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### Emotional Disturbance in Fifty Children in the Care of the Child Welfare System

A. H. Thompson<sup>a</sup> & Deanna Fuhr<sup>b</sup>

<sup>a</sup> Director, Mental Health Research Unit, Alberta Mental Health Services, Edmonton, AB, T5J3E4

<sup>b</sup> Research Associate, Alberta Mental Health Services

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# Emotional Disturbance in Fifty Children in the Care of a Child Welfare System

A. H. Thompson  
Deanna Fuhr

**ABSTRACT.** Fifty Canadian children in out-of-home placements under the jurisdiction of a child welfare district office were administered a battery of psychological assessment instruments. The purpose was to obtain an estimate of the proportion showing psychopathology. The child's social worker's opinion on the presence or absence of psychopathology and need for mental health services was also determined. The results showed that 72% of the children were rated by their social workers as displaying emotional disturbance, with 56% recommended for counselling. Depending on the cut-off level used, the test results showed psychopathology rates ranging from approximately 60-80%. Native Indians were over-represented in the sample, but showed no meaningful differences from non-Natives in psychopathology levels. The overall profile of test results suggested that the sample was characterized by disorders that are

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Dr. Thompson is Director, Mental Health Research Unit, Alberta Mental Health Services, 4th Floor, South Tower, 10030-107 Street, Edmonton, Alberta T5J3E4 Canada. Ms. Fuhr is a Research Associate at the Alberta Mental Health Services. Portions of this paper were presented at the Child Welfare League of America conference, Group Care in North America: Today and Tomorrow, Houston, February, 1986. This study was supported in part by Government of Alberta grants under the Priority Employment Program and the Student Temporary Employment Program. We gratefully acknowledge the assistance of Alberta Child Welfare, in particular Gordon Schmaus, Liz Messiah, Sharon Whitworth and the staff of the Centennial Mall District Office, with special thanks to the Manager Salim Akhtar. Sheena Woodhead, Alana Kyne and Clint Patterson contributed to the study with their work on literature reviews and client interviews. This paper benefited from the comments of anonymous reviewers. Reprints may be obtained from Dr. Thompson.

relatively enduring and difficult to treat, rather than by those expected in reaction to adverse social conditions.

It is clear that the mental health of children in care is a high priority among child care givers. The literature contains numerous references to treatment programs that are provided, and the negative effects on mental health of particular forms of abuse and neglect are studied intensively. However, the number of studies on the prevalence of mental or emotional disorder in populations of children in the care of child welfare systems is limited.

Those studies that have been reported indicate that children in foster care are, as most practitioners would predict, at much higher risk for psychopathology than those who have not been in care. For example, Wolkind and Rutter (1973) found that English 10 and 11 year olds with emotional disorders (based on teacher and parent ratings) were much more likely to have been in care than those who did not display an emotional disorder (6 to 15 times more likely, in fact, depending on the sample and on the judged severity of the disorder). Bohman and Sigvardsson (1980) studied a sample of Swedish children eligible for adoption. Teacher ratings were obtained at age 11 and again at age 15. They found that these children were several times more likely to show maladjustment than normal controls, and that, at age 15, those who had remained in foster care were more likely to be disturbed than those who had been adopted. Frank (1980) examined interview/questionnaire ratings of psychosocial adjustment made by two professionals taken from a sample of American six to twelve year olds in long-term foster care. A second rating was made five years later. Frank's results showed nearly 80% maladjustment when reassessed. Finally, Fanshel and Shinn (1978) examined American children in foster care, assigning ratings of abnormal, normal, or "suspect," based on clinical psychologists' use of observation and projective tests. Over the five-year period of this investigation, just over 50% of the subjects were normal on each of three testings. Nearly 25% were rated as emotionally maladjusted.

These four studies, which differed in methodology, in sub-samples of children in care that were studied, and which represented three different countries, all found a strong relationship between child welfare involvement and mental disorder.

