Adoption and fostering

Jill Hodges

Abstract

Children adopted in infancy do not generally stand out from community samples with regard to rates of disturbance. Foster children are at high risk of psychiatric difficulty, as are children adopted after infancy from the care system. Both groups are likely to have suffered abuse and/or neglect before entering care, as well as losses and discontinuities of carer. Post-traumatic symptoms, and difficulties in forming attachments and relationships, are the mental health difficulties most particularly related to these earlier adversities. Systematic evaluation of the various treatment approaches to attachment difficulty is lacking, but certain approaches are clearly contra-indicated. Support for adoptive and foster parents of these children is an essential part of their treatment.

Keywords adoption; attachment disorder; fostering; looked after children; maltreatment; trauma

Adopted and foster children are a very heterogeneous group. What they have in common is that they are brought up in families other than their birth family, and have often, though not invariably, suffered earlier maltreatment and the loss of earlier attachment figures.

Adopted children range from those adopted as infants to those placed as much older children, after periods in foster care and, often, failed attempts at rehabilitation to their family of origin. Infant adoptions of UK-born children by unrelated adopters are now relatively rare, though adoption of infants from overseas has increased. Most children adopted by unrelated adopters are older, looked-after children, who have suffered the damaging experiences that led to their leaving their families of origin as well as the further losses likely as they move within the care system.

Foster children, again, comprise a wide range of backgrounds and experiences. What follows is not relevant to temporary placements, where there are no concerns about the birth parents' care of the children (e.g. children briefly accommodated in foster homes because other care is unavailable during a parent's hospitalization). Rather, it applies to children in long-term foster placements, under a Care Order, where it is intended that they remain until they are 18; it also applies to children who may spend a long period in foster care on an Interim Care Order while Care Proceedings are under way to determine their future placement, which in 5–6% of cases will be adoption.

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Foster children

National statistics give a figure of 42,000 children in foster care at 31 March 2007, out of a total of 60,000 looked-after children in England; 62% of foster children were 10 or more years old. Around one-sixth are fostered by a relative or friend, but most live with unrelated carers.

Psychiatric difficulties

Foster children are much more likely to show psychiatric difficulties than children living in private households, even when these children suffer significant deprivation. A recent study examined socio-demographic characteristics and psychopathology by type of placement among children looked after in Britain by local authorities, comparing them with deprived and non-deprived children living in private households.[1] 46.4% of looked-after children had at least one International Classification of Diseases (ICD)-10 psychiatric diagnosis, compared with 14.6% of deprived and 8.5% of non-deprived children living in private households. Children in residential care showed the highest rates of disturbance, but 38.6% of children in foster care showed psychiatric difficulties. Foster children showed somewhat higher rates than children placed in kinship care, but considerably lower rates than looked-after children placed with their biological parents.

'Looked after' status was independently associated with nearly all types of psychiatric disorder but was most strongly associated with disorders in which environmental factors appeared to have a leading role, such as post-traumatic stress disorder and conduct disorder. Educational difficulties and neurodevelopmental disorders were also more prevalent among looked-after children than deprived and non-deprived children in private households. Literacy and numeracy problems were correlates of all disorders except depression among looked-after children, whereas global learning disability was related only to pervasive developmental disorders and generalized anxiety disorder. Older children were more likely to have anxiety disorders, post-traumatic stress disorder, depression and conduct disorder, whereas younger children were more likely to have oppositional defiant disorder, hyperkinetic disorder and separation anxiety disorder. Girls were more likely to be diagnosed with post-traumatic stress disorder and boys with hyperkinetic disorder, and conduct or oppositional defiant disorder. Prevalence of disorder was increased where there were many recent changes of placement.

The difficulties of children in foster care may relate both to experiences in the care system itself and to factors before they entered care. To begin with the latter, neurological changes have been described in children subjected to pre- and neonatal stress and maltreatment, as well as in those maltreated in childhood, and these changes may be related to some of the children's difficulties, including aggression, overactivity and underattainment. Psychiatric disorder in the birth parents would clearly be a risk factor. In the study outlined above[1] no data were available on this risk factor, but it appears unlikely to account for the enormous

discrepancy in rates of psychiatric difficulty between looked-after children and others. Only 6% of the children studied entered care because of any type of parental illness, and the authors note that even if mental illnesses in the biological parents were shown to correlate with psychiatric disorder in the children, a biological or genetic basis would not necessarily be indicated. Mental illness can impact on parenting practices, and because the children studied entered the care system at a mean age between 7 and 8 years, their difficulties could as well indicate exposure to maladaptive parenting. A large part of the children's difficulties are likely to be related to the reasons why they were removed from the care of their birth families, including abusive or neglectful parenting.

