors and individual idiosyncratic turns of phrase have not been changed. Repetitions and sentence fragments have in some cases been deleted in order to ensure reader accessibility, however only when nothing is lost from the meaning and content of the quote. Deletions and pauses in the text are denoted as follows: A quote from the focus group is denoted as follows: (UMM), and a quote taken from the UMMQ is denoted: (UMMQ-TQ).

5.2.1 Demographic Characteristics

The demographic characteristics of the participants are presented in Table 5.1 below:

DEMOGRAPHIC INFORMATION			
1. Age	Min = 16 yrs	Max = 20 yrs* [two over 18]	Average = 17.5 yrs
2. Country of Origin	Africa = 21	Eastern Europe = 2	Total = 23
3. Gender of child	Male = 12 (52.2%)	Female = 11 (47.8%)	Total = 23
4. Age of child	Min = 3 months	Max = 60 months	Average = 12.5 months
5. Number of children	One child = 22	Two children = 1 (only one child in Ireland)	Total = 24
6. Country of birth of child	Ireland = 20 (87.0%)	Nigeria = 2 (8.7%) Lesotho = 1 (4.3%)	Total = 23
7. Accommodation	Hostel = 13	Private rented, alone = 10	Private rented, with partner = 5
8. Income (child benefit universal)	Supplementary Welfare Allowance = 17	Unemployment Assistance = 5	Full-time work = 1
9. First language	English = 3	Other = 19 (missing data = 1)	Number of other languages = 16
10. Spoken English	Yes = 23	No = 0	Level = varies
11. Literacy	Read & write in English = 14	Read & write in own language = 12	Level = adequate – well
12. Completed Second Level School exams	Yes = 6 (26.1%)	No = 17 (73.9%)	Total = 23
13. Currently in any Education	No = 16 (69.6%)	Yes = 7 (30.4%)	Total = 23
14. Work	No = 20 (87.0%)	Voluntary = 2 (8.7%)	Full –time work = 1 (4.3%)
15. Legal Status	Refugee Status = 6	Awaiting decision = 17, as in box to the right:	(Includes S.11 interviews; Appeal hearings; TLR applications; IBC applications.)

* Indicates two mothers over the age of 18 years who due to a high level of vulnerability remained clients of the service.

Table 5.1 - Demographic characteristics of study participants (n=23)

Of particular note in the demographic information are the statistics relating to **educational level, literacy, employment, and current income**. (Note that this information was obtained from participants themselves - educational level and literacy were not independently verified). Almost 75% (n=17) of participants have not completed second level school exams; sixteen participants (69.6%) are not in current education; English is the first language for three (13%) of the twenty three participants; just over half (52%) the participants (n=12) are literate in their own language, with 61% (n=14) being literate in English; one participant is in full-time work; the remainder (n=22) are unemployed and in receipt of Social Welfare Allowance or Unemployment Assistance, depending on their legal status. Also of interest are the countries of origin of the participants as presented below.

Countries of Origin

Figure 5.2 presents, in visual format, the countries of origin of study participants. The majority (92%) are from Sub-Sahara Africa with the remainder (8%) from Eastern Europe.

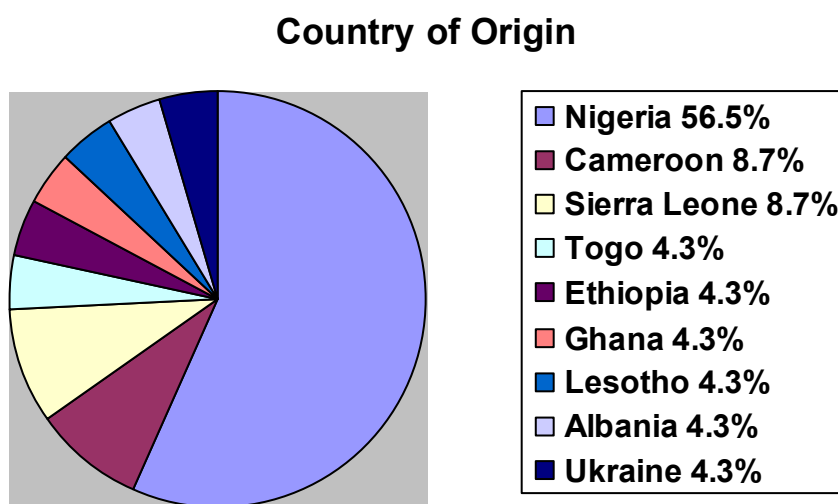


Figure 5.2 – Country of Origin of study participants

5.2.2 Culture

Summary

The information in relation to culture was drawn primarily from the results of the focus group. The members of the focus group (a total of six) were all from West Africa, therefore the observations made and opinions given relate to that particular cultural context.

Within the focus group, a number of topics relating to culture were discussed. Attitudes in country of origin were noted in relation to pregnancy; to “single mums”; and to abortion. The high level of support given to the new mother in the first three months was described, as were a number of traditional practices with both the mother and baby following the birth. Issues relating to childrearing and discipline were also discussed and the differences between Ireland and country of origin were noted in relation to discipline, childrearing practices, the level of support available and also religion. Belief systems in relation to health, in particular the attribution of blame for illness or death were also discussed. Observations were made by participants relating to the process of acculturation and also about their country of origin.

Results

The following observations on attitudes and practices in relation to women, pregnancy, birth, and parenting are derived from a content analysis of the focus group transcripts. As already noted the members of the focus group (a total of six) were all from West Africa, therefore the observations made and opinions given relate to that particular cultural context. This section provides both useful information and insights into some of the beliefs and practices within West African culture. The primary focus of the discussion on culture was on the participants sharing information about their cultures of origin rather than an explicit exploration of the stressful and supportive aspects of living in a different culture.

Responses to being pregnant were explored during the focus group and an atmosphere of secrecy was described in relation to the initial stages of pregnancy:

... you don't tell people until your bump is out... (UMM)

... I say that in my country if you are pregnant... one month... two months you don't want to tell anybody... that is Africa... (UMM)

Attitudes to mothers were explored, including attitudes towards mothers parenting alone. Negative reactions towards ‘single mums’ were described:

... everybody's just talking about her... and (she's) publicly humiliated even from her family...from her friends, everybody sees her as an outcast... (UMM)

... no... we don't accept, we don't accept single mums... you can't even call them single mums... (UMM)

Against this backdrop of negativity in relation to parenting alone in the country of origin, one respondent spoke about the 'shame' and 'rejection' experienced. The 'desperate' measures, including abortion, that were considered were also described:

...these girls are so desperate to get rid of this baby and they can't face the shame... and they can't face the rejection from the family... and the father of the baby that is supposed to be there for them has rejected them... and so they can't face anything... (UMM)

The **risks of abortion** and the concern of parents were discussed in that context:

... maybe she goes to a friend and she says ... you can take that and it will do a lot of good... and then she takes it...then she dies ...(UMM)

...some parents don't encourage abortion because in some cases the abortions are 'quacks'... (UMM)

... the best way to do it is to look for something, a remedy, anything can serve a purpose... she does not want to know 'will I die of it' or anything... (UMM)

On the contrary **attitudes to women who gave birth within marriage** were reported by respondents as being very positive and the event of birth in fact represented a significant improvement in their status as described by the following participants:

...the period that the woman has the baby is the best moment of her life...like I mean in Nigeria or maybe other African culture... the woman might be treated like a shit or anything... but the moment that she has a baby...is the best moment of her life...(UMM)

... that's the time the husband will appreciate her...people around her will appreciate her...they really show it to her that you've done so well...from the food and the way she is being cared for...being pampered...(UMM)

A **high level of support** for the mother was described both at the time of birth and after the birth, particularly in the first three months. The support is provided by the mother of the new mother, or other older women from within the family or the community who are experienced in childbirth and childcare, as described in the following:

...so what they do is to arrange for the mum or whoever is an elderly person who has had the experience of childcare to come down to my home until the baby is born...you know to be ready so that I would not lack anything...so that it would not be a big shock or anything ...so this person would be handy...would be right there...waiting for me to have the baby...and in some cases whereby the person

was unable to make it on time...then maybe a neighbour who has had a baby would come in like assisting me to go to the hospital and then being with me to have the baby...and then bring me back home...(UMM)

...all she has to do is feed the baby and then give the baby back to the mum...you know and goes to rest...the mum is there to make the dinner and take care of other work and then wash the baby ...and even give her a bath, and give her a massage ... (UMM)

The **mother of the new mother** clearly plays a central role in terms of both practical care and support, and in the event of her not being available, the extended family or community take on the supporting role:

...extended family like your father's brother...your mum's sister...your grandmother... (UMM)

... even if mum is not there a relative from the family or a neighbour can do that for her as well... (UMM)

A number of **specific practices after the arrival of the baby**, in relation to both the mother and the child were described. One respondent described a 'special kind of food' that is prepared for the mother and is believed to be beneficial:

... they cook a very special kind of food... that the woman will eat... they will add in some spices... they believe it kind of flushes out the system...and makes the woman's uterus to go back to its normal size...and heal quickly...(UMM)

And for the baby, there is a ritual which is different according to the religion of the child:

... (for Christians)...they can be baptised or maybe a christening... in Muslim they ...have to sear the child...most people have mark... (UMM)

A **'bath' or 'massage'** given to the baby shortly after birth was graphically described. The reasoning behind giving the massage was described by one of the young mother's as follows:

...a dramatic way of giving the baby a bath...because they believe that the baby is 'squash' in the womb and like that in the womb and so they need to straighten all the parts of the babies body...you know like massage the head and the bones to straighten them...when I was having my baby he came out with a bump ...I was so afraid to massage the head...but back home they usually massage the head...at least make sure that the heads are equal...so they would not have one side higher than the other one ...and the bones as well would not be straight so they have to do a lot of massage...(UMM)

According to one of the respondents, the person who gives this message should be experienced:

...and so you need a more experienced hand to do that...not just anybody you know... (UMM)

The issue of **childrearing** was discussed and in particular the values, attitudes and principles that the mothers wanted to impart to their children. **Respect** for parents and older people was a recurring theme in the discussion:

... an African child he has to be very respectful... (UMM)

...a kid needs a discipline... and I am going to give that to my daughter. I love her so much... it's not a wicked thing...we call it a principle...she has to follow that as I am her mother... (UMM)

...you have to give respect to an elderly person, you know... (UMM)

Discipline was also discussed:

...spare the rod and spoil the child, that is the way African view of it ..., if my child get up now and say to any person 'shut up' ... listen I am going to smack the child and say it is not right to say 'shut up'. I won't condone it; I won't laugh about it... (UMM)

One respondent related the need for discipline to prevention of later problem behaviour:

...I don't want my daughter to be on the streets and lighting fire to people's cars... (UMM)

Further observations were made of the **differences in terms of practices and behaviour between Ireland and country of origin**, with references to:

'bathing a baby'

...the system of our bath here is totally (different)...compared to back home and here... (UMM)

'social etiquette'

...when I first came I found it very hard to address people by their names because back home we were not allowed to do that... (UMM)

...that I find really really hard and even up to this moment I find it very hard to go to someone and say 'oh you know...'scream out somebody's name... (UMM)

and 'discipline'

...one of Irish lady came and said... 'no no no you are not allowed to smack' ...and she was like 'oh my god' and I...complained and I said no I don't think its fair ... (UMM)

Belief systems in Africa in relation to health were discussed and in particular the concept of attribution of blame for the illness. Examples were given by the focus group participants as follows:

...like if someone died today even if a natural death, they will attribute and say 'because of this and that' ... (UMM)

...if anything happen to your child, for instance, maybe a disease or whatever...but they have to say that the kid died by something... (UMM)

One of the participants gave the example of a women she knew in Ireland whose twins had died before birth, in terms of the explanation that would be offered in her own country to explain the deaths:

...if that had happened in Africa... they would say its maybe is someone killed the twins...you know they would never take that it could happen...nobody would take it as 'oh its natural' they would say...oh...it must be that uncle that killed those twins you know...(UMM)

Belief in 'black magic' and 'witchcraft' and 'cults' was referred to by one of the participants:

...and you know like we believe in black magic and witchcraft and all sorts of things like that...its actually happening...like where I come from we generally have this belief in my state that there are certain families or certain people that turn into animals....its real...because I have seen ...I have witnessed one occasion whereby this woman definitely changed into half human and half animal...half lion... (UMM)

And the anxieties associated with these, in relation to a new born baby:

...and so like they are always like coming to say like... please don't let this person see this baby because they might ...you know... kind of initiate the baby to part of them... to be like the animal... (UMM)

Religion was discussed primarily in relation to the differences between Ireland and the country of origin.

One participant remarked on the difficulties encountered in accessing pastors in her country of origin when money was not available:

... if you don't have money to you...you do not see the pastors...no its true...yeah...if you don't have money you will not be so close to them...they will not pray for you...(UMM)

However her experience was different in Ireland:

...here even just walk by to any Catholic church and explain your feelings to any priest... (UMM)

Another participant reported a friend's difficulty in locating a church in Dublin where her child could be baptised:

...so that she wants to get her child baptised...the priest said that they are not a member of that church...and can't be baptised and has to go to (another church)... (UMM)

Some **negativity** was expressed on relation to aspects of their country of origin. Within the discussion about religion one participant declared, in relation to traditional religion in her country:

...nothing good about it...they are idol worshipper...they don't believe in Christians... (UMM)

Another respondent expressed **negative attitudes about her country of origin**:

...I am from (country of origin)...there is nothing good about (country of origin)... (UMM)

The process of **acculturation** (i.e. the psychological adjustments and adaptations made when moving from one culture to another) was not widely discussed, however a number of related references were made to the process.

One heartfelt comment captures the sense of distance from country of origin:

...my god it is really really a long way from home... (UMM)

Another respondent makes a more direct observation of her own psychological adjustment:

...like I am nearly a year now so I think my own view of everything now is beginning to change... (UMM)

A particular challenge for a parent living in a different culture to that of his/her culture of origin is to make decisions in relation to **impacting their culture** to their children. One respondent describes her intention:

*...but all the same the culture that I bring to my son is to be respectful... and then I will teach him the different cultures, languages and the history of Nigeria. .. I will let my son understand where he came from and this is what your country is like...
(UMM)*

The stressful aspects of these experiences of acculturation and rearing a child in a different culture were not explicitly raised or discussed within the focus Group, however it cannot be therefore be assumed that there was no stress involved. Similarly the issue of racism as a stressor was not raised, however neither can this be therefore discounted. Both of these issues require more explicit exploration.