A potential difficulty, however, is that those studies tended to use assessment instruments that, while not without merit, were not standardized, particularly in terms of published test norms. Wolkind and Rutter (1973), however, created their own norms in that their study was epidemiological in nature, comprising a large number of children sampled from the general population. However their instruments, although well developed, are not widely used in either Canada or the United States. Although Bohman and Sigvardsson (1980) also used a normal control group, their rating scale has not been validated, and is thus difficult to evaluate. The landmark work of Fanshel and Shinn (1978), while capitalizing on the richness of the clinical interview and of the use of projective tests, nonetheless leaves us with some difficulty. That is, clinicians' judgements have not shown high reliability (e.g., Mischel, 1968) and projective tests have not demonstrated adequate reliability or validity (Vernon, 1964; Zubin, Eron, and Schumer, 1965).

As noted above, the major studies on this topic were conducted in three different countries; England, Sweden, and the United States. To date, no study has appeared in the literature on a Canadian sample (although Offord, Boyle, and Jones, 1987, have shown that the prevalence of mental disorder is high in children whose families are on welfare). While there is no overwhelming reason to believe that the Canadian situation would differ, this question remains undressed.

In light of the above-noted issues, the present study was designed to re-examine the prevalence of psychopathology in children in foster care, but in a Canadian sample, using standardized psychological assessment instruments.

Another issue of interest is the degree to which social workers can accurately identify emotional disturbance in the children that they are responsible for. In practice, these social workers are required to make judgements on a child's need for clinical services, often without the benefit of access to any diagnostic information. Unfortunately the literature does not provide data on the agreement between social workers' judgements of emotional disorder and that derived from standardized test results. As a consequence, a secondary goal of the present study was the determination of the level of social worker and test-battery agreement.

## METHOD

### *Subjects*

The sample consisted of 50 children with child welfare status who were randomly selected from the caseload of an urban child welfare office in Alberta. There were 25 individuals with permanent ward status and 25 individuals with temporary ward status. It should be noted here that the term "permanent ward" refers to a child whose legal guardianship has been taken away from the parent(s) and assigned to the state. A temporary ward is a child placed in care under the authority of the state, but whose guardianship can be returned to the parents if and when they become able to care for the child again. The distribution of males and females was unequal with 19 females and 31 males. Ages ranged from 6 to 18 years ( $\bar{x} = 13.0$ ,  $SD = 3.51$ ). The criteria for selecting subjects for testing were that the child still resided in the region; was between 6 to 18 years of age; and was not on the adoption list nor on the mentally handicapped list. This left 89 subjects from the original permanent ward population of 160, and 94 subjects from the temporary ward total population of 112. These subjects were contacted in a pre-selected random order until 25 were tested from each group. In the process, 28 cases were rejected for the following reasons: the social worker's refusal because the child was emotionally or psychologically disturbed (9), the child was again living with the parent(s) and it was felt to be disruptive if assessed at that time (6), AWOL (2), on holidays (3), or "other" (8).

The fact that nine children were not allowed to participate because they were emotionally disturbed (and testing might be upsetting to them) adds, of course, an interesting bias. That is, considering that the subjects removed would have constituted a significant proportion of the sample of 50, prevalence estimates will thus err on the conservative side to a considerable degree.

### *Assessment Instruments*

The following measures were selected for use in this study because they show adequate reliability and validity, are well normed, and are widely used and accepted.

*Child Behavior Checklist (CBCL)* (Achenbach and Edelbrock, 1983). This scale is designed to record in a standardized format the behavior problems and competencies of children aged 4 to 18 years. The checklist was administered to either the foster parent, child care counsellor, or one familiar with the child. This scale provides measures of internalizing (neurosis, anxiety), externalizing (conduct disorders, hyperactivity), and social competence, as well as a measure of the extent of problem behavior (behavioral competence). In addition, subscales dealing with more specific behavioral characteristics, which differ according to age and sex, are provided (e.g., schizoid, anxious, depressed, uncommunicative, immature).

*Eysenck Personality Questionnaire (EPQ)* (Eysenck and Eysenck, 1975). This questionnaire was completed by the child. Measures of psychoticism, neuroticism, and potential for criminality are produced.