With regard to the impact of experiences in the care system itself, these include moves and changes of carer, which have been shown to correlate with psychiatric difficulty. They also include, even in stable long-term foster care, a sense of difference from children growing up in their own families, and the lack of a sense of permanent belonging within the family. The latter may be improved by Special Guardianship, introduced by the Adoption and Children Act 2002, and aimed at providing permanence in a legally secure placement for children who cannot return to their birth families, but where adoption is unsuitable and where, usually, links with the birth family are retained as they are in foster placements.

A proper medical, family and developmental history may often be lacking. Foster carers often have rather little information about the child's history with which to make sense of their behaviour – less than is commonly available to adopters, where the giving of information is systematized by the British Association for Adoption and Fostering (BAAF) forms.

Educational underattainment

According to the 2006 figures from the Department for Children, Schools and Families (DCSF) and the Department for Innovation, Universities and Skills (DIUS), 27.6% of looked-after children eligible for full-time schooling had statements of special educational needs, compared with 2.9% for the whole child population. Compared with school-age children in general, looked-after children show markedly lower educational performance at Key Stage 1, declining further at Key Stages 2 and 3, and have much poorer GCSE or GNVQ attainments. Children who have been in care at any point are already a severely disadvantaged group (likely to be from larger, low-income families, with a single parent or a father in semi- or unskilled manual work, and living in overcrowded housing). They would be at risk of lower attainment whether or not they became foster children; but foster care (even long-term settled placements in middle-class families) does not remedy this disadvantage. Attainment may be further impaired by moves within care and consequent changes of school, non-attendance, emotional stress and difficulties, lack of help with schoolwork, and sometimes lack of liaison between schools and foster carers, as the latter do not have parental responsibility for a child. Beside the limitation of subsequent life chances inherent in poor educational attainment, the study described above showed that carer-reported learning difficulties were frequently an independent predictor of psychiatric disorder.

Educational underattainment among foster children is particularly marked in children who have experienced early abuse and/or neglect, even if they are in settled long-term placements. A study of fostered 8–14-year-olds concluded that children's early histories, before entry to care, can profoundly affect their educational achievement in middle childhood, and that more than 'normal' family life and 'normal' parental interest may be necessary to compensate for earlier deprivation. Greater-than-average input from the schools was associated with some progress, but scarce resources mean that this tends to be discontinued once a child's worst educational problems have been alleviated.

Adoption

Children adopted in infancy

From the 1970s, there was a sharp fall in the number of UK infants given up for adoption. Very few adoptions of UK infants by non-relatives now take place, and the figures for adoption from care in 2007 show that only 5% of placements were of children aged less than 1 year old – under 170 in total. However, there are more than three hundred intercountry adoptions a year, generally of infants and very young children, the largest individual sources being China, Russia, India, Guatemala, and the USA.

Studies of community samples, both longitudinal and cross-sectional, show that most infant-adopted children are within the normal range of functioning and adjustment. As a group, they do at least as well as children in other situations, and better than children in the kinds of family situation to which adoption might have been considered as an alternative including single parenthood where the mother had initially requested adoption for the child. These studies have not pointed to any consistent pattern of differences in behaviour and adjustment between infant-adopted children and others, but tend to find externalizing problems, including aggression and hyperactive behaviour, and some school adjustment difficulties. Those differences found are generally small, in relation to differences accounted for by demographic variables. Longitudinal studies indicate that the risk of adjustment problems (relative to non-adopted children) is greater in middle childhood to early adolescence (Table 1).

An adoptive family environment acts as a developmental protective factor for adopted children whose biological parents abused alcohol, had a criminal record, or had a heritable mental illness and thus can be regarded as genetically 'at risk'. Adopted children show lower rates of criminal or antisocial behaviour, psychiatric hospitalization, and alcohol abuse than their biological parents, or siblings who remained with these biological parents. However, these rates are still higher than for non-adopted children in families equivalent to the adoptive families in socioeconomic status.

Although in community samples adopted children do not stand out as a group with difficulties, they are over-represented in clinical populations (both outpatient and inpatient) relative to their representation in the population as a whole. This is true even for infant-adopted children. Some part of the explanation may lie with possible genetic and pre- and peri-natal risk factors, including neurological changes, which have been described in children subjected to prenatal and neonatal stress, as well as those maltreated in childhood. These factors may related to some of the commonly found behaviour difficulties, including