5.2.3 Micro level

Summary

The micro level as defined by Bronfenbrenner (1979) includes the roles and characteristics of the individual. In this section some of **the psychological characteristics** of the participants are described together with their experiences of the **parenting role**, drawing particular attention to what they articulate as either stressful or supportive. The issue of **gender specific trauma** is noted in relation to the results of the HTQ (adapted by the authors of this research for use with the study population).

The results are drawn from the following standardised instruments:

- (1) Parenting Stress Index– Short Form (PSI-SF) (Abidin, 1983)
 - (2) General Health Questionnaire –12 (GHQ-12) (Goldberg and Williams, 1988)
 - (3) Harvard Trauma Questionnaire (adapted) (HTQ – a) (Mollica et al, 1992)
- and also from the transcripts of the Focus Group (FG).

Results

(1) The Parenting Stress Index– Short Form

The following subscores were computed by hand, following the standard scoring system:

- (a) **Parental Distress score** which determines the distress the parent is experiencing as a function of personal factors in his or her role as parent.
- (b) **Parent-child Dysfunctional Interaction score** which determines distress within the parent-child relationship.
- (c) **Difficult child score** determines the perception of his/her child by the parent.
- (d) **Total score** which determines the total score for parental distress.
- (e) **Defensive score** which determines the level of bias in the responses.

The scores need to be considered in conjunction and interpreted for each individual profile. For the purposes of this study, any score close to, at or above the 90th percentile was considered high and noted as such. (See section on Ethics for procedures taken in the event of concern for the well-being of mother or child) The table below presents the numbers and percentages for such scores. The Defensive scores showed no evidence of bias and so have not been included in the table.

Name of PSI-SF Subscore	Number	Percentage
Parental distress	15	74%
Parent-child dysfunctional interaction	2	9%
Difficult child	2	9%
Total score	7	33%

(Two incomplete data sets were not included)

Table 5.2 - Results of the Parenting Stress Index – Short Form (n = 21)

Just under a third of participants had a high 'total' score in parental distress. Of particular note is the overall percentage (74 %) of participants with a high 'Parental distress' score together with the low percentage of participants with high 'Parent-child dysfunctional interaction' score (9 %) and 'Difficult child' score (9 %). A closer examination of the scores reveals that of the fifteen participants who had a high 'Parental distress' score, four had high scores in the two other areas i.e. two with a high 'Difficult child' score and another two with a high 'Parent-child dysfunctional interaction' score. This suggests that for over two thirds of those who had high parental distress scores, the primary sources of stress relate to personal factors of the mother herself rather than problems in the parent-child relationship or the experience of her child as being difficult.

Data from the focus group further suggests that the young mother's experience of their children is primarily positive rather than negative - as evidenced in the following comments:

...the baby makes you laugh...and all the time...I play with her... (UMM)

... I just look at my baby and I just feel happy... (UMM)

...when you look at a child it brings joy... (UMM)

(2) The General Health Questionnaire-12

Scores were computed by hand following the Likert scoring system. The scores were then divided into two sets using a cut-off score of 17 as the reference point. High scores were determined as those of 17 and above, with low scores determined as those of 16 and below. The range of the scores is from 5 to 29. The table below presents the numbers and percentages in each category.

N=23(no missing data)	NUMBER	PERCENTAGE
HIGH SCORE	8	34%
LOW SCORE	15	66%

Table 5.3 – Results of the General Health Questionnaire – 12 (n=23)

These results indicate that just over a third of this group have a high score, with two thirds having a low score, as determined above.

Combined analysis of the PSI-SF and the GHQ-12

A closer examination of the data revealed that a total of six respondents had both a high score for the PSI-SF total score (i.e. close to, at or above the 90th percentile) and a high score for the GHQ-12 (i.e. a score of 17 or over). While the remaining two with a high score for the GHQ-12 did not have a high Total PSI-SF score, they did score in the high range for Parental distress. This result is not altogether surprising since each of these scores claim to measure either general or specific psychological distress. The consistency of these results lends support to the decision to use these instruments with this population. Table 5.4 below presents some of the characteristics of the subgroup of six.

Legal status	Living with partner	Accommodation	Level of support	Traumatic events	Health issues mother
Awaiting decision	Yes	Private rented	3	9	Yes
Refuge status	Yes	Private rented	5	10	Yes
Awaiting decision	Yes	Private rented	11	6	Yes
Awaiting decision	No	Hostel	8	4	Yes
Awaiting decision	No	Hostel	4	6	Yes
Refugee Status	No	Mother & baby home	7	10	Yes

Table 5.4 - Characteristics of high scorers in PSI-SF and GHQ-12 (n=6)

A number of observations can be made about the characteristics of this group as follows: three quarters (n=4) are awaiting a decision about the future of their legal status; half the group (n=3) experienced above the average number of traumatic events for the study group as a whole and the level of perceived support appears low for half of the group (n=3). A consistent theme for each however is the experience of **personal health problems** as defined by participants themselves. An examination of the other seventeen participants' responses indicated that two noted health problems for themselves. Unfortunately the size of this subgroup is considered too small for further statistical analysis.

(3) The Harvard Trauma Questionnaire -adapted

A summary of the most commonly traumatic events experienced is presented in the following Table (5.5). The number of traumatic events experienced by the study participants is presented in the subsequent Table (5.6).

TRAUMATIC EVENT	NUMBER	PERCENTAGE
1. RAPE	12	52%
2. OTHER FORCED SEPARATION FROM FAMILY	12	52%
3.EARLY SERARATION FROM PARENTS/CAREGIVERS*	10	43%
4. EARLY TRAUMATIC HISTORY *	9	39%
5.FORCED TO HIDE	9	39%
6.FORCED EVACUATION UNDER DANGEROUS CIRCUMSTANCES	6	26%
7. TRAUMATIC CIRCUMCISION * /THREAT OF	6	26%
8. FORCED MARRIAGE*	6	26%
9.EARLY SEXUAL ASSAULT *	5	21%
10.ENFORCED ISOLATION FROM OTHERS	5	21%
11.BEATING TO BODY	5	21%
12. OTHER TYPES OF SEXUAL ABUSE/SEXUAL HUMILIATION	4	17%

The five items marked with an asterix * are items included by the authors of this study.

Table 5.5 - Range of Traumatic events experienced (n=23)

Number of traumatic events

Because the HTQ- adapted was completed via content analysis of the participant's file rather than by self report, it is possible that the results presented in table 5.6 below are in fact an under-estimate of the actual extent of trauma experienced.

These results indicate that each participant has experienced at least one significant traumatic event, and that 68% of participants experienced between four and twelve traumatic events.

Of particular note is the incidence of sexual assault including early history experience of rape and sexual abuse/humiliation. Of further note is the incidence of gender specific abuse i.e. in this instance forced circumcision (or threat of) and forced marriage.

While these experiences were neither discussed in the Focus Group nor explored in the UMMQ, it can be reasonably assumed that these experiences were psychologically stressful to a greater or lesser degree for each individual.

No. of Trauma	No. of respondents	Percentage
1	1	4.3%
2	4	17.4%
4	4	17.4%
5	2	8.7%
6	2	8.7%
7	4	17.4%
9	3	13.0%
10	1	4.3%
11	1	4.3%
12	1	4.3%

Table 5.6 - Number of Traumatic Events

(4) Health problems of mother and baby

Over 34% (n=8) of mothers reported that they themselves had experienced serious illness since the birth of their baby, and a further 30% (n=7) of babies were reported to have experienced serious illness. Although the details of the illnesses were not noted it can be safely assumed that these health problems represent a significant stressor.

(5) Role as mother

From these accounts of their joys, their pride, together with an acknowledgement of the difficult aspects of their role as parents, some of the meaning of their child for these mothers is eloquently articulated.

Respondents discussed their experience of motherhood - both the rewards and the positive emotions that were associated for them with being a mother:

...just I just look at my baby and I just feel happy... (UMM)

...I am a mother as well now...so I think it is a good experience... (UMM)

...a lot of meaning when a first time mum...am very glad to have had a girl...very delighted... you feel excited... (UMM)

A number of participants acknowledged that there were also difficulties associated with being a parent:

*...I think it is very good to be a mother for me, though life is just a compromise
(UMM)*

*...there is a lot of thing that I've missed... like I wish that I could be at home
having my child... (UMM)*

*...I mean motherhood could be rewarding and at the same time it could be very
difficult... (UMM)*

One respondent spoke of the important **role of her baby** in the context of the absence of her own family:

*...and for most of us that don't have families that are here...we see the baby as a
major part of our family now... (UMM)*

Another respondent described her **personal pride** in her role and status as a mother, particularly given the difficulties she had encountered and overcome:

*...I am very glad I am a mother... now I am very proud of myself and I see myself
like if I see those mothers with the kids I can say I can be like you ...we are like the
same level...(UMM)*

While difficulties were not ignored in this discussion of motherhood and the role of their child in their lives, it is evident that the predominant tone is positive. It is apparent that for these focus group participants having a child and being a mother is more a positive experience than a negative one. This finding is supported by the results of the PSI-SF which suggested that the parent – child relationship was not, for most of the respondents, considered stressful.

5.2.4 Meso system

Summary

In line with the ‘conceptual map’ (Figure 5.1) this section presents the data from the study pertaining to the Meso Level, focusing on the supportive and stressful functions of each area. To begin this presentation, the construct of ‘support’ is operationalised. This has been done in two ways. The first way was through an analysis of the results of the UMMQ where the young mothers identified the presence or absence of support in four key areas: **practical support; advice/information about care for the baby; emotional support; childcare** and also identified the **source of these supports** (e.g. friend, professional etc). The second part of the data presented is drawn from the young mother's narrated experiences regarding stressors and supports in the focus group. From this data ‘support’ includes: friends; professionals; specific services and income; and ‘stressor’ includes: isolation; income; professionals; services; accommodation and education.

This section concludes with the results of what the young mothers considered to be the most important areas of support that they need in caring for their baby.

Concept of ‘support’

In order to understand ‘support’ as it relates to this group of young mothers, a specific question was asked in the focus group in order to gain a working definition of the **concept** from the group participants. The following comments illustrate two key concepts that were highlighted through this discussion. Firstly, one mother provided a definition regarding how she constructs support:

...like my own (definition of) support is like a Mother... (UMM)

This was then elaborated by another participant who stated:

...yeah and encourage us, in any life you need encouragement... (UMM)

Further, in relation to levels of support as a young mother, another participant noted:

...and I think we actually need more support... as a single mum, you really need support and understanding... (UMM)

5.2.4.1 Meso level - SUPPORTS

Sources of support

Section 10 in the UMMQ specifically sought to identify the locus of support for the young mothers in four key areas - practical support: childcare; advice/information and emotional support. For the purpose of analysis **the sources of support** can be categorised into two groups – the first being formal professional workers and organised services and the second being informal support sources. If structured supports include the Project or Social Worker; the Public Health Nurse; Hospital staff; Crèche; Community Volunteer, and Place of Worship, then by deduction informal

support sources are: partner; friend, and another mother. Once this distinction has been drawn, it becomes evident that the locus of the vast majority of support is from the formal/organised/professional realm. A further observation is that if the source of support being drawn from the partner (n=5) was taken out of the equation for the remaining young mothers (n=18), then the distinction as noted is further accentuated.

The following Table (5.7) provides a visual description and summary of sources and areas of support:

Source of Support	Practical	Baby advice/info	Emotional	Childcare	Total
Project/Social Worker	6	9	12		27
Friend	7	6	8	14	25
Partner	6		6	5	17
Public Health Nurse	5	12			
Another Mother		7	4		11
Place of Worship	3		6		9
Hospital Staff		4			4
Crèche				2	2
Community Volunteer				2	2

Table 5.7 - Sources and areas of Support

(1) Friends, Other Mothers and Partners as support

Friends as the locus of support consistently rated as a high factor, and was indeed the only source of support present in the results spanning the four areas (Table 5.7). The UMMQ text answers (UMMQ-TQ) from Section 10 provided further information about the level and type of support received:

Had a little help with friend, mostly on my own - (UMMQ -TQ)

Friends when I was in the hostel, but not now - (UMMQ -TQ)

I call my friends for advice - (UMMQ -TQ)

friends in the hostel helped out with shopping - (UMMQ -TQ)

Since over half (56%) of the young mothers share accommodation directly with other young mothers, it can be inferred from the above data that the categories of ‘friend’ might also include a proportion of **other young mothers** in similar circumstance. The focus group narrative also revealed some of the difficulties that one young mother

found in accessing support from friends or other mothers, feeling that at times she might be placing undue demands on them:

...everyone is their own position, you have to ask 'please could you please come and help me do this'... because I know she has a family... I don't want to intrude in her own family ... (UMM)

In the following passage the same participant notes that while support is available, it is not consistently so, and therefore:

... you have to learn to stay on your own... and you have to then think and pass information on the phone... but for someone to come... to come and sit with you... she would not be able to give you that time ... (UMM)

Partners as a locus of support for the young mother need to be analysed on a number of levels. A total 21% (n=5) of the young mothers reported that they lived with their partner/boyfriend/husband (herein referred to as 'partners'). However, just over 30% (n=7) of respondents indicated that they had a partner so it can be inferred that two of the young mothers with partners were not living with him. The age range of the partners was from 17 – 29 years, with the mean at 21 years, in contrast to the mean age of the females as 17.5 years. Over 95% (n=6) of the partners came from Africa with one from Eastern Europe. It was beyond the remit of this study to investigate the duration of these relationships, whether the relationship commenced in Ireland or their country of origin, or indeed if the partner was the father of the child. Despite these limitations, the results indicate that young women receive practical, emotional and childcare support from their partners.

(2) Professional support

The results clearly indicate a significant number of formal and professional supports accessed by the young mothers. The results demonstrate that access to these supports is active and appropriate, for instance the **Public Health Nurse** scoring highly as the main source of support for advice regarding caring for the baby. In three out of four categories the **Project or Social Worker** (SCSA -ECAHB) were named as a source of support – the most significant of these in the role of providing emotional support for the young mother. One of the participants of the focus group indicated that the receipt of this support is viewed as active rather than passive as follows:

...because if you don't know where to go... it has to be somewhere and you have to stop by somewhere... like for instance if you provide a social worker... that's helping them... and we are saying we have to help ourselves as well... we shouldn't ignore that. But once the social worker is involved... and tells you where to go... and then you go there... and then you get more information there and so on... and then you move on... (UMM)

Another focus group participant described what she considered a 'supportive' professional to be and gave some examples:

...and I think that the social worker should be someone very ready to help...because I met social workers so far and I will never forget them.... (Name), she's Australian...and (CWO name)... she's Irishthose people... they are very good and they are ready to help... and sometime even they don't want to know 'why did you come to Ireland?...' they will never ask you...because sometime 'why did you come to Ireland' is (an) impossible question...some Social... they don't even want to know... they want to help you because they found you here with the problem that they want to help... they don't want to know your past... they just want to move on... (UMM)

The following from another participant further explains what is experienced as supportive:

...at the moment I would say we all think here the work you (social worker) are doing is very good... giving us the social workers to work with us... and at least to know where to go and what to do... what you are entitled to... someone to really guide you... because for me I'm totally nervous in every aspect... But each time I ring up (name)... to ask her 'oh what will I do'... and she tells me what to do... or sometimes she can even do it for me... I think that has been a very, very helpful thing ...and in a most supportive way for all of us young girls and single mum... (UMM)

The **GP, PHN, and maternity hospital staff** consistently emerge both in the UMMQ questionnaire data and in the focus group transcripts as the professionals who, for the study participants, provide advice about how to care for their baby.

