

# **Effects of Foster Care Placement on Young Children's Mental Health: Risks and Opportunities**

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## **Introduction**

Children younger than 5 are twice as likely to be placed in foster care and spend longer in care than older children (Goerge & Wulczyn, 1998). Given the importance of relationships with primary caregivers for young children's social and emotional functioning, these statistics carry special significance. This paper describes the potential impact of foster care placement on young children's attachment relationships and mental health. We also describe opportunities to ameliorate the psychological risks inherent in foster care placement for young children and address their mental health needs.

## **Factors leading to placement in foster care**

Removal from caregivers and placement in foster care is typically precipitated by concerns regarding the child's safety. Parental substance abuse and associated problems account for the majority of young children removed from their homes and placed in foster care or kinship placements (Zuravin & DePanfilis, 1997). There is evidence that foster care placement decreases the risk for physical harm for infants of substance-abusing parents (Tyler, Howard, Espinosa, & Doakes, 1997). However, young children placed in foster care continue to be at significantly elevated risk for mental health problems. A longitudinal study of young children in poverty found children placed in foster care had more emotional problems than children reared by maltreating caregivers (Lawrence, Carlson, & Egeland, 2006).

## **Attachment disruptions among young children in foster care**

Separation from a primary caregiver is distressing for infants and young children, even if the caregiver maltreated them or failed to provide adequate care. Once they enter the foster care system, young children often experience additional changes in caregivers undermining their potential to form a secure attachment with a primary caregiver and healthy emotional development. 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). These behavioral and emotional difficulties can lead to further disruptions in care as children's behavioral and emotional difficulties are one of the major reasons for disruption of a foster care placement (Oosterman, Schuengel, Slot, Bullens, & Doreleijers, 2007).

Since infants and toddlers soon come to view the caregiver providing for their daily emotional and physical needs as their primary attachment figure, reunification with parents or placement in an adoptive home constitutes another attachment disruption. Increase in mental health problems and psychiatric emergencies have been associated with disruptions in attachment relationships with foster parents (Lawrence, et al., 2006; Pilowsky & Kate, 1996). Repeated disruptions in caregivers can lead to Reactive Attachment Disorder of Infant or Early Childhood, a psychiatric disorder in which the child exhibits severe disturbances in relationships with caregivers (American Psychiatric Association, 1994).

Disruptions in attachment relationships also affect the child's physiological functioning. Young children who experience disruptions in caregiving exhibit alterations in hypothalamic-adrenal-pituitary (HPA) axis activity (as assessed by diurnal patterns of salivary cortisol activity), the physiological system that is associated with response to stress, sleep, and ability to fight off infections (Fisher, Stoolmiller, Gunnar, & Burraston, 2007). The more neglect and disruptions in foster care placements they experience, the greater the likelihood they will exhibit these alterations. These alterations in HPA axis activity are associated with sleep difficulties, the child's ability to cope with subsequent stressors, and the child's vulnerability to illness.

### **Reducing attachment disruptions**

Allowing young children to stay with their mothers in prison or during residential treatment for substance abuse can reduce attachment disruptions (Harris, 1992; Wobie, Eyler, Conlan, Clarke, & Behnke, 1997). In addition, it provides an opportunity to offer interventions to improve the quality of the parent-child attachment relationship.

Concurrent planning, one feature of the Adoption and Safe Families Act (ASFA), can also reduce further disruptions in attachment relationships. 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 a concurrent plan for the child's long-term placement if reunification efforts fail. Concurrent planning has the potential to limit the number of 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.

Also, according to ASFA guidelines, the length of time for biological parents to make significant progress on the goals outlined by the reunification plan is typically twelve months, though judges have the ability to make exceptions. This time limit is consistent with children's need for a stable, continuous relationship with a primary caregiver.

## **Maintaining attachment relationships with parents while in foster care**

Young children in foster care face two big challenges: forming a positive attachment relationship with their substitute caregivers and maintaining an attachment relationship with their biological parents. Both goals are extremely important to the child's short-term and long-term mental health. However, it is important to recognize how challenging it can be for young children and their caregivers to try to achieve these goals. Even young children with previously good relationships with their parents can become angry and detached following relatively brief separations.

Children and parents need the opportunity to maintain an attachment relationship, address negative interactions and feelings, and increase positive interactions. However, visits with parents can be upsetting to young children in foster care and disruptive to other aspects of their development. The majority of young children who visit their biological parents in their parents' home exhibit symptoms (toileting problems, sleep disturbance, aggressive behavior, clinging, and crying) before, during, and/or after these visits (Gean, et al., 1985). The difficulty in maintaining healthy attachment relationships with both a primary caregiver and a non-primary caregiver is not specific to foster care. Infants of separated and divorced couples who have overnight visits with their fathers, typically against their mother's wishes, 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. In both studies, the attitude of the current primary caregiver towards visitation affects the infant's adjustment to visitation. Situations where the primary caregiver believes they are placing the child in a potentially harmful situation have the potential to undermine their relationship with the child. Thus, visitation plans need to address both the need for frequent visitation with biological parents and the need for the visitation to occur in such a way that it is attentive to the child's developmental needs and the concerns of their current caregiver. For example, visits should not be scheduled during the child's regular nap time.

