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The role of cultural dissimilarity factors on child adjustment following foster placement

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ABSTRACT

Understanding the cultural factors associated with children's experiences in foster care is important because they may contribute to child psychological adjustment to foster placement. Despite considerable public policy debate of the role of ethnicity on foster placement decisions, there are virtually no empirical studies about the contribution of cultural dissimilarity factors on child psychological adjustment such as internalizing and externalizing problems shortly after children enter non-kinship placement.

Using a sample of N = 106 ethnic minority children (clustered in 62 families), we hypothesized that the number (ranging from 0 to 5) and types (i.e., ethnic status, country of birth, and spoken language) of cultural dissimilarity factors between biological and foster families contribute to child internalizing symptoms (CDI depression and LSD loneliness) and externalizing problems (ECBI conduct) after considering family and agency clustering and adjusting for confound variables (child age, gender, and severity of child maltreatment).

Results showed that a higher number of dissimilar types and certain types contributed to lower scores in child psychological adjustment. Dissimilar ethnic status between caregivers contributes to CDI depression and LSD loneliness symptoms while dissimilar spoken language between caregivers contributed to ECBI conduct problems in the foster home. These results inform the public policy debate of transethnic placements for children involved in the foster care system.

1. Introduction

In 2010, nearly half a million (408,425) children were placed in foster care (Adoption and Foster Care Analysis Report [AFCARS], 2010). While placing a child in foster care provides a temporary safe environment for abused or neglected children, all too often, their life is tumultuous and unstable. Shortly after children are removed from their homes and over the following three years about half (46%) meet diagnosis for separation anxiety disorder (Linares, Li, et al., 2010; Linares, Rhodes, & Montalto, 2010) suggesting that children experience considerable distress related to family loss and separation. Children placed in foster homes are at a greater risk of delayed development, have problems with behavioral regulation, and suffer from higher rates of internalizing and disruptive behavior disorders (Chipungu & Bent-Goodley, 2004; Linares, Li, et al., 2010; Linares, Rhodes, et al., 2010; Pecora et al., 2000; Russell, Cutrona, Rose, & Yurko, 1984). After placement in foster homes, many children continue to experience social isolation and family instability (Bass, Shields, & Behrman, 2004; Pecora et al., 2000).

Responding to historical gaps in the adoption of African-American children from foster homes, the Multiethnic Placement Act amended by the Interethnic Adoption Provision of 1996 (MEPA-IEP; http://www.acf.hhs.gov/programs/cb/pubs/mepa94/mepachp3.htm) was designed to prohibit routine consideration of race, color, and national origin in the foster placement process as a ways to improve adoption rates of ethnically minority children freed for adoption. As a remedy to high rates of minority children lingering in the foster care system, this legislation mandated that cultural factors may only be considered on an individualized basis when necessary to protect the best interests of the child. MEPA-IEP also encourages the active and diligent recruitment of foster and adoptive parents of all backgrounds that reflect the ethnic and racial diversity of children for whom foster and adoptive homes are needed. Following MEPA-IEP legislation, our local child welfare system endorsed the notion that '*a placement must be reflective of, and responsive to, a child's specific culture, religion, and background* (*Principle 6c; http://www.nyc.gov/html/acs/downloads/pdf/stats_placement_report.pdf; retrieved May 20, 2011*); consistent with this principle in 1999, 76% of children in NYC were placed in ethnically 'compatible homes' (http://www.nyc.gov/html/acs/downloads/pdf/stats_placement_report.pdf; retrieved May 20, 2011).

Ethnic compatibility of biological and foster families may facilitate the child's positive ethnic identity. Research suggests that individuals identify themselves ethnically on the basis of appearance and group

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membership (Phinney, 2003; Phinney & Ong, 2007). Ethnic identity is "that part of an individual's self-concept which derives from [his] knowledge of [his] membership of a social group (or groups) together with the value and emotional significance attached to that membership" (Phinney & Ong, 2007). Ethnic identity is an aspect of self-concept which begins to develop in early childhood and serves as a protective factor enabling individuals to be resilient against social adversity and discrimination (Phinney, 2003). A stronger and more positive connection to an individual's ethnic group predict higher self-esteem, academic achievement, psychological adjustment, coping abilities, and lower levels of depression and loneliness (Hollingsworth, 1997; Umana-Taylor, Bhanot, & Shin, 2006; White et al., 2008).

Ethnic dissimilarity in foster placement may also contribute to fewer ethnically compatible social networks for the child (Peplau & Perlman, 1982). Diminished social support networks may leave children unprotected to buffer symptoms of loneliness, social isolation, and depression (Sumer, Poyrazli, & Grahame, 2008). Children in foster care are often conflicted by dual loyalties as they wish to develop a sense of belongingness which may further interfere with positive ethnic identity formation (White et al., 2008). For ethnic minorities, the development of a positive ethnic identity is more complex because beyond navigating new interpersonal relationships, individuals must also deal with their minority status within the majority culture (White et al., 2008).