A further point was made by number of young mothers who spoke of wanting a '**guide**' or a **mentor** to assist them in their role as parents. By definition, the participants in this study are without family members with only a minority who report being with a partner in Ireland. It is not therefore surprising that the need for '**someone to really guide you**' as in the above quote, was a theme that was often repeated in the focus group.

Results from the UMMQ also point to the need of the UMM's for 'someone to ask questions/get advice' with sixteen of the twenty three mothers noting the need for this type of support.

(3) Place of Worship as support

The results from the UMMQ indicate that for the young mothers their place of worship is seen as a location of both **practical and emotional support** and also a place where one participant describes feeling :

...safe, yeah, very safe... (UMM)

In describing the emotional support provided one participant said:

...they pray for you... they take care for you... they talk to you ...if you are down they advise you and give you your spirit back... (UMM)

She also noted differences between churches in her country of origin and Ireland in relation to payment for services:

...in Africa if you don't have money to you, you do not see the pastors... if you don't have money you will not be so close to them... they will not pray for you... but here you can even just walk by to any Catholic church and explain your feelings to any Priest... (UMM)

Similarly, another participant noted that:

...So if I said that I want to be baptised ...or that I want to go for catechism... where in Nigeria in a situation like that ...you have to use money to book an appointment to see the pastor or an evangelist... but here is different... back home it was about financial... (UMM)

(4) Services as support

As noted earlier in this section, the results of the UMMQ indicate that the locus of many of the supports for the young mothers is in the community service arena. In this category the young mothers speak of experiences that they have had with **services specifically targeted at young mothers**, and also with **services that support asylum seeking / refugee communities**. A small number of the respondents in this study had been accommodated in facilities designed to provide extra support for Irish single mothers. The following comment is from a young mother, who had been initially accommodated in one such facility, describing it as a very positive experience:

...I would say for me when I had my baby... I was moved into Eglington house... It's a home for single mums and their babies... so that made life a bit easier for me ...because when my baby came I was so scared... very afraid... but when I moved there luckily the majority of them had been marvellous...so it was a very good experience for me... (UMM)

A range of other organisations were also specifically named by participants as providing much needed support. Services such as the Vincentian Refugee Centre; Catherine McCauley Centre; Cherish (now One Family); Focus

Ireland and Barnardo's were noted in the text answers of the UMMQ as providing both practical and emotional support. Similarly, in the focus group a number of the young mothers confirmed these noted supports and one participant elaborated as follows:

...I think as well she mention Cherish (One Family)... and also I've been to the Catherine McCauley (centre) just down the road... well I wouldn't have known the place if not my social worker (name)... so she took me there... so I think these are the kind of things that your team should look into... (UMM)

She also specifically mentioned and clearly welcomed the educational opportunities offered:

... because back home I've never done computer before and I never went close to computer screen... I was so frightened... but the way she took me there... and with the kind of support I got there... I was able to do courses and was able to write a few exams on computers which was very helpful... So I think if we can be introduced to this sort of organisation... (UMM)

As noted previously, an underlying tone in the voices of the participants clearly indicate they want to be **active** in seeking out, forming support networks and problem solving for themselves, as in the following quote from one participant:

...you know there are a lot of organisations that they provide in Ireland but we don't know... And if someone say... there is something here...and you go there... and then from there you get something... they say... oh there is something else... and you go there and you go there and you find yourself... your problem will be solved...that's the way... (UMM)

(5) Health Services

A key finding from this study from question 15 in the UMMQ related to accessing health services. The table below presents the findings that, from the perspective of the participants, a majority (87%) do not find it difficult to **access health services** for either themselves or their baby. This is a positive finding as 34% (n=8) of mothers reported they themselves had experienced serious illness since the birth of their baby, and a further 33% (n=7) of babies were reported to have experienced serious illness and therefore frequent access to health services would have been necessary. One respondent gave her opinion in the text answers of the UMMQ:

No problem, the staff in the hospital and GP are very nice - (UMMQ -TQ)

Difficulties in access	Number	Percent
No	20	87%
Yes	3	13%

Table 5.8 - Accessing Health Services

The text answers in the UMMQ questionnaire provide some of the reasons why the remaining 13% of participants find **access difficult**. Lack of information and distance from the GP were both cited as reasons, as follows:

My GP used to be far away ...and that was difficult if my baby was very sick - (UMMQ -TQ)

My baby was crying before during the night and I did not know what to do...so I waited until the morning and because she was not better I went to the GP - (UMMQ -TQ)

I did not know a hospital is open at night ...or how to call an ambulance - (UMMQ -TQ)

Have to travel to doctor and dentist (UMMQ -TQ)

GP full in new area and require too much documentation... so I travel to my old GP - (UMMQ -TQ)

When the issue of health services and access to same was discussed in the focus group it became clear that the young mothers perceive that the **quality of service** that they have received has been high compared to their country of origin. One participant noted as follows:

...when I had my baby here... I had my baby like a millionaire... like someone who is very very wealthy back in my country...the kind of attention I had here... I don't think anybody would have that... I mean any class... very top or middle class would have that in my country... (UMM)

(6) Accommodation

At the time that this research was initially considered one of the significant stressors for young mothers was the lack of **suitable accommodation** and researchers therefore anticipated a high level of dissatisfaction to be reported. However by the time the UMMQ were being distributed and administered, significant positive changes had already occurred in relation to the vast majority of ECAHB provided accommodation. For UMMS in particular, appropriate self-contained accommodation had been identified for their use and a number had secured private rented accommodation.

Section 16 of the UMMQ explores the type and suitability of the accommodation that the young mothers were in at that stage. The breakdown of accommodation type is as follows: 52% (n = 12) of young mothers lived in ECAHB self catering, hostel type accommodation; 39% (n = 9) lived in the private rented sector; with 1 respondent (4.3%) living in supported mother and baby accommodation. Table (5.9) presents the data regarding their perceptions in

relation to the suitability of their accommodation. An overwhelming majority i.e. 82.6 % (n = 19) reported that their accommodation was either 'very suitable', or 'suitable' and only 17.4 % (n= 4) described the accommodation as 'not at all suitable'.

	Frequency	Percent	Valid Percent
Very suitable	9	39.1	39.1
Suitable	10	43.5	43.5
Not at all suitable	4	17.4	17.4

Table 5.9 -Suitability of accommodation

In the UMMQ questionnaire the respondents were also asked to describe **why** they found their accommodation suitable or unsuitable. The reasons for **suitability** included having space, private toilet facilities, own cooking facilities and having a garden. The following quotes are taken directly from the UMMQ text answers:

The hostel is very comfortable to me and my baby compared to (previous hostel) where I lived before - (UMMQ -TQ)

Not a lot of people, place where she (child) is free - (UMMQ -TQ)

Suitable for children, lots of room, back garden, safe (UMMQ -TQ)

No disturbance, able to sleep, toilet good – very good having my own toilet - (UMMQ -TQ)

I can cook for myself - (UMMQ -TQ)

Not having to share a bathroom and only having to share the kitchen with one other - (UMMQ -TQ)

Size and cleanliness - (UMMQ -TQ)

Reasons for **unsuitability** of accommodation included not having own space or space for their baby and having to share kitchen facilities. The following quotes are also taken directly from the UMMQ text answers:

Because I am sharing with lots of people - (UMMQ -TQ)

No cross ventilation, too many people sometimes at the kitchen struggling to cook at the same time with a baby is murder - (UMMQ -TQ)

Need a house environment with own kitchen and room for baby - It is unsuitable because its very small, sitting room is downstairs, bedroom is single room, no space for the baby to crawl - (UMMQ -TQ)

The UMMQ further asked the respondents to indicate their preferred type and location of accommodation. Table 5.9 presents the preferred type of accommodation. The majority (n = 22) indicated a preference for living in a flat or

house, either with or without a partner. In relation to location, over 47% (n = 11) of the respondents indicated that they would prefer to live 'near the city', with a further 34% (n = 8) indicating that they would prefer to live in the 'area they live now'.

	Preference
Living alone in a flat/house with your baby	12
Living with partner in a flat/house with your baby	10
Sharing a house/flat with another mother	1
Hostel	1
Mother and Baby Home	1
Other, Please specify	1

Table 5.10 – Preferred type of accommodation

Support needs

The UMMQ directly asked respondents the type of support they would like in 'looking after your baby'. Figure 5.3 presents the results. The most frequently marked support option was 'Information on legal rights and entitlements' followed closely by 'Someone to ask questions /get advice' and 'Playgroup for child and mother'. Meeting mums - older/from own/any country' as well as getting 'Information about caring for baby' and about 'own health' were also popular as forms of support that would be welcomed.

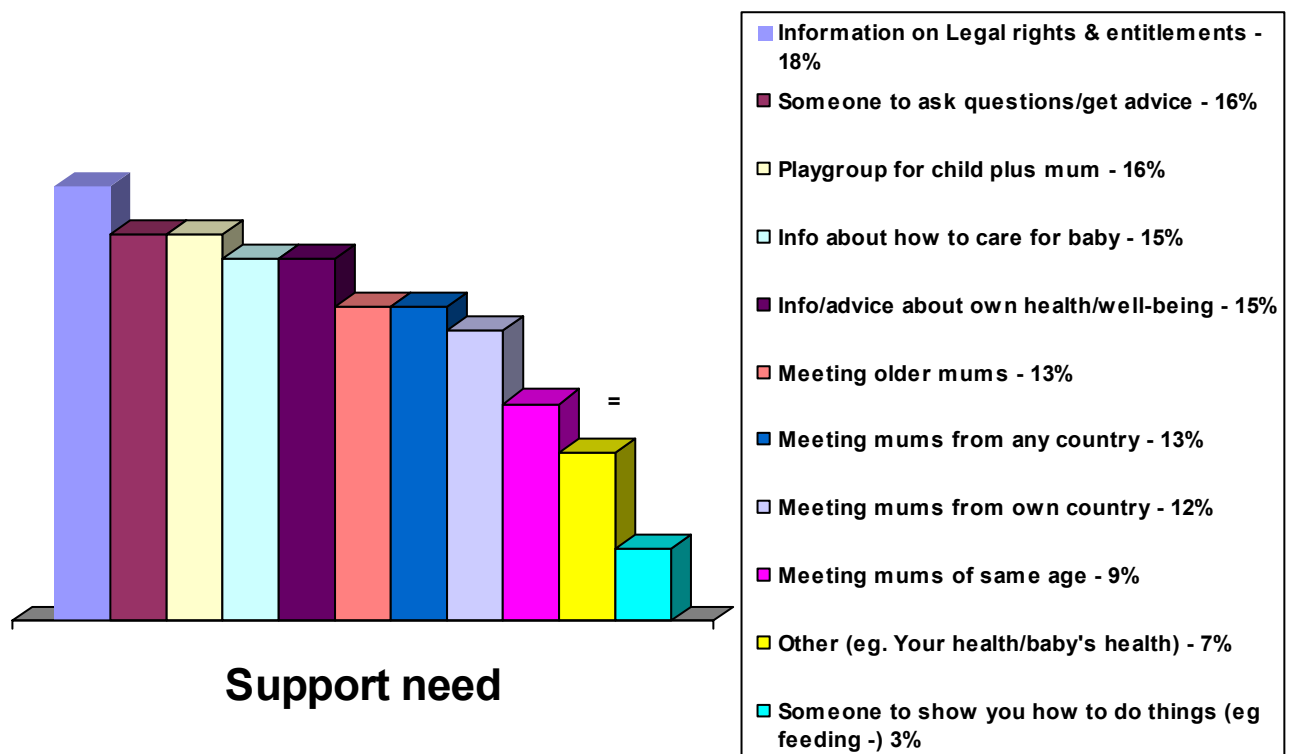


Figure 5.3 -Desired type of support in 'looking after your baby'

5.2.4.2 Meso Level - STRESSORS

(1) Absence of Family and Social Isolation

As hypothesised, the **absence of family and community of origin** together with the consequent lack of access to cultural practices and **social isolation** proved to be significant stressors for the respondents. Results from the UMMQ indicated that social isolation in particular is a very real experience for the young mothers as evidenced by quotes such as the following:

I did all the work myself - (UMMQ -TQ)

I am always with my baby, I have no access to somewhere - (UMMQ -TQ)

I have nobody - (UMMQ -TQ)

This issue also emerged in the focus group when participants were asked to describe stressful or difficult experiences that they had had in Ireland as a young mother. The **absence of one's own mother** and one's home at the time of becoming a mother was described by one participant:

...then I missed home very very much... and I missed my mum... that was a particular time in my life that I know that I needed my mum - more than anything in my life... because I had to view back what my mum used to do to other young women back home...and what other women would do to other young mothers... especially the no nights sleep at all... and then it was really really miserable... and then I missed home very very much ...and I missed my mum....(UMM)

Another significant issue that was reported in the focus group was **limited levels of support** the young mother experienced in Ireland compared to in her country of origin. One participant explained as follows:

...because back home usually when a woman has a baby ...more especially the first time mum ... so what they do is to arrange for the mum... or whoever is an elderly person who has had the experience of childcare... to come down to my home until the baby is born...you know to be ready ...so that I would not lack anything... so that it would not be a big shock or anything... (UMM)

And another elaborated:

... the woman has to stay in at least three months... in the house... to be nursed for three months by the other mums... by her husband... by every other person... three good months she would not see apart from the door... she would not see the outside until the baby was at least three months... (UMM)

The unavailability of this level and type of support and the accompanying cultural ritual was discussed in the focus group and described by participants as stressful. The following quote captures this clearly:

...the distress you know... being a mother and being so far from home... that stress is there... (UMM)

The well meaning advice offered by professionals and/or members of the community can serve to further isolate the young mother from her own cultural practices when that advice is contrary to her cultural experience, as the quote from the following participant describes:

...and like I found it very hard when I came back from the hospital... It's like 'you go for a walk now' ... that was it ... go for a walk!... (UMM)

To go for a walk a few days after the birth of her baby was clearly contrary to her cultural expectation of staying indoors for three months after the birth as described in an earlier quote.

