Children and Youth Services Review 35 (2013) 1071–1077

Contents lists available at SciVerse ScienceDirect

Children and Youth Services Review

journal homepage: www.elsevier.com/locate/childyouth

Sibling relationships and internalizing symptoms of youth in foster care ☆

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ARTICLE INFO

Article history:
Received 29 January 2013
Received in revised form 15 April 2013
Accepted 16 April 2013
Available online 2 May 2013

Keywords:
Foster care
Trauma
Mediation
Perceptions of sibling relationship quality
Adolescents
Internalizing symptoms

ABSTRACT

Compared to the sibling literature of the general population, little is known about sibling relationships of youth in foster care. The current study aimed to report on sibling relationships among youth in foster care, and investigate the potential protective nature of sibling relationships of those who have experienced trauma on the expression of internalizing symptoms among a nationally representative sample of 152 adolescents in foster care. Results indicated that the large majority of the sample was currently separated from their sibling. Of those who were not living with their sibling, nearly three quarters saw their sibling monthly or less frequently with one third of the sample reporting never having any contact with their sibling. In addition, bootstrapping methods were used to determine if sibling relationships mediated the effect of trauma on internalizing symptoms. Results indicated that a positive sibling relationship significantly mediated this relationship. Implications of these findings are discussed.

1. Introduction

Siblings play a significant role in development and well-being (Kim, McHale, Crouter, & Osgood, 2007), and during adolescence in particular, positive relationships with siblings can serve as a protective factor against consequences associated with exposure to risks (Soli, McHale, & Feinberg, 2009). Although mental health correlates of quality sibling relationships among youth in the general population have been well established by researchers (Gamble, Yu, & Kuehn, 2011; Tucker, McHale, & Crouter, 2008; Yeh & Lempers, 2004), the effects of sibling relationships among youth in foster care have been under studied. Given that youth in foster care are known to have heightened exposure to risks, and have increased prevalence of mental health problems (McCrae, 2009; Tarren-Sweeney, 2008) it is important to understand the potential protective nature of sibling relationships among this population.

1.1. Living in foster care

Over 400,000 children are currently living in foster care (AFCARS, 2010). Children are often placed in foster care because courts have deemed it too dangerous for them to continue to live in their homes (Lawrence, Carlson, & Egeland, 2006). As such, youth involved with the child welfare system have likely encountered some degree of trauma (McCrae, 2009), either due to the abuse or neglect experienced prior to placement in foster care, and/or experiences following placement in foster care (Holland & Gorey, 2004). Tarren-Sweeney (2008) reported that whereas experiencing a trauma in any form was a significant predictor of mental health problems, overall exposure to multiple traumatic events was the strongest predictor of mental health problems among youth in foster care. Similarly, in a study of 457 adolescents exposed to family violence (i.e., child abuse and/or parental domestic violence), those in the dual exposure group experienced significantly higher internalizing problems compared to those with exposure to one form of violence (Moylan et al., 2009). Thus, beyond examining whether or not a child has been exposed to a traumatic event, is important to consider the level of trauma experienced.

Given the positive correlation between levels of trauma and mental health concerns, it is perhaps unsurprising that youth in foster care have an increased risk for internalizing symptoms (Dunleavy & Leon, 2011; Heflinger, Simpkins, & Combs-Orme, 2000; McCrae, 2009). Internalizing symptoms include depression, anxiety, withdrawal, and somatic complaints (Heflinger et al., 2000). Longer-term consequences of internalizing problems can be serious and include the development of mood and anxiety disorders, drug use, and suicidality (Hughes & Gullone, 2007). These consequences are of concern, particularly given that estimates suggest that one-third of youth in foster care have clinically significant internalizing problems ranking above the normed 90th percentile for their age (McCrae, 2009).

Adolescents, in particular, may be most likely to demonstrate internalizing symptoms. Findings from a locally representative sample

☆ This document includes data from the National Survey on Child and Adolescent Well-Being, which was developed under contract with the Administration on Children, Youth, and Families, U.S. Department of Health and Human Services (ACYF/DHHS). The data were provided by the National Data Archive on Child Abuse and Neglect. The information and opinions expressed herein reflect solely the position of the authors. Nothing herein should be construed to indicate the support or endorsement of its content by ACYF/DHHS.

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0190-7409/$ – see front matter © 2013 Elsevier Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.childyouth.2013.04.021

of 330 children in foster care indicated that adolescents were at highest risk for clinically significant internalizing problems (37%) compared to youth of other ages; there were no significant differences in internalizing problems based on race, or length of time in foster care (Heflinger et al., 2000). Several of these findings were supported in a nationally representative study of 2852 children involved with the child welfare system (although the children may or may not have been removed from the home). Again, no differences in rates of internalizing problems were found in relation to race or ethnicity, and adolescents were most likely to have clinically significant scores on the internalizing subscale of the Child Behavior Checklist (CBCL; Achenbach, 1991) compared to children of other ages (McCrae, 2009).

1.2. Sibling relationships

Positive sibling relationships have been associated with a decreased likelihood of internalizing problems (Gamble et al., 2011), and higher self-esteem (Yeh & Lempers, 2004). In contrast, sibling relationships characterized as having sibling conflict (Gamble et al., 2011), overt (i.e., physical) and relational (i.e., manipulation) aggression (Yu & Gamble, 2008), and a lack of sibling support (Branje, van Lieshout, van Ake, & Hasalenger, 2004; Milevsky & Levitt, 2005) have been predictive of increased levels of internalizing problems. Sibling rivalry has been associated with greater feelings of loneliness and depression and a lower sense of self-worth (Stocker, 1994), and younger siblings who report less intimacy in their relationship with their siblings scored higher on internalizing scales (Dunn, Slomkowski, Beardsall, & Rende, 1994).