Cultural dissimilarity, particularly in the use of spoken language, may also be a risk factor for increased child conduct problems because cooperative parenting practices between biological and foster caregivers may be more challenging when caregivers do not share the same ethnic or language background. Unknown to each other until the placement event, the visiting biological parent and the foster caregiver must learn to share the child's affection and loyalties, acknowledge their parental differences, and negotiate disagreements involving permanency goals, family visitation, and daily routines such as discipline, homework, grooming, and recreation activities. Caregivers who share a similar ethnic background, country, and language may negotiate these co-parenting tasks easier, while dissimilar parents (on the basis of ethnicity, country of origin, or spoken language) may find these new tasks more difficult. Positive co-parenting practices (e.g., cooperation, negotiated conflict, and low triangulation) has been found to be related with fewer conduct problems (Linares, Li, et al., 2010; Linares, Montalto, Rosbruch, & Li, 2006; Linares, Rhodes, et al., 2010; Montalto & Linares, 2011).

Despite the critical need to inform the public policy debate in the child welfare system, controlled studies of the contribution of cultural dissimilarity factors (types) on child adjustment to foster care remain rare. This research is a step in this direction. In this study, cultural dissimilarity types in foster care refers to the mismatch or incompatibility regarding ethnic self-identification, country of birth, and preferred language spoken between the child and foster parent, and the biological and foster parent. The purpose of this study is to investigate the contribution of cultural dissimilarity between biological and foster families in types (i.e., ethnic background, country of birth, and spoken language) and number (i.e., the number of different types) on reported child emotional and conduct problems in the foster home. We hypothesize that cultural dissimilarity factors (separately and in combination) between biological and foster families will be associated with child depression symptoms, feelings of loneliness, and conduct problems shortly after entering placement. We adjust for clustering in family (most children in the study were siblings), and agency (children were drawn from foster care sites) related to sampling procedures, demographic factors (age, gender), and the severity of child maltreatment history. The study advances existing developmental science by examining the association between cultural dissimilarities (in types and number of different types) between families and child behavior at a time of initial family fragmentation (i.e., foster placement) in a unique population of high-risk children.

2. Methods

2.1. Participants

The sample was selected from participants in a longitudinal study of N = 252 children (clustered in 95 families) which examined foster placement shifts, sibling relationship quality, and child outcomes in foster care (Linares, Li, Shrout, Brody, & Pettit, 2007). The children in the larger study entered foster care at one of thirteen participating foster care agencies in NYC; they were drawn from 560 sibling groups consecutively recruited during a 3-year recruitment period. Reflecting nationwide trends, in NYC over half of children (57.3%) enter care as a part of a sibling group (http://www.nyc.gov/html/acs/downloads/pdf/outcomes/ind2_quickview.pdf). From identified sibling groups, 20% were eligible for enrollment (n = 95); 2% refused.

The study sample is comprised of N = 106 children (clustered in 62 families: 28 with one child, 24 with two children; and 10 with three children) drawn from 9 foster care agencies. Children were between ages 7–15 and were selected because they were old enough to provide self-reports of internalizing symptoms (CDI depression and LSD loneliness) at the time of the baseline visit. On average, baseline assessments were obtained within 3-months of initial placement. Children in the study who were siblings were placed together in the same non kinship (i.e., with a caregiver who was a non-relative to the child) foster home.

Children mean age was 10.47 years (SD = 1.95) ranging from 7.7 to 15.0 years. The gender distribution of this sample (55% male) resembles the national foster care population (53% male). According to official records which conformed to the NYS legal definitions of child maltreatment (neglect, physical abuse, and sexual abuse), children were classified as 76% neglected, 20%, physically abused, and 4% sexually abused. Children came from family households of low socioeconomic status. Foster parent had an average of <12 years of education; approximately one third were on public assistance; and approximately one third resided in government-sponsored housing.

2.2. Procedures

Written informed consent was gathered from biological parent, foster parent and child assent was obtained from children ≥7-years of age according to approved IRB protocols from New York University, and local and state Department of Social Services (foster care agency approval was also granted for those agencies with IRB bodies). Multi-informant data were gathered via face-to-face interviews in the foster home from the foster parent, the child, and the biological parent (interviewed in her home or agency). Study outcomes included self-report measures of child depressive symptoms and peer loneliness; and foster parent-reported conduct problems in the foster home. Type of child maltreatment was gathered from Child Protective System (CPS) official records kept at the agency.

2.3. Measures

2.3.1. Predictor variables

Cultural dissimilarity between biological and foster families was assessed by type (mismatched ethnicity, country of birth, and spoken language) and number of dissimilar types:

2.3.2. Ethnicity

Participants were asked to report on their ethnicity using one of the following categories: African-American, Latino, Caucasian, West-Indies, African, Asian, or Mixed. About one quarter of children (26%) identified themselves as mixed ethnicity. Among them, 46% were Latino and African-American, 33% were Latino or African-American and other, while 21% were Caucasian and other. Child ethnic self-identification data were obtained from the child verified by his/her biological parent