*Children's Depression Inventory (CDI)* (Kovacs, 1982). The Children's Depression Inventory is a 27 item self-rated depression scale. The CDI produces a single depression score, based on a wide range of symptoms. The scale is sensitive to changes in depression over time and to the severity of the depressive order.

*Culture Free Self-Esteem Inventory (SEI)* (Battle, 1981). For children 6 to 15 years Form B of the SEI was used. This is a 25 question, self-report scale that produces four scale scores; general self-esteem, social, school, and parental. The lie scale was not included. Children 16 to 18 years were administered Form AD. Excluding the lie scale there are 33 questions. This form of the SEI measures the child's perception in three areas; general, social, and personal self-esteem. A significant factor in the selection of this inventory is that it was normed on children from the same geographic area as the children in the test sample in this study. For the purposes of the present study, only a "total" or overall self-esteem score was used for analysis.

*Historical Data.* Additional data collected on each child included age, sex, grade in school, native status, date taken into care, intake reason, child welfare status, present placement, length of time in care, and treatment proposed. These data were taken from client files and/or based on the opinion of the child's social worker.

### ***Design and Procedure***

The assessment instruments were administered by two research assistants, who also completed an information form on each child. The children were tested at their place of residence. The research assistants handed out the self-reports (SEI, CDI, and EPQ) which the children completed. The CBCL was filled out by the foster parent or person in care of the child. The child's social worker was contacted to provide historical information on the child, and to give an opinion of the primary cause of the child being brought into care. The social worker was also asked to rate the present mental health of the child; the options were (1) no mental problems, (2) emotional disturbances (emotional/behavioral condition resulting in disturbances in one or more areas of life; e.g., school, home), or (3) severe mental illness (severe disturbances, incapacitation resulting from psychotic-like behavior such as hallucinations and delusions).

In the analysis of the test results, raw scores were used for the CDI and the SEI. Raw scores were converted to quotient scores for the EPQ. T-scores were derived for the Social Competence, Behavioral Competence, Internalizing, and Externalizing scales of the CBCL.

In terms of estimating the presence or absence of psychopathology, two levels were considered for analysis. In the first case, those falling in the upper 10% (based on population norms) were deemed to be "abnormal." This is in line with many studies which show a point prevalence of at least 10% in the general population (Dohrenwend, Dohrenwend, Gould, Link, Nengebauer and Wunsch-Hitzig, 1980). The second, more restrictive level considered only those falling above the 98th percentile, as has been suggested by Achenbach and Edelbrock (1983) as indicating a disorder serious enough to require treatment.

## ***RESULTS***

### ***General Sample Characteristics***

All subjects, but one, were in school. Twelve were in special classes, with the remaining 35 spread across all 12 grades. Twenty

of the 50 children were Native Indians. Of these, five held legal Indian status, and the remaining 15 were either non-Treaty Indians or Metis (mixed race) individuals. Thirty-one children were living in foster homes, 8 in group homes, 7 in residential institutions, 3 were with relatives, and 1 was living independently.

The median length of time in care was 5.5 years, with the range being from less than one year to 17 years.

### **Reasons for Placement**

The reasons noted in the file for being placed in care were varied (up to 3 could be listed per case). The predominant categories were "parent-child problems" (80%), "personal problems of parents" (76%), and "child with special needs" (64%). Perhaps more revealing were the opinions of the social workers caring for the children in regard to the primary reason for being in care. These are shown in Table 1. It is interesting that the social workers were able to supply opinions on only 31 of the children. In 19 of the cases (38%), the social workers were unaware of the circumstances surrounding the original assignment of care status. Ordinarily, this was

TABLE 1. Social Workers' Opinions of Primary Reasons for Children Coming into Care

Reason (Max=3 Per Case)	N	% of cases*
Sexual Abuse	9	29%
Unwilling Or Unable To Care	7	23%
Surrendered-Abandoned	6	19%
Neglect	6	19%
Parent-Child Conflict	6	19%
Problems Of Parent	5	16%
Physical Abuse	3	10%
Substance Abuse (Parent Or Child)	3	10%
Other	3	10%

\* Based on 31 cases

because the child was not on the case load at the time of apprehension or the social worker was not yet familiar with the case. The most frequent reasons for which the social worker felt the child came into care were sexual abuse and the unwillingness/inability of the parent to provide care. Note that sexual abuse formed the largest category (29%), and that this would not have been evident from official records.