(2) Professional services as stressors

Whilst it has been noted at the beginning of this section that the locus for the vast majority of support is drawn from the professional or community service sector, these supports were also described by the participants as at times being stressors. This is particularly relevant to services where the participants are not voluntary clients, but rather are obliged to rely on them for needs such as income or accommodation. The focus group specifically sought to ask the participants what professionals/ services could do in order to enhance support and reduce stress. The first group of professionals that the young mothers commented on were the **social work team** (SCSA -ECAHB) and the following suggestion was made with regard to practice:

...so if the social worker would not be very, very nosy ... because when the social worker becomes so nosy... it makes the person very uncomfortable... (UMM)

Another suggestion was made in relation to having an allocated social worker:

...not everybody have their own (social worker)... like some people don't have their own individual social workers ...so you are very reluctant to call in... you don't know who to talk to...so... for people that don't know who their socials are... maybe they (should) have a commitment... if you want anything to discuss with me you can ring me.... (UMM)

The second group of service providers that the UMMs interact with on a regular basis are their **Community Welfare Officers** (CWO) primarily in relation to their financial needs. One focus group participant reported both positive and negative encounters with CWOs:

... In the first place I lived the community welfare officer was very good ...and then I moved down to this place... and its really horrible now... because this was the first person I met when I came here... it seems like money comes from their own pockets, rather than the government is giving the money ...like me I feel so scared each time it comes... I just feel reluctant ... because I'm going to be thrown out...so I think the way most Community Welfare Officers are treating us are not really very good... (UMM)

Another also expressed fear and a level of frustration in her interactions with a CWO:

...particularly maybe the social welfare...most of them are very aggressive... make you feel very afraid... like why am I living in this house... the way they make you feel... you are afraid and they won't explain a thing... (UMM)

(3) Education – access and barriers

Section 18 of the UMMQ asked the participants to give information on their educational needs. Each participant indicated that they would like to continue their education however only 30.4% (n=7) of participants were actively in some form of education at the time the study was conducted.

TYPE OF EDUCATION	NUMBER	PERCENTAGE (of those in education(n=7))
English and computer classes	3	42.8%
Leaving Certificate	1	14.2%
Applied Languages & Teleservices	1	14.2%
Inst. For Further Education	1	14.2%
Catherine McCauley Centre	1	14.2%

Table 5.11 - Type of Education

The **absence of education** in this context can clearly be construed as a stressor for the young mothers.

The UMMQ went on to further ask what were the **barriers to accessing education**. The resounding result of 75% (n = 12) from this question indicated the primary reason for the young mothers not accessing education was **lack of childcare**.

The following excerpts from the focus group further illuminate this result:

...they should provide us with a crèche for school... my baby is two months plus now and I want to go to school... I'm tired of sitting down... (UMM)

Similarly,

...I wasted a year for nothing... I'm a year and some months in Ireland ...and still no school because of no crèche... (UMM)

Again,

...you want to go to school... like we are looking for the crèche to leave the baby... and they always tell us there's no crèche... you can't go to school... (UMM)

The remaining 25% (n = 4) of respondents noted the following reasons for not being in education:

Wanted to take care of my baby first - (UMMQ -TQ)

Just finished course - (UMMQ -TQ)

Don't want to do computers - (UMMQ -TQ)

The respondents were also asked what education or training they would prefer. Table 5.12 presents the results as follows:

TYPE OF EDUCATION/ TRAINING PREFERRED	NUMBER
Training for a specific job(details below) Caring professional (3); Childcare (3); Cleaning (1); Computers (1); Science (1); Nursing (1); Cooking (1); Shop assistant (1); Security (1) Air Hostess (1)	12
Leaving Certificate	9
General skills (e.g. computers)	8
Third Level course(details below) Social Studies (1); French & English (1); Medicine (1); English & Computers (1); Accountancy (1); Computers (1); Nursing (1); Childcare (1)	6
Written English	6
Spoken English	4

Table 5.12 – Preferred Education/Training

What is noteworthy in these results are the specific details of training and education given, with most respondents naming a particular job or career. A further interesting point is the number who noted the need for classes in written and spoken English.

The focus group provides additional data in terms of the difficulties for the young women in accessing education while pregnant, despite their clear desire to do so:

... when I came I was pregnantand then getting sick... and I can't really fit into a normal school situation... (UMM)

Similarly another participant noted difficulties she had encountered:

...when I was pregnant I was still going to school ... when I moved out to (location)I told my community welfare it's too far... I have to get two buses to go to it... she say it's up to me if I want to go to school... but I don't want to be sitting all day doing nothing ... I see my friends that are doing their Leaving Cert and I'm a bit jealous...but you're not encouraged... (UMM)

Further discussion in the focus group revealed a **strong commitment to education and training** as evidenced in the following excerpts:

...I think being pregnant shouldn't stop anybody going on, starting out, to win anything... (UMM)

With some of the young mothers also disputing what they perceived as negative attitudes towards them:

...people they think, I am a teenage girl, yeah fine...I have goals to achieve as a mother... and having a child will not stop me from going to achieve what I want to because... my goal is to be an accountant in my life, that is what I always wanted to become... (UMM)

... Its not that people are being lazy or don't want to do something... I want to be provided for some training for a job...I want to pay tax...(UMM)

(4) Educational needs

Of particular interest in considering the **educational needs** of the study participants is the information given in Table 5.10 on educational level, literacy level and first language. Almost three quarters (73.9%) of participants have not completed second - level school exams and while all can speak English at some level, for nearly 80% English is their second language. Just over half the group say they are literate in their own language. These facts are of considerable importance for both those professionals and services offering education/training and those helping the young mothers in accessing that education/training.

(5) Income

Section 17 of the UMMQ sought data on the perception of **sufficiency of income** for the young mothers. As noted earlier 95.6% (n = 22) of the participants received either full Social Welfare Allowance or Unemployment benefit, with one participant engaged in full time employment. The data indicates that 74 % (n = 17) considered their income to be sufficient or sometimes sufficient to care for themselves and their child, with 26% who considered their income to be insufficient. (Table 5.12).

	Frequency	Percent
Income is not sufficient	6	26 %
Income is sufficient	14	61 %
Income is sometimes sufficient	3	13 %

Table 5.13 – Sufficiency of Income

The text answers of the UMMQ questionnaire provides some further detail in relation to when the income 'is not enough':

Sometimes it is not enough eg. childcare, clothes etc - (UMMQ -TQ)

Sometimes you go to the GP and he writes a prescription of something to get and your medical card doesn't cover - (UMMQ -TQ)

Child benefit... its not enough to buy pampers & food, the rent isn't covered with the money we receive so we have to use to money for food for the rent - (UMMQ -TQ)

Cannot buy myself clothes as I would like - (UMMQ -TQ)

Toys, baby food too expensive - (UMMQ -TQ)

An excerpt from the focus group elaborates further:

...when you're an only parent...if you are not employed, you don't have enough for your family when you don't have support from anybody... (UMM)

Concern was raised within the focus group about the prospective move for some of the young mothers to adult **Direct Provision** accommodation. One of the negative consequences of this move is a significant reduction in income and the discussion included the following comment about the impact of and the risks associated with such a reduction for the young mother:

... because its going to cost people... doing what they don't want to do...hiding...before you know it ...you're already on the streets doing all sorts of things... involving yourself in what is not good... committing a criminal offence...(UMM)

She recommended to the researchers:

...all those things you have to look into...to make sure people don't go astray... (UMM)

5.2.5 Macro level

Summary

The macro level of analysis examines factors in the environment that are common to the group living in it, and involves the physical, social, economic and political structures of the larger society that the individuals live in. It is without debate that being an asylum seeker can be viewed as a 'stressful' experience. Key causal factors of stress as already highlighted in this research include: level of income (for some); Direct Provision policy; not being entitled to work; impact of 'Irish born child legislation' and lack of access to education and training. It can be inferred that 'support' on this level would include being granted refugee status together with the economic, social and educational entitlements associated with this status.

A limited level of support for all unaccompanied minors under the age of 18 years is that they remain in the care of the Health Board and are thus legally afforded the care and protection of the state as children first, and asylum seekers second. They are entitled to secondary education and to be treated as a minor in the asylum process. This latter allows them to have legal advice and the support of a staff member from the Health Board to be present at all interviews throughout the asylum process.

The end of such support once the minor reaches the age of 18 years and is moved into adult accommodation and Direct Provision is viewed as a significant stressor for the participants in this research. The results of this section of study highlight a number of other government policies and legislation, as well as the above, which are perceived by the respondents to be significant stressors. Those policies that are viewed as supportive are also noted.

5.2.5.1 Macro Level - SUPPORTS

(1)Government support

A number of supports provided by the Irish government including the provision of the social work service, child benefit payments and social welfare payments, were greatly appreciated by the study participants. One mother noted as follows in the UMMQ:

Always grateful for it - (UMMQ -TQ).

Others in the focus group noted the contrast between Ireland and their country of origin in terms of availability of financial supports, human rights and services as follows:

... to be honest with you I never, I mean I never in my life remembered my mum saying...oh I am going to the government to get some money... (UMM).

...Ireland is better than (country of origin) Ireland has respect and human and children's rights...(UMM)

...there would be no social worker or support of the government in (country of origin) (UMM)

The following excerpts from the focus group illuminate this contrast further.

... (The country of origin) government of doesn't know how many babies are born to that country... even at this moment we are sitting down ...and there are thousands of babies being born in different hospitals... but we don't take records. I was surprised when I went to register my baby to get the birth cert...and then when I got there ...they were able to tell me the hospital he was born and the day he was born... but in my country... it is not like that because some babies are born on the farm... (UMM)

...so, nobody knows anything about the baby and the government does not care.... like I came here ...and I realised what they call child benefit... and the government will even pay us to take care of these children (UMM)

And another quote from the UMMQ as follows further points to the differences:

In my country single mum is unacceptable.... the Government does not take care of the child - (UMMQ-TQ)

(Note : from the 1st May 2004 newly arrived asylum seekers are no longer entitled to claim child benefit allowance and from the end of 2004 unaccompanied minors who reside in hostel type accommodation will be in full-board provision with meals provided and a small weekly allowance)

5.2.5.2 Macro Level - STRESSORS

(1) Direct Provision

The basis of Direct Provision is to provide asylum seekers with full-board accommodation and income maintenance payment to cover personal requisites – currently 19.10 euro per adult and 9.60 euro per child. Prior to 2003, a significant proportion of unaccompanied minors lived in self-catering hostel accommodation and they were entitled to full Social Welfare Allowance (SWA) amounting to 124.80 euro weekly. The introduction of Direct Provision accommodation and payments for the young mothers once they reach 18years was perceived by the focus group participants to be a significant stressor.

A number of described their concerns at the prospect of the move:

...like I am 18 now and I am going to be receiving 19 Euro... fine... I know that food is going to be provided for me... but that is not going to provide my soap for me... I am a girl I need sanitary pads... I need other things... that are not going to be sufficient enough for me for one week, not for me... (UMM)

...when you see mothers they are crying... 'I don't have money, I can't do this', you can't expect someone to live on 19 euro... a lunch can cost 15 at least...

(UMM)

... I definitely want to go back to school... how am I going to have those supports... where am I going to leave my child... how am I going to be able to pay for the crèche? ...I'm not entitled to child benefit... (UMM)

(2) Work

Since the year 2000, any person seeking asylum in Ireland is not entitled to work. This legislation proved to be a significant stressor for the young mothers participating in this study. Section 19 in the UMMQ explored previous and current work history and wishes.

In relation to previous work history, a majority i.e. 91.3% (n=21) of respondents indicated that they did not work prior to coming to Ireland. Of the two participants who stated that they had worked one indicated that she was employed in farm work and the other in trading.

In relation to current work again a majority i.e. 87% (n = 20) indicated that they currently did not work. Of the remaining three respondents only one person was in fulltime paid employment, with the other two respondents engaged in voluntary work.

However, when asked 'Would you like to work ' 78.3 % (n = 18) indicated 'Yes', with 17.4% (n = 4) indicating 'No' (the remaining participant did not answer the question). The barriers to work were also explored with 'no work permit' and 'lack of education' representing the most common barriers.

The following table presents the main barriers to work (Table 5.13)

Issue	Frequency	Percentage
No Work Permit	10	43%
Lack of education	7	30%
Lack of childcare facilities	4	17%
Sickness	2	8%
Not applicable	3	
Missing data	1	

Table 5.14 - Barriers to work (n = 23)

The text answers provide further information on this issue with the lack of work permit again noted as the main barrier:

If somebody else looked after baby... and I don't have status in Ireland... but at first I would like to go to school - (UMMQ -TQ)

I am an asylum seeker... no work permit and I would like to finish school first - (UMMQ -TQ)

Because I have to take care of the baby... I have no crèche - (UMMQ -TQ)

Can't get a work permit - (UMMQ -TQ)

No work permission - (UMMQ -TQ)

Because I don't have Refugee Status yet - (UMMQ -TQ)

Despite these barriers the desire of the participants to work, to get a career, to support themselves and their child remains strong:

I would like to work and my baby in a crèche - (UMMQ -TQ)

Go back to school and do my leaving cert and go to university or college and get a career - (UMMQ -TQ)

Plans to get a good job, buy a house with my partner - (UMMQ -TQ)

Education, working, and contributing to the society - (UMMQ -TQ)

I want to look after my baby – not social welfare – but work and support us - (UMMQ -TQ)

(3) Irish born child

A Supreme Court ruling on 23rd January 2003 in the case of Fajujonu stated that parents of an Irish born child do not automatically have the right to reside in the State. Prior to this decision a number of participants in this study had applied for residency following the birth of their Irish born child, while some also proceeded with their asylum application. The findings in the research indicate that the uncertainty relating to the future for both themselves and their child in Ireland was a significant stressor as noted by the following participant:

...this is one of the things that are really oppressing, really depressing people...they have to because we are confused... when you see the people on the street and you look at their face they are not happy the way we are being treated... (UMM)

She went on to describe the possible problems in relation to identity and belonging:

... if these children end up going to Nigeria... the Nigeria president is not going to accept them... and the child is going to remain lost forever...and that can lead a child to be arrogant... it can even shut down the mum... because it (her child) will insult the mum and say...'you don't know where I was born, you don't know where I came from'...ok I'm saying I was born in Ireland... I don't have an Irish passport... you went to Nigeria... you don't have a Nigerian passport...

then the child is going to remain lost forever... is going to be maltreated by other people (UMM)

Another participant described feeling hurt:

... law has changed that if you have Irish born baby you are not entitled to stay in the country... and sometime I feel very hurt as a foreigner seeing that being in a ...foreign country is a fairly stressful first...and then to pass through a lot of difficulty... (UMM)

(4) Fear of Deportation

Perhaps the most significant stressor that the young mothers who did not have Refugee Status was that of the fear of being deported to their country of origin. The following is an excerpt from the focus group describing the level of fear and apprehension regarding deportation:

... that's stress...not knowing that maybe tomorrow they might just come... 'ok take your bag and carry your child and go'...and therefore you don't know where you are going... and you don't know how that place is going to be that you left so far,...I'd rather die than go back to my country, that's what I'm saying...(UMM)

Similarly another participant said:

...I have an Irish baby born... I don't have anywhere to go... if they asked me to go to my country my preference is to die because...I(v'e) got an Irish baby now... he can't stay in my country...you can't send an Irish baby away,...So (it's) a lot of confusion... (UMM)

(5) Future

The above stressors were clearly reflected in the results from the UMMQ with regard to thoughts about the future – with 85% of the respondents indicating concern or distress as follows: ‘worried’ (55%), ‘sad’ (15%) or ‘afraid’ (15%). This concern is reflected in the comments in the focus group, and relates especially to the right to remain in Ireland:

...I don't know what is going to happen... if Ireland is going to let me stay here all my life or not... It is hard to plan anything for the moment... but if possible I would love my son to grow in a safe country and myself be able to work... (UMM)

... I would like to come out flying colours in the future... I would like to achieve a goal in Ireland...(UMM)

The remaining 15% indicated that they were ‘happy’ in considering the future.

