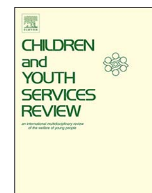
Children and Youth Services Review 84 (2018) 159–167

Contents lists available at ScienceDirect

Children and Youth Services Review

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



Instability in the lives of foster and nonfoster youth: Mental health impediments and attachment insecurities☆

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ARTICLE INFO

Keywords:
Foster youth
Residential instability
School instability
Mental health
Attachment

ABSTRACT

Foster youth are at risk for negative mental health and psychosocial outcomes, including when they are on the brink of emancipation from care into self-sustained adulthood. Factors believed to affect outcomes among foster youth include residential and school instability. Although frequent moves to new homes and schools are common for youth living in poverty, instability for foster youth involves not only changing homes and schools but often also changes in caregivers, thus putting foster youth at risk for disrupted attachment relationships. For the current study, structural equation models examined links between instability, mental health problems, and attachment insecurities in foster and at-risk nonfoster youth. A model containing instability provided a better fit to the data than a model containing foster care status only. Group comparisons revealed that instability was associated with posttraumatic stress disorder symptoms for foster but not nonfoster youth. Implications of instability in the lives of foster youth are discussed.

1. Introduction

Children in foster care are at risk for a variety of negative mental health outcomes, including prior to and after transitioning out of care. These include symptoms of posttraumatic stress disorder (PTSD) and problems with emotional functioning, such as increased depression and anxiety (Courtney & Dworsky, 2006; Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001; Havlicek, Garcia, & Smith, 2013). Compared to youth from the general population with similar demographics, foster youth experience significantly higher lifetime rates of PTSD symptomology (Pecora, White, Jackson, & Wiggins, 2009). Many foster youth have suffered child abuse and/or neglect (Child Welfare Information Gateway, 2013; U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2016), and such experiences can result in PTSD symptoms (Salazar, Keller, Gowen, & Courtney, 2013). Removal from home and subsequent placement moves can also be traumatic for foster youth (Chambers et al., 2017; Unrau, Seita, & Putney, 2008), contributing to symptoms of PTSD.

In addition to foster youth's elevated risk of negative mental health outcomes, foster youth are also at risk of developing insecure attachment with close others (Bowlby, 1980; Schofield & Beek, 2005), which may further increase their vulnerability to mental health problems (Bowlby, 1977; Conradi & Jonge, 2009). According to attachment theory, during distressing or anxiety-producing events, secure youth should exhibit proximity seeking to a trusted individual (Bowlby, 1977), whereas insecure youth are less likely to exhibit such behaviors (Mikulincer, Shaver, & Solomon, 2015). For many youth who are

☆ We thank the California Department of Social Services (CDSS) for providing data for this study. Administrative data were made available through the National Data Archive on Child Abuse and Neglect, Cornell University, Ithaca, New York. The National Youth in Transition Database (NYTD) survey for California (Phase 1) was conducted by the authors through Contract 09-2041 (Goodman, PI) between CDSS and the Regents of the University of California (UC). Nonfoster youth data collection was funded by an internal grant from UC Davis. Neither funding agencies, nor the National Data Archive on Child Abuse and Neglect, bear any responsibility for the analyses or interpretations presented herein. The opinions and conclusions expressed are solely those of the authors and should not be considered as representing the policy of the collaborating agencies or any agency of the California government.

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https://doi.org/10.1016/j.childyouth.2017.10.019
Received 20 June 2017; Received in revised form 16 October 2017; Accepted 16 October 2017
Available online 18 October 2017
0190-7409/ © 2017 Published by Elsevier Ltd.

nearing transition out of foster care (often a distressing and/or anxiety-producing event), not only are their existing attachments insecure, but also their access to social support and mental health resources will soon become even more limited than they have been (Courtney et al., 2001; Courtney & Dworsky, 2006; Cunningham & Diversi, 2012), placing them at further risk (Reilly, 2003).

During foster care, both negative mental health outcomes and insecure attachments may be further amplified by frequent placement changes that result in residential and school instability (Dolan, Casanueva, Smith, & Ringeisen, 2013; Festinger, 1983; Rubin, O'Reilly, Luan, & Localio, 2007; but see Berger, Bruch, Johnson, James, & Rubin, 2009). Instability in the form of frequent placement changes makes it difficult to form secure attachments with foster parents, and as youth mature into adolescence, with peers (Farineau, Wojciak, & McWey, 2013). Moreover, instability is associated with low self-esteem, delays in school performance, and reduced life satisfaction (e.g., Fernandez, 2007; Reilly, 2003). Even children who enter foster care with low or no known internalizing and externalizing problems show an increase in total problem behaviors in direct correlation with their number of subsequent placements (Newton, Litrownik, & Landsverk, 2000).

The purpose of the current study was to gain a better understanding of the possible role of instability in predicting mental health problems and attachment insecurities in foster youth. Our measure of instability combined both residential and school changes. We chose residential changes to reflect instability in homes, families, caregivers, and neighborhoods, whereas school changes captured disruption in peer and teacher relationships. As such, we evaluated relations among foster care status (foster youth vs. at-risk age-matched nonfoster youth), instability, mental health problems, and attachment insecurities in the hope of gaining insight into predictors of negative outcomes for foster youth.