Specific to youth in foster care, sibling relationships have the potential to be the most significant relationship in their lives (Herrick & Piccus, 2005; Shlonsky, Bellamy, Elkins, & Ashare, 2005). When children are removed from their home, the presence of a sibling with whom they have a strong relationship may help maintain a sense of emotional continuity and safety (Shlonsky, Webster, & Needell, 2003). Ward (1984) emphasized that the presence of a sibling helps mitigate the uncertainty of placement in foster care by having one predictable element. Moreover, siblings placed together may be more comfortable with their placement in foster care because of the support they receive from their siblings (Leathers, 2005).

Policies support the placement of siblings together in foster care. Specifically the Fostering Connections to Success and Increasing Adoptions Act of 2008 section 206 requires reasonable efforts be made to:

(A) place siblings removed from their home in the same foster care, kinship guardianship, or adoptive placement, unless the State documents that such a joint placement would be contrary to the safety or well-being of any of the siblings; and
(B) in the case of siblings removed from their home who are not so jointly placed, to provide for frequent visitation or other ongoing interaction between the siblings, unless that State documents that frequent visitation or other ongoing interaction would be contrary to the safety or well-being of any of the siblings (42 USCA section 671(a)(31)).

Although the intent of such policies is to support sibling relationships, estimates indicated anywhere from 23% to 75% of children are placed without their siblings (Leathers, 2005; Staff & Fein, 1992; Tarren-Sweeney & Hazell, 2005; Timberlake & Hamlin, 1982). Because the federal government does not systematically collect data specific to siblings (Herrick & Piccus, 2005), knowledge about placement status and frequency of contact with siblings rests upon these varying estimates.

The potential lack of daily contact with siblings may be an important factor for adolescents in foster care. Although "closeness" is a dimension of positive sibling relationships among adolescents (Hsiu-Chen & Lempers, 2004), and daily interactions with siblings may play a formative role in relationship quality (Brody, 1998), siblings in foster care may not see each other regularly. As such, family transitions associated with placement of youth in foster care may be a vulnerable time for sibling relationships (Drapeau, Simard, Beaudry, & Charbonneau, 2004).

Unfortunately, not much is empirically known about sibling relationships and mental health outcomes among youth in foster care. For instance, McCormick's (2010) review of research on sibling relationships of youth in foster care identified only two studies, and among those only one was related to mental health outcomes. The limited research that has been conducted is primarily focused on outcomes associated with placement trends (e.g., whether or not siblings live together in a foster home; James, Monn, Palinkas, & Leslie, 2008; Leathers, 2005). Specifically, findings from a study of the impact of the transition to foster care upon sibling relationships indicated that older siblings were less likely to be placed together and had lower levels of perceived closeness to their siblings (Drapeau et al., 2004). Sibling relationships were measured by how much contact siblings had with one another and caseworkers' perceptions of siblings' level of closeness per caseworker report (Drapeau et al., 2004).

To our knowledge, the only known study to examine the association between quality of sibling relationship on internalizing symptoms specifically among youth involved with the foster care system (Linares, Li, Shrout, Brody, & Pettit, 2007), reported results contrary to what is known about sibling relationships among youth in the general population. Results indicated that the quality of sibling relationship did not significantly predict depressive symptoms per child report. These findings, however, may not be generalizable to the population of youth in foster care because the sample was limited to youth in a particular area of the US. Given the known importance of sibling relationships among the general population, there is a need for research examining correlates of sibling relationships specific to youth in foster care using nationally representative samples.

1.3. Ambiguous loss and youth in foster care

Youth involved with the child welfare system often experience a considerable amount of confusion (Festinger, 1983) about what placement in foster care means for their lives. Youth in foster care face a unique dilemma of being separated from their families and subsequently may experience a variety of additional losses associated with this separation. These losses may include the loss of their family home, school, peers, or even their siblings. Past research has demonstrated that removal from a sibling can heighten the strains associated with being placed in out-of-home care (Leathers, 2005). Youth who are separated from siblings may experience a loss of identity, self-esteem, and safety (Herrick & Piccus, 2005; Unrau, Seita, & Putney, 2008). These strains may lead to further displacement within the foster care system (Jane Addams Hull House Association, Executive Summary 2001 as cited in Edward, 2011).

Boss (2004) defines ambiguous loss "as an unclear loss—a loved one missing either physically or psychologically" (p. 235). Boss further suggested that this ambiguity in families can be created as a result of system ambiguity or unawareness about whether an individual is in or out of the family (Boss, 2004). The ambiguity can be the result of a lack of knowledge regarding the status of a family member—an unawareness of whether they are temporarily gone or gone forever and individuals may experience several losses at one time (Boss, 2004), as is the case for youth in foster care. Experiencing ambiguous loss can lead to negative outcomes such as experiencing stress, confusion, and causing individuals and systems to be more vulnerable. In addition, a lack of awareness about the status of a family member can lead to increased levels of depression and anxiety (Boss, 2004).

Ambiguous losses can generally be categorized into two types; physical absence with psychological presence or psychological absence with physical presence (Boss, 2004). For the purpose of this