5.3 Summary of 'supports' and 'stressors'

The following Figure provides a visual summary of supports and stressors. This clearly demonstrates the imbalance between the number of supports and the number of stressors as highlighted and described by the young mothers in this study - the number of 'stressors' is almost twice that of 'supports'. The number and combination of supports and stressors is obviously not the same for each participant, so the following summary may be said to represent the range of potential stressors and possible supports for an unaccompanied minor mother in Ireland.

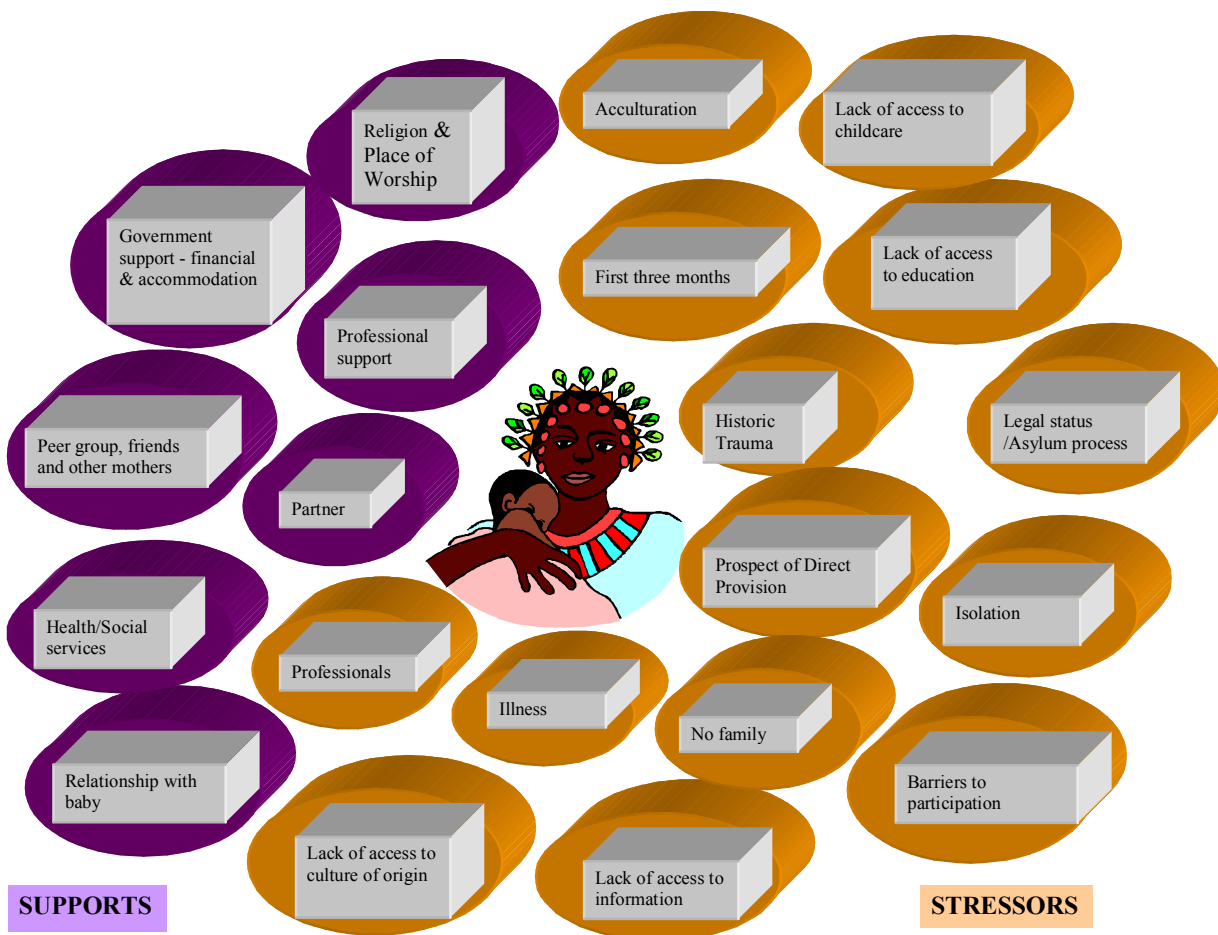


Figure 5.4 - Supports and Stressors

CHAPTER 6

DISCUSSION

The challenge for services is, in an often limiting legislative environment to: promote participation; enhance strengths of the young mothers; build capacities; provide appropriate supports and most importantly pay heed to and value the young mums' voices in order to address their hopes, dreams and aspirations.

6. DISCUSSION

6.1 Introduction

The **analysis of the results** provides a wealth of information concerning the culture, the context and the experiences of this group of unaccompanied mothers. This information viewed through the lenses of stressors and supports facilitates a more focussed analysis on the areas and issues that need to be addressed – in terms of stressors that need to be minimised and supports that need to be maximised. By ‘superimposing’ the ecological framework of micro, meso and macro levels (Bronfenbrenner, 1979) for further analysis, direction is provided in relation to where (or at what level) the stressor or support is located and therefore at what level intervention or attention is required.

6.2 Culture

The issue of culture is of central importance at both the level of the **individual** and at the level of **service provision**. For the **individual**, issues such as questions concerning the level of contact with one’s culture of origin that is desired and/or possible; considering one’s own cultural identity; negotiating the learning and adaptations necessary in a new culture; navigating possible intergenerational conflicts - each an aspect of the process of **acculturation** - require consideration.

As noted in the literature review (Berry, 1995) this process, particularly in the context of an uncertain future, can be extremely stressful. As he points out the negative impact of acculturation is likely to be increased if the climate in the host country is hostile. He also points out that lack of access to one’s culture of origin may contribute to an experience of being marginalized. Although the process of acculturation was not directly addressed in this study there is sufficient evidence from the results to suggest that the related factors of barriers to participation, lack of access to culture of origin and an uncertain future each contribute to a stressful acculturation process for the majority of the participants in this study.

A wealth of information was obtained from participants in the focus group on aspects of West African culture, however given the inevitable time constraints many of the issues could not be explored in detail so it can be safely said that there is much more to learn, both about West African culture and other relevant cultures.

6.3 Stressors

In considering the range of **stressors** identified, it is apparent that many are the same as or similar to those experienced by Irish teenage mothers (Riordan, 2002). **At the macro and/or meso level** two stressors that were perceived as particularly significant for the young mothers in this study were similarly articulated by the young Irish mothers in Riordan’s study. These were difficulties in **accessing appropriate and/or meaningful education** and

access to childcare. Both issues proved to be interrelated in that the lack of opportunities for young mothers to access affordable childcare meant they were unable to attend formal second level education, vocational training, or English language/literacy classes. This was despite the clearly expressed desire for the young mothers to participate in some relevant form of education and training with a view to employment. Lack of access to appropriate educational opportunities and consequent limited employment opportunities is likely to significantly increase the prospect of future financial dependence on the government with all the attendant negative consequences. (Flanagan, 1998; Hill and Tisdall, 1997).

In relation to educational needs the information given by the participants on literacy and educational levels are extremely relevant in particular for those offering education and training and should inform those providing education and training programmes. It is likely that current education programmes may not adequately address the needs of this population and therefore serious consideration needs to be given to the development of and resourcing of appropriate programmes. Education is not an end in itself according to the participants of this study who clearly indicated their desire for education as a means to both accessing employment and to being financially independent and thus contributing to wider society.

Other common stressors, also **at the meso level**, cited both by participants in this study and in Riordan's study (2002) included (1) **difficulties in accessing specialist services** and **obtaining information** relevant to entitlements; and (2) **some negative encounters with some staff** in health and social services. Some, though not all, of these encounters were associated with decisions made at a '**macro**' level rather than at the level of the professionals who were implementing them. These include for e.g. policies in relation to direct provision, financial entitlements and policies relating to access to third-level education. (It is important to note that this latter stressor is not described as a universal experience, but rather related to some individual staff).

As noted in the literature review, there are a significant number of other stressors which are particular to the population of UMM's.

Continuing **at the meso level** a number of these other stressors were described as follows. While **income** and **accommodation** were described as adequate by a majority of UMM's, serious concern was expressed by those still in the asylum process with regard to the prospect of **Direct Provision** accommodation with the consequent reduction in income, change to adult accommodation services and the cessation (except those who are particularly vulnerable) of support from the social work service for unaccompanied minors.

It must be noted that while none of the participants at the time of the study were as yet in Direct Provision accommodation, it is now a reality for a significant proportion of not only these young mothers, but also any young asylum - seeker mother over the age of 18 years. As such, the possible associated risks merit serious attention and must be taken account of by service providers. This population is likely to be at **risk of exploitation** in many contexts but particularly in the context of Direct Provision by virtue of a number of factors including their youth, lack of family structures, and reduced level of income. This issue was particularly evident for the participants of this study in their discussion in the focus group about the prospect of Direct Provision. Their clearly articulated concern about 'being forced to do what I don't want to do' requires serious attention by service providers and policy - makers. In the context of having a reduced income the concerns anxiety appeared to be associated with concerns about being obliged to engage in illegal activities in order to supplement a lowered income.

By definition, an unaccompanied minor is without the care and support of his/her family so the **absence of family supports** is marked. This was particularly evident in the descriptions of social, cultural and family **isolation** given by the young mothers in this study. For these young mothers the absence of their mother, particularly in the **first three months** was experienced as very difficult. For African mothers there appears to be a marked difference between the high levels of support provided in their country of origin to new mothers, especially in the first three months compared to the much lower level of support in Ireland for new mothers. Given that support and support structures are crucial in terms of providing an optimal environment for both a new mother and her baby, their needs at this particular time period require further attention.

At the macro level the findings in this research confirm the observations noted in relation to the stress inherent in an insecure legal status. In fact **insecure legal status, the attendant limitations and barriers to inclusion/participation** were, in one form or another, consistently cited stressors for those in this study without refugee status. Some of the consequences of this insecure status and associated restrictions have been noted in the literature review - lack of belonging, an uncertain identity, a thwarting of a desire to participate (Berry, 1992) The desire to participate, to contribute and to achieve is evident in the participants of this study from both the content of the focus group and also from the results of the UMMQ questionnaire. Participating in and contributing to one's community and to society is the fundamental measure of social inclusion and enhances a positive sense of belonging, which in turn has positive consequences for psychological health. The converse is also true – that an experience of exclusion from society is likely to have a negative cost for psychological health. (Beiser et al, 1998 in Berry, 1992). The results from the PSI/SF which locate the primary source of stress for almost three quarters (74%) of these young mothers in their personal circumstances, rather than their role as parent, adds further support to the conclusion that the barriers to participation are a primary source of stress.

A further factor is a low level of income. Active participation in society is acknowledged as being much more difficult in the absence of adequate income so that for those in society who live in **poverty** the possibility of inclusion is further reduced (Sidebotham et al, 2001, Hill and Tisdall, 1997).

There are a number of factors related to the **micro level** issue of **psychological health** which gives evidence of some of the consequences of multiple stressors. The impact of an imposed passive role with the attendant powerlessness and resultant exclusion from society may, as already noted in the literature review, have negative consequences for psychological health (Beiser et al, 1988 in Berry, 1992). The results from the relevant data (GHQ-12) are consistent with that of the extant literature, and indicate that there is a higher level of distress than in non-refugee adolescent populations (Rea, 2001). Approximately a third of participants were, at the time of data collection, experiencing significant psychological distress (GHQ-12 (34%). The results from the PSI-SF locate the primary source of stress for almost three quarters (74%) of these young mothers in their personal circumstances rather than in their role as parent. As well as the other stressors identified, personal **health problems** for the mother may be a central stressor, in interaction with other stressors, as evidenced by the results of the six participants with high scores in both the PSI-SF and GHQ-12. Though this is not possible to confirm on the basis of these results, clinical experience would support the conclusion that significant health problems either for the mother or the child will add considerably to the overall stress experienced (see section on Ethical Considerations for details of action taken in this event of parental or child distress being identified in the course of this research).

However, despite the high level of historic traumatic experience described and the wide range of current stressors experienced, 66% of this group do not present with high levels of psychological distress (GHQ-12). This serves to remind the reader that, despite the multitude of stressors, the level of psychological **resilience** for two thirds of this group is high. This result is consistent with much of the literature relating to refugees and asylum-seekers (Ager, 1997). Further evidence of this psychological resilience is provided via the clearly **articulated dreams and goals** presented by the participants. A **high level of motivation** and a strong will to achieve, as evidenced by the participants of this study, are likely to contribute to the level of resilience experienced.

A further factor and possible stressor at **the micro level** is a history of **traumatic** experience. Of particular note is the high level of historic traumatic stress with 68% of participants experiencing between four and twelve traumatic events. The gender specific nature of the traumatic experiences is evident from the results. These issues were not discussed directly with participants so the extent of associated stress or distress involved is not possible to ascertain. In terms of recovery from traumatic experience, both Summerfield (1999) and Bracken (2002) point out this, to a large extent, involves the resumption of ordinary life and structures such as work/education, religious activity, family/social life, and cultural rituals which restore a sense of purpose and normality. This resumption is however

not possible or is, at the least, is very difficult in the context of the legal process of seeking asylum and attendant limits on participation in society.