### ***Mental/Emotional Status***

*Worker Estimates.* In all but one of the cases, the child's social worker provided an opinion on the presence or absence of emotional disturbance in the child in their care. Seventy-four percent were deemed to have an emotional problem, while 26% were thought to have no mental problems. None were rated as showing severe mental illness. Anecdotal evidence suggests that at least some of the nine children who were dropped from the sample because of their mental state, would have fallen into this category. Fifty percent of the children who were rated as having emotional problems by the social worker did not have information in their files indicating this.

*Child Depression Inventory.* Scores range from zero to 24, with a mean score of 8.7 ( $SD = 6.27$ ). This figure is somewhat lower than the mean score of 9.28 found in a normative group of Canadian children (Kovacs, 1983), indicating that, while some individuals were depressed, the present sample was collectively no more disturbed than a group of normal children.

*Self-Esteem Inventory.* The data on this test show that over half of the subjects scored in the HIGH (34%) to VERY HIGH (22%) self-esteem categories (when looking at total self-esteem). Conversely, only ten percent of this sample scored in the LOW (8%) or VERY LOW (2%) ranges. As in the case of depression, there is no evidence of abnormality for the group as a whole.

*Eysenck Personality Questionnaire.* Data were produced by converting raw scores to quotient scores (QS) for each of the scales. Raw scores are not presented as these vary across age and sex categories. Significance tests were based on a comparison of the subject sample scores against a population with a mean of 100 and a stan-

dard deviation of fifteen. Only the Criminality scale (mean QS = 122.4) showed a statistically significant difference from the norm ( $t = 5.05$ ,  $p < .001$ ) with Psychoticism (QS = 103.3) approaching significance ( $t = 1.34$ ,  $p < .10$ ). The mean QS for Neuroticism was 98.7.

*Child Behavior Checklist.* A total of 30% of the sample scored above the 98th percentile on the Social Competence Scale (implies social deficits in this area), and 20% of the sample scored above the 98th percentile on the Behavioral Problems scale. For the Internalizing and Externalizing scales respectively, the figures were 16% and 20%. Table 2 shows the percentage of children scoring in the deviant range on the various sub-scales. It would appear that those behavioral tendencies with the highest prevalence tend to be the least amenable to treatment. For example, "schizoid" is based heavily on symptoms reflective of weak reality testing (Achenbach and Edelbrock, 1983), which are thought to be predictive of later psychotic disorder (Eysenck and Eysenck, 1976). Furthermore, "delinquent," insofar as it is correlated with conduct disorder, im-

TABLE 2. Percentage of Children Scoring in the Deviant Range on CBCL Sub-scales\*

0 - 10%	11- 20%	21 - 20%	30%+
Sex Problems (7)	Aggressive (50)	Schizoid (33)	Social Withdrawal (17)
Somatic Problems (50)	Uncommunicative (31)	Hostile Withdrawal (21)	
	Depressed (17)	Depressed Withdrawal (12)	
	Obsessive Compulsive (31)	Immature (21)	
	Anxious Obsessive (12)	Immature Hyperactive (12)	
	Schizoid Obsessive (7)	Hyperactive (38)	
	Schizoid or Anxious (10)	Delinquent (50)	
		Cruel (19)	

\*Bracketed figures refer to the total number of children assessed on the factor in question.

plies a behavior pattern that is quite intractable (Gould, Wunsch-Hitzig, and Dohrenwend, 1980). Note that, because of the age-sex subgroupings, some of the sub-scales were not applied to all of the children. The percentages presented in the table were based only on the portion of the sample to which the particular sub-scale applied.

*Social Workers' Recommendations on Services Required.* The social workers were asked to recommend services they felt were required for the child and/or family. Counselling (56%) and Support Services (18%) were recommended most often. Support Services include homemakers, parental aides, family support workers, and social worker's general support.