## **Improving parent-child relationships while child is in foster care**

When young children are placed in foster care, ASFA requires states to provide services that enhance parents' capacity to provide for their children's needs. Thus, foster care placement or risk of foster care placement can provide an opportunity to provide specialized services that improve the quality of the parent-child relationship. An intervention with research support in the child welfare population is Parent-Child Interaction Therapy (PCIT) (Chaffin, Funderburk, Bard, Valle, & Gurwitch, 2010; Timmer, Urquiza, & Zebell, 2006). This approach focuses on teaching the parent specific skills for improving the quality of the parent-child relationship. A therapist behind a one-way mirror communicates with the parent through a transmitter in the parent's ear

while they are interacting with their child. This allows the therapist to provide ongoing feedback in order to change the parent's pattern of interaction with the child. In the first phase of the therapy, child-directed interaction, parents are coached in skills that use child-led play to improve the quality of the interaction. In the second phase, parent-directed interaction, parents are coached in methods of safe, effective discipline. In a study where the majority of the children were in foster care, children whose parents received PCIT were more likely to be reunified with their parents and, after controlling for reunification rates, less likely to be subsequently abused or neglected by their parents (Chaffin, et al., 2010).

### **Risk of unresponsive care in foster care**

The quality of care children receive in foster care is a major factor in the type of relationship they develop with the foster parent and their psychological adjustment. 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. Factors associated with the quality of the child's attachment with the foster parent include the foster mother's attachment style, the foster mother's responsiveness to the child's attachment needs, the foster parent's commitment to the child, and the foster mother's delight in the child (M. Dozier, Higley, Albus, & Nutter, 2002).

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 (Mary Dozier, Stoval, Albus, & Bates, 2001). That is, foster mothers with a secure attachment style provide care that leads to a secure attachment relationship with the foster infant. However, with toddler placements, the child-foster mother relationship reflects the child's previous attachment experiences. 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). Subsequent research has confirmed these initial observations (Zeanah, Smyke, Koga, & Carlson, 2005). In some parts of the U.S. the lack of a sufficient number of foster families has led to the use of group care. Thirteen to eighteen percent of children placed in group settings in California from 1988 to 1995 were under age six (Berrick, Needell, Barth, & Jonson-Reid, 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 further contributing to the likelihood of children in these settings receiving unresponsive and inconsistent care.

### **Improving the responsiveness of foster care**

In the past decade, there has been significant progress in identifying interventions that improve foster parents' ability to respond to the attachment and mental health needs of young children in foster care. Three interventions with research supporting their efficacy with children in foster care and their foster parents are: Parent-Child Interaction Therapy (PCIT), Attachment and Bio behavioral Catch-up (ABC), and Multidimensional Treatment Foster Care for Preschoolers (MTFC-P) (M. Dozier, et al., 2002; M. Dozier, Peloso, Lewis, Laurenceau, & Levine, 2008; Fisher, et al., 2007; Timmer, et al., 2006). As noted above, there is research on the efficacy of PCIT when conducted with the biological parents of children involved in the child welfare system. There is also research on the efficacy of PCIT when conducted with the foster parents of children involved in the child welfare system. Specifically, children who are involved in PCIT with their foster parents exhibit decreases in both disruptive behavior and symptoms of anxiety and depression (Timmer, et al., 2006). Research has not yet examined the outcomes associated with providing PCIT to both biological and foster parents but such a model would appear to be consistent with the goals of ASFA to develop concurrent plans for the child's long-term placement, address the child's mental health needs, and ensure biological parents have the opportunity to remediate parenting difficulties that led to the child's placement in foster care. PCIT with both the biological parents and the current caregivers also addresses the child's need for maintaining or building positive relationships with their biological parents and building positive relationships with their current caregivers.

Another model that has been found to improve the functioning of young children in foster care is Attachment and Biobehavioral Catch-up (ABC). This intervention has been studied in foster children aged 15 to 24 months. ABC helps foster parents provide nurturing responsive care to the child and a predictable interpersonal environment (M. Dozier, et al., 2002). This intervention has been found to help normalize HPA axis functioning in young children in foster care (M. Dozier, et al., 2008).

Multidimensional Treatment Foster Care for Preschoolers (MTFC-P), an intervention for children aged 3 to 6 in foster care, is a comprehensive approach that teaches foster parents to maintain a warm, positive approach to managing the child's behavior, provides individual treatment to address the child's behavior in preschool or day care, provides therapeutic playgroup sessions to facilitate school readiness, and works with the child's biological parents or adoptive parents to provide a warm, positive approach to managing the child's behavior if the child is moved to a new placement (Fisher, et al.,

2007). MTFC-P has been found to reduce disruptive behavior, decrease disruptions in foster care placements, and improve HPA axis functioning (Fisher, et al., 2007).

## Conclusions

Safeguarding the physical safety of infants and toddlers in foster care is not enough. It is important to also address the attachment and mental health needs of young children in foster care. Both the child's need for continuity of attachment 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, it is important to provide interventions that maximize the possibility of 1) the child experiencing sensitive responsive care with the alternative caregiver, 2) addressing the child's attachment and mental health needs within the context of their current relationships with caregivers, and 3) the biological parent receiving interventions that improve the quality of parent-child interactions.

While placement in foster care is associated with significant psychological risks for young children, it can also be an opportunity. Specifically, there is the opportunity to provide evidence-based interventions that have the potential to significantly improve the child's long-term psychological adjustment by improving the quality of their relationships with primary caregivers. Individuals involved in the child welfare system can increase the availability of these evidence-based interventions by advocating for their availability in their communities. One example of the impact of such advocacy is the increase in the availability of PCIT for children involved in Iowa's child welfare system. In the past 4 years, almost 100 Iowa therapists providing services to children in the child welfare system have been trained in PCIT. The increased availability of this evidence-based intervention is the result of the advocacy and joint planning efforts of individuals involved in Iowa's child welfare system, judicial system, community mental health system, university system, private agencies, and state government.

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