At the **macro and/or meso level** it is surprising to note that none of the participants reported experiencing **racism** or hostility in the wider community. However it cannot be concluded that since it was not reported it was not experienced. There are a variety of possible reasons why this issue was not raised including: a sense of shame; lack of time; the specific focus of the study being on parenting. This is an issue that requires separate attention both at the level of support services and also in terms of further research.

While Flanagan (1998) points out there are positive as well as negative consequences of being a teenage parent and recommends maintaining a balanced perspective, there can be little disagreement that the interacting stressors and consequent accumulative stress for this particular population arising from these various stressors is considerable. The long-term effects of sustained and interacting stressors for this population and the subsequent impact on their role as parent cannot be underestimated. The possible long-term impact of such sustained accumulative stress has not to date been firmly established, however it would not be unreasonable to suggest that **without supportive intervention** the cost may be significant both in human terms and in subsequent costs to health and social services. As already noted approximately a third of the participants of this study appeared to be experiencing significant psychological distress and as such required further supportive intervention.

6.4 Support

In considering **the supports** available or where support is experienced for this population what is most apparent is the paucity of support networks particularly at the level of the wider community and of course, by definition, at the level of family. This results in social isolation and further compounds the risk of social exclusion.

Social connection to family and community is acknowledged as a primary vehicle within which identity and a sense of belonging are developed. Without a family it is necessary that the community takes on a more important role with the work environment, the school environment, the social environment providing access to the possibilities for social interaction, connection and support.

Promoting access to culture of origin (if desired), through the relevant community support groups and other means has been noted in terms of supporting identity development and psychological health. A further benefit has been noted in relation to generation of a psychological sense of belonging. (It is important to point out that this may not be appropriate for all UMM's, as some may have negative associations with their own culture/country of origin as a result of difficult experiences there).

The main locus of support at **meso level** for participants is from the **professional** sector i.e. social worker, public health nurse, project worker, community welfare officer, G.P. and maternity hospital staff. Specialist services for single parents such as Onefamily (formerly Cherish) and supported accommodation for young mothers such as Eglinton House were also identified together with other support services such as The Catherine McAuley Centre, Vincentian Refugee centre, Barnardo's and Focus Ireland. While it is extremely positive that this type of support is available, there is a risk that this becomes the only type available with the possibility of an entrenched dependency on professional supports and increasing isolation from the wider, more informal, community supports. Although **friends** were noted as a consistent support as were **partners** (if present) this was not to the same extent as the professional/service support. These findings contrast with the primary presence of family support noted for teenage mothers who have access to their families of origin (Bunting and McAuley, 2004).

At the **macro level** the financial support provided by the **government** was appreciated and was contrasted with the lack of same in their country of origin. In comparing the supports available in their own country and in Ireland what is most apparent is the availability of material support (apart from that available in Direct provision) in Ireland, with limited emotional and practical support while the converse appears to be the case in their own country where there is less financial /material support but significantly more emotional and practical support.

At the **micro level** the role of **their child** as a source of positive experience needs to be highlighted. As Flanagan (1998) and Furstenberg et al (1987, in Manlove, 1997) have pointed out there are positive as well as negative consequences of being a teenage mother. This is supported in this study by the many positive accounts of the young mother's experiences of being a mother.

The results indicate that **religious faith** together with attendance at place of worship represented a significant source of personal support. This is consistent with the conclusions of Lowenthal (1995), as noted in the literature review.

6.5 Summary

The findings of this study underline the centrality of the role of culture in this area, including the process of adaptation and acculturation for the young mother and the need for the development of culturally sensitive services. The wide range of stressors experienced by the young mothers in comparison to the paucity of supports is demonstrated in Figure 5.4.

Absence of family and insecure legal status together with the associated limitations emerge as some of the most significant stressors. The first three months of parenting represented a particularly stressful time during which the absence of family together with access to cultural practices was keenly felt. Despite the challenges associated with parenting as a young mother in another culture, the overwhelming positive nature of the parent child relationship

was evident. The experience of historic trauma was a significant characteristic of each mother's profile. A considerable future stressor for those young mothers still within the asylum process was the pending move to Direct Provision accommodation. Of particular concern is the risk of exploitation of this vulnerable group of young women in light of this policy and practice. Barriers to participation as a result of limitations associated with asylum seeker status, lack of access to childcare and as a result lack of access to education, represent significant stressors. Health problems also constitute a significant stressor. In terms of the impact on psychological health approximately a third of participants were, at the time of data collection, experiencing significant psychological distress GHQ-12 (34%). The remainder of participants demonstrated considerable resilience.

In terms of available supports **professional support** and **services** play a predominant role with **friends** and **partners** providing support to a lesser extent. The support provided by **religious faith and worship** was also evident. Their **relationship with their child** emerged clearly as a very positive aspect in their lives.

While UMM's face many simultaneous challenges and multiple demands including adapting to a new country, for some a new language, a new role, for many in the context of an insecure legal status, against a background of forced migration, and in the absence of family – their resourcefulness and capacity is manifest in their words as is their commitment to achieve, their hope's for their children's future, and their desire to contribute. What emerged very clearly is their desire for relevant education and thus ultimately being able to play an active role in Irish society. The lack of access to childcare provision cannot be underestimated in this context as a barrier. What has emerged through their words is the need for support but simultaneously the desire to contribute to and participate in society, together with the need to be connected with their culture of origin. The research literature also points to the importance of these central factors.

The focus therefore in service provision must be primarily on **support** designed to enhance the natural resilience and capacities of UMM's and to facilitate their active engagement with and participation in society. Such supportive provision would serve to promote positive psychological health for the mother which in turn would impact positively on the parent-child relationship and on the child directly, serving to **prevent and/or reduce** future psychological health and social problems. A cornerstone of service delivery must thus be the active empowerment of the young mothers to work toward independent active engagement in the wider society. This type of active and inclusive positioning in society will serve to enhance identity, esteem and sense of belonging of the young mother, which will have in turn direct benefits for her relationship with her child.

There is an onus on **service providers** to take account of the centrality of the cultural background of clients in order to provide relevant and effective services. In order to address this central concept in the context of service delivery the related issues of developing **culturally sensitive services** and **cultural competency** in staff need to be seriously

considered. As noted in the literature review Fernando (1995) suggests that ‘fundamental changes are necessary in professional practice if service provision is to be relevant, appropriate and just in a multi-ethnic society’. Though his comments are directed primarily at mental health service provision, it can safely be argued that these observations apply equally well to general health and social services.

Cultural competency is an increasingly pressing issue in relation to both access to and provision of quality health and social services in a multi-cultural context. The development of such **cultural competence and awareness** for health and social service professionals must be seen a priority in the interests of both equity of access to such services and quality of service delivery. It can best be developed by utilising and mobilising both the knowledge that currently exists together with facilitating the development of that knowledge base in relation to and with identified ethnic minority communities.

In relation to the development of **culturally sensitive service provision**, the following practice based questions are suggested as some of those necessary for consideration in the context of service delivery to this population:

- How can services ensure a culturally sensitive approach and encourage cultural competency in staff?
- How can the unaccompanied minor mother be supported to actively engage in a new culture (to participate, to belong,) in the context of an uncertain future?
- How can she be best supported so that she can effectively parent in a different cultural context, which is likely to have different attitudes and practices in relation to parenting?
- How can community supports and relationships, particularly from her culture of origin (if she wishes) be mobilised?
- How can she maintain a sense of cultural identity while in the process of acculturation?
- How does she generate a sense of belonging in different culture at a time of major role transition?
- How can each UMM be encouraged to develop supporting relationships outside formal service provision?
- How can her educational needs be identified and addressed?
- How can she be facilitated to participate in education and ultimately employment?
- How can childcare needs be most effectively addressed in a sustainable way?
- How can possible risks of exploitation be addressed?
- How can her natural resilience and capacities be enhanced?
- How can her participation in and contribution to society be supported?
- How can the parent-child relationship be best supported?
- How can health education, including sexual health education, be best promoted?

Essential in the effective provision of these services is **cooperation and communication between service providers**, both at the level of service planning and at the level of service delivery.

6.6 Recommendations

The recommendations which follow centre upon positive actions and interventions at the meso and macro levels. It is the responsibility of all the service providers and policy makers in the relevant statutory and non-statutory sectors to engage with these issues in a cooperative, coordinated and sustained way in order that the following recommendations are realised.

These recommendations are designed to enhance the resilience of the young mother in order to provide better outcomes and protective factors on all levels for her and her child. Each of the following recommendations should involve at the individual level, a consultative process with the unaccompanied minor mother.

No.	WHAT?	LEVEL	RECOMMENDATION	HOW?
1	PARTICIPATION	Meso	Support for active participation in decision – making , including within interagency working parties	Involve UMM as members of groups and forums where decision making takes place
2.	CULTURE	Meso	Facilitate contact with own ethnic group (cautionary note – some may not be positive about this...)	Link with ethnic groups/ individuals/ organisations in the community
3.		Meso	Facilitate access to support for (legal) cultural practices eg. bathing	Identify and link with appropriate individuals & groups
4.		Macro	Enhance cultural competency skills for staff within services	Training and development of skills
5.		Macro	Develop good practice guidelines in relation to the provision of a culturally sensitive service	Development of guidelines in each service to be informed by ethnic minority representatives
6.		Macro	Actively promote cultural diversity within staffing/volunteers of agencies and groups	Encourage application/involvement from diverse cultural backgrounds
7.	EDUCATION	Meso	Identify educational needs, including literacy level and any possible learning difficulties	Ensure individual educational needs profile for all UMs

8.		Meso	Facilitate appropriate education and/or training, directed toward economic self-sufficiency – (whether in Ireland or in county of origin)	Identify and develop appropriate education and training opportunities
9.		Meso	Provide career guidance for those who are entitled to work having been granted Refugee Status	Provide appropriate career guidance
10.	CHILDCARE	Macro	Facilitate access to childcare	Access to childcare for all mothers
11.		Macro	Consideration of support in education until age 21 (in line with the Child Care Act) for those who have obtained Refugee Status, whilst in the care of the Board	Provide financial or other support in an ‘after care’ framework for those leaving care, who wish to continue their education
12	SUPPORT	Meso	Facilitate access to more experienced mothers – either Irish or from C.O.O - particularly in the first three months	Through using existing programmes such as Community Mothers Programme; Teenage Parent Support Initiative; Homestart; ECAHB Befriending Project etc.
13.		Meso	Development of culturally appropriate parenting courses	Appropriate adaptation of existing courses to be informed by relevant ethnic minority representation
14.		Meso	Encourage the development of peer support networks	Establish peer support groups
15.		Meso	Facilitate access to place of worship	Provide information and facilitate as appropriate
16.		Macro	Development of an easily accessible (visual) information pack regarding services, legal rights and financial entitlements for UMMs	Adaptation of current information and resources to include needs of UMMs

17.		Macro	Support and information in transition to adult services and Direct Provision accommodation once over the age of 18 years	Establish post/s to co-ordinate the transition process
18.	HEALTH	Macro	Access to appropriate services to address historic trauma, where necessary	Identify and liaise with appropriate services for e.g. Psychology service (PSRAS)
19.		Macro	Development of health education program to include sexual and reproductive health	Ensure all UMs have access to appropriate health education program
20.	STRUCTURAL	Macro	Ensure an allocated social worker for each UMM	Increase funding to create additional posts in the social work service
21		Macro	Establish a policy forum for key interagency players in service development & delivery to UMMs	Establish forum with key players, to be hosted by the ECAHB
22.		Macro	Develop interagency policies and guidelines in relation to UMMs	Develop policy document
23.		Macro	Establish a specialist practice sub-group within the Social Work Team SCSEA, to act as resource within team and wider interagency context	Establish sub group to include Team Leader, Project Worker, Social Worker, Clinical Psychologist

Table 6.1 - Recommendations

Finally, in line with the philosophy of this research to value to voices of the young women, the last words regarding **dissemination** of the results must belong to them:

...Ok, I also want to say ...that everyone should... all the Socials... the Boss should see this...so they can see we try... Pass it on to the Minister for Justice, the Government, and the President of the country to look into this... (UMM)

6.7 Limitations of this research and suggestions for further research

While it is hoped that this study provides useful results in terms of an initial exploration of the experiences of unaccompanied minor mothers in Dublin, Ireland there are a number of limitations to the research which need to be acknowledged.

The first relate to the small size of the group. The small size limited the possible statistical analysis to descriptive statistics only.

The second relates to the nature and purpose of the research. Being primarily exploratory and descriptive, the results are naturally limited in terms of establishing the precise interactional nature of the stressors and role of supports.

Also related to the nature and purpose of the research are the issues that were either not explored or explored in a limited way. Given that this is the first time that research has been conducted in this area, it was considered essential to start with a 'broad brush stroke' approach, which sought to initially identify the main issues in relation to supports and stressors. The results have highlighted a number of issues and areas that require further and closer examination including the question of racism and its impact; historic traumatic experiences and their impact; the risks of, or any experiences of exploitation; literacy and educational level and educational needs; belief systems about health and illness, amongst other cultural issues.

Finally, the focus of the study was on the experiences of the UMM's following the birth of their child and therefore did not overtly address the experiences of pregnancy or birth. It further did not directly address either the context of conception or the motivations for becoming pregnant. Information on the latter issue in particular is essential in order to inform the important question of health education programmes for unaccompanied minors.

Further research will be necessary to explore these important questions.

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APPENDICES

Appendix (I)

Letter to Agencies and Service Providers

01st July 2003

Dear

I write in relation to a proposed research project in the N.A.H.B. and E.C.A.H.B., which will consider the needs of unaccompanied minor mothers. Some of these young women have arrived in Ireland already pregnant and/or with a young child, while others have become pregnant after their arrival. A current estimate is that there are approximately 60 such unaccompanied minors in the E.R.H.A. area.

These young mothers represent a particularly vulnerable group for a wide variety of reasons. In acknowledgement of this a joint proposal to conduct an assessment of needs within this group has been made by the Social work service for unaccompanied minors, E.C.A.H.B. and the Psychology Service for Refugees and Asylum Seekers, N.A.H.B., with the Separated Children's Project Co-ordinator, CDVEC acting in an advisory role.

The design of the research includes a questionnaire to be completed with the young mother and the relevant social/project worker, a number of focus groups, as well as consultations with services providers and interested parties within both statutory and non-statutory agencies.

It is to this end that we now write to you and your organisation.