*Native Indian Children.* Although an investigation of ethnic differences was not an original objective of the study, a decision was made to compare Native Indian children with non-Natives because Indian children are often dramatically over-represented in foster care in Alberta (Thompson, 1988), and a significant number appeared in the present sample, allowing such a comparison.

Within the permanent ward category Indian children predominated (14 of 25; 56%), in comparison to the figures for temporary wardship where 6 out of 25 (24%) were Native ( $\chi^2 = 4.08$ ;  $df = 1$ ;  $p < .05$ ). Overall, forty percent (20 children) of the sample were of Native Indian origin. This compares to a figure of 3.8% of the children in the general population of the Region. Of all Child Welfare status children in the Region, Indians make up 22.1% of the population (Yamada, 1985). Thus, not only are Indian children over-represented in the Child Welfare population, but within it they appear to be over-represented in the permanent ward category.

Table 3 shows a summary of the comparison of Native Indian children with non-Natives on all personality measures. Note that there were no significant differences, thus providing no evidence to support the view that Native Indian children in care differ from non-Native children in level of psychopathology.

### ***Psychopathology***

When psychopathology criteria are considered, the test results showed that Psychoticism, Criminality, Internalizing, Externalizing, Social Competence and Behavioral Competence have a greater

number of subjects scoring above the 90th percentile than would be expected (refer to Table 4). For example, twelve children (24%) scored in the upper 10% on Psychoticism, where as we would have expected only 5 individuals in a normal population.

Overall, the same set of scales also showed statistically signifi-

TABLE 3. Differences in Native and Non-Native Test Scores

Personality Scale	Native		Non-Native		t
	$\bar{x}$	(SD)	$\bar{x}$	(SD)	
Psychoticism(EPQ)	106.36*	(20.09)	101.23*	(15.29)	.311
Neuroticism(EPQ)	99.73*	(12.02)	97.93*	(18.06)	.698
Criminality(EPQ)	113.55*	(16.35)	111.66*	(18.39)	.713
Internalizing(CBCL)	54.00	( 7.38)	57.83	(14.48)	.283
Externalizing(CBCL)	56.50	( 8.89)	58.59	(14.43)	.568
Social Competence(CBCL)	36.15	( 5.78)	37.83	(13.28)	.598
Behavioral Competence(CBCL)	55.90	( 8.88)	61.21	(14.19)	.145
Depression(CDI)	99.32*	(11.04)	99.30*	(14.61)	.996

\*quotient scores

TABLE 4. The Number of Subjects Scoring in Psychopathological Ranges (10% and 2% Cutoffs)

Psychological Measure	Upper 10%			Upper 2%		
	n	‡	χ <sup>2</sup>	n	‡	χ <sup>2</sup>
Psychoticism(EPQ)	12	24‡	10.89**	03	06‡	4.08*
Neuroticism(EPQ)	08	16‡	2.00	01	02‡	0.00
Criminality(EPQ)	21	42‡	58.78**	07	14‡	36.75**
Internalizing(CBCL)	15	30‡	23.13**	08	16‡	50.02**
Externalizing(CBCL)	17	34‡	33.20**	10	20‡	82.69**
Social Competence(CBCL)	28	56‡	121.00**	15	30‡	200.08**
Behavioral Competence (CBCL)	16	32‡	27.94**	10	20‡	82.69**
Depression(CDI)	06	12‡	0.22	00	00‡	1.02
Self-Esteem(SEI)	04	08‡	0.22	01	02‡	0.00

\* p < .05      \*\* p < .001

cant proportions scoring above the 98th percentile. Neuroticism, Depression and Self-Esteem did not yield any significant results at either the 90th or 98th percentile levels.

Note that in the comparison of means, noted earlier, that the group deviation on Psychoticism fell short of significance. In the present analysis however, a significant proportion ranked above both the 90th and 98th percentiles, reflecting the fact that, unlike the other test scales that were used, Psychoticism is not normally distributed in the general population. It is, in fact, positively skewed, with the majority of the scores clustered tightly around the low end of the scale. Thus, a rise in a score of one or two points for an individual would have very little effect on the group mean, but it would have a dramatic effect on the relative ranking of that person.

