The Effects of Foster Care Placement on Young Children's Mental Health

Beth Troutman, Ph.D., Susan Ryan, M.A., and Michelle Cardi, M.A.
University of Iowa Hospitals and Clinics

Introduction

Young children are more likely than older children to be placed in foster care and to spend a larger proportion of their life in the foster care system (Goerge & Wulczyn, 1998). In a recent review of foster care in several states, the incidence of placement in foster care for children under age 5 was double that of children aged 5–17 (4 per 1,000 vs. 2 per 1,000) (Goerge & Wulczyn, 1998). Young children are in foster care longer than older children and infants are in foster care significantly longer than other age groups (Goerge & Wulczyn, 1998). In the 5 states studied, the median length of time infants spent in foster care ranged from 11 to 42 months (Goerge & Wulczyn, 1998). This paper explores the potential impact of foster care placement on young children's attachment relationships and mental health.

Factors Leading to Placement in Foster Care

Children are removed from their homes to protect them from immediate physical harm (Zuravin & DePanfilis, 1997). Substance abuse and the drug culture account for the majority of young children placed in foster care (Simms, 1991). Race and socioeconomic status does not appear to have a major impact on decision making regarding foster care placement (Zuravin & DePanfilis, 1997). In general, foster care placement adequately provides for the physical protection of children. For example, in a study comparing home and out-of-home placements of infants born to substance-abusing mothers, there was a 7% death rate and a 4% rate of abuse and neglect in the home placements compared to none of these events in the infants placed in kinship or foster care placements (Tyler, Howard, Espinosa, & Doakes, 1997). However, foster care placement has implications for the healthy emotional development of young children.

Attachment Disruptions Among Young Children in Foster Care

Out-of-home placement is typically associated with numerous disruptions in attachment relationships. These losses and lack of permanence undermine a child's attempt to form a secure attachment with a primary caregiver. The more changes in caregivers young children in foster care experience the more likely they are to exhibit oppositional behavior, crying, and clinging (Gean, Gillmore, & Dowler, 1985). Disruptions in attachment relationships can lead to Reactive Attachment Disorder of Infancy or Early Childhood (American Psychiatric Association, 1994), a disorder in which the child exhibits severe disturbances in relationships with caregivers.

The importance of the relationships foster children develop with their foster parents is sometimes underappreciated. Psychiatric emergencies among

children in foster care are often precipitated by disruptions in their attachment relationships with foster parents (Pilowsky & Kates, 1996). Infants placed in out-of-home care for several months will come to view the caregiver who provides for their daily emotional and physical needs as their attachment figure. When working with infants in out-of-home placements, it is important to keep in mind that, unless the out-of-home placement is very brief, reunification with parents or placement in an adoptive home constitutes an attachment disruption.

Reducing Attachment Disruptions

In order to reduce attachment disruptions for infants, there has been an increasing emphasis on allowing infants to stay with their mothers despite the mother's difficulties. For example, allowing babies to stay with incarcerated mothers (Harris, 1992) or mothers in residential treatment for substance abuse (Wobie, Eyler, Conlan, Clarke, & Behnke, 1997). Ideally, these programs not only reduce attachment disruptions but allow close supervision of the mother and infant and the opportunity for interventions to enhance the quality of the mother-child interaction.

In an attempt to expedite placement with a consistent caregiver, concurrent planning has been promoted as a useful tool. Development of concurrent plans, when a child is in foster care, allow efforts to reunify children with their biological parents to take place simultaneously with efforts to achieve an alternative plan. Concurrent planning is one feature of the Adoption and Safe Families Act (ASFA) which was passed in 1997. An additional feature of ASFA is that the length of time for the biological parents to make significant progress on the goals outlined by the reunification plan is limited to twelve months, though judges can make exceptions. Both policies have the potential to reduce the attachment disruptions experienced by young children in out-of-home placements.

Concurrent planning has the potential to limit the attachment disruptions faced by infants placed in substitute care. By placing the child in the home of a foster family or family member who could become the child's adoptive family if the biological parent fails to regain custody, further disruption of attachment relationships is prevented if the child is unable to be reunified with biological parents. Concurrent planning does not eliminate the stress that attachment disruptions cause babies and toddlers. However, it may limit the extent of the disruption by reducing the number of disruptions the child experiences.

According to ASFA guidelines, if biological parents have failed to make significant progress toward reunification at the end of twelve months, a petition to terminate parental rights can be filed. This time limit serves the ultimate goal to reunify child and biological parents within a timely manner. If the biological family is unable to make the changes needed to provide adequate care by this deadline, then the child may obtain permanency by remaining with the current caregiver for the purpose of adoption. This time limit is more congruent with a

child's sense of time and a child's need for a stable, continuous relationship with a caregiver.

There are a number of issues with the application of concurrent planning that have not been resolved. For the attachment needs of infants, concurrent planning is clearly superior to the current system as it has the potential to reduce the number of attachment disruptions experienced by the child. For caregivers, however, the loyalty conflicts inherent in the plan have the potential to create friction between substitute caregivers and the biological parents. Although time limits are responsive to the child's sense of time, this deadline creates additional stress for parents seeking to resolve the difficulties that lead to their child's placement in foster care.