1.1. *Instability*

Family instability is associated with adverse outcomes for children over and above negative life events (Marcynyszyn, Evans, & Eckenrode, 2008). Residential and school instability are two key contributions to such findings. Instability among child and adolescent populations is linked to a range of negative mental health and educational outcomes (Jelleyman & Spencer, 2008; Keller, Cusick, & Courtney, 2007). Although frequent relocation is a common experience for many at-risk populations, including economically disadvantaged segments of society, instability is an especially common problem for foster youth. According to the National Survey of Child and Adolescent Well-Being (NSCAW), more than 25% of foster children experienced placement disruptions within their first 18 months in care (Dolan et al., 2013). Foster children report that frequent moves have a substantial negative effect on their mental health (Ellermann, 2007; Keller et al., 2007). Conversely, stable placement is associated with better outcomes: For example, interviews with social workers indicate that children's expressions of unhappiness, nervousness, anxiety, and worry *decrease* over time when they are in a stable placement (Barber & Delfabbro, 2005). Although selection bias likely influences an understanding of foster youth's reactions to placement instability (Berger et al., 2009), a "cascading effect" may nevertheless still be operative in which mental health problems at first placement contribute to instability, and the instability exacerbates these existing mental health problems and possibly creates even more.

A fundamental concern regarding instability for children in foster care is that moving is frequently accompanied by a change in caregiver and severed ties with possible attachment figures (Fernandez, 2007). A change in caregiver causes added stress that is not always experienced by nonfoster youth. According to Bowlby (1980), when children lose their primary caregivers, it is imperative to their mental health to form secure attachments with alternate caregivers. Forming secure attachments to new caregivers can be difficult when placement disruptions are frequent.

Instability among at-risk nonfoster youth and among foster youth also involves changing schools. However, foster youth typically experience the added stress of school instability more frequently than nonfoster youth (Blome, 1997). Repeated school changes can be harmful to youth well-being. It is estimated that every time a foster youth changes schools, it takes 4 to 6 months to recover academically (Casey Family Programs, 2007). Moreover, for foster youth, not only are relationships with attachment figures, such as caregivers, severed, but attachment relationships with teachers and peers are disrupted, leaving youth more vulnerable. Thus, school instability is widely considered a source of distress for foster youth (e.g., Hango, 2006).

Conjoined, residential and school instability result in accumulation of risk (Sameroff & Seifer, 1990). Thus combined residential and school instability may be associated with more severe adverse mental health outcomes and attachment insecurities (e.g., Leonard, Stiles, & Gudiño, 2016) compared to residential or school instability alone.

1.2. *Attachment across the life course*

According to attachment theory (Bowlby, 1969, 1988), individuals develop systematic patterns of expectations, beliefs, and emotions concerning the availability and responsiveness of close others in the context of early experiences with caregivers. Over time these beliefs and expectations become internalized and form mental representations (i.e., internal working models) of the self and others in close relationships. Research indicates that individual differences in internal working models influence emotion regulation as well as individuals' perceptions of and coping with stressors and negative life events (e.g., Mikulincer & Shaver, 2016). Individuals who score high on one underlying dimension of attachment, *attachment anxiety*, experience high levels of distress when caregivers or close others are unavailable or unresponsive. This can be characterized by persistent fear of rejection or abandonment (Bartholomew & Horowotz, 1991). Anxious attachment in adulthood has been linked to a wide range of maladaptive outcomes, including PTSD and depression (Mikulincer, Florian, & Weller, 1993; Ogle, Rubin, & Siegler, 2015).

Individuals who score high on the second critical dimension of attachment, *attachment avoidance*, experience discomfort with close interpersonal relationships and tend to be chronically self-reliant (e.g., Fraley & Shaver, 1997). Attachment avoidance is associated with a broad range of negative outcomes, including reduced social support seeking (Simpson, Rholes, & Nelligan, 1992), affect regulation problems (Mikulincer, Shaver, & Pereg, 2003), increased depression (Wei, Russell, Mallinckrodt, & Vogel, 2007), and greater PTSD symptomology (Fraley, Fazzari, Bonanno, & Dekel, 2006). In contrast to individuals with anxious and avoidant attachment, individuals with secure attachment, as indexed by low levels of attachment anxiety and avoidance, appraise stressful events as less threatening (Mikulincer & Florian, 1998) and seek social support (Mikulincer et al., 1993), which enable them to cope more effectively with stress (Solomon, Ginzburg, Mikulincer, Neria, & Ohry, 1998).

Although attachment orientations that are established in childhood theoretically influence the developmental course of emotion regulation and behavior in close relationships throughout adulthood (Bowlby, 1988; Fraley & Shaver, 2000; Hazan & Shaver, 1987), research on the longitudinal stability of attachment indicates that individuals' attachment orientations can be modified by later experiences. In particular, the attachment security of children's bonds with their primary caregivers may decline following negative changes in the family environment and exposure to adverse life events, such as divorce, child maltreatment, and removal from the home into foster care (Belsky & Fearon, 2008; Lewis, Feiring, & Rosenthal, 2000; Thompson, 2013). Moreover, changes in school interrupt positive relationships with teachers, who can also promote secure attachment (e.g., Bergin & Bergin, 2009; Howes & Ritchie, 1999). Compared to youth in normative

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