With the use of all scale scores, we can determine the proportion of children showing psychopathology on one or more of the measures. Table 5 shows that 82 percent of the subject population scored in the psychopathological range (upper 10%) on at least one of the scales. Looking at a stricter criterion, that is, two or more of the scales above the 90th percentile, we find that 31 (62%) of the children fall into this category. When only considering the upper 2% of the population as showing psychopathology, 30 (60%) of the

TABLE 5. Frequency Distribution of the Number of Scale Scores Showing Psychopathology

# Scales Scoring in Pathological Range	# Children Identified Upper 10%	%	# Children Identified Upper 2%	%
0	9	18%	20	40%
1 or more	41	82%	30	60%
2 "	31	62%	13	26%
3 "	22	44%	7	14%
4 "	14	28%	4	8%
5 "	9	18%	1	2%
6 "	6	12%	0	0%
7 "	3	6%	0	0%
8 "	1	2%	0	0%

subjects scored in the psychopathological range on at least one of the scales. Twenty-six percent (13) scored above the 98th percentile on 2 or more of the measures.

### ***Agreement Between Social Workers and Test Results***

The levels of correspondence between the social workers' opinions on the presence/absence of emotional disturbance and estimates of psychopathology produced from test results are shown in Table 6. The data indicate that while reasonable agreement can be obtained, this can be affected by the strictness of the definition of disorder that is used.

When considering, for example, the correspondence of social workers' ratings with the criterion of at least one psychopathological test result (upper 10%), we find that of the 49 cases with valid

TABLE 6. Agreement Between Test Results and Social Workers Ratings of Emotional Disturbances

		<u>1+ SCALES IN UPPER 10%</u>	
		-	+
TEST RESULTS	-	5	4
	+	8	32

  

		<u>3+ SCALES IN UPPER 10%</u>	
		-	+
TEST RESULTS	-	9	18
	+	4	18

ratings, 37 (76%) showed agreement. In four cases (8%) the social workers identified emotional disturbance, which was not reflected in the test results (false positives), and eight cases (16%) showing abnormal test results were not identified by the social workers (false negatives). Looked at another way, of the 36 cases identified by the social workers as disturbed, there was disagreement on only four (11%). On the other hand there was disagreement on eight (62%) of the 13 cases deemed not to be disordered by the social workers. When looking at a more extreme cut-off of at least three psychopathological test results and comparing these results with the social workers' ratings, we find that overall agreement has dropped to 55% (27 cases). While the false negative rate has improved, the false positive rate has risen to 37% of all cases, and 50% of those identified as disturbed. Note that these figures were calculated with test results taken as base or "true" values. Considering that we do not know whether either social worker ratings or test results are "true," this approach was arbitrary. The conclusions, however, would be about the same with social workers' ratings taken as the base.

### DISCUSSION

The results appear to suggest that this specific child welfare population has a high need for mental health intervention. Adopting the cautious criterion of a score in the psychopathological range on two or more of the tests, 62% of the sample would appear to exhibit some form of mental disorder. The social workers' estimates, on the other hand, were that 72% of the children showed signs of emotional disturbance. Recall that these estimates of psychopathology can be considered to be conservative because of the exclusion from the sample of those children deemed to be too emotionally disturbed to participate.

In regard to Native Indian status, the results indicate that overall there is very little difference in the prevalence of mental disorders when Native and non-Native children in care are compared. The most useful conclusion that can be drawn here is that the rates of emotional disturbance are high for both groups. However, any conclusions must be tempered by consideration of the fact that there

were only 20 Native children in the study. Thus, the results should be interpreted with some caution. The issue is nonetheless an important one. Given that the socioeconomic status of Native people is generally quite different from that of the population as a whole, the reasons for their children coming into care may also differ. Thus, it is not necessarily to be expected that the emotional status of Indian and non-Indian children would be the same. This is an area where further research, using larger samples, would be in order. It would be illuminating if future studies were not restricted to children in foster care, but also considered the mental well-being of Indian children not in care. Furthermore, the finding of the over-representation of Indian children in permanent versus temporary care requires confirmation, and if replicated, subsequent exploration of the possible causes of this differential application of permanent guardianship status.