We would be most grateful if you would offer any comments/observations on the proposed needs assessment, and in particular any issues that you consider need to be included. A suggested outline (broadly following the content of the questionnaire) is enclosed with areas/issues for your comment. A draft copy of the questionnaire is also enclosed and we welcome your opinion on its content.

It is hoped to commence the interviews with the young mothers as soon as possible - therefore we would be grateful if you could respond by 31st July 2003.

If you feel it would be useful to include any other relevant service or organisation please let us know so that we can contact them.

A full presentation of the results is planned on completion of this research, to which all interested parties will be invited in order to discuss the results and service/resource implications.

Please do not hesitate to contact any one of us for further information and discussion.

Thanking you in anticipation.

Jennifer Rylands, Senior Clinical Psychologist, Psychology Service for Refugees and Asylum Seekers, Psychology Department, St. Brendan's Hospital, Rathdown Road, Dublin 7. Ph: 8680166.

Leanne Robins, Team Leader, Social Work Service for Unaccompanied Minors, Baggot Street Hospital, Dublin 2. Ph: 6681577.

Jessica Wanzenbock, Separated Children's Project Co-ordinator, CDVEC, 1 Parnell Square, Dublin 1. Ph: 8786662.

Appendix (II)

List of Agencies and Service providers contacted

1. Brenda Brooks & Margaret Acton Barnardo's, Old School House, Dun Laoghaire.	28. Principal Social Worker Holles Street Hospital Holles Street Dublin 2.
2. Karen Kiernan/Tracy Sherret Cherish, 2, Lower Pembroke St, D2.	29. Stephanie Whyte Cáirde 19 Belvedere Place Dublin 1.
3. Dave Ellis/Margot Doherty/Natalie McDonnell Treoir, 36 Upper Rathmines Rd, D6	30. Dr. Lucky Cáirde 19, Belvedere Place Dublin 1.
4. Margaret Morris National Co-Ordinator Teen parents support programme 14 Gandon House, Custom House Square, IFSC Dublin 1.	31. Director/Co-ordinator Ruhama 23, Herbert St Dublin 2.
5. Director of Public Health Nursing Ms. Elizabeth Doyle Croncastle Road Coolock Dublin 5.	32. Natasha Bailey Co-ordinator Young Women's Education Programme Jobstown Tallaght Dublin 24.
6. Director of Public Health Nursing Ms. Marianne Healy Rathdown Road Cabra Dublin 7.	33. Anne Moroney Access Ireland 40-41 Dominic Street Lower Dublin 1.
7. Director of Public Health Nursing Ms. Teresa Scully 193, Richmond Road Dublin 3..	34. James Stapleton Irish Refugee Council 40 Lower Dominic Street Dublin 1.
8. Ms. Brenda Molloy Director, Community Mothers Programme First Floor Park House North Circular Road Dublin 8.	35. Director Breaking Through Unit 2 Westside Centre 51 Main Street Leixlip Co. Kildare.

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| <p>9. Director of Public Health Nursing
Health Centre
Tivoli Road
Dun Laoghaire
Dublin.</p> <p>10. Director of Public Health Nursing
Vergemount Hall
Clonskeagh
Dublin 6.</p> <p>11. Director of Public Health Nursing
Carnegie Buildings
21-25, Lord Edward Street
Dublin 2.</p> <p>12. Director of Public Health Nursing
Health Centre
Old County Road
Dublin 12.</p> <p>13. Director of Public Health Nursing
Cherry Orchard Hospital
Ballyfermot
Dublin 10.</p> <p>14. Director of Public Health Nursing
Health Centre
Poplar Square
Naas
Co. Kildare.</p> <p>15. Director of Public Health Nursing
Health Centre
Glenside Road
Wicklow Town
Co. Wicklow.</p> <p>16. Rosemary Grant, Chairperson,
Teenage Parents Support Initiative.</p> <p>17. Jackie Farrelly
Unite
Southside Partnership
24 Adelaide Street
Dun Laoghaire
Co. Dublin.</p> <p>18. Sharon Foley
Director, Crisis Pregnancy Agency
4th Floor
89-94 Capel Street
Dublin 1.</p> <p>19. Cherie de Burgh
Family Planning, I.F.P.A. Association
16/17 Lower O'Connell Street
Dublin 1.</p> | <p>36. Ms. Marion Quinn
Director of Childcare
E.C.A.H.B.
Southern Cross House
Southern Cross Business Park
Boghall Road
Bray
Co. Wicklow.</p> <p>37. Alice Binchy
Director/Co-ordinator
Tallaght Refugee Project
17 Glenshane Close
Brookfield
Tallaght
Dublin 24.</p> <p>38. Integrate Ireland
C/o Cómhlámh
10 Upper Camden Street
Dublin 2.</p> <p>39. Mary Hartigan/Dora Hennessy
Child Care Policy
Dept of Health and Children
Hawkins House
Hawkins Street
Dublin 2.</p> <p>40. Yvonne O'Neill
Service Planning
Children and Families
E.R.H.A.
Mill Lane
Palmerstown
Dublin.</p> <p>41. Cate Hartigan A.C.E.O., ECAHB</p> <p>42. Pat Dunne A.C.E.O., N.A.H.B.</p> <p>43. Philip Crowley
Irish College of General Practitioners
4/5 Lincoln Place
Dublin 2.</p> <p>44. Frank Mills
Director of Social Inclusion
S.W.A.H.B.</p> <p>45. Frank Edwards
Breda Naughton
Reception and Integration Agency,
St, Stephen's Green,
Dublin.</p> |
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| <p>20. City of Dublin Youth Service }
David Tracy, Director
C.D.V.E.C.
70, Morehampton Road
Donnybrook
Dublin 4.</p> | <p>46. Diane Nurse
Service Planning
E.R.H.A.
Mill Lane
Palmerstown
Dublin.</p> |
| <p>21. Jim McVeagh, Country Youth Development Officer
County Dublin V.E.C.
Main Street
Tallaght
Dublin 24.</p> | <p>47. Brian Glanville
Director of Psychology
St. Brendan's Hospital
Rathdown Road
Dublin 7.</p> |
| <p>22. Peter O'Brien
Dun Laoghaire V.E.C.
Administration Offices
Pearse Street
Sallynoggin
Co Dublin.</p> | <p>48. Maeve Stokes
Head of Psychology Service for Refugees and
Asylum- Seekers
St. Brendan's Hospital
Rathdown Road
Dublin 7.</p> |
| <p>23. Dr. Sean Denyer
Director
Best Health for Children
1 Conyngham Road
Dublin 8.</p> | <p>49. Ann Garvey
An Cosán
Kiltalown Village Centre
Jobstown
Tallaght
Dublin 24.</p> |
| <p>24. Mary King
Dun Laoghaire Refugee Project.
C/o Haven, Crosthwaite Park South
Dun Laoghaire
Co. Dublin.</p> | <p>50. Director/Co-ordinator
African Refugee Network
90, Meath Street
Dublin 8.</p> |
| <p>25. Sr. Breege
Vincentian Refugee Centre
St Peters Church
Phibsboro
Dublin 7.</p> | <p>51. Muhammed Haji
Co-ordinator
A.R.A.S.I.
213, North Circular Road
Dublin 7.</p> |
| <p>26. Principal Social Worker
Social Work Department
Coombe Hospital,
Dublin.</p> | <p>52. Marilyn Roantree
Principal Social Worker
Social Work Team for Separated Children Seeking
Asylum, ECAHB , Baggot St Hospital, Dublin.</p> |
| <p>27. Principal Social Worker
Rotunda Hospital
Parnell Street
Dublin 1.</p> | <p>53. Sheila Marshall
Child Care Manager
N.A.H.B.</p> |
| | <p>54. Director
An Siol
19, Manor Street
Dublin 7.</p> |
| | <p>55. Pia Prytz Phiri
Regional Representative
U.N.H.C.R.
Merrion House
1-3, Lower Fitzwilliam Street
Dublin 2.</p> |

Appendix (III)

Consent Form

<u>Confidential – Consent Form</u>

Having a new baby can often be a time of stress particularly if you are in a different country and culture and without a family. So we are asking you these questions in order to help us know what types of services are needed to support you and your baby. We will be concentrating on how your life has been since your baby was born.

Consent:

The purpose of completing this questionnaire has been explained to me and I have asked any questions I need to. I know that I can stop at any point, without any later problems. I understand that the main reason for these interviews is to help staff in health and social services to understand more fully what are the main difficulties for a young mother, and how best young mothers can be supported.

I am clear that if I become worried or upset about anything while discussing this that I can tell my project/social worker and he/she will be able to advise me.

We are interested in having a group discussion with some mothers. This would take place in Baggot Street and would last approximately 1 hr 30 mins. If you are interested in participating please tick here.

Your discussions and answers will be absolutely confidential.

I agree to complete this questionnaire with the help of project/social worker.

Signed: _____ Name: _____

Name of Project/Social Worker: _____

Appendix (IV)

Focus Group Information Letter

TITLE OF PROJECT:

The experiences of unaccompanied minor mothers in Ireland.

NAME OF RESEARCHERS:

Jennifer Rylands – Senior Psychologist, Psychology Service for Asylum Seekers & Refugees

Leanne Robins – Team Leader, Social Work Team for Separated Children Seeking Asylum in Ireland

The purpose of this study is to explore the experiences of unaccompanied minors who are mothers here in Ireland.

To better understand these experiences we want to talk to several minors who are mothers. In the group we are interested in finding out about your experiences of caring for your child in Ireland. There will be only a few broad questions that will be used as a starting point for our conversations.

We are doing this so that we can try to find out some common themes and issues so that we can plan better ways of working with unaccompanied minor mothers.

There will be two group facilitators, the group will last for about 1- 2 hrs and we will help to arrange childcare for you so that you can attend. We will try and hold the group in a place that is easy for you to get to. There will be approximately 8-10 young mothers in the group. You may already know some of them already so you will need to consider this before agreeing to participate.

If you agree to help us in this project we will meet with you to discuss any questions you might have both before and after the group meeting. We will be asking you if it is ok to audio tape the group conversation so that we can use the information to write up some recommendations. You will not be identified in any way when we write reports or recommendations.

You are free to withdraw from the project at any time without any problems.

If you feel upset or worried about anything that we discuss in the group and you would like to talk to someone further, we will provide you with the name of a counsellor that can help you.

For your information, this study has been approved by the East Coast & Northern Area Health Boards Ethics committee. If you have a complaint about this project or the way you have been treated during the group discussion, please contact: Barbara Kane-Round, East Coast Area Health Board, Boghall Rd Bray.

If you agree to participate in this project, you should sign both copies of the consent form, keep one for your records and return the other copy to either Jennifer or Leanne.

Yours sincerely,

Jennifer Rylands

Leanne Robins

Appendix (V)

Focus Group Consent Form

TITLE OF RESEARCH PROJECT:

The experiences of unaccompanied minor mothers in Ireland

NAME OF RESEARCHERS:

Jennifer Rylands

Leanne Robins

I _____ (the participant) have read and understand the information provided in the Letter to Participants and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity realising that I can withdraw at any time.

I agree/do not agree to allow an audio recording of the interview.

I agree that the information collected for the study may be published or provided to other researchers in a form that does not identify me in any way.

NAME OF PARTICIPANT _____
(block letters)

SIGNATURE _____ **DATE:** _____

NAME OF RESEARCHER _____

SIGNATURE _____ **DATE:** _____

Appendix (VI)

Unaccompanied Minor Mother Questionnaire – Robins & Rylands, 2003

1. **Age:**

2. **Country of Origin**

3. **Current address**

4. **Type of accommodation**

Living alone in a flat/house with your baby

Living with partner in a flat/house with your baby

Sharing a house/flat with another mother

Hostel

Mother and Baby Home

Other, Please specify

5. **Do you live with a partner/boyfriend/husband?**

Yes No

(i). **His Age:**

(ii) **His Country of Origin** _____

5. **If you do not live with the father of your child, is he regularly involved or have access to your child?**

6.

Yes No

7. **How many children do you have?**

8. **How many are boys or girls, what are their ages and where were they born?**

Gender: _____

Age _____

Country of Birth _____

Gender: _____

Age _____

Country of Birth _____

Gender: _____

Age _____

Country of Birth _____

9. **Were you pregnant with any of your children before arriving in Ireland?**

Yes No

SUPPORT

Since your baby was born:

10(i). **Who (if anyone) helps you with practical things e.g. going shopping?** (You can tick more than one).

Project/Social Worker	<input type="checkbox"/>	Friend	<input type="checkbox"/>	Relative	<input type="checkbox"/>
Another Mother	<input type="checkbox"/>	Hospital Staff	<input type="checkbox"/>	Public Health Nurse	<input type="checkbox"/>
Partner	<input type="checkbox"/>	Place of Worship	<input type="checkbox"/>	Other	<input type="checkbox"/>

Please Specify: _____

(ii). **Do you have access to somewhere that your baby can be taken care of?** Please tick which of the following you use.

Playgroup	<input type="checkbox"/>	Who? _____
Partner	<input type="checkbox"/>	
Friend	<input type="checkbox"/>	
Creche	<input type="checkbox"/>	
Relative	<input type="checkbox"/>	

Other:

Please Specify: Other _____

(iii). **Who (if anyone) helps you with advice/information about how to care for your baby?**

Project/Social Worker Friend Family Member
Another Mother Hospital Staff Public Health Nurse
Partner Place of Worship Other

Please Specify: Other_____

(iv). **Who (if anyone) helps you with emotional support, e.g. if you are feeling unhappy, sad, afraid, worried or thinking too much?**

Project/Social Worker Friend Family Member
Another Mother Hospital Staff Public Health Nurse
Partner Place of Worship Other

Please Specify: Other_____

(v) **At the moment, would you like to discuss your worries or difficulties from the past, present or the future with a professional?**

Yes No Unsure

(vi) **If in the future you wanted to discuss your worries, do you know where to ask for help?**

Yes No Unsure

HEALTH

11 **Since the birth of your baby have you experienced serious illness?** If Yes, give details:_____

12. **Are you currently taking any medication?** If yes give details:_____

13. **Have you/ are you attending counselling/therapy?**

Yes No

14. **Have any of your children experienced serious illness?** If Yes, give details:

15. **Is it difficult for you to access health services for either you or your baby?** If Yes, give details: _____

ACCOMMODATION

16(i). **Is your current accommodation suitable?**

Very Suitable Suitable Not at all Suitable

Please describe what makes it suitable/unsuitable?