It is unclear whether concurrent planning and the new time limits will affect quality of care. It is possible that concurrent planning may indirectly have a positive effect on the quality of care children receive in foster care. The possibility that foster parents may adopt the child may increase their emotional investment in the child, enhancing the quality of care. However, there is also the possibility that reduced time lines in ASFA may lead to premature reunification with parents in order to avoid termination of parental rights, indirectly causing a negative effect on quality of care.

Maintaining Attachment Relationships with Parents While in Foster Care

One of the biggest challenges faced by young children in foster care is maintaining attachment relationships with their parents. Children and parents need the opportunity to maintain an attachment relationship and develop more positive interactions. However, visits with parents can be upsetting to young children in foster care and disruptive to other aspects of their development (Gean, et al., 1985). The majority of young children who visit their biological parents in the parents' home exhibit symptoms (toileting problems, sleep disturbance, aggressive behavior, clinging, and crying) before, during, and/or after these visits (Gean, et al., 1985). This difficulty in maintaining a relationship with a non-primary caregiver is not specific to foster care. Infants of separated and divorced couples who have overnight visits with their fathers are more likely to have insecure attachment relationships with their mothers (Solomon & George, 1999). However, the overnight visits do not lead to improved attachment relationships with their fathers (Solomon & George, 1999). In both studies (Gean et al., 1985; Solomon & George, 1999), the attitude of the primary caregiver (foster parent or mother) towards visitation affected the infant's adjustment to visitation. Thus, it may be that having to place the infant in a situation the caregiver is uncomfortable with undermines the caregiver-child relationship.

Risk of Unresponsive Care in Foster Care

Care that provides for the infant's basic physical needs but is relatively insensitive or unresponsive to the infant's attachment signals and emotional needs can lead to an insecure infant-caregiver attachment (Ainsworth, Blehar,

Waters, & Wall, 1978; De Wolff & van Ijzendoorn, 1997). Although early insecure attachment relationships are not pathological, they place children at risk for subsequent emotional and interpersonal difficulties (Carlson, 1998; Erickson, Sroufe, & Egeland, 1985; Lyons-Ruth, Alpern, & Repacholi, 1993; Lyons-Ruth, Easterbrooks, & Cibelli, 1997).

Among infants placed in foster care at less than a year of age, the nature of the infant-foster mother relationship is a reflection of the foster mother's attachment style (Stovall & Dozier, 1998). That is, sensitive foster mothers provide responsive care that leads to a secure attachment relationship with their foster infant. Conversely, with toddler placements, the child-foster mother relationship reflects the child's previous attachment experiences (Stovall & Dozier, 1998). Thus, toddlers placed in out-of-home care after experiencing neglect, abuse, and/or unresponsive care actually need more responsive care than typical toddlers in order to develop a secure attachment.

The type of out-of-home placement most likely to interfere with the development of healthy attachment in infants and toddlers is placement in a group care setting. During the 1930s and 1940s, there were detailed observations of the deleterious effects of group care on the physical and emotional health of young children (Freud & Burlingham, 1944; Spitz, 1945). Although the events of the 1980s and 1990s have been less dramatic than the events leading to the out-of-home placement of children in the 1930s and 1940s, the number of "displaced" children has again led to the placement of young children in group care settings. Thirteen to eighteen percent of children placed in group settings in California from 1988 to 1995 were under age six (Berrick, et al., 1998). The minimum staffing ratio for infants in California group care is one adult to ten infants and there is a high staff turnover rate (Berrick, et al., 1998). Thus, it seems highly unlikely that babies placed in group care will receive consistent, responsive care in these settings and make good attachments.

Improving the Responsiveness of Foster Care

Foster parents may need guidance in how to effectively respond to the special attachment needs of infants and toddlers in their care (Stovall & Dozier, 1998). The more opportunities foster parents have to make decisions about the child's needs (e.g., how to reduce distress associated with visitation), the more likely they will feel confident in their abilities to provide a secure base for the child in their care. In addition, foster parents may need concrete support such as day care or respite care that helps them have the energy needed to respond to the attachment needs of young at-risk children. Day care or respite care should be brief and predictable in order to minimize attachment disruptions. When a young child's previous experiences in relationships make it difficult for him to communicate his needs to a caregiver, it may also be necessary for a play therapist to work directly with the child.

When it is necessary to place infants in group care, the care should simulate, as much as possible, the type of care infants receive in a family setting. Caregivers should be assigned to particular infants rather than to particular tasks. The group care should be organized such that caregivers have the time and flexibility to learn the infant's attachment needs and communications and respond to them.

Conclusions

Safeguarding the physical safety of infants and toddlers in foster care is not enough. Although there are no easy solutions, it is important that we address the mental health needs of young children in foster care. Both the child's need for continuity of relationships and his need for sensitive, responsive care should be considered in foster care placement decisions. When it is necessary for the child to experience an attachment disruption, we need to maximize the possibility of him experiencing sensitive, responsive care with the alternative caregiver.

Beth Troutman, Ph.D. is Assistant Professor of Clinical Psychiatry at the University of Iowa Hospitals and Clinics; Susan Ryan, M.A. is a Doctoral Candidate in the School Psychology Program at the University of Iowa; and Michelle Cardi, M.A., is a Research Assistant at the University of Iowa Hospitals and Clinics. All are located in Iowa City, Iowa.

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