The fact that there were no differences between temporary and permanent wards in levels of psychopathology suggests that the relative "stability" of permanent care is not reflected in a higher degree of mental health. However, there are a number of other factors, other than status, that might explain this result. For example, the actual living arrangements of permanent wards may not be any more stable than that for temporary wards. In fact, the distribution of placements is about the same for both groups. A further influence on group differences could be a selection factor. That is, the "healthier" children are more likely to either be adopted or returned to their parents, leaving the more disturbed proportion of temporary wards in care. Considering the suggestions made by Maas and Engler (1959), Bohman and Sigvardsson (1980), and Frank (1980) that staying in care is harmful to mental health, these factors require continued serious study. In this vein, Fanshel and Shinn (1978) have found that positive change in mental well being over time was related to such factors as frequency of parental visits, the quality of the foster home, and casework skill. Interestingly, those who entered foster care as disturbed children tended to show improvement over time while in care.

The categorical statements made by the social workers regarding the mental health of each child showed moderate agreement with the test results. Unfortunately, there were significant disagreements

between the two points of view. It should be noted that these results do not necessarily implicate either the social workers' judgements or the veracity of the tests used. It may, in fact, be that neither is contextually incorrect in that different sources of information are used to formulate a designation of emotional disturbance. However, the practical problem remains that agreement between the two sources would be expected to be somewhat higher for use in a referral service such as that provided by the social workers. It should be noted that the social workers in the system under study had not necessarily received significant formal training in the mental health area. The highest level of training was at the Master of Social Work level, but with the majority holding a Bachelor of Social Work as the highest university degree, and a smaller number at a general Bachelor of Arts level.

In an effort to eliminate or diminish this problem, the social workers could receive more training and/or increased consultation with mental health professionals in the identification of emotional or psychological disturbances. Psychological tests could also be given upon intake as a screening procedure allowing both methods to be combined, resulting in increased positive identification. In fact, considering the high prevalence of emotional disturbance in this group of children, psychological assessment of all children coming into care would appear to be called for.

The profile that appears for this group of subjects when one considers scores in the psychopathological range is a cause for some concern. That neuroticism, depression and self-esteem did not show abnormal distributions suggests that we are not just dealing with unhappy children who are responding to very difficult life events. Rather, the over-representation of psychopathology on psychoticism, criminality and externalizing behaviors indicates that we appear to be looking at a personality pattern, or patterns, that could lead to serious adult disturbances that are difficult to treat. Behaviorally, the striking deficit in social competence reflects a serious problem, but also suggests an avenue for treatment. Treatment approaches would appear to require a component focusing on the teaching of social skills. Furthermore, it is clear that the problems are severe, requiring extensive involvement of specialists in clinical work with children. Recognizing that the prediction of adult disor-

ders is tenuous at best (Kohlberg, Ricks, and Snarey, 1984), the data nonetheless provide a strong suggestion that early mental health intervention with disturbed wards may have preventative as well as immediate benefits. This represents an area where further research is certainly required. Information is needed on adult sequelae of childhood disorders, and on the effects of early treatment and prevention efforts within the child care context.

A limitation of the present study is that the relatively small sample size did not allow for an examination of the many factors that are thought to predict emotional disturbance of those in care (e.g., frequency of parental visiting, age when entering care, number of placements, duration of care; Fanshell and Shinn, 1978; Gruber, 1978). While it was not the purpose of the present study to examine these factors, the prevalence of emotional disorder that was found is indicative of the need to investigate these factors in future, larger-scale studies.

Finally, it should be noted that the data in this study focus on psychopathology and thus point to treatment interventions. These appear to be necessary, but other types of interventions such as those leading to stability and quality of care that involve competent case planning and the creation of support systems should not be ignored. The reasons for children coming into (and staying in) care are many, and it follows that potential solutions cannot operate as isolated factors. It is questionable whether professional involvement can be of much use without concomitant strengthening of the home environment and support systems.

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