(ii). **What type of accommodation would be most suitable for you and your baby?**

Living alone in a flat/house with your baby

Living with partner in a flat/house with your baby

Sharing a house/flat with another mother

Hostel

Mother and Baby Home

Other, Please specify

(iii). **Where would be more suitable?**

Near the city centre Rural Area
(Within 30 mins by bus)

In the city Other city/town in Ireland
(i.e. no transport necessary)

In the area that you live now Please name: _____

MONEY

17(i). **Is your income sufficient to be able to care for yourself and your child?**

Yes No Sometimes

(ii). **If no/sometimes, please outline the areas of difficulty (e.g. Money for childcare)**

EDUCATION

18(i). **Are you currently in any form of education?**

Yes No

If Yes what? _____

If No what is preventing you from accessing education?

(ii). **What is your first language?** _____

(iii). **Can you read and write in your first language?**

No A bit Adequately Well

(iv). **Can you speak English?** _____

(v). **Can you read and write in English?**

No A bit Adequately Well

(vi). **How many years of formal (school) education have you had?**

0-6 7-9 10+

(vii). **Have you done your final second level school exams?**

Yes No

Which country did you complete these exams in? _____

(viii). **Do you have any other qualifications? If so please name:**

1. _____

2. _____

3. _____

(ix) **Did you have any further education after second level school?**

Yes No

If yes – please specify

(x). **Would you like to continue your education?**

Yes No

(xi). **If yes, what would you like to do?**

Leaving Certificate (final second level exams)

English Language – Spoken
- Written

Training for specific job What type of job? _____

General Skills (with no qualification e.g. computers)

Third level course

Please specify _____

19. (i) **Did you work before you came to Ireland??** Yes No

What did you do? _____

(ii) **Do you currently work?** Yes No

Part-time Full-time Voluntary (i.e. not being paid)

(iii) **Would you like to work?** Yes No

(iv) **If Yes (and you're not working) what is preventing you at present?**

Please specify _____

LOOKING AFTER YOUR BABY

(i). **What type of help would you like in relation to your baby and you?**
(You can tick more than one)

More information about how to care for your baby

Time off from looking after the baby

Someone to show you how to do things
e.g. Feeding

Meeting mums from own country

Meeting mums from any country

Meeting mums of same age

Meeting older mums

Playgroup for child plus group of young mums

Information/advice about my own health and well-being

Someone to ask questions/get advice

Information on legal rights and entitlements for you or your baby?

Other (e.g. your health/baby's health)

Please specify _____

Which of the above are the three most important?

(i) _____

(ii) _____

(iii) _____

NEGATIVE EXPERIENCES

21(i). **What have been the most difficult experiences for you since your baby was born?**

1. _____

2. _____

3. _____

4. _____

What would have made these difficult experiences easier?

1. _____

2. _____

3. _____

4. _____

POSITIVE EXPERIENCES

22(i) **What have been the most positive experiences for you since your baby was born?**

DIFFERENCES AND SIMILARITIES (Between Ireland and Country of Origin)

23(i) What would have been different for you and your baby if your baby had been born in your country of origin?

(ii) What would have been the same for you?

(iii) How do you generally spend your day?

(iv) What would have been different for you in your country of origin?

FUTURE

24(i). Do you think about the future for you and your child?

Yes No

(ii) When you think about the future do you generally feel:

happy sad afraid worried

(ii). What ideas/plans do you have for yourself?

(iii). What ideas/plans do you have for your child?

THANK YOU FOR YOUR TIME!

Appendix (VII)

Text of: Harvard Trauma Questionnaire (Mollica et al, 1992)

HARVARD TRAUMA QUESTIONNAIRE		YES	NO
1.	Lack of Shelter		
2.	Lack of food or water		
3.	Ill health without access to medical care		
4.	Confiscation or destruction of personal property		
5.	Combat situation (eg shelling and grenade attacks)		
6.	Used as a human shield		
7.	Exposure to frequent or unrelenting sniper fire		
8.	Forced evacuation under dangerous conditions		
9.	Beating to the body		
10.	Rape		
11.	Other types of sexual abuse or sexual humiliation		
12.*	Traumatic female circumcision or threat of		
13.	Torture (ie while in captivity you received deliberate and systematic infliction of physical or mental suffering)		
14.	Serious physical injury from combat (eg shrapnel, burn, bullet wound, stabbing or landmine)		
15.	Imprisonment		
16.	Forced labour (like animal or slave)		
17.	Extortion or robbery		
18.	Brainwashing		

19.	Forced to hide		
20.	Kidnapped		
21.	Other forced separation from family members		
22.*	More than 1 day in a refugee camp		
23.	Forced to find and bury bodies		
24.	Enforced isolation from others		
25.	Present while someone searched for people or things in your home (or the place you were living)		
26.	Forced to sing songs you did not want to sing		
27.	Someone was forced to betray you and place you at risk of death or injury		
28.	Confined to home because of danger outside		
29.	Prevented from burying someone		
30.	Forced to desecrate or destroy the bodies or graves of deceased persons		
31.	Forced to physically harm family member, or friend		
32.	Forced to physically harm someone who is not family member or friend		
33.	Forced to destroy someone else's property or possessions		
34.	Forced to betray family member, or friend placing them at risk of death or injury		
35.	Forced to betray someone who is not family member or friend placing them at risk of death or injury.		
36.	Murder or death due to violence of spouse		
37.	Murder or death due to violence of son or daughter		
38.	Murder or death due to violence of other family member or friend		

39.	Disappearance or kidnapping of spouse		
40.	Disappearance or kidnapping of son or daughter		
41.	Disappearance or kidnapping of other family or friend		
42.	Serious physical injury of family member or friend due to combat situation or landmine		
43.	Witness beatings to head or body		
44.	Witness torture		
45.	Witness killing or murder		
46.	Witness rape, sexual assault or circumcision		
47.*	Prolonged sexual abuse/exploitation (e.g. in Rebel Camp)		
48.*	Forced marriage, or threat of		
49.*	Held against will in Rebel/Soldier combat		
50.*	Life treating illness or diagnosis of illness		
51.*	Traumatic journey to Ireland		
52.*	Racist attack here in Ireland (verbal)		
53.*	Racist attack here in Ireland (physical)		
54.*	Early Traumatic history		
55.*	Early sexual assault		
56.*	Early separation and or loss/death of parents/caregivers		
57.*	<i>Any other situation that was very frightening or in which you feel your life was in danger.</i> Specify:		
58.*	Asylum process: <ul style="list-style-type: none"> • Status • S.11 Interview • Appeal • TLR Application • Irish born child application 		

* Items in purple text indicated those added for the purposes of this study

Appendix (VIII)

Text of: Parenting Stress Index - Short Form (Abidin, 1983)

SA= Strongly agree	A= Agree	NS= Not Sure	D= Disagree	SD = Strongly Disagree					
1. I often have the feeling that I cannot handle things very well.					SA	A	NS	D	SD
2. I find myself giving up more of my life to meet my children's needs than I ever expected.					SA	A	NS	D	SD
3. I feel trapped by my responsibilities as a parent.					SA	A	NS	D	SD
4. Since having this child, I have been unable to do new and different things.					SA	A	NS	D	SD
5. Since having a child, I feel that I am almost never able to do things that I like to do.					SA	A	NS	D	SD
6. I am unhappy with the last purchase of clothing I made for myself.					SA	A	NS	D	SD
7. There are quite a few things that bother me about my life.					SA	A	NS	D	SD
8. Having a child has caused more problems than I expected in my relationship with my spouse (or male/female friend).					SA	A	NS	D	SD
9. I feel alone and without friends.					SA	A	NS	D	SD
10. When I go to a party, I usually expect not to enjoy myself.					SA	A	NS	D	SD
11. I am not as interested in people as I used to be.					SA	A	NS	D	SD
12. I don't enjoy things as I used to.					SA	A	NS	D	SD
13. My child does things for me that make me feel good.					SA	A	NS	D	SD
14. Sometimes I feel my child doesn't like me and doesn't want to be close to me.					SA	A	NS	D	SD
15. My child smiles at me much less than I expected.					SA	A	NS	D	SD
16. When I do things for my child, I get the feeling that my efforts are not appreciated very much.					SA	A	NS	D	SD
17. When playing, my child doesn't often giggle or laugh.					SA	A	NS	D	SD
18. My child doesn't seem to learn as quickly as most children.					SA	A	NS	D	SD
19. My child is not able to do as much as I expected.					SA	A	NS	D	SD
20. It takes a long time and it is very hard for my child to get used to new things.					SA	A	NS	D	SD
21. It takes a long time and it is very hard for my child to get used to new things.					SA	A	NS	D	SD
For the next statement, choose your response from the choices 1 to "5" below.									
22. I feel that I am:	1	2	3	4	5				
	1	2	3	4	5				
	2								
	3								
	4								
	5								
23. I expected to have closer and warmer feelings for my child that I do and this bothers me.					SA	A	NS	D	SD
24. Sometimes my child does things that bother me just to be mean.					SA	A	NS	D	SD
25. My child seems to cry or fuss more often than most children.					SA	A	NS	D	SD
26. My child generally wakes up in a bad mood.					SA	A	NS	D	SD
27. I feel that my child is very moody and easily upset.					SA	A	NS	D	SD
28. My child does a few things which bother me a great deal.									
29. My child reacts very strongly when something happens that my child doesn't like.					SA	A	NS	D	SD

- | | | | | | |
|--|----|---|----|---|----|
| 30. My child gets upset easily over the smallest thing. | SA | A | NS | D | SD |
| 31. My child's sleeping or eating schedule was much harder to establish than I expected. | SA | A | NS | D | SD |

For the next statement, choose your responses from the choices "1" to "5" below.

32. I have found that getting my child to do something or stop doing something is:
- 1 much harder than I expected
 - 2 somewhat harder than I expected
 - 3 about as hard as I expected
 - 4 somewhat easier than I expected
 - 5 much easier than I expected

For the next statement, choose your response from the choices "10+" to "1-3".

33. Think carefully and count the number of things which your child does that bother you.
For example: dwindles, refuses to listen, overactive, cries, interrupts, fights, whines, etc.
34. There are some things my child does that really bother me a lot.
35. My child turned out to be more of a problem than I had expected.
36. My child makes more demands on me than most children.

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Appendix (IX)

Text of: General Health Questionnaire - 12(Goldberg & Williams, 1998)

HAVE YOU RECENTLY:

1 -	been able to concentrate on whatever you're doing?	Better than usual	Same as usual	Less than usual	Much less than usual
2 -	lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
3 -	felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
4 -	felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
5 -	felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
6 -	felt you couldn't overcome your difficulties	Not at all	No more than usual	Rather more than usual	Much more than usual
7 -	been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
8 -	been able to face up to your problems?	More so than usual	Same as usual	Less able than usual	Much less able
9 -	been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
10 -	been losing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
11 -	been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
12 -	been feeling reasonably happy, all things considered?	More so than usual	About same as usual	Less so than usual	Much less than usual

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Appendix (X)

Focus Group Themes

1. WIDER SYSTEMS	4. BELIEF SYSTEMS INC RELIGION
Services	Health/illness
Legal	Spirits
Health	Evil
Education	Cultural beliefs
Social welfare	Ritual / Initiation
Roles	
Supports within	
Context	5. CULTURAL DIFFERENCES
	Language
2. ATTITUDES TO WOMEN IN Country of Origin	Expectations
Family	Assumptions
Parenting	Differences e.g. bathing
Pregnancy	(construction and meaning of language)
Abortion	Role of older women
Women	
	6. STRESSORS SPECIFIC TO THE POPULATION
3. ROLE AS MOTHER IN IRELAND	
Relationship with baby	Legal / deportation / moving accommodation
Fears	Future – limbo
Anxieties	Predicting stressors
Daily routine	Identity
Attachment	Belonging
Parenting	Raising a child in another country
	Language
	Education
	Child development and parenting
	Psychological consequences of not belonging
	Conditions / contingencies

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Appendix (XI)

Unaccompanied Minor Statistics: January - December 2003

SWSCSA database

Total Number of Referrals to Service	<u>789</u>
Total Number of Reunifications	439
Total Number of Children taken into Care	277
Other (Inappropriate referrals)	73

Countries of Origin of Children taken into Care

Country	Male	Female			
Azerbaijan	1	0	Liberia	6	4
Botswana	0	1	Malawi	1	0
Burma	0	1	Moldova	4	1
Burundi	5	1	Nigeria	33	44
Cameroon	3	7	Palestine	1	0
China	1	1	Romania	4	5
DR Congo	11	6	Russia	1	0
Estonia	2	0	Rwanda	3	3
Ethiopia	0	4	Sierra Leone	2	3
Georgia	8	5	Somalia	11	15
Ghana	1	5	South Africa	1	3
Guinea	1	1	Sudan	1	0
Iran	1	0	Taiwan	1	0
Iraq	4	0	Tajikistan	1	0
Ivory Coast	1	2	Togo	0	1
Kenya	5	13	Uganda	1	7
Kosovo	2	0	Ukraine	1	2
Kuwait	1	0	Uzbekistan	0	0
Latvia	0	1	Zimbabwe	0	2
			Total	134	143

Age Breakdown	
0-9 Years Old	
Male	2
Female	2
10-12 Year Old	
Male	2
Female	2
13-15 Year Old	
Male	24
Female	25
16-18 Year Old	
Male	106
Female	114

Appendix (XII)

Unaccompanied Minor Statistics: January - December 2004

SWSCSA database

Total Number of Referrals to Service	<u>617</u>
Total Number of Reunifications	418
Total Number of Children taken into Care	174
Other (Inappropriate referrals)	25

Countries of Origin of Children taken into Care

Country	Male	Female			
			Russia	0	1
Afghanistan	5	0	Rwanda	1	1
Albania	1	0	Sierra Leone	3	1
Angola	2	0	Somalia	11	7
Azerbaijan	0	1	South Africa	0	3
Bangladesh	0	1	Sudan	5	0
Belarus	1	0	Kazakhstan	1	0
Burundi	2	0	Tanzania	0	1
Cameroon	2	1	Uganda	1	4
China	3	0	Zimbabwe	0	1
Columbia	1	0	Total	88	86
DR Congo	2	4			
Eritrea	2	5			
Ethiopia	4	3			
Georgia	2	0			
Grenada	0	3			
Ghana	0	4			
Guinea	4	4			
Iran	1	0			
Kenya	0	1			
Liberia	4	0			
Malawi	2	0			
Moldova	4	2			
Mongolia	2	0			
Nigeria	17	32			
Romania	5	6			

Age Breakdown	
0-9 Years Old	
Male	4
Female	6
10-12 Year Old	
Male	6
Female	5
13-15 Year Old	
Male	21
Female	21
16-18 Year Old	
Male	55
Female	56